

HEALTH AND WELLBEING BOARD

Minutes of a meeting of the Health and Wellbeing Board held on Wednesday 17th July 2013 at 2.00pm at NFU Offices, Agriculture House, Southwater Way, Telford

PRESENT: Cllr R Overton (Chair) (Telford and Wrekin Council), Dr M Innes (Vice-Chair) (Clinical Commissioning Group), Cllr E Clare (Telford and Wrekin Council), P Taylor (Telford and Wrekin Council), Cllr A England (Telford and Wrekin Council), Cllr G Green (Telford and Wrekin Council), D Harrison (Clinical Commissioning Group), L Johnston (Telford and Wrekin Council), Cllr J Seymour (Telford and Wrekin Council), S Mahmud (NHS England Shropshire and Staffordshire Area Team), Helen Onions (Telford and Wrekin Council), D Saunders (Healthwatch Telford and Wrekin)

Officers: J Eatough (Assistant Director: Law, Democracy and Public Protection), C Jones (Assistant Director Family & Cohesion Services), J Power (Delivery & Planning Manager), J Rowe (Assistant Director: Neighbourhood and Leisure Services), K Grosvenor (Specialist Commissioner), C Harrison (Service Delivery Manager – Commissioning), C Hall-Salter (Partnership and Planning Manager) and J Clarke (Democratic Services Officer).

HWB-14 MINUTES

RESOLVED – that the notes of the meeting of the Health and Wellbeing Board held on 15th May 2013 be confirmed and signed by the Chair.

HWB-15 APOLOGIES FOR ABSENCE

D Evans (Clinical Commissioning Group) and Cllr P Watling (Telford and Wrekin Council).

HWB-16 DECLARATIONS OF INTEREST

None

HWB-17 TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP UPDATE

Dr M Innes gave a brief update from the Clinical Commissioning Group (CCG).

The Comprehensive Spending Review for 2015/16 would have a significant impact on the CCG which would be challenging.

With regard to health and social care the CCG nationally would see a transfer of funds from the NHS in the region of £3.4 billion, which locally would be in the region of £6 million, approximately 3% of the current budget. It was not yet clear if this amount would be new money or whether this had already transferred over to the CCG. The finer details would need further consideration and a **report would be brought back to the Health and Wellbeing Board once this had been finalised.**

The CCG and the Council were working together to set out a plan on how care services could be integrated to provide care around the patient enabling more patients to be cared for at home and promote independent living for as long as possible. **It was hoped that a further report would be brought to the September meeting of the HWB.**

An Urgent Care Network Board (UCNB) had been established with membership from commissioners and providers across the community. The draft Terms of Reference of the

Board were appended to the report. The UCNB would be overseeing the implementation of 5 projects in order to put health and social care community in a good position ready for the winter season:

- Emergency Department Flow
- Admission Avoidance
- SaTH and Community Discharge
- Optimising capacity to support discharge
- Local Health Economy Hub

An update on these projects would be brought to the September meeting of the HWB. Further projects would be based on combined and comprehensive care of the frail, elderly and those with complex needs.

Telford and Wrekin CCG was working together with the Area Team of NHS England with regard to collaborative working in respect of primary care to ensure that service delivery met the needs of the population. There was now a Memorandum of Understanding between NHS England and CCG's in Staffordshire and Shropshire and quarterly meetings were arranged to discuss issues of concern.

Actions had been taken across the area regarding the Francis Report. The CCG had accepted the report and some work had been undertaken on "listening" events. A Board meeting had taken place between Shropshire and Telford NHS Trusts (SaTH) around the ongoing work.

A discussion took place including:

- Integrated Care
- Spending Review
- Integration Pioneers and funding a funding bid
- Community involvement
- Francis Report – listening to views of patients and carers

RESOLVED – that the report be noted.

HWB-18 NHS ENGLAND SHROPSHIRE AND STAFFORDSHIRE AREA TEAM UPDATE

S Mahmud gave a presentation on the Area Team and Primary Care Commissioning Overview and NHS England's response to the Francis Report.

The presentation was appended to the Report at Appendix 1.

A discussion took place including:

- NHS England Area Team's reporting procedure
- Delivery of meaningful services
- Setting up of Patient Forums
- Primary Medical Care - GP Practices and the ratio of GPs to Patients
- Geographical hotspots – **Sultan to provide additional information**
- Single Handed Practices
- Age profile of GPs
- Lack of access to female GPs

- Immunisation Rates and Good Practice
- Validity of the Patient Survey Findings
- Dental Services and the lack of access to emergency NHS appointments – **Sultan to bring a report on NHS Dentistry to HWB when ready**
- NHS England Area Team's Complaints procedure
- Patient and community involvement in the LAT

It was agreed that Sultan would bring the Primary Care Strategy back to the HWB as appropriate, and ensure that it was in line with HWB priorities. It was also agreed that representation from the T&W HWB would be sought to develop the Strategy.

It was also agreed that NHS England LAT would bring quarterly reports back to the HWB to include performance and complaints.

RESOLVED – that the report be noted.

HWB-19 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH FOR TEFORD AND WREKIN 2012/13

Dr C Woodward presented the annual Public Health Report for 2012/13 which highlighted the key messages and recommendations.

Dr Woodward thanked members of the Public Health Team and other officers of the Council who had helped with the production of the Annual Public Health report for their hard work.

The Report had been deliberately ambitious and challenging in its approach in order that it had an impact.

The Public Health Outcomes Framework was published in January 2012 and aimed to promote joint working across the NHS, local government, voluntary sector and communities. The Health and Wellbeing Board were taking the "life course" approach and this would be built on going forward.

If the recommendations were accepted by the Board, this would help to support the HWB rather than adding complexities. It was hoped that the Report would become a useful legacy for the Statutory Director of Public Health which set out the key priorities and framework for action.

Dr Woodward then gave a brief slide presentation. Low Birth Weight was an issue that had been brought to the Board's attention at an early stage. Cardiovascular disease and cancer remain the most significant cause of premature mortality (deaths under 75 years). With regard to Alcohol misuse, a single subject report would be brought to the Board due to the performance metrics drifting. This was a priority of the HWB and it was important not to let this slip. The Board had recently sent a letter to the Government supporting the minimum pricing of alcohol. Due to the announcement on the 17th July that the Bill was not going ahead, **it was agreed that a further letter would be sent to the Government expressing the HWB's regret that this had happened.** An updated policy on the misuse of alcohol should have taken place 2 years ago and it was asked if this policy was due to be updated. It was confirmed that this was to be reviewed through the asset mapping timetable plan. A Lead Commissioner had just been appointed and would take the lead on updating the strategy and a progress report would be brought to a future meeting.

A question was raised regarding electronic cigarettes. **It was suggested that the benefits/harm of smoking electronic cigarettes was looked into and this reported back to the Board at a future meeting.**

A discussion took place surrounding the Children and Young People priorities and recommendations and the increase of incidents of self-harm of young people aged 12-18. Some of the CYP recommendations within the Annual Report would be picked up by the Children and Families Board and some would be the responsibility of the Local Children's Safeguarding Board.

AGREED – that recommendations 1 to 11 contained in the report be endorsed.

HWB-20 JOINT HEALTH AND WELLBEING STRATEGY: DEVELOPING OUR PARTNERSHIP AND OUTCOME FRAMEWORKS

J Power presented a report on the delivery of the Health and Wellbeing Strategy Priorities which included refreshed and refocused partnership arrangements to join-up strategic approaches to service design and commissioning and an emerging outcome framework against each of the Board's priorities.

The Report highlighted issues around commissioning that were needed to take forward the HWB Priorities. A position statement for each priority had been completed against the Health and Wellbeing Strategy underpinning the following principles:

- Equity
- Accessibility
- Integration
- Quality
- Engagement
- Financial sustainability
- Positive Experience of health and social care services
- Early intervention and prevention
- Safeguarding

The key messages from the initial analysis were:

- The need to ensure that delivery plans are in place for each priority
- A sharpened focus on integrated commissioning between services to avoid duplication and ensure an effective care and support pathway for service users
- A need for better joined-up working to address priorities holistically – for example challenges around the time of pregnancy – smoking in pregnancy and breast feeding rates

Also in response to the findings two new partnership groups were proposed:

- Co-operative Commissioning Partnership
- Early Help Partnership

The co-operative commissioning partnership would commence in August and bring together commissioners from the CCG and the Council's adult, children and public health commissioning functions. The initial meeting would focus on agreeing the Terms of Reference. Through its annual review the Children, Young People and Families Board were

developing an Early Help Partnership in order to ensure a joined-up strategic approach to support individuals and families and to address challenges quickly and appropriately. This partnership would also support the delivery of 3 HWB priorities:

- Excess weight in childhood / breast feeding
- Teenage Pregnancy
- Improving emotional health and wellbeing

A series of workshops would be developed over the summer for consultation on asset mapping and the holistic approach.

A progress report would be brought to the September meeting of the HWB.

Appendix 2 to the report set out a simplistic view of priorities and cross working partnerships to address the priorities. The delivery of the strategy relied on working with partners. Two stakeholder events had already taken place and a further engagement event was proposed for the Autumn. This was a way of allowing user groups, parents and service users to be heard. The results of the engagement event would be brought back to the Board.

Performance indicators would be used to get an understanding of where the priorities were being met and services delivered appropriately. The Director of Public Health's report also tied in with the work being undertaken and showed clear consistency and commonality in delivering the priorities. A report would be brought to the HWB 3 times per year.

A discussion took place including:

- The collaborative commissioning approach
- Joined-up working with users/providers/voluntary sector
- Active voluntary sector need to be engaged
- All Age Autism Strategy and links to Early Help Partnership
- Early Help Partnership
- Work of Carers and the Carers Partnership Board
- Local Safeguarding Children's Board and governance links to HWB and CYFB
- Misuse of alcohol/drugs – prevention work / follow up visits

RESOLVED – that

- a) the proposed refocused partnership arrangements taking forward the priorities be endorsed;**
- b) the proposed partnership stakeholder event in Autumn be endorsed; and**
- c) that the emerging priority outcome framework be endorsed.**

HWB-21 FOCUS ON HWB PRIORITIES

Improving Carer's health and wellbeing and Carer's Strategy

C Harrison presented a report on the Improving Carer's Health and Wellbeing and the Carers Strategy.

The Strategy had now been approved together with the Action and Implementation Plan.

There were currently 2 Strategies – Adults Care Strategy and Young Carers Strategy. It was a future aspiration to combine these two strategies into an all age strategy.

There were approximately 18,000 carers within Telford and Wrekin with 4,000 of these caring for over 50 hours per week. At 10.1-10.8 of the report was a jigsaw diagram showing how the Carers Strategy would work for Carers in Telford and Wrekin.

Information advice and support was key to Carers which centred around the Carers Centre Hub

Ongoing work included:

- Planning for the future – ie living wills / crisis planning
- Promotion of wellbeing
- Pampering/recreational sessions for carers
- Nursing Services
- Carers Partnership Board

Carers had identified that the key areas from the jigsaw model were:

- Being financially safe and secure
- Having a life outside of caring
- Taking time for themselves

Three power point presentations were received on the following subjects:

- A life outside Caring
- Healthy Eating Project
- Telford and Wrekin Young Carers Service

A verbal presentation was also received from a full-time carer who was able to talk about her experience of being a carer together with the help and support she had received both in London and in Telford and Wrekin.

A discussion took place including:

- Gap in identifying carers
- Carers Centre to work with GPs to identify carers
- Pop-up surgeries ie pharmacies / schools
- Schools to be more proactive in identifying possible young carers
- Drop-in Sessions within secondary schools
- Promotion of carers
- Cost-effectiveness of a joined-up approach

The Chair thanked the carers for all of their work.

RESOLVED – that

- a) the approval of the Carers Strategy 2013-16 by both the Council and the Clinical Commissioning Group be noted;**
- b) the strategic priorities and associated action plan be supported;**

- c) the progress being made with the Adult Carers Strategy be noted;
- d) the value carers bring to the local health and social care economy be recognised and supported; and
- e) the continued progress against the action plan for young carers be noted.

Supporting People with Dementia

K Grosvenor gave a presentation on Health and Wellbeing Board Priority – Supporting People with Dementia.

Diagnosis of dementia for people of Telford and Wrekin was 44% which was below the national average of 57%. There was a lack of information and quality of end of life care offered to patients.

There were 4 priority work-streams:

- Public and Professional Awareness of Memory Problems
- Information
- Early Identification and Diagnosis
- End of Life

A Commissioning Framework and Action Plan had been drawn up to assure the Board that this was being monitored thoroughly and regularly.

A lot of work had been undertaken on public awareness and AFC Telford Football Club had made a video for youTube and raised awareness at football matches. There had been a lot of support from the press and publicity initiatives.

Two documents had been produced:

- Dementia Services Directory
- Dementia Passport

The Dementia Services Directory was a guide to dementia services within Telford and Wrekin whereas the Passport was a document that could be completed with important information ie medical history, contact details, medicines, allergies. The Passport would be a reference point to support a patients journey through the care settings and would remain with them at all times.

Other public awareness events had taken place during Dementia Awareness Week including a Dementia Awareness Day at Blists Hill Museum on 10th June 2013.

There was now the ability to feed into the West Midlands Dementia Care portal from which support services could be accessed.

A training pathway to meet local priorities had been produced. Worcester University had been invited to develop the programme that led on dementia, with Staffordshire University evaluating the training once it had been undertaken.

Shropshire and Telford NHS Trust had adopted the Pathway to Dementia and were currently embedding this within the Hospitals.

Diagnosis rates for Telford and Wrekin were poor although Telford and Wrekin were the best improving areas. A long term conditions group had been set up.

Other ongoing work included:

- Setting a minimum standard of care
- A review of the Dementia Register
- Improvement of diagnosis rates

An End of Life project had been piloted in Newport which involved identifying people at risk of developing Dementia and producing a virtual wrap-around support network to stop unnecessary admissions to hospitals and care homes.

Case Study

M Sadler from the Alzheimer's Society introduced Mr and Mrs T.

Mrs T had begun worrying about Mr T in 2008. Although Mr T had never really had a good memory, Mrs T noticed little things that were not quite right. Mr T was a sporty, fun loving man who over a few days developed a twitch in his shoulder. Mr T attended an appointment with his GP who referred him on to a Doctor at Princess Royal Hospital. Mr T attended the memory service who undertook a brain scan. It took 2 years for Mr and Mrs T to receive a firm diagnosis that Mr T had Alzheimers. Mr and Mrs T were given no information regarding the diagnosis and Mr T was refused medication at the time as the guidance stated that there was no need to give medication at that stage. Mr and Mrs T wanted Mr T to have the medication the stop the deterioration at an early stage and offered to pay to have the medication, if necessary. After 1 year the guidelines were changed and Mr T was able to receive the medication that he needed.

Mrs T researched the condition on the website. There was too much information contained on the web which gave the worse case scenarios which were quite frightening for Mrs T, so eventually she stopped researching.

Once Mr T was given the medication he was referred to the Alzheimer's Society Dementia Advisor Service. A representative from the Service attended at Mr and Mrs T's home 3 weeks after the referral. This made a huge difference to the lives of Mr and Mrs T. There was lots of information and they were given signposts for dementia and referred on to support groups. Mr and Mrs T stated that this services was "absolutely marvellous".

Mr T was able to access groups such as "Singing for the Brain". This group was highly valued by Mr T as people who would not necessarily talk would join in and sing. Mr T had also learnt to read music. The downside was that there were only 10 sessions 3 times per year, so there was a gap between the sessions and some of the attendees found it hard to understand why the weekly sessions had stopped.

Mr T also attended "Tea for Two" activities which involved both memory and physical activities to stimulate the brain.

Mr T had also received cognitive stimulation – Memory Joggers. This involved Mr T attending at 2 sessions per week for 4 weeks. Unfortunately this was a short burst of intensive sessions, but once this had stopped there was nothing to replace it. It was thought that this may have been better if it was a continuous weekly session.

Mrs T valued the support groups as they were a source of company and someone she could talk to who knew what she was going through and both Mr and Mrs T had made some good friends through the groups. Without the support groups Mr T would have lost a lot of stimulation and the company of other people.

There was now a Dementia Guidebook and Mr and Mrs T expressed that this would have been a big help to them if they had been given this on the initial diagnoses.

A discussion took place including:

- The gap in information whilst waiting for a diagnosis
- Information pack/ contacts for reassurance / someone to talk to
- Possibility of introducing activities for dementia patients in local leisure services

The Chair thanked Mr and Mrs T for attending at the Board.

A further discussion took place regarding:

- The need to support carers
- Breakdown of communication between hospitals and care homes
- Isolation of being cared for at home
- Walk about Wrekin – Walks for Dementia Scheme
- Training
- The length of waiting times

Dr M Innes discussed his role as a “Dementia Friend”. There was a national 1 hour training programme for people to become a dementia friend and it was suggested that the Board received this training.

RESOLVED – that

- a) the significant progress made since the receipt of the last Report in September 2012 be acknowledged;**
- b) Board Members continue to champion Dementia as a priority across the Health and Social Care Economy and contribute to raising public and professional awareness;**
- c) Board Members become Dementia friends to demonstrate the Board’s commitment.**

HWB-22 REVIEW OF THE TERMS OF REFERENCE OF THE HEALTH AND WELLBEING BOARD

J Eatough presented a report on the Terms of Reference for the Health and Wellbeing Board.

It was asked that the Board consider the changes to the HWB’s Terms of Reference following the Board’s move from shadow to formal committee status and to allow a procedure for public speaking to take place within the Health and Wellbeing Board Meetings. The advantages and disadvantages of public speaking were highlighted at 1.4 of the report.

A discussion took place in which members strongly supported public speaking.

RESOLVED – that

- a) the changes to procedure for Board Meetings as shown at Appendix 1 to the report be agreed; and
- b) the recommendations for amendments of the constitution are taken to full Council as appropriate.

The meeting ended at 4.43p.m.

Chairman:

Date:

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

18TH SEPTEMBER 2013

**TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP UPDATE,
INCLUDING CALL TO ACTION**

REPORT OF DAVID EVANS, CHIEF OFFICER, T&W CCG

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

To present an update on a number of areas for the Health and Wellbeing Board.

2. RECOMMENDATIONS

This report is for information

3. IMPACT OF ACTION

N/A

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	No	
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	No	
TARGET COMPLETION/DELIVERY DATE	Will the proposals impact on specific groups of people?	
	No	

FINANCIAL/VALUE FOR MONEY IMPACT	No	
LEGAL ISSUES	No	
EQUALITY & DIVERSITY	No	
IMPACT ON SPECIFIC WARDS	No	
PATIENTS & PUBLIC ENGAGEMENT	No	
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

5.1 Call to Action

NHS England has released the NHS Belongs to the People, a Call to Action paper last month. This paper outlines a number of challenges facing the NHS in England over the next few years around changing demographics, increasing demand for services, new technologies at a time of 'flat' cash. The CCG will be engaging with stakeholders and communities over the coming weeks. I have attached to this report the paper from NHS England and a draft presentation that we propose to use, Appendix 1 and 2.

5.2 NHS 111

I have attached to this report, Appendix 3, the latest update on the position on NHS 111 both in terms of Telford and Wrekin CCG and across the West Midlands. Following the decision of NHS Direct that it was not in a position to continue as the provider of the 111 service contingency arrangements have been put in place locally. It is recommended that West Midlands Ambulance Service provide the NHS 111 service until March 2015 for Telford and Wrekin CCG. Shropdoc will continue to provide the Out of Hours service and I am grateful for the support they have provided over the past few months when there have been considerable issues with the implementation of NHS 111.

In the period up to March 2015 Telford and Wrekin will have to go out to tender for a new NHS 111 provider. This may be as part of a West Midlands procurement exercise or with a number of CCG's locally. To achieve this a local Project Board has been established, with Shropshire CCG which had its first meeting last week. The CCG representatives are the Chair, Chief Officer and Dr Karen Stringer. There are a number of potential options for the procurement which the Project Board is considering. Over the period up to March 2015 there

will be regular reports from the Project Board to the CCG Governing Body and to the Health and Wellbeing Board.

5.3 Maternity Services Review

The Health and Wellbeing Board will be aware that there is a review currently taking place. The lead commissioner (Shropshire CCG) has drawn up a project initiation document (PID) and is consulting on it's services publically. All stakeholders in maternity care are being asked for comment. The public information can be found at <http://www.telfordccg.nhs.uk/maternity-services> and we also have the more extensive PID should anyone wish to read it. This review is not about where maternity provision is - we are half way through the new building at PRH - rather it is about the model of delivery in the main. Responses to maternityreview@shropshireccg.nhs.uk up to 12th September.

David Evans
Chief Officer

A pink speech bubble with a dark pink border, containing the text "HOW CAN WE IMPROVE THE QUALITY OF NHS CARE?".


HOW CAN WE IMPROVE
THE QUALITY OF
NHS CARE?

A purple speech bubble with a dark blue border, containing the text "HOW CAN WE MEET EVERYONE'S HEALTHCARE NEEDS?".

HOW CAN WE
MEET EVERYONE'S
HEALTHCARE NEEDS?

A blue speech bubble with a light blue border, containing the text "HOW CAN WE MAINTAIN FINANCIAL SUSTAINABILITY?".

HOW CAN WE
MAINTAIN FINANCIAL
SUSTAINABILITY?

A green speech bubble with a dark green border, containing the text "WHAT MUST WE DO TO BUILD AN EXCELLENT NHS NOW & FOR FUTURE GENERATIONS?".

WHAT MUST WE DO TO BUILD
AN EXCELLENT NHS NOW &
FOR FUTURE GENERATIONS?

A Call to Action

Aims of Call to Action

- To have an honest and realistic debate about health and care
- To agree our shared priorities
- To help local people understand why the NHS needs to change
- To work in partnership on the bold actions needed to build an excellent NHS now and for the future
- To set out the facts about future demands on NHS services, how the budget is currently spent and how services are delivered
- Provide an opportunity for you to share your views and ideas on the future of the NHS


HOW CAN WE IMPROVE
THE QUALITY OF
NHS CARE?

HOW CAN WE
MEET EVERYONE'S
HEALTHCARE NEEDS?

HOW CAN WE
MAINTAIN FINANCIAL
SUSTAINABILITY?

WHAT MUST WE DO TO BUILD
AN EXCELLENT NHS NOW &
FOR FUTURE GENERATIONS?

WHAT ARE THE NATIONAL CHALLENGES?

A pink speech bubble graphic with a white outline and a drop shadow, containing the text 'The NHS belongs to the people: a call to action'.

**The NHS belongs
to the people:
a call to action**

Every day the NHS saves lives and helps people stay well, but 65 years ago, many people faced choosing between poverty if they fell seriously ill or forgoing care altogether.

Today:

- The NHS treats 1,000,000 people every 36 hours
- Between 1990 and 2010, life expectancy in England increased by 4.2 years
- 88% of patients in the UK described the quality of care they received as excellent or very good

Throughout these changes the NHS continues to be highly valued by the public.

71% agree "Britain's National Health Service is one of the best in the world"



Source: Ipsos Mori 2013

What challenges will the health and care service face in future?

Demand for NHS Services

Ageing Society

Rise of long-term conditions

Increasing expectations

Supply of NHS Services

Increasing costs of providing care

Limited productivity gains

Constrained public resources

What's next?

Rise in Long Term Conditions



Diabetics up 29% by 2025 to reach 4 million

An ageing population



The number of over 80s will double by 2030

Increasing expectations



Seven day access requested

How do we prioritise our resources to address these challenges?



- Limited financial resources
- If we do nothing by 2020, the NHS could face a gap in funding of £30bn

What does this mean nationally?

- Shift the focus from buildings to services.
- Meet the needs of an ageing population, many of whom are living with multiple long term conditions, through strengthened care closer to home.
- Changing, not charging.
- Openness and transparency about where we get it right and where we get it wrong.
- An honest and realistic debate across the country about how the NHS will be shaped.

So what is happening in practice?

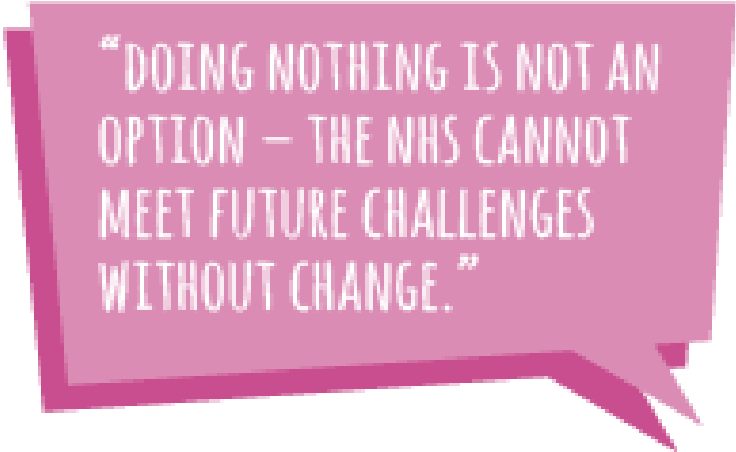
- A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England.
- The engagement will be patient and public-centred through hundreds of local, regional and national events as well as through on-line and digital resources.
- It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients.



Preserving the values that underpin a universal health service, free at the point of use, will mean **fundamental changes** to how we deliver and use health care services.

This is NOT about:

- Privatising the NHS
- Charging for services
- Restricting access

A pink speech bubble with a white border, containing a quote in white, uppercase, sans-serif font.

“DOING NOTHING IS NOT AN OPTION – THE NHS CANNOT MEET FUTURE CHALLENGES WITHOUT CHANGE.”



WHAT ARE THE CHALLENGES IN SHROPSHIRE?

Demographics

Shropshire

290,000 people

Predominantly rural population with county town and market towns, generally older than national averages.

Overall population growth of 8% between 2001 and 2011, with 24% rise in number of people aged 65+

Life expectancy is higher than England averages and all-age all-cause mortality is lower. The overall health of the population is good.

Inequalities persist with no significant increase in life expectancy in the most deprived areas, with the gap between affluent and deprived areas increasing.

Telford & Wrekin

170,000 people

Predominantly urban population, generally younger than national average.

Overall population growth of 8% between 2001 and 2011, with higher proportion of people from BME communities than Shropshire.

Whilst health status is improving, challenges remain in areas such as cancer, heart disease and stroke mortality (particularly for men).

A quarter of children live in poverty and some wards in the 10% most deprived nationally.

Urban and Rural Opportunities

Urban

Urban deprivation

Urban access and congestion

Dense population

Major population centres

Main acute hospitals

Opportunities for providing health centre / hub services

Generally associated with poorer health status

Rural

Rural deprivation and isolation

Accessibility and public transport

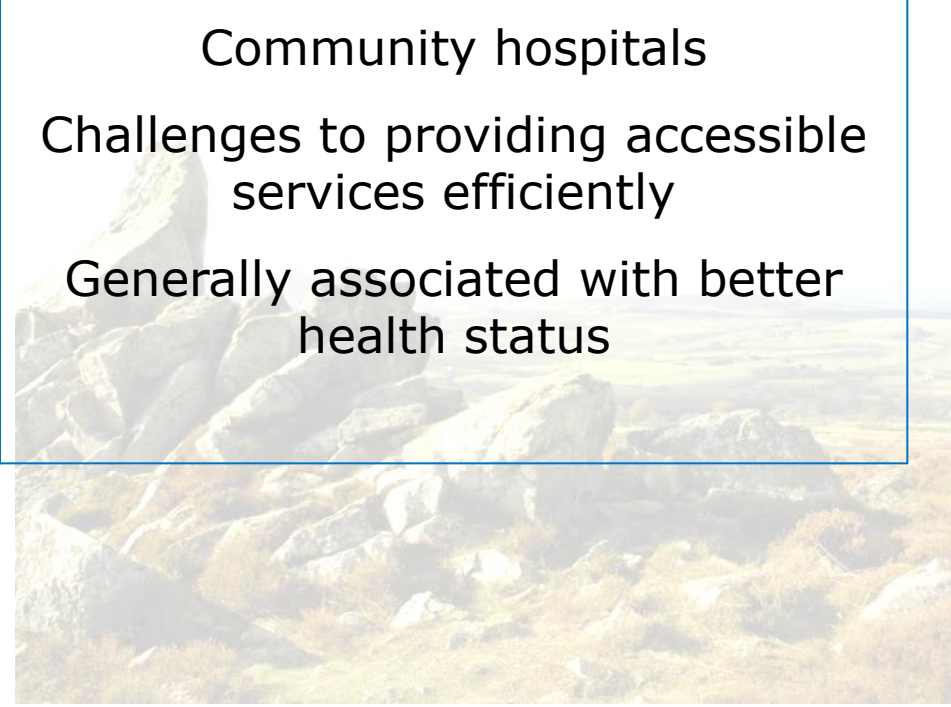
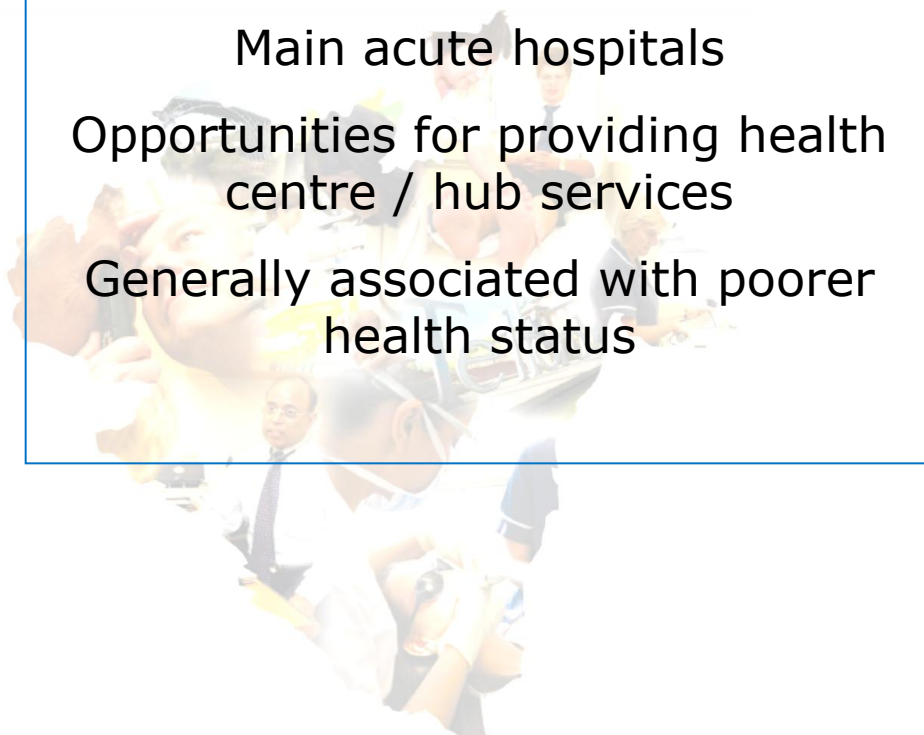
Disperse population

Market towns, villages and hamlets

Community hospitals

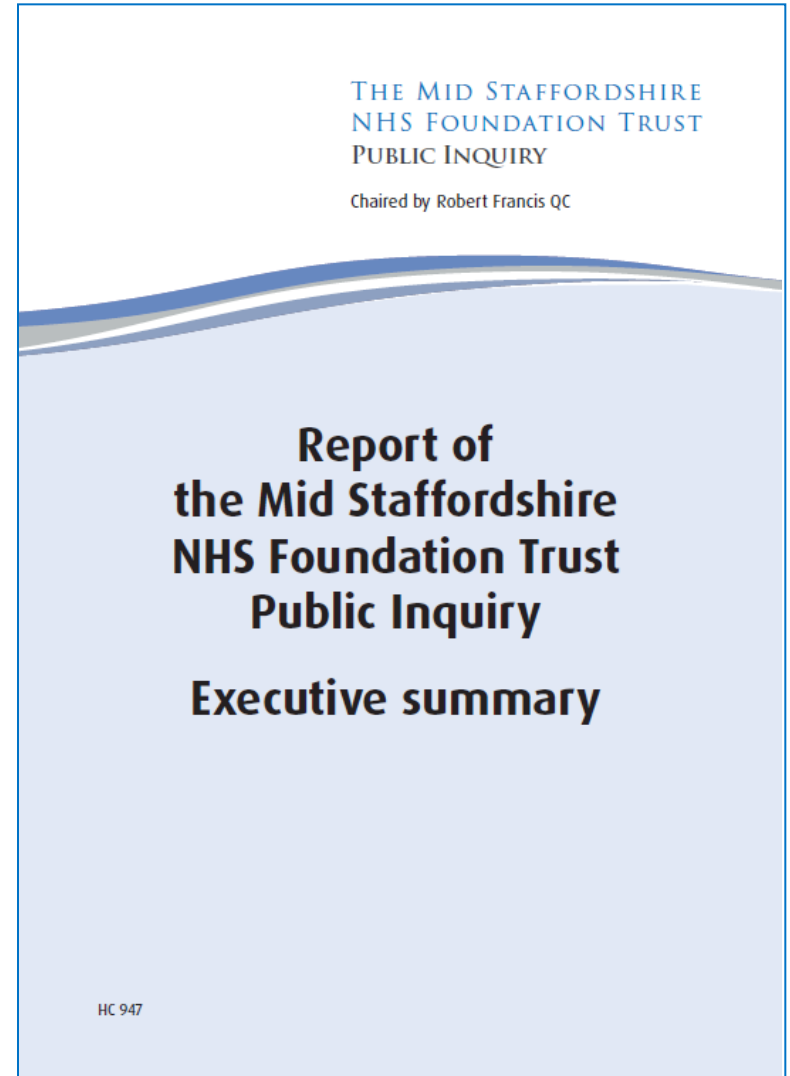
Challenges to providing accessible services efficiently

Generally associated with better health status



Commissioning for quality and outcomes

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm



Shropshire health challenges:



- Ageing population – people aged 85 and over has increased by 35% from 6,211 in 2001 to 8,400 in 2011. Compared to a rise of 24% in England and Wales
- Health inequalities – e.g. people living in the most deprived areas of Shropshire are significantly more likely to die prematurely from cardio vascular disease and cancer than those living in the least deprived areas
- Lifestyle risk factors to health – e.g. almost a quarter of people aged 16 years are classed as obese
- Dramatic increase in the number of people suffering from a long term illness or disability
- Access to health care particularly in rural areas; availability of public transport
- Providing sustainable and high quality services that best meet the needs of our urban and rural communities

Telford & Wrekin health challenges:



- In top 30% of most deprived local authorities in the West Midlands
- Ageing population with both the 65 – 84 and 85+ age groups increasing by over a fifth between 2010 and 2011
- Early death rates (under 75 years) from cancers and heart diseases remain
- Number of people with dementia set to increase by 17% by 2015 (1,850 people)
- Estimated 4,418 people (16+ years) will have diseases related to breathing but only 3,077 were recorded as diagnosed at the end of March 2012
- Providing sustainable and high quality hospital services that best meet the needs of our urban and rural communities

Challenges for our Acute Hospitals

Increasingly moving to consultant-led service with appropriate levels of sub-specialisation to provide the best care, eg

- ITU
- Accident and Emergency
- Stroke Services

National workforce challenges in key areas that reduce our ability to recruit and retain, eg A&E and paediatrics

Local workforce challenges, with split-site services and onerous on-call arrangements making roles unattractive

Poor supporting infrastructure in key areas, eg A&E, critical care



Challenges for our Community Services


- Supporting people in the community to maintain their independence
- Providing care closer to home in a very rural county
- Rising demand



Opportunities

- Improved clinical outcomes, eg single site stroke service.
- Reduced mortality and disability due to consultant decision-making closer to arrival at hospital.
- Bringing teams together provides greater opportunities for seven-day working and more innovative ways of working.
- Attracting the best workforce to sustain services.
- Closer working and integration for community services with social care, voluntary sector and other partners
- Mobile technology provides further opportunities
- The challenge needs radical solutions – not more of the

The Context

National standards and guidance	How do we make sure that our health services are meeting national standards for the future?
Workforce	Can we recruit or develop the workforce we will need to deliver services in new ways?
Partnerships	How do all parts of the health and care system work together with the person at the centre?
Capital	What will it cost in capital terms to transform services? Can we borrow this, and can we afford the revenue consequences?
Revenue	How do we deliver this within the resources available to us from the public purse?
 Needs and expectations	How do we best meet the expectations and needs of both urban and rural communities?

Discussion - thinking to the future



1. What do you think are the main challenges and opportunities for the NHS over the next 5 years?
2. What is most important to you and why?
3. What might be some options for change?

Next steps

- CCGs use feedback from Call to Action (and other involvement/engagement) to inform development of 3-5 year commissioning plans
- Joint “Clinical Services Strategy” Programme will develop options for the future of local hospital services?

HOW CAN WE IMPROVE
THE QUALITY OF
NHS CARE?

HOW CAN WE
MEET EVERYONE'S
HEALTHCARE NEEDS?

HOW CAN WE
MAINTAIN FINANCIAL
SUSTAINABILITY?

WHAT MUST WE DO TO BUILD
AN EXCELLENT NHS NOW &
FOR FUTURE GENERATIONS?

The NHS
belongs to
the people

A CALL TO
ACTION

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Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness, compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more health and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.



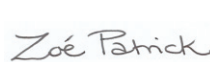
David Behan,
Chief Executive
Care Quality
Commission



Alan Perkins,
Chief Executive
Health and Social
Care Information
Centre



Ian Cumming,
Chief Executive
Health Education
England



Zoe Patrick,
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Local Government
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David Bennett,
Chief Executive
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Andrew Dillon,
Chief Executive
National Institute
for Health and Care
Excellence



Peter Melton,
Chief Clinical
Officer, North East
Lincolnshire CCG,
Co-chair of NHS
Commissioning
Assembly steering
group



David Nicholson,
Chief Executive
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The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.¹ There is still too much unwarranted variation in care across the country, exacerbating health inequalities.² As the Mid-Staffordshire and

Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

¹ Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.

² For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value and improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

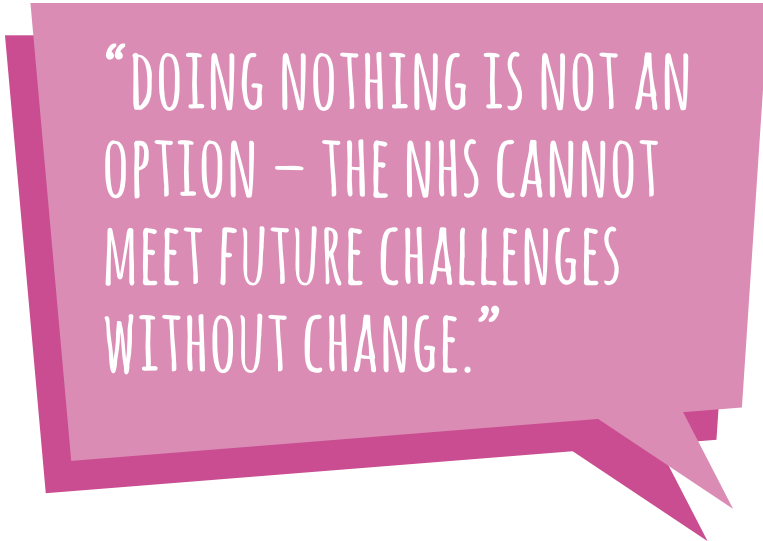
So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing

nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.



“DOING NOTHING IS NOT AN OPTION – THE NHS CANNOT MEET FUTURE CHALLENGES WITHOUT CHANGE.”

How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.³ The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.⁴

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.⁵

³ Office for National Statistics (2011) <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-227587>

⁴ World Health Organisation (2013) <http://data.euro.who.int/hfad/>

⁵ World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.⁶ People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.⁷

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

“BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL.”

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.⁸ A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.⁹

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

⁶ Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

⁷ The Marmot Review (2010), "Fair Society Healthy Lives".

⁸ Royal College of Physicians (2012), "Hospitals on the edge? The time for action".

⁹ Health and Social Care Information Centre

<http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care++England%22&area=&size=10&sort=Relevance>

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study¹⁰ of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

“EVERYONE WORKING IN THE NHS MUST STRIVE TO MAINTAIN AND IMPROVE ON THIS HIGH LEVEL OF PATIENT SATISFACTION AND EXTEND IT TO EVERYONE WHO USES THE NHS.”

¹⁰ Commonwealth Fund (2011), “International Health Policy Survey”.

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,¹² of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.¹¹

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.¹³ The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.¹⁴ Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

¹¹ Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.

¹² National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook"

<http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153>

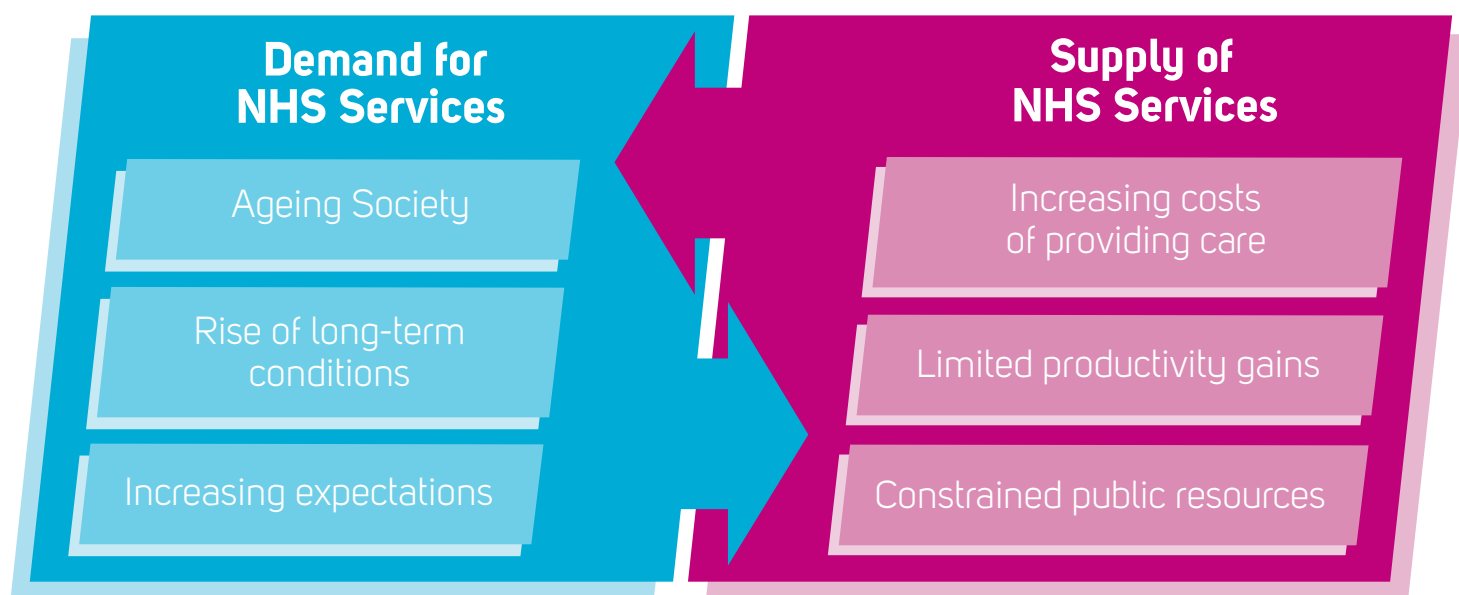
¹³ The Marmot Review (2010), "Fair Society Healthy Lives"

¹⁴ The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.¹⁵
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.¹⁶
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.¹⁷

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.¹⁸

“STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE.”

Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.¹⁹

¹⁵ Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.

¹⁶ Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.

¹⁷ Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".

¹⁸ McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".

¹⁹ A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

Changing burden of disease

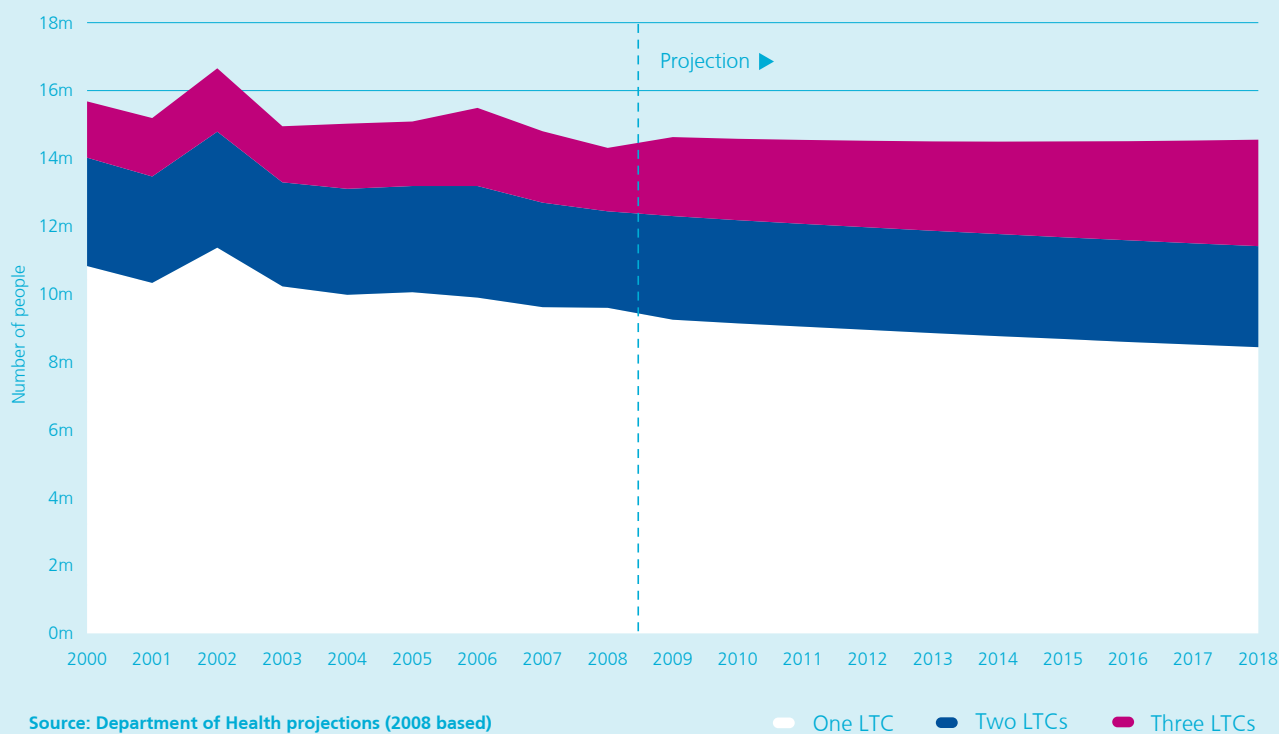
People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.²⁰

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system

made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

“THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND”

Actual/projected numbers with one or more long-term conditions by year and number of conditions



²⁰ Department of Health (2012), “Long Term Conditions Compendium” (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.²¹

Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and

heart disease.²² Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.²³ If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more

information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

²¹ Alzheimer's Society (2012), "Dementia 2012".

²² Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.

²³ See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more

expensive than the old technologies they replace - for example, the latest cancer therapies²⁴ - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.²⁶ We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

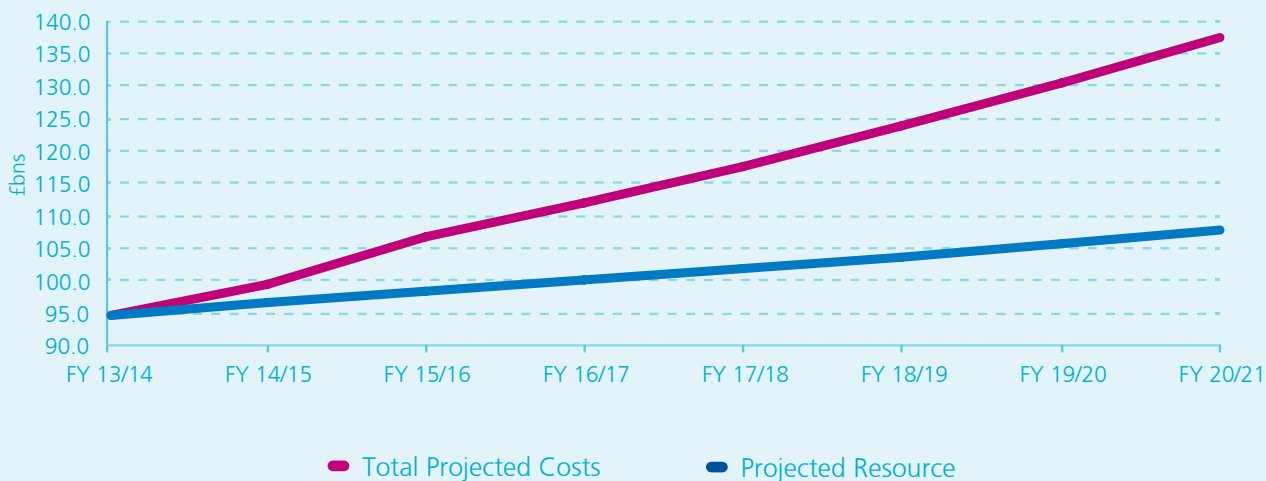
In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.²⁵

²⁴ Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", *The Lancet Oncology*.

²⁵ NHS England analysis.

²⁶ Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?", King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.

Projected resource vs. Projected spending requirements



Source: NHS England

Limited productivity improvements

Measuring the productivity²⁷ of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.²⁸ Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.²⁹ This suggests that the NHS may not be using its capacity as efficiently as it could.

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England’s analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.³⁰ Improvements such as better performance management, reducing length of stay, wage freezes or

“THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14.”

better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called “Nicholson Challenge” of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

²⁷ At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

²⁸ Office for National Statistics (2010), “Public Service Productivity Estimates: Healthcare, 2010”.

²⁹ Office for National Statistics (2010), “Public Service Productivity Estimates: Healthcare, 2010”.

³⁰ This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,³¹ but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

³¹ Department of Health (2009), "Public Health and Prevention Expenditure in England".

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care

and treatment, they have better outcomes, are less likely to be hospitalised,³² follow appropriate drug treatments³³ and avoid over-treatment.³⁴ Personalised care planning is also highly effective.³⁵ A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.³⁶

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.³⁷

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.³⁸ A comparable model in health

would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.³⁹ This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

³² JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.

³³ Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".

³⁴ D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value and improve quality".

³⁵ "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".

³⁶ <https://www.phbe.org.uk/>

³⁷ NHS England (2013), "Catalogue of Potential Innovation".

³⁸ Office for National Statistics (2009), "e-society" (Social Trends 41).

³⁹ For example Kaiser Permanente and the Veterans Administration, both in the USA

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.⁴⁰

“THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013”

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

⁴⁰ Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific

characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.⁴¹ This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.⁴² This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.⁴³

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,⁴⁴ and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

⁴¹ McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".

⁴² Office of National Statistics (2012), "Sickness absence in the labour market".

⁴³ Department of Health (2011), "Innovation, Health and Wealth".

⁴⁴ Department of Health (2011), "Innovation, Health and Wealth".

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association, the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. Do nothing. The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. Assume increased NHS funding. In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. Cut or charge for fundamental services, or 'privatise' the NHS. We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to action engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style

meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.

West Midlands NHS111 Update for CCG Boards

1 Introduction

The NHS111 service launched in the West Midlands in mid March 2013 and immediately encountered significant difficulties. A previous paper was presented to CCG Boards in May which described some of the difficulties following implementation and also set out work that was underway to stabilise service delivery.

This paper provides an update on progress with the work to stabilise the NHS111 service and the actions taken to date along with details of planned actions for the short and medium term.

The paper will cover

- Operational Progress
- Assurance process
- Finance
- Clinical Blueprint for future service specification
- Procurement
- Communications
- CCG decisions required

There have been two West Midlands NHS 111 Project Boards and a number of teleconferences since the May update report was issued, following these meetings and discussions the governance arrangements for NHS111 in the West Midlands have been refreshed. Details of these arrangements are also set out in the paper.

2 Operational Progress

The West Midlands CCGs took a firm grip on recovering a sustainable NHS111 service in the West Midlands, reviewed the early service failure and set about developing service delivery proposals which would rebuild the confidence in NHS111 locally.

NHS Direct subsequently announced that it could no longer continue to provide NHS111 services across the country. This decision will require CCGs to terminate their existing contractual relationships with NHS Direct and to put in place plans that ensure continuity of the NHS111 service during the short and medium term.

A great deal of work has been undertaken with colleagues from all CCGs across the West Midlands to establish the proposed pattern of service delivery for the next 12 to 18 months. The outputs from these discussions have seen the development of three discrete plans covering services that will be put in place until at least October 2014.

The three plans are for Staffordshire; Worcestershire; and the remainder of the West Midlands and details of each are set out below.

Staffordshire

The preferred partner for Staffordshire is Staffordshire Doctors Urgent Care who will provide a county wide service 24 hours per day 7 days each week from call centres in the county.

Detailed action plans are in place to ensure that a safe and sound service is established and implemented on a phased basis from the end of October 2013.

Staffordshire has established its own local project governance structures which feed into the overarching West Midlands wide governance arrangements described below.

The Staffordshire plans will be subject to an assurance process which NHS England will oversee to ensure that as a new service all appropriate risks have been identified and mitigated prior to service commencement.

The arrangements for Staffordshire have been formally agreed by the respective Boards of the commissioner and provider.

Worcestershire

Harmoni has been identified as the preferred service delivery partner for Worcestershire and will provide a county wide service from its call centre in Ipswich 24 hours per day, 7 days each week.

Detailed action plans are in place to support the implementation of a new service from 26 November 2013 along with the appropriate project structures to ensure that all NHS England assurance tests are passed successfully.

The arrangements for Worcestershire have been formally agreed by the respective Boards of the commissioner and provider.

Remainder of West Midlands

West Midlands Ambulance Service has been identified as the preferred step in partner for the rest of the West Midlands and will offer a 24 hours per day, 7 days each week service from a call centre in Dudley.

There is a well developed action plan covering workforce, operational and infrastructure elements of service delivery from 12 November 2013. The West Midlands Ambulance Service plan reports into existing local weekly and monthly project boards.

This plan will be classed as a service transfer from NHS Direct and as such will be subject to separate assurance tests by NHS England prior to implementation.

The plan for West Midlands Ambulance Service to step in as service provider from October was formally agreed by their Trust Board at a meeting on 2 September 2013.

3 NHS England Assurance Process

Each of the service plans which make up the wider West Midlands action plan will be subject to NHS England assurance as indicated above.

There are a number of milestones which will need to be achieved before a plan will be approved for implementation and these are described below.

Each plan will need to set out the service model which has been agreed between the commissioner and provider locally, in addition there is a requirement for each plan to demonstrate that the appropriate IT infrastructure is in place and has been tested rigorously.

A clinical governance submission will be required to ensure that all appropriate measures are in place to maintain the highest levels of quality and safety in patient services.

It will also be necessary to demonstrate that the local Directory of Service is comprehensive and up to date to ensure that callers are signposted promptly to the most appropriate service.

Each of the above milestones will be subject to testing by NHS England to ensure that staff are trained, there is a robust infrastructure for delivery, policies and procedures are in place and that the proposed service is clinically sound.

In addition NHS England will require a letter of assurance from an independent source confirming that a sense check of each plan has been undertaken and that projections on staffing and activity correlate.

4 Financial position

NHS England has confirmed that there will be no central funding to support Clinical Commissioning Groups in establishing new and replacement services.

Each CCG has been advised that they need to expect to commit up to the planned contract value of NHS111 which stands at approximately £15.3 million across the West Midlands.

There is presently an exercise underway to validate details of the wide range of costs incurred thus far as a result of the NHS111 situation including payments to NHS Direct for activity delivered; local CCG costs incurred in mitigating the significant initial difficulties

experienced; also costs for out of hours providers for those not receiving a service from NHS Direct; and central project team costs.

Early indications are that these costs are within the above mentioned £15.3 million already set aside by CCG's for NHS111 contracts. However the costs for delivery of the plans described above from October 2013 onwards are presently being finalised and levels of activity through the winter may be unpredictable, both of these represent a degree of risk for CCGs. There is also an ongoing debate with NHS England over how the continued use of the 0845 NHS Direct number should be funded; this may also represent a further financial pressure.

In the long term there will be the costs associated with re procurement of the NHS111 service across the West Midlands and these are estimated at the moment to be approximately £500k across the West Midlands.

During the period leading up to the end of September 2013 all CCGs agreed to support a risk sharing arrangement so that no one CCG would be exposed to a deficit for their planned NHS111 service costs.

Having collected all costs and assessed against contract value there are a handful of CCGs which are in a deficit position totalling approximately £600k therefore in accordance with the agreement on risk sharing it is proposed to share this across the remaining CCGs who are in a projected surplus position at the end of month 6. Thereafter each CCG would be responsible for costs associated with their interim arrangements and a share of re procurement costs.

5 Clinical Blueprint for Future Service Specification

Throughout July and August a wide range of clinicians representing commissioner and provider organisations have engaged in a process designed to review and define the specification for the NHS111 service when it is re procured for the West Midlands. The aim of the process has been to learn lessons from past experience and also to enable and facilitate collective clinical thinking on what is required for the future. Two workshops have been held to date and the outputs from these and a tailored questionnaire will shape the development of the service specification in readiness for the re procurement to commence. It is envisaged that the redesigned service specification will be available by the end of September.

6 Procurement

There are two phases to the process of procurement for NHS111 across the West Midlands. The first is to secure a partner to support the CCGs in undertaking and completing a procurement exercise which is compliant with current legislation and identifies a new NHS111 provider/providers from October 2014. The CCGs will utilise the GPS Framework during this phase of procurement which will coincide with the completion of the work on the Clinical Blueprint and will allow a period of some 50 weeks for the procurement of the new NHS111 service.

The second phase is the procurement of the new service and work is underway with CCGs across the West Midlands to finalise the preferred basis of procurement and required timescales.

7 Communications

Arrangements have been put in place for West Midlands wide briefings in the first week of September to key stakeholders, to support the local implementation plans. In addition a new GP Newsletter will be produced to keep all practices up to speed with service developments across the West Midlands.

In relation to the West Midlands Ambulance Service step in plans, a series of staff briefings at NHS Direct and at West Midlands Ambulance Service have already taken place, with further staff briefings planned for 4th September 2013. These briefings will keep those staff who may be affected by the service transfer up to date with planned service developments.

8 Governance arrangements

Sandwell and West Birmingham CCG are the coordinating commissioner of the NHS111 service for the West Midlands and with the agreement of the other West Midlands CCGs have established a West Midlands NHS111 Project Board which is comprised of all the CCG Accountable Officers. This Board provides oversight and direction to the development of NHS111 service in the short and medium term.

Beneath the Project Board a central project team has been established which runs a number of workstreams relating to operational delivery, finance, clinical governance, procurement and communications. The project team consists of

Andy Williams (Sandwell & West Birmingham CCG Accountable Officer)
James Green (Sandwell & West Birmingham CCG Chief Finance Officer)
Jon Dicken (Sandwell & West Birmingham CCG Chief Officer (Operations))
Dr Jonathan Leach (Arden, Hereford & Worcester Area Team)
Rachael Ellis (Sandwell & West Birmingham CCG, NHS111 Project Lead)
Anna Donaldson (Central Midlands CSU)

The project team will remain in place until the completion of the procurement process and the implementation of the new NHS111 service across the West Midlands.

9 Recommendations

The CCG Governing Body is asked to

- Note the contents of the report

- Agree that West Midlands Ambulance Service are confirmed as the preferred step in partner for transfer of the NHS111 service for the period up to October 2014
- Note the proposed date for commencement of the interim services
- Note the requirements of the NHS England assurance process
- Note and agree the financial position, proposed costs and risk sharing arrangements
- Commit to utilising the outputs from the Clinical Blueprint workstream
- Note the GPS Framework approach for identifying a procurement partner
- Agree to terminate the existing contractual relationship with NHS Direct
- Note the governance arrangements

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TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

18 SEPTEMBER 2013

TELFORD & WREKIN COUNCIL UPDATE

REPORT OF THE DIRECTOR OF HEALTH, WELLBEING & CARE

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 This report provides a summary of some key developments impacting on Adult Social Care, with particular reference to the findings of the recent Peer Challenge in Adult Social Care and the current financial pressures facing the service.

2. RECOMMENDATIONS

2.1 Board members note the findings of the Peer Challenge Team and the Council's response.

2.2 Board members note the financial challenges facing the Council and consider the impact they could have on the local health and social care system.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Co-operative Council priorities?	
	Yes	Vulnerable Children & Adults Health and Wellbeing
	Will the proposals impact on specific groups of people?	
	Yes	Will impact on people who are ill or disabled, who need support and on their family carers
TARGET COMPLETION/DELIVERY DATE		
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The Care and Support Service Area faces significant financial challenges going forward. The Personalisation

		<p>Transformation Plan and the Financial Improvement Plan. are key to addressing these challenges and it is vital that the actions within these plans are delivered.</p> <p>The financial implications of any additional actions within these plans resulting from the Peer Challenge have not yet been assessed but will need to be met from within existing resources.</p> <p>The Service have sufficient one off resources to fund the additional staff required to deliver the Transformation Plan.</p>
LEGAL ISSUES	Yes	<p>As outlined in the body of the report, there are significant changes ahead in the field of Adult Social Care.</p> <p>The Care Bill was introduced into the House of Lords on 9th May 2013 The Bill is due to enter the Report Stage in the House of Lords on 9 October 2013 and will consolidate and modernise existing care and support law from over a dozen Acts into a single framework.</p> <p>The Bill and subsequent Statute, once it receives Royal Assent ,will be accompanied by relevant Statutory Instruments and Guidance.</p> <p>Legal advice and support upon specific issues can be either provided by or obtained by Legal Services upon request</p>
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact

PART B) – ADDITIONAL INFORMATION

4. INFORMATION

- 4.1 Until 2010 Council's were subject to very intensive inspection and monitoring arrangements in respect of their commissioning and delivery of Adult Social Care responsibilities, set out by Government and led by the Care Quality Commission (CQC) on their behalf. Our last inspection was in 2010 when CQC rated the Council as performing "well" in safeguarding adults and performing "well" in supporting older people with "promising" capacity to improve.
- 4.2 Following lobbying from Council's and the Association of Directors of Adult Social Services (ADASS), Government agreed that the burden created by the inspection regime outweighed the benefits of the process and the system was abolished. This should not be confused with CQC's continuing responsibility to regulate and inspect registered care providers (residential & nursing homes, domiciliary care providers, etc) including our own in house provision.
- 4.3 However there was an expectation that ADASS would introduce a new system of self regulation based on a sector-led improvement approach. A local Peer Challenge programme has now been developed as part of sector-led improvement approach across the West Midlands region. It recognises that self-aware Councils will always want to improve and share expertise and experience whilst also looking for help and support in areas where they are less well developed.
- 4.4 Telford & Wrekin volunteered to be the pilot Local Authority for this approach in the region and therefore will be instrumental in shaping the format and content of future Peer Challenges.
- 4.5 The Peer Challenge team were on site for 3 days during the period 22-26 July 2013 and engaged with staff, managers, service users, carers, elected Members and partners. They were able to review documentary evidence around our performance, structures, processes and policies in advance as well as conducting interviews and group sessions whilst on site in Telford.
- 4.6 The key lines of enquiry which we asked the team to review were:
- **how well are we addressing our original principles and priorities relating to the introduction of Personalisation to underpin our approach to the delivery of community care services** particularly in the context of service user and carer experience, especially around choice and control
 - **the sustainability of our model** given the future opportunities and challenges presented by demographic and funding pressures, legislative change such as the Care Bill and the national cross-party 'integration' agenda

These areas were selected by T&W Council, as our own self-assessment had highlighted challenges in these areas and we

considered we would get best value from the Peer Challenge looking into these aspects specifically.

4.7 In summary they identified the following strengths:

- dedicated, hard working and loyal workforce
- real commitment from partners
- clear insight into challenges and issues
- Cabinet Member focused on budget strategy and need for transformation
- understanding of the financial challenges
- support for carers
- strong partnership working with the Clinical Commissioning Group (CCG)
- good basis of joint commissioning with the CCG which can be re-launched and extended
- robust safeguarding response to Winterbourne
- engagement with service users and carers
- innovative workforce development
- vibrant, well informed voluntary and community sector (VCS) - keen to be more involved
- commitment and potential for greater integration with NHS
- enablement integrated with Health
- hospital discharge processes are lean with good support
- budget strategy and efficiency plans in place
- significant level of efficiencies already achieved

4.8 They also stated, *“we have learnt from the process ourselves and we have really appreciated the opportunity to take away some good examples of care and support that we can share with our own Councils”*

4.9 However whilst the Peer Challenge Team identified these strong foundations to build on, they also identified that the:

- Personalisation journey had stalled and *“would benefit from a fundamental review”* and re-launch *“to develop the step change”* required
- *“That the sustainability of the budget strategy is predicated upon the transformation plans that need revision, and clear leadership to ensure delivery by the Council”*
- *“Co-production with people who use services and family carers is central to the success of personalisation and this should be exploited in developing further transformation plans*
- *“Challenges faced by the Directorate, like all Councils, are immense and there will need to be consistent and further leadership and support from senior Elected Members and the Corporate centre of the Council to assist the response to the challenges”*

4.10 In summary the following areas were set out for the Council to consider in moving forward:

- corporate visibility of adult social care
- stronger relationship between finance, performance and operational management
- whole system vision to underpin transformation programme
- dedicated transformation resource and expertise for budget and service redesign
- allow time for staff and managers to come together to learn, share and deliver the vision
- actions required on culture, performance and leadership
- re-launching choice and control and achieving/sustaining cultural shift
- further work needed on Resource Allocation System (RAS)
- approach to personalisation needs to be more creative and embedded
- implement new market development strategy - emphasise building community capacity
- signposting - single source, better recording in CareFirst, fuller role for VCS
- embed integration of teams and expertise
- focus on service user reviews
- use of common language

4.11 Unlike the former inspection regime there is no statutory requirement to publish the findings or consider them formally within a Council Committee. However the approach we have taken is in line with the Council's co-operative principles and the letter, with the agreement of our Cabinet Member, has already been shared with all who took part in the process, including our partner agencies, providers of care, voluntary organisations, etc.

4.12 Actions relating to the Challenge findings will be incorporated within the existing Personalisation Transformation Plan and the Financial Improvement Plan.

4.13 A series of team sessions are arranged during September and October to feed back the key messages to frontline staff and seek their views, suggestions and support to take this forward.

4.14 Key messages will also be fed back to stakeholders and partners during September and October through existing, established meetings.

4.15 Fundamental to delivering the personalisation agenda and in turn supporting our savings requirement will be the introduction of Personal Budgets for all service users in receipt of community care funding, calculated through a Resource Allocation System (RAS). This will ensure that there is a fair and equitable system in place so that people with the same level of need receive an equal level of resource which is sufficient to meet their eligible, unmet needs. The Council purchased

such a system last year, with Council approval, which we have been testing. We now need to move forward as soon as is practical to use it as an integral part of our community care process. Initially for all new cases and on a phased basis for all existing service users, as recommended by the Peer Challenge Team.

4.16 Use of a RAS will require a new Policy & Procedure (P&P) to be agreed by Council and we intend to bring a report for Cabinet approval in the near future. The report will need to set out:

- the overall budget available for meeting eligible community care need to allow the system to be calibrated to reflect this
- an implementation date from which all new people will be given a RAS generated indicative budget as the maximum amount of Council funding they can expect to receive once their personal budget is confirmed
- a transition process for existing service users where their RAS generated personal budget is significantly different to our existing expenditure on their care package.

4.17 The Peer Challenge highlighted the difficult financial situation facing both the Council and Adult Social Care. In fact since the Peer Challenge the financial pressures facing Adult Social Care have increased still further. Against a background of the Council receiving 33% less funding between 2010/11 and 2014/15, Adult Social Care has been expected to deliver it's proportion of savings. However given the current demands the service is projected to be heading for over £4m overspend by the end of this financial year. We are facing unprecedented demand for services as we support the health economy to meet the demands placed upon it to reduce hospital admissions and speed up discharge, which means that people with much higher needs are remaining in the community care system and the average cost per person is increasing.

4.18 The Council is therefore in the process of considering what actions it can take to to rectify this position. The pressure can be eased to some extent in year by the use of a small amount of one off funding and we believe there are savings to be made by reducing the unit price we pay for care. However given that during 2014-16 Adult Social Care has to make a further £6.5m saving we will have to start making significant reductions now in the amount of care we provide for people and reduce the number of people receiving support.

4.19 A further report will need to be brought back to the Board once a Financial Improvement Plan has been agreed within the Council to take account of the current projected overspend and savings required in the next two years. Inevitably this will be extremely challenging for our local whole system approach, our Health and Wellbeing Strategy and Health and Wellbeing Board.

5. PREVIOUS MINUTES

None

6. BACKGROUND PAPERS

None

**Report prepared by Paul Taylor, Director: Health, Wellbeing & Care
Telephone: 01952 381200**

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD: 18TH SEPTEMBER 2013

JOINT HEALTH AND WELLBEING STRATEGY: PERFORMANCE AND PARTNERSHIP PROGRESS UPDATE

REPORT OF HELEN ONIONS, INTERIM ASSISTANT DIRECTOR: HEALTH & WELLBEING AND JON POWER, DELIVERY & PLANNING MANAGER.

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

This report provides the Board with an update on partnership developments to drive delivery of the Health & Wellbeing Board Strategy's priorities. It describes the progress to develop integrated approaches to commissioning between partners for 'Early Help' and 'Co-operative Commissioning'.

2. RECOMMENDATIONS

That the Health and Wellbeing Board support the:

- Development of an operational and strategic commissioning groups
- Continued development of the Early Help Partnership approach

3. IMPACT OF ACTION

- Both proposed partnerships will ensure that service design and delivery is better, more effectively designed and co-ordinated to ensure that service users needs are met in a seamless and efficient manner through high quality services.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority?	
	Yes	All priorities through the proposed Co-operative Commissioning model
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	<ul style="list-style-type: none"> • Protect and support our vulnerable children and adults • Improve the health and wellbeing of our communities and address health inequalities • Put our children and young people first
	Will the proposals impact on specific groups of people?	
Yes/No	<i>If yes, briefly summarise any impact(s) – see separate guidance note for groups to consider</i>	
TARGET COMPLETION/DELIVERY DATE	The Board receive strategy development updates at every meeting.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	Financial sustainability is a cross cutting principle of the HWB strategy.
LEGAL ISSUES	Yes	<p>In establishing the arrangements proposed in this report the starting point should always be that procurement/commissioning undertaken by the Council must comply with statutory requirements and the contract procedure rules contained in the Council's constitution. Accordingly any arrangements must be established with that requirement in mind.</p> <p>Moreover, during any collaborative arrangements with local stakeholders the Council will need to ensure that its statutory obligations and its own procedures for working with contractors can be met and that there are sufficient provisions within the relevant contract for Council officers to monitor performance and address concerns.</p>
EQUALITY & DIVERSITY	Yes	These proposals are designed to ensure services better meet the needs of all of our population. This will require effective understanding of the needs of individuals whatever their specific needs.

IMPACT ON SPECIFIC WARDS	No	Borough-wide
PATIENTS & PUBLIC ENGAGEMENT	Yes	Through the Early Help partnership and proposed stakeholder engagement event.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	Both proposed partnerships provide the opportunity to improve outcomes and efficiency through better, joined-up service delivery across our priorities.

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

Asset mapping workshops

As part of the development of the HWB strategy further asset mapping workshops have been held to engage stakeholders in discussions around our priorities. Workshops were held for the emotional health and wellbeing priority in August and early September. There have been a series of preparatory meetings with key stakeholders who contribute to the excess weight priority. These leads will come together at a workshop on 26th September to discuss the priorities for the refreshed strategy and action plan for excess weight. A stakeholder consultation workshop is being organised to refresh the drug and alcohol strategy for mid September/early October.

Developing the Co-operative Commissioning Approach

A group of HWB members and key officers met on the 18th August to develop proposals for collaborative commissioning approach across a range of children, family, adult and health services in the Borough. The group identified resources available in terms of commissioning staff to support collaborative commissioning function.

The commissioning cycle framework was used to work through a recent commissioning example, the smoking cessation services procurement exercise to understand and map key functions and roles and responsibilities across HWB partner organisations.

The exercise generated a set of principles which were agreed as important for successful collaborative commissioning, as follows:

- Importance of a strategic overview for each commissioning organisation setting out and agreeing commissioning intentions
- Identification of key partners at the outset to ensure stakeholder involvement in the process
- Identification of target groups
- Identification of priorities/outcomes
- Systematically adopt the “Every Contact Counts” approach through use of existing services to provide or signpost where possible
- Consider use of schools, family nurse partnership, school nurses, youth and community, family support, social workers etc.
- Establish strong voluntary sector coordination role for within the sector
- Need robust but not bureaucratic set of rules for measuring quality of internal service provision

- Accountability for collaborative commissioning should be through the Health & Wellbeing Board as this is a key part of the making it happen focus of the strategy

The following collaborative commissioning groups were proposed:

Operational Co-operative Commissioning Group:

- Louise Mills (Telford & Wrekin Council)
- Christine Harrison (Telford & Wrekin Council)
- Viv McKay (Telford & Wrekin Council)
- Sarah Bass (Telford & Wrekin Council)
- Helen Swindlehurst (Telford & Wrekin CCG)
- Michael Bennett (Telford & Wrekin CCG)
- Nicky Wilde (Telford & Wrekin CCG)
- Ann-Marie Morris (Telford & Wrekin CCG)
- NHS England representative e.g. Andrea Westlake or Rebecca Woods (Public Health commissioning) or Jim Barlow (Primary Care commissioning)

Strategic Co-operative Commissioning Group (will become part of the HWB Advisory Group function):

- Laura Johnston (Director of Children & Family Services, Telford & Wrekin Council)
- Paul Taylor (Director of Adult, Care, Health & Wellbeing, Telford & Wrekin Council)
- Fran Beck (Executive Lead for Commissioning Telford & Wrekin CCG)
- Karen Kalinowski (Assistant Director Care and Support, Telford & Wrekin Council)
- Clive Jones (Assistant Director Family & Cohesion Services, Telford & Wrekin Council)
- GP commissioning lead Jim Hudson (Telford & Wrekin CCG)
- Sultan Mahmud, Director of Commissioning (NHS England)
- Liz Noakes (Assistant Director: Health & Wellbeing, Telford & Wrekin Council)

The group proposed that a member of the Strategic Group chair the Operational Group and that consideration be given to using part of the Health & Wellbeing Advisory Group for Strategic Group purposes. Terms of reference for both groups are being developed.

Early Help Partnership

The Telford and Wrekin 'early help' offer for children and young people is being developed at the request of the Children, Young People and Families Board. The Board recognised the need to enhance and refresh our offer because of the need to ensure that Our Early Help offer is fully developed across partners to ensure the right help at the right time is provided to children, young people and families to ensure their needs are met effectively quickly and so avoid the need for more expensive and intensive intervention.

The recent Children's Safeguarding Peer Review supported this view recognising that whilst the Council has an 'early help' offer it needs to be joined-up across all children and family services across partners regardless of the provider.

The Council's Public Health Team is working collaboratively with key colleagues from the Council and relevant partner organisations to identify and agree the 'early help' offer for children and young people in Telford and Wrekin. The Council's Community Engagement Team will support the active engagement of children, young people, parents and carers to ensure that their views inform the development of the 'early help' offer.

Several Council service reviews have been undertaken, the outcomes of which will inform the development of the 'early help' offer. Service reviews include: Transition and Leaving Care Service Review; Youth and Community Team Youth Offer; Education Psychology Review; and the Special Educational Needs and Children's Centre Review.

The threshold document is currently being refreshed by the Family and Cohesion Service and will include early help. This document will be used to clarify the pathway to access the 'early help' offer locally. Key national documents which will support the development of the 'early help' offer include: The Healthy Child Programme, Ofsted framework and Working Together to Safeguard Children.

A multi-agency stakeholder early help workshop took place in August 2013 and will be repeated again on 9 September. Following the two workshops and consultation a clear definition for early help will be agreed and our local offer defined so that it is universally understood and publicised amongst all partners and the public. This will provide clarity to our community as to what early help services are available based on the need of their child.

HWB Communication and Engagement

A HWB communications and marketing plan is in development. The Public Health England marketing strategy has provided a framework for this plan, with local priorities and campaigns picked up aligned to the strategy. Key themes for communications during the Autumn and Winter include: 'flu immunisation, Stoptober.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

See summary impact assessment section on pages 2-3 for details.

3. PREVIOUS MINUTES

- 17/07/2013
- 15/05/2013

Shadow Health and Wellbeing Board meetings:

- 22/02/2012
- 25/04/2012
- 13/06/2012
- 12/09/2012
- 14/11/2012

4. BACKGROUND PAPERS

**Report prepared by Jon Power, Delivery & Planning Manager,
Telephone: 01952 380141**

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD: 18th September 2013

TITLE: Health & Wellbeing Priority Update: Reducing Teenage Pregnancy

REPORT OF:

Clive Jones Assistant Director Family & Cohesion Services, Telford & Wrekin Council
Helen Onions Interim Assistant Director, Health & Wellbeing, Telford & Wrekin Council

HEALTH & WELLBEING BOARD PRIORITY SPONSOR:

David Evans, Chief Operating Officer, Telford & Wrekin CCG

LEAD CABINET MEMBER – Cllr Paul Watling

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

This report provides the Board with an update on the reducing teenage pregnancy priority, including:

- performance in relation to reducing the under 18 conception rate
- a summary of progress on the development of the Teenage Pregnancy and Sexual Health Strategic Partnership Board and strategy
- an update on sexual health services

2. RECOMMENDATIONS

The Board is asked to note the information in this report and acknowledge the recent developments towards delivery of the teenage pregnancy priority.

3. IMPACT OF ACTION

To ensure the teenage pregnancy and sexual health agenda is owned across partners and services are delivered effectively the Council leads work with a range of stakeholders through the Teenage Pregnancy and Sexual Health Strategic Partnership Board to deliver the a series of outcomes associated with teenage pregnancy, including:

- Increased uptake of Chlamydia screening in sexually active under 25s
- Delivery of modern, high-quality, young people-friendly sexual health services
- Increased numbers of pregnant young women who quit smoking
- Improved breastfeeding rates

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Reduce Teenage Pregnancy Rates.
	Do these proposals contribute to specific Co-Operative Council priority 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	It impacts on all people in the Borough who may be sexually active, but particularly young people and more vulnerable groups.
TARGET COMPLETION/DELIVERY DATE	Ongoing improvement as part of the Health & Wellbeing Strategy	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	In 2013/14 a £1.05m budget has been allocated to sexual health services as part of the local authority public health grant. This budget consists of commissioned external services of £1.012m and council delivered services for teenage pregnancy of £38k.
LEGAL ISSUES	Yes	The mandatory duty to ensure the provision of sexual health services was transferred to the Council in April 2013. Following a competitive process by the PCT in 2012/13 the Council inherited commissioning of the current contract. Reducing the number of teenage pregnancies is one of the Board's ten priorities, therefore the reduction in the rate in 2011 is welcome news and ties in with the focus to improve the health and wellbeing outcomes of the population of Telford and Wrekin.
EQUALITY & DIVERSITY	Yes	There are specific health inequalities associated with teenage pregnancy which are highlighted in the report, see section below
IMPACT ON SPECIFIC WARDS	Yes	Borough-wide impact but the highest rates of teenage conceptions are seen in the most deprived wards in the Borough
PATIENTS & PUBLIC ENGAGEMENT	Yes	A period of consultation on a draft version of the action plan is planned, with feedback being used to influence the final Teenage Pregnancy and Sexual Health position statement and action plan.
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	There are key links to other HWB priorities, including smoking in pregnancy

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1 Why is it important?

For some young 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. In Telford & Wrekin rates of teenage pregnancy have historically been high over the past two decades. Although the recent decline in numbers is promising the rate in 2011 remained significantly worse than the national average for England. As such reducing the number of teenage pregnancies is one of the ten strategic priorities agreed by the Telford and Wrekin Health and Wellbeing Board.

1.2 National Strategic Context

The national focus on teenage pregnancy as a major public health issue began in 1999 with the previous government's Teenage Pregnancy Strategy. This set the ambitious target to reduce teenage pregnancy by half by 2010. Although this ambition wasn't fully met by 2010, the conception rate in England had fallen by 24%. The coalition government has retained a focus on reducing teenage pregnancy as it is identified as one of the four priorities in the national Framework for Sexual Health Improvement¹, published in March 2013. In addition, the new public health outcomes framework includes the under 18 conception rate as a key health improvement outcome indicator for local authorities.

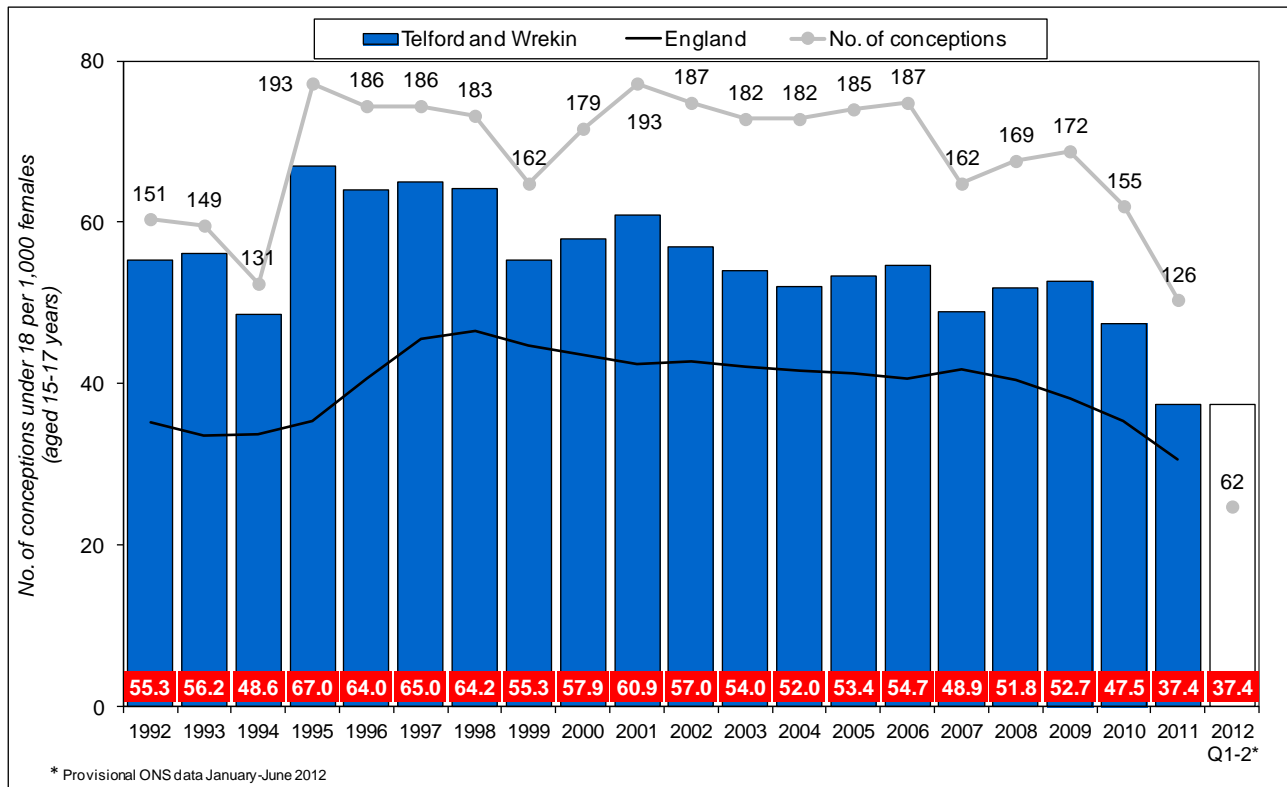
1.3 Teenage Pregnancy in Telford & Wrekin

- During 2011 there were 126 conceptions amongst women under 18 years of age in Telford and Wrekin
- The rate in 2011 (37.4 per 1,000 population) was the lowest rate recorded since local authority-level rates were first published in 1992 (Figure 1)
- This was a reduction of 29 conceptions compared to 2010, when the recorded rate was 47.5 per 1,000 population. However, the rate remained statistically significantly higher than the average for England (30.7 per 1,000 population)
- Provisional national data for January – June 2012 indicates a similar rate to the 2011 picture, i.e. 37.4 per 1,000 population, which equates to 62 conceptions in the first half of the year
- The proportion of women under 18 years in Telford & Wrekin who chose to terminate their pregnancy has consistently been below the national average over the past twenty years. In 2011 41.3% of women who conceived under the age of 18 terminated their pregnancy, compared to 48.8% of under 18s in England as a whole

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

- Nationally teenagers living in deprived areas are four times as likely to become pregnant as those in more affluent areas. In Telford & Wrekin the highest rates of under 18 conceptions are seen within the most disadvantaged wards, including Woodside and Brookside

Figure 1 Trends in Under 18 Conceptions



Source: Office for National Statistics, <http://www.ons.gov.uk/ons/rel/vsob1/quart-conc-to-women-und-18/q2-2012/index.html>

1.4 Partnership Arrangements: Teenage Pregnancy & Sexual Health Strategic Partnership Board

The multi-agency teenage pregnancy strategic partnership board has been re-launched this year to include a broader sexual health remit. In July 2013 the board organised an asset mapping workshop, which contributes to the health and wellbeing strategy development process. The workshop was attended by 35 stakeholders across a number of partner agencies. David Evans, Chief Officer for NHS Telford & Wrekin Clinical Commissioning Group and HWB sponsor for teenage pregnancy launched the event. The aim of the workshop was to consider and agree the high level priorities for the strategy, which are as follows:

- Priority 1: To provide early intervention for young people who are deemed to be at increased risk of teenage pregnancy and poorer sexual health
- Priority 2: To ensure the needs of people who come under the remit of the Teenage Pregnancy and Sexual Health Action Plan are understood and addressed through effective use of local data

- Priority 3: To increase access to high-quality contraception and sexual health services so that young people have easier access and greater choice of contraception methods available and supported by care pathways
- Priority 4: To ensure children, young people and their parents/carers benefit from high quality relationship and sex education provision, advice and guidance
- Priority 5: To protecting the future health and wellbeing of teenage parents and their children
- Priority 6: To ensure workforce training across key organisations includes the ability of staff to identify young people at risk as a way to ensure young people and families have access to professionals who can effectively support them

The workshop discussions also considered outcomes, identifying what success will look like and the key areas for local improvement, these were agreed as follows:

- Acknowledge the power of social media and to be more social media aware as a way to communicate with young people
- The need to link sexual health services to other local services i.e. Children's Centre Services
- Map the delivery of relationship and sex education provision and develop a systematic, high quality core offer across schools so all young people can benefit
- Development of a professionals network to share best practice
- Improve support for young fathers
- Develop support for mums, dads and carers to gain the confidence to talk to their child about sex and relationships
- Map training and develop standards for professionals on key teenage pregnancy and sexual health messages

The priorities and emerging areas for improvement agreed at the asset mapping workshop are due to be considered by the Teenage Pregnancy & Sexual Health Strategic Partnership Board on 11 September 2013. The next phase will be a period of consultation on a draft local action plan, this will ensure that public and service user feedback influences the final teenage pregnancy and sexual health position statement and action plan.

1.5 Update on Sexual Health Services in Telford & Wrekin

The HWB Board received an update on the new contract for integrated, community-based sexual health services in Telford and Wrekin at their meeting in May 2013. On-going contract monitoring of all sexual health services is in place. During April-June 2013 there were a total of 1,770 Telford and Wrekin attendances at sexual health services provided by Staffordshire and Stoke on Trent Partnership Trust, which is in line with the target set out in the contract. Of these 345 were planned appointments and 1,425 were walk-ins. Feedback from service users on the new hub located at Aqueduct has been positive with comments that the reception area is much more confidential. A new free phone number has also been launched.

Sixteen of the 22 GP practices in Telford & Wrekin have Locally Enhanced Service contract agreements in place with the Council for the provision of Long-Acting Reversible Contraception. During April – June 2013 a total of 418 patients visited their GP for this service.

Across Telford & Wrekin 10 of the 15 pharmacies have Locally Enhanced Service contract agreements in place with the Council to provide Chlamydia screening and Testing, Emergency Hormonal Contraception and the Condom Distribution Scheme. During April – July 2013 a total of 210 people accessed a local pharmacy for Emergency Hormonal Contraception and for the same period a total of 27 people aged under 25 years of age were been screened at their local pharmacy for Chlamydia.

A small working group has been convened to develop a communications and marketing plan to publicise sexual health services. The aim of the plan is to ensure high quality information and advice and key messages are publicised comprehensively and consistently across the borough. The plan will also include website development and other social media approaches and innovative campaign programmes.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

Measures to reduce teenage conceptions and improve sexual health services will help to reduce the health inequalities and social exclusion impact of teenage parenthood. Efforts to improve outcomes for teenage mothers and young fathers will, in turn, reduce the chances that children born to teenage mothers and young fathers become teenage parents themselves, because they are less likely to experience some of the factors associated with teenage pregnancy.

3. PREVIOUS MINUTES

- Health & Wellbeing Board Meeting 15th May 2013

4. BACKGROUND PAPERS

- No previous minutes specifically relevant to this report

Report prepared by: Stacey Norwood – Commissioning Specialist, Telford & Wrekin Council, Telephone: 01952 388910.

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD: 18th September 2013

TITLE:

Health & Wellbeing Priority Update: Reduce the number of people who smoke

REPORT OF:

Vicki Pike Health Improvement Commissioner, Telford & Wrekin Council
Helen Onions Interim Assistant Director, Health & Wellbeing, Telford & Wrekin Council

HEALTH & WELLBEING BOARD PRIORITY SPONSOR:

Paul Taylor, Interim Director of Health, Wellbeing and Care , Telford & Wrekin Council

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

A new strategic approach for tobacco control in Telford & Wrekin is currently in development. The main elements of the strategy, which is being developed to reduce the number of people who smoke, include:

- Ensuring high-quality, innovative stop smoking services are delivered by the new providers as part of the recently awarded contracts
- Reconvening of the local tobacco control network across HWB partners
- Undertaking the Ash CLear self assessment for tobacco control with partners
- Development of an action plan to reduce smoking in pregnancy, following the asset mapping workshop in July
- Support for national campaigns: Stoptober (October), harm reduction (January) and second hand smoke (March)

2. RECOMMENDATIONS (AND TO WHOM ACTIONS APPLY e.g. CCG, Council)

The Board is requested to note the recent developments for the smoking priority, in particular: the award of stop smoking services contracts and the outline of the developing strategic approach being taken for tobacco control

3. IMPACT OF ACTION - (How it is intended that action will make a difference)

- Stop smoking services contracts will be managed to ensure delivery of high quality and value for money services
- Reduction in smoking-related harm and health inequalities related to smoking
- Reduction in the number of mothers smoking during pregnancy
- Ash CLear self assessment undertaken across partners as part of the development of a multi-agency tobacco control strategy and action plan

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority -	
	Yes	Reducing the number of people who smoke
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	To improve the health and wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
	Yes	See equality and diversity section below
TARGET COMPLETION/DELIVERY DATE	<ul style="list-style-type: none"> ➤ Stop smoking services contracts start date - September 2013, with quarterly contract reviews in Dec 2013, March 2014, June 2014 and Sept 2014 ➤ Quarterly data entry to the national data system ➤ Tobacco control self assessment to be completed December 2013 ➤ Tobacco control strategy and action plan to be agreed by March 2014 	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	<p>The budget agreed for smoking cessation services and tobacco control work as part of the local authority public health grant is £713.6k for 2012/13.</p> <p>There is sound evidence that smoking cessation services are highly cost effective.</p>
LEGAL ISSUES	Yes	The mandatory duty to ensure the provision of stop smoking services transferred to the Council in April 2013 in accordance with the provisions of the Health and Social Care Act 2012. The award of the contracts set out in this report are to ensure that those statutory obligations are met. This report confirms that provisions are in place to check and review the performance of the contractors in meeting their obligations and accordingly ensure that the Council's statutory responsibilities are fulfilled.
EQUALITY & DIVERSITY	Yes	Contracts include specific targets around engagement with hard to reach groups. The evidence is that people from our most deprived communities are more likely to smoke. Local JSNA intelligence has helped to inform service provision, with data supporting the stop smoking providers to design and deliver their services. As part of the new contracts the service providers are encouraged to recruit and support smokers from the following specific demographic

		<p>subgroups:</p> <ul style="list-style-type: none"> ➤ Pregnant women ➤ People from Ethnic Minorities ➤ Unemployed people ➤ People living in deprived areas ➤ Young people under 25 years ➤ People with mental health problems ➤ People who are deaf, hard of hearing, blind or partially sighted
IMPACT ON SPECIFIC WARDS	Yes	Ward-level data are collected as part of the JSNA and this intelligence is being used to identify and prioritise wards and GP practices with high levels of smoking.
PATIENTS & PUBLIC ENGAGEMENT	No	<p>The intention is to engage with pregnant women who smoke during the Autumn 2013 to ensure their views influence the future development of stop smoking services and tobacco control measures.</p> <p>All quit smoking clients are asked to complete a satisfaction forms as they leave the service or at 4 and 12 weeks quit.</p>
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	<p>There are smoking key performance indicators in a number of Council and CCG contracts, including: school nursing, health visiting, maternity and health improvement services. A co-commissioning approach between the Council and the CCG is vital given the key role the CCG has in commissioning healthcare services e.g. maternity services.</p> <p>It is expected that providers will use the Making Every Contact Count approach at every opportunity, checking smoking status and either providing smoking information or making referrals to a stop smoking service. The current contract for maternity services has an 'opt out' measure where all smoking mothers are automatically referred to a stop smoking service unless they specifically 'opt out'.</p>

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1 Background

Research has shown that smoking is a major cause of health inequalities, accounting nationally for half of the difference in mortality between the richest and poorest in our society. People who smoke are more likely to be from lower socio-economic groups and due to their increased risk of smoking-related disease have a reduced life expectancy. Smoking is also a key risk factor in foetal growth restriction, low birth weight and sudden infant death syndrome.

Reducing the numbers of people who smoke was agreed as a HWB strategy priority in Telford & Wrekin in light of JSNA intelligence which indicates: the high rate of smoking-related deaths and smoking-related hospital admissions and the persistently high level of maternal smoking, particularly amongst young women.

1.2 Stop smoking services contracts

Following a competitive tender process Telford & Wrekin Council recently awarded one year contracts for stop smoking services to two new providers. During August 2013 there was regrettably a gap in service in Telford & Wrekin, with no stop smoking service operating. This was due to unforeseen issues relating to the contracts award. The new contracts commenced in September 2013 and smokers identified as wanting to quit during August are rapidly being followed up by the new providers. Commissioning leads working with the two new providers have been carefully managing associated issues linked to the establishment of the new services, for example through:

- communications with GP practices and pharmacies
- supporting clients referred in August who are waiting for support
- marketing and communications to the public
- development of service implementation plans from the two providers

1.2.1 Core and out of hours services

Ice Creates Ltd, a national company with a proven track record of delivering evidence-based behavioural change through their Stop4Life service, was awarded contracts for the stop smoking core service and the out of hours service. Over the coming year the contracts expect 1,500 4-week quits, 750 12-week quits and 375 6-month follow-up quits as part of the core service and 500 4-week quits, 250 12-week quits and 125 6-month follow up quits through the out of hours service.

Stop4Life is an experienced NHS-funded stop smoking service providing services to councils in Staffordshire, Stoke on Trent, Coventry, Warwickshire and Worcestershire. The Stop4Life service model for Telford & Wrekin will include a blended delivery approach - ensuring equitable access and the ability for clients to be seen in hours and out of hours, elements included are:

- **Proactive Community Outreach** – to generate quality referrals for the service and deliver smoking cessation support in appropriate

community settings such as community centres, faith venues, retail settings, Children's Centres, leisure centres as well as health settings

- **Primary Care sub contracting arrangement** – development of a network of GP, dental and pharmacy sub-contractors who will receive close mentoring and training. Services will also be delivered within GP practices and pharmacies
- **Workplace Service** - working with employers of all sizes to deliver workplace-based 1-1 and group support to employees wishing to make a quit attempt
- **Online/Telephone Support/home visits** - offering clients the remote support, using proactive telephone cessation, text messaging, email and online support alongside face-to-face appointments.

1.2.2 Pregnancy services

The company North 51 were awarded the smoking in pregnancy service contract. Through their Quit51 service they will support 150 pregnant women to quit and also follow up women for 6 months. The service is led by Emma Croghan who was previously the national tobacco control delivery lead at the Department of Health. Therefore the company has a pedigree in relation to the evidence of effectiveness in smoking cessation service delivery and thorough understanding of national guidance.

Quit51 is led, delivered and managed by qualified clinicians who have been working in behaviour change and smoking cessation for many years; and who come from a variety of clinical backgrounds, mainly public health nursing. Quit51 aims to provide services which are fully evidence-based and which give every smoker the best chance of quitting at every attempt. Quit51 works closely with the National Centre for Smoking Cessation and Training (NCSCT) and is also commissioned to undertake external audits of delivery against the national training protocols. The focus will be the offer of known evidence-based options to reduce the harms of smoking and to improve health outcomes for every pregnant smoker in Telford & Wrekin. The service aims to support women through friendly and informative conversations to discuss all of the practical options available to maximise their success.

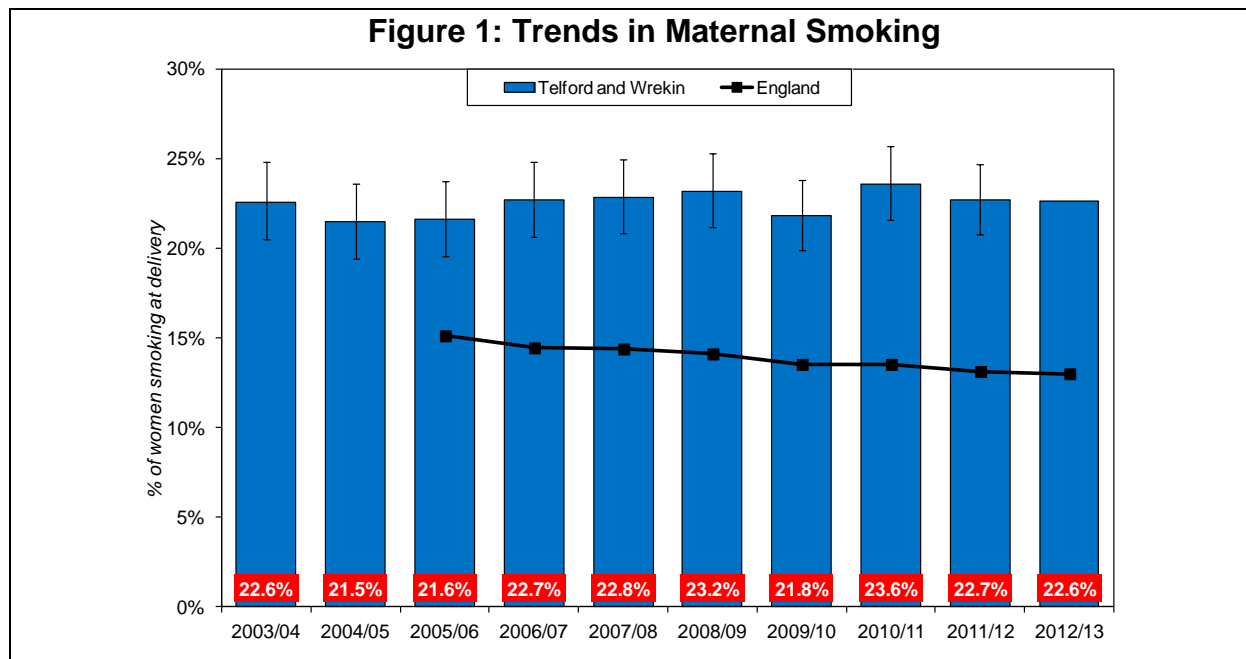
1.2.3 Hospital stop smoking service

The Council also have a contract with Shrewsbury and Telford Hospitals NHS Trust (SaTH) to deliver the stop smoking in hospital service, which supports both in and out patients. Over the years the service has grown considerably, consistently increasing the number of people it has reached and referred to onto community-based stop smoking services. The number of referrals into the hospital service increased from 800 in 2002/03 to 2,347 in 2012/13. Figures for 2012/13 indicate impressive quit rates with over 80% of smokers setting a date still quit at 4 weeks. This is considerably higher than the national average quit rate of 55%.

1.3 HWB priority focus: Maternal smoking

Reducing maternal smoking was agreed as a key focus for this priority at the HWB stakeholder event in January 2013. The 2012/13 public health report for Telford & Wrekin re-iterated key messages which emerged through the JSNA, including:

- Maternal smoking rates in Telford & Wrekin remained significantly worse than the national average over the past decade (Figure 1)
- 35% of mothers from the most deprived local communities were smokers at delivery, compared to 11% of mothers from the more affluent areas
- Nearly 40% of women aged under 20 years are still smoking at delivery



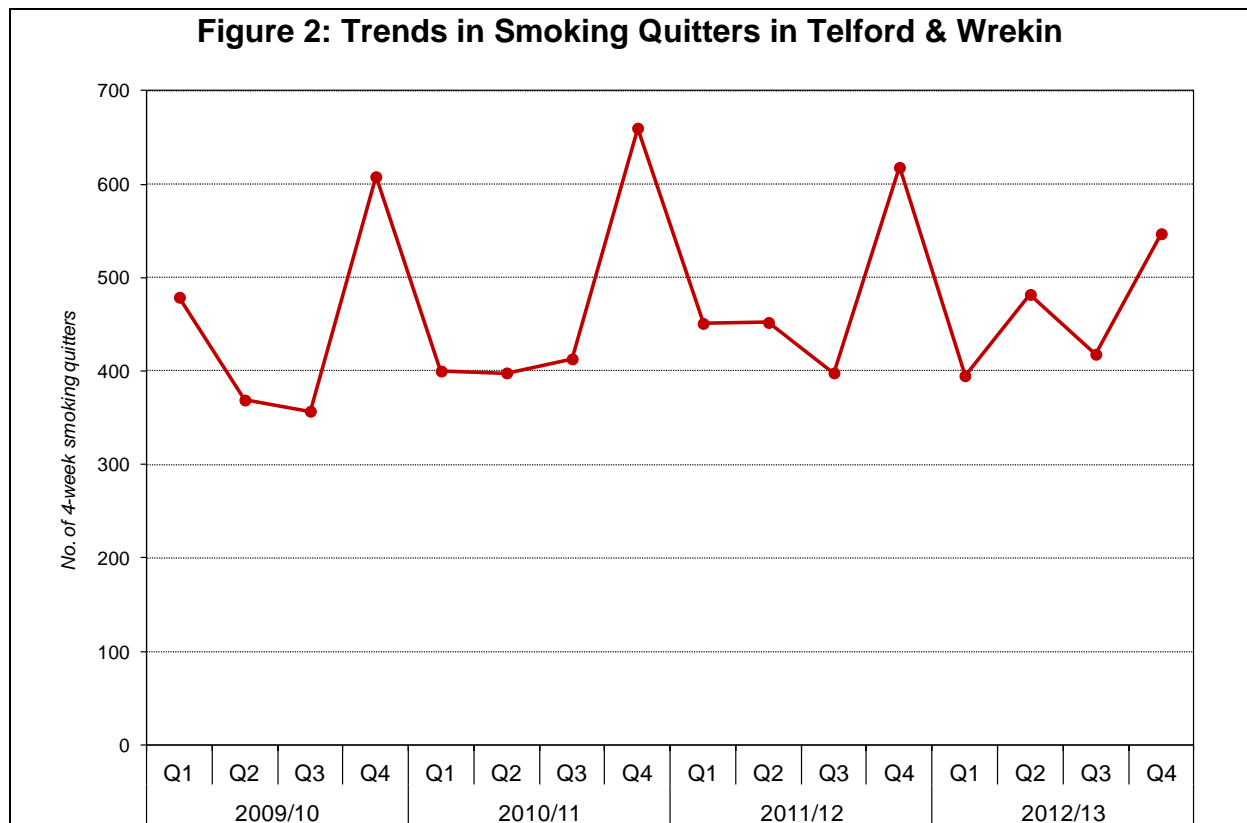
As part of the further development of the health and wellbeing strategy an asset mapping workshop for smoking in pregnancy was held in July 2013. There were 30 participants at the event hosted by Telford & Wrekin Council and Shropshire County Council, including: midwives and a consultant obstetrician from Shrewsbury and Telford NHS Hospitals Trust (SaTH), representatives from Children's Centres, the Shropshire and Staffordshire NHS England Area Team, Homestart, Telford and Wrekin CCG and stop smoking service provider teams. The key areas for further consideration and action were agreed as follows:

- **Preconception and getting pregnant**
 - Risk assessment
 - Robust referral systems
 - Good links with GPs and health professionals
 - Young people champions
 - Targeting final year primary school children with key messages
- **Confirmation and booking**
 - Training for children centre staff and GP receptionists
 - Link to community scanning clinics
 - Improved sharing of smoking at booking data
 - Consistency of booking and monitoring by midwives
 - Robust referral systems with sexual health services
 - Celebration of achieving quitters

- Analyse current datasets
- Better understanding of the mother perspectives
- **Antenatal period**
 - Referrals from the sonographer
 - Improved data capture during pregnancy
 - Updated training for midwifery
 - Healthcare Assistant post in maternity to focus on lifestyle behaviours
 - Working with the whole family
 - Audit of process during scan and midwifery appointments
 - Development of apps and mobile phone technology
 - Involve wider workforce such as pharmacists
- **Delivery**
 - Bounty pack information
 - Smoking policy in SaTH
 - Communication on marketing for second hand smoke
 - Smokefree grounds
 - Opt out system if still smoking at delivery
 - Streamline data capture

1.4 Performance and activity update

The prevalence of smoking amongst adults in Telford & Wrekin is estimated to have reduced from 28% in 2000/02 to 24% in 2010/12. Some of this improvement has been due to the successful stop smoking services which have been in place. The provisional figures for 2012/13 show that 3,597 Telford & Wrekin smokers set a quit date and 1,842 of these remained successfully quit at 4 weeks. This equates to a 51% quit rate, an increase on previous year's performance. There is a recognised seasonal effect for smoking quitters, however the peak usually seen during January-March was not as great in 2013. (Figure 2)



1.5 Tobacco Control Partnerships

The Telford and Wrekin Tobacco Control Network supports and manages the local tobacco control agenda. The network is made up of representatives from the Council and CCG commissioning teams, SaTH clinical leads, stop smoking service providers, the Fire Service, HMRC, and the Council's public protection team. This established group has not met for some time but is due to be re-invigorated and will ultimately become responsible for the development and delivery of the local tobacco control strategy.

Part of the strategy development will involve undertaking the self assessment for the new Ash CLear approach. This excellence framework is specially designed for councils in England as they take on their new responsibilities for tobacco control. The CLear approach will be used as an opportunity to undertake structured reflection across the partnership in Telford & Wrekin. The simple self assessment exercise will allow council leads and partners to review our local action to tackle tobacco. After the assessment, which will be undertaken by the end of December 2013, an improvement report will be produced. This report will highlight strengths and areas for improvement and will contribute to the development of the new strategy by March 2014.

There is also an existing West Midlands Tobacco Control Network made up of the tobacco control commissioners from across the councils within the region. The group reviews best practice, NICE guidance, shares experiences, acts as a reference group and supports each other acknowledging the different areas of expertise. This group meets twice per year as well as working as a real time virtual group. Going forward it is envisaged this network will be coordinated by the PHE West Midlands Centre.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

See summary impact assessment section on pages 2-3 for details.

3. PREVIOUS MINUTES

Health & Wellbeing strategy priority position statement May 2013: reduce the number of people who smoke.

4. BACKGROUND PAPERS

Report prepared by Vicki Pike, Health Improvement Commissioner, Telephone: 01952 381026 telephone extension

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

18TH SEPTEMBER 2013

CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

FRAN BECK, EXECUTIVE LEAD FOR COMMISSIONING, TELFORD & WREKIN CLINICAL COMMISSIONING GROUP

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

Child and Adolescent Mental Health Service (CAMHS) update for Telford & Wrekin Health and Well-being Board, August 2013.

1.1 Background

This report is to update the Health & Wellbeing Board on the current CAMHS position and the on-going work in progress across both Telford & Wrekin and Shropshire.

CAMHS services are normally provided in a four-tiered model as described in the 1995 Health Advisory Service's Review of Child and Adolescent Mental Health Service (CAMHS) Together we Stand - A Thematic Review of CAMHS but also taking into account the model adopted by Local Authorities i.e. - those of universal, targeted and specialist services as described in the CAMHS Review. The tiers of the framework are outlined below.

Tier 1 (Universal): A primary level of care. Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2 (Targeted): A service provided by specialist individual professionals relating to workers in primary care. Services provided by specialist Senior Mental Health Practitioners. They offer consultation to families and other practitioners at Tiers 1 & 2, provide outreach services to identify children and young people with severe/complex needs, and also provide assessments and training to practitioners at Tiers 1 & 2 to support service delivery.

Tier 3 (Specialist): A specialised multi-disciplinary service for more severe, complex or persistent disorders. Services are provided by a multi-disciplinary team working in a number of community locations. This team provides a specialised service for those children and young people with more severe, complex and persistent disorders that have a significant impact on their mental health. This service covers children up to their 18th birthday and includes a neurodevelopmental service.

Camhs Learning Disability team: A multidisciplinary team providing evidence based mental health and behavioural interventions to children and young people with a learning disability and a concurrent mental illness.

Tier 3 + Service (The Reaching Out Service - ROS) is commissioned to offer intensive support for the most complex of children but where the risk can be managed in the community.

Early Intervention in Psychosis Team

This team is commissioned from South Staffordshire & Shropshire Healthcare NHS Foundation Trust to provide detection and treatment of early symptoms of psychosis for people aged from 14-35yrs. Where a young person is believed to be displaying early symptoms of psychosis they will be referred to the EIP service in the first instance. The EIP service will contact CAMHS to identify if they are known to CAMHS prior to undertaking an assessment.

Tier 4 (Complex): Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units. These are services for children and young people with the most serious problems. Where inpatient treatment is indicated this is commissioned by the West Midlands Specialist Commissioning Team.

The Child and Adolescent Mental Health Tier 3 Service (CAMHS) in Telford & Wrekin is a multi-disciplinary team working with children and young people who require targeted mental health provision. At tier 3 the aim is to assist those children and young people who have complex, severe and/or persistent mental health needs. This type of service provides mental health and psychosocial assessments, interventions, and treatment which may include prescribing and medication monitoring. There has been work on-going with the service to address identified issues that have arisen.

1.2 Waiting list progress to date

- Shropshire Community Health NHS Trust had met with CCG representatives to highlight concerns about service delivery due to operational issues that had resulted in an increase in waiting times for CAMHS
- CAMHS investigated utilising other providers to help address the waiting list but found there were similar waiting list issues across other providers. CAMHS are now in the process of recruiting agency staff to

increase capacity to manage the waiting list/referrals. The referrals are prioritised in to 3 categories:

Priority 1	Seen within 24/48hrs: Referrals from SaTH wards when children have been admitted following a deliberate self-harm.
Priority 2	Seen within 2 weeks: Referrals where the level of risk is heightened by information given by the referrer e.g. low mood for an extended period, suicidal thoughts, self-harm by cutting.
Priority 3	Seen within 13 weeks: Routine referrals and those requiring neurodevelopmental assessments which may result in a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)/Autistic Spectrum Disorder (ASD)

- The current position (August 2013) with regards to the numbers exceeding the waiting list targets in Telford is as follows:
 - **Priority 1 patients – NIL**
 - **Priority 2 patients – 2**
 - **Priority 3 patients – 3**
- Of those patients whose wait is exceeding the target CAMHS has commenced regular review of those referrals and in some cases are writing to GPs. The letters reiterate that should the GP have any concerns then they should contact the service by phone to arrange a clinician to clinician conversation
- All parents/carers of children who have been referred for ADHD assessments have been contacted and informed they are still on the waiting list. They are also informed of the possibility of having appointments at short notice due to cancellations
- Risk assessments of all Priority 3 referrals are underway to ensure that the Multi-Disciplinary Team (MDT) are aware of the types of referrals waiting. Information from this is being communicated to GPs and parents/carers. These patients will form part of the caseloads for the temporary staff who are commencing in post during August

1.3 Other actions

- Locum consultant cover to fill the gap between consultants leaving and posts being filled. Recruitment is being expedited with job descriptions submitted to the Royal College of Psychiatrists for approval
- Temporary clinical and administrative staff employed to assist with waiting lists/caseloads

- Review of geographical areas covered by medical staff to ensure equity of caseloads
- Implementation of an interim management structure to ensure teams are working efficiently and that caseload management and supervision is integral to the management of the teams
- Identification of a dedicated team and a consultant with a special interest to manage the neurodevelopmental waiting list
- The introduction of dedicated slots for neurodevelopmental assessments in addition to dedicated multi-disciplinary team clinic days for specific conditions such as eating disorders
- New referrals are being assessed upon receipt of referral and then discussed at a weekly MDT meeting. This will identify, at an early stage, the level of need and whether interventions may need to be long-term, short-term or suitable for discharge/signposting to other services
- Staffing input into Family Connect in order to divert referrals that do not meet the Tier 3 CAMHS criteria
- There is on-going work to ensure that the data flow of information to Commissioners is timely and informative
- A workshop has taken place which included a variety of stakeholders at which the definitions for CAMHS Tier 3 and eligibility criteria was discussed. The conclusions from this will be incorporated in the service improvement plans and the development of the service specification
- Meeting of the strategic steering group has taken place and it was agreed that the first draft of a new service specification will be available at the end of August
- Commissioners have met with parent groups to discuss some issues relating to CAMHS. There has also been a workshop arranged to meet with PODs (Parents Opening Doors)
- There is work on-going with Telford & Wrekin Council Placement Stability Team for looked after children to ensure that those young people have appropriate and timely access to services, and also with Family Connect with regard to the contribution of time from CAMHS to Family Connect to provide support with regard to safeguarding and CAMHS referrals

CAMHS and the Adult Mental Health Service are working in partnership to develop and implement a pathway of care for young people who are in the period of transition from children's to adult services to ensure they are well

supported and all identified needs are met. The final workshop relating to this work will take place in October.

2. RECOMMENDATIONS

This paper is for information

3. IMPACT OF ACTION

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes/No	<i>If yes please state relevant priority</i>
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes/No	<i>If yes, please list relevant Co-Operative Council objective(s)</i>
	Will the proposals impact on specific groups of people?	
	Yes/No	<i>Children & young people who have mental health problems</i>
TARGET COMPLETION/DELIVERY DATE	<i>Insert date and if more than 6 months after the date of the Cabinet report, list key milestones</i>	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes/No	<i>N/A</i>
LEGAL ISSUES	Yes/No	<i>N/A</i>
EQUALITY & DIVERSITY	Yes/No	<i>N/A</i>
IMPACT ON SPECIFIC WARDS	Yes/No	<i>N/A</i>
PATIENTS & PUBLIC ENGAGEMENT	Yes/No	<i>Workshop arranged with PODs on Wednesday 25th September</i>
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes/No	<i>Development of a new service specification will give commissioners the opportunity to influence the service provision in terms of access, provision and expected outcomes</i>

Report prepared by Helen Swindlehurst, Head of Commissioning – Mental Health and Children, Telephone: 01952 580300

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD
WINTERBOURNE VIEW – TOWARDS AN EFFECTIVE LOCAL RESPONSE
REPORT OF PAUL TAYLOR – DIRECTOR
LEAD CABINET MEMBER – COUNCILLOR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 The context of this report is located within national efforts and aspirations to respond effectively to the revelations which originated from Winterbourne View Hospital in May 2011, where the ill-treatment of learning disabled patients was highlighted in an edition of Panorama. The justified outcry at what was identified resulted in moves organised at a high level to minimise recurrence, and to engender local arrangements which would militate strongly against the practice of placing vulnerable people far from their locality of origin.

1.2 The report presents the stocktake for Telford & Wrekin (attached) which was completed at the behest of the Local Government Association and NHS England in July 2013, as part of a national programme covering all local authority areas, as a means of collating a range of baseline information. It goes on to outline how this is being progressed locally, where health, social care and commissioning colleagues are collaborating closely with their counterparts in Shropshire.

1.3 As background to this report, reference is also made to earlier partnership work in Telford and Wrekin to respond to the needs of people with learning disability and challenging behaviour, including autism.

2. RECOMMENDATIONS

2.1 That the Board note and endorse the work which is ongoing in seeking to implement locally the plans and requirements set out at a national level and to bring about the changes needed to ensure that the occurrences at Winterbourne View are not repeated.

2.2 That the Board furthermore recognise the multi-agency and multi-disciplinary nature of this task and request a further update on progress as required.

3. IMPACT OF ACTION - (How it is intended that action will make a difference)

The difference made as a result of these action will be seen in these areas

- The return to our locality of most of those people with learning disability and/or autism whose behaviour may challenge and who were placed externally. Exceptions to this will reflect the needs of the individual or other extenuating factors which support not returning to area.
- The continued development and enhancement of locally-based care provision, to include services for those whose needs have previously challenged local providers. This will reflect a commitment to developing personalised responses, which over time are expected to become less resource intensive, due to providing an environment that appropriately matches and suits the needs of the individual.
- Access to independent advocacy provision.
- A locality which takes responsibility for all its citizens, regardless of their difference and tendency to challenge.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	We will improve emotional health and wellbeing of borough residents. We will support people with autism
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	We will protect and support our vulnerable children and adults We will improve the health and wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
	Yes	People with learning disability and/or autism and whose behaviour can challenge, who live within Telford and Wrekin or are placed outside the Telford/Shropshire locality in hospital or large residential settings (ie those accommodating 5 or more people)
TARGET COMPLETION/DELIVERY DATE	1 st June 2014 The completed action plan and a report on progress will be made to the Board at its meeting in xxx.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The recommendations may give rise to financial implications for the Council and CCG. However, there is not a financial model in place to map the progress of the current placements and the sources of funding to meet the costs of those placements. This model needs to be developed to track cases and determine the impacts of any future movements of clients within the Borough. Some important points to note are: - Any financial model created will of course reflect the cost of individuals placed in the Borough in specialist settings or in Community based

		<p>settings.</p> <ul style="list-style-type: none"> - It is recognised that where placements from other Local Authorities remain in Borough then there is a requirement for those authorities to fund those placements in accordance with Ordinary Residence rules. There is also a recognition that should those individuals become Ordinarily resident and cared for in a Community setting in Telford & Wrekin, liability to pay for care will at some point become the responsibility of the Public Agencies in the Borough. <p>The Council is currently facing significant pressure on its revenue budget for purchasing care. A significant contributor to this pressure has been the impact of the PCT's review of Continuing Healthcare. Further financial pressure on Council budgets will result in significant changes to the availability and possibilities afforded to clients within the local care economy and this needs to be carefully considered when funding decisions are being made.</p>
LEGAL ISSUES	Yes	<p>On 10 December 2012 the Department of Health published its final report into the events at Winterbourne View hospital and, in a Concordat with key partners, set out a programme of action to transform services. A progress report on these actions will be published by December 2013.</p> <p>https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response</p> <p>NHS England and the Local Government Association have set up</p>

		<p>The Winterbourne View Joint Improvement Programme to provide leadership and support to transform services locally, building on current good practice.</p> <p>http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/3912043/ARTICLE</p> <p>The Department of Health guidance “Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services, England” was last updated on 12 April 2013.</p> <p>https://www.gov.uk/government/publications/identifying-the-ordinary-residence-of-people-in-need-of-community-care-services</p>
EQUALITY & DIVERSITY	Yes	It is expected that there will be a beneficial overall impact for people with learning disability, autism and behaviour that can challenge
IMPACT ON SPECIFIC WARDS	No	No ward-specific impact
PATIENTS & PUBLIC ENGAGEMENT	Yes	Updates on the project are regularly delivered to the Learning Disability Partnership Board. An engagement day to involve a range of stakeholders is planned for Tuesday 4.2.14
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

Background and Context

5.1 In general the local authority takes the lead in the area of Learning Disability, although the NHS, through the Clinical Commissioning Group is responsible for commissioning Continuing Healthcare or specialist placements, as is NHS England for the most complex needs.

5.2 Telford and Wrekin undertook a significant review of services for people with learning disability and challenging behaviour in 2008, following the publication of '*Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs*' (Department of Health, 2007). This review led to the (then PCT) decommissioning an in-patient service from the South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) and commissioning two new services:

- Residential/respite/emergency community based service for people with learning disabilities and challenging behaviour, including autism.
- Re-commissioning the SSSFT to develop a community based Challenging Behaviour service to support other providers or family carers in situ, minimising and reducing the need for in-patient services.

5.3 This approach has been highly regarded by a range of external organisations. Currently, a further review and evaluation of the service is taking place. The review will take account of all matters relating to Winterbourne View and inform future commissioning intentions for both authorities.

Winterbourne View

5.4 Locally the Winterbourne Review Group started life in late summer 2012. This followed the publication of initial reports in the wake of the scandalous events at a private hospital for people with learning disabilities near Bristol. Initially it was established as a Task & Finish group in Telford & Wrekin. The group's aim was:

- to take stock of the local position with regard to out of area placements, and
- to plan the way forward locally in response to the many challenges which arose for health and social care agencies from the revelations about Winterbourne View.

5.5 Since similar work was being done in Shropshire, there were strong arguments for collaborating across the Telford and Shropshire localities and pooling such resources as were available. A joint group has therefore been

meeting since December 2012, with agreed terms of reference, and representation from the following organisations:

- Telford & Wrekin Council
- Shropshire Council
- Telford and Wrekin CCG
- Shropshire CCG
- South Staffordshire and Shropshire Healthcare Foundation Trust
- Shropshire Partners in Care
- Taking Part
- Healthwatch

5.6 The Winterbourne View Group has subsequently transformed into a Programme Board and reports to the Shropshire and Telford& Wrekin Safeguarding Adults Board. The group is seeking to construct an effective response on behalf of agencies in our locality to rethink our approach to the care of people with learning disabilities, and especially to abandon the practice of placing people in faraway locations, where the risks posed by infrequent monitoring , sporadic oversight and loss of contact are greatest.

5.7 Among the difficulties which the group has inevitably faced is that of inconsistent and varied attendance as the group's membership has evolved, the challenge of transcending the organisational nature, language and approach of the constituent agencies who make up the group, and the multiplicity of guidance items which have been emanated from a range of sources since the work began. We have also become painfully aware of the limitations of trying to move forward without administrative support and are appreciative of the support provided by the CCG.

Work on the draft Action Plan

5.8 The Department of Health's publication in December 2012 of '*Transforming Care – a national response to Winterbourne View Hospital*' in its final form, together with the '*Concordat – programme for action*', provided impetus and focus to the work of the group. It set out a clear time-tabled agenda for the changes which the Department required of the range of public agencies engaged in the care of people with learning disability.

5.9 The initial task for the Review Group was to identify from the 63 action points set out in the Concordat:

- those which will require a specific response from local agencies,
- those which apply to national bodies, but which will have a direct local impact, and
- those which are to be noted.

5.10 A provisional draft action plan was drawn up at review group meetings on 7th March, 16th April 2013 and 15th August. It is set for completion on 3rd

October. In its final form it will incorporate all the requirements from the first two of the above points, and pay particular attention to the following thematic areas:

- Developing and maintaining accurate records for all external placements
- The development of a 'repatriation' pathway and protocol for joint working, based on a presumption against external placement,
- Conditions for making out-of-locality placements in the future, for example, linked to a specific clinical treatment and time limited,
- Specifications on the frequency of direct contact including care plan reviews with people placed out-of-locality,
- Development of effective quality monitoring/contract compliance arrangements for the remaining external placements,
- Monitoring the quality and implementation of behaviour management systems, including the use of physical restraint,
- Assurance of access to independent advocacy provision for all in area, and those 'out of area', and
- Development of commissioning strategies based on local provision.

5.11 The particular circumstances of Winterbourne View have drawn a sharp focus on placements which are distant from the commissioning authority area. However the conduct of this and related pieces of work will undoubtedly have implications for commissioning, quality assurance and safeguarding work in placement settings closer to home. The question has frequently been raised '*What assurance do we have that there is not a Winterbourne View in our locality*'? The implementation of the completed action plan needs to result in an increased and genuine assurance that this question can be answered positively and confidently for the Telford locality, although 100% assurance cannot be given at present.

5.12 Satisfactory progress is being made locally against the requirements, largely through the construction of a comprehensive action plan, with the input of all stakeholders. This will be submitted to the Board at a future meeting, along with details of progress in the specific areas where this is required, notably

- Numbers of people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care (wholly or part funded) or other large scale accommodation.
- Numbers of people with a named lead health and social care professional
- Numbers of people have had a joint review which reflects the guidance contained in toolkit 'Checking for Quality Reviews and Care Plans'?

The Stock-Take

5.13 Each local authority was required to submit a stock-take on 5th July 2013, which set out the local position with regard to progress made and organisational capacity to meet specified requirements. Separate reports were prepared for Telford and Shropshire, but there was nevertheless a high degree of multi-agency collaboration from across the locality in the production of both items.

The final submission (attached herewith) was countersigned by the chair of this Board, a senior leader within the CCG and the Council's Managing Director.

Considerations for the future

5.14 The Programme Board has also assumed responsibility for overseeing progress in respect of two additional major requirements which will be made of local health and social care economies during the next few months, which relate to adults with learning disability, notably:

- Responding to the Joint Health and Social Care Self Assessment (2013)
- Responding to the confidential inquiry into premature deaths of people with learning disabilities – CIPOLD (Bristol University, 2013),

5.15 Separate sub-groups are now in place to work on these issues. The Programme Board as a whole reports quarterly to the Safeguarding Adults Board, on progress on each theme. For Telford & Wrekin however, it is however assumed that the progress of work in this area overall will be reported to and monitored by this Health and Wellbeing Board.

6. PREVIOUS MINUTES

None

7. BACKGROUND PAPERS

None formally, but the Concordat published by the Department of Health in the wake of the Serious Case Review and a number of enquiry reports provided a clear summary of the expectations on a wide range of agencies in the wake of Winterbourne View.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213217/Concordat.pdf

**Report prepared by
Dave Robson (Service Delivery Specialist for Adult Safeguarding)
01952 381101**

Kit Roberts (Commissioning Specialist)
01952 388890

Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA [website](#)

May 2013

Winterbourne View Local Stocktake June 2013

1. Models of partnership	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
<p>1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).</p>	<p>Yes. The arrangements are Pan Shropshire, incorporating Telford & Wrekin Council (T&WC) and Shropshire Council (SC) and Telford & Wrekin Clinical Commissioning Group (T&WCCG) and Shropshire Clinical Commissioning Group (SCCG). A programme Board has been established that reflects this representation and the key partners outlined in 1.2.</p> <p>For the purposes of the stocktake exercise, Telford & Wrekin and Shropshire will, however submit individual responses.</p>	<p>Yes. Annex 1</p>	
<p>1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).</p>	<p>Yes <u>NHS Provider:</u> South Staffordshire and Shropshire NHS Foundation Trust (SSSFT)</p> <p><u>NHS England:</u> Telford & Wrekin CCG has established links with the specialised commissioning team in the West Midlands.</p> <p><u>Housing:</u> 4 main housing providers work in Telford & Wrekin. They seek to work in a flexible and responsive way to</p>		

	<p>include the needs of specific vulnerable groups.</p> <p><u>Care Providers</u> Named providers work with specific client groups, including those with behaviour which can challenge, including Autism and/or mental health.</p> <p><u>Private Provider Sector</u> Shropshire Partners in Care (SPIC): umbrella organisation to which the majority of local providers are affiliated.</p> <p><u>Voluntary Sector</u> Taking Part: Advocacy Healthwatch: Becoming established and beginning to engage with the agenda.</p>		
<p>1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.</p>	<p>T&WC/T&WCCG (via the Programme Board referred to in 1.1) are progressing an Action Plan developed in response to the original WBV Concordat. This work will inform planning to support the development of services which are personalised and appropriate to the needs of named individuals with complex needs.</p>	<p>Yes. Annex 2</p>	
<p>1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.</p>	<p>Yes. We are regularly reporting to the Learning Disability Partnership Board on progress. However, there is a concern about the plethora of different initiatives and questions being asked in different ways, at different times by different parts of the DH which seem to reflect a lack of planned and co-ordinated requests for data and analysis of submissions. For the next meeting, due to be held in September, the Partnership Board have requested a report which explains all the different strands.</p>		

	At the last LDPB in June it was agreed that the co-chair of the LDPB will receive a copy of this Stocktake submission.		
1.5. Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	<p>A paper went to the Health and Wellbeing Board (H&WB) in December 2012 relating to the last Health Self Assessment and reference was made to Winterbourne View (WBV).</p> <p>Two papers have gone to the T&W CCG (Jan 2013 and May 2013) which refer to the work being progressed on WBV. At the last meeting of T&W CCG, approval and support was given to the establishment of the Programme Board. The Safeguarding Adults Board has accepted the remit to provide overall governance to the Programme Board and submits its annual report to the H&WB. Further work is currently in hand to finalise and formalise all the governance arrangements and Terms of Reference for the Programme Board and various strands, referred to, above.</p>		
1.6. Does the partnership have arrangements in place to resolve differences should they arise.	Jointly agreed dispute resolution policy in place to manage disputes between statutory bodies.		
1.7. Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards.	<p>Yes, see 1.5.</p> <p>Primary accountability will be to the Safeguarding Adults Board and this will be formally ratified at the next meeting on 26 July 2013.</p> <p>Further work is required to align work with children's services and the Children's Safeguarding Board.</p>		

<p>1.8. Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this?</p>	<p>Yes. Areas such as Telford & Wrekin are in relative terms seen as cheaper places to live. There is therefore a need to establish clear protocols with authorities that may be considering placing individuals in the Telford & Wrekin area. This is to ensure that placing authorities remain clear about their on-going obligations under ordinary residence guidance. The local policies held by both the T&WC and T&W CCG is only to place people out of area in exceptional circumstances and for a defined period of time, unless there is a compelling reason to not return someone back into area.</p>		
<p>1.9. Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.</p>	<p>Yes.</p>	<p>Annex 2.</p>	
<p>2. Understanding the money</p>	<p>Assessment of current position evidence of work and issues arising</p>	<p>Good practice example (please tick and attach)</p>	<p>Support required</p>
<p>2.1 Are the costs of current services understood across the partnership.</p>	<p>Yes, except costs related to individual specialist commissioning placements and those placed from out of area into Telford & Wrekin. Also, there are issues around young people in transition who are placed out of area – further work required with Children’s Services to gain full clarity.</p>		
<p>2.2. Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.</p>	<p>Specialist Commissioning placements are funded centrally by NHS England. NHS Continuing Healthcare is a needs led assessment process jointly undertaken by the MDT.</p>		

	<p>Full NHS funding is a consequence of an individual meeting the eligibility criteria. Telford & Wrekin Council and Telford and Wrekin CCG maintain ongoing dialogue regarding the determination of appropriate levels of NHS CHC funding in present and future cases.</p> <p>Telford & Wrekin CCG also fully fund individuals who are not eligible for NHS Continuing Healthcare who are subject to the Mental Health Act and as such remain the funding responsibility of the NHS.</p>		
2.3. Do you currently use S75 arrangements that are sufficient & robust.	Yes		
2.4. Is there a pooled budget and / or clear arrangements to share financial risk.	Yes However, there is real concern about increased number of complex cases coming through transition and the need to appropriately manage client expectation in regard to the resources available in adult services.		
2.5. Have you agreed individual contributions to any pool.	Yes LA through annual grant and CCG through existing contract routes.		
2.6. Does it include potential costs of young people in transition and of children's services	No		
2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	No, but are exploring		

3. Case management for individuals	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
3.1. Do you have a joint, integrated community team	The multi-disciplinary team is co-located but not fully integrated. There is ongoing collaboration and partnership working.		
3.2. Is there clarity about the role and function of the local community team.	Yes, and there is also collaboration with the specialist NHS Staff working in the SSSFT (Mental Health Foundation Trust)		
3.3. Does it have capacity to deliver the review and re-provision programme	<p>As above, we will continue to work in partnership. However, there is a real concern that numbers of people coming through transition who have behaviour which can challenge, including those with mental health issues and/or are on the autistic spectrum is continuing to rise. Both T&WC and T&W CCG are aware of the increasing financial challenges, particularly in light of the overall efficiencies drive.</p> <p>The outcome of working on a Pan Shropshire basis is the potential for more local, community-based services.</p> <p>Further discussion is planned with children's services and again, this may assist in achieving further progress despite the overall drive for efficiency and reduced funding.</p>		
3.4. Is there clarity about overall professional leadership of the review programme	<p>Yes.</p> <p>As referenced above, at a local level governance is provided via the Safeguarding Adults Board. A range of different professional and clinical colleagues are also involved in the work.</p>		

3.5. Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.

Yes.

Both T&W C and T&W CCG engage family carers in reviews and maintain ongoing dialogue in between formal meetings.

Local discussions are taking place around the ongoing review of named individuals who are out of locality, supported by named workers. If reviews are required on a quarterly basis this will have significant resource implications.

Independent advocacy is viewed as very important. At a local level we seek to ensure this is available. The local advocacy service seeks to work in a flexible manner to support individuals. When this is linked to safeguarding, we are also able to consider a request to provide independent advocacy support within the West Midlands region. However, it would be helpful if there was national guidance to inform local practice. Some geographical areas refuse to support people in their area if they are from another authority.

Thus, at a local level we have identified and are continuing to discuss the challenge of providing independent, good quality advocacy to individuals placed out of locality.

4. Current Review Programme	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
4.1. Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	Yes We have identified the people involved and do seek to work with and involve family members throughout the process.		
4.2. Are arrangements for review of people funded through specialist commissioning are clear.	This arrangement has been in place for several years. However, the process has become more fragmented following the transfer of responsibilities to NHS England which has adopted a geographically based commissioning model.. Previously, PCTs worked with a single, specialist commissioning team. Now, they are expected to work with a far larger number of Area Teams, which has resource implications and can adversely impact on effective and timely communication		
4.3. Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	Yes, referred above. Also, as stated above, it would be helpful if there was an improved level of co-ordination at a national level to assist in maintaining focus on WBV via one work stream, rather than several routes – as appears to be the case at the moment.		
4.4. Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used	T&W CCG has an up to date register of people who require in-Patient care and support. The local authority similarly keeps data on individuals who do not require in-patient care.		

<p>4.5. Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual</p>	<p>The T&WCCG NHS Complex Care team maintain the register and act as the first point of contact of those patients who require in-patient care and support funded by the CCG.</p> <p>The T&W CCG NHS Complex Care Team maintain the register of those who are the commissioning responsibility of NHS England, who also hold case management responsibility for the individuals. The local authority similarly keeps data on individuals who do not require in-patient care.</p>		
<p>4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes</p>	<p>See 3.5. above.</p> <p>At a local level, we also work closely with the Carers Centre and the Carers Partnership Board to provide named support to individual families.</p>		
<p>4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.</p>	<p>We will seek to implement the recently issued guidance 'Framework for Individual Care Reviews</p>		
<p>4.8. Do completed reviews give a good understanding of behaviour support being offered in individual situations.</p>	<p>Yes T&WC and T&WCCG seek far more detailed, robust and evidenced information and additional scrutiny of provider led assessments will enhance this, particularly with regard to Children and Transition Services.</p>		
<p>4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.</p>	<p>Yes, all reviews have been completed.</p>		

5. Safeguarding	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
5.1. Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol	Yes. If safeguarding issue arise for people who are placed out-of-locality we are notified and respond pro-actively.		
5.2. How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	Yes. We work closely with colleagues in Housing and Planning and also with local housing providers. The major route for effective communication and discussion, to mitigate risk and plan appropriate local responses in a monthly Accommodation meeting. The meeting is chaired by the T&WC Assessment and Case Management Team Manager (Adult Social Work Team) with social workers, a commissioner, housing and others. This helps to take account of the needs of individuals and creates a greater level of confidence about appropriate housing solutions. This work applies across the board for all people with learning disabilities and other vulnerable groups, and includes local people with behaviour which can challenge.		
5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	Yes Quarterly liaison meetings take place with CQC in order to address any concerns arising in regulated settings. These meetings are well established. The CQC presented to the Learning Disability Partnership Board about WBV in October 2012.		
5.4. Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme	Not yet – work is now taking place to begin to establish and develop an aligned approach.		

5.5. Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint	As above.		
5.6. Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	Not yet – this needs to be developed		
5.7. Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	Yes The CSP has undertaken work on Hate Crime including support to adults with a learning disability		
5.8. Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	Yes. An Extraordinary meeting of the Safeguarding Adults Board is planned for the 26 July and Andrea Pope Smith (WM ADASS lead for LD) is due to meet with and brief a wide range of colleagues on WBV on the afternoon of the 26 July 2013.		
6. Commissioning arrangements	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
6.1. Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	As referred to above, T&WCCG began this work after Mansell 2. A formal process of review and evaluation is currently in hand for this financial year and will inform the future Action Plan. This work was commissioned by T&WCCG in 2012/13, to be implemented in 2013/14 and includes engagement with family carers and users of services, with support from a local advocacy service. The Review will be supported by colleagues from T&WC.	Annex 2.	

6.2. Are these being jointly reviewed, developed and delivered.	Yes, as above		
6.3. Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	Yes.		
6.4. Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people	Yes. Further work will take place to ensure there is alignment between Adult and Children's services.		
6.5. Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	Yes.		
6.6. Have the potential costs and source(s) of funds of future commissioning arrangements been assessed	This work remains ongoing and in hand. However, as stated above, there is an ongoing concern about meeting additional costs, particularly if they require capital investment, given the current climate of financial pressure. Investment from the DH to support local solutions would be welcomed.		
6.7. Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	Yes. Work has taken place locally to establish a generic, general advocacy service specification to inform the work of several advocacy service providers. We are continuing to discuss how good quality, independent advocacy can be provided in reviews for individuals who are located out of area, particularly when they are beyond the West Midlands area. If there are safeguarding concerns, T&WC agree to fund advocacy services to support people in those locations.		

6.8. Is your local delivery plan in the process of being developed, resourced and agreed	The original review, post Mansell 2 established a local delivery plan and the Review that is in hand will inform ongoing work and the local Action Plan.		
6.9. Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment	Plans are well advanced, with all cases being managed on an individual basis and therefore the pace of repatriation will be subject to the ability of local services to maintain the safety of the individual and the quality of the service provision. As referenced above, if there is a need for capital investment to support further local development, this may go beyond June 2014, although this will be minimised as far as possible and subject to close monitoring of progress. Locally, we also recognise that in responding to the best interests of individuals, a return to the locality may not always be the most appropriate outcome and we will continue to take a person centred approach.		
6.10. If no, what are the obstacles to deliver (e.g. organisational, financial, legal).	The ongoing work on progressing the Action Plan will help to better quantify these issues.		
7. Developing local teams and services	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
7.1. Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Yes.		
7.2. Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	Only locally. As referred to above, there is a recognition that further work is required to assure good quality, independent advocacy for people who are out of area.		

7.3. Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	Yes, but as referred to above, there may be a need to consider the overall resource impact of taking this forward.		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	Yes As part of the service commissioned, we have established an emergency bed which enables us to respond locally to crisis situations.		
8.2. Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	Across Shropshire, there has been significant investment to develop 'the Redwood Centre' run by the SSSFT which facilitates the provision of an appropriate therapeutic environment to minimise the need for detention under the MHA. This includes support for people with learning disabilities who may also have behaviour which can challenge.		
8.3. Do commissioning intentions include a workforce and skills assessment development	This will be picked up as part of the Action Plan.		
9. Understanding the population who need/receive services	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges.	Existing local planning supports us to develop appropriate services at a local level. The review, referred to above will inform further, future development.		
9.2. From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	Yes, in relation to adults. As acknowledged above, further work is required to align planning and commissioning across adult and children's services.		

10. Children and adults – transition planning	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
10.1. Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.	As referenced above, this has been flagged up as an area for more detailed work.		
10.2. Have you developed ways of understanding future demand in terms of numbers of people and likely services.	Yes. There is an effective Transition Team in place – linked to Adult Social Care. However, despite considerable work, cases still emerge which have not always been flagged up in good time. As we seek to work more closely with children’s services, we expect that all individuals will be known to services in the future (with the exception of people who move into area, and we are not aware of it).		
11. Current and future market requirements and capacity	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
11.1. Is an assessment of local market capacity in progress.	Via the review, this will assist. However, further work is required to align understanding between Adult and Children’s services.		
11.2. Does this include an updated gap analysis.	It will be included.		
11.3. Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice	See below.		

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

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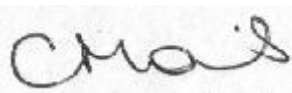
Councillor Richard Overton

LA Managing Director



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CCG representative: .



Christine Morris

Annex 1

Pan Shropshire Programme Board.

Establishment of Programme Board which is accountable to the Adult Safeguarding Board.

The Programme Board has 3 strands:

- Winterbourne View
- Joint Health and Social Care self Assessment 2013, and
- Confidential inquiry into premature deaths of adults with learning disabilities.

The outcome of the work of the Programme board will be to reduce inappropriate placements of individuals into services where individuals are potentially subject to neglect and abuse.

In addition, by working Pan Shropshire, we will reduce duplication, improve collaborative partnership working and increase opportunities for joint investment to avoid out of area placements.

Annex 2

Local planning of services for people with learning disabilities and behaviour which can challenge.

This work began in 2008/9 with a review of Mansell 2. At a local level steps were taken by T&W CCG (then PCT) to decommission the local specialist NHS Service. The process of de-commissioning took place in an open and transparent manner. Subsequently, a new small, community based care service was commissioned. After a full and robust tender process, a company called Creative Support were selected to run the local service.

In addition, a new Pan Shropshire service was commissioned by T&W CCG and SCCG from the SSSFT to establish a Community Based Team to support people with behaviour which can challenge. This service supports providers and families and seeks to reduce or remove the need for admission into acute, specialist in-patient services.

Work is currently in hand to review and evaluate progress so as to inform the next stages of strategic and operational planning and development. This work is being led by the SSSFT.