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Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 8 September 2016 at 4.30 pm in Ernest Saville Room - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Carmody **Gibbons**	**Greenwood** **Bacon** **A Ahmed** **T Hussain** **Nazir**	**N Pollard**

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Barker **Poulsen**	**Berry** **S Hussain** **H Khan** **Mullaney** **Shaheen**	**Griffiths**

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Trevor Ramsay	Strategic Disability Partnership
Jenny Scott	Older People's Partnership

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.
- **At the discretion of the Chair, members of the public may be allowed to speak on a particular agenda item for a maximum of five minutes in total.**

From: **To:**

Parveen Akhtar
City Solicitor
Agenda Contact: Claire Tomenson
Phone: 01274 432457
E-Mail: claire.tomenson@bradford.gov.uk

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 28 July 2016 be signed as a correct record (previously circulated).

(Palbinder Sandhu – 01274 432269)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Palbinder Sandhu - 01274 432269)

B. OVERVIEW AND SCRUTINY ACTIVITIES

5. REPORT FROM HEALTHWATCH RE. CONSULTATION ON CHANGES TO ADULT SOCIAL CARE CONTRIBUTIONS POLICY 1 - 10

Healthwatch Bradford and District spoke to people affected by the proposed changes to the contributions policy, to gain an understanding of the potential impact on individual service-users and carers, and to add depth to the Council's own consultation.

Healthwatch Bradford and District will submit **Document "G"** which provides case studies highlighting the potential impact on people's lives if the Council adopts the proposed Adult Social Care Contributions Policy.

Recommended –

That the concerns highlighted in the report and case studies be noted.

(Victoria Simmons – 01535 665258)

6. OUTCOME OF CONSULTATION ON THE PROPOSED CHANGE TO BRADFORD COUNCIL'S CONTRIBUTIONS POLICY FOR NON-RESIDENTIAL SERVICES 11 - 120

From 1st April 2015 statutory guidance on charging for care and support under the Care Act is provided in The Care and Support (Charging and Assessment of Resources) Regulations 2014. The new law for adult care and support sets out a clearer approach to charging and financial assessments with one of the drivers of the Care Act 2014 being the portability of care and financial assessments; this would be better achieved if Bradford was to adopt the standard alternative.

Prior to any changes being made to the Policy, the Council is required to carry out a formal consultation on the proposed change. The Interim Strategic Director of Adult and Community Services will submit **Document "H"** which details the outcome of that consultation.

The report also suggests that consideration should be given to including charges for the Shared Lives Scheme in the Contributions Policy. It also suggests introducing charges for other services not currently charged for under the Policy.

Recommended –

That the Committee considers the feedback received to date as part of the consultation on changes to the Contributions Policy and that this Committee requests that the views and comments raised by Members be included in the final report to Executive on 20 September 2016.

(Bev Tyson – 01274 431241)

7. 0-5 HEALTH VISITING AND FAMILY NURSE PARTNERSHIP SERVICE REVIEW 121 - 146

The Director of Public Health will submit **Document "I"** which briefs Members on the review of 0-5 Health Visiting (HV) and Family Nurse Partnership (FNP) Services and sets out the proposals for a new model which supports and contributes to the Councils vision *'For every one of our children to have the best possible start in life*' through the commissioning and delivery of an evidence based service which considers the needs of our local communities.

The review for both services has been informed by key national and local policy and strategy, the needs of young children aged 0-5 years as well as consultation and engagement with key stakeholders including strategic leads from within the Council, service users, Primary Care, Clinical Commissioning Groups, NHS, Voluntary and Community sector and other partners. This report highlights the key findings from

the review, details the draft service model and requests approval from the Overview & Scrutiny Committee to proceed with commissioning a new service model which is fit for purpose and based on these recommendations.

Recommended –

(1) That the Committee considers the Business Case for the Health Visiting (HV) and Family Nurse Partnership (FNP) and:

(i) Provide any feedback and/or raise any queries or comments for clarity.

(ii) Support Public Health to proceed with the development of the proposed service model and service specification/s, based on the high level service principles, and to procure the service through a competitive tender process. The length of the contract and the procurement approach and timescales will be agreed with the BMDC Commercial Team.

(Shirley Brierley/Ruksana Sardar-Akram – 01274 432767)

8. JOINT SCHOOL NURSING SERVICE REVIEW 147 - 166

The Director of Public Health will submit **Document "J"** which provides information on the commissioning review of the School Nursing service.

The report highlights the key findings from the review and provides an overview of the proposed service model.

Recommended –

(1) That the Committee consider the Business Case for the School Nursing Service and;

(i) Provide any feedback and/or raise any queries or comments for clarity;

(ii) Support Public Health to proceed with the development of the proposed service model and service specification/s, based on the high level service principles, and to procure the service through a competitive tender process. The length of the contract and the procurement approach and timescales will be agreed with the BMDC Commercial Team.

(Shirley Brierley/Linda Peacock – 01274 435316)

9. WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At its meeting of 29 October 2015 the Committee considered a report of the Chair and resolved 'That the West Yorkshire Joint Health Overview and Scrutiny be supported'. It also nominated two members from within its membership to sit on the Joint Committee.

As the Committee has since been reconstituted, there is now a need to appoint two new members to sit on the Joint Committee.

Recommended –

That the Committee nominates two members from within its membership to sit on the West Yorkshire Joint Health Overview and Scrutiny Committee.

(Caroline Coombes – 01274 432313)

10. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016/17 167 - 176

The City Solicitor will submit **Document "K"** which presents the work programme 2016/17.

Recommended –

That the information in Appendix A and B of Document "K" be noted.

(Caroline Coombes – 01274 432313)

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Report of Healthwatch Bradford and District to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 8th September 2016

Subject:

G

Consultation on changes to Adult Social Care Contributions Policy, City of Bradford Metropolitan District Council

Summary statement:

The proposed changes will have significant impact on many vulnerable people across the District, affecting over 3,500 service users. The biggest impact will be on young people and working age adults with disabilities.

Healthwatch Bradford and District have heard concerns from a number of organisations and individuals about the proposed changes.

This report is based on case studies which highlight the potential impact on people's lives if the Council adopts the proposed contributions policy.

Portfolio:

Health and Wellbeing

Report Contact: Victoria Simmons
Phone: (01535) 665 258
E-mail: victoria@healthwatchbradford.co.uk

1. Summary

Healthwatch Bradford and District spoke to people affected by the proposed changes to the contributions policy, to gain an understanding of the potential impact on individual service-users and carers, and to add depth to the Council's own consultation.

The appendix to this report contains five individual case studies, which highlight the potential impact on people's lives if the Council adopts the proposed contributions policy.

2. Background

In May, Healthwatch went along to the first public meeting for this consultation. We heard significant concerns from people who attended; they were frightened and worried about the impact of the changes, and they were also concerned that the information which had been sent out to service-users was not accessible or easy to understand.

Healthwatch raised concerns with the Council about the consultation; we asked them to extend the closing date to enable more people to participate, to work with partner organisations to help spread the information, and to create Easy Read information about the proposed changes. The Council told us they would extend the consultation and would send out improved information which would include examples and be more accessible.

Healthwatch put information about the extended consultation on our website, on social media, and in our newsletter. We encouraged people to share their views in the Council's consultation.

Healthwatch worked with partner organisations to understand their perspectives on the changes, including People First organisations in Bradford and Keighley, Choice Advocacy, the Parents Forum, and some supported living services.

We carried out a small number of one to one and group interviews with service-users and carers, to enable people to share the direct impact that the proposed changes would have on their lives.

3. Report issues

The proposed changes will have significant impact on many vulnerable people across the District, affecting over 3,500 service users. The biggest impact will be on young people and working age adults with disabilities.

People we heard from have found the consultation difficult to understand, and have struggled to work out how the changes will affect them. For example, the questions about 'double-ups' confused people as it was not made clear that this would only affect service-users who fund their own care. As a result of the difficulties with the consultation, many people have not understood the proposals and therefore the full impact of the changes has not been realised.

Many people will face significant increases (in some cases almost 100%) in the amount of contribution they will be expected to pay. This will mean some service users will be unable to continue with activities that benefit their health and wellbeing; it may also increase

social isolation among vulnerable groups, push people into poverty, and lead to some people disengaging from services.

Although Disability Related Expenditure can be taken into account in a financial assessment, it is unclear how this will be applied and the Council's guidance does not include a full range of costs, particularly for people with learning disabilities or communication needs. Many care plans do not currently include such Disability Related Expenditure.

The Council carried out an Equality Impact Assessment (EIA) on the proposed changes to the contributions policy. The EIA signed off on 12 February 2016 judged that there were high impacts relating to age and disability, but only a 'medium' negative impact on people on low income / low wage. The feedback Healthwatch has had from service users makes clear that there will be a disproportionate impact on low income groups. It is not clear how this impact will be mitigated.

4. Options

The committee may wish to consider the following issues:

- Whether the proposed changes may adversely impact on the health and wellbeing of service-users, and cause unintended consequences for service-users, carers, and the health and social care system
- The need for greater clarity on Disability Related Expenditure and how this will be applied.

5. Contribution to corporate priorities

- Supporting and safeguarding the most vulnerable adults, children and families
- Reducing health inequalities

6. Recommendations

6.1 That the concerns highlighted in the report and case studies be noted.

7. Background documents

N/A

8. Not for publication documents

N/A

9. Appendices

9.1 Case studies

Proposed changes to Adult Social Care Contributions Policy: Case studies

The following case studies are based on individual conversations with service users and/or their carers. We have changed people's names in order to protect their anonymity. Figures given are based on service users reported income/expenditure and calculations have been made using the Council's published examples of the new contributions policy.

Case study 1 - Abbas

We spoke to Mrs A, who is the main carer for her son Abbas. Abbas is 22 years old; he is autistic. He lives at homes with her and his younger brother. The family have adapted their home to accommodate his needs and allow him to have some independence while remaining in the supportive family environment, where he doesn't rely too heavily on social care services.

Abbas attends college. He has been through travel training which was successful and he is now able to travel on the bus independently to get there. Sometimes his autism and his obsessions take over; without appropriate activities to keep him engaged he can become very aggressive and difficult to manage. He receives 5 hours support each week from Supported Lives. They take him out in the community; help him participate in activities like playing snooker or football. In addition to paying his contribution to the council for this service, Abbas takes money to pay for the activities, food/drink while they are out and has to pay for the support workers too.

Mrs A has received the information from the council about the consultation:

"I got the letter and the questionnaire from the Council but to be honest I didn't have a clue how to respond and it didn't make sense to me. I did fill it in but I just ticked 'I don't know' for everything."

Mrs A says that Abbas wouldn't be able to understand the information in the consultation, it was too complicated, and he hasn't got a real concept of money.

- **Currently Abbas contributes £18.18 per week for services.**
- **Under the proposed policy, his contribution would potentially increase to £42.84.**

Mrs A is very worried that the increased contribution will make their lives very difficult. If Abbas is not able to continue with the activities he enjoys, she feels his behaviour will deteriorate and he will become more withdrawn and his mental health will suffer.

“I don’t think people understand what the impact will be; they don’t know how hard it is. If we’re not able to manage to keep him at home like we do now, it’ll be much more expensive in the long run.”

“If he was unable to go out and do his activities like he does at the moment, he might start having more outbursts and aggression. Then we’d need to have involvement from social workers, and the behaviour team. That costs more money.”

Mrs A felt that the council’s list of Disability Related Expenditure was very limited, and she was worried that it said only items in the care plan would be included. Abbas sometimes wets or soils himself, so he incurs additional laundry and replacement bedding/clothing costs. However this is not documented in his care plan, because at that time they didn’t realise it would need to be. She says she will request a new care assessment in order to make sure all his needs and expenses are recorded.

Case study 2 - Kate

Kate is in her fifties; she has learning disabilities and health problems, she lives independently in a sheltered housing scheme. Four days a week, she receives care at home – they support her with personal care and prompt her medication.

Kate doesn’t remember getting a letter about the consultation. She says she finds it difficult to understand lots of things that she receives, so ignores them.

“It’s a bit awkward because I don’t know the value of money.”

Kate says she doesn’t have much money. A few months ago she was taken advantage of by someone who pretended to be her friend but took her money, the police were involved and it was a very distressing experience. Since that happened, she has received an additional service where someone comes to help her with her bills and paperwork once a week.

She currently pays a contribution towards her services, but doesn’t know how much it is. She says sometimes she thinks it’s too much and it’s not worth it.

When we explained the Council’s proposals for the contributions policy, she was quite worried. If she had to contribute more than she pays now she would find it very hard. She thinks it would be hard for a lot of disabled people.

“A lot of people might not even have a couple of quid to spare. It’d take me whole income off me, every week.”

Kate’s main social activity is to go to the pub with her friend, apart from this she doesn’t go out much or do any activities. If she wasn’t able to afford to go out and meet her friend as often, she would get lonely and depressed.

“I wouldn’t talk to anybody. I suffer with depression. It makes me feel angry to think about it.”

Kate talked about what she might have to give up if she had less money to spend. She thought that maybe she could stop paying for the support she receives to manage her money and bills, because she'd rather give that up than to stop seeing her friend. Kate's learning difficulties meant that she is unable to recognise that this might leave her open to someone taking advantage of her again, or of getting into further financial difficulty. This highlights the choices that vulnerable people might make as a result of increased contributions for services, and which could have significant impacts on their safety and wellbeing.

Case study 3 - Tahid

Tahid is 21, he is autistic. He lives at home in the BD3 area of Bradford with his mother Mrs H, who is his full time carer, she takes him to and from college and support services, helps him with personal care, cooks for him and looks after his health needs.

Tahid goes to college four days a week in Shipley - Mrs H drives him there every morning and picks him up every afternoon. They have been through travel training, but it was not successful and he is not yet able to travel independently.

Tahid enjoys creative activities, such as art, knitting. These things give him a focus and keep him calm. He spends about £20 per week on materials for these activities. Without this outlet he gets easily bored and this leads to outbursts and aggression. His communication and social interaction is limited but he uses the internet to follow his interests.

Once a week, he goes to the Learning Zone where he takes part in a range of activities. Since he has been attending, his social interaction and confidence have slowly increased.

He does not currently receive any other social care services.

Tahid gets Employment and Support Allowance (ESA) and Disability Living Allowance (DLA) with both the care and mobility competent awarded at the higher rate.

- **Tahid contributes £22.73 per week to the cost of the Learning Zone service.**
- **Under the new proposals, his potential charge could increase to £42.84**

"If he didn't have the money to follow his interests, it would really be bad for his health and wellbeing. We need to keep him busy otherwise he will get angry and violent – he's hard to handle. I wouldn't be able to handle him if his behaviour was worse. This is the fear I have, that he'll have to end up going into a care centre somewhere."

"I am struggling on a low income already, and they are saying we need to pay more for services. I don't think it's fair. It's really upsetting for the family, because you don't know what is going to be happening tomorrow. The lifestyle that he is living at the moment is ok, but if the contribution goes higher it's going to be very difficult to manage."

"I have suffered depression in the past; it's sometimes hard to deal with everything. I worry a lot about money, and when I am worried and depressed it's harder to care for Tahid. If I got ill, I don't know what would happen."

Mrs H has not responded to the consultation.

"I don't understand the questions they are asking. I was really confused. The second letter had some examples, and that was a little bit better. It asks if Bradford should be the same as the rest of the country – but I don't know what it is in the rest of the country, so how can I answer?"

Mrs H thinks a lot of people will not have understood the information that was sent out, and then when they suddenly get a big bill it will be a shock. She thinks many people might then just stop using services.

Case study 4 - Robert

Robert is 27, he has Down's Syndrome and related health issues including a heart condition. He lives in Supported Living accommodation, where he is thriving and has good social interactions.

Robert receives DLA at middle rate with low rate mobility and ESA. He has a tenancy agreement and receives housing benefit which pays his rent. He pays all the normal living costs such as utility bills, insurance and maintenance charges, furnishings and bedding etc, food shopping, clothes, etc. His mobility allowance does not fully cover the cost of a car pool at Supported Living, so he also pays additional travel costs.

- **He contributes £43.14 per week towards the cost of the support services he receives.**
- **If the new contribution policy is implemented, his contribution will rise to £85.69.**

Currently Robert is able to pay to attend his weekly rugby training, associated matches and trips to play other clubs. Taking part in sport has significant emotional and physical health benefits for Robert. Down's syndrome puts him at increased risk of diabetes and he has a heart condition, so keeping active and maintaining a healthy weight are vital.

Robert's other passion is music and he plays his drums every day. This is an electronic kit to minimise noise and it is starting to fail due to usage and age, and will need to be replaced. Robert goes out with his Personal Assistant one day per week, and he has to cover the PA's admission fees to activities, food and travel costs as well as his own.

Robert's mother is very worried about the impact on her son.

"If the new charging policy is implemented it will have a life changing impact on him. It would take away all of his disposable income! The amount the government is saying can be allowed does not fully cover the normal living costs associated with

Supported Living accommodation, let alone any hobbies, sporting and social activities or anything else that requires any payment no matter how small."

"I asked him how he would feel if he couldn't play in rugby matches. He was visibility upset about that and said 'people shouldn't steal my money'. What could I say? How can I explain to someone who asks for very little and accepts society's poor standards and expectations of people with learning difficulties that he won't be able to buy his girlfriend a birthday card let alone have a holiday or leave the house at evenings or weekends because there won't be any money to do so. He will effectively be reduced to institutionalised living with all the risks that that carries."

"I feel a tremendous sense of guilt and worry about Robert's future which in turn affects my own health and wellbeing."

It is very difficult to quantify Disability Related Expenditure for Robert. He has a pace maker fitted and this means he needs additional heating to keep himself warm. He also has a tremor which means he tends to spill food so extra washing is required. He struggles with dexterity and is more likely to drop and break things, and also often loses things, e.g. his glasses, which need to be replaced. Not all of these additional expenses are reflected in his care plan.

Case study 5 – Jack & Steven

Two brothers, Jack 51 and Steven 39 have lived in Supported Living for the past 5 years with enormous success. They both have learning disabilities and a progressive physical disability.

Their mother, Mrs S, is very frightened about the impact on her sons of the proposed changes to how much they pay towards their care and support.

The manager of the Supported Living scheme where they live has looked at their current income and contributions, and calculated how much they spend at the moment on day to day living. Taking into account the bills they have to pay, spending on food and other groceries, personal care, clothing, and transport, she has estimated that their 'bare minimum' weekly expenditure is around £163.21 per week, more than the minimum income guarantee figure of £156.31. And this does not account for taking part in any activities, or what they spend when going out with their support workers.

At the moment, although things are tight the brothers are able to pay all their bills, live independently and take part in a range of activities.

- **They currently contribute £43.14 towards the cost of their services.**
- **Under the new proposals, contributions would almost double to £85.69.**

The Supported Living manager tells us that this could mean that they would not have money to afford any other 'extras' like holidays, Christmas or birthdays, or to keep anything aside for emergencies. And importantly that it would leave them with no money to spend on activities.

Due to their physical disabilities, it's vital for Jack and Steven to be as active – physiotherapists and doctors have recommended regular swimming. The brothers go swimming twice a week, at a cost of £10 each – they have to pay the costs for their support workers as well as themselves. To make this affordable, their mother provides transport at the moment, but due to her own health this may not continue to be possible for much longer. The costs would significantly increase if other transport was needed. Mrs S is worried that with the proposed changes, her sons would not be able to afford swimming and other activities, which are so important for their health and wellbeing.

"If they become wheelchair bound earlier in life with all the consequences of internal organ damage, surely this will cost the country even more? If their behaviour deteriorates they will need double the staffing they have now- more expense!"

"If they are left with insufficient disposable income their lives will be very much changed and possibly shortened."

She is particularly worried about her younger son Steven, who is doing well at the moment but whose behaviour and health were very hard to manage in the past.

"If he is bored and frustrated he hits himself in the face, knocking out teeth, and bangs his head on anything available resulting in hospital visits and stitches etc. At the present time, since he has been in Supported Living his behaviour is perfect and he is very contented with all the social activities he can go out and enjoy."

"It would break my heart as a mother and carer if he could no longer afford the activities that keep him and his brother well."

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Report of the Interim Strategic Director of Adult and Community Services to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 8 September 2016.

Subject:

H

Outcome of Consultation on the proposed Change to Bradford Council's Contributions Policy for non-residential services

Summary statement:

From 1st April 2015 statutory guidance on charging for care and support under the Care Act is provided in The Care and Support (Charging and Assessment of Resources) Regulations 2014. The new law for adult care and support sets out a clearer approach to charging and financial assessments with one of the drivers of the Care Act 2014 being the portability of care and financial assessments; this would be better achieved if Bradford was to adopt the standard alternative.

Prior to any changes being made to the Policy, the Council is required to carry out a formal consultation on the proposed change and this report details the outcome of that consultation.

The report also suggests that consideration should be given to including charges for the Shared Lives Scheme in the Contributions Policy. It also suggests introducing charges for other services not currently charged for under the Policy.

Bernard Lanigan, Interim Strategic Director of Adult and Community Services

Report Contact: Bev Tyson
Phone: (01274) 431241
E-mail: bev.tyson@bradford.gov.uk

Portfolio:

Cllr Val Slater

Overview & Scrutiny Area:

Health and Wellbeing

1. SUMMARY

From 1st April 2015 statutory guidance on charging for care and support under the Care Act is provided in The Care and Support (Charging and Assessment of Resources) Regulations 2014. The new law for adult care and support sets out a clearer approach to charging and financial assessments with one of the drivers of the Care Act 2014 being the portability of care and financial assessments; this would be better achieved if Bradford was to adopt the standard alternative.

Prior to any changes being made to the Policy, the Council is required to carry out a formal consultation on the proposed change and this report details the outcome of that consultation.

The report also suggests that consideration should be given to including charges for the Shared Lives Scheme in the Contributions Policy. It also suggests introducing charges for other services not currently charged for under the Policy.

2. BACKGROUND

2.1 Current Contributions Policy for non-residential services

Bradford Council's Contributions Policy was implemented originally in 1996 and was revised in August 2012. The current Policy covers charges for homecare, day care, sitting services and direct payments and creates a single charge for whatever combination of these services a service user may receive. The weekly value is calculated by cumulating notional costs for each service received and this is then compared to the amount the service user has been financially assessed as being able to afford, the actual weekly contribution applied being whichever figure is the lower.

Due to the design of Bradford's current Contributions Policy, it is generally more generous than the standard alternative. There are however, circumstances where the current Bradford Policy is less favourable, which impacts those with low incomes. For instance, a single pensioner without Severe Disability Premium but in receipt of Attendance Allowance is likely to pay more under the Bradford policy, if their other income is lower than £160 per week.

Service users with more income are more favourably treated under the Bradford Policy and, broadly, the more income that you have, the more you benefit from the Bradford's approach. In addition if the service user is in receipt of Severe Disability Premium, Bradford's Policy is almost invariably more favourable.

The Policy ensures that no individual service user, especially those with limited income, contributes more than they can reasonably afford to pay, which will not change even if the proposed changes are implemented.

2.2 Legislative changes

From 1st April 2015 statutory guidance on charging for care and support under the Care Act is provided in The Care and Support (Charging and Assessment of Resources) Regulations 2014. The new law for adult care and support sets out a clearer approach to charging and financial assessments with one of the drivers of the Care Act 2014 being the portability of care and financial assessments; this would be better achieved if Bradford was to adopt the standard alternative.

The benefit changes with the introduction of Personal Independent Payments and Universal Credit which started to be rolled out in Bradford in November 2015 will have an impact on the current Contributions policy as Severe Disability Premium has no direct equivalent in Universal Credit and this is likely to have a negative impact on the income collected.

2.3 Proposed changes to the current Contributions Policy

2.3.1 The Current Contributions Policy

Bradford Council's current Contributions Policy is composed of the following four components:

- a basic charge
- a charge of 33% of middle rate Disability Living Allowance Care Component/ Attendance Allowance and 33% of Severe Disability Premium.
- a charge on income
- a charge on capital and savings

The total is used to calculate the service user's maximum weekly contribution. Calculating the contribution this way adds an extra level of complexity that is difficult to explain to service users.

2.3.2 The Standard Alternative

The standard alternative would be simpler to administer, would generate more income and is based on a single component as follows:

- The total income of the service user is determined (including capital and savings)
- From this the minimum income guarantee is deducted (this is the amount that the government says that you need for living costs and is based on basic income support/pension credit plus 25%).
- If you have any housing related costs and disability related costs these are also deducted.
- The money remaining is the amount used to calculate the contribution.

2.3.3 Impact on Service Users of changes to the current Policy

There are currently over 3500 service users across the District and the impact of the charging proposals is likely to have a greater impact on the savings and net disposable income of older people and working age adults that have more income, and young people under the age of 25.

Approximately 400 service users (40%) of working age will see an increase of between 25p and £116 per week and approximately 700 service users (34%) of pension age will see an increase of between 2p and £110 per week.

Young people under the age of 25 in receipt of high rate DLA/PIP would see an increase of up to £40 per week once they are in receipt of benefits as an adult; there are currently approx 226 service users under 25, 127 of which are in receipt of high rate DLA/PIP.

By definition virtually all those people receiving a social care service have a disability. However the proposed changes to the contributions policy have the greatest impact on young people under the age of 25 and those people who have acquired savings or have higher levels of income, and certainly above income support levels. In general people with severe and life limiting disabilities are less likely to be earning or acquiring savings.

Approximately 400 service users (40%) of working age will see a decrease of between 13p and £43.70 per week and approximately 450 service users (23%) of pension age will see a decrease of between 8p and £52.49 per week.

2.3.4 Implications of changing the existing Policy

If the proposal is agreed, in order to avoid increased charges, some service users may choose to reduce their care packages or purchase their care on the private market, which will benefit the purchased care budget, rather than the income budget.

The extra income available would depend on choices made in setting a new Contributions Policy - for example, if a higher standard rate Disability Related Expenditure was used or if less than 100% of disposable income were included in the assessment, then less extra income would be obtained.

Changing the existing Contributions Policy to the standard alternative suggested would see potential extra income achieved of approximately £500,000 per year. This figure has been based on a standard policy that would use 100% of net disposable income after any deductions for Disability Related Expenditure and Housing Related Costs.

Whilst every effort has been made to produce accurate figures they should be treated as estimates as the complexities of the policy and the factors taken into account may change

2.4 Further additional recommended changes and additions to the Contributions Policy

In addition to the proposal to amend Bradford Contribution Policy to the Standard alternative used by many other Local Authorities, further additional changes are recommended to the existing Policy to ensure that a comprehensive Contributions Policy is in place across the District which captures all services for which a charge could possibly be made.

2.4.1 Shared Lives

Short Breaks - Currently the charge for Shared Lives short breaks is £8.97 per night which is less than the current charge for short breaks in Learning Disability Services of £11.49. The proposal is to bring Shared Lives in line with Learning Disability Services. There would be a potential increase in income of £6,400 and the change would ensure that all service users would be paying the same charge.

Appendix 3 contains a letter sent out to service users.

Full Time Placements - Consideration needs to be given to bring the Shared Lives Full Time Placements under the non-residential Contributions Policy. The current payment system is based on the residential charging model which is not applicable.

The Shared Lives Scheme provides up to 37 full time placements for vulnerable adults. Placements are funded by a combination of housing benefit, client contribution and Local Authority top up with the current average cost of placement to the Department being £124.31 per week (excluding HB).

The service users are not currently put through the financial assessment arrangements but are left with a personal allowance of £72.50 per week. Under the non-residential Contributions Policy the service users would be left with a personal allowance of between £91.38 and £176.38 depending on their income.

This would increase the Local Authorities costs by £50,000 per year. However national research shows that a full time Shared Lives match can save the funding authority £26,000 p.a. for someone with a Learning Disability and £8,000 p.a. for someone with a Mental Health problem.

Research locally (October 2013) showed that there was a saving of over £28,000 per placement for each person with a Learning Disability using Shared Lives on a fulltime basis (compared to alternative housing).

2.4.2 Charging for cost of service - Double Up's

Under Bradford's current Policy, the cost for care visits which require two workers to be present at the same time is calculated on the time taken for the visit rather than the actual cost of the service.

The Care Act 2014 determines that the actual cost of the service has to be used for

calculating the Care Account and therefore the actual cost of the service should be used for calculating the contribution.

If implemented, this change will only affect those service users who have been financially assessed as contributing the full cost of their care i.e. self funders.

Currently there are 417 service users that have two workers present. Of those, 70 pay the full cost of service and 67 have chosen not to disclose their financial circumstances and therefore also pay the full cost of their care and in those cases contributions would double with the increase in costs being between £13.75 and £409.06 per week. This could potentially increase income by £10,343.00 per week or alternatively reduce the purchased care budget as the service users would organise their care privately or request a financial assessment.

2.4.3 Charging for care provided in Supported Living

Supported Living is not currently an assessed charge under the existing Contributions Policy. There are currently 221 service users in Supported Living care settings who receive 24/7 support in their Supported Living accommodation. 151 of those service users currently receive other services that do come under the Contributions Policy for which they are assessed as being able to make a contribution towards and are charged. The remaining 70 do not receive any other services and therefore do not make a contribution towards the cost of their care.

If the Supported Living service was to be considered under the Contributions Policy the 151 already being charged will not see an increase in their charge because they are already paying the maximum they can afford to pay. However if the remaining 70 are assessed as being able to afford the minimum contribution of £22.73, this would generate extra income of £82,737 per year.

3. REPORT ISSUES – CONSULTATION FEEDBACK

3.1 Consultation process

The initial consultation ran from 29th February to 20th May 2016. A letter and questionnaire (Appendix 1) was sent out to approximately 3,500 service users. The questionnaire was available on line where a printable version could be down loaded for return in the post and a telephone helpline was available to support service users complete the form and for questions to be answered. A consultation meeting was also held on 12th May 2016 for interested parties to attend.

During the initial consultation period concerns were raised regarding the questionnaire and the level of detail given in the documentation regarding the changes. As a result of those representations, the consultation period was extended to the 10th August 2016 and the Council worked with Keighley Peoples First and Health Watch to further improve the documentation. An amended letter and questionnaire was developed, together with additional examples (Appendix 2) and was sent out to approximately 3,500 service users.

A further consultation meeting was held on 19th July 2016 for interested parties to attend.

In relation to the Shared Lives proposals, a letter was sent out to 140 service users regarding the short breaks (Appendix 3) and a meeting was held on 6th May 2016. A 1:1 meeting was held with all 40 service users and carers to discuss the full time placement charges and a meeting was also arranged for 10th May 2016.

3.2 Summary of the results of the consultation questionnaires

723 service users responded to the first questionnaire, a response rate of 21% and 639 responded to the revised questionnaire, a response rate of 18%. A detailed analysis of the responses to each of the questions in the two questionnaires is attached at Appendix 4 and 5 respectively.

In summary, the specific questions asked on the questionnaire and the responses received over the two questionnaires are highlighted below;

Question 1 - The Councils policy is different to the rest of the country do you think it should be changed and made the same?

Response - 39 % of respondents agreed that the Councils policy should be brought in line with the rest of the country and only 28% disagree.

Question 2 - Do you think the standard policy is fair?

Response - This question was only asked in 2nd questionnaire. 45% of respondents agreed that the standard policy was fair. Only 15% strongly disagreed that the proposed standard policy is fair.

Question 3 - Is the standard alternative as described easier for you to understand than the current policy?

Response - The response to this question was evenly split between those agreeing and those disagreeing.

Question 4 - The cost of two workers should be charged for those who can afford to meet the cost?

Response - This issue resulted in a response of 36% agreeing and 38% disagreeing.

Question 5 - The support that service users receive in supported living should be charged for?

Response - This issue resulted in a response of 36% agreeing and 37% disagreeing.

3.3 Feedback from consultation events

In addition to the two questionnaires, two consultation events were also held. Approximately 100 people attended the two events made up of service users, representatives of service users, carers and voluntary organisations. A brief introduction on the proposed changes was given and then facilitated discussion groups were asked to respond to a set of questions. At the events, all parties were offered the opportunity to make comments or written representations on the proposed changes.

The notes of the two meetings and comments received in written representations are attached at Appendix 6 and 7 respectively.

Some of the main issues raised include:

- General comments - During the consultation meetings a range of comments and concerns were raised in relation to the fact that changes to Social Care contributions were even being considered as part of the Councils budget setting process. There were also questions raised as to why alternative options in relation to local decisions were not being considered instead of raising charges e.g. increases to Council Tax or taking the cuts from other Departments.

- Changing to the standard alternative policy - The general feeling was that Bradford should stay with its existing policy and that the standard alternative was not fair and would leave service users with less money and a poorer quality of life. It seemed that the service users in the 25 years to pension age group would be adversely affected. There were also concerns about Disability Related Expenditure (DRE) and what type of expenditure would be allowed, particularly if the service user had a Learning Disability. The amount of the increase in contributions was also a concern as some service users may see their contributions double under the new policy. The majority did not think that the standard alternative was any easier to understand than current policy.

- Concerns about the time it will take to do a financial assessment and also that a care assessment should be done at the same time and would there be enough resources available to do this.

- Charging for cost of service - Double ups - The general feeling was that it was not the fault of the service user if they required two carers so why should they be penalised by being charged for both.

- Charging for care in the Supported Living Service - The general feeling was that it seemed fair that service users should contribute if they are receiving care but that if charged for this under the standard policy, then they would have less money and a poorer quality of life.

3.4 Results from the shared lives consultation

The Shared Lives Fairer Charging Consultation took place between May and June 2016.

A summary of the feedback is below.

Short Breaks

140 letters were sent out to people using shared lives short breaks about the proposed flat rate increase from £8.97 to £11.49 per overnight. 17 replies were received a 12% response rate.

The questions were:

	Strongly Agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
1) The charge for Shared Lives should be the same as for residential short breaks (respite)	1	8	3	1	1
2) Increasing the charge will make no difference to how much I use the Shared Lives service	1	1	6	8	2

The theme of comments was that people felt that they were being expected to pay for more and more aspects of care and support and transport and were unsure how an increase would affect them. Others felt it was a big increase but a fair rate.

A meeting was arranged to discuss the short breaks increase on Friday 6th May 2016 at City Hall but no one attended.

Full Time Shared Lives Services

There are 40 service users who use Shared Lives on a fulltime basis living with 27 Shared Lives carers. Individual 1:1 discussions were held with all the fulltime carers and service users about the potential impact of the Non residential Contributions Policy principles regarding their contribution to the Shared Lives fulltime matches.

Overall service users felt that the proposed changes will make the payment system more straightforward and easy to understand and all were in favour as it does not leave anyone worse off.

A meeting to discuss the short breaks increase was held on 10th May 2016 at City Hall to discuss the issue and only 1 person attended who was in favour of the new system

4. FINANCIAL & RESOURCE APPRAISAL

In finalising the budget for 2016/17 onwards at Council on 25 February 2016, the Director of Finance report Document R 'The Council's Revenue Estimates for 2016-17 and 2017-18' was agreed.

The report included proposal 3A1 and identified additional income of £466,000 in 2016/17 and a further £611,000 in 2017/18 as a result of 'Changes to the Contributions Policy for Adult Social Care'.

Any shortfall in the achievement of that identified income will need to be found from elsewhere within the Adult Social Care budget.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

There are no risk management or Governance issues in relation to this report.

6. LEGAL APPRAISAL

The Care Act 2014 now provides a single legal framework for charging for care and support under sections 14 and 17 supplemented by The Care and Support (Charging and Assessment of Resources) Regulations 2014.

The framework is based on the following principles that local authorities should take into account when making decisions on charging:

- Ensure that people are not charged more than is reasonably practicable for them to pay;
- Be comprehensive, to reduce variation in the way people are assessed and charged;
- Be clear and transparent, so people know what they will be charged;
- Promote wellbeing, social inclusion and support the vision of personalisation, independence, choice and control;
- Support carers to look after their own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so; and
- Be sustainable for local authorities in the long-term.

The new framework is intended to make charging fairer and more clearly understood by

everyone. There is however no single prescribed national charging policy for care services provided in a setting other than a care home (e.g. own home, extra care housing, supported living or shared lives accommodation). Local Authorities have the discretion to decide whether or not to charge and should enter into consultation when deciding how to exercise this discretion. If a Local Authority chooses to charge, a means test based charging policy is required. Any charging policy must be Care Act 2014 and Regulation compliant.

The Regulations determine the maximum amount that can be charged and the minimum amount of income a service user must be left with but charging policies can be more generous. The overarching principle of the new framework is that people should only be required to pay what they can afford and no more than the actual cost of the services.

The Regulations require charging policies ensure that after charging service users are left with enough money to meet their daily living and any disability related costs that are not met by the local authority. This is referred to as the minimum income guarantee (MIG) . The Regulations prescribe the MIG and service users' income cannot be reduced below the MIG. The government has indicated it considers it is inconsistent with promoting independent living to assume, without further consideration, that all of a person's income above the MIG is available to be taken in charges. Local authorities should consider whether it is appropriate therefore to set a maximum percentage of disposable income over and above the MIG to be taken into account in charging. Local authorities should also consider whether it is appropriate to set a maximum charge to help ensure that people are encouraged to remain in their own homes and promote independence and wellbeing

Consideration should be given to how any charging policy will impact on carer services. Local Authorities are not required to charge a carer for support provided to them. Local Authorities should ensure any charges do not negatively impact on a carer's ability to continue to care.

Any charging policy must be Care Act 2014 compliant and implemented in accordance with the overriding statutory principles so as not to create inequity between existing and new service users.

Consultation must be full and meaningful. A consultation should ensure that all relevant parties receive sufficient information to enable them to provide informed feedback which should be taken into account prior to any final decision being made. The consultation process and timing should be sufficient to enable consultees to be informed of the proposals, raise queries, consider alternatives and respond to the issues and complexities of the proposals whilst remaining coherent, focussed and proportionate. A public body is not bound to act upon the preferred option of consultees but must take full account of any preferred view, expressed opinion and overall feedback. The requirement is for consultation to be meaningful. Clear reasons must be given for not taking a preferred course of action expressed by consultees.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

There are currently 3355 service users across the District and the impact of the charging proposals is likely to have a greater impact on the savings and net disposable income of older people and working age adults that have more income, and young people under the age of 25. Young people under the age of 25 will all see an increase of up to £40 per week once they are in receipt of benefits as an adult, there are currently approximately 270 service users in this category. Approximately 400 service users (40%) of working age will see an increase of between 25p and £116 per week and approximately 700 service users (34%) of pension age will see an increase of between 2p and £110 per week.

By definition virtually all those people receiving a social care service have a disability. However the proposed changes to the contributions policy have the greatest impact on those people who have acquired savings or have higher levels of income, and certainly above income support levels. In general people with severe and life limiting disabilities are less likely to be earning or acquiring savings. Approximately 400 service users (40%) of working age will see a decrease of between 13p and £43.70 per week and approximately 450 service users (23%) of pension age will see a decrease of between 8p and £52.49 per week.

The majority of current service users are female and therefore the majority of those affected by the proposed changes are elderly women.

Any proposed changes will pay particular attention to the minimum income buffer required under current Legislative guidance of Income Support/Guarantee Credit plus 25% when considering the impact of any change to existing policy and the amount of funding available to them to continue to pay their other day to day living expenses.

In mitigation before any individual changes are made as a result of the new proposals clients will still be offered the opportunity to be financially assessed as being able to afford to pay any new charges and those assessed as being unable to pay will not be charged.

An Equality Impact Assessment has been prepared and is attached as Appendix 6

7.2 SUSTAINABILITY IMPLICATIONS

There are no specific sustainability implications in this report.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

N/A

7.4 COMMUNITY SAFETY IMPLICATIONS

There are no specific community safety implications in this report.

7.5 HUMAN RIGHTS ACT

Under the Human Rights Act 1998 it is unlawful for any public body to act in a way that is incompatible with an individual's human rights. Where an individual's human rights are endangered Local Authorities have a duty to balance those rights with the wider public interest and act lawfully and proportionately. The most relevant rights for the purposes of this report are:

- the right to respect for private and family life
- the right to freedom from inhumane and degrading treatment
- the right not to be discriminated against in respect of these rights and freedoms

The obligations on public bodies under the Human Rights Act 1998 require vulnerable individuals their families, carers and relevant members of the public be involved in any consultation process and planning of changes and that planning of change is fair and proportionate.

7.6 TRADE UNION

There are no current Trade Union matters for consideration. However as the work progresses, should any Trade Union implications be identified which need to be considered, will be addressed through the usual consultation mechanisms.

7.7 WARD IMPLICATIONS

There are no specific Ward or area implications in this report.

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

N/A

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

There are no options to consider. The report is being made available to the Overview and Scrutiny Committee to ensure that any comments or considerations can be included in the report to the Executive on the outcome of the consultation on 20 September 2016, prior to any decisions being taken.

10. RECOMMENDATIONS

That the Committee considers the feedback received to date as part of the consultation on changes to the Contributions Policy and that this Committee requests that the views and comments raised by Members be included in the final report to Executive on 20 September 2016.

11. APPENDICES

Appendix 1 - Original letter and questionnaire
Appendix 2 - Revised letter, examples and questionnaire
Appendix 3 - Shared Lives Letter
Appendix 4a - Results from the original questionnaire
Appendix 4b - Comments from the original questionnaire
Appendix 5a - Results from the revised questionnaire
Appendix 5b - Comments from the revised questionnaire
Appendix 6 - Notes of first consultation meeting held on 12 May 2016
Appendix 7 - Notes of second consultation meeting held on 19 July 2016
Appendix 8 - Equality Impact Assessment

12. BACKGROUND DOCUMENTS

None

Appendix 1 – Original letter and questionnaire

[Insert Name and Address]
[Insert Address]
[Insert Address]
[Insert Address]
[Insert Address]
[Insert Address]

Department of Adult and Community Services

Olicana house
Chapel Street
Bradford
BD1 5RE

Tel: (01274) 437975
Fax: (01274) 432933
Email: cca.charges@bradford.gov.uk

Date:

Dear Service User

Reviewing your financial contribution to care services you receive

We are writing to you today as we are reconsidering the way that people contribute financially for the services they receive and we want to get your views before the Council makes a final decision.

From 1st April 2015 statutory guidance on charging for care and support under the Care Act is provided in The Care and Support (Charging and Assessment of Resources) Regulations 2014. This new law for adult care and support sets out a clearer approach to charging and financial assessments with one of the drivers of the Care Act 2014 being the portability of care and financial assessments; this would be better achieved if Bradford was to adopt the standard contributions policy that is used by the majority of Local Authorities in England.

We want to make clear that anybody who has limited income will not be asked to contribute financially unless they can reasonably afford to pay.

A three month consultation started in March which will review how the financial contribution we ask people to make towards some care services they receive is calculated.

The review will specifically consider a number of changes and attached to this letter is a questionnaire asking your views on these changes. These include:

- Adopting a standard contributions policy that is used by the majority of Local Authorities in England and is a much simpler process to understand.

- If a person can afford to pay for the full cost of their care to charge for the actual cost of two carers if two carers are needed.

- If a service user is living in a Supported Living Accommodation, the support that they receive in that accommodation should be charged for.

We really would like to hear your views. We understand that these are difficult times for people but the Council are looking at as many ways as possible to sustain services for the future.

There are a number of ways that you can make your views known:-

- Complete the questionnaire attached to this letter and/or contribute your own ideas and return to Adult and Community Services in the enclosed pre-paid envelope by **Friday 6th May 2016.**

- Write direct to Adult and Community Services Contribution Consultation, 5th Floor Britannia House Bradford BD1 1HX

- Email cca.charges@bradford.gov.uk

- Use our website http://www.bradford.gov.uk/bmdc/Consultations/current_consultations

- Telephone us on 01274 437975 between 9am and 5pm

The consultation has already begun and will run for a 12 week period from Monday 29TH February until Friday 20th May 2016.

Clearly, the Council is faced with making some difficult decisions in the near future and we would value your thoughts in order to work together to continue to provide the best possible service for the adults we support in Bradford. All the information you provide is treated in the strictest confidence and will only be used to help us make these decisions. Your personal information will always remain confidential and will not be passed on to any other organisation.

Bernard Lanigan

Strategic Director
Adult and Community Services

Contributions Policy Questionnaire

Contributions

From 1st April 2015 statutory guidance on charging for care and support under the Care Act is provided in The Care and Support (Charging and Assessment of Resources) Regulations 2014. This new law for adult care and support sets out a clearer approach to charging and financial assessments with one of the drivers of the Care Act 2014 being the portability of care and financial assessments; this would be better achieved if Bradford was to adopt the standard contributions policy that is used by the majority of Local Authorities in England.

We would value your thoughts in order to work together to continue to provide the best possible service for the adults we support in Bradford.

Changing to a standard Contributions Policy

Currently your contribution is composed of four components:

- A basic charge
- A charge on the care component of Disability Living Allowance/ Attendance Allowance/ Personal Independence Payments and Severe Disability Premium
- A charge on income
- A charge on capital and savings

The standard alternative is based on a single component:

- The total income of the service user is determined and from this the minimum income guarantee is deducted (this is the amount that the government says that you need for living costs and is based on basic income support/pension credit plus 25%). If you have any housing related costs and disability related costs these are also deducted. The money remaining is the amount used to calculate the contribution.

The standard alternative would be simpler to administer and also simpler for service users to understand.

Please indicate how strongly you agree or disagree with the following statements about the changes we are proposing.

Please tick one box for each statement

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
1) The Councils policy is different to the rest of the country do you think it should be changed and brought into line with the rest of the country?					
2) Is the standard alternative as described above easier for you to understand than the current policy?					

Charging for cost of service - Double ups

Currently in Bradford the cost of care visits which require two workers to be present at the same time are calculated and charged for one worker only.

We are proposing that the actual cost of two carers should be charged for and if a person can afford to pay for the full cost of that they should do so.

Please tick one box for each statement

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
3) The cost of two workers should be charged for those who					

can afford to meet the cost.					

Charging for care in Supported Living Service

If a service user is living in a Supported Living Accommodation, the support that they receive in that accommodation is not currently charged for. The proposal is that these services come under the Contributions Policy and are charged for.

Please tick one box for each statement

	Strongly agree	**Tend to agree**	**Neither agree nor disagree**	**Tend to disagree**	**Strongly disagree**
4) The support that service users receive in supported living accommodation should be charged for.					

5) Any other comments please write them in this box	**Comments**

Appendix 2 – Revised letter, questionnaire and examples

[Insert Name and Address]
[Insert Address]
[Insert Address]
[Insert Address]
[Insert Address]
[Insert Address]

Department of Adult and Community Services

Britannia House
Hall lings
Bradford
BD1 1HX

Tel: (01274) 437975
Fax: (01274) 432933
Email: cca.charges@bradford.gov.uk

Date:

Dear Service User

Reviewing your financial contribution to care services you receive

From 1st April 2015 the law about charging for care and support changed. The Care and Support (Charging and Assessment of Resources) Regulations 2014 is the new law for charging for adult care and support services. The aim is to make things easier to understand and that if you move to another part of the country you should not need a new financial assessment or care plan.

We wrote to you in March asking your opinion about the possible changes to how much you pay for the services you receive. From the feedback we were told that it was hard to understand and there was not enough information. We are now extending the consultation period until the 10th August 2016, and sending out this information again in more detail and in a way that is easier to understand.

We want to make clear that anybody who has limited income will not be asked to contribute financially unless they can reasonably afford to pay.

We really would like to hear your views. We understand that these are difficult times for people but the Council are looking at as many ways as possible to sustain services for the future.

There are a number of ways that you can make your views known:-

- Complete the questionnaire attached to this letter and/or contribute your own ideas and return to Adult and Community Services in the enclosed pre-paid envelope by **10th August 2016.**

- Attend our consultation event on the 19th July 2016 at 2.00pm at Cornerstones Community Centre Littlelands Bingley BD16 1AL

- Write direct to Adult and Community Services Contribution Consultation, 5th Floor Britannia House Bradford BD1 1HX

- Email cca.charges@bradford.gov.uk

- Use our website http://www.bradford.gov.uk/bmdc/Consultations/current_consultations

- Telephone us on 01274 437975 between 9am and 5pm

As your Council we are having to make some difficult decisions in the near future and we would value your thoughts in order to work together to provide the best possible service. All the information you provide is treated in the strictest confidence and will only be used to help us make these decisions. Your personal information will always remain confidential and will not be passed on to any other organisation.

Bernard Lanigan

Strategic Director
Adult and Community Services

Contributions Policy Questionnaire

Contributions

From 1st April 2015 the law about charging for care and support changed. The Care and Support (Charging and Assessment of Resources) Regulations 2014 is the new law for charging for adult care and support services. The aim is to make things easier to understand and that if you move to another part of the country you should not need a new financial assessment or care plan.

We would value your thoughts in order to work together to continue to provide the best possible service for the adults we support in Bradford.

Changing to a standard Contributions Policy

Currently your contribution is composed of four components:

- A basic charge
- A charge on the care component of Disability Living Allowance/ Attendance Allowance/ Personal Independence Payments and Severe Disability Premium
- A charge on income
- A charge on capital and savings

The standard alternative calculated as follows:

- The total income of the service user is determined (including capital and savings)
- From this the minimum income guarantee is deducted (this is the amount that the government says that you need for living costs and is based on basic income support/pension credit plus 25%).
- If you have any housing related costs and disability related costs these are also deducted.
- The money remaining is the amount used to calculate the

contribution.

The standard alternative would be simpler to administer and also easier for service users to understand.

Attached are examples to explain this.

Please indicate how strongly you agree or disagree with the following statements about the changes we are proposing.

Please tick one box for each statement

	Strongly agree	**Tend to agree**	**Neither agree nor disagree**	**Tend to disagree**	**Strongly disagree**
1) The Councils policy is different to the rest of the country do you think it should be changed and made the same?					
2) Do you think the standard policy is fair? If not please tell us why in the comments box					
3) Is the					

STANDARD ALTERNATIVE as described above easier for you to understand than the current policy?					

Charging for cost of service - Double ups

Currently in Bradford the cost of care visits which require two workers to be present at the same time are calculated and charged for one worker only.

We are proposing that the actual cost of two carers should be charged for and if a person can afford to pay for the full cost of that they should do so.

Attached are examples to explain this.

Please tick one box for each statement

	Strongly agree	**Tend to agree**	**Neither agree nor disagree**	**Tend to disagree**	**Strongly disagree**
4) The cost of two workers should be charged for those who can afford to meet the cost.					

Charging for care in Supported Living Service

If a service user is living in a Supported Living Accommodation, the support that they receive in that accommodation is not currently charged for. The proposal is that these services come under the Contributions Policy and are charged for.

Attached are examples to explain this.

Please tick one box for each statement

	Strongly agree	**Tend to agree**	**Neither agree nor disagree**	**Tend to disagree**	**Strongly disagree**
5) The support that service users receive in supported living accommodation should be charged for.					

5) Any other comments please write them in this box	**Comments**

Examples to help you understand the questionnaire

Changing to a Standard Contributions Policy

Example 1

Service user is under 25 and receives a service 10 hours home care of which 3 and a half hour are provided by two carers. Cost of service £113.43 per week.

Service User income per week

Employment Support Allowance £109.85

Disability Living Allowance – High Rate Care £82.30

Disability Living Allowance – Mobility £57.45

Total Income £249.60

Contribution under the current policy

Basic charge of £4.55 as income excluding DLA Mobility is over £137.31

Charge of £18.18 which is 33% of the middle rate DLA Care of £55.10

Assessed contribution £22.73

Contribution under the proposed policy

Income taken into account

Employment Support Allowance £109.85

Disability Living Allowance – Middle Rate Care £55.10

Total Income £164.95

Minimum Income guarantee £137.31

Assessed contribution £27.64

Less any Disability Related Costs

Disability related costs will be considered in the financial assessment where the expenditure is needed to support independent living and where a service user has little or no choice but to have the expense because of their disability/illness and that this is written in their care plan.

Less any Housing Related Costs

Mortgage payments/Rent – allow full amount less any Housing Benefit paid.

Council Tax - allow full amount less any Local Council Tax reduction applied.

Example 2

Service user is between 25 and pension age and receives a service 5 days day care.

Cost of service £175.00 per week.

Service User income per week

Employment Support Allowance £125.05

Severe Disability Premium £61.85

Disability Living Allowance – Middle Rate Care £55.10

Disability Living Allowance – Mobility £21.80

Total Income £263.80

Contribution under the current policy

Basic charge of £4.55 as income excluding DLA Mobility is over £156.31

Charge of £18.18 which is 33% of the middle rate DLA Care of £55.10

Charge of £20.41 which is 33% of the Severe Disability Premium of £61.85

Assessed contribution £43.14

Contribution under the proposed policy

Income taken into account

Employment Support Allowance £125.05

Severe Disability Premium £61.85

Disability Living Allowance – Middle Rate Care £55.10

Total Income £242.00

Minimum Income guarantee £156.31

Assessed contribution £85.69

Less any Disability Related Costs

Disability related costs will be considered in the financial assessment where the expenditure is needed to support independent living and where a service user has little or no choice but to have the expense because of their disability/illness and that this is written in their care plan.

Less any Housing Related Costs

Mortgage payments/Rent – allow full amount less any Housing Benefit paid.

Council Tax - allow full amount less any Local Council Tax reduction applied.

Example 3

Service user is pension age and receives a service 14 hours home care a week .

Cost of service £192.50 per week.

Service User income per week

State Pension £69.44

Pension Credit £86.16

Attendance Allowance – High Rate Care £82.30

Disability Living Allowance – Mobility £57.45

Total Income £295.35

Contribution under the current policy

Basic charge of £4.55 as income excluding DLA Mobility is over £194.50

Charge of £18.18 which is 33% of the middle rate DLA Care of £55.10

Assessed contribution £22.73

Contribution under the proposed policy

Income taken into account

State Pension £69.44

Pension Credit £86.16

Attendance Allowance – Middle Rate Care £55.10

Total Income £210.70

Minimum Income guarantee £194.50

Assessed contribution £16.20

Less any Disability Related Costs

Disability related costs will be considered in the financial assessment where the expenditure is needed to support independent living and where a service user has little or no choice but to have the expense because of their disability/illness and that this is written in their care plan.

Less any Housing Related Costs

Mortgage payments/Rent – allow full amount less any Housing Benefit paid.

Council Tax - allow full amount less any Local Council Tax reduction applied.

<u>Example 4</u>

Service user is pension age and receives a service 3.5 hours home care a week.

Cost of service £48.13 per week.

Service User income per week

State Pension £117.20

Pension Credit £11.12

Private Pension £27.28

Severe Disability Premium £61.85

Attendance Allowance – High Rate Care £82.30

Total Income £299.75

Contribution under the current policy

Basic charge of £4.55 as income excluding DLA Mobility is over £194.50

Charge of £18.18 which is 33% of the middle rate DLA Care of £55.10

Assessed contribution £43.14

Contribution under the proposed policy

Income taken into account

State Pension £117.20

Pension Credit £11.12

Private Pension £27.28

Severe Disability Premium £61.85

Attendance Allowance – Middle Rate Care £55.10

Total Income £272.55

Minimum Income guarantee £194.50

Assessed contribution £78.05

NB The policy never charges more than the cost of service so in this instance the assessed contribution would be £43.14

Less any Disability Related Costs

Disability related costs will be considered in the financial assessment where the expenditure is needed to support independent living and where a service user has little or no choice but to have the expense because of their disability/illness and that this is written in their care plan.

Less any Housing Related Costs

Mortgage payments/Rent – allow full amount less any Housing Benefit paid.

Council Tax - allow full amount less any Local Council Tax reduction applied.

Charging cost of service for double up

The following service user gets 16 hours home care of which 14.25 requires two carers.

The cost of the service is;

16 x £13.75 = £220.00
14.25 x £13.75 = £195.94

Total £415.94

The service user has chosen not to disclose their financial information and to pay the cost of the service.

Currently as we only charge for one carer the service user pays £220.00

Under the proposals to charge for two carers the service user would pay £415.94

The following service user gets 10.5 hours home care of all which requires two carers.

The cost of the service is;

10.5 x 2 x £13.75 = £288.76

The service user has been financially assessed as being able to contribute £22.73

Under the proposals to charge for two carers the service user would pay still only pay £22.73 as this is what they have been financially assessed as being able to contribute.

Charging for care and support in Supported Living Accomodation

In Bradford some people who live in Supported Accommodation and receive social care funded care and support are not charged for these services now. Other service users who live in their own home and receive social care funded care and support are charged for these services. To ensure everyone is treated the same the proposal is that these services come under the contributions policy and are therefore charged.

A service user living in supported accommodation receives 40.5 hours of care and support. Because they live in supported accommodation they do not make a contribution to this service.

A service user living at home receiving 1 day at day care and 6 hours care and support makes a contribution of £22.73.

Appendix 3

Department of Adult and Community Services

Shared Lives and Compass
5 Canon Pinnington Mews
Cottingley
Bingley
BD16 1AQ

Tel: (01274) 432211
Email: Nancy.plowes@bradford.gov.uk

Ref:

Date 11th April 2016

Dear

Proposal to increase the flat rate contribution for the Shared Lives Short breaks (respite) service

You will be aware that Council is faced with making some difficult decisions, which include looking at how much people contribute to the cost of the services they receive.

Shared Lives currently charges £8.97 for each 24 hour session of care and supported provided by Shared Lives carers. This rate has not increased for over 5 years.
This charge represents a contribution to the cost of the service and does not cover the whole cost.

We propose to bring the charges in line with those made for residential services such as Whiteoak or Copwood or the older people's residential services.

This would mean the charge for people who are of working age would increase to £11.49 per 24 hours or £34.49 for a stay from Friday night to Monday morning.
For people who are in receipt of older people's benefits the charge would increase to £18.67 per 24 hours or £56.01 for a stay from Friday night to Monday morning.

The charge someone would pay would be discussed on an individual basis .It is calculated according to the level of welfare benefits that people receive or savings /income they have. We want to make it clear that anyone on a very limited income will not be asked to contribute unless they can reasonably afford to pay.

This charge would be introduced from October 2016.

Shared Lives is registered with CQC

We would really like to hear your views on this proposal.

There are a number of ways you can make your views known:

- complete the questionnaire attached to this letter and / or add your comments and send back to me by Friday 6th May 2016
- write to me directly at Shared Lives 5 Canon Pinnington Mews Bingley BD16 1AQ
- email me at nancy.plowes@bradford.gov.uk
- come to a meeting on Friday May 6th 11.00 – 12.00 at City Hall Bradford in Committee Room 1.

Yours sincerely

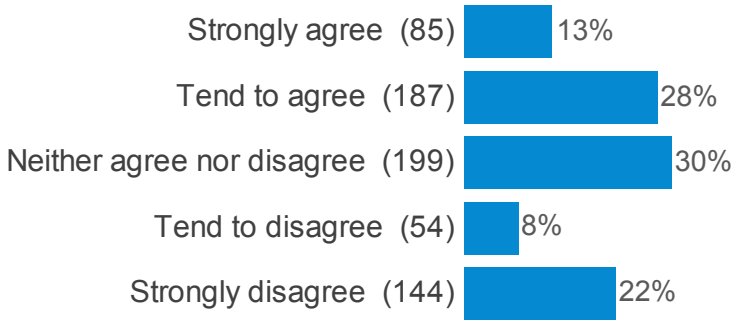
Nancy Plowes Team Manager – Shared Lives / Time Out

Appendix 4a - Results from the first questionnaire

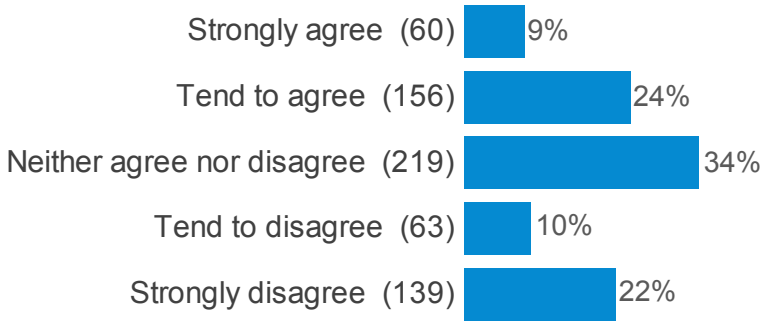
This report was generated on 19 August 2016. Overall 723 respondents completed this questionnaire.

The following charts are restricted to the top 1200 codes.

The Council's policy is different to the rest of the country do you think it should be changed and brought into line with the rest of the country? ()



Is the standard alternative as described above easier for you to understand than the current policy?
()



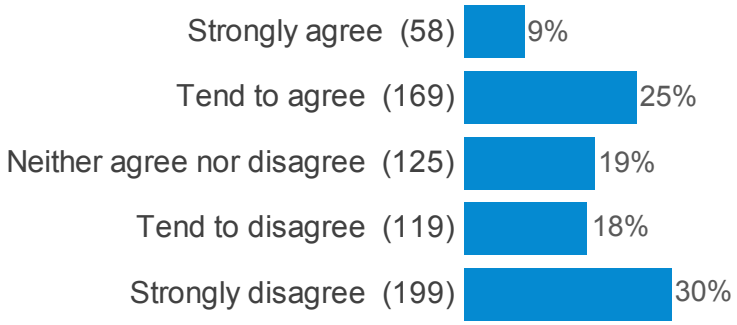
Charging for cost of service - Double ups

Currently in Bradford the cost of care visits which require two workers to be present at the same time are calculated and charged for one worker only.

We are proposing that the actual cost of two carers should be charged for and if a person can afford to pay for the full cost of that they should do so.

Please tick one box for each statement

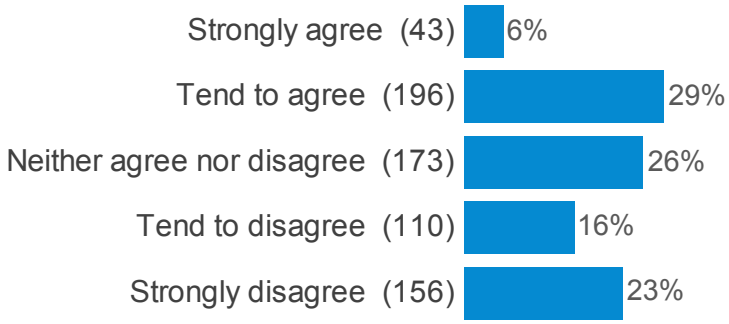
(The cost of two workers should be charged for those who can afford to meet the cost.)



Charging for care in Supported Living Service

If a service user is living in a Supported Living Accommodation, the support that they receive in that accommodation is not currently charged for. The proposal is that these services come under the Contributions Policy and are charged for.

Please tick one box for each statement
(The support that service users receive in supported living accommodation should be charged for.)



Appendix 4b Comments from the first questionnaire

I have worked all my life i think i have paid mt contributions I now feel we shgould be respected enough to be thought of as an individual not a price tag.
The way bradford has worked over the year's seems to have been ok. If its not broken dont change it. Cut form the top not the bottom.
I agree in theroy that people who can afford to pay could contribute towards care needs but i am talking about wealthy poeple. My reluctance to agree here is with talk of what the goverment decidesis the amount ndded to live on in recent years. The Goverment has proven that they do not think disabled people should have more then the bare minimum to survive which has lead to stress, depression anxiety and turmoil for many people. I am worried that those who can afford to pay will deemed as most people on benefits. Disabled people are already dealing with untold challenges to their health: mentally and physically. Worrying about finances and not being able to afford periods of respite and fun will make it worse.There will be terrible strain on the NHS as people spital. I am devasted that more financial stress is likley for already vulverable and overburdened people. My responses depend very much on the farness of judgement about what level of finances p!eople need to live.
'Completed by step-daughter & carer'
Q3) 'Already charged for 2 carers having being in the Direct Payments scheme'
Q1 - Not if there are extra cost implications Q2 – X does not partuclarly understand current or alternative policy Q3 - This does not apply, however it would need to be affordable Q4 - X already contributes to access Specialist Autism Services. If he were to move into supported accomodation, which is likely in the future, he would struggle to afford further charges.
Whats the point, if you can disrupt someone's life style, when they have enough to cope with through no fault of their own, it looks like you will do it, the fact that money has been wasted by making a duck pond in Town Hall Square and other stupid things seems to get the ok from the council it doesn't seem to matter that some people have worked all their lifes, paid taxes and never claimed a penny that you think fit to punish them in their hour of need.
I go to Norman Lodge Care Home Monday Friday for Day I look forward to going and whe i go for a wed all the carers are good rooms nice
My understanding of Supported Living service is that an amount is levied to the tenant/resident which Housing Benefit does not pay so this is happening already anyway.
Your letter mentions changes to a Standard Contributions policy, but it gives no information about what this would actually mean. Nor is the difference between the current policy and the proposed new policy explained clearly. As such, I am unable to make a properly informed decision, or give a properly informed response to your survey.
I fail to see how the single component is easier to understand!
I have a rare bone disease & have had breast cancer I keep going for check ups at Airedale General Hospital. I think I have bowel cancer now I get stabbings pains in my stomach and a lot of diorhera. A few months ago I nearly fell over in the shower I went blind, I have cataeachs in my eyes. When I had cancer there was a bit of a scare saying we had to pay for cancer tablets I an on he NHS I would have died I was on home for 15 years.
Q3 - However two carers need to be providing a service! Unsure when council is paying costs of care exactly how it is monitored! for example we had carers who would frequently miss calls, but we had no idea if the Council was still being charged. At no time during the 3yr period care (I use the term loosely) was being provided did any body from the Council check to see if we were happy with the service being provided. It's not very clear who to speak with a query regarding this. On a coupd of occassions tried to speak to somebody but just kept bein gtold it wasn't that dept & told somebody else. Just went round in circles & gave up in end.
I have looked after my husband since 2000 (Jan) when he had a major stroke, he now has Parkinson as well, I have saved the Government thousands of Pounds, and Social Services told me that Carers have come in now for the last 2 years only to transfer him into his chair, most of the time he stays in bed, the carers are only here 5 min to readjust him in Bed, if we

have to pay for 2 carers that will be over £6.00 for 5 min that works out at over £1.00 a min, 60 min in an hour, that works out at £60.00 an hour, thats outrageous. I know we are charged at 15 min slots, but that's not the point I do everything for X he can't do anything for himself. I will have to cut down on the number of calls we have. I don't think David Cameron would agree to a charge of £60.00 an hour.
Q1 - That depends, each individual has different needs this letter doesn't really explain what changes are really going to be made and at what cost. Q2 - No - its words on a page. For me to understand this new policy I need figures i.e. give me an example X has a total income of . . . and show me a case study of what the figures could be. This is the only way I can see fully the extent of this policy. Q3 - This depends again if an individual has been assessed on their medical condition to have 2 workers to support them why should they be penalised for this? It is for their safety in order to live a full life without any problems. However if an individual chooses to have that extra worker for support but haven't been assessed for the need of this it would be more understandable. Q4 - I personally haven't had to deal with Supported Living so I am unsure of the requirements now. My concern for paying towards this is t!hat my daughter will not be left with much if not any money to live comfortably.
Q1 - I do not know what other Councils do. Q3 - Residents in care homes have to pay if can afford it. My son's rent for this Supported Living Accommodation is high & I assumed that part of that rent was for care. There are 3 of them living in the Accommodation, each with different needs & different amounts of care. If these services are charged for I assume that the cost would be covered by Direct Payments or Individual Budgets just making for a complicated system - more invoices, more receipts more accountancy - often done by busy family members. I just can't cope with any more complications.
Are people with profound & multiple disabilities going to be paying more than people with moderate disabilities? This would not be fair. People with profound disabilities have higher living costs in any case - altering of clothes, bespoke clothing, heating, transport etc. (The severe disability premium does not cover all these costs).
Do not get Bo?ie care, we do not have much care do everything ourself i.e. shower with a little help from X get dressed by myself.
In terms of those in 'supported accommodation' there should be a level playing field. Your document makes the financial impact of this change far from clear. In particular it is not at all clear what will be considered 'disability related expenses' and what will not. This gives the impression that people will be bullied and somebody will be telling them how to manage the income that should help them with their disability and give them control. This does not sound simple at all. As it stands the cost of care is prohibitive and means that my social life has come to a near full stop. Maladministration by Bradford council means I am paying for two years charges at once - while the council did apologise only after vigorous and forceful complaint they are being quite 'Shylockian: about the impact of their failures. I must make a decision whether to continue care and have no social life whatsoever, or discontinue it at risk to me and others !but have some quality of life. I simply do not trust the council with such a woolly proposals to be at all fair. The disability payments should be for that purpose, not a revenue stream for the council. The receipt of care has had minimal impact on the cost of my disability and removed a very large part of my income as it stands. This appears to be an attempt to raise greater income rather than one to be fairer. The word 'fairness' is not even mentioned in your document. Disability payments are supposed to help with the costs of being disability, not be a revenue stream for the council. Care by no means removes all of the costs of being ill, only the care component of DLA should be considered and then at most half of it. The mobility component and the Severe disability premium should be left alone.
Whilst I appreciate that the current financial climate is challenging I do not believe that the full cost of two carers should be imposed as a blanket policy. It is regrettable that a person who has worked hard and exercised financial prudence should sacrifice all that they have worked for. It is however right and proper that increases in the cost of home care services are increased but imposing an immediate 100% rise is perhaps a step too far. I am of the view that this could be somewhat short sighted in that th erapid depletion of a n individuals' savings to the current disregard level only takes a couple of years then the benefit to BMC is short lived.

My partner has Parkinson's Disease and whilst his care needs may increase his life expectancy may be a couple of decades away. No one dies of Parkinson's Disease but the deterioration of mobility may create a range of other health isses. I suspect that there is a willingness of service users to re!cognise the need to increase care costs. However, a year on year increase would make sense. The level of the savings disregard when calculating client contributions has remained static for a number of years. Perhaps there is some merit in re-visiting this element of the system. At present my partner pays for 7 hours social care each week, but two carers are required to mobilise him. He currently pays £96.25 pw. For the same service and hours this would rise to £192.50 pw. His savings above the £23,250 threshold would be spent on social care in less than two years but his life expectancy is likely to be 15-20 years. I am the main carer which occupies me for about 17/18 hours each day. I am in my seventies but as long as I draw breath I will care for this very special person. I probably save BMC a few pounds and I am not alone. There are thousands of us who physically and emotionally still face the daily/yearly chal!lenges with a smile and ask for nothing in return. Seeing our loved oneshappy is payment enough.
Suggestions: *Revisit the Disregard Threshold which has remained the same for years * Introduce an annual incremental scale of social care costs * Identify the users who are able to pay outright for two carers by stipulating a savings benchmark which triggers the full cost to the service user. * Esablish a common hourly rate charged by service providers *The many departments dealing with Adult Services is frustrating and for me some bewilderment. Not knowing who does what if there are any queries or concerns. The staff, to their credit, is very helpful but it woudl be much easier if there were teams dedicated to geographical areas. At least there is some chance of speaking to recognisable voice. * Clarity of who to speak to about care being provided and/or the financial elements of the Adult Services. A system that includes annual reviews of client needs. * Acknowledge the financial value informal carers provide wit!h their time and energy for free, without whom the present financial crisis would be much greater. This is a priceless resource often taken for granted. * A more holistic approach to social care provision and greater clarity. It is pleasing to know that there will be some consideration to the financial costs linked to the health and well-being of the social care users apart from the cost of home care, i.e. extra heating/lighting, care products i.e. wipes, bed mats, purchasing additional continence products, suitable clothing, daily laundry (increased water bills), social trips to reduce isolation, respite care costs, more frequent need to purchase bedding, living costs (board, rent, dietary needs etc.) May common sense prevail especially for those service users who have worked hard during their working life and prudent with their hard earned money. They are the ones who are subsidising those once fit for workindividuals who have contributed very little to the system and get all their needs met anyway. I wish BMC good wishes in their endeavour to sort this out in a realistic and fair manner. Creative thinking sometimes seems elusive but is well worth the effort much of the time.
My son has a severe learning need this information he wouldn't be able to read. Where is the Inclusion? for people like him. I suggest this form should be differential for people like my son. At the moment I have to employ a care company to care for my son whilst I go to work and also pay service charges. So I can continue in employment any further care costs and changes surly would put family's and carer's like myself out of work and stop our disabled children from enjoying they already difficult life.
I am employed by Bradford Council myself, children's specialist services at Sir Henry Mitchell House. If I was to pay for a second carer, I would be using all my wage to pay for an additional carer & as I only work part time, it would not be worth my while working. To me it is discriminating against disabled people who have complex health needs & require the support of 2 carers to carry out basic personal care needs. The money I receive only just pays enough to cover care & mobility needs & having to pay for an extra carer through no fault of my own, would leave me having to cancel services & rely on the support of my mum to carry out my basic needs as a human being. The care act 2014 does not really relate totally to financial assessments, it is about promoting the rights & choices of an individual to be entitled to receive care in a way which suits the individual so they can live their lives in a dignified manner. I think you sho!uld look at alternative way before disabling peole further.

Personal security, physical health concerns - eg lifting and many possible other issues mean that two workers are needed for the worker's wellbeing.
The cost of care that my mother is charged is probably the maximum she can afford as she only has her pension, if they increase it, and she also has double up care, she would be in dire straits, hopefully the new system will not let that happen.
Q1 - Do not knwo what the policy is so cannot comment Q3 - Depends on who makes the decision Disabled only have a limited income with no opportunity to increase it yet still need to pay the same bills as everyone else which increase every year, and pay for extras that they need because of their disabilities eg taxis, specialist clothing, footwear etc Just realised benefits will remain the same as 2015 up to March 2020 with inflation alone that means a cut every year for 4 years.
Q2 - What is the current policy? Are we better off Very difficult to answer as the answers are subjective: No information about costs involved so we can't make an informed decision.
I don't know anything about Supported Living Packages & so cannot comment. My daughter lives at home with me & receives my support free of charge.
Do not get enothe? of care. I do everything myself and wife so why do I have to pay charges
As a service user approaching ninety years of age I welcome a change that makes any policy easier to understand.
As a carer for my mother the help I receive from the other carers (10 min visits) is most welcome & I am very grateful. She already pays for the phone to be fitted & the alarm & pendant etc. She has very little in savings so could not afford anything else. She has Vascular Dementia with Alzeimers. Your questions can be misconstrued.
Mr X circumstances have not changed. He is an 87 year old man and finds receiving these forms very stressful. His eyesight is deteriorating as well as his general well being. I am a friend who visits him and have filled this form in on his behalf with his permission.
Q3 - As sometime there will be one & sometime two & office will not adjustice account. This office will not always adjust my account if I should at times need one or two people - where I usually have only one.
Q3 - It depends what this is based on. People should be allowed some savings. Q4 - If this means they really have support. These are difficult questions as you know or you wouldn't be sending a questionairre. Sometimes there has to be room for individuality. Some people have help from family others are truely alone. People needing care should be allowed a margin of savings which is not affected as otherwise its like punishing people for being careful with their money. The bedroom tax shoudl not be deducted from those needing care. It is a totally unfair tax to many who are paying for a box room.
Q3 - My daughter does not use the above service but I strongly disagree a disabled person is being punished by this government & have had enough taken from them. My daughter does not receive Supported Living Service but I disagree that you are to charge people who can least afford it. In reply to the letter & form I received this morning. I have filled it in where appropriate for my daughter. She attend a day centre 5 days a week - my husband takes her in the care & picks her up - my daughter does not use the transport service I filled in a detailed financial form last year on my daughter outgoings. She has limited income and cannot afford to apay any-more. I do understand the council are having a hard time but so are disabled people. This government seems hell bent on distroying the welfare state. My husband & self worked hard all our lives as well as care for X - she uses no other respite.
The respite home that was near me before it closed my partner who lived with me went in for a week's respite and this is how it worked out my partner did not declare his earning (do you think thats unfair I am sure you do I don't suppose you would like becuase he did not declare it he had to pay full £436.45p for a week the next payment down was £300 depending on your money if you only had your pension you paid £100, what made me mad most of the old dears moved the money out the bank, I know this becuase the ladies who worked there told us what was happening and told us to do the same I dont think you should charge somebody full becauseits quite expensive to look after somebody who is ill I know I looked after my daughter for years had M.S. I was 69 when she went into hospital I didnt get a penny for looking after her so the Government must have made thousands out of me. I hope you read all this.

Service user charge & cuts to some services have already driven most of us in hardship. Please don't dig in deeper from vulnerable people.
1. Service user charges 2. Cuts to some services and support have already driven us in hardship please don't dig deeper into vulnerable people.
1) Don't understand proposal letter - badly written 2) Not fair to charge for 2 carers 3) Not enough examples of charges 4) Not enough help for learning difficulties - why only help physical why? Are you including travel as need, without help cant go out - big need 6) Why pay more in supported living? Not right 50% more and more again! Straing for social workers needed
It is difficult enough to afford to pay the contributions never mind paying for additionals. My sister lives in my house and I care for her full time. This is not an easy job. I do not apply for any additional income from the government. Therefore we do not wish to make further contributions. I need to question how is the contribution my sister is paying currently worked out?
Nothing has been mentioned about other costs that are incurred - eg someone pays a contribution for support services for someone to take them out into the local community but then the client also has to pay for the costs of the person supporting them while out such as travel, food, entrance fees (cinema) etc etc . . . Also how will living costs be calculated for someone living with relatives/parents - food and bills needs paying for.
Only just started this service, so do not know a lot about it yet.
It should be an easy & stress free process to allow the service users to be more independent Im all for bringing them up to standards but thats all
This form is not very clear. He already pays money for going 3 days a week to go to Springfield.
I dont agree that people who can afford it should pay more. This is because its seems that the more people have worked all their lives, contributed to the country financially with taax & NI etc and have worked hard to save up to help their families get penalised. They get little back so where is the incentive. The less you do in life means you get to continue to reap more benefits for free. Its time to give something back to the workers.
Not sure what to put only that if the charge increases it will add financial difficulties. As he is almost 92 years old apart from living expenses re food, heating, insurance, etc He needs new bedding clothes etc due to them being messed up, he has diabetes so special food. I am trying to keep him out of an old persons home. But increase will add to the emotional anxiety he causes due to his dementia, it is taking a toll on me, but I am trying my best.
People who have means to pay should pay. People without means should receive a free service.
Qs 1&2 - As it is explained on page 1, the new option may be easier to work out, but for anyone elderly, and also for anyone not so old, any calculations sent to them will be difficult to understand. Q3 A lot depends on who makes the decision as to how many are needed. In the case where it might be useful on a rare occasion and the care company decides to double up as a precaution it would be rather unfair to penalise the service user. For instance it has been known for an older carer to come in and do all the work while the younger one spends all the time inher car on the phone.
X lives with me she is badly disabled Im her main carer appointee I take her every where sir she lives me the house own get no help X doesn't live in Supported Housing she lives me Im her carer main appointee get no help just get crossroads care shipley who take X out just tuesdays 2 hours thats all sir we own house sir now - - is real - - - - - and X - has X - - - - - - - claiminghe owned my home when Im the sole owner will look into it sir talk to no one all my family are dead I sole owner lived - since 1963 in same house just me daughter
I am quite happy with my carers
Agree as long as everyone is means tested
waste millions one shop centre then try to take it from the vulnerable. Thats not right!!
I already pay about £100 a month from X money, if this goe's up too much more I will not be able to manage has I am also a pensioner

The people who can afford these services should have to pay so that more is available for those who can't afford to pay
Sir, without any specific figures to work on, it is impossible to comment on any of this. In our case (X) I cannot say one way or the other, since no figures are quoted. Without them, I suggest that the consultation is merely a sop to the users of the service. I suspect that, whatever the outcome, costs will increase to the users. What exactly does 'Portability of care' mean? P.S. Please try and use correct English!
I set a direct debit but now in arrears due to a mistake on your behalf.
The elderly & disabled are penalised and charged for services that should be part of their entitlement. They've paid their taxes and at their time of need are bled dry of the small amount of income they receive along with gas & electric. As his carer I receive peanuts £62.10 a week yet I care 24/7 for him, why does that get reflected upon? Two workers that attend although paid at 7 receive more than I do who attends to his every need. The system is unfair, unjust & many flaws.
I pay my mum rent on a monthly basis, I live at home. How does this affect me please let me know.
I have answered to the best of my ability, but the way these charges are worked out is not explained clearly. For those in Supported Living Accommodation, if the support they receive is not currently charged for, one wonders how it is financed at the moment, & if it is charged for will there be a reduction in the cost of the accommodation.
In the current economic climate and with the cost cutting that the current government proposes it seems that the people requiring aid are being victimised costwise.
Q2 - Not based on the information supplied no mention of the elements which are taken into account in total (only discovered by a phone call) I think it is extremely difficult to make a decision without a real example of what this means. No doubt a higher cost! If my father-in-law had received this letter he would have had no idea what to fill in (1t 93 years of age!) Can I also say I have just received my council tax bill which - surprise! surprise! has had the 2% - the government says councils may add for support services, added in. - What exactly is that to be used for - if your new system is to raise more money from users. I would not want my father-in-law to be any worse off than he is now.
If people can pay for there own care I think they can pay to have people look after there own care if like my dad worked all is life for a low wage and doe's not have a lot of safings and could pay a - of - towards is care.
a) Form didn't arrive til the 24th March, rather late considering your time span (29th Feb - 20th May) b) My mother can't fill it in due to having had a stroke last May (reading & writing affected) and having dementia. c) My mother is in an Anchor Trust flat with a care package:- quite extensive. My concern is that with a rise in care payments plus her rent, electricity and a few basic needs her money will soon run out and then she will no longer be able to pay th erent. Where does she go then? d) My sister (X) and I have Power of Attorney just in case you wondered who was filling in this form.
Lots of people will miss out on going out if they hav eto pay for 2 carers. My son needs 3 to 1 when going to theatre. Hense why he doesn't go much. But still needs 2 to 2 when outside as he has no sence of danger and will just run off.
The support payment should be subsidised highly as this is saving the governement thousands in care charges. I want to stay in my home for as long as possible with the help of my family I am doing this. If costs go up then this will not be the case.
You do not stipulate what the difference is between the councils policy and the rest of the country so how can you say it should be brought in line.
Question 3- Either send 1 worker tape recorder as required or send 2 workers at double the intervals keep the same cost. Question 4- If there is no increase in governement payment to user, how can charges be increased. Increase your charges in line with any changes to the benefits paid to service user. Service user can only pay out to care services deprnding on her benefits paid to her by the government.
My reason for strongly disagreeing is my son is not getting the care that he needs when out on the minibus twice weekly. He is also prone in getting upset stomach at any time and he is not

allowed to take any spare clothes in case of emergency, with this disallowment of spare clothes it brings concerns of poor hygiene for my son. When asked why I was informed that it was due to no space on the bus for a bag and the lack of resources (Listerhills)
1. It is hoped that a national charging strategy will be fair to all parties. 3. Double up charges: Those who are seriously disabled will be quite heavily penalised if two carers are charged for. Every transfer requires a double up, that could be in excess of 12 transfers per day. Would that be taken into account? 4. Supported Living Charge: We already pay high service charges and rent. Much as the service os appreciated, savings of the residents will decrease and housing benefit might be required sooner. What percentage of the total would be charged for support? In general: I have been disabled from birth and with time my condition has deteriorated yet I worked in a professional capacity for 20 years: now I have never paid so much for my housing or care (£1700 a month). Please make the charges clear to each individual.
He soesn't really understand the implications.
My wife lives in a wold of darness and unabble to move so lets punish the disable. She does not want to be like this and she says she can save you money. Let here die she want to end here life.
Q1 - Not familiar with policy for rest of country. Quite content with the way things work at the present time.
Financially people with learning difficulties are abused. Money is required for everything now and this is difficult to understand for someone with a learning disability and is not how it should be in a perfect society.
If you have lived and worked here all your live and over 80 yrs you should not after pay.
My mother is 94 years old and lives in extra care sheltered housing. She receives the assistance of 1 carer morning and evening for personal care and does already pay a substantial amount for this service. Considering the substantial increase in rent she is already paying I worry that she will not be able to afford to continue living there is the care cost also increases. She is in receipt of all benefits and has no savings or surplus money.
If people need two carers they should pay extra if they can but people shouldn't have to pay for two carers if one is sufficient.
People on low income should not have to pay for the cost of support service their get from the Government specially if their are receiving amount of money once a fortnight from the government as for my self specially under a send amount of money their is not right.
I agree that if only one carer is needed - only one should be paid for. It is not necessary to constantly target those who cannot pay. Carers need to have a person with them in case of emergency so it may be necessary to have 2 attending. From experience I know that some carers only stay 15 mins when they record that they have stayed 30 mins. Honesty is the best policy! I do my caring for free.
I think the Governement has a nearve to rejuice allowances for disable people
Why is it that when cuts, or increased costs, are to be imposed it is always the handicapped who are picked upon. People who have contributed, or certainly their parents have, to the tax, both national and local, for several years; in our case over 50 years!! Also, pardon if we suspect, that this letter, is merely a 'sop' to us to try to make us believe our opinions account when the decision what is to happen has already been made! Years and years of experience of decisions of this nature are in mind. In addition we now find, as was suspected when ILF monies was transferred from government to local authority control that this would be reduced if local authority could do so, despite what we are lead to believe this money is still government funded. Now I would be surpised if you have even read this!!
I have to pay for everything, so why should not they. I payed taxes etc: for 39 years.
I strongly disagree because I feel it is ok for living accomodation to be charged for by the supported living service that give's support.
We contribute to my mothers care we could not afford to pay! I have just paid a £455.00 gas and electric bill and their is other bills to pay so the f*** wit who sent this letter to people who are 'Stressed' and f****d off should spend 1 week doing this f*****g job they would skip home! F******g moron

I am unable to answer any of the above questions. As I do not have the amount of money will is already payed by other Authorities for support care if you sent me the rate they are paying I would have a comparison to work with. If you can do this then I will answer the above questions.
Not neccessary to 'mend what isnt broken'
This letter has told me nothing. Should be made clearer. More information is required. 3 month consultation, but one month as already gone, should have recived this letter earlier.
Thought if you could afford to pay you already did. Dont understand the different policies in Q1
To cgharge additional monies to those souls who receive two carers at certain times of the day is to punish the most vulnerable in society. People who receive double ups receive them for good reason and not because it is a 'nice to have'. The council needs to appreciate that those of us who are receiving double ups are so physically impaired that without the double ups we would be denied any sort of everyday living and in many cases, like my own, would be presented with additional health issues. If a double up task were to be undetaken by a single carer then this would present many physical and health-related dangers. Therefore, we do not get a choice! If we are to be assisted safely to have any sort of everyday living a double up must be remain a double up. If this is accepted by the council that double ups are essential, then it is illogical to charge for the cost of the double up, any more than charge people with single calls half of what t!heir call costs. In the end, if the service users, are to pay a larger contribution, this should be shared out amongst all service users and not just a selection of those of us who are the most vulnerable.
If some people can pay then maybe they shoudl pay for thier care or part of it.
Q1 - cant have a decision as youhave not given both sides of argument to compare. Q2 - You have not explained either policy to my satisfaction dont understand either. Q3 - How do you decide who can afford this? Q4 - You have not explained and told ushow you decide this.
Very upset at this form and proposed changes. 1 - You ave not given a breakdown of both systems so we cant make a educated decision 2 - You have not said how you intend to judge whatever a person can afford to pay or not very disturbing - not enough info
I only recieve a direct payment electronically once a moth from you for which yu charge me 149.00!! No one visits me, I employ my own staff, saving you time money and hassle, your system stinks!!! PS. SACK YOUR SENIOR MANAGERSWHO ONLY SEEM TO BE IN MEETINGS OR ON COURSES AND SAVE SOME MONEY.
Q3 - Clients should not be 'punished' as a result of their disability / poor health. This is a health & safety issue for both client & carer. The temptation would be to try & cut costs and 'make-do' with just one carer. Clients should not be 'punished' as a result of their disability / poor health. The health and safety of both client and carer must be the prime consideration in determining policies / charges. These are vulnerable people whose choices in life are considerably restricted. Thus it would seem unfair to expect them to pay for 2 carers if thier needs require 2 carers. Policies should reflect the needs of the community the Council serves. Just because other parts of the country have different policies shouldn't mean they are necessarily best for theresidents of Bradford.
Fairer to keep as it is and find money to improve the service from other areas of council spend that doesn't affect the care provided.
I only have my money to pay for enything like my morgage and daily bills monthly bills so I could afford to pay for it.
It is hard enough being born with cerebral palsy, quadriplegic and registered blind, spending all my life wheelchair bound without the extra worry of Bradford Council trying to take extra money from my meagre allowance. The government is now having a rethink about reducing P.I.P.S for the disabled. Even Robin Hood helped the needy
I don't have much to live of I get income support and my mother cant take me enywhere as she is poorly so she cant take me as I cant afford to go I would have to stop all my care as I cant afford to pay for my care as my mother pays when she can.
The charge for this service is too much for many people. It would be helpful if more help was provided with the financial side of things. This service is essential for the users its something they need help with

Whatever te outcomeings of this survey reveal, the council will just do what they want to. It is all wrong to charge disabled people anything off what they are given to help them live a almost normal life, a lot of them who are born with disabilities did not as to be born this way, and nothing should be done to make there lifes mor miseable
Dont understand the questionnaire
What happens to the disabled adults who have no savings or cant pay
I pay for the commode emptying every day and I dont get any more help as I can manage to do everything else (so far) as i have everything to hand, but i cant climb the stairs yet as I have broke my ankle falling down the stairs. I am 85 years of age so I hope I have answered your questions. I live in a cottage and have my bed downstairs for now
I have just started with needing help so I don't really understand every thing yet.
I think if people work hard and pay into the system they should get it free just like everone else.
We strongly disagree with this, we receive just enough with Benefits to live a normal life, if this is to go ahead then benefits should increase.
Two workers calling is not the fault of the patient.
It's too complicated for some elderly people to understand, especially those with dementia problems.
Surely the cost of Rent etc in Supported Living accommodation already includes an element towards the cost of support? Your new proposal seems to imply you will be charging twice! Not fair!
I am struggling to understand what the propsals mean for me. Will the proposals mean that I will not be able to provide some financial support for my full time carer? I see the proposals as an attack on the poorest and most vulnerable members of our society.
Again the council is penalising the adult care and support groups. These are adults that are vulnerable and in many cases unable to earn money to pay for care, homes etc.
This is too complicated to understand. How do you expect people to understand complicated words, how can ordinary people understand what you say. No it isn't easier to understand the alternative rather than the current policy, the language is only what you people who work in this industry will understand. Your words and intentions-family and carers just suffer. All costs and charges are unfair and processes are beurecratic. You make money, we lose out. People clearly have needs which need addressing properly, how will they pay?
The only reason I have 2 carers is because of the health and safety regulations when using the hoist. The carers are here for 10 minutes am and pm. I pay for 15 minutes each visit. To pay for 2 carers each visit would obviously double the financial burden on myself.
I accept that local authorities have been placed in a very difficult position and that the Council has a huge task in financing care packages- so 'Savings' are necessary. Any change should ensure that those with the greatest needs are not disproportionately faced with additional costs. It is difficult to assess what the impact of any changes to the Contributions Policy night be in specific cases. A few examples would enhance my understanding of what the change in practice will mean, as distinct from changes in policy, which I accept have a face validity. Best of luck! Thank you for inviting our participation.
X has dementia, and will not understand this questionnaire or be able to respond to it. It has been completed by her husband / registered carer X, who holds LPA (Finance and Property)
Many feel there is no support only from families or the care we pay for, the care is rushed and not carried out correctly. Old people can not move quickly or be rushed in morning's due to severe illness. Aslo community spirit has been stopped and there's nothing going on for residents through the week anymore, due to outside people using day centre why can't we be included if we would like to join in willing to pay for it. I've heard there are many volunteers willing to come in and do things with residents. There are a lot of lonley residents here and becoming depressed. Only asking for 1 or 2 days a week something going on or every fortnight. many thanks Would like to add not many carers about when needed always seem to be smoking round the back of building, food on premises not good need new cook.
Q1 - wha'eva Q2 - you will always do as you wish Q3 - as above, I have few years left Eventually, I will haunt you whatever you do! The choice is eventually yours!!

These proposals are fine if the carers bother to turn up. In my experience they don't always turn up, so who does that workk when paying for 2 people?
There is nothing wrong with service and charge at moment
Regarding paying for 2 carers:- I feel this is very unfair - the person needing care can't help their situation & many people would try to manage with only one! - The present system of charging is extremely unfair to those who have saved to provide for any eventualities & while I have no objection to a charge, I'm sure that those with many benefits should also be charged. I think some charge for everyone would be welcomed by the majority!
Q1 - Don't understand what Bradford Council assessment and how different this from standard more or less? Q 3 - Only require one person for personal care. Showering, hairwashing etc.
Q2 - Providing a financial example i.e. figures would have helped
The current system is very confusing and not clear at all! I welcome the standard contributions policy that is used by the majority of local Authorities in England. I strongly agree the standard contributions policy will be more fairer and clearer to the service users and I want the council to adopt this.
Q1 - not understood what is the difference to the rest of the county - no explanation
Q2 - My son cannot understand this so is unable to give an opinion Q4 - This needs more information My son is not able to answer these questions, he can read but does not understand this kind of question I would like to add that I am my sons carer & receive no allowance for this so he should not have to pay hope this answers your question
sometimes for safetys sake two people are needed and often unforseen things arise
The fact that charging for any help after paying NI for years is very disagreeable.
The answer to question 4 is only relevant to people iving in supported accomodation. Again if people can afford it ONLY then they should be charged
- Service users should not pay contribution - Users cannot afford the services but are in need of them. - People who are able to pay for them and can afford to should pay - if they want to make contributions they can do. - People should not be forced or feel threatened to pay for services!
I have no money to pay for things anyway, my husband has it all, for what ive got, not much, I'm O.A.P. If you take me off my injection & discharge me from hospital properly, you wont have to worry about me then will you.
what this document needed was 'worked examples' to help users, or their carers/relatives, to be sure they fully understood the questions and implications of their answers. Thers a degree of ambiguity about some of the information.
I believe everyone should pay something but it should be a standard charge for everyone.
what does the word 'portability' mean please? These odd expressions lead to much confusion.
I am not to my knowledge. in receipt of any services currently from Bradford MDC, ither than a weekly visit from the district Nursing Service, which I understand to be part of NHS. Please clarify my situation as soon as possible, as this is causing much distress.
I left school at 14, started to work 1 week later as apprenticed butcher. In total I worked 46 years including 2 years compulsory army service I only had 1 week without work in all that time, I worked hard saved a little joined a pension scheme when I was 24 was told in was a non-taxable scheme but I've had to pay taz on it since retirement. I think it pays to be the opposite from me don't bother about work, draw any benefits possible, gamble, drink, smoke, and let the country keep me. As a country we can borrow from the moneytory funds to give it away to soon as foreign aid ect but not to our hospitals, national health or council ect.
The money that they get charged is enough without putting the charges up when will it end that the people that need it most get more and more taken off them. Would cost the government more if they went into care
I disagree with the concept of using a persons income to calculate the contribution towards care cost. This appears to be an extra tax on the income of disabled people which is unfair.
I have worked all my life, I think I have paid my contributions, I now feel we should be respected enough to be thought of as an individual not a price tag.
Question 3- Only if they can really afford it and if necessary. The careworkers themselves take decision I needed 2 care workers but I manage all day without any help. With 2 care workers

half the time one is in another room making bed, emptying commode etc. I don't think that I need 2 workers but it was decided without consulting me.
Services are being cut as a result of political cutbacks.
Having read and re-read this letter I am finding it impossible to make a decision on which is the best method as you have not provided me any information as to how a new system would impact my finances. I have called your office and made my views known and feel let down by the Council's ineptness to clarify these proposed changes. X 29/3/2016
All answers are middle of the road as I found the questions hard to understand.
question 3- Tend to agree unless this is going to mean more paper work etc e.g if 2 workers are not working for the same period of time. question 4- Tend to agree, as long as they can afford it. At the moment the system by which my daughter is funded couldn't be much easier. Every month 3 cheques (2 DLA & 1 mobility) are paid into my bank account and a direct debit goes to the Coincil. If there is an easier way for it to be done, I agree it should be used, but I'm not in favour of changing things that work well.
I don't quite understand what is required according to your letter the act has been in force since 1 April 2015-almost 12 monrgs ago! There is then mention of a new act-when will this come into force? Why am I being asked to comment on something that has been in force since April last year.
We feel that our contribution level is currently too high, so would welcome any reduction.
question 1- Don't know what other councils do I don't feel there is enough information to agree or disagree to the new proposal. Also when there are cuts to be made it's always social care.
question 3-depends on whether they would end up worse off than someone who only needs one worker. It would be easier to choose an answer if some worked examples were shown for each question i.e given different scenarios where a person is in receipt of the full rate of all available benefits and another person only receives a proportion of the highest rates.
question 4- this is not very clear as the type of support which may be charged for is not specified (I would have assumed that the charges for supported living accomodation would already take any extra support into account. If this is not the case, it would be useful to know what types of support are not included).
Disabled people pay a lot of money as it is.
It is upto the care provider to set the charges for episodes of care, we expect the Adult & Community Services Team to negotiate the best quality and cost effective care on our behalf.
I think for most users it is the cost of the 'Care Package'which is the main issue. 'Care Packages' cannot be budgeted for as users do not know for how long they will need the service. There is also the worry that if health problems worsen, the 'Care Package' will change resulting in higher costs.
As a worker all my life and contributed all my life I feel the needy are penalised for this and other ways of saving money needs looking at. A lot of the needy cannot speak for themselves and need the people who can.
I feel more people will lose out if the changes are made
I am filling this questionnaire on behalf of my father who has vascular dementia. the way the questionnire has been worded has not allowed me to fully assess what the outcome of any changes would be. Perhaps a few examples of circumstances would have helped.
The person named on this letter does not have the understanding to understand the content of this letter. Therefore can not form an opinion
X doesnot understand this so does not form an opinion
I do not have enough moeny coming in to contribute for carers and I can not do anything for myself!
Q1 - as long as it does not affect the person in question's level of care Q2 - I do not totally understand your proposed changes. I am assuming you are trying to reduce mums present entitlement to save money Q3 - My mum does not require to workers to visit her at each of her visitis. I have spoken to the girls and they have stated thay they double up to save travelling costs (eg petrol) for which their employers do not contribute (tow workers, on ecar, less petrol costs, but they have to make twice as many attendances) This means they spean less than the

allocated time to each receiver because they use one car, instead of two, for each service user. Q4 - I do not agree that my mum should pay for the care she receives. I have to visit my mum 5 days a week to tidy the house, do her shopping, wash and tidy her clothes and other various duties. Comments - My mum has worked all her life and paid her dues to ensure a reasonablestandard of living in her old age. She brought up my sister and myself, with no help from the state, eg. 1)my father paid no maintenance 2) my mother received no help from the state. My father left my mum to look after us both, when I was 5 years old becuase unlike some of the people in Bradford, she has paid her dues from being school leaving age. I am not going to support the suggestions in this survey that would lower my mums standard of care because your Care Budget is being reduced. Sincerely X 31.03.2016 (X's son)

I think that the extra costs incurred by family unpaid carers should be taken into account. I am a pensioner looking after my mother with dementia 96 years old. The cost of washing, drying sheets, clothing daily plus cost of extra heating incontinence items all have to come out of my pension, I get no financial assistance. If mother was in a care home it woudl cost hundreds of pounds a week. I am expected to care 24 x 7 without any assistance financially. It is pensioner looking after pensioners on very limited money. If mum cost of daycare or respite increase I cannot manage to keep her at home.

Items 3 and 4 'strongly agree' seem fair and proper to each situation

My wife and myself are executors of X's mother's will and as such I have completed this form on his behalf and without asking for his authority. Mrs X's will allowed for a sum of money to be used for X's welfare. This money is used to pay for care costs, where approriate, as well as other forms of support.

Why do changes effect the most vulnerable?!

Q2 - No different all over the UK Q3 - What about full time carer in form of husband/wife etc. Over 60 no carer's allowance.They are free and dependent upon disabled person. Badly disabled people need 24 hrs companionship from wife/husband/son/etc. They are free! On my answers based on 29 years of living with my husband who had the misfortune to have an accident causing a spinal injury at neck level meaning all physical movements below the neck do not work correctly. He cannot feed himself, wash himself but can use a computer with many aids and his mind which still works fairly well. All help to live is essential. He has had two holidays in Wales, two in Scotland, and one in N. Ireland. A district nurse is needed to perform manual evacuation as his bowels do not work normally. I did the care by myself. If I go away for respite he stays in his own house as no nursing home is suitable. Very expensive. Being like thisis not a state either of us would have chosen. We have never smoked, drank alcohol or not tried to be good citizens. Hoever luck was ot on our side. We are grateful to the state for all the help we have had so farand have no problem paying a fair portion as I believe we have done. I gave up a good career to look after my husband. As a result I have to share his occupational pension until continuing care was set up recently to pay half the bill we paid over £9000 a year. I always thought disability should be graded and means tested. If you use your method the most disabled will be severely punished for something they did not choose.

These questions are a wast of time, paper and the council will do what they want whatever answers are given question (4) we already pay for this service, and until we know all the facts and figures these are all erelavent questions!!!

I don't feel able to comment on Q4 as it does not concern me and everyones situation is different.

! - Already pay for double up (for both workers) 2 - Have not received any increments in my benefits (inflation?)

Q1 - How can I@ Don't know other policy Q2 - Do not knwo other policy Q3 - If / providing carers actually turn up at all! How do you intend to police this? Stop sending funds abroad! Help those in the UK before taking services away from disabled. Q4 - Not in supported living accommodation. Why send funds abroad? Why pay child benefit to people who do not even live in UK? Why pick on disabled? Why isn't there a full assesment on peole who wrongly claim disability? On the flip side, why make it so difficult for people who are disabled to claim? Why do people add money on when they are disabled? Spend a couple of days in

our shoes! Carer's needs to be policed correctly. Companies providing care do this so poorly. Why don't you stop paying Job Seekers to those who don't activily get a job? Push them!!! Please don't pretend this is a consultation. Where is the easy read version for someone with a learning disability. When I rang your helpline the officer I spoke he said none had been produced. This is disgraceful. Obviously anyone in supported living will be worse off with these proposals. I do hope any system you bring in will be fully reactive to benefit changes which as you knwo are coming thick and fast at the present time.
Q1 - It is not very clear what the current policy is, or how it is calculated. Q4 - My mum has a cart package which she pays towards and is in supported accomodation - so I don't understand point 4
Every case is different making it very difficult to generalise fairly. People place various levels of importance in how money is spent and as a result some have more difficulty in making payments such as the ones we are currently discussing Continued pressure should be kept on the government to help to a greater level to pay a greater share of the cost.
No comments to make
A clear detailed view of what the proposed changes are and how they differ from the current approach. Also why there is a need for the changes and how individuals will be affected if the changes go ahead.
Q1 - majority is not all / rest of country Language in letter too Corporate. Difficult to understand. No examples of calculations given to enable decisions. No information of charges in rest of country. Currently pay same for 1 visit or 2 visits and yet letter suggests 2 carers on 1 visit would cost more than 1 carer on 1 visit. This is inconsistent. Will this change. Have you consulted any organisation before writing this letter. Care Qual Com? Cannot comment on the unknown.
All you seem to do is take more & more money away from disabled people. Stop the benefit fraudsters first. Disabled people are the most vulnerable & an easy target for you.
I have ticked 'strongly disagree' to all questions asked as not enough info has been given to enable me to make an informed decision. On the face of it it makes sense to have a standardised contributions policy but if no prices are given what is the point of agreeing? Why would anyone agree if they are not told whether they will be paying more for services? What a wasted letter.
Q3 - Since the presence of more than one carer is demanded by health & safety for use of equipment, hoists for example, I think some of the cost should be met by the authority making these demands. Q4 - Would agree if the disabled persons financial situation were taken into consideration. Dear sir, This form has been a poorly explained and difficult to understand form of any that I have had experience of completing. I honestly feel this form exists so that it can then be stated that 'you' were consulted but did not respond in an inteligible manner inmaking your views known.
Don't know how much is charged to live at supported accomodation, if clients were charged, will it leave enough money for them to go out and socialise and but things.
This charge is another attack on the poorest people in our society to pay for mismanagement by central government who are trying to look after people from many countries who bring no benefit to UK at all. Where has the manufacturing base gone which generates prosperity for us. Look around you empty factories, coal mines, steelworks, ships, car manufacter even the humble matches have gone. The present economy is housebuilding which will eventually come to an end what then?
I am in sheltered housing & I pay in my rent for support
This explanation, is far from 'simple' to understand, even to me. I doubt my mother, who has dementia, would understand it either. We all grow old, if we are lucky and don't die young. Poor health often accompanies the aging process so nobody wants to be ill. Therefore why burden the elderly and ill with a financial burden too. The fact that Bradford Council is forced to make cuts to its services is largely the fault of well-paid government officials who can afford the price-hikes you are promising even though they are likely to rely on private health schemes anyway. So I disagree with all of these statements on principle. Money saving is a political strategy that ordinary people are penalised by.

I changed to my current support team 8 months ago. Thankfully the service is much improved.
Without actual figures it is difficult which system would be beneficial. No one wishes to pay more. It appears from the wording that the standard alternative does not include a charge on capital and savings - though I can hardly think that is the case. What is, of course, is unclear is that while the new system may be simpler to administer and simpler to understand, will more cost be borne by the service user and less by the council. One suspects that for this exercise to be worthwhile the answer to that has to be yes . . .
Q1 - I dont now any thing about the rest of the countyr even Bradford Q2 - I don't understand any of it on behalf of my uncle Q3 - If they can afford it yes I dont understand these comments about these things. But my uncle has dementure he needs help in every way. he gets help. but some of these things you mention I dont even now what it means. I am sorry he is on incom support or pension credit but I dont now how mutch it would cost other wise I am not the person in the care system he is my uncle. and I try to do what I can for him
If service uses have too pay for everything such as 2 care workers instead of the one or accomodation in supported living then PIP should be given generously and other benefit for the service user to live on comfortably. If the DLA or PIP or any other benefits are given currently they don't cover what the future is considering so benefits should need to rise for all service users as should carer's allowance.
I feel the new way of means testing will be less fair, as an individual may be on highest rate benefits but no savings pay more than someone with thousands in the bank. I feel people will struggle to pay therefore not receive appropriate care based on cost.
Understand care needs to be paid for but feel people who require care whether they need 1 carer or 2 should be able to pay feeling that not all their savings will be depleted. £23,250 is not very much when the care fees have been paid especially when the client maybe paying for other support to make their life comfortable. They hardly live in luxary.
I dont really understand these questions
when people have paid tax all their lives they need to be helped by all resources that are available they need the dignity and respect they deserve
Q1 - Not enough information given for a comparison Q2 - Both complicated Q3 - If someone requires double-up surely this is needs based. Following an assessment - not enough info to give an answer. For someone to make this decision, more information is required, i.e. how much they need to pay. With calculations in easy to understand information. (person has learning disabilities). Some people are already paying maximum contribution out of benefits, which, may be cut. It does make sense that Bradford chooses to work the same way as other authorities. But how can someone say yeswhen you havnt said what these are? In real terms. Its not clear if the amount paid by people will increase or decrease or stay the same. This has been filled in by support staff. I have spoken with the person this was sent to and they agree its very difficult to understand.
All the work the Lady's, they all cheerful and fantastic job, they do I can not thank them enough I am x (x) sole carer (wife) He attends Beckfield day centre, we are both very happy with that.
I do not understand this issue due to my learning disability
Sorry I'm not sure how the Council's policy is different to the rest of the country so I'm unable to answer question 1) and that also applies to question 2)
With regards to the elderley, carers cost enough money. Two persons are for Health & Safety. The people who have the most should pay the most, and those at the bottom of the income scale should not be made to suffer more.
The money charged should be charged for the time spent and not a flat charge. Many calls are only a few minutes and not 30 mins as now
Surely if living in supported living that is what they already pay for and depends on service records
I understand changes are necessary. But please can you let the disabled and their carers a chance for normality. We have such difficult lives and constant changes to services and policies are very stressful and cause alarm and panic for families

If a person requires the help of two carers it means they are acutely disabled and to charge them for this would seem to be unfair because they would not choose to be disabled and this would make life more miserable for them.
Central Government should provide adequate funding for social/elderly care. Most people would be happy to pay a little more to ensure adequate care is provided. The disabled and or elderly should not suffer as a result of government doctoring, after all if we're lucky, we all get old!
It is difficult for people who have a disability to find paid work. They might not be able to afford service charges. The money that they do receive is needed for everyday living.
Stop penalising those who are in need and struggle on a daily basis to survive.
I worked for social services for over 13 years on the homecare, the service was free and strongly abused. I am now retired but looking after my uncles welfare, he's 85 years old and has carers going in 4 times a day at a cost of £900 per month. I feel it's gone from one extreme to the other. I feel he's being penalised for being careful with his money so wouldn't it be better to charge contributions on income and not on savings. Thats my view.
My main concern is that day services (ie E4 Print Services and Melville House) continue. My brother with Learning Disabilities and others like him need the dignity of somewhere to go to meet their friends and have some occupation. If we have to pay more to keep things going, then we have to pay it.
question 1- I am not able to make an informed decision on this as I have no idea how other authorities work. Please rewrite and send out another questionaire. question 2- Not necessarily. question 4- There are many factors to be considered and a full discussion with the prople who it will affect should be arranged. Firstly I do not feel that there is enough information in the letter and questionaire which you have sent out and it is not at all clear how it will affect my learning disabled son. What is being proposed does not suit all service shapes, as your proposed policy seems to be a one size fits all scheme. There are so many different factors to consider which do not appear to have been considered. Elderly clients are being lumped together with Learning Disabilities, when they have quite different needs. Your charging needs to consider daycare/college costs allowances for carers food if the carer lives in with the client. Supported Living and domiciliary care work quite differently and there are other costs to consider re the service user. I am sure that the form you have sent out, most people will have difficulty filling it in and they will not fully understand what is being asked. Rewrite the form in clearer english please.
I receive help for half an hour 6 days per week and am very grateful for it. I think I contribute towards the cost and am quite willing to do so. I agree that the Council has difficulty with finances because of government cuts and that where possible people receiving care should help financially.
It is not clear how this will affect me directly.
question 4 - not applicable. I contribute enough according to my means.
If moving to another Council e.g Wakefield or Skipton, would I be able to transfer services?
1. We feel that it would cost the council to provide 24 hour care much more than paying home care to come in. 2. You are putting more pressure and worry on carers. 3.You are looking at short term savings in long term it may cost you more when caters can no longer cope. 4.Who assess what is affordable, I was told if my daughter cut down on her food expenditure she could afford to pay for homecare. She is already underweight.
Currently it is possible to not declare income/savings if they are over the stated threshold-thus accepting the maximum contribition is levied and maintaining some privacy over financial affairs. The new system appears to require full disclosure of all income/savings etc even if the full contribution is to be paid by the service user. I'm not sure that this is desirable as it looks as if a significant amount of personal dats is going to be held by the council unnecessarily. Or have I misunderstood?
I have discussed this matter with Roger in the Contributions team. I have completed this form in accordance with the advice I received. I do not live in Supported Accommodation.

At 94 years old the only service I receive at the present that I am aware of is that I get my ironing done once every fortnight for which I pay by DD. I do not fully understand the changes that are proposed.
I have daily care 'Bronte', I asked for calls to be before 11am as I feel at my worst in the mornings. They have frequently ben late up to 12.00-12.30. I have spoken to them and they are starting to come earlier but still a little late. Because I pay towards the service I am not totally happy, although the girls who call are very good.
Consideration needs to be given to sons/daughters who do not have powers of attorney. This leaves children/family in vulnerable postitions if being asked to give information regarding financial matters. My parent who receives home care at high levels @ present has only 1 current account I am aware of and my parent has always kept financial matters to themself.
Regarding Q3 If you have worked and saved and are suddenly struck down with a chronic illness why should you be penalised because you need two people to assist you?! Surely it's bad enough that you are in a situation where you need more help. Most of the time there is a carer who takes the lead and does the majority of the work anyway. I think this will dissvad people from getting the proper care required.
It depends on the amount of money they receive for support. A detailed cost of the care (personal) system on one sheet of paper would be welcome.
I am utterly appalled by this questionnaire! The majority of your clients will probably be elderly often with some form of demntia but at least, CONFUSED! How on earth do you expect them to understand these proposals? is it a case of simply payling lip-service to these new contribution charges, are they already being put in motion - I strongly suspect so! As for statement 2. Asking clients whether the standard alternative is easier to understand than current policy is again, nothing short of ridiculous!There are no figures, no examples - NOTHING. How you can think that people can give informed decisions when you fall to give them detailed but clear/easy to understand information is just beyond me! I rang your office on nehalf of my mother (who is 95 years old and has vascular denmentia) who couldnt understand one sentence of your letter; I wasnt allowed to speak to anyone in authority and was passed to the office dealing with t!his. The gentleman I spoke to couldnt answer one single question - He couldnt understand it himself and stated that there had been countless complaints about the letter. He said he was telling everyone to put their comments at the end - No 4, I told him that I had already started! The whole scenario is nothing short ofa farce, I would love to know who put together this questionnaire as they are either idiots and have no knowledge of the elderly OR (and i suspect this) they are very clever & deliberatley confusing them more in order to fool people into thinking it to be a democratic vote; whichever it is i find this to be disgisting, it leaves a very bad taste in the mouth.
I do not really understand the difference between the councils policy of charging and the standard alternative, so I have only answered the final two questions.
question 1- would this mean savings would not be considered at all? This leaves opportunity for people to play the system and put their money in savings and not show true income. How will this be prevented? question 3- should be means tested. question 4- is this extra support? Not sure how it works.
I pay for all my care and regret that other people don't especially when they grumble.
The support team are in the house 24/7, 7 days a week.
We agree that care received should be paid for and this may mean that carers receive an adequate wage which would lead to retention of staff. The system proposed seems easier to understand and therefore may be cheaper to administer meaning finances are available to continue supporting services. The amount to be paid and what is included needs clearly stating to ensure service users are clear about what they are being charged. This would reduce anxiety.
Elderly people should be cared for, especially from poor backgrounds. If these people do have to pay it should be a low amount and not a contribution (small) or shouldn't have to pay at all.
To the first 2 questions, I do not understand how this would affect me financially. I would be happier if the carers that I pay for now turned up on time or came at all. Question 3 - I don't

agree that people should pay double because they are more severly disabled or heavier.
Question 4-I don't agree that people should get free services if they can pay.
question 1 - I don't understand if a person lives with parents & gets DLA would they pay more? If so, I disagree. questions 1 & 2 - Not clear how would affect our daughter who lives with us at present. Would she pay more if moved to new policy-if so we disagree. Our daughter has learning disabilities so how is she meant to understand this if I don't?
I think the standard of care in Bradford is good, I hope any changes do not alter the status quo.
These are questions NOT statements I find this whole document completely incomprehensible with over use of jargon and an assumption that the recipient of this communication has a clear understanding of the relevant statutory provision and is able to respond accordingly.
As a service user the time carers are here is approx 10 min per visit not long enough to do what is needed most times and I contribute to costs. Care companies should be monitored with more care as to how they perform.
Please keep present charges if possible
I have just been informed that my pension has been reduced by £80 pounds per week. I am more or less a prisoner in my own home because I have not got a ramp to get my wheel chair or scooter out. People have rung me about it but that was about 2 weeks ago. I have a prosthetic leg above the knee and my wife passed away on the 8th of January.
Q1 - I do not understand I do not like paying
To make a informed decision we really should have had examples of how these charges would effect individuals. Showinging old costings via new costings. Not really enough information provided
Its important that, having made the contribution calculation, the whole package is assessed to make sure there is no detioration in the quality of care. Disabilities vary widely and a 'condition' in one individual may be relatively easily managed compared with the same condition in another individual. If BMDC is involved in paying for care, they should ensure that standards of care are monitored and maintained.
The care given should be the same high quality whether the person pays for care or not and the time allocated should be what the person requires (a min of half an hour) not what someone thinks they should have because it fits as everyones care needs differ from person to person. E.G. there may be two people with say Artritis one may need only half an hour the other may need an hour but both may only be given half an hour. Different people react differently to same illness.
Q1 - As long as it is the majority of councils As long as that persons costs are based on their ability to pay a reasonable amount
Mr X deceased 1 March 2016. I am living on my own and paying all bills for limited finances Received invoice for £1200 for year and woudl like council to support
With question (1) I have strongly agreed - only because I do not know or understand what either the councils policy or the rest of the countries policy is! Therefore, one single structure sounds sensible & we do not have a postcode lottery.
The previous plan seems better structured.
Why should a person living in supported living accommodation pay for it? The previous plan is simpler and easier to understand.
Difficult to be definite with answers as questions seem to assume that all people and their circumstances are equal which I find a strange basis for the questions asked.
I feel strongly concerning the possibility of charging for two care workers. If two workers are required, then this is because they are needed and is not a 'choice' situation. It is no fault of the service user if more than one worker is required. When a person is disabled in such a way as to require two care workers, they and the family have enough stress and anxiety to deal with without additional worries over extra financial payments.
Mr X does not have capacity to complete this form & we are unable to express what his views would be.
My care needs require the services of one person only at this time. However, the present care providers often use 2 carers, with one basically providing transport for the other. So often

there are 2 carers present on a visit. This is a situation presumably dictated by the provider& as such, should not be chargeable to me!
It is difficult to comment without having the benefit of illustrative examples. Also does an individual have an element of capital/income that is protected. If a person needs care & support it should be provided without the worry of finance issues. My mother has worked all her life until 65+, paid her dues. It is now time for pay back: her quality of life shouldn't be compromised for lack of finance.
question 2. I feel unable to give a definite/clear opinion (0ne way or the other), because my experience of the working of the Council's current policy is very limited. My son receives 'Direct Payment' for just 6 hours of support per week from a Personal assistant. question4. My response is based simply upon principle. I found it difficult to decide which box to tick without having any knowledge of the actual costs of support. 7.4.16 X Father of X ADDRESS
My husband has only just started needing 2 carers & also just started having more than one visit per day, after 12 years just having one 1 hour call. My husbands income has not changed in that time so I do not know if we can afford anymore. BUT we are paying into a fund by our increased Council Tax.
The standard of care is so variable it is not good value for money if the service user has to pay.
Q1 - Most old people have worked all their lives and care and support should be given without thought when they need it. Q2 - Don't understand the policies at all some people pay little or nothing others are charged ridiculous charges very unfair system Q3 - In my knowledge dont know anything about double ups Q4 - Benefits pay a lot to people who never contributed in taxes and never will is it not fair that the elderly should be cared for in the same way. In fact are they not the ones who made the country what it is today. Never understand the logic of migrants being allowed to come and receive every benefit and right when our elderly are living in dire needs cold, hungry and unhelped by an uncaring society. Baffles me!! We should care more for our own especially elderly. My father never got to retire he killed his self working at 55 years he passed from working from 12 years old. My mum gets more pension because he never claimed his and she is to be penalised in care charges because of this (DISGRACEFUL) She is entitled to this unlike most of the benefits claimants who contribute nothing to they system or society in general. My mum is 83 years of age care should be provided by the council and costs cut else where the elderly are forgotten too much and are the most valuable assests Britain ever had or will ever HAVE!! If they do have to pay would it not be fairer that they all should pay same nominal charge. Not some pay quarter of the pension and ie: £50 a week for help with 10 mins on a morning for shower help and a call to remind her to take tablets on an evening where the carer comes in says have you had tablets and nothing more. 2 minutes top call. Average 15 mins top a day and mis costs £50? They do no washing hair in shower they turn shower on and off and she washes herself dresses herself thats all they do. Then nothing on an evening apart from the question have taken the tablets. NO WASHING DONE I DO THIS! NO CLEANING DONE I DO THIS! NO MEAL MAKING I DO THIS! NO SHOPPING I DO THIS! NO IRONING I DO THIS! and they are charging her £50 a week for this Disgraceful. She also pays service charge £140.00 a month should this not include minimal care. I am in full time employment with a family and I still manage to do all this. Do you think that this is acceptable as I dont. She lives in assisted living not a care home but if I didnt care what would HAPPEN Most of the people living there pay nothing for care or a very low amount between £15.00 and £30.00.
For Q4 I believe that further information on what services are being included in this charge before an informed opinion could be made. Please note these answers have been made with only limited information provided.
Cannot make any further comments as I do not know other payment details so have nothing to compare.
Re Question 3-Double Ups Difficult to answer without guidance on the cost implications supported with an average cost example.
You will do what you want regardless of any input from outside.
Obviously this proposal will result in a larger contribution otherwise you would not be considering it. My experience has tagt me that when we are told about a consultation

document it usually means it is already a done deal. By sending out a letter makes it look like you're taking notice of our opinions. I can't believe anyone has agreed to the above. What has happened to the ILF money-provided by the Government for disabled people? We were told the ILF payments wouldn't change when passed over to the LAs, already we are hearing that the Council will only pay a maximum of £16/hr! Why is it always the handicapped and disabled who are targetted, because they are easier to target than those who make no contribution to society what so ever.
The cost of 2 care workers should not be charged because an individual has a need for 2 people to take care of them. By putting cost before care of the individual we are taking away a basic need of theirs, also in many cases 2 care workers are required not just for the care & safety of the individual being cared for but also for the safety of the one carer who will find it difficult to handle a volitile individual on their own. In these extreme cases the individual in need of 2 carers should not be penalised because of their basic need. Every council is different & all have different policy & approaches to take care of their service users. If Bradford adopts this universal policy it could have a financial detrimental effect on some if its users. Service users not only pay a contribution to care services they are also paying costs for trips out, mileage (if they have to be ferried about in the carer's car) theatre tickets, meals out or just for lunch, this has to be paid for by the service user aswel as other expenses e.g breaks or holiday accommodation for the carer that has to be paid for by the service user. So in my opinion that would leave little money left to pay other bills plus service users would in my opinion cancel services and would go back to being alone and isolated. A lot of people depend on these services for well being.
Bradford Council and the services they provide should in no way be charged for those people who receive benefits to help them lead a more comfortable life. Bradford Council seem to have adopted a policy of making cuts and taking or charging the most vulnerable people in our society for anything they think they can get away with. These people can not defend themselves so they are obviously seen as an easy target.
X does not live in Supported Accommodation, she lives at home with me (her mother). X does not have any carers as I look after her. I do not claim Carers Allowance but April helps in the running of the house so she contributes in that way. X does not claim Attendance Allowance, she gets DLA middle and lower rate and some Income Support.
My son - aged 32 with autism lives at home with my husband and I as his carers. He has support from an excellent man who takes him out once or twice each week, it is his life line to the outside world and he loves the days he goes out. He currently pays approx £90 per month towards the care he receives. I don't think he should pay any more. He only has his benefit money to live on. I don't understand how the change to 's ---- contributions' will affect my son (in money terms) so I am unable to make a reasonable judgement. I am supposing that this new system would mean him paying more out of his benefit money which I think is unfair and unreasonable. I am confused as you give no examples (in money) of how these changes would affect people (and my son).
It must be noted that keeping people in their own homes is a much cheaper alternative to them being in sheltered accommodation so should therefore be supported. Equally the care wardens deserve a wage that is a decent living wage - to equal the important care that they give to vulnerable individuals. NB My sister is unable to read or write but as her advocate I have filled this questionnaire in - trying to include her as much as possible.
Any changes to be phased in over several years to avoid shock of change affecting suddenly.
If you require two carers to attend it is because the person receiving care is more severely handicapped and should not be charged more. The person looking after this patient is already struggling to cope and needs all help possible without having added payment.
As long as it can be afforded disabled daughter living with our family cost a fortune on everyday living (gas / elec / water (needs).
The person addressed does not have the understanding to complete or understand the content of this letter.
Q2 - They are both difficult to understand Q4 - All depends on how much money they have.

I was attacked so i dont think I should have to pay towards my care which I do pay towards with me on benefits I cant afford to do this.
Question 2- Not at all, maybe an example needed. Question 3-People should be given the same opportunities. The questionaire is very difficult to understand.
We already struggle to pay for our care.
We struggle already to pay for our care.
I also think that if it is shown that you cannot afford to pay towards the cost of carers and being supported that you should not be left without the ability to pay bills or feed yourself aswell.
I agree we should be charged for living accommodation if we live alone & cannot cope easily with all chores.
I don't really understand how these charges will effect me.
I can't answer the questionaire because you haven't provided enough information.
This is quite confusing without the Council changing its policy from yearly to every 16 weeks and then dividing payments into 3 monthly cycles. Surely with all the people at your disposal you can come up with something more simplistic so the elderly can understand more clearly.
I feel that this form is biased to try and achieve the result that you prefer. People who need 2 care workers are chosen to by BMC because of their needs being more so. It is not a luxury but a requirement forced upon them and they should receive full financial support to continue. In fact having paid into a sysytem for 50 years that was going to pay for looking after us should the need arise it should be free.
I do not feel able to comment without knowing who will be affected and by how much.
Can not make an informed judgement as would need to know the rest of the country's policies. The standard alternative appears a simpler approach, however the major factor for the user will ultimately be based on the financial implications, assuming the standard of care remains at least equal to it is at present.
The proposed changes will cause financial hardship to majority of the service users. This would not be fair. A lot of people may have worked hard during most of their lives and have paid Income Tax and National Insurance Contributions and now when they need essential services from the authorities they are asked to pay for those services would be very unfair.
Question 1. The same rules should apply to all regardless of post code. Question 2. Unknown. Question 3. Just because an individual needs more care & support they should not have all their money taken. If a person needs support regardless of the amount there should be one charge. Question 4. Again one equal payment. May be have one set of charges for individuals who require health & social care support:- a lower rate eg needs less than 20 hours of support per week a higher rate eg 20+ hours of support per week. This is capped regardless how big the care package. There should be more 'red tape' so that those who do not clearly have a long term care need are challenged once they have accessed support every 12 months eg must provide 2-3 health care statements from different professionals to support claim.
You are asking us to accept an unkown quantity (no illustrated example shown) in place of a system that we already budget for.
Question 1- I don't understand. As I am struggling to pay towards the care , it is very difficult to pay the care cost and run your own home too. It's a different matter if someone is in a care home.
Q4 - Not if they can't afford it. Yes, but does not apply to me I live in a sheltered housing flat (Anchor Trust). I receive DLA and ESA (support group) with Severe Disability Premium. I rent a CLAIII scotter from Motability (mobility component of DLA), the money left over from that & care component of DLA comes to £85.74. Out of this amount I pay for my homecare, cleaner (cleans my flat), does laundry and ironing), and beutician for pedicure and facial each month as I am diabetic and need my feet attending too. I like to take care of my face, I look very young for my age (57) I look about 35. I am quite happy to pay you a bit more each week, I have more than enough money left after paying my direct debit bills, rent and groceries, as well as private bills. I have to save over £200 for a new folding scooter shed for my scooter, as the lady who owned the current scooter shed has passed !away. She let me store my scooter in her shed over 2 years that I have lived here. I have one debt I have to pay my joiner quite

a lot of money cos he did a lot of work for me in my flat eg fixed fire surround (solid oak) tiled the fireplace, made the walk-in wardrobe, put curtains up and blinds, painted bathroom etc We have agreed to pay a small amount each fortnight. So after everone has been paid I have quite a bit of money left for meals on wheels service and for my yarn/knitting supplies for my very small knitting/crafts business (online only) as I only get paid a very small irregular income for my knitted socks.

(filled in by daughter as mother unable to do this) The Double ups concern me. My mother is on the one carer regime, but at times two carers visit. There is no need for this and no extra is done. Presumably she would not be charged for the extra as it is not part of her care plan and it has not been requested by myself. If she really needed a double up and got the time due (not done in half th etime) I would be willing to pay extra - but maybe not the full double cost. Recently I have spent more time checking up on the care provision and time actually spent doing the jobs required. I can't ask mum as she has no short term memory. Some of the carers are excellent and I would happily pay more in this case. However, the standard of others falls far short of what I would expect. I realise staffing is a problem and pay is not good but when I'm in the middle of numerous problems with care for mum, I am not going to happily consider pay!ing more! Perhaps if care charges are changing in structure, the pay structure and assessment of carers should also be reviewed. I have no experience or knowledge of supported living accommodation and care provision so unable to comment.

Basically it boils down to cost. The nett cost of care for my mother (assuming standards are the same) is the primary driver. You do not show any examples of cost, surely this would make the decision making far easier if you did,

If a person is sent a yearly bill, broken down on this bill just like on a council tax bill then it will be easier to understand. But if a bill is sent out weekly, monthly or however you may want to change it to this could confuse people especially if as like my mother you have started with altzeimers. If you are thinking of putting up the charges, considering that most people who are being looked after get more care from their families then this is disgusting. Also the people who are being cared for have paid taxes for a long time and shouldn't be charged high costs for being cared for when they cannot do it for themselves anymore.

I feel all the cuts and actions applying to DLA is not fair. We feel as disabled people are being unjustly treated and feel that the new posed actions should not affect us as our living standards are not as 'normal' as decreasing and applying cuts makes our living standards more difficult. Thank you.

I do not really understand the changes enough to make a comment. Clearer explanation is needed of the new system. Does it include savings? If yes is there a threshold that some savings are not counted ie £10,000? These systems are so difficult to understand for elderly & disabled people. The explanations should be extreemly simple in bullet points. Also examples would be usefulso people would see how it would affect

Any extra charging a service user may incur must be kept to a minimum.

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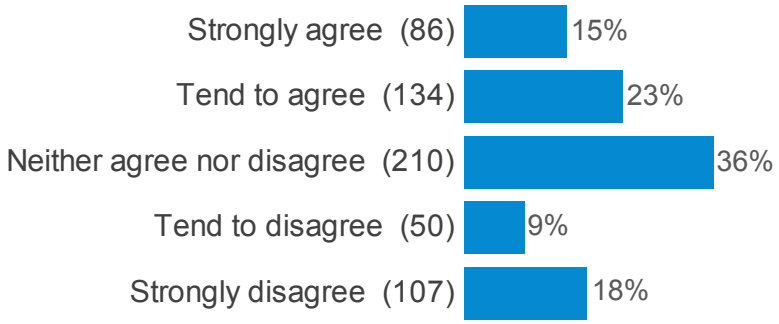
Appendix 5 - Results from the revised questionnaire

This report was generated on 19 August 2016. Overall 639 respondents completed this questionnaire.

The Council's policy is different to the rest of the country do you think it should be changed and made the same? ()



Do you think the standard policy is fair?
If not please tell us why in the comments box
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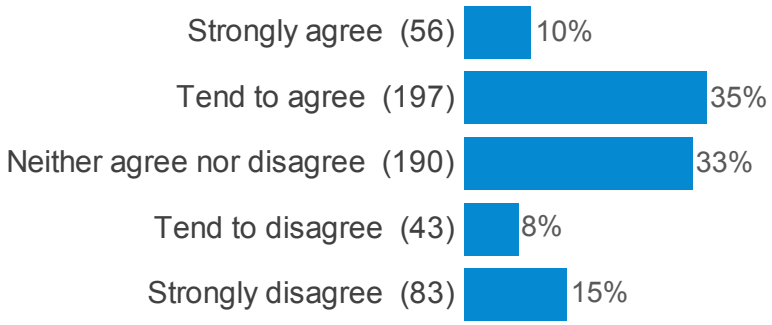

Is the STANDARD ALTERNATIVE as described above easier for you to understand than the current policy?
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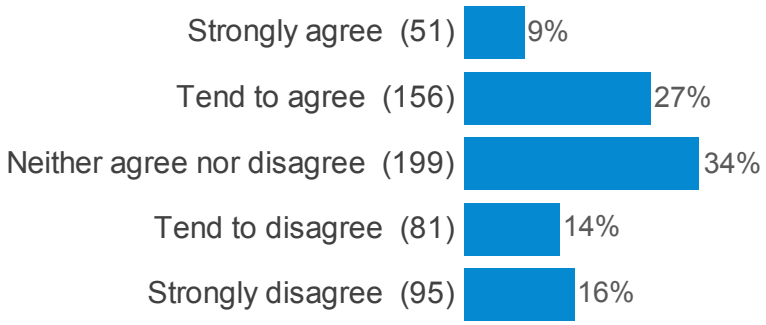


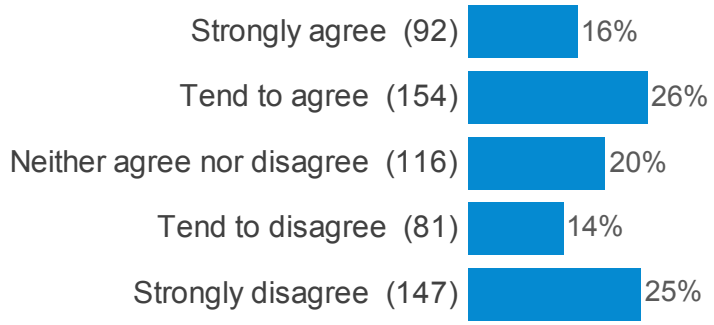
Charging for cost of service - Double ups

Currently in Bradford the cost of care visits which require two workers to be present at the same time are calculated and charged for one worker only.

We are proposing that the actual cost of two carers should be charged for and if a person can afford to pay for the full cost of that they should do so.

Please tick one box for each statement

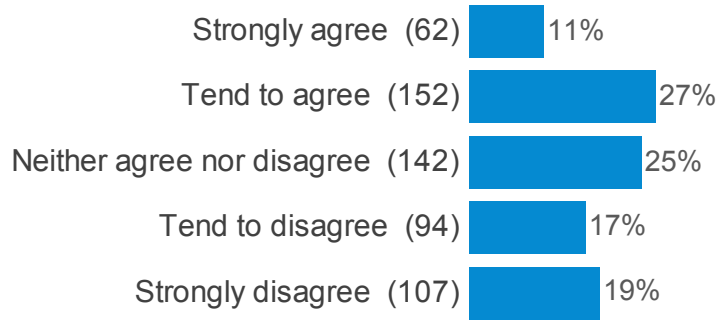
(The cost of two workers should be charged for those who can afford to meet the cost.)



Charging for care in Supported Living Service

If a service user is living in a Supported Living Accommodation, the support that they receive in that accommodation is not currently charged for. The proposal is that these services come under the Contributions Policy and are charged for.

Please tick one box for each statement
(The support that service users receive in supported living accommodation should be charged for.)



Appendix 5b Comments from the revised questionnaire

Any other comments please write them in this box
I am happy with the support I get from both care companies but I do feel that I could do with two cares of a bed time
I strongly agree that everything should stay the same in this part of the country.
Have not got a clue
I had some savings from my own pension which i thought i could use if i needed anything apart from the things i am intiltled to where i stay at woodside court as it is ive been bullied into paying full amounts for single nurse help at less then 10 hours a week am paying full for all the care i dont even receive now i am pennyless and only have a pension. paying any of these bills that i am not suppoed to pay so you say. thank you
My father is entitled to 45 mins x1 plus 3x20 mins now that 2 come he gets 20 mins x 1 plus 3x10 mins so it should not make any difference . Each council works independently and have different prorties weather councils where there is more affulence the elderly can afford private care. In my father' case and 92 years of age his money is spent trying to keep him at home for the remainer of his life it is cheaper for the council this way.
I think the standard policy is not as fair as the standard alternative which is easier to understand and better way to calculate the contribution
Will be at your meeting on the 19th July
The document is to hard to understand
Before the council didnt charge. Now the charges service use's 120 a month and say is it 20,000 user's council sets 40,000 in their pocket why? service's users need cloths food if you take money off disabled people it wrong
Standard policy leaves very little money for holidays clothing and person care equipment transport sports and gifts
the service given is very good. My husband does not appreciate all of it - as I am 'on duty' 24/7 & to have help is great for me. Thank you.
My daughter attends a day care centre 5 days a week - that is all the respite as her parentsreceive & we dont want any-more. My daughter has a very limited income and while we understand the financial problems the council has - our finances are stretched to the limit now. My daughter has had cuts to her benefits by this awful government - we cannot afford to pay any-more than we pay now. Outgoing's I filled in in th eform last year about my daughters living costs have gone up - but her finances have not. My daughter can-not read or write I have filled the form in for her as her legal appointee.
Whether you live in supported living accomodation or not everyone should be treated the same, and pay why should the people that have their own homes be penalised - AGAIN!!
The changes in your policy affecting my services which make my life uncomfortable and i am not happy. I do not receive state pension i am on limited income
Sorry but i do not understand still all these different charges. Happy the way things are still confused
X was supported with this form but found it hard to understand the changes. An wasy reas version would be a good idea.
Provide a good service enabing service users to live has independantley has possible. If you look at the cost of full time care i think the charge of the council services is very reasonable.
I am fortunate to be able to pay for my needs. What littel help i did have from the council was not needed at the time it was avaible to me. I do not feel i am qualifield to answer these questions i feel if people can afford a payment they should pay toward cost.
I think the amount fo payment which is paid is far to much.I dont have any savings and never will have, because of the payment i have to pay. I never used to pay but now i have to. Some time the carers dont come of if i have to some where to go i still have to pay the same it all wrong.

As a disabled pensioner i do believe we should pay something towards our care and not rely on our goverment. But take into account i di not choose to be disabled and i think the goverment should do more.
how can i compare your council's policy with the rest of the council's if i dont know what it is?
The problem with charging any system is that during change problems which effect the person needing the care usually arise. Obviously changes take time but in my experieince far to much time and its the people reuiring the care who alway suffer no matter what assurances are made. having gone through the change from disability pension to PIP the emontional and stress caused was immense even though eventually imaintained the axact same status. others whom i know were given 3 week to sort out financing. it hard enough now with out changing the format. Beourocracy and red tape civil servant paper work computer files and re-assessingeach persons financies will cause chaos. Been there worn t-shirt had to go on extra medication as well as excema running riot.
It is very kind of your to exclude DLA and mobility however there is no mention of the £20.25 per week of fuel. there is no mention of extra heating bills etra washing bills ect. Extra clothing for soled cloths special dietes ECT. 3 examples does not fit all. Does the carer have to pay all these extras. It must be nice to finish your 37 hours work giong home knowing you have ripped some vunealbe perosn off by £30 or £40 er week. Try being a carer this a 24/7 job. My wife has severe back problems for continuously lifting my son for 45 years. By the way how much is the cost of the extra letters which are as clear as mud costing the tax payers. no doubt the letters will go in the bin.
Why the big change most people do not have the means coming into there house.
Why should old people have to pay when we have paid all or working life's. I dont have a carer so i need my scooter to do my shopping and other jobs i was told i could have a get out by my doctor. I wll get a doctors note if required.
This is not an easy read format is not explicit enough.
This is not an easy read document not explicit enough
I feel i am penalised because i receive a teacher pension.
I have no complaints
Given that my mother is 101 next week and i have no end of bother with the carers re short visits never knowing when they are turning up ect. Life is to short to fill in this form.
I can not understand why the council think it is acceptable to charge a whopping 33% of my sons DLA care this is currently used to met his needs and to buy stuff for his autism. It is apparent you are using this income towards his needs and like every other goverment department it should be totally disregarded!! his is currenty no means of income therefore you are penalising hard working parentsyet again. This is disgraceful and the council should be ashamed this needs to be challanged legally.
The goverment should pay. I think disabled people pay enough now without charging more and more because once it start it will go up every year Why are disabled people who have enough in there lives to put up with. carers and old aged pensioners be penalised all the time. They seen to be at the bottom of the pecking order. My daughter has never walked since the day she was born and never will. If there was a possibility she ever would you could keep you money as that is all i have ever wanted.
I feel like we should not be charged for my son i am struggling to make ends meet.
I have 1 disabled arm and broke my other in a fall I am profoundy deaf and unalbe to use the phone to call anyone. I can not have an op as i will not survive or end up a cabbge. I try hard and still find i am unable to do things myself. This last fews months i have had to have personal help and cant afford to pay any more toward help.
I dont totaly understand the figures you have made avaiable. All i can say is that at the present my mother has a comfortable but modest existance on the money she manages to save and receives from socila services. I have to save some of her income to pay for respite which you have reduced on your finances form 8 weeks 3 years ago to 4 week per year., which i had to fight for this year. she does not walk very well and thus requires the restpite which we manage at the moment. A reduction in the amount she receives at the moment would reduce the

standard of living she has paid her dues for during her working life from the age of 15 years to 60 years of age all in this country.
The service received by a thrird party (contracted out) was adequate.
Q2. I am retired but this still costs me money! Q3. It is all complicated & difficult for me to understand when written in local authority jargon! Q4. What will be will always be:- 'Wha'eva'
Those whom can not afford it should not pay anything
People are already @ suicide position due to cutts in services and benefits, any further increase of contributions charges for services is more dangerous, pleaase dont target disabled people for claw back DLA benefits find another route - At present climate disabled people are feeling no life and its means.
Not living in a surported liveing acomandation. 2) not fair because some of my benefits have been cut
As a 90 year old with memory problems how am i supposed to make any comment
I am 92 years old am I supposed to understand this.
My dad would be happy to contribute what ever is deemed fair.
Q1. No leave things as they are
Get very little help from the Council & the Social Services It's been 6 weeks I requesting Social inclusion but yet to hear anything.
This makes no sense at all my dad's 87. He only receives Disability Allowance.
non denpendent part of rent should be part of the expenses has it has to be paid for by disabled if they are over 18 and it is not in their name on the housing benefit claim
both methods are qually confusing
none
If there is going to be further changes then the costs should not go up for thosethat are on pension credit and elderly
i am the duaghter of Mrs X, aged 95 and have tried to make sense of this in order that I respond usefully. I read the examples, more than once and would suggest this was not a good way to promote understanding
vertually same scenarios only worded differently. your examples (unless i am being rather slow and dim) are not 'like for like'. Confusing! How can you justify, what appears to be double the exsisting payments? Bradford Council are a disgrace to their cause, you are bleeding some dry and allowing far too many (for various reasons) off free. If property is involved then national guidlines go out of the window - you are a law into yourselves!
I go to day centre 2 days a week, they allow me £75 per week which goes to the day centre not to me. I was assessed 6 weeks ago by someone in Bingley. This is all I am allowed they said they will get in touch in 12 months time. Mrs X
cost to the user have to remain reasonable - NO MASSIVE INCREASES
I dont understand the systems you are using or proposed to use but that I understand is that the Authority.Government is sqeezing the most volunerable people and claw back as much as possible froom their DLA Benefits - the strain is put so people would commit suicde and Gov / wouldsave all the money - in the current situation people are feeling worthless to live and lifes purpose - Gov should find different area and route to get money to their needs and not from disabled people. GB is moving towards third would country status. GREAT BRITAIN - ????
NO FURTHER COMMENT
Some area have bigger wages than other like London. South England people dont mind paying if they get the time they shoukd have as having to travel from one to another not having to rush becuase of traffic in some areas
Would like the service to remain the same.
Difficult to say as your examples make no sense anyway
It is difficult to comment when you do not know what other councils charge.
The policy does not take into account individual needs.
I dont know either your policy or that of the rest of the country so cannot answer. have insufficient knowledge to answer your questions
Under the new proposals if implemented service users on supported living will have no money left for recreation which isnt a lixury it is essential for the well being of the perso. These people

are unable to indulge in free entertainment such as reading a book following a television programme or giong for a walk without paid support. many will be depressed and others will exhibit such server behaviour problems theywill end up needing double the staff support they have now at what cost?
I agree that 2 carers should be charged for but no one gets a refund when carers do not turn up this should be a general rule of the thumb now as it has happened numerious times at my parents and my father has had to give medication to my mum.
The examples given are still not very clear to understand so it didnt seem right to fill in this questioniare. Still feeling a little baffled but i hope it helps ive answered the best i can with what i understood.
People not vetted who coming in the home. Not trained saff expected top money when no qualification. Bradford council uped the charges already.
Will not be able to pay for the services
Carer who take there own child to centre's morning and afternoon should be paid extra for fuel cost council saving 5 to 7 thousand pounds a year for mini bus.
I have help (1 helper) for 30 mins each day at breakfast time as I cannot stand for long periods. I am very grateful for this help and believe I am already paying for this service via Bradford Council. I have complete trust in them to do the right thing and will continue to pay whatever they ask.
I think the standard policy could be too expensive for service users, even though there are safeguards in place, I still don't feel reassured, any increases in contributions and paperwork etc can cause anxiety, my mental health could be affected and I think any change could also adversely affect other users.
This is not an easy read format.
Q2 - No idea - Am intelligent person but examples made no sense to me Q3 - Never had the current policy explained so no idea and still do not understand the new one. Specific personal examples would have been better but assume you did not want to do this. Please get on with this now - these letters are distressing please either tell me what I am to pay for definite as you are scaring me - or cancel it all off and stick with what we have now just make your minds up
If someone is able to pay for there care they should do. I do not think it is fair disable people who live at home with parents and only get support for 4 days a week no rest bite or anything else should be charged the same as others who need two supports or a lot more hours. The system seems unfair at times.
Thank you for your statements for money I do not understand I'm just a poor pensioner not a private investor. Thank you for sending peoplehere I do not ever remember asking you to come here. I have the dat eyou did and what I said I will pay per hour? or half hour I get The social services ask for help when I left hospital my operation was on 20th April for 11 days when I cannot I still have some people she asked for shopping for my diabetes which is ignored my people who come here and disgusted with them also they are writing a book. Dignicare my ----. When I say you threaten me with will you get same treatment again, if I go some where else.
Dear Sir or Madam, I don't remember what I put on the form I did before. But I dont understand these things very mutch? There are very rich people - middle class poor & porer? What can I say for those who can afford they should pay? My uncle had a stroke he get some help he needs 24/7 care. And even tho he gets that I think he could do with a lot more to help him properly. I even help him as often as I can. So I dont want you to make your decision on what I say? I could be saying something that I now nothing about I also would not want to do the wrong thing sorry if Ilet you down.
I do not have 2 workers at present. However I think it is very unfair if people need 2 workers that they should be charged more. A person may have two workers because they are disabled or have mental health issues - I think to charge more for 2 workers would discriminate against those people.
Hi, I would like to comment of ---- pay ---- benefits the ---- ---- 2 ----. Support ---- ---- pay ----. Support is ----- ------ 2 ----- ---- too ----- ----- pay from my benefit. I only receive £900 per month I barely survive and I cannot afford to pay for my (support)

I think it is fair to charge people who can afford it. However, benefits are not a lot of money and disabled people would much rather not have to hav ecare but it is needed and should not cost a fortune!
I do not want to pay becuase why should I have pay.
The examples are too complicated and none apply to my husbad. cuts are always targeted at the most vunerable.
It is fine to charge for services as long as everyone is treated the same and people have enough money after charging to be able to afford some kind of quality of life and be able to afford the rest of their bills
I have and need 3 carers 3 times a day. Dont like two carers in flat at once. dont know what one is up to
i consider the current contributions policy to be fair
If a person needs care and cant afford to pay they should not be charged. If the workers are needed then two should be paid for
I have one carer 3 times aday for 15 minutes each time. I do not have thwo carers at any time. I do not need a double up and also my carers do not alway use their 15 minutes but are here for about 10 minutes as everything is ready for them. The only time is in the morning when more time is spent as she has to help me get dressed. I really think I am charges a little too much @ 172.56 for what they do.
I am 77 in September, at the moment my savings are 15.944 I can continue my duties for the present. I require water bill & council tax, this comes to well over £1,000 a year. I have gas, electric and gas and safe & sound, safe & secure telephone, your gradually taking it all off me. I envisage it will all be gone in about 5 years, maybe a bit longer but no more, who pays the bills then. I wont have it, I require and answer to this.
I am 35 in November this year, currently i have one care worker visit me twice a week for 2 hours a visit as my care plan states I got for hours of care a week which is all i need at present. I am very happy to continue to pay my service cotribution thak youassistance you give me it is most viable
everyone should contribute a little, instead of penalising those people who have worked haed and been careful with their money. As opsed to people who have been careless and squandered their money
these that have plenty of money pay for care
Its not fair that people with severe disabilities should be charged for two people to help with care when its not their fault that one person cant manage. If they have worked all their lives and manage to pay off there morgage, worked for a good pension then they are penalised while other people take liberties with the service.
The system should stay as it is
The people we support have learning disabilites and can not fully understand the questions asked
The people we support have been asked the quesions by staff, but do not fully undertand the questions asked
My mother has 6 hiurs time out visit per week. she likes the lady very much abd wouldnt like anither person visiting. so under our circumstances two carers would certainly be overkil and mum would not be happy
Examples provided are not given for those in receipt of PIP. A weekly living cost can not be generalised expectation for each individual. A disgustingly pharsed questionnaire for an appointee of 81 years to receive already been dictated to with current amount, contributed to and been told what my son should receive.
As I take care of my family, I do not claim any allowances. I do agree that if a person can and have the finance to pay they should pay a higher contribution if the care they receive is good. The policy should be the same, why are they not, please tell me why. Do I have to pay for my care. I do not no because I have had a brain injury. Thank you if you can help
The service used has learning disabilites and this is hard for him to think about,please dont send more information about this to him

I strongly diagree with the proposal of charging the actual cost of double up (x 2 workers) for 2 workers instead of 1 worker. disabilities of people isnt their fault ie in wheelchairs where hoists are used which is why 2x workers are needed, but it is not there fault so shouldnt be charged for this. somebody could have a higher disabilty but only needs 1 x worker so therefore would only be charged for 1. No logic at all.
Firstly thank you for the clear and concise explanation regarding the contribution policy. it is therefore now clear what has to happen, charges should be fair accross the board
- Still confused by the examples - Are these examples correct? ie the contributor under the proposed policy includes Disability Living Allowance at the Middle Rate Care whilst for examples 1, 3 and 4 the contribution under the current policy, includes high rate care ie the proposed policy examples understate the assessed contributions.
carers emplyed by care service providers work long hours on a minimum salary. owners of service providing companies see to all extract millions each fromtheir business. This can not be right. The council should select service providers who do not opperate like this
client doesnt have capacity to complete
My mother only gets one carer at a time, they help to support me inlooking after my mother of 86 yrs with Vascular Dementia plus Alzeimers I would have thought it was obvious that if people have substantial savings etc then they should pay for their care. Unfortunately my mother does not fall into this category. I recall the goverment suggested this in the budget, but of course Labour critisized it!! Funny that dont you think!!
Users should not be charged for services they are in need of these services. If they weren't then they would not be accessing such services. - people with disabilities and theor carers are already stressed and find it difficult to cope with life or the disabilty they have and this is just a burden on them. - if they can not pay, they will be stressed out more and you should be helping reduce stress rather than causing it. - I strongly disagree with charging users and carers for any of the services that are available. These people did not choose to be disabled!
I strongly disagree with the payments you charge for going out my daughter hardly goes out she dont go to no Day Centres and she only may go out twice a week or sometimes not at all She don't always use the services our daughter is very difficult so why pay for the services you are fiddling the disabled I have even told the social worker about this it is a waste of money. She don't even go out six hours. maybe two or three hours. I think it is a rip off how come it took you so long to tell us about carges since April 2015 why has it taken so long by telling us my daughter gets her money from the Govement and you take it for services I don't think this is a fair system and it is no good sending letter to my daughter like this because she don't understand and can hardly read we have got to explain to her then she gets upset about it so the £23 constabushion a week just for a couple of hours. Sometimes she don't go out at all. You cannot make her goout if she don't want to so you are taking money of thesee people who dose'nt understand I am not paying anymore until the currcomstancy change because so far we have payed £200 what for because my daughter won't go out
My husband is 81 and has dementia. He has his state pension, plus a small [ension from his job and a low rate attendance allowance. we dont have DLA and we dont have any home care. He has 1 day aweek @ day centre for which we pay a bill. Thats alright. I also have arthritis and a 50 year old daughter with learning disabilities she does not have any home care. I do it allmyself and I dont know what other people pay. I dont know what else to say.
X lives @ home with us, her parents. we dont have any home care workers. she goes to a day centre 1 day a week, 2 days in Bradford, food works, has 2 nights a month @ Rix House, respite care for which we get a bill. Thats alright. X dad has dementia. I dont know what else to say
I dont think you should have to pay towards your care if you have D.L.A. My husband gets his state pension and pension credit, I only get D.L.A. High Rate Mobility High Rate Care My d.l.a. money goes to paying for my cleaning, shopping, overnight stays etc And I have to pay £72.72 towards my carer on direct payments I am only allowed 8.75 hours a week.
It is completley unfair that someone should have to pay a sum greater than the cost of their care, as in example 4.Is this even legal?

Those who can avoid should pay. But those on little income should not have to pay the full amount.
please not i now only have a single carer
You may have to make difficult decisions in the near future BUT the care is poor and will not get better. No way will the Council suffer but old people will.
This form is quite difficult to complete as personally I do not know any one who has 2 carers per visit
The cost has always been clear. I hold a certificate in accounts. My question is how does a conclusion of cost occur without an assessment of time required? When is it legal to give information regarding charges to pay and the sum decided upon? My present plan was done in accordance to your readings. Costa are less than the estimated charges more time is involved?
If this is supposed to be easy to understand - I think you need to try again or get someone with a degree to fill it in.
Disability benefits especially care allowance should not be touched by the council. Indeed its illegal. Its is awarded to that person to help with thier life needs.
Parent and carers pay for the centres Mon-Fri and we have to pay over £1000 for it. The policy is unfar.
I Find the new policy is unfair becasue we have no other payment that need to be paid for
I write on behalf of my mum. My mum dosent really understand any of this as life at 95 is about telly and getting her hair done. As long as there is some financial support to assist her to live safely and in comfort we are fine with the support at the moment.
What money i have i barley get through I pay for cleaning washing and ironing fridge cooker micr. I pay just under £200 for care for half hour breakfast 15 mins lunch 15 min tea and half an hour for supper and a shower wash up and make bed
I have to day read your questionannaire and cannot make head nor tale of it. My 81 year old father would certainly have been baffled. I suggest in future you send out only the information that is relavent to the individul and in much simpler form. I have written some comments but i am afraid it may be illegible my stress certainly shows in my writing. He pays £43.50 pw at the moment your prpposal suggest he pays either £117.19 or 97.19 depending on what care cost you are willing to deduct from the following. £20 pw care pendant for extra care as and when needed he lives in an exra care facility. £15pw utility section of his rent. £20 pw petrol. Plus i use some of his income to take him out to try give him some pleasure in life. I am not in a position to always cover the cost. The fact that you are proposing such a fiancial life changing change to someone so ill is beyond me.
If care support needs are not included in the base cost of supported living accommodation, then they should be charged for. However as supported living accommodation can benefit from multiple service users living at the same location requiring fewer care staff, the cost should not be as high as for service users not in supported living accommodation.
This is still not clear for myself (the carer) or my daughter, needs a more simple questionaire and clearer policy. X lives at home with her mother she does not have any carers and I do not claim carers allowance. She gets middle DLA no Mobility Allowance and has just received some ESA. She pays £18 on her direct payment.
My father lives in own house and just needs 3 visits per day to ensure he has meals which are already prepared and medication, sometimes 2 carers turn up but this is not necessary. I have spoken to service provider who says it is due to training & transport. I assume he would not be charged for the occassions 2 carers are there.
This explanation is still not very clear and I feel it's intentional on the part of the council to confuse the vulnerable.
I'm confused by this form. My mum receives a high level of care.
We have not had your previous correspondence 'in March', so can't compare. Thank you for asking our opinion, but the local authority, we hope, employs officers well qualified in care, finance and policy issues to take these decisions. If not, why not? As client I, X, find myself stressed and mentally overloaded by such letters/questionaires which are complex to understand (the first one must have been very difficult indeed!) As wife/carer I, X, have a

similar reaction but, because we are supported by the Adult Services Department, feel beholden to reread the letter/questionaire several times to make sense of it and then try to respond. We have already found the care and the dinancial assessment procedure lengthyand unwieldy. We are however very grateful for the support and happy to make a fair contribution. Our only criticism is that our agreed contribution is not simply subtracted f!rom our allowance before payments are made to us. This would make our complex series of bank transfers (and the need to check they have been received) unecessary. Would changing to the standard alternative correct this system?
I don't believe that anyone who requests for help through the Council can afford to pay any additional payments. If this was the case then they would organise care for themselves and not expect any help from resources.
I agree for those who can afford it.
I feel that the examples you have sent are not easy to follow and I am sure the changes are being made purely with the purpose of getting the people who need the care to pay more for it if they have the means to do so, which penalises them for having savings. I realise we are all going through difficult times and we also appreciate the care we get and pay for but as far as I can tell from your examples it seems a lot more complicated if you change to a different assessment policy.
It will cost us more, penalised for working all our lives & saving for a rainy day. Why should people who have a disability be penalised because they need two carers rather than just one when its for everyones benefit in terms of safety. There have been occasions when carers have not been required but there is no way we can cancel them.
If these forms were supposed to be easier to understand I am sorry to say that they are not. None of the examples apply to our situation so it is very difficult to makr a judgement.
I am the carer/siter of X. I get no help from you for this service i provide and i give him a loving safe home i get no care allowance because i have recently lost my husband and get £54.22 widows pension which canncelled out my £62.00 care allowance. X social worker applied for a wage for me to continue this full time FREE support care. This was refused he is allowed to live here with FREE crae and support 24/7 but your willing to pay for anyone else to plunder around markets pictures ect at a price from me for entertainment anda wage of £13 per hour from HFT. Who on earth made these rules is beyond me. I will deffinately use these hours also. I will need to go to work to support myself but at a cost I will NOT be working around X. Will be needing respite if i work i need sleep 7am - 9am will be working times respite needed nightly I would earn appro £85 weekly but your cost could be costing much mor!e but sadly needs must
I think means testing for care would be a good idea
Once again this form is not clear. And the exaples set out within it make no sense to me and my situation. I think the onlyway forward is for you to assess each indivdual case and put the information to us.
The information sent to us is not helpful and i dont understand your questions. Looking at the examples it seems some people will enjoy a reduction in charges but some will see a huge increase in charges esp on elderly people who would rather cancel their services and make do causing worry for their family and friends. A small increase we feel is acceptable but shoud be capped at no more than £?.
putting the charge up by this amount in one go is very severe. I am aware services need to be paid for but not in such a drastic fashion. why didint bradford council adopt thescharge form day one if they are now trying to fall into line with all other locla authorities. it feels a very unjust way to treat disabled people living on benefits through no fault of their own.
I am the authorised of X who is my daughter and has an intellectual disability with a reading and writing age of 5 so her ability to comprehendthe questionnaire or respond is limited. I have nevertheless discussed the content with her in basic terms and she and i have the following comments. Lack of increments over time of direct payments in linewith inflation. X was assessed for direct payment in APril 2012. Her needs have not changed and will not change as her difficlties are long term and evident from birth so a reassessment is not appropriate. Our concern is that there a inomechanism in place for incerements in line with inflation. Therefore

is in real terms the value of the payments and the ability of the package to meet her needs is being undermined over time especially in light of increases in the livin wage which has effected the number of mentoring hours which she can buy. At the same time her contribution have increased. X's personal contribution has been increased in line with increases in DLA. Therefore BMDC is benefiting form a percentage increase in a national award whilst making no corresponding increase in the element they fund. If there is never an increase in the D/P package it cannot continue to meet by daughters needs and her service will break down. I also have a general concern that under the proposals the greatest cuts to service will be to the larest recipient group adults with long term disabilities. The calculation proposal is that income shoud be base lined in line with a national mimimum. Therefore bringing to zero all the benefits which are awarded in recongnition that an individual with a long tern significant disability has greater expenses than the average person. I would welcome feedback to point 1 of our comments as this had been a concern for some time regardless ofthe questionnaire.
This is not easy to understand and follow. If the support required included the need for extra care i think the goverment should pay however if its not essential and the individual has the ability to afford the price of extra care then this should be charged and paid for through the goverment. As the individual obviously needs that support for continuing to deal with therir health needs a rehabilitating to cope with living a developing in the community.
It seems an awfull waste of money sending these out yet again.
As a new comer to your services i dont feel i can comment on your questions As yet i do not know what my charges are. Also i wish to add to your information that in a question i am having frech windows at the back of the house and a raised patio to coinidside with the height surrounding my railings for safety reasons. This is so that i can sit outside for fresh air. There are steps at both outside doors which i cannot manage on my own. The cost will be 7 or 7 thousand.
I oay weekly for my husbands care, you send far too much paperwork for us to understand. My husband has dementia so i do what i can but forms i cant
The examples of the proposed policy are just as confusing to understand
How will you work out a charge based on the 'living costs' of a person living at home? How much do you allow for their contribution to running costs of thier home? The fact the people in supported accomodation do not contribute to 40.5 hours of support and yet a person living at home (with parents) has to contribute! This seems to be the wrong way round - who is costing the council more?
do not understand how this will effect me
The changes just like a way of charging me more for the help i need to live a semi-normal life. I feel like you are punishing me for being disabled. I resent any charge when others get so much free of charge. Any increase in charge to me will mean I have to reduce my service which will put more strain on my husband who works full time. This will be unfair on him. I feel that you rely on him too much now - an unpaid carer - less help from an outside agency will probably mean he has to give up work, this means he will claim benefits thus costing you more in the long run. Just remember you may become disabled one day and may require help.
The layout of the numerous examples is appauling - hardly clear for older people,people with complex disabilities or other vulnerable groups. Its about time BMDC got a real grip on charging. The current system is charging too high, most of the examples for the proposed 'alternative' arr asking those who can least afford to contribute more. Appauling! Go back to the drawing board and try some fresh and fair thinking. The questions asked dont even follow #2 asks of old policy is fair #3 asks if std 'alternative' is easier to understand.
The councils policy needs to change to what people want and service users. YOU are charging extortionate rates for services which should be paid by you.
I have filled this in for my son as he cant. He has during the past 3 months gone into residential care which has been exceedingly taumatic for me his mum, his dad and him himslef. as yet no money from DWP has gone into his account and we are told we need to buy him a bed and the trimmings and supply money for treats. I believe those with learning disabilites should have funds so they can have treats and be able to spend money lavishly to

boost their mood and self esteem. My son has absolutley no concept of finance I do believe that consistency of charges throughout the country is essential.
People who need double ups may be for health and stafety reason of care staff not fair to charge
My mum is 92 and takes her all her time to read so she just passed this to me. I don't understand the dispute or charges across the country.
Maybe care could be means tested.
Do not understand any of the examples. I dont think a person should be penalized for requiring two carers. What about respite care? How does that figure in to this/ What if the young adult is still living with parents are we expected yo pay any shortfalls in covering persons everyday needs eg food coths heating gas eclectric etc? so that the person can afford to pay for care? How much would it cost toprovide 24 hour care for someon? I am sure that it will be much more expensive as parents we provide excellent care but again if care becomes too expensive we will have to struggle unaided puttin everyones health at risk Again last time my daughter was assessed she was told to cut down on her food to pay for home care. She is already under weight are we expected to starve her to pay for someone to bath her!
Not quite sure if having 2 workers you will get good value for money, 2 workers double the amount of work, will we get that!!! Also in supported living taking all allowance would leave the person with no expense.
Everyones circumstances are different but I think everyone needs to be treated fairly and consider their capabilities. Some carers have more to do than others and most carers are not paid e.g people who are pension age caring for someone usually someone disabled or elderly.
I am writing on behalf of my son and wish to say that anyone that needs care due to eill health or disability should pay what they can for that care or just to live a nornal life they can alot of people think that things come free but life does not work like that. When they get benifits to help them they should pay what they need by contribution from there benefits and not let others think what thay save for later in life is giong to be there's when things come to an end of thre 'life' If 2 carers are need they should pay for 2 carers but they shoudl also be given time with them they are caring for not 20 mins slots some people need more time than others.
The DRE is not fairly applied it needs to include travel especially when social services is slashing support social worker need to listen and include these in their care assessements report becasue its not made clear to servie users that by specifying what they use their bulls will be reduced. I.e people say we dont need someone else to come and wash because they do it, it doesnt mean they dont have that expence, travel taxis ect. I think its quite underhanded the way the assessments are being propsed for vulnerable people. The examples for cost are doubled and poorly explained again very poor and underhanded! There is not enough tables set out who attended the consultation 19/7/16 Parents forum meeting a few forms on a table and on one there to explain it was ridiculous It was not a serious consultation. The questions on tables no board maker not clear for people with severe learning disabilites. The May consultation was ignored and repeat paper wo!rk set out again no support for people with LD consultation breaks DDA for disability.
SAvers are penalised. most needy are penalised. Not enough information to answer the questions.
I believe that charges should be the same for all if a loaf costs £1 we all pay a £1 but if you cant afford a loaf you should receive more benefits to pay the same price its very easy to work out.
I dont have a feeling that the standard alternative financial contribution policy would be fairer. There are winners and losers on both sides but i can see that it wold be better to administer. I dont think that a second carer should be charged at the same rate as the first carer. It would be fairer for the second carer to be charged at a cheaper rate eg half or a quarter of the full rate. Although i can see a clear difference between the charges currently made to people living in supported accommadation and those in their own home. I am uncomfortable that those living in support accommadation will suddenly be billed for a lot fo hours.
I would prefer the system to stay as it is I could not afford to pay any more than i currently do.

Its hard enough t live off these amounts of benefits with rent and houses although i live with my family. It is still hard to make ends met sometimes therefore i would not recomend any changes.
For people living in supported living they should by paying a biasic rent and then extra care paid for as required. This is because some people do not require as much help as others often the people in this accommadation are helping out those who cannot help themselves. but this is often misread by jealous and greedy people. And these reviews should often be done at the homes of the disabled people because like my son who i am filling this form out for suffers from autism and finds the way things are very hard to sorce and find out even the basic's
Been a carer is a hard thankless job All the money given goes on the person with special needs. Why oh why do they keep trying to make life even harder for people. If we dont do the care at honme and have carers coming in it would cost the govement a lot more money PLEASE give people a break the job we do as caers with carers should be paid let alone wanting more and more money form poeple.
Disabled people need more help and less paperwork.
Every one should pay these charges and be fair to all
Fiolled out to the best fo my knowledge
At present i am happy with the current policy and strongly disagree with the proposed policy plan
I think the care required is different for every person therefore you cant put a price on any ones care till they have been correctivley assessed this includes personal living and indivual needs.
Dear whoever this may concern I dont know what you lot mean by giving meless as I have got epilesy and slight cebsy palsy I alot of activities and work to do. I also have moved to be inderpent which I am enjoying and I find it disgustreia. I am very concered about my money please can you find a way to make me feel a bit better because I am finding it annoying when i get to Wednesday when I have less to last till Money day which is Saturday and I have to do my rent bills etc. Why is it done so I dont understand? and I cant fill forms in myself, I have found jobs in town that are urgent to report anddo and I have been sent something I cant do or inderstand. If you can make themso I can do them and undertand I get frustated and anoyned when some stupid forms or letter arive that is complcated for when youmean I have got to pay for my carrers to look after me I dont agree with it and asfor TV lience I find reallydisgussing when I have to pay for a new lience a!nd I hate it how it ischanging again why is it alwayschanging everyday oneday I is right the next day somethingelse and so one I also have jobs I do get one job pay for 18 year and enjoying and love it and I am not changingmy shifts forno one not even you lot which notonly anyoying but I have trains buses and other sort of transport to do what do I doif I cant get to my deination I get angray and also seasand durning the Autumn, Winter, spring I only like it Summer and I go out, I find it not fair and not om either. I makes me as if amhaving to find anotherway of doing my things I just cant work out howto do thepolicy, Disability Living allowance. what does it mean when you put eveything like youhave because I like it in order and told how it is beendone and wrote so I alsodont like it what do you think you are? please read and think what you lot have done stop be so anoying.
1. The letter to Service Users, dated 29 June 2016 and entitled 'Reviewing your financial contribution to care services you recive', places a distinct emphasis on 'the aim is to make things easier to understand and that if you move to another part of the country you should not need a new financial assessment or care plan'. With respect, this is a side issue for the vase majority of the service users that this is addressed to, since the main thrust of the exercise is, dependent on which side of the fenceyou sit, either to augment the Council's care services budget or to prop up the Council's finances by extracting money from some of the most vulnerable people in society. 2. The letter referred to in point 1, says that 'we want to make clear that anybody who has limited income will not be asked to contribute financially unless they can reasonably afford to pay', but the method of calculating an individual's 'spare cash' is d!emonstrably unreasonable. The worked examples provided to the consultation meeting on 19 July 2016 contain the statement 'Disability related costs will be considered in the financial assessment where the expenditure is needed to support independentliving and where a service user has little or no choice but to have the expense because of their disability/illness

and that this is written into their care plan.' However the schedule of Disability Related Expenditure (DRE), presented at the same meeting (admittedly prefaced with the word 'examples'), worringly does not include significant items of expenditure that many disabled people have. Using my own relative as an example, in order to support independent living he needs accompanying whenever he leaves his accommodation and this inevitably leads to doubling up on incidental expenses, snacks, entrance charges to entertainment venues, holidays etc. To go shopping or to go for a meal , a ta!xi is often required. I don't see reference to any of these expenses on the DRE list and, unless the Council recognise these additional costs, they can expect challenge on all the assessments issued on the grounds they are discriminatory. The overall perception of whether the assessed contributions are fair will be heavily influenced by the policy adopted as regards DRE. 3. Given that the recognition of DRE is going to be influenced by what is written into care plans, there is an urgent need for updated care plans for every single individual targeted in these proposals, before commencement of the financial assessment. Old and outdated care plans (or care plans with a lack of sufficient detail for assessment purposes) are not a reliable basis for informing the financial assessment. Again, expect challenge if care plans are not fit-for-purpose. 4. The minimum amount that a service user requires in order to live is handled by way of the'Minimum Income Guarantee'. However, the calculation of 'Minimum Income Guarantee' is inconsistent. The worked examples indicate that this minimum income requirement varies according to what benefit the service user is in receipt of. A service user on a state pension of £117.20, Pension Credit of £11.12 and Private Pension of £27.28 is said to need £194.50 per week minimum income, whereas the service users on the two different rates of Employment Support Allowance (ESA) are said to need only £156.31 and £137.31 minimum income respectively and, presumably, those service users on Income Support and Disability Living Allowance will also only be assessed at needing the lower amounts. The Disability Living Allowance is a case in point, it is given for a reason (the clue is in its name) yet the proposed formula recongnises only approximately one-third of it as being required. In summary, it makes !no sense to calculate a service user's minimum needs from variable rates of benefit. It should be a flat, more generous, amount. 5. The worked examples provided to the consultation meeting indicate that the whole of any income calculated as 'excess' will be confiscated. These people are by no means living a life of luxury and the individual should be allowed to retain a part of the 'Excess' (particularly as their income is so low) in order to lead a life somewhere above the breadline. Therefore, having established an 'excess' of income, the Council should take only a part of it, and not confiscate the lot. 6. The Council should establish a cap on the amount it will take from any one service user. 7. Where an increase in financial contribution is agreed, there should be transitional arrangements whereby the increase is phased in over a number of years. There is a precendence for this in the way that Business Rates a!re collected after a rating revaulation. 8. Before the assessor comes to a final judgement on how much the service user must pay as a financial contribution, they should 'sanity-check' the result by establishing how much net income that leaves the individual and whether it is sufficient for them to meet the basic cost sof living. The Council's idea of the basic costs of living need not consist of more than half-a-dozen items, but shoudl be published. To repeat a point made earlier, one cannot establish what it costs an individual to live from a calculation based on what benefits they get. 9. Where an increase in financial contribution is assessed, there should be a period for comment by the service user or their representative and, indeed, an appeal process. 10. In summary, given the subject is so controversial, it is essential that the Council's position is seen to be fair and reasonable under the circumstances. It wi!ll not be sufficient, in the event of legal challenge, to fall back on the excuse that the general methodology is that used by other local authorities.

Why are some people going to be better off?? Surely a raise should be across the board Whatever the council needs to raise share the cost with everyone. Fair!

How can the Council put a charge up 100%in one stage. Is that legal!!

Please don't take double money

X does not think it fair that some people may be better off when you are taking over £40 off her per week.

I think everyone should pay the same amount then it may be fair. Some peoples contribution only go up a bit! The government have already discussed what we need to live on they give us that in benefits!
100% increase in one go!! is that legal.
Q1. Do not know about other areas
X began to get very upset about this so stopped as really could not understand.
I suggest Bradford Council only change people who have means to pay. They already increased Council tax this year. If you have 4 kids & special needs child to look after 24/7. The Council have been closing down facilities for young people with special needs. They should have more inhouse facility to cater for.
Do not understand all the ins & outs
It is not fair that a person who requires two carers should be charged extra. To be highly disabled is a miserable, helpless state to be in, and to charge extra for something they have no control over is adding harshness to injury.
I don't understand sorry.
Whats the point, you probably know already what your going to do.
We are only just able to make the current contributions, any further increases would be extremely difficult for us to meet. I hope our views are taken into consideration.
Charge on capital & savings too high.
The cost of caring for some one at home is not consider - some one who workes for basic wage for 35 hrs a week would earn £252 but as carer - gets £62.10. Unfortunately the harsh reality is the disable persons income is used for extra heating car petrol insurance extra shopping etc. I think minimum charge is better than ---------- people may be driven to poverty by contributing more just because they need more care.
Q1. There should only be change if the policy in the rest of the country is an improvement on the present policy in Bradford. Q2 & Q3. Even though I have a good level of intelligence I have found it difficult to comprehend. Q4. I definitely need two carers. At the moment I am paying the full cost of one carer. I cannot afford to pay for 2 carers. I simply need to know whether my contribution under the new scheme will be the same, more or less. If things change it should only be because there is an improvement, both in service and charges.
The proposal seems to affect anybody with any savings more adversely. Plus it isn't clear how their contribution is calculated. I vehemently diasgree with having to pay for two carers!! Why should somebody who requires two people be penalised financially. Is it their fault they are so incapacitated. My husband is bed ridden and has carers each day to wash & dress him - the lead carer does all the work and the other just stands and does almost nothing until they use a slide sheet to move him up the bed!! On occasion I have been asked to be the double up???
We have savings and we are having to use them to live as I have had to give up work to care for my husband! I would agree to pay half the cost for a second carer. It's as if people expect us to use our savings until we are down to the minimum level and then get subsidised even more by the council - why? Also I do not really understand th epremise of taking into account level of d!isability who makes that decision and how?
People pay enough taxs to this government that they make old peoples life misry by charging the in their old age again.
I live on my own and my bills are high I have commited to pay things and I may not be able to pay them I am very worried.
I do think everyone should contribute but I have to spend more money when I go out as I need a support worker with me. This is not taken into account. I get seven hours per week I now pay £43 - it will go up to £85.69 I think I may say don't bother & let probation support me like before!
For me this would be a 100% increase in one fell swoop. I don't think that its ok to do?
Charge should be fair and not excessive taking into account cost of other expenses an ill person has to pay
We dont know what the other councils charge?
Do not understand what you mean about suppoerted living
Depends if you need 2 carers sometimes 2 carer come and not needed

I dont understand this at all. I havnt got a clue what you are on about at all. I am confussed. You are between a rock and a hard place as no one wants to pay anything! But most reasonable people realise these things have to be funded and those receiving help need to contribute. In these notes and rules there is no mention of a maximum contribution- so someone with severe problems amy use all there savings and capital eg house topay for things. Your examples should have been relating to the person you have written to. Your system has details of care plan so why you cloud the issue for a 92 year old, against an 18 year old is diffucult to understand. Something that is missing from your examples is a description of how saving or capital are dealt with. Question 4 whilst we 'tend to agree' that 2 womens should be charged at a higher rate you may consider that say of a 15 minuits visit 2 carers are needed to help with toileting for half the time only and the second carer can then be free to move off to another client. You may of course already acc!ount for this but we mention it becasue if the overall charges are increasing then the clients contribution is effected more BUT please also consider the care given as that person may feel some clients demands are in need of 2 staff and this is not always only need!

I apologise but i am unable to answer yur questions because i do not full understand them. Your examples do not help me as the circmumstances are no way near mine. If it helps i am finding it hard paying whay we are charged now. If the cost increases i would not be able to pay thank you.

If as client needs more than one carer they should be charged appropiatley.

I have had a lot of problems with my son ripping up his cloths and coming home with dirting cloths when he needs the toilet and he also have said he has headache.

I dont think disabled peoople should pay anything they should find the money elswhere

For someone who lives independantly in their own flat with a private landlord where the flat has been fully adopted to the tenants needs paid for by the landlord. The need to then charge this person for electronically receiving a direc payment that's all you do!!

This questionnaire is still extremely difficult to understand. The examples sent actually make it more confusing. I am sure i am not the only one to think this!. Does everyone understand exactly how much they receive i am sure most of the elderly do not!. I think the whole excercise has been a complete wast of tax payer money. Whilst i understand the council has to make changes whoever compiled this quesionnaire has not put it in term the 'general public' can understand. Please think gain before you waste more money sending out yet another questionnaire!

I dont think that anybody should have to pay for care should be provided by the NHS

The proposed standard contribution policy is hard to understand.

Because of age the people aged 25 to 65 are to be disciminated against for 40 year why? Why does it increase so much for the age group equality!!. The weekly charge is dueto quadrople!! It will not be worht having or keeping a personal budget for us a rise from £92 per month to £342 a month. We already have to provide our transport out of the person benefits this is on top of the charge. How can they lead a full life. People who live in supported accommodation may not be able to afford to contuinue living there with the propsed charges. If they do they will have none of their living income left over to have a life other then basic. How is this person centered or enabling? This is about needs about human beings about a duty to meet care needs which is already subject to massive limitations becasue of budgets. Risk: Vulnerable people will be unable to afford to go out and do choice and life will be limited there is a risk of isolationa social exclusion, access to work and training and voluntearing yet the push to increase independance and enablement. This is not the best way to do it. When the impact of the implementation of the proposals take effect parent/carers will end up picking up the pieces. they have the same rights as the person with disabioities to have work, life, education your proposals will effect their rights!

Disability related costs? that's a bit vague purposefully so i bet a chance to claw back some money no one trust the council

It seems you are discriminating agaisnt severely physically disabled people if you charge for 2 carers. This is a health and saftey ussue also surely it seems morally unjust to charge for 2 carers because of the severity of physical disability means 2 carers are needed.

The examples you give do not cover my son who is 32 years old and living at home with a gentleman wo takes home out for 1 or 2 times a week. We pay £90 per month my son only has his benefits money to live on and all the support we give him free of charge.
I have been a nurse for 23 years dealth with money benefits ect . The information and examples you sent with this questionnaire are hard to understand it is terribly worded and confusing with no glossary examples. It is hard to understand and its not the amount but quality of information that is the problem
Everyone shoudl pay the same people who have saved all their lives are paying the price now. Popkle who have lived recklessly are receiving everything they want
It appears that discable adutls under pension age will pay double. it that really fair? some pensioners paying a lot more and that all the people that have contributed all their lives not really fair
the lack of provding the care is very hard and the support avaiable is disapearing so we feel fear and concerned for the future.
Each case must be looked at on it own merits snd these are regional differences with provision of services including different levels of pay rent ect.
Each case should be looked at on its own merits.
Depands how the care is worked out
I believe the proposed change will mean the most vunerable people will be worse off by having to pay more from their benefits, they already live on minimum income
keep the whole thing simple all i need to know is :- What are we paying now? and what will we pay? after the change
The disabled people need to be looked after so why should they be charged its not their fault if they were normal people i am sure they would pay there way. This people cant work its not that they want work.
I do not fully understand what it all means. It seems to me you intend to want me to pay extra money. I am happy with the help i am receiving at the price i now pay. But i dont feel that it is worth any more money. If that is not the case then perhaps you could spare someone to explain it to me fully
Did not understand
X thinks everyone can pay towards their care. It would be fair it all paid same increase
Mr X doesnt have the capacity to answer any of these questions. He has a learning disability and a degenerating condition this letter was sent to his mother. X now lives at the Gables
X (Carer) feel that the contributions are too much to pay, given her daughter has high needs. contribution bill comes in a lump sum which can be difficult and feel overwhelming to pay. familes should be provided with a different way to pay. Weekly/fortnighlty. Anual billneeds to be brocken down to an easier way to pay. although the contribution is based on service and income it still feels a lot to pay, specially with X being a single parent.
everyone should pay towards care. The council need to think of a fairer way. The impact on the client group could be great in some cases and leas to more support/health needs
It should only be chargd for if people can afford it. The caers who come to see my mum are there 5 mints give her tablets and go that is not a service we desire.
I'm not absolutely sure of the questions regarding my daily help i get from the 'carer' (one) but I have done my best - aged 86 plus (born 23.10.29)
I have committed to go to things and pay for a contract phone could you put it up in stages.
X has just moved and is very busy but he is very worried cos he does not know what his bill will be.
Dont understand the questions.
current system is satisfactory as long as care service provider is satisfactory
did not understand questions
did not understand questions
Dont understand any of this.
Dont understand any of this
Giving examples no good. everyone is different so still confusing. So people pay other on benifits. all that can be said prices will go up

increase should be shared by all
X is worried becuase he does not have £40 a week spare and he will be sad not to go out he says it will make him depressed and lonely
Had no comprehension of what i was saying
My contribution will double in one i think it will be hard
I have lots of expense due to disability. I ware my shoes out quicker cos I walk differently. I stainmy clothes more. i need a support walker to go out with me so I often pay double. I may not be able to go out often may get depressed.
April lives on her own and her heating bills are quite high she does not accumulate money so taking over £60 per week extra will have a massive impact
Did not understand
X says the council need to do this in better way and spread the eaise of contribution evenly
X does think everyone should pay towards their care. She also thinks the increase should have been absorbed by everyone . Why should somme people be better off. When others are alittle but worse off and some people are having to pay double
The service user does not understand
Why have you oicked on the most vulnerable people? I agree everyone needs to pay towards theor care but all same
Did not understand
Share the money you need to raise within adult social service with everyone who gets a service
We struggle as a support provider to get this lady to pay her contribution when i asked her about the charges going up she was verbally abusive
Last time I had an assessment it went to a pannel and they said can I pay for some of the things - activities out of my moeny which I agreed to but now I dont think I will be able to
Did not understand
Examle 1 has 222.96 left to live on Example 3 272.62 left to live on Example 4 14.50 left to live on An adult with LD between 25 & pension age 178.11 To pay bills, food, petrol. car or taxis water rate.Often for two people out in the community cos they cant go unsupported.
X thinks he should have to pay forhis service but thinks everyone should have had the same increase and thinks its not good if some people are better off
Unfair - Price should go up to everyone same
X is unable to understand this document as he has learning disability suported living
This is not very easy to understand without more information please
If the care was better I think the level paid now would be fine. However some carers barely step over the threshold. Never gets bathed etc so therefore too expensive plus leaving just £14,000 doesnt leave much to improve home to stay out of care homes longer. Making a downstairs toilet would use this.
It always seems that cutting down on costs, is the older people are at the top of the list
Want policy to stay as it is as it is fairer clients/service users
Some of the points are very unclear. How can I make a comment on council policy in the rest of the country when there ISNT any specific information. The examples do not make it clear as they are not suitable for ALL circumstances. I had to ring up for clarification. Once the principle of assessing total income and taking account of expenditure was explained, this clarified the postition somewhat. Still a confusing questionnaire. The examples complicate and confuse the reader.
Because people who are justover the total income, end up paying full rent, if they need, glasses, dentist, chiropadist, dont have a mobility car, have to pay for car tax, insurance, so they end up paying more for services as well. You work all your life and are paying for those who didnt and are better off
Not sure I still understand, I think eberyone should get the care they need and deserve but they also need to be able to afford to enjoy life to the best they can, so which policy would allow that? If people need help with day to day care surely it is up to the Government to see everyone get that help without takking all their money. Savings isnt the system we have now enough. The proposed policy is rediculas, people will cancel and there will be a lot more

problems. People should not be penalised for being old or disabled they need the care they deserve at a price they can afford.
When a person reaches the stage pf needing residential care and the persons pension is taken towards the cost of their care often leaves the spouse with insufficient funds to pay for the upkeep of their home. This is particulary so when the woman has not paid a full stamp as in my case and her income is insufficient to pay the bills. This puts an intolerable strain on the person
I generally find the examples different to follow but think that the service users who can not afford to pay should be assessed carefully for their degree of disability and income and also assessed for amount of family support available.
As a parent of a disabled [erson i feel strongly regarding rising costs to them they already have a short straw in life and feel they should be helped more. We discount them already and if charges were increased for them to continue with their activities and holidays it is us who would suffer - both pensioners! The council could make cuts in other areas - not the most needy in society. wake uo, if we are pushed much further we also will need care costing you even more. From an angry parent
My son is unable to fill this form. I suspect there are a lot of people in this situation, I have done it for him, dont know if this is acceptable. My son who is Autistiv lives with me and I recieve no payment for this. 2 overnight stays per month he goes to stay with carers and we contribute to this the rest of the time he lives with me and as i have said I recieve no payment for this so I hope you will not deduct this from hosmoney. If you wish to interview me,or my son please let us know
Who decides if 2 carers are needed? What is the distinction of SLA? Is this sheltered housing? If so my mother is visited once a day by the warden but only Mon-Fri 09.00 - 05.00. There is no other support other then careline. A standard policy is fair if applied consistantly. There are standard parameters for all claims... I'm afraid the examples still dont help without a list of destinctions for all the different benefits regarded to eg what are disability related costs and how are they calculated? I have been a civil servant for 40 years and struggling to understand this - y 88 years old mother is just anxious becasue she doesnt know with is happening will there be an online calculator available? will there be a roght to appeal will the assessed contribution be fully implemented how does this impact on care home fees a council assisted funding
Insufficient information has been provided on which meaningful comments can be made. For example, it is not stated which other councils use the standard alternative. Is Bradford the only council in the country not to use the standard alternative? The basis upon which the charges have been determined under the present system is not explained. There is presumably a rationale for why those rates had previously been set. It is clear that in all but one example the service user pays more and is worse off under the new policy. To dress this up as a means of harmonising these charges so that when a person moves to another authority there is no change, is nothing other than a window dressing exercise to avoid stating that this is about providing the disabled adult with greater costs to maintain themselves, leaving them worse off, but saving the council money. Why does this consultation exercise not say that? Of course people with money should contributeif they can. For example if a person had a significant pension that could be taken into account. But every example you use considers only those on DLA. That is all that is taken into account. These benefits are not significant sums. It is simply unfair to foist greater hardship upon yulnerable people in this way. Ironically, the one example in which the service user is better off is from someone of pension age. So, yet again, those with the triple lock pension assurance are sheltered, in contrast to the young. My son has autism and shall have a lifelong need for residential care and support. We shall not be there forever and shall need to be reassured that he will not live in extreme circumstances in his later years. This is yet another example of the salami slicing which has taken place over the last few years, to impoverish those on limited means and who have special needs. It has been said that a civilised society is measured by how it !treats those who, through no fault of their own, fall at the lower end of the human heap. This is a shameful proposal by that standard.

- Examples provided dont allow for a comparison to be made. eg. Charging for a double up - What savings does the individual have? (I recognise they havent declared so how could you impose?) -Some service users are already paying all their care components. -Vulnerable adults who have severe learning disabilities have no choice but to accept the expence.
I find this very complicated and not at all clear. It seems you are asking me to approve a scheme which you have already decided on, to allow you to charge more on the whole.
Nothing here is totally relevant to my own payments and its unclear whether my charges would be increased or not. As far as people needing 2 carers is concerned, I think cases should be judged individually. We have people in their late 90's here, who need 2 carers in their later years, but may not be able to afford higher charges. Im not sure about such decisions.
Living at home with family and one has to pay all the charges and bills etc. Living in a supported accommodation is cuttently not charged. This is not fair. They use more hours - ie. 40+ hours. I think every person using the service should be charged. This will help the council pay every worker. This will not burden service users that need more workers. I hope this is helpful Thankyou
Unable to complete - did not understand the questions.
Minimum contributions will be appreciated as already we have hardships to meet his livelihood.
1) Cost for 2 carers + charging for care in supported living : - I find it very difficult to comment on other peoples circumstances/proposals which do not, at present, apply to our case. The exammples do not really help, as they do not fit our case. 2) On the face of it, the Standard Contributions Policy sounds a better idea, in that it means service users could move to other parts of the country (eg. if they need to be near relatives, to avoid isolation from family) without the need for continued re-assessment, writing of care plans etc.
Dont really understand the policy.
Why should people who can afford to pay - have to pay for 2 carers when they only need 1?.
I wondered why the care company we employ began sending 2 carers.
Didnt really understand the policy
Under proposed policy those with disability will be at a disadvantage and in a worse position. They would be required to pay more and many could face financial difficulty. This would have an effect on other daily activities, which are already expensive to cover.
Areas should NOT be the same as cost of living is different in north + south - urban + rural.
Current policy is better than the standardised. All these costs, while I agree things like DLA + PIP are there to provide income to pay for services, it still feels like we are penalised for our disabilities. - Example shows a disabled adult under pension age paying double! Doesnt seem fair. - Pensioners should be paying less not more. They have contributed all their working lives and should get credit for that by paying LESS not MORE.
When someone needs care because of e.g. illness, disability or dementia, their needs are assessed and may increase over time. I feel that care is the important factor, not how many people it takes to give that care. A charge for the 'care visit' would be fairer and more appropriate.
I do not agree with what you are proposing. I still do not understand most of it but I think the payments should stay as they are. Most people will have been paying these payments for a long time but they will have gone up each year so thaty should carry on as they are. I have worked jolly hard for any money I have and i have never had any money left for me. I used to go out and find any work to do so its not fair that we have to pay from our savings.
1. How can anyone assess the councils policy to the rest of the country when they dont know what the rest of the countries policy is? 2. The standard policy is not wholly fair in so much as looking after and caring for a person at home twenty four hours a day seven days a week is far less expensive for the council and much more rewarding both socially and mentally for the person concerned. Therefore more support in every way should be given. If more time and energy were put into practical care and creative support instead of wasted time in meetings and unnecessary form filling and paperwork employing surplus staff, everyone needing care would benefit.
I notice that in assessments the figure is £22.73 The amount we pay is £37.18

The amount of benefits does not cover their cost of living costs anyway currently. All the proposed additional costs, especially when a young person turns 25, they face quadrople the contribution costs and will not be able to afford to live. Parents/carers will end up not being able to afford to care for them at home or put them into supported living. Its very difficult for parents/carers to maintain normaility as it is and this proposal should should focus on needs and not the cost. This is making life even more of a difficult fight. The jusmp from 24 to 25 years onld is rediculous. Vulnerable people are being descriminated against because of their age and for 40 years!

(comment was crossed out but may still be useful) It is very unfair that I have to pay for adjustments made to my property to meet my needs due to my wifes income. Her outgoings were not considered and I personally know people living in manchester with the same condition/needs as me, their partners are earning a lot more than my wife but they have had all adjustments without having to contribute anyhting which means my wide will not be able to care for me at home soon. I will have to move to a residential/nursing home where the council would have to pay a maority of my care fee and in the long term this would not be viable for the council.

I disagree with many of your suggestions. Many of us are not paid enough to get enough looking after, or to pay for so much care.

You have not given examples of someone over 25 living with parents/relations in their own home. How is cost of living/expenses worked out? You have not given examples of someone recieving only 1-2hr service per week/fortnight. How will they be assessed? Who will decide how much 1 hour of service will cost?

Impossible to assess as the BMDC annual assessment charge per week show one weekly contribution charge and is not broken down in detail, and cannot be compared with your examples given. The council charges should be clearly set out in detail to see if calculations are correct. Minimum income guarantee needs explaining. For the ordinary person calculations for weekly contributions are difficult to verify without an explanation

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Appendix 6

Changes to Contributions Policy Proposals
Responses from the Consultation meeting May 12th 2016

What do you think about the change to a 'Standard Policy' Does it seem fairer?

People felt that the 25 – pension age group were by far the hardest hit and this was both unfair and discriminatory
The reasons for this was that it is the very time when people spend more creating and furnishing hobbies and interests and creating social networks By hitting this group so hard this would limit their opportunities in life for 40+ years – too late for many

People in the 25 – pension age group will be paying ridiculously more money but their costs over 40 years will be greater than other groups

Many disabled people in this group continue to live with in the family home with their parent as carers (saving health and social care services millions of pounds) but are never entitled to Housing related costs.

Quote from carer 'Bradford should be brave to be different. Portability is of no interest to me - I can't afford to move out of Bradford'

People felt they were already paying more both as services users and carers due to the changes in assessments and the negotiations about encouraging people to provide more themselves – so penalised twice and leaving people with no social life and often the persons carers too

Personal budgets are less and less well funded. We are already paying for services ourselves and will be paying Bradford Council more for the privilege of having a personal budget. It may prove cheaper and easier to give the Council back everything and wait for a crisis to happen.

Some services users do not see the value of services and refuse to pay e.g. someone on the autistic spectrum, acute mental health episodes. Their carers often end up having to foot the bill because

they recognise that with out a service/ support the person health will deteriorate and they will end up picking up the crisis – what else do you do?

It's hard to work it out. There was nothing that went out with the original questionnaire.

"My son lives in supported living. He has no means of increasing his income. It's not fair on him and others like him as people have different/limited opportunities to earn extra income. The change from charging nothing to the new policy is far too much.

The Council should do its best to make people understand.

Why is only the middle rate of DLA/PIP taken into account?

There were lots of misunderstandings with the examples. They need to be clearer.

It's not clear whether and how direct payments are taken into account?

This consultation has reached a relatively small number of people. How are others going to have the opportunity to have their say?

1-1s or 1-2s are very important.

There needs to be a lot more information about who can help.

There needs to be more information given to carers about the contributions policy and the Care Act

This will have a huge impact upon carer's finances> It will squeeze on the disposable income of carers and the guilt that they feel to cover the shortfall so the people they care for retain a decent quality of life.

There are unintended consequences for carers (see previous comment)
Not really sure there is not enough clarity and information. The message does not seem to have been communicated clearly. It is difficult to understand. The questionnaire was not simple, needed

clarity and has to be accessible for all to understand and comprehend.
The examples that were given needed clarity. There was no explanation of how the figures were derived and what they meant in reality. There was confusion on how mobility allowance is used or not used/deducted from the the examples
There seems not standardised way in which a formula can be applied bearing in mind each person's situation will be different.
Would like to get information about how many questionnaires were returned and their analysis
Need clarity in terms of how the policy will be applied. Some people will end up being worse off so it will be a case of who can best provide as much or as little income evidence to get the best deal.

Until the individual financial assessment is done will not be able to say whether fair or not.

Not enough information provided to make a decision.

The policy questionnaire didn't give any examples therefore didn't feel able to make decision one way or another.

Fairer to whom?
Yes – Portability
Yes – simplifying assessment
No – depending on if have to pay more
Just increased Council Tax
What about priority debts
Should be transitional arrangements

The papers sent out did not give much info on the changes.

What do you think about disability related expenditure/ Do you have any concerns?

The examples are all very physically disabled or older people based. It does not in any way illustrate disability related costs for people with LD/ on the autistic spectrum or who access mental health services

If people have had work funded by DFG they have been financially assessed for this too and many people have contributed – so why don't they get some acknowledgement of this under disability related expenditure (Appears as though only if you have paid full cost)

Felt that Social Workers and Community Care officers need more training about what they put in their care plans because this affects what can be classed as disability related expenses by the finance team. Suggestions that Adult services randomly check a selection of support plans and if they reflect peoples real disability related expenditure?

There needs to be examples of costs for people with learning disabilities and for people with autism. All the example relate to physical disabilities.

Question: Please could you clarify how carers allowance for pensioners is worked out (pension credit)?

Main concern is about life opportunities and social interaction. Disabled people are already penalised for using taxis, or extra cost for living i.e. accommodation in supported housing i.e.. for extra heating. It will restrict social outings and will mean people will be isolation because they cannot go out as they wont have money to pay for extra treats,
We need clarity as to how the social housing and supporting accommodation aspect will be applied to people accessing disability related benefits.

Disability related expenditure good thing especially if it is tailored to individual needs not just physical needs

One comment made from a carer was that if she told Adult Services about DRE this could exclude her from service's such as incontinence as not all day centres can deal with this.
Most welcomed this as part of an assessment if it would bring the charges down.
If service users are in receipt of DLA care shouldn't that be good enough for Adults Services to include DRE.
If a social worker can clearly see a hoist or wheelchair and its noted in the service plan is that good enough.

Step lift should be included, specialist equipment if Blind or deaf.
Expenditure on wellbeing/dignity costs if on care plan.
Cost of adaptations.

What do you think about Housing Related costs? Do you have any concerns?

Too limiting and physically related. Doesn't take into account changes in care needs or adaptations for people with LD or autism.

No provision for maintenance of your property if you own it. Rent usually includes property maintenance so discriminatory. (Reading Council now allows money for maintenance in their policy – why can't Bradford?)

There should be a recognised (notional) figure factored in for people paying "board" living at the family home. This needs consider their contribution to family living expenses including utilities costs (which may be a lot more because of the person being supported).

Feel that the expenditure is reasonable and does seem like a fair way in which is will be implemented. All the reasonable factors have been taken into account

Housing related expenditure good thing especially if it is tailored to individual needs not just physical needs

All the group thought this was a good idea and would welcome this change.

Housing maintenance should be included.

Is the non dependant rent of £14.55 classed as housing costs?

Any concerns or issues regarding double ups?
No comments as we ran out of time

Doubling up need to be means tested to ensure that quality and care is appropriate.

What happens if someone cannot pay for 2 carers or requires services of female/male carer?
It does seem that those who are well off will be affected but it need to be clearly communicated and documented as to who it will be applied.

Concern that self funders who the “double up” will affect more are being penalised for double ups when in a lot of cases it is a health and safety issue.

The main concern was that service users might feel discriminated against.
People would cancel trying to make the cost cheaper which could be detrimental to their health.

If for health and safety reasons why should service users pay?

What do you think about charging for care in supported living?
No comments as we ran out of time

Need to know how this will be implicated on people who are not supported through supported accommodation.
Supported living and the bands in which people fall into need to clear and what factors are taken into consideration when applying the policy. It does seem vague as to what is and what can be supported

Think its fair should be charged the same as everyone else

The group thought that everybody should pay.

If don’t use should not pay.

Any concerns around shared Care
No comments as we ran out of time

Need further clarification as to what is shared care ad what doe this mean in terms of how this policy will be applied.
How will individual support needs be met through shared care in cases where the carer is working on rotational basis.

Think its fair should be charged the same as everyone else

OK as will be better off

What information do you think would help people understand the proposals and how can we most effectively get the message out if there are any changes ?
No comments as we ran out of time

Information needs to be distributed through lots of different networks:

- Carers Resource
- Patient Participation Groups
- CCGs/GPs

There needs to be more consultations in different areas at different times of the day.

There needs to be a central database which is used to communicate with service users

Information must be accessible to the individual (SYSTM 1?)

A lady in our group says she can read it but it's far too difficult to understand.

Another lady asks for leaflets to be put in community centres

Need standardised examples and further clarity as to how the figures are derived.
The policy needs to be clear and accessible and easy to read for all
Where can source information be obtained of exact figures that are being applied.

The agreed policy should be sent out to everyone.

Letter advising them of what happens next – timescales etc

Meetings at older peoples forums

Letting advice centres /cab know the new policy.

Group meetings.

Visits day centres.
Speak to 3rd party agencies so they can get the message out.

Talk to each individual – visit – give examples
Use organisations to pass on information
Not enough information to make a decision.

General Comments

More than one person said they were tired and fed up of fighting a cause they never won
This proposal has the driver of the Care Act yet the carers in this case will be bailing out the cared for person because of the huge bills – Care Act legislation gives the same rights to carers as cared for person

If this was a business proposal would you go for it from a personal perspective? Would you be prepared to lose out and get into debt?

The contributions policy is incredible complicated and it's operation particularly when you have a direct payment or personal budget is complicated and not clear. Paper work is confusing and suits the purpose of the system not the services user .

This new policy takes more money from the individual services user and more money from their carers

Learning Disability has not been considered in the examples. It's not easily quantifiable but should at least be considered.

The proposals will leave the most disadvantaged people with learning disabilities and crucially no possibility of generating extra income which would be needed to access any kind of social activity. Where does this fit with the requirements of the Care Act?

Not clear how the contributions currently made to direct payments is dealt with in the context of these additional charges. This will cause huge concern.

"Utilities: People who rely totally on another person to leave the house – either because of a safety issue or disability. This incurs

extra heating/lighting costs. This isn't taken into account. Again further penalising people having genuine additional needs"

"Care Act 2014 supports people to access activities in an equitable way. This proposal does not facilitate this in any way because it means loss of most disposable income for the most disadvantaged in society"

At the moment the increase for people in supported living is according to the "examples" quite extortionate. Could this be done in more manageable stages? - Over a three year period for example? How is this fair otherwise?

Amazing amount of spin! The language used at the introduction sounded very much like decisions have already been made (i.e. "will be etc). This doesn't really seem like a consultation more a job done!

How many consultation groups will be held (apart from this). Answer was this is the only one. How on earth does that help people – especially with communication difficulties to contribute?

Carers cannot always leave the cared for etc.. More sessions at different times needed.

Consultation letter and questionnaire confusing not clear

How are we rolling this out some will be reassessed on new policy before others – not fair.

How long will this take – over what timescale – before everyone is on new policy.

Parents with children receiving service do not want too much extra work i.e. providing evidence needs to be as simple and less painful process as possible.

Unfairness that some supported employment clients have been making a contribution and others not so new policy will be fairer.

Transitional protection on implementation.

How will the decision be communicated after the committee meeting?

What's the date of the committee meeting?
Broadly this table felt that it was a positive change (but will be hard to adjust to?

Need to keep financial assessments up to date – annual reviews do not currently take place.

How to request a new financial assessment if circumstances change.

Need to keep care assessments up to date – annual reviews do not currently take place.

Information needs to be accessible.

Comments about the process

It would have been useful to get the information beforehand

There should have been more face to face consultation sessions with service users and carers. These should have been advertised when the questionnaires went out

It would have been useful to have sent separate questions to carers (many people thought that services users have never shown them the consultation questions)

Information beforehand needs to get to grips with how peoples own personal financial situation and how the proposals affect us

Are insurance costs included on the Direct Payments awarded
It would be helpful if these were clearly itemised?

Comments from written representations received after this meeting

'*One of the drivers of the Care Act 2014 is the portability of care and financial assessments and that this would be better achieved if*

Bradford was to adopt the standard contributions policy that is used by the majority of Local Authorities in England'
Can you please advise/respond to the following?

- On what evidence is 'that this would be better achieved' based on?
- Compared to what other possible alternatives?
- Why have no potential alternatives been suggested/offered
- Is the financial charging formula you propose the same throughout all Local Authorities in England – there are some which state that the charge will be 90% of a person's disposable income. Is this what BMDC is proposing as no indication was given in consultation?

How do you define what is reasonably affordable and what is it compared to? By definition many people with different types of learning disability and autism not only have limited income but the vast majority have never had and never will have the opportunity to gain increased income through employment. They also are at a further disadvantage in that they do not have the same opportunity to create assets.

Regarding the possible 90% of disposable income – The government sets benefit amounts it deems meets the needs of the person. How can the proposal to take such a huge amount of disposable income away from what was previously deemed as necessary be fair??

The lack of information or any indication relating what the likely charges were going to be, made responding in any kind of properly informed way impossible.
The questionnaire as part of a review consultation piece was unfit for purpose and potentially falls outside of Gunnings Principles.

How can service users be asked to give an opinion or form a view when no understandable information i.e. EasyRead or pictures and symbols have been used, or the potential impact explained. Asking Ryan if he agrees to a charge would mean very little to him. Ask him if he would be happy about not being able to go on a simple holiday, remain involved with his disability Rugby , or afford

a meal with family or friends he would be able to answer with a very clear NO!!

At the moment I do not pay any contributions because I live in supported accommodation.

If you change this policy I will start having to make contributions and this will affect my chances to do things such as socialising. As the moment I go out with my friends to sports clubs, this helps to keep me healthy and fit, it also helps me to keep my mind healthy. If I cannot do these things I am worried I will start to feel unwell.

I travel independently through the day, in the evenings I use my money to pay for taxi's so I can go out, if I have to use my money to pay a contribution I will not be able to go out, this means I can only go out in daylight or in the summer.

I am very unhappy about the way this has been handled and wish to request that the closing date 20th May 2016 is extended and the consultation to be carried out again to allow

- The consultation to be widely publicised across the whole district
- Accessible information to be developed
- Recognition of different client groups support needs for small or 1-1 consultation.

Appendix 7

Changes to Contributions Policy Proposals
Responses from the Consultation meeting 19th July 2016

What do you think about the change to a 'Standard Policy' Does it seem fairer?

How do we fair against other Districts? If we compare well then that's a good thing. We should be proud of the fact that Bradford District treats disabled people and their carers well.

No allowance is taken for when I take my son on holiday. He wants to come. I couldn't leave him behind. This would cause a lot of problems but it is seen as luxury/extras which I have to find the funds for.

Disgusting I don't understand the policy.

Not fair, seems sensible but not necessarily fair.

What do you think about disability related expenditure/ Do you have any concerns?

The disability related expenditure example discriminates against people with a learning disability.
Hard to see what might be accepted as eligible disability related expenditure for people with a learning disability.
Disability related expenditure - it needs to be clearer about what it covers.
People who do Care plans need to be know and make sure that Care plans highlight what is accepted Disability Expenditure that will be taken into account during the financial assessment.
.
People felt trapped. They do not feel current care plan does recognise disability related expenditure but afraid to ask for reassessment of Care package because they may loose some support.

More than one person said the Social Worker / person doing the assessment said things like 'you won't be able to get that', 'we are short of money, x wouldn't be considered – you will have to provide yourself'. People find that what they consider to be

disability related expenditure is not included in the care plan because family / carers end up funding it / providing it.

There needs to be more examples of the social aspect/needs in what can be considered as Disability Related Expenditure. One example was of a person who went to a drama club which has really brought them on and their behaviour is a lot better as a consequence (which supports their well being in line with the Care Act and saves money down the line). People doing the assessments need to make sure these are recognised as Disability Related Expenses.

There would be a need for advocacy to help with DRE. Opportunity for Carer organisations to be involved.

Need to take into account expenditure like paying for carers meals.

Assistive technology and assistance for communication and social WI-FI need to be included in the list.

What do you think about Housing Related costs? Do you have any concerns?

Some people pay now who are in Supported Living and some don't.
It costs a lot more to keep people "banged up". This doesn't appear to be understood by the Councils proposed actions.

That seems OK.

Any concerns or issues regarding double ups?

It's not anybody's fault that they need two carers. Why should they be penalised?

Two carers: Does it mean day & night services? Clarity needed.

If charging for two carers does this contravene the Disability Discrimination Act Health and Safety?

Unclear that only if they are paying full cost of care will have to pay for 2 carers.

Is this about having 2 support/carers.
People who live in supported housing with others sharing a single worker – how would that be divided.

The double up issue is very unfair – not their choice that 2 members of staff have to be present.

What do you think about charging for care in supported living?

Does DRE include a psychological and health impact assessment for each person? Due to total lack of ability to engage in “normal” social activities.

Do people at home receive extra benefits for their care?
Confused by this.

Will have a direct impact, people living together will have to spend differently – may not join in when others go out.

Any concerns around shared Care

Not discussed.

What information do you think would help people understand the proposals and how can we most effectively get the message out if there are any changes?

General Comments

100% increase is not fair.
Will an up to date care package be done?
How do people have any sort of quality of life.
This does not meet the well being principles of the care act.
Winterbourne View in waiting!!!
Draconian and brutal.
Total lack of care and understanding about the impact on those with Learning Disabilities.
The wider impact on health and wellbeing has not been considered.

Feels like a waste of time as no proper decision makers are here to know how distressed and angry we all are!!!
What are the other options to make savings by the councils?
Everyone wants a face to face financial assessment not a light touch.
Charge should be proportionate not 100% increase.
DRE needs looking at not enough consideration has properly been given to LD extra costs.
A member of the table said that she has changed her mind about her son going into supported accommodation as there will be no disposable income left.
The life expectancy in Bradford for LD is only 52 how will these changes and the impact help to improve these terrible stats?
This is taking away the opportunities that have been created in communities in recent years – going back to institutional ways
What about carer impact.
We request an open meeting with councillors and decision makers from BMDC prior to overview and scrutiny.
The changes are about saving money – what about the extra costs of Social workers to do new care assessments and other staff to do the new financial assessments?

The Care costs for paid workers has not gone up! Where is the expense – administration?

Why could it not be an increase across the board? Why should there be savings for some and huge increases for others?

I recognise the increasing cost of care and the Council need to balance budgets but this seems an unfair way with some people being better off and other much worse off.

Nearly 100% rise in one swoop for some people. What if people have already committed to other things/ finance etc?
Could there not be a step in amounts (Phased increase)

Feel that taking 100% of people is wrong.

Concerns for self funders who require double up's. When they can no longer pay they will not know how to get reassessed and there will be a big time lapse in getting a new assessment. Also people worried that a reassessment in the current climate will mean less service – people feel they are caught between a rock and a stone.

Generally fell there is a lot of discrimination between people.

Threat to informal Circles of support

Circles of support of those informal links people make as they interact with others. They form a sort of 'free' safety net. Its where people get a bit of support, where people check people are Ok and can alert others if there are concerns, people get advice, people get social contact that makes them feel valued and believe in themselves etc. We all have them to a greater or lesser degree.

People having the opportunity and finance to go out and mix with people in a wide range of circumstances, experience independence and take part in projects etc create circles of support that are not recognised or written down anywhere. However, they form the basis of people maintaining their independence and not relying heavily on services.
If people don't have a realistic expendable income their opportunities to go out and create these circles of support will diminish and will fold and be lost for ever – increasing the cost to Social Care and Health services in the long term.

There was a real worry that when these informal circles of support are lost private organisations that are much more expensive will set up to fill the gap and people will be forced to use them or the Council pay for them.

If people can't afford to go out people become isolated leading to mental and physical health issues and increasing possibilities of undetected hate crime.

Day care services are businesses and are making money. This means we have to pay more.
"My son was under ILF and was re-assessed under DLA. These are two different rates of pay and limit his opportunities."

There are some good examples of joined up EHSC plans of people coming out of King Park School.

If you're lucky enough to be under 25 and in the Education system then you have a chance of joined up assessments. Even when this happens this is still a massive shock for people as the support for

adults is not joined up (e.g compare the information on the Local Offer to the lack of information on Connect Support).

People need to know they are entitled to a Carers Assessment and encouraged to have one. It's still not widely known or people are sceptical about it.

My son's contribution will double: He can't afford that!

If it wasn't for us carers it would cost a lot more!

What happens when the carer is no longer around? Who picks up the cost of care then? It costs a lot less when things are supported in working well.

Care Plans: How often am I entitled to get a re-assessment?

If you phone the finance department the left hand doesn't know what the right hand is doing?

- Better communication is needed across all Council Departments:

- Better understanding of care plans/assessments and the reality of what things cost needs to worked on.

- Independent Living Fund: Some people appear to be paying twice (e.g under ILF assessment and Assessment of Needs).

- Better communication needed (there were examples of people in credit but the council didn't know and were chasing fees already paid which then include interest.

There was a debate around savings:

- Not clear how much can you have in savings?

- Is it fair that people can have savings when some people have none but have to pay the same?

Could increase be averaged out so that eveyone pays a little more rather than some groups having a high increase.

How long before financial assessments take place?

Some service users will need help doing financial assessment.

Still don't feel that they have reached LD service users.

Struggled with examples.

If you are paying more on the old system and your financial is taking a long time will you be paid back the difference?

Not having clear information do not understand how this will affect me.

What will it take for the changes not to take place? Share the cost across the board ie LD elderly. Some clients will be worse off.

The most vulnerable members of society are being penalised.

Concerns that there will be further increases next year and the next and the next….when will it end?

Re examples none included any tariff income.

Comments about the process

Information sent out and used for this meeting is hardly any different from previous and still very difficult to understand.

The majority of the consultation still doesn't reach people with Learning disabilities / difficulties – same paperwork and still too wordy. Therefore consultation techniques discriminate against people with a learning disability.

Examples are too vague of Disability Expenditure.

Will everyone who wants a face to face new financial assessment really get one?
Suppose they want a reassessment of their care plan first because they feel that their disability related expenditure is not evidence in it. How will this work?

How will the changes be implemented?
If you have a new assessment will the new costs be implemented straight away for that individual or will you await until everyone is reassessed – seem unfair if you are the first one picked. As you said it would take up to a year to reassess everyone that last person assessed will be much better off.

Can we share the consultation notes before the deadline for the consultation ends. This will allow us to add any further comments on line if we felt they had been missed.
Can you check that people can send in comments on line – one person thought you could only download the form and write in it then send in by post.

When sending things relating to this out make sure the first sentence in bold and block capitals is **IF YOU DO NOT UNDERSTAND THIS SHOW IT TO YOUR PARENT OR CARER**.

Will this consultation make a difference is a done deal?

Letter received from Mencap

I am writing in relation to the consultation being held around adult social care and the charging policy.

It is imperative that where possible the local authority protects monies for services pertaining to people with a learning disability.

Often services provided or commissioned by the local authority provide not only primary and essential support but also secondary support allowing people with a learning disability to have quality of life and become integrated in the wider community.

Aside from the legalities that the local authority is subject to in relation to support and services provided, there is a moral obligation to work toward equality

I have noted that you are looking to make changes to your charging policy that will significantly impact on the lives of many people with a learning disability.

In an increasingly difficult financial environment for people with a learning disability, I have no qualms in stating that this will severely and adversely impact on many people with a learning disability.

Your proposed changes will further isolate many of the 1670 people with a learning disability that you currently support. This will result in an increase in need and ultimately an increase in cost to the Local authority. I would also question how you can make an informed equality impact assessment when only 495 people have received personal assessments and just 792 people have received a financial assessment in the last 12 months

Within adult social care you will no doubt be aware that each consultation should be transparent, accessible and inclusive of a dual direction dialogue with those affected and their families.

You will also be aware that a full equality impact assessment should be carried out.

Having spoken to a plethora of local charities and local people, it is apparent that your previous attempt at a consultation fell way below par and so I am encouraged you are holding the consultation again. I will point out though that many people are still unaware of your intentions and people, including people with a learning disability, are still very much unaware of the impact of such changes.

Should you choose to implement the changes, and I hope you do not, you should make it very clear to each and every person affected that they can challenge decisions and how to go about this. I would also expect a full and thorough assessment under the care act for ALL of those affected and financial assessments that are a true reflection of need.

Please do take the time to fully consider the impact of the changes that you are proposing.

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Equality Impact Assessment Form – Appendix 8 Reference – 3A1

Department	Adult & Community Services	**Version no**	4.0
Assessed by	Bev Tyson	**Date created**	13/11/2015
Approved by	Bev Tyson	**Date approved**	10/2/16
Updated by		**Date updated**	
Final approval	Lynn Sowray	**Date signed off**	12/2/16

Section 1: What is being assessed?

1.1 Name of proposal to be assessed:

Changes to the Contributions Policy for Adult Social Care

People who are able to reasonably afford it will pay more towards the cost of their non-residential care. Bradford's current policy is generous compared to other authorities and treats people with more income more favourably. No service user would pay more than they can reasonably be expected to afford.

A significant number of service users out of a total of 3,500 would see an increase of between 2p and £116 per week. People with higher levels of income or savings would be most affected.

1.2 Describe the proposal under assessment and what change it would result in if implemented:

Due to the design of Bradford's Contributions Policy, it is generally more generous than the standard alternative contributions policies adopted by the majority of Local Authorities. Service users with more income are more favourably treated under the Bradford Policy, broadly the more income that you have, the more you benefit from the Bradford's approach.

Bradford Council's current Contributions Policy is composed of the following four components:

- a basic charge
- a charge of 33% of middle rate Disability Living Allowance Care Component/ Attendance Allowance and 33% of Severe Disability Premium.
- a charge on income
- a charge on capital and savings

The total is used to calculate the service user's maximum weekly contribution. Calculating the contribution this way adds an extra level of complexity that is difficult to explain to service users

The standard alternative is based on a single component as follows:

- the total income of the service user is determined; from this the Minimum Income Guarantee (their basic income support/pension credit plus 25% buffer) and any housing related costs are deducted.
- an amount for Disability Related Expenditure (DRE) is disregarded. For the figures used in this report we have used a set figure of £10, however some local authorities assess each item of DRE separately.

After the above has been applied for the figures used in this report we have taken 100% of the remaining disposable income into account to calculate the service user's maximum weekly contribution, a lower percentage may be used.

The standard alternative would be simpler to administer. There are currently over 3500 service users across the District and the impact of the charging proposals is likely to have a greater impact on the savings and net disposable income of older people and working age adults that have more income and young people under the age of 25. Young people under the age of 25 in receipt of high rate DLA/PIP would see an increase of up to £20 per week once they are in receipt of benefits as an adult; there are currently approx 226 service users under 25 of these 127 (56%) are in receipt of high rate DLA/PIP. Approximately 400 service users (40%) of working age will see an increase of between 25p and £116 per week and approximately 700 service users (34%) of pension age will see an increase of between 2p and £110 per week. By definition virtually all those people receiving a social care service have a disability. However the proposed changes to the contributions policy have the greatest impact on young people under the age of 25 and those people who have acquired savings or have higher levels of income, and certainly above income support levels. In general people with severe and life limiting disabilities are less likely to be earning or acquiring savings. Approximately 400 service users (40%) of working age will see a decrease of between 13p and £43.70 per week and approximately 450 service users (23%) of pension age will see a decrease of between 8p and £52.49 per week.

If the proposal is agreed, in order to avoid increased charges, some service users may choose to reduce their care packages or purchase their care on the private market, which will benefit the purchased care budget, rather than the income budget.

In addition to the proposal to amend Bradford Contribution Policy to the Standard alternative used by many other Local Authorities, further additional changes are recommended to the existing Policy to ensure that a comprehensive Contributions Policy is in place across the District which captures all services for which a charge could possibly be made.

Shared Lives Full Time Placements

Consideration needs to taken to bring the Shared Lives Full Time Placements under the Contributions Policy. The current payment system is based on the residential charging model which is not applicable and leaves Bradford open to challenge and the possibility of being required to pay compensation.

The Shared Lives Scheme provides up to 37 full time placements for vulnerable adults. Placements are funded by a combination of housing benefit, client contribution and Local Authority top up with the current average cost of placement to the Department being £124.31 per week (excluding HB).

The service users are not currently put through the financial assessment arrangements but are left with a personal allowance of £72.50 per week. Under the fairer charging model the service users would be left with a personal allowance of between £91.38 and £176.38 depending on their income.

Shared Lives Short Breaks

Currently the charge for Shared Lives short breaks is £8.97 per night which is less than the current charge for short breaks in Learning Disability Services of £11.35 the proposal is to bring shared lives in line with Learning Disability Services.

Charging for cost of service – Double Up's

Under Bradford's current Policy, the cost for care visits which require two workers to be present at the same time are calculated on the time taken for the visit rather than the actual cost of the service. The Care Act 2014 determines that the actual cost of the service has to be used for calculating the Care Account and therefore the actual cost of the service should be used for the calculating the contribution. If implemented, this change will only affect those service users who have been financially assessed as contributing the full cost of their care i.e. self funders.

There are 417 service users that have two workers present. Of these 70 pay the full cost of service and 67 have chosen to pay the full cost of their care and not disclosed their financial circumstances. Their contributions would double with the increase in costs being between £13.75 and £409.06 per week.

Charging for care provided in Supported Living

Supported Living is not currently an assessed charge under the existing Contributions Policy. There are currently 221 service users in Supported Living care settings who receive 24/7 support in their Supported Living accommodation. 151 of those service users currently receive other services that do come under the Contributions Policy for which they are assessed as being able to make a contribution towards and are charged. The remaining 70 do not receive any other services and therefore do not make a contribution towards the cost of their care.

If the Supported Living service was to be considered under the Contributions Policy the 151 already being charged will not see an increase in their charge because they are already paying the maximum they can afford to pay. However, if the remaining 70 are assessed as being able to afford the minimum contribution of £22.73.

Section 2: What the impact of the proposal is likely to be

The Equality Act 2010 requires the Council to have due regard to the need to-

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

2.1 Will this proposal advance equality of opportunity for people who share a protected characteristic and/or foster good relations between people who share a protected characteristic and those that do not? If yes, please explain further.

No

2.2 Will this proposal have a positive impact and help to eliminate discrimination and harassment against, or the victimisation of people who share a protected characteristic? If yes, please explain further.

No

2.3 Will this proposal potentially have a negative or disproportionate impact on people who share a protected characteristic? If yes, please explain further.

This proposal is likely to have a disproportionate impact on older people and working age adults with disabilities who have more income and young people under the age of 25 in receipt of high rate Disability Living Allowance/Personal Independence Payment.

There are currently over 3500 service users across the District and the impact of the charging proposals is likely to have a greater impact on the savings and net disposable income of older people and working age adults that have more income and young people under the age of 25. Young people under the age of 25 in receipt of high rate DLA/PIP would see an increase of up to £20 per week once they are in receipt of benefits as an adult; there are currently approx 226 service users under 25 of these 127 (56%) are in receipt of high rate DLA/PIP. Approximately 400 service users (40%) of working age will see an increase of between 25p and £116 per week and approximately 700 service users (34%) of pension age will see an increase of between 2p and £110 per week. By definition virtually all those people receiving a social care service have a disability. However the proposed changes to the contributions policy have the greatest impact on young people under the age of 25 and those people who have acquired savings or have higher levels of income, and certainly above income support levels. In general people with severe and life limiting disabilities are less likely to be earning or acquiring savings. Approximately 400 service users (40%) of working age will see a decrease of between 13p and £43.70 per week and approximately 450 service users (23%) of pension age will see a decrease of between 8p and £52.49 per week.

The Shared Lives Scheme provides up to 37. Under the proposals the service users would be left with a personal allowance of between £91.38 and £176.38 depending on their income as apposed to £72.50 currently.

Charging for double up's, there are 417 service users that have two workers present. Of these 70 pay the full cost of service and 67 have chosen to pay the full cost of their care and not disclosed their financial circumstances. Their contributions would double with the increase in costs being between £13.75 and £409.06 per week.

Charging for supported living, there are currently 221 service users in Supported Living.

If the Supported Living service was to be considered under the Contributions Policy the 151 already being charged will not see an increase in their charge because they are already paying the maximum they can afford to pay. However if the remaining 70 are assessed as being able to afford to contribute they will have to start to make a contribution. This amount will depend on their income.

2.4 Please indicate the level of negative impact on each of the protected characteristics?

(Please indicate high (H), medium (M), low (L), no effect (N) for each)

Protected Characteristics:	Impact
Age	H
Disability	H
Gender reassignment	N
Race	L
Religion/Belief	N
Pregnancy and maternity	N
Sexual Orientation	N
Sex	M
Marriage and civil partnership	N
Additional consideration:	
Low income/low wage	M

2.5 How could the disproportionate negative impacts be mitigated or eliminated?

The current Contributions Policy ensures that no individual service user, especially those with limited income, contributes more than they can reasonably afford to pay. That principle will not change under this proposal and all existing service users will have a new financial assessment with help to maximise benefits. There is also an appeals process if the service user cannot afford any newly assessed contribution

Section 3: What evidence you have used?

3.1 What evidence do you hold to back up this assessment?

A snapshot was taken of existing service users and the above proposals were implemented against the information we held.

3.2 Do you need further evidence?

A new financial assessment would be needed for all existing service users to ensure that we had the correct financial information on which to base the new contribution.

Section 4: Consultation Feedback

4.1 Results from any previous consultations

None Done

4.2 Your departmental feedback

N/A

4.3 Feedback from current consultation

Concern was expressed that the change in policy will have a disproportionate impact on low income groups.

It was also suggested that the process needs to be reviewed to ensure its fair for all service users e.g. not everyone who gets benefits gets everything for free and those with small savings have to pay.

4.4 Your departmental response to this feedback – include any changes made to the proposal as a result of the feedback

When people are financially assessed their outgoings including home maintenance are taken into account. People can also appeal against a decision if they feel they cannot afford to pay.

The basis of the proposal is that people are assessed in line with most other local authorities and based on people's assessed ability to pay. The current policy has a system of appeal in place and this will also continue to be the case.

The intention and practice continues to be the equitable application of all Council policies

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Report of the Public Health Director to the meeting of the Health & Social Care Overview & Scrutiny Committee to be held on 8th September 2016

Subject: 0-5 Health Visiting and Family Nurse Partnership Service Review

Summary statement:

This report briefs Health & Social Care Overview & Scrutiny Committee Members and strategic partners on the review of 0-5 Health Visiting (HV) and Family Nurse Partnership (FNP) Services and sets out the proposals for a new model which supports and contributes to the Councils vision *'For every one of our children to have the best possible start in life*' through the commissioning and delivery of an evidence based service which considers the needs of our local communities.

The review for both services has been informed by key national and local policy and strategy, the needs of young children aged 0-5 years as well as consultation and engagement with key stakeholders including strategic leads from within the Council, service users, Primary Care, Clinical Commissioning Groups, NHS, Voluntary and Community sector and other partners. This report highlights the key findings from the review, details the draft service model and requests approval from the Overview & Scrutiny Committee to proceed with commissioning a new service model which is fit for purpose and based on these recommendations.

Anita Parkin
Director of Public Health

Portfolio: Health and Wellbeing
Cllr Val Slater

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Health and Social Care

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1. SUMMARY

The purpose of this briefing note is to update and inform Overview & Scrutiny Committee members of the 0-5 Health Visiting (HV) and Family Nurse Partnership (FNP) Service Review, so members can consider the Business Case (Appendix 1) for a new service model based on the high level service principals, consultation and key recommendations.

2. BACKGROUND

2.1 Contract for Health Visiting and FNP services transferred to the Local Authority from NHS England on 1 October 2015 and is one of the largest funded contracts (10.6m) managed within Public Health and delivered by a Local NHS provider.

2.2 The transfer of commissioning responsibilities provided opportunity to review the current HV and FNP Service and identify if and how the current service model meets current and emerging need.

2.3 Currently the service is based on nationally defined mandated services, with some additional KPIs been agreed locally.

2.4 The review has informed the development of a report with key findings and recommendations with various options, and a Business case report is now developed

2.5 A detailed report of appendices to the Business case is available including a full consultation document for both the HV and FNP services.

2.6 The purpose of the review is to inform and identify how the current Health Visiting (HV) and Family Nurse Partnership (FNP) fits within the 'Journey to Excellence' and 'New Deal' (specifically Good schools and a great start for all our children and Better Health Better Lives) programmes, the Integrated Early Years Strategy for children 0-7 years and to highlight opportunities for service improvement, with recommendations for approval. The review also recognised the importance of other parallel changes in health and social care, such as new models of accountable care and the district's emerging Sustainability and Transformation plan (STP) which is part of the local 'Five Year Forward View'.

3. OTHER CONSIDERATIONS

The detailed Business Report is outlined in **Appendix 1**. National and local evidence, guidance and policy were used to inform the Review alongside the current health and wellbeing needs of children aged 0 -5 years, see **Appendix 2** for full details. A full and detailed report from the Consultation can be found in **Appendix 3.** As part of the consultation, views were sought from a range of stakeholders and whilst many of the findings were positive, key themes and issues emerging from the findings included:

3.1 Findings from Health Visiting Consultation

a) *Concerns regarding Access:* Such as contact to the health visitor and particularly in relation to the Single point of access (Hub), equity of access, and location.
b) Peoples experience of the service: insufficient quality and support, continuity of care and confidentiality and privacy both in home visits and community/GP venues.
c) *Organisational concerns*: concerns about whether current IT systems will support integrated working and data sharing between HVs and all of the other organisations involved in delivering services to children aged 0-5 years; The current "flat" structures of HV teams, and the consequent lack of leadership; alignment of HV teams; better integration with other services;
d) *Needs:* particular attention needs to be paid to the availability and quality of interpretation services and how these services are used in practice. There is acknowledgement of the prevailing economic environment of austerity across all services amongst participants.

3.2 Findings from Family Nurse Partnership Consultation

a) *Access:* The FNP service is seen as providing very good support for a very small number of mothers and children. The Family Nurse is accessible and fits around the needs of the

family; provides continuity of care" and "robust support from very early on in pregnancy until (the) child is 2"

b) *People's experience of the service:* Knowledge and understanding the role of the HV is poor amongst clients of the FNP.

c) *Organisational concerns:* Concerns were expressed about whether the FNP service will continue in Bradford due to funding restrictions, organisational changes and the negative findings of the recent Randomised Control Trial participants were also concerned about losing the FNP service, or it becoming 'watered down',

d) *Opportunities for the future***:** Participants expressed concern about the results of the national research evaluation of FNP services, which showed no significant improvement in some short term outcomes for participants.

3.3 Public Health has worked closely with the NHS Provider throughout the Review period including working with Senior leads within the Children's Directorate of the NHS Provider; both in terms of the Review itself but also in terms of improvements in the current service provision, this is acknowledged as being very positive.

4. FINANCIAL & RESOURCE APPRAISAL

The current service transferred from NHSE with a part year budget and Contract value £6,020,319 for 2015/16. The contract value for 2016/17 is £10,692,530.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The identification of new and increasing risks is managed via an on-going risks and Issues Log.

6. LEGAL APPRAISAL

The commissioning of the HV and FNP Service will be conducted in accordance with the Council's Contract Standing Orders, and National and European procurement regulations.

In the event of this contract for services (once developed) being awarded to persons other than those currently providing all or part of the services then the "Transfer of Undertakings (Protection of Employment) Regulations 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 (TUPE), may apply to protect the rights of staff currently assigned to provide these services. This employment protection framework does not affect the Council directly. The application and impact of TUPE is a matter for any new Provider to resolve with the existing service Provider. The Council's material interest in such circumstances is that the transfer is managed effectively and in a way that poses no threat to service provision or service quality. Further as staff are entitled to participate in a public sector pension scheme, then the Council will need to ensure that those pension rights are protected on transfer, in accordance with the provisions of "Fair Deal for staff pensions: staff transfer from central government"(October 2013).

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

An Equality Impact Assessment (EIA) has been completed and there are no Equality Issues to Report. The EIA can be found in Appendix 2 to this Report.

7.2 SUSTAINABILITY IMPLICATIONS

None reported

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None reported

7.4 COMMUNITY SAFETY IMPLICATIONS

None reported

7.5 HUMAN RIGHTS ACT
There are no human rights implications to report.

7.6 TRADE UNION
Not required at this time.

7.7 WARD IMPLICATIONS
None reported

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS
Not Required

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

A number of high level principles have been developed from the priorities identified through the Review. These form the basis of the proposed Service Model and include recommendations as follows for both Health Visiting and FNP:

9.1 Proposed new Health Visiting Service Model

1. Effective leadership, coordination and delivery of the Healthy child programme as highlighted in the 4-5-6 model, including the five mandated health checks, 6 high impact areas and both universal and targeted services.
2. Delivery of evidence based outcome focused interventions to improve health and wellbeing and reduce inequalities by focusing on needs of young children including vulnerable groups.
3. Effective teams and partnerships, working across professions and organisations; using evidence based interventions and the development and implementation of appropriate pathways to support families with prevention and early intervention.
4. Improved access to health visiting services through a geographically aligned model with clear alignment to children's centre clusters as well as recognising the importance of robust links to GPs and Primary care and Voluntary and community Sector organisations and groups.
5. Improved communication and resources according to community needs, ensuring more "visibility" of health visitors and information and resources in appropriate languages.
6. Workforce capacity and development to ensure diverse needs of communities are represented but also appropriate training to ensure a competent workforce and relevant skill mix providing consistency in messages.
7. Targeted work with vulnerable Families and children with specific needs, and to ensure appropriate structures in place so families of children age 0-5 and mothers do not miss out on vital health checks.
8. Service delivery to incorporate 'Journey to Excellence' with 'Early Help' and 'Signs of Safety' as well as the Integrated Early Years Strategy for children aged 0-7 years.
9. A caseloads model to be developed and delivered according to need and priority.
10. Nurse prescribing to include advice and support in managing minor illness and reducing hospital admissions, as well as providing level 1 contraceptive advice.
11. Ensure robust transition to Early Years services and schools, and close working with the School Nursing service and Early Years services.

9.2 Proposed new Family Nurse Partnership model

Whilst evidence from the consultation and findings from the FNP have provided excellent feedback from service users and key stakeholders, this has not correlated with national

evidence from the literature review and in particular the recent publication of the Randomised Control Trial (RCT), and the following recommendations are therefore proposed:

1. Develop of a new model of FNP (FNP ADAPT) which is fit for purpose and developed with locally defined outcomes.
2. Embed the learning from the FNP into the proposed health visiting service, focusing on child development and a smoother transition from FNP to health visiting services.
3. Work in partnership with Better Start Bradford to develop and pilot a model which is based on local need and supported by the National FNP Team.
4. Ensure robust performance and monitoring processes in place which can compare outcomes from Health visiting to FNP.
5. Review and inclusion of long term outcomes and wider determinants, such as educational achievement, with attached measures to be monitored as part of FNP.

An integral strand of the delivery model will be flexibility, so the Health Visiting Service can meet changing need, demand, and strategic/policy changes.

9 RECOMMENDATIONS

The Overview & Scrutiny Committee considers the Business Case for the Health Visiting (HV) and Family Nurse Partnership (FNP) and:

10.1 Provide any feedback and/or raise any queries or comments for clarity.

10.2 Support Public Health to proceed with the development of the proposed service model and service specification/s, based on the high level service principles, and to procure the service through a competitive tender process. The length of the contract and the procurement approach and timescales will be agreed with the BMDC Commercial Team.

11. APPENDICES

Appendix 1: **Business Case for the Health Visiting and Family Nurse Partnership Review**
Appendix 2: **Full Appendices Document**
Appendix 3: **Consultation Report**

12. BACKGROUND DOCUMENTS

- Best Start in Life and Beyond, PHE, Jan 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493617/Service_specification_0_to_19_CG1_19Jan2016.pdf
- Council Contract Standing Orders, Dec 2015 http://intranet.bradford.gov.uk/working-day/accountancy-and-financial-advice/financial-regulations-and-contract-standing-orders
- Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing, DH, March 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Healthpdf
- Integrated Early Years Strategy, BMDC, 2015-18 https://www.bradford.gov.uk/NR/rdonlyres/4F168FB7-3239-496A-9029-F96B32556BD6/0/W32253IntegratedEarlyYearsStrategy.pdf
- Public Contracts Directive, 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472985/A_Brief_Guide_to_the_EU_Public_Contract_Directive_2014_-_Oct_2015__1_.pdf
- Public Procurement, The Public Contracts Regulations, 2015 http://www.legislation.gov.uk/uksi/2015/102/contents/made

- Joint Health and Wellbeing Strategy
  http://www.cnet.org.uk/_library/downloads/W27843_Health_and_Wellbeing_Strategy_Plain_English_Ver.pdf
- Bradford Health Inequalities Action Plan 2013 - 2017
  https://jsna.bradford.gov.uk/documents/home/Bradford%20and%20Airedale%20Health%20Inequalities%20Action%20Plan%202013.pdf
- Children and Young People's Plan 2014-16
  http://www.bradford.gov.uk/bmdc/health_well-being_and_care/child_care/young_peoples_plan

City of Bradford Metropolitan District Council

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Business Case for the Review of Health Visiting and Family Nurse Partnership Service for Children age 0-5

CONTENTS:

1. INTRODUCTION

This is the Business Plan for the review of Health Visiting and Family Nurse Partnership (FNP) service for children age 0-5 and sets out the proposals for a new model which supports and contributes to the Councils vision 'For every one of our children to have the best possible start in life' through the commissioning and delivery of an evidence based service which considers the needs of our local communities. The Plan initially sets out the background for the Health Visiting and FNP Service and its purpose, examining literature, strategic policy context, needs of young people and informs the service model. It then proceeds to outline the key findings from the service review, detailing the proposed model which will be discussed with the various local Commissioning and Children's Boards and require approval from the Council Executive.

1.1 Purpose

The purpose of the report is to:

1.1.1 To brief Members and Strategic Partners on the Councils review of the Health Visiting and Family Nurse Partnership (FNP) service.

1.1.2 To highlight key findings from the review, detail the draft service model in order to gain approval from the Council Executive to proceed with re-commissioning or re-design of the Health Visiting and FNP Service.

1.1.3 To identify any proposals affecting the local Clinical Commissioning Groups (CCGs) and Children's Services which will be taken for discussion through the Bradford Health and Care Commissioners Group (BHCC) and the Children's and Maternity Transformation and Integration Group (TIG).

2. BACKGROUND INFORMATION

2.1 Aim of the review

The transfer of commissioning responsibilities to the Council has provided an opportunity to review the Health Visiting Service and Family Nurse Partnership service including:

1.1.1 Review current guidance, policy and good practice to inform/identify a set of standards of which to review the current service and service model

1.1.2 Analyse the current and emerging health and wellbeing needs of parents and the 0-5 (years) population within the Bradford District

1.1.3 Engage with key stakeholders; Parents, GPs, Early Years etc.

1.1.4 Develop a model that meets current and emerging need, demonstrating quality and value for money.

1.1.5 Integrating with current early years services for young children.

1.1.6 To review current national and local policy, guidance and strategy relating to children age 0-5 and the transfer of Public Health into the Council, I order to improve the health and wellbeing outcomes for children and young people and their families.

2.2 Commissioning Health visiting and Family Nurse Partnership services

2.2.1 From 1 October 2015 public health commissioning responsibilities for children aged 0 to 5 transferred from NHS England to local authorities. This will mark the final part of the much larger transfer of public health functions to local government which took place on 1 April 2013 under the Health and Social Care Act 2012.

2.2.2 NHS England Area Team put in place a single contract for the full-year of 2015/16, with a deed of novation.

2.2.3 Health visiting and family nurses partnership are now commissioned by the Bradford Metropolitan District Council and is one of the largest funded contracts managed within Public Health, currently delivered by Bradford District Care NHS Foundation Trust (BDCFT).

2.2.4 The current contract is based on national KPIs with some local variations agreed prior to transition, and is based on "resident populations". A joint statement on resident populations has been agreed for West Yorkshire to ensure providers had protocols in place to ensure no child or family is left without a Health Visitor, both during the transition of 0-5 PH Commissioning and following the transfer of commissioning into local authorities.

2.2.5 The transfer of commissioning responsibilities to Public Health has provided opportunity to review the Health Visiting Service and Family Nurse Partnership (FNP) service with the overall aim to improve health and wellbeing outcomes for babies, children and their families.

2.3 Strategic National context

Detailed information on key national policy drivers can be found in *Appendix 2*. Health visitors lead delivery of a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity. It is underpinned by an up-to-date evidence base and national standards as highlighted in section 3, 5 and 5 in *Appendix 2*.

2.3.1 The Department of Health, alongside its partners, has produced 6 documents to support local authorities and other stakeholders through the transition. The documents identify 6 areas where health visitors have the most impact on children aged 0 to 5's health and wellbeing. Local authorities should use this information to ensure that health visiting services are commissioned effectively.

2.3.2 Best start in life and beyond: Improving public health outcomes for children, young people and families – Published in January 2016, this Guidance forms a suite of support guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and co-ordinate delivery of public health for children aged 0-19. This includes the 4-5-6 service model described in 'Best start in life and beyond':

- **Four** progressive tiers of health visiting practice – building community capacity; the universal elements of the Healthy Child Programme; targeted interventions to meet identified need, and partnership working to meet complex needs
- **Five** universal Healthy Child pathway (HCP) checks and reviews in line with the proposed mandate of local authority commissioning of the five universal checks and reviews. A significant addition to the performance report is the percentage of children who receive a six to eight week review.
- **Six** high impact areas – maternal mental health, transition to parenthood, breastfeeding, healthy weight, child development and managing minor illness/ accident prevention

2.3.3 Professor Sir Michael Marmot's review of health inequalities gives priority to action in the early years. Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood.

2.3.4 NHS England has published a national core health visiting service specification for 2015-16. The refreshed specification has a strengthened focus on the role of health visitors as leaders for improving health and wellbeing outcomes for young children and their families

2.3.5 Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims "to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest." (Healthy Lives, 2012)

2.3.6 The Health Visitor Implementation Plan 2011-15 published in February 2011 set out the full range of services that families would expect from health visitors and their teams as part of the rejuvenated and transformed health service. The Plan sets out a call to action to expand and strengthen health visiting services (2011-15)

2.3.7 One of the Department of Health (DH) key policy drivers is to give all children a healthy start in life. *The healthy child programme: pregnancy and the first 5 years of life* sets out plans for a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

2.3.8 Health Visiting services lead and deliver the *Healthy Child Programme* (HCP), which is designed to offer a core, evidence based programme of support, starting in pregnancy, through the early weeks of life and throughout childhood.

2.3.9 Frank Field's review (2010) of child poverty emphasises the importance of improving parenting and children's early development as a means of ending the inter-generational transmission of child poverty. He points to the impact that high-quality early education for two year olds can have on later life chances, noting that known vocabulary at age five is the best predictor of whether children are able to escape poverty in later life.

2.3.10 Developments will also take account of Dame Claire Tickell's Review of the Early Years Foundation Stage and Professor Eileen Munro's Review of Child Protection.

2.3.11 Graham Allen's first report sets out his vision for system reform and recommends "early intervention" places, a greater reliance on evidence-based programmes, and an early intervention foundation. Supporting Families in the Foundation Years is a joint publication between DfE and DH, recognising that, as Graham Allen says, coherent integrated services are essential.

2.3.12 Local authorities have statutory duties under the Childcare Act 2006 to secure sufficient provision of children's centres to meet local need, as far as is reasonably practicable. Every child's centre should have access to a named health visitor.

2.4 Local Policy Context

Detailed information on key local policy drivers can be found in *Appendix 3*. In addition to key themes raised in the national policy context, a review of local policy and planning emphasises the importance of working collaboratively with key partners to improve services and get better value for money. Focussing on delivery of interventions to improve health and wellbeing and reduce health inequalities in children and young people include:

2.4.1 New Deal for Council - Good Start in Life and Good schools for all children

2.4.2 Health and Well Being Strategy & Health Inequalities Action Plan 2015-2018 - Infant mortality, Oral health, Obesity, Parenting & early years, children SEN and disabilities and Child poverty

2.4.3 Children & Young People's Strategic Plan 2014-16

2.4.4 Key Strategic Outcomes for Integrated Early Years Strategy (0-7 years) Bradford district 2015-2018 - Infant mortality, Oral health, Obesity and School readiness (Good level of development), Year 1 Phonics and KS1 phonics Year 2 reading, writing and maths

2.4.5 Better Start Bradford –improved outcomes for pregnant women and young children aged 0-3 years - School readiness, obesity and other key outcomes. HV services and FNP are an important part of the Better Start Bradford, £49 million Big Lottery Programme targeting pregnant women and children age 0-3 via 22 evidence based projects to improve outcomes

2.4.6 Integrated Care Pathway (ICP) in 2014 incorporating health visitors, midwifery and children services for children age 0-5 is key

2.4.7 Children Centres : Health visiting services are an important in relation to the Children centre (CC) services and CC Review –both services have similar focus and targets and effective integrated working is key for the future

2.4.8 Five Year Forward Plan for Bradford Airedale and Craven & 3 CCG Plans - Improved Maternal and Child Health

2.5 Demographics of Children 0-5 years

Bradford District is one of the most deprived local authority in the whole of England, ranking 19th in the 2015 indices of multiple deprivation (IMD) and 2nd most deprived in the Yorkshire and Humber region (after the City of Kingston upon Hull). This compares to the ranking of 26th for IMD 2010. Bradford's position relative to other English districts has worsened by 7 places.

The number and proportion of the district's total population aged under 19 years is increasing. This presents the District with a growing challenge as over the last decade there has been an increase of over 20% in 0-4 year olds. Detailed information can be found in *Appendix 4*

Age Groups	2014
0-4yrs	41,018
5-9yrs	40,036
10-14yrs	36,145
15-19yrs	35,393

Source: Mid-2014 Population Estimates, ONS

- There are 49,270 children aged 0-5 in Bradford District this equates to 9% of the total population (Mid 2014 population estimates, ONS.)
- The sub national population projections suggest that the 0-5 population is due to increase by 10% by 2021.
- A third (33.1%) of all births in Bradford are to mothers born outside the UK, higher than the average for England (27.3%).

2.6 Health and wellbeing needs of young children

Bradford has significant inequalities compared to both regionally and nationally, with local variations where some areas within the District are worst than others. These are highlighted below and further information is available in *Appendix 5.*

2.6.1 Infant mortality: The latest figures show the infant mortality rate in Bradford was 5.9 per 1,000 live births in 2011-13 but still higher than regionally or nationally.

- In 2013 there were 8,039 live births in Bradford district compared with 8,322 live births in 2012 (a decrease of 3.4%)

- The birth rate fell from 15.9 live births per 1,000 population in 2012 to 15.3 live births per 1,000 population in 2013 despite the birth rate having decreased over the last few years the rate still remains higher than the average for both England and Yorkshire and the Humber.
- The sub national population projections suggest that the 0-5 population is due to increase by 10% by 2021.

2.6.2 Obesity: Obesity rates are higher than regionally or nationally. Health Visitors have an important role in relation to a healthy start from birth to five where diet and weaning advice is crucial.

2.6.3 Oral Health: Tooth decay in 5 year olds is measured as the average number of decayed, missing or filled teeth (dmft).The latest dmft rate in Bradford is 1.98 in 2011/12; higher than nationally or regionally dmft is significantly higher in wards such as Toller, Bradford Moor and Little Horton. Oral health has been included as an important part of the health visiting service where a universal service is provided to all children with information.

2.6.4 Emergency admissions for unintentional injuries (2012/13):
Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at Accident & Emergency departments and hospitalisation amongst the under 5s. Managing minor illnesses and reducing accidents is identified as one of the six high impact areas for children age 0-5, and an important part of the early intervention and prevention role health visitors can promote.

Out of 496 emergency admissions for children age 0-4 for unintentional injuries, the following include the top five areas:

Unintentional injuries (2012/13) for children age 0-4	**%**
1. Open wound of head	25.0%
2. Open wound of wrist and hand	14.1%
3. Other and unspecified injuries of head	9.5%
4. Superficial injury of head	7.9%
5. Fracture of forearm	7.2%
Total	**63.7%**

2.6.5 School readiness: Below average 'Good levels of development' aged 5 years in Reception year (Early Years Foundation Profile) –also known as 'school readiness' -compared to nationally 62% Bradford versus 66% for England, and worse in more deprived areas.

3. CURRENT HEALTH VISITING & FAMILY NURSE PARTNERSHIP SERVICE

Detailed information on the health visiting service can be found in *Appendix 6* and detailed background to the Family Nurse Partnership can be found in *Appendix 9.* The health visiting contract including Family Nurse Partnership (FNP) is one of the largest contracts managed by Public health and delivered by the Bradford District Care Foundation NHS Trust, commissioned as detailed in 2.2 above.

3.1 Current Level of service

Universal services ensure that families can access the Healthy Child Programme and that parents are supported at key times and have access to a range of community services. Universal plus offers rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting. Universal partnership plus provides ongoing support from the health

visiting team and a range of local services to deal with more complex issues over a period of time. Current level of service provided by Health visiting teams indicate the following level of services for Universal and targeted services.

Level	Service	Number	%
Tier 1	**Universal**	**39,918**	**94.1%**
Tier 2	**Universal Plus**	**1,577**	**3.7%**
Tier 3	**Partnership**	**767**	**1.8%**
Tier 4	**Partnership Plus**	**180**	**0.4%**
Total		**42,442**	**100%**

3.2 Staffing and Finance

The current service transferred from NHSE with a part year budget and Contract value £6,020,319 for 2015/16. The contract value for 2016/17 is £10,692,530.

The Health Visiting Service is split into multidisciplinary teams comprising of qualified Nurses, Nursery Nurses and Health Care Support Workers. Expansion of FNP took place from 2011 over 3 years and is now funded for Supervisors, Family Nurses and Quality Support Officer during 2015. The team has a maximum capacity for delivery of FNP to 245 clients. There are a total of:

- WTE HV staff 215.66
- FNP staff 12.61
- Total Staff 228.27

3.3 Health Outcomes

Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims "to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest." Specifically, children's public health contributes to the following four domains:

1. Improving the wider determinants of health ▪ PHOF 1.2: School readiness
2. Health Improvement ▪ PHOF 2.2: Breastfeeding initiation and prevalence at 6-8 weeks after birth ▪ PHOF 2.5: Child development at 2-2½ years ▪ PHOF 2.6: Excess weight in 4 – 5 year olds ▪ PHOF 2.7: Hospital admissions caused by unintentional and deliberate injuries in under 5s ▪ PHOF 2.21: Access to non-cancer screening programmes
3. Health Protection ▪ Population vaccination coverage (PHOF 3.3)
4. Healthcare public health and preventing premature mortality ▪ PHOF 4.1: Infant mortality ▪ PHOF 4.2: Tooth decay in children aged 5

In July 2012, the Children and Young People's Health Outcomes Forum recommended a number of new outcome measures, some of which are relevant to the Public Health of 0-5 year olds. For example, an outcome measure of mother's mental health.

3.4 The universal elements of the Healthy child pathway

The universal elements of the Healthy Child pathway are delivered by a team led by health visitors working in way that is most appropriate to local public health needs and across a range of settings and organisations including general practice, maternity services and children's centres (except where families are accessing FNP, in which case the FNP nurse – family nurse – will take on this

role until the child is two years old). As an overview, core elements of the HCP include:

- Health and development reviews – To assess family strengths, needs and risks; provide parents the opportunity to discuss their concerns and aspirations; assess child growth and social and emotional development; and detect abnormalities.
- Screening – support with screening is an integral part of the universal HCP.
- Immunisations – At every contact, members of the HCP team should identify the immunisations status of the child.
- Promotion of social and emotional development **–** The HCP includes opportunities for parents and practitioners to review a child's social and emotional development, for the practitioner to provide evidence-based advice and guidance and decide when specialist input is needed.
- Support for parenting **–** One of the core functions of the HCP is to support parenting using evidence-based programmes
- Effective promotion of health and behavioural change – Delivery of population, individual and community-level interventions based on NICE public health guidance.
- Sick children – Supporting parents to know what to do when their child is ill.
- Children with a disability – Early diagnosis and early help.

3.5 The current service reflects the 4-5-6 model which includes:

Further information is available in *Appendix 6*.

- **Four** progressive tiers of health visiting practice – building community capacity; the universal elements of the Healthy Child Programme; targeted interventions to meet identified need, and partnership working to meet complex needs
- **Five** universal HCP checks and reviews in line with the proposed mandate of local authority commissioning of the five universal checks and reviews. A significant addition to the performance report is the percentage of children who receive a six to eight week review.
- **Six** high impact areas – maternal mental health, transition to parenthood, breastfeeding, healthy weight, child development and managing minor illness/ accident prevention.

3.6 Targeted Services and Safeguarding

An important part of the health visiting services includes both targeted and universal services as highlighted in *Appendix 6* (section 3). The current service has access to a multidisciplinary team consisting of a safeguarding team which is recognised a major strength locally.

3.7 Delivery of the Five universal Healthy Child pathway (HCP) checks and reviews

As part of the transfer of services the Department of Health (DH) has mandated local authorities (under section 6C of the NHS Act 2006) to ensure the provision of the following five key elements of the HCP to be delivered by health visitors:

1. **Antenatal health promoting reviews**
2. **New baby reviews**
3. **Six to eight week assessments**
4. **One year assessments and**
5. **Two to two and a half year reviews.**

Health visitor service delivery metrics were developed by NHS England in order to provide assurance on service transformation in England around the five key areas and is detailed in *Appendix 6* (4b).

3.8 Delivery of Six High Impact Areas

Working in partnership with other services in supporting assessment of education and health and care plans for children aged 0-5s is a strong focus, including a family centred approach to meeting the needs of children with Special Educational Needs and contributing to high intensity multi-agency services where there are safeguarding or child protection concerns. The current specification highlights the health visiting contribution as experts and leaders in delivering better health and wellbeing for 0-5s. This includes:

1. **Transition to Parenthood and the Early Weeks**
2. **Maternal Mental Health (Perinatal Depression)**
3. **Breastfeeding (Initiation and Duration)**
4. **Healthy Weight, Healthy Nutrition (to include Physical Activity)**
5. **Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)**
6. **Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'**

3.9 Current Service Performance

Various metrics have been set to performance manage the current service, with new KPIs such as the use of the ASQ to monitor child development outcomes at age 2 to 2½ years is a new indicator in the 2015/16 collection. A new indicator for child development outcomes will be included in the PHOF from 2015/16. In the first instance this indicator will be coverage of the ASQ but later iterations will include achievement of child development milestones across a number of dimensions.

The current service is based on national KPIs, although local variations include Healthy start and oral health, as well as ensuring integrated working and Health Visitor leadership to the children centre clusters of which there are now seven.

3.9.1 Mandated Health Checks

Current performance based on the nationally defined five mandated health checks following transition from NHSE into local authority includes the areas identified in 3.7.

3.9.2 High impact areas

These KPIs relate to local variations which were included at the time of transfer and refer to new KPIs in addition to the nationally defined ones. Hence the data is not complete but shows the level of detail expected as part of the service as can be seen in *Appendix 9*.

4. HEALTH VISITING AND FNP SERVICE REVIEW

The aim of the review is to drive a culture change towards prevention, early intervention and integration of services to ensure children, young people and their families can access the support when they need it most, either through universal or targeted services. This is important given the pressure on budgets and the changing demographics and needs of the population where a system change is also necessary which means Public Health need to change the way we commission and deliver services so they are evidence-based and draws on qualitative and quantitative information from

key stakeholders, whether primary care, education, early years, health visiting staff or service users.

The review is timely given that an integrated care pathway has already been developed and aligned with children centre clusters and linked to other pathways across early years services, including the early help offer and signs of safety. It is also an opportunity to ensure the approach links into the school nursing (5-19) review which is also being reviewed by Public Health, so there is a clear transition from early years into school.

4.1 Purpose

The purpose is highlighted in 1.1 but the main purpose of the HV and FNP Review is to detail the draft service model in order to gain approval from the Council Executive and to proceed with the commissioning of a new model of Health Visiting and FNP Service.

4.2 Objectives

The overall objective is to consider the Local Authorities local vision for the health and wellbeing of babies, young children and families to ensure that the transfer adds value to local efforts to address health inequalities among this age group, which include:

- To identify if and how the current service model meets current and emerging need taking into consideration the changing demographic profile of children and young people within the Bradford District
- To review how the service model fits with children and young people's services with particular emphasis on the new offer for children and young people.
- To identify key opportunities to make improvements in prevention and early intervention in partnership with key stakeholders such as schools, primary care, Children's Social Care, Voluntary and Community Groups and other organisations

4.3 Leadership & Governance

- A Project Board was established for the 0-5 Health Visiting Review.
- This review was led by a Project Board made up of representatives from the following Council departments and organisations:
  - Airedale, Wharfedale and Craven Clinical Commissioning Group
  - BMDC Department of Childrens Services
  - BMDC Department of Public Health
  - Bradford City Clinical Commissioning Group
  - Bradford Districts Clinical Commissioning Group
- A Project Plan was developed to identify the key tasks, stakeholders, methods of engagement and timescales
- Consultation and engagement with key stakeholders, including health visitors, family Nurses, staff, service users, families
- Information and evidence collated into a final report (Business Case) document detailing the findings of the review

4.4 Scope of Review

The scope of the review includes Health Visiting and FNP
The review does not include the immunisation and vaccination service commissioned by NHS England Commissioning Board.

4.5 Risks

- Funding cuts of 6.2% have been agreed nationally in year for 2015/16
- There is no guarantee that the Public Health allocations will remain the same.

- Local Authority Regulations (2015) and the HV National Service Specification both refer to a local authority's area and defined geographical population in line with Local Authority boundaries and localities, unlike current CCG boundaries.
- RCT findings on Family Nurse Partnership

4.6 Methodology

The methodology used for the HV and FNP Review was based on three key priority areas.

4.6.1 Literature review of key national and local policy context and strategy as summarised in 2.3 and 2.4 above and detailed in *Appendix 2.*

4.6.2 Demographics and health and wellbeing needs of children age 0-5 so this informs the development of a new service model. Detailed information is available in *Appendix 4 and 5* and summarised in section 2.5 and 2.6 above.

4.6.3. Consultation and engagement using both qualitative and quantitative methods of consultation and engagement were used in order to consult with key stakeholders. As part of the review of Health Visiting Services and the Family Nurse Partnership, the views of stakeholders were sought using Questionnaires and Organised group discussions. Three different questionnaires were used, to collect the opinions of:

- Families in receipt of Health Visiting Services
- Families in receipt of the services of the Family Nurse Partnership
- Stakeholders with an interest in Health Visiting Services and the Family Nurse Partnership

Organised discussion groups were also carried out using SWOT analysis with the following groups:

- Families with experience of Health Visiting Services and / or the Family Nurse Partnership, Health Visitors, Family Nurse Partnership staff, Health Visitor Service Strategic Management Group, Maternity Partnership, Children's Centres, Early Years Services, Education, Children's Transformation and Integration Group, Children's Social Care, Clinical Commissioning Groups and General Practitioners.

4.7 Findings

4.7.1 Literature review

Details of literature review can be found in *Appendix 2.* It is apparent from literature nationally and locally that there is a real emphasis on integrated working as well as a focus on early intervention and prevention, and targeted work in areas of greatest need.

4.7.2 Demographics

Bradford District is one of the most deprived local authorities in the whole of England with a changing population and a growing population of young children. A significant number of children age 0-5 are from diverse backgrounds, mainly Pakistani mothers, who are not all born in the UK. Further information is available in *Appendix 4*.

4.7.3 Health and wellbeing needs and Health Inequalities

There are huge inequalities within the district and targeting these early is an important part of the health visiting and FNP service as this is a universal service providing huge opportunities in terms of access and targeted interventions. Further detail is provided in *Appendix 5.*

4.7.4 Consultation for Health Visiting services

Details of the full consultation report can be found in *Appendix 12.* The aim of the consultation was to understand how people feel the system is working currently, and what their future expectations are of the services. There were two main methods used to obtain these opinions: (A) Questionnaires which were available both online and on paper and (B) Organised group discussions.

(A) Questionnaires
There were three questionnaires designed to obtain views from;

I. *Families in receipt of Health Visiting Services*;
   - 227 respondents
   - Majority female
   - 77% aged 20-39
   - 60% of respondents described themselves as White or White British, 15% as Asian or Asian British, 4% as Central or East European remaining 21% from other minority ethnic groups. There is an over representation from the White British population.

II. *Families in receipt of the services of the Family Nurse Partnership*;
   - 62 respondents
   - Majority female
   - 56% aged 19 and under, 32% aged 20-25 years which is expected with the nature of the service.
   - 84% of respondents described themselves as White or White British and 6% as Asian or Asian British; 10% of respondents did not complete the question. This is consistent with the ethnic groups within the service population.

III. *Stakeholders with an interest in Health Visiting Services and the Family Nurse Partnership;*
   - 129 Responses
   - Respondents were asked to identify which organisation they were responding on behalf of 49 selected 'other,' those who selected 'Other' included a number of people from the Bradford District Care Trust, including health professionals and commissioners, and from Family Centres, Nurseries and Social Services. 44 of which were GPs, 19 childrens centres, 11 voluntary and community sector, 5 from education.

(B) Organised Group Discussions
For Health visitors there were seven events set up to get the views of HV staff and key stakeholders, the attendees at each event consisted of:

- Event 1- Strategic Management Team**;** 13 attendees
- Event 2 (Bradford) and 3 (Keighley) – Health visiting teams**;** 28 attendees in Bradford and 26 in Keighley
- Event 4 and 6 - Stakeholders (Allied Professionals); 31 attendees in total
- Event 5 and 7 – GPs and Practice Managers; 104 attendees in total
- Families in receipt of HV service; In total there were 115 participants of which, 105 were female and 10 were male.
- 27% identified themselves as White or White British and 51% Asian or Asian British 10% did not disclose their ethnicity, the groups were diverse and gave views of people who may not necessarily complete the questionnaire.

Summary of key findings for consultation on Health Visiting Services:

Access
1. There is concern around the difficulties that service users experience when

	trying to contact their Health Visitor (HV); the most challenging aspect for families, HVs and allied professionals alike is the single point of access hub. Families also see the requirement to disclose their problems to an unknown intermediary as challenging.
2.	There is concern about the equity of access and the consistency of care given to service users and their families by HVs, both in terms of the amount and quality of support provided, and the clarity and consistency of the health messages offered.
3.	Participants feel that the location of services, and the environment in which they are delivered, are crucial to determining whether services are used efficiently and effectively; the key point made was that services should be delivered in locations that families already access routinely.
People's experience of the service	
4.	Experiences of health visiting services reported by participating families have tended to be positive, but this positive view is not necessarily matched by the views of other stakeholders (Allied professionals.)
5.	The experiences of support received by mothers have tended to be positive; however, the amount and quality of support provided has not always been sufficient eg Breastfeeding and support around postnatal depression
6.	Participants feel that greater attention needs to be paid to continuity of care because service users get more out of the service, and say that they feel safer, when they are able to rely on a HV with whom they have established a trust based relationship.
7.	Participants report that the willingness of families to disclose personal issues is influenced by the environment in which the conversations with their HV take place; participants feel that services, whether these are delivered in a community setting or in the family home, need to afford greater privacy than is currently available.
Organisational concerns	
8.	Participants expressed concerns about whether current IT systems will support integrated working and data sharing between HVs and all of the other organisations involved in delivering services to children aged 0-5 years and their families.
9.	Participants are aware of the pressures under which HVs operate and feel that this has a negative impact on the quality of services; concerns were expressed about the capacity of HVs to meet the demands of their increasing workloads and continue to perform their role to required standards.
10.	The current "flat" structures of HV teams, and the consequent lack of leadership, were perceived as a problem by participants.
11.	Amongst participants a range of views were expressed about the organisation and alignment of HV teams; the majority of HV staff and stakeholders from partner organisations were in favour of geographical alignment and GPs expressed views that they wanted GP alignment to remain.
12.	Whilst many participants regard partnership working as strength of the current HV service, it was suggested that the service may function better through closer working and better integration with other services; the examples given included better integration with midwifery services, school nurses, general practitioners and Children's Centres.
Needs	
13.	Participants understand that Bradford has a particularly diverse population and that needs vary from community to community; they feel that particular attention needs to be paid to the availability and quality of interpretation services and how these services are used in practice.
14.	There is acknowledgement of the prevailing economic environment of austerity across all services amongst participants, and a recognition that this will impact upon the HV service in the future.

4.7.5 Consultation for Family Nurse Partnership (FNP)

There were four events to obtain views of FNP staff members, key stakeholders and families in receipt of FNP. The attendees at each event consisted of;

I. Event 1- FNP Staff Members; 12 attendees
II. Event 2 - Stakeholders (Allied Professionals); 9 Attendees
III. Event 3 - (Keighley) and 4 (Bradford) – Families in receipt of FNP**;** 11 attendees in Keighley and 3 in Bradford

This report on the consultation can be found in *Appendix 12*

Summary of Key findings for consultation for Family Nurse Partnership (FNP):

Access
1. The Family Nurse Partnership (FNP) service is seen as providing very good support for a very small number of mothers and children. However, families in receipt of HV and FNP services reported that they feel care is not delivered equitably across the district or across the population.
2. Participants report that the service provided by their Family Nurse is accessible and fits around the needs of the family; it is seen as providing them with "valued continuity of care" and "robust support from very early on in pregnancy until (the) child is 2" to "break the cycle of deprivation".
People's experience of the service
3. Families in contact with FNP services value the continuity of care provided by their Family Nurse and the consistency of their advice and support. FNP clients welcome the structured support provided by their Family Nurse and feel that "it prepares us properly for parenthood".
4. Knowledge and understanding the role of the HV is poor amongst clients of the FNP. The step from intensive support to the lower level of support provided through the general service is a challenge for clients who do not have the same trust-based, well established relationship with their HV as they do with their Family Nurse. Participants report finding the transition abrupt and also challenging because they are not sure that continuity of care will be maintained with the HV.
Organisational concerns
5. Concerns were expressed about whether the FNP service will continue in Bradford in the face of continuing funding restrictions, the organisational changes currently underway and the negative findings of the recent national evaluation of the FNP.
6. Participants see the possibility of losing the FNP service, or it becoming 'watered down', as a significant threat to the children and families that the service supports who, because of the nature of FNP, are some of the most vulnerable families living the most deprived areas of the district.
Opportunities for the future
7. Participants expressed concern about the results of the national evaluation of FNP services, which showed no significant improvement in some short term outcomes for participants. Locally in Bradford, there is a strong belief that the programme has made a difference.

5. RECOMMENDATIONS FOR A PROPOSED NEW MODEL

5.1 Recommendations for proposed new Health visiting service model

National and local policy context is being implemented locally and overall we have good HV and FNP services in place with both national and local performance monitoring arrangements established. Whilst the outcomes of the review and consultation have been mainly positive, we have drawn out areas

from the consultation, which require improvement and further development in order to have a new model which is fit for purpose for the future and geographically aligned. Given the current financial climate it is even more important we have a model which is cost effective and demonstrates value for money.

Throughout the review there has been consistency in the identification of the priorities and high-level service expectations. This has been reflected in national and local policy, guidance, planning and informed by our key stakeholders and partners. A Summary of the proposed Service Model which will incorporate the key themes is provided in *Appendix 14*, with a summary of the high level principles provided below:

1. Effective leadership, coordination and delivery of the Healthy child programme as highlighted in the 4-5-6 model, including the five mandated health checks, 6 high impact areas and both universal and targeted services.
2. Delivery of evidence based outcome focused interventions to improve health and wellbeing and reduce inequalities by focusing on needs of young children including vulnerable groups.
3. Effective teams and partnerships, working across professions and organisations; using evidence based interventions and the development and implementation of appropriate pathways to support families with prevention and early intervention.
4. Improved access to health visiting services through a geographically aligned model with clear alignment to children's centre clusters. This includes recognising the important role and links to GPs and Primary care, and mapping of Voluntary and community Sector organisations and groups to support and signpost to where necessary.
5. Improved communication and resources according to community needs, ensuring more "visibility" of health visitors and information and resources in appropriate languages.
6. Workforce capacity and development to ensure diverse needs of communities are represented but also appropriate training to ensure a competent workforce and relevant skill mix providing consistency in messages.
7. Targeted work with vulnerable Families and children with specific needs, and to ensure appropriate structures in place so families of children age 0-5 and mothers do not miss out on vital health checks.
8. Service delivery to incorporate 'Journey to Excellence' with 'Early Help' and 'Signs of Safety' as well as "Integrated Early Years Strategy for Children 0-7"
9. A caseloads model to be developed and delivered according to need and priority.
10. Nurse prescribing to include advice and support in managing minor illness and reducing hospital admissions, as well as providing level 1 contraceptive advice.
11. Ensure robust transition into Early Years and schools, and close working with the School Nursing and Early Years Service.

5.2 Recommendations for a new Family Nurse Partnership model

In conclusion, whilst evidence from the consultation and findings from the FNP have provided excellent feedback from service users and key stakeholders, this has not correlated with national evidence from literature review and in particular

the recent publication of the RCT, details of the RCT and outcomes is available in *Appendix 11*. A Summary of the proposed Service Model which will incorporate the key themes is provided in *Appendix 15*, with a summary of the high level principles provided below.

1. Develop a new model of FNP ADAPT which is fit for purpose and developed with locally defined outcomes.
2. Embed the learning from the FNP into the proposed health visiting service, focusing on child development and a smoother transition from FNP to health visiting services.
3. Work in partnership with Better Start Bradford to develop and pilot a model which is based on local need and supported by the National FNP Team
4. Ensure robust performance and monitoring processes in place which can compare outcomes from Health visiting to FNP
5. Consideration needs to be given to the longer term outcomes and wider determinants such as educational achievement and how these can be obtained and monitored as part of FNP

This provides an opportunity to embed the learning from the FNP into the local health visiting service, which is identified as a gap in current service provision. This will need to focus on child development and a smoother transition from FNP to health visiting services. One of the advantages locally in Bradford, unlike other neighbouring areas where - is that we have the Better Start Bradford. This provides a real opportunity to develop and pilot a model which is based on local need and supported by the national team with robust monitoring processes with more locally defined outcomes and criteria.

5.3 Service specification

It is recommended that a detailed service specification be developed to articulate the proposed service model. The new service specification will be developed with advice from the Council's Commercial Team and supported by a working group consisting of commissioning colleagues from Health, CCGs, BMDC Children's Services (and other specialist input where it is required).

5.4 Key Milestones

Key milestones will be developed following approval at Council Executive and will include:

DATE	MILESTONE	OBJECTIVE
1/5/16	**CMT/DMT MEETING**	Agree final business case/report
6/5/16	**BHCC MEETING**	Agree final business case/report
18/5/16	**HV REVIEW BOARD**	Amend final business case/report
14/6/16	**EXECUTIVE/OSC APPROVAL**	Final business case/report to be approved with preferred option

5.5 Performance Management

5.5.1 During the Mobilisation period and the first six months, the provider will be required to meet with Public Health Commissioners on a monthly basis. Following this, the Provider will be required to submit quarterly performance monitoring information and meet (quarterly) with Public Health Commissioners to discuss performance.

5.5.2 The contract and service specification will include a suite of performance indicators and targets. Robust contract management arrangements will be put in

place to ensure that services are delivered effectively and in accordance with the Council's expectations.

5.6 Understanding Service Demand

5.8.1 As highlighted in Appendix 3 the sub national population projections suggest that the 0-5 population is due to increase by 10% by 2021. This presents the District with a growing challenge as over the last decade there has been an increase of over 20% in 0-4 year olds. A third of all births (33.1%) in Bradford are to mothers born outside the UK, higher than the average for England (27.3%). The second highest place of birth for mothers in Bradford are to those born in Pakistan (18.3%) followed by Poland 2.8% and Bangladesh (2.0%). Bradford East and Bradford West accounted for over half the total live births in 2013 (26.4% and 25.7% respectively). Across Bradford district, live birth rates vary from ward to ward, with higher rates seen in wards such as Manningham, Bradford Moor, Bowling and Barkerend and Little Horton and lower rates seen in Ilkley, Baildon, Bingley Rural and Wharfedale

5.8.2 If the new contract is to improve the health and wellbeing of babies, children and their families and reduce health inequalities it will need to allow scope for innovation and include consideration of:

- Better utilisation of the workforce and skill mix, including delivery models based on geographical alignment
- Integration with other key early years services to ensure effective efficient delivery of services including integrated pathways and joint training using the latest evidence to ensure interventions work effectively and have high impact on Children and families
- Improved outcomes especially in those most at risk of health and well being inequalities
- A focus on 'must do' business and identification of areas of current work that are no longer required or could be delivered by other services
- A focus on 'New Deal' principles; focusing on 'Early Help', and empowering families and communities.

6. COUNCIL POLICIES AND PRIORITIES

6.1 Equality and Diversity

An Equality Impact Assessment has been undertaken and is included as *Appendix 16* of this report and assesses the equality and diversity impact of the recommendations and proposed service model described in this report.

6.2 Council Policies and Priorities

6.2.1 Bradford Council Strategic Priorities; despite the financial challenges that the district faces the Council remains committed to achieving the key objectives of:

- Better health and better lives
- Better skills, more good jobs and a growing economy
- Safe, clean and active communities
- Decent homes that people can afford to live in.
- Good schools and a great start for all our children

6.2.2 The commissioning of health visiting services directly supports the delivery of objectives and priorities from a range of Council strategies including the:

- Health and Well Being Strategy & Health Inequalities Action Plan 2015-2018
- Children & Young People's Strategic Plan
- Integrated Early Years Strategy (0-7 years) Bradford district 2015-2018
- Better Start Bradford –improved outcomes for pregnant women and young children aged 0-3 years - School readiness, obesity and other key outcomes.

HV services and FNP are an important part of the Better Start Bradford, £49 million Big Lottery Programme targeting pregnant women and children age 0-3 via 22 evidence based projects to improve outcomes

- Integrated Care Pathway (ICP) in 2014 incorporating health visitors, midwifery and children services for children age 0-5 is key
- Children Centres : Health visiting services are an important in relation to the Children centre (CC) services and CC Review –both services have similar focus and targets and effective integrated working is key for the future

6.3 New Deal

6.3.1 New Deal is the Council's approach to changing the way the Council and other public services work with people, communities, businesses and the voluntary sector to improve and protect the quality of life for people in the Bradford District.

6.3.2 In order for the Council to achieve the key priorities, the Council will need to make changes to the type of services we buy and the way they are delivered by:

- Reducing the demand for services by changing expectations and promoting involvement
- Investing in prevention and early intervention
- Reducing inequality

6.4 Resources and Value for Money

6.4.1 Like all Councils, Bradford has to cut spending. Government funding for Council funded services has been cut by £165 million over the last few years and the reductions are set to continue.

6.4.2 Between now and 2020, the money for Council services (under the Council's direct control) is forecast to reduce by at least another 25%, on top of the savings already made.

6.4.3 The numbers of younger and older people are growing and so are the numbers of people with disabilities. Other challenges include more children needing care and protection and managing the increase in costs associated with Inflation. This all puts pressure on services.

Given the current financial climate, it is likely that the total cost of investment will be reduced so innovative solutions will need to be considered to ensure the proposed service model demonstrates value for money whilst managing an increase in demand and changing demographic need.

6.5 Legal Implications

The re-commissioning of the Health Visiting and FNP service will be conducted in accordance with the Council's Contract Standing Orders, National and European procurement regulations. Public Health is working with the Council's Commercial Team to agree an appropriate sourcing option.

6.6 Risk Management

6.6.1 Risks associated with the re-commission of the health visiting service have been identified, reviewed and managed through fortnightly Project Team meetings and four weekly Project Board meetings.

6.6.2 The identification of new and increasing risks is an on-going process and will continue to be identified and managed through the life of the project.

7. CONCLUSION

National and local policy context is being implemented locally and overall we have a good HV and FNP services for children aged 0-5 years with both national and local performance monitoring arrangements in place. Whilst the outcomes of the review and consultation have been mainly positive, we have drawn out areas from the consultation,

which require improvement and further development in order to have a model which is fit for purpose for the future and geographically aligned. Given the current financial climate it is important we have a model which is cost effective and demonstrates value for money, as well as ensuring we develop a new model according to the needs and findings identified within the review process.

8. RECOMMENDATION

It is recommended that the Executive Committee consider the Business Case for review of Health visiting and Family Nurse Partnership and give approval to proceed with the development of a detailed service specification to articulate the proposed service model.

The new service specification will be developed with advice from the Council's Commercial Team and supported by a working group consisting of commissioning colleagues from Health, CCGs, BMDC Children's Services (and other specialist input where it is required).

9. BACKGROUND DOCUMENTS

Please refer to the Appendices document for the following Appendices:

City of Bradford Metropolitan District Council

www.bradford.gov.uk

Review of Health Visiting and Family Nurse Partnership Service for Children age 0-5

APPENDICES

APPENDIX 1: INTRODUCTION

The aim of the review is to drive a culture change towards prevention, early intervention and integration of services to ensure children, young people and their families can access the support when they need it most, either through universal or targeted services. This is important given the pressure on budgets and the changing demographics and needs of the population. A system change is also necessary which means we need to change the way we commission and deliver services so they are evidence-based and draws on qualitative and quantitative information from key stakeholders, whether primary care, education, early years, health visiting staff or service users.

The review is timely given that an integrated care pathway has already been developed and aligned with children centre clusters and linked to other pathways across early year's services, including the early help offer and signs of safety. It is also an opportunity to ensure the approach links into the school nursing (5-19) review which is also being reviewed by Public Health, so there is a clear transition from early years into school.

This report sets out the background for the Health Visiting and Family Nurse Partnership (FNP) Service and its purpose, examining the strategic policy context, local demographics and population needs. It then proceeds to explore the current service specification and model and outlines the key findings from the service review, detailing the proposed model which will be discussed with the various local Commissioning and Children's Boards and require approval from the Council Executive.

Background

On 1st October 2015 NHS England transferred commissioning responsibilities for children aged 0 to 5 to local authorities. This marks the final part of the much larger transfer of public health functions to local government which took place on 1 April 2013 under the Health and Social Care Act 2012

NHS England Area Team put in place a single contract for the full-year of 2015/16, with a deed of novation transferring the contract to Public Health in year.. Health visiting and family nurses partnership. FNP services are now commissioned by the Bradford Metropolitan District Council and the contract held is one of the largest funded contracts managed within Public Health, currently delivered by a local NHS Provider. The current contract is based on national KPIs with some local variations agreed prior to transition, and is based on the Councils "resident populations" The transfer of commissioning responsibilities to Public Health has provided opportunity to review the Health Visiting and Family Nurse Partnership (FNP) service with the overall aim to improve health and wellbeing outcomes for babies, children and their families.

Overview of the Health Visiting Service

Evidence shows that what happens in pregnancy and the early years of life impacts throughout the life course. Therefore a healthy start for all our children is vital for individuals, families, communities and ultimately society. The experiences during the early years of childhood (including before birth) have lifelong effects on health and wellbeing. Health visitors play a crucial role in ensuring that children have the best possible start in life and lead delivery of the 0 to 5 elements of the Healthy Child Programme (HCP) which is an early intervention and evidenced based programme and is led and delivered by health visitors in partnership with other health and social care colleagues.

Level of service provided by Health visiting teams

Universal services ensure that families can access the Healthy Child Programme and that parents are supported at key times and have access to a range of community services. Universal plus offers rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting. Universal partnership plus provides ongoing support from the health visiting team and a range of local services to deal with more complex issues over a period of time. Current level of service provided by Health visiting teams indicate the following level of services for Universal and targeted services.

Level	Service	Number	%
Tier 1	**Universal**	**39918**	**94.1%**
Tier 2	**Universal Plus**	**1577**	**3.7%**
Tier 3	**Partnership**	**767**	**1.8%**
Tier 4	**Partnership Plus**	**180**	**0.4%**
Total		**42442**	

Overview of the Family Nurse Partnership Service

The Family Nurse Partnership (FNP) is a voluntary home-visiting programme for first time young parents aged 19 or under. It is not a universal service. A specially trained family nurse visits the young parent regularly, from early in pregnancy until the child is two years old. Where a family is under the care of the FNP, described in the Regulations as FNP beneficiary, the mandated reviews will be carried out by the family nurse. To ensure continuity for the family, the family nurse should carry out the 2 to 2½ year review.

Aim of Review

The transfer of commissioning responsibilities to the Council has provided an opportunity to review the Health Visiting Service, including:

a) Review current guidance, policy and good practice to inform/identify a set of standards of which to review the current service and service model
b) Analyse the current and emerging health and wellbeing needs of parents and the 0-5 (years) population within the Bradford District
c) Engage with key stakeholders; Parents, GPs, Early Years etc.
d) Develop a model that meets current and emerging need, demonstrating quality and value for money.
e) Integrating with current early years services for young children.
f) To review current national and local policy, guidance and strategy relating to children age 0-5 and the transfer of Public Health into the Council, I order to improve the health and wellbeing outcomes for children and young people and their families.

APPENDIX 2: NATIONAL CONTEXT & EVIDENCE BASE

Nationally new guidance and legislation highlight the importance of delivering prevention and early intervention services which are needs led and targeted to meet the needs of children, young people and their families. In fact the importance of pregnancy, birth and beyond highlights the need to engage with families early through both universal and targeted interventions in areas of greatest need reducing the inequalities gap. Health visitors lead delivery of the HCP, this is a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity.

1. National Context

a) The Department of Health, alongside its partners, has produced 6 documents to support local authorities and other stakeholders through the transition. The documents identify 6 areas where health visitors have the most impact on children aged 0 to 5's health and wellbeing. Local authorities should use this information to ensure that health visiting services are commissioned effectively: Best start in life and beyond: Improving public health outcomes for children, young people and families – Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services. https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

   Published in January 2016, the Guidance forms a suite of support guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and co-ordinate the delivery of public health for children aged 0-19.

b) Working together to Safeguard Children (revised Guidance) 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

   The guidance makes clear that everyone who works with children – including teachers, GPs, nurses, midwives, health visitors, early year's professionals, youth workers, police, Accident and Emergency staff, voluntary and community workers and social workers – has a responsibility for keeping them safe.

   The guidance outlines the importance of early help in promoting the welfare of children rather than reacting later. Early help can also prevent further problems arising and professionals should, in particular, be alert to the potential need for early help for children with specific needs or vulnerabilities.

   The guidance also highlights the Section 11 duties of the Childrens Act 2004 which will need to be considered as part of current service provision and alongside the role of School Nurses in their role in safeguarding and Child Protection.

c) A new home for public health services for children aged 0-5 - Nationally, new guidance and legislation for children age 0-5

d) Health visiting service specification for 2015-16 - NHS England has published a national core health visiting service specification for 2015-16. The refreshed specification has a strengthened focus on the role of health visitors as leaders for improving health and wellbeing outcomes for young children and their families. This document is a core specification detailing the core elements for the commissioning of health visiting services. It is an update of the 2014/15 document.

e) Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims "to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest." (Healthy Lives, 2012)

f) The healthy child programme: pregnancy and the first 5 years of life - One of the Department of Health (DH) key policy drivers is to give all children a healthy start in life and sets out plans for a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Health Visiting services lead and deliver the *Healthy Child Programme* (HCP), which is designed to offer a core, evidence based programme of support, starting in pregnancy, through the early weeks of life and throughout childhood.

g) Health visitor implementation plan 2011-15: a call to action, February 2011 - Sets out a programme for renewing the Health Visiting Service, stressing the importance of pregnancy and the early years in laying the foundations for future health, learning and wellbeing. *The Health Visitor Implementation Plan 2011-15* sets out the full range of services that families would expect from health visitors and their teams as part of the rejuvenated and transformed health service. The Plan sets out a call to action to expand and strengthen health visiting services (2011-15)

h) Both the Healthy Child Programme 0-19 and the Munro Review acknowledge that integrated services and greater partnership working are essential to improving outcomes for children, young people and their families.

i) The Marmot Review into health inequalities in England was published on February 2010 as 'Fair Society, Healthy Lives'. The Review looked at the differences in health and wellbeing between social groups and described how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood and so on. Professor Sir Michael Marmot's review of health inequalities gives priority to action in the early years. Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood.

   http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

   Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life, and reducing this disadvantage and associated health inequalities requires action on six policy objectives including:
   - Giving every child the best start in life
   - Enabling all children, young people and adults to maximise their capabilities and have control over their lives
   - Creating fair employment and good work for all
   - Ensuring a healthy standard of living for all
   - Creating and developing sustainable places and communities
   - Strengthening the role and impact of ill-health prevention

j) Healthy lives, healthy people: our strategy for public health in England
   This White Paper sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

k) Annual report of the chief medical officer 2012. Our children deserve better: prevention pays. This is volume two of the Chief Medical Officer's annual report which focuses on children and young people. It is based on an examination of the life course stages experienced by those up to the age of 25 years.

l) Rapid review to update evidence for the healthy child programme 0–5
   The purpose of this rapid review is to update the evidence which underpins the Healthy Child Programme, including systematic review level evidence about 'what works' in key areas: parental mental health; smoking; alcohol etc.

m) Frank Field's (2010) review of child poverty emphasises the importance of improving parenting and children's early development as a means of ending the inter-generational transmission of child poverty. He points to the impact that high-quality

early education for two year olds can have on later life chances, noting that known vocabulary at age five is the best predictor of whether children are able to escape poverty in later life.

n) The new health visiting service will be a key part of the response to the challenges they pose. Developments will also take account of Dame Claire Tickell's Review of the Early Years Foundation Stage and Professor Eileen Munro's Review of Child Protection.

o) Early intervention: the next steps. An independent report to her Majesty's Government - The first independent report to the government by Graham Allen MP considers how costly and damaging social problems for individuals can be eliminated or reduced. Graham Allen's first report sets out his vision for system reform and recommends "early intervention" places, a greater reliance on evidence-based programmes, and an early intervention foundation.

p) Under the Childcare Act 2006 Local authorities have statutory duties to secure sufficient provision of children's centres to meet local need, as far as is reasonably practicable. Every children's centre should have access to a named health visitor.

q) Supporting Families in the Foundation Years is a joint publication between DfE and DH, recognising that, as Graham Allen says, coherent integrated services are essential.

2. Legislative requirements

a) Children Act 2004
http://www.legislation.gov.uk/ukpga/2004/31/contents
The Children Act 2004 provides the legal basis for how social services and other agencies deal with issues relating to children and was designed with guiding principles in mind for the care and support of children. These are:

- To allow children to be healthy
- Allowing children to remain safe in their environments
- Helping children to enjoy life
- Assist children in their quest to succeed
- Help make a contribution – a positive contribution – to the lives of children
- Help achieve economic stability for our children's futures

This act was brought into being in order for the government in conjunction with social and health service bodies to help work towards these common goals.

b) Public Services (Social Value) Act 2012
http://www.legislation.gov.uk/ukpga/2012/3/enacted
The Public Services (Social Value) Act came into force on 31 January 2013 and requires local authorities commissioning public services to consider how they can secure wider social, economic and environmental benefits.
Before the procurement process begins, commissioners should consider about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

c) Health and Social Care Act 2012
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
Local Authorities are now responsible for improving the health of their population including commissioning of public health services for children and young people Directors of Public Health have taken responsibility as commissioners for school nursing services which are now funded through the Public Health grant, but also oral health improvement for children and more recently the transition into the local authority of health visiting and family Nurse partnership.

d) Children and Families Act 2014
http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

The Children and Families Act makes provision to provide greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life.

3. Evidence Base, Applicable National Service Standards and Suite of Evidence Based Interventions/Pathways

Best start in life and beyond: Improving public health outcomes for children, young people and families provides guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services as highlighted below (**Commissioning Guide 4**: Reference guide to evidence and outcomes)

- Healthy Child Programme – Pregnancy and the first five years of life (DH, 2009 – amended August 2010)
- Better health outcomes for children and young people Pledge
- The Children and Young People's Health Outcomes Strategy (DH, 2012)
- Allen, G. (2011a) Early Intervention: The Next Steps. HM Government: London
- Allen, G. (2011b) Early Intervention: Smart Investment, Massive Savings. HM Government: London
- Field, F. (2010) The Foundation Years: preventing poor children becoming poor adults. HM Government: London.
- Health visitor implementation plan 2011-15: A call to action (DH, 2011)
- The National Health Visitor Plan: progress to date and implementation 2013 onwards (DH, 2013)
- The Operating Framework for the NHS in England 2012/13 (DH, 2011)
- The NHS Outcomes Framework 2012/13 (DH, 2011)
- Improving outcomes and supporting transparency, Part 1: A public health outcomes framework for England, 2013-2016 (DH, 2012)
- Improving outcomes and supporting transparency, Part 2: Summary technical specifications of public health indicators, (DH, 2012)
- The Marmot Review (2010) Strategic Review of Health Inequalities in England, post-2010
- Dame Clare Tickell (2011) The Early Years: Foundations for life, health and learning – An Independent Report on the Early Years Foundation Stage to Her Majesty's Government
- Hall D and Elliman D (2006) Health for All Children (revised 4th edition). Oxford: Oxford University Press. (Please note: this link opens to the bookstore for purchase of copies of this edition).
- Service vision for health visiting in England (CPHVA conference 20-22 October 2010)
- Securing Excellence in Commissioning for the Healthy Child Programme 0 to 5 Years 2013 – 2015
- Equity and excellence: Liberating the NHS (DH, 2010) and Liberating the NHS: Legislative framework and next steps DH, 2011)
- Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people (DH, 2010)
- Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs (DH, 2010)
- Healthy lives, healthy people: our strategy for public health in England (DH, 2010) and Healthy lives, healthy people: update and way forward (DH, 2011)
- Healthy lives, healthy people: a call to action on obesity in England (DH, 2011)
- UK physical activity guidelines (DH, 2011)

- Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children (HM Government 2013)
- Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 (The Marmot Review, 2010)
- The 1001 Critical Days: The importance of the conception to age two period. Wave Trust, 2013
- Conception to Age two: The Age of Opportunity. WAVE Trust and DfE
- Annual Report of the Chief medical Officer 2012. Our Children Deserve Better: Prevention Pays. Department of Health, 2013
- UNICEF UK Baby Friendly Initiative

4. Applicable National Standards (NICE public health guidance) includes:

Best start in life and beyond: Improving public health outcomes for children, young people and families provides guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services as highlighted below (**Commissioning Guide 4**: Reference guide to evidence and outcomes)

- PH3 - Prevention of sexually transmitted infections and under 18 conceptions
- PH6 - Behaviour change at population, community and individual level (Oct 2007)
- PH8 - Physical activity and the environment
- PH9 - Community engagement (July 2010)
- PH11 - Maternal and child nutrition
- PH12 - Social and emotional wellbeing in primary education
- PH14 - Preventing the uptake of smoking by children and young people
- PH17 - Promoting physical activity for children and young people
- PH21 - Differences in uptake in immunisations
- PH24 - Alcohol-use disorders: preventing harmful drinking
- PH26 - Quitting in smoking in pregnancy and following childbirth (June 2010)
- PH27 - Weight management before, during and after pregnancy (July 2010)
- PH28 - Looked-after children and young people: Promoting the quality of life of looked-after children and young people (October 2010)
- PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 Issued (November 2010)
- PH30 - Preventing unintentional injuries among the under-15s in the home
- PH31 - Preventing unintentional road injuries among under-15s
- PH40 - Social and emotional wellbeing – early years: NICE public health guidance 2012
- PH42 - Obesity working with local communities
- PH44 - Physical activity: brief advice for adults in primary care
- PH46 - Assessing body mass index and waits circumference thresholds for intervening to prevent ill heath a premature death among adults from black, Asian and other minority ethnic groups in the UK.
- PH49 - Behaviour change: individual approaches
- CG43 - Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
- CG45 - Antenatal and postnatal mental health: clinical management and service guidance (February 2007)
- CG62 - Antenatal care: routine care for the healthy pregnant woman (March 2008)

- CG89 - When to Suspect Child Maltreatment (July 2009)
- CG93 - Donor milk banks: the operation of donor milk bank services
- CG110 - Pregnancy and complex social factors**:** A model for service prevision for pregnant women with complex social factors
- QS22 - Quality standards for antenatal care
- QS31 - Quality standard for the health and wellbeing of looked**-**after children and young people
- QS37 - Postnatal Care
- QS43 - Smoking cessation**:** supporting people to stop smoking
- QS46 - Multiple pregnancies
- QS48 - Depression in children and young people

5. **The evidence base and key policy documents for the FNP include:**

- Ball, M. et al (2012) Issues emerging from the first 10 pilot sites implementing the Nurse Family Partnership home-visiting programme in England. London, Department of Health (https://www.wp.dh.gov.uk/publications/files/2012/08/3-Birkbeck-Final-Issues-Evaluation-Report-For-Publication-July-2012.pdf)

- Barnes, J. et al (2008) Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England, London DCSF. (http://education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-RW051)

- Barnes, J et al (2009) Nurse-Family Partnership Programme: Implementation in England – Second Year in 10 Pilot Sites: the infancy period. London DCSF. (www.education.gov.uk/research/data/uploadfiles/DCSF-RR166.pdf)

- Barnes, J. (2011) The Family-Nurse Partnership Programme in England: Wave 1 Implementation in toddlerhood and a comparison between Waves 1 and 2a implementation in pregnancy and infancy (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123238)

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APPENDIX 3: LOCAL CONTEXT

INTRODUCTION

In addition to the themes raised in the national policy context a review of local policy and planning emphasises the importance of working collaboratively with key partners to improve services and get better value for money, all underpinned by the ‘Journey to Excellence’ and ‘New Deal’ programmes and focusing on the delivery of sustainable interventions to improve health and wellbeing and reduce health inequalities. There is a

particular focus on early help and integration of services, with opportunities from Better Start.

1. **New Deal for Bradford Council**

   To support the management of budget reductions, the Council is talking to local people, communities, partners and businesses to develop a 'New Deal' for Bradford. The numbers of younger and older people are growing and so is the number of people with disabilities. Other challenges include more children needing care and protection. Inflation is also increasing costs. This all puts pressure on services. These are:

   1. Good schools and a great start for all our children
   2. Better skills, more good jobs and a growing economy
   3. Better health, better lives
   4. Safe, clean and active communities
   5. Decent homes that people can afford to live in

   The Council is working with partners to innovate, share money and resources, work towards the same goals, and liaise with local people and communities to establish a 'New Deal' about what they can expect from local services, their rights and responsibilities, and how they and other people could help by doing things differently and the support required to achieve. The review of the health visiting service will support New Deal.

2. **Bradford District Health and Well Being Strategy 2015-2018**
   http://www.observatory.bradford.nhs.uk/Documents/Bradford%20and%20Airedale%20Joint%20Health%20and%20Wellbeing%20Strategy%202013.pdf
   Bradford's Health and Wellbeing Strategy "Good Health and Wellbeing: Strategy to improve health and wellbeing and reduce health inequalities 2013-2017 outlines the key objectives, priorities and actions required to secure improvements in health and wellbeing, to reduce health inequalities and ensure life expectancy continues to improve in line with national and regional trends. The Joint Strategic Needs Assessment (JSNA) provides a strategic examination of "need" across the Bradford District and provides the evidence-base to inform the Joint health and Wellbeing Strategy (JHWS), in particular helping to identify the key priorities for the District.

   The following objectives and priorities are particularly relevant to health visiting Service:
   - Objective 1; Give every child the best start in life
   - Objective 2: Enable all children, young people and adults to maximise their capabilities and have control over their lives.
   - in particular Priority 5: Reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people
   - Objective 6: Strengthen the role and impact of ill health prevention

3. **Bradford District Health Inequalities Action Plan 2013 - 2017**
   http://www.observatory.bradford.nhs.uk/Documents/Bradford%20and%20Airedale%20Health%20Inequalities%20Action%20Plan%202013.pdf
   The Health Inequalities Action Plan was developed to support the Joint Health and Wellbeing Strategy to improve health and wellbeing specifically targeting activity to address the significant inequalities within the district; in some parts of the district, people lead far shorter, less healthy lives than those in other areas.
   The Key Priorities for the Action Plan that relate to the Health Visiting Service are Infant mortality, Oral health, Obesity, Parenting & early years, children SEN and disabilities and Child poverty.

4. **Children and Young People's Plan 2014-16**
   http://www.bradford.gov.uk/bmdc/health_wellbeing_and_care/child_care/young_peoples_plan

The Children and Young People's Plan is the joint strategic plan for the Bradford Children's Trust.
The plan identifies how partners will work together to promote the health and wellbeing of children and young people in the Bradford District. It summarises activity to plan, commission or provide services, as well as the impact expected on the lives of children, young people and families.

The key priority areas for the plan are:

- Ensuring that children start school ready to learn
- Acceleration educational attainment and achievement
- Ensuring young people are ready for life and work
- Ensuring that there is education, employment and skills for all
- Safeguarding vulnerable children and young people
- Reducing health and social inequalities

5. **Child Poverty Strategy 2014-2017**
   https://www.bradford.gov.uk/NR/rdonlyres/D5E6B555-992E-4779-A8BF-AD09C053051C/0/ChildPovertyStrategy201417.pdf
   The Child Poverty Strategy describes the most important issues to address to reduce the impact of child poverty.
   In the most recent district child poverty data for 2011, one in four children and young people (25.8%) aged 0-19 lived below the child poverty line in households with less than 60% of average income. Nationally the rate is one in five (21.1%).
   The three priorities of the Strategy are:
   - Boosting educational attainment and skills for children, young people and families in poverty to improve their job prospects and reduce worklessness.
   - Reducing health and social inequalities
   - Creating safe homes and neighbourhoods for all children and young people.

6. **5 Year Forward Plan for Bradford Airedale and Craven & 3 CCG Plans**
   Improved Maternal and Child Health is a key part of the CCG plans

7. **Key Strategic Outcomes for Integrated Early Years Strategy (0-7 years) Bradford district 2015-2018**
   This is particularly relevant to health visiting and FNP services as objectives and priority areas include a focus on infant mortality, Oral health, Obesity and School readiness (Good level of development), Year 1 Phonics and KS1 phonics Year 2 reading, writing and maths.

8. **Better Start Bradford (Improved outcomes for pregnant women and young children aged 0-3 years)**
   HV services and FNP are an important part of the Better Start Bradford**,** £49 million Big Lottery Programme targeting pregnant women and children age 0-3 via 22 evidence based projects to improve outcomes in relation to School readiness, obesity and other key outcomes.

9. **Integrated Care Pathway (ICP)** in 2014 incorporating health visitors, midwifery and children services for children age 0-5 which is key to health visiting.
10. **Children Centres**
    Health visiting services are an important part of Children Centre services and particularly in relation to the integrated care pathway. Health targets in relation to key priorities have also been included into children centre specifications.
    There is also an expectation that there will be a named Health Visitor attached to the children centre and also a health Visitor lead on the Advisory Board.

11. **Children Centre Review**
    Both services have similar focus and targets and effective integrated working is key priority for future. The 7 children centre clusters will have health visitor leadership to deliver on integrated working and support and enhance the care pathways for children

age 0-5 in particular there is a string focus on the two year reviews and child development as well as enhancing support offered for mothers, babies and children.

12. Families First

http://www.bradford.gov.uk/bmdc/BCYPP/families_first

Families First has been recognised within the recent specifications as an important part of the links with health visiting and FNP.

Families First is a local programme forming part of the national Troubled Families Programme, working with families facing serious problems. The programme addresses other issues that these families are likely to experience including: debt and financial difficulties, housing problems, health issues, substance abuse and domestic violence.

Families First is unique in Bradford in that the scheme focuses on the needs of the whole family rather than individual members, the family is supported by a key worker working within a multi-disciplinary team, and includes health. Those families with the greatest needs are targeted, this comprises of up to 600 families a year. The programme is also designed to last beyond the end of the funding, by making long-lasting changes to the way that different agencies, such as the Council, Police and Health Services, work together, in order to improve services and get better value for money.

13. Journey to Excellence

http://www.bradford.gov.uk/bmdc/health_wellbeing_and_care/child_care/journey_to_excellence_thriving_children_strong_families

Journey to Excellence is a new programme of change involving key partners across the district. Its purpose is to ensure there is a shared approach to working with families that builds on their strengths and provides safety and stability for children. Hence is an important part of health visiting and FNP as focuses on developing the integrated Early Help offer across all key agencies which includes:

- develop an 'Early Help' gateway for the public and staff
- develop an approach that takes account of the whole family
- get it right first time to reduce repeat referrals
- focus on reducing the demand on children's specialist services

BMDC Childrens Services are working with partners, including Health Visiting services to develop a plan to use Signs of Safety to cut across the programme. Signs of Safety is a practice tool to identify strengths, risks and clear action plans with families. It provides an assertive and shared approach to assessing needs and draws upon techniques from Solution Focused Brief Therapy. The programme has worked well in other Local Authorities to reduce demand for specialist services and improve outcomes for children and young people.

APPENDIX 4: DEMOGRAPHICS

Bradford District is one of the most deprived local authorities in the whole of England, ranking 19th in the 2015 indices of multiple deprivation (IMD) and 2nd most deprived in the Yorkshire and Humber region (after the City of Kingston upon Hull). This compares to the ranking of 26th for IMD 2010. Bradford's position relative to other English districts has worsened by 7 places.

1. POPULATION

The number and proportion of the district's total population aged under 19 years is increasing and the relatively high proportion that live in poverty is likely to increase the general demand for services and support to families including early help and preventive

services as well as those that seek to reduce the impact of poverty. This presents the District with a growing challenge as over the last decade there has been an increase of over 20% in 0-4 year olds.

Age Groups	2014
0-4yrs	41,018
5-9yrs	40,036
10-14yrs	36,145
15-19yrs	35,393

Source: Mid-2014 Population Estimates, ONS

a) Children aged 0-5

- There are 49,270 children aged 0-5 in Bradford District this equates to 9% of the total population (Mid 2014 population estimates, ONS.)
- In 2013 there were 8,039 live births in Bradford district compared with 8,322 live births in 2012 (a decrease of 3.4%)
- The birth rate fell from 15.9 live births per 1,000 population in 2012 to 15.3 live births per 1,000 population in 2013 despite the birth rate having decreased over the last few years the rate still remains higher than the average for both England and Yorkshire and the Humber.
- The sub national population projections suggest that the 0-5 population is due to increase by 10% by 2021.

b) Deprivation

Of the 8,039 live births registered in 2013, 58.9% (4,731 births) occurred in the most deprived quintile of Bradford. The live birth rate increases as deprivation increases across Bradford district with the crude birth rate for the most deprived quintile of Bradford being 2.5 times greater than the least deprived quintile (19.9 live births per 1,000 population compared to 7.7 live births per 1,000 population respectfully).

c) Gender

As would be expected, there is an even split between the number of girls and boys in Bradford and district.

d) Ethnicity

Bradford district contains a rich mix of ethnic groups and cultures. Approximately just under half of the Districts 0-19 population are from Black and Minority Ethnic (BME) groups. The district has some newly established communities that are growing relatively fast through inward migration. These communities are mostly of white ethnicities from Central or Eastern European countries with a significant Roma/Gypsy element within some of the communities.

Approximately half of the 0-4 population identify themselves as White British or White Other (this category is likely to include individuals from Central Eastern European communities previous years have seen an increase in migration from these communities, however it is difficult to understand the true extent of the migration.) The other half is made up of Black and Minority Ethnic groups, with a significant amount from Pakistani heritage. The following table shows the proportion of 0-4 year olds by ethnicity based on the 2011 census.

Ethnicity	**0 to 4 year olds**
White British	47.3%
White: Other (Including Irish and gypsy or Irish traveller)	3.4%
Mixed/ multiple ethnic group	5.7%
Pakistani	32.3%

Other Asian (Including Indian, Bangladeshi and chinese)	7.6%
Black/African/Caribbean/Black British	1.7%
Other ethnic group	2.0%

e) Religion

It is important that the health visiting service understands the diversity of religious beliefs present in the population of Bradford. According to the 2011 census, the largest religious category amongst 0-14 year olds is Muslim, as the following table shows. It is essential that certain interventions and/or advice may need to take religious beliefs into account. This was highlighted in the consultations where cultural needs were a barrier to access for some services.

Religion	Age 0 to 4	Age 5 to 9	Age 10 to 14	Age 15 to 19
Muslim	38.96%	40.44%	36.73%	32.04%
Christian	26.69%	31.28%	34.64%	36.24%
No religion	24.87%	20.48%	20.89%	23.95%
Not stated	7.90%	6.14%	5.86%	5.86%
All other	1.57%	1.65%	1.87%	1.91%

f) Child poverty

The large and growing 0-19 population in the District mean that a 25.8% child poverty rate equates to 35,820 children and young people aged 0-19. Consistently we find that just over half of children who live in poverty live in 6-8 of the most urban of the District's 30 wards. The most recent figures show that half of children in poverty (51.8%) live in 8 wards. In order of the largest number of children in poverty per ward these are: Bradford Moor, Little Horton, Manningham, Bowling and Barkerend, Tong, Toller, Great Horton and City wards (HM Revenue and Customs, 2013).

This Bradford Public Health Analysis provides a broad analysis of live births and stillbirths within Bradford district as follows:

2. BIRTHS

a) Live births

There were 8,039 live births in Bradford district in 2013 compared with 8,322 live births in 2012 (a decrease of 3.4% compared to a 4.3% decrease for England). Between 2007 and 2010 the total number of births increased year on year from 8,288 in to 2007 to 8,629 in 2010. Since then however, the number of annual live births have fallen and are now below those seen in 2007.

b) Crude live birth rate

The crude live birth rate for Bradford has fallen annually from 16.9 live births per 1,000 population in 2008 to 15.3 live births per 1,000 population in 2013.

c) Stillbirths

The number of stillbirths in Bradford district fell from 59 in 2012 to 58 in 2013. Although the number of live births per year has generally fallen since 2010, the number of stillbirths has remained the same, at an average of 59 per year.
The stillbirth rate in Bradford district increased from 7.0 stillbirths per 1,000 total births in 2012 to 7.2 stillbirths per 1,000 total births in 2013. The increase in stillbirth rate in 2013 can be attributed to by the number of stillbirths remaining the same as previous years, but the number of live births falling from previous years.

d) Low birth weight

The proportion of those babies who have a birth weight less than 2,500g in Bradford district in 2013 was 8.1% compared to 8.6% in 2012. Both the number and proportion of low birth weight babies have generally fallen over the last 7 years, from 808 low birth weight births (9.8%) in 2007 to 646 (8.6%) low birth weight births in 2013

e) Live births to mothers born outside the UK

A third of all births (33.1%) in Bradford are to mothers born outside the UK, higher than the average for England (27.3%). The second highest place of birth for mothers in Bradford are to those born in Pakistan (18.3%) followed by Poland 2.8% and Bangladesh (2.0%).

f) Live births across Bradford district

Bradford East and Bradford West accounted for over half the total live births in 2013 (26.4% and 25.7% respectively). Across Bradford district, live birth rates vary from ward to ward, with higher rates seen in wards such as Manningham, Bradford Moor, Bowling and Barkerend and Little Horton and lower rates seen in Ilkley, Baildon, Bingley Rural and Wharfedale

g) Location of birth

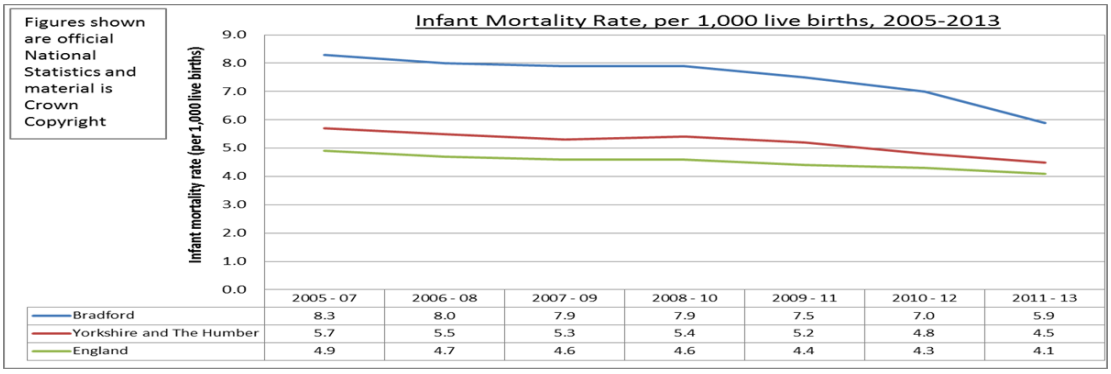
Approximately 90% of all births occur within the two main hospitals in Bradford, with babies born in Bradford Royal Infirmary accounting for over two thirds (69.0% in 2013) of all the births in Bradford district. The proportion of births occurring at each location has remained relatively similar since 2007, with a slight increase being seen in the proportion of live births occurring at home and those births at Bradford Royal Infirmary and a small decrease in the proportion of births occurring at Airedale General.

APPENDIX 5: HEALTH & WELLBEING NEEDS & INEQUALITIES

There are inequalities in the Health and Wellbeing for young children, and those particularly relevant to the Health visiting services which focus on families and children age 0-5. Infant mortality rates, obesity rates and poor oral health are all worse than average compared to regionally and nationally, and are worse in more deprived areas.

a) Infant Mortality

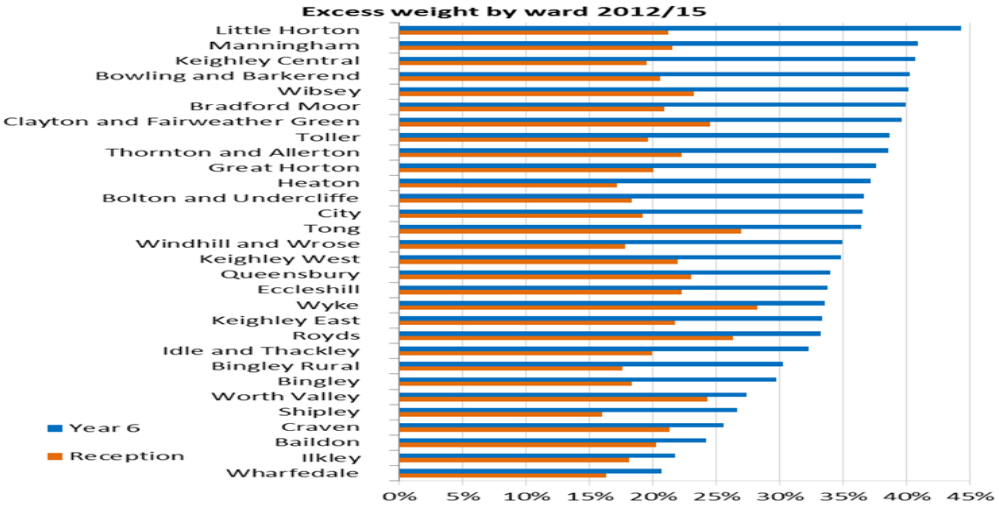
Infant mortality is the death of a child less than one year of age. The latest figures show the infant mortality rate in Bradford was 5.9 per 1,000 live births in 2011-13 but still higher than regionally or nationally. Health visitors have a crucial role as they offer a universal service to all women with children in this age group and offer early intervention, prevention and more targeted support. Health visitors have a crucial role in supporting early access to services.



	2005 - 07	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13
Bradford	8.3	8.0	7.9	7.9	7.5	7.0	5.9
Yorkshire and The Humber	5.7	5.5	5.3	5.4	5.2	4.8	4.5
England	4.9	4.7	4.6	4.6	4.4	4.3	4.1

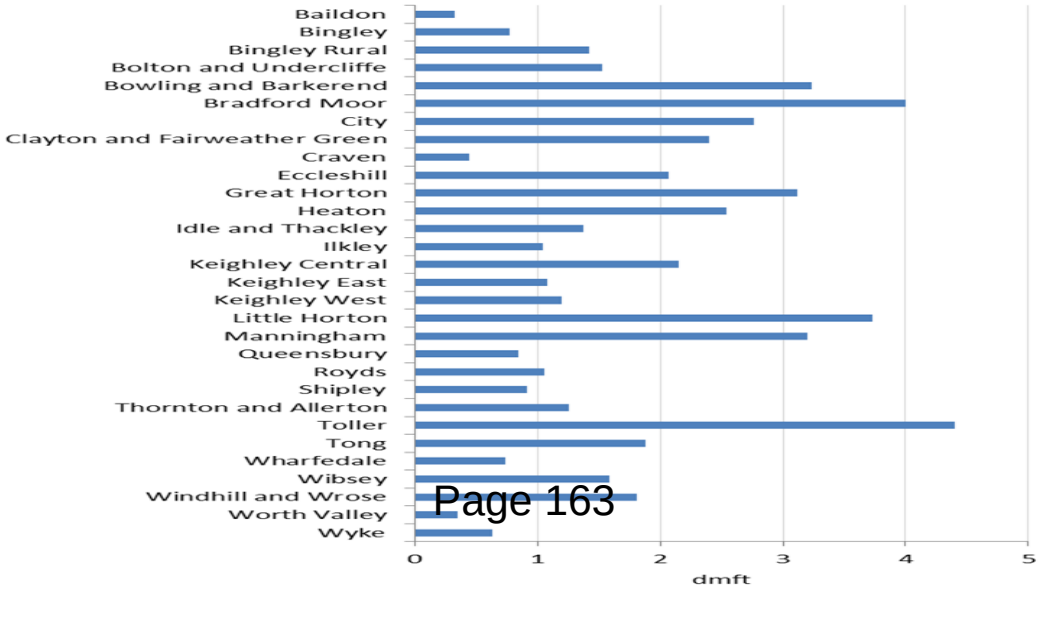
b) Obesity

Obesity rates are higher than regionally or nationally 19.7% of reception pupils in Bradford are overweight or obese (NCMP 2014/15) 35.7% of Year 6 pupils in Bradford are overweight or obese (NCMP 2014/15). Health Visitors have an important role in relation to a healthy start from birth to five where diet and weaning advice is crucial.



c) Oral Health

Tooth decay in 5 year olds is measured as the average number of decayed, missing or filled teeth (dmft).The latest dmft rate in Bradford is 1.98 in 2011/12; higher than nationally or regionally Dmft is significantly higher in wards such as Toller, Bradford Moor and Little Horton. Dmft is significantly lower in wards such as Baildon, Worth Valley and Craven. Oral health has been included as an important part of the health visiting service where a universal service is provided to all children with information



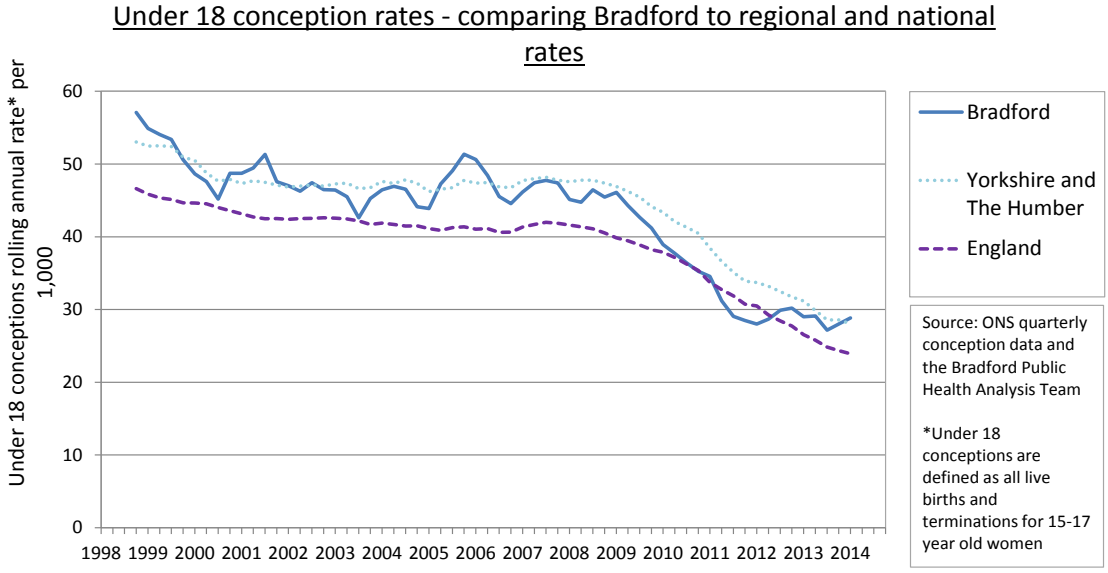
d) Emergency admissions for unintentional injuries (2012/13)

Managing minor illness and reducing accidents (reducing hospital attendance/admissions). Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at Accident & Emergency departments and hospitalisation amongst the under 5s. Managing minor illnesses and reducing accidents is identified as one of the six high impact areas for children age 0-5, and an important part of the early intervention and prevention role health visitors can promote. As can be seen from local data ct areas Out of **496** emergency admissions for children age 0-4 for unintentional injuries, the following include the top five areas:

Unintentional injuries (2012/13) for children age 0-4	**%**
1. Open wound of head	25.0%
2. Open wound of wrist and hand	14.1%
3. Other and unspecified injuries of head	9.5%
4. Superficial injury of head	7.9%
5. Fracture of forearm	7.2%
Total	**63.7%**

e) Sexual Health - Teenage conceptions

The latest data shows that, when averaged across the four quarters of Q2 2013 to Q1 2014, the teenage conception rate of 28.9 per 1,000 in the Bradford district was higher than the Yorkshire and The Humber rate of 28.1 per 1,000 and the England rate of 23.9 per 1,000. The Bradford district teenage conception rate has decreased considerably over time from 57.1 per 1,000 in 1998 which, at the time, was the highest rate in West Yorkshire. The trend over time has decreased in all West Yorkshire local authorities and the rates are now very similar. Improved education and working with young people and their parents has been key to reducing teenage pregnancies across the Bradford district, and the role of the School Nurse may be key in influencing this



Across the four quarters of Q2 2013 to Q1 2014, there were 308 conceptions for 15-17 year old women in the Bradford district, although it is unknown what proportion of the conceptions results in a live birth and what proportion terminates the pregnancy.

The following map shows that the wards with the highest teenage conception rates in 2010-2012 were Wyke, Tong and Keighley West. Between 2009-2011 and 2010-2012, the ward with the greatest increase in rate was Wyke which has not been considered a hotspot historically. This highlights the importance of monitoring the changing Public Health needs of local people.

f) Educational outcomes

Below average 'Good levels of development' aged 5 years in Reception year (Early Years Foundation Profile) – also known as 'school readiness' - compared to nationally 62% Bradford compared to 66% for England. This is worse in more deprived areas of the district.

- Educational attainment is improving but remains below national averages and much lower in more deprived areas. 53% of children obtain 5 A-C GCSEs including English and Maths compared to 59% nationally.
- Less children achieve a good level of development at age 5 than nationally. 36% of children eligible for free school meals achieved a 'good' level of development aged 5, compared to 56% of children not so eligible.

g) Child Health Profile – 2016

The Child Health Profile for Bradford local authority is published annually (last updated 15 March 2016) via Public Health England, and provide a snapshot of performance around child health and wellbeing, using 32 selected key health indicators. This profile (below) enables comparisons to be made locally, regionally and nationally.

http://www.chimat.org.uk/resource/view.aspx?RID=273397

Bradford Child Health Profile — March 2016

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	1 Infant mortality	47	5.8	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	24	17.3	12.0	19.3	5.0
Health protection	3 MMR vaccination for one dose (2 years) >=90% <90%	7,695	94.1	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	7,875	96.3	95.7	79.2	99.2
	5 Children in care immunisations	550	82.1	87.8	64.9	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	5,030	62.2	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	3,060	47.5	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	990	5.4	4.7	9.0	1.5
	10 First time entrants to the youth justice system	283	487.2	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	29,595	24.0	18.6	34.4	6.1
	12 Family homelessness	192	0.9	1.8	8.9	0.2
	13 Children in care	880	63	60	158	20
	14 Children killed or seriously injured in road traffic accidents	34	27.5	17.9	51.5	5.5
Health improvement	15 Low birthweight of term babies	278	3.7	2.9	5.8	1.6
	16 Obese children (4-5 years)	582	8.6	9.1	13.6	4.2
	17 Obese children (10-11 years)	1,345	21.5	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	46.0	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	164	497.2	322.0	1,406.8	11.7
	20 Under 18 conceptions	299	27.9	24.3	43.9	9.2
	21 Teenage mothers	81	1.1	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	45	32.5	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	77	111.3	88.8	278.2	24.7
Prevention of ill health	24 Smoking status at time of delivery	1,192	15.1	11.4	27.2	2.1
	25 Breastfeeding initiation	5,481	70.7	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	3,226	41.6	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	19,109	465.9	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	1,593	135.9	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	1,238	179.4	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	420	287.3	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	111	79.9	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	483	463.8	398.8	1,388.4	105.2

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2012-2014
2 Directly standardised rate per 100,000 children age 1-17 years, 2012-2014
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2014/15
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2014/15
5 % children in care with up-to-date immunisations, 2015
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2014/15
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2014/15
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
9 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2014
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2014
11 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2013
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2014/15
13 Rate of children looked after at 31 March per 10,000 population aged under 18, 2015
14 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2012-2014
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2014
16 % school children in Reception year classified as obese, 2014/15
17 % school children in Year 6 classified as obese, 2014/15
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
19 Crude rate per 100,000 (age 1-4 years) for hospital admissions for dental caries, 2012/13-2014/15
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2014/15
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2012/13-2014/15
24 % of mothers smoking at time of delivery, 2014/15
25 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2014/15
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2014/15
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2014/15
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2014/15
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2014/15
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2014/15
32 Directly standardised rate per 100,000 (age 10-24 years) for emergency hospital admissions for self-harm, 2014/15

APPENDIX 6: CURRENT HEALTH VISITING SERVICE

Based on the tier waiting lists Bradford District Health Trust (BDFHT) indicate a total number of **42,442** children age 0-5, of which **39,918** are universal contacts (94.1% respectively) as stated below:

Level	Service	Number	%
Tier 1	**Universal**	**39918**	**94.1%**
Tier 2	**Universal Plus**	**1577**	**3.7%**
Tier 3	**Partnership**	**767**	**1.8%**
Tier 4	**Partnership Plus**	**180**	**0.4%**
Total		**42442**	

1. Health Outcomes

Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims "to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest." Specifically, children's public health contributes to:

Improving the wider determinants of health	▪ PHOF 1.2: School readiness
Health Improvement	▪ PHOF 2.2: Breastfeeding initiation and prevalence at 6-8 weeks after birth ▪ PHOF 2.5: Child development at 2-2½ years ▪ PHOF 2.6: Excess weight in 4 – 5 year olds ▪ PHOF 2.7: Hospital admissions caused by unintentional and deliberate injuries in under 5s ▪ PHOF 2.21: Access to non-cancer screening programmes
Health Protection	▪ Population vaccination coverage (PHOF 3.3) ▪
Healthcare public health and preventing premature mortality	▪ PHOF 4.1: Infant mortality ▪ PHOF 4.2:Tooth decay in children aged 5

The Government, NHS England, Public Health England, Royal Colleges, local government organisations and others signed up to the pledge for *Better health outcomes for children and young people* in February 2013.

The indicators set out in the Public Health Outcomes Framework can be used to monitor and measure effectiveness of local efforts to improve public health:

- Child development at 2 – 2 ½ years
- Hospital admissions caused by unintentional and deliberate injuries

Other indicators include:

- Children in poverty
- Improved vaccination coverage
- Improved School readiness
- Reduced Pupil absence
- Increase in 16-18 yr olds not in education, employment or training
- reduction in Under 18 conception rate
- reduced 1st time entrants to the youth justice system
- reduced hospital admissions for intentional self-harm
- reduced Hospital admissions for alcohol-related harm
- reduction in Domestic violence
- reduced Rates of violent crime including sexual violence

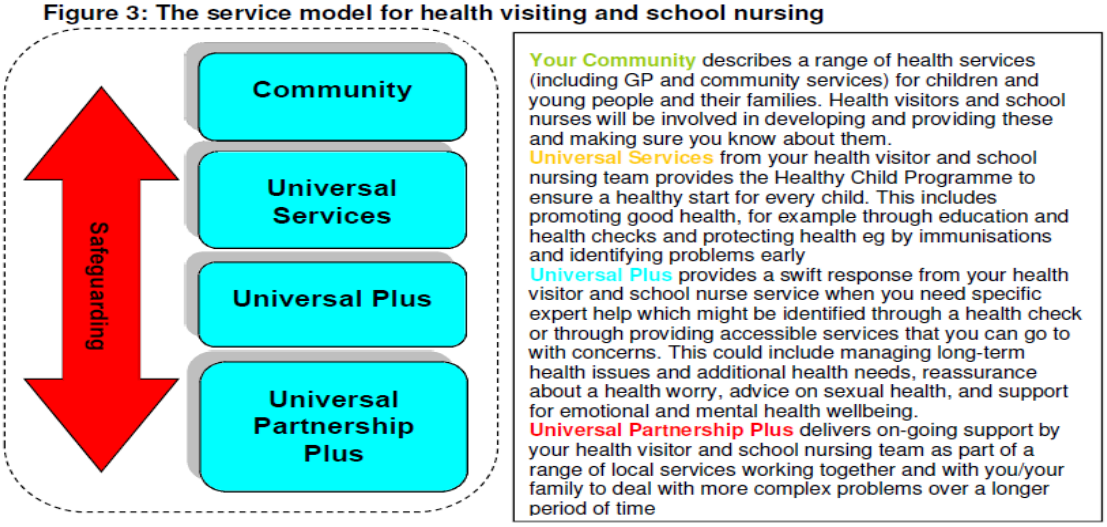
2. Service description for the universal elements of the HCP

The universal elements of the HCP are delivered by a team led by health visitors working in a way that is most appropriate to local public health needs and across a range of settings and organisations including general practice, maternity services and children's centres (except where families are accessing FNP, in which case the FNP nurse – family nurse – will take on this role until the child is two years old). As an overview, core elements of the HCP include:

a) **Health and development reviews** – To assess family strengths, needs and risks; provide parents the opportunity to discuss their concerns and aspirations; assess child growth and social and emotional development; and detect abnormalities.
b) **Screening** – an integral part of the universal HCP. Commissioning of national childhood screening programmes is specified separately (NHSE)
c) **Immunisations** – Immunisations should be offered to all children and their parents. General practices and child health record departments maintain a register of children under five years, invite families for immunisations and maintain a record of any adverse reactions in the CHIS. Commissioning of childhood immunisation programmes is specified separately (NHSE).
d) **Promotion of social and emotional development –** The HCP includes opportunities for parents and practitioners to review a child's social and emotional development, for the practitioner to provide evidence-based advice and guidance and for the practitioner to decide when specialist input is needed.
e) **Support for parenting –** One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who are trained and supervised.
f) **Effective promotion of health and behavioural change** – Delivery of population, individual and community-level interventions based on NICE public health guidance.
g) **Sick children** – Supporting parents to know what to do when their child is ill.
h) **Children with a disability** – Early diagnosis and early help.

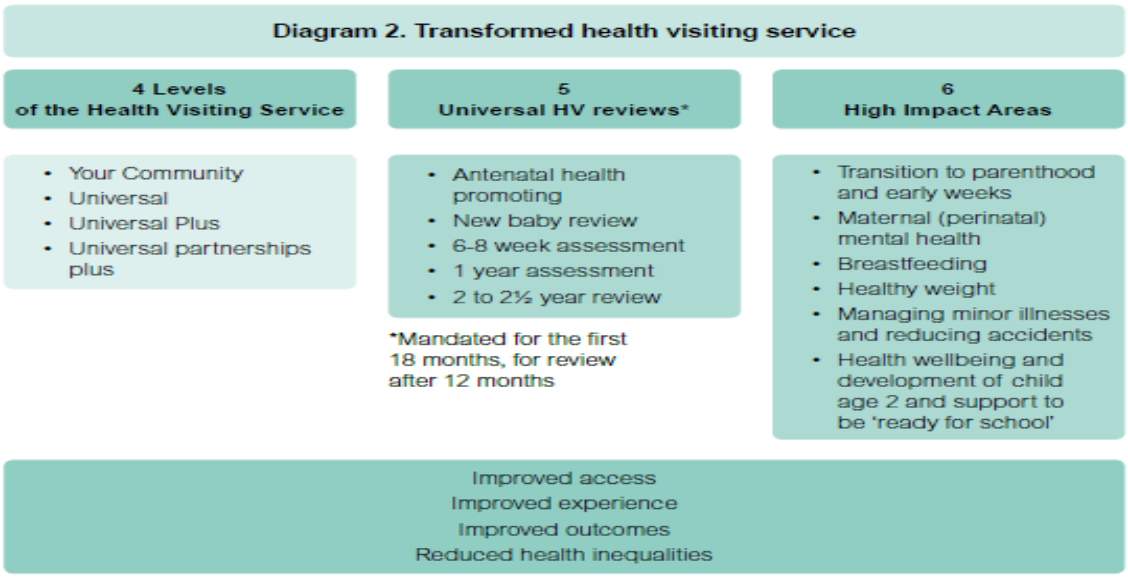
3. Safeguarding

Figure 3: The service model for health visiting and school nursing



4. The specification reflects the 4-5-6 model

a) **Four progressive tiers of health visiting practice** – building community capacity; the universal elements of the Healthy Child Programme; targeted interventions to meet identified need, and partnership working to meet complex needs



b) Delivery of the Five universal HCP checks and reviews

As part of the transfer of services the Department of Health (DH) has mandated local authorities (under section 6C of the NHS Act 2006) to ensure the provision of the following five key elements of the HCP to be delivered by health visitors:

1. **Antenatal health promoting reviews**
2. **New baby reviews**
3. **Six to eight week assessments**
4. **One year assessments and**
5. **Two to two and a half year reviews.**

Health visitor service delivery metrics were developed by NHS England in order to provide assurance on service transformation in England around the five key areas and reporting included the following indications:

- Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above;
- % of new birth visits completed after 14 days;
- % of 6 to 8 week development reviews completed by 8 weeks;
- % breastfeeding (fully or partially) at 6 to 8 weeks;
- % of 12 month development reviews completed by the time the child turned 12 months;
- % of 12 months development reviews completed by the time the child turned 15 months;
- % of 2 to 2½ year reviews completed by age 2½ years;
- % of 2 to 2½ year development reviews delivered using the ASQ-31 (new indicator).

c) Six high impact areas:

- Working in partnership with other services in supporting assessment of education and health and care plans for children aged 0-5s is a strong focus, including a family centred approach to meeting the needs of children with Special Educational Needs and contributing to high intensity multi-agency services where there are safeguarding or child protection concerns. The specification highlights the health visiting contribution as experts and leaders in delivering better health and wellbeing for 0-5s. The Six High Impact Area documents have been developed to articulate the contribution of health visitors to the 0-5 agenda and describe areas where health

visitors have a significant impact on health and wellbeing and improving outcomes for children, families and communities. This includes:

1. **Transition to Parenthood and the Early Weeks**
2. **Maternal Mental Health (Perinatal Depression)**
3. **Breastfeeding (Initiation and Duration)**
4. **Healthy Weight, Healthy Nutrition (to include Physical Activity)**
5. **Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)**
6. **Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'**

APPENDIX 7: STAFFING AND FINANCE

Staffing

The Health Visiting Service is split into multidisciplinary teams comprising of qualified Nurses, Nursery Nurses and Health Care Support Workers.

Expansion of FNP took place from 2011 over 3 years and is now funded for Supervisors, Family Nurses and Quality Support Officer during 2015. The team has a maximum capacity for delivery of FNP to 245 clients. There are a total of:

- There are a total of 215.66 WTE HV staff (Qualified HV and FNP (Band 6 and above) = 163.12WTE.
- 12.61 FNP staff
- **Totalling 228.27 staff**.

Finance

The current service transferred from NHS England with a part year budget and Contract value of £6,020,319 for 2015/16. At the point of the Review, the contract value for 2016/17 was £10,692,530.

APPENDIX 8: CURRENT PERFORMANCE (HV) SERVICES

Level of service provided by Health visiting teams

Based on the tier waiting lists BDCFHT indicate the following level of services for Universal and targeted services.

Level	Service	Number	%
Tier 1	Universal	39918	94.1%
Tier 2	Universal Plus	1577	3.7%
Tier 3	Partnership	767	1.8%
Tier 4	Partnership Plus	180	0.4%
Total		42442	

Current Service Performance

The current service is based on national KPIs, although local variations include Healthy start and oral health, as well as ensuring integrated working and Health Visitor leadership to the children centre clusters of which there are now seven.

Mandated Health Checks

Current measures based on the five mandated health checks and reviews and includes the KPIs highlighted in table below which is collected quarterly.

Indicator/Measurement
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above
% of new birth visits completed within 14 days
% of new birth visits completed after 14 days;
Total number due 6-8 week check
Number of infants where breastfeeding status is recorded at 6-8 week check
% breastfeeding (fully or partially) at 6 to 8 weeks;
Total Number of children age2.5 in that qtr
% of 12 month development reviews completed by the time the child turned 12 months;
% of 12 months development reviews completed by the time the child turned 15 months;
% of 2 to 2½ year reviews completed by age 2½ years
Total number of children 2 to 2½ year in that Qtr

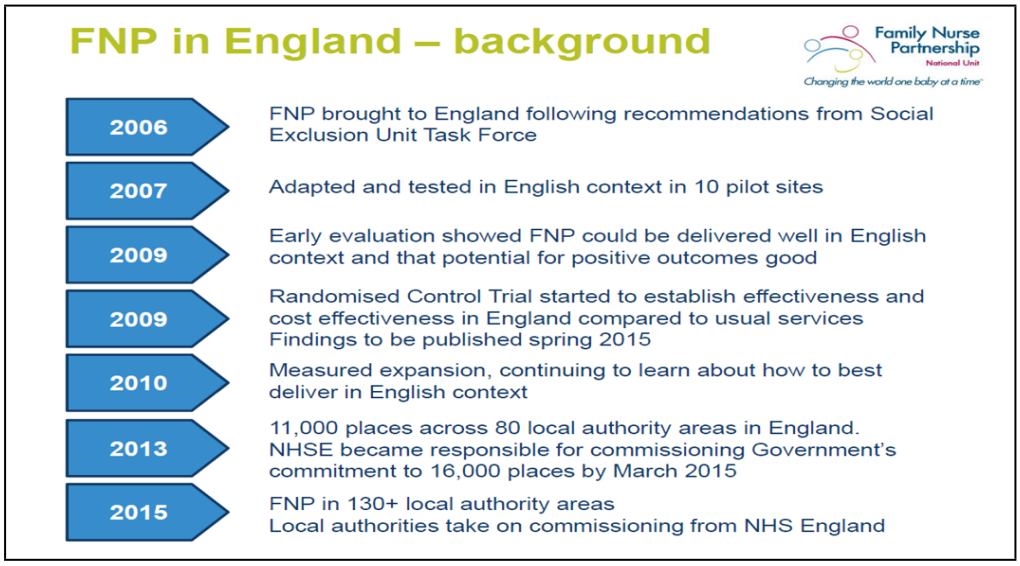
High impact areas

These KPIs relate to local variations which were included at the time of transfer and refer to new KPIs in addition to the nationally defined ones. Hence the data is not complete but shows the level of detail expected as part of the service. Where areas are not met, action plans and reports are provided.

APPENDIX 9: FAMILY NURSE PARTNERSHIP PROGRAMME

1. Background - Why is FNP important?

- Number of births to teenage mothers in England was substantial - 32,000 in 2013
- Teenage mothers often have low economic and psychological resources which can be a barrier to them being an effective parent
- There is strong evidence indicating that children of teenage mothers and mothers themselves are at high risk of poor health and development outcomes over the course of their life as well as increased risk of infant mortality
- Levels of safeguarding and domestic violence are high in young parents



2. FNP licence and national leadership

a) The FNP programme is a licensed programme and therefore has a well-defined and detailed service model, which must be adhered to.

b) DH retains policy responsibility for FNP. The FNP National Unit provides FNP providers with support and guidance for implementation of the programme, provides sub-licences to providers, delivers the learning programme for family nurses and supervisors, provides the FNP Information System, leads quality assurance and improvement processes, offers networking between sites and the coordination of programme developments and augmentations and supports the commissioning of FNP by NHS England.

3. Roles

a) Three key organisations are involved in delivery of the FNP programme. The Department of Health retains responsibility for the overarching policy for the FNP programme. DH holds the national licence for FNP from the University of Colorado, Denver, and must ensure that the programme is delivered in England in accordance with that licence.

b) NHS England was responsible for commissioning providers to deliver the commitment to increase the number of places on the FNP programme to 16,000 by 2015, in line with the agreed commissioning priorities.

c) The FNP National Unit is responsible for ensuring the delivery of the programme to the licence standards. The FNP National Unit leads implementation support and the family nurse and supervisor learning programme as set out in its contract

with DH. It provides a quality improvement programme, in line with the FNP and provides intensive support with regular review and follow up.

d) Public Health in Local Authority took over commissioning in October 2015.

4. FNP target population

FNP is a voluntary programme, targeted to first time mothers aged 19 and under (at last menstrual period) with the aim to enrol women on the programme as early as possible in pregnancy, ideally before 16 weeks and no later than 28 weeks gestation. Other specific criteria include geographical location according to predicted population needs.

5. Aims

FNP shares the over-arching aims of the HCP to reduce inequalities in outcomes and to ensure a strong focus on prevention, health promotion and early identification of needs. It has additional specific aims, which are to:

1. improve the outcomes of pregnancy by helping young women improve their ante-natal health and the health of their unborn baby;
2. Improve children's subsequent health and development by helping parents to provide more consistent competent care for their children; and
3. Improve women's life course by planning subsequent pregnancies, finishing their education and finding employment.

6. Service description

a) The FNP programme consists of structured home visits from early in pregnancy until the child is two, delivered by family nurses. The visits cover the six domains of: personal health, environmental health, life course development, maternal role, family and friends, and health and human services. FNP is based on the theories of human ecology, attachment and self-efficacy.

b) FNP is delivered in an integrated way with maternity, general practice, community health services, health visiting, children's centres, Job Centres and third sector providers within the context of integrated children's services and the HCP.

c) The service will be flexible and responsive, adapting to the individual needs of children and families whilst ensuring fidelity to the licensed FNP programme model.

7. Expectation of Providers

a) Providers will be expected to have systems in place for early recruitment of young women (before 16 weeks gestation) to maximise the enrolment of eligible clients in early pregnancy, enabling them to get maximum benefit from the programme.

b) Providers will be expected to have clear operational standards in place, in relation to how the FNP interfaces with, and relates to, all of the agencies supporting the delivery of the HCP. Providers will also be expected to have pathways in place for families moving from FNP to universal HCP and children's services. Providers will be expected to provide strong organisational leadership and support so the FNP programme can be delivered well in their area.

c) Family nurses will work in partnership with parents using the FNP guidelines, other programme materials and methods to enable mothers and fathers to increase their knowledge and understanding, set goals, make behaviour changes and develop their reflective capacity. This will enable them to build strong attachments with their baby, enhance their self-efficacy, develop effective strategies for good infant and toddler care-giving, strengthen and adapt to their parenting role.

d) Each site is required to recruit an FNP supervisor to lead the clinical implementation of the FNP programme with families. The FNP supervisor is responsible for the quality of programme delivery, using the FNP information system to support their assessment and improvement of implementation quality.

8. Service model

a) FNP will be delivered by a team of trained family nurses, led by the FNP supervisor and accountable to the local FNP Advisory Board. The FNP Advisory Board consists of senior decision makers for children and young people's services from the NHS, Local Authority and appropriate partner services. The Advisory Board is, generally speaking, chaired by the relevant commissioner from an Area Team.
b) Programme of FNP visits include:

- 1 per week first month
- Every other week during pregnancy
- 1 per week first 6 weeks after delivery
- Every other week until 21 months
- Once a month until age 2 10.18 Visits last approximately one hour and cover the following domains:
  - Personal health – women's health practices and mental health
  - Environmental health – adequacy of home and neighbourhood
  - Life course development – women's future goals
  - Maternal role – skills and knowledge to promote health and development of their child
  - Family and friends – helping to deal with relationship issues and enhance social support
  - Health and human services – linking to other services 10.19 The provider will implement the programme in accordance with the FNP Sub-licensing agreements and the expectations set out in the latest FNP Management Manual, provided by the FNP National Unit. This includes providing local safeguarding arrangements.

9. Recruitment Pathway

Those eligible will be identified by maternity services and notified to the FNP supervisor at 12 weeks gestation or earlier as far as possible. Clients must be enrolled on the programme no later than 28 weeks gestation with a specific fidelity goal to enrol at least 60% by 16 weeks gestation. Other services (e.g. GPs, education, children's centres) are able to identify and refer potential clients to FNP. Offer of the programme and recruitment will be carried out by the FNP team. FNP teams are expected to enrol clients onto the programme using a staged approach.

10. Care Pathway

The following is an outline of the FNP care pathway:

a) First time young mothers aged 19 and under will be offered FNP as part of the preventive pathway within the HCP. Young mothers enrolling on the programme will be visited by the same family nurse until the completion of the programme when the child is 2 years of age;

b) The programme will be delivered to young mothers within the context of the immediate and extended families involving fathers and grandparents;

c) Young mothers who accept the programme will receive structured visits from the family nurse in line with the FNP programme model;

d) The family nurse will work closely with the midwives who will be responsible for the young mother's midwifery care;

e) Babies born into the programme will receive the HCP as part of the FNP. The family nurse will deliver the HCP and is responsible for ensuring access to the

physical examination, newborn hearing screening, blood spot screening and immunisations;

f) Before children reach the age of two years, the family nurse will notify the health visitor lead for the HCP team, and agree future service delivery. Families will be supported to access wider children's services to meet their individual needs;

g) The FNP Supervisor will have systems in place for effective communication, audit and information sharing for all aspects of the FNP with midwives, social care, health visitors, GPs and children's centres;

h) Young mothers who choose not to enrol on FNP will be notified back to the midwife who will continue to coordinate care for the family until 14-28 days after the birth of the baby ensuring the young mother has access to the universal and progressive aspects of the HCP;

i) Every effort will be made by the family nurse to ensure continued engagement of the client in FNP. Clients who leave the programme before their child is 2 years old will be notified to the health visitor who is responsible for universal services, ensuring access to preventive services and to others providing the HCP (e.g. GPs). FNP teams will follow the FNP National Unit's guidance and local guidance regarding clients who cannot be traced and will act to safeguard the child or other family members where risks are identified requiring further actions;

j) Family nurses and supervisors will use the FNP Information System to record data about their clients and use this to inform how they deliver the programme; and,

k) Where the FNP client has a second child during the time of her involvement with FNP, the family nurse will be responsible for delivery of the HCP to the family for the second child, in addition to the first, until the first child reaches the age of 2 years.

11. Discharge Criteria and Planning

a) A client graduates from the programme when the child reaches 2 years of age. Responsibility for HCP delivery is transferred back into universal HV services.

b) Before children reach the age of two years the family nurse will notify the health visitor lead for the HCP team and discuss the handover process with the client. Families will be supported to access children's centres and the HCP will match services and interventions to their individual needs.

c) Family nurses will continue to make all efforts to locate clients who cannot be found and persist in their efforts to re-engage clients who indicate that they no longer wish to receive the programme, either directly or by repeated missed visits.

d) If a client with significant risk or safeguarding factors is not receiving programme visits for any reason, local safeguarding processes should be implemented.

e) Young mothers who choose not to accept FNP will be notified to the midwife who will continue to coordinate care for the family until 14-28 days after the birth of the baby ensuring the young mother has access to the universal and progressive aspects of the HCP.

APPENDIX 10: FINDINGS FROM THE RCT & BRADFORD FNP

Family Nurse Partnership

FNP in Bradford & Airedale began in November 2010 as a Wave 3b site with 1 (0.8 WTE) Supervisor, 4 (3.75 WTE) Family Nurses and 1 (0.5 WTE) This gave an approximate coverage of 10% of eligible clients. Recruitment of clients was from identified teenage pregnancy hotspot areas and compliant with licence requirements.

As a result of the successful implementation and evaluation and the measured expansion nationally, expansion of FNP took place from 2011 over 3 years and is now funded for 1.32 WTE Supervisors, 9.42 WTE Family Nurses and 0.96 WTE Quality Support Officer and a maximum capacity for delivery of FNP to 245 clients.

This gives an approximate coverage for 30% of eligible clients.

Clients are currently recruited from the following wards:

Tong, Low Moor, Wyke, Great Horton, Little Horton, Bowling & Barkerend, Allerton, Royds and Keighley

Direct referrals of potential clients from Looked After or Leaving Care systems and Families First are not restricted to geographical areas. Additionally, potential client with other risks such as ongoing mental health issues are considered outside the current geographical area.

The findings of the key national research on FNP published in September 2015 have been discussed with the National FNP Team alongside local data for FNP. Primary health outcomes were not improved but there was evidence of some improvements in other secondary outcomes and the results and implications are under consideration nationally and locally as part of the FNP ADAPT approach

APPENDIX 11: CURRENT PERFORMANCE (FNP)

The current FNP programme has demonstrated high fidelity to the licensed FNP programme and the recent FNP Advisory Board in March 2016 confirmed this. There is evidence that the FNP team overall perform better than similar teams across the country in terms of both fidelity and adherence to the programme and also in terms of improving outcomes for pregnant women and children in a range of areas monitored via this programme.

APPENDIX 12: HEALTH VISITING & FNP CONSULTATION

See pdf attached.

Health Visiting Service Review - Con

APPENDIX 13: PROPOSED MODEL FOR HEALTH VISITING

Future commissioning needs to support sustainable health visiting services and the '4, 5, 6' model helps to explain the public health services for 0-5s. The four levels of health visiting service, the five elements which are mandated, and the six high impact areas focus on evidence based interventions which are up to date and align with early years and other appropriate services.

It is also important that we continue with the 4-5-6 model but align this more effectively within children services so that it is more integrated. As part of this it will be important we review the current integrated care pathways

Although it is anticipated that the Regulations to mandate the five universal reviews will expire on the 31 March 2017, it is important locally that we continue mandating the five universal reviews within the Healthy Child Programme. Future commissioning needs to continue to support sustainable health visiting services identified in the '4-5-6' model. This includes the six high impact areas which focus on evidence based interventions which align more effectively within children services and the CCGs so that services are more integrated. As part of this it will be important we review and enhance the current integrated care pathways, and in conjunction with the children centre review.

National and local policy context is being implemented locally and overall we have a good 0-5 service with both national and local performance monitoring arrangements. Whilst the outcomes of the review and consultation have been mainly positive, we have drawn out areas from the consultation, which require improvement and further development in order to have a model which is fit for purpose and geographically aligned. Given the current financial climate it is even more important we have a model which is cost effective and demonstrates value for money.

Recommendations for proposed model of health visiting services

1. **Effective leadership, coordination and delivery of the Healthy child programme as highlighted in the 4-5-6 model, including the five mandated health checks, 6 high impact areas and both universal and targeted services.**
   a) Effective delivery of both Universal and targeted services in order to deliver mandated health checks and child development reviews in accordance with the integrated care pathway
   b) Effective delivery and support of the six high impact areas

2. **Delivery of evidence based outcome focused interventions to improve health and wellbeing and reduce inequalities by focusing on needs of young children including vulnerable groups.**

3. **Effective teams and partnerships, working across professions and organisations; using evidence based interventions and the development and implementation of appropriate pathways to support families with early help.**
   a) Deliver on an area-based service structured in line with local children's services, using an integrated approach to improving child and family health locally, including leading partnerships within early year's settings, Children centre clusters and other partner agencies including social care and the voluntary and community sector.
   b) Ensure local intelligence and mapping of services is incorporated into appropriate delivery models to improve outcomes for children, young people and their families (with effective signposting).
   c) Provide proactive 'early help' and leadership as part of a multi-agency team with direct partnership with schools to provide improved access and delivery of the Healthy Child Programme and school readiness

d) Develop effective professional partnership pathways working with other parts of the health system so there are clearer pathways and referrals and a single child health record (for example primary care, speech language therapy, audiology, screening and child health systems).
e) Establish positive partnerships with families to support effective lifestyle and behaviour change.

4. **Improved access to health visiting services through a geographically aligned model with clear alignment to children's centre clusters. This includes recognising the important role and links to GPs and Primary care, and mapping of Voluntary and community Sector organisations and groups to support and signpost to where necessary.**
   a) Better access to the health visiting service (not through a hub), and direct access for vulnerable families and special needs.
   b) Access to health visiting services in locations closer to where families live
   c) Access to private facilities with flexibility where needed to target vulnerable groups, such as minority groups and engagement with fathers.
   d) Every family has access to an appropriate interpreter where needed.

5. **Improved communication and resources according to community needs, ensuring more "visibility" of health visitors and information and resources in appropriate languages.**
   a) To ensure a clearer understanding about the role of the health visiting/FNP and what families/services can expect from the service using different methods of communication according to need (social networks/media/campaigns)
   b) To be more visible in the community setting (drop ins)
   c) Information provided in appropriate community languages
   d) Bilingual support available to vulnerable women who do not speak English (Asylum Seeker/Travellers/ Gypsies)

6. **Workforce capacity and development to ensure diverse needs of communities are represented but also appropriate training to ensure a competent workforce and relevant skill mix providing consistency in messages.**
   a) To ensure appropriately skilled and experienced workforce working in multi-disciplinary roles (skill mix and students) with appropriate leadership.
   b) To ensure workforce reflects the diversity of the local population and communities it serves, with an understanding of the diverse and cultural needs of the District.
   c) To undertake Public Health and relevant training as required.

7. **Targeted work with vulnerable Families and children with specific needs, and to ensure appropriate structures in place so families of children age 0-5 and mothers do not miss out on vital health checks**
   a) To identify families with high risk and low protective factors
   b) To utilise specialist skills to identify risk factors in protecting children. Some risk factors may be so high that no amount of protective factors will compensate and action to prevent the child from harm must be taken;
   c) To link to wider stakeholder and services, for example local A&E services and the local Troubled Families Team
   d) To map out services in their geographical areas so women and families can be signposted to (e.g. local areas to Voluntary and community health organisations and groups - such as bereavement support, Homestart, children centres, community groups, obesity groups and other Early years services)
   e) To ensure structures in place so no families with children age 0-5 miss out on vital health checks and reviews – for example women who have not given birth in Bradford (migrant communities) and Mothers with babies with special needs still in hospital.

8. **Service delivery to incorporate 'Journey to Excellence' with 'Early Help' and 'Signs of Safety' as well as implementation of the Integrated Early Years Strategy for children age 0-7**
   a) Undertaking comprehensive population, community family and individual needs assessments and undertaking wider public health work to reduce inequalities
   b) Consistency of health messages given to service users and their families.
   c) Support to vulnerable families and those with complex and additional needs;
   d) Working with GPs to ensure referrals and raising of concerns, prompting for 6-8 week check.
   e) Service delivery forming a key part of 'Journey to Excellence' with 'Early Help', 'Signs of Safety' integrated within the service model.

9. **A caseloads model to be developed and delivered according to need and priority**
   To prioritise caseloads according to need.

10. **Nurse prescribing to include advice and support in managing minor illness and reducing hospital admissions, as well as providing level 1 contraceptive advice.**

11. **Ensure robust transition to school for children and close working with the school nursing service.**

The New Service Offer

APPENDIX 14: PROPOSED MODEL FOR FNP

Family Nurse Partnership

One of the key priorities for Public health is to ensure future commissioning supports sustainable public health services for 0-5s, and provides the best outcomes for children and their families, through universal health visiting services and targeted support such as the Family Nurse Partnership (FNP).

Whilst evidence from the consultation and findings from the FNP have provided excellent feedback from service users and stakeholders, this has not correlated with national evidence from literature review and the recent publication of the RCT. Given the funding cuts and recent research highlighting the impact of FNP, it is recommended that a new model of FNP which is fit for purpose is developed locally. This should include how this can be embedded into the local health visiting services with a focus on child development and a smoother transition from FNP to health visiting services

One of the advantages locally in Bradford, unlike other neighbouring areas where decision has been made to decommission FNP - is that we have the Better Start Bradford. This provides a real opportunity to develop and pilot a model which is based on local need and supported by the national team with robust monitoring processes with more locally defined outcomes and criteria.

The current model of FNP would need to include an exit strategy incorporating any risks and a revised model which is based on local outcomes agreed with the national unit. It is proposed that the local model is based on less frequency of contact, which will allow for more targeted work with an increase in the numbers of women targeted. It is proposed that the new model reduces the frequency in terms of number of visits and length from two years to one year, with a smoother transition to the health visiting service which will have a revised model incorporating the learning from the FNP.

Recommendations for a new Family Nurse Partnership model

Recommendations are based, not only on consultation and stakeholder engagement but also contextualised in relation to literature review and current research evidence such as the FNP RCT and discussions with the FNP Board and Better start.

Whilst evidence from the consultation and findings from the FNP have provided excellent feedback from service users and key stakeholders, this has not correlated with national evidence from the literature review and in particular the recent publication of the RCT, and the following recommendations are therefore proposed

1. Develop of a new model of FNP (FNP ADAPT) which is fit for purpose and developed with locally defined outcomes
2. Embed the learning from the FNP into the proposed health visiting service, focusing on child development and a smoother transition from FNP to health visiting services.
3. Work in partnership with Better Start Bradford to develop and pilot a model which is based on local need and supported by the National FNP Team
4. Ensure robust performance and monitoring processes in place which can compare outcomes from Health visiting to FNP
5. Review and inclusion of long term outcomes and wider determinants, such as educational achievement, with attached measures to be monitored as part of FNP.

   This provides an opportunity to embed the learning from the FNP into the local health visiting service, which is identified as a gap in current service provision. This will need to focus on child development and a smoother transition from FNP to health visiting services. One of the advantages locally in Bradford, unlike other

neighbouring areas where - is that we have the Better Start Bradford. This provides a real opportunity to develop and pilot a model which is based on local need and supported by the national team with robust monitoring processes with more locally defined outcomes and criteria.

APPENDIX 15: EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Form

Department	Public Health	**Version no**	1.0
Assessed by		**Date created**	8.03.2016
Approved by		**Date approved**	
Updated by		**Date updated**	
Final approval		**Date signed off**	

Section 1: What is being assessed?

1.1 Name of proposal to be assessed:

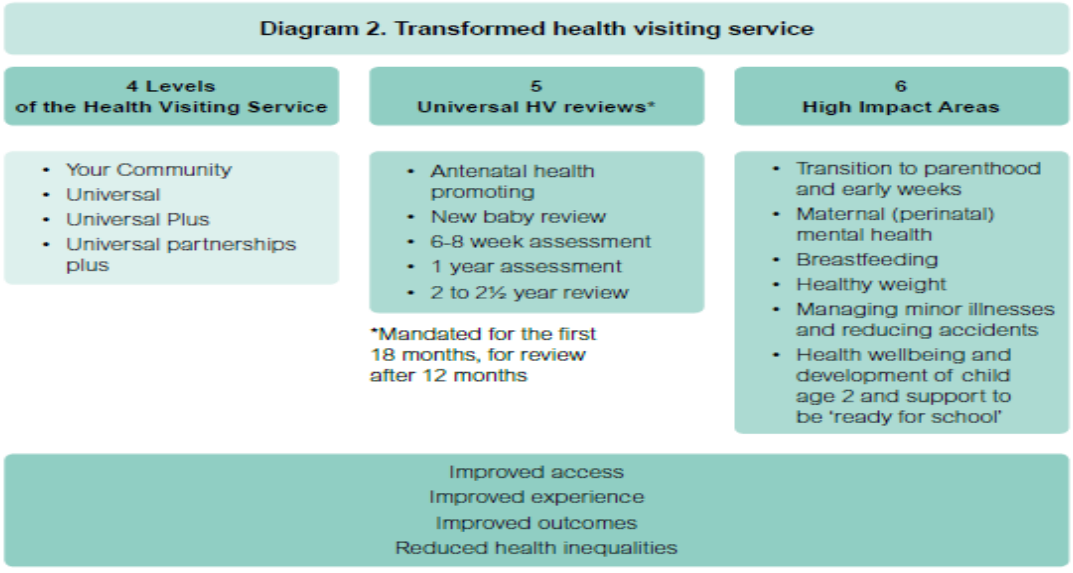
Health Visiting and FNP service for children age 0-5

1.2 Describe the proposal under assessment and what change it would result in if implemented:

Following transition of the 0-5 health visiting service into the local Authority in October 2015, it was a timely opportunity to undertake a review of the health visiting and FNP service.

The purpose of the review was to identify if the current service model meets current and emerging needs, fits within the 'Journey to Excellence' and 'New Deal' programmes and to identify opportunities for service improvement.

The service was reviewed in line with key national and local policy, guidance and strategy and was informed by consultation and engagement with key stakeholders. Key priority areas for Health visiting included both mandated and high impact areas as highlighted:



The current service is based on a national specification with four tiers of services to ensure both a universal and targeted service to ensure safeguarding is at the forefront of service delivery. The current services also includes mandated

services such as the universal reviews, as well as the high impact areas which are already an important part of the local early years strategy and objectives for the district.

Key stakeholders and partners reiterated the importance and strengths of a universal health visiting service identifying areas for improvement which will be outlined in the recommendations. This will result in a more accessible service that is better able to respond to the equality and diverse needs of children, young people and their families.

Section 2: What the impact of the proposal is likely to be

The Equality Act 2010 requires the Council to have due regard to the need to-

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

2.1 Will this proposal advance equality of opportunity for people who share a protected characteristic and/or foster good relations between people who share a protected characteristic and those that do not? If yes, please explain further.

The proposal will advance equality of opportunity and support a reduction in health inequalities in children age 0-5 and their families including those with a protected characteristic. The new service model will ensure improved service accessibility for priority groups such as pregnant and breastfeeding mothers, babies and children as well as ensure effective delivery targeted at most vulnerable groups.

2.2 Will this proposal have a positive impact and help to eliminate discrimination and harassment against, or the victimisation of people who share a protected characteristic? If yes, please explain further.

The proposal will not directly eliminate discrimination, harassment or victimisation but it will support this as the focus is on pregnant and maternity which is a protected group.

2.3 Will this proposal potentially have a negative or disproportionate impact on people who share a protected characteristic? If yes, please explain further.

The Equality assessment carried out indicates that this proposal is not likely to have a negative disproportionate impact on most if not all protected characteristics. However, one of the main aims of the new service model is to reduce health inequalities so will therefore have a positive impact on children and young people who experience health inequalities.

2.4 Please indicate the level of negative impact on each of the protected characteristics?
(Please indicate high (H), medium (M), low (L), no effect (N) for each)

The current service is a universal service, hence should not have any negative impact on any group, however in some cases such as the FNP, there will be a positively high impact on low income groups and because the service is for mothers with children age 0-5 will have positive impact on pregnancy and maternity.

Protected Characteristics:	**Impact** (H, M, L, N)
Age	**L**
Disability	**L**
Gender reassignment	**N**
Race	**L**
Religion/Belief	**L**
Pregnancy and maternity	**L**
Sexual Orientation	**L**
Sex	**L**
Marriage and civil partnership	**N**
Additional Consideration:	
Low income/low wage	**L**

2.5 How could the disproportionate negative impacts be mitigated or eliminated?

Consideration has been given to protected characteristics through engagement and consultation with fathers, minority ethnic groups and carers. Evidence collated will support review and recommendations.

Section 3: What evidence you have used?

3.1 What evidence do you hold to back up this assessment?

Consultation and engagement findings, and the Business Case for Health visiting and FNP Review.

3.2 Do you need further evidence?

No

Section 4: Consultation Feedback

4.1 Results from any previous consultations

Yes

4.2 Feedback from current consultation

Yes

4.3 Your departmental response to this feedback – include any changes made to the proposal as a result of the feedback

The proposed service model has been informed by consultation feedback.

Health Visiting and Family Nurse Partnership Review Consultation

Introduction

As part of the review of the Health Visiting (HV) service and the Family Nurse Partnership (FNP,) the Public Health Department of Bradford Metropolitan District Council sought the opinions of a variety of people and organisations with experience of the two services in the Bradford District.

The aim of the consultation was to understand how people feel the system is working currently, and what their future expectations are of the services.

There were two main methods used to obtain these opinions, which were questionnaires which were available both online and on paper and through organised group discussions.

Questionnaires

There were three questionnaires designed to obtain views from;

- ***Families in receipt of Health Visiting Services***;
    - 227 respondents
    - Majority female
    - 77% aged 20-39
    - 60% of respondents described themselves as White or White British, 15% as Asian or Asian British, 4% as Central or East European remaining 21% from other minority ethnic groups. There is an over representation from the White British population.
- ***Families in receipt of the services of the Family Nurse Partnership***;
    - 62 respondents
    - Majority female
    - 56% aged 19 and under, 32% aged 20-25 years which is expected with the nature of the service.
    - 84% of respondents described themselves as White or White British and 6% as Asian or Asian British; 10% of respondents did not complete the question. This is consistent with the ethnic groups within the service population.
- ***Stakeholders with an interest in Health Visiting Services and the Family Nurse Partnership;***
    - 129 Responses
    - Respondents were asked to identify which organisation they were responding on behalf of 49 selected 'other,' those who selected 'Other' included a number of people from the Bradford District Care Trust, including health professionals and commissioners, and from Family Centres, Nurseries and Social Services. 44 of which were GPs, 19 childrens centres, 11 voluntary and community sector, 5 from education.

Organised Group Discussions

Health Visitors

For Health visitors there were seven events set up to get the views of HV staff and key stakeholders, the attendees at each event consisted of;

- **Event 1- Strategic Management team;** 13 attendees

- **Event 2 (Bradford) and 3 (Keighley) – Health visiting teams;** 28 attendees in Bradford and 26 in Keighley
- **Event 4 and 6 - Stakeholders (Allied Professionals);** 31 attendees in total
- **Event 5 and 7 – GPs and Practice managers;** 104 attendees in total
- **Families in receipt of HV service;**
    - In total there were 115 participants of which, 105 were female and 10 were male.
    - 27% identified themselves as White or White British and 51% Asian or Asian British 10% did not disclose their ethnicity, the groups were diverse and gave views of people who may not necessarily complete the questionnaire.

Family Nurse Partnership

There were four events to obtain views of FNP staff members, key stakeholders and families in receipt of FNP. The attendees at each event consisted of;

- **Event One - FNP Staff Members;** 12 attendees
- **Event 2 – Stakeholders (Allied Professionals);** 9 Attendees
- **Event 3 (Keighley) and 4 (Bradford) – Families in receipt of FNP;** 11 attendees in Keighley and 3 in Bradford

This paper provides a report on the consultation in five separate sections:

- Summary of key findings
- Consultation methodology
- Summary of participation
- Results of the consultation split into two parts;
    - Part 1 Health Visiting Service
    - Part 2 Family Nurse Partnership
- Strengths and weaknesses of the consultation exercise

Summary of Key Findings for Health Visiting Services:

The key findings from the consultation exercise can be categorised as follows:

Access

1. **There is concern around the difficulties that service users experience when trying to contact their Health Visitor (HV); the most challenging aspect for families, HVs and allied professionals alike is the single point of access hub. Families also see the requirement to disclose their problems to an unknown intermediary as challenging.**

See pages:27,29, 33, 37, 41 & 44

2. **There is concern about the equity of access and the consistency of care given to service users and their families by HVs, both in terms of the amount and quality of support provided, and the clarity and consistency of the health messages offered.**

Pages: 27,28, 34, 37 &39

3. **Participants feel that the location of services, and the environment in which they are delivered, are crucial to determining whether services are used efficiently and effectively; the key point made was that services should be delivered in locations that families already access routinely.**

See pages:26, 32 &39

People's experience of the service

4. **Experiences of health visiting services reported by participating families have tended to be positive, but this positive view is not necessarily matched by the views of other stakeholders (Allied professionals.)**

See pages:25, 28, 30, 31 & 36

5. **The experiences of support received by mothers have tended to be positive; however, the amount and quality of support provided has not always been sufficient. eg Breastfeeding and support around postnatal depression.**

See pages:28 & 37

6. **Participants feel that greater attention needs to be paid to continuity of care because service users get more out of the service, and say that they feel safer, when they are able to rely on a HV with whom they have established a trust based relationship.**

See pages:37

7. **Participants report that the willingness of families to disclose personal issues is influenced by the environment in which the conversations with their HV take place; participants feel that services, whether these are delivered in a community setting or in the family home, need to afford greater privacy than is currently available.**

See pages:37 & 39

Organisational concerns

8. **Participants expressed concerns about whether current IT systems will support integrated**

working and data sharing between HVs and all of the other organisations involved in delivering services to children aged 0-5 years and their families.

See pages:41,42 &45

9. **Participants are aware of the pressures under which HVs operate and feel that this has a negative impact on the quality of services; concerns were expressed about the capacity of HVs to meet the demands of their increasing workloads and continue to perform their role to required standards.**

See pages:28, 33 &42

10. **The current "flat" structures of HV teams, and the consequent lack of leadership, were perceived as a problem by participants.**

See pages:41, 44 & 45

11. **Amongst participants a range of views were expressed about the organisation and alignment of HV teams; the majority of HV staff and stakeholders from partner organisations were in favour of geographical alignment and GPs expressed views that they wanted GP alignment to remain.**

See pages:33, 42 & 45

12. **Whilst many participants regard partnership working as a strength of the current HV service, it was suggested that the service may function better through closer working and better integration with other services; the examples given included better integration with midwifery services, school nurses, general practitioners and Children's Centres.**

See pages:34, 38, 39, 42 & 45

Needs

13. **Participants understand that Bradford has a particularly diverse population and that needs vary from community to community; they feel that particular attention needs to be paid to the availability and quality of interpretation services and how these services are used in practice.**

See pages: 39, 40, 42, 43 &45

14. **There is acknowledgement of the prevailing economic environment of austerity across all services amongst participants, and a recognition that this will impact upon the HV service in the future.**

See pages: 38, 42 & 46

Summary of Key Findings for the Family Nurse Partnership:

The key findings from the consultation exercise can be summarised as follows:

Access

1. **The Family Nurse Partnership (FNP) service is seen as providing very good support for a very small number of mothers and children. However, families in receipt of HV and FNP services reported that they feel care is not delivered equitably across the district or across the population.**

See pages: 60 & 62

2. **Participants report that the service provided by their Family Nurse is accessible and fits around the needs of the family; it is seen as providing them with "valued continuity of care" and "robust support from very early on in pregnancy until (the) child is 2" to "break the cycle of deprivation".**

See pages: 53 ,56, 59 & 62

People's experience of the service

3. **Families in contact with FNP services value the continuity of care provided by their Family Nurse and the consistency of their advice and support. FNP clients welcome the structured support provided by their Family Nurse and feel that "it prepares us properly for parenthood".**

See pages: 54 & 56

4. **Knowledge and understanding the role of the HV is poor amongst clients of the FNP. The step from intensive support to the lower level of support provided through the general service is a challenge for clients who do not have the same trust-based, well established relationship with their HV as they do with their Family Nurse. Participants report finding the transition abrupt and also challenging because they are not sure that continuity of care will be maintained with the HV.**

See pages: 62

Organisational concerns

5. **Concerns were expressed about whether the FNP service will continue in Bradford in the face of continuing funding restrictions, the organisational changes currently underway and the negative findings of the recent national evaluation of the FNP.**

See pages: 62 & 63

6. **Participants see the possibility of losing the FNP service, or it becoming 'watered down', as a significant threat to the children and families that the service supports who, because of the nature of FNP, are some of the most vulnerable families living the most deprived areas of the district.**

See pages: 62

Opportunities for the future

7. **Participants expressed concern about the results of the national evaluation of FNP services, which showed no significant improvement in some short term outcomes for participants. Locally in Bradford, there is a strong belief that the programme has made a difference.**

See pages: 62

Summary of Participation

Questionnaires

Who: Families in receipt of Health Visiting services
How many: 227 Responses
Where:

Gender: 210 Female 9 Male
Age: 77% aged 20-39

Postcode area	Wards	No of respondents
BD5	Bowling and Barkerend, City, Great Horton, Little Horton, Tong, Wibsey, Wyke	28
BD10	Baildon, City, Eccleshill, Idle and Thackley, Manningham, Windhill and Wrose	26
BD6	Great Horton, Little Horton, Queensbury, Royds, Wibsey, Wyke	22
BD2	Bolton and Undercliffe, Bowling and Barkerend, Bradford Moor, City, Eccleshill, Heaton, Manningham, Windhill and Wrose	20
Not completed/ incomplete	Unknown	19
BD4	Bowling and Barkerend, Bradford Moor, City, Little Horton, Manningham, Tong, Wyke	16
BD13	Bingley Rural, Clayton and Fairweather Green, Manningham, Queensbury, Thornton and Allerton	14
BD18	Heaton, Idle and Thackley, Manningham, Shipley, Windhill and Wrose	12
BD22	Bingley Rural, Keighley Central, Keighley West, Worth Valley	10

Ethnicity: 60% of respondents described themselves as White or White British, 15% as Asian or Asian British, 4% as Central or East European.

Who: Families in receipt of Family Nurse Partnership services
How many: 62 Responses

Gender: 60 Female 2 Male
Age: 56% aged 19 and under, 32% aged 20- 25 years

Where:

Postcode area	Wards	Number of respondents
BD21	Bingley Rural, Keighley Central, Keighley East, Keighley West, Worth Valley	13
BD22	Bingley Rural, Keighley Central, Keighley West, Worth Valley	9
BD5	Bowling and Barkerend, City, Great Horton, Little Horton, Tong, Wibsey, Wyke	7
BD4	Bowling and Barkerend, Bradford Moor, City, Little Horton, Manningham, Tong, Wyke	5

Ethnicity: 84% of respondents described themselves as White or White British and 6% as Asian or Asian British; 10% of respondents did not complete the question.

Who: Stakeholders; Allied Professionals
How many: 129 Responses
Which organisation type:

Please select the type of organisation you represent:	Number of respondents
GP practice	44
Children Centre	19
Voluntary and community sector organisation	11
Education	5
Not completed	1
Other (Please specify)	49

Those who selected 'Other' included a number of people from the Bradford District Care Trust, including health professionals and commissioners, and from Family Centres, Nurseries and Social Services.

Organised Group Discussion - Heath Visiting Services

Date	Who Attended	Number of attendees
10th November 2015	**Health Visiting Strategic Management Group:** • Head of Service • Business Support Manager • Service Managers • Health Visitors	13
25th November 2015	**Health Visiting Teams (Bradford):** • Health Visitors • Health Visiting Service Manager • Head of Service • Breastfeeding Co-ordinator • Named nurse for Looked after Children • Safeguarding Practitioner	28
1st December 2015	**Health Visiting Teams (Keighley):** • Health Visitors • Specialist Practitioner, Safeguarding Team • Named nurse for Looked after Children • Head of Service • Community Nursery Nurse • Speech Therapist • Specialist Service Manager • Family Nurse Supervisor	26
2nd December 2015	**Allied Professionals:** • Children's Centre Managers • Head of Service • Service Managers • Specialist Midwives • Early Years Specialists	19
2nd December 2015	**GPs** • GPs • Advanced Nurse Practitioners • Practice Managers	59
3rd December 2015	**Allied Professionals:** • Child Health Specialists • Service Managers • Specialist practitioners	12
16th December 2015	**GPs** • 22 GPs	45

Who: Families in receipt of Health Visiting services
Events: 16
Residents:

How many: 115 participants
Gender: 105 Female 10 Male

Postcode	Number of respondents
BD5	21
BD21	16
BD8	15
BD17	9
BD7	8
BD3	7
BD20	3
BD22	3
BD2	1
BD4	1
BD15	1
BD23	1
Unknown	29

Age Group	Number of respondents
20-29	36
30-39	46
40-49	18
50-59	4
60+	11

Relationship to child	Number of respondents
Mother	100
Father	11
Other	4

Ethnicity: 27% of participants described themselves as White or White British and 51% as Asian or Asian British; 10% of respondents did not complete the question.

Organised Group Discussion - Family Nurse Partnership

Date	Who Attended	Number of Attendees
16th November 2015	**FNP Staff:** • Family Nurses • Family Nurse Supervisors	12
10th December 2015	**Allied Professionals:** • Head of Service • Safeguarding Nurses • FNP Supervisor • Childrens Centre • Head of Midwifery • Children's Services practitioner • Former client	9
11th December 2015	**FNP Clients (Keighley)**	11
30th December 2015	**FNP Clients (Bradford)**	3

Contents

Consultation Methodology

As part of the review of Health Visiting Services and the Family Nurse Partnership, the views of stakeholders were sought conducted using two methods:

- Questionnaires
- Organised group discussions

Questionnaires

Three different questionnaires were used, to collect the opinions of three groups of consultees:

- Families in receipt of Health Visiting Services
- Families in receipt of the services of the Family Nurse Partnership
- Stakeholders with an interest in Health Visiting Services and the Family Nurse Partnership

Table 1 below summarises how each of the questionnaires was designed, promoted, administered and analysed.

Organised discussion groups

Stakeholders in the Health Visiting Service Review were mapped as part of the project initiation process for the Review; these were:

- Families with experience of Health Visiting Services and / or the Family Nurse Partnership
- Health Visitors
- Family Nurse Partnership staff
- Health Visitor Service Strategic Management Group
- Maternity Partnership
- Children's Centres
- Early Years Services
- Education
- Children's Transformation and Integration Group
- Children's Social Care
- Clinical Commissioning Groups
- General Practitioners

Representatives from the above groups were invited to contribute their views through a series of facilitated group discussions.

Table 2 below, and the notes that accompany it, summarise the methods by which this element of the consultation was organised.

Section Three: Consultation Methodology

Table 1: Questionnaires

Questionnaire respondents	Questionnaire Design	Promotion	Administration	Information collected / analysis performed
Families in receipt of the Health Visiting Service	• Initial Design by Health Visiting review team	Sent by email	Online and paper copies	Quantitative and Qualitative
Families in receipt of the Family Nurse Partnership Service	• Initial Design by Health Visiting review team	Sent by email	Online and paper copies	Quantitative and Qualitative
Key stakeholders for Health Visiting and Family Nurse Partnership including; • GPs • Education • Local NHS • Children's Centres • Voluntary and Community Sector	• Initial Design by Health Visiting review team	Sent by email	Online and paper copies	Quantitative and Qualitative

Table 2: Organised Group Discussions

Membership of Group	Date:	Time:	Venue:	Topic:	Administration/ Promotion	Information collected / analysis performed
HV Strategic Management Group Event	10/11/15	11.30-14.30	Douglas Mill, Bradford	HV	Invitation by email	Qualitative
FNP Staff Event	16/11/15	14.30-16.00	Woodroyd centre, Bradford	FNP	Invitation by email	Qualitative
Health Visitors Event	25/11/15	13.00-16.00	The Bradford Hotel, Bradford	HV	Invitation by email	Qualitative
HV Event Keighley	01/12/15	10.00-13.00	Victoria Hall, Keighley	HV	Invitation by email	Qualitative
Stakeholder Event	02/12/15	13.30-16.30	City Hall, Bradford	HV	Invitation by email	Qualitative
GPs, Bradford District CCG	02/12/15	12.30-13.00	Carlisle Business centre, Bradford	HV/ FNP	Invitation by email	Qualitative
Stakeholder Event	03/12/15	12.30-15.30	Millennium Business Park, Keighley	HV	Invitation by email	Qualitative
FNP stakeholder event:	10/12/15	10.00-12.30	Woodroyd Centre, Bradford	FNP	Invitation by email	Qualitative
FNP service users Keighley	11/12/15	13.30-15.30	Rainbow Children's centre, Keighley	FNP	Invitation by email	Qualitative
GPs, Bradford City, CCG	16/12/15	12.30-14.30	Dubrovnik Hotel, Bradford	HV/FNP	Invitation by email	Qualitative
FNP service users Bradford	30/12/15	13.30-16.00	City Hall, Bradford	FNP	Invitation by email	Qualitative
Parents	20/01/16	09.30-11.30	Girlington Community Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	21/01/16	09.30-11.30	Canterbury Children's Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	22/01/16	09.30-11.30	Woodroyd Children Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	25/01/16	11.00-12.30	Keighley Women & Children's Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	26/01/16	13.00-15.00	Farnham Children Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	28/01/15	09.30-11.30	Burnett Fields Children's Centre	HV	Organised by Centre representative/ Manager	Qualitative

Parents	28/01/15	13.30-15.30	Tyersal The Barn	HV	Organised by Centre representative/ Manager	Qualitative
Parents	29/01/16	09.30-11.30	Rainbow Children's Centre, Keighley	HV	Organised by Centre representative/ Manager	Qualitative
Parents	29/01/16	13.30- 15.30	Hirstwood Children's Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	01/02/16	09.30-11.30	Kirkgate Community Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	02/02/16	09.30-11.30	Barkerend Children's Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	02/02/16	13.30-15.30	Baildon Children's Centre	HV	Organised by Centre representative/ Manager	Qualitative
Parents	03/02/16	13.30-15.30	Cottingley Cornerstones Community Centre	HV	Organised by Centre representative/ Manager	Qualitative
East European Parents	19/02/16	13.00-15.00	St Edmunds Nursery and Children's Centre	HV	Organised by Centre representative/ Manager	Qualitative
Traveller Parents	22/02/16	11.00-12.30	Margaret Macmillan Towers	HV	Organised by Centre representative/ Manager	Qualitative
Fathers Group	22/02/16	13.00-15.00	Midland Road Nursery School	HV	Organised by Centre representative/ Manager	Qualitative

Questions and Format

At each of consultation event attendees were divided into groups of approximately eight to ten participants. The discussions, led by experienced facilitators, took place in two parts, both conducted in the form of SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses.

The first part of each discussion looked at Health Visiting services. Consultees were asked to describe what they felt the strengths and weaknesses of the current Service were, and what threats and opportunities they felt were present in the course of this review and by the recommissioning of the Service. The second part of each discussion collected the same information about the current Family Nurse Partnership.

Recording Responses

Responses were recorded by the facilitator and transcribed following the session. The key themes emerging from the discussions with each group of consultees were identified and the results reported.

Results of the Consultation

The results of the consultation are presented in two sections:

- Consultations focussing on current Health Visiting Services
- Consultations focussing on the Family Nurse Partnership

In each section, the results for the questionnaires and the organised group sessions are presented sequentially.

Questionnaires

The results of the questionnaires are presented below for:

- Families in receipt of the Health Visiting service
- Stakeholders with an interest in Health Visiting

Families in Receipt of Health Visiting Services

Response rates and coverage

A total of 227 responses were received.

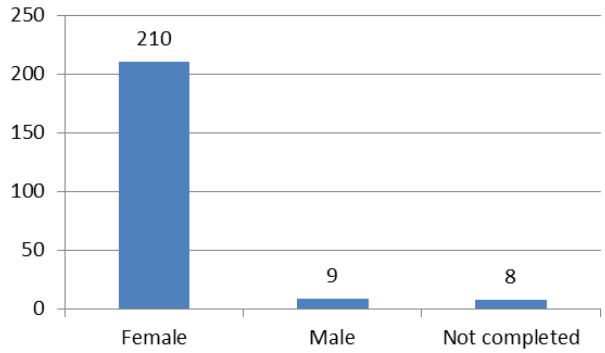
The questionnaire for families in receipt of Health Visiting Services collected the following factual information about respondents:

- Relationship to the child
- Gender
- Marital Status
- Age
- Disability
- Postcode area
- Sexual Orientation
- Religion
- Ethnicity

Relationship to the child
94% of respondents identified themselves as the mother of the child; the individual who selected "Other" did not specify their relationship.

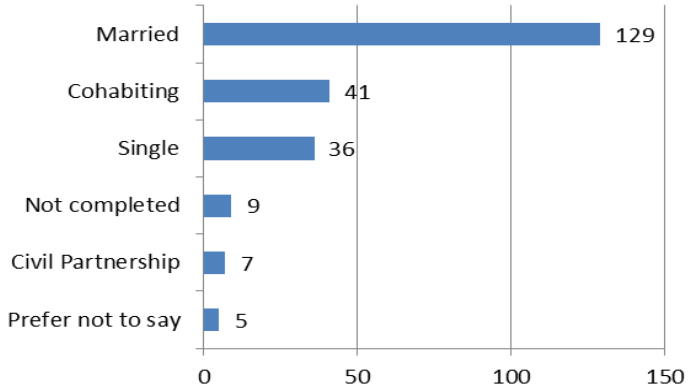
Relationship to the child	Number of respondents
Mother	212
Father	7
Not Completed	4
Carer	1
Grandparent	1
Guardian	1
Other (please specify)	1

Gender:
As expected the majority of respondents identified as female. There were however, fewer females than there were mothers in the group; this is due to a combination of some mothers not recording their gender and others identifying as male.



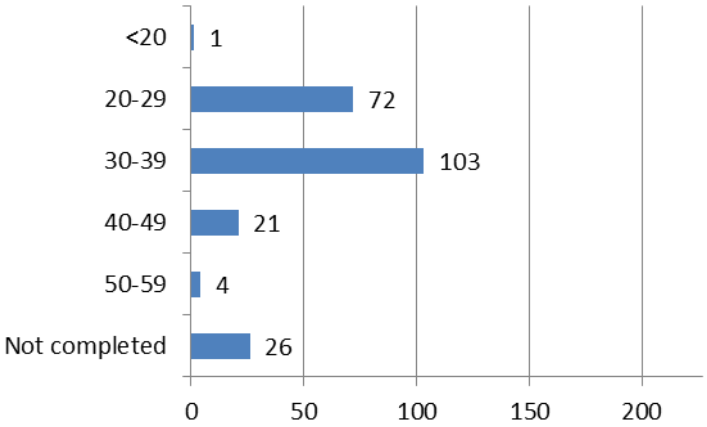
Marital Status

The majority of respondents, 57%, identified themselves as married; 21% of respondents reported that they were cohabiting or in a civil partnership and 16% reported that they were single. The remaining 6% either preferred not to disclose their status or did not complete the question.



Age

Respondents aged 30-39 years made up the largest proportion at 45%; respondents aged 20-29 years made up 32% of the group, those aged 40-49 years made up 95 and those ages 50-59 years made up just 2%. 11% of respondents did not complete this question,



Disability

12% of respondents reported that they had a disability, whilst 6% preferred not to say; 85% of respondents did not complete this question.

Do you have any of the following disabilities?	Number of respondents
Not completed	194
Prefer not to say	13
Mental ill Health	10
Learning difficulties	5
Other substantial and long term condition	5
Mobility	3
Physical Disability	2
Visual impairment	1
Hearing impairment	1

Postcode area

The following table shows the results where there were 10 or more responses from each postcode area.

Postcode area	Wards	No of respondents
BD5	Bowling and Barkerend, City, Great Horton, Little Horton, Tong, Wibsey, Wyke	28
BD10	Baildon, City, Eccleshill, Idle and Thackley, Manningham, Windhill and Wrose	26
BD6	Great Horton, Little Horton, Queensbury, Royds, Wibsey, Wyke	22
BD2	Bolton and Undercliffe, Bowling and Barkerend, Bradford Moor, City, Eccleshill, Heaton, Manningham, Windhill and Wrose	20
BD4	Bowling and Barkerend, Bradford Moor, City, Little Horton, Manningham, Tong, Wyke	16
BD13	Bingley Rural, Clayton and Fairweather Green, Manningham, Queensbury, Thornton and Allerton	14
BD18	Heaton, Idle and Thackley, Manningham, Shipley, Windhill and Wrose	12
BD22	Bingley Rural, Keighley Central, Keighley West, Worth Valley	10
Not completed/ incomplete	Unknown	19

Sexual Orientation

90% of respondents identified themselves as heterosexual/ straight, less than 1% described themselves as bi-sexual and the remaining 9% either did not complete or preferred not to say.

Which of the following options best describes your sexual orientation	Number of respondents
Heterosexual / Straight	205
Not completed	17
Prefer not to say	3
Bi-sexual	2

Religion

34% of respondents described themselves as Christian, 19% as Muslim and 8% as “Other”; 6% described themselves atheist, whilst 23% described themselves as having no religion. 10% of respondents either did not complete this question or preferred not to say.

Religion/ Belief	Number of respondents
Christian	77
No Religion	53
Muslim	42
Other	19
Atheist	14
Not completed	14
Prefer not to say	8

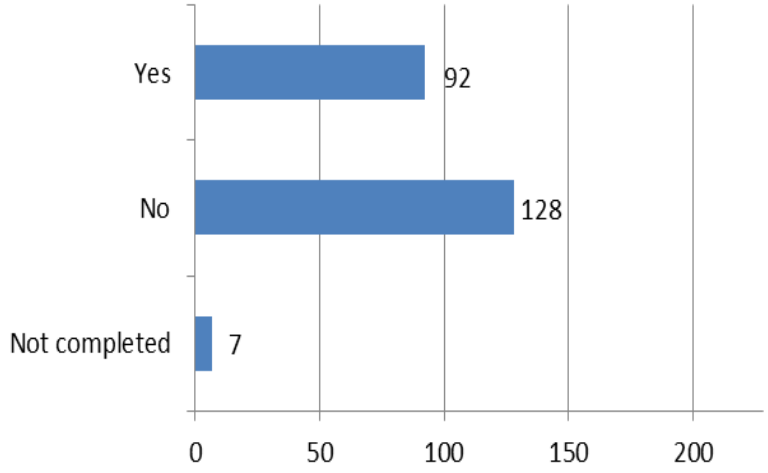
Ethnicity

60% of respondents described themselves as White or White British, 15% as Asian or Asian British, 4% as Central or Eastern European, 4% as White Other and 12% as 'Other'. 5% of respondents did not complete this question.

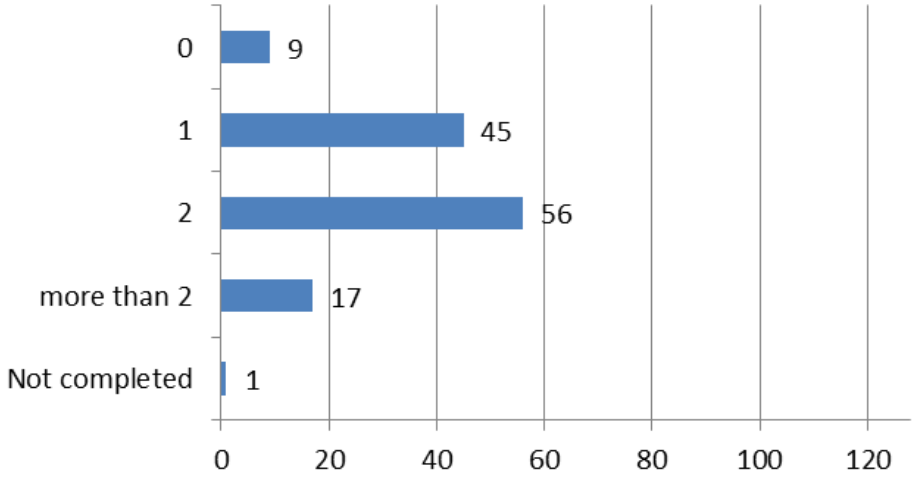
Ethnicity	Number of respondents
White English / Welsh / Scottish / Northern Irish / British	137
Asian or Asian British Pakistani	35
Not completed	11
White East / Central European	8
White Other	8
Other (including 11 other defined ethnicities)	28

Responses by question

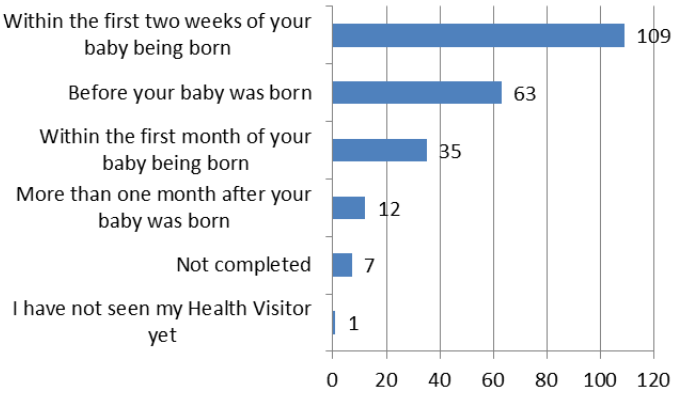
Is this your first child?



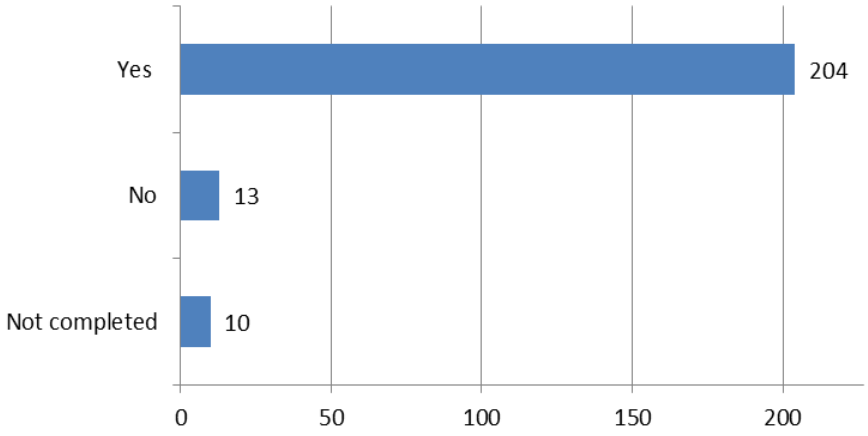
If this is not your first child, how many children do you have aged 5 and under?



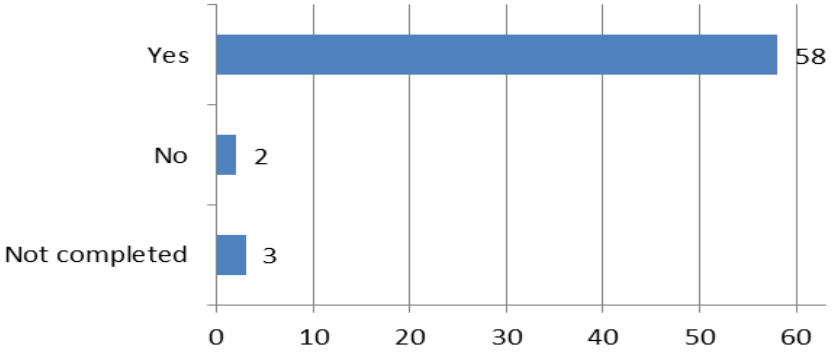
When did you first meet your Health Visitor?



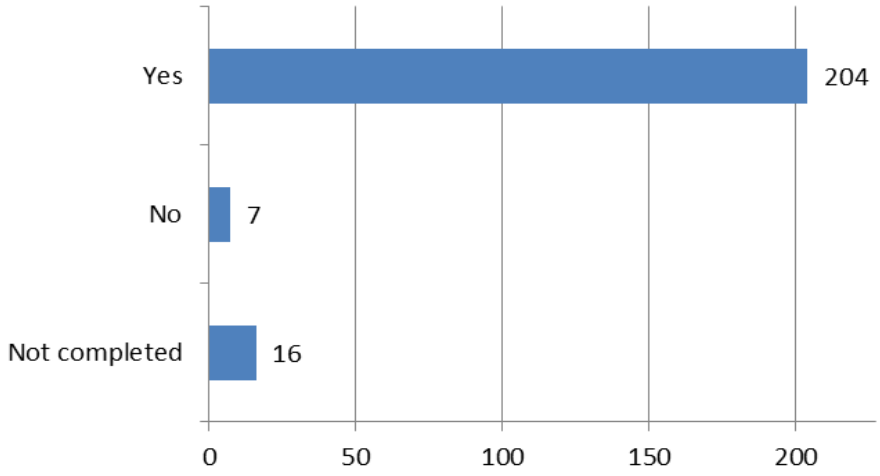
Did your Health Visitor come and see you at home after your baby was born (usually within the first two weeks)?



If answered 'Before your baby was born' to 'When did you first meet your Health Visitor?' Did your Health Visitor ask how you were feeling before birth?



Did your Health Visitor ask how you were feeling after birth?



Did your Health Visitor offer you advice on: (please tick all that apply)

Support topic	Number of respondents
Your baby's immunisations	179
Breastfeeding your baby	175
Weaning your baby	159
Postnatal depression	157
Accessing services (i.e. children centres)	146
Healthy eating for you and your baby	144
Your baby's physical and emotional development	140
Coping with your baby crying	135
Bonding with your baby	129
Family planning/contraception	128
Accident prevention	119
Mental health	117
Helping your baby learn good sleep habits	115
Domestic Violence	103
Oral health	99
Coping with minor illnesses	98
Stopping smoking	68
Other (Please specify)	31

Those who selected 'Other' were asked to specify what they meant by 'other,' answers included; advice around benefits and behavioural issues. Not all respondents who selected 'Other' specified a topic; amongst those who did specify a topic, a large proportion did not provide sufficient information to allow the responses to be analysed.

What would you like your Health Visitor to offer you advice on? (Please tick all that apply)

Support Topic	Number of respondents
Helping your baby learn good sleep habits	102
Your baby's physical and emotional development	101
Weaning your baby	96
Accessing services (i.e. children centres)	96
Healthy eating for you and your baby	93
Coping with minor illnesses	93
Breastfeeding your baby	92
Coping with your baby crying	90
Your baby's immunisations	89
Postnatal depression	88
Bonding with your baby	88
Accident prevention	82
Mental health	76
Oral health	69
Family planning/contraception	69
Domestic Violence	54
Stopping smoking	51
Other (Please specify)	37

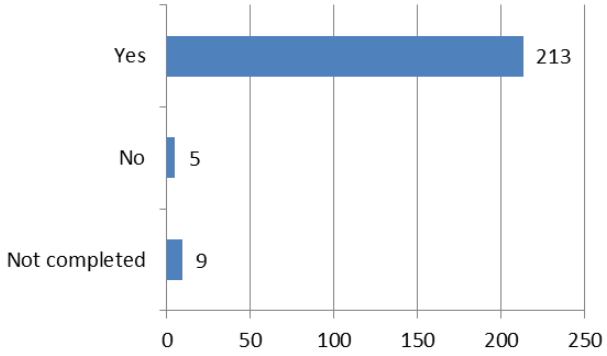
Where 'Other' was selected, topics which people would like their health Visitor to offer advice on included exercise, child development and mental health support for both Mothers and Fathers.

Did you find your Health Visitor: (please tick all that apply)

Description	Number of respondents
Polite	186
Helpful	179
A good listener	161
Supportive	153
Punctual	148
Reassuring	134
Kind	131
Thoughtful	125
Knowledgeable	124
Flexible (could see them when it suited you)	122
Unsupportive	19
Not flexible	17
Not helpful	16
Impolite	7

- **The chart above shows evidence of key finding 4**

Did you understand the information provided by the Health Visitor?

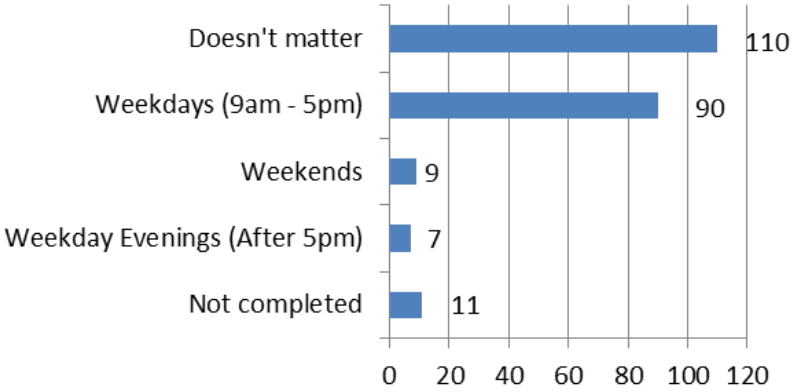


If 'No' to 'Did you understand the information provided by the Health Visitor?'

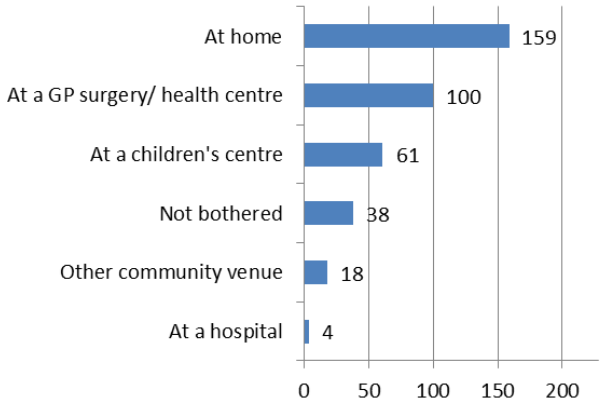
What would make the information easier to understand? (Please tick all that apply)

What would make the information easier to understand?	Number of respondents
Easy to read	3
Make it available in a different language	2

When would you prefer to see the Health Visitor?

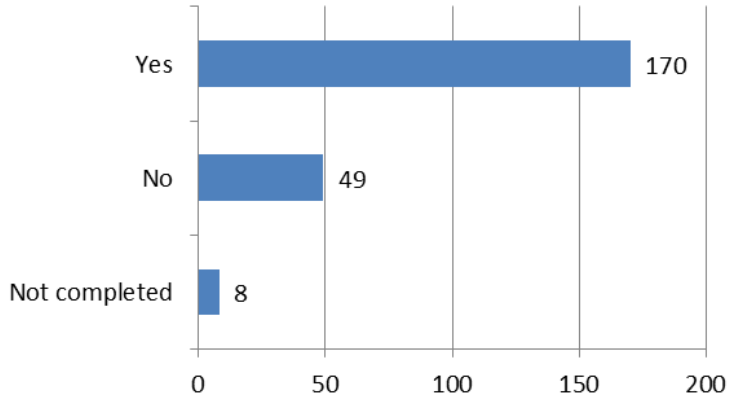


Where would you prefer to see the Health Visitor?



➢ **The chart above shows evidence of key finding 3**

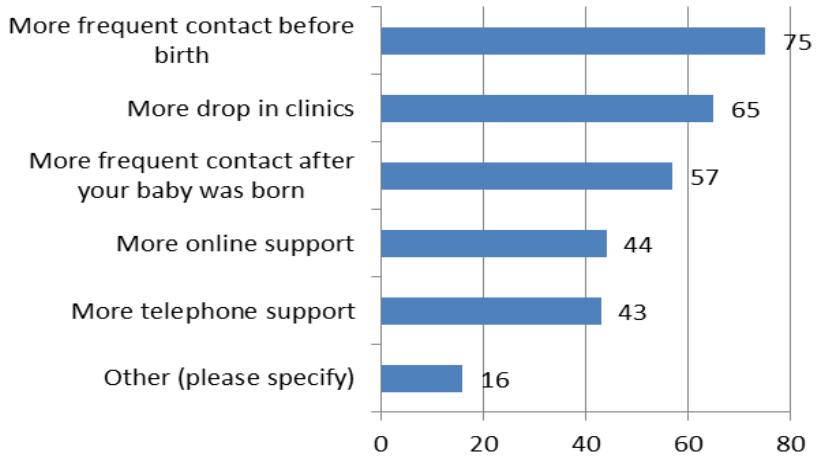
Do you feel you can easily contact your Health Visitor if you need advice or information?



KEY NOTE: over a fifth (22%) of respondents did not feel they could contact their Health Visitor easily.

➢ **The chart above shows evidence of key finding 1**

What additional support do you feel you need/needed?



➢ **The chart above shows evidence of key finding 1**

Other (please Specify)

Some respondents felt that HV staff needed more training, in particular around breastfeeding advice and support, because the information provided was conflicting at times; continuity was an issue for some families when the same Health Visitor was not seen at each contact, which meant that they had to explain things more than once.

➢ **The chart above shows evidence of key finding 2**

Please use this space for any other comments you would like to make about the Health Visiting Service:

This was an 'open' question which allowed respondents to express themselves freely, rather than to select from a number of options. 78 out of the 227 respondents provided a response to this question. The responses received were coded into themes. Many responses could be categorised into more than one theme; for instance, a comment such as "my HV is very supportive and has given me lots of advice on breastfeeding" would be coded as both a 'Positive personal experience' and 'Breastfeeding'. The following table illustrates the most common themes, in descending order of recurrence.

Theme	Number of occurrence
Positive personal experience	30
Negative personal experience	10
Breastfeeding	6
Single Point of Access Hub	6
Accessible	2
Antenatal support	2
Overworked	2
Training	2
Website	1

Positive Personal Experience
"…listen and offer sensible advice…"
"…invaluable…support…good relationship…"
"…fantastic…support…offer advice whenever needed it…"

➢ **The table above shows evidence of key finding 4**

Negative Personal Experience
"…abrupt…just wanting to tick boxes…"
"…overstretched…did not support as well as should…very disappointing service…"
"…inconsistencies in support…lack in basic knowledge…"

➢ **The table above shows evidence of key finding 2,5,9**

Breastfeeding
"…require proper training regarding breastfeeding…advice is often detrimental to breastfeeding…"
"…did not support…breastfeeding attempts…"
"…was supportive of…breastfeeding for as long as they were comfortable…"

➢ **The table above shows evidence of key finding 5**

The Single Point of Access Hub
"…don't like that you have to phone a call centre…"
"…telephone number should be direct…don't want to tell anyone else …just my Health Visitor…"
"…unable to get through to the Health Visiting team due to having to ring … the hub…"

- **The chart above shows evidence of key finding 1**

Stakeholders with an interest in Health Visiting Services

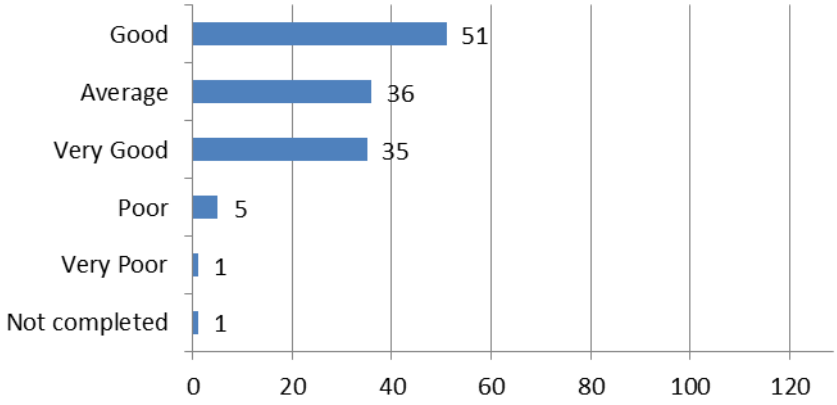
Response rates and coverage

A total of 127 responses were received.

Please select the type of organisation you represent:	Number of respondents
GP practice	44
Children's Centre	19
Voluntary and community sector organisation	11
Education	5
Not completed	1
Other (Please specify)	49

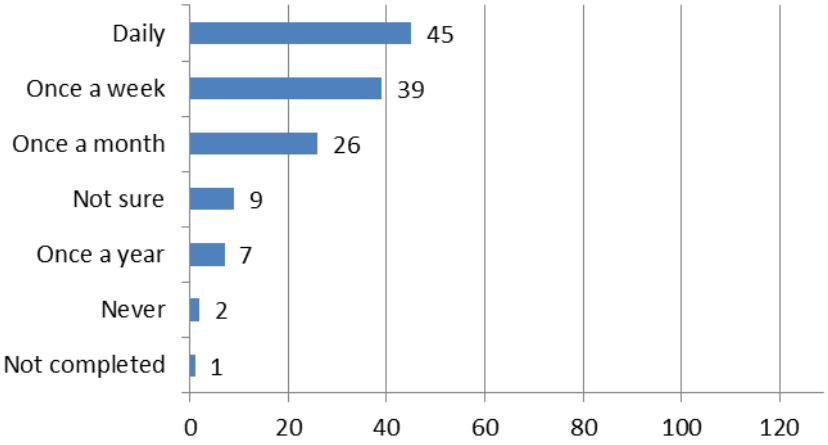
Those who selected 'Other' included a number of people from the Bradford District Care Trust, both health professionals and commissioners, and from Family Centres, Nurseries and Social Services.

How would you rate the quality of the Health Visiting service?

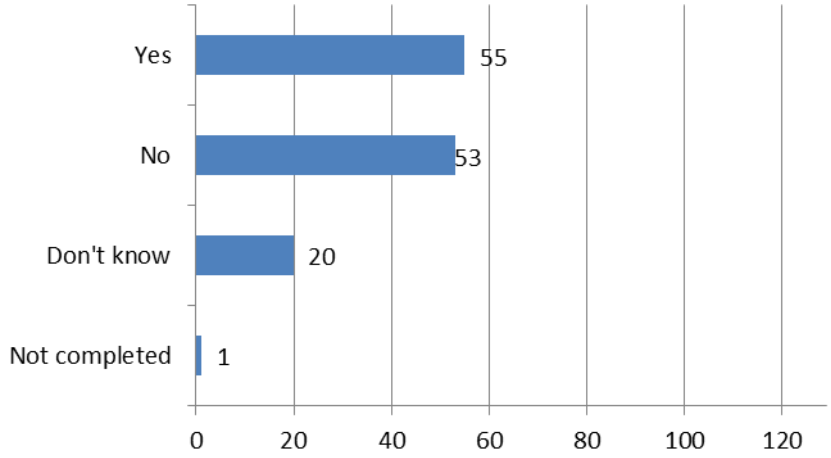


➢ **The chart above shows evidence of key finding 4**

How often does your service come into contact with the Health Visiting service?



Do you think the current Health Visiting service fully addresses the needs of children under the age of 5, mothers and their families?



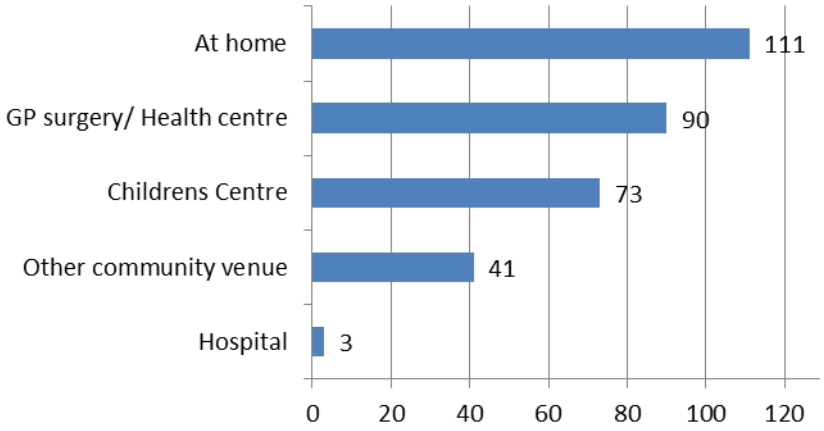
- **The chart above shows evidence of key finding 4**

Which of the following support do you think would benefit children aged under 5 and their families?

Which of the following support do you think would benefit children aged under 5 and their families?	Number of respondents
Postnatal depression	116
Mental health	116
Your baby's physical and emotional development	116
Healthy eating for you and your baby	112
Breastfeeding your baby	111
Weaning your baby	110
Coping with your baby crying	109
Your baby's immunisations	109
Accessing services (i.e. children centres)	109
Domestic Violence	109
Helping your baby learn good sleep habits	108
Coping with minor illnesses	108
Accident prevention	106
Oral health	105
Bonding with your baby	104
Family planning/contraception	102
Stopping smoking	98
Other (Please specify)	36

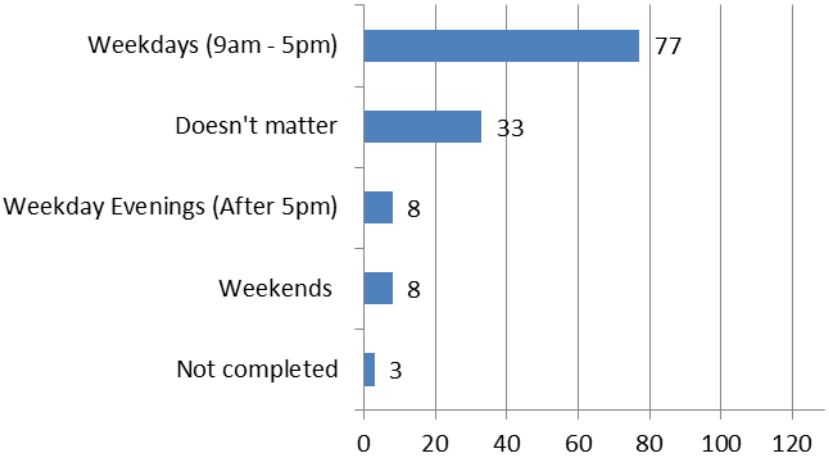
Amongst those who selected 'Other', suggestions were referrals to other services and closer links with Children's Centres, rather than anything new in terms of support to families.

Where do you think families of babies and young children would prefer to see the Health Visitor?

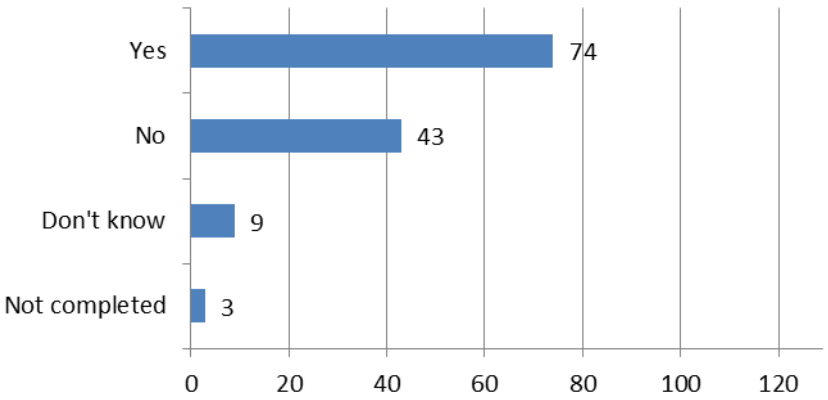


- **The chart above shows evidence of key finding 3**

When do you think mothers and families of children aged under 5 would prefer to see the Health Visitor?



Do you feel you can easily contact the Health Visiting service if you need advice or information?



Please use this space for any other comments you would like to make about the Health Visiting service:

This was an 'open' question which allowed respondents to express themselves freely, rather than to select from a number of options. 99 out of the 127 respondents provided a response to this question. The responses received were coded into themes. Many responses could be categorised into more than one theme; for instance, a comment such as "I find the Health Visiting service to be variable across the district and contacting via the hub is very difficult" would be coded as both 'Inconsistencies and 'The Hub'. The following table illustrates the most common themes, in descending order of recurrence.

Theme	Number of Respondents
The Single Point of Access Hub	25
Capacity	24
Evidence of good partnership working	16
Practice based	14
Links with other organisations	13
Inconsistencies	12
Safeguarding	7
Accessibility	3
Training	3

The Single Point of Access Hub
"…contacting the service is difficult via the hub…"
"…more difficult to contact them since the hub system was introduced…"
"…The central call system is frustrating…"

➢ **The table above shows evidence of key finding 1**

Capacity
"…having … staff to be able to cope with the total demand of the case load…"
"…health visitors … appear very stretched at present…"
"…health visitors … are often burdened with caseloads and paperwork…"

➢ **The table above shows evidence of key finding 9**

Evidence of good partnership working
"…we have some excellent links with some local health visiting team…"
"…we work closely with … HV team including doing joint visits…"
"…established excellent working relationships and improved communication and access to clinicians for advice …"

Practice based
"…health visitors used to be co-located with GPs … I never see them anymore…."
"…it is vital that health visitors and GPs continue to work closely together… health visiting teams must be aligned with GP surgeries and ideally co-located…."
"…very keen to retain practice based provision … working relationship so much easier as co-located…"

➢ **The table above shows evidence of key finding 11**

Links with other organisations
"…HV Service should … work more closely with other agencies or charities…"
"…it is extremely important that the existing links that exist between health visiting teams and GP practices are maintained and strengthened…"
"…HV's have poor links with Midwives and which make integrated working challenging…."

- **The table above shows evidence of key finding 12**

Inconsistencies
"…variable across the district from excellent to poor…"
"…service seems to be quite varied among different health visiting teams…"
"…the HV's vary in their knowledge and experience … the service delivery is not equitable for … families…"

- **The chart above shows evidence of key finding 2**

Organised Discussion Group Findings – Health Visiting Service

The findings of the consultation events are reported in three subsections, each summarising the information collected from one of the following groups of stakeholders:

- Families in receipt of Health Visiting services
- Health Visitors and their Strategic Management Team
- Allied Professionals, including; GPs, FNP staff, the Maternity Partnership, Children's Centres, Early Years Services, the Children's TIG, Education and Social Care

Consultations with Families in Receipt of Health Visiting Services

Attendees

A total of 14 focus groups were held in Children's Centres across the Bradford District; three of these were for service users from minority interest groups, one for single fathers, one for Eastern Europeans and one for Gypsy and Traveller families. The events were attended by 115 parents plus a small number of staff from the Children's Centres and Nurseries.

Questions and format

At each event the discussions were led by experienced facilitators, who asked participants what they felt worked well about the current health visiting service and what did not work so well. Participants were also asked what concerns they had about changes to the current service and what they would like to see changed. Where necessary, the discussions were supported by interpreters able to converse in the languages appropriate to the participants present.

Results and Findings

Responses were recorded by the facilitators and transcribed following each event. The key themes emerging from the discussions were then identified and the results are as follows.

What works well?

Theme	*Summary of the views of the discussion groups*
Contact with the Health Visitor	HVs were seen as approachable and non-judgemental and participants felt that they were less time-pressured than midwives and went out of their way to help. The support and guidance provided for new mothers was seen as a strength of the current service and contact with the HV, particularly at home visits, and was highly valued by all.
Support for disabled children	This was described as "good" or "excellent" by the majority of consultees. Participants described their relationship with the HV as trust-based, with the HV provided reassurance and empowerment, enabling the families and facilitated their choices in relation to the care of their disabled child.
Diet, nutrition and weaning	Advice provided by HVs was described as "very, very good" and as covering "everything"; this included advice on diet and nutrition for older children also. This support was particularly valued amongst families with infants who were lactose intolerant.
Child development	The developmental assessments undertaken by HVs were valued by participants; HVs were regarded as a good source of advice and reassurance on child development.
Oral Health	Good support and advice was provided by HVs around oral health and hygiene. The availability of free toothbrushes/packs was valued by participants because these were felt to be essential items, not just more freebies.

- **The table above shows evidence of key finding 4**

What doesn't work as well?

Theme	***Summary of the views of the discussion groups***
Lack of continuity of care	Continuity of care was seen as important, not only for the mother and father, but also the child. Participants felt when they saw the same HV every time, the HV knew their children and knew them, and this made them feel more relaxed and confident. Participants also felt that familiarity with the child and the wider family enabled the HVs to more easily recognise symptoms and problems. The lack of continuity of care in the current system was seen as a significant barrier to establishing a good, trust-based relationship between the family and the HV. Participants felt that seeing a HV who was not familiar was a barrier that stopped mothers revealing their concerns, particularly in relation to topics such as postnatal depression and domestic abuse. Participants also felt that the lack of continuity of care led to conflicting advice as a consequence of having to see different practitioners.
Lack of privacy	HV clinics were not well regarded, regardless of where they were situated. A key issue for participants was the lack of privacy, which they felt inhibited disclosure of information, both in relation to the infant, the mother and the wider family. The examples of topics participants would prefer to discuss in private included breast feeding problems, bed wetting, postnatal depression and domestic abuse.
The single point of access Hub	Experience of contacting HVs via the single point of access Hub was overwhelmingly negative. The problems described included long waits on the line, messages left and no response received, and long delays in receiving a call back. Participants reported that they often could not speak to their own HV when they rang for help, but had to speak to a stranger; this they found difficult to do because there was no established relationship or trust which inhibited disclosure of problems. Participants did not like the fact that they have to tell the person answering the phone what their call was about and why they want to speak to their HV.
Breast feeding support	Although some mothers reported receiving good support from their HV for breast feeding, the majority felt that they received plenty of information but very little practical support. Participants felt that HVs were also not very knowledgeable about locally available peer support networks for breast feeding.
Interpretation services	Participants reported a number of problems associated with interpretation services including the use of interpreter at first and some second home visits only, concerns over the accuracy of interpretation, the lack of privacy and the potential for misrepresentation that existed when family members were used as interpreters. The lack of interpretation services was of particular concern to families with disabled or unwell children, who were unable to obtain understandable information about their child. Google Translate is being used with variable success to access literature provided by HVs. Written material in appropriate languages would be greatly welcomed.

- **The table above shows evidence of key finding 1,2,5,6 & 7**

What are their concerns?

Theme	*Summary of the views of the discussion groups*
Loss or reduction in the universal service for monitoring child development	Infant weight and height monitoring by the HV were seen as very important and were highly valued by the participants, as were the developmental checks and monitoring of milestones. Concerns were expressed about the potential for losing these services as local authorities face their budget cuts.
Reliance on peer support	Concerns were also expressed about the reliance on volunteer support for what were seen as essential services, and in particular for breast feeding support.
Communication	Examples of poor communications between professionals were seen as common and were a source of frustration to participants because it led to them having to "repeat the story" many times when they moved between professionals or were referred to specialist services. Participants expressed particular concerns about what the potential consequences of this on the accuracies of information recorded about the health of their children.

- **The table above shows evidence of key finding 12 & 14**

What opportunities do they see for change?

Theme	*Summary of the views of the discussion groups*
Direct contact	Participants saw opportunities for improvement in the transfer of responsibility for the commissioning of HV services to the local authority. In particular, they expressed a hope that a system that enabled them to contact their HV directly might the established. The ability to telephone or send a text message direct to their HV would be very much welcomed.
Use of technology	Better communication through the application of currently available technology would be welcomed as a means of improving access to information; examples given included text messaging for contact with HVs, Facebook for support groups and the use of free applications such as WhatsApp and social media for the dissemination of information and the provision of support.
Improve clinics	More convenient times and locations for HV clinics would be seen as an improvement. For some participants this meant clinics running in their local Children's Centres, for others it meant a move back to clinics run at GP surgeries or local community venues. The key point made by participants was that clinics need to be local and close to home for families, they need to be easy to access and open for longer, and should not run over lunch times or in the early mornings which are challenging periods for many families. The message is that clinics need to run where people already go in their communities even though this may mean

	using different premises at different locations across the district.
More contact with the HV	There was a desire amongst participants for more contact with their HVs. The gap between the first visit and the second at 6-8 weeks after delivery was seen as too long, particularly for mothers who develop postnatal depression. Participants felt the shorter gaps between contacts would also provide better support to vulnerable mothers and children. Although home visits were the preferred option, there was recognition of the potential impact of this on already stretched resources; participants hoped that more flexibility about the location might be possible so that choice could be driven by the needs of the child and family, rather than the availability of resources.
More work with fathers	An opportunity exists for HVs to do more to facilitate the involvement of fathers with the care of their children through education about child care and development. Participants identified a particular need amongst what they report are increasing numbers of single fathers in the district. Participants felt that education for fathers and the wider family about postnatal depression in particular, would be invaluable.

- **The table above shows evidence of key finding 3 & 7**

Future challenges

Theme	***Summary of the views of the discussion groups***
Financial challenges	Participants were aware of the challenges facing local authorities in the light of current budget cuts and expressed concerns about the potential for further reductions in where are seen as already decreasing services.
Increasing inequalities and inequity of access to Health Visiting services	Participants highlighted what they perceived were inequalities in the amount of support received by families and inequity of access to HV services across the District. Some, but not all, participants had met their HVs before their child was born. Some, but not all, were visited at home after their initial contact postnatal with the HV; however, many had no option but to attend clinics after their first postnatal visit, where they experienced long queues and might not get seen within the session. Support for breast feeding varied greatly across the groups. Not all HVs provided vitamin supplements. Not all children had had their mandated developmental checks. Participants felt that inequalities might increase as local authority funding is cut.

- **The table above shows evidence of key finding 2, 12 & 13**

Consultations with Allied Professionals

Attendees

The events were attended by a total of 88 professionals with an interest in Health Visiting services. These includes representatives from general practices, Children's Centres, Nurseries, the FNP, the Maternity Partnership, Early Years Services, Education, Social Care and the Children's TIG.

Questions and format

At each of the consultation events attendees were divided into groups of approximately eight to ten participants. The discussions were led by experienced facilitators who asked participants what they felt worked well about the current service and what did not work so well. They also asked participants what concerns they had about the move from NHS to local authority commissioning and what opportunities they saw for change and improvement.

Results and Findings

Responses were recorded by the facilitators and transcribed following each event. The key themes emerging from the discussions were then identified and the results are as follows.

What works well?

Theme	*Summary of the views of the discussion groups*
Safeguarding	HVs were seen by professional colleagues as having expertise in this area. They were described as good at identifying vulnerable, at risk children. HVs were regarded as central to the integrated partnership working around safeguarding. Communication with GP practices and other key stakeholders around safeguarding issues was described as excellent.
Partnership working	HVs enjoy a high profile in the district and are well regarded for their joint working, for example with education services. They were described as having a multi-disciplinary approach that facilitates better engagement with families by other services.
Universal service	The universal service provided by HVs was valued highly amongst participants. HVs were seen as unique because they are the only professionals that visit healthy families in their own homes, a position that enables them to provide a holistic assessment of health and unmet need for each family in a way that was seen as non-threatening and without stigma.
Highly skilled and professional service	Health Visitors were seen as committed and passionate professionals who were highly trained and highly skilled. Their excellent working knowledge of complex and extended families and focus on the wider determinants of health supports family and child welfare.

- **The table above shows evidence of key finding 13**

What are their concerns?

Theme	***Summary of the views of the discussion groups***
The single point of access Hub	The difficulties and frustrations of contacting HVs via the single point of access were clearly articulated and closely similar to those described by families in receipt of HV services. These challenges were seen as a barrier to effective collaboration.
Reducing visibility in the community	HVs were described as becoming increasingly remote, with less contact or engagement with GP practices in recent. Awareness of when clinics were running and where is decreasing. HVs response to emails was described as "slow, if at all".
Data and information sharing	The lack of shared access to data and information was seen as inhibiting good communication and effective joint working. The organisational changes currently underway impact negatively on data sharing arrangements, as do current information governance constricts. Communication across professions and organisations was seen as challenging because IT systems are not compatible or interconnected.
Team structures	HVs were described as a very transient population; staff turnover means staying up to date can be a challenge due to the constant influx of new staff. The absence of team leaders in the current HV teams makes it hard for other professions to get anyone to act as a representative for their HV colleagues. It also leaves teams without effective leadership and fewer options for professional development. Specialisation and the lack of skill mix make absences due to sickness and leave difficult to cover, impacting on their ability to provide continuity of care.

- **The table above shows evidence of key finding 1,8 & 10**

What does not work well?

Theme	***Summary of the views of the discussion groups***
Safeguarding	Participants felt taking HVs out of their GP attachment would pose significant risks for safeguarding and that these risks would increase while the changes were being implemented. Participants noted that the greatest risks would be for missing children and the children of Roma and Traveller families, both of which may not be registered with a GP or routinely in contact with HV services.
IT infrastructure	Effective IT systems were seen as underpinning efficient and effective working. Participants questioned whether IT systems across health visiting services and Children's Centres were compatible and whether they would support data and information sharing between the services. HVs are also dependent on connectivity to support agile working and participants questioned whether this would be adequately supported going forward.
Local authority commissioning of HV Services	Moving the commissioning of HV service from the NHS to the local authority was described as challenging. Participants questioned whether the local authority has the experience, knowledge, capacity and resources to effectively commission, manage or monitor the new service. The local authority was viewed as having a strong political agenda that leads to the development of short term 4 year priorities. Participants also questioned whether the local authority would, as

	commissioners, will keep the necessary funding in the health budget.
Capacity and workloads	Population change and the increasing number of 0-5 year olds in the district were highlighted as a concern in relation to the workload of HVs and their capacity to manage their caseload. Participants noted this in the context of what they felt were increasing numbers of children in the district with complex health needs and increasing numbers of children from hard to reach groups, such as transient communities and families seeking asylum.

- **The table above shows evidence of key finding 8& 9**

What opportunities do they see for change?

Theme	***Summary of the views of the discussion groups***
Equity and equality	Participants felt that opportunities exist for standardisation of services across the district so that access is equal and quality is consistent and high. Services should be flexible so that they can respond to the needs, and special needs, of the population.
Integration	Participants highlighted the opportunity that now exists to develop a seamless, fully integrated service for 0-19 year olds, bringing together health visiting, school nursing, social care and education services, and other council-led services such as planning and housing. The possibility exists for a fully integrated service across all services and pathways that safeguards children and families, improves health and well-being and supports child development and children's outcomes.

- **The table above shows evidence of key finding 11, 12 & 13**

Future challenges

Theme	***Summary of the views of the discussion groups***
Financial challenges	Participants expressed significant concerns about the threat of further cuts because these would increase the workloads of HVs and the pressures under which they are operating, and in turn increase the risks for children.
Recruitment and retention	Participants were of the opinion that, "here in Bradford, we regularly undersell ourselves", making it less likely that HV services locally will be able to attract or retain a good workforce and making it more difficult for the existing workforce remain motivated. Participants also highlighted the loss of skills that may result where HVs choose to leave or take early retirement because of current uncertainties.

- **The table above shows evidence of key finding 14**

Consultations with Heath Visitors

Attendees

The events were attended by a total of 61 health visitors, members of their Strategic Management Team and specialist practitioners covering breastfeeding, safeguarding, looked after children, coping with crying and speech therapy.

Questions and format

At each of the consultation events attendees were divided into groups of approximately eight to ten participants. The discussions were led by experienced facilitators who asked participants what they felt worked well about the current service and what did not work so well. Participants were also asked what concerns they had about the move from NHS to local authority commissioning and what opportunities they saw for change or improvement.

Results and Findings

Responses were recorded by the facilitators and transcribed following each event. The key themes emerging from the discussions were then identified and the results are as follows.

What works well?

Theme	*Summary of the views of the discussion groups*
Local knowledge and awareness of needs	HVs know their communities; they know what is happening in the community and how it affects its families. Positive flexibility within Bradford with services more sensitivity to different cultures across the district. HVs understand the area and become part of the community, building up trust which encourages individuals to access the HV services. They know the needs of the community and deliver services to meet those needs, They know a lot about how to secure resources for their families at low cost
Local knowledge and awareness of needs – Relationships with families	HVs are a committed service which deals with very difficult and complex issues. They build strong trust-based relationships with their clients; they are accepted by everyone and are seen as a "safe pair of hands" and a trusted conduit to other services. They see their fundamental strength as engagement with children and families.
Breast feeding support	HV services are one of the few organisations locally to have achieved full Baby Friendly accreditation. HVs see the provision of breast feeding support and the development of breastfeeding champions and breastfeeding buddies as an area of strength.

- **The table above shows evidence of key finding 13**

What does not work well?

Theme	*Summary of the views of the discussion groups*
The single point of access Hub	The single point of access if no more popular with HVs than it is with their clients. HVs report that since phone calls from clients have been routed through the hub, fewer calls are being received by HVs and more clients are not returning calls when messages are left for them. HVs feel the hub may therefore also be having a negative impact on attendance, affecting both attendances at

	clinics and the number of unsuccessful home visits where the family are not in when the HV calls.
Data sharing	Participants raised a number of concerns related to the sharing of data and information across partners in the integrated care pathway, including health visitors, midwives, GPs, Children's Centres, social care and the school nursing service. The number of different IT systems involved across services has an impact on effective data sharing and also inhibits communication across services. There were concerns also about referrals where it is proving impossible to get any feedback on the outcome.
Team structures	The current team structures were felt by some of those present to be a weakness where the team dynamics were not working well; the HVs felt that negative environments were persisting because of a lack of leadership that is inherent to the current "flat" team structure. The "flat" team structure also means that achieving change within these teams is a challenge in the absence of leadership. Participants felt that this situation was unlikely to change in the current climate where the ability to financially reward staff for taking on a leadership role has been removed.
Duplication	Participants highlighted concerns about duplication of effort and confusion about respective roles of GPs, HVs and Children's Centres, particularly where this leads to confusion and inconvenience for clients. An example was given of the 3-4 month safety check which is carried out by both HVs and Children's Centres.

- **The table above shows evidence of key finding 1 & 10**

What are their concerns?

Theme	***Summary of the views of the discussion groups***
Loss of local services and resources	Concerns about the loss of local services and resources were wide ranging. The HVs reported that Third Sector organisations with which they have had long standing relationships are being lost and that they therefore have fewer resources to draw on to support their clients. Loss of the Mother and Pregnancy Support Service workers was regarded as a threat to their ability to support their clients housing needs. Reductions in other services such as the contraception and sexual health services are affecting families because services are less local and therefore less accessible. Access to interpretation services is essential for many clients in this district. Participants expressed concerns about the potential loss of interpreters under the current organisational changes and financial cuts.
Increasingly target, rather than needs, driven	HVs feel their work is becoming more target driven rather than led by the needs of clients and they saw this as a threat to their ability to deliver quality of care. The outcomes for health visiting are very long-term, requiring activities that change behaviours at generational levels. HVS feel that this is very difficult to achieve and even more difficult to measure. HVs saw the requirement to deliver on key performance indicators as removing the flexibility from the HVs working practices that enabled them to address the needs of their clients rather than hit a target.
Loss of professional identity	Participants questioned whether their role will be perceived differently as they become local authority employees. HVs have a multifaceted role; this

	has the potentially to leave them to be overstretched in all areas. They felt there was a risk of the HV role becoming diluted as parts of the role are passed to volunteers or other services in the course of the organisational changes currently underway, possibly leaving them more involved in social care than health visiting. Concerns were expressed about the potential for their role to become de-professionalised and ceasing to be a 'specialist' role on the NMC register.

➢ **The table above shows evidence of key finding 13**

What opportunities do they see for change?

Theme	***Summary of the views of the discussion groups***
A seamless, integrated service	A strong desire exists for a fully integrated service, offering 'one assessment, one journey' for children and families. The vision is to have all the relevant professionals, including midwives, HVs, nursery nurses, social care, Children's Centre workers and early childhood services under one roof, with alignment of HV services and Children's Centre clusters.
Better use of technology	Participants felt that a review of IT systems would be timely. Better use of IT systems to bring together people, processes and technology to find the most appropriate and effective way of working to carry out a particular task, working within guidelines for the task but without boundaries on how that task can be achieved. Opportunities exist to utilise modern technology, such as Facetime, Skype, WhatsApp, SMS and Baby Buddy apps in innovative ways to better support their clients. An example was given of a way in which a website providing information on early years services in multiple languages, together with an explanation of the role of the HV, could be used to support the non-English speaking communities in the district
Data and information sharing	Participants felt that the current organisational changes presented an opportunity to establish joint records to overcome the problems associated with sharing data and information and to support the provision of a seamless service to their clients.
Better team structures and administration	Participants felt there was an opportunity to build more resilient teams with embedded leadership and better caseload management in the course of the current organisational changes. Opportunity to pool knowledge and experience across teams, bringing together ideas from others to find answers and address specific health needs. The opportunity of coming under the responsibility of the local authority should be used to enable HVs to work more closely with other organisations and to develop the role of the HV to deliver services to groups that are traditionally hard-to-reach.

➢ **The table above shows evidence of key finding 8, 10, 11, 12**

Future challenges

Theme	***Summary of the views of the discussion groups***
Financial challenges	HVs were particularly concerned about the impact of financial cuts on training opportunities for new health visitors and on opportunities for on-going professional development for existing health visitors.

- **The table above shows evidence of key finding 14**

Families in Receipt of Family Nurse Partnership

As part of the review of Health Visiting services the views of stakeholders were sought on the Family Nurse Partnership using two methods:

- Questionnaires
- Organised group discussions

Questionnaires

A questionnaire was used to collect the views of:

- Families in receipt of the services of the Family Nurse Partnership
- Stakeholders with an interest in the Family Nurse Partnership

Response rates and coverage

A total of 62 responses were received to this questionnaire.

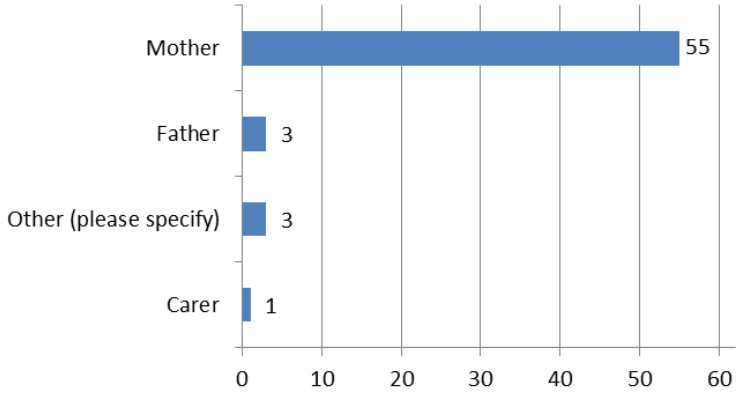
The questionnaire for families in receipt of services from the Family Nurse Partnership collected the following factual information about the respondents:

- Relationship to the child
- Gender
- Marital Status
- Age
- Disability
- Postcode area
- Sexual Orientation
- Religion
- Ethnicity

Relationship to the child

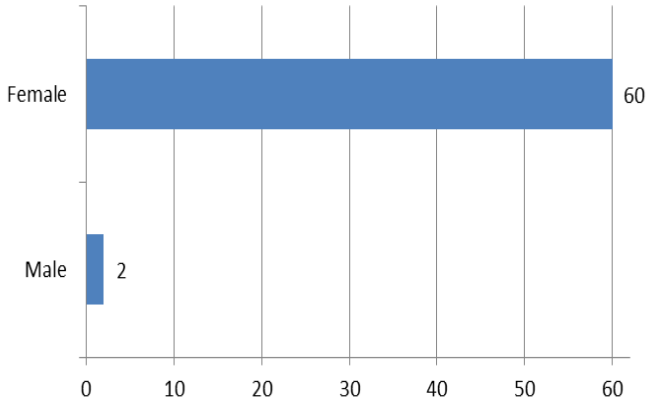
89% of respondents identified themselves as the mother of the child, 5% as the father and 2% as the carer; the individuals who selected “Other” did not specify their relationship.

PART TWO – FAMILY NURSE PARTNERSHIP – QUESTIONNAIRES (FAMILIES IN RECEIPT OF FNP)



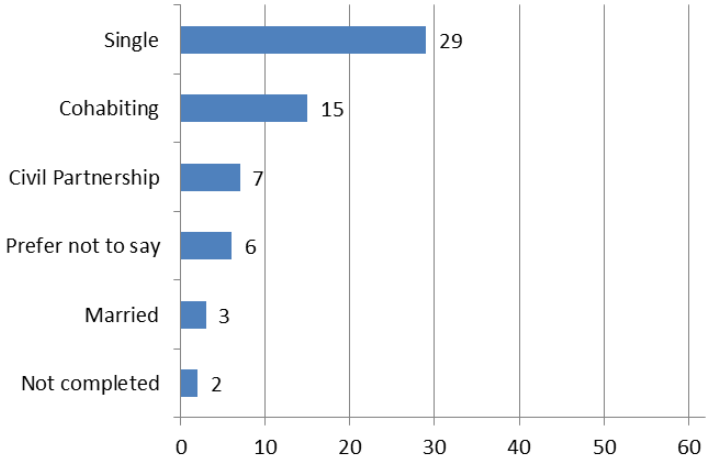
Gender

97% of respondents described themselves as female and 3% as male.



Marital Status

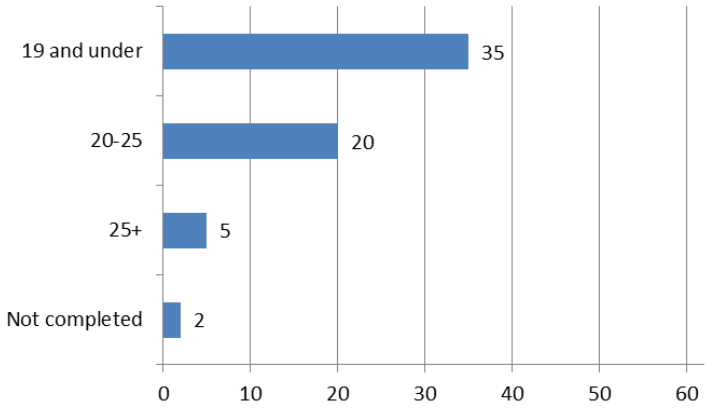
16% of respondents described themselves as married or in a civil partnership and 24% as cohabiting; 47% of respondents described themselves as single and 13% either preferred not to say or did not complete this question.



PART TWO – FAMILY NURSE PARTNERSHIP – QUESTIONNAIRES (FAMILIES IN RECEIPT OF FNP)

Age

56% of respondents were aged 19 and under, 32% were aged 20- 25 years and 8% were over 25. 3% of respondents did not complete the question.



Disability

Do you have any of the following disabilities?	Number of respondents
Not completed	47
Mental ill Health	9
Learning difficulties	3
Prefer not to say	2
Other substantial and long term condition	1
Visual impairment	1

Postcode area

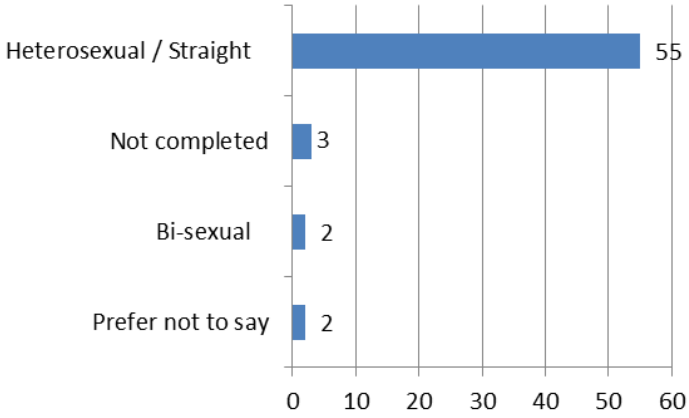
The following table shows the geographical distribution of respondents.

Postcode area	Wards	Number of respondents
BD21	Bingley Rural, Keighley Central, Keighley East, Keighley West, Worth Valley	13
BD22	Bingley Rural, Keighley Central, Keighley West, Worth Valley	9
BD5	Bowling and Barkerend, City, Great Horton, Little Horton, Tong, Wibsey, Wyke	7
BD4	Bowling and Barkerend, Bradford Moor, City, Little Horton, Manningham, Tong, Wyke	5

PART TWO – FAMILY NURSE PARTNERSHIP – QUESTIONNAIRES (FAMILIES IN RECEIPT OF FNP)

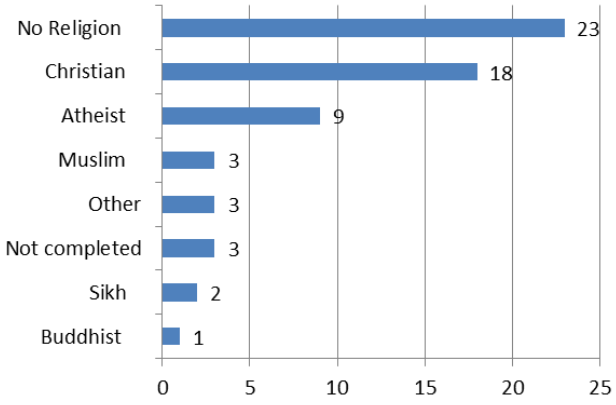
Sexual Orientation

89% of respondents described their sexual orientation as heterosexual/straight and 3% as bisexual; 35% of respondents preferred not to say and 5% did not complete the question.

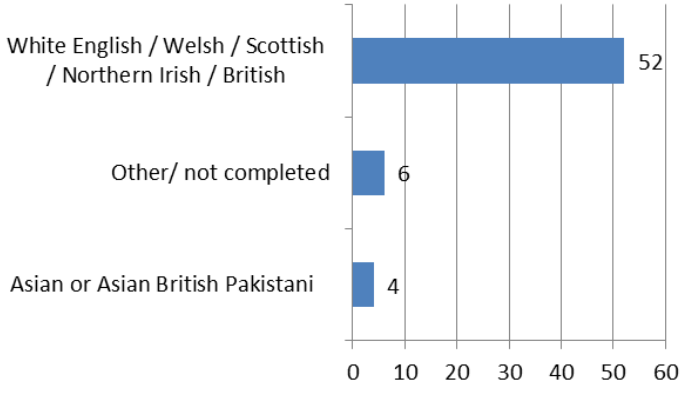


Religion

29% of respondents described themselves as Christian, 5% as Muslim and 10% as belonging to a small number of other religions; 15% described themselves as atheist and 37% as having no religion. 5% of respondents did not complete the question.



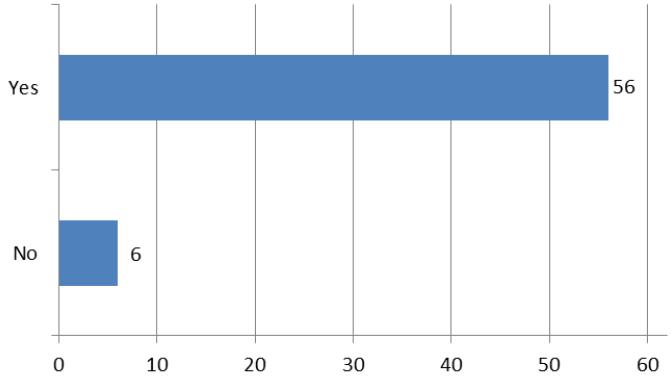
Ethnicity



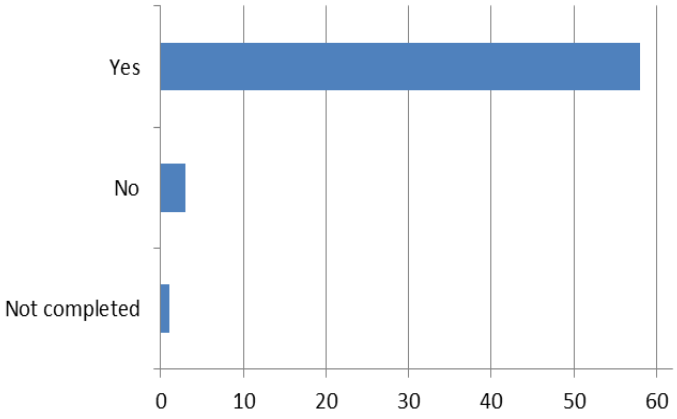
PART TWO – FAMILY NURSE PARTNERSHIP – QUESTIONNAIRES (FAMILIES IN RECEIPT OF FNP)

Responses by question

Is this your first child?



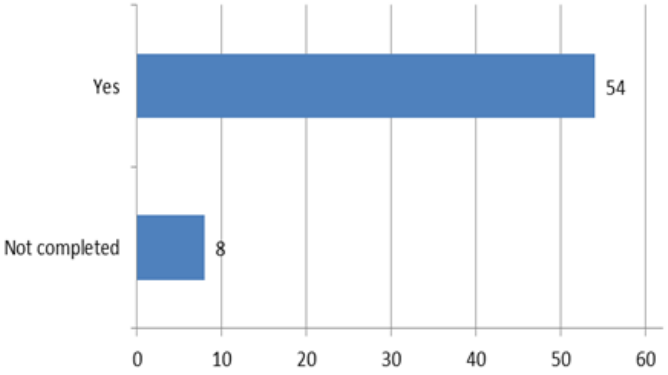
Did you first meet your Family Nurse before your baby was born?



Did your Family Nurse ask how you were feeling before birth?

All respondents confirmed that their Family Nurse asked about how they were feeling before the birth.

Did your Family Nurse ask how you were feeling after birth?



Which of these did your Family Nurse offer you advice on?

Topic	*Number of responses*
Bonding with your baby	57
Breastfeeding your baby	55
Healthy eating for you and your baby	55
Coping with your baby crying	54
Weaning your baby	53
Family planning/contraception	53
Benefits	53
Your baby's immunisations	52
Your baby's physical and emotional development	51
Helping your baby learn good sleep habits	51
Accessing services (i.e. children centres)	50
Accident prevention	49
Education of parents	48
Housing support	48
Oral health	47
Coping with minor illnesses	47
Relationships	46
Mental health	45
Postnatal depression	44
Stopping smoking	44
Domestic violence	37
Employment	36
Other (Please specify)	21

What would you like your Family Nurse to offer you advice on?

Topic	*Number of responses*
Healthy eating for you and your baby	24
Housing support	24
Weaning your baby	23
Helping your baby learn good sleep habits	23
Your baby's immunisations	23
Coping with your baby crying	22
Accident prevention	22
Your baby's physical and emotional development	22
Stopping smoking	22
Family planning/ Contraception	22
Bonding with your baby	21
Coping with minor illnesses	21
Accessing services (i.e. Children Centres)	21
Domestic violence	21
Benefits	21

Relationships	21
Education (of parents)	20
Employment	20
Breastfeeding your baby	19
Oral health	19
Postnatal depression	18
Mental health	18
Other (Please specify)	10

Did you find your Family Nurse…?

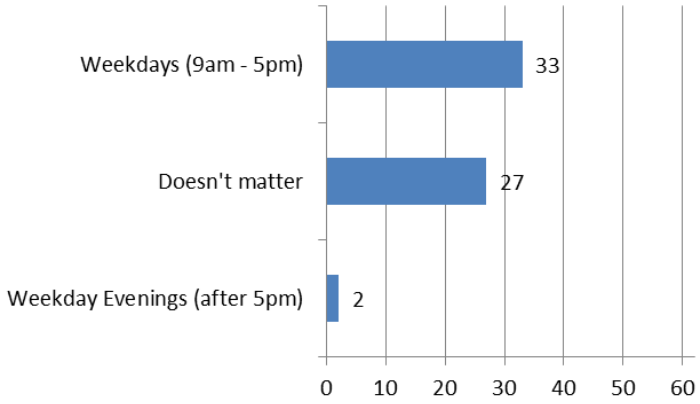
Characteristic	*Number of respondents*
Polite	62
Kind	60
Helpful	59
A good listener	59
Thoughtful	58
Supportive	57
Punctual	56
Flexible (could see them when it suited you)	55
Knowledgeable	53
Reassuring	53
Impolite	4
Not helpful	4
Unsupportive	3
Not flexible	0

➢ **The table above shows evidence of key finding 2**

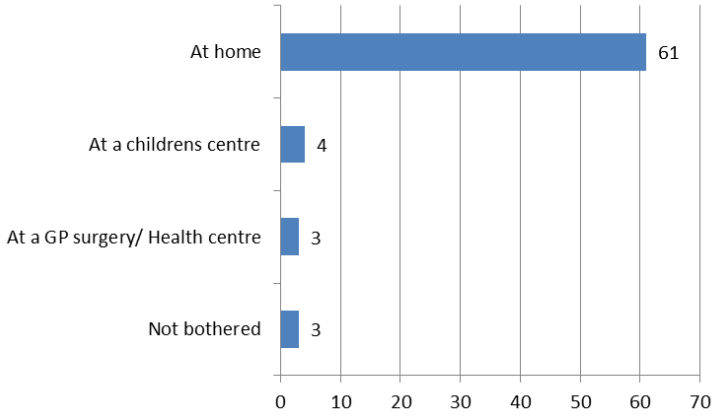
Did you understand the information provided by the Family Nurse?

All respondents reported that they were able to understand the information provided by their Family Nurse.

When would you prefer to see the Family Nurse?



Where would you prefer to see the Family Nurse?



Do you feel you can easily contact your Family Nurse if you need advice or information?

All respondents reported that they felt they could easily contact their Family Nurse if they needed advice or information.

What additional support do you feel you need/ needed?

Additional Support	*Number of respondents*
Not completed	35
More frequent contact after baby was born	6
More online support	6
Other (please specify)	6
More drop in clinics	5
More frequent contact before birth	5
More frequent contact after baby was born	3

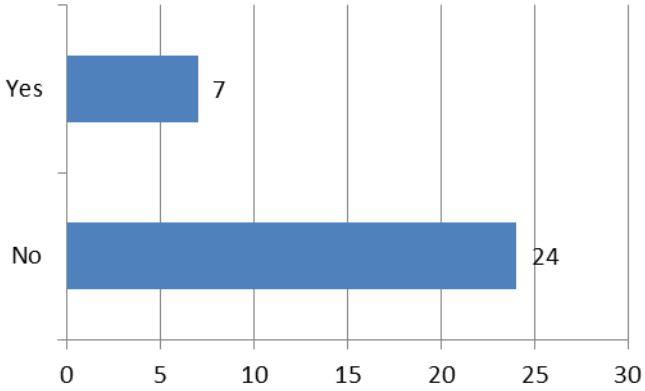
'Other (please specify)'

Respondents who chose other said they felt that they did not require any additional support as they already received all the help they needed.

➢ **The statement above shows evidence of key finding 3**

PART TWO – FAMILY NURSE PARTNERSHIP – QUESTIONNAIRES (FAMILIES IN RECEIPT OF FNP)

If your child is now 2 or over, have you had a handover to the Health Visitor?



It is unclear how many respondents this would refer to as age of child was not obtained, there may have been individuals who selected 'No' simply because their child was not yet 2 years old.

If your child is now 2 or over and you have had a handover to the Health Visitor, what was your experience of this?

6 respondents provided a response to this question, of those who answered all had a positive experience, nobody identified any issues with the process however this was small numbers, 2 respondents identified that there child was not yet two and this could be a limitation in how the question was asked.

Please use this space for any other comments you would like to make about the Family Nurse Partnership:

This was an 'open' question which allowed respondents to express themselves freely, rather than to select from a number of options. 37 respondents provided responses for this question. The responses received were coded into themes. Many responses could be categorised into more than one theme; for instance, a comment such as "…really helpful experience felt supported through pregnancy…" would be coded as both 'Positive personal experience' and as 'Supportive'. The following table illustrates the most common themes, in descending order of recurrence.

Theme	*Number of occurrence*
Positive personal experience	23
Supportive	11
Accessible	5
Antenatal	5
Post Natal Depression	2
Bonding with your baby	1
Breastfeeding	1
Consistency	1
Domestic Violence	1
Flexible	1
Reassuring	1

Understanding 1

Positive Personal Experience
"…happy with the help [Family Nurse] have gave me…been so helpful…"
"…would recommend to anyone before and after birth…"
"…wouldn't have a clue about how to look after a baby if it wasn't for the service…"

➢ **The table above shows evidence of key finding 3**

Supportive
"…amazing support…helped me through problems…"
"…enjoyed having the support of my family nurse…"
"…felt more at ease with the support I have been given…"

➢ **The table above shows evidence of key finding 3**

Accessible
"…if there is a problem day or night she is there…"
"…felt always have someone to talk to when I have needed to…"
"…can easily give them a call or a text…"

➢ **The table above shows evidence of key finding 2**

Stakeholders with an interest in the Family Nurse partnership

Response rates and coverage

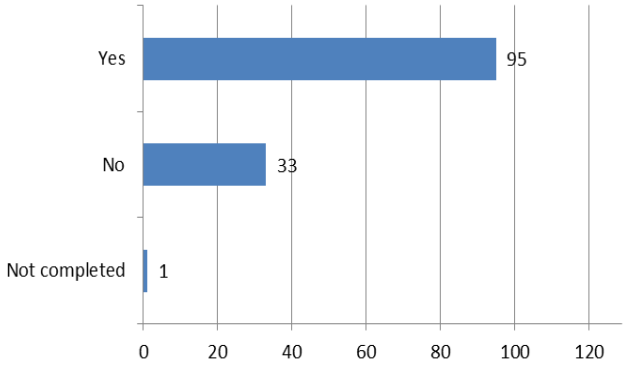
A total of 127 responses were received.

Please select the type of organisation you represent:	*Number of respondents*
GP practice	44
Children's Centre	19
Voluntary and community sector organisation	11
Education	5
Not completed	1
Other (Please specify)	49

Those who selected 'Other' included a number of people from the Bradford District Care Trust, including health professionals and commissioners, and from Family Centres, Nurseries and Social Services.

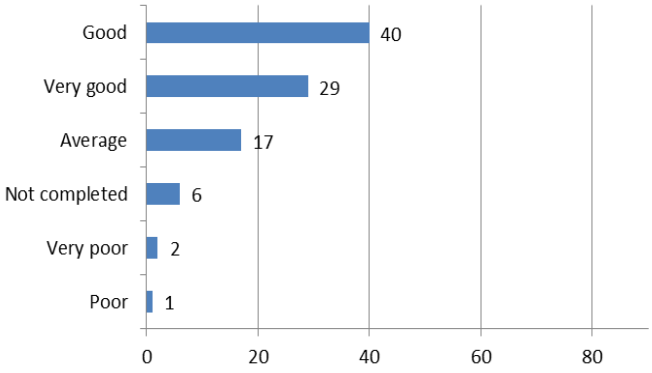
Responses by question

Are you aware of the Family Nurse Partnership?



If yes, to 'Are you aware of the Family Nurse Partnership?'

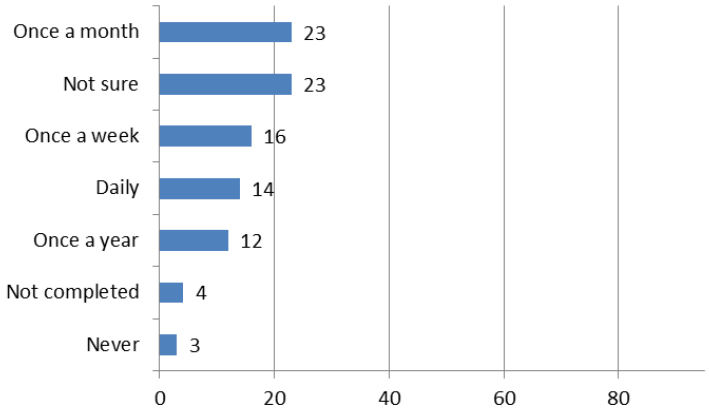
How would you rate the quality of the current FNP service?



If yes, to 'Are you aware of the Family Nurse Partnership?'

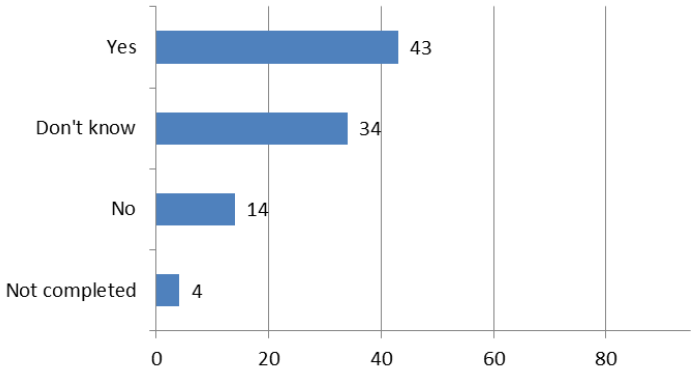
PART TWO – FAMILY NURSE PARTNERSHIP – QUESTIONNAIRES (STAKEHOLDERS)

How often does your service come into contact with the FNP?



If yes, to 'Are you aware of the Family Nurse Partnership?'

Do you think the current FNP service fully addresses the needs of families?



Which of the following do you feel would benefit families in receipt of support from the Family Nurse Partnership?

Which of the following do you feel would benefit families in receipt of Family Nurse Partnership support?	Number of respondents
Mental health	93
Postnatal depression	91
Healthy eating for you and your baby	87
Bonding with your baby	86
Accessing services (i.e. Children's Centres)	86
Your baby's physical and emotional development	85
Family planning/ Contraception	85
Oral health	84
Coping with your baby crying	84
Weaning your baby	83
Helping your baby learn good sleep habits	83
Accident prevention	82
Education (of parents)	82
Domestic violence	82

Coping with minor illnesses	81
Stopping smoking	81
Breastfeeding your baby	80
Relationships	80
Your baby's immunisations	79
Benefits	72
Housing support	71
Employment	69
Other (Please Specify)	37

Those who selected 'Other' were given the opportunity to specify what they meant by other. A number of respondents used the opportunity to say that they didn't know enough about the service to comment, others included that the service is designed to build resilience and independence.

Please use this space for any other comments you would like to make about the FNP service?

This was an 'open' question which allowed respondents to express themselves freely, rather than to select from a number of options. 59 respondents provided responses for this question. The responses which were received were coded into themes. Many responses could be categorised into more than one theme. For instance a comment such as "…I am really pleased with the support provided by the Family Nurse partnership…" would be coded as both 'praise' and 'support'. The following table illustrates the most common themes, in descending order of recurrence.

Theme	Number of Respondents
Lack of awareness	14
Praise	14
Restrictions	7
Support	4
Expensive	2
Link with other organisations	2

Lack of awareness
"…need to know more about the FNP service…"
"…please raise awareness in practices regarding their role…"
"…not familiar with this service…"

Praise
"…the Family Nurse Partnership makes such a difference to young mums because they are able to give more time…"
"… the intensive input … is really valuable…"
"… valued and needed service…"

- **The table above shows evidence of key finding 2**

Restrictions
"…limited in … area…"
"…need to consider the needs of teen late presenters…"
"…good if it could be extended to include vulnerable groups in any age group…"

- **The table above shows evidence of key finding 1**

Organised Discussion Group Findings – Family Nurse Partnership

Attendees

A wide variety of stakeholders attended the consultation events focussed on the Family Nurse Partnership; these included clients receiving support from the FNP and professionals from:

- Children's Centres
- Education
- Child and Adolescent Mental Health Service
- Public Health
- Voluntary and community sector
- School Nursing
- Children's Services

Questions and format

At each of the consultation events focussing on the Family Nurse Partnership, participants were divided into groups of eight to ten. The discussion were led by experience facilitators who asked participants what they felt worked well about the current service and what did not work so well. Participants were also asked about what concerns they had about the move from the NHS to local authority commissioning and what opportunities they saw for change and improvement.

Results and Findings

Responses were recorded by the facilitators and transcribed following each event. The key themes emerging from the discussions were then identified and the results are as follows.

What works well?

Theme	*Summary of the views of the discussion groups*
Approach	Participants pointed out that the FNP works with most vulnerable in the District and makes a difference in the areas of highest deprivation. It works with the whole family, with the needs of the child being central. FNP staff build strong, trust-based relationships with parents and work with them to build self-efficacy and self-esteem, the aim being to break cycle of deprivation so that outcomes for child are improved.
Flexibility	The FNP was seen as a flexible service that fits around the needs of the family. Participants reported that families found it easy to contact their Family Nurses and that this could be done direct without involving the Hub. Family Nurses made frequent home visits and provided clients with robust support and reassurance for their complex issues from the antenatal period through until their child is 2 years old. Participants noted that the support provided ranged from simple advice and information, through to education for parenting and practical assistance with obtaining furniture and benefits.
Continuity and consistency of care	Participants reported that families in contact with FNP services valued the continuity of care and friendship provided by their Family Nurse. Because clients always see the same Family Nurse, repetition is eliminated, meaning that they only have to tell their story once, and the advice they receive is consistent. FNP clients welcomed the structured support provided by their Family Nurse; for example, clients of the service reported that they feel it "prepares us properly for parenthood".

➢ **The table above shows evidence of key finding 2**

What does not work well?

Theme	*Summary of the views of the discussion groups*
Access	Participants saw the FNP as providing very good support for a very small number of mothers and children in some areas of the District. They noted that it was not a universal service and therefore care was not equitable. Participants felt that the fact that the FNP was an opt-in service might add to this, since mothers might decline the service without understanding what it was or how helpful it might be.

➢ **The table above shows evidence of key finding 1**

What are their concerns?

Theme	*Summary of the views of the discussion groups*
Losing the FNP service or important elements of it	The possibility of losing the FNP was seen by participants as a threat to the vulnerable families in the District currently supported by the service. Participants expressed concerns about the possibility that the service might be "watered down" and important elements of it lost as a result of the findings of the recent national evaluation.
Knowledge of HV Services	Participants felt that knowledge and understanding the role of the HV was poor amongst FNP clients. The abrupt step from intensive support to what was seen as the much lower level of support provided through the universal service was seen as a challenge for these clients who did not have the same well established, trust-based relationship with their HV as with their Family Nurse. Participants reported that as a consequence, FNP clients frequently continued to contact their Family Nurse even after their care has been transferred to the HV.

➢ **The table above shows evidence of key finding 4, 5 & 6**

What opportunities do they see for change?

Theme	*Summary of the views of the discussion groups*
Outcomes	Participants were aware that the recent national evaluation of FNP services has shown no significant improvement in some short term outcomes for participants. There was a strong belief amongst participants that locally, the programme has made a difference to outcomes for the children of some of the most deprived families in the District. They felt that an opportunity now exists to undertake a local evaluation to determine whether this difference is significant in Bradford.

➢ **The table above shows evidence of key finding 7**

Future challenges

Theme	***Summary of the views of the discussion groups***
Retaining the FNP	In the face of continuing funding restrictions, the organisational changes currently underway and the negative findings of the national evaluation, there were concerns expressed amongst participants about whether the FNP service would continue in Bradford.

- **The table above shows evidence of key finding 5**

Strengths and Weaknesses of the Consultation Exercise

Strengths

- Consulted with a wide range of stakeholders to ensure that a large number of individuals had the opportunity to give their views. Furthermore, the contributions have been received from individuals from different backgrounds, whose opinions and expectations of the service will have been formed by very different experiences and perspectives.
- Good representation of families in receipt of HV and FNP services- organised group discussions were set up across the district to enable more families to have their say, which gave an opportunity for groups who would not necessarily complete a questionnaire to give their views. Feedback received from service users who have participated in the consultations is that they have very much welcomed the opportunity to express their views and are pleased to have had the opportunity to be heard.
- Attended established clinical commissioning group meetings to ensure a good response from GPs. At the meetings a short organised discussion was carried out to obtain views and GPs were also made aware of the questionnaire which would enable them to give their views and this was reflected in an encouraging number of responses from GPs.

Weaknesses

- The majority of the organised group discussions with families took place at a Children's Centres; this means that those who do not attend a Children's Centre will have had less opportunity to attend. There is also a possibility that the findings of the consultation may have been positively-skewed in as much as those who attend Children's Centres are more likely to have had a positive experience of the services, and, equally, those who have had a positive experience of the services are more likely to attend Children's Centres.
- There was limited coverage in some Children's Centre cluster areas with an over representation in the BD5 area. This was also reflected in the questionnaire responses.
- Although efforts were made to obtain the views of minority groups, some groups – such as asylum seekers and LGBT families - were not represented in the consultation.
- The presence of senior management at organised group discussions designed to get the views of HV and FNP staff members may have had a detrimental impact on enabling attendees to give their views open and honestly and may therefore have resulted in the service being portrayed in a positive light.

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Report of the Public Health Director to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 8th September 2016.

J

Subject: Joint School Nursing Service Review

Summary statement:

This report briefs Members and strategic partners on the commissioning review of the School Nursing service.

The commissioning of School Nursing will contribute towards the Council and Public Health objectives of 'working with people and partners for a healthier, caring, more prosperous and sustainable Bradford District'.

This review has been informed by national and local strategy, opportunities relating to the transfer of Public Health into the Council, and a drive to improve the health outcomes for children and young people.

The proposed service model will benefit children and young people and support the delivery of a range of strategic outcomes relating to health and wellbeing.

Included within the scope of the review is the generic School Nursing Contract managed by Public Health. The annual Contract value is £3 million and is held by a local NHS provider.

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Overview & Scrutiny Area: Health and Social Care

1. SUMMARY

1.1 The purpose of the briefing note is to inform members of the Committee of the School Nurse Review, highlighting key activities undertaken, and emerging themes and to seek support for the recommendations for the new service model going forward.

2. BACKGROUND

2.1 In April 2013, responsibility for commissioning the public health school nursing service for children and young people aged 5-19 years transferred to the Council.

2.2 The annual value (2016/17) of the School Nursing Contract is £3 million, making it one of the largest value (single service) contracts held by Public Health (PH). The Contract is delivered by a local NHS provider and is incorporated within a wider Public Health services Contract held with that provider.

2.3 The Service has not been reviewed for some years and the transfer of commissioning responsibilities to the Council provided an opportunity for PH, with partners, to review the School Nursing Service with the overall aim to improve health and wellbeing outcomes for children and young people.

2.4 A detailed review of the public health school nursing service for school aged children 5-19yrs (currently referred to as 'school nursing services') was undertaken.

2.5 The purpose of the review was to identify if the current service model meets current and emerging need, fits within the 'Journey to Excellence', 'New Deal' (specifically Good schools and a great start for all our children and Better health, better lives), and Future in Mind programmes, the Integrated Early Years Strategy (0-7), Joint Health and Wellbeing Strategy, Health Inequalities Action Plan, and the Children and Young People's Plan, and to highlight opportunities for service improvement. The review recognised the importance of other parallel changes in health and social care, such as potential new models of accountable care and the district's emerging Sustainability and Transformation plan (STP), part of the local 'Five Year Forward View'.

3. OTHER CONSIDERATIONS

Findings from the Consultation

National and local evidence, guidance and policy were used to inform the Review alongside the current health and wellbeing needs of children and young people aged 5-19 years **(see Appendix 1 and 2).** A full and detailed report about the Consultation can be found in **Appendix 3.** Opinions from a range of stakeholders were sought to ascertain their views about the school nursing service. The two main consultation methods were questionnaires and organised group discussions.

There were 5 questionnaires in total to obtain the views of;

- Primary School pupils (830 responses);
- Secondary School pupils (215 responses);
- Parents (156 responses);
- Teachers (82 responses);
- GPs 17 (responses).

There were five organised group discussions set up to better understand stakeholder views of the current service and future expectations. The key findings from the consultation exercise have been divided into a number of broad categories:

Access and Awareness

- There is good awareness of the role of the School Nurse, but in secondary schools, most boys do not know of the role of the School Nurse
- Girls are more engaged with the school nursing service.

People's experience of the service

- People's experience of the service experience has tended to be positive.

People's expectations of the service

- Children and Young People would prefer to see someone "in school" and for them to be easily contactable.
- Girls and young female students prefer to see a woman. Boys and young male students are less concerned about the gender of the school nurse, but those who did in primary school showed an overwhelming preference for seeing a male nurse.

Needs

- The issues on which children, young people and parents most want advice and help relate to two main categories; Emotional and mental health, and lifestyle choices, including healthy eating; diet and exercise and medical conditions.

Organisational Matters

- Those working in, or closely with the service are unclear about the boundaries of the role of the School Nurse, and feel that it is misunderstood by others.
- Some key stakeholders expressed the view that schools need to be more supportive of the service.
- Many people suggested that the service needs to be more accessible generally, and particularly to harder-to-engage groups e.g. children who are not in school.
- Concerns were raised around the capacity of the current service, and whether demand outweighs provision.
- Whilst many contributors reported that partnership working was a strength of the current service, it was suggested that the service may function better through closer working with other services including CAMHS, GPs, Health Visitors, Children's Centres and Children's Social Care.

3.1 Throughout the review there has been consistency in the identification of the priorities, needs of children and young people, and high-level service expectations. This has been reflected in national and local policy, guidance, planning and, in what key stakeholders and partners have identified as important to them in a School Nursing Service.

3.2 Key themes identified through the Review included:

- Mental health and emotional wellbeing
- Obesity: healthy eating and physical activity
- Substance use: tobacco, drugs and alcohol
- Sexual health and contraception
- Support for the management of Long Term Conditions
- Safeguarding
- Oral health
- Flexible, needs led service delivery
- Delivery of the Healthy Child Programme
- Service design and delivery to include national recommendations (4-5-6 model) and local programmes (Journey to Excellence/New Deal)

3.3 Key stakeholders and partners reiterated the importance of a community based service model providing access to those children and young people who either do not wish to use the service within a traditional school setting, or who do not access education within a traditional school setting because they are:

- Home schooled
- Excluded
- Not registered to attend education (because they have not been allocated a place, recently moved into the area etc.).

3.4 Public Health has worked closely with the NHS Provider throughout the Review period including working with Senior leads within the Children's Directorate of the NHS Provider; both in terms of the Review itself but also in terms of improvements in the current service provision, this is acknowledged as being very positive.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 The total cost of investment in School Nursing Services in Bradford for 2016-2017 is approximately £3 million. Given the current financial climate, it is likely that the total cost of investment will be reduced so innovative solutions will need to be considered to ensure the proposed model can respond to financial and service (demand) pressures.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The identification of new and increasing risks is an on-going process and will continue to be managed through the life of the project via the Risks and Issues Log.

6. LEGAL APPRAISAL

The commissioning of the school nurse service will be conducted in accordance with the Council's Contract Standing Orders, and National and European procurement regulations.

6.1 In the event of this contract for services (once developed) being awarded to persons other than those currently providing all or part of the services then the "Transfer of Undertakings (Protection of Employment) Regulations 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 (TUPE), may apply to protect the rights of staff currently assigned to provide these services. This employment protection framework does not affect the Council directly. The application and impact of TUPE is a matter for any new Provider to resolve with the existing service Provider. The Council's material interest in such circumstances is that the transfer is managed effectively and in a way that poses no threat to service provision or service quality. Further as staff are entitled to participate in a public sector pension scheme, then the Council will need to ensure that those pension rights are protected on transfer, in accordance with the provisions of "Fair Deal for staff pensions: staff transfer from central government"(October 2013).

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 An Equality Impact Assessment (EIA) has been completed and there are no Equality Issues to Report. The EIA can be found in Appendix 2.

7.2 SUSTAINABILITY IMPLICATIONS

None reported

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None reported

7.4 COMMUNITY SAFETY IMPLICATIONS

None reported

7.5 HUMAN RIGHTS ACT

There are no human rights implications to report

7.6 TRADE UNION

Not required at this time.

7.7 WARD IMPLICATIONS

None reported

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS

Not Required

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

A number of high level principles have been developed from the priorities identified through the Review. These high level principles will form the basis of the proposed Service Model:

a) Delivery of an integrated public health nursing service according to the needs of children and young people aged 5-19 years and linked to primary and secondary care, early years, childcare and educational settings which follow locally agreed pathways.
b) Community based teams with nominated leads known to stakeholders and a named School Nurse/Practitioner for every educational establishment and GP surgery.
c) Appropriately skilled and experienced workforce working in multi-disciplinary roles (comprising of different grades and skill mix).
d) Flexible workforce that reflects local need and capacity, providing year round service availability.
e) Delivery of the universal Healthy Child Programme through assessment of need by appropriately qualified staff; health promotion, screening, and engagement in health education programmes.
f) Delivery of evidence based outcome focused interventions to improve health and wellbeing and reduce inequalities by focusing on the needs of all children and young people, specifically vulnerable groups (including those who do not attend mainstream education).
g) Assessment, referral and (if appropriate) delivery of targeted interventions to address Public Health and Bradford district priorities including tobacco, substance misuse, contraception and sexual health, mental health and emotional wellbeing, physical activity and healthy eating, and oral health.
h) Safeguarding embedded and fully engaged within all work.
i) Service delivery forming a key part of 'Journey to Excellence' with 'Early Help' and 'Signs of Safety' integrated within the service model.
j) Service delivery to incorporate the 4-5-6 service model as outlined in 'Best start in life and beyond' (PHE, 2016) and take consideration of Future in Mind and the Integrated Early Years Strategy.
k) Work with children, young people, parents, education providers and other key partners as public health leaders, championing health improvement, and good health and wellbeing.
l) Build on resilience, strengths and protective factors to improve autonomy and self-efficacy with a focus on 'parity of esteem' between mental/emotional, and physical health and wellbeing
m) Work proactively with key partners to support children and young people with long term conditions and health needs to promote resilience and self-care.
n) Supporting transition into education and adulthood.

An integral strand of the delivery model will be flexibility, so the School Nursing Service can meet changing need, demand, and strategic/policy changes.

10. RECOMMENDATIONS

10.1 The Committee consider the Business Case for the School Nursing Service and;

a) Provide any feedback and/or raise any queries or comments for clarity;

b) Support Public Health to proceed with the development of the proposed service model and service specification/s, based on the high level service principles, and to procure the service through a competitive tender process. The length of the contract and the procurement approach and timescales will be agreed with the BMDC Commercial Team.

11. APPENDICES

Appendix 1: Business Case for the Review of Public Health Nursing Service for School Aged Children and Young People (5-19)
Appendix 2: Appendices to Support the School Nurse Consultation
Appendix 3: School Nurse Consultation

12. BACKGROUND DOCUMENTS

- Best Start in Life and Beyond, PHE, Jan 2016
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493617/Service_specification_0_to_19_CG1_19Jan2016.pdf
- Council Contract Standing Orders, Dec 2015
  http://intranet.bradford.gov.uk/working-day/accountancy-and-financial-advice/financial-regulations-and-contract-standing-orders
- Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing, DH, March 2015
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Healthpdf
- Integrated Early Years Strategy, BMDC, 2015-18
  https://www.bradford.gov.uk/NR/rdonlyres/4F168FB7-3239-496A-9029-F96B32556BD6/0/W32253IntegratedEarlyYearsStrategy.pdf
- Joint Health and Wellbeing Strategy
  http://www.cnet.org.uk/_library/downloads/W27843_Health_and_Wellbeing_Strategy_Plain_English_Ver.pdf
- Bradford Health Inequalities Action Plan 2013 - 2017
  https://jsna.bradford.gov.uk/documents/home/Bradford%20and%20Airedale%20Health%20Inequalities%20Action%20Plan%202013.pdf
- Children and Young People's Plan 2014-16
  http://www.bradford.gov.uk/bmdc/health_well-being_and_care/child_care/young_peoples_plan
- Public Contracts Directive, 2014
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472985/A_Brief_Guide_to_the_EU_Public_Contract_Directive_2014_-_Oct_2015__1_.pdf
- Public Procurement, The Public Contracts Regulations, 2015
  http://www.legislation.gov.uk/uksi/2015/102/contents/made

Business Case for the Review of Public Health Nursing Service for School Aged Children and Young People (5-19)

Summary of Main Issues

A detailed review of the public health school nursing service for school aged children 5-19yrs (currently referred to as 'school nursing services') was undertaken.

The purpose of the review was to identify if the current service model meets current and emerging need, fits within the 'Journey to Excellence' and 'New Deal' programmes, and to highlight opportunities for service improvement.

The key themes identified in national and local policy, guidance, planning, and in what key stakeholders and partners have told us is important to them in a School Nursing Service included:

- Mental health and emotional wellbeing
- Obesity: healthy eating and physical activity
- Substance use: tobacco, drugs and alcohol
- Sexual health and contraception
- Support for the management of Long Term Conditions
- Safeguarding
- Oral health
- Flexible, needs led service delivery
- Delivery of the Healthy Child Programme
- Service design and delivery to include national recommendations (4-5-6 model) and local programmes (Journey to Excellence/New Deal)

Key stakeholders and partners reiterated the importance of a community based service model providing access to those children and young people who either do not wish to attend the service in school or do not access education within a traditional school setting.

Recommendation

It is recommended that the Executive Committee consider the Business Case for the School Nursing Service and give approval to proceed with the re-commission of the proposed service model for the public health nursing service for school aged children aged 5-19.

1. Introduction

1.1 This report briefs Members and strategic partners on the commissioning review of the School Nursing service.

1.2 The review of School Nursing will contribute towards the Council and Public Health objectives of 'working with people and partners for a healthier, caring, more prosperous and sustainable Bradford District'[1].

1.3 This review has been informed by national and local strategy, opportunities relating to the transfer of Public Health into the Council, and a drive to improve the health outcomes for children and young people.

1.4 The new service model will benefit children and young people and support the delivery of a range of strategic outcomes relating to health and wellbeing.

1.5 Included within the scope of the review is the generic School Nursing Contract managed by Public Health. The annual Contract value is £3 million and is held by a local NHS provider.

1.6 This report highlights the key findings from the review, details the draft service model and requests approval from the Council Executive to proceed with re-commissioning the School Nursing service.

1.7 Proposals affecting the local Clinical Commissioning Groups (CCGs) and Children's Services will be taken for discussion through the Bradford Health and Care Commissioners Group (BHCC) and the Children's and Maternity Transformation and Integration Group (TIG).

2. Background Information

2.1 Commissioning Background to School Nursing Services

2.1.1 In April 2013 the responsibility for the commissioning public health school nursing service for children and young people aged 5-19 years transferred to the Council as part of the changes outlined in the Health and Social Care Act 2012.

2.1.2 The transfer to Public Health provided an opportunity to review the school nursing service in partnership with CCGs and BMDC Children's Services, with the overall aim to improve health and wellbeing outcomes for children and young people.

2.2 Strategic Context

2.2.1 Nationally, new guidance and legislation (**Appendix 1**) places school nursing services at the heart of delivering prevention and early intervention services that are needs led and targeted to when and where children and young people need them most.

2.2.2 The Healthy Child Programme and 'Getting it right for children, young people and families – Maximising the contribution of the school nursing team: Vision and call to action' (2012) are the key drivers informing the review of the school nursing service.

2.2.3 The Healthy Child Programme focuses on school aged children up to the age of 19 and offers a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support for

children, young people, and families, with additional support when they most need it.

2.2.4 'Getting it right for children, young people and families – Maximising the contribution of the school nursing team: Vision and call to action' (2012) sets out a national service model to strengthen health services for school aged children and young people and to promote optimal health and wellbeing. The model will focus on a community based tiered approach with safeguarding integrated within each tier.

2.2.5 Subsequent national guidance and legislation builds on the 'Vision and call to action' outlining a school nursing service comprising multi-disciplinary teams with safeguarding at the heart of all work, being more responsive to the needs of children and young people, and taking a frontline role in areas such as contraception, sexual health, drugs and alcohol, and the National Child Measurement Programme.

2.2.6 The recently published guidance – 'Best start in life and beyond: Improving public health outcomes for children, young people and families' (January 2016) outlines the new '4-5-6' service model (**Section 4.6.1.3**) for the school nursing service. The guidance forms a suite of support guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and co-ordinate the delivery of public health for children aged 0-19.

2.2.7 Services should be delivered through a community based tiered approach delivering evidence based practice and interventions that are outcome based and measurable.

2.2.8 Commissioners and providers of school nursing services should consider the wider impact on the community including the development of career opportunities through a clear route from local colleges and universities into the school nursing profession.

2.3 **Justification for Continued Investment and Business Need**

2.3.1 Continued investment in a public health nursing service model for school aged children is integral to improving the health and wellbeing of children & young people aged 5-19 across the Bradford district in terms of early intervention and prevention, early help (as part of the Journey to Excellence programme), and through the provision of specific interventions for vulnerable children, young people and families.

2.4 **Children & Young People's Strategic Plan/Health and Wellbeing Strategy**

2.4.1 In addition to the key themes raised in the national policy context, a review of local policy and planning (**Appendix 2**) emphasises the importance of working collaboratively with key partners to improve services and get better value for money; focusing on the delivery of interventions to improve health and wellbeing and reduce health inequalities in particular:

- Ensuring that children start school ready to learn
- Accelerating educational attainment and achievement
- Ensuring young people are ready for life and work
- Ensuring that there is education, employment and skills for all
- Safeguarding vulnerable children and young people
- Reducing health and social inequalities

2.5 **Service vision**

'Maximising the school nursing team contribution to the public health of school aged children' and 'Best Start in life and beyond' set out a vision for School Nursing Services "to improve the health and wellbeing of children and young people and reduce health inequalities."

2.6 **Outcomes**

To achieve this ambition, the school nursing service should focus on the following outcomes referenced in 'Best start in life and beyond' (PHE, 2016) and incorporating key public health outcomes for children and young people:

- More children and young people achieve positive physical and emotional milestones (contributing to improved rates of school readiness)
- More children and young people who have the greatest need make the greatest improvement, closing the gap in inequality in health outcomes
- All children and young people are safe and protected within their families wherever possible
- Children and young people are safe and protected resulting in a reduction in hospital admissions caused by unintentional injuries to children and young people
- More children and young people are a healthy weight, through a reduction in the number of children who are overweight and obese at 4-5 years and 10-11 years
- More children and young people have better mental health
- More children and young people are smoke free, reducing the prevalence of smoking locally.
- Children and young people are supported to reduce substance misuse
- Children and young people parents and carers are supported to reduce teenage conceptions and improve sexual health
- More children and young people grow up free of tooth decay
- Education providers, parents, and children and young people are supported to proactively manage long term conditions or complex health needs within education based settings.

3. Current Service Provision

3.1 **Current Service Model**

3.1.1 The school nursing service specification is embedded within a larger block contract between the Council and the provider. Performance information is submitted quarterly and any contract or performance related issues are raised and managed within the quarterly Service Managers Group (SMG) meeting between the Council and the provider.

3.1.2 The key functions of the service have been developed to meet the service expectations set out in the national 'Getting it right for children, young people and families' guidance which is detailed below:

Tier		Descriptor
1	SAFEGUARDING	**Your Community** School nurses have an important public health leadership role in school and the wider community. School nurses will work with others to increase community participation in promoting and protecting health thus building local capacity to improve health outcomes.
2		**Universal services (U)** School nurses will lead, coordinate and provide services to deliver the Healthy Child Programme(HCP) for the 5-19 years population. They will provide universal services for all children and young people set out in the HCP working with their own team and others including health visitors, general practitioners and schools.
3		**Universal Plus (UP)** School nurses are a key part of ensuring children, young people and families get extra help and support when they need it. They will offer 'early help' (for example through care packages for children with additional health needs, for emotional and mental health problems, sexual health advice) through providing care and/or by referral or signposting to other services. Early help can prevent problems developing or worsening.
4		**Universal Partnership Plus (UPP)** School nurses will be part of teams providing ongoing additional services for vulnerable children, young people and families requiring longer term support for a range of special needs such as disadvantaged children, young people and families or those with a disability, those with mental health or substance mis-use problems and risk taking behaviours. School nursing services also form part of the high intensity multi-agency services for children, young people and families where there are child protection or safeguarding concerns.

3.1.3 The current service model comprises of ten area based multidisciplinary teams; each team working with an established number of schools ranging from 15-29 per team (**Appendix 3**).

3.1.4 The staffing model comprises of approximately 54 fte (70 people) multi-disciplinary practitioners including School Nurses, Staff Nurses, Nursery Nurses, Health Care Support Workers and additional support e.g. (a bi-lingual support worker).

3.1.5 The staffing demographic is not reflective of the demographic profile of Bradford and district; 98.7% of all staff are female and 89.7% of all staff define themselves as White British (followed by 6.4% Asian Pakistani). This compares with a district breakdown of 51.3% female, 63.9% White British and 20.4% Pakistani (Census 2011).

3.2 **Safeguarding**

A significant amount of school nurse time is spent on safeguarding as the school nurse is likely to adopt a key role, taking responsibility for assessing health issues, delivery of interventions, compiling relevant reports for multiagency safeguarding meetings, Child Protection meetings and case/review conferences.

4. Review of School Nursing Services

4.1 A commissioning review of school nursing services has been undertaken by Public Health and strategic partners including CCG's and CBMDC Children's Services.

4.2 **Purpose**

The purpose of the review was:

- To identify if and how the current service model meets current and emerging need taking into consideration the changing demographic profile of children and young people within the Bradford District.

- To review how the service model fits with children and young people's services with particular emphasis on the new offer for children and young people.
- To identify key opportunities to make improvements in prevention and early intervention in partnership with key stakeholders such as schools, primary care, Children's Social Care, Voluntary and Community Groups and other organisations.

4.3 **Scope of Review**
The scope of the review is limited to the generic School Nursing Service.

4.3.1 Services out of scope of the review include the Immunisation and Vaccination Service commissioned by NHS England Commissioning Board, and the Community Nursing Service (Children with Special Needs), commissioned by the CCGs and forming part of a separate review which runs concurrent to this review.

4.4 Value of Service in Review
The total value of the service in scope of the review is in the region of £3 million per annum.

4.5 Project Leadership
4.5.1 This review is being led by a Project Board made up of representatives from the following Council departments and partner organisations:
- Airedale, Wharfedale and Craven Clinical Commissioning Group
- BMDC Department of Childrens Services
- BMDC Department of Public Health
- Bradford City Clinical Commissioning Group
- Bradford Districts Clinical Commissioning Group
- NHS England

4.6 Key Findings of the Review
A set of key findings has been developed which have been informed by the literature review of national and local legislation, guidance and, policy, and consultation with school nurses, schools, children, young people and parents, and other key stakeholders. These findings will directly inform the design of the school nursing service across the district. A detailed overview of these findings is provided in the Appendices. The following provides a brief summary of the key findings:

4.6.1 Literature Review – National Guidance, Policy and Legislation
Please refer to **Appendix 1** for further information.

4.6.1.1 National guidance and legislation describe a school nursing service embedded within the prevention and early intervention agenda.

4.6.1.2 The school nursing service should ensure that safeguarding is embedded within all work, being more responsive to the needs of children and young people and taking a frontline role in areas such as contraception, sexual health, drugs, alcohol and tobacco.

4.6.1.3 Services should be delivered through a community based tiered approach delivering evidence based practice and interventions that are outcome based, measurable and incorporate the 4-5-6 service model described in 'Best start in life and beyond' (PHE, 2016):

- 4 levels of service: Community, Universal, Universal Plus, Universal Partnership Plus (please refer to Section 3.1.2).
- 5 Health Reviews: 4-5 year old health needs assessment (HNA), 10-11 year old HNA, 12-13 year old HNA, School leavers – post 16, Transition to adult services.
- 6 High Impact Areas: Building resilience and supporting emotional wellbeing, Keeping safe – managing risk and reducing harm, Improving lifestyles, Maximising learning and achievement, Supporting additional health and wellbeing needs, Seamless transition and preparing for adulthood.

4.6.1.4 The literature review also highlighted the need for the school nursing service to comprise of an appropriately skilled and experienced workforce, working in multi-disciplinary roles (comprising of different grades and skill mix) that reflect local need, taking into account workforce capacity (providing year round service availability), population health need, and the core (4-5-6) school nurse offer (PHE, 2016):

- 4 Levels of service
- Health promotion and prevention
- 5 Health Reviews
- Targeted support for vulnerable young people
- Defined support for children with long term conditions, and additional and complex needs
- 6 High Impact Areas
- Local pathways and arrangements in place to support collaborative working with partners
- Ensuring safe and effective practice and enhancing personal and professional development

4.6.2 Literature Review – Local Guidance and Policy

Please refer to **Appendix 2** for further information.

4.6.2.1 In addition to the themes raised in the national policy context a review of local policy and planning emphases the importance of working collaboratively with key partners to improve services and get better value for money, all underpinned by the 'Journey to Excellence' and 'New Deal' programmes; focusing on the delivery of sustainable interventions to improve health and wellbeing and reduce health inequalities, in particular:

- Keeping children and young people safe
- Reducing the incidence of obesity, drug, alcohol and tobacco use
- Increasing the levels of physical activity and healthy eating

4.6.3 Population: Current and Future Need

Please refer to **Appendix 6** for further information.

4.6.3.1 The number (152,592 at 2014) and proportion of the Bradford district's total population aged under 19 years of age is increasing and the relatively high proportion that live in poverty is likely to increase the general demand for services and support to families, in particular, early help and preventative services. This presents the Bradford district with a growing challenge; over the

last decade there has been a population increase of over 20% in 0-4 year olds which will impact on the 5-19 population over the next few years.

4.6.3.2 The 2011 census data for the 5-19 population shows a White British population of 54% and a South Asian Pakistani population of 30%. The gender split is broadly similar at approximately 50%.

4.6.3.3 The greater number (nearly half) of the young population are concentrated in more deprived wards and just under half are from Black and Minority Ethnic communities, including newly established communities from Central and Eastern European Countries; many of which may not speak English as a first language.

4.6.3.4 It is recognised that this diversity is likely to continue to grow. The population of Central and Eastern European (CEE) migrants has grown significantly over recent years, but the extent to which this may have occurred may not be fully understood. This may have a profound impact on the way services are delivered, since different ethnic groups are likely to have different needs.

4.6.3.5 Given this context, it is possible that as the diversity of Bradford district's young population increases, children entering the education system will have higher levels of need and therefore may require proportionally greater support from the school nursing service to ensure their health and wellbeing is considered.

4.6.3.6 Emerging themes from local needs and population data specifically the Joint Strategic Needs Assessment (JSNA) and the Child Health Profile for Bradford (2016) include:

- Oral health
- Long term conditions
- Obesity
- Mental Health/emotional wellbeing – ensuring 'parity of esteem' between emotional and physical health
- Educational attainment
- Hospital admissions for injuries amongst young people
- Vulnerable young people including those with disabilities, at risk of sexual exploitation, substance misuse, domestic violence

4.6.4 Findings from the Consultation

A full and detailed report about the Consultation can be found in **Appendix 7**.

Opinions from a range of stakeholders were sought to ascertain their views about the school nursing service.

The two main consultation methods were questionnaires and organised group discussions.

There were 5 questionnaires in total to obtain the views of;

- Primary School pupils (830 responses);
- Secondary School pupils (215 responses);
- Parents (156 responses);
- Teachers (82 responses);
- GPs 17 responses).

There were five organised group discussions set up to better understand stakeholder views of the current service and future expectations.

The key findings from the consultation exercise have been divided into a number of broad categories:

4.6.4.1 Access and Awareness

- There is good awareness of the role of the School Nurse, but in secondary schools, most boys do not know of the role of the School Nurse
- Girls are more engaged with the school nursing service.

4.6.4.2 People's experience of the service

- People's experience of the service experience has tended to be positive.

4.6.4.3 People's expectations of the service

- Children and Young People would prefer to see someone "in school" and for them to be easily contactable.
- Girls and young female students prefer to see a woman. Boys and young male students are less concerned about the gender of the school nurse, but those who did in primary school showed an overwhelming preference for seeing a male nurse.

4.6.4.4 Needs

- The issues on which children, young people and parents most want advice and help relate to two main categories: Emotional and mental health, and lifestyle choices – including healthy eating, diet and exercise and medical conditions.

4.6.4.5 Organisational Matters

- Those working in, or closely with, the service are unclear about the boundaries of the role of the School Nurse, and feel that it is misunderstood by others.
- Some key stakeholders expressed the view that schools need to be more supportive of the service.
- Many people suggested that the service needs to be more accessible generally, and particularly to harder-to-engage groups e.g. children who are not in school.
- Concerns were raised around the capacity of the current service, and whether demand outweighs provision.
- Whilst many contributors reported that partnership working was a strength of the current service, it was suggested that the service may function better through closer working with other services including CAMHS, GPs, Health Visitors, Children's Centres and Children's Social Care.

5. Recommendations for the proposed Service Model

5.1 Throughout this review there has been consistency in the identification of the priorities and high-level service expectations. This has been reflected in national and local policy, guidance, planning and, in what key stakeholders and partners have told us is important to them in a School Nursing Service.

5.2 Key themes identified included:

- Mental health and emotional wellbeing
- Obesity: health eating and physical activity
- Substance use: tobacco, drugs and alcohol
- Sexual health and contraception
- Support for management of Long Term Conditions
- Safeguarding
- Oral health
- Flexible, needs led service delivery
- Delivery of the Healthy Child Programme
- Service design and delivery to include national recommendations (4-5-6 model) and local programmes (Journey to Excellence/New Deal)

Key stakeholders and partners reiterated the importance of a community based service model providing access to those children and young people who either do not wish to use the service within a traditional school setting, or who do not access education within a traditional school setting because they are:

- Home schooled
- Excluded
- Not registered to attend education (because they have not allocated a place, recently moved into the area etc.)

As a result it is recommended that the name of the service reflect the community based nature and ethos of the proposed service model.

5.3 A summary of the proposed Service Model which will incorporate the key themes is provided in **Appendix 8**. It incorporates the following high level principles:

- Delivery of an integrated public health nursing service according to the needs of children and young people aged 5-19 years and linked to primary and secondary care, early years, childcare and educational settings which follow locally agreed pathways.
- Community based teams with nominated leads known to stakeholders and a named School Nurse/Practitioner for every educational establishment and GP surgery.
- Appropriately skilled and experienced workforce working in multi-disciplinary roles (comprising of different grades and skill mix).
- Flexible workforce that reflects local need and capacity, providing year round service availability.
- Delivery of the universal Healthy Child Programme through assessment of need by appropriately qualified staff; health promotion, screening, and engagement in health education programmes.
- Delivery of evidence based outcome focused interventions to improve health and wellbeing and reduce inequalities by focusing on the needs of all children and young people, specifically vulnerable groups (including those who do not attend mainstream education).
- Assessment, referral and (if appropriate) delivery of targeted interventions to address Public Health and Bradford district priorities including tobacco, substance misuse, contraception and sexual health, mental health and emotional wellbeing, physical activity and healthy eating, and oral health.
- Safeguarding embedded and fully engaged within all work.
- Service delivery forming a key part of ‘Journey to Excellence’ with ‘Early Help’ and ‘Signs of Safety’ integrated within the service model.

- Service delivery to incorporate the 4-5-6 service model as outlined in 'Best start in life and beyond' (PHE, 2016)
- Work with children, young people, parents, education providers and other key partners as public health leaders, championing health improvement, and good health and wellbeing.
- Build on resilience, strengths and protective factors to improve autonomy and self-efficacy with a focus on 'parity of esteem' between mental/emotional, and physical health and wellbeing
- Work proactively with key partners to support children and young people with long terms conditions and health needs to promote resilience and self-care.
- Supporting transition into education and adulthood.

5.4 It is recommended that a detailed service specification be developed to articulate the proposed service model. The new service specification will be developed with advice from the Council's Commercial Team and supported by a working group consisting of commissioning colleagues from Health, CCGs, BMDC Children's Services (and other specialist input where it is required).

5.5 The service specification and contract, along with advice from the Council's Commercial Team will be used to inform the preferred sourcing option.

5.6 Key Milestones

Key milestones will be developed following approval at Council Executive:

- March – May 2016: Approvals – PHDMT, CMT, School Nurse Project Board, BHCCG
- June 2016: Approval from Council Executive to proceed with the development of the service specification.

5.7 Performance Management

5.7.1 The service specification will include a suite of performance indicators and targets. Robust contract management arrangements will be put in place to ensure that services are delivered effectively and in accordance with the Council's expectations.

5.8 Understanding Service Demand

5.8.1 The Joint Strategic Needs Assessment and the Office of National Statistics (ONS) predicts an increase in the Bradford and district school aged population and an increase in the demand for services. Population projections (**Appendix 6**) indicate that the increase in the 5-19yrs school aged population could be in the region of 3.6% (from 113,100 in 2017 to 117,300 in 2023) during the standard contract term of 5-7 years.

5.8.2 If the contract is to improve the health and wellbeing of children and young people and reduce health inequalities it will need to allow scope for innovation and include consideration of:

- Better utilisation of the workforce and skill mix
- A focus on 'must do' business and identification of areas of current work no longer required or which could be delivered by other services
- A focus on 'New Deal' principles; focusing on 'Early Help', and empowering children, young people, parents, education providers and other key partners to be more proactive in promoting and managing their own health and wellbeing

6 Equality and Diversity

6.1 Equality and Diversity

An Equality Impact Assessment has been undertaken and is included as **Appendix 9** of this report. This document assesses the equality and diversity impact of the recommendations and proposed service model described in this report.

6.2 Council Policies and Priorities

6.2.1 Bradford Council Strategic Priorities; despite the financial challenges that the district faces the Council remains committed to achieving the key objectives of:

- Good schools and a great start for all our children
- Better skills, more good jobs and a growing economy
- Better health and better lives
- Safe, clean and active communities
- Decent homes that people can afford to live in.

The key objective 'Better health and better lives' reinforces the main aim of the School Nursing Service of increasing health and wellbeing of the 5-19 population.

6.2.2 The commissioning of school nursing services directly supports the delivery of objectives and priorities from a range of Council strategies including the:

- Good Health and Wellbeing: Strategy to improve health and wellbeing and reduce health inequalities 2013-2017
  Objective: Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Children and Young People's Plan 2014-16
  Priority: Reducing health and social inequalities
- Bradford and District Child Poverty Strategy 2014-2017
  Priority: Reducing health and social inequalities
- Integrated Early Years Strategy 2015-18
  Objective: Improve health and wellbeing for all children in the district and reduce inequalities

6.2.3 New Deal

6.2.3.1 New Deal is the Council's approach to changing the way the Council and other public services work with people, communities, businesses and the voluntary sector to improve and protect the quality of life for people in the Bradford District.

6.2.3.2 In order for the Council to achieve the key priorities, the Council will need to make changes to the type of services it buys and the way they are delivered by:

- Reducing the demand for services by changing expectations and promoting involvement
- Investing in prevention and early intervention
- Reducing inequality

6.3 Resources and Value for Money

6.3.1 Like all Councils, Bradford has to cut spending. Government funding for Council funded services has been cut by £165 million over the last few years and the reductions are set to continue.

6.3.2 Between now and 2020, the money for Council services (under the Council's direct control) is forecast to reduce by at least another 25% (9.56% within Public Health), on top of the savings already made.

6.3.3 The numbers of younger and older people are growing and so are the numbers of people with disabilities. Other challenges include more children needing care and protection and managing the increase in costs associated with inflation. This all puts pressure on services.

6.3.4 As noted in **Section 4.4** of this report, the total cost of investment in School Nursing Services in Bradford for 2016-2017 is £3,000.000. Given the current financial climate, it is likely that the total cost of investment will be reduced so innovative solutions will need to be considered to ensure the proposed service model demonstrates value for money whilst managing an increase in demand and changing demographic need.

6.4 Legal Implications

Commissioning of the school nurse service will be conducted in accordance with the Council's Contract Standing Orders, and National and European procurement regulations. Public Health is working with the Council's Commercial Team to agree an appropriate sourcing option.

6.5 Risk Management

6.5.1 Risks associated with the commissioning of the school nursing service have been identified, reviewed and managed through fortnightly Project Team meetings and four weekly Project Board meetings.

6.5.2 The identification of new and increasing risks is an on-going process and will continue to be through the life of the project.

7 Conclusion

The Review and subsequent commissioning provide an opportunity to ensure that the public health nursing service for school aged children (5-19) is able to deliver and respond effectively to national and local priorities, improve the health and wellbeing of children and young people, and reduce health inequalities; all within a climate that requires new and innovative ways of working to address increasing need and limitations in investment.

8 Recommendation

It is recommended that the Executive Committee consider the Business Case for the School Nursing Service and give approval to proceed with the development of the proposed service model for the public health nursing service for school aged children (5-19).

9 Background Documents

Please refer to the Appendices document

APPENDICES

Business Case for the Review of Public Health Nursing for School Aged Children and Young People 5-19

Contents:

NB: In the event that any of the hyperlinks contained within this document do not work, please contact the Public Health Analyst Team

APPENDIX ONE: NATIONAL POLICY CONTEXT

1. The Healthy Child Programme

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

Published in November 2009, the Healthy Child Programme (HCP) sets out a recommended framework of universal provision and progressive services for children and families from pregnancy to 19 years of age to promote optimal health and wellbeing.

The HCP recognises the key role of a variety of professionals in promoting children and young people's wellbeing, with particular focus on health visiting from pregnancy to five years, and school nursing for 5-19 year olds.

Collectively the Programme has a key focus on the following:

- Identification of children with high risk and low protective factors
- Partnership working to develop high quality services
- Effective use of resources informed by a local needs assessment
- Delivery at a local population level regardless of school status - academy's, educated at home
- Evidence based programmes.

The Healthy Child Programme (5-19) offers a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support for children, young people and families, with additional support when they need it most.

The core ambition of the HCP is to have children and young people who are happier, healthier and ready to take advantage of positive opportunities and reach their full potential. The programme provides a Framework for universal and progressive services for prevention and early intervention,

2. Getting it right for children, young people and families- Maximising the contribution of the school nursing team: Vision and call to action

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf

In 2012, the Department of Health published a vision and call to action for school nursing services based on a framework for local services, to meet both current and future needs.

The national service model for school nursing is described within a community based tiered approach with safeguarding an integral part of each tier:

'School nursing is a Universal Service, which also intensifies its delivery offer for children and young people who have more complex and longer term needs (Universal

Plus). For children and young people with multiple needs, school nurse teams are instrumental in co-ordinating services (Universal Partnership Plus).

The guidance aims to:

- revitalise school nursing
- review and revise local services
- reaffirm school nurses as leaders and key deliverers on public health
- develop a framework for local service delivery
- involve children & young people in service development
- provide a service that is 'in sync with the way young people live their lives'

3. Maximising the school nursing team contribution to the public health of school aged children 5-19

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf

In 2014, the Department of Health published a national service specification for school nursing and guidance providing a framework for local commissioners and providers to support the development of local service specifications. The guidance emphasised the need for the skill mix within school nursing teams to reflect local need taking into account workforce capacity and population health need.

The guidance outlines the core school nurse offer and innovative ways that school nursing services can be commissioned and developed to meet local need and ensure effective, seamless delivery of public health services for school-aged children and young people.

4. Best start in life and beyond: Improving public health outcomes for children, young people and families 2016

https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

Published in January 2016, the Guidance forms a suite of support guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and co-ordinate the delivery of public health for children aged 0-19.

The Guidance describes the new '4-5-6' service model for the school nursing service, incorporating:

- **4** levels of the school nursing service: Community, Universal Services, Universal Plus, Universal Partnership Plus;
- **5** Health reviews: 4-5 yrs, 10-11 yrs, 12-13 yrs health needs assessments, School leavers –post 16 and the transition to adult services
- **6** High Impact Areas: Building resilience and supporting emotional wellbeing, Keeping safe, Improving lifestyles, Maximising learning and achievement, Supporting additional health and wellbeing needs, Seamless transition and preparing for adulthood

5. Working together to Safeguard Children (revised Guidance) 2015

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

This guidance was developed to help professionals understand what they need to do and what they can expect of one another to safeguard children. It focuses on core legal requirements, making it clear what individuals and organisations should do to keep children safe.

The guidance makes clear that everyone who works with children – including teachers, GPs, nurses, midwives, health visitors, early year's professionals, youth workers, police, Accident and Emergency staff, voluntary and community workers and social workers – has a responsibility for keeping them safe.

The guidance outlines the importance of early help in promoting the welfare of children rather than reacting later. Early help can also prevent further problems arising and professionals should, in particular, be alert to the potential need for early help for children with specific needs or vulnerabilities.

The guidance also highlights the Section 11 duties of the Childrens Act 2004 which will need to be considered as part of current service provision and alongside the role of School Nurses in their role in safeguarding and Child Protection.

6. Guidance from the Royal College of Nursing and Department of Health

The Royal College of Nursing (RCN) has developed a series of literature to support the role of school nurses:

6.1 Royal College of Nursing Position Statement: The role of school nurses in providing emergency contraception services in education settings 2012

https://www2.rcn.org.uk/__data/assets/pdf_file/0005/78665/Emergency_contraception_position_statement_Final.pdf

The Position Statement clarifies the school nurses responsibility when providing Emergency Hormonal Contraception (EHC) to students in educational settings. The RCN clarifies the position that school nurses with appropriate training and experience are able to assess the need for EHC and supply this contraception using a Patient Group Direction (PGD). School nurses should also be appropriately skilled and competent to offer sexual health advice, and appropriate follow-up and referral to other health professionals.

6.2 Royal College of Nursing Toolkit for School Nurses: Developing your practice to support children and young people in educational settings 2014

http://www2.rcn.org.uk/__data/assets/pdf_file/0012/201630/003223.pdf

This toolkit complements the Department of Health's (DH) framework and suite of documents for School Nursing Services. The RCN toolkit provides school nurses with information and examples of good practice, including the promotion of a year round service availability and multi-disciplinary school nursing teams comprising of different grades and skill mix.

The toolkit sets out the following principles for school nursing:

- Having the responsibility for leading and delivering the Healthy Child Programme 5 -19 years.
- Identifying the health needs of children and young people both as individuals and communities, and planning work on the basis of local need
- Promoting the health, wellbeing and protection of all children and young people aged 5-19 years of age, in any setting
- Undertaking service design and workforce planning which is underpinned by local need, evidence and national health priorities
- Effective communication and partnership working
- Ensuring safe and effective practice and enhancing personal and professional development
- Using research to deliver evidence based services with clear outcomes, audit and evaluation integrated into the service

7. Department of Health: Health Visiting and School Nurse Programme: Supporting implementation of the new service offer: Developing strong relationships and supporting positive sexual health 2014

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299269/Sexual_Health_Pathway_Interactive_FINAL.pdf

This guidance has been developed by the Department of Health (DoH) in partnership with Public Health England (PHE) and key partners and provides a pathway to support school nurses, sexual health service providers and partners working to support the contraceptive and sexual health needs of young people.

It builds on the evidence from the healthy child programme (5-19) and sets out the rationale for effective partnerships pulling together the core principles to support effective working, improve outcomes and promote a positive approach to sexual health.

It sets out the rationale for an integrated pathway between school nursing, sexual health services and partners, highlighting that school nurses are in a unique position to build trusting and enduring professional relationships with school aged children in which they can identify cultural and individual risk factors that may benefit from intervention that may otherwise go unnoticed.

Supporting young people to prevent early pregnancy and improve their sexual health contributes to a number of other indicators in the Public Health Outcomes Framework.

8. DoH and Public Health: Health Visiting and School Nurse Programme: Supporting implementation of the new service offer: Promoting emotional wellbeing and positive mental health of children and young people 2014

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299268/Emotional_Health_and_Wellbeing_pathway_Interactive_FINAL.pdf

The document highlights the evidence that investment in promoting the mental health and wellbeing of parents and children in pre school years can avoid health and social problems later in life. The document outlines the contribution the Health Visiting and School Nursing service can make to improving emotional health and wellbeing

outcomes for children, young people and their families describing different levels of intervention across four tiers of the new health visiting and school nurse service model.

The guidance demonstrates how health visiting and school nurse services can support prevention, early intervention, on-going support and referral to specialist services whilst working collaboratively with partners.

9. The Marmot Review

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

The Marmot Review into health inequalities in England was published on February 2010 as 'Fair Society, Healthy Lives'. The Review looked at the differences in health and wellbeing between social groups and described how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood and so on.

The Review set out a framework for action under two policy goals: to create an enabling society that maximises individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.

Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life; reducing this disadvantage and associated health inequalities requires action on six policy objectives (the highest priority being given to the first objective):

1) Giving every child the best start in life
2) Enabling all children, young people and adults to maximise their capabilities and have control over their lives
3) Creating fair employment and good work for all
4) Ensuring a healthy standard of living for all
5) Creating and developing sustainable places and communities
6) Strengthening the role and impact of ill-health prevention

10. Healthy Lives, Healthy People: Our strategy for public health in England 2010

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

The White Paper outlines a new approach empowering individuals to make healthy choices and giving communities the tools to address their own, particular needs, placing local communities at the heart of public health.

The White Paper highlights the commitment to protecting the population from serious health threats; helping people live longer, healthier and more fulfilling lives and improving the health for the poorest, fastest.

For the 5-19 population this includes taking care of children's health and development which could improve educational attainment and reduce the risk of mental illness, unhealthy lifestyles, road deaths, and hospital admissions due to tooth decay.

11. Legislation

11.1 Children Act 2004

http://www.legislation.gov.uk/ukpga/2004/31/contents

The Children Act 2004 provides the legal basis for how social services and other agencies deal with issues relating to children and was designed with guiding principles in mind for the care and support of children.

These are:

- To allow children to be healthy
- Allowing children to remain safe in their environments
- Helping children to enjoy life
- Assist children in their quest to succeed
- Help make a contribution – a positive contribution – to the lives of children
- Help achieve economic stability for our children's futures

This act was brought into being in order for the government in conjunction with social and health service bodies to help work towards these common goals.

11.2 Public Services (Social Value) Act 2012

http://www.legislation.gov.uk/ukpga/2012/3/enacted

The Public Services (Social Value) Act came into force on 31 January 2013 and requires local authorities commissioning public services to consider how they can secure wider social, economic and environmental benefits.

Before the procurement process begins, commissioners should consider about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders

In the context of school nursing Services, this could include investing in a local workforce through stronger links with local universities, and the impact of stronger community based services for 5-19 year olds across the district.

11.3 Health and Social Care Act 2012

http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

The Health and Social Care Act sets out the Government's aims to reduce central control of the NHS, to engage doctors in the commissioning of health services, and to give patients greater choice.

Local Authorities are now responsible for improving the health of their population including commissioning of public health services for children and young people aged 5-19, as well as the National Child Measurement Programme and other early intervention and prevention services.

Directors of Public Health have taken responsibility as commissioners for school nursing services which are now funded through the Public Health grant. The commissioning of immunisation and specialist nursing care for children became the responsibility of NHS Commissioning Board and services such as CAMHS are now the responsibility of Clinical Commissioning Group.

11.4 Children and Families Act 2014

http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

The Children and Families Act makes provision to provide greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life.

In addition, the Act places a Duty on 'the appropriate authority for a school' which must make arrangements for supporting pupils at the school with medical conditions.

12. Public Health Outcomes Framework

The Public Health Outcomes Framework sets out a vision for public health outlining desired outcomes and indicators that will help local areas to understand how well public health is being improved and protected, with a key focus on the reduction of inequalities in health. School nurses contribute to a number of these indicators as indicated in the table below:

Domain 1: Wider Determinants	▪ Reduced incidence of domestic abuse
Domain 2: Health Improvement	▪ Under 18 conception rate ▪ Excess weight in 4-5 and 10-11 year olds ▪ Reduced hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years ▪ Emotional health and well-being of looked after children ▪ Smoking prevalence – 15 year olds ▪ Self-harm ▪ Diet and nutrition
Domain 3: Health Protection	▪ Chlamydia diagnosis (15-24 year olds) ▪ Population vaccination coverage ▪ Late diagnosis of HIV
Domain 4: Healthcare public health and preventing premature mortality	▪ Tooth decay in children aged 5 years

13. Summary and Key Themes

Nationally new guidance and legislation place school nursing services at the heart of delivering prevention and early intervention services which are needs led and targeted to when children and young people need it most.

The school nursing service should comprise of multi-disciplinary teams with safeguarding at the heart of all work, being more responsive to the needs of children and young people, taking a frontline role in areas such as contraception, sexual health, and drugs and alcohol.

Services should be delivered through a community based tiered approach delivering evidence based practice and interventions that are outcome based, measurable and incorporate the 4-5-6 service model.

Commissioners and providers of school nursing services should consider the wider impact on the community including the development of career opportunities through a clear route from local colleges and universities into the school nursing profession.

APPENDIX TWO: LOCAL POLICY CONTEXT

1. Families First

http://www.bradford.gov.uk/bmdc/BCYPP/families_first

Families First is a local programme forming part of the national Troubled Families Programme, working with families facing serious problems with the aims of:

- Reducing truancy
- Reducing crime and anti-social behaviour
- Supporting all over 16s in the family into work

The programme addresses other issues that these families are likely to experience including:

- debt and financial difficulties,
- housing problems,
- health issues,
- substance abuse
- domestic violence.

Families First is unique in Bradford in that the scheme focuses on the needs of the whole family rather than individuals, supported by a key worker working within a multi-disciplinary team.

Those families with the greatest needs are targeted, this comprises of up to 600 families a year.

The programme is also designed to last beyond the end of the funding, by making long-lasting changes to the way that different agencies, such as the Council, Police and Health Services work together, in order to improve services and get better value for money.

2. Joint Health and Wellbeing Strategy

http://www.cnet.org.uk/_library/downloads/W27843_Health_and_Wellbeing_Strategy_Plain_English_Ver.pdf

Bradford's Health and Wellbeing Strategy 'Good Health and Wellbeing: Strategy to improve health and wellbeing and reduce health inequalities 2013-2017' outlines the key objectives, priorities and actions required to secure improvements in health and wellbeing, to reduce health inequalities and ensure life expectancy continues to improve in line with national and regional trends. The Joint Strategic Needs Assessment (JSNA) provides a strategic examination of "need" across the Bradford District and provides the evidence-base to inform the Joint health and Wellbeing Strategy (JHWS) in particular, helping to identify the key priorities for the District.

The following objectives and priorities are particularly relevant for the School Nursing Service:

- Objective 1; Give every child the best start in life
- Objective 2: Enable all children, young people and adults to maximise their capabilities and have control over their lives.

- in particular Priority 5: Reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people
- Objective 6: Strengthen the role and impact of ill health prevention
- in particular Priority 17 – reduce harm from preventable disease caused by tobacco, obesity, alcohol, and substance misuse.

3. Bradford Health Inequalities Action Plan 2013 - 2017

https://jsna.bradford.gov.uk/documents/home/Bradford%20and%20Airedale%20Health%20Inequalities%20Action%20Plan%202013.pdf

The Health Inequalities Action Plan was developed to support the Joint Health and Wellbeing Strategy to improve health and wellbeing specifically targeting activity to address the significant inequalities within the district; in some parts of the district, people lead far shorter, less healthy lives than those in other areas.

The Key Priorities for the Action Plan that relate to the School Nursing Service are:

- Priority 1: Reduce and alleviate the impact of child poverty
- Priority 4: Ensure young people are well prepared for adulthood and work, with a focus on helping children with disabilities to maximise their capabilities
- Priority 5: Reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people.
- Priority 17: Reduce harm form preventable disease caused by tobacco, obesity, alcohol and substance abuse

4. Children and Young People's Plan 2014-16

http://www.bradford.gov.uk/bmdc/health_well-being_and_care/child_care/young_peoples_plan

The Children and Young People's Plan is the joint strategic plan for the Bradford Children's Trust.

The plan identifies how partners will work together to promote the health and wellbeing of children and young people in the Bradford district. It summarises activity to plan, commission or provide services, as well as the impact expected on the lives of children, young people and families.

The key priority areas for the plan are:

- Ensuring that children start school ready to learn
- Acceleration educational attainment and achievement
- Ensuring young people are ready for life and work
- Ensuring that there is education, employment and skills for all
- Safeguarding vulnerable children and young people
- Reducing health and social inequalities

5. Child Poverty Strategy 2014-2017

https://www.bradford.gov.uk/NR/rdonlyres/D5E6B555-992E-4779-A8BF-AD09C053051C/0/ChildPovertyStrategy201417.pdf

The Child Poverty Strategy describes the most important issues to address to reduce the impact of child poverty.

In the most recent district child poverty data for 2011, one in four children and young people (25.8%) aged 0-19 lived below the child poverty line in households with less than 60% of average income. Nationally the rate is one in five (21.1%).

The three priorities of the Strategy are:
1) Boosting educational attainment and skills for children, young people and families in poverty to improve their job prospects and reduce worklessness.
2) Reducing health and social inequalities
3) Creating safe homes and neighbourhoods for all children and young people.

6. Integrated Early Years Strategy for children up to 7 years 2015-2018

https://www.bradford.gov.uk/NR/rdonlyres/4F168FB7-3239-496A-9029-F96B32556BD6/0/W32253IntegratedEarlyYearsStrategy.pdf

The Integrated Early Years Strategy is a three year strategy that aims to improve the life chances of children in Bradford by addressing inequalities, narrowing the gap and improving outcomes for all children including disadvantaged children and families across the district.

The five objectives of the Strategy are:
1) Children ready for school and schools ready for children
2) Improve health and wellbeing for all children in the district and reduce health inequalities
3) Support and increase parents knowledge and skills
4) Support the development of high quality leadership together with a highly skilled and responsive workforce
5) Integrated working and system change

7. Journey to Excellence

http://www.bradford.gov.uk/bmdc/health_well-being_and_care/child_care/journey_to_excellence_thriving_children_strong_families

Journey to Excellence is a new programme of change involving key partners across the district. Its purpose is to ensure there is a shared approach to working with families that builds on their strengths and provides safety and stability for children.

The programme will deliver the following changes:

Developing the integrated Early Help offer across all key agencies to:

- develop an ‘Early Help’ gateway for the public and staff

- develop an approach that takes account of the whole family
- get it right first time to reduce repeat referrals
- focus on reducing the demand on children's specialist services

Refocusing children's placement provision within the district to deliver:

- smaller children's homes
- more foster carers for teenagers
- a shared model of care across placements, health, education and other key services

Provide a better response to young people in crisis:

- young people in crisis receive a rapid and supportive response
- develop a model for more joint working across key social care and health teams
- there are more safe spaces for young people when they are in crisis

Develop an integrated service across children's, adult's and health services for young people with aged 14-25 years with complex health and/or disabilities:

- timely plans which prepare young people for adulthood
- adult services within the Council will lead more young people and families to direct their own support through direct payments

BMDC Childrens Services are working with partners to develop a plan to use Signs of Safety to cut across the programme. Signs of Safety is a practice tool to identify strengths, risks and clear action plans with families. It provides an assertive and shared approach to assessing needs and draws upon techniques from Solution Focused Brief Therapy. The programme has worked well in other Local Authorities to reduce demand for specialist services and improve outcomes for children and young people.

8. New Deal for Bradford

Government funding for the Council's services has been cut by £167.6 million since 2010 and the reductions are set to continue. Inflation and rising demand for services mean that the size of the cuts (in real terms) is even higher.

To support the management of budget reductions, the Council is talking to local people, communities, partners and businesses to develop a 'New Deal' for Bradford.

The numbers of younger and older people are growing and so is the number of people with disabilities. Other challenges include more children needing care and protection. Inflation is also increasing costs and this all puts pressure on services.

The Council already spends about half of the money it has for services on helping schools, families and young people and giving care and support to children, older and disabled people and people with mental health issues.

So the demand for and cost of services is going up while the money to pay for them is going down. Business as usual is not an option.

The ‘New Deal for Bradford’ has five outcomes to build a bright future for the district. These are:

1. Good schools and a great start for all our children
2. Better skills, more good jobs and a growing economy
3. Better health, better lives
4. Safe, clean and active communities
5. Decent homes that people can afford to live in

The Council is working with partners to innovate, share money and resources, work towards the same goals, and liaise with local people and communities to establish a ‘New Deal’ about what they can expect from local services, their rights and responsibilities, how they and other people could help by doing things differently and the support required to achieve this.

9. Summary and Key Themes

In addition to the themes raised in the national policy context a review of local policy and planning emphases the importance of working collaboratively with key partners to improve services and get better value for money, all underpinned by the ‘Journey to Excellence’ and ‘New Deal’ programmes and focusing on the delivery of sustainable interventions to improve health and wellbeing and reduce health inequalities in particular:

- Keeping children and young people safe
- Reducing the incidence of obesity, drug, alcohol and tobacco use
- Increasing the levels of physical activity and healthy eating

APPENDIX THREE: CURRENT SERVICE PROVISION

1. School Nursing: Public Health Funded Provision

The key functions of the service have been developed to meet the expectations set out in the national 'Getting it right for children, young people and families 2012' guidance.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf

1.1 Health Assessment at school entry in reception (4/5 years)

1.1.1 At school entry the school nurse takes over responsibility for a child from a health visitor and undertakes a holistic health assessment. This is informed by the pre-school information shared by the health visitor and the results from a parental questionnaire. The review of this information identifies children needing a face to face health and development review. Components to be included in this review are:

- Review of immunisation status, identifies any outstanding immunisations and refers to GP practice or other provider for vaccinations as required
- Review of access to primary care, urgent care and dental care.
- Review of appropriate interventions for any physical, emotional or developmental problems that may have been missed or not addressed.
- Ensure seamless transition between health visitor and school nurse for those children with additional risks and health needs that require ongoing care as part of the active caseload.

1.2 National Child Measurement Programme (NCMP)

1.2.1 NCMP in Reception Year

The school nurse ensures all children aged 4/5 years have their height and weight measured for the National Child Measurement Programme, following NCMP guidelines, feeds back the results of the measurements to parents/carers. If indicated general advice and support is provided or signposted to, and where necessary in the case of children who have a BMI over the 90% centile are followed through with appropriate support and intervention.

1.2.2 NCMP in Year 6

The school nurse ensures each child aged 10/11 years has their height and weight measured for the National Child Measurement Programme, following NCMP guidelines, and where appropriate follows those children who are above the 91st centile or below the 0.4th centile with appropriate intervention and support.

1.3 Case Load Management

1.3.1 School nurses will work with individual children and young people who have additional risk and health needs in line with the tiered model for school nursing provision and addresses statutory responsibilities in relation to Safeguarding, Children Looked After by the Local Authority and children with complex health needs and disability.

1.3.2 Individual professionals will be alert to potential indication of abuse or neglect and will work with health, social care and education colleagues to promote wider awareness.

1.3.3 Close liaison with other agencies is critical; depending on the threshold of risk and need, either a CAF should be initiated or safeguarding policy and protocols adhered to.

1.3.4 The school nursing service should contribute to relevant inter-agency processes in accordance with statutory, national and Local Safeguarding Children Board policies and procedures. The service will work with individual children and young people who have additional health needs in line with the tiered model for school nursing provisions outlined in the new vision 'Getting it right' and local Well Child Pathway.

1.4 Safeguarding and Child Protection

1.4.1 School nurses are required to assess and support children where there are safeguarding issues or child protection concerns, this includes the assessment of health issues and delivery of appropriate interventions.

The service will attend all initial Child Protection Case Conferences for school aged children and young people and provide the required report as per the Local Safeguarding Children Board procedures. The school nurse will undertake a holistic assessment for all children subject to a Child Protection Conference (either prior to the conference or as soon after the conference as possible). There is an expectation that a representative from the school nursing service will attend all relevant review conferences and be a member of the Child Protection Core Group where the school nurse is the lead professional. The schools nursing members should:

- Follow Safeguarding Children Policies, Procedures and Guidance.
- Allocate a named school nursing team member to each family where safeguarding children concerns exist, to lead school nursing assessment, planning and evaluation of interventions.
- Attend and provide written reports for multi-agency safeguarding meetings.
- Undertake child and family focussed assessments using professional knowledge, skills and tools such as the Common Assessment Framework (CAF) to identify indicators of vulnerability or child maltreatment.
- Participate in multi-agency procedures for safeguarding children, including appropriate information- sharing, multi-agency assessment, joint working and referral, as set out in BSCB guidelines.
- Participate in safeguarding children supervision at least three monthly.
- Access safeguarding children training

1.5.1 Other Activities

- Contribution to the statutory Health Needs Assessment of Looked After Children
- Management of Long Term Conditions and Additional Care Packages
- Short –term packages of care for specific health need e.g. Asthma, severe allergy, anaphylaxis, nocturnal enuresis
- Advice, support and assessment (including risk assessment if needed) to support emotional health and wellbeing
- Health advice and support

APPENDIX FOUR: SCHOOL NURSING SERVICE TEAM CONFIGURATION

1. Current Service Model (as of 04.11.2015)

1.1 The school nursing specification is embedded within a larger block contract between the Council and the Provider. Performance information is submitted quarterly and any contract or performance related issues are raised and managed within the quarterly Service Managers Group (SMG) meeting between the Council and the Provider.

1.2 The school nursing service is split into ten area based multidisciplinary teams comprising of qualified School Nurses, Staff Nurses, Nursery Nurses and Health Care Support Workers. Each team works with an established number of schools ranging from 15-29 schools per team.

1.3 The school nursing service comprises of approximately 54 fte (70 people) multi-disciplinary practitioners including School Nurses, Staff Nurses, Nursery Nurses, and additional support e.g. (a bi-lingual support worker).

1.4 The staff demographic is not reflective of the demographic profile of Bradford and district; 98.7% of staff are female and 89.7% of staff define themselves as White British followed by 6.4% Asian Pakistani. This compares with a District breakdown of 51.30% female, 63.86% White British and 20.41% Pakistani (Census 2011).

APPENDIX FIVE: SCHOOL NURSING SERVICE: FINANCIAL BREAKDOWN

1. The current contract for school nursing (2016/17) is £3 million per annum.

1.1 When examining the budget against the current contract value of £3 million high level budget lines can be broken down into:

- 68% on direct staffing
- 31% on overheads – including clinical overheads, premises etc.

1.2 The remaining budget is allocated against indirect and non-pay costs including clinical/office consumables, travel, locality management etc.

APPENDIX SIX: CURRENT AND FUTURE HEALTH AND WELLBEING NEEDS OF CHILDREN AND YOUNG PEOPLE

1. Bradford district is one of the most deprived local authorities in England, ranking 26th (out of 149) in the 2010 Index of Multiple Deprivation. Nearly a quarter of the population is aged under 16 (23.5%). The large 0-19 population in the District means that our most recent 2011 child poverty rate of 25.8% equates to 35,820 children and young people.

2. Children and Young People Aged 5-19

2.1 The number and proportion of the district's total population aged under 19 years is increasing and the relatively high proportion that live in poverty is likely to increase the general demand for services and support to families including early help and preventive services as well as those that seek to reduce the impact of poverty. This presents the District with a growing challenge as over the last decade there has been an increase of over 20% in 0-4 year olds which will have an impact on the future school aged population.

Age groups:	2014
0-4	41.018
5-9	40,036
10-14	36,145
15-19	35,393

Source: Mid-2014 Population Estimates, ONS

2.2 The ONS subnational population projections for Bradford District suggest that, although the population overall will continue to grow steadily, the 5–19 year old age group will reach a peak in 2025.

Age groups	No of C&YP	% increase pa	% increase accumulative
Year 2017			
5-9 yrs	**40,500**		
10-14 yrs	**37,600**		
15-19 yrs	**35,000**		
Total	**113,100**	**n/a**	**n/a**
Year 2019			
5-9 yrs	**40,500**		
10-14 yrs	**39,000**		
15-19 yrs	**34,700**		
Total	**114,200**	**+ 0.96%**	**+0.96%**
Year 2021			
5-9 yrs	**40,600**		
10-14 yrs	**39,500**		
15-19 yrs	**35,700**		
Total	**115,800**	**+1.4%**	**+2.3%**

Year 2023			
5-9 yrs	**40,400**		
10-14 yrs	**39,800**		
15-19 yrs	**37,100**		
Total	**117,300**	**+1.3%**	**+3.6%**
Year 2025			
5-9 yrs	**40,300**		
10-14 yrs	**39,900**		
15-19 yrs	**38,300**		
Total	**118,300**	**+0.85%**	**+4.4%**

Source: ONS 2012 Subnational Population Projections

2.3 The District has approximately 223 schools (including Pupil Referral Units). As the larger child population moves into and through primary school the District is estimated to need 320 additional class groups across the primary sector compared to 10 years ago. As the higher number of children currently aged 2 to 11 moves into the secondary sector the District will require around 200 additional secondary class groups.

2.3.1 Poverty is linked to many factors and is a key determinant to poor health outcomes. This in itself highlights the importance of ensuring school nursing services and extra resources, are delivered in an effective way in order to tackle inequalities in health and wellbeing of school age children.

3. Age

3.1 The number and proportion of the district's younger population is set out in **6.1.**

3.2 The age profile of the population varies across the wards. The more deprived wards in the inner city have a particularly young population. Nearly half of the District's young people are concentrated in just 10 of its wards; Little Horton, Bradford Moor, Bowling and Barkerend, Toller, Manningham, Tong, Keighley Central, City, Great Horton, and Heaton.

4. Gender

4.1 As would be expected, there is an even split between the number of girls and boys in Bradford and district.

5. Ethnicity

5.1 Bradford district contains a rich mix of ethnic groups and cultures. Just under half of the Districts 0-19 population are from Black and Minority Ethnic (BME) groups. The district has some newly established communities that are growing relatively fast through inward migration. These communities are mostly of white ethnicities from Central or Eastern European countries with a significant Roma/Gypsy element within some of the communities.

6. 0-19 Age Group

6.1 This diversity is more pronounced in the younger population, as the following table based on 2011 census data shows:

	Age Band	
Ethnicity	0 to 4 year olds	5 to 19 year olds
White	50.69%	54.23%
Pakistani	32.31%	30.20%
Other Asian	7.61%	7.82%
All Other	9.39%	7.75%

6.2 It is recognised that this diversity is likely to continue to grow. The population of Central and Eastern European (CEE) migrants has grown significantly over recent years, but the extent to which this may have occurred may not be fully understood.

6.3 This may have a profound impact on the way services are delivered, since different ethnic groups are likely to have different needs. For example, 81% of CEE migrants speak Polish, Slovakian or Czech at home. There may also be a significant issue with school attendance; in 2013, 43% of the children missing from education were CEE. Furthermore, CEE children are more likely to have special educational needs and to live in temporary accommodation.

6.4 Given this context, it is possible that as the diversity of Bradford district's young population increases, children entering the education system will have higher levels of need and therefore may require proportionally greater support from the school nursing service to ensure their health and wellbeing is considered.

7. Religion

7.1 It is vital that the school nursing service understands the diversity of religious beliefs present in the population of Bradford. According to the 2011 census, the largest religious category amongst 0-14 year olds is Muslim, as the following table shows.

	Age 0 to 4	Age 5 to 9	Age 10 to 14	Age 15 to 19
Muslim	38.96%	40.44%	36.73%	32.04%
Christian	26.69%	31.28%	34.64%	36.24%
No religion	24.87%	20.48%	20.89%	23.95%
Religion not stated	7.90%	6.14%	5.86%	5.86%
All other	1.57%	1.65%	1.87%	1.91%

7.2 It is possible that certain interventions and/or advice may need to take religious beliefs into account.

8. Main/first Language

8.1 Almost 32,000 school children in the Bradford district have a first language that is not English; this equates to 43% of primary pupils and 35% of secondary pupils. This is nearly three times higher than the Yorkshire and Humber averages; which are 16% and 12% respectively for primary and secondary pupils.

http://www.migrationyorkshire.org.uk/userfiles/attachments/pages/664/bradfordImpsummarynov2015.pdf

9. Health and Wellbeing of Children and Young People

9.1 Joint Strategic Needs Assessment

A statutory duty to produce a Joint Strategic Needs Assessment (JSNA) has existed since 2007. The Health and Social Care Act 2012 identified a central role of the JSNA as bringing together partners from NHS, Local Government and the voluntary and community sector to analyse current and future health needs of the population.

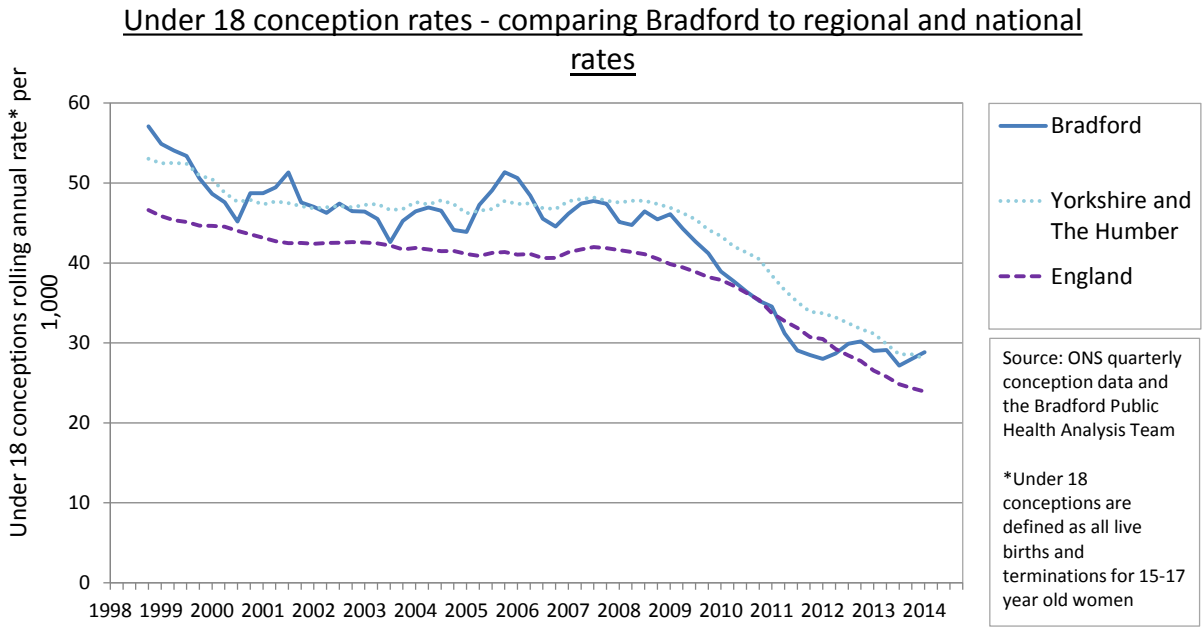
The local JSNA for Bradford District analyses the health and wellbeing needs of the population so it informs the effective commissioning and planning of children's services across the district.

The key priorities identified through the Joint Strategic Needs Assessment are identified within the Joint Health and Wellbeing Strategy, the Bradford Health Inequalities Action Plan and the Children and Young People's Plan (**Appendix 2**)

https://jsna.bradford.gov.uk/documents/Miscellaneous/JSNA%20-%204/CYP%20JSNA%202015%20Executive%20Summary.pdf

9.1.1 Sexual Health

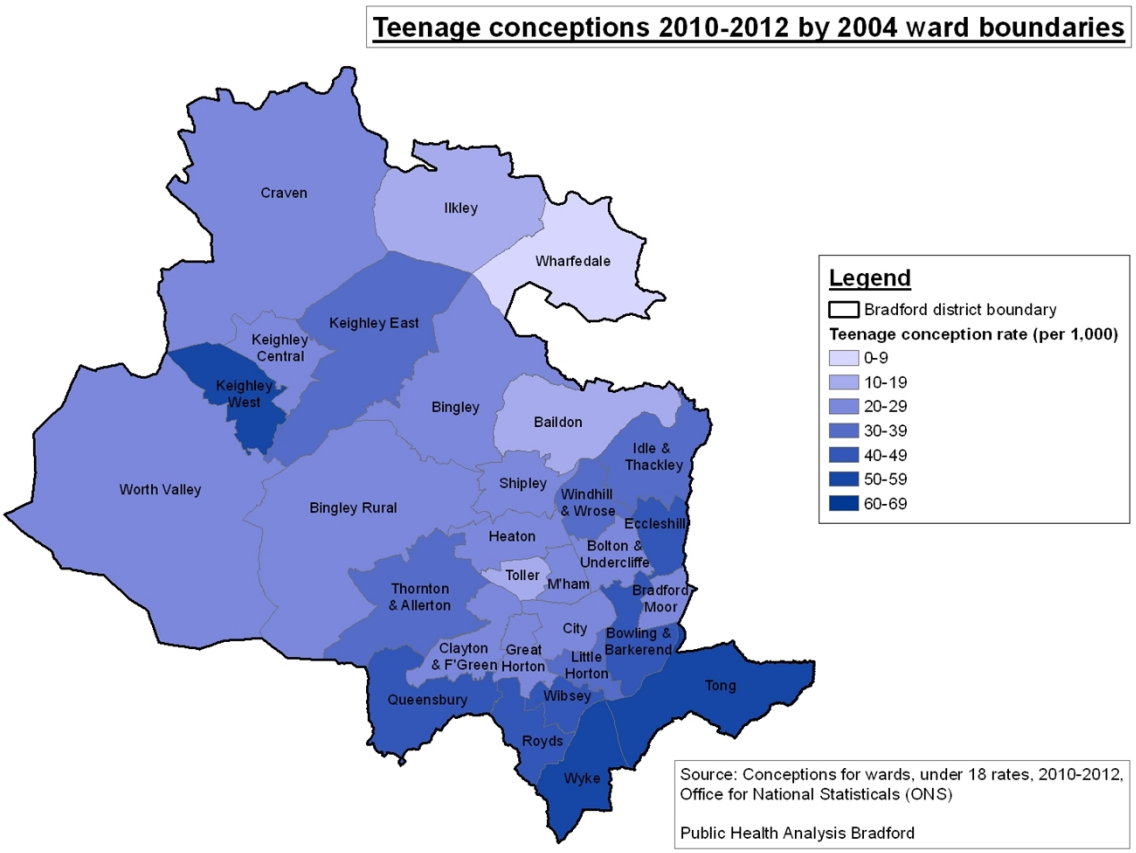
9.1.1.1 Teenage conceptions



The latest data shows that, when averaged across the four quarters of Q2 2013 to Q1 2014, the teenage conception rate of 28.9 per 1,000 in the Bradford district was higher than the Yorkshire and Humber rate of 28.1 per 1,000 and the England rate of 23.9 per 1,000. The Bradford district teenage conception rate has decreased considerably over time from 57.1 per 1,000 in 1998 which, at the time, was the highest rate in West Yorkshire. The trend over time has decreased in all West Yorkshire local authorities and the rates are now very similar. Improved education and working with young people and their parents has been key to reducing teenage pregnancies across the Bradford district, and the role of the School Nurse may be key in influencing this.

Across the four quarters of Q2 2013 to Q1 2014, there were 308 conceptions for 15-17 year old women in the Bradford district, although it is unknown what proportion of the conceptions results in a live birth and what proportion terminates the pregnancy.

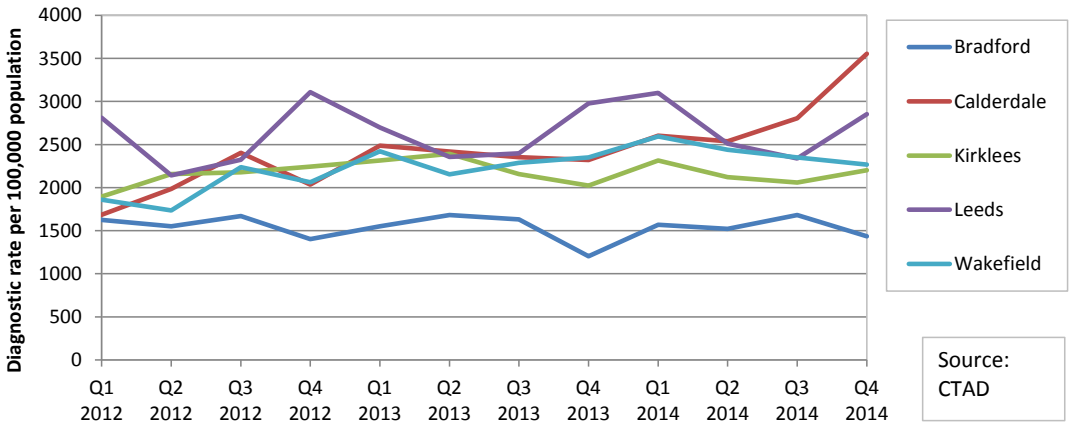
The following map shows that the wards with the highest teenage conception rates in 2010-2012 were Wyke, Tong and Keighley West. Between 2009-2011 and 2010-2012, the ward with the greatest increase in rate was Wyke which has not been considered a hotspot historically. This highlights the importance of monitoring the changing Public Health needs of local people.



9.1.1.2 Chlamydia

Public Health England has recommended a target of 2,300 Chlamydia diagnoses per 100,000 15-24 year olds to reduce the prevalence of Chlamydia in the population. Bradford has the lowest Chlamydia diagnosis rate for 15-24 year olds in West Yorkshire at 1,436 per 100,000 in Q4 2014. Bradford district's low diagnosis rate could be due to low testing coverage, low numbers of tests performed in outreach services or a low prevalence of Chlamydia within the population.

Chlamydia detection rates in the 15-24 year old population across West Yorkshire Local Authorities



9.1.2 Oral and Dental Health

Within West Yorkshire Bradford district has the highest prevalence of decay amongst 5 year olds with almost half (46%) having dental decay. Bradford district's prevalence is significantly higher than Yorkshire and Humber (34%) or England (28%). The prevalence of dental decay has reduced from 52% in 2007, achieving 2012 target of 50% set in Oral Health Strategy (2009).

9.1.3 Long Term Conditions

School nurses have a crucial role in the prevention and management of long term conditions. These conditions are becoming more prevalent and are better-diagnosed than ever before, and Bradford has a much higher proportion of children that are disabled and have complex health needs than the national average.

9.1.3.1 Asthma

In 2012, hospital admissions for asthma in Bradford and Airedale were higher than both the national and regional average. Local data showed a large increase in admissions among 5-10 year old children – ie those of primary school age.

9.1.3.2 Epilepsy

The prevalence of epilepsy is 25% higher in the most socially deprived areas of the UK compared to the least socially deprived areas (Purcell 2002). Parts of Bradford district are known to be amongst the most deprived in England, and so it follows that the prevalence of epilepsy may present a significantly greater challenge to Bradford district than to less deprived areas.

9.1.3.3 Diabetes

In Bradford district there were 229 children registered as having Type 1 diabetes and 18 with Type 2 diabetes under 19 years of age in 2010.

Diabetes prevalence by age and type 2010		
Age Range	**Type of Diabetes**	**Number of cases**
0 - 9 years	**Type I diabetes**	**50**
10 –19 years	**Type I diabetes**	**179**
0 – 19 years	**Type II diabetes**	**18**

9.2 Weight and Physical Activity

9.2.1 In 2013/14, the National Child Measurement Programme (NCMP) showed that 36.4% of year 6 pupils in the Bradford district are overweight or obese. This is higher than the National average of 33.5%, and the proportion of year 6 pupils in Bradford district who are overweight or obese has increased over the last 5 years.

9.2.2 21.6% of Reception aged (4-5 years old) pupils in the Bradford district were overweight or obese. This is slightly lower than the National average of 22.5%. However, the proportion of those who are obese in Reception is slightly higher than the National average with 9.8% compared with 9.5% nationally.

9.3 Mental Health and Emotional Wellbeing

9.3.1 Mental health disorders are common among children and young people, as shown in the table below:

Estimated Numbers of Children and young people with a Mental Disorder in Bradford				
Age Range	**Gender**	**Number of Children**	**ONS 2004 Prevalence**	**Number with a Disorder**
5 - 10 years	**Female**	21057	5.1	1074
	Male	22048	10.2	2249
	All 5 - 10	43105	7.7	3319
11 - 15 years	**Female**	17501	10.2	1785
	Male	18195	13.1	2384
	All 11 - 15	35696	11.7	4176
5 - 15 years	**All**	**78801**	**9.6**	**7565**

9.3.2 School nurses are an important part of providing universal Tier 1 services offering health & wellbeing support and signposting to more targeted services and specialist support.

9.4 Young Carers

9.4.1 Data, compiled from the 2011 census, shows nearly a quarter of a million people aged 19 and under in England and Wales were caring for parents, siblings and others. These young carers may remain hidden due to the fear of being identified, not realising they are a young carer or through professionals not acknowledging their role and therefore failing to identify and support them.

9.4.2 Key statistics:

- 9% of the 166,363 young carers in England care for 50 hours a week or more (census 2011)
- 80% care for 1-19 hours per week; and 11% for 20 – 49 hours per week
- 22% of young people under 16 in the UK (2.6 million) live with a hazardous drinker (BMC Public Health 2009).
- In the UK, 335,000 children live with a drug dependent parent (BMC Public Health 2009)
- Young carers have significantly lower educational attainment at GCSE level, the equivalent of nine grades lower overall then their peers e.g. the difference between nine Bs and nine Cs
- (The Children's Society, Hidden from View, 2012).

9.4.3 The 2011 Census identified a 7.6% increase in the number of young carers in Yorkshire and Humber, and estimated there to be 175,000 young carers nationally, equating to in the region of 2500 young carers in the Bradford district. This is likely to

be an under-estimate due to the low recognition of the caring roles taken by children and young people in relation to parental substance misuse.

9.4.4 The term Young Carer should be taken to include children and young people under 18 who provide regular and on-going care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. A young carer becomes vulnerable when the level of care giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical wellbeing or educational achievement and life chances.

9.4.5 The current NHS and Public Health Outcomes Framework contain indicators for child health, each having an impact on the health and wellbeing of the population along the life course. Families with particular illnesses or disabilities such as HIV, mental ill-health and substance misuse may still feel stigmatised and fear seeking external support. Practitioners supporting young carers should be aware of the prejudices and stereotypes that may exist around cultures, and disability, or about adults who misuse drugs/alcohol or have mental health needs in terms of their parenting capacity and competence (Working together to support young carers and their families August 2012)

10. Child Protection and Safeguarding

10.1 Child protection/Safeguarding

The number of children who were the subject of a Child Protection (CP) Plan in the Bradford district at 31 March 2013 was 374 (a reduction of 16 children compared to the previous year). This is a rate of 27.2 per 10,000 under 18 population, This is lower than the national rate of 37.9. The proportion of boys (56%) was higher than girls. The category of abuse reasons for children subject of a CP Plan were: Neglect (46%); Emotional Abuse (39%); Physical Abuse (10%); Sexual Abuse (5%).

Children from an ethnic minority background are under-represented in terms of being subject to a CP Plan (29%) compared to 47% of children and young people from ethnic minority background in the district.

10.2 Children affected by Parental Risk Factors

From 1st April 2013 to mid-September 2013, 2684 child assessments were carried out by Children's Social Care; the following parental risk factors were identified:

- 220 (8.2%) of social care assessments carried out noted parental drug use to be an issue.
- 228 (8.5%) of social care assessments carried out noted parental alcohol use to be an issue.
- 297 (11.1%) of social care assessments carried out noted parental mental health to be an issue.
- 440 (16.4%) of social care assessments carried out noted domestic abuse to be an issue.

10.3 Child Sexual Exploitation

Analysis of local data shows the number of children and young people in the District at medium to high risk fluctuates between 60 and 100. Whilst the majority of children at risk are female, local and national analysis indicates that approximately 10% of the total is male. The majority of those at risk (approximately 70%) are recorded as White British. However, some 15% are recorded as British Pakistani origin, with the

remaining 15% recorded as other Black or Minority ethnicity; this includes a growing proportion of children of Eastern or Central European origin. The age of these young people range from 11 – 18 years; the peak age for victimisation being approximately 15 years 6 months.

11. Youth Justice

Bradford's child health profile shows there were 261 first time entrants to the youth justice system in 2013/14, which was not significantly different from the England average. The rate has shown a reduction for four consecutive years.

Work with the Youth Justice Board and Youth Offending Team (YOT) has established children's mental health as an important partner in delivery of services to this vulnerable group of young people. In the context of a high young population within the Bradford District and high levels of social deprivation, crime is something that young people in Bradford may be drawn to. The role of the school nurse may be crucial in ensuring that young people presenting challenging behaviours have the support and access to experienced mental health workers who will be able to ascertain any psychologically-based causes or consequences of offending.

https://www.bradford.gov.uk/NR/rdonlyres/86B0CA85-02F7-49CD-8448-4A4C5C7FB6BA/0/CYPTransformationPlanFutureinMind2015.pdf

12. Child Health Profile – 2016

The Child Health Profile for Bradford local authority is published annually (last updated 15 March 2016) via Public Health England, and provide a snapshot of performance around child health and wellbeing, using 32 selected key health indicators. This profile (below) enables comparisons to be made locally, regionally and nationally.

http://www.chimat.org.uk/resource/view.aspx?RID=273397

Whist there have been improvements against the key health indicators, Bradford local authority is significantly worse both regionally and nationally in key areas such as:

- Oral Health
- Hospital admissions caused by injuries in young people
- Educational attainment
- Obesity

This is consistent with the priority areas highlighted through the JSNA.

Bradford Child Health Profile — March 2016

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	**1** Infant mortality	47	5.8	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	24	17.3	12.0	19.3	5.0
Health protection	**3** MMR vaccination for one dose (2 years) >=90% <90%	7,695	94.1	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	7,875	96.3	95.7	79.2	99.2
	5 Children in care immunisations	550	82.1	87.8	64.9	100.0
Wider determinants of ill health	**6** Children achieving a good level of development at the end of reception	5,030	62.2	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	3,060	47.5	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	990	5.4	4.7	9.0	1.5
	10 First time entrants to the youth justice system	283	487.2	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	29,595	24.0	18.6	34.4	6.1
	12 Family homelessness	192	0.9	1.8	8.9	0.2
	13 Children in care	880	63	60	158	20
	14 Children killed or seriously injured in road traffic accidents	34	27.5	17.9	51.5	5.5
Health improvement	**15** Low birthweight of term babies	278	3.7	2.9	5.8	1.6
	16 Obese children (4-5 years)	582	8.6	9.1	13.6	4.2
	17 Obese children (10-11 years)	1,345	21.5	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	46.0	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	164	497.2	322.0	1,406.8	11.7
	20 Under 18 conceptions	299	27.9	24.3	43.9	9.2
	21 Teenage mothers	81	1.1	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	45	32.5	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	77	111.3	88.8	278.2	24.7
Prevention of ill health	**24** Smoking status at time of delivery	1,192	15.1	11.4	27.2	2.1
	25 Breastfeeding initiation	5,481	70.7	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	3,226	41.6	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	19,109	465.9	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	1,593	135.9	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	1,238	179.4	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	420	287.3	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	111	79.9	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	483	463.8	398.8	1,388.4	105.2

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2012-2014
2 Directly standardised rate per 100,000 children age 1-17 years, 2012-2014
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2014/15
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2014/15
5 % children in care with up-to-date immunisations, 2015
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2014/15
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2014/15
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
9 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2014
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2014
11 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2013
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2014/15
13 Rate of children looked after at 31 March per 10,000 population aged under 18, 2015
14 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2012-2014
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2014
16 % school children in Reception year classified as obese, 2014/15
17 % school children in Year 6 classified as obese, 2014/15
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
19 Crude rate per 100,000 (age 1-4 years) for hospital admissions for dental caries, 2012/13-2014/15
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2014/15
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2012/13-2014/15
24 % of mothers smoking at time of delivery, 2014/15
25 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2014/15
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2014/15
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2014/15
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2014/15
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2014/15
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2014/15
32 Directly standardised rate per 100,000 (age 10-24 years) for emergency hospital admissions for self-harm, 2014/15

13. Health and Lifestyles Survey - 2013

13.1 Key Issues

In 2013, the Council and the three Clinical Commissioning Groups (CCGs) in the area carried out the Children and Young People (CYP) Lifestyle Survey. The survey was designed to gain an understanding of the health and wellbeing of school age children in the Bradford district. Pupils across the years 4, 7 and 10 were asked to complete the questionnaire; there were 9,732 responses to the questionnaire. Half of the respondents were from primary schools and the other half were split roughly equally between the two secondary school year groups. 70% of primary schools in Bradford, and 64% of secondary schools took part in the survey. There was also an almost equal distribution of gender (51%: Male, 49%: Female). 48% of respondents were White British and 38% were South Asian.

The survey suggested several things about Children and Young People in the Bradford district:

https://jsna.bradford.gov.uk/documents/home/Children%20and%20Young%20Peoples%20Lifestyle%20Survey%202013%20-%20FULL%20VERSION.pdf

https://jsna.bradford.gov.uk/documents/home/Children%20and%20Young%20Peoples%20Lifestyle%20Survey%202013%20-%20SUMMARY.pdf

13.1.1 Healthy eating

Pupils in year 10 were more likely to consume fizzy drinks and snacks on most days than were pupils of the same age and sex in the England sample.

13.1.2 Oral health

Responses from secondary school pupils showed that pupils in the most deprived quintile are more likely than others to have gone to the dentist last time because they were having trouble with their teeth.

13.1.3 Smoking

About a third of year 10 pupils had tried smoking, with 10% reporting that they smoke regularly. Pupils from more deprived areas were more likely to have tried smoking, and be regular smokers; similarly pupils from more deprived areas reported exposure to smoke in the home and in a car, compared with those from other areas.

Despite a change in law around the sales of cigarettes restricted to those aged 18 and above, 51% of smokers reported that they obtained their cigarettes by buying from a shop.

13.1.4 Substance use

Year 10 pupils in the Bradford district were less likely to have drunk alcohol in the week before the survey than males in the same age in the England sample. Alcohol consumption is higher among those in the least deprived quintile compared with those who live in the more deprived areas, which is the opposite of those reporting to have tried smoking.

Year 10 pupils in the Bradford district were less likely to know a drug user than were pupils of the same age in the England sample. 16% of year 4 pupils said they would like to talk with their school nurse about drugs; this was higher for girls (18%) than boys (14%).

13.1.5 Access to contraception

47% of year 10 pupils say that they know where to get free condoms from; this was lower than their peers across the rest of the country when compared with the England sample. Pupils from the most deprived quintile were the least likely to know where to get condoms free of charge. Year 10 pupils were asked where they can get condoms from free of charge 6.1% said that they can obtain them from school.

13.1.6 Bullying

The 2013 Children and Young People (CYP) Lifestyle Survey highlighted that 32% of Year 4 pupils in the Bradford district reported that they had been bullied at school in the 12 months preceding the survey; this figure fell to 23% for Year 7 and 17% for Year 10 pupils. The most common perceived reasons for being picked on or bullied were size/weight and appearance. Compared to an England sample, young people in Bradford were no more or less likely to be bullied.

12. Summary and Findings

Examination of the local population identifies a growing young population. The greater number (nearly half) of the young population are concentrated in more deprived wards and just under half are from Black and Minority Ethnic communities, including newly established communities from Central and Eastern European Countries; many of which may not speak English as a first language.

As the population increases, children entering the education system will have greater levels of need and therefore may require proportionally greater support from School Nurse Services.

Emerging themes from the local population data include:

- Oral Health
- Management of Long Term conditions
- Obesity
- Mental Health/emotional wellbeing
- Targeted Support for Vulnerable Young People

APPENDIX SEVEN: STAKEHOLDER CONSULTATION

Please refer to attached document

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School_Nursing_Revie

APPENDIX EIGHT: SCHOOL NURSING SERVICE MODEL

Key principals of the service model

- Delivery of an integrated public health nursing service according to the needs of children and young people aged 5-19 years and linked to primary and secondary care, early years, childcare and educational settings which follow locally agreed pathways.
- Community based teams with nominated leads known to stakeholders and a named School Nurse/Practitioner for every educational establishment and GP surgery.
- Appropriately skilled and experienced workforce working in multi-disciplinary roles (comprising of different grades and skill mix).
- Flexible workforce that reflects local need and capacity, providing year round service availability.
- Delivery of the universal Healthy Child Programme through assessment of need by appropriately qualified staff; health promotion, screening, and engagement in health education programmes.
- Delivery of evidence based outcome focused interventions to improve health and wellbeing and reduce inequalities by focusing on the needs of all children and young people, specifically vulnerable groups (including who do not attend mainstream education).
- Assessment, referral and (if appropriate) delivery of targeted interventions to address Public Health and Bradford district priorities including tobacco, substance misuse, contraception and sexual health, mental health and emotional wellbeing, physical activity and health eating, and oral health.
- Safeguarding embedded and fully engaged within all work.
- Service delivery forming a key part of ‘Journey to Excellence’ with ‘Early Help’ and ‘Signs of Safety’ integrated within the service model.
- Service delivery to incorporate the 4-5-6 service model as outlined in ‘Best start in life and beyond’ (PHE, 2016)
- Work with children, young people, parents, education providers and other key partners as public health leaders, championing health improvement, and good health and wellbeing.
- Build on resilience, strengths and protective factors to improve autonomy and self-efficacy with a focus on ‘parity of esteem’ between mental/emotional, and physical health and wellbeing
- Work proactively with key partners to support children and young people with long terms conditions and health needs to promote resilience and self-care.
- Supporting transition into education and adulthood.

Figure 1 (below) illustrates the service model for public health nursing services referenced in the 'Getting it right for children, young people and families. Maximising the contribution of the school nursing team: Vision and call to action'. It outline the key service functions.

Figure 1:

Tier		Descriptor
1	SAFEGUARDING	**Your Community** School nurses have an important public health leadership role in school and the wider community. School nurses will work with others to increase community participation in promoting and protecting health thus building local capacity to improve health outcomes.
2		**Universal services (U)** School nurses will lead, coordinate and provide services to deliver the Healthy Child Programme(HCP) for the 5-19 years population. They will provide universal services for all children and young people set out in the HCP working with their own team and others including health visitors, general practitioners and schools.
3		**Universal Plus (UP)** School nurses are a key part of ensuring children, young people and families get extra help and support when they need it. They will offer 'early help' (for example through care packages for children with additional health needs, for emotional and mental health problems, sexual health advice) through providing care and/or by referral or signposting to other services. Early help can prevent problems developing or worsening.
4		**Universal Partnership Plus (UPP)** School nurses will be part of teams providing ongoing additional services for vulnerable children, young people and families requiring longer term support for a range of special needs such as disadvantaged children, young people and families or those with a disability, those with mental health or substance mis-use problems and risk taking behaviours. School nursing services also form part of the high intensity multi-agency services for children, young people and families where there are child protection or safeguarding concerns.

Figure 2: School Nurse Delivery Model: Flexible Community Based Working

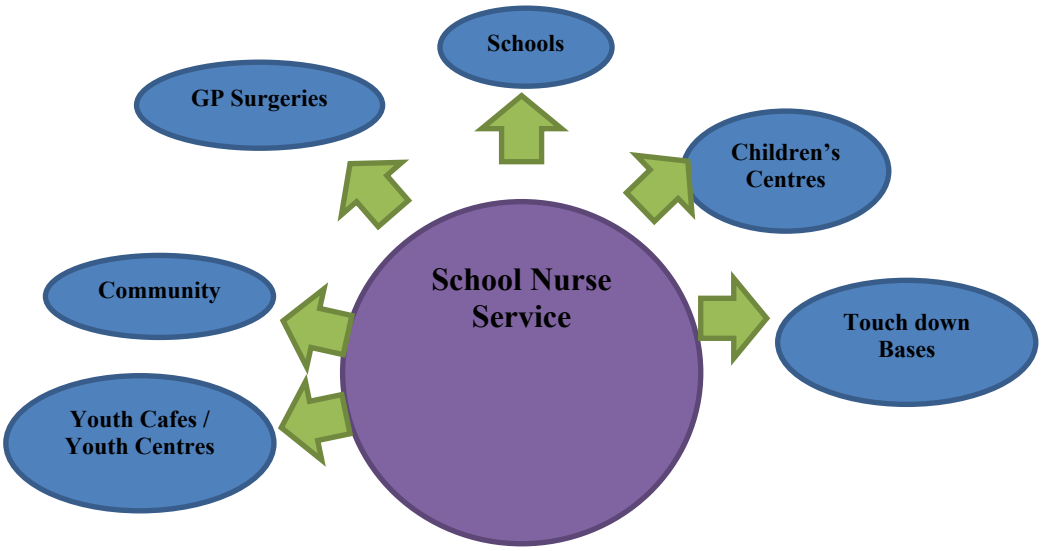
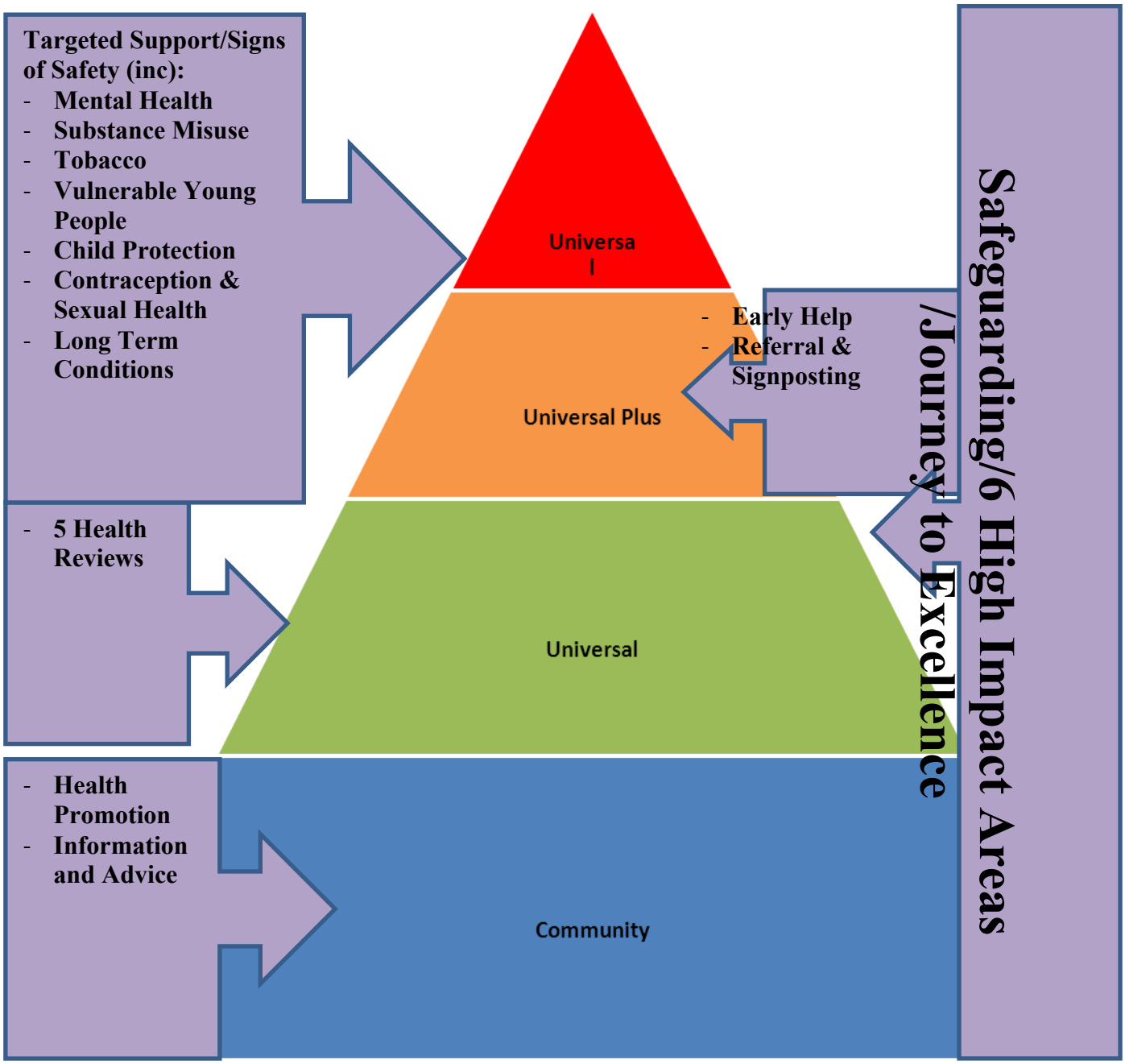


Figure 2 illustrates an example of a community based model providing easy access to children and young people.

Figure 3


Targeted Support/Signs of Safety (inc):
- Mental Health
- Substance Misuse
- Tobacco
- Vulnerable Young People
- Child Protection
- Contraception & Sexual Health
- Long Term Conditions
- 5 Health Reviews
- Health Promotion
- Information and Advice
Universal
Universal Plus
Universal
- Early Help
- Referral & Signposting
Community
Safeguarding/6 High Impact Areas /Journey to Excellence

APPENDIX NINE: EQUALITY IMPACT ASSESSMET

Equality Impact Assessment Form

Reference –

Department	Public Health	**Version no**	1.0
Assessed by		**Date created**	29.01.2016
Approved by		**Date approved**	
Updated by		**Date updated**	
Final approval		**Date signed off**	

Section 1: What is being assessed?

1.1 Name of proposal to be assessed:

Recommendations for the Public Health Nursing Service Model for School Aged Children aged 5-19.

1.2 Describe the proposal under assessment and what change it would result in if implemented:

A detailed review of the public health school nursing service for school aged children aged 5-19 (currently referred to as 'school nursing services') has been undertaken.

The purpose of the review was to identify if the current service model meets current and emerging needs, fits within the 'Journey to Excellence' and 'New Deal' programmes and to identify opportunities for service improvement.

Key themes identified in national and local policy, guidance, planning and, in what our key stakeholders and partners have told us is important to them in a School Nursing Service included:

- Mental health and emotional wellbeing
- Obesity: health eating and physical activity
- Substance use: tobacco, drugs and alcohol
- Sexual health and contraception
- Support for management of Long Term Conditions
- Safeguarding
- Oral health
- Flexible, needs led service delivery

- Delivery of the Healthy Child Programme
- Service design and delivery to include national recommendations (4-5-6 model) and local programmes (Journey to Excellence/New Deal)

Key stakeholders and partners reiterated the importance of a community based service model providing access to those children and young people who either do not wish to attend the service in school or do not access education within a traditional school setting.

The proposed changes outlined in the recommendations will result in a more accessible service that is better able to respond to the needs of children and young people.

Section 2: What the impact of the proposal is likely to be

The Equality Act 2010 requires the Council to have due regard to the need to-

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

2.1 Will this proposal advance equality of opportunity for people who share a protected characteristic and/or foster good relations between people who share a protected characteristic and those that do not? If yes, please explain further.

The proposal will help to reduce health inequalities among children and young people aged 5-19 and this will include those with a protected characteristic. The new service model will ensure improved service accessibility for priority groups such as children who do not access education through traditional settings, and those not in education. This will be achieved through service delivery that community and available throughout the year.

2.2 Will this proposal have a positive impact and help to eliminate discrimination and harassment against, or the victimisation of people who share a protected characteristic? If yes, please explain further.

The proposal will not directly eliminate discrimination, harassment or victimisation.

2.3 Will this proposal potentially have a negative or disproportionate impact on people who share a protected characteristic? If yes, please explain further.

The Equality assessment carried out indicates that this proposal is not likely to have a negative disproportionate impact on most if not all protected characteristics. However, one of the main aims of the new service model is to reduce health inequalities so will therefore have a

positive impact on children and young people who experience health inequalities.

2.4 Please indicate the level of negative impact on each of the protected characteristics?
(Please indicate high (H), medium (M), low (L), no effect (N) for each)

Protected Characteristics:	**Impact** (H, M, L, N)
Age	L
Disability	L
Gender reassignment	N
Race	L
Religion/Belief	L
Pregnancy and maternity	N
Sexual Orientation	L
Sex	L
Marriage and civil partnership	N
Additional Consideration:	
Low income/low wage	L

2.5 How could the disproportionate negative impacts be mitigated or eliminated?

Not applicable

Section 3: What evidence you have used?

3.1 What evidence do you hold to back up this assessment?

The Business Case for the Review of the Public Health Nursing Service for School Aged Children Aged 5-19 years

3.2 Do you need further evidence?

No

Section 4: Consultation Feedback

4.1 Results from any previous consultations

Yes

4.2 Feedback from current consultation

Yes

4.3 Your departmental response to this feedback – include any changes made to the proposal as a result of the feedback

The proposed service model has been informed by consultation feedback

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School Nursing Review Consultation

Introduction

As part of the review of the School Nursing Service, the Public health department sought the opinions of a variety of people and organisations with an interest in how the School Nursing Service is delivered in Bradford. The aim of the consultation was to understand how people felt the system is working currently, and what the future expectations are of the service.

This paper provides a report on the consultation in five separate sections:

- Summary of Findings
- Summary of Participation
- Detailed explanation of consultation methodology
- Full report on results of the consultation
- Strengths and weaknesses of the consultation exercise

A full breakdown of the contents of the report appears in the Table of Contents, *after* the Summary of Key Findings.

The two main consultation methods were questionnaires and organised group discussions.

There were 5 questionnaires in total which were to obtain the views of;

- **Primary School pupils**;
  - 830 responses
  - 382 (46%) Boys, 417 (50%) Girls, 31 did not disclose their gender.
  - 97% were aged 10 and 11
  - 34 Schools across 20 Wards; good representation of the population.
- **Secondary School pupils;**
  - 215 Responses
  - 10 Schools across 5 Wards;
  - 97% were aged 13 to 15 with the greatest proportion aged 14 (132/ 61%)
  - 33% were Asian Pakistani and 33% were White British.
- **Parents;**
  - 156 responses
  - Were parents of pupils across 26 schools ALL of which were primary- we did not get the views of parents with children at secondary school.
  - 88% (138) were Female only 4% (14) were Male, the remaining 8% did not disclose
  - 66% of respondents were aged between 30 and 49.
  - 64% (100) White British 14% (22) Asian Pakistani.
- **Teachers;**
  - 82 responses
  - From 42 Schools across 5 wards
  - Schools were asked to nominate one member of staff to complete the survey on behalf of the school; however 45% of the responses were from two schools.
  - 74% of the teachers who responded were from a primary school which equates to 70% of all the responses.

- **GPs**
    - 17 respondents
    - An additional questionnaire was set up for GPs to enable them to give their views on the consultation. This was designed differently to the previous four questionnaires as it was the same questions as the organised group discussions.

There were five organised group discussions set up to understand how people feel the system is working currently, and what the future expectations are of the service. The attendees at each event consisted of;

- **Event 1: School Nursing teams (35 attendees);**
    - School Nurses,
    - Health Care Assistants,
    - Team Leaders,
    - Trainee School Nurses.
- **Event 2: Stakeholders (31 attendees);**
    - Education
    - Child and Adolescent Mental Health Service (CAMHS)
    - Public Health
    - Voluntary and Community Sector
    - School Nursing
    - Children's services
    - Local NHS
    - Born in Bradford
- **Event 3: School Nurse Leads (4 attendees)**
- **Event 4: Strategic Leads (6 attendees);**
- **Event 5:** This event was set up to provide an extra opportunity for individuals from education and health in particular teachers and GPs to give their views however there was only one attendee at this event.

Summary of Findings

The key findings from the consultation exercise can be divided into five broad categories:

Access and Awareness

1. **There is good awareness of the role of the school nurse but, in secondary school, most boys do not know of the role of the School Nurse.**

(See pages 17 & 27)

2. **Girls are more engaged with the School Nursing service. Whilst this may be entirely appropriate, and based on the relative health and wellbeing needs of boys and girls, care needs to be taken to ensure that the service is as accessible and available to boys as it is to girls.**

(See pages 19 & 29)

People's experience of the service

3. **People's experience of the service experience has tended to be positive.**

(See pages 20,29,40,42 & 44)

People's expectations of the service

4. **Young People generally would prefer to see someone "in school" and for them to be easily contactable.**

(See page 30 &31)

5. **Girls and young female students prefer to see a woman. Boys and young male students are less concerned about the gender of the school nurse, but those that did in primary school showed an overwhelming preference for seeing a male nurse.**

(See pages 22 & 30)

Needs

6. **The issues on which children, young people and parents most want advice and help relate to two main categories: Emotional and mental health, and lifestyle choices – including healthy eating, diet and exercise and Medical conditions.**

(See pages 21,32 & 41)

Organisational Matters

7. **Those working in, or closely with, the service are unclear about the boundaries of the role of the School nurse, and feel that it is misunderstood by others.**

(See pages 44,52,53 & 56)

8. **Some key stakeholders expressed the view that schools need to be more supportive of the School Nursing service.**

(See pages 52,53,56 & 59)

9. **Many stakeholders suggested that the service needs to be more visible and accessible generally, and particularly to hard-to-engage groups eg children who are not in school.**

(See pages 21.28.33.42.48.50 &53)

10. **Concerns were raised around the capacity of the current service, and whether demand outweighs provision.**

(See pages 30, 52 & 56)

11. **Whilst many contributors reported that partnership working was a strength of the current service, it was suggested that the service may function better through closer working with other services including; CAMHS, GPs, Health Visitors, Children's centres and Children's social care.**

(See pages 51, 53, 56, 58 & 59)

Summary of Participation

Questionnaires

Who: Primary Pupils
How many: 830 Responses
Where: 34 Schools across 20 Wards:

Gender: 382 Boys 417 Girls
Age: 97% were aged 10 and 11

Ward	Number of responses
Little Horton	91
Ilkley	86
Keighley Central	81
Worth Valley	78
Great Horton	72
Tong	72
Wibsey	45
Queensbury	39
Wharfedale	33
Keighley West	32
Toller	31
Bowling and Barkerend	27
City	27
Clayton and Fairweather Green	26
Craven	26
Manningham	22
Thornton and Allerton	20
Bolton and Undercliffe	18
Heaton	2
Bingley	1
Eccleshill	1

Who: Secondary Pupils
How many: 215 Responses
Where: 10 Schools across 5 Wards:

Ward	Number
Bolton and Undercliffe	63
Royds	48
Toller	45
Keighley Central	42
Thornton and Allerton	14

Secondary pupils were asked to provide the first part of their postcode 37% of responses lived in BD2, BD6 and BD21 postcode area which covers the following wards:

Postcode area	Wards
BD2	Bolton and Undercliffe, Bowling and Barkerend, Bradford Moor, City, Eccleshill, Heaton, Manningham, Windhill and Wrose
BD21	Bingley Rural, Keighley Central, Keighley East, Keighley West, Worth Valley
BD6	Great Horton, Little Horton, Queensbury, Royds, Wibsey, Wyke

Age: 97% were aged 13 to 15 with the greatest proportion aged 14 (132/61%)
Ethnicity: 33% were Asian Pakistani and 33% were White British.

Who: Parents
How many: 156 Responses
Where: 26 Schools ALL primary
Where: Parents were asked to provide the first part of their postcode the table below shows the top three postcode areas and the wards in which it covers:

Postcode Area	Wards
BD6	Great Horton, Little Horton, Queensbury, Royds, Wibsey, Wyke
BD8	City, Clayton and Fairweather Green, Manningham, Thornton and Allerton, Toller
LS29	Craven, Ilkley, Wharfedale

Gender: 88% (138) of respondents were Female only 4% (14) were Male, the remaining 8% did not disclose
Age: 66% of respondents were aged between 30 and 49.
Ethnicity: 64% (100) White British 14% (22) Asian Pakistani.

Who: Teachers
How many: 82 Responses
Where: 42 Schools across 5 Wards:

Ward	Number
Bolton and Undercliffe	63
Royds	48
Toller	45
Keighley Central	42
Thornton and Allerton	14

Who: Schools were asked to nominate one member of staff to complete the survey on behalf of the school; however 45% of the responses were from two schools.
School Type: 74% of the teachers who responded were from a primary school which equates to 70% of all the responses.

Group Discussions

Date	Who Attended	Number of attendees
22nd September 2015	School Nursing Teams; • School Nurses, • Health Care Assistants, • Team Leaders, • Trainee School Nurses.	35
30th September 2015	Stakeholders • Education • CAMHS • Public Health • Voluntary and Community Sector • School Nursing • Children's services • Local NHS • Born in Bradford	31*

Section Two: Summary of Participation

Date	Who Attended	Number of attendees
30th October 2015	School Nurse Leads	4
7th December 2015	Strategic Leads • Head of Children's Directorate • School Nursing Manager	6
9th December 2015	Individuals	1

*On reviewing the 'signing in' sheets for this session, it was noted that not all those who had attended had signed in. The most reliable estimate of attendance suggests 31 people were involved.

Contents

Methodology

The consultation for the School Nursing review was conducted using two main methods:

- Questionnaires
- Organised group discussions

Questionnaires

Five different questionnaires were used to collect the opinions of five separate groups:

- Primary School children (10 and 11 year olds)
- Young people in Secondary School (13, 14 and 15 year olds)
- Parents, Guardians and Carers
- Teachers (and other school representatives)
- GPs

Table 1 summarises how each of the questionnaires was designed, promoted, administered and analysed.

Organised group discussions

A variety of people and organisations were invited to contribute their views in a number of organised discussion groups.

Table 2 and the notes which accompany it summarises how each of the group discussions was organised.

Table 1: Questionnaires

Questionnaire respondents	Questionnaire Design	Promotion	Administration	Information collected / analysis performed
Primary School children (10 and 11 year olds)	• Initial design by School Nursing Review team • Tested in open discussion at focus group with Children and Young People, at Barnardo's • Amended to take into account feedback from Focus Groups	• Each school was contacted via a letter to the headteacher. The headteacher was asked to nominate a staff member who would co-ordinate the school's contribution, including arranging for pupils to complete the questionnaire. • Follow-up telephone calls were made to individual schools to encourage participation. • The offer was made for paper copies of the questionnaire were provided to schools on request. No schools accepted this offer.	Online	Quantitative and Qualitative
Secondary School children (13, 14 and 15 year olds)		• Each school was contacted via a letter to the headteacher. The headteacher was asked to nominate a staff member who would co-ordinate the school's contribution, including arranging for pupils to complete the questionnaire. • The initial letter also offered the opportunity for the school to contribute via an organised discussion ('focus group'). • Follow-up telephone calls were made to individual schools to encourage participation. • Further follow-up telephone calls were made to stimulate a response from schools based in more deprived areas. • Paper copies of the questionnaires were provided to schools on request. • Some schools agreed to carry out the exercise on paper, rather than online.	Online and paper copies – see note on 'Promotion.'	Quantitative and Qualitative

Section Three: Detailed explanation of Consultation Methodology

Questionnaire respondents	Questionnaire Design	Promotion	Administration	Information collected / analysis performed
Parents, Guardians and Carers	• Initial design by School Nursing Review team • Tested by email with volunteer panel of Parents, Guardians and Carers • Amended to take into account feedback from panel	• Each school was contacted via a letter to the headteacher. The headteacher was asked to nominate a staff member who would co-ordinate the school's contribution, including encouraging parents to fill out the questionnaire. • Paper copies of the questionnaires were provided on request. • Some Parents, Guardians and Carers filled out the questionnaire paper, rather than online.	Online and paper copies - see note on 'Promotion.'	Quantitative and Qualitative
Teachers (and other school representatives)	• Initial design by School Nursing Review team • Amended to take into account feedback from testing of other questionnaires	• Each school was contacted via a letter to the headteacher. The headteacher was asked to nominate a staff member who would co-ordinate the school's contribution.	Online	Quantitative and Qualitative
GPs	• Adaptation of SWOT*-style approach	• An email was sent out to all of the CCG's who then passed it on to all of the Practice Managers and GPs	Made available online	Qualitative

Notes:

* Strengths and Weaknesses, Opportunities and Threats.

Table 2: Organised Group Discussions

Date / Venue / Time	Membership of Group	How the group was identified	Administration / Promotion	Information collected / analysis performed
1. 22nd September Carlisle Business Centre 1-5pm	School Nursing Service	The current provider was asked to contact school nursing staff and invite them all to the consultation event.	Invitation by email from current service provider	Qualitative
2. 30th September Jacobs Well 1-5pm	Stakeholders	The basis of the membership was the invitation list for the 'Health and Wellbeing of School Age Children' Steering Group, with additional members having been identified at a meeting of the group.	Invitation by email	Qualitative
3. 30th October Shipley Health Centre 10-12pm	School Nurse Leads	The current provider was asked to identify school nurse leads and invite them to the consultation event.	Invitation by email	Qualitative
4. 7th December Jacobs Well 12-1pm	Strategic Leads	The membership was identified from within existing provider strategic leads.	Invitation by email	Qualitative
5. 9th December Carlisle Business Centre 12-2pm	Drop-in session	School Nursing Review team identified that the views of GPs and Teachers may have been under-represented in earlier sessions and organised another session accordingly.	Promoted through Bradford Schools online and CCGS	Qualitative

Questions and Format

At sessions 1 and 2, attendees were divided into groups. The discussions were led by experienced facilitators, and the discussion took place in two sessions. The first session looked at the current service and in particular what attendees feel does and does not work well. The second session focused on the future service and what needs to change.

At sessions 3 and 4, the discussion was in a single group of all attendees.

Recording responses

Responses were recorded on flip chart paper and were typed up following the session. Key themes were then identified from each group and the results are presented later in this report.

Full report on the results of the consultation

In common with the section on Methodology, the results of the consultation are separated into two sections.

- Questionnaires
- Organised group discussions

Questionnaires

The results of the questionnaire are further divided into five separate parts:

- Primary School children
- Secondary School children
- Parents, Guardians and Carers
- Teachers (and other school representatives)
- GPs

Primary School children

Response rates and coverage

830 responses were received.

The Primary school questionnaire collected the following factual data about the respondents:

- School attended
- Sex
- Age

School attended:

Which school do you go to?

- 34 schools were represented by the responses
- The following table lists all the schools where 15 or more pupils responded, together with the ward in which the school is located.

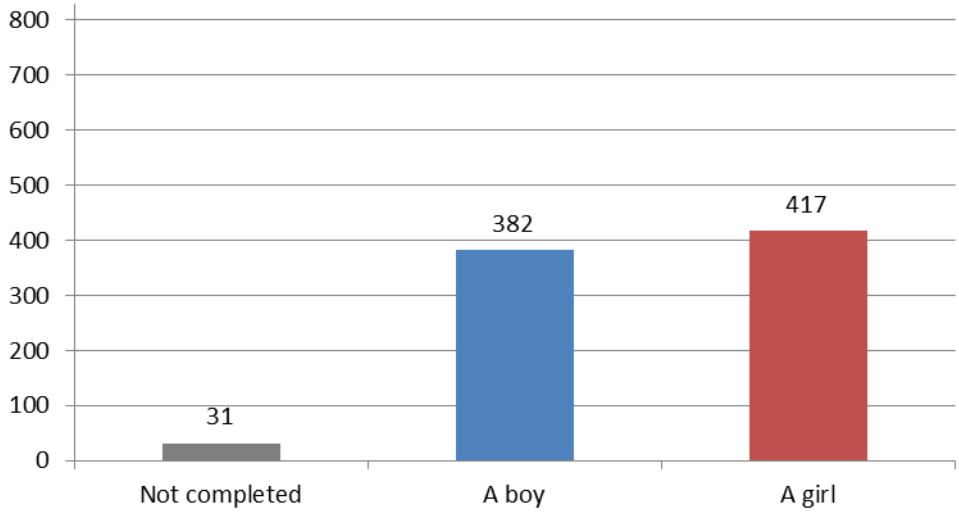
School Name	Number of respondents	Ward
Ashlands Primary School	60	Ilkley
Newby Primary School	58	Little Horton
St John's CE Primary School	58	Tong
Hollingwood Primary School	57	Great Horton
St Anne's Catholic Primary School	52	Keighley Central
All Saints' CE Primary School (Bradford)	33	Little Horton
Burley and Woodhead CE Primary School	33	Wharfedale
Nessfield Primary School	32	Keighley West
Girlington Primary School	31	Toller
Victoria Primary School	28	Keighley Central
Barkerend Primary School	27	Bowling and Barkerend
Farnham Primary School	27	City
Lees Primary School	27	Worth Valley
Addingham Primary School	26	Craven
Clayton Village Primary School	26	Clayton and Fairweather Green
Haworth Primary School	26	Worth Valley
Ben Rhydding Primary School	25	Ilkley
Oakworth Primary School	25	Worth Valley
Shibden Head Primary Academy	25	Queensbury
St Paul's CE Primary School	25	Wibsey
Sandy Lane Primary School	20	Thornton and Allerton
St Winefride's Catholic Primary School	20	Wibsey
Bradford Grammar School	18	Manningham
Westminster CE Primary School	18	Bolton and Undercliffe
St Oswald's CE Primary Academy	15	Great Horton

Section Four: Full report on the results of the consultation:

PART ONE – PRIMARY SCHOOL CHILDREN

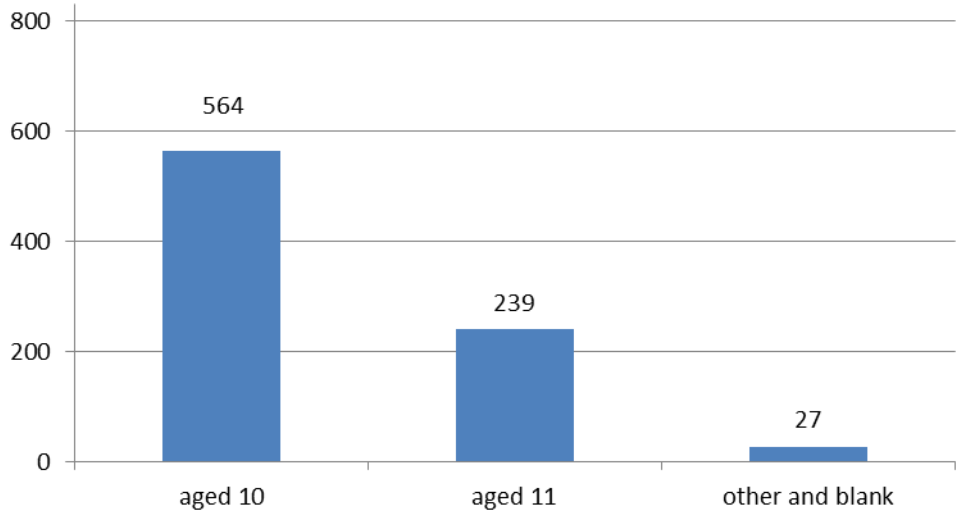
Sex:

Are you?



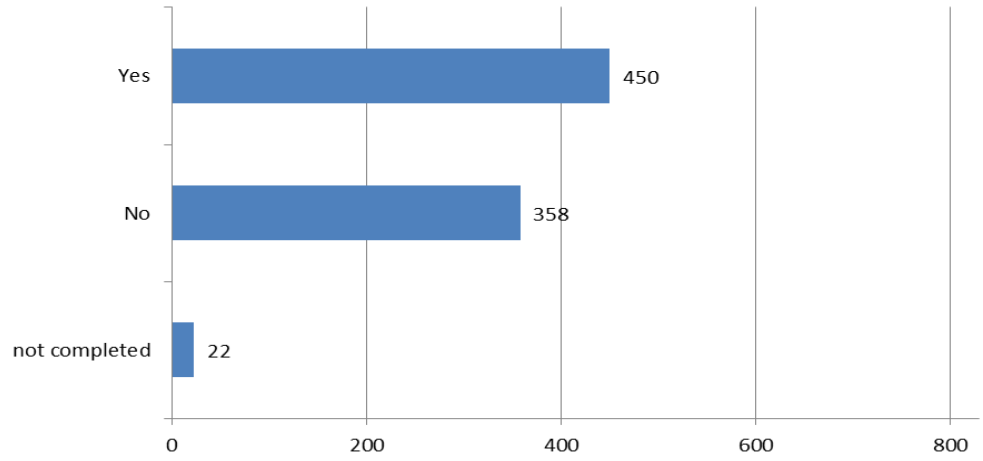
Age:

How old are you?

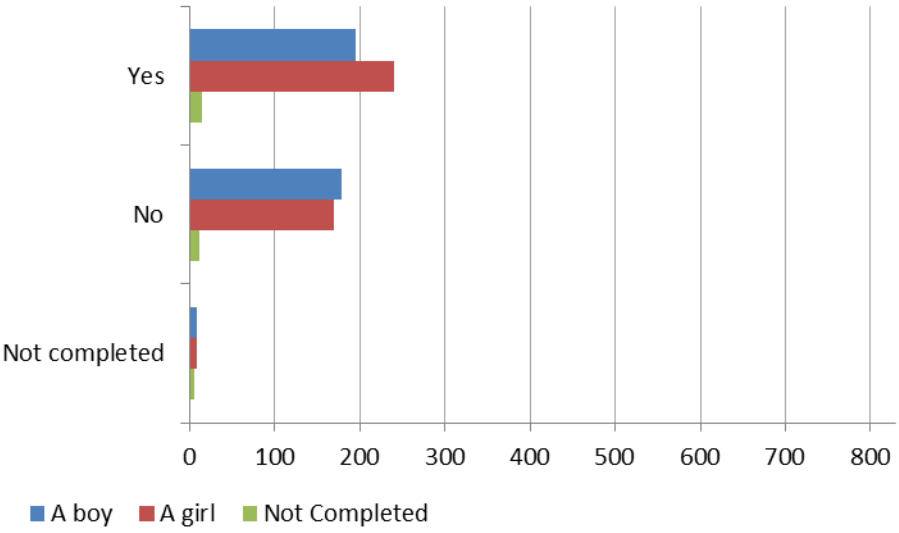


Responses by question

Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?



The following chart shows the number of people who said whether or not they knew there was someone in their school whose job it was to talk to them about things like your health as you are growing up broken down by gender

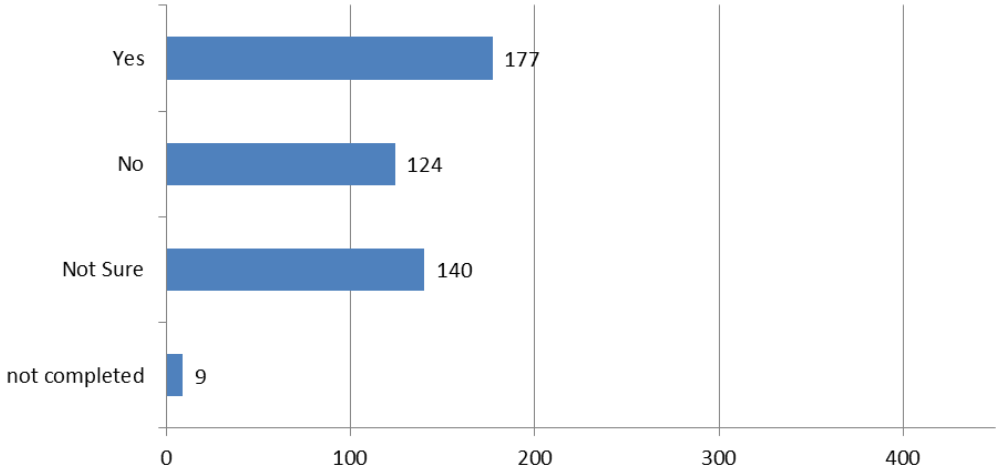


➢ **The chart above shows evidence of key finding 1**

If "Yes" to "Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?"

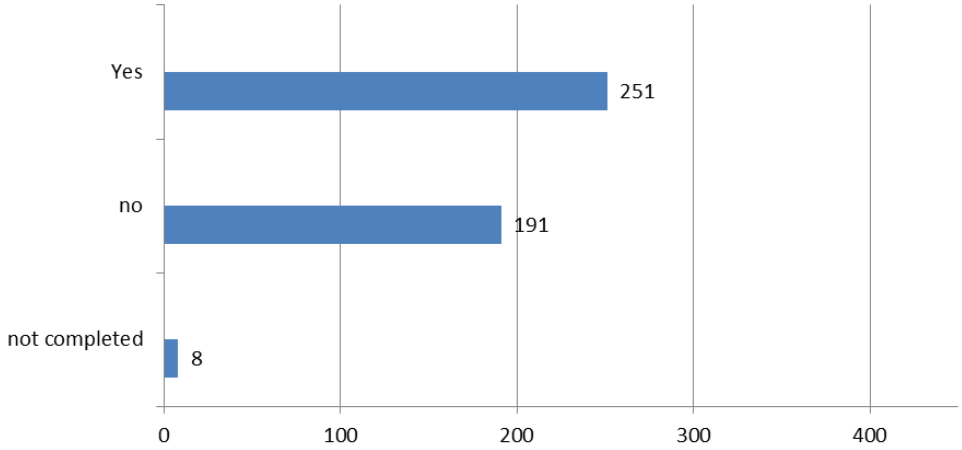
Do you know who this person is?

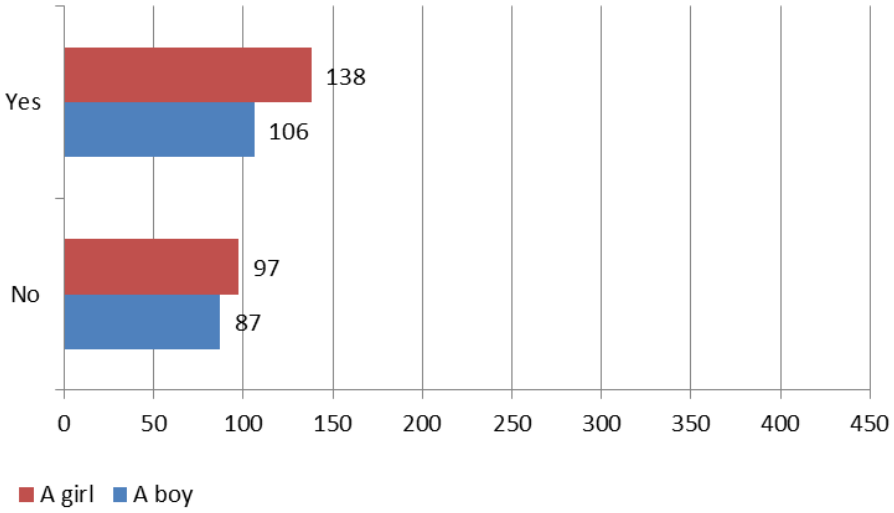
PART ONE – PRIMARY SCHOOL CHILDREN



If “Yes” to “Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?”

Have you ever been to see or talk to this person?





- **The chart above Shows evidence of key finding 2**

If "Yes" to "Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?"

Do you think they are (tick all that apply)?

Description	Number of respondents
Friendly and nice	175
Caring	172
Kind	161
Honest	151
Knowledgeable about health	148
Easy to talk to	143
Trustworthy	122
Good	113
Non-judgemental	53
Easy to find	46
Nosy (asks lots of questions)	16
Judgemental	11
Scary	6
Grumpy	2
Mean	2
Rude	0
Cross	0

➢ **The table above shows evidence of key finding 3**

NOTE: The experience of Primary school children appears to be positive – all of the positive terms were recorded more frequently than all of the negative terms.

What do you think this person should be able to help you with? (Tick all that apply)

Topic	Number of respondents
Healthy eating	484
Medical conditions eg asthma, diabetes	404
Problems at school	367
Puberty	328
Things I'm worried about	324
Feeling sad	320
Fitting in / making friends	263
Being angry	240
Problems at home	204
Smoking	193

Sexuality	186
Head lice	180
Relationships	157
Changing school	149

➢ **The table above shows evidence of key finding 6**

What else would you like this person to do to help you stay healthy and happy?

This was an 'open' question which allowed respondents to express themselves freely, rather than to select from a number of options. The responses which were received were coded into themes. Many responses could be categorised into more than one theme. For instance a comment such as "help around keeping active and eating healthy food" would be coded as both 'Exercise' and 'Healthy Eating'. The following table illustrates the most common themes, in descending order of recurrence.

Theme	Number of respondents
Healthy eating	61
Be available more	44
Exercise	38
Advice (general)	34
Provide more information	33
Bullying	24
Health checks	21
Help with feeling sad	21
Check ups	20

Some of the comments corresponding to the most common themes were as follows:

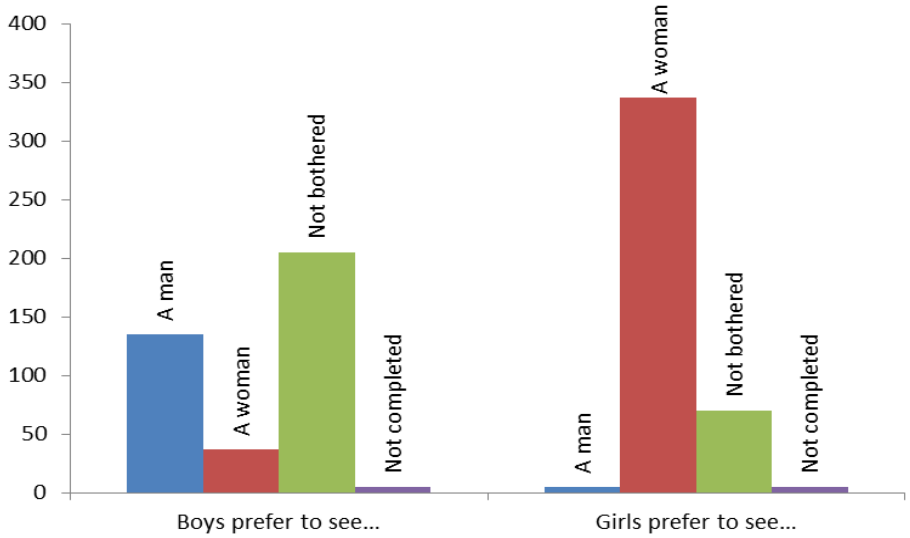
Healthy eating
"..a food plan to help …to eat healthier"
"…make sure we eat what is healthy for us…"
"…tell me what happens when I eat too much sugar"

Be available more
"…around in school more often"
"…you can go to at anytime"
"…able to see them more…able to see on your own"

Exercise
"…help staying fit"
"…make fun games in the playground… help me stay happy"

➢ **The table above shows evidence for key finding 9**

Would you prefer to see?



- **The chart above shows evidence of key finding 5**

Secondary School children

Response rates and coverage

215 responses were received.

The Secondary school questionnaire collected the following factual data about the respondents:

- School attended
- Sex
- Age
- Disability status
- Home postcode
- Sexual orientation
- Religion / belief
- Ethnicity

School attended:

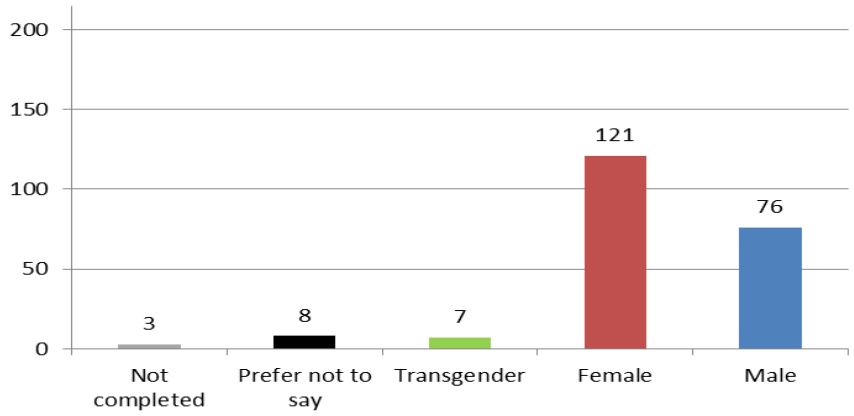
Which school do you go to?

- 10 schools were represented by the responses
- The following table lists all the schools where more than 10 pupils responded, together with the ward in which the school is located.

School	Number	Ward
Buttershaw Business & Enterprise College	48	Royds
Bradford Girls' Grammar School	45	Toller
Hanson	42	Bolton and Undercliffe
The Holy Family Catholic School	22	Keighley Central
Feversham College	21	Bolton and Undercliffe
University Academy Keighley	20	Keighley Central
Thornton Grammar School	14	Thornton and Allerton

Sex:

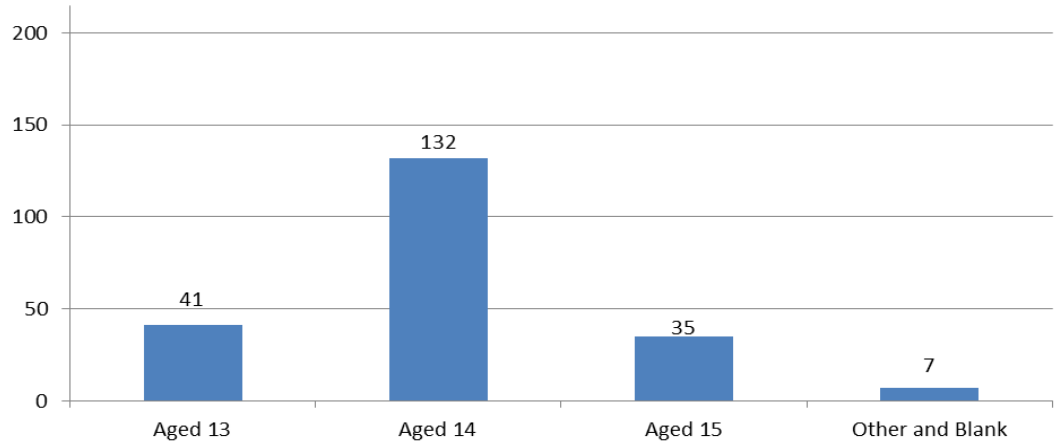
Are you?



PART TWO – SECONDARY SCHOOL CHILDREN

Age:

How old are you?



Disability Status:

Do you have any of the following disabilities?

Disability	Number of respondents
Prefer not to say	34
Visual impairment	10
Physical Disability	9
Learning difficulties	9
Other substantial and long term condition	9
Mental ill Health	7
Hearing impairment	7
Mobility	5
Speech impairment	5

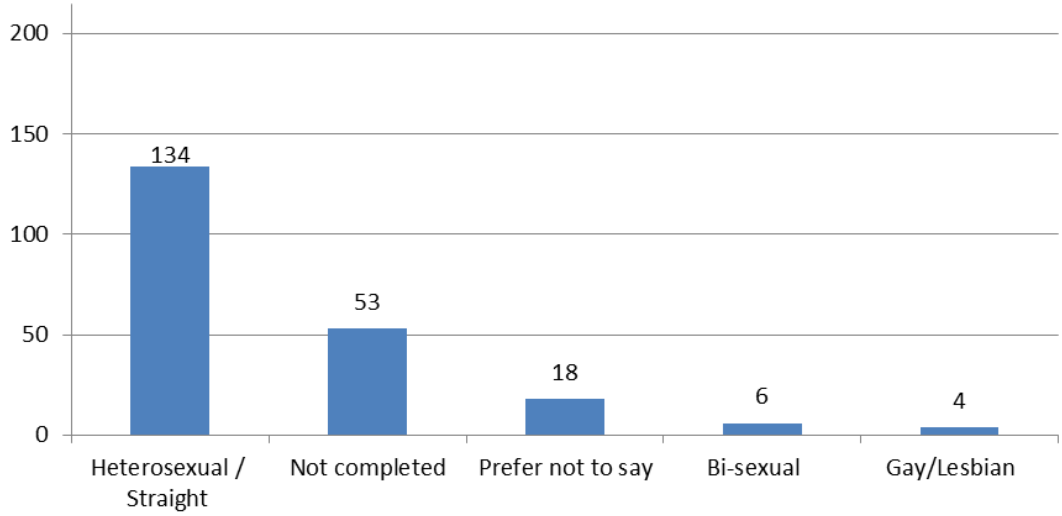
Home postcode:

Please provide the first part of your postcode eg BD13

Postcode area	Number of respondents
BD2	28
BD6	28
BD21	24
BD7	17
BD3	15
BD5	14
BD8	14
BD9	10
BD13	9
BD20	9
Not completed/ not valid	20

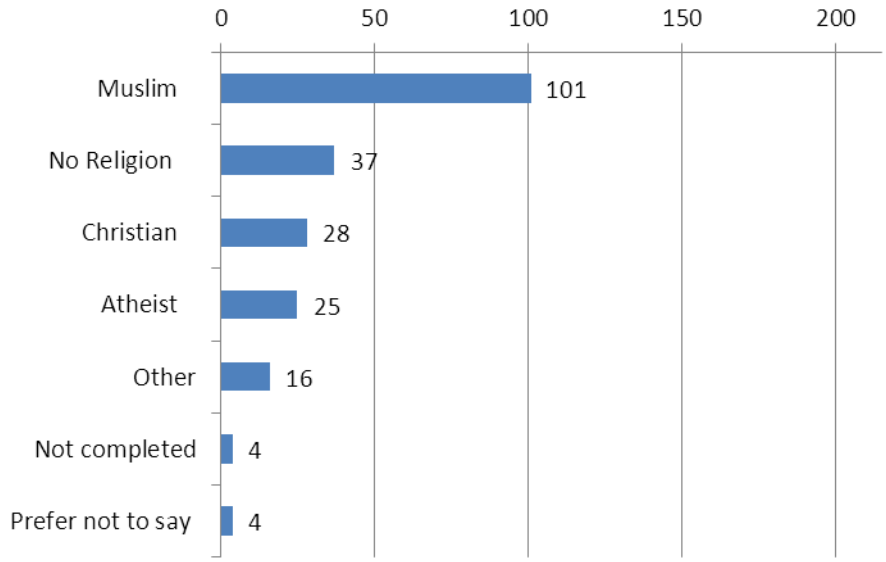
Sexual Orientation:

Which of the following options best describes your sexual orientation?



Religion / belief:

Which of the following options best describes your religion or belief?



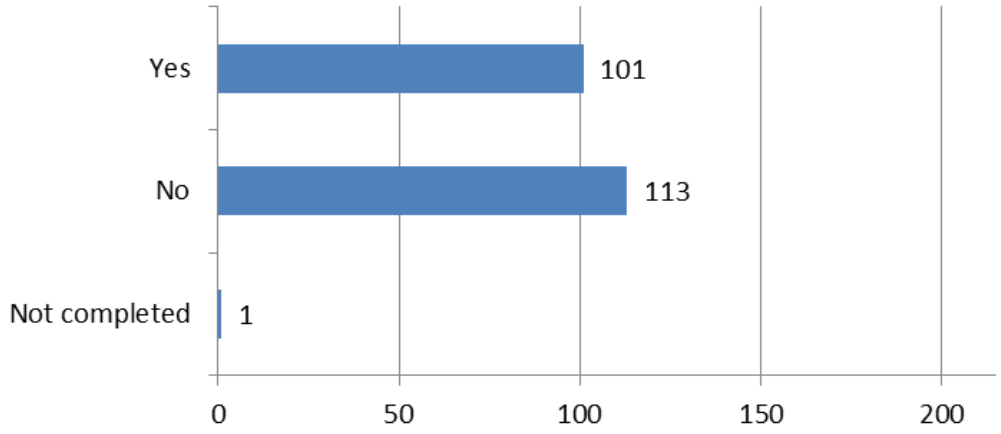
Ethnicity:

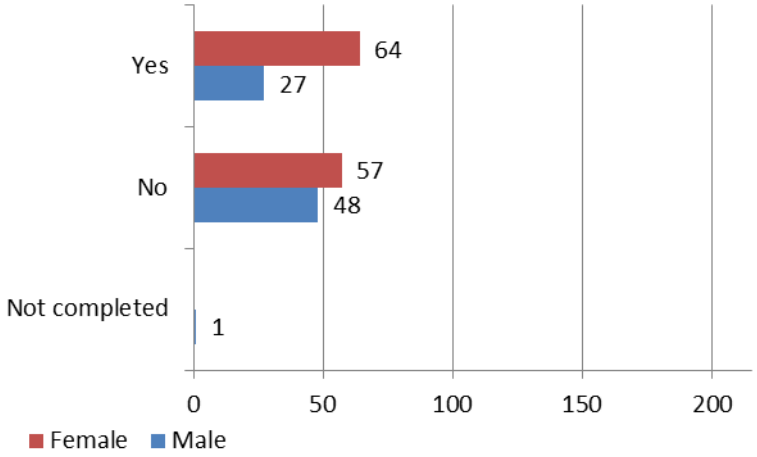
Which of the following options best describes your race, ethnic or cultural origin?

Ethnicity	Number of respondents
Asian or Asian British Pakistani	70
White English / Welsh / Scottish / Northern Irish / British	70
Not completed	13
Asian or Asian British Other	8
Don't Know	8
Asian or Asian British Bangladeshi	7
Asian or Asian British Indian	7
Mixed White / Asian	6
Asian or Asian British Kashmiri	4
White Other	4
Gypsy /Traveller	3
Mixed White / Black Caribbean	3
Prefer not to say	3
Other (*8 other stated ethnicities*)	9

Responses by question

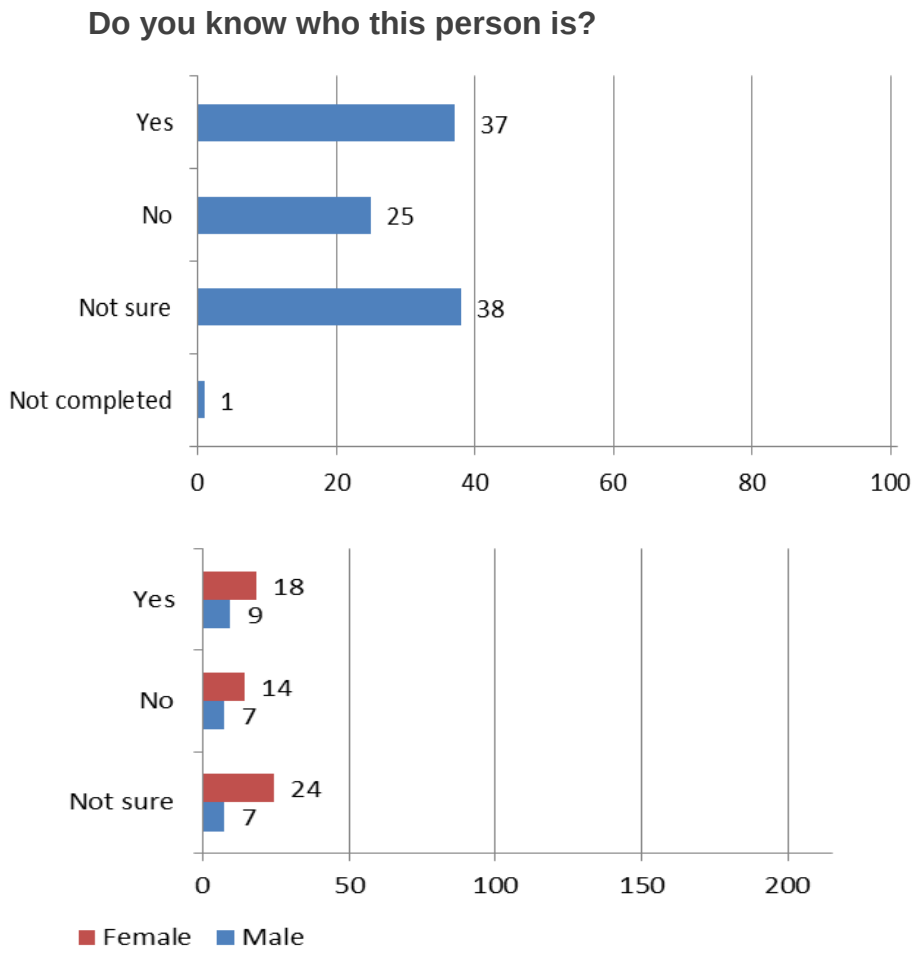
Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?





➢ **The chart above shows evidence of key finding 1**

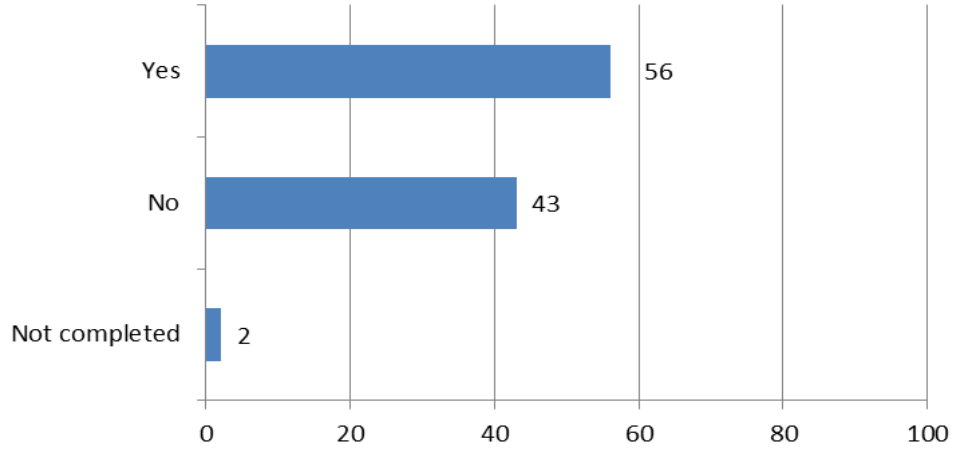
If "Yes" to "Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?"



➢ **The chart above shows evidence of key finding 1**

If “Yes” to “Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?”

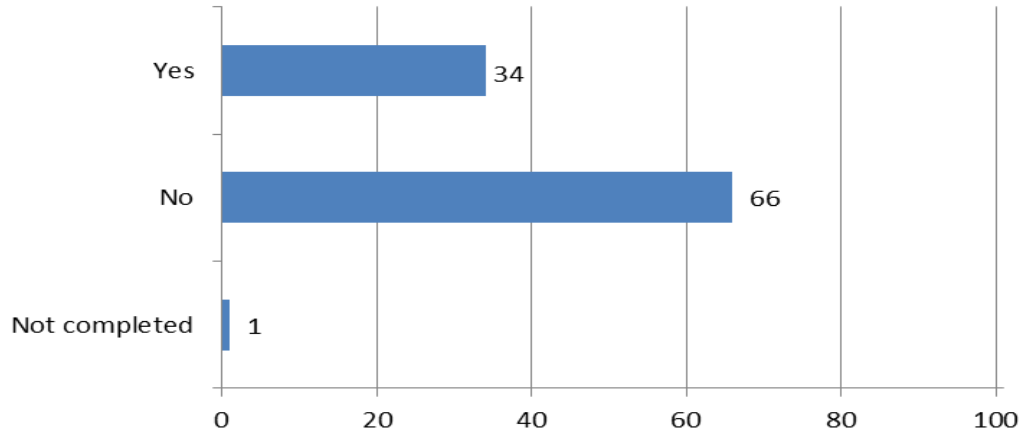
Do you know how to contact this person?

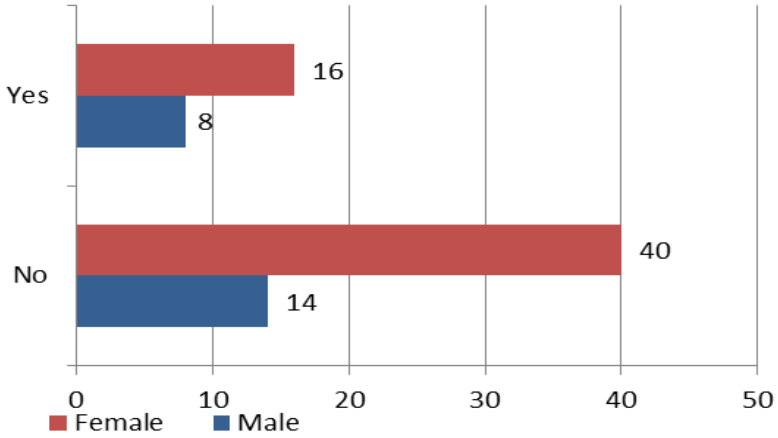


➢ **The chart above shows evidence of key finding 9**

If “Yes” to “Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?”

Have you ever been to see or talk to this person?





➢ **The chart above shows evidence of key finding 2**

If "Yes" to "Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?"

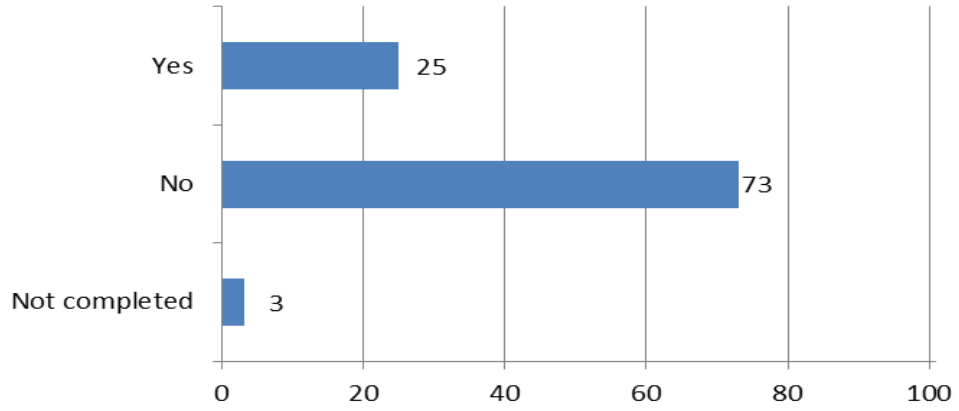
Do you think they are?

Description	Number of respondents
Caring	45
Friendly and nice	43
Easy to talk to	41
Knowledgeable about health	41
Kind	39
Non Judgemental	38
Honest	32
Trustworthy	32
Good	31
Easy to find	20
Nosy (asks lots of questions)	13
Grumpy	7
Judgemental	6
Scary	6
Rude	5
Mean	3
Cross	2

➢ **The table above shows evidence of key finding 3**

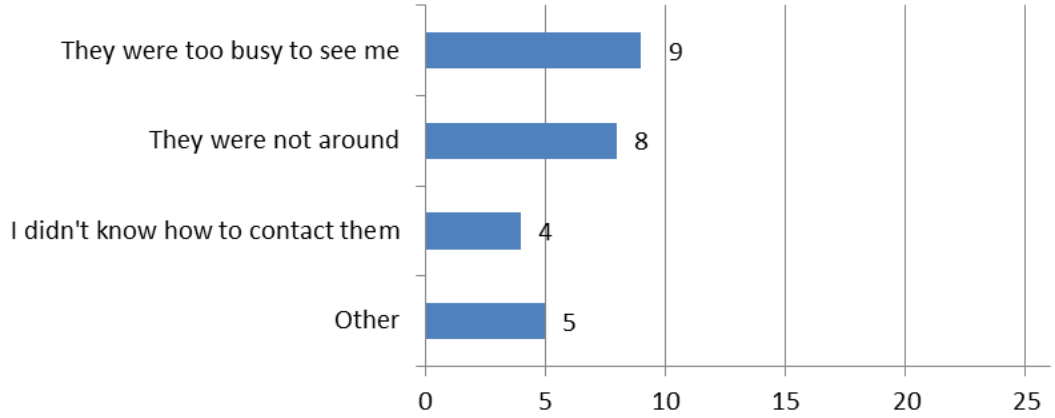
If "Yes" to "Did you know that there was someone in your school whose job it is to talk to you about things like your health as you are growing up?"

Have you ever been unable to see this person when you needed to?



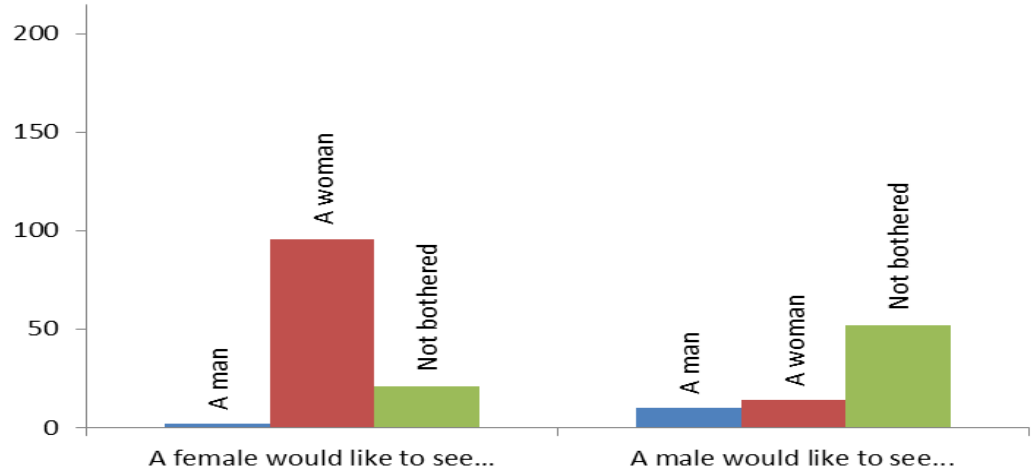
If "Yes" to "Have you ever been unable to see this person when you needed to?"

Why were you unable to see them?



- **The chart above shows evidence for key finding 10**
- **The chart above shows evidence for key finding 4**

Would you prefer to see?



- **The chart above shows evidence of key finding 5**

How would you like to be able to contact them?

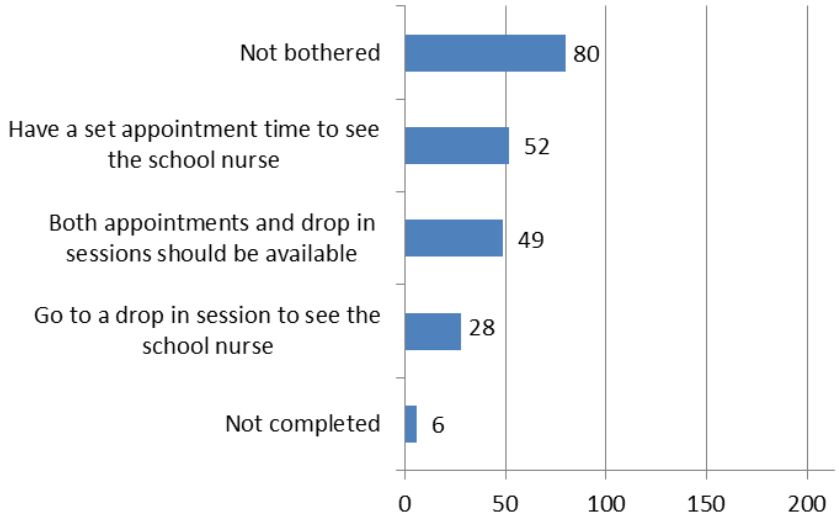
Method of contact	Number of respondents
Go and see them	134
Ask a member of staff	55
Text	41
Email	30
Phone	20

Where would you like to be able to see them? (tick all that apply)

Location	Number of responses
At school	161
Doctor's surgery / Health centre	42
Hospital	24
Somewhere else out of school	24
Other	14
Youth centre	9
At a community venue	6
Children's centre	2

➢ **The table above shows evidence of key finding 4**

Which of the following options would be best for you?



What do you think they could help you with? (Tick all that apply)

Topic	Number of respondents
Exam stress	132
Problems at school	103
Help around depression, stress and anxiety	98
Bullying	88

Problems at home	81
Help around healthy eating and healthy weight	79
Cyber bullying	79
Self-harm	75
Mental health problems	73
Medical conditions eg asthma, diabetes	73
Puberty	66
Settling in at new school	62
Relationships	62
Help around drug and alcohol use	58
Help to Stop Smoking	57
Sexuality	54
Pregnancy tests	54
Condoms	51
Grooming (online or street based)	49
Chlamydia screening	47
Emergency contraception (morning after pill)	46
Contraception	44
Head lice	33

➢ **The chart above shows evidence of key finding 6**

What else would you like this person to do to help you stay healthy and happy?

This was an 'open' question which allowed respondents to express themselves freely, rather than to select from a number of options. The responses which were received were coded into themes. Many responses could be categorised into more than one theme. For instance a comment such as "being in school more and teach us about healthy eating" would be coded as both 'be more accessible' and 'Healthy Eating.' The following table illustrates the most common themes, in descending order of recurrence.

Theme	Number of respondents
be more accessible	8
offer advice	6
Healthy Eating	5
listen	3
problems at school	4

Some of the comments made by the children in the most common themes were as follows:

Be more accessible
"…come in every week…"
"…able to talk whenever …have a problem…"
"…appointments…when I am free…"

Offer advice
"…give advice to people who are suffering…"
"…give advice…inform…parents"

Healthy Eating
"… give… a healthy diet like the 5 a day"
"…information on what to eat…"

- **The table above shows evidence for key finding 9**

Parent responses

Response rates and coverage

156 responses were received

The Parents' questionnaire collected the following factual data about the respondents:

- School attended by the children
- Sex
- Marital Status
- Age
- Disability Status
- Home postcode
- Religion / belief
- Ethnicity
- Pregnancy

Due to technical errors, data on "Sexual Orientation" was not collected.

School attended by the children:

- 26 schools were represented by the responses

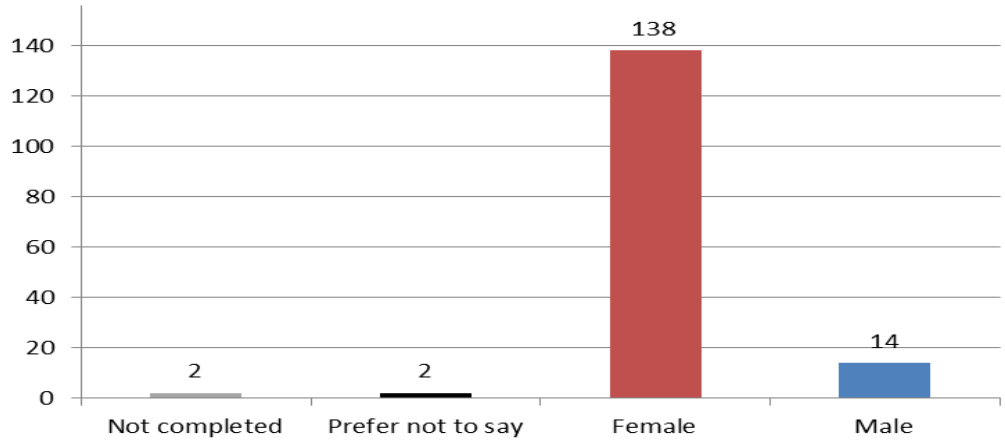
The following table lists all the schools where more than 10 pupils responded, together with the ward in which the school is located.

School	School Type	Ward	Number of responses
Ashlands Primary School	Primary	Ilkley	25
St John's CE Primary School	Primary	Tong	25
Ben Rhydding Primary School	Primary	Ilkley	14
One In A Million	Primary	Manningham	13
Girlington Primary School	Primary	Toller	11

PART THREE – PARENTS

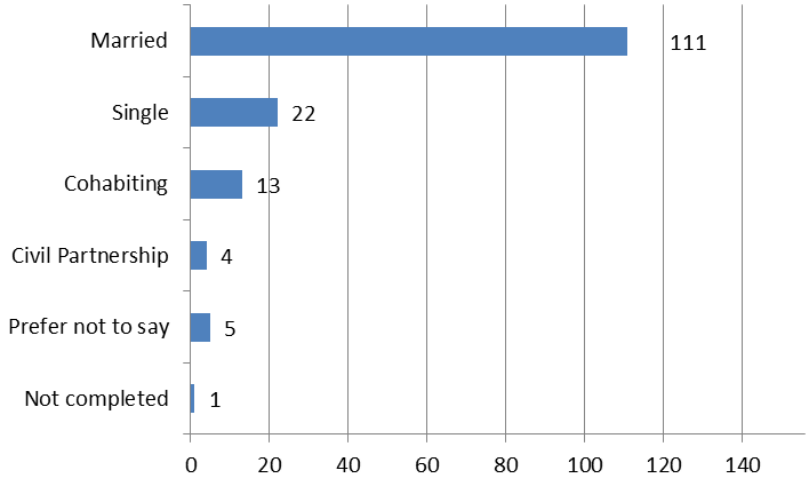
Sex:

Are you?



Marital Status:

Which of the following options best describes your Marital Status?



Age:

How old are you?

Age band	Number of respondents
20-29	8
30-39	52
40-49	51
50-59	7
Other and Incomplete	38

PART THREE – PARENTS

Disability Status:

Do you have any of the following disabilities?

Disability	Number of respondents
Prefer not to say	10
Mental ill Health	6
Physical Disability	5
Learning difficulties	5
Other substantial and long term condition	5
Hearing impairment	4
Mobility	2
Speech impairment	2
Visual impairment	0

Home postcode:

Please provide the first part of your postcode eg BD13

Postcode	Number of respondents
LS29	51
BD4	19
BD8	18
BD12	6
BD22	6
BD6	6
BD3	5
BD5	5
BD10	2
BD13	2
BD18	2
BD20	2
BD21	2
BD7	2
Other valid postcodes	8
Not completed/ invalid postcode	20

Religion / Belief:

Which of the following options best describes your religion or belief?

Religion	Number of respondents
Christian	58
Muslim	35
No Religion	31
Atheist	12
Not completed	8
Other	7
Prefer not to say	5

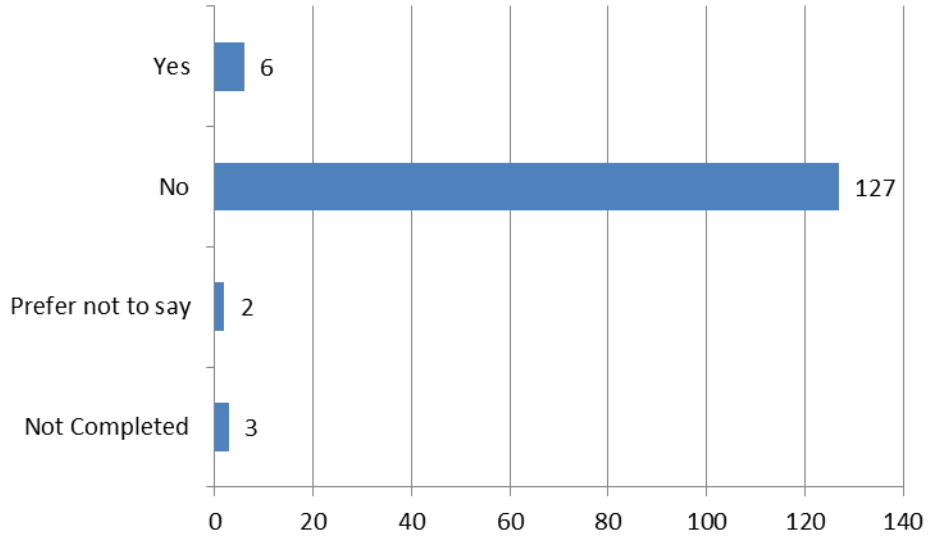
Ethnicity:

Which of the following options best describes your race, ethnic or cultural origin?

Ethnicity	Number of respondents
White English / Welsh / Scottish / Northern Irish / British	100
Asian or Asian British Pakistani	22
Asian or Asian British Bangladeshi	4
Black or Black British African	4
Mixed White / Asian	4
White Other	4
Not completed	4
Asian or Asian British Other	3
White Irish	3
Other (6 other stated ethnicities)	8

Pregnancy:

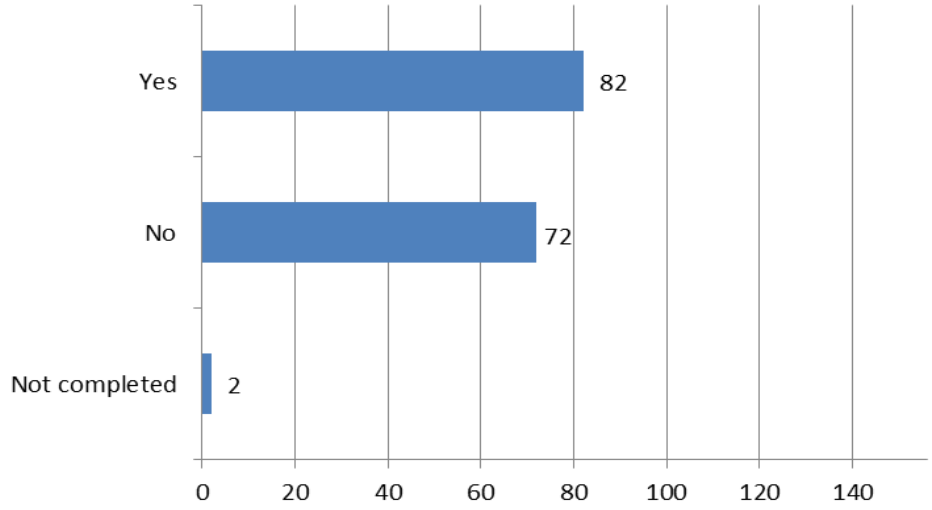
Are you pregnant or have you given birth in the last year?



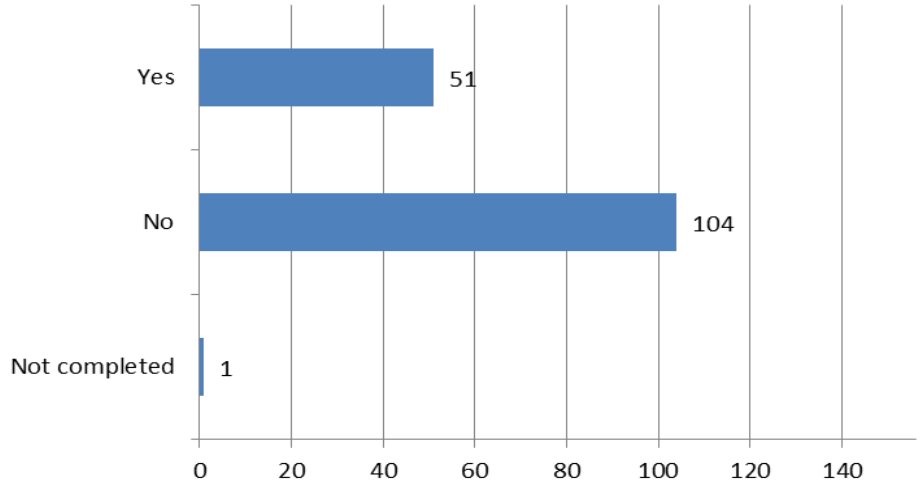
Responses by question

Has your child's school let you know that there is someone at school - other than their teacher - whose job it is to talk to your children about health and wellbeing?

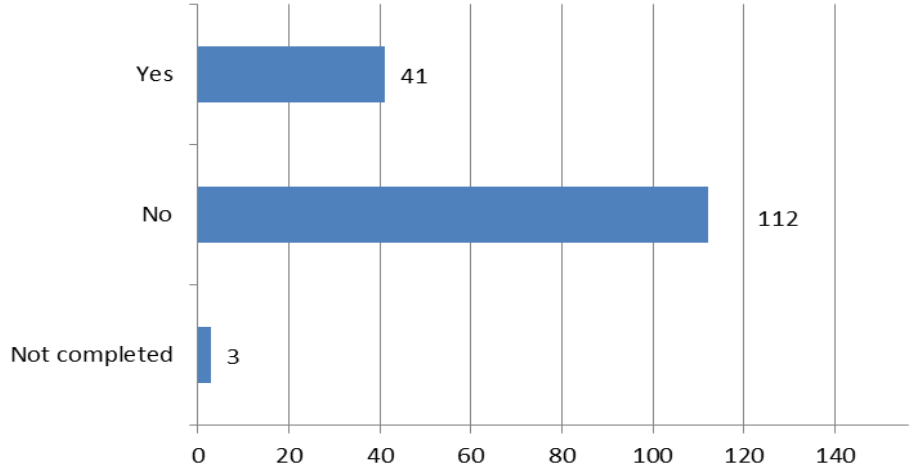
PART THREE – PARENTS



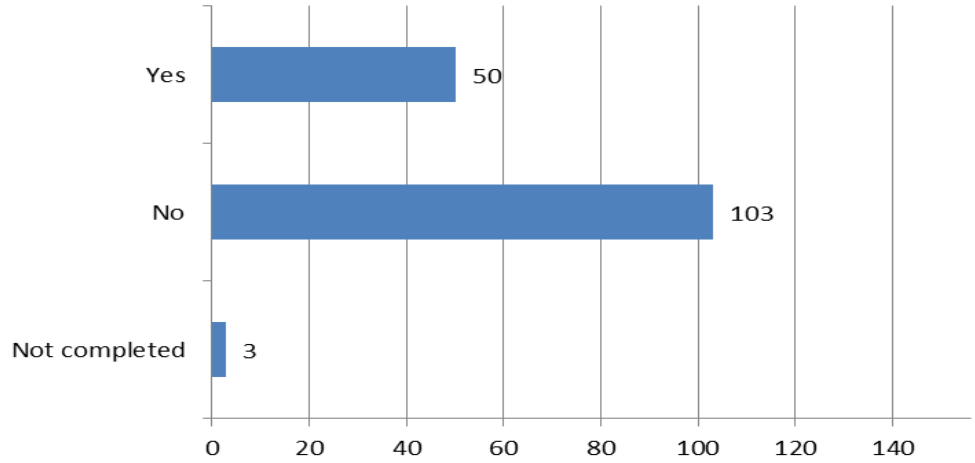
Do you know who this person is?



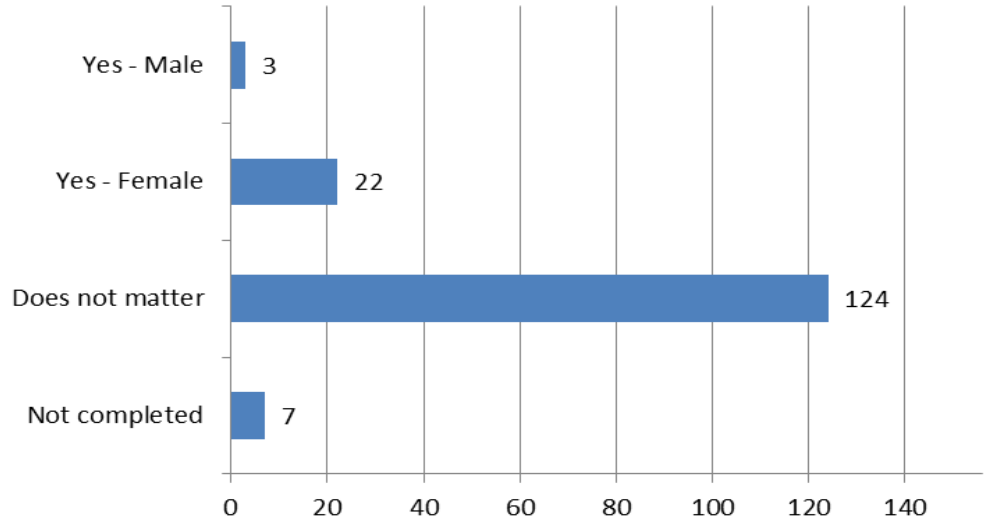
Does your child/ do your children know how to contact this person if they want to see them?



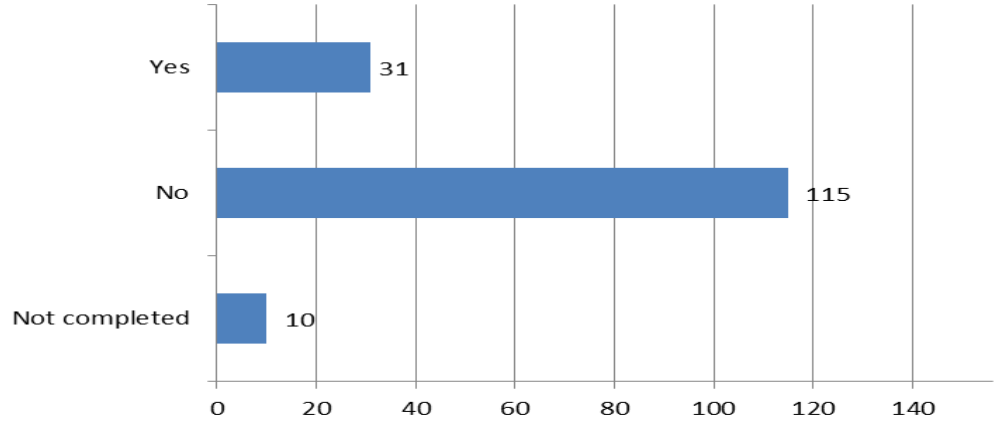
Do YOU know how to contact this person if you want to see them?



Does it matter to you if the person is male or female?

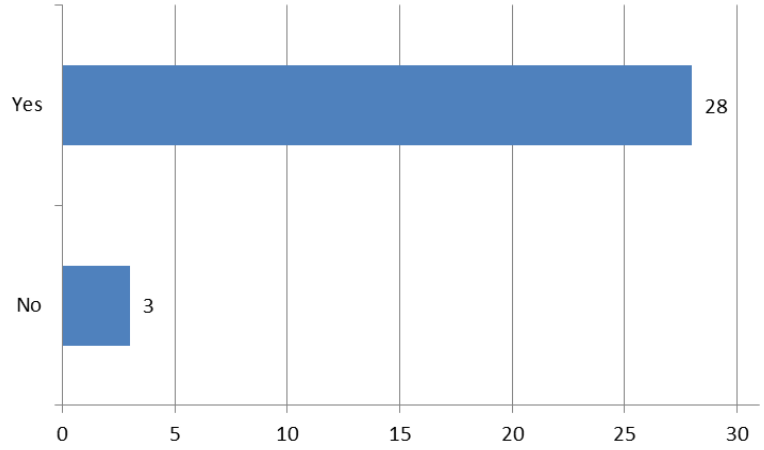


Have you ever spoken to this person about your child/children?



If "Yes" to "Have you ever spoken to this person about your child/children?"

Were you happy with the discussion?



➢ **The chart above shows evidence of key finding 3**

If "No" to "Were you happy with the discussion?"

Please explain why you were unhappy: (tick all that apply)

Respondents were invited both to select from a list of potential reasons *and* to provide comment. The comments received identified that those that were unhappy felt:

- They were not given enough time
- They were not happy with the outcome
- They did not feel that they or their child was being listened to
- Nurses did not deal with issues age-appropriately, and were patronising

As a parent, guardian or carer, which of the following things would you like your child/children to be able to speak to this person about? (Tick all that apply)

Topic	Number of respondents
Healthy Eating	108
Bullying	88
Weight	71
Behaviour	70
Puberty	68
Safety	68
Anxiety/ Pressure	67
Body image	58
Head Lice	57
Vision	57

Hearing	55
Sleep	54
Long term illnesses	51
Family health	50
Other worries at home	50
Immunisations	49
Allergies	48
Anorexia/ eating disorders	46
Grooming	46
Smoking	45
Self - harming	44
Bed wetting	44
Sexual Health	43
Drugs	43
Alcohol	40

➢ **The chart above shows evidence of key finding 6**

If you needed to make an appointment to see the person in question, how would you prefer to do so? (Tick all that apply)

Contact method	Number of respondents
By phone	94
By going into school	76
By email	57
By text	42
By letter	13

If you needed to make an appointment to see the person in question, where would you prefer to meet? (Tick all that apply)

Location	Number of respondents
In school	115
At a GP's surgery / health centre	54
At home	49
I would prefer to discuss the matter on the phone	31
At a children's centre	22
Somewhere else outside of school	16
At a hospital	10

How would you like to find out more about services which relate to your child / children's health and wellbeing? (Tick all that apply)

Information method	Number of respondents
Letter home	91
Email to parents	88
Leaflets	71
Information on school website	65
School Newsletter	56
Parent evenings	45
Information in school starter pack	40
School notice board	21
Posters	12

Please use this space for any other comments you would like to say about the School Nursing Service.

This was an 'open' statement, encouraging respondents to express themselves freely, rather than to select from a number of options. The responses which were received were coded into themes. Responses could be categorised into more than one theme. For instance a comment such as "I don't really know much about the school nursing service, however with the issue with head lice this would be a good service to have within schools" would be coded as both 'lack of information/ awareness' and 'Head lice' The following table illustrates the most common themes, in descending order of recurrence.

Theme	Number of respondents
Lack of information/awareness	11
praise	7
health checks	3
Communication with parents	3
more accessible	2
questionnaire design	2

Lack of information/ awareness
"…didn't know… had a school nurse…"
"…make more of it…making everyone aware…"
"…need to have more of a presence around school…"

Praise
"…very proactive…made it easy to meet…gave good advice"
"…listened to and taken seriously…"
"…nothing but good experiences…"
➢ **The table above shows evidence of key finding 3**
➢ **The table above shows evidence for key finding 9**

Teachers

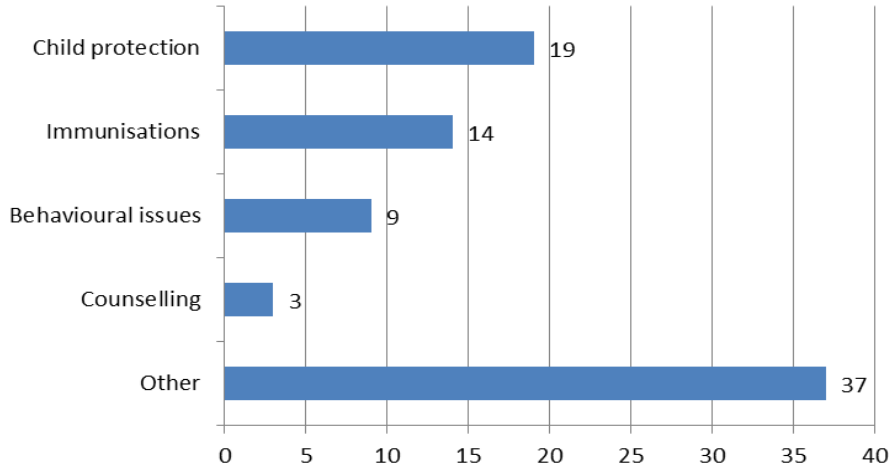
Response rates and coverage

- 82 responses were received
- 42 schools were represented by the responses

To monitor that the overall response was reflective of schools across Bradford, respondents were asked to provide information about the size and nature of the school.

Responses by question

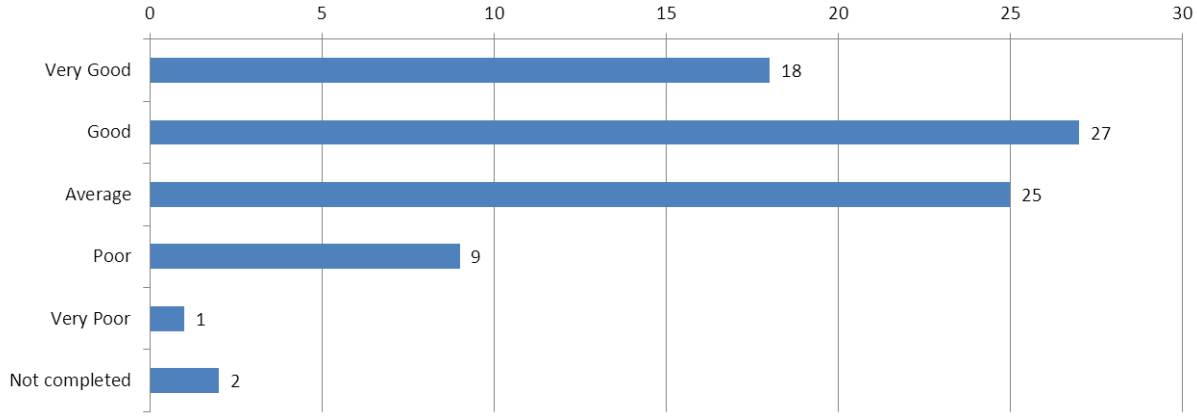
What do you consider to be the main role of the school nursing service within your school (1 selection only)?



The table below gives the reasons given for other; the main reason why respondents selected other was because they felt they were all important and could not select one as the main role. The second highest was health concerns and medical checks highlighting a more medical role.

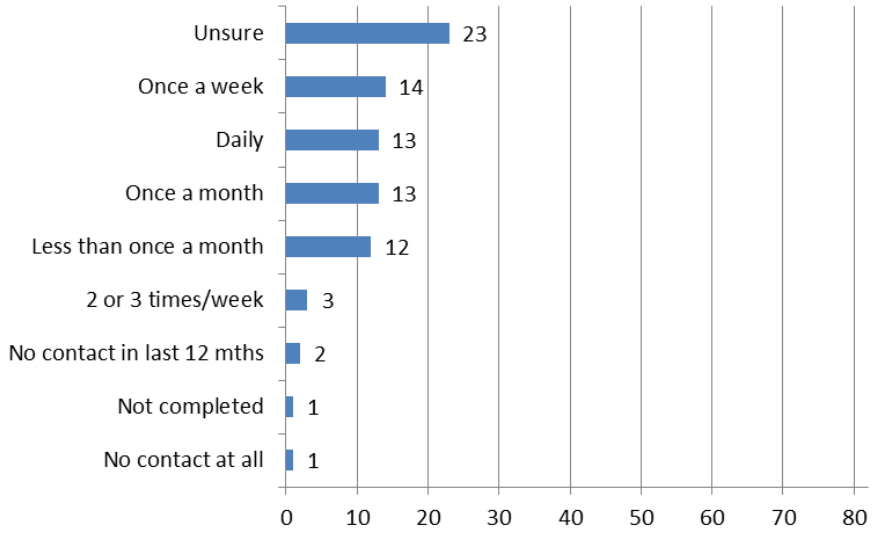
Main role Other	Number of respondents
All of them	11
health concerns	5
medical checks	4
support for parents and/or teachers	4
referrals	3
don't know	2

How would you rate the quality of the school nursing service?



➢ **The chart above shows evidence of key finding 3**

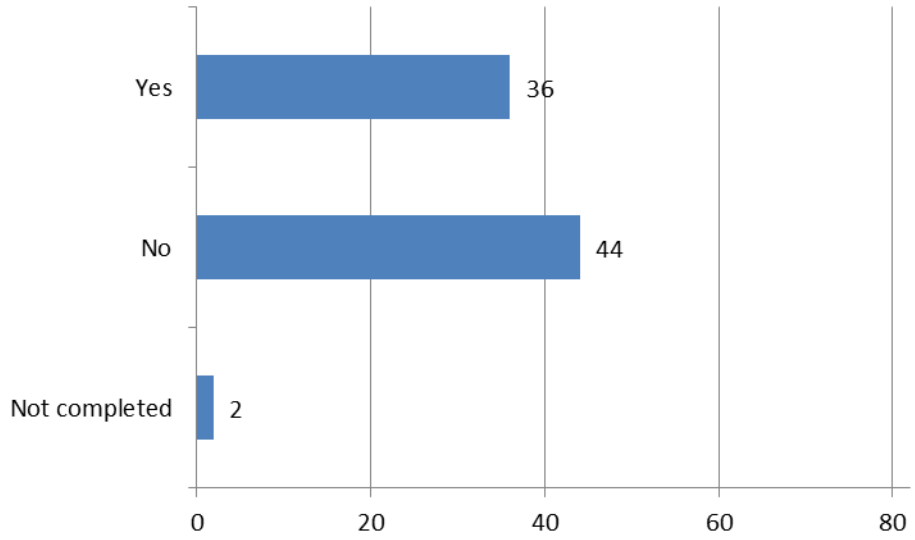
To the best of your knowledge, how often is the school nursing service available in your school?



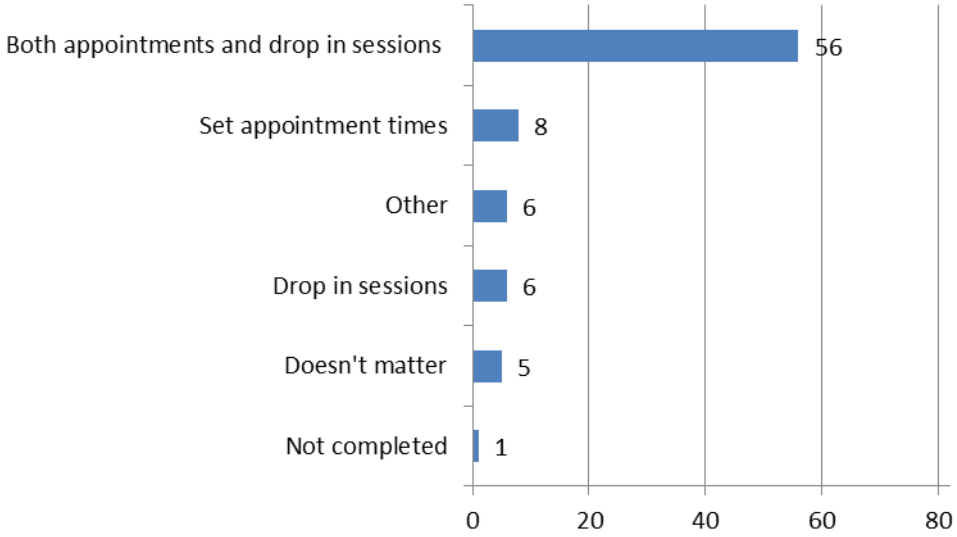
➢ **The chart above shows evidence for key finding 7**

PART FOUR – Teachers

Do you think the school nursing service is in your school often enough to address the health needs of the children and their wellbeing?



Which of the following options do you think should be available to pupils?



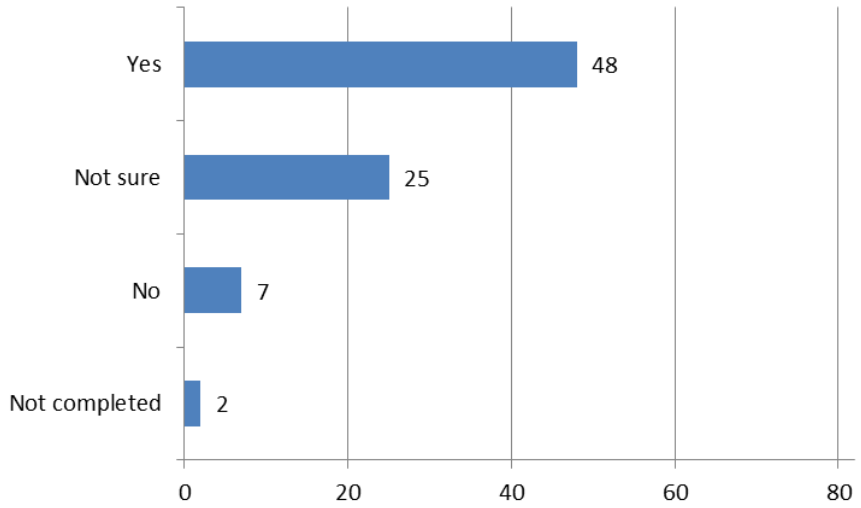
In your opinion, which of the following would most benefit the children in your school? (Tick all that apply)

Topic	Number of respondents
Counselling/signposting to mental health services (CAMHS)	60
Behavioural interventions	44
Help around healthy eating and healthy weight	43
Health care interviews (height, weight, vision and hearing)	42
Advice on Puberty	41
Advice on health issues	40
Head lice checks or advice	39

Supporting safeguarding	38
support with medical conditions eg asthma, diabetes	38
Help around depression, stress and anxiety	37
Relationship and sex education	35
Vaccinations	34
Signposting to health services	33
someone to talk to about problems at home	33
Advice about exam stress	32
Help for students with long term conditions	31
Someone to talk to about problems at school	30
Help around drug and alcohol use	26
Information about Self harm	26
Advice about bullying	25
Having someone to talk to about sexuality	24
Help to Stop Smoking	23
Advice on relationships	19
Advice about contraception	19
Advice about cyber bullying	19
Help with settling in at new school	19
Advice on Child sexual exploitation (grooming online or street based)	19
Pregnancy tests	15
Condoms	14
Chlamydia screening	13
Emergency contraception (morning after pill)	12

Boys' Health

We would like to understand what could help boys with their health
Would it be helpful if boys had access to a male school nurse?



What else do you think the School Nursing service do to help children and young people stay healthy and happy?

This was an 'open' question which allowed respondents to express themselves freely, rather than to select from a number of options. The responses which were received were coded into themes. Many responses could be categorised into more than one theme. For instance a comment such as 'provide information on what service is available. And carry out training for school staff on asthma and the use of an EpiPen' would be coded as both 'communication' and 'training.'

N.B: A number of the responses answer 'what 'could' the School Nursing Service do to help children and young people stay happy and healthy, rather than what they currently do, some responses were less clear.

The following table shows the responses which answer the correct question about the current service in descending order.

Topic	Respondents
Support families	5
praise	2
Don't know	1
health checks	1
Support School staff	1
service deteriorated over the years	1
quick to respond	1
Proactive	1
lack of understanding	1
good links	1
Flexible	1
Child protection	1
Accessible	1

The following table shows the responses which highlight what the service could provide in descending order.

Topic	Respondents
More accessible	6
drop in sessions	3
Health Talks	2
build relationships with pupils	2
Support families	1
health checks	1
Communication	1
Advice	1
referrals in a timely manor	1

mental health checks	1
Have a male nurse	1

- **The table above shows evidence for key finding 9**

More accessible
"…be a more of a familiar face…"
"…Constant…Known presence…"
"…regular contact with the school…"
"…need to have more of a presence around school…"

Support Families
" … brilliant support to ….parents"
"…Support…parents in many ways"
"…advise in our Parents forum about health related issues"

GPs

Response rates and coverage

There were 17 responses to the questionnaire for GPs.

Responses by question

All of the questions in the questionnaire for GPs were 'open' questions, which allowed respondents to express themselves freely. The responses which were received were coded into themes. Many responses could be categorised into more than one theme. For instance a comment such as 'to work with other services when safeguarding/ child protection needs are identified, and to deliver health promotion advice when needed' would be coded as both 'Safeguarding' and 'Health Promotion.' The following tables illustrate the most common themes, in descending order of recurrence, together with sample responses from contributors.

What are your expectations of the School Nursing Service?

Theme	Summary of the views of the discussion groups
Mental Health	they are the first contact for children and young people aged 5 and over with Mental Health issues, support with low level behavioural and mental health issues through tier one services and to provide counselling and assessments.
management of long term conditions	advice and support on use of medications and managing health problems, training of school staff to support children with long term conditions.
Discuss health issues with GP	Liaise with GPs when children have health needs, Discuss health issues with GP and feedback where possible. Having good communication with GPs
safeguarding	Awareness of safeguarding issues and to refer where appropriate, liaise with appropriate services around safeguarding issues
Advice and support	Health advice to children and young people and supporting parents with health related issues, supporting schools with issues such as Sexual Health, emotional problems and developmental problems.

What do you think works well?

The key point to draw from responses to what works well was that they were using the same IT system which helps when sharing information between services. Referrals can be made via the system and enables services to task other services which mean that things get done in a timelier manner and has increased communication.

What do you think doesn't work as well?

Despite the use of the same IT systems having been seen as a positive to increase communication it was highlighted that communication was seen as an issue, this was demonstrated in the majority of the responses with issues with School nurses not having a presence and being difficult to contact,

some respondents indicated an issue with the use of system1 (IT system) with some school nurses not sharing information.

What would you change?

The final question gave the GPs the option to make suggestions to what they would change in the future service:

Theme	Count of What would you change?
communication	going back to being able to contact individual School Nursing teams and having the contact list well publicised. Having easier communication routes.
better use of IT Systems	ensure all school age children and on the system one module to make contact more straightforward and allow entry of notes in system one so that it includes more information
flexible service	More flexibility for example understanding the extant to what school nurses are involved during school holidays.
safeguarding	attend more of the monthly safeguarding meetings held in the practice when appropriate

- **The table above shows evidence for key finding 9**

Group discussion 22nd September

Coverage

The event was attended by School Nurses, Health Care Assistants, Team Leaders and Trainee School Nurses.

Responses by question

What works well?

Theme	Summary of the views of the discussion groups
Current team Structure	the skills mix within the teams seems to work well, and they all work well together to achieve the same goal 'Best outcome for young people,' strong communication and committed and passionate staff, which work together in teams with lots of peer support.
Partnership working	strong partnership working was identified this includes; close links among school nursing and health visiting is working in some teams, School Nurses work well with CAMHS, this is developed through good relationships with services. There were pockets of good practice seen in some PRUs and voluntary and community services however it was identified that this wasn't universal across the district.
Safeguarding	- School Nurses provide tier 1 mental health services to reduce demand on the CAMHS service, they work closely with vulnerable families to ensure that appropriate safeguards are in place. Attending Child Protection conferences.
Needs Assessments	identifying health needs both individually and school wide to identify 3 priorities that are agreed with the school head teacher.

➢ **The table above shows evidence for key finding 11**

What Doesn't Work as well?

Theme	Summary of the views of the discussion groups
Clarity of the role	the role is very varied and there are quite a lot of demands from lots of different areas; school, GPs, Hospital, CAHMS. They need clarification for themselves and others around their role so that they can prioritise work effectively. In addition they feel the children and young people are unsure what their role is and what they can do for them so clarity is needed for them also.
Schools understanding of the service	Similar to the clarity of the role, it is unclear whether the school understands what it is that the service provides and they often rely on the service. The expectations of the service vary from school to school, it is clear from some schools that they are not aware of what the service can provide and therefore do not utilise it efficiently.
Barriers put in place by	Due to the schools having conflicting priorities they are not always

schools	very engaged with the service and quite often put barriers in for them to be able to carry out their role effectively. Whether this is having a physical place within the school to carry out screening tests e.g. one team mentioned that some schools put them in the disabled toilets to carry out hearing tests. This affects the relationships with the schools as they do not feel values and can often find this disrespectful.
Capacity	the size of the team does not always reflect the workload. There is a lot of demand on the team to go to child protection conferences and deal with referrals that they often do not have the time to carry out the role they are supposed to be doing. The current service provision does not fit the demands of the service.
IT systems	Education social and NHS all on different systems and data sharing agreements are not always in place, this can lead to duplication or things not being followed up. In addition to the different system there are also issues among those who have the same system e.g. GPs, Dentists who are all on system one, they often get the school nurses to check things up for them when they all have access to the same information. Also sometimes GPs block information that the School Nurses can access.

- **The table above shows evidence for key finding 7**
- **The table above shows evidence for key finding 8**
- **The table above shows evidence for key finding 10**

What takes up most of the time?

Theme	**Summary of the views of the discussion groups**
Safeguarding	the thing that the school nurses felt that took up most of their time was safeguarding, this involves risk assessments, responding to referrals, attending Child Protection conferences (even those that do not have a health issue)
Admin	since the reduction of admin support the School nursing teams feel that a lot of their time has been spent doing admin which has been preventing them from carrying out their role this includes; ○ ***Chasing Consent Forms*** ○ ***Looking into Missing children*** ○ ***Contacting parents (often who have changed their contact details)***

How can this be improved?

Theme	**Summary of the views of the discussion groups**
Clarification of the role	The role of the School Nursing Service needs to be clarified for all involved. This will help the teams prioritise their workload, it should impact on the inappropriate referrals they receive and the schools, and children and young people will be able to utilise the

	service more effectively.
Accessibility	Changing how people can access the service and having somewhere that they can meet which is convenient for all. Suggestions included a text messaging service for young people, creating an app for advice and working better overall with technology whilst ensuring that the service remains confidential.
Agile working	Working more efficiently for example online referral system, automated letter system, opt out for referrals to reduce time in chasing up consent forms. All having access to laptops so that they can work remotely, instead of waiting till they are in the office to type up notes etc.
Safeguarding procedures	Having better procedures in place to ensure that the service is only involved when there is a health need.
Joint working with schools	Working with health and social care to ensure there is a full picture of the child and that work doesn't get duplicated or missed.

- **The table above shows evidence for key finding 9**

What would you change?

Theme	**Summary of the views of the discussion groups**
Team	A couple of suggestions were made on how they would change the teams these included; having a broader range of skill mix in each team, larger teams across areas with greatest need or having a more flexible approach so that people can work across teams when demand is higher. It was suggested that having a specific mental health nurse within the team to focus on mental health would allow the rest of the team to focus on the other aspects of the role.
Accessible	Ensure a service that is accessible for all; this includes those who don't go to school, and be able to see children and young people where they want to be seen so long as this is appropriate, this should come out of the consultation with the young people.
Communicate with young people	This is similar to accessibility, ensuring that children and young people are able to contact the service when they need to, introduction of a text or email service, creating an app for advice and contact details for the service.
Joint working	improve communication across organisations, cross organisational working- physically working in the same setting (creating a hub of services) this could include; health visitors, School Nursing Team, Children's Centres, children's social services, CAMHS etc.
Clarification of the role	Overall the key theme that is coming across is clarity of the role, this is for the service itself and other key stakeholders who work closely with the service.

- **The table above shows evidence for key finding 7**
- **The table above shows evidence for key finding 9**
- **The table above shows evidence for key finding 11**

Name change

There were a few suggestions around the change in the name of the service but the main points to draw from the discussion was that the majority were happy to drop the 'School' from the name however it was quite important the 'Nurse' was retained. Some groups did not see the need in changing the name as it has been around for a long time.

Group discussion 30th September

Coverage

There were various stakeholders who attended the session which including representatives of:

- Education
- CAMHS
- Public Health
- Voluntary and community sector
- School nursing
- Children's services
- the NHS locally
- the Born in Bradford Project.

Responses by question

What works well?

Theme	Summary of the views of the discussion groups
Safeguarding	this was considered a key role of the School Nursing service in particular the tier 1 services they provide which there was lots of praise for one attendee was "in awe of the work they do" in addition to the tier one service they refer into the CAHMS service where appropriate.
Needs assessment	School nurses carry out needs assessments within school with pupils in reception in primary, and in year 7 and 10 in secondary. In addition to the needs assessments the school nurse service is good at identifying children and young people who are in need of additional support.
Partnership Working	The School Nursing Service work well with other agencies including the youth service, there is a good skill mix within the team and people work well together.
Communication	Similar with partnership working the School Nursing Service communicates well with other services including the CAMHS service and they have a good relationship with commissioners. In addition to other services the School Nurses communicate well with parents, it was noted by some participants that parents have elected to discuss issues with the school nurse as they find them more approachable than other professionals.
Health Education	The School Nursing Service is good at delivering key health

	messages i.e. keeping safe, sexual health and coping with stress and anxiety.

What doesn't work well?

Theme	Summary of the views of the discussion groups
Clarification of the role	There was a lot of discussion around what the School Nurses role is and was even questioned if the School Nurses even knew what their role was. It is apparent from the responses that the School Nursing Service requires clarity, currently it is seen that they take on too much as the role isn't defined and there is a lack of clear pathways and procedures.
Capacity	several comments were made about the capacity of the current service, provision outweighs demand 'not enough nurses' 'everyone wants a school nurse'
Availability	School Nurses are only available in term time only and when they are dealing with safeguarding and mental health issues they are needed all year round. What happens to vulnerable pupils during this time? There was quite a bit of discussion around this which led to questions around other services for example do A&E attendances increase over the holiday period?

- **The table above shows evidence for key finding 7**
- **The table above shows evidence for key finding 9**
- **The table above shows evidence for key finding 10**

What are their expectations of the service?

Theme	Summary of the views of the discussion groups
Safeguarding	The School Nursing Service is seen as the key referral pathway into CAHMS, the service will receive referrals from GPs and other agencies and based on a risk assessment will decide whether it requires specialist CAHMS or whether they can provide tier one services.
Clarification of the role	Despite a few individual level responses around the heights and weights being recorded and signposting to services, and championing health interventions such as Oral Health interventions it was felt that the role was very vast and there wasn't a clear definition of what the service actually provides, it was noted that it is unrealistic to have the service oversee everything as the role is so diverse.

What needs to change?

Theme	Summary of the views of the discussion groups
Clarification of the role	The main aspect that needs to change is the clarity of the role; need to be really clear of what the role of the School Nurse

	actually is and what the service can provide. In addition to the role of the School Nurse there needs to be clarity on the roles of other services for example there are some aspects of the service that the voluntary and community sector could provide.
Partnership working	It was suggested that the service could work more jointly with other services and develop and health and social care approach so that all areas are working together, especially in terms of commissioning to avoid duplication and ensure a seamless service, closer links with health visiting especially on the 0-7 agenda to ensure a smooth transition between services.
Capacity	Need to work more efficiently to increase capacity, examples given was around access to laptops and mobile phones, having IT systems that link with other services so that data is shared efficiently to reduce duplication. It was also identified that there are issues with recruitment in that nationally there is a shortage in School Nurses. Ensure that the service is fit for purpose and perhaps having more resources in areas with greater need- set number of families/ young people per School Nursing team.

- **The table above shows evidence for key finding 7**
- **The table above shows evidence for key finding 10**
- **The table above shows evidence for key finding 11**

In addition to the key themes other suggestions were around the name of the service and the visibility of the School Nurse within the school whether this is having a set place/time where people can access the service when they need it or having some form of branding e.g. a uniform.

Future challenges

Theme	**Summary of the views of the discussion groups**
Financial challenges	
Widening inequalities/changes to population	Developing a service which is fit for purpose in an ever changing environment.
Schools to buy in	Conflicting priorities the school have their own outcomes that they need to achieve, it was suggested that a meeting needs to be arranged with the chairs and vice chairs of the partnership group, and get governors involved through governor forums.

- **The table above shows evidence for key finding 8**

Group discussion 30th October

Coverage

A consultation session was held on the 30th October with School Nurse leads the session looked at the current service and suggestions for the future service.

Section Four: Full report on the results of the consultation:

ORGANISED GROUP DISCUSSIONS

Responses by question

The current service has agreements with schools where in addition to the core 'statutory' requirements they carry out focussed work on 3 priority areas identified by the school which is need focussed for example; obesity, sexual health and mental health. They provided a list of other core work that they do however it was apparent that this wasn't universal across all schools for example there are parent drop-ins at breakfast club in some but not all primary schools. There are posters to advertise the service and there was an attempt to set up a text messaging service but it wasn't successful due to legal reasons.

The leads were asked what they felt the least effective aspect of the service was and unanimously the response was around attending child protection conferences when there is no health need. Another area which is very time consuming is the lack of admin support and having to chase consent.

In terms of the future vision for the service there were a few key points, these included; the need to spend more time on site in secondary schools in particular for transition in year 7 pupils. It was suggested that the service becomes more flexible examples of how this can be achieved include using Skype or face time for appointments, working Saturday mornings and being available during school holidays at a base other than schools. Skill mix was seen as a positive however it isn't utilised to the best of its ability due to pressures on the service. It was suggested that the skill mix should include more specialisms for example a CAMHS worker.

Group discussion 7th December

Coverage

A consultation session was held on the 7th December with Strategic leads the session looked at the current service and suggestions for the future service. There were six people in attendance at the session including the head of Service for the children's directorate, the School Nursing Manager and the Clinical Lead.

Responses by question

The first part of the session focussed on where the service is now and what it looks like and what pressures are on the service.

Where the service is now and what it looks like?

- There are currently 10 teams which consist of;
    - Specialist practitioners
    - Band 5 School Nurses/ Staff Nurses
    - Nursery Nurses
    - Health care practitioners

- Every school has a named nurse; either a School Nurse or a Staff Nurse
- Every Children centre has a named nurse
- GP have a named nurse
- They deliver targeted interventions which include;
    - Health and wellbeing of schools
    - Drop in sessions for pupils and families
    - Behavioural and Mental health interventions

ORGANISED GROUP DISCUSSIONS

- Health needs assessments which are carried out annually which enables them to profile the school and get a better understanding of the needs of the pupils
- Timetable of interventions
- Health questionnaires are carried out for pupils in transition years; reception and year 7 (previously carried out in year 10 but this is no longer captured) for the reception pupils the parents complete the questionnaire and they use the notes received from the Health Visitor. Year 7 pupils are completed by the previous school.
- The year 10 questionnaire wasn't giving them any more information than they already have; it was likely that if they had any health problems then they would already be known to the service.
- Currently trying to raise the profile of the service via a website and posters
- The service delivers a targeted approach based on the needs of the service

- There are inconsistencies across the service as not all schools are engaging, for example the faith schools are offered a core service but they are difficult to engage with.
- All of the Pupil Referral Units (PRUs) have a named nurse
- They have good links with the Special Education Needs Co-ordinators (SENCOs)

What are the current pressures on the service?

- Partner agencies want a lot more from the service
- Lack of clarity of role eg Enuresis who's role is it
- Safeguarding- expectation that health need to be around even when there is no health need
- Pressures from social services
- Complex needs in mainstream school eg children with enteral feeding needs- expectation to provide equipment and train parents and teachers- training for parents should be done at discharge
- Pathways from community discharge are unclear
- Capacity issues
- SENCO don't like to deal with health needs
- Time consuming tasks- Basic assessment of mental health needs can take up to 3 hours

The second part of the session looked at the Future of the service

➢ **The table above shows evidence for key finding 11**

Future Direction

- Training and enablement model for staff in the school eg dealing with an asthma attack
- Clearer pathways eg enuresis
- Consent from parents, other areas are using the opt out method- this is being reviewed strategically
- Safeguarding- don't attend if no health need
  - Identify what health needs are the responsibility of the school nurse
  - Hold other professionals to account when it is not their responsibility
- Self-care model- pro-active instead of reactive
- Identify priority areas
- Clarification of the role of the School Nurse
- More flexible service- out of hours/ term time
- Use of technology to offer support to children and young people

ORGANISED GROUP DISCUSSIONS

- Work closer with the voluntary and community sector- see what services they can provide
- Be more creative- get schools to buy in to a more enhanced model
- Better understanding around CAMHs to ensure appropriate referrals

- **The table above shows evidence for key finding 8**
- **The table above shows evidence for key finding 11**

Group discussion 9th December

Coverage

One person attended.

Responses by question

The person was asked to fill in the stakeholder questionnaire, and the response was added to the other questionnaire results.

Strengths and weaknesses of the consultation exercise.

Strengths

- The consultation has taken into account the views of a large number of people – in total well over 1,000 individuals have offered their views on the School Nursing Service. Furthermore, the contributions have been received from individuals from different backgrounds, whose opinions and expectations of the service will have been formed by very different experiences and perspectives. Furthermore, throughout the period of consultation effort was made to ensure that the Children and Young People who responded represented a mixture of those who live in the most- and least-deprived parts of the District.
- The consultation exercise has been conducted in such a way that individuals have been able to express their views freely and frankly. Some of the material that cannot be used in the report has demonstrated that people have been completely uninhibited in their responses, and the messages conveyed have been reflected in the key findings that have emerged.
- The consultation also benefitted from the testing of the questionnaires. It was important to design survey methods which reflected the language used by key stakeholders – including Children and Young People.

Weaknesses

- There is some concern that the responses from parents may not reflect the diversity of parents in Bradford and District. Specifically, the number of responses from parents who described themselves as 'White British' far outnumbered the responses from all other Ethnic Categories combined – whereas in the population at large, one would expect that around half of parents are of ethnicities other than 'White British'.
- For all it has been apparent that individuals have been able to express their views freely and frankly (see ' Strengths'), an acknowledged weakness of any survey of Children and Young People is that by their very nature, they may not be able to make informed decisions about their own Health and Wellbeing.
- Whilst this consultation exercise has been designed to contribute to a review the School Nursing *service,* there has inevitably been a good deal of contribution from the current service *provider.* This has particularly been the case in the organised group discussions. Although this has perhaps been unavoidable, as it has been necessary to get a real-world view of the current service from a variety of different perspectives, it means that the consultation exercise is inherently more likely to portray the current service model in a positive light.

City of Bradford MDC
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Report of the City Solicitor to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 8 September 2016

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Subject: Health and Social Care Overview and Scrutiny Committee Work Programme 2016/17

Summary statement:
This report presents the work programme 2016/17

Parveen Akhtar
City Solicitor

Portfolio:

Adult Social Care and Health

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1. **Summary**

1.1 This report presents the work programme 2016/17.

2. **Background**

2.1 The Committee adopted its 2016/17 work programme at its meeting of 14 July 2016.

3. **Report issues**

3.1 **Appendix A** of this report presents the work programme 2016/17. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over the coming year**. Appendix B** lists items for inclusion in the work programme that have not yet been scheduled.

4. **Options**

4.1 Members may wish to amend and / or comment on the work programme at **Appendix A** and **B**.

5. **Contribution to corporate priorities**

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2016/17 reflects the ambition of the District Plan for 'all of our population to be healthy, well and able to live independently for a long as possible' (District Plan: Better health, better lives).

6. **Recommendations**

6.1 That the Committee notes the information in **Appendix A** and **B**

7. **Background documents**

7.1 Constitution of the Council

8. **Not for publication documents**

None

9. **Appendices**

9.1 **Appendix A** – Health and Social Care Overview and Scrutiny Committee work programme 2016/17

9.2 **Appendix B** – Unscheduled items for inclusion in Committee's work programme 2016/17

Democratic Services - Overview and Scrutiny

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 6th October 2016 at City Hall, Bradford. Secretariat deadline 23/09/2016			
1) Healthwatch dentistry report	Details to be confirmed	Healthwatch Bradford and District	
2) NHS England (West Yorkshire) dental commissioning update 2015	Update	Kathryn Hillliam, NHS England (West Yorkshire)	resolution of 8 Oct 2015 that the update 'include details in relation to commissioning models and work being
3) Adult and Community Services Annual Performance Report	Annual report	Bernard Lanigan	resolution of 10 Sept 2015
4) Clinical Commissioning Groups' Annual Update	Annual performance report	Michelle Turner / Sue Pitkethly	resolution of 10 Sept 2015
5) CCGs Primary Care Commissioning Strategy	Details to be confirmed	CCGs	
Thursday, 27th October 2016 at City Hall, Bradford. Chair's briefing TBC Secretariat deadline 14/10/2016			
1) Children's and Young People's Mental Health Issues and Services	A joint meeting with Children's Services OSC to consider young people's mental health issues. Young people to be to be invited to attend the meeting	Heather Wilson / Jonathan Hayes / Bradford District Care Foundation Trust	Referral from the meeting of Children's Services OSC of 12 April 2016 and resolution of the Health and Social Care OSC of 4 Feb 2016
2) Transitions	This issue was raised as part of the Committee's previous discussion of the Adult and Community Services Transformation Programmes Update	Mairead O'Donnell	Minutes of 10 Dec 2015
Thursday, 17th November 2016 at City Hall, Bradford Chair's briefing 02/11/2016. Secretariat deadline 04/11/2016			
1) Joint health / social care learning disabilities services	Update on the improvement plan	Lyn Sowray / NHS	resolution of 5 March 2015

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 8th December 2016 at City Hall, Bradford.			
Chair's briefing 22/11/2016. Secretariat deadline 25/11/2016			
1) Consideration of policies relating to removal Of Obstruction on the highway	Executive resolved that: Subject to the performance of this trial in addressing the concerns of disabled user groups, a further report be presented to the Health and Social Care Overview & Scrutiny Committee to review the findings of the trial and make recommendations as to any amendment to the scope of the zero tolerance policy following the initial trial period. Report to include consideration of the referral from Council of petitions in support of A boards in Saltaire and Ilkley	Richard Gelder	Exec resolution of 13 Oct 2015 and referral from Council of 12 July 2016 of petitions in support of A boards in Saltaire and Ilkley
2) Bradford District dementia strategy and action plan update	Update	Andrew O'Shaughnessy	resolution of 8 Oct 2015
Thursday, 26th January 2017 at City Hall, Bradford.			
Chair's briefing 10/01/2017. Secretariat deadline 13/01/2017.			
1) Budget and financial outlook	Budget	Wendy Gregory	
Thursday, 9th February 2017 at City Hall, Bradford.			
Chair's briefing 25/01/2017. Secretariat deadline 27/01/2017.			
1) Community mental health services	Report to include information on pressures on the service and the outcomes of the review looking at recovery and early intervention.	Mark Trewin / Debra Gilderdale	Resolution of 4 Feb 2016
2) Access to primary medical (GP) services in Bradford	Update including on Pharmacy First, innovative workforce initiatives and the standard access offer to patients	Karen Stothers	resolution of 4 Feb 2016
3) Access to primary medical (GP) services in Airedale, Wharfedale and Craven	Update	Lynne Hollingsworth	resolution of 4 Feb 2016
4) Accessible Information Standard	Details to be confirmed	Alec Porter	

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 2nd March 2017 at City Hall, Bradford. **Chair's briefing 15/02/2017. Secretariat deadline 17/02/2017.**			
0) Items to be scheduled			
Thursday, 23rd March 2017 at City Hall, Bradford. **Chair's briefing 08/03/2017. Secretariat deadline 10/03/2017**.			
1) Care Quality Commission	12 month update on inspection activity in the District	Rachel Bowes	resolution of 3 March 2016
2) Respiratory Health in Bradford and Airedale	Report to cover the high level areas outlined in the 'Bradford Breathing Better' programme and to include an update on self care	Andrew O'Shaughnessy	resolution of 3 March 2016
3) Great Places to Grow Old programme	Update	Lyn Sowray	resolution of 3 March 2016
4) Update on the progress made by Airedale and partners enhanced health in care homes Vanguard	Update	Helen Bourner	resoultion of 24 March 2016
Thursday, 6th April 2017 at City Hall, Bradford. **Chair's briefing 22/03/2017. Secretariat deadline 24/03/2017**			
0) Items to be scheduled			

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Democratic Services - Overview and Scrutiny
Scrutiny Committees Forward Plan
Unscheduled Items

Health and Social Care O&S Committee

	Agenda item	Item description	Author	Management comments
0	111 service / out of hours primary care	Update on performance and previous resolution around tagging of patient notes and promotion	Commissioners (Greater Huddersfield CCG)	
0	Independent Complaints Advocacy Team (ICAT) Bradford & District	Annual update	Andrea Beever	
0	CCG/Council joint 5 year mental health strategy	Draft strategy for consultation	Mick James	
0	Diabetes	Details to be confirmed	Public health / CCGs	
0	Oral and Maxillofacial Services in Bradford District	Update on the position regarding: (i) The sustainability of the on-call rota for out-of-hours / emergency cover. (ii) The sustainability of the OMFS head and neck cancer service.	Donna Thompson, BTHFT	
0	Domiciliary Care	See resolution of 21 Jan 2016	Bernard Lanigan	

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