HEALTH SCRUTINY PANEL

Tuesday, 18 November 2014 at 7.00 p.m.

Committee Room 1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Asma Begum
Vice-Chair**:** Councillor David Edgar

Councillor Danny Hassell, Councillor Suluk Ahmed, Councillor Denise Jones, Councillor Mahbub Alam and Councillor Craig Aston

Deputies:
Councillor Sirajul Islam, Councillor Abdul Mukit MBE, Councillor Rachael Saunders, Councillor Chris Chapman, Councillor Julia Dockerill, Councillor Peter Golds, Councillor Shah Alam, Councillor Gulam Kibria Choudhury and Councillor Md. Maium Miah

Co-opted Members:

David Burbridge	(Healthwatch Tower Hamlets Representative)
Dr Sharmin Shajahan (PhD)	(Healthwatch Tower Hamlets)

[The quorum for this body is 3 voting Members]

Contact for further enquiries:
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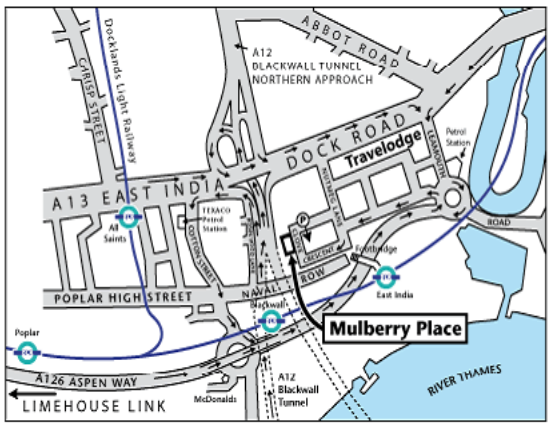

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APOLOGIES FOR ABSENCE

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS — 1 - 4

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.

2. MINUTES OF THE PREVIOUS MEETING(S) — 5 - 10

To confirm as a correct record the minutes of the meeting of the Health Scrutiny Panel held on 16 September 2014.

3. REPORTS FOR CONSIDERATION

3 .1 Transfer of Commissioning Responsibility for Early Years (0-5 years) Public Health Services from NHS England to the Local Authority — 11 - 28

To consider the forthcoming transfer of commissioning responsibility for early years public health services.

3 .2 Health and Wellbeing Strategy (Healthy lives, and Maternity and early years)

To receive a verbal update.

3 .3 Carers — 29 - 38

To receive a presentation.

3 .4 Update on GP Services and Funding Cuts — 39 - 54

To receive an update on GMS funding changes.

4. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

Next Meeting of the Panel

The next meeting of the Health Scrutiny Panel will be held on Tuesday, 27 January 2015 at 7.00 p.m. in Committee Room 1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:-

- Meic Sullivan-Gould, Interim Monitoring Officer, 020 7364 4800
- John Williams, Service Head, Democratic Services, 020 7364 4204

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 7.10 P.M. ON TUESDAY, 16 SEPTEMBER 2014

COMMITTEE ROOM 1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Danny Hassell
Councillor Denise Jones
Dr Sharmin Shajahan (PhD)

Co-opted Members Present:

Dr Sharmin Shajahan (PhD)	–	(Healthwatch Tower Hamlets)

Guests Present:

Dr Sam Everington	–	(Chair, NHS Tower Hamlets Clinical Commissioning Group)
Neil Kennett-Brown	–	(Programme Director, Transformational Change NEL Commissioning Support Unit)
Dr Judith Littlejohn	–	
John Wilkins	–	Deputy Chief Executive, East London NHS Foundation Trust
Dr Gabrielle Faire	–	East London NHS Foundation Trust

Officers Present:

Tahir Alam	–	(Strategy Policy & Performance Officer, Chief Executive's)
Antonella Burgio	–	(Democratic Services)

Apologies:

Councillor David Edgar and Councillor Mahbub Alam

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

No declarations of interest were made.

2. MINUTES OF THE PREVIOUS MEETING(S)

The minutes of the meeting held on 15 July 2014 were presented.

RESOLVED

That the minutes of the meeting held on 15 July 2014 be approved as a correct record of proceedings without amendment.

3. TO CONSIDER THE START TIME OF FUTURE HEALTH SCRUTINY PANELS DURING THE MUNICIPAL YEAR

The Chair invited members to consider whether they wished the start time of meetings for the remainder of the municipal year to be changed to 6.30pm or continue at 7.00pm.

RESOLVED

That the starting time of Health Scrutiny Panel meetings for the remainder of the municipal year remains at 7.00pm

4. REPORTS FOR CONSIDERATION

4.1 Community Health Services (CHS) review (verbal update)

The Panel received a verbal report from Dr Sam Everington Chair of Tower Hamlets CCG on the review of Community Health Services (CHS). He informed the Panel that the current CHS contract will expire in September 2015 and the CCG has decided that it will reset in train the CHS as a result of the need for savings, concerns about the variability of delivery, service integration and encourage development of partnerships across services and that personal care delegations contracts will cross the pathway to eliminate competition that occurs between acute and primary care.

In response to Members' questions, the following information was provided:

- The scheme was closed to enable healthcare and services to be to be aligned with the integrated care vision/ This would provide a flexible approach and better working together in order to deliver appropriate care to patients at each stage of their indisposition.
- The contract at Barts had been extended to March 2016
- The revised CHS would deliver its services at no extra cost and the new model would be different to previous ones. Barts presently provided much support to CHS and would take on wider responsibility for the patient journey.
- Better communication and interconnectivity would provide a solution to previous issues concerning patients that were discharged from hospital but did not have assistance at home through data sharing, discharge planning and 7-day working to provide necessary support.

RESOLVED

That the report be noted.

4.2 Transforming Services, Changing Lives

The Panel received a presentation from Neil Kennet-Brown, Programme Director, Transformational Change NEL Commissioning Support Unit on the Transforming Services, Changing Lives programme and Dr Sam Everington, provided supplementary information to the report at agenda item 4.2.

The Panel was informed that:

- The programme's scope was broad involving Acute Trusts, Community Mental Health Trust, East London Tri-borough and neighbouring CCGs and local authorities.
- The purpose was to meet future demand with the aim of achieving great health and health outcomes for East London. A work programme had been created and had begun to identify work that was required to be done.
- Further reports would be made as the programme progressed.
- The population increase anticipated in the forthcoming 20 years has highlighted financial and staffing pressures therefore it would be necessary to consider how healthcare could be delivered, ensure consistency of services and design new kinds of services such as virtual access services.
- Access to new kinds of service would enable more effective outpatients' style service delivery, encourage patients to take control and work in partnership to deliver their own healthcare.
- The programme would also include work to improve patients' end of life experience including burial considerations relevant to their cultures.
- Technological improvements in medical procedures would also be encompassed.

It was agreed that a visit to the new Barts Cardiac unit be arranged for Panel Members.

In response to Members' questions, the following information was provided:

- New roles anticipated under this programme were; care coordinators, and expanded roles for healthcare assistants, nurse practitioners and physicians associates. These would alleviate current pressures experienced by district nurses, paramedics and traditional health workers.
- In general, life expectancy in the borough was low and the pathological age was high. Statistical data on mortality would be provided post-meeting.
- Some work had been done around integrated care at end of life aimed at addressing issues that arise at end of life situations such as advice after the death of a person, certificates etc..
- There were now more midwife led services in the borough which increased the likelihood of one-to-one care and better continuity of care.
- To promote the benefits of the new style services in the context of changing funding arrangements, it was intended that the vision would be promoted from a patient perspective and clinicians fully engaged in the change process to ensure that a patient focus would be retained.

The change pathway would be demonstrated in clear logical journey ensuring that there was clinical input.

- The future healthcare funding gap was a driver for change. Providers were aware of this as the structure was commissioning led and therefore it was necessary to achieve shared solutions.
- Privatisation might have diverse impacts and some types could reduce competition such as that currently experienced by small GP practices while other such arrangements might prove unaffordable.

RESOLVED

That the report be noted.

Action by:
Tahir Alam, Senior Scrutiny Strategy and Policy Officer

4.3 Modernising In-patient Assessment Services for Older Adults with a Functional Mental Health Problem in Tower Hamlets, City of London & Hackney

Representatives from East London NHS Foundation Trust gave a presentation on a programme to modernise in-patient assessment services for older adults with a functional health problem in the localities of the Trust.

The representatives informed the Panel that:

- An options appraisal had been conducted and Members were asked to consider the proposal before them.
- The proposal concerned centralising the service as part of broader modernisation programme.
- Usage of the in-patient service had declined and therefore the Trust wished to consolidate to a single site to provide better service for in-patients, community patients and better efficiency.
- In recent years, longer life expectancy had led to more complex care needs and the Trust had established a range of provisions to meet chronic health conditions experienced by older adults with a function mental health condition.
- There had been consultation with Hackney Council's health scrutiny body and CCG. The Panel was asked to consider whether there were any other appropriate bodies the Trust should consult with and an undertaking given that any advised would be consulted.
- After consultation a proposal would be placed before the relevant Health and Wellbeing Boards.

In response to Members' questions, the following information was provided:

- The proposal to reduce in-patient provision was due to a downward trend in service usage. Due to active planning, streamlining processes and provision of integrated care, further decrease was also expected. However this would be reviewed if demand were to change.

- The average in-patient stay was 60 days and was in the mid-range for this type of care.
- While some people leaving in-patient care went into sheltered care and a very small number into 24-hour care, most were expected to be discharged home.
- Wards at the in-patient unit were mixed but there was gender separation
- The service was not aimed at those with dementia as old age psychiatry segregated mental health services from those with dementia
- The service was not aimed at those in end of life situations
- The new provision was for Tower Hamlets and City and Hackney.
- There had been fewer issues around transport than expected and it was found that the most affected group were spouses.
- Clinicians felt that this proposal would use resources more effectively and savings could be directed towards community care.
- The consultation would be undertaken with a focus out towards the community rather than an expectation that consultees would be required to approach the Trust.
- There had not been wide engagement with GPs but those who had expressed a view have not caused concern.

Having considered the information and responses given by representatives of East London NHS Foundation Trust, the Panel supported the proposal in principle as a basis for the consultation to be taken forward.

RESOLVED

That the proposal to modernise in-patient assessment services for older adults with a functional mental health problem in Tower Hamlets, City of London & Hackney be agreed in principle and following the consultation receive a report on the outcome of the consultation.

4.4 Work Plan

The draft work plan was tabled for approval. The Panel considered the items proposed and requested that:

- The aims of each challenge session be clearly outlined to enable appropriate discussion and questions at these sessions
- A briefing will be circulated to Panel Members by the Strategy, Performance and Policy Officer prior to each challenge session
- That the timings of the sessions be added to the work plan

RESOLVED

That the Health Scrutiny Work Plan be approved.

4.5 Review Working Group

The Strategy, Performance and Policy Officer informed the Panel that a Review of the Self-management Programmes for Patients with Long-term Conditions (with a focus on measuring the impact on health outcomes rather than cost reduction) had been selected from the review topics included in the work plan. The Chair asked Members to consider if they wished to be involved advising that the working group should be politically balanced.

It was agreed that the working group comprise 5 members and the following agreed to participate:
Councillors Asma Begum and David Edgar, Dr Sharmin Shajahan.
The remaining two positions would be occupied by a Conservative Member and Tower Hamlets First Member respectively.

RESOLVED

That:

1. A review working group comprising five Members of Health Scrutiny Panel be established to Review the Self-management Programmes for Patients with Long-term Conditions (with a focus on measuring the impact on health outcomes rather than cost reduction)
2. That Councilllors Asma Begum and David Edgar, and Dr Sharmin Shajahan be appointed to the working group and the remaining two positions be occupied by a Conservative Member and Tower Hamlets First Member respectively.

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

Nil items.

The meeting ended at 8.47 p.m.

Chair, Councillor Asma Begum
Health Scrutiny Panel

Committee:	Date:	Classification:	Report No:	Agenda Item:
Health Scrutiny Panel	18th November 2014	**Unrestricted**		

Report of:	Title:
Public Health, ESCW **Originating officer:** Esther Trenchard-Mabere, Associate Director of Public Health **Presenting officers:** Somen Banerjee, Interim Director of Public Health Simon Twite, Public Health Strategist	Transfer of commissioning responsibility for early years (0-5 years) public health services from NHS England to the local authority **Wards Affected:** All

1. SUMMARY

1.1 The purpose of this report is to provide information about the forthcoming transfer of commissioning responsibilities for early years (0-5 years) public health services (the health visiting service and family nurse partnership) from NHS England to the local authority on 1st October 2015.

1.2 The report provides background information on what these services are, their importance in terms of the long term impact of early years on lifelong health and wellbeing, current commissioning arrangements and preparations underway to prepare for the transfer of commissioning responsibilities to the local authority.

1.3 The report highlights that this transfer provides an opportunity to review the health visiting service and develop a new localised specification to improve integration with other early years services and that a Stakeholder Engagement process should be undertaken to inform the development of this new specification.

2. RECOMMENDATIONS

The Health Scrutiny Panel is recommended to:-

2.1 Endorse the proposed Stakeholder Engagement process and have an overview of the implementation of the new localised service specification where Public Health will report back periodically to the panel on progress.

3. BACKGROUND

3.1 The transfer of public health commissioning responsibilities for 0-5 year olds from NHS England to local authorities on 1st October 2015 marks the final part of the overall transfer of public health responsibilities to the local authority. The services transferring are:

- Health visiting services (HV services) – universal and targeted services;
- Family Nurse Partnership (FNP) – intensive targeted service for vulnerable teenage mothers

3.2 The Marmot Review (2010) highlighted the importance of early years as a critical period for virtually every aspect of human development with lifelong effects on health and wellbeing. The HV and FNP services are central to ensuring that children and families have access to health promotion, preventive and early intervention services to support healthy physical, emotional, social and cognitive development.

3.2 In recognition of their potential impact on long term health and wellbeing and inequalities, the Coalition Government has prioritised these services for additional investment to enable expansion of the national workforce by an extra 4,200 health visitors by 2015 ('Call to Action') and roll out of the family nurse partnership (FNP). The implications for Tower Hamlets is an increase in the qualified health visiting workforce to at least 95 WTE (not including Clinical Lead posts and support staff) which will enable a significant strengthening of the service. Tower Hamlets already had a FNP and so there are no changes proposed for this service.

3.3 In order to ensure the expansion of the HV service and roll out of FNP, in April 2013 commissioning responsibility for these services was temporarily transferred to NHS England when the responsibility for the majority of local public health services transferred to the local authority.

3.4 Negotiations are still underway regarding the commissioning budget for these services to transfer to the local authority. The current estimated budget submitted by NHS England covers workforce but does not cover accommodation, IT and other running costs and so has not been signed off by the local authority. There are a number of other London Boroughs who also have not signed off the budget.

4. BODY OF REPORT

4.1 The transfer of 0-5 public health commissioning to the local authority, along with the significant expansion of the health visiting workforce, provides an important opportunity to strengthen the public health role of health visitors in prevention and early detection and to improve integration with other local authority children's services, improving continuity for children and their families. It will

also be important to maintain strong links with primary care, and other NHS and voluntary sector services.

4.2 The services will transfer to the local authority with standard NHS contracts that will run up to 31 March 2016 based on national service specifications. Local authorities have been advised that these contracts can be novated and extended up to 31 March 2017 and that timescales for re-procurement are for local decision.

4.3 Local authorities will have the freedom to 'localise' the national service specification to reflect local needs and priorities and ensure good integration with other local services.

4.4 Subject to parliamentary approval, the Department of Health is proposing to "mandate" the following aspects of the 0-5 Healthy Child Programme, in the same way as it has for the national child measurement programme, sexual health and health checks:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2-2½ review

4.5 This is to ensure that these services are provided in the context of a national, standard format, to ensure universal coverage, and hence that the nation's health and wellbeing overall is improved and protected. This would mean there is less local flexibility and discretion regarding how these universal services are provided. Any mandated elements will be set out in regulations under section 6C of the NHS Act 2006 and will be fully funded.

4.5 The proposed 2015/16 commissioning budgets submitted to the local authority by NHS England are £6,693,000 for the HV service and £540,000 for FNP, making a total budget of £7,233.000. This budget is adequate to cover the full projected workforce but does not include funding for accommodation, IT and other running costs and so has not been signed off by the local authority.

4.6 Following sign off, DH is planning to consult (for 4-6 weeks) with local government on budgets for health visiting and FNP with the intention of announcing part year effect budget for 2015/16 by 1st December 2014. However the delay in sign off of the budget by Tower Hamlets and 18 other London Boroughs means that this timescale may no longer be feasible. This budget will be added to the ring fenced public health grant.

5. COMMENTS OF THE CHIEF FINANCIAL OFFICER

5.1 At present the proposed 2015/16 commissioning budgets totalling £7.233million cover workforce related costs however do not include overheads such as IT, accommodation and other resources. These are estimated to be in the region of £1million for Tower Hamlets, as a consequence the current proposals have not been agreed by Tower Hamlets and a number of other London Boroughs. A joint concern has been registered by the London Boroughs to Public Health England, with the expectation that negotiations will continue and that the full expected costs of the HV and FNP services will be included in the transfer.

5.2 Once agreed the funding will be added to the Public Health Grant received by the authority. It is expected that the funding for both the HV and FNP services will be recurrent each year.

5.3 It is also noted that funding for additional commissioning resources has not been identified as part of the transfer. Securing the maximum funding in respect to overheads and any other incidental costs will be imperative for the borough. Once transferred any pressures will need to be met from within the Public Health Grant allocation.

6. LEGAL COMMENTS

6.1 The Council assumed responsibility for the provision of various public health functions following the amendment of the National Health Service Act 2006. By regulations under that act the Secretary Of State may require local authorities to provide further services relating to Public Health from time to time. It would appear that there is an intention to do exactly this, although the exact wording of the new regulations is not clear.

6.2 The introduction of further regulations by the Secretary Of State will legally oblige the Council to provide these services. However, it is anticipated that (as with the existing transfer of services) the Council will have general duties to discharge obligations relating to public health but will have the discretion to determine how this is carried out.

6.3 However, best practice dictates that the Council should give due regard to professional and health service led opinion when determining the exact nature of the services.

6.4 Where the Council elects to purchase the relevant services from organisations outside of the Council the Council has a duty to achieve Best Value in accordance with the Local Government Act 1999. This means that the Council should subject any purchases to an appropriate level of competition.

6.5 It is anticipated that the law in respect of European tendering will have changed by the time the Council becomes responsible for these services. The most significant change will be that the distinction between Part A and Part B services will have disappeared. Currently, services of the nature covered in this report would be determined as Part B services which would have meant that the Council would not have had to advertise these services in Europe in any event. However, the new procurement regulations will introduce a "light touch" regime which may mean thyough that these services may have to be advertised either in Europe or in some other new manner.

6.6 Currently NHS England has a number of contracts with existing providers for these services. It is understood that NHS England are currently extending the existing arrangements such that the contracts will still be in place on the date of transfer. It is the intention that on the date of transfer the Council will take over the existing contracts in place of NHS England so that there is continuity of service provision following the transfer to the Council of the duty to provide these services.

6.7 However, as stated previously the Council is under an obligation to obtain best value and so the value of these contracts needs to be tested as soon as possible after the transfer. However, the Council after the transfer will be obliged to comply with the agreements throughout the remainder of the term. Therefore the Council should take a number of steps:

6.7.1 be part of the extension discussions as we will take over the contracts. Ideally we require an extension of a term just long enough to carry out a procurement for the same services. An extension of some sort is required to ensure that there is no break in service provision whilst the Council carries out the tender.

6.7.2 prepare to carry out a number of tender exercises as soon as possible. This means not only preparing for the volume of tenders but also ensuring the availability of resources.

6.7.3 consider the nature of the existing services and start to determine the reconfiguration of services that will still meet our statutory obligations created by the Secretary Of State but will also assist us in the achievement of best value.

6.8 Many of these services may well deal with persons who have protected characteristics for the purposes of the Equality Act 2010. Therefore, the Council must ensure that it eliminates any discrimination in the provision of the services between people who have a protected characteristic and people who do not and also to actively promote the equal treatment of people who have a protected characteristic when compared with people who do not in accordance with its obligations under section 149 of the Equality Act.

6.9 For the purposes of promotion as described under clause 6.8 the Council should ensure that its contractors are under a similar duty created by terms under the contracts

7. ONE TOWER HAMLETS CONSIDERATIONS

7.1 The health visiting service provides both universal and targeted services and plays an important role in improving life chances for all children and also reducing inequalities by identifying and supporting vulnerable families. The family nurse partnership is a targeted service supporting first time teenage parents. There is a strong evidence base showing that this programme improves short, medium and long term health, educational and social outcomes for both mother and child. It is estimated that the FNP programme produces a return on investment of at least £1.94 for every £1 spent as a result of savings in spend on social care, youth offending and benefits.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 N/A

9. RISK MANAGEMENT IMPLICATIONS

9.1 The biggest risk to the local authority is begin allocated a commissioning budget that does not cover the full costs of the service and for this reason the local authority has not yet signed off the budget.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There is evidence that the family nurse partnership programme will contribute to a long term reduction of crime and disorder.

11. EFFICIENCY STATEMENT

11.1 Reports concerned with proposed expenditure, reviewing or changing service delivery or the use or resources must incorporate an Efficiency Statement. Please refer to the relevant section of the report writing guide.

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

Brief description of "background papers"	Name and telephone number of holder and address where open to inspection.

12. APPENDICES

Appendix 1 – Transfer of commissioning responsibility for early years (0-5 years) public health services from NHS England to the local authority (full report)

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Transfer of commissioning responsibility for early years (0-5 years) public health services from NHS England to the local authority

1. Background

1.1 The transfer of public health commissioning responsibilities for 0-5 year olds from NHS England to local authorities on 1st October 2015 marks the final part of the overall transfer of public health responsibilities to the local authority.

1.2 The Marmot Review (2010) highlighted the importance of early years as a critical period for virtually every aspect of human development with lifelong effects on health and wellbeing[1]. The 0-5 Healthy Child Programme (HCP) is central to ensuring that children and families have access to health promotion, preventive and early intervention services to support healthy physical, emotional, social and cognitive development.

1.3 The 0-5 HCP consists of:

- Health visiting services (HV services) - universal and targeted services;
- Family Nurse Partnership(FNP) – intensive targeted service for vulnerable teenage mothers
- Child Health Information Systems (CHIS)
- The 6-8 week GP check (also known as Child Health Surveillance).

1.4 Health visitors are qualified nurses with additional post graduate training to prepare them for a public health/preventative role focusing on improving child health and reducing inequalities.The HV visits the family in their home and undertakes a holistic assessment of the whole family's social, emotional and physical health and well-being at each visit that can identify a range of health and well-being issues including housing, relationships, emotional health, mental health, social inclusion, physical health or financial circumstances[2].

1.5 TheHV service plays a key role in helping to ensure that families have a positive start, working in partnership with GPs, maternity and other health services, Children's Centres, other early years services and wider services such as social care, housing and education. However, across the country and particularly in London, numbers of health visitors were in decline and in many areas there are not enough health visitors to offer all families the support they need[3]

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[1]Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010, 11 February 2010

[2]The role of the Health Visitor in a multi- agency team, Institute of Health Visiting (2014)

1.6 This lack of capacity has meantthat sometimes health visitors have beenunable to fully perform the wider public health role that they have trained for, working with communities to improve health outcomes, and that opportunities for early intervention can be missed. For example, to provide a clinically effective intervention to a depressed mother struggling with a new baby; to identify during a developmental check a child with speech and language problems who would benefit from early help or to help families access other local services, like parenting or relationship support through their local Children's Centre[3].

1.7 In recognition of the importance of the HV service and the overall lack of capacity, the government made acommitment to expand the national workforce by an extra 4,200 health visitors by 2015.This has been translated into a 'Call to Action trajectory' for each local area. In Tower Hamlets the 'Call to Action trajectory' will take the workforce to 95 WTE qualified health visitors (not including clinical leads and support staff), subject to successful recruitment and retention.

1.8 The FNP provides more intensive, targeted support for vulnerable teenage first time mothers and their families by a family nurse who is usually a health visitor or midwife. The family nurse receives additional specialist training to deliver the programme.

1.9 The FNP is an evidence-based, licensed programme that is still in pilot phase in this country. Findings from a randomised controlled trial of the impact of the programme in the English context (compared to existing universal services) are due to be reported in 2014/15.It has been estimated that the FNP could provide savings five times greater than the cost of the programme in the form of reduced welfare and criminal justice expenditures; higher tax revenues and improved physical and mental health[4].

1.10 The DH also made a commitment to expand the FNP, with particular priority to areas with a high level of need. Not all areas have a FNP established. Tower Hamlets was in the first wave of FNPs and established a service in April 2007 with local funding that was expanded by two additional family nurses in 2009 as part of the DH funded randomised controlled trial 'Building Blocks'. Funding for the two additional nurses was picked up by NHS England in April 2013. The local funding for the core service was transferred from the PCT to NHS England in 1st April 2013.

1.11 In order to ensure the expansion of the HV service and roll out of FNP, in April 2013 commissioning responsibility for these services was temporarily transferred to NHS England when the responsibility for the majority of local public health services transferred to the local authority.

[3]The Health Visitor Implementation Plan 2011-15: A Call to Action (DH, February 2011)
[4]Department for Children, Schools and Families (2007) Cost–Benefit Analysis of Interventions with Parents. Research Report DCSF-RW008

2. Opportunities arising from the transfer of these responsibilities to the local authority

2.1 The transfer of 0-5 public health commissioning will enable join-up with the public health services for children and young people 5-19[5], notably School Health, that are already commissioned by the local authority, improving continuity for children and their families.

2.2 The transfer of commissioning responsibility to the local authority also provides important opportunities for closer integration with the wider early years workforce in Children's Centres, voluntary sector and children's social care and the development of a service that is more responsive to local priorities and needs. It will also be important to maintain and strengthen links with general practice, primary care and other NHS services.

2.3 In Tower Hamlets, due to the priority given to early years, we already commissioned a number of 0-5 public health services e.g. Baby Friendly Initiative, Breastfeeding Support service, Universal Healthy Start Vitamins, Healthy Eating and Active Play programme,Cook4Life courses, Brushing 4Life, Fluoride varnishing and Child and Family Weight Management (which includes an early intervention) . Responsibility for commissioning the HVservice and FNP will provide the opportunity to develop closer links across these services.

2.4 During September – November 2013 we conducted a consultation and engagement process, The Healthy Child Review, to get stakeholder input into the process of re-designing and re-commissioning child public health services 0-19. The findings of this review will be of value to inform the process of 'localising' the service specification for the health visiting service[6].

2.5 We are currently developing a new parent and infant emotional health and wellbeing programme to strengthen and join up services provided across the NHS, local authority and voluntary sector. This programme will provide a useful framework to support the development of a more community focused HV service.

3. Governance of transfer process

3.1 The transfer is primarily a local one: from NHS England Area Teams as the "sender" to the local authority as the "receiver". A national task and finish group co-chaired by Mark Rogers, Chief Executive, Birmingham City Council and Viv Bennett, Director of Nursing, Department of Health has been set up

[5] and up to age 25 for young people with Special Educational Needs and Disability (SEND)

[6] Healthy Child Review: Progress report and recommendations for commissioning and wider service and partnership development. Paper for the Children and Families Partnership Board meeting on Monday 27th January 2014

under the leadership of Jon Rouse at the Department of Health (DH) to support the process.

3.2 The national task and finish group includes representatives from the Local Government Association (LGA), the Society of Local Authority Chief Executives (SOLACE), Association of the Directors of Public Health (ADPH), Association of the Directors of Children's Services (ADCS), NHS England, Public Health England and the Department for Communities and Local Government. Each partner will keep their members up to date on the progress of the transfer via their networks.

3.3 Local authorities have been provided with a data collection detailing workforce and finance for 2014/15 and 2015/16 for sign off to enable the DH to set baseline funding allocations (see section 6 below). To date Tower Hamlets, along with a number of other London Boroughs, have not been able to sign off the workforce and finance data as the funding presented did not cover accommodation and other infrastructure requirements.

4. Commissioning responsibilities to be transferred

4.1 Commissioning responsibilities for the following services will transfer to local authorities on 1st October 2015:
The 0-5 Healthy Child Programme (universal/universal plus) which includes:

- Health visiting services (universal and targeted services);
- Family Nurse Partnership (targeted service for teenage mothers)

4.2 It is responsibility for commissioning, not service provision, which will transfer. It is not therefore a transfer of the health visiting workforce who sit in provider organisations.

4.3 The following commissioning responsibilities will remain with NHS England:

- Child Health Information Systems (CHIS) in order to improve systems nationally. This will be reassessed in 2020
- The 6-8 week GP check (also known as the Child Health Surveillance).

5. Proposed mandationof universal services

5.1 Subject to parliamentary approval, the Department of Health is proposing to "mandate"the following aspects of the 0-5 Healthy Child Programme, in the same way as it has for the national child measurement programme, sexual health and health checks:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment

- 2-2½ review

5.2 This is to ensure that theseservices are provided in the context of a national, standard format, to ensure universal coverage, and hence that the nation's health and wellbeing overall is improved and protected.

5.3 This would mean there is less local flexibility and discretion regarding how these universal services are provided. Any mandated elements will be set out in regulations under section 6C of the NHS Act 2006 and will be fully funded.

5.4 Subject to Parliamentary approval, the aim is that regulations are in place by May 2015, with a 'sunset clause' at 18 months (ie March 2017). A review at 12 months, involving Public Health England, will inform future arrangements.

5.5 Mandation will ensure that the increase in HV services' capacity continues as the basis for national provision of evidence-based universal services - supporting the best start for all our children and enabling impact to be measured. Local authorities will be able to demonstrate progress on the relevant public health outcome indicators through early years profiles. Local authorities will have flexibility to ensure that these universal services support local community development, early intervention and complex care packages[7].

6. Process for agreeing funding allocations

6.1 Funding for the 0-5 Healthy Child Programme will sit within the overall 'ring-fenced' public health grant.

6.2 National guidance has stated that, as in the previous public health transfer, the baseline expenditure on 0-5 services by local authority will provide the basis for each local authority's individual allocations for 2015/16. This would be based on the cost of existing services (and contracts) to be transferred in each area. Over time funding allocations would be expected to move towards a needs-based funding formula, in the same way as anticipated for the wider public health grant[8].

6.3 In London concerns have been raised that health visiting staffing levels are significantly below the 'Call to Action' trajectories and, despite a major recruitment and retention drive, will remain so at the time of transfer,

[7]Transfer of 0-5 children's public health commissioning to local authorities. Factsheet: Commissioning the national Healthy Child Programme - mandation to ensure universal prevention, protection and health promotion services, DH

[8]Transfer of public health commissioning responsibilities for 0-5 year olds from NHS England to local authorities. Letter from Carolyn Downs, Chief Executive Local Government Association to Local Authority Chief Executives cc Directors of Children's Services, Public Health and Human Resources, July 2014

1st October 2015. If funding allocations are based on the cost of existing services this would not be sufficient for the local authority to continue to expand the service up to the 'Call to Action' trajectory.

6.4 At a meeting on 8th August 2014 between representatives from NHS England (London Area team), London Councils and LBTH Public Health it wasconfirmed that the funding allocation will be sufficient to cover the full 'Call to Action' trajectory and that the funding for the health visiting service will be based on the cost of the existing service (including 'on costs' estates, IT etc.) plus funding for additional posts up to the 'Call to Action' trajectory of 95 WTE funded at mid-point Grade 6 (NHS Agenda for Change pay scales). Funding for the FNP will be based on the cost of the existing service.

6.5 We were informed that a data return with a detailed analysis of workforce and finance would be submitted by NHS England to the local authority by the end of August 2014 for checking and sign off by 12th September. There was a delay in submission of the data return which did not reach us until 8th September 2014.

6.6 The data return submitted by NHS London on 8th September detailed the following current (2014/15) establishment for the health visiting service:

Management / Clinical Leadership	1.0 WTE (Grade 8C)
Qualified Health Visitors	58.38 WTE (5.2 WTE Grade 8A[9], 41.27 Grade 7, 11.91 Grade 6)
Registered Nurses	12.48 WTE (Grade 5)
Nursery Nurses	7.0 WTE (Grade 4)
Healthcare Assistants	21.77 WTE (Grade 3)
Other	1.5 WTE (Grade 5)

6.7 The current (2014/15) funding for this service was given as £4,582,000 which includes £4,524,000 for employee costs (including agency costs) and £58,000 for non-employee costs. However it was noted that the 2014/15 contract value does not cover overheads including accommodation, IT and other running costs.

6.8 The data return indicated that for 2015/16 the contract value would include additional growth funding of £2,111,000 (£1,961,000 employee costs and £150,000 non-employee costs) to fund 45.0 WTE additional Health Visitors (costed at mid-point Grade 6), making a total of £6,693,000.

6.9 The data return detailed the following current (2014/15) establishment for the FNP:

Management / supervision	1.5 WTE (Grade 8A)
Family Nurses	5.6 WTE (Grade 7)
Quality Support Officer	1.0 WTE (Grade 4)

[9]Note: the Grade 8A Clinical Leads do not count towards the 95 WTE target

6.10 The data return indicated that the current (2014/15) funding for FNP is £540,000 (including £450,000 employee costs and £90,000 non-employee costs). The same value was given for 2015/16.

6.12 It has also been noted that no funding has been identified to cover the additional commissioning resource that will be required to manage these contracts. NHS England have indicated that it would be difficult to identify resources for commissioning as it is currently managed by one post working across the 31 London Boroughs.

7. **Process of transfer**

7.1 At the meeting on 8th August we were informed that NHSEngland would send the local authority a data collection by the end of August which they would ask us to sign off by 12th September to confirm that we are confident that the workforce and funding are adequate. This needs to be agreed by our Section 151 Officer (Director of Finance/Resources).

7.2 Following sign off, DH intends to consult (for 4-6 weeks) with local government on budgets for health visiting and FNP. By 1st December the part year effect budget for 2015/16 should be announced.

7.3 At the meeting on 8th August we were informed that we should expect a 1.17% salary uplift for subsequent years.

7.4 The NHSEngland contracts for both services will run up to March 2016 and can be novated to the local authority. We will need to decide at what time we might want to start the process of re-procurement or to explore other options. The NHSE England (London Area Team) representative has advised that if we decide to start a re-procurement process prior to 1st October 2015 it would be advisable to agree an Integrated Governance Framework with NHS England.

7.4 In light of the late submission of the workforce and finance data collection, NHS England informed us that the deadline for sign off could be extended to 30th September 2014, although a request was made to meet the original deadline if possible.

7.5 After checking the data collection it was concluded that we could not sign it off as it did not include funding for accommodation, IT and other resources necessary for the running of the services. We estimate that these costs could be in excess of £1,000,000.

7.6 We informed Clive Grimshaw (Programme Manager, Early Years Commissioning Transfer, London Councils/NHS England) and on

24th September Joanne Murfitt, Head of Public Health, Health in the Justice System and Military Health, NHS England (London) wrote to Mark Ogden, Barts Health with a request for an urgent response by 26th September but no reply has been received to date.

7.7 At a regional briefing on 9th October we were informed that 25 London Boroughs had not signed off the workforce and finance data. NHSE reported that in 16 cases the issues to be resolved were relatively minor but for 9 cases (including Tower Hamlets) the issues were more serious and more difficult to resolve.

7.8 At a local authority chief executives meeting held on 24th October it was confirmed that 19 London Boroughs have not been able to sign off the workforce and finance data. Cheryl Coppell, Chief Executive for London Borough of Havering and Chair of the group is submitting a paper to NHSE stating that they will not accept the transfer unless additional funding is found for the 19 of London boroughs.

8. Local preparations to date

8.1 A meeting was held on 8th August 2014 between representatives from NHS England (London Area team), London Councils and LBTH Public Health to confirm the process for transfer of the commissioning responsibilities.

8.2 A memorandum of understanding (MOU) has been signed between NHS England and Tower Hamlets CCG which allows for joint performance management of the Tower Hamlets health visiting service by NHS England, Tower Hamlets CCG and LBTH Public Health. Maintaining links with the NHS, particularly primary care, is important.

8.3 Following an initial meeting on 21st July 2014 to agree terms of reference, process etc. the first joint quarterly performance meeting was held on 23rd October 2014. At this meeting it was confirmed that the service is meeting the coverage targets for the new birth visit but is below target for the other universal visits. The service manager confirmed that the full range of mandated services will be achievable once the full workforce has been recruited.

8.4 Concerns about difficulties in recruiting and retaining student health visitors have been raised and discussed a number of times at the Children and Families Partnership Board and support has been offered to Bart Health including confirming eligibility for health visitors on the Key Worker scheme that affords additional priority on the Council's Housing List.

8.5 After a difficult start the service is doing better in recruiting and retaining student health visitors. At the performance meeting on 23rd October it was

confirmed that there are currently 13 students in post, 8 students just due to start and an additional 12 students due to start in January 2015. However it is projected that we will not have fully achieved the target of 95 WTE by 1st October 2015.

8.4 Dame Elizabeth Fradd, Chair of the Health Visitor Taskforce, arranged a visit to Barts Health on 25th September 2014 to review progress on the 'Call to Action' including what is being done on recruitment and retention. Dame Elizabeth Fradd commended the service on the innovative work that they have developed and noted local concerns to feed back to the National Health Visiting taskforce.

8.5 LBTH Public Health was invited to present at the above event and also to the Health Visitors Forum on 6th October 2014 on the implications of the transfer of commissioning responsibility to the local authority and on the proposed local consultation process.

8.6 LBTH Public Health chairs the Strategic Advisory Board for the FNP and supports the service in developing partnerships (e.g. with Housing), needs assessment, planning and monitoring outcomes. Two family nurses and a client attended the Children and Families Partnership Board on 14th July 2014 to raise awareness of the service and the opportunities associated with the forthcoming transfer of commissioning responsibilities.

9. Issues for action and decision

9.1 Ensure that the budget transferring to the local authority is sufficient to cover the full costs of delivering these services, including accommodation and IT.

9.2 Review and localise the national service specification for health visiting.
The new national service specification provides a good starting point but it will be important to review and localise the service specification to ensure that the service is responsive to local needs and priorities, to optimise the benefits from the larger workforce and ensure closer integration with other local services.

The work of the Healthy Child Review and our new service specification for the School Health service will helpto inform this process but it is proposed that we run an additional stakeholder engagement process during early 2015. This would involve workshops with parents and carers, the service providers, Children's Centre staff, GPs and other primary care staff, Children's Social Care, other local authority and NHS commissioners and providers and community and voluntary sector organisations.

9.3 Decide the timescales and approach for any future re-procurement of these services

NHS England have confirmed that we can novate the NHS contracts that will be transferred to us and postpone any re-procurement or on the other hand start the process prior to 1st October so that new contacts would be issued during 2015/16. An options paper is being prepared to inform a decision about the timescales and approach for re-procurement. Broadly the options are as follows:

1. Rapid re-procurement commencing prior to 1st October 2015 to have new contracts in place by early 2016
2. Rapid decision to bring one or both services into local authority management
3. Postpone decision regarding re-procurement or bringing the services in house until the stakeholder engagement process to inform a new localised service specification has been completed (January - April 2015)

Some key considerations that will need to be taken into account include:

- The impact on staff recruitment and retention. In view of the difficulty in recruiting and retaining health visitors and the currently highly competitive recruitment situation across London, it is important to ensure that the service is seen as an attractive, innovative and secure place to work. It will be important to ensure that NHS terms and conditions are maintained to enable opportunities for career progression.
- Clinical governance arrangements for the services
- The synergies and fit with the proposed new model and organisational arrangements being developed for the Education, Social Care and Wellbeing Directorate of LBTH
- Adequate time to develop a new service model and specification to encourage innovative thinking and set the foundations for effective, holistic, child and family centred services that are responsive to local needs and priorities.
- Relationships with other services, including School Health as well as other local authority, NHS and voluntary sector early years and children's servicesto ensure integrated, efficient, accessible and responsive services.

Committee	Date	Classification	Report No.
Health Scrutiny Panel	**18 November 2014**	Unrestricted	

Reports of:	Title:
Education, Social Care and Wellbeing (ESCW) **Presenting Officers:** Barbara Disney, Strategic Commissioning Manager	**Carers and the Care Act 2014** **Ward(s) affected:** All

1. Summary

The following document summaries the councils plans around implement a strategic plan for engaging carers, and how the Care Act 2014 influences these priorities.

2. Recommendations

As per any recommendations as an outcome from the health scrutiny panel meeting.

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Carers and the Care Act 2014

18 November 2014

Barbara Disney, Strategic Commissioning Manager

London Borough of Tower Hamlets

A carer is someone of any age who provides unpaid support to family or to someone who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

(Carers Trust)

Tower Hamlets JSNA Summary (2014)

- Life expectancy in Tower Hamlets remains lower than rest of country but continues to improve.
- Life expectancy is:
  - 76.7 years compared to 78.9 years nationally for males (2009-11)
  - 81.9 years compared to 82.9 years nationally for females (2009-11)

Long-term limiting illness

- 56% of 65-84 year olds report long term limiting illness compared to 48% nationally
- 80% of 65+ have at least one chronic condition of which 35% have at least 3 'comorbid' conditions
- A larger proportion of 65+ used social services in 2009/10 compared to London (20% compared to 15%)
- Stroke is predominantly a condition of older age and Tower Hamlets has the second highest stroke mortality in London
- Older people account for 70% of strokes and 90% of caseloads of community heart failure services in the borough
- The age-standardised prevalence of COPD shows that Tower Hamlets has a higher burden of COPD than nationally. Mortality from COPD is also significantly higher than the London and England average

The Plan for Carers for the three years 2012 to 2015 set out how the Council and Tower Hamlets Clinical Commissioning Group working in partnership with the Third Sector, will meet the needs of carers in Tower Hamlets. The Plan set out the financial context in which we work, our priorities, and how this Plan was to be delivered over the three year period.

The Plan introduced a number of changes summarised as:

- improving information ,advice and advocacy for carers
- introducing carers budgets to give carers more choice and flexibility
- supporting carers to stay healthy
- Reviewing the balance between block contracts for carer services and with carers personal budgets

This Plan is underpinned by the following principles:

- Carers will be valued as being fundamental to strong families and stable communities
- Support will be tailored to meet individual needs, enabling carers to maintain a balance between their caring responsibilities and a life outside, while enabling the person they support to be a full and equal citizen
- Enable carers to design and direct their own support, have access to direct payments and be engaged in the support plan of the person they care for and the assessment where appropriate
- Wherever possible, establish whole family approaches that ensure there is integrated support planning that benefits everyone involved
- Fully recognise the differing social and emotional impacts of providing support to another person, and
- A range of support options and opportunities to match the diverse needs of carers (including those who do not choose to identify themselves as carers) and the outcomes they wish to achieve in their lives.

Purpose of the Care Act 2014

The Care Act provides the Council with a statutory obligation to provide support for all carers. It

- Combines over 40 separate pieces of legislation
- Emphasises wellbeing and independence
- Puts people's needs, goals, aspirations and outcomes at the centre of care and support
- Supports people to make their own decisions and realise their potential
- Improves working relationships with health providers

What Does it Mean For Carers?

- Puts carers on the same footing as those they care for, by placing a duty for local authorities to undertake a 'carer's assessment'
- New assessment criteria that is clear and fair
- Creates a new focus on preventing and delaying needs for care and support, rather than only intervening at crisis point
- Improving advice, information and advocacy
- Personalised support plans and personal budgets ensuring a range of high quality services
- Cap on care costs

According to the 2011 Census:

In terms of residents providing unpaid care:

- 19,311 of the population of 254,100, identify as providing unpaid care (7.6% of the population compared with 10.3% for England and Wales and 8.4% in London)

This can be broken down as:

- 4.3% provide 1- 19 hours per week,
- 1.4% provide 20-49 hours per week and
- 1.9% 50 hours or more per week.

For all three ranges, this is below that for England and Wales (6.5%, 1.4% and 2.4%) as well as London (5.3%, 1.3% and 1.8%).

Who is a carer?

Clause 10 (3) of the Care Act defines a carer as:
"an adult who provides or intends to provide care for another adults ("adult needing care")

What have we got for Carers in Tower Hamlets now?

Carers Hub, Tower Hamlets Carers Centre

- Information, advice, advocacy, signposting and referrals on a range of issues including benefits, housing and financial advice
- Carers Assessment and assessments for one off direct payments
- Case work
- Carers forums
- Events for carers

Dementia Carers Support Service, Alzheimer's Society Tower Hamlets

- Information, advice, signposting and referrals for carers caring for people with dementia
- Dementia specific training for carers
- Carers annual event
- Range of other services for cared for person and carer including Dementia Café

Somali Carers Support Service, Black Women's Health and Family Support

- Information, advice, signposting and referrals for Somali carers
- Somali Carers Group Support
- Health and social events for Somali carers

Bangladeshi Women Carers Support Service , Usha Mohila Somity (Dawn Women's Group)

- Information, signposting & referrals for Bangladeshi women carers
- Bangladeshi women carers group support
- Social and health events for women carers

Carers retreat and breathing space, London Buddhist Centre

- Information & signposting for carers
- Breathing Space Group Support for carers
- 2 x carers retreat each year

Mental Health Carers Support, Rethink

- Casework support: assessment, support plan, advice, emotional, practical, and advocacy support, peer support
- Support groups and activities
- Training
- Input to planning and strategy
- Signposting – with specialist knowledge of mental health services

Carers Short Break, Age UK

- Home based short breaks for carers
- Take cared for person out

Carers Short Break, Apasenth

- Home based short break for carers
- Take cared for person out
- Saturday female day service
- Residential for carers

Carers Short Break, St Hilda's

- Home based short break for carers
- Attendance at day centre for cared for person
- Take cared for person out

Carers Short Break, Stepney Jewish Centre

- Home based short break
- Attendance at day centre for cared for person
- Take cared for person out

Carers Short Break, TLC

- Home based short break
- Emergency break for carers for 72 hours

Carers Health Check, LBTH

- Health check and action plan to address health and wellbeing issues
- Access Carers Direct Payments
- Information and signposting to other services

For more information:

- Department of Health factsheet 8: The Care Act – the law for carers

www.gov.uk/government/uploads/system/uploads/attachment_data/file/366089/Factsheet_8_-_Carers.pdf

- The Carers Centre Tower Hamlets

www.carerscentretowerhamlets.org.uk

- Carers UK

www.carersuk.org

- The Carers Trust

www.carers.org

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**18/11/14**	Unrestricted		
Reports of: NHE England **Presenting Officers:**		**Title:** **GMS Funding Changes – an updated position** **Ward(s) affected:** All		

1. Summary

The attached report was the NHS England position on **GMS Funding Changes. This was developed by NHS England prior to the correspondences between the INEL JOHSC and NHS England, both correspondences of which are attached.**

2. Recommendations

Any recommended actions arising from panel meeting.

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GMS Funding Changes – an updated position

1 This note provides an update on the position of NHS England (London Region) on the support available to practices facing a significant impact from changes to GMS funding arrangements (defined nationally as a reduction greater than £3 per weighted patient population in 2014/15). These funding changes arise largely from the Government's decision in 2013 to withdraw the Minimum Practice Income Guarantee (MPIG) over seven years and to recycle MPIG resources into GMS global sum payments, and from last year's agreement with the BMA General Practitioners Committee to reduce the size of the Quality and Outcomes Framework (QOF) and move the associated resources into GMS global sum.

2 The changes to MPIG are part of a national policy to bring all practices into an equitable financial position, which will support GPs in providing the same high level of service for patients wherever they live. At present, practices serving similar populations may be paid very different amounts of money per registered patient. The changes to QOF were designed to reduce administrative burdens on GPs and give GPs greater flexibility to decide how best to provide high-quality care for people with long term conditions.

3 NHS England offered to meet with each of London's most affected practices to discuss their unique financial challenges and how they can be supported on a case by case basis. There has not been significant take up of this.

Offer of financial support for 2014/15 & 2015/16

4 There are some circumstances where the Carr-Hill formula may not sufficiently reflect the relative workload of London's GPs because of demographics, deprivation etc. amongst a local practice population.

5 Pending the outcome of the review of the national funding formula, London Region, in discussion with NHS England's national primary care team, has decided to offer non recurrent financial help for those practices losing more than £3 per weighted patient population from these GMS funding changes in 2014/15 and in 2015/16 and where Carr Hill may not provide sufficient sensitivity to the local position. There must be evidenced extenuating circumstances within the practice population related to workload and patient demographics that impact practice business and patient services, and the threshold of where Carr Hill does not provide sufficient sensitivity is defined as an Indices of Multiple Deprivation (IMD) score of 35 or higher (the upper quintile) for the practice. Among other factors, this measure is designed to take account of health inequalities.

6 In making this decision to offer support, London has to be mindful of its current recurring primary care financial allocation which does not include funding to make this offer. Therefore, the support is to be offered for 2014/15 and 2015/16 on a non-recurrent basis. The level of support would be the total annual loss arising from GMS global sum changes for 2014/15 and 2015/16 (and no greater than this), subject to confirmation that pensionable income does not increase beyond £106,100 during this period.

7 NHS England has established some criteria (all need to be met) and these are set out below:

Criteria	Rationale
There must be a reduction in GMS global	There must be a negative financial impact on

sum funding greater than £3 per weighted patient in 2014/15 and 2015/16	the practice
No doctor in the practice should have declared pensionable earnings in excess of £106,100 p.a. (Source: DDRB 2014 England Average 2011-12) (pro rata'd for part time GPs)	Support not designed to increase pensionable income of GPs
Practice expenses must be evidenced to be greater than 63%	National average ratio of expenses: profit is 63:37
No contract breaches for any reason issued since 1 April 2013	Marker of poorer quality practice
That a significant proportion of contract holders (significant defined as =>50%) do not have "live" cases with NHS England performer machinery or GMC, including the Interim Orders Panel. Suspensions which are a neutral act, will be disregarded and will not prejudice a practice's position under these criteria	Marker of poorer quality practice
Fewer than five outliers on the GPHLIs on current system	Potential marker of poorer quality practice
There must be evidenced extenuating circumstances within the practice population related to 1. Workload 2. Patient demographics …that impact practice business and patient services For the purposes of this exercise, this will be defined as there being an IMD score of 35 or higher for the practice population	Must be evidence that local demographics dictate workload that are not adequately reflected in Carr Hill IMD is a marker of deprivation with a consequential impact on a practice workload.

8 This support would need to be set up via a formal agreement under Section 96 of the National Health Service Act 2006.

Next steps - How to apply

9 Practices NHS England believed to be eligible have been sent a form if they wish to claim this support. The form has been pre populated to show assessment against those criteria set out above which have been answered from information already held in NHS England.

10 Practices must request the money, sign the claim form and submit the latest set of signed accounts. The s96 agreement must be signed by 30 September 2014 as it is this that will confirm the funds can be released.

11 The financial data being used for this exercise was provided centrally and is NOT in the public domain.

Into the Future

12 The London team will continue to work with national colleagues and with CCGs to identify potential future options for supporting practices.

Neil Roberts
Head of Primary Care Commissioning (NCEL)
NHS England (London Region)

CLAIM FOR GMS FUNDING CHANGE SUPPORT PAYMENT 2014/15

SUPPORT Y/N	Reason for NO	Practice Code	Name	CCG	Weighted List (Jan 2014)

Criteria	NHS England Input	Practice Validation/Input
There must be an GMS Funding change loss greater than an average £3 per weighted patient per annum		
No doctor in the practice should have declared pensionable earnings in excess of £106,100 p.a. (pro rata'd for part time GPs)	Practice to submit latest year's signed accounts	
Practice expenses must be evidenced to be greater than 63% (National average ratio of expenses:profit is 63:37)	Practice to submit latest year's signed accounts	
No contract breaches for any reason issued since 1 April 2013		
That a significant proportion of contract holders (significant defined as =>50%) do not have "live" cases with NHS England performer machinery or GMC, including the Interim Orders Panel. Suspensions which are a neutral act, will be disregarded and will not prejudice a practice's position under these criteria		
Fewer than five outliers on the GPHLIs on current system		
There must be evidenced extenuating circumstances within the practice population related to 1. Workload 2. Patient demographics …that impact practice business and patient services For the purposes of this exercise, this will be defined as there being an IMD score of 35 or higher for the practice population		

Practice statement: I claim GMS Funding Change support funds for 2014/15 & 2015/16. I acknowledge payment will be contingent on the signing of a s96 agreement with NHS England by 30 September 2014. I confirm the detail on this form to be correct. I attach a copy of the latest year's financial accounts for the practice.

Signature……….. Date……

PLEASE EMAIL THIS CLAIM WITH ATTACHMENTS TO e.nurse@nhs.net

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**18/11/14**	Unrestricted		
Reports of: The Inner North East London Joint Health Scrutiny Committee **Presenting Officers:**		**Title:** **Threats to viability of GP Practices in East London due of the withdrawal of the 'Minimum Practice Income Guarantee' (MPIG)** **Ward(s) affected:** All		

1. Summary

This is a letter sent to NHS England in behalf of the Inner North East London Joint Health Scrutiny Committee in regards to GP funding cuts. It raises the issues in relation to the new funding system proposed, and the current temporary systems in place, both unfairly disadvantage and threaten the viability and future continuation of GP services located across East London.

2. Recommendations

Any recommended actions arising from panel meeting.

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Inner North East London Joint Health Overview and Scrutiny Committee
c/o Hackney Council
Overview and Scrutiny Team
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2nd Floor, Area K
1 Hillman St
London E8 1DY

jarlath.oconnell@hackney.gov.uk

26 Sept 2014

Mr Neil Roberts
Head of Primary Care
NHS England (London Region, North, Central & East)

(by email)

Dear Neil

Threats to viability of GP Practices in East London due of the withdrawal of the 'Minimum Practice Income Guarantee' (MPIG)

Thank you for your briefing note '*GMS funding changes – an updated position'* which we received on 9 Sept and which outlined the support available to GP Practices in East London facing a significant impact from the withdrawal of MPIG. This was a follow up to the briefing you kindly provided to Health in Hackney Scrutiny Commission on 17 July.

At the first meeting of the newly appointed INEL Committee on 11 Sept we discussed NHSE's latest offer on this with GP representatives from both Tower Hamlets LMC and City & Hackney LMC. While it was unfortunate that an NHSE representative could not be present, we are grateful to you for the updated briefing note.

The following key points were made by the senior GPs present:

a) MPIG was originally offered "in perpetuity" for as long as it was needed to prevent GP Practices falling below their 2004 levels of income, prior to the introduction of the new funding formula. Had GP incomes risen above 2004 levels then the MPIG would in effect have phased it self out. This hasn't happened and NHSE has now reneged on this promise. Furthermore by withdrawing MPIG the affected Practices will now fall back below their 2004 income levels.

b) The Carr-Hill formula gives an advantage to areas with significant numbers of older people (e.g. Eastbourne) and disadvantages areas, such as east London, where there are significant pockets of both younger people who are ill and populations who fall ill at a younger age, both linked to levels of deprivation.
c) While there are 22 Practices in Tower Hamlets, City & Hackney and Newham, which you say, are affected by the withdrawal of MPIG, there are many more just beneath this strict qualifying threshold (of losing more than £3 per weighted patient population) and their future must now also be called into question, certainly in the longer term.
d) The new stop-gap (non-recurrent funding for 2014/15 and 2015/16, which you are inviting the affected Practices to apply for this month) will have the effect of just postponing the problem and Practices currently in difficulty will be back in the same position in two years time unless and until the underlying inequity in the funding system is tackled.
e) NHSE admits that if Practices go under, and this is not unlikely, the cost of replacing them will be more than any savings accrued by these changes.
f) Of the 5 Practices in Tower Hamlets, which you indicated are affected, only 2 have been sent letters indicating that they might be eligible for this stopgap funding. Practices in City & Hackney disagree with your claim that they didn't respond to your offer of a meeting, so there are obviously communication problems.
g) The cuts are also affecting those on PMS and APMS contracts as we learned from Newham, where all Practices are on PMS contracts. The issue is broader than just GMS contracts.

We asked the LMC and BMA representatives if they could prepare a joint business case to put to NHSE to challenge your proposals and we suggested that it would be helpful if they could aggregate evidence from the Practices affected on the following issues:

a) how many have extenuating circumstances relating to workload and patient demographics (and list these)
b) how many are undergoing a crisis in recruitment involving both GPs approaching retirement age and challenges in filling vacant posts
c) How are the increases in population and population churn impacting on them at present
d) how many have an IMD score of 35 or higher thus indicating significant health inequalities and so an increased workload for their GPs

In point 4 of your briefing you say: "*There are some circumstances where the Carr-Hill formula may not sufficiently reflect the relative workload of London's GPs because of demographics, deprivation etc. amongst a local practice population*". This implies you are aware of the extent of the problem and as a Committee we would argue that you have a duty therefore to ensure that these Practices are properly funded.

We would also ask NHSE to explain how the revision of the Carr-Hill Formula is going to reconcile the ongoing tensions between 'age' vis-à-vis 'deprivation'

in how the formula is devised. Unless the funding formula takes proper account of what is known as “healthy-life expectancy” the formula will continue to weighted against GP Practices in areas where there are both significant health inequalities and where Practices are under increasing pressure because of the population pressures.

While we wish to support the LMCs in our boroughs on this campaign we continue to be hampered in our understanding by the lack of transparency on Primary Care funding from both sides. As I expressed in my letter of 17 July, we do not see why, even if confidentiality clauses prevent you from revealing some data, you cannot provide us with redacted data. This would give us a clear indication of the extent of the problem, including those that may just fall below the “£3 requirement” and also what proportion of Practices might have gained as well as lost. And finally we would be interested to know how many of the Practices are likely to be eligible for the interim funding.

We look forward to hearing from you.

Yours sincerely

Cllr Ann Munn
Chair
Inner North East London Joint Health Overview and Scrutiny Committee

cc
Members of INEL JHOSC
LMC Chairs for City & Hackney, Tower Hamlets and Newham
Members of the HOSCs in Newham, Tower Hamlets, City of London, Hackney
Cabinet Members for Health in Newham, Tower Hamlets, City of London, Hackney
MPs for Newham, Tower Hamlets, Hackney and City of London

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Committee **Health Scrutiny Panel**	Date **18/11/14**	Classification Unrestricted	Report No.	Agenda Item No.
Reports of: NHS England **Presenting Officers:**		**Title:** **Response letter from NHS England to: Threats to viability of GP Practices in East London due of the withdrawal of the 'Minimum Practice Income Guarantee' (MPIG)** **Ward(s) affected:** All		

1. Summary

This is the response letter from NHS England sent to the Inner North East London Joint Health Scrutiny Committee in regards to GP funding cuts.

2. Recommendations

Any recommended actions arising from panel meeting.

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28 October 2014

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Cllr Ann Munn
Chair
Inner North East London Joint Health
Overview and Scrutiny Committee

Dear Ann

Threats to viability of GP Practices in East London due of the withdrawal of the 'Minimum Practice Income Guarantee' (MPIG)

Thank you for your letter of 26 September 2014.

I note the key points made by the senior GPs present and that the Committee had asked the BMA and LMC representatives to prepare a joint business case to put to NHSE to challenge our proposals. I also note the Committee's suggestion about the type of aggregated evidence from the practices affected that might be useful in such a case. I shall await this document with interest. On the assumption that such a case is made we are likely to discuss this with national colleagues.

Your letter went on to say that if NHS England is aware of the extent of the *(MPIG/Global Sum)* problem, as a Committee that you would argue that NHS England has a duty to ensure that these Practices are properly funded. Whilst NHS England is the main commissioner of GP services, part of their income is also derived from services commissioned by the CCGs and the Local Authorities' public health functions. Co-commissioning between area teams and CCGs is likely to increase the proportion of GP practice funding that is being managed through CCGs. The duty on commissioners is to secure services that enable patients to receive

- Health- and Wellbeing-promoting care
- Fast, responsive access to care
- Proactive and coordinated care
- Holistic and person-centred care
- Consistently high-quality care

To deliver this, those GPs that are on the GMS contract type are funded for their core service provision (and a range of Directed Enhanced Services) on nationally determined contracts (specifications for DES) for which a "price" is negotiated nationally with NHS Employers (for NHS England) and the General Practice Committee of the BMA for the GPs. Government sets out the level of any national pay award/uplift by responding to evidence submitted by the Doctors' and Dentists' review Body (DDRB). The duty of NHS England is to establish those contracts and ensure that they are paid in accordance with the contract terms and the various Statutory Instruments that sit behind them. Income is only one side of the equation. NHS England has no control or sway over practice costs

(which includes staffing costs) or the amount doctors choose to take “as profit” from their businesses. The NHS England position is that through contract negotiations with the GPC we are discharging our responsibility to ensure that practices are fairly funded for the work they do.

You asked NHS England to explain how the revision of the Carr-Hill Formula is going to reconcile the ongoing tensions between ‘age’ vis-à-vis ‘deprivation’ in how the formula is devised. Your view is that unless the funding formula takes proper account of what is known as “healthy-life expectancy” the formula will continue to be weighted against GP Practices in areas where there are both significant health inequalities and where Practices are under increasing pressure because of the population pressures.

There is an expert group established nationally to look at revisions to the Carr Hill funding formula. It is worth noting that Carr-Hill was reviewed in 2007 by a group which included GPC / BMA representatives, but then in the negotiations on the GMS contract subsequently, the GPC refused to see the implemention of the recommendations, their concern being that any changes, would inevitably result in there being winners and losers.

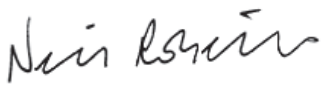
I have already referred upwards to the national team some interesting proposals about life expectancy being used within a funding model. That will be ultimately for the national review group, working with the GPC / BMA to consider.

Finally, I have discussed the issue of production of redacted data with the national Head of Primary Care. Our position remains that it would be inappropriate for NHS England to release any information regarding funding to practices in advance of what the HSCIC will publish in relation to 2013/14 practice income from our audited accounts in December.

We do not believe redaction can effectively anonymise financial data, and whilst we intend to move towards a position of greater transparency of GP income, this is necessarily sensitive and is being currently negotiated with the GPC. Our stance does not however preclude individual practices disclosing their own data to the LMC and the overview and scrutiny committee of its funding streams.

I hope this clarifies the position of NHS England (London) and is of help.

Yours sincerely,



Neil Roberts
Head of Primary Care
NHS England (London Region, North, Central & East)