REFERENCE: H&WB/7/13

HEALTH AND WELLBEING BOARD

Date: WEDNESDAY 17TH JULY 2013

Time: 6.00 pm

Place: Committee Room 3, Town Hall, Luton

Members: **Councillor Simmons (Chair)**

Councillor Akbar
Councillor Ashraf
Councillor Campbell
Pam Garraway (Director of Housing & Community Living)
Linda Hennigan (Community Safety Executive)
Councillor M. Hussain
Nisar Mohammed (Healthwatch Luton)
Nina Pearson (Luton Clinical Commissioning Group)
Martin Pratt (Director of Children & Learning)
Gerry Taylor (Director of Public Health)
Sarah Whiteman (NHS Commissioning Board)

Quorum: **7 of the members listed above, in person.**

Emergency Evacuation Procedure – Room 3

Proceed straight ahead through two sets of double doors, follow the green emergency exit signs to the main town hall entrance and proceed to the assembly point at St. Georges Square.

INFORMATION FOR THE PUBLIC

This meeting is open to the public and you are welcome to attend.

AGENDA

Agenda Item	*Subject*	*Page No.*

1. **Apologies for Absence**

2. **Minutes from the last meeting on: 3rd June 2013**

3. **Introductions**

4. **Disclosable Pecuniary Interests**
Members to declare any disclosable pecuniary interests in any item to be considered at the meeting.

5. **Urgent Business**
To consider any urgent business and determine when, during the meeting, any items should be discussed.

6. **References from Other Committees etc. if any**

7. **Report of Healthwatch Luton**
1. **Healthwatch Luton Business Plan Outline**
(Presented by: Nisar Mohammed)

8. **Report of the Clinical Commissioning Group**
1. **Commissioning Intentions for 2014/15 (**Author: Carol Hill)
2. **Luton CCG Prospectus** (Author: Rod While)

9. **Presentation by Pauline Phillips from the Luton and Dunstable Hospital**
1. **The Future of the L&D**
(Author: Pauline Phillips)

10. **Presentation by Sarah Whiteman on NHS England**
1. **NHS England**
(Author: Sarah Whiteman)

11. **Reports of the Director of Public Health**
1. **Wellness Service – Business Case** (Author: Morag Stewart)
2. **On Street Sex Work Strategy** (Author: Nikki Middleton)

12. **Reports of the Director of Housing & Community Living**
1. **Section 256 Transfer from Health to Social Care**
(Author: Simon Pattison)
2. **Delivery of Winterbourne view Concordat and review commitments** (Author: Pam Garraway)
3. **Whole System Integration** (Author: Pam Garraway)

13. Work Programme

1. To review and update the work programme
(Author: Bren McGowan)

14. Exclusion of Public

To consider whether to pass a resolution to exclude the public from the meeting.

Contact Officer: Eunice Lewis **Direct Line: (01582) 547149**

AGENDA ITEM
2.1

MINUTES OF THE HEALTH AND WELL BEING BOARD

MONDAY 3RD JUNE 2013 AT 6.00 PM

PRESENT:

Cllr. Simmons	- Leader of the Council (Chair)
Cllr. Akbar	- Portfolio Holder – Children's Services
Cllr. Ashraf	- Portfolio Holder – Public Health
Cllr. Campbell	- Opposition Groups Representative
Pam Garraway	- Director of Housing and Community Living
Linda Hennigan	- Community Safety Executive
Cllr. Hussain	- Portfolio Holder - Adult Social Care (Vice- Chair)
Nisar Mohammed	- Project Manager, Healthwatch Luton
Dr Nina Pearson	- Chair, Luton Clinical Commissioning Group
Martin Pratt	- Director of Children and Learning
Gerry Taylor	- Director of Public Health
Dr Sarah Whiteman	- Medical Director, NHS England

Observer:

David Palmer	- Member of the public

In Attendance:

Penny Fletcher	- NHS Commissioning Support Unit
Noelette Hanley	- Chief Officer, Luton Irish Forum
Carol Hill	- Chief Officer, Luton CCG
Bren McGowan	- Partnership Manager
Bert Siong	- Democracy and Scrutiny Officer
Morag Stewart	- Deputy Director of Public Health
Heather Wicks	- Associate Director Clinical Strategy, NHS England

1.	**APOLOGIES FOR ABSENCE (REF: 1)**
	An apology for absence from the meeting was received on behalf of Cllr. Aslam Khan.
2.	**INTRODUCTIONS (REF: 2)**
	Following introductions, the Chair invited nominations from Elected Members to serve as Vice-Chair to the Board. Cllr. Hussain was the sole candidate nominated, seconded and duly elected Vice-Chair of the Health & Wellbeing Board for 2013-14. **Resolved:** That Cllr. Hussain be elected as Vice-Chair of the Health & Wellbeing Board for 2013-14.

3.	REFERENCES FROM OTHER COMMITTEES ETC. IF ANY (REF: 5)
	A reference from the Executive was received requesting the Board to consider and respond to the Scrutiny Health & Social Care Review Group's (HSCRG) recommendations relating to the Coroner and related services' procedures and practices. Gerry Taylor, the Director of Public Health advised she was willing to chair a working group of relevant partners to discuss the recommendations in-depth and co-ordinate a partnership response for consideration by the Board and feedback to HSCRG. This was agreed. Democratic Services was requested to arrange a meeting of relevant partners and write back to HSCRG to explain the situation, as the responses would be outside the 28 day response deadline. **Resolved:** (i) That the Director of Public Health be delegated the responsibility to lead a working group of relevant partners to discuss the HSCRG's recommendations and prepare a partnership response for consideration and approval by the Board prior to feedback to HSCRG. (ii) That Democratic Services be requested to make the necessary arrangements for relevant partners of the working group to meet for the purpose of (i) above; (iii) That Democratic Services be requested to write to HSCRG to explain the approach being taken, which will mean the responses would be outside the 28 day deadline.
4.	**HEALTHWATCH LUTON (REF: 6)**
	Noelette Hanley and Nisar Mohammed gave a presentation of the report (Ref: 6) on the progress achieved by the Luton Irish Forum in setting up Healthwatch Luton, as contracted to do by Luton Borough Council. The following key points were highlighted: • Initial set up completed, with 2 members of staff recruited, with another one to provide administration support about to be recruited; • Policies and procedure developed and a benchmarking exercise completed; • Volunteer strategy being developed in collaboration with the Council, after wide consultation, as volunteering was key to Healthwatch. Special focus on attracting under represented groups, e.g. minority groups, women and religious groups. ; • Board members being recruited – 14 applications received; • Healthwatch Champions would be appointed and trained to undertake specialist roles, working at ground levels to create current and live data. There would be fewer meetings to reduce the bureaucracy of the former LINk, with the Champions making representations and providing feedback; • Different levels of training would be provided for the various categories of volunteers; • A panel was looking how to build on the former LINk's performance on 'Enter and View' as an area for improvement; • A Healthwatch Forum was being developed to enable those who could not be actively involved in Healthwatch activities to receive information and share their views;

- Stakeholder engagement and marketing strategy being developed, making use of modern social media and Healthwatch branding;
- Although the first 3 months since April mainly taken to set up Healthwatch, some engagement activities ongoing, including, e.g., L & D Hospital re-development, dealing with NHS Quality Accounts and LBC's Partnership Board and Wellness Project Board;
- A 2 year business plan being developed, covering 4 key areas: to enhance representative stakeholder engagement, increase two way flow of information, provide effective representation on the Health & Wellbeing Board through Nisar Mohammed, the Healthwatch Project Manager and to develop service standards and delivery;
- The Healthwatch Luton launch date was on 12th July 2013 for which invitations had been sent out. The event would promote the organisation, introduce its Board members, present its proposed objectives and obtain stakeholder views on areas to focus on;
- Monitoring and evaluation of performance would be through quarterly reports, annual review and external audit of finances.

Responding to questions, the following further information was provided:

- Schools Governors canvassed to be Board Members. Several had expressed interest and applied;
- All former LINk volunteers were given the opportunity to become Healthwatch members and were still involved. The intention was that volunteers would represent their community, a particular service or community organisation in town. This would take time to develop;
- Learning had been taken from Healthwatch in other areas, which had been in shadow form for a year. Healthwatch Luton also providing learning to other areas not yet developed;
- In respect of marginalised groups, e.g., children, older people, those with mental health, Healthwatch was committed to engage and have direct dialogues at grass root levels. Work was underway to see how to get information to them and get them involved;
- The Healthwatch draft business plan would be presented at the launch event on 12th July 2013 to get people's views. When finalised, would be presented to the Health & Wellbeing Board;
- Children Services consulted about engagement with the various children's groups and were helping;
- Engagement work was ongoing on the ground, but the launch event would be the official starting shot for the business plan;
- Merchandising, e.g., T-shirts with logos, used to give a young and fresh image to maximise interest;
- Monitoring/ evaluation reports would go to LBC's contract team, but reports on research/ work on the ground would go to the affected organisations. Information would be shared with overview and scrutiny, Healthwatch England and the Care Quality Commission. Quarterly reports would also be presented to the Health & Wellbeing Board;
- In relation to consultation with GP surgeries, selected local practices would be targeted for patients' surveys pre and post appointments to gauge, e.g., ease of access and satisfaction. The intention was to train specific volunteers for

	this role, to gather live data; • Healthwatch would be happy to work and share information with Luton CCG and the NHS England Local Area Team. **Resolved:** (i) That the presentation on the progress achieved by the Luton Irish Forum in setting up Healthwatch Luton be noted; (ii) That Healthwatch Luton be requested to present its business plan to the Health & Wellbeing Board's meeting in July 2013; (iii) That Healthwatch Luton be requested to present its regular quarterly reports to the appropriate Health & Wellbeing Board meeting for review. Details to be included in the annual work programme.
5.	**"RESPONDING TO FRANCIS" - PATIENTS FIRST AND FOREMOST LUTON CCG PLANS (REF: 7.1)**
	Carol Hill gave a presentation on her report (Ref: 7.1), outlining Luton CCG's response to the Francis report. She said as the report was quite lengthy, she would focus on how Luton CCG was responding to the key messages, highlighting key points as follows: • There was a role of commissioners to help a change of culture, which was particularly important to do, as nuances of the problems identified by Francis probably existed with every provider whose performance monitoring was inward looking and opaque; • Commissioners needed to work with providers to ensure way of working was transparent, which Luton CCG was doing. A good example was the current Discharge from Hospital scrutiny review, where partners were open about areas for development; • Luton developing its own Quality & Safety Team, as currently shared with Beds CCG; • There was a change of focus post Francis, although Luton was more proactive and had good record on patients' engagement and listening and triangulating patients' experience information; • Luton CCG had a cost improvement plan, addressing impact of taking money out of the budget; • Luton CCG had good stakeholder engagement, working with Healthwatch, overview and scrutiny, Neighbourhood Governance and Area Boards, to try and understand patients' perspectives; • Luton CCG also working with voluntary organisations to enhance activity and representativeness of Patients and Public Groups; • Luton CCG developing 'community ownership', encouraging communities to work with the CCG to re-design health services to meet their needs and empowering them to take responsibility for their own health and wellbeing; • The CCG taking opportunity to develop processes to better engage with practices, to encourage and facilitate them to raise issues/ concerns earlier than used to, so as to enable them to be addressed; • The CCG to share information with Healthwatch and overview and scrutiny, in case they might be working on similar concerns; • Also looking at complaints to ensure prompt review and action to address

trends;

- The CCG had developed a Patient and Public map showing how information was triangulated;
- Staff training and development focused on getting culture right, balancing learning against sanctions, when things went wrong;
- Series of meetings/ networks developed to improve engagement with providers, e.g. Exec to Exec meetings and Healthier Luton Partnership;
- Luton CCG embedding quality and safety at all levels of commissioning plan;
- Structure also in place to ensure delivery of its operational plan, with detailed considerations at lower Executive committee level, and overseen by the CCG Board at the top.

Carol Hill advised the CCG response was work-in-progress and what was presented was a flavour of where the CCG was working towards.

Responding to questions, further information was provided as follows:

- There was a need for organisational culture to provide role modelling. The Exec to Exec meetings with all providers discussed issues around culture in their organisations and whether failures were related to dereliction of duty by individuals, who should be held to account or systems failure, which needed to be addressed. People should be encouraged to share information or concerns without fear for their jobs;
- There was a different approach pre 'Francis', but now focus was on building relationships and appropriate role modelling, with patients and public, providing work/ life balance, responding to different cultures.

Dr Sarah Whiteman, as representative of NHS England and a GP, said quality affected all, not just hospitals. She offered to do a presentation to the Board at a future meeting on the work of NHS England, which was accepted.

Linda Hennigan asked how it would be known if the CCG was achieving its goals, what was wrong and what was being done about it.

Carol Hill said there would be an all levels detailed report to the CCG Board which met in public, so that concerns could be aired and addressed openly. She added the papers would also be presented to the Health & Wellbeing Board, so that high level issues could be discussed.

Dr Nina Pearson said there would be a quarterly report to the Health & Wellbeing Board.

Pam Garraway commented it was known what was happening in Mid Staffs but no one took notice. She added it was a strength Healthwatch would look at complaints across the system and develop working relationship with scrutiny, which would examine and triangulate evidence and identify fundamental problems, so that nothing was missed.

Dr Pearson commented there was a need for an early warning system.

Cllr Simmons said the quarterly report to the Health & Wellbeing Board was a good idea.

	Carol Hill said the CCG would triangulate soft intelligence and hard data to identify concerns which needed a more in-depth look. She added all partners would be relied on to raise issues. Pam Garraway commented in Adult Social Care standard expected of staff was formalised in a 'whistle-blowing' policy. She added there was a need for all providers to make use of whistle-blowing as part of the way to obtain information on concerns. **Resolved:** That Carol Hill's presentation (Ref: 7.1) and comments and views expressed by members be noted.
6.	**SECTION 256 TRANSFER FROM HEALTH TO SOCIAL CARE (REF: 8.1)**
	Pam Garraway presented the report (Ref: 8.1) requesting the Board to agree proposals for the transfer of funds from NHS England to support adult social care through a Section 256 agreement and to delegate the final decision on the use of the funding to her, as Director of Housing, Community Living and Adult Social Care, in consultation with Luton CCG and NHS England. She said just over £2.8 million was allocated to Luton and since March 2013 work was underway on how the funds would be used. She advised £1.9 million was already committed in the system, and that they were looking at areas where the remaining £1.9 million would be used to enhance services. Dr Whiteman said NHS England had seen and were happy with the plan, but had not yet got the money to transfer and hence why not signed off yet. She agreed with Pam Garraway there was no formal mechanism for the transfer of the funds. In response to Cllr Simmons, Dr Whiteman said NHS England agreed in principle with the proposed plan. As other authorities believed in the same position, Pam Garraway suggested the Board write to the Local Government Association for advice. Dr Whiteman concurred other local authorities were in the same position. Martin Pratt suggested the Chair should write to the Secretary of State. **Resolved:** (i) That the Board agrees with the proposed plan for the transfer of funds from NHS England to support adult social care through a S. 256 agreement; (ii) That the Board delegates the final decision on the use of the funding when received to the Director of Housing & Community Living in collaboration with Luton CCG and NHS England and after consultation with the Chair; (iii) That Pam Garraway consults with the Chair to write a letter to the Secretary of State for Health to ascertain the mechanism for the transfer of funds from NHS England to Luton Borough Council.
7.	**REABLEMENT JOINT PLAN (REF: 8.2)**
	Carol Hill presented the report (Ref: 8.2) requesting the Board to agree future plans for re-ablement be included in Luton CCG's Long Term Conditions and Urgent

	Care work-streams. She said the CCG supported the re-ablement plan as outlined in the report. She added the Department of Health allocated £504,000 for re-ablement in Luton for 2013/14. The funding was not ring-fenced and would continue to be invested in the same areas as the previous year. **Resolved:** That the inclusion of the plans for re-ablement in Luton CCG's Long Term Conditions and Urgent Care work-streams and the proposal to continue investment of funding as outlined in the report be agreed.
8.	**INTEGRATED CARE PIONEERS (REF: 8.3)**
	Pam Garraway presented the report (Ref: 8.3) requesting the Board to support the submission of an expression of interest for Luton to be included in the national Integrated Care Pioneer programme. She advised work was about to take place to develop a plan to build on work already carried out for Luton to become a pioneer. She added there was good evidence of local joint working and making efficiencies, which should help Luton get on the short list. **Resolved:** That the proposal for Luton to submit an expression of interest to be included in the national Integrated Care Pioneer programme be supported by the Board.
9.	**WELFARE REFORM – STRATEGIC ISSUES (REF: 8.4)**

Pam Garraway gave a presentation on the current and anticipated impact of welfare reform in Luton, seeking members' views on any actions required.

She presented key points as follows:

Time Table For Implementation:

By July 2013:

- **New Bedroom (Under occupancy) Rules –** Restriction on Housing Benefit entitlement for tenants whose accommodation was larger than allowed under the new rules. People in receipt of pension credit would not be affected;
- **Council Tax –** National Council Tax benefits scheme replaced by localised Council Tax Support Schemes;
- **Personal Independence Payment (PIP)** - Disability Living Allowance, to be replaced by Personal Independence Payments for new claimants;
- **Benefit Cap Pilot** – introduction of a maximum weekly total benefit entitlement of £350 for individuals and £500 for families. Would go national by September 2013.

By October 2013:

- **Universal Credit -** Benefit payments for working age people (16-64) to be paid monthly in one lump sum. People would be moved over to the new system between 2013 and 2018;
- **Direct payments -** As part of Universal Credit, Housing Benefit to be paid

directly to claimants, who would be responsible to pay their rent;

- **Personal Independence Payments (PIP) -** Between October 2013 and March 2016 people in receipt of Disability Living Allowance would be moved over to PIP;
- **Pension Credit –** Couples would only qualify when the younger partner reached retirement age, not the elder.

Impact of Changes:

Ongoing analysis of the 'Bedroom Tax', Council Tax Scheme, Council Tax Support Scheme, PIPs, and Crisis Support Scheme to gauge which households would be affected and the impact on individual households and on Luton, as follows:

Bedroom Tax
Local Authority/RSL Tenants:

1136 households affected, with greatest impact as follows:

- Lewsey – 170 households
- Northwell – 132 households
- Leagrave – 114 households
- Farley -113 households

Work on under-occupancy to move people to smaller accommodations ongoing, but it was unlikely there would be enough houses to move them to.

Benefit Cap

368 households affected as of May 2013, of which 297 were receiving Housing Benefits. The greatest impact would be on larger families. Over 50% were on income support and 68% having their Housing Benefits paid direct to landlords. Benefit cap would apply from mid-July for Housing Benefits recipients only.

The Benefit Cap level meant households in Luton would be worse off per week as follows:

- £200+ - 2 households
- £100 - £200 - 54 households
- £50 - £100 - 77 households
- Up to £50 - 164 household

The breakdown between social and private rented households affected as follows:

- Social rented - 166 households (71 Council Tenants)
- Private rented - 131 households

Universal Credit

There were 15,900 Housing Benefit claimants receiving direct payment in Luton, with the highest number in Farley and South. Issues facing claimants were as follows:

- Money management – 1 monthly payment;
- No direct payments to landlords;
- Sanctions applied to whole benefit;
- Digital by default.

The biggest issue was how to communicate the changes to claimants.

Personal Independence Scheme

Comprehensive data was not yet available, but using those known to the Council via housing or council tax benefit claims, 536 people, excluding children were affected. Believed many more would be impacted on. If Disability Living Allowance was withdrawn, those affected would also lose associated benefits, such Blue Badge, Disability Premiums.

Local Support Scheme

From April 2013, there had been 432 applications for support, with 172 awards (40%) made. £25,362 was spent as follows:

- Noah Goods 50%
- Food bank 44%
- Cash 4%
- Tesco Vouchers 2%

29% was spent on crisis and 71% on Community Care element.

Discretionary Housing Payments

Increase in demand in April 2013 compared with April 2012 shown below:

	Apr-2012	**Apr-2013**
Claims Made	105	197
Total Successful	78	124
Total Refused	27	73
Total Spend	£25,683	£43,258
Annual Spend	£152,000	£519,096 est
Annual Claims	813	2364 est
Staff Dealing with claims	3	4

The estimated spend for 2013 did not take into account a possible £250,000 needed if Discretionary Housing Payments were awarded to all those being capped. This could take spend to around £769,000, with only a £570,000 contribution from the Department for Work and Pension.

Impact on Luton

A study by Sheffield Hallam University found the cumulative impact of all benefit changes would be about £19 billion taken out of the economy nationally and £60 million in Luton. Although most affected households would be in those areas already disadvantaged, all wards would have some households affected in some way by the Welfare Reform Programme, with the potential for major disruption, e.g., due to loss of income and effect on education, therefore increasing inequality in Luton.

Linda Hennigan queried how data would support family/ offender management, given the likelihood of increased domestic violence.

Pam Garraway said data and addresses were available on which households were affected.

Martin Pratt commented the data needed to be overlaid with those available through the work of his department.

Cllr Simmons said the affected households needed to be written to.

Pam Garraway said there was an issue with data accuracy, as there was a variance between Luton's and the Department for Work and Pensions data.

Linda Hennigan queried if it was possible not to give money directly to people with alcohol and/ or drug dependency.

Pam Garraway said direct payment was in terms of Universal Credit due in later in the year.

Martin Pratt commented it was a function of the policy and no decisions could be made locally.

Having got information on implications, Gerry Taylor suggested it was now for partners to decide how to tackle the impact on their services.

Noelette Hanley queried if there was a crisis fund for service users and if LBC was writing to families to provide advice.

Cllr Simons said if people were homeless they would be a priority. She clarified families would be provided advice.

Pam Garraway said money was tight and there was a lack of information from the Department for Work and Pensions, leaving services to gather evidence how to do things differently to deal with the impact.

Dr Pearson commented the CCG understood there would be an impact on the wider public. She said there was a need to galvanise the goodwill of volunteers to help once it was know what needed to be done.

Pam Garraway commented some people would not have enough money to live on in Luton.

Cllrs Simmons said Luton was cheaper than elsewhere, although the bedroom tax would cost people £50 a week.

Martin Pratt said there would be an increase in demand for all services, resulting, e.g., from break up of families, the impact on both mental and physical health, an increase in offending, tension in families leading to domestic violence. He added the systemic impact would necessitate a re-think of the Joint Strategic Needs Assessment, given the disproportionate impact of the reform on Luton.

Pam Garraway said LBC needed to work with all affected households to see

how to help, not just the two households most affected.

Responding to a query, Pam Garraway said direct payments would also apply to those in privately rented property. LBC provided for homeless, but downsizing to cheaper accommodation was not possible due to lack of availability in Luton. She advised not all the changes were coming at the same time, and warned there could be another implication, if council house tenants could not pay their rents.

Pam Garraway added it was not known how many households would lose tax credits, which needed another big piece of work to find out.

Cllr. Simmons requested that the matter be brought back to the Board, once further work had been done.

Cllr. Akbar commented there was need to provide information how the issues would be tackled collectively.

Cllr Simmons agreed to cover the short-term and long-term.

Resolved: (i) That Pam Garraway's presentation and comments and views expressed by members be noted.

(ii) That further work be undertaken on the impact of the welfare reform on services and information be provided to the Board on how partners would collectively address the issues arising.

10.	**PUBLIC HEALTH GRANT GROWTH PROPOSALS (REF: 9.1)**

Gerry Taylor presented her report (Ref: 9.1) seeking the Board's support for proposals relating to the use of the Public Health grants for 2013/14 and 2014/15.

She reminded the Board Public Health was now the statutory responsibility of LBC, with ring-fenced grants for the next 2 years. She said the funding represented growth over the baseline, which needed to be allocated to public health services.

She advised that it had been agreed that the growth funding would be allocated in line with Health and Wellbeing Strategy priorities and the three delivery groups had developed programmes to commission to deliver the Strategy's objectives. The report also proposed one off funding for programmes related to the wider determinants of health.

She sought the Board's support for the proposals, which she said needed to be approved by the Executive by the beginning of July 2013. She said there was an amendment to one of the proposals, in that the focus of the work on street sex work was to be extended to the whole Borough, instead of just the High Town ward.

Answering questions, further information was provided as follows:

- Drugs and alcohol services as part of the street sex initiative would be delivered in all women's environment where appropriate;
- Several agencies were involved delivering the domestic abuse services. Co-ordination and integration needed across affected victims, as not always clear which service was the right one;
- The Positive Parenting and Drugs and Alcohol programmes were a priority;
- The Street sex initiative involved multi-agency work;

	• Funding had been identified in the Public Health budget to support work to reduce Infant Mortality; Martin Pratt suggested the Children's Trust Board could expand its existing programme to focus on Early Intervention to deliver public health outcomes, as part the 'Healthy Start' priority. **Resolved:** That the recommendations contained in the Director of Public Health's report (Ref: 9.1) relating to how Public Health grants should be spent be supported and commended to the Executive.
11.	**HEALTH & WELLBEING STRATEGY PERFORMANCE FRAMEWORK - UPDATE ON PROGRESS (REF: 9.2)**
	Morag Stewart presented her report (Ref: 9.2) to update the Board on the progress made in developing a performance framework to support the Health and Wellbeing Strategy. She said a robust structure was required to monitor the key outcomes of the strategy and the high level indicators set out n the report. She added the report outlined the progress achieved by the Children's Trust, the Health Inequalities and the Healthier and More Independent Adults and Older People delivery boards to monitor the priority outcomes: • Every Child has a Healthy Start in Life; • Reduced Health Inequalities within Luton; • Healthier and More Independent Adults. She advised developments were at different stages, with baseline data and improvement targets for the next five years set out in the various tables and charts in the main body of the report and the appendix. In terms of next steps, she said each board needed to agree their final list of indicators and targets after removing any duplications and set improvement targets to 2017. A system of scorecards would be used to monitor and evaluate progress and provide feedback to the public. She added the final performance framework would be brought back to the Health & Wellbeing Board in October 2013. Dr Pearson commented the target for reducing premature circulatory disease mortality by 20 percentage points appeared to be over ambitious. Morag Stewart agreed it is ambitious and is based on a previous national target to reduce inequalities in circulatory disease, but this would be regularly reviewed and could be re-set if needed. **Resolved:** (i) That the report the Deputy Director of Public Health (Ref: 9.2) outlining the progress achieved in developing the Health & Wellbeing Strategy Performance Framework be noted; (ii) That the Deputy Director of Public Health be requested to present the finalised Health & Wellbeing Strategy Performance Framework to the Board's meeting on 29th October 2013.

12	REVIEW AND UPDATE THE WORK PROGRAMME (REF: 10)
	Bren McGowan advised the following items were proposed for the Health & Wellbeing Board's work programme: • On street Sex Work Strategy - Gerry Taylor • Luton CCG – Commissioning Intentions for 2014/15 – Dr Nina Pearson • NHS England Presentation – Dr Sarah Whiteman • Healthwatch Luton Business Plan - Nisar Mohammed He said other items would be included in the work programme as requested by the Board and circulated for members' information. Gerry Taylor proposed the Board should receive a quarterly report from overview and scrutiny so that any concerns could be raised. It was accepted a request be made to the Scrutiny: Health & Social Care Review Group for a regular quarterly report on issues of concerns. Cllr. Hussain proposed the Board also received a report on the outcomes of any health and social care Task & Finish group's reviews, including the current ones on Discharge from Hospital and Infant Mortality. It was accepted a request be made for a report on the outcomes of the current reviews. Carol Hill proposed to present Luton CCG's Prospectus to the Board in July, following launching the draft in June, when stakeholders' views would be obtained. Dr Whiteman said Board meetings should be scheduled for 2 hours, which Cllr Simmons said had been the usual duration for the shadow Board. **Resolved:** That the Health & Wellbeing Board's work programme be updated as discussed and circulated to members for information to ensure sufficient notice to prepare and submit reports within the scheduled deadlines.
	Notes: The meeting ended at 8:15 p.m.

HEALTH AND WELLBEING BOARD	AGENDA ITEM: **7.1**

DATE OF MEETING: **17th JULY 2013**

REPORT AUTHOR & CONTACT NUMBER: **Mr Nisar Mohammed 01582 817060**

SUBJECT: Healthwatch Luton Business Plan Outline

WARD(S) AFFECTED: ALL

1. PURPOSE

To review and consider issues arising from the Healthwatch Business Plan

2. RECOMMENDATION(S)

The Health and Wellbeing Board is recommended to note the information presented

3. BACKGROUND

Local Healthwatch was created by the Health and Social Care Act 2012. Created on 1 April 2013, Healthwatch Luton is the independent consumer champion for health and social care and is in place in order to gather and represent the views of the public, Healthwatch Luton brings together people's views and experiences in order to improve health and social care services in Luton. Healthwatch Luton enables people to access advice and information about local services and understand choices available to them.

4. REPORT

1. The Service

The Healthwatch Luton service will be provided to any person including children and young people, who either:

- Receives health or care services in the Borough of Luton (whether resident in the area or not); or
- Lives in the Borough of Luton but receives health and care services in another local authority area[1]

[1] Luton Borough Council, Healthwatch Luton – Service Specification, 24.12.2012

2. Mission Statement

Healthwatch Luton is the independent local consumer champion bringing together people's views and experiences to improve health and social care. It will provide effective information, advice and signposting for people to support their choices about health and social care services. It will be:

- *Accessible, inclusive and representative of all*
- *Well known, professionally managed and organised*
- *Built on existing knowledge and expertise, using partnerships and collaborations to provide high quality functions and services*
- *Independent and for the benefit of the whole community*
- *Influential respected and trusted by local people, decision-makers and service providers*

3. Objectives

There are three key components of the service to be provided:

1. gathering people's views (influencing function).
2. representing community views in order to influence decisions (influencing function).
3. enabling people to access advice and information about local services and understand choices available to them (signposting function).

4. Structure

- **Healthwatch Champions**: trained volunteers conducting research and gathering views within the local community
- **Enter and View Action Group**: trained volunteers carrying out visits to health and social care services
- **Community Forum**: exchange of information within the community between service users and service providers/commissioners
- **Information, Advice and Signposting**: create a single point of access for the local community to share their concerns, experiences and receive information, advice and signposting to appropriate services

- **Healthwatch Board**: oversee, contribute and support all activities and functions

5. Communication

Our message the Healthwatch Luton service will be advertised and promoted throughout all areas of Luton. Our message will be consistent in all our communication, engagement, marketing and advertising:

We have information that will help people make choices
We are independent and community facing
We are inclusive and work in partnership
We listen to people's opinion and experiences
We train and support local people to shape services
We can make a difference
We are powerful

Launch event our launch event will take place in July 2013. This event will be advertised in local newspapers, community centres and general practices. Information about our launch will be circulated to all registered volunteers, key third sector organisations, all groups and contacts established during Luton LINk, service providers and commissioners, Healthwatch England and NHS England.

Media we will seek opportunities to publish articles on a regular basis. We will do this by engaging directly with staff and newspaper editor's in order to develop and ensure a mechanism is in place for coverage of our campaigns and achievements. The launch event will be used as a gateway for dialogue and the development of a positive working relationship with the local press. We will also contact local radio stations to promote awareness and take part in radio shows.

Website we will work with Healthwatch England and develop an interactive website.

Social media we will establish informative and up-to-date accounts on facebook and twitter.

Advertising we will design and purchase promotional merchandise (including banners, leaflets, posters) advertise in newspapers, local radio and carry out targeted advertisement throughout the year including community events such as the Luton Carnival and 'Your Say Your Way' community events.

Our leaflets and posters will be made available for display in all general practices, pharmacies, dentists, community centres, third sector organisations, care homes, hospital wards and departments, mental health services, youth clubs, college and university campuses, shops and businesses, places of worship, wider and specialist health services and within local authority departments, such as social services, public health.

Newsletter we will produce a bi-monthly newsletter which will be made available to all members and the wider community, including the third sector and staff/contacts. Our newsletter will include information on our activities and outcomes, progress to

date, information from our volunteers, local news, events and opportunities to get involved and provide information to Healthwatch Luton.

Membership Hub we will create an active, open and inclusive information hub which will provide regular information to all our members and partners (individuals and groups). All of the information circulated will be sent out by Healthwatch Luton via the preferred method of communication as stated by our members (email, post etc). The Membership Hub will include:

the latest news about health and social care services in Luton
information on what is going on within the local community (events, workshops, training opportunities)
opportunities to participate in specific pieces of work both internally and externally

6. Signposting Function

Healthwatch Luton will provide a single point of access service that will:

- Listen to worries and concerns about health and social care services and provide appropriate signposting;
- Provide information to promote choice and signpost people to health and social care services;
- Ensure that information is made available when required in alternative and appropriate formats.

Healthwatch Luton will use the NHS Choices website to provide accurate information to the local community. Information will also be drawn from Luton's Clinical Commissioning Group (LCCG) and Luton Borough Council's (LBC) Directory of Services. Healthwatch Luton will signpost individuals to Pohwer who offer independent NHS Complaints Advocacy. Individuals will also be provided with information about NHS Patient Advice Liaison Services, local complaints departments (LCCG, LBC) and national regulators/bodies such as the Care Quality Commission, General Medical, Nursing, Pharmaceutical and Dental Council's.

Healthwatch Luton will also carry out a comprehensive mapping exercise in order to identify and document the services available from health and social care providers (LBC, NHS Community Services and South Essex Partnership Trust: SEPT).

Healthwatch Luton will research and identify the services provided by the third sector in Luton. We will research and record information about all of the active services provided in these areas and this information will also be included in our signposting service.

The information we will record includes:

- Organisation type
- Service(s) provided
- Contact details
- Access type (referrals only, walk in etc)
- Access times

- Eligibility and costs

All calls, enquiries and information requests will be logged and reviewed. This data will include the recommendations, actions and outcomes from each enquiry we receive.

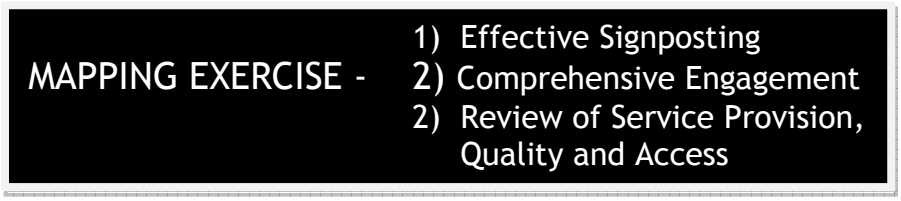
7. Engagement

Influencing Function the Healthwatch Luton influencing function entails the following:

- To promote, support and enable local people to be involved in and monitor local health and social care services;
- To gather local people's views about their needs and experiences of local health and social care services;
- Promote access to the service in a range of settings and to all people and communities in Luton ensuring representation across the local population and communities.

Healthwatch Luton will actively advertise, recruit, offer information and seek the views of the local population, including but not restricted to young people, older people, Black and Minority Ethnic, disabled people, lesbian, gay, bisexual and transgender, people with learning disabilities, carers, mothers and expecting mothers, faith groups, patient groups, people with HIV/AIDS, mental health service users, people in education, people who access drug and alcohol services, people with long term conditions, people that access third sector organisations, vulnerable women, travellers, homeless, refugees and people who access social, primary, secondary and tertiary care.

We will do this by conducting a mapping exercise. This research will provide us with information on the services, forums, patient/service user groups and organisations currently active in the local area.



We will use this information for (a) our signposting service, (b) refer to this information when assessing the provision of services and support available to the local population and (c) to make contact with key organisations, providing information about Healthwatch Luton to these organisations. Leaflets and posters will also be circulated along with an offer to join the Healthwatch Luton membership. Healthwatch Luton will seek and identify opportunities to meet with service users and groups in order to conduct direct engagement and further increase our activity in seeking people's views, encouraging local people from all sections of our community

to get involved in the work of Healthwatch Luton and to promote the availability of our information and signposting service.

We will use existing information from Luton Borough Council and Luton's Clinical Commissioning Group/Commissioning Support Unit directory of services to further develop a comprehensive and accurate database.

Commissioners and Providers we will develop a joint working and information sharing protocol with:

- Luton Borough Council including the Public Health Department
- Overview and Scrutiny Committee
- Luton Clinical Commissioning Group (including NHS Central Eastern Commissioning Support Unit)
- NHS England
- Cambridge Community Services NHS Trust
- South Essex Partnership NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Bedfordshire Clinical Commissioning Group

Each protocol will be designed with a view of ensuring that:

1) we have a named individual as our central point of contact
2) we have a clear process for submitting our reports and recommendations
3) the provider/commissioner has clear information about their role and responsibilities for responding to our reports and recommendations
4) we have an agreement on the most appropriate way for making requests for information and for receiving this information within the specified time[2]
5) we have a clear process for arranging announced enter and view visits
6) we meet the named individual on a regular basis to review the protocol and ongoing activity
7) we agree an effective method for raising awareness and understanding of the work of Healthwatch Luton with all staff within the respective organisation
8) we identify and agree effective methods for partnership working; the following list is an example of areas of partnership working which we will aim to explore further with the relevant commissioners/providers:

    - Luton Borough Council's Neighbourhood Governance Framework
    - Luton Borough Council's Partnership Boards
    - Luton Clinical Commissioning Group's Strategic Implementation Groups
    - Luton and Dunstable Hospital's Patient Experience Group
    - South Essex Partnership Trust's Service User Involvement Group
    - Cambridge Community Services Patient Experience Committee
    - East of England Ambulance Trust's User Group

[2] Section 44(3)(a) The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012

Our involvement and activities will be reviewed on a regular basis and the above is not an exhaustive list.

Priority areas Healthwatch Luton has been set up to gather the views of local people and use these views to influence the design and delivery of services. Our work plan items and activities will be responsive and according to the issues and trends we identify through engagement in the local community.

We will also have priority areas which will underpin our core activities. These target areas will be central to the work of our Healthwatch Champions. Six Priority areas have been identified following a review of the 2012-2017 Health and Wellbeing Strategy, the 2011 Joint Strategic Needs Assessment and consultation with all of our registered members, our steering group and our recently appointed board.

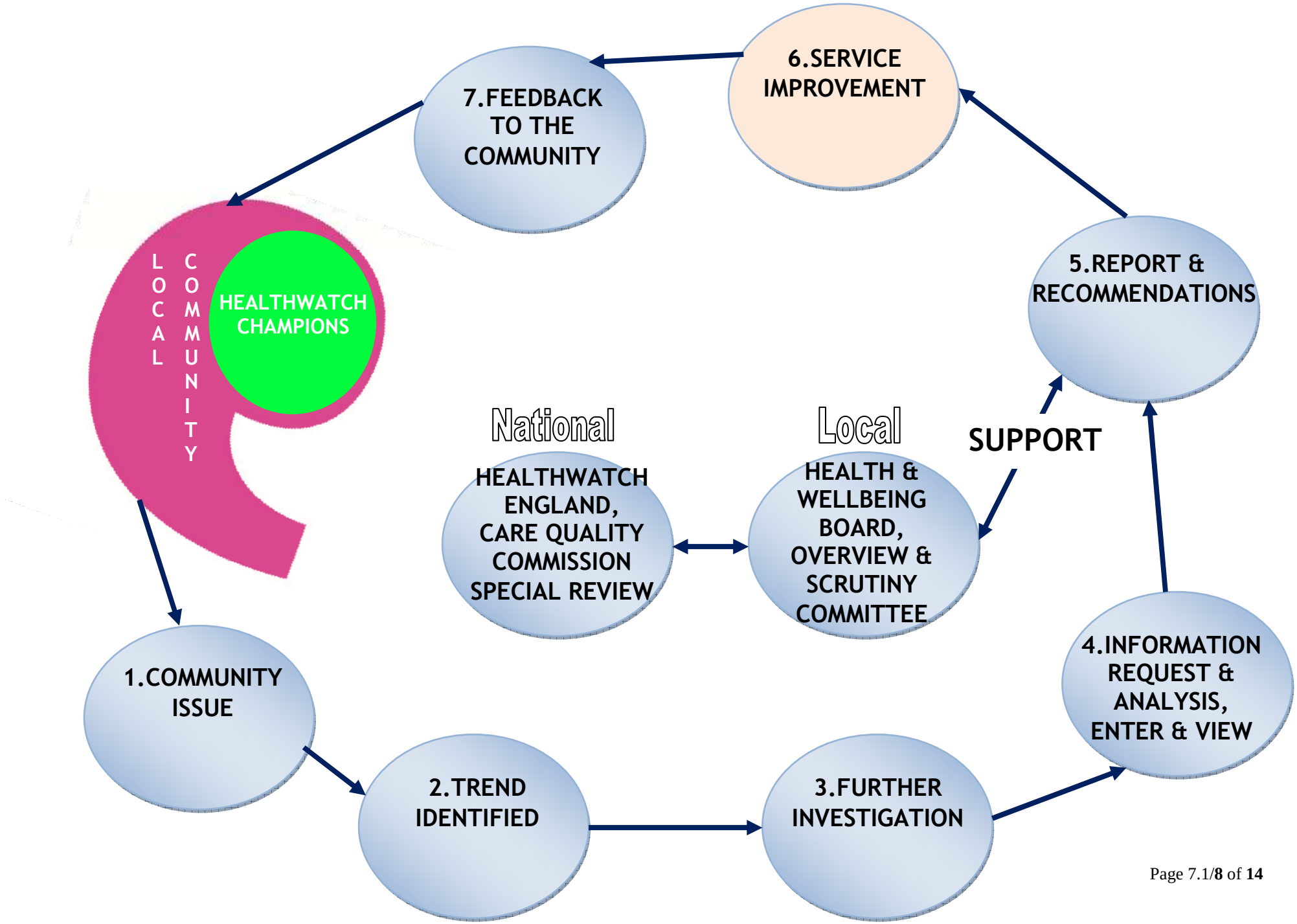
Our work plan priority areas are:

1) Accessibility and quality of health and social care services for children and young people
2) Service accessibility and quality for disabled people
3) Patient experience and satisfaction at the Luton and Dunstable Hospital
4) Care and assistance for the elderly and resident experience and satisfaction in care homes
5) General Practice accessibility and patient experience
6) Care pathways and service quality within mental health services

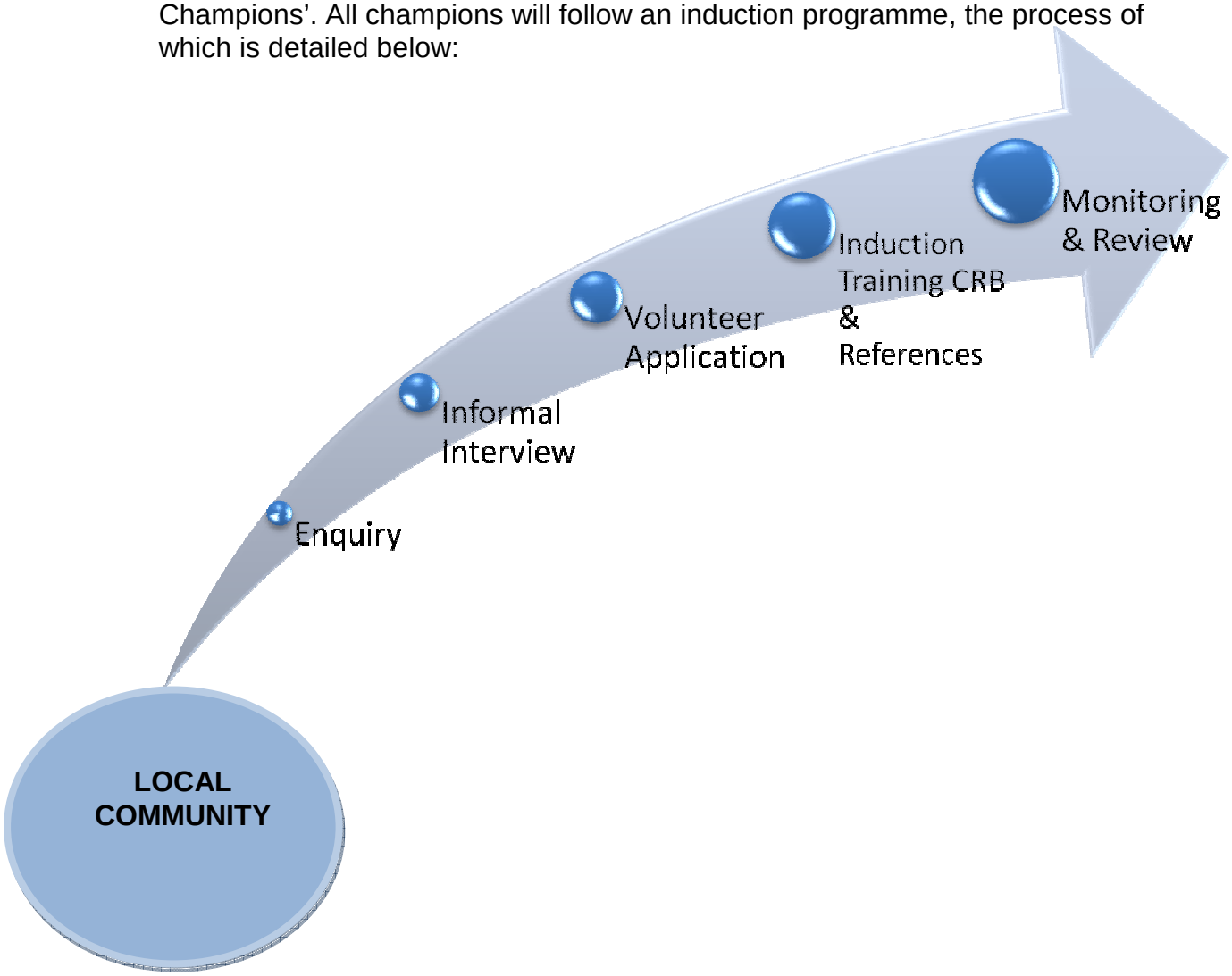
The six priority areas will be central to the work of targeted engagement, research and will also underpin the activity of our Enter and View Action Group.

The Healthwatch Luton launch event will be used as a platform to consult all stakeholders and the local community on our work plan priorities. We will also use the launch event as an opportunity to identify additional work plan areas for consideration.

Healthwatch Luton Engagement Cycle



Volunteers Healthwatch Luton is a voluntary organisation. All members, including the Chairperson and Board members, are volunteers from the local community. Continuing with the ethos, values and principles of Luton LINk; we will be constantly promoting the opportunity for local people and organisations to actively participate in the work of Healthwatch Luton, in order to influence and shape services. Our active volunteers will be known as 'Healthwatch Luton Champions'. All champions will follow an induction programme, the process of which is detailed below:



A core responsibility for all Healthwatch Luton Champions is to gather and record people's views and experiences of services. This information and evidence will be used to effectively represent the local community and shape health and social care according to local need.

Our volunteers will participate (with the support of staff) in targeted research across areas within health and social care. The research topics will be identified in accordance with the views and experiences of local people. This will enable the effective identification of trends and gaps in service provision. Research

areas will also be identified in accordance with the skills/knowledge and area(s) of interest of our volunteers.

Information Points Healthwatch Luton will establish regular information points in order to effectively gather people's views from across the community and recruit volunteers from all backgrounds. We will organise and publicise our information points as widely as possible, ensuring that we hold information points across all 19 wards within Luton. We will organise regular community information points at the following:

- Community centres
- Luton Sixth Form
- Schools and Barnfield College
- The Mall
- Libraries
- University of Bedfordshire
- General Practices
- Ward Forums/Area Committee
- Luncheon Clubs
- Places of worship (Churches, Mosques, Gurdwaras etc)

Healthwatch Luton is also committed to attending as many events in the local community as possible, including events within the third sector and stakeholder events organised by the local authority/statutory organisations.

Reporting following training, all Healthwatch Champions will use a variety of tools and techniques to gather information and report this information back to staff. Reporting tools will be made available to ensure data and intelligence is recorded in a consistent manner and used for comparative assessments. Information and activities will be publicised in our newsletter, on our website and via social media (when appropriate). We will also create an online forum for our Champions to upload and share information and discuss topics. The information collected by our volunteers will be used to identify trends and gaps in services. This activity will then be progressed further and in accordance with the steps detailed in our operating model.

Our Healthwatch Champions will be invited to attend events; creating an opportunity for all of our volunteers to come together to share good practice, review activities and carry out forward planning.

Training all active volunteers will be required to attend the following training modules:

- Induction to Healthwatch Luton
- Community Engagement
- Equality and Diversity

- Safeguarding of Children and Vulnerable Adults
- Physical and Learning Disability Awareness
- Dementia Awareness

Volunteers involved in specific work will undertake a training needs assessment and additional training will be provided to assist volunteers in their roles, as and when appropriate.

Community Forum the Healthwatch Luton Community Forum will convene every two months and will be advertised and held in a public setting. The Forum will be established in order to hold themed meetings/workshops for the purpose of:

- Finding out from providers/commissioners how a particular service has been designed and is being delivered
- Finding out what local people/service users are experiencing when accessing a particular service

Executive Board the Healthwatch Luton Board is made up of 9 people from the local community. All Board members are required to participate in at least one Forum session and accept at least one board Champion role. All board members will be required to participate in at least one regional/national meeting or event per year.

Once in position, the Healthwatch Luton Board will be responsible for ratifying the Healthwatch Luton delivery plan, including the organisation's operating model and structure along with company policies and procedures.

The following policies have been compiled for the Healthwatch Board's consideration and ratification:

- Child protection policy
- Code of conduct
- Confidentiality
- Data protection policy
- Data sharing policy
- Decision making policy
- Disability discrimination policy
- Disciplinary rules and procedures
- Disclosure and barring check policy
- Enter and view policy
- Equal opportunities policy
- Evacuation of Disabled people in the event of fire
- Expenses policy for volunteers
- Finance guidance

- Health and safety policy
- Individual grievance policy
- Information and advice policy
- Information sharing policy
- Issue and escalation process
- Joint and partnership working policy
- Lone worker policy
- Protection of vulnerable adults policy
- Record retention and destruction of records policy
- Risk register
- Volunteering policy
- Whistle blowing policy

Information Repository Healthwatch Luton will actively seek the experiences of people who have used services, including the views of family members/carer's. This information will be logged (anonymously if requested), categorised and forwarded to the service provider and commissioner of the service (with the individuals consent). Healthwatch Luton will then seek a response from the relevant provider. Healthwatch Luton will request that improvements to the provision of the service/lessons learnt are considered and acted upon. This work will be done in partnership with the service user/individual and this activity will be logged by Healthwatch Luton in order to effectively monitor the implementation of changes to services and the impact that this change has on the quality of service and patient experience.

Healthwatch Luton will add information held locally to the Healthwatch England Repository and will assist Healthwatch England in identifying a national picture of the state of health and social care services across England.

Enter and View the process of establishing authorised Healthwatch Luton representatives[3] for the purpose of carrying out 'Enter and View' visits on health and social care services will be developed through a comprehensive recruitment and training programme.

The enter and view action group will establish its initial work plan items according to the six Healthwatch Luton priority areas. Provisions will be in place to prioritise services/areas that have not already been identified if it can be evidenced that they are in need of urgent review. This information will be drawn from engagement in the community and evidence and trends identified from the Healthwatch Champions.

Partnership Healthwatch Luton recognises the importance of working in partnership with the community and voluntary sector and neighbouring Local Healthwatch services. We will invite neighbouring Local Healthwatch services to

[3] Section 225 (5) Local Government and Public Involvement in Health Act 2007

our launch event and will request meetings to agree processes and procedures for effective joint working and information sharing at the earliest possible opportunity.

We will contact all relevant Third Sector organisations with an invitation for organisations to sign up as members. We will request an opportunity for Healthwatch Luton to hold workshops/focus group meetings with service users and staff to increase awareness of Healthwatch Luton and to use this platform to gather people's views, promote our volunteering opportunities and increase awareness of our information, advice and signposting services.

Regional and National activity we will ensure that we receive and share information with the Care Quality Commission, Healthwatch England, NHS England, Local Government Association and Public Health England. This information will also include information about events, conferences and training opportunities. We will also ensure that we are registered and involved in regional networks such as the NHS England Eastern Region Quality Surveillance Group and the Healthwatch England Eastern Regional Network.

We will ensure we establish the appropriate mechanism in order for us to make recommendations to the Healthwatch England Committee, which may include advising the Care Quality Commission about special reviews or investigations to conduct.

Health and Wellbeing Board we will ensure the data we collect, the trends we identify and the recommendations we put forward to improve the quality of health and social care services is represented at the Health and Wellbeing Board. The Health and Wellbeing Board will be used to receive and share information, we will also ensure we have representation and influence on the Children and Young People's Trust Board, Health Inequalities Delivery Board and Healthier and More Independent Adults Board

Joint Strategic Needs Assessment we will ensure the data we collect, the trends we identify and the recommendations we put forward to improve the quality of health and social care services is captured within the Joint Strategic Needs Assessment annual refresh.

8. Contract Management: Luton Irish Forum is contracted to oversee the delivery of the Healthwatch Luton service. This includes the control and management of the budget and the employment of staff.

9. Monitor, Evaluation and Review

Our delivery plan is subject to approval by the Healthwatch Luton Board, who will oversee and monitor the effectiveness and success of the Healthwatch Luton service. Once agreed by the Board, our delivery plan will be subject to approval

by Luton Borough Council's contract monitoring team. Luton Borough Council contract monitoring team will also agree a set of measures which will be used to monitor the effectiveness and impact of Healthwatch Luton and this process of monitoring will take place on a regular basis.

This delivery plan will be reviewed between February – March 2014 and the review will include consultation and requests for feedback from all of our members, stakeholders and partners.

IMPLICATIONS

5. Not applicable

6. Not applicable

CONSULTATIONS

7. Not applicable

APPENDICES

8. None

9. LIST OF BACKGROUND PAPERS

Luton Borough Council, Healthwatch Luton – Service Specification, 24.12.2012

Section 44(3)(a) The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012

Section 225 (5) Local Government and Public Involvement in Health Act 2007

Report last updated on 04 July 2013

HEALTH AND WELLBEING BOARD	AGENDA ITEM: 8.1

DATE OF MEETING: **17th JULY 2013**

REPORT AUTHOR & CONTACT NUMBER: **Rod While 01582 532043**

SUBJECT: **Process for Developing Luton Clinical Commissioning Group's Commissioning Intentions for 2014/15**

WARD(S) AFFECTED: ALL

PURPOSE

1. To share the process for development of LCCG's 2014/15 Commissioning Intentions

RECOMMENDATION(S)

2. The Board is requested to note this report and consider what additional inputs it would like into the development of the CCG's Commissioning Intentions

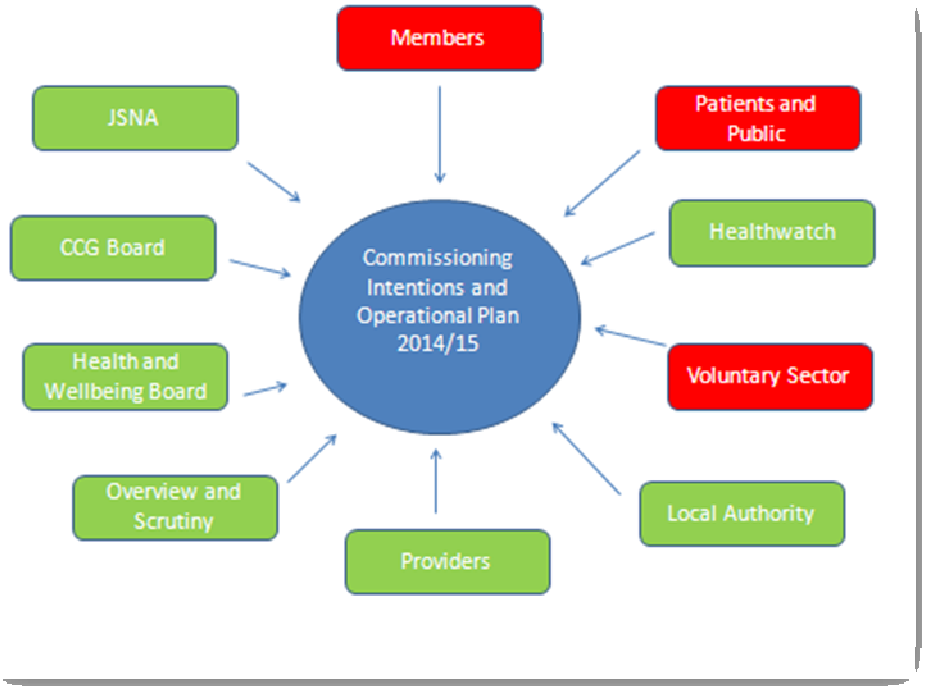
BACKGROUND

3. The CCG is beginning the process of formulating commissioning intentions for 2014/15 so that they can be shared with providers and potential providers before the end of September, just prior to commencing the contract negotiation process for 2014/15.

4. Commissioning Intentions for 2013/14 were developed later than would be ideal and due to the CCG authorisation process the CCG was not able to devote sufficient time to stakeholder engagement, particularly with practices and the general public. The CCG is committed to developing a robust set of Commissioning Intentions which incorporates and is shaped by key stakeholders and represents an opportunity to build on recent successes around practice engagement and the CCG launch event.
.

REPORT

5. The diagram below summarises the local inputs to Commissioning Intentions and Operational Plan. Those in red are where the CCG needs to improve dialogue to gain meaningful recommendations to shape the operational plan for 2014/15.



9. Timetable

Activity	Objective	CCG Clinical Lead	CCG Management Lead	Timeframe
Stakeholder Event - CCG Launch	Input into CCG Commissioning Intentions	NP	Comms	June 17th
Review JSNA Core Dataset	Recommendations from Public Health for CCG Commissioning Intentions	NP	RW	By July 5th
CCG Board	Review of current plan. Gain Board inputs into CIs	NP	RW	July 30th
Local Citizens Survey	Determine key issues for local communities	NP	RW	June to August
CCG Public Survey – Web Site	Determine key issues for local communities	NP	RW / PF	June to August
Practice Engagement	Practice proposals for Commissioning Intentions	NR	RW	June to August
SIG Meetings	SIG proposals for Commissioning	Clinical Directors	RW	June to August

Activity	Objective	CCG Clinical Lead	CCG Management Lead	Timeframe
	Intentions			
Provider Meetings	Gain provider perspectives on Commissioning Intentions	NP	RW	June to August
Members Forum	Members sign off of Commissioning Intentions	NP	RW	September 19th
Patient Reference Group	PRG Proposals	SC	Comms	Meetings on July 9th September 3rd
HealthWatch	Health Watch Inputs to Commissioning Intentions	NP	RW	July 12th (launch meeting) July - August
Health and Wellbeing Board	Input and Sign Off of Commissioning Intentions and Operating Plan	NP	CH	July 17th September January March
Prioritisation process	Prioritise CIs for investment in 14/15	NP	RW	September to November CCC sign off - November
Draft Commissioning Intentions Published	Commissioning Intentions sent to providers	NP	RW	September 20th
Operating Plan Development	Develop first draft of written plan	NP	RW	October to March
Scrutiny Committee	Task and Finish Recommendations. Review of Plans	NP	RW	T&F Hospital Discharge – August T&F Infant Mortality – November Review of Commissioning Intentions and Operating Plan October to January

IMPLICATIONS

10. Health

11.

CONSULTATIONS

12. Consultation will take place as part of the development process

APPENDICES

13. The following appendices are attached to this report: (If any)

None

LIST OF BACKGROUND PAPERS
LOCAL GOVERNMENT ACT 1972, SECTION 100D

None.

HEALTH AND WELLBEING BOARD	AGENDA ITEM: 8.2

DATE OF MEETING: **17th JULY 2013**

REPORT AUTHOR & CONTACT NUMBER: **Rod While 01582 532043**

SUBJECT: **Luton Clinical Commissioning Groups Public Facing Operational Plan 2013/14 ("Prospectus")**

WARD(S) AFFECTED: ALL

PURPOSE

1. To present the final version of Luton CCG's public facing operational plan 2013/14.

RECOMMENDATION(S)

2. The Board is requested to approve this document

BACKGROUND

3. CCGs are required to publish a "prospectus" aimed at informing the local population. The intention of the prospectus is to be a very short guide which explains to the local community what the CCG is, and the ambitions the CCG has for the local population's health services.

4. Each CCG's prospectus should be locally determined to reflect the needs of the people served. NHS England have not provided any central requirements around content or the means of communication since they consider that it is essential it reflects what the CCG, in discussion with key stakeholders, believe will meet the populations needs and wishes.

5. There are a few principles which NHS England considers to be important and they assume that we will take into account of:

- reflecting the local health and wellbeing strategy and as such ensuring the prospectus has been agreed with the Health and Wellbeing Board;
- setting out what the key health priorities are for the population;
- describing the standards that local people can expect from the services we have commissioned on their behalf;
- a high level description of how the budget for these services will be spent;
- demonstrating how we and key partners will address health inequalities; and high quality care for all, now and for future generations .
- clarity on how the population's views have been, and will continue to be, heard.

6. The attached document has been developed from the CCGs full Operational Plan 2013-14 “Planning for a Healthier Luton” and ensures the above listed principles are included. It is proposed that we do not use the title “prospectus” as this is not appropriate for the local population.

7. In order to comply with NHS England’s timeframes, the document has been made available on the CCG web site, though can be updated with feedback from the CCG Board and Health and Wellbeing Board

.

REPORT

8. See attachment – LCCG Public Facing Operational Plan 2013-14 Final

9.

IMPLICATIONS

10. Health

11.

CONSULTATIONS

12.

APPENDICES

13. The following appendices are attached to this report: (If any)

LIST OF BACKGROUND PAPERS
LOCAL GOVERNMENT ACT 1972, SECTION 100D

None.

HEALTH AND WELLBEING BOARD	AGENDA ITEM: 11.1

DATE OF MEETING: 17 July 2013

REPORT AUTHOR & Morag Stewart
CONTACT NUMBER: 01582 548438 (5438)

SUBJECT: Integrated Wellness Service: Business Case

WARD(S) AFFECTED: All

PURPOSE

To update the Board on the business case for the integrated wellness service.

RECOMMENDATION(S)

The Health and Wellbeing Board is recommended to:

1. **To consider any implications arising from the business case**
2. **To support the business case and recommended option**

BACKGROUND

A number of existing Public Health lifestyle service contracts end in March 2014, providing an opportunity to do things differently and in line with the principles and priorities in Luton's Health and Wellbeing strategy.

Early intervention and prevention, keeping people healthy and out of acute and expensive urgent services, has direct financial advantage to the Council and longer term health and wellbeing advantages for residents.

In January, 2013, the shadow Health and Wellbeing Board supported the proposal to develop an integrated lifestyle service based on 'wellness' principles and agreed to the development of a business case.

REPORT

Since the presentation to the Health and Wellbeing Board in January, 2013, a consultation exercise has been carried out with service users, the wider public and key

stakeholders. The feedback from the consultation has been used to inform the options in the business case.

A pre-tender market testing exercise has also been undertaken which confirmed that there is a market for this type of service. This exercise was followed up by site visits to Ipswich, Salford and Bedford to review different models of 'wellness'. The learning from these visits has helped to shape a model which will meet the needs of Luton residents.

Four service delivery options are presented in the business case (section 7) and the advantages and disadvantages of each model have been considered. It is recommended that Option 3 be approved:

> *to establish an integrated Wellness Service by bringing together existing lifestyle services under a single provider*

This model meets the key principles of the Health and Wellbeing Strategy, for greater integration; improved efficiency; reduction in health inequalities and addressing the wider determinants of health. It also provides a single point of contact for customers through both face to face and virtual delivery vehicles.

The Wellness Service will be funded from existing budgets (£924,000) together with a proposed re-investment of £100k, realised through efficiency savings from re-commissioning sexual health services. A proposal was submitted to the Public Health growth fund to re-invest the £100k in the Wellness service to strengthen adult weight management and increase the focus on mental wellbeing, and this was approved.

The service establishment budget of £1.024m (see 10.2) will be used to fund a new outcomes-focussed, integrated service with a customer-centric focus at its core and not simply to replicate existing services. The efficiency savings accrued from removing duplication and the overhead and management costs will be re-invested to provide a better quality service with a wider range of services.

The full business case is attached as an appendix

NEXT STEPS

The business case will be presented to the Executive Committee on the 27th August.

If approved, the tender process will begin in September with the aim of awarding a contract in February 2014 and the new service in place in May 2014.

PROGRESS AGAINST HEALTH AND WELLBEING STRATEGY PRINCIPLES:

Promoting Integration/Pooled Budgets/Joint Commissioning

The Wellness Service will bring together existing lifestyle services into an integrated model of provision and also aims to integrate advice and guidance services addressing wider social issues

Improving Quality and Efficiency – Service/Pathway Redesign

Improving quality and efficiency is a key driver for the proposed integrated wellness service

Addressing the Wider Determinants of Health

The proposed new service will take account of the wider determinants of health

Focussing on Early Intervention and Prevention

The aim for Luton's Wellness Service is *"to reduce health inequalities through better service integration and through moving resources towards prevention and early intervention and away from avoidable treatment and care".*

IMPLICATIONS

CONSULTATIONS

Consultation undertaken with the public, existing service users and key stakeholders

APPENDIX

Detailed Business Case

LIST OF BACKGROUND PAPERS
LOCAL GOVERNMENT ACT 1972, SECTION 100D

None

Appendix 1

Wellness Business Case

Executive Summary

1. A number of existing Public Health lifestyle service contracts end in March 2014. This document sets out the business case for re-commissioning services under one provider as an integrated Wellness Service.

2. Wellness is defined as a proactive, preventive approach that emphasises the whole person and which works to achieve optimum levels of physical, mental, social and emotional health.

3. Individuals who manage their lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services.

4. Early intervention and prevention, keeping people healthy and out of acute and expensive urgent services, has direct financial advantage to the Council and longer term health and wellbeing advantages for residents.

5. The promotion of self-help, for those who are able to self support, will be an important design feature of the proposed service.

6. In January, 2013, the shadow Health and Wellbeing Board supported the proposal to develop an integrated lifestyle service based on 'wellness' principles and agreed to the development of this business case.

7. A public consultation exercise was undertaken to ensure that resident needs were defined and were used to inform the design process for the Wellness Service (section 4).

8. A pre-market tender exercise has also been undertaken to inform the service design process (section 13.2).

9. The money required to establish the service is available from current budgets.

10. Four service delivery options are presented (section 7) and it is recommended that Option 3, to establish an integrated Wellness Service by bringing together existing lifestyle services under a single provider, be approved.

Authors: Morag Stewart, Sue Dimmock & Olena Sawal, July 2013.

1. Purpose of document

A number of existing Public Health lifestyle service contracts come to an end in March 2014. This document sets out the business case for re-commissioning services under one provider as an integrated Wellness Service, to:

- improve service outcomes and quality of service delivery for Luton residents
- place a greater emphasis on prevention and early intervention by promoting health and wellbeing rather than on diagnosing and treating illness
- empower individuals to maintain and improve their own health and remain independent for as long as possible
- support the Government's commitment to improving health and wellbeing, as set out in a number of recent publications [1, 2, 3, 4, 5, 6]
- achieve efficiency savings that will be re-invested into effectiveness gains

Wellness is defined as a proactive, preventive approach that emphasises the whole person and which works to achieve optimum levels of physical, mental, social and emotional health. Good nutrition, healthy weight, exercise, increased resilience and avoiding risk factors such as tobacco use and alcohol misuse, all play a role in wellness. Individuals who manage their lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services.[7] The wellness approach goes beyond looking at single-issue, healthy lifestyle services with a focus on illness, and instead aims to take a whole-person and community approach to improving health. Further details are provided in section 3. (Proposed Wellness Service).

> Health is a resource for everyday life, not the objective of living.
>
> Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.
>
> Ottawa Charter for Health Promotion. World Health Organization, 1986

A review of wellness services carried out by the Liverpool Public Health Observatory concluded that the *majority of services reviewed....showed potential to give a return on investment and save future costs due to ill health. Some initiatives not only made savings in care costs, but improved quality of life, enabling individuals to live independently.* The report also found that wellness services could provide an effective response to frequent attendees in primary care by

[1] Health and Social Care Act (2012)
[2] Dept of Health White Paper*: Healthy Lives, Healthy People: Our strategy for public health in England* (2010)
[3] Public Health Outcomes Framework *Healthy lives, health people: Improving outcomes and supporting transparency*
[4] Medical Research Council, *Lifelong Health and Wellbeing (LLHW)*
[5] Dept of Health, *Our health, our care, our say: A new direction for community services (2006)*
[6] Dept of Health, *Commissioning framework for health and well-being (2007)*
[7] From illness to wellness, NHS confederation briefing Oct 2011, issue 224

tackling the underlying causes of their visits. Many of the services, such as social prescribing (where patients are linked to non-medical facilities and services available in their wider community), had little or no cost in comparison to medical treatment.[8]

Early intervention and prevention, keeping people healthy and out of acute and expensive urgent services, has direct financial advantage to the Council and longer term health and wellbeing advantages for people.[9]

2. Background & business objectives

In January, 2013, the shadow Health and Wellbeing Board supported the proposal to develop an integrated lifestyle service based on 'wellness' principles and agreed to the development of a full business case which will be presented for approval prior to entering into a competitive tendering process.

Developing an integrated approach to the provision of healthy lifestyle services has been highlighted as a commissioning priority for Luton Borough Council,[10] and it is well documented that lifestyle issues contribute to poorer health outcomes in Luton:[11]

- The average life expectancy in Luton is 1.7 years less than the England average for females and 0.9 years less for males.
- The life expectancy gap between most and least deprived areas in Luton is 8.9 years for males and 6.4 years for women.
- Premature mortality (<75 years) from CHD is significantly higher than the England average.
- Diabetes mortality is significantly higher than the England average.

These issues are compounded by the fact that:

- There has been a silo approach to the commissioning and provision of health prevention services based on single issues e.g. smoking, obesity, alcohol. Currently services are provided by a range of organisations, in a variety of different locations, with individual contact numbers and different methods of access.
- Professionals and the public are often unaware of the full range of services on offer due to the complexity of navigating pathways through services. This is backed up by

[8] Liverpool Public Health Observatory: *Wellness services – evidence-based review and examples of good practice*. Observatory Report Series No.76, Winters L, Armitage M, Stansfield J, Scott-Samuel A, Farrar A www.apho.org.uk/resource/item.aspx?RID=105856

[9] London Health Observatory. (2012). *Marmot Indicators for Local Authorities in England, 2012.* [Online] http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/Documents/2012_PDF_LA_00KA.pdf

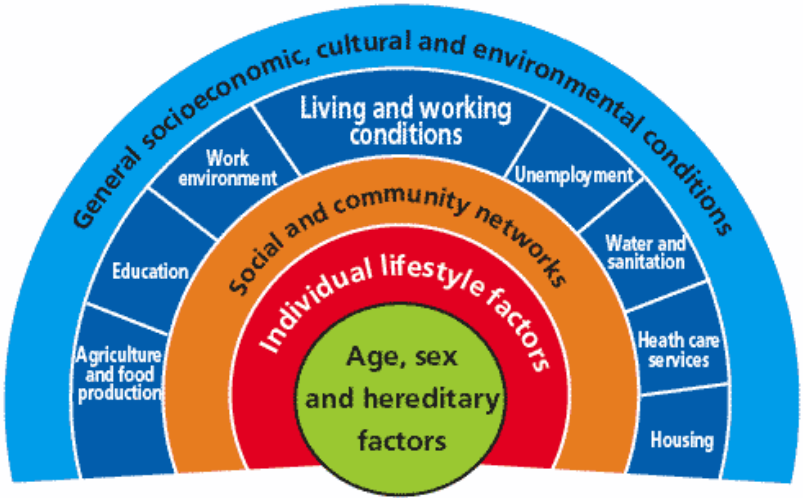
[10] Luton Borough Council, Health & Wellbeing Strategy, *A Healthier Future - Improving Health and Wellbeing in Luton* (2012-2017)

[11] Joint Strategic Needs Assessment (JSNA, 2011)

anecdotal evidence from GPs at a Stakeholder Meeting (28 March 2012) where a presentation was made to senior representatives from LBC, Public Health and the CCG, to raise awareness of the concept of 'wellness' services and to secure buy in for moving towards this way of working.

- Those that do manage to access services are in some cases the 'worried well'' and the more empowered members of the community who can navigate their way around the system. This contributes to the widening health inequalities gap, evidenced through the 2011 Health inequalities profile for Luton and the 2012-13 Annual Public Health Report:
    - The gap for life expectancy has shown increasing inequalities for females both compared with England and between the most and least deprived areas within Luton. Specific areas of concern are premature death from circulatory and respiratory disease.
    - The inequality gap for males has reduced compared to England as a whole, but has widened within Luton between the most and the least deprived areas.
    - The gap between the most deprived areas and the rest of Luton has widened for deaths related to smoking.
- The Marmot Review (2010) demonstrated that social and economic inequalities are key determinants of health, yet there is very little join up between prevention services and these wider determinants of health, in Luton.
- The current system is not financially sustainable as too many people are ending up with long term conditions and are reliant on on-going health and social care. The Wellness Service aims to reduce the impact of some of these factors at an avoidable early stage.

The link between lifestyle and wellness is well documented. Some of the wider social determinants of health that influence both health outcomes and health inequalities are shown in the diagram below.[12]



2.1 Current Lifestyle Services

[12] Dahlgren & Whitehead, 1991

Luton Borough Council currently offers 'lifestyle' services through a number of different service providers, in a variety of different locations, all with different access and registration processes. Residents do not get an integrated, tailored, intervention programme and can end up being signposted between services and dropping out of the system along the way.

Several existing lifestyle contracts end in March 2014, providing an opportunity to review and re-design service provision in this area. To date, there has been under investment in adult weight management and this proposal provides an opportunity to strengthen delivery around adult weight management outcomes and place greater emphasis on mental wellbeing which are identified as priorities in the JSNA[10].

An options appraisal of four potential delivery models was undertaken by the project team and the results are summarised in section 7 (Delivery Options and Recommendations). In addition, desk based research was undertaken between 2012 and 2013, by the Public Health team to identify best practice in wellness services (principally within the UK, USA and Australia). This was followed up by three visits to areas providing integrated models. The findings were used to establish a best fit solution that will adapt to meet the diverse and changing needs of Luton's residents.

3. Proposed Wellness Service

It is proposed to bring existing lifestyle services together and deliver an improved service to Luton residents under an umbrella wellness service with a single service provider. This service would primarily deliver preventative lifestyle advice, guidance and tailored interventions and would have clearly defined referral pathways through to services dealing with the wider determinants of health.
The service will improve customer access by operating through a single point of primary contact with multiple service delivery points around Luton, particularly in areas of identified need. An individual entering the service will have a holistic assessment to identify not only their health issues, but also the underlying social issues (e.g. housing, debt and unemployment) which may be contributing to poor health. A tailored programme of support will be prepared based on the needs of each individual, focussed on those with poorer health outcomes including BME communities; people with physical or learning disabilities and / or mental health issues and those living in the more socially deprived areas of Luton.

The service will be designed so that those people who *are* able to 'self-help' can access the information they need in a format that is appropriate for them[13]. Face to face contact will primarily be for people who require more support to make changes to their lives. There will be clearly identified referral pathways in place to and from other health services, as well as to

[13] Luton Borough Council's Prospectus 2013-2016

advice and guidance services addressing the wider social issues to establish a partnership approach to wellness.

3.1 Wellness Service Aim

The aim for Luton's Wellness Service is *"to reduce health inequalities through better service integration and through moving resources towards prevention and early intervention and away from avoidable treatment and care".*

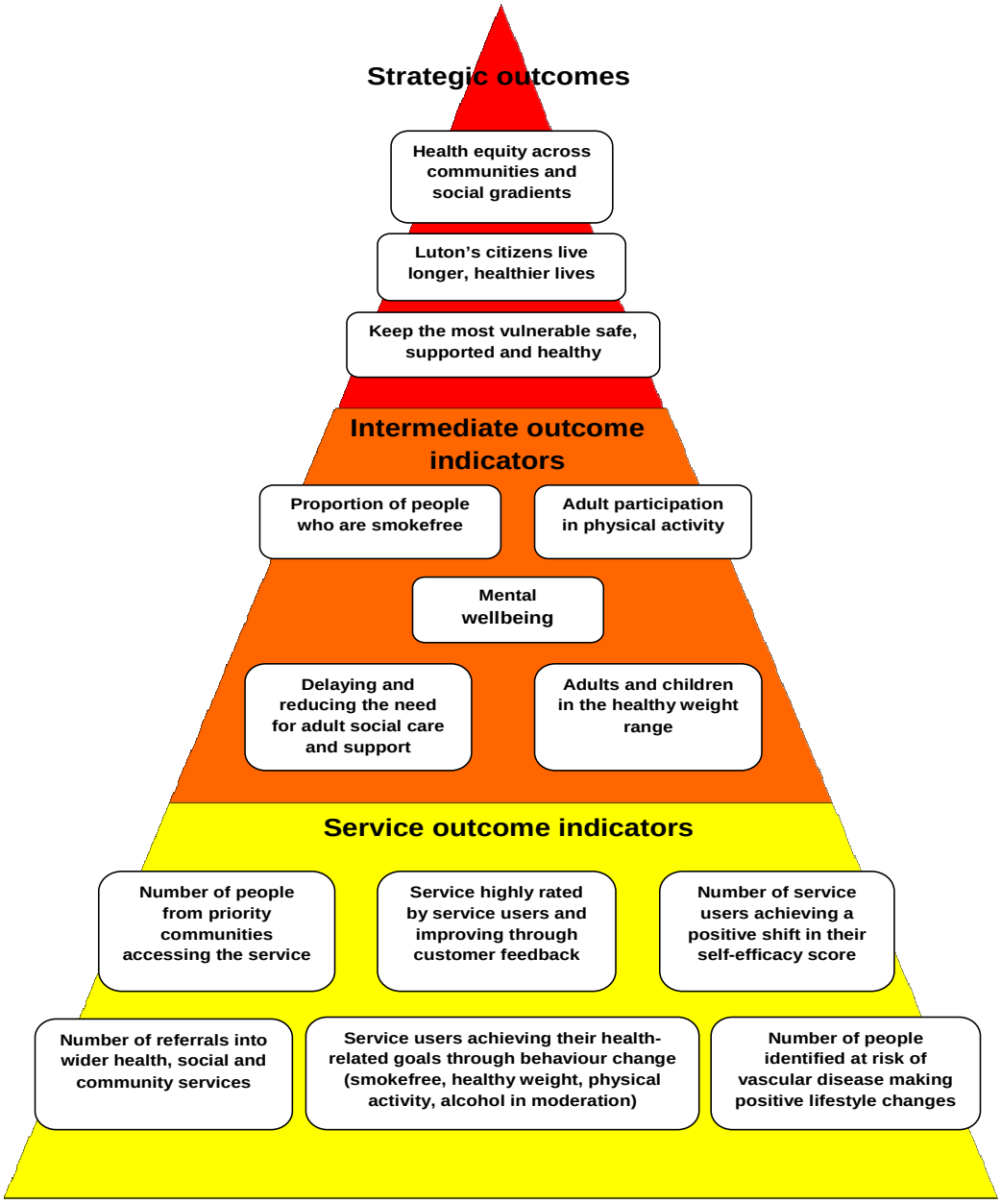
3.2 Wellness Service Strategic Outcomes

The Wellness Service will divert people from primary and secondary healthcare services towards prevention pathways, helping to contain rising healthcare costs. It will empower people to live their lives to the fullest possible potential by enabling people to increase control over their health through making changes to their lives.

The Wellness Service will contribute to the following strategic outcomes, to:

- Create health equity across communities and social gradients
- Assist Luton's citizens to live longer healthier lives
- Keep the most vulnerable safe, supported and healthy

The intermediate and service level outcome indicators are shown in the outcomes triangle below.



Service outputs are detailed in Appendix 1.

3.3 Wellness Service Strategic Objectives

The objectives of the Wellness Service are to:

- provide a person centred, integrated, single point of access wellness service which includes:
    - Diet and nutrition
    - Physical activity

    - Weight management (for adults and children)
    - Tobacco/smoking cessation
    - Alcohol
    - Mental wellbeing
    - NHS Community Health Checks
    - Volunteer Community Health Champions
- provide an holistic assessment of individuals to identify their needs, support them through behaviour change and monitor their progress,

- proactively tackle health inequalities through working with a range of diverse communities where the needs are greatest and the health is poorest,

- develop links with other services and organisations to provide an integrated approach to wellbeing and clear referral pathways to:

    - other preventative / treatment services such as mental health; sexual health; drugs and alcohol

    - primary healthcare services (e.g. GPs)

    - social health services (e.g. debt, housing and benefits crisis services)

- promote and market the service including the delivery of wider health promotion campaigns (national and local) and training frontline staff in brief interventions.

3.4 Wellness Service Critical Success Factors and Design Principles

It is expected that the service procured will meet the following critical success and design principles:

- Meeting local needs – address inequality issues by focussing on BME communities; people with physical or learning disabilities and / or mental health issues and those living in areas of socio-economic deprivation.
- Self help – this will be critical for those who are able to help themselves and will be supported principally through web access from the service's home site.
- Brand – develop a brand for wellness in Luton that has high affinity and recognition amongst potential service users
- Service Levels - meet the key performance indicators as set out in the contract.
- Capacity - provided by an experienced and capable provider who has sufficient capacity to deliver the service required within the required timescales.
- Quality - delivered to a high quality and satisfying all regulatory requirements.
- Effectiveness - achieve high standards of management and governance.
- Good Practice - expected to show a commitment to innovation and demonstrate good practice.
- Value for Money - affordable and provide value for money

3.5 Market evaluation / Timing of Proposal

This proposal is well timed in terms of:

1. Public Health transfer to Luton Borough Council and the Council having a new responsibility to improve health and reduce health inequalities.
2. Establishment of the Health and Wellbeing Board and approved health and wellbeing strategy that sets out to reduce health inequalities through better service integration and through moving resources towards prevention and early intervention and away from avoidable treatment and care.
3. The new Health and Wellbeing Strategy for Luton signals a move towards a 'wellness' approach and includes a priority to re-commission an integrated healthy lifestyle (wellness) service
4. Focus on partnership working (with the Clinical Commissioning Group and VCS)
5. A significant number of lifestyle-related Public Health contracts coming to an end in March 2014 and must be re-tendered.
6. Luton's JSNA[10] identifying a number of health and wellbeing priorities, including:
   - Reducing obesity, smoking and alcohol related harm
   - Reducing variation and improving outcomes in general practice
   - Promoting independent living
   - Improving mental wellbeing
7. The Ernst & Young Review - *Whole Systems Integration of Health and Social Care*. Service re-commissioning will need to be cognisant of the outcomes from this review.

4 Public Consultation Exercise

4.1 Process

A public consultation exercise was undertaken between 10th April and 10th May 2013 to ensure that resident needs were defined and informing the design process for the Wellness Service.

The identified target groups (i.e. BME communities; people with physical or learning disabilities and / or mental health issues and those living in the more socially deprived areas of Luton), were contacted to ensure they had an opportunity to respond to the survey.

This was achieved through attendance at Ward Decision Days, distributing questionnaires through the library, Healthwatch, Children's Centres and the Voluntary and Community Sector as well as direct contact through appropriate service providers including MIND, Age Concern and the Luton Irish Forum.

A follow-on consultation was organised specifically with service users, through the Stop Smoking and exercise on referral programmes, to increase the number of responses from service users.

In total (between the two consultations) there were 332 responses, of which 61% were service users.

4.2 Results

For the initial public consultation, a total of 281 responses were received. 86 respondents expressed an interest in taking part in a further consultation to help develop the service.

The consultation report is attached at Appendix 2, and results are summarised below:

- Most of the respondents live in Luton and rate their health as being good, fairly or very good (67%).
- The top 3 health topics indicated as being most important to them are - exercise and fitness (64%), healthy eating (63%) and losing weight (41%).
- 67% of all respondents are most likely to contact/visit their GP practice or health/medical centre to get information about making healthy life choices followed by using internet/online (49%) and thorough family/friends (29%).
- 66% are most likely to make contact in person
- 57% of all respondents have not contacted/visited or been referred by their GP to any of the listed wellness services in Luton and 40% don't know or are not sure how easy or difficult it is to access wellness services in Luton
- Most respondents do not access any wellness services in Luton primarily because they feel they do not require advice or support of wellness services at present (50%) followed by not being aware of what these services offer (42%).
- Respondents would be more likely to access wellness services in Luton if they receive a referral from their GP/healthcare professional (72%), if they get practical advice that fits their lifestyle (38%) and if the services offered are close to where they live (34%).

The results of the survey are perception based evidence and provide a good evidence base for consultation with service users (43%) and non-service users (57%) to help to understand:

- which services interest them
- which services they are currently accessing
- why they are not currently accessing wellness services in Luton, and
- what would encourage them to access services in the future

The key findings from the initial exercise were:

1. There appears to be a general lack of awareness of wellness services in Luton.
2. GPs have a significant role to play in raising awareness of wellness services and referring / signposting patients.
3. There appears to be a positive shift towards people seeking health information online.
4. The demographic profile of respondents is fairly well represented for age, ethnicity, disability, religion/faith/belief, employment status and sexuality.

5. There is an imbalance in gender with an over representation of female respondents. This is to be expected as we know that women are twice as likely to access health services as men[14]

For the follow-on consultation with service users, 51 responses were received with 68% of respondents having used the Stop Smoking service in the last 12 months, and 28% having used the Exercise on Referral programme. Results are also attached at Appendix 2:

1. Again, GP practices were identified as an important entry point to services.
2. Two thirds of users who responded accessed services in person (65%) followed by telephone (47%).
3. There was a general lack of knowledge about services other than the one being accessed.

It is important to note that the number of responses returned for the second consultation does not constitute a statistically significant sample size.

5 Drivers for Change

See Appendix 3

6 Service Benefits

6.1 Strategic benefits - See Appendix 4.

6.2 Cost effectiveness

The Liverpool Public Health Observatory review of wellness services concluded that the *majority of services....showed potential to give a return on investment and save future costs due to ill health. Some initiatives not only made savings in care costs, but improved quality of life, enabling individuals to live independently.* The report also found that wellness services could provide an effective response to frequent attendees in primary care by tackling the underlying causes of their visits. Many of the services (such as social prescribing where patients are linked to the non-medical facilities and services available in their wider community) had zero cost when compared to medical treatment.[15]

An assessment of the cost-effectiveness of public health interventions was conducted in 2012 by the National Institute for Health and Clinical Excellence (NICE)[16]. Reviewing NICE public health guidance from 2006-2010, they concluded that the majority of the 200 cost-effectiveness

[14] Men's Health forum 'Challenges and Choices: Improving health services to save men's lives. 2009
[15] Liverpool Public Health Observatory: Wellness services – evidence-based review and examples of good practice. Observatory Report Series No.76, Winters L, Armitage M, Stansfield J, Scott-Samuel A, Farrar A www.apho.org.uk/resource/item.aspx?RID=105856
[16] Owen, L., Morgan, A., Fischer, A., Ellis, S., Hoy, A. and Kelly, M. P. (2012). The cost-effectiveness of public health interventions. J. Public Health 34(1): 37-45.

estimates for public health interventions were cost effective and represented good value for money. These include interventions around smoking cessation, increasing physical activity including exercise on referral programmes and preventing harmful drinking.

In 2009, the Eastern Region Public Health Observatory (ERPHO)[17] published high level indicative cost savings which are estimated to accrue from tackling the significant public health issues of obesity, vascular risk and smoking.

Full details are provided in Appendix 5.

Health Checks determine a person's risk of developing diabetes, heart or kidney disease or having an event such as a heart attack or stroke over the next ten years. By reducing risk through interventions targeted at those people at highest risk, it is possible to prevent or delay the onset of disease and disability. The table below shows the potential cost benefit of providing the Health Checks programme. From experience, the community Health Checks are an important opportunity to engage with people who would not normally visit their GP or attend for a Health Check.

% Population at risk of vascular events (>2% pa)	% Likely uptake of screening	Costs of screening (£1000s)	Events over next 5 years	Savings (£1000s) if programme reduces risk by:		
10	7	247	726	**25%**	**40%**	**60%**
				44	218	450

ERPHO predicted that it will cost Luton £6.4 million per year more to treat obesity in 2015 than it did in 2007. Through increased investment and a sustainable weight management programme delivered through the Wellness Service, it is possible to realise the savings in the table below[18].

	Year 1 impact of savings £'000	Year 2 impact of savings £'000	Year 5 impact of savings £'000	Year 10 impact of savings £'000	Year 20 impact of savings £'000
GP consultations & prescriptions	19.51	23.48	19.51	19.51	19.51

[17] Eastern Region Public Health Observatory: Investing in public health for PCTs - medium term strategies (Update - final) Flowers J, Evans S, Walford H. 2010
http://www.erpho.org.uk/download.aspx?urlid=20940&urlt=1

[18] Cost savings calculated using the NICE costing templates (2006/2010) and the 'Computer Modelling the Health and Economic Outcomes of the Weight Watchers GP Referral Scheme' study.

Obesity related surgical intervention avoided	5.70	5.70	5.70	5.70	5.70
Ongoing savings for reduced expenditure on diseases related to overweight and obesity	15.47	25.52	45.63	86.61	163.94

The wider cost of tobacco to Luton is over £57 million per year. The Wellness Service has a role to play in reducing tobacco use through health promotion campaigns and by providing a Stop Smoking Service. Costs calculated through the Mott McDonald economic model show a net savings on investment in Stop Smoking Service over a five year period of approximately £85,000. The ERPHO report estimated a £60,000 saving on smoking related secondary care admissions with every 1% drop in smoking prevalence (based on an annual 1% drop over a six year period).

The current configuration of services is expensive. It is estimated that approximately 25% of each service budget is spent on overhead costs (management staff, rent, utilities, administrative support etc). Efficiency savings can be made by bringing services together under one provider.

7 Delivery options and Recommendations

7.1 Delivery Options

Four possible service delivery models were included in the options appraisal exercise:

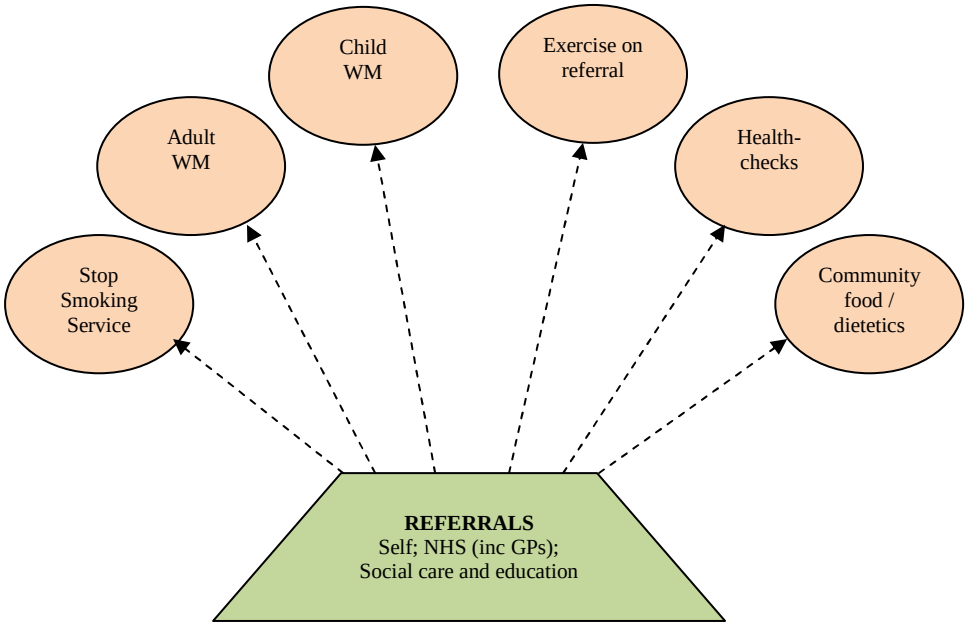
1. Maintain current service provision under several providers (no change option)
2. Establish a virtual Wellness Service under a single provider
3. Establish an integrated Wellness Service by bringing together existing lifestyle services under a single provider. This would Include a virtual service alongside face to face service provision
4. Establish a fully integrated service under a single provider by incorporating a wider range of health services e.g. mental health, sexual health, drug and alcohol services

7.2 Details of options and recommendations

The four options service delivery models are covered in sections 7.2.1 to 7.2.4.

7.2.1 Option 1 - Maintain current service provision

This model is the existing model but with the Health Trainer programme removed as shown below:


Child
WM
Exercise on
referral
Adult
WM
Health-
checks
Stop
Smoking
Service
Community
food /
dietetics
REFERRALS
Self; NHS (inc GPs);
Social care and education

Advantages	Disadvantages
No additional cost – potential for £124k cost saving or re-investment into other services	Silo services with multiple contact numbers and referral pathways
No change to contact numbers and referral pathways	Inefficient use of officer time in managing separate contracts (client side)
Relationships well established with existing service providers	Expensive in terms of administrative service overheads (delivery side)
	Does not improve access for those most in need - potential to increase inequalities
	Does not provide one holistic assessment of need
	Does not meet the key principles in the Health and Wellbeing Strategy – integration; efficiency; wider determinants of health

RECOMMENDATION: Reject

- This model is not in line with the key principles in the Health and Wellbeing Strategy.
- This model fails to address the wider determinants of health.

7.2.2 Option 2 - Establish a virtual Wellness Service

This option involves establishing a standalone, online Wellness Service with no face to face contact. Health education can be effectively delivered online for those groups who have access to the internet. It is important to recognise, however, that the Wellness Service will go beyond education to support people to change their behaviour. There is mixed evidence to show the effectiveness of this through a standalone, virtual-delivery model.

Advantages	Disadvantages
Single point of contact	No face to face contact for those who need support to change behaviour so limits client choice
Addresses the need for self-help and Channel Shift	Risk of increasing health inequalities amongst some groups
No cap on access	Potential to remain a sign-posting/referral service leaving a gap in provision for lifestyle interventions
	Mixed evidence to show the effectiveness of

	health interventions delivered online. Internet-based therapy for mental health has shown some success, but the field is less developed for weight management and physical activity. Conversely, the evidence for face to face and telephone intervention for smoking cessation is rated highly effective (A) with online intervention receiving a lower rating (B).
	Reliant on good access to internet and skills to access services.

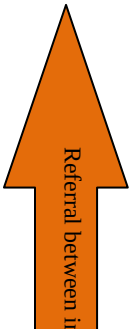
RECOMMENDATION: Reject

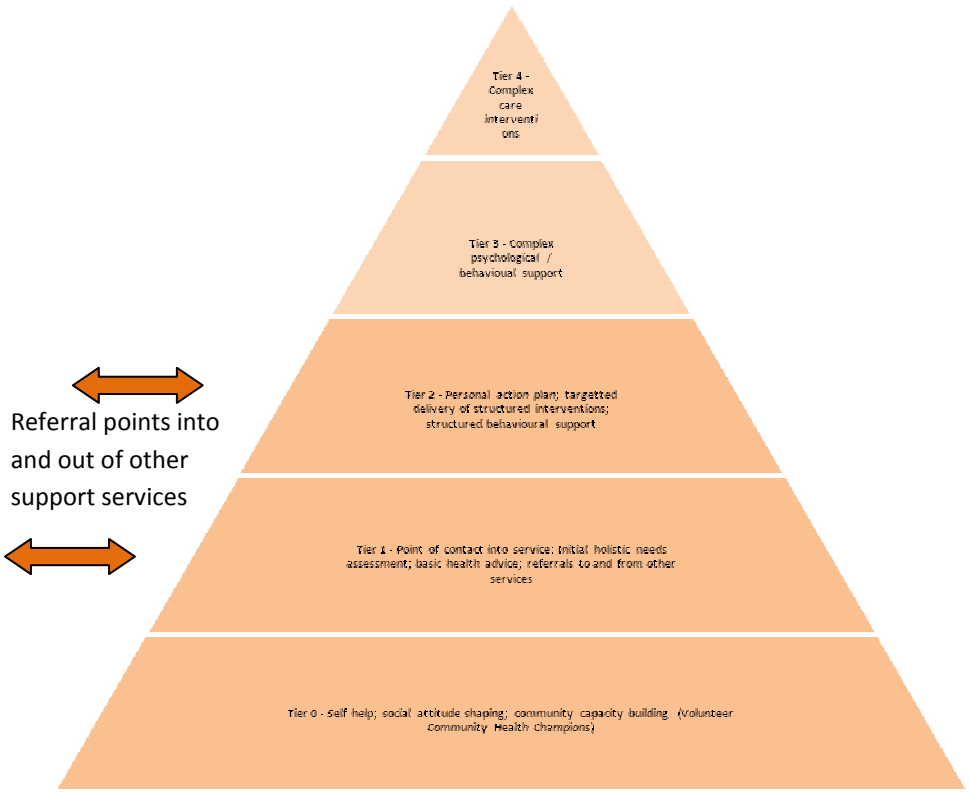
- This model has the potential to widen health inequalities by excluding groups that do not access the internet, for example due to age or disability. The Office for National Statistics found in their 2012 survey of adults in Great Britain that: 'Approximately, one in five households (22%) indicated that they did not have the Internet due to a lack of computer skills. Further barriers included equipment costs and access costs being high at 15% and 14% of households without Internet access respectively.'[1] As of the quarterly update (Q1 2013), 14% of adults have never used the internet.
- This model denies face to face access for those who need support to change their health behaviours.

7.2.3 Option 3 - Establish an Integrated Wellness Service by Bringing Together Existing Lifestyle Services Under a Single Provider

This option brings together integrated wellness services under one service provider with both face to face and on-line service delivery. It provides an holistic service offering by bringing together physical, social, emotional and mental wellbeing.

The Wellness Service would operate in Tiers 0 to 2 in the diagram below. The pyramid layout depicts how services will work together and how the total number of interventions reduces as you move up through the pyramid (below).





Tier 0 services – this tier will actively build capacity within communities to reduce unhealthy behaviours and increase levels of self-care through support of volunteer health champions and peer support. It will also increase community awareness of key messages through the delivery of local and national campaigns and promote the self help principle for those that are able to.

Tier 1 services – this tier will provide points of access into the service for those that are require more personalised support (telephone, web, face to face). It will provide holistic needs assessments and deliver brief intervention services and referrals to other services as appropriate e.g. drugs & alcohol; sexual health and mental health services as well as services providing advice and guidance on wider social issues including employment, debt and housing.

Tier 2 services – this tier will provide structured interventions e.g. stop smoking, weight management and referral to other services, as above.

Tier 3 & 4 services will not be covered in the Wellness Service but through structured referrals to more complex support and treatment services

Advantages	Disadvantages
Single point of contact	Requires a strong marketing campaign to bring customers into the service
Provides holistic assessment of health and wellbeing needs together with any underlying social issues impacting on health	Requires a significant effort to implement
Provides face to face contact for those who need support to change behaviour	
Meets the key principles in the HWBS	
No additional cost - more effective use of existing funding to strengthen the range of services provided	
Reduced service overheads (both client and delivery side)	
Addresses the need for self-help and Channel Shift	

RECOMMENDATION: Accept

- This model meets the key principles of the health and Wellbeing Strategy, for greater integration; improved efficiency; reduction in health inequalities and addressing the wider determinants of health.
- This model provides a single point of contact for customers through both face to face and virtual delivery vehicles.

7.2.4 Option 4 – Fully integrated service incorporating health and social services

This option establishes a fully integrated service under a single provider by incorporating a wider range of health services (mental health, sexual health, drug and alcohol services) and services addressing the wider social issues (debt, housing, employment). Tier 1 and 2 referred services (in option 3) are now incorporated into the delivery model.

Advantages	Disadvantages
Brings together early intervention and prevention services around mental health; sexual health and drug and alcohol services	These services are already commissioned using integrated models with clearly defined referral pathways in place. Bringing the prevention and early intervention elements of these services under the new Wellness Service would be confusing for both the public and professionals
Single point of contact	This model could potentially overlap with integrated advice and guidance services being planned by Luton Access
Addresses the need for self-help and Channel Shift	Some of these wider services are commissioned by different parts of the health and social care system and cut across organisational budgets
Provides face to face contact for those who need support to change behaviour	To bring together the wider health services will take much longer (politically and practically) than the timeframe allowed for this project
	Some of the health services proposed for integration are presently mid-contract

RECOMMENDATION: Reject

- The additional health services are already commissioned using integrated models and this option would impact on their integrated delivery.
- To separate off prevention and early intervention activities into a Wellness Service could be confusing for health professionals and existing customers of these services.

8 Impact of non delivery

Non-delivery of this integrated service would mean that the maximum health benefits for service users would not be achieved. Fewer residents would access services and there would be an expected increase in health inequalities. Long term smoking, obesity and inactivity related outcomes would all be compromised, resulting in increased costs to the public sector.

9 Proposed funding source

The Wellness Service will be funded from existing budgets (£924,000) together with a proposed re-investment of £100k, realised through efficiency savings from re-commissioning sexual health services. A proposal has been submitted to the Public Health growth fund to re-invest the £100k in the Wellness service to strengthen adult weight management and an increased focus on mental wellbeing.

The service establishment budget of £1.024m (see 10.2) will be used to fund a new outcomes focussed, integrated service with a customer-centric focus at its core and not simply to replicate existing services.

10 Cost and timescales

10.1 Project set-up costs (financial year 2013/14 – costs are within current budgets)

Item	**Budget**
Communications & marketing	£2,500.00
Consultation	£1,000.00
Pre-market engagement - provider meetings	£500.00
Travel / transport	£500.00
Total	**£4,500.00**

10.2 Service establishment budgets (for re-tendering exercise)

Service / Programme	**Cost of current provision**
Stop Smoking Service	£400,000
Health Trainers (re-investment budget)	£124,000
Child Weight Management Service (CWM)	£148,600
Slimming on referral (AWM)	£58,000
Exercise on referral	£30,000
Community food programme / dietetics	£89,000
NHS Community Health Checks	£75,000
Sexual health services (re-investment of savings)	£100,000
Total	**£1,024,600**

A total service delivery budget of £1,024,600 is proposed to enable a broader scope of integrated services to be incorporated into the newly designed and commissioned Wellness Service. This includes £124,000 from the Health Trainers budget which will be re-invested to deliver different service outcomes, and £100,000 of savings from the re-commissioning exercise of sexual health services. The £100,000 would be used to strengthen adult weight management

services as currently there is limited provision to support adults to lose weight. Approximately 26% of the adult population are obese which costs the NHS alone an estimated £30 million per year[19]. The costs to the wider economy in Luton are considerably higher due to lost productivity through absence from work.

It is proposed that service set up costs are included within the total service budget, identified above (i.e. no additional set-up costs are required). In order to assist the new service provider with up-front service establishment costs, it has been proposed that the first contract payment could be paid in advance.

It is anticipated that the new contract will be awarded in February 2014 for a service commencement date in mid May 2014. This allows for a three month lead-in time to the new service.

11 Resource requirements

11.1 Service Provider

The service provider resource requirements will be established during the competitive tender process, taking into account the service establishment budget identified above. Potential service providers will be asked to detail (through their service delivery model) how they will deliver services and what resources they will employ to deliver the specified outcomes.

11.2 Client Services (for 2014/15 onwards)

The client service resource requirements will be more intensive in Year 1 while the service is being established. In year 1 a public health improvement manager will manage the contract as well as provide support to ensure relationships are established and referral pathways are in place. Once the service is set up the amount of officer time required to support the new provider and manage the contract will be significantly reduced, to 0.2 FTE. Under the current arrangements, officers are managing five separate contracts which is time consuming and expensive, taking up approximately 1 full time equivalent (FTE) or £40,000 per annum.

The costs associated with officer support time are within current budgets.

	Year 1	**Cost**	**Years 2-5**	**Cost**
Officer support and contract management	0.4 FTE	£16,000	0.2 FTE	£8,000
Travel and subsistence costs		£500		£500
Advertising and promotion		£2,000		£0

12 Governance

[19] Healthy Weight Healthy Lives Toolkit, October 2008

The Wellness project board is chaired by the Project Sponsor with representation from LBC (project / workstream leads and service specialists); the Clinical Commissioning Group and Healthwatch.

The Wellness project board reports through the Health Inequalities Delivery Board to the Health & Wellbeing Board / and Executive, as appropriate.

Terms of Reference for the project board are attached at Appendix 6.

The project has close links with Luton Access; the proposed CCG Integrated Care Hub; the Ernst & Young Review - *Whole Systems Integration of Health and Social Care.*

13. Procurement approach and methodology

13.1 Procurement process

Re-commissioning requires an OJEU tender process. Early involvement and advice has been taken from LBC Procurement & Shared Services Team.

13.2 Pre-market tender exercise

Prior to the issue of Invitations to Tender, a pre-tender market engagement process with potential suppliers, including members of the voluntary and community sector in Luton, was undertaken to assist in developing the service specification documentation.

Some of the potentially valuable design features that came from this exercise included:

- Designing the model on an asset based approach to improving health and wellbeing rather than the usual deficit based approach.
- Placing greater emphasis on the social model of health rather than on the medical model.
- Working with the business sector to access large numbers of people e.g. supermarkets, workplace, and job centres.
- Delivering services from faith centres, mosques and football clubs.
- Training staff to combine cognitive behavioural therapy (CBT) and motivational techniques with strong subject matter knowledge.
- Use of a structured case management approach and using case management software to track outcomes together with a comprehensive evaluation framework.
- Establishing strong links with the voluntary sector for sub-contracting or referral into their specialist areas.

13.3 Decommissioning existing services

Notice will be given to existing service providers within their contract terms. Provision will be made to extend essential services (Child Weight Management and Stop Smoking) for up to 6 months. TUPE may apply to some services (Stop Smoking, Health Trainers and Child Weight Management) and a review of potential TUPE implications is included in the project timetable.

13.4 Project timetable

The timetable for project delivery is included at Appendix 8.

14. Stakeholder communications strategy

For the period up to implementation, the Stakeholder Communication Strategy and related documents are included at Appendix 9.

Thereafter, marketing and promotion of the service will become the responsibility of the service provider. This will feature in the tender exercise as an essential criterion.

Appendix 1 - Wellness Service Outputs

Service outcomes will be delivered through the following proposed service outputs*:

1. Provision of consistent and accurate healthy lifestyle advice for Luton residents.
2. Improved access for Luton residents to wellness services.
3. Increased uptake of wellness services.
4. Increased number of clients enabled to make lifestyle changes.
5. Increased uptake of wellness services by priority groups. For example BME, areas of deprivation, people with disabilities and mental health issues.
6. Increased number of service users making healthier lifestyle choices.
7. Increased uptake of NHS Community Health Checks.
8. Increase in intervention uptakes through NHS Community Health Checks.
9. Increased public and professional awareness of services available to support lifestyle changes.
10. Increased number of staff trained to deliver brief interventions to support the dissemination of consistent healthy lifestyle messages through communities and health professionals.
11. Established, effective referral pathways including to partners who deliver services relating to the wider determinants of health.
12. Increased referrals from primary and secondary care services.
13. BMI changes evidenced across adults and children accessing weight management services.
14. Increase in the number of people who have quit smoking at 12 weeks.
15. Increase in the number of people identified at risk of vascular disease.

***** Specific measure and targets will be agreed with the successful provider

Appendix 2 – Results of Public Consultation

Initial Public Consultation

Wellness Services - FINAL results 23 May

Follow-up Service User Consultation

Wellness Services (service users) summ

Appendix 3 - Drivers for Change

Driver	
National priority	• Health and Social Care Act (2012) gives local authorities the responsibility for improving the health of their local populations. • Public Health White Paper*: Healthy Lives, Healthy People: Our strategy for public health in England* (DH, 2010) aims to create a 'wellness' service and to strengthen both national and local leadership. • The Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health and the outcomes and the indicators to demonstrate how well public health is being improved. Indicators include: smoking prevalence, prevalence of adult and childhood obesity, diet, physically active and inactive adults, alcohol related admissions to hospital. • Lifelong Health and Wellbeing (LLHW) is a major national initiative established to meet the challenges and opportunities of an ageing population by moving resources into prevention and early intervention and away from avoidable treatment and care. • Government spending review and value for money.
LBC corporate objectives	• Luton's Sustainable Community Strategy (2008-2026), includes commitments to "promoting healthy living and tackling the key risk factors which affect health", "focusing on prevention and early intervention" and "improving mental health services". • Luton's Prospectus priority – supporting and protecting the vulnerable. • Joint Strategic Needs Assessment (JSNA, 2011) • Health & Wellbeing Strategy (2012-2017) • Alcohol Strategy (2012-2015) • Tobacco Free Luton Strategy (2010-2015) • Healthy Weight Strategy (2009/10 – 2013/14) • Luton's Early Intervention Strategy (2011) – prevention and early intervention.

Sustainable community plan objectives	• Luton's Family Poverty Strategy (2011-14) – includes a commitment to "develop programmes to encourage safe and healthier lifestyles" recognising the links between a number of health priorities and poverty. • The socio-economic make-up of Luton's Citizen's indicates that a failure to address wellness issues will contribute to the widening health inequalities gap.
Statutory duty	• Health and Social Care Act (2012) – NHS Community Health Checks
Departmental priority	• ***Public Health Vision***: To achieve a healthier Luton population. • ***Public Health Mission Statement***: To lead on the improvement in health in Luton by influencing and informing decision making and driving effective Public Health action. Reducing smoking, obesity and alcohol related hospital admissions are key national and local priorities picked up in the JSNA and H & WB Strategy: • Smoking – is the primary cause of avoidable premature death and the leading cause of health inequalities in the UK. Although the prevalence of smoking has fallen in recent years, 1 in 5 adults in Luton are regular smokers. This contributes significantly to poorer health outcomes and health inequalities in Luton. • Obesity - reducing adult and childhood obesity is a national priority. Obesity increases the risk of developing heart disease, some cancers and Type 2 diabetes and can reduce life expectancy by up to 9 years. A quarter of all adults in Luton are obese (42,385 people); 11.2% of Luton's 4-5 year olds and 22.3% of 10-11 year olds, which is higher than the national average. • Alcohol - rates of hospital admissions for alcohol related conditions are increasing year on year in Luton.
Other priority	• Luton Borough Council Prospectus (2013-2016) - to ensure the most vulnerable in Luton are safe and supported.

Appendix 4 – Strategic Service Benefits

Customer benefits:
• Improved customer journey designed around needs and delivered through a variety of access channels (e.g. web; face to face; telephone etc) • Easier access to a wide spectrum of co-commissioned and co-located services • Easier referral to other services addressing health and the wider social issues • Access to appropriately designed, improved and targeted self-service / self-help capability • Face to face service provision and access, where required • Holistic assessment of individual needs and structured case management • Improved physical and mental health and wellbeing
LBC benefits:
• Improved service delivery to customers, in keeping with corporate priorities • Mid to long-term savings through prevention and early intervention • Long term cost avoidance of expensive treatment and ongoing social care • Reduction in expenditure on short and long term care for Luton residents • Improved health outcomes for Luton residents, defined through a reduction in obesity, smoking and alcohol related harm and improved mental wellbeing • Improved cost-effective commissioning of health-related advice and guidance services with clearer outcomes for customers and commissioners alike • Service efficiencies through rationalisation of duplicated service provision (administration) • Joined up, cost-effective service provision
Partner benefits:
• Joined up, cost-effective service provision • Single point of contact to wellness services • Clear referral pathways • Improved health outcomes for Luton residents • Improvement in general practice outcomes • Increased use of social prescribing • Reduction in appointments and prescribing • Long term cost avoidance of expensive secondary care • Expands the options available in a primary care consultation

Appendix 5 – Wellness Service Economic Benefit

Wellness Service Economic Benefits - C

Appendix 6 – Wellness Project Board Terms of Reference

Wellness PB ToR v1.03.doc

Appendix 7

Intentionally Blank

Appendix 8 - Project Timetable

Outline timetable for Wellness project v03.

Appendix 9 – Stakeholder Communications Strategy (Phase 1) and related documents

Strategy

Wellness Comms Strategy SJD v03.doc

Plan

Wellness Comms Plan v03.docx

Stakeholder Overview

WellnessOV.pdf

Wellness Services in Luton
Resident Consultation 2013
FINAL RESULTS: 281 responses

****For this consultation the confidence interval / margin or error has been calculated to be 5.85%. Results are considered to be statistically significant on achieving a margin of error of +/- 5%.**

The **confidence interval** (also called margin of error) is the plus-or-minus figure usually reported in newspaper or television opinion poll results. The **confidence level** tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95% certain; the 99% confidence level means you can be 99% certain. **Most researchers use the 95% confidence level

Q1. Do you . . . ? *please tick all that apply*

236 (85%) *live in Luton*
117 (42%) *work in Luton*
10 (4%) *other*

Other, please specify

14 responses

- work in Bedford
- Volunteer work with Borough Council and Hospital
- Houghton Regis
- Retired
- Am a volunteer with Age concern
- Volunteer, school governor
- Live in NW Herts
- Retired - helping with grandson aged 9
- volunteer in Luton
- retired
- unemployed with disabled schizophrenia
- Eddlesborough
- Work in Hitchin
- Dunstable

Q2. Overall, how would you rate your health? *please tick one box only*

68 (24%) *5 - very good*
119 (43%) *4 - fairly good*
58 (21%) *3 - neither good nor poor*
27 (10%) *2 - fairly poor*
6 (2%) *1 - very poor*
0 *don't know / not sure*

Q3. Which of the following health topics are most important to you? *please tick all that apply*

42 (15%) *quitting smoking*
176 (63%) *healthy eating*
74 (27%) *cooking on a budget*
177 (64%) *exercise and fitness*
131 (47%) *mental wellbeing*
115 (41%) *losing weight (adults)*
106 (38%) *family health and wellbeing (carers and children)*
106 (38%) *serious illness / disease i.e. heart disease, diabetes, cancer etc*
17 (6%) *alcohol advice*
5 (2%) *none of the above*
4 (1%) *other*

Other, please specify

9 responses

- Working with a disability
- A contractile bladder
- Access to natural open space
- holistic health such as reflexology, massage
- GP Services
- emotional health
- was going to give smoking up but altered budget
- Mental / physical illness e.g. eating disorders
- Managing symptoms of cancer, COPD and diabetes

Q4. Who are you most likely to contact / visit to get information about making healthy life choices i.e. about your diet, getting exercise or to stop smoking? *please tick all that apply*

184 (67%) *your GP practice or health / medical centre*
26 (9%) *community centre*
41 (15%) *local voluntary or community groups e.g. MIND, Impact, Alcohol Services for the Community*
66 (24%) *gym / leisure centre*
80 (29%) *family / friends*
134 (49%) *internet / online service*
45 (16%) *library / books*
12 (4%) *other*

Other, please specify

25 responses

- Age Concern Luton
- Yoga
- if your unemployed there is not a lot of money and also GP know your condition but sometimes don't
- independent charitable organisations
- Pharmacist
- Active Luton
- Active Luton
- churches
- children's centre
- Health trainer programme
- My Health Trainer
- community nurse
- Therapeutic enjoyment from Barnfield College massages etc.
- school
- This is mainly available as leaflets and books but whether this works for everyone remains to be see
- myself
- social worker
- Health trainer
- health trainer
- health trainer
- health trainer
- Health visitor
- weight loss group / Wii / line dancing
- age concern Luton
- Age Concern

Q5. How are you most likely to make contact with them? *please tick all that apply*

136 (49%) *by telephone*
140 (50%) *internet / online*
185 (66%) *in person / visit*
8 (3%) *other*

Other, please specify

5 responses

- would mainly consult books/ online then next important visit the pharmacy for general advice
- depends on situation
- text/BBM
- email
- Have volunteer visitor but also phone office.

Q6. Have you contacted / visited or been referred by your GP to any of the following wellness services in Luton over the last 2 years? *please tick all that apply*

22 (8%) *Stop Smoking Service*
17 (6%) *Health Trainers*
9 (3%) *Alive 'n' Kicking (Child Weight Management Service)*

23 (9%) *Weight Watchers or Slimming World*
9 (3%) *Exercise Referral Programme (Active Luton)*
5 (2%) *Community cooking sessions*
3 (1%) *Alcohol services for the community*
50 (19%) *Health Checks*
152 (57%) *no, none*
11 (4%) *Other*

Other, please specify

13 responses

- Talking Therapies
- Desmond
- Bedford
- Desmond for diabetes
- would like to go to weight watchers
- Breast screening clinic
- mental health
- Luton Mind & Ace Enterprise
- Mental health problems
- Referred to exercise programme by health trainer
- Mental health services - SEPT Luton
- L&D hospital
- hospital

Q7. In your opinion, how easy or difficult is it to access wellness services in Luton at present? *please tick one box only*

18 (7%) *very easy*
58 (22%) *quite easy*
43 (16%) *neither easy nor difficult*
35 (13%) *quite difficult*
6 (2%) *very difficult*
108 (40%) *don't know / not sure*

If quite difficult / very difficult, please tell us why

17 responses

- Don't meet the criteria for target groups
- Do not know what is available as never see any information about services
- am in Dunstable but have heard Luton is better
- Did not know about them
- For working parents the times and dates are always not suitable for us to attend.
- If I was asked where someone could get 'Wellness' information, I would know for where to direct them
- Disappointing GP & customer services, incomplete & problematic referrals, information not given, etc
- Didn't know much about it
- Information on services is limited and hard to find.
- Do not know how to contact them
- sometimes not sure who to approach
- I can only be referred by GP and no mental health book in libraries other than Central library.
- you don't even hear about them
- Finding out about the courses. Usually only hear by word of mouth and then it can be too late to sign
- never tried
- Have not tried
- Was arranged by Age Concern

Q8. If you DO NOT access any wellness services in Luton, is it because: *please tick all that apply*

112 (50%) *your do not require advice or support of wellness services at present*
94 (42%) *you are not aware of what these services offer*
59 (26%) *you do not know how to access these services*
16 (7%) *other*

Other, please specify

16 responses

- Only work in Luton
- Do not live in Luton
- Hadn't thought about it!
- Services not easily accessible by BME
- Nothing available local to my house, which also fits in with my work and family priorities
- Live outside Luton
- out of area
- Do access
- live elsewhere
- I have my own wellness business / do research myself and already attend yoga for social / health wellbeing purposes.
- not a Luton resident, just work here
- n/a
- I only work in Luton - live in another local area.
- don't live in Luton
- Access national resources
- Main problem - pain

Q9. Would any of the following make you more likely to access a wellness service in Luton? *please tick all that apply*

187 (72%) *referral from your GP / healthcare professional*
64 (25%) *impartial advice and support at health and wellness service*
12 (5%) *support with speaking, reading and/or writing English*
72 (28%) *services offered during the evenings and/or weekends*
89 (34%) *services offered close to where I live*
70 (27%) *friendly / helpful staff at reception*
25 (10%) *crèche facility*
98 (38%) *practical advice that fits with my lifestyle*
8 (3%) *other*

Other, please specify

9 responses

- Would seek advice on line
- a draw down on alcohol, if a person is addicted then a ban after treatment, yes i know you can get drink anywhere
- No - this answer is not listed above
- as above
- post
- none
- Health trainer met me at sport centre - would not have joined otherwise
- Health trainer
- no

Q10. Would you be interested in taking part in further consultation to help shape the future of the Wellness Service in Luton? *please tick one box only*

85 (32%) *yes*
181 (68%) *no*

Q11. Please provide your following contact details:

name	86 – ***see attached excel file***
email address	68 (100%)
postal address	80 (100%)
postcode	77 (100%)
telephone number	45 (100%)
mobile number	54 (100%)

About you

Public Bodies have a legal duty to ensure that both services and employment are provided fairly. The following questions are voluntary, however without monitoring we cannot know whether our services are reaching all our communities or that citizens felt able to respond.

Q12. Are you? *please tick one box only*

76 (29%)	*male*
189 (71%)	*female*

Q13. If female, are you currently pregnant or have had a baby in the last 6 months? *please tick one box only*

8 (4%)	*yes*
172 (96%)	*no*

Q14. Which age group do you belong to? *please tick one box only*

9 (3%)	*under 18*	62 (24%)	*45 - 54*
16 (6%)	*18 - 24*	33 (13%)	*55 - 64*
63 (24%)	*25 - 34*	31 (12%)	*65 and over*
46 (18%)	*35 - 44*		

Q15. At present, are you? *please tick all that apply*

94 (36%)	*in full-time employment*
48 (18%)	*in part-time employment*
18 (7%)	*self-employed*
22 (8%)	*unemployed*
15 (6%)	*full-time student*
6 (2%)	*part-time student*
34 (13%)	*looking after home/family*
7 (3%)	*long term sick/disabled*
39 (15%)	*retired*
8 (3%)	*other*

Other, please specify

9 responses

- Volunteer, parent governor at school
- Carer
- 24/7 carer for my wife at our home address
- Carer
- Carer for my child
- Volunteer, parent governor
- foster carer
- do voluntary work
- volunteer at Keech Cottage Charity

Q16. Which of the following groups best describes you? *please tick one box only*

132 (51%)	*White - British*	27 (10%)	*Asian/Asian British - Pakistani*
10 (4%)	*White - Irish*	11 (4%)	*Asian/Asian British - Bangladeshi*
9 (3%)	*Other White*	2 (1%)	*Other Asian*
2 (1%)	*Mixed - White and Black Caribbean*	16 (6%)	*Black/Black British - Caribbean*
1 (0%)	*Mixed - White and Black African*	8 (3%)	*Black/Black British - African*
6 (2%)	*Mixed - White and Asian*	1 (0%)	*Black Other*
1 (0%)	*Other Mixed*	2 (1%)	*Chinese*
19 (7%)	*Asian/Asian British - Indian*	0 (0%)	*East European*
8 (3%)	*Asian/Asian British - Kashmiri*	5 (2%)	*Other*

Other, please specify

8 responses

- English
- Black Jamaican
- Caribbean Asian
- White mixed central European
- White ENGLISH
- Turkish
- Albanian
- Brazilian

Q17. Do you consider yourself to have a disability? *please tick one box only*

45 (18%)	*yes*
208 (82%)	*no*

Q18. Please state which of the following best describes your disability. *please tick all that apply*

3 (6%)	*hearing impaired/deaf*
4 (8%)	*visually impaired/blind*
26 (53%)	*physical*
21 (43%)	*emotional/mental health*
3 (6%)	*learning*
5 (10%)	*other*

Other, please specify

7 responses

- I live with cancer
- alcohol addiction
- A contractile Bladder
- Asthma Arthritis
- Diabetes
- Angina
- disc degenerative disease (spine)

Q19. Please indicate your religion/faith/belief? *please tick one box only*

124 (49%) *Christian*
0 (0%) *Buddhist*
20 (8%) *Hindu*
1 (0%) *Jewish*
59 (23%) *Muslim*
0 (0%) *Sikh*
50 (20%) *None*

Any other religion/faith/belief - please specify

7 responses

- Christian-based but not Christian
- Catholic
- spiritualist / deist
- Catholic
- Church of England
- Catholic
- Catholic

Q20. Which one of the following best describes your sexuality? *please tick one box only*

225 (96%) *Heterosexual*
3 (1%) *Lesbian*
3 (1%) *Gay man*
3 (1%) *Bi-sexual*

Appendix 2 – Results of Consultation **Agenda Item 11.1**

Wellness Services in Luton 2013 - Service user consultation
Summary results: 51 responses

1. **Do you . . . ?** *please tick all that apply*

46 (94%) *live in Luton*
9 (18%) *work in Luton*
2 (4%) *other*

Other, please specify

3 responses

- worship in Luton
- Live in Dunstable
- Retired - live in Harlington

2. **Overall, how would you rate your health?** *please tick one box only*

9 (18%) *5 - very good*
28 (55%) *4 - fairly good*
8 (16%) *3 - neither good nor poor*
5 (10%) *2 - fairly poor*
0 (0%) *1 - very poor*
1 (2%) *don't know / not sure*

3. **Please indicate which of the following wellness service(s) you currently access or have accessed over the last 2 years?** *please tick all that apply*

34 (68%) *Stop Smoking Service*
4 (8%) *Health Trainers*
1 (2%) *Alive 'n' Kicking (Child Weight Management Service)*
0 (0%) *Weight Watchers or Slimming World*
14 (28%) *Exercise Referral Programme (Active Luton)*
0 (0%) *Community cooking sessions*
2 (4%) *Alcohol services for the community*
5 (10%) *Health Checks*
3 (6%) *none / I do not access* - **go to Q9**
0 (0%) *Other*

Other, please specify

0 responses

4. **How did you hear about this/these wellness service(s)?** *please tick all that apply*

13 (28%) *my GP referred me*
9 (19%) *GP practice(s) / medical centre(s)*
4 (9%) *community centre(s)*
1 (2%) *local voluntary group(s) e.g. MIND, Impact, Alcohol Services for the community etc*
3 (6%) *gym / leisure centre*
9 (19%) *family / friends*
2 (4%) *internet / online*
0 (0%) *library*

10 (21%)	*other*
2 (4%)	*don't know/not sure*

5. How do you usually make contact them? *please tick all that apply*

23 (47%) *by telephone*
4 (8%) *internet / online*
32 (65%) *in person / visit*
1 (2%) *other*

Other, please specify

1 responses

- text

6. In your opinion, how easy or difficult is it to access wellness services in Luton at present? *please tick one box only*

31 (65%) *very easy*
10 (21%) *quite easy*
4 (8%) *neither easy nor difficult*
2 (4%) *quite difficult*
0 (0%) *very difficult*
1 (2%) *don't know / not sure*

If quite difficult / very difficult, please tell us why

3 responses

- Mobility versus location of service. Knowledge (lack of) about how you can access service. Cost of service.
- Can't get in touch by text but telephone difficult as they are so busy with clients
- Depending on service to be accessed.

7. In general, how satisfied or dissatisfied are you with the following aspects of wellness services in Luton? *please tick one box per row*

	very satisfied	*fairly satisfied*	*neither satisfied nor dis satisfied*	*fairy dissatisfied*	*very dissatisfied*	*don't know/not sure*
GP referral(s) to relevant wellness services	19 (42%)	4 (9%)	11 (24%)	1 (2%)	0	10 (22%)
reception staff friendliness / helpfulness at wellness services	26 (57%)	8 (17%)	8 (17%)	2 (4%)	1 (2%)	1 (2%)
impartial advice, information and guidance	23 (52%)	9 (20%)	8 (18%)	0	1 (2%)	3 (7%)
support with speaking, reading and/or writing English	15 (42%)	10 (28%)	6 (17%)	0	0	5 (14%)
timings of sessions / services	30 (67%)	10 (22%)	5 (11%)	0	0	0
location of sessions / services	32 (71%)	8 (18%)	5 (11%)	0	0	0
practical advice that fits your lifestyle	29 (63%)	12 (26%)	4 (9%)	0	0	1 (2%)
disability access	13 (37%)	0	3 (9%)	2 (6%)	0	17 (49%)

If fairly / very dissatisfied, please tell us why

3 responses

- very satisfied with my trainer
- Live in Dunstable so GP referral not applicable. Would like disabled a bit nearer
- language understanding

8. Do you have any suggestions on how access to wellness services in Luton can be improved? - go to Q10

8 responses

- The info is there people must want to get fit. To get the message across do you advertise on buses, hospital waiting rooms. I don't access this myself so I don't know. You may already do so.
- Improve communication between health professionals and awareness of services.
- no keep up the good work
- Not experienced it so cannot comment - need more support for blind - need to make people aware.
- no suggestions
- service currently very good no improvement
- Do like more health and fitness training and support do not know when to access, GP does not know and feels cannot pay for service.
- no

9. If you DO NOT access any wellness services in Luton, is it because: *please tick all that apply*

3 (30%) *your do not require advice or support of wellness services at present*
5 (50%) *you are not aware of what these services offer*
2 (20%) *you do not know how to access these services*
1 (10%) *other*

Other, please specify

1 responses

- Dr refused to send me on weight watchers

10. Would you be interested in taking part in further consultation to help shape the future of the Wellness Service in Luton? *please tick one box only*

23 (48%) *yes*
25 (52%) *no*

11. Please provide your following contact details:

name	24 – see attached excel file
email address	14 (100%)
postal address	24 (100%)
postcode	24 (100%)
telephone number	15 (100%)
mobile number	15 (100%)

About you

Public Bodies have a legal duty to ensure that both services and employment are provided fairly. The following questions are voluntary, however without monitoring we cannot know whether our services are reaching all our communities or that citizens felt able to respond.

12. **Are you?** *please tick one box only*

29 (59%) *male*
20 (41%) *female*

13. **If female, are you currently pregnant or have had a baby in the last 6 months?** *please tick one box only*

1 (5%) *yes*
18 (95%) *no*

14. Which age group do you belong to? *please tick one box only*

1 (2%) *under 18*
3 (6%) *18 - 24*
7 (14%) *25 - 34*
11 (22%) *35 - 44*
3 (6%) *45 - 54*
8 (16%) *55 - 64*
17 (34%) *65 and over*

15. At present, are you? *please tick all that apply*

10 (20%) *in full-time employment*
6 (12%) *in part-time employment*
6 (12%) *self-employed*
4 (8%) *unemployed*
2 (4%) *full-time student*
1 (2%) *part-time student*
0 (0%) *looking after home/family*
6 (12%) *long term sick/disabled*
17 (34%) *retired*
1 (2%) *other*

Other, please specify

1 response

- home carer

16. Which of the following groups best describes you? *please tick one box only*

28 (58%) *White - British*
1 (2%) *White - Irish*
3 (6%) *Other White*
1 (2%) *Mixed - White and Black Caribbean*
0 (0%) *Mixed - White and Black African*
0 (0%) *Mixed - White and Asian*
0 (0%) *Other Mixed*
1 (2%) *Asian/Asian British - Indian*
0 (0%) *Asian/Asian British - Kashmiri*
5 (10%) *Asian/Asian British - Pakistani*
5 (10%) *Asian/Asian British - Bangladeshi*
0 (0%) *Other Asian*
0 (0%) *Black/Black British - Caribbean*
0 (0%) *Black/Black British - African*
1 (2%) *Black Other*
0 (0%) *Chinese*
0 (0%) *East European*
3 (6%) *Other*

Other, please specify

2 responses

- Sri Lankan
- Kenyan - Indian

17. Do you consider yourself to have a disability? *please tick one box only*

14 (29%) *yes*
34 (71%) *no*

18. Please state which of the following best describes your disability. *please tick all that apply*

1 (7%) *hearing impaired/deaf*
1 (7%) *visually impaired/blind*
10 (71%) *physical*
3 (21%) *emotional/mental health*
1 (7%) *learning*
1 (7%) *other*

Other, please specify

1 response

- back and shoulder

19. Please indicate your religion/faith/belief? *please tick one box only*

28 (58%) *Christian*
0 (0%) *Buddhist*
1 (2%) *Hindu*
0 (0%) *Jewish*
9 (19%) *Muslim*
1 (2%) *Sikh*
9 (19%) *None*

Any other religion/faith/belief - please specify

1 responses

- spiritualist

20. Which one of the following best describes your sexuality? *please tick one box only*

43 (98%) *Heterosexual*
0 (0%) *Lesbian*
0 (0%) *Gay man*
1 (2%) *Bi-sexual*

Wellness Service Economic Benefit Appendix 5/Agenda Item 11.1

Measuring the cost effectiveness of health interventions

A standard and internationally recognised method to compare different treatments and measure their clinical effectiveness: the quality-adjusted life years measurement (the 'QALY').

A QALY gives an idea of how many extra months or years of life of a reasonable quality a person might gain as a result of treatment. A number of factors are considered when measuring someone's quality of life, in terms of their health, for example, the level of pain the person is in, their mobility and their general mood.

Although one treatment might help someone live longer, it might also have serious side effects. Another treatment might not help someone to live as long, but it may improve their quality of life while they are alive (for example, by reducing their pain or disability).

If a treatment costs more than £20,000-30,000 per QALY, then it would not be considered cost effective.

Cost-effectiveness of public health interventions

An assessment of the cost-effectiveness of public health interventions was conducted in 2012 by the National Institute for Health and Clinical Excellence (NICE).[1] Reviewing NICE public health guidance from 2006-2010, they concluded that the majority of the 200 cost-effectiveness estimates for public health interventions were cost effective and represented good value for money. They noted that interventions aimed at the population as a whole are among the cheapest in terms of cost per quality-adjusted life year (QALY); examples include mass-media campaigns to promote healthy eating (£87 per QALY) and legislation to reduce young people's access to cigarettes (£49 per QALY). The study found that:

- 15% of interventions were cost saving (that is, both more effective and cheaper than the comparator);
- 85% were cost effective at the threshold level of £20,000 per QALY;
- 5.5% were not cost effective at a threshold of £30,000 per QALY; and
- 5.5% were dominated, that is, are less effective and more expensive than the comparator.

Weight Management

The Eastern Region Public Health Observatory (2008) estimates costs for overweight and obesity attributable conditions will reach between £23.4 million and £56.2 million in Luton by 2015 if no action is taken. In 2015 it is predicted that it will cost Luton £6.4 million per year more to treat obesity than it did in 2007.

Value for money of weight management interventions

Weight management programmes, such as commercial slimming organisations, are highly cost effective.

Type	Intervention	Cost per QALY
Commercial slimming	Weight Watchers	£1,022
Pharmacotherapy - obesity	Orlistat	£24,431
Bariatric surgery	Gastric band, bypass	£6,289 to £8,527

Return on investment for lifestyle intervention, Public Health Commissioning Network (2010)
Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE (2006)

Potential savings of weight management programmes

Prescribing

A study by the Counterweight programme[1] looked at the increased cost of prescribing per unit of BMI in men and women and attributed 16% of the cost of prescribing to obesity. Each unit of BMI lost and maintained represents a prescribing saving.

BMI threshold*	**Cost for men**	**Cost for women**
BMI 20 baseline	£50.71	£62.59
BMI 25	£77.04 (£5.27 per unit)	£78.91 (£4.20 per unit)
BMI 30	£115.93 (£7.78 per unit)	£111.23 (£5.53 per unit)
BMI 40	£198.66 (£8.27 per unit)	£160.73 (£4.95 per unit)

*Healthy BMI range is 18.5 to <25

GP contact

People carrying excess weight have an increased number of GP contacts[2] based on patients with a BMI >30 the table below demonstrates the potential annual impact on Primary Care.

Adult population with BMI >30	40,000
Average number of GP consultations per year per patient	4
Total number of GP contacts for people with BMI >30	160,000
% additional contacts due to BMI >30	64.00%
Additional contacts due to BMI >30	102,400

Overall savings of commercial weight management programmes

The study 'Computer Modelling the Health and Economic Outcomes of the Weight Watchers GP Referral Scheme[3]' used a model to simulate individuals with varying changes in obesity level predicted on interventions to affect those changes. These individuals suffer disease according to their age and sex but also their current obesity level and existence of other conditions such as diabetes and hypertension, whether related to existing obesity or not. It estimated a health saving of £1,860 per intervention person. However, accounting for attrition and changes in BMI over time, the researchers estimate a realistic saving of £232 per referral over the lifetime of the individual. This is compared to the cost of £60 per 12 week referral, or £120 per patient if they complete 24 weeks.

Cost savings for Luton

Cost savings calculated using the NICE costing templates (2006/2010) and the 'Computer Modelling the Health and Economic Outcomes of the Weight Watchers GP Referral Scheme' study. Savings* based on estimates of variable uptake of the programme (900 then rising to 1300 per year) and impact on surgical and prescribing savings. It does not include savings related to prevention.

	Year 1 impact of savings £'000	**Year 2 impact of savings £'000**	**Year 5 impact of savings £'000**	**Year 10 impact of savings £'000**	**Year 20 impact of savings £'000**
GP consultations & prescriptions	19.51	23.48	19.51	19.51	19.51
Obesity related surgical intervention avoided	5.70	5.70	5.70	5.70	5.70
Ongoing savings for reduced expenditure on diseases related to overweight and obesity	15.47	25.52	45.63	86.61	163.94

[1] Journal of Health Services Research & Policy Vol 13 No 3, 2008: 158–166

[2] Cost impact on the NICE guidance on obesity, NICE, 2010

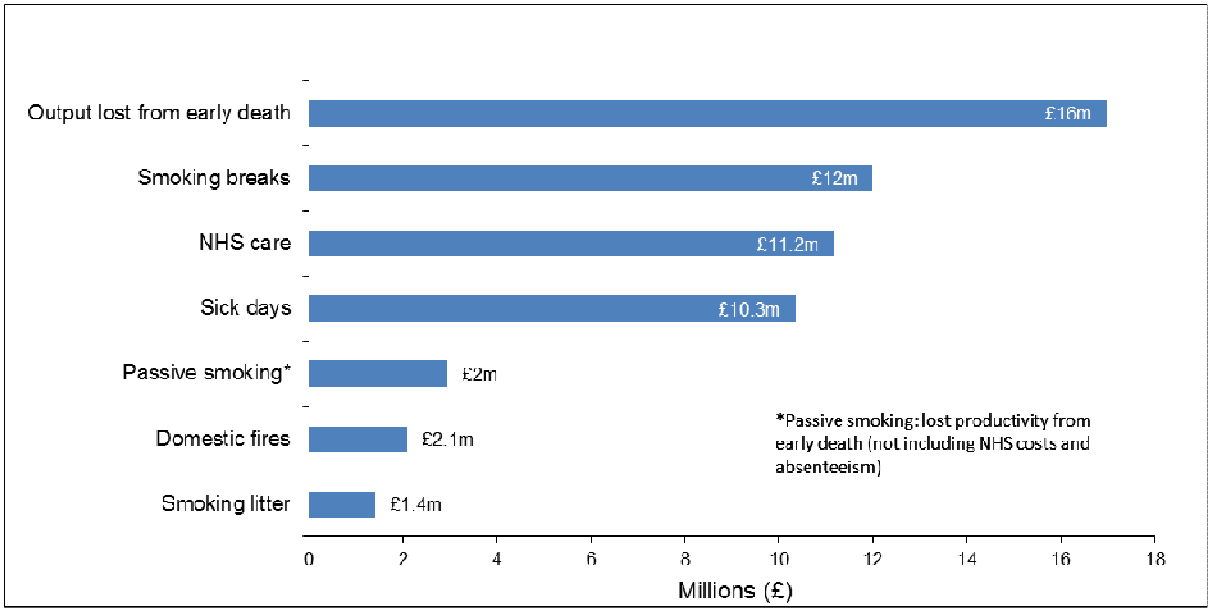
[3] Computer Modelling the Health and Economic Outcomes of the Weight Watchers GP Referral Scheme. M Brown and K McPherson. *Obesity Facts.* 2:115, 2009

Total estimated annual savings	**40.68**	**54.70**	**70.84**	**111.82**	**189.15**

*Assuming 30 years average remaining life.

Smoking cessation

The wider cost of tobacco in Luton (Estimated values from ASH ready reckoner, 2011) and benefits for LBC



The Wellness Service plays an important role is reducing smoking prevalence and tobacco use through providing a Stop Smoking Service. Direct related savings due to health costs are outlined below.

Avoided events for Stop Smoking Service treated smokers only over a five year period (Mott McDonald economic model)	
CHD	41
Cerebrovascular	2
Other	58
Savings (Net)	£85,500.00

Savings made if 75 pregnant women are supported to quit smoking (NICE costing template).

Details	Cases due to smoking [1]	Total cost £
Maternal complications		
Ectopic pregnancy	0.7	756.7
Premature rupture of membrane	5.58	14948.82
Placenta praevia	0.28	1366.29
Abruption placenta	0.28	750.12
Pre-term delivery	3.28	8787.12
Pre-eclampsia	-0.42	-1125.18
Total maternal complications	**9.93**	**25483.87**
Infant complications		

Low birth weight	3.92	3410.4
Respiratory distress	1.67	1452.9
Sudden infant death syndrome (SIDS)	0.91	791.7
Total infant complications	**6.5**	**5655**
Total savings	**16.43**	**£31,138.87**

Physical activity

In the UK, physical inactivity causes:

- 10.5% of coronary heart disease cases
- 18.7% of colon cancer cases
- 17.9% of breast cancer cases
- 13.0% of type 2 diabetes cases
- 16.9% of premature all-cause mortality[4]

Physical activity has many health and social benefits and can:

- prevent ill health and reduce the number of people dying prematurely
- enhance mental health, quality of life and self-reported wellbeing
- delay the need for care in older adults (age 65+)
- reduce health inequalities and improve wider factors influencing health and wellbeing.

Four commonly used methods to increase physical activity from the NICE public health guidance review.

Intervention	Median cost (£) per QALY
Interview	84
Exercise prescriptions	77
Interviews with exercise voucher	227
Intensive interviews	105
Exercise prescription and exercise information	425

Cardiovascular risk

The table below shows the potential cost benefit of providing the Health Checks programme. From experience, the community Health Checks are an important opportunity to engage with people who wouldn't normally visit their GP or attend for a Health Check.

Health Check determines a person's risk of developing diabetes or heart disease or having an event such as a heart attack or stroke over the next ten years. By reducing risk through interventions targeted at those people at highest risk, it is possible to prevent or delay the onset of disease and disability.

In 2013/14 the Council is expected to deliver over 7000 Health Checks, which equates to at least 1120 people eligible for referral to a lifestyle intervention programme. Using the national Health Check ready reckoner, Luton could expect to see 446 additional people completing a weight management programme through this route alone.

[4] Lee I, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT, for the Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: An analysis of burden of disease and life expectancy. The Lancet. 2012;July 2012:9-19.

% population at risk of vascular events (>2% pa)	% likely uptake of screening	Costs of screening (£1000s)	Events over next 5 years	Savings (£1000s) if programme reduces risk by:		
				25%	40%	60%
5	4	140	412	25	124	256

Calculated by Gerard Abi-Aad at the Healthcare Commission from NICE lipid modification template data.

Public Health

Wellness Service Project Board

TERMS OF REFERENCE

Version:	1.03
Approved by:	CLMT (11/4/13) Luton Borough Council (LBC)
Date of approval:	
Review date:	2 months from first meeting

Remit of the Wellness Project Board (WPB)

- To deliver a Wellness Service for the citizens of Luton.
- To provide project direction for the planning and implementation of the Wellness Service.
- To champion the vision for the Wellness Service as an *'integrated healthy lifestyle service, based on 'wellness' principles for Luton citizens, in order to reduce health inequalities through better service integration by moving resources towards prevention and early intervention and away from avoidable treatment and care'.*
- To ensure that relevant strategic priorities from the Health and Wellbeing Strategy are implemented on behalf of the Wellness Service.
- To ensure that an informed business case is prepared for the Wellness Service.
- To identify service providers and manage the procurement process for the Wellness Service.
- To ensure that any issues are resolved in a collaborative, open and honest manner.
- To ensure that appropriate bodies and organisations are communicated to in respect of the Wellness Service, including tendering organisations.
- To ensure that any data protection and information sharing issues between stakeholders are fully resolved, within an appropriate governance framework.
- To ensure that the delivery model for the Wellness Service is appropriately financed.
- To ensure that the delivery model for the Wellness Service is developed with reference to the agreed organisational benefits and wider programme drivers.
- To be accountable to the Luton Borough Council (LBC) Health and Wellbeing Board.

Relationship to other groups

The WPB acts as a delivery group, taking strategic direction from the Health and Wellbeing Board.

Responsibilities

The WPB has responsibility for:

- Implementing and delivering the Wellness Service in line with the project mandate (PSU document), including the procurement process to identify of a new service provider.
- Overall direction and management of the project within the project remit.
- Ensuring the project remains on course to deliver.
- Reporting progress periodically to the Health and Wellbeing Board.
- Management of project risk, including change control and exception planning.
- Project communications (publicity and dissemination of information).
- Ensuring the strategic priorities and business benefits for the Wellness Service are delivered.
- Proposing and seeking approval on project budgets for the Wellness Service.
- Reflecting the interests of all stakeholders who will be involved in delivering the Wellness Service including all business, user and supplier interests.
- Board members are required to update their respective business areas following meetings
- Board members are required to represent the interests of their business area in a collaborative and open manner to ensure that decision are made on an impartial basis in the interests of delivering the vision of the Wellness Service for LBC.
- Decision making – requires a 2/3 quorum of board members. Final sign off on decision making rests with LBC Executive.

Membership

Role	Name
Project Sponsor	Morag Stewart, Deputy Director, Public Health
Public Health team members	Olena Sawal
	Sue Hazleton
	Stuart Lines
Project Manager	Sue Dimmock, Luton Excellence Team
CCG members	Rod While, Management Lead
	Dr Sahadev Swain, Clinical Lead, Prevention
Healthwatch champion	Beth Gregson-Allcot
Healthwatch champion	Maria Collins
Housing & Community Living representative, LBC	Sarah Rowe, Supporting People Manager
Children & Learning representative, LBC	Stephanie Cash, Commissioning Manager
Environment & Regeneration representative, LBC	Paul Adams, EH & Interim Econ. Dev. Manager
Local Strategic Partnership Manager	Bren McGowan
Minute taker / meeting co-ordinator	Jane Glenister
The following service specialists will be called to meetings as required:	
Procurement adviser	Phil Hucklesby
HR representative (for TUPE advice)	Anne Davies
Finance representative	Aklakur Rahman
Communications representative	Rob Leigh; Fiona Mair
Consultation representative	Farah Ismail

Absences

If members are unable to attend meetings they should inform the Meeting Co-ordinator and Project Manager at the earliest opportunity. If appropriate, they should arrange for a deputy to represent them. The deputy should have sufficient authority and knowledge to speak on behalf of the business area they represent.

Frequency of Meetings

Weekly at start-up or as dictated by need.

Standing agenda items

To be agreed

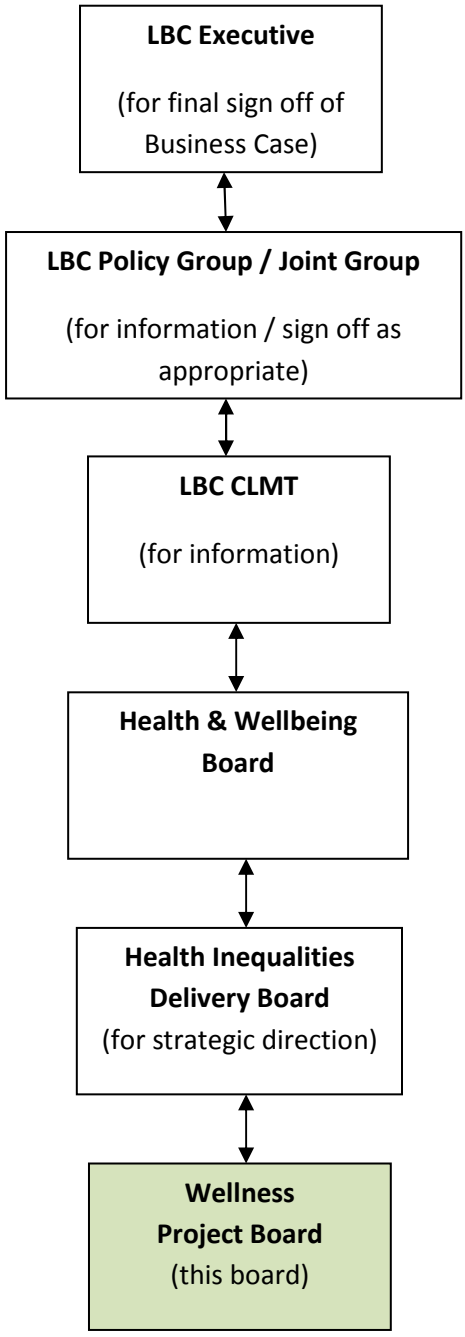
Minutes

Minutes of all meetings will be recorded and agreed at the next meeting as a true and accurate record of proceedings. A copy of the agenda, minutes, reports and any supporting documents will be placed on file for information or audit purposes.

Notes:

Terms of Reference to be reviewed at the first meeting of the WPB.

Wellness Project Board – Strategic Governance



Wellness Timetable

Date	Activity
18th March 2013	PSU signed off, business case commenced
5th April 2013	Project Initiation Document ready for CLMT
10th April 2013	Public consultation exercise commences
11th April 2013	Project Initiation Document to CLMT
10th May 2013	Public consultation exercise closes
Mid - late May 2013	Pre-tender market engagement with potential suppliers (soft market testing, one month)
31st May 2013	Consultation report completed
5th June 2013	Outcomes specification finalised from public consultation exercise
7th June 2013	Full Business Case ready for CLMT (incorporating consultation results)
13h June 2013	Full Business Case to CLMT (incorporating consultation results)
2nd July 2013	Full Business Case ready for Policy Group
9th July 2013	Full Business Case to Policy Group
9th or 10th July	Paper for Health & Wellbeing Strategy
17th July 2013	Presentation to Health & Wellbeing Board (tbc)
Early August 2013	Tender specification prepared and ready for sign-off (by Project Board)
Mid August 2013	Prepare OJEU advertisement and PQQ
13th August 2013	Full Business Case ready for Executive
27th August 2013	Full Business Case to Executive
Early September 2013	OJEU tender notice issued (37 days)
Mid September / early October	Request TUPE information
Mid October 2013	Evaluate PQQ or Expressions of Interest (14 days)
Mid October 2013	Information workshop / dialogue with potential suppliers
Late October 2013	Issue Invitations to Tender (40 days)
Early December 2013	Evaluate ITTs (14 days minimum, 4 weeks elapsed for Christmas)
Early January 2014	Site visits (if required). Notification of presentation dates to suppliers
Mid January 2014	Presentations by suppliers (if required, 2 weeks elapsed)
Early Febraury 2014	Agreed supplier finalised (+10 days cooling off)
Mid February 2014	Contract awarded (*this allows for a 3 month service establishment time). Where necessary, (e.g. Stop Smoking) costings and existing contract end dates will need to reflect this).*
Mid May 2014	Contract start date

Date	Activity	Key Comms Activities
18th March 2013	PSU signed off, business case commenced	
5th April 2013	Project Initiation Document ready for CLMT	
10th April 2013	Public consultation exercise commences	
11th April 2013	Project Initiation Document to CLMT	
10th May 2013	Public consultation exercise closes	
Mid - late May 2013	Pre-tender market engagement with potential suppliers (soft market testing, one month)	Premarket tender questionnaire and letters to potential providers. Dates for site visits agreed and set in diaries.
31st May 2013	Consultation report completed	Report will be used to develop marketing information for press and web release
5th June	Outcomes specification finalised from public consultation exercise	
7th June 2013	Full Business Case ready for CLMT (incorporating consultation results)	
13h June 2013	Full Business Case to CLMT (incorporating consultation results)	
2nd July 2013	Full Business Case ready for Policy Group	
9th July 2013	Full Business Case to Policy Group	
Early August 2013	Tender specification prepared and ready for sign-off (by whom???)	
13th August 2013	Full Business Case and tender specification ready for Executive	
27th August 2013	Full Business Case and tender specification to Executive	
Early September 2013	OJEU tender notice issued (37 days)	Advertisements in relevant publications
Mid September / early October 2013	Request TUPE information	
Mid October 2013	Evaluate PQQ or Expressions of Interest (14 days)	
Late October 2013	Issue Invitations to Tender (40 days)	
Early December 2013	Evaluate ITTs (14 days minimum, 4 weeks elapsed for Christmas)	
Early January 2014	Site visits (if required). Notification of presentation dates to suppliers	If required, dates agreed with suppliers
Mid January 2014	Presentations by suppliers (if required, 2 weeks elapsed)	
Early Febraury 2014	Agreed supplier finalised (+10 days cooling off)	Press and web releases
Mid February 2014	Contract awarded (*this allows for a 3 month service establishment time). Where necessary, (e.g. Stop Smoking) costings and existing contract end dates will need to reflect this).*	New provider takes on responsibility for communication activities relating to the Wellness Service
Mid May 2014	Contract start date	Local press releases counting down to new service; posters; flyers in VCS and community groups; radio advertisements???

Wellness

STAKEHOLDER COMMUNICATION STRATEGY

June 2013

V03

Plan owner

Morag Stewart, Deputy Director, Public Health

Background

A number of existing Public Health lifestyle service contracts come to an end in March 2014. A business case is being developed to propose re-commissioning services under one provider as an integrated wellness service, to improve service outcomes.

Wellness can be defined as a proactive, preventive approach that emphasises the whole person and works to achieve optimum levels of physical, mental, social and emotional health. Factors such as good nutrition, proper weight control and exercise all play a role in wellness as do controlling risk factors such as smoking, alcohol and drug abuse. Wellness services could provide an effective response to frequent attendees in primary care by tackling the underlying causes of their visits which are best addressed when tackled holistically.[1]

Luton's JSNA identified a number of health and wellbeing priorities, including:

- Reducing obesity, smoking and alcohol related harm
- Reducing variation and improving outcomes in general practice
- Promoting independent living
- Improving mental health

These priorities are taken forwards in the Health and Wellbeing Strategy to reduce health inequalities through better service integration and through moving resources towards prevention and early intervention and away from avoidable treatment and care. The Wellness Service will form an integral part of delivering this strategy.

The communication aim

[1] From illness to wellness, NHS confederation briefing Oct 2011, issue 224

This communications strategy aims to:

- Help develop awareness of the Wellness project within LBC and amongst external stakeholders.
- Support the Wellness public consultation exercise (underway).
- Support and compliment the rollout of the new Wellness Service.
- Provide a structured approach to communications between the Wellness project board and its stakeholders.

Time scale

12 months initially to cover the project implementation, consultation; pre-market engagement and OJEU procurement phases.

Key business-related messages to communicate

The Wellness Service is a new approach which will assess holistic needs on an individual basis ('one stop shop' approach), rather than signposting people between services without any joint assessment of needs, as at present.

Luton's Wellness Service vision is *"to reduce health inequalities through better service integration and through moving resources towards prevention and early intervention and away from avoidable treatment and care".*

The Wellness Service will deliver a range of consistent advice, guidance and tailored intervention services on key lifestyle issues, to improve health and to address:

- Diet and nutrition
- Physical activity
- Weight management (for adults and children)
- Smoking

- Alcohol
- Mental wellbeing

The service will also offer:

- Community health checks
- Volunteer Community Health Champions
- Clear referral pathways to:
    - other preventative / treatment services such as mental health; sexual health; drugs and alcohol
    - primary healthcare services (e.g. GPs)
    - social health services (e.g. debt, housing and benefits crisis services)

Key underlying messages (to embed in all communications, where possible)

Customer benefits:

- Improved customer journey designed around needs and delivered through a variety of access channels (e.g. web; face to face; telephone etc)
- Easier access to a wide spectrum of co-commissioned and co-located services
- Easier signposting to referral services (primary and secondary care)
- Access to appropriately designed, improved and targeted self-service / self-help capability
- Face to face service provision and access, where required
- Holistic assessment of individual needs
- Improved health and wellbeing
- Improved mental wellbeing

LBC benefits:

- Improved service delivery to customers, in keeping with corporate priorities
- Mid to long-term savings through prevention and early intervention

- Long term cost avoidance of expensive primary treatment and ongoing social care
- Reduction in cost of short and long term care for Luton residents
- Improved health outcomes for Luton residents, defined through a reduction in obesity, smoking and alcohol related harm (through brief intervention or referral)
- Improved cost-effective commissioning of advice and guidance services with clearer outcomes for customers and commissioners alike
- Service efficiencies through rationalisation of duplicated service provision (administration)
- Joined up, cost-effective service provision

Partner benefits:

- Joined up, cost-effective service provision
- Single point of contact to wellness services
- Clear referral pathways
- Improved health outcomes for Luton residents
- Improvement in general practice outcomes
- Increased use of social prescribing
- Reduction in appointments and prescribing
- Long term cost avoidance of expensive secondary care

Stakeholders and means of influence

Wellness Stakeholders	Contact	Level of interest now	Level of interest required	Their level of influence	How to influence them?
Existing Service Providers					
Cambridge Community Services		M	H	L	Pre-market tender; web and news releases; PQQ and ITT
Weight Managemet Centre		M	H	L	
SEPT		M	H	L	
Weight Watchers		M	H	L	
Active Luton		M	H	L	
Members of Public					
Existing service users		M	H	M	Web and news releases
Non-service users (target groups are areas of socio-economic deprivation; BME communities and those with physical or learning disabilities and / or mental health conditions)		L	H	M	
Clinical Commissioning Group		H	H	M	Board meetings; presentations
Primary Care Staff (GPs, Pharmacies etc)		L	H	L	CCG; web and news releases
LBC					
LBC Executive	Trevor Holden	L	H	H	Intranet; one to one and board / group meetings
	Pam Garraway	H	H	H	
	Gerry Taylor	H	H	H	
	Martin Pratt	H	H	H	
	Colin Chick	L	H	H	
	Robin Porter	L	H	H	
Staff		L	M	L	
Member lead	Cllr Ashraf	M	H	H	
Health and Wellbeing Board		H	H	H	
Health and Wellbeing commissioners		L	M	L	
Other interested parties					
Luton Access		M	H	M	Web and news releases
Luton Culture		L	H	M	
MIND BLMK		H	H	L	
Luton Irish Forum		H	H	L	
Other potential providers (not yet aware)	CCS; WMC; SEPT; Active Luton	M	H	L	

Target audiences

For the consultation exercise:

Groups / Organisations
General Public (on-line consultation)
Via Economic Development Service, VCS organisations including Health, Welfare, Youth, Elderly, Advice, Sports, Arts, Conservation, Housing, Lunch Clubs, Social Clubs, Schools, Colleges, University of Luton, Nurseries, After School Clubs, Tenants Groups, Residents Assoc's, Police, Families, Disability, groups working to represent different communities, Radio Stations, Churches and Faith groups, training and learning, women's groups, domestic violence, film makers, martial arts, debt advice
Reception Unity House
Reception Town Hall
LBC staff who live in Luton
Children's' Centres (Stay & Play Groups)
Discover Islam; Council of Faiths and Council of Mosques
CYCD, Khidmat and Ghar Se Ghar
Community Centres - Lewsey; Farley; Dallow; Marsh Farm; Hightown
BME Lunch Clubs
Disability Resource Centre
Blue badge holders
Sight Concern
Age UK
British Red Cross
Area Dean of Luton
Luton Central Library (and area libraries)
Volunteer Health Champions
MIND BLMK
Healthwatch (Luton Irish Forum)
Doctor's Surgeries (Practice Managers and CCG extranet)

Potential providers for pre-market tender exercise:

Organisation	Details
Existing Service Providers	Cambridge Community Services; SEPT; Weight Management Centre
Cafe West - Bradford	http://www.cafewest.org.uk/
Health Exchange	http://www.healthexchange.org.uk/
MyTime Active	http://www.mytimeactive.co.uk/
The Healthy Living Centre - Bucks	http://healthylivingcentre.com/
LiveWell	http://www.livewelluk.org/
Local VCS organisations who may have an interest in bidding	Luton Irish Forum, Active Luton; MIND
Existing service providers	Cambridge Community Services; Weight Management Centre; SEPT; Active Luton

For non-continuance of services:

Existing Service Providers
Cambridge Community Services
Weight Management Centre
SEPT
Weight Watchers
Active Luton

General:

LBC (Director Lead, Gerry Taylor)
Councillors (Cllr Ashraf Lead on Public Health)

Health & Wellbeing Board
Staff

Timeline

The project communications plan is listed overleaf together with an indication of relevant communications activities

Date	Activity	Key Comms Activities
18th March 2013	PSU signed off, business case commenced	
5th April 2013	Project Initiation Document ready for CLMT	
10th April 2013	Public consultation exercise commences	
11th April 2013	Project Initiation Document to CLMT	
10th May 2013	Public consultation exercise closes	Identifiation of what the public want from the service to inform the service specification
Mid - late May 2013	Pre-tender market engagement with potential suppliers (soft market testing, one month)	Premarket tender questionnaire and letters to potential providers. Dates for site visits agreed and set in diaries.
31st May 2013	Consultation report completed	Report will be used to develop marketing information for press and web release
5th June	Outcomes specification finalised from public consultation exercise	
7th June 2013	Full Business Case ready for CLMT (incorporating consultation results)	
13h June 2013	Full Business Case to CLMT (incorporating consultation results)	
2nd July 2013	Full Business Case ready for Policy Group	
9th July 2013	Full Business Case to Policy Group	
Early August 2013	Tender specification prepared and ready for sign-off (by whom???)	
13th August 2013	Full Business Case and tender specification ready for Executive	
27th August 2013	Full Business Case and tender specification to Executive	
Early September 2013	OJEU tender notice issued (37 days)	Advertisements in relevant publications
Mid September / early October 2013	Request TUPE information	
Mid October 2013	Evaluate PQQ or Expressions of Interest (14 days)	
Late October 2013	Issue Invitations to Tender (40 days)	
Early December 2013	Evaluate ITTs (14 days minimum, 4 weeks elapsed for Christmas)	
Early January 2014	Site visits (if required). Notification of presentation dates to suppliers	If required, dates agreed with suppliers
Mid January 2014	Presentations by suppliers (if required, 2 weeks elapsed)	
Early Febraury 2014	Agreed supplier finalised (+10 days cooling off)	Press and web releases
Mid February 2014	Contract awarded (*this allows for a 3 month service establishment time). Where necessary, (e.g. Stop Smoking) costings and existing contract end dates will need to reflect this).*	New provider takes on responsibility for communication activities relating to the Wellness Service
Mid May 2014	Contract start date	Local press releases counting down to new service; posters; flyers in VCS and community groups; radio advertisements???

Finance

At present, no funding is earmarked specifically for internal or external communications relating to Wellness.

Evaluation

Evaluation of the strategy will initially be through:

- Responses received to the Wellness public consultation exercise (ended on 10th May 2013).

Links

This strategy and the corresponding action plan will link with and support key messages in the communication plans for:

Public Health
Health and Wellbeing Board

SJD
24/6/13

Wellness: outline communications plan (phase 1) **Appendix 9 – Agenda item 11.1**

Objectives

- present the concept, including aims, objectives and benefits, to service users, potential service users, health care partners and the public at large
- maintain open, positive communications with stakeholders, particularly current service providers
- minimise the risk of any negative response, misinformation or media criticism
- provide a solid foundation of information to support the tendering process

Key messages

- a bold new approach to promoting and enabling healthy living
- offers clear, convenient access to local citizens
- better integrates specialist services (eg smoking cessation, weight control & nutrition, exercise, addressing alcohol misuse) to benefit service users in a proper, holistic way
- ensures that limited resources deliver the maximum health benefits
- helps us better track service uptake and outcomes, enabling better targeting of resources in the future

Key audiences

- healthcare partners
- stakeholders, particularly current service providers and groups/individuals who have taken part in consultation programmes to date
- third sector partners, particularly via the Luton Forum
- members
- MPs
- Whitehall and national local government and healthcare organisations

Collateral

- a well-designed 'e-mailer', briefly describing concept to third sector groups and inviting further questions/comments (distributed via Local Strategic Partnership's mailing lists)
- if required - 'script' for presentations to third sector groups (Luton Forum) and well designed supporting *Powerpoint* material and briefing note
- dedicated pages on LBC's website, hosting report and consultation results, etc
- a well designed introductory brochure/prospectus that can be mailed electronically to target audiences
- briefing material for members and MPs
- carefully crafted covering emails linking brochures and briefings etc with partners and stakeholders
- news release(s) and media briefing material
- media briefing for portfolio holder and lead officer(s)

Timescale

Now until mid May 2014, as per the timetable in the main *Wellness* report. But immediate priorities:

- (early) June: website, e-brochure, presentational material prepared
- July: updates for stakeholders and partners, presentation to Luton Forum, briefing for members
- briefing for portfolio holder and lead officer(s); July/August local media launch

The website and e-brochure could then be deployed to support the tendering process.

Resources

- design in-house, therefore no cost
- most collateral electronic, therefore minimal print cost (c £500 maximum)
- appropriate library pictures would be useful: c.£500
- email addresses of partners, stakeholders and, if/where possible, consultees

Key information requirement

What data do we hold about the take up of the services that will be replaced?

Phase 2

Will update partners, stakeholders and the local media on tendering progress and will be developed as appropriate to support introduction of the new contractor and the hand-over process.

Rik Hammond , transformation communications lead, Luton Excellence, 54 64 14 May 2013

An integrated *wellness service* for Luton

Introduction and overview June 2013

LUTON BOROUGH COUNCIL

The opportunity...

The contracts for a number of public health and lifestyle services come to an end next March.

These include information, advice and help with diet & nutrition, exercise, weight management and stopping smoking.

Currently, such services are all provided by different agencies. This makes it difficult to deliver the right combination of help, properly tailored to meet people's individual needs.

Residents often end up being signposted between different services and, along the way, just drop out of the system.

Now we have a chance to look at alternatives. In particular, we see an opportunity for one agency to run a fully integrated *wellness service* - a proper one stop shop that can deliver health support to the maximum number of Luton people in the most cost-effective way.

The vision and the objectives...

It is well documented that lifestyle issues contribute to poor health outcomes. Luton is no exception in this respect. Hence, an integrated approach is now a council priority when it comes to commissioning healthy lifestyle services.

Our vision for a new 'integrated wellness service' is to: *reduce health ineqaulities through better service integration, moving resources away from avoidable treatment and care and towards prevention and early intervention.*

We also see it helping to deliver some of the priorities in Luton's health and wellbeing strategy, including a healthy start in life for children and yound people, reducing the health inequality gap and healthier, more independent adults and older people.

In particular, we need to:

- decrease health risks and prevent the onset of disease
- divert residents from primary and secondary care to prevention pathways
- help contain rising healthcare costs

The new service...

We see the new integrated wellness service delivering a range of advice, guidance and tailored interventions on key lifestyle issues to improve health and address:

- diet and nutrition
- physical activity
- weight management (for children and adults)
- smoking
- alcohol misuse
- mental wellbeing

The service could also offer:

- NHS community health checks
- volunteer community health champions
- clear referral pathways to and from other health and social care services

What we are looking for...

We want the new integrated wellness service to:

- provide good, consistent healthy lifestyle advice for Luton residents

- improve access to wellness services for people in the town, particularly priority groups such as BME communities and people with disabilities

- increase uptake of wellness services and enable more people to make positive lifestyle changes and become more physically active

- reduce the number of residents at risk of developing long term conditions

- increase the uptake of NHS health checks

- establish effective referral pathways and increase referrals from primary and secondary care services

- increase the number of staff trained to deliver brief interventions

The benefits...

The integrated wellness service could deliver a number of important benefits, including:

- improved access to wellness services through a single point of contact
- savings in the mid to long term through prevention and early intervention
- long term cost avoidance of expensive treatment and ongoing social care
- improved health outcomes for Luton residents
- improved, more cost-effective, commissioning of advice & guidance services
- service efficiencies through better, joined-up working and by avoiding duplication

The plan...

We have already carried out some initial 'soft market testing' to get a better idea of potential providers who would be interested in pitching to run an integrated wellness service in Luton.

We are now studying the results of some public consultation we carried out in May. This will inform the business case we will put before councillors later this summer.

At the moment, there are four possible options. These are detailed in our business case summary, a copy of which can be downloaded from: www.luton.gov.uk/wellness

Depending on the proposal that members finally choose, it is likely that we will invite tenders this September. The entire process could take around four to five months.

By mid January 2014 we should have completed our evaluation of all the bids. We anticipate awarding the contract by mid February.

If everything goes to schedule, the new service could be up and running by May 2014.

This is but a brief overview.
For more details: www.luton.gov.uk/wellness

LBC public health team
4th floor
Unity House
Luton LU1 5NP

morag.stewart@luton.gov.uk
01582 54 84 38

LUTON
BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD	AGENDA ITEM: 11.2

DATE OF MEETING: **17th JULY 2013**

REPORT AUTHOR & CONTACT NUMBER: **Nikki Middleton 01582 547253**

SUBJECT: **Tackling the Street Sex Trade**

WARD(S) AFFECTED:

The strategy is borough wide however the ward most affected by the on street sex trade is High Town although this activity has also been identified in South and Biscot wards.

PURPOSE

1. To seek the HWB endorsement of the Community Safety Partnership's Street Sex Trade Strategy's overall objective and four strand approach.

RECOMMENDATION(S)

2. The HWB is recommended to agree and endorse the strategic objective and approach.

BACKGROUND

3. Tackling the Street Sex Trade is the first dedicated prostitution strategy developed by soLUTiONs, Luton's Community Safety Partnership (CSP).

   The strategy has been developed as a result of growing concerns articulated by partners, residents and businesses about the impact of prostitution on both the town and its communities.

4. The original intention of the CSP was to develop a strategy to deliver a significant and sustainable reduction in the on-street sex trade. However this has subsequently been revised to reflect a more ambitious goal; that of removing the on street sex trade from Luton within 5 years.

5. The CSP has therefore undertaken a review of effective practice and the varying approaches to tackling the issue of the on-street sex trade adopted by other community safety partnerships. To date, Ipswich has been identified as the only area to have successfully adopted a strategy with the stated objective of actually removing the on-street sex trade. Consequently the CSP has been keen to learn from their experience and success and in May 2013 undertook a Peer Review with colleagues from Suffolk.

6. While it is evident that Luton will not be able to replicate the high level of additional resources that were available to support the Ipswich strategy, the CSP is confident that through a combination of mobilising and reconfiguring existing resources and the provision of some additional resource funded by the Public Health Grant it will be possible to develop a Luton model which adopts and emphases best practice to deliver successful outcomes in Luton.

REPORT

7. The stated overall aim of the strategy is:

   To protect our communities and residents from the nuisance and harm associated with the on street sex trade, by engaging in sustained and co-ordinated multi agency initiatives to remove the on-street sex trade from Luton by 2018.

8. The strategy details four strands of activity to be undertaken by partners to achieve this objective:

   - Tackling Demand
   - Developing routes out of sex work for those already involved
   - Prevention
   - Ensuring Justice

IMPLICATIONS

9. The strategy's stated objective to remove on-street prostitution from Luton in five years is a bold one. The successes achieved by Ipswich resulted from a significant and sustained increase in resources to tackle the issue including nightly police patrols to deter kerb crawlers and the development of a dedicated multi-agency team to support the women.

   To achieve this objective it will be necessary for sustained activity and resources to be targeted at this issue over the five year period. Specifically this requires an ongoing commitment from Bedfordshire police to target kerb-crawlers and other criminal activity related to the on-street sex trade.

   If this does not occur then it is unlikely the strategy's stated aim will be achieved and there is a reputational risk for all parties involved. This is heightened by the high level of public and media interest in this issue.

10. The strategy acknowledges that in removing the on-street sex trade from the town there is a possibility of increasing off-street activity. Whilst this is generally considered to be a

less harmful form of prostitution both for residents and those selling sex it will be necessary for agencies to be alert to possible risks relating to exploitation and abuse.

CONSULTATIONS

11. The strategy has been subject of discussion with key agencies within the Community Safety Partnership structure and by LBC's Corporate Leadership Management Team. It will also be considered by the Overview and Scrutiny prior to final sign off by Executive on the 29th July. The Strategy is also due to be presented at both Luton Safeguarding Boards for approval.

The development of the strategy has been informed by a multi-agency officer group including senior representatives of the LBC, Bedfordshire Police, Beds Probation Trust and Public Health.

This work has also been informed by a community reference group which includes academics from the University of Bedfordshire, Elected Members from the affected wards, Olly Martins Police and Crime Commissioner, Gavin Shuker MP and representatives from Drug and Alcohol Services and voluntary sector organisations which work directly with women who sell sex.

The Community Safety Partnership has also consulted with High Town Against Prostitution, a resident led organisation and held public meetings to discuss the issue and the approach being taken to resolve this.

An IIA is also in the process of completion.

At the time of submitting this report the strategy remains in the final stages of consultation and it is expected that further changes to the document will be made.

APPENDICES

12. The following appendices are attached to this report: (If any)

Appendix 1 – Tackling the Street Sex Trade Strategy

LIST OF BACKGROUND PAPERS
LOCAL GOVERNMENT ACT 1972, SECTION 100D

None.

TACKLING THE STREET SEX TRADE

A MULTI-AGENCY STRATEGY FOR LUTON

Version Control	
Date	5/07/2013
Version	2.3

Contents

Introduction

Local Background

The National Policy Context

Developing the Strategy

Our Aims

Strands of Activity

Tackling Demand

Developing Routes Out

Prevention

Ensuring Justice

Engaging with the Community

Delivering the Strategy

Resourcing the Strategy

Tackling the Street Sex Trade Action Plan

Governance and Accountability

Street Sex Trade Operational and Tactical Group

Street Sex Trade Reference Group

Sources

Introduction

Tackling the Street Sex Trade is the first dedicated prostitution strategy developed by soLUTiONs, Luton's Community Safety Partnership (CSP).

The strategy has been developed as a result of growing concerns articulated by partners, residents and businesses about the impact of prostitution on both the town and its communities.

Prostitution is most commonly defined as the exchange of sexual services for some form of payment (usually money or drugs). This can take place on the street or in massage parlours or saunas, through escort agencies or at private addresses.

It is difficult to be precise about the scale and prevalence of prostitution in the U.K, however we know that it exists in most towns and cities, sometimes on the street, but also in commercial premises and private residential properties. The Home Office has estimated that there could be as many as 80,000 people involved in prostitution in the UK with up to 70% entering into the sex trade as children or young people[1]. Prostitution takes place in a variety of ways and involves both men and women, girls and boys. Those involved are far from a homogeneous group, however common characteristics include:

- History of Abuse: As many as 85% of those involved in prostitution report physical abuse in the family, with 45% reporting familial sexual abuse.
- Homelessness: Many report having run away from home, or having suffered periods of homelessness.
- Problematic Drug Use; as many as 95% of those involved in street-based prostitution are believed to have significant substance misuse problems[2].
- History of poor school attendance and being in care.

Local Background

Luton is a large urban authority consisting of 19 wards with a population of approximately 202,500. The town has greater similarities to inner city communities than to the surrounding towns and cities in its region.

The town is ethnically diverse, with just over one third of the population being of Black and Minority Ethnic (BME) origin with significant Pakistani, Bangladeshi, Indian and

[1] Paying the Price: a consultation paper. Home Office 2004
[2] Church et al. 2001

African Caribbean communities. The diversity of the population has recently increased both with the arrival of foreign students and the migration of citizens from other EU countries, notably Poland and other Central and Eastern European countries with one in five of the population being born outside the UK.

Unemployment remains comparatively high at 5.0%, compared to the East of England and national averages. Gross Disposable Household Income (GDHI) per head in Luton is £11,935 which is lower than the East of England and national averages.

Recent research undertaken by Ipsos MORI indicates that Luton is the fifth most 'challenged' area outside London in terms of factors that impact on public perception but which public services have little control over (such as Indices of Multiple Deprivation, ethnic diversity, young people, population churn, physical living conditions etc).

Luton does however benefit from a variety of transport links including an international airport and direct rail links to London St Pancras. The M1 provides a link from Luton to the rest of Britain's road network and the new East Luton Corridor links the town, airport and motorway.

Like many other towns and cities both within and outside the UK, areas of the Luton have and continue to be affected by prostitution.

In developing the strategy the Community Safety Partnership has analysed and considered information and data from a range of partners to clearly identify the local dynamics and issues. This analysis has identified that;

- Of the known forms of prostitution operating within the town it is the highly visible on-street sex trade which appears to be having the most significant and detrimental impact on our town and communities.

- Although reports relating to the on-street sex trade have been received from a number of wards within the town this activity is most concentrated in a relatively small geographical area close to the town centre and train station.

- Those seeking to buy sex are travelling to the affected areas both in vehicles and on foot.

- All those currently identified as engaged in selling sex "on-street" in Luton are women over the age of 21.

- The vast majority of those involved in selling sex have drug and/or alcohol misuse problems and a history of abuse and/or emotional trauma,

- Those purchasing sex are predominantly men. Most are residents of the town although approximately a quarter are visitors to Luton.

The CSP recognises that there is a need for further and more detailed analysis of the issue to ensure that the Partnership approach is evidenced based and effectively targeting the local dynamics and underlying causes of this problem.

Furthermore whilst the initial analysis of the local data appears to confirm a number of national findings, in particular the correlation between the street sex trade and drug and alcohol abuse, there are also variations in the local picture which are not consistent with the national data and which require further consideration. In particular the Home Office estimates that as many as 70% of women engaged in prostitution become involved as children or young people, yet there is currently no evidence of children or young people engaging in this activity locally (although one hypothesis is that younger women and girls may be involved in less visible forms of prostitution). As establishing how and when individuals commence working in the sex trade will be pivotal to developing effective preventative work it is clear that further analysis in this area is required.

As such developing detailed local evidence base and problem profile will feature as a significant piece of work throughout the duration of the strategy and will be used to inform the development of key initiatives and interventions and broader partnership working.

The National Policy Context

Selling sex is not currently a criminal offence in Britain. This is the subject of extensive public, political and academic debate with some commentators arguing for tougher legislation and penalties for those involved in sex work and others arguing for more a permissive approach. Although this debate has clear implications for the development of both policing, community safety and health and social care policy, as a Partnership we are responsible for operating within the existing legal framework and while selling sex is not currently criminalised, there are many pieces of legislation which seek to regulate and limit the effects of on-street sex trade.

The table below outlines the main legislation currently relating specifically to street sex work in England and Wales and the penalties attached to these offences.

Table 1: Key legislation pertaining to street sex work, England and Wales

Offence	Act	Maximum penalty
Soliciting or loitering for purposes of prostitution	1959 Street Offences Act	A Fine

Causing or inciting prostitution for gain	1956 Sexual Offences Act 2003 Sexual Offences Act	Six months' imprisonment or fine (magistrates court) to seven years' imprisonment (crown court)
Kerb crawling (with persistence and in a manner likely to cause annoyance)	1985 Sexual Offences Act 2001 Criminal Justice and Police Act 2003 Sexual Offences Act	Arrestable offence: seizure of vehicle or driving ban
Antisocial behaviour	1998 Crime and Disorder Act	Serving of Anti-Social Behaviour Order, with up to five years' imprisonment or up to six months' imprisonment plus fine for breach

Approaches to tackling the on-street sex trade have tended to focus on the activities of those selling sex rather than those who purchase it. There is often a general assumption that those involved are in control of their situation. However, evidence shows that this can be far from true: high levels of childhood neglect; emotional, physical and/or sexual abuse; domestic abuse; emotional trauma; homelessness; problematic drug use; and poverty experienced by those involved strongly suggest the overriding motivation is survival.

Nationally, a common pattern appears to be for men and women to be trapped in street-based prostitution after having been coerced into it at a young age, or to fund their own, and often their partner's, problematic drug use. Those involved in this way rarely benefit, apart from ensuring their drug supply. The profits of the 'trade' go straight into the pockets of drug dealers. Therefore while for a very small minority selling sex may represent financially profitable work, for the vast majority involved in the on-street sex trade the reality is very different.

Developing the Strategy

This strategy reflects the initial findings of the Community Safety Partnership's analysis of the local data. As such the strategy typically refers to "women who sell sex" as opposed to a more gender neutral term. This reflects the local data that those selling sex on the street in Luton are exclusively women, however the partnership response detailed in this strategy and specifically the interventions it proposes to support those involved in selling sex to exit, are designed to be tailored to each individual on a case by case

basis. As such should it become evident that men are also involved in directly selling sex, the local response will be robust enough to respond appropriately.

The strategy also refers to, and is in fact titled; ”Tackling the Street Sex Trade”, in recognition that it is this form of prostitution which is causing the most harm to our residents and consequently this form of prostitution the CSP is most keen to address. In specifically targeting the on-street sex trade the CSP recognises that it is possible that there may be an inadvertent increase in “off-street “activity. While it is a generally held view that this is a less harmful form of the sex trade for communities, the CSP is clear that where there is evidence of harm or exploitation occurring, off-street premises will also be targeted.

In the development of this strategy, the Community Safety Partnership has looked extensively at national guidance and research, as well as existing Home Office and Association of Chief Police Officers (ACPO) strategies, to identify the underpinning factors and issues associated with the on street sex trade and for evidence of effective approaches to tackling this problem.

> The victims of the so-called ‘trade’ are the young boys and girls, and the men and women trapped in it. But communities are also victims as street-based prostitution increases the general level of disorder and creates a climate of criminality. Those who choose to be involved should understand what it is like to live in an area in which kerb crawlers habitually harass young women and where used condoms and dirty needles are regularly dumped in front gardens.
>
> Paying the Price
> Government Consultation 2004

The Partnership has also listened to the concerns and experiences of the residents and communities in Luton. This has highlighted the direct impact that the problem of on street sex work is having on individuals, families and businesses within the town. Residents in areas where on street sex work is known to take place have reported feeling threatened, intimidated, and being propositioned by both women selling sex and men seeking to buy it. They have also reported the detrimental effect that the street sex trade has on the local environment; an increase in litter (including used condoms and syringes); increased noise and traffic; and the visibility of individuals publically engaging in sexual activity. It is also evident that there is a public perception that the on-street sex trade has contributed to an increase in other types of offending including burglary and drug dealing.

In developing the strategy the Partnership has also explored models of working which have been widely acknowledged as representing best practice including projects in Ipswich, Slough, London, Cardiff and Bristol. Each of these models has highlighted the

importance of effective and co-ordinated multi-agency working. Indeed the Home Office's 2006 Co-ordinated Strategy acknowledges; [3]

"Addressing prostitution will require strong partnerships, involving a wide range of enforcement and support agencies. Success in delivering safer communities through a significant reduction in street prostitution and other forms of commercial sexual exploitation will depend on the will and commitment of local partnerships to address prostitution with confidence and energy – confidence that it really is possible to make a difference, and energy to tackle the many challenges involved."

Other common themes within successful initiatives include a focus on prevention and developing exit strategies for those already involved in the on street sex trade.

Case Study – Ipswich

Following the murders of 5 women involved in the on-street sex trade in Ipswich in 2006, agencies adopted a new multi-agency strategy focussing on a more holistic approach to tackling the issue.

Helping women involved in on-street prostitution to stop using drugs was an important part of the multi-agency approach in Ipswich led to a significant reduction in the number of women involved in street prostitution. Action taken to achieve this included:

- Prioritising funding for residential drug rehabilitation for sex workers ;
- Funding a Community Drugs Team to offer extended opening hours;
- Supporting the voluntary sector project ICENI to provide specialist support to help women in street prostitution to stop using drugs.

Main achievements

- 85 women have been in contact with the project, and around 30 are still being intensively helped (although 4 of these are 'hard to reach');
- Of the 30 women being helped, 8 women are drug free, and 19 are still in drug treatment. 26 are housed and 4 homeless.

[3] Home Office 2006:A Co-ordinated Prostitution Strategy

By contrast there is little evidence that initiatives which have endorsed vigorous enforcement action against women selling sex have resulted in any sustainable improvement. One Home Office research[4] study concluded "the use of "traditional" enforcement involving police crackdowns did not appear to reduce disorder or nuisance for the local community". Further guidance published by the Home Office's Drug Strategy Directorate[5] adds: "To be effective, enforcement has to be set in the context of interventions that provide treatment and other services for drug users".

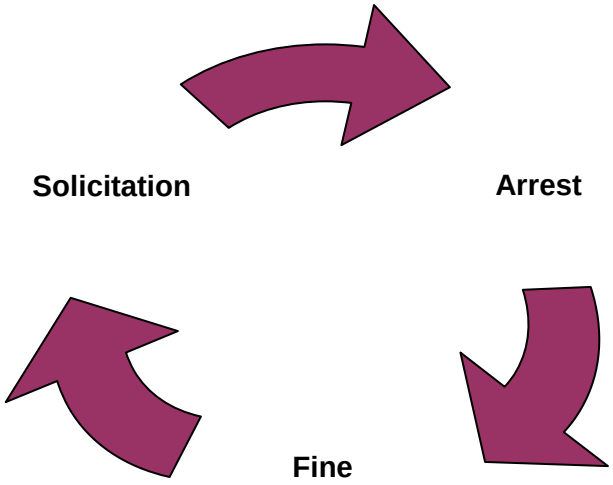
There is however some evidence that such enforcement approaches can result in increasing the vulnerability of women involved in the street sex trade, for example by displacing such activity to remote locations where there is an increased risk of physical attacks against women selling sex.

Furthermore as soliciting is a summary-only offence, the sentencing options of the courts are very limited and convictions of this nature most commonly result in either a conditional discharge or a fine. This can have the unintended effect of actually increasing the amount of time that women selling sex are visible on the streets as they seek additional income to pay off court fines - thus creating a cycle of soliciting and arrest as illustrated below.

Diagram 1: Illustration of the cycle of offending and punishment observed in relation to traditional enforcement action.

[4] Home Office Research Study 279. Tackling Street Prostitution: Towards an holistic approach. Marianne Hester and Nicole Westmarland. University of Bristol

[5] Solutions and Strategies drug problems and street sex markets. Gillian Hunter, Tiggey May and the Drug Strategy Directorate. 2004



This model illustrates the ineffectiveness of taking enforcement action against women who sell sex, without ensuring that it is undertaken in conjunction with structured support and services to break this cycle of behaviour.

This is reflected in the 2011 ACPO Strategy[6] which recommends:

"Arresting on-street sex workers under the existing laws only as part of a staged approach that includes warnings, police engagement with local support projects, voluntary engagements with projects, existing diversionary mechanisms and Engagement and Support Orders (ESOs)"

The CSP recognises the significance of this model and the guidance from ACPO and is committed to adopting an approach which promotes and supports individuals to exit the on-street sex trade as opposed to perpetuating their involvement in it.

Our Aims

In Luton, the Community Safety Partnership is committed to working with a broad range of agencies and organisations to address the problems associated with the on-street sex trade and to reduce the impact on individuals, residents, businesses and communities affected.

Underpinning this commitment is the belief that the on-street sex trade is not inevitable and that through joint working, implementing evidenced based interventions and by effectively targeted resources the Partnership can, and will remove the on-street sex trade from the streets of Luton,

[6] ACPO Strategy & Supporting Operational Guidance for Policing Prostitution and Sexual Exploitation. 2011

Overall Aim

Our overall aim is to protect our communities and residents from the nuisance and harm associated with the on street sex trade, by engaging in sustained and co-ordinated multi agency initiatives to remove the on-street sex trade from Luton by 2018.

We will work to accomplish our overall aim by focussing on three interconnected strands of activity**; Tackling and reducing demand** for sexual services**, Developing Routes Out** for those already involved and **Prevention;** ensuring individuals, particularly children and young people, are safe from sexual exploitation and can avoid becoming involved in the on-street sex trade.

By effectively addressing each of theses strands it will be possible to permanently disrupt the supply and demand dynamic which perpetuates the on-street sex trade, and ultimately bring an end to this activity in Luton

Underpinning or framing this work is a further strand of activity: **Ensuring Justice;** ensuring that serious and organised crime is addressed and that those who control, coerce, abuse or exploit others are brought to justice.

Ensuring Justice is pivotal not only to the success of the strands above (and therefore to the overall aim of removing the on-street sex trade from Luton), but also to protecting our communities and residents from a wider range of crime, antisocial behaviour and fear of crime.

The inter-dependency between the activity strands identified within the strategy is illustrated in the diagram below which demonstrates the Partnership's aim of Protecting Communities by removing the on-street sex trade through Prevention, Tackling demand, Developing exits and Ensuring justice.

Diagram 2: Our Partnership approach to removing the on-street sex trade[7]

[7] Diagram developed by Luton CSP

Protecting our communities and residents is at the heart of both the Partnership and everything that we do. The issues associated with the on-street sex trade are clear to all who live and work in towns and cities with sex markets. As well as violence and exploitation, and the misery from serious drug misuse experienced by the majority of those involved, the on-street sex trade can also mean neighbourhood nuisance. No one should be expected to tolerate harassment from kerb crawlers or sex workers, drug-related litter (including used condoms and needles), public sex acts, and the general degradation of areas used for the on-street sex trade.

This level of nuisance impacts on relatively few residents and local businesses but, for those affected, it is hugely distressing. Communities have a right to expect protection from neighbourhood nuisance but, while some areas have very active residents' groups focusing on this issue, many people feel powerless. The concerns of communities must be addressed in a way that can achieve a long-term solution.
As stated, it is the overall aim of this strategy to remove the on-street sex trade from Luton by 2018. This time scale recognises the complexities of the issues involved and reflects our aim that this should represent a permanent solution to this problem as opposed to a short term but unsustainable improvement.

However, the Partnership recognises that five years is too long for the residents and communities affected by the on-street sex trade to wait for an end to the nuisance and harm they are experiencing.

To this end, whilst this is a five year strategy, the Partnership is committed to undertaking a range of immediate targeted measures in the areas most affected to alleviate the nuisance affecting local residents and businesses including:

- Ensuring victims of Anti-Social Behaviour are referred to the ASB Priority Team for tailored responses; including risk assessment and the co-ordination of activity to assist and support residents.

- Recognising where the built environment encourages the on-street sex trade to develop, and addressing this by introducing further environmental measures to deter and disrupt on-street sex work including general improvements to the built and natural environment.

- Maintain the “dawn patrol” to clear up litter associated with the on-street sex trade and drug use.

- Utilising legislative powers to disperse those selling on-street sex from residential areas.

Furthermore it is our belief that as a result of Partnership the residents and communities of Luton should notice a significant and sustained reduction in the on-street sex trade throughout the lifespan of this strategy culminating in a cessation of the on-street sex trade by 2018.

Strands of Activity

The first three strands of activity identified in this strategy; Tackling Demand, Developing Exits Out and Prevention, are intrinsically linked.

It is anticipated that reducing demand for the on-street sex trade will limit the financial rewards for those engaged in this activity and as such will incentivise and motivate those currently involved to exit this type of work. By simultaneously offering improved support to individuals who are seeking to exit the on-street sex trade there is an opportunity to create a significant reduction in the availability of sex for sale, which if effectively sustained, will make it more difficult for men to purchase sex and may prompt those committed to doing so to source it elsewhere.

A reduction in supply created by women exiting the sex trade will however only be sustainable if we can actively prevent other individuals from entering the on- trade. Prevention is therefore a vital component of this approach, both in terms of securing a

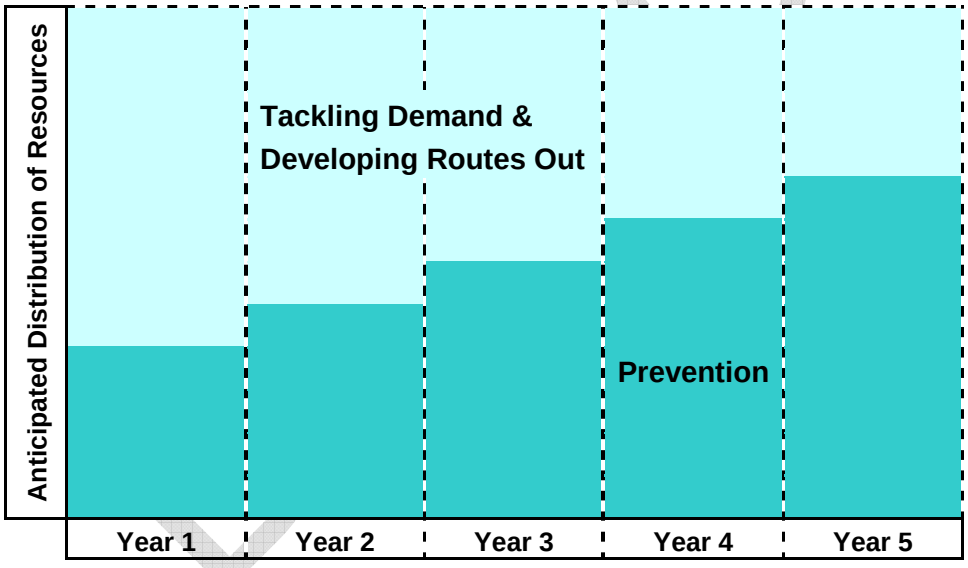
reduction in the availability of on street sex trade but also in relation to safeguarding children and young people from exploitation and abuse.

As tackling demand and supporting women to exit becomes less resource intensive (due to reducing numbers requiring support), these resources will be redirected to activities with a greater focus on prevention.

It is therefore anticipated that while the early stages of the implementation of the strategy will be characterised by a more visible partnership focus on disrupting supply and demand, over time the model will shift to one which is more focussed on prevention as illustrated below.

The continued targeting of resources into the Tackling demand / Developing Routes Out strands in the final years of the strategy is in recognition of the need for ongoing enforcement action to deter kerb crawlers from returning to an area leading to a re-emergence of the on-street sex trade there.

Diagram 3: Expected redistribution of Partnership activity and resources over the period of the Strategy[8]



Tackling demand

The on-street sex trade may be driven by economic necessity but it can only exist because there is a demand for it. A coordinated strategy designed to reduce its

[8] The chart represents the focus of activity relating to the Community Safety Partnership. However, preventative work is also undertaken by the Luton Safeguarding and Health and Wellbeing Boards.

prevalence must address demand as well as tackle the factors that lead individuals to become involved in its supply. To do this there must be a clear and common understanding of the issues involved in order to develop a response to deter those who create that demand. Buying sex can mean supporting the illegal drugs industry, as well as perpetuating a situation in which women may be subject to violence and exploitation. It can also mean contributing to the current rise in Sexually Transmitted Infections (STIs).

As previously discussed this strategy recognises that enforcement has a key role to play, particularly with respect to those who create the demand for the on-street sex trade. Accounts from residents indicate that the presence of kerb crawlers and those who buy sex on foot in an area has a significant impact on perceptions of safety and can result in slow moving traffic, congestion and noise and the unwanted propositioning of local residents including young people.

To this end dedicated targeted Police enforcement activity is regularly undertaken with over 100 arrests related to the on-street sex trade between January 2013 and March 2013.

Bedfordshire Police and the wider Community Safety Partnership have agreed and implemented a zero-tolerance approach to kerb-crawling in Luton. All identified perpetrators, including first time offenders, will be arrested and will be required to provide their fingerprints and a sample of their DNA which will be added to the National DNA Database.

Additionally:

- The CSP will send a clear message that kerb crawling will not be tolerated and will consider a range of methods to promote and highlight this stance including: media coverage of enforcement action, use of warning signs in localities affected, sending warning letters to those identified as buying or attempting to buy sex.

- There will be continued targeted Police enforcement activity to deter and disrupt the sex market.

- We will seek to raise awareness of the harm caused by buying sex through the use of media messages and kerb crawler re-education programmes.

<u>Developing Routes Out</u>

Exiting sex work is a long-term and complex process that will involve receiving help and support to deal with a whole range of practical and emotional issues. Exiting is,

therefore, not a linear process and individuals may attempt to leave a number of times[9]. In a hierarchy of needs, providing drug treatment and responding to health and accommodation problems will have to be addressed.

Evidence from a two year study conducted by London South Bank University and Eaves[10] highlights that women can and do wish to leave prostitution. The study evidences the need for services to support women who sell sex to overcome the barriers which can prevent them from exiting from this work. Nine specific barriers are identified; problematic drug use, accommodation issues, physical and mental health problems, history of childhood violence; criminalisation; financial problems; experiencing coercion from others; lack of training or qualifications; and age of entry (specifically those who began selling sex at a young age).

The CSP recognises the importance of assisting women to overcome these barriers and exit on-street sex work as part of ensuring a sustained and visible reduction. To this effect, developing routes out for those already involved is a pivotal strand of this strategy, and the Partnership will continue to work with agencies and services which support those selling sex to exit by addressing the barriers which can prevent this.

The Partnership also recognises that, given the range and complexity of the barriers which can affect the exit process, this approach is unlikely to deliver instant results; however it is a fundamental strand to ensuring long term lasting change.

"Make a Change Team"

To support women to exit the on-street sex trade, the Partnership will adopt a multi-agency case-management approach based upon the successful Ipswich "Make a change " model to co-ordinate services and interventions to help women to overcome the barriers to exit, and to develop the skills and tools necessary to permanently cease engaging in the on-street sex trade.

Where individuals are identified to pose a high risk of re-offending, this support may be offered within the context of the existing Integrated Offender Management model.

For those for whom this approach would not be appropriate the partnership will develop and implement a new multi-disciplinary team to co-ordinates service provision and provide a case management approach. This will include:

- Ensure the provision of and access to drug and alcohol services.

[9] Solutions and Strategies drug problems and street sex markets. Gillian Hunter, Tiggey May and the Drug Strategy Directorate. 2004

[10] Breaking down the barriers: A study of how women exit prostitution. Julie Bindel, Laura Brown, Helen Easton Roger Matthews and Lisa Reynolds Eaves and London South Bank University (LSBU)

- Work with housing providers to identify need and support individuals into safe accommodation

- Ensure access to healthcare provision to meet both the physical and mental health needs of individuals

- Work with partners to facilitate access into counselling and support services to address childhood experiences of violence and abuse

- Utilising existing multi-agency working arrangements and information sharing protocols to identify and bring to justice those who are harming and exploiting vulnerable children and adults.

All interventions will be developed on a case by case basis based on an individual analysis of need and risk assessment. Where those involved in selling sex opt not to engage with services then alternative disposals and enforcement options will be explored.

Prevention

As the work of the Partnership supports women to exit the on-street sex trade it is vital to ensure that they are not simply replaced by others moving into this work.

Research nationally indicates that many of those working in the on-street sex trade commence this work as children or young people, often as a result of abuse and/or exploitation.

The issues surrounding the sexual exploitation of children and young people are becoming increasingly well documented. A number of high profile incidents of the organised exploitation of vulnerable young people have highlighted the risks posed to young people, and the need for agencies and professionals to act to safeguard potential victims.

Since April 2013, Bedfordshire has adopted a structured multi-agency process to identifying and supporting children and young people at risk of sexual exploitation.

The SERAC (Sexual Exploitation Risk Assessment Conference) process ensures that any child or young person identified as being at risk of sexual exploitation is referred to a multi-agency panel of professionals for support and to ensure that information regarding risk and possible perpetrators is communicated across

agencies.

This provides Partner agencies with an opportunity to gather and pool information; enabling them to identify trends and patterns of behaviour, the connections between individual cases and to identify individuals and potentially groups who may pose a risk to young people.

In the long term this approach will assist to safeguard not only the individual children and young people referred to the panel but (by providing information which will assist in addressing the underpinning issues and enable agencies to target those who pose a risk) will contribute to making the town a safer place for all children and young people[11].

The sexual exploitation of children and young people is a complex issue which is not wholly restricted to the on-street sex trade but which nonetheless has clear links to it. As a Community Safety Partnership we are committed to working closely with our Local Safeguarding Boards to address these broader issues and to hold those who abuse and exploit children and young people to account.

As a Partnership we will contribute to the work of the Safeguarding Boards to raise awareness among young people; both boys and girls, about safe and equal relationships and the dangers associated with prostitution, and to ensure that those who work with young people are able to recognise the warning signs and take appropriate action to safeguard those they believe to be at risk.

We are clear that using children and young people for the purposes of prostitution is child abuse. Offenders who buy sex from children and young people will be subject to the full weight of the law.

Any child or young person under the age of 18, who is identified as selling or being sold for sex, or at risk of selling or being sold for sex, will be acknowledged as a victim of abuse and referred under existing child protection procedures to safeguarding services.

Ensuring Justice

Disrupting sex markets will not be wholly successful unless we can remove the opportunity and advantage for those who use, abuse and exploit individuals through the on-street sex trade. This requires proactive policing and a robust legal framework with

[11] At time of writing SERAC is in its pilot phase. Initial findings are positive and it is anticipated this initiative will continue, if not alternative options will be explored.

severe penalties. Bringing perpetrators to justice is the best way to disrupt commercial sexual exploitation and sends a clear message that it will not be tolerated.

This strand also recognises the links between the on-street sex trade and other criminality including drug dealing, and that many of those directly involved in selling sex will be doing so as a result of coercion, abuse and exploitation.

It acknowledges Home Office, ACPO and extensive academic research findings that street sex workers can be a vulnerable and marginalised group. Research[12] shows high levels of violence and robbery against street sex workers, perpetuated by clients, passersby, 'pimps' or managers.

Sex workers may also be vulnerable to exploitation from drug dealers and other drug users and may experience coercion to sell sex to fund their drug use. It is also recognised that some women will be pressured to sell sex to fund the drug habits of others.

Both Home Office and ACPO guidance and strategies therefore clearly acknowledge the vulnerability of those who sell sex and the risk of violence and exploitation that they face. This acknowledgement requires that local agencies increase their understanding of this issue and ensure appropriate responses to address the needs of this group albeit balancing this responsibility with responding to the legitimate concerns of the wider community about street sex work and its impact on local residents and communities.

The Partnership will work robustly to identify and address the serious and organised crime including violent and drug related offences which frequently co-exists alongside the street sex trade.

Furthermore while the partnership approach is to support those selling sex to exit the on-street sex trade through the provision of co-ordinated intervention and support, enforcement action will be taken against those committing other offences or exploiting others.

As a Partnership we are committed to:

- Enforcing the law against those who coerce, exploit and abuse individuals as a means of addressing sexual exploitation and contributing to a reduction in the on-street sex trade.

- Investigating and acting on the links between the on-street sex trade and serious organised crime including drug dealing, robbery and trafficking, to protect victims and reduce overall crime in affected areas.

[12] McKeganey and Barnard, 1996; Phoenix, 2002; Hester and Westmarland, 2004

- Encouraging individuals who sell sex to report when they are the victims of violent or sexual crime and responding to these reports robustly and with sensitivity and respect.

- Taking enforcement action against those who harass, threaten or intimidate residents and members of the community including those directly involved in the on-street sex trade.

- Safeguarding any child or young person who is identified as engaging in commercial sexual activity by recognising them as a victim of abuse and by ensuring those buying sexual services from those under 18 are prosecuted to the full extent of the law.

Engaging with the Community

Multi-Agency activity to address the issue of the on-street sex trade has been undertaken in Luton for a number of years lead by a multi-agency group comprising of representation from Health Services, Luton Borough Council, Bedfordshire Police and CCTV Operators.

This led to the development a multi-agency action plan to reduce the demand for street sex in Luton and address the associated community safety issues.

As part of that action plan, the Partnership has undertaken targeted enforcement action, made changes to the physical environment of areas affected by the on-street sex trade to deter and disrupt the sex market and worked with statutory and voluntary groups to develop services to support those engaged in the on-street sex trade to exit.

These measures have achieved some degree of success. Local health providers have reported that the provision of dedicated “women only” services (which provide a safe environment for vulnerable women to access multi-agency support to improve their health, emotional wellbeing, settle in secure housing, stabilise in drug treatment and live a drug free and independent life) has resulted in 50% of the women attending these services to exit sex work, some on a permanent basis.

Anonymous Case Study – Luton Successful Exit

However, the Partnership acknowledges that more needs to be done to ensure a sustained and perceptible reduction in the on street sex trade and that more must be done to engage and work with the community to develop and implement measures to ensure a balance between protecting the rights of residents and the local community to live without fear or the nuisance associated with the on-street sex trade and supporting vulnerable individuals to exit such work.

The partnership is therefore committed to:

- Providing regular updates to local communities regarding the activity undertaken by partners and agencies to address the issues of on-street sex work
- Seeking direct representation from members of the local communities affected by the on-street sex trade on multi-agency reference groups to inform and shape the direction of future initiatives and activity.
- Working with community based services to mediate between residents and those engaging in the on-street sex trade to produce collective benefits for all those concerned.
- Encouraging all residents to report concerns, incidents and issues to the Police, relevant local authority officers and/or elected representatives to assist them to obtain a full picture of the prevalence and impact within our communities.

"Good local strategies take account of the concerns and interest of all groups, including local residents, voluntary organisations and local partner agencies, as well as reaching out to those involved in prostitution themselves. Similarly, multi-agency approaches and partnership working can help all of the relevant issues to be tackled.

…. It is (also) important that the response to prostitution recognises people involved in prostitution as part of the community, and is developed with their involvement."

Home Office, 2011. A review of Effective Practice in Responding to Prostitution

Delivering the Strategy

This strategy represents the joint commitment of the agencies and stakeholders discussed in this document to address and challenge the issues of the on-street sex trade in Luton.

As a Community Safety Partnership led approach this strategy is owned by the Community Safety Executive (CSE), a statutory multi-agency body consisting of senior representatives from the "responsible authorities" as identified in the Crime and Disorder Act 1998. The Community Safety Executive is currently chaired by the Chief Executive of Bedfordshire Probation Trust, and is responsible for setting the strategic direction of partnership activity in Luton.

However it is recognised that the challenges posed by the on-street sex trade and many of the issues arising from it and detailed in this document extend beyond the responsibilities of the CSP and that there are clear overlaps and parallels with the work of the Health and Wellbeing Board and both Local Safeguarding Boards. As such, while the strategy is owned by the CSE the objectives and principles of this strategy have also been endorsed and approved by the Luton Safeguarding Adults Board, Luton Safeguarding Children Board and the Luton Heath and Wellbeing Board[13] and regular updates and progress reports on the implementation will be made available to these boards on request.

Resourcing the Strategy

This strategy details a new approach to resolving the on-street sex trade which will require the long term commitment and effort of partners across the town to deliver. The strategy also requires a significant level of resources to deliver the stated objectives.

The cross cutting nature of the issues and challenges posed by the on-street sex trade and the recognition from partners of the harm and distress it causes has enabled the CSP to draw on a range of funding streams to provide additional resources to support the work detailed in this strategy.

[13] Timetabled for approval; HWB 17 July 2013, LSCB 16 July 2013

Appendix one provides a summary of the financial and other resource commitments made by partners to support and deliver the objectives of this strategy. This includes significant levels of funding from the Public Health Grant and Local Authority Budgets.

(Appendix one is not currently attached, as formal commitments are still being agreed)

Action Plan

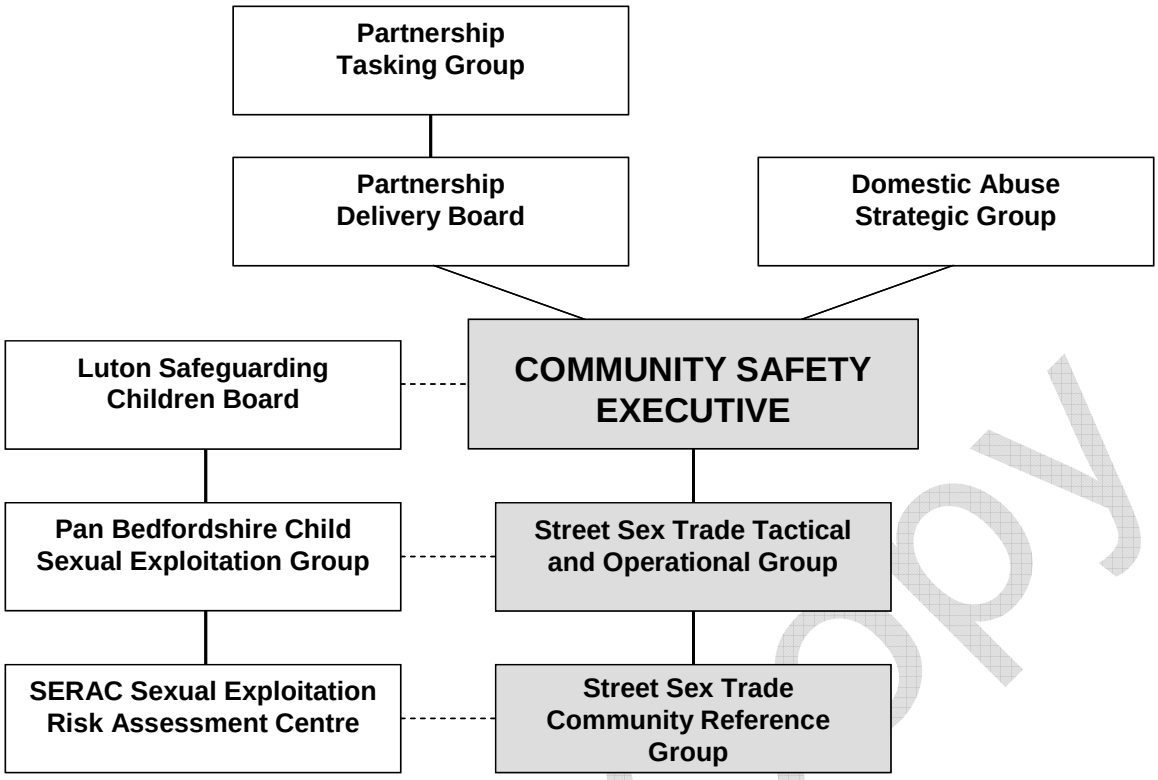
Central to the strategy is a multi-agency action plan, detailing the strategic priorities and identifying actions, outcomes and measures of success. The action plan names agencies and individuals leading areas of work and will be regularly reviewed to ensure that the objectives and priorities of the strategy are being met.

This regular review will also enable the partners to respond to potential changes in the problem profile resulting from partnership activity or other factors and ensure the appropriate allocation and distribution of resources across the various strands of activity outlined in the strategy.

Governance and Accountability

In order to ensure that the strategy is effective and the objectives delivered, the Strategy will be subject to ongoing monitoring and evaluation by the Community Safety Executive. These evaluations will be used to ensure that activity and resources are being utilised most effectively and that issues of performance are addressed promptly and decisively.

Diagram 4: Luton Community Safety Partnership Group Structure



Street Sex Trade Operational and Tactical Group

While the Community Safety Executive is responsible for the content and direction of the Strategy, it has established the Street Sex Trade Operational and Tactical Group to oversee its implementation and delivery.

This group, consists of senior officers and operational leads within partner agencies meets frequently and will provide regular reports to the Community Safety Executive.

These reports will detail the ongoing activity being undertaken by partners and should demonstrate the impact of the strategy by evidencing:

- Outcomes of police operations including enforcement action.
- A visible reduction in the number of women working on the street.
- A reduction in ASB complaints relating to the street sex trade
- Increase in individuals exiting the street sex trade

Street Sex Trade Community Reference Group

The CSE has also established a community reference group to ensure that the views and experiences of local communities and residents are reflected in the strategic aims and objectives of the Partnership. This group will also enable the Partnership to draw on

the wealth of local expertise and knowledge by inviting representation from groups and individuals who can inform and guide the local response. The group, will also provide an additional means of ensuring ongoing communication between residents and the partnership.

This will assist the Partnership to assess the effectiveness of the strategy and respond accordingly.

Sources

ACPO Strategy & Supporting Operational Guidance for Policing Prostitution and Sexual Exploitation. 2011

A Co-ordinated Prostitution Strategy. Home Office 2006:

A review of Effective Practice in Responding to Prostitution. Home Office, 2011.

Breaking down the barriers: A study of how women exit prostitution. Julie Bindel, Laura Brown, Helen Easton Roger Matthews and Lisa Reynolds Eaves and London South Bank University (LSBU), 2012

Home Office Research Study 279. Tackling Street Prostitution: Towards an holistic approach. Marianne Hester and Nicole Westmarland. University of Bristol. Home Office Research , Development and Statistics Directorate, July 2004

In the Name of Protection : Youth Prostitution Policy in England and Wales, J Phoenix. Critical Social Policy Vol 22, 2002

Living and working in areas of street sex work. Jane Pitcher, Rosie Campbell, Phil Hubbard, Maggie O'Neill and Jane Scoular. Joseph Rowntree Foundation 2006

Paying the Price: a consultation process on prostitution, Home Office. July 2004

Prof David Wilson, Director of Birmingham City University's Centre for Criminal Justice Policy and Research. 2009

Sex work on the streets: prostitutes and their clients, McKeganey and Barnard, Open University Press, 1996

Solutions and Strategies drug problems and street sex markets. Gillian Hunter, Tiggey May and the Drug Strategy Directorate. 2004

HEALTH AND WELLBEING BOARD	AGENDA ITEM: 12.1

DATE OF MEETING: **17th July 2013**

REPORT AUTHOR & CONTACT NUMBER: **Simon Pattison, Head of Adult Joint Commissioning, simon.pattison@lutonccg.nhs.uk or 07500 918906**

SUBJECT: **Section 256 Transfer from Health to Social Care**

WARD(S) AFFECTED: All

PURPOSE

To approve the Section 256 agreement between LBC Adult Social Care and NHS England as required by the Department of Health (DH) in their letter of 19 June.

RECOMMENDATION(S)

The Health and Wellbeing Board is recommended to:

- **Sign off of the attached Section 256 legal agreement between LBC and the NHS National Commissioning Board, subject to changes that may be required by Luton CCG, NCB or solicitors.**
- **Agree to delegate the final sign off including any changes required by the above to the Director of Housing, Community Living and Adult Social Care.**

BACKGROUND

A report was brought to the Health and Wellbeing Board on 3rd June outlining the background to the transfer and the allocation to Luton of £2,820,830 for 2013/14.

The meeting on 3rd June agreed the use of the S256 including that £1,711,000 should be spent on supporting on going schemes and agreed priorities for the remaining £860,000, which were both outlined in the 3rd June report. These schemes are now detailed in schedules B and C of the attached 256 agreement.

On the 19th June the Department of Health (DH) wrote to CCGs (DH Gateway Reference 00186), confirming the allocation and conditions of the transfer which are set out at: https://www.gov.uk/government/publications/conditions-for-payments-between-the-nhs-and-local-authorities

https://www.gov.uk/government/publications/funding-transfer-from-the-nhs-to-social-care-2013-to-2014-directions.

The key aspects of the letter are:

- The funding will transfer from the National Commissioning Board to local councils, it is not part of the CCG's budget allocation.
- The funding must be used to support **adult social care services** in each local authority, which also has a **health benefit**.
- How the funding will be spent should be agreed by Health and Wellbeing Boards, after discussion between the NCB, local CCGs and each council.
- In making decisions on how the money is spent partners should think about the needs identified in the Joint Strategic Needs Assessment (JSNA) and existing commissioning plans for both health and social care.
- A condition of the transfer will be that local authorities demonstrate how the funding will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.
- The money can be used to support existing council services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The money can also be used for new investment, again where this can demonstrate benefits for the health and care system.

In terms of governance the letter also requires that:

- The CCG/s and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, any measurable outcomes and the agreed monitoring arrangements in each local authority area.
- The Health & Wellbeing Board approves the report which has appended to it the agreed Section 256 agreement between the local authority and NHS England.
- A copy of the signed agreement should be sent to NHS England Finance Allocations Team at england.finance@nhs.net so that a national review of the transfer can be undertaken
- Purchase Orders using the format set out in table 1 are set up by the NHS Area Teams with each Local Authority that confirm the precise financial arrangements.

SECTION 256 AGREEMENT

This is attached as appendix 1.

PROGRESS AGAINST HEALTH AND WELLBEING STRATEGY PRINCIPLES:

PROMOTING INTEGRATION/POOLED BUDGETS/JOINT COMMISSIONING

The Section 256 funding is aimed at social care funding that also has an NHS benefit. A number of the individual projects are aimed at improving integration through joint commissioning.

IMPROVING QUALITY AND EFFICIENCY - SERVICE / PATHWAY REDESIGN
Individual schemes will support this objective by promoting integrated working – e.g. investment in IT systems will support pathway redesign by making it easier for staff across health and social care to share information.

ADDRESSING THE WIDER DETERMINANTS OF HEALTH
The schemes proposed include housing, social care and voluntary sector support.

FOCUSING ON EARLY INTERVENTION AND PREVENTION
A number of the schemes proposed have prevention elements.

IMPLICATIONS

The proposal is that the Health and Wellbeing Board agree the Section 256 as set out in the attached appendix and delegate any changes required to the Director of Housing, Community Living and Adult Social Care, following consultation with LBC solicitors and Luton CCG and the NCB.

LIST OF BACKGROUND PAPERS

Report to Health and Wellbeing Board 3rd June 2013
DH letters 19 December 2012 and 19 June 2013.

SECTION 256 OF THE NATIONAL HEALTH SERVICE ACT 2006
LOCAL GOVERNMENT ACT 1972, SECTION 100D

DATED 2013

LUTON BOROUGH COUNCIL

and

NHS ENGLAND

MEMORANDUM OF AGREEMENT SECTION 256 TRANSFER

for the PROVISION of
HEALTH RELATED SOCIAL CARE
by way of the TRANSFER OF FUNDS UNDER THE PROVISIONS OF
SECTION 256 OF THE NATIONAL HEALTH SERVICE ACT 2006

Section 256 Transfer Reference number…XXXX

Title of scheme

PROVISION of SOCIAL CARE AND WELLBEING SERVICES WHICH ALSO HAVE A HEALTH BENEFIT

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

This is covered in Clause F of the Agreement. Additionally some schemes are intended to improve productivity and efficiency through service and pathway redesign including IT investment, or focus on prevention and early intervention

2. Description of scheme (In the case of revenue transfers, please specify the services for which money is being transferred).

This is covered in Clause 3 of the Agreement and Schedule B and C.

3. Financial details (and timescales)

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum and Agreement must be amended and re-signed)

Year (2013/14) Amount Revenue *£2,820,830*

Year (2013/14) Amount Capital NA

In the case of the capital payments, should a change of use outlined in direction 4(1)(b) of the National Health Service (Conditions Relating to Payments by NHS bodies to Local Authorities) Directions 2013 occur, both parties agree that the original sum shall be recoverable by way of a legal charge on the Land Register as outlined in direction 4(4) of those Directions.

This is covered in Clauses 4 and 5 and Schedule B and C.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

This is covered in Schedule A.

(Note: Execution of this agreement can be found on pages 13-14)

This **AGREEMENT** is made this day 2013

B E T W E E N

(1) **LUTON BOROUGH COUNCIL** of Town Hall, Luton, LU1 2BQ ("**Council"**) and

(2) **NHS ENGLAND** of Charter House, Parkway, Welwyn Garden City, Hertfordshire, AL8 6JL

together "**the Parties**"

WHEREAS

A. The Council is a local authority with social service functions under the Local Authority Social Services Act 1970 ("1970 Act") and for the purposes of section 256 (5A) (5B) of the National Health Service Act 2006 ("2006 Act") is the local social services authority discharging certain social service functions set out in Schedule 1 to the 1970 Act and is a prescribed local authority within the meaning of section 75 of the National Health Service Act 2006 ("the 2006 Act").

B. **NHS England** is the NHS commissioning organisation for Luton who is the prescribed NHS body for the purposes of agreeing this section 256 funding.

C. The Council is to act as the commissioner for a range of social care and preventative services along with related care and support services which support the delivery of certain healthcare outcomes.

D. This Agreement deals with the transfer of revenue funds from NHS England to the Council to facilitate the provision of services described in this Agreement and is not intended to cover payment commitments which are existing and being made or to be made under other arrangements, including previous funding arrangements between the Parties under Section 28A National Health Service Act 1977, Section 31 Health act 1999, Section 256 National Health Service Act 2006, or Section 75 National Health Service Act 2006.

E. The purpose of this Agreement ("Agreement") is to state the amount of the funding to be transferred and how those revenue funds are to be applied for the benefit of those persons registered with GP practices within Luton Borough and those persons not so registered but who are resident within Luton Borough and strengthen local services, highlight how these services relate to the provision of reablement, care and support service for all adults, detail the revenue funds that will transfer from NHS England to the Council in the financial year ending 31st March 2014 and specify the outcomes expected.

F. It is the intention of both Parties to endeavour to secure more health gain than an equivalent expenditure of money in the NHS by removing organisational barriers and maximising opportunities to commission services as part of a whole system approach to reablement and recovery, the integrated service to be conducted by the Council as the lead authority in furtherance of the Government's proposals to strengthen social care related services. This whole systems initiative is intended to seek to promote, recover and maintain people's independence resulting in a reduction in demand for health and social care services and in improved patient/service user outcomes. This approach has been outlined as part of the Government's Spending Review, November 2010 and is referenced in Local Authority Circular (LAC) 2010 (6) issued by the Department of Health and is further detailed in the Gateway letters 18568

December 2012 and 00186 June 2013 which explain that funding to support adult social care has been passed to NHS England as part of the 2013/14 Mandate.

IT IS AGREED THAT:

1. INTERPRETATION

1.1 In this Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:-

"Agreement"	means this agreement in writing including all Schedules to this agreement and all documents referred to herein and in the event of a variation or any other modification in accordance with the provisions of this agreement means this agreement as so modified or varied;
“Base Rate"	means the Bank of England Base Rate for charging interest at the relevant time;
‘CCG’	means Luton NHS Clinical Commissioning Group or any other successor in title to any of their statutory functions;
"Council"	means Luton Borough Council or any successor authority and in so far as relevant any body to which all or part of its function relevant to this Agreement is lawfully transferred or assigned;
“Force Majeure"	means in relation to either party, any circumstances beyond the reasonable control of that party (including without limitation any strike lockout or other form of industrial action);
‘NHS England’	means the NHS Commissioning Body for England or any other successor in title in so far as relevant to which all or part of its function relevant to this Agreement is lawfully transferred or assigned
“Re-ablement Service”	means the Local Authority Support at Home Service, and similar services purchased from other registered domiciliary care agencies;
“Revenue Funding”	means the monies transferred by the NHS England to the Council under the terms of this Agreement for the provision of the Services; and
“Services”	means the services required to be performed by this agreement to include those areas referred to in Clauses 3, 4 and 5 and Schedules B and C (and if varied by written agreement of the Parties in accordance with the terms of this Agreement to be the areas as so varied) and to achieve the outcomes described in Schedule A .

1.2 In interpreting this Agreement:-

1.2.1 references to Clauses and Schedules are to clauses and schedules of this Agreement unless otherwise stated;

1.2.2 a "Party" means any Party to this Agreement individually and "Parties" refers to both parties to this Agreement collectively;

1.2.3 references to the singular include the plural and vice versa and references to a gender include both genders;

1.2.4 references to a "person" include an individual, firm unincorporated association or body corporate;

1.2.5 the headings are for convenience only and shall not affect the meaning of this Agreement;

1.2.6 the Schedules are an integral part of this Agreement and shall be interpreted accordingly; and

1.2.7 references to statutory provision, enactment, order, regulation or other similar instrument shall be construed as a reference to the statutory provision, enactment, order, regulation or instrument (including any EU instrument) as amended, replaced, consolidated or re–enacted from time to time and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made under it.

2. DURATION

2.1 Subject to Clause 2.2, earlier termination as permitted by this Agreement, and subject to Clause 5, this Agreement shall commence on the 1st April 2013 and shall expire on 31st March 2014 without prejudice to any existing rights or liabilities at the date of expiry or termination.

2.2 Subject to further funding being available to NHS England to transfer to the Council and they will so transfer and such funding being sufficient then this Agreement may be extended by mutual agreement between the Parties annually for a period of one year up to a maximum of 2 further years.

2.3 Any extension of this Agreement must be evidenced in writing by exchange of letters taking place before this Agreement or any extension terminates and subject to any appropriate approvals or/and authorisations.

3. SERVICES

3.1 The Council and the NHS England agree that the aim of the re-provision of services is to develop and maintain social care and wellbeing services that also have a health benefit, in particular services centred on promoting, recovering and maintaining levels of independence and self care wherever possible.

3.2 This integrated system will contain service and support elements which actively promote independence, provide opportunities for reablement and recovery and support those in the community with long term health conditions and other health conditions to remain as independent as possible for as long as possible. This will include:-

3.2.1 a range of preventative services designed to promote health and prevent or

delay admission to hospital;

3.2.2 services which provide the opportunity to maximise recovery and reablement for both those discharged from hospital and in the community and

3.2.3 services which enhance the management of people with long term health conditions and other health conditions within the community with a view to reducing or delaying hospital admissions.

The above will be supported, in achieving these outcomes, by the provision of services including telecare and telehealth services and by the provision of equipment (aids to daily living) and required adaptations to property or accommodation

3.3 Indicative budgets for those areas which will initially be covered by this Agreement for 2013-2014 are set out in Schedule B of this Agreement and commissioning by the Council under this Agreement will be subject to the availability and sufficiency of funding by NHS England and it is accepted by both Parties that the Council has no obligation or liability in respect of commissioning or provision of services under this Agreement if such funding is not available and that where funding is available but restricted that the commissioning and provision of services may be limited or reduced accordingly. The areas to be covered for 2014-15 and any subsequent years will be subject to the written agreement of both Parties if different from those for 2013-2014.

3.4 Part of the Revenue Funding is to be applied to new areas by the Council in 2013-14 as set out in Schedule C. Alterations to the areas or sums to be applied to those areas must be agreed in writing by the Council and the CCG before they occur.

3.5 The agreement will require the commissioning of services and support from a range of statutory, third sector and independent sector service providers and as such the Council is best placed to secure the provision of such services from specialist care providers. This may include inter alia the commissioning of services from Council provider services, Cambridge Community Services (CCS) and South Essex Partnership University NHS Foundation Trust (SEPT). The Council agrees to act as the commissioner, insofar as supported by the funding under this Agreement, in the procurement and delivery of these services and may contract with any such service providers as is appropriate provided that NHS England transfer funds as set out in Clause 4.

3.6 The revenue transfer will be applied to meet the costs of the expenditure incurred by the Council on the following items:-

3.6.1 Project management required for the integration of services to enable whole system benefits

3.6.2 The ongoing co-ordination and management of the agreed services

3.6.3 The contracts and service level agreements entered into by the Council in respect of those functions outlined above and associated costs

3.6.4 The cost to the Council of procuring, managing and monitoring the services being provided.

This sum may be reviewed at the request of the Council accompanied with a case for why a review is appropriate. For as long as both NHS England and the Council (at all times acting reasonably and in accordance with their respective legal obligations)

consider the Services necessary and desirable, the Council will meet the cost of the Services to the extent that they are not funded by the Revenue Funding.

4 FINANCIAL DETAILS (and timescales)

4.1 The total amount of money to be transferred in each year is as shown in this sub-clause and if this subsequently changes, the Agreement must be amended and re-signed. The amounts referred to below are those referred to in the Department of Health letter dated 19 December 2012 (Gateway number: 18568) as 'Funding Transfer from the NHS to Social Care in 2013/14 – What to Expect' and confirmed in the letter 19 June (Gateway number: 00186) 'Funding Transfer from the NHS to Social Care in 2013/14.

YEAR	Revenue (£)
2013/14	**£2,820,830**

4.2 NHS England shall pay to the Council the Revenue monies shown in the Table at Clause 4.1 above in advance in 2 equal instalments. The first payment will be made as soon as the conditions set out in the letter of 19th June have been met and the second on 1st October.

4.3 If NHS England default on the agreed timescale for payment of Revenue Funding to the Council, the Council is entitled to seek and NHS England must pay if required by the Council an interest payment for the period that the payment has been outstanding at an interest rate of one (1) percent above Base Rate.

4.4 An annual voucher in the format laid out in Annex 2 must be completed by the Council in respect of each financial year and submitted to NHS England by no later than 31 December following the end of the financial year in question.

5 TERMINATION

5.1 Either Party may at any time by notice in writing to the other Party terminate this Agreement provided this is allowable under the legislation at that time as from the date of serving of such notice whenever one of the following events occurs:-

5.1.1 there is a fundamental breach by any other Party of any provision hereof;

5.1.2 a Party (other than the Party serving the notice) commits a material breach of any of its obligations hereunder which is not capable of remedy or if capable of remedy has not been remedied within a reasonable time after receipt of written notice from the Party serving the termination notice requiring it to remedy the breach; or

5.1.3 a change in legislation prevents a Party from fulfilling its obligations under this Agreement unless the obligations concerned can reasonably be accommodated by way of variation to the Agreement in accordance with Clause 13.

6.2 For the avoidance of doubt, and without limitation, each of the following shall constitute a fundamental breach of this Agreement by the Council for the purposes of

Clause 6.1.1:-

6.2.1 all or part of the Revenue Funding is used by the Council for a purpose other than to fund the Services, or is otherwise not properly applied to the funding of the Services; and

6.2.2 in the reasonable opinion of NHS England, the level of performance of the Services by the Council falls substantially below the level required to meet the objectives of the Services.

6.3 Either Party may on the giving of not less than 6 months notice to the other Party terminate this Agreement whenever one of the following events occurs:-

6.3.1 fulfilment of a Party's obligations would contravene any guidance from the Secretary of State; or

6.3.2 the Parties are unable to reach agreement on a dispute and following compliance with Clause 7 no resolution is achieved.

6.4 The Agreement shall terminate in so far as applicable to any unpaid revenue fund payments should those remaining revenue fund payments cease to be made by the Department of Health to NHS England but be paid directly by the Department of Health to the Council and such termination will apply from the date of such said cessation of payments by NHS England

7 MONITORING & OUTCOMES

7.1 The evidence set out in full in Schedule A of this Agreement will be required to indicate that the purposes described at Clauses 3 above have been achieved.

8 DISPUTE RESOLUTION

8.1 Any dispute between the Parties in connection with this Agreement shall be referred to the dispute resolution procedure as provided in this Clause

8.2 In the first instance in the event of a dispute between the Parties in connection with this Agreement the matter shall be referred to Hertfordshire and South Midlands Area Team Director of NHS England (or their nominated deputy) or their successor and the Director of Housing and Community Living of the Council (or their nominated deputy) or their successor who shall meet solely in order to resolve the matter in dispute and endeavour to settle the dispute between them and each Party shall act in good faith.

8.3 If the dispute cannot be resolved by the Parties representatives under Clause 8.2 within a maximum of fourteen (14) days after it has been referred under Clause 8.2, the dispute shall be determined in accordance with Clauses 8.4 to 8.7 inclusive

8.4 If the meeting referred to in Clause 8.2 fails to resolve the matter then the Parties will attempt to settle the dispute by mediation through an Alternative Dispute Resolution Procedure ("ADR") in accordance with the Centre for Effective Dispute Resolution ("CEDR") Model Mediation Procedure ("MMP"). To initiate a mediation, either party shall give written notice ("Mediation Notice") to the other party requesting a mediation of the dispute and shall send a copy of the Mediation Notice to CEDR requesting

CEDR to nominate a mediator in the event that the parties are unable to agree such appointment by negotiation.

8.5 The mediation shall commence within twenty-eight (28) days of the Mediation Notice being served. Neither party will terminate such mediation until each Party has made its opening presentation and the mediator has met each Party separately for at least one (1) hour. Subject to this thereafter the MMP will apply.

8.6 The Parties will co-operate with any person appointed as mediator providing all required information and such Party will pay costs, as the mediator shall determine or, if no determination is made by the mediator, by the parties in equal portions.

8.7 If the matter has not been resolved by the ADR procedure or if the either Party will not participate in an ADR procedure, then either party may give the other 14 days notice that the mediation is considered as failing. If mediation fails to resolve the dispute then the dispute shall be referred to the English Courts in accordance with Clause 11.

9. NOTICES

9.1 Any notice or communication hereunder shall be in writing.

9.2 Any notice or communication to the Council shall be deemed effectively served if sent by registered post or letter fax or delivered by hand to the Council at the address set out above or such other address as the recipient may designate in writing to the other from time to time and marked for the attention of the Director of Housing and Community Living at the Council (or his / her nominated deputy) or successor or to such other addressee and address notified from time to time to NHS England.

9.3 Any notice or communication to NHS England shall be deemed effectively served if sent by registered post or letter fax or delivered by hand to the address set out above or such other address as the recipient may designate in writing to the other from time to time and marked for attention of the Chief Executive of NHS England (or his/her nominated deputy) or successor or to such other addressee and address notified from time to time to the Council.

9.4 Any notice served by delivery shall be deemed to have been served on the date it is delivered to the addressee provided that where notice is posted it shall be sufficient to prove the notice was properly addressed and posted and the addressee shall be deemed to have been served with the notice 48 hours after it was posted or if by fax when despatched.

10 The Contracts (Rights of Third Parties) Act 1999

10.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Parties to this Agreement agree that this Agreement does not confer upon any third party any rights under the Contracts (Rights of Third Parties) Act 1999.

11 GOVERNING & JURISDICTION

11.1 The formation, interpretation and operation of this Agreement and all contractual and non-contractual disputes relating to this Agreement will all be subject to English Law.

11.2 Subject to the provisions of Clause 8, the Parties each submit to the exclusive jurisdiction of the English Courts

12 ENTIRE AGREEMENT

12.1 This Agreement constitutes the entire agreement between the Parties and supersedes all previous agreements (written or oral) between the Parties in relation to its subject matter.

12.1.1 Each Party acknowledges that in entering into this Agreement it has not relied on, and shall have no right or remedy in respect of, any statement, representation, assurance or warranty (whether made negligently or innocently) other than as expressly set out in this Agreement.

12.1.2 Nothing in this clause shall limit or exclude any liability for fraud.

13. VARIATIONS

13.1 This Agreement may not be amended other than in accordance with this Clause 13

13.2 Any variation to the terms of this Agreement must be recorded in writing and agreed by both Parties before such variation takes effect.

14 WAIVERS

14.1 The failure of either Party to enforce at any time or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Party thereafter to enforce such provision

14.2 No waiver in any one or more instances of a breach of any provision hereof shall be deemed to be a further or continuing waiver of such provision in other instances.

15 WINDING DOWN

15.1 In the event that this Agreement is terminated (whether by effluxion of time or by notice of termination) the Parties agree to co-operate insofar as reasonably practicable to ensure an orderly wind down of their activities as set out in this Agreement.

16 CONFIDENTIALITY

16.1 The terms of this Agreement are confidential to the Parties. Apart from disclosure in confidence to their respective professional advisers or as required by law the Parties will make no disclosure as to the terms of this Agreement without the prior written consent of the other.

17. PREVENTION OF BRIBERY AND CORRUPTION

17.1 Either Party (such Party, in this Clause 17, the "**Affected Party**") is entitled to terminate the Agreement and to recover from the other Party (such Party, in this Clause 17, the "**Non-Affected Party**") any loss resulting from such termination:-

17.1.1 if the Non-Affected Party offers or gives or agrees to give any person any gift or consideration of any kind as an inducement or reward for doing or not doing, or for having done or not done any action relating to the obtaining or execution of this Agreement, or for showing favour or disfavour to any person relating to this Agreement or any other contract with the Affected Party, or

17.1.2 if in relation to this Agreement or any other contract with the Affected Party, the Non-Affected Party (i) commits any offence under the Prevention of Corruption Acts 1889 to 1916, or (ii) gives any fee or reward the receipt of which is an offence under Section 117(2) of the Local Government Act 1972, or (iii) contravenes the Bribery Act 2010, when such Act comes into force.

17.2 Clause 17.1 shall apply to any person employed by the Non-Affected Party or acting on behalf of the Non-Affected Party (whether with or without the knowledge of the Non-Affected Party) as it applies to the Non-Affected Party.

17.3 Termination pursuant to Clause 17.1 shall not prejudice or affect any right of action or remedy which shall have accrued or shall accrue thereafter to the Affected Party.

18 HUMAN RIGHTS ACT

18.1 The Parties acknowledge their respective duties to act in a way which is compatible with the Convention Rights as defined by Section 1(i) of the Human Rights Act 1998 ("Convention Rights").

19 FREEDOM OF INFORMATION

19.1 The Parties acknowledge their respective duties under the Freedom of Information Act 2000 (the "**FOIA**") and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

19.2 In particular, each Party (such Party, in this Clause 19, the "**First Party**") shall at no cost to the other Party (such Party, in this Clause 19, the "**Other Party**") use all reasonable endeavours to respond fully to information requests from the Other Party within five (5) working days of the day of receipt of the request for information from the Other Party in order to enable the Other Party to comply with its obligations under the FOIA. If the First Party is unable to respond fully to such requests within the time period above, then as soon as possible, but in any event within such period, it shall notify the First Party of the same and shall provide all such information as it is able, the actions required to respond and the estimated time to respond in full.

19.3 As soon as reasonably practicable and in any event by no later than the end of the period referred to at Clause 19.2 the First Party shall:-

19.3.1 provide to the Other Party all data and other information which it has obtained in response to the request; and

19.3.2 demonstrate to the reasonable satisfaction of the Other Party the steps taken by the First Party to comply with its obligations under Clause 19.2 and the amount of time and resources expended in so doing.

19.4 If requested by the Other Party, the First Party shall advise the Other Party of what further steps will, in the First Party 's reasonable opinion, be required in order to respond in full to the information request from the Other Party. If the Other Party instructs the First Party to continue to seek a full response to the information request then the First Party shall be entitled to be reimbursed for its reasonable costs which it properly incurs in continuing to seek to obtain such information provided that in so doing it does not incur costs in excess of the "appropriate limit" as defined in the FOIA without seeking the prior written consent of the Other Party to proceed. The Other Party shall then determine whether it requires the First Party to continue to use all

reasonable endeavours to obtain the information requested until an agreed point of further review or instruction from the Other Party to cease further work, whichever shall occur first.

19.5 Each Party shall at all times act promptly and in good faith and shall mitigate all costs incurred in complying with its obligations under this Clause 19.

20 DATA PROTECTION

20.1 The Parties acknowledge their respective duties under the DPA and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

20.2 Each party warrants to the other that in providing the other Party with information under the terms of this Agreement it is not, and will not be, in breach of the Data Protection Act 1998 and all subordinate legislation relating thereto including the eight data protection principles.

21 FORCE MAJEURE

21.1 For so long as such circumstances prevail, no Party shall be liable for any failure or delay in the performance of its obligations and/or duties under this Agreement (other than a payment of money) to the extent that such failure or delay is caused by circumstances beyond that Party's reasonable control.

21.2 NHS England shall not be entitled to withhold payment, and NHS England is not entitled to be indemnified for any payments made where there is an adverse affect on the services and the ability of the Council to provide those services to the extent that the circumstances giving rise to that situation arise as a result of a Force Majeure.

21.3 The Party claiming relief shall serve initial written notice on the other Party immediately it becomes aware of the Force Majeure. This initial notice shall give sufficient details to identify the particular event. The Party claiming relief shall then serve a detailed written notice within 14 days which shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it and resume full delivery of Services.

21.4 If a Force Majeure event prevents either Party from performing all of its obligations under the Agreement for a period in excess of 6 Months, either Party may terminate the Agreement by notice in writing with immediate effect.

21.5 Clause 21 does not affect the Parties rights under Clause 6 (Termination)

22. INTELLECTUAL PROPERTY RIGHTS

22.1 All copyright and rights in the nature of copyright in materials produced with the help of the Payments shall vest jointly in the CCG and the Council unless otherwise specifically agreed in writing and any dealing with those intellectual property rights shall only be with the agreement of both Parties and any benefit shall be shared equally between the Parties

IN WITNESS WHEREOF the duly authorised representatives of the Council and Luton CCG on behalf of NHS England have executed and delivered this Agreement as a deed the day

and year first above written

THE COMMON SEAL of **THE COUNCIL OF THE BOROUGH OF LUTON** was hereunto affixed pursuant to a resolution of the Council in the presence of:-)

Authorised Signatory

Authorised Signatory

Signature:
Name:
Position:

SIGNED and delivered as a deed on behalf of **Luton CCG** by:

Signature:
Name:
Position:

SCHEDULE A

Measures for Monitoring LBC Performance against Section 256 Transfer

Performance Measures will be monitored through Health and Wellbeing Board and the Joint Commissioning Group and include all adult social care performance indicators selected by the Independent and Healthy Lives Delivery Board and some joint indicators selected by the Board. (Public Health indicators, NHS GP survey indicators and others that social care cannot influence have been omitted from the list below):

- 'Yes' indicates areas that LBC has lead responsibility for – performance may affect NHS England's funding allocation of the Section 256 in 2013/14 and future years
- 'Partial' indicates areas that LBC have a contributory role and partial responsibility for – performance will not affect NHS England's decision on the funding of the Section 256 agreement

These measures will be reviewed for future years and updated by mutual agreement.

	Measure	**Influenced by Adult Social Care**	**Frequency of collection**	**Source**	**Target 13/14**	**Basis Of Target**
ASCOF 1 A	Social care related quality of life for users (composite measure)	Partially	Annual	Adult Social Care Survey	18.4	Maintain current performance
ASCOF 1C -old N1 130	Proportion of people using social care who receive self-directed support, and those receiving direct payments	Yes	Annual	ASC RAP	73 % of eligible users	Maintain current performance
ASCOF 1D	Carer reported quality of life (composite measure)	Partially	Every 2 years	Carers Survey	8.1 in 14/15	Maintain current performance
Local measure	Equipment delivered within 7 days (integrated service includes social care and NHS)	Yes	Annual	Local data base	95%	To maintain current high performance
NHS	Percentage of emergency re admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital	Partially	Annual	NHS HES	Not yet set	Maintain current performance
ASCOF	Older people discharged from	Partially	Annual (but	ASC CAR	73.9	Maintain current

	Measure	Influenced by Adult Social Care	Frequency of collection	Source	Target 13/14	Basis Of Target
2B part 1-old NI125 NHSOF 3.6i	hospital to rehabilitation or intermediate care, who are living at home 91 days after discharge		only captures 3 months of year Oct-Dec)			performance
ASCOF 2C part 2	Delayed transfers of care attributable to ASC	Yes	Weekly	UNIFY2	5.8	Maintain current performance
ASCOF 2C part 1	Delayed transfers of care ASC ie 2C part 1	Partially	Weekly	UNIFY2	Target of 14.1	Maintain current performance
ASCOF 1E (was NI146)	Proportion of adults with Learning Disabilities in employment	Yes	Annual	ASC CAR	13	Maintain top quartile performance *(12/13 outturn 14.7%)*
Local indicator	Numbers of LD patients who have had a health check	Partially	Annual		61.6	Maintain current performance
ASCOF 1F	Proportion of adults in contact with secondary mental health services in employment	Partially	Annual	MH Provider Database	6%	Maintain current performance

SCHEDULE B

Initial Service Areas
2013/14 for maintaining existing investment

Service Area	Indicative Budget £'s
Telecare	326,000
Community Based Directed Prevention	737,000
Equipment and Adaptations	3,277,000
Reablement, Rehabilitation and Support	3,502,000
Falls Prevention –(social work input)	£50,000
Reablement team to provide 7am to 11pm cover	£200,000
Total	**8,092,000**
NHS Investment to support this LBC funding	1,961,000

SCHEDULE C

2013/14 Areas for New Council investment

Service Area	Indicative Budget £'s
Step Up / Step Down Flats (mainstreaming current investment) - 6 flats	£109,000
Brokerage post to help find care homes and home care agencies to support hospital discharge and CHC placements	£30,000
Additional Social Work Staff in the Integrated Hospital Discharge Team at the L&D to expedite discharges	£100,000
Short Term social care beds at Collinson House to allow discharge from hospital where home care package is not in place	£5,500
LBC Funding for CART staff in CCS	£80,000
Joint Autism strategy priorities - ongoing funding for Autism Bedfordshire to deliver training across a range of professionals	£20,000
Admin Support towards the integrated GP pilot	£40,000
Continuation of Alzheimer's Society pilot improving information and advice on dementia for people in BME communities	£30,000
Expansion of Alzheimer's Society support to the SEPT Memory Assessment Service	£20,000
Care Home monitoring and improvement work within LBC Contracts and Quality Assurance team	£50,000
Support to bring back Learning Disability people in independent hospitals (intensive work with the individuals and their families, developing local bespoke services around the individual and potential transition costs	£50,000

One off piece of work to add all NHS numbers to CareFirst (social care system) - currently about 30% of people on CareFirst have an NHS number recorded on the system and better integrated working requires the NHS number as a starting point	£20,000 (estimate)
Integration - IT costs to implement a system to allow shared access to electronic records across health and social care (CareFirst, SystmOne etc.)	£50,000 (estimate)
Funding for SEPT to complete Mental Health social care reviews more quickly and to extend this responsibility to older persons' services	£50,000
Long Term Conditions Fund administered by Age Concern	£10,000
Increased Occupational Therapy staff or service to reduce waiting list	£70,000
Additional funding for Disabled Facility Grants and / or minor adaptations to prevent hospital admissions and reduce delays	£50,000
Project costs for the E&Y (ASC part) of Integrated Care work up/redesign and implementing a new model	£15,000
Joint Programme Manager to implement proposals to further integrate services between LBC and LCCG	£60,330
Total	**859,830**

In line with the requirements set out in the DH letter of19 June (Gateway number: 00186) the breakdown of funding will following discussion with NHS England Area Teams be set out using the table 1 below. The Annual Voucher set out in Schedule D will also be used

Table 1:	**Analysis of the adult social care funding in 2013-14 for transfer to local authorities**		
Service Areas- 'Purchase of social care'		***Indicative budget***	***Subjective code***
Community equipment and adaptations			52131015
Telecare			52131016
Integrated crisis and rapid response services			52131017
Maintaining eligibility criteria			52131018
Re-ablement services			52131019
Bed-based intermediate care services			52131020
Early supported hospital discharge schemes			52131021
Mental health services			52131022
Other preventative services			52131023
Other social care (please specify)			52131024
	Total		

SCHEDULE D

ANNUAL VOUCHER

SECTION 256 ANNUAL VOUCHER

LUTON BOROUGH COUNCIL

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2014..

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	Revenue Expenditure	Capital Expenditure	Total Expenditure
£	£	£	£

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by Luton Health and Well Being Board and Luton Clinical Commissioning Group in accordance with Directions.

Signed…….

Date…….Local Authority Chief Financial Officer or other relevant responsible Council financial officer.

Certificate of independent auditor

I/We have:

- examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- carried out such tests and obtained such evidence and explanations as I/we consider necessary.

(Except for the matters raised in the attached qualification letter dated)* I/we have concluded that

- the entries are fairly stated: and
- the expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …… Name (block capitals)

Company/Firm ……

Date ……..

* Delete as necessary

HEALTH AND WELLBEING BOARD	AGENDA ITEM: 12.2

DATE OF MEETING: **17th July 2013**

REPORT AUTHOR & CONTACT NUMBER: **Simon Pattison, 07500 918906**

SUBJECT: **Winterbourne View – Update and Stocktake**

WARD(S) AFFECTED: All

PURPOSE

To update HWBB on progress against the key priorities identified as a result of the various reports into Winterbourne View and the poor quality care identified at this independent hospital for people with learning disabilities

RECOMMENDATION(S)

The Health and Wellbeing Board is recommended to note the attached stocktake document and support the ongoing work across a number of organisations to ensure Luton residents with a learning disability are not subject to poor quality care.

BACKGROUND

The original trigger for this workstream was the BBC Panorama investigation aired on the 31st of May 2011 which uncovered serious physical and mental abuse of patients being perpetrated by staff at Winterbourne View Hospital, an independent hospital for people with Learning Disabilities. This resulted in a number of reports and a national compact agreement to ensure the situation was not repeated elsewhere. A full report was presented to HWBB on 12th April.

REPORT

The April HWBB report summarised the local action plan put in place by LBC and LCCG to respond to the concerns raised after Winterbourne View. There has been a strong national focus on the issue with Norman Lamb, Minister of State for Care and Support, writing to each local area individually to ask them to respond to the issues resulting from Winterbourne. He has created a national team, the Winterbourne View Joint Improvement Programme, to lead the work nationally.

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF).

Local councils have been asked to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The Luton Stocktake is attached and was submitted to the Department of Health before the deadline of the 5th of July. There are 11 headings in the document as follows:

1. Models of partnership
2. Understanding the money
3. Case management for individuals
4. Current Review Programme
5. Safeguarding
6. Commissioning arrangements
7. Developing local teams and services
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies
9. Understanding the population who need/receive services
10. Children and adults – transition planning
11. Current and future market requirements and capacity

The overall position in Luton is reasonably strong. In particular there are long standing Section 75 arrangements covering integrated commissioning and pooled budgets for Learning Disability services and an integrated Community Learning Disability Team, containing both Social Workers and Learning Disability nurses. These arrangements ensure that there is a clear understanding of financial flows and responsibilities for assessments and reviews for all people with Learning Disabilities.

The following areas have been identified as potential areas of concern:

- **Are the arrangements for review of people funded through specialist commissioning clear? (1.2, 4.2 and 6.5)** To date we have not been able to meet with specialist commissioning (SCG) and have received only limited information on the four SCG funded people they believe fit the criteria, only one of whom is known to Luton's Community Learning Disability Team.

- **Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used? (4.4)** All people with a Learning Disability known to adult social care are recorded (registered) on CareFirst, the social care IT system. However there is not a field on CareFirst which identifies whether people have behaviour that challenges and so this is not recorded in a consistent or easily accessible way. Local concerns have been raised about where the boundary lies in terms of defining this behaviour and whether or not you would include people whose behaviour challenges occasionally, but not on a regular basis. A national definition would support consistent recording in this area.
- **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? (6.4)** The joint Luton Learning Disability commissioning strategy is currently in development and will include this in the completed document.
- **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)? (6.9)** There are four current Luton funded people in this position. The answer given in the document is that we are reasonably confident but have identified a couple of significant obstacles to overcome:
    - o Most people are sectioned under the Mental Health Act and so cannot be moved until the Section is removed.
    - o There is a lack of current suitable provision so a commissioning exercise is underway to develop new services. This is a very lengthy process which will take us close to the deadline of 1st June 2014.
- **Do you have plans to ensure that there is capacity to ensure that Best Interests Assessors (BIA) are involved in care planning? (7.3)** We are trying to encourage practitioners who are employed by the council or who are in integrated teams to see becoming a BIA as a continuing professional development issue. There are plans to train 2 more BIAs in Luton in the autumn.
- **Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally? (8.1)** Bedfordshire CCG are currently leading a review of Specialist Learning Disability services within the SEPT contract. This includes the Intensive Support Team who provide crisis response locally.

Risks

The most significant risk is that we will find it very difficult to identify suitable local services for the people currently in independent hospitals to be moved to. This will be mitigated by work with providers to develop local services but this will be a lengthy process and will not necessarily provide a cost saving from the current model. This will be monitored closely through the Future Joint Commissioning Strategic Group, responsible for managing the various partnerships between the CCG and LBC.

Appendix:

Completed Stocktake Document for Luton

PROGRESS AGAINST HEALTH AND WELLBEING STRATEGY PRINCIPLES:

Promoting Integration / Pooled Budgets / Joint Commissioning

Placements for people with a Learning Disability are already managed through a pooled budget and lead commissioning arrangement. This is hosted by LBC working in partnership with the CCG.

Improving Quality And Efficiency - Service / Pathway Redesign

Developing appropriate services for people with learning disabilities so that they do not need to access independent hospital settings will be a key part of the action plan.

Addressing The Wider Determinants Of Health

This is not directly relevant to the Winterbourne View work.

Focusing On Early Intervention And Prevention

The development of early intervention services to ensure that in the future people with Learning Disabilities do not end up in independent hospital settings is a key part of the action plan.

IMPLICATIONS

No specific implications from this report.

CONSULTATIONS

The draft stocktake document was consulted on widely within LBC Adult Social Care and Luton CCG, and an earlier draft was presented to Luton Safeguarding Adults Board.

APPENDIX

Completed Stocktake document for Luton

LIST OF BACKGROUND PAPERS
LOCAL GOVERNMENT ACT 1972, SECTION 100D

None

Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

Winterbourne View Local Stocktake June 2013			
1. Models of partnership	**Assessment of current position evidence of work and issues arising**	**Good practice example (please tick and attach)**	**Support required**
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	Joint arrangements in place - established through existing joint commissioning and integrated Community Learning Disability Team arrangements		
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	Support from housing in place – good links with LBC strategic housing team to identify potential Supported Living accommodation		
1.3 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.	JSNA includes overarching information on people with Learning Disabilities. Meetings set up to review individual cases relevant to Winterbourne View and aggregate needs into plans		
1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	Yes – report to LDPB 6th February 2013 and on agenda for future meetings		
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	Yes – report to Healthier and More Independent sub group of Health and Wellbeing Board 12th April 2013		
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	Yes – through Section 75 agreement		
1.7 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 – through Section 75 agreement covering joint commissioning and joint post		
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	Two current cases but impact is not significant		

1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	Yes – funding identified through Section 256 agreement to support delivery of the plan		
2. Understanding the money			
2.1 Are the costs of current services understood across the partnership.	Yes – through Section 75 pooled budget		
2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	Yes – through Section 75 pooled budget		
2.3 Do you currently use S75 arrangements that are sufficient & robust.	Yes – updated Section 75 agreement signed off in April 2013		
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	Yes – updated Section 75 agreement signed off in April 2013		
2.5 Have you agreed individual contributions to any pool.	Yes		
2.6 Does it include potential costs of young people in transition and of children's services.	Costs of children in transition assessed and monitored on a regular basis and additions to the pooled budget agreed on a case by case basis at the point of transfer to adult services		
2.7 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.	Yes – information on children in transition and demand trends forms part of discussions about annual allocations. Council medium term strategy includes a recognition of the additional numbers of people with a learning disability requiring support and both partners have considered potential savings options within medium term strategies		
3. Case management for individuals			
3.1 Do you have a joint, integrated community team.	Yes, with Section 75 agreement to support		
3.2 Is there clarity about the role and function of the local community team.	Yes, through Section 75		
3.3 Does it have capacity to deliver the review and re-provision programme.	Yes, with additional resource identified through Section 256 transfer		
3.4 Is there clarity about overall professional leadership of the review programme.	Yes – joint commissioning arrangements in place		
3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	Yes – named workers identified. Advocacy support available to all who require it		
4. Current Review Programme			
4.1 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.	Yes – agreement on people and named workers in place		

4.2 Are arrangements for review of people funded through specialist commissioning clear.	To a degree – list provided from SCG but meetings to discuss arrangements have been cancelled		More information from SCG
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	Yes – people with a learning disability, carers and advocacy involved through LDPB. Healthwatch is in the process of identifying an appropriate lead.		
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	No – no clear comprehensive list of people with behaviour that challenges. Need to develop this.		National definition of behaviour that challenges would help
4.5 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 – through joint commissioning and integrated Community Learning Disability Team (CLDT)		
4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	Yes		
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	Reviews signed off by Community Learning Disability Team Manager and quality assured by Service Manager		
4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	Yes - in most situations. Monitored through panel process		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.	All reviews completed		
5. Safeguarding			
5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	Yes – alerts are shared and CLDT staff attend / contribute to any investigations		
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	Regular attendance of safeguarding team at provider forums; Safeguarding Managers visiting providers to raise awareness of Safeguarding Adults, MCA and DOLS)		

	as part of a rolling programme) Plans to develop a safeguarding forum for all providers of services to attend, whether LBC contracts with them or not; to offer opportunities to learn more about local and national developments in safeguarding adults; Attendance at Housing vulnerable tenants meetings Plans to engage with the new domiciliary care providers to raise awareness of safeguarding procedures etc. locally and ensure robustness Engagement with providers during safeguarding interventions to develop robust care plans and risk assessments Safeguarding Adult team acts as a resource and is available to offer advice and guidance to providers and other professionals and members of the public		
5.3 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. 5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme. 5.5 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.	No units within Luton Report to Adult Safeguarding Board in March 2013 and June 2013. Will be going to Children's Safeguarding Board on 15th December. The LSAB has requested that all partners demonstrate in their Board Reports how they are implementing the winterbourne view report recommendations; regular data reporting to the LSAB outlining trends in alerts can assist in identifying potential areas for concern; a single point for the management of alerts ensures all alert information is captured centrally; development of IT system to ensure robust reports are available to assist LSAB; ongoing training on DOLS and MCA 2005 available to professionals.		

5.6 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.	See above		
5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	Yes – Keeping Safe in the community will be a theme of the October LD Partnership Board with input from community safety partnership colleagues and the Bedfordshire Police representative		
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	Yes – good multiagency representation at Safeguarding Board and regular information sharing		
6. Commissioning arrangements			
6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Yes – through individual reviews. Will be collated and fully assessed in early July.		
6.2 Are these being jointly reviewed, developed and delivered.	Yes		
6.3 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 – through pooled budget arrangements		
6.4 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.	Commissioning strategy being rewritten to reflect this intention. To be completed by October 2013.		
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	No – has been difficult to engage with SCG		
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	Yes – through joint commissioning arrangements		
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	Yes – revised contract in place from April 2012		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed.	Yes		
6.9 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).	Reasonably confident. The main obstacles identified so far are that 1) Most people are sectioned and so cannot be moved until the Section is removed. 2) There is a lack of current suitable provision so a commissioning exercise is underway to develop new services. This is a very lengthy		

6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	process		
7. Developing local teams and services 7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings. 7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements. 7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	Yes Yes – regular contract monitoring meetings with provider We are trying to encourage practitioners who are employed by the council or who are in integrated teams to see becoming a BIA as a Continuing Professional Development issue. There are plans to train 2 more BIAs in the autumn		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies 8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally. 8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.) 8.3 Do commissioning intentions include a workforce and skills assessment development.	Bedfordshire CCG are currently leading a review of Specialist Learning Disability services within the SEPT contract. This includes the Intensive Support Team who provide crisis response locally. Intensive Support Team in place within SEPT contract The role of the Bedfordshire and Hertfordshire Workforce Partnership includes maintaining a workforce assessment for NHS staff. For social care workforce LBC are developing a workforce strategy to include independent sector providers.		
9. Understanding the population who need/receive services 9.1 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. 9.2 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	Market assessment in development Yes		

services.			
10. Children and adults – transition planning 10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults. 10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	Yes – transitions team in place and regular information supplied by the team to commissioners and CLDT to support planning for new services Yes – spreadsheet with potential transition cases from children's services maintained and updated on a regular basis		
11. Current and future market requirements and capacity 11.1 Is an assessment of local market capacity in progress. 11.2 Does this include an updated gap analysis. 11.3 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.	Yes – Market Development Strategy being developed It will include a gap analysis when complete		

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

This document has been completed by

Name……Simon Pattison, Head of Adult Joint Commissioning……

Organisation…Luton Borough Council and Luton Clinical Commissioning Group..

Contact……simon.pattison@lutonccg.nhs.uk……

Signed by:

Chair HWB ……Councillor Hazel Simmons…

LA Chief Executive ……Pam Garraway (Director of Housing, Community Living and Adult Social Care (DASS)), Luton Borough Council

CCG rep…Carol Hill, Chief Officer, Luton CCG

HEALTH AND WELLBEING BOARD	AGENDA ITEM: 12.3

DATE OF MEETING:	**17 July 2013**
REPORT AUTHOR:	**Pam Garraway, Director of Housing & Community Living**
CONTACT NUMBER:	**01582 546215**
SUBJECT:	**Whole System integration**

WARD(S) AFFECTED: ALL

PURPOSE

To ensure appropriate arrangements are in place to support whole system integration.

RECOMMENDATION(S)

The Health and Wellbeing Board is recommended to:

1. **Note the project implementation document for whole system integration**

2. **Note the application to become a pioneer site for whole system integration**

3. **Request progress reports, as appropriate, from the Integration project manager**

BACKGROUND

1. There are significant national and local drivers supported the development of whole system integration. At a national level, the Health and Social Care Act (2012) puts a responsibility on Health and Wellbeing Boards to promote integration; at a local level, integration is identified in the Health and Wellbeing Strategy as one of the key factors in improving health and reducing health inequalities.

REPORT

2. Ernst & Young was commissioned by Luton Borough Council and Luton Clinical Commissioning Group to develop a project initiation document for whole system integration. The scope of this work covers the Council – including public health, adult social care, children's services (excluding education) - and the Clinical Commissioning Group.

3. The project initiation document recognises that both organisations are working facing significant financial challenges and that the strategic redesign of services, focusing on independence and early intervention, can lead to the delivery of improved outcomes at a lower cost.

4. In order to move away from viewing services in the silos of LBC Adults, LBC Children's, Health and Public Health, four 'service bundle' areas have been developed and validated with Board members and Stakeholders across LBC and LCCG. These are:

    1. *Wellness* - Universal or preventative services

    2. *Early intervention* - Targeted services for those who may be at risk in the future

    3. *Help at home* - Services for adults who need support in the community and children on the edge of care

    4. *Specialist* - Services for children in care and for adults and children who cannot be supported in the community, including acute the sector

5. The strategic approach to taking whole systems integration in Luton forward at a high level is as follows:

    1. Bundle reviews- review of each of the four bundle areas in parallel, assessing options available to re-configure services within each of these areas.

    2. Whole systems case – Builds a case on services to be re-configured across the whole systems economy, including the investment model.

    3. Operating model – Future operating model for whole systems integration including service architecture for example shared IT and back office functions.

6. The project initiation document outlines the plan to prepare the business case for change by November 2013 with implementation taking place over

a five year period. It has been signed off by Luton Borough Council's Directors of Public Health, Children and Learning and Housing and Community Living as well as the Clinical Commissioning Group.

7. The role of the Health and Wellbeing Board is recognised in the governance of the project, and the board will need to receive reports at key stages to have assurance that the project is achieving what is requiring within its governance framework.

PROGRESS AGAINST HEALTH AND WELLBEING STRATEGY PRINCIPLES:

Promoting Integration/Pooled Budgets/Joint Commissioning

The programme will be designed to facilitate the changes that are needed in order to make progress in these areas.

Improving Quality and Efficiency – Service/Pathway Redesign

The expected benefits of integrated commissioning and provision include financial savings from reducing duplicate management and overhead functions, improved outcomes for service users and improved performance management.

Addressing the Wider Determinants of Health

Whole system integration will support a person-centred approach which will be able to take into account lifestyle factors and other issues which have an impact on health.

Focussing on Early Intervention and Prevention

The project is based on the expectation of shifting resources, where possible, towards promoting wellness and early intervention with the aim of reducing avoidable reliance on more intensive specialist services.

IMPLICATIONS

Legal, financial and equalities issues will be considered during the development of the project.

CONSULTATIONS

APPENDIX

Appendix 1 – Whole Systems Integration - Project Initiation Document

Appendix 2 –Submission for Integration Pioneer

LIST OF BACKGROUND PAPERS
LOCAL GOVERNMENT ACT 1972, SECTION 100D

Set out here the public papers used in the compilation of this report, which may be viewed by the public.

LUTON BOROUGH COUNCIL

NHS Luton Clinical Commissioning Group

Sent via e-mail to: pioneers@dh.gsi.gov.uk
Cc: natalie.pemberton@dh.gsi.gov.uk.

28th June 2013

Dear Sir,

I have great pleasure in enclosing our submission to become a Health and Social Care Integration Pioneer Programme. This is an important, high profile programme, and we welcome the opportunity to be part of this to support us on our path to integrated working.

Luton makes a compelling case to become a Pioneer site. We are taking a *whole life, whole systems* approach to integration, providing a holistic view of integrated services. The Borough faces a number of demographic challenges that are consistent with other areas; however, Luton also has the added dimension of having high levels of deprivation in a population that is also increasingly young and "super diverse". As a pioneer site, we will develop learning which is relevant and can be shared with many areas across the country, but will also offer valuable insight to others into how these defining factors affect the outcomes achieved from integration.

Luton has a track record for innovation in integration. We were one of the first locations to establish a Health and Wellbeing Board, and we are working closely with partners across the Borough to develop and implement a number of pioneering initiatives with our innovation partner, the University of Bedfordshire. These established mechanisms will support us in delivering our ambition.

You will see in our submission that we are already working on an integration programme and have a number of pilot initiatives in place. We believe this is an agenda which can not wait, and are excited to be pioneers in this area and committed to working with the Department of Health to share our learning with others as part of the programme.

Yours faithfully,

Trevor Holden
Chief Executive
Luton Borough Council

Cllr Hazel Simmons
Chair, Health & Wellbeing Board

Dr Nina Pearson
Chair, Luton Clinical Commissioning Group

Carol Hill
Chief Officer
Luton Clinical Commissioning Group

Pauline Philip
Chief Executive
Luton & Dunstable University Hospital

Matthew Winn
Chief Executive
Cambridgeshire Community Services NHS Trust

Dr Patrick Geoghegan
Chief Executive
South Essex Partnership University

AGENDA ITEM: 13.1

LUTON BOROUGH COUNCIL
HEALTH AND WELLBEING BOARD
WORK PROGRAMME 2013 / 2014

DATE OF MEETING	TITLE	ISSUE	BOARD MEMBER	REPORT AUTHOR
17 July 2013	Luton and Dunstable Hospital	To consider future plans, including estate issues		
17 July 2013	Wellness Service – business case	To support business case (Presentation)	Gerry Taylor	Morag Stewart
17 July 2013	On street Sex Work Strategy	To agree strategy	Gerry Taylor	Nikki Middleton
17 July 2013	Luton CCG – Commissioning Intentions for 2014/15	To set out the time table	Nina Pearson	Carol Hill
17 July 2013	NHS England	To update members on the work of NHS England	Sarah Whiteman	Sarah Whiteman
17 July 2013	Luton CCG Prospectus	To agree final version	Nina Pearson	Carol Hill
17 July 2013	Healthwatch Luton Business Plan	To receive the Healthwatch Business Plan	Nisar Mohammed	Nisar Mohammed
17 July 2013	Delivery of Winterbourne View Concordat and review commitments	To confirm progress against agreed actions	Pam Garraway	TBC
17 July 2013	Integration – report from Ernst & Young		Pam Garraway	
17 July 2013	Health and Social Care Integration Pioneer		Pam Garraway	

DATE OF MEETING	TITLE	ISSUE	BOARD MEMBER	REPORT AUTHOR
	programme			
17 July 2013	Section 256	To agree proposals	Pam Garraway	Simon Pattison
Date to be confirmed	Development: Support from NICE			
Date to be confirmed	Healthy Child Programme / Early intervention	To note progress	Martin Pratt	Jo Fisher
Date to be confirmed	Winter Pressures	To ensure arrangements are in place for winter 2013/14	Pam Garraway	Simon Pattison
Date to be confirmed	Health and Wellbeing Strategy – headline indicators	To report progress and related issues	Gerry Taylor	Caroline Thickens
Date to be confirmed	Reference form Executive – Coroner and related services	To confirm response to Overview & Scrutiny	Gerry Taylor	TBC
Date to be confirmed	Luton CCG – Commissioning Intentions	To sign off commissioning intentions	Nina Pearson	Carol Hill
29 October 2013	Health and Wellbeing Strategy – performance report	To confirm arrangements for reporting progress	Pam Garraway / Martin Pratt / Gerry Taylor	Morag Stewart

HEALTH AND WELLBEING BOARD – 17th July 2013

AGENDA ITEM: 13.1

DATE OF MEETING	TITLE	ISSUE	BOARD MEMBER	REPORT AUTHOR
29 October 2013	Overview and Scrutiny Task and Finish Group – Hospital Discharge	To consider the recommendations of the review	Cllr Khan (obs)	Bert Siong
29 October 2013	Overview and Scrutiny annual report	To consider the implications for the Health and Wellbeing Board	Cllr Khan (obs)	Lisa Jerome
29 October 2013	Healthwatch quarterly report	To consider issues arising from the Healthwatch work programme	Nisar Mohammed	Nisar Mohammed
29 October 2013	Safeguarding – Adult's and Children's	To identify key issues for consideration by the Board	Pam Garraway / Martin Pratt	
16 January 2014	Overview and Scrutiny Task and Finish Group – Infant mortality	To consider the recommendations of the review	Cllr Khan (obs)	Eunice Lewis
16 January 2014	Healthwatch quarterly report	To consider issues arising from the Healthwatch work programme	Nisar Mohammed	Nisar Mohammed
16 January 2014	Luton CCG Draft Operating Plan	To sign off draft	Nina Pearson	Carol Hill
31 March 2014	Wellness – implementation plan	To approve final plan	Gerry Taylor	Morag Stewart

DATE OF MEETING	TITLE	ISSUE	BOARD MEMBER	REPORT AUTHOR
31 March 2014	Joint Strategic Needs Assessment / Pharmaceutical needs Assessment	To note progress and agree priorities	Gerry Taylor	Morag Stewart
31 March 2014	Healthwatch quarterly report	To consider issues arising from the Healthwatch work programme	Nisar Mohammed	Nisar Mohammed
31 March 2014	Luton CCG - Final Operating Plan	To sign off final plan	Nina Pearson	Carol Hill
To be confirmed				