Telford and Wrekin Health and Wellbeing Board (HWB)

23rd January 2013 at 2.00pm

NFU Offices, Agriculture House, Southwater Way, Telford, TF3 4NR

Key Decisions/Actions/Discussion:

Agenda Item	Discussion Points	Who
1.	**Attendees:** **Board Members:** Cllr Richard Overton (Chair HWB and Deputy Leader TWC), Cllr Arnold England (Cabinet Member: Leisure & Wellbeing), Cllr Liz Clare (Cabinet Member: Adult & Social Care), David Evans (Chief Operating Officer T&W CCG), Dr Catherine Woodward (PCT Director of Public Health), Ros Francke (Representing Graham Urwin NHS Commissioning Board), Lilian Owens (LINkS (representing Dag Saunders)), Laura Johnston (Director of Children and Family Services T&WC), Paul Clifford (Director of Adult and Community Services TWC), Dylan Harrison (CCG Non-Executive Director), Dr Mike Innes (Chair of T&W Clinical Commissioning Group), **Support Officers:** Clare Hall-Salter (TWC Partnership and Planning Manager), Jon Power (Delivery and Planning Manager TWC), Helen Onions (Public Health Specialist), Karen Kalinowski (Assistant Director: Care and Support TWC), Clive Jones (TWC Assistant Director: Family and Cohesion Services), Karen George and Eunice Foster (Heart and Stroke Network), Sara Vale (Health Visiting and Family Nurse Partnership) and Jayne Clarke (Democratic Services Support TWC) **Apologies:** **Board Members:** Cllr Paul Watling (Cabinet Member: Children, Young People & Families), Dag Saunders (LINkS), Graham Urwin (NHS Commissioning Board LAT Director)	
2.	**Action notes 14.11.12:** There were no action points arising from the Minutes of the last meeting.	
3.	**Board Function**: **Health and Wellbeing Board Engagement** Clare Hall-Salter presented an update on the activity which had taken place or was due to take place regarding engagement. A provider engagement workshop had been held on 9th January 2013 which had been facilitated by the LGA as part of their development support to the HWB. The workshop had involved senior representatives from 7 key health provider organisations. The providers were keen to get involved early on in the engagement process around the HWB priorities and the mechanisms for	

	engagement and effective communication. The voluntary sector, in particular, expressed the need for greater input in the development of the JSNA in identifying the needs of the local community. Providers did not request a seat on the Board and did not feel it necessary to attend at all meetings of the HWB. There was potential for some "joining up" across geographical boundaries, where appropriate, in terms of future engagement across Shropshire and T&W HWB. The 7 key health providers had been invited to attend at the stakeholder engagement event to be held on 30th January. Additional representation had also been requested from these organisations in order to contribute towards the asset mapping. An update on progress would be given during the event and a draft Agenda for the stakeholder event on the 30th January 2013 had been circulated. The first HWB Newsletter had been produced in October 2012 which had been circulated by e-mail and published on the HWB website. A second newsletter would be published in March in advance of the Board becoming statutory and would include engagement feedback. It was raised that the HWB should also engage with Primary Care providers. **RESOLVED – that** **a) the updates received in relation to the Telford and Wrekin Health and Wellbeing Board be noted;** **b) that the proposed next steps for provider engagement be agreed; and** **c) the agenda for the second HWB stakeholder engagement event to be held in January 2013 be agreed.**	
4.	**Progress Report Health and Wellbeing Strategy and Joint Strategic Needs Assessment** John Power and Helen Onions presented a joint report on recent developments on both the Health & Wellbeing Strategy and Joint Strategic Needs Assessment (JSNA). A piece of work had been undertaken benchmarking the developing work against the National guidance and the HWB were currently in line with this and adhering to best practice in both the strategy and the JSNA. The review has continued since the publication of the national Operating Principles for JSNA and JHWS and these guidelines, through the six operating principles, confirm the HWB's robust approach to both the JSNA and JHWS. An issue had arisen during the development of the HWB strategy due to feedback from the consultation around the priority 'ensuring people have a positive experience of health and care services'. A question was asked as to whether this should be a cross-cutting principle or a stand alone priority. A discussion took place including: • positive experience at the heart of the service design	

- should be “part of the day job” rather than a separate plan
- using a cross-cutting approach the priority could be lost
- already 3 other cross-cutting principles
- suggestion it could be both
- most important priority of the 10
- integral to commissioning
- underpins the whole ethos/attitude to care services
- reporting process – 1 annual overarching report

<u>AGREED</u> – that the priority of ‘Ensure people have a positive experience of health and care services’ should be a cross-cutting principle and that it would continue to be an Agenda item, as appropriate.

With regard to the priority of Smoking and Drug / Alcohol Misuse, it was suggested that this was split into two priorities:

- smoking
- misuse of alcohol / drugs

A discussion took place including:

- the ability to give both priorities the appropriate focus
- the need for different approaches for each priority
- easier to monitor and evaluate if separate priorities

<u>AGREED</u> – that the priority of Smoking and Drug / Alcohol Misuse be separated into two priorities of:

- **Reduce the number of people who smoke**
- **Reduce the misuse of alcohol and drugs**

As the Board becomes statutory and formal from 1st April 2013. This would be an opportunity to build a new relationship between the Council and the CCG which in turn would help the Board to work better and more effectively. A discussion around existing priorities would take place at the stakeholder event as well as identifying 2 or 3 “Making It Happen” themes. A list of priority sponsors from the Board were identified to champion the 10 priorities at the upcoming stakeholder engagement event and to sit around the table for the discussions. The priority sponsors were identified as:

- Excess Weight – Cllr Arnold England
- Improve Life Expectancy / quality of life – Cllr Richard Overton
- Teenage Pregnancy – Dave Evans
- Emotional Health & Wellbeing – Dag Saunders / Lillian Owens
- Support Autism – Dylan Harrison
- Smoking – Paul Clifford
- Drug / Alcohol Misuse – Laura Johnston
- Support Independent Living – Catherine Woodward
- Dementia – Mike Innes
- Improve children and adult carer’s health and wellbeing – Cllr Paul Watling

	It was also suggested that sponsors be included in any relevant cross-cutting priorities – NHS Commissioning Board rep would be the sponsor for positive experience of health and care services. The role and expectations of the sponsor were outlined in the paper and the sponsors would meet with the leads at the stakeholder event. Cllr Paul Watling was unable to attend at the stakeholder event and it was agreed that Clive Jones would be his representative. Cllr Liz Clare was also unable to attend at the event and was not allocated to a priority at this stage.	
5.	**<u>Other Areas of Focus</u>** **Health and Wellbeing board as a Statutory Committee of the Council** Paul Clifford gave an update on the current position as the Board approached formal status on 1st April 2013. The regulations and secondary legislation was still currently awaited and was expected at the end of January. This meant that work currently being undertaken was from the guidance rather than the secondary legislation so may be subject to change. Several issues had been highlighted including: • Formal status of committee • Existing legislation which may need to be set aside • Changes to voting rights • Equal voting powers for officers and Members Any proposed changes to the Board would be taken to the Council Constitution Committee and then recommended to Full Council for approval. An updated list of proposed Board members was tabled at the meeting. Although LINk was on the list of representatives from 1st April this would be replaced with Healthwatch. An approach had been made from the Criminal Justice Board for the Probation Service to be considered as a board member and a discussion took place around concerns of the size of the board and how to differentiate between requests to be members of the Board. The Board concluded that they would continue to limit the membership but invite specific groups to attend at the meetings where necessary or form sub-committees/forums. The HWB was not currently politically balanced and this was something that the Board might want to consider. A public questions session may also be considered, similar to the procedure of Full Council. This would allow the public to have the opportunity to contribute to the meetings. It was suggested that Council would delegate the role of scrutinising health and social care matters to the relevant Scrutiny Committee. A discussion took place including: • The size and structure of the committee • Sub-committees/forums to report back to HWB • Public questions / advance notice of questions • Political Balance • Proposal of Mike Innes as Vice-Chair to represent Health	

	<u>RESOLVED</u> – that the provisional recommendations be referred to Council Constitution Committee and then on to Full Council for approval.	
6.	**Heart and Stroke Network (Can you Feel It) Project** Karen George and Eunice Foster gave a presentation on the Heart and Stroke Unit (Can you Feel It) Project. Care homes had a significant number of hospital admissions from falls and dementia and a pilot study was undertaken. Following this study a training programme was developed for care workers in order to try and reduce the number of ambulance call outs and reduce hospital admissions. It was also hoped that care home staff would develop a more proactive approach to the management of illness. There were currently 170 care homes across Shropshire with a bed provision of 4700 and a workforce of approximately 8000 staff who would potentially require the stroke management training. The number of staff that had been trained to date was 125 and data from 14 care homes had been assessed. In November 2012 the number of homes actively taking pulses was 23. The analysis of data had not been as successful as hoped and the reporting system had been amended to try and address this. The key message from the project was to move away from the current thinking regarding aspirin and instead to move towards using warfarin as the first line treatment for Atrial Fibrillation (AF). A number of patients with AF had been identified since introducing the project and they were now on an anticoagulant. The next steps were to firm up the data collection and to work closely with CCG Chairs and GPs across Shropshire/Staffordshire on the project. Links had been made with Social Care and the project was now included with their training. A poster had been presented at the 2011 Stroke Forum in Glasgow and flyers had been developed for distribution to all care homes. Patient information leaflets were currently being produced. The training package was now available on the website and a data report had been produced. A competency framework was being developed. RCN Accreditation had been achieved which was funded by T&W PCT. Social care had purchased 15 BP machines which were able to detect AF. A train the trainer package had also been developed. A meeting had taken place with an educational lead from Boots in Nottingham Head Office and they had agreed to include AF training into their e-learning package in April 2013. The e-learning package had also been put onto the Shropshire OD website and negotiations were taking place with SHA. An invitation had been received to present the poster at the International Forum on quality and Safety in Healthcare in London in April 2013. A discussion took place including:	

	• A local initiative that had gone national and regional • Training in care homes and relationship with Shropshire Partners in Care • Partnerships with care workforce – LAs / Health Agencies / Domicillary agencies • Training in both residential and nursing homes • Nursing care • Presentation of training to full time carers	
7.	**Health Visiting – Early Implementation /Family Nurse Partnership** Sara Vale presented an overview report on Health Visiting and the Family Nurse Partnership. The Health Visiting Implementation Plan 2011-15: A call to Action was published in January 2011 and set out the commitment or a larger, re-energised Health Visiting Profession. It was aimed at transforming, increasing and redesigning the service in order to deliver the following four key offers for families and communities: • Community development • Universal Services – including the Healthy Child Programme • Universal Plus • Universal Partnership Plus The national documentation for the vision for health visiting provision was based on progressive universalism detailing a core service to be received by all families based on the healthy child programme. This was a core model with every family having an entitlement to the service. In a local context this means that for T&W the whole time equivalent (wte) health visiting workforce in May 2010 was 36.1. Commissioners have agreed an increase of 5.6 wte by 2015 which equates to a total health visitor workforce for T&W of 41.7 wte. It was noted that this total also included other posts which have a health visiting qualification ie family nurses / safeguarding/ and looked after children nurses / health visitor coordinator. These were not all hands-on posts. Case load numbers would reduce from 373 children to 311 children per wte by 2015. NHS Telford and Wrekin and Shropshire County PCT were one of 6 additional Early Implementer Sites (EIS) in the 1st wave – 2nd cohort. Significant progress had been made and close monitoring was taking place. Work would continue with key partners with a commitment to deliver the full offer to families by 2015. The Family Nurse Partnership is an intensive home visiting programme offered as an alternative to health visiting and uses a different model of working which is reflected in the skill set and training of the team. The caseload was based on 100 first time parents under the age of 19 from the	

	time of booking the pregnancy with midwifery service until the child is 2 years of age. There were a team of 4 family nurses and one supervisor working across T&W. Each nurse has a small case load of 25 families per 1 wte and was able to deliver an intensive home visiting programme following additional training. The local Family Nurse Partnership Advisory Board (FAB) had been convened to meet quarterly and key stakeholder representation and reporting arrangement were currently being clarified. A discussion took place including: • Case loads • Growth of workforce • Partnership Working • Links to the Strengthening Families Task Group	
8.	**Development of A Local Healthwatch** The development of a local Healthwatch report provided an update on the position regarding the procurement process and the current development of the local Healthwatch. **RESOLVED – that the report be noted.**	
9.	**Update on the Unscheduled Care Programme** Mike Innes presented an update on the unscheduled care programme of activity across Shropshire. The programme of work had been in progress for approximately two years and had been driven by population needs: • Be “joined up2 and responsible for care • Understanding the Urgent Care service • Appropriate access to care • Hospital admissions only when necessary • Hospital stays to be short, safe and effective • Home care, even when patients are ill. It had become clear that these themes work for both scheduled and unscheduled care. There was concern regarding walk-in-centres and their capacity to see patients, especially with the added pressure of winter. The CCG was hoping to secure extra funding to expand the walk-in element of the Centres from 29 to 60 appointments. Access to primary care was currently being looked at and an audit of the finances being undertaken up to the end of the financial year. A discussion took place including:	

	• Access to walk-in-centres • Rapid Access to Intervention and Diagnosis (RAID) **<u>RESOLVED</u> – that** **a) the progress to date and focus on the main themes be noted; and** **b) the next steps to deliver transformational change in Unscheduled Care be noted.**	
10.	**Autism Strategy** Michael Bennett presented a report on the Autism Strategy. Following the Autism Strategy guidance, the PCT needed to have both a strategy and a pathway to diagnosis in place by end March 2013. The Telford and Wrekin Strategy had been developed with the aim of addressing the five core areas highlighted within the national strategy. This was to ensure an all age approach that incorporated the needs of both children and adults. A national template had been set although local areas could adapt this to redesign their service model. The local autism strategy included: • A user and carer led service • Locally rooted services with care closer to home • Services that offer early recognition and intervention, that encourage and facilitate recovery and maintaining independence • A review of the workforce skill base • Development of training programmes for staff to enable them to deliver high quality effective services. Autistic Spectrum Conditions (ASC) was a HWB priority and would be closely monitored by the local partnership. The action plan focussed on the following specific priorities for children, young people and adults: • Workforce development/training of staff who provide services for people with autism across children's and adult services • Assessment of needs, identification and formal diagnosis of ASC if wanted • Having an effective ASC pathway in place for children, young people and adults • Development of co-ordinated high quality services so that individuals of all ages with ASC can lead ordinary lives • Planning in relation to the provision of services as individuals with ASC move from children to adults (Transition planning) • Local planning and leadership for the provision of services including data collection, meaningful engagement and consultation with children,	

	young people, adults, families and carers. The aims of the strategy were: • Ensure a planned and open approach to commissioning of services for people with all ages of an autistic spectrum condition, making use of information about demand, unmet needs/service gaps, resources and involvement of the third, independent and voluntary sector. • Ensure that services are centred on service users' needs and where appropriate family carers. • Develop approaches that engage individuals and family carers in quality assurance, training of staff, recruitment and co-production of service development • Ensure a transparent relationship with stakeholders in the commissioning and provision of services. • Provide direction and structure for both Health and Social Care provision within Telford and for other mainstream services such as Housing, Leisure, Education/School and Training. • Continue to review service requirements identified through the Joint Strategic Needs Assessment with due regard to available resources and the need to work within existing decreasing budgets for the main Stakeholder organisations A Transition service for 15-25 year olds was now in place to ensure effective transition of those in children's services and needed ongoing support into adulthood. A discussion took place including: • Children with trauma • Labelling • Care homes/therapeutic care • Early years training • Diagnosis and screening • Transitions • Referrals • Early recognition **<u>RESOLVED</u> – that the report be noted.**	
11.	**Child and Adolescent Mental Health Service Review Update** During 2011 two reviews of the CAMHS were carried out. The recommendation was to develop an Adolescent (15-25) service across the two main providers and to re-design the service to meet the emotional health and well-being needs of young people. CAMHS needed to decide whether to put the service out to tender or to give the current provider a chance to provide the new service. It was decided to use a partnership approach as this could be delivered more quickly and there would not be the need to go out to tender. As this raised issues for the	

	Foundation Trust outside help was sought. The providers had been officially told that this was the way forward. An implementation plan was being developed and a steering group was held monthly. A maintenance plan was currently being worked through. The Community Trust was now very much engaged and had taken on board the risks of not making the changes. The Foundation service had been less forthcoming and a challenging conversation had been undertaken to get them to engage. A Service specification model was being used to assess the options. More formal options would be brought back to HWB in July 2013 although this would be a real challenge. A discussion took place including: • 15-25 service • Placement stability team • Development of service	
12.	**Service & Financial Planning Update** <u>NHS Commissioning Board</u>**:** Ros Francke gave an update on the development of the NHS Commissioning Board Local Area Team. All senior appointments to the NHSCB had been put in place by December 2012. Planning Guidance had now been received and the NHSCB were putting plans together based on central priorities and it was hoped that there would be joined-up planning and that HWB would be key in the partnership. It also encouraged the HWB to review key actions and re-iterated the contributions that NCB / CCGs can make in order to help reinforce and support. This had been a key week for finances. The CCG plans and NHSCB area team plans were not a clear picture so it had been difficult to give any real feedback. **A further report would be brought to the next meeting once more information was available**. A discussion took place including: • 7 day working <u>Clinical Commissioning Group</u>: Mike Innes presented a report on the development of CCG. David Evans had now been officially appointed Chief Officer. The CCG had received approval and authorisation with only 3 conditions. These were technical items and were work in progress. It was expected that these conditions would be closed off before April.	

	<u>RESOLVED</u> – that: **a) note the progress to date; and** **b) the Board agree to take a major role in a transformational process for our local health and economy.** Mike Innes also presented a report on the Clinical Commissioning Group Finance. Delivery of the 2.5% savings required had been a challenging budget for the CCG and had required a reduction in administrative activity and sharing functions with the local authorities and neighbouring CCGs. Although the budget allocation for next year had yet to be determined the CCG had started considering plans to deliver budget for the coming year as well as the medium to long term financial position. A discussion took place including: • Uncertainty on the coming budget • Specialised Commission Services • Level of support to CHC • Retrospective claims **<u>RESOLVED</u> – that** **a) the Board note the situation for the current year; and** **b) the Board note the work that is happening for the future.** <u>Council</u>: Paul Clifford gave a brief overview of the Council's budget for children's services, adult social care and public health for information. The Government cuts of 27% were in cash terms alone, this was on top of the savings for 13-14 / 15-16. An action plan for Safeguarding to enable cost improvements had been put in place following the continuing overspend on the children's placement budget. There were no quick wins and this would be monitored on a monthly basis. This was the position across all Local Authorities due to the increasing population of children in care. The Adult Social Care Budget was on the bottom quartile compared with other Local Authorities. The CCG were still able to support the CHC. It was hoped that resources could be moved around to support where needed.	
13.	**Public Health Transition Progress Update (including contracts update and Draft Public Health Vision)**	

	Following that late announcement of Public Health grants for the next 2 years, the savings proposals for Public Health have been revisited. Discussions with the Director of Public Health on the original proposals highlighted areas of concern underpinned by the evidence of local need and inequalities from the JSNA, relevance to the agreed Health and Wellbeing priorities and some local poor performance indicators in the recently published Public Health Outcomes Framework (PHOF) which the Council will be monitored against from April 2013. In summary this review resulted in a reduction in the proposed savings to protect investment in specific areas. A document was tabled that superseded the previously circulated report following the refreshed proposals around the savings for public health: • £1.48m for 13-14 • £1.98m for 14-15 Contingencies had also been built in until everything became clearer. A discussion took place including: • The impact on Local Authorities following the late announcement of the Public Health grant • Transfer of clinical services	
14.	**Position Reports on Programmes transferring to the Council (for information)** The briefing notes provided the Board with an update on: • Obesity (Children, Young People and Adults) • Mental Health Promotion • Contraception and Sexual Health Services`	
15.	**Proposed Agenda Items for March:** • Position reports on Programmes transferring to the Council (for information): Health Check/Tobacco control and smoking cessation/CYP Health Promotion; Healthy Lifestyles hub and MECC • Public Health Report; • Carer's Strategy Update (to include young carers); • HWB Strategy development and JSNA	
	Dates of future meetings: SHWB meeting 13th March 2013, 2pm – 4.30pm, Business Development Centre HWB meeting 15th May 2013, 2pm – 4.30 pm, Business Development Centre	

The meeting ended at 4.41pm

Signed ....

Dated ....

TELFORD & WREKIN HEALTH & WELLBEING BOARD MARCH 2013

UPDATE ON TELFORD AND WREKIN CCG

MR DAVID EVANS

1. PURPOSE

To update the HWB Board members on Telford and Wrekin CCG.

2. RECOMMENDATIONS

That the Board:

- **Note the report**

3. UPDATE ON TELFORD AND WREKIN CCG

The CCG was notified at the end of January 2013 by the National Commissioning Board that it has successfully gone through the authorisation process and has been authorised as a statutory organisation of the NHS with 3 conditions. The 3 conditions relate to a Memorandum of Understanding with Shropshire CCG and a Service Level Agreement with Staffordshire and Shropshire Commissioning Support Unit. Both of these documents have now been signed and have been submitted to the NHS Commissioning Board for consideration and we are hopeful that this will result in the 3 remaining 'reds' being turned 'green' when the final panel meets before the end of March 2013.

Almost all of the appointments have now been made to the CCG team. Mr Andrew Nash has been appointed as the substantive Chief Finance Officer for the CCG following a competitive interview process at the beginning of February 2013, which means that all the executive posts are now filled.

The Halesfield building will now host the CCG, Area Team, CSU and Public Health, together with Shropshire Community staff, and moves are planned next week to facilitate all of these teams. Accommodation needs will include the relocation of the Joint Commissioning Team and other staff at Edward James House moving into Halesfield. The CCG will occupy the first floor of Halesfield with the other organisations occupying the ground floor accommodation.

There continue to be pressures within Shrewsbury and Telford Hospitals NHS Trust in meeting both the A&E national target and the RTT elective and non-elective patients target. Considerable work is on-going within the health economy to look at achieving a sustainable position for both of these targets, which clearly impact on patient quality and patient experience. Further updates on the current position and action taken will be provided to the Health and Well Being Board in due course.

David Evans
Chief Officer
Telford and Wrekin CCG

TELFORD & WREKIN HEALTH & WELLBEING BOARD MARCH 2013

UPDATE ON SHROPSHIRE AND TELFORD AND WREKIN WHOLE SYSTEM COMPACT AND WHOLE SYSTEM PROPOSAL

MR DAVID EVANS

1. PURPOSE

To update the HWB Board members on the Shropshire and Telford and Wrekin Whole System Compact and Whole System Proposal

2. RECOMMENDATIONS

That the Board:

- **Note the report.**

3. UPDATE ON SHROPSHIRE AND TELFORD AND WREKIN WHOLE SYSTEM COMPACT AND WHOLE SYSTEM PROPOSAL

Attached as an appendix, is the latest version of the Whole System Compact which has been drawn together by all of the health and social care partners in the Shropshire and Telford and Wrekin health economy. Essentially, this sets out the modus operandi of how partners will work together to address significant issues within the health economy.

There is now a weekly Chief Officers meeting where all the Chief Officers of the NHS organisations and directors from both local authorities attend to begin to look at the strategic direction for the health economy as a whole.

A further update will be given in due course.

David Evans
Chief Officer
Telford and Wrekin CCG

Shropshire, Telford and Wrekin

Health and Social Care Partnership

Compact

Version Number	Date	Notes
V1	25.1	First (incomplete) draft
V1.1	28.1	Minor amendment to V1
V2.0	11.2	Incorporates draft Vision/Strategy section
V3.0	18.2	Added “measuring success” and “joint programmes” sections
V4.0	25.2	Amendments to 2.4 and 4.1, new section 3.9
V5.0	26.2	Amendment to 3.2
V6.0	27.2	Amendments following CE meeting on the 26 February, to include changing the word “patient” to “citizen”.

Partners to Agreement

To be completed

1. Introduction

1.1 Chairs, Accountable Officers and leaders across NHS and social care in Shropshire, Telford and Wrekin have agreed to establish a 'Compact' which sets out their commitment to partnership working to deliver improved health and wellbeing for the people they serve.

1.2 The Compact sets out a high level vision and strategy for the health and social care system, drawing on the visions and priorities of individual organisations and other partnerships, including the respective Health and Wellbeing Strategies of the two local authorities.

1.3 It commits all organisations to a set of principles and ways of working which will provide a framework for collaborative working through which key elements of the strategy will be delivered. Whilst the improvement of all health services and social care depends on effective partnership working, the Compact is focussed on particular priority areas where all organisations are agreed that collaborative action to achieve significant change and improvement is needed to ensure that the health and social care system can achieve improving outcomes and remain financially sustainable in the longer term.

1.4 Finally, the compact includes a programme of joint work through which the priority areas for action will be taken forward. These priority areas will evolve and change over time as the system achieves its goals, identifies further local priorities and responds to legislation and other national imperatives.

1.5 NHS and Local Authority partners face the challenge of meeting their statutory duties at a time when there are major constraints on the availability of public funding. The NHS is being asked to meet rising demands and improve outcomes within existing resources and local government is being asked to manage with significantly reduced funding. All partners are agreed that these challenges can only be met through effective collaborative working, working together to find better ways of using health and social care resources across Shropshire, Telford and Wrekin.

2. Vision/Strategy

2.1 Shropshire and Telford & Wrekin CCGs, alongside their main providers and Local Authority partners, have collectively recognised that through collaborative working across the health and social care economy they can better meet the challenge of creating a sustainable care system.

2.2 There is a shared vision of a local health and social care system that is financially sustainable, high quality, responsive to citizen and carer needs whilst being agile enough to meet changes in legislation and national directives. All parties hold true a mutual understanding that only through joint planning and collective responsibility can they attain this goal.

2.3 Although the need for transformational change is often framed in financial terms, in fact the main drivers for it must be to improve the quality of services and the citizen experiences of them. This is based on the view that the provision of quality services delivered in a streamlined way will reduce the inefficiencies inherent in the current provision of services. These drivers are eloquently summarised by the seven 'patient statements' which underpin the Urgent Care strategy but which are applicable across the whole system:

- Be 'joined up' and responsible for my care
- Help me understand the services you provide
- Let me access them appropriately
- Assess and treat me promptly and in the right place
- Admit me to hospital only when necessary
- Make my stay in hospital short, safe and effective
- Try to care for me at home, even when I am ill

2.4 Our vision for the health and social care system is:

- That through our commissioning and provision of services we empower citizens to better manage their own health and well-being, utilising self-care programmes, strengthening prevention, supporting the development of community capacity and expanding the use of personal budgets.

- That as a health and social care system we view every unplanned admission of a citizen with a LTC as a system failure

- That our services provide seamless care across organisational boundaries, that our workforce is flexible (responsive to citizen and system need), sustainable and healthy and that we share training and learning across the system.

- That we aspire to improving the health and wellbeing of our citizens delivering care from services that recognise the fundamental importance of care and compassion

- That we champion innovation where new ways of delivering services will make best use of resources and improve care for citizens, with a particular recognition of the challenges of delivering services in a large rural county.

- That we will provide services in community settings and seek to retain services within the county where it is safe and affordable to do so.

- That action to tackle health inequalities is central to everything that we do.

2.5 Each year, through the Chief Officers Group, we will set at least one shared objective for each of the seven facets of our vision set out above.

2.6 The clinical and service strategies through which we will move towards this vision are being developed using methods which do focus on improving the quality of care, rather than only reducing its cost. During their development, a number of key principles emerged which have become, and must remain, central to the operational planning and delivery of transformational change across the health and social economy. These principles are:

- The central role of attitudes, behaviours and relationships
- Healthy stakeholder organisations which are capable of large scale change
- Enduring full stakeholder involvement
- Clinical engagement at the heart of the change process
- Working across organisational boundaries
- Developing integrated teams

3. Principles of Collaborative Working

3.1 We will seek authentic savings – making changes which reduce costs through higher quality, service redesign and real productivity. We will seek to avoid making changes which save costs in one part of the system only to result in equal or greater costs to another organisation.

3.2 We will share the financial risk of making agreed system-wide changes which form part of our work programme, using an open-book approach to assess the costs and benefits of system and service change to individual organisations with the aim of reallocating resources across the health and care system to reflect impacts arising from the changes.

3.3 We will make shared decisions about which major whole-system innovations to roll-out at scale, recognising that any innovation may not always favour all parties and that at times some individual sacrifice for the common good will be necessary.

3.4 We will share appropriate information and records where that facilitates improved outcomes for the people we serve.

3.5 We will take collective responsibility for making progress towards our shared strategic vision and will agree a shared set of objectives and measures of success through which we will individually and collectively hold ourselves to account.

3.6 We will commit our organisations to a programme of collaborative work, to be agreed through the Shropshire, Telford and Wrekin Chief Officers Group. We will provide the necessary resources to individual projects and programmes and ensure senior clinical and executive participation and leadership, usually through existing groups

and structures. We will share in the overall governance of the work, through individual boards and jointly through the Chief Officers Group.

3.7 We will share organisational plans and be transparent about budgets, costs, activity and utilisation data where that is required to enable the best joint decision making and the agreement of three-year financial strategies for each part of the health and social care system and for the system overall.

3.8 We will respect the need for individual organisations to pursue their own objectives alongside these whole system objectives. We recognise that aspects of the system will be subject to competition, whether through national policy or local decisions made by commissioners, and that this may in some circumstances limit the information which an individual organisation is willing or able to share. All efforts will be made to minimise the risk that this might compromise achievement of the objectives of this Compact.

3.9 We will remain mindful of the impact we may have on other providers within our wider health economy not represented in this compact agreement

3.10 This Compact will support and complement the wider strategic role of Health and Wellbeing Boards in setting health and well-being strategies for Local Authority areas and overseeing achievement against them.

4. The Programme of Joint Work

4.1 We will establish a joint programme of work to bring together our resources and focus senior clinical and managerial resources on the major programmes of work that we believe need a shared commitment and joint action to deliver the transformational changes that we need to make. We will request an external review of the programme of work to ensure we have the greatest chance of delivery by triangulating the proposed projects

4.2 The joint work programme will change over time and will be reviewed at least annually. For 2013/14 our joint work programme will include:

1. **Development of frail and complex pathways/services**

2. **Implementation of RAID**

3. **Establishing a shared approach to managing demand and capacity,** including the creation of a system for near real-time reporting.

4. **Shared leadership and joint working in the implementation of the recommendations of the Francis Report and the vulnerable children's strategy**

5. Measuring Success

5.1 We will agree a short list of measures that we will use to monitor and report our progress as a health and social care system.

5.2 The purpose of these measures will not be to develop a comprehensive 'balanced scorecard' looking at the performance 'across the board' of the health and social care system. Instead, we will identify a few high level measures which reflect the shared priorities where we believe that effective collaborative working will be most critical to achieve the improvements to which we are all committed.

5.3 The measures to be used will be agreed by the Chief Officers Group no later than May 2013 following consultation amongst partners. Performance will be monitored by the Chief Officers Group and will be reported using a common report to constituent boards (or equivalent). Additional measures may be added over time.

6. Conclusion

This Compact underpins the philosophy of approach and principles of behaviour through which we will work together to achieve better outcomes for the citizens we serve.

BOROUGH OF TELFORD & WREKIN

HEALTH AND WELLBEING BOARD – 13 MARCH 2013

CARE AND SUPPORT BILL & CARE AND SUPPORT FUNDING UPDATE

REPORT OF THE ASSISTANT DIRECTOR – SOCIAL CARE SPECIALIST

1. SUMMARY

1.1 The report summarises Government proposals for adult care and support contained in the Care and Support White Paper, Care and Support Bill, Caring for our Future progress report on funding reform and more recently a "Policy Statement on care and support funding reform and legislative requirements"

1.2 Generally there is support for the proposals however there are significant concerns about the delay in addressing the adult social care funding situation for at least another 3 years at a time when budgets are already under such pressure.

1.3 The proposals will impact on the way the service is currently delivered by the Council, there will be more assessment activity for more people and new systems will need to be put in place.

2. RECOMMENDATIONS

2.1 **Board members note the content and implications of these proposals and receive further updates at regular intervals as the Bill proceeds through Parliament and more detail is developed.**

3. IMPACT

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

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

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

4.0 INFORMATION

4.1 The Council's Cabinet on 20 September 2012 were informed of the government's publication on the 11 July 2012 of the Care and Support White

Paper, the draft Care and Support Bill and a progress report on Funding Reform.

4.2 **The White Paper** updated the Vision for Adult Social Care that the Government released in November 2010. It confirmed that local authorities will "sit at the heart of how care and support will work in the future". Central to the vision is the principle of promoting wellbeing and independence instead of waiting for people to reach crisis point, availability of better information and high quality services.

4.3 Actions identified in the White Paper included:

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

4.4 **The Care and Support** Bill (For electronic link see Section 6 below) underpins many of the above proposals and completely overhauls care and support law as recommended by the Law Commission's review in 2011.

4.5 The Bill if it becomes law would replace nearly all the existing adult social care law that has been built up on an ad-hoc basis since the National Assistance Act, 1948 which is still applied today. The Bill was published in draft for public

consultation (deadline for comment was the 19 October 2012) followed by Parliamentary pre-legislative scrutiny.

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

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

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

4.7 The **Caring for our future: progress report on funding reform** report made it clear that the Government agreed with the principles of the Dilnot Commission's recommendations published in 2011 which were:

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

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

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

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

Initial response to announcements

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

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

Summary of consultation responses to the draft Care and Support Bill

4.12 The Department of Health published a summary of the views received as part of the consultation on the 10 December, 2012. Over 1,000 comments were received, with around 430 unique respondents submitting written comments via email, post and the dedicated website. Some of the findings from the summary of consultation responses include:

4.13 **Part 1: Care and Support**:

- respondents were on the whole very supportive of the consolidation, clarification and modernisation of existing law and the increased emphasis on outcomes
- there was an eagerness to see the regulations and guidance that will provide further detail on the provisions in the draft bill, and suggestions were made about what they should cover.
- strengthened rights for carers to access support were particularly welcomed.
- respondents were supportive of the principle of a national threshold for eligible needs but wanted to see more detail about where the threshold would be set and how it would work.
- there was a strong desire to expand the duty to provide information and advice to include more detailed requirements to help the person understand and make use of information, and to support the role of advocacy.
- some felt that the provisions should go further in ensuring that the balance of decision-making lies with individuals rather than the local authority, so that people are supported to feel in control of their care and support in line with the wider personalisation agenda, and people's ability to challenge decisions made about them is clarified.
- some wanted to see a stronger focus on prevention of needs and the role of communities in providing universal services.
- concerns were raised about the pressures on local authority budgets and the consequential impact on care and support. People also expressed disappointment about the absence of clauses in the draft Bill to implement the recommendations of the Dilnot Commission.

Part 2: Health Education England (HEE) and Health Research Authority (HRA)

- respondents broadly welcomed the proposals to establish HEE and HRA as non-departmental public bodies and local education and training board (LETB) governing bodies as committees of HEE.
- they were keen to understand more about how HEE will ensure that the system is accountable, integrated, professionally informed, and that quality improvement underpins all education and training activity.
- they welcomed clarification of the HRA's role in promoting standardised practice in the regulation of health and social care research and in ensuring such regulation is proportionate, but wanted to see greater clarification of its role in facilitating research governance to address the complexity, duplication and delays in obtaining approval to undertake research in the NHS.

4.14 The comments are being used to assist and challenge the government in considering how to improve the proposals in the draft bill. The draft bill is currently coming to the end of pre-legislative scrutiny by a joint committee made up of members of the House of Commons and the House of Lords which will report with recommendations by the 7 March 2013. The LGA and ADASS submitted joint written evidence to the joint committee on the 17 January 2013 (Appendix 1). The government will in due course respond formally to the public consultation alongside its response to the recommendations of the joint committee.

Funding of Care and Support

4.15 Possibly recognising the major criticism of delay in implementing Dilnot, the Government released it's decision about implementing the Dilnot recommendations on the 11 February 2013 in a short paper titled "Policy statement on care and support funding reform and legislative requirements" (Appendix 2).

4.16 In summary they are proposing at 17/18 prices:

- Placing a cap on the total amount an individual will have to pay for care of £75,000 (a lower cap will be set for people of working age and a zero cap for those entering residential care for adults immediately they turn 18. Currently there is no cap. However under the new proposals everybody will be expected to contribute towards general living costs (non care costs) such as food, accommodation rent and utilities of around £12000 a year - £230 a week from there income including benefits, which will not count towards the £75,000 cap
- Setting an upper capital limit threshold for means-tested Council funded support of £123,000 (including the value of their home) for residential care. Currently individuals have to fund all residential costs when they have capital of over £23,250
- Setting a lower capital limit threshold for the means test at £17,500 (compared to £14,250 currently) for when a notional weekly income against capital is assumed as part of the means test

4.17 In addition the Government have accepted Dilnot's recommendations to introduce from April 2015:

- deferred payments against the value of their property for people in residential care, with the aim of giving people peace of mind that they will not have to sell their home in their lifetime to pay for care

- a national minimum threshold of eligibility with the aim of helping remove the variation in access to care depending on where people live

- information and advice (available from local authorities) on planning and paying for care costs

4.18 Clearly their will be significant additional costs associated with the cap and extended means-test

4.19 There will also be significant additional costs for local authorities in carrying out more assessments - currently self funders do not always enter the system but will be required to do so for local authorities to administer the cap (and agree eligibility and a reasonable weekly care related cost). The general public are likely to find these proposals very complex.

4.20 We will need to understand how disability related benefits are off set in the cap as self funders carry on receiving attendance allowance under the current system but Council supported residents do not.

4.21 We will also have to recognise that a new national minimum eligibility threshold will reduce the scope for individual councils to manage their budget and allocation of resources for adult social care by varying the eligibility threshold

4.22 Obviously all of this is going to cost, estimated to be £1billion a year by the end of the next Parliament. Local Authorities can expect to receive increased national funding but it would be prudent for the Council to remain fully aware of the implications, particularly as some of the changes are only 2 annual budgets away.

4.23 Even if the new costs are fully funded these announcements have not addressed the financial sustainability of the current system. Failure to adequately plan for and resource these policy changes could leave the Council open to increasing likelihood of legal challenge and impact on the whole local health and social care system

4.24 It has also been identified that the variation in house ownership and prices across local authorities will have varying impact for Councils in financial terms and it is hoped government will take this into account in due course.

5. PREVIOUS MINUTES

5.1 Cabinet – 20 September 2012

6. BACKGROUND PAPERS

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

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

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

6.4 Factsheet 1 – Assessments and eligibility
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-1-Assessments-and-eligibility.pdf
Factsheet 2 – Charging and financial assessments
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-2-Charging-and-financial-assessment.pdf
Factsheet 3 – Who is entitled to care and support?
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-3-Who-is-entitled-to-care-and-support.pdf
Factsheet 4 – Personalising care and support planning

http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-4-Care-and-support-planning.pdf
Factsheet 5 – The law for carers
http://www.dh.gov.uk/health/files/2012/07/2900021-Fact-sheet-5-v1_1W-21.pdf
Factsheet 6 – Protecting adults from abuse or neglect
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-6-Protecting-adults-from-abuse-and-neglect.pdf
Factsheet 7 – Health Education England
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-7-Health-Education-England.pdf
Factsheet 8 – Health Research Authority
http://www.dh.gov.uk/health/files/2012/07/Care-and-Support-Bill-Factsheet-8-Health-Research-Authority.pdf

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

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

6.7 Joint written evidence submission from the LGA and ADASS – 17 January 2013

6.8 Policy statement on care and support funding reform and legislative requirements – Department of Health – 11 February 2013

Report prepared by Paul Taylor, Assistant Director – Social Care Specialist
Telephone 381200 Email paul.taylor@telford.gov.uk

Policy statement on care and support funding reform and legislative requirements

1. Following the Government's announcement to implement a new funding model for adult social care, based on the recommendations of the Commission on the Funding of Care and Support, this document sets out further detail on what the new system will mean and how it may be legislated for. It will support pre-legislative scrutiny of the draft Care and Support Bill.
2. Section 1 of this document describes the case for change, and the Government's objectives in bringing forward these proposals for a reformed system. In particular, it is envisaged that the new funding model will provide greater fairness and certainty for people faced with the costs of care, either now or in the future.
3. Section 2 describes how this would work for individuals and the changes that might be provided for in legislation, including where revisions might be required to the proposals set out in the draft Care and Support Bill. Provisions to enact these reforms would be included when legislation is introduced.

Section One

The new approach to care and support funding

The case for change

4. The current system offers little financial protection for the cost of care and support. The report by the Commission on the Funding of Care and Support, and *Caring for our Future: progress report on funding reform*, set out in detail the difficulties this creates for people receiving care and support.

5. The Commission found that because care needs are unpredictable, individuals and families are unable to know what care costs they might face in the future. A quarter of people may need to spend very little, but one in ten people will have more serious care needs, and will face care costs in excess of £100,000 (see Figure 1 below). Those who pay the most are likely to be those with long-term chronic disabilities such as dementia, which mean that they need care and support for a long period, whilst those without significant care needs spend very little, if anything, on care. People feel it is unfair that if they have budgeted carefully through their working life, they feel you are penalised because they receive little or no help.

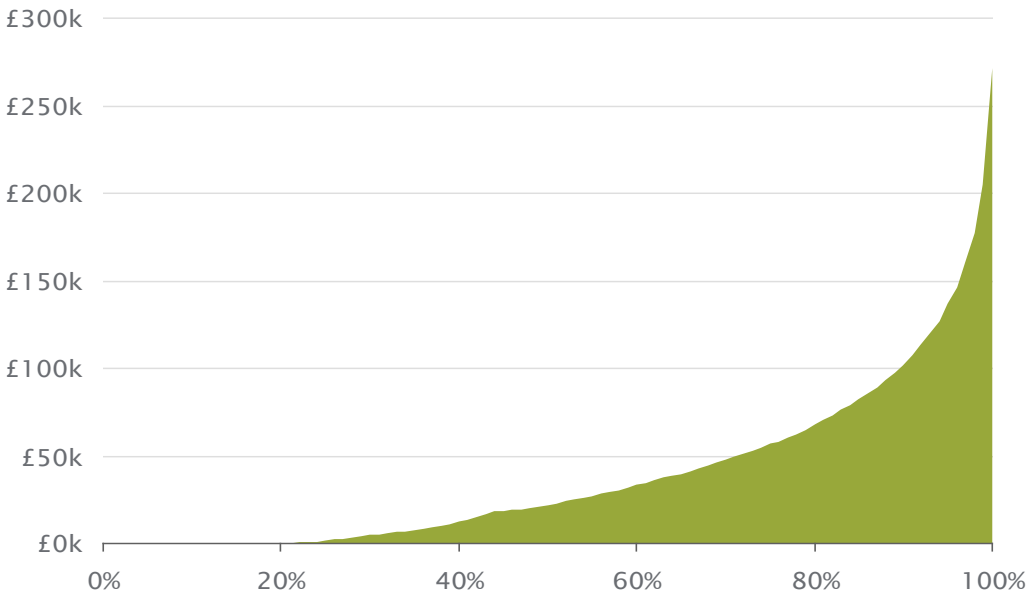


Figure 1: Percentile distribution of expected lifetime care costs for people currently aged 65 (2009/10 prices). Source: Commission on the Funding of Care and Support

6. Under the current system, if someone has a care need, their local authority will carry out an assessment of their financial income and assets to determine how much they should contribute to the costs of their care. If the person goes into residential care, their housing assets will also be taken into account, and they will

continue to pay for their care until they only have £23,250 left, at which point they will receive state support. Once someone qualifies for state support, their local authority will assess how much they can still afford to contribute towards the cost of their care.

7. Only a small proportion of people ever experience catastrophic costs. However, in the worst-case scenarios, people have had to sell their home or exhaust their life savings to pay for their care. People with low housing wealth can be particularly adversely affected (see Figure 2 below). Someone with a house worth £100,000 with indicative lifetime residential care costs of £100,000 would lose around 80% of their assets. Faced with the same care costs, an individual with a house worth £400,000 would only lose 25% of their assets.

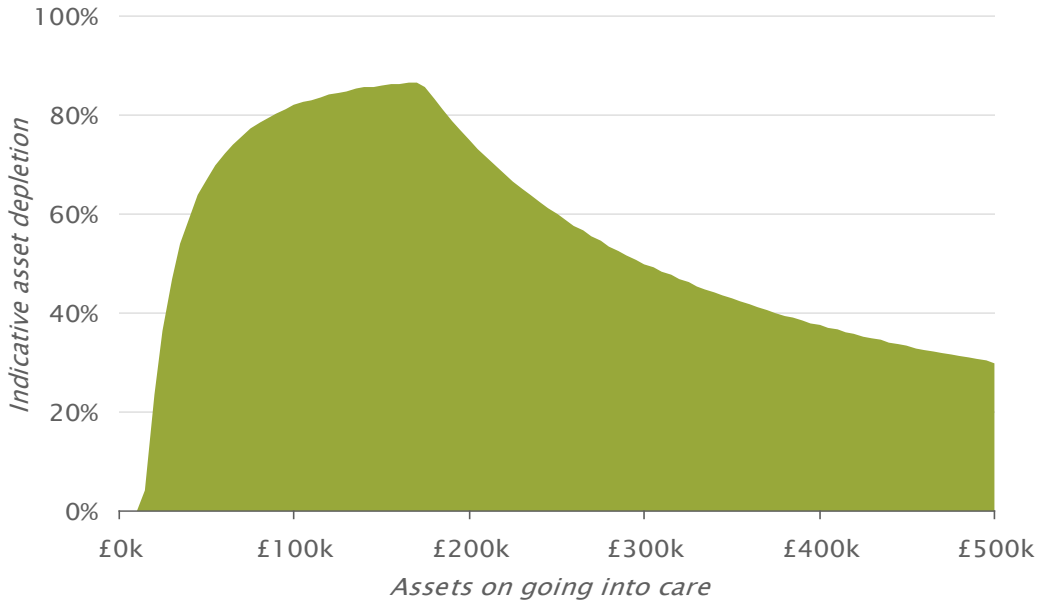


Figure 2: Indicative proportion of assets depleted under the current system for someone with very high residential care costs, by level of assets on going into care. Source: Commission on the Funding of Care and Support.

8. The Commission on the Funding of Care and Support concluded that the heart of the problem is the lack of an effective way for people to protect themselves from catastrophic costs. Unlike in other areas of our lives – pensions, healthcare, home insurance – there is limited private insurance against high care costs. People cannot pool their risk through insurance, so they are exposed to unlimited costs and cannot use their savings effectively.
9. There is very little that people can do to effectively plan and prepare for their care needs in later life. In the worst case, people hoard assets to ensure they have enough for care needs, rather than using them to improve their health and wellbeing, including spending to prevent care needs or more generally to contribute to economic growth.
10. The Government agrees with the Commission's view that people should contribute to their care costs where they have the ability to do so. However, the

current system does little to reward prudent financial management and forward planning: people may fear that with no limit on care costs, every pound saved could potentially be used to pay for care costs. The current system therefore creates uncertainty for all, and fear and distress for the worst affected, who also tend to be the most vulnerable and frail. Those who have saved throughout their lives can lose almost everything, including their house.

11. The problem of extremely high costs for care also applies to working age adults with care needs. The current system requires people aged 18 to 64 with care needs to contribute towards their care fees if they have the means. This causes distress to them and their families, as they are unable to financially plan in the usual way for the future, potentially impeding their quality of life.

Changes to the current system

12. We accept the recommendations of the Commission and will:

- place a cap of £61,000 in 2010/11 prices (equivalent to £75,000 in 2017/18) on the costs an individual has to pay to meet their eligible care and support needs[1] for adults resident in England;
- set the cap for those who turn 18 with eligible care and support needs at zero, and set a lower cap for those of working age;
- for adults in residential care, set the upper capital threshold for means-tested support at £100,000 in 2010/11 prices (equivalent to £123,000 in 2017/18). This will be higher than for other types of care, to reflect the fact that the value of the person's home is taken into account when determining how much the person pays towards their care; and,
- for adults receiving residential care, increase the lower threshold for the means-test from its 2010/11 value of £14,250 in line with indexation, which subject to assumptions would mean a starting value of around £17,500.

13. The cap will provide financial protection for eligible needs for care and support. Individuals will remain responsible:

- for a contribution towards general living costs. In domiciliary care, people remain responsible for non-care expenses such as utilities and rent. In residential care, they will pay a contribution of around £10,000 in 10/11 prices (equivalent to around £12,000 in 2017/18) to help meet expenses associated with room and board; and,
- for the cost of paying for additional services, such as having a spare room for family visits in a care home.

14. The new system will come into effect from April 2017, subject to the passage of legislation. Due to the economic circumstances, we have chosen a cap slightly

[1] A person's "eligible" needs for care and support are those needs which meet the national minimum threshold, to be specified in regulations.

higher than the Commission recommended. The reforms will still deliver certainty and peace of mind for people, as the Commission intended.

15. The Commission's report recognised that the care and support system should be sufficiently flexible and responsive to evolve over time. The Government accepts the Commission's recommendation each of the values should increase over time.

16. In summary, when the reforms take effect from April 2017, we estimate this will mean a[2]:

    - £75,000 cap;
    - £123,000 upper capital limit in residential care;
    - £17,500 lower capital limit in residential care; and,
    - Around £12,000 contribution to general living costs.

17. In addition, we have accepted the Commission's recommendations to introduce deferred payments and a national minimum threshold for eligibility. The Government has already committed to introducing these reforms from April 2015, subject to legislation.

Effects of the reforms

18. A new system based on the cap and extended means-test, will define a clear and fair partnership between individuals and the Government, with shared responsibility for care costs. People will still have responsibility for their initial care costs, but if they are unlucky enough to need a lot of care, they will not face catastrophic costs.

19. The increase to the upper capital threshold for adults in residential care removes the cliff-edge in the current financial assessment. This will result in a gradual increase in state financial support. Adults with the least wealth will receive financial support towards their care costs and avoid the risk losing all their assets before they reach the cap.

20. The cost of meeting all people's eligible needs will count towards the cap – rather than their financial contribution. The additional financial protection provided by the cap and the increased upper capital limit will provide people with financial protection for their care needs, significantly reducing the proportion of assets they need to spend on care, as shown in Figure 3 below.

[2] This is based on the latest HMT GDP deflator figures and assumes a long-term care cost inflation rate of 2.5%.

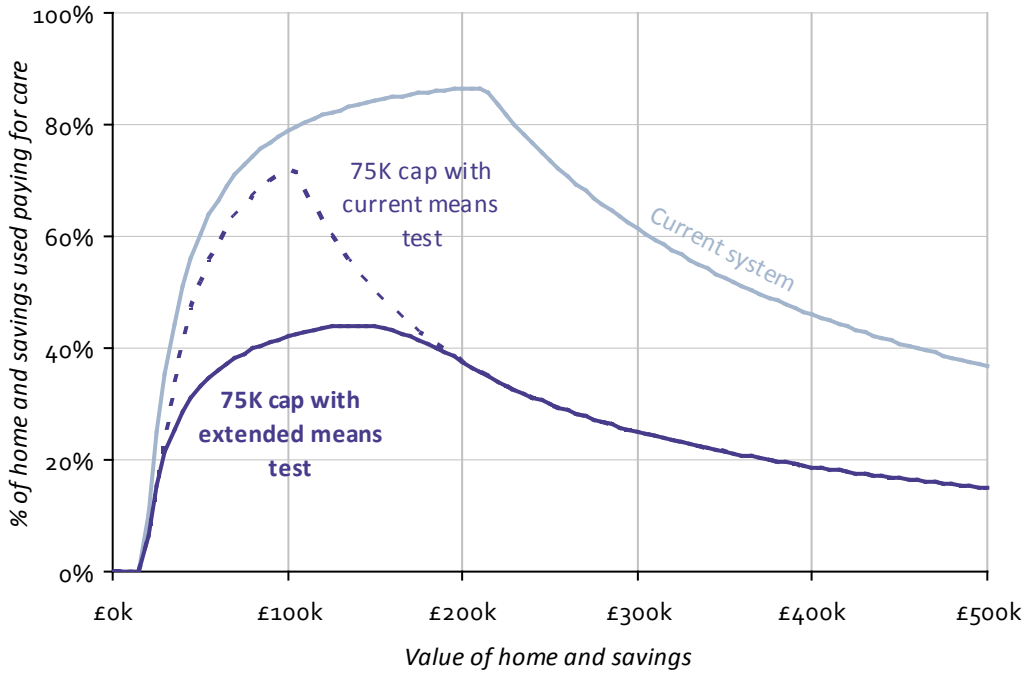


Figure 3: Possible asset depletion for people who enter residential care and have lifetime care costs of £150,000 with a £75k cap and extended means test of £100k. Source: internal DH analysis

Benefits of the reform

21. There is significant consensus from the care and support sector that the cap will lead to greater peace of mind and a subsequent improvement in quality of life. Our work with the care and support sector confirms that, as the Commission itself suggested, the new model will also bring wider benefits in addition to greater financial protection.

Improved well-being

22. The financial protection offered by the cap and extended upper capital limit will lead to increased well-being. Currently, people cannot protect themselves from high care costs as they might want. The reforms give people a fixed amount to plan for, such as they have when they buy car insurance with an excess for the first £250 of a claim, rather than facing the full cost of replacing the car. Having this smaller, known amount to plan for will help people feel protected against using most of their wealth to pay for care.

23. This will benefit everyone, not just the 16% of older people who need care who currently face care costs of £75,000 or more, by allowing them to plan on the basis of how much they might have to spend. People renew home insurance, even if they have not claimed on it the previous year, in order to feel protected against a financial loss. Some people will never claim on their home insurance, but will still buy it. The analogy applies to those who do not reach the cap, they still benefit from the cap as they feel protected against the cost.

Increased planning, preparation and prevention

24. In the current system, some people delay buying care for as long as possible to mitigate the risk of losing everything by having to pay for care. Removing this risk by giving people a limited liability that they can realistically plan for will make it easier for people to buy care when they need it. Not only will this reduce unmet need, this can also prevent people's needs deteriorating and leading to more expensive care in the long run.

Space for financial services products

25. Some people may choose to plan their finances by using financial products. The current options for people to protect themselves are limited to immediate needs annuities. The financial services industry support the reforms, since the limit on people's care costs will provide greater incentives to provide relevant products that people see the benefit of purchasing.

26. The Government expects the financial services industry to work creatively to amend existing products and develop new products that support people in making choices about how to plan for their care costs.

People make informed choices about their care

27. In the current system, many people funding their own care will have very little contact, if at all, with their local authority. Many stakeholders view the introduction of a cap on care costs as a potential "game changer" because it will encourage people to make contact.

28. In the new system, people with care needs will need to contact their local authority, who will assess their needs and calculate the cost of meeting them. This will provide an opportunity for self-funders to access information and advice from their local authority and to make choices about the care services available in their local area.

29. This in turn will make care services more responsive and more personalised, helping to drive up quality and create a more diverse care market.

Reduced gaming of the system

30. There are large incentives in the current system for people who would otherwise not receive financial support to hide their assets to gain access to Government support. Limiting the amount that people have to spend on care costs would reduce this incentive and make it more likely that people would pay their fair share.

31. The cap and extended means test are a significant improvement on the current system. Combined with other reforms we intend to take forward from 2015, people will be supported to make informed choices about the best care for them, which they can pay for in a way that best suits them. These reforms include:

    - a national minimum threshold for eligibility, which will help remove the variation in access to care, depending on where people live;

- universal deferred payment agreements for people in residential care, which will give people the peace of mind that they will not have to sell their home in their lifetime to pay for care; and
- information and advice on paying for care costs, which alongside a wider strategy to help people when care needs arise, will provide people with information and support to plan and prepare for their care costs.

Costs of the reforms

32. The Commission recognised that implementing the cap and extended means-test will have a cost to Government. This includes the additional cost of services for all adults, the cost of local authorities carrying out more assessments and a change in the amount of disability benefits payments local authorities can use towards the cost of care (since people receiving state-funded residential care are not eligible for some disability benefits).
33. We anticipate the costs will be £1bn a year by the end of the next Parliament, and have set out our plans for meeting those costs in the next Parliament. We will work with authorities to ensure implementation is proportionate and fair to everyone.

Distributional impact of the reforms

34. The Government has undertaken analysis to understand who benefits from the additional expenditure. Figure 4 demonstrates the distribution of current spending in the social care system, and the distribution of spending after the introduction of the cap.
35. The current system is highly progressive, as it provides support to those with less than £23,250. Care and support remains progressive following introduction of the cap and extended means test, with the most being spent on the lowest quintile.

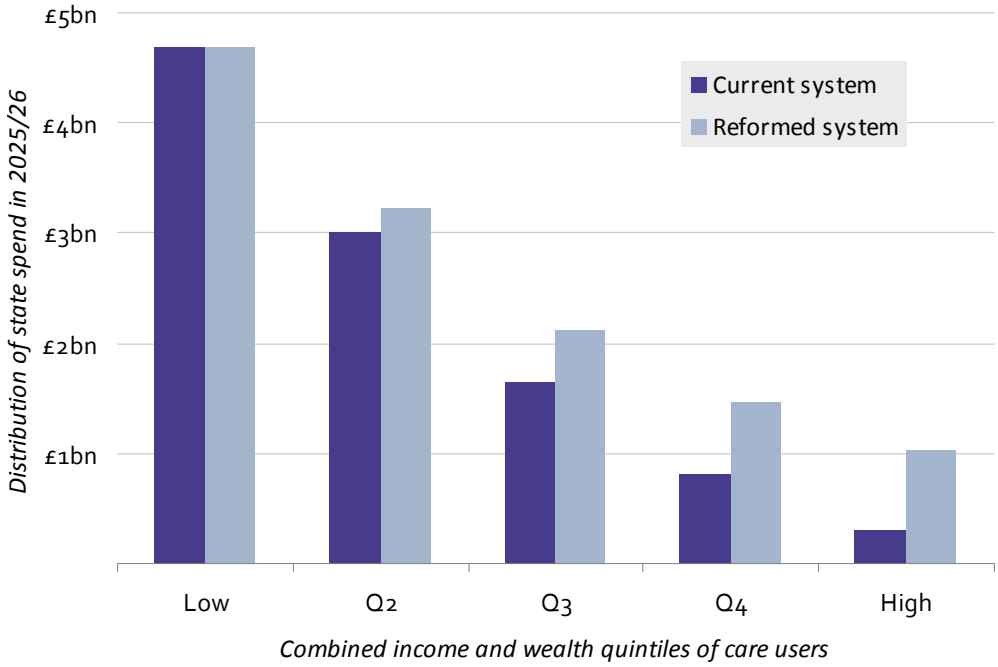


Figure 4 – Public expenditure on care and support for older people by wealth quintile of care users (2012/13 prices). Source: DH internal analysis

36. Adding the universal cap to the means-tested system necessarily leads to additional expenditure on people above the lowest quintile – these are the people who face the prospect of losing everything to pay for care.

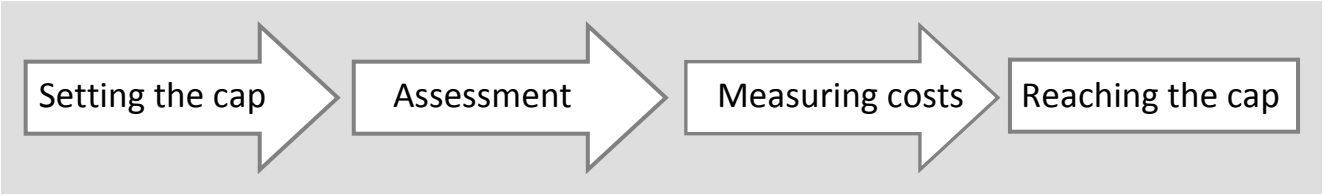
37. In terms of welfare gain, it is the people who lose the greatest proportion of their assets that will see the biggest improvement in their well-being. These are the least wealthy home owners, those in the middle of the wealth distribution, as shown in figure 3.

Section Two

How the reformed system will work and the required legislation

38. The Government will need to establish the capped cost system in law, to set the framework for the reforms. In addition to establishing the cap itself, the process by which an individual enters the capped costs system, and how their progress towards the cap is measured and recorded over time, will need to be provided for. Finally, legislation should provide for what happens when a person reaches the cap.

39. Each of these stages, summarised below, will require primary and secondary legislation, necessitating a number of changes to the legal framework set out in Part 1 of the draft Care and Support Bill. This section of the document sets out our current thinking on legislation to inform pre-legislative scrutiny of the draft Bill.



40. Since the means-test threshold changes do not need any change to primary legislation, and the deferred payments provisions are already in the draft Bill, the detailed explanations in this section will focus on the provisions required to make the cap work.

41. This section sets out what happens for individuals in each of these stages and what may be required in legislation to enable this to happen.

Setting the cap level

42. The cap will enable individuals to plan and prepare for their care costs. The cap will be set at £75,000 in 2017 for those aged over pension age when it first comes into effect.

43. It is expected that the level of the cap would be specified in regulations. This approach would allow flexibility to amend the level of the cap over time, for example to reflect changes in the cost of care, without a requirement to amend primary legislation (see section on *care and cap indexation*). It is also envisaged that the Secretary of State would use these regulation-making powers to ensure that the scheme remains affordable and sustainable over time, following review at regular / fixed intervals.

44. The power to make regulations specifying the level of the cap would also provide a power for the Secretary of State to amend the cap, and to specify different levels of the cap for different age groups, by reference to the age at which a person first has eligible care and support needs. This would allow for different caps to be set for different age groups.

Assessment

45. The process for assessing individuals can be split into four sections, each of which is explained below. Firstly, people would need to contact their local authority and for an assessment of their care and support needs, to determine what costs count towards the cap. Individuals would be able to choose how much support they want from their local authority to meet their needs, and have their finances assessed separately to see if they qualify for financial help. Everyone with eligible needs would have their needs monitored and their progress towards the cap reviewed over time.

Assessment – Initial contact and assessing needs

46. Individuals must have their care needs assessed, before they can enter the capped cost system. As now, an adult, or someone acting on their behalf, will contact their local authority to discuss their care needs. The local authority will carry out an assessment (under clause 9 of the draft Bill), and work with the individuals and their family to identify their needs and the outcomes they wish to achieve.

47. Under the provisions in the draft Bill, local authorities would assess people's needs against a national eligibility framework. If their needs are determined to meet the eligibility criteria (which will be set out in secondary legislation), then the person would enter the capped cost system. The local authority would be required to calculate the cost of meeting those eligible needs, based on what it would expect to pay for care and support (see section below).

48. People without eligible needs would not enter the capped cost system. However, they will still be able to receive universal services, such as preventive services, and information and support. They will also receive information and advice about how to meet the needs they do have, as is provided for in the draft Bill.

49. The process of monitoring the individual's care costs up to the cap will apply to all adults who have needs that meet the eligibility criteria, regardless of whether the local authority is actually meeting the person's needs. Where the local authority is not under a duty to meet the person's needs, these people would still have their costs measured in order to start (or update) their progress towards the cap. This might include, for instance, people who want to arrange their own care, or who have financial resources above specified limits (as set out in regulations under clause 15(6)).

Assessment – Support from the local authority

50. After their assessment, individuals will have information about their needs and the local authority's estimate of the cost of meeting their eligible needs. At this point, people will be able to make a choice about the level of support which they would like from the local authority in meeting their needs.

51. Some people will want to organise their own care and pay for it themselves, without any extra support from the local authority. In such cases, the person would not need to undergo a financial assessment. To support this, the legislation would need to allow for people to decline a financial assessment (or "means-test"), to clarify that this does not need to be undertaken where the person has asked for this not to take place. We expect that the local authority would also be required to inform the person of their ability to decline the financial assessment.

52. Other people may want additional help from their local authority to arrange their care and support. This could be financial or practical help. In order to receive financial help, the local authority will conduct a financial assessment of an adult's income and assets to determine whether they receive financial help towards meeting their eligible needs. This process is already provided for in the draft Bill (clause 15).

53. Financial support will be extended to those who have less than £100,000 (in 10/11 prices – rising to £123,000 by April 2017) in assets in residential care, depending on their income. These provisions will be made through regulations. Regardless of whether the adult receives financial support or not, or has chosen not to undergo a financial assessment, the costs of meeting all of their eligible needs will count towards the cap.

54. An adult might have a financial assessment and find that they are required to pay for their own care. In this case, they may choose to organise their own care, or they may choose to request the local authority to meet their needs, but fully funding their own care, as already provided for in clause 17(3). If they exercise the ability to request support, the local authority will be under a duty to meet their needs.

55. The local authority may or may not be under a duty to meet the person's eligible needs, depending on the person's circumstances and choices as above. However, in either case, the local authority would be required to provide the person with a personal budget, which sets out the amount which is calculated to be the cost of meeting their eligible needs:

    - for people whose eligible needs the local authority is under a duty to meet (under clause 17), the personal budget will be included in the care and support plan, as in the draft Bill; and,

    - for people with eligible needs, but where the local authority is not under this duty, a personal budget would be provided separately, as part of the information which the person would receive following their assessment.

56. If the local authority is to meet the person's needs, the personal budget will be determined through the care planning process. It will therefore record the adult's current care costs, based on their eligible needs at that moment in time. However, there will be an adjustment if the amount specified in the personal budget includes an element of general living costs (see section on *General Living Costs*).

57. If the local authority is not to meet the person's needs, the personal budget would be ascertained by examining the individual's eligible needs and assessing what the cost of meeting those needs would be, if the local authority were to do so – or "notional cost" of meeting the adult's needs. The personal budget would reflect this "notional cost", with a similar adjustment if the amount includes an element of general living costs (see section on *General Living Costs*).

Assessment – General living costs and additional costs

58. If an individual's needs are met in residential care then they will be expected to pay a contribution towards their general living costs (for costs such as food, accommodation and energy)[3] of around £12,000 in April 2017 This amount will not count towards the cap, and would need to be specified in, and subtracted from, the amount in the personal budget.

59. The amount of general living costs will be set by the Secretary of State in regulations. A new regulation-making power will be provided for, and will enable both the amount to be varied (up or down) from time to time, and for different amounts to be set for different cases.

60. An adult would still be able to buy more expensive services. However, the amount that counts towards the cap will be the assessed amount to meet their eligible needs, to ensure that people in the same local authority area with the same needs reach the cap at the same time, regardless of their ability to purchase extra care.

Assessment – Monitoring and reviewing progress over time

61. A person's needs can change over time. To ensure that the individual continues to receive the right support, and that the costs that count towards the cap are an accurate reflection of their needs, the local authority would be required to keep personal budgets under review and reassess people's needs as required. For instance, if a person's care needs increase, and the cost of meeting those needs also increase, the amount that counts towards their cap also increases.

62. Where an adult's needs are being met and there is a care and support plan, clause 26 of the draft Bill contains provisions for keeping this plan under review; this includes a requirement to carry out a new needs assessment and reconsider the eligibility criteria where appropriate (clause 26(4)).

[3] We expect these costs to be set at around £12,000 per year at the time of implementation consistent with £10,000 in 10/11 prices put forward as an option by the Commission, increased in line with care cost indexation.

63. We expect that a similar duty to review will be required for adults who have a personal budget, but whose needs the local authority is not meeting. The duty would be equivalent to the effect of clause 26. The local authority will have a power to reassess the person if it has grounds to believe that their needs might have changed, and it should also be required to respond to reasonable requests by the adult (or their representative) for a reassessment.

64. The local authority is to be required to review the personal budget at least annually, or on the reasonable request of the adult. In both cases, the local authority is to be required to consult the adult in deciding whether to revise the statement, and to provide a written explanation of any changes, or to confirm that no changes are to be made.

65. If an adult's care needs no longer qualify for the cap, or if the adult refuses a reasonable request by the local authority for a re-assessment, then progress towards the cap will be frozen. The local authority will retain the record of progress made towards the cap up to this point.

66. If the adult's care needs subsequently increase, and qualify for the cap again, then their progress towards the cap will start from where they left off, accumulating at the rate which meets their current needs.

Measuring care costs over time

67. People will need to have their care costs monitored over time, to record their total accumulated costs and demonstrate progress towards the cap. Where care costs change over time, for instance as a result of uprating for indexation, the total of their accumulated costs will need to be amended accordingly, so that they are not disadvantaged. Both points are covered below.

Measuring care costs over time – the Care Account

68. Individuals should be kept informed by their local authority of their total care costs that count towards the cap – providing an annual update – and of any changes to the costs that count towards their cap, whether they are under a duty to meet their needs or not.

69. Whether the local authority is meeting the person's eligible needs or not, where they have a personal budget, the local authority will also be required to keep an up-to-date record of total costs accumulated over time. This record – called a Care Account – must be updated at least annually, and the person provided with a written statement to notify the total amount.

70. A Care Account would also be provided to all people who have had a personal budget at any time since the implementation of the legislation, but who do not have either at the moment (for example, because they do not currently have eligible needs).

71. The local authority would have to retain the record of the person's Care Account until it is requested by another authority because the person's ordinary

residence has changed (see continuity of care below). If no request is received from another authority, the original authority must retain the record until the end of the person's life; or for 99 years.

Measuring care costs over time – Care and cap indexation

72. The price of care will change over time. To reflect this, the level of the cap and the amount in the Care Account that count towards people's cap will increase in parallel every year.

73. This increase will be applied in a way that will ensure people with a Care Account would not be disadvantaged; a person who is 50% of the way towards the cap will remain 50% of the way towards the uprated cap. This will ensure that the real value of the cap remains constant and the partnership between the state and individual is stable.

74. It is envisaged that the legislation would provide for this to be automatically uprated annually, according to a defined measure, though the specific index has not yet been decided. When the adult's Care Account has been increased this way, the local authority will be required to inform the adult as part of the annual review statement.

Measuring care costs – Moving between local authorities

75. If a person chooses to move to another area in England, the costs accumulated in their previous local authority should move with them and continue to count towards their cap.

76. The process of taking care costs between local authorities would be provided for by an addition to the continuity of care provisions set out in clause 31. Where the local authority is meeting the adult's needs, both the personal budget (i.e. the current accrual rate) and the Care Account (i.e. the total accumulated costs) would be required to be passed from the sending authority to the receiving authority. Such information would be included in the care and support plan.

77. Further provisions are likely to be required for the receiving authority to adopt the Care Account from the date of the person's arrival, and to continue to measure the adult's care costs at the same rate in the personal budget as provided for by the sending local authority. This requirement would continue until the receiving authority has carried out its own assessment and taken any other necessary steps, in accordance with clause 31(7).

78. Where the LA is not meeting an adult's needs, similar principles should apply. The process of notification of local authorities already set out in the draft Bill should apply, as should the requirements regarding provision of information and assessment.

79. In addition, we expect that a new requirement would be placed on the sending local authority to share the Care Account, as well as other relevant information, with the receiving local authority. The receiving local authority will be under a

duty to continue to record the accumulated costs in the Care Account from the same point, either on the basis of the sending authority's personal budget, or on the basis of its own assessment, once it has carried one out.

Reaching the cap

80. When a person reaches the cap, the local authority would come under the duty to meet the individual's eligible care and support needs in accordance with clause 17, but may not charge for meeting those needs.

81. The person will only be entitled to receive free care and support to the extent that the actual costs of that care and support do not exceed the amount specified as necessary to meet their eligible needs in their personal budget. People will still be able to choose more expensive care, should they wish to do so, and would have to arrange to pay any additional amount above their personal budget.

82. In many cases where a person reaches the cap, it is likely that they will already be having some or all of their care and support needs met by the local authority, so the effect of reaching the cap will simply be that the authority is no longer empowered to charge for meeting those needs under clause 14(1). However, where a person who reaches the cap is not already having their care and support needs met by the local authority, the authority is to come under a duty to meet their eligible care needs at the point when the cap is reached.

83. The person will also be expected to pay the required amount towards their general living costs, where they are in particular types of accommodation (see section on *General Living Costs*). Therefore, the local authority should still be able to charge for this element of the total costs, where applicable, in cases where a person has reached the cap.

84. Once an adult's accumulated costs have reached the cap, the local authority should be under a duty to inform the adult.

Additional notes

Ordinary residence

85. The local authority would only be under a duty to measure a progress towards the cap, or to meet eligible needs once the cap has been reached, if the person is ordinarily resident in its area, or of no settled residence but present in its area. The ordinary residence requirement is currently covered by clause 17(1)(a) in relation to people whose eligible needs the local authority must meet.

86. The ordinary residence requirement should also apply to people in respect of whom there is no duty to meet needs but who are in the capped costs system (i.e. those who opt out before the financial assessment, or who do not meet the financial requirements and do not request the LA to meet their needs). This requirement will be clarified in new provisions relating to the preparation of the personal budget and Care Account, as noted above.

Joint Committee on the Draft Care and Support Bill

Joint written evidence submission from the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS)

17 January 2013

About us

The **LGA** is here to support, promote and improve local government.

We will fight local government's corner and support councils through challenging times, focusing our efforts where we can have real impact. We will be bold, ambitious, and support councils to make a difference, deliver and be trusted.

The LGA is an organisation that is run by its members. We are a political organisation because it is our elected representatives from all different political parties that direct the organisation through our boards and panels. However, we always strive to agree a common cross-party position on issues and to speak with one voice on behalf of local government.

We aim to set the political agenda and speak in the national media on the issues that matter to council members.

The LGA covers every part of England and Wales and includes county and district councils, metropolitan and unitary councils, London boroughs, Welsh unitary councils, fire, police, national park and passenger transport authorities.

We work with the individual political parties through the political group offices.

Visit www.local.gov.uk

The **Association of Directors of Adult Social Services** (ADASS) represents directors of adult social services in councils in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of other responsibilities for the commissioning and provision of housing, leisure, library, culture, arts, community services and a significant proportion also hold the statutory children's director role.

1. What is your view of Part 1 of the draft Bill (care and support)? In your view, are there omissions in this part of the draft Bill?

1.1. The LGA and ADASS broadly welcome the proposals set out in Part 1 of the Draft Care and Support Bill (DCSB). For some time, local government (which is inclusive of adult social care) has been at the forefront of making the case for change in the way that support and care is commissioned and delivered. Making these changes is essential for a number of reasons, in particular:

- to meet the demands of demographic change (in terms of an increase in the numbers of both younger disabled people and older people, and the complexity of presenting need)
- to meet the rising expectations of increasingly diverse communities
- to enable cost-effective, sustainable care and support when people need it and however funded.

1.2. Achieving these changes requires modernisation, consolidation and clarification of the existing legal framework. We are pleased therefore, to support the principle of a single legal framework and we are committed to supporting a care and support bill passing into law in order to achieve these reforms. In addition to the benefits that simplification of the legal framework will bring – for people, organisations and professionals – we particularly welcome:

- The principles set out on the face of the DCSB.
- A single, streamlined statute that gives greater clarity to legal entitlements to care and support.
- The focus on ensuring that people have a better understanding of (i) the care and support 'system' in order to plan for the future, and (ii) how to secure help when needed.
- The recognition of, and intention to provide for, the needs of carers and young carers.
- Proposals to encourage and enable delivery of better integrated and responsive care and support, and the introduction of both general and specific duties on partner organisations to cooperate.
- Recognition of the essential role of housing in delivering the care and support that people want.
- Proposals to ensure continuity of support for young people in need and in transition to adulthood.
- Placing Local Safeguarding Boards on a statutory footing and, in general terms, the proposals relating to safeguarding adults whose circumstances make them vulnerable.

- The flexibility to delegate a range of functions where this appears to be locally appropriate.

1.3. However, we also have substantial concerns. In summary these are:

- **Funding:** There is a fundamental difficulty with the proposals in that both the White Paper and the DCSB have detached policy direction and decisions from financial direction and decisions. These need to be realigned and, in our view, need to include:

    - A sustainable funding settlement for adult social care.
    - Funding reform.
    - Financial impact on local government of wider welfare reform.
    - Decisions on the Dilnot Commission recommendations.
    - Resources for prevention and early intervention.

    - Further comment on these matters is given in response to Question 9 below.

- **Scope:** Although we broadly welcome the intent behind the population-level duties proposed for local authorities, greater clarity is needed in respect of the following:

    - **Interfaces between local and central government and with the NHS and regulatory bodies**. The ways in which some of these interfaces are described (for example, in respect of information and advice services, operation and integration with local NHS services, and delivering on prevention initiatives) is as standalone functions and responsibilities, rather than ensuring appropriate coordination with national systems and supporting and or providing leadership to enable cohesive local systems and functions.
    - **Promoting diversity and quality of provision**. As currently framed, the proposed duties on local authorities appear to include quasi regulatory functions with no reference to the Care Quality Commission (CQC) or Monitor.

    - Further comment on these matters is given in response to Question 3 and Question 11 below.

- **Detail:** A large number of provisions in the DCSB reference regulations that have not yet been written and which will have significant impact in relation to eligibility/entitlements for people, as well as in relation to concerns outlined above. Further comment is given in response to

relevant sections below. Additionally, and in terms of omissions from the DCSB, we are concerned that a Bill so strongly focused on personal entitlements does not provide for any means of redress other than through judicial review.

- **Safeguarding**. This is intermittently integral to the DCSB and, where it is, that is very welcome and positive. We make some comments and suggestions to extend this, such as the integration of safeguarding alongside personalisation to assist consistent practice when the legislation is implemented.

2. Has the Government made it clear what it aims to achieve in the draft Bill's provisions on care and support? In particular, will it be effective in clarifying the law on social care?

2.1. Yes, in general terms the White Paper and the DCSB set out both a vision of a 'successful' care and support system and how this might be delivered through a combination of population-level duties on local authorities, duties on statutory organisations to cooperate and clearer entitlements and continuity for citizens.

2.2. Modernisation and consolidation of the current legal framework should also (subject to the detail that will be in regulations) be effective in clarifying the law both for professionals and for citizens.

2.3. We are concerned, however, as outlined above, both that funding arrangements remain far from clear and that, notwithstanding engagement exercises, the level of public debate and awareness of its provisions and intent remains low.

2.4. We are also concerned that some of the rhetoric associated with the wider welfare reform agenda unhelpfully classifies disabled individuals and or groups as 'deserving or undeserving'. This challenges the ethos of the DCSB, which promotes a system build around people's needs and what they want to achieve in their lives.

2.5. The wellbeing principle is welcomed, and particularly that it explicitly includes protection from abuse and neglect as well as a number of other factors and that no one is excluded 1 (2).

2.6. The particulars of 1 (3) – that the local authority must have regard to are – are welcomed, including:

- That people are best placed to make their own judgements about their wellbeing.
- The need to protect individuals from abuse and neglect.
- Minimum necessary restrictions of the individual's rights and freedoms.
- The balance between an individual's wellbeing and that of friends or relatives who may care for them.
- We would welcome clarity on these areas in the accompanying guidance.

2.7. The integration of a number of pieces of adult social care law is helpful. While understanding the wish not to replicate other legislations, however, there remain cross-overs with care standards and other legislation – such as that which may be utilised in relation to safeguarding – that it would be helpful for guidance to address.

2.8. It is suggested that the term 'Adult/s' should be replaced by the term 'people', specifying the distinction that this is not children at the beginning of the DCSB.

3. The Government states in its White Paper that "the quality of care is first and foremost the responsibility of the provider". Does the draft Bill support this policy intention, and does it pay due attention to the responsibilities of commissioners and regulators for quality of care?

3.1. The Bill makes no reference to the responsibilities of providers or regulatory bodies, or of the interface with the Care Standards Act. Although the overall principle of local authorities having a role in the operation of local markets – in particular to promote quality and improvement – is welcome, we are concerned about how this is framed. In our view, it is essential to understand the intended responsibilities of local commissioners (including Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board (NCB)) and regulators, in particular where these cross-geographic or service boundaries (as, for example, with large providers delivering both health and social care services, 'uncommissioned' services, and or unused local services and so on.)

3.2. Without clarity about scope and interface with other bodies, we are concerned that this is another uncosted burden upon local authorities.

3.3. Failure of service quality forms a significant proportion of the work of safeguarding teams. However, there are many providers in any area with whom the local authority has no contact, and no control over. In some areas there are more privately arranged services than those contracted by the local authority. While a local authority can stimulate and encourage a market of quality services and supports, it is unreasonable for local authorities to be held responsible in these circumstances, or for the quality of NHS provided or commissioned services. We would therefore suggest a change of wording.

3.4. As noted in 3.1, reference to the role and responsibilities of the regulators is absent in the DCSB. While we can see an argument for not duplicating other legislation, we are concerned that if they are not mentioned then it appears from the wording that the local authority is solely responsible, with the duty to ensure that people have a range of high-quality services to choose from. We believe that CQC should have a role in ensuring that providers are fit to provide a service in the same way that professional regulators have fitness to practice functions. Otherwise, local authorities will require powers and associated budgets to regulate and inspect, to achieve these aims.

4. Are there other ways of framing the draft Bill's underlying principle, that local authorities must promote an individual's wellbeing? Are there other principles that might be substituted for it?

4.1. We are content with the principles as described on the face of the DCSB.

5. Does the draft Bill make sufficient provision to achieve the Government's stated goal of greater integration within the NHS and with care and support and housing?

5.1. The principle of achieving better integration between health and care and support services is welcome and it is important that the duty in this regard reflects the similar duty on CCGs in the NHS act 2006 / NHS&CCA 2012. It is for local systems and communities to take this forward through the development and discharge of local joint strategic needs assessments and joint health and wellbeing strategies.

5.2. However, as currently drafted, the DCSB articulates a system built around people's lives, with clear entitlements to care and support for a broad range of needs. How this sits with responsibilities described in the Health and Social Care Act (particularly for CCGs) appears unclear. We are concerned that the DCSB and the Health and Social Care Act are not pulling in the same direction – particularly at a time when local systems are under significant

financial pressure – and that there is therefore the potential for a gap to develop between what local authorities are required to do and what CCGs must do "to the extent they consider it necessary". We note, for example, that the 'prohibitions' in Clause 21 are different to the existing prohibitions in the National Assistance Act, 1948. We are keen to clarify the intentions and implications of this, for example in relation to NHS continuing healthcare. LGA, ADASS and NHS colleagues are in continued discussion with the Department of Health in this regard.

6. What benefits or problems may arise as a result of the draft Bill's scope being restricted to adult care and support?

6.1. The DCSB makes provision for transition from children's services to adult services and for the provision of support to carers. However, the position relating to young carers and parent carers is unclear. It will be important to ensure that further drafting and the regulatory framework makes equitable provision for young carers and parent carers of disabled children.

6.2. The NHS and the police and criminal justice system are critical to safeguarding. While local authorities have the lead, and while the duty to cooperate is incorporated in the DCSB, we hope that guidance will ensure that this is absolutely a shared duty.

7. If it is found necessary to stage the implementation of the care and support provisions of the draft Bill, in what order should they be implemented?

7.1. Issues relating to funding need to be resolved. These include addressing the current funding gap, providing funding for reform (particularly the population level duties on local authorities and the focus on prevention), and the government's response to the Dilnot Commission (particularly clarifying the contributions that citizens will be required to make).

7.2. If implementation is to be staged this will mean that the eligibility framework and entitlements will need to be clear and funded upfront.

8. Are the provisions of the draft Bill in relation to the views of service users, carers and prospective users of services sufficient? Would you suggest any improvements to these provisions?

8.1. The provisions and principles set out in Clause 1, the outcomes to be achieved outlined in 1 (2) and the matters to which the local authority should

have regard in 1(3) set out a framework which puts citizens, their wellbeing and their circumstances at the at the centre of assessment and delivery of social care and support.

8.2. Critical to whether the provisions of the DCSB deliver the expectations this sets out will be the funding arrangements, eligibility threshold and details relating to assessment and other matters that will be set out in regulations.

9. What is your view of the financial and other implications for local authorities of the new care and support responsibilities set out in the draft Bill?

9.1. It is difficult to be specific about the financial implications of the new and additional care and support responsibilities set out in the DCSB without knowing the full details still to be set out in underlying regulations. Moreover, we must frame the Bill, and the wider reform agenda, by recognising that the whole system is greater than the sum of its parts. Therefore, the aspirations of the DCSB must be built upon solid foundations – namely a pre-existing good care and support system. Ensuring this starting position will require proper funding.

9.2. As previously indicated, there is a fundamental difficulty with the proposals in that both the white paper and the draft Bill have detached policy direction and decisions from financial direction and decisions. These need to be realigned and in our view need to include:

- **A sustainable funding settlement for adult social care:** Against a backdrop of a 28 per cent reduction to local government budgets and a further reduction by 1.7 per cent, current levels of funding for adult social care are not sufficient. The ADASS Budget Survey shows that £1.89 billion has been taken out of care and support budgets over the last two years and the impact of this has, in part, led to reviews of eligibility criteria and the thresholds at which local authorities are able to offer support.

- **Funding reform:** There needs to be clarity about how the Government intends to fund reforms outlined in the White Paper and the DCSB to ensure a sustainable care system going forward. Additional duties are set out in relation to information and advice, market shaping and oversight together with extended responsibilities for assessment – particularly in respect of carers. These reforms are not cost neutral and clarity about how they will be funded is urgently required. The focus on prevention, though very welcome, will mean nothing without sufficient money to resource it.

- **Financial impact of wider welfare reform:** There needs to be greater understanding and recognition of (and clarity for the public about) the financial impact of the wider welfare reform agenda on local government and local funding for adult social care. Lack of clarity about the impact of this agenda restricts effective forward planning.

- **Decisions on Dilnot:** The Commission's recommendations are needed in order for people to have clarity about their own liabilities for contributing to the costs of care. It is not satisfactory for people or local authorities to have continuing uncertainty on this crucial agenda which also further exacerbates the difficulties of future planning and budget setting as outlined above.

- **Resources for prevention and early intervention**. To achieve the intended shift towards care and support services that are based on early intervention and prevention there needs to be both national and local leadership that commits to shift funding from acute NHS settings to community based support. Prevention and early intervention must be a central feature of a future system but without adequate resource the aspirations of the White Paper and DCSB will not be realised.

10. What are the risks and benefits of the duty on local authorities to provide advice on adult care and support? Are they the same for the duty to provide information?

10.1. We agree that good, local information and advice is an essential component to supporting people to understand the care and support system, and to determine ways that their needs and preferences might be met. For some people, good information will be sufficient to their needs, though it is clear that others will need greater levels of support/advice. A tiered approach is therefore most likely to deliver an effective and comprehensive service that enables people to make good choices at the right time. The LGA and ADASS, together with a range of other organisations, are contributing to the Think Local Act Personal workstream on information and advice and the implications of proposals in the White Paper and the DCSB.

10.2. The provision of information and advice is welcomed, specifically that the DCSB includes providers of care and support and how to raise concerns about the safety of people needing care and support. Section (3) of this might be strengthened by not only stating that it should be sufficient to enable people to make plans for meeting their needs for care and support, but also how to keep themselves safe and seek help if necessary.

10.3. While considerable efforts have been made in relation to information for the public, the public generally requires information to answer key questions such as: “is this service safe?”; “can I afford this service?”; and “is the service I want available?” To provide this information fully, most local authorities will require considerable investment in systems, technology and people. At present, no such information bank exists nationally so support and resources are needed in this area. Those websites that do exist (including NHS Choices, DirectGov, First Stop and SCIE’s Find Me Good Care) are all building separate information sources without being able to yet answer these key questions.

10.4. The provision of advice is essential if people are to make wise choices about their care and finances. The provision of financial advice is problematic. While the new requirement that financial advisors should be fee- rather than commission-based makes the arrangement more transparent, and while there is a form of an accreditation system through the Society of Later Life Advisors, this is not easy for local authorities to facilitate. The public are also generally wary since the mis-selling of pensions, endowments and the demise of the Nursing Homes Fees Agency.

11. How can local authorities ensure that the local care market provides enough care services to meet local needs? How can they encourage a diverse range of high-quality providers?

11.1. As previously indicated, we are keen to get greater clarity about the proposed duties on local authorities in respect of promoting diversity and quality in provision of services. Although we agree that local authorities have an important role and function in contributing to the shape and direction of local markets and services, it is clear that this cannot be discharged as a ‘standalone’ function of local authorities. Other commissioners, in particular CCGs and the NHS Commissioning Board, have a significant role to play, as do a range of other stakeholders – not least citizens with experience of using support and care services. Another particular issue that needs to be addressed – and where we agree that local partners can support development – is in relation to market entry, especially by small and micro providers and in relation to increasing diversity of provision to reflect community needs.

11.2. Local government – via ADASS – is taking forward a workstream on market development, commissioning and procurement to support development is this regard.

11.3. We are concerned that, as described, the role of the local authority appears to include quasi regulatory functions with no reference to the CQC or Monitor. The intention behind this requires further clarity.

11.4. The impact assessment on quality, care providers and the workforce (IA No 7063) details the need for sufficient numbers of a well-motivated and skilled workforce. Furthermore, policy proposals set out in the white paper aim to improve system leadership and develop a quality framework. These are clearly important components of effective market development.

11.5. There is a direct relationship between adequacy of funding and the ability of providers to recruit and retain the quality and quantity of front-line workers that are critical to the success of a good care and support system. This relationship needs to respond to the challenges of providers supporting the National Minimum Wage.

12. Are the draft Bill's provisions adequate to ensure that service users are protected in the event of serious market failure among providers?

12.1. Local authorities have for a long time taken responsibilities in this regard and, as in the case of Southern Cross, ADASS took a lead role with other stakeholders in responding effectively to serious market failures. The DCSB as it stands does not make provision in this regard beyond the "Importance of ensuring sustainability of the market". We note that a separate consultation has been issues in this regard and will respond to this in due course.

13. The White Paper talks about "approaches that promote support within communities" and calls for the adoption of "asset-based" approaches. Is the draft Bill successful in embedding this approach, or should other preventative approaches be adopted?

13.1. It is difficult to comment on this aspect as, in our view, the balance between a service framed around crisis responses as opposed to prevention and timely support (that has regard to a person's skills, family and community resources) goes to the heart of our concern that the policy direction and decisions set out in the white paper and the DCSB are detached from the financial and other resource implications of the DCSB. It is clear that the DCSB has some **potential** to support these aspirations – through the principles set out on the face of the DCSB – but equally, the way the DCSB is framed (and in particular how regulations may be put in place) may determine the care and support system as a **crisis only** service framed entirely around eligible needs

(particularly if this is set nationally at “Substantial”). Again, decisions relating to the funding settlement and response to the Dilnot commission recommendations are required in this regard.

14. What are the risks and benefits associated with self-assessment for care and support as proposed in the draft Bill?

14.1. As currently framed, proposals relating to self-assessment are not entirely clear and will be subject to regulations which must make provision in this regard.

14.2. However, self-assessment is an important component both as a means to enabling self-determination and timely access – in particular to prevention service and support. As such this is an essential ingredient to the development of personalised support and care.

14.3. Promoting self-assessment will require a good information and advice service and support. As indicated in response to Question 10 above, it will be important to ensure tiered approaches that ensure that people with complex needs and/or limited capacity are properly and professionally supported through assessment processes consistent with the principles to which the local authority must have regard under clause 1 of the DCSB.

14.4. The risks associated with these provisions of the DCSB are that eligibility will be so tightly drawn as to describe a crisis response service.

14.5. This section of the DCSB omits reference to safeguarding, risks and protection (often the primary need for health and social care intervention) and would benefit from their inclusion. If safeguarding is not integrated in this section there are risks that risk assessment, leading to risk management and risk mitigation, will not be addressed through all stages of the assessment process and subsequently. It links to both our comments on the safeguarding section of the bill and the consultation on new powers which we are responding to separately.

14.6. It is noted that while self-assessment is clearly important for some people, for others assessment is a service in its own right, supporting them to think through and weigh up the risks and benefits of different options.

15. What are the best ways to increase the numbers of people identified as carers? What are the risks and benefits of placing a duty on public bodies to identify carers?

15.1 It is noted that any duty upon local authorities to identify carers must be fully reflected in the corresponding Impact Assessment and further clarity is required as to how this duty will be coordinated across “public bodies”.

16. Do you consider that variable local charging regimes for services are compatible with national eligibility criteria, and any future funding changes involving capping individual financial liability?

16.1. As previously noted, further clarity is needed about the regulatory framework both with regard to eligibility and assessment. Both of these need to be framed in the context of the funding settlement for social care, funding for reform and, crucially for people who use and rely on services, the contributions they will be expected to make. These arrangements need to be clear, understandable, fair and consistent. It is difficult to see that variable charging **regimes** are compatible with national criteria particularly when combined with the Dilnot proposed capping of personal liability, though there may be circumstances in which different rates are appropriate (for example, to reflect costs in different parts of the country).

17. The White Paper says that assistance with care and support needs will be subject to a reasonable charge. Do the charging provisions in the draft Bill reflect this policy intention, and is the policy intention clear?

17.1. The arrangements for charging set out in Clause 14 appear clear, though again will be subject to regulations relating to detail.

17.2. The arrangements as drafted appear to differ from those currently in place in that it appears there will be discretion as to whether or not to apply a charge in respect of residential care services.

17.3. It is noted that there is a need to join up the DCSB with ongoing welfare reform – particularly with reference to the interface between what is reasonable to charge, and the benefits that individuals receive.

18. Are the arrangements for setting and enforcing national minimum standards for care and support clear? What part should the new social care

quality standards developed by NICE play in supporting local authorities in discharging their new market shaping duties?

18.1. As previously noted, issues relating to regulation of providers – other than through the proposed duties in respect of local markets – are not covered in the DCSB. Quality standards will need to be incorporated into those duties and commissioning/procurement practice.

18.2. CQC have established standards for care provision. The LGA have established Safeguarding Standards, which have been endorsed by ADASS, NHS Confed and SCIE (Social Care Institute for Excellence). While clear standards are welcome and support the public and local authorities, a degree of caution is necessary in order not to duplicate or confuse

19. Do the care and support plan provisions allow adequately for input from service users and carers?

19.1. Yes. Provisions for care and support planning require consultation with the adult (and or carer) concerned and must have regard to the outcomes the person wants to achieve (clause 9(4) / 10(4)).

19.2. If safeguarding is integrated into assessment, then this should lead to needs being identified to either support safeguarding the individual or their carer, or to protect the person and address the harm caused. These should be included in this section. It may be helpful to add examples of how people may be supported when they have experienced harm, for instance through counselling, peer support, access to some form of justice etc.

20. Does the draft Bill make adequate provision to help people achieve personalised care and support and to manage the payment process?

20.1. The DCSB frames both assessment and care planning processes around the outcomes that people wish to achieve. As currently framed – and unless regulations are introduced – the DCSB does not govern support to manage the payment process beyond the authority being satisfied that the person is capable of managing the payment. The more significant challenge is securing a diverse local market – in particular of small and or micro providers – capable of delivering the type and range of bespoke support and service that people choose.

21. The White Paper says that commissioning practices which put tight constraints on how care and support is provided – so-called 'care by the minute' – are unacceptable. Does the draft Bill have a part to play in addressing such practices, and if so how?

21.1. No. However, our view would be that such practice is generally incompatible with the principles set out on the face of the DCSB and the outcome focus to which the authority must have regard in relation to assessment and care planning.

21.2. The use of electronic monitoring of 'care by the minute' is not necessarily a bad thing, but misuse is. When used for good, such approaches support flexible responses to meeting individual assessed needs and improved outcomes, while also ensuring providers are paid for actual care and support delivered.

22. To what extent do the safeguarding provisions ensure that all those at risk are adequately protected, and should these provisions be extended in any way?

22.1. Putting safeguarding adults boards on a statutory footing, the duty to make enquiries and the ability to make (or cause to be made) enquiries together with duties to co-operate in specific cases are all helpful and welcome. It may be helpful to explicitly link enquiries to assessment and care planning processes in order to emphasise a focus on the outcomes that people wish to achieve, as well as whether harm or abuse has taken place and by who.

22.2. It is unrealistic to expect that all those at risk should be adequately protected, particularly in domestic relationships. However, ensuring that services safeguard people's dignity and rights will contribute significantly.

22.3. We welcome Safeguarding Boards being put onto a statutory footing. We have commented on membership and a desire to see financial contributions to safeguarding activity also made by the police and NHS.

22.4. We believe that this section could be strengthened to link safeguarding enquiry to assessment (including risk assessment) and planning for care and support, as we have commented on in previous sections. Without this, the DCSB runs the risk of perpetuating too much focus simply on whether the harm or abuse took place and the action to take in relation to the alleged perpetrator, rather than focusing as well on what the desired outcomes, experiences and needs of the victim are. The care and support they may need could include post trauma support, access to healing activity, access to justice, peer support and so on, rather than additional services or monitoring.

22.5. The section on “it must make (or cause to be made)” could be helped by an explicit link to the duty to cooperate section at the beginning of the DCSB.

22.6. Our points about providers, community safety and CQC being partners, and about eligibility and thresholds are relevant here. We have some concerns about the power embedded in “or cause to be made”? Does this mean that councils can request, or that they can require people/organisations to do something? Does it only apply to “relevant partners”? It would be helpful to have some robust wording in guidance to support cooperation, otherwise, other operational priorities may be an excuse for inaction. Explicit cross-referencing to duties of care by the police and NHS would be helpful.

22.7. In relation to deciding “whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom”, we suggest that “should” be replaced by either “must” or “we recommend that…”

22.8. We have also commented that the impact assessment should give far greater weight to workforce training and development, in relation to all aspects of the DCSB, but particularly safeguarding. Currently, local authorities fund and arrange considerable amounts of training for other organisations in all sectors. We would welcome further consideration of the implementation of the new legislation to ensure that it is consistent and effectively implemented.

22.9. Whether or not there are new powers, it is evident that while there has been considerable investment in training and development in relation to the Mental Capacity Act, there remains significant under use of other legal and welfare responses to safeguarding circumstances and a need for investment in staff up-skilling in order to use them.

22.10 We would like clarity on what support is available to those individuals being cared for, or their carers, who are the victims of abuse and subsequently whistle-blow.

23. Does the draft Bill strengthen corporate accountability for neglect and abuse? What would be the risks and benefits of creating a new offence of corporate neglect?

23.1. Arrangements relating to providers of service and the regulatory framework – including issues relating to corporate accountability – are not covered in the DCSB. The final report on Winterbourne View Hospital and the programme of action set out in the report and accompanying concordat includes a commitment to bring forward proposals to strengthen the accountability of

corporate boards. Any proposals to legislate in this regard should make clear both the duties and responsibilities of providers and of the regulatory bodies.

24. Will the draft Bill's provisions smooth transition from child to adult services, and should they be extended in any way?

24.1. Provisions to secure transition from children and young people (CYP) social care services to adult services are welcome and should secure both continuity of support and security for the young people concerned. As identified above, the arrangements for young carers/transition appear to be inconsistent with arrangements for adult carers and need to be regularised.

24.2. There is a need to ensure that the DCSB is properly aligned with the forthcoming Children and Families Bill, which will introduce Education, Health and Care (EHC) plans, potentially up to the age of 25. It is proposed that the EHC plan will cease when a young person is no longer in education or training.

24.3. The draft SEN and disability provisions of the Children and Families Bill place a number of new duties on councils, which will include a duty to keep education and adult care services under review for those aged 18-25 and consider whether this is 'sufficient' to meet local need. Councils will have to set out what services are available, including in relation to adult social care services, to meet the needs of young people locally.

24.4. Although it is not intended that the new SEND (Special Educational Needs and Disability) approach should give an entitlement to education up to the age of 25, there is already anecdotal evidence that parents are assuming that it will, and that college courses in day and residential settings may be created for this age group. This could result in a significant increase in the number of young people with complex needs staying on in education. We have welcomed the recommendation of the Education Select Committee that the entitlements should be clarified in the Children and Families Bill.

24.5. A consistent approach between the provisions in the two bills would also help. It is possible that a young person aged 18-25 could be eligible for both an EHC plan under the Children and Families Bill and a care and support plan under the DCSB. But it would make sense to bring these plans together to create a consistent approach from 18-25. The expectation should be that social care needs identified in an EHC Plan should be met through a care and support plan post-18.

24.6. The SEND reforms are being tested in 20 pathfinder areas, covering 31 councils and their health partners. Work is underway in the pathfinder areas to

raise aspirations and help prepare young people with disabilities and learning difficulties for adulthood, and we are keen to ensure that this is shared with other non-pathfinder councils.

25. Does the draft Bill promote greater integration between health, social care and housing around hospital discharge?

25.1. Not specifically, however, if the DCSB's aspirations of improved outcomes for individuals through better integrated commissioning are realised, then a natural consequence will be the improvement in timely and appropriate transfer from hospital.

25.2. As previously noted, issues relating to the consistency of Clause 21 exceptions in relation to health with the current arrangements (and how these might be improved) are the subject of continuing discussion with the Department of Health. This includes the omission in Schedule 2 of the DCSB of the need for the NHS body to consider NHS continuing healthcare prior to issuing an assessment notice to the local authority. This omission is unhelpful and needs to be regularised.

TELFORD & WREKIN COUNCIL

HEALTH AND WELLBEING BOARD – 13 MARCH 2013

PUBLIC HEALTH TRANSITION PROGRESS UPDATE

REPORT OF THE DIRECTOR OF ADULT AND COMMUNITY SERVICES AND DIRECTOR OF PUBLIC HEALTH

1.0 SUMMARY

1.1 This report summarises the arrangements that are in place to ensure a successful transition to the new public health responsibilities the Council has as result of the Health and Social Care Act 2012

2.0 RECOMMENDATIONS

2.1 The Board notes the new public health responsibilities placed on the Council from 1 April 2013, the transition planning and activity that has taken place and the final arrangements now made through delegated authority to ensure the Council meets these responsibilities

2.2 The Board welcomes the opportunities that the new Health and Wellbeing and Public Health arrangements bring for the area

3. INFORMATION

3.1 Whilst the transition process has been difficult and not helped by the delays in publishing regulations and guidance, locally we will be prepared to move forward with the new agenda from the 1 April, as set below.

3.2 **Council Senior Management Team**: As part of a review of senior management arrangements in the Council, the Council's Managing Director confirmed on 27 February the designation of a new post in the Council's Senior Management Team of Assistant Director: Health & Well-Being. This post will pick up the new Health & Wellbeing and Public Health responsibilities transferring to the Council from the NHS and will carry the statutory officer status of 'Director of Public Health'(DPH). This post will report directly to the Director of Care, Health and Wellbeing but with a direct link to the Managing Director as necessary in fulfilling the statutory DPH role, as is the case with other statutory officers in the Council. Dr Catherine Woodward will transfer across from the PCT into this role. A copy of the revised Council senior management structure is appended.

3.3 **Public Health England** (PHE) is now well established to

- Support transparency and accountability across the system
- Provide professional support and leadership to the public health system
- Ensure consistent high quality services are provided by Public Health England units
- Ensure the delivery of the national Emergency Planning, Resilience and Response strategy

3.4 Duncan Selbie was appointed **Chief Executive of PHE** and took up post July 2012. The PHE 'delivery chain' includes PHE regions and PHE centres. The PHE regions are aligned with National Commissioning Board Regions .Within the Midlands and East region which is led by Dr Rashmi Shukler,we are part of the West Midlands PHE Centre, led by Dr Sue Ibbotson which will provide local presence, leadership and delivery of some PH services including:

- Provision of Health Protection Services (previously offered by Health Protection Agency)
- Building PHE's relationships with local authorities and providing professional support to them
- Ensuring the local NHS has access to high quality PH advice
- Employment and professional development of Immunisation and Screening teams located with NCB Local Area Teams
- Development of the specialist and wider public health workforce
- Provision of PH specialists to support specialised commissioning and dental commissioning
- Oversee delivery of Drug and Alcohol services (previous National Treatment Agency role)

3.5 **Local Public Health services** – Previous reports have set out the Public Health (PH) responsibilities transferring to the Council and amongst other things the concerns about the late publication of Regulations, Guidance, the PCT's Public Health budget and spend and the amount of Public Health Grant, Councils would receive. However despite this a Transition Board with the support of officers from the PCT (in particular the Public Health staff) and the Council have been working to ensure a smooth transition is achieved when the Council assumes its new responsibilities on the 1 April 2013.

3.6 **Public Health Grant** :We now know and welcome that the ring-fenced Public Health grant has been set at £10.6m for 2013/14, rising to £10.9m for 2014/15 which has enabled the Council to set the Public Health budget as part of its overall budget strategy.

3.7 **Public Health Contracts**: As previously reported the majority of current spend by the PCT is on services commissioned from providers, in particular Shropshire Community Trust and all contractual periods end 31st March 2013. With the budget position finalised we have now agreed which existing contracted services will still be required and gained agreement from Graham Urwin, NCB

Director for the PCT to extend these contracts for periods of up to 12 months maximum which allows them to novate to the Council. Contact has been made with each provider to explain the position. Our Commissioners (including transferring PCT commissioners) will now put together an action plan for the next few months to review all these contracts against the Council's new, emerging vision for Public Health services & value for money approach and enter into detailed discussion with providers. The Council has also been party to and approved decisions to let two new contracts in respect of Sexual Health services and Smoking Cessation.

3.8 **Staff Transfer**: National regulations in respect of staff transfer have been followed and we are in agreement with T&W PCT about the list of transferring staff. Council HR staff have had regular meetings with the transferring staff and we are not aware of any significant problems. They will transfer on their NHS terms and conditions, retain access to the NHS pension scheme and be subject to a range of protections currently being negotiated nationally for 24 months.

3.9 Most transferring staff will transfer as currently located within the current Public Health unit and continue to be based at the Halesfield base of the CCG, line managed by the Assistant Director: Health & Well-Being. Two posts with responsibility for Sexual Health Services commissioning and Drugs and Alcohol Services commissioning will be located with the existing Council Children's and Adult Social Care commissioners respectively at Darby House. Over the next few months we will then review current structures transferred across, to ensure they best support delivery of both Public Health and Health & Wellbeing responsibilities within the Council setting.

3.10 **Transfer Scheme**: A range of delegated authorities have already been given to deal with the Public Health Transfer (Cabinet Report – 20 September 2012). Transfer Schemes/lists being put together by T&W PCT in respect of all their current responsibilities, contracts, assets, liabilities, staff, etc transferring to the CCG, NCB, CSU and Council will be approved nationally within the NHS on the 28 March. Through delegated authority the relevant Council officers in consultation with the Chair of Health & Wellbeing Board will need to approve agreement to receive the transfers later this month.

4.0 MINUTES OF PREVIOUS MEETINGS

4.1 Cabinet Report – 22.12.2011 – NHS Transformation and Implications for the Council.

4.2 Cabinet Report – 29.3.2012 - NHS Transformation Update.

4.3 Cabinet Report – 20.9.2012 – Public Health Transition arrangements

5.0 Background Papers

5.1 The Health and Social Care Act 2012

Report prepared by: Paul Taylor, Assistant Director – Social Care Specialist
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Revised Senior Management Team Structure

Richard Partington
MANAGING DIRECTOR
(Statutory Head of Paid Services)

CO-OPERATIVE COUNCIL & COMMERCIAL DELIVERY TEAM

Laura Johnston
DIRECTOR OF CHILDREN & FAMILY SERVICES
(Statutory Director of Children's Services)

Vacant
DIRECTOR OF DEVELOPMENT BUSINESS & CUSTOMER SERVICES

Paul Clifford
DIRECTOR OF CARE, HEALTH & WELL- BEING
(Statutory Director of Adult Social Services)

Ken Clarke
Assistant Director: Finance, Audit & Information Governance (Statutory Chief Financial Officer)

Jonathan Rowe
Assistant Director: Neighbour-hood & Leisure Services

Jim Collins
Assistant Director: Education & Skills

Karen Perry
Assistant Director: Children's Safeguarding

Clive Jones
Assistant Director: Family & Cohesion Services

Angie Astley
Assistant Director: Customer & People Services

Michael Barker
Assistant Director: Planning Specialist

David Sidaway
Assistant Director: Development Business & Housing

Karen Kalinowski
Assistant Director: Adult Care & Support

Paul Taylor
Assistant Director: Social Care Specialist

Catherine Woodward
Assistant Director: Health & Well Being (Statutory Director of Public Health)

Jonathan Eatough
Assistant Director: Law, Democracy & Public Protection (Statutory Monitoring Officer)

Telford & Wrekin
Local Involvement Network

Interim annual report

1 April 2012 – 31 December 2012

The LINk: what it is and what it does

The primary purpose of the Telford & Wrekin Local Involvement Network (LINk) is to find out what people think about local health and social care services and to use this information to improve the way that services are planned, commissioned, delivered and reviewed.

By collecting first-hand accounts of health and social care from service users, carers and patients the LINk is able to put forward practical proposals which illustrate how existing services can be improved and gaps in provision addressed in ways that are cost-effective.

The area within which each LINk operates is based on the boundaries of the unitary authority that is responsible for providing social services. That is why in this area there is one LINk covering the Borough of Telford and Wrekin and another LINk covering Shropshire. Telford & Wrekin LINk covers:

- Telford South (Coalport, Ironbridge, Madeley, Sutton Hill, Coalbrookdale, Tweedale, Woodside)
- Telford Central (Lawley, Dawley, Lightmoor, Aqueduct, Hollinswood, Town Centre, Randlay, Stafford Park, St George's)
- North West Telford (Wellington, Shawbirch, Dothill)
- Telford North East (St George's, Priorslee, Oakengates, Ketley, Leegomery, Hadley, Hortonwood, Trench, Donnington, Wrockwardine Wood)
- Newport and the rural area of north Telford.

Local involvement networks were set up in 2008. They will be replaced throughout the country by new local organisations known as Healthwatch from 1 April 2013.

Contents

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Introduction

Over the last four years the LINk has concentrated its resources on giving the whole community a stronger voice, making sure that the views of local people have been listened to and reflected in the way that health and social care services are planned, commissioned and delivered in Telford and Wrekin. Many examples of the differences that have resulted directly from our activities in 2012 are highlighted in the pages that follow (a fuller list covering the years 2008–2013 can be found in the appendix to this report). You can also read about how we have tackled the specific goals that were identified as priorities at our annual general meeting in June.

However, as a result of the sweeping changes being introduced by the Health and Social Care Act 2012 the LINk will cease to function on 31 March 2013. Its place will be taken by Healthwatch Telford & Wrekin, one of 152 local Healthwatch organisations which will become operational across the whole of England from April 2013. A summary of the LINk's programme of activities from January through to the handover to Healthwatch in April is on page 16.

As this is the final annual report of Telford & Wrekin LINk it is an appropriate time to reflect on what we have done well, and also on what has been less effective. Firstly, the good news. This report contains a long list of changes that have improved services for local people. This goes to the very heart of what LINks are for. None of this would have been achieved without the contribution of the Central Management Group and the battalion of other volunteers who have supported our work as authorised visitors and community champions. To all of these people I extend a very warm thank you.

A particularly noteworthy success has been Telford & Wrekin Youth LINk, which was initiated in 2011 by Rebecca Dove, the LINk's community engagement worker. The health and care needs of younger people are often not given their due importance by those responsible for providing services and it is of great credit to Youth LINk that it has shone a very bright spotlight on this issue. The LINk's youth development worker, Catherine Pert, has much to be proud of in the work she has done with Youth LINk, along with the members of the group. All of this work will need to be continued by the local Healthwatch, and I very much hope that it can be built on to provide the residents of Telford and Wrekin with an even better service.

So what are some of the things we have not done well? The LINk depends on the motivation, goodwill and energy of its volunteers but when local involvement networks were first launched across the country there was no national publicity drive to tell the public about the scheme. I have a particular regret that there is very little knowledge about the LINk among local people — and in this regard I regret that the public of Telford and Wrekin is not well-served by its local press: neither the *Shropshire Star* nor the *Telford Journal* have seen fit to cover meetings of local health and social care bodies in recent years (apart from the occasional hospital board meeting) and because of this the public are much the poorer in their knowledge about what is done on their behalf. This lack of awareness is not confined to the general public: at a recent meeting with over 20 representatives from a local NHS provider fewer than one-third of those present said they had "a working knowledge of LINks".

Another area in which we have been less than successful has been in engaging the harder-to-reach members of our community, particularly those from the black and ethnic minority communities. Again, this is an issue which will need to be considered by Telford & Wrekin Healthwatch.

Finally I would like to express my personal thanks and those of the Central Management Group to the host team for all their support and hard work over the years: we would not have achieved what we have done without them. We wish them well for the future wherever they, and we, may be.

Dag Saunders
Chair, Telford & Wrekin LINk

For more information

If you have any questions about the LINk's activities over the last four years we would be pleased to hear from you (our contact details are on page 18). And if you are interested in becoming a community champion or taking part in surveys or focus groups — or you are a local organisation with an interest in improving health or social care services — please do email, call or write to us and we will ensure that your contact details are given to Healthwatch Telford & Wrekin.

The differences made to local services by the LINk in 2012 — a summary

Some of the differences made in the last nine months as a direct result of Telford & Wrekin LINk's activities include:

- ✔ **a review of staffing levels and procedures at the Princess Royal Hospital.** Additional improvements included the replacement of worn carpets and a new bed for birthing partners, and the refurbishment of the outdoor play area used by young in-patients. All of this resulted from visits undertaken on our behalf by lay visitors.
- ✔ **improvements to residents' welfare at two care homes.** Trip hazards identified during a visit to one care home were rectified. At another home an activity co-ordinator was appointed after we expressed concern that the activities being provided were insufficient to meet the residents' needs.
- ✔ **better information for blind and partially sighted patients at Shrewsbury and Telford Hospital NHS Trust.** The trust has committed itself to providing information for blind and partially sighted patients in their preferred format. This will ensure that patients who are visually impaired do not have to rely on family, friends or colleagues to read their personal correspondence about appointments or test results.
- ✔ **improvements to the signage at the Redwoods Centre, the new acute psychiatric hospital.** South Staffordshire and Shropshire Healthcare NHS Foundation Trust has agreed to display more prominently the availability of hearing loops for use by patients and visitors who are hard of hearing. On the wards, beds have been repositioned to ensure that patients can more easily reach the alert buzzers when they require assistance.
- ✔ **establishing new patient participation groups at 16 medical practices.** These groups have carried out surveys and held focus groups to help identify priorities based on patient feedback. Patient representatives from 20 medical practices across Telford have also started meeting to share ideas about how they can work together to improve access to health care.
- ✔ **helping mental health service users to identify changes needed to improve the quality of care they receive from their doctor, the hospital and community mental health services.** The LINk is ensuring that the agreement to address the issues raised at a meeting arranged by service users with the commissioner, the main service provider and the local MP are implemented by early summer 2013.

In addition, young people involved in Youth LINk have helped to evaluate the tenders for the provision of sexual health services in Shropshire and Telford and advised a number of commissioners and service providers about the barriers that prevent access to out-of-hours care. They also took part in the 'round table' of service users which acts as a sounding board for the newly-formed Clinical Commissioning Group.

The LINk's priorities for 2012/13

At its annual general meeting on 21 June 2012 the following six issues were endorsed as the key priorities for Telford & Wrekin LINk in 2012:

- Priority 1: Countdown to local Healthwatch
- Priority 2: Youth LINk
- Priority 3: Patient participation
- Priority 4: Donnington VOICE
- Priority 5: Adult social care
- Priority 6: Using the LINk's statutory powers to scrutinise local health and adult social care services

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Priority 1: Countdown to local Healthwatch

To raise public awareness of the forthcoming changes to the way that patients and carers can influence the way that health and social care is planned, commissioned and delivered.

Between April–December 2012 the LINk:

- worked with Telford & Wrekin Council and NHS Telford & Wrekin to raise public awareness of the changes taking place nationally, regionally and locally
- provided information on the passage of the Health and Social Care Bill through Parliament to individuals and local organisations, including the Voluntary Sector Partnership Board
- contributed to a stakeholder event and two workshops on the tendering process for local Healthwatch
- represented West Midlands LINks on the executive committee of the National Association of LINks Members, the Healthwatch Transformation Board and the Department of Health Programme Board for Local Healthwatch
- invited Dr Michael Innes, a local GP and chair of the Clinical Commissioning Group, to make a presentation entitled "Changing the face of healthcare in Telford and Wrekin" at our annual general meeting
- co-hosted a workshop about the importance of Parliamentary democracy and citizen engagement in decision-making which was attended by David Wright MP.

The difference we made

The LINk has helped to achieve a more effective transition from LINk to local Healthwatch by:

- making the civil servants involved in drafting the legislation more aware of the needs and aspirations of patients and service users (as a consequence of which Dag Saunders, chair of the LINk, has been appointed as one of only three patient representatives on Healthwatch England)
- using our experience and insight to shape the specification for the local Healthwatch service.

Priority 2: Youth LINk

To investigate what young people think about local healthcare services. (This work is being supported by the National Children's Bureau, which was commissioned by the Department of Health to help 15 Healthwatch 'pathfinders' in England to develop good practice.)

Between April–December 2012 Youth LINk:

- used the character of 'Sherlock Bones: Health Detective' to engage with young people to help them identify issues with healthcare services and assist him in 'cracking the case'
- ran a 'world café' event at Hadley Learning Centre in which 20 young people took part
- presented the findings of the out-of-hours care survey to the Urgent Care Network
- evaluated the appropriateness of literature provided by the NHS, the local authority and voluntary organisations to inform young people about the services available locally
- organised a stall in Telford town centre to promote awareness of World Mental Health Day. This led to 42 young people taking part in a survey about mental health needs and their experiences of using local health services
- helped to evaluate the tenders for the provision of sexual health services in Shropshire and Telford.

The difference we made

By encouraging young people to speak up about healthcare, Youth LINk was able to influence decisions being made by commissioners in areas such as the provision of sexual health services. It also focused attention on the prevalence of self-harm among young people revealed by the mental health survey, which found that:

- 40.5 per cent of young people agreed that self-harm has become more accepted in schools as "something everybody does"
- 78.6 per cent know a young person who has self-harmed
- 40.5 per cent know a young person who is depressed.

Youth LINk has started to discuss these issues with the commissioner for mental health services and will examine them further at the workshops that are being held in February 2013 with the National Children's Bureau.

Youth LINk also raised awareness of the role played by young people in translating complex health information for members of their family who do not speak English. This prompted the primary care trust to remind all local health professionals of the translation services available for producing correspondence in Polish and other languages.

Youth LINk's success in engaging their peers in discussions on out-of-hours urgent care and mental health services was acknowledged by an award from the Telford & Wrekin Council for Customer Service.

As a result of Youth LINk's activities young people are more knowledgeable about service planning and procurement, and commissioners are more likely to involve them in service reviews or decision-making in the future.

Priority 3: Patient participation

To encourage the local community to get involved in the patient participation groups (PPGs) being set up by medical practices in Telford so that everyone has an opportunity to influence the quality of healthcare provision locally.

Between April–December 2012 the LINk:

- worked closely with the primary care trust to support the patient groups that have been set up by 22 medical practices in Telford
- worked closely with seven practices (Donnington, Hadley, Ironbridge, Limes Walk (Oakengates), Sutton Hill, Wellington, and Woodside) which were keen to develop activities with wider groups of service users within their localities
- introduced health outreach workers from the Community Health Enterprise Centre to patient representatives and practice managers
- worked in partnership with Telford MIND to evaluate how well services in community and acute settings are meeting the needs of people with a range of mental health conditions
- organised two events for representatives from each of the 22 PPGs to help them identify issues of common interest to inform and influence the priorities of the Clinical Commissioning Group.

The difference we made

At **Donnington Medical Practice** people with long-term conditions such as diabetes and heart and respiratory problems, as well as the parents of children with autism and Asperger syndrome, were encouraged by the PPG to take part in the health forum and identify services where improvements are needed. The commissioners and service providers who attended these meetings described them as “invaluable”.

At **Ironbridge** the PPG persuaded more people to come forward to help distribute a patient survey in the community, thereby reaching more people than previous attempts which had relied on a ‘virtual’ patient group that could only be accessed online. The **Limes Walk** PPG has championed the provision of health information in different languages and supported calls for a dedicated clinic for young people.

At **Sutton Hill** the need for improvements to the quality of care provided for people with mental health conditions by all health services were raised with the commissioner by service users from across Telford. This resulted in a commitment to review the services provided by the crisis team and care ‘pathways’ with family doctors, the out-of-hours service (Shropdoc) and the crisis and home treatment teams based at Castle Lodge, as well as the providers of acute services at the Redwoods Centre, the aim being to establish a more seamless service.

At **Wellington** the PPG made the practice aware of local expertise in arts therapy for people with dementia. This led to the commissioner agreeing to fund a trial project in the area.

At **Woodside** the PPG organised an event with the Alzheimer’s Society to raise awareness of dementia and to encourage more local people to seek diagnosis and support. It has also recruited new patients’ representatives from a range of diverse and vulnerable groups.

Priority 4: Donnington VOICE

To provide an opportunity for everyone who lives in Donnington and Donnington Wood to have a say about their community and become a community health champion.

Between April–December 2012 the LINk:

- established a local steering group to oversee the way the project is run
- started to collect information about the needs and aspirations of the local community through events, focus groups, social media and surveys
- encouraged local people who would like to 'speak up' for Donnington to take part in the Community Development and Health Course run by Telford College
- set up the Donnington Health Forum to provide a regular opportunity for local people to share their experiences of managing long-term conditions with commissioners and providers
- organised an event in partnership with Donnington Medical Practice and its PPG for around 30 people with neurological and rheumatoid conditions. This was attended by representatives from the Rheumatoid Arthritis Group, STABLE (Supporting Those Affected By Lifelong Epilepsy), Brainwave, the Patient Advice and Liaison Service, the Telford & Wrekin Health Improvement Team, Impact Alcohol Advisory Service, the West Mercia Ambulance Service, and the Red Cross Help-at-Home scheme
- hosted a lunch event for 12 people with diabetes at which Diabetes UK (Telford branch) contributed valuable information about managing the condition and staying healthy, and a podiatrist provided practical advice about diabetic foot care
- invited the parents of children with autism to identify services that work well — and those that need to improve — at a session on autism and Asperger syndrome which was presented by Autonomy, a local organisation. The commissioner for mental health services also took part in the discussion.

The difference we made

As a result of their involvement with Donnington VOICE a number of local residents have become more involved in the PPG and have helped to devise questions for the annual patient survey. Several others have become involved with Diabetes UK.

Members of the local community are planning four events in Donnington in February and March to provide further opportunities to influence the way local services are delivered.

Priority 5: Adult social care

To produce a response to the government's White Paper on the future of adult social care that is informed by what is best for the people of Telford and Wrekin.

Between April–December 2012 the LINk:

- submitted a joint response to the Department of Health consultation on the draft Care and Support Bill, taking into account feedback from partner organisations including Listen not Label and the Mental Health Forum
- responded to Telford & Wrekin Council's first Quality Account for adult social care
- worked closely with Listen not Label, Taking Part, the Red Cross and Age UK to help develop the Telford & Wrekin Mental Health and Wellbeing Commissioning Strategy Action Plan 2010–2015
- helped to develop the draft policy for the joint self-assessment validation process of services for adults with learning disabilities (which will be subject to public consultation in 2013)
- helped to organise a celebration of World Mental Health Day based on the theme of 'investing in mental health' in collaboration with Listen not Label, the mental health trust, and other statutory and voluntary sector service providers throughout Telford and Wrekin.

The difference we made

The importance of the local knowledge and expertise that local voluntary organisations bring to service delivery has been reflected in the development of an 'outcomes-based' commissioning framework. Service users are also being involved in designing the new statutory framework for adult safeguarding and this has enabled them to draw attention to the lack of regulation and scrutiny in relation to domiciliary care.

Responding to concerns that not everyone has access to the internet the LINk has successfully lobbied health and social care organisations to make information and advice more readily available in supermarkets, libraries and GP surgeries, which is essential if vulnerable people are to exercise choice and control over their care. Information about the welfare reforms is now being routinely provided to advocacy organisations enabling them to 'cascade' the information to service users.

Involving service users with learning disabilities or mental health conditions in the planning and design of local services — using 'No health without mental health' as a mantra to help prevent stigma and discrimination — is increasingly becoming the norm.

Priority 6: Using the LINk's statutory powers to scrutinise local health and adult social care services

To visit premises where health and social care services are delivered, especially hospitals and care homes. To comment on the Quality Accounts published by the acute, community and mental health provider trusts. To seek information from commissioners and providers to enable the LINk to scrutinise health and social care services, and to promote diversity of representation and equality of access.

Between April–December 2012 the LINk used its statutory powers:

- to formally comment on the draft Quality Accounts published by the three NHS trusts that provide acute, community and mental health services in our area: Shrewsbury and Telford Hospital Trust, South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Shropshire Community Health NHS Trust
- to make a total of 24 visits to premises where health and social care services are delivered:
  - 12 visits to the Royal Shrewsbury Hospital to meet patients receiving general medical care as well as specialist support for diabetes, vascular and urological conditions, and intensive care and rehabilitation. We also visited the maternity and medical assessment units and wards providing gynaecological treatments, colorectal surgery, and chemotherapy (see table 1 on page 14)
  - eight visits to the Princess Royal Hospital to ask patients with heart disease or breathing problems, or who have had a stroke, about their experience of the quality of care. We also visited the Paul Brown Day Hospital, which provides rehabilitation, and the accident and emergency department (see table 2)
  - four visits to residential and nursing homes: St George's and Lake View in Telford, and Bowbrook House and Lymehurst in Shrewsbury (see table 3).

Seven of the visits were undertaken jointly with authorised representatives of Shropshire County LINk. Only nine of the 24 visits were announced in advance. Around half the visits were to wards and premises not previously visited; the remainder were repeat visits to check that issues identified as needing attention on earlier visits had actually been addressed.

As well as using its statutory powers to enter and view premises the LINk contributed to providers' quality assurance systems by providing independent scrutiny of their services. Two LINk representatives who sit on the Patient Experience and Involvement Panel took part in a number of patient-led assessments of the care environment, which led to immediate action being taken to address the issues they identified. A LINk representative was also invited to provide the 'patient perspective' in the annual Patient Environment Assessment Team inspection.

LINk representatives also acted as independent lay observers in the Essential Standards Reviews which are carried out by staff and governor members of the South Staffordshire and Shropshire Healthcare NHS Foundation Trust. In 2012 they visited Elm House and the Redwoods Centre where they met patients on Holly ward, which provides assessment and care for people with dementia (see table 4). Six weeks after the opening of the Redwoods Centre (which has replaced Shelton Hospital as the acute in-patient facility for people from Shropshire, Telford and

Powys) they requested a tour of the premises to familiarise themselves with the layout and the services provided there.

The difference we made

The LINk's comments on the three sets of Quality Accounts emphasised the need for more comprehensive information about the range of services available locally, and requested that future reports contain less jargon. We also asked the three trusts to ensure that patients and service users are able to become more involved in determining their care plans.

In 2012/13 the LINk's activities led to a number of notable improvements to patient safety, staffing levels and the overall quality of care. The most noteworthy of these are highlighted on page 6.

Concerns raised by the LINk about the acoustics at the Redwoods Centre remain under investigation but the mental health trust has given a commitment that these will be satisfactorily addressed.

LINk representation on national, regional and local strategic forums in 2012/13

National strategic forums

- National Association of LINks Members National Executive
- Department of Health Healthwatch Programme Board

Regional strategic forums

- Strategic Health Authority Patient Revolution
- West Midlands Trauma Network

Local strategic forums

- Telford & Wrekin Council Health Scrutiny Committee
- Joint Local Authority and NHS Health and Wellbeing Board
- Shrewsbury and Telford Hospital NHS Trust Patient Experience and Involvement Panel
- Shrewsbury and Telford Hospital NHS Trust Stakeholder Conferences
- Urgent Care Stakeholder Network
- Mental Health Provider Forum
- Mental Health Commissioning Board
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust Community Engagement Forum
- Shropshire Community Health NHS Trust stakeholder events (patient participation in the organisation's plans to become a foundation trust)
- Telford Clinical Commissioning Group Patients' Roundtable
- Telford Referral and Quality Service pilot programme.

Table 1. Visits to the Royal Shrewsbury Hospital in 2012

Date of visit	Ward number	Ward name	Announced?	Shropshire County LINk
02.03.12	21	Chemotherapy	No	
02.03.12	25	Colorectal	No	
12.03.12	19	Maternity (antenatal)	Yes	
12.03.12	20	Maternity (delivery)	Yes	
10.04.12		Coronary care	Yes	✓
10.04.12	32	Gynaecology	No	✓
07.05.12	22E	Diabetes/general medical	Yes	
07.05.12	25	Colorectal	No	
22.05.12	26	Vascular/urology	No	
22.05.12	22S	Rehabilitation/complex discharge	Yes	
21.11.12		Intensive care area	No	✓
21.11.12	19	Maternity (antenatal)	No	✓
21.11.12	20	Maternity (delivery)	No	✓

Table 2. Visits to the Princess Royal Hospital in 2012

Date of visit	Ward number	Ward name	Announced?	Shropshire County LINk
07.03.12	15	Elderly care	No	
07.03.12	6	Coronary care	No	
12.04.12	4	Stroke care	No	
12.04.12		Paul Brown Day Hospital	Yes	
14.05.12		Accident and emergency	Yes	
24.05.12	6	Coronary care	Yes	
24.05.12	9	Respiratory medicine	No	

Table 3. Visits to residential care and nursing homes in 2012

Date of visit	Name of home	Announced?	Shropshire County LINk
14.08.12	Lymehurst	No	✓
27.09.12	Bowbrook	No	✓
16.11.12	St George's	Yes	
13.12.12	Lakeview	No	

Table 4. Other visits (not using statutory powers)

Date of visit	Name of premises	Announced?	
21.06.12	Elms House	No	Essential standards review with SSSFT
07.11.12	Redwoods Centre	Yes	Tour of new facilities
06.12.12	Redwoods Centre	No	Essential standards review with SSSFT
Various dates	Royal Shrewsbury Hospital Princess Royal Hospital		Patient-led assessment of the care environment inspections

Other issues the LINk maintained an interest in during 2012/13

The reconfiguration of mental health and acute hospital services

Between April–December 2012 the LINk:

- monitored the modernisation of mental health services by seeking feedback from service users and carers about the quality of care being provided in the community and the capacity of the acute psychiatric in-patient facilities at the Redwoods Centre and Castle Lodge (the community psychiatric in-patient facility) [Note. The LINk's scrutiny has led to the service commissioner being required formally to explain the delays in the implementation of the Next Steps strategy which had been subject to public consultation in 2010. It had been agreed that there would be a mid-term review of the roll-out of the service in summer 2013.]
- called the mental health trust and the commissioner to account for failings in the design of the new Redwoods Centre which have led to excessive noise levels throughout the premises
- provided the 'patient perspective' at a number of strategic forums, including the acute trust's Patient Experience and Involvement Panel, the patient and community forum established by South Staffordshire and Shropshire Healthcare NHS Foundation Trust, the Shropshire Community Health NHS Trust stakeholder event, and the Joint Local Authority and NHS Health and Wellbeing Board
- reminded the trust of the commitment given by the chief executive during the consultation in 2010/11 to ensure improved access to the two hospital sites for users of public transport.

Children's health and wellbeing, especially those with disabilities

Between April–December 2012 the LINk:

- worked closely with local voluntary organisation Parents Opening Doors to raise awareness of the needs of families caring for children with disabilities
- organised an event on autism and Asperger syndrome which enabled parents to meet with the commissioner as part of the Donnington VOICE Health Forum.

Hospital discharge arrangements

Between April–December 2012 the LINk:

- worked with Telford Senior Citizens' Forum to collect the first-hand experiences of discharge arrangements from 150 elderly patients and their families. These findings formed the basis for recommendations for improvements which will be presented to commissioners and providers in spring 2013.

The Mid Staffordshire Hospital Public Inquiry

Between April–December 2012 the LINk:

- continually reminded statutory bodies about the importance of involving patients, service users and their carers in decision-making, especially in regard to patient safety and quality assurance issues.

The Equality Delivery System

Between April–December 2012 the LINk:

- helped to evaluate the extent of compliance with the Equality Act by NHS organisations using qualitative and quantitative data
- represented patients, service users and carers on the Joint Shropshire and Telford Primary Care Trust Equality Delivery System Steering Group
- helped in the planning of events to raise awareness of the Equality Act so that community and voluntary organisations can help NHS organisations to identify priorities and monitor outcomes.

Accessible information

Between April–December 2012 the LINk:

- supported the West Telford Visually Impaired Group's request for correspondence from the Ophthalmology and Patient Access Centre to be made available in the format preferred by individual blind and partially-sighted patients.

The LINk's workplan for January–March 2013

Telford & Wrekin LINk will cease to function on 31 March. Despite this we have a very full programme of activities planned for January, February and March, including:

- visiting premises where healthcare or adult social care is provided, including the Lake View residential care home in Telford, Castle Lodge community mental in-patient health unit, and the accident and emergency department at the Princess Royal Hospital
- continuing to support the work of practice-based patient participation groups
- organising two health forums in Donnington about: (1) inequalities in health outcomes, and (2) improving access to health services for young people
- taking part in two workshops with the National Children's Bureau to underline the importance of the participation of patients and service users in improving the quality and safety of services
- organising a series of conferences on access to health services for young people that will be run by Youth LINk
- raising awareness of the new 111 service for access to non-urgent care that will be introduced nationally in March 2013
- preparing commentaries on the Quality Accounts that will be published by all local NHS service providers in the early summer.

We will also be supporting the transition from the LINk to Healthwatch by producing a series of 'LINk legacy' documents to ensure that the knowledge, expertise and insights gained since 2008 are not lost. These will include a patient participation 'toolkit' containing advice on running a health forum, influencing commissioners and providers, methods for involving people, monitoring and evaluation, and how to deal with equality, diversity and cultural awareness issues.

LINk membership 2012/13

Central Management Group (elected members)

Trevor Dickenson (until August 2012)
David Edwards
Muriel Fellows
Anthony Glover
Jean Gulliver (vice-chair)
Tina Jones
Tanya Love (from September 2012)
Julie Mellor (from September 2012)
Lilian Owens
Lorraine Parkes
Dag Saunders (chair)
Richard Shaw
Jayne Stevens
Gaynor Stevens
Derek Tremayne
Martyn Withnall (until October 2012)

Authorised representatives

Christine Alford
Brian Begley
Jacky Bowyer
Christine Choudhary
Annette Deakin
Hayley Dyson
Muriel Fellows
Anthony Glover
Jean Gulliver
Jo Havell
Gwen James
Sue Jenkins
Lilian Owens
Lorraine Parkes
Gaynor Stevens
Gerry Stokes-Harrison
Audrey Thompson
Derek Tremayne
Ken Whitcombe
Paula Whitcombe

Community champions

Belinda Ezeazu
Joy Lilley
Natasha Rocket
Jenny Shaw
Ken Whitcombe
Paula Whitcombe

In memoriam

Trevor Dickenson — Trevor died in hospital on Friday 3 August 2012 following a cardiac arrest a few days earlier. A member of the Central Management Group since May 2011 and chair of the Patient Participation Steering Group since January 2012, Trevor was also chair of the Shropshire Disability Network.

Caroline Bond — Caroline died in mid-July 2012 as a result of complications following a stroke. Caroline was an authorised representative of Shropshire County LINk who had taken part in several joint visits to health and social care premises organised jointly with Telford & Wrekin LINk.

The host organisation

Telford & Wrekin Council has been the LINk's host organisation since April 2012 following Staffordshire University's decision not to seek an extension to its contract to provide support services.

The hosting service

In 2012/13 the LINk's support services have been provided by:

- Linda Seru, director of the hosting service
- Rebecca Dove, project manager for patient participation
- Catherine Pert, administrator and Youth LINk development officer
- David Hayes, systems administrator
- Leah Tirmizi, project manager for Donnington VOICE (until December 2012 after which this role has been shared between Catherine and Rebecca)

LINk contact information

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Appendix

The impact of Telford & Wrekin LINk's activities, 2008–2012

2008

What we did: **Shropdoc survey**

The benefit: Home visits to patients who are unable to attend the accident and emergency department or Shropdoc's centre at the Princess Royal Hospital were agreed as a 'variation' to the out-of-hours care contract

Outcome: Improved patient care and safety

2010

What we did: **Visit to the Royal Shrewsbury Hospital maternity unit**

The benefit: Women staying on the maternity unit at the Royal Shrewsbury Hospital had a more pleasant stay because a redecoration programme was agreed following feedback from patients. Safety cords were replaced with the correct colour-coding

Outcome: Improved patient care and safety

What we did: **LINk survey**

The benefit: Clearer information was provided about the reconfiguration of hospital services when feedback indicated the public's limited awareness of the changes being proposed

Outcome: Improved information for patients

What we did: **Use of the LINk's statutory powers and referral to the Overview and Scrutiny Committee**

The benefit: Following the closure of Lime Ward a commitment was given by South Staffordshire and Shropshire Healthcare NHS Foundation Trust that patients, their families and their advocates would be consulted before action was taken in future

Outcome: Stronger patient voice

What we did: **Patient survey of renal services**

The benefit: Patients with kidney conditions were given improved access to counselling at the Hamar Centre at the Royal Shrewsbury Hospital. A newsletter was produced for patients receiving dialysis and their families, and information was provided about the support available from voluntary organisations

Outcome: Patient choice and improved care

What we did: **NHS Telford & Wrekin pharmaceutical needs assessment**

The benefit: Details of what the local community would like local chemists to provide contributed to the planning and commissioning process

Outcome: Service planning and improvement

What we did: **NHS Telford & Wrekin cataract survey**

The benefit: Feedback from people with experience of the cataract service was used to inform the primary care trust's ophthalmology review and led to enhanced care and support. Blind and partially-sighted patients supported the proposal to relocate to Euston House

Outcome: Service planning and improvement

What we did: **Care Quality Commission review of adult social care**

The benefit: Service users highlighted the need for more information about the introduction of personal budgets and other changes in social care when they met the Care Quality Commission inspectors

Outcome: Improved information and communication

What we did: **'Big changes to the NHS' LINk roadshow**

The benefit: Local people contributed to a national consultation about equity and excellence (the health White Paper) when the LINk roadshow visited local shopping centres, community centres and libraries. The chief executive of the primary care trust, the chief officer of Age Concern and a family doctor answered queries raised at a 'Question Time'-style event organised by the LINk to raise awareness of the changes being proposed

Outcome: Stronger patient voice

2011

What we did: **Visit to Ward 15 at Princess Royal Hospital**

The benefit: Unacceptable nursing practices identified by LINk visitors led to a safeguarding review and an increase in staff numbers, including a 'modern matron' and new ward manager appointed to oversee improvements to the quality of care

Outcome: Improved patient care and safety

What we did: **Supported West Telford Visual Impairment Group campaign**

The benefit: Telford's first eye clinic liaison officer was appointed to provide early intervention and support for individuals when registering as blind

Outcome: Improved patient care

What we did: **Shrewsbury and Telford Hospitals reconfiguration review**

The benefit: A patient representative ensured a more balanced approach — without LINk's contribution the sole perspective of the review would have been clinical

Outcome: Stronger patient voice

What we did: **Youth LINk unscheduled care survey**

The benefit: The Unscheduled Urgent Care Stakeholder Group took the experiences of young people into account when planning improvements to out-of-hours care services

Outcome: Improved service planning

What we did: **Attendance at NHS Telford & Wrekin board meetings**

The benefit: Greater openness and transparency in decision-making as a result of the LINk challenging the rationale for so many reports not being discussed in the public sessions of board meetings

Outcome: Stronger patient voice

2012

What we did: **Feedback about the quality of care on Ward 26 at the Royal Shrewsbury Hospital**

The benefit: Additional drip stands were purchased to replace the makeshift equipment being used. Staff were reminded to make diabetic patients aware of the availability of snack packs

Outcome: Improved patient care and safety, dignity and respect

What we did: **Involvement in new-build project at the Royal Shrewsbury Hospital**

The benefit: Patients with impaired mobility or a visual impairment who use the new Lingen Davies cancer unit have benefited from improved accessibility due to design suggestions made by LINk representatives

Outcome: Improved service planning

What we did: **Supported the establishment of patient participation groups**

The benefit: Eighteen medical practices set up patient participation groups in 2012 taking the total number of active PPGs in Telford to 22. They have carried out surveys and published action plans based on priorities identified by patients

Outcome: Stronger patient voice and improved service planning

What we did: **Visit to the Princess Royal Hospital maternity ward**

The benefit: Increased staffing at night. New mattress for bed in partners' room

Outcome: Improved patient care and safety. Improved support for carers

What we did: **Shrewsbury and Telford Hospital NHS Trust Patient Experience and Involvement Panel**

The benefit: Recommendations from the Patient Environmental Assessment Team mini-inspections at the Royal Shrewsbury Hospital and the Princess Royal Hospital in which LINk members have been involved have resulted in 'on-the-spot' improvements in cleanliness and care

Outcome: Improved patient care and safety

What we did: **Walking the wards with a commissioner**

The benefit: The play area at the Princess Royal Hospital was refurbished when it was identified as being not fit for purpose by a LINk member taking part in the 'walk the wards' initiative

Outcome: Improved patient care and safety

What we did: **Raised awareness of Parliamentary democracy**

The benefit: Fifteen local people attended a session run by a LINk community champion on ways of influencing Parliament

Outcome: Stronger patient voice

What we did: **Involvement in the Telford Referral and Quality Service pilot scheme**

The benefit: The LINk provided the 'informed patient voice' to assist in the introduction of a streamlined assessment scheme by local GPs to support patients who need a specialist referral

Outcome: Improved patient care and safety, and improved service planning

What we did: **Donnington VOICE**

The benefit: Improvements identified in meetings with commissioners at the Donnington health forums by people with diabetes, other long-term conditions and autism will improve service planning and delivery

Outcome: Stronger patient voice

2013

What we did: **West Telford Visual Impairment Group campaign**

The benefit: As a direct result of support for the campaign from the LINk's community champions appointment letters will in future be issued in the format preferred by blind and partially sighted patients

Outcome: Patient choice and dignity

What we did: **Patient participation in GP surgeries**

The benefit: The involvement of a broad cross-section of patients in patient participation groups has led to the needs and wants of the community being prioritised in the action plans of medical practices

Outcome: Stronger patient voice

What we did: **Visits to social care premises**

The benefit: An activities co-ordinator has been appointed by the Lake View Care Home. St George's Residential and Nursing Home has improved the presentation of its activity programme to residents and families

Outcome: Service user choice and enhanced support

What we did: **Joint inspections of the hospital wards**

The benefit: Improvements to seating and signage in the outpatient ward

What we did: **Visits to hospital premises**

The benefit: Staffing levels and the way that care is provided on the maternity ward at the Royal Shrewsbury Hospital have been reviewed as a direct result of feedback given to LINk visitors by patients. New furniture and equipment have improved the comfort and safety of patients. Training for consultants and nurses who look after patients with dementia has been introduced. Staff are more aware of the signs of potential abuse and the use of safeguarding procedures

Outcome: Patient care and safety, dignity and respect

What we did: **Youth LINk activity**

The benefit: Sherlock Bones: Health Detective has helped eight young people to gather evidence from other young people about their experiences of local healthcare services, including out-of-hours care, family doctors, mental health and sexual health services

Outcome: Stronger patient voice

What we did: **Youth LINk activity**

The benefit: Three members of Youth LINk sat on the evaluation panel for the tender to provide sexual health services in Shropshire, Telford and Wrekin

Outcome: Stronger patient voice

What we did: **Youth LINk activity**

The benefit: Forty-three young people took part in a survey about mental health and self-harm, the findings of which were given to the commissioner for mental health and children's services

Outcome: Improved service planning

What we did: **Youth LINk activity**

The benefit: The Youth LINk representative on the Clinical Commissioning Group's PPG raised the issue of the needs of the Polish community to receive health information in their own language. As a result, the primary care trust issued a reminder to all medical practices about the translation service that is available for producing letters and reports in all the languages spoken in the local community

Outcome: Improved patient care and safety, dignity and respect, and improved service planning

TELFORD & WREKIN COUNCIL

HEATH AND WELLBEING BOARD 13th March 2013

IMPROVING CARER'S HEALTH AND WELLBEING – STRATEGY UPDATE

REPORT OF THE ASSISTANT DIRECTOR, CARE & SUPPORT

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 The Health and Wellbeing Board has identified carer's health and wellbeing as one of its key priorities and this report details the progress being made in relation to carers.

1.2 Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partners. Caring can take its toll on your finances, your health, and your social life and on your family and work commitments. However, given reasonable level of support and understanding carers are prepared and able to go to great lengths to care for their loved ones

1.3 The strategic framework for carers is set within the context of national guidance and expectation in relation to supporting carers, but is also reflective of local needs and priorities. The strategic framework includes eight outcome areas as follows:

Information, advice and support, time for yourself, having your say, planning for the future, feeling safe and secure, promotion of well-being, meeting diverse needs and life outside of caring. The eight outcome areas are illustrated in a jigsaw model entitled 'making connections for family carers in Telford and Wrekin (see Appendix 1).

1.4 The draft carer's strategy (2013-2016) is currently being consulted on and the commentary received is being incorporated into a revised final draft. The strategy, plus an action plan of implementation will be subject to formal approvals by the council and the Clinical Commissioning Group.

2. RECOMMENDATIONS

2.1 It is recommended that Board members:

- Note the progress being made in developing the strategy and associated action plan to support the implementation of the strategy.
- Note the strategy, once finalised will be subject to the Council and Clinical Commissioning Board approval.

- That further reports will be provided to the Health and Wellbeing Board to up-date in relation to the implementation of the Carer's strategy and provide progress against the action plan of implementation.

3. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="4">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to specific Priority Plan objective(s)?</td></tr>
<tr><td>Yes</td><td>Council's priority:
Improve the health and wellbeing of our communities and address health inequalities.
Health and Well- being priority:
Improve adult and children carers' health and wellbeing.</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>The Carers Partnership Board are being kept informed of developments. Carers and other key stakeholders including evidence provided by Department of Health Survey for Carers, liaison with the Carers Forum, feedback from the Carers Contact Centre and other carers services</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">The draft strategy will be completed by the end of March, together with an action plan of implementation.
The strategy will then be subject to formal approval by the council and the Clinical Commissioning Group, it is anticipated final sign off of the strategy will be by June 2013.</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>The implementation of the strategy will be within existing resources. A pooled budget (Section 75 Agreement has recently been agreed.
Council contribution- £340,000/ year. This is re-occurring finance which has been allocated to carers respite services (including emergency respite) and carers support services.

CCG contribution £195,000/ year. This is made up of £125,000 allocated to carers respite (</td></tr>
</table>

		reoccurring) and £70,000 allocated to emergency response service for carers. The cost of the Carers Commissioning Officer post (Band 6 , part time 21 hours) is £23,340 is included in the above funding commitments. This post is currently jointly funded by the Council (£14,950) and heath (via the Joint Commissioning pooled budget £8,390)
LEGAL ISSUES	Yes/No	No
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact

PART B) – ADDITIONAL INFORMATION

4. INFORMATION

Background- National and policy context

4.1 The National Carers' Strategy, published in 2008, has five objectives for carers to be achieved by 2018:

- Recognised and supported as an expert care partner
- Enjoying a life outside caring
- Not financially disadvantaged
- Mentally and physically well; treated with dignity
- Children will be thriving, protected from inappropriate caring roles.

4.2 The Coalition Government refreshed this strategy retaining these aims but inserting four priority areas:

1. Supporting early self-identification and involvement in local care planning and individual
care planning
2. Enabling carers to fulfil their educational and employment potential
3. Personalised support for carers and those receiving care
4. Support carers to remain healthy

4.3 In addition the NHS Operating Framework also details specific expectations in relation to its obligations to carers which stipulates that Primary Care Trusts (PCT's) and successor CCGs are expected to work with councils to develop and promote

respite opportunities which reflect the personalisation agenda where carers are able to receive a break away from their day to day caring role.

Carers strategy-2013-2016

4.4 The carers strategy has been subject to recent consultation with a view to developing a final strategy by the end of March 2013. The strategy will be supported by an action plan of improvement based on eight key outcome areas as follows:

- Information, advice and support,
- time for yourself,
- having your say,
- planning for the future,
- feeling safe and secure,
- promotion of well-being,
- meeting diverse needs, and
- life outside of caring.

4.5 The development of the carers strategy and the action plan of improvement are based on the Joint Strategic Needs Assessment (JSNA). Detailed work has taken place during 2012 to develop a clear statement on carers and the current JSNA is being up-dated to take account of the 2011 census. At the time of the census a total of 17,944 people in Telford and Wrekin provide unpaid care (10.8% of the population).This is an increase of 1.1% on the 2001 census. Locally we are aware of approximately 2000 adult carers and approximately 230 young carers.

4.6 In developing the Adult Carers Strategy, consideration has been given to young carers and specific reference is made to younger carers which is captured in the Young Carers Strategy 2012-2015.

4.7 In producing both the strategy and the JSNA detailed and ongoing engagement has occurred with carers and other key stakeholders including evidence provided by Department of Health Survey for Carers, liaison with the Carers Forum, feedback from the Carers Contact Centre and other carers services The Health and Wellbeing stakeholder event held on the 30th January was also used as an opportunity to consult more widely with key stakeholders.

4.8 The consultation on the draft strategy ended on the 29th February and the feedback received is being incorporated into a revised document. The final strategy and associated action plan of implementation will be completed by the end March 2013.

4.9 The strategy will then be subject to formal approval processes of the council and the CCG Board. An outline of the proposed time line is as follows:

- Final draft- by end March 2013
- Council Cabinet approvals SMT, Policy and review and Cabinet April- May (Cabinet 30th May)

- Clinical Commissioning Board, May- June
- Carers Partnership Board - May
- Health and Wellbeing Board- date – May 15
- Strategy approved by June'13

4.10 Both the council and the CCG has committed to a pooled budget Agreement (Section 75) for carers respite care and other support services for carers. This demonstrates strong collaborative approach to supporting the needs of carers locally in Telford and Wrekin and the strategic approach as detailed within this report.

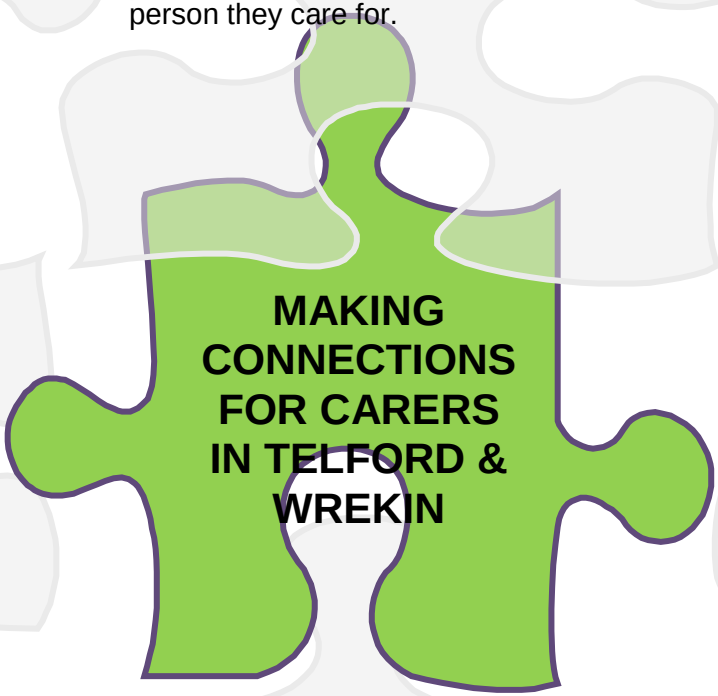
5. PREVIOUS MINUTES

5.1 This is the first report to be presented to the Health and Wellbeing Board, however reports regarding the creation of a pooled budget have been received by the CCG Board the council's Cabinet.

6. BACKGROUND PAPERS

Appendix 1(Making connections for family carers in Telford and Wrekin)

Report prepared by Christine Harrison, Service Delivery Manager, Commissioning and Contracting, 01952 381205,
Christine.harrison@telford.gov.uk



Information/Advice and Support

Early identification of carers

Up to date easy to access information given at an appropriate time.

Accessing a range of information and resources which promotes choice

Feeling Safe and Secure:

Accessing, Education and Employment.

Feeling Safe where you live.

Income Maximisation

Promoting Well Being

Accessing a range of resource which supports carers to maintain, emotionally, physically and mentally, well being

Time for yourself

Carers have a life outside caring and have choices independent to the person they care for.

Having Your Say

Acknowledging the value of carers contribution and respecting as expert partners

Partnership in planning, delivery and evaluation of quality of services

Meeting diverse needs

Meeting the diverse needs of carers

Promote opportunities for Socially disadvantaged and former carers to have a life of their own.

A life outside caring

Accessing employment, education and vocational training opportunities.

Planning for the future

Taking the pressure out of caring through pre planning arrangements and technology.

Title:	NHS Health Checks
Report to:	Health and Wellbeing Board
Author:	Ann Marie McShane, Clinical Advisor to the Health Check Programme, NHS Telford and Wrekin
Date:	13th March 2013

Purpose

This briefing provides the Board with an overview of NHS Health Checks, a nationally mandated Public Health service which will become the responsibility of Local Authority from April 2013. The report describes the national context, local performance, current services commissioned by the PCT public health team and next steps to support transition.

Why is it important?

The Public Health Outcomes Framework indicates that in Telford and Wrekin the mortality rate from preventable, premature cardiovascular disease (before the age of 75) is significantly worse than the national average for England. This includes preventable deaths from both heart disease and stroke.

Improving life expectancy and reducing the major causes of premature mortality is a Joint Health and Wellbeing Strategy priority in Telford and Wrekin. Inequalities in life expectancy and premature mortality from cardiovascular diseases (CVD) are new national Public Health Outcomes Framework indicators. Premature mortality is also included in the NHS outcomes framework indicator.

What are Health Checks?

An NHS Health Check lets people know what their risk is of developing heart disease, stroke, kidney disease or Type 2 Diabetes. Some risk factors are fixed, such as age and family history of vascular disease. Risk is also influenced by lifestyle, such as diet and physical activity, weight, alcohol intake, and whether people smoke. Everyone is at risk and everyone can reduce their risk. The Health Check lets people know what their risk is and most importantly, what they can do to reduce their risk.

The check involves a blood test, some simple measurements such as blood pressure and weight, as well as questions about lifestyle habits. The results allow an individual's risk to be calculated and tailored advice given on how to reduce their risk. For many people reducing risk can be achieved by changing lifestyle habits. People found to be at higher risk also have the opportunity to receive appropriate clinical management before any signs or symptoms of disease appear; this may include medication or referral for further tests, for example if they are found to be at high risk of developing diabetes.

The national picture

Since April 2009 PCT's have been required to offer an NHS Health Check to all adults aged 40-74 years, who do not already have a known diagnosis of heart disease, stroke, kidney disease or type 2 Diabetes. The mandated target expects 20% of the eligible population to be invited each year, on a five-year rolling programme and a 50% uptake rate is expected. Currently the numbers of people invited and seen as a percentage of the eligible population are reported to the Department of Health on a quarterly basis.

The local picture

In Telford and Wrekin the NHS Health Checks are delivered in GP practices, commissioned by the Public Health Team, through two complementary Local Enhanced Service agreements. Health Checks are carried out by practice nurses or health care assistants, using a point of care blood testing model. Results are available immediately and the check can be completed in a single visit. The programme is very well embedded from the initial start-up in 2009/10 and all except one GP practice in Telford and Wrekin are delivering NHS Health Checks.

Local performance is well ahead of target expectations for both Health Checks offered and carried out. The most recent data (for April-December 2012) show Telford and Wrekin ranking 5th of all PCTs in England on Health Checks offered. See performance detail in Appendix 1.

Development of the Health Check Programme

Fifteen Health Care Assistants and one practice nurse have recently completed an extensive training programme leading to a City and Guilds Level 3 Health Trainers Award. This means that Telford and Wrekin practices are now able to provide a unique Health Check service to their population through a well-trained clinical workforce who can confidently support patients to address lifestyle risk factors and instigate behaviour change.

From April 2013 there will be two new additions to the NHS Health Check:

***Alcohol screening*:** all those attending will be asked about their alcohol intake using a standard screening tool and will receive intervention and brief advice appropriate to their level of intake, and signposting if necessary. In January 2013, all practice staff providing Health Checks attended training to fully support the delivery of this element of the programme.

***Dementia awareness-raising*:** all those aged 65-74 at the time of their Health Check will also be offered advice and information about dementia and how to reduce the risk of developing it. The national training tool has just been released and dates agreed locally with the Clinical lead for Memory Services to deliver the required training in March 2013.

Planned next steps

The role of NHS Health Checks in the prevention arm of the proposed CCG's Long Term Conditions Strategy is currently being reviewed to strengthen and maximise opportunities. Additionally, steps are in place to develop a joint proposal with the CCG to explore the feasibility of having a dedicated team of Health Trainer's to support patients with long term conditions to make lifestyle changes.

Contact has been made with the Council's Leisure Services Department to identify opportunities for joint working; in particular agreeing referral pathways to leisure services to support the management of risk.

NHS Diabetes and Kidney Care (which supports the implementation of the NHS Health Check) and the Local Government Association (LGA) wrote to all chairs of Health and Wellbeing Boards in January 2013. The letter describes the development of a programme of information and support to local authorities in taking up their commissioning responsibility for Health Check. Public Health England is also undertaking an assessment of what support will be required from April 2013. A briefing pack for local authorities and Health and Wellbeing Boards, with detailed information on the NHS Health Check programme is also expected.

Appendix 1

NHS Health Check Performance in Telford and Wrekin
Local Targets and Performance 2012/13

		2012/13				2012/13
		Q1	Q2	Q3	Q4	
PHQ31_01	Number of eligible people who have been offered an NHS Health Check	2,000	2,300	2,050	3,111	9461
PHQ31_02	Number of eligible people who have received an NHS Health check	1,000	1,150	1,025	1,560	4735
PHQ31_03	Number of people aged 40-74 eligible for an NHS Health Check in 2012/13	47305				47305
PHQ31_04	Percentage of eligible people who have been offered an NHS Health Check in 2012/13	4.23%	4.86%	4.33%	6.58%	20.00%
PHQ31_05	Percentage of eligible people that have received an NHS Health Check in 2012/13	2.11%	2.43%	2.17%	3.30%	10.01%

Performance Update		2012/13			2012/13	YTD % Annual Target	Total Ytd
		Q1	Q2	Q3			
SQU27_01	Number of eligible people who have been offered an NHS Health Check	3917	2969	3784	9461	113%	10,670
SQU27_02	Number of eligible people who have received an NHS Health check	1592	1558	1509	4735	98%	4,659
SQU27_03	Number of people aged 40-74 eligible for an NHS Health Check in 2012/13	47305	47305	47305	47305	% Population Invited/Screened	
SQU27_04	Percentage of eligible people who have been offered an NHS Health Check in 2012/13	8.3%	6.3%	8.0%	20.0%	22.6%	
SQU27_05	Percentage of eligible people that have received an NHS Health Check in 2012/13	3.4%	3.3%	3.2%	10.0%	9.8%	

Title:	Tobacco Control and Smoking Cessation Services
Report to:	Health and Wellbeing Board
Authors:	Vicki Pike, Health Improvement Commissioner, NHS Telford and Wrekin Helen Onions, Public Health Specialist, NHS Telford and Wrekin
Date:	13th March 2013

Purpose

This report provides the Board with an update on local arrangements for tobacco control and smoking cessation services.

Why it is important?

Smoking is the single biggest cause of preventable deaths in England. Nationally smoking causes more than 81,400 premature deaths each year[i]. The British Medical Journal has described this situation as 'death on an industrial scale'.

Smoking is implicated in the causation of, and survival from almost every disease process. It is the direct cause of many common illnesses, most of which only become apparent after many years of smoking. In England in 2009 smoking was responsible for:

- 35% of all deaths from respiratory diseases
- 29% of all deaths from cancers
- 14% of all deaths from circulatory diseases
- 6% of all deaths from diseases of the digestive system

Local Context

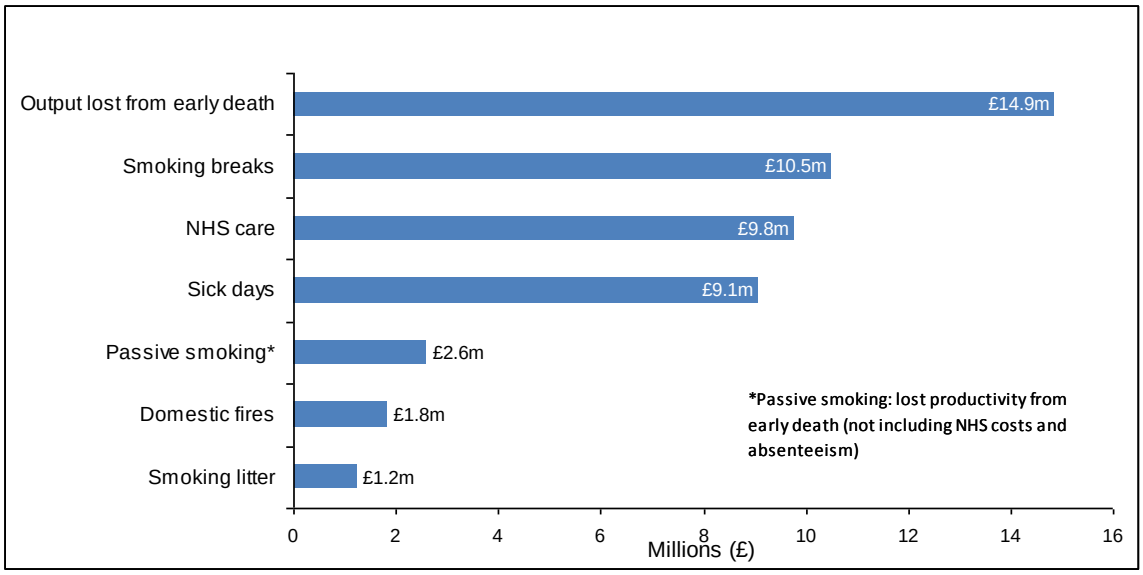
Intelligence from the Joint Strategic Needs Assessment indicates the following for Telford and Wrekin:

- Over a fifth (23.5%) of adults over 18 years (circa 32,000 people) were estimated to be smokers in 2010/11. This estimated smoking prevalence is statistically significantly higher than the England average (20%), but not statistically different from the West Midlands average (19.5%)
- Maternal smoking at time of delivery was 22.7% in 2011/12 (524 with women smoking during pregnancy). This rate is statistically significantly worse than both the average for England (13.2%) and the regional average for West Midlands (15.4%)
- There are an estimated 259 deaths due to smoking-related diseases every year. The smoking attributable mortality rate during 2008-10 was 238 per 100,000 population, which was statistically significantly worse than both the England average (211 per 100,000) and West Midlands average (209 per 100,000)

The national campaigning public health charity ASH (Action on Smoking and Health) has developed an economic model[ii] that provides estimates of the local economic impact of smoking on smokers, the NHS and the broader community. The model for Telford and Wrekin estimates the annual cost of tobacco products to local smokers is circa £56.6 million, with £43.1 million of that spend going to the exchequer.

The financial impact of smoking on the local community is estimated to be £49.9 million. Figure 1 shows the different elements of the estimated financial impact of smoking on the community in Telford and Wrekin.

Figure 1 Financial Impacts of Smoking in Telford and Wrekin



Tobacco Control and Smoking Cessation in Telford and Wrekin

There are two broad responses proposed to deliver improved tobacco control across Telford and Wrekin:

- The development of a Telford and Wrekin Tobacco Control Commissioning Partnership
- The provision of high quality smoking cessation services

The Tobacco Control Commissioning Partnership is a developing multi-agency partnership, which has proposed the following three areas of operation:

- An intelligence driven multi-agency partnership approach
- Coordination of strategic measures to ensure effective tobacco control across the partnership
- Facilitation of the tobacco control response across the partnership

Historically, the smoking cessation services commissioned by the PCT have produced impressive quit rates year-on-year. However, the uncapped nature of the Payment by Results tariff pilot has presented financial challenges.

From April 2013 local authorities will become responsible for commissioning tobacco control services, including smoking cessation services. Telford and Wrekin Council's procurement team are leading the tendering process for stop smoking services for 2013/14. The tendering process, which will start in March 2013, will award new contracts from 1st August 2013. The three lots are being tendered are outlined in Table 1, the value of the contract for stop smoking services will be circa £600k.

A contingency plan to ensure continued service delivery between March-July 2013 is being developed by the procurement team in the local authority and the public health commissioner for smoking.

Table 1: Stop Smoking Service Tender Outline

Lot number	General Description	Activity levels
1	Stop Smoking services for the general population (core service)	1500 x 4 week quits
2	Stop Smoking services for the general population (out of hours service)	500 x 4 week quits
3	Smoking in pregnancy – Midwifery and community	150 x 4 week quits

Planned next steps

Reducing the number of people who smoke is one of the ten strategy priorities agreed by the Telford and Wrekin Health and Wellbeing Board. The Tobacco Control Commissioning Partnership will manage and oversee the following in 2013/14:

- Further development of the commissioning partnership
- Contract monitoring of stop smoking services
- Development of a Telford and Wrekin Tobacco Control Strategy
- Asset mapping work for the smoking priority as part of the joint health and wellbeing strategy

Stakeholders participating in the local health and wellbeing engagement event held on 30th January identified preventative strategies and plans aimed at stopping young people starting to smoke as a key area for development.

In 2013/14 the Director of Public Health and her team will lead the development of a plan which will specifically target pregnant women who smoke. It is envisaged that a service will be actively developed and delivered within the local healthcare community. An effective partnership between the CCG, Maternity Services, Stop Smoking Services, Children and Family Centres and Community and Voluntary Services will be crucial to improving outcomes and reducing inequalities in this area. The CCG have recognised maternal smoking as a key local issue and have identified reducing the number of women who smoke at delivery as one of their three priorities for 2013/14.

For further information please contact Vicki.pike@nhs.net

[i] http://www.ash.org.uk/files/documents/ASH_107.pdf
[ii] http://ash.org.uk/localtoolkit

Title:	Children and Young People - Health Promotion
Report to:	Health and Wellbeing Board
Authors:	Sarah Evans, Health Improvement Commissioner, NHS Telford and Wrekin Helen Onions, Public Health Specialist, NHS Telford and Wrekin
Date:	13th March 2013

Purpose

This briefing provides the Board with an overview of the health promotion services for children and young people currently commissioned by the PCT in Telford and Wrekin, in the wider context of the Healthy Child Programme.

Introduction to the Healthy Child Programme

The Healthy Child Programme (HCP), issued by the Department of Health in 2009, is an early intervention and prevention public health programme for all children. It sets out the recommended framework for universal and progressive services for children, young people and their families to promote optimal wellbeing:

- **The Healthy Child Programme: Pregnancy and the first five years of life** is led by the health visiting team. It offers every child a programme of screening tests, an immunisation schedule, health and development reviews, health promotion guidance and support for parents tailored to need, with additional support as required at key times
- **The Healthy Child Programme: From 5-19 years** is led by the school nursing service. The good practice framework sets out a universal service for all 5-19 year olds with additional services for those with specific needs and risk factors.

Why is it important?

The first years of life are one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down, and it is a time when parents are particularly receptive to learning and making changes. Focusing on early intervention and prevention, rather than on treating problems after they develop, is both socially and economically more effective in the long term. Supporting children and young people through childhood and adolescence into adulthood lays the foundations for a healthy, fulfilled life. Lifestyle and habits established during childhood, adolescence and young adulthood influence a person's health throughout their life.

A focus on prevention and early intervention has a vital role to play in breaking the cycle of health inequalities within families. Certain groups of children and young people have particular vulnerabilities and susceptibility to poor health outcomes. The HCP seeks to reduce health inequalities and meet the needs of the most 'at risk' children, young people and families, through a universal model with additional targeted support.

Future delivery of the Healthy Child Programme: Pregnancy to 5 years old

From April 2013, the NHS Commissioning Board will be responsible for commissioning public health services for children from birth to five years, including health visiting, family nurse partnership and Child Health Information Systems. Responsibility for commissioning public health services for the under fives is then due to transfer to local authorities in 2015.

Future delivery of the Healthy Child Programme: 5 to 19 years old

From April 2013 local authorities will become responsible for commissioning the HCP for school aged children (5-19 years), including the school nursing service.

Schools have an important role to play in promoting healthy lifestyles and providing extra support to at risk children. It is recommended that the HCP is delivered in schools by School Health Teams who provide a key link between health, education and wider children and young people's services, providing guidance and support on a range of health related issues. The composition of School Health Teams varies from locality to locality according to local needs and service configurations, with school nurses at working with a range of other professionals and support staff locally.

Key health priorities included in the HCP are as follows:

- Breastfeeding
- Promoting health weight
- Unintentional injury
- Emotional health and wellbeing
- Teenage pregnancy and sexual health
- Drugs, alcohol and tobacco

Tackling Healthy Child Programme Priorities in Telford and Wrekin

Promoting healthy weight and supporting breastfeeding

An outline of the local services commissioned to promote healthy weight and prevent and manage obesity and also breastfeeding support services were included in the obesity briefing to the Health and Wellbeing Board in January 2013. Please refer to this report for further details of these programmes.

Unintentional injury

The Telford and Wrekin unintentional injury strategy and action plan for children and young people has recently been reviewed and refreshed. This involved a multi-agency stakeholder workshop to map current activity and identify gaps against the recommendations made in the National Institute of Health and Clinical Excellence (NICE) public health guidance. The strategy and provides a multi-agency framework aimed at preventing unintentional injuries in children and young people in Telford and Wrekin. The action plan forms an evidence-based programme of activities, which are led by relevant partner organisations.

Emotional health and wellbeing

Improving emotional health and wellbeing and delivering a comprehensive range of CAMHS is central to the HCP. Early intervention is crucial when young people first experience mental distress, by building their resilience and providing them and their families with appropriate support. A briefing on mental health promotion was provided to the Health and Wellbeing Board in January 2013, please refer to this report for further details.

Teenage pregnancy and sexual health

A new contract for Contraception and Sexual Health Services in Telford and Wrekin will start from 1st April 2013, following a competitive tender exercise. The revised service specification reflects the latest evidence base, including clinical and professional standards and guidelines. The majority of contraception and sexual health services in Telford and Wrekin will be commissioned through one contract, which has recently awarded to Staffordshire and Stoke-on-Trent Partnership NHS Trust.

Historically, there has been limited sexual health promotion work in Telford and Wrekin due to reliance non-recurring monies for campaign work which have not been recently available. All sexual health consultations by clinicians should involve an appropriate level of sexual health promotion, rather than focussing purely on the presenting complaint. The new service specification has been significantly strengthened in the area of sexual health promotion and prevention. It includes a planned calendar of monthly campaigns and an increased emphasis on encouraging and enabling self-management and informed decision making.

Drugs alcohol and tobacco

The public health team currently commission Shropshire Community Health Services NHS Trust Health Improvement Team to deliver school, college and community-based alcohol health promotion information and workshops sessions for children and young people and their parents and carers. These sessions are based on the Chief Medical Officer recommendations and are delivered in a fun and interactive way where possible and tailored to the needs of the individual or group.

A separate briefing on tobacco control and smoking cessation programmes is provided with these Health and Wellbeing Board papers for information.

Please contact sarah.evans24@nhs.net for further information

Title:	Making Every Contact Count and Healthy Lifestyles Hub
Report to:	Health and Wellbeing Board
Author:	Louise Mills, Head of Health Inequalities and Lifestyles, NHS Telford and Wrekin
Date:	13th March 2013

Purpose

The purpose of this briefing report is to provide an update of the progress made towards implementing "Making Every Contact Count" (MECC) in Telford and Wrekin and to report the outcomes of the Healthy Lifestyles Hub pilot project. Both programmes of work contribute to reducing inequalities in health outcomes associated with lifestyle behaviours.

Background

Investing in the prevention of ill health can produce enormous benefits. It has been estimated that at least 80 per cent of all premature heart disease and over 40 per cent of all cancers could be prevented through healthy diet, regular exercise and by not smoking.

MECC is one of the five "ambitions" of NHS Midlands and East. Initially focused on NHS organisations, the ambition is to systematically utilise the millions of contacts that people have with providers of health and social care to deliver brief advice on healthy lifestyle behaviours and to signpost people to appropriate behaviour change services. NHS Telford and Wrekin is working in close partnership with Shropshire County PCT to provide support to the local NHS provider Trusts for the rollout of MECC; some elements of the Telford and Wrekin MECC delivery plan are being delivered jointly with Shropshire County PCT.

To support MECC implementation, guidance from the Strategic Health Authority recommended that local areas establish a referral system to enable staff trained to be able to refer appropriate clients into lifestyle services. Locally this development work had already been undertaken. During 2011/12 and following a period of consultation and engagement with clinicians, stakeholders, patients and members of the public, the public health team identified widespread support for a single point of access into lifestyle services to simplify the referral process for professionals and the public. Working in partnership with Telford and Wrekin Council, the Shropshire Community Health NHS Trust were commissioned to develop and deliver the Healthy Lifestyles Hub from First Point, Civic Offices (now operating from Addenbrooke). The service was officially launched in August 2011, with a full complement of staff from December 2011.

The Healthy Lifestyles Hub provides members of the public with access to: health information; over the phone advice and signposting; face to face brief interventions; health trainer support; and onward referral to specialist programmes for weight management, physical activity, smoking cessation, alcohol and emotional health and wellbeing. A vital part of the service is providing a central point of contact for professionals referring patients,

clients and service users for health information, advice and support to access quality assured Lifestyle Risk Management Services.

Progress to date

- All local NHS provider Trusts (Shrewsbury and Telford Hospital NHS Trust, Robert Jones Agnes Hunt, Shropshire Community Health NHS Trust and South Staffordshire and Shropshire Healthcare NHS Foundation Trust) have a Board level lead for MECC
- All local NHS provider Trusts have a MECC implementation lead and an agreed implementation plan
- Not including South Staffordshire and Shropshire Healthcare NHS Foundation Trust, total activity delivered in Q1 – Q3 combined includes:
    - 286 NHS frontline staff have completed MECC training
    - 6,000 MECC contacts by these trained staff
    - 1,663 referrals to smoking cessation services on the back of these contacts
    - 56% of those referred in this way have (to date) accessed smoking cessation services
    - Of those accessing smoking cessation services, 44% have achieved a 4-week quit
    - In addition, a further 350 referrals into other lifestyle risk management services

Total activity delivered from the Healthy Lifestyles Hub in Q1 – Q3 combined includes:

- 11,700 adults received opportunistic brief advice (less than 5 minutes)
- 3525 adults received a brief intervention (5 minutes – 30 minutes)
- 653 adults referred for an extended brief intervention (6 – 12 week lifestyle risk management service)
- 78% of those referred have accessed lifestyle risk management services. Health outcomes for adults that have completed an extended brief intervention will be reported at the end of Q4
- 608 adults have received support to agree a personalised health plan – to date 70% have achieved their healthy lifestyle goals (increased physical activity levels; improved emotional health and wellbeing; weight loss; a reduction in alcohol consumption; quit smoking)

Planned next steps

Although full guidance has not yet been received, it is understood that Clinical Commissioning Groups (CCG's) will lead MECC from 2013/14 with public health support. Information received (24th January 2013) from the Midlands and East SHA Cluster highlights the continuing importance of Making Every Contact Count as a key contributor to achieving the health outcomes in Domain 1 of the NHS Outcome Framework; reducing premature mortality. MECC will be supported by Public Health England and embedded in the training and education of health professionals via Local Education and Training Boards. Within local health economies local authority public health staff will support CCG's to embed MECC in health care contracts and work with local providers to sustain and build on their

achievements to date. MECC has been included in the agreement for the provision of Healthcare public health advice to the CCG. The CCG have identified a lead Director and officer support to take forward this programme of work with Public Health.

Discussions are also taking place with senior officers from the Council to consider the potential rollout of MECC to the wider non-NHS frontline workforce. The initial focus is to provide MECC training for frontline staff working at First Point, Wellington Civic and Leisure Centre and Madeley Library.

A service evaluation, including service user feedback and an audit against service standards is currently being completed for the Healthy Lifestyles Hub. The outcomes will inform further development of the service during 2013.

BOROUGH OF TELFORD & WREKIN

HEALTH AND WELLBEING BOARD – 13 MARCH 2013

HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

REPORT OF THE PARTNERSHIP AND PLANNING MANAGER

1. SUMMARY

1.1 The report updates HWB members on the revised Terms of Reference for the Telford and Wrekin Health and Wellbeing Board

2. RECOMMENDATIONS

2.1 Members note the revised Terms of Reference for the Telford and Wrekin Health and Wellbeing Board

3. INFORMATION

3.1 The Health and Social Care Act 2012, sets out the establishment, functions and supplementary information relating to the Health and Wellbeing Board. The Act places a statutory responsibility on the Council to have a Health and Wellbeing Board in place from 1st April 2013.

3.2 Further regulations come into force on 1st April which will allow the Health and Wellbeing Board to function as a committee of the local authority. There is some opportunity for local determination, as has been previously discussed.

3.3 The attached revised Terms of Reference for the Health and Wellbeing Board covers all the key points.

3.4 The Council's Constitution Committee at their meeting on 19th February 2013, have agreed the Terms of Reference and the key points will be included as recommendations to Full Council on 7th March 2013.

Report prepared by Clare Hall-Salter, Partnership and Planning Manager
clare.hall-salter@telford.gov.uk , 01952 382016

Telford and Wrekin Health and Wellbeing Board (HWB)

Terms of Reference

Date: February 2013

Background

The White Paper *Equity and excellence: liberating the NH,* published in 2010, set out the Government's strategy for the NHS. The consultation document, '*Local democratic legitimacy in health*', gave further information on proposals for increasing democratic legitimacy in health and included the proposed establishment of local Health and Wellbeing Boards. The *Health and Social Care Act 2012,* sets out the establishment, functions and supplementary information relating to the Boards. The legislation places a statutory responsibility on the Local Authority to take on its full statutory role from April 2013 and to have a Joint Health and Wellbeing Strategy in place. The HWB will be a formal Committee of the Council.

Important areas to be highlighted are:

- The transfer of commissioning to GPs
- The abolition of primary care trusts and strategic health authorities
- Transferring the public health budget and responsibility to local authorities
- Giving local authorities the responsibility to promote integration and partnership by working through statutory health and wellbeing boards

Aims of the HWB

1. The HWB is responsible for guiding and overseeing:
    a. The ongoing development of the joint strategic needs assessment (JSNA)
    b. Developing a high-level joint health and wellbeing strategy (JHWBS), based upon the findings of the JSNA
    c. The establishment of sound joint commissioning arrangements
    d. The development of HealthWatch forum for public and patient engagement and involvement
    e. The transfer of Public Health responsibilities and arrangements to the local authority

2. The HWB will provide a key forum for public accountability of NHS, social care for adults and children and other commissioned services that the HWB agrees are directly related to health and wellbeing in Telford and Wrekin.

3. The HWB has a duty to encourage integrated working between local health, social care and health-related commissioners.

4. The HWB will have a link to the overarching Telford and Wrekin Local Strategic Partnership but will also very much function in its own right. The HWB will work closely with the Children, Young People and Families Board, Safer Community Board, in addition to the existing adult partnership boards, in order to ensure the focus on the improved health and wellbeing outcomes for the whole population of Telford and Wrekin.

Objectives of the HWB

1. To lead on the development of a Telford and Wrekin Joint Health and Wellbeing Strategy (JHWBS) for residents which drives health improvement, plans to deliver this strategy and keeps the implementation of these plans under review.

2. Through the JHWBS, to oversee a commissioning programme of service and/or pathway redesign to better meet the needs of patients and service users and to deliver improved outcomes. Successful delivery of this will be dependent on the HWB developing effective management mechanisms with both primary care and secondary care providers where relevant or appropriate.

3. To link into the Local Strategic Partnership, Strategic Boards and associated Partnership Boards, making recommendations to Full Council, NHS Commissioning Board, and the Clinical Commissioning Group Board, as appropriate.

4. To analyse the priorities for deployment of health and care resources in the area based on information collected through the JSNA and other sources.

5. To consider options and opportunities to maximise the impact of aligning the deployment of resources of the health and care agencies in the area on agreed priorities. This will include the joint commissioning of health and social care services for children, families, and adults in Telford and Wrekin, to meet identified needs and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

6. To oversee the development of this proposed joint commissioning activity, ensuring any proposed activity is aligned with local priorities and levels of need and is undertaken within available resources. To consider options for joint commissioning and procurement between relevant organisations to support this work.

7. To oversee all areas of health and social care commissioning activity for people of all ages, to ensure that commissioning priorities are in line with those set through analysis of the JSNA and the local JHWBS. This commissioning activity includes all local services commissioned by Telford and Wrekin CCG, Telford and Wrekin Council, Joint Commissioning CCG/Council and NHS Commissioning Board, which could include local: specialised services; secondary dental care; general dental

services; GP services; general ophthalmic services; pharmaceutical services; any services for the Armed forces or Offenders; and other primary care.

8. To consider options for the development of HealthWatch and establish relevant joint working groups in order to undertake this work, ensuring that appropriate engagement and involvement with existing patient and service user involvement groups takes place.

9. To consider appropriate arrangements for the transfer of Public Health responsibilities to Telford and Wrekin Council, and to propose and consider relevant governance and organisational structures to support this work.

10. To keep under review, the financial and organisational implications of joint and integrated working across health and social care services, ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

11. To identify and act upon changes that may be required following new guidance to establish a formal Health and Wellbeing Board.

12. To propose recommendations, as appropriate to:

    a. Telford and Wrekin Council's Full Council
    b. NHS Commissioning Board
    c. Telford and Wrekin Clinical Commissioning Group Board

13. To ensure that the HWB works to promote the achievement of the objectives of the organisations represented on the Board, including the establishment of the Council's new health improvement responsibilities.

Membership

Members of the HWB will comprise representatives from the Clinical Commissioning Group, Council, Healthwatch (currently LINKS) and NHS Commissioning Board. The core members are:

- Cabinet Member responsible for wider Health services and Deputy Leader TWC (Chair HWB)
- Cabinet Member for Adult and Social Care
- Cabinet Member for Children, Young People and Families
- Cabinet Member for Leisure and Wellbeing
- Director responsible for Adult Social Care
- Director responsible for Children's Services
- Director of Public Health

- Local Area Team NHS Commissioning Board representative
- Chair of Telford and Wrekin Clinical Commissioning Group (CCG) (Vice Chair HWB)
- Non Executive Director from Clinical Commissioning Group
- Chief Operating Officer CCG
- Representative of local Healthwatch/LINks
- Each opposition Group with 4 or more elected members shall have one place on the Health and Wellbeing Board with voting rights.
- Such other persons, or representatives of such other persons, as the Local Authority thinks appropriate

Attendance and support from such other persons, according to the agenda, including:

- Assistant Directors responsible for Commissioning (AD Care & Support for Adults plus AD Family & Cohesion for Children)
- Assistant Director: Social Care Specialist
- Director of Commissioning, CCG

This reflects the statutory minimum membership in the Health and Social Care Act. The members of the Board will be advised and supported by officers from the local authority and CCG.
Members agree to share all relevant information and data, to allow performance, and other joint working arrangements, to be properly monitored and managed.

Disqualification for Membership

Any person who would be disqualified from being able to stand for election as a councillor will be disqualified from being a member of a committee or sub-committee of a local authority. The regulations state that these disqualifications will be retained for HWB, but the regulations will ensure the disqualifications do not apply to HWB in so far as they cover disqualifications in respect of members of the board holding any paid employment or office in the local authority – this allows the Directors of Adult Social Services, Children's Services and Public Health to be formal members of the HWB. The following disqualifications will be retained for members of the HWB:

- Being the subject of a bankruptcy restrictions order or interim order
- Having been convicted in the United Kingdom, the Channel Islands or the Isle of Man of any offence and has had passed a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine

Voting Rights

All Members of the HWB will be able to vote alongside the elected representatives. This applies to any additional board members appointed in addition to the statutory membership set out in the Health and Social Care Act 2012.

Meetings

The Health and Wellbeing Board will meet bi-monthly. Dates and times of meetings will be agreed and published in advance.
Agendas and supporting papers will be issued at least five clear days before each meeting and action notes will be produced, confirmed as a true record of the meeting and signed by the Chair.
Members of the public, and press will have access to the meetings. Protocol to be developed and agreed by HWB.

Quorum

Quorum of one quarter is required, cross section of partners represented, (the minimum number of members that need to be in attendance before decisions can be taken). Business shall not be transacted at a meeting of any Council Committee unless at least one quarter of the whole number of the Committee is present.

Code of Conduct and Declaration of Interest

The HWB will adopt the Council's code of conduct. Any interests in item(s) on the agenda should be declared at the start of the meeting.

Access to Information/Transparency Provisions

Meetings of the HWB will be held in public, although the press and public may be excluded during consideration of any matter which would involve the disclosure of confidential or exempt information.
The agenda and papers for meetings of the Board, except for any documents that may disclose confidential or exempt information, will be made available for public inspection five days before the meeting.

Reporting Mechanisms/Accountability

The HWB, as a Committee of the Council, will report to Full Council.
The HWB will regularly update the Telford and Wrekin Local Strategic Partnership with its progress and specific contributions to achieving the vision and priorities of Telford and Wrekin.
The actions of the HWB will be subject to independent scrutiny by the relevant members of the Overview and Scrutiny Committee of the Council.

The Board will review its structure, membership and activities in response to any further guidance.

Establishment of Sub-Committees

The HWB will be able to establish sub-committees and delegate functions to them.

Scrutiny

Health scrutiny function and powers will be delegated by Full Council to the relevant Scrutiny Committee and the power of referral to the Secretary of State is also delegated to this Scrutiny Committee. Scrutiny Committee will notify Full Council of an intention to refer a matter to the Secretary of State before a referral is made.

BOROUGH OF TELFORD & WREKIN

HEALTH AND WELLBEING BOARD – 13 MARCH 2013

HEALTH AND WELLBEING BOARD ENGAGEMENT & DEVELOPMENT

REPORT OF THE PARTNERSHIP AND PLANNING MANAGER

1. SUMMARY

1.1 The report updates HWB members on:

- HWB stakeholder engagement event
- LGA HWB Development Workshop

2. RECOMMENDATIONS

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

2.2 Members agree to hold the next HWB Stakeholder event in September 2013.

2.3 Agree the focus of the final LGA development session

3. INFORMATION

3.1 HWB Stakeholder Engagement Event January 2013

Our second HWB stakeholder engagement event was held on Wednesday 30th January. The agenda was developed in order to provide an update on progress on those areas that were discussed at our first stakeholder event in July 2012, and to launch the HWB strategy, its priorities and principles. During the event, workshops were held to inform the asset mapping around our priorities, including an update on each priority from the Priority Lead Officer.

Each attendee was given the opportunity to choose two priority areas to work with the Priority Leads and Board Member Sponsors during the event.

There was also an opportunity for stakeholders to put any 'relevant' questions to the HWB members who were present during the event.

The feedback from those who attended was very positive and a summary of the evaluation can be seen in Appendix 1.

Next steps

The information gained from the discussions together with key messages has now been collated and will be available for all via the HWB website: www.telford.gov.uk/hwb

This information will be used by the Priority Leads to further develop the improvement action plans for each respective priority area. Each priority area will also now develop specific outcome measures which will underpin the performance framework for the HWB Strategy. These measures of performance will be monitored regularly, with highlight reports being brought to the HWB to show the impact we are making against the priorities identified in the strategy throughout 2013/14.

Stakeholders and providers are keen to be involved in the on going development and delivery of the priorities and as such Priority Leads will continue to involve and engage with our stakeholders and providers in their work to improve outcomes for the community.

It is proposed that we hold the next Stakeholder event in September 2013, in order to update on the progress that will have been made during the first six months of our first year as a statutory Health and Wellbeing Board.

3.2 **LGA HWB Development Support**

As previously discussed, we have been allocated up to 4 days support until March 2013. We have had two such sessions facilitated by the LGA to date in order to develop our role and agenda which we want to pursue linked to our strategy and what powers/influence we will have to make sure we can deliver, together with looking at Board structure and operation - how we keep a tight decision making Board but ensure engagement/input from local people/client groups, providers and partners.

The first development session with the LGA facilitator Liam Hughes took place on 11th October. The Board used the structure of the LGA Development Tool to explore their strengths and opportunities for improvement.

The second development session took the form of a provider engagement work shop which was held on 9th January 2013, facilitated by Liam Hughes and Francis Stickland. Representatives of 7 key health provider organisations were invited to discuss their thoughts around future engagement with the HWB and the possible mechanisms for this engagement.

It is proposed that the final LGA development work shop, which will take place on Wednesday 27th March, for the Board members and support officers, will concentrate on exploring what difference the Board will make as a collective. The work shop will again be facilitated by Liam Hughes and Francis Stickland.

4. PREVIOUS MINUTES

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

4.2 Board Structure/Representation/Role report 12th September 2012.

4.3 Health and wellbeing Board Development 14th November 2012.

4.4 Health and Wellbeing Engagement Report 23rd January 2013.

5. BACKGROUND PAPERS

5.1 Health and Social Care Act 2012.

Report prepared by Clare Hall-Salter, Partnership and Planning Manager
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Appendix 1:The Future of Health and Wellbeing in Telford and Wrekin

Stakeholder Event – Wednesday 30 January 2013

Total of 102 attendees:

64 Stakeholders
8 HWB Board members
14 Priority Leads/assistants
16 Support Officers

Participant Evaluation Number of Responses = 42

Question 1: The words that best reflect views on the session:

Interesting 29	Important 29	Relevant 29	Complicated 6	Enjoyable 9	Clear 3
Comfortable 5	Rushed 1	Thorough 3	Confusing 3	Boring 1	Irrelevant 1

Question 2: Agreement to statements:

I was given enough notice to make arrangement to attend this session

Yes	No
40	2

I was given enough information beforehand to understand the purpose of the session

Yes	No
35	7

I feel that today's session has been a good use of my time

Yes	No
41	1

Question 3: How far do you think the aims of this session were met?

Fully	Partly	Not at all
13	29	

Remark from Question 3:-

- I am not sure what the aims were

Positive Comments

- Pleased to see so many delegates, but would like to see more younger people

participate.

- A very valuable opportunity to influence strategy and to network with other providers
- Made a contact for support to offer staff training.
- Please carry on with these events – cross fertilisation of ideas from different experiences/fields is invaluable to gathering a breadth of views /ideas
- Good opportunity to share thoughts, experiences and ideas.
- Much is achieved by bringing so many people together to network and develop the synergies that have not yet occurred to any degree.
- Very encouraging to see the progress from the meeting in July, and in particularly an increase in the variety of people in attendance.

Areas of Improvement

- There was a lot of jargon e.g. cross-cutting principles, mapping, stakeholders, voluntary sector etc. Which ought to be defined.
- A huge subject to understand and participate on when it is not your full time occupation.
- Seriously folks, your introductory speakers needed to be a bit more about PASSION, PEOPLE & POSSIBILITIES and less about PROCESS. Enthuse us!
- Was only able to attend half the event/useful discussion but didn't feel that any firm conclusion was drawn at end of discussion.
- Chose groups beforehand.
- Needed more time for outcome based workshops.
- Circulate agendas would be useful. Handouts of presentations would have helped more. Frequency of these HWB events needs to be better – left too long between events – given the changes and the speed of change – sharing info, development of program needs to be better. Still not convinced that Telford CCG has a clear understanding of services that provide preventative roles of outcomes. G.P.'s' certainly need to be aware and have an understanding of FAC of self funders.
- All priorities are complex – There isn't just one solution. Needs a more holistic approach to individuals Health & Wellbeing need to target resources carefully.

Actions Required

- Lots of talk now for some action.
- Event should take place every 6 months with feedback on progress from current event.
- Ensure feedback obtained from event is fed back to participants.
- A network session where agencies can discuss methods of working together in the future, to ensure each partner is working efficiently and are making impact in their priority area.
- To engage and communicate with voluntary and community sector assembly would be useful hosted within council.

HEALTH & WELLBEING BOARD
MARCH 13 2013
PROGRESS REPORT HEALTH & WELLBEING STRATEGY AND JOINT STRATEGIC NEEDS ASSESSMENT
REPORT OF DELIVERY & PLANNING MANAGER AND PUBLIC HEALTH SPECIALIST

1. Purpose

1.1. This report presents the final Health & Wellbeing Strategy 2013/14 - 2015/16 for approval and provides an update on progress developing the delivery model against the priorities and performance framework. Further development of the Joint Strategic Needs Assessment (JSNA) process is also described.

2. Recommendations

That the Board:

- **Approve the final draft of the Health & Wellbeing Strategy**
- **Note the arrangements for progressing priority and 'making it happen' work programme**

3. Health & Wellbeing Strategy

3.1. The Health & Wellbeing Strategy is presented in Appendix One for approval. Core to the strategy are the priorities which the Board will oversee improvement against. Each priority has a Board sponsor and lead officer as set out below:

Priority		Lead Officer	Board Sponsor
1	Reduce excess weight in adults and children	Clare Harland	Cllr Arnold England
2	Reduce teenage pregnancy	Chris Marsh	David Evans
3	Improve emotional wellbeing	Michael Bennett	Dag Saunders
4	Support people with autism	Richard Smith	Dylan Harrison
5	Reduce the number of people who smoke	Vicki Pike	Paul Clifford
6	Reduce the misuse of alcohol and drugs	Michael Bennett (Barbara Jones)	Laura Johnston
7	Improve carer's health and wellbeing	Christine Harrison (Jill Tiernan)	Cllr Paul Watling
8	Improve life expectancy and reduce health inequalities	Louise Mills/ Helen Onions	Cllr Richard Overton
9	Support people to live independently	Karen Kalinowski (Christine Harrison)	Dr Catherine Woodward
10	Support people with dementia	Kim Grosvenor	Dr Mike Innes

3.1. The role of the champion is:

- To act as a Board champion for the priority
- To support in a mentoring and advisory capacity the priority lead officer, meeting up on at least a quarterly basis, but also being available more reactively as issues demand
- To QA and sign-off priority assurance reports produced by the officer lead before presentation to the Health Wellbeing Board, Children, Young People & Families and CCG Boards

3.2. The Board Sponsor will not discharge a line manager role for the officer lead (unless already acting in that capacity). Any performance issues will be dealt with by respective line managers, having been raised by the Board Sponsor.

4. Delivering the Strategy

4.1. A series of key actions were derived from the stakeholder discussions at the engagement event on 30th January. These actions will contribute to the asset mapping work being undertaken for each of the priorities. Priority leads will be expected to complete asset mapping for their lead areas between April-June 2013. The Board will receive a progress update on this work in May.

4.2. The Board supported the development of an annual 'making it happen' focus for the strategy. Actions identified at the stakeholder event and during the asset mapping process will be used to define the 'making it happen' work programme. Some common themes were identified at the engagement event through the 'priority workshops', including: improved communication with the stakeholders and the community to raise awareness of health and wellbeing issues, promote messages and signpost to local services, for example:

- Increased use of community champions and real-life local stories
- Fully capitalise on the new Telford Loyalty Card
- Stronger involvement with community and voluntary services and local charities
- Development of training across stakeholder organisations to deliver Making Every Contact Count

4.3. The actions agreed which will be delivered by Council teams are a key part of the developing Public Health Vision for Telford and Wrekin Council. One of the key elements of this work is the strengthening of actions to improve population health in a fully integrated way across a range of functions within the Council.

4.4. A detailed performance framework for the strategy is currently in development. This builds on the set of outcome measures outlined in the strategy, drawing together other key indicators from the national performance frameworks for the NHS, Public Health and Adult Social Care. The Director of Public Health Annual Report for 2012/13 will be presented at the Board meeting in May. The report will be structured around the new national Public Health Outcomes Framework and will consider trends over time in detail as well as presenting new indicators.

5. Taking the Joint Strategic Needs Framework Forward

5.1. Since the last Heath & Wellbeing Board we have continued to develop the JSNA. These developments include:

- Publication of State of the Borough Report – an overview report drawing together core messages from JSNA reports. This will be refreshed annually.
- 2011 Census 'Key Messages' presentations (to the Council's Senior Management Team, Managers and Team Leaders, CCG Planning, Performance and Quality Committee and the LSP Executive) and development of topic briefing notes – see www.telford.gov.uk/downloads/download/1362/2011_census_updates
- Benchmarking against the Public Health Outcomes Framework
- Development of 'Children Centre' profiles
- Review and redesign of the JSNA 'facts & figures' website www.telford.gov.uk/factsandfigures

5.2. A meeting has been arranged with the voluntary and community sector (Chief Officer Group) on 25 March to explore how the knowledge and evidence of 'need' in the community understood by these organisations can be used to inform the JSNA.

5.3. The first meeting of the JSNA Development Group will take place on 4 April. This group will determine how we use our available analytical resources to develop JSNA products. From this, we will agree a JSNA work programme for the coming year – which will be presented to the Board.

Telford and Wrekin

Health and Wellbeing Strategy 2013/14 to 2015/16

NHS
Telford and Wrekin
Clinical Commissioning Group

a co-operative council

Telford & Wrekin
COUNCIL

Foreword

In the Borough, people's health and wellbeing is improving and more of the population are maintaining a good quality of health for longer and later into life. However, our Joint Strategic Needs Assessment process has identified communities within the Borough where we need to take action to address those inequalities to ensure residents experience the same level of good health and life expectancy.

This strategy sets out our commitment to working in partnership to improve the health and wellbeing of people living in Telford and Wrekin.

Addressing these challenges, is complicated by the financial pressures facing families and public sector organisations.

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

We have a track-record of effective partnership working and this strategy will ensure that improving health and wellbeing and addressing health inequalities, and, importantly, the wider determinants of health are embedded across our wider partnership framework.

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

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

1. Telford and Wrekin Health and Wellbeing Strategy

The 2012 Health and Social Care Act requires local authorities to establish a Health and Wellbeing Board. The purpose of the Board is to identify the health and wellbeing priorities for Telford and Wrekin and define what will be done to address them.

Our Board has been in development since March 2011. Its current members include representation from:

- Telford & Wrekin Council Elected Cabinet Members and Officers
- Telford & Wrekin Clinical Commissioning Group
- Public Health (transfer to Telford & Wrekin Council from April 2013)
- NHS Telford & Wrekin and NHS Commissioning Board
- LINk – representative of patient and service users

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

The strategy priorities have been identified through the development of our 'Joint Strategic Needs Assessment (JSNA)' process and a programme of public consultation.

The JSNA process uses data, performance information and intelligence to help us identify health and wellbeing needs and inequalities in Telford and Wrekin. A long-list of local health and wellbeing priorities (see Appendix 1), was identified to inform the development of this strategy based on:

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

From this list, ten priority areas were identified by the Board to inform a detailed programme of public consultation which took place over the summer of 2012 with the final priorities agreed by the Board in September 2012.

Our approach to both this Strategy and our JSNA has been developed with close reference to national guidance which will continue to be used moving forward. This includes the adoption of a life stage approach described in the National Health Inequalities Review by Prof. Marmot (see Appendix 2).

- Our JSNA can be found at www.telford.gov.uk/factsandfigures
- Further information about the public consultation can be found at http://www.telford.gov.uk/info/200190/health_and_wellbeing/1498/health_and_wellbeing_board_hwb.

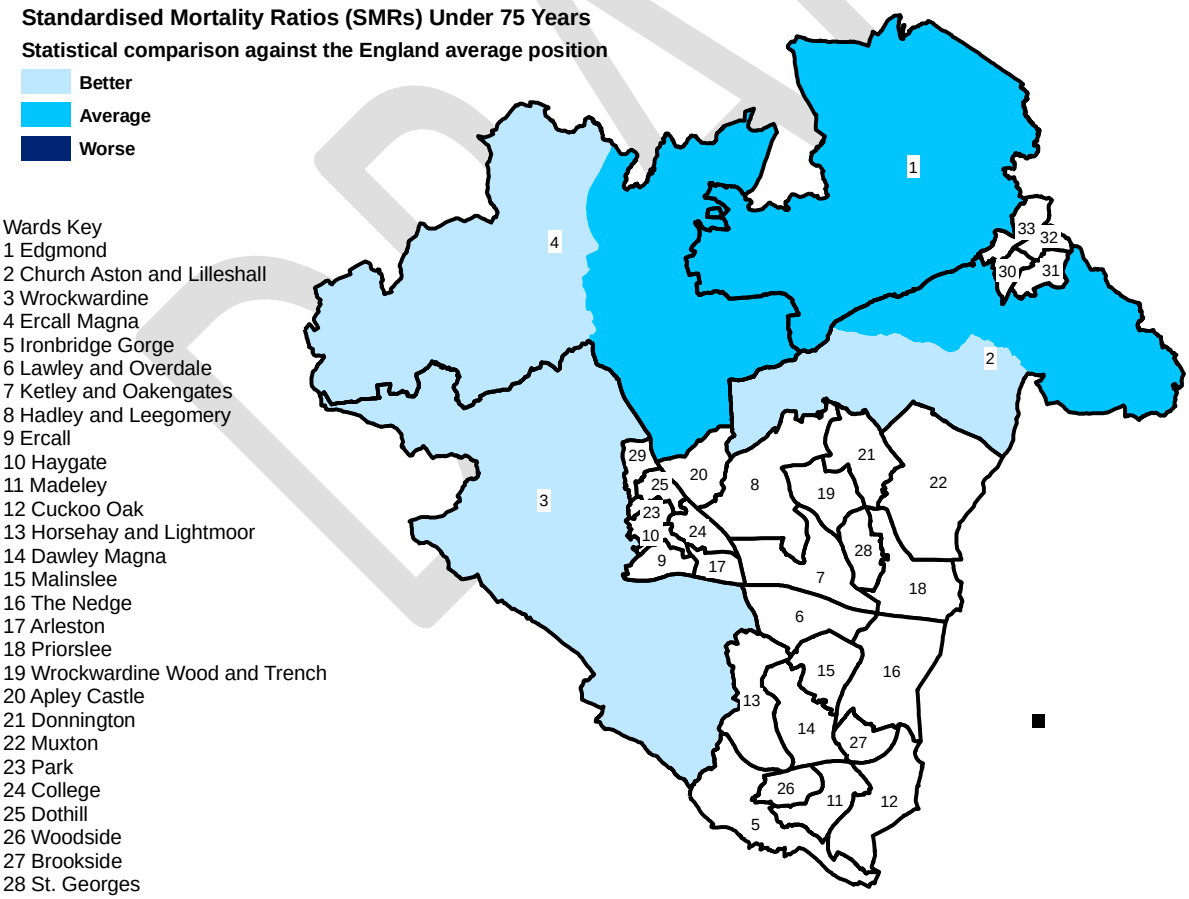
2. Health and Wellbeing in Telford and Wrekin

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

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

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

Premature Mortality in Telford and Wrekin



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

3. Telford and Wrekin Priorities

Our Vision *"To improve the health & wellbeing of our communities and address health inequalities"*

CHILDREN

ADULTS

Priorities	Proposed Outcome Measures
Reduce excess weight in children and adults	• Increase the number of babies breastfed at birth and at 6-8 weeks • Reduce the number of children aged 4-5 years and 10-11 years who are overweight or obese • Reduce the number of adults who are obese • Increase the numbers of people who are physically active
Reduce teenage pregnancy	• Reduce the number of conceptions amongst women under 18 years • Reduce risk taking behaviour
Improve emotional health and wellbeing	• Reduce the number of people who are admitted to hospital as a result of self-harm • Increase the numbers of people reporting positive wellbeing
Support people with autism	• Measures to be developed and linked to the strategy
Reduce the number of people who smoke	• Reduce the number of mothers who smoke during pregnancy • Reduce the number of babies born with a low birthweight • Reduce the number of people admitted to hospital with smoking-related diseases • Reduce the number of people who die as a result of smoking-related diseases • Reduce the number of smoking-related deaths
Reduce the misuse of alcohol or drugs.	• Reduce the number of people admitted to hospital due to alcohol-related diseases • Reduce alcohol related violent crime • Increase the number of people successfully taking part in drug programmes • Reduce the number of people admitted to hospital with alcohol-related liver disease • Reduce the number of people who die from preventable liver disease
Improve adult and children carers' health and wellbeing	• Carer-reported quality of life • Carers who feel they have been included in discussions about the person they care for
Improve life expectancy and reduce health inequalities	• Improve male life expectancy at birth • Narrow the gap life expectancy • Reduce the number of people who die before age 75 from cardiovascular diseases and cancers • Improve the number of people who take part in cancer screening programmes • Improve the management and treatment of long term conditions such as diabetes and chronic respiratory diseases • Increase the numbers of people immunised against 'flu
Support people to live independently	• Social care self-directed support • Older people who were still at home 91 days after discharge from hospital into re-ablement services • People receiving re-ablement services who need ongoing support • Delayed transfers of care from hospital
Support people with dementia	• Increase the number of dementia services available

CROSS-CUTTING PRINCIPLES

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

Priority 1 - Reduce Excess Weight in Children and Adults

Why is it important?

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

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

What is the situation in Telford and Wrekin?

- Obesity amongst 4-5 year olds has decreased during the past five years from 12.5% in 2006/07 to 10.4% in 2010/11. 'Excess weight' in 4-5 year olds (24.9%) remains worse than the average for England (22.6%).
- Amongst 10-11 year olds 252 were overweight and 318 were obese in 2010/11.
- More boys than girls are obese in both the 4-5 and 10-11 year age groups
- Breastfeeding at birth has improved in recent years increasing to 65% in 2010/11 from 58% in 2003/04. However, levels of breastfeeding remained significantly worse than the national average in 2010/11 with:
    - 65% of infants breastfed at birth, compared to 74% in England and;
    - 33% of infants breastfed at 6-8 weeks, compared to 46% in England
- Breastfeeding rates are significantly lower amongst:
    - Younger mothers with 42% of teenage mothers breastfeeding at birth, compared to 72% of mothers aged 35 years and over
    - Deprived communities with: 51% of infants are breastfed at birth in the most deprived areas, compared to 81% in the most affluent areas
- The prevalence of obesity amongst adults is estimated to be worse than the national average at 26.5% of adults compared to 24.2% in England as a whole, this equates to 36,00 adults 16 years and over

Priority 2 - Reduce Teenage Pregnancy Rates

Why is it important?

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

What is the situation in Telford and Wrekin?

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

Priority 3 - Improve Emotional Health and Wellbeing

Why is it important?

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

What is the situation in Telford and Wrekin?

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

Priority 4 - Support People with Autism

Why is it important?

Autistic Spectrum Condition (ASC) is a lifelong condition that affects how a person communicates with and relates to other people. It also affects how a person makes sense of the world around

them. Autistic Spectrum Condition is a lifelong developmental disability, affecting social interaction, communication, social relationships and making sense of the world.

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

What is the situation in Telford and Wrekin?

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

Priority 5 - Reduce the Number of People who Smoke

Why is it important?

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

What is the situation in Telford and Wrekin?

- 23% of adults are estimated to be smokers (circa 32,000 people aged 16+ years)
- During the past five years smoking quit rates have been amongst the highest in the country, with over 3,900 quitters during 2010/11
- However, mortality rates due to smoking-related deaths and hospital admissions rates attributable to smoking remain statistically significantly worse than the national average
- Levels of smoking in pregnancy are persistently, significantly worse than the national average. 23.6% of mothers smoked during pregnancy in 2010/11 (515 women), compared to 13.5% in England as a whole
- There are clear inequalities with:
    - 41% of teenage mothers smoking in pregnancy compared to 14% of 35+ year olds
    - 35% of mothers from the most deprived communities smoked throughout pregnancy, compared to 6% of mothers from the most affluent communities.

Priority 6 - Reduce the Misuse of Drugs and Alcohol

Why is it important?

Drug and alcohol misuse cause chronic disease and early deaths and are a significant financial burden on treatment services. The wider burdens on the community in terms of crime and anti-social behaviour are also far reaching and costly.

What is the situation in Telford and Wrekin?

- It is estimated that 21% of adults (circa 29,000 people) can be classified as 'increasing and higher risk drinkers'
- There were 770 reported violent crimes related to alcohol in 2010/11, with a higher than average ratio compared to England.

Priority 7 – Improve Carers' Health and Wellbeing

Why is it important?

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

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

What is the situation in Telford and Wrekin?

- Estimated 16,200 people over 18 providing unpaid care. Over 4,000 of these people are providing substantial and intense care
- 193 young carers are known to us though there are an estimated 600 young people in the Borough with caring responsibilities
- Carers are more likely to be female and the largest proportion are aged 35-64
- Carers aged 18-45 are less likely to receive support services than those who are older
- People who care for someone over 65 get fewer carers' services than the national average
- The reported health of carers is below national average. Carers' health is poorer than that of non-carers, and the more hours spent caring, the poorer the reported health of carers.
- There is a predicted decline in the proportion of people able to care for family, friends or neighbours in the borough as the ratio of adults to older people decreases.

Priority 8 – Improve Life Expectancy and Reduce Health Inequalities

Why is it important?

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

What is the situation in Telford and Wrekin?

- Male life expectancy at birth is statistically significantly worse than the national average position (77.5 years compared to 78.6 years)
- Female life expectancy at birth is not statistically significantly different to the national average position (82.1 years compared to 82.6 years)
- Cancers cause 40% of early deaths, with on average 217 cancer deaths under 75 years every year
- The early death rate from cancer is significantly worse than the national average
- CVD causes 25% of early deaths, with on average 140 deaths every year
- Despite a significant decrease the early death rate from CVD remains significantly worse than the national average
- The uptake of cancer screening programmes is below the national average
- Male life expectancy in the most affluent areas is 79.8 years, compared to 74.9 years in the most deprived areas
- Female life expectancy is 82.5 years in the most affluent areas, compared to 80.6 years in the most deprived areas

Priority 9 – Support People to Live Independently

Why is it important?

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

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

What is the situation in Telford and Wrekin?

- 48% of people who completed a period of reablement in 2010/11 did not require any ongoing social care support.
- There are pockets of good practice but these services are not joined up, are complex to navigate and patchy, leading to inequity in access

- Where investment has taken place, there is evidence of reduced on going costs
- Only approx. 30% of people who would benefit from re-ablement are currently accessing the service

Priority 10 – Support People with Dementia

Why is it important?

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

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

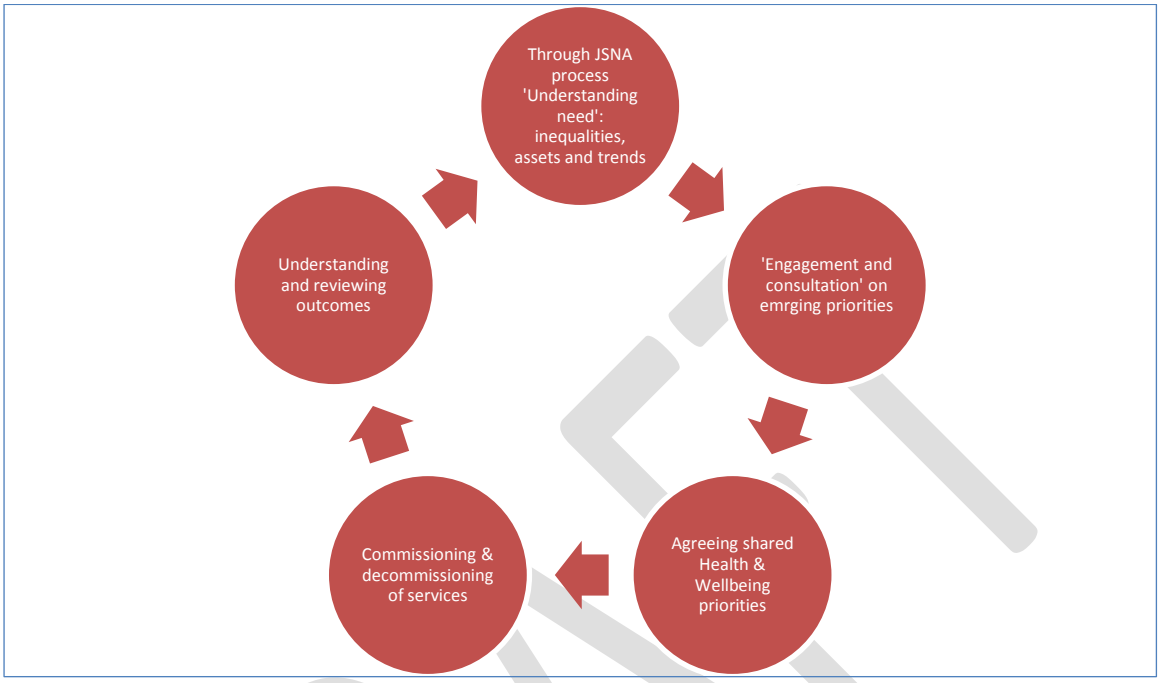
The Government is committed to improving the care and experience of people with dementia and their carers by transforming dementia services to achieve better awareness, early diagnosis and high quality treatment at every stage and in every setting. Dementia makes the lives of people who have it, and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

What is the situation in Telford and Wrekin?

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

4. Delivering the Priorities

Effective commissioning and design of services is central to the delivery of our priorities. The Health & Wellbeing Board creates new relationships between the Council and the NHS and provides us with a real opportunity to explore new approaches to commissioning, service design and collaborative, partnership working.



To drive delivery of our priorities and harness these opportunities we will:

- Review the existing strategies and delivery plans for our priorities. All of the Health & Wellbeing priorities are existing challenges and have strategies or action plans in place which will be reviewed, taking an “assets-based” approach. The focus will be on building further on the significant improvements we have already made to develop innovative and new ways of delivery, with both our stakeholders and communities.
- Allocate a member of the Board as ‘sponsor’ to take a critical role challenging progress to deliver each priority. The sponsor will liaise with the operational lead for each priority who will be accountable for developing appropriate delivery plans and responsible for performance against that plan.
- Develop and annual ‘Making it Happen’ focus for the Board, specifically exploring two or three new ways of working between partners such as pooled budgets, new models of delivery.
- Test our strategic and commissioning decisions against strategy’s cross-cutting principles

Principles

The Board has agreed the following set of principles, which should systematically underpin the improvement of health and wellbeing outcomes in Telford and Wrekin:

Equity

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

Accessibility

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

Integration

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

Quality

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

Financial Sustainability

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

Positive Experiences

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

Early Intervention and Prevention

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

Engagement

Putting the public at the heart of service design

Safeguarding

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

Appendix 1: Strategic Priorities Long List

To inform the development of our Health & Wellbeing priorities, our Joint Strategic Needs Assessment (JSNA) process was used to develop a long list of local priorities. The following table sets out this long-list together with the reason why each issue was included. To ensure that all the priorities on the long-list have appropriate focus, those which have not been aligned to the Health & Wellbeing Strategy, have been aligned with another local partnership or partner organisation (see Appendix 3). This will ensure that appropriate action to address the 'wider determinants of health' are delivered.

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

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

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

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

HWB = Health and Wellbeing Board
CCG = Clinical Commissioning Group
PH = Public Health
CFB = Children and Families Board
LSP = Local Strategic Partnership Executive
LSCB / LSAB = Local Safeguarding Children and Adults Boards
SCCB = Safer Cohesive Communities Board
SETF = Skills and Employment Task Force
SFTF = Supporting Families Task Force
HPLTF = Homelessness / Private Landlord Task Force
TWC = Telford and Wrekin Council

Appendix 2: The National Life Stage Approach: Fair Society, Healthier Lives

The national Health Inequalities Review: Fair Society, Fairer Lives led by Professor Marmot, proposed significant action to reduce the social gradient in health across key life course stages. The significant stages are:

Starting well

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

Developing well

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

Living well

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

Working well

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

Ageing well

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

Appendix 3: Partnership Framework