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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 19 August 2015	Committee Room 2 - Town Hall

Members: 12, Quorum: 5

BOARD MEMBERS:

Elected Members:	Cllr Steven Kelly, Chairman Cllr Wendy Brice-Thompson Cllr Meg Davis
Officers of the Council:	Phillipa Brent-Isherwood
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, NHS Clinical Commissioning Group Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer, Havering CCG Alan Steward, Chief Operating Officer, Havering CCG
Healthwatch:	Anne-Marie Dean, Havering Healthwatch John Atherton

For information about the meeting please contact:
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What is the Health and Wellbeing Board?

Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information
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Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or

- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

1. CHAIRMAN'S ANNOUNCEMENTS

   The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. APOLOGIES FOR ABSENCE **-** (If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

   Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting.
   Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. MINUTES (Pages 1 - 8)

   To approve as a correct record the minutes of the Committee held on 15 April 2015 and to authorise the Chairman to sign them.

5. MATTERS ARISING (Pages 9 - 10)

   To consider the Board's Action Log

6. MEMBERSHIP

   The membership to formally confirm Councillor Steven Kelly to remain as Chair of the Health and Wellbeing Board.

7. MENTAL HEALTH - OVERVIEW (Pages 11 - 20)

Overview of children and young people's mental health in Havering – Susan Milner

8. MENTAL HEALTH - PREVENTION (Pages 21 - 36)

Prevention**:** what we currently do - Debbie Redknapp

9. MENTAL HEALTH - TREATMENT (Pages 37 - 46)

Treatment: Current Services for CYP with mental health issues - Alan Steward

Local Transformation Plan – new investment in CYP MH services – for comment and to agree sign off process. CAMHS / Schools Link bid - for info only.

10. WORKING BETTER TOGETHER TO COMMISSION AND DELIVER MH SERVICES FOR CYP (Pages 47 - 50)

Mary Pattinson to present attached report.
Governance arrangements: role and function Options paper - for decision.

11. STROKE SERVICES

Stroke Services – The case for change in rehabilitation pathway - Clare Burns – verbal update.

12. FORWARD PLAN

Forward Plan – to be tabled – Susan Milner

13. ANY OTHER BUSINESS

14. DATE OF NEXT MEETING

Wednesday 14 October 2015.

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
15 April 2015 (1.40 - 3.15pm)

Present:

Councillor Steven Kelly (Chairman)
Councillor Wendy Brice-Thompson, Cabinet Member – Adult Services and Health
Councillor Meg Davis – Cabinet Member – Children & Learning
Atul Aggarwal, Chair, Havering CCG
Anne-Marie Dean, Chair, Healthwatch Havering
John Atherton, Head of Assurance North Central and East London, NHS England
Alan Steward, Chief Operating Officer, Havering CCG
Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs
Cheryl Coppell, Chief Executive, LBH (for part of the meeting)

Also present:
Claire Still, External Relations Officer
Jade Fortune, Public Health Strategist

One member of the public was also present.

CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised of arrangements in case of fire or other event that would require the evacuation of the meeting room.

APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Andrew Blake-Herbert, Group Director – Communities and Resources
Joy Hollister, Group Director – Children, Adults and Housing, London Borough of Havering Sue Milner, Interim Director of Public Health, London Borough of Havering
Dr Gurdev Saini, Clinical Director, Havering CCG

DISCLOSURE OF PECUNIARY INTERESTS

No pecuniary interests were disclosed.

109 MINUTES

The minutes of the meeting held on 11 March 2015 were agreed as a correct record and signed by the Chairman.

110 MATTERS ARISING

Item 103: BHRUT hospital admissions. There had been a slight recent drop, but the total was relatively static. There had been a drop of about 1% in the meeting of A&E targets with a significant dip expected in January, but otherwise totals remained the same. At Queens, looking at the seasonal variation, there was an overall drop in performance in meeting the A&E targets, but there were grounds for optimism as it was the right direction of travel.

There were issues within the Care Board around the Joint Assessment and Discharge team due to the reduction in size of the team. The Health and Wellbeing Board wanted some reassurance about how the team was to work. The reorganisation which created the Joint Assessment and Discharge team – hosted by Barking and Dagenham (and set up jointly with NELFT) – had shown a very good improvement of management organisation. The reduction in staff level was due to the funding being cut, but for the time-being those members of staff were being kept on (to June) whilst attempts were made to put in place other funding arrangements. In the short term, funding was covered, but planning for its replacement was needed now.

Conor Burke reported that Winter Planning had cost £5m and that projects were being reviewed to see what could be kept and what dropped. He reminded the Board that it needed to be aware of these funding issues. Doubts were expressed about the Primary Care Strategic Commissioning framework.

Item 106: Primary Care Commissioning – Orchard Village. Alan Steward stated that the CCG were looking for a move to different facilities, partly due to CQC requirements. They were in the process of negotiating a move from the current clinic accommodation. It was asked whether this would have greater medical capacity and the answer was that it would provide more than the existing facility as it would include a “walk-in” centre and a practice on the estate. The Chairman expressed his concerns about this being an under-resourced area within Havering. He was assured that there would be more local control than previously.

The Chairman emphasised the need to have a medical practice on the estate and asked for more information to come to the next Chairman’s Briefing. He said that there was a need to provide a ”proper” service to what was, he added, the most deprived area in the borough. He felt that there needed to be an end to the referrals to Harold Wood. This was not good. He was informed that temporary measures would be in place shortly.

Dr Aggarwal observed that there would be some 10,000 people in the area and there was a need to match service provision to the population’s needs. The Chairman agreed saying that there would be a huge demographic swing and there would be a need to model all provision for the area over a ten year period.

He wondered whether there would be a large influx of people from Barking & Dagenham. It was observed that there would be a large Somali population growing in the area and he added that this was what the HWB should be doing: looking closely at the infrastructure required.

Anne-Marie Dean observed that there was a need to inform the population about what services were available and how they could be accessed.

Item 107: The Chairman asked whether the Federation Hub had received any publicity and was informed that a full page advert had been placed in the Romford Recorder as well as advertising in other local papers. The Chairman was concerned that advertising needed to be more widely presented as newspaper sales and general circulation were falling. Other media needed to be exploited.

Anne-Marie Dean stated that there was a need to ensure that reception staff etc. were properly briefed and trained to ensure they could advise properly. The problem was that it was difficult to get all the staff together at the same time due to their different shift patterns. She added that it was happening, it just needed developing.

The Chairman asked how many people were using the Hubs. It was stated that in the Romford Hub there was a 50% - 60% take-up of this new service. He asked whether there was scope for a third hub at the northern end of the borough and was reminded that the Harold Wood Centre had a walk-in facility so there was a possibility that one in Harold Hill could be used. There had been a pilot trial of weekend openings. This closed at the end of March (this had always been the intention) and was now being evaluated. The Chairman observed that the Romford Hub should receive more promotion that the Astra Close Hub.

A question was asked about the funding of the hubs. Conor Burke replied that once the initial funding from the Prime Minister's Challenge Fund expired, the CCG would continue to match-fund them from the Nuffield Trust (LBBD). If the hubs failed to prove effective, it would be wrong to continue to seek funding and the availability of the PM's Challenge Fund was very much dependent on the outcome of the General Election. The Chief Executive added that funds could be taken from other services to use where it was most needed. There was an element of dual running, so the Challenge Fund money would be useful.

Conor Burke stated that hospitals needed to cover their costs. This would not be easy, particularly in light of their reduced income. This would challenge most to manage themselves more efficiently.

The issue concerning the retirement of many of the borough's General Practitioners was raised. The reality was that Havering was likely to be particularly hard hit as it differed from the rest of London – and even the rest of the country - as most of its current GP partners were reaching – or soon would be reaching – retirement (50% were already over 60) and there were serious concerns about what was being done to secure GP cover for the future. Conor Burke stated that he had only taken over primary care a fortnight earlier and so was only beginning to get to grips with the problem, but he agreed that it needed

to be addressed as a matter of urgency because it took a long time to produce a GP.

The Chairman said that there was a need to look at single practice issues. One in three GPs said they were "fed up" and wanted to leave general practice whilst the General Medical Council had fewer numbers becoming qualified.

Dr Aggarwal added that new doctors were expressing a preference to be salaried rather than become partners. This could have an unfortunate effect when current partners came to retire; indeed, many returned to work even though they were officially in retirement. It was because of this that accurate figures in respect of GPs in an area could be skewed. To add to the problem, the earlier creation of "nurse-practitioners" was misleading – they simply did not exist.

The Chairman observed that to make matters worse, there was no accredited course for training health-care assistants who would help take pressure from GPs. He was of the opinion that such a course needed to be set up as a matter of urgency. He also wondered whether it would be feasible to employ underused education establishments and whether, if a suitable course could be found, the Board could set it up.

Conor Burke stated that this issue about aging had an impact across all health-care areas, for example: 50% - 60% of all care workers were over 50. The situation for the future did not look very promising.

Reference was made to the Commissioning Board and that it should become a Transformation Board. Anne-Marie said that it was the responsibility of the CCG and should be held in public and that perhaps a paper should be provided. Alan Steward replied that he would bring one to the next meeting.

111 REVIEW OF ACTION LOG

The Board decided that this should be considered at the next development session by which time some of the elements should have been filled in.

112 INTEGRATED MASH PILOT- PROGRESS UPDATE

The Council Chief Executive informed the Board that the Multi-Agency Safeguarding Hub (MASH) had been short-listed for an award which was due to be announced imminently. The formal multi-agency audit in the Children's Agency had produced good results. Most areas had reached their targets – though there were some areas where improvements could still be made. It was clear that there was a need for better communication between agencies, though overall things were moving in the right direction. Once again, Havering was leading the field. The MASH had been very well received and this was good for staff – indeed, the morale of those working in Children's Care was high. Those asked said that even though they were under considerable (and rising) pressure, they felt supported, so this was all very positive.

113 COMPLEX CARE (HEALTH 1000)

Conor Burke tabled a document concerning Individualised Personal Commissioning (IPC) on behalf of Havering CCG. He reminded the Board that this involved the hubs and referenced a new type of primary care relating to those who suffered from multiple conditions (a minimum of five), which could encompass a whole range of issues crossing several agencies. The basic concept was that the GP was not always best placed to decide what mix of support a patient needed and that whilst most of those receiving this sort of care package would be elderly, that need not always be the case.

The funding to pilot this came from a successful application to the PM's Challenge Fund. So far, 79 patients had been taken onto the scheme and this was indicative that the scheme's target of 1,000 by the end of the year would be achieved. Conor explained that this would be rolled-out across Barking & Dagenham, Havering and Redbridge and it was estimated that it ought to attract some 2,000 patients across the three boroughs.

So far the data showed that - including costs – each patient would cost between £25 - £30,000 and receive 24/7 support and advice. The bottom-line was that the team would deal with everything on behalf of the individual. Conor explained the illustrations. These had been put together from the accounts of those now using the pilot and showed how they perceived the change between having to arrange each component of their care themselves, to having a team member take control of the process and ensure that what they experienced was trouble-free and seamless.

The idea was to release the individual from the anxiety and frustration associated with complex socio-medical problems (which were usually encountered by patients who were probably least able to cope and more vulnerable than those with simpler, or single issues) and by removing the multiple and frequently conflicting processes, empower them to use their commissioning capacity effectively and within a secure, supported environment. It was, he said, the provision of a "concierge" service.

Not only were patients recording that they were now less stressed, but staff too were reporting that they were happier. It appeared that because the patient was more relaxed and confident, many underlying problems which raised tension between the practitioner and patient were correspondingly lowered or removed altogether.

Patients now considered that they were able to fulfil some life ambitions. The ethos of the team was to facilitate these ambitions and aspirations. The fact remained that some 30% of those on the programme would die within the next 12 months, so it was imperative that the team focussed on their needs – and delivers those expectations - and not simply provide immediate "care".

The team were, in fact "care negotiators". It would broker well considered and approved care plans. A Care Negotiator would work with an individual patient to provide a tailor-made package for that person – a package that factored in that person's aspirations. Care negotiators would come from the voluntary sector and

it was hoped to empower them further by providing essential funding. They would give a percentage of their budget to the patient for them to manage.

IPC would provide a directory of approved services from the healthcare market and patients would make their own choices. This was potentially a model for the future of provision of healthcare across the nation. Nowhere else in the country was piloting such a scheme and while there were undoubtedly risks, the outlook was potentially good.

The Chairman asked how it was proposed to expand across the three boroughs. Conor replied that King George had facilities and a clinic would be set up in Havering as soon as possible – though the teams were mobile, so the lack of a site in Havering should not prove to be a disadvantage.

Dr Aggarwal said that he would be meeting a medical director who had some 25 patients who might benefit from the programme. A question was posed about where assessments were to take place, and it was considered that they should be undertaken where the patient lived and not centrally as that was not necessary and ran counter to the patient-centricity of the scheme.

The Chairman asked whether there were sufficient patients to fill the places on an on-going basis and was assured by Dr Aggarwal that this would indeed be the case as some 50% of those put forward would take up the scheme and with a mortality of around 30% and an aging population, there should be no shortage of patients to keep the scheme moving forward. It was also a flexible scheme as it could embrace new conditions and accommodate unusual combinations of them. He cited references to diabetes and hypertension (30% of the population), COPD (25% of the population). These areas alone cost some £30m pa.

A question was asked about how this would be greeted by GPs as it would impact on their funding, but in answer, overall a GP would only lose £65 per patient per year – the greatest cost was in respect of hospital treatment.

The Chairman asked what would happen to those who missed the criterion of five conditions – even if those they had were unusual. Were there plans to provide something running in parallel to cater for those patients? In response Dr Aggarwal said that there was a need to be creative with provision. Integrated case management was important and different solutions needed to be tried. He mentioned that health analysis could be integrated A&E attendance forms.

Anne-Marie Dean added that this depended on the relationship between the A&E and the practices. It couldn't all come from the GP, A&E needed to be proactive in alerting practices about frequent attendees. She drew attention to the need for "befriending" those who had mental health and/or social care issues and felt that social networks were very important.

The Council Chief Executive observed that Havering had a seemingly paternalistic stance in respect of social care. With reference to the scheme, nothing was really known, there was no data: no attrition rate and no-one had yet left the scheme. With regards to funding, the PM's Challenge Fund money would run out – it was only meant to last two years, but it needed to be remembered that this was being conducted as an experiment. It was set up as such and programmed to run for two years.

Anne-Marie Dean added that if the experiment proved successful, there would be less dependence on GPs. At present it was more of a medical rather than a psychological process, but the psycho/social elements were real. She said that loneliness and uncertainly were factors which needed to be built in. There was a need to reassure people.

The Chairman suggested that perhaps NELFT should be considered as a topic for discussion by the Board. The Chief Executive said that studies needed to be more evidence-based as with work on the Care Act.

114 ANY OTHER BUSINESS

Members were reminded about the recent CQC inspections. When the report had been published concerning BHRUT, it would be brought to the Board.

115 DATE OF NEXT MEETING

The next meeting would be held on 19 August 2015, 13:00, CR2, Havering Town Hall.

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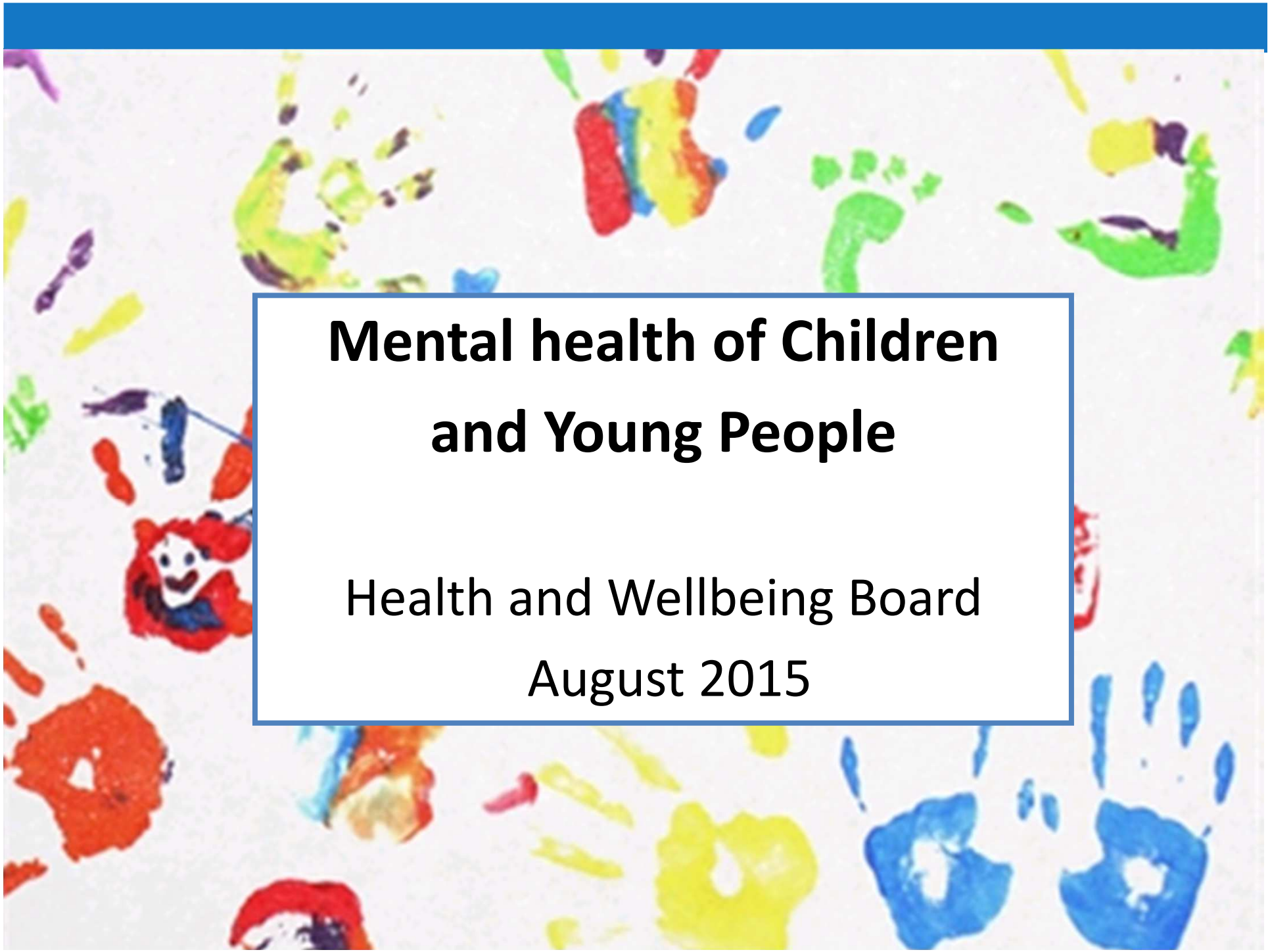
CHAIRMAN'S BRIEFING -

Date Raised	Owner	Brief Description	Action to be taken	Worked on date(s)	Chased date	Completed	Comments
Chairman's Briefing 01/04/2015	Sue Milner	Scoping Paper	Need to reframe and review Board priorities as delivery and performance needs to be measured. More focus on prevention required. HWB Strategy needs to be overarching. ½ day workshop to be arranged to flesh out.	13 May and 2 June mtgs			Workshop / Development Session planned 13 May
01 April 2015	Sue Milner	Primary Prevention	To be centrally focused – SM will produe presentation				
01 April 2015	Sue Milner	JSNA	How can we make this into a more user friendly / "live" - possibly Dashboard?				
01 April 2015		Affordable Housing and Mental Health	Agenda items to be added to Forward Plan.	April		Yes	
01 April 2015		Bi-monthly Board and Development Sessions	Board mtgs to take place bi-monthly, with a Development Session on alternative months. First Development Session mtg scheduled for May - agenda items will be Mental Health and Re-visiting priorities. Chairman's Briefing mtgs will continue to be held 2wks before Board mtgs.			Yes	
Development Session 13/05/2015	Cllr Kelly	Next Meeting	Cllr Kelly requested that the next meeting of the HWB, scheduled for 16 June, be used as a private meeting to continue our review of the role and function of the HWB				

13 May 2015	Sue Milner	Forward Plan	The Forward Plan has been amended to cover all HWB-related meetings. This will provide a complete overview of what is being scheduled where. Any additions/deletions/errors to Sue Milner and c.c. in Agatha Williams (Clerk).				
13 May 2015	Cllr Kelly	Distribution List	Distribution list to be reviewed to ensure that only HWB members, their PAs and appropriate LBH support officers are included.	18-May			Lists with Jade F to update
13 May 2015		Agenda Items / Themes	12 August should have a Mental Health theme. 8 July HWB development session will be used as an opportunity to look at mental health issues in more depth in preparation for the board meeting and any formal decisions that the board has to make. We need to start pulling the programme together for the development session and identify any items that need to go to the formal board. All ideas and suggestions for what should be covered under this theme to Sue Milner by CoP 29 May				



Mental health of Children and Young People

Health and Wellbeing Board

August 2015

What is mental health?

WHO Def:

- *'a state of mind in which an individual is able to realise his or her own abilities, cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'*

Things that can help keep children and young people mentally well include:

- being in good physical health, eating a balanced diet and getting regular exercise.
- having time and the freedom to play, indoors and outdoors.
- being part of a family that gets along well most of the time.
- going to a school that looks after the well-being of all its pupils.
- taking part in local activities for young people.

Other factors are also important, including:

- feeling loved, trusted, understood, valued and safe.
- being interested in life and having opportunities to enjoy themselves.
- being hopeful and optimistic.
- being able to learn and having opportunities to succeed.
- accepting who they are and recognising what they are good at.
- having a sense of belonging in their family, school and community.
- feeling they have some control over their own life.
- having the strength to cope when something is wrong (resilience) and the ability to solve problems.

Risk factors for poor mental health :

There are certain ‘risk factors’ that make some children and young people more likely to experience MH problems than other children, but it doesn’t mean they will.

Biological - non genetic

Biological abnormalities of the central nervous system that influence behaviour, thinking or feeling can be caused by injury, infection, poor nutrition, low birth weight, prenatal damage from exposure to alcohol or other drugs, or exposure to toxins such as lead in the environment

Biological - genetically linked

Mental disorders most likely to have genetic components include: autism, bipolar disorder, schizophrenia, and attention-deficit/hyperactivity disorder .

Non-biological risk factors

- having a long-term physical illness
- having a parent who has had mental health problems, problems with alcohol or has been in trouble with the law
- experiencing the death of someone close to them
- having parents who separate or divorce
- having been severely bullied or physically or sexually abused
- living in poverty or being homeless
- experiencing discrimination, perhaps because of their race, sexuality or religion
- acting as a carer for a relative, taking on adult responsibilities
- having long-standing educational difficulties.

Young people's mental health in Havering

NB Data are estimates based on national predictive models and are likely to be an underestimation of local prevalence

- 9.1% children aged 5-16 years [3,093] have a mental health disorder compared to 9.6% nationally

Below is a partial breakdown of this figure:

- 3.5% children aged 5-16 years [1,194] have Emotional disorders e.g. phobias, anxiety, OCD
- 5.5% children aged 5-16 years [1,862] have Conduct disorders e.g. aggression, vandalism
- 1.5% children aged 5-16 years [505] have Hyperkinetic disorders e.g. hyperactivity, ADHD

Source: * Public Health Profiles, PHE, Accessed July 2015

**DSR per 100,000 (age 10-24 yrs) for hospital admissions for self-harm, 2013/14, Havering Child Health Profile, PHE, 2015

Hospital Admissions

- 206 per 100,000 young persons aged 10-24 years [279] have been admitted to hospital as a result of self-harm (lower than the England average)
- 'Avoidable' paediatric A&E admissions – seeing increased numbers of children with behavioural difficulties brought in by parents who are unable to cope with their behaviour, and GP doesn't know what to do

Source: Child Health Benchmarking Tool, Public Health England, June 2015

Risk factors in Havering

- 19.6% children aged under 16 [8,755] in Poverty (similar to England)
- 11.8% children in Reception [326] are obese (significantly higher than England)
- 1% children aged under 15 [443] providing unpaid care
- 4.6% children aged 16-24 [1260] are carers
- 130 per 100,000 parents of children aged 0-15 [58] are in drug treatment
- 124 per 100,000 parents of children aged 0-15 [55] are in alcohol treatment
- 10.5 % adults [20,191] current marital status is separated or divorced

Source: Child Health Profile, Public Health England, June 2015

Promotion of mental health and prevention of mental ill health in CYP

The Children and Young People's Mental Health and Wellbeing Taskforce

- In summary, the themes are:
- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency

What we currently do:

- Antenatal
- 0-5 years
- School age children
- Children with special needs
- Transition points

Universal Services

- Perinatal Mental Health Service
- Health Visiting
- Healthy School inc. School Nursing
- Early Help
- Counselling Services
- CAMHS

Perinatal Mental Health Service

- Referral rates: Av. 234 per year
- Treatments times vary dependant on need
- Can remain in service until child reaches 3 years of age
- Those referred in the antenatal remain until child reaches 1 year.

Health Visiting 0-5

- Aim: Universal prevention and early intervention detected at the 5 mandated checks
  - Antenatal – maternal mental health, 0%
  - New Birth Visit – emotional attachment, 90%
  - 6-8 weeks – mood assessment, targeted 45%
  - 1 year check – assess family strengths, risks 47%
  - 2 ½ year check – learning and behaviour 61%

Health Visitors

- Tensions
  - Ability to meet the mandate
  - Introduction of integration of ages & stages questionnaire at 2 ½ years with PVI settings
  - Additional funding to bring us up to a floor (1 of 12 L.A.)
  - 32 HV team to carry out circa 15000 assessments per year (470)
  - PH grant cuts
  - No requirement to improve on existing performance *versus* evidence for early identification and intervention = reduced demand

Early Help

- Early Help Assessment
- Team around the family
- Family support workers

- Children Centres:
  - Integration with Midwifery, health visitors, perinatal mental health team, postnatal support group

Early Help

- Tensions:
  - ➢ Diminishing commitment for evidence based interventions:
    - perinatal/baby massage
    - breastfeeding/attachment/emotional health/peer support

      lowest breastfeeding rates in London
  - ➢ Assumptions regarding appropriate training – consistent messages (e.g. HV, children centre staff, family support workers
  - ➢ Financial cost pressures

Healthy Schools

- Newly commissioned Schools Nursing Service – Universal health and development assessments of reception and year 6.
- With Schools:
  - ➢ develop a school health profile
  - ➢ develop a Health and Wellbeing Action plan
  - ➢ support school to deliver actions in year
  - ➢ facilitate school to achieve the HS award

School Nursing

- School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.
- They can play a crucial role in supporting the emotional and mental health needs of school-aged children. School nursing services are universal and young people see them as non-stigmatising.

Healthy Schools

- Tensions:
  - 9 School Nurses to cover: 43000 5-19 children and young people in 81 schools and colleges
  - Attendance at increasing numbers of Safeguarding CP conferences
  - Ad hoc commissioned counselling services not specifically linked to schools
  - Optional to develop a Health & wellbeing action plan

Vulnerable groups

- Increasing numbers of Early Help Plan, CIN, CP and LAC
- Theme: Neglect = Long term chronic problems
- Dedicated CAMHS support for Looked after children placed out of borough
- Some young carers support
- Respite

Vulnerable groups

- Tensions

  - Timeliness of LAC health assessments and regular reviews – identification of appropriate support
  - Ad hoc commissioning by partners of counselling services enforcing a tiered approach
  - No single point of access or a “one stop shop” service

Transition

- Transition group exists

Tensions:

- Various commissioned services – requires a multiagency approach.

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HEALTH & WELLBEING BOARD

Subject Heading:	Local Transformation Plan
Board Lead:	**Alan Steward, Chief Operating Officer, Havering CCG**
Report Author and contact details:	Jessica Arnold, Senior Locality Lead, Havering CCG Jessica.arnold@haveringccg.nhs.uk Natalia Clifford, Senior Public Health Strategist, London Borough of Havering Natalia.clifford@havering.gov.uk

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Following the recent report of the Children and Young People's Mental Health Taskforce, *Future in Mind*, the Government announced increased funding for Children's mental health services to the total of £1.25 billion over five years. Havering's allocation of the funding will be £507,000 per annum. The purpose of the additional funding is to improve quality and access of children to mental health services by 2020. Specific ringfences exist for perinatal mental health, eating disorders and children's psychological therapies.

Release of funding is subject to approval of a local Transformation Plan. Plans are required to enhance and extend new and existing services and projects, through a multi-agency approach of commissioners, providers, schools, families and other stakeholders. Plans also require a named local commissioner for children's mental health to be identified. The deadline for submission of Transformation Plans is 16th October. Havering CCG, London Borough of Havering and partners have begun early work to commence development of the Havering Transformation Plan for children's mental health, and ask the Health and Wellbeing Board to approve the proposed approach and sign off process ahead of the national deadline.

RECOMMENDATIONS

The recommendations of this report are that Health and Wellbeing Board members:

a) note the opportunity presented by the national call to develop Children and Young People's Mental Health Transformation Plans for local areas, in the context of local challenges
b) approve the proposed approach to developing the local Transformation Plan
c) approve the proposed sign off process for the Plan ahead of the 16th October deadline

REPORT DETAIL

The local position of children's mental health

An in-depth assessment of needs and current provision for children's mental health can be found in the Havering JSNA. Key findings include:

- There are an estimated 3,275 children with mental health problems in Havering; with the most common conditions being conduct, emotional and hyperkinetic disorders
- The rate of children with a learning difficulty, moderate learning difficulty or autistic spectrum disorder is significantly lower than the England rate; but the rate with severe difficulties is similar to England as a whole
- There are 230 Havering Looked After Children and more living here from other boroughs; this is a cohort who are significantly more likely to have mental health problems
- There are 443 children were identified as carers through the 2011 census, but the true number is likely to be greater as many would not self-identify or disclose their caring roles
- There is increasing youth offending and gang activity in Havering as the borough's demographics changes; again there is a significant correlation between youth offending and mental health problems
- There are 8,800 children living in relative poverty; and an association between poverty and behavioural problems
- The rates of breastfeeding in Havering are low and smoking in pregnancy is high; so there are many families where children's health is not being given the best start in life
- Queen's Hospital is experiencing increased numbers of children with behavioural difficulties brought into A&E by parents who are unable to cope with their behaviour, and GP doesn't know what to do. This is boosting avoidable paediatric A&E attendances

The opportunity of the Transformation Plan

"There is now a welcome recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked."

Simon Stevens, *Future in Mind,* March 2015

The recent report of the Children and Young People's Mental Health Taskforce, *Future in Mind*, jointly chaired by NHS England and the Department of Health, establishes a clear direction and key principles about how to make it easier for children and young people to access high quality mental health care when they need it. Within the report, there were 49 recommendations for improving children's mental health, covering the five key themes of:

- Promoting resilience, prevention and early intervention
- Improving access to effective support and a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Within the report, and subsequently the Chancellor's autumn statement (December 2014) and Budget (March 2015), the Government announced increased funding for Children's mental health services. A total of £1.25 billion over five years will be provided (£250 million per year) to implement the recommendations of the review. This money is additional and not within the CCG baseline. Of the total, £15 million per year will be ringfenced for perinatal mental health. In addition to this funding, a further £120 million (£30m per year) has been ringfenced for eating disorders.

In addition to perinatal mental health and eating disorders, the Transformation funding is intended to focus on catalysing roll-out of the Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT). By 2018, it is envisaged that CAMHS will be delivering a choice of evidence based, outcomes focussed interventions, and working collaboratively with children, young people and their parents or carers. The additional funding will also extend access to training for staff working with children under five and those with autism spectrum disorder and learning disabilities. New access targets and a new waiting times standards are also expected as an outcome of the Future in Mind review.

Future in Mind recommends that CCGs take ownership and become the lead organisation around Children and Young People's emotional health and wellbeing across all tiers. CCGs have been invited to produce Transformation Plans for children' mental health services over the next five years with key partners (such as Public Health, Local Authorities, NHS England, voluntary sector and acute, community and mental health provider Trusts).

This is set in a national context running in parallel to the *Future in Mind* recommendations, of new national Key Performance Indicators (KPIs) and calls to action to improve access to services. Aimed at achieving major national systemic change across children and adult services, these include:

- A new KPI to ensure that 50% of Children and Adolescents referred for psychosis begin treatment within 2 weeks
- A focus on developing a culture of 'parity of esteem' to ensure that there is a culture of improving mental health in line with physical health and closing the gap between people with mental health problems and the wider population
- Mental Health Crisis Care Concordat plans set out local ambition for adult and children in terms of emotional and mental health and can be used as a starting point to build a Transformation Plan for Children and Young People. The Concordat is key to ensuring systemic changes in improving emergency care including place of safety for adults and children

Requirements of Transformation Plans

Full guidance on the development and requirements of Children and Young People's Mental Health Transformation Plans was published in early August 2015. Key elements of the Plans will need to include:

- a strong focus on creating best evidence based community Eating Disorder teams, with details of how capacity freed up by specialist teams will be redeployed to improve crisis and self harm services
- work with collaborative commissioning groups in place between specialised commissioning teams and CCGs; commitments to transparency, service transformation, meeting legal duties with regard to equality and health inequalities and demonstrating improvement
- commitments to:
  - transparency
  - service transformation including data and IT infrastructure
  - outcomes monitoring improvement

The guidance advises that Transformation Plans should demonstrate clear local ownership and co-commissioning across health, local authority and schools, and with clear evidence of

collaboration with children, young people and their families. The Plans are required to name a lead commissioner for children's mental health in each local area, which might be the CCG or local authority.

Finally, the guidance explicitly states that new ideas, projects and innovations are not required within the Plans. The funding can be used to extend and advance existing services and projects that are already in place.

Early thinking on Transformation Plan content

From early discussions between the CCG, council and NELFT, and based on July 2015 guidance on transforming children's mental health services, a proposed transformation model has been drafted. The key principles and partners within the model, subject to impending discussions, multi-stakeholder engagement and development, are:

Whole systems approach	Other key principles	Key partners
• Joint working between agencies • Co-location of workers • Support for self-help and self-management • Health promotion, prevention and early intervention • One single point of access • Integration with NHS 111 at single point of access • Close working relations with LAS and police • 24/7 availability • Emphasis on keeping people at home and treating them as close to home as possible • Services developed around patient needs • Integrated electronic records with modern ways where patients can carry their records as apps on their phones • Development of digital directory of services • Modern ways of communication with patients as well as use of digital platforms in assessing outcomes and for use in clinical applications	• Stratification and care navigators for the10% highest service users • Care co-ordination to ensure seamless transfer between quadrants • Has whole pathway outcome measurement including a goals based approach that's compatible with new CAMHS PBR and personal budgets • Is digitally enabled • Focuses on harnessing community assets and opportunities to improve self-care. • Focuses on early intervention through effective outreach into schools, primary care and hard to reach groups	• Primary care • NELFT • Local authorities of Redbridge, B&D and Havering, both as commissioners and providers of children's services • CCGs • Public health • Youth justice • Education • Health watch and other relevant patient groups • PELC and LAS • Police • Relevant third sector groups such as CVS of the three boroughs • UCLP • Care city

Financial allocations

The following below shows the allocations of funding to the BHR boroughs, as set out in annexe 4 of the Local Transformation Planning Guidance. These are initial allocations and additional funding available for 2016/17 when the Transformation Plan is 'assured'.

	Eating Disorders Service 15/16	Local Transformation Plan 15/16	Minimum recurrent uplift from 2016/17 if plans are assured
Barking and Dagenham	£111,358	£278,739	£390,097
Havering	**£144,659**	**£362,096**	**£506,755**

Redbridge	£146,066	£365,619	£511,685
BHR CCGs	£402,083	£1,006,454	£1,408,537

Proposed approach to developing the Transformation Plan

The proposed approach to developing the Transformation Plan is set out in the following table of processes and milestones.

Please note that this will be a multi-agency, multi-disciplinary approach, drawing on the expertise and input of commissioners, clinicians, providers and other professionals from across Havering's health and social care system. Also note that there will be a coordinated approach across the six BHR CCGs and local authorities to ensure our plans align where we share common challenges, and to maximise the benefits of sharing one provider (NELFT) across the patch. This coordination will have regular oversight by the CCG Joint Management Team (JMT).

Activities	Lead	Timeline
Agree engagement and sign off process for the local transformation plan	CCG Chief Operating Officer	At the 19th Aug HWB
Development of an 'as is' position statement	Joint children's commissioner	By 28th Aug
Development of a core offer / plan based on guidance	Joint children's commissioner	By 28th Aug
Service gaps to be identified – GP clinical lead engagement	Joint children's commissioner with Dr Adur (MH)/Dr Deshpande (CYP)	By 28th Aug
Provider view to be gathered on gaps identified – secondary care clinical engagement	Joint children's commissioner with NELFT and BHRUT	Meeting arranged for 25th Aug
Service values to be identified and aligned to investment	BHR Finance	By 30th Aug
Develop plans to deliver the Plan and secure services	Joint children's commissioner with clinical leads and Procurement advice	By 14th Sept
Stakeholder engagement with service users / carers	Joint children's commissioner	Begin in Aug until 25th Sept
Consistency check and joint working coordination across BHR	Joint Management Team (JMT)	Throughout Aug-Oct
First draft plan for discussion / dissemination	Joint children's commissioner and comments invited from all stakeholders	Draft plan by 11th Sept; feedback until 25th Sept
Draft Plan is taken for discussion at the HWB Chair's briefing	CCG Chief Operating Officer	For 30th Sept
Delegated authority for sign off	To be agreed (see below)	By Fri 9th Oct
Final draft Plan is taken for information to the HWB	CCG Chief Operating Officer	14th Oct
Deadline for submission	CCG Chief Operating Officer	16th Oct

Proposed sign off process

This paper proposes the following sign off process for the Transformation Plan:

- The draft Plan is taken for discussion at the HWB Chair's briefing of Wednesday 30th September

- Delegated authority for sign off is given to the Health and Wellbeing Board Chair (Cllr. Kelly), the LBH Director of Adults, Children's and Housing (Isobel Cattermole) and the CCG Accountable Officer (Conor Burke). This will take place by Friday 9th October

- Optional: The final draft Plan is taken for information to the Health and Wellbeing Board meeting of Wednesday 14th October (although this will be too late to make any significant amendments)

- Deadline for submission is Friday 16th October 2015

NHS England assurance process

A bespoke assurance process is currently being developed for 2015/16 (year 1) by NHS England. This will be integrated within the mainstream planning framework from 2016/17 onwards. Guidance has been explicit that assurance will need to include that CCGs have worked closely with key stakeholders to develop their local Transformation Plans. NHS England have advised that the assurance process will be co-ordinated by regions (London region in our case) and led by DCO teams locally with support from a central team of expert clinicians. It is envisaged that, from September, progress against locally set objectives will become an integral part of CCG assurance discussions. From 2016/17, the intention is that any refresh of Transformation Plans and the continuing development of services will be embedded within mainstream planning and assurance processes.

Next steps

The Health and Wellbeing Board is asked to agree the approach to developing the Havering Children and Young's Mental Health Transformation Plan and agree the sign off process of the Plan ahead of the submission deadline of 16th October. Once approved, delivery of the action plan will commence to ensure the Havering Plan is developed robustly and jointly across the CCG and council and consistently across BHR.

IMPLICATIONS AND RISKS

Financial implications and risks:

If successful, Havering's Plan will yield award of over half a million pounds for children and young people's mental health per annum for the next five years. Securing the money requires approval of the submitted Transformation Plan. Therefore the Plan will need to be high quality, clear and robust, and have been formed through engagement with the range of stipulated stakeholders. It will need to meet with NHS England requirements as set out in the August 2015 guidance. To mitigate this risk, the proposed approach to developing the Plan for Havering includes engagement with stakeholders as required and adherence to published and any forthcoming guidance during the period between now and 16th October.

Legal implications and risks:

There are no legal implications at this time.

Human Resources implications and risks:

There are no HR implications at this time.

Equalities implications and risks:

Financial investment and delivery of a local Transformation Plan for children's mental health is aimed at having a positive impact of health inequalities within the child and young person population of Havering. This will benefit local children (especially at-risk groups such as those with learning difficulties, Looked After Children, children in poverty, potential young offenders and carers) and lead to a longer term reduction in health inequalities between those with mental health conditions and those without. There are no negative equalities implications at this time.

****All risks will be reviewed throughout the process of development of the local Transformation Plan, and subsequent delivery of the Plan, and flagged as appropriate to the Health and Wellbeing Board.****

BACKGROUND INFORMATION

1. The key document that provides the overall strategy for this work is the Children's Mental Health Taskforce report:

   - Future in Mind

2. NHS England guidance published on 3rd August 2015:

   - Local Transformation Plans for Children and Young People's Mental Health and Wellbeing *http://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf*

   - Access and Waiting Time Standard for Children and Young People with Eating Disorder, July 2015 Commissioner Guide. *http://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf*

3. BHR CCGs have been working together to agree common areas of development for children's services including CAMHS within the NELFT service contract. This has taken place against a background of significant change in the commissioning of children's services as well as new legislation (the Children and Family's Act 2014). BHR CCGs each have joint children's commissioning post in place with their respective councils

4. There will be a number of interdependencies between the CYP MH Transformation Plans and the work that is underway on mental health more broadly, particularly in relation to the development of the Early Intervention in Psychosis services and the delivery of the Crisis Care Concordat

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Mental Health of Children and Young People in Havering - Options paper for a new governance structure
Board Lead:	Isobel Cattermole
Report Author and contact details:	Natalia Clifford, Senior Public Health Strategist, Natalia.clifford@havering.gov.uk

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ✓ ☐ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The Local Authority, CCG and voluntary sector provide a range of universal and targeted services for the mental health of children and young people (CYP) in Havering. Historically services have been commissioned by each organisation and there is now a desire to develop a strategy across the partnership to inform commissioning and ensure maximum benefit for the Havering population.

The Mental Health Partnership Board focuses on Adult mental health and there is currently no similar forum to strategically support children's mental health in the borough.

Scope
Mental health and wellbeing prevention, support and treatment services from Antenatal to 19 years old (25 years for SEND)

Key deliverables

1. Develop and oversee implementation of a CYP Mental Health strategy across the partnership
2. Inform the development the Local Transformation Plan
3. Provide commissioning recommendations to LA and CCG
4. Provide forum for relevant ad-hoc work e.g. CAMHS / Schools Link bid

This paper provides 3 options for the governance arrangements for the Mental Health of Child and Young People Havering.

RECOMMENDATIONS

For decision – The Health and Wellbeing Board is asked to make a decision on the governance arrangements according to the Options listed below.

REPORT DETAIL

1.0 Option 1

1.1 Incorporate Children and Young People into the Terms of Reference of the Adults MH Partnership Board. Establish subsets of the MH Partnership Board to act as 'Task and Finish' groups to carry out the key deliverables. The MHPB reports directly to the Health and Wellbeing Board and has 'dotted line' advisory relationship with Joint Commissioning Board established by HCCG and LBH.

1.2 Benefits – the key benefit is that a single board allows for a whole system approach to providing mental health promotion and services across the borough. A single board could aid transition arrangements and support primary prevention opportunities. There is a lot of crossover with antenatal provision, perinatal services and the children's agenda including young carers of adults with mental health conditions. The governance structure is already in place with appropriate stakeholders.

1.3 Challenges - likely to be a very unwieldy long agenda particularly at present when there is a large amount of work to do in the Children's area to even establish what is currently being delivered across all parties before

further work can begin. Key partners e.g. Health, schools , PVI sector will need to be represented to allow a meeting which is relevant and these partners in particular and other members may prefer the board to have an adults or children's focus depending on their background.

2.0 Option 2

2.1 Establish a separate CYP Mental Health Partnership Board with similar Terms of Reference to the Adult-MHPB. Establish subsets of the CYP MH Partnership Board to act as 'Task and Finish' groups to carry out the key deliverables. The group reports directly to the Health and Wellbeing Board and has 'dotted line' relationships with (adult) MHPB and with Joint Commissioning Board established by HCCG and LBH.

2.2 **Benefits -** The CYP MH PB Mental Health Partnership Board would be a single place for all Children's Mental Health issues to be addressed across the wide partnership.

2.3 **Challenges** – Would need to have strong links with the Mental Health Partnership Board to support appropriate planning for transitions and to ensure a consistent pathway for service users. Would need to establish a new board before implementation.

3.0 **Option 3**

3.1 Establish a stand-alone Children's and Young People Mental Health Working Group in the first instance that reports directly to the Joint Commissioning Board with recommendations and advice on commissioning. This would have membership from the LA and the CCG only. There would need to be a separate service user / carer and provider forum that would feed into this working group

3.2 Benefits – a tight working group with focus exclusions in the first instance with key deliverables might be able to deliver to short deadlines.

3.3 Challenges – Would need to establish 2 new groups as there is no service user / provider forum in current existence. Labour and resource intensive to manage.

4.0 Option 4 (Option 2 – Option 1) – Preferred Option

4.1 To establish a Children's MH Partnership board in the first instance to undertake key tasks related to children's mental health which would merge with the Adults Board in the Medium Term. With a view that the two groups merge together once significant work has been undertaken

4.2 Benefits – Board would have appropriate representation across all partners including the education sector, YOS etc. It can focus on the very

considerable areas of work needed to create a strong vision for children and young people.

4.3 **Challenges** – Ensure appropriate dialogue is maintained in the Adults MH board. (This could be addressed by the Chair of Children's MH Board attending Adults MHPB). Providing admin support for a new group

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IMPLICATIONS AND RISKS

None. Decisions will be made within the agreed governance arrangements taking into account financial, legal, HR and equalities implications and risks.

Financial implications and risks:

Legal implications and risks:

Human Resources implications and risks:

Equalities implications and risks:

BACKGROUND PAPERS

None