Calderdale MBC

Wards Affected **All**

Cabinet **18 July 2011**

7

Plan for Commissioning Services for Children, Young People and Maternity in Calderdale for 2011/12

Report of the Director for Children and Young People's Services

1. Issue

1.1 The purpose of this report is to secure Cabinet approval for the Plan for Commissioning Services for Children, Young People and Maternity in Calderdale for 2011/12.

2. Need for a decision

2.1 This is a new approach for the Council and the PCT which partly replaces the Children and Young People's Plan. It sets out new priority areas for the Children and Young People's Partnership and sets out how we can continue to develop a single commissioning approach.

3. Recommendation

3.1 The recommendation to Cabinet is to approve the Plan for Commissioning Services for Children, Young People and Maternity in Calderdale for 2011/12.

4. Background and/or details

4.1 The *Plan for Commissioning Services for Children, Young People and Maternity in Calderdale 2011/12* is a joint plan developed by the Council and the PCT and approved by the Children and Young People's Partnership Executive. It sits underneath and supports the Single Commissioning Plan 2011/12 which was approved by Cabinet at its meeting on 18 April 2011.

4.2 The Plan has been developed at a time of significant structural change for organisations that commission children and young people's services. It is intended to ensure that across the partnership we are able to meet our strategic priorities. It aims to:

- Outline how we can continue to develop a single commissioning approach in order to improve outcomes and services to children and young people in Calderdale from April 2011 onwards.

- Set out key developments and implications for commissioning across schools, post 16 learning, children and young people's services, public health and health commissioning.

- Set out a framework within which services can be commissioned against the Calderdale Continuum of Need and Response both across Calderdale and within communities and localities.

- Identifies resources available and commissioning priorities for 2011-2012.

- Describe the potential scope of a single commissioning function for children, young people and maternity services.

- Describe how we will begin to develop the market.

4.3 The plan outlines four broad priorities for Children's Services for 2011/12, these replace the priorities from the previous Children and Young People's Plan and are:

- Raising and supporting attainment

- Early intervention and prevention

- Additional and targeted services

- Safeguarding vulnerable children

4.4 An Action Plan has been developed which sets out how these priorities will be implemented and which will be supported by clear delivery group arrangements.

4.5 The plan describes a co-ordinated approach to commissioning services for maternity, children and young people. This approach outlined is intended to support the further development of a single approach to commissioning within Children and Young People's Services, with schools and with the health service and we are committed to working with health and school partners on an integrated approach to maximise the commissioning capacity and impact by improving outcomes for children faster together, whilst also supporting the implementation of the Health and Social Care Bill and Public Health and Education White Papers.

4.6 This approach builds upon existing integrated commissioning arrangements. A jointly appointed Deputy Director for Children's Joint Commissioning has been in post since November 2008 jointly managed by the Head of Children's Services. This post holder has led the development of an integrated commissioning team with the PCT which is responsible for commissioning children and maternity services and overseeing joint commissioning arrangements which include teenage pregnancy, disabled children, substance misuse and CAMHS. This arrangement will provide the basis for future developments.

4.7 The plan outlines a number of key issues which will need to be addressed as a single commissioning function is developed. These include:

- Ensuring that commissioning is undertaken in a systematic way which is based upon evidence of need.

- Alignment with adults commissioning and transition processes
- The capacity and core roles for an integrated commissioning function
- Co-location of children and young people's commissioning functions
- Market development – stimulating a more open market within which a wider range of providers are able to offer and deliver their services.
- Commissioning on behalf of and with schools.
- Voluntary and community sector engagement, support and development.
- Anticipation of the implications of the Public Health White Paper for the commissioning of children, young people and maternity services and the responsibilities of the Council.
- Ensuring that participation by children, young people and their families is central to the commissioning process
- The impact of collaboration and joint working outside Calderdale, e.g. with neighbouring local authorities or PCTs.

4.8 The NHS and the CYP and Adult Health and Social Care directorates in particular often provide services to the same people and operate within integrated systems. Their commissioning activity may cover the same areas and/or can have a considerable impact across the system as a whole. In some areas, (Mental Health, Teenage Pregnancy, Substance Misuse, Children with Disabilities) there are already joint programmes.

4.9 Having a Single Commissioning Plan will allow us to use our available commissioning resources to best effect as well as promoting the development of effective integrated service provision for the people of Calderdale. As responsibilities are allocated for the delivery of the plan, managers and staff from both the local authority and the PCT will take forward areas of the plan and deliver the identified improvements for both organisations. It will also make it easier for the public to understand what the organisations are trying to achieve and increase the transparency for effective scrutiny.

5. Options considered

5.1 None

6. Consultation

6.1 The Plan has been developed in consultation with a range of partners, including schools, the voluntary and community sector and parents and carers as well as officers within CYPS and the PCT.

6.2 The Plan was presented to the Children and Young People's Partnership Executive on 20 May 2011. Their recommendation was that the plan be approved.

6.3 As a joint plan with the PCT the plan was presented to the Calderdale Commissioning Executive on 16 June for approval. Their decision was to approve the approach outlined in the plan and to request that further work was done to identify the commissioning outcomes which the plan would achieve.

6.4 The plan was presented to the Children and Young People's Scrutiny Panel on 5 July 2011, at the time of writing this meeting has not taken place and a verbal update regarding their comments will be provided to Cabinet when this report is presented.

7. Financial implications

7.1 There are no financial implications to approving this plan

8. Equality and Diversity

8.1 The Plan has been subjected to an Equality Impact Assessment, and further assessments will be carried out as the plan is implemented.

9. Contribution to Delivering Population Outcomes

9.1 The Plan for Commissioning Services for Children, Young People and Maternity in Calderdale contributes to a number of the council's population outcomes, particularly

- Healthier Communities
- Children and Young People
- Narrowing the Gap
- Use of Resources

10. Corporate implications

10.1 For 2011/12 the Plan only relates to CYP directorate commissioning, although as part of the overall Single Commissioning Plan it will also have implications for Adult Health and Social Care.

10.2 The plan will be monitored through the Making a Difference performance management system work is underway in order to accommodate the requirements of the PCT.

11. Conclusion

11.1 The Plan for Commissioning Services for Children, Young People and Maternity Services is a significant development in integrated working between the Council and the PCT. It underpins the development of commissioning services within CYPS and will ensure more efficient and effective commissioning and the development of better and more effectively integrated services and ultimately improved outcomes for children and young people.

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The documents used in the preparation of this report are:

1.
2.
3.

The documents are available for inspection at:

Plan for Commissioning Services for Children, Young People and Maternity in Calderdale 2011/12

Calderdale Council and NHS Calderdale

DRAFT

May 2011

Version Control

Version	Date	Author	Changes
6.0	25.3.11	CJ	Draft for approval by CYP exec and wider consultation
6.1	29.3.11	SR	Foreword
6.2	6.4.11	CJ	Minor amendments included from AS and inclusion of SEN Green Paper
6.3	18.4.11		Amendments from SR, PCT SMT and via consultation
6.4	19.4.11	CJ	Renamed to Plan, priorities updated
6.5	4.5.11	CJ	Priorities list updated
6.6	17.6.11	CJ	Changes to foreword signatories

Calderdale Council

ONE DIFFERENT EVERYONE MATTERS EVERYONE

Children and young people

NHS Calderdale

Contents

Foreword

In Calderdale we are committed to ensuring the way we commission services makes a real difference to children and young people's lives.

This plan has been developed in a period of significant change for everyone involved. New national priorities are taken account of with a commitment to local decision making within the challenging financial environment.

We want to promote a clear and consistent way forward for the commissioning of children and young people's services.

We believe that this will help us to work better in partnership with service users, carers, providers and other key stakeholders whilst achieving best value and ultimately resulting in better outcomes for children, young people and families.

This document should be read alongside the complementary Calderdale Council and NHS Calderdale, Single Commissioning Plan for 2011 -2012, this plan provides the detail for children and young people and family services. This transitional plan paves the way for the Health and Well Being Strategy which will complete our transitional phase.

This plan explains how commissioning will take place across the next year and how in the medium term we will work together with all our partners to further develop this model.

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Lead Member, Children and Young People
Calderdale Council

Janet Donaldson
Director Of Children's Services
Calderdale Council

Graham Wardman
Director of Public Health
NHS Calderdale/Calderdale Council

1 Introduction

This Plan is being developed at a time of significant structural change for organisations that commission children and young people's services. It aims to

- Outline how we can continue to develop a single commissioning approach in order to improve outcomes and services to children and young people in Calderdale from April 2011 onwards.
- Set out key developments and implications for commissioning across schools, post 16 learning, children and young people's services, public health and health commissioning.
- Set out a framework within which services can be commissioned against the Calderdale Continuum of Need and Response both across Calderdale and within communities and localities.
- Identifies resources available and commissioning priorities for 2011-2012.
- Describe the potential scope of a single commissioning function for children, young people and maternity services.
- Describe how we will begin to develop the market.

This document is intended to set out both how services will be commissioned in the short term for 2011 – 2012 and also how a medium to longer term strategic approach will be developed. It sits under the NHS Calderdale and Calderdale MBC Single Commissioning Plan for 2011-2012 which encompasses services for adults as well as children and young people and sets out the following high level outcomes:

- Preventing deterioration, delaying dependency and supporting recovery particularly in relation to long-term chronic conditions and disabilities
- Promoting personalisation and improve life-quality
- Ensure a positive user/patient experience
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- Reducing premature death

1.1 Strategic Commissioning

For the purposes of this plan commissioning is defined as:

> *the process for deciding how to use the total resource available for children, young people, and parents and carers in order to improve outcomes in the most efficient, effective, equitable and sustainable way.*
>
> Commissioners are not just those with 'commissioning' in their job title, but include all those who work within the children's services system and actively contribute to the commissioning process. They might be in a strategic role, helping to develop a local commissioning framework, in a procurement role as a local resource holder, such as a cluster manager for a group of schools, or in a role shaping the strategy for the children's workforce.

The important thing is that there are lots of resources across the organisations that make up local children and young people's partnerships (i.e. the whole local system of cooperation between partners, including local authority children's services, children's health services, schools and colleges, youth justice agencies and others), which can be deployed in the best way possible to improve outcomes. Another way of putting it is depicted . . . below (Commissioning Support Programme, 2010, p7).

Figure: Graphical description of strategic commissioning

As such it is seen as a strategic process which needs to embrace all those who are involved in commissioning services for children and young people, including Schools, General Practitioners (GPs), public health commissioning and the Local Authority.

This process is underpinned by an understanding of need which is supported by the preparation and production of a Joint Strategic Needs Assessment (JSNA). This is a statutory responsibility of the Directors of Public Health, Children's Services and Adult Social Services.

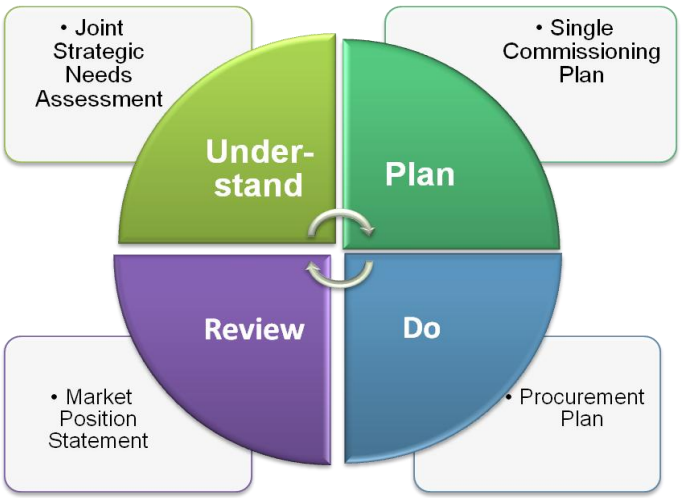


Figure: Relationship of key plans to each other across the commissioning cycle

The JSNA provides a systematic method for reviewing the health and well being needs of a population, leading to agreed commissioning priorities that will improve health and

well-being outcomes and reduce inequalities. The Calderdale JSNA provides the evidence base which underpins the commissioning intentions described in the Single Commissioning Plan and this Plan. The relationship between the Calderdale JSNA and the Single Commissioning Plan is described in the diagram above.

This Plan sets out how we need to adopt a single commissioning approach for Children, Young People's and Maternity Services which will be used to:

- Ensure that commissioning is undertaken in a systematic way which is based upon evidence regarding need and reflects the commissioning cycle;
- Develop our future strategy for children and young people across the Children and Young People's Partnership;
- Oversee implementation of partnership priorities;
- Shape arrangements for commissioning health care and outcomes for children, young people and their families;
- Support the development of a commissioning approach and framework on behalf of schools;
- Support future Children's Partnership arrangements

1.2 Strategic Environment

This plan has been developed in the context of significant legal and financial change, including:

- Significant reductions in funding allocations to Local Authorities as outlined in the Comprehensive Spending Review and confirmed in the Revenue Support Grant Settlement for 2011-2012.
- The removal of ring fencing and reduction in number, and total value, of grant allocations.
- Voluntary and community sector (VCS) providers of commissioned and grant aided services currently provide a range of services to vulnerable and 'seldom heard' children and young people. The sector also represents opportunities for developing value for money provider markets.
- Developments, outlined in the Schools White Paper 2010 *The Importance of Teaching* and the Education Bill*,* in funding to schools, the development of more independent models of school provision and the emergence of schools as significant local commissioners.
- Proposals for significant changes to the provision of support for children adn young people with special educational needs and disabilities outlined in the Green Paper *Support and aspiration: a new approach to special educational needs and disability.*
- The Health and Social Care Bill, the NHS White Paper *Equity and Excellence: Liberating the NHS* and changes to the responsibility to commission health care which will move from Primary Care Trusts to GP consortia as well as changing the role of the Local Authority in overseeing local health services.
- Changes to the provision of Public Health, outlined in the Public Health White Paper, *Healthy Lives, Healthy People*.

- The removal of the statutory requirement for local areas to have a Children's Trust Board or a Children and Young People's Plan.
- Local and national arrangements for Health Watch that would mean that children and young people's voices "are fed into local commissioning" and that the internet and evidence-based tools for engagement are used to gather the views of children, young people and their parents, drawing on the expertise of local authorities.
- A potential radical change in the function of Children and Young People's Services from being a significant provider to being mainly a commissioner of services.

Within this complex and changing environment our continuing priority is to ensure that children, young people and families are supported to achieve their potential, have access to value for money services that meet their needs and that we continue to narrow the gap in health and other inequalities experienced by and between our populations.

1.3 Single Commissioning Plan 2011-2012

Calderdale Council and NHS Calderdale have developed a Single Commissioning Plan for 2011 -2012, under which this Plan sits. Whilst this has been developed specifically for the 12 months of 2011/12 it is part of a wider planning framework within both the local authority and the NHS. It will be followed up later in the year by the Health and Well-Being Strategy which will be agreed by the shadow Health and Well-Being Board. That will be based upon the revised JSNA currently being developed, and will underpin future single commissioning plans.

Fundamental to the success of both the wider Single Commissioning Plan and this specific Plan is the extent to which they assist us in achieving the overall strategic aims and direction of travel of the two organisations, the emerging GP commissioning consortium and, for the purposes of this Plan, schools.

The Single Commissioning Plan reflects the Council priorities set out in "A Fresh Start and also the requirements of the NHS Annual Operating Framework (AOF) for 2011/12, and constitutes the Annual Operating Plan for NHS Calderdale in 2011/12.

Whilst the plan is firm and clear in what it sets out, elements of both the Single Commissioning Plan and this Plan will develop further as review activity takes place and risk management processes may identify emerging pressures and risks that need to be incorporated and addressed through the year.

The plan is based upon some clear principles which are shared with this Plan:

- We will focus on what is right for Calderdale and align the national agenda where this meets local needs
- We will ensure services commissioned are safe and high quality
- We will deliver a single plan that meets the requirements of both organisations and the GP commissioning consortium
- Where commissioning activity can be integrated it will be
- Statutory duties will be met
- We will maximise the impact of available resources

- Delivery of Quality Improvements and cost savings are integral to the plan
- Pre-commitments will be delivered wherever possible
- Emerging risks and pressures will be identified and managed
- We will ensure alignment with our transition plans
- We will ensure alignment with financial plans
- We will ensure engagement and clearly communicate with key stakeholders: (Patients, Public, Staff, Providers and Partners)
- Underpinning processes will be systematic, clear and well-understood

Case Study
The partnership arrangements for commissioning substance misuse services for children, young people and families are well established in Calderdale.

A partnership budget is hosted by the PCT which is used to prevent the harms of substance misuse. The partnership commissions a specialist substance misuse service for young people which includes treatment, family support and education, specific activities have been funded, including a grants programme and theatre in schools project.

In 2009 the partnership redesigned the young people substance misuse system to create a more holistic service better able to meet the needs of young people in Calderdale. A full tender process took place and a new voluntary sector provider was awarded the contract. Since this time there have been dramatic improvements in meeting need and delivering positive outcomes.

Each year a needs assessment is undertaken and a Prevention Plan drawn up which steers the work of the partnership. This is closely managed and monitored in order to continually improve outcomes. Governance is via the Children and Young Peoples Joint Commissioning Group.

The commissioning process uses the whole of the commissioning cycle in order to systematically improve and deliver best value in a transparent way.

1.4 Partners

Key partners who will need to be involved as this plan is developed and implemented include:

- Calderdale MBC:
  - Elected Members
  - Children and Young People's Services (as both a commissioner and a provider)
  - Adult Health and Social Care
  - Housing, Safer and Stronger, Finance and Legal Services
- Schools
- Calderdale College
- Director of Public Health/Public Health
- Calderdale GP Consortium
- NHS Calderdale

- Children and young people, parents and carers.
- West Yorkshire Police and criminal justice system.
- Calderdale Local Safeguarding Children Board
- NHS Providers
- The voluntary and community sector
- Private and independent sector providers

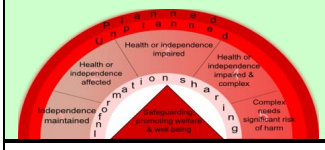
1.5 Governance

Following removal of the statutory requirement to have a Children's Trust Board revised governance arrangements are being developed which incorporate the role of the Health and Wellbeing Board, its oversight of service commissioning and any joint commissioning arrangements. In addition the current structure of strategic sub groups, many of which reflect previous grant based funding streams, will need to be revised and streamlined.

As these structures are developed we will need to retain and develop arrangements for ensuring that children and young people, parents and carers and other stakeholders such as the VCS continue to be appropriately involved in the development and oversight of strategic plans.

1.6 Calderdale Single Commissioning Framework

In implementing this plan we will adopt following single commissioning framework which has been outlined within the Single Commissioning Plan and has been developed from the Calderdale Continuum of Need and Response. This sets different levels of commissioning, such as commissioning for individuals or across a locality, against levels of need and is illustrated with some examples in the table below.

		**Universal**	**Targeted**	**Specialist**
Commissioning level	**Individual**		Disabled Children	Individual Budgets, Direct Payments
	Locality Based Commissioning	Schools, Children's Centres	Family Support, Children's Centres	
	Calderdale	Maternity, Healthy Child Programme: 5-16	Family Nurse Partnership, VCS Family Support and Counselling Services	LAC, Safeguarding, Paediatrics, disabled children
	Regional			LAC placement arrangements, CAMHS inpatient
	National	Healthy Child Programme < 5		Specialist health Commissioning

The framework gives us a common understanding and a common language to use when describing services and the level at which they are being commissioned.

Increasingly services are being categorised in terms of what proportion of the population they are aimed at and the means of access to them. This approach emphasises the links between preventative and universal services and measures (including , for example, Public Health) and more targeted services designed to meet more specialist needs, requiring more intensive interventions (including for example, the provision of family support services or hospital services) . Overall the strategic intention across the Council and NHS Calderdale is to retain as much activity as possible at the lower levels of intensity, recognising that this is better for individuals and families and also the most effective way to deploy the available resources.

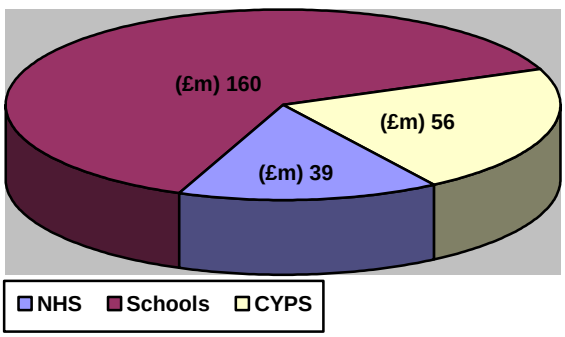
We will develop a segmented approach for different types of activity with different commissioning strategies and roles as appropriate. Thus, for example, the approach to locality based commissioning with schools might be to advise and provide a procurement framework whilst commissioning for looked after children's placements might require a co-ordinated working across Calderdale and with other local authorities on a regional basis.

Within each segment we will need to identify key data requirements and data sharing issues, population characteristics and needs analysis. Alongside this, in order to support the development of locality based commissioning, locality based analysis and tools will also need to be developed.

Similarly, arrangements regarding performance management, quality assurance and participation will also need to be developed which can support the commissioning process within each segment and which will support the development of single commissioning.

1.7 Current Expenditure

Accurately identifying total expenditure on services for children and young people can be difficult. Many services, for example parts of the health service, are funded to deliver across all age groups. However, taking into account the Council's budget proposals for 2011-2012 it is estimated that at least £255m will be spent across schools, children and young people's services and the NHS. This includes grant funding from the NHS and Children and Young People's Services (CYPS) in the Council to VCS organisations but does not include other Council directorates or expenditure by services which are delivered to the whole community including children and young people, such as, for example, the Police or GPs.



	£m
Schools	160
Health Spending (approx)	39
CYPS	56.31
TOTAL Spend	**255.31**

Figure: Estimated expenditure on services for children and young people 2011 – 2012

A more detailed breakdown is contained within Appendix 1.

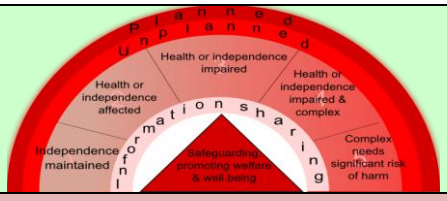
1.8 Equality Impact Assessment

A draft equality impact assessment (EIA) is attached at appendix 4; this examines the needs analysis and identifies the impacts on children and young people in relation to:

- Race and ethnicity
- Age
- Disability
- Religion or belief
- Sexual Orientation
- Other socially excluded groups.

These impact and the actions required to address them will be addressed in each of the priority areas outlined below. We will use the equality impact assessment to ensure that the needs of all children and young people are met as we further develop our commissioning intentions. Each commissioning programme will include an EIA and providers will be required to evidence how the needs of specific groups of young people are being met as part of performance management arrangements.

2 Children and Young People in Calderdale in 2011

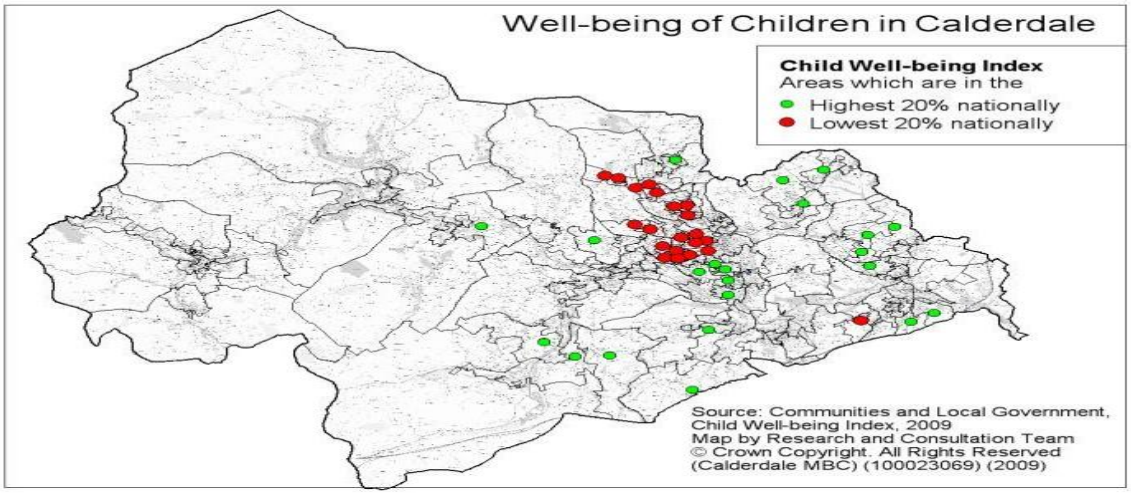


- There are about 50,000 children and young people aged 0 – 18 and 61,000 aged 0-25.
- About 2,500 births per year and the under 15 population is projected to increase rapidly in both 2014 and 2019.
- There are over 33,000 children enrolled in 101 Calderdale Maintained Schools of which there are 87 Primary and 14 Secondary (Including Special Schools).
- 18.5% of the school population are from a minority ethnic group.
- 76.5% (1997) of students achieved 5 A*-C GCSE's, in 2010
- In 2009-10 the obesity rate for children in reception was 7.7%, however for children in year 6 it increases to 17.4% and this rate is increasing.

- Approximately 8000 children live in households with no-one in employment.
- 5046 children are eligible for Free School Meals.
- As of 30 November 2010 there were 399 (6.4%) 16 and 17 year olds who were not in education, employment or training, down from 524 (8.6%) in 2009.
- There are an estimated 1500 young carers, of which 280 are known to the Young Carers service.
- Approximately 3000 children and young people aged 5-16 will have an identifiable mental health problem
- 48% of young people in the electronic health needs assessment indicated that they had experience of being bullied.
- For 2006/08 Calderdale had an Infant Mortality Rate of 5.8 compared to an England rate of 4.8.
- In 2010 2238 children were present at 1251 Domestic Violence incidents (WY police).

- The quarterly teenage conception rate for quarter 3, 2009 was 48.3, per thousand females aged 15-17. This is a drop of 9.6% from the 1998 baseline.
- 918 pupils have a Statement of Educational Need.
- Approximately 156 Children have a Child Protection Plan
- There are approximately 775 Disabled Children with a range of needs (based on a census in November 2008).
- As of 31 March 2010 there were 270 Looked after Children.
- For the period 2006-10 over 130 young people were referred to the child sexual exploitation co-coordinator.

The map below shows the Lower Level Super Output Areas identified as having high and low levels of child well-being in Calderdale. Around Halifax, parts of Mixenden, Ovenden, Lee Mount, Pellon, and Park Ward all fall within the worst 20% nationally. Outside Halifax, Field Lane in Rastrick is also in this group.



In contrast, areas with a high score are more widely dispersed and include parts of Mytholmroyd, Rishworth, Barkisland, Sowood, Greetland, Bradshaw, Northowram, Shelf, Hipperholme, Lightcliffe and Rastrick. (Source: Communities and Local Government, Child Well-being Index, 2009).

The Joint Strategic Needs Assessment makes the case that social circumstances have a significant impact on health and well-being and should be taken into account in planning and commissioning services.

3 Priorities

3.1 Existing Priorities 2010 – 2011

In the Children and Young People's Plan for 2010 – 2011 the following priorities were identified:

Being Healthy

Improve young people's sexual health and lower the number of teenage pregnancies

Make children and young people's lives healthier and lower the number of children and young people with poor health

Staying Safe

Provide more support for children and young people who are on the edge of coming into care by improving family support services and referral and assessment processes

Improve and promote the safety of children and young people affected by domestic abuse

Lower the number of young people who are at risk of sexual exploitation

Make sure children and young people feel safe out and about, in and around Calderdale

Enjoying and Achieving

Make sure personal development needs and learning opportunities are both met and enjoyed

Making a Positive Contribution

Remove barriers that stop children and young people taking part in decisions about their lives

Reduce youth offending and involvement in anti-social behaviour

Achieving Economic Well-Being

Make sure 13-19 learning routes are effective and lead to improved outcomes for all young people at 16 and 19

Improve support for all young people to get round barriers to make a smooth change to adult life and independent living

3.2 Context

The priorities in this plan have been developed in the context of the political environment described above. The priority areas reflect the political priorities set out nationally and locally as well as evidence from the Joint Strategic Needs Assessment which is in the process of being revised. These are summarised in the table in Appendix 2. Key documents include:

- Department of Education and Department of Health Business Plans
- Early Intervention Grant guidance
- Calderdale Coalition 'Fresh Start' document
- 'Grasping The Nettle'
- The Munro Report
- The Marmot Review
- 'Early Intervention: The Next Steps' by Graham Allen MP
- Schools, NHS and Public Health White Papers
- NHS Operating Framework 2011 - 2012

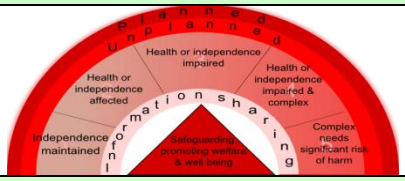
3.3 Priorities Framework 2011 - 2012

Taking into account these developments four broad priority areas have been identified for 2011 – 2012:

1. **Raising and supporting attainment**
2. **Early intervention and prevention**
3. **Additional and targeted services**
4. **Safeguarding vulnerable children**

These priorities were developed in consultation with a wide range of stakeholders, including colleagues from schools, the VCS, the NHS and the Children and Young People's Services Directorate at two priority planning workshops which were held in November 2010. The following table outlines some of the areas for implementation although many of the areas will have an impact across two or more priorities and more detailed plans will need to be developed. This will also be supported by the emerging Early Intervention and Prevention Plan which is being lead by Children and Young People's Services.

A draft action plan is included at appendix 3. Indicators will be included to provide evidence of delivery against each of the four priority areas. A priority subgroup will be established to drive the performance and the delivery against each priority area.

PRIORITY AREAS		
Universal		Specialist

PRIORITY AREAS			
Raising and Supporting Attainment	**Early Intervention and Prevention**	**Additional and Targeted Services**	**Safeguarding Vulnerable Children**
Priority Implementation / Outcomes to Include:			
• Review secondary provision (Fresh Start) • Narrowing the attainment gap • Progression	• Improving mental health in schools • building resilience • Anti bullying • children's centres • Healthy Child Programme • Breastfeeding • Infant Mortality • Child Poverty Strategy • Early Intervention and Prevention Strategy • Obesity • Common Assessment Framework • Substance misuse awareness	• Teenage Conception • Mental Health and Emotional Well-being • Behaviour support • Think family / parenting • Family Nurse Partnership • Unplanned care • disabled children and young people • personalisation / transition • Short Breaks • young peoples services • SEN • Communication needs • NEET • Substance misuse • Youth Offending Team • Young Carers	• Looked After Children's Placement Strategy • Kinship carers • Out of district educational placements for behavioural needs • Leaving Care services • Sufficiency duty • Children and young people on Child Protection Plans • Child sexual exploitation • Prevention

4 Current Joint Commissioning Arrangements

Partnership and joint commissioning arrangements currently exist in a number of areas which were previously funded through ring-fenced or similar arrangements. These include CAMHS, Short Breaks for Disabled Children, Young People's Substance Misuse and Teenage Pregnancy. Arrangements for continuing to commission in these areas will need to be reviewed as new single commissioning arrangements are developed. Some of the key issues to consider include:

4.1 Teenage Pregnancy

The teenage conception rate for quarter three of 2009 was 48.3 with 47 conceptions recorded. This represents a drop of 9.6 per cent from the 1998 baseline but has been rising for seven consecutive quarters. The outcomes for teenage parents and their children are significantly poorer than the outcomes experienced by those where the mother is over 20 years old.

The prevention of teenage conceptions and the improving of outcomes where babies are born to teenage mothers are key to narrowing the gap in health inequalities across the population. The Teenage Pregnancy Board is overseeing the development of a targeted approach which will focus on the following three areas:

1. Community contraceptive services
2. Work with target schools
3. Communication, using social marketing to inform young people, parents and professionals of contraceptive interventions and how to access services.

4.2 Mental Health and Psychological Well-being.

Mental Health problems in children and young people:

- Are very common – using figures from the Organisation for National Statistics it is estimated that about 3000 (about one in ten) children and young people have a clinically recognisable mental disorder;
- Create distress - not only for the children themselves but for all those who care for them;
- Can be prevented or minimised if we work together to create supportive environments which enable children and young people to develop resilience and learn coping strategies;
- Have an impact upon all areas of a child's life;
- Manifest themselves in different ways and cannot be addressed by agencies acting in isolation;
- Create problems at school and with education more generally, affect attitudes to learning and result in lower educational attainment, attendance and punctuality;
- Increase demands on all children's services;

- Can be associated with low self esteem and risk taking behaviour with an impact upon physical health, for example, smoking, bullying substance misuse and teenage pregnancy;
- Are associated, particularly with conduct disorders, with increased anti-social behaviour and offending;
- May continue or increase in adult life, possibly leading to self harm, suicide depression and anxiety, with a long term impact upon educational achievement, economic well-being, parenting abilities and the next generation.

The CAMHS Strategy Group is responsible for overseeing the multi-agency strategy to support children and young people's mental health which aims to ensure:

- An improvement in the mental health of all children and young people;
- That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems;
- That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

In 2010 – 2011 this has been supported by the Targeted Mental Health in Schools (TaMHS) programme, this has focussed on supporting the mental health of children aged 5-13, within schools in the Lower Valley area of Calderdale, using a range of group, targeted and individual interventions.

This programme was funded for one year by the Government and it is intended to look at how the lessons learned can be applied in order to support schools across Calderdale and reshape the provision of specialist mental health services, including consultation and advice to universal services.

There has also been a significant increase in admissions of young people into inpatient mental health care, particularly due to eating disorders. As a result we are planning to review current provision with a view to providing more intensive outreach and support within the community and thus prevent or reduce the need for admission.

4.3 Substance Misuse

Delivery of Young People's substance misuse interventions in Calderdale is integrated into broader children and young people's services provision, with planning and commissioning an integral part of the strategic Children and Young People's planning.

This ensures that substance misuse services for young people in Calderdale are part and parcel of integrated provision targeted at vulnerable young people and their families. There are close links between the commissioning of young peoples substance misuse services in Calderdale and other key priorities that affect the delivery of young people's health, for example education, health services, social services and criminal justice.

The overall aim in Calderdale is to:

1. Prevent drug and alcohol misuse in young people
2. Prevent young people developing dependency as adults
3. Prevent harm to children and young people via their own or their parent's / carers misuse of substances

This covers young people (under the age of 18 with transition up to age 21) who experience current harm as a result of substance misuse as a result of their own or parents / carers use which significantly disrupts their lives. It also covers those young people who are not currently using substances in order to prevent the risk of drugs and / or alcohol use. Substances in this context are defined as alcohol, illegal drugs, 'legal highs' / designer drugs, prescription drugs and volatile substances.

In the two year period 2006/07 to 2008/09 there were 152 hospital admissions of under 18s in Calderdale with more young women than men being admitted.

A *Children, Young People and Families' Substance Misuse Needs Assessment* is undertaken annually. This results in a Substance Misuse Prevention Plan being developed to meet the needs of communities in Calderdale. This impacts positively on young peoples' outcomes in attainment, health and criminal activity

The majority of young people seeking treatment in recent years present with poly rather than single substance use. There is evidence of Ketamine, M-Cat, cocaine, crack cocaine and heroin being used. Cocaine / crack cocaine and heroin use in young people remains low for those entering treatment but data in relation to some vulnerable groups suggests that they are more likely to be involved in substance misuse and to use hard drugs. We are also aware that the average age at which young people enter treatment is reducing.

<u>Presenting substances for those in treatment:</u>

- Cannabis and alcohol misuse collectively makes up 88 per cent of service users at tier 2, with alcohol at 22 per cent and cannabis at 66 per cent respectively
- Cannabis and alcohol misuse collectively makes up 74 per cent of service users at tier 3, with alcohol only at 13 per cent and cannabis only at 11 per cent and cannabis and alcohol at 50 per cent
- Only 4 per cent young people in treatment used heroin or crack

Outcomes for young people who enter treatment are good and most young people become abstinent or reduce use. In addition there are other health and social gains from treatment.

4.4 Disabled children and transition

A census in November 2008 identified approximately 775 disabled children and young people with complex needs across Calderdale. These Children and their families have specific needs and require additional support. These children and their families exist across the continuum of need and make use of universal and specialist services. Some of these children will have needs that are so complex that they will need very specialist services for their own specific need. These will be high cost, low frequency packages of care.

Following the Success of Aiming High for Disabled Children in Calderdale we will continue to commission accessible leisure activities and good quality short breaks. This will offer children and young people the opportunity to meet new people, gain confidence and develop new interests opportunities and provide their parents a break from caring.

The transition from children's services to adult services for children with complex needs requires planning at both an individual and a strategic level. The local authority and the PCT have developed strategic transition planning group to progress this complex area of work and will continue to support the development of Person Centred Approaches for disabled children and young people, Person Centred Transition Reviews at year nine and individual budgets for social care services. Individual health budgets will be explored following the development of this work.

5 Public Health

Significant changes are outlined to the provision of public health in the White Paper *Healthy Lives. Healthy People*. Responsibility for Public Health will be shared between a new national body, Public Health England, and Local Authorities and the Director of Public Health (DPH) will be jointly appointed and employed by the Local Authority.

It is envisaged within the White Paper that the DPH

> Will be the principal advisor on all health matters to the local authority, its elected members and officers, on the full range of local authority functions and their impact on the health of the local population, including identifying health inequalities and developing and implementing local strategies to reduce them. . .
>
> He or she will play a key role in the proposed new functions of local authorities in promoting integrated working; contribute to the development of the local Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy; be an advocate for the public's health within the community; and produce an authoritative independent annual report on the health of the local population (DH, 2010, p83)

The delivery of public health will be supported through ring-fenced funding to local authorities from within the overall NHS budget and it is proposed that the DPH will be responsible for significant aspects of commissioning for children and young people, including sexual health, the healthy child programme, obesity, breastfeeding and substance misuse.

As such the DPH will be central to the successful implementation of the single approach to commissioning outlined in the plan. In terms of our commissioning priorities public health commissioning will have the greatest impact upon delivery of *early intervention and prevention* and the development of *additional and targeted services* in order to 'narrow the gap' and ensure that we are able to improve the health of the poorest fastest. This is outlined in the table below.

Early Intervention and Prevention	**Additional and Targeted Services**
RING FENCED PUBLIC HEALTH BUDGET AND PRIORITIES	
• Universal immunisation programmes: childhood (NHS CB); school-age (LA level) • Screening (via PHE/NHS CB) • Accidental injury prevention (LA level) • Mental health promotion (LA level) • National nutrition programmes e.g. Healthy Start (PHA/LA level) • Physical activity programmes (LA level) • Obesity prevention programmes included in the National Child Measurement Programme. (LA level) • Drugs and Alcohol misuse prevention (LA level) • Tobacco control (LA level) • Behavioural /lifestyle campaigns (LA level) • Dental public health & oral health promotion (PHE/ LA level) • Children's public health < 5 years (will transfer from NHS CB to LA level) • Children's public health 5-19 years (LA level)	• Sexual health services (LA level) • Targeted neonatal immunisations (via NHS) • Obesity treatment e.g. weight management services (LA level) • Drug misuse treatment(LA level) • Alcohol misuse treatment (LA level) • Reducing & preventing birth defects (PHE / LA level) • Children's public health < 5 years – health visiting services, prevention by multi-professional team, FNP (will transfer from NHS CB to LA level) • Children's public health 5-19 years – school nursing, health promotion /prevention interventions by multi-professional team (LA level)

6 Health Commissioning

The Health and Social Care Bill and the NHS and Public Health White Papers outline significant changes to the commissioning of health services. As a result it is envisaged that Local Authorities will be responsible for promoting integration and partnership, health improvement and for supporting the development of Health and Well Being Boards. GP consortia will be responsible for commissioning health services for children and young people and for maternity services alongside the NHS Commissioning Board. Within Calderdale it is the intention that this will be delivered through an integrated commissioning function with strong clinical leadership.

Key strategic influences on the commissioning of children and young people's health services and maternity services include:

- The National Service Framework for Children, Young People and Maternity (2004) which established clear standards for promoting the health and wellbeing of children, young people and for providing high quality services to meet their needs.
- The NHS Operating Framework 2011 – 2012
- *Achieving Equity and Excellence for Children* which accompanied the NHS White Paper and sets out the Government's vision for how the proposed arrangements will improve services for children and young people.

For the four year period 2011/12 to 2014/15 NHS Calderdale along with Calderdale Council has developed an *Integrated Single Commissioning Plan 2011/12 to 2014/15,* which has been submitted to the Yorkshire and The Humber Strategic Health Authority. This plan sits alongside the Single Commissioning Plan referred to above and provides a basis for aligning resource, capacity and capability to our priorities locally to ensure a focus on delivery in the context of a changing environment. It describes where we will be commissioning differently against our four year 'QIPP' (quality, innovation, productivity and prevention) plan. These areas of work are critical to long-term financial stability and improved service provision, and as such will continue to develop and grow over the entirety of the four year period.

A substantial amount of work has been undertaken using a locally agreed improvement methodology in order to ensure we have identified the right problems and then worked to the solutions – using a wide range of data sources, including demand data, activity, finance, benchmarking and evidenced-based practice. This is primarily focused on eight areas, of which the commissioning of maternity, children and young people's services will contribute to six:

- Unplanned Care – including admissions to accident and emergency
- Planned Care
- Mental health – including CAMHS
- Continuing care – including placements for children and young people
- Procurement – via joint working with CMBC
- Running costs – internal to NHS Calderdale

In line with the JSNA, the prevention of avoidable ill health and the reduction of health inequalities are priorities for health commissioning. A key priority is to develop services

which ensure that children have the best start in life through early intervention and prevention with an increased focus on vulnerable children. Increased numbers of health visitors with an enhanced role working with children's centres and GPs will lead and deliver the healthy child programme – working together to give support to children and their families.

Continued primary care engagement in the delivery of care for children and young people and in the design of services that meet their needs will be fundamental to the development of commissioning arrangements for children and young people which demonstrate value for money and will support the development of cohesive arrangements across health, schools and local authority funded services.

Most children and young people in Calderdale are healthy. Central to commissioning for children and young people is health promotion and prevention – specifically around teenage pregnancy, smoking, substance misuse and obesity. We need to commission services that maintain and protect good health across the population and also ensure that children's needs, including complex health needs, are met at the lowest possible tier of intervention and as close to home as possible.

Where children and young people are not healthy and particularly where they have complex health needs and chronic conditions we will work towards the co-location and integration of services around these children, including establishing a single point of access, person centred planning and streamlining assessment and decision making processes.

6.1 Healthy Child Programme

The Healthy Child Programme is the universal preventive programme overseen by the Department of Health that begins in pregnancy and continues through childhood. It is an evidence based programme of developmental reviews, screening, immunisations, health promotion and parenting support.

Health Visiting and School Nursing are universal services for all children, young people and their families, beginning in pregnancy and ending in early adulthood. These services will be commissioned to deliver the healthy child programme focussing on pregnancy, parenting and family; early identification of risk and need, health development reviews and screening, health promotion and behavioural change across the age range.

The Family Nurse Partnership (FNP) will be commissioned as part of the Healthy Child Programme, providing support to our most vulnerable first time mothers.

The government have made a commitment to developing the role of health visitors across England whilst also increasing their numbers by 4200 over the four years to 2015. In Calderdale this equates to 13.3 additional health visitors. An action plan is being developed which sets out how this will be implemented and how links with children's centres and primary care will be supported.

Immunisation is a cost effective means of improving the health of children and young people and Calderdale has good immunisation uptake rates.

Despite the success of immunisation programmes in tackling vaccine-preventable communicable diseases there is still room for considerable improvements to some parts of the routine childhood immunisation programme. Uptake of MMR by the age of 2 years currently stands at 88% against a target of 95% and uptake of the pre-school booster is 84% by the age of 5 (compared with 97% uptake of primary baby immunisations).

A further drop off in immunisation uptake is seen with the school leaver booster (given in school year 10). Low immunisation rates are associated with outbreaks and clusters of infections which in theory should not be frequently encountered, for example measles and congenital rubella syndrome.
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6.2 Obesity

Annual data is available for Reception (aged 4-5 years) and Year 6 (aged 10-11 years) children in Calderdale from 2006/7 when 'The National Child Measurement Programme' began.

In summary, whilst the prevalence of obesity in Reception aged children is remaining roughly the same, at Year six it is increasing by approximately 1 per cent year on year. Worryingly the prevalence of overweight Reception aged children has increased by about 2 per cent in 2009/10, previously being fairly static, whilst this has remained roughly the same for Year 6 children.

This means that more Reception aged children are becoming overweight and that more Year 6 children are becoming obese. Additionally, the percentage prevalence of overweight and obese children in Calderdale has increased over the last 4 years. This means that at Reception age, 1 in 5 children are overweight or obese and at Year 6, 1 in 3.3 children are overweight or obese.
Key figures (06/7, 07/8, 08/9, 09/10):

Further analysis has been done to ward level and this shows that the percentage overweight or obese, Reception and Year 6 combined, are higher than the Calderdale average for Warley, Sowerby Bridge, Park, Town, Skircoat, Ovenden, Todmorden, Ryburn with Northowram & Shelf, Calder, Illingworth & Mixenden only slightly lower (listed in order).

By ethnicity and age, Year 6 South Asian children show higher percentage prevalence overweight or obesity. By sex and age, boys for both age groups show higher percentage prevalence overweight or obesity.

The strategic vision for Calderdale must be a community where:

- Every child grows up eating well and enjoying being active. Parents will have the knowledge and confidence to make this happen – including as many mothers breastfeeding as possible – and will be supported by schools, children's centres, health and other services, all promoting healthy weight.

- The food that we eat is far healthier, with major reductions in the consumption and sale of foods high in fat, salt and sugar, and everyone eating their '5 A Day'. Individuals and families will make decisions on their diet based on a good

understanding of the impact of their health, and the food, drink and other related industries will support this through clear and consistent information, doing all they can to help parents raise healthy children.

- Everyone is as active as they feel able and understands the impact of this on their health, taking responsibility for how they travel and how they spend their spare time. Local Government, businesses, local communities and others will create urban and rural environments that make activity accessible, safe and the norm

- Individuals have easy access to information and advice on healthy eating and activity that is clear, consistent and personal to them. Obese and overweight individuals will be able to access services that are tailored to help them achieve and sustain a healthy weight.

Our role is to give people the information and opportunity to make the right choices for themselves and their families, to ensure that they have clear and transparent information about food and exercise, and to put in place the right incentives and facilities to support people to make healthier choices in everyday life.

6.3 Oral Health

Poor dental health is preventable – by reducing the frequency of the consumption of food and drink containing high levels of sugar or acid and maintaining good oral hygiene.

- The average number of decayed, missing or filled teeth (DMFT) is higher in Calderdale than in England or the Yorkshire and the Humber.

- In the most deprived areas of Calderdale, dental health is significantly worse, with each child having, on average 3.5 DMFT

- There is a difference in the number of DMFT between areas of higher and lower deprivation

Interventions need to be targeted at the areas of highest need.

6.4 Breastfeeding

Babies need to be given the best start in life. We are committed to supporting mothers and their families to make well informed choices about how to feed their babies and to supporting them to continue with this chosen method of feeding for as long as they wish.

80 per cent of women will initiate breastfeeding, with the percentage of women breastfeeding by 10 days dropping to just over 40 per cent

The reasons given for stopping breastfeeding vary, however the majority of women stop because of breastfeeding problems rather than by choice. The National Infant Feeding Survey (Bolling, et al, 2007) indicates that the vast majority of women feel very disappointed with their decision to discontinue breastfeeding earlier than planned. Over ninety per cent of mothers who stop breastfeeding within two weeks of birth would have liked to have breastfed for longer. The reasons given by mothers for discontinuing

breastfeeding in the early weeks relate to problems, which could be avoided or solved if more support were available (UNICEF, 1998)

We aim to improve the nutritional status, growth, development, health and survival of infants and young children by supporting mothers and their families, during initiation and duration of breastfeeding.

6.5 Maternity Services

There are approximately 2500 births a year within Calderdale. Of these approximately 19 per cent are caesarean sections. 85 per cent of women are booked with a midwife by 12 completed weeks of pregnancy. Almost `10 per cent of women will continue to smoke during pregnancy.

Nationally there is an increasing birth rate and increasing complexity of need relating to obesity, smoking, older and younger mothers, medical and social needs is increasing pressure on maternity services. The impact of these changes is being felt in Calderdale.

Single commissioning for Maternity Services will concentrate resources on ensuring that pregnant women are as healthy as possible and give birth to healthy babies with the lowest possible level of medical intervention

6.6 Access to Children's Secondary Care

Secondary care refers to health care provided by specialists who are usually hospital based and generally do not have first contact with patients and can be either planned unplanned care. Services need to be commissioned in a way which enables need to be met in primary care settings and thus prevents the need to access secondary care. This will lead to improved experience of care and better value for money. As part of a broader approach to commissioning health services across all ages improved pathways will be commissioned for children and young people with specifically identified conditions that are likely to increase the need for secondary care.

Appropriate management in community settings, close to home will prevent unnecessary travel, unnecessary admissions and potentially long waits.

We will work with services to support children, young people and parents to respond to minor illnesses or manage their long term conditions appropriately and when additional care is required the appropriate choice and access to service is used commensurate with the needs on the child or young person.

6.7 Children with Complex Health Needs

Children with complex health needs and disabled children use more health services than non disabled children. The overarching aim for disabled children and those with complex health needs is that they grow up to be happy and healthy through the use and support of universal, specialist and targeted services.

Where children are in receipt of more than one service, the Common Assessment Framework (CAF) will be used by professionals to coordinate care and support for children, young people and their families. We aim to ensure that the needs of disabled

children and young people are met at the lowest appropriate level of intervention and within universal services wherever possible.

Pathways are being developed for children and young people with the most complex needs. We are developing joint assessment and provision around children and young people with complex physical impairment and postural needs. There are an increasing number of children with the most complex disabilities and services will be commissioned on this basis. We are currently supporting the development of person centred planning and individual budgets, this development is supported by intentions outlined in the SEN Green Paper to move towards a system of joint assessment and individualised budgets, including health care budgets.

6.8 Infant Mortality

Infant Mortality in Calderdale is higher than the national average. Infant Mortality is a sensitive indicator of the health of a population. The issues are multi faceted. Different groups experience higher risk. These groups are likely to include first time young mothers, women who smoke, women experiencing or at risk of depression, women who are ambivalent about their pregnancy, families with a history of congenital abnormalities, drug users and women on their own.

Infant deaths account for 50 per cent of all child deaths with 49 per cent occurring in the 1st week of life and 65 per cent in the 1 month of life. There were 18 infant deaths in 2008.

The National Support Team visit in March 2010 consolidated learning about infant mortality, and the resulting action plan outlines how we will work to

- Reduce Teenage Pregnancy
- Support Teenage Parents
- Reduce Overcrowding and improve housing
- Reduce Sudden Deaths in Infancy (SUDI)
- Reduce Smoking in Pregnancy
- Reduce Obesity
- Improve Infant Nutrition
- Reduce Child Poverty
- Improve Access to Maternity Care

6.9 Long Term Conditions

For many children with long term health conditions such as diabetes, epilepsy or asthma, the aim of treatment and care is to manage their illness in such a way that they are able to enjoy and achieve fully in their lives and make a positive contribution.

Children young people and their families should have the opportunity to become 'expert patients'. To achieve this, they should have access to services that help them to develop the self-confidence and self management skills needed to deal with the impact of the condition on the child and their family or carers; these services may be similar to those

run under the 'expert patients programme' (EPP) which will be rolled out to parents and young people.

Improving care in primary and community settings for children and young people with chronic long-term conditions will be contribute to reducing emergency bed days and offering a personalised care plan for the most at risk vulnerable people.

7 Schools Commissioning

7.1 Schools White Paper

The Schools White Paper, *The Importance of Teaching,* outlines significant development to the ways in which schools are organised, their funding arrangements, their relationship with local authorities and the role of the local authority itself. This places local authorities as 'strategic commissioners' responsible for ensuring that there is sufficient capacity to meet demand, coordinating admission arrangements and supporting failing schools as well as ensuring that disabled children and those with special educational needs have provision which meets their needs.

Schools will have increased financial autonomy and will be responsible for commissioning and procuring a range of services to meet the needs of their pupils, many of which are currently provided by the local authority. National Funding of schools will probably result in the end of arrangements whereby Schools Forum and Calderdale Council agree funding and financial matters on behalf of schools.

As such schools will become increasingly important both as local commissioners and, as a group, across Calderdale. It will therefore be necessary to work with schools to develop a commissioning approach which is able to meet their needs. This will need to address a number of issues including:

- Working within a 'mixed economy' of academies, maintained and, potentially, Free Schools.
- The sharing of services by schools, school clusters and federations. This will both provide economies of scale and a support network as the Local Authority's role is reduced.
- The role of schools forum/schools as an integral part of joint commissioning arrangements.
- The role of schools, alongside other commissioners, in developing and maintaining their pupils' health and well being, including childhood obesity, promoting mental health, teenage pregnancy and healthy schools.
- The potential role for joint commissioning, including strategic coordination, and brokerage/procurement arrangements.
- Joint funding arrangements.
- Arrangements for partnerships and collaborative arrangements between schools and with other commissioners in localities

7.2 School Finances

The funding available for all Calderdale schools in 2010/11 is £160 million (this includes formula grant and specific grants that will be rolled into one from next year). This equates to £4,800 per pupil based on 33,000 children. Approximately £15 million of this is spent on central support services such as pupil support in particular for pupils with special educational needs.

Of the remainder, under school delegated control, 80per cent is spent on direct staffing in schools (teachers and admin staff) with the remaining 20per cent being spent on non-teaching staff, business and professional support services.

This level of funding will be unchanged for 2011/12 and for the term of the current Comprehensive Spending Review. All schools will receive an additional Pupil Premium of £430 per pupil on free school meals in order to provide additional support for those pupils. This funding could provide a first real opportunity to commission something new to support all schools, rather than starting with funds that have existing commitments attached to them.

7.3 School Service Development

It will be important to work with schools to shape the services that they will need into the future. These are expected to be broadly around intervention services, support for pupils in need (particularly vulnerable children and those with special educational needs) and to provide a range of business and professional services to support the school.

A dialogue has already commenced with secondary and primary head teacher groups (CASH and CPHA). These discussions are now taking place on a regular basis at a number of levels, meetings with the Directorate Leadership Team, a specific schools services development group and an Academies Working Group, all of which are meeting monthly. As part of the commissioning process is it expected that a key role of the Authority will be to provide a brokerage service within which services currently provided by the Authority will need to compete with other service providers.

Whilst it will be possible to make some immediate changes to services from April 2011, significant changes to the design of services and the way in which they are commissioned will need to be planned for implementation from the new school year in September 2011, with more radical thinking about new commissioning arrangements from April 2012.

7.4 School Service Provision

The types of services that schools are likely to need include;

- **School Improvement and Curriculum Support** – analysis of performance data for individual schools, across clusters, partnerships and district-wide; school development and improvement planning, external challenge and support (building upon the previous School Improvement Partner role), support for partnership curriculum delivery 14-19, music services, library resources, and swimming services.
- **Pupil Support** – support for vulnerable and looked after children, Special Educational Needs support, education psychologists, welfare and behaviour attendance support, child protection advice, foreign language support, and youth service provision.
- **Facilities Management** – buildings and architectural advice, hard and soft maintenance, cleaning, caretaking, catering, grounds maintenance, health and safety, security services and school crossing patrols.

- **Business and Professional Services** – financial management advice and cash collection, human resources and pensions advice, payroll processing, legal support, risk management and insurance advice, workforce development, governor support, training programmes, information, communication and technology, management information and data collection, electronic mail communications, and school licences.
- **School Transport**

8 14 – 19 Provision and Post 16 Learning

8.1 Campus Calderdale

Calderdale's 14-19 Partnership, Campus Calderdale, is overseen by the Calderdale Association of Secondary Heads (CASH). The Campus brings together all providers of learning, including secondary schools, school sixth forms, Calderdale College, voluntary and community sector providers and private work-based learning providers. The Campus is responsible for working with CASH to develop and deliver the 14-19 Strategy for Calderdale, ensuring access to a rich, relevant, personalised, high-quality curriculum leading to high standards of attainment achieved by all students by the ages of 16 and 19 years.

CASH members are planning future partnership and collaborative approaches to meet the demands outlined in *'The Importance of Teaching'*, including school to school support and future commissioning of services by schools.

8.2 Post 16 funding arrangements

The Local Authority has a duty to secure sufficient suitable learning provision for all children and young people in their area. Young people are those who are over compulsory school leaving age (age 16) but under 19, or are aged 19 to 25 and subject to a learning difficulty assessment.

The Local Authority funds schools and appropriate placements to provide education up to the compulsory school leaving age. The Local Authority responsibility post 16 is slightly different in that there is a duty to secure sufficient suitable provision but the funding of the provision lies with the Young People's Learning Agency (YPLA). Local authorities cannot carry out their duties without the funding from the YPLA, as they have no access to other funding for post-16 learning. And the YPLA cannot carry out its resourcing function – including managing the budget the Government provides it with - without working in close partnership with local authorities. The local authority will have regard to the quality of education and training in deciding whether education or training is suitable and has a role to challenge and support providers to improve.

8.3 Implementation and Strategic Commissioning

To take forward this responsibility we will develop a strategic commissioning approach within the framework of the YPLA Statutory Guidance http://readingroom.lsc.gov.uk/YPLA/Statutory_Guidance-Funding_16-19.pdf to shape provision by identifying gaps, enabling new provision if necessary and develop the market to meet the needs of all young people. Recognising that the needs of young people are much more likely to be met where there is a strong partnership with those that provide post 16 education and training, we will work with key partners to establish a post 16 partnership of schools, academies, colleges, work based learning providers, apprenticeship providers, other specialist providers, youth services and employer representatives to agree a strategic overview of provision and needs in the area. We will publish an annual statement identify the learning needs of young people and the

needs of employers, the extent to which these needs are being met and any changes needed.

Schools, colleges and other providers are recognised as autonomous organisations with the responsibility to design and deliver learning programmes and their own improvement. It is expected that all providers will respond to leaner need through the lagged learner funding model. Any reshaping of provision within the automatic allocation of learner numbers will be agreed by the post 16 partnership.

We will work with the National Apprenticeship Service to identify the requirement for 16-18 Apprenticeships.

Arrangements to ensure needs are met for learners who travel across administrative borders are currently under review following recent changes to statutory requirements. Meanwhile we will continue to work with other local authorities to ensure needs are met across these travel to learn areas through the West Yorkshire Sub Regional Group and the Yorkshire and the Humber Regional Planning Group.

9 Local Authority Commissioning – Children and Young People's Services

9.1 Moving from Provider to Commissioning

Local authorities, unlike the NHS, have not previously been required to develop a clear commissioner – provider split for children and young people's services. As a result each service area within CYPS is responsible for both providing and commissioning services in order to deliver its strategic priorities. However, in response to the strategic changes outlined above, including significant reductions in funding and the changes outlined in schools funding it has been recognised that there is now a need for CYPS to develop as a commissioning organisation. This will involve the development of a clear commissioner-provider split which will enable greater clarity regarding how the 'Total Resource' available for services is being used, in a way which improves value for money and drives up quality. This takes place alongside the overall development of joint commissioning with NHS Calderdale, the implementation of the NHS White Paper and the development of the role of the Health and Well-being Board in Calderdale.

The Government has highlighted the need to modernise commissioning by driving

> transformative improvements in public service quality and efficiency, by improving its ability to buy public services intelligently and making better use of all available resources. This will enable commissioners to drive and implement public spending cuts in fully informed ways, removing unnecessary duplications and responding to local priorities' (Modernising Commissioning Green Paper December 2010 p6)

The Government in the Comprehensive Spending Review committed to increase the diversity of provision in publicly funded services by increasing competition and consumer choice and are considering setting proportions of specific services that should be delivered by independent providers, including civil society organisations and introducing new rights for communities to run services, own assets and for public service workers to form mutual organisations.

9.2 Current Position

To date the commissioning of services by CYPS has on the whole been undertaken by officers who have been both provider and commissioner. As the local authority move towards being a commissioning organisation this will not be sustainable. Where commissioning has been undertaken in a systematic way using the full commissioning cycle this has tended to be with the use of ring fenced grants, for example 'Think Family' Substance Misuse Services or the 'Aiming High for Disabled Children Short Breaks Project' rather than as part of a wider strategic approach to commissioning across the Directorate.

However, as an early adopter of this Plan, Family Services are leading on the commissioning of Children's Centres between April and June 2011. This has involved writing the Family Services Commissioning Strategy, preparing service specifications, and developing robust mechanisms for effective evidencing of impact and performance

as part of the review process. This will lead to full commissioning of all Children's Centres by March 2012.

Over a number of years limited resources have been available to contract manage or monitor the performance of some commissioned services. The lack of commissioning and contracting capacity, alongside uncertainty regarding future funding, has also resulted in contracts being extended by default in preference to services being re-tendered.

The detail on what we currently commission (orders over £10k only) can be found in Appendix 1 and a list below is provided to give an overview:

- External fostering, residential and day educational placements
- Children' Rights Service, spot purchase of independent visitors
- Post Adoption
- Information, advice and guidance (Connexions)
- Transport for pupils with special needs
- Creative Arts with LAC
- Family Support
- Children's Centres to a social enterprise
- Short break provision
- Speech and Language Therapy
- Moving and Handling Risk Assessments
- Children's Centres
- Leaving Care
- One to one support for disabled children in private nursery provision
- Early intervention and preventative services through the Area Based Grant
- Parenting support courses
- Speech and Language therapy
- Work experience health and safety assessments

It is anticipated that much of the current in house services provided by family services will be contracted out whilst maintaining a role as a commissioner in terms of inspection, quality assurance and evaluation to ensure outcomes are being achieved. Clearly the changes in funding for schools will see parts of Learning Services no longer funding services for schools and a power shift whereby schools can choose which provider they buy a whole range of services from.

Children's social care has in the past commissioned a range of support services for looked after children which have been historically viewed as best provided by the third sector. There is potential for a range of social care services to be commissioned.

There is scope for significant improvement in the way we commission and procure external placements by taking a joint approach across education, social care and health placements in order to improve outcomes and lessen duplication in service delivery, stimulate the market and provide value for money. By using intelligent commissioning the Local Authority will have a clearer approach to providers which reflects Best Value

principles. There will also be the opportunity to explore opportunities for a regional collaborative approach to achieve savings

Case Study
A commissioning approach to the use of £1.3m of ring-fenced funding for short breaks for disabled children and young people as part of the Aiming High for Disabled Children Programme has been developed locally.

This built on a disabled children's census which had helped to determine the level and extent of need and was followed by substantial consultation with parents and carers of disabled children to identify the vision for short breaks.

Service specifications were designed with the involvement of parents and carers and a range of services procured using a small grants programme, tender for a framework agreement and a service level agreement with family support and social care. Evaluations of the services commissioned have been taken by young disabled people working as 'young inspectors', satisfaction questionnaires and spot checks by the Project Manager. The commissioning cycle continues as further refinement of needs is undertaken to ensure the vision is current and will deliver outcomes.

The Commissioning Green Paper outlines the possibility that, in order to increase the diversity of provision in public services and increase competition and choice, central Government may introduce legislation so that they can set the proportion of specific services that should be delivered by independent providers, including civil society organisations and introduce new rights for communities to run services, own assets and, for public service workers, to form mutual organisations (Commissioning Green Paper December 2010).

9.3 Early Intervention Grant

Previously a range of grants were allocated by Central Government to local authorities that were ring fenced for a specific purpose, for example the Child-care Grant and included within the Area Based Grant. These grants have now been replaced by the Early Intervention Grant and the ring fence removed. The total EIG allocation for Calderdale for 2011-12 is 11.8 million, the provision of Children's Centres, the offer of free places for 2 year olds and the provision of short breaks for disabled children are included in the provision required to be funded from this grant. An Early Intervention and Prevention Strategy is being developed to inform the commissioning intentions for early intervention services.

10 Developing a Single Commissioning Function

The development of a single commissioning function which is capable of responding to the context described above will be critical to the successful implementation of this plan. At the time of writing decisions still need to be made regarding the future location of health commissioning for children, young people and maternity services and there is therefore still too much uncertainty to enable clear structures to be developed. However there are a number of key issues which will need to be addressed, including:

- Ensuring that commissioning is undertaken in a systematic way which is based upon evidence regarding need and reflects the commissioning cycle
- Alignment with adults commissioning and transition processes
- The capacity needed for a commissioning function
- Market development – stimulating a more open market within which a wider range of providers are able to offer and deliver their services.
- Co-location of CYP commissioning functions
- Agreeing functions and responsibilities
- Commissioning both for and with schools
- Governance – the role of the Children and Young People's Partnership and the Health and Wellbeing Board
- Core responsibilities for a CYP commissioning function
- Implication of the Public Health White Paper for the commissioning of children, young people and maternity services
- Ensuring that participation by children, young people and their families is central to the commissioning process
- The impact of collaboration and joint working outside Calderdale, e.g. across the local health economy or with neighbouring local authorities.
- Voluntary and community sector engagement.

These issues will need to be addressed as part of the transition arrangements and implementation of 'early adopter' arrangements from April 2011.

Appendix 1 – Commissioning and Finance Breakdown

These tables provide a summary of spending on commissioned activity. It includes expenditure by the NHS and the Council but not schools and does not include direct spending on Council services, as such these tables give an overview of the range of services which are currently commissioned rather than a detailed breakdown of expenditure.

Health and Well Being High Level Outcomes:

Outcome	Reference
Preventing deterioration, delaying dependency and supporting recover particularly in relation to long – term chronic conditions and disabilities	1
Promoting personalisation and improving quality of life	2
Ensuring a positive child/adult/patient experience	3
Treating and caring for people in a safe environment and protecting them from avoidable harm	4
Reducing premature death	5

Contracted and spot purchased activity 2010/11

Service	Tier	Funding 2010/11	Which Outcomes were impacted on?
Children & Maternity Services – Block Contract and PBR	2 – 5	£37.5M	1, 2, 4, 5
Children & Maternity Services and CAHMS	2 - 5	£1.99M	1, 2, 4, 5
Young People's Substance Misuse	4 – 5	£380K	1, 2, 4, 5
Access and Transport	1	£1.4M	1, 2
Children's Social Care	3 – 5	£165K	1, 2, 3, 4
Fostering and Adoption	3 - 5	£3.5M	1, 2, 3, 4
CAHMS Tier 2	2	£32K	1, 2, 4, 5
LAC CAHMS Tier 2 and 3	2, 3	£147K	1, 2, 4, 5
Children's Residential Placements	4, 5	£3.5M	1, 4, 5
Children's Fund Activities	2 - 4	£1.7M	2, 3
Children and Young People's Participation	1	£100K	2, 3
Safeguarding Review	4, 5	£80K	1, 4, 5
Calderdale Schools Ltd	1	£6.7M	2, 3
Calderdale College	1	£2.2M	2, 3
Family Support Services	2 – 5	£4.5M	2, 3, 4
Family Services – Direct Services	3, 4	£27K	2, 3, 4
Family Services – Early Years Development	1	£630K	2, 3, 4

Inclusion Services – Behaviour Support	3, 4	£146K	2, 3, 4
Inclusion Services – Disabled Children	3, 4	£58K	2, 3, 4
Sensory Support	2 - 4	£194K	2, 3, 4
Special Educational Needs	2 - 4	£2.5M	2, 3, 4
Young People's Service – Central Halifax	1	£39K	2, 3
Youth Offending Team	3 - 5	£175K	1, 4, 5
Standards Fund YPS Family Support	1	£290K	2, 3, 4
Adult Learning	1	£90K	2, 3
Inclusive Learning	3 - 4	£546k	2, 3, 4
Learning Services	1	£120K	2, 3
Music Service	1	£40K	2, 3
Standards Fund	1	£1.9M	2, 3

Further breakdown of these services into identified contracts is available from NHS, AHSC and CYP contract teams. Contract values may be withheld as being commercially sensitive

In-house services provided in 2010/11

Service	Tier	Funding 2010/11	Which Outcomes were impacted on?
Home to School Transport	1	£145K	2, 3
Post 16 Transport	1	£36K	2, 3
Aiming High - Short Breaks	1	£24K	2, 3
Commissioning Connexions/Children's Fund	1	£132K	1, 2, 3
Young Carers	3 – 4	£30K	1, 2, 3
Education for LAC	3 – 4	£35K	1, 2, 3
T A M H S	3 - 4	£13K	1, 2, 3
Young People's Service- North & East Halifax	1	£25K	2, 3
Youth Offending Team	3 - 5	£10.5K	1, 4, 5

APPENDIX 2
PRIORITIES EVIDENCE

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
Early Intervention						
Health Improvement						
Obesity	88% of schools have met the standard of the Health Schools Initiative.	Information provided by School Improvement Officer (SIP) for Healthy Schools – Learning Services	Obesity Trends Reception to Year 6.	The Information Centre for Health & Social Care annual December reports (DH). Report to Scrutiny May 2009.	National Indicator (NI) 57a Percentage of 5-16 year olds participating in sport - 2 hours – 74% NI 57b - Percentage of 5-19 year olds participating in sport - 3 hours – 51%	National indicators
Smoking	Two in twenty students regularly used tobacco, most of them smoked daily	Key findings from electronic Health Needs Assessment (eHNA) Calderdale	More were worried about using tobacco than alcohol or drugs	Key findings from eHNA Calderdale		
Exercise	88% of schools have met the standard of the Healthy Schools Initiative.	Information provided by SIP for Healthy Schools – Learning Services		Key findings from eHNA Calderdale	NI 57a Percentage of 5-16 year olds participating in sport - 2 hours – 74% NI 57b - Percentage of 5-19 year olds participating in sport - 3 hours – 51%	National indicators
Teenage Pregnancy	Teenage conception rates /trends: The overall trend for conception rates for under-18s is downwards and the rate for Calderdale is reducing at a faster rate than that of the region or country, and is relatively low compared to statistical neighbours. The under-16	Reducing Teenage Pregnancy in Calderdale: Teenage Pregnancy Data Feb 2011.	Identification of areas to be targeted in terms of schools etc.	Key findings from eHNA Calderdale		

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
	conception rate is also reducing and lower than that of the region and country. There were 166 under-18 conceptions in 2008.					
Health Visitors	The coalition government have made a commitment to increasing the number of health visitors by 4200 by 2015	Operating Framework Health Visiting – A Call to Action	Delivery of the Healthy Child Programme 0-5.	The Healthy Child Programme		
Breastfeeding	The initiation rate for breastfeeding is good across Calderdale with rates dropping by 10 days and 6-8 weeks	Primary Care Trust (PCT) Priorities				
Health Protection						
Immunisation	Immunisation provides an effective and 'cheap' opportunity to improve public health	DH Handbook – Immunisation against Infectious Diseases. (Green Book)	MMR uptake is lower than other childhood immunisations	Vital Signs	Immunisations uptake is lower in areas of increased deprivation.	Vital signs
Child Poverty	22.5% of children aged under 16 are living in income-deprived households. This is significantly higher in both Halifax Central (at 31.5%) and Halifax North & East (27.1%).	This has been taken from the 'Reducing Infant Mortality in Calderdale' Document.	The number of children eligible for free school meals is increasing. There has been a significant rise in last 2 years. Those achieving 5+ A*-C on FSM is increasing. There is a higher	School Census/Attainment data available via MIT.	21.7% of the households with dependent children in Calderdale are headed by a lone parent - which is in line with the England average. However, these figures mask variation: for comparison at ward level, the equivalent figures are: Ovenden 35%, Illingworth & Mixenden 28%; Town	This has been taken from the 'Reducing Infant Mortality in Calderdale' Document.

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
			% of children receiving FSM in Halifax North & East.		29% and to the lowest, Skircoat 12%.	
Infant Mortality	The infant mortality rate for 2006-08 is 5.8 per 1000 live births which is not significantly higher than the National rate.	'Reducing Infant Mortality in Calderdale'				
FIP	Number of families with DV, drug, alcohol, housing issues etc.	Number of referrals and costing analysis	Family profiles	Reference to the National perspective. Frank Field – The foundation years.	Continuum of need	Tracking families from high levels of need to universal services
Parenting	Families' Information Service – number and types of enquiries being made.	Information provided by FIS.Impact Evaluation Studies relating to parenting support can be supplied.	Outreach events around the borough to inform parents of childcare and FIS services.	Statistics on the number of parents engaged at each event.	Number of contacts through to FIS email address and text number: FIS@calderdale.gov.uk 07624 803657	Number of emails logged and texts received.
Language and Communication	2011 National Year of Communication.	The Communication Trust, a coalition of 38 children's charities are working with the government to co-ordinate the year.	It is estimated in the UK that over 1 million children (2-3 in every classroom) have some form of speech, language and communication need, which means that they require extra help to communicate. In socially deprived areas, over 50% of children start school with			

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
			delayed language skills.			
Targeted Support and Services						
Health Improvement						
Alcohol Misuse	National and Local evidence of need in the alcohol strategy needs assessment. Calderdale spening £6 million on alcohol admissions. 2nd highest admissions to hospital for young people. Alcohol associated with young people's crime. Alcohol mist misused substance	Alcohol strategy Children, young People and Families Needs Assessment for Substance Misuse. Strategic assessment	Alcohol Models of Care NTA. LAPE data.	Alcohol Models of Care NTA. LAPE data. Drug and Alcohol Strategy	Performance management of services / audit etc	Minutes of PMM. Audit data
Substance Misuse	4.5% of LAC have a substance misuse problem. Poly drug use common 10% of LAC young people having a HA disclosed D or A problem. 41% of people in drug treatment have	Information provided by MIT. Alcohol strategy Children, young People and Families Needs Assessment for Substance Misuse.	Children, Young People and Families Prevention Plan NTA young peoples Substance Misuse	NICE Guidance NTA Guidance Orange Guidelines Criminal Justice Green paper Drug and Alcohol Strategy	Performance management of services / audit etc	Minutes of PMM. Audit data

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
	children. Profile of client group and drugs used changing. Hints of hard drug use in NEET, BEM groups and CSE victims. Strategic assessment					
Statement of Educational Needs (SEN)	2.7 of Calderdale Children have a SEN. This has stayed constant – but the number of children who are considered to have a need is increasing.	School Census/ Attainment data available via MIT.	Processing of SEN statement is one of the best in the country.	100% for NI103 (Statements issued within 26 weeks) for last two years	The number of Children with SEN's and educated outside the LA is increasing.	Scrutiny report Jan 2009. 'Extra District Expenditure for children and young people with special educational needs'.
Family Nurse Partnership	Support to Teenage parents to access appropriate services. Government support given to this.	Family Nurse Partnership is referenced within the operating framework and evidenced based best practice. Resource (non ring fenced) in 3% increase to baseline allocations				
Youth Offending Team (YOT)	Reducing the rate of reoffending.	Performance Report Improvement Plan Strategic Assessment	Reduction in First Time Entrants	Performance Report Improvement Plan Strategic Assessment	Reduce custodial Sentences	Performance Report Improvement Plan Strategic Assessment.
Disability	There are 775 Disabled Children living in Calderdale	Disabled Children's Census.	Delivery of the Every Disabled Child Matters Action Plan	Every Disabled Child Matters Charter – joint commitment by LA and PCT		
Short Breaks	During 2009/10 there was a 57% increase	LAIMP return to DfE				

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
	in the number of disabled children receiving a short break compared to 2008/9 when 204 children received a short break. An extra 117 children in 2009/10 received a short break. Projections are that the figure will reach approx 500 children by the end of the AHDC programme 31 March 2011.					
Personalisation	Government Policy for all – NHS white paper.		Holistic Person centred reviews established in Ryburn Valley High School and Rastrick High School Year 12.		Transition Guides for Children, Young People & Parents	
Transition	Government Policy for all – NHS white paper.	Report to Scrutiny 17th March 2010 entitled 'Transition of Children with Special Educational Needs into Adulthood'	Transition Guides for Children, Young People & Parents		Transition Mentor Scheme now in place. Outline planning in place for individual budgets.	
Other – Bullying	Reported racist bullying incidents have reduced from 234 in 08/09 to 191 in 09/10.	Anti bullying co-ordinator, provided this evidence.	There was a significantly greater proportion of Year 7 pupils reporting having being bullied (50.2%) than Year 10 (37.1%).	Documents eHNA Calderdale. Scrutiny Report 'Children who Experience Bullying'.		
Emotional Well-Being	10% of 5-16 year olds have a clinically	Office of National Statistics (ONS) 2004.	Amongst Children with learning	ONS 2004	Amongst LAC in residential care 70% will	ONS 2004.

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
	diagnosable mental disorder. National Figure.		disabilities 40% will have a mental disorder.		have a mental disorder.	
Raising Attainment						
Vulnerable Groups	6.7% of Looked After Children (LAC) achieved 5 good GCSE's A* to C passes including English and Maths, Compared to 54.1% in Calderdale. 20% of LAC achieved 5 good GCSE's A* to C not including English and Maths. Compared to 75.5% in Calderdale 87% of LAC aged 16 went into full-time education/training/ employment - well above the national average.	Stats from MIT/LACE	87.5% of health checks and 82.1% of dental checks were completed for LAC.	Stats from MIT/LACE		
Free School Meals (FSM)	The number of children eligible for free school meals is increasing. There has been a significant rise in last 2 years.	School Census/ Attainment data available via MIT.	The gap between the percentage of pupils eligible for FSM and achieving 5+ A*-C and those not eligible for FSM and achieving 5+ A*-C is reducing	School Census/ Attainment data available via MIT.	There is a higher % of children receiving FSM in Halifax North & East.	School Census/ Attainment data available via MIT.
Statement of Educational	2.7% of Calderdale Children have a SEN.	School Census/ Attainment data	Processing of SEN statement is one of	100% for NI103 (Statements issued within	The number of Children with SEN's and educated	Scrutiny report Jan 2009.

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
Needs (SEN)	This has stayed constant – but the number of children who are considered to have a need is increasing.	available via MIT.	the best in the country.	26 weeks) for last two years	outside the LA is increasing.	'Extra District Expenditure for children and young people with special educational needs'.
Personalisation						
13-19	Reduce 16-18 young people who are NEET – linked to 'Raising Participation Age' – more pre level 2 and level 2 vocational opportunities (14-19) and 16-18 apprenticeship places required	NEET data from Connexions and national data.	Whilst GCSE attainment 5 A*-C (level 2) is improving, Calderdale has fallen behind the national average in 2010 and is improving at a slower rate.	School Census and DfE Performance data	Average points score per entry at A level (2010) is below national average. Although indicators have risen over recent years achievement of full level 2 and 3 at 19 still lags behind regional and national averages and the gap is widening.	School Census and DfE Performance data L2 and L3 attainment tables – FFT matched data
Safeguarding						
Common Assessment Framework (CAF)	Increasing number of CAF's being undertaken	Information available from MIT/CMAS	Increase in CAF is significant in Halifax Central	Information available from MIT/CMAS		
Child Sexual Exploitation (CSE)	Between January 2006 to December 2010 over 130 children and young people were referred to the CSE Co-ordinator for consideration by the CSE Operational Group. All victims female bar one. Between 11 to 14 years old. Hard drug use is a feature	CSE Needs Assessment – April 2010				

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
	in this group, alcohol misuse widespread. Drugs regularly used as part of grooming.					
Domestic Violence (DV)	There were 3692 Domestic Violence Incidents reported to the Police in 2010.	In Q1 2010/11 there were 4 Harbouring Notices issued. In 2009/10 14 harbouring notices were issued.	Documented evidence that the incidents of DV increase with pregnancy.	Eden Team work specifically with vulnerable women and families. They have expertise in areas of domestic abuse, substance misuse, teenage pregnancy, homelessness and mental health.	The number of referrals made to the Women's Centre is increasing year on year.	Information from Women's Centre.
Child Protection (CP)	156 Children have a Child Protection Plan (CPP). This has increased over the last 5 years. Around 34 out of every 10,000 in Calderdale are allocated a CPP. This is in line with the National Average. This is twice as likely in Halifax North & East. The Reasons for Child Protection plans 47% is due to neglect.	Average figure available from MIT if required also ward/locality area could be investigated. Other reasons for the plans are available if required.	About 31 children per 1000 in Calderdale are referred to Social Services. This rises in Halifax North and East to 37 per 1000			
Feeling safe	Improving the levels to which children and young people feel safe within their local area.	The eHNA states that Eight out of ten young people say the area where they live feels safe				

	Evidence1	Documentation	Evidence2	Documentation	Evidence3	Documentation
	The main reasons for the area not feeling safe were gangs, crime, drug dealing and knives					

Item 4 Appendix 3

	TASK	ACTION	LEAD OFFICER	END DATE
1.0	STRATEGIC ACTIONS			
1.1	Ensure evidence and needs based commissioning approach	Complete JSNA refresh and ensure information used to inform commissioning intentions	AR	End of May 2011
		review NICE guidance and action where required	PB	September 2011
1.2	CYP Commissioning strategy agreed and implemented	Consult on CYPP commissioning strategy	CJ	8th April 2011
		Calderdale Commissioning Executive board approval	CJ	TBC
		Cabinet approval	SR	June 2011
		Support development of arrangements for NHS commissioning across Cluster and within Calderdale	CJ	September 2011
1.3	Develop and implement participation strategy	Draft strategy completed	KS	End of June 2011
		Proceed to consultation	KS	End of September 2011
		Implement and embed strategy	KS	End of December 2011
		Explore arrangements for Health watch to ensure children and young people have a voice in the planning of local health services	KS	September 2011
1.4	Supporting schools as commissioners	Task and finish group established and work planned	MW	June 2011
		Develop families of schools and link into locality developments	DW/AS	September 2011
		Work with schools on health needs assessment and strategies to address health needs identified	JF/PaB	March 2012
		Propose commissioning framework	MW/CJ	September 2011

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	TASK	ACTION	LEAD OFFICER	END DATE
		on behalf of schools		
1.5	Support Development of Health and Wellbeing Strategy	Support from CYP perspective to task and finish group lead by DPH	SR	September 2011
2.0	CYPS FINANCE			
2.1	Identify commissioning resource across the directorate and bring into the joint commissioning arrangements	Identify commissioning budgets and agree transfer into central commissioning budget	MW/SR	June 2011
		Development of contract register to support effective procurement	KS	July 2011
2.2	Plan and agree commissioning and priorities from Early intervention grant	Identify EIG budget headings and profiles, agree at DLT	MW	May 2011
		Map commissioning and provider activity against EIG	CJ	May 2011
		Members to examine EIG proposals at scrutiny	SR	June 2011
3.0	ADDITIONAL AND TARGETED SERVICES			
3.1	Reducing teenage conception	Work with partners to commission community contraceptive services and agree contract.	KN	July 2011 (contract signed) April 2012 – Service commences
		Work with target schools to improve access to support and advice	JF/CS	End of September 2011
		Develop social marketing to inform young people, parents and professionals to improve access to services	DG	End of September 2011
3.2	Improving Mental Health and emotional well-being	Review CAMHS multi-agency strategy	CJ/JB	July 2011
		Review Tier 2/3 services	JB	July 2011

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	TASK	ACTION	LEAD OFFICER	END DATE
		Review of in-patient provision tier 4 provision specifically for eating disorders, plan for intensive outreach and support	JB	September 2011
3.3	Early years health provision	Commission against FNP fidelity requirements within the funding allocated. Agree prioritisation of referrals	EPH	June 2011
		Commission the additional requirement for health visitors as agreed by PCT Board	EPH/JF	April 2012
3.4	Disabled children and young people	Develop personalised/individual budgets	KS/PB	December 2011
		Commission short breaks provision under framework agreement	KS	Ongoing
		Work with voluntary sector to develop small grants commissioned by the sector for the sector	KS	July 2011
		Planning for transition project	MM/AS	July 2011
		Development of person centred planning approach	PB	July 2011
		Develop response to SEN Green Paper and prepare for implementation	AS	April 2012
		Service redesign of postural seating and wheelchair provision	PB	September 2011
3.5	Substance misuse	Deliver the annual needs assessment	DG	March 2012
		Plan for and monitor delivery of effective intervention of SMS services.	DG	Ongoing

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	TASK	ACTION	LEAD OFFICER	END DATE
4.0	RAISNG AND SUPPORTING ATTAINMENT			
4.1	Review secondary provision	Deliver on proposal for secondary capital programme	DW	April 2012
4.2	Post 16 provision	Identify and secure sufficient suitable provision for young people aged 16-18 (up to age 25 with a learning disability assessment) including apprenticeships.	AC	July 2011
4.3	Challenge and intervention service	Agree and implement structure	DW	September 2012
		Consult with schools and agree additional SIP provision	DW	July 2011
5.0	EARLY INTERVENTION AND PREVENTION			
5.1	Universal health provision	Commission children's public health 5-19 years , school nursing, health promotion, by multi-professional team, linked to school health needs assessment	EPH/JF	On-going
5.2	Implement early intervention and prevention strategy	Strategy agreed and taken through scrutiny – link to public health interventions.	SW/JF	July 2011
		Align priorities to EIG and delivery streams	SW/MW	July 2011
5.3	Reduce inpatient admissions	Support reduction in A&E admission and attendance and pathway development	EPH	Sept 2011
5.4	Building resilience	Sustain and rollout programmes developed under TAMHS funding stream through schools commissioning approach across	CP	July 2011

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	TASK	ACTION	LEAD OFFICER	END DATE
		Calderdale.		
		Identify programmes to support schools with implementation of the anti-bullying strategy with funding identified as part of the budget growth.	CS	September 2011
5.5	Commission the healthy child programme	Oversees the delivery of the routine and targeted immunisation programmes for children and young people	DaG	Ongoing
		Commission accident prevention programmes in conjunction with Safer and Stronger Communities	PaB/JF	September 2011
		Commission physical activity and obesity programmes	GS	September 2011
		Commission dental public health and oral health promotion	PaB	September 2011
		Commission service to implement breast feeding strategy	PaB	Ongoing
		Newborn infant physical examination screening programme	JF/EPH	September 2011
5.6	Sexual health services	Commission services to deliver the sexual health strategy	KN/JF	July 2011
		Chlamydia screening programme	KN/JF	September 2011
5.7	Infant mortality	Implement targeted neonatal immunisations	EPH	September 2011
		Commission antenatal /newborn	JF/EPH	March 2012

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	TASK	ACTION	LEAD OFFICER	END DATE
		screening programmes		
		Lifestyles behavioural interventions in pregnancy incl. obesity, nutrition, tobacco cessation etc.	GS/PB	September 2011
		Healthy start vitamins / early nutrition / family nutrition	GS	September 2011
		Child poverty strategy	AS	September 2011
		Housing strategy	HW	September 2011
5.8	Review of Young people's service	Agree scope with scrutiny panel	AS	June 2011
		Develop project timeline	CS	July 2011
		Agree programme with task and finish group	AS	July 2011
		Review IAG contract and agree timetable for re-tender of extension	KS	July 2011
6.0	SAFEGUARDING VULNERABLE CHILDREN			
6.1	Looked after children's strategy	Implement the strategy	RI	May 2011
		Reduce costs of out of area placements through sub-regional collaboration project.	KS	September 2011
6.2	Leaving care	Procure leaving care service through tender process	KS	July 2011
		Engage V4 to support post award contract negotiations to ensure value for money	KS	July 2011
6.3	Develop specification for service to support young people who are sexually exploited	Identify resource from EIG	SR	May 2011
		Develop specification and procurement timeline	KS	July 2011
6.5	Intensive interventions for looked after children and those on the edge of care or custody	Develop bid and lead on implementation if successful	CJ	TBC

Item 4 Appendix 3

	TASK	ACTION	LEAD OFFICER	END DATE

Key:

AC	Anne Craven, Director, 16-19 Team
AR	Andrew Ramsay, Principal Officer, Policy and Planning
AS	Anne Scarborough, Head of Services, Family Support
CJ	Chris Jewesbury, Deputy Director, Joint Commissioning for Children, Young People and Maternity Services
CP	Catherine Putz, Project Manager, Targeted Mental Health in Schools
CS	Carol Stone, Principal Officer, Young People
DG	Donna Green, Programme Manager, Young People and Substance Misuse
DaG	David Green, Immunisation Co-ordinator
DW	David Whalley, Head of Service, Learning Services
EPH	Emily Parry-Harries, Senior Programme Manager, Children, Young People and Maternity
GS	Gaynor Scholefield, Public Health Manager
HW	Heidi Wilson, Housing Access Manager
JB	Jeevan Bhadare, Senior Programme Manager, Mental Health
JF	Jill Farrington, Consultant in Public Health Medicine
KN	Kate Naylor, Senior Programme Manager
KS	Karen Smith, Principal Officer, Strategic Commissioning
MM	Mick Mellors, Joint Head of Service, Mental Health and Learning Disabilities
MW	Mark Woolley, Principal Officer, Business Support
PB	Phil Brayshaw, Programme Manager, Disabled Children and Young People
PaB	Paul Butcher, Deputy Director, Public Health
RI	Raheeda Inayat, Principal Officer, Localities
SR	Sue Rumbold, Head of Service, Children's Trust
SW	Steve Woodhead, Principal Office, Family Support

Equality Impact Assessment

Full assessment form

Directorate:	CYP
Title of policy, function or service:	**Strategy for Commissioning Services for Children, Young People and Maternity in Calderdale 2011/12**
Lead Officers:	Sue Rumbold / Chris Jewesbury
People involved with completing the EIA:	Chris Jewesbury

Type of policy, function or service:

Existing	☐
New/proposed	x
Changed	☐

Step 1 – Make sure you have clear aims and objectives

Give a brief summary of your policy, project or service

The aim of the Calderdale Council NHS Calderdale Commissioning Strategy 2011/12 is to

- Outline how we can continue to develop a single commissioning approach in order to improve outcomes and services to children and young people in Calderdale from April 2011 onwards.
- Set out key developments and implications for commissioning across schools, post 16 learning, children and young people's services, public health and health commissioning.
- Set out a framework within which services can be commissioned against the Calderdale Continuum of Need and Response.
- Identifies resources available and commissioning priorities for 2011-2012.
- Describe the potential scope of a single commissioning function for children, young people and maternity services.
- Describe how we will begin to develop the market.

What outcomes do you want to achieve?

The joint commissioning activity is intended to help us deliver our high levels outcomes, as set out nationally for the NHS and for Adults Social Care and Children and Young People. These are:

- Preventing deterioration, delaying dependency and supporting recovery particularly in relation to long-term chronic conditions and disabilities,
- Promoting personalisation and improve life-quality,
- Ensure a positive user/patient experience,
- Treating and caring for people in a safe environment and Protecting them from avoidable harm,
- Reducing premature death

Step 2 – Collecting your information

What existing information/data do you have?

We have drawn upon a range of information held in a variety of places, including the JSNA, other public health and demographic and population data, performance data, council budget options, PCT Quality, Innovation, Performance and Prevention (QIPP) plans and a range of exiting strategies and programme data.

Using your existing data, what does it tell you?

The data sources used reinforce some key messages around the health inequalities of ethnic minority communities and also the needs of:

- Children with disabilities
- Children and Young People in identified pockets of the borough
- Children in care
- Vulnerable children and young people

Step 3 – What's the impact?

Race or ethnicity

There is an acknowledgement that BME groups may not have take up services, comparison to other groups and therefore there is a recognition of different outcomes for different people. For example, the incidence of infant mortality is higher for the South Asian population as compared with non-Asian population requiring targeted work and awareness raising initiatives.

There is also a need to ensure commissioned services can demonstrate that all groups can access their services and they have the resources and skills to be able to target services at particular groups. Further work will be needed to ensure all sections of the population benefit from planned improvements and do not suffer disproportionally where changes are made and/or disinvestment takes place

Gender

Long term health outcomes are different for men and women. Mortality rates and premature death rates are different for men and women. The determinants of health start in childhood programmes such as breastfeeding or obesity prevention will have an impact.
There are also differences in attainment and outcomes between genders.
There is a need to ensure that providers can ensure that where possible there is need to cater for the specific needs of boys and girls.

Age

This strategy is specifically focussed on maternity services and services for children and young people and is intended to ensure that services are commissioned in a way which meets the needs of children and young people.

Disability

One of the key outcomes outlined in the plan is preventing deterioration, delaying dependency and supporting recovery particularly in relation to long-term chronic conditions and disabilities. Significant changes to the provision of services for disabled children and young people are outlined in the strategy as a result of central government developments. We know that many disabled children and young people suffer from long-term conditions that often may not be identified and treated as early as possible. Specific actions identified in the plan relate to disabled children and young people and other actions will clearly also impact positively upon them.

Religion or belief

The NHS Calderdale/Calderdale Council Commissioning Strategy 2011/12 does not have an adverse or negative impact on people with different religion or beliefs.

Sexual orientation

Diminished support networks for lesbian and gay people in times of crisis and presumption that all people who use services are heterosexual by mainstream providers, can cause isolation and lead to needs remaining unmet. Evidence form GALYIC suggests that young LGBT people suffer from discrimination and harassment may experience problems as a result.

Other socially excluded groups or communities, e.g. rural communities, carers, areas of deprivation

There is considerable evidence that suggests that communities which live in areas of deprivation are more likely to suffer from health and social inequalities, such has higher rates of infant mortality, teenage pregnancy, obesity and lower educational attainment. Therefore, there is a need to ensure that the commissioning function ensures that providers target these areas. Also, Calderdale has one of the largest geographic areas for a metropolitan borough and one of the smallest populations. There are relatively remote and isolated communities who may have difficulty accessing services.

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, project or service?

The NHS Calderdale/Calderdale Council Commissioning Strategy 2011/12 does not aim to adversely affect any group. The outlined actions are developed with the aim to ensure our commissioning function ensures that the services provided, target groups which have higher rate of health inequalities and other groups whose needs are different.

Does your policy, project or service either directly or indirectly discriminate?

Yes [ ] **No** [x]

If yes, how are you going to change this?

Detailed action plans will be developed to deliver the actions identified in the Strategy, and these will be subject to further focussed Impact assessment. Generally, the draft actions outlined in the action plans aims to further target our services to target groups which have higher rates of health and social inequalities and meet forthcoming legal obligations outlined in the Equality Act 2010.

Step 5 – Consultation

Who have you consulted with?

The Commissioning Plan is largely drawn from strategies and actions already identified by the PCT and/or the local authority. As such there has been wide-ranging consultation on many of the areas covered. A broad example of this is the very wide-ranging consultation exercise undertaken by the Council over the setting of its budget for 2011/12.

More focussed examples include the consultation undertaken by the Local Authority with children and young people regarding the previous children and young people's plan and consultations undertaken with parents and carers of disabled children and young people as part of the Aiming High for Disabled Children project.

If you have not consulted yet, please list which specific groups or communities you are going to consult with and when

The Plan as a whole will be consulted on with members of Calderdale Council's Community Equality Forum. As indicated above, detailed action plans will be developed to deliver the actions identified in the Plan, and these will be subject to further focussed Impact assessment.

Step 6 – Conclusions and Recommendations

What areas of the policy, project or service have you changed or improved as a result of this assessment?

The action plan outlines a number of draft proposals which include:

- how the commissioning of services continually meets the needs of our communities and,
- that our equality data illustrates how we are tackling health inequalities in Calderdale.

Who will be responsible?

It is envisaged that both the Council and the Primary Care Trust will be jointly responsible for actions along with other partners such as schools.

This EIA has been approved by:

Date:

Contact number:

Please send an electronic copy of the EIA to:

1. Equality Lead in your Directorate

2. Council's Equality Team who will publish it on the Council's website

Action Plan