Telford and Wrekin Health and Wellbeing Board (HWB)

13th March 2013 at 2.00pm

Wrekin Room, Business Development Centre, Stafford Park 4, Telford TF3 3BA

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), Dawn Wickham (Representing Graham Urwin NHS Commissioning Board), Dag Saunders (LINkS), 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), Christine Harrison (Service Delivery Manager- Commissioning) and Jayne Clarke (Democratic Services Support TWC). **Apologies:** **Board Members:** Cllr Paul Watling (Cabinet Member: Children, Young People & Families), Dr Catherine Woodward (PCT Director of Public Health), Graham Urwin (NHS Commissioning Board LAT Director), Laura Johnston (Director of Children and Family Services T&WC). Cllr Richard Overton welcomed Dawn Wickham from NHS Commissioning Board who was representing Graham Urwin.	
2.	**Action notes 23.01.13:** There were no specific action points arising from the Minutes of the last meeting as a number of the items discussed were Agenda items at this meeting. **RESOLVED – that the minutes of the meeting held on 23rd January 2013 were a true record.**	
3.	**Areas of Focus:** **Update on Telford and Wrekin CCG** David Evans updated the Board on the Telford and Wrekin CCG.	

	The Clinical Commissioning Group (CCG) had been notified at the end of January 2013 by the National Commissioning Board (NCB) that it had been authorised as a statutory organisation of the NHS with 3 conditions. These conditions related to the Memorandum of Understanding with Shropshire CCG and a Service Legal Agreement with Staffordshire and Shropshire Commissioning Support Unit. Further evidence had now been submitted to the Panel and it was hoped that at its meeting on the 22nd March that these conditions would be removed. With regard to service and financial planning a lot of work had been undertaken on the transition of services and around the legacy documents and it had been decided that a bottom-up budget approach would be used. It was believed that a budget in the region of £184m would be available for Commissioning Services although there were some outstanding issues around specialised services ie neuro-surgery and heart/liver transplants. A £3m-£4m dental budget had been allocated to the CCG but it was believed that this should lie with the NHSCB. There continued to be pressure within Shrewsbury and Telford Hospital NHS Trust in relation to their performance position and treatment times. A project plan event was due to take place on 12 April and invitations had been sent to all participants which included the Senior Responsible Officer (SRO). The first Board meeting had taken place on 12th March and it had been reported that there were long waiting lists for spinal surgery at the Robert Jones and Agnes Hunt Hospital and that it was important to be explicit about the longer waiting times. A discussion took place and it was raised that there were concerns from patients regarding the waiting times, cancelled appointments and referrals out of the area, particularly over the last 2-3 months. **RESOLVED – that the report be noted.**	
4.	**Update on Shropshire and Telford and Wrekin Whole System Compact and Whole System Proposal** David Evans gave an update on the Shropshire and Telford and Wrekin Whole System Compact and Whole System Proposal. The Whole System Compact document had been drawn together by all health and social care partners within the Shropshire and Telford and Wrekin Health Economy and set out the agreement for joint working arrangements. A weekly meeting of Chief Officers of NHS Organisations and Directors from both Shropshire and Telford and Wrekin were now taking place to look at the health economy as a whole. There was a risk of cost transference and it needed to be clear how the organisations could work together.	

	A discussion took place including: • Patient representatives • Listening to Local Authorities with regard to resources • Patient experience • Cost savings and the impact on patients • Net savings and re-distributed funding **<u>RESOLVED</u> – that the report be noted.**	
5.	**NHS Commissioning Board Update, including transition progress** Dawn Wickham gave a presentation on the NHS Commissioning Board which included transition progress. There had been changes to the Commissioning Board. An Area Team for Shropshire and Staffordshire had been established, this was part of the national NHS working at an area level. Members of the Area Team were: • Graham Urwin – Director • Dr Ken Deacon – Medical Director • Brigid Stacey – Director of Nursing • Ros Francke – Director of Finance • Dawn Wickham – Director of Operations • Sultan Mahmud – Director of Commissioning The makeup of the Commissioning Board was exactly the same around the Country as it was now following a single operating model to ensure national service delivery. The PCTs were now being replaced by CCGs and Local Authorities. The Commissioning Board's new roles and responsibilities were: • Primary Care – GP Providers • Dentists • Opticians • Community Pharmacies • Some Public Health • Infant vaccinations and children's services 0-5 until 2015 This would be a dual role system in order to both develop and hold to account CCGs and work closely with Telford and Wrekin Council, only intervening where necessary. The Commissioning Board would be working with 8 CCGs and would work in partnership with Health and Wellbeing Boards in its own right as a Commission. It would hold the Board to account for the NHS Mandate in order to move towards outcomes rather than measuring targets, working jointly on areas such as poverty and equality and would have on overview of the system re-configuration.	

	Specialised Commissioning is managed by Birmingham and the Black Country. Offender Health would be managed by the Area Team as Shropshire and Staffordshire had the largest amount of prisoner/offender institutions within the West Midlands, although there were no institutions within Telford and Wrekin. With regard to the financial prospects for 2013/14 all CCG budgets had increased by 2.5%. The Telford and Wrekin Public Health Budget had increased by 2.8% on its transfer to the Local Authority on 1st April 2013. NHS providers were to receive funding increases of 2.5% for inflation, although NHS providers would be required to deliver 4% year on year efficiency gain. The Area Team budget for Shropshire and Staffordshire was £422m with a budget of £36m for Telford and Wrekin. The transition from strategic health and PCTs to the CCG and the new Area Team had been more challenging in some areas. The Legal Transfer was currently with the Department of Health and it was hoped that during the final 2 ½ weeks that the legacy and handover documents together with intelligence and information on quality issues would be handed over. A discussion took place including: • Public/Patient Participation • Health Service – Access to GPs • Cost inflation figures • Offender health outside of the prison service • Primary Care Access (**future meeting agenda item proposal – Baseline information on Primary Care in the context of our HWB priorities**) • Area Director responsibilities and Shropshire and Telford Area Team Lead Officers • "Joined-up" Public Health Service • Public Health Contracts • Joined up commissioning of GP's (**proposal to discuss this at a future Board meeting**)	
6.	**Implications of the Francis Report (NHSCB)** Dawn Wickham gave a presentation on the Francis Report. The Report had been published on the 6th February 2013 and looked at Staffordshire NHS Trust between 2005-2009 and the serious problems and the lessons to be learnt. The report highlighted the terrible unnecessary suffering that had taken place and listed 290 recommendations in order to change the culture of the Hospital and put patients first. Four key themes were identified:	

	• Standards and Compliance • Openness, transparency and candour • Compassionate, caring and committed nursing • Strong leadership Standards and compliance – a patient was entitled to expect a basic standard of care and permit the hospital to continue care. To prevent providers from providing services if standards cannot be met. An example of this would be 24/7 A&E Care and the number of clinicians needed to run a safe and effective service. The delivery of the service may have to be achieved in a different way ie a senior clinical review to be undertaken within 12 hours of arrival. This would have an impact on ways of working and service delivery together with provider needs ie less senior staff in hospitals at night and weekends gives poorer outcomes for patients. This will cause challenges for CCGs, the NHS and Local Authorities. Openness, transparency and candour – Truthful to patients where harm has been caused. Saying “we’ve got it wrong”. Compassionate, caring and committed nursing – better training, better nurses. Nursing - the ability to care not just to pass an exam. Absolute compassion. Stronger healthcare leadership – Code of Conduct and Code of Ethics – failure to live by them. This needs to be strengthened. HWBs and Partners are engaging better than before. There would be a push for this to continue and to make effective changes and improvements. There was a need to look at the current position and how to move forward. A discussion took place including: • Listening to patients concerns earlier • The ability to meet new standards • Pressure on the health economy • Waiting times – reasonable timescales • Different approaches to resolving challenges • Compassionate nursing – how do we measure up • Challenges for health and social care • Patient focus at all times • Nursing – qualification and training • Health care assistants • Hospital care delivery package – compassion from all hospital staff • Responsibility including partners, agencies, HWBs and officers of Local Authorities	
7.	**Care and Support Bill & Care and Support Funding Update** Paul Clifford presented a report on the Government’s proposals for adult care and support contained in the Social Care draft Bill to reform legislation of social care and to bring together the updated legal framework which was	

	welcomed. The Dilnot report recommended that funding was “not fit for purpose” on a national scale the Government had produced a short paper entitled “Policy Statement on care and support funding reform and legislative requirements” on 11th February 2013 and changes would be introduced from April 2015. The Council currently had 4 levels of funding criteria for care. The Local Authority contribute and put together care for packages for those with the most substantial level of need but following the changes in 2015 some of these people will be knocked out of the system. There were bigger changes with regard to deferred payments set against property. Appendix 7b to the report set out the funding regime. A cap would be introduced on care costs but not residential day-to-day costs which could cost up to £12,000 per year. Once the cap on care costs had been reached then any further costs would be borne by the Local Authority. Stay at home care funding would have changes to thresholds for homeowners which would be valued on a sliding scale. The implications for the Local Authority would be the actual care costs that would be incurred. Raising the threshold of loans and costs over £75,000 would increase administration costs ie support for assessments and annual support for self-funding clients. The cap for costs up to the age of 18 was £0. There would be a sliding scale for 18-65 year olds, but where a person was born with a condition then the cap would remain at £0. There would be one more financial year before the changes come into place in 2015, but it was important that the Local authority start to look at the implications for service and financial planning. **A further report would be brought to the HWB in July.** A discussion took place including: • What this meant for residents • Implications for the Local Authority • Government Model **RESOLVED – that the report be noted.**	
8.	**Public Health Transition Progress Update** Paul Clifford presented a report on Public Health Transition. The basic message was that the transition process was on track despite the delays with the regulations and guidance and should be able to move forward quite comfortably on 1st April 2013 without major issues. A new structure of senior management in the Council had taken place with a	

	major investment into business development and Health and Wellbeing. Public Health was intrinsic to the Board and this was reflected in the structure and job titles. The Board were asked to welcome opportunities that the new arrangements bring to the area. **RESOLVED – that** **a) 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 meet these responsibilities be noted;** **b) the opportunities that the new Health and Wellbeing and Public health arrangements bring for the area be welcomed.**	
9.	**LINk Interim Annual Report and DVD** Cllr Richard Overton thanked Dag and LINk for their work to date. Dag Saunders gave a verbal update on LINk. Following the White Paper Bill LINk had been visiting local groups to explain the changes. Youth LINk had undertaken a lot of work and had held a meeting last Friday. CCG work in participation had meant that there were approximately 20 active groups. A lot of good work had taken place in Donnington and it was hoped to replicate this in other parts of the Borough. This had been LINk's most active year with visits to hospitals and care homes. LINk had been invited to have representation on the Health and Wellbeing Board whilst it was in its shadow form and this was not mandatory. Dag Saunders thanked the Board for giving LINk this opportunity. A short film was presented highlighting the work that had been undertaken by LINk and to promote the transition into Healthwatch. The film was to be shown in the Telford Town Centre in April. A discussion took place including: • LINk transition to Healthwatch and the continuance of the good work undertaken, including Youth LINk • Youth ambassadors;	

	• The importance of not losing volunteers	
10.	**Healthwatch Update** Christine Harrison gave a verbal update on Healthwatch. The procurement process had now taken place and Parkwood Healthcare and been announced as the successful provider. The legacy of LINk was built on working with partners to capture what was the important work. Healthwatch wanted to assure the Board that it would continue to build on this work and take it forward from the 1st April 2013. A meeting with Parkwood and Key Stakeholders was to take place shortly in order to build a positive relationship. There would be a Q&A session regarding **the implementation plan which would be brought to the Board at the next meeting by a representative of Healthwatch.**	
11.	**Improving Carer's Health and Wellbeing – Strategy Update** Christine Harrison gave an update on the Improving Carer's Health and Wellbeing Strategy which was one of the Board's key priorities. The report focussed on adult carers as the timing for young carers was slightly different with the draft consultation period being 2013-16. Review date for young carer's strategy was 2015. There was connection between the adult and young carer's strategy and work, as this was vital. There were eight key outcomes: • 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 • Life outside of caring These were developed from the evidence within the JSNA for carers. A stakeholder event had been held which had proved very helpful with constructive feedback. The three top priorities were: • Information, advice and support • Planning for the future • A life outside caring The consultation exercise closed on the 20th February 2013 and feedback	

	would be included in the final documentation by the end of March. It would then be taken forward for approval by the CCG and Cabinet. A summary position had been produced connecting young carers beginning their journey into adult carers. It was hoped to connect across with the Carer's Contact Centre in the Service Level Agreement in order to strengthen the voice of young carers. The newsletter had been amalgamated and it was hoped to build on the Carer's Partnership Board to strengthen representation. **A further report would be brought back to the Board together with an action plan in future.** A discussion took place including: • Young carers – need the highest level of support but are those least likely to be able to benefit from services • CYP Families Board • Calendar of priorities • Combined Carer's Contact Centre • Transition from young carers to adult carers • Opportunities for older young carers **<u>RESOLVED</u> – that the report be noted.**	
12.	**Position Reports on Programmes transferring to the Council (for information)** Four update reports had been supplied for information giving an update on the following areas: • NHS Health Checks • Tobacco Control and Smoking Cessation Services • Children and Young People – Health Promotion • Making Every Contact Count and Healthy Lifestyles Hub A discussion took place regarding Health Checks and around the 1 practice that was not currently delivering this service. This was due to the trained member of staff currently being on maternity leave and no other staff member had been trained to deliver the health checks. This needed to be moved forward, although it was a very small practice and health checks may have been undertaken by an independent provider. A discussion took place around Children and Young People's health promotion and access to school nurses. The rooms supplied for the nurses were inadequate for them to perform their role and support the children properly. This seemed to be a key point and would be considered when the Healthy Child Programme was before the Children and Families Board. **A suggestion was made that the HWB write a letter of support to the Government for the minimum cost of alcohol. This was agreed by the Board.**	

	Board Function and Governance:	
13.	**Revised Terms of Reference for HWB** Clare Hall-Salter presented a report on the Health and Wellbeing Board Terms of Reference following The Health and Social Care Act 2012 which would come into force on 1st April 2013. The Board would then become a full Committee of the Council. The Terms of Reference had been to Council's Constitution Committee and had been agreed at the Full Council meeting on 7th March 2013. The key points were: • Membership – each opposition Group with 4 or more elected members shall have one place on the Health and Wellbeing Board with voting rights. • The Chair of the CCG would be the Vice-Chair of the Health and Wellbeing Board. • The HWB would report to Full Council and the CCG • Health Scrutiny function had been delegated to the relevant Scrutiny Committee by Full Council with the power of referral to the Secretary of State. **RESOLVED – that the report be noted.**	
14.	**HWB Stakeholder Engagement and Development Update** Clare Hall-Salter gave an update on the HWB Stakeholder engagement event and the LGA HWB Development Workshop. The second stakeholder event had taken place on 30th January 2013 and provided an update on progress to stakeholders that had attended the first event in July 2012. This had been a very positive meeting and launched the Strategy together with the priorities and principles. The event concentrated on the priorities and the priority leads and local sponsors had been able to work together during the event to choose two key priorities which would be used to identify areas for improvement and actions and to highlight future work and planning. The next steps would be to collate the information and make this available on the website. The Priority Leads would then further develop the specific outcome measures which would underpin the performance framework for the HWB Strategy. Outcome measures would be reported back regularly and stakeholders and providers would continue to be involved. It was suggested that a further stakeholder event was held in 6 months time, September 2013, and that the HWB continue to review the attendance list.	

	The HWB had been offered up to 4 days of support from the LGA. The first session had taken place on 11th October and looked at the structure of the LGA Development Tool. The provider engagement workshop held on 9th January 2013 was the second development session and health providers and organisations were invited to discuss their thoughts around future engagement. On 27th March 2013 it is proposed that the HWB have the final LGA workshop which would involve Board Members and support Officers exploring the difference that the Board would make as a collective Board. **RESOLVED – that** **a) the updates received in relation to Telford and Wrekin Health and Wellbeing Board engagement be noted;** **b) the next Stakeholder Event to be held in September 2013 be agreed; and** **c) the focus for the final LGA development session be agreed.**	
15.	**HWB Strategy Development and JSNA (including sign off of final strategy)** Jon Power and Helen Onions presented a joint report on the final version of the HWB Strategy and the next steps to deliver the JSNA. The final set of 10 priorities had now been identified together with the Lead Officer and Board Sponsor for each of the priority areas. The next steps would be to approve the Strategy and for the Lead Officers to engage with the Board Sponsors in order that they understood their roles and then work on delivering the strategies. The output from the engagement was to feedback and work better/differently against the priorities in order to develop over the next few months. The 'making it happen' focus to drive the new priorities was discussed. The Board had to seize the opportunities to improve the health and wellbeing of the community and draw from the engagement event in order to raise awareness of health and wellbeing issues. A detailed performance framework for the strategy was currently in development. This built on the set of outcome measures outlined within the strategy. A further report would be brought to the May meeting in order for the Board to understand the position and challenge and ask questions in order to make improvements. The JSNA was an evidence based framework and had identified priorities to be updated and developed. Some priorities may cease and new priorities come along. Information regarding Public Health outcomes framework, benchmarking and area profiles could be found on the JSNA website and any feedback would be welcomed.	

	There had been two important developments: • A meeting with Voluntary Groups on 25th March who are firmly involved with the JSNA. These services have grass routes intelligence and the HWB can draw from this. • On the 4th April there would be a JSNA Development Group. A report would be brought back to the Board once the key messages had been identified for the JSNA. The reports would be taken to CCG, HWB and Council to promote and highlight the latest community intelligence. A discussion took place including: • 10 priorities and other work • Working with Sponsors **RESOLVED – that** **a) the final draft of the Health and Wellbeing Strategy be approved; and** **b) the arrangements for progressing priorities and 'making it happen' work programme be noted.**	
16.	**Proposed Agenda Items for May to include:** • **Proposed working arrangements for Health and Social Care Scrutiny** • **HWB Partner Schools Initiative** • **Physical Activity 'The Gold Legacy' - Dr W Bird** • **Offenders and Health and Wellbeing – G Branch** • **National Pledge – Children's Outcomes** • **Impact of the HWB – what difference have we made at each meeting** • **Annual Public Health Report** • **Continuing Health Care** • **Census – Health Information (July/September HWB meeting)**	
	Dates of future meetings: 15th May 2013, 2pm – 4.30 pm, Business Development Centre 17th July 2013, 2pm – 4.30pm, NFU Offices, Southwater Way 18th September 2013, 2pm – 4.30pm, Business Development Centre 13th November 2013, 2pm – 4.30pm, Business Development Centre 22nd January 2014, 2pm – 4.30pm, Business Development Centre 12th March 2014, 2pm – 4.30pm, Business Development Centre 14th May 2014, 2pm – 4.30pm, Business Development Centre	

The meeting ended at 4.06pm

Signed ....

Dated ....

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15 MAY 2013

CONTINUING HEALTH CARE AND WHOLE SYSTEM APPROACH

REPORT OF ASSISTANT DIRECTOR – SOCIAL CARE SPECIALIST

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 The report highlights the issues arising from a change in application of national Continuing Healthcare criteria by the PCT in 2009 which have impacted detrimentally on local people both directly and through displacing over £8m costs onto the Council already subject to Government funding cuts of 27%.

2. FOR INFORMATION OR DECISION

2.1 Decision and information

3. RECOMMENDATIONS

3.1 Board Members consider the information set out in the report.

3.2 Board Members recommend that within 3 months Officers of the Council and CCG develop a jointly agreed approach to CHC funding decisions alongside a sustainable financial agreement for both organisations.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	To improve the health & wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
	Yes	CHC is of relevance to people of all ages (18 and above), who have

		significant care needs resulting from a primary health care needs and their immediate family
TARGET COMPLETION/DELIVERY DATE	*N/A*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	Detail of the financial implications of the change in application of Continuing Healthcare Criteria are contained in the body of the report. The financial impact to the Council is an ongoing budget pressure of over £8.0m. This has grown in impact since 2009/10 and reached this ongoing level in 2011/12. There has been some one off funding from the PCT for 2011/12 and 2012/13 to partially offset the impact plus agreement to use £2m national NHS allocations to local government for the same purpose in both years. These funds should have been available for service improvements and protection of existing social care services against the pressures on Council grant funding. Instead they have been utilised to meet part of the local NHS cost shift. In 2012/13 the combined one off local and national NHS funding used to cover around £8.5m NHS costs shifted onto the Council was around £4.8m leaving £3.7m to be funded by the Council. Discussions around 2013/14 and beyond are continuing with a minimum £2.4m contribution by the CCG proposed for this year only at present.
LEGAL ISSUES	Yes	See legal comment, attachment 1
EQUALITY & DIVERSITY	Yes	
IMPACT ON SPECIFIC WARDS	No	
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

5.1 A report on the 22 September 2011 to the shadow Health and Wellbeing Board highlighted the concerns of the Council in respect to a number of actions within the NHS that were creating financial pressures for the Council, in particular in respect of continuing health care. Through the Shropshire Health economy's QIPP plan it had been noted (though there was no formal consultation with the Council) that there was an intention to make over £6million savings in the Continuing Health Care (CHC) budget between 2011/12 and 2014/15 with an assumption that £2.3 million of this was attributable to NHS T&W. In the end this target was vastly overachieved by the PCT and used partly to cross subsidise the failure to deliver other QIPP targets and partly to allocate additional funds to the hospital trust.

5.2 T&W Council had recognised in 2009 that numbers of people locally, receiving NHS CHC funding to meet all their care needs was significantly above the national average and therefore the Council agreed to increase its community care budget to achieve a more equitable balance between CHC and council funded community care. However at the time of writing the first report there were concerns that the reduction in the numbers of people receiving CHC funding was reducing at a rate that was much higher than anticipated. Not only was this impacting on the Council's budget, but Officers were concerned that some individuals may be denied a legal right to free NHS care where they had a primary health need and therefore the Council may be acting illegally by providing such care.

5.3 A person should be considered to have a primary health need when the nursing or other health services they require, when considered in their totality, are:
"(a) where that person is, or is to be, accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or
(b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide".

5.4 The Council had been raising concerns with the PCT Board since June 2010 but with continued lack of progress, The Council's Managing Director wrote to the Chief Executive of the West Mercia Cluster asking for mediation at a higher level (see attachment 2). This letter pointed out that the cost transfer to the Council was now over £8million and still expected to rise given the approach. An update report to the shadow Health and Wellbeing Board on the 14 December 2011, informed members of the escalating situation.

5.5 As a result of discussions with Eamonn Kelly and his resulting concerns over the actions of the PCT, agreement was reached in January 2012 to pass one off funds of £3million to the Council from the Cluster in respect of 2011/12

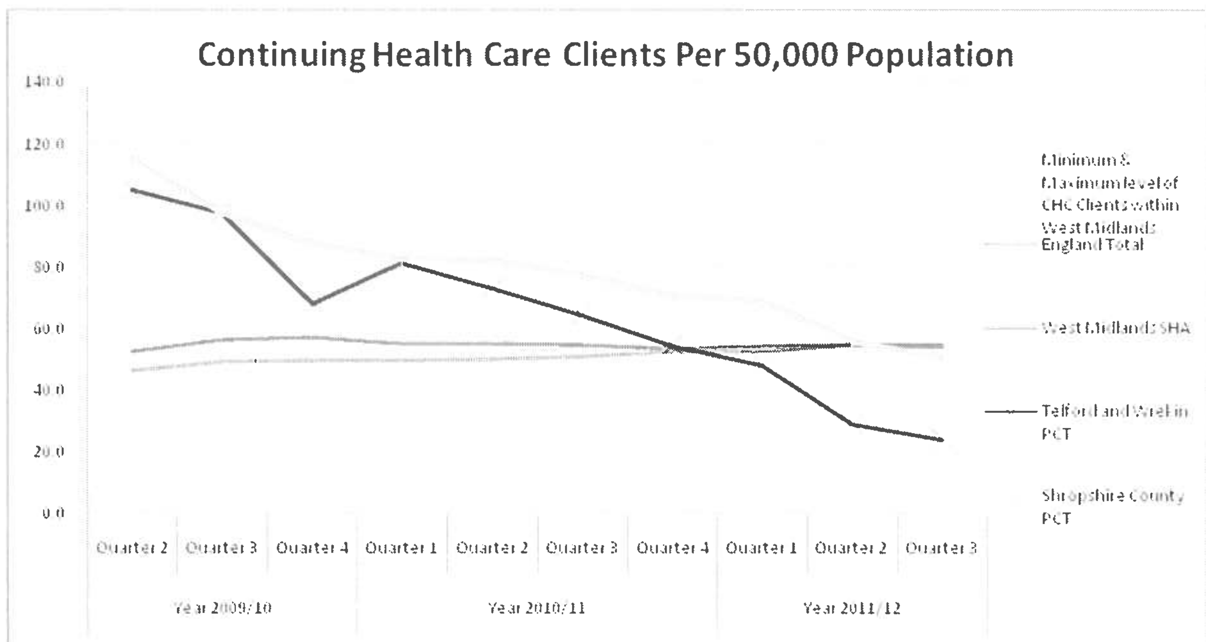
and agreement to our use of the "Lansley" money passported across to the Council to offset part of the shortfall hitting the Council in that year as well. It was also agreed to set the PCT budget for CHC in 2012/13 at a level "proportionate to average levels of CHC support". In effect this meant that the CHC budget was set at £6.5m even though the spend in 2011/12 was only £3.8m and still falling. This positively meant that £2.7m would be transferred to the Council which together with £2.1m Lansley money would offset £4.8m of the £8m plus impact on Council budgets in 2012/13. However using the Lansley money in this way means it was not available via the Council as a contribution to whole system development and integration initiatives.

5.6 For 2013/14, when T&W CCG take over responsibility for CHC from the PCT/West Mercia Cluster there is a proposal to replicate the transfer of one off funding from the CCG at a slightly reduced level of £2.4m but no ongoing arrangement for future years and currently no resolution of the concerns about the ongoing CHC decision making which has now passed to the CCG.

5.7 Officers of the Council and CCG are now in discussions with officers from NHS England to arrange externally facilitated sessions to find a mutually acceptable approach for day to day operation of the CHC process. This will require both sets of officers to approach this work with open minds if we are to resolve the situation in the interests of our local people.

5.8 The numbers of people receiving CHC funding has continued to reduce throughout this period as people have been reviewed and a decision made that they are no longer eligible, even though their situation and needs have not changed (or have deteriorated in some cases).
At the same time very few new people are agreed to be eligible and ill people in receipt do die. **The dramatic decrease in the numbers of people in T&W receiving CHC funding compared with the national and regional averages is shown in a table (see attachment 3) and the graph below. The latest NHS information available to the Council from mid 2012/13 shows that in the period 2009/10 to mid 2012/13 the numbers of people in receipt of funding locally has dropped from 100 to 17.4 cases per 50,000 population- a cut of just under 83%, while the West Midlands average has risen from 51 to 58 and the national average has increased from 44.2 to 57 leaving support for local people at only 30% of the national and regional averages.**

Graph 1: Comparative Funding Rates for Continuing Healthcare Funding



5.9 Locally in the last year there have been other developments too:

5.10 T&W Health and Social Care Scrutiny became involved, stimulated by an individual appeal and complaint, where the family had sought support from one of our Councillors. The Scrutiny Report is on today's agenda for consideration

5.11 Within the Council, our Assessment and Case Management staff have become totally disillusioned with the local CHC process, feel their assessments are not valued and there is no point in referring people into the system. We now recognise that we need to provide our staff with more training, knowledge, skills and support to overcome this. To achieve this we have agreed (having looked at models in place elsewhere) to recruit 2 CHC specialist workers who will support this training process, support colleagues in completing and pro-actively promoting their part of the assessment process as well as undertaking assessments in situations where we feel the need to challenge and dispute the local CHC decision. One Officer has been in place for 2 months now and a second will be in place shortly.

5.12 Our local MP became involved last summer and wanted to raise the issue in Parliament, see attachment 4. Following discussion he agreed not to do this on the basis that we were hopeful of resolving this locally. With little progress having been made it may be hard to delay this happening now, particularly given the findings of the Scrutiny Review which is also on the Board's agenda today.

5.13 An illustration of where the PCT approach has brought us is that recently we discovered (we should have identified this much earlier and thereby

avoided there being an issue) that 2 people who had been taken off CHC funding, were in fact placed in private hospitals by the PCT but without alternative NHS funding. Our staff concerned about not removing care packages from vulnerable people continued to fund the placements, without establishing the nature of the placement. There is no statutory basis for a LA to fund hospital placements. The PCT prior to their abolition did agree to reimburse the Council in these particular cases.

5.14 Nationally the CHC National Framework was reviewed and updated at the end of 2012 to take account of the changes brought about by the Health and Social Care Act 2012 and in particular the passing of CHC commissioning responsibilities to CCGs and the CHC independent appeals process to NHS England. There were no significant changes to the eligibility criteria. Locally the Team responsible for CHC decision making has transferred into T&W CCG and their lead officer has reviewed the local operational framework, to update it accordingly. National guidance states the local framework should be agreed with the local authority. On the 20 April, the Council wrote to the CCG making it clear that we could not sign up to the framework without significant changes to bring it in line with the national framework and evidence that the approach which currently unduly restricts the number of people deemed eligible for CHC funding is adjusted. Subsequently the CCG have positively decided to use the content of the National Framework as their local position statement but the Council still need to see an increase in local CHC funded activity.

5.15 On the 12 March 2013 our Director of Adult and Community Services wrote to Graham Urwin, Director of the Shropshire & Staffordshire Area Team of NHS England to ensure he was aware of the history of CHC in T&W Wrekin. The letter (see attachment 5) outlined most of the points above and expressed concern about the impact CHC practices in T&W could have on relationships with the new CCG and the potential repercussions for the whole health and care economy if not resolved soon.

5.16 Board members will be aware of the pressures in the health and care economy at a time when the Council's funding is being reduced by 27% in cash terms alone (now rising to 33%) with further pressures ahead. Health initiatives to make changes across the health economy through a Shropshire Compact to reduce costs and improve people's experiences, particularly in the acute sector, will inevitably involve an element of switching costs out of the acute sector and into community settings. The Council are supportive of these policy initiatives.
We believe we are a critical stakeholder in the "whole system" and without our

involvement such changes will be severely restricted. However our ability to support these initiatives will entirely depend on appropriate resource switching across the health economy into the care system. Our current experience of CHC and the resulting budget implications for the Council do not bode well and make it very difficult for the Council to support the changes. Our relationships with the PCT and now CCG have otherwise been very positive and we hope that we can find an agreeable way forward to both organisations, before relationships are damaged and put at risk the strategic approach we all agree with.

5.17 Interestingly, across the country there is an increasing trend to Local Authorities being commissioned to deliver CHC functions by their respective CCGs, with evidence where this can be agreed, that it results in a significant reduction in the tensions that are inherent at the interface between CHC and Council funded community care, given the current legal position.

6. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

N/A

7. PREVIOUS MINUTES

5.1 Health and Wellbeing Board members were first informed about the local position in a report prepared by the Council for the shadow Board meeting on the 22 September 2011.

5.2 A short update to the Board was provided at the next meeting of the shadow Board on 14 December 2011

6. BACKGROUND PAPERS

6.1 National Framework for NHS Continuing Health care and NHS Nursing Care - November (2012) – Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127199/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf.pdf

Report prepared by Paul Taylor, Assistant Director – Social Care Specialist.
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CHC Report Legal Comment

On 28 November 2012, the Department of Health announced that the National Framework for NHS Continuing Health Care and NHS Funded Nursing Care had been updated. This sets outs the how eligibility for funding should be determined and replaces the previous version of the National Framework published in July 2009

The Framework was revised to reflect changes introduced by the Health and Social Care Act 2012 relating to the new NHS framework and structures and came into effect from 1 April 2013

In addition to the amendments made to the Framework itself, the supporting tools have been updated and The NHS Continuing Healthcare (Responsibilities of Social Services Authorities) Directions 2013 also came into force on 1st April 2013.

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

As set out in the Framework at paragraphs 18 to 29 , the relevant legislation does not use or define the expressions 'continuing care', 'NHS continuing healthcare' or 'primary health need'.

Section 1 of the National Health Service Act 2006 (the 2006 Act) (as amended by the 2012 Act) requires the Secretary of State to continue the promotion of a comprehensive health service, designed to secure improvement:

a) in the physical and mental health of the people of England; and
b) in the prevention, diagnosis and treatment of illness.

Section 1A of the 2006 Act requires the Secretary of State to exercise these functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with:

(a) the prevention, diagnosis or treatment of illness, or
(b) the protection or improvement of public health

Section 1H of the 2006 Act establishes the National Health Service Commissioning Board ("the Board") , an independent body which will hold CCGs to account for the quality of services they commission, the outcomes they achieved for patients and for their financial performance. The Board also has the power to intervene where there is evidence that CCGs are failing or are likely to fail to fulfil their functions. The specific functions of the Board are set out in the 2006 Act.

The Board is subject to the duty to promote the comprehensive health service (other than in respect of those services falling within the public health functions of the Secretary of State or local authorities).

Section 3 of the 2006 Act requires CCGs to provide a range of services, to such an extent as they consider necessary to meet all reasonable requirements. These services

must include, amongst other categories, 'such other services or facilities for the prevention of illness, the care of persons suffering from illness, and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service' (section 3 (1)(e) of the 2006 Act).

The Secretary of State for Health remains accountable for the NHS and the amendments to the 2006 Act do not change the Secretary of State's core duty to promote a comprehensive health service, which dates back to the1946 NHS Act . The Secretary of State must bear this duty in mind whenever he exercises any of his functions.

Each LA is under a duty to assess any person who appears to it to be in need of community care services (section 47 of the National Health Service and Community Care Act 1990).

Community care services may include residential accommodation for persons who, by reason of age, illness or disability are in need of care and attention that is not otherwise available to them (section 21 of the National Assistance Act 1948), as well as domiciliary and community-based services to enable people to continue to live in the community. The LA, having regard to the result of that assessment, must then decide whether the person's needs call for the provision of community care services.

The LA must also notify the relevant CCG if, in carrying out the assessment, it becomes apparent to the authority that the person has needs which may fall under the 2006 Act, and invite the CCG to assist in making the assessment (see section 47(3) of the National Health Service and Community Care Act 1990).

If an NHS body is assessing a person's needs (whether or not potential eligibility for NHS continuing healthcare has been identified) and the assessment indicates a potential need for community care services that may fall within an LA's responsibilities, it should notify the LA of this in order for the LA to fulfil its responsibilities.

Section 21(8) of the National Assistance Act 1948 states that nothing in section 21 authorises or requires an LA to make any provision that is authorised or required to be provided under the 2006 Act. This was considered by the Court of Appeal in the *Coughlan,* case where it was held that an LA is excluded from providing services if the NHS has, in fact, decided to provide those services.

Section 21 should not be regarded as preventing a local authority from providing any health services. The subsection's prohibitive effect is limited to those health services which have been authorised or required to be provided under the 2006 Act. Such health services would not therefore include services which the Secretary of State legitimately decided under section 3(1) of the 2006 Act it was not necessary for the NHS to provide.

LAs also have the function of providing welfare services under section 29 of the National Assistance Act 1948 (which includes functions under section 2 of the Chronically Sick and Disabled Persons Act 1970). Section 29(6)(b) of the National Assistance Act 1948 only prohibits LAs from providing such services under section 29 as are 'required' to be provided under the 2006 Act and so excludes only those services that must, as a matter of law, be provided under the 2006 Act.

Section 49 of the Health and Social Care Act 2001 prohibits LAs from providing, or arranging for the provision of, nursing care by a registered nurse in connection with the provision by them of community care services. 'Nursing care by a registered nurse' is defined as 'services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse'.

The balance between LA and NHS responsibilities with respect to continuing care has been the subject of key court judgments , which are summarised in paragraphs 30 to 32 and Annexes B and C of the Framework , namely *R v North and East Devon Health Authority, ex parte Coughlan (1999)* and *R v Bexley NHS Trust, ex parte Grogan (2006)*

To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the 2006 Act, and to distinguish between those and the services that LAs may provide under section 21 of the National Assistance Act 1948, the Secretary of State has developed the concept of a 'primary health need'. Where a person has been assessed to have a 'primary health need', they are eligible for NHS continuing healthcare. Deciding this involves looking at the totality of the relevant needs. Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for providing all of that individual's assessed health and social care needs – including accommodation, if that is part of the overall need.

The Framework sets out the requirements for review and is clear that neither the NHS nor an LA should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement.

If agreement between the LA and NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved. There is a separate disputes procedure for when the individual disagrees with the decision. Both procedures are set out in paragraphs 145 – 165 and Annex F of the Framework.

CCGs and LAs in each local area should agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS continuing healthcare, about the apportionment of funding in joint funded care/support packages, or about the operation of refunds guidance (Annex F). Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to LAs and CCGs in different geographical areas, the disputes resolution process of the responsible CCG should normally be used.

The National Health Service Commissioning Board/ CCGs and Las should have clear jointly agreed local processes for resolving any disputes that arise between them on the issues covered in the Framework guidance. The Standing Rules Regulations and Directions to LAs require the Board or CCGs and LAs to have an agreed local process for resolving disputes between them on issues relating to eligibility for NHS continuing healthcare and for the NHS elements of joint packages. The Board, CCGs and LAs could extend the remit of their local disputes process to include disputes over refunds. It is

important that it should include an identified mechanism for final resolution, such as referring the case to another CCG and LA and agreeing to accept their recommendation. Where an individual disputes the Board's or a CCG's decision on whether to provide redress to them, or disputes the amount of redress payable, this should be considered by the Board or CCG through the NHS complaints process

The Framework at Annex G: Local NHS Continuing Healthcare Protocols provides a best practice guide for what to include when drawing up and updating local protocols and procedures regarding NHS continuing healthcare.

Telford & Wrekin
COUNCIL

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Sent by email to:
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Contact: Richard Partington **Telephone:** 01952 380130 **Fax:** 01952 380104
Your Ref: **Our Ref:** **Date:** 24 November 2011

Dear Eamonn

Re: Continuing Health Care Funding

It is with regret that I must raise with you a very urgent issue of great concern to this Council in the hope that you will take some action to help resolve an issue that, otherwise will potentially undermine the Council's financial position and the local health and care economy.

I have been aware for some time of the issues for the Council created by the local PCT's changed approach to funding of Continuing Health Care (CHC) as part of the NHS QIPP agenda. While the issues of the knock-on impacts for the Council and consequences for our ability to play our part in the local health and care economy have been raised regularly at the PCT Board for over 18 months now, we have tried to approach this positively in order to sustain the good partnership working between PCT and Council which has been built up in our local area and the changes that we are all looking to make to service delivery. Telford and Wrekin Council has a long and proud track record of partnership working and this is demonstrated through the way that we have supported the recent proposed reconfiguration of acute services and also the way that we have sought to work with the PCT – without seeking to make a major issue out of this with members, scrutiny, MPs, the media etc – in relation to its changing approach to CHCs. However our wish to try to work through this issue with the PCT has now placed us in a totally untenable position as the PCT's proposed further disinvestment in CHC continues and accelerates the transfer of costs to the local council at an unsustainable level for us.

The Council has to meet grant cuts of 27% in cash terms alone from mid 2010 through to 2014/15 which after taking account of inflation and service pressures is nearer to 40% in real terms. We carry low balances and the front end loading of severe grant cuts in a settlement only announced mid December last year meant much of those had to be deployed as part of the current year's budget while savings programmes already planned had a chance to deliver. Current Government policy also effectively deprives councils from any recourse to council tax increases. Thus as we are and have been for some years delivering all the efficiency savings and increased charges we can, including a second wholesale restructuring of the Council in 2 years, any additional burdens inevitably result in extra service cuts now at a time when the economic situation actually increases the demands on our services.

We appreciate the NHS also finds itself with significant savings to make and will naturally look at areas of higher spend /lower priority to disinvest in, but this ought to take some account of the

consequences for other parts of the health and care economy in making a judgement on the degree and pace of adjustment. The PCT set itself a target of saving £1.8m in 2010/11 for CHC costs and actually delivered savings of around £4m (of which £0.5m was then helpfully returned to the Council as a one-off), the balance of over achievement was then used to pass additional funding to SaTH to help meet its ongoing financial overspend issues. For 2011/12, the PCT then set itself a target of a further £2m savings and by September was flagging an over-achievement of around £1.4m to date, but latest full year projections in November show a £4m (200%) overachievement and this is again being used to switch additional funding to the hospital trust plus meeting all other PCT overspend areas. While these savings may look relatively 'easy' on paper for the NHS to realise, the reality on the ground here is very different and will get much worse.

The Council has previously set aside additional ongoing funding of around £1.5m from its savings for transferred CHCs and is also utilising £2m additional NHS funding transferred to the Council as part of the Lansley money to promote integrated health & care working. This should have been sufficient to meet the PCT's cumulative budget savings target given some element of self-funding in CHC cases, however the disinvestment/cost transfer has just carried on accelerating. The additional in-year pressure to the Council has been largely absorbed so far by use of one-off funding, contingencies and programmed in-year savings made early in other services. However these will not be available in 2012/13 and thus the continual and rapid rise in CHC costs being shifted to the Council is not sustainable in our current budget strategy for 2012/13. Taking account of the full year impacts in 2012/13 of decisions to date and further CHC investment we have already set aside for that year from our own funds, we estimate a further shortfall of at least £3m in our current overall deficit projections for which no funding is now projected and we are due to launch our overall budget strategy for consultation in papers to be issued mid December.

The PCT's Board report in November on its financial position brought some clarity to the CHC position in terms of historic CHC spend trends plus outlining a possible strategy. Given the PCT policy changed around Autumn 2009 and therefore was already impacting on 2009/10 spend, this shows a net cash disinvestment by the PCT of around £8m to date - a cut of some 55%, though an extrapolation of the 3 years' growth up to 2009/10 would indicate a far higher potential real terms cost shift towards the Council and cut of nearer 70% over the last 2 years. At present taking account of projected full year impacts into 2012/13 we estimate at least £8m CHC costs will effectively have been transferred to the Council by next year even if no more cases are reviewed from now. We have no ongoing funding for £3m of this and the availability of the £2m NHS funding beyond 2012/13 must be in doubt which will make the position even worse.

Our ability to support the local health and care economy is therefore going to be reduced which is concerning given the Government priority of greater health and care integration and the NHS need for Council support to deliver QIPP savings. It is clearly in everyone's interests to support the acute hospitals and avoid bed-blocking, however, if because of the scale of these funding pressures we are unable to fund some of our community-based care services at their current levels, then this will inevitably have a financial and operational impact for NHS resources. To stress, we want to avoid this situation, but the position, without any change in policy/implementation regarding CHCs, is one that should concern us all greatly.

We have regularly flagged for over 18 months with the PCT Board the impact of overachieving their budget strategy targets which is switching funding away from the preventative, community based services we provide and into the acute sector – the complete opposite of current Government strategy and generally accepted good practice. The issue was raised in more detail through a paper to Health & Wellbeing Board in September. While we appreciate the need for some measured and phased reduction in CHC spend by the PCT it has been too far, too fast without consideration of the wider impact and in our view has at the margin resulted in individual decisions which are concerning. It has also put a considerable strain on working relations in front line services in some cases which impacts on our vulnerable clients.

POSITIVE ABOUT DISABLED PEOPLE

As mentioned, we welcome the presentation of a strategy in the latest Board monitoring papers but would wish to discuss the applicability of the target of average spend when arguably ours is not an average position locally with no community hospitals/very limited intermediate care provision, particularly significant long term health issues in our more deprived areas and some concern around CHC spend classification consistency between PCTs.

As I said at the beginning it is with real and genuine regret that I find myself having to write such a letter. I know Paul Clifford is meeting with Leigh Griffin and Mike Innes to discuss this issue next week and, given the urgency of resolving this before our budget process, I would be grateful if we could then meet the following week – w/c 5th December - so I can then advise our Cabinet of the next steps. Apologies for requesting a meeting at such notice when I know how big your workload is handling all the NHS change agenda across the West Mercia area but this has reached a critical point for us. To this end, both Paul and I are very happy to travel down to Worcester to see you and will look to re-schedule pre-arranged meetings in our diaries to ensure that a meeting can be held and we can look to find a satisfactory resolution to this very difficult situation.

Yours sincerely

Richard Partington
Interim Chief Executive

cc: Leigh Griffin, Managing Director, Shropshire & Telford PCT
Mike Innes, Chair, Telford & Wrekin Clinical Commissioning Group

POSITIVE ABOUT DISABLED PEOPLE

Summary of NHS Continuing Health care data – taken from the Department of Health data on numbers of individuals in receipt of NHS continuing healthcare 2009/10 to date, by PCTs in England

Full data can be accessed by the following link http://www.dh.gov.uk/health/2013/01/nhs-continuing-healthcare/

PCT	2009/10								2010/11								2011/12							
	Qtr1		Qtr2		Qtr3		Qtr4		Qtr1		Qtr2		Qtr3		Qtr4		Qtr1		Qtr2		Qtr3		Qtr4	
	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop
England Total	45k	44.2	47k	46.4	50k	49.3	50k	49.7	50k	49.9	51k	50.3	51k	51	53k	52.5	53k	52.7	55k	54.7	54k	54	55k	54.8
T&W PCT	324	100	341	105	317	97.9	221	68.3	264	81.5	237	73.2	209	64.5	177	54.7	156	48.2	94	29	78	24.1	64	19.8
West Mids SHA	5.4k	51	5.6k	52.7	6k	56.3	6.1k	57.2	5.9k	55	5.9k	55.2	5.8k	54.6	5.7k	53.5	5.8k	54.3	5.8k	54.6	5.8k	54.7	5.9k	55.5

12/13			
Qtr1		Qtr 2	
People	Per 50k pop	People	Per 50k pop
56k	55.6	57.6	
70	21.6	56	17.4
6.173k	57.5	6.175	

The data shows that T&W PCT moved from being the 5th highest ranked PCT for CHC funded people per 50,000 population at Qtr 1- 2009/10 to the 14 lowest by Qtr 2 – 2011/12 and 4th lowest by Qtr 4 – 2011/12. By the end of Qtr 2 2012/13 the number of people receiving CHC funding fell to a new low and 14 fewer than the previous quarter suggesting that people are still leaving the system at a faster rate than new people are accepted into the system, at a time when nationally figures are still on the increase

These trends have resulted in the financial impact on the Council as set out in the attached paper.

MP BRIEFING 29/8/12: CONTINUING HEALTH CARE

Continuing Health Care (CHC) funding eligibility is decided by the PCT after considering health and care information and is intended to fund the health and care needs of those clients whose primary need is for health care, though this can be supported in a community setting rather than acute hospital. Revised national guidance to be applied in deciding on CHC eligibility was issued in 2009 to bring greater uniformity in its application across the country. At that point spend per head of population by the T&W PCT for this area, though on a par with the rest of Shropshire, did appear to be high compared with other areas of the country -5th highest out of over 150 PCTs- so some adjustment was potentially to be expected .
Since then existing cases already in receipt of CHC have been reassessed by the PCT even though their needs have not changed, and the majority assessed have had CHC withdrawn which means the costs then fall on the individual if they are 'self funders' under social care criteria, or in most cases the costs then default to the council. The impact has been:

- A decision making process driven largely by PCT cost saving needs
- A 73% cut in PCT spend on CHC from £13.9 in 2009/10 to £3.8m last year...and falling. This is in cash terms only and thus ignores demographic trends (new cases) and inflation. In the 3 years leading up to 2009/10 spend was increasing at 18% pa on average-taking that into account the cut is over 80% in the space of 2 years
- PCT savings targets for CHC of £3.8m over the 2 years have been exceeded by 165%. The in year overachievement in savings has been used to give additional funding to SaTH thus in the overall Health and Care economy switching funding away from preventative, community based services into acute-the complete opposite of stated intentions from the Health Secretary
- PCT spend is now 4th lowest per capita in the country, lowest in the West Midlands and half that of Shropshire
- PCT spend is now only 55% of that as far back as 2005/06 in cash terms alone ie without building in inflation and demographic increases
- Social workers feel worn down by a CHC process and approach by the PCT team they describe as generally bullying and dismissive of their input where decisions appeared already made before their input was considered – relations otherwise with the PCT and now CCG are good and this is the sole area of conflict
- Around £8m of the PCT cost savings have hit the Council...on top of the Government's 28% funding cuts – this nearly doubles the cuts to be made by social care. It leaves us in the position of considering consulting shortly on explaining this impact and how it means we must now raise our care assessment criteria to critical for next year unless an ongoing solution can be found. This risks judicial reviews and we would join only a handful of councils nationally having to take this step so far.

The issue has been raised with the PCT for over 2 years now with no ongoing resolution, but discussions with the PCT Cluster Chief Exec in January 2012

around the impact on the Council's financial position and services,put in place a temporary solution for 11/12 and 12/13 only, on top of using £3.4m ongoing of the Council's own funding created from service cuts across the Council:

- Use of £2m pa 'Lansley money' from the national £1bn intended largely for investment in services to reduce future pressures on acute services but instead used to offset part of this cost switch from the PCT
- £3m one off PCT funds to cover the balance of the Council overspend in 11/12
- A one year agreement to set the PCT budget for 12/13 CHC at the national per capita average of £6.5m compared with 11/12 outturn of £3.8m and transfer any unused balance to the Council.
- An external review of the PCT's application of the criteria for CHC assessments. Despite our stated reservations, this was arranged to be carried out as a paper based exercise only, which found on the basis of the information originally included for consideration the decisions chosen for review were ok. Our view, stated at the time, is that this exercise was severely limited by being solely paper based as the papers can only reflect the outcome of the PCT driven DST discussion and not the application of the criteria to the individual which could only be properly achieved by an actual reassessment of a sample of individuals.

This arrangement with the PCT cluster has safeguarded the Council's position this year but there is still no ongoing solution in place and responsibility for resolving a situation created by the PCT this has been passed to the CCG. The PCT pledge to spend up to national average by transferring unused budgets to the Council is for this year only and while there is verbal assurance from the CCG to carry on this arrangement, there will be a growing risk of challenge from their auditors. There are also no 13/14 allocations available yet of any Lansley money, thus neither of these funding sources is sustainable and the Council potentially faces an additional funding shortfall of around £5m for 2013/14 or 2014/15. This will mean additional service cuts including raising care criteria…all of which will be counterproductive for keeping out/getting people out of hospital. Hence our concern all along with an adjustment applied too far and too fast with no consideration of the overall health and care position for the area and its people…..the complete opposite of the integrated approach promoted by the Secretary of State. This outlines the overall impact on the Council and the health and care economy…at a more detailed level there are local people who are being affected both in terms of care and support as well as financially.

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Your Ref: **Our Ref:** **Date:** 12th March 2013

Dear Graham,

Continuing Health Care in Telford and Wrekin

Further to our brief discussion at Cluster Board regarding the unresolved issues around the PCT's approach on CHC, I am setting out the local position from the Council's perspective.
There was a change in approach to the application of CHC criteria by the PCT from October 2009 which was not discussed with the Council or assessed for impact. We agree that CHC spend in 2009, though on a par with the rest of Shropshire, did appear to be high compared with other areas of the country – 5th highest out of 152 PCTs and thus warranted some review and adjustment. However we completely disagree with the speed and extent of change which has cut PCT supported cases by 83% (see attached table of NHS data) taking T&W PCT to lowest spender in the West Midlands, one of the 3-4 lowest in the whole country . T&W now provides less than half the level of support given by Shropshire PCT even though that has also declined (and they have a community hospital network as well to handle NHS responsibilities post acute settings)

Since 2009/10 CHC spend has fallen from £13.9m to £3.8m in 2011/12 in cash terms alone ie without allowing for inflation or demographic increasesand continues to fall. While some has fallen on local people who are 'self funders', over £8m NHS spend has been shunted onto the Council-a massive impact on top of 27% government grant cuts to local government. CHC spend by the PCT in 2011/12 is only 55% of what was incurred as far back as 2005/06-again without any adjustment for inflation or demography.

Our concerns have been raised regularly at PCT Board since June 2010 and because of lack of action, led to this being raised with Eamonn Kelly in November 2011-letter from Richard Partington attached.The letter sets out the key issues but is obviously based on the data at that point in time.As a result of discussions with Eamonn who was concerned with the scale of what had happened and the impact on the Council's Adult Care budget, there was an agreement to pass one off funds of £3m across to the Council in respect of 2011/12 and agreement to our use of the 'Lansley' money passported across to the Council to offset part of the shortfall in that year as well.It was also agreed to set the PCT budget for CHC in 2012/13 at a level 'proportionate to average national levels of CHC support' Thus a budget of £6.5m was set although spend outturn in 2011/12 was only £3.8m and still falling, and this will cover an agreement to transfer £2.7m across to the Council -and again with use of the £2.1m Lansley money together they will offset £4.8m of the £8m+ impact on Council budgets. For 13/14 there is a proposal to replicate the transfer of one off funding from the CCG at a slightly reduced level-£2.4m, however there is currently no progress on resolving the concerns with the ongoing CHC decision making within the PCT/CCG which was one of the elements of the agreement with Eamonn back in January 2012.

Given the continued difficulties and her own concerns with our PCT on this issue, Rachel Holynska, Deputy Director for People,Communities and Local Government at Midlands and East has for some time been trying to facilitate further discussion on the matter. Through Rachel it was suggested that facilitators for a joint CCG/Council workshop could be Jim Ledgwidge (consultant with Social care background) and Su Fitzgerald (Health background) as they have taken part in joint training events on CHC regionally and nationally. We were in agreement but the CCG would not accept Su Fitzgerald as the named health facilitator. We flagged this with Rachel who discussed the position with Corinne Taylor, Regional CHC lead and there was a proposal for Corinne instead to take the NHS part in the workshop but we understand she may not be the lead beyond March 31st so haven't yet put this forward to the CCG.

Locally there have been other developments.

- The Health and Social Care Scrutiny Committee have been undertaking a review of the local CHC position, stimulated in particular by an individual appeal and complaint, where the family were supported at their request by one of our Councillors. They are nearing the completion of their review and I understand in finalising their conclusions are considering whether to refer the matter to the Secretary of State on the basis that what has happened constitutes a major change in local NHS policy and as such should have been referred to Scrutiny before implementation.

- Within the Council, our Assessment and Case Management staff have become totally disillusioned with the local CHC process, feel their assessments are not valued, and there is no point in referring people into the system. We now recognise that we need to provide our staff with more training, knowledge and skills to overcome this but have also decided (as per models in place elsewhere) to recruit 2 CHC specialist workers who will support this training process, but also support colleagues in attending panels as well as undertaking assessments in situations where we feel we need to challenge and dispute the local CHC decision. They will be in place by April.

- Our local MP Dave Wright has become involved –see briefing note from last August -and wanted to raise the issue in the House when it came back from the summer recess. We managed to put that on hold saying we were still trying to resolve this locally but we have made no progress since then and would find it hard to justify delaying him again, particularly with the Scrutiny Review under way.Dave has asked for another briefing this month.

- Since 2009/10 T&W PCT support for CHC cases has fallen from 100 to 17.4 cases per 50,000 population while the West Midlands average has risen from 51 to 58 and national average has gone from 44.2 to 57 highlighting why both the 2009 and current positions are outliers in opposite directions.

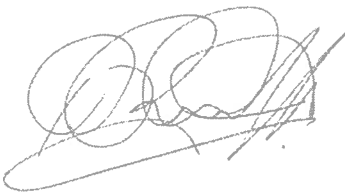
- The local approach is still reviewing existing cases to remove even more people from CHC (there's only 56 left!!) on top of very few new ones being allowed.It also results in issues such as we now find ourselves funding 2 people in private hospitals with no NHS support at all-clearly wrong for us but symptomatic of an approach where in contrast to the PCT, our staff are concerned not to remove care packages from vulnerable people and thus want to avoid people getting caught between the 2 organisations and suffering as a result.

- An update on CHC will be going to our Health & Wellbeing Board in May and under the new arrangements then on to full council.

- An initiative driven by the 2 local CCGs to make changes across the health economy through a Shropshire compact saving costs and improving people's experiences will inevitably involve an element of switching costs out of the acute sector and into community settings. Our ability to support these initiatives will entirely depend on resource switching across the health and care economy to follow consequent organisational impacts given our financial position, and our continuing and disturbing CHC experience will inevitably colour our approach and level of trust.

Our relationships with the PCT and now CCG have been very positive in all but this area and we haven't wanted to damage this ,but due to that concern and the actions of one team in the PCT we are left in an untenable financial position ongoing which will have repercussions for the whole health and care economy locally if not resolved soon.

Yours sincerely



Paul Clifford
Director, Adult and Community Services

Telford & Wrekin Health and Well Being Board
15th May 2013

NHS Continuing Healthcare (CHC)

1.0 Introduction

This report details the Telford and Wrekin Clinical Commissioning Group's (CCG) position in relation to the application of the National Framework for Continuing Healthcare (2012) and the legal framework in which it is required to operate.

As a new organisation, the CCG is keen to ensure all services it commissions for the population of Telford and Wrekin are provided equitably, consistently and in accordance with national NHS directives and guidance. Failure by the CCG to comply with national guidance could lead to judicial review.

CHC is an emotive issue and a nationally devised, prescriptive process must be followed by CCGs in their consideration of each individual's case. (The National Framework for Continuing Healthcare 2012 and Practice Guidance 2012).

It must be remembered that this is an individual process for each person and decisions are made on an individual basis depending on the level of assessed need. The ratification of these decisions is for the NHS organisation to determine.

The NHS can only support funding where the individual has a primary need for healthcare. In simple terms, the process involves a holistic view of an individual's overall needs to determine their health needs and their need for personal and social care. (Personal care is washing, dressing, mobility and moving, nutrition, elimination needs, maintaining a safe environment, providing some psychological support.) If health care is the primary need then the NHS is required to fund the entirety of the individual's package of care , whether this is in a nursing or residential home or in their own home.

1.1The National Process

The national screening tool or checklist is completed by a suitably trained nurse or social care professional; this is usually a hospital or community nurse or social worker from the Local Authority. Referrals for the checklist process are also made by individuals or family members themselves or by nursing/ care home staff. This process determines whether an individual's level of assessed needs trigger the eligibility for a full continuing health care assessment. (N.B. There is a low national threshold set for eligibility for a full CHC assessment.)

The CHC assessment is carried out jointly by health and social care professionals (employed by the Local Authority) who make the recommendation in respect of eligibility for NHS funding to the CCG for ratification. The guidance states that the CCG should accept this recommendation in all but exceptional cases and in practice this is always the case at T&WCCG.

The CCG's appeal process is communicated to all claimants and their families with each outcome decision, should they wish to request a review of the decision. This process is rarely used in practice as the CCG and PCT before it receives a low number of appeals.

It is nationally recognised that the continuing healthcare process is complex and potentially confusing for individuals, usually at a time when they are most vulnerable, and as such the CCG's Complex Care Team, made up of expert nursing staff and social workers, will always help individuals and their families (where appropriate) to understand the process as much as possible.

The Board should note that the CCG, as a new organisation, has given a real commitment to work with the Local Authority (LA) and others to build effective working relationships. Furthermore, the CCG has agreed with the Chair of the Health and Adult Social Care Scrutiny Committee to address some of the recommendations that it is legally able to address, within their report.

2.0 Background

The CCG is aware that there have been tensions between the previous PCT and Telford and Wrekin Council in this area since 2009 in relation to funding.

The LA has maintained that the PCT changed its policy in relation to CHC at this time; however the PCT was merely applying the revised national guidance (as per the National Framework for Continuing Healthcare 2009) that gave a greater level of clarity to the eligibility decision making process aligned to the national criteria.

The CCG is clear that the National Framework for Continuing Healthcare (2012) is appropriately adhered to and implemented in the spirit for which it is intended.

The CCG has assurance of this via several mechanisms:

- An external peer review of cases selected by the Local Authority (LA) was carried out with jointly agreed terms of reference. The independent panel agreed the CCG decisions were in line with national procedure. The LA subsequently disagreed with the findings of this review.
- Review of challenged cases considered by the Independent Review Panel chaired by NHS Midlands and East resultantly upheld PCT decisions.
- Case referred to NHS Ombudsman's Office was not accepted for review.
- External audit of CHC carried out in August 2012 at the request of the PCT Board - outcome of this was "significant assurance" given.

3.0 Financial Impact

The national benchmarking of CHC across England commenced in 2009/2010.

At this time guidance to PCTs on data submission was unclear and PCTs did not readily have information in the required format to submit. This resulted in widely different data sets being submitted across the country. The resulting list of PCTs generated (to which the LA has consistently referred) does not compare "like with like" and as such is still published with a "health warning".

Since the start of the data collection in 2009/10 PCT/CCGs have refined the information they submit to show pure CHC funded cases- removing data related to other NHS funded care such as mental health and adult learning disability special placements and funding to support individuals following their detention under specific sections of the Mental Health Act. The funding of such cases continues to be met by the CCG but this is not reported in the nationally submitted data.

An example is evident in the increase of mental health specialist placement costs:

2009/2010	**2010/2011**	**2011/2012**	**2012/2013**
£1.356m	**£1.744m**	**£1.724m**	**£1.85m (FOT)**

This budgetary realignment is the reason why the national data has shown a reduction since 2009/10. This matter has been discussed on several occasions with the LA and latterly with HoSC members.

The CCG recognises that the Local Authority has financial constraints and to this end transitional support of £6million has been given by the PCT/CCG. It is recognised this can only be a temporary solution as this is not a statutory requirement of the CCG, indeed the CCG would be acting outside of its legal framework if it were to continue to fund social care; this funding could be used for other NHS services.

(It should be noted that the LA applies means testing processes before funding an individual's care whereas the NHS fully funds all care needs if eligible for CHC funding.)

Similarly, comparisons based on national data or even within the West Midlands are not easy to make, as each CCG will commission services that support individuals in a different way e.g. some areas fund 24/7 community nursing teams and have a resultantly low incidence of CHC in their population, whereas other CCGs commission different models of care for their population.

The CCG wish the Board to know that all outstanding financial issues raised by the LA with the former PCT have been resolved amicably and this includes the 2 cases cited by the LA in their report.

The health and social care economy pan Shropshire faces significant challenges in the coming years and it is imperative that the CCG and LA work effectively together to ensure the population is appropriately served.

4.0 Moving Forward

The CCG have given a commitment to work with the LA and its team to review:

- roles and responsibilities of both organisations,
- ways of working for both operational teams
- escalation processes in relation to CHC

Similarly, there is a commitment from the CCG to continue to work with provider organisations on training and education to ensure ongoing appropriate support is available to individuals and their families. The CCG will also be working with

its patient group, to identify any improvements to the advice and support currently in place.

In order that moving forward is successful the CCG requires a reciprocal level of commitment from the LA and their teams, as this will improve the understanding of the shared objectives and ensure both organisations teams understand the legal frameworks in placed upon them I their respective roles. By working together this should help to begin to demystify the CHC process helping individuals and their families understand the process more clearly.

. **Recommendations**

The Health and Well Being Board is asked to:

- fully consider the contents of this report from the CCG
- Note the CCG's commitment to work in partnership with the LA and other agencies to promote a greater understanding of roles, responsibilities and processes in relation to CHC.
- Seek assurance from the LA that it is willing to work constructively with the CCG to move forward for the benefit of the population of Telford and Wrekin

Christine Morris

Executive Nurse, Lead for Quality & Safety

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15th MAY 2013

TITLE – SCRUTINY REVIEW OF CONTINUING HEALTHCARE IN TELFORD AND WREKIN

REPORT OF – HEALTH AND ADULT CARE SCRUTINY COMMITTEE

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 The Scrutiny Committee have made a series of recommendations set out in the report attached that if implemented will improve the Continuing Healthcare (CHC) assessment process. A fair assessment process will ensure that all patients assessed for CHC funding will have their needs appropriately assessed to determine both health and social care needs and address the funding issues for the Council's Adult Care budget.

2. FOR INFORMATION OR DECISION

2.2 This report is for Decision

3. RECOMMENDATIONS

3.1 The Health and Wellbeing Board:

3.2 Consider the Scrutiny report and recommendations and agree to provide a response to a future meeting of the Health and Adult Care Scrutiny Committee.

3.3 Agree to monitor the level of CHC funding, the number of jointly funded care packages made following a CHC assessment and the total funding contributions by partner organisations on a quarterly basis as set out in recommendation 21 in the Scrutiny Report.

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="4">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>Improve: emotional health and wellbeing of borough residents

Improve :unpaid carers health and wellbeing

Support :people with specific health needs to live independently for as long as possible

Support :people with dementia</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>The report has a direct impact for patients who are assessed for CHC funding and their families.</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">Response from Health and Wellbeing Board to be presented to a future meeting of the Health and Adult Care Scrutiny Committee</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>Detail of the financial implications of the change in application of Continuing Healthcare Criteria are contained in the body of the report. The financial impact to the Council is an ongoing budget pressure of over £8.0m. This has grown in impact since 2009/10 and reached this ongoing level in 2011/12. There has been some one off funding from the PCT for 2011/12 and 2012/13 to partially offset the impact plus agreement to use £2m national NHS allocations to local government for the same purpose in both years. These funds should have been available for service improvements and protection of existing social care services against the pressures on Council grant funding. Instead they have been utilised to meet part of the local NHS cost shift. In 2012/13 the combined one off local and national NHS funding used to cover around £8.5m NHS costs shifted onto the Council was around £4.8m leaving £3.7m to</td></tr>
</table>

		be funded by the Council. Discussions around 2013/14 and beyond are continuing with a minimum £2.4m contribution by the CCG proposed for this year only at present.
LEGAL ISSUES	Yes	The Health and Social Care Act 2012 and the National Health Service Act 2006 (as amended) and Regulations made under the Acts make provision for local authority scrutiny of health services and include a power to refer matters to the Secretary of State. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care governs the approach that should be taken by bodies in relation to CHC and refers to protocols being established between relevant bodies.
EQUALITY & DIVERSITY	Yes	The Scrutiny report identifies the difference in level of CHC funding between different PCT areas across the West Midlands.
IMPACT ON SPECIFIC WARDS	No	
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	The Scrutiny Committee have received evidence from individuals, Age UK Shropshire, Telford and Wrekin Advocacy Service
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	The Scrutiny Report has set out how the Committee will measure if the recommendations have been effectively implemented and the further recommendations the Committee will make if the issues regarding CHC are not resolved.

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

5.1 The Scrutiny Report and Recommendations are attached.

6.0 IMPACT ASSESSMENT – ADDITIONAL INFORMATION

6.1 The effect of the reduction of CHC funding is set out in the main report.

7.0 PREVIOUS MINUTES

7.1 HACSC- 42

8.0 BACKGROUND PAPERS

8.1 Report prepared by Fiona Bottrill, Scrutiny Group Specialist, Telephone: 01952 383113

Health & Adult Care Scrutiny Committee

Scrutiny Review of Continuing Healthcare in Telford and Wrekin

April 2013

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Chair's Foreword

I have been involved in Health Scrutiny since it started in 2003 (and in the Shadow Health Scrutiny arrangements for 2 years prior to this) and believe that this is one of the most significant pieces of work that the Health & Adult Care Scrutiny Committee in Telford and Wrekin has undertaken.

I also believe that this Scrutiny Review is particularly timely as the new Telford and Wrekin Clinical Commissioning Group (CCG) has recently taken formal responsibility for the commissioning of many local health services. The system of assessment for Continuing Healthcare (CHC) funding that is criticised in this report has been inherited from the Primary Care Trust. I am pleased to report that my most recent discussions with the CCG regarding CHC have been very positive, and I am confident that this report will provide the basis for future improvements in the CHC process.

Whilst the issue of Continuing Healthcare cannot be separated from funding, the Committee's primary concern has been that the people of Telford and Wrekin should get the level of healthcare based on their need and that this should be consistent with the level of healthcare provided in other areas. As a new organisation the CCG has the opportunity to make the changes necessary to make a real difference for some of the most vulnerable patients and their families. However, the other inescapable finding of this review is that the issue of Continuing Healthcare cannot be seen in isolation from other parts of the health and social care system. The solutions to the problems identified in this report must be resolved through partnership working that puts the patient at the centre – not funding.

This has been a challenging piece of work and it is the first time that the CCG has been involved in a Scrutiny Review and also the first time the Council's new Health and Wellbeing Board will be involved in responding to Scrutiny recommendations. I welcome the approach taken by the CCG in recent discussions and I believe that this establishes a good working relationship with our new NHS colleagues based on the principles of good scrutiny:

- Providing constructive "critical friend" challenge.
- Amplifying the voices and concerns of the public.
- Led by independent people who take responsibility for their role.
- Driving improvement in public services

The Scrutiny Committee is independent of the Local Authority Executive and while a Cabinet Member and Local Authority officers have given evidence to the Committee, we have seen this in the wider context of all the evidence received. The independence of the Committee is greatly enhanced by the Co-opted Members of the Committee who have participated fully in this review. The recommendations in this report were agreed unanimously.

I want to thank everyone who contributed to this review – but especially Mr. S Wood and Mrs. M. Wood, Shropshire Partners in Care, Lightmoor View Nursing Home and Age UK Shropshire, Telford and Wrekin who provided compelling evidence to the Committee of how the CHC assessment process affects patients and their families.

Cllr. Derek White

Chair Telford & Wrekin Health & Adult Care Scrutiny Committee

About Scrutiny

Local Authorities were given the power to scrutinise local health services in 2003. The Health and Social Care Act 2012 reinforced the role of Health Scrutiny Committees setting out their power to review and scrutinise matters relating to the planning, provision and operation of the health services in their area.

The Centre for Public Scrutiny promotes 4 principles of good scrutiny. Scrutiny should be:

- Providing constructive "critical friend" challenge.
- Amplifying the voices and concerns of the public.
- Led by independent people who take responsibility for their role.
- Driving improvement in public services

In Telford & Wrekin, the Health & Adult Care Scrutiny Committee carries out the Health Scrutiny function. The Committee can undertake reviews into local services and is a statutory consultee where the NHS proposes substantial variation or development in services. The legislation and guidance sets out that scrutiny should not be an adversarial process but where a substantial change has been made to NHS services and the Health Scrutiny Committee has not been consulted, the consultation has not been adequate or the Committee believes that the outcome of the consultation is not in the interest of the local health service, the Committee can refer the matter to the Secretary of State for Health. This power of referral should only be used if all other options have been explored to resolve the issue locally.

The Members of the Health and Adult Care Scrutiny Committee are:

Cllr. Derek White (Chair)
Cllr. Veronica Fletcher
Cllr. Jackie Loveridge
Cllr. Adrian Meredith
Cllr. John Minor
Cllr. Roy Picken
Cllr. Jacqui Seymour
Cllr. Chris Turley

Co-optees: Dilys Davis
Jean Gulliver
Cllr. Ralph Perkins
Richard Shaw

About Continuing Healthcare (CHC)

Continuing Care means care provided over an extended period of time to a person aged 18 or over, to meet physical or mental health needs arising from disability, accident or illness.

Historically, responsibility for continuing care rested either with the NHS when the person was in a hospital setting or with Local Authorities when they were in their own home or in residential or nursing home care.

However, with the closure of many long stay hospitals (specialist hospitals for people with a learning disability or mental health need, geriatric hospitals, cottage hospitals, etc.), and reducing stays in general hospitals, this division of responsibility based on the location of the person in need became increasingly problematical. Emerging concerns were that some funding arrangements may be ultra vires if the NHS or Local Authorities were funding care that was outside their statutory roles. There were also concerns about :

- Cost shunting of NHS responsibilities to Local Authorities
- Cost shunting of some (community care services are means tested and many people pay a contribution towards the total cost of their care) or all (where a person is financially assessed as being wholly responsible for funding their community care services as a "self-funder") of the costs to the individual

This led in 1995 to the Department of Health (DoH) setting out guidance for the first time for the NHS in respect of people with long-term or end of life care needs who were no longer receiving their care in hospital. From 1996 each Health Authority (with responsibility subsequently passed to Primary Care Trusts (PCTs)) were required to have criteria (locally developed) defining when the NHS would be wholly responsible for all elements of a person's care and treatment needs even though they were no longer receiving this care and treatment in a hospital setting.

Over time an increasing number of people were deemed to meet these local criteria and therefore had all of their care and treatment costs funded by the NHS, with no personal contribution. However there was significant variation across the country.

Whilst this was a step forward many legal challenges and judgements followed, ultimately resulting in the Department of Health announcing in 2004 that it was commissioning the development of a national consistent approach to funding NHS Continuing Healthcare.

One further positive development was recognition for people in nursing homes (not residential care homes) whose care was either funded by Local Authorities (together with a personal contribution) or wholly funded by the individual, that an element of their care should be the responsibility of the NHS. This led to the introduction of the right to "free nursing care" in a nursing home, which meant that the NHS would pay a proportion of the nursing home fee for all individuals as NHS-funded Nursing Care. The standard rate for 2013 is set at £109.79 a week. This applied to each nursing home resident whether or not they had also been assessed as meeting CHC criteria.

In 2007 the first national framework for NHS CHC and NHS-funded Nursing Care was published followed by a revised framework in July 2009. The Department of Health issued a further revised framework in November 2012 and this is the document that the Committee has used in this review. The framework tried to bring more consistency to the determination of eligibility for NHS funded CHC by applying a "primary health need" test to determine the nursing or other health services

required by the individual. The term 'primary health need' does not appear, nor is it defined, in primary legislation, although it is referred to in the Standing Rules where it sets out that a person should be considered to have a primary health need when the nursing or other health services they require, when considered in their totality, are:

> "(a) where that person is, or is to be, accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or
>
> (b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide".

The Local Authority can only meet nursing/healthcare needs when, taken as a whole, the nursing or other health services required by the individual are below this level. If the individual's nursing/healthcare needs, when taken in their totality, are beyond the lawful power of the Local Authority to meet, then they have a 'primary health need'.

The process to determine if a person has a primary health care need and is therefore eligible for CHC funding is made through the CHC assessment process which involves a two stage assessment. An initial Check List is completed by a qualified healthcare professional or social worker to establish whether an individual needs a full assessment of eligibility. If the outcome of this initial Check List is that the person should have a full assessment, it is the responsibility of the Primary Care Trust (PCT) / Clinical commissioning Group (CCG) to work with other relevant professionals as a multi-disciplinary team (MDT). The MDT will make a recommendation to the PCT / CCG which will decide if the patient is eligible for CHC funding.

The multi-disciplinary assessment is based on 12 domains, scored on a 6-point scale from "no need" through to "priority" – though not all domains attract the higher ratings.

The 2012 Decision Support Tool (DST) Guidance states that a clear recommendation of eligibility to NHS Continuing Healthcare would be expected in each of the following cases:

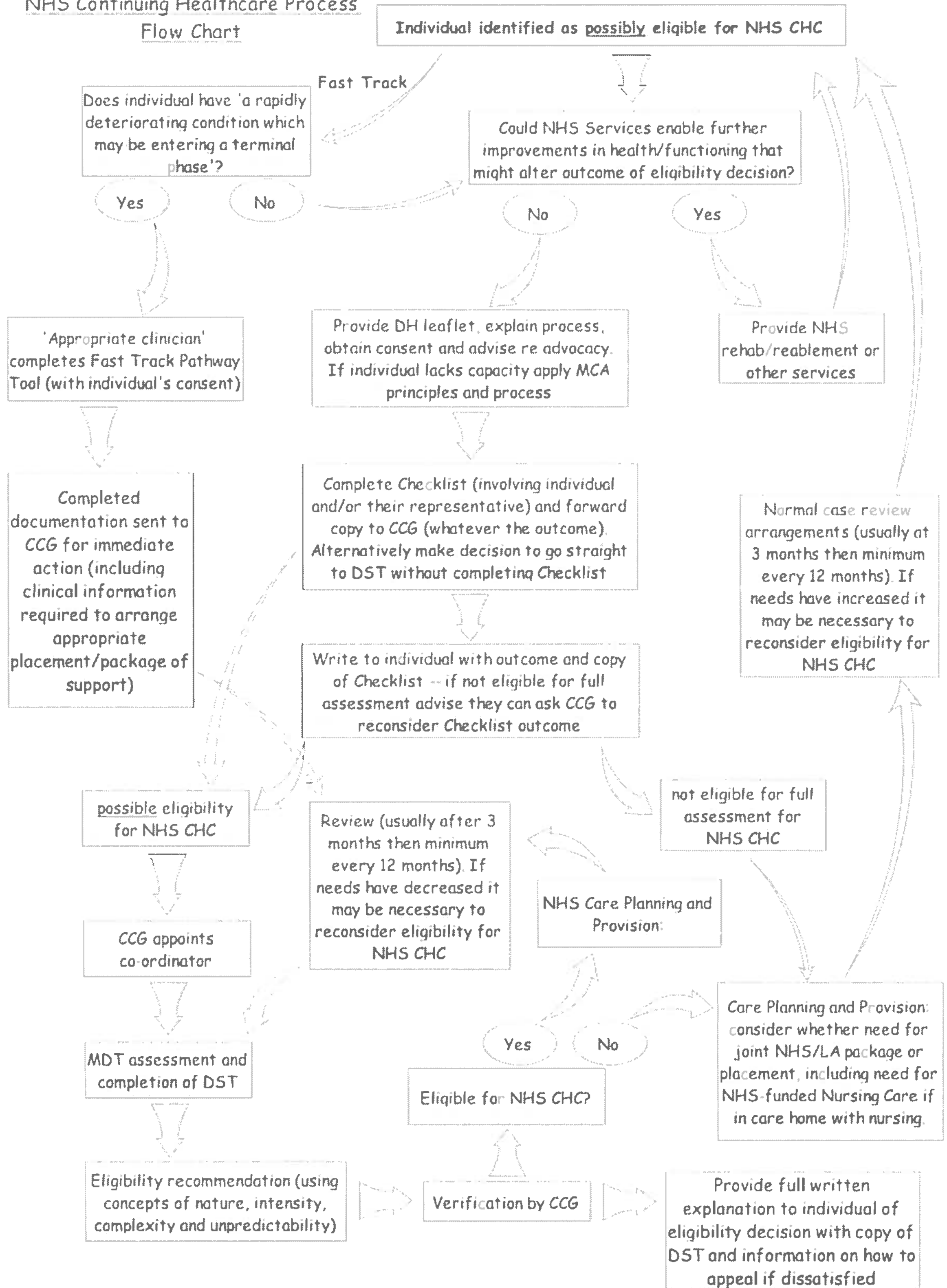
- A level of **priority** needs in any one of the four domains that carry this level.

- A total of two or more incidences of identified **severe** needs across all care domains. Where there is:

- one domain recorded as severe, together with needs in a number of other domains, or
- a number of domains with high and/or moderate needs.

This may also, depending on the combination of needs, indicate a primary health need and therefore careful consideration needs to be given to the eligibility decision and clear reasons recorded if the decision is that the person does not have a primary health need. In all cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in deciding whether a recommendation of eligibility for NHS Continuing Healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example 'two moderates equal one high'. The judgement whether someone has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual's needs. Multi-Disciplinary Teams are reminded of the need to consider the limits of Local Authority responsibility when making a Primary Health Need recommendation.

The Flow Chart below, from the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care sets out the CHC assessment process.


NHS Continuing Healthcare Process Flow Chart
Individual identified as possibly eligible for NHS CHC
Fast Track
Does individual have 'a rapidly deteriorating condition which may be entering a terminal phase'?
Yes
No
Could NHS Services enable further improvements in health/functioning that might alter outcome of eligibility decision?
No
Yes
'Appropriate clinician' completes Fast Track Pathway Tool (with individual's consent)
Provide DH leaflet, explain process, obtain consent and advise re advocacy. If individual lacks capacity apply MCA principles and process
Provide NHS rehab/reablement or other services
Completed documentation sent to CCG for immediate action (including clinical information required to arrange appropriate placement/package of support)
Complete Checklist (involving individual and/or their representative) and forward copy to CCG (whatever the outcome). Alternatively make decision to go straight to DST without completing Checklist
Normal case review arrangements (usually at 3 months then minimum every 12 months). If needs have increased it may be necessary to reconsider eligibility for NHS CHC
Write to individual with outcome and copy of Checklist – if not eligible for full assessment advise they can ask CCG to reconsider Checklist outcome
not eligible for full assessment for NHS CHC
possible eligibility for NHS CHC
Review (usually after 3 months then minimum every 12 months). If needs have decreased it may be necessary to reconsider eligibility for NHS CHC
NHS Care Planning and Provision:
CCG appoints co-ordinator
Care Planning and Provision: consider whether need for joint NHS/LA package or placement, including need for NHS-funded Nursing Care if in care home with nursing.
Yes
No
MDT assessment and completion of DST
Eligible for NHS CHC?
Eligibility recommendation (using concepts of nature, intensity, complexity and unpredictability)
Verification by CCG
Provide full written explanation to individual of eligibility decision with copy of DST and information on how to appeal if dissatisfied

The current Framework from the Department of Health Continuing Healthcare and NHS-funded Nursing Care is available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127199/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf.pdf

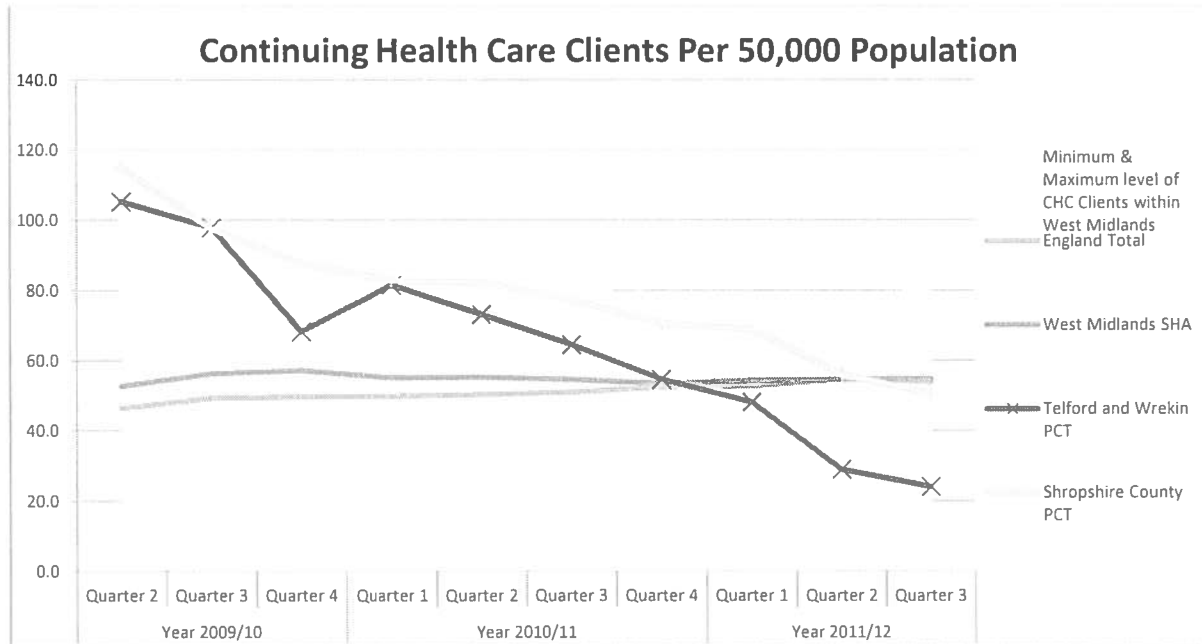
The Committee also received a copy of the House of Commons Library 2011 briefing on NHS Continuing Healthcare which provided a useful summary. This has been attached as Appendix 1. (It should be noted that this has not been updated since the 2012 Framework and so references are still made to PCTs)

Continuing Healthcare (CHC) Funding in Telford and Wrekin

During 2009 it was recognised that the rate of CHC funding in Telford and Wrekin was above the national and regional averages and though on a par with the rest of Shropshire, Telford and Wrekin PCT was the 5th highest funder of over 150 PCTs. It was expected that there would be some reduction in CHC funding in Telford and Wrekin to bring the rate more in line with other areas. However it was reported to the Committee by Telford & Wrekin Council that there had been a 73% cut in PCT spend on CHC from £13.9m in 2009/10 to £3.8m in 2011/12 in cash terms alone and still falling. Therefore, the total reduction in CHC funding over this period has been £10.1 million – around £8.5m is placing an additional burden on the Council's budgets - with the balance falling directly on local people who 'self fund'. During this period the regional and national average rate for CHC funding increased. The figures reported by the CCG showed a reduction in CHC funding from £13.7m in 2009/10 to £4.4m in 2011/12.

Graph 1 below shows the rate of change in CHC funding in Telford and Wrekin compared to the regional range, the regional and national average and the funding rate in Shropshire based on the Department of Health CHC data. It is noticeable that while the funding rate in Shropshire was higher than the rate in Telford in 2009 this has decreased but is now only slightly below the regional and national rates. The total reduction of CHC funding in Telford and Wrekin does not take into account inflation costs and demographic increases.

Graph 1: Comparative Funding Rates for Continuing Healthcare Funding



The CCG informed the Committee that the Department of Health data comes with a 'Health Warning' which makes it difficult to use to compare the level of funding between different areas. However, any inconsistencies in data between authorities would not affect the accuracy of the reduction of CHC funding in Telford and Wrekin. The Committee made it clear at the meeting with the CCG that their concerns about CHC in Telford and Wrekin were not based on the statistical data alone - the data served as a further indicator of the problems identified by other people who had given evidence. A statistical analysis of the rate of change between quarters for the past 3 years demonstrated that over this time period, the change in Telford and Wrekin is significantly different to national and West Midlands trends. (The full analysis is set out in Appendix 2.)

Following the meeting with the CCG the Members asked for clarification regarding the number of people in Telford and Wrekin who are assessed as eligible for CHC funding and their age profile. This was towards the end of the scrutiny review and the CCG was unable to provide clarification before this report was produced. Table 1 below summarises the data that the Committee has considered. The Committee understands that Department of Health data is based per 50,000 population and that the number of people who receive CHC funding every quarter will not equal the total annual number of people who are assessed each year – but the Committee found it difficult to reconcile the two sets of figures and requested a further explanation.

Table 1: Data from the Department of Health and Telford and Wrekin CCG regarding CHC

	2009/10				2010/11				2011/12				2012/13
DoH Data*	Q1 100.1	Q2 105.3	Q3 97.9	Q4 68.3	Q1 81.5	Q2 73.2	Q3 64.5	Q4 54.7	Q1 48.2	Q2 29.0	Q3 24.1	Q4 N/A	Q1-4 N/A
CCG Data**	185				99				127				101

*Number of people receiving CHC funding per 50,000 population

**Number of people assessed as eligible for CHC funding

It may be the case that the local data provided by the CCG includes figures for young people under 18 who receive funding through a separate CHC funding stream who would not be included in the Department of Health data.

The PCT / CCG has made some arrangements to transfer one off funds to the Local Authority to mitigate the ongoing £8.5m financial impact of the reduction in CHC funding but there is no ongoing funding transfer commitment. This included:

- Agreement to use £2m per annum 'NHS Lansley money' from the national £1bn intended largely for investment in services to reduce future pressures on acute services but instead used to offset part of this cost switch from the PCT to the Council. This is not ongoing funding.

- £3m one off PCT funds to cover part of the Council's overspend in 2011/12. £2.7m in 2012/13 and an estimated figure of £2.4m in 2013/14 (the actual figure will be based on how much the CCG actually spend in 2013/14 against what would be the per capita national average relating to Telford and Wrekin).

The Committee have been informed by Local Authority officers that discussions with the CCG have been ongoing regarding CHC, and both the Strategic Health Authority and the National Commissioning Board have been involved in these discussions as was the PCT Cluster. At the time of writing this report the Local Authority and CCG are planning a workshop which will be externally facilitated.

Scrutiny Review of Continuing Healthcare (CHC)

The issue of CHC funding was brought to the attention of the Health & Adult Care Scrutiny Committee through a number of routes:

- It had been reported to Cabinet and the Budget & Finance Scrutiny Committee that that over a period of about 3 years the level of funding from the PCT had reduced and this was having an impact on the adult care budget
- It was reported by adult care services that there were concerns about the CHC assessment process and the impact the reduction in funding had on the adult care budget
- A letter from Shropshire Partners in Care which raised concerns about the effect of the reduction in the level of CHC funding on patients, their family and care homes
- A ward Member raised concerns about the CHC process following the experience of a family in his ward.

Following these concerns the Health & Adult Care Scrutiny Committee included the issue of Continuing Healthcare in the work programme. It is not the role of the Scrutiny Committee to consider the quality of individual assessments – but the Committee has gathered evidence which has provided an overview of the CHC process.

Prior to the review, the Chair of the Health & Adult Care Scrutiny Committee wrote to the CCG highlighting the scale of the change in CHC which had resulted in a substantial change in service. The letter also asked for details of any consultation and impact assessments carried out regarding the change in the local interpretation of the CHC framework. The response from the Chief Operating Officer of the CCG to these questions was "Whilst I appreciate that the level of reduction in spending on CHC is extremely significant, I would not agree that this forms a substantial variation in service as changes have been brought about as a result of changes in national policy in the revised framework. In that respect therefore there was no requirement for a consultation, nor indeed a requirement for an impact assessment. I am sure however that as this was a national policy change, then consultation should have taken place at a national level." (Letter from CCG Chief Operating Officer to Chair of the Health & Adult Care Scrutiny Committee, 10th September 2012.)

There were a number of issues that the Committee would like to have considered in more detail but this would have taken more time and based on the strength of the evidence received the Committee concluded that it was more important to ensure that the CCG was presented with the report and recommendations and therefore given the opportunity to take action sooner rather than later. Where the Committee felt it was appropriate, recommendations have been included that request further work is carried out by the relevant organisations to investigate the issues the Committee did not pursue.

Evidence Received

Mr. Steve Wood and Mrs. Marion Wood

Shropshire Partners in Care

Lightmoor View Nursing Home

Age UK, Shropshire, Telford and Wrekin

Telford and Wrekin CCG: Chair, Chief Operating Officer and Executive Lead and Quality, Nursing and Safety

Shrewsbury and Telford Hospital Trust: Deputy Chief Nurse, Discharge Liaison Nurse, Princess Royal Hospital

Shropshire Community Health Trust: Nurse Consultant

Telford & Wrekin Council: Cabinet Member, Resources & Service Delivery; Assistant Director, Care & Support; Assistant Director, Social Care Specialist; Two Service Delivery Managers from Adult Care & Support; Continuing Healthcare Team Leader.

Issues Identified by the Committee

Effect on Individuals and their Families

One of the Committee's primary concerns is that the local interpretation and application of the national CHC framework results in an unfair assessment process and that some patients are receiving care that is not adequately meeting their needs.

The Committee have spent a great deal of time understanding the CHC assessment process and recognise that making an assessment of health and social needs is complex. However, the Committee felt very strongly that every effort must be made to explain the process and the consequences of the decisions that will be made to patients and family/carers so that they can understand and contribute to the process and challenge where they feel necessary. From the evidence that the Committee received many patients who are assessed for CHC funding will be very frail and some will be receiving end of life care. The Committee asked the local NHS organisations how patients' mental capacity is assessed and how the professionals involved in the CHC process decide if and how to involve family in the assessment process. The answers provided by NHS organisations stated that their procedures were in line with legislation and good practice. However the evidence from care homes, Local Authority officers, Age UK Shropshire, Telford and Wrekin and a family who had been through the CHC assessment process highlights that people are often very confused by the assessment process and do not understand the implications of the decisions that will be made. It was suggested by a family who had been through

a CHC assessment process that each patient and their family should be provided with a full guide setting out the CHC process, how this fits with the hospital discharge process and clearly sets out the implications of the decisions regarding CHC for the patient and their family. The Committee did consider this proposal when making the recommendations in this report. However the Committee recognise that people who are assessed for CHC will have different conditions and live in different environments and it would be impossible to produce a single document that would cover all eventualities for all patients. The Committee has therefore focussed on the need for advocacy services that would provide advice and support based on individual needs.

The Committee understands that difficult decisions have to be made regarding CHC and that in some instances patients or their family will not be happy with the outcome of a fair assessment on the basis that it has not produced the outcome they would like. However, the principles of good care as set out in the Francis Inquiry should relate not only to direct medical and nursing care for patients but also to the supporting systems and processes within the healthcare system. The effectiveness of the CHC must also demonstrate the values of "Caring, Compassionate and Considerate Nursing". The Committee wants to ensure that this caring culture is established at all levels of staff in the CHC team. The Francis Report highlights the role of leaders modelling these vaules and the Committee wants to ensure this, and that CCG managers lead by example. The National Framework is clear that the "individual, their perception of their support needs, and their preferred models of support [is] at the heart of the assessment and care planning process." (p.17)

The Committee received evidence that the Council's policy has been that if the NHS is not meeting the cost of care through CHC funding or joint packages of care and the person is eligible for Local Authority funded care then the Council has covered the cost of this care. However, the Committee was informed by care homes that the contracted local authority rate and the NHS-funded Nursing Care do not cover the full cost of some patients' nursing health care needs. In such cases, the patient or their family would be asked to make a 'top up' payment. The Committee was impressed with the dedication and level of care provided by the nursing homes to the extent that in some cases the care home had provided the higher level of care needed without receiving the additional payment where this was not possible. It was stressed that it would always be a last resort for patients to be moved to a different care home which charged lower fees. The Committee was concerned that any move for a frail patient can be traumatic and detrimental to their health and in some cases terminal. Members were also concerned that where a care home charges lower fees this would probably result in less qualified staff providing the care and the home would therefore be less able to meet the needs of patients with complex physical and mental health needs or there will be fewer staff to complete essential tasks.

The Committee was also greatly concerned about the consequences of the CHC process for people who are not eligible for Local Authority funded care. The Committee was informed that where an individual has capital of over approximately

£23,500 they will have to cover the costs of the care themselves i.e. they are self-funding. Based on demographics, Telford and Wrekin does not have a high proportion of people who are self-funding – but as some people who self-fund do not contact the Local Authority but arrange their own care, it is difficult to estimate the numbers involved. Shropshire Partners in Care provided some data based on 26 care providers in Telford and Wrekin which showed that of the 164 self-funding residents, 16.5 % were eligible for CHC funding, 32.9% were not eligible for CHC funding and 50.6% had not been assessed for CHC funding. This data does not provide a comprehensive analysis of people who fund their own care in the borough – but it does illustrate that there are a number of patients who are not funded by the Local Authority who have been through the CHC process. These individuals and their families will be coping with illness which in itself is stressful but in addition will also be trying to understand the complexities of health and social care funding perhaps without any independent advice or advocacy. The Committee is extremely concerned that there are individuals and families who are paying for their own care needs who have not been assessed fairly throughout the CHC process.

When asked about this, the CCG responded that irrespective of where the funding comes from the care received by individuals should of the required level. This does not take account of the fact that the standard contracted rate for Local Authority care is between about £364 and £424 per week, which even with the additional £109.79 NHS-funded Nursing Care does not cover the cost to the nursing home of providing the level of nursing led care of around £800 per week. There are cases where the Council does pay a higher rate and this contributes to the pressures on the adult care budget.

Patients and Families Understanding of and Involvement in the Continuing Healthcare (CHC) Process

A strong theme that came throughout the review was that patients and their families do not understand what the CHC assessment process is, what the implications of the decisions are or how they can appeal these decisions. The Committee has concerns that families are not involved appropriately in either the Initial Check List or the Full Assessment.

More seriously, Members were also informed that there had been occasions during the assessment meetings when a member of the CHC Team had informed family members that the family should not worry about the outcome of the assessment because if the person was not eligible for CHC funding the Local Authority would pay. The Committee objects most strongly that this message is given to families when they are very vulnerable and may not be aware that Local Authority care is means tested and a 'top up' payment may be required.

The Full Assessment Process

The Committee has concluded that based on the evidence received the CHC Assessment process in Telford and Wrekin is fundamentally flawed. As part of the review the Committee considered the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and came to the conclusion that it is the local interpretation and implementation that is causing problems. The Committee commented that the November (2012) revised Framework addresses many of the issues identified in the scrutiny review and Members found the Practice Guidance section of the document particularly helpful.

The Committee concluded that the CCG has not adequately explained why the local interpretation of the Framework has resulted in the reduction in CHC funding from £13.7m to £4.4m between 2009/10 and 2012/13 (CCG figures) while the regional and national trend has seen an increase in CHC funding. In the evidence presented by the CCG to the Committee at the meeting on the 25th March 2013, it was stated that the "eligibility for NHS CHC is based on the needs of the individual and the level of need to be assessed as a 'primary health need' – this fundamental criteria has not changed since the publication of the first National Framework in NHS Continuing Healthcare and NHS Funded Nursing Care in 2007". The Committee was also informed that no decisions had been made to change the local interpretation of the national framework and the implementation of the Decision Support Tool. The Committee was not satisfied that the evidence presented by the CCG explained why such a dramatic change in CHC funding has occurred without a change in policy at some level within the organisation.

The Committee noted that the 2012 Guidance on the Decision Support Tool does make some changes to the indicative guidance in the Decision Support Tool that will lead to a clear recommendation of eligibility for CHC funding. Under the 2009 Framework the Decision Support Tool Guidance sets out that:

> "A clear recommendation of eligibility to NHS Continuing Healthcare would be expected in each of the following cases:
>
> - A level of priority needs in any one of the four domains that carry this level.
> - A total of two or more incidences of identified severe needs across all care domains.
>
> If there is one domain recorded as severe, together with needs in a number of other domains, or a number of domains with high and/or moderate needs, This **may well** also indicate a primary health need."

However the 2012 Decision Support Tool Guidance sets out that a clear recommendation of eligibility to NHS Continuing Healthcare would be expected in each of the following cases:

- A level of **priority** needs in any one of the four domains that carry this level.
- A total of two or more incidences of identified **severe** needs across all care domains. Where there is:
  - one domain recorded as severe, together with needs in a number of other domains, or
  - a number of domains with high and/or moderate needs.

The difference identified by the Committee is that whereas in the 2009 Decision Support Tool Guidance there is some ambiguity regarding the eligibility of patients who do not 'score' a priority need in any of the domains, the 2012 Decision Support Tool Guidance states clearly that patients who do not have any needs identified as a "Priority Need" can still be eligible for CHC funding under certain circumstances.

There are several issues that the Committee concluded were particularly problematic within the local approach to CHC assessments:

Multi-disciplinary Approach to the Full Assessment for Continuing Healthcare (CHC)

The Committee heard from a number of sources that the local CHC assessment process did not pay sufficient regard to the views of non-NHS professionals. This view was expressed by Local Authority officers, care homes and families who have been involved in the process. Both the framework documents issued by the Department of Health in 2009 and 2012 stress the importance of joint working between the PCT / CCG and other professionals "respecting each other's professional judgement, knowledge and experience and working together to obtain the best outcome for the individual" (NHS Continuing Healthcare Practice Guidance 2009). The 2012 Framework explains at length how the Multi-Disciplinary Team (MDT) should work and it is the view of the Committee that this guidance is not implemented locally in the spirit in which it is intended. The Committee was most concerned that staff from care homes reported that they were prevented from fully taking part in the Multi-Disciplinary Team meeting with the families. Local Authority staff reported that they are pressured by the CHC assessors into complying with the view of the PCT / CCG that the person being assessed is not eligible for CHC funding. The information presented to the Committee said that this has resulted in the social work staff becoming disillusioned with the CHC process and no longer challenging unfair decisions as it will not change the outcome. A significant piece of evidence on the quality of the CHC assessment process came from Shropshire

Partners in Care and the nursing homes which provide services commissioned through CHC funding from other PCT / CCG areas. The care homes reported that the process managed by other NHS areas valued the professional opinions of their staff and produced better care outcomes for the patients. It was reported that of all the NHS areas, the CHC assessment and re-assessment process managed by Telford and Wrekin PCT / CCG was the most difficult for the patients, their families and the care homes. The Committee was informed that the PCT had previously included a panel as part of the decision making process - however this ended some time ago and the CCG does not operate a panel. The Committee considered the advantages and disadvantages of a panel in the process including the additional resources and time to administer a panel and the check and balance that the panel can provide in a system.

The Committee received evidence that the PCT / CCG approach to the assessment was based entirely on the Decision Support Tool (DST). Nursing homes and Local Authority officers reported that when full assessments are carried out the CHC assessors do not take account of the holistic needs of the patient, (physical, mental cognitive and behavioural) in the setting they are in. This is contrary to the 2009 and 2012 Department of Health Frameworks which describe the "purpose of the DST is to help identify eligibility for NHS Continuing Healthcare; it is not designed as an assessment tool in its own right." (p.71). The CCG reported to the Committee that "all recommendations made to the PCT are made by a properly constituted MDT". However, this did not provide the assurance the Committee wanted that the views of all the professionals and carers are seen by the CCG as an essential part of the assessment process. The CCG provided information about a peer review of 45 CHC cases. However the Committee understands that this was a desk-based exercise based on the assessments managed by the PCT. It is the Committee's view that a desk-based exercise of a flawed assessment process will produce a flawed result. The peer review did not take into account all the necessary information and therefore does not provide assurance that in all cases the correct decision regarding CHC funding has been made.

The Committee has been informed that the working relationship between the CCG and the Local Authority in all other respects has been very positive and so the difficulties experienced by the Local Authority in relation to CHC cannot be seen as symptomatic of wider problems between the organisations. In fact the Local Authority had raised issues concerning CHC funding locally with the PCT / CCG and at a regional level with the Strategic Health Authority / National Commissioning Board. However the Local Authority had purposely not pursued a confrontational line with local NHS organisations which might be detrimental to wider partnership working. The Committee hopes that the CCG will take the opportunity now they have full and legal responsibility for the CHC process to listen and respond to the concerns expressed by the other organisations and individuals who have taken part in this review.

Other issues

The Committee is also concerned about the quality of the assessment forms used in Telford and Wrekin. The Department of Health Framework is clear that only the information set out in the framework document should be used as part of the CHC assessment to determine eligibility for CHC funding. However it was reported to Members that one section of the Telford and Wrekin Integrated Health Assessment used in hospital (which includes the Initial Check List) states within the Cognition Domain that "if a patient has suffered a CVA (stroke) and has not had previous cognitive issues do not refer to MH [mental health] team." Members are concerned that including this information on the form provides a poor basis for the assessment and is not good clinical practice as it is common for people who have survived a stroke to suffer depression or other mental health issues regardless of their previous mental health.

The Committee also investigated how the CHC process fits with other health and social care processes, for example hospital discharge. There was general consensus on the principle that if a patient is referred for a Full Assessment that this should take place in a setting where the patient has received enablement support and their condition has improved as far as can be expected. It was generally accepted that a patient is unlikely to reach this level while in hospital and therefore in most cases the Full Assessment should take place following hospital discharge and a period of enablement. (An exception to this is Fast Track assessments which are initiated while a patient is in hospital.) However this presents a potential funding issue as the NHS is required to fund post-hospital care for 6 weeks but it was reported by the Local Authority that on average it will take 16 weeks to complete the full assessment. When the Committee met with representatives from the Hospital Trust and Community Trust it was also raised that it would be helpful for NHS staff to have access to the assessment carried out by social workers so that they are aware of the social care support needs that have been identified and the care package that has been put in place for patients once they are discharged.

Due to time constraints the Committee did not explore the full extent of the use of Joint Packages of Care but on the basis of the evidence provided by the Local Authority it appears the majority of cases are funded wholly by the Local Authority or the NHS. The Department of Health Framework advises that "if an individual does not qualify for fully funded Continuing Healthcare the NHS may still have a responsibility to contribute to meeting that individual's health care needs" (p. 89). In addition the Framework sets out that "CCGs are reminded that joint funding will be appropriate where someone in a care home with nursing has nursing or other health needs that, whilst not constituting a primary healthcare need, are clearly above the level of needs intended to be covered by NHS-funded Nursing Care." (p. 91).

The Committee met with the officer recently appointed by the Local Authority to support front line social work staff to re-engage with the CHC process and challenge

where appropriate. The Committee was pleased to hear that this role will also include working with nursing care homes to ensure they have the necessary skills to demonstrate the level of nursing care required by their patients.

Re-Assessment

The problems with the assessment process were highlighted during discussions regarding the re-assessment process. The Committee understands that the Department of Health Framework sets out that "a case review should be undertaken no later than 3 months after the initial eligibility decision" (p. 40). However the evidence from the care homes and the Local Authority indicated that the re-assessment process is financially driven and used as a mechanism to withdraw CHC funding at the earliest opportunity. The Framework states clearly that "neither the NHS or LA should unilaterally withdraw from an existing funding arrangement without a joint re-assessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement……and current funding and care management responsibilities should remain in place until the dispute has been resolved" (p. 41). The evidence from the Local Authority is clear that this part of the framework is not implemented. The Committee asked for information on the number of re-assessments and the outcome of these re-assessments. When asked to provide this information the CCG responded that this data is not routinely captured.

Another major concern for the Committee with regard to the re-assessment process is the local interpretation of the Well Managed Need principle as set out in the Framework document (p. 61). Nursing care homes reported that it felt that they were being penalised for providing high quality care that stabilised a patient's condition or where the care resulted in a decrease in the symptoms but the underlying condition remained. The Framework states that the "decision making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs." (p. 61). Nursing homes reported that the re-assessment process did not recognise that while the direct care may be provided by care staff that the patients' care plans are designed by qualified nursing staff who are on site 24 hours a day, 7 days a week. The nursing staff supervise the care and are the first point of contact if a non-nursing member of staff has concerns about a patient. The Committee debated at length the distinction between the roles of nursing and care staff and the changes in professional roles in recent years. During this discussion Members of the Committee made comparisons between care provided in hospital where care that would have previously been provided by qualified nursing staff is now provided by Healthcare Assistants. The Committee concluded that if this is the situation in a hospital setting, the same principles should apply in a nursing led care home setting. This view is confirmed in the Department of Health Framework which states that "Eligibility for NHS continuing healthcare is, therefore, not determined or

influenced either by the setting where the care is provided or by the characteristics of the person who delivers the care" (p21).

One of the major concerns expressed by the care homes was that the local interpretation and implementation of the re-assessment process was very difficult for families to understand. Nursing care homes reported that they can be placed in a difficult position where they do not agree with the outcome of the assessment but the family can come to the conclusion that the outcome of the assessment is because there has been a problem with the care provided. This is all happening at a time when the family is particularly vulnerable.

The issues regarding re-assessment were highlighted to the Committee when considering the cases of patients with dementia. When visiting a nursing home which specialised in dementia care, Members were informed that the proportion of patients who received CHC funding had reduced from 80% to 20% over the last 3 years, resulting from a higher threshold for new patients who are assessed for CHC and also patients who are re-assessed as no longer eligible for CHC funding.

Members were aware that dementia is a progressive illness and while the symptoms can be managed there is no cure. While the review was carried out a report from the Care Quality Commission highlighted the scale of the problem of dementia - 80% of people living in care homes have a form of dementia or severe memory problems and that this will increase as the aging population increases. The Census figures for 2011 showed that since 2001 the population aged between 65 - 84 years of age increased by 22.2% and the population aged over 85 grew by 27.3%. The Members recognise that not all patients with dementia would be identified as having a 'primary health need' but were very concerned about dementia patients who were re-assessed as no longer having a primary health need and therefore would not continue to receive CHC funding to provide the level of nursing care they require. The Department of Health Framework is clear that "only where the successful management of a healthcare need has been permanently reduced or removed an on going need, such that the active management of this need is reduced or no longer required, will this have a bearing on the NHS continuing healthcare eligibility." (p21).

Appeals and Reviews

The Committee received compelling evidence from a senior Member of the Council who has supported a family through the CHC appeals process that this suffered from all the problems that marred the assessment process. The appeals process was not explained to the family, the CHC staff had undue influence during the appeal meeting and the letter informing the family of the outcome of the appeal did not come from the Chair of the Panel but from the CHC Team. The Committee was extremely concerned that, if a Councillor who is familiar with the processes and systems within

the public sector was confused by the CHC appeals process, families who are in a vulnerable position appealing a decision on behalf of a family member will be overwhelmed by this experience and denied the opportunity of a fair appeal.

The Committee was particularly concerned for patients and families who have been assessed as not eligible for CHC funding and do not meet the criteria for Local Authority funding. The particular concern was that these individuals and families may be going through an appeals process without independent support or advocacy.

The Committee was informed toward the end of the Review that the CCG removes CHC funding if a patient is re-assessed as not eligible for CHC funding even if the patient or their family dispute this decision. The Committee were informed that this is not in line with the Framework.

Effect on Local Authority Adult Care Services, Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Care/Nursing Homes and Domiciliary Care Services

The consequences of the CHC process in Telford and Wrekin is not just an issue between the CCG and the Local Authority. There are consequences for individuals and their families as set out above and also for the wider health and social care system. The change in the assessment process locally has directly resulted in additional costs to the Council of around £8 million. If the current approach to the CHC assessment process continues, it is likely that the financial burden this places on the Local Authority adult care budget will result in the Council having to raise the level of eligibility for care to critical. In practice this would mean that people whose care needs are assessed as substantial and are currently receiving care funded by the Local Authority would no longer receive this funding and would have to fund their care themselves. The impact of the transfer of these costs must be seen in the broader context of the savings that all areas of the Council must make as part of the austerity measures, equivalent to a real term cut of £40m to the Council's budget. The average reduction in funding for Government departments over the 4 year period of the Comprehensive Spending Review is 8.3% - the average reduction in Local Government funding is 27% rising to 33% after recent government announcements. The CCG has recognised that the reduction in funding is an issue and has transferred one-off funding to the Local Authority on an annual basis during 2011/12 and this agreement has continued for 2012/13 to make up some of the pressure that the reduction in CHC funding has created on the adult care budget. While there is verbal assurance from the CCG to carry on this arrangement, there will be a growing risk of challenge from their auditors.

As well as the financial implications for the Local Authority the Committee was concerned about the morale and wellbeing of Local Authority staff involved in the CHC assessment process. An indication of the break down in the working

relationship between the PCT / CCG and Local Authority reported to the Committee is that social work staff feel bullied, that their professional opinion is not valued and as a consequence many have disengaged from the CHC process. They have ‘given up’ challenging decisions that they do not agree with as they feel this will not make any difference to the outcome.

It was reported to the Committee that the reduction in funding for nursing care homes will mean that some nursing care homes in Telford and Wrekin may close and that more places at nursing care homes that continue to provide services could be commissioned by other CCGs. The consequence of both of these outcomes would be a reduction in the availability and choice of nursing care in the borough.

The implications set out above will have a direct effect on the Hospital Trust through an increase in demand for acute services and delay in hospital discharge. The Hospital Trust is under great pressure and has recently announced that non-emergency operations and outpatient appointments were cancelled on one day in order that the Trust could ensure safe emergency services. There are financial consequences for the CCG if the Hospital Trust is not able to resolve these capacity and patient flow issues.

The Committee was not able within the time constraints of the review to explore the views of domiciliary care providers on CHC. The Committee recognises that in many cases, care staff who visit people in their homes can regularly identify deterioration in a patient’s condition – but the Committee received evidence that they are not always aware of how to raise these concerns. The Committee discussed the need to ensure that domiciliary care providers and their care staff are engaged in the CHC process so that they can contact the relevant professionals to request and contribute to an Initial Check List. Care staff should also be able to contribute to the Full Assessment.

Conclusion

The CHC assessment process is fundamentally flawed resulting in the situation that people in Telford and Wrekin are less likely than people in other areas of the West Midlands to receive CHC funding. This has consequences for the level of nursing care they will receive and may have financial implications for the patient and their family. As previously highlighted, a statistical analysis has demonstrated that over the last 3 years the change in Telford and Wrekin is significantly different to national and West Midlands trends.

Given that the CCG set out in the evidence presented to the Committee that the fundamental criteria for CHC funding has not changed since the publication of the first CHC National Framework in 2007, the Committee has concluded that the CCG has not adequately addressed the following points:

- If the eligibility for CHC is determined on the level of a patient's need – a reduction in funding of 73% and rising should be the result of a reduction in the overall level of need. This reduction in the level of need has not been demonstrated by the CCG and the Committee does not accept that the flawed assessment process can be used to justify this reduction.
- Why the rate of change of CHC funding has been so much greater compared to other areas while regional and national average rates have increased.
- How such a change in the interpretation of the Decision Support Tool has been made and without a decision being made and recorded at some level in the PCT.

The Committee has also concluded that the extent of the change in CHC funding in Telford and Wrekin constitutes a substantial variation in the provision of this service as set out in the Regulations of the Health and Social Care Act 2012. It was explained in the introduction to this report that the PCT did not undertake any consultation on the local interpretation of the Framework issued by the Department of Health in 2009. The Committee sincerely hopes that the CCG will consider the issues identified in this report and implement the first stage recommendations set out below. The Committee has concluded that these consequences are so serious and so far reaching, that if the CCG is not prepared to accept and implement the recommendations of this report without an explanation that is accepted by the Committee, that it is in the best interest of the local health service and the people of Telford and Wrekin that there is a full public consultation on the future provision of CHC in the borough.

If a consultation is undertaken, the Committee has also concluded that while the CCG, as the commissioning body, will be responsible for the consultation, the Terms of Reference for the consultation must be agreed by the Health & Wellbeing Board in consultation with Shropshire Partners in Care and Age UK Shropshire, Telford and Wrekin and other advocacy services involved in supporting patients and families during the CHC process. In order to demonstrate that the CCG is taking an open minded approach to the consultation it is important that, while the CHC and Complex Care Team contribute to this consultation, it is managed, the responses analysed and the report written by an independent body.

It is the expectation of the Committee that if this consultation is carried out that this will produce an outcome that best meets patient needs and is supported by the organisations involved in the CHC process. However, in the event that the CCG does not agree to carry out the consultation as described or that the consultation does not satisfactorily resolve the issues identified in this report, the Health & Adult Care Scrutiny Committee retain the right to refer this matter to the Secretary of State for Health.

Recommendations

The Committee has made a series of recommendations that are set out in the three stages below. The Committee is aware that the issue of CHC in Telford and Wrekin has not been resolved despite attempts by the Local Authority to raise its concerns. The Committee needs to ensure that this report sets out clearly what its expectations are of a successful CHC process, how they will measure this and what action they will take if the issues identified in this report are not resolved.

While the recommendations are directed at the different organisations involved in the CHC process, the report will be presented to the CCG Board and the Health & Wellbeing Board. The Health & Wellbeing Board will have a role in co-ordinating the response to the recommendations and monitoring implementation. The Scrutiny Committee will hold the Health & Wellbeing Board to account for its role in resolving the issues regarding CHC.

First Stage Recommendations

The Scrutiny Committee Recommend that:	**Made to**	**How the Scrutiny Committee will Measure that this has been successfully implemented**
Involving patients and Family 1. The CCG put systems in place to ensure that all patients and their families are appropriately involved in the assessment process. The CCG must ensure that the assessment is patient centred and that the assessment is carried out in a caring and compassionate manner in line with the Francis Report.	CCG	CCG to seek and analyse the patients' and families' experience of CHC. One option that has been suggested is that patient and their family are encouraged to use the patient options website to provide feedback. However, the Committee are of the view that other methods of feedback must also be developed for people who do not or cannot use the internet. The feedback should include specific questions on the assessment process rather than the quality of care. The Committee recognise

		that in some instances patients or their family will not provide positive feedback on the basis of the outcome of the assessment – not the quality of the assessment. This must be recognised in any audit or evaluation of the CHC process.
Advocacy 2. All patients who are assessed using the Initial Check List and their families should be given written information about independent advice and advocacy services with specialist knowledge of CHC BEFORE the checklist is initiated. The information should provide the contact details for the advocacy services. 3. This advocacy service must be adequately resourced to respond in a timely manner and provide the necessary support to individuals and their families throughout the CHC process. The Committee recommend that the CCG contribute toward the cost of this service in line with the National Framework Practice Guidance (p.98)	CCG AGE UK and other CHC advocacy services CCG LA	There is an increase in the uptake of advocacy by patients and their family Part of the contract with the organisation(s) providing the advocacy service is that they will provide quarterly report to the CCG, Health and Wellbeing Board and the Health and Adult Care Scrutiny Committee on the advocacy work provided and the views of patients and their families of the CHC process.
Multi-Disciplinary Team Working 4. The Multi-disciplinary working can only be delivered through a successful partnership approach both at organisational level and practitioner level where all the people involved in the care of an individual feel that their views are valued. The views of all	CCG LA SaTH Community Health Trust Domiciliary Care	The DST will provide a record of the contribution of the range of professionals and carers and how their views are taken into account.

professionals in the MDT must be evidenced in the decision making process.	Providers (Other organisations as set out p. 74 of the National Framework)	
5. All the organisations involved in the care of an individual being assessed for CHC must be included in the Personal Details section of the DST (p. 53 of the draft Operational Arrangement Document). All these organisations must be contacted to provide evidence for the assessment including mental health services.	CCG	This will be evidenced in the completed Decision Support Tool
6. Joint training is undertaken (including role play) ensuring that all professionals from the different organisations involved in CHC understand the full implications of the decisions that are made from the perspective of the patient, their colleagues from other organisations and the implications for wider health and social care economy.	CCG LA SaTH CT SPIC Advocacy organisations	Attendance and feedback from training provided
7. Domiciliary care providers and their care staff are involved in this training so that they can engage in the CHC process to contact the relevant professionals to request and contribute to a check list and contribute towards the Full Assessment.	CCG LA Domiciliary Care Providers	Attendance and feedback from training provided
Initial Checklist 8. The CCG record and monitor the number of people who have an Initial Check List and the outcome of this i.e.	CCG LA SaTH	Robust data collected and monitored.

how many of these are referred for a Full Assessment.	CT	
9. All staff who carry out the Initial Check List must be appropriately qualified professionals and have had training on how to carry out the assessment, what information to provide to patients and their families and how to promote the advocacy support that is available. The information provided to patients should include health care and financial implications for patients and their families in the event of the range of outcomes of the assessment process.	CCG SaTH	All staff who complete the Initial Check List receive training that includes the full CHC process, the need to ensure patients and their families are informed of and involved in the process, how the CHC process fits with other health and social care processes, the consequences of the possible outcomes of the assessment process and the advocacy services that are available.
10. The CCG should work with the hospital Trust to review the Integrated Health Assessment Form which incorporates the CHC Checklist to ensure that all information is clinically appropriate – of specific concern is the current instruction that patients who have not had previous cognitive impairment and have suffered a stroke must not be referred to mental health services	CCG SaTH	The CCG and SaTH undertake a review of the Integrated Health Assessment.
Assessment Process		
11. That as part of the agreement of the Operational Arrangements document the CCG, Local Authority and other partners agree to a local protocol on the interpretation of the revised Decision Support Tool guidance on the eligibility of patients who do not have a Priority Need but do have needs that meet indicative guidance set out on p.14 and 15 of	CCG LA SaTH SPIC Age UK and other advocacy services	The local protocol is agreed and set out in the Operational Arrangement document

the revised guidance. 12. The CCG should work with partner organisations including the Local Authority, SPIC, the Community Health Trust, the Hospital Trust, Age UK and other advocacy services to establish a panel that will consider the MDT assessment and make recommendations to the CCG regarding CHC eligibility. The terms of reference and operation of the panel should be reviewed annually to ensure that it is adding value to the process. 13. The CCG and Local Authority work together to agree a dispute process as set out in the National Framework (p. 136) and jointly monitor the number and outcome of the assessments disputed by the Local Authority	 CCG LA SaTH SPIC Age UK and other advocacy services CCG LA	 That the Terms of Reference for the Panel are agreed by consensus and the Panel is operational within 3 months of the CCG receiving this report. As a measure of the level of engagement by local authority staff the Committee would expect a robust multi-disciplinary relationship between the CCG and Local authority to result in an increase in the number of disputed cases. If managed properly this should not be seen as a failing in the CHC process but an effective check and balance in the system.
Re-Assessment Process 14. As part of the Operational Arrangements document the CCG must include information on the re-assessment process. This must include a local policy on the interpretation of the principle of well managed needs as set out in the 2012 Department of Health Framework (p. 61) agreed by the CCG, Local Authority, Community Health Trust, SaTH, SPIC and the local advocacy services.	 CCG LA CT SaTH SPIC Age UK and other advocacy organisation	 Inclusion of an agreed policy and procedures in the Operational Arrangements document.

Review / Appeal Process		
15. The CCG records and monitors the number of appeals / review and their outcomes.	CCG	Robust data is collected
16. All patients and their family / representatives should be offered independent advice and advocacy before and during the appeal / review process. Patients should also be made aware of independent legal advice available e.g. free 15 minute appointments with a solicitor through Age UK and other specialist legal advice.	CCG Age UK and other advocacy services	An increase in the number of people seeking and using advocacy services in relation to CHC.
17. The CCG ensures that it is adhering to the Framework when the patient or their family dispute the outcome of a re-assessment where funding is withdrawn.	CCG	Assurance that the review/ appeal process is carried out as set out within the Framework.
18. The Membership of the appeal panel should reflect the good practice established by the regional appeal panel (previously at the SHA) which included an independent chair. All communication from the Panel should come from the independent Chair.	CCG	The CCG review the terms of reference and procedures for the Appeal / Review Panel.
Funding		
19. The Committee has not made any specific recommendations regarding the level of CHC funding as the funding inequality is a product of the failings in the CHC assessment process.		If the previous recommendations are fully implemented the Committee expects that the level of CHC funding in Telford and Wrekin will move to the regional and national average.
20. The CCG and Local Authority work together to explore the option of Joint Funding Packages for patients	CCG LA	Assessment of the potential benefits of Joint Packages of Care

who are not eligible for CHC in line with the National Framework 21. The Committee does however recommend that the number of CHC cases, the level of funding and the number of jointly funded care packages made following a CHC assessment and the total funding contributions by partner organisations is reported quarterly to the Health and Wellbeing Board.	 CCG LA HWB	 Monitoring reports to the Health and Wellbeing Board
Other Issues		
22. The Local Authority should ensure that any staff who report bullying or harassment are appropriately supported – this should include policies and procedures to cover partnership arrangements.	LA	The Council ensures that all managers working in partnership arrangements are aware of the Council's policies. If there are patterns or trends that are identified these should be raised with the relevant Director.
23. In line with the Framework (p. 21) should the Initial Check List or full assessment identify a carer they should be informed of their right to a carer's assessment and advised to contact the Local Authority or, with their permission, refer them for this purpose.	CCG LA CT SaTH	Increase in number of Carers Assessments and support to carers for people who have been through the CHC assessment process
24. Further work is carried out to clarify the number of patients assessed as eligible for CHC funding and receiving CHC funding and the age profile of people receiving CHC funding.	CCG	The CCG provide this information to the Scrutiny Committee and the Health and Wellbeing Board in the response to this report and recommendations.
25. The Operational Procedure Document that was presented to the Scrutiny Committee is an opportunity for the CCG to have genuine dialogue with partner organisations. The committee recommend that the concerns expressed by the local	CCG LA SPIC Age UK and other advocacy organisations	The operation procedure document for CHC is agreed in partnership by all the key organisations involved in the CHC process.

authority regarding this document are taken into account and that SPIC and Age UK and other advocacy organisations are also given the opportunity to comment on the Operational Procedures for CHC.		

CCG – Clinical Commissioning Group, LA – Local Authority, SaTH – Shrewsbury and Telford Hospital NHS Trust, SPIC – Shropshire Partners in Care, CT – Shropshire Community Health NHS Trust.

Second Stage Recommendation

If the CCG does not agree to implement the recommendations set out in this report or if they are agreed but do not achieve the measures of success set out above without adequate explanation, the Committee recommends that the CCG undertake a public consultation on Continuing Healthcare. As the Commissioning body the CCG would be responsible for this consultation – but because of the implications for other organisations the Committee recommends that the Terms of Reference should be agreed by the Health & Wellbeing Board in consultation with Shropshire Partners in Care, Age UK and other advocacy organisations . The Committee recognises the role of the National Commissioning Board and that as a member of the Health & Wellbeing Board they will be involved in this process. The consultation should be managed by an independent body and the CHC and Complex Care Teams would have a role in responding to the consultation.

Third Stage Recommendation

As a last resort, the Committee recommends that if in response to the second stage recommendations above the CCG does not undertake the consultation as described or that in the view of the Scrutiny Committee the outcome of the consultation is not in the interest of the local health service, the Committee retains the right to refer the matter to the Secretary of State for Health.

NHS Continuing Healthcare in England

Standard Note: SN/SP/6128

Last updated: 22 November 2011

Author: Thomas Powell

Section: Social Policy

NHS continuing healthcare means a package of care arranged and funded solely by the NHS to meet physical and/or mental health needs that have arisen because of disability, accident or illness. Eligibility decisions for NHS continuing healthcare rest on whether someone's need for care is primarily due to health needs. For example, people who are eligible may have complex medical conditions that require highly specialised nursing support. This note is intended to help Members respond to queries from constituents about eligibility to NHS continuing healthcare.

As services provided by the NHS are free whereas those arranged by local authority social services are means tested, the outcome of any decision as to who has responsibility for providing care can have significant financial consequences for the individual concerned.

Since the early 1990s, the Parliamentary and Health Service Ombudsman has investigated a large number of complaints about local criteria used for making decisions about eligibility for NHS continuing healthcare. The legality of individual eligibility decisions has also been challenged in the courts on a number of occasions. In 2007 the Department of Health issued a *National Framework for NHS Continuing Healthcare*, to try and improve the consistency of approach taken by local NHS bodies, by providing a common framework for decision making and the resolution of disputes. A separate Library note, *Background to the National Framework for NHS Continuing Healthcare* (SN04643) is intended to help Members to understand the background to the introduction of the Framework through an account of the preceding guidance and case law.

The key Department of Health documents, and briefings from other organisations, are listed at the end of this note. The Department of Health guidance should be consulted for a fuller account of the rules and duties that apply to NHS bodies (currently primary care trusts (PCTs) are responsible for determining eligibility for NHS continuing healthcare but, subject to the passage of the *Health and Social Care Bill*, formal responsibility will transfer to Clinical Commissioning Groups in 2013).

This information is provided to Members of Parliament in support of their parliamentary duties and is not intended to address the specific circumstances of any particular individual. It should not be relied upon as being up to date; the law or policies may have changed since it was last updated; and it should not be relied upon as legal or professional advice or as a substitute for it. A suitably qualified professional should be consulted if specific advice or information is required.

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1 What is NHS Continuing Healthcare?

NHS continuing healthcare is a package of care provided outside hospital, arranged and funded solely by the NHS, for people with ongoing healthcare needs. Services may be provided in any setting including, but not limited to, a residential care home, nursing home, hospice or a person's own home. The *National Framework for NHS Continuing Healthcare* (the National Framework)[1] uses the term NHS continuing healthcare to describe the situation where the NHS takes full responsibility for ongoing, sometimes long-term, care.

Primary legislation governing the health service does not explicitly define the duty of the NHS to provide continuing healthcare. It is from the broader requirements to provide a health service under sections 1 to 3 of the *NHS Act 2006* that the duty is derived. The Secretary of State has issued instructions, known as Directions, to the NHS that specify what sections 2 and 3 of the *NHS Act 2006* mean for PCTs when they determine eligibility for NHS continuing healthcare.[2]

The National Framework explains that the actual services provided as part of that package should be tailored to meet the specific health and social care needs of the individual, and should be seen in the wider context of best practice and service development for each "client group". Eligibility for NHS continuing health care is not based on having a specific medical condition and eligibility places no limits on the settings in which the package of support can be offered or on the type of service delivery.

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[1] Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-funded nursing care (revised July 2009)*

[2] Regulation 1, *The NHS Continuing Healthcare (Responsibilities) Directions 2009.*

There is thus no specific set of services that must constitute NHS continuing healthcare. Services will depend on the needs of the individual in question and, whatever the services may be, people in receipt of NHS continuing healthcare continue to be entitled, like other people, to the usual range of NHS primary, community, and secondary care, and other NHS services.[3]

Someone may have a package of support provided or funded by both the NHS and the local authority, this is known as a 'joint package' of continuing care. Local authority social services have duties to provide welfare services, for example, residential accommodation "for people who, by reason of age, illness or disability, are in need of care and attention that is not otherwise available to them."[4]

How that division of responsibility is made between the NHS and local social services has been a major point of contention over the years and has repercussions for the respective expenditure of the NHS and the local social services authority. For individual patients it can mean the difference between a service that is provided free (if it is the responsibility of the NHS) and one that is means-tested (if it is the responsibility of the local authority).

2 The National Framework

2.1 Publication

The *National Framework for NHS Continuing Healthcare* was published in June 2007[5] and became mandatory from 1 October 2007. Instead of each Strategic Health Authority (SHA) having its own rules for determining eligibility, the National Framework introduced a national approach for the NHS in England, with a common process and national "tools" to support decision making.[6] The Secretary of State issued Directions requiring PCTs, SHAs and local authorities to comply with key aspects of the new policy. The relevant Directions, as updated in 2009, are:

- *NHS Act 2006, Local Authority Social Services Act 1970: The NHS Continuing Healthcare (Responsibilities) Directions 2009*

The following Directions also contain relevant provisions:

- *The Delayed Discharges (Continuing Care) Directions 2009*
- *The National Health Service (Nursing Care in Residential Accommodation) (Amendment) (England) Directions 2009*

As well as dealing with the arrangements for NHS continuing healthcare, the National Framework simplified the arrangements for *NHS-funded nursing care* (that is, care provided by a registered nurse in a nursing home for someone not otherwise funded by the NHS - sometimes known as the Registered Nursing Care Contribution). The National Framework made clear that in all cases, individuals should be considered for eligibility for NHS continuing healthcare before a decision is reached about the need for NHS-funded nursing care.

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[3] The National Framework paragraph 107.

[4] The basic legal framework governing the social services is summarised on pages 6 and 7 of the National Framework, which also describes the legal framework governing the NHS.

[5] Written Ministerial Statement : HC Deb 26 June 2007 20-21WS and Department of Health Press Notice, "Streamlining the system for NHS continuing care," 26 June 2007:

[6] See the final page of the note for a list of the current associated documents.

Following a Government commitment to review the National Framework after one year, a revised Framework was published in July 2009. The revised document says that the main change concerns fast track treatment for people with a rapidly deteriorating condition entering a terminal phase. If an appropriate clinician considers a person to have a *primary health need* arising from such a situation and has given a completed *Fast Track Pathway Tool* to the PCT, that PCT is required to determine that the person is eligible for *NHS continuing healthcare*, until such time as a full assessment is completed using the standard *Decision Support Tool*. The revised document also includes some changes to processes, for example, in relation to obtaining a review of an initial screening decision, but the main basis of eligibility was not changed.

2.2 Who is eligible? The *primary health need* test

The central criterion for receipt of NHS continuing healthcare, set out in the National Framework, is whether a person's primary need is a health need:

> Where a person's primary need is a health need, they are eligible for continuing NHS healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs. Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for providing all of that individual's assessed needs – including accommodation, if that is part of the overall need.[7]

The Framework document expands on this, saying that as there should be no gap in the provision of care, the *primary health need* test is partly dependent on the limits of a local authority's responsibilities. This, it says, means that the test should be applied in such a way that a decision of <u>ineligibility</u> is only possible where, taken as a whole, the nursing or other health services required by the individual satisfy the definition of what a local social services authority might provide, as established by the *Coughlan* judgement[8]. In other words, a decision of ineligibility is only possible where the health services:

> a) are no more than incidental or ancillary to the provision of accommodation which LA social services are, or would be but for a person's means, under a duty to provide; and
>
> b) are not of a nature beyond which an LA whose primary responsibility it is to provide social services could be expected to provide.

The National Framework adds that there are limitations to this test as neither the PCT or local authority social services can dictate what the other agency should provide. In addition, the *Coughlan* judgment itself, on which the criterion was based, focused only on general and registered nursing needs. A practical approach to eligibility was therefore required, including situations in which the 'incidental or ancillary' test was not applicable because, for example, the person would be cared for in their own home.

Certain characteristics of need – and their impact on the care required to manage them - might help determine whether the 'quality' or 'quantity' of health services required was more than the limits of a local authority's responsibilities. These characteristics are listed in the National Framework as:

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[7] National Framework, paragraph 25

[8] The significance of the *Coughlan* judgement is explained in a separate Library note, *Background to the National Framework for NHS Continuing Healthcare* (SNSP.....). The impact of the judgement is also summarised in Annex B of the National Framework.

Nature: This describes the particular characteristics of an individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.

Intensity: This relates both to the extent ('quantity') and severity ('degree') of the needs and to the support required to meet them, including the need for sustained/ongoing care ('continuity').

Complexity: This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/ or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.

Unpredictability: This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.[9]

Each of these characteristics may, alone or in combination, demonstrate a *primary health need*. In order to minimise variation in the interpretation of these characteristics, the Department of Health has published a Decision Support Tool, which is outlined in the section on *Assessment Process* below).

As well as describing the characteristics on which eligibility should be based, the Framework includes a section on what **not** to base eligibility. It lists the following examples:

- the person's diagnosis;
- the setting of care;
- the ability of the care provider to manage care;
- the use (or not) of NHS- employed staff to provide care;
- the need for/presence of 'specialist staff' in care delivery;
- the fact that a need is well managed;
- the existence of other NHS-funded care; or
- any other input-related (rather than needs-related) rationale.

In addition, the Framework says that the possibility of deterioration should generally be taken into account. In particular, where an individual has a rapidly deteriorating condition that may be entering a terminal phase, this would be a *primary health need* because of the rate of deterioration. The Department of Health has published a Fast Track Tool to help decide eligibility where this may be the case (see section on *Assessment Process* below).

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[9] The National Framework page 10.

2.3 Assessment Process

Getting an assessment

The NHS choices website provides advice about getting an assessment for NHS continuing healthcare. It says:

> PCTs are responsible for assessing eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care, as well as ensuring that the national eligibility criteria are used consistently. They also identify, arrange and fund all the services required to meet your needs:
>
> - if you qualify for NHS Continuing Healthcare, or
> - for the healthcare part of a joint care package.
>
> The PCT for your area can provide more information on the eligibility criteria and assessment process. If you think you have care needs that should be assessed, or if someone you care for has needs that you think should be assessed, you should contact your PCT.
>
> You can get contact details for PCTs by calling NHS Direct on 0845 4647 or visiting the NHS Choices website. When you contact your PCT, ask to speak to the co-ordinator for NHS Continuing Healthcare.[10]

The Directions specify circumstances where eligibility must be considered and place a general duty on PCTs to take reasonable steps to ensure that an assessment of eligibility is carried out in all cases where it appears to the PCT that there may be a need for *NHS continuing healthcare*. A couple of specific circumstances where an assessment should be carried out are set out below (these are not the only ones mentioned).

- When patients are discharged from hospital: where the NHS is intending to refers someone to social services for help with social care needs, it should first carry out an assessment for NHS continuing healthcare.
- Before any decision is made by the NHS to make a registered nursing care contribution when a person goes into a care home that provides nursing care.

The National Framework sets out principles and values that should be applied to the process of assessment, for example, obtaining the patient's consent, what happens when the patient does not have capacity to consent, and making patients aware of advocacy services that might be available. The Framework then describes the process of establishing eligibility, much of which is covered in the Directions to PCTs, which also contain requirements for local authorities to co-operate in the procedure.

If the NHS is commissioning, funding or providing any part of the care, a case review should be undertaken no later than three months after the initial eligibility decision, in order to reassess care needs and eligibility for NHS continuing healthcare, and to ensure that those needs are being met. Reviews should then take place annually, as a minimum. These reviews are separate from the dispute resolution reviews described in part 3 of this note.

Screening: *The Checklist*

The first step for most people is a screening process where a nurse, doctor other qualified healthcare professional or social worker applies the *Checklist* to see if the individual needs a

[10] *NHS Choices website: What is NHS continuing healthcare?*

full assessment of eligibility.[11] Whatever the outcome of the *Checklist* process, the decision, including the reasons why the decision was reached, should be communicated clearly and in writing to the individual and (where appropriate) their representative.

Where the outcome is not to proceed to a full assessment of eligibility, the written decision should also contain details of the individual's right to ask the PCT to reconsider the decision. The PCT should give such requests due consideration and provide a clear, written response as soon as is reasonably practicable. The response should also give details of the individual's rights under the NHS complaints procedure.

Full Assessment: *The Decision Support Tool*

If the person has passed the screening test, the next step is a full assessment (in some cases an individual may be referred directly for a full assessment, in which case the full assessment would be the first stage). The assessment should be carried out by a multidisciplinary team and, irrespective of the setting, the PCT has responsibility for coordinating the process until a decision is reached.

The aim is to capture the nature, complexity intensity and/or unpredictability of a person's needs (see section 2.2 on the *primary health need* test above). In order to do this, the *Decision Support Tool*[12] provides a framework for recording the person's needs in 12 generic areas. The 12 areas are: behaviour, cognition, psychological and emotional needs, communication, mobility, nutrition (food and drink), continence, skin (including tissue viability), breathing, drug therapies and medication (symptom control), altered states of consciousness, other significant care needs. For each domain, the assessment records: low, moderate, high.

However, the *Decision Support Tool* is not an assessment in itself; it is meant to be a way of applying the *primary health need test* by bringing together evidence in a single format in order to improve consistency and evidenced-based decision. It is not intended to directly determine eligibility and "Professional judgment should be exercised in all cases to ensure that the individual's overall level of need is correctly determined."

Once the multidisciplinary team has reached agreement, it should make a recommendation to the PCT on eligibility. Only in exceptional circumstances and for clearly articulated reasons, should the PCT reject the multidisciplinary team's recommendation and a decision not to accept the recommendation should never be made by one person acting unilaterally.

The Framework says that many PCTs use a panel to ensure consistency and quality of decision making but that a panel should not fulfil a gate-keeping function. Nor should it be used as a financial monitor.

The time between the *Checklist* (or other notification of potential eligibility) being received by the PCT and the funding decision should, in most cases, not exceed 28 days. In acute settings it may be appropriate for it took take much less than this. When there are valid and unavoidable reasons for the process taking longer, timescales should be clearly communicated to the person, and (where appropriate) their carers and/or representatives.

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[11] *Healthcare Checklist (September 2009)*
[12] *Decision Support Tool (September 2009)*

Terminal Care: *The Fast Track Pathway Tool*

The *Fast Track Pathway Tool*[13] is designed for assessing individual who need urgent attention because they have a rapidly deteriorating condition that may be entering a terminal phase with an increasing level of dependency. The Tool needs to be completed by an "appropriate clinician" who should give the reasons why the person meets the conditions required for the fast-tracking decision.

The 'appropriate clinician' is defined as someone who is, pursuant to the *NHS Act 2006*, responsible for an individual's diagnosis, treatment or care and who are medical practitioners (such as consultants, registrars or GPs) or registered nurses. Clinicians should have an appropriate level of knowledge or experience of the type of health needs, so that they are able to comment reasonably on the situation. They can be clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example, hospices), provided that they are offering services pursuant to the *NHS Act 2006.*

Where a recommendation is made for an urgent package of care via the fast-track process, this should be accepted and actioned immediately by PCTs. The framework says that it is not appropriate for individuals to experience delay in the delivery of their care package while disputes over the use of the *Fast Track Pathway Tool* are resolved. As mentioned in section 2.1, this is one of the areas where there has been a change since the first version of the National Framework was published in 2007.

2.4 Individual choice of care arrangement and limits on choice

The National Framework says that "the package to be provided is that which the PCT assesses is appropriate for the individual's needs".[14] However, practice guidance states that the PCT should take full account of the individual's own views of their needs and their preference as to how they should be met and that they "should be given as much choice as possible, particularly in the care planning process."[15]

PCTs have powers to offer personal health budgets for NHS continuing healthcare, either as a notional budget or a real budget held by a third party. Direct payments for NHS continuing healthcare can currently only be offered by PCTs that are pilot sites approved by the Secretary of State. In October 2011, Andrew Lansley announced that, subject to the evaluation of these pilots, by April 2014 everyone who is eligible for NHS continuing healthcare will have the right to ask for a personal health budget including a direct payment (although granting one would be at the discretion of the NHS commissioning body).[16]

The practice guidance provides some additional information about the limits that can be put on individual choice where, if followed, this would result in the PCT paying for a more expensive care arrangement, and the circumstances under which a PCT can decline to provide care in the preferred setting of the individual (see para 11.7). This section is set out below and notes that cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment:

> In many circumstances there will be a range of options for packages of support and their settings that will be appropriate for the individual's needs. The starting point for agreeing the package and the setting where NHS continuing healthcare services are to

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[13] *Fast Track Pathway Tool for NHS continuing healthcare (September 2009)*
[14] The National Framework, paragraph 100
[15] *NHS continuing healthcare practice guidance* (April 2010)
[16] Department of Health press release, 5 October 2011

be provided should be the individual's preferences. Individuals will not always be aware of the models of support that it is possible to deliver (for example, they may assume that it is only possible to receive support in a care home). Those involved in working with individuals to plan their future support should advise them of the options and the benefits and risks associated with each one. PCTs should be aware of the models of support offered by partners and by other PCTs and of evidence about their benefits and risks so that the options offered are maximised and that generalised assumptions are avoided.

In some situations a model of support preferred by the individual will be more expensive than other options. PCTs can take comparative costs and value for money into account when determining the model of support to be provided but should consider the following factors when doing so:

a) The cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost.

b) Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes. For example, individuals can sometimes be described as needing 24-hour care when what is meant is that they need ready access to support and/or supervision. PCTs should consider whether models such as assistive technology could meet some of these needs. Where individuals are assessed as requiring nursing care, PCTs should identify whether their needs require the actual presence of a nurse at all times or whether the needs are for qualified nursing staff or specific tasks or to provide overall supervision. The willingness of family members to supplement support should also be taken into account, although no pressure should be put on them to offer such support.[27] PCTs should not make assumptions about any individual, group or community being available to care for family members.

c) Cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment (see the Gunter case in box below).

Gunter Case

In the case of *Gunter vs. South Western Staffordshire PCT*, a severely disabled woman wished to continue living with her parents whereas the PCT's preference was for her to move into a care home. Whilst not reaching a final decision on the course of action to be taken, the court found that Article 8 of the European Convention of Human Rights had considerable weight in the decision to be made, that to remove her from her family home was an obvious interference with family life and so must be justified as proportionate. Cost could be taken into account but the improvement in the young woman's condition, the quality of life in her family environment and her express view that she did not want to move were all important factors which suggested that removing her from her home would require clear justification.[17]

The Alzheimer's Society notes that "the highest proportion of people receiving NHS continuing healthcare are in nursing homes and far fewer are awarded it while living at

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[17] *Ibid.*

home."[18] The practice guidance provides information on the respective responsibilities of PCTs and local authorities when a person is supported in their own home.[19]

3 Dispute resolution

The formal responsibility for informing individuals of the decision about eligibility for NHS continuing healthcare, and their right to request a review, lies with the Primary Care Trust (PCT). There are two possible levels at which a review of an eligibility decision (as distinct from a screening decision, for which see the section on the *Checklist* above) may take place:

- a local review process at PCT level; and
- a request to the Strategic Health Authority (SHA), which may then refer the matter to an Independent Review Panel.

If the Independent Review Panel upholds the original decision and there is still a challenge, the next stage is referral to the Health Service Ombudsman.

It is up to each PCT to agree a local review process, including timescales, which should be made publicly available and a copy should be sent to anybody who requests a review of a decision. The local review process may include referral of the case to another PCT for consideration or advice, in order to provide greater patient confidence in the impartiality of the decision making.

If a person has been unable to resolve the matter through any local dispute resolution procedure s/he may apply to the relevant SHA for an independent review of the decision if s/he is dissatisfied with:

a) the procedure followed by the PCT in reaching its decision as to the person's eligibility for NHS continuing healthcare; or

b) the application of the eligibility criteria for NHS continuing healthcare (i.e. the primary health need test).

Once local procedures have been exhausted, the case should be referred to the SHA's Independent Review Panel, which should consider the case and make a recommendation to the PCT. If using local processes would cause undue delay, the SHA has discretion to agree that the matter should proceed direct to an Independent Review without completion of the local process.

The Framework says that because Independent Review Panels have a scrutiny and reviewing role, it is not generally appropriate for any party to be legally represented at an IRP hearing although individuals may be represented by family, advocates, advice services and others in a similar role. It also says that although the role of the Independent Review Panel is advisory, its recommendations should be accepted by the PCT in all but exceptional circumstances.

The Framework sets out principles to be followed both locally and by Independent Review Panels (gathering of available evidence etc.). Annex E of the Framework provides further

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[18] *When does the NHS pay for care? Guidance on eligibility for NHS continuing healthcare funding in England*, Alzheimer's Society (2011).

[19] *NHS continuing healthcare practice guidance* (April 2010), paragraph 11.8

details of procedures to be followed in relation to Independent Review Panels. There are also provisions regarding disputes between PCTs and local authorities.

An individual's right under existing NHS complaints procedures and his or her existing right to refer a case to the Health Service Ombudsman is not affected by the Independent Review Panel procedures. In particular, where an individual is dissatisfied with issues other than the process followed or the application of the criteria, the Framework says that the matter should be considered via the complaints procedure.

4 Refunds guidance

NHS continuing healthcare: refunds guidance (March 2010) sets out the approaches to be taken by PCTs and local authorities when a decision is awaited on eligibility for NHS continuing healthcare or there is a dispute following a decision. It explains responsibilities for providing services during these periods and for refunding the costs of services provided.

If someone disputes a PCT's initial eligibility decision and this decision is revised following further consideration or as a result of a recommendation by an Independent Review Panel, the PCT should reimburse any costs incurred by the local authority or individual concerned. Ex-gratia payments from PCTs should aim to restore an individual's finances to the state they would have been in had the correct decision been made at the outset and to remedy any injustice or hardship as a result of the incorrect decision.

The period of reimbursement or ex-gratia payment should start from the date the initial PCT decision was made (or earlier if an unjustifiable delay has been acknowledged) until the date the revised decision comes into effect.

Disputes about PCT decisions on whether to provide reimbursement, or on the amount it intends to provide, can be addressed through the standard NHS complaints procedure.

5 Key guidance documents

The following Department of Health guidance, together with the Directions from the Secretary of State mentioned in the text of this note, should be consulted for a fuller account of the rules and duties of NHS bodies to provide NHS continuing healthcare.

- The National Framework for NHS Continuing Healthcare and NHS-funded nursing care (revised July 2009): This sets out principles and processes for establishing eligibility.

- Healthcare Checklist (September 2009): This is a screening tool to help establish who might need a full assessment of eligibility.

- Decision Support Tool (September 2009): This is a detailed questionnaire to help assess eligibility.

- Fast Track Pathway Tool for NHS continuing healthcare (September 2009): This is for urgent assessments of those with rapidly deteriorating, possibly terminal, conditions.

- NHS continuing healthcare practice guidance (April 2010): This provides a practical explanation of how the Framework should operate on a day-to-day basis and cites examples of good practice.

- Training materials for the revised National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (December 2009): These training materials have been developed to support local training on specific issues.

- NHS continuing healthcare: refunds guidance (March 2010): This sets out the approaches to be taken by PCTs and local authorities when a decision is awaited on eligibility for NHS continuing healthcare or there is a dispute following a decision. It explains responsibilities for providing services during these periods and for refunding the costs of services provided.

There are several introductory sources that constituents may find useful, for example:

- *NHS continuing healthcare and NHS-funded nursing care*, NHS public information booklet;

- NHS Choices website: *What is the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care?*;

- Age Concern factsheet 20, *NHS continuing healthcare and NHS-funded nursing care* (September 2010); and

- *When does the NHS pay for care? Guidance on eligibility for NHS continuing healthcare funding in England*, Alzheimer's Society (2011).

95% Confidence Interval

If Confidence intervals overlap, the samples are not significantly different.
Calculated using the Wilson method as recommended by Public Health Observatories

	2011/12 Quarter 3		
	Lower Level	Value	Upper Level
England	53.6	54.0	54.5
West Midlands	53.3	54.7	56.1
Telford & Wrekin	19.3	24.1	30.1

This table shows England and West midlands are not significantly different, but Telford & Wrekin is significantly different to both National and West Midlands.

Rate of Change

The rate of changes in CHC funding per 50,000 population has been analysed using the Mann-Whitney test. It covers the quarterly changes over the last 3 years (11 Quarters).
The Mann-Whitney U-value test has been used as the sample is less that 30.
The Mann-Whitney U-value test ranks the rate of change. If both samples are very similar you would expect the ranks below and above the middle value to be split 50:50 from both samples.
A 50:50 split is demonstrated in this test by a U-value of 50.

Rate of change between Quarters

	Year 2009/10				Year 2010/11				Year 2011/12		
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3
England		4.9	6.2	0.8	0.5	0.8	1.3	2.9	0.4	3.8	-1.2
West Midlands		3.3	6.8	1.6	-3.7	0.4	-1.1	-2.1	1.6	0.6	0.1
Telford & Wrekin		5.2	-7.0	-30.3	19.5	-10.2	-11.8	-15.3	-11.9	-39.7	-17.0

Using the data above gives a U value of 19.
The value is the same against England and West Midlands.
Using a Mann-Whitney look up table gives a critical value relevant for the sample size of how far away from 50 the value would need to be before being counted as significant.
In this instance the critical value is 27, meaning a number less than 27 is considered significant.

The rate of change of CHC clients over the last 3 years in Telford & Wrekin can therefore be considered as significantly different to National and West Midlands changes.

As the sample contains 20 measures a Z-score was also calculated at the same time as the U-value.
The Z-score was 2.3056 against both National and West Midlands.
Using a Z-score look up table this represents a p-value of 0.0209
A p-value less than 0.05 is considered significant, again demonstrating that Telford & Wrekin rate of change is statistically significantly different to both National and West Midland changes.

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15th May 2013

TITLE – Healthwatch Telford & Wrekin Update

REPORT OF – Clare Davis, Operations Manager, Parkwood Healthcare

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

To present an update of Healthwatch Telford & Wrekin, since contract start on 1st April 2013

2. FOR INFORMATION OR DECISION

For Information

3. RECOMMENDATIONS (and to whom e.g. CCG, Council, etc)

Suggest any further key priorities that need to be addressed while Healthwatch Telford & Wrekin is becoming established.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	*Through gathering information from local communities, groups and individuals, Healtwatch can become a hub for service user, consumer, patient views and opinions on the priority areas.*
	Will the proposals impact on specific groups of people?	
	Yes	*An effective Healthwatch Telford & Wrekin will impact on all groups in the local community. Community Engagement to follow.*

TARGET COMPLETION/DELIVERY DATE	*Delivery plan to follow*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	*Through contract monitoring Parkwood Healthcare will be providing evidence of value for money.*
LEGAL ISSUES	No	
EQUALITY & DIVERSITY	Yes	*Healthwatch will have a full equality and diversity policy and will be able to evidence that it is fully accessible to all individuals.*
IMPACT ON SPECIFIC WARDS	Yes	*An effective Healthwatch Telford & Wrekin will impact on all groups in the local community. Community Engagement to follow.*
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	*See above (this is a core element of Healthwatch)*
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	*A SWOT analysis will form part of the development plan*

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

Detailed information and longer term development plans (including community engagement, communications and marketing) will be produced once the board of directors and manager are in place.

Short term development plans are currently being produced and will be available shortly.

The table at the end of this report is an outline of activities so far.

6. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

Impact assessments to follow once Manager is in place

Activities Overview

	Overview
Staffing	*TUPE* 1 member of staff TUPE'd over to Healthwatch Telford & Wrekin from the Local Involvement Network, Catherine Pert. Since starting working for Healthwatch Catherine has been promoted to the position of Community Engagement Officer. She was covering some of this work for the LINk and has a good skill set in this area. *Manager* The position of Manager has been advertised, the closing date was 1st May 2013 and interviews are scheduled to take place on the 7th May 2013. There has been a lot of interest in the position and there appears to be a strong pool of candidates. *Research & Information Assistant* This is a key post to the organisation but will be recruited once the manager is in post.
Chairperson & Board of Directors	These are voluntary positions, but will provide the organisational leadership for Healthwatch Telford & Wrekin. The posts have been re-advertised to ensure that as many people as possible have sufficient time to apply. Interviews for the role of Chairperson are scheduled to take place on the 14th May 2013, in the morning. The 16th May 2013 is also available if needed. To ensure a robust recruitment process, a mixed panel will be interviewing prospective candidates. The panel includes a patient representative from the CCG, Paul Taylor, Cllr Richard Overton, a service user representative and the Operations Manager from Parkwood Healthcare, Clare Davis Once appointed, the chairperson will be attending the Health & Well Being Board, representing Healthwatch Telford & Wrekin.

	Director interviews are likely to take place on the 24th May 2013, ideally with the new Chairperson being involved.
LINk legacy	A workshop with active LINk volunteers is taking place on the 9th May 2013. The purpose of the event is to encourage active volunteers to remain involved, answer any questions about the future of Healthwatch Telford & Wrekin as well as map out current activities that individuals have been involved in. Although it is important that Healthwatch is recognised as being different to LINk it is also equally important not to lose momentum for any positive pieces of engagement work that are taking place. The LINk legacy document will play a key part in the LINk celebration / Healthwatch launch event that will take place once the manager, chair person and board are in place.
Community Engagement	Meetings are taking place between Parkwood Healthcare and individuals and groups and will continue to do so over the next few months and into the longer term future. The purpose of these meetings is to build relationships in the local community and answer any questions that individuals or groups may have. Along with meeting active LINk members, staff also attended the Stakeholder Event on the 30th April 2013, met with Macmillan Nurses, the patient involvement representative from NHS T&W. A further stakeholder meeting is scheduled for the 14th May 2013.
Contract Monitoring	Monthly monitoring currently takes place along with regular contact with key staff from the council. The contract will be measured against KPIs, and the reports will be widely available.
Website & contact details	The website went live on the 1st April 2013 and is work in progress. Feedback is always appreciated, and it will become more populated over the next couple of months.
Location	As part of the contract, the council have set out that the local community must be involved in the identifying the right location for Healthwatch Telford & Wrekin.

	Initially a questionnaire was going to be used to gather people's views, but it was felt that more use could be made of a workshop type event where individuals can give their views and opinions on other priority areas for Healthwatch. The workshop is scheduled to take place on Thursday 16th May 2013.

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15 May 2013

TITLE - Overview: Annual Public Health Report for Telford and Wrekin 2012/13

REPORT OF – Dr Catherine Woodward, Interim Statutory Director of Public Health, Telford and Wrekin Council

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

This report introduces the Annual Public Health Report for Telford and Wrekin 2012/13, prior to full presentation of the Report to the Health and Wellbeing Board at its next meeting.

2. FOR INFORMATION OR DECISION

For information

3. RECOMMENDATIONS

That the Health and Wellbeing Board notes the content of this report.

4. SUMMARY IMPACT ASSESSMENT OF THE ANNUAL PUBLIC HEALTH REPORT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	No	*If accepted, the recommendations of the Annual Public Health Report potentially contribute across a range of priorities, not one specific priority*
	Will the proposals impact on specific groups of people?	
	Yes	*As above*
TARGET	*Insert date and if more than 6 months after the*	

COMPLETION/DELIVERY DATE	*date of the HWB report, list key milestones* *Progress with recommendations of Annual Public Health Reports are generally reviewed as part of the next Annual report (or by agreed exception)*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	*The final financial outturn information for Public Health has been requested from the PCT who are in the process of closing the accounts for 2012/13. Once this has been received this will be reported to the Board together with any useful information from mapping outcomes against spending.*
LEGAL ISSUES	Yes	*In accordance with the provisions of The Health and Social Care Act 2012 the DPH for the Council must prepare an annual report on the health of the people in the Council's area. The Council must publish that report.*
EQUALITY & DIVERSITY	No	*The Annual Public Health Report is not a policy document. Some of its recommendations (if accepted) will deliver action(s) which potentially address health inequalities*
IMPACT ON SPECIFIC WARDS	No	*Borough-wide*
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	*The report will contain (anonymised) statements from service users. The methodology behind this will be described in the Report*
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	*Overall impact/opportunity: local health improvement* *Risk: legacy (although this will be mitigated by a clear handover process)*

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

Summary

The 2012/13 Annual Public Health Report of the Director of Public Health for Telford and Wrekin is currently in its final editorial stages. The purpose of this position report to the Health and Wellbeing Board is to summarise some key features of the Annual Report, prior to its presentation to the Board at its July meeting.

As in previous years, the Report offers a broad review of health status in Telford and Wrekin. However, for the first time, the Report has been largely developed with reference to the new national Public Health Outcomes Framework, while also presenting other intelligence on the health of the local population. The overall approach adopted in the report is:

- To summarise the local position (where this is known) across the indicators used in the Public Health Outcomes Framework, highlighting in particular where local performance is either statistically significantly better or worse than the England average

- Where possible, to map indicators to the well-recognised Marmot "life course" – Starting Well; Developing Well; and Living, Working and Ageing Well

- Within this, to summarise some of the programmes and actions in place in Telford and Wrekin to improve health and wellbeing

The Report includes explanatory and summary sections on the National Public Health Outcomes Framework and the current Telford and Wrekin Joint Strategic Needs Assessment (including the recent local impact of the JSNA). In addition to health inequalities, some of the health issues considered under the lifecourse approach in the Report include:

- Starting Well: low birth weight babies; maternal smoking; immunisation

- Developing Well: accidental injury; childhood obesity; sexual health; emotional health and wellbeing

- Living, Working and Ageing Well: smoking-related mortality and morbidity; cancer; circulatory disease; suicide; performance of screening programmes

It is well recognised that the current priorities of the Telford and Wrekin Health and Wellbeing Board were informed by the local JSNA and the Public Health Outcomes Framework. Going beyond this, the Report will present a small number of recommendations for action which will further support (generally or

specifically) progress towards delivery of these priorities in Telford and Wrekin. The Health and Wellbeing Board will be asked to consider and accept these recommendations when it receives the full Report.

6. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

No additional information.

7. PREVIOUS MINUTES

No previous minutes specifically relevant to this report.

8. BACKGROUND PAPERS

None at this stage.

Report prepared by Dr Catherine Woodward, Interim Statutory Director of Public Health, Telford and Wrekin Council. 01952 385001

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15 MAY 2013

TITLE – TELFORD & WREKIN CCG DRAFT LONG TERM CONDITIONS STRATEGY

REPORT OF – NICKY WILDE, HEAD OF COMMISSIONING PRIMARY CARE AND PLANNED CARE, AND JULIA MEAKIN, COMMISSIONING MANAGER, MARKET DEVELOPMENT

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

With the approval of the Telford and Wrekin CCG Board, the CCG has commenced a programme of work to improve the quality of care delivered to patients and carers in Telford and Wrekin who have one or more Long Term Condition.

This document provides high level details of a strategy (in diagram format) and provides the areas which will form the framework within which the CCG anticipates to work with Partner Organisations. The purpose of presenting the outline to the Health and Wellbeing Board at this early stage is to ensure that there is opportunity to include recommendations from the Board into the Strategy at an early stage and to engage the Board with the on-going work programme.

The intention of the strategy is to provide a framework and action plan to deliver measureable improved outcomes to include improved life expectancy, enhanced quality of life for those with a long term condition and their Carers and a reduction in health inequalities. The strategy will be a concise document, with links to the major supporting documents such as the Joint Strategic Needs Assessment, Health and Wellbeing and CCG objectives and national documentation on improving the identification and management of Long Term Conditions. The principle element will concentrate on an overarching action plan for delivery rather than an extensive "wordy" document. The "Strategy on a Page" can be found at page 6. The strategy covers:-

- Principles
- Prevention
- Identification
- Management planning (3 stages)
- End of Life

The CCG has mapped the CCG Objectives and stakeholder outcomes relevant to Long Term Conditions and these can be found at page 7, however particularly in relation to the Health and Wellbeing Board, the priority of Improving Life Expectancy and Reducing Health Inequalities will be included and will include the Board priorities of:

- Cardiovascular disease (CVD)
- Cancer – although the CCG has a separate work stream for cancer, this will link into the Long Term conditions strategy work
- Lifestyle risk factors smoking, alcohol misuse and overweight and obesity
- Prevention opportunities
- Making Every Contact Count
- Review of the national and local recommendations such as the Health Inequalities National Support Team (HINST) recommendations for CVD and the West Midlands Quality Review for Long Term Conditions

The delivery approach will focus on prevention and earlier diagnosis as well as treating the symptoms. Processes will be established to identify when increased care is required. There will be a strong emphasis on patients being consulted, enabled and supported to self-manage their conditions where appropriate and carers and families will be supported. At the heart of the delivery system, there will be integration of working across health and social care, the third and independent sectors. This will facilitate improvements in care, through eliminating duplications and gaps in service delivery. Consideration will be given to telehealth/telecare initiatives where this is an option.

Processes will be put in place that encourage an understanding of End of Life issues not only those people with long term conditions but also their families, carers, the public, and the health and social care economies. Similar to Cancer, End of Life is a separate work programme which will link in with the Long Term Conditions Strategy.

The Health and Wellbeing Board have quality outcomes which have been identified as a measure for improving Life expectancy and reducing health inequalities which include:-

- Premature mortality rates
- Health Check programme performance indicators (% of eligible population offered and % take up of checks)
- Cancer waiting and treatment times targets
- Management and treatment of patients with CVD in primary care (% of patients treated appropriately for hypertension, high cholesterol and any other relevant LTC indicators)

In addition to these, the CCG will also monitor use of Acute and Community Services for both scheduled and unscheduled care and improvement in outcomes within General Practice, via the Quality and Outcomes Framework and practice level benchmarking.

<u>Consultation</u>

The consultation and engagement process will be on-going throughout the design and delivery of the strategy and regular updates will be made available as required. To date discussions have been held with:-

CCG Board
CCG GP Forum
CCG Patient Round Table
CCG Long Term Conditions Patient Group
GP Practice patient groups
Health and Wellbeing Board
Public Health Colleagues

CCG Commissioners
Shrewsbury and Telford NHS Hospital Trust
Shropshire Community Health NHS Trust
Robert Jones and Agnes Hunt NHS Trust
Shropshire and Staffordshire Mental Health NHS Trust
Shropshire County CCG

The process has been both formal and informal and a plan of recommendations and actions is being formulated based on feedback of the ongoing discussions, national and local recommendations and priorities. It is expected that the final draft for approval will be available July / August 2013. A copy of documentation is also available on the CCG website.

Progress to date

During the consultation and engagement process and to ensure that improvements continue to be delivered, various work-streams have already commenced such as:-

- Supporting GP Practices with Long Term Conditions and workgroups for Respiratory, Hypertension, Diabetes and Dementia have already commenced
- Risk Stratification to identify patients at risk was commenced in Practices in 2012/13 and this is being further developed in 2013/14 and funding has been secured via the CCG to deliver some actions recommended in the recent West Midlands Quality Review
- Data on Practice level Long Term Conditions is being sent to Practices to provide a benchmark and this will be revisited at the end of the financial year 2013/14 to allow Practice to monitor changes in outcomes.
- GP Practice providing individual patient management plans to support patients to self-manage exacerbations in their conditions
- Engagement and Consultation of initial outline documentation for discussion
- Funding secured from CCG to support the following local developments
    - Pulmonary Rehabilitation
    - 7 day pilot for community respiratory services
    - Anxiety management for patients with severe COPD
    - Supply and distribution of nebulisers
    - Respiratory Consultant to support community nurses
    - Tele-health remote monitoring
    - Diabetes education programmes for type 1 and 2, information and management booklets and Expert patient programme
    - Expansion of community services
    - Pilot for Health trainers linked to GP Practices
    - Pilot for Care navigators linked to GP Practices
    - Direct Access Echo and B-type natriuretic peptide testing
- An action plan for implementation is being developed alongside the consultation and engagement programme. This plan is centred around Principles, Prevention, Identification, Management planning (3 stages) and End of Life allowing it to be easily monitored against the "Strategy on a Page". It also identifies the person and organisation responsible for delivery and the proposed timeframe for delivery. This action plan is being discussed as part of the consultation and engagement programme and Leads are being asked to complete their sections of the plan and return to the CCG Lead.

2. FOR INFORMATION

There are around 15 million people in England with one or more long term condition. The interpretation of a Long Term Condition is a condition that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions – Diabetes, Asthma, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease, Mental Health and Neurological conditions can all be included.

The impact on the NHS and Social Care of supporting people with long term conditions is significant with 70% of the health and social care costs being spent on long term conditions. This means that 30% of the population accounts for 70% of the health and social care spend. Long term conditions are responsible for 70% of emergency admissions and 55% of GP consultations. Supporting the 30% of the population who have one or more long term condition is therefore essential for the viability of the health economy.

The paper is submitted for information and discussion.

3. RECOMMENDATIONS

The Health & Well-being Board are requested to;

Receive the key health messages, the draft Long term Conditions Strategy "on a Page" and note actions to datea

Provide feedback to Telford & Wrekin CCG (Julia.meakin@telfordccg.nhs.uk)

Agree that a final version of the strategy with an implementation plan be brought back to Health & Well-being Board for an update in July/August 2013

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="4">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority?</td></tr>
<tr><td>Yes</td><td>Improve life expectancy and reduce health inequalities</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>The strategy will impact on people with a long term condition their families and carers.</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">A final version of the strategy with an implementation plan be brought back to Health & Well-being Board for an update in July/August</td></tr>
</table>

	2013. The overall strategy will commence its implementation during 2013/14 and will continue to develop and react to changing situations.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The ability to achieve early diagnosis and the stabilisation and optimised management of patients with Long Term Conditions will allow care to be provided in a community setting thus reducing the impact on secondary care services. The QiPP plan for Planned Care for 2013/14 identifies a recurrent net saving of circa £300,000 when supporting services have been put into place.
LEGAL ISSUES	No	
EQUALITY & DIVERSITY	Yes	The adoption of a clear integrated health and social care strategy will ensure that there is equality in the management of all patients with Long Term Conditions
IMPACT ON SPECIFIC WARDS	No	To strategy covers the geographical area of Telford and Wrekin.
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	To date the strategy has been discussed at the CCG Roundtable and the CCG LTC Patient Group. In addition Practices, via the GP Practice Forum, have been encouraged to discuss the strategy at their respective patient groups. Ongoing engagement with patient groups is a requirement of the strategy.
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

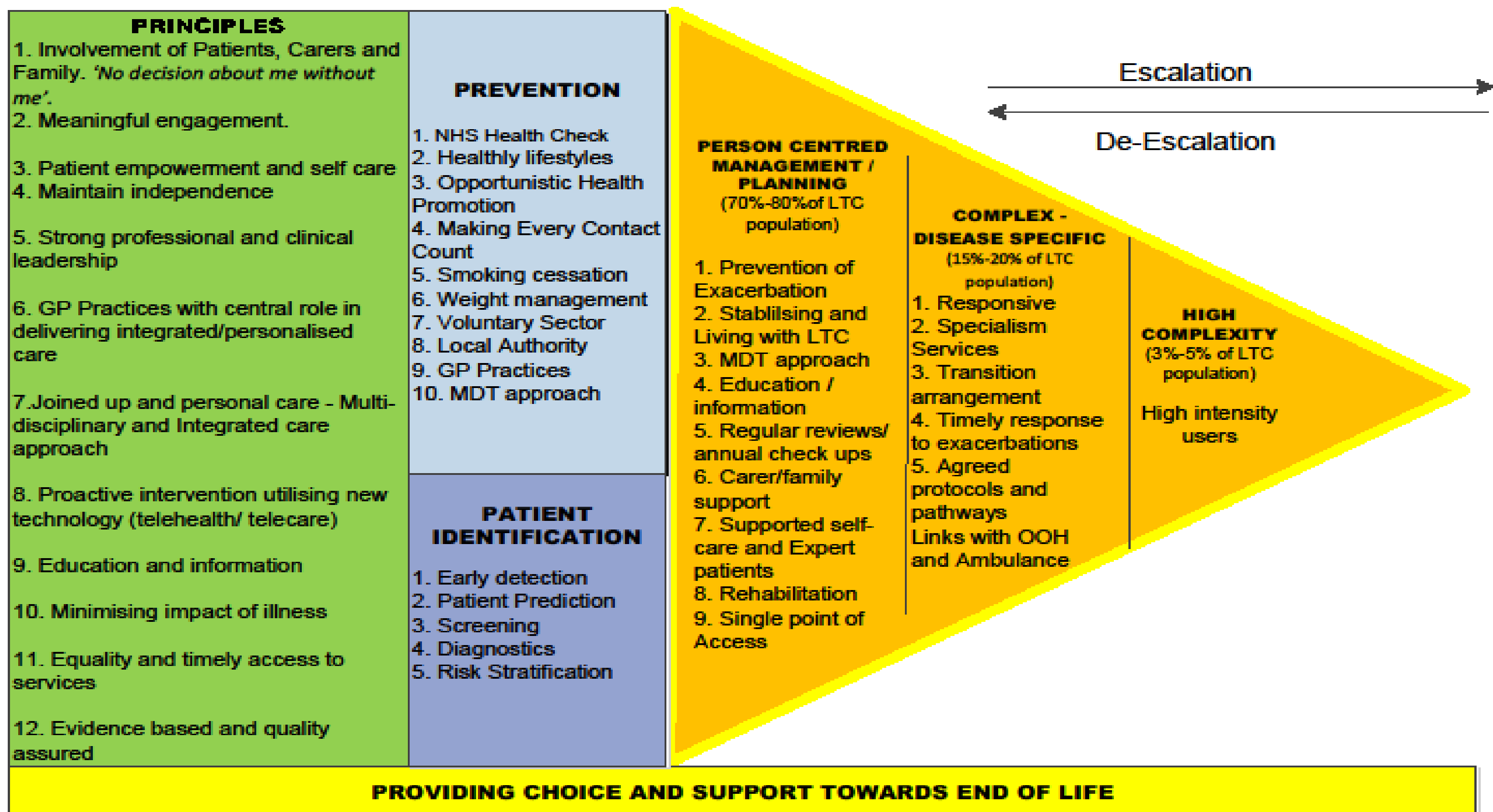
PART B) – ADDITIONAL INFORMATION

5. INFORMATION

Some specific data for Telford and Wrekin and the projections for our population can be found in the Joint Strategic Needs Assessment; the key messages are set out at pages 6 and 7.

Report prepared by:-

Mrs N Wilde, Head of Commissioning for Planned and Primary Care
and Mrs J Meakin, Commissioning Manager
NHS Telford and Wrekin Clinical Commissioning Group
Telephone: 01952 580418


TELFORD AND WREKIN CCG LONG TERM CONDITIONS (LTC) STRATEGY
PRINCIPLES
1. Involvement of Patients, Carers and Family. 'No decision about me without me'.
2. Meaningful engagement.
3. Patient empowerment and self care
4. Maintain independence
5. Strong professional and clinical leadership
6. GP Practices with central role in delivering integrated/personalised care
7.Joined up and personal care - Multi-disciplinary and Integrated care approach
8. Proactive intervention utilising new technology (telehealth/ telecare)
9. Education and information
10. Minimising impact of illness
11. Equality and timely access to services
12. Evidence based and quality assured
PREVENTION
1. NHS Health Check
2. Healthly lifestyles
3. Opportunistic Health Promotion
4. Making Every Contact Count
5. Smoking cessation
6. Weight management
7. Voluntary Sector
8. Local Authority
9. GP Practices
10. MDT approach
PATIENT IDENTIFICATION
1. Early detection
2. Patient Prediction
3. Screening
4. Diagnostics
5. Risk Stratification
Escalation
De-Escalation
PERSON CENTRED MANAGEMENT / PLANNING
(70%-80%of LTC population)
1. Prevention of Exacerbation
2. Stablilsing and Living with LTC
3. MDT approach
4. Education / information
5. Regular reviews/ annual check ups
6. Carer/family support
7. Supported self-care and Expert patients
8. Rehabilitation
9. Single point of Access
COMPLEX - DISEASE SPECIFIC
(15%-20% of LTC population)
1. Responsive
2. Specialism Services
3. Transition arrangement
4. Timely response to exacerbations
5. Agreed protocols and pathways
Links with OOH and Ambulance
HIGH COMPLEXITY
(3%-5% of LTC population)
High intensity users
PROVIDING CHOICE AND SUPPORT TOWARDS END OF LIFE
*Multi-disciplinary Team = Community teams, GP Practices, Voluntary Sector, Social Care, Mental Health, Medicines Management, Secondary Care, Housing, Schools etc

Mapping CCG objectives and stakeholder outcomes relevant to long term conditions

Telford & Wrekin JSNA key messages for Long Term Conditions		
➢ **Coronary Heart Disease:** It is estimated[1] that 5.6% of people aged 16+ years (approximately 7,849 adults) have coronary heart disease. However, at the end of March 2011 only 3.2% of the general practice population (5,472 adults) were recorded as having a diagnosis of CHD in primary care ➢ **Hypertension:** It is estimated that 30.9% of people aged 16+ years (approximately 39,798 adults) have hypertension. However, at the end of March 2011 only 13.5% of the general practice population (23,059 adults) were recorded as having a diagnosis of hypertension in primary care ➢ **Chronic Obstructive Pulmonary Disease:** It is estimated that 3.4% of people aged 16+ years (approximately 4,418 adults) suffer from COPD. However, at the end of March 2011 only 1.8% of the general practice population (3,136 adults) were recorded as having a diagnosis of COPD in primary care ➢ **Stroke and TIA:** It is estimated that 2.5% of people aged 16+ years (approximately 4,418 adults) have suffered a stroke or TIA. However, at the end of March 2011 only 1.5% of the general practice population (2,656 adults) were recorded as having suffered a stroke or TIA in primary care ➢ **Dementia:** It is estimated that 1,580 people were suffering from dementia in 2010. The numbers of people expected to be suffering from dementia by 2015 is set to increase by 17% to 1,851. At the end of March 2011 only 644 adults were recorded as having dementia in primary care		
CCG Objective	**Telford & Wrekin Health and Wellbeing Strategy – priority outcomes**	**Commissioning Outcomes Framework**
1) To improve quality and service transformation		
Ensuring people have a positive experience of secondary care services by continuing to improve the quality and safety of secondary care services.	Ensure people have a positive experience of health and care services	Domain 4 – Ensuring that people have a positive experience of care; patient experience of hospital care; friends and family test
Ensuring that people have a positive experience of primary care services by continuing to improve quality and safety in primary care by assessing GP and out of hours services	Ensure people have a positive experience of health and care services	Domain 4 – Ensuring that people have a positive experience of care; patient experience of primary care i) GP services ii)GP out of hours services
2) To increase life expectancy and reduce health inequalities		
Reducing premature mortality from cardiovascular disease by further improving the management and treatment of CVD in primary care	Improve life expectancy and reduce health inequalities	Domain 1 – Preventing people from dying prematurely; Under 75 mortality rate from CVD Domain 2 –Enhancing quality of life for people with long term conditions; proportion of people feeling supported to manage their condition
Reducing premature mortality from cancer	Improve life expectancy and reduce health inequalities	Domain 1 – Preventing people from dying prematurely; under 75 mortality rate from cancer Domain 2 – Enhancing quality of life for people with long term conditions; proportion of people feeling supported to manage their condition
Meeting the needs of the ageing population, specifically around mental health and dementia services	Support people with dementia	Domain 2 –; estimated diagnosis rate for people with dementia
Addressing long term conditions management and treatment, specifically around COPD and Diabetes	Improve life expectancy and reduce health inequalities	Domain 2 – Enhancing quality of life for people with long term conditions; unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's Domain 3; Helping people to recover from episodes of ill health; emergency admissions for acute conditions that should not usually require hospital admission; emergency admissions within 30 days of discharge from hospital
3) To encourage healthier lifestyles		
Addressing the obesity rates in adults and children	Reduce excess weight in children	Domain 1: preventing people from dying prematurely
Reducing the number of alcohol-specific admissions (including in children)		
Improving access to information regarding lifestyle advice and ensuring services are delivered through front line staff e.g. through every patient counts		
Reducing smoking-attributable hospital admissions and deaths by smoking intervention programmes	Reduce the number of people who smoke	
4) To support vulnerable people		
Ensuring carers have appropriate access to health and prevention services	Improve carers' health and wellbeing	Domain 4; Ensuring that people have a positive experience of care; friends and family test
Ensuring patients recovering form episodes of ill health or following injury have access to rehabilitation and re-ablement	Support people to live independently	Domain 3; helping people to recover from episodes of ill health ; emergency readmissions within 30 days of discharge from hospital

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD - 15 May 2013

TITLE - Sexual Health Services & Commissioning Process

REPORT OF – Laura Johnston Director of Children & Family Services

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

This report provides the Board with an update on the current position and future commissioning process for the delivery of Sexual Health Services in Telford & Wrekin.

2. FOR INFORMATION OR DECISION

This report is for information for Board members.

3. RECOMMENDATIONS

Board Members are recommended to consider and note the information provided to enable them to be fully informed about the process.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Priority 2 - Reduce Teenage Pregnancy Rates.
	Will the proposals impact on specific groups of people?	
	Yes	It impacts on all people in the Borough who may be sexually active but particularly the more vulnerable groups.
TARGET COMPLETION/DELIVERY DATE	*Insert date and if more than 6 months after the date of the HWB report, list key milestones* N/A	

FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The 2013/14 Public Health Grant of £10.6m has been allocated provisionally based on the known contracts, service costs and staffing establishment for 2013/14. There is some work to do to complete this exercise but much of the budget work is done. The current estimates for sexual health within the provisionally allocated budget is £1.042m, split between prescribed services, including Sexually transmitted infections £277k, contraception £454k and non prescribed services such as advice £311k.
LEGAL ISSUES	Yes	Following the transfer of a number of public health functions to this Council from 1.04.2013 members will be aware that the Council has taken on the management of current contracts and also the commissioning process going forward. The current contract is based on a national model. A number of other contracts have been extended in accordance with Guidance for a short term and this will give the Council an opportunity to progress the commissioning process in accordance with procurement regulations to put in place new contracts on the expiry of the extended contracts.
EQUALITY & DIVERSITY	No	Sexual health services are 'open access' which means someone can just turn up to clinics without an appointment. All sexual health services as outlined in this report are provided free to users.
IMPACT ON SPECIFIC WARDS	No	
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	Consultation with young people and adults was carried out to inform the way the service will operate. Four young people formed part of the tender evaluation.
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

5.1 Why is it important?

The provision of Sexual health services is an important and wide-ranging area of public health and an important function for this Council. Most of the adult population of England are sexually active, and having the correct sexual health interventions and services can have a positive effect on population health and wellbeing as well as individuals at risk. Access to effective contraception services is essential for reducing teenage pregnancy.

5.2 The commissioning landscape

As of 1st April 2013, a number of different commissioning organisations are involved in commissioning various aspects of sexual health services. Local authorities are now responsible for commissioning most sexual health services and interventions, but some elements of care will be commissioned by Clinical Commissioning Groups or by the NHS Commissioning Board.

Table 1: Sexual Health Commissioning Responsibilities as of 1st April 2013

Local Authorities	Clinical Commissioning Groups	NHS Commissioning
comprehensive sexual health services, including: • Sexual Health Local Enhanced Service delivered by GP's (excluding contraception provided as an additional service under the GP contract) • Sexually Transmitted Infections (STI) treatment and testing and HIV testing Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV	• Abortion services • Vasectomy • Non-sexual health elements of psychosexual health services • Gynaecology, including any use of contraception for non-contraceptive purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care • Sexual health elements of prison health services • Sexual Assault Referral Centre • Cervical Screening • Specialist fetal medicine

prevention and sexual health promotion work, services in schools, colleges and pharmacies		

It will therefore be important for this Council to develop robust commissioning processes which will include putting in place partnership arrangements with other commissioners across this changed commissioning landscape to ensure continuity of high quality provision.

5.3 Sexual Health Services in Telford & Wrekin

Last year Telford & Wrekin Primary Care Trust gave notice to Shropshire Community Health NHS Trust that it intended to go to a competitive tender process for all sexual health services provided by them.

The reason to tender was commissioning requirements placed on the PCT and the need to test the market given the significant service redesign required to deliver a modern 21st Century contraception and sexual health service.

The tender exercise was led by the Healthcare Commissioning Service to ensure complete transparency and integrity of the procurement process. This also involved consultation with young people and adults as well as four young people forming part of the tender evaluation.

The contract was awarded to Staffordshire and Stoke on Trent Partnership Trust, who have many years of experience in delivering sexual health services.

In the past, Sexually Transmitted Infections (STI) testing and treatment, and contraception were provided in different settings. As of 1st April 2013 the new and improved sexual health service contrart includes a mixture of 'one stop shops' where all levels of sexual health, contraception and sexual health needs from basic to complex/specialist can be met at one site, supported by satellite clinics and targeted clinical outreach for vulnerable/at risk groups. By having an integrated sexual health service means that service users only need to visit one clinic for all their sexual health needs.

Current provision provides:-

- a combination of walk-in and appointment clinics
- easy accessible clinics delivered in a range of settings, including one in a children's centre
- Specialist genito-urinary medicine (GUM) services delivered outside of the hospital setting
- regular and predictable opening hours extending into evenings and weekends

5.4 Other sexual health initiatives commissioned by the Council

5.4.1 Local Enhanced Services

16 GP practices in Telford have Locally Enhanced Service agreements in place for the provision of some methods of Long-Acting Reversible Contraception and Chlamydia screening.

9 pharmacies in Telford provide Chlamydia screening and Testing, Emergency Hormonal Contraception and Condom Distribution.

5.4.2 HIV Prevention and Support

To support early diagnoses and help people living with HIV in Telford, Telford & Wrekin Council commission Terrence Higgins Trust who provide a range of work programmes, including self-help groups.

5.5 Planned next steps

Reducing the number of teenage pregnancies is one of the ten strategic priorities agreed by the Telford and Wrekin Health and Wellbeing Board. The teenage pregnancy board which will be re-launched to include Sexual Health Services will manage and oversee the following in 2013/14

- Development of a multi-agency sexual health and teenage pregnancy/support strategy and action plan
- Outcome and performance monitoring of sexual health services and teenage pregnancy initiatives

6.0 IMPACT ASSESSMENT – ADDITIONAL INFORMATION

N/A

7.0 PREVIOUS MINUTES

N/A

8.0 BACKGROUND PAPERS

N/A

Report prepared by: Stacey Norwood – Commissioning Specialist
Telephone: 01952 388910

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15 MAY 2013

JOINT HEALTH AND WELLBEING STRATEGY DEVELOPMENT UPDATE

REPORT OF DELIVERY & PLANNING MANAGER AND CONSULTANT IN PUBLIC HEALTH

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

To present a progress update against Health & Wellbeing Strategy priority 'asset mapping' process

2. FOR INFORMATION

- For information

3. RECOMMENDATIONS

That the Board:

- consider the initial analysis of the emerging themes from the priority asset mapping exercise completed to date, with particular reference to review of existing partnership structures and strategies.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	*All Health & Wellbeing Board priorities are considered in this strategy update report*
	Will the proposals impact on specific groups of people?	
	Yes	*The Board's priorities will impact across all of the Borough's different communities. Some priorities will target specific groups, for example carers.*
TARGET COMPLETION/DELIVERY DATE	*The Health & Wellbeing Strategy priorities will be reviewed on an annual basis.*	

FINANCIAL/VALUE FOR MONEY IMPACT	Yes	*Financial sustainability is a key aspect of delivering Health & Wellbeing priorities. All priorities will be delivered from within existing budgets. Through better, more efficient partnership working – for example pooled budgets - it is expected that the Board will deliver better outcomes for the Borough's population.*
LEGAL ISSUES	Yes	*The Health & Wellbeing Board is a statutory partnership through the 2012 Health & Social Care Act. It has a duty to drive improvement of the health and wellbeing of the Borough's population, through effective partnership working. Its strategic priorities should influence commissioning decisions of both the Council and the Telford & Wrekin Clinical Commissioning Board*
EQUALITY & DIVERSITY	Yes	*Across all priorities inequality issues are expected to be considered as 'equity' is one of the key underpinning principles of the Joint Health & Wellbeing Strategy*
IMPACT ON SPECIFIC WARDS	Yes	*Reducing health inequalities is one of the ten specific Joint Health & Wellbeing Strategy priorities. The Joint Strategic Needs Assessment indicates that key health inequalities can be seen in our most deprived communities, particularly the targeted intervention areas*
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	*Patient and public engagement is one of the key underpinning principles of the Joint Health & Wellbeing Strategy.*
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	*The asset mapping approach is in the process of capturing significant impacts, risks and opportunities across the ten Joint Health & Wellbeing Strategy priorities*

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

Introduction

At their last meeting, the Board received an update on progress towards delivery against its strategic priorities as identified in the Health & Wellbeing Strategy. The development of an annual "making it happen" focus and the expectations for an asset mapping approach were outlined.

The asset mapping work has now commenced with Board sponsors and officers meeting to discuss their current position and issues for their priority areas. These discussions have been structured systematically using a common template. Completed templates received to date have captured valuable information, including an overview of the current programmes commissioned, the existing partners involved and the partnership arrangements.

To date, templates have been completed against the following priorities, and are appended to this report:

- Reduce excess weight in adults and children
- Reduce teenage pregnancy
- Support people with autism (draft)
- Reduce the number of people who smoke
- Reduce the misuse of alcohol and drugs
- Improve carer's health and wellbeing (all age)
- Improve life expectancy and reduce health inequalities
- Support people to live independently
- Support people with dementia

Each template provides position statements for delivery of the strategy's cross cutting principles, i.e. equity, accessibility, integration, quality, engagement, financial sustainability, user satisfaction, early intervention and prevention and safeguarding. Key emerging common themes are:

- In terms of quality and evidence-based commissioning, the use of NICE guidance to underpin local commissioning processes was reported for the majority of priorities
- For safeguarding, contractual requirements ensuring providers protect children and young people and vulnerable adults as service users, clients and patients was frequently noted
- Equity issues are tackled regularly across priorities through the targeting of services, which is often shaped by JSNA intelligence on inequalities

Further consideration will be given as part of the strategy development process to review the extent to which plans for the priorities satisfy the aspirations of all the agreed cross cutting principles.

The common areas for specific focus during 2013/14 reported across the priorities included:

- Review and re-establishment of partnership governance arrangements for the priorities
- Refresh and update of strategies and action plans, including an update of related JSNA intelligence

The Role of the Health and Wellbeing Board in adding value and making a difference

The key areas cited by sponsor and officer leads where the Board can add value across the priorities included:

- Champion the agreed priorities across organisational and professional boundaries across health and wellbeing partners. For example reinforce the importance of healthy eating and physical activity across Council services and with wider partners
- Provide governance, oversight and challenge for the improvement in priority outcomes. This is especially important for priorities where HWB partners have direct commissioning roles across pathways and programmes, for example the local authority, CCG and NHS England responsibilities in commissioning cardiovascular disease pathways to improve life expectancy
- Provide capacity to facilitate the asset mapping approach e.g. strategy and action plan refresh workshops for professionals and partners and community engagement events
- Identify interdependencies across priorities and join up key workstreams to work more efficiently and effectively e.g. linking of CVD and smoking programmes with dementia priority

Next steps

The outstanding/draft Priority templates will be collated and reviewed prior to the next Health & Wellbeing Board meeting. This will enable analysis of the common challenges and risks and opportunities for all priorities to be considered. Furthermore, this analysis will enable us to complete the development performance framework and enable the Board to understand outcomes the strategy will deliver – this too will be reported at the next Board meeting.

6. PREVIOUS MINUTES

- Shadow Health & Wellbeing Board Meetings on:
  - 22nd February 2012
  - 25th April 2012
  - 13th June 2012
  - 12th September 2012
  - 14th November 2012

7. BACKGROUND PAPERS

- Telford & Wrekin Health & Wellbeing Strategy

Report prepared by Jon Power, Delivery and Planning Manager, Telephone: 01952 telephone extension 380141

Health & Wellbeing Strategy Priority position statement: May 2013

Priority 1: Reduce Excess Weight in adults and children

Specific Focus for 2013/14:
Expand scope to include all those who are above a healthy weight (previous focus has been on obesity, overweight is now included)
Embed the importance of preventing and managing excess weight throughout services delivered by the Council and partner agencies

Lead Officer, Organisation & HWB Member Sponsor:
Clare Harland, Telford and Wrekin Council
Councillor Arnold England

Integration
What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help groups)

Services currently commissioned

Weight management and excess weight prevention services that contribute to the Obesity action plan and form part of the obesity pathways for adults and children are commissioned by Public Health.
These include:

Why Weight Mums
This is a weight management programme for pregnant women with BMI >30 at 12 week booking. The model includes one to one appointments and home visits. The programme aims to minimise weight gain during pregnancy, reduce weight post nataly and improve healthy lifestyle behaviours within the family.

Breastfeeding
The UNICEF UK Baby Friendly Initiative (BFI) action plan is being implemented to achieve full BFI accreditation. A workforce development programme is in place for frontline staff working with pregnant and breastfeeding mums. Antenatal and post natal breastfeeding education and information is delivered to groups and on a 1-1 basis in the community. Home support is also provided for breastfeeding mums where appropriate. BEST (breastfeeding encouragement support team) peer support volunteers provide support to breastfeeding mothers in the community.

Healthy Start
Healthy Start is a UK-wide government scheme to improve the health of low income pregnant women and families on benefits and tax credits. Vouchers for fruit, vegetables, milk and vitamins for mother and child are promoted through pharmacies and by midwives and health visiting teams.

HENRY
Health Exercise Nutrition for the Really Young (HENRY) provides workforce training for frontline staff working with families with children under 5 and 8 week courses for parents with children under 5 at risk of obesity. It is a partnership programme and is linked to Big Lottery Funded

Parents Champions project.

YW8? 4-7
YW8? is a family weight management programme for families with children between 4 and 7 years old who are above a healthy weight. Group programmes run each term and one to one work with individual families is also in place.

YW8? 8 – 13
YW8? is a family weight management programme for families with children between 8 and 13 years old who are above a healthy weight (referrals are taken up to 15 years old on a case by case basis). Courses are run each term across the borough.

National Child Measurement Programme (NCMP)
The NCMP is a mandated programme which involves measuring the heights and weights of children in reception and year 6 across Telford and Wrekin. Feedback and offers of support are provided to parents/carers regarding their child's results. Anonymised data is submitted to the Department of Health contributing to national and local statistics.

Slim to Trim
Telford and Wrekin Council Leisure Services offer a weight management session that provides weight loss advice with the addition of fun interactive exercise.

Why Weight? Plus
This is an adult weight management programme for those with BMI >30 (or >28 with co-morbidity). It consists of a 12 week programme with one to one and group sessions.

Health Trainers
Health Trainers offer one-to-one support on smoking, healthy eating, physical activity, alcohol and other topics. They complete lifestyle assessments, offering goal setting and practical advice, and encourage and motivate people to make a lifestyle change.

ALD Healthy Living Project
This is a pilot project working with staff, carers, families and service users at Downing and Carwood residential homes to create an environment where healthy eating and daily physical activity are the norm. This is being achieved through a range of approaches including staff training and support, health checks, taster sessions, physical activity programmes and weight management services. Where possible service users and staff have been encouraged and supported to engage with mainstream services.

Healthy Lifestyle Hub
The Healthy Lifestyle Hub at First point provides a single point of access for both professionals and the public. It offers information, advice, signposting and referral onward for lifestyle issues including healthy eating, physical activity, emotional health and wellbeing, smoking and alcohol.

Community Food programme
The community food project offers weaning sessions, healthy eating for under-fives, basic nutrition training for health and social care staff, cooking on a budget course for families, evidence and best practice advice for practitioners in health and social care.

Cooking Bus projects

The Cooking Bus provides a mobile facility to deliver outreach cooking and healthy eating sessions including Let's Cook Together and Let's Cook Mini.

Physical Activity Projects
Telford and Wrekin Council provides a wide range of opportunities for people to get active through their leisure services, green spaces and cycle and walking routes. In addition a number of programmes are in place to encourage adults, children and young people to make their first steps into physical activity and improving their health. These include community based programmes and activities specifically designed to target health inequalities and those who are less likely to access mainstream leisure provision.

Fit for Life
Telford and Wrekin Council provides a GP referral Scheme to support individuals who may have underlying medical conditions to take part in physical activity. Fit for Life promotes better health through physical activity.

Tackle your health
Telford & Wrekin Council working in partnership with AFC Telford United, deliver 'Tackle Your Health', a project aimed at men (30- 74 years) who live or work in Telford & Wrekin and want to improve their health and wellbeing. The team help men adopt and sustain a healthier lifestyle be offering free health checks, advice and one to one support , to support this 'Tackle Your Health' offers a range of activities including gym, football 'kickabouts', walking football, badminton and circuit sessions.

Inclusive Leisure Scheme
The Inclusive Leisure Scheme aims to recruit and train a group of community volunteers to motivate and support disabled adults who have registered an interest in participating in the scheme. Recruited volunteers will support disabled adults within a gym and swimming environment at Telford & Wrekin Council leisure facilities.

Key partners
Telford and Wrekin Council (service delivery teams including Public Health, Leisure Services, Children and Family Services, School Catering, Transport)
Shropshire Community Health NHS Trust

Partnership arrangements/governance
The Obesity Partnership Group oversees delivery of the Strategy and Action Plan.

A partnership Obesity strategy has been in place in Telford and Wrekin for approximately 10 years, during which time services and interventions have been developed and established to deliver the action plan and obesity pathways.

The Obesity Strategy Group oversees delivery and performance of:
Obesity pathway for Children and Young People
Obesity Pathway for Adults
Obesity Action Plan

The Obesity Strategy group previously reported to: Telford and Wrekin PCT Board, the Children's Trust Board, and the Adult Health and Wellbeing Board.

As part of transition it is anticipated that reporting lines will include the Health and wellbeing board, Children and families board, Telford and Wrekin Clinical Commissioning Group. All three of these bodies have excess weight or obesity in adults and/or children a one of their priorities.

Informal provision
An asset mapping approach is being taken with stakeholders to capture the wider provision in place that contributes to this priority.

Making Every Contact Count (MECC) is being rolled out through NHS frontline services to educate and encourage staff to initiate conversations with patients about subjects including excess weight.

Financial Sustainability
What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?

Commissioned programmes are funded from public health budget however significant contributions are made to delivery of the action plan by Council service delivery teams and other partners. Grant and Lottery funding supports a number of projects including HENRY.

Equity
How has current provision been designed to meet the differing needs from across the community?
Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?

Programmes and services target those at higher risk of overweight and obesity, this includes those living in deprived areas and children whose parents are overweight or obese.

Accessibility
What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

The majority of adults (estimated 62%) in Telford and Wrekin are overweight or obese. Excess weight and its contributing behaviours (inactivity and poor eating habits) have become normalised. There is also a lack of recognition by parents of overweight and obesity in their children.

Quality
What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?

Overarching indicators:
National Child Measurement Programme results for 4-5 year olds and 10-11 year olds
Public Health Outcomes Framework indicators:
Breastfeeding
Excess weight in 4-5 year olds and 10-11 year olds
Excess weight in adults
Proportion of physically active and inactive adults

Programme performance measures: Performance measures include referrals, recruitment and retention, weight change, BMI, DALYs and evidence of behaviour change. These are detailed in the service specifications, performance is reported quarterly as part of the overall Health Improvement contract. *Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NCIE guidance/national guidelines etc* National Guidelines Healthy Lives, Healthy People: A call to action on obesity in England (2011) https://www.gov.uk/government/news/department-calls-for-action-on-obesity National Child Measurement Programme Operational Guidance for 2012/13 school year http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133671 Healthy Start Guidance http://www.healthystart.nhs.uk/for-health-professionals/healthy-start-resources/ NICE Public Health Briefings for Local Government PHB3 Physical Activity PHB8 Walking and cycling NICE Guidance CG43 Obesity NICE Public Health Guidance PH11 Maternal and Child Nutrition PH13 Promoting physical activity in the workplace PH17 Promoting physical activity for children and young people PH27 Weight management before during and after pregnancy PH 41 Walking and cycling PH 42 Obesity – working with local communities
Engagement & Positive Experience *What are service users' views on current provision? How have service users' views been used to inform current provision?* The Obesity Strategy was developed using an Outcomes Based Accountability approach with stakeholders and service users Evaluation, service user feedback – are required as part of all service specifications on commissioned programmes and are included in the end of year report. This also includes case studies.
Early Intervention and Prevention *What provision is in place to reduce future demand for this service/intervention?* *Please describe the preventative or early intervention approach being adopted and the rationale?*

A universal and targeted approach is taken with an emphasis on creating environments where it is easier to take the healthy option, especially healthy eating and physical activity. A wide range of opportunities and support for getting active are offered by the Council through use of green spaces, walking and cycling initiatives and Leisure Services. Particular emphasis is placed on supporting those less likely to access mainstream activities to adopt an active lifestyle.

Prevention programmes include:

Change4life clubs in schools
Change4life clubs have been set up in the Phoenix and Madeley School Games Area targeting years 3/4 for an out of school hours club to encourage less active, including overweight, children to participate in fun physical activities. The club sessions led by teachers, parents or sports leaders include discussions about food choices, eating and family activity.

Street Games & Doorstep Sport Clubs
Telford and Wrekin Council works with and helps local communities to organise and deliver a free range of sports activities for young people in disadvantaged communities.

Sportivate
Sportivate is a national initiative that is delivered locally to get more 14 – 25 year olds regularly participating in sport. Telford and Wrekin Council works with local voluntary sports clubs and colleges to deliver a wide range of activities to engage young people and hopefully sustain their interest.

Friday Night Football
This is a project that engages young people in free quality coaching football sessions and games. Currently sessions are delivered in Hadley, Madeley and Wellington. Teams from each area play four times a year and are entered into the annual Street Games Festival.

Ican2 sports and leisure
Telford and Wrekin Council Leisure Services deliver a sports activity programme for disabled children and young people to provide them with a positive sporting experience and respite for carers/parents. Activities include computer club, skiing, multi activities, swimming and cycling.

Run England
Run England is a recreational running project which aims to get the whole nation running, regardless of age, fitness level, aspiration, background, or location. Telford and Wrekin Council is supporting this project to help and encourage more people to run, and to run more often. Volunteers have been recruited as ‘run leaders’ and are now delivering led runs locally.

No strings badminton
No strings badminton is a project to encourage people to start playing, improve their play or simply enjoying making new friends and improving their fitness. It is a unique, semi structured pay and play set up that is designed to be fun and free from fuss.

Kids for a £1
Every holiday, Leisure Services offer a sports and activity programme for children and young people. For only £1 a session children and young people can take part in a wide range of activities such as trampolining, tobogganing, golf, dance mats, street dance, cheerleading, and tennis

nRGIZE
nRGIZE is a range of health and fitness activities geared towards 11-15 year olds with purpose built facilities at Stirchley Recreation Centre, Abraham Darby Sports & Leisure Centre and Oakengates Leisure Centre.

‘aspirations’
‘aspirations’ offers local people the opportunity to become members of health and fitness venues within the Telford area. They have state of the art gym facilities and offer an aerobics programme with over 85 classes per week

Personal Training
Qualified, ‘goal orientated’ instructors work with individuals on a one to on basis to ensure that their workouts are as enjoyable and effective as possible.

Senior Gym Club
Telford and Wrekin Council Leisure Services supports senior Gym Club sessions at Stirchley Recreation Centre.

Football in the Community Programme
Telford and Wrekin Council will be supporting the Telford and Wrekin Football Partnership at strategic and operation level. The Council will manage a Football Coaching Officer who will be instrumental in developing the AFC Telford Football in the Community programme.

Town Park
The Town Park offers the opportunity for informal recreation and physical activity opportunities. The park also hosts Parkrun, a free weekly 5k run every Saturday.

Swimming
Free swimming under 16s in any public session.

Concessions scheme
Concessionary rates are available to specified groups of Telford and Wrekin residents. These include Carers accompanying a person in receipt of a disability allowance, who are admitted free of charge.

Telford Visually Impaired Group
Telford and Wrekin Council works with the Telford Visually Impaired Group to help support sessions including; walking, self defence and slim to trim.

Disability Gym sessions
Disability Gym sessions are offered every Tuesday for disabled adults. TWC also work with Club 2000 providing gym sessions for adults with Learning difficulties.

Active Travel Programmes
A range of walking and cycling projects are delivered by Telford and Wrekin to encourage the take up of active travel for every day journeys to school and work.

School Catering
A range of menu options compliant with nutritional guidelines are offered in primary and

secondary schools across Telford and Wrekin.
Safeguarding *How does current provision, ensure the safety of its most vulnerable clients?* Safeguarding requirements are included in all service specifications Example: Adults with learning difficulties are attending mainstream services supported by their carer
What difference/added value can the HWB make to this priority in 13/14 and how? Raise the profile of overweight and obesity and reinforce the importance of healthy eating and physical activity across service delivery areas in the Council and with wider partners in the public, private and voluntary sector. Support the development of a workforce programme across the Council focussing on excess weight which would: Result in a healthier workforce Encourage staff to influence their friends and families to adopt healthier behaviours Empower staff to encourage their clients and service users to adopt healthier lifestyles Enable teams to embed healthy eating and physical activity messages into their service delivery

**HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT:
MAY 2013**

Priority: Priority 2 - Reduce Teenage Pregnancy Rates

Specific Focus for 2013/14:

Strategic Leadership, Performance Management and Governance
There is in place a multi-agency Teenage Pregnancy (TP) Board, however due to Telford & Wrekin's new public health responsibilities this board will be re-launched to include Sexual Health Services.

Needs Analysis, Strategy and Action Plan
Develop a multi-agency strategy and action plan based on need analysis that sets out Telford & Wrekin's continued commitment to reducing under 18 conceptions.

The Government's teenage pregnancy unit has identified key areas for effective practice in reducing teenage conceptions and improving outcomes for the children of teenage parents.

These areas, which will provide the foundations of Telford & Wrekin's Reducing Teenage Pregnancy and Support for Young Parents Strategy and Action Plan, are:

- Giving young people the knowledge and skills they need to experience positive relationships and good sexual health
- Improving young people's access to and use of effective contraception when they need it
- Intervening early with those most at risk
- Improving outcomes for teenage parents
- Improving the life chances of newborns

Lead Officer, Organisation & HWB Member Sponsor:

HWB Sponsor: David Evans – Chief Officer Telford & Wrekin CCG
Lead Officer: Clive Jones – Assistant Director, Family & Cohesion Services
Organisations:

- Telford & Wrekin Council
- Telford & Wrekin CCG
- Shropshire Community Health NHS Trust
- The Shrewsbury and Telford Hospital NHS Trust (maternity services)
- Cabinet Member Paul Watling, Children, Young People and Families

1. Integration
*What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help groups)*The governance board for Teenage Pregnancy (TP) consists of key commissioning and delivery partners responsible for the delivery of the TP action plan. This Board is chaired by Clive Jones and meets on a quarterly basis.

Teenage Pregnancy & Support – *Commissioning high quality support services for pregnant young women, young parents and their families including access to education, employment and training*

Telford & Wrekin CCG have responsibility for commissioning abortion services. It will be important to continue are partnership arrangements to ensure the abortion provider services are delivering in line with are local strategy. This is commissioned by Children's & Families Commissioners

Telford & Wrekin CCG commission Teenage Identified Midwifery service for young mothers under 17 and their partners. This service is delivered by SaTH.

National Commissioning Board commission Health Visiting Service (and Family Nurse Partnership programme)

Healthzone - Community School Nurse drop-in delivered in partnership with schools and targeted youth services delivering a number of health promotion programmes. These two services are delivered by Shropshire Community Health NHS Trust.

Through Children Centre Services there are a number of work programmes being delivered to support young parents including young parents' support group (Bump2Baby and Beyond).

Sexual Health Services – *Commissioning to ensure delivery of accessible, high quality contraception and sexual health services*

As part of the public health transfer the Council now commissions:
Staffordshire & Stoke on Trent Partnership NHS Trust:

A new contract for integrated community based sexual health services in Telford and Wrekin has been awarded and started on 1 April 2013, following a competitive tender exercise. The revised service specification reflects the latest evidence base. It will significantly increase access to services through the provision of integrated Levels 1, 2 and 3 contraceptive and sexual health services. This is a three year block contract arrangement.

Local Enhanced Service (LES):

There are 22 GP practices in Telford of which 16 have Locally Enhanced Service agreements in place for the provision of some methods of Long-Acting Reversible Contraception and Chlamydia screening.

Within Telford & Wrekin there are 15 pharmacies of which 9 have Locally Enhanced Service agreements in place for the provision on Chlamydia screening and Testing, Emergency Hormonal Contraception and Condom Distribution.

For services delivering LES there is in place Patient Group Directive (PGD) which is being supported by Telford & Wrekin CCG Medicines Management Team.

HIV:

National data for 2010 indicates that there were 74 people living with HIV infection in Telford and Wrekin. The cumulative rate of diagnosis of HIV infection locally is significantly lower than the average for the West Midlands. The prevalence of infection in Telford is <1 per 100,000

population. These figures refer to people living with diagnosed HIV only, and do not account for people who are not aware of their HIV infection. Nationally it is estimated that 24% of people living with HIV in the United Kingdom in 2010 remained undiagnosed and were therefore unaware of their infection.

To support early diagnoses and support people living with HIV Telford & Wrekin Council commission Terrence Higgins Trust (charity organisation) to provide a range of work programmes, including HIV testing and self help groups. This is currently a one year block contract arrangement.

Staffordshire & Stoke on Trent Partnership NHS Trust provide same day HIV testing and all forms of treatment and ongoing support to people living with HIV in Telford & Wrekin.

2. Financial Sustainability

What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?

Telford & Wrekin Council

Sexual Health Services & Teenage Pregnancy Projects - £954,000 pa

Telford & Wrekin CCG

Termination Provision £226,614 pa

3. Equity

How has current provision been designed to meet the differing needs from across the community?

Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?

Teenage Pregnancy is an outcome which results from a range of issues. Five hundred risk and protective factors associated with teenage pregnancy have been identified (Kirby D, 2007) so the solution to this issue has to be multi-faceted and one which focuses widely on prevention and is closely linked to other priorities:

- Increased uptake of Chlamydia screening in sexually active under 25s
- Increased participation of teenage mothers in education, training or employment to reduce their risk of long term social exclusion
- To reduce postnatal depression
- To improve breastfeeding rates
- To increase numbers of pregnant young women who quit smoking
- To reduce numbers of children of young parents taken into care
- Delivery of Child Health Programme

Services are commissioned that enable, help and support people, especially the most vulnerable, to access services and continue to use them. Future work areas will include more targeted work programmes.

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

The new sexual health service has been re-designed to ensure all service user needs can be met at which ever site they attend with services delivered over extended opening hours and in easily accessible locations. A new sexual health clinic is being delivered at Sutton Hill Children's Centre which has seen a high level of attendance. Future work will ensure the link with targeted youth support and other appropriate services.

5. Quality

What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?

Teenage Pregnancy & Support

Outcome Measures: Reduction in u18 conception rate by 55% on the 1998 baseline.

Progress in December 2012 - Telford & Wrekin's rolling average quarterly rate of 46.4/1000 15-17 year olds shows a 23% reduction on the same period the previous year but this has slightly increased by 3% by Q2. This compares to a 6.7% reduction in the national rate and a 6% reduction in the West Midlands rate in the same period.

The rate of 46.4 equates to **150 conceptions**, 10 less than the same period in the previous year.

Sexual Health

New guidance has been published by Department of Health – A Framework for Sexual Health Improvements in England. This sets out the key priorities:

- Continue to tackle the stigma, discrimination and prejudice often associated with sexual health matters
- continue to work to reduce the rate of sexually transmitted infections (STIs) using evidence-based preventative interventions and treatment initiatives
- reduce unwanted pregnancies by ensuring that people have access to the full range of contraception, can obtain their chosen method quickly and easily and can take control to plan the number of and spacing between their children

- support women with unwanted pregnancies to make informed decisions about their options as early as possible
- continue to tackle HIV through prevention and increased access to testing to enable early diagnosis and treatment
- promote integration, quality, value for money and innovation in the development of sexual health interventions and services

The new sexual health service has only been delivering since 1st April, therefore at this time we can not report on any detailed performance activity. The service is delivering in line with the above priorities which also include 28 Key Performance Indicators of which commissioning will monitor and report against to the partnership board ***(see appendix 1 for more detail)***

Is current service provision based on best practice or other evidence of effectiveness? Please list

the relevant NCIE guidance/national guidelines etc

- Better prevention, better services, better sexual health – The national policy for sexual health and HIV 2012
- NSH Operation Framework 2012-13 – planning, performance and financial requirements for NHS organisations
- NHS Outcome Framework 2012-13 – Key Indicators: Clinical Effectiveness, Patient Experience, Patient Safety
- Public Health Operating Framework 2011 – Commissioning Responsibilities
- Public Health Outcomes Framework 2012 – Sexual Health Indicators
- Department of Health 'Making Every Contact Count' (2011)

6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision?

To inform the new sexual health service a number of consultation methods took place which included:

- 20 young people and adults formed part of a serious of focus groups
- 152 young people and adults completed and returned a questionnaire
- 38 staff working in the service or have referred young people or adults into the service completed a questionnaire
- 4 young people formed part of the tender process and evaluated bidders

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?
Please describe the preventative or early intervention approach being adopted and the rationale?

Planned calendar of sexual health promotion/prevention activities/campaigns linked to key national campaigns such as Sexual Health Week and World AIDS Day and other key dates such as Freshers Week, Valentine's Day, Summer Holiday season, Halloween and Christmas/New Year.

Promote healthier lifestyle choices by 'Making Every Contact Count' - Frontline staff delivering appropriate advice, including 'signposting' services, as part of their everyday contact with Service Users.

Co-ordination, management and on-going development of the Condom Distribution Scheme an additional 50 sites will be introduced over a 12 month period.

Link to 2011-14 strategy, 'Changing Behaviour, Improving Outcomes: A new social marketing

strategy for public health.

8. Safeguarding

How does current provision, ensure the safety of its most vulnerable clients?

Delivery of targeted intervention for young people and adults at risk:

- Multi agency Homeless Board meet to look at accommodation needs for vulnerable young people under 18 - Housing, Cohesion, Social care
- Care pathways identified – pre-birth pathway adapted for vulnerable young parents
- Targeted Clinical Outreach – delivering contraception and sexual health outreach services to young people and adults at risk
- Specialist midwife for under 18 parents (TIMs)
- Family Nurse Partnership (FNP)
- Risk assessment tool for Early Identification of vulnerable young people

Telford & Wrekin Intervention Screening Tool (TWIST) is a tool that has been introduced to identify, moderate or reduce risk taking behaviour in young people that may lead to teenage pregnancy or early parenthood. Front line workers use the tools to screen and make an informed decision about the most appropriate intervention a young person may need to reduce their identified risk taking behaviour which may include referral to a specialist service. To date a total of 59 assessments have been completed by a range of professionals with young people being referred into appropriate support services.

Preventing Sudden Infant Deaths

Research evidence indicates that infants with young mothers are at four times greater risk of Sudden Infant Death Syndrome (SIDS) than those with older mothers. A safer sleeping practices workshop was undertaken for professionals in Telford in March 2013, The current practice, in terms of advice and support given to parents by midwives, local health visitors and children's centre staff was reviewed. A comprehensive, evidence-based safer sleeping policy is now in development to ensure consistent advice is given to families by all healthcare professionals.

9. What difference/added value can the HWB make to this priority in 13/14 and how?

There are a number of areas the HWB can help and support these are to:

- Development of strategic framework
- Provide the governance arrangement for reporting outcomes, performance, risks and issues
- Ensure a close working with other key partners; including Public Health England

Appendix 1 – Sexual Health KP’s

Key Service Outcomes/Key Performance Indicators (KPIs)
1. Service Users receiving urgent provision the same working day 2. Service Users receiving telephone advice on the same working day 3. Walk-ins seen within 2 hours of arrival 4. Non-urgent Service Users seen within 2 working days of initial contact 5. Women receiving LARC within 4 weeks of initial contact (if clinically appropriate) 6. Women receiving EHC on the same day of request 7. Service Users seen for their psychosexual counselling appointment within 4 weeks of receipt of referral 8. Service Users assessed by a doctor who provides HIV care within 2 weeks of a positive HIV test result, irrespective of the place of testing, unless the patient chooses to defer this. 9. Service Users seen within 30 minutes of their appointment time. 10. Split of walk-in attendances versus appointment attendances 11. Total clinic capacity offering an integrated service 12. New attenders having sexual history taken and STI/HIV risk assessment 13. Sexually active young people under the age of 16 (and 16-17 years where cause for concern) risk assessed for sexual abuse or exploitation 14. Sexually active vulnerable adults risk assessed for sexual abuse or exploitation 15. Women receiving LARC as their chosen method of contraception 16. HIV testing by first attenders 17. Newly diagnosed HIV patients with a CD4 count <350 when measured for the first time after testing positive 18. Service Users where the period of time between their consultation and receipt of their results by the Service is no more than 14 working days, taking account of the recommended laboratory turnaround times. 19. Service Users notified of positive results within 3 working days of receipt of result by the Service. 20. Chlamydia screening in eligible patients 21. Positive index cases confirmed as treated 22. Partners/contacts of positive index cases confirmed as treated

23. Partners/contacts of HIV positive index cases contacted and confirmed tested for HIV
24. Clinical staff with the skills and competencies to both fit all methods of contraception and undertake STI testing and treatment
25. Nursing staff delivering services under PGD
26. Staff trained to deliver ‘Making Every Contact Count’ brief interventions
27. Increase in the number of referrals to smoking, alcohol and healthy eating support services
28. Clinic venues You’re Welcome (Young People Friendly) accredited

<u>DRAFT</u> HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT: MAY 2013

Priority 4: Support people with Autism <u>DRAFT</u>
Lead Officer, Organisation & HWB Member Sponsor: **Richard Smith Telford and Wrekin Council** **Dylan Harrison, NED CCG**
1. Integration *What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help groups)* *Services are commissioned on an adhoc needs lead basis until recently we did not have a commissioning strategy so services have been commissioned on a reactive basis rather than preventative, services range from low level information advices provided by voluntary organisations to specialist health placements. The local authority is committed to ensuring that the training and support is in place for all front line staff.* *Key partners are voluntary sector, housing, advocacy groups, information and advice providers, probation service, police, user groups, health providers,*
2. Financial Sustainability *What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?* we do not routinely collect this information and provision is across multiple organisations No saving targets
3. Equity *How has current provision been designed to meet the differing needs from across the community?* *Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?* No services have been designed on an adhoc bases unfortunately with service users often been inappropriately supported or left with no support which is recognised within the strategy

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

Fragmented transition pathways
Resources,
Access to low level preventative support,
Lack of clear diagnostic pathways
Poor information advice and guidance
No formal pre and post diagnosis support

5. Quality

What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level

Performance will be measured against the autism strategy's action plan been able to evidence improved access to low level services, diagnostic services, housing, employment and training, This information is not easily available and a performance frame work will need to be developed across the economy

Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NCIE guidance/national guidelines etc

Yes new draft NICE guidelines

6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision

STACS and Autonomy are the key user groups which have been involved in the production of the strategy recognise the lack of specialist service provision, low level preventative services, clear diagnostic pathways, lack of transition arrangements and user involvement

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?
Please describe the preventative or early intervention approach being adopted and the rationale?
Proposal to commission a low level preventative service which will provide information advice and guidance to enable people to access appropriate services as and when required this will include, housing, education employment and benefit advice, When more specialist services are required pathways into health and social care will be more efficient. Currently the local authority are aware of over 200 people who would benefit from access to such a service, preventing the need for expensive inappropriate services be it criminal justice or health and social care

8. Safeguarding

How does current provision, ensure the safety of its most vulnerable clients?
It doesn't as it is not a discreet service often people are not defined as vulnerable and hence behaviour becomes criminalised and inappropriate service provision either Mental Health or Learning disabilities

9. What difference/added value can the HWB make to this priority in 13/14 and how?
Support the strategy divert resources when required bring together interested parties

HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT: MAY 2013

Priority 5:
Reduce the number of people who smoke

Specific Focus for 2013/14:

- Continue to reduce smoking in adults and pregnant women
- Reconvene the multi agency tobacco control network
- Develop a tobacco control strategy

Lead Officer, Organisation & HWB Member Sponsor:
Lead Officer Vicki Pike, Health Improvement Commissioner, Telford and Wrekin Council
HWB Member Sponsor, Paul Clifford, Director of Care, Health and Well-Being, Telford and Wrekin Council

1. Integration

What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help groups)

Stop Smoking Services Contracts

- Telford and Wrekin Council have currently extended existing contracts for stop smoking and stop smoking in pregnancy until 31st July 2013
- The contract extensions are an Any Qualified Provider (AQP) 'Payment by Results', uncapped contract, therefore no upper delivery levels exist. While this has proven to increase innovation and outcome, it has had an effect on budgets. As such the delivery levels and budgets have to be closely monitored by the commissioner on a monthly basis.
- The estimated cost of extending the current contracts for 4 months is £191,846. The criteria for clients are those living, registered to a GP or working, in Telford and Wrekin

Telford and Wrekin Council are due to go out to tender with three new Lots for stop smoking and stop smoking in pregnancy services, early 2013/14. The services will cover clients living, or registered to a GP, in Telford and Wrekin. Contracts will start from 1st August 2013 for one year with the option to extend, until 31st March 2015. The three lots are:

- LOT 1 – Stop Smoking Core service for 1500 4-week quits, 750 12-week quits and 375 6-month follow up quits
- LOT 2- Stop Smoking out of hours service for 500 4-week quits 250 12-week quits and 125 6-month follow up quits
- LOT 3 – Stop Smoking in Pregnancy service, for 150 4-week quits and 70 quits, either at delivery or 12-weeks which ever is furthest away, 35 6-months follow up quits.

The annual value of each of the contracts are:

LOT	Expected	5% incentive 6 month quit payment
1	331,526 (353,833)	16,576 (17,692)
2	110,509 (121,630)	5,525 (6,081)
3	101,005 (121,872)	5,050 (6,094)
Totals	543,040 (597,335)	27,151 (29,867)
Grand total		570,191 (627,202)

Hospital Stop Smoking Contract

- Telford and Wrekin Council have extended the Hospital Stop Smoking service for 12 months

- The services aim is to
  - Raise the health issues linked to smoking within the hospital
  - Identify smoking service users
  - Deliver brief interventions on smoking
  - Signpost into community stop smoking services
  - Train hospital staff on smoking and the hospital service.
- The annual cost of the service is £38,600
- The service provides quarterly reports to the commissioner against agreed key performance outcomes.

Making Every Contact Count

- Additional to the commissioned services smoking is one of the health issues discussed as part of the Making Every Contact Count (MECC) programme
- In 2012/13 MECC was one of the CQUIN (Commissioning for Quality and Innovation) targets
- SaTH is using the measure of an increase to the hospital stop smoking service, as the indicator to measure the success MECC. As MECC was a CQUIN target in the previous year it now becomes a key performance indicator for 2013/14.

Performance Monitoring

There are smoking key performance indicators in a number of contracts including school nurses, health visitors, maternity and Shropshire Community health trust. The indicators require service to offer MECC, check smoking status and either give out smoking information or making a referral to a stop smoking service. The maternity contract has an 'opt out' measure where all smoking mothers are automatically referred to a stop smoking service unless they 'opt out'.

Partnership Landscape

There are a number of services/organisations that support the smoking agenda giving out information, advice and signing posting to stop smoking services, these include: Children centres, Fire and Rescue Service, Police, Age Concern and St Johns Ambulance.

Previously the governance structure for the Stop Smoking contracts was through the Quality Performance Review meeting of the PCT and then the PCT board. It is expected that the future governance arrangements will be through the Health and Wellbeing Board.

There are two main partnerships that support and manage the smoking agenda in Telford and Wrekin; a Telford and Wrekin Tobacco Control Network; this is made up of representations from the commissioning team, SaTH, stop smoking service providers, fire service, HMRC, and the public protection team (Trading standards & licensing). This group used to meet once per quarter. Due to maternity leave it has not meet been meeting regularly. It needs invigorating and developing to become responsible for the development and delivery of a local tobacco control strategy.

The second group is a West Midlands Tobacco control network, this is made up of the tobacco control commissioners from across the councils within the region. The group reviews best practice, NICE guidance, shares experiences, acts as a reference group and supports each other acknowledging the different expertise everyone has. This group meets twice per year, at a central location and works as a real time virtual group.

2. Financial Sustainability

What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?

T&W Council – public health team – annual budget of £713,600- between 80-90% to be spent on

quitters, 38,600 spent on the hospital stop smoking service

T&W Council – licensing and trading standards – within their budget and portfolio they carry out work in the area of illicit tobacco and 'proof of age' as part of their annual business plan.

Number of providers use the Department of Health developed flyers and leaflets – these are free and we have had confirmation they will still be available and free for 2013/14.

A saving of 25% against the 2012/13 budget has already been made. No additional savings for 2013/14 are currently being requested. An investment in more preventative work should be put forward for consideration when looking at the deployment of additional funding available within the PH grant in 2014/15.

3. Equity

How has current provision been designed to meet the differing needs from across the community? Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?

Research has shown that smoking is closely linked to health inequalities, people who smokes are most likely to be from the lower socio-economic classes and have a reduced life expectancy, due to their higher risk of smoking related disease. Smoking is also a risk factor for foetal growth restriction, low birth weight and sudden infant death.

Duncan Selbie, Chief Executive of Public Health England says:
'Smoking is the major cause of preventable deaths in England, responsible for more deaths than the next six causes combined. It is also a crucial factor in health inequalities, accounting for half the difference in mortality between the richest and poorest in society. No council can hope to reduce health inequalities without reducing smoking rate',
http://www.ash.org.uk/information/clear-excellence-in-local-tobacco-control/clear-foreword-by-duncan-selbie

Locally the data from the JSNA has helped to inform the service provision. The data has supported the stop smoking providers to design and delivery their service. The current AQP contract encourages providers to work with the targeted groups by paying more for their quits. In the new contracts the Provider can offer the service to any eligible Service User, the Provider is particularly encouraged to recruit and support Service Users using primary care risk registers and from specific demographic subgroups. The identified targeted groups are listed below:

- Pregnancy
- People from Ethnic Minorities
- Unemployed People
- People Living in Deprived Areas
- Young People under 25 years
- People with Severe Mental Health Difficulties
- People who are deaf, hard of hearing, blind or partially sighted

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

There are a number of NICE guidance documents which have evaluated best practice to increase the number of quitters across different sectors of the populations. Locally we ensure providers and contracts adhere to this guidance and review annually.

The West Midlands tobacco control group have sponsored a number campaign across the region and within Telford and Wrekin. These have been evaluated and look at engaging clients from different groups via face to face campaigns.

All service users are asked and offer a customer satisfaction questionnaire. These are reported to the commissioner at the quarterly contract meetings.

There are a number of barriers around smoking including:

- The clients readiness to quit
- The level of importance given by other services
- The understanding and usage of MECC and signposting
- The support and sign up of senior management and members

5. Quality

What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?

The stop smoking and stop smoking in pregnancy contracts have;

- 3 activity performance indicators
- 2 key service outcomes
- 9 quality indicators

(see appendix 1 for more detail)

Current delivery: In Telford and Wrekin our providers are delivering above quit rates for 4 and 12 weeks. We have also higher than national average number of clients from the 'targeted' groups. Currently the findings from the review of the AQP contract have demonstrated an increase in the number of contacts and successful quits from the targeted groups.

Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NICE guidance/national guidelines etc

PH1	Mar-06	http://www.nice.org.uk/guidance/PH1	Brief interventions and referral for smoking cessation	Brief interventions and referral for smoking cessation in primary care and other settings
PH5	Apr-07	http://www.nice.org.uk/guidance/PH5	Workplace interventions to promote smoking cessation	Workplace health promotion: how to help employees to stop smoking
PH10	Mar-08	http://www.nice.org.uk/guidance/PH10	Smoking cessation services	Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities
PH23	Feb-10	http://guidance.nice.org.uk/PH23	School-based interventions to prevent smoking	School-based interventions to prevent the uptake of smoking among children
PH26	Jun-10	http://guidance.nice.org.uk/PH26	Quitting smoking in pregnancy and following childbirth	How to stop smoking in pregnancy and following childbirth
PH39	Sep-12	http://guidance.nice.org.uk/PH37	Smokeless tobacco cessation - South Asian communities	

Annually the commissioner RAG rates the recommendations in each of the guidances, against current practice. A full action plan is then developed if required. Currently Telford and Wrekin are meeting most of the recommendations in the NICE guidance and red on none.

6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision?

Every stop smoking provider is expected to offer their service users the opportunity to complete a customer satisfaction questionnaire. These are reviewed at the quarterly contracts meetings with the commissioner and any issues are addressed accordingly.

In 2010 the commissioner led a session on the patients' journey with smoking in pregnancy and hospital stop smoking services. Both had the presence and collected the views of the service users. These sessions were very useful and resulted in both services making changes and improvements.

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?
Please describe the preventative or early intervention approach being adopted and the rationale?

The new contract has a 6 month incentive payment. The 6 month quit rates should have an impact on smoking prevalence and reduce the demand to services.

National campaigns, such as 'Stoptober', encourages individuals to go 'cold turkey'. Through the information collected from the quit kits, by the Department of Health, they have been able to evidence a number of self reported quits

The maternity service offers every pregnant woman a CO reading at booking, and asks about their smoking status. All smokers are referred to the stop smoking services as routine, unless the mother opts out. This has had a really positive impact on the number women contacted and engaging with the stop smoking service.

A PHSE module for school has been developed by, SPARKS, West Midlands (protecting children and young people from tobacco). This currently has not been rolled out in Telford and Wrekin.

The current MECC project has evidenced an increase in the number of frontline staff talking about health issues, including smoking and referring into services. Smoking needs to become something everyone feels happy to discuss and staff need the right skills to refer to the appropriate teams.

. An investment in more preventative work should be put forward for consideration when looking at the deployment of additional funding available within the PH grant in 2014/15.

8. Safeguarding

How does current provision, ensure the safety of its most vulnerable clients?

- All providers have had to show their policies for both working with children and young people, and vulnerable adults to become accredited. Providers are required to evidence that all staff have been CRB checked and that these checks are kept up to date.

- All service provision has to ensure they have a policy and procedure to record incidents and accidents and these are reported as part of the quarterly review meeting.

9. What difference/added value can the HWB make to this priority in 13/14 and how?

There are a number of areas the HWB can help and support the smoking agenda these are to:

- Support the development of a patient focus groups for general population and pregnancy

- Support making smoking everyone’s business
- Provide the governance arrangement for reporting outcomes, performance, risks and issues
- Develop an agreement for the benefits of smoking that include the wider social economical impacts, sickness absence, littering etc,,,
- Support the asset mapping process for smoking in pregnancy
- Support the commissioner to carry out the CLeaR self assessment for tobacco control
- identify a tobacco control champion in each Senior Management team of the council, offering support, training and guidance on their role.
- Ensure a close working relationship with the CCG on shared priorities such as smoking at time of delivery

HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT: MAY 2013

Priority: 6 Reduce the misuse of drugs and alcohol

Specific Focus for 2013/14:

Key Issues

- Simplify pathways
- Substance misuse is **Payment by result**; Performance management needs to be maintained.
- Support service user's recovery group
- Move away from maintenance into the recovery

Lead Officer, Organisation & HWB Member Sponsor:

Lead Officer-Christine Harrison, Service Delivery Manager Commissioning & Contracting
H&WB Sponsor- Laura Johnson

1. Integration

What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is in place? Is there any informal service provision (e.g. self help groups)

A wide range of services are commissioned in Telford & Wrekin to support a person's journey with substance misuse and that of their family carers. This includes, health, social care, Voluntary and wider community support services.

Services have been commissioned based on national evidence and best-practice, derived predominantly from the National Institute for Clinical Excellence (NICE), Drug and Alcohol strategy and Joint Strategic Needs Assessment, treatment plan supported by the DAAT (Drug and Alcohol team)

Key partners in the identification, treatment, support and good quality care of people with substance misuse include;

Drug and Alcohol recovery services (DARS) - Drug and Alcohol treatment services. Community drug and alcohol treatment e.g. supporting residential rehabilitation, community based Recovery and de-tox, prescribing of methadone, drug interventions to reduce harm.
Shropshire Community Trust - Harm reduction activity by NHS staff (doctors and nurses) including prescribing clinics and sessions, supervision and support to primary care, harm reduction strategy activities and needle and syringe programme equipment, governance regarding shared care. Includes Alcohol Liaison Nurses based at PRH.

NACRO - Prevention of drug misuses in schools, community and outreach. Contracts include for adults with substance misuse and young people for substance misuse and alcohol.

IMPACT - Psychological interventions for dependent and severely dependent drinkers within GP practices and within provider's base. Includes alcohol treatment requirement programmes for those on probation. Includes delivering a Single Point of Access. GP enhanced service providing shared care treatment and monitoring of alcohol related harm.

Supported housing Provided by Stonham Housing – to support users in their tenancy and housing.

WM Probation services - 2 workers to provide assessment intervention for the prison population.

Pharmacy dispensing methadone and needle exchange -supervised methadone. Provided by identified pharmacies paid on dispensing rates.

GP Enhanced service - providing shared care treatment and monitoring of substance misusers.

TACT - aftercare and mutual aid. The focus of the programme is on recovery as opposed to maintenance. The programme would provide one to one support from an experienced mentor who would work with individuals on a daily basis.

SMART - to support the running of promotion of an independent Service User Group with recovery oriented activities.

Formal partnership arrangements are embedded within Contracts and Service Level Agreements and monitored through standard contract monitoring processes.

DAAT is the responsible group for implementing best practice in service improvements and should be accountable to the Health and Well-being Board. This DAAT meets every two months.

Treatment group members meets every 2 months, to ensure integration across the substance misuse Pathway, whilst seeking to continuously drive quality standards and efficiencies, by working in partnership to deliver a seamless journey for people with substance misuse and their family carers.

2. Financial Sustainability

What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?

The current level of spend is sustainable, budget is aligned to contract values, and activity levels across health and social care.

Services, contracts and performance measures are now aligned, and it is commissioned to reflect the need. In the contract we capture access criteria, hours of operation, differing funding and contract cycles, make capturing finance data incredibly easier. It is estimated that health and social care in Telford & Wrekin spent in approx 2.7 million a year on substance misuse services. 1.2 million, of this comes directly from National Treatment Agency (NTA), now known as Public Health England (PHE)

Risk to services

No significant risks for drugs, however the finance from Public Health for this, is related to Payment by Result (PbR), therefore the performance targets must be met on annual basis to ensure budget.

However in relation to risk for Alcohol, the costs of providing alcohol care is largely those require medical treatments, counselling or brief intervention, recovery and housing, so the costs associated with it, are health and social care. However, poor coordination of health and social care services, leads to avoidable hospital admissions, prolonged length of stay as a hospital inpatient and detox. Therefore, there is significant financial risk, relating to demographic increase and inappropriate crisis and use of unscheduled care.

3. Equity

How has current provision been designed to meet the differing needs from across the community? Are there any known equity issues apparent? E.g. inequalities in the provision uptake or outcomes for services?

Annual JSNA leading to treatment plan takes place and equality and assess is the key part of the

treatment plan and is being actioned which includes:

- Younger adult drug users (often those whose drug use has not reached a level where it has a significantly negative effect on their health and lifestyle) where treatment is considered necessary, are significantly more likely to be treatment-naïve.
- Services need to be more effective in engaging and responding to this cohort in order to prevent more problematic behaviours.
- The successful completion rate has improved considerably and it is well above average, we still need to ensure that the number of drug users having had multiple episodes of treatment does not increase as well as unplanned exits.
- Injecting rates among drug users appears to be falling. Those drug users who are injecting are possibly adopting riskier injecting practices.
- The number using legal highs, alcohol and cannabis seem to be increasing.
- The involvement of family, i.e. children and substance misuse needs better co-ordination which includes Domestic Violence associated with Alcohol/Substance Misuse. There needs to be further training and review of the pathway in order to raise the profile within services.
- People with other mental health problems with substance (e.g. depression). The service re-design model for early intervention will address this along with alcohol related dementia.

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

As above section 3 see attachment above.

Annual JSNA leading to treatment plan takes place and equality and access is the key part of the treatment plan and is being actioned which includes:-

- The prevalence of Hepatitis C among injecting drug users continues to increase, while that of Hepatitis B is falling. Services need to be moved from the acute hospital into local satellite services.
- The use of heroin has dropped considerably since 2011 and is unlikely to be repeated in the near future but the use of methadone remains the same and the spare capacity in shared care.
- Housing outcomes of those in treatment are broadly poor, although anecdotal evidence indicates that particularly for those with complex needs it is in limited supply and prevents individuals from fully engaging in recovery.
- There can be occasions when an individual feels it is not required and feels it is more a condition of their tenancy. There needs to be better use of Integrated Offender Management housing project and 'bond scheme for service user in treatment. Improved pre-release plan within prisons to identify the needs of the offender and the family setting
- Employment outcomes of those in treatment are broadly poor. Clients do not feel they receive training or employment support and there is negligible difference in employment levels of those starting and finishing treatment.
- The number of people maintained in treatment has increased from the previous year. Although retention in treatment has improved, we still require ongoing improvements and input on data collection and performance targets.
- We also have a poor number of people being referred from the Criminal Justice system. We need

to work with police to re-introduce 'test on arrest' or at least improve testing. Representation from the criminal justice into the treatment plan also needs improving. This is timely as West Mercia Police have recruited an Integrated Offender Officer and we need to ensure that there are better links between community Substance Misuse services and the criminal justice system.

- Little support is provided for the parents and carers of drug users. This cohort can require support in their own right, in addition to the need for treatment services to improve family relations as part of promoting sustained recovery.

5. Quality

*1. **What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?***

Key performance Indicators (National and Local) are embedded in local contract agreements with individual Providers of services and monitored and reviewed on a regular basis and these are as follows:-

- **Key Performance Indicators:** Drugs and Alcohol
- **Completions (above average)** Successful completions as a proportion of all in treatment:
- **Representations (average)** Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months
- **In Treatment (above average)** Proportion of clients still in treatment for longer than one year **-** Effective Treatment (above average) Numbers in effective treatment
- **Reduced drug use, housing and employment outcomes (Treatment Outcome Profiles): (average)**
- **Waiting Times (above average)**
- **Harm Reduction (above average)**
- **Parents and Families (average)**
- **Drug Intervention Programme (nationally low)** *Please note, all on DIP need a review every 12 weeks, this in addition to Care Plan review and TOP Review*
- **Integrated Offender Management (Nationally low)**
- **Prison (Nationally low)**

2. Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NICE guidance/national guidelines etc

- Models of Care for Alcohol Misusers (MoCAM), Department of Health
- Models of Care for Drug Misusers, Department of Health
- Drug Misuse and Dependence - Guidelines on Clinical Management, Department of Health

- Drug scope QuADS
- Recovery Toolkit form NTA
- The Models of Care for Alcohol Misusers (MOCAM) 2006
- Department of Health and National Treatment Agency Guidance
- DH/NHS Clinical Governance and Supervision regimes and agreements
- DH Standards for better Health (2004)
- BACP standards and accreditation purposes
- Drug Misuse and Dependence- Guidelines on Clinical Management, Department of Health

3. Service Quality

Quality are embedded in local contract agreements with individual Providers of services and monitored and reviewed on a regular basis and these are as follows, the quality are in the following areas:-

- **Person Centred Approach with substance misuse user and using a family focus**
- **Screening and Assessment**
- **Care Planning and Case Management**
- **Effective Treatment**
- **Discharge**

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6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision?

Each provider has its own carers and uses involvement as part of the contract arrangements on a regular basis. Through the regular meeting it did highlight some good practice and positive experiences, to a disaggregated system of 'hit and miss' support and inconsistent delivery of good quality of care.

All contracted services regularly carry-out service user and patient satisfaction surveys as part of their contractual obligations. Some cases, this is undertaken under the banner of a quality standard. In 2011, the South Staffordshire and Shropshire, NHS Healthcare Foundation Trust.

Further more, ad hoc consultation events have been undertaken to influence local JSNA and commissioning plans, including but not limited to;

- Consultation events via the Mental Health Pathway Development Group
- Annual Consultation events as part of the Joint Strategic Needs Assessment
- Community Service Reviews
- Review of the users participation in S M services

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?
Please describe the preventative or early intervention approach being adopted and the rationale?

Model of care is based on a tiers system and the service is commissioned based on this model of care. (Tier 1 and 2 are the Early Intervention)

Interface and Training
An effective training and communication programme is developed. This is expected to ensure a clear understanding of the services the provider delivers; the referral pathways into specialist services; and to support the deliver of information, advice, brief interventions and effective referral as appropriate.
In line with Partnership requirements for Telford and Wrekin, the provider will offer and deliver brief intervention training and substance misuse awareness to a range of appropriate partner agencies, to improve the understanding of, access to and efficiency of the treatment system as a whole. Partners will include, but not be limited to, adult social care services, children's services, magistrates, pharmacies, primary care including GP practice staff, A&E and ambulance staff, police and fire and rescue staff, employment and training staff, and domestic violence and abuse agencies. The training will be delivered to agreed numbers of individual's people per year. A schedule and course outline will be provided to commissioners prior to the commencement of the service. Training programmes will be tailored to specific groups according to their needs. Booking and administration, including venue hire, will be the responsibility of the provider. Training will be provided free of charge to attendees working and non working within Telford and Wrekin.

Communication and Community Engagement
There is effective promotion of their service to suit the variety of potential service users, family members and carers and organisations referring to the service. Access to appropriate internet presence to effectively communicate with drug or alcohol users, family members and carers and professionals. A range of campaigns in relation to drugs and alcohol to raise awareness amongst the general public and also specific groups e.g. parents, young adults, employers etc. Also support the partners to build community confidence and engagement in work to tackle drug and alcohol misuse.

Advice and Information
The services offer an effective advice and information to substance misusers on the effects, alcohol and related problems and the minimisation of drug and alcohol related harm. This should take into account the particular risks of drug and alcohol and any other drugs used either currently or historically. There is a use of any necessary screening tools with service users and relaying back to the service user result and inferences.

Motivating users for change and enhancing treatment readiness where relevant, by paying special attention to:

- Good worker interpersonal skills (good outcomes are linked to client satisfaction with workers)
- Good worker/client relations (including client feeling that they are listened to, their concerns are understood, helpful responses, worker empathy, and good rapport with workers) work to enhance client perception of helpfulness of service work to improve client's confidence in treatment system.

Reinforcement of the harm reduction messages on a regular basis, Referral to other health and social care services where relevant. Facilitation of GP registration where relevant. Production and distribution of drug and alcohol interventions packs.

Outreach Services
Services offers approaches that proactively seek out those in need of drug and alcohol services to target under-represented and specific vulnerable groups. Use outreach to make initial contact with users unable or unwilling to access site-based services. These interventions are made available to facilitate access to community-based services and the use outreach to provide an ongoing service for users unable to access site-based services. Use outreach to re-engage users who have disengaged in services

8. Safeguarding
How does current provision, ensure the safety of its most vulnerable clients?

All providers have contract and within this, there is clear specification to train staff, support and prioritise any safeguarding issues and are obligated, under contractual agreement to follow the policies and agreements written in the Telford & Wrekin Multi-Agency Adult Protection Policy. For further information, please visit http://www.telford.gov.uk/downloads/731/protection_of_vulnerable_adults

9. What difference/added value can the HWB make to this priority in 13/14 and how?

a. Telford and Wrekin Drug and Alcohol services may need to be tendered but emphasis on local providers

b. Connect priorities across Health and Wellbeing Board work-streams for universal 'quick-wins' e.g. well being

c. To ensure simply further the pathways and reduce duplication and confusion for users and carers.

d. Alcohol needs assessment to be undertaken taking into account the new National Alcohol strategy

e. Firm handling of Performance Management to maintain budget from PHE beyond 2015

f. Support Service user's recovery group and SMART to drive the agenda of recovery

g. Review services in relation to demand, capacity and value for money

h. Move agenda from maintenance on methadone and services into recovery and abstinent.

i. Champion substance misuse as a strategic priority across organisational and professional boundaries.

j. To advocate for prioritisation of training for the health, social care and Voluntary sector workforce, in contact with people with substance misuse, to improve professional awareness of the condition and the giving of high-quality information, care and support.

k. To raise potential risks around disaggregation of joint-commissioning in-light of expectations around delivery and to identify appropriate clinical and non-clinical colleagues to work collaboratively within identified priority areas.

HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT: MAY 2013

Priority 7: Improving carers health and wellbeing(all age)
Specific Focus for 2013/14: Carers Strategy and Action Plan This priority areas is linked to other Health and well-being priorities and in particular priority areas: 3(Emotional Health and wellbeing) 4 (support people with autism) 6 (reduce the misuse of drugs and alcohol) 8 (Improve life expectancy and reduce health inequalities) 9 (,Support People to live independently) 10(Support people with Dementia). The National Careers' 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 Both the adults and younger carers local strategic objectives are reflective of this national context
Lead Officer, Organisation & HWB Member Sponsor: **Christine Harrison: Service Delivery Manager: Commissioning and Contracting** **Cllr Paul Watling: HWB Sponsor**
1. Integration *What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help group* Telford and Wrekin Council and Telford and Wrekin Commissioning Group recognise the importance of working collaboratively in the commission and delivery of services which improve our offer to carers. Through the development of the refresh of the Carers Strategy a range of stakeholders including carers were consulted with from the 20th January until the 22nd February 2013. A range of commentary was received which in principle supported the eight outcomes identified and illustrated within the strategy. These are: • Information, Advice and Support • Planning for the future • Promotion of well being • Time for yourself • Having your say • Addressing diverse needs • A life outside caring • Feeling financially safe and secure. From the consultation, stakeholders were asked to select three key outcomes for prioritisation.

The outcomes marked with an asterisk indicate the stakeholders choice and these will form the initial part of our work programme for 2013/14. The high level implementation plan provides clarification how each outcome will be approached and measured. As this is a collaborative strategy it is our intention to work with a range of stakeholders including carers to deliver this strategy over the next three years

The strategy and action plan to support its implementation is available and is being taken through formal approval process by the Council and the Clinical Commissioning Group to seek their endorsement. With regard to young carers a separate Young Carers Strategy G:\Young Carers\Strategy\Young Carers Strategy 2012-15 v1 read only.doc outlines the priorities for young carers and links are made within the Adults Carers Strategy , reference Appendix 2.

The main priorities for the Young Carers service are:

- Service promotion and identification
- Equitable access
- Access criteria
- Family case support
- Transition to Young Adult Carer
- Group support and activities
- Involve Young Carers in the development of the service

To promote greater integration with regard to carers, the aspiration is to combine both strategies by 2015. as the priorities connect across the age ranges.

In preparation to provide a seamless service , the Carers Centre which is the primary commissioned service to deliver information, advice and support to both Young Carers (up to the age of 18 yrs) and Adults have already combined services and has rebranded themselves as Carers Centre from March 2013. This arrangement has achieved efficiencies, but more importantly has sent out a strong signal to promoting a seamless approach from children to adult services in relation to carers services and support..

There are a number of partner agencies who support the strategic implementation of the strategy which includes :

- Carers Centre
- NACRO
- IMPACT
- Emergency Carers response service_ commissioned via Direct Health Care
- Telford and Wrekin Council
- Clinical Commissioning Group
- Range of voluntary sector provision eg Age UK, Red Cross, WRVS and RELAT and micro providers Wyldwoods, A Helping Hand, Tickwood.

A number of formal contractual arrangements support the implementation of the strategy and are monitored via the contractual frameworks in place.

The Carers Partnership provides the local governance framework for this agenda and sits within the context of the Health and well –being Board. However, further work is required to consider the formal links and representation of this and other existing Partnership Boards including Health and Well Being Board, Safer and Stronger Communities Partnership, and the Children and Young

People & Families Partnership Board.

2. Financial Sustainability

What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?

Pooled budget arrangements were agreed on the 6th December 2012 at Cabinet (CP71): Development of a pooled budget (Section 75 arrangement) for carer services will support the delivery of the following services:

- Respite which enhances the well being of the carer. This respite is awarded following a carers assessment.
- Carer specific services such as Moving and Handling, Family Care Adviser, Admiral Nursing Service which supports the carer in their carering role.
- Emergency Response Carers Service: which provides peace of mind when a crisis occurs in the carer's life. Replacement care is provided free of charge for up to 48 hours or 72 over a weekend or bank holiday period.

The Local Authority support the young carers service as follows:

- Individual sessions with a key worker at tier one.
- Support at Team Around the Child and case conferences.
- Respite activities. Clubs, whole family activities, 16+ activities and holiday provision.
- Volunteer/Be-friending programme,-providing young carers with opportunity to take part in an activity on an individual basis with someone to listen to them.
- Solid bank of 24 trained volunteer (300 hours of volunteers time has been offered since Oct 11).
- Transition work to enable Young Carers 16-24 years to engage and benefit from the support available in each service.
- Supporting healthy eating by providing opportunity for young carers to take part in 'come dine with us' sessions.
- Supporting young carers with increasing their skill base with workshops around first aid and sexual health information sessions.

3. Equity

How has current provision been designed to meet the differing needs from across the community?

Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?

From consultation we are aware of those carers who are hidden or do not formally identify themselves as a as undertaking this role.. Through the Carers Centre, specific work is being undertaken in raising awareness at Princes Royal Hospital, Pharmacies, and within general practices to ensure carers receive information, advice and support at the right time in their life. In addition the development of Carer Ambassadors within general practices, linked to patient user groups will help to break down barriers and profile carer awareness.

Through the Carers Centre a large piece of work is on going to ensure the young carers service identifies young carers who do not recognise they are caring or who don't want to tell anyone. They are currently working closely with all secondary schools, where monthly drop ins are offered informally during lunch times for young carers who are know to the service to call in and bring along a peer who may also be taking on a caring role.

Our primary schools have been approached and offered carer aware training within assemblies or staff team training.
Close links with colleagues in early intervention teams seeing an increase in referrals received December 12-March 13.

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

Through the Carers Centre, and other carer related commissioned services the common principle of making every contact count is being promoted.

In addition to ensuring publicity materials remain relevant, the revision of web material and use of social networking sites could lead us to cohorts of carers who would not normally access information, advice and support through the more traditional methods.

Our relationship with local media particularly Radio Shropshire has assisted to share good news stories. In addition we have a range of interest from carers to lead on and contribute to working groups linked to the Carers Partnership Board. Currently cares are contributing to work on education and employment and well being through a healthy eating initiative.

The young carers service is promoted regularly through local media through good news stories of local support by independent companies, local hotels and rotary clubs within the area. This year sees young carers being the charity of the year for Park Inn, Leek Building society and receiving a nomination to be a charity for the tree of light in December.

The first point of referral to the Carers Centre for Young Carers is through Family Connect.

5. Quality

What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?

All service level agreements provide evaluation material which allows us to measure the impact of the service on carer's lives. In addition case studies from a variety of service providers provide qualitative evidence of the impact each service brings to the individual.

With specific services such as recreational respite carers are asked to measure their well being prior to accessing services and this process continues through each contact and when the period of intervention ceases.

The quality standards, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following frameworks:

- The Adult Social Care Outcomes Framework 2013–14
- The NHS Outcomes Framework 2013–14
- Public Health Outcomes Framework for England 2013–16
- Ofsted Framework for the inspection of Local Authority arrangements to protect children,

including the effectiveness of early identification and help for children, young people, their families and carers

Quality standards support the role of HealthWatch as a consumer champion. www.healthwatchtelfordandwrekin.org.uk

The Adult Social Care Outcomes Framework (ASCOF) carer quality of life measures for Telford and Wrekin obtained form the survey are as follows:

ASCOF outcomes
1D Carer Reported Quality of Life
3B Overall satisfaction of carers with Social Services
3C The proportion of carers who report that they have been included of consulted in discussions about the person they carer for.
3D The proportion of people who use services and carers who find it easy to find information about services.

Young Carers outcomes achieved across all tiers (accumulating)

	Q1	Q2	Q3	Q4 Tier 1	Q4 Tier 2/3
Increased attendance	14	14	16	7	11
Improved family relationships	33	32	38	12	31
Maintained caring role	32	35	35	10	32
Greater emotional wellbeing	51	56	65	16	51
Engaged in education and training	16	18	23	9	15
Engaged with other agencies	30	29	35	13	28
Increased engagement in community	46	48	55	10	46
TOTAL	**222**	**232**	**267**		**291**

Increased Confidence	**Q1**	**Q2**	**Q3**	**Q4 Tier 1**	**Q4 Tier 2/3**
Through activities	71	74	78	10	73
Through 1-to-1	27	27	33	14	22
TOTAL	**98**	**101**	**111**		**119**

Increased Resilience	**Q1**	**Q2**	**Q3**	**Q4 Tier 1**	**Q4 Tier 2/3**
Bullying	20	21	24	6	22
Increased support networks	65	66	74	15	66
Coping better	42	43	48	11	49
Managing stress	14	15	18	8	14
Decreased risk of harm	4	4	5	1	6
TOTAL	**145**	**149**	**169**		**198**

Enhanced Knowledge	**Q1**	**Q2**	**Q3**	**Q4 Tier 1**	**Q4 Tier 2/3**
Housing	3	3	5	4	3
Benefits/finance	12	13	14	6	9
Illness/disability	16	14	17	10	10
Parenting	3	3	3	0	3

	Q1	Q2	Q3	Q4 Tier 1	Q4 Tier 2/3
Caring for others	16	18	19	11	14
TOTAL	**50**	**51**	**58**		**70**

Social Skills	**Q1**	**Q2**	**Q3**	**Q4 Tier 1**	**Q4 Tier 2/3**
Peers	51	53	61	8	58
TOTAL	**51**	**53**	**61**		**66**

Lifestyle Improvement	**Q1**	**Q2**	**Q3**	**Q4 Tier 1**	**Q4 Tier 2/3**
Healthy eating	15	16	17	7	13
Sexual health	6	6	6	2	4
Alcohol/substance misuse	4	5	5	2	3
Sleeping stress	15	15	18	10	12
Hygiene	6	7	7	1	6
Life skills/independence	21	22	26	13	18
Keeping self safe	17	17	18	11	14
E-safety	5	5	6	4	3
Fitness	9	11	13	1	11
TOTAL	**98**	**104**	**116**		**135**

Friendship Groups	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
Peers	63	63	72	14	65
TOTAL	**63**	**63**	**72**		**79**

Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NCIE guidance/national guidelines etc

National Guidance focuses on the carer and their wellness and ability to continue in their care giving role.

6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision?

Carers contribute in a variety of ways, from a strategic level via the Carers Partnership Board which has senior managers and Cabinet members, and meets bi monthly. This Board is chaired by a Carer and supported by the Commissioning and Contracts Team. The Board is currently considering how to seek contribution from young adult carers and young carers by revising the times when the Board meets.

In addition the chair is a member of the Health Round Table. A range of carers have actively contributed to the commissioning of services including , Emergency Response Service, Admiral Nursing and more recently Healthwatch.

The Carers Centre facilitates a Carer Forum whose agenda is shaped by a group of carers who form the Carers Forum Advisory Group. The forum which is promote through the Carers Centre newsletter and web pages is available to all carers to attend and meet four times a year.

Commentary from the forum is fed back into the Carers Partnership Board.

From a grassroots level, Support Group, Patient User Groups within general practices collate the concerns presented by the individual carer. It is this level of engagement which requires further consideration, to ensure the core messages/concerns/suggestions are fed back into the Forum and Partnership Board governance arrangements.

Carers views are also sought from the carers survey, which is a national survey run bi annually. Previous surveys were undertaken in 2009 and 2012 and cover a sample of carers who are aged 18 or over and who are helping or looking after someone aged 18 or over.
http://www.hscic.gov.uk/article/2214/User-survey-guidance-Carers-2012-13

Young Carers regular engage in consultation exercises within the context of OFSTED inspections etc and the views of the children and young people are gained informally through post it note boards at Youth Club.

The 'voice' of Tier 1 carers is captured through the key worker. The key worker will ask 'how can we make your life better in your carer role?' and 'what would work better to help other children in a caring role?' This information is monitored and acted upon.

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?
Please describe the preventative or early intervention approach being adopted and the rationale?

As iterated within Section 3 (Equity) we need to understand who we can support those carers who are marginalised, isolated with our local community. The top three priority outcomes identified during the consultation process will assist to identify routes into identifying and supporting carers. The three outcomes were:

- Information advice and support
- Planning for the future
- A life outside caring

Ina addition, other areas were also requested to be considered

- Promotion of well being
- Meeting diverse needs-

In addition the principle of working with local organisations and communities to develop carer friendly environments in parallel with the creation of dementia friendly communities will go some way to in reaching to carers who are often ignored thereby avoiding crisis planning and breakdown in relationships and well being.
Current preventative initiatives include a 'healthy eating and 'a life outside caring' working groups. Both groups are headed up by a Carer and report into the Carers Partnership Board

- *Healthy eating: (10.3 Promotion of well being)* A series of pilot cookery workshops are being delivered in conjunction with Council Catering Services, Public Health and Carer Centre. The first workshops are focussing on male carers (menu planning, bulk cooking and confidence skills), Young Adult carers(budgeting/menu planning and shopping) and women who find it difficult to cook after caring. This group will focus on skill sharing and socialisation.

- *A life outside caring: (10.7)* Carers while they are actively caring and those who role has ceased often find it difficult to access employment and education. In addition financial impact of caring

can reduce drastically life style choices. This working group is focussing on employment, education, income maximisation and Housing issues which all influence on the role carers have and the contribution they make to the local community.

The developments within our Family Connect service mean that young carers should be identified at the earliest opportunity to support the family to avoid the need for more intensive support thereafter.

The development of a bank of trained volunteers and be-frienders to work on a one to one basis with individuals supports young carers at an early opportunity and also reduces the demand on the service.

8. Safeguarding

How does current provision, ensure the safety of its most vulnerable clients?

All commissioned services are obligated, under contractual agreement to follow the policies and agreements written in the Telford & Wrekin Multi-Agency Adult Protection Policy. For further information, please visit http://www.telford.gov.uk/downloads/731/protection_of_vulnerable_adults

Where vulnerable adults are identified Carers are supported and signposted to the most appropriate service to support the identify situation. The service is aware of Family Connect and the Multi-Agency Safeguarding Hub (MASH) which is a customer service single point of contact providing information, advice, guidance, assessment and or support at the earliest opportunity.

The Young Carers services are obligated, under contractual agreement to follow the following policies and agreements: Child Protection Policy, Every Child Matters,' compliance and understanding of the relevant provisions of the Children Act 1989, Health & Safety, Valuing People, Anti-Oppressive Practice, Equal Opportunities, Complaints Procedure, Confidentiality, Disciplinary and Grievance Procedure, Dignity at Work Procedure, Recording Accidents and Emergencies, Whistle Blowing, Volunteer Policy, Lone Worker Policy.

9. What difference/added value can the HWB make to this priority in 13/14 and how?

Endorsement and recognition of the Health and Well Being Board of the value carers bring to the local health and social care economy.. Locally carers are saving the locally economy in the region of £340 million.(Ref Carers UK 2007)

The Health and well-being Board can promote and support carers priorities and ensure connection across a range of other priorities.

The needs of carers can be championed and connected across a number of partnership Boards which more strongly reflect an holistic approach to both adult and younger carers.

To inform and reflect priorities as captured by the developing Joint Strategic Needs Assessment (JSNA) for carers.

HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT: MAY 2013

Priority 8:
Improve life expectancy and reduce health inequalities

Specific Focus for 2013/14:

- The focus for this priority is the prevention, early detection and treatment of cardiovascular disease (CVD) and cancer. This focus has been chosen as the JSNA indicates cancer and CVD make the most significant contribution to reduced life expectancy and associated inequalities.
- It is well acknowledged that the lifestyle risk factors smoking, alcohol misuse and overweight and obesity influence the development and progression of both CVD and cancer. These three risk factors are HWB priorities in their own right and as such action to tackle these is not repeated as part of this priority.
- Deaths from suicide and accidental deaths also have the potential to make a significant contribution to reduced life expectancy due, despite their number being small. This is because these causes of death tend to affect younger adults disproportionately, so the younger age at death of people dying from these impacts on life expectancy figures.

Specific areas of work will include:

- Development and agreement of the Telford and Wrekin Long Term Conditions Strategy (incorporating the local response to the national call to action on reducing premature mortality and CVD strategy)
- Review of the local cancer services action plan, including age expansions for breast and bowel screening
- Awareness raising plan for prevention opportunities e.g. screening, immunisation and Health Check
- Making Every Contact Count
- Update of the JSNA profile for life expectancy and health inequalities
- Review of the Health Inequalities National Support Team (HINST) recommendations for CVD

Lead Officer, Organisation & HWB Member Sponsor:

- Board Sponsor: Richard Overton, Health and Wellbeing Board Chair
- Lead Officers: Helen Onions, Consultant in Public Health, Louise Mills, Head of Inequalities and Lifestyle

1. Integration

What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help groups)

Range of services for CVD and cancer (and other LTCs) are commissioned by HWB partners as follows:

- Local authority: Health Check programme
- NHS England: primary care e.g. identification and management of LTCs in general practice (CCG in their provider role), referral for patients with suspected cancer. In addition public health commissioning role for screening and immunisation e.g. breast and bowel cancer screening and ‘flu immunisation
- CCG: outpatient and inpatient acute care

2. Financial Sustainability

What is spent by each partner? Is the current level of spend sustainable or is the investment at

risk? Are any savings required against this budget in 2013/14?

- Local authority: Health Check, budget for 2013/14 is circa £457k
- Further work will be undertaken to understand the current levels of expenditure currently invested by the CCG and NHS England

3. Equity

How has current provision been designed to meet the differing needs from across the community?

Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?

- Health inequalities in life expectancy are clearly demonstrated in Telford and Wrekin. There are geographical areas where premature mortality rates are significantly worse than the national average, as indicated in the JSNA
- There are variations in the treatment of cardiovascular disease in primary care across general practice and these inequities need to be ironed out to reduce health inequalities
- There are variations in the uptake of cancer screening and 'flu immunisation (for all 65 year olds and also for those patients in risk groups, such as those with chronic diseases)

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

- Further work is required to understand the barriers to accessing services.
- A programme of work will be agreed with partners during April-June 2013 and implemented during July-September, the outcomes will inform service improvement plans.
- Awareness raising is considered important, particularly for the Health Check programme which is relatively new

5. Quality

What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?

A series of performance measures will be selected, these will include measures from the NHS and Public Health Outcomes Framework, including:

- Premature mortality rates
- Health Check programme performance indicators (% of eligible population offered and % take up of checks)
- Cancer waiting and treatment times targets
- Management and treatment of patients with CVD in primary care (% of patients treated appropriately for hypertension, high cholesterol and any other relevant LTC indicators)

Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NICE guidance/national guidelines etc

- Identifying and supporting people most at risk of dying prematurely (PH15)

- Prevention of cardiovascular disease (PH25)

6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision?

- Evaluation of services during 2013/14 e.g. for Health check
- Using CCG patient involvement groups
- Working with Council engagement processes, including use of the community panel

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?
Please describe the preventative or early intervention approach being adopted and the rationale?

The vision for early intervention and prevention is to design services that promote good health. Communities will become actively engaged in improving their own health and everyone, throughout their life, will be encouraged to adopt a healthier lifestyle and informed of how to avoid preventable disease. A vital part of this vision is directing services to people with long-term conditions to ensure patients are supported to stay healthy with improved quality of life.

Local service provision includes:
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. A vital part of the service is providing a central point of contact for professionals referring patients for support to adopt a healthier lifestyle.

Lifestyle risk management service provision includes services for: weight management, physical activity, smoking cessation, alcohol and emotional health and wellbeing.

All 22 General Practices are delivering the NHS Health Check Programme and have been provided with additional resources to manage the lifestyle risk factors of patients with a higher risk score.

8. Safeguarding

How does current provision, ensure the safety of its most vulnerable clients?

Within all relevant commissioned programmes (e.g. those commissioned by the CCG, NHSE and LA) the contracts include measures to ensure the safeguarding of vulnerable people, within specific contract schedules with standard requirements

9. What difference/added value can the HWB make to this priority in 13/14 and how?

- Using wider partner organisations to raise the profile of CVD and its importance to reduced life expectancy and health inequalities
- Provide strategic oversight for the priority as key HWB partners have direct commissioning responsibilities across pathways, e.g. for CVD – LA has role for Health Check which aims to identify risk and manage risk, NHSE commissioning of primary care for the treatment of those with established CVD and the CCG is responsible for commissioning outpatient and inpatient care for those requiring further treatment

- Ownership of the Health Inequalities National Support Team visit plan across the health and social care system

HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT: MAY 2013

Priority 9: Support People to live independently

Specific Focus for 2013/14:
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.
The specific focus of supporting people to live independently is predominantly older people, although it is acknowledged strategically an all age approach is adopted.
This priority areas is linked to other Health and well-being priorities and in particular priority areas:

- 7(Improve carers Health and well-being),
- 10(Support people with Dementia), an
- 3(Emotional Health and wellbeing).

The priorities within Telford and Wrekin areas follows:

- Prevention- working with the voluntary, community and independent sectors to help people helping themselves. this will involve asset mapping with partners, combined with signposting of information and advice
- Fall prevention
- Support to the independent care sector in particular residential/ nursing care homes to support timely discharge and hospital avoidance.

Lead Officer, Organisation & HWB Member Sponsor:
Christine Harrison – Lead Commissioner
Sponsor Dr Catherine Woodward

1. Integration

What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help groups)

The Rehabilitation and re-ablement strategy was endorsed by both the council and health in June 2011. The strategy articulated an overall aim of rehabilitation and re-ablement which is to actively promote the restoration and improvement of a person's physical, emotional or social state, lost or impaired through the effects of disability, disease or injury.

There is a wide range of services which are currently commissioned to support this priority area, which includes, health, social care, voluntary and independent care sectors.
Evidence tells us this is best achieved through health and social care services working together across professional and organisational boundaries with sign up to a core set of principles;

- Co-located Health and Social Care Teams
- _Multi-disciplinary working
- _ A local Telford & Wrekin Focus
- _ Aligned Management and Budgets
- _ Resources focused on rapid, intensive re-ablement
- _ Constructive relationships

- _ Common aims and pathways

Rehabilitation services cover a wide range of essential support, from short – term interventions to longer term support for older people. For example, helping adults return to work after an illness and older people
to live as independently as possible in their own homes.

Re-ablement can be described as an approach or a philosophy within home care services – one which aims to help people do things for themselves, rather than having things done for them. Home care reablement services provide personal care, help with activities of daily. living and other practical tasks for a time-limited period (normally up to a maximum of six weeks). Support is provided in such a way that
individuals are enabled to develop confidence and practical skills to carry out activities themselves.

The Council's Service Transformation Programme – Putting People First has put a greater emphasis on prevention and re-ablement. Service redesign has shifted resources to support the strategy and all people who have the potential for rehabilitation will receive rehabilitative support for a period of up to six weeks.

It should also be noted that there are strong strategic links to Long Term Conditions, Dementia, Mental Heal and Public Health prevention.

2. Financial Sustainability

What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?

Prevention, early intervention and rehabilitation and re-ablement is at the heart of future care and support. Promoting independence will deliver greater efficiencies in health and social care and provides better outcomes for people and carers. To be most effective, health and social care services must work together. This is particularly important at a time when demand is increasing and there is a reduction in funding

Pooled budget (Section 75 Agreement) is in place to support ten Intermediate Care beds. In addition a Section 256 Agreement supports a number of service areas including: therapy and care support into the integrated rehabilitation and enablement team, nine intermediate care beds, low level preventative services and assistive technology.

3. Equity

How has current provision been designed to meet the differing needs from across the community?
Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?

An Equalities Impact Assessment has been completed as part of the development of the Rehabilitation and Re-ablement strategy and no significant issues have been highlighted. The strategy has been progressed in collaboration with key stakeholders and reflects a partnership approach across the Health
and Social Care economy taking in to account evidence of best practice and the local context**.**

The principles that guide the development of rehabilitation and re-ablement can be summarised

as:

1. Putting people at the heart of planning and developing services.
2. Adopting a person centred approach to service planning.
3. Integrating services across departments and organisations.
4. Increasing choice and control.
5. Prevention - supporting people before the point of crisis.
6. Flexible and inclusive– being able to change to meet diverse and changing needs of people.
7. Treating people and their carers with respect and dignity
8. Accessible – being clear about what services are available and how these are accessed.

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

There is evidence that:
Most older people seeking assistance from adult social care do so after a crisis of some kind, which makes them and/or their carers feel that they can no longer cope. The crisis is often an illness, injury or fall or a sudden event such as the death of a partner or experience of crime. This usually represents a low point in the person's life. A period of recovery, rehabilitation and rebuilding of confidence is usually needed before
longer term care and support needs can be accurately identified. Therefore promotion of prevention and self help is critical.

Older people suffering from ill health and disability are twice as likely as those in good health to suffer from depression. This is usually related to the impact their health problems have on their capacity to undertake every day tasks and maintain their social networks. The onset of depressive symptoms and anxiety initiate a downward spiral, resulting in further reductions in activity and social interaction, leading to poorer health and a worsening mental state. Depressed older people are at high risk of increased physical disability and functional decline. Depressive mood together with poor physical function causes progressive
impairment in the physical and psychological health of older people. Mortality and morbidity are more strongly related to the experience of control over one's own life than exposure to health risks, per se
Rehabilitation should focus on preventing or delaying this downward spiral of increasing dependence, declining physical and mental health and poorer quality of life. Interventions need to address physical aspects (e.g. mobility, physical functioning, pain management etc) and mental health and the factors which promote it (e.g. social relationships and support, self esteem, self efficacy).

5. Quality

What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?

The following frameworks provide the strategic quality and performance context covering this priority area:

- The Adult Social Care Outcomes Framework 2013–14
- The NHS Outcomes Framework 2013–14
- Public Health Outcomes Framework for England 2013–16

Quality standards support the role of HealthWatch as a consumer champion. www.healthwatchtelfordandwrekin.org.uk

The performance framework for this area is within the context of the following outcomes:

- Promote and maintain independence and improve quality of life
- Prevent the unnecessary admission to hospital
- Reduce the number of people admitted to long term care
- Facilitate speedy and coordinated discharges from hospital.
- Reduce the number of re-admissions to hospital or inappropriate referrals to community services

Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NCIE guidance/national guidelines etc

6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision?

In developing the rehabilitation and enablement strategy comprehensive engagement was undertaken with key stakeholders.

Department of Health Survey annual survey- This survey forms part of the ASCOF framework and consider the quality aspects of services.

Some services are required to be Registered with the Care Quality Commission (CQC). Service user perspectives are sought as part of the inspection programme.
Services under contract regularly carry-out service user and patient satisfaction surveys as part of their contractual obligations .

Healthwatch the new consumer champion will be responsible for capturing the service user voice in registered CQC services, as well as wider signposting, information and advice.

Carers views are also sought from the carers survey, which is a national survey run bi yearly. Previous surveys were undertaken in 2009 and 2012 and cover a sample of carers who are aged 18 or over and who are helping or looking after someone aged 18 or over.
http://www.hscic.gov.uk/article/2214/User-survey-guidance-Carers-2012-13

Both the CCG and the Council supports a number of representative groups such as the Senior Citizens Forum, Age UK , Listen not Label and advocacy support.

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?

Please describe the preventative or early intervention approach being adopted and the rationale?

Prevention- working with the voluntary, community and independent sectors to help people helping themselves. this will involve asset mapping with partners, combined with signposting of information and advice
Directory of services examples include: Directory of adult Social Care, Alzheimer's dementia directory, Carers Directory, Council My- Life Portal,
The CCG and the council is working with the voluntary sector to develop a collaborative approach to the delivery of information and advice and the delivery of low level preventative services .

Fall prevention
Demographic pressures of people 65years + will increase pressures on services. Falls related injuries are the leading cause of death due to accident in older people and have a significant impact on physical and mental health, independence and life expectancy. Targeted interventions can identify and reduce risk factors. (Reference Falls and Bone Health Business Plan May 2013)
Good information and advice about reducing the risk of falling, multi agency approach to assessing risks and promotion of exercise for all focusing on older people

Support to the independent care sector in particular residential/ nursing care homes to support timely discharge and hospital avoidance.
Further develops initiatives of support to the sector to reduce hospital admissions and support timely discharge, such as use of assistive technologies, proactive nurse care support and flexible rehabilitation and enablement support.

8. Safeguarding
How does current provision, ensure the safety of its most vulnerable clients?

All commissioned services are obligated, under contractual agreement to follow the policies and agreements written in the Telford & Wrekin Multi-Agency Adult Protection Policy. For further information, please visit http://www.telford.gov.uk/downloads/731/protection_of_vulnerable_adults

Contracted services are proactively monitored and intelligence is gathered from a variety of sources to inform safeguarding for example, reviews, site visits, CQC, Healthwatch, family/carers etc.

9. What difference/added value can the HWB make to this priority in 13/14 and how?

Promote the co-ordination and integration of health, social care and public health to support older people's prevention and enablement initiatives.

To inform and reflect priorities as captured by the developing Joint Strategic Needs Assessment (JSNA)

To more strongly connect to the Public Health, Council and Health prevention agendas.

To ensure the priorities identified are resourced and supported

HEALTH & WELLBEING STRATEGY PRIORITY POSITION STATEMENT: MAY 2013

Priority 10: Support people with Dementia

Specific Focus for 2013/14:

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

Lead Officer: **Kim Grosvenor, Specialist Commissioner, Telford & Wrekin Council**
Sponsor: **Dr Mike Innes, Chair, Telford & Wrekin Clinical Commissioning Group**

1. Integration

What services are currently commissioned and on what basis? Who are the key partners? What partnership arrangements/governance is place? Is there any informal service provision (e.g. self help groups)

A wide range of services are commissioned in Telford & Wrekin to support a person's journey with dementia and that of their family carers. This includes, health, social care, Voluntary and wider community support services. Please click on the following link to view the Telford & Wrekin Dementia Pathway http://www.telford.nhs.uk/Telford-and-Wrekin-CCG/Services/Dementia1/

Services have been commissioned based on national evidence and best-practice, derived predominantly from the National Institute for Clinical Excellence (NICE), the National Dementia Strategy, https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy a local Joint Strategic Needs Assessment, the Prime Minister's Challenge on Dementia https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia and local patient and service user experience, although, other resources have been used, as appropriate. Plans for service development and improvement have been driven and implemented by a Joint Telford & Wrekin Dementia Strategy (2009 – 2013) and a Multi-Agency Carers' Strategy. Please follow this link to view the respective strategies and action plans: http://www.telford.nhs.uk/Telford-and-Wrekin-CCG/Services/Dementia1/

Key partners in the identification, treatment, support and good quality care of people with dementia include;

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust South Staffordshire and Shropshire Healthcare Foundation Trust.
- Alzheimer's Society Alzheimer's Society
- British Red Cross Red Cross
- Age UK Age UK
- Carers' Centre Carers Centre
- Shropshire Community Health NHS Trust www.shropscommunityhealth.nhs.uk
- Telford & Wrekin Council Telford and Wrekin Council MyLife
- Shropshire and Telford Hospitals Trust Shropshire and Telford Hospitals Trust
- Shropshire Partners in Care www.spic.co.uk

Formal partnership arrangements are embedded within Contracts and Service Level Agreements and monitored through standard contract monitoring processes.

A pan-Shropshire, Telford & Wrekin, multi-agency group, (Health Economy Steering Group for Dementia) is the responsible group for implementing best practice in service improvements and is accountable to the Health and Well-being Board. This group meets bi-monthly. To view the Terms of Reference for this meeting, please visit: http://www.telford.nhs.uk/Telford-and-Wrekin-CCG/Services/Dementia1/. In addition, a Telford & Wrekin Dementia Provider Forum, meets twice-yearly, to ensure integration across the Dementia Pathway, whilst seeking to continuously drive quality standards and efficiencies, by working in partnership to deliver a seamless journey for people with dementia and their family carers.
There is a developing infrastructure of informal care and support being developed in Telford & Wrekin through our commitment to Dementia Friendly Communities. The Dementia Advisor Service, Dementia Adviser Service provides information about community-based support services and the newly published Telford & Wrekin Dementia Service Directory also contains information and signposting to self-help and other low-level support services, which includes information about the following:

- Telford Carers' support group
- Newport support group
- T42 (Wellington) support and activity group
- Singing for the brain group.

Please follow this link to view the on-line Dementia Services Directory Telford and Wrekin Council MyLife.

2. Financial Sustainability
What is spent by each partner? Is the current level of spend sustainable or is the investment at risk? Are any savings required against this budget in 2013/14?

Except in the case of specifically defined dementia services, aligned to contract values, there is still ambiguity about resource deployment and activity levels, across health and social care. This is because it is difficult to quantify with any certainty the resources allocated specifically to dementia by the Clinical Commissioning Group and Telford & Wrekin Council, by service type, by age, and sometimes by geography. For example, many services do not routinely collect diagnoses for coding purposes, therefore it is not possible to separate 'older peoples' services from, say, dementia services. Where diagnoses are recorded it is not uncommon for the primary diagnosis for admission to be recorded, (e.g. the broken leg/hip), but not the secondary one which may be the reason for the delayed discharge, (e.g. dementia). Similarly, services, contracts and performance measures are not always aligned and so it is often not possible to compare like with like. Services overlap geographic boundaries differently, some include Staffordshire or Shropshire with Telford and Wrekin and others are Telford-specific. This coupled with variable access criteria, hours of operation, differing funding and contract cycles, make capturing finance data incredibly complex and challenging. However, from existing available data in the Joint Strategic Needs Assessment of Dementia (2009), it was estimated that health and social care in Telford & Wrekin spent in excess of £10.5 million a year on dementia services. For more detailed information, please see: http://www.telford.nhs.uk/Telford-and-Wrekin-CCG/Services/Dementia1/

Risks

The annual cost of care for each person with dementia is higher than the median salary in the UK, and is higher than the annual cost of care for a person with cancer and cardiovascular disease (stroke and heart disease) combined. The costs of providing dementia care are largely those required to provide support and care for activities of daily life, rather than medical treatments, so the costs associated with it, are predominantly social care. However, poor coordination of health and social care services, leads to avoidable hospital admissions, prolonged length of stay as a hospital inpatient and increased need for residential care. Therefore, there is significant financial risk, relating to demographic increase and inappropriate crisis and use of unscheduled care.

This pressure, coupled with inadequate investment aligned with raising prevalence, will widen the gap of unmet need.

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

3. Equity

How has current provision been designed to meet the differing needs from across the community?
Are there any known equity issues apparent? e.g. inequalities in the provision uptake or outcomes for services?

The Dementia Joint Strategic Needs Assessment, (2009) considered the needs of a range of people with dementia, which included:

- Younger people with dementia - Numbers are relatively small in Telford & Wrekin rising from 44 estimated cases in 2009, to 51 cases in 2019. Small-scale services currently exist.
- People with learning disabilities - People with Down’s syndrome are at high risk of developing dementia at a younger age; however, the Deep Dive analysis suggests that numbers in Telford & Wrekin will remain small, rising from 6 in 2009, to 7 in 2019. Commissioners continue to investigate good practice in models of care and local alternatives.

- People with alcohol-related dementia - Work is planned by Commissioners to define the level of need in Telford & Wrekin.

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

- People on low incomes and in poverty - The Older Adults’ Strategy, (which includes Dementia) prioritises assisting people to access benefits and entitlements and Commissioners currently purchase specialist support from Age UK, Shropshire Telford & Wrekin.
  http://www.telford.gov.uk/downloads/file/2686/older_adults_strategy_refreshed_2010-2014

- Minority ethnic groups – Age UK, Shropshire Telford and Wrekin is commissioned to provide a BME Neighbourhood Contact Officer, who has received Dementia training. Wider connectivity occurs throughout health promotion and social care, to ensure engagement and access to services.

- People living in isolated rural areas – Age UK, Shropshire Telford and Wrekin provides a Dementia Neighbourhood Contact Officer, to identify people at risk of social isolation and support them in accessing mainstream and other services.

- Disabled people - Commissioners continue to lead on the transformation of rehabilitation and reablement services, which will provide access and support for people with dementia.

4. Accessibility

What are the barriers to accessing services currently provided? Are the reasons for 'non-use' understood?

It is well understood both from national benchmarking and local understanding that dementia is under-diagnosed in Telford & Wrekin. Lack of diagnosis is a large barrier to access to dementia services.

The stigma associated with dementia can lead to reluctance to address the possibility of an individual having dementia and to professional groups giving lower priority to the development of the skills needed to identify and care for people with dementia. Sometimes, wrongly, people attribute the symptoms of dementia to an inevitable part of the ageing process. There is a view shared by some professionals and members of the public that little can be done to assist people with dementia, *(Alzheimer's Society (2008) Worried about your memory?).* This leads to failure to recognise and refer people early in the illness, creating problems later, as individuals present for the first time when in a crisis.

The work-stream around public awareness of memory problems will support the early identification and diagnosis priority because it is well evidenced that as a result of improved awareness, people will report symptoms earlier to their GP, which is the gateway to a formal diagnosis.

5. Quality

What are the key performance measures for this priority? How is the service currently performing? Do we understand why the service is performing at the current level?

Key performance Indicators (National and Local) are embedded in local contract agreements with individual Providers of services and monitored and reviewed on a regular basis.

Suggested key performance milestones for this priority work-streams include;

1) **Public Awareness of Memory Problems**

This is linked to the early identification and diagnosis performance milestones. (See below)

A base-line understanding of stigma and barriers to accessing diagnosis will be investigated by Race and Fairness Telford, (RAFT) in a distinct project, which will feed into this priority work-stream.

In addition, public awareness is best improved by a targeted and clear campaign. As part of this work-stream, we will identify five or less features that typify early dementia and advertise these intensely, whilst measuring the before and after effect.

2) **Information**

Promoting choice

Quality statement in the 2010 quality standard on dementia

5 Decision making

3 Written and verbal information

Quality statement in the 2013 quality standard on supporting people to live well with dementia

2 Choice and control in decisions

4 Leisure activities of interest and choice

9 Independent advocacy

3) **Early Identification and Diagnosis**

Current performance:

In 2012, the number of people on the General Practice Quality Outcomes Framework Dementia Register with a diagnosis of dementia was 693. In line with predicted local prevalence, the estimated number of people with dementia (diagnosed and undiagnosed) in 2012 was 1784. The percentage of people with a diagnosis of dementia in 2012 was therefore, 39.3%. It is therefore estimated that 1,071 people were without a diagnosis in 2012. This position puts Telford & Wrekin, 149th worst performing CCGs out of a total of 178.

However, it is also one of the PCTs/CCGs showing the most improvement, demonstrating a 3.7% increase in diagnosis rates for 2010-11[2].

Milestone Target:

To increase diagnosis rates by 7% year-on year for the next 5 years.

4) **End of Life**

Quality statement in the 2013 quality standard on supporting people to live well with dementia

1 Discussing concerns about possible dementia

Palliative and end-of-life care

Quality statement in the 2010 quality standard on dementia

5 Decision making

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

9 Palliative care needs

A local performance indicator could be developed linked to family experience of the death of their loved-one with dementia as part of this priority work-stream.

As part of this priority work-stream, health and social care will work in partnership to define and agree appropriate quality metrics to evidence the impact of these agreed actions.

Is current service provision based on best practice or other evidence of effectiveness? Please list the relevant NCIE guidance/national guidelines etc

Current service provision has been developed in-line with clinical evidence and best practice, including but not limited to:

NICE http://pathways.nice.org.uk/pathways/dementia,
NICE Guidance CG42 (Dementia: Supporting people with dementia and their carers in health and social care) http://publications.nice.org.uk/dementia-cg42
NICE Dementia Quality Standard (QS1) http://publications.nice.org.uk/dementia-quality-standard-qs1 This covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings.
NICE Dementia Quality Standard (QS 30) http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia-qs30 This quality standard covers supporting people to live well with dementia. It applies to all social care settings and services working with and caring for people with dementia.

These quality standards, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following frameworks:

- The Adult Social Care Outcomes Framework 2013–14
- The NHS Outcomes Framework 2013–14
- Public Health Outcomes Framework for England 2013–16

Quality standards support the role of HealthWatch as a consumer champion.
www.healthwatchtelfordandwrekin.org.uk

For a comprehensive up-date of progress against implementation of the Commissioning Framework for Dementia please visit http://www.telford.nhs.uk/Telford-and-Wrekin-CCG/Services/Dementia1/

As part of this priority work-stream the Commissioning Framework will be up-dated by March 2014, which will include a list of achievements against the priority areas.

6. Engagement & Positive Experience

What are service users' views on current provision? How have service users' views been used to inform current provision?

In 2009, the Telford & Wrekin Senior Citizens' Forum, in partnership with the Alzheimer's Society interviewed 87 carers of people with dementia culminating in the report; Now You See Me, Now --- ---'-. Though the report did highlight some good practice and positive experiences, it largely eluded to a disaggregated system of 'hit and miss' support and inconsistent delivery of good

quality of care.

Services under contract regularly carry-out service user and patient satisfaction surveys as part of their contractual obligations. In some cases, this is undertaken under the banner of a quality standard. In 2011, the South Staffordshire and Shropshire, NHS Healthcare Foundation Trust received an ‘excellent’ rating for the Shropshire, Telford & Wrekin Memory Service, with Accreditation by the Royal College of Psychiatrists for example.

More recently, patient and service user representation is captured in the Health Economy Steering Group for Dementia and Admiral Nurse Steering Group, which influences service re-design, development and drives service improvements. For example, patient and carer input has been pivotal to the design and implementation of the General Hospital Dementia Pathway, which strives to improve quality of care by a ‘care-bundle’ approach and minimising ward transfers. Further more, ad hoc consultation events have been undertaken to influence local commissioning plans, including but not limited to;

- Consultation events via the Mental Health Pathway Development Group
- Consultation events as part of the Dementia Deep Dive/Joint Strategic Needs Assessment
- Millbrook Day Centre Service Review & Questionnaire
- Community Service Reviews
- Review of the Older Adults’ Strategy through the Older Peoples’ Partnership Board
- Consultation on the Falls and Bone Health Strategy (including carers of people with dementia) through the Falls Prevention Network
- Consultation on the Rehabilitation and Re-ablement Strategy (including carers of people with dementia).

7. Early Intervention and Prevention

What provision is in place to reduce future demand for this service/intervention?
Please describe the preventative or early intervention approach being adopted and the rationale?

Up to 50 % of cases of dementia may have a vascular component, giving an option of prevention by promoting better cerebro-vascular health. Current health promotion for diet, lifestyle and health checks are therefore likely to have a positive impact, though the full extent of this impact is not yet known. *The National Dementia Strategy* suggests that even the possibility that these activities may help the overall impact of the campaigns, makes them worth pursuing.

Furthermore, there is an evolving evidence base around activities which slow the progression of cognitive decline and therefore, there is an opportunity to link this aspect of prevention across other Health and Wellbeing Board Priority work-streams, as well as to work more closely with Public Health in the exploration and commissioning of specific initiatives which support these outcomes.

Given the ageing demographic in Telford & Wrekin, dementia prevalence will increase significantly over the next 20 years and therefore, there will be an increase in demand on services. However, failure to diagnose early can lead to individuals in crisis presenting late and therefore needing to access services that are more intensive and costly than would otherwise have been required and which reduce their quality of life unnecessarily. Therefore, identifying, diagnosing and treating people, where appropriate will ensure both clinical and cost effectiveness. *Banerjee and Wittenberg, Clinical and cost effectiveness of services for early diagnosis and intervention in dementia, International Journal of Geriatric Psychiatry (2009).*

Telford & Wrekin Clinical Commissioning Group (CCG) is currently implementing a Primary Care Pathway, with the intention of achieving early detection of people with memory problems. Furthermore, the CCG commissions a Primary Care Liaison Nurse to support early identification of memory problems, whilst regularly reviewing and supporting people with Mild Cognitive Impairment. A range of service providers, such as the Alzheimer's Society Dementia Advisor and Age UK Dementia Contact Officer is also commissioned to raise awareness of dementia in the community and signpost to appropriate services, including the GP for an initial assessment.

Other target-driven incentives relating to early identification of dementia include the National Commissioning for Quality and Innovation (CQUIN) plan for hospitals to identify people with dementia, visit Shropshire and Telford Hospitals Trust to find out more. Furthermore, training has recently been delivered by the South Staffordshire and Shropshire Healthcare Foundation Trust in support of the NHS Health Check programme which will mean that from April 2013, people aged 65 to 74 will be given information on dementia and Memory Services. The intention is to raise awareness of dementia and highlight the relationship between the risk factors for CVD and dementia. For more information visit: http://www.nhshealthcheck.nhs.uk/

8. Safeguarding

How does current provision, ensure the safety of its most vulnerable clients?

All commissioned services are obligated, under contractual agreement to follow the policies and agreements written in the Telford & Wrekin Multi-Agency Adult Protection Policy. For further information, please visit http://www.telford.gov.uk/downloads/731/protection_of_vulnerable_adults

9. What difference/added value can the HWB make to this priority in 13/14 and how?

- Connect priorities across Health and Wellbeing Board work-streams for universal 'quick-wins' e.g. CVD and Dementia.
- Champion Dementia as a strategic priority across organisational and professional boundaries.
- To advocate for prioritisation of resources inline with expected prevalence rates.
- To advocate for prioritisation of training for the health, social care and Voluntary sector workforce, in contact with people with dementia, to improve professional awareness of the condition and the giving of high-quality information, care and support.
- To raise potential risks around disaggregation of joint-commissioning in-light of expectations around delivery and to identify appropriate clinical and non-clinical colleagues to work collaboratively within identified priority areas.
- To support the timely refreshment of the Joint Strategic Needs Assessment for people with Dementia.
- To consider developing a refreshed, multi-agency Dementia Strategy.