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To: Members of the
HEALTH AND WELLBEING BOARD

Councillor Peter Fortune (Chairman)
Councillor David Jefferys (Vice-Chairman) and Councillor Diane Smith (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Judi Ellis, Robert Evans, Peter Fookes, Ellie Harmer, William Huntington-Thresher and Charles Rideout

London Borough of Bromley Officers:

Dr Nada Lemic	Director of Public Health
Terry Parkin	Executive Director: Education, Care & Health Services (Statutory DASS and DCS)

Clinical Commissioning Group:

Dr Angela Bhan	Managing Director BSU
Dr Andrew Parson	Bromley GP Consortia

Bromley Voluntary Sector:

Colin Maclean	Healthwatch
Sue Southon	Chairman, Community Links Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **MONDAY 29 JULY 2013 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from www.bromley.gov.uk/meetings

AGENDA

1 APOLOGIES FOR ABSENCE

2 MINUTES OF LAST MEETING AND MATTERS ARISING

This item to follow.

3 QUESTIONS BY COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5pm on Tuesday 23rd July 2013.

4 JOINT STRATEGIC NEEDS ASSESSMENT (Pages 1 - 18)

5 PROMISE PROGRAMME UPDATE (Pages 19 - 22)

6 INTEGRATED DIABETES SERVICE UPDATE (Pages 23 - 26)

7 BROMLEY'S RESPONSE TO WINTERBOURNE VIEW RECOMMENDATIONS (Pages 27 - 34)

8 FUTURE MEETINGS AND AGENDA ITEMS

9 ANY OTHER BUSINESS

10 LOCAL GOVERNMENT ACT 1972 AS AMENDED BY THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) (VARIATION) ORDER 2006 AND THE FREEDOM OF INFORMATION ACT 2000

The Chairman to move that the Press and public be excluded during consideration of the items of business listed below as it is likely in view of the nature of the business to be transacted or the nature of the proceedings that if members of the Press and public were present there would be disclosure to them of exempt information.

Items of Business	**Schedule 12A Description**

11 DATE OF NEXT MEETING

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2012

Executive Summary

1. Introduction

This report describes the main issues affecting the health and wellbeing of the population of Bromley. Its purpose is to provide the basis for an understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years), and the longer term future (five to ten years) to inform strategic planning commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

2. Demography

This year, the initial findings of the 2011 Census are included in the JSNA, although the population projections are still based on the 2001 Census data.

The population of Bromley is rising and is predicted to continue to rise. The 2012 estimate of the resident population is 316,647; this is expected to increase to 326,217 by 2017 and 332,956 by 2022.

The number of births has risen considerably in recent years (an increase of 29.1% in 2011 compared to 2002) and is likely to continue to do so. This has resulted in a concomitant increase in the numbers of 0 to 4 year olds.

The number of older people in Bromley is increasing in line with the rise in the overall population, so the proportion of older people is predicted to remain fairly stable at 15.6% over the next 10 years.

There has been an increase in the proportion of the ethnic minority population in Bromley from 13.5% in the 2001 Census to 22.6% in the 2011 Census. For the first time, the 2011 Census has included Gypsy/Irish Travellers as an ethnic category, with 0.2% of Bromley's population stating that they belong to this category.

The 2011 Census shows that although there has been a significant increase in the proportion of people working in higher professional occupations, there has also been a marked increase in the proportion of "never worked" and "long term unemployed" in Bromley.

What this means for the JSNA

Services need to cater for an increasing number of people in Bromley.

Consideration needs to be given to the increasing numbers of older people and young children who are higher users of health and social care services.

The increase in numbers of children will impact on requirements for primary and secondary school places.

3. The Health of People in Bromley: Life Expectancy and the Burden of Disease

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2007-09) report a life expectancy of 79.9 years for men and 83.8 years for women.

However, life expectancy is 7.8 years lower for men and 6.2 years lower for women in the most deprived areas of Bromley compared with the least deprived areas.

The infant mortality rate in Bromley (3.0 per 1000 live births) is lower than in England as a whole (4.4 per 1000 live births), and has been fairly steady over the last 4 years.

The key causes of death in Bromley remain circulatory disease, cancer and respiratory disease.

The prevalence of heart disease has been stable over the last four years and mortality rates continue to decrease.

The NHS Health Checks Programme is identifying a high risk of CVD in the next 10 years in 8% of screened individuals.

The prevalence of stroke has increased in the last year, but the mortality rate continues to decrease.

The prevalence of hypertension remains above 17% (with over 46,000 cases), despite evidence of under identification of cases. Control of hypertension in Bromley is less effective than across London and England.

The numbers of people in Bromley with diabetes continues to rise, with 13,335 cases on the disease register in 2011-12.

The incidence of all cancers in Bromley has been rising over the last 28 years, but mortality has been falling and survival has been improving. The number of cancer registrations per year has increased since 2002, but has been fairly stable since 2006.

The four most common cancers registered in Bromley in the last 10 years are breast, prostate, lung and colorectal cancer.

About 13% of deaths in Bromley are caused by respiratory disease. This includes influenza and COPD.Chronic Obstructive Pulmonary Disease (COPD) is mainly caused by smoking. Although the prevalence of smoking in Bromley is lower than the London and England averages, smoking prevalence is higher in routine and manual workers.

Mental health problems affect a large proportion of the population, with approximately 158 people per 1,000 of the Bromley population aged 16 to 74 years suffering from a mild to moderate disorder (i.e. anxiety and/or depression).

In 2012 it was estimated that there were 4102 people with dementia in Bromley. GP registers identify 1,703 patients with dementia, suggesting that some cases are not known to clinical services.By 2030 the number of people with dementia in Bromley is estimated to increase to 6047.

In 2010 there were 143 conceptions in females aged between 15 and 17 years. This represents a rate of 26.4 per 1000 female population aged 15 to 17 years, which is lower than both the London rate (37.1) and the England rate (35.4). There has been a 17.8% reduction in the under 18 conception rate since 1998.

Of the 143 under 18 conceptions in 2010, 93 (65%) resulted in a termination of pregnancy. This is significantly higher than the England rate (50.3%), and slightly higher than the London rate (62.5%).

The rate of sexually transmitted infections (STIs) in Bromley is significantly lower than the London rate and the England rate.

Bromley has a high rate of hospital admissions with any mention of pelvic inflammatory disease in women aged 15 to 44 years (564 per 100,000 population) as compared with the London rate (240.3) and the England rate (247.9). This high rate in Bromley merits further investigation.

The prevalence of HIV in people aged 15 to 59 years in Bromley is significantly higher than the prevalence across England, but is lower than the prevalence for London. The number of people living with HIV in Bromley has increased by 68% in the last five years, with the highest rates in the North West of the borough.

Of concern is the increase in the number of cases of whooping cough (Pertussis) in 2012. This is in line with the national trend. In Bromley, most cases have occurred in adults aged over 25 years.

Coverage rates for immunisation have been improving over the past four years, but remain lower than the World Health Organisation (WHO) recommendation of 95%. Rates of immunisation uptake of the preschool booster and 2nd MMR are especially low.

Smoking is a major risk factor for circulatory disease, cancer and respiratory disease. Smoking prevalence in Bromley is estimated to be 18.1% and prevalence has been rising since 2009.

A survey in Bromley last year found that a significant proportion of people asked had been offered and bought illicit tobacco products in the last year.

Obesity is a key risk factor for circulatory disease and cancer, and also for diabetes, which is a precursor to circulatory disease.

The modelled estimate for obesity prevalence in Bromley of 21.8% of those aged 16 years and overrepresents approximately 54,163 adults in Bromley.

Data collected for Bromley as part of the National Child Measurement Programme (NCMP) shows rising trends in the prevalence of overweight in children in Reception Year and Year 6 with a slight drop in the prevalence of obesity in the same age groups.

There is scope to increase levels of physical participation in Bromley.Current levels for adults are below the national average.

Cycle segmentation data suggests that certain areas within the borough have greater propensity to take up cycling. Households broadly within Bromley North, Shortlands, Copers Cope, Beckenham and around Crystal Palace have the greatest propensity and should be areas in which cycling promotion and activity should be targeted to generate the greatest return.

What this means for the JSNA

There is a need for continued action to address health inequalities with the disparity in life expectancy between the most and least deprived areas of the Borough.

Prevention, identification and good management of long term conditions (in particular obesity, diabetes, hypertension and HIV) continue to be a priority for Bromley.

Improving immunisation uptake remains a priority in the face of recent outbreaks of infectious diseases such as pertussis.

Smoking prevalence is rising and there is evidence of illicit tobacco trading.

The prevalence of obesity is still a matter for concern.

There is scope to increase levels of physical activity participation in Bromley.

4. Renewal Areas

Action on health inequalities requires action across all the social determinants of health. Although deprivation scores for Bromley are low overall, there is considerable variation across different areas in the borough, resulting in about 5% of Bromley's population living in the most deprived quintiles of the country.In order to improve deprivation scores, action is needed across all of the domains used in establishing the Index of Multiple Deprivation: income, employment, health deprivation and disability, education, skills and training, barriers to housing,living environment and crime.

In response to the London Plan Regeneration Areas Policy, six of the Bromley "Places" are being identified in the evolving Local Plan as five Renewal Areas: "Crystal Palace, Penge&Anerley", "Bromley Common", "The Cray Valley", (combining "Cray Valley, St Paul's Cray & St Mary Cray" with "Orpington, Goddington& Knoll", "Mottingham" (abutting Lewisham and Greenwich regeneration areas) and "Ravensbourne Plaistow &Sundridge" (abutting a Lewisham regeneration area).

5. Housing

The 2011 Census found that there were 130,862 households in Bromley and this figure is predicted to rise together with a reduction in average household size. Approximately 71% of dwellings are owner occupied; this figure is falling and there has been a growth in the private rental sector.

A Housing Condition Survey (2005) indicated that approximately 33% of private sector dwellings in the borough fail the Government's Decent Homes Standard.Vulnerable households are four times more likely to occupy non-decent dwellings if they live in certain wards within the borough.

The main cause in Bromley of homes not meeting the Decent Homes Standard is lack of thermal insulation.

Bromley continues to experience a significant increase (over 150%) in the number of households presenting faced with homelessness. This has resulted in a significant rise in the number of households having to be placed in temporary accommodation.

What this means for the JSNA

- Managing expectations of people who are not in priority need
- Increasing demand for housing
- Increasing numbers of repossessions
- Decreasing supply of affordable housing and temporary accommodation further exacerbates the gap between supply and demand

6. Children & Young People

Educational Attainment

Approximately 20% of the borough's school intake is from neighbouring boroughs (mainly Lewisham and Croydon).

Early Years Foundation Stage (EYFS) performance has been improving year on year since 2008, with 68% of Bromley pupils attaining the expected level of performance in 2012. In addition, the gap between the highest performing pupils and the lowest 20% at EYFS has been reducing (33% in 2010 and 29.2% in 2012).

Bromley's performance at Key Stage 1 is consistently at or 1-2 percentage points higher in all areas than performance nationally.However, the gap in performance at Key Stage 1 between pupils eligible for Free School Meals (FSM) and non-eligible is not narrowing. Pupils not eligible for FSM consistently perform better than those eligible.

Bromley's performance at Key Stage 2 is alsoconsistently above performance achieved nationally.At Key Stage 2, the gap in attainment in combined English and mathematics between those pupils eligible for Free School Meals and those who are not has decreased year on year, from a gap of 29% in 2008 to 22% in 2012.

Girls tend to out-perform boys in most subject areas across all key stages.

A higher percentage of pupils in Bromley schools made the expected amount of progress between the Key Stage 1 and Key Stage 2 assessments in 2012 than nationally.

At GCSE (Key Stage 4), Bromley pupils also achieve higher that the national average, with 68% of pupils gaining 5+ A*-C grades (including English and mathematics) in 2012, compared with 58% nationally.

At Key Stage 4, the Free School Meal/Non Free School Meal gap has fluctuated over the last 3 years when looking at attainment of 5+ A*-C grades, and 5+ A*-C grades including English and mathematics. In 2011 the gap was 21% for the former and 26% for the latter.

What this means for the JSNA

- Continue to develop and sustain relationships with schools which convert to Academies to achieve jointly agreed outcomes to improve the lives of children and young people in the Borough.

- The number of five year olds achieving the expected level for the Early Years Foundation Stage Profile is in line with that of national attainment and it is an area where performance is improving, however the rate of improvement is not at the same high level as the other key stages. A focus is therefore provided on improving attainment at the Foundation Stage as studies, such as the Marmot and Field Reviews, clearly identified the importance of intervention in the early years.

- The attainment gap at Key Stage 2 and Key Stage 4 is a particular area of focus for the LA and for the Department for Education. The priority is addressing the gap between those with FreeSchool Meals/ Non Free School Meals in particular, but there are also gaps in performance across the genders.

Young People in Secondary School

- Young people in Bromley are generally faring well. They have high levels of self-reported health and life satisfaction, they achieve well at school, and they are generally optimistic about their futures.
- These high levels, however, are unevenly spread - by age, sex and affluence. Girls, in particular, have significantly lower levels of reported health and life satisfaction, and higher perceived school pressure, than boys. Well-being and healthy behaviours decrease significantly with age.
- Interventions that have been found effective in improving well-being in young people include parenting programmes and whole school approaches to improving social behaviours and reducing bullying.
- While some interventions are in place in Bromley, implementation and knowledge about what is actually happening is, respectively, variable and incomplete.

What this means for the JSNA

- Whole school approaches are needed to improve well-being of both young people and staff, and through this to reduce exclusions, truancy and crime, improve behaviour at school, increase educational attainment, and reduce risky behaviours.
- Special attention should be given to supporting all parents, not just those whose children already have problems.

Children with Special Educational Needs (SEN) and Disabilities

During the past decade Bromley has experienced a significant increase in volumes of children with Special Educational Needs (SEN) and Disabilities.

In 2012 there were 9,205 pupils in Bromley schools with Special Educational Needs, an increase of 1,193 since 2008.

The number of pupils in Bromley with Statements of Special Educational Needshas also increased, from 1,585 in 2008 to 1,779 in 2012.

Pupils who have a significant degree of Special Educational Needs and Disability perform less well than their peers at all Key Stages and subjects.

In 2012, 30.8% of the 117 Statemented pupils in Bromley achieved the required level in reading at Key Stage 1 compared to 96.4% of pupils who have no SEN. This shows a decline on 2011 where 38.9% of 95 children with a Statement achieved the required level in reading compared to 95.9% of pupils who have no SEN. There is a similar pattern across all subjects.

The results are similar for subjects at Key Stage 2.

Performance at Key Stage 4 shows that 78.3% of pupils who have no special needs achieve the expected level of 5+ GCSEs A*-C including English and maths compared to 20.8% of the 68 pupils who have a full Statement. This shows an improvement on 2011 where 16.8% of 68 children with a Statement achieved the expected level of 5+ GCSEs A*-C including English and maths compared to 79.5% of pupils who have no SEN.

The number of referrals of children to the Specialist Support and Disability Panel has increased by 19% between 2010-11 and 2011-12 – an increase of 38 children to 240.

The Borough's Supporting Inclusion in Pre-School (SIPS) programme supported 8% more pre-school children with severe and complex needs within their local community pre-school setting.

In addition, 22 children with complex health needs, including some requiring airway support, Hickman lines, support for complex diabetes and gastrostomy tube feeding have been supported across 18 mainstream primary and secondary schools in the Borough without requiring a full Statement.

What this means for the JSNA

- Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life.
- The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities has required more specialist and high cost provision to be made available.

Children's Safeguarding and Social Care Referrals

Within Bromley, between 2007/08 and 2011/12 safeguarding referrals have increased by 85% (from 1,441 in 2007/8 to 2,679 in 2010/11), whilst initial contacts also increased by almost 300% (from 3,425 in 2007/8 to 10,132 in 2011/12).

What this means for the JSNA

- Initial contacts to, and Assessments by, Children's Social Care Services have significantly increased creating considerable pressures on the Council's staffing and budgets.
- There does appear to be a trend for decreasing numbers of Referrals to Children's Social Care Services.

Children in Care

The numbers of Children in Care in Bromley have increased by 18% (46) between 2007/08 and November 2011/12 to 301.

During the three year period from 2009 to 2012 the average time between a child entering care and moving in with its adoptive family within Bromley is 689 days. This shows a significant decrease compared with the average time between 2008 and 2011 which was 804 days. However, this average is longer than both the average for England (636 days) and the average of the Borough's 'statistical neighbours' (580 days).

Within Bromley, the percentage of young people aged 19 who were looked after at age 16 who were in education, employment or training has increased by 18% between 2010 (31%) and 2012 (49%). This is now above the national average of 36% in 2012.

The percentage of young people aged 19 who were looked after at age 16 who were in suitable accommodation has increased by 7% between 2010 (84%) and 2012 (91%). This is now above the national average of 88% in 2012.

Whilst being in the care of the Council it is acknowledged that it is important for children and young people to have stability in their placements. This means keeping movements between care placements to a minimum. Bromley has been above the England average for the percentage of children in care with three or more placements during the year since 2010.

What this means for the JSNA

- There has been a significant increase in the number of children in care over the last 5 years.
- The average time between a child entering care and moving in with its adoptive family within Bromley is below both the average for England and the average of the Borough's 'statistical neighbours'.
- The percentage of children in care who have more than 3 placement moves a year in Bromley is above that of national average.

7. Older People

Bromley has an ageing population – the largest in London with approximately 54,000 people aged 65+ years in Bromley at 2012. It is expected that this will increase to 57,000 (5%) by 2015 and will continue to increase to 74,100 (37%) by 2030.

There are currently over 4,100 people living in Bromley with dementia, and with the ageing population the incidence of dementia is set to rise by 4% (159 people) by 2015 and will continue to increase by 47% (1,945 people) by 2030.

The numbers of older people supported by Adult Social Care Services has decreased over the last four years. The largest decrease in services has been a 23% decrease in the number of people in nursing care from 320 in 2007/08 to 244 users in 2011/12. However, the number of people using Direct Payments over the last four years has increased by 94% from 103 in 2007/08 to 200 users in 2011/12.

For people with dementia, the introduction of more self-directed support and less reliance on residential care is leading to an increased demand for complex need care packages, increasing referrals to Oxleas Memory Service, a doubling of specialist dementia residential care since 2006/7 and the need to explore alternative models of accommodation and support to reduce need for residential and nursing care.

What this means for the JSNA

- An increasing number of older people are being supported within their own home which will have an increasing impact on community based services by all organisations that are required.
- The increase in older people who chose to manage their own support through direct payments are likely to change both the way in which services are provided and the types of services that are provided across the Borough.

- The increasing complexity of needs of the older people in residential care will impact on the services required to be provided by care homes, and the cost to the Council.

8. Learning Disability

The number of adults up to the age of 64 years with learning disability in Bromley is predicted to increase by 7.3% over the next 8 years.

Identification of adults with LD is significantly lower in Bromley than the England average. In addition, the proportion of adults known to GPs who have had a health check is already significantly lower in Bromley than the England average. This is important because people with learning disabilities have a higher prevalence of certain health problems and also have more difficulty than others in recognising health problems and getting treatment for them.

Bromley has significantly higher rates of emergency admissions for adults with learning disability than the England average.

The proportion of people with learning disability in Bromley living in non-settled accommodation is 24.08%, which is significantly higher than the England average and has been rising over the last two years.

What this means for the JSNA

There is a need to improve the identification of people with learning disabilities in primary care.

There is a considerable shortfall in the numbers of people identified with learning disability who have had an annual health check.

9. Physical Disability and Sensory Impairment

It is estimated that there are around 20,000 people of working age in Bromley who have a physical disability or sensory impairment, about 10% of the population aged 16-64. This figure is projected to increase to 21,750 by the year 2020.

10. Mental Health

The percentage of over 18s with depression is significantly higher in Bromley than the percentages for both England and London.

Overall, suicide rates for men in Bromley are about three times higher than for women.

In 2010, 69.2% of all people dying by suicide were men, of which the 65 years and over age group had the highest number of male deaths.

In 2010 there were 287 hospital admissions for deliberate self-harm (a significant increase from the 122 in 2001). 86% of these admissions were for self-poisoning.

The 15 -19 year old age group have the highest number of admissions following self-harm, numbers remain high and throughout life up to the age of 49 for women.

Within the next four years there will be an increase of nearly 300 people with dementia, with the greatest increase in the over 85 year age group. As well as suffering from dementia, this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.

Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16-25 years sooner than the general population.

The measure of overall emotional well-being in Bromley children and young people is lower than would be expected and changes to services locally have resulted in difficulty accessing Child and Adolescent Mental Health Services (CAMHs) by front-line services.

Local Special Educational Needs and Disabilities (SEND) data from schools shows higher rates than would be expected of children with learning disabilities and children on the autistic spectrum.

What this means for the JSNA

Implementation of the Mental Health Strategy and Clinical Commissioning Group Mental Health Programme are key tasks over the next few years.

11. End of Life Care

Between 2008 and 2010, the majority of deaths in Bromley occurred in hospital (56%).

There has been no change in the proportion of people dying at home between the 2005-09 and 2008-10 periods in Bromley. However, there has been an increase in the proportion of people dying in care homes between the two time periods.

Of the deaths that occurred in hospital in Bromley during 2010, 90% of these terminal hospital admissions were emergency admissions.

Considerable progress has been made in implementing the Gold standards Framework in Care Homes and improving End of Life Care services in General Practice.

What this means for the JSNA

Since there has been little change in the numbers of those dying at home in Bromley between 2005-09 and 2008-10, new approaches to increase the number of those able to die at home may need to be considered.

Given the increase in proportion of those dying in care homes in comparison to their own homes, closer examination of what is happening in care homes in Bromley to achieve this in comparison to people's own homes may be required.

An analysis of the source of terminal admissions to hospital may be useful in order to ascertain some of the factors that contribute to the high proportion of terminal hospital admissions that present as emergencies in Bromley.

12. Carers

Bromley has a similar percentage of carers (10%) compared to the England total (10.3%); however, the Borough has a significantly higher percentage than across London (8.4%).

A higher proportion of carers in Bromley provide a lower level of care of under 19 hours per week (6.9%) than both London (5.3%) and England (6.5%).

Fewer carers provide intensive care of more than 50 hours per week in Bromley (2%) than England (2.4%); however, the figure for Bromley is higher than that for London (1.8%).

The number of young carers identified and supported by Carers Bromley has increased significantly over the past few years; however, it should be noted that from national research it is expected that these are only a portion of the actual number of young carers within the Borough.

In September 2012, a total of 847 young carers were known to Carers Bromley compared to 539 in June 2009. This is an increase of 57%. This also reflects an increase of 22% between June 2011 [693] and September 2012, and an increase of 6% since February 2012 [802].

Young carers are less likely to be happy at school and more likely to be bullied than young people with no caring responsibilities. Furthermore, carers are more likely to experience poor health with people providing high levels of care twice as likely to be permanently sick or disabled.

Within the next three to four years the number of people needing care will outstrip the number of people able to provide that care.

As the number of carers increase this will also have an impact on businesses as most carers fall into the 45-64 age brackets at the peak of their careers.

During 2012 the London Borough of Bromley and the Bromley Clinical Commissioning Group published a revised Strategy for Carers for 2012/13. This will be reviewed and revised again during 2013.

What does this mean for our JSNA?

There continues to be insufficient local data/ joint identification of carers and young carers

Bromley has a similar percentage of carers compared to the England total; however, the Borough has a significantly higher percentage than across London

The 2011 Census indicates that a higher proportion of carers in Bromley provide a lower level of care of under 19 hours per week than both the London and England averages

It also indicates that fewer carers provide intensive care of more than 50 hours per week in Bromley than the England averages; however, this is higher than the London average

Although it is difficult to identify the actual number of young carers in the borough, the number of young carers known to Carers Bromley has increased 57% since June 2009

The Carers Strategy, including the Young Carers Strategy, is being refreshed during 2013

Carers assessments have a low take up and how they are presented to carers needs to be revisited in terms of the benefits

The carers survey undertaken during Winter 2012 will provide valuable information on the needs of identified carers

13. Substance Misuse

In Bromley the rate of adults estimated to currently be using an illicit drug is 5.4 per 1,000 population (or 1,106 people).

During 2010/11 there were 1,085 adults treated for drugs misuse in Bromley, of these the highest proportion was aged between 35 and 44 years.

In Bromley, 6% of the population in treatment present for cannabis misuse, nearly 10% for cocaine misuse and less than 1% for amphetamine and ecstasy use. Adults treated for opiates and crack make up the largest proportion of those in treatment (80%).

The emerging AACCE (Alcohol, Amphetamine, Cannabis, Cocaine, Ecstasy) substances are more popular with those aged between 16 and 24 years and there is little information about the long term effects or of patterns of misuse.

During 2010/11 there were a total of 274 people in Bromley who exited from drug treatment services. Three quarters of them were male and over 85% were white. Those aged between 25 and 44 years made up two thirds of treatment exits. Nearly half of those that exited treatment (45%) planned to do so. One quarter were referred on, and another quarter dropped out. Under 5% had unplanned exits from treatment.

What this means for the JSNA

The patterns of substance misuse in Bromley are not high.

The available data looks mainly at those receiving treatment for substance misuse related to opiates and crack. The emerging AACCE substances are more popular with those aged between 16 and 24 years and there is little information about the long term effects or of patterns of misuse.

Prevention work on substance misuse should be done early and in conjunction with other risk taking behaviours such as smoking and alcohol consumption.

14. Alcohol

Overall, data published in 2012 shows that Bromley is significantly better than the average for England for many alcohol-specific and alcohol-attributable indicators. These include binge drinking, alcohol-specific and alcohol-attributable hospital admission (in both males and females), and alcohol-specific mortality. However, indicators relating to alcohol and crime were significantly worse in Bromley, compared to the England average.

Rates for alcohol-attributable hospital admissions in both males and females have been increasing year on year between 2006/07 and 2010/11 in Bromley.

What this means for the JSNA

More preventive work is needed to reduce the levels of alcohol-related crime in Bromley.

An increased understanding of the impact of alcohol on domestic violence is needed.

The levels of alcohol-related hospital attendance and admissions to reduce pressure on secondary care services.

More work is needed to raise awareness of the risks of alcohol misuse in Bromley, particularly in young people.

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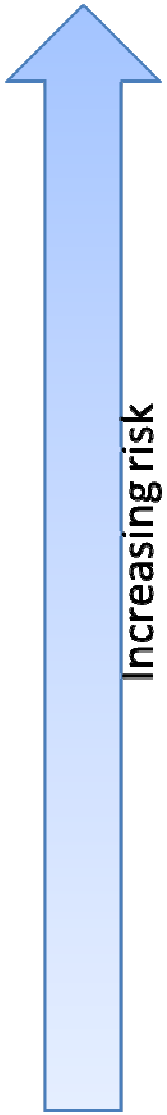
Programme Overview



	Care plan	Frequency of review	Access to rapid response?	Active case management ?	Pro-active screening?	Project areas
Highest Risk	Yes- likely that this will be a range of End of Life Coordination Services or Community Matrons	As required	Yes	Yes	Falls, dementia, medicines management, EoL screening at each appointment/ assessment	End of Life Coordination, Care Planning, Virtual Ward, Integrated Teams, Improved Discharge
High Risk	Yes- this will include coordination from the integrated care teams, initially assessed by the ProMISE CMs	Monthly- Six weekly	Yes	Yes	Falls, dementia, medicines management, EoL screening at each appointment/ assessment	Case Management : ProMISE, Care Planning, Integrated Team, Improved Discharge, Falls and Fracture, Flo
Medium Risk	Yes- likely to be managed by primary and community care	Quarterly	Yes- unlikely to need	No	Falls, dementia, medicines management at each appointment/ assessment	Self Care, Care Planning, Integrated Teams, Falls & Fracture, Flo
Low Risk	Low risk patients will be encouraged to undertake self care led care planning and some may benefit from a care plan	Annually	Yes- unlikely to need	No	Falls, dementia, medicines management at each appointment	Expert Patient, Self Care, Care Planning, Falls and Fracture Prevention

Case Management Update

Project Timetable	FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	I	I	I	I	I	I	I	R				

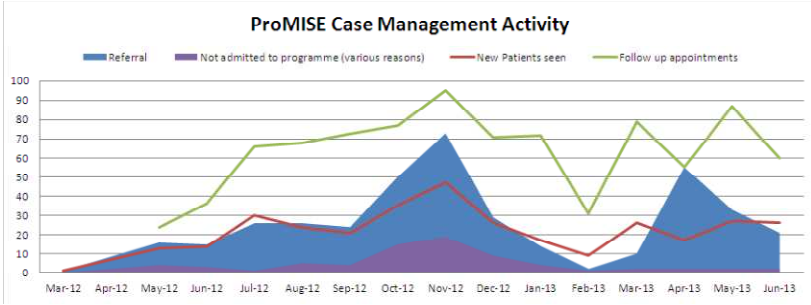
I- Implementation, R- Review

Confidence Matrix		
Rating Type	**RAG**	**Comments**
Quality of Planning		On track
Likelihood of delivery		Phasing and savings may slip due to low referral rates
Budget status		Minimal spend to date, other than PMO costs
Capability status		Capacity issues may impact

Phases	GP Surgeries
Phase 1	Ballater Surgery, Chislehurst, Knoll Medical Practice, Links- Mottingham, Links- Downham, Southborough Lane, Stock Hill, Whitehouse Surgery
Phase 2	Green Street Green, Dysart, Derry Downs, Bank House, Cornerways, Bromley Common, Southview Lodge
Phase 3, Tranche 1	Woodlands, London Lane, Cator, Elm House, Wickham Park
Phase 3, Tranche 2	Poverest, St Mary's Cray, Trinity, Chelsfield, Sundridge, Pickhurst

Key Milestones Achieved

- Phase 1, 2 and 3 Tranche 1 risk stratification patients ran and seen.
- 21: 46 of GP Practices within ProMISE
- Total of 395 patients seen (equivalent to 1227 contacts)
- Balanced scorecard developed and ratified
- Care Plan reconfigured and updated on to EMIS system for operational ease
- Memorandum of understanding, including data sharing agreed
- Phasing of handover to BHC of Phase 1 & 2 patients agreed with BHC
- Invested in Community Matron capacity within ProMISE and BHC
- DES agreed and implemented for incentivisation of Care Planning and risk profiling with emphasis on a multi-disciplinary approach
- 39:49 Practices have opted in to the Direct Enhanced System- equivalent to 295,206 of the total Bromley population. 3396 residents will be directly affected (1:1000 per month per surgery- not just >65yrs)



Risks

	Title	Description	Owner	RAG	Mitigation Actions Taken in Period
1	Stakeholder buy-in	GPs will need to recognise that they will be key to case management of patients & support & encourage their role within this.	KD		Comms and Engagement Plan to ensure steps for successful engagement. Presenting at Cluster meetings, information via news weaver and relationship management
2	Ownership of the case management aspect of the programme	Discord and disagreement relating to who case manages patients	PW		Ongoing discussion with various provider stakeholders to flesh out the operations of this.
3	Technologies and Information Systems	Each agency has a different information system, which do not communicate with one another	KD		New technologies will be required to ensure that systems are aligned/ communicate. Data sharing contracts will be mandated BHC to use EMIS Web
4	Information	BCCG unable to access patient level data for risk strat updates	SO		Meeting with NHSL for a work around regarding the contracts. Interim solution- GPs are to use their own clinical knowledge, supported by other info, e.g. housebound register, falls registers etc

Outlook for next period

- Pseudonymised data being monitored but issue relating to United Health and data sharing.
- Recruit GP/IT Lead
- Review of original assumptions of activity, e.g. condition type, complexity
- Full engagement and comms plans to be developed in partnership with Comms colleagues at LBB
- Commencement of assessments of Phase 3, tranche 2 patients by ProMISE Matrons
- Commencement of assessment of newly identified patients in Phases 1 & "
- Sending out MoU to all Ph1 & 2 practices, for further access to systems and agree new process

Integrated Care

Project Timetable	FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	D	I	I	I	I	R	I					

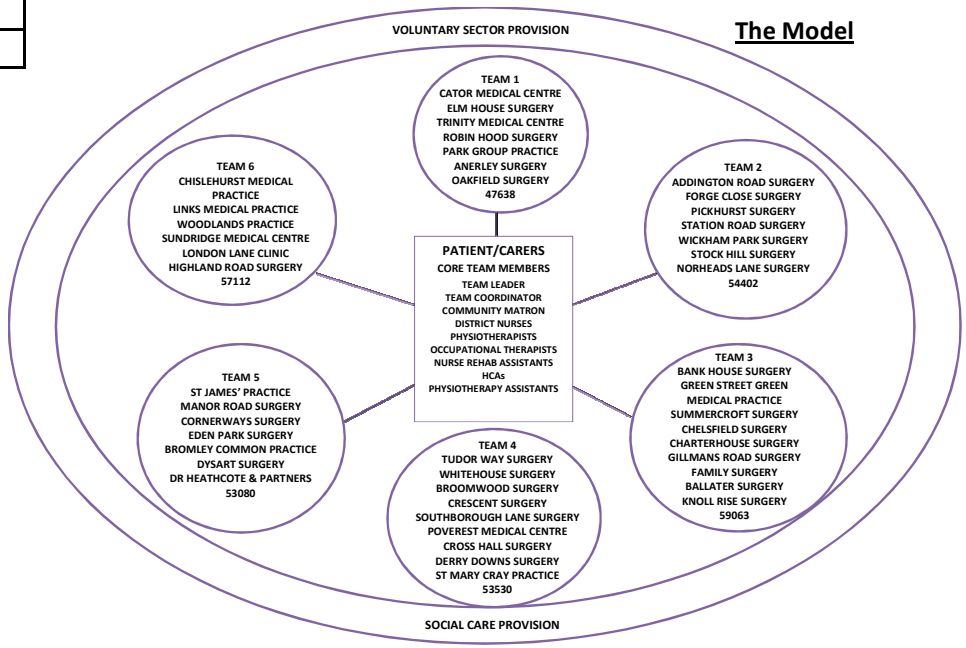
D- Design, I- Implementation, R- Review

Confidence Matrix		
Rating Type	**RAG**	**Comments**
Quality of Planning		On track
Likelihood of delivery		Steady progress being made. Internally the BHC team is aiming for roll out in November 2013
Budget status		The restructure of the current BHC resources is being carried out within existing budgets
Capability status		

Key Milestones Achieved

- Development and design of the model
- GP and stakeholder engagement for wider resource inclusion- LBB, Oxleas, Voluntary Sector
- Roll out of Pilot- included 4 practices from March 2013- July 2013
- Inclusion of LBB Social Worker as part of the pilot team
- Pilot Project Evaluation produced
- Community Health Team structures and GP groupings ratified
- Development of full implementation plan
- Staff consultations commenced for remodelling BHC workforce

The Model



Risks					
	Title	**Description**	**Owner**	**RAG**	**Mitigation Actions Taken in Period**
1	GP Engagement	Good positive buy in for the project from pilot GPs. Work still needs to be achieved around comms and attending appropriate meetings	AH		Integrated team have increased presence in the surgery, attending MDT practice meetings GP Cluster meeting attended
2	EMIS Web	Information sharing agreements to be agreed	RS		Ongoing dialogue with BCCG Developing dialogue with GPs and LMC Community Matrons being given access to EMIS Web EMI(S Steering Group commenced
3	Staff Consultation	Staff engagement and consultation key and needs to be carefully managed	RS		Staff engagement meeting scheduled and feedback has been positive
4	Suitability of estates	The current estates may not be fit for purpose to support integrated community team working	RS		Review of estates requirements and resource is underway.

Outlook for next period

- Further GP engagement
- Plans to include the rest of the Practices in Team One ahead of the November 2013 roll out
- Staff engagement to continue
- Staff consultation to commence early August 2013
- Evidence based and data analysis framework to be developed- shared data analyst now in post
- Outcomes Frameowrk development – to be reviewed by CAG
- Oxleas to propose a parallel integrated model for their CPNs to that of BHC
- Falls Prevention to go live
- Awaiting proposal from Bromley Links regarding the improved coordination of voluntary services to support a more integrated approach for individual patients.

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NHS
Bromley
Clinical Commissioning Group

Integrated Diabetes Service

Author: Usha Chappiti, Project Manager

Project Update for the Health & Well Being Board

18th July 2013

helping the people of Bromley live longer, healthier, happier lives

1. Background

Diabetes care is fragmented and quality of care and outcomes are poor across Bromley. To address these issues a new model of care was proposed and agreed across Bromley, Bexley and Greenwich (BBG) CCGs at the BBG Clinical Strategy Group in February 2013. The next step was for individual CCGs to further develop this for local implementation. The agreed model of care is an integrated specialist service which merges Tier 3 and 4 (hospital and community) into ONE Specialist team. This has been adapted from Portsmouth and Derby which have evidenced significant savings from reduced admissions and outpatient activity.

Evidence from these models has shown that we could achieve 40% reduction in outpatient activity and 50% reduction in emergency admissions year on year. This was achieved by clearly identifying categories of patients with Diabetes which the specialist service will manage. This is known as the Super Six: Insulin pumps, Adolescents/ uncontrolled Type 1, Inpatients, Antenatal care, complex foot care and Dialysis/ CKD>5. In order for us to achieve these new standards of service, new investment is required in primary care to up skill the workforce to manage a larger proportion of Type 1 and Type 2 diabetics. Locally we have set inspirational target of 90% reduction in acute out-patient activity when the model if fully implemented in year 3.

Additionally, it is planned that primary care professionals will have greater direct access to specialist advice and support for complex care which is intended to be more flexible and responsive to people's needs. This is a critical interdependency in order to ensure this model effective. GP practice staff will be offered a programme of training followed by supervision for initiation and ongoing management of patients requiring insulin as well as better management of uncomplicated foot care and renal. Patients will be able access the

right level of care in the most appropriate setting through the advice and support provided to GP Practices by diabetes specialists nurses and Consultants. The model of care is illustrated in Appendix A. The objectives and outcomes to be achieved are detailed in Appendix B.

2. Where are we now?

BCCG approved the new model of care for local implementation at the Clinical Executive in April 2013. Current services will be redesigned and developed over a six month period (April – September 2013) with our current provider, Bromley Healthcare against a challenging set of milestones. If there is insufficient evidence of achievement of the milestones, BCCG will move to its next step procure the service externally.

A joint project team has been established with Bromley Healthcare working in conjunction with the Kings Diabetes Service to develop a mobilisation plan and the requirement for resources and potential impact of acute savings. In addition, there is active engagement and support from the LMC with respect to support from GP practices. Patient engagement is being strengthened through working with Diabetes UK. Aspects of primary prevention are being consulted with the Public health team.

The CCG is working towards approval of the mobilisation plan by the end of August, so that implementation can commence.

For further information, please contact:

Usha Chappiti

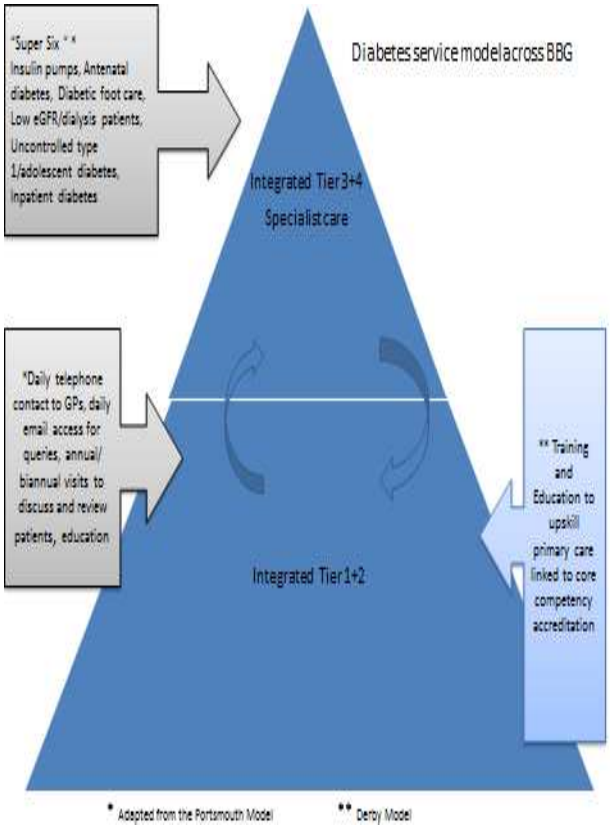
Project Manager

Bromley CCG

Mobile 07825699610.

Appendix A: The New Integrated Diabetes Model of Care

Specification of the diabetes integrated specialist service model[1] in Bromley

Now	Future : Proposed model	Future provision (fully operational)
Tier 1 – routine diabetes management. Delivery based on QOF **• Tier 2 – enhanced diabetes care.** Type 2 Diabetics requiring initiation of insulin and injectables. 15 GP practices delivering this level of service **• Tier 3 – BHC delivering specialist diabetes management** Type 1, adults 18+ and young people 16-18, gestational, Type 2 (insulin initiation), DESMOND and DAFNE (patient education), complex diabetes with neuropathy, Nephropathy, foot care, retinal screening, Primary care education **• Tier 4 – complex specialist care.** Inpatient and out-patient (predominately multiple co-morbidities and pathology, paediatrics, diabetic foot care, nephropathy	**Integrated Specialist Service Model - effectively merging tiers 1&2 and merging tiers 3&4.**  	**Fully Integrated 3 & 4 to form ONE Specialist Team** Reduce PBR activity – IP and OP (A&E admissions/ readmissions, follow ups) Highly specialised service Community service acts a gatekeeper to acute care Structured & accredited Education and Training – primary care staff DAFNE and DESMOND for patients Specialist Advisory service – email, telephone and visits for complex care delivered by DSN/ consultant Diabetolgists Paediatrics Super six – Uncontrolled Type I / Adolescent, antenatal, insulin pumps, complex foot care, Dialysis/ Renal CKD>5, inpatient Allocated DSN support 1wte/50,000 resident population **Integrated 1& 2** GP Practices Sole responsibility of diabetic care for at least 85% of Type 2 and shared care of 75% of Type 1 diabetics (stable) Primary care skilled to initiate, manage and monitor Type 2 diabetics who require insulin and injectables Access to specialist support through visits, telephone or email Delivering on NICE treatment outcomes as part of enhanced service

[1] Arora.A (2012). Draft Diabetes Service commissioning Strategy. Proposed solution and model.

Appendix B: Service Objectives

<table>
<tr>
<td>Primary Outcomes
Service benefits:
• Timely, responsive and seamless care across care settings delivered by an integrated care model
• More effective use of specialist services through clear identifies categories of patients which require complex care
• Upskilled primary care workforce with the confidence to provide greater level of routine care, supported by timely access to specialist advice and support when required
Patient benefits:
• Local access to a full range of services closer to patients home
• Responsive and timely service for patients with no delays in accessing care in emergency care when required.
• Access to specialist support if and when required
• Improved access to patient education

Financial benefits:
• QIPP savings achieved through reduced acute activity (inpatient and out-patient attendances) - £855K full year savings after year three.</td>
<td>SMART Objectives
Patient Safety:
• To reduce the number of emergency admissions with primary diagnoses of diabetes by 50% and secondary diagnosis by 10% using 2012-13 as a baseline
• To reduce outpatient appointments by 90% using 2012-13 as baseline
• To reduce non-emergency admissions with secondary diagnoses by 10% using 2013-14 as a baseline
• Reduce renal diabetic outpatient appointments by 70% using 2012-13 as baseline
Clinical Effectiveness:
• To increase the number of patients achieving the four treatment standards to 80% by the end of 14/15
• Achievement of clinical outcomes to NICE guidance – KPIs set within GP enhanced service
• To enhance primary care capability to manage people 85% of Type 2 diabetics and 25% of Type 1 diabetics with 100% achieving the required standard to initiate, manage and provide ongoing monitoring of patients requiring conversion to insulin and injectables.
Patient Satisfaction:
• To achieve a high level of patient satisfaction measured regularly via a patient survey which aligns to the National OPD and In-patient surveys</td>
</tr>
<tr>
<td colspan="2">Secondary Outcomes as a result of clinical effectiveness
Overall health gains
• Improvement in health benefits e.g. reduction in incidence of blindness, amputations and renal failure and overall life expectancy
Address health inequalities
• Improved access to services closer to patients home and delivered in a manner which targets the hard to reach will address inequalities to health
Effective prescribing of insulin and injectables
• Non analogue (long and intermediate acting) insulin as a % of all insulin (long and intermediate acting) for newly initiated patients *(TA053)
• Adherence to NICE guidelines for exenatide (CG087), prolonged release exenatide (TA248) and liraglutide (GLP-1) (TA203) and long acting insulin analogues insulin detemir and insulin glargine</td>
</tr>
</table>

Winterbourne View Programme - Local Stocktake

NOTE: Historically Bromley has never had an ATU service located within its boundaries. This fact means that many of the following questions relating to ATU's are answered from the perspective of us as a placing Authority/CCG. A private provider recently opened a service supporting young adult males with a diagnosis of an ASD, complex needs and challenging behaviour – CCG & LA Commissioners are monitoring the development of this service closely and liaising with CQC Inspectors on the quality of this provision.

1. Models of partnership	Assessment of current position and issues arising	Support required	Good practice example
Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	There is a joint group comprised of CCG & LA Commissioners with the CLDT Team Manager looking at the requirement of the winterbourne view programme and to ensure we deliver to targets.	No	
Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers &	The key partners working together are the Local Authority, the CCG, the provider Oxleas NHS Foundation Trust is also involved in the process. It would be our intention as commissioning organisations to work with our partners in housing to plan for those individuals who may want to return to the borough to find suitable accommodation and support. This will be commissioned through a joint strategic approach to this programme.	Yes support will be required from a project lead to develop accommodation requirement	
Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs	We are currently in the process of establishing this with our partner organisations and working closely with the CTLD in terms of establishing who is returning to the borough and who will not due to their personal needs, where it is not possible for someone to return due to the circumstances		
Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	This will be the case although at present there is a consultation on partnerships groups that will affect the outcome of this group.		
Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	Yes the H&WB is aware of this programme of work in relation to Winterbourne. It will be our intention to update and provide reports to this group to ensure objectivity an oversight from this external body to provide assurance to NHS England and to the board of the CCG that work is being undertaken in a robust way to meet the overall needs of the programme.		

Does the partnership have arrangements in place to resolve differences should they arise?	Yes these will be escalated within each organisation where this has been determined to be appropriate in moving specific issues forward to ensure that key decisions and development are not obstructed.		
Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships &Safeguarding Boards	Yes. Reports have been presented to our Safeguarding Board. The CCG Programme Groups for Adults & Children will have governance oversight from a CCG perspective with LA oversight from the Senior Mgt Team & elected Members.		
Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with these	We currently have no OR claims against the Borough. We do track and monitor any OOB placements made into this authority.		
Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	In the area of crisis services and what the model of this might be in terms of LD. Whilst there are examples of this in the mental health system in terms of crisis houses, CRT/HTT and such services. However how would this translate in terms of LD. In terms of those services who have a mild LD with an associated mental health diagnosis may be able to be seen by HTT/CRT if we widen the definition. The local CTLD is able to deal with this as there is a current MH/LD team which does deliver this service at present. There would be a need to establish how robust this is in terms of meeting this definition		
2. Understanding the money			
Are the costs of current services understood across the partnership.	Yes these costs are understood in terms of both the LA and the CCG. Any such placements are agreed at a joint funding panel.		
Is there clarity about source(s) of funds to meet current costs, including any funding from specialist commissioning bodies.	Yes		
Do you currently use S75 arrangements are the sufficient & robust	S75 arrangements are in place regarding the joint funding of the CLDT. We are currently in the process of a joint review and development of a joint commissioning function with the end outcome being a S75 agreement based on appropriate outcomes for the borough in terms of users and the commissioning organisations that will be involved in this work.		
Is there a pooled budget and / or clear arrangements to share financial risk	At this time there is no pooled budget; each organisation clearly accepts responsibility for the areas that it is		

	responsible for and ensures that financial risk is managed and mitigated as appropriate.		
Does it include potential costs of young people in transition and of children's services	As an SEN Pathfinder we are reviewing all arrangements regarding services to Children with the CCG. This includes both identification of need, business processes and financial management.		
Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	At this time no – but see responses above.		
3. Case management for individuals			
Do you have a joint, integrated community team	We currently have a partially integrated CLDT Team		
Is there clarity about the role and function of the local community team.	Yes		
Does it have capacity to deliver the review and re-provision programme	No – additional support may be required with those individuals who have complex needs and where the development of support options is much more complex		
Is there clarity about overall professional leadership of the review programme	Yes in terms of the commissioning functions of both the LA and the CCG. In terms of the CLDT and providers we are working with them in a collaborative way using our contracted arrangements for the delivery of the key aspects of this programme on clinical priority, clinical appropriateness, development of models of support, and working with housing and housing providers		
Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates	Yes – we also purchase advocacy services from the localities people are placed in to ensure their views are represented .		
4. Current Review Programme			
Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	There are currently 5 people who will be affected directly by the programme. Currently 3 of those individuals are having plans made for alternate accommodation options locally. However; in terms of any final agreements we have not as yet reached this position. Each family will have the support of care management and advocate where the family finds this valuable in enabling them to put across their views and wishes to any multi-disciplinary panel about future accommodation for a particular individual.		
Are arrangements for review of people funded through specialist commissioning clear	We do not have any people currently funded through specialist commissioning at this stage all funding is either		

	completely through the CCG or the LA.		
Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	These are already in place through the partnership board arrangements. In terms of the specifics of this piece of work a specific task group will be convened (see previous response) to ensure that we have covered the various outcomes associated with this programme in order that we meet the overall priorities of the group.		
Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed	Yes		
Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	Yes we have a lead commissioner in the CCG at present who is responsible for this. The CCG has entered into negotiations with the LA on the establishment of a joint commissioning function and this is at an early stage but it is hoped that this review and development will be completed as quickly as possible to ensure the best outcomes locally for LD Commissioning.		
Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	Yes there is a commissioned service locally and discreet pieces of work have also been commissioned for specific individuals.		
How do you know about the quality of the reviews and how good practice in this area is being developed.	Care managers within CLDT are being trained on the use of the HoNOS-LD assessment tool.		
Do completed reviews give a good understanding of behaviour support being offered in individual cases	Yes where this is done and a good level of understanding of this key areas		
Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed	Yes all reviews have been completed and we are satisfied with the quality of these reviews.		
5. Safeguarding:			
Where people are placed out of your area, are you engaged with the local safeguarding arrangements – e.g. in line with the ADASS protocol.	Yes. When a safeguarding alert is raised by another LA we are informed. The host LA takes the lead in line with ADASS protocols and we track & record progress through our own client recording systems. We also attend SG investigation meetings as appropriate and discuss recovery plans with providers as necessary.		
How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments	See linked Safeguarding Board newsletter for details on this area http://www.bromley.gov.uk/downloads/file/1532/bsab_newsletter_december_2012		

Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	The CQC carried out an inspection of the private service mentioned under Notes and informed us of their initial issues immediately.		
Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	Yes, a status report will be going to the Board.		
Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	Yes. DOLS Assessments are carried out by the locality in which a service is located.		
Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	We are unclear as to whether this relates to individual clients – then information sharing protocols are in place. If it relates to general service provision we have no in borough ATU facilities.		
Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	The ASB Unit monitor all vulnerable adults in the community. MAPPA track anyone at various levels who is seen as a risk in the Borough. Work has been previously done through the LD Partnership Board around safeguarding, advocacy and hate crime to raise awareness and knowledge.		
Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	Yes		
6. Commissioning arrangements			
Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings	The CCG & LA have carried out assessments and have a clear view in terms of those who will be able to be transferred to appropriate accommodation and support options locally.		
are these being jointly reviewed, developed and delivered.	Yes		
Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services	Yes		
Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	See previous comments re people currently placed in ATU's. All requests for any ATU placement are rigorously reviewed at a joint CCG/LA panel to ensure that all avenues are addressed.		
Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	This is not relevant in terms of the service users in A&T units as none of these are low secure.		

Have the potential costs and source(s) of funds of future commissioning arrangements been assessed	These are being developed.		
Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	Yes – within borough it is a contracted service with appropriate quality assurance & monitoring functions built in. Externally it is commissioned on a spot basis for individuals against a set of person centred outcomes.		
Is your local delivery plan in the process of being developed, resourced and agreed.	This is currently a work in progress		
Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	Yes		
If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	N/A		
7. Developing local teams and services			
Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Yes		
Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	Yes		
Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning	If there is a need to have BIA's involved this is something that we will ensure. The CLDT have trained BIA's and BIA for DOLS is conducted by the host Authority for OOB placements.		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies			
Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally	See comments below		
Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA)	We have in Borough responsive teams (MH & LD) operating in a specialist community based service, including nurse prescribers, to mitigate hospital admission.		
Do commissioning intentions include a workforce and skills assessment development	In development.		
9. Understanding the population who need/receive services			
Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges	Yes – through the JSNA.		

From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	Yes		
9. Children and adults – transition planning			
Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.	See previous comments re the role of the SEN Pathfinder. We are also a national Preparing for Adulthood Pathfinder site.		
10. Current and future market requirements and capacity			
Is an assessment of local market capacity in progress.	We are developing Market Position Statements in relation to our services as per the Care & Support Bill, this is also linked to the Local Offer development under the SEN Pathfinder.		
Does this include an updated gap analysis	Currently in development in light of changing market situations		
Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.	Not at this time.		

IW/TH

10/05/13

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