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A

Social Services, Housing and Public Health Policy Overview Committee

Date: **WEDNESDAY, 22 APRIL 2015**

Time: **7.00 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Councillors on the Committee

Wayne Bridges (Chairman)
Teji Barnes (Vice-Chairman)
Peter Davis
Jas Dhot
Beulah East (Labour Lead)
Ian Edwards
Becky Haggar
John Oswell
Shehryar Wallana

Co-Opted Member

Mary O 'Connor

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Putting our residents first

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SOCIAL SERVICES, HOUSING & PUBLIC HEALTH

To perform the policy overview role outlined above in relation to the following matters:

1. Adult Social Care
2. Older People's Services
3. Care and support for people with physical disabilities, mental health problems and learning difficulties
4. Asylum Seekers
5. Local Authority Public Health services
6. Encouraging a fit and healthy lifestyle
7. Health Control Unit, Heathrow
8. Encouraging home ownership
9. Social and supported housing provision for local residents
10. Homelessness and housing needs
11. Home energy conservation
12. National Welfare and Benefits changes

Agenda

CHAIRMAN'S ANNOUNCEMENTS

1	Apologies for Absence and to report the presence of any substitute Members	
2	Declarations of Interest in matters coming before this meeting	
3	To receive the minutes of the meeting held on 26 March 2015	1 - 6
4	To confirm that the items of business marked in Part I will be considered in Public and that the items marked Part II will be considered in Private	
5	Report on Hillingdon's Better Care Fund Plan	7 - 20
6	Review of Adult Community Mental Health Services - Update on Review Recommendations and Further Service Development Progress	21 - 28
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Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

26 March 2015

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Wayne Bridges Teji Barnes Peter Curling Peter Davis Beulah East Ian Edwards Becky Haggar John Oswell Shehryar Wallana Mary O'Connor **Officers Present**: Rod Smith, Service Manager - Tenancy Services John Higgins, Head of Safeguarding Sharon Daye, Consultant in Public Health Charles Francis, Democratic Services	
	APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS *(Agenda Item 1)* Apologies for absence were received from Cllr Dhot. Cllr Curling acted as substitute.	
	DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING *(Agenda Item 2)* None.	
	TO RECEIVE THE MINUTES OF THE MEETING HELD ON 24 FEBRUARY 2014 *(Agenda Item 3)* Were agreed as an accurate record subject to the following amendments. That the attendance be changed to read: Cllr Lakmana and Cllr Khatra were not present but Cllr Dhot and Cllr Oswell were.	
	TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED IN PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE *(Agenda Item 4)* All the items were considered in Part 1.	

REVIEW OF THE CAUSES OF TENANCY FAILURE AND HOW IT CAN BE PREVENTED - UPDATE REPORT

The Service Manager - Tenancy Services introduced the report which provided an update on the progress made by Officers since the last report which was received in October 2014.

Officers explained that new ways of working had created a specialist tenancy sustainment function over and above that delivered as an integral part of the tenancy management function. The sustainment team was now central to supporting the objectives of a number of housing teams across the 'housing specialist' and 'tenancy management' services.

The Committee learnt that underpinning the entire 'end to end' process was the adoption of a risk-based approach to the management of all tenancy types. Central to this approach was:

- The initial and ongoing assessment of risk.
- A more tailored approach to the management of the tenancy which is person centred.
- The adoption of a planned [risk-based] approach to the management of the tenancy.
- The use of annual 'tenancy checks' alongside 'new tenant visits' and 'probationary tenancy visits' as a minimum.
- Drawing in more specialist resources where required.
- Recording planned and unplanned 'tenancy events' in a single 'living plan' [the Tenancy Management Plan] during the life-time of the tenancy which is held on Civica.

Officers confirmed that a risk based approach to the management of successful tenancies ensured the Council intervened at an early stage to help 'at-risk tenants' retain a secure home while meeting the responsibilities of their tenancy agreement. This approach also took account of people moving in and out of vulnerability during the lifetime of their tenancy and in response to certain 'trigger events' e.g. bereavement, relationship breakdown, ill-health and loss of employment. Therefore, contact with the tenant and the ongoing assessment and management of risk were central to the mitigation of tenancy failure.

Officers explained that all new tenants would receive a 'new tenant visit' within 4 weeks of tenancy commencement. This important meeting would fulfil a number of functions including, the establishment of the landlord and tenant relationship moving forward and it would also be the first occasion for the Housing Officer to 'assess' the tenant's needs and requirements for any support to effectively sustain the tenancy.

In addition to assessing the tenant and identifying any unmet needs, the Committee learnt that the completion a new tenant visit checklist was an opportunity to share a number of key messages with the

tenant. Working through the new tenant visit form and using the checklist approach, it was possible for the Housing Officer to identify 'risks' and support 'gaps' which needed to be picked up as an integral part of developing the 'tenancy management plan'.

As part of the new tenant visit process, all new tenants would be assessed as either 'low', 'medium' or 'high' risk of tenancy failure. This risk rating tool could then be used to help formulate the content of the plan and recognise the impact of a range of 'trigger incidents'.

The Committee heard that a more person centred approach to the management of a tenancy required the Housing Officer to consider a number of factors at the start of the tenancy. These factors were considered critical to enable the effective assessment and support of vulnerable households. During the course of the tenancy it would be necessary to re-assess the tenant in recognition that people moved in and out of vulnerability and or are disproportionally affected by life events which could put their tenancy at risk.

The Committee heard that the following core areas were seen as critical to the adoption of a risk-based approach to the management of tenancies:

- Managing the tenancy and accommodation.
- Self-care and living skills.
- Managing money and personal administration.
- Social networks and relationships.
- Drug and alcohol misuse.
- Physical health.
- Emotional and mental health.
- Meaningful use of time.
- Offending.
- Motivation and taking responsibility.

To improve performance, Officers explained that it was essential to ensure appropriate support was in place to ensure that vulnerable residents were able to comply with their tenancy obligations. To monitor progress, a range of performance indicators had been developed to demonstrate the value of the service and positively influence behaviours within the staff group.

- **%Tenancy management plans completed within 6 weeks of tenancy commencement** [this is about 'front loading' work at the start of the tenancy which culminates in the production and completion of a tailored approach to managing the tenancy]
- **Number of Tenancies ending within the first 12 months** - [Testing the Council's work on 'sustainment' and ensuring that tenants progress through their Probationary period]
- **Numbers of tenancies extended / reasons** - [Ensuring Officers make effective use of the probationary tenancy framework to manage risk and address breaches]
- **Number of Tenancy management interventions completed / outcomes** - [Focus on the work undertaken to resolve breaches and ensure tenancies are 'successful']

- **Numbers and outcomes from annual 'tenancy checks'** - [Capturing the value of seeing people in their own homes and the extent and nature of outcomes / follow up actions]
- **Outcomes of tenancy reviews** - [To show how the Council's policy on introducing a fixed tenancy policy is working i.e. numbers 'moving on']
- **Number of cases / time U&O cases are running where the review outcome is that the tenant cannot stay in their existing property** - [Measure of how slick / swift the process is to match people to suitable alternative property so that their existing property can be relet in line with the allocations policy]

Summarising the performance as at February 2015, the Committee noted that:

- 258 Tenancy management plans had been completed - all within 6 weeks of tenancy commencement.
- 3 Tenancies had ended in the first 12 months (Given that the number of re-lets exceeds 400 each year, a total of 3 tenancies ending within the first 12 months was extremely positive).
- 13 Probationary Tenancies had been extended.
- There had been 334 'tenancy management interventions'.
- 631 'Tenancy checks' completed.

The report summarised the role of Housing Support Officers and the outcomes of the referral process. Officers concluded by highlighting what the next steps would be taken to enhance tenancy sustainment.

The Committee noted that the transformation process in respect of tenancy management and tenancy sustainment was still ongoing. Managers were looking to maximise the value of delivering housing related support on a tenure neutral basis to minimise the extent of tenancy failure. Officers explained that this would incorporate the need to ensure effective approaches to joint working and problem solving in addition to shared use of information.

Key areas of further work included:

- Further Civica development work, using the work flow processes already developed, to extract and automate the production of management information and performance reports from Civica.
- From February 2015 Support Workers had been working closely with colleagues in the Lettings Service to ensure that they attended new tenant 'sign-ups'.
- Developing the role of Housing Officers with regards to risk assessment and risk management in the context of delivering tenancy management services across a range of tenancy types
- Addressing the implications of the Care Act.
- Welfare Reform and the introduction of Universal Credit.

The Committee welcomed the significant progress which had been made since October 2014.

Commenting on the introduction of Universal Credit, the Committee noted there might be issues with rent arrears going forward. In

	response, Officers confirmed that the real challenge would be managing the spike in the first 3 months and to reduce this as much as possible. Noting the timing of tenancy visits, Members asked about the rationale for this. Officers reported that undertaking this visit too early i.e. before 4 weeks had elapsed might not give the tenant sufficient time to 'settle in' whilst completing the visit after 4 weeks might be 'too late' in terms of maximising the potential from 'early intervention' if the tenant had underlying unmet needs which would impact upon their ability to manage their tenancy and live independently. Officers were asked whether adequate provision was in place to assist vulnerable tenants, especially those with mental health issues. The Committee were assured to learn that the added flexibility of the new ways of working meant links were in place between services. In addition, it was noted that the tailored approach and tenancy management plans meant that the most vulnerable could be visited regularly at the start of their tenancy. In response to a question related to the increased use of the Private Rented Sector(PRS), Officers confirmed that the Council was running a PRS leaving scheme to reduce the number of void properties as well as increasing the amount of rental income it could generate. As a general closing remark, Officers commented that effective tenancy sustainment focused on the right skill sets and getting the right people in place to intervene at an appropriate point to assist tenants. **Resolved -** **1. That the report be noted**	
50.	**MAJOR REVIEWS IN 2014/15 - DRAFT FINAL REPORT** Officers introduced the draft final report and explained this summarised the findings of the witness session which had been held on 24 February 2015. The report and recommendations were agreed subject the following amendments: 1. That reference be made to the lack of an over arching dental strategy in paragraph 23 of the report. 2. That the NICE recommendations, be included as an appendix to the report to Cabinet. **Resolved -** **1. That subject to the amendments listed above, the report and recommendations be agreed.** **2. That the report be circulated to the Chairman and Labour Lead for agreement outside the meeting.** **3. That the report be considered at April / May 2015 Cabinet.**	Democratic Services

	FORWARD PLAN *(Agenda Item 9)* The Committee considered the latest version of the Forward Plan. **Resolved –** **1. That the report be noted.**	**Action by**
	WORK PROGRAMME *(Agenda Item 10)* Reference was made to the work programme and timetable of meetings. **Resolved** **1. The Committee noted the Work Programme 2013/14.**	**Action by**
	The meeting, which commenced at 7.00 pm, closed at 7:56 pm.	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Charles Francis on 01895 556454 . Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

REPORT ON HILLINGDON'S BETTER CARE FUND PLAN

Contact Officer: Gary Collier
Contact Number: 01895 250730

REASON FOR ITEM

This report is intended to make Policy Overview Committee aware of the Better Care Fund Plan and what this means for residents, the Council and its partnership with the local NHS.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To note the contents of the report.

2. To question officers on its content.

INFORMATION

Background

1. The Better Care Fund (BCF) is a national initiative intended to deliver integration between health and social care in order to improve outcomes for residents. The key objectives of this initiative are that:

- Individuals with care needs receive more joined up care
- That the independence of residents is maximised or maintained through better prevention and early intervention
- Scarce resources are used more effectively
- There are joint plans with agreed priorities to achieve a greater positive impact for local people.

2. The BCF is a mechanism that is being used by the Government to implement the new integration duty under the 2014 Care Act, which came into effect on the 1st April 2015. The BCF does not provide new money for Hillingdon; it is about creating efficiencies through integration to ensure that existing funding is used more effectively.

3. Both the Council and Hillingdon Clinical Commissioning Group (HCCG) agreed that they would keep the level of investment in Hillingdon's first BCF Plan to the minimum permitted, £17,991k. This was in order to minimise the risk to both organisations.

4. The plan has gone through several iterations during 2014/15 and the final plan was agreed by the Chairman of the Health and Wellbeing Board and the Chairman of HCCG's Governing Body on the 9th January 2015. This followed some changes being made as a result of feedback from the National Consistency Assurance Review (NCAR) team, which was the team responsible for assessing the submitted plans on behalf of the NHS Commissioning Board, known as NHS England (NHSE). Hillingdon's plan was finally approved on the 6th February 2015 without any conditions.

5. All of the BCF plan documents can be accessed on the Council's website using the following link http://www.hillingdon.gov.uk/article/28647/Introducing-the-Better-Care-Fund.

Hillingdon's BCF Plan Summarised

6. The focus of Hillingdon's plan is on the 65 and over population, which is a reflection of the increasing demand placed on local authority and NHS services by an ageing population. For example, the population of people aged 65 and over is projected to increase by 13% from 36,200 in 2015 to 38,600 by 2020 and the population of people aged 85 and over is projected to increase by 16% in the same period to 6,300. It also reflects the importance for the wellbeing and independence of older residents of more joined up models of care being established.

7. **Appendix 1** provides the Committee with more information about the profile of Hillingdon's older people population.

8. The 2015/16 BCF Plan, which is for one year from the 1st April 2015 until the 31st March 2016, is intended as a prototype to give both the CCG and the Council experience of a much closer working relationship. The plan comprises of 7 schemes and these are summarised in Table 1 below:

Table 1: Better Care Fund Schemes Summary	
Scheme	**Scheme Aim**
Scheme 1: Early identification of people susceptible to falls, dementia and/or social isolation.	• Reduce the movement of residents from lower tiers of risk into higher tiers through education, training and early proactive intervention.
Scheme 2: Better care for people at the end of their life.	• To realign and better integrate the services provided to people towards the end of their life. • To develop the ethos of 'a good death' for people and for their family and carers.
Scheme 3: Rapid response and joined up intermediate care.	• Maximising the independence of residents through community based crisis response and intermediate care interventions.
Scheme 4: Seven day working.	• To improve quality and patient safety by reducing inconsistent care provision by: a) Enabling discharge from acute trust seven days a week; and b) Enabling access to community support seven days a week, thereby preventing unnecessary emergency department attendance and hospital admission.
Scheme 5: Review and realignment	• To ensure that community based

of community services to emerging GP networks.	resources work as effectively and efficiently as possible within primary care for the benefit of patients.
Scheme 6: Care home initiative.	• To reduce avoidable emergency admissions from residential and nursing homes resulting from a health care exacerbation**.**
Scheme 7: Care Act Implementation.	• To implement the following aspects of new duties under the Care Act, primarily in respect of Carers: a) increasing preventative services; b) developing integration and partnerships with other bodies; c) providing quality information, advice and advocacy to residents; d) ensuring market oversight and diversity of provision; and **e)** strengthening the approach to safeguarding adults.

Integrated IT Systems

9. The development of integrated IT systems across health and social care is a key enabler to the effective delivery of many of the above schemes and to achieving the position where residents with care needs only have to tell their story once. A pan-Hillingdon IT Project Board involving representatives from the Council, CCG and local health providers is working on this. The ultimate goal is to have systems that enable partners involved in a resident's care (including third sector) to update their care plan to reflect their respective interventions. Technological and information governance complexities mean that this goal could take up to three years to achieve.

10. However, by March 2016 health partners should also be able to access the Council's care management database called Protocol to identify whether an individual is known to Adult Social Care and, if so, the content of their care package. In addition, Adult Social Care, Hillingdon Hospital and community health professionals should be able to access GP patient records in real time to identify diagnoses, treatments and medication information. The sharing of any of this information will be subject to consent being provided by residents.

Links to Integration in Hillingdon Programme

11. There are strong links between the BCF plan and the wider Integration in Hillingdon Programme. This programme was formerly known as Whole Systems Integrated Care (WSIC) and is based on the premise that the GP should be the lead professional responsible for coordinating an individual's care. It is part of a national initiative intended to develop a more proactive approach to increasing need that is anticipatory, e.g. people's needs are identified at an earlier stage and timely interventions made available in order to prevent a deterioration in need resulting in an avoidable loss of independence requiring more significant (and more costly) interventions by the statutory agencies. The links between the BCF plan and the Integration in Hillingdon programme can be seen in the following areas:

- ***Care planning and care coordination*** - Active care planning for older people with one or more long-term conditions is intended to better support residents to manage their own conditions. This includes people with lower needs who may not at this stage meet the eligibility criteria for social care but where early interventions, particularly by the third sector, can prevent or at least delay this occurring.

- ***Multi-disciplinary Teams (MDTs)*** - These comprise of professionals across health providers, e.g. GPs, Central and North West London Foundation Trust (CNWL) and The Hillingdon Hospital Foundation Trust (THH) and Adult Social Care. They consider the needs of older people with complex needs referred by partner agencies or identified as a result of the use of a risk stratification tool.

- ***Early identification*** - The Integration in Hillingdon model of care proposes a model of support for people with lower levels of need that would be provided by the third sector. The BCF scheme 1 would lead to referrals of older people previously unknown to services to ensure that they have timely access to the right levels of support to address their needs.

- **Access to information, advice and advocacy** - Local authority duties under the Care Act about access to these services and Hillingdon's response with the development of the Connect to Support resident portal provides an opportunity to bring a range of services together in one place that can be accessed by all Hillingdon residents regardless of whether their needs are health or social care-related. The portal also includes information about social events and activities.

- **Supporting carers** - New responsibilities towards the support of carers under the Care Act is reflected in the BCF and is critical to supporting the independence of older people with long-term conditions in the community.

12. A pilot based in 6 GP practices in the north of the borough will be starting in April 2015 with the intention of rolling out the new model later in the year.

Performance Metrics

13. There are six key performance indicators within Hillingdon's BCF plan that we are required to report to NHS England on our performance and these are summarised in table 2 below.

KPI Summary	Target
1. Emergency admissions - Reduction in emergency admissions per 100,000 65 and over population.	Reduction of 388 emergency admissions.
2. Residential admissions - Reduction in permanent admissions of older people (65 and over population) to residential and nursing care homes per 100,000 population.	Up to 104 admissions during 2015/16. (Lower is better)
3. Reablement - Proportion of older people (65 and over population) who were still at home 91 days after discharge from hospital into reablement.	95.4% (Higher is better)
4. Delayed transfer of care (DTOC) - Delayed transfers of care (delayed days) from hospital per 100,000 (aged 18 and over).	Reduction of 18.2% or 737 days
5. Service user experience - In the past year, how easy or difficult it has been to find information and advice about services or benefits.	2% increase on 2013/14 performance in people answering question who found it easy to find information and advice. (Adult Social Care Outcomes Framework Survey)
6. Local metric: Social care-related quality of life - Questions about 8 quality of life issues covering control over daily life, personal care, food and nutrition, accommodation, safety, social participation, how people spend their time and dignity.	1% increase on 2013/14 performance of people answering question who have had their needs met. (Adult Social Care Outcomes Framework Survey)

14. The emergency admissions (also known as non-elective admissions or NEL) KPI has a performance funding element attached to it, which for Hillingdon is £660k. As this sum has already been included within the plan to cover the cost of pre-existing NHS contract commitments, achieving the target will not make new money available to the Health and Wellbeing Board to enhance any aspects of the plan. If the target is not achieved, then this will be released by HCCG to cover the costs of emergency admissions.

15. **Appendix 2** sets out other success measures for individual schemes that will be reported to the HWBB but will not be reported to NHSE.

Financial Arrangements and the Section 75 Agreement

16. Table 3 below summarises the key components of the BCF financial plan for 2015/16. A more detailed breakdown is provided in **Appendix 3**.

Table 3: BCF Plan Agreed Funding Components 2015/16	
Component	**£000's**
NHS Commissioned Services Funding	9,372
Emergency admission saving/Performance Fund	660
Care Act New Burdens Funding	838
Protecting Social Care Funding	7,121
Overall BCF Total funding	**17,991**

17. £15,642k of the funding for Hillingdon's BCF plan comes from NHS England. Using powers under the 2006 National Health Service Act (NHS Act), NHSE makes the release of this money conditional on a pooled budget being established between the Council and HCCG under an agreement established in accordance with section 75 (s.75) of the NHS Act. It is also a requirement that the remaining £2,349k of the £17,991k, which is a capital grant (Disabled Facilities Grant and Social Care Capital Grant) provided directly to the Council by the Department of Health be included within the pooled budget.

Pooled Budgets Explained

Pooled budgets enable local authorities and health bodies like clinical commissioning groups and NHS foundation trusts to put funding into a single pot. The effect of this is that the different funding streams lose their separate identities and the money is used to deliver the goals and objectives agreed by the organisations putting the money into the pooled fund.

18. It has been Government practice since 2010 to passport money from the NHS under section 256 of the National Health Service Act, 2006, to the Council to protect adult social care services. In 2014/15 the value of the protecting adult social care funding was £4,772k and in 2015/16 this funding and the capital funding of £2,349k is included in the BCF. In addition, there is a contribution of £838k to support the implementation of the Council's responsibilities under the Care Act.

19. The funding retained by HCCG to commission services is £9,372k together with the performance payment of £660k arising from the nationally set target to reduce emergency admissions of the 65 and over population previously mentioned. The majority of this funding, as can be seen in **Appendix 2**, is committed to existing contract arrangements.

20. The s.75 agreement, which was approved by Cabinet and the CCG's Governing Body at their respective meetings in March 2015, gives legal effect to the plan and its financial arrangements. For 2015/16 this will be equivalent to a joint bank account, which means that no contracts will transfer from the CCG to the Council and that the 2014/15 contract management arrangements will continue in 2015/16.

Governance and Performance Management

21. The delivery of the plan will be overseen by the Health and Wellbeing Board (HWBB), which will receive quarterly performance reports. An officer group comprising of the Council's Corporate Director of Finance, Corporate Director of Adult Social Care, the Chief Operating Officer and Chief Finance Officer of HCCG and also the Council's Head of Policy and Partnerships will performance manage the plan's delivery. A monthly Delivery Forum including providers and Healthwatch amongst its membership will address operational issues that may arise during 2015/16.

22. It is already possible to see the benefits of the much closer working that is taking place between partners across health, social care and the third sector. For example, there was a drop of 7% in the number of emergency admissions to hospital from care homes in December at a time when this would be expected to rise. In addition, closer working between agencies has seen a speedier discharge of patients from the emergency department at Hillingdon Hospital and the Hawthorn Intermediate Care Unit (HICU) back into the community.

Planning for 2016/17 and Beyond

23. All the political parties have given a commitment to further integration between health and social care and consideration is already being given locally to what this may look like from 2016/17 should the new government wish to continue with the BCF or something like it. For example, a future BCF plan could include adult mental health and/or learning disabilities. Approval of any future plan would be subject to approval by the Health and Wellbeing Board, the Council's Cabinet and HCCG's Governing Body.

Engagement and Consultation

24. A plan is being developed to make stakeholders aware of the BCF plan and also to involve them in developing plans for 2016/17 and beyond once the results of the general election are known and there is clarity about the future shape of integration.

Conclusions

25. The BCF is a prototype for integration between health and social care in Hillingdon that will enable the Council and HCCG to build a much closer working relationship. The experience of developing the BCF plan facilitated a much better working relationship amongst professionals across partner organisations and this has already produced positive results, e.g. reduced admissions from care homes and accelerated discharges from Hillingdon Hospital. It has also resulted in a greater understanding of the critical preventative role of the third sector.

26. The BCF schemes represent work that was already in progress or that was required to be undertaken. This means that the schemes are at different levels of development. The experience so far provides a positive foundation both for accelerating progress with some of the less developed schemes but also increasing the ambition of integration plans post April 2016

Appendix 1

Hillingdon's 65 + Population Profile to 2020: Key Issues

Demographics

1. Ageing population.

The current 65 and over population is projected to increase by 13% from 36,200 in 2015 to 38,600 by 2020.

2. Large increase in the number of 85 and over population.

Projections suggest that between 2015 and 2020 there will be a 16% increase in the number of people aged 85 and over from 5,300 to 6,300.

3. Limited ethnic diversity in older people population

Ethnic diversity in Hillingdon is concentrated in the younger age groups. For each of the five year age band for people aged 65 and over there is an increasing proportion of White British. This is expected to change over time as the general population ages. The 65 and over population living in the Ruislip and Northwood locality is the least diverse part of the borough, with only 12.8% of people being from ethnic minority communities.

4. Older population concentrated in the north of the borough

The 2011 census shows that 46% of the 65 to 84 age group and 51% of the 85 + population live in the Ruislip and Northwood locality.

Tenure

5. High proportion of older population own their home.

The 2011 census showed that 77% of older people households owned their own home and that of these 89% owned outright without a mortgage. This means that a high proportion of Hillingdon's older population are likely to be self-funders if and when they develop care needs.

Emergency Hospital Admissions

6. Highest spend on emergency hospital admissions is on 75 and over population.

70% of the total cost of emergency admissions is attributable to the 75 and over population. The 65 and over population account for 41% of the total number of emergency admissions.

7. Falls and fractures a major cause of emergency hospital admissions

17% of emergency admissions of Hillingdon's 65 and over population in 2013/14 were related to falls. 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury, e.g. neck of femur fracture. In 2013/14 277 patients aged 65 years or over were admitted to THH with a fractured neck of femur as a result of a fall. The average cost of the acute inpatient stay was £6.1k.

Long-term Conditions

8. Increase in the number of people living with dementia.

Dementia is predominantly a condition related to old age. Projections suggest that this will increase by 12% from 2,670 in 2014 to 3,037 in 2020.

9. Increase in the number of people with learning disabilities living into old age.

The number of people with learning disabilities aged 65 and over is expected to increase by 9% between 2014 and 2020 to 860. This is particularly important because of the increased susceptibility of some people with learning disabilities, e.g. people living with Down's syndrome, to develop dementia after the age of about 45.

10. Increase in the number of older people who are obese.

The number of the 65 and over population with a body mass index (BMI) of 30+ is projected to increase by 8% between 2014 and 2020 from 9,864 to 10,626. Obesity is a contributory factor in the development of diabetes.

11. Increase in the number of older people living with diabetes.

The number of the 65 and over population living with types 1 and 2 diabetes is projected to increase by 8% between 2014 and 2020 from 47,702 to 4,966.

Risk Factors

12. High proportion of older people who live alone.

31% of older people live alone, which is important because of the links between living alone and being socially isolated. Although living alone does not automatically lead to social isolation, it is one of the risk factors that can lead to loneliness and depression, which can be contributing factors in the development of dementia and deterioration in physical health.

Adult Social Care

13. Older people represent the largest group of people supported by Adult Social Care

In 2013/14 older people represented 71% (3,020) of the total number of people supported by Adult Social Care (4,245). Addressing the care needs of older people accounted for 46% (£40.3m) of the gross Adult Social Care spend in 2013/14 (£87.2m).

(Information sources: Joint Strategic Needs Assessment (JSNA), Health and Social Care Information Centre (HSCIC) and NHSE)

Appendix 2

BCF Schemes Success Measures

Scheme	Success Measures
***Scheme 1*: Proactive early identification of people with susceptibility to falls, dementia and social isolation.**	a) Falls treatment and prevention services continuing from 2014/15 to deliver a 10% reduction in falls related emergency admissions to acute care during 2015/16 (a reduction of 175) b) Increase in number of referrals to voluntary and community organisations. c) Satisfaction rates with third sector provided services. d) Training programme evaluation. e) Increase in dementia diagnosis rates (10 more people with a dementia diagnosis).
***Scheme 2*: Better care for people at the end of their life.**	a) Increased coordination of care between agencies; b) Utilisation of the Co-ordinate my Care (CMC) data base/care planning tool across agencies; c) 80% of people at end of life with advanced care plans on CMC. d) Establishing a baseline of people aged 65 + on CMC dying in their preferred place of care.
***Scheme 3*: Rapid response and joined up intermediate care .**	a) Identification of Carers. b) Carers being referred for a carer's assessment. c) 50% of service users completing reablement in less than 4 weeks. d) 80% of service users take up at least the minimum telecare offer. e) Service users with a self-managed personal budget. f) A readmission rate during a period of reablement of 19.5% or less.
***Scheme 4*: Seven day working initiative.**	a) Parity in mortality rates across the week, with a whole week mortality rate to be below the London average. The baseline to be agreed in Q4 2014/15. b) The achievement of a readmission rate of 19.5% or less.

	c) A reduction in the variation in service provision between weekdays and weekends. d) Improvements in patient experience of A & E services.
***Scheme 5*: Review and realignment of community services to emerging GP networks.**	a) An increase in the number of people with long-term conditions with an active support plan. b) People identified as a Carer being referred for a Carer's assessment. c) Carers being sign-posted to information and advice.
***Scheme 6*: Care home initiative.**	a) Establishing a baseline for the number of 65 + population dying within first week of admission to hospital from a care home and a setting a reduction target. b) Effective engagement of care home providers. c) Increased use of advocacy where there are complaints about service provision and/or safeguarding issues.
***Scheme 7*: Care Act Implementation.**	a) Carers will have access to effective information, advice and advocacy services. b) A broader range of people caring for another adult having access to a timely assessment of their health and social needs. c) The needs of carers identified from an assessment of need will be met. d) The care and support market will be managed to ensure that there is a range of quality providers available. e) Statutory safeguarding arrangements to address abuse of adults will be put in place. f) A more coordinated approach between the Council and the CCG to the management of provider quality and safeguarding adults.

Appendix 3

Planned Contract/Service Spend Breakdown

Contract/Expenditure	Provider	Value (£,000)	Owner
Scheme 1: Proactive early identification of people with susceptibility to falls, dementia and social isolation			
a) Falls Prevention Service	Age UK	130	HCCG
b) Primary Care	Network	50	HCCG
	SCHEME TOTAL	**180**	
Scheme 2: Better care for people at the end of their life			
Community	CNWL	100	HCCG
	SCHEME TOTAL	**100**	
Scheme 3: Rapid response and joined up intermediate care			
a) Rapid Response	CNWL	1,660	HCCG
b) Hawthorn Intermediate Care Unit	CNWL	1,354	HCCG
c) Community Rehab	CNWL	807	HCCG
d) Pressure relieving mattresses	Talley Group	278	HCCG
	CCG TOTAL	4,099	
a) Spot purchased intermediate care beds	Various P & V	341	LBH
b) Cottesmore Reablement Flats	Paradigm Housing Group	38	LBH
c) Hospital Social Workers	LBH	250	LBH
d) Packages of care: maintaining eligibility criteria	Various P & V	57	LBH
	LBH TOTAL	**686**	
	SCHEME TOTAL	**4,785**	
Scheme 4: Seven Day Working			
a) Reablement Team	LBH	654	LBH
b) Mental Health Social Workers	LBH	100	LBH
	SCHEME TOTAL	**754**	
Scheme 5: Review and realignment of community services to emerging GP networks			
a) Community equipment	Medequip	664	HCCG
b) Continence service	CNWL	493	HCCG
c) Community matrons	CNWL	574	HCCG
d) District Nursing	CNWL	3,092	HCCG
e) Twilight Service	CNWL	158	HCCG
f) Tissue Viability	CNWL	531	HCCG

g) Care Home Prescriber	HCCG	30	HCCG
h) Care Plan coordination	Network	63	HCCG
	CCG TOTAL	5,605	
a) Community equipment	Medequip	125	LBH
b) Reablement Team	LBH	1,961	LBH
c) Telecare	LBH	682	LBH
d) Packages of Care: maintaining eligibility criteria	LBH	354	LBH
e) Care home project	LBH	150	LBH
	LBH TOTAL	**3,272**	
	SCHEME TOTAL	**8,877**	
Scheme 6: Care Home Initiative			
Community matrons	CNWL	48	HCCG
	SCHEME TOTAL	**48**	
Scheme 7: Care Act Implementation			
a) Carers' assessments and review	LBH	271	LBH
b) Services to carers (inc respite)	LBH	500	LBH
c) ICT	Shop 4 Support	50	LBH
d) Adult safeguarding	LBH	17	LBH
	SCHEME TOTAL	**838**	
CAPITAL			
a) DFG	Various P & V	1,769	LBH
b) Social Care Capital Grant	LBH	580	LBH
	TOTAL CAPITAL	**2,349**	
PROGRAMME MANAGEMENT			
Project Manager	LBH	60	LBH
PROGRAMME MANAGEMENT TOTAL		**60**	
CONTRIBUTION SUMMARY			
HCCG CONTRIBUTION		**10,032**	
LBH CONTRIBUTION		**7,959**	
	BCF TOTAL	**17,991**	

REVIEW OF ADULT COMMUNITY MENTAL HEALTH SERVICES

UPDATE ON REVIEW RECOMMENDATIONS AND FURTHER SERVICE DEVELOPMENT PROGRESS

Contact Officer: Sunny Mehmi
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REASON FOR ITEM

The Policy and Overview Committee conducted a review of mental health services in 2012/13. At its meeting in April 2014 and November 2015, the Committee expressed a wish to receive an update report on developments in Mental Health Services and in relation to performance, the Committee asked for further information to be provided in a future report on recovery rates, waiting times (to access services), crisis provision and the out of hours service. Where possible, the Committee requested for this information to be expressed as a scorecard so that progress could be clearly monitored.

INTRODUCTION

This report pulls together a range of responses from partners across the health and social care economy who have a remit in delivery Adult Mental Health services.

A joint commissioning strategy was agreed by the Council Hillingdon Clinical Commissioning Group (HCCG) in 2013. This sets out the key areas of priority for the commissioning and development of mental health services in Hillingdon. Since the joint commissioning strategy was published Public Health have undertaken a comprehensive mental health needs assessment for Hillingdon which was published in January 2015.

Hillingdon Clinical Commissioning Group (HCCG) is responsible for commissioning mental health services in the borough.

Adult Mental Health services are provided in partnership with Central and North West London NHS Foundation Trust (CNWL) who manage the social care staff on behalf of the London Borough Hillingdon through a section 75 partnership agreement.

Public Health also have a range of projects and initiatives that they delivering which promotes emotional well-being across the borough.

OPTIONS AVAILABLE TO THE COMMITTEE

1. **To note progress on the development of Adult Mental Health services in Hillingdon**

Hillingdon Mental Health Transformation Board

The implementation of the Joint commissioning Strategy is over seen by a multi stakeholder Transformation Board, which consists of HCCG, LBH (Adult Social Care and Public Health), CNWL, MIND and Healthwatch.

The Transformation Board held a priority setting meeting on the 19th February 2015 to set the agenda for the Board in 2015/16. The Board used a scoring matrix developed by Hillingdon CCG which uses a range of domains to enable priority setting for allocation of resources. These discussions were framed by key national and locally agreed priorities, as well as number of key criteria such as level of need, cost effectiveness, magnitude of benefit, patient engagement and health inequalities. Discussions were further informed by the outcome of the Mental Health Needs Assessment published in January 2015. All proposals scored high on magnitude of benefit, which was in line with the strategic priorities within the Hillingdon Mental Health strategy.
Based on these criteria and national requirements the following will form the basis of the work plan for the MH Transformation board in 2015/16.

The priorities for the Board for 2015/16 are:

1st = Child and adolescent mental health services (CAMHS) and Universal Mental Health wellbeing
3rd = Dementia Pathway
4th = Crisis Care (Adult)
5th = Primary Care Mental Health and Secondary Care Community Mental Health Services
7th = IAPT Services
8th = Perinatal Services
9th = Mental Health services for people with Learning Disabilities
10th = Reviewing supported accommodation for people with Mental Health issues

The Board will prioritise the **top 6 areas**, however, work will progress in other areas but not monitored at a strategic level.

It is proposed that in 2015/16, the Transformation Board will provide updates on progress to the Policy Overview Committee on these top 6 priority areas.

The remainder of this report gives POC an update on the development of mental health services since the last report in November 2014.

Mental Health Needs Assessment

The Mental Health Needs Assessment (MHNA) was completed in December 2014 and informed the Joint Hillingdon Mental Health Transformation Board priorities for 2015/16. The MHNA has

also been used to inform the External Services Scrutiny Committee Report *Policing and Mental Health Services* (December 2014)

Perinatal Mental Health

It is known that perinatal mental health problems (experienced by women during and after pregnancy) can have a serious impact on the health of mothers and their children both in the short and longer term.

A multiagency working group has reviewed local provision using a review carried out by Public Health of the known and expected impact of these problems in Hillingdon. They have identified significant gaps in current services for women across the whole pathway from prevention and early intervention to treatment and care of those who become ill.

Hillingdon CCG agreed funding for an interim perinatal mental health service that will be rolled out in 2015/16. The service will include Psychologist, Psychiatrist and a Community Psychiatric Nurse.A report and recommendations of the service will be completed in June 2015.

In addition, CNWL 'Talking Therapies' (IAPT) service has increased its capacity to provide more psychological services, with one of the priorities identified are women with perinatal mental health needs.

Child and adolescent mental health services (CAMHS)

Through the Children's Health Programme Partnership the HCCG and the Council have established a programme across partners and service providers. One of the work streams is *social, emotional well-being and mental health*. This group have coordinated a joint stakeholder event to refresh the work undertaken as part of the review in 2013 and develop a joint commissioning strategy and action plan.

The strategic vision is based on information from the recent JSNA in Hillingdon and is informed by the report by Hillingdon Healthwatch. The intention is to deliver a model identifying how all agencies are required to work together to ensure the holistic mental health and wellbeing needs of children and young people are met. The model will be delivered through three key principals;

1) Universal Promotion and Prevention

Prevention is viewed as an essential mechanism to minimise mental health and wellbeing problems occurring. A holistic universal prevention and promotion approach incorporates the provision of services to support positive parenting and attachment in the early years, delivering programmes to minimise risk, delivering services in and around schools, and within the community.

2) Early Help and Intervention

Taking action to tackle problems that have already emerged and will generally provided within a community setting. Services will be developed to ensure they have the knowledge, skills and competencies, and provide access to the appropriate specialist advice/consultation. Children and young people will be supported earlier to help prevent mental health issues developing.

The developed model identifies the importance of 'pathways' in the delivery of specialist CAMHS.

3) Specialist Therapeutic Intervention

Specialist mental health services will ensure that the problem are assessed in a timely way and, where appropriate, diagnosed and treated in order that the child or young person makes a swift recovery and has follow up support to prevent problems recurring. Care pathways will be developed based on good practice and that acknowledge new evidence. The joint stakeholder working group will develop an overarching three year delivery plan specifying year one priorities for delivery within each of the objective areas:

I. Universal Promotion and Prevention
II. Early help and Intervention
III. Specialist Therapeutic Intervention
IV. Emergency Assessment and Intensive Community Support/Home treatment
V. Needs of Vulnerable Groups
VI. Improved joint working including joint commissioning arrangements

Early Intervention, Mental Health Promotion and Wellbeing

The Specialist Health Promotion Team lead and LBH Communications Team have developed the 'Five Ways to Wellbeing' leaflets promoting the key messages and where in Hillingdon residents can access support and resources for their wellbeing.
2500 Five Ways to Wellbeing (FWtWB) Leaflets and posters have been printed and distributed to all Hillingdon Libraries; HAGAM; DASH and Hillingdon Carers.

The Specialist Health Promotion Team lead has developed the 'Five Ways to Wellbeing' training resource and plan and delivered this to, Job Centre Plus, Library Services across Hillingdon, Hillingdon Mind, Age UK, Com.Cafe, Community Groups, Older People's services and at Older People's Tea Dances and Wellbeing Events, below outlines the number of participants attending:

- Wellbeing Events: 348 residents
- Tea Dances: 2329 residents
- Staff Training Library Staff: 35 members of staff
- Job Centre Plus: 16 members of staff
- HAGAM: 9 members of staff

The Specialist Health Promotion Team lead is undertaking a scoping exercise to find out what local services and organisations are currently providing support for early intervention and promotion of mental health, wellbeing and physical health, across all ages.

The Specialist Health Promotion Team supported the Council's Champion for Health, Disabilities and Wellbeing to hold an Infant and Junior School Mental and Physical Health and Wellbeing Event entitled 'Looking after the whole of me' on 19th March'15. 6 schools in the south of the Borough participated, with pupils from each school presenting and performing what mental and physical health school based programmes has helped their health and wellbeing.

98% of respondents felt: *proud; inspired; want to do more for children and young people; want other schools to follow the same format; very valuable and enjoyable; showed the importance of early intervention; understand the key issues for early intervention around mental health*

Plans have been approved for 2015/16, to hold a 'Time to Change' (anti-stigma and discrimination around mental illness) public event in Hillingdon; and to hold a series of half-day training days using the 'Making Every Contact Count' workforce approach for frontline workers across the Council, NHS and the voluntary sector. The training will focus on increasing the knowledge and confidence and skills of frontline staff to address mental health issues as well as other lifestyle issues (smoking, weight management, alcohol and substance misuse).

The Specialist Health Promotion Team is planning a wider scoping exercise to identify good practice around prevention and promotion of community mental health and wellbeing, across all ages, in the borough. A stakeholder event will be held in October 2015, to align with World Mental Health Day and findings from the scoping exercise will be presented at this event.
The process of analysing Hillingdon Suicides that occurred between 2010 - 2014 is underway. This information will form part of the Hillingdon Suicide Prevention Needs Assessment, which is due in the autumn 2015.

Supported Housing

The Department funds 152 people in either residential care or supported housing.
In May 2014 the Swan House supported housing scheme opened. This has 24 flats with 24 hour staff on site and telecare support. There are six flats for people with mental health needs, the other 18 flats are for people with a learning disability. The flats have been allocated to people who were previously living in shared accommodation and were ready to move into their own flat. They have benefited from the privacy of their own front door but are still able to receive the support that they require from the on site staff team.

In March 2015, the Sessile Court supported housing scheme opened. This provides 14 modern one bedroom flats of which, 2 which could be used for people with physical disabilities. Sessile Court is a 24 hours a day scheme. Similar to Swan House, staff will provide regular support to each person in line with their support plan.

The LBH Mental Health Service Manager will continue to meet with the CNWL team to review packages of care and ensure service users are in the most appropriate setting which meets their needs. Over the period 2014/15, 28 mental health service users stepped down to less intensive placements..

Dementia Pathway

A multi-agency group has been formed and has been meeting monthly since January 2015. The group will aim to take forward development of the Dementia action plan to improve dementia services and the dementia pathway in the borough. To date the group have identified the key gaps across the pathway and which areas of work should be prioritised in 2015/16.

Approved Mental Health Practitioners (AMHP) Service

Local Authorities have a statutory duty to ensure that there are sufficient Approved Mental Health Practitioners (AMHP) available to undertake assessments under the Mental Health Act that can result in a person been detained in hospital.

In 2014 the service was centralised and additional investment made to create a permanent co ordinator role to manage the service. In addition a member of staff has been seconded to the service which provides considerable continuity and consistency in the provision of the service. In addition social workers receive improved management support in carrying out what at times can be a difficult role.

Nationally it is difficult to recruit trained AMHP's in recognition of this the borough has reviewed pay scales with comparator authorities and has agreed to offer all AMHP qualified social work posts an additional 2 increments from April 2015.

The team leader role has widened to include providing training in mental health to the Police in partnership with a Police Sergeant. This is creating a greater understanding and also better use of Mental Health law used by the Police.

The AMHP service and Children's Services have agreed a joint protocol regarding the interface between the AMHP service and the Hillingdon's Children's Multi-Agency Safeguarding Hub (MASH). The protocol outlines what and how the AMHP service will be supporting MASH with information or other safeguarding issues that arise.

The AMHP extended out of hours pilot will cease at the end of April because the funding was short term winter resilience funding and has had a marked impact in the delays in A&E for the prompt response for urgent assessments.

Urgent Care

The Business Case prepared by CNWL is under consideration by Hillingdon CCG. Delivering a clear Urgent Care Pathway and Single Point of Entry remains a CCG priority and discussions are ongoing at a Strategic level across the 5 NWL CCGs as part of the 2015/16 contracts.

Hospital Liaison

CNWL, The Hillingdon Hospital and CCG have been looking at ways to reduce the pressure on A&E from people with mental health needs.

On completion of an audit the CCG has now commissioned a Psychiatric Hospital Liaison Service at Hillingdon Hospital. This service is based on the RAID Model (Rapid Access, Intervention and Discharge), which is nationally recognised best practice for such services. The service provides psychiatric interventions and support in Accident and Emergency, input onto the general wards for those with physical as well as mental health presentations, as well as training to non-mental health trained staff in the hospital.

Shifting Settings of Care and Primary Care Mental Health services

The CCG have approved funding to support the development of a Primary Care Mental Health service. This initiative has been in development during 2014/15, two Mental Health Navigators who are employed by MIND, have been working across all Practices in the Borough supporting up to 75 clients transferring from secondary to primary care services. The operational policy has now been agreed, transitional funding approved and the team base identified. CNWL are currently in the process of recruiting Clinical staff and these should be in place by July 2015. Activity trajectories have been agreed for 2015/16.

Conclusion

This report outlines the progress to date of various mental health workstreams across Hillingdon Council, Hillingdon Clinical Commissioning Group and CNWL Foundation Trust. The work will be consolidated and programme management via the Hillingdon Mental Health Transformation Board.

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CABINET FORWARD PLAN

Contact Officer: Charles Francis
Telephone: 01895 556454

REASON FOR ITEM

The Committee is required to consider the Forward Plan and provide Cabinet with any comments it wishes to make before the decision is taken.

OPTIONS OPEN TO THE COMMITTEE

1. Decide to comment on any items coming before Cabinet

2. Decide not to comment on any items coming before Cabinet

INFORMATION

1. The Forward Plan is updated on the 15th of each month. An edited version to include only items relevant to the Committee's remit is attached below. The full version can be found on the front page of the 'Members' Desk' under 'Useful Links'.

SUGGESTED COMMITTEE ACTIVITY

1. Members decide whether to examine any of the reports listed on the Forward Plan at a future meeting.

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Ref	Decision	Further information	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Private decision?
Council Departments: RS = Residents Services CYPS =Children and Young People's Services ASCS= Adult Social Care Services AD = Administration FD= Finance									
Cabinet meeting - 23 April 2015									
31	**Award of Contract: Support Living for Adults with Learning Disabilities**	Cabinet will be requested to award care and support contracts for a number of Supported Living Schemes within Hillingdon.	Various		Cllr Philip Corthorne	ASCS - Tony Zaman / FD - Richard Robbins	All key relevant stakeholders, inc Service Users, Providers and Internal Teams		Private (3)
33	**Carers Strategy 2015-18**	Cabinet will be asked to approve a refreshed Carers Strategy on behalf of the Council, with respective approval from the NHS by the Hillingdon CCG Board. The ongoing delivery of the Strategy will then be monitored via the Health & Wellbeing Board, as one of the actions within the Health and Wellbeing Strategy.	All		Cllr Philip Corthorne	AD - Vicky Trott / ASCS - John Higgins	Carers and stakeholders		
Cabinet Member Decisions - April 2015									
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of decisions each month on standard items - details of these standard items are listed at the end of the Forward Plan.	Various		All	AD - Democratic Services	Various		

Ref	Decision	Further information	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Private decision?

Council Departments: RS = Residents Services CYPS =Children and Young People's Services ASCS= Adult Social Care Services AD = Administration FD= Finance

Cabinet meeting - 21 May 2015

SI	**Reports from Policy Overview & Scrutiny Committees**	Major Policy Review recommendations for consideration by the Cabinet as and when completed.	TBC		as appropriate	AD - Democratic Services			

Cabinet Member Decisions - May 2015

SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of decisions each month on standard items - details of these standard items are listed at the end of the Forward Plan.	Various		All	AD - Democratic Services	Various		

WORK PROGRAMME 2014/15

Contact Officer: Charles Francis
Telephone: 01895 556454

REASON FOR ITEM

This report is to enable the Committee to review meeting dates and forward plans. This is a standard item at the end of the agenda.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To confirm dates for meetings

2. To make suggestions for future working practices and/or reviews.

INFORMATION

All meetings to start at 7.00pm

Meetings	Room
3 July 2014	CR 6
31 July 2014	CR 5
9 September 2014	CR 6
7 October 2014	CR 6
5 November 2014	CR 5
21 January 2015	CR 6
24 February 2015	CR 6
26 March 2015	CR 5
22 April 2015	CR 5

2014/15 - DRAFT Work Programme

Meeting Date	Item
3 July 2014	SS, Hsg & PH Policy Overview Committee Possible Review Topics 2014/15
	Departmental Overview report
	Work programme for 2014/15
	Cabinet Forward Plan

31 July 2014	Budget Planning Report for SS,Hsg&PH
	Scoping Report for Major Review
	Work Programme
	Cabinet Forward Plan

9 September 2014	Major Review - Witness Session
	Cabinet Forward Plan
	Annual Complaints Report
	Work Programme

7 October 2014	Major Review - Witness Session
	Update on previous review recommendations (Tenancy Review)
	Cabinet Forward Plan
	Work Programme

5 November 2014	Adult Mental Health Services - Update report
	Adaptations - Update report
	Annual Public Health Report
	Cabinet Forward Plan
	Work Programme

21 January 2015	Budget Proposals Report for 2015/16
	Cabinet Forward Plan

	Major Review - Draft Final Report - Shared Lives
	Adults Safeguarding report
	Work Programme

24 February 2015	Cabinet Forward Plan
	Work Programme
	Single Item Review Topic

26 March 2015	Cabinet Forward Plan
	Work Programme
	Single Item Review topic - Report
	Update on previous review recommendations (Tenancy Review)

22 April 2015	Cabinet Forward Plan
	Mental Health Update
	Better Care Fund 2015/16

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