Notice of Meeting

HEALTH & WELLBEING BOARD

The legal status, role and detail about the governance of the Health & Wellbeing Board can be found in Part B, Article 5 of the Council Constitution. Full terms of reference for the Board can be found in Part C, Section D. More information about the work of the Board is listed on the Council's website www.lbbd.gov.uk

Tuesday, 5 November 2013 - 4:00 pm

Venue: Conference Room, Barking Learning Centre
2 Town Square, Barking, IG11 7NB

Date of publication: 28 October 2013

Graham Farrant
Chief Executive

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Membership for 2013/14:

Councillor M Worby (Chair)	(LBBD)
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Councillor J Alexander	(LBBD)
Councillor L Reason	(LBBD)
Councillor J White	(LBBD)
Anne Bristow	(LBBD)
Helen Jenner	(LBBD)
Matthew Cole	(LBBD)
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Martin Munro	(North East London NHS Foundation Trust)
Dr Mike Gill	(Barking Havering & Redbridge University NHS Hospitals Trust)
Chief Supt. Andy Ewing	(Metropolitan Police)
John Atherton (Non-voting member)	(NHS England)

Barking and Dagenham's Vision

Encourage growth and unlock the potential of Barking and Dagenham and its residents.

Priorities

To achieve the vision for Barking and Dagenham there are five priorities that underpin its delivery:

1. **Ensure every child is valued so that they can succeed**

- Ensure children and young people are safe, healthy and well educated
- Improve support and fully integrate services for vulnerable children, young people and families
- Challenge child poverty and narrow the gap in attainment and aspiration

2. **Reduce crime and the fear of crime**

- Tackle crime priorities set via engagement and the annual strategic assessment
- Build community cohesion
- Increase confidence in the community safety services provided

3. **Improve health and wellbeing through all stages of life**

- Improving care and support for local people including acute services
- Protecting and safeguarding local people from ill health and disease
- Preventing future disease and ill health

4. **Create thriving communities by maintaining and investing in new and high quality homes**

- Invest in Council housing to meet need
- Widen the housing choice
- Invest in new and innovative ways to deliver affordable housing

5. **Maximise growth opportunities and increase the household income of borough residents**

- Attract Investment
- Build business
- Create a higher skilled workforce

AGENDA

1. **Apologies for Absence**

2. **Declaration of Interests**

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

3. **Minutes - 17 September 2013 (Pages 1 - 8)**

Business Items

4. **Commissioning GP Premises (Pages 9 - 14)**

5. **The 0-5 year Healthy Child Programme (Health Visiting) Service (Pages 15 - 32)**

6. **Public Health Commissioning Priorities 2014/15 (Pages 33 - 49)**

7. **Children and Families Bill (Pages 51 - 76)**

8. **The Care Bill (Pages 77 - 85)**

9. **Integration Transformation Fund 2015/16 (Pages 87 - 94)**

10. **Learning Disability Joint Health and Social Care Self Assessment Framework (Pages 95 - 102)**

11. **The Francis Report (Pages 103 - 107)**

12. **Tender of Specialist Domestic Violence Services (Pages 109 - 120)**

13. **Diabetes Scrutiny: Update on Delivering the Recommendations (Pages 121 - 128)**

Standing Items

14. **Sub-Group Reports (Pages 129 - 143)**

15. Chair's Report (Pages 145 - 149)

16. Forward Plan (Pages 151 - 155)

17. Date of Next Meeting - 10 December 2013 (6pm, Barking Learning Centre)

18. Any other public items which the Chair decides are urgent

19. 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 Health and Wellbeing Board, 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.***

20. Any other confidential or exempt items which the Chair decides are urgent

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 17 September 2013
(6:05 - 8:25 pm)

Present: Councillor M M Worby (Chair), Councillor J L Alexander, Matthew Cole, Councillor L A Reason, Anne Bristow, Councillor J R White, Helen Jenner, Frances Carroll, Martin Munro, Dr Waseem Mohi (Deputy Chair), Dr John, Conor Burke, Chief Superintendant Andy Ewing and Dr Mike Gill and John Atherton.

Also Present: Cllr C Geddes

Apologies: None.

36. Declaration of Interests

Martin Munro (Executive Director, NELFT) declared a pecuniary interest in agenda items 12 (Tender of Specialist Structured Day Provision) and 13 (Re-Tendering of the Stop Smoking Service) as NELFT will be bidding for the contracts under consideration.

37. Minutes (16 July 2013) and Matters Arising

The minutes of the meeting held on 16 July 2013 were confirmed as correct.

Further to minute 29, the Health and Wellbeing Board noted the comments from the Community Safety Partnership Board meeting and await the recommendations from the Domestic and Sexual Violence Strategic Group meeting on 28 September.

38. Focussing on Obesity

Matthew Cole (Director, Public Health) gave a presentation to the Board. The presentation outlined some of the work underway to tackle obesity and a top level plan for what the borough needs to do, or bring together, to dramatically improve its position.

The Board noted the approach of New York where a task force was established by the Mayor to get to grips with the problem. By bringing together partner organisations, government departments, and health organisations it was possible to make a significant impact. Political leadership to drive the agenda forward was especially important to the success of the task force as policy and legislation was developed with the goals of the task force in mind.

The Board also noted the London Borough of Lambeth's approach to tackling obesity which aimed to change the image of the borough and its population through the promotion of healthy lifestyle choices. Once the image was embedded, developing the service provision to improve people's outcomes was less difficult.

Dr John highlighted that a problem for GPs is a lack of awareness of services that could help obese people live healthier lifestyles. In the past there was a directory of services, but it is unclear whether all services in that directory are still running.

Dr John called for closer links between GPs and schools so that GPs could recommend children to participate in extra-curricular activities. Helen Jenner was confident that links between children's centres, schools and primary care could be strengthened.

The Health and Wellbeing Board agreed:

- that the H&WBB Forward Plan will be revised to focus on obesity with work streams of sub-groups following suit. As proposed in the report the Board will commit to this theme for a period of 18 months, after which point progress/impact will be reviewed.
- to hold an 'obesity summit' to bring together partners to define an approach to making a co-ordinated and concerted effort to tackle obesity.
- that the Executive Planning Group will take responsibility for ensuring that obesity features prominently in the Work Programme and that plans arising from the obesity summit are delivered.

39. Summary of Healthwatch Work Programme (2013/14)

Frances Carroll (Chair, Healthwatch Barking and Dagenham) presented the work programme to the Board, updated the Board on recent Healthwatch activity and provided the Board with details of forthcoming public events to engage with residents and to raise awareness about the existence and work of Healthwatch.

Dr Mohi (Chair, B&D CCG) recommended that Healthwatch might benefit from developing their work programme with input from the CCG to maximise impact and make consultations more robust. Dr Mohi also stated the importance of Healthwatch collecting intelligence from local people and using this to counter other more quantitative types of data.

Helen Jenner (Corporate Director, Children's Services) asked that Healthwatch takes account of existing mechanisms to engage with children and young people to avoid duplication or missing out on opportunities to improve participation.

Cllr Worby (Chair of the Board) asked how Healthwatch was using social media and its website to collect feedback, especially from younger people who are more inclined to engage digitally. Frances Carroll advised the Board that the Healthwatch website is still under development and there are some limitations as it must comply with Healthwatch England design principles. Those issues aside Frances was confident that Healthwatch will have an effective online platform from which to engage.

The Board noted that the development of an engagement strategy for the Board will help to link Healthwatch activities with what is going on elsewhere across the Partnership.

The Health and Wellbeing Board agreed:

- to note the work programme of Healthwatch Barking and Dagenham which identifies issues affecting the provision of Health and Social Care services to local people.
- to disseminate findings of Healthwatch reports through the H&WBB sub-groups with summary reports of Healthwatch findings and activities

presented to the H&WBB roughly every six months.

40. Quarter 1 Performance

Matthew Cole (Director, Public Health) presented the performance report to the Board.

Matthew Cole drew the Board's attention to indicator 20 (Percentage of eligible population that received a health check in last five years) where the target of 15% is unmet.

Dr John (Clinical Director, B&D CCG) explained to the Board some of difficulties in relation to improving uptake of health checks and stated the CCG's commitment to see improvement against this indicator.

Conor Burke (Accountable Officer, B&D CCG) and Dr Mohi (Chair, B&D CCG) stated their preparedness to re-commission the service under a different provider if performance does not improve. Dr Gill expressed his view that health checks are best integrated within primary care and the current provider should be given every opportunity to improve before alternative providers are considered.

Before switching provider Dr Mohi felt it was important to understand the drivers behind the low take up of health checks so that problems could be addressed at the source. How health checks are publicised to the community is one such problem that the Board suggested should be reviewed.

The Board noted that some GP practices have 90% take up of health checks proving that there are pockets of good performance to build from.

Cllr Worby (Chair of the H&WBB) expressed her disappointment that only 63% of looked after children had received an annual health check (indicator 13). Helen Jenner advised the Board that performance on this indicator is being addressed and by November 2013 it is expected that 80% will have received their health check. Helen Jenner pointed to increased case loads as a reason behind current performance figures.

The Health and Wellbeing Board noted the commentary of the performance report, the performance dashboard and the exception reports on areas of concern.

41. Urgent Care

Conor Burke (Accountable Officer, B&D CCG) updated the Board about the work of the Urgent Care Board. Further to the content of the report, Conor Burke updated the Health and Wellbeing Board on the following matters:

- Following an announcement from the Secretary of State £7 million of funding will be made available to support the local emergency care system over the winter period. The Urgent Care Board will be deciding how best this money is used.
- Following a clinical review of the emergency care system the Urgent Care Board can confirm that the proposal to cease blue light ambulances to King George's Hospital will not be taken forward.
- The Urgent Care Board has signed off a 'Demand and Capacity Plan' for emergency care in the sector.

Frances Carroll (Chair, Healthwatch Barking and Dagenham) asked about the arrangements for local Heathwatch representation on the Urgent Care Board. Cllr Worby (Chair of the H&WBB) recommended that the Healthwatch organisations of Barking and Dagenham, Redbridge, and Havering have discussions about the representation arrangements before escalating the matter to the Urgent Care Board.

Matthew Cole (Director, Public Health) commented that the borough's measures to reduce seasonal flu will have a significant impact on how the health and social system handles winter pressures. Matthew Cole asked for assurances that staff working at BHRUT will receive flu jabs in advance of the winter period.

John Atherton (Head of Assurance, NHS England) commented that NHS England is suitably assured that winter pressures will be handled well as planning and additional funding has been sorted earlier in the year. However, certain aspects of the local A&E improvement plans need expediting before winter pressures begin.

The Health and Wellbeing Board noted the progress of the Urgent Care Board. The Board agreed to receive a further update at its meeting on 10 December 2013.

42. GP Profiles

Dr Mohi (Chair, B&D CCG) introduced the report to the Board. In his opening remarks Dr Mohi stated how important the GPOS tool is for the CCG to drive improvements and standardisation in quality across all practices.

Cllr White (Cabinet Member for Children's Services) raised his concern that a practice in Chadwell Heath which has a patient list predominantly consisting of Barking and Dagenham residents but operates outside of the Barking and Dagenham Clinical Commissioning Group's remit, and is considered by the NHS as a Havering practice. Several Board Members felt that this arrangement undermined the ability of the CCG to influence service delivery at this practice and felt that it should be re-categorised as a Barking and Dagenham practice. John Atherton (Head of Assurance, NHS England) offered to raise this issue through NHS England on behalf of the borough.

The Health and Wellbeing Board noted the current progress of Barking and Dagenham CCG against the delivery of improved primary care services in the borough.

The Board requested that the data from the GPOS system is shared with the Board for the purpose of scrutinising GP performance.

43. Pharmaceutical Needs Assessment: A New Statutory Requirement of the Health and Wellbeing Board

Matthew Cole (Director, Public Health) presented the report to the Board and outlined the Local Authority's responsibilities to develop and maintain a Pharmaceutical Needs Assessment (PNA) for the borough. The Board noted that the development of the PNA is a lengthy process and to meet the requirements to produce the PNA for April 2014 will mean beginning the work now.

Matthew Cole explained to the Board that the PNA gives the borough the opportunity to determine what additional services pharmacies in the borough will provide, this means that pharmacy services can be tailored to suit the borough's health and wellbeing priorities.

The Health and Wellbeing Board agreed:

- To approve the presentation to a future meeting of the Board an updated pharmaceutical services map, as required by regulation.
- To approve any supplementary statement to the PNA (as required by regulation) and to delegate a task and finish group in Public Health to prepare this and present it to the Board.
- To delegate as a responsibility of the Public Health Programmes Board, the governance and delivery of the first PNA, taking into consideration the long planning cycle required.
- To approve the development of appropriate robust stakeholder engagement and consultation, and use of resource by the subgroup of the Board, in delivery of the PNA.

44. Allocation of Barking & Dagenham Reablement Funding 2013/14

Anne Bristow (Corporate Director, Adult and Community Services) presented the report to the Board.

The Board noted that the borough needs to improve its end of life care (EoLC) arrangements. Developing a strategy for EoLC will be an important step for improving as will pursuing 'gold standard' accreditation. It was noted that the St Francis Hospice is an outstanding provider of EoLC giving the borough a good platform from which to develop the EoLC offer.

Cllr Alexander expressed her concern that people in receipt of the substance mis-use social work support would lose this support when the service is withdrawn as the funding only lasts one year. Bruce Morris (Divisional Director, Adult Social Care) advised the Board that the service will be evaluated towards the end of its funding spell. It is possible to fund the service beyond 2013/14 if outcomes for users of the service are good.

The Health and Wellbeing Board agreed the expenditure of £650,000 for the proposals as set out in sections 2.2 and 2.3 of the report to improve re-ablement services and outcomes for residents.

45. The Francis Report: Progress Update

The Health and Wellbeing Board noted the report which was introduced by Conor Burke (Accountable Officer, B&D CCG). It was confirmed that the invitation for service user representatives would include Healthwatch Barking and Dagenham. It was noted that the task and finish group membership has been broadened to include provider organisations as this will help ensure the delivery of the agreed implementation plan.

46. Tender of Specialist Structured Day Provision

(Martin Munro advised that in view of his pecuniary interest in the matter he would

take no part in the discussions and he left the meeting prior to the consideration of the report.)

The Health and Wellbeing Board agreed:

- to approve the procurement of Structured Day provision, on the terms detailed in the report; and
- to delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer, LBBD to award the contract to the successful contractor upon conclusion of the procurement process.

47. Re-tendering of the Stop Smoking Service

(Martin Munro advised that in view of his pecuniary interest in the matter he would take no part in the discussions and he left the meeting prior to the consideration of the report.)

The Health and Wellbeing Board agreed:

- to approve the procurement process (jointly with the London Borough of Havering) for the Stop Smoking Service for the duration (including the option to extend the contract for up to one year) and upon the terms set out in this report.
- to delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer to award the contract to the successful contractor upon conclusion of the procurement process.

48. Health & Wellbeing Theme: Protection and Safeguarding

(i) Adult Social Care Local Account 2012/13

Having reviewed the content of the Local Account, the Health and Wellbeing Board agreed to approve the Local Account for publication. In doing so the Board agreed that sections about the views of service users will be moved to the front of the document for ease of reference.

(ii) Safeguarding Adults Board Annual Report 2012/13

The Health and Wellbeing Board noted the Safeguarding Adults Board (SAB) annual report and in doing so the following points were raised:

- 2012/13 saw the SAB make great efforts to raise awareness about safeguarding among the community. As a result LBBD has a high number of referrals. The SAB is pleased that residents feel comfortable to report abuses but at the same time this does make LBBD an outlier.
- All agencies have reviewed their internal safeguarding measures. The focus of work is now looking across agencies and the

robustness of the system as a whole.

- The safer places initiative was a major area of focus for the SAB in 2012/13.

(iii) Local Children's Safeguarding Board Annual Report 2012/13

The Health and Wellbeing Board noted the report and in doing so the following points were raised:

- Training for children's safeguarding is regularly updated to keep up with current events and incidents from other areas.
- The LSCB has used the failures of Mid-Staffordshire and Winterbourne View to examine how systems fall down and taking away relevant learning for children's safeguarding.
- The LSCB has a robust Child Death Overview Panel.
- The LSCB is in the process of embedding multi-agency auditing.
- The troubled families agenda was a major area of focus for the LSCB in 2012/13.

49. Report of Sub Groups

The Health and Wellbeing Board noted the reports of the sub-groups and agreed the proposal (Appendix 6) to establish a local task and finish group to investigate how the borough can increase the use of children's centres for children aged 0-2, in particular through the registration of births process.

50. Chair's Report

The Health and Wellbeing Board noted the Chair's Report.

51. Forward Plan (2013/14)

The Health and Wellbeing Board noted the items listed in the Forward Plan.

52. 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.

The Board **agreed** to exclude the public and press for the remainder of the meeting by reason of the nature of the business to be discussed which included information exempt from publication by virtue of paragraph **3** of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended).

53. Joint Assessment and Discharge Proposals

Bruce Morris introduced the report to the Board. As well as outlining the process for implementing the Joint Assessment and Discharge (JAD) proposals through the three borough's Health and Wellbeing Boards and the Integrated Care Coalition, Bruce Morris explained how the new service would simplify hospital discharges, make better use of resources, and improve integration.

The Board noted that identifying a host organisation for the service has been a difficult process as there are complexities due to the sums of money and numbers of staff involved. To ensure accountability and clarity in relation to service delivery it is recommended that the Integrated Care Coaltion partners enter into section 75 agreements with performance of the service monitored by an Executive Steering Group made up of Coalition partners.

Dr Gill (Medical Director, BHRUT) commended the development of the JAD and believed that outcomes for patients could be further improved by adding in quality standards. For example, Dr Gill suggested that all occupational therapy should be done in the home and that nursing care placements could only be given once a full assessment has been conducted.

Dr John (Clinical Director, B&D CCG) offered his support to the JAD proposal and encouraged innovations that improve integration. He felt that the JAD would result in speedy discharge from hospital which in the past has been problematic.

Anne Bristow (Corporate Director, Adult and Community Services) commented that there needs to be a consistent approach among professionals about the advice given to patients, especially from doctors. A Patient in hospital will tend to regard the advice of their doctor as more compelling than that of other professionals. It is therefore important that doctors offer advice that does not conflict with the advice of social work teams in relation to care issues

Dr Gill offered to collaborate on any training to help change the mind set of Hospital Trust employees working in the new set-up. He felt it was important to confront the culture of recommending patients to nursing or residential placements when the home setting with the right care package is the best environment following discharge.

The Health and Wellbeing Board agreed to delegate authority to the Corporate Director of Adult and Community Services to enter discussions with Coalition partners on the proposals and agree implementation.

54. Tender of Specialist Structured Day Provision - Appendix 1

See decision minute 46.

55. Re-tendering of the Stop Smoking Service - Appendix 1

See decision at minute 47.

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Commissioning GP Premises**
Report of NHS England	
Open Report	**For Decision**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Neil Roberts, Head of Primary Care, NHS England (London Region, North, Central & East)	**Contact Details:** Tel: 020 7932 3888 E-mail: neilroberts@nhs.net
Sponsor: John Atherton, Head of Assurance, NHS England	
Summary: The purpose of this paper is intended to give an overview of how decisions are taken with regard to commissioning GP premises. It is intended for wide and different audiences and so is general in approach. The processes described herein are applied the same way across the London Region of NHS England.	
Recommendation(s) The Health and Wellbeing Board is asked to: • Note the current approach to premises investments and consider how this approach applies locally. • Note the position of NHS England in developing an overarching Premises Policy.	

1 Background

1.1 As part of the national re-organisation of the NHS, Primary Care Trusts were abolished and the PCT Clusters closed down on 31 March 2013. New organisations were created to assume the Clusters' commissioning functions and responsibilities have been divided between:

- Clinical Commissioning Groups
- NHS England
- NHS Property Services Ltd

1.2 Some functions have also gone to Public Health England and to Local Authorities.

1.3 One of the functions of NHS England is to commission primary care services i.e. GP, Dental, Community Pharmacy and Optical services directly. This function is

carried out through Local Area Teams. In London these cover North, Central and East London; North West London and South London. The area team funds GP practices to provide medical services and also reimburses certain overhead costs including rent, rates and clinical waste services.

1.4 NHS Property Services Ltd has been established to manage all the former Primary Care Trust estate (about two thirds) not transferred directly to NHS Trusts (about one third) and provides strategic and operational management of NHS owned or leased property. As such they are responsible for agreeing lease and service charge with the local GP practices.

1.5 Generally speaking, GPs are responsible under the terms of their national contracts, to provide appropriate accommodation from which they provide their services. There is a small number of time limited primary care contracts where the commissioner has the responsibility to provide the accommodation.

2 NHS England and Single Operating Model (SOM)

2.1 NHS England as a national body is expected to work from national single operating models, so that the way business is transacted and the interaction with stakeholders is done in a similar way across England. There is a significant range of work underway nationally to deliver this SOM for GP premises arrangements. Some outline of this work is set out below:

- **"Principles of Best Practice"**

2.2. A suite of documents have been developed by a Primary Care Premises Experts Advisory group to support Areas Teams with decisions which include:

i. Procurement & Development of Primary Care Premises
ii. Public consultation and engagement arrangements for premises development
iii. Facilities Required For Minor Surgery in Primary and Community Care Settings
iv. Code of Practice on the prevention and control of infections and related guidance
v. Prevention and control of infections risk
vi. Premises and Infection Control audit
vii. Resilience and Emergency Planning in Primary and Community Care
viii. A Guide to Town Planning for NHS Staff
ix A Guide to the NHS for Local Planning Authorities
x. S106 and CIL effective partnership arrangements between LATs and Local Planning Authorities
xi. Handling and management of clinical waste
xii. Business Case prioritisation and approval process

These are currently in the final stages of development and will hopefully go through the Gateway process for approval during the autumn of 2013, alongside the Premises Policy.

- **Single Operating Model for Rent Reimbursement**

2.3. Current Market Rent forms have been developed and shared with Area Teams for implementation in May 2013. Comments and snagging issues are being collected from ATs and the forms will be reissued with updates in October 2013.

- **Developing a Primary Care Premises policy**

2.4. NHS England has commissioned the development of an overarching Premises policy; the first draft is likely to be out to consultation during October.

- **Clarify NHS Property Services' role**

2.5. An SLA has been drafted and shared with NHSPS. It is likely that this SLA will not be nationally implemented until April 2014; however some elements can be implemented prior to April 2014. Further clarity will follow once formal agreement has been reached.

- **Premises Directions**

2.6. Further development of premises directions are being negotiated by NHS Employers. It is envisaged that updated Directions will be re-issued in January 2014. These form the basis of what NHS England might reimburse under the GP contracts for premises costs etc.

- **Trade Waste**

2.7. There are inconsistencies within Area Teams across the country around who reimburses trade waste. The Central team is currently considering ways to standardise this process and will be part of contract negotiations with the General Practitioners' Committee of the BMA.

- **District Valuer SLA**

2.8. Final comments and issues are being discussed with the District Valuer's Office to ensure national service and support from the DV. Planned sign off of the SLA is autumn 2013 (the DV is used by the NHS to provide opinion etc. on levels of reimbursement on individual premises).

- **Understand baseline of all national capital and revenue commitments and pipeline business cases**

2.9. A national picture of the premises commitments is being captured. Decisions will be taken at an NHS England senior level of what the financial implications are and how premises developments can be supported for 2014/15.

London Region has identified the various schemes "in the pipeline".

- **Determine and agree a process to deal with prioritisation and approval of primary care premises developments**

2.10. A Project Initiation Document PID and supporting documents have been developed which are part of the Principles of Best Practice and it is intended that all applications for premises developments, including extensions and requests for additional room usage will follow this same PID process.

- **Strategy**

2.11. As part of the National Strategic Framework for Commissioning Primary Care, a Strategy workstream is currently developing NHS England strategic direction around premises which is being supported by the Premises Operational Group.

3 Current Approach to Premises Investments

3.1 In the absence of the completion of national Single Operating Models, London Region of NHS England is using a standardised interim approach that we believe is likely to be consistent with the new national process. This is described in the following paragraphs.

3.2 A request for development can arise from a number of sources (The list is not exhaustive):

- Local Authority in relation to new planning/population developments in an area
- NHS Property Services or NHS Trust related to development or disposal of NHS Estate
- LIFTCo or Community Health Partnerships (CHP)
- 3rd party developer with/without GP identified
- NHS England, CCG or other Body in relation to development of service strategy
- GP or other primary care contractor

…… and may be for a variety of reasons:

- New and significant population developments via re-generation schemes e.g. Canning Town, White City, Nine Elms
- Statutory closure of premises
- Growth of a practice so that accommodation is no longer fit for purpose
- Termination of leases
- Implementing strategic change in an area, etc.

3.3 Requests should be directed to the appropriate Area Primary Care Commissioning (PCC) Team (NC&EL, South, NW) at NHS England in the first instance.

3.4 The PCC team takes responsibility to convene a meeting of local interested parties as a Task and Finish Group to:

- Discuss what type of development is being considered
- Draw local information together, from local strategies, JSNA etc
- Share criteria for development of GP premises
- Give a preliminary view of viability in principle (e.g. not viable if local suitable NHS estate exists with void space).

3.5 The Group will agree

- How/what agency/GP commitment to a project is given <u>before</u> significant costs are incurred

- Complete a Project Initiation Document (PID) for Finance, Investment, Procurement & Audit Committee (FIPA) - a copy of the current national draft is attached at Appendix 1; London currently uses a variant of this which is not dissimilar.

- Decide where a business case is to be developed and by whom if FIPA agrees the PID

- Determine if capital or revenue only is involved as a different approvals route would need to .be used (different for capital and revenue only projects). The rest of the paper describes the route for revenue only projects which comprise the significant majority of GP premises business cases.

3.6 The PID once developed will go to an NHS England internal Screening Group which will consider the matter and make a recommendation to approve or not. The PID will then go to the next available meeting of the FIPA at NHS England. This Committee will take the decision whether a proposal should move forward to business case production. NHS Property Services will provide advice and technical support to NHS England.

3.7 The business case is prepared and submitted to PCC at NHS England and addresses the various criteria. Clinical and service case for change, benefits to be achieved, schedules of accommodation, leasing proposals and costings showing the revenue consequence, etc. are included. Case will need to show the outcome of engagement with key stakeholders.

3.8 The CCG will be asked for a view as to whether it supports the development (at both PID and business case stages). The CCG may also be asked for a financial contribution to the development dependent upon scale and scope of services to be delivered from the development. Any NHS England contribution to a GP development is solely for the delivery of NHS general medical services.

3.9 Once completed, the business case will be considered at the Screening Committee by primary care and finance colleagues and then go to FIPA for formal consideration. This Committee will decide whether the case should be approved and to what extent recurrent expenditure will be committed to the scheme. It will apply the prioritisation criteria current at the time of the consideration of the case and will have regard to the financial resources available to the Region.

3.10 By way of example, the criteria NHS England is using to determine the c160 “legacy cases” inherited from the former PCTs are set out overleaf:

Prioritisation Key

Description	Sub Category	Type of scheme
MUST DO	1a	Prior NHSLondon and/or PCT Board approval with contractual commitment/overhang from 12/13
	1b	Prior commitments based on previous approval by PCT Board/NHSL
	1c	Clinical imperative that we have to do this because they are urgent - e.g. lease expiry, unsuitable premises etc.
	1d	Scheme needs to be done due to local considerations/pressure
	2	Important schemes that need to be done but details are not worked up or known
	3	Other known schemes that are "nice to do"
	4	Ideas

These criteria will doubtless change once NHS England has worked through the legacy cases to enable NHS England to consider new requests. We know that a national prioritisation matrix is being developed so that in future all schemes are assessed in the same way.

3.11 NHS England will move to use the national models once they are finally produced. Having had significant input to their development, we do not expect the new national process to be wildly different.

3.12 NHS England will always be mindful of its legal obligations to commission safe and effective primary care services that meets the needs of local people and of its statutory fiscal duties

4 Conclusion

4.1 There is an interim process in place designed to handle all types of premises developments including large regeneration schemes. The Primary Care Commissioning Team should be the first point of contact to provide advice and guidance to navigate through the processes put in place.

5. Implications

5.1. Financial Implications

Financial implications of each business case are considered by NHS England at the Finance, Investment, Procurement & Audit Committee.

5.2. Legal Implications

None.

(Finance and Legal Implications completed by NHS England)

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**The 0-5 year Healthy Child Programme (Health Visiting) Service**
Report of NHS England	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Authors: Nicky Brown HV/FNP and Child Information Services, NHS England Gillian Mills, Children's Service Director NELFT	**Contact Details:** Tel: 0207 932 3824 E-mail: nickybrown1@nhs.net Tel: 0300 555 1201 ext 5053 E-mail: Gillian.mills@nelft.nhs.uk
Sponsor: John Atherton, Head of Assurance, NHS England	

Summary:

The purpose of this report is to provide the Health & Wellbeing board with an overview of Early Years Programme (Health Visiting) services in Barking and Dagenham which are now commissioned by NHS England following the NHS reforms which came into effect on 1 April 2013[1]. The health visiting service is provided by North East London NHS Foundation Trust (NELFT).

The national health visiting programme aims to improve the quality of services and health outcomes in the early years for children, families and their communities, through expanding and strengthening health visiting services, with an additional 4200 health visitors in post nationally by April 2015. For Barking and Dagenham this means an increase from 46.2 WTE in July 2011 to 87.7 WTE health visitors in March 2015.

The report provides a summary Early Years Programme (Health Visiting) services in Barking and Dagenham.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

(i) To note the progress against the Health Visitor Implementation Plan is on track to deliver the required outcomes and outputs and that in order to do so the service is undergoing significant service redesign.

(ii) To note the progress being made to deliver the national programme, which will considerably increase Barking and Dagenham's health visiting workforce by 2015, enabling NELFT to develop the capacity to deliver the Healthy Child Programme within the context of an integrated model with a view to improving children's health

[1] Commissioning of the Healthy Child Programme 0-5 will be transferred to local authorities on 1 April 2015

outcomes and reducing demand for targeted services.

1. Background and Introduction

Changes in Commissioning Responsibility

1.1. The Health and Social Care Act 2012 introduced a number of changes to the NHS which came into force on 1 April 2013. Significant changes in the responsibility for commissioning healthcare services have occurred as a consequence of this act. Clinical Commissioning Groups (CCG's) retained some commissioning responsibilities of Primary Care Trusts (PCTs), mainly areas of acute and community commissioning. Some areas transferred to other organisations e.g. the commissioning responsibility for the healthy child programme for children aged 0-5years and immunisations transferred to NHS England, while school nursing commissioning transferred to local authorities.

1.2. NHS contracts for public health services were transferred from the Primary Care Trust to the local authority on the 1 April 2013 without amendments to service specifications or budgets for the first financial year (2013/14).

1.3. The Council also has a duty to improve the strategic co-ordination across local NHS, social care, children's services and public health. The Barking and Dagenham Health and Wellbeing Board (H&WBB), a partnership board established with effect from 1 April 2013 as a result of the Act, is the means through which the Council will deliver this duty.

1.4. Appendix 1 includes further detail on the commissioning responsibilities of Clinical Commissioning Groups (CCGs), Local Authorities, NHS England and Public Health England.

Healthy Child Programme 0-5 and Health Visiting

1.5. There is much evidence to suggest that prioritising early childhood provides opportunities to add the most years to life expectancy and to reduce inequalities. As such, the H&WBB has included giving children the best start in life a key theme in its Joint Health and Wellbeing Strategy. Children's health services are crucial to this and will be of central importance to the local authority and to partners moving forward. The H&WBB will provide strategic direction to the development of children's health services locally as well as agreeing and overseeing any changes.

1.6. The 'Healthy Child Programme: Pregnancy and the First 5 Years of Life', published in 2009, sets out standards for delivery of a programme to improve the health and wellbeing of children as part of an integrated approach to supporting children and families using 'progressive universalism'. Health Visitors have a crucial role in ensuring that children have the best possible start in life and have been identified as the lead professional for delivery for the Healthy Child Programme (HCP 0-5) n partnership with other health and social care colleagues.

1.7. The Health Visitor Implementation Plan 2011-2015 was published in February 2011, and sets out the full range of services that families will be able to expect form health visitors and their teams. A refreshed document, 'implementing the Health Visitor Vision: 2013 Onwards' has been recently produced to solidify these aims and describe the role of the various key players in the new NHS landscape.

1.8. From April 2013, NHS England assumed responsibility for health visiting workforce growth and service transformation. As a single national organisation, however, NHS England will be responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality and outcomes across England, whilst still allowing for local tailoring of needs.

1.9. However, on 1st April 2015, the commissioning of health visiting will become the responsibility of the local authority public health function. NHE England London Region will work closely with local partners through Health and Wellbeing Boards and Children's Partnerships to help achieve the necessary co-ordination of commissioning of services for children in readiness for the handover of commissioning responsibilities to local authorities in 2015.

1.10. A London Health Visiting Transformation Board has been established to inform the transition of responsibility from NHS England to local authorities. The aims of this board are: to map the current provision of health visiting services across London including the deployment of health visitors and health visiting teams, the delivery of Healthy Child Programme and identification of high risk areas; and to model future service delivery of public health services for 0-5s, specifically health visiting and health visitors, including links with the 5-19 Healthy Child Programme and other early intervention services commissioned or provided by local authorities

1.11. In the meantime, the Barking and Dagenham Public Health team is in discussion with NHS England around being closely involved in the performance management of the Health Visiting Service prior to the transition of commissioning responsibility.

1.12. In September 2013 NHS England has commenced the collection of an Early Years and Immunisation minimum data set which will provide regular, and comparative, performance data on the service. This information will be disaggregated by borough, provider and general practice as well as by NELFT the provider.

1.13. Family Nurse Partnership (FNP), an intensive home-visiting programme for young first time parents who are considered at risk, has been provided in Barking and Dagenham since 2010/11. This separate service is also commissioned by NHE England and delivered by NELFT. The programme continues until the child is 2 years old and families on FNP do not form part of the caseload of Universal Health Visitors.

Current Service and Work Programmes

- **Growing the workforce**

1.14. In Barking and Dagenham, the Health Visiting service is delivered by North East London Foundation Trust (NELFT).

1.15. Analysis by NHS London in 2011 showed that the number of Health Visitors in Barking and Dagenham was insufficient to meet the needs of the children and families or deliver HCP 0-5 years.

1.16. Barking and Dagenham currently has 40.87WTE Health Visitors (HVs) in post. However, NHS London estimated that the borough would require 87.7WTE HVs in post by April 2015 to meet the needs of our children and families. This is a shortfall of 41.5WTE, doubling the current complement.

1.17. The national Call to Action (C2A) for Health Visitors has led to funding for 13 WTE additional posts in Barking and Dagenham in 2012/13 and NELFT is currently recruiting to existing vacancies as well as the 12/13 C2A growth allocation.

1.18. NELFT has been commissioned by NHS England to recruit a further 17.5 new C2A posts in 2013/14 on top of existing vacancies.

1.19. NHS England will support this with funding once the vacancy factor for NELFT is below 10% and the use of agency staff is below an agreed % which is still being discussed and awaiting agreement.

1.20. NELFT recognises that despite the improved number of health visitors appointed this year, recruitment into the Barking and Dagenham area still remains a significant challenge. Recognising this the trust has embarked on an exciting web based recruitment campaign (Open Up Possibilities[2]) that has successfully resulted in a significant increase in enquires and job applications from qualified and student health visitors.

1.21. A workforce strategy has been developed to support the recruitment of health visitors. The strategy includes:

- A 'grow our own' approach to developing health visitors within NELFT, with guaranteed employment upon successful completion of the Specialist Community Public Health Nursing degree (SCPHN).
- The development of a range of Band 7 special interest health visitor posts.
- A significant increase in the numbers of Practice educators.

1.22. The current average caseload of 0-5 year olds in the borough is 450 families per Health Visitor. This is higher than Laming recommendation caseload of 400 children per WTE Health Visitor, however the significant socio-economic, demographic and culturally diverse needs of the local population add considerable complexity to the health visitors work with families.

1.23. Delivery of the full Healthy Child Programme will not be possible until recruitment to all C2A posts has been completed. This will also reduce the average health visitor caseload to 228 families.

- **Professional mobilisation**

[2] http://www.nelft.nhs.uk/about_us/working/open_up_possibilities/health_visiting_open_up

1.24. Part of the Call to Action: Health Visitor Implementation Plan includes the engagement and re-energisation of the health visiting profession; promote learning and good practice, including building community capacity. Within Barking and Dagenham, health visitors have established excellent collaborative working relationships with Children's Centres and other early years settings. With the additional growth in health visiting posts, this will be further expanded to enhance activities to achieve better early identification and early intervention of problems relating to health, development and behavioural issues.

1.25. NELFT is particularly keen to introduce the evidence based MECSH programme into the health visiting service within Barking and Dagenham (Appendix 2).

1.26. Introduction of the MECSH programme would first require additional core training for health visitors to enhance their skills in breastfeeding support, working with vulnerable families, child and adult mental health, ante natal assessment, healthy lifestyles, obesity prevention and strengths delivery of the Healthy Child Programme.

1.27. In addition to the Call to Action requirements an integrated pathway of care is under development for all 0-5 community and mental health service provided by NELFT health visitors and primary mental health workers. This will be supported by a proposed reconfiguration of teams of multi-disciplinary staff across the six geographical clusters within Barking and Dagenham.

1.28. Further expansion of the integrated model of working will see NELFT 0-5 staff collaboratively delivering an Early Year's Service Model of care with Early Years Outreach Workers and Children's Centre's, ensuring that services are joined up and that when children and families are identified as requiring additional support, they receive the right evidence based interventions which are delivered as part of an integrated package of public services.

- **Service Delivery Core Offer**

1.29. Barking and Dagenham children and families can expect with the planned successful service developments that health visitors and their skill mix teams will deliver the new four levels of the Family Offer:

  - Your Community – Building Community Capacity
  - Universal Services
  - Universal Plus
  - Universal Partnership Plus

1.30. The Health Visiting service provides the Health Child Programme (HCP) for babies and children. The HCP checks currently are New Birth Visit (10 -14 days old), 1 year review and 2 year review. Families are offered appointments for these when they reach required age. There are also open Child Health clinics running in different locations which are drop ins. Families can get their babies weighed, checked and raise any concerns they have with the Health Visitor and get appropriate advice.

1.31. New Birth Visits ideally need to take place by the time the baby reaches 14 days (Target 95%). Currently 88% is undertaken within 14 days which is slightly below the target. The new birth visit is key to identifying safeguarding issues (pregnancy/new birth associated with domestic violence) and post natal depression.

1.32. In 2012/13, 2158 of 1 year olds received a Health Review and 2649 received a 2 year Health Review. Due to a data error the organisation is unable to give percentages at this time.

1.33. Health Visitors are also responsible for supporting women with continuing to breastfeed (after initiation which is supported by midwives).

2. Summary

2.1. NELFT has a comprehensive programme to develop the Barking and Dagenham Health Visiting service offered in line with the nationally set strategy. NELFT is fully engaged with NHS England to confirm the transition process for the transfer of service commissioning arrangements to Barking and Dagenham Local Authority as smooth as possible minimising the impact on families. NELFT is also using this opportunity to explore innovative approaches to utilise its health visiting skill mix workforce to deliver a broadened service offer that would support key commissioning challenges e.g. reducing obesity and supporting the shift of care from acute hospitals into community settings.

3. Mandatory Implications

3.2. Joint Strategic Needs Assessment

The report is well aligned to the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

3.3. Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The transition of the Health Visitor service, currently commissioned by NHS England is integral to the Strategy's delivery on improving child health and early years. The transition must take place by April 2015 so plans to ensure the commissioning and delivery functions are transferred seamlessly must be in place in 2014/15. Training for staff such as Maternal and Early Childhood Sustained Home Visiting Programme (MECSH) should be considered as part of the transition process.

3.4. Integration

The responsibility for Health Visiting Services will transfer to the Local Authority in April 2015. Plans are currently underway to examine the most effective models of integration into existing services across the partnership. A local group led by the

Local Authority will be formed to commence the integration planning with the CCG, NELFT and NHS England. Implementation will be overseen by the Children's Trust and the Health and Wellbeing Board through the Children's Health and Maternity Sub Group.

3.5. **Financial Implications**

(Implications completed by John Atherton, Head of Assurance, NHS England)

None at present.

3.6. **Legal Implications**

(Implications completed by John Atherton, Head of Assurance, NHS England)

None at present.

4. Background Papers Used in Preparation of the Report:

— Health Visitor Implementation Plan 2011-2015

— Healthy Child Programme: Pregnancy and the First 5 Years of Life

— Implementing the Health Visitor Vision: 2013 Onwards

5. List of Appendices:

— APPENDIX 1: Commissioning Responsibilities post 1 April 2013

— APPENDIX 2: Maternal Early Childhood Sustained Home-visiting – at a glance

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APPENDIX 1

Commissioning Responsibilities post 1 April 2013

Services Commissioned by Clinical Commissioing Groups	Services Commissioned by NHS England	Services Commissioned by Local Authorities	Services Commissioned by Public Health England
•Urgent and emergency care (including 111, A&E and ambulance services)	•GP contract services	•Healthy Child Programme (including school nursing)	•Health improvement support for local authorities and NHS England
•Elective hospital care	•Healthy child programme, health visitors and Family Nurse Partnership	•Contraception outside of GP contract, testing and treatment of sexually transmitted infections, sexual health prevention and advice	•Current functions of Health Protection Agency
•Maternity and including ante-natal and newborn screening (excluding neo-natal ICU)	•Newborn blood spots	•National child measurement programme and weight management services	•Emergency preparedness (including pandemic influenza)
•Children's health care services (e.g. CAMHs and children's community services)	• Immunisation prorgammes	•Drug and alcohol misuse services	•Health intelligence and information
•Services for children with learning disabilities	•Primary care pharmacy contract services	• Population level interventions to reduce and prevent birth defects (with Public Health England)	
•Children's continuing healthcare services	•Primary care opthamlic contract services	•Dental screening and oral health improvement	
	•All dental services		
	•Health services for people in custodial settings (e.g. secure children's homes)		
	•Specialised and highly specialised services		

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Maternal Early Childhood Sustained Home-visiting

MECSH At a Glance

About MECSH

Sustained and structured home visiting

- International evidence has shown that home visiting programs comprising intensive and sustained visits by nurses during pregnancy and over the first two years of life promote child health and family functioning.
- MECSH draws together the best available evidence on the importance of the early years.
- The MECSH program is delivered as part of a comprehensive, integrated approach to services for young children and their families.

The Maternal Early Childhood Sustained Home-visiting (MECSH) program is a structured program of sustained nurse home visiting for families at risk of poorer maternal and child health and development outcomes. It was developed as an effective intervention for vulnerable and at-risk mothers living in areas of socio-economic disadvantage.

The MECSH program draws together the best available evidence on the importance of the early years, children's health and development, the types of support parents need, parent-infant interaction and holistic, ecological approaches to supporting families to establish the foundations of a positive life trajectory for their children. The MECSH program requires organisations, and practitioners to work differently with families, to truly act on the rhetoric of prevention and early intervention to improve outcomes for some of the most vulnerable families.

The MECSH program is delivered as part of a comprehensive, integrated approach to services for young children and their families. The program is delivered by child and family health nurses who are embedded within universal child and family health nursing services. The program is managed by universal child and family nursing services and embedded within the broader child and family health services system.

Child development parent education DVD
Mother expecting her first child watching the *Learning to Communicate* program.

History of the MECSH Program

Originally titled the Miller Early Childhood Sustained Home visiting program, MECSH was a program of intervention and research conducted in the Miller/Green Valley (postcode 2168) area of south western Sydney, NSW, Australia. The MECSH intervention and trial were funded by the Australian Research Council (LP0560285), Sydney South West Area Health Service, NSW Department of Community Services and NSW Department of Health. It was the first Australian randomised trial to determine the impact of a comprehensive sustained nurse home visiting program commencing antenatally in a population group living in an area of known disadvantage.

MECSH Program Components

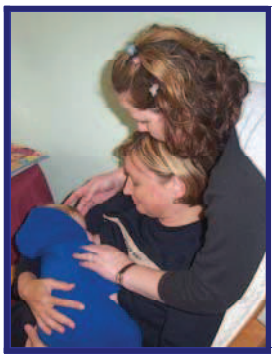
1 **Supporting mother and child health and wellbeing**, including observation and support of child, maternal and family health and development, parent-infant interaction, and provision of primary health care and health education.

2 **Supporting mothers to be future oriented and aspirational** for themselves, their child and family.

3 **Supporting family and social relationships** within the extended family, with the family's communities and with other health and social services.

4 **Additional support in response to need** including interventions by the MECSH nurse and additional support accessed through the tiered service system.

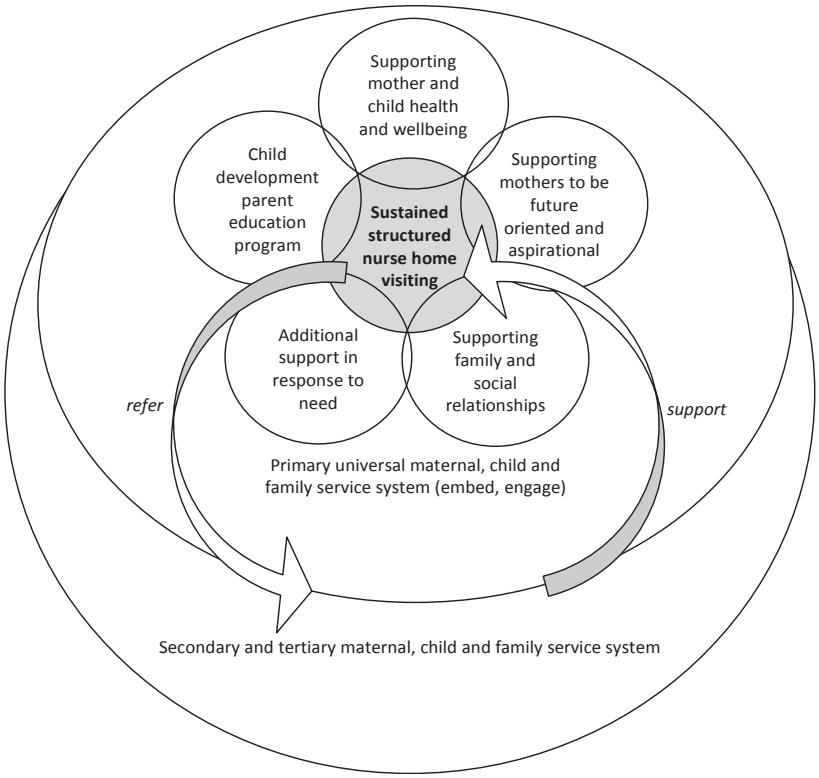
5 **Child development parent education** program delivery. This is a structured program of parent education about child development. The MECSH trial used the "Learning to Communicate" (LtC) program.



Breastfeeding support

The nurse is supporting the mother in breastfeeding. The MECSH program builds on and extends core child and family health nursing practice by providing greater opportunity for the mother and nurse to engage in supportive activities within the family home.

MECSH Program Model



Mother reading with baby

The child development parent education program supports parents to support the development of their child. It particularly builds on everyday activities that parents can do with their children, and provides parents with ideas, such as early reading, which are key to development. Observe how engaged this young baby is with the book.

The MECSH Program is delivered through three program activities:

1 **Home visiting.**

2 **Group activities for MECSH families.**

3 **Engagement with and referral to other services and supports.**

MECSH Program Goals

The home visiting components of the MECSH program intervention consists of at least 25 home visits by the same MECSH program child and family health nurse during the remainder of pregnancy and the first 2 years post birth. The program goals are:

- **Improve transition to parenting by supporting mothers through pregnancy**. This includes providing support with the mother's and family's psychosocial and environmental issues, supporting the health and development of the family including older children, providing opportunity for discussion, clarification and reinforcement of clinical antenatal care provided by usual antenatal midwifery and obstetric services, and preparation for parenting.
- **Improve maternal health and wellbeing by helping mothers to care for themselves**. Guided by a strengths-based approach, the nurse will support and enable the mother and the family to enhance their coping skills, problem solving skills and ability to mobilise resources; foster positive parenting skills; support the family to establish supportive relationships in their community; mentor maternal-infant bonding and attachment; and provide primary health care and health education.
- **Improve child health and development by helping parents to interact with their children in developmentally supportive ways**. This includes supporting and modelling positive parent-infant interaction and delivery of a standardised, structured child development parent education program.
- **Develop and promote parents' aspirations for themselves and their children**. This includes supporting parents to be future oriented for themselves and their children, modelling and supporting effective skills in solving day to day problems and promoting parents' capacities to parent effectively despite the difficulties they face in their lives.
- **Improve family and social relationship and networks by helping parents to foster relationships within the family and with other families and services**. This includes modelling and supporting family problem solving skills, supporting families to access family and formal and informal community resources and providing opportunities for families to interact with other local families.

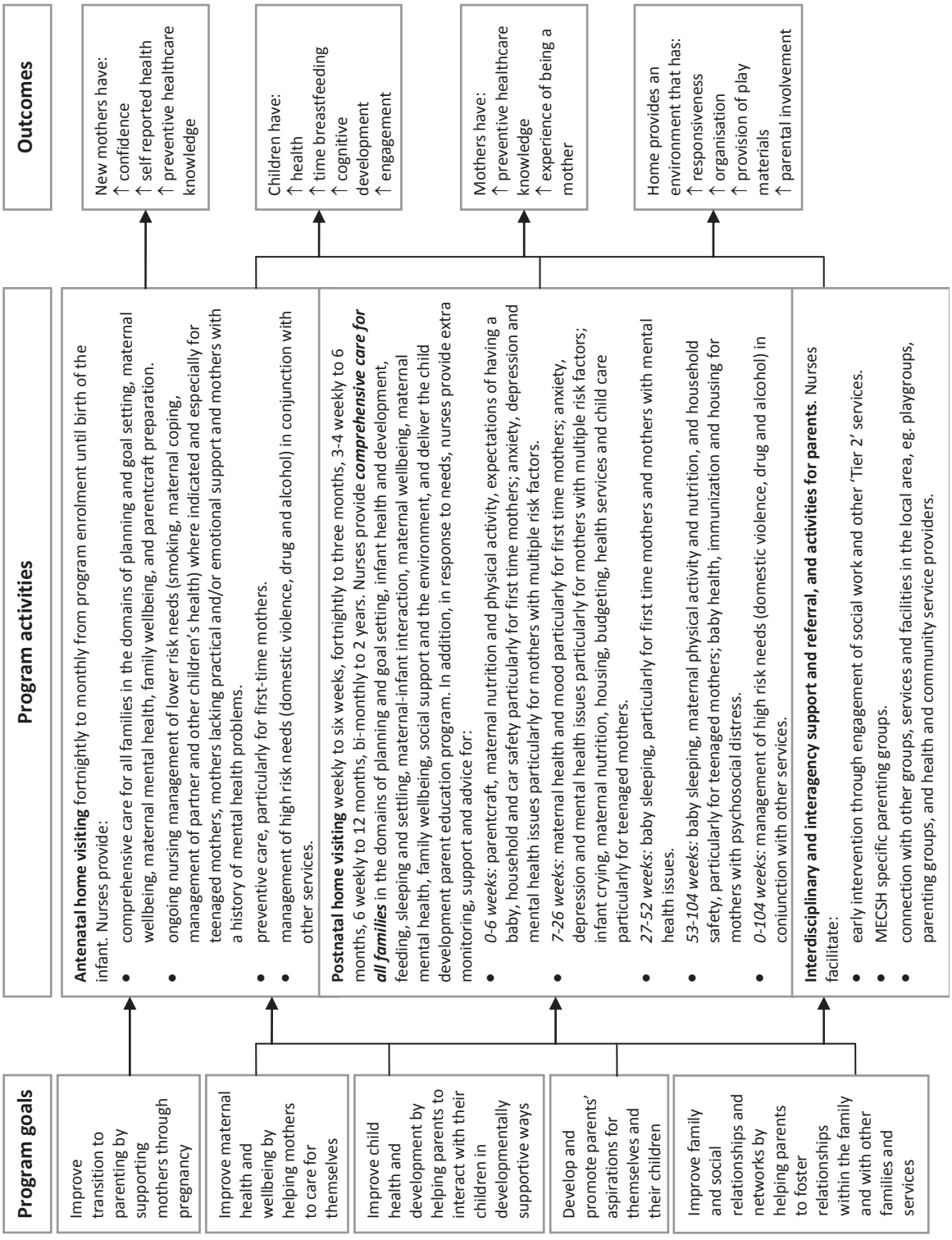
The MECSH program consists of at least 25 home visits primarily by the same MECSH program nurse

Mother and baby communicating

Discussing this image of an everyday activity with the mother, the mother would be supported to observe the way she is effectively communicating with her baby through positioning and eye contact, and celebrate the development of her baby's skills in attending to her. This celebration encourages positive parenting as well as a desire to "see what she can do next", and an orientation to achievement and the future.

Drawing by a child of the MECSH Trial aged 4 years.

MECSH Program Summary



A System of Care Approach

Case review

Here two nurses in the MECSH team are reviewing a case and using local service directories and program information to source some additional support to assist a family with their needs. Working with the whole MECSH team, including the extended MECSH team (Tier 2) is essential for supporting families with additional needs

The MECSH program uses a tiered service model as the System of Care. The tiered model encompasses the primary health care and more specialised services that families may need (see MECSH Four Tier Strategic Framework Table.)

Services or individual providers may not fall neatly into tiers, but rather, their function will be different. For example, a speech pathologist may function as a Tier 2 provider by providing education, support or advice for the Tier 1 child and family health nurse working with a family concerned about their child's speech and language development. The speech pathologist may also be a provider of a Tier 3/4 service providing specialised treatment for a child with a speech or language disorder.

The tiered service system enables skilled Tier 1 workers and families to consult with, and be supported by, more specialised Tier 2 staff, and have timely access to Tier 3 and 4 services for families. This facilitates the provision of effective and efficient support to families, by improving the quality of help available to all families.

Tier 1

Tier 1 services are the 'front-line' service providers. In the MECSH program Child and Family Health Nurses (C&FHNs) are the Tier 1 provider. The role of Tier 1 services is to provide primary health care to families as described above, and identify problems early in their development, offer general advice and pursue opportunities for health promotion and prevention. The bulk of more minor problems can, and should be, identified and handled within the primary care service, supported by Tier 2 and other specialist health and intersectoral services. The Tier 1 C&FHNs in the MECSH program should establish good relationships with the other Tier 1 providers of care for families, particularly midwifery services during the antenatal period and general practice.

The MECSH program is implemented within a System of Care approach

Tier 2

Tier 2 providers function as a member of the extended MECSH team. Access to Tier 2 providers is through direct contact between the Tier 1 and Tier 2 workers rather than through a formal process of referral. This direct contact may be facilitated through strategies such as regular case review meetings or ad hoc contact between the C&FHN and a designated Tier 2 provider. A key Tier 2 provider within the MECSH program is a Social Worker.

Tiers 3 and 4

The service system for MECSH program should identify relevant Tier 3 and 4 service providers for families and ensure that there are processes for timely referral and access to specialised and tertiary level services.

MECSH Four Tier Strategic Framework

Tier	Key Program provider	Other providers	Function	
Tier 1 Primary level of care	Child and family health nurse	Midwives General practitioners School teachers	Provide primary level of care Identify problems early in their development Offer general advice Health promotion and prevention	Extended Program team
Tier 2 A service provided by professionals relating to workers in primary care	Social worker	Aboriginal Health Workers Cultural health workers Paediatricians (especially community) Perinatal psychiatrist/ psychologist Allied health workers Mental health workers Drug and alcohol health workers Housing workers Community Service workers	Training and consultation to professionals within Tier 1 Consultation to professionals and families Outreach Assessment	
Tier 3 A specialised service for more severe, complex or persistent issues		Paediatricians Perinatal psychiatrist Allied health teams Mental health teams Drug health teams Psychologist Housing (including refuges) Child Protection Services Family support workers	Assessment and treatment Assessment for referrals to Tier 4	Specialist referral services
Tier 4 Tertiary level services such as day units, highly specialised out-patient teams and in-patient units			Inpatient and residential care Specialist teams (eg. for developmental delay, child abuse) Specialist provision of treatment services	

The Social Worker should be co-located with the MECSH program team, and should be introduced to every family participating in the MECSH program, as part of the team.

MECSH Trial Outcomes

The randomised trial of the MECSH program demonstrated that children, mothers and their families who received the program achieved the following impacts and outcomes:

New mothers

- tended to be more likely to experience a normal, unassisted vaginal birth.
- felt significantly more enabled and confident to care for themselves and their baby.
- had significantly better self rated health.
- could name two or more measures to reduce cot death risk.

Children

- tended to have better health (lower rates of respiratory infection).
- were breastfed for longer.
- had improved cognitive development, particularly for children of mothers who were recorded as having psychosocial distress antenatally.
- were more engaged with their mother.

Mothers of infants and toddlers

- tended to have a better experience of being a mother, particularly for mothers who were recorded as having psychosocial distress antenatally and mothers who were born overseas.
- provided a home environment that was supportive of their child's development through improved verbal and emotional responsiveness, providing a more organised environment, providing developmentally appropriate play materials and greater parental involvement.

Drawing by a child of the MECSH Trial aged 4 years.

MECSH Research Publications

1 Kemp L, Anderson T, Travaglia J, Harris E. Sustained nurse home visiting in early childhood: exploring Australian nursing competencies. *Public Health Nursing* 2005;**22**:254-9.

2 Kemp L, Eisbacher L, McIntyre L, O'Sullivan K, Taylor J, Clark T, et al. Working in partnership in the antenatal period: what do child and family health nurses do? *Contemporary Nurse* 2006;**23**:312-20.

3 Kemp L, Harris E, McMahon C, Matthey S, Vimpani G, Anderson T, et al. Miller Early Childhood Sustained Home-visiting (MECSH) trial: design, method and sample description. *BMC Public Health* 2008;**8**:424.

4 Aslam H, Kemp L, Harris E, Gilbert E. Socio-cultural perceptions of SIDS among migrant Indian mothers. *Journal of Paediatrics and Child Health* 2009;**45**:670-5.

5 Kardamanidis K, Kemp L, Schmied V. Uncovering psychosocial needs: perspectives of Australian child and family health nurses in a sustained home visiting trial. *Contemporary Nurse* 2009;**33**:50-8.

6 Kervin B, Kemp L, Jackson Pulver L. Types and timing of breastfeeding support and its impact on mothers' behaviour. *Journal of Paediatrics and Child Health* 2010;**46**:85-91.

Further information

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September 2010

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Public Health Commissioning Priorities 2014/15**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Authors: Matthew Cole Director of Public Health John Currie Head of Public Health Commissioning	**Contact Details:** Tel: 020 227 3861 Email: john.currie@lbbd.gov.uk
Sponsor: Matthew Cole Director of Public Health	

Summary:

The report advises the Health and Wellbeing Board on the process for developing Public Health commissioning priorities for 2014/15. A number of priority areas within our Joint Health and Wellbeing Strategy have been identified where further focused investment is required to expand and reinforce our existing interventions to support the delivery of outcomes.

Recommendation(s)

The Health and Wellbeing Board is asked:

- To consider the priorities and set the strategic framework for commissioning public health programmes for 2024/15.
- To note that the next stage is to look at resourced delivery programmes, in respect of what is being done now, what could be stopped or done differently, and what else is needed to make a difference.

Reason(s)

The Health and Social Care Act 2012 introduced the requirement for health and wellbeing boards to prepare joint health and wellbeing strategies for their local areas. The Joint Health and Wellbeing Strategy should provide an over-arching framework to ensuring a strategic response to the health and social care needs of the local population.

1. Introduction

This report sets out the Public Health Commissioning priorities for 2014/15. Council officers and NHS Commissioners were asked to consider the priorities. The Director of Public Health has undertaken a review of the performance against key priorities in the Joint Health and Wellbeing Strategy. This report is for discussion and agreement of the priorities contained within. Further to the outcome of the Health and Wellbeing Board on the 5th November, Council officers together with partners will develop the programmes for delivery from the 1st April 2014.

2. Strategic Context

2.1 2014/15 will be the second year for which the Council has received the Public Health Grant and the accompanying statutory responsibilities, but in effect it is the first year that the Board has had real flexibility, given that the majority of the 2013/14 contracts were inherited from Barking and Dagenham Primary Care Trust.

2.2 The Council and its partners have already agreed a Joint Health and Wellbeing Strategy and mapped out the actions and outcomes (Appendix A - Plan on a page) which are needed to address the priorities for improving the health and wellbeing of local people. These priorities are based on the needs identified in the Joint Strategic Needs Assessment and the national and local priorities identified in the various outcome frameworks (Public Health, Adult Social Care, NHS and the local Children and Young People's Plan).

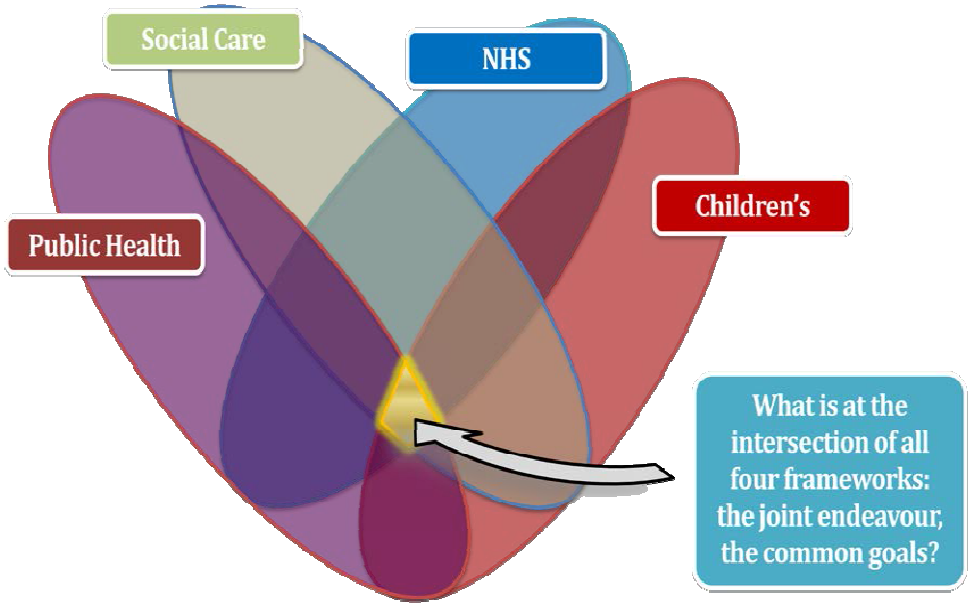
The outcomes contained within the Strategy are:

- To increase the life expectancy of people living in Barking and Dagenham
- To close the gap between the life expectancy in Barking and Dagenham with the London average
- To improve health and social care outcomes through integrated services.

2.3 In order to achieve these high level outcomes, the focus of investment needs to be on actions that contribute to the goals set out in Appendix A. The overall policies and spend of the Council and the NHS are inter-related and fundamental to making progress. In addition Public Health commissioning provides an opportunity to innovate and improve the impact on resident's health and wellbeing.

2.4 **Outcome Frameworks**

For the Joint Health and Wellbeing Strategy to have the desired impact in improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives by 2015, it cannot be done in isolation of other key policy documents and strategies that the borough has in place currently. The diagram overleaf illustrates the inter-relationship between the NHS, Public Health and Adult Social Care outcome frameworks also taking into account the Children and Young People's Plan across the three frameworks.



Using the frameworks and the Children and Young People's Plan, we need to capitalise on the opportunities presented by the inter-relationships between the NHS, Local Authority and Public Health responsibilities for joint commissioning.

2.5 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment 2013 draws out the important challenges to our residents' health and wellbeing. It helps to provide the evidence on which the proposed priorities for commissioning investment are based.

In June 2013, one of Public Health England's first major initiatives, *Longer Lives,* was launched. This is an online tool, giving information about premature mortality for all 150 local authorities in England, including a breakdown of early deaths due to cancer, heart disease and stroke, liver disease and lung disease. The tool allows national ranking of local authorities based on rates of mortality, as well as ranking within groups of local authorities that have similar levels of deprivation. Given the overall aim of the Joint Health and Wellbeing Strategy is to improve life expectancy and to close the gap in life expectancy between Barking and Dagenham and the London average this is a valuable tool for local use.

The mortality figures used as the basis for the tool are expected to form part of the allocation formula for the Public Health Grant and the Health Premium in 2015/16, according to early indications from the Advisory Committee on Resource Allocation. The cause for concern is that this tool highlights that Barking and Dagenham have disproportionately high rates of early deaths, under the age of 75, even when taking into account the level of deprivation locally.

Over the course of three years, there were 1,411 premature deaths in Barking and Dagenham (a directly standardised mortality rate of 337 per 100,000 population). This ranks the borough 133rd out of 150 boroughs in England, where 1 ranks best and 150 ranks worst for premature deaths.

For all the four major conditions highlighted in the tool, Barking and Dagenham has early death rates that are significantly worse than the national picture. Appendix B provides a comparison of Barking and Dagenham with other local authorities within the same socioeconomic deprivations bracket (socioeconomic Decile 2 – "most deprived"). Of the 1,411 deaths, nearly 80% were due to the four main disease groups considered

here (1,113 in total). The impact translated into the actual number of people that died from each condition is:

- **545** were due to cancer
- **342** were due to cardiovascular disease
- **148** were due to respiratory disease
- **78** were due to liver disease

Between 2009-11, more than half (**56.7%**) of all deaths under 75 in Barking and Dagenham were considered amenable to healthcare. A large scale sustained approach is needed, from birth onwards, to health promotion, primary prevention, early diagnosis and treatment in order to impact on the mortality rates seen in Barking and Dagenham.

3 Resources

The Council received a two year ring-fenced Public Health Grant allocation of:

- 2013/14 £12.921 Million
- 2014/15 £14.213 Million

Local authorities have five public health mandatory functions that must be delivered. Just over one quarter of the Grant (27.6%) is spent on mandated services in Barking and Dagenham. These services are:

- appropriate access to sexual health services
- steps to be taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- the National Child Measurement Programme
- NHS Health Check assessment.

The budget setting process for 2014/15 will be informed by a zero based budgeting exercise being conducted during October 2013. Following this we will be in a position to identify the resource available for investment. This will then allow us to make recommendations on the priority order for investment based on impact and value for money.

The Department of Health has recently confirmed that the Public Health Grant for 2015/16 will also be ring-fenced in line with earlier allocations. However, the funding formula will change for 2015/16 and will also see the introduction of the new Health Premium.

The Health Premium is a cash incentive payable to those local authorities that makes progress against public health indicators, including the reduction of premature mortality, fewer children under 5 with tooth decay, more women breastfeeding their babies and fewer over 65s suffering from falls. The premium would, in the Government's view, "reward improvements in health outcomes, and

incentivise action to reduce health inequalities". The first payments are expected to be made under this scheme in 2015/16 and so this will also be a key year in the development of the formula. For example, the Health and Wellbeing Board may wish to consider the current investment in oral health across the lifespan, from children to older people, and evaluate whether this is a priority in the context of the imminent Health Premium.

4 Priority areas for Consideration

In consultation with other Council officers and NHS colleagues, an assessment has been undertaken of our performance against the key priorities etc. The following priority areas have been identified as areas where action is needed and which the Health and Wellbeing Board will be asked to consider.

4.1 Transformation of Health and Social Care

Public Health commissioning priorities have a role to play in realising NHS and Adult Social Care outcomes through shared priorities and indicators particularly around those geared to reducing hospital admissions, supporting care outside of the hospital and reducing A&E attendances. Some of the more common reasons for acute care are time-limited children's conditions like gastrointestinal and chest conditions and in adults and older people, chronic lung disease, dementia related issues, falls and terminal illness. Therefore, consideration should be given to expanding and reinforcing our existing interventions that decrease illness and disease progression to support the delivery of health and social care outcomes, these include:

- Immunisation of adults and children – whilst the responsibility for commissioning lies with NHS England, local support is still needed to improve immunisation rates.
- Early disease identification and effective early interventions especially for diabetes, high blood pressure, irregular heart beat (atrial fibrillation), chronic lung disease and certain cancers.
- Breast feeding which is proven to decrease gastrointestinal conditions and infectious diseases.
- Falls prevention and bone fracture prevention in those defined as high risk.
- Dementia prevention through addressing hypertension, diabetes and cardiovascular disease control and treatment.
- Sustaining and expanding current programmes to reduce the health and social care impact of isolation on vulnerable people and families.
- Maintaining vulnerable people, especially older people enabling them to live in their own homes safely, without fuel poverty (winter warmth) and minimising their risk of hospital admission from hypothermia and respiratory infection.
- Chronic lung disease (COPD) – ensuring effective treatments including pulmonary rehabilitation.
- Alcohol – improving availability and access to relevant services that support reduction in alcohol intake.

- End of Life Care – pathway analysis and improvement.

4.2 **Improving premature mortality**

The top three priorities that would impact on premature mortality and help to realise the potential opportunities of the Health Premium in 2015/16 are:

- Reducing smoking prevalence
- Reducing obesity and increasing physical activity (covered in 4.3)
- Diagnosing disease early and treat effectively

Priorities for intervention:

- There is substantial scope for Public Health programmes and initiatives to promote cancer prevention as well as increase screening coverage and early diagnosis as outlined in the recommendations from the JSNA. Enhancing the promotion of the breast, bowel and cervical screening programmes in Barking and Dagenham both through public awareness campaigns as well as through Primary Care (General Practice and Pharmacy) staff would be expected to result in greater uptake of each of the three programmes and subsequently contribute to improving cancer outcomes through earlier diagnosis. Currently other than invitational letters from the screening programme, there is little promotion of the services locally.
- The need to support national campaigns to raise awareness of the signs and symptoms of common cancers. However, with additional funding, greater local efforts and wider reaching, more innovative outreach campaigns could be delivered across the borough. It would be expected that such campaigns would increase public presentation of symptoms and subsequently earlier diagnosis and improved patient outcomes.
- There should be investment and a significant increase in the number of local health and social care staff, including primary care staff, who can provide Level 2 smoking cessation services.

The JSNA 2012/13 ill health reduction section includes further information, analysis and recommendations on:

— Smoking in Pregnancy

— Cancer Mortality

— Cardiovascular Disease

— Health Checks

— COPD

4.3 **Tackling obesity and increasing physical activity**

Obesity accounts for a great deal of disability, illness and premature death in Barking and Dagenham being a contributory factor in arthritis, diabetes, and cardiovascular disease. Childhood and adult overweight and obesity levels and inactivity levels are very high in the borough. To lengthen life in the borough and to

narrow the gap with the rest of London, we must reduce obesity. Our two main evidence-based ways focus on helping residents to reduce the amount they routinely eat and drink and improve their diets, and by increasing the length of time each week they are physically active. While obesity prevention is complex, there is good evidence to support the use of reducing barriers to healthier eating and regular activity, particularly where this is tailored to different groups' needs.

Accordingly, obesity has become one of the Health and Wellbeing Board's top priorities for the next 18 months and an Obesity Summit is planned in December 2013. There we plan to combine anti-obesity programmes and more, easier access to cheaper healthier eating and easier pathways to fitness with major re-branding of the borough as a place where it is easy to eat and be active. NICE guidelines also recommend encouraging partner agencies and the private sector to create and manage more safe spaces for physical activity, and planning buildings to encourage more physical activity, while promoting healthier schools and workplaces.

Priorities for intervention:

- NHS England will need to work with local partners to ensure public health interventions to promote breastfeeding, child nutrition and physical activity are embedded and developed through to 2015.
- Barking and Dagenham Clinical Commissioning Group and Council commissioners will need to review the treatment pathways and support for weight management interventions to address the growing demand.
- Council commissioners will need to work with sports clubs and education to improve the uptake of sport and physical activity and build on the legacy of the 2012 Olympics games.

The JSNA 2012/13 section on obesity and healthy weight includes an overview, analysis and recommendations on adult and child obesity.

4.4 Improving Sexual and Reproductive Health

Barking and Dagenham faces a challenge in terms of sexual and reproductive health, with rising levels of sexually transmitted infections (STIs), pregnancy, terminations and Human Immunodeficiency Virus infections (HIV). Numbers and rates may be low in comparison with some of the inner London boroughs, but they are higher than in our neighbouring boroughs of Redbridge and Havering. There is a comparatively young population compared to the England average and quite a high rate of teenage pregnancies although this has declined from the peaks seen in 2002/03.

Priorities for intervention:

- More needs to be done in order to halt the spread of STIs and HIV as well as to reduce the number of teenage pregnancies. Targeted work such as community outreach and near- patient testing needs to be done to encourage more people to be tested early, combined with messages about prevention.
- There is a need to increase access (in terms of geography, timing and timeliness), to services that support better sexual health and address the challenges of teenage pregnancy.

- Services must be non-judgmental and 'young person friendly'. Available services and screening should be promoted widely, to increase awareness of the need for better sexual health and to encourage people of all ages to attend for treatment and care.

- Further preventative work aimed at improving sexual health is undertaken as part of the Chlamydia Screening Service commissioned from the Terrence Higgins Trust, and an element of the contract for provision of sexual health services from Barking, Havering and Redbridge University Hospitals NHS Trust is also focused on prevention.

- The evidence is that young people favour accessing specific sexual health services targeted at their age group rather than attending their local GP for sexual health and family planning services.

The JSNA assessment section on sexual health includes additional information, analysis and recommendations.

4.5 **Improving Child Health and Early Years**

The evidence and analysis set out in Fair Society, Healthy Lives (Marmot Review) has been developed and strengthened by the report of the Independent Review on Poverty and Life Chances. The reports draw attention to the impact of family background, parental education, good parenting, primary education and the opportunities for learning and development in the crucial first five years of life, and identified what matters most in preventing poor children becoming poor adults as:

- healthy pregnancy
- good maternal mental health
- secure bonding with the child
- love and responsiveness of parents with clear boundaries
- primary education
- opportunities for a child's cognitive, language and social and emotional development
- good services including health services, Children's Centres and high quality childcare

Priorities for intervention:

- The transition of the Health Visitor service, currently commissioned by NHS England should be considered by the Health and Wellbeing Board. The transition must take place by April 2015 so plans to ensure the commissioning and delivery functions are transferred seamlessly must be in place in 2014/15. Training for staff such as Maternal and Early Childhood Sustained Home Visiting Programme (MECSH) should be considered as part of the transition process.

- The School Nursing service currently has 11 nurses working with 60 schools and despite there being additional funding this year to increase the numbers of

school nurses, Ofsted and the Care Quality Commission (CQC) reported some issues around a lack of admin and supervision capacity. Due to the high caseloads of the nurses this was seen as an area of risk that local Commissioners need to address.

- There are approximately 446 Looked After Children in Barking and Dagenham the majority of whom have been removed from their families due to domestic violence. This puts Barking and Dagenham in the top quartile and is an area that must be considered by the Board. Due to the psychological and physical needs of this group and other vulnerable groups such as young offenders and disabled young people the joint commissioning arrangements between Public Health, the Clinical Commissioning Group and Children's Services are key to improving outcomes. There is currently one designated nurse for Looked After Children as this is a statutory requirement but due to the high number of Looked After Children in the borough an increase in this capacity should be considered.

- There has been a reported increase in the numbers of alcohol affected children and young people attending A&E although the under 18 alcohol admission rate is low compared with the national average. There is an opportunity to utilise Children's Centres more effectively to deliver alcohol Brief Advice and referral to structured treatment and or Targeted Parenting Support to children, young people and their families.

- The Baby Family Intervention Programme (FIP) due for roll out in 2013/14 will be of significance in Barking and Dagenham realising positive outcomes for children and families in 2014/15 and the Health and Wellbeing Board should note the progress of this initiative.

The JSNA 2012/13 includes an overview, analysis and recommendations on Maternity, Child Immunisation, Breastfeeding, and Support for Parents in section 2 – The best Start in Life.

4.6 **Improving Community Safety**

In partnership with the Community Safety Partnership there are a number of areas from a health and wellbeing perspective that need consideration:

- In September 2011 there were 193 young offenders active on the Youth Offending Service's (YOS) caseload. This is the highest caseload the YOS have ever held at any one time. The ages of the young people on current caseloads ranged from 13 to 18 years with the highest number of offenders aged 17 (33%).

- The increased rate in young re-offenders is being linked to emerging gang activity where gang members are more prolific offenders and have different profiles to the major youth offending population and transfer in from other boroughs due to cheaper accommodation.

- The Serious Youth Violence Partnership should recommend to the Health and Wellbeing Board interventions to address the Public Health needs of this group, in particular in the context of sexual exploitation and violence where females associated with gang members have been subject to assaults and abuse.

- There are a number of sex workers working across a tri-borough patch of Barking and Dagenham, Redbridge and Newham and a cross-borough strategic approach to responding to the women and clients is being planned. However, there is a gap in outreach provision for this group and there is an opportunity to jointly commission an outreach service with Redbridge so that the health needs of the women can be addressed more effectively.

The JSNA contains subject overviews, analysis and recommendations on the following topics

— First time entrants into the Youth Justice System

— Rates of Violent Crime including Sexual Violence

— Crime and Violent Crime victimisation

— Reducing reoffending

4.7 **Alcohol and Substance Misuse**

Barking and Dagenham has a high rate of alcohol related hospital admissions with a rate of 2,276 per 100,000 of the population in 2012/13 compared with the London average of 2,035. Although the rate is down 1% from the previous year alcohol misuse still presents a significant challenge to the Health and Wellbeing Board. The impact of alcohol misuse is experienced across the spectrum Primary Care, Acute Trust, Police, Licensing and environment all have a significant strategic role to play in achieving improved outcomes.

The Department of Health estimates that interventions for dependent drinkers (a range of interventions to suit a variety of users – those based on cognitive behavioral approaches have the best chance of success) that the average local population of 350,000 for every £583,464 invested there would be a saving of £1,808,737 in return on the investment. For every additional £1Million invested in appropriate levels of intervention, up to 1,200 alcohol related hospital admissions could be avoided

Priorities for intervention:

- Early Identification and Intervention of alcohol misuse is key to reducing alcohol-related hospital admissions and reducing alcohol-related anti-social behavior in the long-term. Alcohol Identification and Brief Advice (IBA) is the evidence based approach that should be embedded in a local health system to achieve this aim. The coverage of Alcohol IBA in Barking and Dagenham is limited and consideration should be made of the impact investment in this could have on alcohol misuse.

- Barking and Dagenham's alcohol treatment outcomes have a high success rate with around 70% of individuals being discharged from treatment with a successful outcome. However, there is still significant potential in the system to treat more individuals and improve pathways into community based treatment preventing attendance at A&E. The Health and Wellbeing Board should consider joint initiatives between Public Health and the CCG for increasing the number of GPs prescribing for community detox. There is a strong evidence base for providing pharmacological detox with psychosocial interventions in the community that are highly cost-effective compared with emergency admission

and residential detox and rehabilitation.

- The consumption of high strength ciders and lagers and street drinking is a significant problem for retailers, licensing and the police and the adoption of the Ipswich Model may have a positive impact on alcohol related disorder in the major centres in the borough. This Model involves the voluntary participation of retailers in banning the sale of high strength ciders and lagers and this has been proven to be effective in Ipswich. However, the utility of this approach in an urban environment such as Barking and Dagenham has yet to be investigated and will require significant buy-in from retailers to be a success.

- In relation to alcohol related violence, the Alcohol Hot Spots analysis that is underway will contribute to an improved intelligence led response to reducing alcohol related violent crime in 2014/15. This is a data sharing initiative based on the Cardiff Model that uses anonymous information collected at A&E and is shared with the Community Safety Partnership so that preventative policing approaches can be used where there has been an instance of alcohol related violence.

- Barking and Dagenham's success rate in drug treatment completions has been recognised as high by Public Health England. There is a strong evidence base for investing in drug treatment with research suggesting that every £1 invested in drug treatment saves society two and a half times that in the crime and health costs of drug addiction. NICE estimates the costs generated by each injecting drug-user add up to £480,000 over their lifetimes. While people are in treatment they use fewer illegal drugs and commit less crime to fund the purchase of drugs from street dealers. There is also less risk to the public's health from drug litter. Additionally, individual users are better able to cope, so can attend education and training, hold down jobs, and look after their families.

Priorities for intervention

- Consideration should be given to the invest to save model promoted nationally as good practice and how this impacts positively on substance misuse outcomes for the individual and community.

The JSNA 2012-13 contains information, analysis and recommendations on:

— Alcohol

— Substance Misuse

4.8 **Improving Mental Health**

The Joint Health and Wellbeing Strategy recognises that poor mental health is a massive 'burden of disease' affecting our residents and that poverty, disadvantage, disability, chronic illness, exclusion and debt are major factors that drive it, while trauma, domestic violence, hate crime, and bullying at school and work also create much stress, depression and anxiety.

The Health and Adult Services Select Committee (HASSC) identified that the economic downturn plus the government's benefits changes and cuts in public services would lead to a great deal of stress for disadvantaged adults and families. These changes have already resulted in many residents having severe housing problems this year. They will also potentially be catastrophic for people with

existing mental health problems, and more mitigation will be needed.

Many residents with less severe (but nevertheless misery-creating) mental health problems will go undetected or untreated and will encounter barriers to getting help and getting better. The Joint Health and Wellbeing Strategy currently aims to increase the number of troubled families getting integrated help, and increase access to mental health services for people from ethnic minorities.

Priorities for intervention:

- To consider the recommendations from the HASSC scrutiny review.
- The need for a mental wellbeing strategy to address the economic and social determinants of poor mental health, prevention and detection of problems, and good access to help, support and treatment.
- There is a great deal of evidence to support the use of interventions such as psychological therapies and school-based programmes, but there is also evidence to support programmes addressing the social determinants of mental health, such as interventions to reduce the impact of debt.

4.8 **Reducing Injuries and Accidents**

The Joint Health and Wellbeing Strategy aims to reduce falls and accidents in the home among older people (which add to pressures on local hospitals as well as increasing risks of earlier death, and the borough has a higher than average rate of older people admitted to hospital due to falls and injuries).

Priorities for intervention:

- The need to reduce the risk of traffic accidents in order to make big increases in the numbers of children and adults walking and cycling, since the borough also has a higher rate of hospital admissions from traffic accidents than the England average.
- The need to reduce the risk of vulnerable older people being admitted to hospital for falls and injuries through falls prevention and bone fracture prevention programmes.

5. Mandatory Implications

5.1. Joint Strategic Needs Assessment

The priorities for consideration in this report align well with the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

5.2. Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The Strategy is based on four priority themes that cover the breadth of the frameworks and in which the priorities under consideration are picked up within.

These are Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

5.3. Integration

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report makes several recommendations related to the need for effective integration of services and partnership working.

5.4. Financial Implications

(Implications completed by Roger Hampson, Group Manager, Finance)

As indicated in the report, the allocation of the ring-fenced Public Health Grant for 2014/15 is £14.213m; the grant will again be ring-fenced in 2015/16 but the amount has not yet been announced.

Officers propose to make recommendations on the priority order for investment for 2014/15 based on impact and value for money at the meeting of the Health and Wellbeing Board on 11th February 2014.

5.5. Legal Implications

(Implications completed by Chris Pickering, Principal Solicitor)

This report sets out the current position and priorities for future commissioning of health services. There are no legal implications to this report and the report's author asks the Health and Wellbeing Board to consider the priorities and set the strategic framework for commissioning public health programmes for 2014/15. There may be the need for future consultation which is a legal requirement, as are Equality Impact assessments.

5.6. Risk Management

Delivery of the commissioning intentions is a key dependency in the delivery of the Public Health, NHS and Adult Social Care Outcome Frameworks challenge as well as the delivery of the Children and Young People's Plan

6. Background Papers used in the preparation of the Report

- Barking and Dagenham's Community Strategy 2013-1016
- Joint Strategic Needs assessment
- Joint Health and Wellbeing Strategy
- 'Fair Society Healthy Lives (The Marmot Review)
- Longer Lives
- Independent Review on Poverty and Life Chances

7. List of Appendices

APPENDIX A: Health and Wellbeing Strategy 2012-15. Plan on a page

APPENDIX B: Comparison of Barking and Dagenham with other local authorities

within the same socio-economic deprivations bracket

Barking and Dagenham Health and Wellbeing Strategy 2012-15. Plan on a page

	Care and Support	Protection and Safeguarding	Improvement and Integration of Services	Prevention
Pre-birth, early years	All children are offered a health review.	Children are protected through vaccination from preventable diseases.	More children and families have access to urgent care in the community.	More babies are breastfed, more children are physically active.
Primary school	More children with special education needs have improved health and education outcomes.	Fewer children experience bullying, hate crime or domestic violence.	More children with chronic or complex needs are supported to continue education.	Children are supported to maintain a healthy weight.
Adolescence	More young parents access the Family Nurse Partnership, and support from children centers.	More adolescents protect their health through take up of chlamydia screening.	More services are young people friendly.	Fewer teens smoke or problem drink.
Early adulthood	More people living with severe mental illness will be physically healthy.	Fewer women will have unplanned or unwanted pregnancies.	Services for people living with sickle cell disease or with diabetes will improve.	More young adults will exercise regularly and use active forms of transport.
Maternity	All women receive high quality support during pregnancy and labour.	The majority of women take up the offer of antenatal screening, during pregnancy.	Maternity pathways are clear, integrated and include safeguarding.	More women have their first maternity appointment by the 13th week of pregnancy.
Established adults	More adults aged over 40 take up the offer of a health check.	More adults take the opportunity to protect their health through cancer screening.	More adults with early signs of chronic disease are identified in primary care and get appropriate treatment.	More adults will maintain a healthy weight and have access to healthy food.
Older adults	More of those with signs of dementia or depression are recognised in primary care and referred for treatment.	More older adults protect their health through seasonal flu vaccination	Residents approaching end of life can do so with dignity with more enabled to die in their own homes.	More take regular exercise using borough green spaces and are actively engaged in their community.
Vulnerable and minority groups	All individuals with learning difficulties or disabilities have a key worker and a structured health and wellbeing plan.	More people from minority groups feel confident to report abuse and harassment.	More integrated support is provided to troubled families.	The gap in health outcomes is reduced between those from minorities and the wider population

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APPENDIX B

Comparison of Barking and Dagenham with other local authorities within the same socio-economic deprivations bracket[1]

All rates are per 100,000 directly standardised population	Barking & Dagenham		Blackburn With Darwen		Brent		Greenwich		Lambeth		Lewisham		Salford	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Overall Premature Mortality	337.2	133	354	143	252	52	292	85	322	121	305	106	382	147
Premature Mortality from Cancer	135.9	142	117	99	98	26	111	83	123	120	124	124	135	140
Premature Mortality from Heart Disease and Stroke	83.7	135	89.8	146	65.2	79	71.3	104	74.2	117	69.8	93	90.6	147
Premature Mortality from Lung Disease	36.9	142	36.0	139	17.8	27	30.2	112	28.5	100	28.1	98	49.1	147
Premature Mortality from Liver Disease	18.7	107	25.9	145	14.5	69	14.6	72	19.3	112	15.4	79	22.7	133

Key:

- Significantly better than England average
- Better than England average
- Worse than England average
- Significantly worse than England average

[1] (socio-economic Decile 2 – "most deprived")

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HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Children and Families Bill**
Report of the Corporate Director of Children's Services	
Open Report	**For Decision**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Helen Jenner, Corporate Director, Children's Services	**Contact Details:** Tel: 0208 227 5800 E-mail: helen.jenner@lbbd.gov.uk
Sponsor: Helen Jenner, Corporate Director, Children's Services	

Summary:

The Children and Families Bill was introduced into the House of Commons on 4 February 2013 and (according to the 'long title') and aims to:

"Make provision about children, families, and people with special educational needs; to make provision about the right to request flexible working; and for connected purposes."

This report provides further detail on the plans to ensure the recommendations of part 3 the Bill, which have particular relevance to the JSNA and Health and Wellbeing Strategy, are implemented by September 2014, including work to date and consultations plans for the Local Offer for children who have learning difficulties or disabilities, including those requiring statements of special educational needs.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

(i) To support the integrated project team

(ii) To endorse the direction of travel

(iii) To ask for regular updates on progress against the Project Plan, particularly through the Children and Maternity Sub-Group.

(iv) To support the input from across the partnership to a Local Offer

Reason(s)

The Bill expects strong ownership of this agenda through the Health and Wellbeing Board. Its expectations cannot be delivered without excellent integrated working.

1. Background and Introduction

1.1 The Children and Families Bill was introduced into the House of Commons on 4 February 2013 and (according to the 'long title') aims to

'Make provision about children, families, and people with special educational needs; to make provision about the right to request flexible working; and for connected purposes.'

1.2 The Bill covers the work of children's services (for adoptions, family justice, special educational needs, childcare and the Children's Commissioner), local government legal teams (for adoptions and family proceedings) and HR teams (shared parental leave, paternal time off work for ante-natal care, and reform of law on requesting flexible working).

1.3 There are eight parts to the bill (A summary of the 8 sections is available as Appendix 1):

— Part 1: Adoption and children looked after by local authorities

— Part 2: Family Justice

— Part 3: Special Education Needs

— Part 4: Childcare

— Part 5: The Children's Commissioner

— Part 6: Statutory rights to leave and pay

— Part 7: Time off work: ante-natal care etc

— Part 8: Right to request flexible working

1.4 Although all 8 parts have some relevance to the Health and Wellbeing Board it is Part 3, Special Educational needs that is of particular relevance. This report provides further detail on the plans to ensure the recommendations of part 3 the Bill are implemented by September 2014, including work to date and consultations plans for the Local Offer.

1.5 The Bill retains current definitions of special educational needs and special educational provision extends them, to include young persons in education or training under the age of 25: "a child or young person has special educational needs if he or she has a learning difficulty or disability which calls for special educational provision to be made for him or her". The "learning difficulty" has to be 'significantly greater' than any learning difficulties experienced by others of the same age and the "disability" has to prevent or hinder the child or young person from making use of facilities of a kind generally provided for others of the same age. The Government has resisted calls to include all children with disabilities in the definition of special educational needs.

2. Proposal and Issues

The Bill requires the implementation of the following proposals

2.1 Role of local authority

A local authority must use its powers to identify all children and young people in its area who have or may have special educational needs and is "responsible" for them when the authority has identified them or they have been brought to the authority's attention.

A local authority must work with health and social care services to ensure the integration of special educational provision where this promotes the well-being of children with special educational needs and improves the quality of provision for them. In particular, the local authority must work with its local clinical commissioning groups to secure integrated provision for children and young people with special educational needs. This is known as "EHC provision": education, health and care provision for children and young people requiring special educational provision.

A local authority must keep under review the local special educational provision and consider the extent that it is meeting the needs of the children and young people for whom it is responsible. The local authority must work with schools and other education providers to keep this provision under review.

In carrying out these and other functions, the local authority must co-operate with a range of local partners including maintained schools and academies, and they must co-operate with the local authority.

2.2 The Local Offer

A local authority must publish a "local offer" of services it expects to be available for children and young people with special educational needs. The offer must include education, health and care provision, other education and training, and travel support. This document is currently being produced and receiving input from across the partnership. A programme of extensive consultation with children, young people and their families is also planned. As at present, the local authority can secure provision in a school or college outside England and Wales.

2.3 Education, health and care plans

The legislation on Education, health and care (EHC) plan is based on the current legislation for statements of special educational needs. Where the local authority believes that a young person's needs are such that provision may need to be set out in a plan, then the local authority must secure an EHC needs assessment. The current rights of parents to be informed about the process and be involved in the assessment are retained. If required by the assessment, an EHC Plan must "specify" the special educational and other provision needed by the child or young person.

The local authority, as at present, must secure provision in a mainstream institution unless this is incompatible with the wishes of the parents or the provision of efficient education for others. Also, as at present, the local authority remains responsible for securing the educational provision but there is no equivalent duty on social care and health providers to comply with requirements in the plan (although Government

amendments have been laid to change this). Maintained schools and academies named in EHC plans have a duty to admit where the institution is named in a young person's plan.

2.4 Personal budgets

There is currently a pilot being undertaken, but the Bill extends this to all who have an EHC plan. When asked by the parent or young person, the local authority must make available a "personal budget" to allow the parent or young person to be involved in securing provision.

2.5 Appeals

Parents wanting to appeal against an EHC plan will first have the opportunity to take part in mediation before appealing to the First Tier Tribunal. However, participation in mediation will not be a requirement of appealing to the Tribunal (although Local Authorities will be expected to demonstrate that they have tried to take this approach). There are new voluntary arrangements for resolving disputes between local authorities, schools and colleges, and parents. Provision is made for children themselves to make appeals to the Tribunal.

2.6 Duties on schools and colleges

Institutions must use their "best endeavours" to secure special educational provision for children who have special educational needs. Schools, but not FE colleges, must appoint an SEN co-ordinator. Parents must be informed if special educational provision is being made for their child. Schools must prepare an SEN information report.

2.7 Code of practice

A new SEN Code of Practice will be issued, it will cover FE institutions. The Code will be approved using the negative instrument procedure, and not the affirmative procedure with the current Code. As previously announced, and confirmed by the draft Code published on 15 March, the existing arrangements for School Action and School Action plus will be abolished.

3. Implementing the Bill in Barking and Dagenham (including Consultation proposals)

3.1 A Project Programme Board has been established with multi-agency representation. The Project Initiation Document and Programme Board membership are attached as Appendix 2.

3.2 Work has already been completed, across agencies to put together a draft Local Offer for consultation (Appendix 3)

3.3 The consultation will run until December 2013.

3.4 It is proposed that a Project Update is presented to the Health and Well Being Board in February and June 2014, to ensure we remain on track for implementation in September 2014.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

The Proposals in the reports support Section 2 and 3 of the JSNA. In particular Section 3.2 (Children and Young People with Learning Difficulties and Disabilities)

The 2011 Census found that just under 5,000 households in the borough include children and at least one person with a long term condition or disability, but there is no census data on the number of children living with learning difficulties and disabilities (LDD).

There are several sources of data on the local uptake of services by children and young people living with LDD, and modelling has been refreshed to estimate the level of need in the borough.

The JSNA made the following recommendation:

Recommendations for Commissioners

The Health and Wellbeing board will need to ensure that there is a robust programme and strategic plan in place to meet any emerging statutory responsibilities that are outlined within the current Children and Families Bill.

This report and the Project Plan address this recommendation

4.2. Health and Wellbeing Strategy

The proposals support the Health and Wellbeing Strategy Themes 1 – 5 and 8 in particular, but should also support Themes 6 and 7 as better early support should enable established adults and older adults with LDD/SEN to lead more fulfilled lives.

The priority areas of care and support; protection and safeguarding; improvement and integration of services and prevention will all be addressed through the project. Future reports will evidence how the work is addressing these priorities.

4.3. Integration

The Children and Families Bill has integration at its heart and a key theme for the project is ensuring integrated approaches that make pathways for children with SEN/LDD more straightforward, specifically aiming to reduce a key complaint of families that they have to repeat their life story and circumstances repeatedly for each agency, with multiple assessment being completed, but in some carers views “very little ever changes”.

4.4. Financial Implications

(Implications completed by Patricia Harvey, Group Manager, Finance)

It is difficult at this time to ascertain exact financial implications relating to the Bill as it is still being debated by Parliament. At this stage Board Members should be mindful that:

- The replacement of statements for SEN children from birth to 25 with a health and care plan would have to be modelled within LBBD's current funding envelope within the High Needs block of Dedicated Schools Grant (DSG)

- The introduction of offering families personal budgets is a new service initiative for children and is yet to be explored. Financial impacts are therefore somewhat unknown although there are service issue to be learned from Adult Social Care and its use of personal budgets for the service users.

- The collaborative working of the LA with the Health Service under the umbrella of the Clinical Commissioning Group (CCGs) framework is an area that would have to be explored more fully within the redesign of the service area in support of the statutory requirements within the bill.

- The Funding implications of meeting the statutory responsibilities that will result from the Children's and Families Bill would have to be met from the existing funding envelope which is the High Needs Block of DSG. Clearer impacts will be possible to predict once there has been sufficient modelling and analysis work undertaken.

4.5. Legal Implications

(Implications completed by Lucinda Bell, Education Lawyer)

Draft clauses of the Children and Families Bill include

- **Clause 26** creates a new duty for joint commissioning which will require local authorities and health bodies to work in partnership when arranging provision for children and young people with SEN.

- **Clause 30** places a requirement on local authorities to publish a "local offer" of services they expect to be available for children and young people with SEN.

- **Clauses 36 to 47** set out the requirements relating to the provision and implementation of Education, Health and Care plans.

- **Clause 48** requires local authorities to prepare a personal budget for children or young people with an EHC Plan if asked to do so by the child's parent or the young person.

When preparing the Joint Health and Wellbeing Strategy, there is a duty imposed by the Health and Social Care Act 2012 to consider the extent to which the needs could be met more effectively by arrangements between local authorities and NHS bodies, known as section 75 agreements rather than in any other way.

When making any decision, s149 of the Equality Act 2010 requires the Board to have due regard to:

- The need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EqA 2010;
- The need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- The need to foster good relations between persons who share a relevant protected characteristic and those who do not share it.

4.6. Risk Management

There is a risk log as part of the project programme. A significant risk is lack of resources to meet the rapidly increasing demands of an increasingly complex child population, which now stands at 31% of the total population.

5. List of Appendices:

— APPENDIX 1: Summary of the Children and Families Bill

— APPENDIX 2: SEND Transformation Programme Brief

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APPENDIX 1

Summary of the Children and Families Bill 2013

Part 1: Adoption and Children Looked After by Local Authorities

Implements proposals from the Government paper *An Action Plan for Adoption: Tackling Delay* which has the objective of seeing more children being adopted by loving families with less delay including Fostering for adoption to enable children to be placed with prospective adopters earlier who are already approved foster parents;

- Removing the requirement that adoption agencies must give due consideration to ethnicity, religious persuasion, racial origin and cultural and linguistic background when seeking prospective adopters;
- Improving support for adoptive families through additional information, personal budgets to but support, and prospective adopters access to the national register of children for whom adoptive parents are sought;
- The Government is given a power to require a local authority to outsource its adoption functions;
- A new statutory basis to giving an adoptive child contact with the child's birth family; and
- A requirement on local authorities to have a 'virtual school head' (VSH) who can have a positive impact on the educational achievement of looked after children.

For further information see the DfE Policy Statement on Adoption, the DfE Evidence Pack Adoption Reform: Children and Families Bill, the DfE Evidence Pack Virtual School Head for Looked After Children: Children and Families Bill and the House of Lords Adoption Legislation Committee.

Part 2: Family Justice

Implements commitments the Government made in response to the *Family Justice Review* with the objective of achieving better outcomes for children and families who go to court after family separation or where children may be taken into care including:

- Attendance at a family mediation information and assessment meeting (MIAM) would be required before an application is made to the courts;
- Courts to take into account that both separated parents should continue to be involved in their child's lives where that is consistent with the child's welfare;
- A new child arrangements order to replace the existing residence and contact orders which will focus parents on the child's needs and not on the parents' 'rights' and includes a power for the courts to make activity directions and conditions which, for example, specify what happens when an order is breached;
- The permission of the courts is required before expert evidence is received although this will not apply to local authority social workers or CAFCASS staff;
- A 26-week time limit is introduced when the courts are considering whether a child should be taken into care; the time limits on interim care orders and interim supervision

orders is made subject to the courts; when the courts consider a care plan, only the matters essential for whether to make a care order should be considered; and

- Changes are made to divorce law so that arrangements for children are no longer considered as part of that process but through separate proceedings at any time.

For further information see the DfE Policy Statement on Family Justice, DfE Evidence Pack Family Justice: Children and Families Bill, and the House of Commons Justice Committee's report on Pre-legislative Scrutiny of the Children and Families Bill.

Part 3: Special Education Needs

Implements Government proposals which were first published in the Green Paper *Support and Aspiration: a new approach to special educational needs and disability* (2011) and the *Progress Report* (2012)

The Bill replaces the existing SEN legislation (which will continue to apply in Wales) and includes the Green Paper objectives of bringing together the separate arrangements for children in schools and young people in post-16 institutions and training up to the their 25th birthday, and the integrated Education, Health and Care Plan to replace the statement of Special Educational Needs. The Bill also removes the separate treatment of local authority maintained schools and academies under SEN legislation. Since the Bill's publication, Government amendments have been laid which require Clinical Commissioning Groups to comply with any health service requirements in EHC plans, and an 'Indicative' draft Code of Practice has been published (on 15 March) for the Committee scrutinising the Bill along with nine sets of illustrative regulations and other documents. The reader is referred to the DfE Bill website for these documents.

Principles

The Bill retains the pivotal role of the local authority in identifying, assessing, and securing the educational provision for children and young people with special educational needs. A new requirement is that the local authority must follow four guiding principles, namely that the local authority must:

- Listen to the views, wishes and feelings of children, young people and parents;
- Ensure children, young people and parents participate in decision-making;
- Provide the necessary information and support to help children, young people and parents participate in decision-making; and
- Support children, young people and parents in order that children and young people can achieve the best possible educational and other outcomes.

Special Educational Needs and Provision

The current definitions of special educational needs and special educational provision are retained and extended to include young persons in education or training under the age of 25: "a child or young person has special educational needs if he or she has a learning difficulty or disability which calls for special educational provision to be made for him or her". The "learning difficulty" has to be 'significantly greater' than any learning difficulties experienced by others of the same age and the "disability" has to prevent or hinder the child or young person

from making use of facilities of a kind generally provided for others of the same age. The Government has resisted calls to include all children with disabilities in the definition of special educational needs.

Role of the Local Authority

A local authority must use its powers to identify all children and young people in its area who have or may have special educational needs and is “responsible” for them when the authority has identified them or they have been brought to the authority’s attention.

A local authority must work with health and social care services to ensure the integration of special educational provision where this promotes the well-being of children with special educational needs and improves the quality of provision for them. In particular, the local authority must work with its local clinical commissioning groups to secure integrated provision for children and young people with special educational needs. This is known as “EHC provision”: education, health and care provision for children and young people requiring special educational provision.

A local authority must keep under review the local special educational provision and consider the extent that it is meeting the needs of the children and young people for whom it is responsible. The local authority must work with schools and other education providers to keep this provision under review.

In carrying out these and other functions, the local authority must co-operate with a range of local partners including maintained schools and academies, and they must co-operate with the local authority.

A local authority must publish a “local offer” of services it expects to be available for children and young people with special educational needs. The offer must include EHC provision, other education and training, and travel support. As at present, the local authority can secure provision in a school or college outside England and Wales.

Education, Health and Care Plans

The legislation on Education, health and care (EHC) plan is based on the current legislation for statements of special educational needs. Where the local authority believes that a young person’s needs are such that provision may need to be set out in a plan, then the local authority must secure an EHC needs assessment. The current rights of parents to be informed about the process and be involved in the assessment are retained. If required by the assessment, an EHC Plan must “specify” the special educational and other provision needed by the child or young person.

The local authority, as at present, must secure provision in a mainstream institution unless this is incompatible with the wishes of the parents or the provision of efficient education for others. Also, as at present, the local authority remains responsible for securing the educational provision but there is no equivalent duty on social care and health providers to comply with requirements in the plan (although Government amendments have been laid to change this). Maintained schools and academies named in EHC plans have a duty to admit where the institution is named in a young person’s plan.

Personal Budgets

There is currently a pilot being undertaken, but the Bill extends this to all who have an EHC plan. When asked by the parent or young person, the local authority must make available a "personal budget" to allow the parent or young person to be involved in securing provision.

Appeals

There are innovations on appeals. Parents wanting to appeal against an EHC plan will first have the opportunity to take part in mediation before appealing to the First Tier Tribunal. However, participation in mediation will not be a requirement of appealing to the Tribunal. There are new voluntary arrangements for resolving disputes between local authorities, schools and colleges, and parents. Provision is made for children themselves to make appeals to the Tribunal.

Duties on schools and colleges

Institutions must use their "best endeavours" to secure special educational provision for children who have special educational needs. Schools, but not FE colleges, must appoint an SEN co-ordinator. Parents must be informed if special educational provision is being made for their child. Schools must prepare an SEN information report.

Code of practice

A new code of practice will be issued, with School Action and School Action plus being abolished.

Part 4: Childcare

The Bill contains a small number of provisions to take forward its aim of reforming childcare to ensure "the whole system focuses on providing safe, high-quality care and early education for children" as set out in the paper *More great childcare*. Most measures do not require primary legislation such as increasing the minimum adult to child ratios. The Bill introduces:

- Childminder agencies to contract or employ childminders to stimulate the number of childminders, offer greater support and provide quality assurance;
- Early years settings will be able to request and pay for an Ofsted inspection;
- Although the Local Authority duty to secure sufficient childcare remains, the duty to publish an assessment of the sufficiency of childcare is repealed; and
- A maintained school governing body will no longer have to consult the local authority, staff and parents before making childcare provision at the school

For further information see DfE Evidence Pack Childcare: Children and Families Bill.

Part 5: The Children's Commissioner

The Bill develops the role of the Children's Commissioner's effectiveness, taking forward recommendations in John Dunford's *Review of the Office of the Children's Commissioner* including:

- giving the Commissioner a statutory remit to 'promote and protect children's rights'; and

- introducing changes to make the Commissioner more independent of the Government.

For further information see DfE Evidence Pack: Office of the Children's Commissioner: Children and Families Bill and the Lords and Commons Joint Committee on Human Rights Reform of the Office of the Children's Commissioner: draft legislation.

Parts 6, 7 and 8: Employment

A number of changes are made to workplace practice to support better parenting as set out in the Government's response to the *Modern Workplaces* consultation.

Part 6: Statutory Rights to Leave and Pay

Enables the sharing of parental leave following the birth of a child, on adoption, and prospective adopters who are fostering the child.

Part 7: Time off Work: Ante-natal Care etc

Enables the partners of pregnant women to time off work to accompany the woman to ante-natal care. The new right is extended time off to attend adoption appointments.

Part 8: Right to Request Flexible Working

The right to request flexible working is extended to all employees, not just those with parental or caring responsibilities.

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SEND Transformation Programme

Programme Brief

Revision Date: 9th August 2013

Programme: SEND GP Programme

Programme Reference: 0001

Programme Initiation: August 2013

Programme Sponsor: Helen Jenner

Projects Lead: Chris Bush

Programme Manager: Chris Bush

Draft

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Version 0.3

1. Version control

v.	Author	Comments/Record of Sign-Off	Date
0.1	Chris Bush	Original	27th June 2013
0.2	Chris Bush	Update on original.	9th August 2013
0.3	Chris Bush	Update following SEND Transformation Programme Board	5th Sep 2013

Reviewers

v.	Reviewer	Date
0.1	Meena Kishinani (Div. Director; Strategic Commissioning and Safeguarding)	27th June 2013
0.1	Tony Sargeant (Group Manager; Performance, Programmes and Catering)	12th July 2013
0.1	Chris Martin (Divisional Director; Children's Social Care and Complex Needs)	12th July 2013
0.1	Helen Jenner (Corporate Director; Children's Services)	15th July 2013
0.2	SEND Transformation Programme Board	3rd Sep 2013

2. Background

2.1 On 9 May, the Queen's Speech announced that the Children and Families Bill would be introduced to Parliament, following a draft Bill and pre-legislative scrutiny, in the spring of 2013. The Bill has been given a carryover slot (i.e. it will be carried over to the next Parliamentary session when this session ends in May 2013). On 15 May, the Government published the SEN and disability Green paper *Progress and Next Steps* document. This document fleshes out aspects of the Children and Families Bill and reports on the Government's next steps in relation to other SEN reforms.

2.2 The SEND Green Paper implementation will bring about significant changes in the design and delivery of services to children and young people with Special Educational Needs and disabilities. The headline details of these changes are the introduction of:

- A single assessment process which is more streamlined, better involves children, young people and families and is completed quickly;
- An Education, Health and Care Plan which brings services together and is focused on improving outcomes; and
- An offer of a personal budget for families with an Education, Health and Care Plan.

2.3 To this end it was agreed to implement formal programme management arrangements to manage the implementation of these changes. These arrangements, under the banner of the SEND Transformation Programme, are outlined in this document.

3. Aim

3.1 The purpose of this programme is to deliver the desired objectives of the SEND Transformation Programme. In broad terms, this is the development and implementation of an operating model that is compliant with the directives of the SEND Green Paper. The programme will build on the 'business as usual' improvements that have already been made by the service, and will have a focus on responding to the more immediate concerns in the short-term, with medium to long-term strands of work focussing on ensuring future sustainability.

3.2 This briefing will provide an outline of the programme for agreement by the Programme Board and Programme Sponsor. The subsequent programme documentation - produced once approval has been granted - will include a detailed delivery plan.

4. Objectives

4.1 The objectives of the programme are detailed below.

Ref	Deliverable	Date
1.	Early identification and assessment	
i.	Improve multi-agency collaboration through identification, assessment and planning phases	
ii.	Develop and implement a single assessment process from birth to 25	
iii.	Develop and implement the Education, Health and Social Care Plan from birth to 25	
2.	Giving parents/carers more control	

i.	Develop and publish a Local Offer, clarifying what support is available and from whom
ii.	Parents to have the option of a personal budget to give them greater control over their support
iii.	Parents will have access to transparent information about the funding that supports their needs
iv.	Parents of disabled children will continue to have access to a short break
v.	Parents will have a clear choice of school with equivalent rights to express a preference for any state-funded school, including Academies and Free Schools
vi.	Disabled children and children with SEN will have the right to appeal to the Tribunal
3.	Learning and achieving
i.	Leadership and Professional Development: ensuring teachers and staff are trained in effective identification
ii.	Improve the way we identify and support children with SEN and disability
iii.	Accountability: Schools and colleges will be more clearly accountable to parents, governors and Ofsted
4.	Preparing children and young people for adulthood
i.	Implement early and well-integrated support for, and advice on, their future as part of the proposed birth to 25 single assessment process
ii.	Provide access to better quality vocational and work-related learning options to enable young people to progress in their learning post-16
iii.	Ensure well-coordinated transition from children's to adult health services
iv.	Provide good opportunities and support in order to get and keep a job
5.	Services working together for families
i.	Work with the health sector and the new health and wellbeing boards to consider how the needs of children and young people with SEN or who are disabled can best be met
ii.	Work with the Clinical Commissioning Groups to explore the best ways of providing support for the commissioning for disabled children and young people
iii.	Explore how the different funding arrangements for special educational provision pre-16 and post-16 might be aligned more effectively

5. Scope

5.1 The delivery of the objectives (as detailed above) of the SEND Transformation Programme, including all composite projects as agreed by the Programme Board. All other elements remain outside of scope unless the Programme Board and Programme Sponsor specifically request a change to the programme, and the decision to do so is formalised.

6. Programme success criteria

6.1 The delivery of the objectives (as detailed above) of the SEND Transformation Programme, including all composite projects as agreed by the Programme Board, within budget will be deemed successful within the parameters of the programme.

6.2 Measures of success will be determined against the following criteria;

Successful Project Delivery
The successful delivery of the key projects identified in section four, within timescale and budget as per the agreed scope
Resulting In

6.3 Targets will need to be set for all of the above success criteria.

7. Key assumptions

7.1 In determining the parameters of the programme, the following assumptions have been made.

Ref	Assumption
1.	Sufficient[1] resources will be made available to through the SEND Transformation Programme for the support, implementation and delivery of all projects
2.	There is sufficient[1] funding available to deliver the project
3.	The governance structure is adhered to, with representation at all meetings (exceptional circumstances notwithstanding) assured

8. Projects

8.1 This programme consists of a number of projects that will be formally managed as such. There is a high degree of interdependency between many of these projects, and this will need to be carefully managed. A brief description of the projects that comprise this programme are as follows:

Single Assessment and Planning Project

The Green Paper highlighted the importance of identifying children's support needs early so that parents and professionals can put the right approach in place quickly. Professionals from health services, such as health visitors, and from early years settings will work with parents to assess the development of all children to clarify where they need additional support or a different approach, in particular through the health and development review for children aged between 2 and 2½ years.

By 2014, children and young people aged from birth to 25 who would currently have a statement of SEN or learning difficulty assessment will have a single assessment process and 'Education, Health and Care Plan' for their support which will afford parents the same statutory protection as the statement of SEN. All the services on which the child or young person and their family rely will work together with the family to agree an Education, Health and Care Plan which reflects the family's needs and ambitions for the child or young

[1] Sufficiency will be determined by the Programme Board at the inception of the programme.

person's future outcomes covering education, health, employment and independence. The plan will be clear about who is responsible for which services, and will include a commitment from all parties across education, health and social care to provide their services.

This project will comprise a range of workstreams, including the following:

- Single Assessment Process mapping;
- Education, Health and Social Care Plan development
- Establishment of multi-agency resource panels / allocation systems

Local Offer Project

The Green Paper makes it clear that families should be better able to understand the system of support and range of help available for disabled CYP and those with SEN, including in education, care and health, and can navigate available local support more easily. Local authorities and other local services will, therefore, communicate a clear local offer for families to clarify what support is available and from whom. This should include ensuring that parents of disabled children should continue to have access to a short break from caring while their child enjoys activities with their peers;

This project will comprise a range of workstreams, including the following:

- Local Offer development and publication;
- Short Break Statement revision and publication;
- Appeal/Tribunal process mapping

Multi-Agency Strategic Commissioning Project

Resources for disabled children and young people and those with SEN must be aligned to get the best out of investment, reduce duplication, and simplify resource allocation both for the whole system and individual care plans.

Work should be undertaken with the health and wellbeing board to consider how the needs of children and young people with SEN or who are disabled can best be taken into account through the Joint Strategic Needs Assessment and joint health and wellbeing strategies
Work should also be undertaken with the Clinical Commissioning Groups to explore the best ways of providing support for the commissioning of healthcare services for children and young people with SEN or who are disabled and their families.

There should be greater collaboration between local professionals and services and across local boundaries with an increase in the freedom and flexibility with which funding can be used locally.

Exploration of how the different funding arrangements for special educational provision pre-16 and post-16 might be aligned more effectively so as to provide a more consistent approach to support for children and young people from birth to 25 should be conducted. Consideration should also be given to how funding can be targeted at voluntary and community sector organisations that have a strong track record of delivering high quality services.

This project will comprise a range of workstreams, including the following:

- Develop arrangements for joint strategic planning and commissioning;
- Establishment of multi-agency resource panels / allocation systems (including examination of pooled budgets)

Personal Budgets Project

Parents should have the option of a personal budget by 2014 to give them greater control over their child's support, with trained key workers helping them to navigate different services. Parents should also have access to transparent information about the funding that supports their child's needs.

This project will comprise a range of workstreams, including the following:

- Development of mechanisms to enable families and young adults to access a personal budget;
- Development of a directory of local services;
- Development of resource mechanisms to enable direct purchasing by service users

Transitions Project

It is clear that a well-coordinated transition from children's to adult health services is essential. The family and young person's experience of the support system is better, particularly at key transition points, of there is a single coherent system that applies across the ages. Agencies are better able to develop provision as forecasts if projected needs, and service provision, are more joined-up.

This project will comprise a range of workstreams, including the following:

- Transitions process analysis and mapping;
- Operational design to support seamless transitions

Information Technology Systems Project

To support many of the proposed organisational changes covered by this programme, a number of changes to the IT systems and processes will need to be delivered. This will involve the implementation and/or redesign of key systems. There is also a significant requirement for effective and timely information sharing across agencies, both at an individual, service-user level (to enable effective service provision) as well as at a strategic level (to enable effective commissioning).

This project will comprise a range of workstreams, including the following:

- Implementation of a CMS capable of managing the EHCP processes;
- Information Sharing

Operational Design Project

The impact of many of the above changes will mean that examination of the existing operational structures will be necessary.

At this stage this particular project remains largely unspecified, but is expected to involve many areas of the business with multiple work-streams being established under the following broad headings:

- Service Design/Structure;
- Human Resources;
- Workforce Development/Training;
- Performance Management/Management Information;
- Commissioning and Procurement;
- Quality Assurance;
- Business Support;

This project requires considerable further scoping and, at that stage, a more detailed project synopsis can be produced.

9. Interdependencies

9.1 The interdependencies between the various projects are displayed in a matrix appended to this document. Please refer to Appendix B for further information regarding the full range of interdependencies.

10. Key milestone dates

10.1 Key milestone dates will be established within the Programme Plan that will be derived from the various Project Plans once the programme has been approved by the Programme Board and Programme Sponsor.

11. Key risks

11.1 Key risks to the success of the programme are outlined below with an indication of potential impact and, where possible and/or known, mitigations.

Ref	Risk
1.	Lack of appropriate levels of project resources
	A key factor in ensuring delivery of the programme within tolerance is the commitment of appropriate resources. This includes both financial resources (lack of sufficient programme budget) and human assets (lack of sufficient programme support resources). There will be a similar risk associated with the individual projects; a lack of appropriate resources is likely to reduce the probability of projects being successfully delivered. With multiple project interdependencies, the failure of one is also likely to impact upon many.
2.	Securing of appropriate business resources
	Similarly crucial to the success of the programme will be the commitment of appropriate resources from the business. It is crucial that relevant officers are allowed sufficient time and capacity to perform the functions required of them within the parameters of the programme. Whilst every effort will be made during the planning of each project to account for pressures on officers, one each plan has been committed to, any reduction in the projected availability of resources is likely to have a detrimental impact upon the timeliness with which projects are successfully delivered.
3.	Dependency on a small number of officers for project delivery
	Initial scoping of the range of projects comprising the CSTC Programme suggests a high degree of commonality across the project leads and, potentially, each project steering group. With such a high number of interdependencies it is essential that there is significant communication between projects, and this is most easily achieved through cross-pollination of personnel from project-to-project. The risk with this is that a relatively small number of officers may find themselves leading and participating in a high proportion of the programme activity. This will present significant challenges in terms of availability of these officers as well as an increased risk to the programme through absence of any of these key officers, for whatever reason.
4.	Non compliance with programme methodology
	A failure to adhere to agreed programme methodology and/or operating protocols will compromise the ability of the Programme Board and Programme Manager to apply the necessary level of scrutiny and control to the programme. This includes the use of agreed programme documentation.

5.	Maintaining 'business as usual'
With a significant degree of the project resources coming from within existing resources, there is a risk to maintaining business as usual whilst delivering the project. Similarly, an escalation in the volume of business as usual may impact negatively upon programme delivery.	

11.2 Please note that these represent high-level risks to the *programme*. More detailed risks to each of the individual projects will be outlined in each project plan. These will be collated and reported to the Programme Board via the Programme Risks and Issues Log.

12. Key issues

12.1 Key issues of immediate concern to the programme and in need of resolution in advance of project initiation are outlined below:

Ref	Issue
1.	Programme scope
The scope of the programme needs to be agreed. This should include an agreement that the programme scope can only be amended following discussion at the Programme Board and with the authorisation of the Programme Sponsor.	
2.	Programme management structure and governance
The governance, accountabilities and programme structure will are presented below. This will need to be ratified by the Programme Board prior to programme initiation. In addition, the Programme Board will be requested to issue a clear mandate instructing the participation of relevant officers.	
3.	Budget and resource issues
The required level of appropriate resources to successfully deliver the programme to be established and funding to support this agreed and held by the Programme Manager (or designate).	

12.2 Please note that these represent high-level issues concerning the *programme*. More detailed issues for each of the individual projects will be outlined in each project plan. These will be collated and reported to the Programme Board via the Programme Risks and Issues Log.

13. Governance and accountabilities

13.1 The structure and governance of the programme will be crucial to successful delivery. With the number of projects that will fall under the umbrella of the programme, care has been taken to ensure that the balance is struck between key officer involvement being secured, and not placing unrealistic burdens upon these officers.

13.2 For programme management purposes progress will be reported to the SEND Transformation Programme Board (DMT) through a formal highlight reporting mechanism. This Board will have overall responsibility for the execution of the programme. The Programme Board will be chaired by the Programme Sponsor. This group will meet monthly.

13.3 An 'off-line' decision-making process will exist throughout the life of the project. Decisions outside of the formal Board protocols may be taken providing tripartite approval is provided by the Programme Sponsor, Programme Manager and Projects Lead. All off-line decisions will be formally captured and reported to the next scheduled Programme Board for retrospective ratification. The off-line decision making protocol will not apply to

decisions that change the scope of the programme, these decisions must only be made by the Programme Board.

Programme Board Membership	
Name	Role
Helen Jenner	Corporate Director of Children's Services (Programme Sponsor/Chair)
Kamini Rambellas	Divisional Director; Children's Social Care and Complex Needs (Projects Lead)
Chris Bush	Commissioning and Projects Manager (Programme Manager)
Meena Kishinani	Divisional Director; Strategic Commissioning and Safeguarding
Christine Pryor	Divisional Director; Targeted Support
Jane Hargreaves	Divisional Director; Education
Baljeet Nagra	Group Manager; Children with Disabilities Service
Joy Barter	Group Manager; Early Years and Childcare (and LDD Board Chair)
Ann Jones	Group Manager; Education Inclusion
Jeremy Monsen	Principal Educational Psychologist
Sharon Morrow	Chief Operating Officer; Barking and Dagenham CCG

13.4 Operational programme delivery will be steered by a series of Project Managers who will report to the corresponding Project Sponsor. Each project will be supported by dedicated Project Support. The Programme Manager will meet regularly with the Project Sponsors and Project Managers to monitor progress and to facilitate reporting to the Programme Board. It is expected that Project Managers and Project Sponsors will hold their own steering groups as a way of overseeing the delivery of their individual projects. Details of the structure of this can be found below and in greater detail appended to this document.

Projects Structure			
Project	Project Sponsor	Project Manager	Project Support
Assessment and Plans	Joy Barter	Rosie Herbert	Sarah O'Donovan
Local Offer	Jane Hargreaves	Jacqueline Ross	TBC
Integrated Commissioning	Meena Kishinani	TBC	TBC
Personal Budgets	Jenny Beasley	TBC	TBC
Transitions	Kamini Rambellas	Pete Ellis	TBC
Information Systems	Tony Sargeant	Kevin Taggart	Rob Baker
Operational Design	Baljeet Nagra	Paul Richardson	TBC

13.5 In the interests of developing a more robust approach to project management across the department, a group will be formed of all the Project Support officers. This

group will be chaired by the Programme Manager with the purpose of developing a wider understanding of project management methodology as well as providing a support mechanism to these officers.

14. Communication

14.1 The following groups will receive the following reports in line with the cycles set out below.

Reporting plan			
Report	To	Author	Frequency
Programme Highlight Report	Programme Board	Chris Bush	Monthly
Project Highlight Reports	Programme Board	Project Sponsors	Monthly
Project Highlight Reports	Project Sponsors	Project Managers	Monthly
Workstream Progress Reports	Steering Groups	Workstream Leads	Monthly
Risks and Issues Report	All Groups	All Leads	Monthly

14.2 Standardised project documentation will be used. To minimise the burden upon staff much of this documentation has been rationalised so that only that which is absolutely necessary is being used. In addition to regular highlight reports, Project Sponsors/Managers will be expected to produce a Project Brief and an initial Project Plan and Timeline that will need to be updated as the project requests. A timetable for updates and submissions to the Programme Manager will be produced. Failure to adhere to the reporting structure will reduce the ability to track progress holistically.

14.3 Templates of the above project documentation have been produced and tested.

15. Resources

15.1 ***Funding:*** To be established once information from individual Project Plans has been collated.

15.2 ***Staffing:*** To be established once information from individual Project Plans has been collated.

16. Quality assurance

16.1 Quality assurance is a critical component of the programme delivery. To this end, all Project Briefs (produced by Project Manager/Sponsors) will be quality assured at the Quality Assurance Group prior to the first presentation to the Programme Board. This review will include the recommendation (to the Board) of quality assurance/control measures that should be attached to each project.

16.2 Once the programme is live, the Quality Assurance Group will review the progress of each project prior to presentation to the Programme Board. This will occur as part of the monthly reporting cycle.

17. Further Information

17.1 For further information regarding the contents of this report, please contact Chris Bush, Commissioning and Projects Manager by telephone on 020 8227 3188, or via e-mail on christopher.bush@lbbd.gov.uk

Appendix A

Projects Outline (Summary)

Information Systems Development Project

Project Sponsor: Tony Sargeant

Project Manager: Kevin Taggart

Project Support: Rob Baker

EHCP CMS Implementation Workstream	**Lead** Damien Cole
Information Sharing Workstream	**Lead** TBC
Modern Ways of Working Workstream	**Lead** Jeevan Sharma

Integrated Commissioning Project

Project Sponsor: Meena Kishinani

Project Manager: TBC

Project Support: TBC

Commissioning Strategy Workstream	**Lead** TBC
Multi-Agency Resource Panels Workstream	**Lead** TBC
Resource Allocation Workstream	**Lead** TBC

Personal Budgets Project

Project Sponsor: ACS Rep (TBC)

Project Manager: Jenny Beasley

Project Support: TBC

Resource Allocation Workstream	**Lead** TBC
Personal Budgets Process Workstream	**Lead** TBC
Service Directory Workstream	**Lead** TBC

Single Assessment and Plans Project

Project Sponsor: Joy Barter

Project Manager: Rosie Herbert

Project Support: Sarah O'Donovan

Referral and Assessment Process Workstream	**Lead** TBC
EHCP Plan Development Workstream	**Lead** TBC
Multi-Agency Resource Panels Workstream	**Lead** TBC
Eligibility Criteria Workstream	**Lead** TBC
Resource Allocation Workstream	**Lead** TBC
Multi-Agency Resource Panels Workstream	**Lead** TBC
Consultation and Engagement Workstream	**Lead** TBC

Local Offer Project

Project Sponsor: Jane Hargreaves

Project Manager: Jacqueline Ross

Project Support: TBC

Local Offer Development Workstream	**Lead** TBC
Short Break Provision Workstream	**Lead** TBC
Appeal and Tribunal Workstream	**Lead** TBC

Transitions Project

Project Sponsor: Kamini Rambellas

Project Manager: Pete Ellis

Project Support: TBC

Transition Process Workstream	**Lead** TBC
Transition Model Workstream	**Lead** TBC
Transition Plan Development Worksteram	**Lead** TBC
Resource Allocation Workstream	**Lead** TBC
Consultation and Engagement Workstream	**Lead** TBC

Operational Design Project

Project Sponsor: Baljeet Nagra

Project Manager: Paul Richardson

Project Support: Craig Seymour

Operational Service Structure Workstream	**Lead** Baljeet Nagra
Human Resources Workstream	**Lead** Jackie Manood
Training/Workforce Development Workstream	**Lead** Linnett Whittaker
Performance Management Workstream	**Lead** Vikki Rix
Commissioning/Procurement Workstream	**Lead** Valerie Tomlinson-Palmer
Quality Assurance Workstream	**Lead** TBC
Business Support Workstream	**Lead** TBC

Programme Governance

Work Streams

Managed through the individual Project Steering Groups by each Project Manager with the various 'Workstream Leads'

Projects and Project Managers

Assessment and Plans	Joy Barter
Integrate Commissioning	Meena Kishinani
Personal Budgets	TBC
Information Systems	Tony Sargeant
Local Offer	Jane Hargreaves
Transitions	Kamini Rambellas
Operational Design	Baljeet Nagra

Each Project Manager produces a Highlight and Exceptions Report for their project in conjunction with Project Sponsor and Programme Manager for presentation to the Programme Board

Programme Board

Project Sponsors

Joy Barter	Jane Hargreaves
Meena Kishinani	Kamini Rambellas
TBC	Jeremy Monsen
Tony Sargeant	Chris Bush

Other Members

Helen Jenner Christine Pryor Ann Jones Sharon Morrow	TBC ACS Representative(s)

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**The Care Bill**
Report of the Cabinet Member for Adult Services and HR	
Open Report	**For Decision**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Anne Bristow, Corporate Director Adult & Community Services	**Contact Details:** Tel: 020 8227 2300 E-mail: Anne.Bristow@lbbd.gov.uk

Sponsor:

Councillor Reason, Cabinet Member for Adult Services and HR

Summary:

The Care Bill will have a significant impact on the health economy of Barking and Dagenham; it includes major legislative changes and it is thought that it may lead to large financial implications. This report outlines some of the changes stated in the Care Bill, the perceived impact that they will have locally, and what is being done to prepare for the implementation of the Care Bill by the local authority, to be coordinated through a Care Bill Working Group.

This report also suggests how further discussions of the Care Bill and a local response might be included in the plans of the Health and Wellbeing Board over the next few months.

A presentation will accompany this report at the Health and Wellbeing Board to explore some of the issues that will face the local health economy, and particularly the local authority, from the Bill's implementation in 2015/16.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Note the wide ranging implications of the Care Bill and the steps being taken to prepare for the Bill by the local authority.
- Agree on how the Health and Wellbeing Board might respond to the Bill and prepare for its implementation over the coming year.
- Note the opportunity to attend a workshop on the legal implications of the Care Bill (para 5.1).

1. Introduction and Background to the Care Bill

1.1. The Care Bill is a far reaching piece of legislation, which whilst primarily introducing changes to the provision of adult social care will have significant implications for the local health economy as a whole, both financially and operationally. It is anticipated some additional funding will be available but that this will be unlikely to offset the cost of the changes, particularly in the early years of implementation.

1.2. The Care Bill was initially a response to the recommendations of the report of the Dilnot Commission on Social Care, which found that social care funding was unfair and unsustainable, and to the review of adult social care legislation carried out by the Law Commission. The Bill brings together strands from over a dozen Acts into a single framework for care and support. It has subsequently been used as a vehicle for part of the Government's response to the inquiry into the failures at Mid Staffordshire NHS Foundation Trust led by Robert Francis QC and increasingly is being linked by policy makers to the integration and transformation agenda as it progresses through Parliament.

2. Progress of the Care Bill through Parliament

2.1. The draft Care and Support Bill was published in July 2012 following the white paper *Caring for our future: reforming care and support*. Following some amendments resulting from responses received during its public consultation period, the Care Bill was introduced in May 2013 and is moving through the parliamentary process, where it is currently being discussed and read at the House of Lords (see below). There is no set timeframe for the process, but the Bill's progress can be followed at http://services.parliament.uk/bills/2013-14/care.html

2.2. The Care Bill is not expected to receive Royal Assent until mid-late 2014 and therefore the Bill is still relatively early in the legislative lifecycle and many of its details are yet to be decided. It should be noted that significant numbers of amendments are being tabled during the House of Lords stage. However, the legislative changes within the Care Bill are expected to come into force in 2015/16. It should also be borne in mind that there will be widespread use of Regulations and

Statutory Guidance to bring the new Act in to force which may mean there is very limited lead in time for some aspects of this new legislation.

2.3. The fundamental changes within the Care Bill mean that the local authority and the wider health economy need to begin to plan for the impact of the legislative changes now, in order that we are ready for implementation.

3. Summary of the Bill

3.1. Appendix 1 provides a summary of the main features of the Care Bill 2013/14. Of particular note to the Health and Wellbeing Board are the following:

- Changes to the way in which adults pay a contribution for their care;
- National eligibility criteria;
- Portable assessment;
- Statutory responsibility for carers' assessments and provision of support;
- A single failure regime for all NHS Trusts;
- Placing Safeguarding Adults Boards on a statutory footing.

3.2. The table below summarises the anticipated implementation dates for different aspects of the legislation:

Key Requirements	**Timing**
Duties on prevention and wellbeing	**From April 2015**
Duties on information and advice (including advice on paying for care)	
Duty on market shaping	
National minimum threshold for eligibility	
Assessments (including carers' assessments)	
Personal budgets and care and support plans	
Safeguarding	
Universal deferred payment agreements	
Extended means test	**From April 2016**
Capped charging system	
Care accounts	

3.3. The most significant of the changes relate to Dilnot's findings, with the aim of trying to make the cost of paying for care fairer. This includes the introduction of a £72,000

cap on lifetime care costs in respect of residential or nursing care, although this is less generous than commonly believed as individuals must first meet new national eligibility criteria, and 'hotel costs' of £12,000 per year will not count towards the cap. The option of deferring payment until death to avoid selling an individual's home will also become open to all, although local authorities will be able to charge interest on these payments in order to make the scheme financially viable. For those people reliant on services in the community a lower cap of £27,000 will apply but there will not be the same option to defer.

3.4. Several other areas are also covered in the Bill. For the first time carers will be entitled to support on the same basis as those that they care for, and the criteria for 'qualifying' as a carer have been relaxed. The process of moving care between areas is also clarified in the law and there is a requirement to introduce portable assessments which can be transferred between local authorities.

3.5. In response to the failings at Mid Staffordshire NHS Foundation Trust, a single failure regime is introduced for all NHS Trusts, and care ratings will be protected from ministerial interference.

3.6. Safeguarding Adults Boards will also become statutory, and will have to fulfil certain requirements such as a minimum membership.

4. Impact of the Bill on the London Borough of Barking and Dagenham

4.1. The Care Bill will affect the local health and social care economy in several ways and will throw up significant challenges at strategic, operational and practitioner levels. Though the details may change as the Bill is amended on its course through Parliament the impacts below are estimated on the current provisions of the Bill. The Bill is likely to stretch the Council both financially and in terms of staff capacity, and some aspects, such as Safeguarding Adults Boards becoming statutory, will affect partner organisations.

4.2. Some examples of the types of issues that will need to be addressed include the following:

- Because of greater publicity and the overall positive impact on the finances of those in care, it is thought that there will be an **increase in demand for assessments** from self-funders and others who previously did not seek support from the Council. This is anticipated to **increase the total costs of assessment** and will also have an **impact on staff resources** – it is thought that this may lead to the need to recruit extra staff.
- In order to administrate the Care Account, local authorities will need **extensions to their case management systems** to (a) support Care Accounts for all service users and self-funders, and (b) make this available through a portal for service users. It is expected that this functionality will need to be 'portable', so that an individual's Portable Assessment and Care Account can move with them if they relocate. This will mean changes to the Council's social care information systems which will have obvious financial impacts as well as ramifications for staff training, recording processes and case management procedures.
- As part of the Care Bill, local authorities will be under a duty to provide **care and support information**, including how to access **independent financial advice** where it is needed. This will require local authorities to ensure that independent financial advice is available and review and amend information and advice

channels, particularly the Council's website, to ensure that residents understand the options available to them and plan for meeting care and support needs.

5. Preparing for the Care Act

5.1. The Council has set up a Care Bill Working Group to discuss the implications of the Bill and prepare for its implementation. It is anticipated that as the analysis work progresses there will be significant implications for all partners as the new legislation will require considerable changes to professional practice and operational systems. On 26 November 2013 Belinda Schwehr from Care and Health Law will deliver a session on the legal implications of the Care Bill and its likely strategic impact. Whilst primarily aimed at local authority managers Board members who wish to attend the session or be represented by a senior colleague should advise the Clerk to the Board who will make the necessary arrangements.

5.2. It is suggested that the impact and local response to the Care Bill are given a substantial amount of time by the Health and Wellbeing Board over the coming year, particularly as more details become available and the detailed implications are worked through. The Board may also wish to request an update on changes to the Bill at different stages in the future as it progresses through the Parliamentary process. It is proposed to bring reports to alternate Board meetings over the next year.

6. Mandatory Implications

6.1. Joint Strategic Needs assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall analysis of health and social care as well as a detailed safeguarding element within it. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

6.2. Health & Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The strategy is based on four priority themes that cover the breadth of the frameworks and in which a large number of elements of the Care Bill can be picked up within. These are: Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes. These may need to be reviewed as the Bill goes through its journey to become an Act.

6.3. Integration

6.4. The proposals currently in the Care Bill do little to further the practicalities of integration with the NHS. The underlying principle remains that social care services are chargeable and provided subject to a separate eligibility assessment, while the NHS is free at the point of delivery funded from general taxation.

6.5. However the establishment of statutory Safeguarding Adults Boards with mandated CCG membership is to be welcomed and this should drive local ownership of the safeguarding agenda across health and social care. Furthermore, taken alongside the provisions in the forthcoming Children's SEN Bill, there will be a strengthening of transition arrangements for young people who will require social care services in adulthood.

6.6. **Financial Implications**

(Implications completed by Roger Hampson, Group Manager, Finance)

From April 2015, there will be a universal requirement for local authorities to offer deferred payment agreements to care users who meet certain criteria; and although the cap on care costs does not come into force until April 2016, local authorities will face transitional costs in 2015/16. To meet these costs in 2015/16 the Government will be providing a £285m revenue grant. Of this, £110m is to cover the cost of deferred payments, and £175m is to cover the capacity building and early assessments required for transition to the capped cost model. In addition the Community Capacity Capital Grant, which will form part of the pooled Integration Transformation Fund in 2015/16, will include £50m for IT changes necessary for integration and funding reform. The amounts to be allocated to Barking and Dagenham from these national funds are not yet known.

Other policies in the Care Bill will also lead to additional costs, including new duties for the assessment and support of carers, better provision of information and advice, and a national minimum eligibility framework. Further detailed work is needed to assess the full impact of the Social care funding reform for the Council in 2015/16 and beyond. This work will be overseen by the Care Bill Working Group.

6.7. **Legal Implications**

(Implications completed by)

7. List of Appendices

Appendix 1: Summary of the Care Bill

APPENDIX 1

Summary of the Care Bill

1. New responsibilities for local authorities in supporting and caring for adults

Local authorities will be required to provide comprehensive information and advice on all care and support services in their local area, how the services work, and how to access them. They will also be required to produce market position statements.

2. Core entitlements to public care and support

The Bill will create a single consistent route for establishing entitlement to public care, and a national eligibility threshold for the statutory needs assessment, although the details are not yet specified. For the first time carers will also be entitled to support on a similar basis to those that they care for. The legal duty for an adult's "eligible needs" to be met by the local authority will be subject to their financial circumstances and capacity to organise care. There will be more flexibility to design personalised packages of care.

3. Personalising care and support planning

Personal budgets will be recognised in law for the first time, and direct payments must be given if the service user requests them, and meets requirements set out in the Bill. Local authorities must provide a care and support plan, or support plan in the case of a carer, which will be reviewed and updated.

4. Charging and financial settlements

The Bill consolidates rules on charging for care and support, and opens the option of deferred payment to all homeowners with assets below a certain threshold. Local authorities will be able to charge interest on these deferred payments.

5. Care and support funding reforms

From April 2016 the Bill will put a cap, which is expected to be £72,000 for adults over 65, on lifetime care costs, the cap will be £0 for those under 18, and the working age cap has not yet been set. The upper capital limit, above which an individual has to pay the full cost of their care until they reach the £72,000 cap will be raised from £23,250 to £118,000 in assets, including savings and property. Payments made before 1 April 2016 will not count towards the cap, and both council and individual contributions will count towards the cap.

Not included in the cap are certain extras such as the additional cost choosing a more expensive care option or employing gardeners or cleaners, and individuals will remain responsible for a contribution towards general living costs covering room and board, equivalent to £12,000 p.a. by 2016/17.

6. Protecting adults from abuse and neglect

The Bill creates a legal framework for adult safeguarding, including making Safeguarding Adults Boards (SABs) statutory and specifying minimum membership (LA, NHS and police), and functions such as shared safeguarding plans. Local authorities will be required to make enquiries when they think that a vulnerable resident may be at risk, whether or not they are providing the care. The Bill does not

give local authorities power of entry. Boards will also be responsible for Safeguarding Adult Reviews, and organisations will have a duty to share information requested by the SAB.

7. The law for carers

The Bill brings together legislation on all carers, apart from young carers (under 18) and adults caring for disabled children, who will continue to be supported through children's law and services. Carer's rights are brought more into line with those of the people who they care for, and they no longer need to be providing "a substantial amount of care on a regular basis" to qualify for an assessment. A joint assessment of the needs of a carer and the person that they care for can be undertaken if both agree. Carers should receive a personal budget from the local authority and have the right to request direct payment.

8. Continuity of care when moving between areas

When a service user wants to move areas local authorities need to share copies of care and support plans, and a "care account" and "independent personal budget" if applicable, as well as the carer's support documentation if they are also moving. Any different needs identified by the new authority must be explained in writing. The new authority must continue the same level of care until they carry out their own assessment.

9. Marketing oversight and provider failure

Local authorities will be legally responsible for continuing care when a provider fails, even when that care was privately funded. The Care Quality Commission is given authority to request information from any provider may be in danger, which it will share with relevant local authorities. It can also insist that a provider develop sustainability plans, and where necessary arrange an independent business review.

10. Transition for children to adult care and support services

Young people and carers of children will be given the right to request an assessment before turning 18 to help them to plan for the care that they will need. The Care Bill also explicitly states links to the Children and Families Bill as both Bills advocate the need for cooperation within and between local authorities to ensure that professionals are discussing issues, that the right information and advice is available and that assessments can be carried out jointly.

11. Single failure regime

The single failure regime for NHS Trusts and Foundation Trusts will give regulators clearer roles in tackling failure. CQC will assess providers through peer-led inspections and ratings led by the Chief Inspector of Hospitals. CQC will be given power to issue a warning notice to NHS Trusts and Foundation Trusts, which will allow Monitor additional powers of intervention. The Care Bill also amends the special administration process.

12. Health and social care ratings, and false and misleading information

The Francis Report showed that serious problems with quality of care were not picked up quickly enough, and that false or misleading information allowed poor care to continue. In response the development of ratings will become the sole

responsibility of CQC with no role for Ministers in agreeing the ratings method, and it will become a criminal offence to provide false or misleading information.

13. Health Education England and the Health Research Authority

The Care Bill turns Health Education England and the Health Research Authority from Special Health Authorities into Non Departmental Public Bodies, with clearly defined duties and powers set out in the Bill. The Health Research Authority will also be able to cover social care research as well as health research.

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HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Integration Transformation Fund**
Report of the Integrated Care Sub-Group	
Open Report	**For Decision**
Wards Affected: NONE	**Key Decision: NO**
Report Authors: Bruce Morris, Divisional Director Adult Social Care and Sharon Morrow, Chief Operating Office Barking and Dagenham Clinical Commissioning Group.	**Contact Details:** Tel: 020 8227 2749 E-mail: Bruce.morris@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services Conor Burke, Accountable Officer, B&D CCG	

Summary:

The Integration Transformation Fund was announced in June 2013 within the Government's spending review. It was described as creating a national £3.8 billion pool of NHS and Local Authority monies intended to support an increase in the scale and pace of integration and promote joint planning for the sustainability of local health and care economies.

The fund is made up of a number of differing existing funding streams to Clinical Commissioning Groups and Local Authorities, anticipated annual grants, as well as recurrent capital allocations. At this stage it is not clear there is any new or additional funding. This creates risks for existing services funded from these sources, either if conditions and targets attached to the fund are not achieved or if new priorities are identified for this funding.

Access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. It is anticipated that this plan will need to be agreed by the Health and Wellbeing Board before March 2014. Plans agreed locally will need to align with national criteria which are yet to be announced along with local allocations and Ministers will ultimately approve any plans.

£1 billion of the funding will be held back and released subject to performance against national and local targets. There is a further allocation nationally of £200m (transfer from the NHS to local authorities in 2014/15) which is intended to progress on priorities and build momentum.

At this stage the Board need to be aware that any new priorities which require investment will also require plans for dis-investment. Work is underway between CCG and LBBD officers to agree local priorities for investment for discussion at February's H&WBB meeting.

The announced conditions attached to the Integration Transformation Fund imply a complex set of targets that will be directly overseen by Government. They provide opportunities for greater integration as well as significant challenges for both the CCG and the Local Authority.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

a) That Board Members will ask relevant officers within the CCG and local authority to draft and prepare the plans for discussion at a future Board and submission to the Department of Health.

b) That the Integrated Care Sub-Group lead on both the development of the plan and any subsequent monitoring and reporting to the board, together with any implications.

c) Note the opportunities alongside the implications for disinvestment

d) To note that a further report will come to the Board with the draft two year plan in February 2014.

e) Board Members consider the draft shared priorities in (2.2) that will form the basis for concrete proposals to be considered at a future meeting

1. Background and Introduction

1.1. The Government's spending review in June 2013 announced a £3.8bn fund nationally for NHS and Social Care Services in 2014-16 to support the model of integrated health and social care.

1.2. Practically, this will be delivered through a "pooled budget" with the aim of reducing demand for NHS services and builds on the success of the transfer of funds from NHS to councils since 2011.

1.3. The funds on offer need to be applied for jointly by Local Authorities (LAs) and Clinical Commissioning Groups (CCGs) on the basis of a locally agreed joint commissioning plan by March 2014 which will set out actions to achieve set outcomes in both 2014/15 and 2015/16. The local plan will need to be agreed by the Health and Wellbeing Board and agreed by both parties before submission to the Department of Health who will assure plans prior to funds being released.

1.4. As part of achieving the right balance between national and local inputs the Local Government Association, Association of Directors of Adult Social Services and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

1.5. £1bn of the £3.8bn Integration Transformation Fund in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of those outcomes during 2014/15 as the first half of the £1billion, paid on 1st April 2015 will be based upon performance in the previous year. The rest, will be paid in the second half of 2015/16, and will be based on in year performance. Performance will be judged against a combination of nationally-agreed and locally-agreed indicators. It is not yet clear on what will be measured or how but early indications suggest that these will relate to:

- Delayed Transfers of Care;

- Emergency Admissions;
- Effectiveness of re-ablement;
- Admissions to residential and nursing care;
- Patient and Service User experience.

1.6. It is understood that in the event that agreed levels of performance are not achieved there will be a process of peer review, facilitated by NHS England and the Local Government Association, to avoid any financial penalties which may impact upon the quality of service provided to local people.

1.7. The outline timetable for developing the pooled budget plans, conditions and metrics in 2013/14 is as follows:

- August to October: Initial local planning discussions and further work nationally to define conditions
- November/ December: NHS Planning Framework issued
- December to January: Completion of plans
- March: Plans assured

1.8. NHS England and the LGA and ADASS will work with the DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of funds
- Conditions, including definitions, metrics and application
- Risk sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs

1.9. Further announcements are expected in early November for performance metrics and risk sharing arrangements and a review of 'readiness' is also anticipated in November 2013.

2. Proposal and Issues

2.1. In August, NHS England and the Local Government Association published a joint statement setting out how the integration and transformation fund is to be managed. This guidance states that Local Authorities will be allowed to use part of the Integration Transformation Fund (ITF) to protect social care against cuts.

2.2. The ITF will be a pooled budget which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- Plans to be jointly agreed between the local Authority and the CCG;
- Protection for social care services/spending with the definition determined locally;
- As part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;

- Better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- Ensure a joint approach to assessments and care planning;
- Plans and targets for reducing Accident and Emergency attendances and emergency admissions.
- Ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Risk-sharing principles and contingency plans if/ when targets are not met – including redeployment of the funding if local agreement is not reached; and
- Agreement on the consequential impact of changes in the acute sector.

2.3. The June 2013 Spending Round set out the following:

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned.	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

2.4. In 2015/16 the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration from the following funding streams:
£130 million Carers' Breaks funding.
£300 million CCG re-ablement funding.
c. £350 million capital grant funding (including £220m of Disabled Facilities Grant).
£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in Adult Social Care and some of the costs associated with the Care Bill. £1 billion will be performance related, with half paid on 1 April 2015 (and it is anticipated will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in year performance).

2.5. There needs to be recognition by both parties of the challenges faced by both Local Authorities and Clinical Commissioning Groups and that these are addressed jointly.

2.6. National guidance indicates that given demographic pressures and efficiency requirements of around 4%, CCGs nationally are likely to have to redeploy funds from existing NHS services. It is therefore critical in such cases, that CCGs and Local Authorities engage health care providers to assess the implications for existing services and how these should be managed.

2.7. S256 monies will no longer be an automatic transfer as historically has been the case.

2.8. The conditions the Government has set make it clear that the pooled funds must deliver improvements across social care and the NHS. Robust planning and analysis will be required to:

- target resources on initiatives which will have the biggest benefit in terms of outcomes for people and
- measure and monitor their impact;

2.9. Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS 'Call to Action').
- Road shows in London will be scheduled for November providing key stakeholders with an opportunity to meet with Department of Health leads and further details will be released shortly.

3. The local position

3.1. Integrated Care is a well established model in Barking and Dagenham. The organisation of services around GP practices including social workers and some community health staff has been achieved. However, there is more work to be done to ensure shared goals and objectives across specific projects in health and social care are made explicit, shared targets are set, and achieved. Specific work in relation to integrated care is in hand to target interventions at the most frequent attenders of local Accident & Emergency departments and those with the greatest health need.

3.2. Work is already underway in a number of areas to improve the patient experience. Expected outcomes relate to improving end of life provision, falls prevention and targeted care and support for those leaving hospital. Outcomes for the next two years will build on this and complement what is already available.

3.3. It is proposed that the development of the required two year integrated plan is lead locally by the Integrated Care Sub Group of the Health and Wellbeing Board. The Board recently approved allocations of 2013/14 Re-ablement Funding which included funding for a short term Integrated Delivery Manager who is currently working across the local authority and CCG developing proposals. The board may wish to consider other joint commissioning posts to oversee the delivery of the plans associated with the fund.

3.4. Local Authority and CCG Finance Officers have begun work on identifying where the potential sums that may make up the fund are currently allocated. As the monies comprising the fund are already committed to existing care activity partners under the governance of Health and Wellbeing Boards need to fully consider any assumptions and the implications on existing services of a redirection of funds.

3.5. The basis for determining the local allocation of the £3.8 billion has not yet been announced and will be subject to ministerial decisions. However, at present the working assumption for work so far is this would be the same formula as used for the s256 allocations. For Barking and Dagenham this would approximately be £14m in 15/16. Based on that assumption, approximately £3.7m of the £14m would be tied to performance against outcomes set out in the local joint plan.

3.6. Whilst we are planning on this basis local partners will be able to put additional funding into the pooled budget from their existing allocations if they want to do so and indeed this may be an opportunity for creating a larger "joint pot" for plans that can be jointly agreed.

3.7. Work will need to be done to dovetail performance indicators form both sides into one set. The draft plan with outcome targets will be brought for sign off to the Health and Wellbeing Board in February 2014.

4. Draft Priorities

4.1. Early discussion between commissioners has indicated the need for developing a set of local shared priorities that can be used as a basis for developing concrete proposals. These have been developed mindful of the intended scope of the fund, and the funding streams that will be used to form the pool. These will be developed further but they will be used to guide further discussions and proposals and will be framed around Personalisation and the individual patient or service user.

- Delivery of the Integrated Care Strategy.
- Integrated Health and Social Care working through delivery of the Joint Assessment and Discharge Service supporting 7 day working and improved arrangements for admission avoidance and discharge.
- Exploring opportunities to utilise joint commissioning roles, notably in Learning Disability and Mental Health.
- Supporting a joint and strengthened commissioning role with provider services.
- Improvements in primary care improving access to support and interventions in people's own homes with less reliance upon acute services.
- Improvements in prevention, keeping people well and healthy for longer and protecting support for carers.
- Improving End of Life Care which enables greater numbers of people to be effectively cared for at home or in the place of their choice.
- Protecting Social Care Spending and services.
- Ensuring Integrated Service delivery to those families with the most complex needs.

4.2 Members are invited to comment on the shared priorities at this stage and whether they cover the areas the Board would like the Integration Transformation Fund proposals to focus on.

5. Mandatory implications

5.1. Joint Strategic Needs Assessment

Integration is one of the themes of the JSNA 2013 and this paper is well aligned to address and support the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.

The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and this paper identifies which areas can be addressed in more integrated way to shape future sustainable strategies for the borough.

Social care and health Integration is a recommendation of all seven key chapters of the JSNA but in particular for:

- Supported living for older people and people with physical disabilities
- Dementia
- Adult Social Care
- Learning Disabilities
- Mental health - Accommodation for People with Mental Illness
- End of Life Care

5.2. Health and Wellbeing Strategy

There are areas of health and wellbeing that would benefit particularly from an integrated approach to planning and funding. The Integration of CCG and social care commissioning through the mechanism of a pooled budget provides opportunities for better joined-up care which can lead to better outcomes for service users and improved use of current resources across health and social care.

A specific and obvious area for the Integration Transformation Fund is supporting older people's health and care needs. Older People often have complex co-morbidities and interacting health and social care needs. In particular discharging older frail people with a number of health conditions back home requires careful planning and a coordinated plan of support.,. Development of an integrated team to oversee the planning of complex hospital discharges should positively impact upon people leaving hospital in a safe and timely way and avoid the need for re-admission.

5.3. Integration

One of the established outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. This report makes recommendations related to the need for effective integration of services and partnership working.

5.4. Financial Implications

(Implications completed by: Roger Hampson, Group Manager Finance)

Information on the health and social care Integration Transformation Fund in this report has been taken from the joint statement from NHS England and the Local Government Association issued on 8th August 2013. Details of how the scheme will work at national and local level have yet to be finalised; further detailed work alongside the completion of the plan and its priorities will be necessary to consider the impact of the proposed pool upon existing services, and the sharing of risk between the local authority and the Clinical Commissioning Group.

As can be seen the fund is made up from a number of existing funding streams both capital and revenue. While many of the revenue funding streams are currently committed to core services and assist with pressures in base budgets the capital allocations are currently the subject of grant conditions and dedicated to one purpose and the consequences of any dis-investment proposals will need to be considered carefully. For example Disabled Facilities Grants (DFG) are dedicated for use to fund major adaptations in privately owned property and any reduction would have an impact on the availability of grants for this purpose.

5.5. Legal Implications

(Implications completed by Chris Pickering, Principal Solicitor)

The report sets out the basis for the fund and there are no legal implications at this stage. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets. Government officials are exploring the options for laying any required legislation in the Care Bill. Further details will be available in due course. The wider powers to use Health Act Flexibilities to pool funds, share information and staff are unaffected. Consultation will be necessary as well as an Equalities Impact Assessment with regards to how monies are spent.

5.6. Customer Impact

It is expected that integrated systems will improve the service user journey and experience. Work will need to be done to assess the impact on existing service provision to ensure any redirection of resources is not detrimental.

5.7. Contractual Issues

Services will need to be jointly commissioned by Local Authorities and CCGs. Agreement will need to be reached on contract leads for particular aspects of delivery.

5.8. Staffing issues

Any staffing implications will need consideration as part of the development of the joint plans.

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title: Learning Disabilities 2012/13 Joint Health and Social Care Self Assessment Framework	
Report of the Learning Disability Partnership Board	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: No**
Report Authors: Jamil Ahmed, Commissioning Manager, NHS Barking and Dagenham CCG. Pete Ellis, Strategic Commissioner, LBBD	**Contact Details:** Tel: 020 3644 2376 email: Jamil.Ahmed@barkingdagenhamccg.nhs.uk Tel: 0208 227 2492 email: pete.ellis@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services	

Summary:

The Joint Health and Social Care Self-Assessment Framework (JHSCSAF) is one of the key elements of the Winterbourne View Concordat which has previously been reported to the Board.

The new framework replaces and combines the local authority *Valuing People Now* Self-Assessment and the NHS Learning Disability Health Self-Assessment and becomes a comprehensive needs assessment.

This report sets out the content of the JHSCSAF and provides the board with an overview of the areas for improvement that have been identified as part of this process.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Note the initial findings from the Joint Health and Social Care Self-Assessment Framework (JHSCSAF);

(ii) Note there are areas that have been self-assessed as 'less effective' at this stage, and require the Learning Disability Partnership Board to report back with an improvement plan to tackle these areas to a future meeting.

Reason(s)

As part of the governance arrangements for the Joint Health and Social Care Self-Assessment Framework (JHSCSAF) there is a requirement to bring the borough's submission through the Health and Wellbeing Board for validation.

1. Introduction

1.1 This report provides members of the Health and Wellbeing Board with information about the work currently being undertaken within the Joint Health and Social Care Learning Disability Health Self Assessment Framework (JHSCSAF).

1.2 The JHSCSAF has been created from intelligence gained during the development of the previous Learning Disability Partnership Board annual report and the Learning Disability Health Self Assessment Framework. The aim of this framework is to provide a single, consistent way of identifying the challenges in meeting the needs of people with learning disabilities, and documenting the extent to which our shared goals of providing good quality care are being met.

1.3 This is intended to assist Learning Disability Partnership Boards, Health and Wellbeing Boards, Clinical Commissioning Groups and Local Authorities identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities in their areas. It should also provide a sound evidence base against which to monitor progress.

2. Background to the current arrangements

2.1 The Learning Disability Health Self-Assessment was introduced in 2009/10 and was led by Strategic Health Authorities. It has become an important guide for both the NHS and Local Authorities as one of the key sources of data intelligence. The aim was to identify the overall needs, experience and wishes of both young people and adults with learning disabilities and their carers; and bring these perspectives into the tasks of determining local commissioning priorities and monitoring services.

2.2 In January 2009, the Department for Health published '*Valuing People Now: a new three-year strategy for learning disabilities*'. This set out the Government's strategy for people with learning disabilities and included a recommendation that local Learning Disability Partnership Boards should write an annual report on their progress towards the strategy's goals.

2.3 The March 2009 report from the Local Authority and Parliamentary Health Service Ombudsmen entitled *'Six Lives: the provision of public services to people with learning disabilities'* recommended that all NHS and social care organisations should:

- Review the effectiveness of the systems they have in place to enable them to understand and plan for the needs of people with learning disabilities;
- Review the capacity and capability of the services they provide and/or commission to meet the additional and often complex needs of people with learning disabilities; and
- Report accordingly to those responsible for the governance of those organisations.

Winterbourne View Joint Improvement Programme

2.4 Action 38 of the *Winterbourne View Concordat* committed the NHS Commissioning Board (now NHS England) and Association of Directors of Adult Social Services (ADASS) to '*implement a joint health and social care self-health assessment framework to monitor progress of key health and social care inequalities from April 2013*.'

2.5 A key successful feature of the current self assessment process is the inclusive approach which listens to and incorporates the lived experience of service users and carers. The Winterbourne View report has identified the need to engage and empower people and their families, and the SAF will provide a robust mechanism to identify areas to make improvements to our services.

3. Overview of the JHSCSAF

3.1 The JHSCSAF comprises three comprehensive sections which have been completed and submitted to Public Health England. These are:

- 'data collation';
- 'self assessment' against nationally agreed measures;
- 'Shared stories' completed by people with a learning disability and carers.

3.2 **Data collation**
As part of the SAF we are required to collate a comprehensive and a wide range of data across health and social care. This covers the following sections:

- Healthcare and health needs (such as numbers of people known to GP's, those in inpatient services, continuing healthcare and those with challenging behaviour);
- Assessment and Social Care services;
- Inclusion and where I live (e.g. employment and housing);
- Quality (e.g. number of safeguarding alerts and money spent on training); and
- Transition.

3.3 **Self assessment against nationally agreed measures (SAF)**
As part of the SAF we were required to self assess ourselves against **27** measures using a RAG 'Traffic Light' system. These are aligned to the outcome frameworks - Adult Social Care Outcomes Framework (ASCOF), Public Health Outcomes Framework (PHOF), National Health Service Outcomes Framework (NHSOF), Winterbourne View Concordat and Health Equalities Framework (HEF). These nationally agreed outcome frameworks and policies were used as the evidence base for the three broad areas in the SAF, which are:

- **Section A - Staying Healthy**
  This asks questions about making sure people with learning disabilities can be as healthy as everyone else. It includes questions about making sure we have the right information about people, health action plans and annual health checks and assess that people are being supported to manage their own health. It also asks questions whether universal or mainstream health services are making reasonable adjustments.
- **Section B – Being Safe**
  This section looks at safeguarding and quality. Making sure that we design, commission and provide services which give people the support they need close to home, and which are in line with well-established best practice. This was highlighted in the Winterbourne Review Concordat.
- **Section C – Living Well**
  This section is about inclusion, being a respected and valued part of society and leading fulfilling and rewarding lives. People with learning disabilities and their family carers deserve an equal opportunity with the rest of the population

to fulfil their lives as equal citizens of our nation safe from crime and intolerance.

3.4 **Shared Stories**
As part of this year's SAF we were required to ask people with learning disability and their carers to feedback on both good and bad experiences of health and social care services that they have received, through an exercise called "shared stories".

Uses of the Framework

3.5 Findings from the JHSCSAF will be used both locally and nationally. Nationally, it will be used to report publicly and to Ministers on the progress in providing services in every part of the country to meet the aspirations of *Healthcare for All* and of *Transforming care: A National Response to Winterbourne View*.

3.6 Locally, the outcomes from the SAF will be used to inform:

- Joint Strategic Needs Assessment (JSNA);
- Health and Wellbeing Strategies;
- Commissioning intentions/strategy;
- Winterbourne improvement joint plans; and
- Learning Disability Partnership Board work programmes.

Submission and Validation processes

3.7 The JHSCSAF was released by Public Health England on the 8th September giving an external deadline for submission for the 30th November. The work required to complete it was extensive and inclusive, requiring input from across the Council, CCG, NHS NELFT, NHS BHRUT, local provider services, people with a learning disability and carers. The summary of the initial results are described in Section 5.

3.8 Following submission, the self assessment framework will be validated jointly by the NHS England Area Teams and regional ADASS leads. Their role is to critically appraise the scoring and evidence and compare our area against other areas in London and provide feedback. As part of the assurance process they will consider the approach taken locally to seek views from people with a learning disability and family carers. A validation panel will be held where a final agreement on the scoring will be made and outcome of the SAF will be confirmed.

4. Data Collation

4.1 As part of the JHSCSAF to a large amount of data held on separate sytems regarding our learning disability population was collated. The initial key areas identified for the H&WBB to note are:

- 673 people with a learning disability are identified on GP registers. These are: 128 0-17 year olds; 506 18-64 and 39 adults aged 65+. 62 of these also have either profound or complex needs.
- 31% of people with a learning disability over 18 are identified as having a BMI in the 'obese' range.

- screening levels for physical health problems were low in comparison to the population's average.

Screening type	B&D Population Average	LD Population Average
Cervical cancer	55%	26%
Mammographic screening	48%	39%
Bowel cancer screening	25%	25%

- 81% of those deemed eligible under the DES received an Annual Health Check. An improvement from lasts year of 69% and well above the London average.
- From 2013 we have 6 people with a learning disability or autism, with challenging behaviour in NHS funded care on the CCG register.
- 119 safeguarding alerts were made for adults with a learning disability. This equates to approximately 10% of all alerts made.
- 54 Young People aged 14+ are currently the subject of a Transition Plan.
- 10% of commissioned out of borough accommodation, residential or nursing placements had unannounced visits.
- 26 adults with a learning disability, known to the council, were in paid employment and 32 in some form of voluntary work.
- There were no adults identified with a learning disability in unsettled accommodation (i.e. homeless, rough sleeping or temporary accommodation).
- There are 1,112 people who care for people with a learning disability.

5. Overview of results

5.1 The findings from the SAF show that plans are in place to continue delivering change and improvements in the commissioning and delivery of care for people with learning disabilities to address health inequalities and achieve comparable health outcomes.

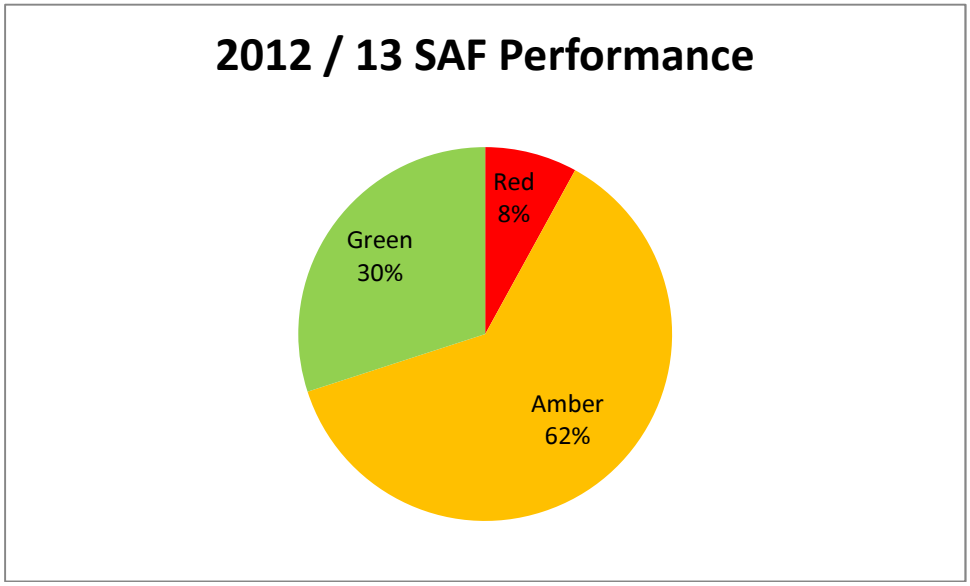
5.2 Each of the domain areas has a range of performance measures, as listed in the self assessment template, against which there are three possible assessment outcomes:

Less Effective

Effective

Exceeds requirements

5.3 A summary of the provisional/draft self assessment for Barking and Dagenham is shown below. The detailed SAF shows there was only 1 measure (4%) where our position was assessed as less effective (red). Our responses and evidence to 66% of the questions were identified as effective (amber), and 30% were considered as exceeding requirements (green). This is shown visually in the chart below:



5.4 Discussions with neighbouring areas indicates that, subject to the external validation processes described above, our position will compare favourably with other London boroughs. However further work will be required to continue to drive up service standards, particularly in the areas highlighted below.

Areas assessed as excelling

5.5 These include:

- Completion of Annual Health Checks and Health Action Plans;
- Barking & Dagenham's sport and leisure offer for people with a learning disability;
- evidence that providers changed practice as a result of complaints, whistleblowing and feedback;
- Equality Impact Assessments in relation to strategies for the provision of support, care and housing are in place;
- A process for contract compliance assurance with commissioned services;
- Completion of Annual Health Checks and Annual Health Check registers.

Areas assessed as "Less Effective"

5.6 **Offender Health and Criminal Justice**
To self assess as effective or excelling there needs to be an assessment process for people with learning disability in the criminal justice system, systematic training for partners in the criminal justice system, good information on the health needs of offender with a learning disability and evidence around prisoners receiving a Health Action Plan.

5.7 The Council has good relationships with criminal justice partners through the Community Safety Partnership, the Safeguarding Adults Board and the Learning Disability Partnership Board where the Autism action plan is reviewed and monitored. In addition, local health and social care practitioners work in partnership on a daily basis via a number of routes including acting as appropriate adults,

working with the Public Protection Unit,MAPPA and local probation services to support the management of vulnerable people who present a risk to the public.

5.8 However there will need to be a more systematic and strategic approach to ensure services are able to demonstrate they have taken the needs of people with a learning disability into account throughout the criminal justice system.

5.9 **Regular Care Reviews**
The expectation is that 90% of all social care packages were reviewed in 2012/13. Our current performance across adults and childrens services is 85% so there is further work to achieve the required standard.

Summary of improvements required

5.10 The self assessment has indicated that we are "effective" in each of the three key domains of the self assessment framework. However a summary of the themes emerging and work required to rate ourselves as excelling is provided below:

- **Section A - Staying Healthy**
  A key theme for improvement emerging from this was improving screening uptake, reasonable adjustments to our health services and better communication with healthcare services on patients with a learning disability.
- **Section B – Being Safe**
  One of the key areas for improvement is to deliver awareness training and ensuring reasonable adjustments within universal services.
- **Section C – Living Well**
  the JHSCSAF placed an emphasis on access to the local community (i.e. local arts and leisure services, sports & culture, transport amenities and employment). The assessment indicated there is further work to be done in this area which will be addressed as we implement the Council's vision set out in Fulfilling Lives.

6. Shared Stories

6.1 In total we received 66 shared stories from people with a learning disability and carers that will support the SAF. These were collated through service user and carer forums, which are part of the Learning Disability Partnership Board structure, and local providers who completed workshops with their service users.

6.2 The main themes emerging from the shared stories were both the good and poor experiences of accessing local health care services (ranging from acute, community to primary care services), and the experiences of being supported in the community by local services. These also confirm the data provided, especially on accessing health screening.

7. Consultation

7.1 In completing the JHSCSAF the partnership consulted service users, family carers, providers and professionals. This was delivered through:

- Completion of the JHSCSAF was overseen and monitored throughout by the Learning Disability Partnership Board.

- Both the service user and carer forums, which are part of the Learning Disability Partnership Board structure, were used as opportunities to gather shared stories around health and wellbeing.
- Local health and social care provider services supported the council and CCG in gathering shared stories from people with a learning disability and their carers.

8. Mandatory Implications

8.1 **Joint Strategic Needs Assessment**

The JHSCSAF provides useful data that can inform and support the JSNA process, in particular the sections on:

- Section 3.2 - Children and Young People with a Learning Disability;
- Section 4.3 – Learning Disabilites and Employment Adults with a Learning Disability Section and health issues they face;
- Section 7.3 – Adults with a Learning Disabiloty and the health issues they face; and
- Section 7.4 - Autism.

8.2 **Health and Wellbeing Strategy**

The JHSCSAF supports and informs the delivery of a number of themes within the borough's Health and Wellbeing Strategy, across the whole life course. In particular, the SAF provides a framework for reviewing the work that is undertaken across all four major themes of the Strategy with respect to people with learning disabilities: to prevent ill-health, promote safety, integrate services and increase choice and control.

8.3 **Integration**

The JHSCSAF has been designed to improve better integration between health and social care in the area of learning disability. Through competing the Joint HSCSAF, along with the ongoing work on joint local strategic plan and the S75 agreement, it strengthens integration and enables us to identify areas for improvement.

9. Non-mandatory Implications

9.1 **Safeguarding**

Through completing this year's JHSCSAF we assessed ourselves as being effective in complying with our statutory duties on safeguarding people with a learning disability.

10. Background Papers Used in Preparation of the Report:

- Winterbourne View Concordat
- Paperwork for the JHSCSAF

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**The Francis Report**
Report of the Barking and Dagenham Clinical Commissioning Group	
Open Report	**For Discussion**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Jacqui Himbury, Nurse Director, BHR CCG's	**Contact Details:** Tel: 020 8822 3152 E-mail: Jacqui.himbury@onel.nhs.uk
Sponsor: Conor Burke, Accountable Officer, B&D CCG	

Summary:

Further to an update report on the implementation of the Francis recommendations and the establishment of a designated task and finish group presented at the September meeting of the Health and Wellbeing Board, this report aims to appraise members of progress made to date.

Recommendation(s)

The Health and Wellbeing Board is asked to:

a) Consider the report noting the progress made to date

b) Discuss the implications for Barking and Dagenham and propose any further actions the Board agrees are required.

1. Introduction

1.1 While the Francis report may have focused on the care failings in Mid Staffordshire, the lessons learned apply to commissioners and providers across the country. The Francis report is arguably the most influential report in recent years on the state and practice of the NHS. The Health and Wellbeing Board confirmed this at their meeting in June and recommended that a system wide task and finish group (the group), led by the Clinical Commissioning Group (CCG) be established. The purpose of the group is to review the recommendations in detail and to develop a system wide plan to implement the recommendations.

1.2 It was acknowledged by the Board that the report describes a systemic failure, over the course of several years, to proactively set meaningful quality standards, monitor compliance by the provider and take effective action when standards were breached. The immediate actions to be implemented across the local health and care system reflect the most important failings described in the Francis report.

1.3 The group is now established and this report details the preliminary progress made since the last update.

2. Progress to date

2.1 Building on the goals outlined in the September update report and the output of the July workshop the group have agreed a series of ten priority actions. The ten actions will deliver 80 of the Francis recommendations. These actions with initial progress are detailed below:

a. All organisations must publish their response to the Report and Recommendations.

Progress: This has been agreed and organisations are currently considering how they will publish responses. Responses are due by December 2013 as this is currently the date the Department of Health has requested an annual report on organisational progress of achieving planned actions.

b. Contracts for services must be clear on minimum standards and be Francis compliant.

Progress: All organisations are reviewing their contracts, and their capacity to monitor the performance of every contract with a view to confirming what formally agreed reference points are in place for addressing and tackling poor performance. The Duty of Candour should be embedded into all contracts, and this is especially relevant to all non NHS standard contracts, which are already Francis compliant.

c. Develop integrated processes for tracking and reporting on patient experience and safety. The Francis report says that the possession of accurate, relevant and useable information, from which the safety and quality of a service can be ascertained, is the vital key to early warning systems and patient/service user safety.

Progress: Each organisation has confirmed that systems and process are in place for tracking and reporting on patient experience, however recent examples of poor patient experience that have been referred to the CCG for formal contractual follow up were reported using informal contacts as opposed to formal processes. This has confirmed that gaps in the quality monitoring processes across the health and care system exist. The group are planning a workshop for early January to confirm current individual systems and processes with the aim of collaborating on the design of a system wide model. This is a very complex work stream and the timeframe reflects the required planning.

d. Develop process for tracking patient experience by primary care as referrers and commissioners of services.

Progress: CCGs need to undertake monitoring on behalf of patients who receive acute hospital treatment and other specialist services and develop internal systems that allow GP's to recognise patterns of concerns. Barking and Dagenham CCG are progressing the implementation of actions to do this.

e. Ensure open and shared communication of up-held complaints by all organisations and for the safeguarding boards to be made aware of all upheld complaints by all organisations related to patient or service user care.

Progress: Each organisation as a first step will consider the process required to obtain consent from patients/service users to share any information. Before any

upheld complaints can be published the consent of the complainant to share must be obtained. Intelligence sharing from complaints is a key driver to improving care across the system.

f. Local Authorities to develop implementation plans to deliver the recommendations related to scrutiny committees and processes.

Progress: Local Authorities are reviewing this action internally.

g. To ensure active involvement of clinical leaders in performance management of quality and safety as routine practice.

Progress: Clinical leaders are active members of the monthly quality monitoring meetings held as part of the formal contract monitoring for both North East London Foundation NHS Trust and Barking Havering Redbridge University Trust.

h. All patients in acute setting to be seen by consultants. Minimum standards to be agreed with both Barking Havering Redbridge University Trust and North East London Foundation NHS Trust.

Progress: This requirement will be addressed and implemented through the contract negotiation process that is just beginning for 2014/15.

i. Have clear workforce plans for safer recruitment and retention that meet national requirements.

Progress: The members of the group are working with Human Resource Departments to report back on this action

j. Develop effective shared governance for quality and safety that forms an element of an early warning system.

Progress: Local Authorities and Healthwatch are now participating members of the regional Quality Surveillance Group which is led by NHS England (London) and are working to identify system wide issues through intelligence sharing.

2.4 It is important to emphasise that the progress detailed above is the first stages of the implementation plan and the group will build on this as the week's progress.

2.5 The group also agreed that the work programmes from the Integrated Care Coalition and the Urgent Care Board should also be considered as many of the actions arising from these senior led programmes will implement the Francis recommendations.

3. Next steps

3.1 Members of the group have agreed to benchmark the ten actions against current organisational activity aimed at driving quality improvements. At the next meeting the benchmarking from each organisation will be combined to develop a system wide high level implementation plan.

3.2 The execution of the implementation plan will be monitored at each meeting with corrective or remedial actions being recommended as required.

3.2 At the next meeting, the group expects to finalise the terms of reference and the membership. It was agreed to invite Healthwatch representation.

3.3 The next meeting is scheduled for 23 October 2013. The Group expects to meet fortnightly thereafter.

4. Mandatory Implications

4.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall mortality analysis as well as a detailed safeguarding element within it. Integration and addressing issues presented by Francis are key themes of the JSNA 2013 and this paper is well aligned to address and follow up these priorities and the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.

4.2. Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The strategy is based on four priority themes that cover the breadth of the frameworks and in which a large number of Francis's recommendations can be picked up within. These are: Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

4.3 Integration

One of the outcomes we want to achieve for our joint Health and Wellbeing Strategy is to improve health and social care outcomes through integrated services. Implementing the recommendations from the Francis Report will need to take account of integration and many of the actions will further support and strengthen integration, such as developing a joint mechanism for capturing service user/patient experience feedback to inform further integration.

4.4 Risk Management

Patient/service user care may be compromised if there is a failure to consider or implement relevant recommendations, which is in addition to organisational reputational risks. Agreement to establish the task and finish group and the consideration the Health and Wellbeing Board has already given to implementing the recommendations will mitigate this risk.

5. Non-mandatory Implications

5.1 Safeguarding

By its very nature the Francis Report has significant safeguarding implications and the overall report is aimed at making both the health and care system and the individual services within this more safe and driving continuous quality improvement. The CCGs are actively collaborating with the Children's and Adults Safeguarding Boards to lead and progress the implementation of the recommendations.

6. Background Papers Used in Preparation of the Report:

— The Mid Staffordshire NHS Foundation Trust Inquiry. Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – march 2009. February 2010. Chaired by Robert Francis QC
http://www.midstaffsinquiry.com

— Report from the Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Sir Robert Francis QC. February 2013
Http://www.midstaffspublication.com/report

— Kings Fund. Francis Report Lessons learnt from Stafford. June 2013
http://www.kingsfund.org.uk/events/francis-inquiry

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HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Tender of Specialist Domestic Violence Services**
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Authors: Helen Oliver, Group Manager, Safeguarding Adults Saleena Ankle, Strategic Commissioning Manager	**Contact Details:** Tel: 020 227 5646 E-mail: saleena.ankle@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult and Community Services	

Summary:

In response to the recent review undertaken by the Director of Public Health focusing on domestic violence services and the recommendation from the findings to prioritise 'the funding of services which focus on identification and protection of those individuals (including children) at risk and experiencing domestic violence'. [1] Further work has now been undertaken by the Council to take recommendations forward.

There is now an opportunity to remodel existing services in line with the recent review and the draft guidance on domestic violence: how social care, health services and those they work with can identify, prevent and reduce domestic violence by National Institute for Health and Care Excellence (NICE).

The Local Authority currently has two contracts in place which deliver support in relation to domestic violence. These consist of supported accommodation for women fleeing violence from outside the borough and the Independent Domestic and Sexual Violence Advocates (IDSVA) in both community and Maternity BHRUT settings.

The IDSVA service offers residents of Barking and Dagenham a specialist independent domestic violence advocacy service and specialist sexual violence services to female victims of DV, (including pregnant women experiencing DV using BHRUT) and also provides a signposting function for male victims of domestic violence. The service outcomes in the current specification include reducing the harm domestic violence/sexual

[1] A review of Services for those Affected by Domestic Violence – Matthew Cole Director of Public health July 2013

violence causes to individuals and families, and maximising the immediate and long-term safety of adults and children (including unborn) at risk due to domestic violence/sexual violence.

The supported accommodation refuge is intended to offer a high quality supported accommodation environment for women and their families fleeing violence. The refuge is split across two sites in the borough; one with shared facilities where license agreements are issued and one with self-contained facilities using Assured Short-hold Tenancies (ASTs). The service outcomes in the current specification include move onto independent living, support to gain education training & employment (ETE) status and improving health and wellbeing.

The Supported Accommodation contract is £135,465 per annum in value and is due to end on 31 March 2014. The IDSVA contract is £250,000 per annum in value and is also due to end on the 31 March 2014. The current IDSVA contract is jointly funded by Clinical Commissioning Group (CCG) (£120,000) and the Local Authority which includes Metropolitan Police Service, Housing Revenue Account & Public Housing (£130,000) however the CCG have come to a decision to cease joint funding arrangements at the end of the current contract period and are now devising an alternative commissioning strategy for the IDSVA maternity function which will be delivered as a payment by results model (PbR) and primarily offer a signposting function.

Victim Support London also currently provides support to victims who would not meet the threshold for IDSVA support (i.e. those assessed as medium risk) providing a signposting and early intervention function The current arrangement will end in March 2014 and cost of provision is £31,500.

Officers recommend that both services are remodelled to include young peoples IDSVA function and low level medium support offering a seamless service that supports people over a life course that are most at risk therefore reflecting draft NICE guidelines. Once remodelled it is recommended that the new services are retendered to ensure continuity of support for those who require it. Plans to retender will consider a reduction in contribution for the IDSVA service and will be remodelled to compliment the CCG's plans, avoiding duplication of services.

Members of the Health and Wellbeing Board are asked to consider the recommendations set out in the report and to approve the retendering of specialist domestic violence services.

Recommendation(s)

(i) To agree that remodelling of existing services reflect recommendations made in the report 'A review of services for those affected by Domestic Violence'

(ii) Approve the procurement of IDSVA community based provision and supported Accommodation, on the terms detailed in the report; and

(iii) Delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer, LBBD to award the contract to the successful contractor upon conclusion of the procurement process.

Reason(s)

To take forward the recommendations outlined within the recent review which took place in July 2013. The review evaluated current impact and value for money and made recommendations based on current and future needs. The review highlighted the importance of targeted preventative action, early intervention and targeting those most at risk.

These contracts also assist the Council and partners to deliver the following priorities within the Health & Wellbeing Strategy:

- To reduce health inequalities.
- To promote choice, control and independence.
- To improve the quality and delivery of services provided by all partner agencies.

1 Introduction & Background

1.1 The recent review undertaken by Public Health which focused on domestic violence[2] outlined key recommendations for commissioners to consider. The recommendations included prioritising funding arrangements which focused on prevention and protection and targeted early interventions across the life course of those most at risk. In addition the draft NICE guidance which is due to be published in February 2014 also refers to the importance of integrated care pathways, creating an environment for disclosure and tailoring support. All the above recommendations have been taking into consideration in preparing the proposal for remodelling existing services. Service utilisation across both IDSVA and Supported Accommodation were included in earlier review[3].

1.2 The function currently provided by Victim Support London offers Domestic Violence casework to those women who do not meet the IDSVA threshold and mainly provides early intervention and signposting. The referral source for this support is mainly via police and IDSVA. In 2012/13 the worker received 1,697 domestic violence referrals. Of these the worker supported victims via 85 attendances at court, 982 cases of advocacy support, 61 cases were escalated back up to IDSVA high risk services and 166 referrals were made for target hardening.

1.3 More recently funding from The Mayors Office for Policing and Crime (MOPAC) was secured to employ a young person specific IDSVA which works with under 18s with a focus on prevention of sexual exploitation, this funding is agreed year on year and is currently delivered as a secondment within the current ISDVA contract. Children's services have now also secured funding via Public health to recruit an additional young person IDSVA in the new financial year.

1.4 The overall aim of the Domestic and Sexual Violence strategy is to ensure that the Partnership has an effective co-ordinated community response to D&SV, this will be achieved by focussing on the following objectives:

- Preventing D&SV from happening in the first place;
- Providing support to victims where violence does occur;
- Reducing the risk and bringing perpetrators to justice; and
- Working better as a Partnership locally to achieve the best outcomes for victims

2 Proposal & issues

2.1 Both the IDSVA and supported Accommodation service contracts will expire on the 31 March 2014, as will the arrangement with Victim Support London. It is proposed

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2 A review of Services for those Affected by Domestic Violence – Matthew Cole Director of Public health July 2013

3 http://moderngov.barking-dagenham.gov.uk/documents/s71032/HWBB%20160713%20Domestic%20Violence%20Service%20Review.pdf

that new contracts which will include a revised model of IDSVA that will focus primarily on the community function as the CCG have now decided to withdraw funding and remodel BHRUT services as part a PbR model. As the maternity function was always a health priority withdrawal of funding has meant that the Council has had to make difficult decisions and focus remaining funding around the community function. It is proposed that the new model will also provide low level medium support and specialist young people advocacy which are in line with draft NICE guidance in relation to early intervention and prevention for those most at risk.

2.2 Both contracts will be tendered and procured as separate contracts to continue to provide specialist domestic violence supported accommodation and independent domestic violence advocacy to commence on the 1 April 2014. Added value will be sought where the same provider is awarded both contracts.

2.3 Our local approach to commissioning domestic abuse services is founded upon a principle of identifying and then prioritising those most at risk of homicide, however we also work to prevent the risk of escalation for all other victims. The services outlined within the report are predominantly delivered by specialist voluntary agencies because research dictates that independent support is most accessible for victims. All of the services currently in place work together as part of a co-ordinated community response and as such are interdependent upon the services offered by one another.

2.4 Domestic violence impacts on many of our local priorities. For example domestic violence is a contributing factor for many of the issues that we collectively grapple with including homelessness, unemployment, child protection, truancy, crimes against the person, missing education, missing persons, pupil mobility, anti-social behaviour, youth crime, GP visits, A& E visits, female offending, sexually transmitted infections, drug and alcohol use, teenage pregnancy, prostitution, mental ill health, adult safeguarding, obesity, reducing the number of children in care, reducing poverty, even some dental neglect can be due to a phobia of another person standing over them and the list goes on. Therefore, work to reduce domestic violence will contribute to the health and well-being of the population on many different levels.

2.5 The view is that the supported accommodation refuge service is improved to provide further specialised focus and targeted support the women and children who live within the schemes. Evidence collated during service reviews as highlighted that this is an area for development to work more holistically. It is recommended that the women and their children are suitably assessed and supported as part of a Family CAF if appropriate to prevent any further crisis and aide transition into the borough.

2.6 It is planned that the service will continue to work with the Substance Misuse Treatment System to engage those with additional substance misuse needs and support children under ‘Hidden Harm’. The service will need to continue to work closely with Housing and build links within the Private Rented Sector to enable move onto independent living due to the shortage of social housing. The new service

specification will also include more outcome focused targets that will enable greater ETE outcomes for women when exiting the refuge.

2.7 The current IDSVA service specification will need to be revised to remove the current maternity related function and redirect advocacy resources within the community. The specification will require CCG and health partners input to shape and inform service delivery, to avoid duplication in functions and create integrated pathways as highlighted within the draft NICE guidelines. In addition it has been identified through contract monitoring that an area to be defined within the new specification is the support IDSVA provide for those applying for independent injunctions that are not in receipt of benefits.

2.8 The new service model for IDSVA will also incorporate support for low level medium risk cases with a view to offering a seamless intervention for those women that may need higher or lower levels of support depending on need and potentially their changing circumstances. This approach will further clarify pathways in the borough and offer victims a seamless transition between low or high risk support.

2.9 To ensure that the provision in the borough does not become disjointed and remains coordinated, it is proposed that the new IDSVA specification also include the young people specific IDSVA's to focus on those under 18 and to prevent sexual exploitation. This will further enhance the local offer to victims and ensure that pathways for support are clear therefore enabling rapid access to support when most needed.

2.10 Confirmed funding for 2014/15 is £241,500 for Community IDSVA of which is currently made up of £161,500 Public Health, £40,000 Housing Revenue Account and £40,000 MOPAC. Please note that the contribution of £39,000 contribution from the Metropolitan Police Service is included in the MOPAC allocation.

2.11 Confirmed funding for 2014/15 is £135,465 for supported accommodation. To alleviate the financial risk to the Council in future years the new contract will have break clauses for early no fault termination.

3 Procurement process

3.1 Both contracts falls under the EU procurement category of health and social care and will be procured under Part B of the EU procurement process and in line with the Council's Contract Rules. Adult Commissioning will work in collaboration with Elevate to identify areas for joint work on the procurement arrangements. The contract will be advertised on the LBBD external website on the Current Tenders page:

- http://www.lbbd.gov.uk/BUSINESS/CURRENTTENDERS/Pages/Tenders.aspx
- and the Contracts Finder website: http://www.contractsfinder.businesslink.gov.uk

4 Tender Evaluation

4.1 The evaluation of tender submissions will be based on a quality: cost: matrix of 70:30. The contract will be awarded on the basis of the most economically advantageous tender (MEAT) criteria.

4.2 Prospective tender candidates will be advised of any weighting to be applied to any of the criteria or sub-criteria beforehand. This will enable a fair and transparent approach to be taken. Prior to award of the contract an evaluation of the price will be carried out to ensure that provider organisations tendering for the contract provide value for money and fair and competitive prices that are consistent with the requirements in the service specification.

4.3 **Tender Timetable**

Outline tender timetable for both Supported Accommodation and IDSVA services (all dates are provisional and subject to change).

Action	**Date**
Health and Wellbeing Board approval	November 2013
Advertise	November 2013
Contract award	February 2013

4.4 The new IDSVA Contract will be awarded to the successful provider for a period of one year with an option to extend for a further two and a half years based on confirmed funding arrangements. It is proposed to award Supported Accommodation to successful provider for a period of three and a half years with option to extend for a further 2 years.

4.5 Supported Accommodation contract for five and half years is estimated up to a value of £745,057. If the contract is not extended beyond the initial three and half year period, then the total contract value over this period is estimated up to a value of £474,127.50. IDSVA contract for three and a half years is estimated up to a value of £845,250. If the contract is not extended beyond the initial one year period, then the total contract value over this period is estimated up to a value of £241,500.

4.6 Confirmed funding sources for the 2014/15 contracts are as follows (see table overleaf):

New Contract	Current Contract Name	Amount	Funding source	New Contract Value
Supported Accommodation	Supported Accommodation	£135,465	LBBD	£135,465
IDSVA Community Function	IDSVA	£130,000	LBBD	£241,500
	Victim Support London	£31,500		
	YP IDSVA	£40,000 £40,000	MOPAC LBBD	

5 Consultation

5.1 This report has been written in consultation with representatives from Refuge, Victim Support London, Barking and Dagenham CCG, Public Health and LBBD partners.

5.2 There is a commitment to working with all members of LBBD diverse communities and understanding the prevalence and impacts of domestic violence on specific groups. We will use a range of communication approaches to ensure all groups are offered equal access to services. This will be carried out through the commissioning cycle process and include service user involvement. Consultation with service users through contract monitoring reported that residents would like supported accommodation to be more responsive to Families needs particularly children and more focus on re engaging women back into mainstream services locally including more focused structured support to gain ETE status. Consultation also includes input from professionals including Health and Public Health which will feed into the development of the new service specification.

6 Equalities & Diversity

6.1 Gender: Domestic and sexual violence can affect people of both genders. However, research shows that despite under-reporting, women and girls are more likely to experience all forms of intimate violence. Whilst both women and men experience domestic violence, it is also important to recognise that they do not experience it at the same frequency, impact or harm and this is reflected in the different priorities female and male domestic violence victims have for services. Women tend to prioritise physical safety for themselves and their children whereas male victims tend to prioritise access to information. As such, setting up emergency refuges for both genders would be ineffective.

6.2 On average, two women a week are killed by a violent partner or ex-partner. This constitutes nearly 40% of all female homicide victims. Women who were killed by

current of former partners significantly outnumber men – around three quarters of the people killed by current or former partners are women. While men are more likely than women to be the victim of a homicide, women are more likely than men to be killed by a partner, ex-partner or other family member. 51% of all female victims of homicide and 5% of male victims were killed by a current or ex-partner.

6.3 Age: Teenage girls between 16 and 19 are now the group most at risk of domestic violence, closely followed by girls aged 20-24 – all victims of a new generation of abusers who are themselves in their teens and early twenties. British Crime Survey estimates that up to 15% of the adult population of the UK have been sexually abused in childhood. This includes 11% of young men. 1.5 per cent of men had suffered a serious sexual assault at some point in their lives with 0.9 per cent reporting rape. It is estimated that 227,000 older people were neglected or abused in the past year, by family members (including partners), carers or close friends. (2.6% of the population aged over 65).

6.4 Pregnancy: Between 4 and 9 women in every 100 are abused during their pregnancies and/or after the birth

6.5 Disability: Disabled women are twice more likely to experience gender-based violence than non-disabled women. They are also likely to experience abuse over a longer period of time and suffer more severe injuries as a result. They are less likely to seek help and often the help is not appropriate.

6.6 Mental Health: In addition to the physical symptoms experienced by victims of domestic violence, it is also thought to be the single most important cause of female suicide, particularly amongst pregnant women and Black, Asian and Minority Ethnic women. Victims often also present to health services with symptoms of traumatic stress, psychosis, depression, anxiety, post-traumatic stress disorder, eating disorders and self-harm; although often professionals will not make the causal link. 75% of incidents of domestic abuse result in physical injury or mental health consequences. (DOH, 2005)

6.7 Substance Misuse: Women with problematic substance use who also experience domestic violence are particularly likely to feel isolated and doubly stigmatised. They may find it even harder than other women to report or even to name their experience as domestic violence; and when they do, are in a particularly vulnerable position, and may be unable to access any sources of support. Other research suggests that in 73% of cases of domestic violence, alcohol had been consumed prior to the incident and 48% of those convicted of domestic violence had a history of alcohol abuse, while 19% had a history of substance misuse.

7 Safeguarding Vulnerable Adults and Children

7.1 Adults at risk and their children are disproportionately affected by domestic abuse and so any work that we do to prevent and de-escalate it will be in keeping with the partnerships work led by the Safeguarding Adults Board and Local Safeguarding Children Board respectively.

7.2 Robust safeguarding policies and procedures will be evidenced as part of the procurement process including compliance with local safeguarding procedures. Both services provide specialist functions which are an integral element of the local suite of services available to residents and connect strongly with the priorities within the Health and Wellbeing Strategy as well as the work of the Barking & Dagenham Safeguarding Adults Team. There remains a robust referral pathway between DV services and the local Safeguarding Adults Team and Social Services. All staff in DV services is qualified to recognise child protection issues. Whilst staff have a duty to respect and protect the confidentiality of service users which is both professional and a legal responsibility; complete confidentiality cannot be guaranteed. There may be cases when it is lawful to break confidence, there are situations that might arise where confidential information may need to be shared; for example in an emergency where there is a risk to the client or others.

7.3 All commissioned voluntary and statutory sector organisations must have their own safeguarding and child protection policies in place. Evidence of these is gathered at tender stage and then through contract monitoring and auditing processes. Case files are audited by commissioners to ensure best practice is routinely undertaken.

7.4 All agencies commissioned to work with adults and young people are aware of LBBD safeguarding procedures and must adhere to incident reporting as part of their contractual obligations. In addition all providers are required to be section 11 compliant and attend relevant borough training sessions.

8 Mandatory Implications

8.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) 2011 shows that the borough has the highest Domestic Violence (DV) reported incident rate in London; therefore DV remains a priority for the borough. Nearly three quarters of children with child protection plans live in households where DV occurs, (Department of Health 2002). It is estimated that serious incidents of DV cost the public purse £20,000 per case, during 2010/11 the Multi Agency Risk Assessment Conference (MARAC), 264 cases with an estimated cost of £5 million locally (including £3.1million in NHS costs), (JSNA 2011).

8.2 Health & Wellbeing Strategy

A key action identified in theme 2 of the Health and Wellbeing Strategy (Protection) highlights the need for “work relating to accident and emergency and maternity services which are both areas where individuals affected by domestic violence may present and require support and signposting”. Approving the recommendations set

out in this report will achieve progress against that safeguarding priority by having an IDSVA service operating from a BHRUT setting.

8.3 **Integration**

Domestic Violence is a cross cutting need across health, social care and crime. The proposed services will form part of a wider response which includes necessary partnership working and specialist input from Health, Police, Social workers Substance Misuse and the local Voluntary Sector. Both new service specifications will include more outcome focused targets.

8.4 **Financial Implications**

(Implications completed by Roger Hampson, Group Manager, Finance)

Budget provision is available in 2014/15 of £241,500 for Community IDSVA and £135,465 for supported accommodation. To alleviate the financial risk to the Council in later years, both contracts will have break clauses for early no fault termination.

8.5 **Legal Implications**

(Implications completed by Eldred Taylor-Camara, Legal Group Manager)

This report is seeking the Health and Wellbeing Board's permission to tender for the service provision of Independent Domestic and Sexual Violence Advocates (IDSVA) and the support service for users requiring supported accommodation.

The services to be procured in this report are classified as Part B services under the Public Contract Regulations 2006 (as amended) (the "Regulations") and therefore not subject to the full tendering requirements of the Regulations. However in conducting the procurement, the Council still has a legal obligation to comply with the relevant provisions of the Council's Contract Rules and with the EU Treaty principles of equal treatment of bidders, non-discrimination and transparency in procuring the contracts.

The tender timetable for the procurement of these services is set out in paragraph 4.3. The contract is to be advertised in November with a view to awarding the contract in February 2014. The EU Treaty principles noted above generally encourage the advertisement of contracts in a manner that would allow providers likely to be interested in bidding for the contracts to identify opportunities and bid for the contracts, should they wish to do so. This report states that the Council's website and the Contracts Finder website will be utilised for advertising to potential bidders.

In keeping with the Regulations this report stipulates the selection criteria to be applied in assessing the tenders. It is noted in paragraph 4.1that this will be on a quality to cost ratio of 70:30, while the contract will be awarded to the tenderer that is considered to have submitted the most economically advantageous tender (MEAT). Officers will need to ensure that they also establish and publish to bidders any sub-criteria and weightings against which the quality element of bids will be evaluated.

In deciding whether or not to approve the proposed procurement of the contracts, the Health and Wellbeing Board must satisfy itself that the procurement will represent value for money for the Council.

Contract Rule 13.3 provides delegated authority to the commissioning Corporate Director, in consultation with the Section 151 Officer, to approve the award of a contract upon conclusion of a duly conducted procurement exercise, in the absence of direction to the contrary from Cabinet/ the Health and Wellbeing Board.

The Legal Practice confirms that there are no legal reasons preventing the Health and Wellbeing Board from approving the recommendations of this report.

Non-Mandatory Implications

8.6 **Staffing Implications**

There are no TUPE implications for LBBD staff; however, there are potential contractor to contractor TUPE implications

12 Background papers used in the preparation of the report

— A review of services for those affected by Domestic Violence

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	Diabetes Scrutiny: Update on Delivering the Recommendations
Report of the Corporate Director of Adult & Community Services	
Open Report	**For Decision**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Dr Sue Levi, Consultant in Public Health Medicine	**Contact Details:** Tel: 020 8227 5343 Email: sue.levi@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services	

Summary:

Between July 2012 and March 2013 the Health and Adult Services Select Committee carried out themed investigations into the management of diabetes locally in response to user dissatisfaction with aspects of the service and a perception of high levels of complications and ill health associated with the disease.

The full review can be found at:

http://modgov/documents/s68507/FINAL%20DRAFT%20Diabetes%20Scrutiny%20Report%2005%2004%2013.pdf

Appendix A is the Diabetes Action Plan Progress Report – from Health & Adult Services Select Committee (November 2013). This Action Plan translated the aspirations of the Select Committee Scrutiny Review into potentially deliverable actions. This is now the update of progress so far.

Recommendation(s)

The Health and Wellbeing Board is recommended to

1) Agree that the Action Plan is progressing.
2) Discuss if any agencies represented can accelerate any areas.
3) Allow the ongoing monitoring of the Diabetes Action Plan to be performed by either the Integrated Care sub-group or the Public Health Programmes sub-group.
4) Agree that there will be a year end summary in February 2014 that will be delivered to the HASSC.

1 Introduction

1.1 Between July 2012 and March 2013 the Health and Adult Services Select Committee carried out themed investigations into the management of diabetes locally in response to user dissatisfaction with aspects of the service and a perception of high levels of complications and ill health associated with the disease.

1.2 The Health and Adult Services Select Committee produced ten recommendations for actions. These recommendations were converted into an action plan which became current in May 2013.

1.3 The key recommendations are around:

- Examining the needs of people living with diabetes;
- Improving the early diagnosis of diabetes;
- Improving patient understanding, knowledge and compliance;
- Improving the frequency and quality of annual (diabetic) health checks;
- Diabetes pathway analysis, redesign and improvement;

1.4 Six months have now elapsed since the initial action plan was agreed at the Health and Wellbeing Board. This document shows how the work is progressing.

2 Progress and Problems

2.1 All agencies have engaged with the process and progress is being made. There have been some notable achievements:

2.2 A diabetes patient booklet has been produced and distributed to practices and community services to share with all diabetic patients/carers – this was achieved by cooperation between Public Health and the Clinical Commissioning Group.

2.3 Over one hundred people with no symptoms have had diabetes detected via the NHS Health Check programme.

2.4 The CCG has secured funding to provide diabetes training for GPs, practice nurses and healthcare assistants.

2.5 The CCG has defined a route to influence primary care improvement via a cluster model.

2.6 The Quality & Outcomes Framework contract with primary care has been altered so that the nine standard monitoring tests in diabetes should be performed each 12 months and the threshold for the highest level of performance has been elevated. This should markedly improve performance.

2.7 The three borough CCGs – Redbridge, Havering and Barking and Dagenham – have started collaborative work around diabetes and are planning to work on pathway redesign/improvement.

3 Summary

3.1 There has been some good early collaborative to improve diabetes care.

3.2 Some useful, high profile improvements have occurred.

3.3 This remains an early stage and, with some of the entrenched diabetes problems, long term work and planning will be required.

4 Mandatory Implications

4.1 Health & Wellbeing Strategy

This document compliments the Health & Wellbeing strategy especially around integration of care and the disease prevention agenda.

4.3 Integration

To deliver the Diabetes Scrutiny Review Action Plan, a high level of collaboration will be required. Informants tell of disjointed services. Effective delivery of this Action Plan should promote integration within and across services.

4.4 Financial Implications

At the point of writing this report, the financial implications of the Diabetes Action Plan are not quantified. However any financial implications will have to be contained within council core funding or the ring fenced Public Health grant.

(Dawn Calvert, Group Manager Finance, LBBD (written in April 2013).

4.5 Legal Implications

There are no specific legal implications that arise from this report.

(Implications completed by: Shahnaz Patel, Senior Lawyer, Legal Services, LBBD (completed in April 2013).

5 Appendix A

— Diabetes Action Plan – November 2013.

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Diabetes Action Plan Progress Report (November 2013)

Number	HASSC recommendation	**Processes Involved**	Responsible Officer:	R / A / G	Progress:
1	The select committee recommended that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the 'best estimate' that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.	Next JSNA clearly defines current prevalence, estimated actual prevalence in terms of percentages and numbers including referencing from whence come the figures. Clearly identify the target that is being used to monitor progress and trends. Provide definitions and simple	Matthew Cole	G	JSNA 2012/13 has a large diabetes section which covers this material and is available at http://www.barkinganddagenhamjsna.org.uk/ Feedback is welcomed by Public Health.
		Identifying the challenges in finding people with undiagnosed diabetes. Increasing diagnosis is a complex process involving public awareness, unique patient factors and healthcare related factors.		A	NHS Health Checks already progressing well and has a diabetes detection component. Other awareness raising, unique patient issues and other healthcare related factors will need to be coordinated.
2	It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GP's to take a more pro-active role in diagnosis.	Programme for proactive screening is established.	Dr Sue Levi	G	Diabetes diagnosis included in the NHS Health Check programme. Audit number of newly diagnosed diabetics annually as have been doing (75 in 2011/12, 36 diagnosed in 2012/13).

3	Specifically, it is recommended that action is taken to improve patients' understanding of the Annual Diabetes Health Checks, what they should expect to receive, and their importance in preventing complications.	Diabetes handbook to be produced for practices and community teams to give to all diabetic patients which will contain lifestyle advice including importance of annual health checks.	Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group.	G	Diabetes patient booklet has been produced and distributed to practices and community services to share with all diabetic patients/carers.
4	It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual Diabetes Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.	Encourage all GPs to refer people with newly diagnosed diabetes attend patient education sessions (DAFNE or DESMOND) within six months of new diagnosis. Continue to commission DESMOND and DAFNE programmes and to raise awareness of these to practices, patients, and providers.	Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group.	A	Continued primary care care training programme to ensure GPs and nurses include patient education as part of diagnosis and annual review.
		It is further recommended that the CCG takes steps to facilitate clinician familiarity with the NICE recommendations for the Annual (diabetes) Health Check and awareness of best practice on performing checks, subsequent interventions and follow up.	Sharon Morrow (CCG) via Primary Care Improvement Group	A	Training bid secured from HENCEL to develop primary care management of LTCs which will include following NICE recommendations.
		Using the locality model to support improved primary care management of patients with diabetes. Enrolling Clinical Champions and Primary Care Improvement Group to produce incremental improvements in care	Sharon Morrow (CCG) via Primary Care Improvement Group	A	The Primary Care Improvement Group has rolled out feedback and peer influencing sessions via the cluster structure. The locality management paper sets out the role of the CCG in influencing primary care improvements through the cluster model.

		DPH to write to the Quality and Outcomes Framework administrators and NICE in official capacity to attempt to move remuneration onto annual checks rather than 15 monthly checks	Dr Sue Levi/Matthew Cole	G	Remuneration has been changed to requiring annual checks (rather than 15 months). Starts in 2013/14 so expect improvement to be 'visible' from late 2014/early 2015.
		DPH to write to NHS England to highlight problems in Primary Care diabetes performance and invite comment on how performance management might be improved	Dr Sue Levi/Matthew Cole	G	Quality and Outcomes framework has been altered for 2013/14 to raise the threshold for maximum payment on many indicators. Hence, remuneration structure should improve performance.
5	For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter	Public Health to provide the CCG and HWB with intelligence on outcomes relating to diabetes through public health profiles and other available datasources to support commissioning devisions	Dr Sue Levi/Matthew Cole	A	Currently, there is a national survey with annual retrospective publication. The data is not held locally and extraction would be complicated and involve confidentiality issues as well as have resource
6	The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.	Patient consultation via Healthwatch to define exactly what information is required beyond the diabetes booklet, 1 to 1 clinical attention and public domain sources.	Healthwatch	A	Diabetes booklets have been revised and distributed to practices. Still need to promote their use in practices, pharmacies and community services.
7	That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.	[Note diabetes is uncommon in children so may need to go via healthcare route to identify families]	Healthwatch to lead on this.	A	Surveys have been developed and sent to all families who attend the children's diabetes service. Report will be available end of October 2013.

8	That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health & Wellbeing Board.		Health Watch – Marie Kearns.	A	Initial meeting to be held on 11th November with the diabetes support group. Final Report to be available end of November 2013.
9	That the Health & Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.	Barking & Dagenham Public Health will work with NELFT to understand the evidence of what actions in relation to the NELFT commissioned service are most likely to impact on patient outcomes. NELFT wishes to emphasise that access to and quality of Primary Care will have significantly more impact than any direct interventions that are under the remit of NELFT.	Dr Steve Feast (MD at NELFT) to provide measures of different performance and Public Health will support him in this review	R	Approach being finalised so as to get the most valuable measures
10	That the Health & Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.		Sharon Morrow/ Sarah D'Souza	A	The planned care steering group is in place covering BHRUT and CCGs and is establishing a diabetes project group that would support pathway redesign. Workshop convened for October 2013

HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Sub-Group Reports**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Authors: Glen Oldfield, Democratic Services	**Contact Details:** Telephone: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: At each meeting of the Health and Wellbeing Board each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Board.	
Recommendations: The Health and Wellbeing Board is asked to: • Note the contents of sub-group reports set out in the Appendices 1-5 and comment on the items that have been escalated to the Board by the Sub-groups.	

List of Appendices

- Appendix 1: Mental Health Sub-group
- Appendix 2: Integrated Care Sub-group
- Appendix 3: Learning Disability Partnership Board
- Appendix 4: Children and Maternity Sub-group
- Appendix 5: Public Health Programmes Board

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APPENDIX 1

Mental Health Group

Chair:

Martin Munro, Executive Director, Human Resources & Organisational Development, NELFT

Items to be escalated to the Health & Wellbeing Board

- None

Meeting Attendance

14 August 2013: 67% (10 of 15)

Performance

Please note that no performance targets have been agreed as yet.

Action(s) since last report to the Health and Wellbeing Board

a) The Sub Group was consulted on the CCG mental health commissioning intentions during September 2013. It was recognised that this was prior to the next scheduled meeting to fit with the commissioning cycle.

b) A task/finish group was established to ensure the patient and service user voice regarding long term mental and physical health conditions is heard, with membership from NELFT senior management, Healthwatch, NELFT Service User Groups (SURG), Public Health and Children's service representation, building on existing expertise and engagement. The first Task/finish group meeting is scheduled for 17 October 2013.

c) The MH Sub Group Chair will be meeting with Locum Consultant in Public Health (LBBD) to discuss future sub-group topics during October 2013.

d) Members of the MH Sub Group were invited to the Children's Health Board to hear presentation about Children and Adolescent Mental Health on 25 September which has been postponed to 27 November 2013, 13:00 - 15:00.

Action and Priorities for the coming period

a) Awaiting next sub-group meeting on 30 October 2013.

Contact: Fran Hayward, PA to Martin Munro

Tel: 0300 555 1047 / Internal Ext: 4292 **E-mail:** Francesca.Hayward@nelft.nhs.uk

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Integrated Care Group

Chairs:

Dr Jagan John, Clinical Lead, NHS Barking and Dagenham Clinical Commissioning Group

Jane Gateley, Director of Strategic Delivery, Barking Havering and Redbridge Clinical Commissioning Groups

Items to be escalated to the Health & Wellbeing Board

- None

Meeting Attendance:

28 August 2013: 62% (8 of 13)

23 September 2013: 69% (9 of 13)

Performance

Please note that no performance targets have been agreed as yet.

Action(s) since last report to the Health and Wellbeing Board

a) Integrated Case Management leads are developing an Integrated Case Management scorecard detailing monthly Integrated Case Management performance against targets. The Integrated Care Group will review this at each meeting. The ICM scorecard should be finalised by October.

b) The group receives a monthly update on the Community Services development. Barking and Dagenham held health and social care panel meetings to review North East London Foundation Trust's proposals, including a new Intensive Rehabilitation Service delivering rehabilitation services in patient's homes. The panel agreed this proposal in principle, and the CCG governing body has subsequently endorsed them. NELFT will now work up the operational detail of the proposals in partnership with health and social care colleagues. NELFT have initiated a recruitment drive for therapy staff that should be in place from November 2013.

c) The group receives a monthly update on the development of the Joint Assessment and Discharge Service (JAD) at BHRUT from Bruce Morris, Divisional Director Adult Social Care. Winter monies are being used to support seven day working from 1st November 2013.

d) The group reviewed a draft end of life update for the November Health and Wellbeing Board. Initial comments by the group have been incorporated into the report.

e) The group discussed the use of a 'this is me' sheet which summarises patient preferences to be used across Health and Social Care to ensure that patient preferences are not lost during transfers of care. The group agreed that the information from the form is already collected during ICM assessments and so a separate form is not required for this service.

f) The Integrated Care Sub group has reviewed the Clinical Commissioning Groups' 2014-15 commissioning strategy plan proposals; the local authority will suggest any

revisions to align the proposals between Health and Social Care.

Action and Priorities for the coming period

a) The group will monitor Integrated Case Management performance, reporting progress to the Health and Wellbeing Board and escalating issues as required.

b) An End of Life paper outlining current provision in Barking and Dagenham and identifying gaps in service is being sent to the Health and Wellbeing Board from the Integrated Care Sub Group, to frame End of Life discussion.

c) The integrated care subgroup will continue to discuss Community Services developments and update the Health and Wellbeing Board on progress.

d) The Integrated Care Sub group will discuss the Integrated Transformation Fund at the October meeting.

e) An analysis of the audit of frequent attendees at A&E will be discussed at the October meeting; the Health and Wellbeing board will be informed of the summary of findings by way of this update report.

Contact: Emily Plane, Project Officer, Strategic Delivery, BHR CCGs
Tel: 0208 822 3052; Email: Emily.Plane@onel.nhs.uk

APPENDIX 3

Learning Disability Partnership Board

Chair:

Jenny Beasley, Group Manager Adult Commissioning (Interim)

Items to be escalated to the Health & Wellbeing Board

- None for this meeting.

Performance

The Learning Disability Partnership Board (LDPB) has recently been given a performance dashboard. The following indicators will be presented at the LDPB in November and performance against these indicators will be reported at future Health and Wellbeing Boards.

Indicator	Lead	Delivery Plan	Outcome/ Activity Indicator	Lifecourse	Suggested Sub Group	HWBB Dashboard
LDD children under 5years with annual health plan in place	NCB London	Healthy Child Programme 0-5yrs	Activity	Pre-Birth and Early Years	LDPB	
% of individuals with LDD with annual health check	CCG	TBC	Activity	Vulnerable and Minority Groups	LDPB	Yes
% of individuals with LDD with health and wellbeing plan	CCG	TBC	Activity	Vulnerable and Minority Groups	LDPB	
% of individuals with Learning Difficulties and Disabilities (LDD) with a named key worker	LBBD	TBC	Activity	Vulnerable and Minority Groups	LDPB	
Learning Disability/Difficulty (LDD) children under 5years with annual health check complete.	NCB London	Healthy Child Programme 0-5yrs	Activity	Pre-Birth and Early Years	LDPB	

Meeting Attendance

12 August 2013: 88% (15 of 18 attendees)

23 September 2013: 22 77% (14 of 18 core attendees)

Action(s) since last report to the Board

Three Learning Disability Partnership Board (LDPB) meetings have now taken place.

The board has appointed representatives from each of its forums and now has three service user representatives, one carer representative and one professional/provider representative. The carer forum is in the process of finding and recruiting another representative.

The Service User, Carer and Professionals/Provider forums all have a programme of future meeting dates. The Chairs of the forums have also held a meeting to ensure they are linking together and plan to have regular meetings from now on. The forum representatives have an opportunity to give feedback and have their own agenda items at every LDPB meeting.

Below is an overview of what has been discussed and agreed at each of the three LDPB meetings.

16th June

- Agreed the Terms of Reference and forward plan
- Agreed the programme for Winterbourne View
- The draft Hate Crime Strategy was presented and discussed

12th August

The theme for the second meeting on 12 August was health. Topics that were discussed included:

- The Joint Strategic Needs Assessment (JSNA);
- The Francis Report and implications;
- Six Lives
- The Joint Health and Social care self assessment framework;
- Confidential inquiry into Premature Deaths of People with Learning Disabilities;
- Barking Havering and Redbridge University Hospitals Trust presented the work it is doing on the Francis enquiry, Winterbourne View and their response to the Jimmy Saville scandal.

In addition, the board in this meeting also

- Updated on Fulfilling Lives;
- Signed off proposals for Learning Disability Week;
- Discussed the draft Market Position Statement and proposed content for the Learning

Disability section;

- Updated on the Winterbourne View Joint Strategic Plan and Section 75 agreement.

23rd September

The theme for the third meeting on 23rd September was Autism where the board:

- Received a presentation delivered by Autism Ambassadors and discussed what it is like to live with Autism in the borough;
- Were introduced to NHS NELFT's diagnostic Autistic Spectrum Disorder (ASD) pathway;
- Received a presentation on and discussed the findings from the recent Autism mapping project.

In addition, the board in this meeting also:

- Agreed the priorities for the joint local strategic plans 'plan on a page'
- Presented initial financial information for the proposed pooled budgets / S75 agreement;
- Were introduced to the role of Healthwatch and their proposed work plan;
- Received a presentation on the key implications in the Children and Families Bill / SEND Green Paper
- Discussed the draft local offer and noted points to feedback

The board now has a news letter that goes out at the end of each meeting and is sent across to providers, in-house services, core and associate members, carers and service users. The idea of this newsletter is to update on what was discussed at each board and is presented in an accessible format.

Forums Feedback

Service User Forum

The service user forum has now sat twice. The first meeting was well attended and had over 85 service users at the event. At the second meeting, in order to limit numbers to enable more meaningful discussion, numbers were limited to five people per 'service'.

The service user forum has elected three representatives to sit on the board and at September's forum, service users gave feedback on their good and bad experiences which is informing the Joint Health and Social Care Self Assessment Framework. To make this meaningful a local artist, with experience of working with people with a learning disability, was brought into to deliver this exercise.

Carer Forum

The Learning Disability Family Carers Forum met on 25 June and 10 September. At the June meeting a representative was elected to the Leaning Disability Partnership Board. The group has yet to elect another representative and it is hoped this will be a younger carer. To date attendance has been relatively low, 6-7 carers. There are plans in place to

promote the forum and to increase attendance.

The carers forum has a mechanism in place for reporting to and from the Learning Disability Partnership Board and a forward plan has been developed for the remainder of the year to ensure this. In addition the carer's forum is raising relevant agenda items.

Provider and Professionals Forum

The Provider and Professionals forum met for its first meeting on the 16th July and will meet on a quarterly basis at the Maples Resource Centre. The forum was attended by six different providers and council officers from Adult Commissioning, in-house services and the Safeguarding Adults Team. In the first forum, providers and professionals were presented the forward plan, agreed the terms of reference and were given a presentation on the Market Position Statement. It has also been agreed that a member from the Safeguarding Adults Team will attend each provider forum to ensure safeguarding is always on the agenda with local providers. The provider forum has a nominated representative to sit on the LDPB to ensure it is feeding in views.

Action and Priorities for the coming period

(a) Future meetings will be themed around:

- Transition – November
- Safeguarding and Community Safety – December
- Housing – February
- Employment, Training and Education- March

(b) The board also has standing agenda items, these are:

- Chairs report
- Progress against key actions in the Winterbourne View concordat
- Implementation of the Children and Families Bill and Transition
- Forum feedback and their agenda items

There is further work to ensure the forward plan links in with the H&WBB forward plan which may require changes to the LDPB's to accommodate this. There are also opportunities and further work to be done to enable closer working with the other H&WBB sub-groups and to explore holding joint meetings around certain themes.

There is good representation from service users, carers and providers on the Board now. Work is being done to enable a second carer's representative and to increase our attendance at the carer forum.

The partnership board meetings to date have been 'business focussed' in their delivery. However, there is a need to be continually mindful that there are people with a learning disability who are a vital component to the board and there is a need to ensure meetings are inclusive and meaningful for everyone who attends. The officer responsible for the service user forum will be working closely with the representatives to ensure that this happens at all meetings.

Contact: Joanne Kitching, Business Support Officer, LBBD

Tel: 020 8227 3216 **E-mail:** joanne.kitching@lbbd.gov.uk

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APPENDIX 4

Children and Maternity Group

Chair:

Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG

Items to be escalated to the Health & Wellbeing Board

- Clarification on the role of each of the Health and Wellbeing Board sub-committees in monitoring performance of the indicators included in the Health and Wellbeing Performance Framework.

Meeting Attendance

25 September 2013: 60% (9 out of 15)

Performance

The performance framework that the CMG will monitor is being finalised in-line with the HWB performance indicators. Discussions are also underway about aligning reporting with the Public Health Programme Board and Public Health Children's Programme Board.

Action(s) since last report to the Board

The CMG at its meeting on 25 September:

a) Discussed the CCG review of policy/legislative changes relating to children with special physical and developmental needs including Special Educational Needs and Disability (SEND) transformation and implications for commissioners.

b) Received a report on the SEND Transformation programme, led by the council and prioritised workstreams for health representation

c) Discussed the arrangements in place within LBBD for agreeing and monitoring public health programmes including the children's public health programmes.

d) Reviewed and commented on the CCG's draft commissioning intentions for children's services

Action and Priorities for the coming period

a) The CMG is aligning its work plan with the priorities in the refreshed JSNA, the HWB performance framework and the public health programme board.

b) Review of children's public health programme to be discussed at next meeting

c) TheNovember of the CMG will be reviewing CAMHS issues in relation to the successful IAPT bid (postponed from September meeting).

Contact: Mabel Sanni, Executive Assistant, Barking and Dagenham CCG

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APPENDIX 5

Public Health Programmes Board

Chair:

Matthew Cole, Director of Public Health

Items to be escalated to the Health & Wellbeing Board ▪ None
Meeting Attendance 10 September 2013: 100%
Performance Please note that no performance targets have been agreed as yet.
Action(s) since last report to the Health and Wellbeing Board a) Public Health now attends Housing DMT, to consolidate the links between public health and housing. b) The Public Health commissioning Intentions Paper has been out to consultation and will be presented at the next Health and Wellbeing Board meeting in November. c) The Health Check Incentive scheme is now under way with full sign up of the General Practitioners. d) Public Health has supported the Stoptober campaign.
Action and Priorities for the coming period a) An obesity summit will take place on the 13th December 2013 this is being configured at the moment. b) The Health and Wellbeing Board will decide the commissioning proprieties for the coming year. c) The future direction of the Public Health Programme Board will be determined over the coming months.

Contact: Pauline Corsan, PA to Matthew Cole, Director of Public Health, LBBD

Tel: 020 8227 3953 **Email:** Pauline.corsan@lbbd.gov.uk

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HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Chair's Report**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Louise Hider, Business Services Unit Manager, Adult and Community Services	**Contact Details:** Tel: 020 8227 2861 Email: louise.hider@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: Please see the Chair's Report attached at Appendix 1.	
Recommendation(s) The Health and Wellbeing Board is recommended to: (i) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.	

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Chair's Report

5 November 2013

In this edition of the Chair's Report, there's much to cover, including developments with urgent care, frail older people and the CQC inspection at BHRUT. Add to that my fantastic Plantastic Gardens visit, and details of some upcoming conference and workshop activity, and it's a busy time for the Board…

I would welcome Board Members to comment on any item covered should they wish to do so.

Helpful videos!

I have recently seen two videos which I wanted to bring to the attention of Members of the Board to watch and to share with their teams:

- Barking and Dagenham CCG have produced an animation which clearly explains what the Clinical Commissioning Group do and how the NHS works. This helpful video is only 2 minutes long and can be found on the right hand side of the CCG homepage. http://www.barkingdagenhamccg.nhs.uk/
- The King's Fund have also recently released an animation which explains 'integrated care' and what it means for patients. Again, this short video (3mins) explains the concept in a clear and concise way and challenges viewers to think about better patient outcomes from more joined up services: http://www.kingsfund.org.uk/audio-video/joined-care-sams-story

Plantastic Gardens visit

As I mentioned at the last Health and Wellbeing Board, on 7 September I visited the Plantastic Prescription Gardens in Dagenham as part of the Council's 'Back-to-the-floor' programme.

Plantastic was set up to provide food growing activities for local people who face mental and physical health challenges. Members attending benefit from adapted healthy gardening exercises, allowing them to learn new skills. I really enjoyed the opportunity to get involved in the project at Plantastic - this oasis of calm, but equally productivity, provides a unique venue for many different people to get involved and ticks many of the objectives for the delivery of our own Board's approach to health and wellbeing.

If you would like to find out any more about Plantastic Gardens, please contact Kathy Mason on 020 8590 9151 or email epo-communitygardening@hotmail.co.uk.

OBESITY SUMMIT

As agreed at the last Board, we are going to hold an 'Obesity Summit' to set out our 'concerted effort' to tackle obesity over the next year. The Executive Planning Group have been making plans and invitations have been sent to the Board and subgroups for the afternoon of 16 December.

Plans are still in development but we are looking at a key note speaker on nudge theory and behavioural change to get people thinking differently, followed by workshops and a plenary discussion. If you have any ideas for the event, please contact Andy Beckingham, Public Health Consultant on Andy.Beckingham@lbbd.gov.uk or 020 8227 8275.

Chair's Report

5 November 2013

Barking and Dagenham Annual Partnership Conference

Members of the Health & Wellbeing Board and subgroups will have been invited to the Barking and Dagenham Annual Partnership Conference on the morning of **Wednesday, 13 November 2013.**

This year the conference will cover two main themes. Firstly, reviewing the Community Strategy and hearing from the theme boards (including HWBB) about past achievements and future aims. The second part has a focus on Civic Engagement. Four interactive workshops are being hosted by the Boards, with our own Board hosting a workshop on civic engagement and emotional wellbeing. We aim to promote the work already going on in the Borough to support residents in their emotional wellbeing and talk about how we can improve our engagement and utilise opportunities that are available that we might not yet have explored.

To book or for more info, contact partnership@lbbd.gov.uk or 020 8227 2463.

Our New Year Development Day…

The final event to let you all know about is the Board's Development Day in the New Year. The Development Day will take place on Monday 13 January 2014 and will be facilitated again by Ian Winter who we thought did a fantastic job at our last session earlier this year. We would hope to get an agenda out to attendees in the next month, however we think that the following will be explored:

- Reviewing the 'Engine Room' of the Health and Wellbeing Board, including the Board's relationship with subgroups, forward planning and administration.
- Challenges for Year 2 of the Health and Wellbeing Board.
- How can we do things differently as a Board? (using a real life example)

These events are great opportunities to refresh our focus for the coming year. More info, contact Glen Oldfield on Glen.Oldfield@lbbd.gov.uk or 020 8227 5796.

Life Study

The Institute of Child Health with support from UCL partners are working with partners in the BHR health and social care economy to undertake a world-leading research study which will be used to understand and improve the lives of UK children and their families. The Life Study is a high profile and ambitious study, which will follow children through to adult life starting in pregnancy with a strong focus on the first year of life. The study focuses on many health and social issues of concern to local population and stakeholders. Pregnant mothers at Queen's Hospital will be invited to join the study, which has obtained Ethics Committee approval. The study is likely to be based at King George Hospital.

An outline of the study has been presented to members of the Integrated Care Coalition and further discussions are due to take place shortly with local Directors of Children's Services and Directors of Public Health. We expect a more comprehensive presentation at a future Board meeting.

Chair's Report

5 November 2013

Winter pressures and 7 day working

As Members of the Board will remember, the Secretary of State has made £7m available to the Barking & Dagenham, Havering & Redbridge health economy, to support the local emergency care system over the Winter period. Colleagues across the local health economy, through the Urgent Care Board, have put forward a bid for the winter monies with the intention of:

- Expanding Urgent Care hours;
- Integrating 7 day working across acute and social care providers;
- Expanding solutions to stream patients to more appropriate care settings;
- Supporting attempts to improve senior staffing levels in A&E.

We are still waiting to hear whether these plans have been approved. However, an important it should be noted that all partners, including the Council's Social Care services, will be implementing 7 day working from 1 November to ensure that patients receive a joined up service in which patients can be discharged quickly from hospital on any day of the week.

Update on the Joint Assessment and Discharge (JAD) service

The Health and Wellbeing Board agreed in September to the proposals for a shared Joint Assessment and Discharge Service (JAD). Final proposals were discussed at the Integrated Care Coalition on 14 October 2013. While all Coalition partners signed up to the principle of a joint discharge team for patients with complex needs, London Borough of Redbridge stated that they were unable to join an integrated service covering BHRUT at this point. They will consider joining in the arrangements when the service is established.

Coalition partners have asked for an urgent redesign of the JAD proposal to take into account these changes and further updates will be brought to the Board in due course.

Frail Older People

One of the Urgent Care Board's priorities is a 18-24 month programme focussed on frail elders being led by UCLP and the Innovation Unit and overseen by the CCG Strategic Delivery team. The aim is to provide the foundation for targeted interventions, in the short term to prepare for winter, and in the longer term to ensure a coordinated approach for better supporting frail and older populations across the BHR health economy.

The team have undertaken an audit in A&E at Queens Hospital, interviewing 293 frail older people in order to understand their journey to hospital, to identify interventions which might have provided an alternative to hospital attendance and to support mapping work on patient demand. Key findings include:

- 25% of presentations were as a result of a fall
- 91% were brought by ambulance
- Over 50% of attendances were called by carers
- Professional carers often called ambulances as a 'default reaction'
- A significant number of attendances were repeats calls
- Most patients and carers were unaware of alternatives to A&E

On 9 October a stakeholder workshop was held, bringing together the strands of audit work, to discuss and agree areas where we could work together to make improvements, and inform the next stages of the programme.

For further information please contact Tara-Lee Baohm, Strategic Delivery Project Manager, BHR CCGs tara-lee.baohm@onel.nhs.uk

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HEALTH AND WELLBEING BOARD

05 NOVEMBER 2013

Title:	**Forward Plan (2013/14)**
Report of the Chief Executive	
Open	**For Comment**
Wards Affected: None	**Key Decision: No**
Report Authors: Glen Oldfield, Democratic Services	**Contact Details:** Telephone: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board	

Summary:

Attached at Appendix 1 is the Forward Plan for the Health and Wellbeing Board. The Forward Plan lists all known business items for meetings scheduled in the 2013/14 municipal year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that we publish the key decisions (within at least 28 days notice of the meeting) in order that local people know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.

Recommendation(s)

The Health and Wellbeing Board is asked to:

- Make suggestions for business items so that decisions can be listed publicly in the May edition of the Council's Forward Plan with at least 28 days notice of the meeting;
- To consider whether the proposed report leads are appropriate;
- To consider whether the Board requires some items (and if so which) to be considered in the first instance by a sub-group of the Board.

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APPENDIX 1

Health and Wellbeing Board Forward Plan (2013/14)

Meeting Date:	10 December 2013 (6pm, Barking Learning Centre)	Sponsoring Board Member/Report Author
Scheduled Business	Commissioning Plans 2014/15	Dr W Mohi/Sharon Morrow
	Integration Transformation Fund 2015/16	Anne Bristow/David Millen
	Adult Social Care Funding	Anne Bristow/Jenny Beasley
	Autism Self Assessment Framework	Cllr L Reason/Pete Ellis
	LES Contracts 2014/15	Matthew Cole/John Currie
	Quarter 2 Performance	Matthew Cole/Margaret Eames
	Urgent Care Board	Conor Burke/Jane Gateley
	End of Life Care	Sharon Morrow, Bruce Morris
	Older People	Matthew Cole/Integrated Care Group
	H&WBB Engagement Strategy	Cllr M Worby/Mark Tyson
	Healthwatch: The First Six Months	Frances Carroll/Marie Kearns
	Sub-Group Report: Children and Maternity	Sharon Morrow/Mary Pirie
	Sub-Group Report: Integrated Care	Dr J John, Jane Gateley/Emily Plane
	Sub-Group Report: Learning Disability Partnership Board	Jenny Beasley/Joanne Kitching
	Sub-Group Report: Mental Health	Martin Munro/Fran Hayward

	Sub-Group Report: Public Health Programmes Board	Matthew Cole/Hanna King
	Chair's Report	Cllr M Worby/Mark Tyson
	Forward Plan	Cllr M Worby/Glen Oldfield

Meeting Date:	11 February 2014 (6pm, Barking Learning Centre)	Sponsoring Board Member/Report Author
Scheduled Business	Impact of the Recession Scrutiny	TBC
	Ofsted Framework for inspection of services for children in need of help and protection	TBC
	Integration Transformation Fund 2015/16	Anne Bristow/David Millen
	Supported Living Tender	Cllr L Reason/Pete Ellis
	Joint Strategic Plan (Winterbourne View)	Cllr J Alexander/Glynis Rogers
	Longer Lives Update: Learning from comparator authorities	Matthew Cole/Andy Beckingham
	Q3 Performance	Matthew Cole/Margaret Eames
	Working Age Adults	Matthew Cole/TBC
	Work Programmes of H&WBB Sub-groups	Cllr M Worby/Glen Oldfield
	Sub-Group Report: Children and Maternity	Sharon Morrow/Mary Pirie
	Sub-group Report: Integrated Care	Dr J John, Jane Gateley/Emily Plane
	Sub-Group Report: Learning Disability Partnership Board	Jenny Beasley/Joanne Kitching

	Sub-Group Report: Mental Health	Martin Munro/Fran Hayward
	Sub-group Report: Public Health Programmes Board	Matthew Cole/Hanna King
	Chair's Report	Cllr M Worby/Mark Tyson
	Forward Plan	Cllr M Worby/Glen Oldfield

Meeting Date:	25 March 2014 (6pm, Barking Learning Centre)	Sponsoring Board Member/Report Author
Scheduled Business	Director of Public Health Annual Report	Matthew Cole
	Healthwatch Barking and Dagenham Annual Report 2013/14	Frances Carroll/Marie Kearns
	Sub-Group Report: Children and Maternity	Sharon Morrow/Mary Pirie
	Sub-group Report: Integrated Care	Dr J John, Jane Gateley/Emily Plane
	Sub-Group Report: Learning Disability Partnership Board	Jenny Beasley/Joanne Kitching
	Sub-Group Report: Mental Health	Martin Munro/Fran Hayward
	Sub-group Report: Public Health Programmes Board	Matthew Cole/Hanna King
	Chair's Report	Cllr M Worby/Mark Tyson
	Forward Plan	Cllr M Worby/Glen Oldfield

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