Telford and Wrekin Health and Wellbeing Board (HWB)

13th June 2012 at 2.00pm

Reception Suite, Civic Offices, Telford

Key Decisions/Actions/Discussion:

Agenda Item	Discussion Points	Who
1.	**Attendees:** Cllr Richard Overton (Chair and Deputy Leader TWC), Cllr Liz Clare (Cabinet Member: Adult & Social Care), Laura Johnston (Director of Children & Family Services), Dr Catherine Woodward (PCT Director of Public Health), Dr Mike Innes (Chair of T&W Clinical Commissioning Group), Dylan Harrison (CCG Non-Executive Director), Karen Kalinowski (Assistant Director: Care and Support TWC), Clare Hall-Salter (TWC Partnership and Planning Manager), Paul Taylor (TWC Assistant Director: Social Care Specialist), Jon Power (Delivery and Planning Manager TWC), Helen Onions (Public Health Specialist), Paul Clifford (Corporate Director TWC), Lilian Owens (LINkS), Michael Bennett (Lead Joint Commissioning and Contracting Manager), Andy Challenor (Community Engagement and Equalities Manager TWC), Nigel Newman (Communications Manager TWC), Stephanie Jones (Scrutiny Group Specialist TWC) and Jayne Clarke (Democratic Services Support TWC) **Apologies**: Cllr Paul Watling (Cabinet Member: Children, Young People & Families), Richard Partington (Managing Director TWC, David Evans (Chief Operating Officer T&W CCG), Dag Saunders (LINkS), Leigh Griffin (Deputy Chief Executive West Mercia PCT Cluster), Clive Jones (TWC Assistant Director: Family and Cohesion Services), Fran Beck (Executive Lead Commissioner CCG)	
2.	**Action notes 25.04.12:** **Tobacco Control in Telford and Wrekin:** This was to be joined up with TWC and there was due to be a meeting held shortly. **Proposed Future Agenda Items:** Some of the proposed Agenda items were covered at this meeting.	
3.	**Health and Wellbeing Board Communication and Engagement** A joint report was presented by Andy Challenor, Nigel Newman and Clare Hall-Salter on the Health and Wellbeing Board Communication and Engagement. <u>Framework 2012/13</u> The framework document aimed to help the Board to co-ordinate and deliver high quality communication and engagement which would allow local people to access services, obtain information, stay healthy and get involved with the decision making process. It also set out shared definitions in order to	

	establish a common understanding by the target audience. It further aimed to give clarity and purpose to the engagement process. The Health and Wellbeing board were asked to • Agree the shared definitions • Agree the commitment and standards for communication and community engagement • Note the HWB communication and engagement action plan • Think about the process of how the HWB will identify its key communication messages for both stakeholders and local people. <u>Action Plan 2012/13</u> The Action Plan was to ensure that the HWB listened, informed, promoted, sought views as well as engaging and communicating with the stakeholders and that outcomes were communicated back in order to establish trust and dialogue. The HWB would need to agree and communicate key messages, priorities as well as drafting the strategy, evaluating efficiencies and co-ordinating activities. <u>Stakeholder Engagement Event</u> The engagement event would be the core to the development of the Board, the strategy, healthwatch and the vision for public health. It was envisaged that this workshop would be informative and be used to gather initial views and ideas of stakeholders. All members of the HWB were also invited to attend at that event. A discussion took place including: • The wording "communication and engagement" and the removal of "communication" • Ensuring that the Public Health Transition Coms Plan ties in with this plan • Acknowledging in the action plan that we have reducing resources and growing needs • Making the inclusion of Children and Young People more prominent • Summary Leaflets listing the key items to be produced • LINkS to be central to the engagement • Youth LINk to review CYP accessibility to the plan • Invitation to the Member of the Youth Parliament to the Stakeholder Event **<u>AGREED</u> – That the Health and Wellbeing Board:** **a) agree the shared definitions;** **b) agree the commitment and standards for communication and community engagement;** **c) note the HWB communication and engagement action plan;** **d) think about the process of how the HWB will identify its key communication messages for both stakeholders and local people.**	**AC/NN** **LINk**

4.	**Joint Health & Wellbeing Strategy Development Update** Jon Power and Helen Owens presented a joint update report on the Health & Wellbeing Strategy Development which built on the report in April 2013. The report set out the draft priorities for stakeholder consultation in order to identify if the right areas had been chosen and that all avenues had been covered. Feedback was currently being collected but one area which needed to be highlighted was substance misuse. The reduction of excess weight in children was a further area that needed to be looked at although this could be taken population wide. The stakeholder event was due to take place on 3rd July and would provide an opportunity to have an "active dialogue" with a wide range of partners. For those stakeholders who would be unable to attend a request for their views would be sent. A copy of the questions would be available on the Council Website and information in "Your Voice" which was sent out to households within the Telford and Wrekin Borough. With regard to engagement "Asset Mapping" would identify resources and the capacity to deliver the proposed priority. A methodology proforma containing a set of consistent questions would be piloted by Public Health on reducing excess weight in children. It was then hoped that this could be rolled out to other key areas if successful. Talks with Social Care and the CCG would begin over the next few months with a view to bringing together the basic strategy. The working draft would be brought to the September HWB meeting. The Strategy needed to be signed off and in place by April 2013. A discussion took place including: • Excess weight in children/population wide – these were two very different approaches to intervention – emphasis should be to prevent weight gain and the promotion of health for children and life expectancy for adults • Strategy would need to deliver a life course approach • Asset Mapping – radical approach and brave decisions • Mental Health – currently not in proposed priorities, preventative care very effective **AGREED – that the report be noted.**	**JP/HO**
5.	**Scrutiny Arrangements** Stephanie Jones presented a report to flag up the changes to health scrutiny arising from the Health & Social Care Act. Key Changes: • The Act conferred the health overview and scrutiny function directly to	

	the local authority itself rather than to the health scrutiny committee. • The Act extended local authority health and scrutiny powers from "local NHS bodies" to "relevant NHS bodies or relevant health service providers". This had been interpreted as all commissioners and providers commissioned and funded by the NHS including GPs and voluntary and private sector providers. • Scrutiny powers will extend to the Health & Wellbeing Board as a committee of the local authority Further detailed guidance and regulations were awaited from the government and there would be further discussion with Council and the Health & Wellbeing Board about the roles and relationships once the picture was clearer. It would be important to develop constructive working arrangements between scrutiny and the Health & Wellbeing Board and to avoid the potential for duplication of work programmes. The work programme for the scrutiny committee was in the process of being agreed. The suggested items were listed in the report and the Board was invited to comment or to suggest other issues which scrutiny could look at. A meeting had been arranged for the Chairman of the Health & Adult Care Scrutiny Committee and the Chair of the Health & Wellbeing Board and Cllr Clare to compare and discuss work programmes. Members of the Board suggested the Community Trust and the South Staffordshire & Shropshire Healthcare NHS Foundation Trust as suggestions for the scrutiny work programme. The good work of the Joint Health Overview & Scrutiny Committee on the hospital reconfiguration was noted. Cllr Overton remarked in the light of changes to scrutiny from the Health & Social Care Act that he valued the work of scrutiny and would not want to see any changes to the health scrutiny arrangements. It was highlighted that this may have the potential of the duplication of work programmes of the HWB and the Health Scrutiny Committee and a good constructive relationship was needed and work programme priorities identified in order to avoid any duplication. **AGREED – that the report be noted.**	
6.	**CAMHS Update:** Michael Bennett presented the progress update on the CAMHS Review. The CAMHS review began around 18 months ago after concerns had been raised across the stakeholders. This now needed to be built on and taken forward. A review had been commissioned by Shropshire for additional work to be undertaken on staff, service users, partners and carers. There needed to be a strong framework as there had been concerns at the lack of HWB intervention and inconsistency. A strategic group had been set up and some "quick win actions" had been implemented. There had also been some work around developing better information. A set of actions/requirements together	

	with a range of strategies/actions were needed to widen how this was looked at and provide potential going forward. Two workshops had taken place on needs assessment and outcomes and service models in order to shape the future service. The workshops had not helped as much as was hoped but some key points were as follows: • A single point of access (Family Connect) • A tool to triage referrals • A pathway for transition between tiers of the Service and between child/adult services • Consideration of the name of the services to reduce stigma • Where appropriate, joint assessment should be the norm. Service issues were outlined in the presentation and a service improvement plan would be produced to help understand how CAMHS could make improvements. An implementation Group had been set up and workshops organised to look at the issues. A discussion took place including: • Timescales for formal decisions • Part of a wider discussion about services with the Community Trust • Ofsted Inspection of Safeguarding Children and Looked After Children • Name change The presentation was noted and a further report would be received at the September 2012 meeting.	**MB/CHS**
7.	**NHS Changes Update: Local impact / Development of HWB across West Mercia** Apologies had been received from Leigh Griffin. Dr Mike Innes would cover the report at item "8." **AGREED – that:** **a) minutes of each Health and Wellbeing Board business meetings are shared with PCT Cluster Board members for information;** **b) regular reports are provided to the Cluster Board providing a summary of the working of health and wellbeing boards and a 'read-across' of their differing approaches;** **c) the Deputy Chief Executive of the Cluster works with all four health and wellbeing boards in an enabling way, to identify and share best practice and variations in approach.**	**LG** **LG** **LG**
8.	**CCG Update** Dr Mike Innes gave a brief overview of the reports.	

	A meeting was to be held on 22nd June – Development of SHA – in Birmingham. This meeting would be to feed into the secondary legislation for Health and Wellbeing Boards ie political proportionality, voting restrictions and access to information provisions. CCG authorisation would be in wave 2 and the CCG were currently undergoing submissions and e-mailing the 360° Stakeholder questionnaire. This was a major piece of work which included a review of performance, a review of the paper documentation and authorisation of key Members following on from Shropshire CCG who were in wave 1. Appointments to the Board were expanding and Members of the Board had already been recruited. There were currently 7 posts being advertised together with 2 Board Observers. Four Commissioning Support organisations had put forward submissions and were being evaluated for a preferred supplier of support services. **AGREED – that the report be noted.**	
9.	**Public Health Transition Update: Project update / Development of Public Health Vision** Clare Hall-Salter gave an update on the Public Health Transition Project. The draft Plan had been rated Green by the SHA. Following feedback on the RAG scale, 41 items had been given the Green rating and 5 received Amber rating. Whilst this was a good result, the Board needed to take heed of the assessment. The plan was to work towards the key milestones and to keep involvement with the Public Health Vision. Five key project work streams had been tasked with scoping in order to achieve a successful transfer by April 2013. Legal support to aid with the transition had now been identified within the Council. Concerns had been identified with the allocation of the shadow budget and a further announcement on the formula was awaited. Further work was needed on emergency planning and progress will be reported to a future meeting of the Board. Telford and Wrekin Council would be required to set out a vision for public health and a task and finish group had been identified to lead on this work. **AGREED – that the progress with respect to the transition plan and approach taken be noted.** Paul Taylor gave an update on the Public Health Vision and Building the Team in Telford and Wrekin. The report set out the initial thoughts for developing the Vision for Public Health and the approach to the programme of engagement which would need to take account of the new emerging Council Priorities. Engagement and consultation with the general public together with stakeholders was fundamental to development of the Vision. The report set out a timeline for development and signing off of the Vision and this would be brought back to a future meeting for approval.	

	A discussion took place including: • The budget • Work streams **AGREED – that** **a) Board Members/Members welcome the opportunities offered by the Public Health changes and support the emerging framework (4.11) and vision statement (4.12) as a baseline for wider engagement and consultation;** **b) Board Members/Members support the approach set out to engagement and consultation.**	
10.	**Equality Diversity System Event Update** Dr Mike Innes gave an update on the progress of the adoption of the Equality Delivery System. The CCG needed to demonstrate that it was and would continue to meet its duty. Following the workshop in March it was decided that the Equality Delivery System (EDS) would be used. The current baseline assessment from the EDS on the "Goals" following the RAG rating was 1 Green and 3 Amber. The PCT/CCG were now considering further community engagement in order to gather further opinions of the stakeholders. A second workshop was to be arranged. Observations from Equality and Diversity were that this had not been properly addressed as it should and a plan of action would be put in place. **AGREED – that the progress made in adopting the EDS and the next steps proposed be noted.**	
11.	**Walk-In Practices – Initial Discussion** Cllr Richard Overton opened a discussion around GP Practices/Walk-in Practices and the inability to get an appointment. The discussion included: • Not uncommon to be unable to get an appointment • PRG's consultation on "how to do it better?" • Encourage Practices to quantify access to appointments • Change from "planned" to "unplanned care" • CCG unable to influence walk-in practices at present. NHS Commissioning Board is responsible for commissioning GP Practices. • Better ways of managing health care advice – "Access to Medical Services" • LINkS to undertake an interim review • Suggestion to call in a report to the HWB, while the responsible officer within the PCT is still available This item would be brought back to a future meeting.	**LINk PT**

12.	**Proposed Future Agenda Items** – noted and an additional agreed item: • Health Visiting/Family Nurse Partnership	
13.	**Dates of future meetings:** SHWB meeting 12th September 2012, 2pm – 4pm, VIP Suite, Civic Offices SHWB meeting 14th November 2012, 2pm – 4pm, VIP Suite, Civic Offices SHWB meeting 23rd January 2013, 2pm – 4pm, venue TBC SHWB meeting 13th March 2013, 2pm – 4pm, venue TBC	

The meeting ended at 3.59pm

Signed .....

Dated .....

HEALTH & WELLBEING BOARD 12 SEPTEMBER
AGREEING OUR HEALTH & WELLBEING STRATEGY PRIORITIES
REPORT OF DELIVERY & PLANNING MANAGER AND PUBLIC HEALTH SPECIALIST

1. Purpose

1.1. This paper provides the Board with an update on the development of the Telford and Wrekin Health & Wellbeing Strategy, the report:

- presents an overview of the implications of the draft Department of Health Guidance on Joint Strategic Needs Assessments and Health & Wellbeing Strategies
- describes the consultation and engagement activities undertaken on the proposed set of health and wellbeing priorities, derived through the JSNA process
- summarises the findings and insight gathered as part of that consultation and engagement work
- seeks agreement for the set of priorities on which the first Health & Wellbeing Strategy will focus

2. Recommendations

2.1. That

- **the latest Department of Health Guidance on Health & Wellbeing Strategies are considered and the draft consultation feedback reviewed and agreed for submission**
- **the proposed Health & Wellbeing priorities are reviewed and finalised in light of the completed community and professional stakeholder engagement programme**
- **a lead member of the Board is aligned as sponsor to each of the agreed priorities**

3. Developing our Health & Wellbeing Strategy Priorities

3.1. The Health & Wellbeing Board has a Duty to agree a Health & Wellbeing Strategy by April 2013. The purpose of this strategy is to:

- meet the needs identified in our Joint Strategic Needs Assessment and explain the priorities that the Health & Wellbeing Board has agreed to tackle those needs

- set priorities for joint action in order to make the most significant impact – the Strategy**is not** about tackling everything

- inform the commissioning cycles of the Clinical Commissioning Group, the NHS Commissioning Board and the Council, ensuring the plans are strongly aligned with the Health & Wellbeing Strategy priorities

3.2. As part of the development of the strategy, the Health & Wellbeing Board identified the following ten proposed priorities (see Appendix One):

- Reduce excess weight in children
- Reduce teenage pregnancy
- Improve emotional health and wellbeing
- Support people with autism
- Reduce the number of people who smoke
- Ensure people have a positive experience of health and care services
- Improve carers' health and wellbeing
- Support people to live independently
- Improve life expectancy and reduce health inequalities
- Support people with dementia

3.3. The identification of these proposed priorities was informed by our Joint Strategic Needs Assessment process which highlighted health and wellbeing issues in the Borough that were:

- a statistical outlier – that is the Borough's health and wellbeing status is significantly worse than the national position
- an existing local priority
- an issue where there was a clear policy requirement or financial pressure

4. Department of Health Draft Guidance:Joint Health & Wellbeing Strategies

4.1. Since this initial work was developed, the Department of Health has published further draft guidance on the development of Joint Health & Wellbeing Strategies. The guidance presents an overview of the statutory requirements now in place for local authorities, CCGs, NHS Commissioning Boards. **An overview of the guidance is presented in Appendix Two along with a draft proposed response to the Department of Health consultation questions.**

4.2. The draft guidance is helpful in that it confirms the approach that the Board is taking to the development of the Joint Strategic Needs Assessment and the Health & Wellbeing Strategy is in line with national expectations and best practice. Primarily, that JSNA/JHWB strategies are a continuous process rather than an end in themselves and should be developed around local commissioning cycles. They are not about action on everything but for setting priorities for joint action in partnership in order to make the greatest impact. The

legislation is in place to support joint action such as pooled budgets, integrated partnership working and joint commissioning arrangements.

5. Community & Stakeholder Engagement

5.1. During the Summer of 2012, a programme of public and stakeholder engagement was undertaken to explain the purpose of the Health & Wellbeing Strategy and seek views on the proposed priorities; exploring whether they are the right ones for the Borough and in particular, whether any key local issues have been overlooked. This engagement programme has included:

- A stakeholder engagement event
- Article in Your Voice in the Council's newsletter,
- Community Panelengagement via an on-line questionnaire on the Council's website
- Invitation to all Council and PCT staff to participate in the on-line questionnaire

5.2. The total number of participants in this activity were:

- 88 participants at the stakeholder engagement event
- 627 Community Panel members
- 128 respondents to the on-line questionnaire
- 4 correspondents who contacted the Council by email

6. Stakeholder Engagement Event

6.1. The event, which took place on Tuesday 27 July at The Place, was attended by 88 people representing a range of organisations including health partners, the voluntary sector and patient groups.

6.2. As part of this event, participants were asked to review the proposed Health & Wellbeing priorities and identify any issues which they felt were missing. The key messages from this event with regard to the priorities were:

- Greater weight should be given to addressing:
    - ***Economic circumstances/disadvantage*** – this was highlighted as a fundamental issue to improving the health and wellbeing of the Borough – with particular reference to the social and mental impact of unemployment. The connection between this issue and the social and physical impact of poor housing was also made and it was also linked to the importance of raising young people's aspirations.
    - ***Drug and alcohol misuse*** – this was a common theme across the workshop with participants highlighting the impact on an individual's

health (e.g. long term liver disease). It was also seen as a key risk factor linked to A&E hospital visits and teenage pregnancies.

- ***Reducing excess weight in children*** to broaden the scope of the priority to include adults – this was linked to the need for 'active lifestyles'. It was also linked to a wider theme of early prevention – i.e. to set children on the 'right path'.

7. Community Panel and On-line Survey

7.1. A questionnaire was sent to the Council's Community Panel and made available online on the Council's website for other participants to complete. Letters were sent to all members of staff in the Council and the PCT asking for their views and signposting to the on-line questionnaire. The survey was also promoted through the Council's 'Your Voice' newsletter, which was sent to all homes in the Borough.

7.2. A total of 749 completed questionnaires were received with 627 responses from Community Panel Members and 128 from the online survey.

7.3. As well as exploring respondents' views on the proposed priorities, the questionnaire asked participants about their awareness of the changes to the way in which the local health and social care economy is being managed:

- 64% of respondents were aware that the CCG is taking the responsibility for local health services
- a third of respondents, 33%, were aware that Public Health functions are being transferred to local authorities

7.4. Overall, there was a strong view that the proposed priorities should be included in the Health and Wellbeing Strategy (see table 1 below)

7.5. For each proposed priority, ***more than a third of respondents strongly agreed*** with its inclusion as a strategy priority - ranging from 34% for 'supporting people with autism' to 58% for 'supporting people with dementia'.

7.6. Levels of disagreement with the proposed priorities were, overall, low. The one proposed priority with a ***higher level of disagreement than others was reducing the number of people who smoke with 12%*** *of respondents in* ***disagreement***. The reason most cited by respondents who disagreed with this priority was that it was the choice of the individual as to whether they smoked or not and not the role of the state to address this.

Table 1: Survey findings for Support of the Proposed Health & Wellbeing Priorities

	Strongly agree	Agree	**Total agree**	Neither	Disagree	Strongly disagree	**Total Disagree**	Don't know	Net agreement score
Ensuring people have a positive experience of health and social care services	49%	42%	**91%**	7%	1%	1%	**2%**	1%	89%
Improving carers' health & wellbeing	51%	40%	**91%**	7%	1%	0%	**2%**	0%	89%
Supporting people with dementia	58%	34%	**92%**	5%	1%	2%	**3%**	1%	89%
Supporting people to live independently	50%	38%	**89%**	8%	2%	1%	**3%**	0%	86%
Reducing teenage pregnancy	56%	32%	**89%**	7%	3%	1%	**4%**	1%	84%
Improving life expectancy and reducing health inequalities	49%	37%	**86%**	10%	2%	0%	**3%**	1%	83%
Reducing excess weight in children	48%	39%	**86%**	8%	4%	1%	**5%**	1%	82%
Improving emotional health & wellbeing	44%	39%	**83%**	11%	3%	1%	**4%**	2%	79%
Supporting people with autism	34%	46%	**80%**	14%	3%	1%	**4%**	2%	76%
Reducing the number of people who smoke	42%	31%	**73%**	15%	8%	3%	**12%**	1%	62%

7.7. From both surveys, 26% of respondents indicated that they felt there were 'issues' missing from the proposed list of priorities, a total of 178 comments were recorded.

7.8. Analysis of these comments shows that just over half (96) covered issues falling under the umbrella of the proposed priorities. For example:

- ***Excess weight:***
  - *'Education about cooking, food and info about what we eat'*
  - *'Encouraging exercise - less use of a car, walk, cycle, dance'*
    - *'Fitness and weight issues affecting adults these people often feel awkward around gyms etc so need to have places for "unfit & larger" people to exercise'*
- **A greater emphasis on long term conditions** such as diabetes, asthma, arthritis, Parkinson's disease and epilepsy. These will be addressed through the current proposed 'life expectancy and reduce health inequalities' priority which has identified the management and treatment of long term conditions as an area for improvement.

7.9. The two key additional themes which emerged from the comments were that:

- drug and alcohol misuse was identified as a missing theme by 15 respondents: *'Need to also look at drinking alcohol abuse in all age groups but especially the young''*

- that adult excess weight should be addressed as well as children (see comment above for example).

7.10. A summary of the findings from the engagement programme will be published on the Health & Wellbeing pages of the Council's website. Equally important, is that the more detailed findings of the programme are used to inform the development of health and social care services in the Borough as well as the strategy. To enable this, a detailed report on the insight gathered will be circulated to key managers within the Council and partner organisations.

8. Developing the Strategy

8.1. Based on the engagement and consultation process, the Board is asked to review its proposed priorities and consider whether:

- the proposed priorities should be retained with any amendments
- any additional priorities be introduced

8.2. In doing this, the Board may wish to consider:

- **introducing an additional priority for alcohol and drug misuse– stakeholder and public engagement, together with conversations with lead professionals have identified this as 'gap' in the proposed list of priorities because of the impact on individuals, wider community and the cost to health and criminal justice services.**
- **broadening the scope of the 'excess weight in children' priority to include adults. The Board may wish for this priority to be developed into an 'active lifestyle' theme.**
- **how economic determinants are addressed in the context of the wider partnership structure (see Appendix 3).**

8.3. Through this activity the Board should finalise its list of priorities for the strategy. The Board are asked to confirm the lead Board sponsor for each priority. Each sponsor will be responsible for:

- nominating an officer lead for the priority
- confirming the outcome measures for the priority
- driving and challenging delivery of that priority

8.4. Working with the Health & Wellbeing Board Executive, it is proposed that a draft strategy is presented to the November 14th Health & Wellbeing Board.

Report prepared by Jon Power, Delivery & Planning Manager and Helen Onions, Public Health Specialist.


Telford and Wrekin
Health and Wellbeing Priorities







Consultation Document
May 2012

NHS Telford and Wrekin

a co-operative council

Telford & Wrekin COUNCIL

Foreword

This document sets out the proposed priorities for a new Health and Wellbeing Strategy. This strategy will describe how we will work to improve the health and wellbeing of people living in the Borough of Telford and Wrekin.

The strategy is being developed by the Telford and Wrekin Health and Wellbeing Board. The Board includes representatives within the NHS and Telford & Wrekin Council with responsibility for health, social care and public health services, together with elected Councillors and service user and patient representatives. The Board's role is to consider local needs and plan the right services for our community.

It is our belief that everyone in the borough has a right to good health. We will work together to provide the support and opportunities to enable this to happen.

The proposed priorities have been identified by the Board members with a commitment to work better, more effectively together to improve the health and wellbeing of people living in Telford and Wrekin. The strategy will then set out where and how we will target our resources over the coming years, both building on our successes and improving our joint working where we need to.

We are now seeking the views of our partners, service providers, service users and residents on these proposed priorities. Please take this opportunity to have your say. Section 5 (page 13) sets out how you can have your say on these priorities.

Councillor Richard Overton
Chair of Telford and Wrekin Health and Wellbeing Board
Cabinet Member responsible for Health
Deputy Leader Telford and Wrekin Council

1. Telford and Wrekin Health and Wellbeing Strategy

The 2012 Health and Social Care Act requires local authorities to establish a Health and Wellbeing Board. The purpose of the Board is to identify and address the health and wellbeing priorities in Telford and Wrekin. It will do this by producing a Health and Wellbeing Strategy, which will be published by April 2013.

The Telford and Wrekin Health and Wellbeing Board has been in development since March 2011. Its current members include representation from:

- Local Authority Elected Cabinet Members
- Clinical Commissioning Group
- Local Authority Officers
- Public Health (currently NHS but will transfer to local authority by April 2013)
- LINk – representative of patient and service users
- NHS T&W/NHS Commissioning Board

The Health & Wellbeing Board is one of a number of ways in which we work in partnership to deliver the right services to shape and improve the quality of life in Telford and Wrekin.

This consultation document sets out the proposed priorities which the Board will address. The priorities have been identified through the development of the 'Joint Strategic Needs Assessment (JSNA)'.

The JSNA uses data, performance information and intelligence to help us identify health and wellbeing needs in Telford and Wrekin. Our JSNA can be found at www.telford.gov.uk/factsandfigures

From all of this work, a long-list of local health and wellbeing priorities have been identified (see Appendix 1), based on:

- Where the borough was shown to be in a worse than the national position
- Existing local priorities
- National priorities
- Areas where we know we need to make financial savings

Using this information the Health and Wellbeing Board identified the proposed priorities, set out in section 3 (page 5).

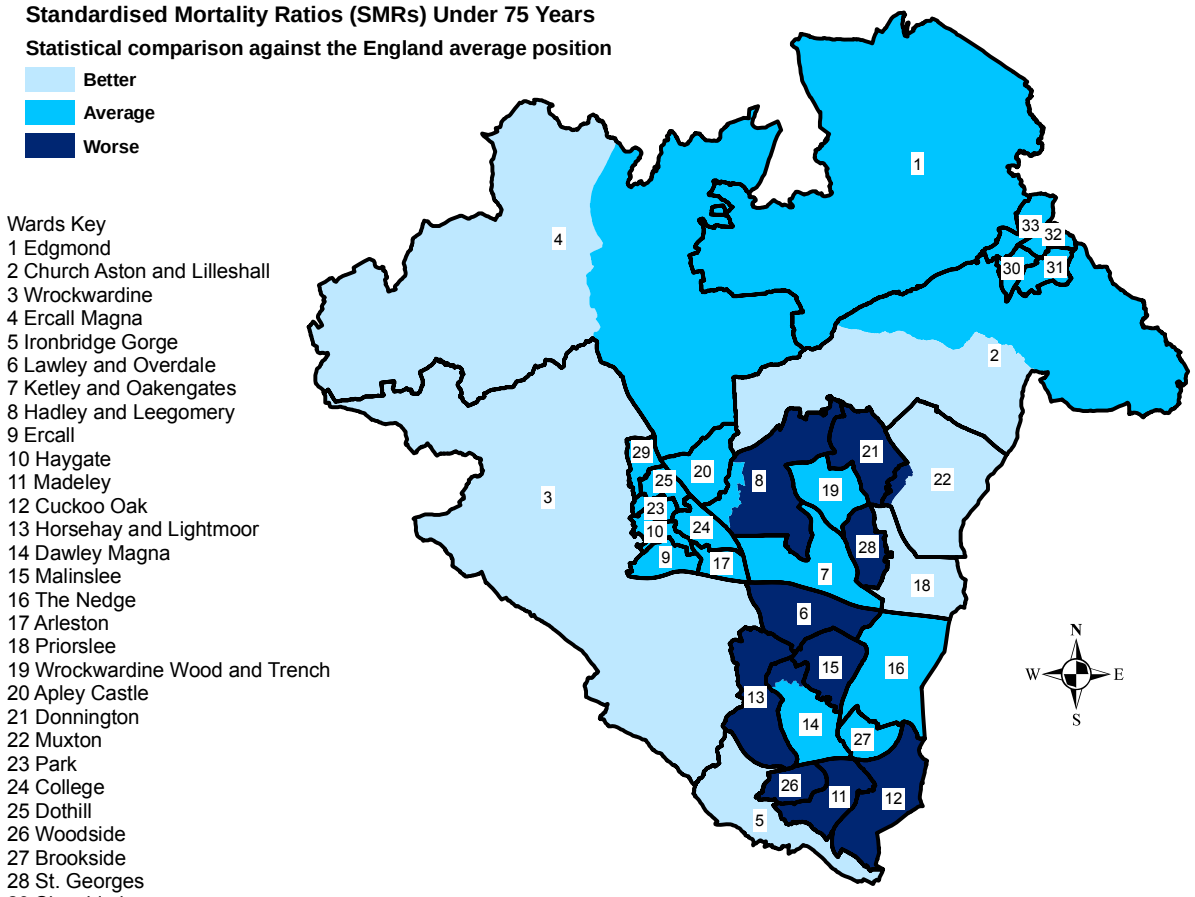
2. Health and Wellbeing in Telford and Wrekin

Over the past 20 years, the health and wellbeing of the Borough has improved significantly with people living longer and staying healthier than ever before. However, there are some real health challenges and differences across the borough which need to be overcome if this improvement is to continue. Too many people in the Borough, particularly men still die early from cancer, heart disease and stroke and rates of teenage pregnancy, maternal smoking, breastfeeding and childhood obesity are all worse than the England average.

A key health challenge in Telford and Wrekin is that the health of residents is not consistent across the Borough, as shown in the map below. People in our more deprived areas are more likely to die earlier and are more likely to have poor physical and mental health.

Whilst people are living longer, many are spending more years at the end of their life in declining health. This places significant demand on health and social care services and highlights the importance of healthy lifestyles. Many of the causes of poor health are largely preventable, as are the costly consequences. Reflecting this, a number of the proposed priorities focus on the prevention of ill health starting from childhood.

Premature Mortality in Telford and Wrekin



Source: Association of Public Health Observatories:
http://www.apho.org.uk/resource/item.aspx?RID=97049

3. Telford and Wrekin Priorities

Our Vision "All children and adults living safe, healthy and independent lives through access to timely, appropriate health and social care services"

	Priorities	Outcome Measures
CHILDREN	**Reduce excess weight in children**	• Excess weight in 4-5 year olds • Breastfeeding initiation and prevalence
CHILDREN	**Reduce teenage pregnancy**	• Under 18 conception rates • Reduction in risk taking behaviour
ADULTS	**Improve emotional health and wellbeing**	• Hospital admission rates from self-harm • Further measures to be developed and linked to the strategy
ADULTS	**Support people with autism**	• Measures to be developed and linked to the strategy
ADULTS	**Reduce the number of people who smoke**	• Smoking related deaths • Smoking attributable hospital admissions • Smoking in pregnancy • Low birth weight babies
ADULTS	**Ensure people have a positive experience of health and care services**	• Overall patient experience measures • People treated with Dignity and Respect • Overall satisfaction with care and support • Overall satisfaction of carers with social services
ADULTS	**Improve carers' health and wellbeing**	• Carer-reported quality of life • Carers who feel they have been included in discussions about the person they care for • Further measures to be developed and linked to the strategy
ADULTS	**Support people to live independently**	• Social care self-directed support • Older people who were still at home 91 days after discharge from hospital into reablement services • People receiving reablement services who need ongoing support • Delayed transfers of care from hospital
ADULTS	**Improve life expectancy and reduce health inequalities**	• Male life expectancy • Premature death from CVD • Premature death from cancer • National cancer screening programme uptake • Management and treatment of long term conditions
ADULTS	**Support people with dementia**	• Increase the number of dementia services available

CROSS-CUTTING PRINCIPLES

EQUITY – ACCESSIBILITY – INTEGRATION – QUALITY – ENGAGEMENT
FINANCIAL SUSTAINABILITY – EARLY INTERVENTION and PREVENTION - SAFEGUARDING

Priority 1 - Reduce Excess Weight in Children

Why is it important?

Being overweight or obese is one of the most widespread threats to health and wellbeing in the country. Obesity reduces life expectancy by on average 11 years. Obese children and adolescents are more likely to become obese adults and therefore are at higher risk of future health problems such as type 2 diabetes, cancer and heart disease. Obesity is notoriously difficult to treat, so prevention and early intervention are very important.

Breastfeeding has many clear health benefits for both mothers and babies. Breastfed babies are less likely to suffer from a range of infections (including chest and stomach infections), insulin dependent diabetes and they are also less likely to become obese. Mothers who breastfeed reduce their risk of ovarian and breast cancer and breastfeeding helps women with weight loss after pregnancy.

What is the situation in Telford and Wrekin?

- Obesity amongst 4-5 year olds has decreased during the past five years from 12.5% in 2006/07 to 10.4% in 2010/11. 'Excess weight' in 4-5 year olds (24.9%) remains worse than the average for England (22.6%).
- Amongst 10-11 year olds 252 were overweight and 318 were obese in 2010/11.
- More boys than girls are obese in both the 4-5 and 10-11 year age groups
- Breastfeeding at birth has improved in recent years increasing to 65% in 2010/11 from 58% in 2003/04. However, levels of breastfeeding remained significantly worse than the national average in 2010/11 with:
    - 65% of infants breastfed at birth, compared to 74% in England and;
    - 33% of infants breastfed at 6-8 weeks, compared to 46% in England
- Breastfeeding rates are significantly lower amongst:
    - Younger mothers with 42% of teenage mothers breastfeeding at birth, compared to 72% of mothers aged 35 years and over
    - Deprived communities with: 51% of infants are breastfed at birth in the most deprived areas, compared to 81% in the most affluent areas

Priority 2 - Reduce Teenage Pregnancy Rates

Why is it important?

For some younger people, becoming a parent is a positive choice. However, teenage pregnancy is often associated with poor health and social outcomes for both the mother and child. Young mothers are more likely to suffer postnatal depression and less likely to complete their education, more likely to live in poverty and more likely to become teenage parents themselves. Raising young people's aspirations and building their resilience can help them make informed decisions enabling them to fulfil their potential. This in turn can reduce risk taking behaviours such as drug and alcohol misuse which can undermine young people's life chances, and potentially prevent involvement in crime and anti-social behaviour.

What is the situation in Telford and Wrekin?

- There were 155 conceptions amongst under 18 year olds in 2010
- There has been a decrease in teenage pregnancy rates during the past decade
- However, the under 18 conception rate in 2010 (47.5 per 1,000 females aged 15-17 years) remained statistically significantly worse than the national average for England (35.4 per 1,000)
- Just over half, 55% of pregnant teenagers (under 18 years) opt to continue with their pregnancy, and 45% choose to terminate the pregnancy
- Smoking in pregnancy is highest amongst teenage mothers and breastfeeding rates are exceptionally low
- The electoral wards with the highest teenage pregnancy rates are also amongst the most deprived wards

Priority 3 - Improve Emotional Health and Wellbeing

Why is it important?

Promoting good emotional and physical health and intervening early, particularly in the crucial childhood and teenage years, can prevent mental illness. Improved emotional health and wellbeing is associated with a range of better outcomes for people including: improved physical health and life expectancy, better educational achievement, increased skills, reduced risk of mental health problems and suicide, improved employment rates, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.

What is the situation in Telford and Wrekin?

- It is estimated that in 2010 around 17,200 people in Telford and Wrekin suffered from a common mental disorder such as depression, anxiety and obsessive compulsive disorder, with around 60% of these estimated to be women.
- One in ten children aged between 5 and 16 years suffers with a mental health problem, and many continue into adulthood. At least one in four adults experience mental health problems at some point during their life.
- There are on average 15 suicides every year. The largest proportion of suicides is amongst men aged 21 to 39 years
- In 2009/10 there were 371 hospital stays for self-harm, 39 of those admitted for self-harm were under 18. The hospital admission rate for self-harm in 2009/10 was significantly higher than the national average

Priority 4 - Support People with Autism

Why is it important?

Autistic Spectrum Condition (ASC) is a lifelong condition that affects how a person communicates with and relates to other people. It also affects how a person makes sense of the world around them. Autistic Spectrum Condition is a lifelong developmental disability, affecting social interaction, communication, social relationships and making sense of the world.

During the last few years there has been a strong message from Government that there is a need for local services to meet the needs of adults and young people with autistic spectrum conditions.

What is the situation in Telford and Wrekin?

- Estimated that 1 in every 100 adults will be on the autistic spectrum, which equates to approximately 1,700 people in Telford and Wrekin.
- More detailed work on the prevalence of autism is Telford and Wrekin is required in the JSNA.
- Historically, services have developed disparately across the local health economy, leading to inconsistencies in the services that users might expect and physical surroundings which are not fit for purpose

Priority 5 - Reduce the Number of People who Smoke

Why is it important?

Smoking is the single biggest preventable cause of early death and illness in the country, causing over 80,000 deaths per year. The overall economic burden of tobacco use to society is estimated at £13.74 billion a year. Smoking cessation is the most cost-effective life saving intervention offered by the NHS. Smoking is more common in deprived communities and low income families and households. Children with parents who smoke are more likely to become smokers and the earlier children start to smoke the more likely they are to continue to smoke as adults. Smoking in pregnancy causes low birth weight and contributes to infant mortality.

What is the situation in Telford and Wrekin?

- 23% of adults are estimated to be smokers (circa 32,000 people aged 16+ years)
- During the past five years smoking quit rates have been amongst the highest in the country, with over 3,900 quitters during 2010/11
- However, mortality rates due to smoking-related deaths and hospital admissions rates attributable to smoking remain statistically significantly worse than the national average
- Levels of smoking in pregnancy are persistently, significantly worse than the national average. 23.6% of mothers smoked during pregnancy in 2010/11 (515 women), compared to 13.5% in England as a whole
- There are clear inequalities with:
    - 41% of teenage mothers smoking in pregnancy compared to 14% of 35+ year olds

- 35% of mothers from the most deprived communities smoked throughout pregnancy, compared to 6% of mothers from the most affluent communities

Priority 6 - Ensure People have a Positive Experience of Health and Care Services

Why is it important?

People can come into contact with health and care services at any point in their lives, sometimes unexpectedly due to illness or crisis and sometimes regularly to support long term conditions. It is important that all people who use our services have a positive experience and that we listen to what they are telling us about the experiences they have.

What is the situation in Telford and Wrekin?

- 83% of patients report that they are satisfied with their GP, and 71% are satisfied with their practice nurse in 2010/11
- 77% of patients report that they are able to see a GP fairly quickly
- 90% of respondents to the 2010/11 Adult Social Care User survey reported that they were satisfied with their care and support services, with 61% extremely or very satisfied, the same as the national rate.
- 95% of people assessed by Adult Social Care were satisfied that they had been treated with dignity and respect during the assessment process, with less than 1% being dissatisfied.

Priority 7 – Improve Carers' Health and Wellbeing

Why is it important?

It is suggested that at some point in our lives most of us will look after an elderly relative, sick partner or a disabled family member. Caring can take its toll on your finances, your health, your social life, and on your other family and work commitments. However, given a reasonable level of support and understanding, carers are prepared and able to go to very great lengths to care for their loved ones for as long as possible in their own home environments.

Without unpaid carers the country would face a care bill it cannot afford. Well-supported carers also contribute directly to reduced care packages and reduced care-home placements.

What is the situation in Telford and Wrekin?

- Estimated 16,200 people over 18 providing unpaid care. Over 4,000 of these people are providing substantial and intense care
- 193 young carers are known to us though there are an estimated 600 young people in the Borough with caring responsibilities
- Carers are more likely to be female and the largest proportion are aged 35-64

- Carers aged 18-45 are less likely to receive support services than those who are older
- People who care for someone over 65 get fewer carers' services than the national average
- The reported health of carers is below national average. Carers' health is poorer than that of non-carers, and the more hours spent caring, the poorer the reported health of carers.
- There is a predicted decline in the proportion of people able to care for family, friends or neighbours in the borough as the ratio of adults to older people decreases.

Priority 8 – Support People to Live Independently

Why is it important?

Maximising people's independence is shown to prevent or delay the deterioration of wellbeing resulting from ageing, illness or disability and delay the need for more costly and intensive services.

The Government's aim is for people to live independently for as long as possible, ensuring that people who need care and support have as much choice, control and freedom over decisions and services as they want.

What is the situation in Telford and Wrekin?

- 48% of people who completed a period of reablement in 2010/11 did not require any ongoing social care support.
- There are pockets of good practice but these services are not joined up, are complex to navigate and patchy, leading to inequity in access
- Where investment has taken place, there is evidence of reduced on going costs
- Only approx. 30% of people who would benefit from reablement are currently accessing the service

Priority 9 – Improve Life Expectancy and Reduce Health Inequalities

Why is it important?

Cancer and cardiovascular diseases (heart disease and stroke) are the most typical reasons people die early (before the age of 75). People living in the most deprived communities, men and people from Black and Minority Ethnic Groups have a lower life expectancy are more likely to die before the age of 75. It is estimated that at least 80% of all early deaths from heart disease and over 40% of deaths from cancers could be prevented through a healthy diet, regular exercise and by not smoking. Screening programmes, early detection for disease through raising awareness of symptoms and prompt effective treatment can dramatically reduce premature deaths.

What is the situation in Telford and Wrekin?

- Male life expectancy at birth is statistically significantly worse than the national average position (77.5 years compared to 78.6 years)

- Female life expectancy at birth is not statistically significantly different to the national average position (82.1 years compared to 82.6 years)
- Cancers cause 40% of early deaths, with on average 217 cancer deaths under 75 years every year
- The early death rate from cancer is significantly worse than the national average
- CVD causes 25% of early deaths, with on average 140 deaths every year
- Despite a significant decrease the early death rate from CVD remains significantly worse than the national average
- The uptake of cancer screening programmes is below the national average
- Male life expectancy in the most affluent areas is 79.8 years, compared to 74.9 years in the most deprived areas
- Female life expectancy is 82.5 years in the most affluent areas, compared to 80.6 years in the most deprived areas

Priority 10 – Support People with Dementia

Why is it important?

Dementia is becoming more common and the cost of looking after people with dementia is increasing – the Government has identified it as a national priority.

People with dementia will progressively get worse, and as they do will become increasingly dependent on other people to carry out everyday tasks. It mainly affects people over the age of 65, although can affect younger people too.

The Government is committed to improving the care and experience of people with dementia and their carers by transforming dementia services to achieve better awareness, early diagnosis and high quality treatment at every stage and in every setting. Dementia makes the lives of people who have it, and the lives of their families and carers, very difficult, however, there are lots of things that can be done to help people overcome the problems and to improve their quality of life.

What is the situation in Telford and Wrekin?

- In 2010 an estimated 1,600 people aged 65 and over in Telford and Wrekin were suffering from dementia, by 2026 this is estimated to rise to 2,100.
- Increased population and increased longevity of life leading to increased dementia prevalence
- Predicted decline in the number of carers due to social factors
- A need for a greater focus on local delivery of quality outcomes and local accountability for achieving them

4. Cross-cutting Principles

To continually improve health and wellbeing and reduce inequalities in Telford and Wrekin, while making the best use of resources, the strategy will ensure that local services are delivered in partnership, in line with the high level priorities and underpinned by the following cross-cutting principles:

Equity

To tackle inequalities the provision, uptake and outcome of services should be equitable i.e. proportional to need, and proactively targeted towards the areas and groups within the community where they are most needed

Accessibility

Services should be accessible to all, particularly for the nine protected groups identified in the 2010 Equalities Act

Integration

Services should be joined up, with all relevant partners working together to ensure patients, clients, service users and carers experience seamless journeys of support, care and treatment

Quality

Services should be safe and evidence-based, providing value for money i.e. both clinically and cost-effective e.g. based on NICE (National Institute for Health and Clinical Excellence) guidance or other national quality standards

Financial Sustainability

Public sector resources should be used responsibly to deliver and develop services with consideration of financial sustainability and value for money with respect to outcomes

Early Intervention and Prevention

A strong focus on prevention, rather than treatment, to deliver greater overall increases in both life expectancy and quality of life, including an early intervention approach to supporting families, sustained lifestyle behaviour change, awareness raising of symptoms and early detection and treatment of risk factors which cause ill-health

Engagement

Putting the public at the heart of service design

Safeguarding

At the core of our approach to service design and delivery is the protection of vulnerable adults and children. This challenge will be overseen by our Adult and Children's Safeguarding Boards.

5. Your Views Matter

We are seeking the views of our partners, service providers and residents on these proposed priorities for Telford and Wrekin. Please take this opportunity to have your say on what is included, or not included, within this document.

We want to know whether you feel these are the right health and wellbeing priorities or whether you feel there are any important issues missing.

We want to hear your views. We will use this feedback to inform the development of the final strategy. The closing date for this consultation is Friday 20th July 2012.

Online questionnaire: www.telford.gov.uk

Email us at Delivery&Planning@telford.gov.uk

Telephone 01952 380131

Or write to

Delivery and Planning

Telford & Wrekin Council

FREEPOST SY1154

Telford

Shropshire

TF3 4ZZ

Appendix 1: Strategic Priorities Long List

To inform the development of our Health & Wellbeing priorities, our Joint Strategic Needs Assessment (JSNA) was used to develop a long list of local priorities. The following table sets out this long-list together with the reason why each issue was included. Those issues which have been identified as a proposed priorities for the Health And Wellbeing Strategy are highlighted in bold text.

To ensure that all the priorities on the long-list have appropriate focus, those which have not been aligned to the Health & Wellbeing Strategy, have been aligned with another local partnership or partner organisation.

This long-list of priorities has been organised by the Marmot 'life stages'. More information about these can be found in Appendix 2.

	JSNA PRIORITY REASONS							
	Marmot Indicator	Significantly worse than England average	Health (PCT/CCG/PH) Priorities	National Policy / Outcome measure	Financial Pressure	Children, Young People and Families emerging priorities	Adult Social Care emerging priority	Responsible partner/ partnership board (see key below table)
STARTING WELL								
Breastfeeding initiation (@ birth and duration 6-8 weeks)		●	●	●				HWB
Supporting teenage parents			●			●		HWB
Excess weight (overweight and obesity) in 4-5 year olds		●	●	●		●		HWB
Smoking in pregnancy		●	●	●				HWB
Low birth weight babies		●	●	●				CCG
Paediatric hospital admission rates (< 5s)		●						CCG
Children achieving a good level of development at age 5	●	●						CFB
DEVELOPING WELL								
Under 18 conception rates		●	●	●		●		HWB
Disabled Children						●		CFB
Inequalities in educational outcomes						●		CFB or SETF
Children in Care rate	●				●	●		CFB
Care Leavers						●		CFB
Child Protection Plan rate	●					●		CFB
First time entrants to the youth justice system				●				SCCB
Special Educational Needs Rate	●							TWC

	JSNA PRIORITY REASONS							Responsible partner/ partnership board (see key below table)
	Marmot Indicator	Significantly worse than England average	Health (PCT/CCG/PH) Priorities	National Policy / Outcome measure	Financial Pressure	Children, Young People and Families emerging priorities	Adult Social Care emerging priority	
WORKING WELL								
Young people not in employment, education or training (NEET)	●	●		●		●		SETF
Households in receipt of means-tested benefits	●	●			●			SETF & SFTF
Unemployment		●			●			SETF
Workforce skills levels		●						SETF
Average earnings		●						SETF
Inequality in percentage receiving means-tested benefits	●	●						SETF
LIVING WELL								
Emotional Wellbeing						●		HWB
Prevention and maximising independence			●	●	●		●	HWB
Hospital admission rates for self- harm		●		●				HWB
Excess weight in adults		●		●				HWB
Adults not consuming 5-A-DAY fruit and veg		●						PH
Family poverty		●	●	●		●		LSP
Strengthening Families				●		●		SFTF
Homelessness (particularly youth)								HPLTF
Crime attributable to alcohol		●						SCCB
Alcohol-related violent crime		●						SCCB
Anti-social behaviour rates		●						SCCB
Fear of crime								SCCB
People from different backgrounds getting on well together								SCCB
AGEING WELL								
Smoking-related deaths		●	●					HWB
Smoking-attributable hospital admissions		●	●					HWB
Dementia			●	●			●	HWB
Rehabilitation and Re-ablement			●	●	●		●	HWB
Male life expectancy		●	●	●				HWB

	JSNA PRIORITY REASONS							Responsible partner/ partnership board (see key below table)
	Marmot Indicator	Significantly worse than England average	Health (PCT/CCG/PH) Priorities	National Policy / Outcome measure	Financial Pressure	Children, Young People and Families emerging priorities	Adult Social Care emerging priority	
Premature mortality rates from all cancers		●	●	●				HWB
Premature mortality rates from cardiovascular diseases		●	●	●				HWB
Meeting the needs of the ageing population			●		●		●	ALL
Bowel cancer and cervical screening uptake		●		●				CCG / PH
End of life care			●					CCG
Long term conditions management (Respiratory disease and diabetes)								CCG
Management of hypertension in primary care		●	●					CCG
ALL-AGE								
Mental Health			●		●	●		HWB
Young Carers and Carers			●		●	●	●	HWB
Positive experience of health, care and support			●			●	●	HWB
Autism			●	●		●	●	HWB
Early intervention and prevention			●		●	●	●	ALL
Safeguarding - protecting from avoidable harm and caring in a safe environment			●			●	●	LSCB / LSAB

HWB = Health and Wellbeing Board
CCG = Clinical Commissioning Group
PH = Public Health
CFB = Children and Families Board
LSP = Local Strategic Partnership Executive
LSCB / LSAB = Local Safeguarding Children and Adults Boards

SCCB = Safer Cohesive Communities Board
SETF = Skills and Employment Task Force
SFTF = Supporting Families Task Force
HPLTF = Homelessness / Private Landlord Task Force
TWC = Telford and Wrekin Council

Appendix 2: The Life Stage Approach

The national drive to improve the public's health is based on a life stage approach. This is aimed at improving health and wellbeing and reducing inequalities at key stages throughout people's lives. These significant life stages are described below:

Starting well

The health and wellbeing of women before, during and after pregnancy is a critical factor in giving children the healthiest start in life. Evidence indicates that: improving maternal mental health, tackling maternal obesity, decreasing smoking in pregnancy and improving breastfeeding will have the greatest impact. Children's development is crucial and better early years support makes a big difference. Good parent–child relationships help build children's self-esteem and confidence and reduce the risk of children adopting unhealthy lifestyles.

Developing well

Teenage years are a crucial time for health and wellbeing. Teenagers and young people are among the biggest lifestyle risk-takers. Behaviour patterns adopted in childhood and adolescence usually persist into adulthood. The younger people start to smoke the more likely they are to remain smokers and the pattern is the same for overweight and obesity. Half of all mental illness starts by the age of 14.

Living well

The majority of illnesses and early death, before the age of 75, are caused by 'diseases of lifestyle' and therefore could be prevented. It is estimated that a substantial proportion of cancers and deaths from circulatory disease (heart disease and stroke) could be avoided, through a combination of stopping smoking, improving diet, increasing physical activity and sensible alcohol consumption. Improving emotional health and well-being impacts significantly on both people's physical health and their lifestyle behaviour choices.

Working well

The health and wellbeing of people of working age is important to our economy and society. Working is in general good for people's health and being unemployed can negatively impact on both physical and mental health. Taking a preventive approach can impact on musculoskeletal problems, work-related stress, depression and anxiety which in turn will reduce sickness absence from work.

Ageing well

Our population is ageing rapidly, but people are living and staying fitter for longer. Dementia is increasing due to the ageing population, but improving diet and lifestyle earlier in life can significantly reduce the impact for over half of people who suffer with dementia. Intervening early to support the vulnerable elderly, such as those who are frail and isolated in order to prevent falls, depression and unnecessary suffering in cold weather, can make a huge difference.

APPENDIX TWO: DEPARTMENT OF HEALTH JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES – DRAFT GUIDANCE

1. Background to the draft guidance

1.1. The Health and Social Care Act 2012 introduces duties and powers for Health and Wellbeing Boards (H&WBs) in relation to Joint Strategic Needs Assessment(JSNA) and Joint Health and Wellbeing Strategies (JHWS). The vision for public services in the Act is that decision making should be made as locally as possible, involving people how use them and the wider community.

1.2. The Act supports local clinical leadership working alongside democratically elected leaders to deliver the best evidence-based health and care services.There is an equal duty on local authorities (LAs) and Clinical Commissioning Groups (CCGs) to prepare JSNA and JHWS, through the H&WB. The local Healthwatch organisation should ensure that involvement and engagement processes reflect all groups within the community, including those who are socially excluded or vulnerable.

1.3. H&WBs are expected, throughout the JSNA process to meet the Public Sector Equality Duty, set out in the Equality Act 2012, specifically involving people for the protected groups and considering the effects decisions are likely to have on people with protect equality characteristics

2. Introduction to the draft guidance

2.1. The Department of Health initially published draft guidance for H&WBs on JSNA and JHWS in January 2012, prior to Royal Asset of the Health and Social Care bill. The Telford and Wrekin HWB were briefed on the implications of this initial guidance at their meeting in February 2012.

2.2. Representatives from Telford and Wrekin (from Delivery & Planning and Public Health Teams and Link) contributed to two regional engagement events held by the DH to gain views on thedraft guidance, first in January 2012 and then again March 2012.

2.3. In July 2012 a further draft guidance document for JSNA and JHWS was published by the DH, this includes a series of consultation questions,with responses requested by 28th September 2012. The following sections of this report summarise the main expectations for JSNA and JHWSs and the opportunities for integrated working as outlined in the guidance and set out the consultation questions with initial draft responses for Telford and Wrekin.

3. Expectations for JSNA and JHWS

3.1. The key expectations set out in the draft guidance can be summarised as follows:

- The main aim of JSNA and JHWSsis to improve the health and wellbeing of the local community and reduce inequalities – they are viewed as a continuous process of strategic assessment and planning, providing the evidence base for the planning of services – rather than an end in themselves

- JSNAs are local assessments of current and future health and social care needs which could be met by the LA, CCG or NHS Commissioning Board (NHS CB). As such a

range of quantitative and qualitative evidence should be included covering for example mental health, health protection and prevention, the role of personal budgets and universal advice and detailed needs assessments for wards or specific groups, or the wider determinants of health

- JHWS should be designed to meet the needs identified in JSNAs, explaining the priorities that the H&WB has set to tackle those needs – they are not about action on everything but setting priorities for joint action in order to make an impact

- JSNAs need to be an integral part of CCG and local authority commissioning cycles, and H&WBs shoulddecide the timing and frequency of update required to ensure they inform local commissioning plans over time

- CCGs, the NHS CB and local authority commissioning plans must be informed by JSNA and the JHWS. When plans appear not to be in line and the H&WB have not been consulted there should be challenge and explanations will be required

- H&WBs need to consider, through JSNA and JHWS processes:

    - The needs of the whole community, including how needs vary for people at different ages, and may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services

    - Wider social, environmental and economic factors that impact on health and wellbeing – such as access to green space, air quality, housing, community safety, employment; and

    - What health and social care information the local community needs, including how they access it and what support they may need to understand it

- Outcome measures from the NHS, Adult Social Care, Public Health Outcomes Frameworks and CCG commissioning framework should help inform joint priorities but should not overshadow local evidence

- JSNAs and JHWSs should be published with a view to explaining the H&WB assessment of local need and assets, the priorities chosen and the proposals to address the need, indicating what evidence has been used and what views have been considered. Sharing JSNA analyses and data (where appropriate) will assist H&WBs make their decision-making process transparent to their partners and the community

4. Opportunities for integrated working

- H&WBs should encourage integrated working between health and social care commissioners, encouraging partnership arrangements such as pooled budgets, lead commissioning or integrated provision

- The Act supports joint working by allowing local authorities to delegate function the H&WBs such as responsibility for developing housing strategies across partners

- H&WBs could develop commissioning arrangements for services which impact on the wider determinants of health across partner organisations such as the Police and probation services, schools and voluntary and community organisations, to get a thorough understanding of local needs and how to address them and encouraging the integration of services to improve health outcomes

- JSNAs and JHWS can support other legal duties and contribute to other strategic partnerships for example Community Safety Partnerships

5. Department of Health Proposals for Consultation

1) Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs must do in relation to JSNAs and JHWSs?

   The inclusion of a summary table for the legal duties, indicating which organisation is responsible is helpful. However, there are a number of areas which could be made more explicitly:

   - The document should state the statutory membership of the Board
   - The duty on the Board to
     - consider flexibilities under the NHS Act 2006 when developing the JHWS
     - exercise functions with a view to securing continuous improvement in quality of services
     - act with a view to secure continuous improvement

2) It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?
   The guidance clearly articulates local determination of timescales for the publication and review of JSNA and JHWS processes and cycles as agreed by the H&WB which is fully supported in Telford and Wrekin.

3) Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?
   The guidance gives a broad outline of the expected content of JSNA and JHWS, with some specific examples. The reiteration that JSNA and JHWS should be a *continuous process of strategic assessment and planning, providing the evidence base for the planning of services – rather than an end in themselves*is useful clarification. The confirmation that JHWS should explain the priorities that the H&WB has set to tackle needs identified and that *they are not about action on everything but setting priorities for joint action in order to make an impact*is also welcomed.

   However, it would help if a best practice toolkit was published to accompany the guidance to provide H&WBs with examples of well-regarded JSNAs/JHWSs. it is described as a process which will consider 'all things' as wrapped up in the 'wider-determinants' of health. It is becoming increasingly common for different Government departments to suggest that issues pertinent to their portfolios will be 'considered by the JSNA'. The scope of a JSNA to be effective and timely must be effectively defined. As such, further, consideration should be given to the development of a set of standards for JSNA. This work on best practice should be clearly linked to the Public Health England Evidence and Intelligence Workstream remit.

4) Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?

The principles of partnership working across the LA and new NHS organisations are described in the guidance in the context of H&WB membership and the expectations for JSNA & JHWS. The opportunity to develop more integrated services is outlined and wider partners and partnerships is mentioned but not prescribed therefore appears flexible allowing for local determination.

5) The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.

a) In your view, have past JSNAs demonstrated that equality duties have been met?

Our previous JSNA has had a specific focus on highlighting health and socio-economic inequalities within the population. Both policy and delivery plans by Public Health Service and the local authority have explicitly focused on 'narrowing the gap'. These policies have been pursued based on local evidence, not to explicitly address equality duties. However, the demonstration of JSNAs meeting the equalities duties is probably inconsistent across the Country. The crucial influence that JSNAs should have in meeting equalities duties is made specific in the guidance which is welcomed. However, at a local authority level a major challenge is the availability of data and intelligence specific to the protected groups. National organisations representing the protected groups could be brought in to support the development of robust intelligence working with PHE given the key link with health inequalities

b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?

The expectation that JSNA and JHWSs identify and tackle inequalities and prevent disadvantage for both vulnerable groups and groups with protected characteristics is clear in the guidance. However, as per the point above at a local level the challenge is the availability of intelligence for all groups

6)

a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?

b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?

In general JSNAs have tended to include some intelligence on health inequalities as it has been a mandated area forhealth improvement for PCTs historically. However, inequalities need to be more systematically assessed through JSNAs. Historically, a Health Equity Audit (HEA) approach has assisted with the understanding and review of health inequalities. The current DH view on HEA is not clear and it would help if a requirement to undertake HEA as part of JSNA and JHWS processes was made explicit.

The London Health Observatory health inequalities intervention toolkit and associated resources should be updated and further developed and widely publicised, providing intelligence for all local authorities - not just spearhead areas.

Further, some of the highly useful tools and resources developed by the DH Health Inequalities National Support Team should be revisited, updated and re-issued given the strong evidence base which underpinned their development. There is a key role for PHE here given its future remit for public health evidence and intelligence at a national level.

Government should continue to breakdown barriers to data sharing between local authorities, CCGs and government departments. The DWP holds significant data to inform JSNAs and JHWBs – whilst the Trouble Families initiative has required greater openness from the DWP the opportunities to community understanding through analysis of their data are still blocked by their approach to data sharing.

Equally, there is a case to be made to facilitate wider use of commercially available data on a national licence to improve access, allow consistent interpretation and drive down costs. E.g CACI Acorn data.

7) It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?

As outlined in responses to other consultation questions we consider PHE to have a key role in providing comprehensive evidence and intelligence, including at an LA-level. Access to this evidence and intelligence which needs to be drawn from a wide range of sources should be available via a single portal to support H&WBs and local officers working on JSNA & JHWS. In particular PHE have a key role in providing public health intelligence as part of the PH outcomes framework and provide access to existing key resources already published by the APHO. The resources produced as part of the previous DH HINST should be revisited and re-issued so previous momentum on tackling inequalities is not lost

8) What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be on the behaviour of local partners?

Historically joint strategies and priorities have been agreed and there have been joint commissioning arrangements between PCTs and LAs and wider partners aligned to for example Children's Trust Boards and Adult Care Health and Well-being Boards. However, the Act and this guidance gives this responsibility to a single partnership board for H&WB the first time. Having one joint strategy for health and wellbeing, including a single set of important key joint priorities will provide partners with clarity on action which needs to be taken collaboratively across organisations. The guidance

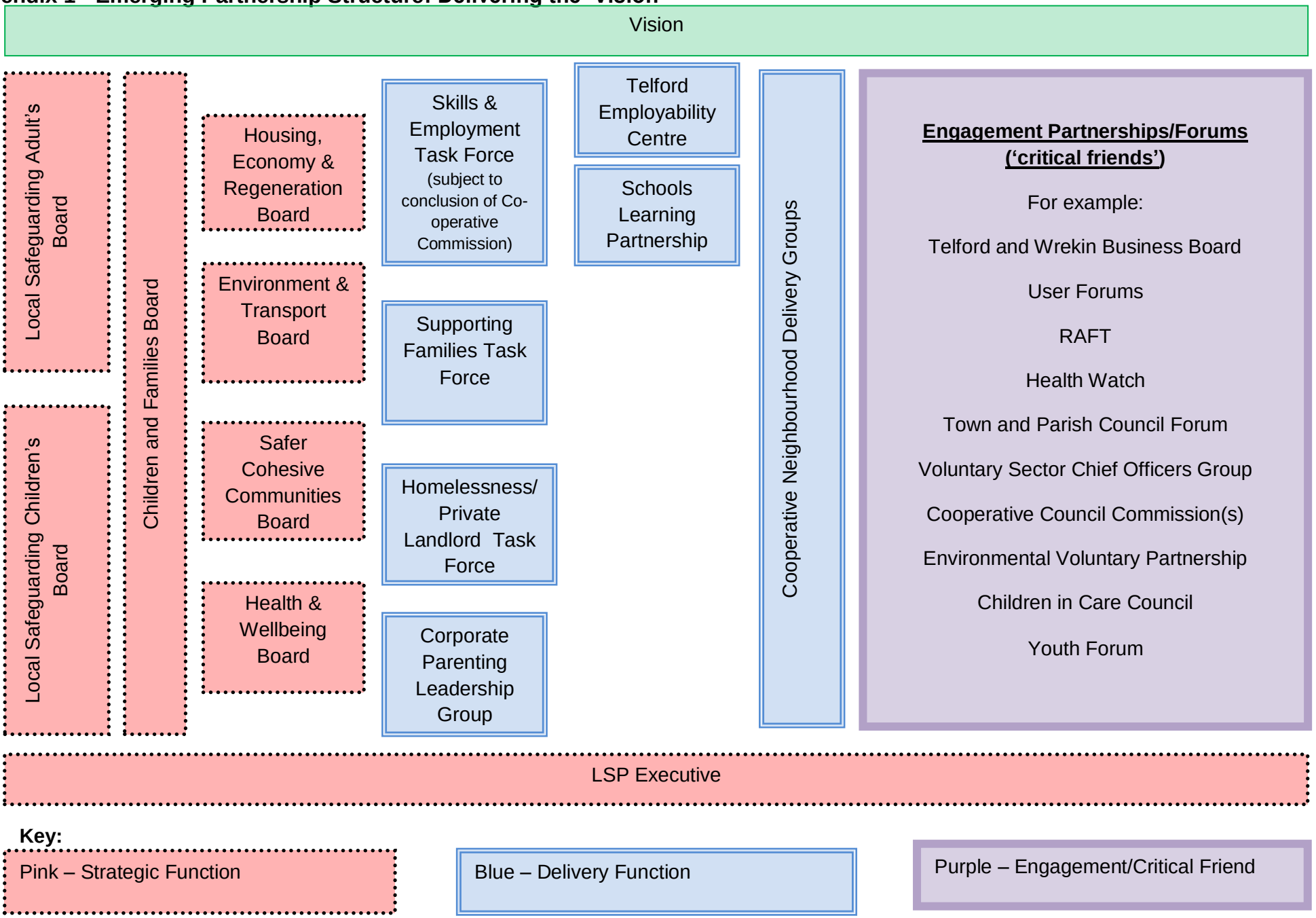
should ensure systematic use of intelligence from the JSNA throughout the commissioning process and the JSNA and JHWS should drive service improvement.

However, strong local partnerships are already being driven still closer together by the need to manage and deliver significant financial savings whilst mitigating the impact as far as possible on the local population.

9) How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – what do you think the impact of this guidance will be on the outcomes for local communities?

The importance of capturing the contribution of community assets in JSNA & JHWS is explicit in the guidance, as is the importance of meaningful and on-going consultation and engagement with the community, particularly through the Healthwatch organisation throughout the JSNA and JHWS processes. However, there could be further practical resources developed following on from the “Glass Half Full” and related asset mapping documents. These reports include examples of community assets and community development which has benefited local populations but a toolkit or check list for asset mapping, based on best practice, would assist H&WBs in the implementation of an asset based approach. However, the context to this, is that there are now significantly less resources to be targeted which may impact on outcomes for the local community, particularly the poorest.

Appendix 1 - Emerging Partnership Structure: Delivering the 'Vision'



BOROUGH OF TELFORD & WREKIN

HEALTH AND WELLBEING BOARD – 12 SEPTEMBER 2012

BOARD STRUCTURE/REPRESENTATION/ROLE

REPORT OF THE ASSISTANT DIRECTOR – SOCIAL CARE SPECIALIST

1. SUMMARY

1.1 The report updates members on:

- The feedback from the stakeholder engagement event with reference to the discussion around the future governance and structure of the T&W HWB and in particular the question – how can local people and stakeholders be involved in and influence the decision making of the HWB?
- The West Midlands Councils HWB Support and Development Programme
- The discussions around scrutiny arrangements
- The Vice Chair and additional Cabinet Member representation on the HWB
- The formation of the HWB Executive Group
- Future frequency of HWB meetings

2. RECOMMENDATIONS

2.1 Members note the updates received in relation to the Telford and Wrekin Health and Wellbeing Board

2.2 It is proposed that the HWB Development Tool is completed individually by members of the Board working independently and collated and presented for discussion at the November HWB meeting.

2.3 Members agree their desired aims/objectives for the initial development session and for the period of support, from the West Midlands Councils Support Offer.

2.4 It is proposed that the HWB work with the Scrutiny Committee to develop a full memorandum of understanding/protocol.

2.5 Members agree the frequency of future HWB meetings

3. INFORMATION

3.1 Feedback from Stakeholder Event

The event focussed part of the discussion on the future governance and structure of the T&W HWB and posed the question: 'How can people and stakeholders be involved in and influence the decision making of the HWB?' Full feedback is attached in Appendix 1. It was clear from the feedback that no one structure/size fits all and that the Board will need to be creative in ensuring the appropriate future representation, structure and communication and engagement channels, to ensure providers, stakeholders, third sector, service users and communities' voices are heard and decisions can be influenced.

In addition to the feedback gained from the stakeholder event, we have also received representations from organisations and existing partnership Boards about how they can have their voice heard in the new arrangements – in particular on behalf of Supporting people providers, SPIC requests, Learning Disability Partnership & Carers Partnership representation.

We will be working with the West Midlands Councils, see 3.2 below, to specifically work through this challenge to ensure that we develop the most appropriate Board and structure to meet the health and wellbeing priority needs of our community. Meanwhile, as a Board, we will continue to reflect the statutory minimum member representation as set out in the Health and Social Care Act 2012.

3.2 West Midlands Councils HWB Support and Development Programme

A number of initiatives have come forward to support the development of Health and Wellbeing Boards:

- **HWB Chairs Network:** to share learning, identify and work on issues of common concern including responding to consultations and lobbying, and to act as a sounding board for new activities. First meeting was held in July with further meetings in Oct, Dec and March 2013. Challenges discussed at this point include: embedding the broad public health agenda within Councils; explaining to communities the new role of Councils, CCGs, PHE, and NHS Commissioning Board; securing relevant engagement from interested parties without opening the flood gates; maintaining a focus on prevention; integrating all Council services with the Health and Wellbeing agenda; securing a fair budget for the new role.

- **HWB Simulation Events:** provide an opportunity for HWB members to explore the challenges and understand the complexities and conflicts of interests within their roles, within a safe and developmental space. Also they will encourage accelerated learning and strengthen the shared leadership capacity of HWBs. The events will help HWB members to shift their focus from individual organisational interests towards a collaborative approach to agreeing priorities and deploying resources to tackle the

health and wellbeing needs of the community. The West Midlands event will run on 10th October and we will be sending representatives, including the Chair to this workshop.

- **HWB Network:** members drawn from across the WM region. Network has met twice to date. At its second meeting it discussed the draft secondary regulations for the Health and Social Care Act 2012. The network will look to support the activities of Boards by offering shared experiences and learning.

- **HWB Development Tool:** aims to assist Boards to explore their strengths and opportunities to improve, and to inspire their ambition to develop a clear sense of purpose and an approach which will help transform services and outcomes for local people. The tool is designed to help Boards to go beyond assessing how ready the Board is, towards how effective it is being in practice, and how that effectiveness is enhanced over a period of time. **It is proposed that the tool is completed individually by members of the Board working independently and collated and presented for discussion at the November HWB meeting. See Appendix 2.**

- **Bespoke Support for T&W HWB:** Up to 4 days support from the Local Government Association until March 2013. Initial thoughts for the period of support are developing our role and agenda which we want to pursue linked to our strategy and what powers/influence we will have to make sure we can deliver, and Board structure and operation - how we keep a tight decision making Board but ensure engagement/input from local people/client groups, providers and partners. The initial work shop has been arranged for 11th October. **We would welcome the Board members views on their desired aims/objectives of this initial session and for the period of support, and we've suggested focussing on our role, structure and operation – particularly looking for information on arrangements in other areas which facilitate involving local people and providers.**

3.3 **Scrutiny Arrangements**

DoH released a consultation paper on 12th July which sets out the Government's intentions to strengthen and streamline the regulations on LA health scrutiny following amendments to the National Health Service Act 2006, by the Health and Social Care Act 2012. New scrutiny regulations will be developed, retaining the best of the existing system but confirming that LAs will no longer be obliged to have an overview and scrutiny committee – it will be for the full council of each LA to determine which arrangement is adopted.

There is now the opportunity to establish the relationship and way of working between the HWB and the council body designated with health scrutiny powers. The LGA advise that a protocol or Memorandum of Understanding is

developed, indicating how each will carry out their functions in relation to health, public health and integrated health and social care services. **It is proposed that the HWB work with the Scrutiny Committee to develop a full protocol.**

3.4 **Vice Chair and Cabinet Member Representation**

It has been agreed that Cllr Liz Clare will be Vice Chair of the HWB, in order to represent the Chair in the event that he is unable to attend the HWB or requires a representative to attend a meeting on his behalf.

It has also been agreed that Cllr Arnold England, Cabinet Member for Leisure and Wellbeing will be a member of the HWB.

3.5 **HWB Executive Group**

An Officer Executive Group has now been formed to operate beneath the Board. The responsibilities of this Group will initially include progressing work between Boards, agenda setting, JSNA and JHWBS development, performance management, communication and engagement, links with joint commissioning plans and links with Scrutiny.

3.6 **Frequency of Future HWB meetings**

Due to the increasing agenda, Board members are asked their views on the future frequency of Board meetings. It is suggested that meetings may become monthly, in order to allocate the appropriate time for discussion.

4. PREVIOUS MINUTES

4.1 Shadow Health and Wellbeing Board Governance report 22nd February 2012.

5. BACKGROUND PAPERS

5.1 Health and Social Care Act 2012.

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Appendix 1

The Future of Health and Wellbeing in Telford and Wrekin Stakeholder Engagement Event Feedback

Discussion 3: Future Governance and Structure of the Telford and Wrekin Health and Wellbeing Board

Q1.	HOW CAN LOCAL PEOPLE AND STAKEHOLDERS BE INVOLVED IN AND INFLUENCE THE DECISION MAKING OF THE HEALTH & WELLBEING BOARD?
Table 1	• Example – HWB contacted Carers Boards: how beneficial are workshops for carers on their health and wellbeing. Wouldn't have been able to provide answers without current monitoring / evaluating. • Carers' partnership board – public gallery giving people opportunities to ask questions. • Promotion of current forums etc and promotion of HWB through these routes, particularly for communities with particular access needs, (deaf, visually impaired etc). Ensure people are getting information in the format they need. • Need to look at different formats for sharing information not just printed English on the internet. Not everyone can access the internet or written English. • JCP want to sit on the board (HWB) feedback from service users on health issues to feed in • One size does not fit all – need to be creative • HWB should not meet in the same place every time; should go into the community • Allow people to input/present to HWB meetings • Need to ensure groups are involved from the start so not surprised with requests – need time to prepare. Need co-ordination so that people are not bombarded. • Accountability. FEEDBACK on what is changing specific – you said, we did. What has changed as a result of input. Need to demonstrate value for money – why bother?
Table 2	• Through its members (unless there is a right to representation, access public meetings, will people get speaker rights? • Leadership (rather than membership) – listening and feeding back, the members bring representation to the meeting. • Recruit members • Health service is a closed shop. Resistance for other voices, new scheme would give opportunities for other voices to speak up about health • T&WC haven't got the right shape in engaging with voluntary sectors, only core group for H&WB to meet culture needs to change. • Is there constitution/questions being asked without constitution being understood, i.e. who as to sit on HWB – does this make it NHS 'top heavy' • Board representation – out of balance. Other structures need to change and develop to influence HWB structure • Needs to avoid massive sub-structure

Table 3	• What decision making will local people be able to influence? • Know it exists – communication • Questioners / newsletters • Representation on the board – links to mapping exercise. Find out what's there and try and encompass all the groups – give a framework • Single point of contact • Support to do this e.g. newsletters • Healthwatch to be represented – need to ensure this covers all organisations • Community panel – issues raised through members (to be a link for the community) Can be raised through scrutiny • Local media e.g. Radio Shropshire • National Campaigns – Healthwatch England • Council tax bill and 'Your Voice' – goes into every household in the Borough • Information through patient reference groups. Find common inlets. • Information on prescriptions / posters in pharmacies
Table 4	• Commissioning services, engaging with S.U.s constantly • T&WC SS not accessible • Are partnership boards still fit for purpose – consultation / review to strengthen role • Generic email address to put forward thoughts and suggestions to the HWB directly. Direct route, email, postal, number • Diverse range of access points • Open surgery – local councillor • General issues • Openness and transparency – accountability • Is there a regular report that is available to non board members after the H&WB meetings • Are there any places on the H&WB board for parent representation • If the H&WB board is going to be accountable to local people , we need to be committed and think of different ways – creative • Not enough (services) for Aspergers
Table 5	• Healthwatch is voice of people • Public meetings • Mixing up other committees and groups going on. Strategic partnerships useful • All got folk can consult with feedback – make sure each of us know which groups are there • Patient participation strategy – how do we engage. Don't dismantle what ever is. All got services users groups – need to co-ordinate • Council community engagement panel • Hard to reach – not hard to reach – they are there every Thursday • Pubs and football grounds • Is there a database of organisations • Datashare sheltered housing providers • Don't know who are our hard to reach group are • Have almighty HWBs leaders and make decision – what gives them the powers – local opinion • Would Debbie's parents group link into Healthwatch

Table 6	• Key way could be via Healthwatch – see records re: Healthwatch engagement (don't duplicate) • Going out doing fun events • Engage at an earlier stage • Building rapport / engagements on the ground • Genuine consultation only • Engage mix of people and support them in attending • Feedback to those taking part – makes engagement meaningful • Be honest about decisions • Have task and finish groups • Review partnership arrangements that sit alongside (what works, what doesn't work) • ? Potential to link in to local members of 2 Foundation Trusts (30,000 people) • SPIC – can help with workforce development skills – share data.
Table 7	• 1 patient representative is not enough. Should be more • Be clear of the scrutiny role / Wellbeing board Scrutiny Board • Democratic accountability of the councillors • Work together with Healthwatch and use existing groups • Right to petition mechanisms – link into existing systems • Health and Wellbeing 'Question time' • Easier to find information, especially on website • The strategy has to be meaningful to T&W residents
Table 8	• Need to know they have the opportunity to • Evidence that HWB board have listened – 'You said We did' - Why? If not acted on • Use a variety of communication channels • Be specific on what you are asking 'Focus' • What is already in place
Table 9	• How do people inform the agendas? • Feed into existing forums • Who is in charge? (ultimately accountable) • Can people lobby the issues through councillors • Not aware of who is on the board and how people have been invited to take part • Third sector involvement is needed (not just link) • Very difficult to involve all sectors unless we regularly communicate with them • Need to be regular opportunities for people to feed in their views and take part • Consultation – need to give people adequate time to take part (no short timescales) • How are decisions made at the moment? • We need to see a constitution • Can other people attend if someone cannot attend • General feeling / questions about the board, before any decisions can be made – not clear at the moment

Appendix 2

Local Government Association

Health, adult social care and ageing

A new development tool for health and wellbeing boards

directors of adass adult social services

ADCS Leading Children's Services

Association of Directors of Public Health

Faculty of Public Health

solace

nhsalliance

The King's Fund

NHS Commissioning Board A special health authority

NHS Confederation

NHS Leadership Academy

DH Department of Health

Introduction

Health and wellbeing boards are now operating in all parts of the country, and many have been working for a significant period of time.

Discussions with representatives of boards show that there is an appetite for products that support boards to assess their progress by reference to indicators of practice.

In response to this, a number of regions have already prepared self assessment documents that measure “levels of preparedness”. Moving beyond this the London Board Assurance Prompt tackles more complex themes, and introduces the idea of a ‘maturity matrix’ allowing boards to track their progress over time.

The Local Government Association has worked with the NHS Leadership Academy, other national organisations and representatives of health and wellbeing boards to co-produce a new development tool, building on the achievements of the previous documents.

Our aim is to provide health and wellbeing boards with a tool that will enable them to go beyond assessing how ready the board is, towards how effective it is being in practice, and how that effectiveness is enhanced over a period of time.

This tool aims to assist boards to explore their strengths and opportunities to improve, and to inspire their ambition to develop a clear sense of purpose and an approach which will help transform services and outcomes for local people.

There have been two design events with board representatives and health leadership partners. Views on ‘what good will look like’ were captured, and have been incorporated as key issues within this development tool.

The approach recognises that to deliver good outcomes on the ground partnerships require an effective structure (in common with all organisations). The model adapted is summarised below:

Strategy, vision, purpose, values			
Strong relationships, agreed ways of working	Good governance	Roles and contributions	Measures and accountability
Outcomes			

Using the development tool

The development tool asks users to assess how their board is performing in relation to 17 key issues. The issues have been identified based on the outcomes from the design events mentioned above. When using the tool it is important to promote dialogue amongst the partners on the board about these issues.

The development tool can be used in a number of ways:

- by board members acting collectively to discuss and agree scores together.
- with the help of an external facilitator, to assist exploration of the issues, and to promote discussion.
- individually completed by members of the board working independently, (however this approach has the significant disadvantage that a useful exchange of views between partners is less likely to occur, and the process may therefore be less helpful to mutual understanding and board development).

Boards are invited to evaluate their position against the suggested criteria that are expected to characterise the achievements of a board now; in one year; and in three years.

It is to be expected that boards in the early stages of development will respond positively to a limited number of the criteria, but as they progress to maturity that position should improve. It is quite possible that a board completing the assessment today may not yet be at the point suggested by all 17 criteria in the 'Now' column. On the other hand, for some criteria it may exhibit advanced behaviour as projected in the 'In three years' column.

The development tool can be found online at http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3638628/ARTICLE-TEMPLATE

Next steps

The aim of the development tool is to support boards to discuss challenging issues, to inspire them towards transformational outcomes for their community, and to help them identify what action they need to take. It is expected that boards will wish to use the tool as a stepping stone towards developing an improvement plan to address their next steps. We intend to keep the content of the tool under review to ensure it meets the future needs of boards; we would therefore welcome comments about how the tool might be further improved. Please send your feed back to healthy.admin@local.gov.uk

Support and assistance

Health and wellbeing boards are challenged to develop complex and innovative methods of working that require partnership of a new order. Help is available from several national and regional organisations to assist boards in finding their way.

A good starting place for assistance is with the LGA Health and Wellbeing Board Leadership Offer at healthy.admin@local.gov.uk where advice can be obtained on the development tool and a range of support options for boards.

Area	Now	In 1 year	In 3 years
Strategy, purpose, vision	1. The board understands its unique potential contribution and is ambitious to improve health and wellbeing.	1. The board has agreed a realistic set of priorities on which to focus its efforts.	1. The board has demonstrated achievement against its priorities. The board has a track record of enabling efficient, effective and integrated re-commissioning of service(s).
	2. The board has a clear statement of purpose and priorities. Existing JSNA reviewed and JHWS initiated.	2. JSNA and JHWS formally agreed. Individual commissioning plans of CCGs and LA align with JSNA/JHWS.	2. JSNA/JHWS embedded in annual plans of service providers. JSNA and JHWS reviewed and revised and commissioning plans of all relevant partners aligned.
	3. HWB has a compelling narrative of its purpose and ambitions for its local community.	3. Partner organisations can describe how HWB will make a difference. A shared and effective communications plan exists (including media handling).	3. Community can describe how HWB has made a difference. The board can describe what it has achieved, the changes made for local people and future improvement plans.

Area	Now	In 1 year	In 3 years
Leadership, values, relationships, ways of working	4. Board members understand the concept of shared leadership and communicate effectively and respectfully.	4. Trust has been established, constructive challenge is the norm, a conflict resolution process is in place.	4. Continuous learning (from own experiences and from others) is well established.
	5. The board has a code of conduct which is explicit about expectations of behaviour, and which describes the values aspired to. The board models appropriate behaviours and has an agreement about minimum attendance at meetings.	5. The board uses both internal and external reviews to test that its code of conduct is effective. Board members attend regularly and make a positive contribution to meetings.	5. The board's annual self assessment incorporates agreed outcome measures against its code of conduct. Stakeholders agree that the board operates on a win-win basis.
	6. Members have effective working relationships and are beginning to influence each other's organisations.	6. Board members look for win-win solutions focused on beneficial health outcomes for the community. Relationships enable members to influence beyond their own organisations.	6. Local organisations seek to contribute to the work of the board.
	7. The board has interim arrangements in place to engage users and the public pending the establishment of local Healthwatch.	7. The board empowers the local Healthwatch member to act as an independent and effective voice for users and the public.	7. The board can demonstrate that it has considered and acted upon the views of local people.
	8. The board understands the needs of diverse communities and is clear about its responsibilities under Equalities legislation, and those of its partners.	8. The board can demonstrate that it promotes equality in all its actions including consultation, priority setting and service improvement, and undertakes equality impact assessment on its plans.	8. The board is a beacon of excellence in relation to equality and diversity and can show positive outcomes for the health and wellbeing of minority groups.

Area	Now	In 1 year	In 3 years
Governance	9. The board is clear on accountability for decisions and action, and has a scheme of delegation.	9. Decision making is clear and transparent, and effectively communicated to stakeholders and the public.	9. Decisions of the HWB are accepted and acted on by all organisations in the local system.
	10. The board has governance frameworks which align with those of the LA and CCGs.	10. Board membership, operational structures, and mechanisms for engaging partners, are clear.	10. The board has regular updates on the priorities of the wider LA, NHSCB and key local partners.
	11. The relationship between the HWB and the LA scrutiny function is clear.	11. The relationship between scrutiny and external regulators is agreed and an initial effectiveness review has been completed.	11. Scrutiny and regulators work constructively with the HWB.
	12. An agreement re pooling of resources is in place.	12. A risk sharing agreement exists between the LA and CCGs.	12. A risk sharing agreement exists between the LA, CCGs and other relevant partners.
Roles and contributions	13. The board knows what each member brings in the way of skills, experience, knowledge and potential contribution.	13. Each board member has a clear role description and acts in accordance with this. An annual board development plan has been agreed.	13. The board regularly reviews its own effectiveness and development needs.
	14. The board knows what's good about its existing partnership working and can describe what has been successful, what hasn't, and why.	14. A stakeholder map exists for external partners and each board member has agreed partners that they work with proactively. A 360 degrees feedback survey with partners has been completed.	14. A 360 degrees feedback survey is completed with stakeholders; with key partners; with the public and an appropriate action plan developed.

Area	Now	In 1 year	In 3 years
Measures and accountabilities	15. The board's priorities balance improvements in service provision with improvements in population health and wellbeing.	15. The board has an agreed set of outcome measures, matched to its priorities.	15. The board's annual report demonstrates achievement of outcomes.
	16. The board has reviewed the current position as regards service integration, population health and use of resources.	16. The board has identified outcomes with defined early wins in the areas of: a) more integrated and/or personalised services b) improved population health c) better use of resources.	16. The board has achieved defined outcomes in the areas of a) more integrated and/or personalised services b) improved population health c) better use of resources, including community based assets, and identified early wins in reducing health inequalities.
	17. The board has reviewed its current outcomes against its peer group.	17. The board reviews itself regularly against benchmarks and adapts plans as necessary.	17. The board consistently performs well against benchmarks.

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For a copy in Braille, larger print or audio,
please contact us on 020 7664 3000.
We consider requests on an individual basis.

L12-511

TELFORD AND WREKIN HEALTH & WELLBEING BOARD 12TH SEPTEMBER 2012

COMMUNICATION AND ENGAGEMENT PROGRESS REPORT

ANDY CHALLENOR COMMUNITY ENGAGEMENT AND EQUALITIES MANAGER

WORK COMPLETED

Joined up working

- Communication and Engagement Framework agreed at the HWB Board
- Communication and Engagement Steering Group established with leads from the Council and NHS
- Created a joined up and coordinated Communication and Engagement Action Plan for the future of health and wellbeing (including the PHT and HWB action plans - cross referenced against the CCG Action Plan)
- Action plan can be viewed on the PHT extranet site

Webpage created

- Health and Wellbeing web page www.telford.gov.uk/hwb
- Web page includes key strands - Health and Wellbeing, Healthwatch, CCG, Your Views Matter - consultations and information on the HWB including dates, minutes and agenda
- Template designed to gather regular health updates and leads identified
    - Healthwatch – Chris Harrison
    - HWB and PHT – Paul Taylor and Clare Hall-Salter
    - CCG – Jenny Fullard
- NHS pages on CCG link through from the Council's HWB page

HWB priorities consultation

- Carried out a HWB priorities consultation from July to end of August. We have received 749 completed surveys (620 from the Community Panel and 129 from other stakeholders)
- Key stakeholders including ward, town and parish councillors received a letter from Cllr Overton signposting to the HWB priorities consultation
- External communication to support up take in priorities consultation. Press release around priorities consultation and future of health and wellbeing
- Priorities consultation sent out to Council staff and NHS/PCT staff to take part in the survey
- Reminder external communication sent mid August, to local people and stakeholders to complete the priorities survey by 31 August

External communication

- Full audience database of stakeholders compiled (Council and NHS) and published on the extranet site
- Email sent to all stakeholders signposting the HWB webpage
- Agreed initial key communication messages around the future of health and wellbeing
- Agreed a route to be informed of current key messages and actions around HWB (and PHT)

WORK ONGOING

- Stakeholder engagement within the development of Healthwatch
- To clarify how PHT currently commission and deliver communication and engagement activity – plus current commitments against the budget for communications
- Newsletter on progress of HWB in September

STAKEHOLDER EVENT

- Initial feedback from the stakeholder event published on the HWB webpage
- Key leads for the themes delivered at the stakeholder event to edit their information received and put into a format that people will understand how they are going to use this information gained from stakeholders. We will need to find a way to clearly demonstrate how stakeholders have influenced the HWB priorities

Feedback from event participants on how the HWB needs to communicate and engage with stakeholders and local people below:

Who do we communicate and engage with?

- Participants offered pathways to engaging with a wide range of service users/clients – this information will be used as part of the 'audience database'
- Involve community projects, schools, local groups, churches, public houses, sports organisations etc
- Council links with partnership boards should be a conduit to feed information and concerns back to the HWB
- Use Patient Reference Groups

In general, how we communicate and engage

- Be clear with people on how to make their views heard and how they can make a difference
- How can people be aware of what decisions are made by the HWB. How is this disseminated to people, so that they can influence decisions?
- Meaningful consultation and information that maybe appropriate to local people
- Explain why local people should be involved to influence the HWB agenda and how

- Translate high level strategy into the 'user interface'

- No jargon, simple messages, well written, short, informative articles
- Plain English and easy read documents

- Clear information about where to go for what re: health
- Targeted approach to topic areas e.g. over 40 MOT – has got lots of people talking and interested

- To spread the word through events, surveys, newsletters and information gathering
- Residential homes should put leaflets around the home for service users, family and friends
- Hold local engagement events in central accessible locations
- Advertise via PCT health and social care delivery outlets including childcare support groups/pharmacies/GP's, local free papers etc.

What types of information, about the future of health and wellbeing in Telford and Wrekin, do you think local people would be interested in knowing about?

Healthwatch	• How Healthwatch can help individuals and what it means for them, examples of how others have benefitted, how to get in contact, and how it will make a difference for services
HWB	• Contribute to deliver key priorities of HWB using established forums – databases and groups • Support collection of data from the independent sector providers • Priorities decided - What the local priorities are • Evaluate what is needed within context of HWB – from information given to us from our customers (with their consent) • What difference the HWB strategy is likely to make • What difference will it make to my disabled child? What about their future as they move into adulthood • Feedback to HWB issues as and when they arise • Feedback from Stakeholders event • Training/education opportunities for new ways of working and the workforce needed to deliver the outcomes
NHS	• GP and hospital waiting times • Patients charter
Services	• Changes, cuts, all information that effect people • Services (existing, proposed, gaps and changes and cuts) • Service delivery/performance • New service development • De-commissioning of services • Impact on current services and delivery • What new services may be involved • Information on how to access available local services

Other	• How the following relates to each organisation
	  ○ Health and Older People
	  ○ Alcohol and substance misuse
	  ○ Health and disability
	• Provide information about sport and physical activity
	• Health and social care concerns and joys of the results of the survey and events to feedback to HWB
	• Issues specific to the access needs of Deaf people i.e. interpreter provision in healthcare settings – booking appointments and other communications between services and patients
	• Bench marking with 'like' LA areas
	• How the money from Central Government is to be allocated (not ring fenced)

	• Special interest in issues about long term health conditions and services for frail and complex patients	

Telford & Wrekin
Local Involvement Network
ANNUAL REPORT
April 2011 - March 2012

CONTENTS

Local Involvement Networks

Local Involvement Networks (LINks) were set up to support patient and public involvement in the *independent scrutiny* of publicly funded health and social care.

LINks ask patients, service users and carers about their first hand experiences of health and adult social care services as this offers really good insight into what is working well, and what needs to be improved. Local community groups and voluntary organisations are also asked to contribute evidence of local community needs which is then presented to commissioners and providers as they are responsible for planning and delivering services which improve health and wellbeing.

Telford & Wrekin Local Involvement Network:

what we've been doing in 2011/12

In the last twelve months we have focused our attention on finding out what patients think about the quality of care provided by the Princess Royal Hospital and the Royal Shrewsbury Hospital, community mental health services and medical practices. We have also contributed to national and local consultations, including the review of adult social care services by the council.

Our annual report provides the opportunity to let you know what we have done over the last year so that you can judge for yourselves whether we did what we said we'd do, and whether we focused on the right things. We try to maintain a watchful eye on the way NHS and local authority commissioners plan and procure services, and how well providers care for everyone in Telford & Wrekin. Our relationship s with them are based on the belief that we all have the same goal – which is to improve health outcomes for the local community. We hope you find the annual report informative, interesting and are reassured by what you read.

We have gathered your views about local services by visiting hospital wards, residential care homes and day care centres; we've helped set up patient reference groups in eighteen surgeries in Telford and Wrekin, have arranged focus groups with people who use mental health services and with people living in residential care settings. The report on page 27 regarding the investigation that we sparked into the lack of dignity in care on Ward 15 is one example of how asking questions about what we saw and heard can make a real difference.

During the course of the year we've also supported the formation of Youth LINk by working with young people aged 14 – 20 and helping them to become community investigators. Within a few weeks they had carried out a survey about out of hours care, organised a world cafe event and even attended the council's consultation event about the budget.

We've presented the findings of our investigations to chief officers, directors and board members at meetings including the Shadow Health and Wellbeing Board, the Scrutiny Committee, the Dementia Strategy Group and numerous other forums, which we attend in order to ensure that patients, service users and carer's needs aren't overlooked. We can – and often do – ask challenging questions, and although it isn't usually necessary because of the good relations we have with local statutory bodies, we can resort to using our statutory powers to ask for answers.

....and what we've got planned for 2012/13

We are pleased to report that we are one of a handful of LINks across England to be invited to work with the National Children's Bureau in 2012. This will help us build on what has been achieved by Youth LINk in the last year. We also need to step up our involvement with families with children which we intend to do by working the local Parents Opening Doors (PODS). At the other end of the scale we will increase the number of visits we make to residential care homes in Telford and also Shropshire by combining forces with Shropshire LINk.

In April 2013 Telford & Wrekin LINk will hand over the reins to Healthwatch Telford and Wrekin which will inherit the statutory powers that were given to local involvement networks when we were first established. The unprecedented scale of changes that is taking place is posing considerable challenges for everyone: patients, providers and commissioners alike.

Our number one focus must be to work with Telford and Wrekin Council to ensure Healthwatch Telford & Wrekin continues to be a strong champion of the user and patient voice in Telford & Wrekin. Healthwatch will need to be especially vigilant regarding the quality of health and personal/ social care provided for vulnerable groups: people with dementia, older people who are frail, and adults with learning disabilities.

Finding out what people who use adult social care services think about the changes being introduced as part of the modernisation agenda is another priority that we will be looking at. This will involve us in assessing the impact of personalisation on different groups who need personal care and support including users of mental health services, adults with learning disabilities and older people. It will also help prepare us to respond to the White Paper about social care which will be published some time later this year.

On behalf of the Central Management Group we would like to thank everyone who has been involved in - or supported - Telford & Wrekin LINk in the last year. We look forward to working with you again in 2012 and hope that you will continue to be involved in Healthwatch Telford and Wrekin when it is set up in April 2013 – please see page 42 for brief details about the successor body to LINk.

Details of our other priorities in the year ahead are listed on page . As you will see, w e aren't anticipating putting our feet up until 31 March, so if you are looking for a rewarding way of spending your spare time, then please do consider getting involved with the LINk.

Dag Saunders
Chair

Jean Gulliver
Vice –chair

Telford & Wrekin LINk: who we are

What is really significant about LINks is that they are run by people who live in an area and who use local services. And because LINk volunteers are unpaid, we are beholden to no-one except our local communities.

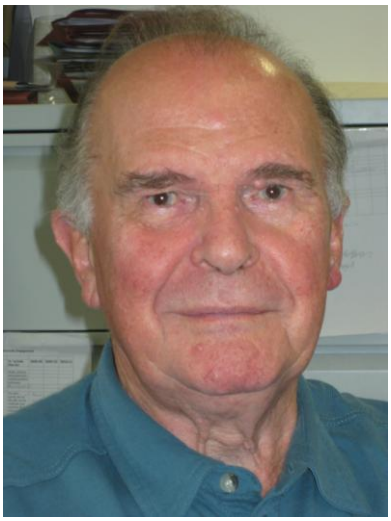
Although everyone in Telford is able to participate in the local involvement network, decisions are taken by the Central Management Group whose 16 members are elected at the Annual General Meeting. A further 25 volunteers were involved in the LINk in 2011/12 as authorised representatives or community champions

Muriel Fellows

Some of us work locally, some of us are retired; others are unemployed 'jobseekers' and several of us have long term health problems that prevent us from returning to work at present. We've all had first hand experience of using local health and social care services so know what its like to be a patient or a service user. Most of us have looked after someone so have some understanding of what being a carer involves.

Between us we've back problems, diabetes and sight loss, survived cancer and nervous breakdowns. We all know how important it is to be able to get an appointment with our family doctor when we need it - and especially when it is for a dependent child or relative. From time to time we've all had to use out of hours care - A&E, Shropdoc or the mental health crisis team.

Derek Tremayne



"We've all been frustrated by red tape and disappointed by poor customer care; we've experienced anxiety and anger. But we've also been grateful for the help we've received from our family doctors, nurses and consultants who've provided expert care for our minds and bodies. We are proud of the NHS, if fearful of what it may become if we don't look after it as well as it looks after us."

Tina Jones

"Many of us have also been involved with adult social care services – if not for ourselves or our own families, then in our role as advocates for people who are vulnerable due to infirmity, disability or complex long term conditions. When it is genuinely tailored to meet the unique needs that every individual has, it makes a huge difference not only to their lives but also to their family. But the amount of care available – or the quality of what is provided – sometimes doesn't seem to be as fair or as accessible as it should be."

.

"Myself and my family are members of the community, so we want the best healthcare service we can. Being involved with LINk allows me to make that happen for everyone"

Gaynor Stevens

"Why did I get involved in the LINk?

Essentially because I don't want other patients go through the same experience as my husband and I did, that led him to die earlier than he should have done.

We help to remind the senior people that they don't just help people get better, they help the and their families achieve a better quality of life We use every opportunity to talk about the experiences of real people – vulnerable older people with dementia or kidney problems – and even with eyes, ears and feet that don't work as well as they used to.."

Jean Gulliver, vice chair

"I want to make sure that the voices of families are heard – especially those who look after children with disabilities"

Jayne Stevens, co-opted member of the Central Management Group

Our top priorities for 2012/13

subject to endorsement by the AGM on 21 June 2012

Countdown to Healthwatch

Raising public awareness of the changes that are taking place to the way that patients and people who use adult social care services and their carers can influence the way health and social care is planned, commissioned and delivered.

Youth LINk

Super sleuth Sherlock Bones, Telford's very own Health Detective, will assist Youth LINk with the Case of the Reluctant Patient. This work will be supported by the National Children's Bureau which has been commissioned by the Department of Health to help 15 healthwatch pathfinders in England to develop good practice.

Patient participation

Encouraging local community involvement in the Patient Reference Groups being set up by medical practices in Telford and the Wrekin so that everyone can influence the quality of healthcare provision.

DonningtonVOICE

Providing opportunities for everyone who lives in Donnington or Donnington Wood to have a say about their community - and have the chance to become community health champions.

Adult Social Care

When the government White Paper on the future of Adult Social Care is published in 2012, we will invite members of the local network to help us produce a response that is informed by what is best for Telford and Wrekin.

Using LINk's statutory powers to scrutinise services

- Visits to premises where health and social care services are being delivered, especially hospitals and care homes
- Commenting on the Quality Accounts published by the acute, community and mental health provider trusts
- Seeking information from commissioners and providers to enable LINk to scrutinise health and social care services

LINk's powers will also be used to promote diversity of representation and equality of access. The projects will also gather evidence to inform policy and practice by monitoring the way that minority interests are identified and supported to ensure that the whole community has a stronger voice.

Other issues that we will maintain an interest in during 2012/13

The reconfiguration of health services – specifically mental health and acute hospital services

Children's health and wellbeing – especially those services needed by children with disabilities

Discharge – LINk and the Senior Citizens Forum will use the findings of the discharge survey to make recommendations about improvements needed

TEEF survey – we will work with the Senior Citizens Forum to investigate older peoples experiences of services that deal with teeth, eyes, ears and feet

Mid Staffs Inquiry – when the Francis Report is published in the autumn we will consider what its recommendations mean for the way we represent patients, and also the impact it will have on those we work with to improve the quality of care and safety for patients and service users

Equality Delivery System – we will review how we can use our limited resources to contribute to the evaluation of NHS bodies compliance with the Equality Act using qualitative and quantitative data

Accessible information – we will monitor whether information is being provided in a range of accessible formats for people who are visually impaired, deaf patients and those who have learning disabilities

Rebecca Dove, Community Engagement Worker sitting still (for a change)

Have YOUR say – making your experiences count

Listening and looking

- we go into hospitals and care homes to talk to patients and service users about their experience of care, and also undertake observations of care
- we put up displays in shopping centres, in the hospital foyer and at events
- we attend forums and consultation events to hear what people are saying

Surveys

- Youth LINk out of hours urgent care survey
- discharge from hospital
- patients feedback about their doctors surgeries

Focus groups

- with people who use MIND at Sutton Hill - focus on GPs and mental health
- Youth LINk used a world cafe event at Hadley Learning Centre to focus on young peoples experiences of out of hours health care
- LINk community champions and Wellington Medical Practice ran themed focus groups with people in residential care, adults with learning difficulties and acute mental health service users

LINk community engagement and outreach activities

- Oakengates Youth Club information session
- Young Carers information session
- LINk stalls in Southwater Square; at PRH and at Donnington Learning Centre (Apprentice events and Lifelong Learning events)

Local consultation opportunities

- Telford & Wrekin Council adult social care services review
- Telford & Wrekin Council budget consultation
- Telford Community Forums (Volunteering; Health)
- Telford & Wrekin Council service review of Age UK(Telford and Wrekin)
- The Redwoods Centre new build project about inpatient facilities being planned to replace Shelton hospital (Open access sessions about organised by South Staffordshire and Shropshire NHS Foundation Trust)
- Looking to the Future - Plans of Princess Royal Hospital Unveiled

Consultation with national bodies

- the Listening Exercise 'pause' in the Health and Social Care Bill
- local healthwatch funding options
- GPs and safeguarding
- Queens Nursing Institute – nursing care at home
- Healthwatch - CQC and Nunwood Healthwatch webinar
- NICE Guidance for Patients and the Public

LINk Events promoted

- LINk AGM 2011
- Meetings in public – Ketley Parish Council offices, the Park Lane Centre in Woodside, and the Civic Offices in the town centre
- Countdown to Healthwatch (October, December and March)
- Mental Health – No decision about me, without me

Other organisations events that we've promoted or supported

- Age UK Shropshire Telford & Wrekin Conference - 9 November 2011
- Telford College of Arts and Technology (TCAT) Disability Awareness Event
- Shropshire LINK AGM
- Culture Kind Chinese New Year Celebration
- Donnington Partnership and Lifelong learning centre
- Listen not Label Personalisation open event
- Rheumatoid Arthritis Group Shropshire Re-launch
- Singing for health! For people with dementia and their carers
- Funding Surgery (Children in Need and Lottery funding)
- Mental Health Service Users and Carer's Forum
- World Mental Health Day/barriers to employment
- Shrewsbury & Telford Hospital NHS Trust AGM
- NHS Telford & Wrekin AGM
- Sikh temple
- Together as one (Sutton Hill)
- Brookside
- CEIA events in Wellington
- Constituency meeting with governor members of SSSFT NHS Foundation Trust
- Centre for Ageing & Mental Health Seminars:
  Extra Care Housing – is it still the answer?
  Why is Psychiatry Addicted to Drugs?
  An Introduction to Personalisation

What YOU told us

Services you PRAISED

- ✓ **Medical practice staff** "the attitude of staff helped me to feel better"
- ✓ **Social care** "letting my elderly father stay in his own home with support"
- ✓ **Health care assistants** "they go out of their way for my comfort"
- ✓ **Walk in centre** "provides quick and prompt attention"
- ✓ **Mental health support** "from my medical practice has been fantastic"
- ✓ **The triage system** "works well for some patients who can't get an appointment with their GP"
- ✓ **Social services** "the assistance provided with my personal care including deliveries, commode, perching stool, raising of bed, easy chair, tea trolley, grips on wall & door, shopping 3 wheeler and bed raiser etc has made me have my home life back which is so important and there is always a person at the end of a phone line, if needed, so a big thank you and my grateful praise to everyone concerned"

...and some that you GRUMBLED about

- ✘ **Hydrotherapy pool** is fantastic "People with psoriatic arthritis and rheumatoid arthritis need to have regular sessions of hydrotherapy (as this is often the only way for them to exercise) – however although the sessions are very good at the Princess Royal Hospital, the sessions do not last long enough".
- ✘ **Hospital car park charges** are too high for patients or family carers who are frequent visitors
- ✘ **Community mental health** service users complain that it is very hard to summons support when needed
- ✘ **Making an appointment** with a specific doctor is very difficult in many surgeries which patients feel affects the continuity of care provided – which is a pity as the quality of care is usually considered to be good
- ✘ **Access to Euston House** is very difficult for people who use public transport as there is no pavement from the train station to the building which is especially hazardous for visually impaired people attending the cataract clinic

What we did in 2011/12

Our overall purpose is to help improve the health and adult social care services that are provided in Telford and Wrekin. The local involvement network does this by listening and consulting and involving as many people so that everyone in the local community has opportunities to be heard.

When we set these priorities in May we had anticipated being replaced by local Healthwatch in April 2012, however in January 2013 the government announced that would continue to function until March 2013.

You will find information about the Health and Social Care Act 2012 and local healthwatch on page 42

When planning our priorities 2011/12 we said we would make the local involvement network stronger and more effective by focusing on

- raising awareness of the LINk
- identifying unmet needs and gaps in provision
- enabling groups which are 'seldom heard' have a stronger voice
- developing effective working relationships with policy-makers, commissioners and providers in areas where feedback from service users indicates that improvements are required

We said we would focus our efforts on

Acute hospital care
We said we would use the LINk's statutory powers to seek information, visit premises and comment on the annual Quality Account to try to make sure that patients receive the best care possible (within available resources). We also said we would find out what patients and carers experience of hospital services has been particularly in regard to A&E, renal and end of life care

Community mental health provision
We said we would find out whether the changes that are currently taking place by asking service users whether the new arrangements are delivering timely and effective care that meets their needs

Adult social care services
We said we would ask vulnerable older people and their carers whether they are receiving a fair and thorough assessment and a care 'package' that meets their needs

WE SAID WE WOULD strengthen the local involvement network

We have done this

(i) by raising awareness of the LINk

- **holding more meetings in public** - wherever possible in community facilities such as Park Lane (Woodside), Ketley Community Centre, Meeting Point House
- **training and supporting eleven new community champions** – whose interests include mental health, dementia, diabetes, renal disability, cancer, visual impairment, children's health – to be more confident communicators and researchers
- **using social media to gather local intelligence** including Telford Talks, Face book, Twitter
- **setting up Youth LINk** so that the views of young people aged 13-21 are taken into account by service commissioners and providers
- **helping establish patient reference groups** in 18 local surgeries
- **producing "Get involved" and "Get elected"** information packs, publishing a newsletter and organising information displays in shopping centres and events

(ii) by involving community and voluntary organisations in LINk activities

- we have provided opportunities for disability groups, patients groups, faith groups and organisations of black and minority ethnic communities, tenants groups and advocacy organisations to become - more familiar with and involved in health and social care issues - see below for details of which groups have become actively engaged

- they have been able to contribute their ideas about how local healthwatch should be set up by the council

- combining our know-how with Telford Senior Citizens Forum knowledge and resources has resulted in more than 160 people being invited to share their experience of discharge from hospital with us

Community and voluntary organisations that were involved in 2011/12

- Telford's user led organisation Listen Not Label
- Rights and Fairness Telford (RAF-T)
- Shropshire Disability Forum
- Telford Senior Citizens Forum,
- Age UK (Telford and Wrekin branch),
- Sutton Hill (Together as One),
- Brookside Information Group,
- Asian Women's Network
- The Sikh Temple elders
- CEIA
- MIND
- Parents Opening Doors (PODS)
- Taking Part
- Terence Higgins Trust
- Gender Matters
- The West Telford VIP Group
- The Red Cross
- Chairs and Spares
- Shropshire Partners in Care (SPIC),
- the ME Society,
- Diabetes UK,
- Shropshire, Telford and Mid Wales Cancer Services Users Forum
- Alzheimer's Society
- A4U,
- ICAS/PoWHER
- registered social landlords and tenants organisations
- the Heart and Stroke network
- Parents and Carers Forum
- Carers Contact Centre
- Voluntary Sector Mental Health Forum of Shropshire, Telford Wrekin

(iii) encouraging 'seldom heard' to become more actively involved so we know more about their needs, and they acquire a stronger voice

- young people from the Telford Youth Forum Young Carers, Terence Higgins Trust, Young Minds and the Youth Forum were invited to take part in a world cafe event organised by Youth LINk

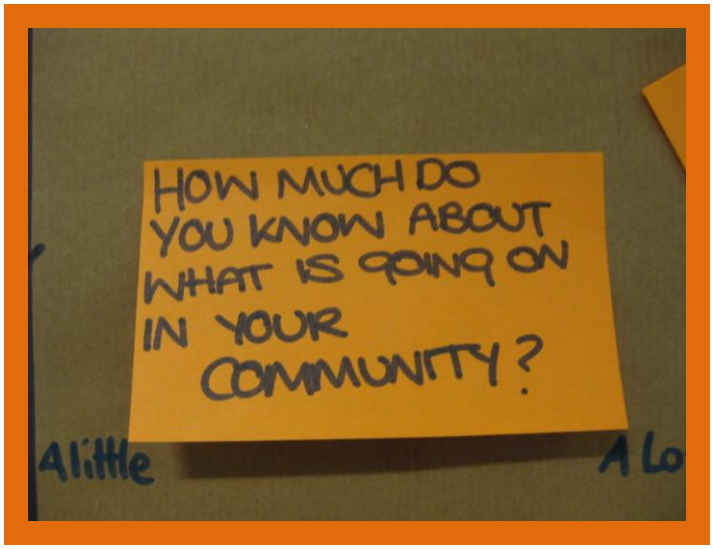
- Gender Matters, Age UK, the West Telford VIP group, Terence Higgins Trust and Taking Part attended a briefing about the NHS Equality Delivery System

- the West Telford Association for Visually Impaired People call for hospital appointments and test results to be provided in an accessible/preferred format for visually impaired patients is being supported by the LINk

Ken Whitcombe
Member of CMG and a community champion for visually impaired patients and service users

(iv) by identifying unmet needs and gaps in provision

- LINk has worked closely with NHS Telford & Wrekin to help four existing patient groups to develop and to set up 14 new Patient Reference Groups
- we have worked closely with all 18 patient reference groups to help them design and carry out patient surveys tailored to the need of their medical practices
- LINk co-opted a new member from Parents Opening Doors (PODS) to sit on the Central Management Group to ensure that the needs of families with children are being taken into account
- when they asked their peers to tell them their experience of urgent care Youth LINk discovered that very few young people are aware of the range of services available out of hours, so we helped them develop surveys and focus groups to look into this more carefully



(v) developing effective working relationships with policy-makers, commissioners and providers

- LINk representatives attended almost all meetings of NHS Telford & Wrekin Board from April until December 2011; we also attended board meetings of the Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Shropshire Community Healthcare NHS Trust (ShropComm) where we have observer status so we able to pose questions about commissioning intentions and decisions and /or about compliance and performance.

- We met with Andrew Mason, chair of the Board and Dr Leigh Griffin chief executive of NHS Telford & Wrekin on a regular basis to discuss local concerns. In 2011/12 these included reconfiguration of hospital services (RSH, PRH and Shelton Hospital); the quality of clinical and nursing care and implications for patient safety; and also discussed concerns being expressed by patients of Wellington Medical Practice.

- LINk representatives regularly contributed to local, regional and national health and social care forums established by service providers to help them better understand the patients perspectives and needs– see page 37 for details of where we represent you

- our relationships with commissioners and joint commissioners – especially those responsible for primary care, mental health, patient and public involvement and quality, ophthalmology - has helped LINk to influence service planning and reviews. In 2011/12 these included the

- Keep well campaign over the winter
- Winter 9 initiative (planned discharge)
- Urgent Care Strategy
- Reconfiguration of community mental health services
- Lingen Davies Cancer Centre - design of the new Haemotology and Head, Neck service
- Shropshire Community Health's stakeholder planning event
- Planning the launch of the Equality Delivery System
- West Midlands Trauma Network – launch of the major trauma centres + PPI strategy and action plan

- LINk worked with Listen not Label to contribute to the review of adult social care services; supported the user led organisation's awareness raising event about personalisation and also considered how we can develop a better understanding of how the Equality Delivery System can measure and endorse the added protection that the Equality Act gives.

WHAT DIFFERENCE did we make - and to whom?

As a result of making the local involvement network stronger we have been able to influence the way services respond to the needs of the local community

- **NHS Telford & Wrekin** reviewed its criteria for determining whether issues are discussed by the board in public or in private session, as a consequence of concerns raised by us.

- **Patient Reference Groups:** hundred of ideas identified by patients to improve the quality of care provided by their medical practice have been posted on practice websites and are being implemented by 18 local surgeries

- **Out of hours urgent care:** the need to provide better information for young people about health services has been identified as a priority action and in 2012 Youth LINk will be involved in designing some of the materials

- **Lingen Davies Cancer Centre:** patients who use this facility at the Royal Shrewsbury Hospital will benefit from the contribution made by LINk representatives regarding access for people with impaired mobility, sight and hearing loss, and cognitive impairment

- **Don't just grumble, praise or rumble:** feedback from patients and service users who praised or grumbled about local services was used to influence the quality of care being provided by the acute trust for patients with learning disabilities and diabetes which ensured they were treated with greater dignity and respect.

- **Wellington Medical Practice:** having attended meetings with patients who had expressed concerns about the length of time it was taking to get an appointment we were able to offer independent advice and also ensure that the issues were raised with the practice's patient reference group.

- **Adult Social Care Services:** raising awareness of the need for adult social care services to practice person-centred care and to demonstrate greater empathy o people who have physical, sensory or cognitive disabilities and long term conditions, mental health needs and who are frail or elderly

- **Voluntary organisations:** by providing information about the passage of the Health and Social Care Bill and its implications for the way services will be planned and commissioned in the future we have enabled providers from the voluntary sector to develop a better understanding of the changes taking place in the local health economy.

What we weren't able to do

- ☒ The Eye Clinic Liaison Officer post that had been commissioned in 2011 to provide timely support for people recently registered as blind or visually impaired. Despite providing early intervention and support pending the involvement of social care specialists, the service was curtailed before it could be properly evaluated by LINk due to funding cuts

NHS
Telford and Wrekin

Over the past three years NHS Telford and Wrekin have had close working relations with LINks to improve patient care across the Borough e.g.:

1. The out of hours urgent care project
2. The reconfiguration of hospital, community and mental health services
3. GP Practice Patient Reference Groups (PRG)

By involving Telford & Wrekin LINk 18 out of 22 practices now have a Patient Reference Group, compared to only 4 in the previous year.

The Urgent Care Project has also achieved wider engagement from a number of local groups because of their involvement in the local network.

The outputs have influenced commissioning decisions and have brought about outcomes. The Primary Care Trust values to work undertaken by LINk and hopes that during transition to Healthwatch our close working patterns will continue.

Sian Huszak
Lead Commissioner Quality, Patient & Public Involvement
(Patient Relations, PALS & Self Care Management)
NHS Telford and Wrekin

Telford & Wrekin LINk: enabling patients to have a stronger voice in local medical practices

When the Primary Care Trust invited LINk to support the development of patient reference groups, we asked our community champions to help local surgeries to

- set up a steering group to oversee the PRG development programme
- advise practice staff about how to engage with patients
- help to design a patient survey
- encourage patients to use the survey to have their say, or to take part in a focus group, or leave comments and suggestions on a graffiti wall
- help the patient groups to work with the practices to devise an action plan based on patients feedback

Ironbridge Medical Practice developed its survey by working partnership with patients to ask how they rated

- receptionists
- the appointment system
- the length of time spent with the doctor or nurse
- the GP or nurse's listening skills
- how well tests and treatments are explained
- patient involvement in decisions about their care
- patients levels of confidence and trust in the GP and nurse

Wellington Medical Practice conducted with

- older people in residential care homes that are serviced by the surgery,
- adults with learning difficulties
- residents of a care home providing rehabilitation for people with acute mental health needs

What issues have patients identified?

☹ difficulty in making an appointment when needed

☹ poor continuity of care as its not always possible to see the same doctor

☹ a lack of understanding of mental health service users needs

What have patients praised?

☺ receptionists who go out of their way to help

☺ doctors and nurses who make an effort to really listen

☺ the range of services available in some surgeries

☺ prompt referrals to specialists when necessary

What difference have PRG's made to the way doctors and practice staff meet their patients' needs....

- ✓ **Linden Hall** has agreed to improve the way it tracks and communicates test results
- ✓ **Wellington** practice has accepted that it needs to speed up its recruitment to ensure better continuity of care. Appointments have now been made.
- ✓ **Donnington** is consulting with patients about the new surgery that is being built
- ✓ **Ironbridge** is introducing a new telephone triage system for patients who can't get a routine appointment
- ✓ **Leegomery** has started to use the TV screen in the waiting area to make sure more people know about the health check service for people age 40+

Changes that are in the pipeline

- **Madeley** is looking to improve privacy by redesigning the waiting room
- **Leegomery** will provide an online appointments system
- **Oakengates** will provide a hearing loop and will provide more health information
- **Donnington** will set up a local health forum with Donnington VOICE to
- **Trinity** is to extend opening hours at weekends
- **Sutton Hill** is improving referrals for hospital appointments, mental health diagnosis and support, and access to physiotherapy

A 'super PRG' may be set up in 2012 with representation by every patient groups so they can consider Telford wide issues and feed recommendations into the Health and Wellbeing Board. This will enable patients to influence service planning

PRG – phase 2

Telford & Wrekin LINk will continue to support the development of patient groups throughout 2012 because we believe patient involvement will be even more crucial to patient care when the new NHS commissioning arrangements are introduced

We will encourage participation by as wide a range of interests as possible to ensure that the reference group reflects diverse needs. We will also provide training and support help patient groups to be involved in shared decision-making.

The 18 medical practices which took part in the PRG Development Project have posted their actions plans on their websites.

If you want to be involved in the patient groups at your surgery please ask your receptionist for more information.

WE SAID WE WOULD use the LINk's statutory powers to make sure patients at the Princess Royal Hospital and the Royal Shrewsbury Hospital receive the best care possible

We have done this by

(i) commenting on the quality of services provided

- we used feedback from patients to inform our response to the 2010-11 Quality Accounts produced by the Shrewsbury and Telford Hospital NHS Trust to confirm that although we agreed with the Trust's choice of priorities which included reducing falls and pressures sores, we felt that these were symptomatic of poor basic nursing care which we urged the acute trust to improve as a matter of urgency. Our response was include in the published Quality Account which can be downloaded from www.sath.nhs.uk

- We also provided a commentary for the Quality Accounts published by South Staffordshire and Shropshire NHS Foundation Healthcare Trust and the community service which was being provided at that time by NHS Telford & Wrekin

(ii) using our power to visit premises where health services are being delivered

- LINk recruited seven new Authorised Representatives (independent visitors) taking the total number of visitors trained to date to 18

- LINk visited eight wards at the Princess Royal Hospital ; and nine t the Royal Shrewsbury Hospital ; two residential care homes and two day care centres in 2011/12 (see pages 23, 24 and 32 for details of the visits carried out).

"If visits can help to improve patient experience, then it has all been worth it"

Gerry Stokes-Harrison
Authorised Representative

Visits to Royal Shrewsbury Hospital in 2011/12

Date	Ward	Services provided	Announced in advance?
21 March 2011	Ward 32	Discharge Ward	Yes
21 March 2011	Ward 21	Cancer treatments	Yes
23 March 2011	Ward 22	Stroke	Yes
23 March 2011		Children's Ward	Yes
1 April 2012	Ward 21	Neurological and Rehabilitation Unit.	No
2 March 2012	Ward 21	Cancer treatments	No
2 March 2012	Ward 25	Colorectoral	No
12 March 2012	Ward 19	Maternity ante natal	Yes
12 March 2012	Ward 20	Maternity labour	No

Examples of actions taken as a result of our visits

- Comments about food quality been referred to food standards group and a patient focus group will be set up to use first hand experience to assist the Trust
- Improvements in communication skills to be raised in ward meetings
- Staff training to improve dignity and respect being arranged
- Staffing review led to increased numbers on maternity ward

"Since the LINk visit [on 12 March 2012] we have undertaken a review of our current staffing establishment on each of these ward areas and have increased the staff numbers on the post natal ward to reflect the workload of the transitional care babies."

Anthea Gregory-Page, Midwifery Matron

Visits to the Princess Royal Hospital Telford in 2011/12

Date	Ward	Services provided	Announced
1 April 2011	Ward 4	Acute elderly/stroke.	Yes
1 April 2011	Ward 16	Neurological and Rehabilitation Unit	Yes
1 April 2011	Off ward 7	Discharge	Yes
22 May 2011		Accident &Emergency	No
10 June 2011	Ward 15	Stroke rehabilitation	No
10 June 2011	Ward 16	Neurological and Rehabilitation Unit	No
7 March 2012	Ward 15	Stroke rehabilitation	No
7 March 2012		Coronary Care Unit	No

Note: we also accompanied the commissioner for patient quality by walking around the Princess Royal Hospital to observe the quality of facilities and services on the Medical Assessment Unit, Ward 14, Accident & Emergency, Outpatients, the cafeteria and the car park. Reports were produced for all of these visits and a response requested from the hospital.

Examples of actions taken as a result of our visits

- Investigation into concerns about lack of dignity and patient safety led to safeguarding investigation and management review
- Review of provision of water jugs
- Funding sought for new dishwasher
- Review use of communication aids

"Poor communication by the nursing and medical staff and the implications of this on the patient experience will be shared with the entire team to raise awareness....and that nurses are encouraged to challenge poor performance to enable us to identify where failing are within the team to provide training and support. Nursing staff are now provided with additional training regarding dignity in care with Professor McSherry; this training will be extended to medical team and domestics as a priority."

Ceri Adamson, Matron Surgical Centre

What patients told us

We asked patients to tell us about their experience in the Princess Royal hospital and also at the Royal Shrewsbury Hospital.

We report this in a way that doesn't identify individual patients.

Dignity and respect

- I am treated with respect
- Nurses are very polite and doctors are pleasant and respectful

Involvement in care (nothing about me, without me)

- I have been well treated and feel well supported
- My treatment and care has been discussed with me

Quality of treatment and care

- The nurses are generally good, but some are not quite up to scratch, and some have been quite rude
- Everything that could go wrong with the treatment and care provided, has gone wrong
- I am satisfied with the quality of care which is very good

Prompt response

- Staff are run off their feet, as there were not enough nurses
- I cant really complain – but you have to wait your turn for attention as everyone's so busy
- Assistance is willingly provided by staff and when help was required the staff were very prompt

Quality of food

- Food not hotel class but it's alright
- The food was disgusting. It isn't seasoned, fish horrendous – don't know what it is,
- Omelettes and scrambled eggs are extremely hard and rubbery
- Pork casserole was good, chunky and tasty

The hospital's response

Each visit results in a report which is sent to the service provider so they can comment on what we found. In 2011 we met with the Chief Nurse, who is also the Director of Safety and Quality, to discuss our findings, which was very helpful as it led to several important changes – see details of how the service on Ward 15 at the Princess Royal Hospital has improved as a result.

In 2012 we have asked service providers to respond with an action plan telling us what they are intending to do to improve any issues identified and to confirm with us when they have taken action. We do a repeat visit within the year to see for ourselves whether there has been any change.

The Shrewsbury and Telford Hospital NHS
NHS Trust

We thank you for your valued contribution to this end and for taking the time to bring your visit findings to our attention. The visit report included many positive observations and patient experience feedback which we have shared with our team

In forming our devolution and cooperation strategy within the Trust, it has been very important to enable the clinical leaders within each centre to review your reports after each visit and to form a response and action plan.

Vicky Morris
Chief Nurse/ Director of Quality and Safety

The Shrewsbury and Telford Hospital NHS
NHS Trust

Quality News *25 November 2011*

A special edition focusing on using patient feedback and mortality measures to improve care

Acting on Concerns: Ward 15

Ward 15 is a 25-bedded Stroke Rehabilitation Unit at the Princess Royal Hospital that cares for patients from other wards in the hospital that have suffered a stroke or stroke type illness and are in need of specialist rehabilitation**. Earlier this year, Telford & Wrekin Local Involvement Network (LINk) shared their concerns with me about a complex complaint relating to Ward 15.**

Their concerns had triggered an unannounced visit to the ward by the LINk, and also led to a detailed review of the ward by the Trust. I, other senior nurses and LINks representatives spoke with patients and staff to form a clear picture of where improvements needed to be made. This approach allowed us to develop a comprehensive plan tailored specifically to improve the way we worked on that ward. Improvements often need fresh eyes, so I put in place a new interim ward manager (the senior nurse responsible for the day-to-day running of the ward) to work with other frontline staff to help with this.

A plan for improvement has been put in place, which helps to give me, our external regulators and most importantly our patients the reassurance that the concerns are being addressed. This work has already brought about significant improvements on the ward, and will continue to ensure it is somewhere our staff can be proud to work on, and our patients happy to receive their care on.

Patient feedback has made a positive difference and helped us to change care for the better, and this two-way communication is now an integral part of the way we work. The approach that we have used on Ward 15 is an approach that we intend to adopt across the Trust when concerns are raised, so I welcome your comments and feedback. I would also like to thank patients and carers, staff on Ward 15, Telford &

By being open and transparent and by co-operating with other agencies involved in the investigation, the matter been resolved, and lessons have been learned – not least being the value of observations of care by indpendent visitors who go in with their eyes - and their ears - wide open.

LINks Authorised Representatives have made a return visit to been Ward 15 recently and reported good improvements in the quality of care being provided. This was a very pleasing outcome, nevertherless we realise that we must remain vigilant.

Dag Saunders, chair Telford&Wrekin LINk

WHAT DIFFERENCE did we make?

- **improving the quality of care:** concerns raised by our visitors regarding poor quality of care being provided on Ward 15 in 2011 led to a safeguarding order being put in place. The investigation into the care of a vulnerable adult found the concerns to be partially substantiated

- **improving patient safety:** concerns raised in 2012 regarding the numbers of staff on duty in the maternity ward at RSH contributed to a review of the way the service was delivered which included a review of staffing levels

- **carer's comfort:** additional resources have also provided to replace beds in the partners room which were reported to be very uncomfortable

- **patient centred care:** the need for more robust planning and improved communications with the family of a patient with profound learning disabilities prior to an operation will hopefully be applied in the future to all other patients with a learning disability

- **Think glucose 1:** provision of drinks and snacks for anyone who has to wait to be seen in the Accident and Emergency Unit was agreed - especially for those patients with diabetes and children.

- **Think glucose 2:** patients with diabetes will be made aware of the snack boxes available on all wards for patients with diabetes

- **Hospital appointments:** visually impaired patients will soon be receiving details of hospital appointments and test results in their preferred format (e.g. Braille, large print, audio or digital) as the Trust has indicated that this will be provided once staff are familiar with a new system that was introduced in January 2012

What we weren't able to do

- ☒ LINk did not systematically monitor the use /avoidance of Section 242 of the Duty to Involve, however we were vigilant about changes taking place and used meetings with chief officers and board members to check out rumours and concerns

- ☒ although we did seek representation on the Shropshire Palliative Care Forum, but to-date this has not materialised; we have not had the capacity to scrutinise palliative care services

- ☒ we have not made follow-up visit to the renal units to ask dialysis patients whether they receive the care and support they need relating to hospital transport, home dialysis and counselling but this service will be included in our schedule of visits for 2012/13.

WE SAID WE WOULD make sure users of mental health service receive the care and support they need, when and where they need it

We did this by

(i) raising public awareness about mental health

- we supported an event organised by governor members of the South Staffordshire and Shropshire NHS Foundation Trust to help raise public awareness of mental health issues

(ii) monitoring the reconfiguration of mental health services

- in our response to the mental health provider's Quality Account we asked SSSFT to provide more evidence of how they had made a difference to the lives of people with poor mental health. We also draw attention to service users anxieties about access to care and provision of good quality care by emphasising the need for workforce training and development to be more advanced if the modernisation of mental health services is going to work.

- we also asked for greater acknowledgement to be given to community and voluntary organisations who work in partnership with SSSFT NHS Trust

- we invited Staffordshire University to run a session about its role in supporting modernisation of the mental health workforce. This was well attended by individuals and local organisations

- we do not attend SSSFT board meetings as they are always held in Stafford, but we do go to the mental health provider forum and the commissioning partnership board where we contribute feedback from service users who tell us what they think of the service they receive

(iii) gathering experiences of the care given to mental health service users at GP surgeries and in hospitals

- we have asked SaTH for reassurance about the care of inpatients who have a previously diagnosed mental health condition as during visits to the hospital patients have reported that the nursing staff at RSH and PRH don't always involve the mental health liaison team. One lady told us that she cried every day as she was mentally ill, but as she was an inpatient being treated for appendicitis, the staff didn't think her mental health responsibility to deal with.

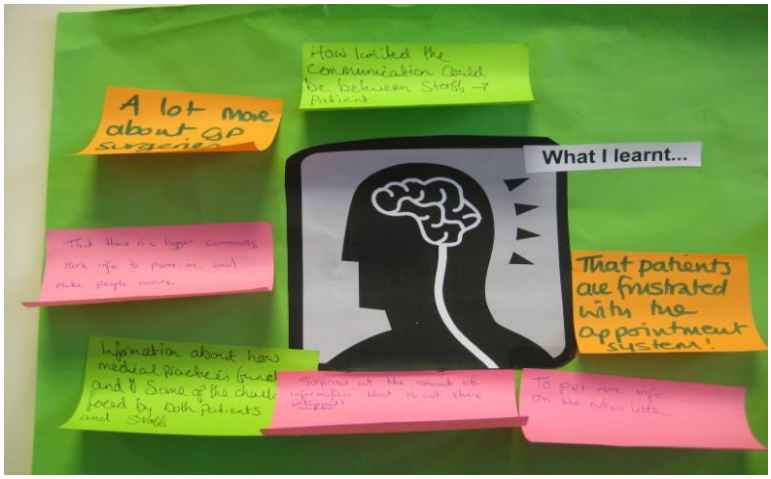
- LINk community champions involved in the Patient Reference Group project at Sutton Hill met with service users from MIND in March 2012 to discuss their experiences of GP support for people with underlying mental health needs. Although the report hasn't yet been finalised or shared with the commissioner, some preliminary findings are that people with mental health problems believe they are treated less favourably than patients who have physical health problems. They also feel that they aren't being taken seriously when seeking early intervention and report significant and frequent difficulties with obtaining help when in a crisis.

WHAT DIFFERENCE did we make?

- **combating stigma:** LINk has raised awareness of how important good mental health is to overall wellbeing by using “No health without mental health” and “No decision about me without me” with the aim of stigma and discrimination

- **early intervention:** we have helped set up patient groups in 18 surgeries which are helping mental health service users to identify practical ways that family doctors surgeries can provide early intervention and support

- **collaborative working:** working with MIND has enabled us to meet with more service users to discuss their experiences – not only has this provided a wealth of information that we can use to inform commissioning decisions and feed into service /contract reviews, it has also reinforced the importance of peer support



WE SAID WE WOULD investigate whether elderly and vulnerable people and their carers who need social care receive a fair and thorough assessment of and a care 'package' that meets their needs

We did this by

(i) using feedback from service users to contribute to the review of adult social care services

- we contributed to the report submitted by Listen Not Label, the user led organisation for people with disabilities and long term conditions

(ii) supporting the Senior Citizens Forum discharge project

- more than 160 patients have been interviewed about their experience of discharge from hospital. The Shrewsbury and Telford Hospitals Trust (SaTH) and Shropshire Partners in Care (SPIC) were both very supportive and helped us meet patients who were about to be discharged or who had recently left hospital.

WHAT DIFFERENCE did we make?

➲ **quality account:** we have however been invited to comment on the approach being proposed by Telford & Wrekin Council regarding its first quality account this autumn, which is appreciated as there has previously been limited

➲ **joined up action:** LINk and the Senior Citizens Forum are still analysing the feedback from the discharge survey. Our report will be sent to the Primary Care Trust, the Clinical Commissioning Group, the Shadow Health and Wellbeing Board, Health Scrutiny Committee, the acute hospital trust (SaTH), the Care Quality Commission and also Shropshire Partners in Care (SPIC) when the findings have been considered.

"We are confident that the report will be taken note of as there is considerable evidence which indicates that much better coordination is needed at discharge if vulnerable older people are to be supported properly so they can recuperate and regain their independence, and maintain their dignity.

How this is going to be achieved with the cutbacks to services is a real concern."

Visits to social care premises in 2011/12

We also visited two residential care homes and two day centres in 2011/12, all of which were announced

Millbrook Daycare Centre

- Activities appropriate to the needs of service users
- Advice being given about access to personal budgets to fund their day care
- Safeguarding policies and CRB checks for staff, volunteers and others e.g. transport providers and staff training - POVA/Mental incapacity/DOLS
- Staff engagement with service users e.g. at lunch time
- Methods for making family carers aware of how to raise concerns

Bennett House Residential Home and Daycare Centre

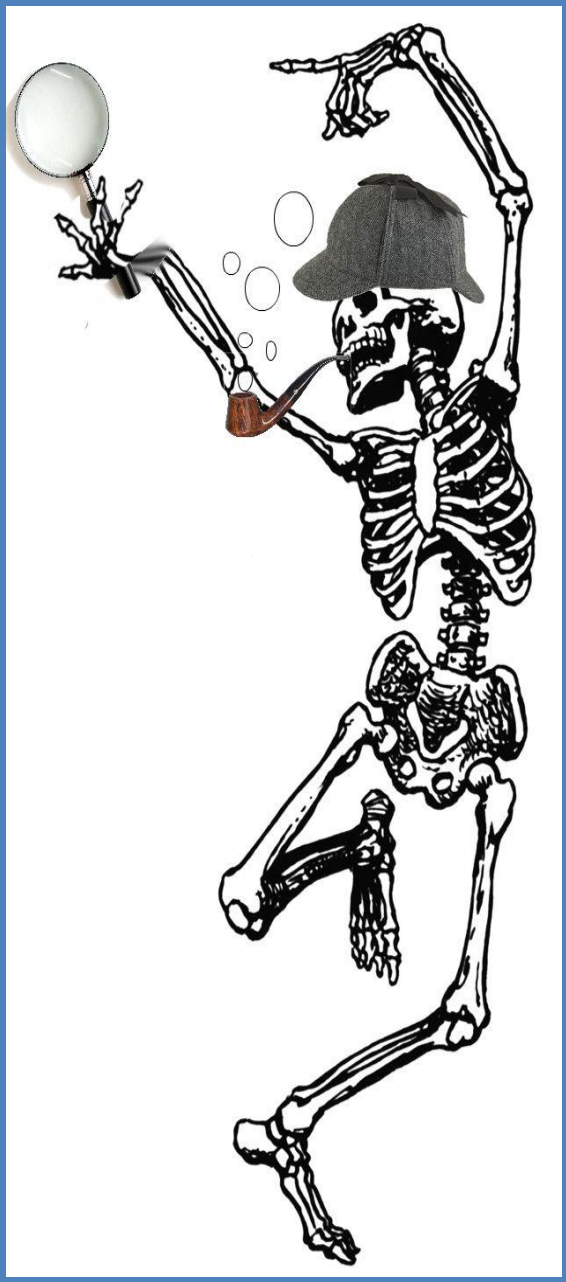
- Residents right to retire to their own rooms during the day
- Staff training/ skills e.g. helping residents form friendship/social engagement
- Social activities and use of reminiscence activities
- Nutrition and assistance with eating
- Medicines management and access to GPs
- Communication and support for people with sensory loss and cognitive impairment

High Mount, Donnington

- Staffing levels – day and night
- Volunteer and student placement opportunities
- Psychological assessment / support
- Staff have regarding non verbal communications
- Meal planning and preparation – choice, nutrition and hygiene training

Youth LINk: the case of the reluctant patient

Youth LINk has been set up by a group of volunteers aged between 14-21 who champion young people's voices by creating opportunities to talk about their experience of local health services and to identify improvements.

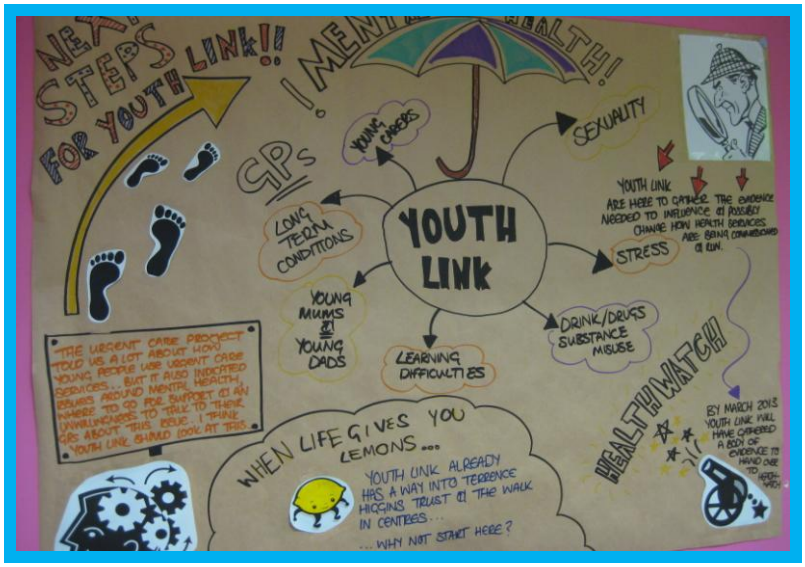


Towards the end of 2011 Youth LINk was asked by the PCT to find out what young people knew about out of hours urgent care provision. We conducted 70 semi-structured interviews around Urgent and out-of-hours care provision and when the results were analysed Youth LINk identified a real issue around young people not feeling able to go to see their family doctor for a number of reasons which included strong perceptions that :

- **family doctors aren't as knowledgeable as hospital doctors leading to a lack of confidence in their GP**
- **breaches of confidentiality were possible/probable**
- **being forced to see a GP they didn't want to see, or to see a same-sex GP**

Many young people also said they felt ashamed, embarrassed or judged so we decided to hold a world cafe event at Hadley Learning Centre to establish if this is a minority viewpoint or if most young people feel this way. The feedback confirmed that the feelings identified by the survey were fairly typical: most young people don't know much about out of hour care and the potential for little problems to become big issues was a real consequence. It also highlighted the need for information to be provided that young people find attractive.

In 2012 Youth LINk will go into existing youth group settings to do some targeted consultation work with young people who are involved in the youth forum, Terence Higgins Trust, Young Minds etc where super sleuth Sherlock Bones – Telford's very own Health Detective will help Youth LINk investigate specific issues and help them solve cases by making evidence based recommendations to the NHS or local council


NEXT STEPS FOR YOUTH LINK!!!
MENTAL HEALTH!
YOUTH LINK
SEXUALITY
STRESS
DRINK/DRUGS SUBSTANCE MISUSE
LEARNING DIFFICULTIES
YOUNG MUMS & YOUNG DADS
LONG TERM CONDITIONS
YOUNG CAREERS
GPs
WHEN LIFE GIVES YOU LEMONS...
HEALTHWATCH


RESPECT
CONFIDENTIALITY
ANONYMITY
OPENNESS
RIGHT TO PASS
SENSITIVITY 2
DIVERSITY
GROUND RULES
NON JUDGEMENTAL APPROACH
ACCEPTANCE
HAVE A GOOD TIME!

Who is involved in Telford & Wrekin LINk?

The Central Management Group is LINk's governing body. It decides the annual priorities, and determines how our limited resources will be spent to support implementation of the workplan.

CMG also appoints the LINk Authorised Representatives who are allowed to 'enter and view' premises on our behalf.

Telford & Wrekin LINk Central Management Group 2011/12

Trevor Dickenson
David Edwards
Muriel Fellows
Jean Gulliver (vice chair)
Tony Glover
Tina Jones
Lilian Owens
Lorraine Parkes
Dag Saunders (chair)
Richard Shaw
Gaynor Stevens
Derek Tremayne
Ken Whitcombe
Paula Whitcombe
Sally Carter (resigned October 2011)
Jayne Stevens (from March 2012)

The Central Management Group assigned tasks to subgroups

- **Executive subgroup:** governance and internal policy/operational issues including insurance cover

- **Enter and view subgroup:** safeguarding training (POVA and DoLs/Mental Capacity Act); recruitment and induction of new visitors; undertaking visits to hospitals and care homes and reporting the findings

- **Mental health subgroup:** monitoring the reconfiguration of mental health services; nurturing relationships with SSSFT governor members; working in partnership promoting information on services available

- **Acute subgroup:** SaTH reconfiguration; walk the wards; urgent care network**;** patient involvement and engagement panel; patient environmental assessment team inspection

- **Primary care (Community Services and West Midlands Ambulance Service) subgroup:** meeting the CEO and Chair of NHS Telford & Wrekin; attending board meetings; supporting the development of Patient Reference Groups; trauma care network

- **Social care subgroup:** Review of Adult Social Care Services

- **Community engagement subgroup:** communications, PR; training and capacity building; establishment of Youth LINk

- **Transition into Healthwatch subgroup:** Local Healthwatch Pathfinder; Equality Delivery System; Donnington Voice

The Central Management Group also appointed representatives to attend local forums

- **Representation on local health and social care forums**
- *Telford & Wrekin Council*
  Scrutiny Committee
  Health and Wellbeing Board

- *Joint NHS and local authority forums*
  Dementia Provider Forum
  Dementia Strategy Group
  Mental Health Providers Forum
  Mental Health Commissioning Board
  Mental Health Modernisation Sub Committee

- *Clinical Governance Group*

- *Shrewsbury and Telford Hospitals NHS Trust*
  Patient Experience and Involvement Panel
  Urgent Care Stakeholder Group
  Dementia Strategy Group

- *South Staffordshire and Shropshire NHS Healthcare Foundation Trust*
  Community Engagement Forum

- *Shropshire Community Healthcare NHS Trust*
  Stakeholder forum

- **Representation on local voluntary organisations**
- *Rights and Fairness -Telford (RAFT)*
- *Listen not Label*
- *Steering Group - Patient Reference Group*

- **Representation on regional health bodies**
- *Regional Action West Midlands (RAWM)*
- *West Midlands Trauma Network*

- **Representation on national health bodies:**
- *National Association of LINks Members (NALM)*:
  NALM Executive

- *Department of Health:*
  Healthwatch Programme Board

Conferences attended by LINk representatives in 2011/12

- NHS West Midlands The Equality Delivery System (EDS) training workshop
- National Ambulance Conference of the Equality Delivery System (EDS),
- National Children's Bureau – involving children and young people
- Trauma Care System - Implementation Planning Day
- Community, Patient, Service Users and Carer Engagement in the New Health and Social Care Landscape
- National Association of LINk Member (NALM) AGM and national conference
- RAWM workshops
- DH LINk Learning Sets

Youth LINk members

Youth LINk was established in mid 2011 by

- ☺ Scott
- ☺ Joanna
- ☺ Nikita
- ☺ Jade
- ☺ Bart
- ☺ Alice
- ☺ Lauren
- ☺ Mike

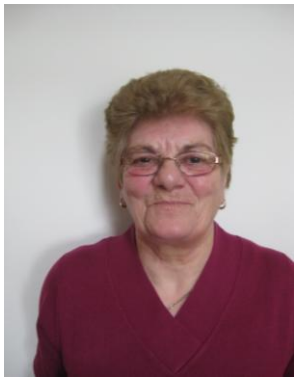
March 2012
The World Cafe event at Hadley Learning Centre
Sponsored by Telford &Wrekin Council

Authorised Representatives

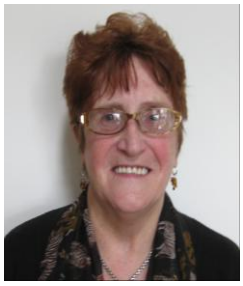
Local involvement networks have the right to authorise representatives to visit premises where health and social care services are being delivered so that they can speak to patients and service users about the care they are receiving, and then report their findings to the Central Management Group.

All members of the visits team have to satisfy stringent requirements including an enhanced CRB disclosure and have to agree to comply with the national code of conduct. Visitors have to attend training about safeguarding adults and demonstrate that they can understand what to do if they identify causes for concern regarding vulnerable adults so these can be referred to the local council for investigation.


Brian Begley


Gwen James


Audrey Thompson


Chris Alford


Tony Heathcote


Geraldine Stokes - Harrison

Our Authorised Representatives are:

- Chris Alford
- Brian Begley
- Jacky Bowyer
- Muriel Fellows
- Tony Glover
- Jean Gulliver
- Jo Havell
- Tony Heathcote
- Gwen James
- Sue Jenkins
- Lilian Owens
- Lorraine Parkes
- Gaynor Stevens
- Geraldine Stokes-Harrison
- Audrey Thompson
- Derek Tremayne
- Paula Whitcombe

LINk community champions

Community champions support LINk by:

- attending events and meetings to promote the LINk's work
- taking the LINk into communities, sharing information and showing people that LINks can make a difference
- gathering local people's views
- getting involved in events and projects

Natasha

Tanya

In 2011/12 our community champions were

- Ken Whitcombe
- Tanya S Love
- Sally Mason
- Jenny Shaw
- Natasha Rocket
- Belinda Ezeguzu
- Dorothy Hughes
- Anne Fletcher
- John Chadderton
- Jayne Stevens
- Sian Hallewell
- Mohamed Choudhary
- Christine Choudhary
- Heather Osborne
- John Tuck
- Jaime Rixom

When I was asked to attend a meeting about the new trauma centres patients I was really pleased It was 12 months since I was working and I really missed being with patients on daily basis.

From that initial meeting I became a member of the patient and public engagement group representing Telford & Wrekin LINk. I now try to attend the trauma network meeting every month. I've also been asked to join a regional group doing work which reports to the national commissioning board.

One of the tasks I've been given recently is to comment on the documents for the relatives/carers of trauma patients. A strategy has been produced by the West Midlands Trauma Network and I have been commenting on this document. Recently as part of regional clinical reference group I've also been working on the service specification for trauma to be sent to the national commissioning board (NCB).

"I hadn't been involved with my community until I took part in the expert patient programme and getting involved with LINks. This opened up the possibilities for me. It hit me how can we improve our ability to speak to and give people a voice."

I now feel like I am combining my experience as a professional and also as a patient representative - so can make a real difference to patient care."

Tony Glover, CMG member and Patient Representative on the West Midlands Trauma Network

Local Healthwatch

Health and social care is changing – don't just watch and wait, use your voice to influence what happens in Telford

The Health and Social Care Act will introduce significant changes to the planning, commissioning and delivery of health and social care services.

A cornerstone of the reforms is the introduction of Healthwatch, both at a national and local level. The reforms propose that LINks will evolve into local Healthwatch, with the aim to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their area.

What is a Local Healthwatch?
Local Healthwatch will be a new local champion for people who use health and adult social care services. It will help get local people's views heard in order to ensure the best possible services are provided locally.

What will Local Healthwatch do?

- Local Healthwatch will build on the work of Telford & Wrekin LINk to:
- Get more adults, young people and children involved in the planning, delivery and monitoring of health and social care services;
- Get more people involved in talking about what you get from health and social care services in Telford & Wrekin;
- Make sure people who make decisions know about your experience and how you think services could be improved;
- Put forward everyone's ideas for improving local services and assist local people to influence change;
- Make sure Healthwatch England knows what you think which should help shape services nationally;
- Have a seat on the local council's Health and Wellbeing Board.

When will Local Healthwatch start?
Local Healthwatch in Telford & Wrekin will start in April 2013.

How will Local Healthwatch be funded?
Funding will be available for Local Healthwatch from the Department of Health who will provide the money to Telford & Wrekin Council as a grant.

Health and Wellbeing Boards
A shadow Health & Wellbeing Board was established in Telford & Wrekin in January 2011. The Board is a subcommittee of the Council and plays a strategic role in planning the borough's Health and Social Care provision, assessing community health and social care needs and developing a Health & Wellbeing Strategy to address them.

The hosting service

In 2008 a three-year contract to provide the LINk hosting service was awarded to Staffordshire University which was extended for a further year in 2011/12.

When LINks were extended for a further year (from April 2012 until March 2013) the university indicated that it did not wish to seek an extension to the contract. As a consequence of this decision and owing to the fact that LINk will cease to exist after 31 March 2013, Telford & Wrekin Council undertook to take on the function previously provided by Staffordshire University. The officer responsible for the host performance is

Paul Taylor
Assistant Director
Social Care Specialist
Telford &Wrekin Council
Civic Offices
Telford
TF3 4HD

01952 381200
paul.taylor@telford.gov.uk

The host support team

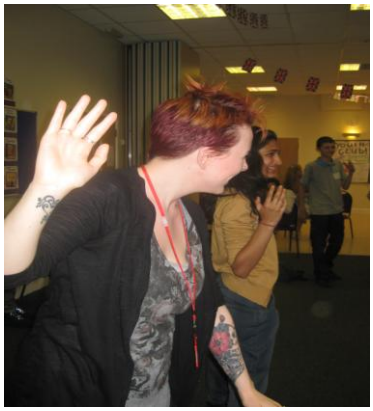
The role of the host is to enable the LINk members to carry out their activities by providing them with advice and organisational support. In 2011/12 the hosting service consisted of:

- Linda Seru Director
- Marie Jones LINk Administrator
- Catherine Pert LINk Administrator and Youth LINk support worker
- Rebecca Dove Community Engagement Worker

Two additional staff were appointed in January 2012 to assist with the project work and office move

- Leah Tirmizi, Community Engagement Worker
- Dave Hayes, LINk Administrator

The team's contact details are on page 44



Catherine declining to have her photograph taken

PS: thanks to Catherine for the creative artwork she contributes to Youth LINk

How to contact us

Telford & Wrekin Local Involvement Network

This is the fourth annual report to be produced by Telford & Wrekin LINk. Reports produced for 2008/09, 2009/10 and 2010/11 may be downloaded from our website (www.telfordandwrekinlink.org.uk), or can be obtained on request from the address opposite.

Although produced for the general public, we hope it will also be of interest to policymakers, commissioners and providers. It is formally presented to the Annual General Meeting of LINk members and stakeholders to enable them to decide whether we did what we said we'd do in 2011/12; it also explains how we spent the grant given to support our activities and seeks endorsement for the workplan priorities proposed for the year ahead. The AGM is held in public; in 2012 it will be held at 7pm on Thursday 21 June at Meeting Point House.

A copy of this report is also sent to

- The Secretary of State for Health
- The Care Quality Commission
- Telford & Wrekin Council Overview and Scrutiny Committee and the Shadow Health and Wellbeing Board
- Shropshire County Council
- The West Mercia Cluster of primary care trusts which includes NHS Telford & Wrekin and Shropshire County Primary Care Trust
- Telford & Wrekin Clinical Commissioning Group
- West Midlands NHS (Strategic Health Authority)
- Telford & Wrekin Clinical Commissioning Group

Please contact us if you would like

- **a copy of this annual report in a different format or community language**
- **more information about Telford & Wrekin LINk**
- **or want to get involved in the LINk or in Healthwatch Telford & Wrekin**

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You can also find Telford & Wrekin LINk and Telford Talks on www.facebook.com

This annual report is available in two versions: a full version (this one) and a summary. Both can be downloaded from the website or supplied as an attachment to an email, and both are available in a range of alternative formats including Braille, large print and audio tape. Translation into a number of languages other than English can be arranged on request.

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD –12th September 2012

DEVELOPMENT OF LOCAL HEALTHWATCH

REPORT OF :Service Delivery Manager- Commissioning

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 This report provides a progress update in relation to the requirements under the Health and Social Care Act 2012 to develop a local Healthwatch.

1.2 The report outlines work undertaken to date and outlines the procurement approach to secure a local Healthwatch provider.

2. RECOMMENDATIONS

2.1 Board members/members note the progress made to date against key milestone dates to develop a local Healthwatch.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Priority Plan objective(s)?	
	Yes	Vulnerable children, young people and adults are safeguarded from harm and neglect. Improved health which enables people to live active, positive and independent lives Even more children and young people are on the path to success in adult life through the provision of good quality education, training and jobs.
	Will the proposals impact on specific groups of people?	
	Yes	The proposals impact on people of all ages who use health services and more specific groups of patients and service users who receive on-going support through or for part of their adult life
TARGET COMPLETION/DELIVERY DATE	*April 2013 (see key milestones in report)*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	Funding of a local Healthwatch will be made up of: • Existing LINK's contract funding- £114,000 • Department of Health funding for Healthwatch- £37,419 • Start up costs for Healthwatch- £19,228
LEGAL ISSUES	Yes	Delegated authority to enter into a contract with the preferred provider following a tender process has already been approved by the Council's Cabinet (29th March 2012)
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact

PART B) – ADDITIONAL INFORMATION

4. INFORMATION

Background

A report was presented to the Health and Wellbeing Board on the 22nd February. This report outlined the functions and responsibilities of Healthwatch .The report was considered by Cabinet on the 29th March and sought delegated authority to enter into contract following a procurement process.

Building on our pathfinder status gained in 2011, the approach to developing a local Healthwatch was launched at the Health and Wellbeing event held on the 3rd July 2012.

Key stakeholders were invited to contribute to the local Healthwatch development and sought to seek views on the following key questions:

- How can we ensure everyone can access local Healthwatch in ways that suit them?
- How can we ensure local Healthwatch is able to represent the views of everyone in ways that suit them?
- What does a good health and social care consumer champion look like?

These views have been collated and fed into a developing service specification (see Appendix 1)

Developing a Local Healthwatch

The development of a local Healthwatch is very much grounded in working in partnership with our local communities, and organisations in recognition that Healthwatch will be a local consumer champion for patients, service users and carers. Therefore, the approach to developing what is required for Telford and Wrekin needs to be influenced and shaped by local people and organisations to ensure we build on what is positive whilst also recognising what we need to do differently.

The first workshop held on the 8th August was positively received by those who attended and will form the basis for the service specification. To further shape the service specification we asked the following:

- What ideas do you have for how Healthwatch could be delivered locally?
- What are the challenges around delivery and what are the potential solutions?
- What organisational strengths already exist in meeting the intended functions of a local Healthwatch and how could these be utilised in a delivery model?

- How could a local Healthwatch be creative and demonstrate best value?
- What will organisations need to consider in recruiting and sustaining a vibrant volunteer infrastructure?

Again the summary information from this workshop has been collated. (See Appendix 2)

The next scheduled event on the 6th September will focus on the prospective providers becoming 'bid ready' and further develop the service specification.

To ensure we are communicating with all interested parties we have established a website: http://www.telford.gov.uk/info/200190/health_and_wellbeing/1556/healthwatch.

We have also set up a group e-mail for interested parties following their request at the August workshop.

The next workshop in September will focus on the following:

- Developing Key Performance Indicators (KPI's)
- Clarifying roles and responsibilities, which includes:
    - Structure and governance/pathfinder models
    - Management and infrastructure (ideas)
    - Volunteer recruitment and support (your feedback)
    - Enter and View and regulations (legislation)
- The session will also provide procurement support to interested parties.

Time Lines

A small project group is leading the process to ensure the milestones are achieved. This group reports to the pathfinder group which comprises of health, social care and LINks representatives.

The outline programme, which was communicated to key stakeholders at the Health and Wellbeing launch event on the 3rd July, to progress the procurement process is as follows:

Activity	Time Line
Community dialogue to develop and inform the service specification	Workshops scheduled 8th August and 6th September
Formal invitation to tender	28th September
Closing date/return of tenders	31st October
Evaluation of bids	November
Contract award and confirmed with providers	December

Shadow implementation	January- March
Healthwatch Telford and Wrekin operational	1st April 2013

Next Steps

The project is on target in accordance with the milestones detailed above. The tender pack which includes the invitation to tender, contract terms and conditions, and the evaluation framework is being developed in parallel to the service specification.

Following the workshop session scheduled for September the service specification will be finalised to be include in the tender pack.

5. PREVIOUS MINUTES

5.1 Cabinet Report – 22.12.2011 – NHS Transformation and Implications for the Council

5.2 Health and Wellbeing Paper- LINk and Healthwatch transition, 22nd February 2012-

6. BACKGROUND PAPERS

Report prepared by Christine Harrison, Service Delivery Manager- Commissioning, Care and Support
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APPENDIX 1

DEVELOPMENT OF HEALTHWATCH FOR TELFORD AND WREKIN
NOTES FROM AWAY DAY

Q1.	HOW CAN WE ENSURE EVERYONE CAN ACCESS LOCAL HEALTHWATCH IN WAYS THAT SUIT THEM?
Table 1	• Ensure appropriate communications (visual, translators, interpreters etc) • Promotion and publicity – need to be talked about and shared with all current groups/forums • Using existing channels allows people to be supported into the process • Need to ensure information is provided in BSL not just written English (video cameras etc, around 300 sign language users in Telford)
Table 2	• Social Network Site • Local GP • Library • Better communication/awareness • School packages, starter packages (advertising) – targets families • Needs quick wins i.e. on this leaflet – catchy that engages people straight away. Telling people how they are going to make a difference. • Make information relevant i.e. visit to care homes if patients are concerned or if they are able to help them – making their duty meaningful to patients/public. • More awareness i.e. box saying if not happy where to go? Better publicity – with help from LA/other org (small budget) • Advertise on appointment letters • Information hubs • Advertise where issues are likely to arise • Strap line/branding/catchy

Table 3	• Signposting – need to know how we are doing this
	• Needs to be housed in an independent neutral space
	• Doctors surgeries play an important part/dentists surgeries.
	• Ensure anonymity
	• Single list/computer system of info/data that everyone has access to – confidential and robust system .
	  ➢ Mapping exercise of which groups currently exist. One point of access for people.
	  ➢ Needs to be in plain English/do not have too much info on it.
	• Text/email doctors although recognise not everyone ICT literate
	• Need to cross all boundaries – age/ethnicity etc
	• Training.

Table 4	• Not like banks – closed at weekend. • Location, accessibility. • What Healthwatch can and can't deliver • Intergrated into the community – not an add on. • Promotions – various methods depending on situation and particularly on-line. • Making sure it fits the needs at the time, keeping it 'live' fresh. • Links to a wide range of other services and help to promote and support Healthwatch and understand and access.

	• Community champions • Community peer mentors – all links in dynamic relationships with full progression • Cascading information • Targeting.

Table 5	• Email and website
	• Social networking sites
	• 24 hour communication
	• Legislation – not include safeguarding children
	• Council – Your Voice – making use existing communication
	• Be clear about what its purpose is – don't understand concept
	• Public confused – LINK – Healthwatch – don't know who LINK is.
	• More fundamental questions – give people more information on what is Healthwatch – did not understand presentation.
	• Done 50 consultations and never heard of LINKs - never seen anything in paper.
	• Done basic SWOT. Weaknesses – not known.
	• Professional/representative/community well
	  ➢ What are their objectives
	  ➢ What are the outcomes Council want to see.
	  ➢ What drives the change
	• Council document what it wants to secure – use workshops to define that.
	• Presentation – not put in context what happens now.
	• LINk setup to be voice – but as small group not?(unable to decipher text) - Key feature Healthwatch – need to know who are
	• Healthwatch is a good name!

Table 6	• Social media
	• Radio
	• SMS
	• Website
	• Newspaper
	• Forums
	• 2 way information eg on facebook
	• With local organisations
	• Promotion via GP surgeries
	• Where people meet/gather
	  ➢ Churches
	  ➢ Pubs
	  ➢ City centres
	• Make it simplistic/easy to understand
	• Emphasise its 'independence' so people will feel happy to use it.
	• Be clear it is '<u>your</u>' voice
	• Look at working/language
	• Hold focus groups on key messages within the ? (unable to decipher text)
	• (Vicky asked for easy read versions)
	• Also need to focus on reaching 'individuals' not just groups/organisations. Promotions via C&YP and other groups who don't usually engage.

Table 7	• Promotion PR – every format • Facebook and social media • Newsletter } sign interpreted • Link with groups } 1st language • Interpreters } • Good advertising before point of need. • GP surgeries and health professional and social care • Difficulty – distinguish health and social care • Hard to reach groups • Networks – 'network of networks' • Local influence – going to shops/public places • Shout about it – explain purpose clearly • Use existing infrastructure • People have to know about it.
Table 8	• Healthwatch to 'get out there' • Internet • Use other peoples newsletters • Newsletter sent with Council Tax i.e. like fire and police do. • Healthwatch England to have a national promotion- tag onto this.
Table 9	• Providing access through various contacts/services (creating awareness – through GP's, hospitals etc – as and when people need it) • Plasma screens in reception areas • Developing the relationships/partnerships – to share and promote the information • Local magazines (Council/Parish Council etc) • Community engagement • Think about timing/out of hours • What are they going to do with the information when they have got it? • Tap into other peoples resources/evidence • Costs?? (implications) – make better use of existing resources

Q2.	**HOW CAN WE ENSURE LOCAL HEALTH WATCH IS ABLE TO REPRESENT THE VIEWS OF EVERYONE IN WAYS THAT SUIT THEM?**
Table 1	• Have accountability measures in place. Can only work if existing group feed in two-way street need to be prepared to be involved. • You never can. Need to manage expectations and ensure a fair representation. • Understanding and knowing how people prefer to communicate • Complex process will take time • Groups of practice patients cascade down – network of networks – start local.
Table 2	• Those delivering front line services must be and are given information, they are in peoples homes • Cascade simple pack of information to staff/information needs to be readily available. • Anonymity/ do not want to be identified if making a complaint would encourage people to make their views • Joined-up working - how do organisations link with different groups/use common approach, best practice to target groups. (common approach to consult with harder to reach groups) part of bigger operations/pooling resources . • Must not trickle into existence needs to come in with a "big bang" – national campaign would benefit Telford and Wrekin.

	• Majority reached by TV • National marketing, Healthwatch needs to be proactive in finding people and use good news story. • Word of mouth best way to embed in the community • Organisation goes to harder to reach people instead of them coming to a faceless organisation • Proactive, get intelligence from other organisations i.e. complaints – care home to target their energy – burning issues. • Membership and structure – deliberately drawing from groups of individuals - identify people which will bring masses to the organisation.
Table 3	• Tangible • More professional • Local people looking at peoples problems • Link into patient reference group and other network groups • 2 way dialogue with Healthwatch/doctors/patients/community • Increase awareness among the community – need to spread the message. • Include as part of staff induction training in hospitals
Table 4	• Targeting • Broad membership • Local champions • Reflect on areas that have worked well and not so well • Proactive – challenge • Representing the issues at Health and Wellbeing - nationally. • Touchstone – in touch with local community, have to feel something is being done. • Community dialogue – working both ways. Feeding back to people the difference Healthwatch has made. • Ensure enough time to embed Healthwatch effectively Review ➢ Appropriate membership ➢ Re-evaluate priorities ➢ Performance measures ➢ Resolutions on complaints • Conflict of interest – as a resident of Telford and Wrekin and working for NHS/Telford and Wrekin Council – is there any exclusion?
Table 5	• Needs to be known • High profile • Difficult to answer until know what Healthwatch is for. • Does PALS fit in with Healthwatch? • Is this leaflet to public – terminology/jargon is difficult. • If dyslexic difficult to read. • Leaflet is awful – cut out jargon – plain English. • Own organisation – Safeguarding Children Board – Act with legislation within presentation. 2004 Children's Act • Health governance gap – does that have a place? • Contact CVS as they can disseminate information. Age UK – see self as part of consortium. • Real visibility/obvious communication.
Table 6	• Hinges on being accessible • PR campaign using icon/character to bring it to life • Pick up and use intelligence gathered/encourage staff to record capturing information at the time. • Supports/facilitate GPs/organisation in understanding. • Some people need advocates to speak for them – e.g. health champions from the community • Using the community as 'family'.
Table 7	• We can't! • Guest speakers at meetings • Two way dialogue • Elected governors from parishes

	• Focus on needs of hard to reach communities • Representative from all groups (is this manageable?) • Events/roadshows to promote services throughout the year. Must be targets e.g. diabetes. • Coordinate meaningful events • Private businesses to assist e.g. possible sponsorship (must avoid conflict of interest)
Table 8	• Act as a 'voice' • Make sure not dis-proportional • Represent networks • Link to Health and Wellbeing Board • Outcomes needs to be identified
Table 9	• Social media • Staff newsletters • First point/family connect • Getting partners on board • Regular communication • Community engagement • Making it as local as possible/as cheap as possible • Local supermarkets • Responding • Make better use of members of trusts/local groups/ (shared resources) • Monitor who is inputting/contributing and who is not • Schools • Targeted approach where needed • Potential users as well as existing users • Getting local GP's on board • Not just about getting information out – it is about getting it back as well.

Q3.	**WHAT DOES A GOOD HEALTH AND SOCIAL CARE 'CONSUMER CHAMPION' LOOK LIKE?**

Table 1	Consumer champion – group or individual who champion rights of people using the service.
	• What is the role?
	  ➢ Critical friend
	  ➢ Advice and information
	  ➢ Enter and view
	• Is it a lobby group? Do local individuals need to be part of it or is it professionals?
	• All about patient voice – find out what people's need are, what is working well, what needs improvement?
	• LINK led by volunteers with staff to support
	• Statutory powers
	  ➢ Go into public funded properties and talk to users
	  ➢ Ask questions over and above FOI
	  ➢ Make formal commentary on annual reports of providers
	• Need community support. Cannot function without the public.
	• Representing all of the community ensuring appropriate communication with all (deaf, visually impaired, learning disabilities etc!)
	• Input from current forums/boards (e.g. carers) to help ensure representation of all.
	• Consumer champion group of people – uses all networks as feedback, governing body should be representative of community.
	• Need a mix of people to ensure agenda is not focused on one opinion.
	• Representatives from voluntary sector
	• Ability for people to feed in to particular issues of interest – working on the ground.
	• Service users need to be part of representation.

Table 2	• Links in past hidden – as patient was not visual (comm. In new structure) • Benefit from not having any past history being brought in i.e. not bringing link in, should be a 'new' organisation, should be a new entity. • Valuing/principles/characteristics ➢ Independent

	➢ No vested interest ➢ Not part of the NHS ➢ Representation from all aspects/parts of community ▪ Children ▪ Disability • Multi-task • Realistic expectations of what organisations can/should achieve i.e. do not set up to fail. • Once people walk away can't get them back again – don't raise peoples expectations. • Relevant people to area/topic discussed at the time. • Smaller committee, working groups • Strong links with people they are 'watching' – reporting back issues(whilst still being independent. – what's going well/not well • Can't just be a complaints board • What do they look like in other organisations (model from more established organisations – i.e. thing that can be learnt taken from them) • See the changes quicker/knowledge about process/feed into annual report/look for trends • Sharing best practice.
Table 3	• Independence, not associated with health service/council already • Looks at good and bad practice • Unannounced visits, 'end review' • Getting things done • Having a relationship with providers • Statutory powers (rules and regulations) • Access to health and social care provision inc private homes and carers at home • Delicate and diplomatic • Looks at care for all ages • Transparency – things are recorded properly • Open to other organisations (advocacy) • Confidential – data protection • Be aware of range of local services • Good feedback loops Healthwatch – range of organisations to make changes. • Care of existing LINK organisation is good – needs to be more professional • Talk to local people in language that it can be understood – plain and simple. • Signpost people to patient ref GPs and other avenues to have your say. • Information to local people about what it provides • Train staff in social care and in health services – about Healthwatch so they can signpost. • Each individual member of Healthwatch should be seen as a champion. • Uses a range of method to communicate including social media.
Table 4	• Approachable • Passionate • Listens • Local • Non judgmental • Know of them • Resourceful • Able to make a difference • Accessible • Respect, integrity, communicators – relating the issue back in different ways and situations and authentic, empathy. • Facilitators – in terms of needs • Respected by the community they are dealing with • Clearly understand their role - not office, open door. • Pro active • Supporting? • What commitment they have to give to deliver priorities • Being motivated.
Table 5	• Visible

	• Network of organisations – bring in coms issues • Why/how LINK has been a success? – why are we changing? – Can't LINk expand? • Look at what works and use it. • What are the gaps – listen • Characterising like – knowledge local. How far reaching are they? • Feeling of losing what we have? • Consortium – become who not part of it – self selective • Governance of organising managing arms length. • Getting people included and engaging. • Constitutional – as a charity it is allowed to take on broader role – if charity? – save other charities • Look at governance of organisations • What do we expect them to do? – as role covered by other organisations e.g. council advisory services • Is Healthwatch about maximising what we have – then do specific targets . role is it co-ordinating, or is it duplication • Another organisations needing volunteers = pressure – or do you use cohorts already exist collectively. • Different volunteering roles – could they also be fulfilling Healthwatch role. • Does it have to be volunteers – it is £ issue? • Where does CQC fit? • Take recommendation of enquiries.

Table 6	• Representative/the face of the people
	• Flexible
	• Open to ideas
	• Non-judgemental
	• Credible
	• Respected
	• Independent
	• Not having its own agenda
	• Being able to listen
	• Open-minded
	• Plain speaking
	• Accessible
	  ➢ Language
	  ➢ Easy read documents
	  ➢ Different formats
	  ➢ Different channels
	  ➢ Approachable
	  ➢ Publicised.
	• Can be trusted and won't judge
	• Shouldn't stigmatise
	• Challenge in constructive way
	• Focus on solutions
	• Important that they are well known to local people.

Table 7	• Independent and knowledgeable • Eclectic • Strong communication • Listening • Inclusive • As many links as possible • Good networking • Professional • Credible/integrity • Engage with difficult to reach groups • No fixed agenda • Flexible

	• Open agenda • Keep agenda consumer led • Open minded • Operate at all levels (local) • Friendly and approachable • Committed • Representative of communities • Trustworthy and honest • Organised • Influential in getting things done • Have a purpose • Be accountable
Table 8	• Must have connections/links to other organisations • Easily accessible • Local champion who use services • Not appear 'official' • Impassive users • Bring together patients reference groups • Build capacity with volunteers • 'trust' 'respect' • Must ensure everyone knows about them • Social enterprise
Table 9	• Sharing relevant up to date information in a timely manner (at the right target audiences) • Regular communication (different methods) • People friendly/approachable • Representative of the people it is speaking for • Respected • Challenge being the most difficult thing(must be able to challenge) • Giving people a voice • Getting a response when it is needed • Needs to be very honest about what it can/can't do (of health provision in general) – managing expectations • Getting the balance right (in representing individuals/community/groups) • Have good /reliable up to date information and listening • Giving the opportunity to network(how do we do this?)

Further feedback from Table 5 – felt the leaflet (Healthwatch – A stronger voice for the whole community to improve Health and Social Care services) was too "jargony" and people felt that they did not understand the presentation.

APPENDIX 2

HEALTHWATCH – WORKSHOP 1 – 8 AUGUST 2012
NOTES

Q1.	WHAT IDEAS DO YOU HAVE FOR HOW HEALTHWATCH COULD BE DELIVERED LOCALLY?

Table 1	• LINK becomes a formal body corporate and responds to tender
	• Group of voluntary organisations form a "legal" collaboration and responds to tender
	• Public interest organisation (local or national)sets up to respond
	• What is local? Telford and Wrekin or Telford and Wrekin and Shropshire
	• Needs to be
	  ➢ Visible
	  ➢ Accessibility
	  ➢ Easy to understand
	  ➢ Easy to relate to
	• Use existing volunteer systems rather than invent new ones eg volunteer training
	• Power and strength should be kept at local grass roots level – this should be highly weighted as a tender criteria.

Table 2	• This community can't afford to lose the expertise of LINK – a back bone for moving forward – harness it and keep it going.
	• We are volunteers driven by wanting to do it – not by finances
	• Bid from LINK – experience, values, motivation, expertise most people bring their background to improve services.
	• Need good back office – need to improve too
	• Opportunity to partner – choose?
	• Selection process can't be avoided (LA)
	• Developing specification – in order to bid influencing it now.
	• Development of champions, strengthen links to communities i.e. youth link, PRG champions – giving confidence engaging and involving
	• Volunteers actively involved in decision making
	• Action not meetings and committee orientated
	• We can tap into action groups – but can other organisations. Tap into these so easily. Delivery model building on good things in Telford and Wrekin.
	• Need to see how do you think you will deliver network of networks, partner
	• How can the model have a more formal view of what the whole network is about
	• LA only small number of funding/commissioning of organisations. Want to help and support that through LA contracts.
	• Performance manage – Christine's team - KPis
	  ➢ Service specification
	  ➢ What other information do we need for good service provision
	  ➢ Connecting with CQC etc own quality
	• What thinking has the prospective provider done about this
	• Example – LINK more diverse, but still failing to engage BME groups. How do we work with to ensure involvement.

Table 3	• Learn from legacy of LINKS • Existing LINKS as a 'hub' for other organisations to join. Housing • Holistic vision (police/community) • Needs to be representative of wider well-being • 'mystery shopping' as a mechanism for leaving quality and risk in health and social care economy • Access/gateway needs to be very wide 'networks' – capturing new ways of 2 way communication (patient ref groups) etc. • Must link to priorities of Health and Well-being Board. Must target work. • Meeting with key stakeholders • Must be good relationships with providers/stakeholders • Use GP referral letter to access Healthwatch • TRAQs – access to website (Patient Opinion a good format for a model) • 'Enter and view' – 'needs training' and resources • Diverse community ? (children)
Table 4	• LINK in Telford is very active – don't lose this. • Engagement with voluntary and other organisation could be improved. • Good relationships with statutory service regardless of legal status CIC Sec, 3rd Sec, private. • Use the existing voluntary organisations • Include people who have experience of health issues – e.g. deaf and heard of hearing group • Keep it pan Shropshire • Issues raised with Shropshire County Council and Telford and Wrekin. Experience of Telford and Wrekin have been very good. • Keep it local – rural knowledge. Demographic • Some one in charge who can deliver training and keep the interest for volunteers and who has qualifications and standing to do this. • Look to promote volunteering to those out of work. • Ensure you keep up the partnership working.

Q2.	**WHAT ARE THE CHALLENGES AROUND DELIVERY AND WHAT ARE THE POTENTIAL SOLUTIONS?**
Table 1	Challenges • Expectations are huge for a volunteer led service • Expectations need to be managed (by Telford and Wrekin Council) • Dealing with volunteers who have their own personal agenda • Timescale to deliver performance from day 1 starting all over again to market a new brand • Healthwatch must be transparent • 'no one in Healthwatch should know something which is not in the public domain' • To have the capacity to identify trends and take action. Solutions • Don't lose good aspects of Link that is up and running • Build on knowledge already there • Use exiting local infrastructure
Table 2	• **Challenge** - Time frame is biggest challenge • **Solution** - not spending 2 years reinventing wheel don't lose knowledge and experience/passion • **Challenge** – someone else comes in – time to set up will services and people suffer – identify gaps • <u>New provider shadow form by Jan 2013 – transition</u>

	• Transition period??? Community suffer??? • Social enterprise less incentive for profit making organisation • Commercial morning earning – real risk of imbalance between generating income • Valuing volunteers – commercial organisations • Connect link volunteers/user led locally • Larger back room staff/governance staff will be different • Bids – positive – go for those contract that are relevant to the core work. • Contract length – needs to be long enough • Need to work • Recognised operation level • Increase of workload already overloads, under resourced as it is. • Responsibility of body corporate to employ staff concerns i.e.: maternity cover, long term sick smallness is an issue. Robust body corporate. • The 'competition' nose out of joint because of tendering process – stifles good work. • Collaborative approach to overcome.
Table 3	• Duplication in system (community mapping) • Identify specialists in info etc (or each function) etc that links into a 'hub' event that will prevent duplication. Resources should follow the 'specialists' • 'network' solution and coming together as service providers. If there is a separate infrastructure, people may fall between the gaps. • Central database - people could subscribe to (generating income) for the network data. • Need to link more closely to preventative services • Resources – 'sharing back office' functions • If LINKS isn't known about, how can we get people to know about Healthwatch? • Model must be 'representative' • Lots of self help groups (user-led) how do we engage – link with Healthwatch • Profile needs to be raised (opening ceremony launch in park) and sustain that • 'launch' is opportunity to get it out and about. 'launch' must be different – get it on the map • Understand value of Healthwatch • Embrace new communications, social media etc – understanding what people need • GP surgeries is "critical". Use professional development time. Links with CCG in developing services. • Children's services – mail out to all Governors – a mechanism for access (every house hold) use Council tax bill for voice.
Table 4	• There is a massive expectation on "Healthwatch"! • We will not be able to afford what is needed • Concentrate on recruiting volunteers • Make sure there are standards • Make sure there is training • Challenge may be commitment to provide a quality service • Work with partners Doctors and hospital surgeries to ask "can you help someone else like you?" • Need to know the budget – note how Healthwatch can function in this • Health and Well-being Board – need to supply a wealth of information but need to know where to go to get it! • There is no voluntary sector rep on the Health and Well-Being Board – would like to explore this • Ever changing legislation and meetings meeting

Q3.	**WHAT ORGANISATIONAL STRENGTHS ALREADY EXIST IN MEETING THE INTENDED FUNCTIONS OF A LOCAL HEALTHWATCH AND HOW COULD THESE BE UTILISED IN A DELIVERY MODEL?**
Table 1	• There are lots of existing local organisations in Telford and Wrekin already fulfilling some of Healthwatch functions – needs mapping • Good existing volunteer body in Telford and Wrekin • Existing volunteer and organisation structures need to be the start point. • This is an opportunity to be creative and innovative and not just do the same that has gone before • Danger of national provider winning contract the local strengths might be ignored or lost

	• Income generation important but danger of conflict on interest. Healthwatch to remain independent.
Table 2	• Existing network of networks – strong some places and can grow (LINKS) and anyone • Strong volunteers trained enter and view, youth link (time it takes) mentoring and sharing of information • Demonstrable links to other networks – keyword how would you demonstrate that? • Expand LINKS – look for gaps • Awareness/relationships local commissioner/providers • Strong individuals • Model of training volunteers in other organisations i.e. WRVS • Robust ongoing training programme for volunteers • Patient Ref Groups in GP surgeries- a strength that can be mapped into local communities • Training/supporting • Linking up more within voluntary sector – interlinking • Got to be able to involve • Consortia – strong expertise – but strong functioning partnership – How! - triggers for partners • LA could influence how partnerships joined up working • Com members empowered and calling organisations to account. Collaborative Council approach. • Family member of service user when things go wrong so many barriers – need to move on.
Table 3	• Staffordshire Cares – is a good model to look at – a central database for information. Each provider is responsible for up-dating • Telephone contact is important. Healthwatch could hold the database. Every contact must count. E.g. if someone goes to library, librarian must know how to "access" database • 1 month email circular. Need 1 x lead for responsibility or central point responsible. • If part of consortia with part of pie will have incentive for committed input • Generate income/advertising • An "app" for access – younger people – need to think about access all age groups. • A marketing campaign – capturing people at there time of need. • What does Healthwatch have to offer teenagers – until an 'episode or event' affects their family. • Bus advertising • Admin/back office functions very important • Share some functions where appropriate (back office) with Shropshire • Too big for organisation. Need to be a partnership approach (must be representative) organisation may not be able to fulfil/function • Where are we going to get back office support, HR, employed staff? • What management structure would you have? Critical • Leadership is key (director role) • Right staff is important
Table 4	• How do we know all the organisations that are out there? • Tap into parish councils and neighbourhoods to spread word of mouth about what's happening. Church networks are useful. • Use schools to spread word too. • In Telford there is a strong LINK already with a strong leadership team.

Q4.	**HOW COULD A LOCAL HEALTHWATCH BE CREATIVE IN DEMONSTRATING BEST VALUE**
Table 1	• Clear core values and aims to enable income generation • Care needs to be taken to avoid conflict of interest when income generating • Economies of scale and collaboration with e.g. Shropshire or volunteer organisations (Network of networks) • Trading arm (income generation)being kept separate • Approach research/academic establishments for research funding • Charge for training

	• Apprenticeships and training • Best use of local knowledge
Table 2	• <u>Resources</u> • <u>Cost</u> • Building on things ongoing at the minute i.e. big local etc public health improvement • Addressing stronger governance – flatten staffing structure? • Encouragement to get best value • Got to indentifying 'greatest need' – not just priority geographical area - expand idea of communities • Targeted health inequalities? • Or universal service • What is this really • Get Healthwatch to answer everything you're baying at the moon • Careful clear analysis what is realistic and can be done - frustration of knowing need – what are our priorities to do that value • Tap into commissioning resources • Mandatory – face of organisation. Need to have training equality • Influencing skills – feedback • Consistency of training • Information gathering/research • Working together – silos and barriers gone experience link not siloing issues a consortia might separate too much.
Table 3	• Charging subscription (levels, charities for free etc) • Advertising • Contracting • Application for grants for specific projects • Demonstrate best value by demonstrating 'savings' to community • Consultation projects for statutory organisations • Retails (community well-being) – "Hub" • Festival • Service organisations (rotary, WI) – parish councils for project – town hall guild. Churches. • **NB – need to think about 'out-reach' service to hard to reach**
Table 4.	• **Conflict of interest?** • **How can be a watchdog and critic and review?** • **Could take away good will** • Patient Reference Group funding come from PCT • Healthwatch should not aim to do it <u>ALL</u> itself when there are other organisations who can do parts of it efficiently • Facilitator rather than service provider • Ways of generating income must be a priority at every stage • Fundraising? • Police for example may commission Healthwatch to carry out research for them • Could there be a Healthwatch kite mark that business could strive to achieve • Pre inspection 'enter and view' visit? • Lottery like hospice • Cross boarder working – second opinions

Q5	**WHAT WILL ORGANISATIONS NEED TO CONSIDER IN RECRUITING AND SUSTAINING A VIBRANT VOLUNTEER INFRASTRUCTURE?**
Table 1	• Cost • Cost of support to meet ➢ volunteering needs ➢ recruiting volunteers • Change in characteristics of volunteers (away from 'ladies that lunch' to volunteers who do so to

	add to CV) Questions: • How many volunteers are need to deliver Healthwatch function? • How much training? (and recruitment to sustain) • Reliability and if 24 hour how sustainable and reliability of volunteers? • Healthwatch could sub-contract functions to other organisations (which may already do similar) • Flexible timetabling – scheduling resources properly • Receptive marketing to raise awareness and recruit volunteers
Table 2	• Strong values – listen to them, evaluate their strengths, interests and skills • Training and support – robust – where do you draw line – enter and view • Request rather than order • Mentoring • Community development and health link to NHS/TCAT • Enter and View – value, ensure • Skills to work within environment • Use their skills • Empower volunteers through knowledge and opportunity • Risk management • Everyone has something to offer • Support for the support/coordinator volunteers risk • Proper supervision/counselling for distressing issues • Safeguarding – training and process • Interesting and appropriate you involvement and children • Need money • Working together – this is about peoples health! • Could it be an ethos everyone signs up to • Sustainability • Managing this so it does not take off in the wrong direction • Times and availability of organisations • Support/or volunteers • Referral for people – access easily – local not just central
Table 3	• Identify dedicated people • Need a "board" (salaried?) to support staff and volunteers • Campaign/consistent for recruitment • A dedicated staff member to support volunteers • A 'volunteer' contract – 6 month, input • Need to identify appropriate skill-mix (?) of volunteer and clear roles • Needs to be supported – supervision, training • Need a 'vibrant' volunteer office • Advertise roles – 'CV' • Link with universities 'for placements' for experience • Apprenticeships • "expenses" for volunteers need to be built into business model • Volunteers should be properly reimbursed • Need to make 'recruitment' relevant to them. They need to see value in their contribution. • Establish links into communities i.e. BME • Target eg diabetes champions • Recruit people where issue has meaning to them.
Table 4	• Reality is you need both! • Ownership - get all the community to own • Look at employees in Telford and Wrekin and ask them to consider their corporate social responsibility - promote volunteering to all staff – resettlement schemes • Using students during their degree course – placements are a good idea as they are then supervised by their tutors in some places • Resources for training and expenses • Time is needed to manage these groups once they are trained • CRB – can this be done centrally?

	ANY OTHER BUSINESS
Table 3	• Needs to be better at communicating our successes. • What “made a difference”

	POINTS TO BE DISCUSSED AT NEXT WORKSHOP

	• Actual practical delivery and KPIs
	• Cabinet member to be invited to next session
	• The actual budget
	  ➢ £114k per annum on link ringfenced
	  ➢ plus £40k 13/14
	  ➢ £10k one off start up
	  ➢ how long do we have this 3+1
	• Attendees list
	• Confirm who is on the evaluation panel
	• Provide outcomes prior to the next event
	• Skill sets need for the ‘Healthwatch’
	• Definition – local person re cross boundary or RSH
	• Working with other LA’s and do not duplicate
	• DONT GO BACKWARDS

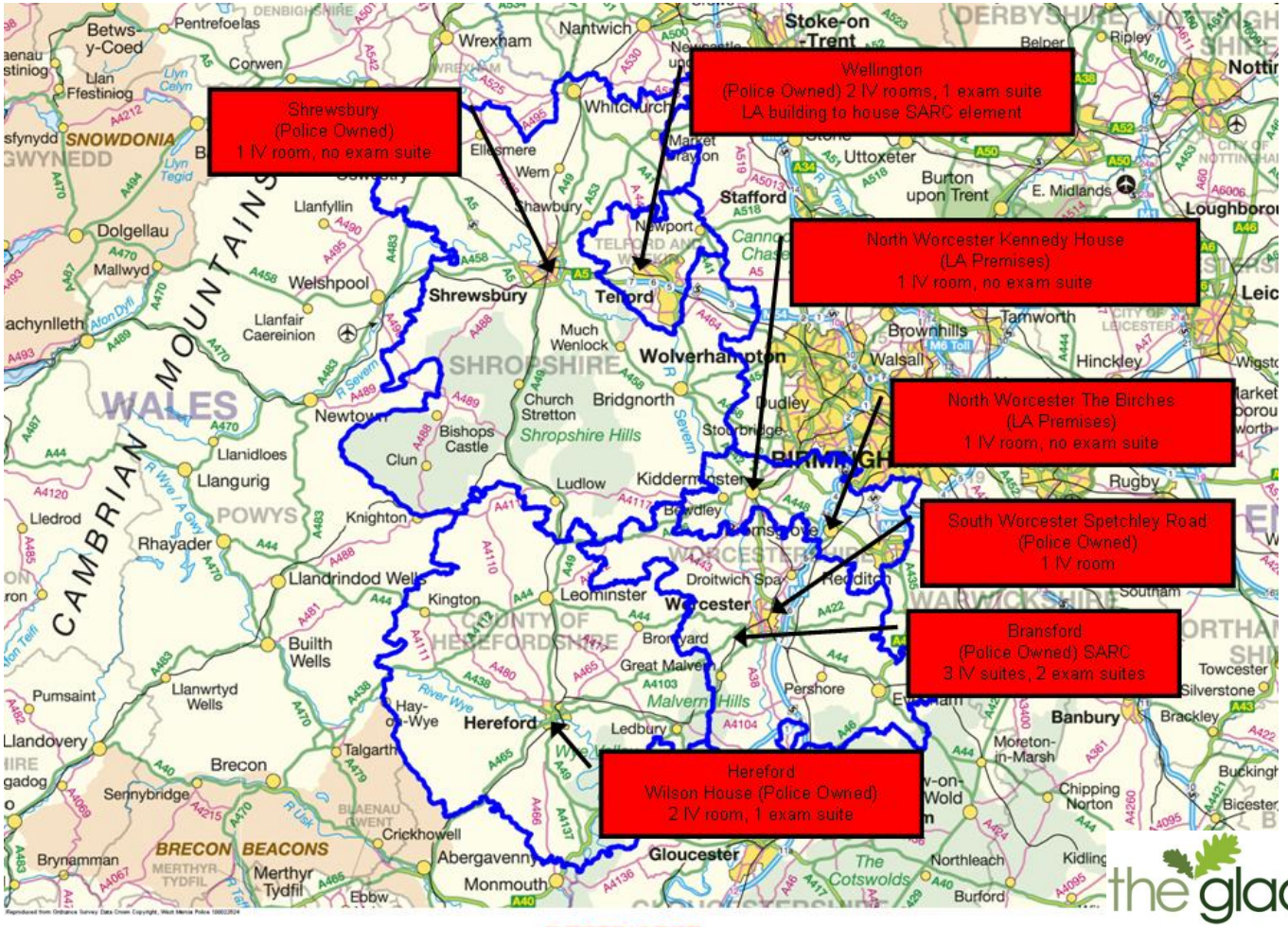
West Mercia SARC

Objectives

- To provide a holistic service for all victims of rape and serious sexual abuse.
- To ensure all victims have access to services.
- To provide a cost effective and sustainable service.
- To ensure services are within reach for all victims in our communities.
- To promote the recovery and health of victims following a rape.
- To streamline pathways to care.
- To improve confidence in the community to seek support after rape.
- To provide 24hr support
- To provide ability to self refer

the glade

Locations



RESTRICTED

Bransford

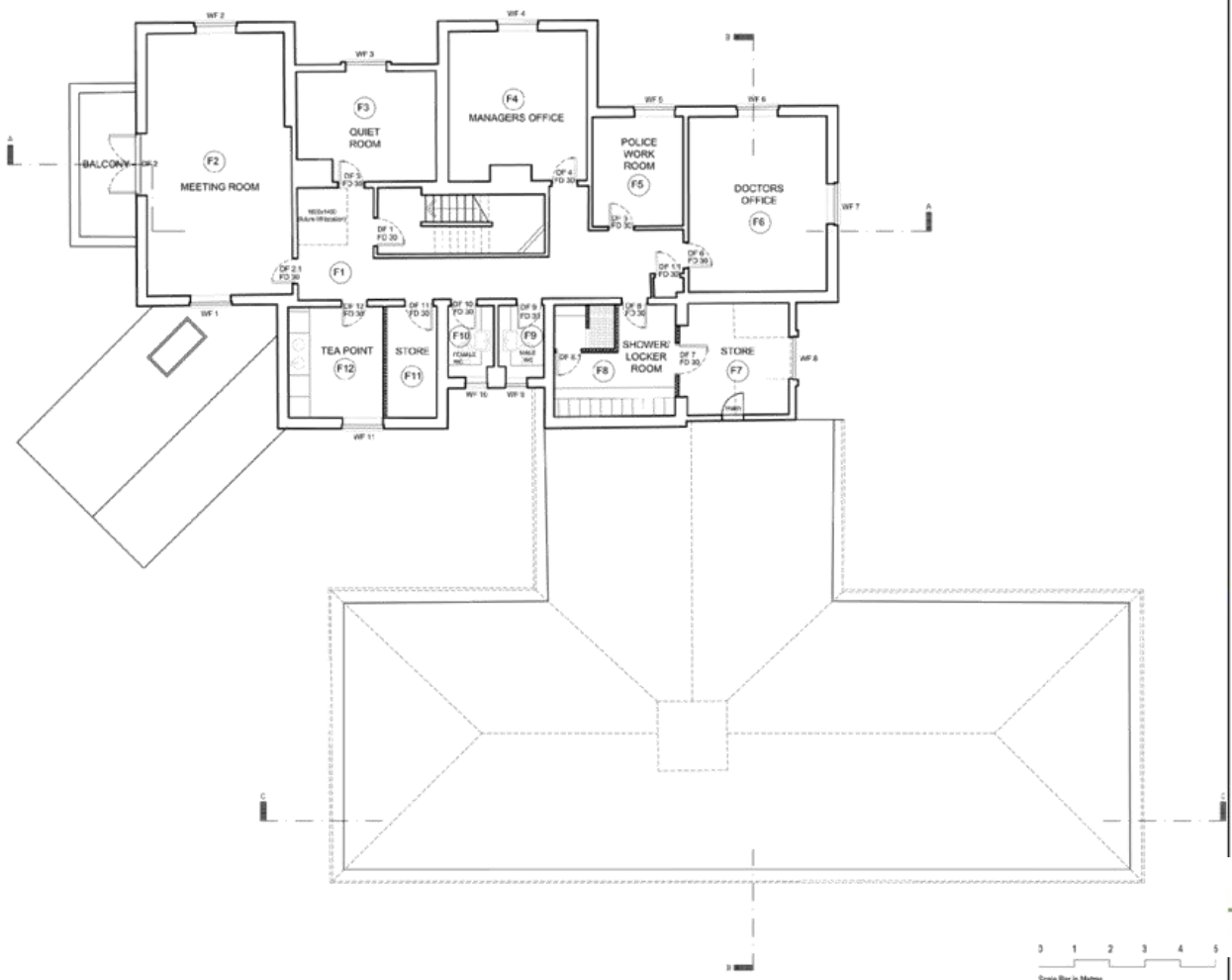
- 4 miles south of Worcs
- A4103
- 2 forensic suites
- Offices
- Counselling space
- Parking

- Significant investment into building
- New interview facility

the glade

Ground Floor Plan

First Floor Plan



(PROTECT-CONTRACTS)

BOUGHTON BUTLER

Client
West Mercia Police

Project
Works to Former Ambulance Control Centre

Title
First Floor Plan, Proposed Layout

the glade

Job No.	Dwg No.	Rev
1131	201	C2

Wellington

- West Road
- Use of existing facilities
- Conversion of space rented for SARC purposes
- On call facility
- Counselling space
- Good access for the North

the glade

Key Elements of the Service

- 24 hour access
- Crisis workers
- Choice of gender of Physician wherever possible
- Access to forensic Physicians
- Dedicated forensically approved premises
- Medical consultation including a risk assessment
- Immediate access to EHC PEP and follow up as needed
- Minimum dataset and appropriate data collection
- Coordinated interagency arrangements
- Access to ISVA
- Access to counselling

the glade

The benefits

- Victims seen in a dedicated caring setting
- Victim pathways clear between agencies, providing victims with more efficient service.
- Dedicated trained staff to complete full assessment of needs
- At Bransford a dedicated Paediatric suite with separate U10 and YP recovery rooms
- Clinical Governance of staff and forensic examinations.
- A ‘One Stop Shop’

the glade

Any Questions

Launch date 9th Nov

SAFE & SOUND South Worcestershire

Worcestershire Rape & Sexual Abuse Support Centre

West Mercia POLICE

TELFORD & WREKIN COUNCIL

HEALTH AND WELLBEING BOARD - SEPTEMBER 12th 2012

THE COMMISSIONING FRAMEWORK FOR DEMENTIA

REPORT OF SPECIALIST COMMISSIONER – COMMISSIONING CARE AND SUPPORT

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 This report provides background information on the national and local health and social care implications, (set out in the National Dementia Strategy, 2009) in supporting a person and their family carer, through their journey with dementia.

1.2 It provides a full and comprehensive up-date of progress in improving dementia services locally and is set within the context of the Commissioning Framework for Dementia, (Department of Health, 2011).

2. RECOMMENDATIONS

- Board members/members acknowledge and support dementia as a strategic priority across health and social care
- Board members/members support the proposal that the Health Economy Steering Group, responsibile for meeting expectations in the Commissioning Framework, should be accountable to the Health and Wellbeing Board and this should be reflected in the governance arrangements of the Steering Group
- Board members/members acknowledge good progress in implementing component parts of the National Dementia Strategy
- Board members/members acknowledge and support areas for accelerated improvement, specifically increasing diagnosis rates in Telford & Wrekin.

3. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="5">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to specific Priority Plan objective(s)?</td></tr>
<tr><td>Yes</td><td>Telford & Wrekin Council’s Medium Term Plan for 2012/13 to 2014/15

• Protect and support our vulnerable children and adults
• Improve the health and wellbeing of our communities and address health inequalities.

Telford & Wrekin Council’s Corporate Priority, Adult Social Care:

• Improve quality and range of Dementia services locally.

The Health and Wellbeing Board Draft priorities:

<u>Improve</u>

• Emotional health and wellbeing of borough residents
• People’s experience of health and care services
• Unpaid carers’ health and wellbeing.

<u>Support</u>

• People with specific health needs to live independently for as long as possible
• People with dementia.</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>Dementia is mainly a disease of people aged over 65 years but its impact on families and carers is far-reaching and can affect people of all ages.

The Dementia Deep Dive considered the needs of a range of people, which</td></tr>
</table>

		included; younger people with dementia, people with learning disabilities, people with alcohol-related dementia, people with other mental health problems (e.g. depression), people on low incomes and in poverty, minority ethnic groups, people living in isolated rural areas, disabled people and people living alone.
TARGET COMPLETION/DELIVERY DATE	The latestest policy reference point, (Prime Minister's Challenge on Dementia) advocates for quality improvements by 2015 but see Commissioning Framework (Appendix 2) for more details. Key milestone: From April 2013, there will be a quantified ambition for diagnosis rates across the country and there will be a new indicator in the NHS Outcomes Framework 2013/14.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes/No	Within existing resources and jointly commissioned across health and social care. See costs and impact on health and social care in the full report.
LEGAL ISSUES	N/A	
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	Financial risks relating to demographic increase and inappropriate crisis and use of unscheduled care, largely due to late diagnosis or no diagnosis at all. Inadequate investment aligned with raising prevalence widening the gap of unmet need. Reputational risks relating to failure to meet Prime Minister's Challenge on Dementia as performance becomes more widely publicised.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact.

PART B) – ADDITIONAL INFORMATION

4. INFORMATION

4.1 In 2009, NHS Telford & Wrekin and Telford & Wrekin Council, in partnership with stakeholders, people with dementia and their family carers developed a Dementia Care Pathway, (see Appendix 1) which set out the vision for good quality dementia care locally. This holistic, partnership approach was deemed good practice and features in the National Audit Office Report, (2010)[1] as an example of good joint-commissioning.

4.2 Since then, a detailed analysis of population need and service user and carer feedback was undertaken in the Dementia Deep Dive and fed into, the Joint Strategic Needs Assessment to inform future commissioning decision making. An action plan, setting out local implementation of the National Dementia Strategy was written and regularly presented to the Older Peoples' Partnership Board, Professional Executive Committee, Primary Care Trust (PCT) Board and Adult Social Care Board to provide assurances about progress in improving dementia services.

4.3 In 2011, two years after the publication of the National Dementia Strategy, a pan-Shropshire, Telford & Wrekin Action Plan was developed to accelerate improvement in specific areas such as; early diagnosis, standards of care in care homes, reduction of anti-psychotics, quality of care in hospital, workforce development and post-diagnostic support. These areas for improvement are reflected in the full progress up-date, attached to this document in Appendix 2.

4.4 The progress up-date (Appendix 2) has been written in the context of the Commissioning Framework for Dementia, which came into effect in July 2011 to support Clinical Commissioning Groups. It still reflects the objectives, originally set out in the National Dementia Strategy but benefits from drawing more closely on the expected journey with dementia, matched with outcomes and NICE quality standards and this is why commissioners have revised local plans, within this context.

4.5 The national commissioning framework for dementia sets out good quality dementia care across six phases of the anticipated journey with dementia. The summary table below highlights performance against these phases.

[1] National Audit Office Report, *Improving dementia services in England – an interim report, 2010*

High level-performance summary (Red, Amber, Green) of implementation of the National Commissioning Framework for Dementia, (Department of Health, 2011)

Phase 1
When memory problems have prompted me, and/or my carer/family to approach my GP with concerns.
Phase 2
Learning that the condition is dementia.
Phase 3
Learning more about the disease, options for treatment and care, self-management and support for me and my carer/family.
Phase 4
Getting the right help at the right time to live well with dementia, prevent crises and manage together.
Phase 5
Getting help if it is not possible to stay at home, or if hospital care is needed.
Phase 6
Receiving care, compassion and support at the end of life.

The Red, Amber, Green rating correspond with progress against expectations set out in the National Commissioning Framework for Dementia and NICE Quality Standards.

Red	Falling short of expectations
Amber	Demonstrable concern in fully or partially meeting expectations
Green	Meeting expectations

- For the full, detailed progress up-date, see Appendix 2

5. INFORMATION

5.1 Policy Context

A report by the National Audit Office in 2007[2] concluded that dementia services in England cost £8.2bn per year and were not providing value for money for the taxpayer, patients or carers. This report helped to trigger the development of the National Dementia Strategy in 2009[3]. Other key guidance on how to deliver high-quality care for people with dementia and their carers include the NICE-SCIE clinical guideline (2006)[4], the Alzheimer's Association report *Dementia UK* (2007)[5], the 10 quality standards for dementia produced by NICE in 2010[6] and the Common core principles for supporting people with dementia, a guide to training the social care and health workforce, produced

[2] National Audit Office (2007) *Census of CMHTs.*
[3] Department of Health (2009) *Living well with dementia: A National Dementia Strategy.*
[4] National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (2006) *Dementia: Supporting people with dementia and their carers in health and social care.*
[5] Alzheimer's Society (2007) *Dementia UK: The full report* The Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London.
[6] National Institute for Health and Clinical Excellence (2010) *Dementia quality standards*

by Skills for Care, Skills for Health and the Department of Health in June 2011[7].

More recently, in March, 2012 the Prime Minister launched the National Challenge on Dementia, to escalate major improvements in dementia care by 2015, (Department of Health, 2012).[8] This document makes 14 Key Commitments to the improvement of health and care services which includes; (relevant to this report):

Key commitment 1
Increased diagnosis rates through regular checks for the over 65s *From April 2013, there will be a quantified ambition for diagnosis rates across the country, underpinned by robust and affordable local plans.*

Clinical commissioning groups and local health and wellbeing boards will be encouraged to work with wider local partners to improve diagnosis rates. The Department of Health will incentivise improved diagnosis rates by including a new indicator in the NHS Outcomes Framework 2013/14.

Key commitment 2
Financial rewards for hospitals offering quality dementia care *From April 2012, £54m will be available through the Dementia CQUIN to hospitals offering dementia risk assessments to all over-75s admitted to their care. From April 2013, this will be extended to the quality of dementia care delivered. Also for April 2013, access to CQUIN rewards will be dependent on delivering support for carers in line with NICE/SCIE guidelines.*

Key commitment 5
Promoting local information on dementia services *The Department of Health will promote the information offer pioneered by the NHS South West, which will be launched on 28 March 2012 and rolled out across the south by the end of 2012. From April 2013, similar information will be available in all other parts of the country.*

Key commitment 6
Dementia-friendly communities across the country *By 2015, up to 20 cities, towns and villages will have signed up to become more dementia-friendly.*

Key commitment 8
Awareness-raising campaign *From autumn 2012, The Department of Health will invest in a nationwide campaign to raise awareness of dementia, to be sustained to 2015. This will build on lessons learned from previous campaigns and will inform future investment.*

[7] Skills for Care, Skills for Health (2011) *Common core principles for supporting people with dementia.*
[8] Prime Minister's challenge on dementia *Delivering major improvements in dementia care and research by 2015 – Department of Health March 2012*

5.2 Outcomes

Outcomes have been developed by NICE (National Institute for Health and Clinical Excellence) Dementia quality standards[9] and *Quality Outcomes for people with dementia: building on the work of the National Dementia Strategy* (Department of Health, 2010).

5.3 Dementia

Dementia is caused by structural and chemical changes eventually leading to the death of brain cells which causes a progressive loss of a person's mental functions which are necessary to live independently and safely. The most common form of dementia is Alzheimer's disease, (60%) with vascular dementia second most common (15-30%)[10].

5.4 Prevalence

Because many people have not received a formal diagnosis, we can only estimate the actual number of people with dementia. However, it is known that the number of people with dementia is increasing as the proportion of elderly people in the population increases. In 2007, the Alzheimer's Society estimated that there were 750,000 people in the UK with Dementia.

In 2011, it was estimated that 1,691 people were living with dementia in Telford & Wrekin. This is estimated to increase by 45% leading to 2,448 people with dementia by 2021.

Only 38.1% of people with dementia had a diagnosis in 2011, which means that 1,047 people did not receive a diagnosis. This represents Telford & Wrekin as one of the poorest performing PCTs/CCGs in the UK, ranking 134 lowest out of 176[11].

However, it is also one of the PCTs/CCGs showing the most improvement, demonstrating a 3.7% increase in diagnosis rates for 2010-11[12].

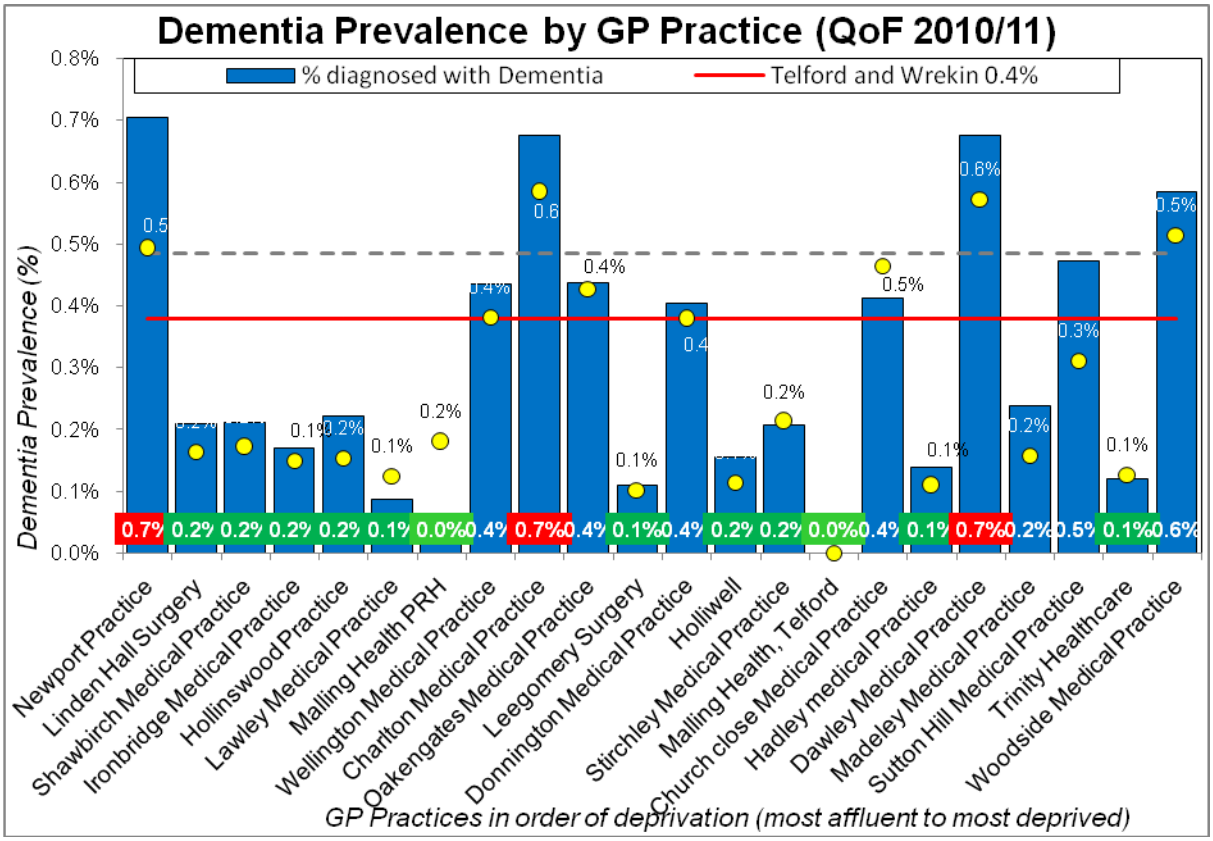
[9] National Institute for Health and Clinical Excellence, www.nice.org.uk/aboutnice/qualitystandards/dementia/

[10] Spotlight on DEMENTIA CARE, *A Health Foundation improvement report,* Health Foundation, October 2011

[11] UK ranking (1=highest 176=lowest), Alzheimer's Society, *PCT dementia prevalence and diagnosis rates*

[12] Improvement ranking of 29 (1=most improved, 163=least), Alzheimer's Society, *PCT dementia prevalence and diagnosis rates*

Table 1 Dementia prevalence and diagnosis data for Telford & Wrekin using GP QOF data for 2010/11.



5.5 Prevention

Certain risk factors have been associated with the development of dementia. Dementia can be caused by mini strokes and factors that increase the risk of stroke can also increase the risk of dementia – such as smoking and diabetes. This means that treatments that reduce the risk of heart disease and stroke also have the potential to reduce the risk of vascular dementia. Better prevention and treatment of cardiovascular disease may mean that fewer of the middle-aged people currently receiving these treatments will develop dementia as they age.

5.6 Cost of dementia care

Costs of care for people with dementia in the UK were calculated to be almost £23bn in 2008[13]. The annual cost of care for each person with dementia is higher than the median salary in the UK, and is higher than the annual cost of care for a person with cancer, heart disease or stroke combined[14].

The costs of providing dementia care are largely those required to provide support and care for activities of daily life, rather than medical treatments, so the costs associated with it, are predominantly social care[15]. 40% of the total

[13] Alzheimer's Research Trust (2010) *Dementia 2010 The economic burden of dementia and associated research funding in the United Kingdom*

[14] *Ibid*

[15] Spotlight on DEMENTIA CARE, *A Health Foundation improvement report,* Health Foundation, October 2011

costs are for long-term residential social care and 55% for informal care. Only 5% are for primary or secondary healthcare or medication costs for dementia[16].

However, dementia is mainly a disease of people aged over 65 years and older people will often have other health needs, therefore, poor coordination of health and social care services, leads to avoidable hospital admissions, prolonged length of stay as a hospital inpatient and increased need for residential care[17]. In 2008, there were 7m GP consultations for people with dementia, half of which were home visits. Almost 300,000 were visits to emergency departments and 490,000 were outpatient consultations for people with dementia. An estimated 1.5m inpatient bed-days were for dementia itself and an additional 4.2m bed-days were for other problems of people with dementia (as a secondary diagnosis), at a total healthcare cost of £1.2bn[18].

This is often compounded by care and support provided to people with dementia and their carers being inadequate because the disease goes undiagnosed.

It is nationally recognised that cost data is under-reported[19] but estimated costs in Telford & Wrekin suggest direct service expenditure in the region of £10,558,000 across Health and Social Care[20]. However, in the absence of comprehensive data related to resource deployment and activity levels, it is difficult to quantify with any certainty the resources allocated specifically to dementia by the NHS and the Council. It should also be noted that many costs are hidden. For example, most care is provided by informal carers, who have reduced earnings and make smaller tax payments and estimating the true cost of this is difficult.

With increased diagnosis rates and improved quality of care, as the national Dementia Strategy, NICE/SCIE guidelines are implemented; cost savings may be possible within several years. In the meantime, implementation is likely to add to the total cost of care.

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[16] *Ibid*

[17] National Audit Office reports of 2007 and 2010

[18] Alzheimer's Research Trust (2010) *Dementia 2010 The economic burden of dementia and associated research funding in the United Kingdom*

[19] Spotlight on DEMENTIA CARE, *A Health Foundation improvement report,* Health Foundation, October 2011

[20] Joint Strategic Needs Assessment, *Dementia Deep Dive, NHS Telford & Wrekin and Telford & Wrekin Council, 2010*

5.7 Interventions which reduce costs

Table 2 Estimated UK costs of care for people with dementia and potential savings, Spotlight on DEMENTIA CARE, A Health Foundation improvement report, Health Foundation, October 2011.

	Estimated Costs	Potential Savings
Healthcare costs	Direct healthcare costs £8bn a year in UK. Memory clinic service for early diagnosis: £220m a year in England.	Cost saving after six years if use of memory clinics for early diagnosis leads to 20% or more reduction in need for residential care.
	Anti-Alzheimer drugs: £720 per patient per year (assume £60 per month). 18 Excess bed-days in acute hospital: £1,400 per week. Clinical leader to implement dementia care pathway in every acute trust: £3m a year in UK.	12% reduction in need for residential care in people with mild to moderate dementia treated for six months or longer. £117m if length of stay is reduced by seven days for every inpatient with dementia admitted for fractured hip, chest infection, urinary tract infection or mini stroke. £700m if length of stay reduced by two days for every inpatient with dementia by providing psychiatrist-led multidisciplinary assessment, or intermediate care. Assuming 25% of people aged 60+ admitted have dementia, and excess bed cost is £200 per day. £38m from seven day reduction in hospital admissions from use of hospital at home scheme. £400 per patient whose length of stay is reduced by two days from use of psychiatrist-led assessment of all elderly patients admitted to hospital.
	Inappropriate use of medication: £84m a year for 140,000 people in England given antipsychotic drugs who are unlikely to benefit and may be harmed by them.	£84m a year from stopping inappropriate use of antipsychotic drugs (assume £600 for one year's treatment per patient).
Social care (local authority) costs	Long-term residential care: £9bn a year in UK. Community social service costs: £2.4bn. Home care: £150 per week. Day care: £90 per week. Residential care: £500 per week, £26,000 per year.	18% fewer people needing residential care after two years with care management to coordinate health and social care. £14,000 reduction in costs of residential care from psychosocial care given to carers (200 day delay in need for residential care).
Costs to the patient, family and other informal carers	Costs of informal care: £12bn a year for UK. £270 per patient per week if carer time estimated at minimum wage.	£1,280 saved per patient over three months from an occupational therapy training service for carers.

5.8 Patient Experience

Late diagnosis or at worst, no diagnosis at all, means that people with dementia and their family carers are not helped and advised in the early stages when, with that support, crisis and the subsequent need for intensive services could be avoided.

The following risks therefore impact on patient, service-user and carer experience and the costs on the NHS and social care system:

1. the high number of people who are never diagnosed, or are diagnosed late so they don't benefit from early support
2. the lack of coordinated care
3. the lack of resources to keep people safe at home and to support carers adequately
4. inappropriate care in hospitals and care homes, in particular the use of medication to sedate patients
5. inadequate training of staff and carers
6. poor quality end-of-life care.

5.9 Carers

There are around 550,000 people in England acting as the primary carers for people with dementia and they save the nation nearly £7 billion every year.

Research shows that carers of people with dementia experience greater strain and distress than carers of other older people. The Dementia Deep Dive identified that Carer 'Burn-out' represented one of the key determinants for a person with Dementia being admitted to the Redwoods Centre.

The NHS is now required to work closer than ever before with local carers' organisations and councils to agree plans, pool their resources and make sure that carers get the support and break they deserve. The Department of Health has provided an additional £400m to the NHS between 2011 and 2015 to provide carers with breaks from their caring responsibilities to sustain them in their role.

6. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

6.1 The Dementia Deep Dive considered the needs of a range of people with dementia to ensure their specific needs were met. These groups included:

- **Younger people with dementia**
  Numbers are relatively small in Telford & Wrekin rising from 44 estimated cases in 2009, to 51 cases in 2019. Small scale services currently exist.

- **People with learning disabilities**
  People with Down's syndrome are at high risk of developing dementia at a younger age; however, the Deep Dive analysis suggests that numbers in Telford & Wrekin will remain small, rising from 6 in 2009, to 7 in 2019. Joint Commissioners across Older People, Mental Health and Learning Disabilities continue to investigate good practice in models of care and local alternatives.

- **People with alcohol-related dementia**
  Work is underway by the Commissioning Substance Misuse Team to define the level of need in Telford & Wrekin.

- **People with other mental health problems (e.g. depression)**
  The service re-design model for early intervention in dementia will address functional mental health issues such as depression and anxiety.

- **People on low incomes and in poverty**
  The Older Adults Strategy, (which includes Dementia) prioritises assisting people to access benefits and entitlements and Joint Commissioning currently purchase specialist support from AgeUK Shropshire, Telford & Wrekin.

- **Minority ethnic groups**
  Joint Commissioning commissions AgeUK, Shropshire, Telford and Wrekin to provide a BME Neighbourhood Contact Officer, who has received Dementia training. Wider connectivity occurs throughout health promotion and social care, to ensure engagement and access to services.

- **People living in isolated rural areas**
  Joint Commissioning commissions AgeUK, Shropshire, Telford and Wrekin to provide a Dementia Neighbourhood Contact Officer, to identify people at risk of social isolation and support them in accessing mainstream and other services.

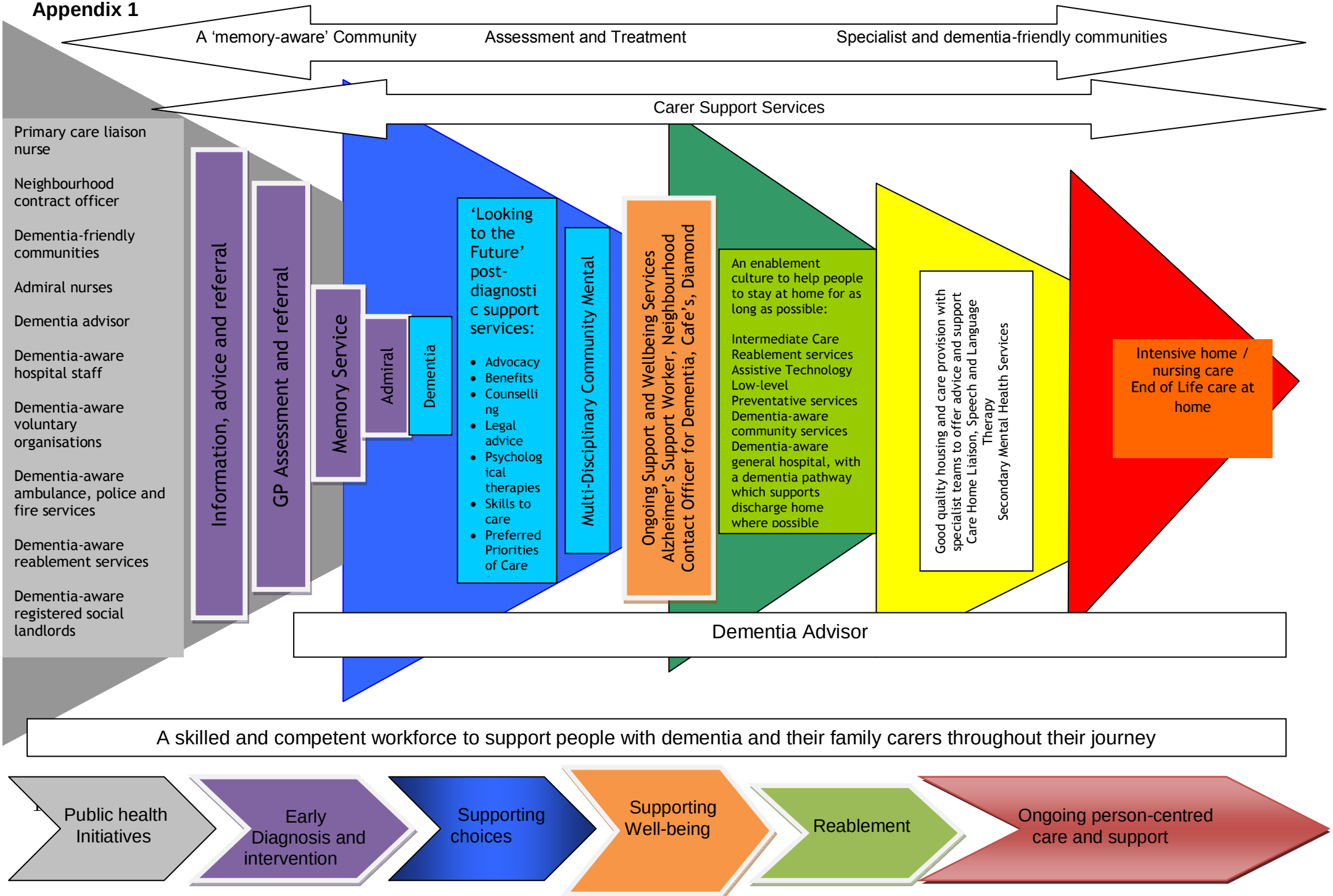
- **Disabled people**
  Joint Commissioning continues to lead on the transformation of rehabilitation and re-ablement services, which will provide access and support for people with dementia.

- **People who live alone**
  A range of options are being considered to support people living alone with Dementia, who want to continue to live at home. These include; specialist domiciliary care, assistive technology and investigating models of compassionate communities.

Report prepared by Kim Grosvenor, Specialist Commissioner,
Telephone: 01952 388916

Appendix 1

Whole System Commissioning Pathway for Dementia



Appendix 2 Progress against Commissioning Framework for Dementia (2010-12)

The Red, Amber, Green ratings correspond with progress against expectations set out in the National Commissioning Framework for Dementia and NICE Quality Standards.

Red Falling short of expectations

Amber Demonstrable concern in fully or partially meeting expectations

Green Meeting expectations

Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 1 When memory problems have prompted me, and/or my carer/family to approach my GP or other primary care practitioner with concerns.	Outcomes/NICE Quality Standard 1,2,3 • I am confident that my primary health care worker/GP has taken my concerns seriously. S/he understands the nature and cause of memory problems and will refer me quickly for an appropriate assessment if needed. • I can access a range of information and guidance in the community about memory problems, as well as resources to support me and my family. • My GP/primary health care worker work with me to help me to stay well and live well.	Objective 1: Improved public and professional awareness and understanding of dementia	GPs and primary health care teams: 1. Have a comprehensive understanding of memory problems and dementia – and appreciate the value of early diagnosis and are aware of the assessment and treatment options as well as the potential for living well with dementia. 2. Know how to promote living well with dementia 3. Understand and recognise the role and support needs of carers. 4. Ensure that there is prompt referral and easy access to a memory service. 5. Has access to an up-to-date directory of community services and support, which is provided in a range of media. 6. Supports dementia awareness which is actively promoted in the local community.
Achievements against outcomes (2010-12)		**RAG Rating**	**Accelerated areas for improvement:**
• Public and professional awareness-raising has been undertaken by multi-agencies and Joint Commissioning, in partnership with Corporate Communications within NHS Telford & Wrekin and Council. This has included a press campaign, linked to World Alzheimer's Day (September, 2010/11), Radio Interviews (January and August 2010), Public Events, (Town Centre and Senior Citizen's Forum) and internal communications, 'Worried about your Memory', Telford & Wrekin Council Bulletin. • Consultant Psychiatrist Dr. Sarah Lyle, South Staffordshire and Shropshire Mental Health Foundation Trust, (SSSFT) has delivered a number of sessions to GPs and Primary Care staff			1. Promoting local information on dementia services, (Key Commitment 5 of the Prime Minister's Challenge on dementia) Planned activities for 2012 include; launch of the Dementia Passport, (October, 2012) and publication of the Dementia Service Directory (November/December 2012). **Responsible Officer: Kim Grosvenor, Specialist Commissioner**

through protected learning sessions and workshops at the Redwoods Centre. • The South Staffordshire and Shropshire Mental health Foundation Trust were commissioned to deliver a programme of education and awareness raising to schools and large employers in Telford and Wrekin. (DARE Project) Specific initiatives, commissioned within the Dementia Pathway focus on sustained public and professional awareness raising, these include, but are not limited to: • Primary Care Liaison Nurse, (SSSFT) • Expansion of the Admiral Nurse Service (Shropshire Community Health Services). These two posts have a dual role of providing specialist support to carers' of people with dementia and delivering professional education. Strategic planning of professional education and delivery is facilitated through the Admiral Nurse Steering Group. • Development of Care Home Liaison, Hospital Liaison and RAID initiative within Princess Royal Hospital (South Staffordshire and Shropshire Mental Health Foundation Trust) to deliver professional education within the Independent and Acute Sector respectively. • Commissioned 30 copies of Practice Development Guide to support staff working with people with a learning disability and dementia. • Commissioned a SaTH information leaflet for public/patients and carers of people with dementia, admitted to the general hospital and professional education, (modular through Staffordshire University for key members of staff and general awareness-raising for members of staff likely to come into contact with a person with dementia). Other commissioned services will continue to deliver information, advice and professional education to public and professionals. These include; Dementia Advisors, Nurse Advisor Role within the Independent Sector and AgeUK Neighbourhood Contact Officer.		2. Reviewing the existing Primary Care Liaison Role (SSSFT) and associated GP Programme of support and education. (March 2013) **Responsible Officer: Michael Bennett, Lead Commissioner for Mental Health**

Commissioning Framework Phase	Outcomes/NICE Quality Standard	National Dementia Strategy Objective	What people should expect:
Phase 2 Learning that the condition is dementia.	Outcomes/NICE Quality Standard 3,4 • I don't have to wait long for an assessment, and I have the option of having the assessment at home. • I am confident that any tests that I have are necessary. • I have a choice about whether I receive a formal diagnosis. • If I am given a diagnosis, it is delivered with sensitivity. • I am able to discuss the condition (and possible diagnosis) with a health professional; my questions and concerns are addressed; and I receive relevant information at the right time for me and in the right way for me. • As a carer/family member, my contribution and experience inform the assessment, and next steps. My own information and support needs are considered and addressed.	Objective 2: Good quality early diagnosis and intervention for all	1. Prompt access to skilled professionals for people with advanced and/or complex presentations. 2. Assessment where required, in preferred place (including home). 3. Investigations to inform assessment. 4. Timely diagnosis delivered with respect and sensitivity. 5. Information and support to establish what the next steps will be. 6. Signposting to resources. 7. The GP to be informed and involved in continuing and longer-term review and management.
Achievements against outcomes (2010-12)		**RAG Rating**	**Accelerated areas for improvement:**
• Additional investment to increase capacity of the memory service was achieved under the Modernisation Agenda in March 2010. This has enabled the move away from a 'clinic-focused' model to a community-based Memory Service offering comprehensive assessment, diagnosis and management with a wide range of medical, psychological and social interventions. • In 2011, the Memory Service participated in the National Accreditation of Memory Services (Royal College of Psychiatrists) and achieved an accreditation of Excellent rating. • A GP Lead, Dr Mark Rousseau has been appointed as the Primary Care Lead for Dementia.			1. Increasing diagnosis rates through regular checks for the over-65s (Key commitment 1 of the Prime Minister's Challenge on dementia) This will require a revised approach to early identification and assessment and a rapid review of demand and capacity and alternative service models. (January 2013). Charlton Medical Practice is utilizing development funds to Pilot the Cambridge Cognition CANTAB Tool for early diagnosis of Dementia. The Practice will circulate the findings, following the 6-month Pilot, for wider implementation across Primary Care. Review findings of CANTAM Pilot, (November 2012) and consider agreed screening protocol by GP Practices in Telford & Wrekin.

			Responsible Officer: Michael Bennett, Lead Commissioner for Mental Health, in partnership with public health colleagues Embed the Primary Care Pathway for Dementia supported by a comprehensive programme of education for Primary Care staff. (November 2012). 2. Maximise opportunities for screening risk factors such as coronary heart disease, stroke and diabetes, during a patients' annual review. (July 2013). **Responsible Officer: Michael Bennett, Lead Commissioner for Mental Health in partnership with public health colleagues** Consider a model of service delivery which maximises use of available resources, including Public Health Screening and IAPT service provision, (Evidence-based) in the identification and management of Mild Cognitive Impairment. (July 2013). **Responsible Officer: Michael Bennett, Lead Commissioner for Mental Health in partnership with public health colleagues**
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 3 Learning more about the disease, options for treatment and care, self-management and support for me and my carer/family.	Outcomes/Nice Quality Standard 4,5,6 • My personal circumstances, and my needs, preferences, strengths and assets are acknowledged and understood. • My carer's/family's needs and concerns are considered and advice, support and help are available to them. • I am helped to understand what I need to know and want to know about the disease, treatment options, and support available to me and my carer/family.	Objective 3: Good quality information for those diagnosed with dementia and their carers Objective 4: easy access to care, support and advice following diagnosis	1. A knowledgeable, skilled practitioner will assess people's needs, strengths and aspirations. 2. A care plan based on this assessment will be developed collaboratively with the knowledgeable practitioner, the person with dementia and the family, and the care plan will be shared with the GP. 3. GPs and primary health care teams: a. are aware of and involved in the assessment and treatment plans and in longer-term review and management; they

	• I know who to contact for more information, guidance and support as my needs change. • I feel confident that effective help and support is available to me now and as my condition develops, to help me live life as fully as possible. • I know what the next steps are; and I have a care plan that reflects my strengths, wishes, preferences and lifestyle, as well as my needs. • I understand the range of issues I need to think about and plan for and what to do to ensure that my wishes for future care options are respected. • My GP is informed about my condition, s/he contributes to my care plan, and we review my needs regularly to help me to stay well and live well.	facilitated by a dementia advisor	know how to promote living well with dementia b. understand and recognise the role and support needs of carers. 4. Carers' needs will be assessed, including the need to stay in employment and the time, availability and other constraints that employment might involve. 5. There is a single point of access to specialist help and advice when needed, with clear contact details using a variety of methods (email, internet, phone etc) and help is available 24/7. 6. Access to up-to-date information about community services and support, provided in a range of media. 7. Dementia awareness is actively promoted in the local community. 8. Signposting to resources and community activities/groups. 9. Carers have access to education and support.
Achievements against outcomes (2010-12)		**RAG Rating**	**Accelerated areas for improvement:**
• The Alzheimer's Society has been commissioned to deliver a Dementia Advisor Service encompassing salaried workers and a pool of volunteers to deliver information and advice, pre and post-diagnosis. • Specific initiatives, commissioned within the Dementia Pathway focus on a continued programme of professional education and awareness raising, these include, but are not limited to; the Primary Care Liaison Nurse, (SSSFT), Admiral Nurse Service (Shropshire Community Health Services, Care Home Liaison, (SSSFT), Speech and Language Therapy Service, Shrewsbury and Telford Hospitals Trust, (SaTH) and the RAID (SSSFT) initiative within Princess Royal Hospital. • A model for delivering 'Looking to the future' services, as recommended by the West Midlands Pathway Development Group, has been developed with service users and providers in Telford & Wrekin. • Education and training about living with dementia for carers and people with dementia, tailored to particular groups is commissioned			1. Improve rates of identification and diagnosis Review and re-design Alzheimer's Advisor Service to focus on up-stream signposting and intervention. (November 2012) **Responsible Officer: Kim Grosvenor, Specialist Commissioner** Planned activities for 2012 include; launch of the Dementia Passport, (October, 2012) and publication of the Dementia Service Directory (November/December 2012). **Responsible Officer: Kim Grosvenor, Specialist Commissioner**

through the Alzheimer's Society, AgeUK and Admiral Nurse Service.			
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 4 Getting the right help at the right time to live well with dementia, prevent crises and manage together.	Outcomes/NICE Quality Standard 1,6,7,8,10 • I can access a range of services to enable me to remain at home as long as possible. • People who support me at home understand my condition and know how to help prevent, modify or make adjustments to manage any behaviours that challenge. • People who support me help me to live as independently and actively as possible. • I can remain involved with my friends and my community. I enjoy life. • My choices and preferences for living my life are respected and I am involved in decisions about my life. • I can access a range of information and guidance in the community about memory problems and resources to support me and my family. • My GP/primary health care worker will work with me to help me to stay well and live well. • As a carer, I can access support, including training, to help cope with the ongoing role of caring for a person with dementia. • As a carer, I have early and flexible access to different types of respite. The respite options suit me and the person I am caring for. • They enable me to live well, to continue to provide care and for the person I care for to continue to live at home. • As a carer, I know who to contact in an emergency.	Objective 5: Structured peer support and learning networks Objective 6: Community personal support services Objective 7: Services within the Carers' Strategy Objective 13: an informed and effective workforce across all services	1. GPs, primary care teams and social care services: a. have a comprehensive understanding about memory problems and dementia b. are aware of the assessment and treatment options and of the potential for living well with dementia c. know how to promote living well with dementia d. recognise the changing needs of people with dementia as the condition progresses and know how to access specialist dementia help, when required, to manage those needs effectively e. understand and recognise the role and support needs of carers as dementia progresses and can respond effectively. 2. Specialist dementia therapies and treatment options are available and accessible. 3. There is a range of practical support including respite, social care and assistive technology for people with dementia and carers. 4. There is access to an up-to-date directory of community services and support which is provided in a range of media. 5. Dementia awareness is actively promoted in the local community.

Achievements against outcomes (2010-12)	RAG Rating	Accelerated areas for improvement:
• A menu of peer support and learning networks for carers has been developed and commissioned in Telford & Wrekin including; Caring with Confidence and Looking after Me. • AgeUK, Shropshire, Telford & Wrekin has developed a 'Dementia Drop-in', from fundraising through their Diamond Appeal. These drop-in centres will offer Peer Support, as a core component of the service offer. • 'Listen, Not Label' User Led Organisation was launched in Telford & Wrekin in April 2010. • The Admiral Nurse service supports a number of community based initiatives, which encourages peer support, together with psycho-education e.g. T-4-2 at Meeting Point House. • The first Dementia Café, (Horizons) was launched in September 2010, at Lightmoor View and promotes peer support and activities which enhance wellbeing. A number of other providers also routinely promote peer support, as part of their service offer e.g. Millbrook Day Centre. • The transformation of rehabilitation and reablement services across health and social care has ensured a clear strategic focus, backed-up by operational services, in the support of people with dementia. (See Rehabilitation and Reablement Strategy and Draft Falls Prevention and Bone Health Strategy). This includes access for people with Dementia to Intermediate Care beds and a dementia-specific Intermediate Care Support Worker. • Commissioners have reconfigured existing resources to provide a Neighbourhood Contact Officer for Dementia (employed by AgeUK), to link people living at home, with their communities to maximise personal skills, independence and wellbeing. • Telford & Wrekin Council has been commissioned to deliver a 'creativity in dementia' programme and to lead on the development of a model for 'Dementia-Friendly' Communities. A full evaluation of the programme will be launched by a public event in the Autumn 2012.		1. Dementia-friendly communities across the country (Key commitment 6 of the Prime Minister's Challenge on dementia) Work with an external agency to develop a validated wellbeing tool to capture a robust evidence-base for the benefit of creativity contributing to wellbeing for people with dementia and their family carers. (January 2013) **Responsible Officer: Kim Grosvenor, Specialist Commissioner** To integrate the dementia-friendly communities model, (Piloted at The Place, Oakengates) within the wider community and to develop the 'creative-space' concept for carers and people with dementia, at the Theatre. (June 2013) **Responsible Officer: Kim Grosvenor, Specialist Commissioner** 2. To develop a 24/7 Crisis Resolution and Home Treatment Team. (April 2013) **Responsible Officer: Michael Bennett, Lead Commissioner for Mental Health** **3.** Up-date and re-fresh of the Telford & Wrekin Carers' Strategy. **Responsible Officer: Jill Tiernan, Commissioning Officer for Carers** 4. Continue to support therapeutic interventions, which may support the reduction of anti-psychotic medication. (Evaluation August 2013). 5. Review and up-date the Health Economy Action Plan for Dementia. (November 2012). **Responsible Officer: Michael Bennett, Lead**

• Specialist day opportunities offering holistic day care, carers' cafes and falls prevention programmes are currently offered at Millbrook Day Centre and Newport Cottage Care for example, together with a range of good quality domiciliary care e.g. Homeinstead and Next Generation Healthcare. • Through the modernisation of Mental Health Services and additional investment, the Memory Service and Community Mental Health Teams can now provide improved support in the community, to prevent admission and facilitate discharge from hospital. A Crisis Resolution and Home Treatment service for people with dementia, is currently being developed. • New and better housing options are being developed in Telford & Wrekin, e.g. Lightmoor View and Parkwood Extra Care Support which focus on inherent aspects of living well with dementia including, minimum transfers, avoidable hospital admissions and wrap-around care and support. This includes support from Community Nursing, Nurse Advisor post, Psychiatry-led 'Clinics' and the Care Home Liaison Service. • A Speech and Language Therapy service for people with dementia living in the community has been commissioned from SaTH. • Carer's Café's have been developed throughout T&W as part of the community model for dementia and a number of voluntary agencies are commissioned to provide generic and dementia-specific carer support services. In addition, a 24/7 Emergency Response Service has been tendered and is now available in Telford & Wrekin. *(Full details of local services can be seen in the local Carers' Strategy and Action Plan, which is currently being up-dated and refreshed.)* • Assistive Technology has been main-streamed in Telford & Wrekin Council, building on the previous pilot projects undertaken to support people with dementia, living in their own home. An initial range of equipment has been identified. Work is ongoing with teams to develop and embed provision as a mainstream service. Key strands are operational procedures, workforce development, public information and performance monitoring. • NHS Telford & Wrekin undertook an audit of anti-psychotic prescribing in 2010 and subsequently, Medicine's Management, developed		**Commissioner for Mental Health and Kim Grosvenor, Specialist Commissioner** 6. Workforce Development A full programme of education and training will be rolled out from November/December 2012 (first round) with an independent evaluation of impact on organisational practice undertaken by Staffordshire University. The competency framework and training pathway needs to be publicised and widely circulated. (June 2013). **Responsible Officer: Kim Grosvenor, Specialist Commissioner** 7. Psychological therapies Evaluation of the Cognitive Stimulation Pilot, (Alzheimer's Society) to be considered as part of prioritisation of funding for the future. (March 2013). **Responsible Officer: Kim Grosvenor, Specialist Commissioner** 8. Primary Care Management of people with Dementia living in the community, (including residential and nursing homes) Evaluation of the risk-stratification pilot to be presented to the CCG for consideration of future funding and wider implementation. (March 2013) **Responsible Officer: Michael Bennett, Lead Commissioner for Mental Health**

shared-care prescribing protocols. In 2012, the audit of anti-psychotic prescribing was undertaken again and some improvements have been made. A full action plan for the reduction of anti-psychotics features as part of the Health Economy Action Plan for accelerated improvement. • A multi-agency Dementia Workforce Steering Group has developed a health and social care competency framework for people working with people with dementia, together with a training pathway. The tender of a comprehensive education and training programme is in the process of being awarded and will begin to be rolled-out in November/December 2012, across health and social care. • The Alzheimer's Society has been commissioned to deliver 'Singing for the Brain' sessions, as an evidence-based approach to supporting wellbeing in people with dementia. The Society is also currently undertaking a pilot in Cognitive Stimulation Therapy, (as per NICE guidance) and the evaluation will be considered as part of the prioritisation of future funding. The SSSFT also provides a variety of psychological therapies to support people with dementia, as part of their contractual obligations. • A Care Home Liaison Service has been commissioned and consists of Psychiatry-led 'clinics' and nurse-led input in order to provide specialist support for people in care homes. • Wellington Road, Newport GP Practice is currently leading on a risk-stratification project, in partnership with Commissioning and the West Midlands Public Health Observatory to identify people with dementia and their family carers at risk of deterioration in the community and to intervene with a virtual model of wrap-around support services. An independent evaluation will feature as part of prioritisation for future funding.			
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 5 Getting help if it is not possible to stay at home, or if hospital	Outcomes/NICE Quality Standard 1,7,8 • I know what my options are, and I have had an opportunity to discuss this with someone who can advise me. • I know that I will be respected as a person,	Objective 8: Good quality care within general hospitals	1. Hospital care, including inpatient psychiatric care, has a clear purpose for each person with dementia admitted and is time-limited. 2. Care options are safe and high quality.

care is needed.	and that I will receive good quality care. • My rights, preferences, interests and culture will be respected. • People supporting me will understand my condition and care for me with compassion. I feel safe. • I feel understood by the people who are looking after me. • My physical and mental health needs are met; I am not taking any unnecessary medication. • I am able to return home when possible, as soon as it is possible. • Staff have the knowledge, skills and values to work with people with dementia. They understand dementia; what can help alleviate distress; how to manage different behaviours and prevent crisis. They are supported to work in this way. • Staff know how to get expert advice, and are able to access help and advice when they need it.		
Achievements against outcomes (2010-12)		**RAG Rating**	**Accelerated areas for improvement:**
• A multi-agency Steering Group, (Pan Shropshire, Telford & Wrekin) has been set-up to drive forward an accelerated programme of improvement in dementia, including quality of care in the general hospital. The group is Chaired by the Assistant Director of Patient Experience and has a membership which includes the Chief Nurse and Non-Executive Director of SaTH. • A Clinical Lead and Nurse Lead have been identified in SaTH to drive service improvement in the general hospital, while the Professor of Dignity at Staffordshire University has responsibility for leading the change agenda. • A dementia screening tool has been developed for clinicians in SaTH, as part of the CQUIN for improving quality of care in general hospital. • A dementia pathway has been developed and a 'dementia bundle of care' implemented, as part of the hourly comfort-rounds within SaTH. Further works needs to be undertaken on elements of the West Midlands 'composite model' such as the Dementia-Friendly			1. Multi-agency Steering Group for Dementia Representation from the CCG needs to be secured on this group to help drive forward accelerated improvement. Accountability of the Multi-Agency Steering Group needs to be clearly connected to the Health and Wellbeing Board. (September 2012) **Responsible Officer: Kim Grosvenor, Specialist Commissioner** 2. Improving care in hospital (Key commitment 2, Prime Minister's Challenge on Dementia) Embed Dementia Pathway and Composite Model of Care. (August 2013) **Responsible Officer: Kim Grosvenor, Specialist Commissioner**

Environment. • An information leaflet has been produced and education and training rolled-out. • The RAID model is currently being developed.			Implement RAID initiative and robustly evaluate as part of evidence-base for prioritisation of future funding. **Responsible Officer: Michael Bennett, Lead Commissioner for Mental Health**
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 6 Receiving care, compassion and support at the end of life.	Outcomes/NICE Quality Standard 1,6,9,10 • I am confident that everything will be done to ensure that I die where I want to, that I am well supported, and that my cultural needs and expectations will be respected. • My carer's/family's needs are respected and supported.	Objective 12: end of life care for people with dementia	• People with dementia have the opportunity to die with dignity at home or where they are living, if they so choose. • People with dementia and their carers/families receive support to achieve this, using advance planning where possible and appropriate. • Carers/families are involved and supported in the end of life care of the person with dementia to the extent that they chose to be. • People with dementia are kept as comfortable as possible, taking into account how discomfort and pain might be communicated and responding appropriately with treatment and care. • The cultural values and preferences of the person with dementia, and those of carers/families are taken into account, and reflected in after death care. • After-death care is in line with national guidance.
Achievements against outcomes (2010-12)		**RAG Rating**	**Accelerated areas for improvement:**
• An End of Life Strategy for Shropshire, Telford & Wrekin has been written, together with an Action Plan for implementation. • Resources have been invested in Training e.g. Care Homes and the Liverpool Pathway. • A Preferred Priorities of Care initiative has been Piloted across the County and further work continues in rolling out the Programme. This has included working with Memory Services and supporting people with their long term choices, post-diagnosis.			1. Further work needs to be undertaken in the wider awareness and implementation of preferred priorities of care. **Responsible Officer: To be identified.**

TELFORD & WREKIN HEALTH & WELLBEING BOARD SEPTEMBER 2012

BRIEFING ON REGIONAL STROKE REVIEW

DR MIKE INNES

1. PURPOSE

1.1. To inform HWB Board members of the purpose and progress of the current Regional Stroke Review

2. RECOMMENDATIONS

2.1. That the Board:

- **Note the rationale for a review and plan for action**
- **Agree for the joint HOSC to take the major oversight role for this programme of work**

3. SUMMARY OF REVIEW

3.1. After it formed, the Midlands and East Strategic Health Authority (SHA) noted a significant variation in performance for care of people who had suffered a stroke. This became obvious when data from across the wider area was pooled. On the back of this, and noting the poor comparisons with other countries, the SHA initiated a region-wide review of stroke services.

3.2. The proposed objectives of this review are to:

- Undertake a full review of services currently provided across the region
- Look at models of best practice
- For each area, compare what is happening with best practice
- Formulate options to inform commissioners in their planning after 2012/13.

3.3. Locally this is likely to result in some changes to the services provided with the potential for amalgamation of some services onto one, as yet unspecified, site.

3.4. There is a comprehensive and regionally prescribed programme of activity that will be followed culminating in public consultation in the early part of 2013. This includes involvement of the HOSC.

3.5. At the most recent T&W HOSC, it was agreed that this should be overseen by the Joint HOSC for Telford and Shropshire.

3.6. The accompanying slides add some more detail and will be presented at the meeting.

TELFORD & WREKIN HEALTH & WELLBEING BOARD SEPTEMBER 2012

UPDATE ON THE CLINICAL COMMISSIONING GROUP

DR MIKE INNES

1. PURPOSE

1.1. To inform HWB Board members on progress with establishment of the Clinical Commissioning Group (CCG)

2. RECOMMENDATIONS

2.1. That the Board:

Note the progress to establishment of the CCG as a statutory organisation

3. SUMMARY OF ACTIVITY AND PROGRESS

3.1. The CCG has been making progress through the authorisation process in Wave 2 of the applications since April 2012.

3.2. The authorisation process requires:

- Submission of a suite of documents in evidence of the organisational preparedness;
- Approval of the 'top' three roles of Chair, Accountable Officer and Chief Finance Officer;
- A Multisource Feeback survey of stakeholders in the CCG;
- A formal report from the Strategic Health Authority;
- A site visit and 'panel day' to pursue Key Lines of Enquiry coming from the submitted evidence.

3.3. Telford and Wrekin CCG has:

- Submitted the suite of documents on the 30th August (ahead of deadline)
- Had all three leaders assessed and judged to be "Ready for appointment now"
- Received the collated results from the Multisource Feedback, which are very favourable
- Received and responded to the report from the SHA
- Agreed the date of the 1st November for the Site Visit.

3.4. Following the assessment, the CCG will receive a final report that both identifies any development needs, and makes a recommendation for authorisation. This can be one of three options. "Authorised now with no conditions", "Authorised now with conditions that can be discharged in time" "Authorised with significant conditions that need to be discharged before the statutory role is assumed". Effectively the last option is to say "Not Authorised yet".

3.5. T&W CCG is optimistic that, following the assessment, we will be "Authorised now"and expect that there will be some conditions, albeit manageable ones

3.6. The CCG has now appointed all members of the Governance Board. There is a development day on the 11th September and a further pre-site visit meeting in October..

3.7. The executive and managerial structure of the CCG has been finalised, following staff and stakeholder consultation. We are now in the process of appointing to the roles, initially from staff within the PCT. It is expected that all roles will filled by the end of September.

3.8. The CCG has appointed the Staffordshire and Shropshire Commissioning Support Organisation to provide back and middle office functions for our commissioning activities. Work is underway to appoint to posts in this organisation. Also to agree a service level agreement for activity.

3.9. The Head of the Local Area Team of the National Commissioning Board has been appointed. He is Graham Urwin, formerly CEO of the Staffordshire Cluster of PCTs. We have an initial meeting on the 13th September. The CCG has also met with The Regional Director of the National Commissioning Board, Dr Paul Watson. It is clear that The Commissioning Board is primarily concerned with health outcomes. Informal feedback from this meeting was very favourable.

3.10. The CCG continues to hold delegated authority from the Cluster Board for Commissioning in the locality. Currently, we are on target financially for the year.

BOROUGH OF TELFORD & WREKIN

PUBLIC HEALTH TRANSITION BOARD – 4 SEPTEMBER 2012
POLICY REVIEW – 6 SEPTEMBER 2012
HEALTH AND WELLBEING BOARD – 12 SEPTEMBER 2012
CABINET – 20 SEPTEMBER 2012

PUBLIC HEALTH TRANSITION ARRANGEMENTS

REPORT OF THE ASSISTANT DIRECTOR – SOCIAL CARE SPECIALIST

1. SUMMARY

1.1 The report updates members on the implications of transferring public health functions and lack of clarity on funding levels for the first year -2013/14.

1.2 Commissioned activity under contract to the PCT makes up the largest proportion of curent spend. Current contracts are due to expire on the 31 March 2013 so we are currently in a position where we have to plan for the continuation of some key services upon transfer to the Council.

1.3 This gives the Council some flexibility about deciding which services to continue with but there is much work to be done to put in place arrangements to secure the procurement of activities that will meet these new responsibilities.

1.4 The report sets out the suggested approach and seeks approval to delegate responsibility for letting the contracts to Officers in consultation with the Lead Member.

2. RECOMMENDATIONS

2.1 **Members note the uncertain situation, the tight timescales and support the prudent approach being recommended towards the award of future public health contracts**

2.2 **Members approve delegation of responsibility to the Director of Adult & Community Services, in consultation with the Director of Public Health, and Cabinet Lead/Shadow Health and Wellbeing Board Chair to progress the consideration of future commissioned services and the award of relevant contracts for those public health services within the finances available once the Public Health ring fenced grant is announced**

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Priority Plan objective(s)?	
	Yes	Improve the health and wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
	Yes	Will impact on all of our community but in particular people living in in more deprived communities with higher levels of poor health
DELIVERY DATE	2012-2015	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The financial implications of public health transition are detailed in the body of the report. Key factors to note include:- • When public health functions transfer to the council on 1st April 2013 they will be funded by a new ring-fenced grant that can only be used to support public health activities. • The recent consultation on a proposed distribution method for the new grant (see Appendix 1 for a copy of the response) indicates that the Council may only receive £7.25m grant against current spend by the PCT of £10.4m. However, it is likely that transitional arrangements will be put in place by the DoH that would limit the "pace of change" to a new settlement or that the actual allocation may be higher than that indicated in the consultation document. We will not know the actual grant allocation until very late in the calendar year and it is therefore essential that a cautious approach, as set out in the report, is taken to entering in to commitments until the level of funding is confirmed.

LEGAL ISSUES	Yes	It is a statuory requirement that certain public health functions transfer from the PCT to this authority in April next year. Of principal concern at the moment is the establishment of the legal position vis a vis existing contractual arrangements for the commissioning of public health services and to what extent and how existing responsibilities are transferred or procured by this authority. We are currently asking the PCT to provide us with due diligence to enable us to ascertain the extent of these arrangements (and the risks/ liaibilities) and we are still awaiting guidance that will support the transfer process from central Government. Furthmore, more work is required on the employment side regarding TUPE transfer of certain NHS staff, ICT systems and the broader governance issues regarding decision-making and delegations A key risk is the short timescale in which this work is to be completed
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	Any other risks and opportunities will be appropriately managed and reported if necessary.
IMPACT ON SPECIFIC WARDS	No	*Borough-wide impact.*

4.0 INFORMATION

4.1 Cabinet received a report on the 29 March 2012 updating them on transfer of public health responsibilities to local authorities with effect from April 2013 (as set out in the Health and Social Care Act 2012 which received royal assent on the 27 March). The report set out the transferring functions and commissioning responsibilities, the role of the Director of Public Health (DPH) and the transitional arrangements being put in place.

4.2 The report highlighted the work that was being progressed at a national and local level to identify the current public health budgets, the likely level of ring-fenced grant funding the council would receive and the current local spend on public health. Even then there were concerns about the timelines for confirmation of the grant income (November 2012) as this, it was felt gives us insufficient time to adequately plan for transfer. Since then however, officers have been working closely with colleagues in the PCT to plan the transfer of staff and commissioned services.

4.3 In July the Department of Health published Healthy Lives, Healthy People: Update on Public Health Funding, for consultation. This document sets out current thinking on local authority public health finance. In particular:

- the next steps on moving from estimates of baseline spend published in February to actual allocations for 2013-14;
- conditions on the ring-fence grant; and
- the health premium incentive (the element of non-mandated expenditure that is dependent upon the local authority making progress against certain public health indicators).

Officers have responded to the consultation and a copy is attached as Appendix 1.

4.4 In respect of the exact sums that each local authority will receive there is still uncertainty. Government has said, "We estimated that in 2012-13 around £5.2bn will be spent on the future responsibilities of the public health system, including £2.2bn on services that will be the responsibility of local authorities. To support planning, we have committed that the amount allocated to local authorities for 2013-14 will not fall below these estimates in real terms, other than in exceptional circumstances". These funding assumptions were based on PCT returns for spend in 2010/11

4.5 However this leaves Telford & Wrekin Council (T&W) in a difficult position in planning for the potential transition of approximately £10.4m of public health related activities currently delivered or commissioned by either NHS T&W's Public Health unit or Joint Commissioning (in respect of Sexual Health and Drugs and Alcohol responsibilities that also pass to local authorities). Applying T&W's indicative percentage of a national share of £2.2bn would suggest an indicative figure of around £7.25m for the Council, a potential shortfall of over £3m.

4.6 Some colleagues in the NHS suggest the gap will not be so great, particularly once there is a recalculation based on the 11/12 NHS spend and that our grant allocation is likely to be nearer £10m. However, we will not know the exact figure until much later in the Autumn when it will potentially be too late to actively consult as part of the budget process. Whilst this may be of some reassurance, we will have to have plans in place that can accommodate the worst case scenario, with particular reference to the main areas of current spend which can be broken down approximately as follows:

Area of Spend	**Amount of Spend - £**
Activity commissioned with NHS providers or GP Practices	£5.2m
Activity commissioned with the Council	£1.2m
Activities commissioned with other providers	£1.1m
Total commissioned services	**£7.5m**
Public Health Unit and Joint Commissioning Staff	£1m
Other	£1.9m

Total Spend	**£10.4m**

4.7 The biggest proportion of spend is on commissioned services, with all the contracts between T&W PCT and the providers expiring on the 31 March 2013. As all contracts are due to expire on transfer our current understanding is that the contracts will not be transferred from the PCT to the Council . Whilst this potentially gives the local authority some flexibility that could help resolve any funding shortfall it also creates significant problems, in particular how to complete a procurement process in the available time, relating to nearly 100 activities currently delivered by 20 different providers There are added problems associated with giving providers 6 months notice of any significant potential changes (particularly where staff are employed), which means that communications with providers will need to commence as soon as possible. Such communications would need to include an indication of:

- Services that are to be transferred to a new contractual framework with the local authority
- Services that may continue subject to funds being available
- Services that we require to be delivered for a defined period giving notice that a tender process will then be undertaken
- Services that will be decommissioned.

4.8 Council officers working with Public Health colleagues are exploring our best procurement options within these timescales, keeping risk of legal challenge to a minimum. At the same time we are awaiting further national guidance on how public health related contracts can be transferred to the Council which hopefully will inform this work.

4.9 Commissioners have already evaluated each existing contract let by the PCT against criteria which will give us an open and fair framework to use to make decisions about the future of each existing contract. The criteria includes factors such as mandated and non-mandated public health services, performance against contract and value for money.

4.10 This initial analysis suggests that:

- Contracts to the value of £112,503 should be ended on 31 March and the activities not continued
- Contracts to the value of £770,311 should be de-commissioned (more work needs to be done to establish whether any of the services in this group need to be recommissioned)

4.11 Further work is also being done across the remaining commisioned services to the value of £6.5m, to determine, the length of period the Council should offer contracts to existing providers. Subject to available funding commissioners favour an approach based on spreading contract awards across a number of different time scales (suggested 6 or 12 or 18 or 24 months maximum) with notification of a tender

process which can be phased depending on the length of award, thus making the process manageable within the available procurement workforce.

4.12 Public Health Commissioners value the opportunity to test the market that the transfer of responsibility provides but also acknowledge that the Council may be best placed to deliver some services directly in due course.

4.13 On this basis it is recommended that Members approve delegation of responsibility to the Director of Adult & Community Services, in consultation with the Director of Public Health and Cabinet Lead/Shadow Health and Wellbeing Board Chair for the to progress the consideration of future commissioned services and the award of relevant contracts for those public health services within the finances available once the Public Health ring fenced grant is announced.

4.13 Whilst this process in itself will be challenging, members should be aware that the Government has indicated that over time it plans to realign allocation of public health funding on a formula basis that could mean that the Council's grant will be reduced. A prudent approach is therefore all the more advisable.

5. PREVIOUS MINUTES

5.1 Cabinet Report – 22.12.2011 – NHS Transformation and Implications for the Council

5.2 Health & Wellbeing Board Report - 22 February 2012 – Public Health Update

5.3 Cabinet Report – 29.3.2012 – Public Health Update

5.4 Health and Wellbeing Board – 13.6.2012 - Development of the Public Health Vision and building the team in Telford and Wrekin

6. BACKGROUND PAPERS

Report prepared by Paul Taylor, Assistant Director – Social Care Specialist
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Appendix 1 Healthy Lives, Healthy People: Update on Public Health Funding

TELFORD AND WREKIN RESPONSE

Introduction

This document summarises the Telford and Wrekin response to the proposals set out in the Department of Health's Healthy Lives, Healthy People: Update on Public Health Funding, published in July 2012. The response has been developed and approved by the Telford and Wrekin Public Health Transition Board, which includes the following as core members:

- Managing Director, Telford and Wrekin Council (PH Transition Steering Group chair)
- Director of Public Health, NHS Telford and Wrekin
- Deputy Chief Executive, West Mercia PCT Cluster (Cluster PH Transition Lead)

Overarching Comments

- It is our view that the commitment to provide adequate funding to Councils for their new public health functions given in the Public Health White Paper, Healthy Lives, Healthy People must operate at a local, rather than a national level. Locally, we know that current spend on public health activities that will transfer to the Council are in the region of £10.4m in 2012/13. However, applying Telford and Wrekin's indicative percentage of national share to the national figure available for public health functions transferring to local authorities of £2.2bn would suggest an indicative figure of around £7.26m for the Council. This clearly falls significantly short of current spend and unless the pace of change is controlled and phased over a long period – at least 10 years as a minimum, unacceptable cuts to local services will have to be made at very short notice.

- Certainty of funding for next year is required as soon as possible as notice to terminate contracts needs to be reasonable – six months notice is considered the norm and yet the grant allocation is not expected until December. It would be very helpful if a guarantee could be provided at an earlier stage that the grant available for next year will not be lower than the current 2012/13 figure reported as part of recent PCT financial returns.

- Councils clearly have the opportunity to make cuts to other services to invest in public health, but given the 28% cuts to local authority grants made in the CSR 2010, the very challenging front loading of many of these cuts in the grant settlements for 2011/12 and 2012/13 together with the uncertainties facing local authority resource levels for future years given the fundamental changes being made to the local government finance system with the localisation of business rates and local support for council tax it would be very difficult for councillors to identify scope to invest additional funding in public health services for next year.

- The Department should ensure that an Equalities Impact assessment is completed that considers the cumulative impact of proposed Government changes on vulnerable groups. For example the changes to public health responsibilities and funding will be introduced at the same time as councils are required to implement a Government cut to council tax benefits and the universal credit is implemented. These changes will all potentially impact on sections of the population that suffer health inequalities and are a further reason that stability of funding for public heath at a local level needs to be guaranteed as soon as possible and that the pace of change should be phased over at least a 10 year period.

Response to ACRA's Interim Recommendations

- A formula based principally on a measure of population health best meets the criteria by which resource allocation formulae are determined.
    - The principle of a formula based on a measure of population health rather than based on demographic indicators is supported

- The standardised mortality ratio (SMR) for those aged under 75 years should be used as the population health measure. This has been applied on a small area basis to take account of localised health inequalities, and aggregated to local authority level.
    - The principle of selecting the premature (under 75) SMR is strongly supported for the following reasons:
        - Availability of nationally published statistics which are consistent, reliable and sufficiently robust at a small area level
        - In preference to the all-age, all-cause mortality rate as the premature mortality ratio is more closely reflective of population health and associated inequalities

- To help reduce inequalities, the SMR measure be incorporated into the public health formula so that the decile of small areas with the highest SMRs have received a weight per head, three times greater that the decile of small areas with the lowest SMRs.
    - The principle of applying a greater weight per head for areas within the decile with the highest SMRs in the context of tackling health inequalities is fully supported

- The adjustment used in the local government funding formula for unavoidable differences in costs due to geographical location should be included.
    - We do not agree that an Area Cost Adjustment factor should be applied outside London. Excluding London, where it is accepted that London weighting is generally applied and does increase costs, salaries for staff working in these services (whether in the public or private sectors) do not currently vary significantly between different parts of the country. However, if a regional cost factor is implemented we would support the use of the ACA as opposed to the MFF as this would be consistent with other local authority services.

- The ONS projected resident population for 2012 should be used as the population base. This is the same approach as followed in the local government funding formula.
    - It is considered vital that the forthcoming new SNPPs based on the 2011 Census are used as the population base for the formula from the outset, rather than relying on the 2010 based figures, which although uplifted, date back to the 2001 Census and are therefore less accurate

- The current methodology for the PTB includes components relating to activity (successful completions and maintaining in effective treatment) and need. This provides a level of certainty of resourcing and is therefore sound and encourages effective, targeted service delivery. Replacing the needs based methodology to an SMR based calculation potentially poses a number of risks: it is unclear how the current SMR profile equates to the needs component currently used and whether this change would increase or decrease funding locally and also whether this need factor will be ranked or apportioned across LA's or solely based on SMR for the area. However, pragmatically there is logic to adopting a similar methodology to the PH budget allocation formula for the PTB.

Response to conditions and reporting for the Public Health Grant

- Telford and Wrekin support the use of the RO and RA forms to report use of the ring-fenced grant, but consider that 15-20 rows would be a disproportionate level of detail on these returns

- Annex E states that payments in respect of finance leases and statutory fines should not count as eligible expenditure against the proposed grant. We disagree with these proposals as any revenue expenditure directly related to the provision of public health services by local authorities should count as eligible expenditure

- Paragraph 13 of Annex E sets out a suggestion that the grant should effectively operate on a cash rather than an accruals basis which is not in accordance with normal local authority accounting practise and would prefer consistency with standard accounting practice

Telford and Wrekin Health and Wellbeing Board September 2012

Record of Main Findings: Safeguarding and Looked After Children Inspection 2012

Safeguarding Services	
Overall Effectiveness	Adequate
Capacity for Improvement	Adequate
Safeguarding Outcomes for Children and Young People	
Children and Young People are Safe and Feel Safe	Adequate
Quality of Provision	Inadequate
The Contribution of Health Agencies to Keeping Children and Young People Safe	Adequate
Ambition and Prioritisation	Good
Leadership and Management	Adequate
Performance Management and Quality Assurance	Adequate
Partnership Working	Good
Equality and Diversity	Adequate
Services for Looked After Children	
Overall Effectiveness	Adequate
Capacity for Improvement	Adequate
How Good are Outcomes for Looked After Children and Care Leavers?	
Being Healthy	Adequate
Staying Safe	Good
Enjoying and Achieving	Adequate
Making a Positive Contribution, Including User Engagement	Good
Economic Well-Being	Adequate
Quality of Provision	Inadequate
Ambition and Prioritisation	Good
Leadership and Management	Good
Performance Management and Quality Assurance	Adequate
Equality and Diversity	Adequate

BOROUGH OF TELFORD & WREKIN

POLICY REVIEW – 6 SEPTEMBER 2012
HEALTH AND WELLBEING BOARD – 12 SEPTEMBER 2012
CABINET – 20 SEPTEMBER 2012

CARE AND SUPPORT WHITE PAPER & BILL

REPORT OF THE ASSISTANT DIRECTOR – SOCIAL CARE SPECIALIST

1. SUMMARY

1.1 The report summarises Government proposals for adult care and support contained in the recently published Care and Suuport White Paper, Care and Support Bill and Caring for our Future progress report on funding reform.

1.2 Generally there is support for the proposals contained in the White Paper and Bill.

1.3 However there are significant concerns about the delay in addressing the adult social care funding situation for at least another 3 years at a time when budgets are already under such pressure.

2. RECOMMENDATIONS

2.1 **SMT/Members/Board Members note the content and implications of the Care and Support White Paper, Bill and Progress Report on Funding Reform and consider whether they want to comment on the Care and Support Bill by the 19 October deadline**

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Priority Plan objective(s)?	
	Yes	Protect and support our vulnerable children and adults
	Will the proposals impact on specific groups of people?	
	Yes	In particular people who are ill or disabled, but their informal carers will be dispersed across our population
DELIVERY DATE	2012-2015	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The key financial aspects of the proposals and vision included in the white paper and Bill are included in the body of this report. The 2012/13 expenditure forecasts reveal a continuation in the recent trend of increasing care costs and resulting pressure on the Care and Support budget. The costs of care have escalated in recent months due to; (i) the review of eligibility of clients for NHS

		funded care and (ii)in some client groups a continued increase in demand. The "additional funding", referred in the white paper etc made available from Government through the NHS has resulted in around £2m of funding being made available to the Council in 2012/13, and forms part of funding totals to 2014/15, but this has not been sufficient to meet pressures on budgets of around £5m. In addition this funding has been made available at a time of significant real term cuts of 28% in the grant settlement to Local Authorities over four years, and to this Council of around £27m over four years. The objective of improving all aspects of the care experience to those in need is laudable, but is likely to push up costs on LA's both in front line care costs from the impact of changes to market provision (such as removing home care charging by the minute), and the transfer of risk into the private sector with the implementation of personal budgets and in back office functions to manage the changes proposed in the funding report. Some additional funding is proposed with the announcement of £100m in 2013/14 and £200m 2014/15 but it is not possible to determine at this stage what level of funding is actually required to meet the additional costs. The forecast financial impacts of the proposed changes to the funding of Social Care from the Dilnot report recommendations are documented in the body of this report. It is not possible to evaluate the local impacts except to say that the costs of care locally will continue to rise in the light of demographic changes. The current strategy being pursued in Telford & Wrekin is to improve and enhance preventative services. This is in order to avoid a reactive approach to providing care when a client has costly high needs. This strategy, should prove to be successful in helping to contain cost increases in future but unlikely to reduce care costs overall. Therefore, cost pressures are likely to remain and will require additional Government resource. Delay in the implementation of funding reform and the placing of Social Care funding on a sustainable footing will result in the continuation of increasing pressure on Local Authority Care budgets. One further key point to note is the proposal to extend the availability to use of deferred payments in order for clients to meet costs once a property has been sold. An increase

		in the use of this scheme will require debt to be resourced during the period the property remains unsold for whaterver reason. The charging of interest is proposed to offset any financing costs.
LEGAL ISSUES	Yes	On 11 July 2012, the Government published a White Paper *Caring for our future: reforming care and support* and the draft Care and Support Bill 2012 Bill setting out reforms for the care and support system in the UK. The draft Bill was announced in the Queen's Speech on 9th May , and proposes a single, codified law for adult care and support which will replace existing legislation. The Government says that the draft Bill aims to consolidate "provisions from over a dozen different Acts into a single, modern framework for care and support" and to enact "a fundamental reform of the way the law works." The Bill sets out the responsibilities for local authorities in relation to the provision of care and support (including charges for such care) and sets out plans to establish Health Education England and the Health Research Authority. Consultation on the draft Bill closes on 19 October 2012. This draft Bill, if it receives Royal Assent , will radically overhaul the current care and support system and its progress through Parliament will need to be closely monitored. Many of the proposals , which are summarised in the body of this report and in the background papers/factsheets detailed at paragraph 6, are aimed at increasing independence but at the same time encouraging personal autonomy and less reliance on state-provided care and support.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	Any other risks and opportunities will be appropriately managed and reported if necessary.
IMPACT ON SPECIFIC WARDS	No	*Borough-wide impact.*

4.0 INFORMATION

4.1 On the 11 July the Government published the Care and Support White Paper, the draft Care and Support Bill and a progress report on Funding Reform

4.2 Care and Support White Paper (For electronic link see Section 6 below)

4.2.1 The White Paper updates the Vision for Adult Social Care that the Government released in November 2010 and follows on from more recent consultation.

4.2.2 The White Paper confirms that local authorities will "sit at the heart of how care and support will work in the future". Central to the vision is the principle of promoting wellbeing and independence instead of waiting for people to reach crisis point, availability of better information and high quality services.

4.2.3 Actions identified in the White Paper include:

• development of initiatives that help people share their time, talents and skills with others in their community.
• establishing a new capital fund, worth £200 million over five years, to support the development of specialised housing for older and disabled people.
• establishing a new national information website, to provide a source of information on care and support, and investing £32.5 million in better local online services.
• introducing national minimum eligibility threshold to ensure consistency in access to care and support, and ensuring that no-one's care is interrupted if they move.
• extending the right to an assessment to more carers, and introducing a clear entitlement to support to help them maintain their own health and wellbeing.
• Working with a range of organisations to develop comparison websites that make it easy for people to give feedback and compare the quality of care providers.
• Placing dignity and respect at the heart of a new code of conduct and minimum training standards for care workers.
• Training more care workers to deliver high-quality care, including an ambition to double the number of care apprenticeships to 100,000 by 2017.
• Appointing a Chief Social Worker by the end of 2012.
• Legislating to give people an entitlement to a personal budget.
• Improving access to independent advice to help people eligible for financial support from their local authority to develop their care and support plan.
• Developing, in a small number of areas, the use of direct payments for people who have chosen to live in residential care, to test the costs and benefits.
• Investing a further £100 million in 2013/14 and £200 million in 2014/15 in joint funding between the NHS and social care to support better integrated care and support.

4.3 Care and Support Bill (For electronic link see Section 6 below)

4.3.1 Underpinning many of the above proposals will be a complete overhaul of care and support law as recommended by the Law Commission's review which reported in 2011. The Bill if it becomes law would replace nearly all the existing adult social care law that has been built up on an ad-hoc basis since the National Assistance Act, 1948 which is still applied today. The Bill has

been published in draft for public consultation (deadline for comments is the 19 October 2012) and Parliamentary pre-legislative scrutiny.

4.3.2 Eight Factsheets (for electronic link see Section 6 below) have been produced to summarise the main components of the Bill:

- **Assessments & Eligibility** – Will create duty on local authority to carry out assessments and determine eligibility against a new national threshold
- **Charging and Financial Assessments** – Will bring all charging for social care together, using a single approach. Also extends right for people to use a deferred payments scheme against the value of their property and will allow local authorities to charge interest.
- **Who is entitled to care & support?** – will clarify in a single piece of legislation the entitlements of people and their carers for eligible needs to be met as opposed to current legal duty to provide certain services
- **Personalising care and support planning** – Will set out new duty, following establishing eligibility, to provide a care and support plan, including legal entitlement to a personal budget and/or direct payment
- **The law for carers** – Creates a single duty for local authorities to undertake carers assessments, whilst removing requirement that they must provide "a substantial amount of care on a regular basis". Carers would be put on same legal footing as the adults they care for.
- **Protecting adults from abuse or neglect** – For the first time will introduce a legal framework for adult safeguarding, requiring establishment of a Safeguarding Adults Board with a core membership, publication of a Safeguarding Plan and requirement for local authorities to make enquiries where there are concerns. A separate consultation exercise, ending on 12 October 2012 is taking place as to whether a specific power of entry is required - http://www.dh.gov.uk/health/2012/07/safeguardingadults/

The other 2 factsheets summarise a small number of health measures which have been included in the Bill concerning establishing Health Education England and the Health Research Authority as non-departmental public bodies

4.4 **Caring for our future: progress report on funding reform** (For electronic link see Section 6 below)

4.4.1 This report makes it clear that the Government agree with the principles of the Dilnot Commission's recommendations published in 2011 which were:

- Government should put a cap on the lifetime care costs (less general living costs) that people face, and raise the threshold at which people lose means tested support; and

- There should be universal access to deferred payments for people in residential care

4.4.2 The report models the estimated costs to the nation depending on the different levels of cap and capital limits. Currently there is no cap, upper capital limits are set at £23,250 and individuals pay an assessed contribution based on level of annual income. Dilnot estimated that a cap set at £35,000, an upper capital limit of £100,000 and an annual average contribution of £10,000 a year by each individual towards general living costs associated with residential care would cost an additional £2.2billion in 2015/16, rising to £3.6billion by 2025/26 (at today's prices).

4.4.3 However in taking the matter forward they add some very significant riders, in particular "if a way to pay for them can be found". In addition they make it clear that no announcements can be expected until the outcome of the next spending review is known, which is outside the planned life of the current parliament (2015)

4.5` <u>Response to announcements</u>

4.5.1 Generally the response to the principles in the White Paper have been positive though there is a need for more clarity, certainty and a definite time frame. The simplification of the legislative framework for Adult Social Care is seen as a big step forward though there is a lot of work is still to be done, which will be led by an Implementation Group (on which the Directors of Adult Social Services (ADASS) will be represented)

4.5.2 However there are some significant concerns being expressed by ADASS, which we would support about the delay in addressing the funding issues at a time when adult social care budgets are already under pressure. There is a risk that in the medium term the funding gap could widen as expectations are further heightened by the White Paper & Bill and demographic trends. However it is important to recognise that the idea of capping individual's liability for care costs and extending the means test threshold would cost billions of pounds and requires a shift in the priority given to adult social care nationally

5. <u>PREVIOUS MINUTES</u>

5.1 None

6. <u>BACKGROUND PAPERS</u>

6.1 A Vision for Adult Social Care – Capable Communities and Active Citizens, DH, 16 November 2010

6.2 Care and Support White Paper – HM Government, 11 July 2012

6.3 Care and Support Bill – HM Government, 11 July 2012, http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

6.4 Factsheet 1 – Assessments and eligibility
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-1-Assessments-and-eligibility.pdf
Factsheet 2 – Charging and financial assessments
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-2-Charging-and-financial-assessment.pdf
Factsheet 3 – Who is entitled to care and support?
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-3-Who-is-entitled-to-care-and-support.pdf
Factsheet 4 – Personalising care and support planning
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-4-Care-and-support-planning.pdf
Factsheet 5 – The law for carers
http://www.dh.gov.uk/health/files/2012/07/2900021-Fact-sheet-5-v1_1W-21.pdf
Factsheet 6 – Protecting adults from abuse or neglect
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-6-Protecting-adults-from-abuse-and-neglect.pdf
Factsheet 7 – Health Education England
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-7-Health-Education-England.pdf
Factsheet 8 – Health Research Authority
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-8-Health-Research-Authority.pdf

6.5 Consultation on new safeguarding power, DH
http://www.dh.gov.uk/health/2012/07/safeguardingadults/

6.6 Caring for our future: progress report on funding reform – HM Government
http://www.dh.gov.uk/health/2012/07/scfunding/

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