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CAERPHILLY COUNTY BOROUGH COUNCIL
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(Tel: 01443 863100 Email: dredga@caerphilly.gov.uk)

Date: 14th October 2015

Dear Sir/Madam,

A meeting of the **Health Social Care and Wellbeing Scrutiny Committee** will be held in the **Sirhowy Room, Penallta House, Tredomen, Ystrad Mynach** on **Tuesday, 20th October, 2015** at **5.30 pm** to consider the matters contained in the following agenda.

Yours faithfully,

Chris Burns

Chris Burns
INTERIM CHIEF EXECUTIVE

A G E N D A

Pages

1 To receive apologies for absence.

2 Declarations of Interest.
Councillors and Officers are reminded of their personal responsibility to declare any personal and/or prejudicial interest (s) in respect of any item of business on this agenda in accordance with the Local Government Act 2000, the Council's Constitution and the Code of Conduct for both Councillors and Officers.

To approve and sign the following minutes:-

3 Health, Social Care and Wellbeing Scrutiny Committee held on the 8th September 2015 (Minute Nos. 1 –12). 1 - 8

4 Consideration of any matter referred to this Committee in accordance with the call-in procedure.

5 To receive a verbal report from the Cabinet Member(s)

To receive and consider the following Scrutiny reports: -

6 Presentation: Cot Deaths and Still Births - Aneurin Bevan University Health Board.

7 Fit for Future Generations - A Childhood Obesity Strategy for Gwent to 2025. 9 - 48

8 Budget Monitoring Report (Month 5). 49 - 62

9 Performance Management 2014/15. 63 - 84

10 To record any requests for an item to be included on the next available agenda.

To receive and note the following information items*: -

11 Fixed Penalty Notices for Dog Fouling and Littering.

**If a Member of the Scrutiny Committee wishes for the above information to be brought forward for discussion at the meeting please contact Amy Dredge, Committee Services Officer, Tel. No. 01443 863100, by 10.00am on Monday 19th October 2015.*

Circulation:
Councillors: L. Ackerman (Chair), Mrs E.M. Aldworth, A. Angel, Mrs A. Blackman, Mrs P. Cook (Vice Chair), M. Evans, Miss E. Forehead, Ms J. Gale, L. Gardiner, C.J. Gordon, G. J. Hughes, L. Jones, A. Lewis, J.A. Pritchard, A. Rees and S. Skivens

Users and Carers: Mr C. Luke, Mrs J. Morgan, Miss L. Price and Mrs M. Veater

Aneurin Bevan Health Board: Mrs B. Bolt (Divisional Director Primary Care and Networks)

And Appropriate Officers

HEALTH, SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD AT PENALLTA HOUSE, TREDOMEN, YSTRAD MYNACH ON TUESDAY, 8TH SEPTEMBER 2015 AT 5.30 P.M.

PRESENT:

Councillor L. Ackerman - Chair
Councillor Mrs P. Cook - Vice Chair

Councillors:

Mrs E.M. Aldworth, A.P. Angel, M. Evans, J. Gale, C.J. Gordon, G.J. Hughes, A. Lewis, J.A. Pritchard.

Cabinet Members: Councillors N. George and R. Woodyatt.

Together with:

D. Street (Corporate Director Social Services), J. Williams (Assistant Director Adult Services), G. Jenkins (Assistant Director of Children's Services), C. Forbes-Thompson (Scrutiny Research Officer), M. Jones – (Interim Financial Services Manager). A. Dredge (Committee Services Officer).

Users and Carers - Miss L. Price, Mrs M. Veater, Mr C. Luke and Mrs J. Morgan.

Aneurin Bevan University Health Board – Ms D. Puckett.
Wales Co-operative Centre - A. Jones.

WELCOME

The Chair welcomed Councillor Mark Evans (New Tredegar Ward), to his first Scrutiny Committee.

1. APOLOGIES FOR ABSENCE

Apologies for absence had been received from Councillors L. Binding, Mrs A. Blackman, Miss E. Forehead, L. Gardiner and A. Rees.

2. DECLARATIONS OF INTEREST

There were no declarations of interest made at the commencement or during the course of the meeting.

3. MINUTES – 8TH SEPTEMBER 2015

RESOLVED that, subject to it being noted that a request had been received for slides in respect of hospital beds that had not been minuted, the minutes of the

meeting of the Health, Social Care and Wellbeing Scrutiny Committee held on 8th September 2015 be approved and signed as a correct record.

4. CONSIDERATION OF ANY MATTER REFERRED TO THE SCRUTINY COMMITTEE IN ACCORDANCE WITH THE CALL-IN PROCEDURE

There had been no matters referred to the Scrutiny Committee in accordance with the call-in procedure.

5. REPORT OF THE CABINET MEMBERS

The Scrutiny Committee received verbal reports from Councillor R. Woodyatt (Cabinet Member for Social Services) and Councillor N. George (Cabinet Member for Community and Leisure Services).

Councillor George advised the Committee that in July, Cabinet approved Public Space Protection Orders at Bargoed, Blackwood, Nelson and Caerphilly bus stations (including Caerphilly train station area) and a number of bus shelters. These Orders are made under new legislation and impose restrictions on a wide range of anti-social behaviour at these locations. The Orders will come into force on 12th October and will be enforced by the Police and the Authority's Community Safety Wardens. Appropriate signage will be in place in readiness for the commencement of the Orders.

Members were advised of the importance of Free School Meals and to the potential benefit to parents who pay for their child to have school meals that could save around £580 per year. Schools are also awarded Welsh Government's pupil deprivation grant for each free school meal claimant. Catering Services are again this academic year, working with other services to promote applications for free school meals. This will include media releases, staff briefings, work with the Parent Network, visits to schools and a template letter for head teachers to send to parents. The same campaign last year generated an additional 300 claimants.

In closing, Councillor George advised the committee of a number of accommodation changes that have been taking place, linked to the closure of the Civic Centre at Pontllanfraith. Public Protection Staff have begun to move into Penallta House with the majority planned to move in the last week of this month. This will include Catering, Environmental Health, Trading Standards and Licensing.

Councillor Woodyatt advised Members that the committee would receive two presentations at the meeting, from the Wales Co Operative Centre and Aneurin Bevan University Health Board. Firstly, the Wales Co-Operative Centre will explain the Principles and Social Care Enterprises. From April 2016 the Social Services & Wellbeing (Wales) Act will require local authorities to promote the use of Social Care Enterprises and the presentation will provide members with an opportunity to understand in more detail the benefits of this model of service delivery. Secondly, colleagues from the Aneurin Bevan University Health Board will present their 'Living well, Living Longer' programme.

Members were informed that Doctor Margaret Flynn, published her review into the events surrounding Operation Jasmine in July. The Director will present his report in terms of how the Authority is responding to the recommendations and make members aware of the other initiatives taking place to ensure an improvement in the quality of Care Homes.

Councillor Woodyatt advised of the recent seminar in relation to the financial challenges facing the Authority and the initial proposals brought forward within Social Services to contribute to the Medium Term Financial Plan, A report regarding the financial position of the Directorate at month 3 of 2015/16, will be presented. Members noted that good financial

management throughout 2015/16 will be essential to ensure the forthcoming challenges do not become more difficult.

In closing, Councillor Woodyatt advised the committee that an updated report would be provided in relation to the Deprivation of Liberty Safeguards (DoLS) that follows up on a report presented to Members in 2014.

The Committee thanked both Cabinet members for their informative reports.

REPORTS OF OFFICERS

Consideration was given to the following reports.

6. PRESENTATION: WALES CO-OPERATIVE CENTRE ALTERNATIVE DELIVERY MODELS – SOCIAL CARE

The Scrutiny Committee received a presentation from Andrew Jones, Business Development Manager of the Wales Co-operative Centre (WCC).

With the aid of slides, Mr Jones gave an overview of his presentation as it relates to Alternative Delivery Models (ADM's). Mr Jones informed members that this organisation was set up in 1982 and is now the largest co-operative development agency in UK. Their role is to support and train Co-operatives and Social Enterprises throughout Wales and work with public sector organisations to re-shape Public Services. The services include Day-Care, Supported Living, Respite and Dementia.

Mr Jones informed the committee of 'cuts' and to the increased pressure on both statutory and non-statutory services and of the requirement to maintain quality at a time of increasing demand and tighter budgets. Reference was made to 'The Barnet Graph of Doom' whereby that Local Authority thought that it would reach 'tipping point' within 5 years. A further example was given in relation to the City of Swansea Council, whereby their annual budget was £400 million pa and they had to make a saving of £100 million over a 5 year period (½ from Education and ½ from Social Services). Mr Jones stated that 'doing nothing is no longer an option'.

A member queried the need for such a service. The Director of Social Services confirmed that Mr Jones was invited to the Scrutiny Committee to share his experience as a report in relation to this subject had been requested by a member at a previous meeting. The Director also confirmed that under the Social Services Wellbeing Act 2014, there is a statutory duty to promote this matter.

Mr Jones informed members that the default position in relation to service delivery should be in-house but if this is no longer possible then Local Authorities should consider Alternative Delivery Models.

A discussion took place in relation to people with disabilities, the impact of how the ADM's would be held accountable for vulnerable people and the issue of funding, long term. Mr Jones assured members that the Local Authority would remain involved and that LA staff could make up 20 per cent of the Board and would have a direct role delivering the service. Staff could be TUPED across, if required. Scrutiny agreements would be reported on a 6 monthly basis. Mr Jones added that all levels of stakeholders would be involved and the WCC also work with the Voluntary Sector, which has resulted in a 'boom' for that area of activity. He further added that Council buildings could be utilised (by possibly leasing the buildings) with the service being externalised.

In closing, Mr Jones informed members that as this is a relatively new process with young organisations, it is difficult to say how many have failed, however, the percentage is quite small.

Mr Jones was thanked for his informative presentation and for responding to the questions raised by the Members.

7. PRESENTATION: ANEURIN BEVAN UNIVERSITY HEALTH BOARD LIVING WELL, LIVING LONGER

The Scrutiny Committee received a presentation from Dee Puckett, Programme Manager of the Aneurin Bevan University Health Board (ABUHB). Ms Puckett handed complimentary packs to those present, that contained water bottles, pedometers and information items relevant to the presentation.

With the aid of slides, Ms Puckett gave an overview and her presentation as it relates to Living Well, Living Longer, she referred to the role of ABUHB in reviewing the overview of patients of Blaenau Gwent West and in particular the age group of 40 – 64. (not on a disease register) living in a deprived area. She confirmed that the pilot scheme took 2 years with 10 workers, modifying behaviour changes.

Ms Puckett advised the committee of the risk assessment checks undertaken, as set out in the presentation, with other relevant factors being considered such as lifestyle, e.g. alcohol, physical activity patterns and family history. The statistics referred to premature mortality are Welsh Government based.

The committee were informed that the Healthcare Support Workers are trained in motivational interviewing and structured brief intervention. Each appointment lasts approximately 30 – 40 minutes with the results being made available during the sessions. Each citizen receives a personalised copy of their Health Check results and the results are data transmitted to the GP. Onward referrals, to support services are also available.

A member raised concerns as to the age group limit of 40 – 64 and Ms Puckett informed members that the ABUHB pilot allowed a 2 year period with 10 staff to undertake the task. The patients in Blaenau Gwent West wanted to employ a Community Worker but this was not considered feasible.

In closing, Ms Puckett, informed members that it was agreed that all patients not currently excluded via the Validation proforma would be invited to have a Health Check in Blaenau Gwent West. It was originally estimated that 25% of the 40-64 yr population in the GP Practices would already be on a chronic disease register/medication. However, in reality, between 32% - 56% were eligible to be invited. The initial Caerphilly modelling has identified 7,000 potential eligible patients, involving all GP practices.

Ms Puckett was thanked for her informative presentation and for responding to the questions raised by the Members.

8. BUDGET MONITORING REPORT (MONTH 3)

M. Jones, Interim Financial Services Manager, provided an overview of the report, which informed Members of the projected revenue expenditure for the Social Services Directorate for the 2015/16 financial year; an update on the progress made against the savings targets built in to the 2015/16 revenue budget and the projected financial position based on information available as at month 3 (June 2015).

The report highlighted the 2015/16 savings targets that have been achieved and the projected

underspends within the Directorate. Members were advised of the 2015/16 revenue budget settlement for Social Services that included targeted savings of £2.084m. Members also noted the projected underspends of £245k for Children's Services; £93k for Adult Services and £18k within Service Strategy and Business Support.

Members were pleased to note that even though the actual savings delivered in 2015/16 fall short of the £2.084m target, there would be no requirement to draw upon service reserves as other underspends are anticipated across the Directorate in 2015/16.

Members thanked the Officer for the report and discussed the £121k overspend in Management, Fieldwork and Administration and The Start Team (Pilot) and questioned whether Social Services are asking service users for ideas, ie transporting themselves to Day Centres, where possible. Officers advised that cases are dealt with on an individual basis. It was explained that the Start Team consists of 1 Team Manager, 1 Social Worker, 1 Occupational Therapist and 1 Admin Person and the Team are regarded as interventionists.

A Member sought clarification on the overspend within the Integrated Transport Unit (ITU) and whether it was as a result of a rise in fuel costs. The Officer advised that Taxi Service Rates have been considered and the Department are looking for better working practices.

Members discussed the targeted savings proposals for Social Services and a member raised a query in relation to proposals for cutting services and whether there has been a 'drop off' in the number of transport and meals on wheels users. Officers highlighted that figures were not available at present but numbers were decreasing. However, it was added that alternative service provision has been sourced for Service Users from the Shopping Service.

Members thanked the Officer for the report and noted its contents.

9. IN SEARCH OF ACCOUNTABILITY – A REVIEW OF THE NEGLECT OF OLDER PEOPLE LIVING IN CARE HOMES INVESTIGATED AS OPERATION JASMINE

Dave Street, Director of Social Services reminded Members that on 13th May 2014 Scrutiny Committee received a report explaining that Welsh Government had commissioned Dr. Margaret Flynn to undertake a thematic review of the issues surrounding Operation Jasmine, this was published on 14th July 2015 and the purpose of the review was, through a report to Welsh Ministers, to;

- Set out the experiences of those people and their families in residential care homes in Gwent that came to be known as Operation Jasmine.
- Set out the key events.
- Consider and set out actions that have been undertaken by the various parties involved in the interim.
- Set out key lessons for the future alongside recommendations regarding policy or legislation, regulation and operational practice, for the various parties involved.

The report summarised the key recommendations of the review, explained how the relevant recommendations would be implemented within Caerphilly CBC and provided an overview of the other initiatives being undertaken to ensure quality of care in care homes.

Mr Street informed Members that the lessons learned to date from Operation Jasmine have been a major factor in the ongoing developments in relation to work for the Protection of Vulnerable Adults, contract monitoring, care management reviews and focus on improving the quality of care.

Members thanked the Officer for the report and a discussion ensued in respect of Dr Daaz and the Care Homes he owned within the Borough. The Officer reminded Members that this

Review was commenced in 1995 and it was not solely in relation to Dr Das.

Members discussed whether it would be beneficial to visit a Care Home within the Borough and the provisions within such settings for families to raise concerns. The Officer confirmed that Members can visit Care Homes, and a rota of visits has been implemented. In addition, it was noted that there are Advocacy Services available for family members who have concerns and it was imperative that people know where to go, if they have concerns to raise.

Members noted that the Local Authority work much more closely with Care Homes and the CSSIW as a result of the review and there is a team in Social Services that visit Care Homes regularly providing advice and gathering statistical information.

Following consideration and discussion, it was moved and seconded that the recommendation in the report be approved. By a show of hands this was unanimously agreed.

The Scrutiny Committee noted the report.

10. DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

Jo Williams, Assistant Director of Adult Services provided Members with an update on the changes in the emerging case law involving authorising Deprivations of Liberty for people in Care Homes and in the community and the changes proposed by the Law Commission, currently out to consultation.

In March 2014, the Supreme Court, considered 2 cases concerned with potential Deprivations of Liberty. In the above ruling the Supreme Court clarified the criteria for judging whether the living arrangements made for a person who lacks capacity amounts to a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights.

The ruling has many implications for how the Mental Capacity Act (MCA) is interpreted and used and for the situations in which people can be lawfully deprived of their liberty. The emerging case law is consistently redefining what is classified as a deprivation of liberty particularly in community settings.

The Law Commission were asked to review current practice and make recommendations for changes in the law and practice following criticism on MCA & DoLS by the House of Lords and the current un-sustainable position following Cheshire West.

Members were informed of the up-dated position on the current state of Deprivations of Liberty within Caerphilly, improvement initiatives within Wales and an outline of the proposed scheme within the current consultation paper ending on the 2nd November 2015.

The Scrutiny Committee noted the report.

11. REQUESTS FOR ITEMS TO BE INCLUDED ON THE NEXT AVAILABLE AGENDA

There were no requests for items to be included on the next available agenda.

12. ITEMS FOR INFORMATION

The following item was received and noted without discussion.

- Summary of Members' Attendance – Quarter 1 – 15th May to 30th June 2015.

The meeting closed at 7.40pm.

Approved as a correct record, subject to any amendments agreed and recorded in the minutes of the meeting held on 20th October 2015.

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CHAIR

CHAIR

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HEALTH, SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE – 20TH OCTOBER 2015

SUBJECT: **FIT FOR FUTURE GENERATIONS – A CHILDHOOD OBESITY STRATEGY FOR GWENT TO 2025**

REPORT BY: **CORPORATE DIRECTOR, SOCIAL SERVICES**

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1. PURPOSE OF REPORT

1.1 This report seeks the Committee's views on a draft childhood obesity strategy for Gwent to 2025. The report also aims to assist in the development of an organisational understanding of the significant impact of obesity and childhood obesity on people and the public service sector.

2. SUMMARY

2.1 The draft childhood obesity strategy and action list attached at Appendix 1presents a vision of healthier, fitter future generations – where obesity will not be harming children and limiting the wellbeing of future generations in Gwent as it is today. It outlines the important and wide ranging benefits to people, communities and public services from effective and coordinated action on childhood obesity.

2.2 The Strategy makes the case that childhood obesity should be included as a priority wellbeing objective, for both Public Service Boards and organisations because of its relevance to the Wellbeing of Future Generations (Wales) Act 2015 and the significant harm childhood obesity causes right across the *wellbeing goals.*

2.3 Following analysis of local action from comprehensively collected sources and a thorough analysis of the evidence, including the views of people and practitioners, the strategy recommends areas for action for ABUHB, Local Authorities and Public Service Boards. This strategy is a *"call to coordinate"* and suggests shared governance for accountability and scrutiny within both organisations and Local/Public Service Boards.

3. LINKS TO STRATEGY

3.1 This draft strategy contributes to the Council's Anti Poverty Strategy as well as all of the priorities of the Single Integrated Plan, *Caerphilly Delivers.*

3.2 The strategy demonstrates how tackling childhood obesity will support organisations and Partnerships to demonstrate they are fulfilling their obligations to the Wellbeing of Future Generations (Wales) Act (2015) and other national and local strategic obligations.

4. THE REPORT

4.1 Childhood obesity harms children and young people now and damages the life chances of future generations. Childhood obesity causes a range of poor physical, mental and social health amongst children and young people and causes more severe chronic ill health in adulthood. In addition to health impact, childhood obesity also damages, education, equality, prosperity, productivity and social inclusion.

4.2 The population scale of childhood obesity, its higher rates in deprived areas and, the fact that up to 80 per cent of obese children go on to become obese adults means childhood obesity is not only harming individuals' lives, but also communities social, economic and environmental sustainability.

4.3 There are an estimated 37,000 children and young people (age 0 to 18 years) in Gwent who are overweight or obese of whom 19,400 are obese (Childhood Measurement Programme, the Welsh Health Survey and Health Behaviour in School-Age Children Survey). Adult obesity rates are at nearly 30 percent and have risen by a third in the last decade. In Caerphilly, it is estimated that 11,614 children and young people (age 0 -18 years) are overweight or obese of whom 5,950 are obese.

4.4 Rates of overweight and obesity are significantly higher in our more deprived areas. *At the age of just four or five years*, many children are at greater risk of becoming overweight or obese just because of factors associated with where they live. This inequality also imposes a disproportionate burden on these already disadvantaged households and communities, magnifying the already serious consequences.

4.5 The economic consequences are staggering. Obese individuals have lower employment rates, lower productivity with more sick days, and people with obesity earn considerably less. The health and social care budgets bear the brunt of these costs through increased dependence, packages of care and equipment much of which is avoidable and can be delayed, particularly for future generations if we coordinate effective action.

4.6 The *effective and coordinated* action to improve diet, physical activity and healthy weight at population scale produces outcomes across *wellbeing goals* in addition to improved 'health', leading to a whole that is much greater than the sum of its parts:

- Less discrimination and bullying leading to better educational achievement
- Improved independence and reduced demand on health and social care services
- Improved local environment
- Offset the impact of our aging population
- Reduced health inequalities
- Greater social cohesion and inclusion
- Increased local economic activity with less limiting long-term ill health
- Stronger local economy
- Better quality of life

4.7 Robust analysis of local action reveals there is a huge amount of activity and investment in obesity and childhood obesity-related topics from the public sector. In addition to that there is a supportive policy context and overlapping objectives held by statutory services and partnership. Yet despite that obesity rates continue to rise.

4.8 The Childhood Obesity Strategy for Gwent presents a vision of healthier, fitter future generations, where obesity will not be harming children and limiting the wellbeing of future generations in Gwent as it is today.

4.9 A thorough analysis of the causes of obesity and the evidence of effective approaches, which included the views of people and practitioners, demonstrate two important things:

- Action has to be public service-wide and coordinated with robust governance for accountability and scrutiny
- There are clear areas for action and achievable activity with the best chance of success

4.10 The causes of obesity are wide ranging and complex, yet the causes of obesity reveal the areas for our joint action to tackle childhood obesity. There is no one single organisation or policy area, let alone one single intervention which will provide the solution to childhood obesity. Sustained, effective action on many of the key causes at the same time is required.

The areas for action in this strategy are:

- Disrupt obesogenic social norms
- Support a healthy start in life
- Coordinate and improve the efforts in early years and schools settings
- Influence healthy food choices in our communities
- Encourage active recreation and play for families
- Create active and safe communities
- Provide community and healthcare based weight management interventions for families who need them

4.11 The strategy includes an action list, which represents the total actions that need to be progressed together to have a chance of turning the curve on childhood obesity. The pace and scale of implementation of actions within local authority must be decided by the Local Authority. The strategy recommends that the UHB, the five local authorities and the five local service boards adopt childhood obesity as a priority piece of work and as a "Wellbeing Objective" under the Wellbeing of Future Generations (Wales) Act 2015. The strategy also calls for the five local authorities in Gwent to identify the relevant existing internal cross-organisational structure(s) who can provide: 1) assurance to Cabinet on progress against the childhood obesity "wellbeing objective", 2) hold local authority departments and other providers accountable for delivery and 3) provide the appropriate cross-policy scrutiny for policy and activity which could impact on childhood obesity. The Strategy recommends that a Cabinet champion be nominated as a senior leader for this cross-government agenda.

4.12 Recognising the unprecedented austerity facing public services, and local authorities in particular, balancing what public services have to do today with tackling childhood obesity for future generations' wellbeing is increasingly challenging. However, this *is* about the *Wales We Want*, defining the development path for our future generations, and, as mentioned there is already a lot of work underway. The success of this strategy and the work behind it will depend on a renewed focus on coordination and the *reorientation* of the actions to achieve closer alignment to what we know to be effective at reducing childhood obesity. Considering the above, this strategy is a call to coordinate and recommends that leadership and governance for delivery needs to be identified within both the University Health Board and local government corporate structures with overall accountability to the Local/Public Service Boards.

4.13 The Caerphilly Well Being Delivery Group is an existing partnership forum operating within the Local Service Board delivery structure. It is Co-Chaired by the Council's Head of Public Protection and Mererid Bowley, Consultant in Public Health, Public Health Wales. This Group has two main priorities, Obesity and Smoking. Whilst the existing Obesity priority requires further development to fully respond to the draft Childhood Obesity Strategy the Group has members from a range of Council services including Leisure, Public Protection, Communities First, Families First, the Sustainability Team, and the Youth Service, and is well placed to take

the Strategy forward.

5. EQUALITIES IMPLICATIONS

5.1 This strategy is about reducing inequalities caused by childhood obesity. Implemented as directed is predicted to have significant positive impact on child health and wellbeing and deprivation-linked health inequalities.

6. FINANCIAL IMPLICATIONS

6.1 There are no financial implications at this stage. This strategy is not recommending new actions requiring investment. The focus is predominantly about reorientation of existing activity but in line with the evidence aligning local authority corporate plans and local service board single integrated plan actions and as such most of the actions in the accompanying action plan are low cost or no-cost.

6.2 However, consideration should be given to balancing the current financial constraints across public services with the costs of doing nothing and the benefits of coordinating effective multi-agency action on childhood obesity.

7. PERSONNEL IMPLICATIONS

7.1 There are no personnel implications arising directly from this report, but consultation would be undertaken with staff should any proposals emerge to alter roles and responsibilities if and when appropriate.

8. CONSULTATIONS

8.1 This report has been sent to the consultees listed below and all comments received are reflected in this report.

9. RECOMMENDATIONS

9.1 The Committee are asked to provide their comments on the attached draft strategy: *"Fit for future generations – a Childhood obesity strategy for Gwent to 2025".*

9.2 The Committee are also asked for their views on the internal structure/process to provide accountability for planning and delivery of relevant actions, as well as providing scrutiny of core business for impact or synergy on childhood obesity.

10. REASONS FOR THE RECOMMENDATIONS

10.1 To ensure effective governance and accountability for Local Authorities to deliver on the Childhood Obesity Strategy.

Author: Jonathan West, Principal Public Health Specialist and Jenny Evans, Senior Public Health Practitioner, Public Health Wales

Consultees: Cllr Nigel George, Cabinet Member for Community and Leisure Services
Mererid Bowley, Consultant in Public Health
Dave Street, Corporate Director Social Services
Rob Hartshorn, Head of Public Protection
Mike Eedy, Finance Manager

Sian Phillips, Acting HR Service Manager
David Thomas, Senior Policy Officer (Equalities and Welsh Language)

Background Papers: None

Appendices:
Appendix 1: DRAFT childhood obesity strategy for Gwent 2015 to 2025 *Fit for Future Generations*

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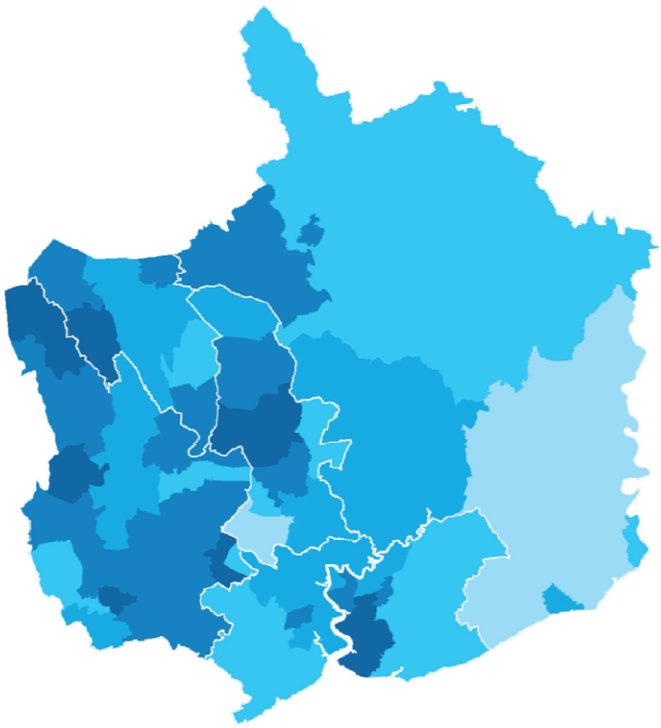
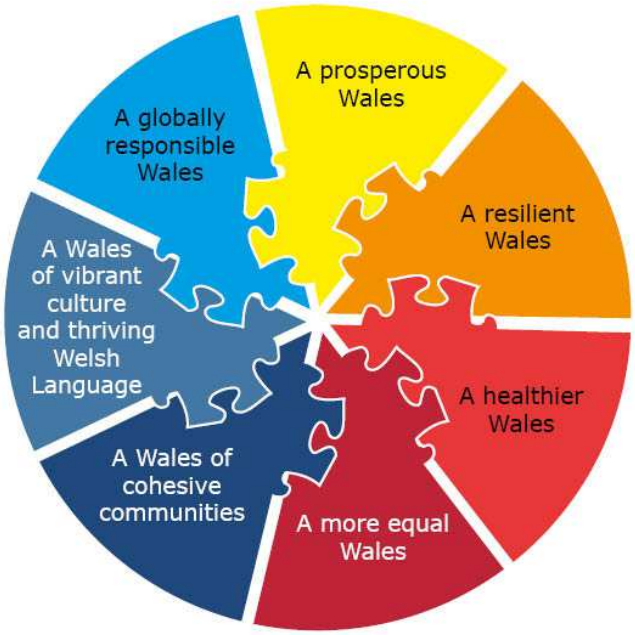
Fit for Future Generations
A childhood obesity strategy for Gwent to 2025



Map produced by Public Health Wales Observatory, using CMP data (NWIS) © Crown copyright and database right 2015. Ordnance Survey1000044810



Developed from the evidence with over 100 health professionals, local people, local authorities, communities first, play providers, early years, education, leisure service providers at health board and locality levels through a process of discussion, engagement and collaboration.

Prepared by: Jonathan West, Jenny Jones, Jennifer Evans, Lucy Usher and Jane Layzell in collaboration with the Gwent Childhood Obesity Strategy Development Group:

The Local Authorities in Gwent, Third sector and Aneurin Bevan University Health Board including:
Communities First
Torfaen Voluntary Alliance
Flying Start
Health Visiting
Early Years Childcare
Dietetics
Paediatrics
Leisure Services
Midwifery
Play Services
Public Health
Healthy Schools
School Nursing

July 2015

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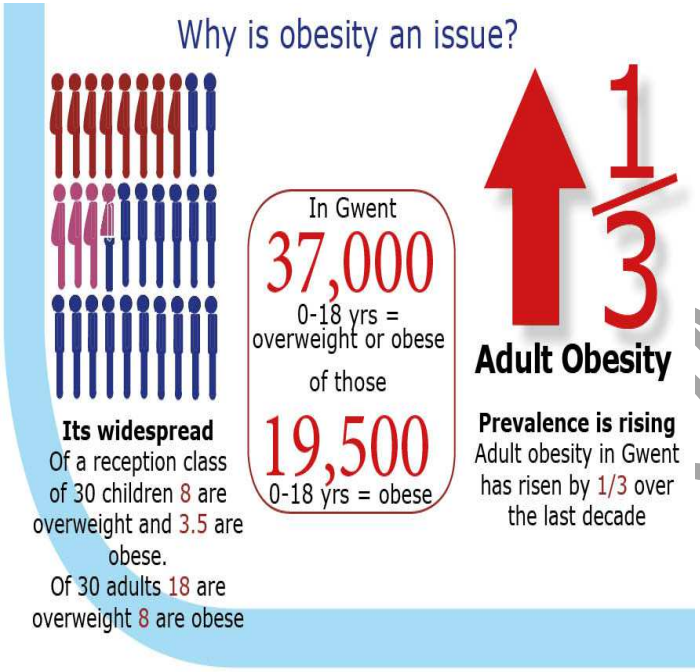
Introduction

A problem that demands an organisational and partnership solution

A child born today has a one-in-three chance of living beyond 100 years, so long-term health outcomes are ever more critical. Recognising the significant benefits to future generations' wellbeing from coordinated effective action on childhood obesity and, the amount of activity already in existence, this strategy is a *call to organise*. This strategy is the beginning of a collaborative journey to achieving our vision; it makes the case for the leadership, accountability and governance for coordinated collective action at both partnership and organisational levels.



Obesity is a consistently underestimated *public service* challenge. The harm it does to children in the short and long term has a negative and significant impact *across* the *Wellbeing Goals*.

Our vision is of healthier, fitter future generations – where obesity will not be harming children and limiting the wellbeing and health of future generations in Gwent as it is today. The recent trend towards present and future generations being more overweight, at a younger age, and having a shorter life expectancy than their parents will be reversed.

There are significant benefits for individuals, families and communities, public services, the environment, and the economy, across the range of *wellbeing goals* from making coordinated, small changes together. This strategy describes the benefits to society and organisations, even accounting for the significant financial constraints in public services, making the case that the timing is right to act now. The actions within this strategy are predominantly concerned with reorienting current activity and as such are low or no-cost.

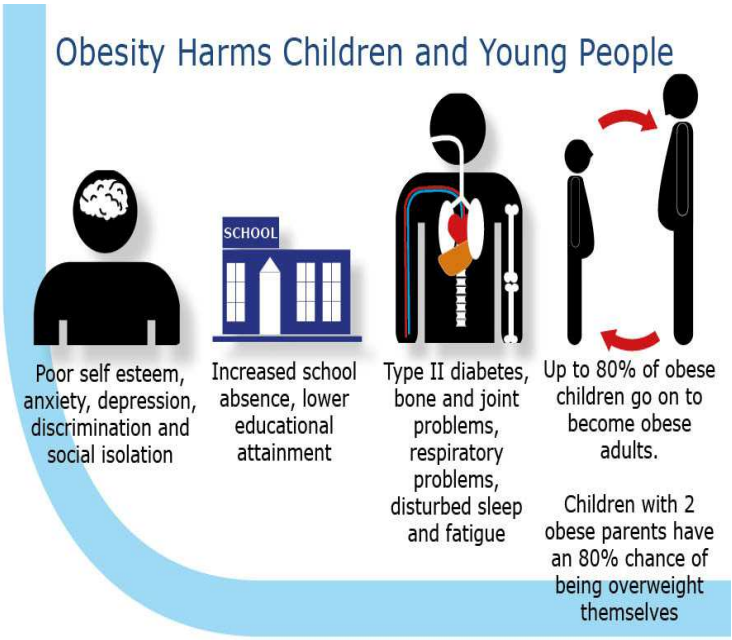
There are an estimated 37,000 children and young people (age 0 to 18 years) in Gwent who are overweight or obese of whom 19,400 are obese. Almost two thirds of the adult population in Gwent are overweight or obese and rates of adult obesity have risen by a third in the last decade. Rates of overweight and obesity are significantly higher in our more deprived communities.

The economic consequences are staggering and are as underestimated a problem as overweight and obesity themselves. Health and care organisations bear the burden of obesity's many co-morbidities, while obese individuals also have lower employment rates and lower productivity with more sick days, earning considerably less with significant impact on the overall economy.

There are significant challenges to be overcome, not least the unprecedented austerity in public services, but there are a number of very clear, very important messages which are consistent from the evidence gathered during the development of this strategy.

Action on childhood obesity prevents damage to other *wellbeing goals* for future generations. This strategy shows how tackling childhood obesity will support organisations and partnerships to demonstrate they are fulfilling their obligations to the Wellbeing of Future Generations (Wales) Act (2015). Tackling childhood obesity leads to:

- Reduced health inequalities
- Greater social cohesion and inclusion
- Stronger local economy
- Improved independence and reduced demand on health and social care services
- Better quality of life
- Less discrimination and bullying leading to better educational achievement
- Increased economic activity with less limiting long-term ill health
- Improved local environment
- Mitigating the impact of our aging population



No single intervention or organisation can offer a unilateral solution – reversing the current obesity trend requires multiple interventions, from multiple sectors, at the same time. There is no *main answer* that lies with another organisation. **We have to see obesity as a public service-wide issue which requires action in collaboration between many sectors and integration with action on the other wellbeing goals of partnership and organisations.**

There is a lot of work going on from all public services and community organisations in Gwent which could be linked to the potential for healthier weight in children and young people. The analysis shows, there is inconsistent delivery and that much of the work mapped as preventing childhood obesity was not really designed for that purpose. The **success of this strategy and the work behind it will depend on a renewed focus on coordination and reorientation of key systems or settings.**

The major sources of high quality evidence, national policy and strategic direction contain strikingly similar findings for the main areas of action required to turn the curve on childhood obesity. This strategy outlines key findings from major sources of evidence reviewed and, presents the areas for action. Included with this strategy is an action list with the things public services can do to move closer to effective action and the specific pieces of work for different professional groups.

The final message from the evidence is that **proper accountability, governance and leadership will be vital.** Local Service Boards/Public Service Boards are well placed to assess the variation of need in

their local communities and coordinate activity in particular areas or settings as well as arranging synergy from other work on the other *wellbeing goals*. The Wellbeing of Future Generations Act will strengthen their role in holding statutory and third sector partners to account for delivery against their priorities. Partnership will also ensure the sustainability of this work through public service reorganisation. The existing corporate governance and delivery structures WITHIN statutory services will be better placed than partnership to ensure consistent delivery and performance from the individual sectors or professional groups working to their separate corporate plans.

This strategy recommends the accountability, governance and leadership should be provided by *both* Partnerships *and* public service organisations using existing structures.

Vision

Healthier, fitter future generations – obesity will not be harming children and limiting the wellbeing and health of future generations in Gwent. The recent trend towards present and future generations having shorter life expectancy than their parents will be reversed.

Individuals, families and communities, the environment, the economy, and public services, will all reap the rewards from the small changes they make together which enable large scale changes in future generations' weight, health and wellbeing.

Future generations will enjoy vibrant, connected communities with people preferring walking and cycling for local journeys, families and children playing in shared open spaces and getting the most out of our abundant natural environment, active recreation facilities and organised activities. Town centres, high streets, market places and community shops will carry the visible, attractive offer of healthy food and drink, and these are patronised and promoted by individuals, communities and services.

The places where we live, work, learn and play make the healthy choice the easy choice, particularly for pregnant women and those families and settings with children in the early years. The media we consume and the virtual communities which we inhabit, which *we* shape *ourselves*, promote our families as healthy and active. Active, healthy weight children and families become the social norm.

Pregnant women, parents, children and young people as well as front-line service professionals understand the benefits of healthy weight, recognise and record overweight and obesity in childhood – and in pregnancy and parenthood – and are enabled with the knowledge and skills to act.

A priority wellbeing objective for Public Service Boards and organisations

Balancing what public services have to do today with tackling childhood obesity for future generations' wellbeing is increasingly challenging in the current economic climate. However, tackling childhood obesity has to be a priority in our long term development path for Wales and is probably *the* foremost relevant *wellbeing objective* to collaborate on and the timing has never been better. There is an almost unprecedented opportunity to collaborate now on talking childhood obesity:

- The benefits to people, services and society, across the range of wellbeing goals, from coordinated action to tackle childhood obesity
- The costs of doing nothing
- The addition of the Wellbeing of Future Generations (Wales) Act to already strong policy context for public service action on obesity
- The consistency of the evidence base – we know what we need to do
- Huge array of activity in multiple-sector silos already underway, just needs realigning
- Existing governance structure of LSBs and future PSBs along with corporate governance and accountability structures within the Health Board and five local authorities can deliver change

A single wellbeing objective with multiple outcomes

The evidence is there; obesity is not only impairing individuals' lives, but also societies' sustainability with regard to its social, economic and environmental dimensions (Lucia, et al, 2010). The *effective and coordinated* action to improve diet, physical activity and healthy weight at population scale produces outcomes across *wellbeing goals* in addition to 'health', leading to a whole that is much greater than the sum of its parts. For example more walking and cycling leads to less car travel, safer more welcoming streets, increased social interaction, supports local business and improved environmental sustainability. Regulation of fast food outlets leads to less litter and a more appealing environment, reduced noise and congestion, improved access to healthier foods and, reduced health inequalities (NICE, 2012). A clear message from the evidence is that effective action on childhood obesity leads to:

- Reduced health inequalities
- Greater social cohesion and inclusion
- Stronger local economy
- Improved independence and reduced demand on health and social care services
- Better quality of life
- Less discrimination and bullying leading to better educational achievement
- Increased economic activity with less limiting long-term ill health
- Improved local environment
- Offset the impact of our aging population

The wide reaching outcomes following coordinated action on obesity has resulted in it becoming an explicit goal in many countries' political sustainability strategies across the EU. Some EU countries – Germany and Austria, for instance – as well as the EU itself have included the aim to reduce overweight and obesity in their population as a goal in their Structural Change Programmes, strategies and plans. Coordinated action on childhood obesity makes public money work smarter.

A central priority for Public Service Boards

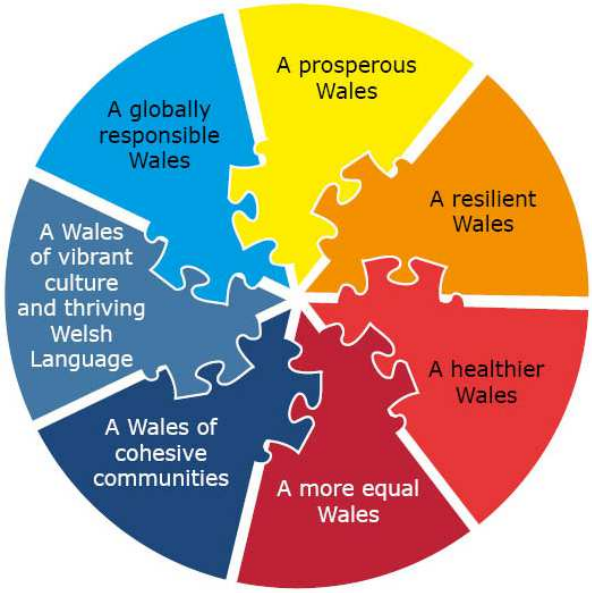
The National Assembly for Wales' inquiry in to childhood obesity (2014) described the issue as a crisis requiring a coordinated multi-faceted solution. Following that, Wales' Public Service Leadership Group (PSLG, 2014) recognised the serious need for action on childhood obesity to prevent poor wellbeing and contribute to sustainable public services for future generations. Emphasising that "public services can only provide an effective, *preventative* response if we regard childhood obesity as a public service-wide issue", the PSLG are explicit that only "*collaborative approaches have the potential to make a greater impact on this issue"*.

The PSLG are clear about the need for collective accountability and governance, and recommend Local Service Boards should prioritise childhood obesity and that they ensure that local areas are taking the necessary steps.

The Wellbeing of Future Generations (Wales) Act 2015 provides a unique opportunity to coordinate effective multi-sector action on childhood obesity. The Act places statutory responsibilities on public sector bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the wellbeing needs of future generations.

The Act expects public bodies and new statutory Public Service Boards, to demonstrate their actions under the seven *wellbeing goals* (see figure one opposite), contribute to improving economic, social, environmental and cultural wellbeing, and securing it for future generations. It is about *defining the long-term development path for the people of Wales*.

Figure 1: Wellbeing of Future Generations (Wales) Act 2015 – seven *wellbeing goals*



The Act requires public bodies to select *wellbeing objectives,* preferably which contribute to multiple *wellbeing goals* and, which require organisations to demonstrate consideration of five things in achieving the objective (see figure 2 below).

With organisations and the Public Service Boards prioritising childhood obesity as a central *wellbeing objective,* then considering the size and scale of its impact on wellbeing and costs, they will demonstrate their commitment to *safeguarding long-term needs*.

Figure 2: Five things public bodies must demonstrate in applying the Sustainability Principle; Wellbeing of Future Generations (WALES) Act 2015

Recognising the wellbeing burden childhood obesity places on future generations – and future generations' public services – and taking action to *prevent* the impacts getting worse, demonstrates the *long term* view required under the legislation.

The research consistently shows the impact of childhood obesity is wide ranging, harming children's health in the short term AND having even bigger impact across the range of wellbeing goals, most notably: health, prosperity, equality, cohesion and resilience.

All detailed analyses of tackling obesity, without exception, emphasise the critical need for action to be public service wide and requiring coordination through collaboration.

Many of the actions in this plan will require involving people and communities particularly when acting on inequality or attempting to change social norms.

Benefits to public service organisations

In addition to benefits across the *wellbeing goals* of the *Wellbeing of Future Generations (Wales) Act 2015*, effective coordinated action on childhood obesity provides significant strategic and operational benefits for public service organisations.

Collaborating towards the longer term outcome of preventing rates of obesity getting worse, by tackling childhood obesity now, will release significant savings to health and care budgets including: packages of health and care provision for people with obesity, clinical management of chronic ill health conditions, dealing with acute exacerbations and emergency hospital admissions, social care, equipment and home adaptations.

Local authorities

Action on childhood obesity helps local authorities demonstrate good performance against a whole range of national policy and legislation. The Social Services and Wellbeing (Wales) Act 2014 and National Outcomes Framework contains action on improving physical and mental health and wellbeing and includes increasing physical activity using a range of environmental and personal development approaches. Action on obesity also supports local authorities response to the Child Poverty Strategy for Wales 2015, Active Travel (Wales) Act 2014, the Core Aims of the United Nations Convention on the Rights of the Child, common outcomes framework for the poverty

programmes including Families First, Flying Start and Communities First, national play policy, Schools ESTYN inspection, food vending and catering standards in schools and leisure centres, national guidance (TAN) for town and country planning and regeneration and, leisure service sector strategies, among others. Our need to involve citizens, supporting people to have more input in to public service planning and delivery, is increasingly central to national policy and legislation relating to local government. This childhood obesity strategy requires understanding of local need to be able to better tailor health promotion messages and services to the people who need them most and through the process of involvement will support local authorities in describing citizen involvement.

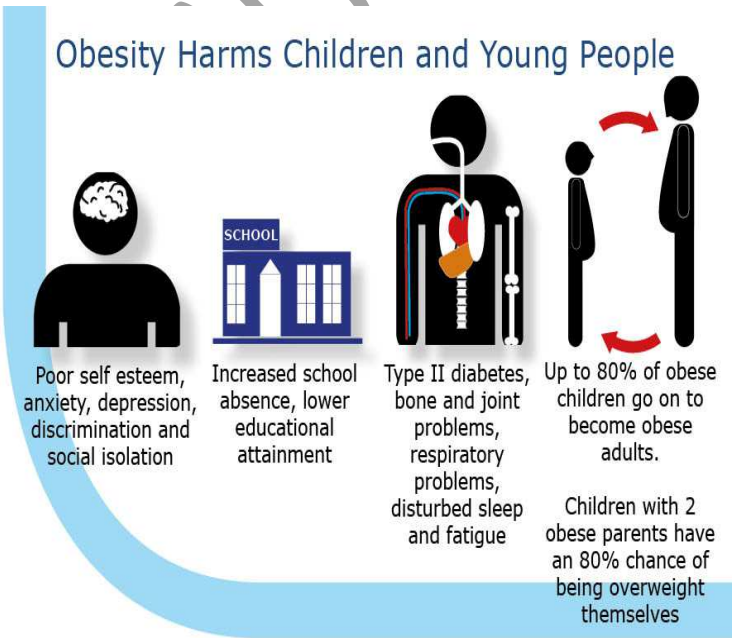
Aneurin Bevan University Health Board

Effective coordinated action on obesity and childhood obesity enables ABUHB to meet important strategic and performance requirements. The NHS Wales National Outcomes Framework (2015/16) includes childhood obesity and the ABUHB three-year plan contains a range of NHS actions on childhood obesity. Action on childhood obesity will contribute to the long-term prevention elements of *Together for Health* Delivery Plans. Making *prudent healthcare* happen to sustain the NHS in Wales for future generations means ABUHB demonstrating a greater focus on prevention, and promoting wellness. Helping families and children to better manage their weight will not only prevent chronic disease and unnecessary health and care interventions in adulthood over the longer term but evidence shows that weight management would be the least intensive intervention to treat many co-morbidities in childhood.

Why children?

With a child born today having a one-in-three chance of living beyond 100 years, long-term health and wellbeing outcomes are therefore ever more critical.

Obesity harms children in the short term but also, as most (between 55 to 80%) go on to become obese adults, childhood obesity harms *life chances* undermining a range of wellbeing goals in future generations. For example, research shows that a healthy weight in childhood predicts better health and wellbeing in adulthood even independently of adult weight, whereas adult obesity which began in childhood results in greater risk of premature illnesses than those who became obese in adulthood.



The human capital (the health, education and skills) of the next generation, will be fundamental in determining their labour market success and the future prosperity of the Welsh economy. Obesity in adolescence has been linked to a range of social and economic consequences in adulthood and these relationships exist even after controlling for socioeconomic background and child ability (Welsh Economic Review, 2011).

Effective, preventative action in pregnancy or childhood has a positive impact on several generations simultaneously, and can lead to huge savings when compared with an action with adults. Healthy diet and weight in pregnancy alone has been shown to improve the health of pregnant women, yields better outcomes in pregnancy and labour, and also provides independent health benefits in adult life.

In addition to numerous important benefits to wellbeing from breastfeeding which track through to adulthood, infants exclusively breastfed have healthier weights compared to both formula fed infants and to those introduced to solid foods early.

Behavioural patterns are laid down early, reinforced through childhood and continue through to adulthood making behaviour change in adults more difficult emphasising the importance of intervention in childhood.

Early policy intervention is also more effective in changing the fortunes of those from disadvantaged backgrounds with the rate of return to policy interventions among young children being higher than those at any other age.

The cost of doing nothing

Wellbeing and health goals

Obesity harms children and young people. The World Health Organization regards childhood obesity as one of the most serious global public health challenges for the 21st century. Being overweight or obese in childhood has serious consequences for wellbeing both in the short term and the longer term.

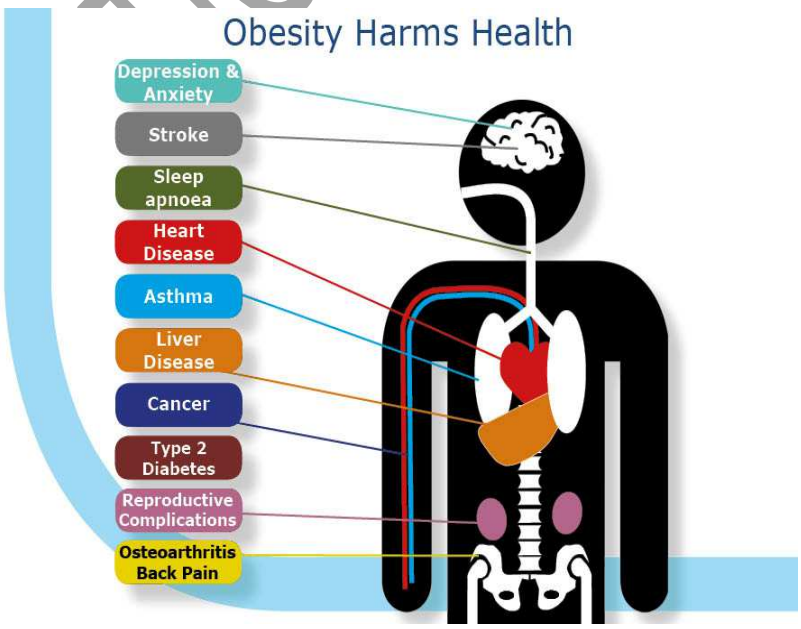
The harms to child health and wellbeing caused by obesity are serious and wide ranging and include physical, psychological and social harms (see figure 3 below). Children with obesity are more likely to be ill, be absent from school due to illness, experience health-related limitations, suffer disturbed sleep and fatigue and, use health and care services more than normal weight children (Wijga et al, 2010). The emotional and psychological damage to wellbeing is often seen as the most immediate and serious by children themselves. They include teasing and discrimination by peers; low self-esteem; anxiety and depression.

Figure 3: Obesity harms child health and wellbeing

Complications of childhood obesity	
Psychosocial	Poor self-esteem, Anxiety, Depression, Eating disorders, Social isolation, Lower educational attainment
Neurological	Pseudotumor cerebri
Endocrine	Insulin resistance, Type 2 diabetes, Precocious puberty, Polycystic ovaries (girls), Hypogonadism (boys)
Cardiovascular	Dyslipidemia, Hypertension, Coagulopathy, Chronic inflammation, Endothelial dysfunction
Pulmonary	Sleep apnea, Asthma, Exercise intolerance
Gastrointestinal	Gartoresophageal reflux, Steatohepatitis, Gallstones, Constipation
Renal	Glomerulosclerosis
Musculoskeletal	Slipped capital femoral epiphysis, Blount's disease, Forearm fracture, Back pain, Flat feet

Source: Ludwig, D. 2007.

The severity and likelihood of poor wellbeing increase as children age and progress through adolescence in to adulthood. Childhood obesity leads to and exacerbates adult obesity which in turn causes or exacerbates our most prevalent limiting long term ill health conditions which also have serious effects on



Adult obesity results in less healthy life expectancy and shorter life expectancy.

Maternal obesity and excess weight gain in pregnancy poses serious risks to the mother and child including: gestational and type II diabetes, pre-term deliveries, macrosomia, late foetal loss, stillbirth, congenital anomalies and increased neonatal intensive care. In addition the evidence suggests that maternal obesity and excess weight gain during pregnancy are related to obesity and ill health in childhood and in adulthood. Pregnant women are particularly relevant to this strategy; the short, medium and long term benefits of healthy weight to a mother and baby, and the importance of preparation for parenthood, all point to pregnancy as a unique intervention point for preventing the intergenerational impacts of obesity.

The Public Services Leadership Group report the overwhelming consensus of the evidence: problems associated with obesity are broader than the direct impact on health, disease and healthcare.

Good health is a resource for life. Obesity and the ill health it causes result in poor wellbeing through: less contribution to family and community; reduced employment opportunities, less income; reduced productivity and absenteeism; and poor school performance. Obesity causes and is caused by low socio-economic status so with rising obesity so equity and fairness erode (IOTF, 2010).

In the same context, poor mental wellbeing, sense of poor self-image, social ostracism or bullying and real or perceived stigma, jeopardizes cohesion and social sustainability.

Economic consequences of doing nothing

The costs of obesity to the economy and health and care services are truly staggering and widely underestimated.

In the UK the economic impact of obesity generates an annual loss to the total UK economy of more than £44 billion (3% GDP) (Mckinsey, 2014). In that analysis obesity ranks second amongst the biggest "social burdens caused by humans" including: 3) armed violence, war and terrorism; 4) illiteracy; 5) alcoholism; 6) drug use; 7) air pollution; 8) climate change; 9) road accidents; and 10) workplace risks.

On the societal level, the *economic consequences* of obesity come in the form of increased healthcare costs and impact on the labour market. Health and care organisations bear the burden of obesity's many co-morbidities, and obese individuals have lower employment rates, lower productivity with more sick days, and people with obesity earn considerably less.

Obesity costs employers in the UK an estimated £4.3 billion annually with the majority £3.2 billion from reduced productivity as opposed to days lost (McKinsey, 2014).

Healthcare spending increases directly with increases in BMI. In 2008 the NHS Wales were estimated to spend between 1.3 and 1.5 per cent of the total budget treating and managing the proportion of disease directly resulting from overweight and obesity. The estimated direct annual costs of obesity to NHS Wales across primary, community and secondary care was £73 million, which increases to nearly £86 million if overweight people are included (WG, 2011).

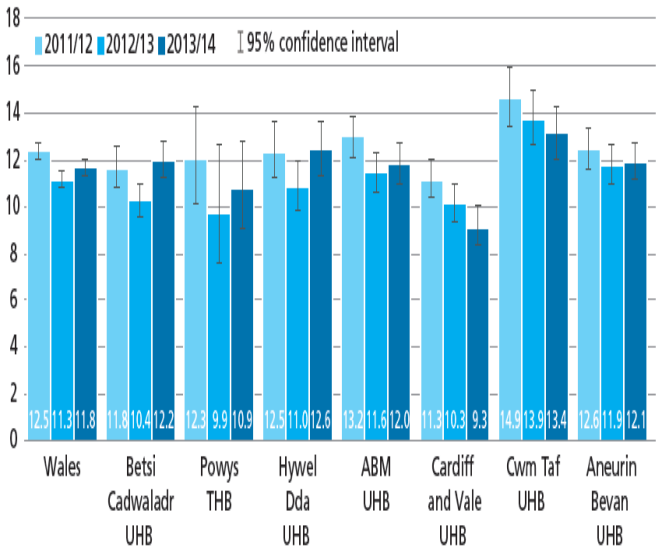
Gwent residents make up about a fifth of the Welsh population, even without adjusting for higher rates of overweight and obesity in Gwent, the *annual* cost to ABUHB could be crudely expected to be in the region of £17 million.

If popular estimations of overweight and obesity doubling in the next 30 to 40 years occur, as in the Foresight report, the costs to ABUHB, without inflation, could also double. The rate of increase over the last decade in Gwent (Figure 5) indicate the situation could be *at least* that bad if we do nothing more than we do currently.

Gwent adult and childhood obesity rates are high, and rising

The Public services Leadership Group state that obesity is steadily increasing, and has been described as a worldwide epidemic (2014). Recent figures suggest rates of childhood obesity more than doubled between 1984 and 2002 (Welsh Economic Review, 2011). The most comprehensive analysis in the UK suggested that 60 per cent of adult men, 50 per cent of adult women and about 25 per cent of all children under 16 could be obese by 2050, and that the annual UK NHS costs attributable to overweight and obesity could double to £9.7 billion (Foresight, 2007).

Figure 4: the proportion of children aged 4 to 5 years who are obese, Wales and Health Boards 2013/14 (Produced by Public Health Wales Observatory using CMP data (NWIS))



The most reliable data available on childhood obesity comes from the Child Measurement Programme (CMP) Wales, surveillance of weight for height of children aged four to five years in primary school reception year. Latest data from CMP measured in 2013/2014 (CMP, 2015) shows that over a quarter of children in Gwent aged just 4 and 5 years are overweight or obese with more than one in every ten already obese in reception year (26.4 and 12.1% respectively; *figure 4*).

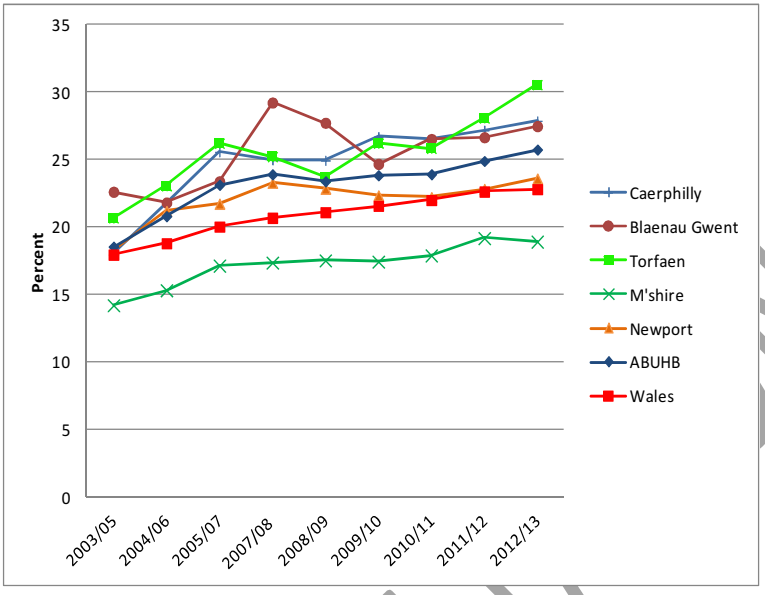
Rates in Gwent are similar to Wales – higher than any English region – with no significant change since measurements began. The trend is similar for overweight.

For older children there is little available data for overall rates of overweight and obesity at Gwent or local authority area level. The rates of overweight and obesity are available at a national level, and for groups of ages. Using the most reliable rates available from the CMP, the Welsh Health Survey and Health Behaviour in School-Age Children Survey we applied them to the Office of National Statistics mid-year population estimates (2013) for ABUHB at the relevant ages.

In Gwent there are an estimated 37,000 children and young people aged 0 to 18 years who are overweight or obese including 19,400 classified as obese.

Almost two thirds of the adult population of Gwent are overweight or obese (61%) with over a quarter (26%) obese (WHS 2012 and 2013). Overweight has now become so common that it is almost unnoticed in society; in a class of 30, four and five year old, children, about eight are overweight or obese, as they age the rate increases until in adulthood more than every other person is overweight or obese – in fact the rate is closer to two out of every three people. Obesity alone rises from nearly four in the reception class of 30 to adult rates of more than one in every four people.

Figure 5: Rising rates of adult obesity in LAs, ABUHB and Wales, WHS 2003 to 2013



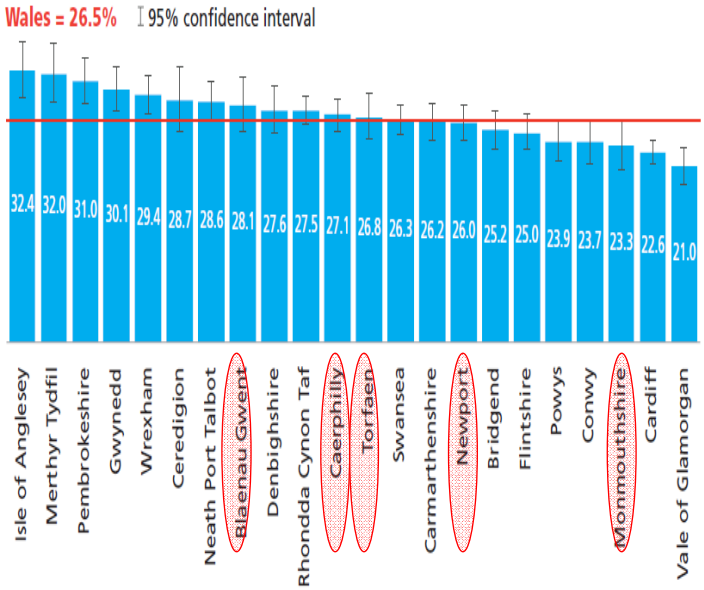
Rates of adult obesity have been rising steadily for decades (see figure 5).

Rates of obesity are rising faster in Gwent than Wales as a whole with rates nearly a third higher in 2012/13 than they were in 2003/2005. Whilst the rise in obesity rates in Monmouthshire is similar to Wales, in Torfaen population rates of obesity have gone up by 50 percent, with an extra 1 in 10 people obese in 2013 compared to 2003.

Obesity and an unequal Gwent

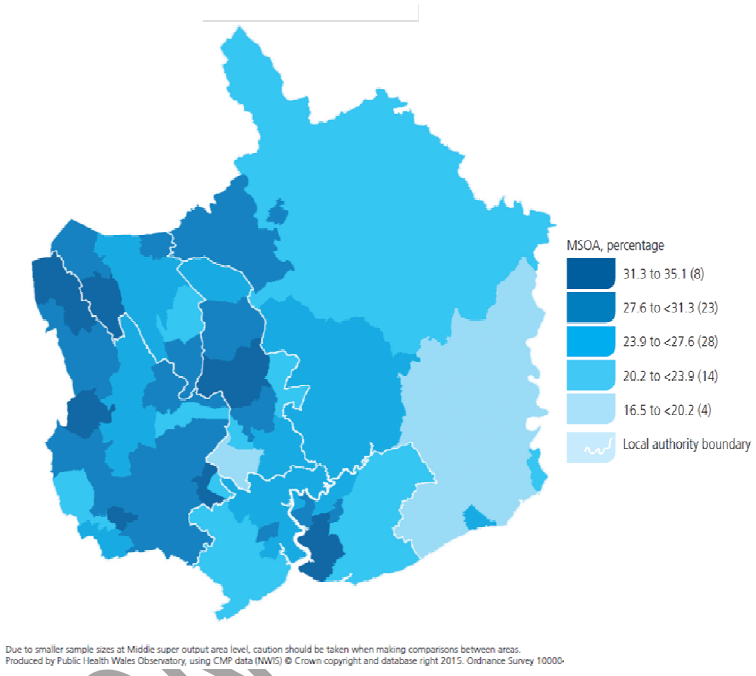
There is significant variation in the rates of obesity across Gwent amongst both adults and children.

Figure 6: the proportion of children aged 4 to 5 years who are overweight or obese, CMP 2013/14



By the time children reach reception year at school, rates of overweight and obesity already vary by local authority. Monmouthshire consistently has the lowest rates of overweight and obesity compared to the other Gwent local authorities, but that is still nearly a quarter of all children aged just four or five years overweight or obese. Blaenau Gwent, Caerphilly, Torfaen and Newport are not statistically different to the Welsh average, with Monmouth alone likely to be lower than Wales as a whole.

Figure 7: Overweight or obese, aged 4 and 5 years, Gwent MSOA, (CMP: 2011-12, 2012-13 and 2013-14)



The map in *figure seven* shows significant variation in rates of overweight or obesity from the CMP at medium super output area level. At the age of just four or five years, many children are at greater risk of becoming overweight or obese just because of factors associated with where they live.

The map is similar for adults with overweight and obesity much more prevalent in the Gwent Heads of the Valleys Region and some areas of Newport.

Each local authority area in Gwent has areas where overweight and obesity is impacting across the wellbeing goals as described. Rates of overweight and obesity are increasing in every local authority area.

Analysis of the CMP data by the Welsh Index of Multiple Deprivation shows that overweight and obesity amongst four and five year olds increase as deprivation increases. Children aged just four and five years old living in areas ranked amongst the most deprived fifth, have significantly higher rates of obesity compared to the Wales average and children living amongst the most affluent 40 per cent. Given the harms to children now and their futures, this is an unacceptable inequity, particularly at this age.

Once more adult overweight and obesity shows the same social gradient with high rates rising as deprivation increases. Obesity causes inequality in wellbeing goals through its impact on health, prosperity, cohesion and resilience AND, multiple deprivation (Welsh Index of Multiple Deprivation) also increases the risk of overweight or obesity.

As obesity has a higher incidence among deprived communities, it also imposes a *disproportionate* burden on these already disadvantaged households, magnifying its usual consequences. Obesity is passed from generation to generation for a wide range of reasons further ingraining this unequal cycle for future generations in Gwent.

From systems of causes to systems for solutions

The cause of overweight and obesity

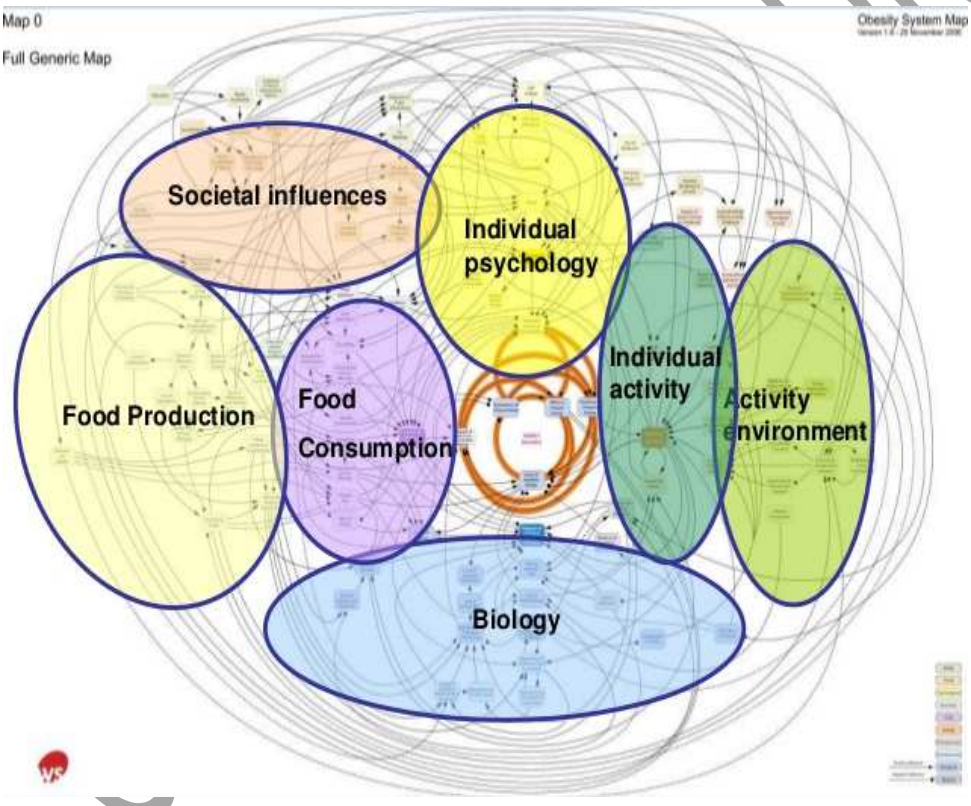
In simplest terms overweight and obesity is caused by consuming more calories than we use, with the excess being stored as fat. Over weeks, months and years the extra fat we store accumulates

until it becomes damaging to our health and wellbeing. Having a poor diet or having low levels of physical activity both independently cause significant damage to our health and wellbeing.

If all things were equal between all people, and whether to be physically active or eat more healthily was just down to personal choice we would not have geographical variation, particularly with deprivation and especially at such early ages.

The reality is many factors influence our ability to be more active or eat more healthily (see figure 8 below). There are many factors which influence our diet and activity levels which go beyond individual choice, further than our individual skills and knowledge, through the social norms of our family and communities, to the availability and promotion of unhealthy food and whether our physical environment makes the healthy and active choices the easy choices. It is important we understand these influences if we are to mount an effective response to this crucial issue. These causes of physical inactivity, poor diet and obesity are the things we must tackle if we are to make an impact on childhood obesity.

Figure 8 – causes of overweight and obesity (Foresight 2007)



This is of course even more relevant when considering childhood obesity; in the antenatal period, infancy and the early years, choices are made for children and behaviours are learned. Through primary school years default behaviours are becoming ingrained and children begin to increase their influence on family choices, however their family, childcare and the school environment still have the major role. As young people grow through secondary school years they gain more personal autonomy of their food and physical activity choices. As with their parents, their peers, the social norms and the physical environments where they live, learn and play continue to influence their choices and continue to do so through adulthood and parenthood.

The challenge – an obesogenic society

One of the reasons society has failed to deal with the obesity crisis is that *there is no one single solution* and that to have a measurable impact at a population level, sustained, effective action on many of the key causes *at the same time* is required.

At the same time, the range of causes mean that many sectors have a small but important role to play, which on their own would have little impact, leading decision makers in individual sectors to other priorities. In addition, because the impact of single interventions is small and multi-sectoral the *invest to save* case for action on obesity in a single sector does not incentivise investment. Furthermore, the research into effective solutions is also limited by the fact that it is the additive effect of multiple action across these determinants which will have an impact, studies into the effectiveness of individual elements have lead to the widespread mis-conception amongst the media and policy makers that there is little we can do.

Neither people, parents, front line professionals nor policy makers see ourselves or our children as overweight or obese. It is well known that adults underestimate their own weight and research shows that over half of parents do not recognise their children are overweight or obese. The sheer scale of the problem has normalised it in society and the media tend to use images of extreme obesity in highlighting the issue. We all consistently underestimate the health impacts, and the benefits of regaining healthy weight, particularly in otherwise healthy children.

Family and community norms remain from generations of food poverty, particularly in more deprived communities with the legacy of heavy industry, where "eating well" actually means overeating, where saving our energy is prioritised over activity and where overweight and even obesity is seen as healthy – this is particularly true in pregnancy, infancy and the early years. Breastfeeding is not visibly commonplace and whilst attitudes are changing and much activity is undertaken, particularly in the health sector, rates of breastfeeding and even intention to breastfeed are still very low.

If we don't see it as a problem we are less likely to act, the situation is gradually improving but still breastfeeding rates or weight and body mass index are not routinely measured and recorded, less still physical activity status or nutritional intake. When we do recognise overweight or obesity as a problem, parents and professionals alike find it a difficult topic to raise: it is a sensitive issue, mis-conceptions exist about damaging therapeutic or caring relationships, there is no agreed single set of key messages or resources, there is a lack of confidence in our ability to intervene effectively, no knowledge of the resources in communities that can help families eat healthily or become physically active and a lack of effective services for treating significant obesity in children for parents or professionals to get help. We all know people who have tried and failed to do something about it.

Although eating more costs more, there is a common concern that healthy diets are more expensive and that becoming physically active requires significant investment of time and money. The food and physical activity environments of the places where we live, learn, work and play have a big influence on how we eat and how active we are.

Healthy food and drink is not marketed in the same comprehensive way as unhealthy food and drink; health just doesn't have the same brand power. It is incredible that the billions of industry pounds spent annually on marketing unhealthy food and drink, associate their brands with slim,

healthy, active, happy, successful children and families. There is a serious amount of money invested in this: it is sustained, effectively targeted at children, young people and families, and is at the leading edge of 21st century web, gaming and social media. The ban on advertising junk food before the 9pm watershed on television doesn't stop our children seeing adverts in cinemas reinforcing the fast food brands just before the feature, at a time of excitement and happiness – the shops are just outside too. The current advertising restrictions do not cover targeted marketing through the games, apps and social media young people use daily. These industry tactics mostly go unnoticed by policy makers, parents and of course the children themselves – we have to try to disrupt that.

Many shops, particularly in more deprived communities, and even public service food provision, sell a significantly larger selection of unhealthy options as they don't think there is a market for healthy choices – despite the overwhelming majority of people wanting to be slimmer or currently trying to manage their weight. That fresh fruit and vegetables are perishable is a further disincentive for retailers. Profit drives food supply, food purchasing promotions disproportionately incentivise o food and drink, high in fat, sugar and salt, particularly in deprived communities.

Structured physical activity is less accessible to parents, it is not marketed at parents specifically and often does not cater for family activity. Almost any investment in our high streets or town centres is seen to have desirable consequences overall: less empty retail units, more revenue, more employment and more choice to encourage people to patronise our local economy. Over the last 20 to 30 years there has been huge growth of food vending in our towns and high streets and along our daily commutes which has increasingly promoted over consumption of energy dense higher fat, sugar and salt foods.

Being careful of unintended consequences, there is a large potential to use local policy and planning vehicles to move closer to what the evidence says support gradual favourable change to our physical environments which make the healthy and active choice the easy choice for future generations.

Currently public service sector actions to tackle the obesity issue are too fragmented to be effective at a population scale (McKinsey, 2014). There is a lot of activity currently undertaken in Gwent, by all sectors, which undoubtedly has beneficial influence on overweight and obesity across the life-course. Coordination, leadership, governance and accountability will be crucial.

Current activity

There has been comprehensive mapping of activity which could impact on childhood obesity in Gwent. The Public Services Leadership Group received comprehensive activity reports from Local Service Boards in six key areas: increase walking and cycling to and from school; safe environments for children to play; more children participate in and become hooked on sport; school children's access to healthy meals on a daily basis; personal skills of children and parents to recognise, eat and prepare healthy food and; healthy choices are easier to access than unhealthy choices.

What is clear from those analyses is that there is a lot of activity currently undertaken in Gwent by all sectors and in all local authority areas, which contribute to healthy weight. These assets include but are not limited to: work of community organisations like Communities First, Gwent Association of Voluntary Organisations, Torfaen Voluntary Alliance and the rest of the third sector and volunteers; leisure services, sporting and active recreations groups and Sport Wales; management of the physical activity and food environment by environmental health, planning, transport,

countryside regeneration, and others such as Groundwork or Natural Resources Wales; play and youth services, Neighbourhood Care Networks; and Aneurin Bevan Health Board across primary, community and secondary care.

However, when we map services we tend to look across the whole provision and include those actions which logically could have an impact on childhood obesity – they are the things we were doing anyway and are rarely designed from what evidence says can reduce childhood obesity. Furthermore, there is a lot of inconsistency with different sectors, focussing on different and individual parts of the solution – rather than a coordinated plan.

This strategy has used the analyses of current activity, and the practical knowledge of the Strategy Development Group, along with what the evidence says we should do, to recommend appropriate actions which will lead to reorientation towards more consistent and effective provision. Apart from developing childhood weight management services this strategy is not recommending new actions requiring new investment.

The challenge of this strategy is to coordinate that work and realign it from this policy perspective towards more and more effective activity aimed at reducing childhood obesity. This strategy recommends that both organisations *and* partnerships take an improvement approach to get from where we are to where we need to be through existing leadership, governance and accountability frameworks.

What we have to do – from evidence to action

The Child Measurement Programme in Wales has followed a group of children from their first measurement at age four to five years with a second measurement at age eight to nine. Analysis shows that children in all categories move up and down healthy and unhealthy weight categories leading to some key messages which are broadly supported by other research:

1. Childhood overweight and obesity is open to change.
2. Action for children is needed across all levels of the pathway to
    a. help healthy weight children stay a healthy weight,
    b. help overweight children halt unhealthy weight gain and grow in to a healthy weight
3. More intense intervention is likely to be required to help children who are obese improve their weight for height.

There is a lot of evidence with a high degree of agreement about the key areas we should focus on collectively and the effective components of action by individual sectors which can have biggest impact. The most recent analysis (McKinsey, 2014) suggests that if we can coordinate the deployment of an ambitious, comprehensive, and sustained portfolio of specific initiatives across the whole of society, at a national level, the rise in obesity could be halted with 20 per cent of the overweight and obese population returning to healthy weight category within five to ten years.

Approach

The public health team with the strategy development group reviewed the evidence, guidance, strategy and policy which suggest the range of important things we should focus on to achieve a

population benefit in rates of childhood obesity. The strategy development group held a number of consultations with the population groups they work with to understand what local people felt about the priority of childhood obesity and the type of action that would be acceptable. Practical actions for each partner have been identified and cross checked and agreed though wider consultation with stakeholders. There were a number of key documents which summarise the available body of evidence, they are outlined below.

Evidence-based action

The Foresight report examined the systems causes of obesity and identified *areas for action* which could have the biggest impact and which were potentially modifiable. The report recommends the most promising policies of:

1. Investment in early-life interventions
2. Increased walkability/cyclability of the built environment
3. Controlling the availability of and exposure to obesogenic food and drink
4. Targeting health interventions for those at high risk

The Public Service Leadership Group considered policy context, known activity and remit of local government policy areas in recommending the six areas they want to see improvement in:

1. Increase walking and cycling to and from school,
2. Safe environments for children to play,
3. More children participate in and become hooked on sport,
4. School children's access to healthy meals on a daily basis,
5. Personal skills of children and parents to recognise, eat and prepare healthy food and,
6. Healthy choices are easier to access than unhealthy choices.

The report goes further in recommending specific actions which they feel are practical and achievable most of which are congruent with the evidence of effectiveness elsewhere.

Public Health Wales have reviewed the evidence and identified ten areas we should focus on in three stages of: preconception and pregnancy, infancy (0 to 24 months) and, two to five years. These are:

1. Adults who are parents or are planning to become parents are a healthy weight
2. Weight gain during pregnancy is within recommended levels
3. Babies are breastfed
4. Babies do not have solid food before the age of six months
5. Babies grow steadily within the first year of life
6. Children play outdoors every day
7. Screen time is kept below eight hours a week

8. Children eat fruit and vegetables every day
9. Children get enough sleep
10. Children have healthy drinks most of the time (water, milk or diluted fruit juice)

There is a large range of guidance, evidence briefings for local authorities and pathways published by the National Institute for Health and Care Excellence (NICE). NICE systematically review evidence of effectiveness and make recommendations for policy makers and practitioners. There are 14 published pathways recommending the actions organisations and partnerships can take in prevention, identification and management of overweight and obesity. In addition to those pathways there are 10 guidelines specifically related to addressing healthy weight and obesity and more in development. In addition there are several guidance documents on nutrition and physical activity with seven dedicated to physical activity alone.

Active Travel (Wales) Act 2013 and Action Plan requires local authorities to identify and map the enhancements that would be required to create a fully integrated network for walking and cycling, and develop a prioritised list of schemes to deliver this network. The ensuing Active Travel Action Plan contains other activities including the promotion of opportunities to be active.

Recent analysis by McKinsey (2014) identifies 74 interventions which the authors place in 18 categories, and which they claim could reduce obesity by 20 per cent if implemented systematically at scale. They include

1. Active transport
2. "Healthcare payors" (incentives and rewards)
3. Healthy meals
4. High calorie food and drink availability
5. Labelling
6. Media restrictions
7. Parental education
8. Pharmaceuticals
9. Portion control
10. Price promotions
11. Public health campaigns
12. Re-formulation of food products
13. School curriculum
14. Subsidies taxes and prices
15. Surgery
16. Urban environment
17. Weight management programmes
18. Workplace wellness

Whilst several of the interventions outlined above require legislative or government action, potentially at the UK level and as such are beyond our control, the vast majority of areas and actions are congruent with the rest of the evidence reviewed for our action plan and can be influenced by public service organisations and Partnerships at regional and local level.

An agenda for action in Gwent

The action list appended to this strategy contains practical and achievable actions from across sectors. The small number of actions for a wide number of partners are not intended to constitute a binding "action plan" for organisations and partnerships. It is more a description of activities different actors can do to get closer to effective action on reducing childhood obesity. It is for the bodies accountable to the LSBs/PSBs and the partnerships themselves to set the pace and priorities which they can achieve. This strategy is clear though, as previously mentioned, there is no one single or even small number of actions from a small number of individuals, that will change things. The actions recommended in this strategy are grouped under the following themes:

- **Disrupt obesogenic social norms** – a sustained and targeted media strategy developed in consultation, particularly in deprived communities where rates of obesity are highest, which engages people and begins to challenge current status quo. Enabling parents, families and professionals to recognise the benefits of a healthy weight and the harms of overweight and obesity to children and their futures. Enabling children and young people to recognise the power of big brands and multi-billion pound targeted marketing on their choices.

- **Support a healthy start in life** – the first 1000 days of a child's life are crucial for future wellbeing; from dedicated weight management services for pregnant women, through breastfeeding and parenting support programmes, to the key actions of early years childcare and education providers; standard effective messages and more coordinated action in from a range of early years professionals, programmes and settings to promote and sustain healthy weight.

- **Coordinate and improve the efforts in early years and schools settings** – practical policy and activity which maximises contribution from children, parents, staff, the curriculum and the environment which promote healthy eating, sport, active recreation and active travel throughout the school day.

- **Influence healthy food choices in our communities** – maximising the community cooking assets as part of coordinated programmes to improve healthy eating, working with local food vendors, including public services who provide food for the public, to increase and promote healthier options. Make the most of planning guidance and local policy to regulate the growth in fast food outlets particularly in close proximity to schools.

- **Encourage active recreation and play for families** – prioritising the needs of families and children, particularly in the early years, getting the most out of open space assessments and play sufficiency audits to plan and promote shared spaces for active recreation and play. Services engaging with parents and families, particularly to identify barriers to participation of provided active recreation and play opportunities.

- **Create active and safe communities** –improving the walkability and cyclability of specific communities and new developments: creating, maintaining and promoting the attractive option of walking and cycling in the natural and built environment, prioritise plans which connect communities to places of community interest, prioritise traffic calming measures in deprived communities and close to schools.

- **Provide community and healthcare based weight management interventions for families who need them** – Ensuring weight management programmes are based on evidence of effectiveness and are multi-component, develop Level 2 and 3 childhood weight management services in line with NICE guidance, developing and testing new models of

community-based level 2 weight management programmes and prioritising young women and parents of young children in existing adult weight management services including evidence-based commercial providers.

Mobilising to deliver

In addition to the striking similarity of the priority areas for action, a small number of vitally important messages about how we should organise to implement. It is unequivocal that:

- No single intervention or organisation can offer a unilateral solution
- The main answer does not lie with another sector in another organisation
- There is the potential for big savings and benefits to society and public services but they are spread across sectors and organisations.
- Reversing the current obesity trend requires multiple interventions, from multiple sectors, at the same time
- This is hardly about new investment, it is about a renewed focus on coordination to harness and reorient current work with incidental impact, towards effective and synergistic action.
- Leadership, accountability and governance are crucial and should be provided by both partnership and organisations.

Systems improvement approach

As well as systems of causes there are also systems of assets – people, places and services – in different settings which need to collaborate, reorienting towards the solutions described. These systems have existing organising structures with strategic, managerial and operational activity; these are the leaders who can generate the scale of reorientation we need at both policy and operational levels. Key systems would be: Pre-school and school settings; those who manage the food and physical activity environment; communities, Communities First and the third sector; Neighbourhood Care Networks including early years healthcare professionals and; public service communications professionals and the media. We have to reach and inspire and empower the leaders within these systems to act differently.

Leadership for change

If we are going to achieve the scale of change required to realise our vision then we need to enable people from all levels across the important public service systems that can make that change possible. Engendering and enabling leadership at all levels across those systems from Cabinet and Board through operational management and front-line personnel to the people who live work and play in our communities today will be important to our success. Building the commitment for change through collaboration and inspiring others with our shared purpose has to come from within the system itself, with the mutual respect only the inside knowledge of shared values and shared experiences can bring. Internal system leaders also enable a better spread of innovation through existing networks and, their ideal placement to locate the resources, risk takers, knowledge, tools, and relationships essential for spreading innovation and change at scale and pace. The 'bodies' we recommend are accountable for delivery against this strategy need to be able to harness that potential for change.

Using an improvement method

Gaining large scale change across the systems will require small scale process changes by leaders and teams within the systems. Using an improvement method will enable change to be rigorously delivered in discrete parts of the system in a managed way, improvement methods are essentially concerned with: agreeing what success looks like and how that can be measured; with the system identifying and agreeing the timely implementation of appropriate and realistic changes and actions; re-measuring using comparators and benchmarking and reacting with different or greater intervention. There are many methodologies to choose including Lean, Total Quality Management or Model for Large Scale Change.

To manage this work will require senior level leadership and sound accountability and governance frameworks. The accountable structures will agree the performance and delivery measures they will use to assure themselves that requisite change has followed and will be at the requisite level to ensure barriers and conflicts are removed with necessary facilitators put in place.

Suggestions for using existing governance and accountability structures are provided in the next section but the urgent first task for each accountable body is to agree the relevant actions from the plan, the measures they will use to demonstrate progress and the timescales. The agreed accountable bodies should agree and report on a three-year rolling plan with annual refresh.

Accountability and governance structures

The Public Service Leadership Group, NICE guidance and the All-Wales Obesity pathway recommend different structures to be accountable for making these actions happen in Wales. The PSLG specifically acknowledges the risk in collective accountability. However, due to the public service wide response required to turn the curve on childhood obesity, and the different roles and competence of partnership and organisational leadership, single accountability and governance would likely fail. There are also different governmental reporting structures for organisations and Partnerships.

Therefore this strategy recommends, whilst ABUHB are providing the initial leadership and call to organise, that the accountability and governance should be at senior strategic levels *both* within organisations and Partnerships (LSB/PSG) providing assurance to Council Cabinet, ABUHB Board and LSB/PSB on sufficient progress. This strategy recommends that the UHB, the five local authorities and the five local service boards adopt childhood obesity as a priority piece of work and as a "Wellbeing Objective" under the Wellbeing of Future Generations (Wales) Act 2015.

Partnerships will not currently be the most efficient place, for example, to enable all Midwives to receive training in *brief intervention* for weight management but they are much more able than organisations to assess the variation of need in their local communities and coordinate activity in particular areas or settings. Through the Wellbeing of Future Generations (Wales) Act 2015 Public Service Boards will develop stronger mechanisms for holding composite organisations to account for delivery against jointly agreed priorities. Public Service Boards will also be able to ensure sustainability of this strategy through public service organisational change. LSB/PSB must be accountable for the *coordination* of actions to meet local priorities, reduce inequalities in health and ensure maximum integration with partnership action on the other six *wellbeing goals*.

Organisational accountability and governance will be required to reorient to provide activity contained within single sectors. Within the ABUHB the Public Health and Partnerships Committee, will provide assurance to the University Health Board for the actions of a healthy weight delivery group with representation from the relevant Divisions including NCNs. The strategy recommends a Board level champion is nominated as a senior leader for this work within the UHB and as an advocate with partners.

This strategy calls for the five local authorities in Gwent to identify the relevant existing internal cross-organisational structure(s) who can provide: 1) assurance to Cabinet on progress against the childhood obesity "wellbeing objective", 2) hold local authority departments and other providers accountable for delivery and 3) provide the appropriate cross-policy scrutiny for policy and activity which could impact on childhood obesity. Each local authority may have different structures which can perform this function. We recommend a Cabinet champion be nominated as a senior leader for this cross-government agenda.

Local Service Board (and future Public Service Boards) structures predominantly concerned with health and equality should provide the locality partnership accountability for directing and coordinating local delivery to local need also considering the activity on the other wellbeing goals. These groups already have governance arrangements in place through to LSB and have the existing networks of practitioners.

Outcomes and delivery framework

Outcomes

- Proportion pregnant women gaining more than recommended weight gain during pregnancy
- Breastfeeding rates: initiation and 10 days
- Proportion of children aged 4 and 5 years overweight or obese and obese (CMP)
- Percent of children reporting walking or cycling to school (National Survey for Wales, WG)
- Percent of adults walking or cycling for active transport (National Survey for Wales, WG)
- Percent of children Hooked on Sport, School Sports Survey Sport Wales

Delivery

Appropriate indicators drive change and measure delivery and performance. The data and information on progress will need to be selected at an action-based level and will often be system or product completion based on the action plan. There are also data currently available or which can be captured which can show improvement over time. Examples of such indicators are provided below, but, as with the actions, the indicators used in delivery will need to be agreed with the accountable delivery team.

- Implementation reports against actions in plan.
- Pregnant women referred and treated by antenatal weight management services

- Percent of parents satisfied with child play areas (National Survey for Wales (LA area?))
- Proportion of pregnant women with a BMI at booking, at 36 weeks
- Proportion solely breastfeeding at 10 days and six weeks
- Proportion of children aged 0-3 with a recorded BMI
- Introduction of solids guidelines implemented
- Numbers of midwives, health visitors and school health nurses trained in weight management BI annually
- Numbers of Primary Care and other front line professionals trained in weight management Brief Advice
- Numbers AWMS participants who are parents of children in the early years or school age
- Number of parents of children in early years or of school age participating in Foodwise
- Live within a 10 minute walk of green or blue space (NSW)
- Safe for children to play outside in local area (NSW)
- WIMD of target areas for
- Walkability of new developments
- Inclusion of healthy environment criteria in CIL or S106/nos HIA carried out on planning

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Action	Lead	Timeframe	Performance Measure
Disrupt obesogenic social norms			
Develop a childhood obesity communication strategy which includes consistant key messages, best resources and promotion of current provision particularly targeted in deprived communities	Public Health and organisational communications leads		
Identify and develop an ABUHB Board Member and senior council members (x5) to be champions for C & YP's physical activity	Public Health, ABUHB, LAs		
Support a healthy start in life			
Evaluate Torfaen antenatal weight management service to include weight management outcomes as well as health outcomes in pregnancy and labour.	Dietetics/ Midwifery		
Develop a business case for the roll out of ABUHB antenatal weight management service across Gwent	ABUHB		
Improve antenatal programmes across Gwent to routinely follow best practice guidelines on healthy eating and physical activity and develop a coordinated approach to provsion	Midwifery/HV/Families First/Flying Start		
Enhance the provision of targeted weaning home visits for parents & families in areas of most need using evidenced based resources e.g. Change4Life 'introduction of solids'	HV		
Promote uptake and use of Healthy Start Vouchers	HV/Midwifery		
Routinely record BMI at booking, 36 weeks and birth on the Protos system and provide brief intervention/brief advice for all pregnant women with a BMI of +25 and referral if appropriate	Midwifery		
Improve the provision of breastfeeding support as part of routine midwifery/HV services and community provision to continue to meet Baby Friendly Initiative Standards	Midwifery, Health Visiting and Flying Start with Communities First		
Increase the availability and promotion of breastfeeding peer support in line with best practice guidance	Midwifery, Health Visiting and Flying Start with Communities First		
Midwifery and Health Visiting services routinely electronically record breastfeeding at agreed intervals.	Midwifery and Health Visiting		
Health Visiting service measure and record weight and height and enter data electronically	Health Visiting		
Improve the physical activity offer for pregnant women and parents of pre-schools children, describe current provision and make recomendations for improvement	Leisure Services		
Map existing parenting programme provision across Gwent and make recommendations for including evidence based information on weight management, timely introduction of solid foods, healthy eating and physical activity	Flying Start and Health Visiting Services with public health		
Families and Therapies Divison to embed behaviour change skills into routine practice through the Making Every Contact Count programme	Families and Therapies		
All health professionals to routinely provide brief intervention/brief advice to overweight or obese women of child bearing age and refer to community weight management services or AWMS as appropriate	NCN		
Promote/create a healthier EY & school settings			
Develop a plan to use the recording of heights and weights for the CMP to inform and support parents and schools for action towards a healthy weight	Healthy Schools and School Health Nurses		

All childcare settings in Gwent to develop and implement a food and physical activity policy that includes breastfeeding awareness training for staff and provides facilities for breastfeeding and storage of breastmilk	LAs
All healthy and sustainable pre school scheme settingsin Gwent to achieve the Gold Standard Healthy Snack Award	Healthy and sustainable pre school scheme
All healthy and sustainable pre-schools scheme settings in Gwent to achive the nutrition and active play criteria	Healthy and sustainable preschool scheme
All healthy pre-school settings staff to undertake brief advice training to be able to provide information to parents on key physical activity, nutrition and healthy weight messages using an effective approach	PHW
Famlies First and Fying Start childcare staff/practitioners to undertake Agored Cymru Nutrition Education training	Families First and Flying Start
Implement Gwent pre school Active Play policy across all healthy and sustainable pre school scheme settings in Gwent	Healthy and sustainable preschool scheme
Develop a policy to increase physical activity in early years childcare/education provision setting, tailoring activities according to the child's developmental age and physical ability. Ensure they are inclusive, progressive and enjoyable	Healthy and sustainable preschool scheme
All schools in Gwent to develop, with school councils and parents a whole-school food and fitness policy which should include provision of free breakfast, healthy lunch boxes, and improving uptake of school meals	Healthy Schools
Encourage parents and carers to complete at least some local journeys (or part of a journey) with young children using a physically active mode of travel	Healthy and Sustainable Pre-schools and Healthy Schools
Deliver a multi-skills physical literacy programme in pre-school and primary schools across Gwent	Leisure Services and Sport Wales
Map current physical activity opportunities within the school day and providing recommendations for further provision in line with NICE guidelines	Leisure Services School Sports Survey - Leisure Services use data to provide equitable provision
Make school facilities available to children and young people before, during and after the school day, at weekends and during school holidays. These facilities should also be available to public, voluntary, community and private sector groups and organisations offering physical activity programmes and opportunities for physically active play. Use Play Wales toolkit	Education & Healthy Schools
Consult with pupils to develop a programme of extra-curricular activity that provides positive experiences for all. SportWales can support schools.	Leisure servises, sport wales and Healthy Schools
Provide training on childhood obesity and the benefits of healthy eating and physical activity to PSE advisors, catering staff, Governors, teachers, parents	Dietetics Link to EAS and PSE action
Develop a process to engage children (e.g. Young Ambassadorss), parents and families in the co-production of whole school F&F policy and interventions to prevent overweight and obesity	Public Health
All primary and secondary schools in Gwent to develop a schools active travel plan which will map the implementation of Safe Routes to School and may include walking buses with parent volunteers and consider a cycle loan scheme - consult with parents and school council	Transport/road safety/Healthy Schools/Sustrans
Map current provision of healthy weight, healthy eating and physical activity education throughout the curriculum (esp PSE) and make recommendations for improvement	Healthy Schools, EAS & PHW

Ensure informal and formal physical activity sessions for children and young people (including play) are led by staff or volunteers who have achieved the relevant sector standards or qualifications for working with children	Leisure servcies
PE/sport & leisure staff to promote a varity of activites that children enjoy and can take part in outside school with friends and family, including a range of activities beyond traditional and competitive sport and without requirement for equipment and facilities	Leisure Services
Influence healthy food choices	
Explore free transport scheme to supermarkets and investigate the feasibility of free delivery particularly to rural, deprived and isolated areas	Transport
Develop local planning policies to regulate the proliferation of fast food outlets in areas of deprivation and particularly in proximity to schools	Planning
Map community cooking resources and provide recomendations to build capacity	C1st
Map existing community food (cooking, eating, growing), healthy eating and weight managment opportunities/projects for families and develop a coordinated approach (Healthier Communities)	C1st
Support retailers to engage in the Healthy Start Vouchers Scheme	C1st
Better promotion of retailers that have acheived the Healthy Options Award	Environmental Health
Work with cafe and restaurant owners across Gwent to achieve the Healthy Options Award	Environmental Health
Increase healthy vending in statutory and public funded institutions - including leisure centres and hospitals	Health Boards and Local Authorities with support from Public Health
Develop street trading polices which restrict trading from fast food vans near schools	Planning
Explore the potential of section 106 agreements and the community infrastructure levy to improve healthy food provision in local communities	Planning
Expand food coops across Gwent	RRU/NRW
Enable/encourage active recreation & play	
Develop an integrated approach to youth service physical activity provision in local communities where young people can have a role in managing and leading their own activities	Youth services
Use Community Infrastructure Levy and Section 106 agreements to increase opportunities for active travel, active recreation and active play	Planning
Develop plans based on Play Sufficiency Assessments to ensure the provision of green spaces and play parks in local communities	Play service, planning
Conduct a play facilities audit and make recomendations for improvements to the physical environment that will increase opportunities for unstructured physical activity in line with NICE guidelines	Leisure services/trusts and Parks
Develop and implement a play strategy which creates many varied opportunities for children to engage in age appropriate play (including play that does not require ready-made facilities and equipment)	Play Service
Identify barriers to physical activity participation in local communities and consider these when planning leisure services (e.g. lack of appropriate changing facilities, inadequate lighting, poorly maintained facilities, lack of access)	Communities First and Leisure Services
Engage local communities to identify and train a wide range of local champions (e.g. community reps, coaches and sports leaders) and charities such as Street Games to promote and deliver physical activity locally	C1st, GAVO, TVA and Leisure Services
Create (safe) active communities	

Identify and develop more family elements, consistent information on behaviour change and include the evidence-based messages on food and fitness in the existing programmes of community food and physical activity opportunities/projects as part of L1 of the WG Obesity Pathway	C1st
Use local planning and transport mechanisms to develop a built environment which increases opportunities for physical activity	Planning
Make the health and activity of children integral and explicit within Local Development Plans to make vibrant healthy places.	Planning
Local authorities to use land assets creatively and investigate special purpose vehicles to give developers viable options for a healthy and active community. Make best use of Section 106 and Community Infrastructure Levy to create active communities supporting walking, cycling and active play	Planning and Transport
Improve promote the availability of opportunites for communities to be physically active in the natural environment	Planning
Improve the connectivity of active travel infrastructure (Schools, places of interest, recreation, public buildings, open spaces, public footpaths, rights of way) to increase opportunities for walking and cycling in local communities	Transport and Planning
Improve walkability & cyclability of communities by introducing traffic calming/traffic free measures including 20 mph speed limits around schools	Transport and Planning
Encourage walkability & cyclability of communities by promoting mapped routes (communication strategy) and ensuring adequate provision for cycle parking	Transport and Planning
Build on the Active Travel (Wales) Act 2013 to put in place measures to make it easier and safer for children to walk or cycle to and from school.	Planning
Routinely undertake Health Impact Assessment on all decisions which affect the food environment or physical activity environment and ensure that planning decisions do not have a negative impact on children	Planning, C1st and SIP engagement teams
Provide evidence base weight management servcies for Children & Young People	
Develop a service specification and business case for ABUHB agreement on a sustainable Level 2 and Level 3 weight management programme for children and their families	ABUHB
Ensure comprehensive delivery and greater scale of Foodwise across all C1st areas and specifically target women of childbearing age and parents of young children	Dietetics linked in with C1st and FS/FF

HEALTH, SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE – 20TH OCTOBER 2015

SUBJECT: BUDGET MONITORING REPORT (MONTH 5)

REPORT BY: CORPORATE DIRECTOR SOCIAL SERVICES

1. PURPOSE OF REPORT

1.1 To inform Members of projected revenue expenditure for the Social Services Directorate for the 2015/16 financial year.

1.2 To update Members on the progress made against the savings targets built in to the 2015/16 revenue budget for the Directorate.

2. SUMMARY

2.1 The report summarises the projected financial position for the Social Services Directorate for the 2015/16 financial year based on information available as at month 5 (August 2015). Full details are attached at Appendix 1.

2.2 The report also identifies the 2015/16 savings targets that have been achieved by the Directorate and identifies the progress that has been made towards delivering the targeted savings that have not yet been achieved.

3. LINKS TO STRATEGY

3.1 The expenditure of the Directorate is linked directly to its ability to shape and deliver its strategic objectives, which in turn assists the achievement of the Authority's stated aims.

4. THE REPORT

4.1 The 2015/16 month 5 position is a projected Directorate underspend of £324k as summarised in the table below: -

Division	2015/16 Current Budget (£000's)	2015/16 Projection/ Commitment (£000's)	2015/16 Over/(Under) Spend (£000's)
Children's Services	19,146	18,860	(286)
Adult Services	52,419	52,371	(48)
Service Strategy & Business Support	2,785	2,795	10
Totals: -	**74,350**	**74,026**	**(324)**

4.2 This equates to a net movement of £32k from the £356k projected underspend that was reported to the Health, Social Care and Wellbeing Scrutiny Committee on 8th September as part of the Month 3 Budget Monitoring Report.

4.3 Full details of the month 5 budgets and projections are provided in Appendix 1 and the following paragraphs summarise the key issues arising.

4.4 **Children's Services**

4.4.1 The Children's Services Division is currently projected to underspend by £286k as summarised in the following table: -

	2015/16 Current Budget (£000's)	2015/16 Projection/ Commitment (£000's)	2015/16 Over/(Under) Spend (£000's)
Management, Fieldwork & Administration	8,638	8,135	**(503)**
External Residential Care	1,542	1,544	**2**
Fostering & Adoption	6,644	6,890	**246**
Youth Offending	402	402	**0**
Other Costs	1,920	1,889	**(31)**
Totals: -	**19,146**	**18,860**	**(286)**

Management, Fieldwork and Administration

4.4.2 In response to the anticipated reductions in Welsh Government funding over the forthcoming financial years, a prudent approach to vacancy management has been adopted. A number of vacant posts have now been withheld for the remainder of the current financial year pending consultation in respect of the 2016/17 corporate budget strategy. This has contributed to a projected underspend of £503k against Management, Fieldwork and Administration posts within the Division.

Child Care Placement Costs

4.4.3 An overall overspend of £248k is projected in respect of residential placements, fostering and adoption which amounts to an increase of £195k since the Month 3 position. Around £120k of this increase can be attributed to 2 short term residential placements that are not expected to have any significant longer term financial implications. Members will be aware that demand for these services can be extremely volatile.

Other Costs

4.4.4 The projected £31k underspend for 'Other Costs' can mainly be attributed to 16 Plus aftercare services.

4.5 **Adult Services**

4.5.1 The Adult Services Division is currently projected to underspend by £48k as summarised in the following table: -

	2015/16 Current Budget (£000's)	2015/16 Projection/ Commitment (£000's)	2015/16 Over/(Under) Spend (£000's)
Management, Fieldwork & Administration	7,659	7,603	(56)
Own Residential Care	5,884	5,815	(69)
Own Day Care	4,377	4,163	(214)
Sheltered Employment	71	70	(1)
Aid and Adaptations	967	900	(67)
Costs of Care Packages			
- *External Residential Care*	11,159	11,005	(154)
- *External Day Care*	879	919	40
- *Home Assistance and Reablement*	12,335	12,054	(281)
- *Other Domiciliary Care*	8,938	9,006	68
- *Resettlement S28a Income*	(1,020)	(1,020)	0
Supporting People	211	920	709
Other Costs	959	936	(23)
Totals: -	**52,419**	**52,371**	**(48)**

Management, Fieldwork and Administration

4.5.2 The £56k underspend in Management, Fieldwork and Administration reflects the prudent approach to vacancy management that has been adopted across the directorate. The savings achieved through vacancy management more than offset projected overspends attributable to the additional temporary staff within the Mental Health Team and the continued pilot of the S.T.A.R.T. team.

Own Residential Care

4.5.3 The underspend of £69k within our Own Residential Care service is largely due to additional income from residents in our own homes for older people. The level of this income is dependent upon the financial means of the cohort of service users in care at any time and the occupancy rates within our homes.

Own Day Care

4.5.4 The underspend of £214k within our own day care services is largely due to the early delivery of the reconfiguration of the service including an element of one-off savings through vacancy management in preparation for the reconfiguration. This projected underspend has increased by around £42k since Month 3 due to a previous over estimation of outstanding energy costs.

Aids and Adaptations

4.5.5 The underspend of £67k is due to a repayment from GWICES in respect of unspent funding passed to the service by Adult Services in 2014/15.

Supporting People

4.5.6 An overspend of £709k is currently projected against the Supporting People budget. Of this amount, £474k is due to a cut in Welsh Government specific grant funding. A specific reserve has been earmarked in response to this grant reduction which can be drawn upon in 2015/16 should the Directorate as a whole overspend in 2015/16. The remaining overspend of £235k reflects the current levels of demand for supporting people services. A cross directorate working group has been created to address this issue.

Costs of Care Packages

4.5.7 The table included in paragraph 4.5.1 separately identifies the position in respect of the budgets for external residential care, external day care, home assistance and reablement and other domiciliary services. The net position in respect of these costs of care packages is a projected underspend of £327k.

4.5.8 This underspend can be attributed to £332k of additional income from service users in respect of non-residential care. The level of this income is dependent on the financial means of each service user but it is felt that the current income levels are largely reflective of changes in charging policies rather than a short term fluctuation in service users' financial means. As such, this additional income could help to deliver the longer term savings required as part of the Medium Term Financial Plan.

4.5.9 If this additional income from service users.is discounted then the projected costs of current care packages would exceed the budget by around £5k. Members will be aware that demand for care packages can be particularly volatile throughout the winter months so this position will require close monitoring throughout the remainder of the financial year.

Other Costs

4.5.10 An underspend of £23k is predicted against other Adult Services budgets. This is largely due to Welsh Government grant funding for the administration of the Welsh Independent Living Fund Grant.

4.6 **Service Strategy & Business Support**

4.6.1 This service area is currently projected to overspend by £10k as summarised in the following table: -

	2015/16 Current Budget (£000's)	**2015/16 Projection/ Commitment (£000's)**	**2015/16 Over/(Under) Spend (£000's)**
Management and Administration	1,281	1,351	70
Office Accommodation	444	466	22
Office Expenses	239	239	0
Other Costs	821	739	(82)
Totals: -	**2,785**	**2,795**	**10**

Management and Administration

4.6.2 The 2015/16 budget settlement for the Directorate included a savings target of £220k in respect of back office staff. Specific full year savings of around £173k have been identified to date but further savings amounting to £47k for a full year will need to be identified during the remainder of the current financial year. Much of the £173k full year savings that have been identified will only deliver a part year effect in 2015/16 resulting in a total projected overspend of £70k against Management and Administration.

Office Accommodation

4.6.3 The £22k projected overspend against Office Accommodation is due to the final settlement in respect of dilapidation costs associated with the Hawtin Park Offices vacated by Social Services in 2009/10.

Other Costs

4.6.4 The underspend of £82k against Other Costs includes a projected underspend of £101k relating to a provision set aside in the Social Services budget in respect of potential overspending within the Integrated Transport Unit (ITU). This provision had been set aside because prior to 2014/15 a recurring overspend had been experienced by the ITU in respect of Social Services transport costs. However, changes in criteria and working practices were implemented in 2014/15 which resulted in a small underspend within the ITU in 2014/15. As a result it is anticipated that this budget provision will no longer be required.

4.6.5 The £101k underspend identified in paragraph 4.6.4 is partially overset by a projected one off overspend of £19k in respect of office furniture costs resulting from a number of office relocations linked to the corporate accommodation strategy.

4.7 **Progress Made Against the 2015/16 Revenue Budget Savings Targets**

4.7.1 The 2015/16 revenue budget settlement for Social Services included targeted savings of £2.084m. The projected overspends and underspends discussed in the above paragraphs take account of these savings targets. However, for ease of reference, the progress made against the individual savings targets included in the £2.084m is summarised in the following table and accompanying paragraphs:-

Ref:	Description	Savings Target	Savings Achieved to Date £000s	Further Savings Required £000s	Details
Soc01	Review of shopping services	40	40	0	Shopping services are only approved in exceptional circumstances
Soc02	Review of meals on wheels service (50p per meal increase)	44	44	0	50p increase has been implemented
Soc03	Review of day centre provision	128	128	0	A further in-year saving of £98k has been achieved in advance of 2016/17 as a result of the early implementation of this review
Soc21	Reduction of 3 social workers per division with the intention to achieve by vacancy management	219	186	33	A post has been earmarked for deletion to achieve this saving but it is currently occupied
Soc22	Review of domiciliary care provision	85	85	0	A small underspend was previously predicted against adult care packages which suggests that this target has been achieved. However, demand for these services has since grown.

Ref:	Description	Savings Target	Savings Achieved to Date £000s	Further Savings Required £000s	Details
Soc4-20 and Soc23-27	General savings that have no direct impact on service users	1,568	1,400	168	An additional full year saving of £33k has been achieved since the position reported to HSC&WB Scrutiny Committee on 8th September 2015. This has been achieved through the deletion of a vacated back office post.
		2,084	1,883	201	

4.7.2 Of the £2.084m directorate savings target for 2015/16, £1.883m (90%) has already been achieved. In addition certain posts have been earmarked for deletion pending retirements and redeployment opportunities which are likely to deliver further full year savings amounting to £104k. This leaves just £97k of savings that the Senior Management Team will need to identify during the remainder of the current financial year.

4.7.3 The remaining saving target of £97k is £33k less than the £130k reported to the Health, Social Care and Wellbeing Scrutiny Committee on 8th September. This reduction is as a result of the Senior Management Team taking a decision not to replace an administrative officer that has recently left the organisation.

5. EQUALITIES IMPLICATIONS

5.1 This report is for information purposes, so the Council's Equalities Impact Assessment (EqIA) process does not need to be applied.

6. FINANCIAL IMPLICATIONS

6.1 As identified throughout the report.

7. PERSONNEL IMPLICATIONS

7.1 There are no direct personnel implications arising from this report.

8. CONSULTATIONS

8.1 There are no consultation responses that have not been reflected in this report.

9. RECOMMENDATION

9.1 Members are asked to note the projected underspend of £324k for 2015/16.

9.2 Members are asked to note the progress made against the savings targets included in the 2015/16 budget settlement for the Directorate.

10. REASONS FOR THE RECOMMENDATIONS

10.1 To ensure that the Directorate manages its budget effectively.

11. STATUTORY POWER

11.1 Local Government Acts 1972 and 2000.

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Consultees: Social Services Senior Management Team
Robin Woodyatt – Cabinet Member for Social Services
Stephen Harris – Interim Head of Corporate Finance

Appendices: Appendix 1 – Social Services 2015/16 Budget Monitoring Report (Month 5)

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APPENDIX 1 – Social Services 2015/16 Budget Monitoring Report (Month 5)

	Revised Budget 2015/16	Actuals	Projection	Over/ (Under) Spend
	£	£	£	£
SUMMARY				
CHILDREN'S SERVICES	19,146,154	6,632,608	18,860,107	(286,047)
ADULT SERVICES	52,418,624	22,052,753	52,370,558	(48,066)
RESOURCING AND PERFORMANCE	2,785,497	1,050,449	2,795,538	10,041
SOCIAL SERVICES TOTAL	**74,350,275**	**29,735,809**	**74,026,203**	**(324,072)**
CHILDREN'S SERVICES				
Management, Fieldwork and Administration				
Children's Management, Fieldwork and Administration	8,637,786	3,295,861	8,135,372	(502,414)
Sub Total	**8,637,786**	**3,295,861**	**8,135,372**	**(502,414)**
External Residential Care Including Secure Accommodation				
Gross Cost of Placements	1,559,169	679,076	1,831,379	272,210
Contributions from Education	0	0	(270,136)	(270,136)
Contributions from Health	(17,456)	0	(17,151)	305
Sub Total	**1,541,713**	**679,076**	**1,544,092**	**2,379**
Fostering and Adoption				
Gross Cost of Placements	5,926,322	2,090,427	6,192,107	265,785
Other Fostering Costs	117,104	18,141	117,104	0
Adoption Allowances	212,343	88,147	191,705	(20,638)
Other Adoption Costs	60,951	(52,756)	60,951	0
Professional Fees Inc. Legal Fees	327,649	105,121	327,649	0
Sub Total	**6,644,369**	**2,249,080**	**6,889,515**	**245,146**
Youth Offending				
Youth Offending Team	401,682	(55,732)	401,682	0
Sub Total	**401,682**	**(55,732)**	**401,682**	**0**
Other Costs				
Equipment and Adaptations	31,623	31,537	31,623	0
Preventative and Support - (Section 17 & Childminding)	178,741	40,889	178,741	0
Local Safeguarding Children Board	11,209	12,167	0	(11,209)
Aftercare	251,259	(69,650)	192,045	(59,214)
Respite Care	119,906	85,796	140,633	20,727
Agreements with Voluntary Organisations	1,097,805	282,794	1,097,805	0
Other	230,061	80,789	248,599	18,538
Sub Total	**1,920,604**	**464,322**	**1,889,445**	**(31,159)**
TOTAL CHILDREN'S SERVICES	**19,146,154**	**6,632,608**	**18,860,107**	**(286,047)**

	Revised Budget 2015/16	Actuals	Projection	Over/ (Under) Spend
	£	£	£	£
ADULT SERVICES				
Management, Fieldwork and Administration				
Management	114,131	50,332	117,386	3,255
Protection of Vulnerable Adults	479,637	166,699	429,036	(50,601)
OLA and Client Income from Client Finances	(154,265)	(77,553)	(154,265)	0
Commissioning	802,993	302,375	769,076	(33,917)
Section 28a Income Joint Commissioning Post	(17,175)	1,431	(17,175)	0
-Less Contribution from Supporting People	(57,784)	0	(57,915)	(131)
Older People	2,328,822	991,746	2,430,320	101,498
Less Wanless Income	(95,862)	7,988	(95,862)	0
Physical Disabilities	1,503,197	643,687	1,456,096	(47,101)
Provider Services	406,917	185,536	423,026	16,109
Learning Disabilities	695,460	282,036	694,400	(1,060)
Contribution from Health and Other Partners	(39,928)	0	(40,628)	(700)
Mental Health	1,216,238	620,186	1,377,555	161,317
Section 28a Income Assertive Outreach	(94,769)	7,907	(94,769)	0
Drug & Alcohol Services	325,309	160,449	341,490	16,181
Emergency Duty Team	240,621	315,174	240,621	0
Structural Review	5,696	0	0	(5,696)
Vacancy Savings	0	0	(215,492)	(215,492)
Sub Total	**7,659,238**	**3,657,991**	**7,602,901**	**(56,337)**
Own Residential Care				
Residential Homes for the Elderly	6,102,445	2,314,009	6,185,734	83,289
Intermediate Care Fund Contribution	(97,387)	0	(104,788)	(7,401)
-Less Client Contributions	(1,514,654)	(680,753)	(1,769,722)	(255,068)
-Less Section 28a Income (Ty Iscoed)	(220,964)	(404,828)	(220,964)	0
-Less Inter-Authority Income	(136,012)	0	(61,331)	74,681
Net Cost	4,133,428	1,228,428	4,028,929	(104,499)
Accommodation for People with Learning Disabilities	2,355,567	875,613	2,372,567	17,000
-Less Client Contributions	(79,903)	(15,360)	(79,903)	0
-Less Contribution from Supporting People	(273,750)	0	(273,750)	(0)
-Less Inter-Authority Income	(251,623)	0	(232,430)	19,193
Net Cost	1,750,291	860,254	1,786,484	36,193
Sub Total	**5,883,719**	**2,088,682**	**5,815,413**	**(68,306)**
External Residential Care				
Long Term Placements				
Older People	7,228,097	2,614,625	7,115,375	(112,722)
Less Wanless Income	(303,428)	27,629	(303,428)	0
Less Section 28a Income - Allt yr yn	(151,063)	12,589	(151,063)	0
Physically Disabled	309,181	123,077	364,765	55,584
Learning Disabilities	2,822,564	1,249,214	2,683,494	(139,070)
Mental Health	901,674	342,558	909,052	7,378
Substance Misuse Placements	53,523	53,454	53,523	0
Net Cost	10,860,548	4,423,147	10,671,718	(188,830)
Short Term Placements				
Older People	234,163	48,450	234,163	0
Physical Disabilities	31,620	26,465	31,620	0
Learning Disabilities	26,192	23,883	60,694	34,502
Mental Health	6,779	2,011	6,779	0
Net Cost	298,754	100,809	333,256	34,502
Sub Total	**11,159,302**	**4,523,956**	**11,004,974**	**(154,328)**

	Revised Budget 2015/16	Actuals	Projection	Over/ (Under) Spend
	£	£	£	£
Own Day Care				
Older People	903,658	307,546	804,405	(99,253)
-Less Attendance Contributions	(16,869)	(12,423)	(16,869)	0
Learning Disabilities	2,947,742	1,109,416	2,867,425	(80,317)
-Less Contribution from Supporting People	(21,224)	0	(21,282)	(58)
-Less Attendance Contributions	(20,691)	(7,932)	(20,691)	0
-Less Inter-Authority Income	(45,523)	0	(38,748)	6,775
Mental Health	710,923	242,314	669,801	(41,122)
-Less Section 28a Income (Pentrebane Street)	(81,366)	6,780	(81,366)	0
Sub Total	**4,376,650**	**1,645,701**	**4,162,675**	**(213,975)**
External Day Care				
Elderly	3,045	3,567	8,987	5,942
Physically Disabled	154,765	31,523	151,119	(3,646)
Learning Disabilities	793,634	238,995	820,117	26,483
Section 28a Income	(72,659)	12,124	(72,659)	0
Mental Health	0	2,478	11,312	11,312
Sub Total	**878,785**	**288,686**	**918,875**	**40,090**
Sheltered Employment				
Mental Health	70,543	17,022	69,500	(1,043)
Sub Total	**70,543**	**17,022**	**69,500**	**(1,043)**
Aids and Adaptations				
Disability Living Equipment	621,300	553,283	554,733	(66,567)
Adaptations	335,967	39,551	335,967	0
Chronically Sick and Disabled Telephones	10,053	4,257	9,268	(785)
Sub Total	**967,320**	**597,092**	**899,969**	**(67,351)**
Home Assistance and Reablement				
Home Assistance and Reablement Team				
Home Assistance and Reablement Team (H.A.R.T.)	2,925,251	1,213,953	3,008,041	82,790
Wanless Funding	(67,959)	5,664	(67,959)	0
Independent Sector Domiciliary Care				
Elderly	5,944,635	1,646,707	5,598,566	(346,069)
Physical Disabilities	818,886	257,699	809,676	(9,210)
Learning Disabilities (excluding Resettlement)	231,366	84,241	278,204	46,838
Community Living	67,338	20,923	66,314	(1,024)
Mental Health	228,084	56,699	212,956	(15,128)
Gwent Frailty Programme	2,187,120	1,037,065	2,148,135	(38,985)
Sub Total	**12,334,721**	**4,322,951**	**12,053,932**	**(280,789)**
Other Domiciliary Care				
Supported Living				
Adult Placement Scheme	542,632	252,063	548,464	5,832
Intermediate Care Fund Contribution	44,891	0	22,182	(22,709)
-Less Contribution from Supporting People	(158,480)	0	(149,417)	9,063
Net Cost	429,043	252,063	421,229	(7,814)
Supported Living				
Older People	47,114	13,255	47,425	311
-Less Contribution from Supporting People	0	0	0	0
Physical Disabilities	340,322	112,981	442,186	101,864
-Less Contribution from Supporting People	(74,361)	0	(65,534)	8,827
Learning Disabilities	6,289,058	1,992,612	6,385,438	96,380
Less Section 28a Income Joint Tenancy	(28,987)	2,416	(28,987)	0
-Less Contribution from Supporting People	(970,905)	0	(942,414)	28,491
Mental Health	1,884,324	484,544	2,039,516	155,192
-Less Contribution from Supporting People	(66,158)	0	(47,500)	18,658
Net Cost	7,420,407	2,605,808	7,830,131	409,724
Direct Payment				

	Revised Budget 2015/16	Actuals	Projection	Over/ (Under) Spend
	£	£	£	£
Elderly People	235,347	205,929	211,436	(23,911)
Physical Disabilities	345,350	413,665	424,836	79,486
Learning Disabilities	270,732	300,215	327,656	56,924
Section 28a Income Learning Disabilities	(20,808)	0	(20,808)	0
Mental Health	14,919	3,439	3,533	(11,386)
Net Cost	845,540	923,248	946,653	101,113
Other				
Tredegar Court	178,984	61,896	155,332	(23,652)
Sitting Service	526,832	109,558	449,376	(77,456)
Extra Care Sheltered Housing	513,500	170,387	512,121	(1,379)
-Less Contribution from Supporting People	(14,308)	0	(13,868)	440
Net Cost	1,205,008	341,841	1,102,961	(102,047)
Total Home Care Client Contributions (net of commission)	(961,752)	0	(1,294,416)	(332,664)
Sub Total	**8,938,246**	**4,122,960**	**9,006,557**	**68,311**
Resettlement				
External Funding				
Section 28a Income	(1,020,410)	83,121	(1,020,410)	0
Sub Total	**(1,020,410)**	**83,121**	**(1,020,410)**	**0**
Supporting People (including transfers to Housing)				
Elderly Supported People	906,714	67,830	1,016,986	110,272
Physically Disabled Supported People	103,000	8,344	97,198	(5,802)
Learning Disabilities Supported People	672,384	177,809	651,739	(20,645)
Mental Health Supported People	1,429,431	417,488	1,493,049	63,618
Families Supported People	2,239,874	525,311	2,370,401	130,527
Contribution to Independent Sector Supported Living	730,202	0	664,636	(65,566)
Contribution to In-House Supported Living	273,750	0	273,750	0
Contribution to Resettlement	381,222	0	390,812	9,590
Contribution to Adult Placement	158,480	0	149,417	(9,063)
Contribution to Leaving Care	0	0	22,221	22,221
Contribution to Garden Project	21,224	0	21,282	58
Contribution to Extra Care	14,308	0	13,868	(440)
Contribution to Supporting People Team	57,784	0	57,915	131
Less supporting people grant	(6,776,997)	(1,558,198)	(6,302,790)	474,207
Sub Total	**211,376**	**(361,415)**	**920,484**	**709,108**
Other Costs				
Meals on Wheels	212,088	69,372	212,088	0
Telecare Gross Cost	579,597	219,834	577,115	(2,482)
Less Client and Agency Income	(336,757)	(103,191)	(337,350)	(593)
-Less Contribution from Supporting People	(100,704)	0	(100,704)	0
Agreements with Voluntary Organisations				
Elderly	249,807	171,382	249,807	0
Physically Disabled	28,433	30,571	28,433	0
Learning Difficulties	111,286	43,009	111,286	0
Section 28a Income	(52,020)	0	(52,020)	0
Mental Health & Substance Misuse	136,185	76,736	173,236	37,051
MH Capacity Act / Deprivation of Libert Safeguards	61,831	41,629	61,831	0
Other	69,388	516,663	11,966	(57,422)
Gwent Enhanced Dementia Care Grant	0	0	0	0
Sub Total	**959,134**	**1,066,005**	**935,688**	**(23,446)**
TOTAL ADULT SERVICES	**52,418,624**	**22,052,753**	**52,370,558**	**(48,066)**

	Revised Budget 2015/16	Actuals	Projection	Over/ (Under) Spend
	£	£	£	£
SERVICE STRATEGY AND BUSINESS SUPPORT				
Management and Administration				
Policy Development and Strategy	181,554	76,882	184,127	2,573
Business Support and Learning & Development	1,071,153	536,176	1,092,396	21,243
Performance Management Consortium	75,473	(63,693)	74,358	(1,115)
Further Back Office Savings to be Identified	(47,431)	0	0	47,431
Sub Total	**1,280,749**	**549,365**	**1,350,881**	**70,132**
Office Accommodation				
All Offices	519,448	247,212	541,620	22,172
Less Office Accommodation Recharge to HRA	(75,832)	0	(75,832)	0
Sub Total	**443,616**	**247,212**	**465,788**	**22,172**
Office Expenses				
All Offices	239,513	49,872	239,513	0
Sub Total	**239,513**	**49,872**	**239,513**	**0**
Other Costs				
Training	280,102	172,471	280,102	0
Publicity/Marketing/Complaints	51,332	(239)	51,332	0
Staff Support/Protection	58,362	175	58,362	0
Information Technology	3,339	0	3,339	0
Management Fees for Consortia	(57,188)	0	(57,188)	0
Insurances	320,933	0	320,933	0
Other Costs	164,739	31,593	82,476	(82,263)
Sub Total	**821,619**	**204,000**	**739,356**	**(82,263)**
TOTAL RESOURCING AND PERFORMANCE	**2,785,497**	**1,050,449**	**2,795,538**	**10,041**

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HEALTH, SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE – 20TH OCTOBER 2015

SUBJECT: PERFORMANCE MANAGEMENT 2014/15

REPORT BY: CORPORATE DIRECTOR SOCIAL SERVICES

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1. PURPOSE OF REPORT

1.1 To inform Scrutiny Committee of the final position for 2014/15 in relation to the performance management figures for both adult services and children's services and to inform scrutiny of forthcoming changes to the way that performance in social care will be managed from April 2016 in line with the requirements of the Social Services & Wellbeing (Wales) Act.

2. SUMMARY

2.1 Members will be aware from previous reports / presentations that social services and public protection have a range of performance indicators. Some of these indicators are national indicators determined by Welsh Government while other are local indicators that have been created by senior managers to oversee areas not covered by the national indicators.

2.2 This report provides the end of year position in terms of performance information for 2014/15 as well as the performance for the first quarter of 2015/16.

3. LINKS TO STRATEGY

3.1 The performance indicators attached support the Directorate in meeting the range of objectives set out in the Single Integrated Plan, Corporate Plan, Improvement Objectives, the Director Of Social Services Annual report and the Adult's and Children's Service Improvement plans.

4. THE REPORT

4.1 As previously stated both the social services and public protection have a range of national and local indicators that oversee the work of the divisions. The targets are set at the start of each financial year and managed via the authority's Ffynnon system. The targets are a mix of national indicators set by Welsh Government and local indicators.

4.2 Performance against the indicators is monitored on a monthly basis initially by the respective Divisional Management Teams and then by the Directorates Senior Management Team before going onto Corporate Management Team. This allows senior managers to identify any potential difficulties and take corrective action where possible.

4.3 In terms of 2014/15 the detailed position regarding performance is set out as Appendix 1 of this report. Performance for the Council as a whole was discussed at Council on the 6 October 2015 but this report will give members the opportunity to scrutinise performance in more detail. Likewise Appendix 2 provides the performance position as at the 30th June 2015.

4.4 In April 2016 the Social Services & Wellbeing (Wales) Act will come into force. The Act will bring with it a change in emphasis in the way in which Social Services Performance is managed. There will now be a much bigger focus on outcomes for service users and a move from quantative indicators to qualitative indicators which can best described as measuring how well we work with people as opposed to how quickly we do things.

4.5 Appendix 3 of the report is a briefing note to Directors at the Greater Gwent Health Social Care & Wellbeing Leadership Group. Whilst this provides a very helpful summary, Members should be aware that this is the position as we understand it at the moment but some of the detail could be subject to change.

4.6 Compliance with the new requirements will require us to have received feedback from 400 service users in a calendar year. In order to be able to achieve this it is estimated that around 1600 questionnaires will need to be distributed each year (a response rate of 25%). Clearly it will take staff service users and staff to adjust to the new performance framework but members need to be aware that 2015/16 will be the last time performance will reported in the traditional way.

5. EQUALITIES IMPLICATIONS

5.1 An equalities impact assessment hasn't been completed at this time as this report is for information only.

6. FINANCIAL IMPLICATIONS

6.1 There are no direct financial implications arising from this report.

7. PERSONNEL IMPLICATIONS

7.1 There are no direct personnel implications arising from this report.

8. CONSULTATIONS

8.1 All comments from consultations are reflected in the main body of the report.

9. RECOMMENDATIONS

9.1 Members are asked to note the content of this report.

10. REASONS FOR THE RECOMMENDATIONS

10.1 This reports sets out the Directorates performance in 2015/16 and also demonstrates the likely changes to performance management that will occur from April 2016.

11. STATUTORY POWER

11.1 Local Government Act 2000.

Author: Dave Street, Corporate Director Social Services
Consultees: Councillor Robin Woodyatt, Cabinet Member, Social Services
Jo Williams, Assistant Director, Adult Services
Gareth Jenkins, Assistant Director, Children's Services
Mike Jones, Interim Financial Services Manager
Rob Hartshorn, Head Of Public Protection
Ioan Richards, Performance Development Officer

Appendices:

Appendix 1 Performance Information 2015/16
Appendix 2 Briefing note to Directors at the Greater Gwent Health Social Care & Wellbeing Leadership Group re new Performance Requirements
Appendix 3 Greater Gwent Health Social Care & Wellbeing Leadership Group Meeting held on 2 Oct 2015

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CMT Scorecard
Social Services

Performance Against Target: Well below | Just below | On or above

Adult Services PIs - Year End

Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Adult Services - Number of adults waiting for an assessment outside of the timescale (28 days)	71.00	70.00	105.00	↑	84	71 service users
Adult Services - The % of assessments started on time	81.30	85.00	75.00	↓	73.6	4489/5520
SCA/001 DTOC - The Rate of DTOC for social care reasons aged 75 plus	4.46	8.00	11.00	↑	12.6	There were only 3 Delayed Transfer of Care for Social Care Reasons for the month of March and 60 delays for the year, this shows a significant improvement over the last 12 months compared to the previous years figure.
SCA/002a The rate of older people supported in the community aged 65 or over	109.04	125.00	135.00	-	120.72	3471/31831
SCA/002b The rate of older people supported in care homes aged 65 or over	16.18	21.00	22.50	-	17.7	515/31831
SCA/007 The percentage of clients whose care plans should have been reviewed that were reviewed during the year	90.20	95.00	83.00	↓	91.5	1877/2080
SCA/018a - % of adult carers who were offered an assessment	87.20	90.00	79.00	↓	88.1	666/764
SCA/019 - % Of adult protection referrals completed where the risk has been managed	87.00	90.00	80.00	↑	84.8	240/276
SCA/020 - The percentage of adult clients who are supported in the community during the year	79.70	90.00	85.00	↓	91.56	

Appendix 1

CMT Scorecard
Social Services

Performance Against Target

Well below	Just below	On or above

Childrens Services PIs - Year to date

Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
SCC/001a % of LAC that began with a care plan in place	100.00	100.00	90.00	-	100	Final - 135/135
SCC/001b % of LAC with a plan for permanence at due date	100.00	100.00	89.90	-	100	Final - 76/76
SCC/002 % of LAC with one or more changes of school	8.50	13.70	15.00	-	8.3	Final - 18/211
SCC/004 % of LAC who have had more than 3 placements during the year	10.60	10.00	12.00	↓	9.5	Final - 29/272
SCC/011a % assessments - child seen by Social Worker	72.10	60.00	50.00	↑	77.3	Final - 1149/1593
SCC/011b % assessments - child seen alone by Social Worker	38.70	40.00	36.00	↑	42.6	Final - 617/1593
SCC/025 % of statutory visits to LAC due in the year that took place	91.10	90.00	80.00	↑	95.5	Final - 1538/1689
SCC/030a % of young carers who were assessed	100.00	95.00	76.40	-	100	Final - 32/32
SCC/033d % of former LAC in contact at age of 19	100.00	100.00	90.00	-	100	Final - 33/33
SCC/033e % of former LAC in suitable accommodation at 19	100.00	95.00	85.40	↑	93.3	Final - 33/33
SCC/033f % of former LAC in educ/training/employment at 19	54.50	50.00	40.00	↑	60	Final - 18/33
SCC/037 Average external qualifications points score for LAC	322.00	200.00	158.00	-	238.1	Final - 8861/27
SCC/041a % of eligible children that have pathway plans	100.00	100.00	89.00	-	100	Final - 112/112
SCC/045 The percentage of reviews of looked after children, children on the Child Protection Register and children in need carried out in line with the statutory timetable	94.80	87.00	78.30	↑	96.6	Final - 2143/2261

CAERPHILLY COUNTY BOROUGH COUNCIL CYNGOR BWRDEISTREF SIROL CAERFFILI

CMT Scorecard Social Services

Performance Against Target: Well below | Just below | On or above

Public Protection

Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Overall client satisfaction receipt of a very good survey result for Registrars [Qtly accum - Year to date]		95.00	90.00		100	For the past 4/5 years, we have attained consistently high percentage results (100%).
The percentage of food establishments which are broadly compliant with food hygiene standards [Qtly accum - Year to date]	95.00	80.00	70.00	↑	92	
The percentage of high risk businesses that were liable to a programmed inspection that were inspected for Food Hygiene [Qtly accum - Year to date]	100.00	100.00	95.00	↑	100	
The percentage of high risk businesses that were liable to a programmed inspection that were inspected for Health and Safety [Qtly accum - Year to date]	100.00	100.00	95.00	↑	100	
The percentage of significant breaches that were rectified by intervention for Animal Health (Qtly accum - Year to date)	100.00	100.00	90.00	↓	83	
The percentage of significant breaches that were rectified by intervention for Trading Standards [Qtly accum - Year to date]	99.00	95.00	90.00	↓	96	
The percentage of these high risk businesses that were liable to a programmed inspection or alternative inspection activity that were inspected subject to alternative enforcement activity for Animal Health [Qtly accum - Year to date]	100.00	100.00	95.00	↓	100	
The percentage of these high risk businesses that were liable to a programmed inspection or alternative inspection activity that were inspected subject to alternative enforcement activity for Trading Standards [Qtly accum - Year to date]	97.00	100.00	95.00	↓	98	Equates to one premise.

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APPENDIX 1

CMT Scorecard Social Services

Performance Against Target: Well below | Just below | On or above

Public Protection

Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
ASB Drop-off rate between strike 1 and 4 intervention stage of the ASB process [Qtly]	100.00	99.00	90.00	↑	100	Monitored quarterly: During Q4 (100%) the following referrals were received: Strike 1 = 119 Strike 2 = 26 Strike 3 = Unavailable Strike 4 = 0 However, for the 14/15 year, the 'Drop-off rate' = 99.42% from the following referrals: Strike 1 = 520 Strike 2 = 108 Strike 3 = 27 Strike 4 = 3 For the 13/14 year, the rate was 99.88%.
Number of enforcement actions issued for Dog Fouling [Qtly accum - Year to date]	53.00	100.00	55.00	↑	61	Result: Q1=22 + Q2=6 + Q3=9 + Q4=16 We are trying to do more work in this area through our environment awareness campaigns Feb-May this year. At present Enforcement Officers are simply witnessing less offences.
Number of enforcement actions issued for litter [Qtly accum - Year to date]	397.00	300.00	250.00	-	268	Result: Q1=117 + Q2=130 + Q3=77 + Q4=73
Number of under age test purchases undertaken for Alcohol Purchases [Qtly accum - Year to date]	42.00	50.00	35.00	↑	50	Trading Standard Officers can only undertake Test Purchase exercises, where there is intelligence to suggest that under age sales are taking place. All intelligence is acted upon.
Response rates to Pest and Straying Animal Control service requests [Qtly]	99.20	99.00	96.00	↓	98.20	Monitored Quarterly, as it is a good management tool to intervene if problems are developing and can indicate issues in service provision early. The; 2014/15 Annual Average = 98.91% 2013/14 Annual Average = 98.59% 2012/13 Annual Average = 99.10%
Total Number of Community Safety Wardens visits to hotspot locations within Caerphilly County Borough [Qtly accum - Year to date]	5139.00	4400.00	4000.00	-	5279	More patrols and non holiday period plus full complement of staff following return of 1 warden from maternity leave.

CMT Scorecard
Social Services

Performance Against Target: Well below | Just below | On or above

Public Protection

Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Number of settings in Healthy Early Years Scheme (schools) [Qtly accum - Year to date]	42.00	41.00	40.00	-	41	The result has increased from 41 in 13/14, 36 in 12/13, 32 in 11/12 and 24 in 10/11.
Primary Free Meals Uptake (Qtly accum - Year to date)	70.66	72.00	67.00	↓	72.30	Free meal figures slightly lower than the last quarter however, there is on-going marketing of the service which incorporates the free meal entitlement aspect.
Primary Paid Meals Uptake (Qtly accum - Year to date)	35.63	28.00	23.00	-	34.26	Paid meal figures continue to stay above set target.
Secondary Free Meals Uptake (Qtly accum - Year to date)	66.32	66.00	55.00	↓	66.61	Free meal figures remain just over target for this period.
Secondary Paid Meal Uptake (Qtly accum - Year to date)	45.32	45.00	35.00	↓	45.79	Secondary school paid meals are above target.

CMT Scorecard
Social Services

Performance Against Target: Well below | Just below | On or above

Adult Services PIs

Period	Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Jun 15	Adult Services - Number of adults waiting for an assessment outside of the timescale (28 days)	96.00	70.00	105.00	↑	106	96 Service Users
Jun 15	Adult Services - The % of assessments started on time	78.90	85.00	75.00	↑	81.6	4462/5652
Jun 15	SCA/001 DTOC - The Rate of DTOC for social care reasons aged 75 plus	2.23	8.00	11.00	–	8.78	Caerphilly now the highest improvement change in Wales in 2014-15 and was in the upper medium quartile.
Jun 15	SCA/002a The rate of older people supported in the community aged 65 or over	107.16	125.00	135.00	–	116.84	3411/31831
Jun 15	SCA/002b The rate of older people supported in care homes aged 65 or over	16.40	21.00	22.50	–	16.96	522/31831
Jun 15	SCA/007 The percentage of clients whose care plans should have been reviewed that were reviewed during the year	89.80	95.00	83.00	↓	93.5	1868/2081. The average across Wales in 2014-15 was 80%. Caerphilly is in the upper quartile.
Jun 15	SCA/018a - The percentage of adult carers who were offered an assessment	85.50	90.00	79.00	↓	89.54	324/379. The average across Wales in 2014-15 was just below 90%. Caerphilly was in the lower quartile.
Jun 15	SCA/019 - % Of adult protection referrals completed where the risk has been managed	88.30	90.00	80.00	↑	85	279/316

APPENDIX 2

CMT Scorecard
Social Services

Performance Against Target: Well below | Just below | On or above

Childrens Services PIs

Period	Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Jun 15	SCC/002 % of LAC with one or more changes of school	1.50	13.70	15.00	-	0	3/204
Jun 15	SCC/004 % of LAC who have had more than 3 placements during the year	1.10	10.00	12.00	-	1.4	3/283. On average 9% of children looked after experienced 3 or more placements in 2014-15.
Jun 15	SCC/011b % assessments - child seen alone by Social Worker	31.10	40.00	36.00	-	45.1	117/376 - Includes Pilot assessments. SWs completed 244 assessments and saw 117 children/young people alone - 117/244 *100 = 48%. The average across Wales in 2014-15 was 44.8%. Caerphilly was in the lower quartile.
15/16	SCC/025 % of statutory visits to LAC due in the year that took place	85.20	90.00	80.00	↓	96.6	335/393
Jun 15	SCC/030a % of young carers who were assessed	100.00	95.00	76.40	-	100	Barnardo's Data 13/13
Jun 15	SCC/033d % of former LAC in contact at age of 19	100.00	100.00	90.00	-	100	Result - 4/4. Performance is amongst the best in Wales.
Jun 15	SCC/033e % of former LAC in suitable accommodation at 19	100.00	95.00	85.40	↑	100	Result - 4/4
Jun 15	SCC/033f % of former LAC in educ/training/employment at 19	75.00	50.00	40.00	↑	62.5	Result - 3/4
2015/16	SCC/037 Average external qualifications points score for LAC		200.00	158.00		322	Annual Indicator. Caerphilly is in the top quartile for 2014-15.
Jun 15	SCC/041a % of eligible children that have pathway plans	100.00	100.00	89.00	-	100	110/110
Jun 15	SCC/045 The percentage of reviews of looked after children, children on the Child Protection Register and children in need carried out in line with the statutory timetable	91.70	87.00	78.30	↓	95.5	488/532. The average across Wales in 2014-15 was 89%. Caerphilly was in the upper quartile.

CMT Scorecard
Social Services

Performance Against Target

Well below | Just below | On or above

Public Protection

Period	Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Q1 15/16	Overall client satisfaction receipt of a very good survey result for Registrars [Qtly accum - Year to date]	100.00	95.00	90.00	-	100	For Birth Registration 100% stated Very Good with 70% stating Excellent. For Death Registration 100% stated Very Good with 88% stating Excellent. For Marriage Ceremonies 100% stated Excellent. For other services 100% stated Excellent
Q1 15/16	The percentage of food establishments which are broadly compliant with food hygiene standards [Qtly accum - Year to date]	94.00	85.00	75.00	↓	91	Across Wales 94.2% of food establishments were broadly compliant in 2014-15.
Q1 15/16	The percentage of high risk businesses that were liable to a programmed inspection that were inspected for Food Hygiene [Qtly accum - Year to date]	15.00	17.00	15.00	↓	14	Monitored quarterly and accumulative. Inspection numbers are weighted until the end of the year.
Q1 15/16	The percentage of high risk businesses that were liable to a programmed inspection that were inspected for Health and Safety [Qtly accum - Year to date]	0.00	7.00	6.00	↓	7	High risk inspection numbers are weighted to the next quarters.
Q1 15/16	The percentage of significant breaches that were rectified by intervention for Animal Health (Qtly accum - Year to date)	75.00	95.00	90.00	↓	100	The 25% of significant breaches not rectified relate to one premise. Work is ongoing to secure compliance
Q1 15/16	The percentage of significant breaches that were rectified by intervention for Trading Standards [Qtly accum - Year to date]	80.00	50.00	40.00	↑	93	
Q1 15/16	The percentage of these high risk businesses that were liable to a programmed inspection or alternative inspection activity that were inspected subject to alternative enforcement activity for Animal Health [Qtly accum - Year to date]	12.50	25.00	10.00	↓	0	Total no. is small over 12 months targets will easily be met
Q1 15/16	The percentage of these high risk businesses that were liable to a programmed inspection or alternative inspection activity that were inspected subject to alternative enforcement activity for Trading Standards [Qtly accum - Year to date]	22.50	22.50	10.00	↑	11	

Appendix 2

CMT Scorecard Social Services

Performance Against Target: Well below | Just below | On or above

Public Protection

Period	Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Q1 15/16	ASB Drop-off rate between strike 1 and 4 intervention stage of the ASB process [Qtly]	100.00	99.00	90.00	-	100	There were a total of: Strike 1 = 111, Strike 2 = 44, Strike 3 = 13, Strike 4 = 0, Referrals made during quarter one.
Q1 15/16	Number of enforcement actions issued for Dog Fouling [Qtly accum - Year to date]	17.00	15.00	13.00	↑	22	numbers resticted one officer on long term sick
Q1 15/16	Number of enforcement actions issued for litter [Qtly accum - Year to date]	55.00	90.00	70.00	↓	117	figure down one officer off on long term sick
Q1 15/16	Number of under age test purchases undertaken for Alcohol Purchases [Qtly accum - Year to date]	3.00	10.00	5.00	↓	4	Lack of intelligence re sales at present so only small number of attempts. Intelligence gathering exercise underway. Legislation requires intel before test purchase can be undertaken
Q1 15/16	Response rates to Pest and Straying Animal Control service requests [Qtly]	98.61	99.00	96.00	↓	98	officer on long term sick plus retirement and non replacemnet of one officer
Q1 15/16	Total Number of Community Safety Wardens visits to hotspot locations within Caerphilly County Borough [Qtly accum - Year to date]	1204.00	1100.00	1000.00	-	1381	There were a total of 1,204 visits to hotspot locations by Community Safety Wardens during quarter one.

CMT Scorecard
Social Services

Performance Against Target: Well below | Just below | On or above

Public Protection

Period	Title	Actual	Target	Intervention	RAG	Result 12 Months Ago	Comment
Q1 15/16	Number of childcare settings in Healthy Early Years Scheme (schools) [Qtly accum - Year to date]	48.00	55.00	45.00		41	There are currently 48 settings recruited on to the scheme. Of these there are: 25 settings in Phase 1, 8 settings in Phase 2 and 15 settings in Phase 3. There are also 7 settings on the waiting list.
Q1 15/16	Primary Free Meals Uptake (Qtly accum - Year to date)	66.33	70.00	67.00		67.81	Free meal figures are down slightly however not all figures are in for this period will update as soon as they are.
Q1 15/16	Primary Paid Meals Uptake (Qtly accum - Year to date)	32.60	32.00	27.00		31.80	Paid meal uptake is lower in period 1 because of school trips and holidays but figures are up compared with the same period last year.
Q1 15/16	Secondary Free Meals Uptake (Qtly accum - Year to date)	62.58	64.00	55.00		61.32	Free school meals are expected to be lower in period 1 due to holidays and school trips however the figures are comparable to the same period last year.
Q1 15/16	Secondary Paid Meal Uptake (Qtly accum - Year to date)	38.73	45.00	35.00		41.01	Paid meal uptake is expected to be lower in period 1 due to holidays and school trips.

APPENDIX 2

APPENDIX 3

GGHSCWB Partnership Leadership Group Meeting

Briefing Report: **Social Services and Wellbeing Act: Performance Management requirements.**

Meeting Date: **2nd October 2015**

Report Author: **Philip Diamond, Theme Lead, Transformation Support Programme**

Purpose of briefing report

This purpose of this briefing report is to provide Leadership Group with an overview of the performance management requirements under the Social Services and Wellbeing Act and points for consideration. This is not an exhaustive overview - as a detailed Code of Practice and National Outcome Framework underpins the related section in the Act.

Introduction

Under Section 145 of the Social Services and Well-being Act, Welsh Government issued and consulted upon a draft code of practice in relation to achieving wellbeing. The code of practice reiterates the definition of well-being, how this will be measured, introduces quality standards for local authorities and performance measurement requirements. The code of practice also builds upon the *'National outcomes framework for people who need care and support and carers who need support'* which was developed to deliver on the actions set out in *'Sustainable Social Services for Wales: A Framework for Action'*. The code of practice includes quantitative and qualitative indicators but reduces the overall number of performance indicators reported annually by Social Services from over 60 to 32.

Quantitative Indicators (measurements).

- There are 18 quantitative measurements that will be reported annually (see appendix 1).
- Majority of indicators are Social Services specific, but some will require linking with other partners such as Housing, Education etc. For example, one is health related (PI 3 appendix 1) and another is related to information, advice and assistance (IAA) (PI 8 appendix 1).

Qualitative Indicators (measurements)

- There are 14 qualitative measurements that will be collected through a service user questionnaire with people receiving care and support services (people known to Social Services). See appendix 2.
- Data to be submitted every 3 years and first return will be for period April 2016 to March 2017.
- Each local authority to achieve a minimum of 400 responses.

[redacted]

Synergies and interdependencies with other legislation

There are potential synergies with the Wellbeing of Future Generations Act which will set ambitious, long term goals to collectively represent what the long term economic, social and environmental well-being of Wales would look like. These will complement the health and social services outcomes frameworks and where appropriate, outcomes and population level measures will be shared and not duplicated.

Current position

The consultation on the performance management code of practice was completed in April 2015. A summary of the consultation responses for the greater Gwent region welcomed the reduction in the total number of PIs. However, in practice some Social Service departments will continue to record much of the data at a local level, as it is still useful e.g. length of time to complete assessments. The qualitative questionnaire will require planning and may benefit from a regional approach.

The Association of Directors of Social Services (ADSS) have identified performance management as a priority work stream for 2015/16 and Practice Solutions will be developing a task and finish group to explore national, regional and local solutions, as well as ensuring links to other outcome frameworks and avoiding duplication.

Points for consideration

1. Under part 9 of the Act Partnership Forums will be required to progress the following priorities: Carers, Integrated Family Support Team (IFST), Children with Complex Needs, Learning Disabilities and Older People with Complex Needs. What performance measures will be identified to ensure the priorities are progressed?
2. The pending Population Needs Assessment (PNA) will highlight need in the greater Gwent region. What priorities and related Performance Indicators (PIs) will emerge from PNA? Will theses differ from above or be in addition?
3. There is a number of existing health and wellbeing PIs collected through a variety of outcome frameworks and strategic groups: Health Boards (NHS and PHW Outcome Frameworks), local authority Single Integrated Plans, Local Safeguarding Boards etc. Will the Partnership Forum assume overall governance for health and wellbeing in the area and aggregate existing performance data? Or will the Partnership Forum be better placed focusing on issues that are not being currently addressed?
4. Quantitative data in the code of practice (appendix 1) sets out how wellbeing is measured under the Act, but it is predominately Social Services specific. Will reporting be left to individual Directors of Social Services through annual returns or will the Leadership Group provide a form of governance?
5. Will the qualitative questionnaire (appendix 2) benefit from a regional approach?
6. What PIs will emerge from WFG Act? How will we avoid duplication?
7. An element of governance and performance management of processes will be required to ensure the Regional Implementation Plan (RIP) is delivered effectively. Will this be wrapped into the overall performance management?

8. How will we report PM data? Partnership Forum or Leadership Group? How often?

Recommendations

1. **Note content of report**
2. **Discuss points for consideration**
3. **Agree Next Steps**

Appendix 1: Social Services and Wellbeing Act: National Outcome Framework – Quantitative Data

1. The percentage of Welsh speakers who took up the active offer to receive care and support through the Welsh language
2. The percentage of adult protection reports where the risk has been managed
3. The percentage of unscheduled admissions of older people (aged 65 or over) to hospital who were receiving care and support services
4. The rate of delayed transfers of care for social care reasons per 1,000 population aged 75 or over
5. The percentage of adults at the end of a completed period of reablement phase who:
    a. have no package of care and support 6 months later
    b. have no package of care and support 12 months later
6. The percentage of adults at the end of reablement phase who have no package of care and support 6 months later
7. The percentage of adults at the end of reablement phase who have no package of care and support 12 months later
8. The percentage of adults who have received advice and assistance and have not contacted social services for 6 months for the same outcome during the year
9. The percentage of people supported to remain in their own home with a home adaptation
10. The average length of time adults (aged 18-64, 65-74 and 75+) are supported in care homes per 1,000 population by the local authority
11. The percentage of re-registrations of children on Local Authority Child Protection Registers (CPR)
12. The average length of time of children on the CPR
13. The percentage of looked after children seen by a registered dentist within 3 months of becoming looked after
14. The percentage of looked after children registered with a GP
15. Percentage of looked after children achieving the core subject indicator at key stage 2 and 4
16. The percentage of looked after children who have experienced (1) or more changes of school, during a period or periods of being looked after, which were not due to transitional arrangements, in the year to 31 March
17. The percentage of looked after children on 31 March who have had three or more placements during the year
18. The percentage of all care leavers who are in sustained education, training or employment for 12 months and 24 months after leaving care
19. The percentage of eligible care leavers who have experienced homelessness during the year
20. The percentage of children supported to stay with their family

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Appendix 2: Guidance for qualitative data returns

Qualitative data must be submitted every 3 years, the first year of data will detail the financial year April 2016 to March 2017. For the purposes of this return, different questions must be asked to:

- children aged between 10 years old and 17 years old;
- young adults aged between 16 and 24 years old;
- young carers aged between 16 and 24 years old;
- carers aged 18 or over; and
- adults aged 18 or over.

The following questions will be asked to people who need care and support and carers who need support, although some questions are specific to groups of people:

1. **Overall, how satisfied are you with the care and support services that you have received? (Very satisfied / quite satisfied / not sure / dissatisfied / very dissatisfied)**

Thinking about the care and support services you have received, please tell us whether you agree or disagree to the following statements: (Yes, I agree / No, I disagree / I don't know)

2. **I have been treated with dignity and respect (aged 10+);**
3. **I have received the right information, advice or assistance when I have needed it (aged 10+);**
4. **I have received advice, help and support to prepare me for adulthood (aged 16-25);**
5. **I have been given written information about a named team in social services (aged 10+);**
6. **I have been involved in decisions made about my care and support (aged 10+);**
7. **I have been involved in any decisions made about my child's care and support (parents);**
8. **I have been involved in designing the care and support plan for the person that I care for (carers aged 10+).**

Thinking about your life at the moment, please tell us whether you agree or disagree to the following statements: (Yes, I agree / No, I disagree / I don't know)

9. **The care and support I have received has helped me to live in a home that is right for me (aged 10+);**
10. **The care and support I have received has helped me to do the things that matter to me (aged 10+);**
11. **The care and support I have received has helped me to feel safe (aged 10+);**
12. **The care and support I have received has helped me to feel like I belong to my community (aged 18+);**
13. **The care and support I have received has helped me to feel supported to continue in my caring role (carers aged 10+);**
14. **The care and support I have received has helped me to enjoy going to school or further education or training (aged 10-25).**

- *The questions must be asked to all people who have a care and support plan during 1 April and 31 March each year which has been in place for a minimum of 3 months.*
- *In order to obtain the minimum number of returns and based on a 25 per cent response rate each local authority should administer a **minimum of 1,600** questionnaires each year. Local authorities must monitor the number of returns throughout the year to ensure they achieve **at least 400 responses** at the end of the year.*