Open Agenda

Health and Wellbeing Board

Wednesday 21 October 2015
1.30 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Membership

Councillor Peter John (Chair)	Leader of the Council
Andrew Bland	NHS Southwark Clinical Commissioning Group
Councillor Stephanie Cryan	Cabinet Member for Adult Care and Financial Inclusion
Aarti Gandesha	Healthwatch Southwark
Councillor Barrie Hargrove	Cabinet Member for Public Health, Parks and Leisure
Jonty Heaversedge (Vice-Chair)	NHS Southwark Clinical Commissioning Group
Eleanor Kelly	Chief Executive, Southwark Council
Gordon McCullough	Community Action Southwark
Professor John Moxham	King's Health Partners
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Dr Yvonneke Roe	NHS Southwark Clinical Commissioning Group
Dr Ruth Wallis	Director of Public Health

INFORMATION FOR MEMBERS OF THE PUBLIC

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Contact
Everton Roberts on 020 7525 7221 or email: everton.roberts@southwark.gov.uk
Webpage: http://www.southwark.gov.uk

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 13 October 2015

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Wednesday 21 October 2015
1.30 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	**APOLOGIES** To receive any apologies for absence.	
2.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in the meeting.	
3.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
4.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
5.	**MINUTES** To agree as a correct record the open minutes of the meeting held on 18 June 2015.	1 - 4
6.	**DIRECTOR OF PUBLIC HEALTH REPORT - LAMBETH & SOUTHWARK** To note the Director of Public Health's report covering the period July to September 2015.	5 - 30

Item No.	Title	Page No.

14. HEALTH AND WELLBEING BOARD WORK PROGRAMME 297 - 300

To note the work plan for the Health and Wellbeing Board 2015/16 and to feed in any further items for consideration at future meetings.

OTHER ITEMS

The following item is also scheduled for consideration at this meeting.

15. TRANSFORMATION PLAN FOR MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE

Date: 13 October 2015

Agenda Item 5

Health and Wellbeing Board

MINUTES of the OPEN section of the Health and Wellbeing Board held on Thursday 18 June 2015 at 2.00 pm at 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Peter John (Chair) Councillor Stephanie Cryan Aarti Gandesha Councillor Barrie Hargrove Jonty Heaversedge Eleanor Kelly Professor John Moxham David Quirke-Thornton Dr Yvonneke Roe Dr Ruth Wallis
OTHERS PRESENT:	Councillor Victoria Mills, Cabinet Member for Children and Schools, (Observer) Carole Pellicci, Head Teacher (Observer)
OFFICER SUPPORT:	Rachel Flagg, Principal Strategy Officer Everton Roberts, Principal Constitutional Officer

1. APOLOGIES

Apologies for absence were received from Andrew Bland and Gordon McCullough.

2. CONFIRMATION OF VOTING MEMBERS

Those members listed as present were confirmed as the voting members for the meeting.

3. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

The late items were circulated on supplemental agenda no.1 and supplemental agenda no.2.

4. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

5. MINUTES

RESOLVED:

That the minutes of the meeting held on 16 March 2015 be agreed as a correct record and signed by the Chair.

6. THE SOUTHWARK PICTURE FOR CHILDREN AND YOUNG PEOPLE

The board received a presentation from Dr Ruth Wallis in respect of children and young people's health in Southwark.

7. KEY PRIORITIES AND PROGRAMMES FOR CHILDREN AND YOUNG PEOPLE IN SOUTHWARK

Kerry Crichlow, Director of Strategy and Commissioning and Jean Young, Head of Primary, Community and Children's Commissioning introduced the report.

RESOLVED:

1. That the joint Southwark CCG and Council strategic framework proposal and timeframe in line with the joint strategic needs assessment work be endorsed.

2. That the priority areas for the joint Children's and Young People's strategy listed below be endorsed:

   - Early Years / Better Start 0-5 / School Ready
   - Emotional wellbeing and Mental Health
   - Long Term Physical Conditions (diabetes / asthma / epilepsy / sickle cell)
   - Emergency Admission avoidance
   - Young People's Health 10 – 25 (sexual health / drugs / self-harm / gangs)
   - Vulnerable children and young people (LAC / SEND / CIP)
   - Childhood Obesity
   - Neglect

3. That the focus of the joint strategy be children and young people, families, perinatal mental health and maternity.

8. UPDATE ON THE CHILDREN AND YOUNG PEOPLE'S HEALTH PARTNERSHIP

Janet Lailey, Programme manager for Children and Young People's Health Partnership introduced the report.

RESOLVED:

That the progress set out in Appendix 1 of the report be noted.

9. HEALTH AND WELLBEING STRATEGY

Dr Ruth Wallis, Director of Public Health introduced the report.

RESOLVED:

1. That the update which sets out the activities relating to the children and young people and prevention priorities of the health and wellbeing strategy be noted.

2. That the high level public health outcomes associated with these priorities be noted.

3. That a report be brought back to the next meeting on the milestones associated with the implementation of the priorities.

10. UPDATE ON LOCAL CARE NETWORKS AND SOUTHWARK'S VISION FOR COMMISSIONING FOR OUTCOMES

David Smith, Head of Transformation – Integration, CCG introduced the report.

RESOLVED:

1. That the update of progress on establishing GP Federations and Local Care Networks and their role in the broader context of integration, as set out in the Appendix to the report be noted.

2. That the approach outlined in the 'Approach to Commissioning and Contracting' as the practical next steps in commissioning health and social care services on an outcome basis for the population of Southwark be approved in principle.

11. BETTER CARE FUND - UPDATE

Adrian Ward, Programme manager – Integration and Better Care Fund introduced the report.

RESOLVED:

That the progress on the Better Care Fund set out in the national quarterly return for January – March 2015, and the latest analysis of progress on key outcomes metrics as out in the report be noted.

12. FORWARD WORK PLAN FOR THE HEALTH AND WELLBEING BOARD

Kerry Crichlow, Director of Strategy and Commission, Children's and Adult's Services introduced the report.

RESOLVED:

1. That the draft work plan for the health and wellbeing board 2015/16 be noted.

2. That items be added for consideration by the Board, according to the work plans of member organisations.

3. That an updated work plan be brought back to the next meeting of the Board, following a meeting of the planning sub-group and liaison with other strategic partnerships.

The meeting ended at 4.04pm

CHAIR:

DATED:

Agenda Item 6

Item No. 6.	Classification: Open	Date: 21 October 2015	Meeting Name: Health & Wellbeing Board
Report title:		Director of Public Health Report – Lambeth & Southwark	
Ward(s) or groups affected:		All wards	
From:		Dr Ruth Wallis, Director of Public Health	

RECOMMENDATION(S)

1. That the Board note the Director of Public Health Report covering the period July to September 2015 attached as Appendix 1 to the report.

BACKGROUND INFORMATION

2. Director of Public Health reports periodically on health issues in the borough.

KEY ISSUES FOR CONSIDERATION

3. This report is a quarterly report of the Joint Director of Public Health to the Lambeth & Southwark Health and Wellbeing Boards and the Lambeth & Southwark clinical commissioning groups. The report covers the following work streams:

- Joint Strategic Needs Assessment (JSNA)
- South East London Illegal Tobacco 'Keep It Out' Campaign
- Stoptober Campaign, Smoke Free Cars and Electronic Cigarettes
- Infection Control Update: Flu Immunisation, Meningitis Vaccination, Neonatal BCG vaccine
- London Cervical Sample Taker Database
- Bowel Cancer Screening
- SH:24
- Wellbeing
- Lambeth Early Action Partnership (LEAP)
- Learning Disability in Southwark

Policy implications

4. This is an overview document and any implications for policy will be subject to a more detailed report

Resource implications

5. Any resource implications are set out in the Appendix attached.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Director of Public Health Report – Lambeth & Southwark

AUDIT TRAIL

Lead Officer	Dr Ruth Wallis, Director of Public Health – Lambeth & Southwark	
Report Author	Dr Ruth Wallis	
Version	Final	
Dated	9 October 2015	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		9 October 2015

Working together for the public's health

APPENDIX 1

Public Health in Lambeth and Southwark

Director of Public Health Report

July – September 2015

Lambeth and Southwark Public Health

Director of Public Health: Dr Ruth Wallis

Introduction

This is the quarterly report of the Director of Public Health for Lambeth and Southwark for the second quarter of 2015-2016. The report is for the London boroughs of Lambeth and Southwark, and Lambeth and Southwark Clinical Commissioning Groups, as well as for all Health and Wellbeing Boards partners.

The aim of the quarterly reports is to update partners on some of the activities of the Lambeth and Southwark specialist public health team and work being done in partnership, and to provide information about public health issues relevant to Lambeth and Southwark, including alerting people to areas of concern or risk.

This quarter summaries are on Joint Strategic Needs Assessment Updates, South East London Illegal Tobacco 'Keep It Out' Campaign, Stoptober Campaign and Smoke Free Cars, Electronic Cigarettes, Infection Control Update: Flu Immunisation, Meningitis Vaccination, Neonatal BCG vaccine, London Cervical Sample Taker Database, Bowel Cancer Screening, SH:24, Wellbeing Update, LEAP and Learning Disability in Southwark.

Comments and suggestions for future issues are welcome. Please contact PHadmin@southwark.gov.uk

1. Joint Strategic Needs Assessment Updates

The JSNA factsheets on demography and life expectancy have been updated with the latest information on public health and population profiles to support commissioning, health improvement and prioritisation. These can be found on the JSNA web pages for Lambeth (www.lambeth.gov.uk/jsna) and Southwark (www.southwark.gov.uk/jsna) but we want to highlight some key findings in this report.

Key headlines are:

Lambeth Demography

- Lambeth resident population count is 321,984, evenly split between men and women. Lambeth resident population is estimated to increase by 30,464 persons over the next 10 years. This equates to a 9% increase, compared to a 10% increase in London. The 65+ age group is predicted to grow the fastest (29%) and the 20-39 group the slowest (1%).
- Lambeth has a higher younger population, 44%, aged 20 to 39 years old compared with 35% in

London and 27% in England. Lambeth has a lower population aged 50 to 64 years old, 13%, compared with 15% in London and 18% in England and a lower older population aged 65 or older, 8%, compared with 11% in London and 17% in England.

- There were 4,589 live births and 1,384 deaths in 2013.
- The report shows population distribution by age and town centres /wards

Town Centre	Ward	0-19	20-39	40-64	65+
Brixton Town Centre	Coldharbour	24%	41%	29%	6%
	Ferndale	14%	57%	23%	6%
	Herne Hill	22%	43%	28%	7%
	Tulse Hill	23%	42%	28%	7%
	Brixton Hill	17%	51%	25%	7%
Clapham and Stockwell	Larkhall	21%	51%	22%	6%
	Stockwell	22%	44%	28%	7%
	Clapham Common	17%	52%	23%	7%
	Clapham Town	17%	52%	24%	7%
	Thornton	25%	41%	26%	8%
North Lambeth Town Centre	Bishop's	17%	47%	28%	9%
	Oval	17%	49%	26%	8%
	Prince's	20%	41%	30%	9%
	Vassall	20%	44%	29%	8%
Norwood Town Centre	Gipsy Hill	28%	33%	31%	8%
	Knight's Hill	27%	32%	31%	10%
	Thurlow Park	24%	37%	30%	9%
Streatham Town Centre	St. Leonard's	20%	47%	26%	8%
	Streatham Hill	21%	43%	28%	8%
	Streatham South	24%	36%	29%	12%
	Streatham Wells	24%	42%	26%	8%
	Lambeth	**21%**	**44%**	**27%**	**8%**

Significantly higher
Significantly lower
Similar

compared to Southwark average

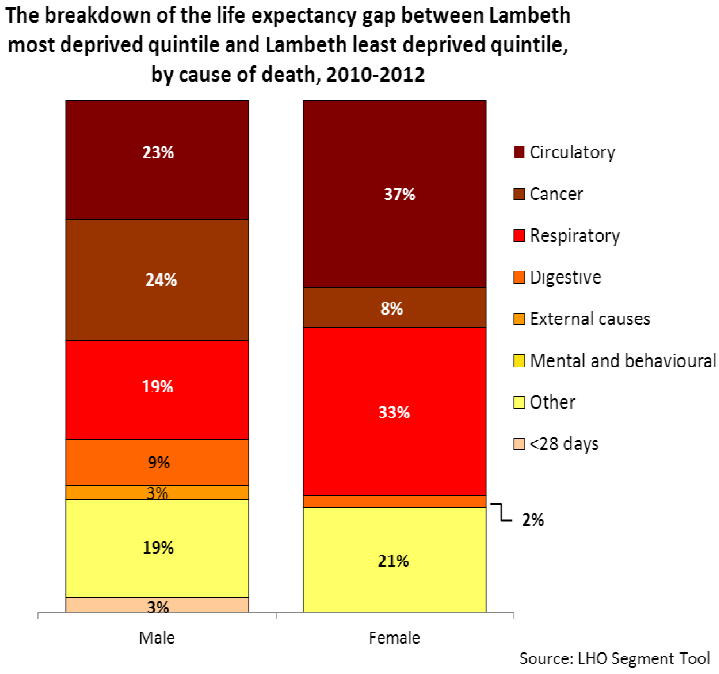
Lambeth Life Expectancy

- Life expectancy at birth in Lambeth is 78.4 years for males and 83.5 years for females.
- The gap in life expectancy between Lambeth and England has narrowed over the years. Life expectancy for females in Lambeth has exceeded life expectancy for females in England.
- Life expectancy for males in Lambeth is lower than in London and England with an average gap of 19 months and 12 months respectively. Life expectancy for females in Lambeth is lower than the London average by 10 months but higher than the England average by 5 months.
- Male healthy life expectancy at birth is 64.2 years and is higher compared to London's 63.4 years and England's 63.3 years. Female healthy life expectancy at birth is 61.7 and is lower than London's 63.8 years and England's 63.9 years.
- The Slope Index of Inequality (SII) measures inequalities in life expectancy within Lambeth. It is

a measure of the difference or gap in life expectancy between the most and least deprived populations in the borough. It is measured in life expectancy years and can be used to track achievements in reducing inequalities.

- Lambeth SII for 2011-13 was 5.6 years for males (+0.6 years from 2010-12).
- Lambeth SII for 2011-13 was 3.2 years for females (+0.4 years from 2010-12).

- The chart below the percentage contribution that each broad cause of death makes to the overall life expectancy gap between the most deprived quintile of Lambeth and the least deprived quintile of Lambeth.



- For males and females **circulatory (i.e. heart disease, stroke and peripheral arterial disease), cancers (i.e. lung cancer, breast cancers and bowel cancers in particular)** and **respiratory** conditions are key contributors to the LE Gap.

- More detailed analysis shows:
  - Top 5 contributors to the gap in **males**:
    - Chronic obstructive airways disease **23%**
    - Other circulatory **17%**
    - Other cancers **14%**
    - Lung cancer **9%**
    - Infectious and parasitic diseases **7%**
  - Top 5 contributors to the gap in **females**:

- Coronary heart disease **22%**
- Chronic obstructive airways disease **16%**
- Lung cancer **13%**
- Stroke **11%**
- Other respiratory disease **9%**

Southwark Demography

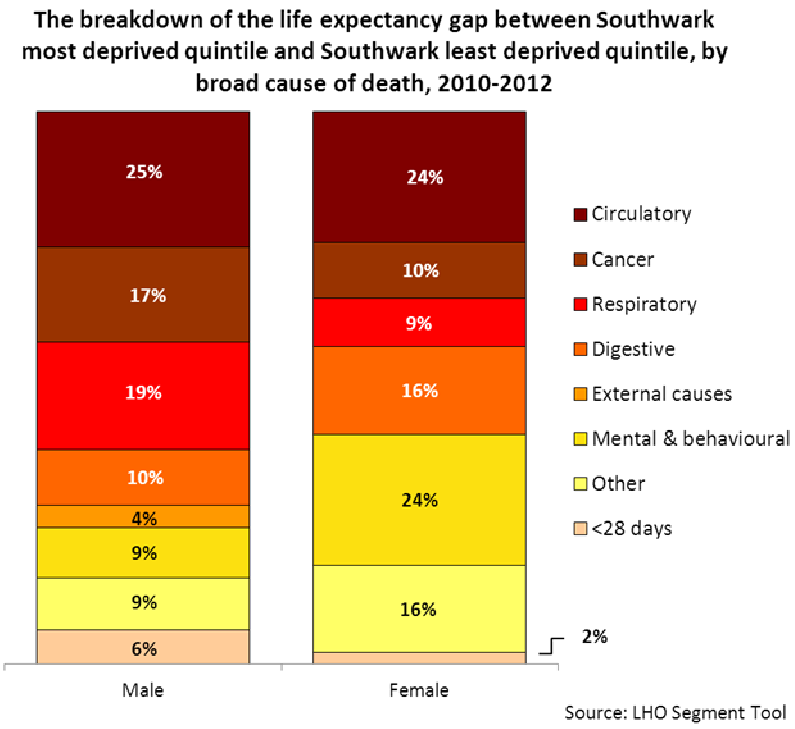
- Southwark resident population count is 306,745 evenly split between males and females. Southwark resident population is estimated to increase by 47,018 persons over the next 10 years. This equates to a 15% increase, compared to a 10% increase in London. The 65+ age group is predicted to grow the fastest (32%) and the 20-39 group the slowest (9%).
- Southwark has a higher younger population, 42% aged 20 to 39 years old compared with 35% in London and 27% in England. Southwark has a lower population aged 50 to 64 years old, 14%, compared with 15% in London and 18% in England and a lower older population aged 65 or older, 8%, compared with 11% in London and 17% in England.
- There were 4,706 live births and 1,305 deaths in 2013.
- The report shows population distribution by age and community council boundaries /wards

Community Council	Ward	0-19	20-39	40-64	65+
Bermondsey & Rotherhithe	Grange	16%	54%	24%	6%
	Riverside	14%	52%	27%	7%
	Rotherhithe	20%	48%	24%	7%
	South Bermondsey	25%	40%	28%	8%
	Surrey Docks	15%	54%	25%	6%
	Livesey	28%	34%	29%	9%
Borough, Bankside & Walworth	Cathedrals	18%	50%	25%	7%
	Chaucer	20%	52%	22%	5%
	East Walworth	21%	45%	26%	8%
	Faraday	28%	36%	29%	7%
	Newington	20%	44%	28%	8%
Camberwell	South Camberwell	25%	39%	28%	7%
	Brunswick Park	23%	40%	29%	7%
	Camberwell Green	25%	38%	30%	7%
Dulwich	College	26%	30%	32%	11%
	East Dulwich	21%	42%	29%	9%
	Village	28%	27%	34%	11%
Peckham & Nunhead	Peckham Rye	25%	36%	31%	8%
	Nunhead	23%	38%	30%	9%
	Peckham	29%	35%	30%	7%
	The Lane	24%	38%	28%	10%
	Southwark	**22%**	**42%**	**28%**	**8%**

Significantly higher
Significantly lower
Similar
compared to Southwark average

Southwark Life Expectancy

- Life expectancy at birth in Southwark is 78.6 years for males and 83.8 years for females.
- The gap in life expectancy between Southwark and England has narrowed over the years. Life expectancy for females in Southwark has exceeded life expectancy for females in England.
- Life expectancy for males in Southwark is lower than in London and England with an average gap of 17 months and 10 months respectively. Life expectancy for females in Southwark is lower than the London average by 4 months but higher than the England average by 8 months.
- Male healthy life expectancy at birth is 59 years and is lower compared to London's 63.4 years and England's 63.3 years. Female healthy life expectancy at birth is 60.6 and is lower than London's 63.8 years and England's 63.9 years. So both men and women in Southwark live longer with some form of long term condition/disability.
- The Slope Index of Inequality (SII) measures inequalities in life expectancy within Southwark. It is a measure of the difference or gap in life expectancy between the most and least deprived populations in the borough. It is measured in life expectancy years and can be used to track achievements in reducing inequalities.
    - Southwark SII for 2011-13 was 7.6 years for males (+0.5 years from 2010-12).
    - Southwark SII for 2011-13 was 6.7 years for females (-0.6 years from 2010-12).
- The chart below the percentage contribution that each broad cause of death makes to the overall life expectancy gap between the most deprived quintile of Lambeth and the least deprived quintile of Southwark.



- For males and females **circulatory (i.e. heart disease, stroke and peripheral arterial disease),, cancer (i.e. lung cancer, breast cancers and bowel cancers in particular)** and **respiratory** conditions are key contributors to the LE gap.

- More detailed analysis shows
    - Top 5 contributors to the gap in **males**:
        - Chronic obstructive airways disease **14%**
        - Other circulatory **12%**
        - Dementia **11%**
        - Lung cancer **11%**
        - Coronary heart disease **9.2%**
    - Top 5 contributors to the gap in **females**:
        - Dementia **25%**
        - Other circulatory **12%**
        - Other digestive **10%**
        - Coronary heart disease **8%**
        - Lung cancer **6%**

Some further analysis is planned to understand the reasons behind the difference in the local gap between Southwark and Lambeth.

2. South East London Illegal Tobacco 'Keep It Out' Campaign

Although smoking prevalence has reduced over the years, prevalence in Southwark is 20.7% and 19.9% in Lambeth are higher than the London average (17%). Smoking is the primary cause of preventable morbidity and premature death because 1 in 2 smokers will die of smoking related diseases. Smoking is also the single biggest cause of inequalities in death rates between the richest and poorest in our communities. There is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local level.

Making tobacco less affordable is proven to be an effective way of reducing the prevalence of smoking, Young people, pregnant women and people from lower socio-economic groups are particularly sensitive to price. The health gain from high-priced tobacco, however, can be undermined if the illicit market in cigarettes and hand rolling tobacco is allowed to thrive at the expense of legal, duty-paid products. Success in reducing the illicit share of the tobacco market helps to reduce consumption, reduce organised crime in local communities, reduce potential revenue loss to the Treasury and support legitimate retailers.

The London Boroughs of Lambeth, Southwark, Lewisham, Royal Greenwich, Bexley and Bromley have been working together for over 3 years to tackle illegal tobacco in South East London. There is a significant market in illegal tobacco within SE London, illegal tobacco represents around 15% of the tobacco consumed and is a trade worth over £20 million per annum across the 6 South East London boroughs. A local survey revealed that approximately 36% of smokers in Lambeth and 56% of smokers in Southwark bought illegal tobacco demonstrating a significant degree of acceptance of the illegal trade. The market is largely covert with 80% of smokers who bought illegal tobacco reported they were known to or introduced to the seller. The ready availability of cheap tobacco is likely to be undermining public health work on tobacco harm reduction.

It has been noted that few smokers that purchase illegal tobacco, and communities at large, recognise that the tobacco is supplied by and funds organised crime and makes it easier for children to smoke.

Public Health and Trading Standard teams across the 6 South East London boroughs are running the "*Keep It Out"* campaign to educate local communities about the reality of the impact of illegal tobacco.

The South East London "*Keep It Out"* campaign consists of

- Engaging face to face with residents at community events
- Promoting the message through Facebook and a new website, www.keep-it-out.co.uk, which provides information, local stories about illegal tobacco and an opportunity for the public to report illegal activity on-line anonymously. The Citizens Advice consumer helpline is also promoted in order for the public to phone in their concerns.

The main key messages for the campaign are:

- Illegal tobacco removes age restrictions and price pressure and has significant implications for the health and wellbeing of residents
- The link between illegal tobacco and large organised crime gangs is well proven
- While all cigarettes are a fire risk in the home, illegal cigarettes pose a particular risk as they do not comply with fire safety standards

3. Stoptober Campaign and Smoke Free Cars

Launched in 2012, Stoptober is the 28 day stop smoking challenge from Public Health England that encourages and supports smokers across England towards quitting for good. Stoptober is based on the insight that if a smoker can stop smoking for 28 days they are five times more likely to be able to stay quit for good. The overarching objective is to trigger significant numbers of quit attempts by increasing motivation to quit and providing products to make this quitting easier.

2015 campaign coincides with new legislation in England and Wales making it illegal to smoke in a car with someone under the age of 18 present. Regulations designed to protect children from the dangers of second hand smoke will come into effect in 1st October 2015. To maximise the impact of both the legislation and Stoptober a combined approach to smoke free activity is in place during September and October.

GSTT Stop Smoking Service are promoting awareness of pharmacy stop smoking services within Lambeth and Southwark. All pharmacy providers are encouraged to display the promotional materials in stores. Twelve outreach sessions in the build up to 1st October will be held at train stations across Lambeth and Southwark. A community outreach campaign targeting high prevalence areas in Lambeth and Southwark is planned with outreach teams at Brixton and Blue markets. Free stop smoking treatments are offered to smokers wanting to take up the Stoptober challenge via local voucher scheme. Primary care and secondary care facilities will be promoting the campaign as well as various workplaces.

4. Electronic Cigarettes

The use of electronic cigarettes continue to dominate the headlines, most recently this has been in relation to the expert independent evidence review published by Public Health England (PHE) in August 2015. The review concludes that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking.

Key findings of the review include:

- the current best estimate is that e-cigarettes are around 95% less harmful than smoking
- almost all of the 2.6 million adults using e-cigarettes in Great Britain are current or ex-smokers, most of whom are using the devices to help them quit smoking or to prevent them going back to cigarettes
- nearly half the population (44.8%) don't realise e-cigarettes are much less harmful than smoking
- there is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers

The publication of the review has prompted several responses ranging from endorsement of e-

cigarettes to challenging the validity of the evidence used in the review.

An electronic cigarette (e-cigarette) is a device that uses battery power to heat an element to disperse a solution of propylene glycol or glycerine, water, flavouring and usually nicotine, resulting in an aerosol that can be inhaled by the user (commonly termed vapour). E-cigarettes do not contain tobacco, do not create smoke and do not rely on combustion. There is substantial diversity between different types of e-cigarettes on the market (such as cigalikes and tank models).

Locally, Lambeth and Southwark Trading Standards teams have reported some e-cigarettes that have failed general products safety tests. Although e-cigarettes contain no risk of second hand smoke, several organisations have banned the use of e-cigarettes on their premises due to health and safety concerns, difficulty in policing and lack of clarity of evidence around the product.

E-cigarettes are currently regulated by the general product safety regulations which do not require products to be tested before being put on the market. However, advertising of e-cigarettes is now governed by a voluntary agreement and from 1 October 2015 regulations to protect children will make it an offence to sell e-cigarettes to anyone under 18 or to buy e-cigarettes for them. Manufacturers can apply for a medicinal licence through the Medicines and Healthcare products Regulatory Agency (MHRA) and from 2016, any e-cigarette not licensed by the MHRA will be governed by the revised European Union Tobacco Products Directive (http://ec.europa.eu/health/tobacco/products/revision/index_en.htm)

Last year, the Lambeth and Southwark Tobacco Control Alliance provided their position on e-cigarettes. The Alliance consisting of representatives from the NHS, Councils, the London Fire Brigade and HMRC, agreed that as e-cigarettes were unregulated, its use should not be actively promoted, however anyone using e-cigarettes to help them quit should be encouraged to access our local stop smoking services for support. Our local Stop Smoking Services remain the most effective way for people to quit.

In light of the PHE evidence findings and the debate that ensued, a consensus statement has been made jointly by PHE and other UK Health organisations. There is agreement that it is important to ensure that the public are made aware that e-cigarettes are less harmful than smoking and tobacco use.

This is the same position that Lambeth and Southwark Public Health holds. Smoking continues to be the number one killer in Lambeth and Southwark and as such there is a responsibility to provide

smokers with information to help them quit completely and stay quit over their lifetime. Our local stop smoking services continue to provide evidence based effective support to smokers to help them quit. Information regarding Lambeth and Southwark Stop Smoking Services can be found on this link: http://www.guysandstthomas.nhs.uk/our-services/stop-smoking-service

5. Infection Control Update

Misuse of antibiotics leads to development of organisms such as those which are resistant to most common antibiotics such as Methicillin-resistant Staphylococcus aureus (MRSA)s and Clostridium Difficile. Antibiotics are losing their power and antibiotic resistance is now a worldwide public health problem. Tackling antimicrobial resistance (AMR) is a Government priority. Preventing infections and practicing good antimicrobial stewardship (AMS) are key components of the AMR.

A revised version of the code of practice on the prevention and control of infections was published in 2015 and reflects now the role of infection prevention (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance . A new criterion was added: "Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance". Providers of health care and adult social care in England are requested to apply these standards and their compliance is monitored through CQC.

While implementation of antimicrobial stewardship is the responsibility of CCGs, Public Health has a role to ensure that stakeholders are taking steps to implement it and facilitate joint working across health and social care. Public health has supported the establishment of an antimicrobial stewardship working group for LSL and a systematic review of all Clostridium Difficile infections. The review of patients with CDI over the past year suggests that the main contributor to the risk of developing this infection is associated primarily with antibiotic prescribing. The prescribing issues related to community care are fed back to Medicine Management teams of each CCG and will inform the work plan of the Antimicrobial Stewardship group.

6. Flu immunisation

Flu is an acute highly infectious illness which spreads rapidly and even people with only mild symptoms can infect others. Annual flu immunisation is one of the most effective ways to prevent flu and so reduce the potential harm it can cause, as well as help minimise significant winter pressures. Key risk groups eligible to receive free flu immunisation are recommended to do so from October each

year. Increasing immunisation uptake amongst health and social care staff with direct service user/client contact is part of the national annual Flu Plan (https://www.gov.uk/government/publications/flu-plan-2015-to-2016). The 2014/15 seasonal flu vaccine provided only limited protection against flu due to a mismatch between the main circulating strain and that used in the vaccine – this is unusual as there has been a good match during each season over the last decade.

In 2014/15 Lambeth and Southwark experienced lower uptake of flu immunisation in all risk groups compared with nationally including healthcare workers.

National and Lambeth/Southwark flu vaccination uptake by targeted risk group 2014/15

	Target	National	Lambeth	Southwark
Over 65's	75%	72.8%	66.9%	70.3%
Risk groups	75%	51.5%	47.4%	51.5%
Pregnant women	75%	44.1%	39%	34%
HCW	100% offer, 75% uptake	54.9%	29%	30%
2 years	75%	30%	31%	30%
3 years	75%	41.3%	22%	29%

Building on last year's campaign to improve seasonal flu immunisation uptake across Lambeth and Southwark, championed by senior officers, Public Health is again working with Southwark Council colleagues to support key frontline social care staff immunisation, and domiciliary worker focus through contracted agencies. Access to a pharmacy voucher is advocated, as well as sustained planning for annual staff immunisation. Lambeth CCG is leading similar work with Lambeth social care colleagues, and links with both CCGs are in place. Southwark Council communications team will be supported by Public Health to update webpages and press information with a focus on 65s & over and clinical risk groups. A new programme of schools childhood flu immunisation for 5 and 6 year olds, co-commissioned by NHS England and local authorities, will extend year on year to encompass additional age groups. This development has been communicated with Education departments alongside providers GSTT Community Services, and Public Health will continue to support communication around this initiative. Public Health in conjunction with CCG practice nurse leads and local PHE team

ran a practice nurse flu update attended by over 100 clinical staff on 2 September 2015. This also drew attention to GP Health Care Worker immunisation and current low levels of related data submission to ImmForm.

7. Meningitis vaccination - changes to the current programme

Meningococcal disease is a life threatening infection. There are five main groups of meningococcal bacteria that commonly cause disease; A, B, C, W and Y. Two new vaccines against this disease have been introduced; Meningococcal B and Meningococcal group W (Men W)

Meningococcal B is the most common cause of bacterial meningitis in the UK and is most commonly seen in infants. Meningococcal B (Men B) is a new vaccine and will help to protect infants under the age of one year who are most at risk and has been added to the childhood immunisation programme as of **1st September 2015**. Men B vaccine will be offered to babies at 2, 4 and 12 months as an addition to the childhood immunisation schedule at their GP practice and parents will be contacted in the usual way.

Meningococcal ACWY (Men ACWY)

Meningococcal group W (**Men W**) has historically been rare in the UK but since 2009, year on year, cases of Men W have increased and continue to do so. A significant increase in a particularly aggressive strain of Men W has been seen in teenagers and young adults over the last five years (Nationally - 22 cases in 2009 increasing to 117 cases in 2014).

Men ACWY vaccine will offer protection against the four groups of meningococcal bacteria A, C, W and Y and replaces the Men C vaccine. Since the introduction of Men C in 1999 disease caused by Men C has fallen by 95% in England.

Teenagers are more likely to carry meningococcal bacteria in the back of their throats. The vaccine is particularly important for those preparing to head off to university as they are at greatest risk of infection, this can be due to high carriage rates while in close contact in shared accommodation like halls of residence.

Introduction of the vaccine for 14 – 18 year olds and new university students will directly protect this age group and reduce the chance of the bacteria spreading to others.

Men ACWY vaccine programme began in **August 2015.**

Over one hundred practice nurses expected to deliver these vaccines attended a joint CCG/ PHE/ PH immunisation update training in July, and further training will be included in a bi-annual practice nurse half day immunisation update in October 2015. CCGs are expected to ensure that all practices are aware of the changes to the vaccine schedule and that appropriate staff attend the immunization update.

8. Neonatal BCG vaccine - shortage of supply

The neonatal BCG vaccine is routinely used to protect new-born babies, who are at an increased risk of exposure to TB infection.

Following a continued decline in TB rates in the indigenous population the schools based BCG programme was stopped in 2005. It has been replaced with a risk-based programme, the key part being the neonatal programme which targets those infants most at risk from or exposure to TB – this includes:

- all infants (0–12 months) living in areas of the UK where annual incidence of TB is 40/100,000 or greater – this includes Lambeth and Southwark.
- all infants (0–12 months) where one or more parent or grandparent was born in a country where the annual incidence of TB is 40/100,000 or greater

Public Health England (PHE) has a contract for the supply of BCG vaccine from the Statens Serum Institute (SSI) in Denmark. SSI was experiencing delays with the supply of BCG vaccine - this resulted in an EU wide shortage of BCG vaccine. PHE has not been able to supply BCG vaccine since March 2015 and notification was cascaded to Hospital Trusts, Clinical Commissioning Groups and GPs at the time with recommendations on how to prioritise immunisation to preserve stocks.

Recently PHE have confirmed that a limited supply of BCG vaccine is now available. However, due to on-going constraints with the global supply of BCG vaccine, the World Health Organisation has called on all countries to reduce BCG vaccine wastage, to ensure that countries with highest TB rates receive priority and to target individuals who will benefit most from BCG vaccination. PHE has endorsed the World Health Organisation's statement to limit BCG vaccination to the risk groups highlighted below:

- All infants (aged 0 to 12 months) with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater.
- All infants (aged 0 to 12 months) living in areas of the UK where the annual incidence of TB is

40/100,000 or greater.

- Infants aged older than 12 months who were not vaccinated during their first 12 months due to BCG vaccine shortage.
- Previously unvaccinated children aged one to five years with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater. These children should be identified at suitable opportunities, and can normally be vaccinated without tuberculin testing.

The community child health team at Guy's and St Thomas' are working to implement these latest guidelines from PHE during this period of extreme global shortage.

9. London Cervical Sample Taker Database

NHS England (London region) is implementing a single pan-London Cervical Sample Taker Database (CSTD) with the aim to improve the quality and safety of cervical sample taking in London.
This is happening soon - roll out in South East London will start in November 2015, with completion by January 2016. As part of the registration process, sample takers will be required to provide their personal details, including professional registration numbers and evidence of foundation and update training attended.
This initiative has the potential to impact on uptake of cervical screening if cytology samples are rejected by the laboratory due to the sample taker not being registered or up to date with their training. All sample takers are urged to ensure they are up to date with the recommended cervical training, as set out in the Interim Good Practice Guidance for Cervical Sample Takers, NHSCSP Good Practice Guide No 2 July 2011 and that they ensure they participate in the registration process. Public health is working with the CCG practice nurse leads to ensure that all GP practices and cervical screening sample takers are aware of these requirements.

10. A pilot of a new bowel cancer screening kit starts in November 2015

The bowel cancer screening programme was introduced in 2008. Men and women registered with a GP aged 60-75 years are sent a bowel screening test kit every two years for self sampling at home.
The NHS Cancer Screening programme target uptake is 60%. Uptake rate in Lambeth and Southwark has been persistently low at around 38%.

In November 2015 the Bowel Cancer Screening Programme will start a six month pilot of faecal immunochemical test (FIT) in London. FIT is already used in many other countries and has some advantages over the current bowel screening test (guaiac Faecal Occult Blood test - gFOBt).

The pilot will assess how FIT works in London and will look at a range of issues, including whether the new kit increases uptake. FIT is better at detecting human cancers and particularly advanced adenomas with fewer false positives. It has a higher participation rate than with gFOBt which may result in challenges for endoscopy services as more people are referred on for colonoscopy. Results from the FIT pilot are likely to be available in July 2016.

The UK National Screening Committee has already started a 3 month public consultation on whether to change the test used from gFOBt to FIT. If approved, FIT will be introduced as the national screening test in 2017.

11. SH:24

Lambeth and Southwark have high rates of sexually transmitted infections and there is insufficient capacity in local sexual health services borne out by queues and waiting times in clinics. SH:24 is revolutionising sexual health care by using telephone and internet technologies to deliver sexual health care remotely – improving access to services, offering early access to treatment thereby reducing the risk of transmission. This is really important in an area of significant public health risk, pressure on services and provides an opportunity to provide a sexual health service which users want and respond to – more efficiently and at lower cost.

SH:24 has successfully launched the online STI testing service for residents of Lambeth and Southwark in March 2015 – providing people with free sexually transmitted infection (STI) test kits, information and advice – 24 hours a day. SH:24 has experienced very strong interest in the service delivering over 3,800 kits and achieving a return rate of 68% - much higher than other home testing services.

SH:24 has successfully targeted its key audience – asymptomatic clinic users (94% of users are asymptomatic and 40% have used a clinic in the past year). These figures suggest that SH:24 is starting to shift clinic activity online (at a lower cost) – helping to free-up capacity for more complex cases in clinics, and creating savings for the local sexual health economy.

Take-up amongst high risk groups is also strong: 25% of users are from black and ethnic minority groups, 16% of users are men who have sex with men and 86% of users are young people. SH:24's diagnostic rate is 8% (compared with 12% in clinics) , which coupled with its rapid results turnaround (24-72 hours) is helping to detect STIs quickly and reduce onward infection.

SH:24 is continuing to develop the service and is nearing the end of its second phase of development – user support. As part of this phase the following has been launched:

- A local services geo-locator/map that allows users to find the services that are local and convenient for them
- 'Talk to us by text' which allows users who have not ordered a test kit to contact SH:24 with questions about sexual and reproductive health
- A call back service which allows users to request a call back from a nurse/clinician

Over the next month contraceptive/additional user support pages will be added to the website and a full web chat service will be launched later in October. This will allow service users to consult with sex and reproductive health specialists remotely and enable SH:24 to deliver interactive advice on protection and prevention messages and ensure appropriate referral.

Following user support the next phases of development will be built into the service - emergency hormonal contraception, oral contraception, chlamydia treatment and partner notification – to create a holistic sexual and reproductive health service. SH:24 expects to deliver this by July 2016. This will enable users of all sex and reproductive services living locally to access a full range of STI testing and contraception on line and be the first area in the country who can provide this service.

12. Wellbeing update

Black Health and Wellbeing Commission implementation

The Brixton Reel Film Festival is in its seventh year. Brixton Reel is a project that uses film as a method of engaging ethnic minority populations in Lambeth and Southwark on mental health and wellbeing; to raise awareness about local mental health support, to improve mental health literacy and to tackle stigma and discrimination. This year there is a particular focus on supporting recommendations made by the Lambeth Black Health and Wellbeing Commission. The festival will take place from 9-15 November in various venues. More information will be available in due course at: http://www.brixtonreel.co.uk/

SLAM mental health promotion are running their Spiritual and Pastoral awareness course for faith communities and are receiving support from a Professor from New South Wales to improve the evaluation. The team held a successful second anti-stigma community event targeted at ethnic minority people at the Karibu Centre, Brixton in July 2015.

PHE public mental health workforce development framework

This framework (https://www.gov.uk/government/publications/public-mental-health-leadership-and-workforce-development-framework) launched by Public Health England (PHE) earlier this year aims to support workforce development in public mental health. The framework covers all staff from leaders to frontline staff. The purpose is to enable staff to be more effective in promoting good mental health across the population, acting to prevent mental illness and suicide and to improve the quality and length of life of people with mental health issues. There are six ambitions:

- Leaders
  - Our leaders advocate for the mental health of citizens as a valuable resource for thriving communities and economies
- Public health specialist workforce
  - Our workforce has expertise to lead mental health as a public health priority
- Public health practitioners and wider workforce
  - Our local workforce works with communities to build healthy and resilient places
  - Frontline staff are confident & competent to support people to improve mental wellbeing
  - Frontline staff are confident & competent to recognise mental distress
  - The health and social care workforce has the knowledge and skills to improve the health

and wellbeing of people with a mental illness and reduce mental health inequalities

Public health worked with SLAM's mental health promotion team, SLAM HR, the Royal society for Public Health (RSPH) and Public Health England (PHE) to submit a bid to Health Education South London (HESL) to develop a new training product on brief intervention for wellbeing using a psychosocial and positive wellbeing perspective. If the bid is successful the training product should help to fill a gap identified by PHE and others. If the bid is unsuccessful we will look at other ways to find the resource to develop this with partners.

Public health representatives will attend a workshop on 15 October with local partners to identify how to individually and collectively support the 'Call to Action' on this workforce development framework in our organisations.

Workplace wellbeing

£54k was identified by trusts in KHP to support the continuation of the happier@work programme delivered by SLAM mental health promotion unit which includes mindfulness, line manager training on mental health and stress awareness. A wheel of wellbeing workshop will be piloted with staff. See www.wheelofwellbeing.org

Public Health is working with employers in Lambeth and Southwark to support and encourage them to adopt the best practice outlined in the *London Healthy Workplace Charter*. At present there are 9 organisations in Lambeth and Southwark which have been successfully accredited, including Southwark Council, and 10 more are actively working towards accreditation, including Lambeth Council. Public Health is also working in conjunction with Community Action Southwark to deliver workplace health focussed learning sets to 16 voluntary sector organisations across Southwark and Lambeth based on elements of the London Healthy Workplace Charter.

What Works Centre for Wellbeing: wellbeing dialogues held in Lambeth

The *What Works Centre for Wellbeing* approached public health to help them host two wellbeing dialogue events in Lambeth. These took place at 'Roots and Shoots' in June and July. The focus was on the link between sports and cultural activities and wellbeing. The events were to help guide the academic consortium selected to take forward the programme of evidence reviews. See http://whatworkswellbeing.org/ for more about the Centre. Cllr Jim Dickson provided a 'vox pop' for the delegates and Cllr Barrie Hargrove attended the June event as an observer alongside relevant

council officers. The events further cemented Lambeth and Southwark's status as leaders in the field of public mental health work.

13. LEAP Update

Leap is a ten year, £38m initiative to improve early years outcomes (social and emotional, communication and language, diet and nutrition) and is based in four wards in Lambeth. It started earlier this year and below is an update on progress to date.

The work continues to gather apace with new staff starting or soon to do so to address its monitoring and evaluation aspects. Public Health will work closely with them and their counterparts in the other sites in the development of measures and evaluation designs. The aim is, where possible, to incorporate best practice into an evaluation framework. This will include joint work with KHP academics, addressing social value and inequalities, and use of peer evaluators.

Two GP leads have been recruited whose tasks include working with Public Health on the GP "Failsafe" initiative. General Practices will have an enhanced role working with other partner agencies along an agreed healthy child pathway to ensure that services are delivered when needed and proactive identification of any risk factors is done.

LEAP's communications is growing with a website (www.leaplambeth.org.uk), Twitter and Facebook presence. Several well attended community based events took place over the summer with some parents expressing an interest in becoming a Parent Champion.

14. Learning Disability in Southwark

In their move towards taking a life course approach in social care Southwark Council requested an updated needs assessment of people with learning disability (LD) and, or autistic spectrum disorder (ASD) that encompassed children, adults and older people. The last learning disability JSNA for Southwark was published in 2013 Although this previous report only covered adults with LD it became clear that most of the recommendations still stood although gaps remain in understanding needs of people with ASD. This is a brief summary of some of the main findings and recommendations. The draft is out to consultation until the 9th October.

1. Children

- There is scope for prevention of LD at population level as risks of LD are increased with

exposure to tobacco and alcohol in utero and in low birth weight which is more likely in teenage mothers and in low income households. Prevention options are less clear for ASD

- Southwark has an estimated 700 boys and 500 girls aged 0-15 with LD (2014). This will increase to 800 boys and 600 girls by 2024. Approximately 660 children and young people (0-18 years) are thought to have ASD. Estimates are relatively close to numbers identified through schools suggesting that most children are identified by local services. However school returns for LD are much higher (30.74 per 1000 (i.e. 1,333 pupils) than the London (19.56/1000) or England (24.53/1000) rates.
- Detection of ASD is also higher than London and England as a whole and the annual numbers detected have increased from 463 in 2008 to 801 pupils in Southwark in 2013. More than 1,100 children and young people with a diagnosis of ASD were known overall to Southwark services which is more than the estimated prevalence but could be within the confidence limits of the estimate

2. Adults and older people

- Southwark has c. 6000 adults (18years and over) with LD or about 1% of the population and the 6th highest in London. 1300 will have moderate or severe LD. By 2020 it is expected that Southwark will have the 2nd highest number, a 13% increase in the total and a 15% increase in numbers of people with moderate or severe LD. Most of the increase will be in the 25-64 year age group but a small steady increase is also expected in older people which will include an increase in numbers with severe LD.
- About 2,300 people aged 18-64 are thought to have ASD. ASD prevalence is higher in men (2%) than women (0.3%) and 60-70% of people with ASD are also likely to have LD.
- The expected increase in LD and ASD is related to population increases, increased survival of disabled infants and the general increase in life expectancy. To some extent the increase in ASD is due to improved identification
- People with LD and ASD who use services are more likely to have moderate or severe disability and there will be others who do not access services because of various barriers so service use is not always a useful guide to prevalence.

3. **In primary care/ general practice and social care:** overall in primary care and social care the numbers of adults identified with LD and ASD are very low (barely 10% of expected prevalence and amongst the lowest in England) In 2013

- 659 adults aged 18 or over registered with their GP were known to have LD (update: 699 in 2014)

- 662 adults aged 18 years and older were known to the local authority (update: 625 in 2014)
- Fewer than 60 adults with ASD were receiving social services (less than 3% of what might be expected)

4. **Health & wellbeing**: people with LD are **more likely** than the general population to:
   - Take risks with their health (they are less aware of the risks and not supported to live healthy lives) e.g. in relation to alcohol, tobacco, sexual health, healthy eating, weight and exercise
   - Experience poor physical health including; cardiovascular disease, diabetes, epilepsy, mental health problems, dementia, and poorer dental health,
   - Attend Emergency Departments especially for acute conditions (where an admission may indicate poor primary or community care) compared to the general population,

   People with LD are **less likely** to
   - Attend screening services (e.g. health checks, cervical and breast screening)
   - Use primary care services: in Southwark, of people known to have LD and eligible to have a health check (introduced specifically for people with LD) in 2011-12 only 41% had received one. This was significantly worse than the England average. The 2014 report suggests that only 194 of 699 known adults (28%) had received a health check.

5. **Independent living**: people with LD are **more likely** to
   - Live on limited income
   - Have lower educational attainment
   - Be at risk of neglect, exploitation and abuse including bullying, violence and sexual abuse, and financial exploitation
   - Be victims of crime and be in the criminal justice system

     And **less likely** to
   - Be in paid employment

6. What is happening?

- The council is increasingly trying to relocate people with LD out of distant institutions into local independent living arrangements wherever possible.
- A transition team was set up in 2013 to support people aged 14-25 and their families negotiate services and make decisions for the future
- A 'health passport' is used in GSTT to enable people with LD to get the care and support they need

7. **Main recommendations** : cover the main findings of the report, in particular:
   - maximise opportunities for prevention especially preventing poverty and minimising exposure to tobacco and alcohol in pregnancy
   - improve access of people with LD and ASD to appropriate primary care including screening services
   - ensure safeguarding arrangements are adequate to enable proper support to people with LD and or ASD including the children of parents with LD/ASD
   - Improve support for carers who are increasingly likely to be elderly parents who may have poor health and be of limited means
   - Improve access to education, employment and other productive activity
   - Promote independent living with appropriate support
   - Improve access to mainstream amenities that promote social inclusion such as exercise and leisure, public transport, libraries etc.
   - Bring to bear the best in research and development and good practice and ensure people with LD and ASD are benefiting

8. **Next steps**: the LD & ASD Needs Assessment is out for consultation until early October with the expectation of publishing a final version in November 2015 that is expected to go to Cabinet.

   Lambeth has indicated it wishes to undertake more targeted needs assessment on Learning Disability in line with existing priorities. The scope of work is under discussion. When this is agreed it will be possible to focus on specific aspects of the life course (e.g. transition, old age) in more detail in both boroughs.

9. **Further reading**
   - Adults with Learning Disabilities in Southwark (2013). http://www.southwark.gov.uk/info/200519/joint_strategic_needs_assessment/3458/5_in-depth_analysis).
   - http://www.improvinghealthandlives.org.uk/publications/313899/The_determinants_of_health_inequities_experienced_by_children_with_learning_disabilities
   - Public Health England Learning Disability Public Health Observatory https://www.improvinghealthandlives.org.uk/
   - PHE ‘fingertips’ health information http://fingertips.phe.org.uk/profile/learning-disabilities/data#page/0/gid/1938132702/pat/6/par/E12000007/ati/102/are/E09000028

Item No. 7.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Health and Wellbeing Strategy: Obesity & Tobacco update	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The board is requested:

   a) To note the obesity and tobacco update (Appendix 1) on the action plan received at the June 2015 Health and Wellbeing Board

   b) To note that the update for alcohol and sexual health is scheduled for Jan 2016

   c) To note the establishment of an obesity strategy task & finish steering group and to agree HWB Board leads across the partnership for this group

   d) To receive a presentation on the progress in developing the adult weight management service

EXECUTIVE SUMMARY

2. The Health and Wellbeing Board received the refreshed Health and Wellbeing Strategic framework in January 2015 and has requested regular thematic updates. This update is on the obesity and tobacco themes. In year progress includes:

   - The successful procurement of community weight management services for children and families
   - The development of a pilot for adult weight management services
   - The launch of a cycling strategy which sets out infrastructure improvements and a range of support to increase cycling, to make cycling safer and to support people who are less confident or less likely to cycle
   - The invitation for free swimming and gyms for children and young people and older people and the targeted support for people who are less likely to be active such as people with poor mental health, with poor physical health and of unhealthy weight.
   - The draft New Southwark Plan which has an inclusive vision of health and includes planning policies that will impact positively on health such as active travel, green space and growing, hot food take away restrictions, housing and the local economy.
   - On going work and progress in producing a comprehensive tobacco control strategy

Policy implications

3. Southwark council and the Southwark CCG have a statutory duty under the 2012 Health and Social Care Act to produce a health and well being strategy for Southwark. The health and wellbeing board leads the production of the strategy. Local health and wellbeing commissioning and service plans have to pay due regard to the health and wellbeing strategy.

Community impact statement

4. The health and wellbeing strategy and associated action plans seek to improve the health of the population and to reduce health inequalities. It is acknowledged that some communities and individuals are less likely to access or make use of the services offered and targeted support or initiatives are expected to address this.

Legal implications

5. The board is required to produce and publish a joint health and wellbeing strategy on behalf of the local authority and clinical commissioning group. The proposals and actions outlined in this report will assist the board in fulfilling this requirement and will support the strategy's implementation.

Financial implications

6. There are no financial implications contained within this report. However, the priorities identified in the health and wellbeing strategy will have implications for other key local strategies and action plans and the development of commissioning intentions to improve the health and wellbeing of Southwark's population.

BACKGROUND PAPERS

Background papers	Held at	Contact
Southwark Joint Strategic Needs Assessment	See link below	jsna@southwark.gov.uk
Link: Southwark Joint Strategic Needs Assessment		
Southwark Health & Wellbeing Strategy 2015/20	See link below	Public Health 020 7525 0280
Link: Southwark Health and Wellbeing Strategy 2015 - 2020		

APPENDICES

No.	Title
Appendix 1	Southwark Health and Wellbeing Strategy: Obesity & tobacco thematic update

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health for Lambeth & Southwark	
Report Author	Jin Lim, Assistant Director of Public Health	
Version	Final	
Dated	5 October 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		9 October 2015

APPENDIX 1

Southwark Health and Wellbeing Board October 2015

Health & wellbeing strategy thematic update

- Obesity & physical activity (October 2015)
- Smoking (October 2015)
- Alcohol & substance misuse (January 2016)
- Sexual health & HIV (January 2016)

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
Obesity	**Strategy & commissioning** ♦ Develop a Southwark Obesity Strategy which takes a whole systems approach to effectively tackle obesity ♦ Continue to progress the commissioning of agreed children's healthy weight services: – Implement INICEF Baby Friendly Initiative – Implement good nutrition and dietary practice in children's centres – Implement healthy schools programme – Provide specialist healthy weight practitioner support – Provide capacity building training to professional	2015/16 2015/16	Southwark Plan Council Plan Physical Activity & Sports Strategy Walking Strategy (in progress) Cycling strategy (in progress) CCG Prevention& Resilience Programme Action Plan Action plans for healthy weight, Kings public health committee work programme	Council Cabinet Proactive Southwark CCG Resilience & Prevention Board Healthy Weight Network King's Public Health Committee	Leader, Southwark Council Cabinet member for public health, parks & leisure Cabinet member for adults care, arts & culture Chief Executive of Southwark Council Director for Public Health CCG clinical lead for resilience, wellbeing & prevention King Health Partners	Proposal for a obesity strategy development steering group to be set up, with a SRO and endorsed by the HWBB Procurement of the agreed commissioned services underway. Community children's weight management service for families commenced in September 2015

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
	workforce to implement healthy weight care pathway – Provide Levels 2 and 3 weight management services					
	♦ Maximise opportunities of supporting plans, strategies and policies	2015/16				To be taken forward in obesity strategy development
	Diet and nutrition					
	● Monitor the free healthy school meals programme	2015/16				All catering contracts for primary schools in Southwark meet the School Food Standards; as part of the Healthy Schools London Accreditation for Southwark, work is taking place to promote healthy eating
	● Monitor and obtain feedback from the implementation of the free fruit scheme	2015/16				All primary schools now receive the free fruit

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
	Healthier environment ● Embed health into the Southwark Plan to create healthier physical environments by promoting active urban design, access to quality green space, balanced mixed local economy and prevent over concentration of uses including A5, active travel and social infrastructure.	2015/16				offer. Work is taking place to assess feedback. The Council is reviewing the Southwark Plan and Core Strategy to prepare a local plan called the New Southwark Plan. The first draft of the New Southwark Plan is online. http://www.southwark.gov.uk/downloads/download/3934/the_new_southwark_plan. The potential for health improvement is integrated across the document and includes active travel, green space and growing, hot food takeaways, housing and local economy growth. The preferred option will be considered at Cabinet in October. There is a

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
	Physical activity ● Embed cycling policies in all strategic documents to improve cycling safety, cycling routes, access and targeted promotion.	2015/16				strategic policy covering health and a consideration of health issues running through all of the policies of the plan. A new cycling strategy has been launched http://www.southwark.gov.uk/news/article/1812/southwark_council_launches_new_cycling_strategy The strategy sets out infrastructure improvement, cycling routes, cycle storage as well as targeted approaches to support people to cycle such as cycling and safety training and cycle loan schemes. The strategy aims to also promote cycling to a broader demographic. The cycling strategy is working across the system for example through planning and

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ⭘ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
	♦ Proactive Southwark Partnership to develop programmes to increase participation in physical activity from at risk groups (early years, CYP, women & girls, older people, disabled, people at risk of ill-health conditions)	2015/16				regeneration, local schools, voluntary and community groups. A range of programmes have been supported and further developed this year to support increased uptake from targeted groups including : Playstreets; London Youth Games; This Girl Can promotions; Free Swim and Gym for young people, older people and soon disabled people; and the Exercise on Referral programme.
	● Deliver free swims and gym for all Southwark residents and support less active to be more active. Focus on under 18s, older people and people with disabilities 2015/16.	2015/16/17				The free swim and gym programme launched in March 2015 starting with Southwark residents who are 18 and under or over 60 can apply to use the gym and swim for free

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ⭘ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
						at set times http://www.southwark.gov.uk/info/200087/sports_and_leisure/3689/free_swim_and_gym/2 Alongside this offer, people who may be less active such as people who have health conditions or are of unhealthy weight are supported to become more active through a variety of local schemes such as exercise on referral http://www.southwark.gov.uk/info/10096/physical_activity/892/southwarks_exercise_referral_programme and risk reduction interventions after a health check such as specialist programmes (such as Walk Away & Shape Up) and weight management.

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ⭘ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
Smoking	♦ Produce a comprehensive tobacco control strategy - Stopping the promotion of tobacco use - Making tobacco less affordable and more effective regulation of tobacco products - Helping tobacco users to quit - Reduce exposure to second hand smoke - Effective communication for tobacco control	2015/16	Action plans for tobacco & smoking Kings public health committee work programme	Council Cabinet CCG Resilience & Prevention Board Tobacco Alliance King's Public Health Committee	Leader, Southwark Council Cabinet member for public health, parks & leisure Cabinet member for adults care, arts & culture Chief Executive of Southwark Council Director for Public Health CCG clinical lead for resilience, wellbeing & prevention King Health Partners	Literature review conducted to identify up to date evidence on Tobacco Control Rapid review of stop smoking service (2013/14 data) workshop with commissioners to identify potential opportunities for increasing the numbers of successful quitters and targeting those at greatest risk Health Equity Audit of Southwark Stop Smoking Service (2011 - 2013) Community insight work gathering residents' views on smoking as well as the local stop smoking services. A

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ⭘ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)	Progress
						further deep dive done with priority groups Workshop with a range of stakeholders including members of the community to share the findings from the community insight and Health Equity Audit. Based on these findings, stakeholders provided recommendations on priorities for future tobacco control priorities. Sessions are being organised for Public Health and Commissioning to use all the collated evidence to come up with a draft commissioning model for future services. This draft model will be consulted upon with stakeholders.

Item No. 8.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark and Lambeth Early Action Commission Final Report	
Wards or groups affected:		Southwark wide	
From:		Gordon McCullough, CEO, Community Action Southwark	

RECOMMENDATIONS

1. The board is requested to:

   a) Provide a response to the Commission's recommendations as set out in the report

   b) To consider the next steps to oversee and take forward the recommendations of the Commission.

BACKGROUND INFORMATION

2. In July 2014 the Southwark Health and Wellbeing Board approved of the creation of an independent Early Action Commission. The broad aim of the Commission is to make a series of recommendations about how organisations such as the local council, NHS, police and voluntary sector can work together to prevent problems that damage people's lives and trigger future demand for services.

3. The commission is chaired by the Rt. Hon. Margaret Hodge MP and is composed of a range of experts in early action and intervention across a range of policy areas. The commissioners are Dr Sue Goss (Office for Public Management); Carey Oppenheim (Chief Executive, Early Intervention Foundation); Dr. Jonty Heaversedge (Chair, Southwark CCG); Prof. David Colin-Thome (Trustee, Guy's and St Thomas' Charity); Helen Charlesworth-May (Strategic Director of Commissioning, Lambeth Council); and, David Robinson (Community Links).

KEY ISSUES FOR CONSIDERATION

4. The Commission has identified four goals for early action in Southwark and Lambeth. These are designed to reverse the balance of spending and to address problems as far upstream as possible. They focus what can be done locally in the context of extreme budgetary constraints. They interact with dynamic effect and are intended to be mutually reinforcing and sustainable over time.

   - ***Resourceful communities*** where residents and groups are agents of change, ready to shape the course of their own lives. To achieve this people need actual resources (but in the broadest sense), connections and control.

- ***Preventative places*** where material conditions have a positive impact how people feel and enable them to lead fulfilling lives and to help themselves and each other.
- ***Strong, collaborative partnerships*** where organisations work together and share knowledge and power, fostering respectful, high-trust relationships based on a shared purpose.
- ***Systems geared to early action***, where the culture, values, priorities and practices of local institutions support early action as the new 'normal' way of working.

Recommendations

5. Effective early action depends on changing whole systems, not just launching new initiatives. These recommendations build on good practice already underway in Southwark, Lambeth and elsewhere. To make a real difference, they must be placed at the heart policy and practice in both boroughs and pursued forcefully and consistently over time. Taken together, they contribute to the four goals as stated above: resourceful communities, preventative places, strong, collaborative partnerships and systems geared to early action. Action to change systems should not wait until resources are found, nor should changes in practice wait for systems to be geared to early action.

Step 1: Prepare the ground

- ***Establish senior leadership and commitment.***

  Health and Wellbeing Boards must ensure that early action is a central feature of their strategy, with Board members firmly committed to implementing it. The Public Health department should play a key role in driving the changes.

- ***Map assets across both boroughs.***

  Asset mapping, already practiced in both boroughs, identifies human and social resources, which are abundant in every locality and play a vital role in early action. This should be strengthened to locate, develop and connect local assets.

Step 2: Find resources

- ***Co-ordinate charitable funding for early action.***

  Bring together independent funders across both boroughs to share knowledge about early action and work together to offer grants for activities that tackle problems more systemically and further upstream.

- ***Set up a dedicated Change Fund to support systems change.***

  This could be financed partly or wholly by a suitable local grant-giving foundation and dedicated to stimulating profound changes in the way local systems are designed and operated.

- ***Review and strengthen community returns from regeneration.***

  Opportunities to generate funds through sale of redevelopment sites, Section 106 negotiations and the Community Infrastructure Levy should be maximised, with funds used to prevent problems, e.g. through housing and spatial planning.

- ***Pool budgets between organisations and departments*.**

  This can help to support early action and make resources go further, by consolidating existing funds and focusing them on early action, as well as strengthening collaboration between the boroughs, and sharing risks and rewards.

- ***Tap into community-based assets.***

  Unlock human and social assets in the community (see asset mapping above), by working more closely with VCS organisations, and by applying the principles of co-production.

- ***Strategic use of Social Impact Bonds***.

  These involve raising investment from the private sector to finance service provision (usually by the VCS). They are useful in *limited* conditions, especially as a tool for experimenting with new initiatives in the transition to early action.

Step 3: Gear local systems to early action

- ***Classify spending to distinguish early action from downstream coping.***

  Spending bodies should know whether the money they spend is allocated to coping with problems or preventing them. Spending should be loosely classified – as a rule of thumb - adapting guidance from the Early Action Task Force.

- ***Establish a long-term plan, across 5-10 years, with specific milestones***.

  To avoid local systems defaulting to downstream coping, leading decision-makers and budget holders in Southwark and Lambeth should commit to a step-by-step transition to early action, over the longer term, with specific milestones.

- ***Commit to shifting a significant % of spending each year to early action.***

  Both boroughs should commit to shifting a specific – and significant - proportion of total spending each year towards early action. Targets should be subject to yearly revision but we suggest 5% as an initial goal.

- ***Establish clear oversight arrangements, with regular monitoring and reporting.***

  Health and Wellbeing Boards should oversee the shift to early action, supported by Public Health, with a shared evaluation framework (see below), quarterly reporting to the HWB, and reporting back to a reconvened Early Action Commission.

- ***Transform the commissioning process to support early action.***

  Decisions about what services and other activities are required should be taken in partnership with local people, with commissioning focused on assets, on how to prevent problems, and on outcomes, and encouraging collaboration.

- ***Develop a shared evaluation framework****.*

  For use by VCS grant-holders and contractors, and public sector bodies, this would establish a theory of change reflecting a shared understanding of early action, and shared criteria for monitoring progress, including wellbeing

indicators.

- ***Assess community assets alongside needs.***

  Asset assessment should be integrated with the Joint Strategic Needs Assessment (JSNA), changing the focus of data collection generate a more rounded view of the local community and higher priority to early action.

Step 4: Change practice

- ***Improve connections, co-ordination and knowledge-sharing.***

  This involves linking up people and organisations, improving communications between them, and enabling them to exchange information, build a shared sense of purpose and complement rather than duplicate each other's efforts.

- ***Stronger partnerships and more integrated working.***

  Stronger partnerships, promoted through information-sharing and the commissioning process, as well as by pooling budgets and more integrated working, should strengthen the momentum towards early action.

- ***Create and support more spaces for people to get together.***

  There should be more opportunities for people in Southwark and Lambeth to use parks, open spaces, schools, underused public buildings and empty properties for meeting each other, building networks and doing things together.

- ***Make more use of "place shaping" powers to support early action***

  Councils should take stock of their "place-shaping" powers and make the best possible use of them to create conditions that help to prevent problems, working with local people and building on existing good practice in the two boroughs.

- ***Devolve more power to neighbourhoods.***

  Local councils and their partners should look for ways of devolving more power and resources to communities and community groups, and transferring community assets to residents.

- ***Promote and support local early action.***

  Health and Wellbeing Boards and their constituent bodies should support local preventative initiatives and draw out lessons that can stimulate similar action elsewhere and contribute to wider, systemic changes.

- ***Increase participatory budgeting.***

  This aims to deepen public engagement in governance by empowering citizens to decide on how public funds are spent, engaging citizens in democratic deliberation and decision making.

- ***Promote and apply the principles of co-production****.*

  Co-production, already applied in some programmes and initiatives in both boroughs, should become the standard way of getting things done, encouraged through commissioning and adopted by choice in all sectors.

- ***Strengthen the focus and funding of the VCS in Southwark and Lambeth.***

  The local VCS should be encouraged and supported to strengthen its focus on upstream measures, and to adopt an inclusive and participative approach to their activities. Funding should be better co-ordinated and directed at early action.

Next steps

5. The Southwark and Lambeth Early Action Commission report will be formally launched on 16 November 2015.

BACKGROUND PAPERS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Southwark and Lambeth Early Action Commission Final Report
Appendix 2	Southwark and Lambeth Early Action Commission Summary
Appendix 3	Southwark and Lambeth Early Action Commission Case Studies
Appendix 4	Southwark and Lambeth Early Action Commission Methodology

AUDIT TRAIL

Lead Officer	N/a
Report Author	Gordon McCullough, CEO, Community Action Southwark
Version	Final
Dated	9 October 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		9 October 2015

APPENDIX 1

Southwark and Lambeth Early Action Commission

Final Draft of the Commission's Report

Contents

Introduction

The Southwark and Lambeth Early Action Commission was set up to find ways of tackling early action at local level to prevent problems that reduce people's quality of life and generate needs for public services. Examples identified by the two boroughs were childhood obesity, social isolation among older people, long-term unemployment and insecure employment, and violent crime: these were seen to generate high demand for services and to be preventable.

Everyone wants to avoid problems like these. The lives of residents in Southwark and Lambeth would be much improved without them. What's more, most people agree that it's far better to invest in early action to prevent problems, than to let things go wrong and cope with the consequences. Both councils are committed to preventing such problems and early action features strongly in their forward planning.

"I want to us to think about how we treat the causes of problems rather than the consequences… Prevention and resilience should be at the forefront of all our work." *Council Leader Lib Peck introducing Lambeth's Community Plan 2013-16*

"For people to lead healthy lives, we need to tackle the root causes of ill health and reduce the inequalities that limit the lives of too many in our society". *Southwark's Fairer Future Council Plan 2014/5to 2016/7*

But this is easier said than done – at local and at national level. The National Audit Office and the Public Accounts Committee of the House of Commons have both noted a persistent gap between recognising the value of early action and realising that value in practice.

"In principle, early action can provide positive social and economic outcomes and reduce overall public spending… although the political and practical challenges are considerable." *National Audit Office 2013, Early Action Review p5.*

"There is broad consensus that early action can lead to savings down the line, and improve people's lives. Successive governments have not, however, been able to convert this consensus into effective action." *PAC Early Action Landscape Review, Second Report p7.*

Many policies and initiatives that are already active in Southwark and Lambeth are trying to prevent problems from happening or getting worse. Examples include Current examples of early action include Southwark's promise to build 1,500 new homes by 2018,[i] and to provide free swimming and gyms for all residents,[ii] as well as Lambeth's Community Safeguarding service where local teams work to "prevent and take tough action against anti-social behaviour, re-offending and violence", and its commitment to "early intervention and prevention services" for young people.[iii] Nevertheless, both boroughs know they must do more to make a real impact on residents' lives and on patterns of public spending.

The funding imperative

Public resources are extremely constrained. Unprecedented cuts in local authorities' budgets, alongside financial retrenchment in the NHS, are the backdrop against which this Commission has worked. Our ideas, analysis and recommendations have been developed in this context, with the question of resources as a primary concern. Lambeth Council is coping with a 56% reduction in its core government funding by 2019, and estimates it will have to find an additional £62m savings, bringing total savings found since 2010 to £238m. Southwark faces a similar challenge. Projected reductions of £76 million in settlement funding over the next three years are expected to leave a budget gap of £96 million.[1] Other parts of the local public sector are also feeling the strain. For example, Southwark's Clinical Commissioning Group (CCG) expects an annual rise in funds in line with projected inflation (currently 2% per annum) and will have to use these resources to meet additional demand generated by a population that is expected to increase by 21% between 2011 and 2021, with the proportion over 60 rising by more than 17% during that period.[2] To deal with the significant deficit this entails, Southwark CCG is trying to redesign health and social care to achieve a 6% annual cost reduction by improved prevention and early management.[3]

The effects of this acute shortage of resources are paradoxical. On the one hand, it can act as a barrier to change, as those in charge of commissioning and running

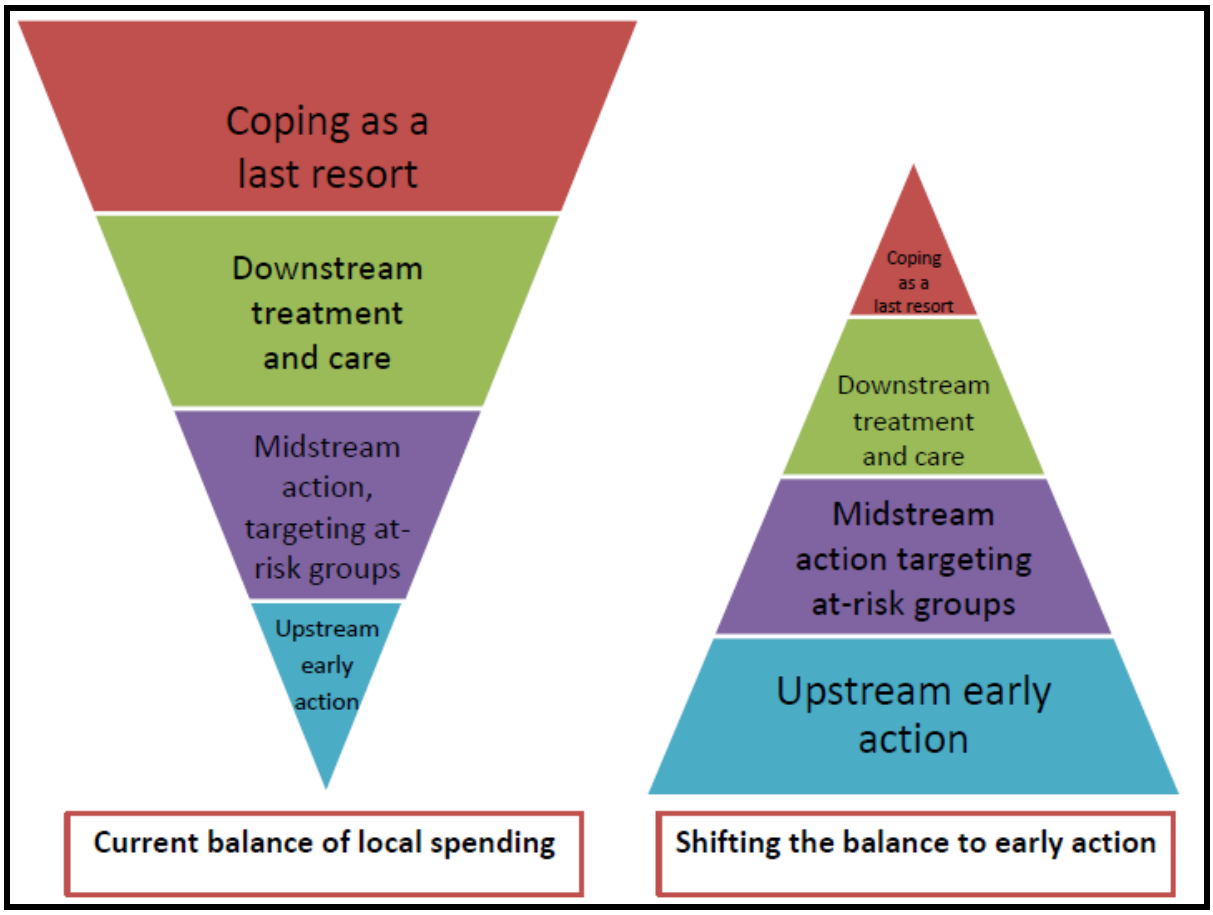
[1] http://moderngov.southwark.gov.uk/documents/s56454/Report%20and%20appendices%202016-17%20PR%20Scene%20setting.pdf
[2] Southwark Demography Factsheet, May 2014
[3] See, for example, Southwark's Primary and Community Care Strategy

services become preoccupied with defending – as far as possible - existing services and managing staff reductions, and more reluctant than ever to innovate and change. On the other hand, it becomes increasingly obvious that the established model of providing services to meet needs - rather than enabling activities that prevent needs arising - is no longer sustainable. Public sector organisations in Southwark and Lambeth are increasingly aware that shifting towards early action and prevention is the only viable response to cuts on this scale.

The vision: shifting the balance of needs and public spending

The diagram below, based on analysis of population needs by Southwark Clinical Commissioning Group,[iv] shows in simple terms what has to change: to shift from spending most money on coping with problems and on "downstream" treatment and care, to spending most on "upstream" early action to prevent problems from happening and on "mid-stream" action, targeting at-risk groups, to prevent problems from getting worse.[4] Realising the vision would transform the quality of life for people in Southwark and Lambeth by reducing needs for acute services and helping to maintain wellbeing for all residents. It would ultimately reduce overall spending and would make much better use of taxpayers' money because last-resort coping and downstream measures such as hospital treatment or imprisonment are almost always more expensive in themselves than upstream and midstream action, such as enabling people to take good exercise and eat a healthy diet, or providing good quality education and skills training. Early action can achieve more and better results for local residents in an era when public funds are in increasingly short supply.

[4] The diagram on page 7 below sets out these distinctions in terms of 'enabling services' (i.e. upstream) and 'prompt interventions' (i.e. midstream), downstream approaches are described as 'acute services' and 'containment'.



The challenge for the Commission has been to build on the best of current practice and identify what more can be done to move from the left-hand triangle to the right-hand one: to make early action the driving force behind policy and practice in Southwark and Lambeth. The aim is get from where we are now, with good intentions and some good practice, but no let-up in the volume of demand for costly services, to a point where early action is embedded in policy and practice across both boroughs, so that more people enjoy greater wellbeing and are better able to help themselves and each other to stop things going wrong. To pursue this aim, we need to understand the underlying causes of problems that trigger demand for costly services, identify early actions that can be taken at local level to address those causes, understand barriers in the way of taking early action at local level, and find ways of overcoming those barriers.

We explain below how we have gone about our work. In the follow section we set out what we mean by prevention and early action and how these relate to underlying causes of problems that trigger demand for costly services. We consider what kinds of early action are necessary and possible to address those causes. We consider

how to make early action become the standard way of working across sectors in both boroughs. Finally, we offer our recommendations for change, with practical examples to show what can be done.

How the Commission has carried out its work

We conducted extensive research to find out about local conditions in Lambeth and Southwark, about the immediate and underlying causes of the problems identified, about what works best to prevent them, about barriers to early action and ways of overcoming those barriers. We have:

- reviewed the literature on prevention and early action;
- analysed official statistics across both boroughs to identify persistent problems and their causes;
- reviewed the forward plans of both boroughs, and more than 70 strategies, initiatives and projects;
- explored 30 case studies as examples of early action and prevention from the two boroughs and from further afield;
- engaged in dialogue with local residents and community-based organisations, through a series of workshops, to tap into their wisdom and experience;
- interviewed experts working with local authorities and with voluntary and community sector organisations, to explore ways of turning ideas for change into practical local action;
- drawn on the expertise of our commissioners to set the agenda, consider findings and develop recommendations;
- developed a theory of change for shifting to early action; and
- discussed our emerging findings with Health and Wellbeing Board members

Understanding prevention and early action

As we have noted, Southwark and Lambeth councils and their Health and Wellbeing Boards aim to prevent problems that afflict residents and trigger demands for services. The big challenge is to turn that ambition into effective early action that makes a real difference to people's lives and to public spending.

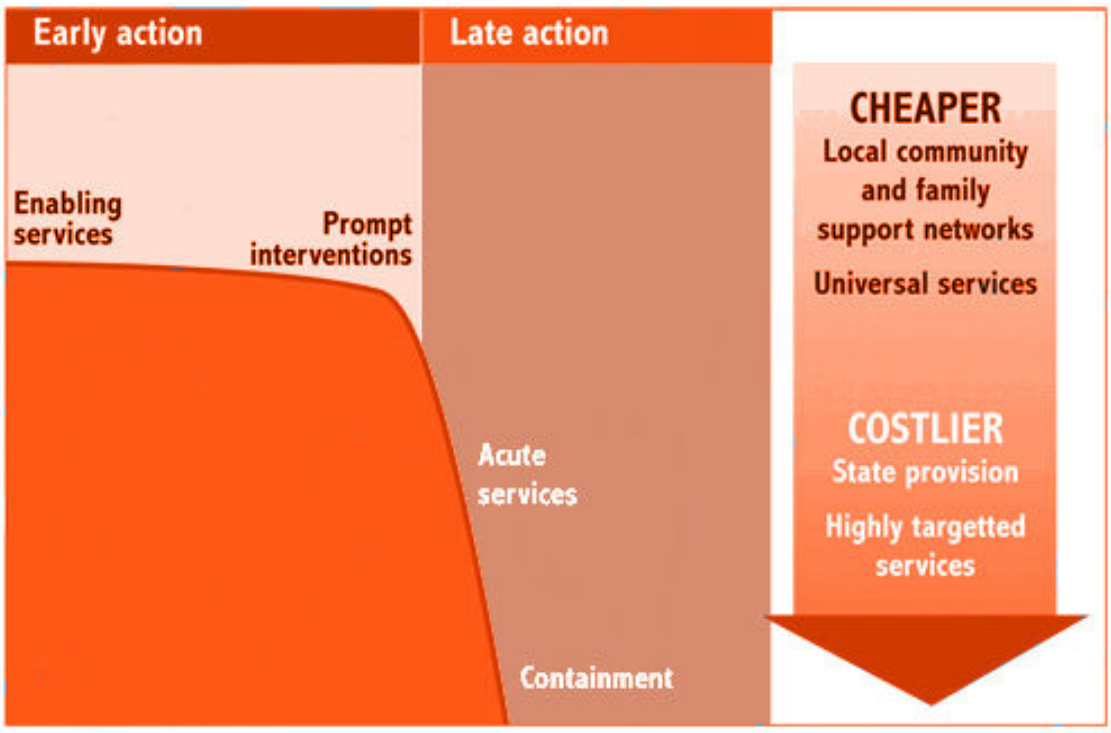
The lion's share of spending on public services is still focused on what has been called the 'rescue principle' – dealing with people who have already developed pressing needs.[v] This is always costly and very often avoidable. It accentuates the negative, not the positive, and it is not the best way to improve people's quality of life.

The Commission builds on the work of the Early Action Task Force (EATF), which was set up to find ways of shifting from intervening at the 'acute' stage of a problem, towards acting earlier to reduce needs.

We agree with the EATF that effective early action can deliver a 'triple dividend' by helping people to flourish in their daily lives and relationships, reducing demand for costly services and creating the conditions for a prosperous economy.[vi] While the EATF works primarily at a national level, the Southwark and Lambeth Early Action Commission has explored what can be done at a local level to generate early action to prevent harm.

Downstream, mid-stream and upstream early action

Once the logic of prevention is accepted, it is important to understand the range of options for tackling such problems as obesity, isolation, unemployment and violent crime. In the diagram below, the Early Action Task Force sets out differences between early and late action.[vii] Late action (often described as short-term or 'downstream' interventions) can only cope with or contain a problem once it has happened. Prompt interventions (medium-term or 'mid-stream' action) can stop people already considered 'at risk' from developing a more serious problem. Early action (longer-term 'upstream' measures) tackles the underlying causes of a problem to remove the risk of it happening in the first place. Upstream measures are usually universal: they are for everyone, not just for people who are 'vulnerable' or 'at risk'. The effects of early action should be to narrow inequalities by addressing the upstream causes of vulnerability to risk, which tend to accumulate among those who are already socially and/or economically disadvantaged. However, this will only happen if preventative measures are genuinely inclusive and do not become the preserve of those who are already better off. Moreover, any shift to early action should not lead to the discontinuation of downstream services which disadvantaged groups often need.



Focusing solely on downstream and mid-stream measures can be costly and ineffective because if nothing is done to tackle the upstream causes of a problem those causes will very likely make that problem happen again. The aim must be to take all possible early action to tackle the upstream causes and at the same time to encourage and strengthen midstream early action that can help to stop things going from bad to worse. Once acute needs arise, they must of course be dealt with, so downstream measures remain essential, but the aim should be to reduce the volume of demand for them as far as possible.

Moving upstream to address problems

We examined the causes of childhood obesity, long-term unemployment, social isolation among older people and violent crime, to explore what an early action approach might look like in practice. By reviewing literature on the subject and by exploring the views of local residents and other experts, we traced not just the immediate causes, but the upstream or underlying “causes of the causes” so that we could identify suitable early action to prevent problems occurring.

As the table below shows, the further upstream you look, the more convergence there is between measures needed to tackle the underlying causes of problems.

OPTIONS FOR ACTION TO ADDRESS PROBLEMS				
PROBLEM	DOWNSTREAM Action targeted at individuals, to cope with a problem they have	MIDSTREAM Action targeted at at-risk group to prevent a more serious problem	UPSTREAM Action aimed at whole populations to prevent problems from happening in the first place	
Childhood obesity	Clinical interventions to reduce food intake by obese children	Advice to parents of overweight children about diet and exercise.	No high-calorie food outlets near schools. Nutritious free school meals for all. Affordable fruit and veg in local shops	Measures to reduce poverty and inequality, to improve education for all, to support universal, high quality childcare, and to enable all to have secure, satisfying work. Housing policies to support affordable high quality homes for all and to help families and friends to stay together. ⇕ Measures to build resourceful communities, preventative local conditions, strong collaborative partnerships between civil society and the local state, and system change for early action
Social isolation among older people	Admission to day or residential care centre	Good Neighbour schemes aimed at visiting isolated older people	Local housing policies help families and neighbours to stay together and connected. Plenty of accessible meeting places and activities for older people	
Long-term unemployment and job insecurity	Work experience, help with CVs and job interviews for unemployed	More education and training for NEETs and others with few or no qualifications	Incentives to local employers to take on apprentices. Living wage and no zero-hours contracts in publicly-funded jobs, including those contracted out. Support for local enterprise and jobs, and accessible, affordable high-quality childcare.	
Violent crime	Special units for disruptive children, women's refuges and rape crisis centres, more street policing. Removal from family home of perpetrators of domestic violence	Weapons amnesty. Self-help groups for violent offenders, and for survivors of violent crime. Intensive support for 'troubled families'.	As above, plus: non-violence and anger-management as part of school curriculum for all children and parents	

Some measures identified in the table appear to be 'issue-specific', such as nutritious free school meals for all as a way of preventing the risk of obesity. But in fact most upstream measures, including school meals, and also good housing, decent jobs and high quality childcare, have a wider impact because they help to create conditions that tackle the underlying causes of a range of problems. This reflects the findings of Michael Marmot's classic study *Fair Society, Healthy Lives*, which showed that the primary causes of most social problems could be traced to the same bundle of social and economic issues.[viii]

What can be achieved at local level?

Some problems that afflict people in Southwark and Lambeth are strongly linked with issues such as poverty and inequality, which are embedded in national economic policy, so that it is difficult for local authorities and their partners to tackle them directly. Nevertheless, there are plenty of opportunities for local action – especially in relation to *local conditions* and *social relationships*.

By "local conditions" we mean what local places are like, what they offer and how they make local people feel. We mean the quality, accessibility and affordability of housing, parks, streets, transport, shops, meeting places, amenities, public services and local businesses, including opportunities for education, training and employment. By "social relationships" we mean the way people get together and interact with each other, not just through families and friendship networks, but also across neighbourhoods, and between local groups and organisations, within and between the public sector and civil society.

Local conditions and social relationships influence and reinforce each other. If conditions are poor and relationships weak, they can create a negative cycle of decline, which reduces the capacity of communities and individuals to stop things going wrong. People need strong social relationships, and secure, supportive local conditions in order to prevent or withstand the kind of problem we have been asked to address. These are challenges that are best met at local level.

At local level, it is possible to identify and make the most of local assets and resources that already exist within communities, including, for example, the

knowledge and experience of local residents, local charities and community-based groups, public buildings and services, and local businesses. Local powers can be used to shape places and create conditions that enable people to thrive, so that they are able to help themselves and each other. It is at this level that people come into most direct contact with public authorities, job markets, civil society organisations and other citizens, so this is where there are opportunities to build strong, creative, collaborative partnerships between residents and organisations across the different sectors. To underpin all this, local public sector organisations can make sure that their own systems and structures are geared to support early action.

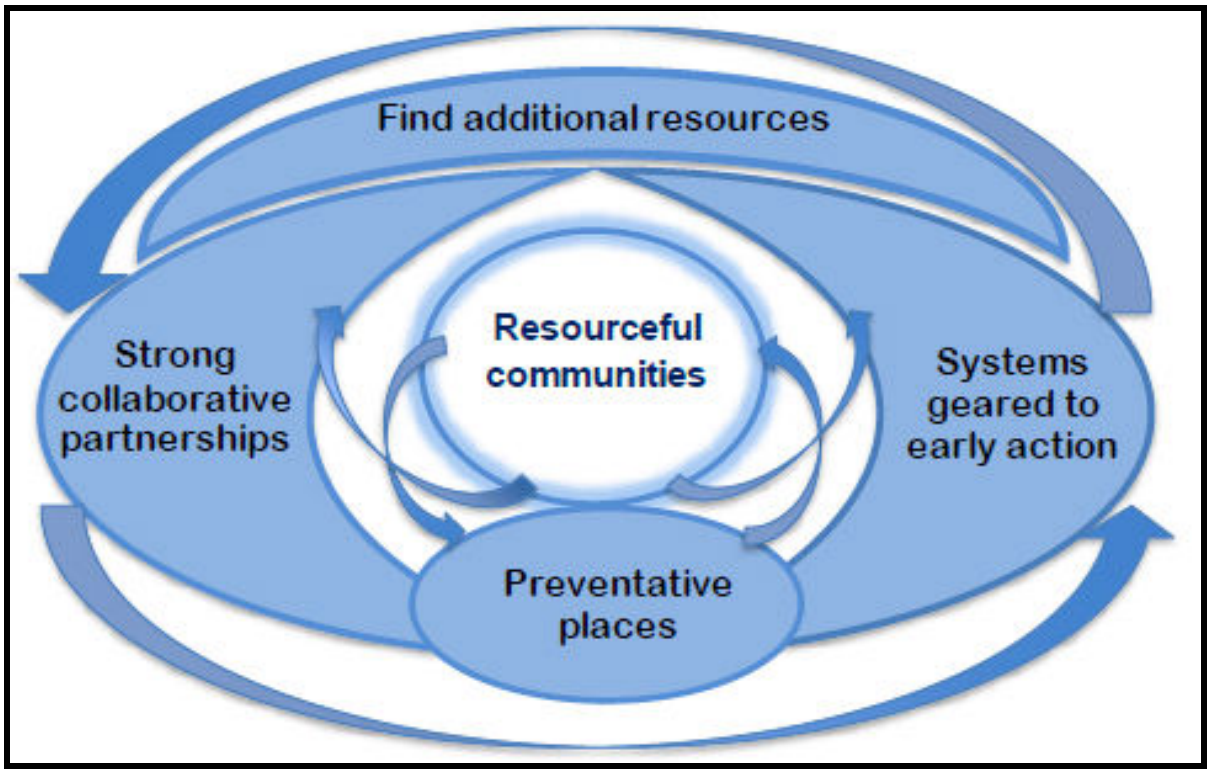
Goals for early action

Our goals for early action in Southwark and Lambeth are designed to realise the vision of reversing the balance of spending from spending most on coping with problems, to spending most on preventing problems occurring in the first place. They reflect our understanding of different levels of prevention and the need to address problems as far upstream as possible. They take account of what can be done locally in the context of extreme budgetary constraints.

Our main goal is to build ***resourceful communities***. These must be embedded in ***preventative places*** and supported by ***strong, collaborative partnerships*** and local ***systems geared to early action.*** To achieve these goals it is also essential to ***find additional resources*** for early action**.**

Overall, we aim to achieve a positive, self-reinforcing cycle of early action that is sustainable over time. The goals interact with a dynamic effect as the diagram below indicates. Partnerships and systems can strengthen each other, as well as helping to generate and support resourceful communities and preventative places. As local conditions improve, they can provide increasing support for communities, and as communities become more resourceful they can help to build more preventative places. Both can help to support and sustain partnerships and systems. Finding additional resources is a vital first step; achieving the goals will help to release additional resources to sustain the process over time.

A dynamic model of early action



These goals reflect, and build upon, existing goals of the local authorities and their partner organisations in both boroughs. What matters for early action is how far they are pursued together, and how far they are given priority in policy and practice.

We briefly explain below what we mean by each goal, and then set out our recommendations for change.

Build resourceful communities

This is the main goal which holds the key to effective and sustainable early action. By resourcefulness, we mean the capacity of individuals and groups to be agents of change, ready to shape the course of their own lives. This is not the same as 'resilience', which refers to people's capacity to withstand external shocks and problems beyond their control. The first is proactive, while the second is reactive.[ix] Both are important, but resourcefulness takes priority. This is both because a proactive approach is needed to prevent problems, and because resourceful people

and groups are more likely to be resilient in the face of problems that cannot be prevented.

What can make communities more resourceful? Our conversations with local people and community-based groups identified three things that they lacked – and needed - in order to be more resourceful: they need actual *resources*; they also need better *connections* and more *control.*

'Resources' can include access to spaces and facilities, and to expert help and advice, as well as help in generating income from government and non-government sources: we want to be clear that it is not just about money, but about a wide range of material and non-material resources. 'Connections' refers to how people and organisations find out about things, communicate information, learn about each other and what's going on, connect with others, work in partnerships, and participate in local activities.[x] 'Control' is about having experience of influencing decisions that affect one's own circumstances, and overcoming a sense of powerlessness in the face of change.[xi] Local residents in general, and local voluntary and community groups in particular, need resources, connections and control as the basis for building resourceful communities.

Build preventative places

By 'preventative places' we mean places – neighbourhoods and groups of neighbourhoods across the boroughs - where local conditions help to make communities more resourceful and support early action. As we have noted, local conditions include physical and economic factors that influence the way people feel about living in a place and the opportunities they find there to lead fulfilling lives and to help themselves and each other.

Many of the people we engaged in Southwark and Lambeth keenly felt the loss of – and need for – more places and spaces where they could get together, and where it was easy and congenial for them to do so. They wanted to stop established local businesses and amenities being replaced by chain stores and betting shops, which robbed their neighbourhoods of character and reduced opportunities for local jobs and enterprise.[xii] They wanted to be able to move around their local neighbourhoods easily and safely. And they were very concerned that escalating property prices and

redevelopment were forcing people to move out, generating a sense of insecurity, and breaking up long-established social and family ties. They wanted a real say in how redevelopment affected established residents. Local authorities have extensive 'place shaping' powers, which can be used to tackle these issues and build preventative places.[xiii]

Create strong, collaborative partnerships

This refers to the quality of relationships and ways of working within and between local public sector bodies on the one hand, and community-based groups and other non-government organisations on the other. Neither government nor civil society can deliver resourceful communities or preventative places on their own. But public bodies can be essential catalysts, working *with* local people and organisations to enable and support early action. Indeed, this is a vital component of local systems geared to support early action. The aim is to minimise atomisation and a sense of distance and distrust between organisations, and to put an end to relationships built on inequalities and competition. Instead, the aim must be to share knowledge and power, and to foster respectful, high-trust partnerships with close co-ordination between organisations, and relationships based on collaboration and shared purpose.[xiv] Strong collaborative partnerships provide an essential underpinning for building resourceful communities and preventative places.

Gear local systems to early action

By "local systems" we mean the institutional arrangements, policies and practices that prevail in a locality: how decisions are made; how services are commissioned; how funds are allocated, and what are thought to be "normal" ways of working. As things stand, local systems are still mainly geared towards downstream action (coping with problems once they have occurred). Especially when funds are scarce, there is a tendency to narrow the focus of investment and action to the most acute needs of the most needy and vulnerable people. This is understandable, but it is the opposite of early action and ultimately counter-productive.

The aim now is not only to stimulate interest in early action and to encourage new ways of working, but also to make sure that these changes are thoroughly embedded, so that they become the new 'normal'. Without Change systems, policy

and practice in Lambeth and Southwark will always revert to the default downstream position.

Changing local systems so that they are geared towards early action is no easy task. It requires shifts in culture and practice in local public sector organisations, including what they value and aim for, and how they set priorities and use their powers to achieve their goals. It's about how – and how far – they walk the talk of early action, so that they do all they can to build and support resourceful communities, preventative places and strong, collaborative partnerships between civil society and the local state.[xv]

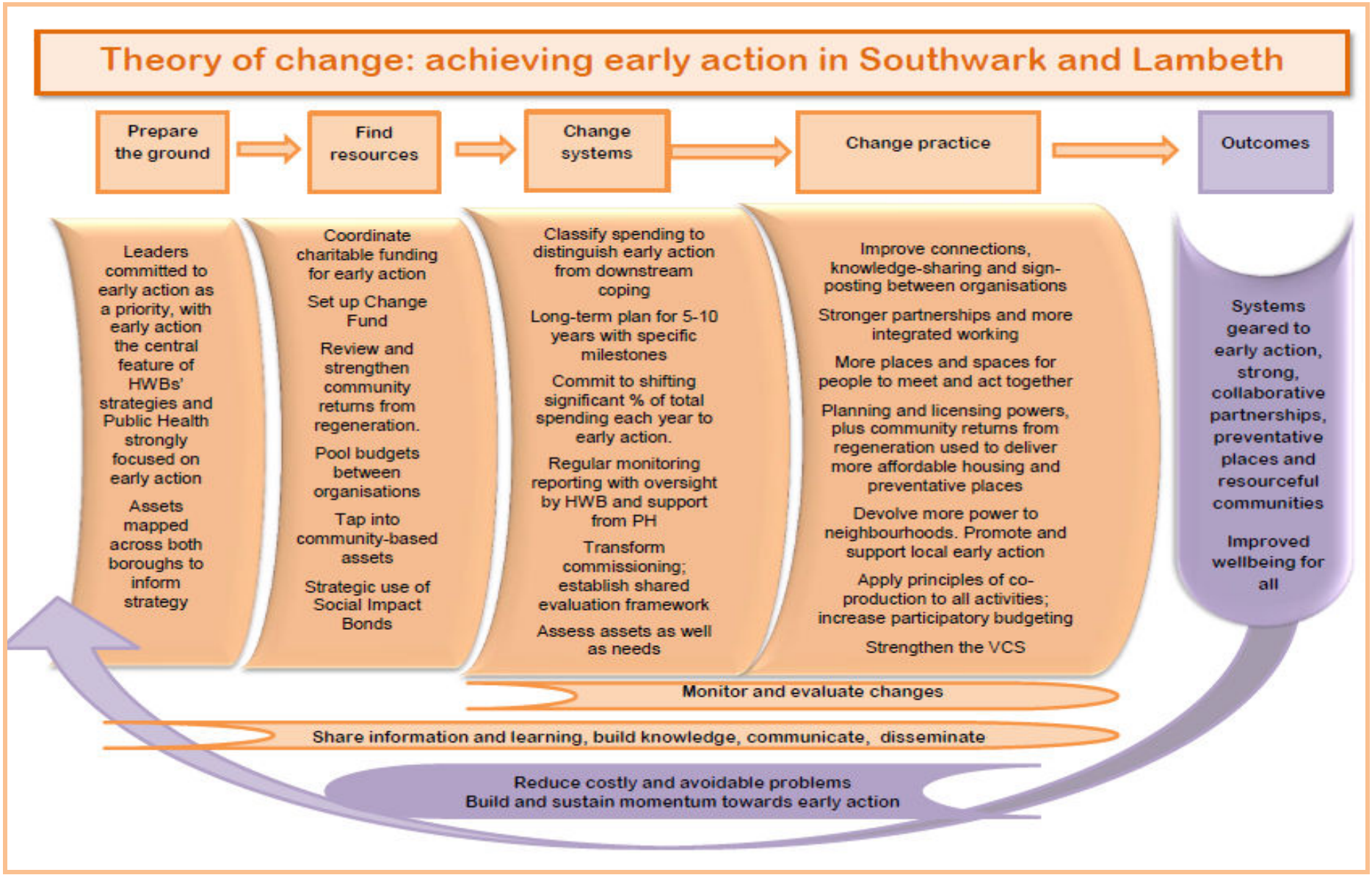
Find additional resources for early action

As we have noted, spending cuts act as a barrier as well as a stimulus for early action. One reason they act as a barrier is because shifting to early action calls for some additional expenditure until savings can be generated by preventing problems that would otherwise call for public expenditure. It is difficult, in practical and political terms, to take increasingly scarce resources away from acute services. Therefore we consider it a priority to find additional resources, beyond local authority budgets, for investment in early action. We recommend ways of making more and better use of resources from charitable and business sources, by pooling budgets between public bodies, and by tapping into uncommodified human and social assets in the community.

Recommendations for change

Effective early action depends on changing a range of inter-related processes and practices, rather than just launching new initiatives. Our goals interact with dynamic effect, as we have noted, and there is no "silver bullet" that will magically shift the balance. Our proposals build on insights that are familiar to many, and on good practice already underway in the two boroughs and in other parts of the country. To make a real difference, these must be brought together and strengthened, placed at the heart policy and practice in Southwark and Lambeth, and pursued forcefully over time.

The diagram below suggests a sequence in which each stage facilitates the next. However, our recommendations cannot be followed strict in chronological order. Action to change systems should not wait until resources are found, nor should action to change practice wait for systems to be geared to early action.


Theory of change: achieving early action in Southwark and Lambeth
Prepare the ground
Find resources
Change systems
Change practice
Outcomes
Leaders committed to early action as a priority, with early action the central feature of HWBs' strategies and Public Health strongly focused on early action
Assets mapped across both boroughs to inform strategy
Coordinate charitable funding for early action
Set up Change Fund
Review and strengthen community returns from regeneration.
Pool budgets between organisations
Tap into community-based assets
Strategic use of Social Impact Bonds
Classify spending to distinguish early action from downstream coping
Long-term plan for 5-10 years with specific milestones
Commit to shifting significant % of total spending each year to early action.
Regular monitoring reporting with oversight by HWB and support from PH
Transform commissioning; establish shared evaluation framework
Assess assets as well as needs
Improve connections, knowledge-sharing and sign-posting between organisations
Stronger partnerships and more integrated working
More places and spaces for people to meet and act together
Planning and licensing powers, plus community returns from regeneration used to deliver more affordable housing and preventative places
Devolve more power to neighbourhoods. Promote and support local early action
Apply principles of co-production to all activities; increase participatory budgeting
Strengthen the VCS
Systems geared to early action, strong, collaborative partnerships, preventative places and resourceful communities
Improved wellbeing for all
Monitor and evaluate changes
Share information and learning, build knowledge, communicate, disseminate
Reduce costly and avoidable problems
Build and sustain momentum towards early action

Where possible we show what can be done in practice by pointing to case studies drawn from Southwark and Lambeth and from elsewhere.

Stage 1: Prepare the ground

This stage covers essential preparations, already underway in Southwark and Lambeth.

- ***Establish senior leadership and commitment***

  The shift toward early action will only happen if it is led at a senior level, with unequivocal commitment. Strategic leadership will rest with the Health and Wellbeing Boards, which must ensure that early action is – and remains - a central feature of the Joint Health and Wellbeing Strategies, which they have a statutory duty to produce. At the same time, Board members must be firmly committed to working together and to implementing the strategy within their areas of responsibility. The Public Health department, which spans both boroughs and whose core purpose is to prevent harm to health and wellbeing, must play a key role in driving the changes.

  Goals: Change systems; Strong, collaborative partnerships.

  Action by: Health and Wellbeing Board members and all senior leaders; Department of Public Health.

  Timing: Current and continuing

- ***Map assets across both boroughs.***

  Mapping assets involves identifying unpriced and unpaid-for human and social resources, which are abundant in every locality (see box below[16]), so that they can play their part in meeting needs and improving residents' quality of life.

Assets in the community

These are physical, human and social resources that are embedded in the everyday lives of every individual (for example, public amenities such as schools and parks, as well as the wisdom, experience, knowledge and skills of individuals) and in the relationships among them (for example, love, empathy, responsibility, care, reciprocity, teaching, and learning). They are central and essential to society. They underpin the market economy by raising children, caring for people who are ill, frail and disabled, feeding families, maintaining households, and building and sustaining intimacies, friendships, social networks, and civil society.

Recognising and valuing people as assets, not just treating them problems, has a preventative effect by drawing on their knowledge about what's needed to improve their lives, and by enabling them to feel valued and more positive about themselves. Asset-based approaches are already widespread in Southwark and Lambeth, wherever residents are treated with dignity and respect, where organisations working with them ask them to participate and contribute in kind, and where the starting point for deciding what to do is to find out what assets people already have, rather than what are their needs and problems. We recommend extending and consolidating this approach as an essential foundation for early action. Ideally, asset mapping involves not only understanding what local "assets" are and where they can be found, but also building upon and supporting efforts to develop and connect local assets and increase their use by local people. A good example is '3-D asset mapping' by Pembroke House in Southwark. We recommend supporting this kind of mapping across both boroughs.

Goals: Gear systems to early action; Strong, collaborative partnerships; Preventative places; Resourceful communities
Action by: Department of Public Health, community engagement teams, local VCS
Timing: Current and continuing

Example: Mapping assets
Pembroke House, a community centre in Walworth, Southwark, has developed a "3-D" approach to asset mapping. A trained community organiser goes from door to door in the neighbourhood, building face to face relationships with local residents and, in turn, providing opportunities for them to build relationships with each other. Within a few months, one resident had launched a Co-Dependents Anonymous meeting, while others had established a Community Fun Club, where young people and their families can eat, talk and play together. This approach goes beyond identifying and valuing local assets: it helps people to tap into them so that they can help themselves and their neighbours.
(Case Study 1)

Stage 2: Find resources

We acknowledge that financial constraints can act as a severe barrier and that additional resources must be found to pump-prime the shift to early action. We therefore recommend ways of making more and better use of resources from

charitable and business sources, pooling budgets between public bodies, and tapping into uncommodified human and social assets in the community.

- ***Co-ordinate charitable funding for early action.***
  At national level, the Early Action Funders' Alliance pools resources from national grant-giving foundations to support early action. There should be scope to apply this approach locally by co-ordinating independent funders across both boroughs to share knowledge about early action and work together to offer grants for activities that tackle problems more systemically and further upstream. We recommend convening a Southwark and Lambeth Funders' Summit to initiate the process.
  Goals: Change systems; Strong collaborative partnerships; Resourceful communities
  Action by: Health and Wellbeing Board, local charitable donors
  Timing: Year One and continuing

Example: Co-ordinating funds for early action
In 2011, prompted by the Early Action Task Force, a group of funders formed the Early Action Funders Alliance, which aims to make the public case for early action, help funders to embed it in their work, and ultimately help the shift towards early action. In 2015, the Big Lottery Fund, Comic Relief and Esmée Fairbairn Foundation announced up to £5.3m of funding for three early action projects in Coventry, Norwich and Hartlepool. The three projects are partnerships led by local voluntary sector organisations, working with statutory agencies, to develop and implement preventative initiatives in family support, young people's wellbeing and legal advice.
(Case Study 30)

- ***Set up a dedicated Change Fund to support systems change.***
  This could be financed partly or wholly by a suitable local grant-giving foundation such as Guy's and St Thomas's Charity. Rather than encouraging a new round of initiatives, the Fund should be dedicated to stimulating profound changes in the way local systems are designed and operated. It could do this by, for example, supporting staff training and spending classification exercises (see below), and making staff time available to plan and pilot new ways of working. One useful example is the Lambeth Early Action Partnership, supported by the Big Lottery, which has long-term systems change as an explicit goal (see box below). Learning can also be drawn from the Scottish Early Action Change Fund, which

is committed to change over a parliamentary term and has £500 million to help realise the Scottish Government's ambition to make prevention a fundamental pillar of public service reform. (*Case Study 23*).

Goals: Change systems

Action by: Local charitable donors, Health and Wellbeing Boards

Timing: Year One

Example: dedicated funding for systems change

In 2014 The Big Lottery awarded £36 million to the Lambeth Early Action Partnership (LEAP), which includes representatives from health, local authority and voluntary sectors and aims to improve the lives of 10,000 babies born between 2015 and 2025. It takes an asset-based approach, aiming to use existing resources and energy within local communities, as well as the experience and expertise of parents in Lambeth, to empower other families and parents to give their children a better start in life. As a condition of the award, LEAP must achieve a 'systems change' in the way that its local health, public services and voluntary sector work together in the long-term to improve outcomes for children across these areas. *(Case Study 3)*

- ***Review and strengthen community returns from regeneration.***

  Regeneration and property development are a major source of additional funds for cash-strapped boroughs. These funds can be generated through sale of land and public buildings for redevelopment; and through Section 106 negotiations and the Community Infrastructure Levy, which are intended to achieve benefits for the community as a result of development projects. Funds generated this way should be given the specific purpose of preventing problems, for example by providing more social and affordable housing, by improving the design of neighbourhoods and green spaces to make them more congenial and accessible, and by making it easier for people to get together.

  Goals: Change systems; Preventative places; Resourceful communities

  Action by: Southwark and Lambeth Borough Councils

  Timing: Current and continuing

- ***Pool budgets between organisations and departments.***

  Money spent on early action does not always produce savings or other benefits for the organisation that originally spent it. This can act as a disincentive for the spending body. Pooling budgets between departments and organisations can

help to address the problem and to make resources go further, by consolidating and focusing existing funds, and sharing risks and rewards. Strengthening partnership working and pooling budgets between Southwark and Lambeth will help to achieve this effect. Beyond the two boroughs, there are useful examples of budget pooling and social profit sharing agreements in Birmingham and Oldham.

Goals: Change systems, strong collaborative partnerships,

Action by: Commissioners and service directors across the public sector in Southwark and Lambeth

Timing: Current and continuing

- ***Tap into community-based assets.***

  There are significant opportunities to respond to budgetary constraints by unlocking human and social assets in the community (see asset mapping above), by working more closely with VCS organisations, and by applying the principles of co-production. The example below shows how Surrey County Council responded to cuts, with notable results.

  Goals: Change systems; Strong collaborative partnerships; Preventative places; Resourceful communities

  Action by: Local voluntary organisations, public sector bodies in Lambeth and Southwark

  Timing: Current and continuing

Example: tapping into community resources

Surrey County Council decided in 2010 to change the way youth services were delivered. They redesigned their approach to young people's services, by commissioning for outcomes and co-production, working with young people and their families.[1] This was found to have delivered 'outstanding' results.[1] It serves as an example of how local public agencies can take a creative approach to confronting austerity and improve outcomes in the process.

(Case Study 26; see also p. x)

- ***Strategic use of Social Impact Bonds***.

  These can generate funding for early action in the right circumstances. Social Impact Bonds (SIBs) involve raising investment from the private sector to finance

service provision (usually by the VCS). The investor receives returns and payment upon the condition of meeting a set of clearly specified and measurable outcomes that are attributable to the service. SIBs are severely constrained by prospects of delayed returns, non-cashable savings, and the need for clear evidence about effectiveness and attribution in order to ensure that payments reflect *real* risk transfer and the delivery of social value. They may be useful in certain limited conditions, as a tool for experimenting with new initiatives in the transition to early action.

Goals: Strong collaborative partnerships

Action by: Local voluntary organisations, public sector bodies in Lambeth and Southwark

Timing: occasional

Example: Social Impact Bonds

A Social Impact Bond (SIB) is a form of payment by results where funds are raised from a non-government source, which receives a return if the intervention is successful. The model can be used for preventive initiatives where the monetary value of the savings can be established, and thus a return provided to the investor. One of the first SIBs in the UK provided funds for an initiative in Peterborough, which aimed to reduce reoffending rates and which produced some positive results. It remains doubtful whether this method of funding offers better value for money than in-house provision or traditional contracting. It has some potential to raise funds for innovative and untested projects, which can, upon evaluation, broaden our knowledge of 'what works'. However, SIBs are only appropriate where results can be precisely measured in the short to medium term, so they are best suited for midstream and downstream initiatives – such as reducing reoffending.
(Case Study 25)

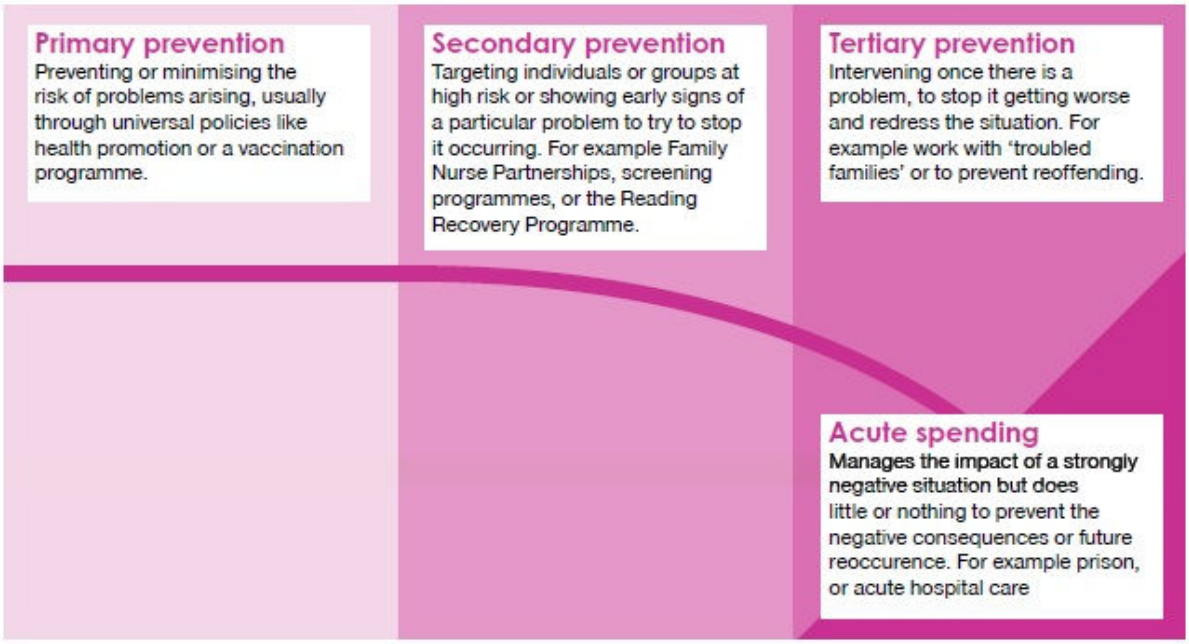
Stage 3: Change systems

Achieving the shift to early action – and making it sustainable - requires systemic change. Here our recommendations focus on understanding and shifting the balance of spending, on having a clear, long-term plan and arrangements for reporting and monitoring, on transforming the commissioning process and establishing a shared evaluation framework.

- ***Classify spending to distinguish early action from downstream coping.*** Local Councils, Clinical Commissioning Groups and others including VCS organisations and police authorities are in a much stronger position to support early action if they know whether the money they spend is allocated to coping with problems or preventing them. Classifying spending in this way makes it possible to plan and scrutinise the transition to early action and to understand trade-offs between prevention and downstream services. This is an essential first step towards shifting a proportion of spending each year to early action (see below).[17] The distinctions between spending on early and late action are not clear-cut, and this should not be regarded as a scientific exercise but as a way of understanding, approximately, how money is allocated. The Early Action Task Force calls it "bucketing": loosely attributing expenditure so that money spent on preventing problems occurring or worsening can be roughly distinguished from money spent on picking up the pieces once things have gone wrong. This exercise should be conducted at regular intervals so that it is possible to trace how far the balance of expenditure is shifting upstream towards early action.

  The EATF has provided initial guidelines to classification and has piloted this approach with members of the Early Action Funders' Alliance.[18] It sets out four approximate categories of spending, as illustrated below, and points out that the process does not have to be time consuming or overly complex.

  If this exercise is carried out internally, it is "an excellent way of introducing staff to the concept of early action and also harnesses staff's knowledge of the ways in which money is spent".[19] Once completed, it can help to inform commissioning, grant allocation and other budgetary decisions, including the budget challenge process. As the EATF argue, "a robust definition of early action is needed to support these new spending rules; otherwise they would be open to abuse. We know this is very difficult, but even a flawed definition consistently applied would be a step forward." [20]



Goals: Change systems

Action by: Led by Health and Wellbeing Board with relevant councillors and officials across the public sector

Timing: Year One and continuing

- ***Establish a long-term plan, for 5-10 years with specific milestones***.
  This must be championed at the highest level in both boroughs and setting out specific milestones. Inertia is the biggest barrier to preventing harm. Local systems too easily default to downstream coping.[21] So we strongly recommend that the leading decision-makers and budget holders in Southwark and Lambeth commit to a step-by-step transition to early action, so that it becomes the normal way of thinking, deciding and taking action. Unless there is a clear pathway, championed at the highest level, little or nothing will change. The Early Action Task Force has drawn up proposals for how such plans could be developed by national government, which could provide a route map for creating similar plans at local level.[22]

  Goals: Change systems

  Action by: Led by Health and Wellbeing Board with relevant councillors and officials across the public sector

  Timing: Year One and continuing

- ***Commit to shifting a significant % of total spending each year to early action.***

  The only way to ensure a significant move towards early action is to commit to an incremental funding shift. We recommend that both boroughs commit to shifting at specific proportion of total spending each year towards early action, preferably near to 5% per annum. Once spending is classified to distinguish early and mid-stream action from downstream coping (described above), it becomes possible to commit to shifting spending upstream.

  Goals: Change systems

  Action by: Led by Health and Wellbeing Board with relevant councillors and officials across the public sector

  Timing: Year One and continuing

- ***Establish clear oversight arrangements, with regular monitoring and reporting.***

  To ensure that early action is embedded in systems for making decisions and allocating funds, there needs to be a mechanism for regular monitoring and reporting, to provide support and momentum for implementing early action. Rather than creating a new unit to oversee early action, this responsibility should rest with the Health and Wellbeing Boards, supported by Public Health across both boroughs. We recommend monitoring within a shared evaluation framework (see below) and quarterly reporting to the HWB, with an annual stock-taking where the HWB reports back to a reconvened meeting of the Early Action Commission.

  Goals: Change systems

  Action by: Led by Health and Wellbeing Board with relevant councillors and officials across the public sector and with research support from public health

  Timing: Year One and continuing

- ***Transform the commissioning process to support early action.***

  Commissioning can be a powerful vehicle for changing systems to promote early action, provided it is designed and deployed for the purpose and conducted in partnership with local people. Commissioning is where decisions are made about how funds are allocated, how things are done, who does them, and what counts

as success. As a starting point, we recommend that the process of deciding what services and other activities are required is conducted in partnership with local people, valuing their assets and pooling their experiential knowledge with the professional skills of commissioners (i.e. co-production, described below pxx). This helps to focus commissioning on assets rather than needs, and on how to prevent problems rather than how to fix them.[23] Commissioning for outcomes, rather than for specific outputs can help shift the focus towards early action, encouraging contractors to think imaginatively about changing systems rather than just services. It also gives commissioners and providers more freedom to innovate. Examples of implementing these recommendations are already underway in Southwark and Lambeth.

The aim is now to extend this approach to establish a new 'normal' for commissioning across both boroughs. Lambeth, Camden and Cornwall local authorities, along with others, have worked with the New Economics Foundation to develop guidelines for effective outcomes-based commissioning.[24]

The commissioning process can be adapted to encourage collaboration, for example through alliance contracting,[25] where a group of providers enter into a single arrangement with the commissioner to deliver services; all parties share risk and responsibility for meeting the agreed outcomes. This departs from the original intention of commissioning to encourage competition, which sets bidding organisations against one another and favours larger organisations over smaller ones.

It can also be stipulated through the commissioning process that contracted organisations demonstrate after a specified period (e.g. 3 years) how far problems have been prevented or diminished – possibly as a condition of securing continued funding

Goals: Change systems; Strong collaborative partnerships; Resourceful communities
Action by: Led by Health and Wellbeing Board with relevant councillors and officials across the public sector; VCS
Timing: Current and continuing

Example: fostering collaboration through commissioning.
The Lambeth Living Well Partnership is made up of people who use services, carers, commissioners across NHS Lambeth Clinical Commissioning Group and Lambeth Council, voluntary and community sector, secondary care and primary care. It aims to deliver services that avoid reliance on acute services by improving physical and mental health, increasing autonomy and participation in community life. It uses a co-produced approach to commissioning as well as alliance contracting to build a consortium of providers. The alliance is not co-ordinated by a prime contractor or provider, and there are no sub-contractual arrangements involved. All organisations are deemed equal partners and rely on governance arrangements to manage their relationships and service delivery. The intention is to formalise collaboration through the contract, as commissioners and providers within the alliance are legally bound together to deliver the specific contracted service, sharing risks and rewards accordingly. *(Case study 4)*

Example: track and reward early action
The Big Lottery, which is funding of the Lambeth Early Action Partnership, calls on applicants to develop short (3 year), medium (7 year) and long (10 year) outcome frameworks, and to set out how their activities will meet those outcomes. Funding for each stage depends on meeting outcomes in the previous stage. The model could be adapted for use by public sector commissioners.
(Case study 3; see also p. x)

- ***Develop a shared evaluation framework***.

  This is for use by VCS grant-holders and contractors, as well as public sector bodies. It would establish a theory of change based on a shared understanding of early action, how it can be put into practice and its potential impacts over the longer term (five to ten years) as well as over one to three years. It would provide a shared set of criteria for monitoring early action across the two boroughs. The LEAP initiative (see example above) is a good example of a framework combining short, medium and long term outcomes.

  A shared framework should be designed in partnership with VCS organisations, and made easy to use by small organisations as well as by others. Contracted organisations should be trained and supported, so that evaluation is not simply a burden (especially where smaller VCS organisations are concerned), and instead becomes a positive experience that helps them learn and improve the quality of their work.

Wellbeing indicators can be used to assess impact of early action initiatives across the boroughs, steering local activity towards promoting wellbeing rather than fixing problems. The Local Government Association has published a useful guide to developing wellbeing measures, which public authorities in Lambeth and Southwark could use to evaluate impact.[26] The Happy City initiative is currently working with cities such as Bristol in the UK to develop a survey instrument that can be used to measure the impact of initiatives and policies on the wellbeing of users and residents.[27] Similar projects are underway in Mannheim in Germany and Santa Monica in the US.

Goals: Change systems; Strong collaborative partnerships

Action by: Led by Public Health with relevant councillors and officials across the public sector

Timing: Year One and continuing

- ***Assess community assets alongside needs.***

  We recommend integrating asset assessment with the Joint Strategic Needs Assessment (JSNA). This involves changing the focus of data collection, which currently relates chiefly to immediate causes of illness, such as smoking and use of alcohol. An upstream, asset-based approach would also collect data relating to the causes of health and wellbeing, to include (for example) questions about social networks and control. This would generate a more rounded view of the local community and help to give higher priority to early action. Wakefield Council has piloted such an approach, and found it is a positive first step towards mobilising and connecting local assets to needs, and developing richer and more intelligent commissioning.

  Goals: Change systems; Strong collaborative partnerships; Preventative places; Resourceful communities

  Action by: Led by Public Health with support from Health and Wellbeing Boards, local authority community engagement teams and VCS

  Timing: Year One and continuing

Example: Assessing assets, not just needs
Wakefield Council in Yorkshire carried out a "strategic assets assessment" in 2010. This complemented its joint strategic needs assessment (JSNA), which every local authority is required to produce every three years. The council saw this as a way of connecting assets more clearly to local needs and public services. It was seen to provide "an innovative and rich understanding of both needs and assets" with the potential to develop a more appropriate commissioning framework.
(*Case Study 24)*

Stage 4: Change practice

With Change systems, it becomes possible to initiate and sustain changes in the way organisations behave and how they work with residents and with each other. Our recommendations focus on improving connectivity, strengthening partnerships, making places more preventative and devolving more power to communities.

- ***Improve connections, co-ordination and knowledge-sharing.***
  This involves linking up people and organisations, improving communications between them, and enabling them to exchange information, to build a shared sense of purpose and to complement rather than duplicate each other's efforts. A strong theme that emerged from our engagement with local people was they know little or nothing about what's going on that could help to improve their lives.[28] They want better ways of finding out what's happening and what different organisations are doing locally, and to let others know what they are doing, so that they can work together more effectively. Noticeboards, newsletters and online channels for sharing information can all help to address this. In addition, VCS organisations and public sector professionals should co-ordinate and signpost their activities, so that people who may need help can be identified and directed between sectors, to services and/or other activities that can prevent problems getting worse. Examples of how this contributes to early action include social prescribing by GP practices and a scheme called Making Every Contact Count (see boxes below).
  Goals: Change systems; Strong collaborative partnerships; Resourceful communities

Action by: Led by Health and Wellbeing Boards with relevant councillors and officials across the public sector and VCS

Timing: Current and continuing

Example: Social prescribing

Social prescribing is increasingly popular with GPs across the country, including in Southwark and Lambeth. It links patients in primary care with non-medical sources of support available through the voluntary and community sector. It aims to prevent problems getting worse, improve outcomes for patients and reduce take up of NHS and social care services. In a Rotherham pilot scheme, for example, patients are referred by their GPs to a small team of five people from the voluntary sector, who work with the individual to identify their needs and then refer them on for further help, with options including: community based activities; information and advice services; befriending; and community transport. Social prescribing schemes in Rotherham and Dundee have been evaluated in their early stages and both have shown promising results. *(Case Study 16)*

Example: Making every contact count

Making Every Contact Count is a scheme that trains frontline staff to talk to people in their care about problems and services that fall beyond their remit. Staff meet residents every day, and can act as early signallers of issues where other agencies can help. For example, when making a routine contact, nurses can also talk to patients about issues such as smoking, healthy eating, parenting, debt, or employment, and provide basic advice or refer people to appropriate agencies for support. This approach is used by Safe and Independent Living (SAIL) in Southwark and Lambeth. Delivered in partnership with Age UK, the scheme has a list of activities and services offered by the local VCS. It works through a simple yes-or-no questionnaire which can identify an older person's needs. Each question is associated with a partner agency, so a 'yes' to any question operates as a flag to bring that person to the attention of the relevant organisation. *(Case Studies 10 and 17)*

- ***Stronger partnerships and more integrated working.***

  Stronger partnerships - one of the four goals for early action identified by this Commission - can be promoted through improved information-sharing and through the commissioning process, as well as by the financial benefits of pooling budgets (see recommendations above). Integrated working between health and social care, now government policy, should be an important stimulus for early action, and is already underway in Southwark and Lambeth. We recommend

closer collaboration between the two boroughs, in these and other sectors, to strengthen the momentum towards early action.

Goals: Strong collaborative partnerships

Action by: Led by Health and Wellbeing Board with relevant bodies and officials across the public sector

Timing: Current and continuing

Example: integrated working
The Southwark and Lambeth Integrated Care Programme (SLIC) aims to join up care provision services and agencies to improve the health of people in Lambeth and Southwark. Launched in 2014, SLIC was one of the first major schemes of integrated care in the UK. It includes general practices, community healthcare services, mental healthcare services, local hospitals and social services, and aims to integrate and co-ordinate services in person-centred ways, in order to allow people to take a more active role in their own health. SLIC also aims to enable joint commissioning through pooling health and social care budgets, and forms an important part of Southwark and Lambeth's 'Better Care Fund' plan – the NHS's national programme to integrate health and social care. SLIC works with Lambeth's Citizens Board to activate a 'citizens' movement' to support change and co-produce better outcomes. (Case Study 9)

- ***Create and support more spaces for people to get together.***

  People in Southwark and Lambeth told us they wanted more opportunities to use parks, open spaces, schools, underused public buildings and empty properties for meeting each other, building networks and doing things together. Hubs and meeting spaces that are inviting and accessible – often at a very local level – are a crucial means for people to take more control in their communities. Local councils and their partners should take stock of existing places and spaces to find out how they are used, how often and by whom, and link up with local residents and groups to explore what could make them more accessible, inclusive and useful. They should review rules and regulations to remove unnecessary barriers to local activities and use of public spaces by VCS organisations. As far as possible, they should enable local people to take control over such spaces.

  Goals: Strong, collaborative partnerships; Preventive places; Resourceful communities

  Action by: Local public sector bodies and VCS

  Timing: Current and continuing

Example: Encouraging more use of public spaces
Pop up Parks creates vibrant spaces in urban environments that encourage children and families to spend more time being playful, creative and active outside the home. It also influences permanent change of outdoor spaces. Working with designers and architects, Pop up Parks is working to change how the city is planned to support play and interaction. In 2015 it was a winner of the Knee High Design Challenge, a partnership between Guy's and Thomas's charity and Lambeth and Southwark Councils, which supports organisations with new ideas for improving the health and wellbeing of children under five. It received a grant of £41,000 to use public spaces for pop-up parks where children and families can spend more time playing out of doors. Although such spaces are temporary, the initiative has the broader aim of encouraging communities to use public spaces more creatively. *(Case Study 13)*

- ***Make more use of "place shaping" powers to support early action***

  The quality of local places can be highly influential in causing or preventing harm, by the impact they have on people's day-to-day experience and by how far they offer opportunities for people to help themselves and each other. Local authorities and their partners can use their powers and influence – their "place-shaping" role - to considerable effect, determining whether and how far local places contribute to early action and prevention. [29]

Place-shaping means "using powers and influence creatively to promote the well-being of a community and its citizens". It is central role of local government and includes: building and shaping local identity; representing the community; regulating harmful and disruptive behaviours; maintaining the cohesiveness of the community and supporting debate within it, ensuring smaller voices are heard; helping to resolve disagreements; working to make the local economy more successful while being sensitive to pressures on the environment; understanding local needs and preferences and making sure that the right services are provided to local people; and working with other bodies to response to complex challenges such as natural disasters and other emergencies. *Lyons Inquiry into Local Government, 2007*

Public bodies in Southwark and Lambeth should take stock of their "place-shaping" powers and make the best possible use of them – transparently and consistently over time – to create local conditions that help to prevent problems arising. This should be done in partnership with residents and VCS organisations,

building on existing good practice in the two boroughs. As we have noted (x ref), councils should press for more ambitious returns from private development, using Section 106 powers and the Community Infrastructure Levy. It should also be possible to engage local residents more closely and consistently in decisions about community returns, and how affordable housing, infrastructure improvements and other benefits are allocated to communities. These funds should be directed to improving the quality of neighbourhoods and increasing affordable homes, to prevent problems (such as homelessness, lack of exercise and social isolation) that would otherwise trigger demand for curative services. In addition, more concerted use should be made of licensing powers, through such means as cumulative impact policies, supplementary planning documents and choice editing controls, to restrict the number and clustering of establishments deemed bad for public health – such as fast food takeaways, gambling establishments and licensed premises – as the examples below illustrate.

Goals: Preventive places; Resourceful communities

Action by: Local authorities, VCS

Timing: Current and continuing

Example: making high streets healthier

Southwark Healthy High Streets was a scheme that brought together a group of local government departments including public health, planning, licensing, trading standards and transport, which worked with local communities to consider how Southwark's high streets could help make people's lives healthier. It imposed restrictions on fast food and licensed outlets, betting shops and pay day loan companies; promoted active travel through high street design, including good cycling infrastructure, bike hire and walking opportunities; and helped local residents to make more use of underused public spaces.

(Case Study 2)

Example: restricting hot food takeaways
Local residents in Waltham Forest, north London, expressed concerns that proliferating hot food takeaway (HFT) outlets were endangering children's health. Waltham Forest council used its place shaping powers to take preventive action, drawing on research by London Metropolitan University which confirmed the negative impact on children's health. It established a corporate steering group to ensure existing HFT businesses operated as responsibly as possible and imposed restrictions on opening new outlets in areas frequented by children (schools, youth facilities or parks), refusing new planning applications. The council has also increased enforcement of environmental health and waste regulations relating to hot food takeaways.
(Case Study 20)

- ***Devolve more power to neighbourhoods.***

Residents are often best placed to decide what would improve the quality of their lives and stop things going wrong; they always have useful knowledge to contribute. So enabling them to take more control over what happens locally is likely to lead to more effective measures and better outcomes for residents.[30] It is well established by public health research that feeling in control is also a factor that contributes directly to wellbeing and reduces risks to health.[31]

A major issue identified through our engagement with local people was a sense of powerlessness in the face of change. Individuals seldom had experience of controlling decisions or actions that affected their own lives. When nothing they say or do makes any difference, they have little motivation to try to change things for the better. Conversely, having some positive experience of making changes (in the private or public sphere) can give people a sense of control and self-worth, which in turn generates hope, determination and efficacy. Communities are resourceful if they are full of people who are able to exercise control – as individuals and with others - over what happens to them.

One way to enable residents to feel more in control is to ensure that they participate fully in decisions and actions that affect their lives. Local councils and their partners should look for ways of devolving more power and resources to communities and community groups, and for transferring community assets to residents, realising the ideal of "double devolution", where power "goes from local government down to local people, providing a critical role for individuals and

neighbourhoods, often through the voluntary sector".[32] This is not about abandoning communities to look after themselves, but about devolving power to where it can be exercised most effectively and recognising the preventative benefits of enhancing local control

Example: Residents increase control of the local food economy
The Lambeth Food Partnership promotes the production and consumption of healthy and sustainable local food. Its vision is for "all Lambeth residents to have the knowledge, passion and skills to grow, buy, cook and enjoy food with their family, friends and community." The partnership, supported by the Council, develops programmes to meet the aims of the Lambeth Food strategy, including improving access to good food, encouraging healthier diets, supporting participation in food communities; eating more sustainably, tackling food waste, growing more food and supporting food businesses. It aims to build on local assets, encourage wide participation and give residents more control over the local food economy, with the capacity to transform it.
(Case Study 5)

Goals: Resourceful communities
Action by: Health and Wellbeing Boards with councils and officials
Timing: Year One and continuing

- ***Promote and support local early action.***
  Devolving power and resources (and participatory budgeting, see below) will enable local groups and residents to identify specific ways in which early action can be taken locally to prevent problems occurring or getting worse. There is an important role for Health and Wellbeing Boards and their constituent bodies to support local initiatives and to draw out lessons (based on a shared evaluation framework, see above) that can stimulate similar action elsewhere and contribute to wider, systemic changes. Some of our case studies show what could be achieved by applying this "social acupuncture" approach to local early action. For example, the integration of asset mapping into JSNAs by Wakefield council (case study 24) has the potential to deliver a series of positive effects in terms of changing broader systems and culture. [i] For example, by raising awareness of local assets amongst commissioners these were attuned to opportunities to develop and deepen co-production. Moreover, asset mapping and engagement

with communities also opened up opportunities for residents to connect and learn from each other, in ways that builds resourcefulness. Other examples include:

- Community development by Pembroke House in Walworth (case study 1)
- Lambeth early action partnership (case study 3)
- Knee high design challenge (case study 13)
- Community wealth building in Preston (case study 21)
- Commissioning of youth services in Surrey (case study 26)

Goals: Strong, collaborative partnerships; Preventive places; Resourceful communities
Action by: Health and Wellbeing Boards with associated organisations and officials; VCS
Timing: Current and continuing

- ***Increase participatory budgeting.***
  Participatory Budgeting (PB) is one way of enabling people to feel more in control. It aims to deepen public engagement in government by devolving control over how public funds are spent. Although PB can be designed in many ways, a central feature is that it engages and empowers citizens in democratic deliberation and decision making about how public money should be spent. Following the first PB in Porto Alegre, Brazil, which was regarded as successful in reducing corruption and redressing local poverty,[33] the PB process has been adopted in more than 1,500 localities around the world.[34] In the UK PB initiatives have handled relatively small budgets and have been limited to marginal issues, although there are some examples of good practice. [35]
  Goals: Strong, collaborative partnerships, Preventive places, Resourceful communities
  Action by: Health and Wellbeing Boards with associated organisations and VCS
  Timing: Year One and continuing

Example: participatory budgeting (1)
Udecide gives people in Newcastle the power to decide how to spend a pot of money so it can make the biggest difference to their lives. It engages communities in identifying their needs, discussing and agreeing priorities and deciding about granting funding to address those needs. In each case, a steering group is recruited which plans and prepares the later phases. People who are expected to benefit from the money being spent are engaged to define issues and explore solutions, which are converted into costed project proposals, which are then voted on by the communities involved. Projects are monitored and evaluated, with learning fed back to inform new initiatives.
(Case Study 29)

Example: participatory budgeting (2)
Since 2010 East Devon District Council has adopted a policy of using participatory budgeting to spend funds raised as community returns from private development (see recommendation 5). To date, more than £1,000,000 of public funds have been allocated for sports and play facilities in new developments throughout the District. For the future, East Devon council aims to allocate these resources to a broader range of facilities such as community buildings, roads and hospitals.
(Case Study 29)

- ***Promote and apply the principles of co-production***.

  This embodies the idea of asset-based development and translates it into practical ways of preventing problems and meeting local needs (see box for details).[36] Co-production values people and enables people to contribute, rather than having things done to or for them. There is a wealth of evidence, especially in the area of health and wellbeing, showing the effectiveness of co-production in identifying and tackling problems at an early stage, in tapping into assets in the community and in generating resourcefulness among people involved in the process.[37]

Principles of co-production

Co-production is a model of public service design and/or delivery that is based on collaboration between public officials and community representatives. NEF has defined it as consisting of six elements

1. Building on people's existing capabilities: altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put them to use at an individual and community level.
2. Reciprocity and mutuality: offering people a range of incentives to engage which enable us to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.
3. Peer support networks: engaging peer and personal networks alongside professionals as the best way of transferring knowledge.
4. Blurring distinctions: removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.
5. Facilitating rather than delivering: enabling public service agencies to become catalysts and facilitators rather than central providers themselves.
6. Assets: transforming the perception of people from passive recipients of services and burdens on the system into one where they are equal partners in designing and delivering services.

The principles of co-production are already applied in a number of programmes and initiatives and feature in the forward planning of both local authorities. We recommend that co-production becomes the standard way of getting things done. It can be introduced through the commissioning process (see p x) or adopted through choice by voluntary and community organisations and public sector bodies. Positive local examples include the Paxton Green Time Bank in Southwark and young people's services in Lambeth.

Goals: System change; Strong, collaborative partnerships; Resourceful communities

Action by: Health and Wellbeing Boards with associated organisations and officials across the public and voluntary sectors

Timing: Current and continuing

Example: Time-banking
Paxton Green, a large GP practice in Southwark, set up a time bank in 2008, which embodies the principles of co-production. It aims to help people to help themselves and each other, to generate and support social networks, and to meet non-clinical needs that could otherwise lead to mental or physical ill-health. It now has more than 200 active members, who help each other out with everything from making phone calls to sharing meals and giving lifts to the shops. The currency is not money but time and everyone's time is equally valued: one hour is worth one time credit that can be exchanged through the time bank.
(*Case Study 6)*

Example: Co-producing services for young people
In 2013 the youth services team in Lambeth worked with a group of young people to co-produce a service for young offenders, with a budget of £20,000. They used a method of appreciative inquiry to identify young people's abilities and aspirations for the future, which then informed a set of outcomes against which a service would be commissioned. The winning bid was for a talent show, which young people would be a part of organising and delivering across Lambeth. This wasn't the commissioning manager's first choice, but was selected because of the leadership space it created for young people. This approach to commissioning can contribute to prevention because by including service users as well as professionals in defining service aims it can pick up and address existing or incipient problems and needs that might be missed otherwise. *(Case study 8; see also px)*

- ***Strengthen the focus and funding of the VCS in Southwark and Lambeth.***
  As one of our four main goals we recommend building strong, collaborative partnerships between organisations and sectors across the boroughs – and the strength of these partnerships depends on a secure, vibrant and inventive voluntary and community sector. In the current economic climate, however, as public funds are increasingly scarce, many VCS organisations are under severe financial pressure, which leads them to narrow their focus to coping with acute problems and undermines their creative potential. Strengthening their focus on upstream measures and building better access to non-government funding is therefore a vital part of the early action agenda.

  A number of recommendations set out above will, if followed, help to strengthen the VCS in Southwark and Lambeth. These include co-ordinating charitable funding for early action; more support for smaller VCS organisations to tender for

local contracts; better co-ordination and more sharing of information, and more spaces for people to get together. In addition we recommend promoting inclusion and participation in the VCS. Some local groups are more inclined than others to take an inclusive and participatory approach to their work, while others adopt a more traditional approach by delivering services to people in need. We recommend encouraging and supporting all VCS organisations to be inclusive and participatory, even if their main activity is service delivery. Commissioning (see p x) is one vehicle for this. It is also possible to encourage inclusion and participation through relationships built around hubs and through events that bring VCS organisations together to share knowledge and experience, and to learn from each other.

Example: Inclusion and participation in the voluntary and community sector
Lambeth's Mosaic Clubhouse is a co-operative organisation that aims to provide support and opportunities for people living with mental health problems. Staff and members work together, doing everything from administration to preparing meals and gardening. This helps members to develop new skills, develop friendships and networks, and find employment. In 2012 Lambeth Council contracted the clubhouse, in collaboration with Southwark MIND, to provide a mental health information centre, accessible via walk-in, email and telephone. This has allowed Mosaic to build its inclusive, participatory approach and to strengthen partnerships. *(Case Study 7)*

Goals: Strong, collaborative partnerships; Resourceful communities
Action by: Health and Wellbeing board with public organisations and officials across the public and voluntary sector
Timing: Current and continuing

Summary of recommendations and goals

The table overleaf summarises our recommendations and indicates in each case how – approximately - they can help achieve one or more of our four goals.

Recommendations	Goals			
	Change systems	Strong, collaborative partnerships	Preventative places	Resourceful communities
Stage 1: prepare the ground				
Establish leadership and commitment	■	■		
Map assets across both boroughs	■	■	■	■
Stage 2: find resources				
Co-ordinate charitable funding for early action	■	■		■
Set up dedicated Change Fund	■			
Maximise community returns from regeneration	■		■	■
Pool budgets between orgs and departments	■	■		
Tap into community assets	■	■	■	■
Strategic use of social impact bonds		■		
Stage 3: change systems				
Classify spending to distinguish early action	■			
Establish long term plan with specific milestones	■			
Commit to yearly budget shift towards early action	■			
Establish regular monitoring and reporting	■			
Transform the commissioning process	■	■		■
Develop a shared evaluation framework	■	■		
Assess community assets alongside needs	■	■	■	■
Stage 4: change practice				
Improve connections, co-ordination and knowledge sharing	■	■		■
Stronger partnerships, more integrated working		■		
More spaces for people to get together		■	■	■
Use “place-shaping” to support early action			■	■
Devolve more power to neighbourhoods				■
Promote and support local early action		■	■	■
Increase participatory budgeting		■	■	■
Promote and apply principles of co-production	■	■		■
Strengthen focus and funding of the VCS		■		■

In conclusion

Early action matters because it helps to improve the quality of people's lives and because it delivers better results without demanding more public money.

We have drawn up recommendations that we believe will help Southwark and Lambeth to make a significant shift towards early action. But to make sure that happens, the recommendations must be pursued together and consistently over time. It's all about changing systems, not just adopting one-off initiatives.

Building on the work of the Early Action Task Force, we have tried to set out a *local* agenda for early action. We hope the approach we have outlined will be helpful to not only to Southwark and Lambeth but to other councils and Health and Wellbeing Boards who want to move in this direction.

As a Commission we will take a close interest in what happens next in Southwark and Lambeth – and we hope to return to review progress after the first year.

[i] see Southwark Council Press Release, "11,000 New Homes", available at http://www.southwark.gov.uk/info/200537/11000_new_council_homes
[ii] See Southwark Council Press Release, "Free Sim and Gym" http://www.southwark.gov.uk/info/200087/sports_and_leisure/3689/free_swim_and_gym
[iii] See Lambeth Council Community Plan 2013-16, available at http://www.lambeth.gov.uk/sites/default/files/ec-lambeth-councils-community-plan-2013-16.pdf
[iv] See Smith, D. (2015) 'Engagement in Developing Local Care Networks', available at http://www.southwarkccg.nhs.uk/news-and-publications/meeting-papers/governing-body-sub-committees/Engagement%20and%20Patient%20Experience%20Committee%20Meetin/ENC%20Bi%20-%20Engagement%20in%20Developing%20Local%20Care%20Networks.pdf
[v] Coote, A. (2012) The Wisdom of Prevention: http://www.neweconomics.org/publications/entry/the-wisdom-of-prevention
[vi] See EATF (2011) The Triple Dividend, available at http://www.community-links.org/earlyaction/the-triple-dividend/
[vii] See EATF (2012). The Deciding Time, available at http://www.community-links.org/earlyaction/the-deciding-time/
[viii] Marmot, M. (2010). Fair Society, Healthy Lives, available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[ix] See. e.g. MacKinnon, D. and Dreickson, K.D. (2013) "From Resilience to Resourcefulness: A Critique of Resilience Policy and Activism", *Progress in Human Geography,* Vol. 37, (2), pp. 253-270.
[x] Our engagement with local residents revealed a sense of resident's low connectivity with activities, groups and people in their local area. Using data from the European Quality of Life Survey Wellbeing

researchers measured the similar concept of 'neighbourhood belonging' and found that the UK scores lowest in Europe – see Abdallah, S. Stoll, L. and Eiffe, F. (2013), Quality of life in Europe: Subjective Wellbeing", available at https://www.eurofound.europa.eu/publications/report/2013/quality-of-life-social-policies/quality-of-life-in-europe-subjective-well-being

[xi] An unpublished literature review by NEF commissioned by the People's Health Trust has found a positive relationship between individual health and an individual's sense of control over the developments that affect them –report available on request – contact adrian.bua@neweconomics.org.

[xii] Survey research by NEF demonstrates that independent businesses and local amenities are dwindling throughout the UK, researchers argue this is due to policies favouring large enterprise – see NEF's 'Ghost Town' and 'Clone Town' reports – available at http://www.neweconomics.org/publications/entry/reimagining-the-high-street

[xiii] For an account of the 'place shaping' potential of local government see the Lyons Inquiry into Local Government - Lyons, M. (2007) "Place-shaping: a Shared Ambition for the Future of Local Government", available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229035/9780119898552.pdf

[xiv] The case for a move towards more collaborative forms of public administration at local level is a strong theme in contemporary political science research both in the UK and internationally, see, for example, Ansell, C. and Gash, A. (2007). "Collaborative Governance in Theory and Practice", *Journal of Public Administration Research and Theory,* Vol. 18, (4), pp. 543-571.

[xv] For an account of the opportunities, and challenges, involved in generating social and political change through institutional reform see John, P. (2012). *Making Policy Work.* London: Routledge

[16] Coote, A. (2010) *The Great Transition: Social Justice and the Core Economy*, p.3. retrieved from http://b.3cdn.net/nefoundation/82c90c4bb4d6147dc3_1fm6bxppl.pdf

[17] EATF (2012). The Deciding Time, p 16, available at http://www.community-links.org/uploads/documents/Deciding_Timefinal.pdf

[18] See 'How to Classify early Action Spend: A Report by the Early Action Task Force', Community Links, http://www.community-links.org/downloads/ClassifyingEA.pdf

[19] Ibid. p 3

[20] "The Early Action Task Force made an initial attempt to classify Treasury spending data on an early action spectrum developed by Community Links, finding that 20% was spent on early action and 40% falling under 'acute' spending. Classification problems meant that a further 40% could not clearly classified according to Community Link's criteria [see EATF (2012) The Deciding time, page 17-18. Available at http://socialwelfare.bl.uk/subject-areas/services-activity/community-development/communitylinks/1515772012_deciding_time.pdf]. It is necessary to develop a more robust approach. There is a wealth of data available on government spending to do this, appropriate classification is the remaining technical challenge.

[21] See Gough, I. (2015). "The Political Economy of Prevention". *British Journal of Political Science,* Vol 45, (2), pp. 307-327.

[22] See Early Action Task Force (2012), *The Deciding Time,* Community Links - http://www.community-links.org/uploads/documents/Deciding_Timefinal.pdf

[23] See e.g. IDEA (2010). *A Glass Half Full: How an Asset-Based Approach can Improve Community Health and Wellbeing*. London: Local Government Association.

[24] See NEF (2014). *Commissioning for outcomes and coproduction.* Available at http://b.3cdn.net/nefoundation/974bfd0fd635a9ffcd_j2m6b04bs.pdf

[25] See e.g. ACEVO (2015). *Alliance Contracting: Building New Collaborations to Deliver Better Healthcare.* Available at https://www.acevo.org.uk/sites/default/files/ACEVO%20alliance%20contracting%20report%202015%20web.pdf

[26] See 'The Role of Local Government in Promoting Wellbeing', LGA, NEF and National Mental Health Development Unit - http://www.local.gov.uk/c/document_library/get_file?uuid=bcd27d1b-8feb-41e5-a1ce-48f9e70ccc3b&groupId=10180

[27] See http://www.happycityindex.org/long-survey

[28] See endnote 10 above.

[29] see the Lyons Inquiry into Local Government - Lyons, M. (2007) "Place-shaping: a Shared Ambition for the Future of Local Government", available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229035/9780119898552.pdf

[30] See, for example, Sirianni, C. (2009). *Investing in Democracy: Engaging Citizens in Collaborative Governance.* Brookings Press

[31] Marmot, M.G. Stansfeld, S. Patel, C. North, F. Head, J. White, I. Brunner, E. Feeney, A. Davey Smith, G. (1991). Health inequalities among British civil servants: the Whitehall II Study, *the Lancet,* Vol. 337, (8754), pp. 1387-1393.

[32] http://www.theguardian.com/society/2006/feb/21/localgovernment.politics

[i] Greetham, J. (2010). *Growing Communities Inside Out: piloting an asset-based approach to JSNAs within the Wakefiled District.* Available at http://www.local.gov.uk/c/document_library/get_file?uuid=679e8e67-6d41-49a9-a8e1-452959f4f564&groupId=10180

[33] See. e.g. Smith, G. (2009). *Democratic Innovations.* Cambridge: Cambridge University Press.

[34] See Participatory Budgeting Project (2014) "Where has it Worked", available at http://www.participatorybudgeting.org/about-participatory-budgeting/where-has-it-worked/

[35] See Participatory Budgeting Network - http://pbnetwork.org.uk/

[36] See the Co-production Practitioners Network Webpage, 'About Co-production', available at http://coproductionnetwork.com/page/about-coproduction#The%20Elements/Principles%20of%20co-production

[37] See, for example, NA. (2012) *People powered health co-production catalogue*, NESTA, Innovation Unit and NEF – available at http://www.nesta.org.uk/sites/default/files/co-production_catalogue.pdf; see also Boyle, D. and Harris, M. (2009). *The Challenge of Coproduction: how equal Partnerships between Professionals and the Public are Crucial to Improving Public Services*. NESTA, Innovation Unit, NEF, availabe at http://centerforborgerdialog.dk/sites/default/files/CFB_images/bannere/The_Challenge_of_Co-production.pdf

APPENDIX 2

Early Action in Southwark and Lambeth

Report from the Southwark and Lambeth Early Action Commission

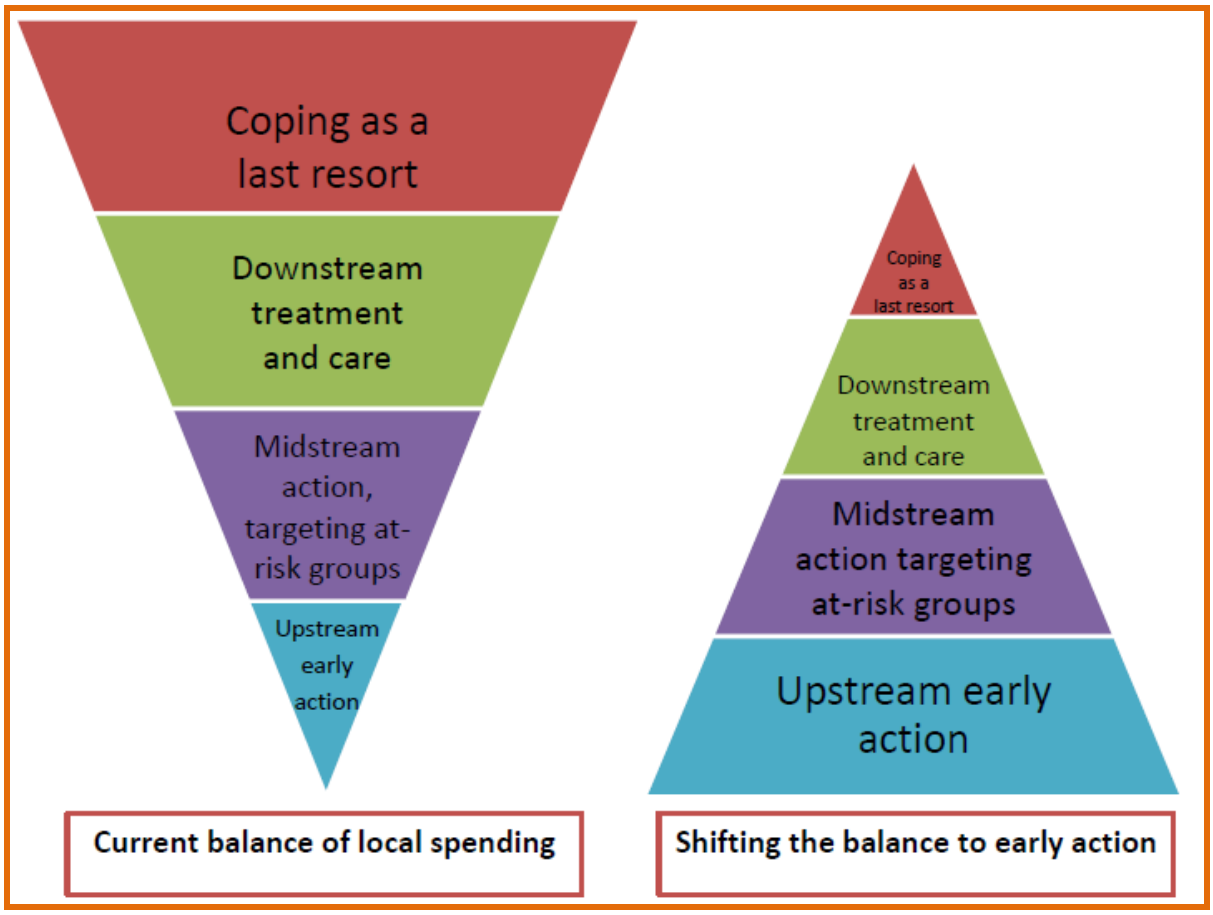
SUMMARY

Aims of the Commission

The Southwark and Lambeth Early Action Commission aims to find ways of taking early action at local level to prevent problems that reduce people's quality of life and generate needs for public services. Problems such as childhood obesity, social isolation, unemployment and violent crime all generate high demand for services and yet are often preventable. Both councils are committed to more effective prevention, but it is a big challenge to turn this commitment into effective and sustainable early action.

> "I want to us to think about how we treat the causes of problems rather than the consequences… Prevention and resilience should be at the forefront of all our work." *Council Leader Lib Peck introducing Lambeth's Community Plan 2013-16*
>
> "For people to lead healthy lives, we need to tackle the root causes of ill health and reduce the inequalities that limit the lives of too many in our society". *Southwark's Fairer Future Council Plan 2014/5to 2016/7*

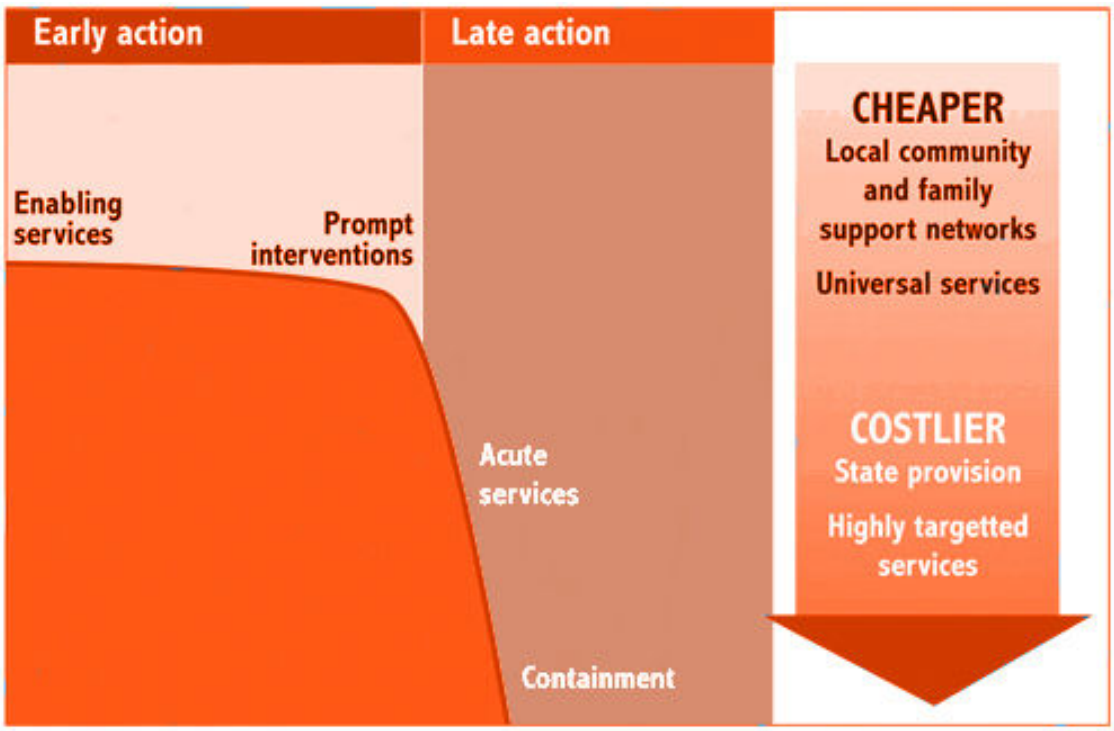
Public resources are severely constrained. This acts as a barrier to change but also as a stimulus, because early action is the only viable response to spending cuts on the scale now demanded of public authorities. The aim must be to shift the lion's share of spending from "downstream" treatment and care, to "upstream" preventative measures. This would avoid waste and make wiser use of public funds. It would also improve the quality of life for people in Southwark and Lambeth by reducing needs for acute services and maintaining wellbeing for all residents.



The Commission has examined local conditions in Lambeth and Southwark, especially the immediate and underlying causes of pressing local problems, and what works best to prevent them. It has carried out a review of local strategy, policy and practice; explored more than 30 examples of good practice in the two boroughs and further afield; and engaged with local residents and community-based groups and with other experts, through workshops and interviews.

Early and late action

The diagram below shows the difference between early ("upstream") and late ("downstream") action. Downstream action can only cope with or contain a problem once it has happened. Prompt interventions or "mid-stream" action can stop people already considered 'at risk' from developing more serious problems. "Upstream measures tackle the underlying causes of a problem to remove the risk of it happening in the first place. They are generally for everyone, not just for people who are 'vulnerable' or 'at risk'.



If acute needs are not prevented, they must of course be dealt with, but the aim should be to reduce the volume of demand for them as far as possible.

The underlying causes of most social problems can be traced to the same bundle of social and economic issues. Some of these, such as poverty and inequality, are strongly linked with national policy, so that it is hard tackle them locally. But there are plenty of opportunities for local early action to prevent problems by improving local conditions and social relationships.

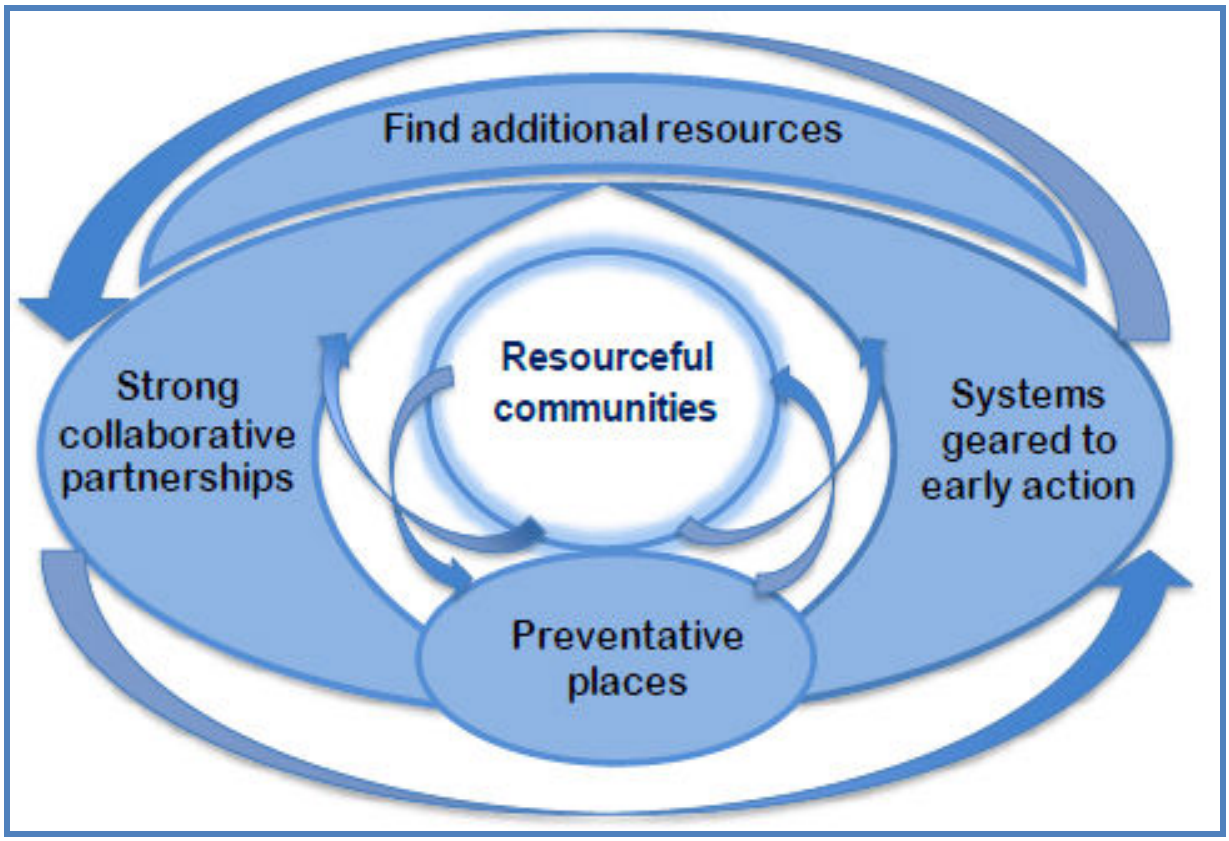
Goals for early action

The Commission has identified four goals for early action in Southwark and Lambeth. These are designed to reverse the balance of spending and to address problems as far upstream as possible. They focus what can be done locally in the context of extreme budgetary constraints. They interact with dynamic effect and are intended to be mutually reinforcing and sustainable over time. It will be important to find additional resources to help achieve these goals.

- ***Resourceful communities*** where residents and groups are agents of change, ready to shape the course of their own lives. To achieve this people need actual resources (but in the broadest sense), connections and control.

- ***Preventative places*** where material conditions have a positive impact how people feel and enable them to lead fulfilling lives and to help themselves and each other.
- ***Strong, collaborative partnerships*** where organisations work together and share knowledge and power, fostering respectful, high-trust relationships based on a shared purpose.
- ***Systems geared to early action***, where the culture, values, priorities and practices of local institutions support early action as the new 'normal' way of working

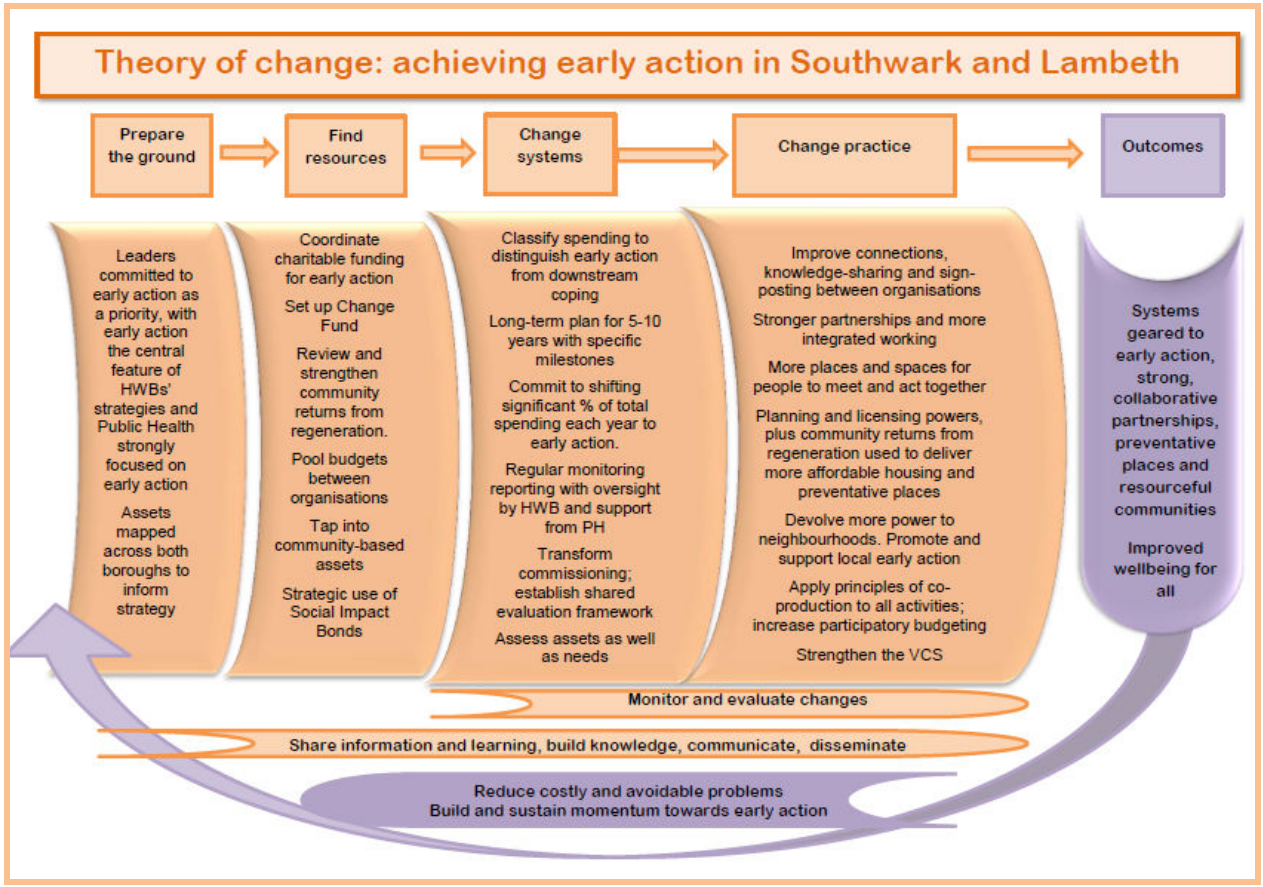
A dynamic model of early action



Recommendations

Effective early action depends on changing whole systems, not just launching new initiatives. These recommendations build on good practice already underway in Southwark, Lambeth and elsewhere. To make a real difference, they must be placed at the heart policy and practice in both boroughs and pursued forcefully and consistently over time. Taken together, they contribute to the four goals: resourceful communities, preventative places, strong, collaborative partnerships and systems geared to early action.

The diagram below suggests a sequence in which each stage facilitates the next. But there is no strict chronological order. Action to change systems should not wait until resources are found, nor should changes in practice wait for systems to be geared to early action.



Step 1: Prepare the ground

- ***Establish senior leadership and commitment.***
  Health and Wellbeing Boards must ensure that early action is a central feature of their strategy, with Board members firmly committed to implementing it. The Public Health department should play a key role in driving the changes.
- ***Map assets across both boroughs.***
  Asset mapping, already practiced in both boroughs, identifies human and social resources, which are abundant in every locality and play a vital role in early action. This should be strengthened to locate, develop and connect local assets.

Step 2: Find resources

- ***Co-ordinate charitable funding for early action.***
  Bring together independent funders across both boroughs to share knowledge about early action and work together to offer grants for activities that tackle problems more systemically and further upstream.
- ***Set up a dedicated Change Fund to support systems change.***
  This could be financed partly or wholly by a suitable local grant-giving foundation and dedicated to stimulating profound changes in the way local systems are designed and operated.
- ***Review and strengthen community returns from regeneration.***
  Opportunities to generate funds through sale of redevelopment sites, Section 106 negotiations and the Community Infrastructure Levy should be maximised, with funds used to prevent problems, e.g. through housing and spatial planning.
- ***Pool budgets between organisations and departments.***
  This can help to support early action and make resources go further, by consolidating existing funds and focusing them on early action, as well as strengthening collaboration between the boroughs, and sharing risks and rewards.
- ***Tap into community-based assets.***
  Unlock human and social assets in the community (see asset mapping above), by working more closely with VCS organisations, and by applying the principles of co-production.

- ***Strategic use of Social Impact Bonds***.
  These involve raising investment from the private sector to finance service provision (usually by the VCS). They are useful in *limited* conditions, especially as a tool for experimenting with new initiatives in the transition to early action.

Step 3: Gear local systems to early action

- ***Classify spending to distinguish early action from downstream coping.***
  Spending bodies should know whether the money they spend is allocated to coping with problems or preventing them. Spending should be loosely classified – as a rule of thumb - adapting guidance from the Early Action Task Force.
- ***Establish a long-term plan, across 5-10 years, with specific milestones***.
  To avoid local systems defaulting to downstream coping, leading decision-makers and budget holders in Southwark and Lambeth should commit to a step-by-step transition to early action, over the longer term, with specific milestones.
- ***Commit to shifting a significant % of spending each year to early action.***
  Both boroughs should commit to shifting a specific – and significant - proportion of total spending each year towards early action. Targets should be subject to yearly revision but we suggest 5% as an initial goal.
- ***Establish clear oversight arrangements, with regular monitoring and reporting.***
  Health and Wellbeing Boards should oversee the shift to early action, supported by Public Health, with a shared evaluation framework (see below), quarterly reporting to the HWB, and reporting back to a reconvened Early Action Commission.
- ***Transform the commissioning process to support early action.***
  Decisions about what services and other activities are required should be taken in partnership with local people, with commissioning focused on assets, on how to prevent problems, and on outcomes, and encouraging collaboration.
- ***Develop a shared evaluation framework***.
  For use by VCS grant-holders and contractors, and public sector bodies, this would establish a theory of change reflecting a shared understanding of early action, and shared criteria for monitoring progress, including wellbeing indicators.

- ***Assess community assets alongside needs.***
  Asset assessment should be integrated with the Joint Strategic Needs Assessment (JSNA), changing the focus of data collection generate a more rounded view of the local community and higher priority to early action.

Step 4: Change practice

- ***Improve connections, co-ordination and knowledge-sharing.***
  This involves linking up people and organisations, improving communications between them, and enabling them to exchange information, build a shared sense of purpose and complement rather than duplicate each other's efforts.
- ***Stronger partnerships and more integrated working.***
  Stronger partnerships, promoted through information-sharing and the commissioning process, as well as by pooling budgets and more integrated working, should strengthen the momentum towards early action.
- ***Create and support more spaces for people to get together.***
  There should be more opportunities for people in Southwark and Lambeth to use parks, open spaces, schools, underused public buildings and empty properties for meeting each other, building networks and doing things together.
- ***Make more use of "place shaping" powers to support early action***
  Councils should take stock of their "place-shaping" powers and make the best possible use of them to create conditions that help to prevent problems, working with local people and building on existing good practice in the two boroughs.
- ***Devolve more power to neighbourhoods.***
  Local councils and their partners should look for ways of devolving more power and resources to communities and community groups, and transferring community assets to residents.
- ***Promote and support local early action.***
  Health and Wellbeing Boards and their constituent bodies should support local preventative initiatives and draw out lessons that can stimulate similar action elsewhere and contribute to wider, systemic changes.

- ***Increase participatory budgeting.***

  This aims to deepen public engagement in governance by empowering citizens to decide on how public funds are spent, engaging citizens in democratic deliberation and decision making.

- ***Promote and apply the principles of co-production****.*

  Co-production, already applied in some programmes and initiatives in both boroughs, should become the standard way of getting things done, encouraged through commissioning and adopted by choice in all sectors.

- ***Strengthen the focus and funding of the VCS in Southwark and Lambeth.***

  The local VCS should be encouraged and supported to strengthen its focus on upstream measures, and to adopt an inclusive and participative approach to their activities. Funding should be better co-ordinated and directed at early action.

FINAL DRAFT

APPENDIX 3

Case studies

This section sets out case studies of good practice to support our recommendations for prevention and early action. They are drawn from Southwark and Lambeth individually, from projects shared by the two boroughs, and from further afield. They show that things can be done differently to help achieve early action and prevent harm. Few have been fully evaluated: we indicate where this has happened. Together, they should be seen as an illustration of what is possible, rather than as a definitive evidence base. .

Southwark Case studies

Case study 1: Community development by Pembroke House in Walworth

Pembroke House is a community centre in Walworth that has recently adopted an innovative asset based community development approach to engaging local residents. In an attempt to reach deeper into, and activate, the local community, Pembroke House complemented asset-mapping exercises by hiring a trained community organiser. Resourced by United St Saviour's Charity and a government grant, this community organiser is tasked with building 'face to face' relationships with local residents and, in turn, providing opportunities for these residents to build relationships with one another. In the first few months, the organiser held more than 300 individual conversations with local residents, exploring their needs, priorities and concerns with a view to supporting them to take action with others who have similar ideas. This produced some swift results. An individual living opposite the community centre initiated a new Co-Dependents Anonymous meeting, while residents who were concerned that there was not enough local youth provision took it upon themselves to establish a bi-weekly "community fun club" for young people and their families to eat, talk and play together. This was born out of a series of meetings of local residents. Firstly, parents and other concerned adults met to discuss options for new local youth programmes. Recognising

that there were no young people at the meeting, however, they invited their children to join the discussion. And this second meeting the families enjoyed the opportunity to be together so much that they began meeting on a regular basis. Between sessions a core group of volunteers—young and old— would meet to plan the following week's activities.

Organisers at Pembroke House see this approach to community development as a first step in strengthening the local social fabric to develop local residents' resourcefulness and ability to organise and engage in collective action. They show that asset based community development has potential to improve the lives of people, and how the public sector can play an enabling and supportive role.

Case study 2: Southwark Healthy High Streets (SHHS)

SHHS aims to bring together public health, planning, licensing, trading standards and transport, as well as work with local communities, to explore ways of changing Southwark's high streets to help make people's lives healthier. Its key objectives include: promoting a healthier eating and living environment through restrictions on the number and distribution of fast food and licensed outlets, betting shops and pay day loan companies; promoting active travel through high street design – including good cycling infrastructure, bike hire and walking opportunities; supporting communities to make use of underused public spaces and supporting the high street revitalisation programme in Southwark.

These work-streams are a good example of upstream ambitions because they look at the high street holistically. SHHS illustrates place shaping ambitions in that it moves beyond an understanding of problems arising from decisions of individuals, to the local conditions that shape their behaviours and choices. It is also an example of partnership working and building on assets: the initiative brings together and co-ordinates people and organisations from different sectors and provides funds for community organisations to develop and implement ideas for healthy high streets. As such, SHHS place-shapes by bringing together

the regulatory power of local bodies (e.g. in restricting certain shops) and creativity of the community through funding local initiatives.

Lambeth Case studies

Case study 3: Big Lottery's 'A Better Start' Funding Model and the Lambeth Early Action Partnership

The Big Lottery's 'A Better Start' programme offers £215m for distribution to applicants wanting to develop innovative approaches to early action. The programme aims to improve child development in three areas - communication and language development, social and emotional development and diet, nutrition, and systems change - and to encourage partnership working to design early years interventions that deliver over a 10 year timeframe. Last year (2014), a Lambeth-based partnership, including representatives from health, local government and the voluntary sector, was awarded £36m to improve the lives of 10,000 babies projected to be born between 2015 and 2025.[1] At the heart of the bid was an asset-based approach that aimed to use existing resources and energy within local communities, as well as the experience and expertise of parents in Lambeth, to empower other families and parents to give their children a better start in life. Funded initiatives must achieve a 'systems change' in the way that local health, public services and voluntary sector work together in the long-term to improve outcomes for children across these areas. In their guidance, Big Lottery outlines examples of short term (3 years), medium term (7 years) and long term (10 years) outcomes.

The theory is that the projects undertaken as part of LEAP will offer sufficient value to release cash savings from "acute" services which can then be used to mainstream the funding for the LEAP projects. Given the financial pressures this means the total project has

[1] The partnership is ambitious in its scope, including Lambeth Council, the CCG, Kings Health, The Children's Bureau, the Police, local schools and nurseries, the Young Lambeth Co-operative and a range of community groups.

to become self-funding over ten years and also generate additional cash savings. All projects are subject to evaluation and monitoring to determine whether they deliver their projected outcomes – and are closed down if they fail to do so after a period of time. This drives systemic change and depends on two things in particular: investment of funds with which to experiment, take risks and evaluate; and a process for closing down unsuccessful projects.

Case study 4: Lambeth Living Well Partnership

The Lambeth Living Well Partnership is a collaborative formed to radically improve the outcomes experienced by people with severe and enduring mental health problems. It is made up of people who use services, carers, commissioners across NHS Lambeth Clinical Commissioning Group and Lambeth Council, the voluntary and community sector, and secondary care and primary care. It aims to deliver services that avoid reliance on acute services by improving physical and mental health, and increasing autonomy and participation in community life. Commissioning is focused on coproduction and outcomes, with services users, providers and commissioners defining needs and priorities for services to address. A process known as “alliance contracting” has been used to pool the capabilities of small local providers, forming an alliance to deliver an evolving service offer defined by people with relevant lived experience. The use of alliance contracting has been important in moving beyond competition by enabling commissioners to incentivize collaboration between providers, each of whom has a unique contribution to make. The project has resulted in a 50% per month average reduction in referrals to secondary care, as well as a 60% increase in people being supported that were not known to secondary services – meaning that previously unmet need is being tackled. The success of this approach is inspiring replication to other service areas.

Case study 5: Lambeth Food Partnership

The Lambeth Food Partnership works towards promoting the production and consumption of healthy and sustainable local food, and includes the council, GP food coops, an organisation known as Incredible Edible, and a range of community groups and individual residents. These are incentivised and supported to establish local food enterprises, and especially food cooperatives. The partnership develops a series of work programmes intended to meet outcomes of the Lambeth Food Strategy, including improving access to good food, encouraging healthier diets, supporting participation in food communities; eating more sustainably, tackling food waste, growing more food and supporting food businesses

The partnership runs a series of projects aligned to these objectives. One is the Lambeth Food Flagship, funded by the GLA, which aims to address obesity and diabetes, engender a "systematic shift towards prevention"; develop a community-led food growing infrastructure; and promote a vibrant local food culture to improve general health and well-being. Another is the CREATE project, which aims to encourage the development of local food-start-ups. The initiative as a whole is an example of positive multi-sector collaboration, as well as asset-based working. It takes a whole-systems approach that not only looks at individual nutrition but also at wider determinants of health. Many of the activities and community groups involved seek to create links between food and other areas such as nature, sport, mental health, the local economy and education. The partnerships explicitly aims to build upon local assets and the capacities of residents in ways that can generate social capital and resilience. By seeking to fashion an alternative local food economy it has an important influence on place.

Case study 6: Paxton Green Time Bank

Paxton Green is one of the largest GP practices in South East London, which has used time banking as a way to complement clinical services with peer support and skill sharing. People who live in the area, whether they are registered patients or not, can get involved in the

mutual exchange of activities that are delivered by members of the time bank. These range from simply providing transport to health and other services, to a variety of social and cultural activities – all depending on the skills and desires of members. Time banking generates connections between residents and help to enrich the social fabric of a community, so that people become less isolated and less dependent on state services. The approach is no panacea: it relies on people's participation and people can let each other down – sometimes seriously. But when successful, it can transform people's lives for the better and in doing so prevents problems from arising. There is much evidence suggesting that community based approaches such as time banking improve people's self-confidence and wellbeing – thus avoiding ill health and social harm.[2]

Case study 7: Mosaic clubhouse

Lambeth's Mosaic Clubhouse is a co-operative organisation that aims to provide support and opportunities for people living with mental health problems. Professional staff-work alongside members to run all aspects of the organisation, from administration to preparing meals and gardening. In this way, Mosaic clubhouse takes an asset-based approach to working with members, which seeks to unlock their capacity and enable them to develop new skills that can lead to a fuller and more independent life. The aim is to help people with mental health problems to re-integrate in society and employment through participating in the club, developing friendships and enhancing family connections. Mosaic is part of a world-wide network of clubhouses and is evaluated every two years by members and staff from the network to continue its clubhouse status – which it has maintained since 1996. In 2012 Lambeth council contracted the clubhouse, in collaboration with Southwark MIND, to provide a mental health information centre, accessible via walk-in, email and telephone. This has allowed Mosaic to develop connections with public sector agencies and increase its

[2] See A Guide to Community-centred Approaches to Health and Wellbeing – Public Health England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402889/A_guide_to_community-centred_approaches_for_health_and_wellbeing__briefi___.pdf

partnership working. Local education providers now allow the clubhouse to run range of courses and offer supported employment opportunities to members.

Case study 8: Coproduced commissioning

In 2013 Lambeth decided to use a co-produced approach to commissioning a service for young offenders. This was a response to criticisms that commissioning processes did not involve service users sufficiently and therefore missed out a valuable source of expertise. A group of young people and commissioners was assembled and, following a method of appreciative inquiry, the aspirations and abilities of both groups were explored. The process began by considering individual aspirations and abstracting from these in group discussions to develop a vision of what an improved Lambeth would look like in five years' time and how this could be achieved. This was used to develop a set of outcomes against which a £20,000 service was commissioned. The young people then interviewed the organisations which had responded to the service specification and shortlisted preferred providers. The winning bid was for a talent show that the young people would help to organise and deliver across Lambeth. This was not the commissioning manager's first choice, but was selected because of the leadership space it created for young people. This co-produced approach to commissioning combines the professional knowledge of commissioners with the experiential knowledge of service users. This means commissioning is better-informed and able to address a wider range of existing or incipient problems.

Southwark and Lambeth Case studies

Case study 9: Southwark and Lambeth Integrated Care

The Southwark and Lambeth Integrated Care Programme (SLIC) aims to join up care services and agencies in ways that help to improve the health of people in Lambeth and Southwark. Launched in 2014, SLIC was one of the first major schemes of integrated care in the UK. The programme includes general practices, community healthcare services, mental healthcare services, local hospitals and social services, and aims to integrate and co-

ordinate the services offered by each in person-centred ways, enabling people to take a more active role in their own health. SLIC also aims to enable joint commissioning through pooling health and social care budgets, and forms an important part of Southwark and Lambeth's 'Better Care Fund' plan – the NHS's national programme to integrate health and social care. SLIC works with Lambeth's Citizens Board to mobilise a 'citizens' movement' to raise awareness about why services need to change; to get more people involved in co-designing better local services; and to play a central role in co-producing better outcomes.

Case study 10: Safe and Independent Living

In Lambeth and Southwark, Safe and Independent Living (SAIL) is a social prescribing scheme that is being delivered in partnership with Age UK, and aims to build and maintain a list of activities and services offered by the local VCS. SAIL works through a simple yes-or-no questionnaire, whicht acts as a guide for anyone working in the community to quickly identify an older person's needs. Each question is associated with a partner agency, so a 'yes' to any question operates as a flag to bring that person to the attention of that particular organisation. All partner agencies have agreed to accept all referrals through SAIL and to contact the client within two weeks of being notified. Age UK acts as the hub for the scheme across both Boroughs**,** receiving completed SAIL questionnaires, forwarding them to the appropriate partner agency within 24 hours of receipt and following up the referral with the older person to ensure their needs are met. In this way, SAIL integrates health activities and services offered by the public and voluntary sectors. It is a good example of how partnership working can contribute to early action through signposting and communication.

Case study 11: Local Care Networks

Local care networks (LCN) integrate health and wellbeing services and activities provided by the public and voluntary sectors in order to shift from a clinical to a more holistic and person-centred approach to local health. At the time of writing, LCN's are being implemented in Lambeth and Southwark. They encourage greater collaboration between GP practices and form the basis for integration between primary care and other services - particularly community nursing and social care and elderly and early years services. LCNs are an

example of ambitions for improved asset-based and partnership working in health. They also aim to embed approaches recommended in this report within their service delivery such as 'every contact counts', social prescribing, pooled budgeting across public agencies, and co-production. The networks are expected to increase personal resilience and reduce dependency on downstream services. Much energy across both boroughs is being focussed upon developing LCNs. It is too early for evidence of success they hold out real promise as a vehicle for early action.

Case study 12: Local Area Co-ordination

Local Area Co-ordination (LAC) is an asset-based approach to empowering people with disabilities and other needs, improving their lives and preventing them from developing worsened conditions. Local workers – known as Local Area Coordinators - act as a single point of contact for people with disabilities and their families in a defined area. Their role is to enable people to develop their own skills and capabilities, help them to access existing local resources and networks and, where these do not exist, working to build them. Co-ordinators work as capacity builders and sign-posters, and help to integrate public services with voluntary and community activity in ways that are shaped around the needs and aspirations of people who use services. Crucially, the starting point is to identify with the individual what they can do to improve their own wellbeing and achieve their own aspirations with support from within their local community. In Lambeth the model already forms part of the Living Well Partnerships' plans to personalise recovery and support plans for those suffering from mental and physical disability. This approach is an important feature of plans to develop Local Care Networks (see case study 11) in both boroughs.

The process was pioneered in Australia, where it was focused on people with disabilities and special needs. In the UK it has been most fully developed in Middlesbrough, where it has included people with lower-level needs.[3] Because it seeks to build upon people's strengths

[3] Other areas that are using, or beginning to use LAC include Derby City, Thurrock, Isle of Wight, Swansea, Neath Port Talbot, Derbyshire, Gloucestershire, Cumbria Suffolk

and to develop community capacity, it can help to prevent people from developing more complex needs. The LAC model yielded impressive results in Australia, where it was seen to have delivered a 30% reduction in costs by keeping people from using more acute services.[4] The greater universality of coverage in Middlesbrough could multiply these savings, by picking up a wider range of people with multiple low-level challenges before they trigger demand for acute services.[5] It has been recommended that Local Area Co-ordination be rolled out throughout the UK.[6]

Case study 13: Knee High Design Challenge

The Knee High Design Challenge is a partnership between Guy's and St Thomas' charity and Lambeth and Southwark Councils. It sets out to find, fund and support people with new ideas for raising the health and wellbeing of children under five. The programme aims to address problems that public health has failed to address by reducing inequalities in children's development when they start school. It offers an opportunity for local people, whether residents, social workers, parents or others, to propose ideas and provides support to turn these into investable ventures. Children and families are involved at every stage in the development and testing of new products, services and initiatives that are beginning to be used throughout Southwark and Lambeth. Launched in 2013, the initiative received 190 initial applications, out of which 25 'design teams' were funded with £1000 pounds each to further develop their ideas. After testing ideas with families, 6 teams receive a larger grant (£41,000) to deliver the project and develop a sustainable business model. Since the autumn of 2014 six project teams have been developing projects. One example is the 'pop up parks' project, which arose from the Design Challenge. This seeks to engage local communities in the creative use open public spaces to design and install temporary park facilities where children and families can spend time playing. Although 'pop-ups' usually last for one day, the

[4] Review of the Local Area Coordination Program Western Australia (2003) http://www.disability.wa.gov.au/dscwr/_assets/main/report/documents/pdf/final_report_lac_review1_ per cent28id_369_ver_1.0.2 per cent29.pdf

[5] http://www.nesta.org.uk/sites/default/files/co-production_catalogue.pdf - p 46

[6] file:///C:/Users/adrian.bua/Downloads/97543996-Local-Area-Coordination.pdf

aim of the initiative is to transform attitudes to urban public spaces and make greater use of them.

Case studies outside Lambeth and Southwark

Case study 14: Key Ring

The KeyRing initiative is a peer support network for vulnerable adults. The UK has 105 local networks, each made up of nine members and one dedicated volunteer, all living within a 10-15 minute walk from each other. Members of the network and the volunteer navigator offer mutual support and link each other with other networks and activities.[7] The volunteer acts as the main hub for the network and follows principles of community development which seek to build and enhance the relationships and resources within a community. Peer support networks like KeyRing have existed for a while and 'soft' evidence (based on user surveys and interviews) suggests that they have a significant positive impact on people's quality of life. Research by the Department of Health also suggests that KeyRing can deliver savings for the public purse by avoiding reliance on acute services.[8]

Case study 15: Richmond users independent living scheme (RUILS)

RUILS is a peer to peer support network for older people, as well as those with learning difficulties and mental health challenges. It was set up to increase users' involvement in running services - tapping into the skills, knowledge and expertise of their members. In the peer-to-peer scheme, buddies act as one-to-one coaches, helping the person they support to overcome challenges and/or achieve a goal that is important to them. RUILS makes it clear that peer supporters are not there to take over or act as advocates; their role is facilitative. Where members of the network have personal budgets, RUILS helps them to

[7] http://www.nesta.org.uk/sites/default/files/co-production_catalogue.pdf

[8] CSED Case study (2009), Keyring: Living Support Networks, HM Department of Health.

pool them, to increase their purchasing power. It helps them to expand and strengthen social networks by bringing people together around activities that they enjoy.

Case study 16: Social Prescribing in the UK

Social prescribing provides non-medical treatments for illnesses, based on activities and amenities that are on offer in local communities. There is increasing evidence, especially in mental health, that this approach provides an early and effective response to mental distress.[i] For this reason, social prescribing is increasingly adopted by GP practices across the UK. Recent evaluations in Rotherham suggest that social prescribing has great potential to reduce admissions to emergency services, and that social outcomes are also significantly improved.[9] In Rotherham patients are referred by their GPs to a small team of 5 people (from the voluntary sector), which works with the individual to identify their needs and then refers them to local services, including community based activities, information and advice services, befriending and community transport. The programme also gives grants to build capacity by supporting community based activity (social prescription services) amongst local CVS groups.

Case study 17: Making Every Contact Count (MECC)

MECC is a cross-agency initiative that trains staff to inform users about problems and services that fall within the remit of other agencies. Thousands of frontline staff working across all services meet residents every day, and can act as early signallers of issues that are beyond the scope of the service they provide. For example, staff talk to the people who use their services about issues such as smoking, healthy eating, parenting, debt, or employment; they then provide basic advice or refer people to appropriate agencies for support. By sharing this kind of information between public and voluntary agencies, problems can be picked up a lot earlier and action taken that can avoid needs becoming

[9] See http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-summary.pdf, and http://www.dundeepartnership.co.uk/sites/default/files/Social%20prescribing%20evaluation%20report.pdf

more complex. An evaluation is underway in Salford, where the local MECC scheme has been opened to include the local NHS and the council as well as the third sector. This approach has also been adopted in Croydon, helping community development workers to draw in and develop local assets.

Case study 18: Lancashire early action policing

Lancashire constabulary has recently formed an 'early action response' service that aims to identify 'at risk' individuals and mobilise appropriate services to pre-empt harm. The initiative consists of 'early action response teams' comprising staff with professional backgrounds in areas ranging from social work, youth work, parenting support and mental health. One integrated team has covered East Lancashire, and is being rolled out to other deprived areas including Preston and Burnley. The model targets intensive users of police and emergency services for assessment and referral to a multi-agency panel, which then develops person-centred solutions. Deputy Chief Constable Andy Rhodes has been a strong advocate of tthis approach, driving the early action agenda locally.[10]

Early Action policing in Lancashire is a good example of mid-to-downstream prevention, where acute costs are saved by developing person-centred interventions that can stop individuals from entering the system through acute services – usually in emergency health or the policing system. It also seems to be a positive example of how action can be moved upstream through innovative thinking and collaboration between different agencies. Lancashire Constabulary has commissioned a two year cost-benefit analysis from the University of Central Lancashire to evaluate the programme.

Case study 19: Partnerships for Older People's Projects (POPPs)

POPPs were established in 2005. They aim to increase partnership working between local authorities, the NHS and the third sector in order to improve health and wellbeing, and to reduce levels of admissions to emergency services and institutional care. It is an example of

[10] See 'Moving Beyond Enforcement: Early Action Policing', available at http://www.community-links.org/linksuk/?tag=andy-rhodes

an early attempt at prevention through greater collaboration. Evidence from 29 pilot sites showed that for every extra £1 spent on the POPP services, there was approximately a £1.20 additional benefit in savings through reduced use of emergency beds. Overnight hospital stays were reduced by 47 per cent and use of Accident and Emergency Departments by 29 per cent. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person. Evidence also showed that when people received 'well-being or emotional' interventions, such as befriending and peer-based initiatives, fewer reported being depressed or anxious following the intervention. Looking at quality of life improvements as a result of better mental health – using evidence from some of the POPPs pilots – the monetary value would be approximately £300 per person per year.[11]

Case study 20: Fast Food Fix, Waltham Forest

When local residents expressed concerns that the proliferation of hot food takeaway establishments (HFTs) in the borough presented a danger to child health, Waltham Forest used its place shaping powers to take preventative action. It established a corporate steering group to ensure that existing HFT businesses operated as responsibly as possible and develop strategies to tackle the wider social, environmental and economic issues associated with HFTs. Supplementary planning documents (SPDs) were developed that restricted the opening of new HFT stores in areas frequented by children, such as schools, youth facilities and parks. The initiative was based on research by the London Metropolitan University which revealed the negative impact these establishments had on children's health. Since March 2009 no new planning applications for hot food takeaways have been permitted by Waltham Forest. By March 2010, the council had refused five new applications, including

[11] See National Evaluation: Partnerships for Older People's Projects (2009): http://www.pssru.ac.uk/pdf/rs053.pdf, see also NDTi (2014) the Economic Value of Older People's Community Based Preventative Services - http://www.ndti.org.uk/uploads/files/The_economic_value_of_older_peoples_community_based_preventative_services_final.pdf

one that went to a planning appeal and was upheld. The council has also increased enforcement of environmental health and waste regulations relating to hot food takeaways. [12]

Case study 21: Community Wealth building in Preston

Preston City Council, working closely with the Centre for Local Economic Strategies (CLES), is spearheading a new approach to community wealth through fostering a diversity of local enterprise and ownership. They are drawing inspiration from the Evergreen Cooperative initiative in Cleveland Ohio, which successfully catalysed a network of green new businesses that are owned by their employees. The Council has worked with a group of anchor institutions (big public sector organisations such as the NHS and Universities) in Preston to develop a shared commitment to supporting local businesses when they purchase resources and services. Along with Preston City Council this group spent an estimated £750 million on goods and services in 2012-13. They are working to support the establishment of local co-operatives to fill the remaining gaps in supply for the biggest contracts. A local 'Guild Co-operative Network' has been established to bring together members of existing and prospective co-operatives to provide mutual support and advice. Currently development of new co-ops focuses on particular 'gap' sectors in the local economy as identified by anchor institutions: these include catering, building, cleaning and maintenance. This is a positive example of local public bodies partnering up to develop a strategic approach to building a more healthy and sustainable economy locally. The establishment of worker co-operatives can bring experience of control to individuals in their workplaces, and create more opportunities for local employment and training.

Case study 22: Greater Manchester Fire and Rescue

In an innovative approach to early action taken by emergency services, Greater Manchester Fire and Rescue Service has redefined aspects of its role, adding to its acute emergency functions a strategic approach that involves working more closely with other public sector

[12] See http://www.local.gov.uk/health/-/journal_content/56/10180/3511421/ARTICLE

bodies as well as with the communities it serves. For example, the service developed a programme of community safety apprenticeships which can potentially reduce demand on emergency services, whilst offering valuable skills to young people entering the labour market. As part of its participation in a pooled budget, the service has also worked across public sector silos by sharing information relating to sixty thousand homes that are deemed most at risk of fire. These homes are often the same as those which require other public services, so sharing this information enables other public agencies to get a better grasp of need and risk and therefore act earlier. This is an example of how effective partnership and information sharing can allow governance systems to act earlier.

Case study 23: Scottish Early Action Fund

In 2012, the Scottish Government followed the advice of the Christie Commission to make prevention a fundamental pillar of public service reform. As a result, it assigned £500m of public sector spending for prevention over the parliamentary term. The pot was mostly made up of contributions from central government funds, local authority and health spend, and was distributed through three funds, one each for early years, reoffending and older people's care.

The early year's fund: is overseen by a dedicated taskforce whose overarching aim is to improve delivery of three outcomes of the national performance framework: to provide children with the best start in life, to improve the chances of children and families at risk; and to develop confident and responsible young citizens. The care for older people's fund is the largest, with £300m distributed to 32 Change Fund Partnerships made up of NHS Boards, local authorities and third sector.. Reoffending prevention is relatively small with just £7.5m over three years. It funds evidence-based mentoring schemes delivered by third sector led partnerships.

Results have been mixed. The change funds have had great symbolic importance, establishing the importance of prevention and leading to some innovative and successful

projects. The care for older people's fund has contributed to the development of joint commissioning strategies as part of the drive to integrate health and social care. Orkney stands out as a site of best practice – where coproduction with health professionals and third sector representatives was used to draft a change fund investment strategy aimed at proactive, preventive and anticipatory care provided at home.[13] However, there is little evidence that the funds have led to systemic change. Research suggests that this is down to many of the barriers that we have highlighted in this report, such as difficulties in overcoming disincentives to collaborate, working in departmental silos and failing to engage in genuine partnership with the third sector. [14]

Case study 24: Joint Strategic Asset Assessments in Wakefield

Local authorities and public health departments in the UK are required to produce a joint strategic needs assessment (JSNA) every three years. This is a detailed report of the different problems facing the local population and is intended to inform the development of strategies and priorities to meet local needs. In 2010, Wakefield Council took a different approach based on the recognition that communities should not simply be seen as bundles of needs and liabilities, but also as possessing assets that can help to overcome local problems. It piloted a 'strategic assets assessment', as a first step towards connecting assets more clearly to public services and local needs. This became a resource for commissioners, heling to support community development and capacity building. A report on the pilot argued that the exercise provided a new and deeper understanding of both needs and assets, which had the potential to develop a different commissioning framework, to promote co-production and to build and strengthen community assets.[15] The JSNA and the Asset Assessment should not be seen as separate, but as complementary processes

[13] See: http://www.orkney.gov.uk/Files/Council/Consultations/2013/Appendix_1_-_JCS.pdf
[14] Horwitz, W. (2013). The Scottish Prevention Drive: What can we learn?, Community Links – available at http://www.community-links.org/uploads/documents/Scotland_learning.pdf, accessed 09/07/2015
[15] Greetham, J. (2010). *Growing Communities Inside Out: piloting an asset-based approach to JSNAs within the Wakefiled District.* Available at http://www.local.gov.uk/c/document_library/get_file?uuid=679e8e67-6d41-49a9-a8e1-452959f4f564&groupId=10180

that produce a richer more intelligent and better informed basis for addressing and preventing local problems.

Case study 25: Social Impact Bond in Peterborough

Peterborough Prison service was one of the first in the world to use a Social Impact Bond to fund a service. A SIB is a form of payment by results (PBR), where funding is raised from private, non-government investors and used to pay for interventions to improve social outcomes. In Peterborough, however, the SIB was sponsored by the Ministry of Justice and the Big Lottery Fund to prove the concept. The pilot was co-ordinated by Social Finance – a not-for-profit financial intermediary – and as part of the SIB the government agreed to pay back a proportion of savings to investors.

The investment was used to fund an intervention called the One Service - a voluntary scheme offering 'through the gate' support to reduce reoffending. The scheme itself was relatively successful and led to a marked reduction in reoffending rates. However, it remains doubtful whether this financing model offers real value for money, or how far it could be for prevention. Setting up a SIB is a complex process, requiring extensive expertise in identifying target populations and measures, as well as a third party to oversee the contract. This generates 'transaction costs' that could be avoided through traditional financing. Also, the whole point of PBR mechanisms is that they transfer risk out of the public sector, but there is still significant risk involved in project failure. Finally, SIBs have little to offer in terms of upstream prevention because they require a clear target population – a 'problem' or a 'risk' must be clearly identifiable and measurable. All in all, SIBs remain a model with some potential for experimentation in midstream and downstream prevention, may best be limited to transitional projects to broaden knowledge of what works.

Case study 26: Commissioning of Youth Services in Surrey

From 2009-2012 Surrey County Council embarked on an ambitious programme to radically improve outcomes for young people, despite a 25% budget cut, by fundamentally

redesigning the commissioning and delivery of young people's services. They did this by commissioning for outcomes and co-production, working with young people and their families.[16] The outcomes frameworks developed had a strong focus on prevention, co-production and the integration of services, and won an award for 'Best Public Procurement' in 2012 from the Chartered Institute of Purchasing and Supply. The reforms delivered outstanding results. An independent academic evaluation identified a number of positive impacts, including a 60% reduction in the NEET population (not in education, employment or training).[17] This serves as an example of what can be achieved despite austerity and cuts, through a creative, long term and co-produced approach to service design and delivery.

Case study 27: Pooled budgets and fuel poverty in Oldham

Warm Homes Oldham is an initiative funded through a pooled budget between the local Clinical Commissioning Group, Public Health and local housing associations to tackle the problem of fuel poverty through measures such as increasing energy efficiency and providing advice about fuel providers and debt. The partners have agreed that the savings generated will be reinvested to expand the scheme, resulting in more than £1.1 million being invested locally to solve fuel poverty within the first six months. [18] Apart from the initial £200,000 investment made by the partner agencies, most subsequent finance has been generated through 'ECO Grants' – money that is provided through a statutory duty for utility companies to provide energy efficiency reforms for those living in eligible areas, or residents on eligible benefits. By tackling fuel poverty in this way substantial savings are expected to be made in other areas such as health and social care services. As the main beneficiary of savings, the CCG pays a greater proportion than other partners for every person bought out

[16] See Slay, J. (2011). An Opportunity to transform Youth Services in Surrey, Blog Post - http://www.neweconomics.org/blog/entry/an-opportunity-to-transform-services-for-young-people

[17] See Bovaird, T. and Loeffler, E. (2014). *The New Model for Commissioning Services for Young People in Surrey: Evaluation of Achievements and Implications.* INLOGOV - http://www.surreycc.gov.uk/__data/assets/pdf_file/0012/865587/Surrey-Report-2014-Executive-Summary.pdf.

[18] http://www.oldham.gov.uk/press/article/637/residents_to_benefit_as_warm_homes_oldham_continues

of fuel poverty. The scheme is a good example of how collaboration and budget pooling can serve to encourage more holistic approaches that are more effective in delivering broad outcomes, such as increased health and well-being, which cut across service silos.

Case study 28: Happy City Bristol

Happy City (HC) is an international initiative that plans to promote happiness and wellbeing, It works across all levels – from small community groups, to national strategists. The organisation campaigns to promote wellbeing, delivers training and works to develop better measures of success. In the UK, Happy City is currently most active in Bristol, where the initiative originated, and which is regarded as a pilot. It working to develop a survey instrument that can be used to measure the impact of policy and practice on the wellbeing of residents.[19]

Case study 29: Participatory budgeting in the UK

Participatory Budgeting (PB) engages citizens in democratic deliberation and decision making about how public money should be spent. Following the impressive successes of the first PB in Porto Alegre (Brazil), the PB process has spread to more than 1,500 localities around the world – including many places in the UK. The implementation of PB in the UK has been piecemeal, however. Many processes have been quite tokenistic - handling tiny budgets relating to policy agendas that are limited to marginal issues. There are, however, examples of good practice that reveal the potential of PB. Since Udecide was set up in 2006, residents in Newcastle have been able to participate in decisions on the allocation of £3.8 million worth of investment in a wide variety of projects, often affecting the most disadvantaged. [ii] Residents in East Devon have benefitted from participating in allocating section 106 funds, totalling £ 200,000 by 2013.[iii] At its best, participatory budgeting can advance prevention because it develops social and human capital and builds resourcefulness for people and communities to act on their own behalf. Because PB draws

[19] See http://www.happycityindex.org/long-survey

on the knowledge of local residents, it becomes possible to identify problems at an early stage and direct investment to them before they require acute action.

Case Study 30: Early Action Funder's Alliance

Prompted by the Early Action Task Force, the 'Early Action Funders Alliance' has bought together a group of major donors to generate funding streams for preventative initiatives. A key aim of the Alliance is to provide proof of concept for the prevention agenda, advocate for greater prevention and ultimately influence other grant givers and the public sector. The Alliance aims to steadily increase its membership and funds committed to early action. One outcome has been the Early Action Neighbourhood Fund, which is composed of £5.3m provided by the Big Lottery, Comic Relief and the Esmee Fairbairn Foundation. The Fund aims to provide resources to initiatives that can change local systems and structures, affect the future commissioning of services, and demonstrate the wider case for early action. Three projects have been funded so far, in Coventry, Norwich and Hartlepool, two of which are aimed at children and young people and the other at providing legal help and training for disadvantaged members of the community. All involve partnership between the public and voluntary sectors.

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[i] See, for example, the NICE's page on social prescribing: https://www.evidence.nhs.uk/search?q=%22social+prescribing%22

[ii] See HM Homes and Communities Agency (No Date), Udecide – Newcastle City Council – available at http://udc.homesandcommunities.co.uk/u-decide-newcastle-city-council

[iii] Hall, J. (2013) Section 106 Funding in East Devon – available at http://participedia.net/en/cases/section-106-funding-east-devon

APPENDIX 4

Southwark and Lambeth Early Action Commission

Appendix: Working Methods

Structure of the Commission

The Early Action Commission was set up and funded by the Health and Wellbeing Boards of Southwark and Lambeth. It has been supported by the New Economics Foundation (NEF), which provided the secretariat and conducted the research and engagement, as well as by an Implementation Advisory Group composed of local professionals with relevant expertise.

Members of the Commission

Chair

Rt Hon Dame Margaret Hodge MP, Chair of the Public Accounts Committee of the House of Commons from 2010-2015

Commissioners

Dr Jonty Heaversedge, Chair of the Southwark Clinical Commissioning Group

Helen Charlesworth-May, Strategic Director of Commissioning, Lambeth Borough Council

David Robinson OBE, Chair of Community Links and the Early Action Task Force

Dr David Colin Thome OBE, Honorary Visiting Professor, Centre for Public Policy and Health, University of Durham

Carey Oppenheim, Chief Executive, Early Intervention Foundation

Dr Sue Goss, Principal, Office for Public Management

Ex officio

Gordon McCulloch, Chief Executive, Community Action Southwark

Valerie Dinsmore, Head of Policy, Research and Customer Relations, Lambeth Borough Council

Implementation Advisory Group

The Implementation Advisory Group (IAG) served as a sounding board for the Commission by scrutinising emerging recommendations. The group consisted of 24 members, including senior public sector officers and leaders of civil society organisations across Lambeth and Southwark. Organisations represented on the IAG include Southwark and Lambeth Public Health, Lambeth Clinical Commissioning Group, Southwark and Lambeth Borough Councils, Age UK, Healthwatch, Blackfriars Advice Centre, the Metropolitan Police, InSpire and Refuge

Research and Engagement

This section explains the Commission's methods of research and engagement as well as our approach to developing recommendations. It is based on the following work-streams:

- Consultation of official local statistics
- Engagement with professional stakeholders across Lambeth and Southwark
- Engagement with residents and local community activists
- Review of initiatives illustrating early action
- A review of council strategies, initiatives, services and activities across both Boroughs
- Iterative consultation with the Commission, and 'Implementation Advisory Group' (IAG).

Identifying persistent problems: analysis of official statistics

Research initially focussed on gathering statistical data, mainly from Joint Strategic Needs Assessment (JSNA) data, to identify pertinent local problems and their proximate causes. This was a useful starting point to identify policy areas that require urgent action, and where a more preventive approach could lead to the most notable benefits. These were:

- Social isolation (esp. high levels of admissions to institutionalised care)
- Long term unemployment, and employment security
- Child obesity

- Violent crime

JSNA data were further consulted to gather insights as to the possible causes of these problems. Through the analysis of official statistics, patterns and correlations were identified that offered opportunities to make plausible claims regarding the immediate causes of these issues, especially in terms of conditions leading to system entry such as incontinence or dementia in the case of care services. However, this information is limited for two reasons. First, identifying the immediate causes of problems does not explain why such problems are not prevented more effectively. For example, the data showed a clear association between social isolation, incontinence and dementia. This suggested a plausible hypothesis regarding cause and effect, but offered a poor basis upon which to develop insights as to how to prevent isolation. This is because isolation is a *social* phenomenon that is not reducible to clinical causes – and its drivers can be expected to vary across different contexts. Second, official statistics are gathered when people enter systems because they have already developed problems. They therefore provide a narrow view of local issues that leads to downstream or, at best, midstream interventions.

To develop a more complete preventative strategy, analysis of official statistics was complemented by a more qualitative approach that shed a different, more contextualised and synoptic, light upon the underlying causes of problems such as isolation.

Engagement with professional stakeholders and residents

Local knowledge was drawn from dialogue between a range of local stakeholders across both boroughs in six sessions. Two of these engaged professional stakeholders, and four engaged local residents and activists across four wards in Lambeth and Southwark.

Participants took part in facilitated deliberations that explored some over-arching questions:

- What are the ‘upstream’ causes of these problems locally?
- What is being done locally to prevent these problems?
- What are the barriers and opportunities to maximise the impact of and build upon this kind of local action?

It was from this engagement that we derived our approach to prevention—based on

- **Building resourceful communities** through capacity building the empowerment of people
- **Creating preventive environments** by mobilising the 'place-shaping' powers of the local public sector
- **Gearing systems to early action** so that they drive and sustain a long term systemic shift in culture, policy and practice towards early action and prevention
- **Building strong collaborative partnerships** amongst and between residents, local VCOs and the public sector
- **Finding additional resources** to initiate and sustain a shift towards early action

Review of local initiatives

Finally, we carried out a review of strategies, policies and practices (henceforth referred to as 'initiatives' for ease of reference). The goal of this part of the research was to gain an understanding of existing practice and the direction of travel in both boroughs. The overall picture we gathered was an approach to prevention which had some notable successes and promising features, but was overall piecemeal and disjointed. An important starting point in catalysing a ***systemic*** shift to early action is to map out existing practice, to identify gaps to fill and activity to build upon.

Researchers began to populate a list of relevant initiatives in both boroughs through consultation with Early Action Commissioners, members of the Implementation Advisory Group, and policy officials across both Councils, and through internet searches. They included examples of local, national and international practice. Initially, the selection of initiatives for review was informed by their relevance to the four policy areas identified above as being particularly problematic. However, as the review progressed, more general and key strategic developments in terms of policy and practice were included. These were then assessed according to the four themes of the preventive framework.

The initiative review has not been exhaustive. The initiatives were reviewed according to the following criteria

- At what ‘level’ (upstream, midstream, downstream) are the initiatives operating?
- Are resources, or ‘assets’, within communities being mobilised or enhanced?
- What forms of partnership are present?
- How do the initiatives influence place, if at all?
- How do the initiatives influence systems change?

Gathering case studies of good practice

Throughout our engagement with the Commissioners, the IAG, local residents and policy experts across Lambeth and Southwark researchers also focussed on gathering information on case study examples of good practice of early action from the UK, and abroad. These case studies are referred to throughout the text, in support of the recommendations we make. It should be noted that not all case studies have been fully evaluated, where they have, we consulted the research and include the results in our accounts. However, many of the cases are currently being implemented or under development and have therefore not been rigorously evaluated. These should be taken as illustrations of promising potential and possibilities, not as a robust evidence base.

Consultation with Commission and Implementation Advisory Group

As the work-streams above progressed, the research team consulted the Early Action Commissioners, members of the Implementation Advisory Group and a broad range of UK policy literature on prevention and early action. This was an iterative process whereby EA Commissioners set the broad strategic direction of the project while IAG members advised on the practicalities of implementation. The resulting recommendations were developed by combining insights gained from research and engagement with responses from the IAG and Early Action Commissioners.

Agenda Item 9

Item No. 9.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Healthwatch Southwark Engagement Update	
Wards or groups affected:		Southwark wide	
From:		Aarti Gandesha, Healthwatch Southwark Manager	

RECOMMENDATIONS

1. The board is requested to:

   a) Note Healthwatch Southwark's engagement since April 2015.

   b) Note Healthwatch Southwark's planned engagement activities.

   c) Agree if Healthwatch Southwark can submit an engagement update for each Health and Wellbeing Board meeting.

BACKGROUND INFORMATION

2. Healthwatch Southwark was created in April 2013, as part of the 2012 Health & Social Care Act reforms and is part of a local Healthwatch network that is supported by a national Healthwatch England body.

3. Healthwatch Southwark's aim is to effectively represent the voice and needs of the local community and to encourage the wider Southwark population - including seldom heard voices – to speak out about their experiences of health and social care.

4. By engaging with members of the public, Healthwatch Southwark learns about key issues and difficulties that local people encounter when using healthcare services.

5. Healthwatch Southwark is the critical friend of publicly provided local health and social care services, and has a presence amongst healthcare boards and committees across the borough where feedback from residents can be relayed to providers and commissioners.

6. Since launching in 2013, Healthwatch Southwark has developed good working relationships with providers and commissioners to share intelligence, and is exploring ways to strengthen this further.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Healthwatch Southwark: Engagement Update (April 2015 – Present)

AUDIT TRAIL

Lead Officer	N/A	
Report Author	Aarti Gandesha, Healthwatch Southwark Manager	
Version	Final	
Dated	12 October 2015	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		12 October 2015

APPENDIX 1

Southwark Health and Wellbeing Board

Engagement Update (April 2015- Present)

Information and Signposting

By providing information to Southwark residents, we help them understand the health and social care system. We do this in a variety of ways: over the phone, via email, face to face, distributing factsheets, delivering workshop sessions.

At the time of writing, Healthwatch Southwark has managed 92 signposting and issues queries since April 2015. These were through our public telephone line and email.

47% of the information and signposting queries since April 2015 were related to GP registration:

- Not being able to register with a 'good' GP (According to NHS Choices reviews)
- Not being in preferred catchment area
- Finding out GP surgery has closed and not knowing what to do next / queries about access to patient records

We submit this information to Healthwatch England on a regular basis so they can collate information from all local Healthwatches. On a quarterly basis, we submit information to NHS Southwark CCG to include in their Quality Reports.

Future plans

- ✓ Exploring possibility of logging quality issues directly onto NHS Southwark CCG's Quality Alert System
- ✓ Developing factsheets to provide people with information and signpost to relevant services e.g. how to register with a GP, where to go if feeling unwell, how to make a complaint

Community Focus Groups

Every quarter, we organise a community focus group. This is one of the ways we fulfil our role to speak to members of the community about access and use of health and social care services. From these sessions, we gain a realistic overview of what works well and what requires improvement in Southwark's health and social care services.

In June, we started engaging with the Gypsy and Traveller community in Southwark, via Southwark Traveller Action Group (STAG). We ran a small focus group, and have plans to carry out further engagement over the next couple of months. After this, we will publish a report with recommendations.

We are currently compiling a report to draw together intelligence from our community focus group on GP access, which is one of our priority areas. This will collate information from 5 community groups: Bengali, Somali and Latin American community, a deaf group and the Gypsy and Traveller community.

Key issues that have been identified:

- Lack of information that is appropriate for people speaking different languages / with communication difficulties
- Lack of understanding by staff around needs of diverse communities
- Difficulty accessing interpreting services in a timely way
- Long waiting times to get an appointment with a GP
- Confusion about what services GPs offer
- Limited knowledge of extended primary care services
- Changes made to services are not always heard about

Suggestions that were made on how services could improve:

- Run workshops / further engage with specific communities to strengthen their understanding of the health system
- Improve access to interpreting services
- Information should be provided in a different format e.g. easy-read, different languages etc.
- Make more appointments available to reduce waiting times
- Avoid changing how things work e.g. the booking system. If this is changed, it needs to be clearly communicated
- Make use of voluntary and community groups and outreach workers to relay information to specific communities
- Training for staff to improve sensitivity/awareness of communication difficulties, equality and diversity, and increase knowledge of services to signpost people to

Future plans

Community focus groups:

- ✓ In partnership with Macmillan Cancer Support, we are running a focus group with the Bengali community to explore how information is best received e.g. written translation materials, audio materials (October)
- ✓ As part of our community focus group programme, we will be working with a Vietnamese mental health group (October) and refugees (January)

Other engagement plans:

- ✓ We have launched a survey for the Transgender community regarding access and experience of health services. This has been sent to 14 community groups (not all Southwark based)
- ✓ As part of our mental health priority, we are focussing on the views of children and young people about support and advice for their emotional wellbeing
- ✓ As part of our social care priority, we are focussing on the views of people who have gone through the assessment process to see how accessible it is, what information is given, and if they are appropriately supported and signposted

Public Forums

Every quarter, HWS organises public events, to give Southwark residents the opportunity to keep abreast of changes to health and social care. We use these forums to give a space for direct dialogue with commissioners, providers and the public.

10 June 2015: *"Your Care, Your Services: Issues to Solutions"*

- 73 people attended
- Presentations from CCG (Local Care Networks) and Southwark Council (Home Care Vision) to hear about plans for better joint working and more person-centred care
- Key discussions on local care networks:
  - People need educating so they use the right services for their needs
  - People prefer to see the same professionals and build relationships with them
  - Communication is key – want to be kept informed and understand
  - Need to be considered as a 'person' not a 'process'

- Key discussions points on home care:
  - Home care workers are front line and should work in partnership with other health and social care professionals
  - Consistency is important – having the same carer so they get to know the person
  - More needs to be done to raise awareness about what local charities can offer
  - Carers need to be 'culturally sensitive' to the needs of individuals
  - More clarity needed on what the roles are of carers, as this is variable
  - Important to record and track what has been done so all professionals are informed
- Full report available online

28 September 2015: *"Everyone is treated equally" - Join the debate*

- 67 people attended
- Purpose of event for members of public to meet key people involved in their health and wellbeing and hear their commitment to addressing inequalities
- In attendance - Gwen Kennedy (CCG), David Quirke-Thornton (Southwark Council), Mark Whitten (Police), John Moxham (King's Health Partners), Zoe Reed (SLaM)
- Key points of discussion:
  - Care of frail elderly, especially when receiving care at home and in homes
  - Getting timely care for the most vulnerable and how 'integrated' services can help with this
  - Difficulties in keeping up with changes that are taking place in services, particularly when you have access and communication needs
  - How patient experience data is collected on equality – need to be more direct
  - Importance of early education about mental health to prevent crisis
  - The impact cuts are having on quality of services, and the value of the voluntary and community sector in supporting diverse communities
  - The importance of listening to people with 'invisible disabilities' and engaging with those that are 'allergic to services'
- Report will be available on website soon (end of October)

Future plans

- ✓ Will be involved in Guys and St Thomas' NHS Foundation Trust's patient and public engagement strategy event (December) which will be promoting the power of patient voice in public service development
- ✓ Exploring joint public event with Healthwatch Lambeth on health and wellbeing of children and young people (December)

Visits to services

Healthwatch Southwark has carried out engagement visits to both Guys and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. These visits will take place on a regular basis through 2015/16 with the aim to:

- Provide feedback that is gathered independently, and given directly to the service
- Increase our presence so that we are able to speak with as many people as possible about their experiences of services

We have so far visited 2 sexual health clinics (at each Trust) and the transport lounge at Guys and St Thomas' NHS Foundation Trust.

Sexual health clinics:

- We spoke with 33 people; most people were there for a routine check-up
- What was highlighted as 'the best thing' about their visit was the interaction with staff (being friendly and respectful) and the timeliness of being seen
- Concerns were raised around the waiting times being long and confusion over how to get an appointment

Transport clinic:

- We spoke with 10 people
- Again, what was highlighted as 'the best thing' about their experience was the interaction with staff (kind and supportive)
- Concerns were raised around the complicated process of booking transport, long waiting times, not being given enough information, and having to travel a long way with strangers in the same care

Future plans

- ✓ Engagement at King's College Hospital NHS Foundation Trust's A&E department (October)
- ✓ Engagement at Guys and St Thomas' NHS Foundation Trust's Evelina Outpatient Department (October)
- ✓ Meeting with GP Federations to explore opportunities for engagement at both North and South Extended Primary Care Services

Item No. 10.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Safeguarding Children Board – Serious Case Review	
Wards or groups affected:		All	
From:		David Quirke-Thornton, Strategic Director of Children's and Adults' Services (Vice-Chair, Southwark Safeguarding Children Board)	

RECOMMENDATIONS

1. The board is requested to:

   a) Note the Serious Case Review Report at appendix 1.

   b) Comment on the key learning points from the Review at paragraph 10; their relevance for Health and Wellbeing Board member organisations; and the action that could be taken across the health and social care system to address them.

BACKGROUND INFORMATION

2. In March 2014 the Safeguarding Board considered a serious incident affecting a young person, Child R, and decided to undertake a Serious Case Review (SCR).

3. This is the first SCR in Southwark for five years and the first informed by *Working Together to safeguard Children 2013/15* and the new requirements in relation to SCR placed upon Safeguarding Children Boards.

4. The Serious Case Review took place between April 2014 and February 2015 when it was signed off by the SSCB subject to further anonymisation of the child's circumstances. Following careful consideration by the review panel, a police colleague and council lawyer to ensure it protects Child R's identity, the SCR report was published in August 2015.

5. Child R is a 15 year old girl who came into care aged 10 and has been looked after by the London Borough of Southwark for the past five years. Currently she lives with foster carers in Greater London and attends school locally.

6. In early spring 2014, R was invited to meet an older, predatory male at a hotel, where he allegedly raped her. The alleged assault was reported by R to her carers the same day and police action was taken to find and arrest the man. A criminal investigation and court process have concluded, in which the perpetrator was found guilty of a separate, lesser sexual offence against another young person.

7. This incident initiated the SCR. It was agreed to use the Welsh Governments Guidance for arrangements for multi agency child practice reviews as a methodology. This guidance complies with Working Together as it is systems based and offers a collaborative approach with agencies to surface the key themes and issues to develop an action plan to take forward the learning points arising in the case. The methodology included senior managers comprising a review panel considering agency chronologies and summaries, a learning event bringing together staff and managers involved across the partnership to consider the themes and issues emerging and informing the learning points.

8. The report has been shared at a number of events led by the SSCB, to take the learning to different parts of the borough and ensure that as many staff and volunteers are able to consider the messages of the report for their agency and their own practice.

KEY ISSUES FOR CONSIDERATION

9. The key points of learning from the Serious Case Review of Child R's case can be summarised as follows:

    1. Knowledge of a child's psycho-social history is essential for effective assessments and planning for children.

    2. In any agency, high turnover and sickness among workers and managers in a team carry the risk of loss of knowledge about cases and potential failure to carry out statutory duties.

    3. Many looked-after adolescents find it hard to trust and communicate with professionals who are tasked with planning for them, and helping to keep them safe – especially when their key worker changes frequently. This can significantly constrain the ability of workers (and the local authority, as 'corporate parents') to respond to the young person's wishes and feelings, and to meet their needs.

    4. Effective care planning for looked-after children requires input from all partners in the form of either attendance or appropriate reports for the LAC Review process. However, LAC Reviews, as smaller, child-centred meetings, do not provide a suitable forum for the full professional network of those who know about and are working with the child. Thus, there may be no regular opportunity for this network to share significant information and concerns.

    5. In addition, the LA needs to ensure that foster carers and the professional network are given full and good information about the determined needs of the child and the current plans, as well as relevant history. These actions can become more difficult for children placed out of borough.

    6. Partners in safeguarding networks continue to struggle with the timing and appropriate use of escalation procedures, often leaving unsatisfactory situations going on for too long.

    7. The choice, and timing, of local authority placements available for looked-after children does not always allow a matching of the child's needs to the

ability of the carers, especially for more complex and 'hard to place' adolescents.

8. Children and families cases will inevitably transfer to a number of different social workers and managers over time. For their work to be effective, case records need to include a genogram, an up-to-date chronology and a transfer summary.

9. The systems for sharing and transferring information about a looked-after child who moves schools do not always operate in a transparent and timely way.

10. Children missing from care are at greater risk of sexual exploitation, not only because of being outside of (corporate) parental control, but also because of the power and reach of social media.

11. There are potential tensions between Police and Children's Social Care, regarding their respective roles and responsibilities in relation to a looked-after child at high risk of harm. This can result, as in this case, in an impasse and an outcome which is not appropriate for the child, even in the short-term.

12. The power and lure of electronic social media carry a risk of harm, particularly to vulnerable young people, which cannot be removed by professionals working with these young people.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children	See link below	SSCB@southwark.gov.uk
Link: https://www.gov.uk/government/publications/working-together-to-safeguard-children		
Protecting children in Wales: Guidance for arrangements for multi agency child practice reviews	See link below	SSCB@southwark.gov.uk
Link: http://www.nspcc.org.uk/preventing-abuse/child-protection-system/wales/child-practice-reviews/		

APPENDICES

No.	Title
Appendix 1	Serious Case Review Report – Child R

AUDIT TRAIL

Lead Officer	David Quirke-Thornton, Strategic Director of Children's and Adults' Services (Vice-Chair, Southwark Safeguarding Children Board)	
Report Author	Rachel Flagg, Principal Strategy Officer	
Version	Final	
Dated	9 October 2015	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		9 October 2015

SOUTHWARK SAFEGUARDING CHILDREN BOARD

Serious Case Review Report
Child R

Author:
Sally Trench
Independent Lead Reviewer

CONTENTS

1. Circumstances that led to this Serious Case Review

1.1 R is a 15-year old girl, who came into care aged 10, and has been looked after by the London Borough of Southwark for the past 4 ½ years. She lives with foster carers in Greater London and attends school locally.

In early spring 2014, R was invited to meet an older, predatory male at a hotel, where he allegedly raped her. The antecedents of this meeting remain uncertain, but R said that a friend of hers had given the man her telephone number, so that he could contact her.

The alleged assault was reported by R to her carers the same day, and police action was taken to find and arrest the man. A criminal investigation and court process have now concluded, in which the perpetrator was found guilty of a separate, lesser sexual offence against another young person. The offence of rape against R remains untried, but is held on the man's records as a not-guilty plea.

1.2 Southwark Safeguarding Children Board (SSCB) decided to undertake a Serious Case Review (SCR), as the following criteria had been met:

(a) abuse or neglect of a child is known or suspected; and
(b) (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.[1]

2. Terms of Reference and the Welsh Model

2.1 The SSCB drew up its terms of reference for this SCR in April 2014, and circulated them to the DfE and Board agencies. They outline the model and process to be used for the SCR, the agencies involved, the learning areas to be addressed, and expectations about completion and publication of the report.

(The full terms of reference are attached as **Appendix 1**.)

2.2 <u>The Welsh Model for case reviews</u>

2.2.1 The 'Welsh Model' refers to Welsh Government guidance for multi-agency 'child practice reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected'.[2]

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[1] *Working Together to Safeguard Children*, 2013, and *Local Safeguarding Children Boards Regulations*, 2006 (Regulation 5)

[2] *Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews*, The Welsh Government, January 2013

It is intended to be used in conjunction with *Working Together*, 2013. The model can be used for all levels of case reviews, including SCRs.

The emphasis is on promoting 'a positive culture of multi-agency child protection learning and reviewing in local areas, for which LSCBs and partner agencies hold responsibility'.[3]

2.2.2 In a shift from the approach in traditional 'Part 8' SCRs, this model focuses on the involvement of agencies, staff and families 'in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability'.[4] Other key features include:

- A more focused, streamlined process with a shorter time period to be reviewed
- Consideration of the context in which professionals work in agencies, including 'culture', policies and procedures, and resources
- A **Learning Event** for all those involved in the case
- Exploring not only **what** has happened, but **why**
- Recommendations and actions to improve future practice

2.3 Individual Management Reviews

2.3.1 The SSCB requested Individual Management Reviews (IMRs) for this SCR, as well as a comprehensive multi-agency chronology. Both of these are features of the 'Part 8' methodology under the previous *Working Together* (2010). As a consequence, this SCR is a 'hybrid' of two models for case reviews.

The IMRs have produced extensive data from agency records about their activities in the two-year review period. The IMR authors, who are independent of management responsibility for this case, have also interviewed staff, with a particular emphasis on **avoiding hindsight**, instead trying to get a feeling for what it was like working with the young person at the time, and what was the context for their work.

The scope and quality of the data have resulted in a longer Overview Report than would normally be the case for a Welsh Model review.

[3] *Ibid*, Para 1.3
[4] *Ibid*, Para 1.4

2.4 Time frame for review

The Welsh guidance recommends a review period of no longer than two years. This is so that the learning is about recent, rather than historical, practice, procedures and agency circumstances. In this case, the time span chosen was just over two years:

1st February 2012 to 27th March 2014

This allowed the SCR to include an 'unsettled' period of placement disruptions, as well as the two subsequent longer and more stable foster placements. The end point of the review, just after the alleged sexual assault, was extended briefly to include initial agency actions in response to the incident.

A Summary Timeline of significant events was made.

2.5 Practice and organisational learning areas

2.5.1 The Welsh guidance offers a set of generic practice areas for exploration and analysis, and these have been adopted by the Board for this review:

- *Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. Establish how that knowledge contributed to the outcome for the child;*
- *Evaluate whether the care plan was robust, and appropriate for R, the family and their circumstances;*
- *Ascertain whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan;*
- *Identify the aspects of the care plan that worked well and those that did not work well and why. Identify the degree to which agencies challenged each other regarding the effectiveness of the care plan, including progress against agreed outcomes for the child. And whether any protocol for professional disagreement was invoked;*
- *Establish whether the respective statutory duties of agencies working with the child and family were fulfilled;*
- *Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).*[5]

[5] *Ibid*, Para 6.15

2.5.2 Further relevant questions were identified by the SSCB in relation to the individual case:

- *How well did professionals understand and manage the different risk factors influencing this case and the particular vulnerabilities of R, during the two years under review?*
- *How well did professionals hear the voice of the child in their work with R? And to what extent were her unique diversity needs met by services?*
- *Review of the application and use of children missing from home and care protocol and e-safety policy in this case.*

2.6 Lead Reviewers

2.6.1 There are two external Lead Reviewers for this SCR, both independent of Southwark. Sally Trench has a background in local authority mental health social work and children's social care, principally child protection. She is the author of many Serious Case Reviews, and has also chaired SCR Panels. She has been trained in traditional 'Part 8' SCRs and in the Social Care Institute for Excellence systems model 'Learning Together'.

Victoria Philipson has a background in local authority children and families social work, also principally child protection. She was a regional director for Cafcass, where she completed a number of Individual Management Reviews. She has been trained in conducting traditional SCRs.

2.7 Review Panel

2.7.1 This is made up of senior representatives of the agencies who were involved in the case. The names/roles listed below comprise the membership of the Review Panel for this SCR.

Name	**Role**
Pauline Armour	Head of Service: Early Help (interim), Education, Southwark Children and Adults Services
Jackie Cook	Head Of Social Work Improvement & Quality Assurance, Children's Social Care, Southwark
Registered Manager & Head of Compliance & QA	Independent Fostering Agency
Ann Flynn	Southwark Safeguarding Children Board (SSCB) Development Manager
Tina Hawkins	Senior Administrator, SSCB
Ros Healy	Designated Doctor Safeguarding, Guy's and St Thomas' NHS Foundation Trust (GSTFT)

Mark Hine	Detective Inspector, Child Sexual Exploitation Team, Metropolitan Police
Interim Service Manager	Safeguarding, Quality Assurance and Learning Development, Greater London Children's Social Care
Gwen Kennedy	Director of Quality and Safety for Southwark Clinical Commissioning Group
Russell Pearson	Specialist Crime Review Group, Metropolitan Police
Child Protection Manager	Children's Charity
Debbie Saunders	Head of Safeguarding Children Nursing, GSTFT

2.7.2 'The Review Panel manages the review process and plays a key role in ensuring the learning is drawn from the case'.[6] In this instance, the panel have worked with Lead Reviewers, to read and review the relevant documentation and analyse the material from the integrated chronology and the IMRs. The learning generated from the panel was considerably enriched by its mixture of representatives from core statutory services, and private and voluntary organisations.

Panel members are also responsible for supporting members of their agency to take part in the learning event.

2.8 Learning Event

A full-day learning event in early September 2014 was attended by over thirty professionals involved in this case, as well as the Independent Chair of the SSCB. The day was used to gather their information and views, via multi-agency small group discussions.

Written feedback from the participants reflected a general appreciation of the opportunity to reflect on the case with colleagues from across agencies. In response to the question 'What did you find useful about today?', here are two representative comments:

- *Being able to hear the different perspectives from the agencies involved. Being able to reflect on one's own practice – how I can improve it. It enabled discussion without looking at blame in that gaps could be identified. It also allowed for reflection on how everyone can improve.*
- *Being able to discuss with different agencies and colleagues openly and honestly the difficulties and challenges around LAC and Child R in particular. We are all saying the same thing but implementing it is the problem. Finance/IT Systems/ geography being some of the issues.*

Attendees were also asked to contribute ideas about 'key messages', and how to implement the lessons from this SCR. Their feedback was valuable, and demonstrated how multi-agency learning can be generated by such an event.

[6] *Ibid*, Para 5.20

2.9 Involvement of family members

R and her mother have been informed about this SCR. R has been invited to give her views about the services she received in the review period, and any other messages she would like the Review Panel and Lead Reviewers to have from her. So far, she has not wished to participate. This means that a significant avenue for learning is missing.

3. Family history

Family member	**Address**
Mother	London
Father	Abroad
Subject R	**Foster placement, Greater London**
Older sibling	London
Half-sibling	Foster care
Half-sibling	Foster care
Half-sibling	Foster care
Maternal Grandmother	Lives abroad/visits London

Members of the family have settled in the country at different times. Child R and her older sibling lived abroad until she was about 8 years old. At a later date the maternal grandmother settled in this country

A genogram is attached as **Appendix 2**.

3.1 Little is known of R's father. Child R and her older sibling were born in their mothers home country. R was left there in the care of her maternal grandmother as a baby, when her mother came to live in London. The family was fully reunited in this country by about 2007, with three younger half-siblings also being born during this period.

3.2 From 2002:

The family had no secure housing or finances in London, and often stayed with other relatives or friends. This meant that they moved a lot, resulting in instability for the children. Both Police and Children's Social Care (from 2002, when Mother's first child initially arrived in the UK) received referrals about criminality in the household, largely related to drug-dealing and other acquisitive offences, and neglect of the children.

R was the main target of her mother's abuse, which included emotional rejection and physical assaults. She was neglected and left in charge of her younger siblings; she was exposed to many adults who could have posed a risk to her.

R was made the subject of a Child Protection (CP) Plan in 2009. She ran away early in 2010, asking to be taken into care because her mother had beaten her. Her siblings were removed shortly after this, and all the children have been looked-after under Care Orders from that point onwards.

3.3 From 2010 (R's entry into care):

(NB, This summary does not include further information about the other children of the family, save to say that the younger children remain looked-after and are in long-term foster care. R's older brother is a care-leaver and lives independently in London.)

R has had an unsettled time in terms of placements, experiencing eight moves in care. There was a stable placement (spring 2010 to late summer 2011), which was followed by a period of highly unsettled behaviour and placement disruptions. In addition, R has now had a total of ten allocated social workers.

R was well supported for the move from primary to secondary school, and she did well in Year 7. A subsequent dramatic deterioration in her behaviour, both in school and in non-compliance with her foster carers, seems to have been prompted by reconnection with her mother and maternal grandmother, who arrived in the country in this period. School staff reported that R began Year 8 presenting and behaving in an entirely different way. Throughout the rest of 2011 and into 2012, she went missing from her foster carers on a regular basis, and her defiant and provocative behaviour in school gave rise to concerns about her vulnerability to sexual exploitation and to 'gang activity'. R was subject to an increasing number of fixed-term exclusions from school.

R's contact with her family – Mother, Grandmother and siblings – has been fragmented and at times entirely absent. This may be because she was, initially at least, blamed for all the children coming into care. However, especially during 2011, when her grandmother arrived in the UK, R began to return to her mother's home on a regular (but unregulated and unsupervised) basis. She continued to decline the proposed arrangements for contact with her younger siblings.

At the point where this case review begins, the school had made a complaint about the persistent lack of response from CSC to their concerns, in what appeared to be a breakdown in communication. R had had three disrupted placements, and one planned move, in the previous six months.

4. The Review Period (February 2012 to March 2014)

A brief narrative

4.1 At the beginning of 2012, R was in her 4th foster placement since coming into care. All of these had thus far been within Southwark, and this meant she did not have to change schools.

R was going missing on a regular basis from her foster home, and was often out very late – sometimes being dropped off by an older man. Details of her time out of placement were unknown, but it was believed that R was spending regular time at her mother's home, and/or staying out with friends. She had a poor relationship with her single foster carer.

4.2 After a placement breakdown in late February, a similar pattern developed in another local foster placement, with a couple. In addition, R's disruptive behaviour at school meant that she was at risk of a permanent exclusion. The school's concerns about the apparent risks to R – and her own risk-taking behaviour – led them to press CSC for a decision to move her away from London for her own protection. This move eventually happened, via another placement breakdown, in the summer of 2012.

4.3 R was next placed with white foster carers in a shire county, provided by the Independent Fostering Agency (IFA). This was R's first trans-racial placement. Shortly after this move, the carers' pre-arranged holiday meant that R was required to go for a fortnight to respite carers. She refused this move, and instead absconded to stay with her mother – as it transpired, for five weeks. Mother and daughter now insisted that they both wished for R to be discharged from care. An assessment to this end was considered by the local authority, but they argued that R should first be returned, via a Recovery Order, to her new foster carers, followed by an assessment of the viability of R returning to her mother. The Judge in these proceedings granted the Recovery Order, but also recommended that the LA find the means to move R closer to home.

4.4 At this time, Mother stated her intention to make an application to discharge the Care Order. This plan did not in fact transpire, and R stayed in her 6th placement without further disruption for two school terms (until April 2013), with only one further missing overnight episode, early on. She attended local school and appeared generally to settle well, and her foster carers supported her to make some local friends. Her relationship with her foster carers and their family improved and she did not continue to go missing. Contact with her family and home area was infrequent, at her own request.

At R's LAC Review in February 2013, R had written down her wishes and feelings, at the encouragement of her foster carers. She said she was '*unhappy with her life'* and again expressed her wish to return to her mother, or at least move nearer to her. However, she did not want to have 'supervised' or organised contact with her (this was proposed as weekly).

In April 2013, R went missing for a week, during which time she apparently stayed, or based herself, with her mother in Southwark. Upon her return to her foster carers, she made an allegation of physical ill-treatment against the female carer (later retracted), which prompted the end of the placement. R was moved to her current foster carers, in Greater London; this is also a trans-racial placement, provided by the same IFA.

4.5 R has remained in this same placement since that time. She attends a local secondary school, and has until recently used a Children's Charity in her familiar part of Inner London once a week. Her school attendance and performance are good, as are her behaviour and general responsiveness in her foster home. It is clear that R has a solid and positive relationship with these carers – the main carer being the male of the couple.

<u>Up to March 2014:</u>
Despite the stability that developed in this placement, R continued to stay out later than allowed on a regular basis, and went missing overnight on 12 occasions, once remaining absent for two nights. Her carers continued to work with her on keeping herself safe, and informing them of her whereabouts. However, in this placement, as in all others before, R remained unwilling to disclose any details about the identity of her friends, or about where she goes when she is missing. Thus, the risk of harm to her has remained unknown, and possibly very high – especially in light of the incident which led to this SCR.

4.6 In early spring of this year, R missed school – something which was entirely out of character for her – and agreed to go to a hotel to meet an older man, someone she didn't know. Reportedly, he had telephoned her and said he had got her number from a friend of hers. They met in a hotel, where he was said to have raped her. During this encounter, R made telephone contact with her foster carer, who notified the police; both foster carer and police spoke to R on her mobile phone whilst she was missing, and to the taxi driver who brought her home, thus retrieving some details about where R had been. The police were able to identify the man and to arrest him within the next 3 days.

(The details of how the man knew, or knew about, R and how he made contact with her have not been verified and remain unclear to the Review Panel. R has declined to talk to anyone about this.).

R was persuaded by her foster carers later that same evening to attend one of the Haven centres for the victims of sexual assault; she was seen and interviewed by staff there, but did not agree to full forensic examination.

The following day, R did not attend school, but did leave the foster home for several hours, from the afternoon through early evening. She stated this was because she did not want to undergo further questioning by the police. The same happened the next day, when R was out and not at school. Police were able to establish that the alleged perpetrator had been in telephone contact with her, and had put pressure on her not to talk to Police. Thus, she was at risk of witness intimidation, if not other threats to her safety. When she returned home on that second day, the Police determined that she could not be kept safe in this placement. They had considerable concerns for her wellbeing (especially because the alleged perpetrator was not yet in custody). Thus it was decided that Police should exercise their Powers of Protection, by removing R from the foster home to the police station, and proposing that she should be placed in Secure Accommodation. This was not agreed by the LA, and she was returned the following day to her foster carers. A Strategy Meeting was held to consider the investigation of the alleged sexual assault, as well as how to promote R's ongoing safety.

R had spent the night in the police station (not in a cell, but in a communal area). The LA emergency duty team were able to send a social worker to be with her through the night. Both R and her foster carers had asked for the male foster carer to accompany her to the station, but this was not permitted. The reasons for this prohibition have not been explained within the Police IMR.

5. Practice and organisational learning

A. Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. Establish how that knowledge contributed to the outcome for the child.

5.1 <u>What historical records and knowledge were available?</u>

Mother moved to the UK in 1999, but most services, apart from the Police, had no contact with her and the family until 2002. At that point, R's older sibling came to join his mother in London; this led to serious concerns about his welfare, due to his exposure to criminality and drug activities in her household. CSC intervened, firstly to accommodate him, and then to return him to his maternal grandmother when she was living abroad.

Details of R's developmental and care history from birth in 1998 to 2007 (care given by her maternal grandmother when she was living abroad) have not been recorded in any agency files and remain largely unknown.

By 2007, there were younger children in the family, when R and her older brother were reunited with their mother.

From this point, the family were known to universal services in London (schools, health), and to CSC and Police because of intermittent CP referrals, investigations and assessments. In 2009, there were reports relating to Child in Need Plans (for the younger siblings) and the CP Plan for R. The Police have records regarding raids on the various households where Mother lived, and charges against her and her partner(s) for a variety of offences, mainly to do with dealing in drugs and theft.

5.2 As often happens, the care proceedings in 2010/11 required the preparation of specialist assessments. In this case, a very full psychiatrist's report was especially useful in that it captured previously unknown information about the family history, obtained directly from the mother, grandmother, and children. It also highlighted the psychiatrist's assessment of R, and the impact of the abusive care she had experienced, as well as her exposure to other traumatic experiences as a young girl – e.g., being used to prepare and deliver drugs to customers, witnessing adult violence, and being left alone to care for her younger siblings. Anyone reading this report, and the judge's use of it in his final judgement, can be left in no doubt about the damage done to R and her degree of vulnerability (including to child sexual exploitation), as well as her need for therapeutic help.

5.3 What was known about R's history, and how was it relied upon in making plans for her?

This question will largely be answered in relation to CSC, where most of the relevant history was recorded and kept. The importance of records was particularly significant, because R was, and continues to be, reluctant to talk openly about her past and her family.

The CSC IMR found that the workers and managers directly responsible for R did not access the relevant records held by them which provide an account of her history. These included key documents: the earlier CP reports for CP conferences, the CP conference minutes, the assessments of R and her siblings, and the legal documents referred to above. As a result, R's psycho-social history, her own and her family's experiences, and the degree and nature of her vulnerability (including to child sexual exploitation) were poorly understood by those acting as her 'corporate parent', as well as by their multi-agency partners.

This affected plans and decision-making, which in many instances appeared to be reactive rather than considered and based on knowledge of R's complex needs.

The social workers relied on the records of R's recent LAC Reviews. These are essential documents, as they include the young person's wishes and feelings, and details of the current care plan. However, they do not include a picture of the child's history before coming into care, or the full journey in care.

5.4 In the view of the Review Panel and the Lead Reviewers, it is good practice for the allocated social worker to read and consider a child's history, especially where that child is looked-after by the local authority.

5.5 Without this basis for his/her care planning, the LA and partners are unlikely to achieve the best possible outcomes for the child.

Learning Point

Knowledge of a child's psycho-social history is essential for effective assessments and planning for children.

Recommendation 1:

CSC managers should use every opportunity (induction, supervision, training) to embed the requirement for the allocated Social Worker to read and understand a child's history, and for the worker's manager to prioritise and protect the time needed to do so. This message should be supported by guidance about key documents and the use of chronologies, to support better understanding of history and patterns.

A means of monitoring whether this has been done should be put in place for all children who are subject to a Child in Need Plan, Child Protection Plan, or Care Plan as a looked-after child.

Recommendation 2:

The audit template for CSC cases should include a question about the consideration of personal/family history in assessments.

5.6 The Review Panel wanted to know whether not reading a child's history had become accepted 'custom and practice', in a busy and pressured work environment. The responses we got suggested that, although this may have been an extreme example, it is not uncommon to work with a child or family without an informed and solid understanding of their history. (Other SCRs indicate that similar practice occurs very widely; this is not a Southwark-only problem.)

Why should this be so?

- Many paper files are archived, so there is a bureaucratic process, and some delay, involved in obtaining them.
- A number of key documents have not previously been scanned onto the Southwark electronic system (CareFirst). This is now improving, with stronger administrative support in the new structure (Social Work Matters).

- Social Workers and their managers are very busy and may not prioritise reading the child's history.

5.6 Specific team factors

(The problems in the Looked-after Children Team, and their impact, are described here, but are equally relevant to several of the other questions posed by the SCR, in the following sections.)

Severe difficulties in the Looked-after Children Team, during the time frame for this review, meant that their work was not carried out as it should have been. Sickness levels were high, and this included one of the two main social workers for R (allocated during 2012), who was off sick for a lengthy period, a practice manager (for several months in late 2012/early 2013) and a service manager (mid-2012). Overall, the team had a sickness rate of 20 to 25%.

Perhaps not surprisingly supervision was irregular for the SWs working with R during 2012 and 2013. This inevitably compounds the difficulties for a worker, who has less opportunity to reflect on her cases and to receive managerial guidance and support to prioritise and complete tasks.

The template for recording case supervision includes a question at the top of the page: 'Have you reviewed the case records since the last supervision?' In the records reviewed for R, this is consistently left blank by the supervisor, and again suggests a lack of the supervisor's time for careful file review.[7]

As a 'knock-on' effect of absences in the team, R's next allocated social worker was assigned an unrealistically high caseload – partly because she was covering cases for several absent colleagues – and was given insufficient guidance about what tasks she was expected to cover. There were no transfer summaries or full chronologies to support this additional work (See Para 5.14.6 below). To make matters worse, the team manager post changed several times during this same period, so that there was little continuity in the supervision and oversight of cases. Two of the acting managers were agency staff who were unfamiliar with Southwark. The Review Panel has not been told how or whether more senior managers took responsibility for assessing the risks to the team (staff and service users) during this extended period.

The impact of staff sickness and serial changes of managers in the LAC Team (2012 and 2013) clearly affected the service provided to R, her carers and other partners – and no doubt others as well. But while these circumstances account

[7] One other oddity is that several recordings, filed as 'Supervision' on CareFirst, contain a variety of different records, including emails, and minutes of meetings. This means that a list of 'supervisions' on CareFirst can mislead about the timing and number of actual supervision sessions with the worker to discuss the case.

for many of the lapses in practice, they do not suffice as an answer to 'what went wrong'.
The responsibility lies with the wider organisation to ensure that the highest priority statutory work continues to be carried out, even when services are under strain, and this clearly includes its duties towards looked-after children.

All organisations must anticipate the times when – inevitably – any team may become highly vulnerable, as in this case. This can happen for a variety of reasons, the most common being high sickness levels, or an unexpected degree of turnover, in workers and managers (both were true for this team). These circumstances are risky for all concerned, but especially for service users. It is the responsibility of individual team managers to deal with these matters routinely and to risk-assess the impact on the service provided. Senior managers need to receive reports to enable them to monitor and prepare for more critical situations in teams.

The recommendations given below try to set out what kinds of preparations might be needed. But there will be different circumstances in every organisation, and in every crisis, which means that details will have to be developed as required. This is even more challenging when resources are already under pressure. The main point is that these situations should not come as a surprise to anyone, and that organisations must develop ways to minimise the detriment to service users and colleagues (and the team members themselves). The Review Panel were told of the system in GSTFT Safeguarding Assurance Board, which has a regular item on its agenda about safeguarding team vacancy rates and how these are being managed.

Learning Point

In any agency, high turnover and sickness among workers and managers in a team carry the risk of loss of knowledge about cases and potential failure to carry out statutory duties.

Recommendation 3:

In order to manage the risks which arise from gaps and vulnerabilities in teams, managers in all agencies should have in place the following:

- **Communication to all levels of management (including the SSCB) when a team is experiencing high levels of sickness and/or rapid turnover of personnel.**
- **A template for risk management of work which is not being covered in the absence of team members.**
- **Communication about staff absence to service users and colleagues, in answer-phone and out-of-office messages, with alternative names, numbers and addresses for anyone trying to make contact regarding a case. More pro-actively, a letter should be sent to the child, family and members of the network when a worker is on long-term sick.**

- **Support for staff in a team experiencing extreme difficulties, as part of the 'risk assessment' of the team's circumstances.**

B. ***Evaluate whether the care plan was robust, and appropriate for R, the family and their circumstances;***

C. ***Ascertain whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan; and***

D. ***Identify the aspects of the care plan that worked well and those that did not work well and why. Identify the degree to which agencies challenged each other regarding the effectiveness of the care plan, including progress against agreed outcomes for the child. And whether any protocol for professional disagreement was invoked.***

(The IMRs' and the Review Panel's analyses of these three areas of practice overlap to such an extent, that it seems best to comment on them together in one section.)

5.7 R's Care Plan was comprised of most of the required elements, touching upon her health, education, practical and emotional needs; a gap has been noted in relation to the attention given to her sense of 'identity'. Both her current and future care was thought about at her LAC Reviews.

In terms of wider planning, a clear and pro-active approach to R's placements was lacking, as most of these were unplanned and appeared to rely on 'what was available at the time'. (See also Para 5.13). There was a muddled decision to proceed with a 'Placement with Parents' assessment when R refused to leave her mother's home for five weeks (August 2012). This appears to have been proposed without a proper risk assessment of Mother's household, possibly because the LA was unsure of obtaining a Recovery Order for R, in order to return her to placement. In fact, Mother was staying in a friend's house, and she was sharing a bed with R. The possibility of Mother applying to revoke R's Care Order continued to be mentioned at R's LAC Reviews for the next year, indicating to all concerned that her future as a LAC was still in some uncertainty.

The Review Panel were told that R continues not to understand her Care Plan, and has a persisting anxiety about whether her current placement will be 'permanent'. It is likely that, while professionals may understand the idea of permanence conferred by a Full Care Order, permanency about a placement can be blurred. And we know that for R, the future security of any placement has become difficult to believe in. In addition, there may be a further obstacle to assuring a young person like R that she will remain in a placement with an IFA, because of funding implications. LAC Reviews should be as transparent as possible about the longer-term commitment to a placement where the child

might remain until age 18, and this message should be clearly conveyed to the child.

R's Care Plan was reviewed at the required frequency. However, there was a delay for most of these in sign-off by the Team Manager, and it must be assumed that they were not uploaded onto CareFirst in a timely way. A section below (Para 5.9) deals with the lack of sharing of these records with relevant partners.

R's LAC Reviews benefited from having a consistent IRO, who knew the case well. It is she who recognised R to be 'an emotionally vulnerable young person…despite her external bravado'.

However, the Review Panel has found that there were significant factors which affected how well the plans for R were implemented. These are described below.

5.8 R's lack of participation

R is of an age and understanding to be an active partner in her care planning, something which can help professionals immeasurably in trying to do a better job for a young person (YP). R has attended her LAC Reviews and listened to what was being said, but she has been unable or unwilling to participate actively in this process. There have been examples of her last two sets of foster carers helping her to write down her wishes and feelings, and these have been important contributions.

In relation to the actions which are proposed in order to meet her needs, she has refused or postponed most of these (counselling, life story work, use of an independent advocate and contact with family members). Working with R to engage her more positively is addressed in more detail in Para 5.22 below.

Many professionals involved with R have commented on her reticence, her lack of engagement, and her stated mistrust of professionals from the core statutory agencies. Perhaps because of her ambivalent feelings about her care status, she has been especially resistant towards her social workers and the IRO for her LAC Reviews.

This has not been helped by R's changes of social worker in the past 4 ½ years (there have been 10). The level of turnover in inner London CSC social work teams is very high (NB, not currently true for Southwark), and we have already noted that the team in question previously had particular pressures which led to even greater inconsistency in the allocated worker. It would be hard for any young person to develop trust and a more open relationship with her key worker under these circumstances.

It has emerged from the Learning Event that R responds better to workers in some settings, such as the specialist staff from the Independent Fostering

Agency, who have conducted many of her 'return interviews', and who have done one-to-one 'life style' work with her. She has also been more open and positive in how she works with mentors from the Children's Charity.
It may be that these organisations are perceived by R as having less authority over her, so that she can retain a sense of her own control and privacy.

Her current foster carers have invested a huge amount of time and effort to building a good relationship with R, on the principles of trust and respect. This has borne fruit, in that R has settled well with the family and is beginning to 'open up' to her main carer about her time outside the home. She now spends most of the time at home with her foster family, and her school attendance continues to be excellent. She has at least one significant local friendship – a new development.

Learning Point

Many looked-after adolescents find it hard to trust and communicate with professionals who are tasked with planning for them, and helping to keep them safe – especially when their key worker changes frequently. This can significantly constrain the ability of workers (and the local authority, as 'corporate parents') to respond to the young person's wishes and feelings, and to meet their needs.

Recommendation 4:

Looked-after children's reviews should identify a named person who is best placed to enable the child or young person to communicate their wishes and feelings. That person should be able to link closely with the child's key worker in children's social care, who represents the local authority's responsibility for the child or young person.

5.9 Care Plan not shared among multi-agency partners

This was a significant finding in this case review[8]. R's last two foster carers received little background information about R from CSC upon her arrival, and were never provided with a copy of her current Care Plan (as reflected in her most recent LAC Review). This left them without the full information they needed to care for R in the best possible way. This changed little over time: although they participated in each LAC Review, they often did not receive a record of the decisions made (although they kept their own notes of these meetings).

[8] A similar finding was found in a recent review, *London Borough of Southwark Safeguarding Children Board: Child P: An Overview of Services Provided,* Smith F, July 2013 (unpublished report), Para 7.3.3.

Key information was not regularly shared by CSC among the partners working with R, and as a consequence other agencies remained working in their own 'silos' and not in-putting to the Care Plan. They operated without a shared understanding of R's history and experiences of abuse, change and loss, and even of her current circumstances. This was true for health professionals (e.g., the GP who carried out her Review Health Assessment in 2013) and for her schools, especially the school outside London which had no contact from CSC, and inexplicably did not receive R's education file. They relied on R's foster carers for information about R.

Some Personal Education Plan (PEP) meetings were held for R, but none resulted in a written-up plan over the two years covered by this case review. This meant that the record of decisions was not distributed and available for use as a working document for R.

It seems inescapable that many essential partnership activities, not least all kinds of communication, work less well when a child is placed out-of-borough. The IMR for Guy's and St. Thomas's NHS Foundation Trust noted that 'LAC Health Assessments of children placed out of borough in 2011/2012 seemed fragmented', and the Review Panel were told that this continues to be the case. CAMH Services are not offered to looked-after children who are placed out of borough, nor is CareLink, a service which works to support foster carers. Generally, establishing good working networks and reliable delivery systems for these children is a major challenge, given that between 70/80% of looked-after children from inner-London authorities are placed outside of their area.

5.10 <u>Limited membership of LAC Reviews</u>

5.10.1 In recent years, local authorities have aimed to make their practice with looked-after children less formal and more 'child-centred'. As a consequence, LAC Reviews have usually become smaller, reflecting the child/YP's wishes about who should be included in something as personal as their LAC review. This is defined as good practice in the IRO handbook (national guidance).

In this case, we have been told that R was not comfortable with being a 'LAC', and was distrustful and even resentful of professionals, at least those in the statutory agencies. For all these reasons, most of R's six-monthly reviews included only her foster carers, R herself, and her social worker (in one instance, school was represented and Mother also attended). For recent LAC reviews, the Independent Foster Agency carers have completed a set of reports and presented these. Other agencies, including those significant for R (e.g., the Children's Charity involved) were not part of the discussions, and it is unclear what, if any, reports they were asked to contribute.
CSC instigated little communication with the Children's Charity, the agency who probably knew the most about R and her peer group back in Southwark.

What we do know, as noted above, is that the network of agencies involved with R were not made aware of the plans made in these reviews – plans which would almost certainly reflect their actions with R.

R's social worker was said (by the IRO) to have consulted with R's mother before each LAC Review, 'to feed her views into the review, but there is no record of these consultations in the LAC review records and it is not clear whether this actually happened'.[9]

5.10.2 The child-focused format of LAC Reviews creates a systems problem, when a wider meeting of professionals in the network is needed but there is no routine occasion for this to happen. In this case, R was the subject of serious and on-going concerns in several of the agencies who worked with her. The professionals from these agencies – workers and their managers – held often discrete sets of information, and needed an opportunity to share these and their concerns arising from their contact with R or her family. Because the LAC Reviews did not serve this purpose, a separate meeting was required, along the lines of a Team around the Child (TAC), or simply a professionals meeting.

Learning Point

Effective care planning for looked-after children requires input from all partners in the form of either attendance or appropriate reports for the LAC Review process. However, LAC Reviews, as smaller, child-centred meetings, do not provide a suitable forum for the full professional network of those who know about and are working with the child. Thus, there may be no regular opportunity for this network to share significant information and concerns.

In addition, the LA needs to ensure that foster carers and the professional network are given full and good information about the determined needs of the child and the current plans, as well as relevant history. These actions can become more difficult for children placed out of borough.

Recommendation 5:

The allocated Social Worker should provide the most up-to-date Care Plan for a looked-after child to carers upon placement, along with a current risk assessment (regarding missing from care).

[9] IMR from CSC, Para. 8.3

Recommendation 6:

For each looked-after child, Children's Social Care should maintain a list of partner agencies who are working directly and regularly with the child, in order to a) obtain a report for the LAC Review, where appropriate; and b) send a copy of the child's updated Care Plan after each LAC Review. This should include private and voluntary organisations.

Recommendation 7:

The DCS should undertake an evaluation of the support for and active work with LAC placed out of borough, to establish whether these children receive an equitable service compared with children placed within Southwark.

Recommendation 8:

CSC should arrange for a separate meeting for the child's professional network, outside the LAC Review, in the following circumstances:

- **The child's move out of borough (where possible, to include 'old' and 'new' professionals in the child's network)**
- **The child going missing on a regular basis (as a Missing from Care Strategy Meeting)**
- **The need to share serious concerns and information about the child, including significant lack of progress in elements of the Care Plan, which means that the child's needs are not being met.**

Such a meeting can also be requested by any member of the network.

This meeting could take the form of a pre-meeting in conjunction with the child's LAC Review.

5.11 Lack of progress on actions from LAC Reviews

The Review Panel noted that some elements of R's care plan remained the same, but without any progress, over the time span of several reviews. In some instances, this was because of R's reluctance to accept services. In at least one other case, it was because there had been a delay of several months in the Social Worker making a referral (for additional tutoring for R).

It may be helpful in future to make it clearer in the LAC review records why some items continue to appear over time, without being implemented.

The IRO for R explained that she 'rolled over' a number of uncompleted actions so that they would not be forgotten, and so that they could be discussed at each review. She did ask for the completion of outstanding processes, such as the Review Health Assessment. Where there is lack of progress, the reasons for this need to be made clear, so that they can be challenged or escalated as required.

5.12 Limited communication by CSC with partner agencies

The staffing problems and workload pressures in the LAC Team (described in Para 5.6 above) inevitably affected how well social workers and their managers were able to communicate with partner agencies.

The IMRs from Education and Independent Fostering Agency describe a persistent and depressing pattern of trying and failing to get responses from Southwark CSC, regarding their concerns about R. During Year 8, R's first secondary school regularly contacted CSC about incidents and behaviour by R which suggested that she was possibly involved in 'gang-related activity', and at risk of sexual exploitation. She had a number of fixed-term exclusions and was at risk of permanent exclusion, based on her disruptive behaviour in school. The Education IMR notes seven instances of formal, and increasingly serious, communication about R from the school to CSC, where there was '*no evidence of action and feedback following the sharing of these concerns'*.

After several months, a letter from the Vice Principal of the school, to the CSC Service Manager, and a formal police notice (Merlin) sent to CSC finally resulted in a 'high risk case/strategy meeting', including Police, school and carers. This was an appropriate use of 'escalation', though it could have happened sooner. At this meeting, one decision was that a 'Missing from Care Strategy Meeting' should be held; this did not happen. Shortly after, R moved away from London and from this school.

For those working with R, frustration about not getting a response from CSC staff generally resulted in arrangements for bilateral foster carer/school communication, and this became the default position during much of the next two placements, including the first move out of London. At this point, the concerns about R's behaviour had reduced, and there was perhaps a sense that she was now safer at some distance from London. After the initial Placement Planning Meeting, and a LAC Review, there was no contact at all from CSC with the child, the carers, or the school for a period of almost three months. The school had no information about R's history, either from CSC or from the (missing) school file, apart from that provided by the foster carers.

A recent Southwark case review (Child P, 2013) noted similar 'poor communication between agencies' as a recurring issue. In that case, the placement distance out of borough was even further and more difficult to manage.

The Review Panel discussed why there may be a reluctance to use escalation procedures, perhaps because of reluctance to 'get colleagues into trouble', or a feeling that it wouldn't do any good. This is an issue which needs greater attention, given the impact of letting an unsatisfactory situation continue. The outcome for the child is likely to be worse and relationships among professional partners likely to deteriorate.

Recommendation 6:

For each looked-after child, Children's Social Care should maintain a list of partner agencies who are working directly and regularly with the child, in order to a) obtain a report for the LAC Review, where appropriate; and b) send a copy of the child's updated Care Plan after each LAC Review. This should include private and voluntary organisations.

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The DCS should undertake an evaluation of the support for and active work with LAC placed out of borough, to establish whether these children receive an equitable service compared with children placed within Southwark.

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- **The child going missing on a regular basis (as a Missing from Care Strategy Meeting)**
- **The need to share serious concerns and information about the child, including significant lack of progress in elements of the Care Plan, which means that the child's needs are not being met.**

Such a meeting can also be requested by any member of the network.

This meeting could take the form of a pre-meeting in conjunction with the child's LAC Review.

5.13 R's placements

R has had 7 placements (plus two respite placements) since her entry into care in January 2010. The joint authors of the CSC IMR are strongly critical, and comment that

'The clearest failing of the care plan has been in finding a suitable long-term placement for R.' (CSC IMR, Para 8.4)

They suggest that some of R's carers were not suitable to meet her needs, but were likely chosen because they were the only local resource available when the previous placement disrupted.
The Review Panel were told by CSC colleagues that this is often the case for older children, especially those deemed 'hard to place', in comparison with the more careful matching of younger children with their carers.

Such decisions are inevitably constrained by capacity in the service. Resources issues (staff and placements) represent significant challenges to all local authorities, and inner-London boroughs probably contend more than most with a lack of local placements, because of the availability of housing space. There is thus a tension between a desire to keep a child within her local network/school, and the ability to achieve this with suitable and skilled carers for the most vulnerable children. In R's case, her vulnerability was now, as an adolescent, expressing itself increasingly as demanding, non-compliant and aggressive behaviour – something which most of her carers were ill-equipped to deal with. This supply/demand imbalance was reflected in the numbers of older children for whom an IFA placement is sought; Independent Fostering Agency reported that most of their referrals are for LAC aged 11 to 15, with complex needs and challenging behaviour.

Clearly, a proper assessment at the outset of R's high level needs (which were fully explored and set out during the care proceedings) should have guided the choice of placement. This might have led to more stability for R. But even this is hard to state categorically, as R herself was torn between her feelings about her family and friends, and a desire to settle in foster care.

The use of the Independent Fostering Agency for the last two placements has been positive, as this IFA has experience and skills in working with children and young people who are hard to reach, distressed, and affected by experiences of poor and abusive care in childhood. Their carers are very well supported by a team of professional colleagues who provide extra input to the child in placement, if needed. In this case, Return Interviews have regularly been carried out by a consistent person from the Independent Fostering Agency, and the same member of staff has done successful 'Life Style' work with R.

Learning Point

The choice, and timing, of local authority placements available for looked-after children does not always allow a matching of the child's needs to the ability of the carers, especially for more complex and 'hard to place' adolescents.

Recommendation 11:

Every LAC Review should set out the child's needs and how well the

placement is meeting these, including identity and diversity needs. This information should be collated so that the LA can monitor its responsibilities as corporate parent.

E. ***Establish whether the respective statutory duties of agencies working with the child and family were fulfilled; and***

F. ***Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).***[10]

5.14 The previous sections have outlined a number of deficits in how (principally) CSC acted as corporate parent to R. The following duties were carried out appropriately.

- **LAC Reviews** were held as required.
- With some exceptions, **boarding-out visits** were made to R every six weeks, as required during the first year of a placement.
- Apart from one extended gap between placements, R's **schooling** has been provided and has been a positive part of her care experience. Her attendance in her last two schools has been excellent, and she is learning well.

Other statutory duties have not been fulfilled, and these are described below, with some analysis of why this should be so.

5.14.1 Annual Personal Education Plans (PEPs) were not completed during the case review period.

PEP meetings were held (apart from during the period in School 2), but the agreed decisions and plans were not written up, distributed to those attending, or uploaded onto CareFirst. There is no explanation for this omission, apart from the workload pressure on workers, or the absence of the allocated social worker on sick leave.

The CSC electronic recording system CareFirst has a section ('Assessments/Forms') which lists the statutory requirements for looked-after children, with templates for recording these actions. This window in CareFirst enables the worker and manager to see what is due to be completed, and whether this has happened, and when.

The Review Panel were unable to discover how or whether this is used as a performance management tool, but consider that it offers a means of supporting effective work both in individual cases and more broadly, and of tracking the completion of required duties towards a looked-after child.

[10] *Ibid*, Para 6.15

5.14.2 Gaps in LAC annual Review Health Assessments

The IMR for Guy's and St. Thomas' NHS Foundation Trust covers the provision of LAC medicals (called either the Initial Health Assessment, or the annual Review Health Assessment, or RHA[11]).

The author states that:

> *The statutory duties with regard to R's Health Assessments were not fulfilled. The Designated Doctor's LAC health records had no indication that the 2011 and 2012 RHAs had been completed; this goes against the statutory guidance. This is a systems issue in terms of monitoring and tracking of assessments.'*

She goes on to speculate that systems difficulties are greater when the child/YP is placed out of borough.

The LAC Health Team have tried to instigate a system which would allow them to track all Southwark LAC, but have not had the resources to develop a system with CSC.

In relation specifically to R, it appears that she did have a RHA in 2011, but not in 2012. It is the responsibility of the SW for the child to request this from the designated doctor for LAC/community paediatricians or from the GP or specialist LAC nurse as indicted on the child's previous IHA/RHA.

In 2013, R had a further RHA. This was sent to the Specialist Child Health LAC team in a timely way so that the "Part C" health summary could be written, but the Health Summary was not completed and distributed to partner agencies for a further four months.

Similar to the problems in the CSC LAC Team, there were significant periods of sickness absence in the specialist child health LAC medical and administrative teams during the period under review.

These circumstances appear to echo those of a similar Southwark case reviewed in 2013 (Child P). The independent author of that case review made the following recommendation:

> *Children's Social Care should, in co-operation with Health and Education partners, review current arrangements under the Care Planning, Placement & Review (England) Regulations 2010, for forwarding of child health records to*

[11] For looked-after children under 5 years old, the RHA is required 6-monthly; for over 5s, it is done annually.

the relevant 'area authority' and arrangements for health assessments (initial and review)…for children placed out of borough.[12]

5.14.3 The Greater London borough where R now lives was not informed of her placement in that area, as is required.[13]

In Southwark, a member of the placements team normally sends the required notification letter to the local authority where the looked-after child or young person has been placed. At the same time, the details of the placement are loaded onto CareFirst, and a record is kept of the letter to the other local authority.

These are routine tasks which were not done when R moved back into the Greater London area; there is no explanation for this omission. An exactly similar omission was noted in the recent case review of Child P (Para 7.3.3). The Head of Social Work Improvement and Quality Assurance has since requested that the Placements Team Manager audit 20 recent placements to find out how compliant the system is generally, and whether there any weaknesses which might lead to omissions, such as occurred in this case.

5.14.4 Gaps in records

The IMR for CSC highlights the following gaps:

- There is no chronology or genogram on R's file. Both of these are expected to be provided for all children who are clients of CSC, but they are often not completed or updated and on file.
- There are no fostering records during R's placement (29/11/11 to 25/2/12). This leaves in doubt the support which the carer at that time was receiving from the fostering service.
- The CSC records, for the critical 5 weeks when R was absent from care (August 2012), are unclear. The plan for this unauthorised arrangement included twice-weekly visits, announced and unannounced, as a way of monitoring the risk to R. The records do not say whether these visits happened.
- Generally, minutes of meetings, including LAC Reviews, were not uploaded onto CareFirst in a timely way. This meant that, in the absence of the

[12] *London Borough of Southwark Safeguarding Children Board: Child P: An Overview of Services Provided,* Smith F, July 2013 (unpublished report)

[13] Where a Child Looked After is placed in the area of another local authority (regardless of the type of placement), the Arrangements for Placement of Children (General) Regulations 1991 (Regulation 5) requires that notification is made by the placing authority to the local authority's children's social care service where the child is living. (The education service and the relevant health trust for the area in which the Child Looked After is placed must also be notified.) The notification will include the address where the child is placed.

allocated SW or manager, there was insufficient up-to-date 'guiding' information for anyone needing to know about or take action in this case. (The CSC representative on the Review Panel could not comment on whether this was individual weak practice, or more widely the case in the service.)

- There are no written transfer summaries, a real problem for the different social workers who took on R's case. The case review of Child P (2013) recommended that

  'The extent to which case transfers are informed by a written handover and briefing requires monitoring, if necessary by means of amending existing case audits schedules'. (Recommendation 4, p.51)

Learning Point

Children and families cases will inevitably transfer to a number of different social workers and managers over time. For their work to be effective, case records need to include a genogram, an up-to-date chronology and a transfer summary.

Recommendation 12:

The CSC case audit template used by the QA team should include questions about compliance with the departmental requirements for genograms, chronologies and transfer summaries. The quality of transfer summaries should be monitored.

5.14.5 Problems in transferring information between schools

The author of the IMR for Education comments on the '*lack of effective systems to document and track the transfer of school files*'. R's moves of schools (she attended three schools during the case review period) revealed various problems in transfer of information. School 1 say that they sent R's education and CP files to School 2 (outside London), who never received these. School 2 did not provide transfer information to School 3. However, the 'missing' files from School 1 eventually turned up in School 3, without material about the intervening two terms in the shire county.

The IMR author for Education has done everything possible to try to find out about how R's files went astray, without success.

Learning Point

The systems for sharing and transferring information about a looked-after child who moves schools do not always operate in a transparent and timely way.

Recommendation 13:

The Director of Education and education team managers should agree and then implement a protocol in relation to the transfer between schools of Looked After Children's education records to ensure that a robust, well tracked procedure is in place across all Southwark schools. The protocol should include a clear line of communication and escalation should information not be received in a timely manner by the admitting school. Ideally transition meetings between professionals from the outgoing and the new school should be built into the process to ensure that learning and support needs are shared prior to the child joining the new school.

5.14.6 Missing from Care procedures were not followed

No Missing from Care Strategy Meetings were held during the two-year period of this case review. The required 'return interviews' were carried out by R's social workers when she lived in Southwark, but these did not continue when she moved out of borough. These issues are explored below, from Para 5.16 onwards.

G. ***How well did professionals understand and manage the different risk factors influencing this case and the particular vulnerabilities of R, during the two years under review?***

and

H. ***Review of the application and use of children missing from home and care protocol***

5.15 Understanding of R's particular vulnerabilities

The first point, remade here, refers back to the initial question in the Terms of Reference (Paras 5.1-5.6): *Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making?* Because this was not the case, those involved with R had a limited understanding of the degree and nature of her vulnerability.

R was undoubtedly affected by her troubled personal history, contributing to her lack of secure attachments, mistrust of those in authority, and a weak sense of her own worth. All these underlie her vulnerability, which was heightened when she was missing from care, and her whereabouts and her activities were not known. Sadly, she has for some time been resistant to the idea of therapeutic help regarding her childhood experiences. Better engagement by CSC with the Children's Charity (where there was early on a very strong attachment from R) might have allowed the LA to build on R's positive relationship with the workers there in order to facilitate R's agreement to therapeutic help.

There has been little apparent awareness of R's risk of sexual exploitation when missing, despite her previous sexualised behaviour and the concerns this raised at the time.

5.16 Missing from care episodes

5.16.1 Southwark Safeguarding Children Board has a multi-agency Missing from Care policy (2012), which is being updated in response to the Metropolitan Police's pan-London protocol, 2014[14]. The current policy covers good practice in relation to reporting missing episodes; the role of carers, CSC and Police in responding to the return of a missing child/YP; the guidance given to children at risk of going missing; and the maintenance of an updated risk assessment for each child/YP.

The section below addresses how well this policy has been followed in relation to R. What is clear is that she has received consistent advice about keeping herself safe, from her carers and other the Independent Fostering Agency staff, her social workers, police officers, her Independent Reviewing Officer (IRO), and staff at the Children's Charity. Arrangements were in place to transport her safely[15] to the evening group she attended back in Southwark on a week-end night (though, oddly, not home again afterwards; this has now been rectified).

5.16.2 During the two years under review, R's patterns of going missing from care varied considerably. From early 2012 until her move away from London, she was regularly outside the care and control of her foster carers. She frequently returned to her placement very late, or was missing overnight (or longer). There was some evidence of potential CSE (R having unexplained amounts of money, being 'dropped off by an older man').

Police responded to all incidents as required – by visiting R and speaking with her, and also by creating a Merlin report for CSC.

However, records from this period suggest that Southwark's Missing from Care Protocol[16] was not being followed in other respects, and this omission was noted in a 'High Risk Case Meeting' held in June 2012. The required strategy meetings were not being held, and return interviews by a social worker[17] were not being carried out consistently, especially when R moved out of borough. The LA was reminded that a strategy meeting is required when a looked-after child is missing for more than 24 hours, and should be considered when there is an on-going pattern of shorter 'missing' events.

5.16.3 R's foster carer (from April 2013 onwards) regularly notified the Police when R was missing. Police records show that they produced Merlin reports and carried out return interviews on every occasion, apart from a handful when they were

[14] *Pan-London Child Sexual Exploitation Operating Protocol*, Metropolitan Police, February 2014

[15] Ladycabs, a taxi firm using female drivers, are routinely used in such instances.

[16] *Southwark Safeguarding Children Board – Multi-agency Protocol for children missing from home and care*, January 2012, Para 8.2

[17] An independent organisation has recently been contracted to provide this service – see below, Para 5.16.5.

informed that she had returned within a few minutes of having being reported as missing (out later than her required time of return)[18], and the record of the report had not yet been formalised.

What was routinely missing was the second, independent Return Interview by the young person's social worker, which is designed to provide a more in-depth picture of the missing episode and levels of risk, as well as giving an opportunity to offer support and guidance to the young person.

In some instances for R, this was conducted by a dedicated worker from Independent Fostering Agency, where this service has been developed (see Para 5.16.6 below).

Major resource implications for Police

The growing incidence of missing episodes – locally, across London and nationally – has major resource implications for the Police. In the case of R alone, there were 20 missing episodes reported between 2010 and 2012; during the review period, there were a further 33 reports, all of which required a police response. Considering the numbers of looked-after children in Southwark alone, as well as around London and across the country, this is a major burden in terms of capacity for Police, not least because it may often involve officers at night when there are other pressing matters to be dealt with.

5.16.4 In August 2012, R was away from her placement for 5 weeks and staying with her mother. This situation was minimally assessed, with a Police check, not from the usual source of CAIT, about the household where Mother and R were staying. This provided a less rigorous and in fact misleading account of potential risks, given Mother's past police record and the findings in the Care Proceedings the previous year. There was no risk assessment completed for R. Guidance for such an assessment is given in Appendix 4 of the Missing from Care Protocol.

5.16.5 There followed the placement outside London, when, with one brief exception, R did not go missing for 8 months. Her school attendance was very good and she settled well with the foster family.

In April 2013, R suddenly absconded for a week, communicating by text with her carers that she was staying with her mother. R was visited (a welfare check) by Police who found her to be safe and well. R was also seen in the local Southwark CSC office once during this period, when she was advised to return to placement. She was not visited at home by a SW, nor was there a 'return interview' by a SW upon her return to placement. Was this because she was not seen as 'missing'? As before, there was no risk assessment of the care Mother was providing, or indeed whether R was actually staying with her mother most or all of her time. (In fact, R absconded from her mother's home for 24 hours during this week, and the records state that 'no one is aware of her whereabouts' – CSC files.)

[18] Agreeing definitions of 'missing' and 'absent', and the respective roles and expectations of different services should be clarified within the local Missing from Care protocol.

The current Southwark Missing from Care policy describes who should carry out Return Interviews ('an independent person…who is able to build up trust with the young person'[19]).

Recent change: Southwark CSC has just commissioned this service, commencing 1st October 2014, from St. Christopher's, a voluntary organisation experienced in working with young people in this area.

5.16.6 In R's next (current) placement, in the 12 months to the end of April 2014, she stayed away overnight 11 times, and was away for 2 days on one occasion. The management of these episodes has included an agreed rule about reporting R missing ('when she is 10 minutes late home'). This was based on her continued refusal to tell her carers or anyone else where she goes, and with whom, when she is absent from her placement.

Her foster carers reported her missing scrupulously, and Police carried out welfare visits when she was returned (and sometimes telephone 'debriefs' with her while she was missing).

As already stated, return interviews have not been consistently undertaken by the local authority Social Workers. The Independent Fostering Agency uses a specialist worker on a regular basis to conduct these, and two members of their staff have offered this service to R and made a good connection with her. However, the Independent Fostering Agency have not viewed this as a substitute for the local authority's responsibility to conduct such interviews.

5.17 Assumptions made

The Learning Event highlighted what had already been suggested in the IMRs, which was a belief that 'R wasn't really missing'. For one thing, her behaviour was in many ways typical of most teen-agers, who want more independence and who are not always obedient to their parents' wishes. In R's case, the lower sense of risk seems to have been because a) she always (almost always) returned to her placement; b) she kept in communication with her carers (usually) ; and c) she had a plausible and consistent story about where she was – either with her mother or with friends. But these stories were not verifiable, and none of these circumstances meant that R was known to be safe.

There are two other flaws in the assumptions about what was happening to R when she was absent from her placement:

- Information about Mother and her care of R described a poor relationship and abusive and neglectful care. R was at risk of exposure to criminality relating to drug-dealing. There should not have been an assumption that Mother could act as a safe carer in a safe household.
- R's friends were not identified, so it was not known where she was staying and in what circumstances.

[19] Southwark *multi-agency protocol for children missing from home and care*, Southwark Safeguarding Children Board, January 2012

Various partners, including the Police and possibly foster carers, may take a different view of risks, depending on what they have been told about the child's likely whereabouts. The Review Panel were told that Police may see a child as lower risk if they go missing a lot, but also regularly return to placement. These different views need to be discussed in a multi-agency forum in order to be shared and challenged – especially in the light of increased understanding (e.g., from the Rotherham Inquiry[20]) of the risks for looked-after children who are regularly away from placements late at night or overnight, as was true for R.

5.18 Lack of risk assessments and Strategy Meetings

Perhaps partially as a result of the assumptions above, the required 'Missing from Care' Strategy Meetings were never held, and an up-to-date risk assessment regarding Missing from Care was not placed on R's file. (A similar failure was identified in the case review of Child P[21], where missing episodes were not recorded on CareFirst.) This seems an extraordinary omission, given the frequency of R's time away from placement (either coming home very late, or staying out overnight), and her degree of vulnerability. It seems that each incident was regarded in isolation, and the pattern of going missing was not understood and evaluated by the network.

LAC Reviews discussed R's time out of placements, and the IRO recorded that her 'frequent unplanned contact with Mother and grandmother was a cause for concern'; but this did not lead to a risk assessment of the contact or any other related action. The reasons for this are not known, apart from the (already outlined) lack of capacity in the LAC Team.

When R was still placed in Southwark (2012) and when concerns about CSE were emerging, a referral was made for her to be discussed at the Multi-Agency Sexual Exploitation (MASE) Panel. This was turned down because at that time, a case without a named perpetrator would not be considered. The Review Panel has learned that the way the MASE operates has been altered, in response to the Metropolitan Police Operating Protocol, 2014. There are now two levels of this structure: a multi-agency strategic group, and a multi-agency panel which will continue the work of the previous group. The remit of the latter panel is being revised to include general concerns and patterns suggesting risk to children like R, even though there may be at that point no suspected perpetrator.

The Southwark Missing from Care Protocol provides a very helpful template for both independent return interviews and risk assessments, both of which are part of the process of safeguarding vulnerable young persons.

[20] *Independent Inquiry into Child Sexual Exploitation in Rotherham, 1997-2013*, Professor Alexis Jay, August 2014, Para 6.37
[21] Para 7.3.3

Learning Point

Children missing from care are at greater risk of sexual exploitation, not only because of being outside of (corporate) parental control, but also because of the power and reach of social media.

Recommendation 14:

Every looked-after child should have an up-to-date 'missing from care' risk assessment on their CSC file. Carers, CSC and Police should contribute to this, as appropriate, and it should be shared within the LAC Review group and any other key safeguarding partners involved with the child.

Recommendation 15:

In particular, high priority should be given to making sure that there is a risk assessment on the file of every child at risk of sexual exploitation.

(This recommendation is taken from the Rotherham Inquiry)

Recommendation 16:

The internal CSC audit and the SSCB multi-agency audit should include a question about compliance with Missing from Care procedures for every looked-after child.

5.19 <u>How the incident of alleged rape was dealt with</u>

5.19.1 The Review Panel for this SCR were initially gravely concerned about how R was dealt with by the Police, on the second night after her alleged rape. The Police IMR has been helpful in explaining the Police's assessment of risk and why they decided to use Police Powers of Protection:

- R had decided not to cooperate further with the police investigation (possibly because of threats from the alleged perpetrator, with whom she was known to be in contact).
- She continued to leave her foster placement and refused to let her carers know where she was going. This was at a time when the alleged perpetrator was still at large and was believed to be intimidating R as a witness, and to offer further risks to her safety. She was in contact with him.
- In these circumstances, the foster home was not deemed to be a secure placement for her.

The Police IMR author sets all this out clearly and takes the view that the protective actions were correct. However, the use of the police station (not the initial intention of the police) overnight was in his view **not appropriate**.

He makes no recommendation about this. The Review Panel have discussed the impasse which arose between Police, who were asking for a different placement to keep R safely on this night, and the local authority refusing either to place her in Secure Accommodation or any other unit. It was their view that she had a perfectly good placement to which she could be returned.

This is a situation which is likely to occur again, and these agencies need to consider how disagreements about high risk young persons can be mediated and dealt with in a child-focused way.

A concern from the Review Panel: was R dealt with differently because she was a looked-after child, rather than someone living with her own parents?

Learning Point

There are potential tensions between Police and Children's Social Care, regarding their respective roles and responsibilities in relation to a looked-after child at high risk of harm. This can result, as in this case, in an impasse and an outcome which is not appropriate for the child, even in the short-term.

Recommendation 17:

The relevant senior managers from Police and CSC should explore the options for keeping children and young people safe in emergency situations, in particular considering how differences between agencies about appropriate placement can be resolved.

It may be useful to use case studies to illustrate the most contentious and complex situations, and how they might be handled.

5.20 Looked-after children and the risk of CSE

5.20.1 The known link between going missing from care and CSE is highlighted in much research evidence and key reports. For example, Barnardo's 2012 report about the risk of CSE provides a list of 'Key indications of vulnerability (to CSE)' [22]. First on its list is 'Going missing for periods of time or regularly returning home late'. (p.5)

This link has provided a focus for this SCR, and was already a priority for the work of the SSCB. In August 2014, the Rotherham Inquiry was published, giving an abundance of useful data and analysis, not only about the cases in that area, but more generally about the risks of CSE to young girls who go missing from care. This will add to the learning from this SCR and support the work of the SSCB in this challenging area of safeguarding.

5.20.2 In early 2013, based on the outcomes of seven earlier Management Overview Reports, Southwark Safeguarding Children Board identified three priority areas for strategic development:

- Safeguarding of adolescents and older children
- Safeguarding issues pertinent to looked-after children
- System-wide understanding and practice regarding sexual exploitation and abuse of young people.

[22] *Cutting them Free: How is the UK progressing in protecting its children from sexual exploitation?, Barnardo's Policy, Research and Media, January 2012*

The Reports clearly pointed to the greater vulnerability of looked-after children, compared with their adolescent peers: a message which is significant in the case of R, and needs to be further disseminated regarding the cohort of Southwark's adolescents in care. The link between going missing and risk of CSE needs to be embedded in the thinking and practice of staff at all levels, including front-line practitioners, who are working with looked-after children aged 10 and upwards.

5.20.3 In September 2013, the SSCB produced a comprehensive review of data, both locally and nationally, to inform their safeguarding work in relation to CSE. The links with 'going missing from care' were very clear – both within Southwark and elsewhere:

- Numbers of LAC going missing for over 24 hours was up 36% in 2012/13, compared to the previous year. (However, this rise has now been wholly attributed to a different way of recording missing episodes. The number of LAC going missing has remained steady for the past two years.)
- The amount of time spent missing, by the same cohort, rose by 100%.
- Over 80% of missing episodes were among children placed out of borough.

An audit of 5 young women (LAC) who were believed to be at risk of CSE found that, like R, the majority had experienced multiple placements, including out of borough. Again like R, the majority had been removed from families at a late stage, after on-going histories of neglect.

As we become more aware nationally of the nature of such 'familiar stories', a more pro-active and protective response should be adopted at a strategic level – across the local safeguarding children network – to reduce the risk to this group.

<u>Work already commenced</u>

The Review Panel were told that the SSCB is considering and responding to the recommendations of the Rotherham Inquiry, including Recommendation 3, which suggests that

> '*Managers should develop a more strategic approach to protecting looked after children who are sexually exploited. This must include the use of out-of-area placements.'*

The SSCR are using the 'See Me, Hear Me'[23] principles and framework for protecting children from CSE to guide the work in this priority area for the SSCB.

I. ***How well did professionals hear the voice of the child in their work with R? And to what extent were her unique diversity needs met by services?***

5.21 Professionals have tried to listen and respond to R's wishes and feelings, whilst needing to balance these with their responsibility to make decisions which support her and protect her from harm. This has not been a straightforward task, for a number of reasons: R was not always consistent in her stated wishes and feelings

[23] Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, Final Report, November 2013

(e.g., about contact with her mother, or returning to live with her mother), and she has been reluctant to talk at any length about these. This has limited her input into her LAC Reviews, which have generally heard from adults rather than from R. Nonetheless, the LA and partners have continued to fulfil their corporate parental duty to her, in the following ways:

- R's links to her family are clearly important, and the LA has consistently tried to arrange for safe contact between R and her mother, grandmother and siblings.
- R's wish to live nearer to her mother was supported by the Judge who made the Recovery Order, and by R's IRO. R's move to her current placement was also noted to be a better match for R, providing a greater degree of diversity than the shire county where she was previously placed. (But it remains less diverse and less like 'home' than Southwark, where R, until recently, continued to return on a regular basis.)
- R's links with her familiar area of inner London have been supported by safe arrangements (taxis) for her to attend the Children's Charity weekly.
- R's experiences of bullying – in all three of her secondary schools – have been addressed by the schools and carers, and she has been enabled to attend and achieve well.

5.22 As has been noted elsewhere, there were gaps in the SW service offered to R, largely but not entirely related to sickness and lack of capacity in the LAC team. R is an adolescent who was already unlikely to trust those in authority over her, and who has had a sequence of changing social workers, then some who did not visit her consistently, and some who were slow to follow up on actions agreed on her behalf (e.g., a referral for extra maths tuition, which took several months to progress). In these circumstances, R has remained disappointed and resistant to communicating with professionals within CSC.

The Review Panel have speculated that, had R had the same SW from the time she came into care aged 10, this relationship might have flourished and allowed R to trust and tell her wishes and feelings. Sadly, the turnover in the SW workforce has not allowed for this to happen.

R's most recent SW was chosen because of her noted ability to 'get through' to young people; in addition, she is a black woman like R (as is R's IRO). She has sought the advice of CAMHS colleagues to help her develop the relationship, and has been advised to persist in offering R an attentive and reliable service – even though rebuffed. This has so far not succeeded, but it is regarded as the best way to demonstrate the role of a responsible parent: one who does not give up on the child, but who sometimes has to take decisions which the child doesn't like.

5.23 Like all young people, R would benefit from a trusted and consistent adult whom she can tell her wishes and feelings.

This role has been slowly and painstakingly developed by her current foster carers, especially the main (male) carer. They have worked hard to build a relationship with R, based on trust and – very slowly – on her willingness to give more information about her time spent out of the home. This remains a work in progress.

Other workers, from the Independent Fostering Agency and from the Children's Charity, have described R's willingness to talk to them more freely than to her SW. This may suggest that she naturally views these private or voluntary agencies differently from the LA, with its unwelcome authority over her. In particular, the Education Advisor/Special Project Consultant from the Independent Fostering Agency has made a good professional link with R, within which messages about her self-worth, welfare and safety can be conveyed.

However, it remains the case that R does not readily share her wishes and feelings with the adults in her life. In this, she is no different from many adolescents living with their own families, who only confide in their peer group.

5.24 Professionals who attended the Learning Event for this review speculated about whether social workers tended to have more skills and confidence for working with the birth-to-12 year age range, than with resistant teen-agers. It was suggested that a 'tool kit' would be helpful for trying to engage with adolescents.

5.24 The consideration of R's identity and her 'unique diversity needs' has not been clearly recorded in her LAC Reviews, or elsewhere, apart from the acknowledgement that the diversity of the London area provides a more suitable environment for her placement. But it is clear that the LA has tried to match black carers and workers with R.

R's first five placements were local (Southwark) and were a racial match for her. Unfortunately, the last two of this series of placements were with very elderly carers who struggled to work with R, who at that time was increasingly troubled and disruptive – and was spending more and more time out of the placement. The choice of these last two placements was quite likely to have been because they were 'the only ones available'. This is a real resource issue, common to all inner-London authorities.

5.25 R's last two placements have been with white carers, and she herself has expressed her preference for a trans-racial placement. Her last two SWs, on the other hand, and her IRO are all black women. Thus, the local authority has tried to ensure R's heritage is reflected by those representing her corporate parent.

J. *Review of the application and use of the e-safety policy in this case*

5.26 The sources and means of possible CSE have expanded hugely as a result of the technological revolution in social media. This worldwide phenomenon shows no signs of slowing, and it undoubtedly leaves many adults – professionals included – far behind in their awareness and understanding of increased risks for children and young people.

Barnardo's 'Cutting them free' report describes why those in positions of care towards young people – including all parents – need to be concerned about the role of technology in exploitation. The following passage describes their experience in this field:

> *Exploited young people and children are typically abused in person, but sexual exploitation also takes place over the internet, through mobile phones, online gaming and instant messaging. This is not surprising given how central technology is now to young people's lives, and the issue has long been a major concern for our services. However, the services reported that the scale of online and mobile abuse has markedly increased even since 2010. Almost all services reported it as an increasing priority, and some have identified that the majority of their service users were initially groomed via social networking sites and mobile technology.*
>
> *…Young people, parents/carers and professionals need to be more aware of how such technology can be used by abusers.* (p.7)

5.27 It has been very hard to comment about the application of an e-safety policy in this case. We do not know its specific relevance in relation to the trigger incident for this case review. This is because the circumstances leading to the alleged attack on R remain unknown, and R is unwilling to say any more about this matter. She has previously stated that the man contacted her on her mobile telephone, the day before they met, and that a 'friend' of hers had given him her mobile telephone number.

Police have been unable to uncover any communication between R and the man online, or any evidence of a process of grooming.

5.28 R's foster carers have put in place sensible precautions regarding her use of mobile phone and the internet. Her phone is on a contract which allows professionals to track calls when necessary (as in the recent incident); and her oyster card also enabled them to see where she was travelling. R's telephone is not allowed in her bedroom at night, but is left in the kitchen of the foster home. These actions are in line with the guidelines in the Independent Fostering Agency e-safety policy.

Those responsible for R are aware of the power and lure of the internet and social media more generally, and have talked to R about the risks arising from these. As for all young people, it is impossible to know whether, how and when R continues to use the internet, and potentially to place herself at risk of harm, especially from CSE.

Learning Point

The power and lure of electronic social media carry a risk of harm, particularly to vulnerable young people, which cannot be removed by professionals working with these young people.

Recommendation 18:

The SSCB should co-ordinate the e-safety 'statement of principles' across the local safeguarding children partnership. These should focus on supporting and educating young people to keep themselves safe.

6. Conclusion

6.1 R is a young person in care who has struggled with the status of being 'looked after'. She entered care as an older child, with a complex history which included neglect and abuse by her parent, and which left her with powerful feelings of rejection and blame by her family. She went on to have a series of 10 different social workers and 7 placements – a difficult and increasingly unsatisfactory experience of being looked-after and cared about, which would only further diminish her sense of self-worth.

6.2 R is like most other teenagers in many aspects of her behaviour, wishes and feelings: the importance of her peer group of friends, her mistrust of adults and her desire to push boundaries. These make it hard for parents and carers generally to keep their adolescents safe and to know what is happening with them. But R is also different, and more vulnerable, because of her earlier traumatic experiences and her number of moves in care. She continues to suffer from the loss of her family, including her siblings, and misses the closeness of friends in her home area.

6.3 This case review has found that the professionals responsible for R's care as a looked-after child have not had a sufficient understanding of her history and of her level of vulnerability – a vulnerability which continues to expose her to significant risk of harm, especially when she is missing. One consequence has been a lack of alertness by these professionals about the risk associated with R's patterns of going missing. It seems R was often regarded as 'not really missing', because she was believed to be visiting her mother or staying out with friends. These stories were perhaps usually true, but the reality was that no one in CSC really knew where R was for most of the times she was missing. This meant they could not know that she was safe.

6.4 The Review Panel has explored the explanations for the inconsistent service by CSC to R, and why Missing from Care procedures were not followed.

The principal reason given is that the team in which R's case was held underwent a period of many months when both SW staff and managers were off sick, and the work of the team suffered as a result. There were periods of time when R was not visited at the required frequency. Partnership work was neglected, and communication across agencies suffered from there being no multi-agency forum for sharing vital information and concerns about R.

These omissions, and their consequences, should have been picked up by more senior managers, and one of the main messages of this report is that organisations must anticipate and plan for periods of serious weakness in parts of their service. Other agencies, when they experience the lack of partnership working and the response to their concerns, should more readily and positively use escalation procedures, in order to achieve a better service to the child.

6.5 The major issues of safety for children and young people raised in this case review have been highlighted on the national stage in the past two years. As a result, there is a renewed focus on children missing from care, linked to a much keener awareness of the risks of CSE, especially for looked-after children and even more so for LAC placed away from their home area. In Southwark, the emerging lessons will hopefully be reflected not only in a better handling of the risks for R, but for all adolescents in their care. The LA and partners need to work together to help these young people develop the appropriate tools to protect themselves, and to offer non-punitive responses when they return home. Sadly, no parent, corporate or otherwise, can achieve this without the young person's engagement and their wish to keep themselves safe.

6.6 In R's case, it is encouraging that she now appears to have found a home where she would like to stay until she is 18, and carers to whom she can attach and trust. Schooling continues to be very important to her, and her attendance is excellent. These are the building blocks which may allow for a better understanding of recent events for R, and therefore further means to increase her safety in future.

The professionals involved in her care have participated very positively in this SCR and by doing so will have already changed their perception and understanding of the issues of going missing from care and risk of CSE. More widely, it is hoped that the lessons from this SCR will contribute to the SSCB's learning and improvement in its priority areas for safeguarding adolescents and older children, including the children for whom the local authority is the corporate parent.

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GLOSSARY

Cafcass	Children and Family Court Advisory and Support Service
CareFirst	Electronic recording system for Southwark CSC
CP	Child Protection
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DCS	Director of Children's Services
DfE	Department for Education
GSTFT	Guy's and St. Thomas's NHS Foundation Trust
IFA	Independent Fostering Agency (operating as a profit-making business)
IMR	Individual Management Reviews (for a Serious Case Review)
IRO	Independent Reviewing Officer (for looked-after children)
IRO Handbook	Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review of looked-after children (DfE)
LA	Local Authority
LAC	Looked-after child
LSCB	Local Safeguarding Children Board
MASE	Multi-Agency Sexual Exploitation Panel
NHS	National Health Service
PEP	Personal Education Plan
School 1 School 2 School 3	In Southwark In shire county In Greater London
SCR	Serious Case Review
SSCB	Southwark Safeguarding Children Board
SW	Social Worker
TM	Team Manager
YP	Young person

Appendix 1: Terms of Reference

Re: Serious Case Review – Child R

Southwark Safeguarding Children Board has decided to undertake a serious case review following a serious incident affecting Child R aged 15 years old. The review was agreed under guidelines within Working Together (2013) and regulation 5 of the Safeguarding Children Board Regulations 2006.

Reason for the serious case review

Child R alleged she was held at a hotel by an unidentified male.

On Sunday 16th March Child R reportedly agreed to meet with friends she had met via the Children's Charity. She returned late to her placement which she said was due to losing her phone. She then returned to SE London on Monday 17th March to retrieve the phone. She did not go to school on the Monday and did not return to the placement and was reported missing. On the phone she informed her carer that she was being held at a hotel by an unidentified male. The police were informed and via mobile phones Child R and the man were tracked. The male put Child R in a cab to return to placement. When she returned she disclosed to her carer that she had been raped.

Child R was supported by her carer to disclose to police, provide forensics and attend Haven. She refused an ABE interview.

A strategy Meeting was held on 20/3/14 at a Sexual Exploitation Unit, linked to the Metropolitan Police. The police subsequently arrested a male, alleged perpetrator. He is said to have been on Bail for a similar offence.

Child R is currently being supported in her foster placement.

Family structure:

Mother	35	London
Father		May live abroad
Subject	15	Foster placement
Sibling	19	London
Sibling	11	Foster care
Sibling	8	Foster care
Sibling	5	Foster care

Family Background

Child R and her family have settled in the country at different times. Child R and her older sibling lived abroad until she was about 8 years old with the maternal grandmother. At a later date maternal grandmother settled in the country.

Southwark social care involvement with Child R and her siblings started in December 2008, following receipt of a police notification stating that a member of the public had reported concerns about Child R's older brother drug running for his mother, and that she was dealing drugs and prostituting. This triggered an initial assessment.

During the assessment Child R made a disclosure that she repeatedly got hit by her mother with a mop and belt.

She said she was treated differently to her siblings, and presented as sad and withdrawn. A subsequent medical examination found evidence of physical abuse including bruises and burns.

Child R was subject of a Child Protection plan from 03/06/09 to 03/11/09 under the category of physical abuse.

On 02/01/10, Child R presented herself at a care home saying she had been beaten by her mother, had packed and escaped out of a window. Following this she was accommodated with her mother's consent on 4/01/10 under S20 CA 1989

On 19/03/10 Child R was made the subject of an Interim Care Order CA 1989, 'following a series of events involving her mother, drugs, the police and her siblings.'

She was made subject of a full Care order on 22/07/11.

Her three youngest siblings are all currently in foster care. Her older brother was previously looked after.

Care History

Child R has had around 9 different foster placements since being in care. Her placement breakdowns were largely attributable to her behaviour – she has a history of returning late from school and going missing from care. In addition she has been reported in the past as being rude, disrespectful and occasionally intimidating to carers.

Child R has been in her current placement, which is an Independent Foster placement, since 24/04/13. She had to move from her previous placement following making an allegation that her previous carer had pushed her in placement. She then went missing from 12/04/13-19/04/13.

In a Looked after review in March 2012 she was described as showing sexualised and gang-related behaviour in school.

Child R has had regular supervised contact with her mother and grandmother. When she absconds she is often found at their home.

Decision making by the SSCB

The serious incident relating to Child R was discussed at a meeting of Southwark Safeguarding Children Board on 1st April 2014 and a decision was made to proceed with a Serious Case Review on the basis Child R was a Looked After Child who was 'seriously harmed and there is cause for concern as to the way in which the authority, board or partners or other relevant persons have worked together to safeguard the child.'

This is specifically in understanding the management of Child R's episodes of missing from her care placement.

The purpose of the Serious Case Review (SCR)

The purpose of the serious case review will be to cover the key areas of inquiry as set out in Working Together (2013) and to follow these principles and those of the Welsh model (2013)

http://wales.gov.uk/docs/dhss/publications/121221guidanceen.pdf
Electronic guidance for arrangements for multi agency practice reviews.

This is to identify improvements that may be needed and to consolidate areas of good practice. Any findings from the review should be translated into programmes of action leading to sustainable improvements.

The SCR should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than just using hindsight
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings

The serious case review will:

- Seek contributions to the review from Child R and appropriate family members and keep them informed of key aspects of progress
- Produce a report for publication available to the public and an action plan

The report will include an analysis of the following, including what happened and why:

- Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. Establish how that knowledge contributed to the outcome for the child;
- Evaluate whether the care plan was robust, and appropriate for Child R, the family and their circumstances;
- Ascertain whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan;
- Identify the aspects of the care plan that worked well and those that did not work well and why. Identify the degree to which agencies challenged each other regarding the effectiveness of the care plan, including progress against agreed outcomes for the child. An whether any protocol for professional disagreement was invoked;
- Establish whether the respective statutory duties of agencies working with the child and family were fulfilled;
- Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Further relevant questions in relation to this case

1. How well did professional understand and manage the different risk factors influencing this case and the particular vulnerabilities of Child R, during the two years under review?

2. How well did professionals hear the voice of the child in our work with Child R? And to what extent were her unique diversity needs met by services?
3. Review of the application and use of children missing from home and care protocol and e-safety policy in this case

Action required

Relevant agencies to secure and check their records to see if they have any contact with Child R and her family, and inform the SSCB development manager.

An independent management review should then be commissioned by senior management, based on a chronology and analysis of the agency's involvement for agreement by the single agencies chief management team and submission to the SSCB serious case review group, within the agreed timescale.

The Welsh model is a new methodology to this Board. There is a need for a **timeline** (in this case for a period of two years before this incident) and a genogram. Family history is important in this case and agencies are asked to review information from the time of their agencies involvement as a brief summary up to 01/02/2012, the beginning of the period under detailed review. The focus on the preceding 2 years will help understand how this information was taken into account for current decision making. **The period in scope is 01/02/2012 to 27/03/2014.** It has been extended to the date of arrest of the alleged perpetrator following the traumatic incident. For this final period, there will be a particular focus on whether the police support a protection and expectation that Child R attend school the following day was proportionate to the concerns raised. The panels concern was that her post incident care was informed by her care status.

The timeline should be submitted to Ann Flynn SSCB development manager by **23rd May 2014**

The agencies final agreed independent management review endorsed at Chief Officer level should be submitted to Ann Flynn SSCB development manager by **21st June 2014.**

Agencies that need to contribute to the review

Independent Fostering Agency
Child and adolescent mental health services (CAMHs)
Children's Charity
A Greater London Children's Social Care
Met Police
Met Child Sexual Exploitation Unit Met police
Southwark Children's Social Care
Southwark Education Department
Southwark looked after children doctor

Review panel and reviewers

There will be a review panel managing the review process and will play a key role in ensuring understanding about the case.

There will be two reviewers. Both will take responsibility for scrutiny of the issues and one reviewer will take responsibility of completing the report. Working Together (2013) requires the SCR to be completed within six months and will be published.

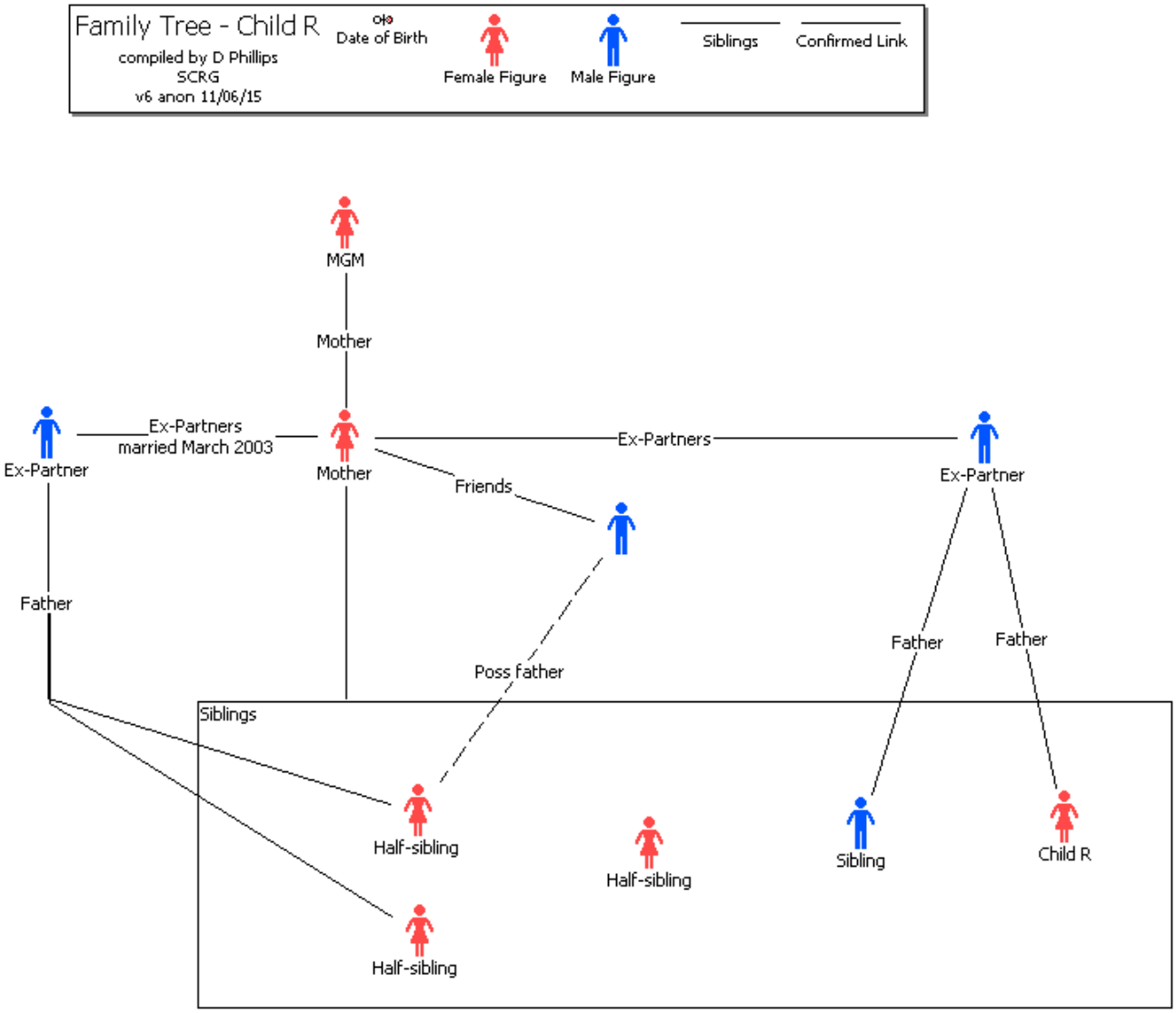
Learning event

At a later date there will be a learning event facilitated by the reviewers. This event is planned for 8th September from 9.30 – 3 pm and further details will be advised at a later date. The event will seek to engage differing levels of staff who worked with the family. The purpose of the learning event will be to start the process of learning and improvement at the earliest opportunity.

Final Report

The date for completion of the final report will be by **31 October 2014**

Appendix 2: Genogram



Agenda Item 11

Item No. 11.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Council and CCG – Joint Five Year Strategic Plan: Key Messages	
Ward(s) or groups affected:		Borough-wide	
From:		Andrew Bland – Chief Officer, Southwark CCG Mark Kewley – Director of Transformation, Southwark CCG	

RECOMMENDATION(S)

1. To agree that the Council and CCG will publish a joint strategic plan relating to a shared approach to transforming the commissioning of health and social care services.

2. To endorse the general approach and key messages set out in the summary report.

BACKGROUND INFORMATION

3. Commissioning teams within the Council and CCG have been working together, and across the local system, to improve health and wellbeing by developing individual and community resilience, and by improving the integration and coordination of health and social care services.

4. Through the Better Care Fund (BCF) both organisations have already begun to change the way that our collective resources are used to commission services.

5. Officers within the Council and CCG have discussed a desire to set out a wider shared approach to commissioning. This report is a summary of the general approach and the key messages that describe, in outline, that joint approach to commissioning.

KEY ISSUES FOR CONSIDERATION

6. As commissioners we need to be able to communicate a clear signal of intent: between our commissioning organisations; within our organisations; and to the external sphere, including both Southwark residents and providers of health and social care services. It is to this end that the Five Year Plan is being developed.

7. Within the plan we note the real need for (and opportunity to) radically change the way that we think about commissioning. This strategic plan proposes that we work towards arranging our resources and contracts around the Southwark population rather than around care providers, and that as commissioners we focus on the full value of care rather than the price of individual contracts (i.e. focusing on the physiological and experiential outcomes of care which are created as a result of the system-wide funding we have available).

8. Taken as a whole this approach gives real emphasis to: the social determinants of health; the need for early action to maintain wellbeing and mitigate illness; and the opportunity to recognize people's capabilities (rather than just their needs). In that context the strategic plan recognizes the need to initiate and support a fundamental shift in the degree of coordination between the different parts of the health system, the social care system, and the rest of the agencies involved in creating resourceful communities and enabling flourishing individuals.

9. This plan will set the ambition and the parameters within which we will work together, and with the system more widely, as commissioners of services for our population. It should also be seen as a local expression of that strategic intent that is described in the Our Healthier Southeast London Strategy.

Community impact statement

10. This strategic plan is explicitly aiming to reduce the health inequalities across the borough.

Resource implications

11. No direct implication.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Our Five Year Plan – Summary Messages

AUDIT TRAIL

Lead Officer	Mark Kewley – Director of Transformation and Performance, Southwark CCG
Report Authors	Mark Kewley – Director of Transformation and Performance, Southwark CCG Drafting support and comments from Dick Frak – Director of Commissioning, Southwark Council
Version	Final
Dated	9 October 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		9 October 2015

NHS Southwark Clinical Commissioning Group | Southwark Council

Our Five Year Plan

Summary messages

October 2015

DRAFT

What is the Five Year Plan?

Purpose of document

A conversation with partners and our population: The purpose of the document is to speak to all people with an interest in improving health and social care: residents, service users, families and carers, care providers and commissioners.

A description of our common purpose: It is a document to describe our vision for care services in Southwark and the approaches we will take to make that a reality.

A description of the journey ahead: It sets out joint perspectives – from Southwark Council and from NHS Southwark CCG – on the changes needed in our local health and care system, and indicates what this means for each of us (citizens, providers and commissioners) over the next five years.

Logic of the argument

What we describe in this plan is the need for significant transformation in:

- how providers are supported and incentivized to work together;
- how commissioners think about and approach the process of commissioning; and in
- how people are supported to be partners in co-producing good outcomes.

Our belief is that commissioners have a role to play in each of these processes, and that transformation of this scale will only be effective if we **approach it in a comprehensive and programmatic way**.

What is it setting out?

Content and structure of the document

The case for change over the next five years

- As commissioners our common purpose is to improve health and social care outcomes for Southwark people
- We know that more can and should be done to improve the value of care
  - We are already doing great things in Southwark that begin to show what is possible
    - Case examples of now
    - Postcards from the future

The approach we will take

- Describing the specific issues we face and the actions we plan to take
  - Addressing the fragmented arrangement of organisations and professions which reinforce boundaries and which can make it too difficult to work together and to work consistently
  - Addressing the fragmented system of contracts that make it too difficult for people to move resources to where they need to be, and to focus on what really matters to people
  - Addressing the disempowerment and confusion that too often makes citizens passive recipients of care
- Describing what this all means when taken together

The way we will make this happen

- How we will oversee this programme of transformation
- How we will approach commissioning

What are we saying in a nutshell?

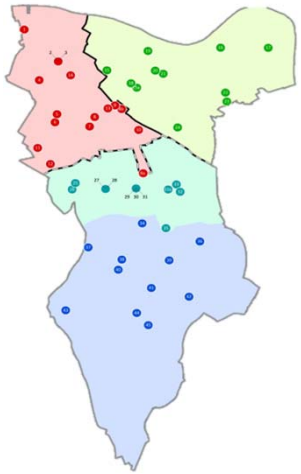
Key messages

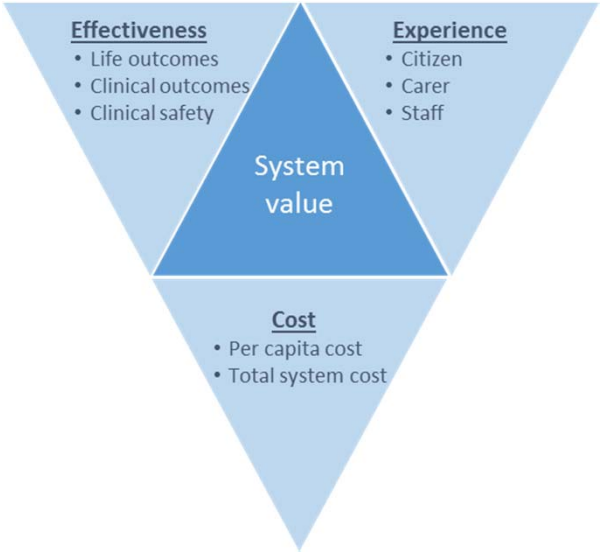
- Commissioners in Southwark are committed to improving the health and wellbeing of local people. The experience of staff, service users and carers suggests that the existing system does not consistently deliver the best outcomes for people, and that **there could be significant improvements if we worked together in new ways**.
- This is a quality and value argument, it is not about cuts: **if funding wasn't an issue we would still want to radically improve the system.**
- This will mean commissioning based on people's holistic needs rather than traditional approaches which result in provider silos and historic service models. Our local ambition is to create a much stronger emphasis on early action as well as stronger integration across health and social care, and wider council services (including education).
- To support this transformation we will increasingly **bring together commissioning budgets** and contracting arrangements that incentivise system changes, focusing on assets and outcomes over inputs or activity.
- In addition, we will increasingly move away from contracting with lots of different institutions for specific services and towards inclusive contracts **which cover funding for the total health and care needs of a population** (or a specific cohort of people with similar needs).
- These contracts will be made available to providers that can demonstrate that they can bring together the various skills needed to meet the needs of the population, for example by working together as a network or consortium. **Our aim is to support the development of multi-specialty community providers serving populations of 100,000-150,000 people**

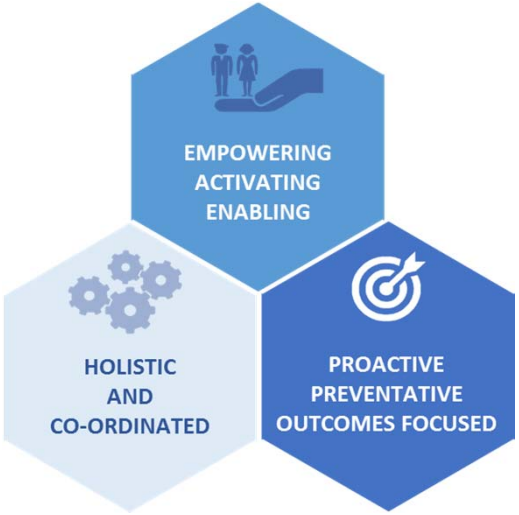
Key concepts: we will focuses on delivering high value for the Southwark population taking into account people's hierarchy of needs

We are changing the way we work and commission services so that we:

Emphasize populations rather than providers	Focus on total system value rather than individual contract prices	Focus on the 'how' as well as the 'what'







Arranging networks of **services around geographically coherent local communities**	Moving away from lots of separate contracts and **towards population-based contracts that maximize quality outcomes** (effectiveness and experience) for the available resources	Focusing on commissioning services that are characterized by these attributes of care, **taking into account people's hierarchy of needs**

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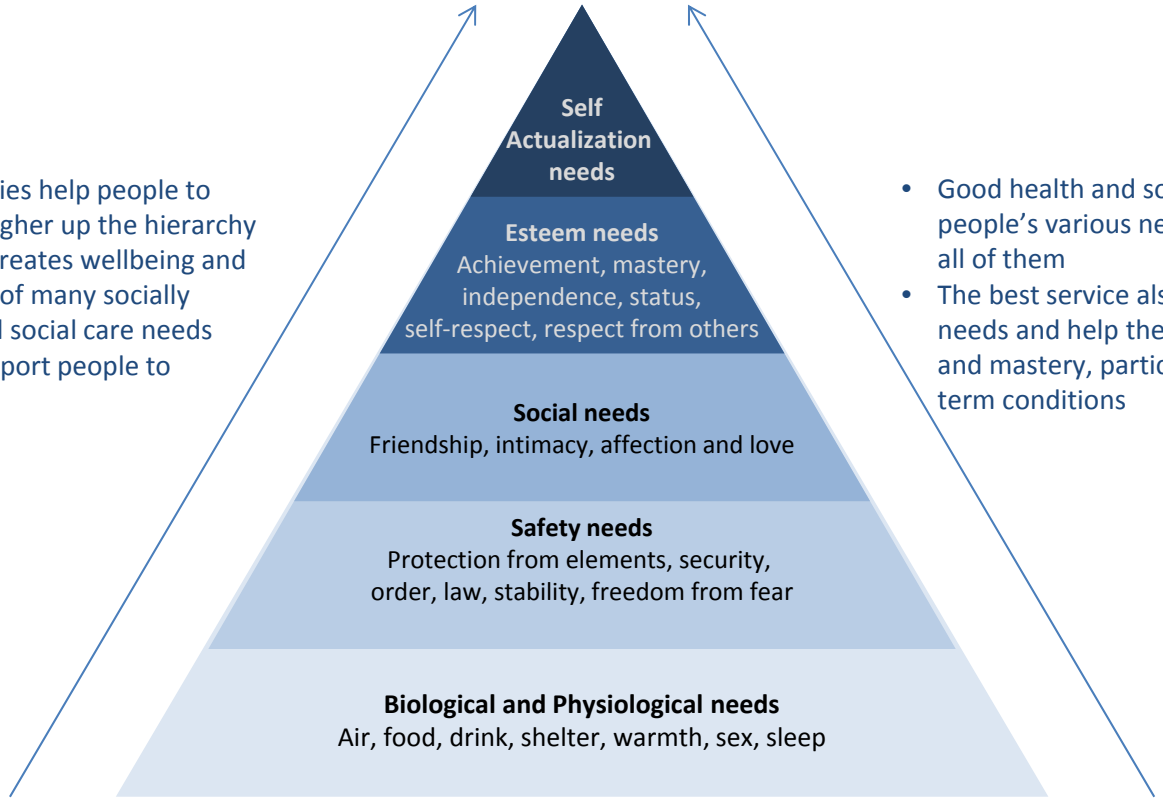
NHS Southwark Clinical Commissioning Group | Southwark Council

Key concept: Resourceful communities and high value health and social care services help people to meet a variety of needs

A common purpose across the council and the CCG: meeting people's various needs to achieve flourishing communities and personal wellbeing

- Resourceful communities help people to meet needs that are higher up the hierarchy
- Meeting these needs creates wellbeing and reduces the likelihood of many socially determined health and social care needs
- This is how we can support people to flourish



Maslow's hierarchy of needs

- Good health and social care services recognise people's various needs and help to address all of them
- The best service also recognise people's esteem needs and help them to develop independence and mastery, particularly when dealing with long term conditions

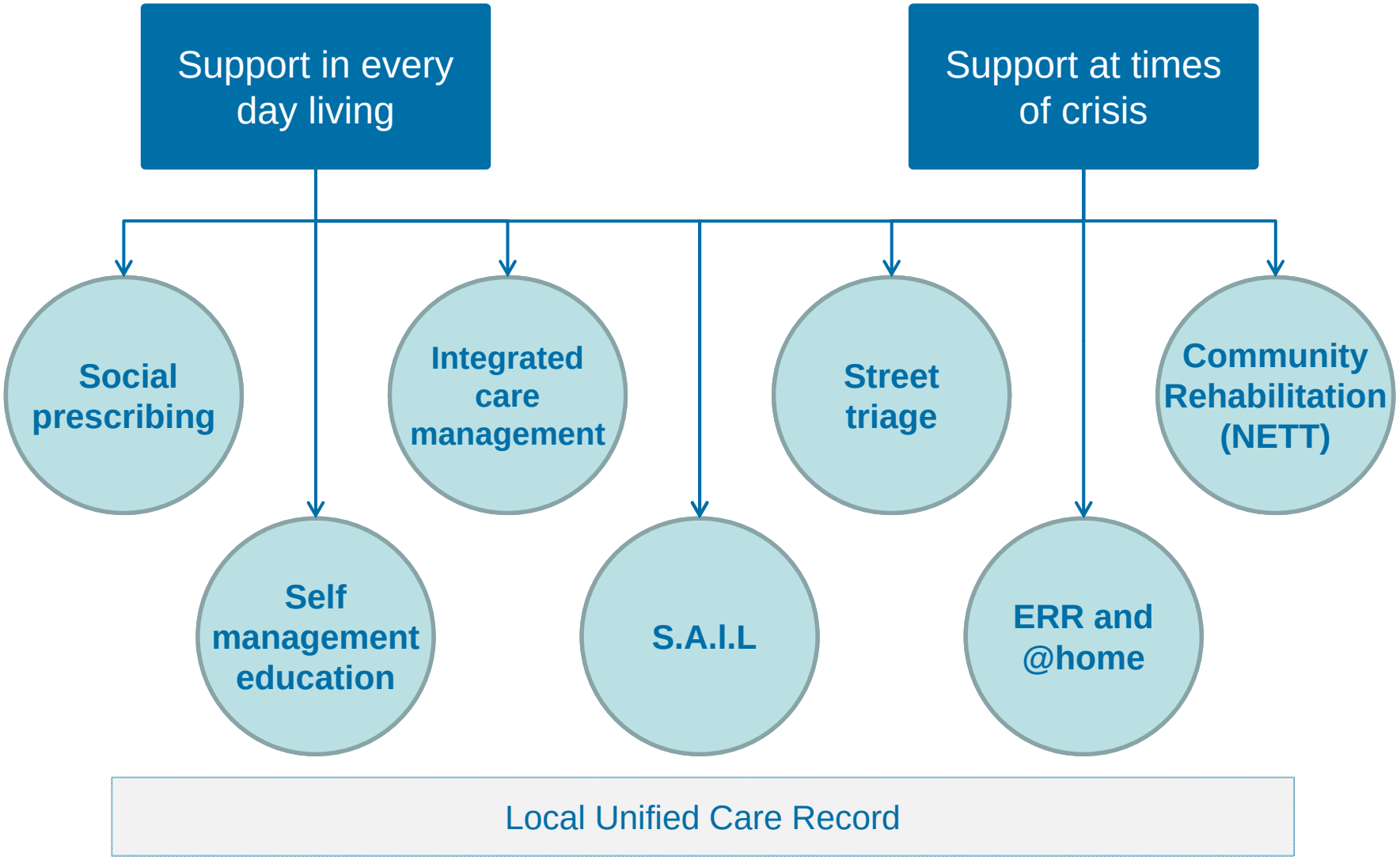
Key concept: people's needs are significantly affected by the social, economic and environmental conditions to which they are exposed

Delivering good health and wellbeing requires us to address the 'causes of the causes': social determinants of health

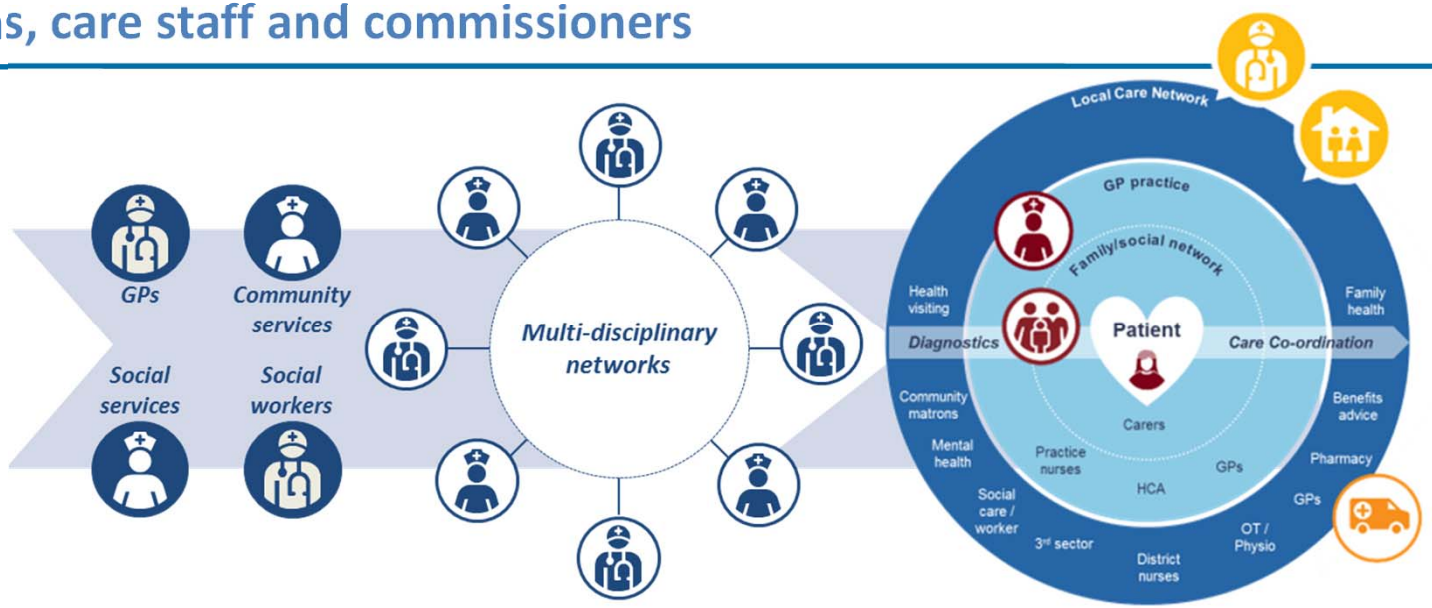
- The social determinants of health have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations.
- They include the conditions of daily life and the structural influences upon them, themselves shaped by the distribution of money, power and resources at global, national and local levels.
- They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances.
- There is a clear link between the social determinants of health and health inequalities, defined by the World Health Organisation as "the unfair and avoidable differences in health status seen within and between countries".

Barton, H. and Grant, M. (2006) *A health map for the local human habitat. The Journal for the Royal Society for the Promotion of Health, 126 (6). pp. 252-253.*

Key concept: lots of fantastic things are already beginning to happening in Southwark for the benefit of our population

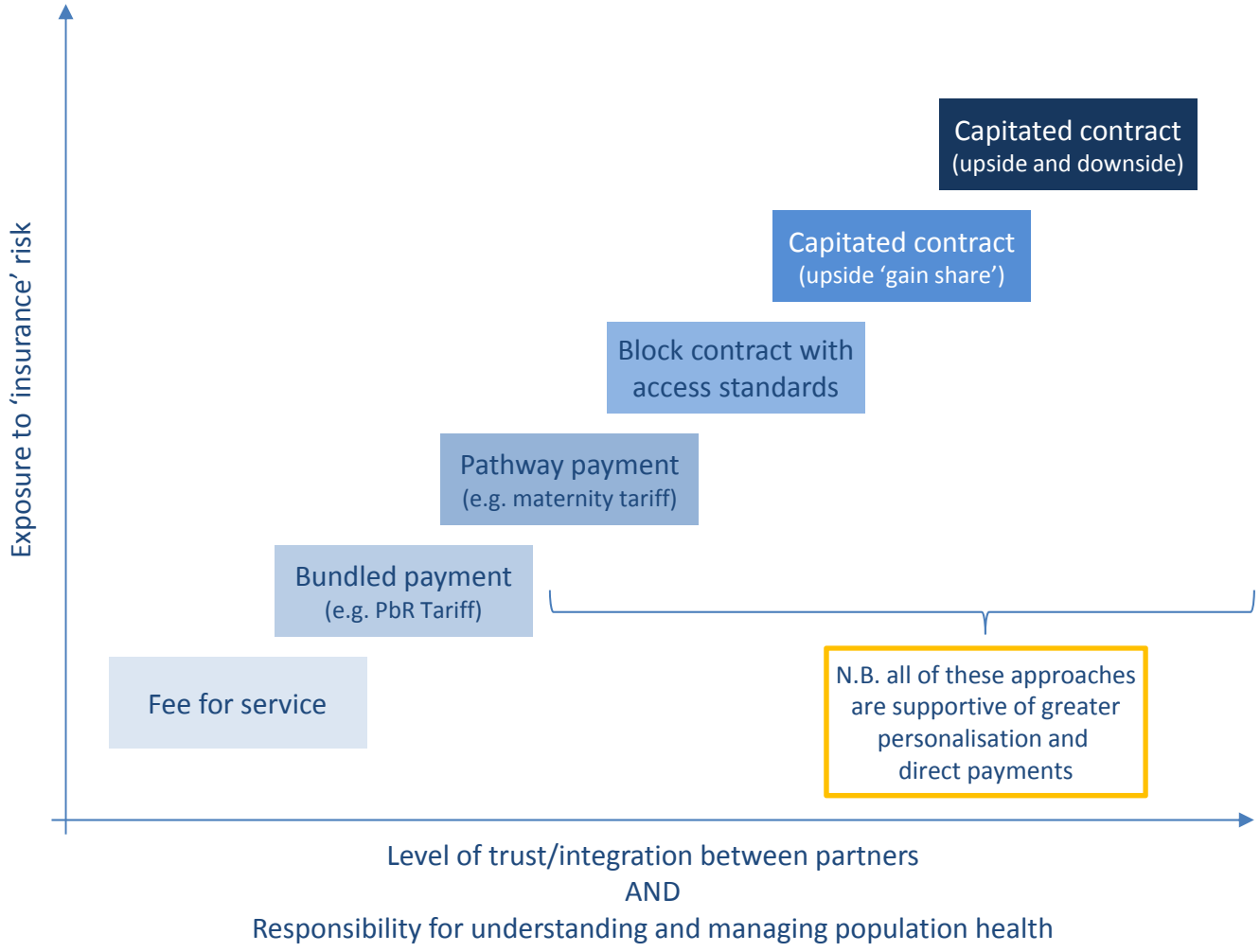


Key concept: over time we are developing better ways to work together which is good for citizens, care staff and commissioners



What this mean for me as a…	Traditional models [Small molecules] *Working as isolated units*	More integrated working [Small cells] *Working as small joined-up teams*	Accountable care [Living system] *Working as a dynamic and complex system*
…service user	• Sometimes services are good, sometimes they are not, it's a bit of a lottery • I feel looked after in an emergency but at other times I'm left confused and disempowered • I have to fit around the system and it's inconvenient	• I know more about what is going on • Clinicians know more about what has happened in my care • People ask me about what I need • I'm feeling more confident about how to live well, and what to do when I start to feel like I'm getting unwell	• I feel in control of my life and the care I receive, and I know what's going on • Professionals work together to support me • The little but important things are thought about
…staff member	• I'm isolated with little opportunity to work in a team • I'm frustrated at the lack of coordination • There is little opportunity to sort things out creatively, at the root of the problem	• I get help from others when confronted with complex situations • I'm developing new relationships and connections • I can sort out the things that count	• I feel part of a team and I am learning new things that make me feel more confident in what I do • I feel I'm able focus on the things I'm good at and let others do what they are good at
…commissioner	• I try to take responsibility for detailed pathway design • I focus on the transactional rather than the transformational	• I can spend more time thinking about what people actually want from services (outcomes) rather than just tracking inputs, targets and expenditure	• I spend my time looking at whether we are really delivering quality outcomes for people for the funding we have. I can see the wood for the trees

Key concept: models of accountable care require different payment mechanisms, but systems rarely succeed by going straight to capitation



In addition to thinking about 'how' payments are made, we also need to consider 'how much': allocations of funding should shift to where needs are greatest as a principle to deliver equity of care and outcomes

Key concepts: we will aim to align incentives across the system now, and use 2016/17 to develop a population-based approach for one client group

Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	…

Making sure different contracts cohere

- The major contracts in the system include a shared system-wide performance measure / objective
- Available non-recurrent 'transformation' monies are used to fund priority projects to integrate the system

Developing a genuinely integrated contract and service model for a chosen population

- For a defined population (e.g. people with Severe Mental Illness) there will be a very different capitated contract delivered through an accountable network of providers

Developing additional contracts to cover other populations

Developing additional contracts to cover other populations

Developing additional contracts to cover other populations

Over time all sections of the Southwark population will be covered by these arrangements

Developing better information systems and analytics to understand our population and value across the system

Key concept: at its heart, this is a strategy of relationship building, culture change and community development

- **Ours is a strategy about relationships and culture change**. It requires us to work differently and in a way that will energise and liberate our staff to put resourceful communities and individuals at the heart of health and social care.

- **Professionals need to be supported to think creatively** about a wide range of responses to a person's needs; and that in order to do so they will operate across our distributed local networks and settings of care, rather than through orthodox hierarchies and within the traditional confines of buildings

- **Importantly it means reimagining our 'workforce'** and engaging with the fact that our citizens – as service users, parents of carers and members of resourceful communities – have significant capabilities and want to feel in charge

Agenda Item 12

Item No. 12.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Our Healthier South East London	
Wards or groups affected:		Southwark wide	
From:		Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	

RECOMMENDATIONS

1. The board is requested to:

- Note the development of the five-year strategy to date and the progress made since the last report.

- Discuss and comment on the development and content of the strategy, the process to date and the next steps set out in the paper.

EXECUTIVE SUMMARY

2. The six Clinical Commissioning Groups (CCGs) across south east London, in partnership with NHS England are developing a joint commissioning strategy.

3. The Health and Wellbeing Board has received regular updates on progress and had the opportunity to review and comment on the draft case for change in March 2014.

4. Since the last report significant progress has been made including:

- The development of clinical models in priority areas;
- The development and sign off the consolidated strategy;
- Modeling of the financial and activity impact of the strategy;
- A revised timeline;
- The establishment of four groups to respond to London Quality Standards and opportunities presented by the clinical models.

BACKGROUND INFORMATION

5. This report summarises the progress made on the strategy and the next steps.

6. The strategy is being developed in partnership with local authorities, NHS providers, patients, local people and other key stakeholders. Its development is overseen by a programme board, the Clinical Commissioning Board, comprising the chairs and chief officers of the six Clinical Commissioning Groups with colleagues from NHS England and representation from local authority chief executives, plus Healthwatch and patient and public voices. The Clinical Commissioning Board is in turn supported by a Partnership Group, bringing together local authority chief executives, NHS providers and other partners. Clinical leadership from CCGs, NHS providers and social care/children's

services is provided by the Clinical Executive Group and six Clinical Leadership Groups.

7. The strategy complements and builds on local work and has a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working collectively. It seeks to respond to local needs and aspirations, to improve the health of people in south east London, to reduce health inequalities and to deliver a health care system which is clinically and financially sustainable. It also meets the NHS England requirement that all CCGs develop a commissioning strategy.

8. The strategy is being developed through an iterative process, so this report reflects the progress to date. It sets out the progress in developing a whole system model for south east London and the six priority areas for intervention: community-based care, children, maternity services, cancer, urgent and emergency care and planned care. Each of these priority areas has a Clinical Leadership Group drawn from local NHS organisations, local authorities, Healthwatch and members of the public. This paper describes the current position in relation to the development of whole system outcomes and modelling the impact of the strategy across health and social care.

9. The paper describes in some detail the development of local care networks, which are the cornerstone of the shift to more care being delivered in primary and community care settings and gives an early example of progress being made in improving access to primary care in Southwark.

KEY ISSUES FOR CONSIDERATION

10. The board is asked to note the update and to discuss and comment on the development and content of the strategy and process.

Policy implications

11. The strategy addresses issues that require collaboration at a south east London level and will sit alongside the CCG's local borough-based strategy.

Community and equalities impact statement

12. A first equality analysis was carried out in 2014 and a further analysis was received in September 2015. The recommended actions are being considered by the CCGs' equality group.

Legal implications

13. Should the proposals that are currently being worked through indicate major service change, a public consultation under section 14Z2 of the Health and Social Care Act 2012 will be carried out in the future.

Financial implications

14. The report includes an update on the financial modelling and the financial implications at a south east London level. The strategy programme is funded jointly by the six south east London CCGs and NHS England.

BACKGROUND PAPERS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Our Healthier South East London – Summary Pack

AUDIT TRAIL

Lead officer	Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	
Report Author	Mark Easton, Programme Director, Our Healthier South East London	
Version	Final	
Dated	9 October 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		9 October 2015

Our Healthier South East London
Improving health and care together

NHS

Programme update

September 2015

Our Healthier South East London
Improving health and care together

NHS

Why are we developing the strategy?

We have a shared understanding of the challenges facing south east London. These are outlined in our **Case for Change**.

Our health outcomes in south east London are not as good as they should be:

- Too many people live with preventable ill health or die too early
- The outcomes from care in our health services vary significantly and high quality care is not available all the time
- We don't treat people early enough to have the best results
- People's experience of care is very variable and can be much better
- Patients tell us that their care is not joined up between different services
- The money to pay for the NHS is limited and need is continually increasing
- Every one of us pays for the NHS and we have a responsibility to spend this money well

Our Healthier South East London
Improving health and care together

NHS

What are we trying to achieve?

Our collective vision for the south east London:

In south east London we spend £4 billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

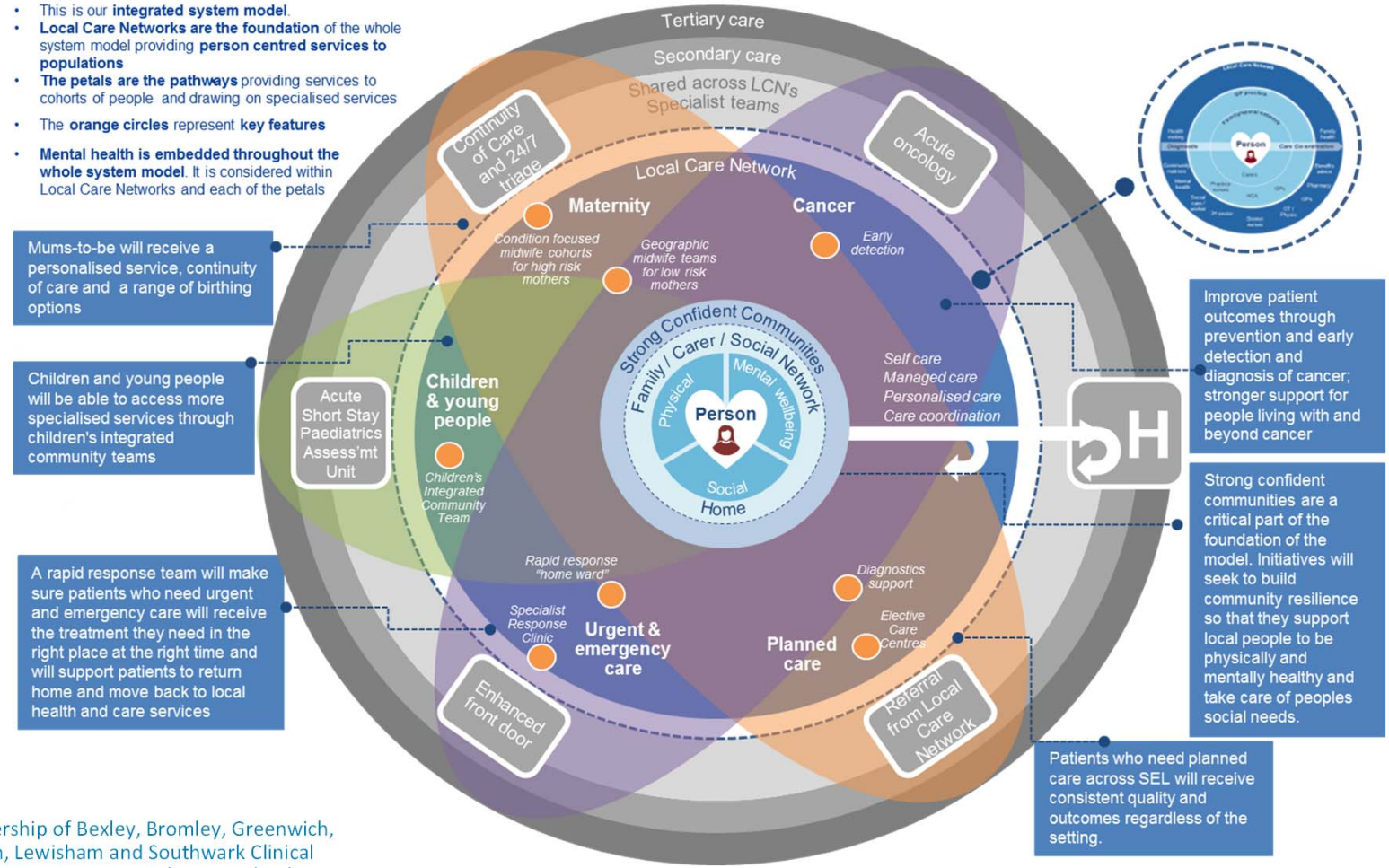
- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste

Our Healthier South East London
Improving health and care together

NHS

Our integrated whole system model

Community Based Care delivered by Local Care Networks is the foundation of the integrated whole system model that has been developed for south east London. This diagram provides an overview of the whole system model, incorporating initiatives from all 6 Clinical Leadership Groups.



A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Progress to date

- **Case for change** published Feb 2015
- **6 Clinical leadership Groups:** Community-based care, Urgent and emergency care, Maternity, Children's services, Planned care and Cancer. Mental Health is an over-arching theme for all 6
- **Governance** : CCGs are decision-makers; Clinical Commissioning Board, Partnership Group, Clinical Executive Group
- **Public and Patient Advisory Group (PPAG) and patient and public voices on each CLG**
- **Draft 5 year Strategy** published June 2014
- **Strong emphasis on community-based care:** Local Care Networks in each borough as the foundation of the integrated whole system model
- **Consolidated Strategy** signed off in August after CCG Governing Bodies approved the direction of travel.
- **Options appraisal process** under development and informed by engagement event in July.
- **Communications and engagement:** A range of local and south-east London wide events have taken place. The plan for the next phase is being revised to take account of the proposed timetable
- **Issues Paper** published in May; further paper in September sharing models of care – responses to both welcome

Our Healthier South East London
Improving health and care together

Community Based Care model

NHS

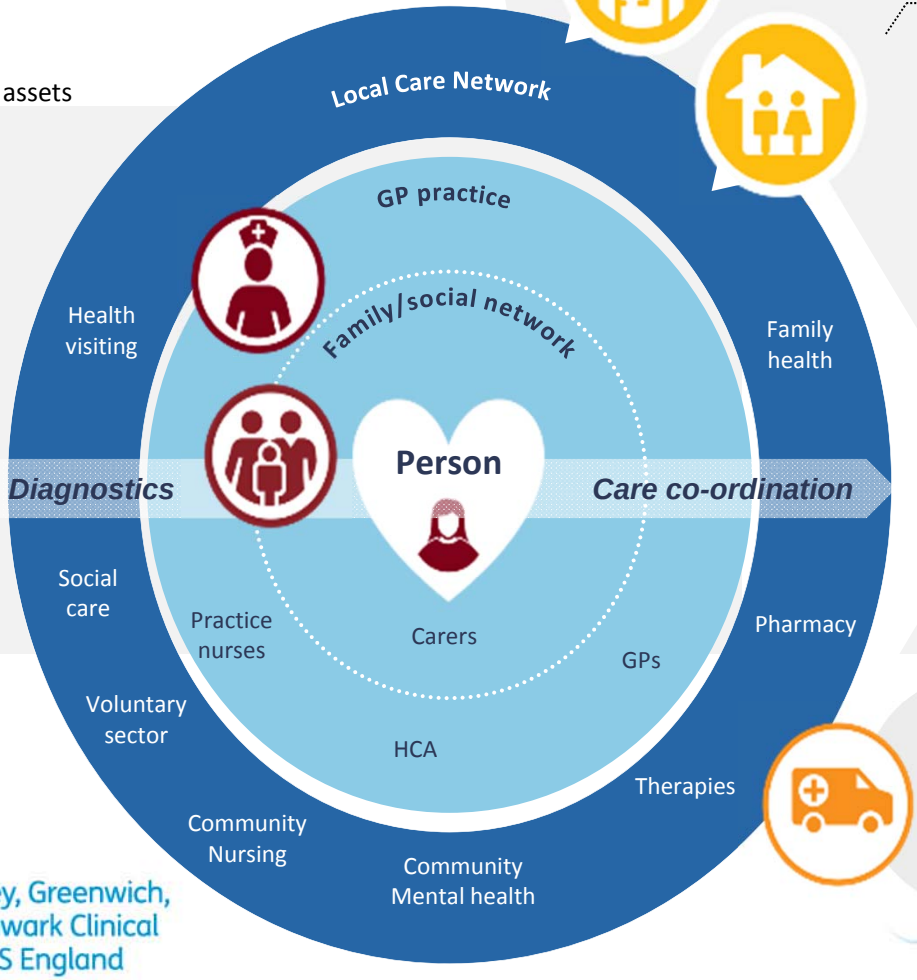
Strong confident communities

Self care

- Health coaching
- Self management tool kits
- Social prescribing
- Optimising neighbourhood assets

Proactive, Accessible , co-ordinated, Continuous Care

Population needs & budget



***Specialist input** shared between LCNs:*

Pulled into care delivery from outside the network: Virtual clinics | Specialist nurses | Consultants | Geriatricians | End of Life expertise | Specialist rehab

Wider community infrastructure:

Police | fire service | schools | Housing

Affordable high quality outcomes

Managed care

- Anticipatory care planning
- Active case management
- Disease management
- Public health programmes

Urgent and emergency

Local Care Networks will operate beyond usual GP hours in order to reduce referrals to emergency care

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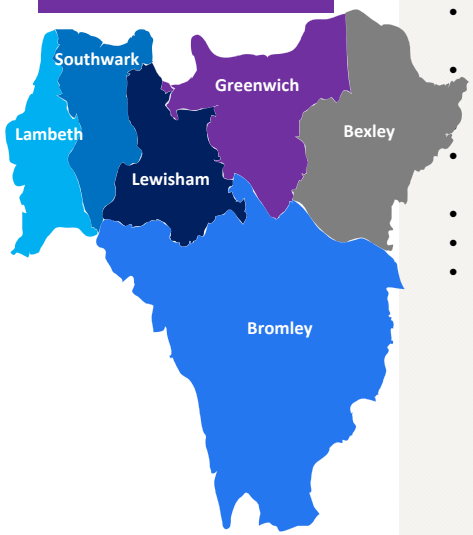
Our Healthier South East London
Improving health and care together

The Community Based Care Target Model

Integrated Single System Leadership and Management

Serving geographically coherent populations between 50,000 – 150,000



'The Core' (as a minimum all LCNs should encompass)

- Leadership team
- All general practices working at scale (federated with single IT system and leadership)
- All community pharmacy
- Voluntary and community sector
- Community nursing for adults and children
  Social care
- Community Mental Health Teams
- Community therapy
- Community based diagnostics
- Patient and carer engagement groups

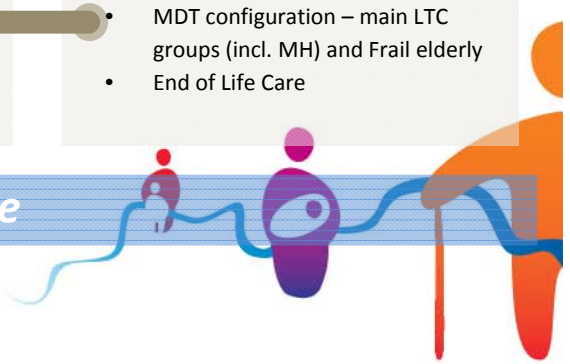
Working with…

- Strong and confident communities
- Accessible HOT clinics and acute oncology (urgent and emergency and cancer care)
- Specialist opinion (not face to face) and clear specialist service pathways
- Pathways to MDTs
- Integrated 111, LAS and OOH system (interface with UCCs co-located with ED model)
- Housing, education and other council services
- Community based midwifery teams
- Private and voluntary sector e.g. care homes and domiciliary care
- Cancer services
- Children's integrated community team and short stay units
- Rapid response services
- Carers
- And there will be others..

Big hitters

- Supporting patients to manage their own health (Asset Mapping, Social Prescribing, education, community champions etc
- Prevention – Obesity, Alcohol and Smoking
- Improved Core general practice access plus 8-8, 365
- Enhanced call and recall – improves screening and early identification and management of LTCs
- Reduction in gap between recorded and expected prevalence in LTC
- Supporting vulnerable people in the community including those in care homes and domiciliary care
- Reduction in variation (level up) primary care management of LTCs
- Reablement – Admissions avoidance and effective discharge
- MDT configuration – main LTC groups (incl. MH) and Frail elderly
- End of Life Care

Integrated Pathways of care

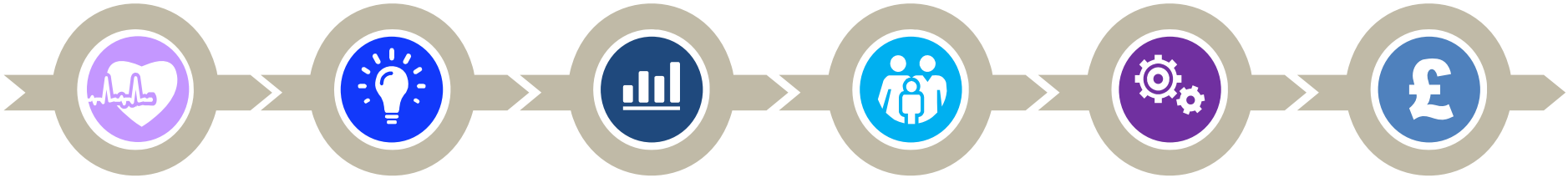


A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Our Healthier South East London
Improving health and care together

Local Care Network Development & Mobilisation

The proposed high-level approach to implementation of Local Care Networks across south east London has been described as:



The case for change and outcomes
Identify why we need to change and what we want to achieve.

Design
Agree the Target Model ('the core', 'working with' and 'big hitters')

Strategic impact assessment
Demonstrate the activity & finance implications for the Target Model assessing the value equation; patient outcomes over cost

Local interpretation
Using the target model to articulate shared design principles, interpret these to meet the needs of local communities

Provider models
Looking at the localised Target Model, outline options and select provider model (for example the provider models described in the Five Year Forward View)

Contracting and business models
With a preferable provider model selected, commissioners consider the contracting models, and providers the business model, that enables them to deliver

In some areas, the plans have progressed quite significantly: in **Southwark**, for example, with the support of the Prime Minister's challenge Fund, primary care access hubs are already offering 8:00 am to 8:00pm, seven days a week bookable appointments

Strategy impact analysis (finance and activity): Key messages

- The NHS in south east London currently spends £4 billion in total across commissioners and providers and has 4,166 acute hospital beds. Over the five years of the strategy , the available money will grow by £8oo million to £4.8 billion
- But the spend will grow in total by £1.1 billion to £5.9 billion, if we do nothing
- The requirement for acute beds will grow because the demand for health services is increasing ; people are living longer but many with long term conditions such as diabetes, high blood pressure and mental illnesses and the technical advances in diagnostics and treatments mean that the costs of providing care are rising faster than inflation each year.
- *Our Healthier South East London* is about responding better to people's needs by providing an alternative high quality model of care that is focused on improved outcomes for the population we serve. This is because,
  - The care models are focused on prevention and early intervention and keeping people healthy and therefore keeping people out of hospital
  - Community Based Care is the foundation of the whole system and is intended to keep people closer to home, treating them in the community and enabling people to only visit hospital when they really need to
  - Pathways and professionals will be more integrated
  - Productivity is expected to increase and providers will continue to deliver efficiency savings (eg through improved procurement, combined support services, improved rostering of staff) which will help to close the gap
  - The plan will be for bed occupancy to meet the national guidance (which is not the case now) which will improve safety, quality and efficiency
- Our current modelling therefore shows that at the end of the five years, we shall need about the same number of beds as now
- But some of them will be used differently (more day case, fewer inpatient beds; shorter lengths of stay…)
- This is therefore not about closing a hospital, but about avoiding the need to build a new one, which we could not afford, by improving health and outcomes and delivering services which better meet people's needs
- It is also about creating a legacy for the future as the improvements in prevention and care should result in benefits which will materialise beyond the current time horizon of the next five years.

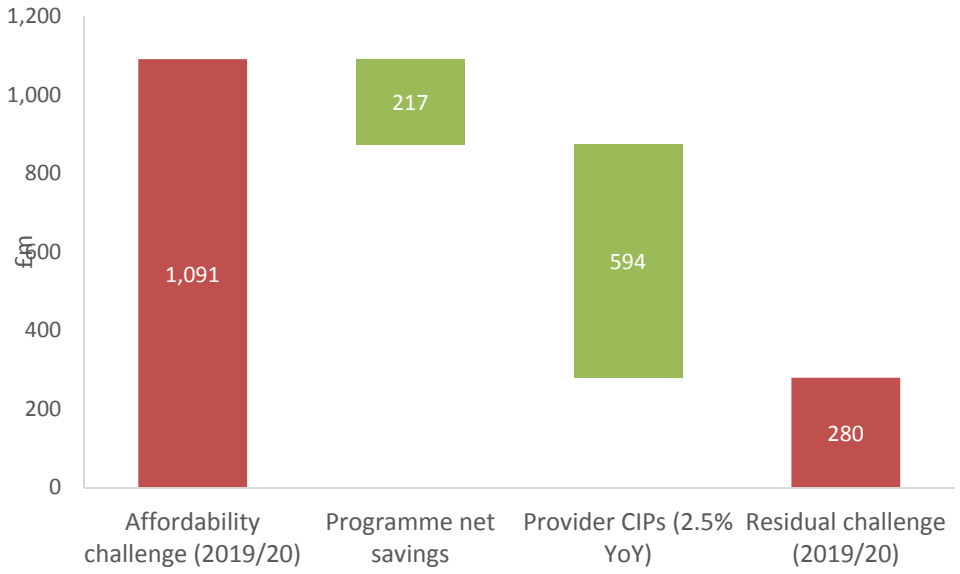
Closing the affordability challenge

The graph to the right demonstrates how the benefits from the programme can be combined with savings within individual organisations to close a substantial amount of the £1.1 billion affordability challenge. The benefits shown are as follows:

1. **Programme central case (gross benefit):** As described previously.
2. **Provider CIPs at 2.5%:** The provider finance leads feel that a 2.5% CIP may be reasonable in addition to efficiencies generated through the programme.

It is important to note that both of these savings are presented gross of investment requirements (which total £87 million in the programme central case). It is expected that these investment requirements will, at least in part, be satisfied through additional funding requested through the Five Year Forward View and committed by the Government. Taking south east London's proportionate share of the £8 billion committed would imply that £248 million is available for this purpose.

The resultant position is a £280 million affordability challenge for the South East London health care economy.



Potential scope for option appraisal

Four areas have been identified which potentially require an option appraisal process:

- **Urgent and Emergency Care** (requirement to meet the London Quality Standards and 7 Day Standards)
- **Maternity services** (requirement to meet the London Quality Standards)
- **Children and Young People's services** (impact of implementing a Short Stay Paediatric Assessment Unit and the requirement to meet the London Quality Standards)
- **Planned Care** (implementing elective care centre(s)

During August a process was undertaken to define the scope and make recommendations for how to proceed

Achievement against the London Quality Standards

- Overall for south east London, a large number of standards are being met or are expected to be met within trusts existing plans
- No single site is meeting all the LQS or 7 Day Standards
- A number of key standards such as consultant presence on site are not currently met by any trust in SEL
- Workforce is the main area where additional investment is required to meet the London Quality Standards in SEL with additional consultant cover and MDT the key cost drivers

Recommendations and next steps

At the meeting on 28 August, the Executive Group of the partnership group considered the scope analysis and adopted the following recommendations:

Urgent and emergency care

The urgent and emergency CLG to establish a group to devise a plan and timeline to establish a trajectory towards LQS across the sector taking into account:

- Workforce considerations
- Financial constraints
- Likely future safety, sustainability and quality issues
- The feasibility of network or collaborative arrangements to help meet the standards in an innovative way

The aim being to devise a plan that demonstrates safety and quality, and a trajectory to LQS. We expect this work to report by the end of October.

Maternity

The maternity CLG to establish a group to devise a plan and timeline to meet LQS across the sector taking into account:

- Workforce considerations
- Financial impact given the possible savings from the strategy
- Likely future safety, sustainability and quality issues
- Whether trusts are likely to meet the standards on their own or whether network or collaborative arrangements would be required

The aim being to determine whether it is possible to meet the standards in a reasonable timescale**.**

Children and young people

The children and young people CLG to establish a group to devise a plan and timeline to implement the agreed clinical model taking into account:

- Workforce considerations
- Financial impact
- The impact of the strategy on our inpatient units and what changes may need to be made to meet safety, sustainability and quality issues in light of the activity projections

Planned Care (Orthopaedic Centre of Excellence/SWLEOC model)

The planned care CLG to establish a Working Group to develop the feasibility and options to deliver the elective orthopaedic centre of excellence model/SWLEOC.

An orthopaedic centre of excellence brings together revision joints, spinal surgery and complex and co-morbid patients.

The SWLEOC model is about consolidation and high throughput of routine cases.

Next steps

- We will continue to plan and implement most of the strategy: taking forward the new models of care and interventions that do not need public consultation. We will work with our partners in secondary, primary and community care, mental health trusts and with local authorities to do so.
- We know where an options appraisal process may be required for some of the care model initiatives. If consultation is needed, we expect it to take place from July-September 2016, with options agreed by December 2016.
- We have published a summary of the draft models of care and further thinking as a follow-up to the Issues Paper. This summarises our very latest thinking, as set out the consolidated strategy.

How stakeholders and local people can help

- Respond to our Issues paper at http://www.ourhealthiersel.nhs.uk/about-us/issues-paper.htm or by writing to Our Healthier South East London, 160 Tooley Street, London SE1 2TZ.
- Invite your local CCG and the programme team to a meeting to brief colleagues or to run a roadshow on your premises for your staff.
- Share this briefing and our Issues paper with colleagues and stakeholders.
- You can email the programme team at SOUCCG.SELstrategy@nhs.net or follow @ourhealthiersel on Twitter.

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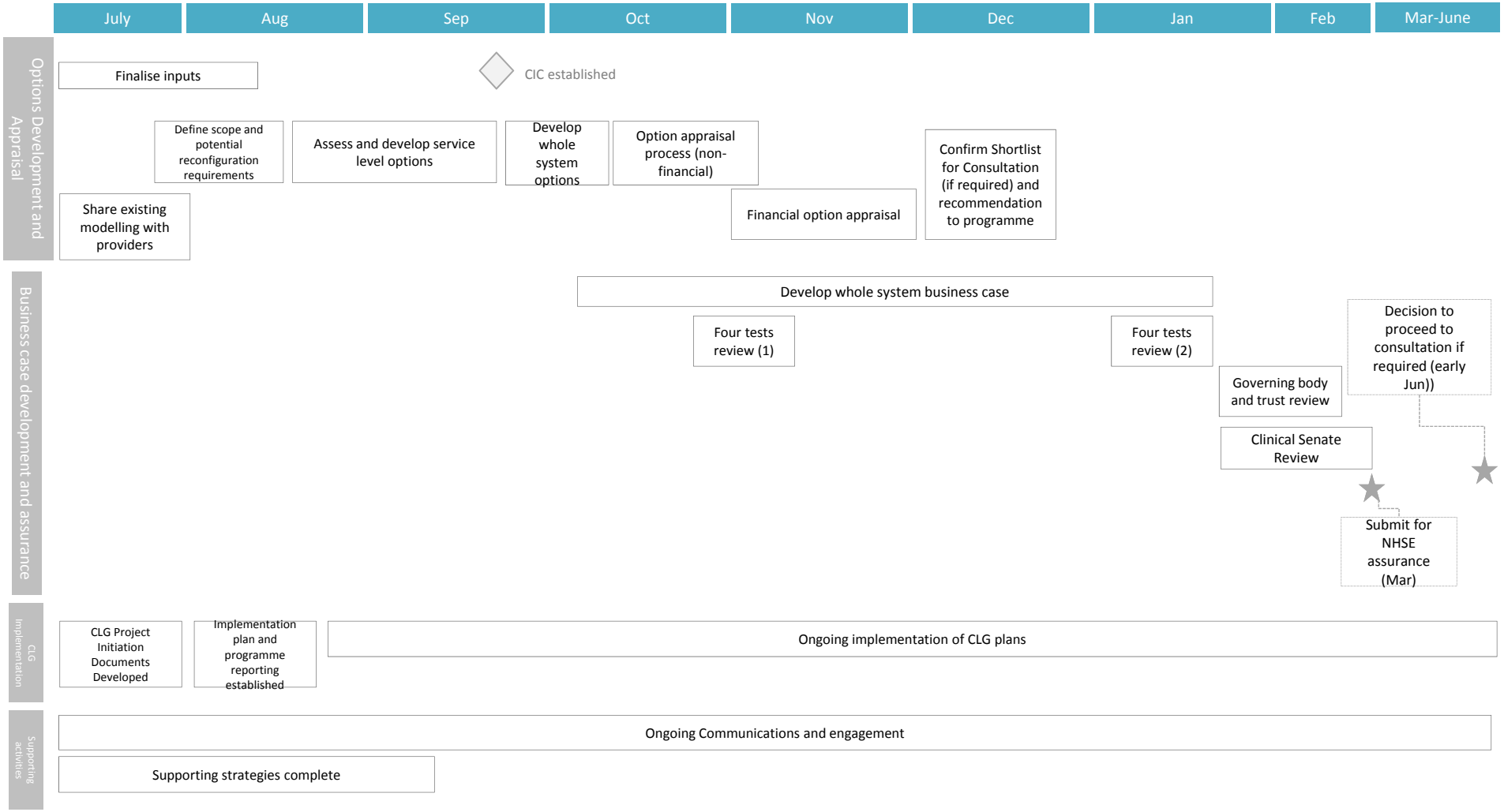
NHS

Summary plan



Agenda Item 13

Item No. 13.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Primary Care Co-commissioning Update	
Wards or groups affected:		Southwark-wide	
From:		Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	

RECOMMENDATIONS

1. The board is requested to:

   - Note the progress made on the development and operation of primary care co-commissioning in the borough.

EXECUTIVE SUMMARY

2. The purpose of this of this paper is to update the Health and Wellbeing Board (HWB) on the development and operation of Primary Care co-commissioning in the borough following the decision of NHS Southwark CCG to enter in to joint commissioning arrangements with NHS England (London Region) for general medical services from the 1 April 2015.

BACKGROUND INFORMATION

3. In line with local commissioning intentions to adopt a population based approach to commissioning of local services the CCG entered in to joint commissioning arrangements with NHS England (London Region) to ensure a greater alignment of activity between those bodies responsible for the commissioning of different aspects of local health provision. In doing so the CCG, together with its HWB Board partners, will seek to ensure a greater integration of care that focuses upon the specific needs of our population and that gives focus to the holistic needs of residents rather than the services they receive from any one part of the health and social care system in isolation.

4. In Southwark arrangements allow for joint commissioning of general practice in the borough with NHS England (London Region). This is a move away from NHS England's sole responsibility for the commissioning of these services following a single operating model (SOM) and provides local commissioners with the opportunity to exert greater influence and have the ability to determine and implement locally sensitive commissioning intentions. However, this arrangement does not allow for the 'Full delegation' of responsibilities in this area. Under fully delegated arrangements the CCG would take full control of commissioning activities along with delegated responsibility for associated budgets for general practice services. Under joint arrangements the statutory responsibility for primary care resides with NHS England (London Region), including budget responsibility.

KEY ISSUES FOR CONSIDERATION

5. Primary Care Joint Committee

5.1. These joint arrangements are undertaken by a Southwark Primary Care Joint Committee (PCJC) that comprises a voting membership of some CCG Governing Body members and the mandated NHS England Commissioners. The membership of the committee also includes non-voting participants from the HWB Board, Healthwatch and the Local Medical Committee. The committee meetings are held bi-monthly in public.

5.2. Under current arrangements the Southwark PCJC meets together with the other five joint committees in the boroughs that make up south east London (Bexley, Bromley, Greenwich, Lambeth and Lewisham). Each borough operates at the same level of commissioning (Joint) in south east London and the committees meet together in order to make most efficient use of administrative resource, to allow the sharing of best practice, and to allow for the most effective management of commissioner time and resource where issues are similar or the same for each of the six boroughs. It is important to note that the committees are separate and are not 'Committees in common' but rather each PCJC is a prime committee of individual CCG Governing Body.

6. Areas of focus to date

6.1. To date the PCJC has met three times in Public in the months of June, August and September 2015. The issues and areas of decision making for the committee have been a blend of agenda items that pertain to general practice in Southwark only and the consideration of regional issues (to date at a London level) where Southwark is impacted upon. The papers and minutes of these meetings are available on the CCG's website.

6.2. Over the first six months the key focus of the committee has been as follows:

6.3. ***Start up and governance***

The co-commissioning arrangements for England are new and the committee has considered and agreed the operating model for the operation of co-commissioning for London and in each borough. Those arrangements as they relate to London are now established in an Operating Model that was approved in late September 2015, having been subject to committee review in the preceding months. That Operating Model is attached for the HWB Board's reference (appendix A).

It is important to note that pan London arrangements and their operation is supported by locally focused work groups that report to the PCJC and the other commissioning committees' of the CCG. The operating model is designed to enable local based decision making wherever possible.

6.4. ***Primary Care Quality, Performance and Finance***

Each committee meeting has received reports and considered actions in each of these areas. In the case of quality and performance this has been with the aim of understanding the current position and seeking assurance upon the actions that are being pursued by commissioners, working together, will address areas of concern and ensure improvement going forward.

In the case of financial reporting, the committee received reports from NHS England (London Region) as the body responsible for the general practice budget. Whilst beyond the responsibility of CCG commissioners it is clearly important that the impact of budget performance and decision making is understood at all times and agreed to be aligned to the commissioning intentions of the system, when taken together.

6.5. ***Alignment of commissioning intentions***

The committee has sought to understand and take action to align the commissioning intentions of NHS England with those of local commissioners. However, it is important to note that local approaches to commissioning of integrated services, and the Southwark based strategies that underpin them, have always involved NHS England commissioners, albeit in more informal arrangements, leading up to these joint arrangements. As a result the focus of Southwark discussions has been on ensuring the implementation of national, regional and borough based plans remain aligned.

At the present time the committee, along with all committees in England, is considering the implications of a nationally mandated Personal Medical Services (PMS) review that should be completed by the end of this financial year. The majority of practices in Southwark hold this type of contract that has historically awarded, through the contract, additional funding for services undertaken over and above the 'core' national contract. The majority of these contracts were awarded to local practices in the late 1990s.

The purpose of the PMS review is to provide assurance that all additional or 'premium' funds made available by this contract are delivering services over and above 'core' services, that they remain locally responsive and that they designed and delivered in such a way that seeks to reduce inequalities. Furthermore the review also seeks to ensure that going forward all residents, irrespective of the practice they are registered with have access to the same range of services and as a result the review seeks to ensure that non-PMS contract holders have the same opportunity to deliver services and be remunerated on that basis.

It is important to note that whilst the majority of England has not been subject to PMS reviews since the inception of the contract, a local review was undertaken by the NHS Southwark (Primary Care Trust) in 2012/13 and as a result many of the objectives of the review have been addressed relatively recently and the impact will be less than in other areas as a result. There is, however, an important piece of work to be overseen by NHS England and the CCG to ensure the commissioning of services remains effective through the contracts that enact it.

6.6. ***Contractual action***

The committee receives recommendations upon contractual actions that pertain to the borough. These relate to the contracts held in this borough and address matters either relating to all practices (e.g. Locum reimbursement policies that relate to England and / or London) or to specific practices where contractual action is required (e.g. Breach notices). In the case of both, recommendations are received and considered in public and most often require the committee to assure themselves that contract terms and conditions are being correctly applied and with reference, where appropriate, to local commissioning intentions.

7. Operation of Joint Commissioning in Southwark

7.1. The HWB Board has received and approved the local arrangements for co-commissioning in the borough at the end of 2014/15 at the point at which the CCG made its application. Those arrangements have been enacted in full.

- The membership of the committee has been constituted in accordance with its terms of reference and is chaired by a Lay member of the CCG Governing Body
- Meetings and the papers that support them are in public and there is opportunity for members of the public to ask questions of the committee at each meeting
- The committee has enjoyed the regular attendance of a Local Authority representative (on behalf of the HWB Board) and of a Healthwatch representative
- The committee acts in accordance with national requirements for, and the CCG policy on conflicts of interest (COI). This includes:
  - Oversight by a Lay Member COI Guardian
  - A fully maintained, updated and publically available register of interests
  - Public declaration of interests and arrangements to ensure the appropriate involvement of committee members where a conflict is identified
  - Regular referral to a the CCG Conflict of Interest Panel, comprised of non-conflicted members of the CCG Governing Body, in line with the usual processes of the CCG

8. Future work plan

8.1. The PCJC for Southwark will give focus to the following areas in 2015/16, over and above its core responsibilities:

- The full and effective completion of the PMS review
- The implementation of the CCG's Primary and Community Care strategy and its emergent commissioning intentions for integration, outcomes based commissioning and new models of care
- The development of commissioning intentions for 2016/17 and the five year planning period to 2020/21

8.2. In addition the CCG will need to consider any enhanced level of co-commissioning responsibility (full delegation) it wishes to assume in future years and engagement on this with local residents, CCG members and partners (including the HWB Board) will be an area of work over the next three months.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	NHS England Operating Model

AUDIT TRAIL

Lead officer	Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	
Report Author	Andrew Bland	
Version	Final	
Dated	9 October 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		9 October 2015

Operating Model

Co-Commissioning of Primary Care Services

FOR APPROVAL

Document filename: Operating Model			
Directorate / programme	Primary Care Commissioning	**Project**	Primary Care Commissioning
Document reference			
Project manager	David Sturgeon	**Status**	For Approval
Owner	Primary Care Management Board/ Primary Care Committees	**Version**	11.1
Author	Patrick Newton	**Version issue date**	02/10/2015

Operating model: Co commissioning of primary care

Document management

Revision history

Version	Date	Summary of changes
1.0	22.04.15	First draft
2.0	23.04.15	Revision following Christina Windle review
3.0	30.04.15	Revision following Heads of Primary Care review
4.0	30.04.15	Draft for review by David Sturgeon
5.0	05.05.15	Review by Primary Care Commissioning and Primary Care Management Board
6.0	03.06.15	Draft updated following comments
7.0	09.06.15	Updated to reference initial comments from CCGs (to be approved in PCMB)
8.0	20.07.15	Draft updated to reflect agreed comments
9.0	14.08.15	Updated following discussion at co-commissioning meeting
10.0	09.09.15	Updated following discussion at co-commissioning meeting
11.0	22.09.15	Final draft for approval
11.1	02.10.15	Factual amendments post approval by SE London (Joint Status of SE London Committees. Some minor editorial changes

Reviewers

This document must be reviewed by the following people before being shared externally:

Reviewer name	Title/responsibility	Date	Version
David Sturgeon	Director of Primary Care Commissioning		
Jill Webb	Head of Primary Care		
Julie Sands	Head of Primary Care		
William Cunningham-Davis	Head of Primary Care		

Approved by

This document must be approved by the following groups:

NHS England:

Name	Signature	Title	Expected Date	Version
Simon Weldon (in recognition of approval at the Primary Care Management Board)		Regional Director for Operations and Delivery (London)		

Following sign off by NHS England (London), this document must be accepted by each of the co-commissioning committees. These groups are therefore shown below:

Co-Commissioning Committees:

Area	Signature	Title	Expected Date	Version
North Central London		Joint Committee		
*City and Hackney**		*CCG*		
South West London		Joint Committee		
Bexley CCG		Joint Committee		
Bromley CCG		Joint Committee		
Greenwich CCG		Joint Committee		
Lambeth CCG		Joint Committee		
Lewisham CCG		Joint Committee		
Southwark CCG		Joint Committee		
North West London		Joint Committee		
Tower Hamlets		Delegated Committee		
Waltham Forest		Delegated Committee		
Newham		Delegated Committee		
Barking & Dagenham, Havering & Redbridge		Delegated Committee		

* This CCG does not have a co-commissioning committee and therefore the forum for this signature is un-confirmed.

Related documents

Title	Owner	Location
NWL Terms of Reference	Primary Care Committee	North West London
NCL Terms of Reference for Joint Committee v0.2	Primary Care Committee	North Central London
SWL Terms of Reference	Primary Care Committee	South West London
Annex F – Delegated TOR Tower Hamlets v0.1	Primary Care Committee	Tower Hamlets
Annex F – Delegated TOR Waltham Forest v1.0	Primary Care Committee	Waltham Forest
Annex F – Delegated TOR Newham vfinal	Primary Care Committee	Newham
BD – Updated Annex F (ToR)	Primary Care Committee	Barking and Dagenham
Havering – Updated Annex F (ToR)	Primary Care Committee	Havering

Document control

The controlled copy of this document is maintained by NHS England. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Contents

1. Introduction

1.1 Purpose of this document

This document aims to provide a blueprint for the way that NHS England (London) primary care commissioning and contracting teams will support CCGs which have moved to joint or delegated co-commissioning arrangements (as of April 2015). CCGs which will be participating at the 'greater involvement' level of co-commissioning should discuss with their local team how they would like to be involved.

As this document provides the standard offer of NHS England in terms of supporting Primary Care Co-Commissioning activities, this document will need to be signed off by NHS England (through the Primary Care Management Board) and then co-commissioning committees, before it is considered final.

It is important to note that some specific details (i.e. the contact points for different committees/ areas) will differ per committee and these added details should be cross referenced with committee terms of reference or other supporting documents. **Governance of this document and Processes**

Once this document has been signed off by both parties, any variance from the processes described here will need to be agreed between the Committee and NHS England as:

- Having no impact on support (for example changes to the contact to be involved in urgent decision making) and can therefore be adopted for a specific Committee
- Is an adjustment or improvement to the process which would be beneficial for all Committees and therefore should be made as a change to standard processes (for example reporting format or processes which makes the reporting cycle more efficient or information more easily understood)
- Is a required change for a specific Committee(s) and therefore a change request will need to be logged (i.e. additional reporting).

In all instances, agreement of these changes will require sign off at the Primary Care Management Board and then with Primary Care Co-Commissioning Committees before it can be considered confirmed. This may require resource and/ or cost implication assessments, and the ownership for any impact of these would need to be discussed as part of the agreement discussions.

1.2 Operating model processes for individual committees

As mentioned above, this document aims to provide a standardised version of the operating model. However the below details will need to be discussed in each individual committee, and therefore decisions relating to the below are seen as acceptable levels of customisation within this standard model:

- Standard policies to assist decision making should be reviewed and agreed by the committee; the committee may wish to add others

- The sub-committee structure is likely to be different per committee. This should follow the principles defined here and be discussed and agreed with NHS England if involved.
- The CCG representative(s) to be contacted in the event of urgent decisions being required.

These elements should be discussed and agreed as part of committee discussions, and should be included as appendices or linked documents.

1.3 Defining co-commissioning

Co-commissioning for primary care refers to the increased role of CCGs in the commissioning, procurement, management and monitoring of primary medical services contracts, alongside a continued role for NHS England. In 2015/16, the scope for primary care is general practice services only. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their regional team and local professional networks, but have no decision making role.

There are three co-commissioning models, and as of April 2015 there are London CCGs at all three of these levels:

- Level 1: where CCGs have involvement in primary care decision making,
- Level 2: which is where the CCG (or CCGs) participate in decision making with NHS England in a Joint Committee
- Level 3: delegates decision making regarding certain functions (see below) entirely to the CCG (or CCGs)

A high level overview of responsibilities is shown below:

Figure 1: High level breakdown of co-commissioning responsibilities

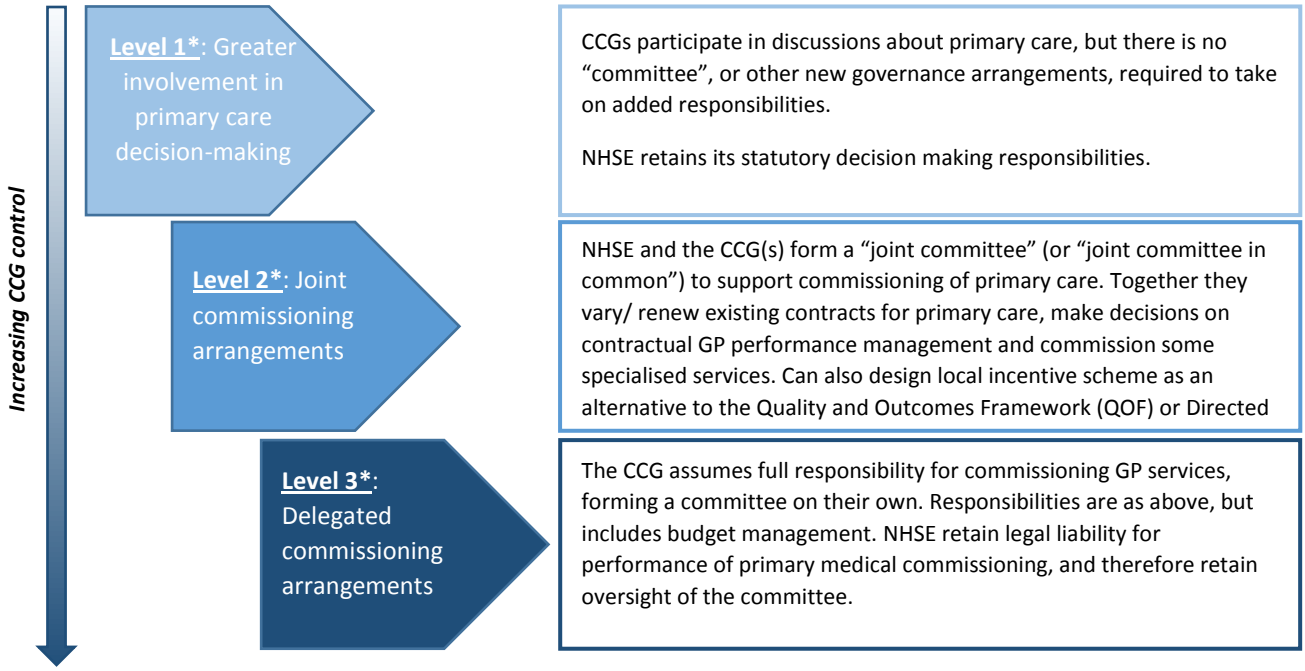


Figure 1: Co-Commissioning Levels

1.4 Terminology:

At levels 2 and 3, co-commissioning decision making is conducted through a, or several, 'committee(s)', which is joint with NHS England, or delegated. The committee could either consist of:

- Committees of single CCGs (with or without NHS England)
- Committees of more than one CCG (with or without NHS England)

The Committees may either be:

- A joint committee is a single committee to which multiple bodies (e.g. NHS England and one or more CCGs) delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision[1].
- In contrast, under a committees-in-common or joint committees-in-common approach, each committee (with our without NHS England dependant on level) must still make its own decision on the issues in question

For simplicity, throughout this document, the body which conducts decision making for co-commissioning is referred to simply as "the committee", and it may refer to any of the parameters above. Where different processes are required for joint or delegated committees, these are called out.

1.5 Differences between Joint and Delegated Committees

The move to co-commissioning, means that certain decisions (see Figure 2) which were previously conducted directly by NHS England, will now be made by the body constituted to support the level of co-commissioning each CCG has applied for – i.e. committees with NHS England (for joint commissioning) or without NHS England (for delegated commissioning).

Regardless of whether the CCGs are conducting Joint or Delegated commissioning, the functions enacted will be for the most part the same; the main difference is whether NHS England is part of the decision making process or not. It should be noted that there will be a joint responsibility for ensuring quality, through the reporting of performance data, and NHS England is likely to support the preparation of papers and other inputs into the committees.

It should be noted that the CCG may ask NHS England to attend and/ or present papers at delegated committees, but this should be done on request and NHS England will not be a voting member.

1.6 Responsibilities remaining with NHS England

At all levels of co-commissioning, NHS England will retain a role in supporting delivery of commissioning and contracting functions. Also the following responsibilities will remain with NHS England and will not be included in joint or delegated committees:

[1] Please note this is only an option for Joint Commissioning arrangements

- Continuing to set nationally standing rules to ensure consistency and delivery goals outlined in the Mandate set by government.
- The terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations/ directions.
- Functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation).
- Administration of payments to GPs.
- Patient list management will remain with NHS England.
- Capital expenditure functions.

2. Decision Making

2.1 Decision making principles

One of the exceptions to this as a standard document across all committees, is that there may be some variation as to what and how decisions are made in the committees. Decisions will be taken in line with the criteria set out in each committee's Terms Of Reference. In addition to principles of good practice which are set out in the *Next Steps in Co-Commissioning* document, conflicts of interest policy, terms of reference etc, the following principles should be considered:

- Any **urgent decisions made outside of the committee should be based on what is necessary to maintain patient care**; wherever possible decisions will be taken within the committee.
- **In the event that an urgent decision is required and action must be taken to maintain patient care outside of a committee, NHS England will communicate with the contact nominated in the committee's terms of reference (via phone and email) to aim to involve them in the decision.**
    - CCG contacts are asked to make themselves available to respond to these urgent discussions

2.2 Decision making process

Co-commissioning of Primary Care will enable committees to take responsibility for many decisions which currently sit with NHS England. Any CCG functions which are to be delegated into this committee are not included here.

Decisions have been classified into three types in order to help capacity in the committee. These types are:

1. **Decision making through policies** which therefore require minimal/ do not require discussion because there is a clear approved policy which provides clarity on the action required
2. **Urgent decisions which cannot wait until the committee**. These decisions require emergency processes (see below)
3. **Decisions to be discussed in the committee**. Other General Practice commissioning decisions should be made within the committee. It is expected in

many cases recommendations will be made into the committee from pre-work or sub-committees as appropriate.

These decision types and the related processes can be seen in the below processes:

2.2.1 Decision Making through policies

The below diagram shows how decisions where policies which are already defined might be used to support the co-commissioning committee. ***Please note, this process would be the same for both Joint and Delegated commissioning decisions***:

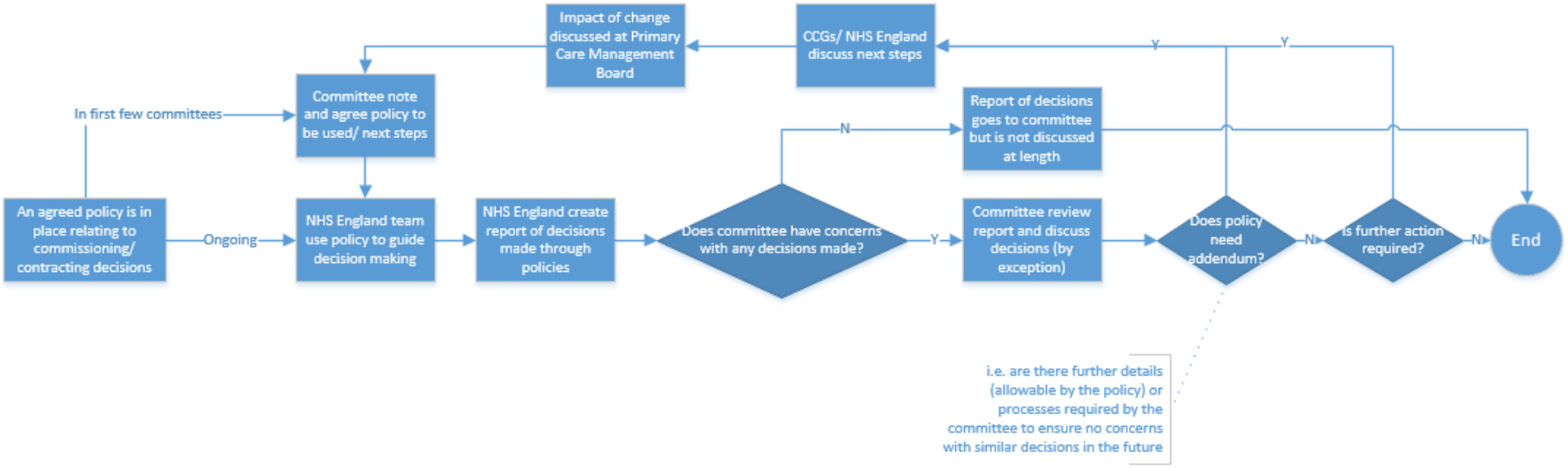


Figure 2: Decisions made through policies

This policy shows that although the policies referred to here would be Nationally or Regionally agreed policies, and therefore with limited scope for change, it is proposed that these are discussed and agreed at one of the early committee meetings in order to confirm that the members are comfortable with the scope and approach. The process also includes provision for addendums to the policy. If for example there are concerns regarding the way a decision has been reached then the committee should talk about the way that this can be improved in the future. It is important to note that the content of an agreed policy may not be able to be changed, and the impact of any material change would need to be signed off at the Primary Care Management Board as well as the committee, but this is to illustrate the opportunity for continual improvement.

The purpose of this process is to relieve agenda pressure in the committee. If there are any decisions or elements of the report which the committee would like to discuss, this can be done and should be offered by the chair at the start of the meeting.

2.2.1.1 Decisions with defined policies

The decisions which can be made through defined policies will be discussed and agreed by each co-commissioning committee, however the expected decisions where policies are expected to be used to make decisions:

- List closure
- Boundary changes
- Discretionary payments
- Contractual changes

There are several other areas where standard operating processes or policies exist, but it is expected that decisions will still need to be made within the committee and therefore are not included here. The full list of potential decisions with policies can be found in Figure 5.

2.2.2 Urgent decision making:

'Urgent' is defined in this document as a decision which cannot be made within a committee because of timing and nature of the decision. The main co-commissioning committee is accountable for all decisions, and should agree to the decision process for this and expected circumstances where this would arise and these agreed arrangements should be reflected in the relevant terms of reference. It is important to note that there are two types of urgent decisions. These are described below, with suggested processes.

It should be noted however that the process and individuals involved should be decided and agreed by the Primary Care Committee, and this should be reflected in their terms of reference (either referring to this operating model and providing details of the individuals to be involved or outlining any changes within the agreed principles).

2.2.2.1 **Urgent unplanned decisions**

An urgent unplanned decision arises when something unexpected occurs that requires immediate action. For example if a practice goes bankrupt a decision will need to be made immediately in order to support the patients on the registered list.

The below principles apply to urgent unplanned decisions:

- Wherever possible, only decisions necessary to maintain patient care should be taken outside of the committee
- The committee must ensure that an appropriate CCG contact is identified to be contacted in the event of an urgent decision being required
- NHS England will communicate with this contact (by phone/ email) in order to make a decision, this will be:
    - A joint decision between the NHS England and CCG representatives if operating in joint commissioning, or
    - The CCG is asked to make a decision in delegated commissioning
    - ***Please note, if the contact cannot be reached, NHS England will make a decision in order to ensure appropriate patient care***
- Depending on timescales for the decision, it may be possible to involve multiple people in the decision making process

- In the event that the CCG is made aware of the need to make an urgent decision, they are:
    - Required to communicate with NHS England to make the decision together if operating in joint commissioning
    - Able to communicate with NHS England if they require support/ advice to make the decision in delegated commissioning

The below diagram shows how urgent unplanned decisions might be made. ***Please note, these process would be the same for both Joint and Delegated commissioning decisions***:

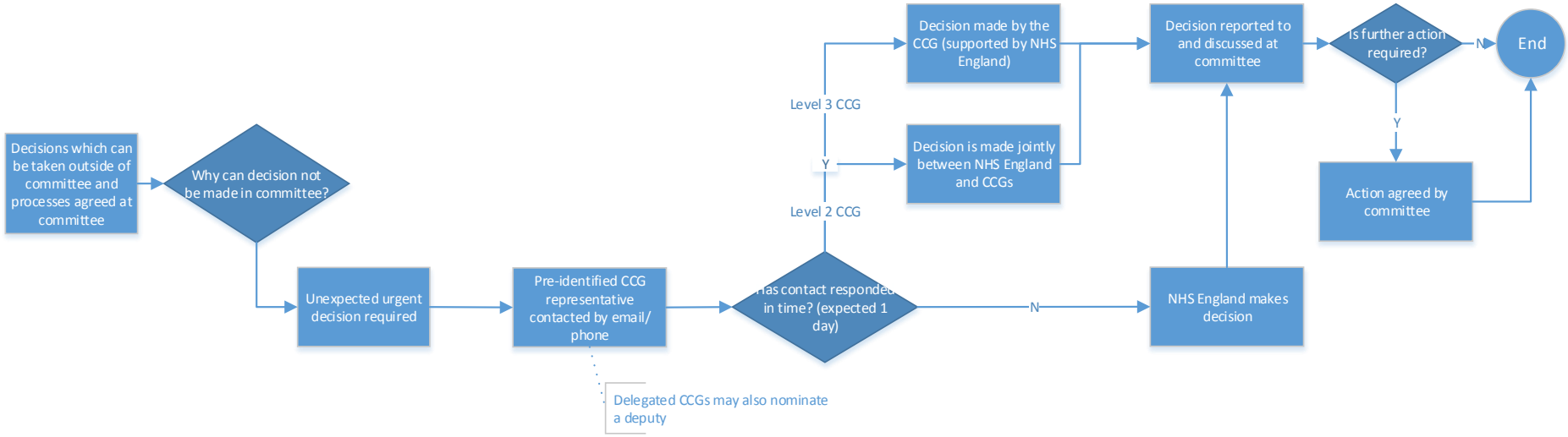


Figure 3: Urgent unplanned decisions

This process is also described below:

- In the event that a situation occurs unexpectedly in which an urgent decision is made, NHS England will communicate with the relevant CCG contact (by phone/ email) in order to support the decision making process
    - For joint commissioning CCGs, the decision will be made by NHS England and the CCG together
    - Delegated commissioning CCGs will make the decision, supported by NHS England as required
- As the definition of urgent decision is that decisions need to be made to maintain patient care, if the CCG contact is not available within the required time (e,g. 1 day), NHS England will need to make the decision on behalf of the CCG. CCGs may nominate a deputy for these circumstances.
- These decisions will be reported back to the committee and discussed. Any further action will be agreed by the committee.

It should be noted that both NHS England and CCGs should aim to learn from and if able create processes for making decisions in these circumstances. Also in the event that the CCG becomes aware of the decision that needs to be made, they will need to:

- In joint commissioning – communicate with NHS England (the relevant Head of Primary Care or Director of Primary Care) in order to jointly make the decision

- In delegated commissioning, the CCG may wish to seek advice or support from NHS England but is not obligated too. They should however inform them of the decision as there may be impacts or other communications which should reflect the decision made.

Some CCGs have outlined a process if the decision making window is longer (for example two weeks), allowing them to bring together a slightly bigger group of people (e.g. Chief officers, the chair of the committee and NHS England representatives). This enables decisions to be more widely considered and tested however it is noted that it may be challenging to gather a wider group at short notice, and it is suggested that virtual or telephone discussions may be easier.

2.2.2.2 **Urgent planned decisions**

There may be some decisions which are expected, but:

- Cannot be made at an earlier committee as, for example there is insufficient information
- Must be made before the next committee

This means that decisions do need to be made through an urgent process, but that some planning can be undertaken ahead of the decision. Specific arrangements and decision rights, for each CCG, should be referenced in their Terms of Reference. The principle of how this should operate is shown below:

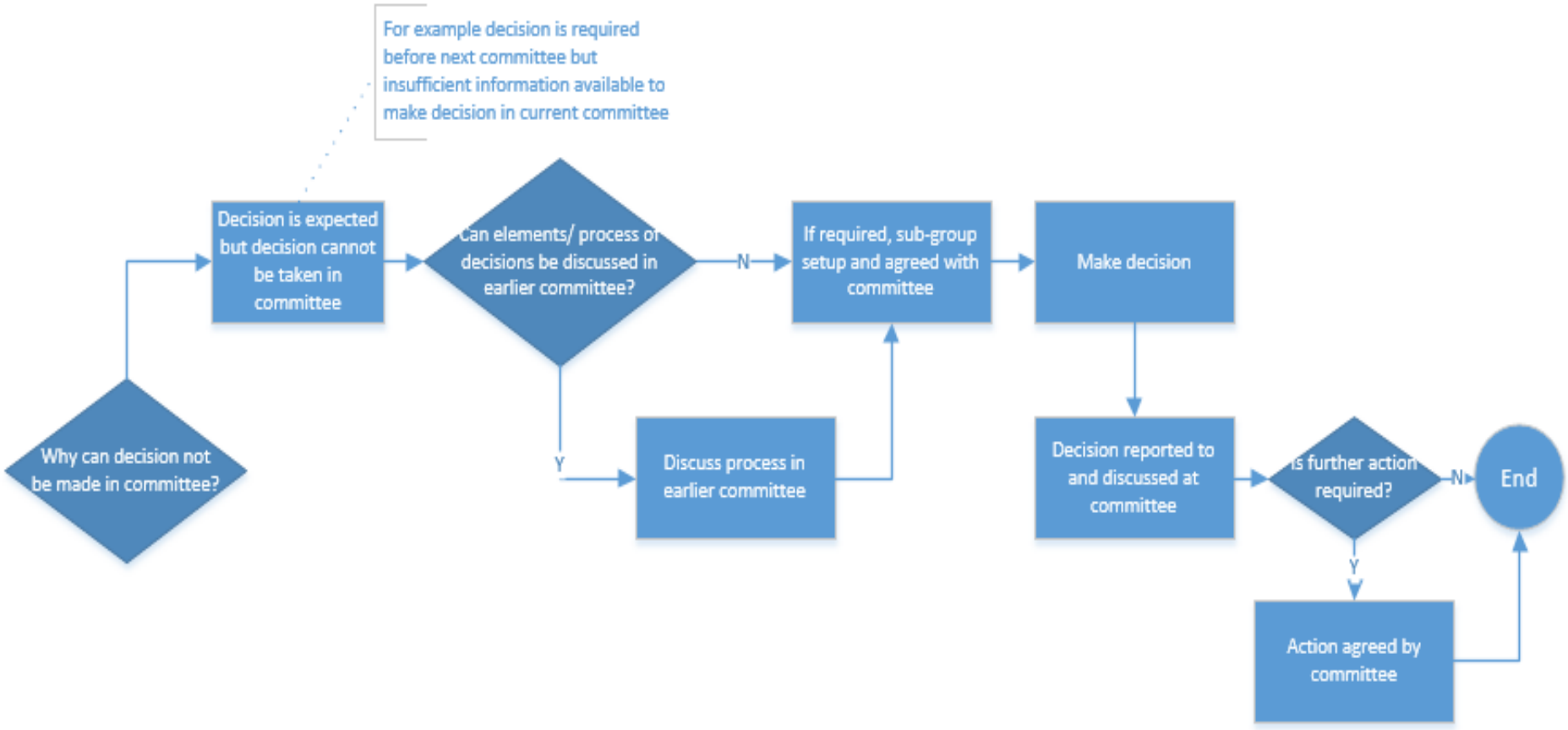


Figure 4: Urgent planned decisions

This process is also described below:

- In the event that a decision cannot be taken in the committee because sufficient information is not known, or there are some other inhibiting circumstances, planning should be undertaken as much as possible to ensure the committee is able to input into the decision making process
- Therefore any elements of the decision or process relating to the decision should be discussed, and if necessary a sub or working group may be set up to continue work towards this decision
    - Please note, there may be an existing group or sub-committee which would undertake this work.
- These decisions will be reported back to the committee and discussed. Any further action will be agreed by the committee.
  It should be noted that both NHS England and CCGs should aim to learn from and if able create processes for making decisions in these circumstances

2.2.3 Main decision types required

2.2.3.1 Business as usual decisions

The table below sets out of the main formerly NHS England functions which will now be decided in the committee. This includes a recommendation as to the type of decision the committee will be asked to make (this is not confirmed until this document has been approved by each committee), as well as estimates of the frequency of each activity.

Please note: these are high level estimates based on the last 12 months and are for all of London rather than the volume any one committee will likely need to decide on.

	Name	Function	Estimated volume of activity across London (12 months)	Committee decisions needed (section 2.2)	Decision possible with approved policy (s 2.2.1)	Need for urgent decisions (s 2.2.2)	Does a national/London SOP/policy/report exist? (If "yes", attached in annex)
Process 1	Determin - ation of key decisions or requests	List Closure	20		■		Yes
		Practice mergers/ moves	100	■			Yes
		Boundary Changes	20		■		SOP practice to apply and general DMG paper derived from this
		Securing services through APMS contracts	40	■			Yes – options appraisal doc
		PMS (reviews etc)	Ongoing	■			In process
		Discretionary Payments	600		■		Process as per SOP. Appeal/ complaint paper below.
		Remedial and breach notices	(Actual)	■		■	Yes (Contractual issues of concern)
		Contract termination-e.g Death/ Bankruptcy/ CQC	(Actual)	■		■	Yes, for bankruptcy, and options paper
		Contractual changes (contentious/ important)	100	■		■	
		Contractual changes (transactional)	650		■		Yes (Contract signatory changes)
Process 2	Financial Processes	Ensuring budget sustainability	Ongoing	■			
		Management Accounting	Ongoing	■			
Process 3	Strategy & Policy	Securing quality improvement	Ongoing	■			Request to issue breach over quality attached
		Developing and agreeing outcome framework e.g. LIS	70	■			Yes (for LIS schemes)
		Securing consistent population based provision of advanced and enhanced services	50	■			As above
		Premises plans, including discretionary funding requests	200	■			Yes, example PID attached

Figure 5: Table showing former NHS England functions which will now be decided in the committee

2.2.3.2 Strategic Discussion and decision making

The committee should also be used to support discussion on Primary Care strategies, such as delivery of the *Strategic Commissioning Framework* and other strategic aims.

2.3 Reporting Requirements

The current standard reporting offer is shown below. NHS England will prepare these reports, and will provide these to CCGs 4 working days ahead of the deadline for circulation of papers to committees, to allow the CCG the opportunity to review and add any comments. Potential developments indicate where advancement of the reports may be possible but discussion would be required on impact and requirement:

Report	Source	Freq.	Usage now	Available immediately	Potential development
Patient satisfaction with access	NHS England Business Analytics (BA) Team	Every 6 months	Not currently used as part of decision making	Data can be shared directly from BA team. This will not be fully analysed	Interpretation/ summary or recommendations based on data as input into the committee
Performance reporting (incl. breaches)	NHS England case management team*	Quarterly	Used to identify under performers (i.e. bottom 5%) for discussion	Reports (not anonymised) will be provided direct to CCGs. They can then decide if/ how to discuss in committees**	• Development of systematic approach to usage and response • CCGs may want to add information to report (such as complaints)
Primary Care Web Tool	Online	Quarterly	This can be used to extract information on practices, such as smoking cessation target achievement, and flus vacs as well as demographics etc	CCG members with nhs.net and nhs.uk emails will have access as required	

Finance & QIPP	NHS England Finance team	Monthly	High level exceptions analysis	Data is available by: • Regional team level (i.e. South, NCEL, NWL) • Contractor type (GMS, PMS etc) Provided to committees: • A summary file would be available to Level 3 committees • No data would be available to Level 2 committees as cannot be broken down to sub regional team level	• Development of information at a CCG level. • Information to provide to joint committees

In addition to making decisions and reviewing other decisions made related to the above, there will also be general reports which the committee will need to review and potential

Report	Source	Freq.	Usage now	Available immediately	Potential development
PMS Contract	NHS England Contracts Management Team		Not systematically available or reviewed	Only available for areas which have developed KPIs	Post PMS review, further information expected
APMS a) KPI Monitoring	NHS England Contracts Management Team	Annually	Not systematic	Annual summary of achievement against targets	
b) NHS England Commissioned APMS contracts	NHS England Contracts Management Team	Annually	Systematic review of achievement against targets	Annual summary of achievement against targets	
List maintenance	Primary Care Services	Annual	For analysing QIPP	*To be determined based on new provider*	*To be determined based on new provider*
Direct Enhanced Services Sign Up report	Primary Care Commissioning team	Annual	Payment analysis & budget setting	List of practices/ practioners signed up to DES schemes	Assurance of compliance and strategic achievement
E-declarations sign off report	Primary Care Web tool	Annual	For due diligence: - Non compliance	List by practice by level of compliance	• Could be added to performance report

			is investigated - Compliance declarations considered as part of performance management		• Further analysis of reports in consideration with other reports/ information

* Subject to continued programme budget
** Need to define who this is sent to – suggest "safe haven" approach

Figure 6: NHS England reporting

2.3.5 Conflicts of interest

All committees must adhere to the conflicts of interest guidance[2] and this must also be adhered to for any sub groups set up to support the committee.

2.3.5 Other decision-making processes – finance and strategy

Finance

Joint Co-Commissioning Committees

For Joint Committees, NHS England will continue to do all financial and management accounting. However, it will produce monthly financial reports (for instance, covering spending against forecast and narrative on variance) which will be provided to each CCG. The CCG may then chose to add information to these reports before they are submitted to the committee(s).

Delegated Co-Commissioning Committees

[2] i.e. *Managing conflicts of interest, Conflicts of Interest guidance* and *Code of Conduct* guides

For Delegated Committees, a monthly journal will transfer costs of delegated functions to the CCG's ledger from NHSE, and the CCG will be responsible for their own reporting, and their own management accounting of their primary care costs. The CCG may also make further queries of NHSE, to support this process. Management accounting activities will likely include, but not be restricted to:

- Month end procedures
- Accruals, prepayments, and any payments additional to those in the financial plan
- The production of monthly & quarterly CCG management reports at GP practice or locality level to ensure robust financial forecasts and analyse variances to ensure they are explained
- Practice list size analysis by CCG locality for GM/system report downloads
- Quarterly forecasting on CQRS
- Additional year end tasks including working papers and support to AOB process
- Liaise with internal and external audit as required.

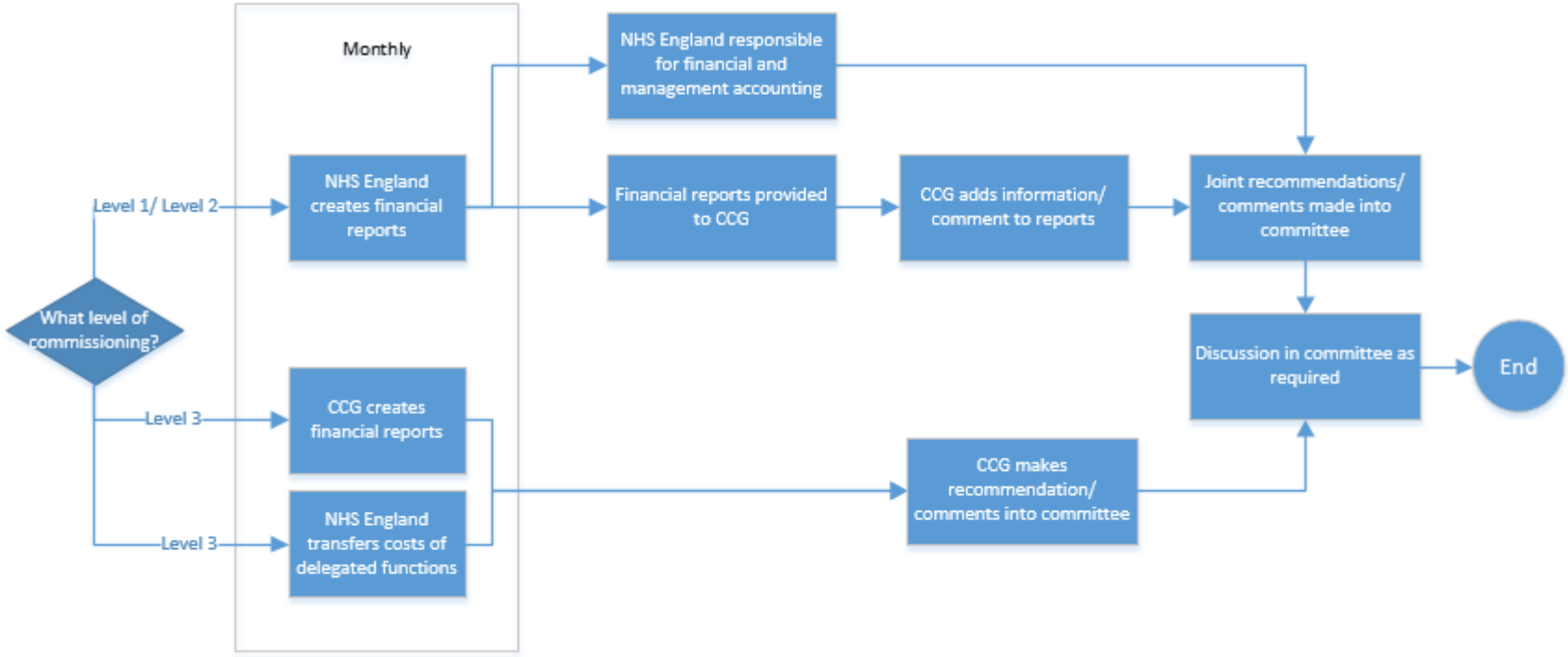


Figure 7: Process map showing financial processes

Strategy and policy

2.4 Other potential Committee responsibilities

In addition to the above standard processes, there are other Primary Care elements which the Committee is expected to be involved in. Some of these areas are listed below however it should be noted that further discussions are required as to how these would be enacted and supported between NHS England and the CCGs at different co-commissioning levels. Further delegation from NHS England to CCGs will not be made without agreement, and without consideration of the resource implications of such delegation.

Item	Committee Requirement
Appeals and disputes	The committee is asked to note the standard operating procedure for managing appeals and disputes submitted by GPs in relation to their GP contract.
Counter Fraud	Ensuring that proper processes are in place to prevent fraud within the NHS
Interpreting services	Ensure that patients can access interpreting services when using GP practices.
Occupational Health	The committee shall ensure that GPs have access to occupational health services in accordance with national guidance
Controlled drugs reporting	The Committee is responsible for ensuring that practices are complying with legal requirements for use of controlled drugs and that CCGs and NHSE have proper controls in place to maintain patient safety. The RT will carry out reporting, analysis and compliance that aids this.
Safeguarding	To set policy and to set the expectation that GP Practices have effective safeguarding systems in place in accordance with statutory requirements, national guidance and Pan London Policy/ Procedures. The CCG will proactively support Primary Care to improve well-being of children and adults, through the provision of training and good practice guidance, and in logging safeguarding issues; providing assurance to NHSE, whose role it is to ensure compliance with safeguarding standards. Further detail on responsibilities for safeguarding are provided under Annex 8.
Incident management	For both serious and non-serious incident management, the Committee is responsible for ensuring that there are proper processes in place for the reporting and review of incidents, so that they can be identified and managed. The CCG and NHS E will support and contribute to investigations, as required.
Domestic Homicide Reviews	The Committee will ensure that GPs contribute to domestic homicide reviews, where necessary. The CCG and NHS E will support this where their resources are appropriate. Further detail on responsibilities for safeguarding are provided under Annex 8.
Communications	For CCGs at level 3 delegation, lead responsibility will be determined by what is appropriate, on the merits of each communication. NHS England remain responsible for communications for CCGs at level 2 delegation.

Figure 8: Other potential Committee responsibilities

3. Governance and people

3.1 Committee constitution

While much of the decision-making processes will be determined by Committees/ Joint Committees, the constitution of the Committees themes have been set by NHSE, as a condition of co-commissioning. The following are the criteria for a Committee (for Level Three co-commissioning), and for a Joint Committee (for Level Two co-commissioning).

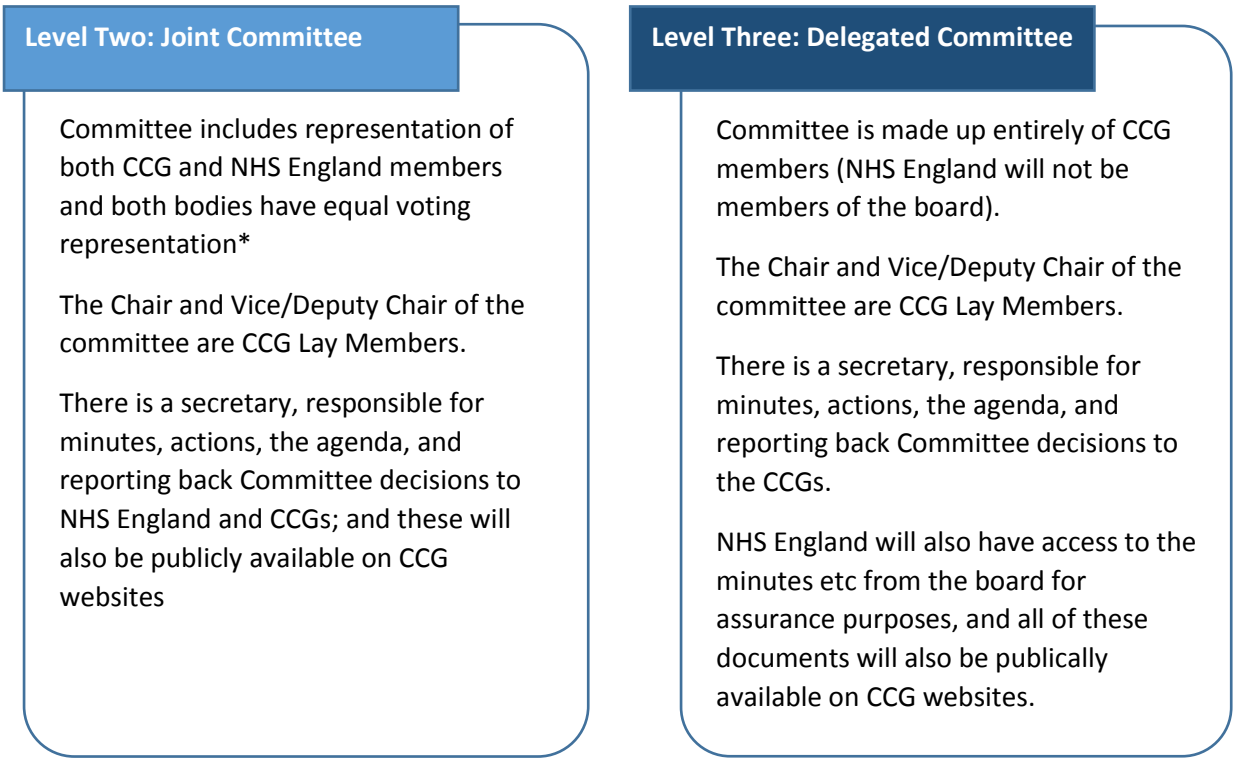


Figure 9: Committee and Joint Committee constitution

Other Committee attendees

In the interests of transparency and the mitigation of conflicts of interest, other interested local representative bodies have the right to join the joint committee as non-voting attendees, such as LMC, HealthWatch and Health and Wellbeing members. Invitees should be determined in line with national guidance, and local terms of reference. Attendees should be agreed so as to support alignment in decision making across the local health and social care system. Other organisations may be invited, and as the committee meets openly it is likely that members of the public and others will attend.

3.2 Committee resourcing

There will not be a nationally-determined model of resourcing for co-commissioning, and there is a recognition of the additional workload these new ways of working will result in. We

expect, therefore, local dialogue between CCGs and their regional teams to determine how the Committees can access the existing primary care team support, recognising that

- CCGs are taking on significant responsibilities from NHSE, and therefore will require access to a fair share of the regional team's primary care commissioning staff resources
- Area teams need to retain a degree of this resource, in order to safely and effectively continue with their remaining responsibilities.

Currently, there is no possibility of additional administrative resources from NHS England at this time, but this will be kept under review.

4. Processes & Capabilities

4.1 Meeting process:

It is proposed that the method of operating the committee should follow processes already established in CCG's. The below illustrates a standard process for meeting setup:

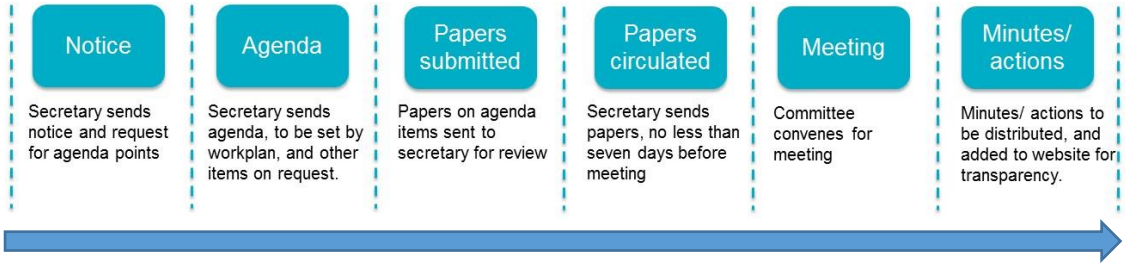


Figure 10: Meeting process map

4.1.1 Agenda contents

It will be important for engagement between NHS England and CCGs ahead of meetings, particularly in cases where a particularly significant matter is on the agenda to be discussed. This may involve the need for additional meetings, or for information from NHS England to inform thinking. This will be particularly important for delegated commissioning, where NHS England will not be participating in the committee discussion. Each Committee should set out how this engagement will take place, as well as when, in the standard meeting process set out above (Figure 10), submissions will be accepted for discussion at each meeting.

In general, clear and active engagement with NHS England, as well as the Committee sub groups, will help inform the content of the agenda we expect that agendas are likely to have the following components:

- *Standard agenda items*, which might involve items that can be expected at each meeting, such as an overview of finance and performance reports.

- *Work-plan items*, such as a review of the annual budget or developing a Primary Care Strategy, which is determined by the known upcoming work
- *Any other items*, which could include submissions from NHSE, sub groups, and the CCG.

There will also need to be a determination for whether part of the meeting needs to be in private. The process for determining the privacy of meetings is set out in 4.2, below.

The schedule of Committee meetings in 2015/16 can be found in Annex 6.

4.2 Meeting Papers

As outlined in the reporting section on page 21, papers created by NHS England should be submitted to the committee secretary 4 days before the papers are circulated in order to allow time for them to be reviewed and comments and adjustments made.

It is expected according to standard meeting processes that papers may be circulated a week before the meeting, although this should be determined by each committee and referenced in their terms of reference.

It is important that requirements in terms of papers and presenters is made clear by the time the agenda is finalised. Working groups and sub-committees should have clarity regarding upcoming meetings and how work should feed into these boards, including the timelines required.

Delegated CCGs should also ensure that where advice, recommendations or papers are required from NHS England, that this is sought and discussed in advance. The CCG may or may not request NHS England presents the paper at the committee.

4.3 Meeting in private:

As standard, the Committee meetings will be held in public. However, the Committee may require to close part of the meeting on account of the matters to be discussed. Only members of NHS statutory bodies, that are bound by standard NHS confidentiality agreements are expected toattend the closed part of meetings. Only attendees of the private part of the meeting will receive the papers for that part of the agenda. If necessary it may be important to redact names and other details from the minutes.

It may be appropriate for the committee to seek the views of the audit chairs once a definition of this policy has been created for each committee. Below is some guidance which Committees may wish to consider:

- Whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; or
- If the discussion is commercially sensitive; or
- Where the matter being discussed is part of an ongoing investigation; or

- For any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

The provision for private meetings should only be used where required (as per the criteria above). Where the discussion is not as sensitive, other mechanisms could potentially be used, such as anonymising the reports. Additionally, Members of the Committee shall respect confidentiality requirements as set out in the CCG Constitution and Standing Orders.

5. Annexes

Annex Introduction

The annexes included with this document aim to provide further detail to elements of the Operating model where it is too detailed to include in the main body of the text. These are not meant to be read as continuous chapters, but are included as reference material if required. A short description of the purpose of each annex is included in a table below:

Annex Reference/ Name	Purpose
Annex 1: Detailed processes – including differences in responsibility by delegation level	This is the detailed memorandum of understanding aiming to outline the relative responsibilities of the CCG, NHS England and "the committee". The committee includes both joint and delegated committees. This can be used if more detail is required on process and ownership, however it is suggested that where activities are unclear it may be beneficial to discuss with an NHS England or CCG colleague.
Annex 2: 13Z – CCG Statutory duties	This lists the duties which effect the CCG that NHS England does not have liability for under section 13Z. This is included for its reference to roles and responsibilities.
Annex 3: Performer Contract Decision Making Process	This process aims to outline the decision making process specifically related to contract decisions arising from performer issues. It links into the overall decision making process flows (section 2).
Annex 4: NHS England (London) Primary Care Commissioning Team Org Chart	This annex provides detail of the target organisational structure of the pan London commissioning and contracting team, including the support available to the different SPG areas.
Annex 5: PCIF Bid Process	This annex outlines the Primary Care Infrastructure fund bid process.
Annex 6: Standard Report Formats	There are several different types of reports which will be sent to the committee. In order to ensure the committee are familiar with the standard report format and content, these are included here for reference.
Annex 7: Meeting Frequency	This calendar outlines the planned committees happening throughout the year. This provides an opportunity to understand when committees in other areas will be convened.
Annex 8: Safeguarding – responsibilities at different levels of	This annex provides a high level analysis of responsibilities related to safeguarding at different

CCG co-commissioning delegation	levels of co-commissioning:

5.1 Annex 1: Detailed processes

The tables below set out the key Co-Commissioning responsibilities and tasks of the Committee, the CCGs and NHS England.

	Responsibilities			Tasks/ Standard		
Definition	The Committee	CCG	NHS E	The Committee	CCG	NHS E
1. Determination of key decisions/ requests						
Determination to secure services through an APMS contract either a consequence of a practice vacancy, a finding that there are inadequate services in the area or following a contract expiration	To decide whether it is appropriate to undertake a procurement to appoint an APMS provider where there is a vacancy or a contract has expired. In making this decision the Committee must ensure that it is a viable and vfm service that will meet the needs of the current and future population, addresses inequalities, improves quality choice and access. The Committee is responsible for ensuring that appropriate engagement processes are in place to support decision making	To secure & provide, to the RT, local intelligence and feedback to support decision making. The CCG shall also provide relevant local strategic context to support decision making. The CCG may, if appropriate, agree additional resourcing for the service. To work jointly with the RT and local representative to identify new or alternative solutions to address the practice vacancy and additional local KPI requirements.	To secure & provide necessary information to support decision : - performance and service data; - equality impact assessment; - needs assessment; - available funding, including transitional funding; -service viability; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee. To work jointly with the RT and local representative to identify new or alternative solutions to address the practice vacancy	Tasks: 1. Determine whether procurement is the best option in the interests of patients and the public and that no other options are viable to secure adequate services 2. Assure that correct processes have been followed, particularly in relation to patient and stakeholder engagement; 3. Confirm that the contract is affordable; 4. Confirm that the service is viable 5. Set tolerances for the cost and timeframe for implementation. 6. Ensure that an equality impact assessment has been undertaken 7. Ensure that the proposed procurement processes are undertaken in accordance with SFI's and regulations. Standard: Maintain a record of the decision, particularly in relation to potential conflicts of interest; Notify RT of decision with details of agreed funding and tolerances for implementation;	Tasks: 1. Provide local intelligence to the RT to support their report: 2. Provide relevant information about local strategies to be included in the RT report: 3. Where necessary present paper to The Committee, with RT 4. Where appropriate, secure additional CCG funding to support a new service prior to the Committee's determination 5. Provide relevant specifications and data to support local KPI's. Standard: To provide relevant information to the RT within 15 WD's of the request. To ensure that the Committee has information to support their decision making, including confirmation of any funding the CCG intends to make available for the service.	Tasks: 1. Undertake required needs assessment, feasibility analysis, financial modelling and impact assessments to support the decision making process. 2. Implement an appropriate engagement plan. 3. Work jointly with the CCG to identify any local KPI's or other commissioning opportunities. 4. Identify and secure any additional resources required to support options. 5. Establish a procurement project team to implement the Committee's decision, if required. 6. To maintain and update a database of fixed term contracts. 7. To procure the service in accordance with directions, regulations and guidance. Standard: To process in accordance with regulatory requirements, Relevant SFI's and agreed procurement processes.
Procurement of new Services under APMS agreements	The Committee is responsible for approving a preferred provider following procurement process following the evaluation process	The CCG is responsible for providing local standards and specifications to address local issues of access, quality and choice	The RT shall develop and implement procurement policies & programmes aimed RT securing new APMS providers.		Tasks: Develop local standards and KPI's to be incorporated into APMS contracts. Support providers to ensure optimum delivery. Communicate with local stakeholders as required.	Tasks: Develop London standards and KPI's to be incorporated in APMS Contracts. Standard: Use standard frameworks to secure services and ensure good value for money - Support providers to ensure optimum delivery. Standard: Procure APMS in line with the agreed commissioning strategy - Initiate formal procurement activity for each APMS scheme, within terms of any national procurement support. - Sign off/ finalise contracts with preferred bidder. - Agree/ implement the local mobilisation plan. - Undertake appropriate checks prior to service commencement (for example, premises inspection). - Make provision for emergency primary medical care services in the event of an unforeseen circumstance.
Determination of a requests; - to close a branch practice; -for practice mergers; -PMS partnerships; -List Closures; -Rent Reviews	To consider and determine requests in a timely manner following appropriate consultation and in accordance with statutory requirements and agreed policy; ensuring that any decision will secure continuity of services and provide benefits for patients and the public. The Committee will pay due considerations to Strategic imperatives and Statutory	To secure & provide, to the RT, local intelligence and feedback to support decision making. The CCG shall also provide relevant local strategic context to support decision making.	To secure & provide necessary information to support decision: - performance and service data; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee.	Tasks: 1. Determine request; 2. Assure that correct processed have been followed, particularly in relation to patient and stakeholder engagement; 3. Provide minutes and decision rationale 4. Ensure continuity services as a consequence of their decision: 5. Maintain records of all decisions; 6. Respond to questions and queries relevant to the decision, including FOI requests.. Standard: Provide decision and rationale within 5 WD of the meeting:	Tasks: 1. Provide local intelligence to the RT to support their report: 2. Provide relevant information about local strategies to be included in the RT report: 3. Work jointly with RT to ensure patient benefit and service continuity; 4. Where necessary present paper to The Committee, with RT . Standard: All requested information to be provided within 10 WD: To make available relevant staff for meetings and case conferences pertinent to the decision	Tasks: 1. Processing the application; 2. Engagement/consulation with stakeholders and patients; 3. Notifying the CCG and The Comittee secretariate ; 4. Preparing & presenting the report to the Comittee, using agreed format; 5. Issue decision letters/ notices; 6. Suport any practice closure using agreed protocol; 7. Updating databases and notifying 111 via CSU. Standard: To process in accordance with:

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
	requirements to secure primary care services to meet the current and future needs of the population.			- Ensure that service continuity is not compromised as a consequence of their decision: - Ensure patient and public benefits are secured: - Acknowledge all queries within 5 WD offering full response within 20 WD: - Comply with FOI timescales		- National & London SOP; - Regulations- Contract and Patient Public engagement
GP Practices list maintenance	The Committee is responsible for decisions on any ad hoc list maintenance requests and for the setting of cleansing periods		NHS England is responsible for coomissioning a process of practice list maintenance in accordance with national guidance as stated in Schedule 2 Part 1 Section 3.1.7 of the Delegation Agreement and will liaise with NHS Shared Business services and any other external partner as part of that.			
Issue of Contract Breach Notice	To determine whether a provider has breached the terms of their contract and to make a proportionate decision as to whether: -a remedial or breach notice is warranted; -the practice should be asked to submit a improvement plan; -no action is required under the circumstances. To review outcome of remediation /improvement plans.	To identify & manage any resultation risk to services they commission as a consequence of an adverse finding. To provide support or facilitation for any relevant improvement plan/actions	To investigate concerns and provide evidence where a contract has been breached together with any mitigation offered by the provider using an agreed London template: To implement decisions	Tasks: 1. Review evidence and confirm that a contract has been breached; 2. determine the most appropriate and proportionate response to the breach taking account of relevant mitigation . Standard: Provide decision and rationale within 5 WD of the meeting: Ensure that service continuity is not compromised as a consequence of their decision: Ensure that there is a formal review of the outcome of all remediation and improvement plans.	Tasks: The CCG may be informed of concerns when a finding has been made, if it is relevant to any contract held between them and the provider. .	Tasks: 1. Identify concerns: 2. Investigate concerns: 3. Notify the provider of concerns and any evidence to support they have breached the contract: 4. Present evidence of the breach to the The Comittee along with any mitigation provided by the provider: 5. Issue notices to the provider: 6. follow up remedial actions /action plans 7. liaise with the CQC and carry out actions to support registration 8. Produce format for local notices and breaches. Standard: Contract Regulations; National SOP Local protocols
Contract Termination	Determine the appropriateness of contract termination	To identify & manage any resultation risk to services they commission as a consequence of an adverse finding. To provide support or facilitation for any relevant improvement plan/actions	To investigate concerns and provide evidence where a contract has been breached together with any mitigation offered by the provider using an agreed London template: To implement decisions	Tasks: 1. Review evidence and confirm that a contract has been breached; 2. determine the most appropriate and proportionate response to the breach taking account of relevant mitigation . Standard: Provide decision and rationale within 5 WD of the meeting: Ensure that service continuity is not compromised as a consequence of their decision: Ensure that there is a formal review of the outcome of all remediation and improvement plans.	Tasks: The CCG may be informed of concerns when a finding has been made, if it is relevant to any contract held between them and the provider. . Standard:	Tasks: Develop contract termination documentation, systems and processes. - Prepare Reports and Evidence for the Committee, securing necessary legal advice. - Issue termination notices. - Develop action plans to manage termination of contracts and implement in consultation with and supported by stakeholders. Update the contractor database with sanction information.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Contractual Payments	The Committee is responsible for assuring that systems and processes are in place to ensure accurate and prompt payments to GP Practices in accordance with Contracts, Agreements, The SFE and SFI's	The CCG is responsible for notifying the Committee of any systematiic failure to promptly pay GP Providers in accordance with the Contract / Agreements and SFE, setting out how this is to be addressed	NHS E is responsible for notifying the Committee of any systematiic failure to promptly pay GP Providers in accordance with the Contract / Agreements and SFE, setting out how this is to be addressed	Tasks: 1. Review evidence and confirm that a contract has been breached;2. determine the most appropriate and proportionate response to the breach taking account of relevant mitigation . Standard: Provide decision and rationale within 5 WD of the meeting:Ensure that service continuity is not compromised as a consequence of their decision:Ensure that there is a formal review of the outcome of all remediation and improvement plans.	Tasks: The CCG may be informed of concerns when a finding has been made, if it is relevant to any contract held between them and the provider.	Tasks: - Agree appropriate contract variations (for example, list size changes) including their input to payment systems. - Calculate any agreed local quality and outcomes framework arrangement. - Calculate the impact of key performance indicators on contractual payments (alternative provider medical services contracts). - Determine entitlements to personal allowances (for example, seniority/ locum reimbursement). - Calculate and pay enhanced services that are specified nationally.- Calculate payments for GP registrars in respect of salary, mileage and travel grants. - Calculate prescribing and dispensing drug payments. - Calculate entitlements under the GP retainer/ GP returner and flexible career schemes.- Calculate payments in respect of the dispensary service quality scheme. Administer superannuation regulations, including all deductions, in relation to joiners, leavers, retirements, increased benefits, adjustments and pay these to the pensions division. - Administer and validate GP annual certificates. - Administer GP locum and GP- Solo contributions. - Provide the NHS pension assurance statement.- For suspended contractors, ascertain the individual's entitlements, advise the contractor, validate all documentation, and adjust payment accordingly.
Disputes and Appeals	The Committee is responsible for agreeing a policy and procedure for managing appeals and disputes submitted by GP's in relation to their GP Contract. This includes ensuring there is a local res.olution process and that a Panel is established to consider disputes and appeals where local resolution is not sucessful.			Tasks: The Committee shall establish a Panel who will consider any appeal or dispute.. Standard: The Committee shall ensure that all decisions are made in accordance with the Contract Regulations,SFE, SOP and previous determinations.		Tasks: The RT shall : 1. Ensure that contractors receive a clear and concise notice setting out any determination under the contract; 2. Implement local resolution where a contractor disputes a determination; 3. Where Local Resolution is not successful notify the Committee of the need to establish a Panel; 4. Provide a report to the Panel setting out their rationale and evidence in support of their decision; 5. Present evidence & representations to the Panel 6. Notify the contractor of the outcome; 7. Provide information as required by the Litigation authority in relation to any appeal

2. Financial processes

Determine total budget requirements for all primary care services, including premises and information technology ***Level 3 delegated CCGs***	The Committee is responsible for ensuring that financial balance is secured and maintained.	Under Delegated Arrangements the CCG CFO will approve the financial plan plus any in year revisions	NHS E will carry out the day to day financial management tasks, including the production of monthly reports showing spending vs the agreed budget and variance analysis. NHSE will develop the annual fianncial plans within the region's allocaiton and overall PC plan, under the oversight of the CCG.	Tasks: Ensure apprpriate financial controls are in place to securely manage the budgets.. Standard: Operates in accordance with NHSE or CCG SFIs.	Tasks: Where CCGs have full delegation: a) Maintain control total for revenue and capital limits and agreement of RFTs b) Financial Planning & Reporting including monthly board report, external reports, financial plan submissions and in year review of plans, budget setting & team co-ordination, month end overview. non ISFE reports to region, QIPP reporting. Standard:	Tasks: a) Maintain control total for revenue and capital limits and agreement of RFTs b) Financial Planning & Reporting including input to monthly board report, external reports, financial plan submissions and in year review of plans, budget setting & team co-ordination, month end overview. non ISFE reports to region, QIPP reporting.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Management Accounts ***Level 3 delegated CCGs***	The Committee will: - review the financial reports; - Make decisions to address financial deficits; - Approve any payments additional to those in the financial plan	The CCG will scrutinise the financial reports prepared by the RT and will ensure that the appropriate decisions are brought to the attention of the Committee	NHS E will provide appropriate monthly financial reports to enable budget holders to monitor and take decisions on the budgets,		Tasks: Where CCGs have full delegation: The production of monthly & quarterly CCG management reports at GP practice or locality level to ensure robust financial forecasts and analyse varainces to ensure any variances are explained: Month end procedures a) complete regular task file b) variance analysis & narrative c) accruals & prepayments d) monthly year end forecasts at practice level or locality level and input to system e) meet with budget holders f) Practice list size analysis by CCG locality for GM/system report downloads g) Quarterly forecasting on CQRS(inform forecasting h) additional year end tasks including working papers and support to AOB process i) liaise with internal and external audit as required.. Standard:	Tasks: The production of monthly & quarterly management reports at GP practice or locality level to ensure robust financial forecasts and analyse varainces to ensure any variances are explained: Month end procedures a) complete regular task file b) variance analysis & narrative c) accruals & prepayments d) monthly year end forecasts RT practice level or locality level and input to system e) meet with budget holders f) Practice list size analysis by CCG locality for GM/system report downloads g) Quarterly forecasting on CQRS(inform forecasting h) additional year end tasks including working papers and support to AOB process i) liaise with internal and external audit . Standard:
Financial systems and BI ***Level 3 delegated CCGs***	The Committee shall assure that appropriate systems and SOPS are in place to manage and maintain financial control in line with the relevant financial instructions	The CCG will ensure correct calculations and payments are carried out in line with the contracts by ensuring that the RT team provides has appropriate internal and external audit arrangements in place audit	NHS England is responsible for the correct calculation of payments to all contractors in line with their contracts	Tasks: . Standard:	Tasks: Where CCGs have full delegation: Ensuring compliance with central requests and timelines and utilising their system and BI reports to best effect: a) Financial System Management including setting up new ISFE reports, locality reporting, controls, exception reporting liaison with with RT finance department. . Standard:	Tasks: Ensuring compliance with central requests and timelines and utilising the system and BI reports to best effect: a) Set up new suppliers or amend existing suppliers on ISFE e.g changes to bank account details, and to reflect practice mergers b) Financial System Management including setting up new reports, locality reporting to CCGs, controls, exception reporting d)Liaison with SBS and central NHS England . Standard:

3. Strategy and policy

Develop and agree a Primary Care Strategy (SPG)	The Committee to: - approve strategy and, - provide oversight to development and implementation	To contribute information & resources to: -support strategy development, -implement plans and strategies, - contribute resources to facilitate joint working To ensure primary care strategies are aligned to CCG strategies and plans To develop and implement engagement plans in line with primary care strategy.	To contribute information & resources to: -support strategy development, -implement plans and strategies, - contribute resources to facilitate joint working To develop and implement engagement plans in line with primary care strategy.	Standard: Engage and consult with key stakeholders, including patients, carers and the public in relation to priority areas for improvement,Ensure that the London Specifications / Framework is integrated into Local CCG and SPG Strategies, Ensure that primary care is integrated into local joint strategic needs assessment planning processes, Integrate and align primary care strategies with health and well being strategies, Integrate and align primary care strategies with CCG and SPG strategies, particularly in relation to urgent care and collaborative care		
Primary Premises Plan /Strategy	The Committee is responsible for reviewing and determining business cases for new premises developments in accordance with local CCG premises development plans, national guidance and primary care directions	The CCG is responsible for developing local Strategies and Development Plans in conjunction with NHS E and NHS property holding organisations (Trusts, NHS PS and CHP)	The RT is responsible for providing information to CCG's and other organisations to support the development of strategic premises plans			

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Workforce Audit and planning	The Committee shall ensure that appropriate workforce audit and planning is place to support service delivery	The CCG to undertake local audits as required	The RT shall implement the national workforce audit and is responsible for ensuring that all practices submit their return			
GP Provider Development - Organisation Structures	The Committee is responsible for determining responses to requests to close or merge practices	To support the below : - performance and service data; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee. The CCG will consult with local stakeholders to arrive at a final decision.	To secure & provide necessary information to support decision : - performance and service data; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee.	Standard: The Committee shall ensure that all decisions in relation to mergers, closures and procurement support the London and Local aims for provider development		
Develop and agree outcome frameworks for GP Services ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee shall agree an outcome framework for GPs services that enables continuous quality improvement and that it is aligned to national and local strategies. The framework shall be based on the national primary care GPOS and High performance indicators plus any local outcome and indicators set by the CCG	The CCG shall make available performance against locally agreed outcome and indicators required under the framework as required	NHSE shall make available practice and CCG performance against national GPOS and High Level indicators via the Primary Care Web-Tool		Tasks: The CCG developf a local Outcomes Framework under the guidance of The Committee by -Collecting and validating performance data againt locally agreed outcomes and standards - Providing locally agreed performance reports Undertake Service reviews : LIS (or LES) Specifications . Standard:	Tasks: The RT will support the development of a local Outcomes Framework under the guidance of The Committee by -Collecting and validating performance data againt nationally agreed outcomes and standards - Providing nationally agreed performance reports on an annual or quaterly basis via the Primary Care Web Tool Undertake service reviews :GP Contracts, Advanced Services & DES. Standard:
Planning PMS Review	The Committee shall oversee the implementation of the national PMS review to ensure that all contracts are reviewed within the national timescales and that agreements are varied to reflect new prices and premium payments	Delegated CCGs shall lead on the development and implementation of Local PMS Premium specifications and payments.	NHS England shall be responsible for the PMS Programme for Greater Involvement (Level 1) and Joint Commissioning (Level 2) CCGs. They may also be asked to support the PMS review for delegated CCGs		Tasks: The CCG developf a local Outcomes Framework under the guidance of The Committee by -Collecting and validating performance data againt locally agreed outcomes and standards - Providing locally agreed performance reports Undertake Service reviews : LIS (or LES) Specifications .	Tasks: Financial Review, contract review, engagement (public and stakeholder), implementation of agreement changes
Securing Quality Improvement ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee is responsible for review and approval of all Local Improvement Schemes (LES's). The Committee is responsible for review and approval of the use of APMS to secure quality improvement under collaborative arrangements	The CCG will develop and lead the implementation of local schemes /Local Enhanced Services aimed at improving the quality in primary care. This will include development of clinical leadership and of peer support for practices.	The RT shall make available information to support quality improvement, and will support the CCG in the implementation of local schemes.		Tasks: Develop and implement local improvement schemes /Local Enhanced Services aimed at improving quality in primary care. -- Procurement and implementation of collaborative services aimed RT quality improvement under APMS arrangements. - Support and develop peer support for practices and practice staff. - Support and develop clinical leadership Standard: LCSF	Tasks: The RT will incorporate any Local Incentive Schemes into the provider contracts as stated in Schedule 2 Part 1 Sections 2.11 The RT will negotiate, in partnership with clinical commissioning groups, quality improvement plan with each practice. Standard:

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Securing Directed Enhanced Provision	The Committee shall review uptake and performance of all national DES and where necessary direct CCG's and RT's to take action to improve uptake or develop alternative local schemes	To support implementation as directed within the specifications	To support implementation as directed within the specifications. To provide information to the Committee on uptake and performance		Tasks: The CCG shall support local implemenation and training as required under the national specification. Standard:	Tasks: The RT will disseminate all national DES specifications to practices together with local implementation guidance and a sign up sheet in accordance with the national timetable/ MOU (KPI's). Standard:
Securing Advanced Service Provision	The Committee shall review uptake and performance of all additional service provision and where necessary direct CCG's and RT's to take action to improve uptake or develop alternative local schemes	To provide information to the Committee about uptake and performance of non GP providers, making recommendations where additional services should be commissioned	To provide information to the Committee about uptake and performance of GP (& Pharmacy) providers, making recommendations where additional services should be commissioned	Tasks: Where necessary to direct the CCG or RT to take action to improve service provision. Standard:	Tasks: Procure additional services from non GP providers where practices do not wish to undertake them. Standard:	Tasks: Agree opt outs from the general medical services contract. Discuss locally the provision of additional services (where practices wish not to undertake them) with clinical commissioning groups. Standard:
Development of Policies and Procedures	The Committee shall approve all Local and endorse all London policies procedures in line with regulations					Tasks: Develop and maintain policies and procedures in line with regulations. Standard:
Contract Maintenance	The Committee shall ensure that the RT and CCG maintain all GP contracts in line with national and local variations and that systems are place to implement material changes		The RT will be responsible for the carrying out of several responsibilities specifically highlighted in the Delegation Agreement, including: 1. Managing Contract Variations Schedule 2 Part 1 Section 2.4.3 The RT shall report, by exception, any failure to properly maintain contract documentation and provide an action plan to address this oversight			Tasks: - Issue national standard contract variations in line with changes to regulations. - Produce and issue local contractor specific variations (including, partnership changes, relocations, and mergers). - Implement changes to relevant systems to contractor payments. - Raise contract variations which may have a significant impact on the delivery of patient services and finances with localities and commissioners. - Maintain the contractor data base, including hard copies of all signed contracts for primary care providers, pertinent to the geographical area covered by the local regional team (including contract variations and breaches).

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Quality Assurance GP Services ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee will reiveiw reports to ensure GP's services are safe and meet all national and local standards. This will be monitored through an annual report on performance and the use of exception reports as required or as a result of a critical incident - Monitor activity on performers lists alongside practice performance data to generate a complete picture of quality		The RT will provide a regular quality report, based on the national framework to The Committee to support locality-wide quality assurance of primary care. This will include exception reports as required.		Tasks: Support practices and performers in the achievement of their quality improvement plan. Standard:	Tasks: The RT shall, using the nationa GPOS, High Level indicators, practice E-Delarations & CQC reports: 1. Collate Compliance Reports 2. Assess practice performance from analysed data and identify priorities for further interrogation 3. Provide an Annual 4. Performance Report and any exception reports 4. Conduct contractual compliance and quality reviews, developing and agreeing action plans to address performance issues with contractors.. - Support each clinical commissioning group in the development of a primary medical care quality improvement strategy involving all practices . - The RT will support the CCG with information to establish any cause for concern and act accordingly, including a quality review where necessary and performance management arrangements for poorly performing practices, as set out in Schedule 2 Part 1 Section 6.2. In particular the RT will ensure that: 1. It maintains regular and effective colaboration withe the CQC and responds to CQC assessments as set out in Schedule 2 Part 1 Section 6.2.1 / 6.2.2 / 6.2.3 2. Ensure and Monitor Practice remedial action plans as set out in Schedule 2 Part 1 Section 6.2.4
Develop processes and systems to ensure fair, open and transparent decision making		The CCG is responsible for implementing processes and systems as required by the Committee	The RT is responsible for implementing processes and systems as required by the Committee			
4. Other						
Counter fraud	To ensure that proper processes are in place to prevent fraud within the NHS		Implementation of the Deloitte Counter-Fraud service			Tasks: Issue notification of stolen prescription forms or persons attempting to obtain drugs by deception, to GPs, pharmacists, counter fraud, drug squads and other interested parties.
Interpreting Services	To ensure that patients have access to interpreting services when using GP practices					
FOI ***For Level 2 CCGs NHS E remain ultimately accountable***		Dependant on source of information as to owner of FOI responsibility			Tasks: To provide any information that the CCG holds about GP services as requested under the FOI act. Standard:	Tasks: To provide any information that the RT holds about GP services as requested under the FOI act.
Occupational Health	The Committee shall ensure that GP practices have access to occupational health services in accordance with national guidance					Tasks: To secure contracts for OH; To make prompt payments under the contract.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
EPRR	The Committee shall ensure that the RT and CCG develop strategies and plans to respond to rising tides, major incidents and service failure.					- Responding to local service disruption. - Responding to major service disruption. - Planning for major service disruption. - Flu Pandemic Planning. - Other Public Health Responses (e.g Ebola). - Issuing Communications to practices.
Implementation of Premises Directions	Approval of DV Rent Reviews, responding reimbursement appeals; Approval of discretionary payments for SDLT, Legal Fees and Development costs to practices; Procurement of Support for the Development of Strategic business cases; Aprroval of improvement grants; Approval of business cases for new premises / expansion; Approval of capital schemes; Approval of business cases for new premises /expansion		The RT shall bring to The Committee's attention as part of the regular reporting any matters requiring decision in relation to the Premises Cost Directions Functions (Schedule 2 Part 2 Section 7 and) including but not limited to: - new payments applications - existing payments revisions		Tasks: The CCG will respond to any requests from NHS England for relvant information to support the assurance of primary care commissioning .. Standard:	Tasks: The RT will provide sufficient information to support The Committee's decision. Following decision from The Committee the RT is responsible for carrying out all subsequent payments (Delegation Agreement Section 13.2.2). The RT must liaise where appropriate with NHS Property Services Ltd., Community Health Partnerships Ltd and NHS Shared Business Services. Standard:
Information sharing	The Committee is responsible for ensuring that information relevant to the assure the quality of primary care commissioning is shared in accordance with legislation and guidance.	The CCG is responsible for making availabe any information required to assure the quality of primary care commissioning as provided within IG rules	The RT is responsible for making availabe any reasonable and available information required to support primary care commissioning.		Tasks: The CCG will respond to any requests from NHS England for relvant information to support the assurance of primary care commissioning .. Standard:	Tasks: The RT will respond to any requests from NHS England around information sharing as specified and will be responsible for auditing and ensuring that providers accurately record and report information as set out in Schedule 2 Part 1 Section 5.1.4. Standard:
Controlled drugs reporting	The Committee is responsible for ensuring that practices are complying with legal requirements for use of controlled drugs and CCGs and NHSE have proper controls in place to maintain patient safety		The RT will carry out any reporting, analysis, complance or investigations involving controlled drugs as specified in Schedule 3 Section 8.5		Tasks: The CCG shall 1. Analyse prescribing data available as set out in Schedule 3 section 8.5.4 2. Complete the periodic self assessments / self declarations as set out in Schedule 3 Section8.5. 3. Report all incidents and other concerns to NHS Englands CDAO as set out by Schedule 3 Section 8.5.3.	Tasks: The RT will support The Committee to comply with its obligations under Controlled Drugs regulations by: 1. Reporting all complaints as set out by Schedule 3 Section 8.5.2
Safeguarding – children	To ensure that GP Practices have effective safeguarding systems in place in accordance with statutory requirements and national guidance and Pan London Policy and Procedures . Ensure appropriate response from primary care to safeguarding enquiries and serious case reviews (including approval of IMRs)	Support and facilitate Primary Care to proactivley improve the safety and well being of children registered within the practice setting, providing assurance to NHSE that practices are compliant with safeguarding standards.	To monitor and review compliance with safeguarding standards			Tasks: The RT will ensure that: 1. GP Contracts include requirements for safeguarding; and 2. GP practices annually declare compliance; The RT shall provide representation at the LSCB. The RT shall approve GP IMRs. Standard:

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Safeguarding – adult	To ensure that GP Practices have effective safeguarding systems in place in accordance with statutory requirements, national guidance and Pan London Policy and Procedures Ensure appropriate response from primary care to safeguarding enquiries and serious case reviews (including approval of IMRs)	Support and facilitate Primary Care to proactivley improve the safety and well being of those adults most vulnerable registered within the practice setting, providing assurance to NHSE that practices are compliant with safeguarding standards.	To monitor and review compliance with safeguarding standards			Tasks: The RT will ensure that: 1. GP Contracts include requirements for safeguarding; and 2. GP practices annually declare compliance; The RT shall approve GP IMRs. Assure primary care relating to safeguarding and MCA awareness, including oversight of training compliance.. Ensure primary care adheres to the pan london policy for safeguarding adults. Representation at LSAB to provide assurance to board around primary care services.. Assure primary care relating to safeguarding and MCA awareness, including oversight of training compliance.. Ensure primary care adheres to the pan london policy for safeguarding adults.
Domestic homicide	Ensure that GPs contribute to domestic homicide reviews – where relevant and where necessary take action to remedy any oversight.	To support practices in undertaking DHR where resources are held by the CCG	To support practices in undertaking DHR where resources are not held by the CCG			Tasks: Provide funding and advice where resources are not held by the CCG Provide representation at DHR Panels.
Serious incidents	The Committee shall processes are in place to report and review incidents so that serious incidents can be identified and managed. This includes reviewing the outcome of SI investigations and where necessary make recommendations to improve patient safety	To support and contribute to investigations	To support and contribute to investigations. To monitor compliance			Tasks: The RT will ensure that: 1. GP Contracts include requirements for reporting incidents; and 2. GP practices annually declare compliance; - Provide Advice and guidance to primary care practitioners and practice staff who wish to report an incident; Co-ordinate SI case management, including evaluation of final report; Liaison with NHS England Performance and Revalidation team regarding performance concerns.
Incident management	The Committee shall ensure that there are proper processes in place for GP practices to report incident (subject to a national review) and shall review reports on incidents at least once annually or where necessary by exception. The Committee shall make recommendations where necessary as a consequence on incident reports	To support and contribute to investigations	To support and contribute to investigations. To monitor compliance			Tasks: The RT will ensure that: 1. GP Contracts include requirements for incident management; and 2. GP practices annually declare compliance; Regularly log into the NRLS site to access any eForms (reported incidents); Ensure reported incidents are assessed to determine if SIs – and manage accordingly; Provide expert guidance on NRLS form/function.
Central Alerting System (CAS) Alerts	The Committee shall ensure that processes are in place to ensure that CAS alerts are disseminated in accordance with guidance.		To monitor compliance			Tasks: The RT will ensure that: 1. GP Contracts include requirements for incident management; and 2. GP practices annually declare compliance; Regularly log into the NRLS site to access any eForms (reported incidents); Ensure reported incidents are assessed to determine if SIs – and manage accordingly; Provide expert guidance on NRLS form/function.
Engagement and Consultation ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee shall ensure that all parties comply with statutory requirements to consult and engage with stakeholders. This is includes reporting to Local OSC, Healthwatch and HWB	For undertaking local engagement Engagement related to strategic planning Engagement linked to chnages in urgent care or LES	Engagement and consultation associated with changes to GP services, including: -closures, - premises development, - mergers			Tasks: Consultation with LMC Presentations to OSC. HWB and Healthwatch Notification letters to patients Consultation letters to patients and stakeholders.

5.2 Annex 2: Section 13Z - CCG statutory duties

Arrangements made under section 13Z do not affect NHS England liability for exercising any of its functions, and in turn, CCG must comply with its statutory duties, and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

Still subject to any directions and decisions made by NHSE or by the Secretary of State.

5.3 Annex 3: Performer Contract Decision Making Process

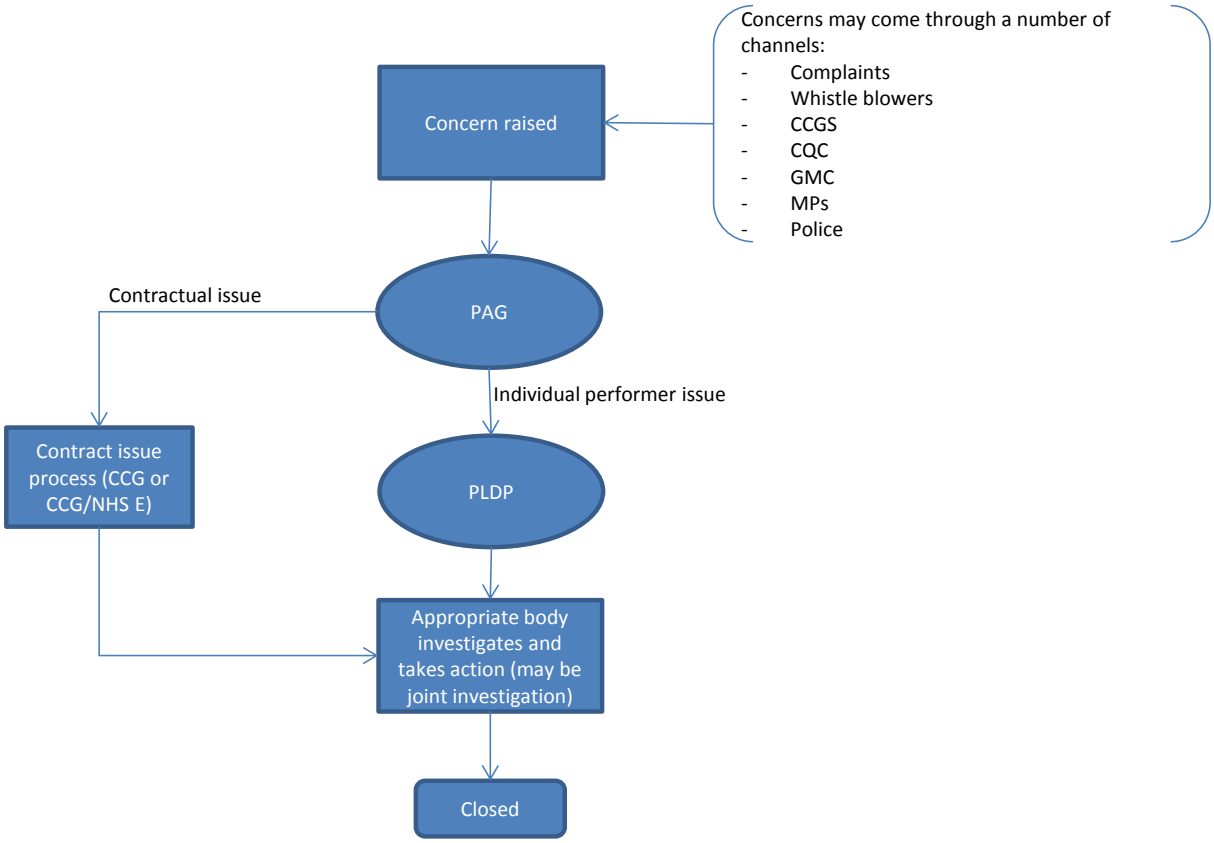


Figure 11 – Interface between the Performer Management and Contract Issue processes

Interface between the Performer Management and Contract Issue processes

Concerns about performer performance may come to NHS England's attention through a number of channels, including:

- Complaints from patients;
- Whistleblowers;
- CCGs;
- CQC;
- GMC or other professional regulator;
- MPs; or
- The Police.

Responsibility for Performer List Management

NHS England retains the responsibility for Performers being admitted to the National Performers List. The National Health Service (Performers Lists) (England) Regulations 2013 entrusts the responsibility for managing the performers lists to NHS England. Issues raised are triaged by the performance advisory groups (PAGs) within regional teams. Where the issue raised may have an impact on the performance of a contract, PAG will escalate information relating to the contractual impact, to the appropriate CCG (Level 3 delegation) and NHS England body (Level 2 delegation).

For issues with a contractual impact, the PAG may carry out a joint investigation with the CCG, with the PAG considering performer issues, and the CCG considering contractual issues. If action is considered to be necessary under the performers' lists regulations, the case is referred to a PLDP.

Commissioner Involvement

Where there are no contractual issues arising, commissioners may choose to receive a quarterly report, for information only, on performer performance issues which provides an overview of the numbers of issues by CCG, and key themes of issues arising. This may be submitted to part one of committee meetings.

Commissioner involvement is expected in instances where poor individual performance will have a contractual impact. Incidents which affect the medical services contract will be discussed at a joint committee or sub-committee, depending on the timeline for providing a response, with a decision provided for the contractual action taken to be taken.

Only information relevant to the contractual impact of issues should be shared. Discussion of sensitive issues should be carried out in a private pre-meeting, or submitted to a private part two committee to maintain confidentiality and to allow for the relevant information to be made available, discussed and any actions agreed. The decisions made on contractual actions should be reported in part one of committee meetings.

Performer List Decisions

NHS England has established performers lists decision panels (PLDPs) within regional teams in order to support its responsibility in managing performance of primary care performers. The role of the PLDP is to make decisions under the performers lists regulations. As a retained role of NHS England, there is no basis for CCG involvement in this process.

5.4 Annex 4: NHS England Primary Care Commissioning Org Chart

Figure 12: Current NHS England (London) GP Primary Care Commissioning Organisation Structure

5.5 Annex 5: PCIF Bid Process

Primary Care Infrastructure Fund (PCIF) bids – a model approval and prioritisation process

This process is included to provide a guide to CCGs on how they may wish to manage the approval and prioritisation of PCIF bids.

Summary

Bids against the PCIF fund are due to be returned to NHS England by 16th Feb 2015. There is a very tight programme for regional teams to sift and assess the bids and recommend support against the agreed assessment criteria in time for a ministerial announcement on the use of the initial £250m during March 2 015.

Each NHS England sub-regional team will ensure that they have a robust process in place that enables them to collate and review bids and provide a recommendation to their regional team. The regional director, supported by a member of the NHS England Project Appraisal Unit, will decide which bids will be supported and will allocate each bid to one of four categories:

- Supported as a priority investment in 2015/16
- Supported subject to clarification of specific issues but deliverable in 2015/16
- Supported in principle but subject to further work up and submission against the 2016/17 PCIF
- Not supported

Regions will produce a brief summary of the bid and submit this report to the national panel by 4 March 2015.

Funds will be allocated to each region so that decisions about bids can be made in regions under the terms of their delegated authority.

Process

The process described here outlines a methodology that is supported by the national project team as one that will provide the necessary assurance whilst aligning to existing governance regimes. Regions may flex this methodology to align with their own existing processes whilst ensuring that they continue to work within the confines of their delegated authority. There are nationally agreed approval criteria that are provided as part of the PCIF toolkit.

There will be a concentration of work within a very short period of time to collate, analyse and recommend support for the PCIF bids received by the sub-regional teams from the national programme team whilst recognising that there will also be a cross over between the criteria for qualification for the PCIF, the Prime Minister's Challenge Fund (PMCF) and the general NHS England capital programme. To enable that, and the ongoing project management of the PCIF to work effectively, it is recommended that local teams consider the procurement of a programme management resource for receiving, collating, recording and managing the whole process, including providing relevant professional premises advice to validate reliability of cost and specification of bids. This resource will be critical to the success of the programme.

The flow diagram attached (Figure 1) describes how the process from receipt of bid to scheme completion is managed. The flow diagram attached (Figure 2) describes the process as recommended in the draft primary care infrastructure Principles of Best Practice document (PoBP) for local determination of business as usual (BAU) schemes submitted as PIDs, improvement grants or business cases.

The PoBP (currently in draft awaiting publication) recommends a primary care screening panel, accountable to the sub-regional team's business case and capital investment pipeline group (or equivalent title), to be set up and take responsibility for assessing and assuring all schemes presented to the sub-regional/regional team, including those supported by improvement grant applications, PIDs, and business cases (see figure 2). The principle described in this draft including the membership and responsibility assigned to the screening panel can be used to form a local sub-regional/regional panel to review the PCIF bids and recommend support to the regional team based on the approval criteria issued by the national team.

The membership of the PCIF screening panel can be flexed to suit local arrangements but the suggested membership will include a senior primary care manager, a senior finance officer, a professional premises adviser and relevant representatives from CCGs. The screening panel can call upon other colleagues as necessary to support its work. This may include an invitation to a representative officer of the Local Medical Committee (LMC). For the purposes of managing the PCIF timelines, it is recommended that LMCs are invited to a meeting – in advance of the PCIF screening panel meeting – in order to share the scope of the bids that have been submitted and to the process by which bids are being assessed. The intention behind this meeting will be to demonstrate that the process that the Regional or sub-regional offices have used are fair and transparent.

It is expected that the regional team will perform the necessary assurance against the national criteria and confirm their support for the bids with assistance and support for this part of the process by a member of the NHS England Project Appraisal Unit. Bids, sorted into the four categories identified above and endorsed by the regional team, are to be forwarded to the national panel by 4th March 2015.

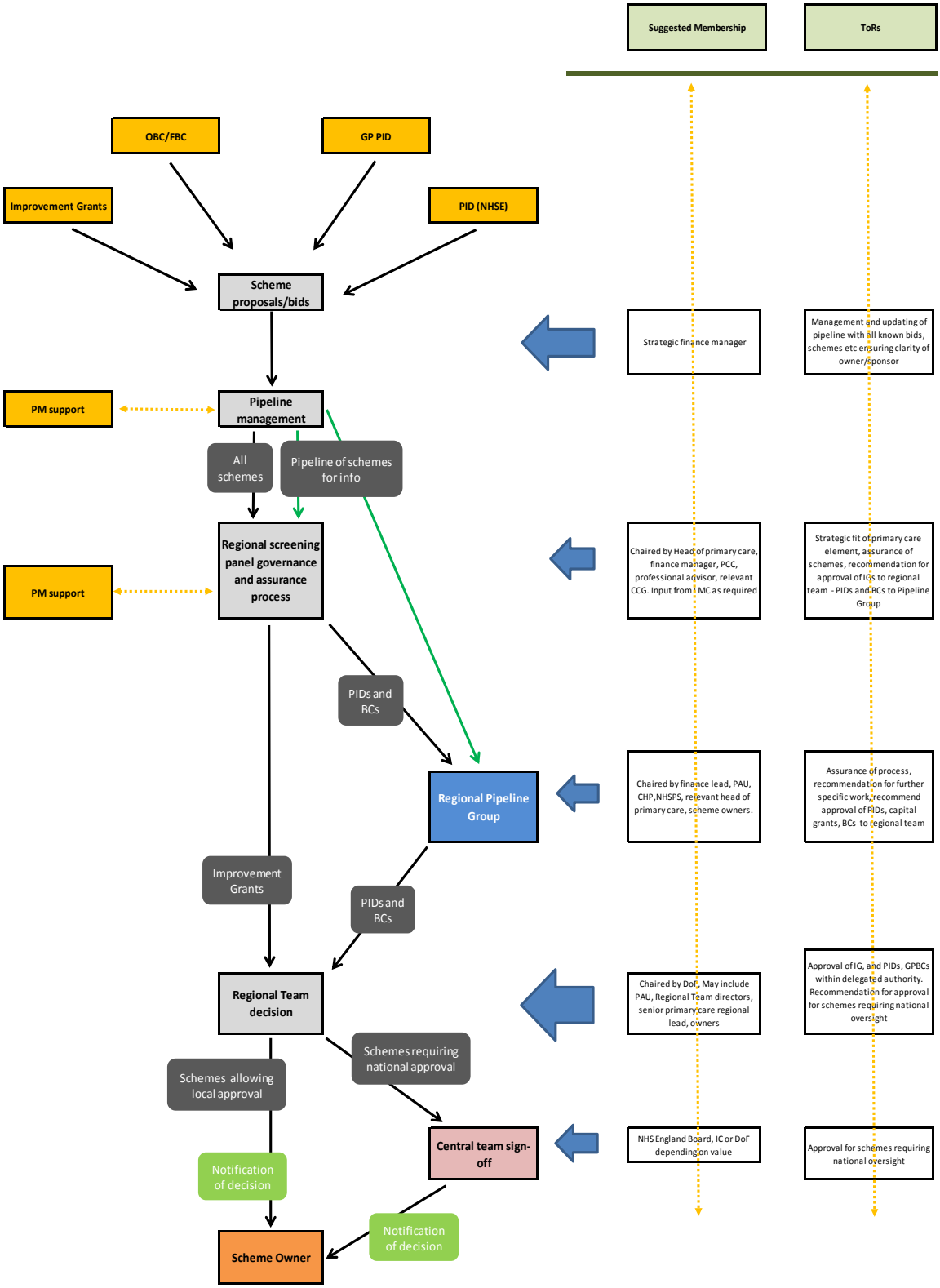
The national programme team will review and assess those returns and use the information to reconcile to the original allocation of funds to regions/sub-regions.

At this point a local assurance process will be followed for those bids that require further development. A suggested regional BAU process is described in Figure 2. This may include reaffirming alignment with strategic estates and service plans and determining what further work is required to move the bid into an approvable form. Following the national programme team's assessment, improvement grant requests that comply with the NHS (GMS Premises Costs) Directions 2013 may be approved by the regional/sub-regional team on recommendation from the screening panel. The pipeline group will be responsible for further assurance and recommendation for approval and prioritisation by the regional team for significant grant or investment proposals via its established approval structures.

It should be noted that proposals that are commissioner led, require capital other than that allowed under the Premises Costs Directions, (for example bullet payments into otherwise revenue funded schemes, or improvement grants in excess of 66% of total cost) or require CHP or NHSPS commitments will require approval from the NHS England central team.

Suggested BAU investment assurance and governance process for regional/sub-regional teams

(Based on the process identified in draft Primary Care infrastructure Principles of Best Practice)



5.6 Annex 6: Standard report formats

The standard report formats, included in this Annex, are provided to give guidance to Committees on the information that will be made available by NHS England.

List closure

REQUEST TO CLOSE PATIENT LIST

Practice Name and address		**Contract (GMS/PMS)**	GMS	**Raw list size**	4950 (April 14)	**CCG Area**	Ealing

Date Application made:	Initial application received June 2014. Commissioning Manager worked with practice to help find solutions. Update application was received in July and August 2014.	Regional team	North West London
Report template completed by	B Johnson	Date completed	26 August 2014

	Assessment Criteria	**Guidance Notes/Evidence that needs to be attached**	**Presentation of Case**
1.	Reasons for applying to close practice's register to new registration.	Application to close practice list template completed by contractor.	
2.	What options have the practice considered, rejected or implemented to relieve the difficulties they have encountered about their open list and, if any were implemented? Details of success in reducing or erasing such difficulties?		
3.	Has the practice had any discussions with their registered patients about their difficulties in maintaining an open list? If yes, practice to provide a summary of same, including whether registered patients thought the list of patients should or should not be closed.		•
4.	Has the practice spoken with other contractors in the practice area		

	concerning their difficulties maintaining an open list? If yes, practice to provide a summary of same of discussions, including whether other contractors thought the list of patients should or should not be closed?		
5.	How long does the practice wish their list of patients to be closed? (This period must be more than three months and less than 12 months).		
6.	What reasonable support does the practice consider the RT would be able to offer, which would enable the list of patients to remain open or the period of proposed closure to be minimised?		
	What plans does the practice have to alleviate the difficulties they are experiencing in maintaining an open list, which you could be implemented when the list of patients is closed, so that list could reopen at the end of the proposed closure period?		
	Does the practice have any other information to bring to the attention of the RT about this application?		
	RT recommendation to the Panel		

Date of PCC Decision Making Group (DMG)		Outcome:	Approved / Approved with Conditions/ Rejected
Feedback from PCC DMG			
Panel Members:			

Mergers between practices

London Regional Teams

Criteria for considering a request for Practice Merger

Practice Name & Address (1)		Contract **GMS E87067**	Raw list size **01/07/2014 6172**	Borough – CCG area - **West London**
Practice Name & Address(2)		Contract	Raw list size	Borough –

		GMS E87699	**01/07/2014 3048**	CCG area – **West London**

Date Application made:	**20/08/2014**	Regional team	**North West London**
Report template completed by	**Rachel Ryan**	Date completed	**22/09/2014**

The Principles of Cooperation and Competition 2010 were replaced by the NHS Procurement, Patient Choice and Competition Regulations 2013. Monitor acts as the Regulator since 1.4.2013.
Principle 10 of the earlier document stated:
Mergers including vertical integration between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' or taxpayers' interests for example because they will deliver significant improvements in the quality of care.

This is not written succinctly in the 2013 Regulations but an overarching guide suggests that the individual components are all still relevant within the full 76 page guide
http://www.monitor.gov.uk/sites/default/files/publications/SubstantiveGuidanceDec2013_0.pdf

Assessment Criteria	Guidance Notes/Evidence that needs to be attached	Presentation of Case
Background in respect of each of the practices	Include relevant background – number of clinical providers and support staff, teaching practice, opening hours, distance between sites	
Information about local demography	Include - Information about local practices - Geographical location and distance - Would a merger result in significant reduction in patient choice	
What are the strategic benefits of agreeing a merger and do they meet the criteria set out above	For example - Services provided from one fit for purpose site in either the short or long term - Longer opening hours - Access to a wider range of services - Within easy reach - Financial savings as a result of the merger - Improved IT access - Improved workforce capability	**Existing patients' access to single service including consistent provision across**: ***Home visits; booking appointments; additional & enhanced hours: opening hours; extended hours; single IT & phone system; premises facilities:*** *(Amended for brevity)*
Performance of the individual Contractors within each practice	Are any providers linked to the existing Contracts voluntarily not working, suspended by the GMC or NHS England, or unable to work by virtue of Bail conditions.	No
Practice performance	Evidence should include information for the past three years in relation to	

	- QOF - GPOS /GPHLI performance - Contractual sanctions And, where applicable, evidence that action plans are in place and being actioned Feedback from NHS choices	
Will the merger result in services being provided from premises that are fit for purpose in accordance with minimum standards set out in 2013 GMS Premises Costs Directions, or that have a Business Plan to achieve within no more than 12 months	Provide available information about the premises and any commitments made by the Contractor to address outstanding issues within the required timeframe. Outcome of infection control visit and outcome of CQC inspection if either or both have been undertaken.	
Has specified a clear plan of service improvements that will arise as a result of the merger	A business case should be supplied by the practice that sets out their future plans. At the minimum this should include a commitment that GP premises and phone lines will be open throughout core hours	
What is the CCG's view of the proposed merger?	Include both the primary care lead and the IT lead (if applicable) in the discussion.	
RT recommendation to the Panel (will be subject to patient engagement)	Any other relevant information not included elsewhere e.g. proposed start date patient engagement proposals	

Date of PCC Decision Making Group (DMG)	*29/09/2014*	Outcome: ***Please delete as appropriate***	Approved / Approved with Conditions/ Rejected
Feedback from PCC DMG: ***Please insert***			
Panel Members: ***Please insert***			

Contract termination – e.g. Death/ Bankruptcy/ CQC

BRIEFING TITLE	**XX Medical Practice**		
TO:	**DMG**		
DATE:	**6/3/2015**	**AUTHOR:**	
Purpose	To brief the DMG on the current position regarding the bankruptcy of XX and the actions taken.		
Background			
Comments:			
Current status			
Next Steps			
Recommendation			

Changes to Contract Signatories

London Regional Teams

Single Handed PMS Practices - Criteria for allowing an additional clinical Contract signatory

Practice Name		Raw list size	
Single Handed PMS Provider's name		CCG	
Date Application made:		Regional team	
Report template completed by		Date completed	
Date of PCC Decision Making Group (DMG)		Outcome:	Approved / Approved with Conditions/ Rejected
Panel Members:			

All of the following criteria will need to be met for the application to be approved:

Assessment Criteria	Guidance Notes/Evidence that needs to be attached	Presentation of Case
There is a strategic need for the practice to be retained, from an RT & CCG perspective	Include relevant background – number of wte providers, teaching practice, local demography, has this practice had multiple Contract signatories in the past. Evidence of feedback from the CCG Detail the links to the primary care strategic direction locally e.g. information about relationship with local practices, new developments, engagement with CCG priorities	
Performance of the single handed Contractor does not give cause for concern.	If any provider linked to the Contract is voluntarily not working, suspended by the GMC or NHS England, or unable to work by virtue of Bail conditions this would automatically give cause for concern.	
Practice performance does not give cause for concern	Evidence should include information for the past three years in relation to - QOF - GPOS /GPHLI performance - Contractual sanctions And, where applicable, evidence that action plans are in place and being actioned Feedback from NHS choices	
Has premises that are fit for purpose in accordance with minimum standards set out in 2013 GMS Premises Costs Directions, or has Business Plan to achieve within no more than 12 months	Provide available information about the premises and any commitments made by the Contractor to address outstanding issues within the required timeframe. Outcome of infection control visit and outcome of CQC inspection if either or both have been undertaken.	
Has specified a clear plan of service	A business case should be supplied by the practice that sets out their future	

improvements that will arise as a result of changes in numbers of partners	plans. (It is not expected that an application which facilitates 24 hour retirement of the Contractor will meet the criteria) At the minimum this should include a commitment that GP premises and phone lines will be open throughout core hours	
Has a list size that can demonstrably sustain proposed WTE extra partner increase,	The business case should demonstrate this. (This would typically be 5000+ patients)	
CV of proposed new provider does not give commissioners cause for concern	The CV should be attached. If the proposed new provider is not yet known it is possible to approve the request subject to review of the CV prior to final approval.	
RT recommendation to the Panel	Any other relevant information not included elsewhere	

Application approved*	
Application approved subject to following conditions*	PCC DMG TO INCLUDE CONDITIONS
Application rejected *	PCC DMG TO INCLUDE REASONS WHY

Contractual Issues of Concern

London Regional Teams

Request for PCC DMG to consider a contractual issue of concern and to make recommendations

Practice Name		Raw list size	
Weighted list size		CCG	
Contract Type		Regional team	
Report template completed by		Date completed	
Date of PCC Decision Making Group (DMG)		Outcome:	
Panel Members:			
Issue for consideration: Include current position, relevant background information and recommendations for consideration			

Relevant background information to support the decision making process

Include relevant background – number of wte providers, teaching practice, local demography, has this practice had multiple Contract signatories in the past. Evidence of feedback from the CCG Detail the links to the primary care strategic direction locally e.g. information about relationship with local practices, new developments, engagement with CCG priorities	
If any provider linked to the Contract is voluntarily not working, suspended by the GMC or NHS England, or unable to work by virtue of Bail conditions this would automatically give cause for concern.	
Evidence should include information for the past three years in relation to - QOF - GPOS /GPHLI performance	

- Contractual sanctions And, where applicable, evidence that action plans are in place and being actioned Feedback from NHS choices	
Provide available information about the premises and any commitments made by the Contractor to address outstanding issues within the required timeframe. Outcome of infection control visit and outcome of CQC inspection if either or both have been undertaken.	
Any other relevant information not included elsewhere	

Recommendations made by the PCC DMG

Request to issue breach over quality

Date:

1. Contractor type

General Practice	Community Dentist	Community Pharmacist	Community Optometrist
General Practice			

2. Area

3. Practice code

4. Practice Name

5. Name/position of lead officer

6. Permission being sought

Issue of remedial breach notice	

7. Local Resolution – LMC involvement

Yes	

8. Summary of case for issuing notice

9. Name/position of determining officer

10. Permission to proceed

Yes	No

11. Determining officer's comments

12. Date of determination

13. S

Local Improvement Schemes

Local Improvement Scheme: NHS England Assessment Template
The template should be submitted with the full specification.

	CCG to complete for each LIS scheme	NHS England to complete – at the point of assessment
Title of scheme		
CCG name		
Named Commissioner		
Status of CCG Approval of Scheme **Either** **1. Approved by CCG subject to NHS England approval** **2. Draft yet to be considered by CCG Governance structure**		
Has the CCG consulted with the LMC? **NB. NHS England cannot approve schemes unless the LMC has reviewed and commented**		
What was the outcome of LMC engagement?		
Does the Scheme fit strategic and/or commissioning priorities of CCG? **CCGs need to specify the link to their primary care strategic priorities.**		
CCGs should specify whether the scheme supports improvement in the quality of primary medical care services under the following categories? **1. Reducing variation in quality** **2. Improving quality** **3. Undertaking clinical audit** **4. Peer review** **5. Other**		
Does the scheme have clear, measurable processes and/or clinical outcomes? **NB. These need to be articulated**		

clearly and process outcomes should show how progress will be tracked against milestones throughout the year in order to demonstrate how the expected outcomes will be achieved.		
Is the scheme rewarding outcomes? **NB. NHS England cannot approve schemes that do not reward outcomes.**		
Is there any overlap with what is paid for under the Primary Medical Care Contract, DES, QOF? **NB NHS England cannot approve duplicate payments but there will be situations where a LIS scheme is paying for work in excess of existing arrangements**		
What are the proposed Contractual arrangements? **e.g. SLA, Letters of Intent, National Contract (not mandated)**		
What is the total financial value of the scheme?		
What is the payment structure? **NB. Itt is expected that there will be a payment that is only realised on achievement of key deliverables. i.e. not all of the payment will be made 'up front'**		
What are the arrangements if outcomes are not achieved? **e.g. Clawbacks or no achievement payment released**		
Is participation in the scheme optional or mandatory for CCG member practices? **If other scenarios apply, please specify**		
FOR NHS ENGLAND USE ONLY		
Does remuneration and pricing model appear reasonable (when compared with specification requirements)?		
Assessor recommendation to the PCC Decision Making Group (PCC DMG)		

Comments/Feedback following the PCC DMG		
Assessor recommendation to the PCC Decision Making Group		
Approved by NHS England: Yes/No: Date		
CCG Informed: Yes/No: Date		

Deputy Head of Primary Care for Relevant CCG Area is responsible for arranging feedback to lead CCG Commissioner

Performer Performance Template

The template below is used for summarising performer performance cases for consideration by PDLP. NHS England retains the responsibility for Performers being admitted to the National Performers List.

Only information relevant to the contractual impact of issues should be shared with CCGs. Discussion of sensitive issues should be carried out in a private pre-meeting, or submitted to a private part two committee to maintain confidentiality and to allow for the relevant information to be made available, discussed and any actions agreed. The decisions made on contractual actions should be reported in part one of committee meetings.

Submission for PLDP – Dr X

Case Ref:

Date:

Prepared by

Introduction & Background

Summary of individual and their professional role(s).

Summary of alleged incident(s).

Summary of Issues Identified

Detail of alleged incident(s).

Individual's version of events, actions taken, and mitigations.

Other parties notified.

Summary of any press interest.

Framework and Regulatory Reference

Consideration of risk and impact against relevant Framework or Regulatory criteria.

Options for the Performers List Decision Panel

There are a number of options open to the PLDP under the Terms of Reference:

a. Take no further action and refer back to the PAG for case closure.
b. Refer for further investigation or monitoring and, if agreed, delegate the actions to PAG.
c. Consider referral to the primary care contracts team for consideration under the relevant contract regulations.

d. Refer to the relevant regulatory body.
e. Refer to the police.
f. Refer to NHS Protect
g. Refer to any other organisation for remediation or intervention agreed
h. Agree an action plan for remediation of the primary care performer or pharmacy contractor when appropriate, including a reporting process for monitoring of the implementation of the action plan.
i. Request the issue of an alert through the agreed NHS England mechanism according to the Healthcare Professionals Alert Notice Direction (2006).
j. Take action by invoking the NHS (Performers Lists) (England) Regulations 2013.

The PLDP is recommended to consider option (x)

5.7 Annex 7: Year Plan: Meeting frequency

		Agreed meeting/ report frequency	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Committee/ Joint Committee meeting schedule	North Central London											19th Jan		15th Mar
	City and Hackney													
	North West London	Monthly		21st May			20th Aug*	17th Sep	29th Oct	19th Nov		21st Jan	25th Feb	24th Mar
	South West London	TBC						3rd Sep		12th Nov		14th Jan		10th Mar
	South East London	Monthly			2nd June		6th Aug	29th Sep					11th Feb	17th Mar
	Tower Hamlets (WEL)	Monthly	28th Apr	26th May	23th Jun	28th Jul	25th Aug	22th Sep	27th Oct	24th Nov	22th Dec	5th Jan		
	Waltham Forest (WEL)	Monthly		6th May	3rd Jun	8th July	5th Aug	2nd Sep	7th Oct	4th Nov	2nd Dec	6th Jan	3rd Feb	2nd Mar
	Newham (WEL)	Monthly												
	WEL	Quarterly		14th May										
	BHR	Monthly			10th June	8th July	5th Aug	5th Sep					10th Feb	9th Mar

Key

Planned meeting

Forecast meeting

5.8 Annex 8 - Safeguarding – responsibilities at different levels of CCG co-commissioning delegation

The table below provides a high level analysis of responsibilities related to safeguarding at different levels of co-commissioning:

Task	Level 1	Level 2	Level 3
IMR sign off	Outcome of report shared with CCG	Joint sign off process	CCG sign off
Named GPs* – role transfer Financial transfer Recruitment Training	MOU in place Costs stay with NHS England Management of recruitment process responsibility stays with NHS England Responsibility for training sits with NHS England	MOU in place Costs stay with NHS England HR process with NHS England, joint appointment panel Responsibility for training sits with NHS England	MOU in place TBC Recruitment process and appointment panel under CCG control Responsibility for training sits with CCG
LSCB attendance	Based on risk based approach NHS England and CCG attendance	Based on risk based approach NHS England and CCG attendance	Based on risk based approach CCG attendance
Domestic homicide	NHS England attends panel and supports GP to complete IMR if required Report shared with CCG	Attendance at panel and support to GP to complete IMR negotiated with CCG	CCG attends panel and supports GP to complete IMR if required
Performance issues	NHS England leads on any performance issues	NHS England leads on any performance issues	NHS England leads on any performance issues
CQC safeguarding issues in practices	NHS England follow up individual issues raised by CQC with practices. Themes/trends undertaken by with CCG	NHS England and/or CCG, by negotiation, follow up individual issues raised by CQC with practices Themes/trends shared with CCG	CCG follow up individual issues raised by CQC with practices Themes/trends shared with CCG
Primary care safeguarding quality assurance	NHS England responsibility	Jointly NHS England and CCG responsibility	CCG responsibility
Quality improvement	CCG responsibility, working with NHS England	CCG responsibility, working with NHS England	CCG responsibility, working with NHS England

*dependent on each regional arrangements

Further detail related to the functions expected of fully delegated (level 3 CCGs) is shown below. The Nursing directorate would retain oversight of these responsibilities, and it is important to note that the tasks might vary dependant on area etc:

Summary of responsibilities	Overview of tasks (not exhaustive)
• Provide advice for GPs undertaking investigations relating to primary care safeguarding issues	• Approval final IMRs or investigations including DH panels • Ensure any actions resulting from investigations
• Manage named GP roles	• Recruit, line manage and provide training for role
	• Represent health system at safeguarding boards
• Contribute to the system wide oversight of safeguarding	• Undertake safeguarding assurance of practices. Follow up on practice issues identified at CQC inspections, review trends and themes
• Quality monitoring and improvement of primary care	

Agenda Item 14

Item No. 14.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Health and Wellbeing Board work plan	
Wards or groups affected:		All	
From:		Rachel Flagg, Principal Strategy Officer, Children's and Adults' Services	

RECOMMENDATION

1. The Board is requested to:

   - Note the work plan for the Health and Wellbeing Board 2015/16.

   - Feed in any further items for consideration at future meetings.

BACKGROUND INFORMATION

2. Agreeing a published forward work plan was a priority action recommended in the Health and Wellbeing Board review of governance, agreed by the Board at its meeting in October 2014.

3. A draft work plan was brought to the Health and Wellbeing Board in June. Since then, member organisations have fed in to the plan and the planning sub-group have met.

4. The work plan has been shared with the other statutory Boards to help ensure alignment and prevent duplication.

KEY ISSUES FOR CONSIDERATION

5. Attached at Appendix 1 is the work plan for the Health and Wellbeing Board for 2015/16.

6. The work plan is driven by the priorities agreed by the Board and underpinned by the Health and Wellbeing Strategy, in the context of the Health and Wellbeing Board's statutory duties.

7. The statutory responsibilities of the Health and Wellbeing Board are to:

   a) Encourage health and social care to work in an integrated manner
   b) Provide assistance for the making of arrangements for pooled budgets/integrated management of provision
   c) Produce the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy
   d) Produce the Pharmaceutical Needs Assessment
   e) Sign off the Better Care Fund plans
   f) Approve governance arrangements for holding the pooled budget

BACKGROUND PAPERS

Background Papers	Held At	Contact
Health and Wellbeing Board report on review of governance	See link below	Rachel.flagg@southwark.gov.uk
Link: Health and Wellbeing Board report on review of governance		

APPENDICES

No.	Title
Appendix 1	Southwark Health and Wellbeing Board work plan 2015/16

AUDIT TRAIL

Lead Officer	David Quirke-Thornton, Strategic Director of Children's and Adults' Services
Report Author	Rachel Flagg, Principal Strategy Officer
Version	Final
Dated	9 October
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		9 October 2015

APPENDIX 1

Southwark Health and Wellbeing Board work plan 2015/16

18 June 2015 – Board meeting

Health and wellbeing of children and young people in Southwark
Local Care Networks and Southwark's vision for commissioning for outcomes
Health and Wellbeing Strategy
BCF update
Board work programme

22 July 2015 – Informal seminar

Our Healthier South East London
Early Action Commission

23 July 2015 - Community engagement

Feedback event for 1,000 Lives volunteers

21 October 2015 – Board meeting

Director of Public Health's quarterly report
Health and wellbeing strategy – focus on smoking and obesity
Early Action Commission report
Community engagement update
Transformation plan for mental health of children and young people
Update from Chair of Safeguarding Board – Serious Case Review
CCG Five Year Strategic Framework
Our Healthier South East London
Update on Primary Care co-commissioning
Board work programme

December 2015 – informal seminar

Single virtual platform for Southwark tbc
Prevention and health improvement – contribution of Guy's and St Thomas' Charity

January 2015 – half day workshop

Developing and Empowering Resources in Communities (DERiC)

28 January 2016 – Board meeting Health and wellbeing strategy – focus on alcohol and sexual health Working Capital (supporting people on health related benefits into jobs) Update on Public Health Annual report Safeguarding Boards' annual reports Community engagement update
Feb/March 2016 – Informal Seminar End of life care

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MUNICIPAL YEAR 2015/16

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Dated: September 2015