HEALTH AND WELLBEING BOARD

Minutes of a meeting of the Health and Wellbeing Board held on Wednesday 12th March 2014 at 2.00pm at the Business Development Centre, Stafford Park 4, Telford TF3 3BA.

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

Also Present: H Onions, (Consultant in Public Health), L Mills (Head of Health Inequalities and Lifestyle), V Mckay (Interim Service Delivery Manager, Children & Family Services), K Roberts (Interim Service Delivery Manager, Commissioning) L Stepanian (DAAT Co-ordinator) and R Eryers (TACT Co-ordinator).

Officers: M Cumberbatch (Legal Services) J Power (Delivery and Planning Manager) and J Clarke (Democratic Services Officer).

HWB-50 MINUTES

RESOLVED – that the Minutes of the meetings of the Health and Wellbeing Board held on 22nd January 2014 and 12th February 2014 be confirmed and signed by the Chair.

HWB-51 APOLOGIES FOR ABSENCE

Cllr A England (Telford and Wrekin Council) and Cllr P Watling (Telford and Wrekin Council)

HWB-52 DECLARATIONS OF INTEREST

D Saunders declared an interest on Agenda Item 9 – Commissioning intentions as he was a member of the Management Committee on the Senior Citizen Forum.

P Taylor declared an interest on Agenda Item 5 – Reduce the Misuse of Alcohol and Drugs as a Director for Provider Services.

HWB-53 PUBLIC SPEAKING

No members of the public had registered to speak.

HWB-54 FOCUS ON HWB PRIORITIES

Reduce the Misuse of Alcohol and Drugs – Telford and Wrekin Drug and Alcohol Strategy 2014/15-2016/17

H Onions (Consultant in Public Health) gave a report on the Telford and Wrekin Drug and Alcohol Strategy 2014/15 – 2016/17 which gave an overview of the health impacts caused by alcohol and drug misuse within communities.

The strategy contributed to the Co-operative Council's priorities to improve health and wellbeing, reduce inequalities, reduce the number of people who misuse drugs and alcohol and to develop an early help offer.

A series of aims and objectives were proposed across the strategy framework to reduce demand and risk, restrict supply, build recovery and reduce harm.

There were considerable cost savings linked to treatment and prevention and early intervention with children and young people. For every £1 spent on this work £5-£8 could be saved later by reduced crime, loss of income, productivity all of which impacted on the NHS burden and health and wellbeing.

The Consultant in Public Health gave a presentation on the strategy.

The key headlines were:

- High rates of early death from "preventable" liver disease
- An estimated 1,020 opiate and crack cocaine users with approximately 50% of these accessing treatment during 2012/13
- Drug treatment completion rates – 8% opiate users / 38% non-opiate users
- Alcohol consumption estimates 24,265 (18.7%) of adults were binge drinkers, 33,997 (26%) of adults were higher risk drinkers and 4,151 were dependent drinkers
- Approximately 440 hospital admissions per year were directly linked to alcohol
- With 3,370 admissions to hospital potentially relating to alcohol

Public Health England set out what needed to be done:

<u>Alcohol</u>

- Raise awareness
- Work with Schools and Education
- Behaviour change
- Intervention programmes
- Hospital liaison
- Treatment and care planning

<u>Drugs</u>

- Avoidable deaths from overdose
- Closer working with NHS, GPs and Pharmacies
- Harm reduction and risk reduction with prescribed / non-prescribed medicines
- Specialist treatment
- Holistic model with wider support for work and housing

A strategy framework had been produced which was based on 3 key areas:

- Reducing demand
- Building recovery and reducing harm
- Restricting supply

The aims of the strategy were to transform treatment and recovery services; expand the provision of mutual aid and service user-led programmes within the treatment system; develop a comprehensive programme for brief interventions which would raise awareness to reduce the risk of harm from drug and alcohol misuse.

A discussion took place including:

- Preventative work with the community ie Mutual Aid
- NHS Health checks and alcohol screening
- Schools and Colleges prevention programme
- Promotion of healthy lifestyles
- Hospital liaison services
- Alcohol and drugs budgetary arrangements
- Alcohol related cancers
- Data collection
- Working with partners, ie Criminal Justice System, DAAT Board and Licensing as well as using local intelligence
- Difficulties accessing support after 4pm on Fridays
- Engagement

The strategy was welcomed by the Board which was clear, simple and straight forward and had a clear pathway from prevention to treatment.

L Johnston, as the Board's sponsor for reducing the misuse of alcohol and drugs, commended all of the people involved in bringing together the Strategy which had taken a lot of hard work. The Board's sponsor had recently visited TACT and praised the exceptional level of awareness and the work which was undertaken with service users.

RESOLVED – that the Health & Wellbeing Board endorse and approve the Telford and Wrekin Drug and Alcohol Strategy 2014/15 – 2016/17 and note the governance which was in place to manage the implementation and to monitor the impact on outcomes and performance.

HWB-55 HEALTH AND WELLBEING SUPPORT/DELIVERY ARRANGEMENTS UPDATE

C Jones (Assistant Director: Family, Cohesion & Commissioning) and L Noakes (Assistant Director: Health, Wellbeing and Public Protection) gave a joint report on the Health and Wellbeing Support and Delivery Arrangements.

The report outlined the proposed changes with regard to the support of the Health and Wellbeing Board, which included the creation of a Strategic Commissioning Group.

The purpose of the Group would be to drive partnership working through the integration between NHS England, the Clinical Commissioning Group and Telford & Wrekin Council.

Appendix 1 to the report set out the Terms of Reference and the purpose of the Strategic Commissioning Group, together with the Membership.

The Strategic Commissioning Group would report back to the Health and Wellbeing Board on a quarterly basis.

A discussion took place including:

- Better Care Fund (BCF) Commissioning Support
- Co-Chairing of Strategic Commissioning Group
- Public/Patient representatives
- Development Sessions

It was suggested that as the Health and Wellbeing Board met on a bi-monthly basis, that a quarterly report would not fit the timetable. It was further suggested that a report be brought back to the Board every 4 months.

RESOLVED – that:

a) **the changes in support/delivery arrangements of the Health and Wellbeing Board outlined in this report be agreed;**

b) **the proposal for a report from the Strategic Commissioning Group to the Health and Wellbeing Board every 4 months be approved.**

HWB-56 FOCUS ON HWB PRIORITIES

Life Expectancy – Focus on Cancer

H Onions (Consultant in Public Health) and L Stepanian gave a joint report on the Heath and Wellbeing Priority - Life Expectancy, with the focus being on cancer.

The report gave an overview of the local picture regarding cancer with a focus being on bowel cancer. It also presented an update on the work the CCG had been leading on with Shrewsbury and Telford Hospitals NHS Trust which aimed to improve the services provided for cancer patients throughout their care and treatment including reducing waiting and treatment times and the quality of the patient experience. Expansions and improvements following further development of the bowel screening programme were due to take place.

On average 222 people died before the age of 75 from cancers each year (115 male and 107 female). Approximately 56% of the early cancer deaths (124 per year) were considered preventable. This included oral cancers, lung cancers, colorectal cancers, skin cancers, breast cancers and cervical cancer.

Within those cancer deaths considered to be preventable 33% (40 per year) were due to lung cancer, 20% (25 per year) bowel cancer and 13% (17 per year) breast cancer.

Approximately 28% of early cancer deaths could be classified as amenable to healthcare, so could have been potentially avoidable through good quality healthcare. The top three in Telford & Wrekin were: Bowel cancers, 40% of amenable early cancer deaths; Breast cancers, 28% of amendable early cancer deaths and Bladder cancer, 9% amenable early cancer deaths (circa 6 per year).

The rates of early death from all cancers during 2010-2012 were significantly higher than the England average for both persons and females. The rate for men was similar to the national average.

There was a significant contribution to the gap in the figures regarding treatment and it was hoped that the work being undertaken on alcohol and smoking would contribute to an improvement on the gap.

During the period 2010-12 the early death rate for bowel cancer was significantly worse than the England average (circa 25 deaths per year before age 75). Bowel cancer screening currently had a 56% take up across Telford & Wrekin ranging from 45% to 67% across the general practices. Joint work had been planned by NHS England, the CCG and the Council to try to improve the take up rates.

The national bowel screening programme was being expanded to include bowel scope screening for both men and women from the age of 55 years. This was in addition to the NHS Bowel Cancer Screening Programme.

A discussion took place including:

- The new screening programme and incentive schemes to improve figures
- Underlying trends of non-take up of screening
- National Development Programme between CCG and NHS England Area Team
- Prostrate Cancer
- Awareness raising
- Patient experience

RESOLVED – that:

a) **the Board note the continued contribution early cancer deaths made to reduced life expectancy in Telford and Wrekin;**

b) **the Board recognised the importance of the bowel cancer screening programme developments in early detection and treatment;**

c) **the Board acknowledged the progress being made to improve cancer treatment and the experience of cancer care at Shrewsbury & Telford NHS Hospital Trust.**

HWB-57 CALL TO ACTION

David Evans and Mike Innes gave a brief overview on the Call to Action and the results from the engagement.

The Call to Action was a joint project between Shropshire and Telford & Wrekin Clinical Commissioning Groups.

Engagement had taken place in September, October and November 2013. Approximately 3,000 responses had been received with 250-300 of these being from Clinicians.

A conference took place at the end of November 2013 which launched the results and the initial analysis and looked at the responses. Both Local Authorities in Shropshire attended at the conference together with providers and members of the public. The event was well attended.

The key themes to come out of the engagement were that changes must be made. The preference was not to go to hospital, but be looked after closer to home or within the home. Access to services was important.

A newsletter had been produced, a copy of which was tabled at the meeting. A copy of the newsletter could also be accessed at Appendix 5 to the report.

A discussion took place including:

- Outcome of the Call to Action Conference
- Launch of the review of acute services
- Whole system approach
- Access to Primary Care ie GP Services, Dentists, Opticians
- Hospital re-structuring exercise

- Future Fit Programme
- Call to Action Feedback

RESOLVED – that the Board note the content of the report and the newsletter summarising the discussions and feedback received from the Call to Action consultation.

HWB-58 COMMISSIONING INTENTIONS

Local Authority Commissioning Intentions

V McKay, L Mills and K Roberts presented a joint report on the Local Authority Commissioning Intentions for Public Health.

This would be a universal whole population approach which included vulnerable children, young people and adults and would contribute to the early intervention and prevention priorities of the Clinical Commissioning Group.

The Local Authority would collaborate with the Clinical Commissioning Group as well as Shropshire and Staffordshire Area Team through the newly appointed Strategic Commissioning Group in order to deliver improvements in health and wellbeing outcomes.

A discussion took place including:

- Alcohol Services
- Contracts
- The reduction of the provision of in-patient beds / hospital detox beds
- Multi-systemic Therapy
- Social Impact Bonds
- Therapeutic input for children with special health needs
- Pooling of funds
- Transport Review
- Incorporation of re-ablement and rehabilitation into the Better Care Fund
- Carers Contact Centre / Carers Partnership Board
- Supporting people to live independently
- Dementia Services
- Care Bill

RESOLVED – that the Board note and endorse the high level of commissioning principles of the Local Authority and the detailed proposals outlined in Appendices 2, 3 and 4 to the report.

Telford & Wrekin Clinical Commissioning Group Commissioning (CCG) Intentions for 2014/15

David Evans presented an overview on Telford & Wrekin Clinical Commissioning Group's Commissioning Intentions for 2014/15.

The longer term implications for the CCG was to shift resources currently committed to acute care into integrated health and social care in the community, which represented a strategic ambition that was linked to the Better Care Fund Plan proposals.

The impact of the commissioning intentions was to improve:

- Quality and safety of care
- Self-care, complementing the Council's personalisation strategy
- Access to appropriate services for the whole population, especially the most vulnerable
- Integrated care close to home
- Value for money
- Performance of NHS Services in order for the NHS to deliver constitutional rights
- Configuration of services

The CCG's model for enhanced integrated care for health and social care could be found at Page 4 of the report.

It was the CCG's aim to move care closer to home and, where appropriate, self-care and self-management of conditions would be introduced

The CCG currently spent 54% of its budget on acute services which was above the national average. This was approximately £6-8m of funding which was not being spent in the right areas. A contract for £3m had been identified as one that could be used to support the Better Care Fund during 2014/15.

A discussion took place including:

- Special Educational Needs and Disability Reforms
- Preventative work through health and social care and within the education and youth services
- Children in Care
- Synergys – ie lifestyle pathways and termination services now linked to sexual health and CAMHS and early health links
- Mental Health Service Review
- IAP Programme

RESOLVED – that

a) **the Board note the information contain in the report; and**

b) **the areas for improved synergy between council/public health and CCG commissioning intentions were identified as: lifestyle pathways; termination services; Children and Adolescent Mental Health Service (CAMHS); Special Educational Need and Disability (SEND) Reforms; Children in Care and Adult Mental Health Services.**

HWB-59 FOR INFORMATION ITEMS

Telford and Wrekin Safeguarding Children Board Annual Report 2012/13

This report was an information only report and a link to the Report could be found at Item 10 – Appendix G1 to the Agenda.

Telford and Wrekin and Shropshire Adult Safeguarding Board Annual Report 2012/13

This report was an information only report and a link to the Report could be found at Item 10 – Appendix G2 to the Agenda.

The meeting ended at 3.47pm

Chairman:

Date:

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD – 14th May 2014

REVIEW OFTHE HEALTH AND WELLBEING BOARD

REPORT OF LIZ NOAKES, ASSISTANT DIRECTOR: HEALTH, WELLBEING AND PUBLIC PROTECTION, MATTHEW CUMBERBATCH, LEGAL SERVICES MANAGER AND JON POWER, DELIVERY& PLANNING MANAGER

LEAD CABINET MEMBER – CLLR R. OVERTON

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1. This report outlines a proposed series of changes to the role of the Health and Wellbeing Board and its relationship with other strategic partnership boards: the Children, Young People and Families Board, the Community Safety Partnership and the Better Care Fund Project Management Group. In line with these proposed changes to the role of the Health and Wellbeing Board, this report reviews the terms of reference for the Board, which includes a review of the members of the Board and the frequency of meetings.

1.2. Please refer to Appendix 1 for the draft revised terms of reference for the Health and Wellbeing Board.

2. RECOMMENDATIONS

That the Board review the following and make recommendations for amendment of the constitution to full Council as appropriate:

2.1 The role Strategic Commissioning Group is developed to integrate the commissioning actions of all the proposed Commissioning and Transformation Partnerships.

2.2 That Commissioning and Transformation Partnerships are established to bring greater consistency and connectivity to partnership working.

2.3 That consideration is given to the creation of a Living Well Board.

2.4 A report is brought back to the Health and Wellbeing Board in January 2015 by the Strategic Commissioning Group on the Telford £.

2.5 Subject to approval of the changes to the membership by the Council, the Chair of the Community Safety Partnership is invited to become a member of the Health and Wellbeing Board.

2.6 That the number of scheduled Health and Wellbeing Board meetings is set at four per municipal year.

2.7 To amend the terms of reference as proposed in Appendix 1 to allow meetings to be quorate in the event that the NHS England and Healthwatch representative are unable to attend.

3. IMPACT OF ACTION

3.1 If the Board accepts the proposals:

- The Board's relationships with the Children, Young People and Families Board, the Community Safety Partnership and the Better Care Fund Programme Management Group will change to become a more strategic role that supports and drives integration to improve the health and wellbeing of our communities and address health inequalities. A new partnership board would be created, Living Well, to improve public health outcomes. The pre-existing Boards will become Commissioning and Transformation Partnerships which will integrate resources to improve efficiency and outcomes.

- The Commissioning and Transformation Partnerships will deliver the existing Health and Wellbeing priorities, with the exception of the "to improve life expectancy and reduce health inequalities" priority which will remain with the Health and Wellbeing Board due to its overarching outcome. The role of the Health and Wellbeing Board in relation to the existing priorities will be focused upon challenging the Commissioning and Transformation Partnerships on the delivery of those priorities.

- If the Board proposed changes to the Board membership, meeting frequency and rules on quorum (depending upon the option chosen from the three choices as detailed in Part B, Section 6) it will require changes to the programme of meetings and their administration.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific Health and Wellbeing Board Priority	
	No	The proposals contribute to all of the Health and Wellbeing Board's priorities and will help the Health and Wellbeing Board meet their principles of accessibility, engagement and positive experience.

	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	The proposals contribute to the Council meeting the 'Health and Wellbeing' objective.
	Will the proposals impact on specific groups of people?	
	No	
TARGET COMPLETION/DELIVERY DATE	If the Board recommend the proposals regarding the changes in membership; they will proceed to Council Constitution Committee and then, if approved, onto full Council at the earliest opportunity.	
FINANCIAL/VALUE FOR MONEY IMPACT	No	There are no foreseen financial implications arising from adopting the recommendations of this report. RP-020514
LEGAL ISSUES	Yes	Section 194 of The Health and Social Care Act 2012 requires the Council to establish a Health and Wellbeing Board as a formal committee of the Council in accordance with section 102 of the Local Government Act 1972 (subject to some exceptions). Accordingly the conduct and procedure of the Board must comply with the appropriate statutory requirements that relate matters such as the publication of the meeting agenda and publishing of reports. Section 194 of the Health and Social Care Act 2012 sets out the membership requirements of the Health and Wellbeing Board set out at paragraph 1.3 of this report. Any changes to the membership must comply with these requirements. In order to give effect to any changes full Council has to approve the changes which will result in the consequent amendment to the Council's constitution to incorporate the new arrangements. Council Constitution Committee also has involvement in the structure and content of the Committee terms of

		reference and procedures. The partnership groups set out in the diagram at paragraph 2.3 of this report are not Committees or Sub-committees of the council, they will not have powers delegated to them and the responsibility for the areas they examine on behalf of the Board will remain the ultimate responsibility of the Board.
EQUALITY & DIVERSITY	Yes	Access to the Health and Wellbeing Board should be for all of the community. The policies which the Council has in place to communicate with all of the community will be utilised where necessary.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	No	
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	Set out at Section 2 of this report below.

PART B) – ADDITIONAL INFORMATION

1. BACKGROUND INFORMATION

1.1. On 3rd April 2014 the Board held a Development Session to look at 'drivers for change' with regards to the role of the Health and Wellbeing Board. The 'drivers for change' were:

- ***The Better Care Fund*** - the Board has previously agreed the governance arrangements for the Better Care Fund with the instigation of the Strategic Commissioning Group and the Better Care Fund Programme Management Group. The Board members were asked to consider the developments that the fund created for its future working with other partnerships.

- ***A review of existing partnership arrangements*** – the Board Development Session on 5th November 2013 identified a need to review how it worked with other strategic boards, how it can work together to deliver outcomes and that it should take a more strategic view to drive integration of health and care. This work was completed and the Board members were asked to consider how the role of the Health and Wellbeing Board could strengthen

the partnerships within Telford and Wrekin and drive forward improving the lives of the community.

2. REFOCUSING THE ROLE OF THE HEALTH AND WELLBEING BOARD

2.1. The Health and Wellbeing Board currently reviews the progress of its priorities on a cyclical basis with a focus on outcomes. It is proposed that the role of the Board is developed to become more strategic and focus on supporting and driving the integration and transformation of services to improve the health and wellbeing of our communities and reduce health inequalities ensuring maximum value from finite resources.

2.2. To enable the Board to do this it is proposed that the partnership landscape is amended as shown in Diagram 1.

2.3. It is also proposed that the delivery of the Health and Wellbeing Strategy priorities is through the Commissioning and Transformation Partnerships, with the exception of the "*improve life expectancy and reduce health inequalities*" priority which would remain with the Board. (Please refer to Appendix 2 for a list of the current priorities/outcomes and the proposed Commissioning and Transformation Partnerships.)

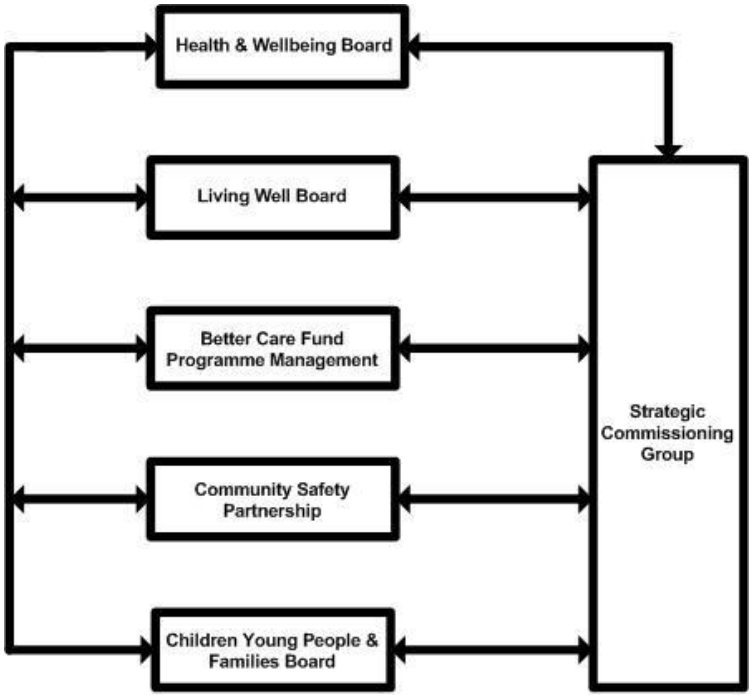


***Diagram 1**: Proposed partnership landscape*

3. DEVELOPING THE ROLE OF THE STRATEGIC COMMISSIONING GROUP

3.1. The Strategic Commissioning Group was established following agreement at the last Board meeting (12th March 2014) to ensure that commissioning by the key partners is integrated and evidence based to ensure efficiency and effectiveness primarily in the delivery of the Better Care Fund.

3.2. In the proposed new partnership landscape the Strategic Commissioning Group would widen its remit to include oversight and understanding of any commissioning within the Commissioning and Transformation Partnerships.

3.3. This group will review the whole commissioning landscape to ensure that services that are commissioned are integrated and able to deliver the Health and Wellbeing overarching priorities and also the priorities of the Commissioning and Transformation Partnerships.

4. PROPOSED ROLE OF COMMISSIONING AND TRANSFORMATION PARTNERSHIPS

4.1. The current role of the strategic partnerships (Children, Young People and Families Board, the Community Safety Partnership and the Better Care Fund Programme Management Group) is to drive the delivery of the priorities identified in their plans to improve the lives of the community within Telford and Wrekin. It is proposed that these three established groups become Commissioning and Transformation Partnerships, along with the creation of a new partnership, the Living Well Board, centring on public health outcomes.

4.2. The focus of Commissioning and Transformation Partnerships will be to bring greater consistency and connectivity to partnership working. As well as focusing on improving outcomes, these partnerships will drive and challenge how services are being delivered. To do this, they will map the resources (the "*Telford £*") which are currently employed delivering these services and explore alternative delivery and commissioning models. This may involve the creation of pooled or aligned budgets with a focus on driving the integration of services and value for money.

4.3. It is proposed that the Living Well Board would focus on upstream measures to improve public health outcomes. The partnership would comprise of a range of council teams and partners that deliver, particularly against health improvement outcomes. It is proposed that it uses a number of means to improve outcomes, including social marketing, community development and encouraging healthy environments as well as commissioning 'prevention' services. It is proposed that the Board will focus on healthy lifestyles and emotional

health and wellbeing outcomes with the drugs and alcohol outcomes sitting with the Community Safety Partnership.

4.4. It is proposed that the Health and Wellbeing Board challenge and hold the Commissioning and Transformation Partnerships to account for the areas they are responsible for.

4.5. As noted in Section 2.3 it is proposed that the Health and Wellbeing Strategy's priorities are distributed amongst the Commissioning and Transformation Partnerships to drive their delivery and that the Commissioning and Transformation Partnerships would provide assurance to the Board that progress is being delivered. Please refer to Appendix 2 for the existing priorities and proposed Commissioning and Transformation Partnerships.

4.6. It is proposed that the Commissioning and Transformation Partnerships report into the Health and Wellbeing Board on a regular basis and that the forward plans for all Commissioning and Transformation Partnerships are combined to ensure that linkages are made and it is clear to all Commissioning and Transformation Partnerships and the Health and Wellbeing Board what is being discussed when.

5. NEXT STEPS

5.1. It is suggested that if the proposal to establish Commissioning and Transformation Partnerships is agreed, the mapping of the "*Telford £*" is completed by October 2014. This work should be led and reported to the Strategic Commissioning Group. A report will then be presented to the Health and Wellbeing Board shortly after.

5.2. It is proposed that the Health and Wellbeing Board hold at least two development sessions per year to build on the experience of the past twelve months and the need to keep the function of the board under periodic review.

6. TERMS OF REFERENCE

6.1. It is good practice for Boards and Committees of the Council to review their terms of reference at the commencement of the new municipal year (it is contained in the Board's terms of reference at paragraph 18); however, it was felt more appropriate considering the nature of the report that the terms of reference were considered at this stage. It is now more than twelve months since the Board emerged from its 'shadow' operations and a number of developments have taken place in the meantime including the provision of public speaking and the establishment of both the Health and Wellbeing Board Strategic Commissioning Group and Better Care Fund Project Management

Group. This section of the report looks at some operational aspects of the Board and to seek decisions on whether adjustments are now required.

Membership of the Health and Wellbeing Board

6.2. The current membership of the Health and Wellbeing Board is made up as follows:

- 6 elected members
- 3 CCG representatives
- 3 Council Officers
- 1 representative from NHS England
- 1 representative from Healthwatch

6.3. The specific titles of the current membership are set out at in the terms of reference at Appendix 1 of this report (section 2 of the Terms of Reference entitled 'Membership'). During the course of the year there have been representations made by a number of external bodies to become members of the Health and Wellbeing Board and the Board are now asked to consider whether the membership should be changed. As outlined in Section 2 of the report it is proposed that the Community Safety Partnership becomes one of the Commissioning and Transformation Partnerships, and thereby the Board are asked to consider that the Chair of Community Safety Partnership becomes a member of the Health and Wellbeing Board. Whilst the expertise provided by other external bodies is always valuable, officers are recommending that there are no other changes to the Board membership at this point. Officers are mindful that the Board already has a large membership and accordingly there is an issue over the impact which an increased membership may have upon the expediency of the operation of the Board. It is suggested that those parties wishing to take part in the Health and Wellbeing Board meetings can be invited for relevant topics of discussion and given the opportunity to contribute as appropriate.

6.4. The Regulations governing the membership of the Health and Wellbeing Board state that the membership should be as follows:

- at least one councillor of the local authority
- the director of adult social services for the local authority,
- the director of children's services for the local authority,
- the director of public health for the local authority,
- a representative of the Local Healthwatch organisation for the area of the local authority,
- a representative of each relevant clinical commissioning group, and
- such other persons, or representatives of such other persons, as the local authority thinks appropriate.

Frequency of Meetings

6.5. As the Health and Wellbeing Board becomes more established and looks to take a more strategic role, it is appropriate to address the frequency of formal Board meetings. Currently the Health and Wellbeing Board meets every couple of months with special meetings when required. It is proposed that with this should be amended to quarterly meetings. This would still allow regular updates, reviews and decision-making whilst also taking into account that the Board's work that is being undertaken via other bodies such as the Health and Wellbeing Board Strategic Commissioning Group and Better Care Fund Project Management Group.

Quorum for meetings

6.6. The quorum is a minimum attendance at Board meetings that is required for the meeting to take place. Currently the quorum is set out in the Terms of reference as stating:

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

6.7. It is recommended that the quorum requirement in relation to partners is clarified to provide some certainty as to when a meeting can proceed if one of the partners is absent. Looking at the responsibilities and nature of the business going to the Health and Wellbeing board the following quorum requirement is proposed:

"*Quorum of one quarter is required, with a minimum of one Councillor Board member from Telford and Wrekin Council and one Board member from the CCG required in attendance*."

7. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

The impact will depend upon which option, if any, is recommended to full Council by Health and Wellbeing Board.

8. PREVIOUS MINUTES

17th July 2013 – Health and Wellbeing Board – 22
12th March 2014 – Health and Wellbeing Board

9. BACKGROUND PAPERS

- Health and Wellbeing Boards – A practical guide to governance and constitutional issues. Issued by the Local Government Association, March 2013

- The Health and Social Care Act 2012

- http://www.legislation.gov.uk/ukpga/2012/7/contents

- Health and Wellbeing Board Support and Delivery Arrangements report – presented to the Health and Wellbeing Board in March 2014.

Report prepared by:
Sarah Constable, Partnership and Planning Officer, Telephone: 01952 380599.
Matthew Cumberbatch, Legal Services Manager, Telephone: 01952 383255

Appendix 1 - *updated terms of reference in light of the changes proposed in the report, with the additions highlighted in yellow.*

Telford & Wrekin Health and Wellbeing Board Terms of Reference

The Committee has the responsibility on behalf of the Council in respect of public health and health and wellbeing responsibilities within the Borough.

TERMS OF REFERENCE

1. The Health and Wellbeing Board is responsible for guiding and overseeing:

1.1. The ongoing development of the joint strategic needs assessment (JSNA)

1.2. Developing a high-level joint health and wellbeing strategy based upon the findings of the JSNA

1.3. The establishment of sound joint commissioning arrangements

1.4. The development of HealthWatch forum for public and patient engagement and involvement

1.5. Public Health responsibilities and arrangements in the local authority

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

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

4. The Health and Wellbeing Board will work with, and receive reports from, the Children, Young People and Families Board, Community Safety Partnership, Better Care Fund Management Group and the Living Well Board.

5. The Health and Wellbeing Board will have a link to the overarching Telford and Wrekin Local Strategic Partnership but will also very much function in its own right. In addition it will link with the existing adult and children safeguarding boards in order to ensure the focus on the improved health and wellbeing outcomes for the whole population of Telford and Wrekin.

6. The Health and Wellbeing Board will lead on the development of a Telford and Wrekin Joint Health and Wellbeing Strategy for residents which drives health improvement, plans to deliver this strategy and keeps the implementation of these plans under review.

7. Through the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board will oversee a commissioning programme of service and/or pathway redesign to better meet the needs of patients and service users and to deliver improved outcomes. Successful delivery of this will be dependent on the Health and Wellbeing Board developing effective management mechanisms with both primary care and secondary care providers where relevant or appropriate.
8. The Health and Wellbeing Board will link into the Local Strategic Partnership, Strategic Boards and associated Partnership Boards, making recommendations to Full Council, NHS England, and the Clinical Commissioning Group Board, as appropriate.
9. The Health and Wellbeing Board will analyse the priorities for deployment of health and care resources in the area based on information collected through the JSNA and other sources.
10. The Health and Wellbeing Board will consider options and opportunities to maximise the impact of aligning the deployment of resources of the health and care agencies in the area on agreed priorities. This will include the joint commissioning of health and social care services for children, families, and adults in Telford and Wrekin, to meet identified needs and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.
11. The Health and Wellbeing Board will oversee the development of this proposed joint commissioning activity, ensuring any proposed activity is aligned with local priorities and levels of need and is undertaken within available resources. To consider options for joint commissioning and procurement between relevant organisations to support this work.
12. The Health and Wellbeing Board will oversee all areas of health and social care commissioning activity for people of all ages, to ensure that commissioning priorities are in line with those set through analysis of the JSNA and the local Joint Health and Wellbeing Strategy. This commissioning activity includes all local services commissioned by Telford and Wrekin CCG, Telford and Wrekin Council, Joint Commissioning CCG/Council, Public Health England and NHS England, which could include local specialised services; secondary dental care; general dental services; GP services; general ophthalmic services; pharmaceutical services; any services for the Armed forces or Offenders; and other primary care.
13. The Health and Wellbeing Board will keep under review, the financial and organisational implications of joint and integrated working across health and social care services, ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

14. The Health and Wellbeing Board will identify and act upon changes that may be required following any new guidance in relation to the Health and Wellbeing Board.
15. The Health and Wellbeing Board will propose recommendations, as appropriate to:

15.1. Telford and Wrekin Council's Full Council

15.2. NHS England Board

15.3. Telford and Wrekin Clinical Commissioning Group Board

16. The Health and Wellbeing Board will ensure that the Health and Wellbeing Board works to promote the achievement of the objectives of the organisations represented on the Board, including the Council's health improvement responsibilities.

General

17. Annually at the first meeting after the Annual Council Meeting consider its terms of reference

PROCEDURE

General

1. Unless specifically provided for in these Terms of Reference the Council Procedure Rules govern the way that committees operate but these may be varied or suspended[1] at the discretion of the Chairman of the Committee in the interests of efficient and effective management of the committee.

Membership

2. Members of the Health and Wellbeing Board will comprise representatives from the Clinical Commissioning Group, Telford & Wrekin Council, Healthwatch and NHS England Local Area Team. The core members are:

2.1. Cabinet Member responsible for Public Health and Public Protection ~~wider Health Services~~ (Chairman of the Health and Wellbeing Board)

2.2. Cabinet Member for Adult ~~and~~ Social Care

2.3. Cabinet Member for Children, Young People and Families

2.4. Cabinet Member for Leisure ~~and Wellbeing~~ Services and Culture

2.5. Director responsible for Adult Social Care

2.6. Director responsible for Children's Services

2.7. Director of Public Health

2.8. NHS England Local Area Team representative

2.9. Chair of Telford and Wrekin Clinical Commissioning Group (CCG) (Vice Chair Health and Wellbeing Board)

2.10. Non-Executive Director from Clinical Commissioning Group

2.11. ~~Accountable~~ Chief Officer from Clinical Commissioning Group

[1] With the exception of paragraph 12

2.12. Representative of local Healthwatch
2.13. Chair of the Community Safety Partnership
2.14. Each opposition Group with 4 or more elected members shall have one place on the Health and Wellbeing Board with voting rights.
2.15. Such other persons, or representatives of such other persons, as the Local Authority thinks appropriate

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

3.1. Assistant Director~~s~~ responsible for Commissioning (AD Family, Cohesion and Commissioning)
3.2. ~~Director of~~ Executive Lead for Commissioning, CCG

4. This reflects the statutory minimum membership in the Health and Social Care Act 2012.
5. The members of the Board will be advised and supported by officers from the local authority and CCG.
6. Members agree to share all relevant information and data, to allow performance, and other joint working arrangements, to be properly monitored and managed.

Disqualification for Membership

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

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

Voting Rights

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

Meetings

10. The Health and Wellbeing Board will meet quarterly ~~bi-monthly~~. Dates and times of meetings will be agreed and published in advance.
11. Agendas and supporting papers will be issued at least five clear days before each meeting and action notes will be produced, confirmed as a true record of the meeting and signed by the Chair.
12. Members of the public and press will have access to the meetings. A Protocol will be developed and agreed by Health and Wellbeing Board.
13. There will be a public speaking section at each Health and Wellbeing Board meeting. A procedure for public speaking at the Health and Wellbeing Board is in place and is available on the Council's website or by contacting Democratic Services.

Quorum

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

Code of Conduct and Declaration of Interest

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

Access to Information/Transparency Provisions

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

Reporting Mechanisms/Accountability

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

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

Establishment of Sub-Committees

22. The Health and Wellbeing Board will be able to establish sub-committees and delegate functions to them.

Scrutiny

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

Appendix 2

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

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

SUPPORT PEOPLE TO LIVE INDEPENDENTLY (PRIORITY 9)

REPORT OF INTERIM DIRECTOR OF HEALTH, WELLBEING AND CARE

LEAD HEALTH & WELLBEING BOARD CHAMPION – CLLR JACQUI SEYMOUR

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 This report provides an update on progress against the Health & Wellbeing Strategy priority, "supporting people to live independently" and information about local performance against related performance measures.

1.2 The report also makes links between this priority and the whole Adult Social Care agenda as covered within the Adult Social Care Outcomes Framework and the wider whole system performance agenda.

1.3 Reference is then made to the Better Care Fund Plan as it picks this up from a whole system perspective and incorporates this priority as one of its key themes.

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board are asked to note the contents of this report.

2.2 The Health and Wellbeing Board request to be kept informed of progress in the future, through reference to work undertaken in relation to 'Better Care Fund Plan' and a whole system/balanced scorecard performance approach.

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

Support people to remain living independently in the community for as long as possible.

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>Priority 9: Support people to live independently</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>Protect and support our vulnerable children and adults</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>Vulnerable adults from all areas of service</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">Ongoing, and will also be aligned to the work in the Better Care Fund Plan.</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>The Council has approved a budget for 2014/15 of £41.265m for Adult Social Care. The current budget strategy includes savings for Adult Social Services of £10.5m to be delivered by the end 2015/16. The savings identified have been determined to contribute towards the overall savings package of £22m which the Council has to find by 2016/17 and also to bring the costs of Adult Social Services into line with that reduced budget.

The budget total includes over £976k being funding passported by the CCG following Government allocations of funding for reablement. This funding is expended by the Council following plans agreed with Health Partners.

The recent Better Care Fund submission to the Department of Health identified joint funding of £14.674m for 2015/16, formulated from the Better Care Fund appropriation to the CCG as part of the 2014/16 finance settlement (funds within existing budgets) and other budgets which already support joint working arrangements, including the</td></tr>
</table>

		£976k reablement funding identified above. The strategy is dependant on significant savings being made as part of the move to providing more Community based support. If these savings are not made then there is a significant risk of exacerbating current financial pressures already being experienced in the Health economy. RP 02.05.14
LEGAL ISSUES	Yes	The Adult Social Care Outcomes Framework (ASCOF) was first published in March 2011 and measures how well care and support services achieve the outcomes that matter most to people. The ASCOF for 2014 to 20015 was published on 11 November 2013 and supports the priorities for social care as set out in the Care Bill, which include supporting people to maintain their independence and their connections to the community, and ensuring that everyone has control over the care they receive. The ASCOF, alongside the NHS Outcomes Framework and the Public Health Outcomes Framework, supports Government ambitions for joined-up seamless services within, and between, health and social care, a renewed focus on preventing and delaying the need for care and support, and progress in delivering personalised care for both users of care and carers. The Care Bill will ensure that each person receiving care and support is placed at the centre of those services. The Bill [as at 29 April 2014] has concluded all stages in the House of Commons and amendments are due to be considered in the House of Lords on 7 May 2014.

		The Bill and subsequent Statute, once it receives Royal Assent, will be accompanied by relevant Statutory Instruments and Guidance, which will be issued for consultation first. On 10 January 2014, the Department of Health published Factsheet 19 on the Care Bill. The factsheet explains how the Bill will facilitate the creation of the Better Care Fund, by providing a mechanism that will allow the sharing of NHS funding with local authorities to be made mandatory. It is planned that CCGs will make use of their powers under Section 75(2) of the National Health Service Act 2006 to set up pooled budgets with local authorities under written agreement. Money invested in a pooled budget can only be spent with the agreement of both parties on activities that benefit both health and social care. KF 29.4.14
EQUALITY & DIVERSITY	Yes	Adult social care supports all adults who may be described at times as 'vulnerable' and require support to remain independent.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	Yes	Throughout the year discussions take place with many groups identified as 'vulnerable adults' linked to consultation & gathering feedback. 'Working Together' events provides opportunities for the council and CCG to gain feedback and insights from many sectors working to support individuals to remain independent.
OTHER IMPACTS, RISKS & OPPORTUNITIES	**Yes**/No	If yes, briefly list any other significant impacts, risks & opportunities- See links below, outlined in the paper.

PART B) – ADDITIONAL INFORMATION

INFORMATION

1. Context

1.1 The national priorities adopted for Adult Social Care and set out in our Local Account for 2012/13 are (for more detail see Appendix 1):

- Domain 1 - Enhancing the quality of life for people with care and support needs
- Domain 2 - Delaying and reducing the need for care and support
- Domain 3 - Ensuring that people have a positive experience of care and support
- Domain 4 - Safeguarding adults whose circumstances make them vulnerable and protecting them from harm

1.2 There are a set of national indicators relating to each of these domains, through the Adult Social Care Outcomes Framework (ASCOF). Every local authority has to provide data for these indicators (21 separate indicators – see Appendix 2) which are in the public domain, allowing benchmarking, peer challenge, etc; and are reported locally by the Council through the Local Account on an annual basis.

1.3.The Health and Wellbeing Board through the Health & Wellbeing Strategy 2013/14-2015/16, identified 'Support people to live independently' (See Appendix 3 – page 10 of Strategy) as one of its key priorities with the intention of improving four main outcomes:

- Proportion of people using social care who receive Self Directed Support (A Domain 1 indicator)
- Proportion of older people who were still at home 91 days after discharge from hospital into re-ablement services (A Domain 2 indicator)
- People receiving re-ablement services who need no support at the end of their re-ablement phase (A Domain 2 indicator)
- Delayed transfers of care from hospital (A Domain 2 indicator)

1.4 Whilst this report focuses on these 4 specific outcome indicators, it would be advisable in the future for the Health & Wellbeing Board to have a focus on all of the ASCOF outcome indicators that the Council will be benchmarked against. Taking a balanced scorecard approach would also look at performance relating to activity figures (currently more eligible people with high cost needs are requiring social care support compared with the number of people leaving the system) and spend against available budget (there are severe pressures in the system, with robust action required to ensure that spend on adult social care is brought within budget at financial year end.

1.5 A whole system/balanced scorecard approach would consider this information alongside specific NHS & Public Health outcome frameworks

to give a whole system approach. Later in the report we make the link to the Better Care Fund Plan, which has a number of nationally prescribed performance measures some of which are ASCOF indicators.

2. Performance against Outcomes Framework

2.1 The Health and Wellbeing Board 6 month Performance Monitoring Report provided information on performance related to the outcomes above and some additional ones. At the time of preparing this report, end of year data for 2013-14 is not available, but will be provided to the H&WBB in due course.

2.2 **Proportion of people using social care who receive self-directed support:**

- 2010/11 outturn: 30.2%
- 2011/12: outturn: 36.62%
- 2012/13 outturn: 58.8%
- National comparator 2012/13: 55.5
- Performance at 6 months (2013-14) 63.8%
- Estimated out turn for 2013-14: 60%
- Overall classification: Getting Better.

2.3 On the face of it we appear to be performing well in this area with most people now being made aware of the value of their personal budget, with a resource allocation system incorporated within the community care assessment process. However, we know that in terms of the process there is much more that needs to be done to embed a more personal and individual approach. We need to support assessment staff to give up control, encourage service users to take more self control of the support planning process once they know what their personal budget allowance will be, to find more cost effective support solutions than is current practice. At the same time commissioners need to initiate capacity building approaches to develop community based, lower cost support options, than the traditional care options.

2.4 **Proportion of people using social care who receive direct payments:**

- 2010/11 outturn: 5.4%
- 2011/12: outturn: 5.8%
- 2012/13 out turn: 8.1%
- National comparator: 16.5%:
- Performance at 6 months (2013-14): 8.8%
- Estimated out turn for 2013-14: 8.8%
- Overall classification: Getting Better

2.5 Direct payments is where a person chooses to receive their personal budget directly into their own care account and control the use of that budget themselves, in agreement with the local authority. You will see from the figures that over the last 4 years we have fallen away from the national performance, with only a relatively small improvement likely to be

reported in 2013/14. The low performance is compounded by relatively low numbers of people using their direct payment to employ their own Personal Assistants, demonstrated to be the most cost effective and personal approach.

2.6 Locally there is a dedicated work being undertaken to significantly alter the care pathway, to ensure that support planning (other than in an emergency) takes place after the individual's personal budget has been identified, with appropriate support planning expertise in place and the development of a Personal Assistant Register.

2.7 **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services (those offered intermediate care):**

- 2010/11 outturn: 77.9%
- 2011/12: outturn: 74.4%
- 2012/13 out turn: 53.7%
- National comparator: 81.4%
- Performance at 6 months (2013-14 TBC)
- Estimated out turn for 2013: Not stated
- Overall classification: Worsening

2.8 Performance in this area dropped dramatically in 12/13 and though it is likely to have improved slightly in 13/14 it will be significantly below the national average. However, nationally there are concerns about the comparability of this indicator from one local authority to another. The deterioration in performance since 2010/11 will be connected to some extent with the significant drop in people being funded through the health system (Continuing Health Care) and the increasing pace of hospital discharge meaning that increasingly frail and ill people could not be sustained in or returned to their own home within the 91 day window. At the same time (12/13) the Council decided to look to every person requiring ongoing public funding for community care services, to go through an initial period of enablement. This was on the basis that this would reduce long-term care costs. This may not have been the right decision with evidence suggesting that enablement should return to being a targeted service.

2.9 Enablement is one of the key themes of the Better Care Fund Plan and a commissioning led review of the existing services will be undertaken with the CCG as part of the Plan (see Section 3 below).

2.10 **People receiving re-ablement service who need no support at the end of their service**

- 2010/11 outturn: Not stated
- 2011/12: outturn: 37%
- 2012/13 out turn: 34.9%
- National comparator: not stated
- Performance at 6 months (2013-14) 39.1%

- Estimated out turn for 2013: 39.1%
- Overall classification: Getting Better

2.11 Whilst this appears to have been improving in 2013/14, we have no benchmarking information to compare with and need to examine what this data is telling us, with more rigour as part of the review reference at 2.9 above.

2.12 **Delayed transfers of care from hospital**

- 2010/11 outturn: Not stated
- 2011/12: outturn: 8.6%:
- 2012/13 out turn: 5.3%
- National comparator: 9.5%:
- Performance at 6 months (2013-14) 5.74%
- Estimated out turn for 2013: 5.74%
- Overall classification: Getting worse.

2.13 Locally we have always performed very well against this indicator, putting this down to good joint working relationships within the hospital, and availability of joint rapid response/intermediate care (now known as enablement) services. Performance is likely to have dipped slightly last year, not helped by some delays as a result of disagreements between the Council over a health contribution towards some individuals continuing care costs. Availability of beds suitable for people with mental health or dementia related needs is also a problem at times.

2.14 Clearly the Council's funding situation could place this performance under further pressure in 2014/15, with both the activity relating to an overspend in 13/14 needing to be reduced and a further reduction in this year's budget of £5m. Again this is a key component of the Better Care Fund plan, with joint requirements to ensure flow through the hospital system whilst also reducing admissions in the first place.

2.15 **The proportion of carers who report that they have been included or consulted in discussion about the person they care for.**

- First collected in 2012/13 out turn: 72.8%
- National comparator: 72.9%
- Performance at 6 months (2013-14) Not stated
- Estimated out turn for 2013: Not stated
- Overall classification: not given

2.16 Another important aspect of supporting people to live independently is the support family carers receive to carry on caring. Improving carer's health and wellbeing (all age) is of course one of the Health & Wellbeing Board's priorities. A bi-annual survey of family carers has to be undertaken by each local authority. The survey provides a wide range of information which informs the Carers Strategy and the data feeds into two of the ASCOF indicators under Domain 3 - Ensuring that people have a positive experience of care and support.

2.17 The next carer's survey is due to take place early in 2015. This will provide important benchmarking information ahead of the Care Bill becoming law from April 2015, which will put family carers on an equal footing with the person they are caring for.

3. Better Care Fund

3.1 Background of the Better Care Fund

3.2 The Health and Social Care Act, 2012 set out expectations around greater integration of health and social care services to provide more effective pathways and better outcomes and value for patients/service users. The Department of Health guidance suggests a step change in current arrangements to share information, share staff, share money and share risk. Overall, the intention of the Better Care Fund is to support people remaining independent for as long as possible and reducing access to acute services by 'growing' the community capacity to respond effectively.

3.3 Submissions in relation to Better Care Fund were made by the CCG and Council on 14 February and 4 April 2014. The 4 April submission has been signed off regionally. Though there is a recognition of the challenges that will have to be overcome in working with the acute health sector, to release funding into the community, to support more people in the community more cost effectively and allow the health and social care system to meet the needs of an increasing number of people within reducing overall budget.

3.4 Considerable work is now taking place to establish a firmer foundation to the Better Care Fund Plan being implemented from 2015-16 and some summary information is outlined below.

3.5 Objectives of the Better Care Fund

3.6 The Better Care Fund will be used to transform the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care. The target focus for the Better Care Fund is to transform public services for adults needing high levels of health or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions/End of Life
- High risk of admission to hospital or care home
- Discharged from hospital with a need for rehabilitation and/or enablement

3.7 The aims are:

- Delivering the best possible health and social care outcomes

- Promoting self-help and self-care wherever and for as long as possible
- Enabling those at increased risk of hospital, nursing or residential care admission to have systems in place to get help at an early stage
- Ensuring financial efficiency

3.8 The thematic objectives are to:

- Building Community Capacity in Telford and Wrekin
- Enhanced community services for Telford and Wrekin as an alternative to hospital provision

3.9 **Outcomes and Deliverables**

3.10 Five nationally set performance measures will be used to monitor progress for the BCF with associated metrics:

- Reducing non-elective hospital admissions, re-admissions and length of stay
- Reducing permanent admissions to residential and nursing care (an ASCOF indicator)
- Patient experience
- Reducing delayed transfers of care (an ASCOF indicator)
- Improving the effectiveness of re-ablement/rehabilitation services (an ASCOF indicator)

Further information on work undertaken to support people remaining independent is given in appendix 1.

4. PREVIOUS MINUTES

- 13.03.2013 – Report to the Shadow Health and Wellbeing Board on HWB Strategy Development and JSNA.
- 17.07.2013 – Report to the Health and Wellbeing Board on the Joint Health and Wellbeing Strategy: Developing our Partnership and Outcome Frameworks
- 22.01.2014 – Report to the Health and Wellbeing Board on 6 month performance report: Health and Wellbeing Strategy Outcome Measures

5. BACKGROUND PAPERS

- TW Adult Social Care Local Account 2012/13: http://www.telford.gov.uk/info/100010/health_and_social_care/1565/local_account

- Health and Wellbeing Strategy 2013/14 to 2015/16: http://www.telford.gov.uk/downloads/file/4123/hwb_priorities_consultation_may_2012

Report prepared by Kit Roberts, Better Care Project Manager, 01952 389990

Appendix 1 – Page 11 of T&W Adult Social Care Local Account 2012-13: Our Priorities

Our priorities, which are in line with the National priority outcomes, for this year are:

1. **Enhancing the quality of life for people with care and support needs**
   - People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs.
   - Carers can balance their caring roles and maintain their desired quality of life.
   - People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

2. **Delaying and reducing the need for care and support**
   - People have the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.
   - Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.
   - When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

3. **Ensuring that people have a positive experience of care and support**
   - People who use social care and their carers are satisfied with their experience of care and support services.
   - Carers feel that they are respected as equal partners throughout the care process.
   - People know what choices are available to them locally, what they are entitled to and who to contact when they need help.
   - People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

4. **Safeguarding adults whose circumstances make them vulnerable and protecting them from harm**
   - People enjoy physical safety and feel secure.
   - People are free from physical and emotional abuse, harassment, neglect and self harm.
   - People are protected as far as possible from avoidable harm, disease and injuries.
   - People are supported to plan ahead and have the freedom to manage risks the way that they wish.

5. **Delivering transformation and managing resources**

Appendix 2

	Telford								Previous year for comparison						
	Indicator	2011-12 (Final)	2012-13 (Prov)	2012-13 Nat Avg	2012-13 Comp Avg	2012-13 WM Avg	2012-13 Quartile	2012-13 T10/L10	2011-12 (Final)	2011-12 Nat Avg	2011-12 Comp Avg	2011-12 WM Avg	2011-12 Quartile	2011-12 T10/L10	2013-14 Projection
1A	Social care-related quality of life	18.3	18.4	18.8	18.9	18.8			18.3	18.7	18.9	18.8			N/A
1B	Proportion of people who use services who have control over their daily life	75.7	74.7	75.9	75.8	75.1			75.7	75.1	75.5	74.5			N/A
1C(1)	Proportion of people using social care who receive self-directed support	36.2	58.8	55.6	58.3	49.2			36.2	43	45.4	36.4			60.0%
1C(2)	Proportion of people using social care who receive direct payments	5.8	8.1	16.4	15.9	16.6		Bottom 10%	5.8	13.7	11.8	14		Bottom 10%	8.2%
1D	Carer-reported quality of life	.	8.0	8.1	8.4	7.9			.	.	.	.			N/A
1E	Proportion of adults with learning disabilities in paid employment	4	4.0	7.2	5.1	5.6			4	7.1	5.1	6.3			4.1%
1F	Proportion of adults in contact with secondary mental health services in paid employment	6.1	9.9	7.7	6.3	10.9			6.1	8.9	8.1	10.3			N/A
1G	Proportion of adults with learning disabilities who live in their own home or with their family	66.7	63.9	73.3	81.3	66.4			66.7	70	79.6	65.4			65.0%
1H	Proportion of adults in contact with secondary mental health services living independently, with or without support	36.5	81.1	59.3	64.0	62.3			36.5	54.6	61.6	51.2			N/A
2A(1)	Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population	21.2	11.6	14.9	14.5	18.2			21.2	19.1	17.4	18.3			N/A
2A(2)	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	723	681.9	708.8	749.3	701			723	695.9	795.7	645.5			N/A
2B(1)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)	74.3	53.7	81.5	80.4	79		Bottom 10%	74.3	82.7	80.2	81.1			63.0%
2B(2)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (offered the service)	3	3.5	3.3	4.8	4.4			3	3.2	3.5	4			N/A
2C(1)	Delayed transfers of care from hospital per 100,000 population	8.3	5.3	9.5	6.5	11.6			8.3	9.7	6.8	13.5			8.2
2C(2)	Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	4.1	2.6	3.3	1.6	5.6			4.1	3.7	2.5	7.4			2
3A	Overall satisfaction of people who use services with their care and support	66.4	58.9	63.7	65.6	64.1			66.4	62.8	65.6	63.3			N/A
3B	Overall satisfaction of carers with social services	.	48.4	42.7	46.9	42.1			.	.	.	.			N/A
3C	Proportion of carers who report that they have been included or consulted in discussion about the person they care for	.	72.8	72.8	75.8	71.2			.	.	.	.			N/A
3D	Proportion of people who use services and carers who find it easy to find information about services	72.9	69.1	71.5	74.4	71.7			72.9	73.8	76.5	72.1			N/A
4A	Proportion of people who use services who feel safe	55.2	61.2	65	65.8	64.1			55.2	63.8	64.9	63.1		Bottom 10%	N/A
4B	Proportion of people who use services who say that those services have made them feel safe and secure	62.7	74.4	77.9	76.4	78.4			62.7	75.5	74.4	74.4			N/A

Appendix 3 – Extract from page 10 of T&W Health & Wellbeing Strategy 2013/14-2015/16

Priority 9 – Support People to Live Independently

Why is it important?

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

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

What is the situation in Telford and Wrekin?

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

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD:

NHS ENGLAND- SHROPSHIRE AND STAFFORDSHIRE AREA TEAM COMMISSIONING INTENTIONS FOR 2014/15

REPORT OF: SULTAN MAHMUD, DIRECTOR OF COMMISSIONING

HWB REPRESENTATIVE: DAWN WICKHAM, DIRECTOR OF OPERATIONS

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

This report summarises the intentions of the Direct Commissioning Function of the Shropshire and Staffordshire Area Team of NHS England for 2014/15.

2. RECOMMENDATIONS

The Board is asked to:-

1. Note the information in this report
2. Highlight any areas for improved synergy between council/public health/CCG and NHS England Area Team commissioning intentions.

3. IMPACT OF ACTION

The impact of the commissioning intentions will be to further improve:-

- Quality and safety of care
- Access to appropriate services for all our population, but especially the most vulnerable
- Performance of NHS services so that NHS ENGLAND can deliver of NHS constitutional rights.

Introduction

Area Team Overview

The Shropshire and Staffordshire Area Team holds responsibility on behalf of NHS England to directly commission Primary Care, Public Health (Screening and Immunisation) and Health and Justice Healthcare. The key drivers in the discharge of this responsibility are to improve quality, reduce inequalities, promote patient involvement and promote more integrated care.

The Area Team:

- Has a population of over 1.56 million
- Has in excess of 1000 primary care contractors
- Covers 8 CCGs and 4 Local Authorities
- Covers Staffordshire, one of the 19 designated challenged Health Economies
- Covers 12 prisons, 5 Sexual Assault Referral Centres (SARCs) and 41 Health and Justice Contracts

Key Priorities at a glance

Primary Care	Health and Justice	Screening and Immunisation
Unwarranted Clinical Variation in the Quality of Primary Care Sustainability of GP workforce Value for money review – re distribution of PMS/APMS premium Ability of Primary Care to add to overall system resilience and sustainability Explore potential for 7 day services	Implement new procurement strategy to embed prime provider model. *Continue to develop NHS England commissioning and contracting structures within the single operating model*	Delivery of the section 7a agreement between the Department of Health (DH) and NHS England.https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2014-to-2015

NHS ENGLANDS -2014/15 Business Rules

In planning for the delivery for these services, NHS England's Area Teams and CCGs will need to ensure plans are aligned with CCG commissioning plans. All commissioning intentions are required to be underpinned by the financial reality of the NHS and must meet nationally pre-determined 2014/15 NHS business Rules.

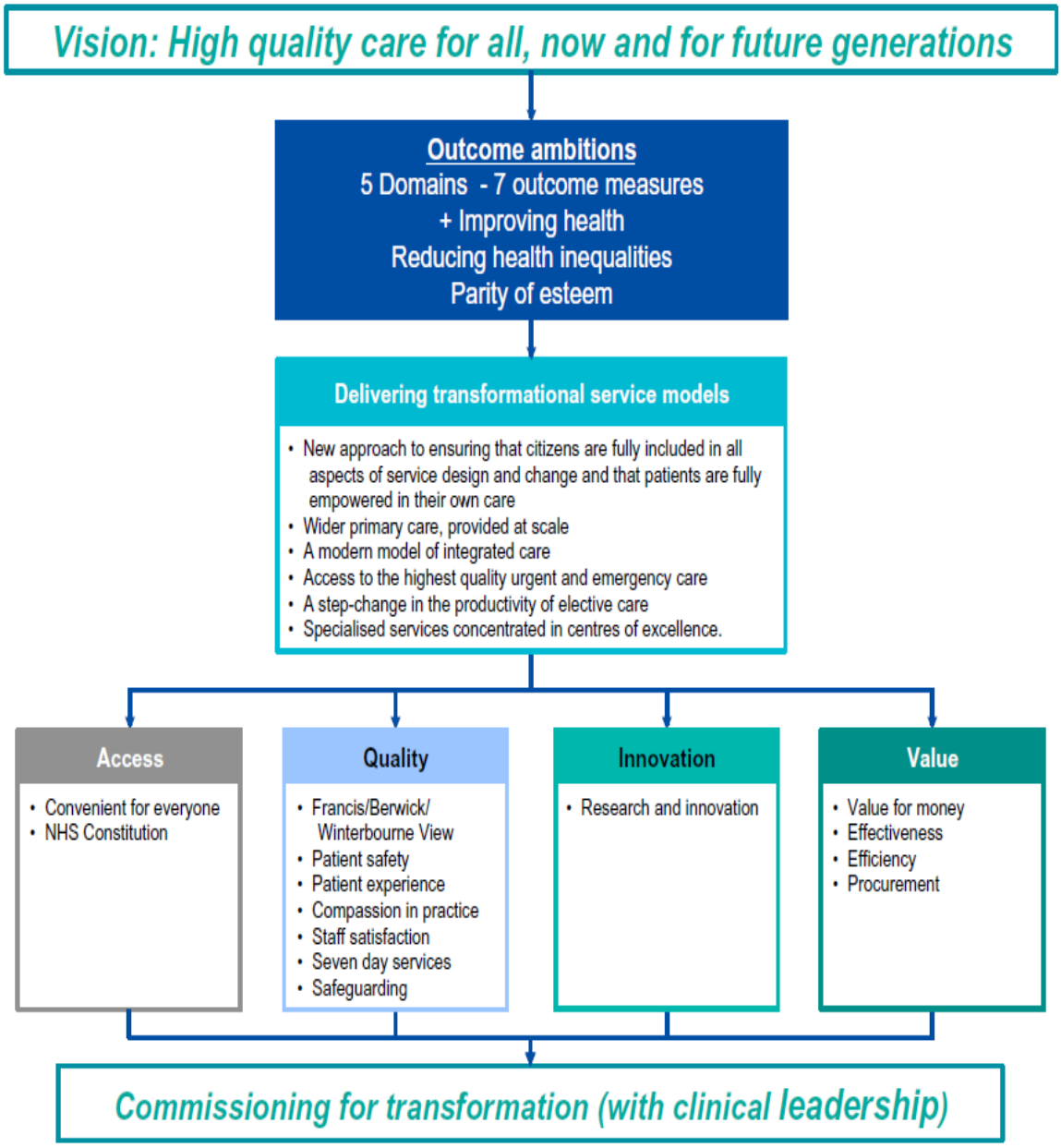
Direct commissioning excluding public health		
Demographic growth	Primary care: Local determination based on resident population in line with crude population projections. Other: Local determination using age profiled population projections for population covered by Area Teams.	
Non-demographic growth	Local determination based on historic analysis and evidence.	
Tariff changes	See above.	
Primary care cost increase	To be confirmed.	
Business rules	**2014/15** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2.5% non-recurrent spend.	**2015/16-2018/19** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2% non-recurrent spend.
Public health		
Demographic growth	Local determination using age profiled population projections for population covered by Area Teams.	
Business rules	• Minimum 0.5% contingency • 0% cumulative surplus carry forward • 0% underlying surplus • 0% non-recurrent spend.	

Vision

The vision set out by NHS England is that we exist to ensure high quality care for all, now and for future generations. The purpose of this initial document is to outline this Area Team's Direct Commissioning Operational Plan for 2014/15 – 2015/16.

In so doing, it recognises the emerging strategic vision of NHS England and attempts to identify the interrelationship of the Direct Commissioning portfolio with CCG and Local Authority's initial operational plans.

This document also looks to address the key fundamentals of the Everyone Counts Planning Guidance as set out below and where possible, provides narrative about the information submitted in the Operational Planning Templates.



PRIMARY CARE

Improving the quality and access to primary care for the population of Shropshire and Staffordshire is a priority for the Area Team

Our Strategic Aims around primary care are simple:

- To improve access to primary care
- To reduce unwarranted clinical variation
- To improve patient experience
- To ensure that practices are sustainable and resilient

This will require the following enablers

- A sustainable workforce to deliver high quality primary care.
- A review of primary care infrastructure and development of an improvement plan to support primary care at scale.
- Strong local clinical, managerial and patient leadership.
- Exemplary delivery of the NHS performance frameworks.

The rate limiting step is consistent collaborative commissioning across 8 CCGs and 4 Local Authorities with the establishment of the Joint Commissioning Board for Primary Care with seven programmes of delivery.

Programme 1- Reducing Unwarranted Clinical Variation. We will look to systematically identify and address the systemic and clinical causes of variation and significantly improve the poorest practices.

Programme 2- Primary Care Incentives and Remunerations Review- We will review current payment systems and contractual models in primary care and suggest novel ways in which primary care could be funded locally to support at scale working and transformational change.

Programme 3- Improved Access. We will explore innovative approaches to improving access to general practice services. We will look to support the changes to the urgent care system to make 7/7 working a reality across the whole system.

Programme 3- Workforce. We will build on existing good work and look to address the workforce problems facing general practice in Shropshire and Staffordshire.

Programme 5 – Optimisation of Professions Allied to Medicines. We will look to these professions play a greater role in treating minor ailments; empowering patients with long term health conditions to manage their own health more effectively; improving the efficiency across the whole system.

Programme 6- Infrastructure- Estates and IT- We will review our infrastructure base to factually understand what is required to deliver 5 year commissioning plans.

Programme 7- Public Empowerment- We will devise a plan to empower more of our local population to take greater responsibility for their own healthcare. We will devise a plan to ensure triangulation and organisation of patient views to foster change in primary care.

Shropshire & Staffordshire Area Team (SSAT) Area Team – Primary Care Direct Commissioning Plan on a Page 14/15 – 15/16

This plan represents a summary of the Area Team's strategic vision for Directly Commissioned Primary Care Services for the 2 year planning period, 14/15 – 15/16. The Area Team commits to ensuring consistently high quality holistic care in the wider primary care system which is more accessible, proactive and coordinated.

Objective One
To continuously improve quality of Primary Care services through systematic review and ensure the reduction in unwarranted variation in quality of primary care services

Objective Two
Ensure business continuity through PCS transition

Objective Three
To work in partnership to redesign primary care services to ensure delivery at scale

Objective Four
Access to the highest quality urgent and emergency care

Objective Five
To support changes to the primary care system to deliver prevention and early intervention

Objective Six
Commission sustainable services in a time of economic restraint that are effective and efficient.

Delivered through effective performance management & joint working with CCG's
Continual use of national tools and local performance frameworks to identify those primary care providers who could offer better services to patients. Responding effectively to unacceptably low quality of care and enabling new providers to offer their services to the public.

Delivered through project management and engaging and supporting colleagues through change
Current planning for change is based on recommended single site/service model and will require support to ensure all independent contractors receive satisfactory service through transition.

Delivered through co-commissioning of primary care services and partnership working
We will work with CCGs to develop a joint, collaborative approach to commissioning general practice services, with a stronger focus on local clinical leadership and allowing more optimal decisions about the balance of investment across primary, community and hospital services. This will be programme managed by the Primary Care Joint Commissioning Board to ensure pace and scale of change.

Delivered through joint & partnership working
In partnership with the CCGs, LAs, PH and other stakeholders ensure service development initiatives will drive existing services to better support urgent care management both in and out of hours. This will link to the work being delivered though the Better Care Fund. Supporting a shift of resources towards general practice and 'wrap around' community services. Enabling patients and carers to play a more active role in their own health and care, involving local communities in shaping services, giving people greater choice over the general practice they register with and transforming patient access to GP services.

Delivered through continuous monitoring and effective system management
Commissioning affordable services that provide better outcomes for patients as well as value for money. Ensuring that QIPPS are managed and delivered.

Overseen through the following arrangements

- **Formal Primary Care Joint Commissioning Board to include Area Team, CCG and Local Authority membership to deliver transitional and transformational change.**
- Primary Care Quality Group
- Quality Surveillance Group
- Intensive Support Team (IST) for Primary Care
- Financial review through Area Team Senior Management Team supported by QIPP Programme Board
- Deployment of the Single Assurance Framework
- Implementation of Area Team GP Intensive Support Scheme

Sustainability

Workforce –Work in collaboration with CCG's, LETC and HEE to ensure there are sufficient training places and identify skills required of post graduate training. Implementation of local retention/return to practice schemes, work with CCG's to attract GP's to the area and remain.
Premises – work with NHS PS to deliver the best use of the premises available and ensure new schemes will support meeting strategy objectives.
Communication – work with the patients and public to design new services understand how to benefit from them and ensure that changes are communicated and explained to patients.

Key measures

- A greater number of providers performing in the upper quartile across a range of clinically relevant metrics.
- Proactive coordination and personalisation of care
- Promoting health & wellbeing
- Ensuring fast, responsive access to care
- Ensuring consistently high quality and value of care.

Detailed General Practice Objectives 2014/15

Improvement Area	Domain	Success Looks Like	Within AT Control?	External Inputs	Enabling Projects	Risks
Primary Care Strategy	**Strategy**	An effective strategy fits with the needs of the people of Shropshire and Staffordshire. A strategy that is executable and drives decision making in day to commissioning activity.	YES whilst there is a national strategic framework . It is locally determined	NHS England National Strategic Framework 8 CCG and 4 HWB commissioning 5 year strategic plans	Regional PC Transformation Programme Joint Primary Care Commissioning Board Delivery of 2014/15 Contract changes	Currently not using loca patient groups and qualitative information a systematic way to inform strategy formulation
Contractual Delivery Gateway ref 00698	**Efficiency**	AT Implementation of GMS contract for 2014/15 which will support our emerging strategic objectives for primary care	Partially	National guidance	Consistent Approach Regionally	Financial consequence of contract changes ne to be explicated at AT level
GP Recruitment	**Access**	To move GP to Patient Ratio in line with national average.	Partially	Ability to use 2.5% NR monies to pump prime at scale recruitment and retention schemes.	CCG Support, HEWM Support, LMC	Lack of local flexibility. Practices resources
Patient Satisfaction	**Acess/Quality**	To achieve 2014/15 UNIFY trajectories for patient satisfaction	Partially	National Patient Survey	we require a high level of knowledge management with additional analytical input and expertise. 2013/14 QOF retirement LES requires practices to submit further details about demand and supply	Currently not using patient groups and qualitative information a systematic way to improve patient satisfaction
Unwarranted Clinical Variation	**Quality**	Reduction from 5% to 2% of practices in the S&S AT footprint that have 5 or more negative outliers in the primary care webtool	YES	Primary Care Webtool, CCG Datasets, PHE Datasets	CCG soft intelligence reports, CCG primary care data and PHE primary care profiles. Agreement with CCGs on practices for targetted agonist action Primary Support team Deployment	Suspension of Primary Care Webtool.
PMS Reviews	**Efficiency**	Continuation and expansion of PMS reviews in line with Gateway reference	YES	National Framework yet to be developed	Consistent Approach Regionally LMC and Practice Engagement	
APMS Procurement	**Efficiency**	Implementation of the AT/CCG APMS algorithm for the 12 APMS practices in the AT footprint that will require reprocurement (2014-16)	CCG/AT	National Framework yet to be developed	Sustained work with CCGs to ensure AT procurement plans are consistent with wider local commissioning priorities	Team capacity Election Year political reticence to decommission services Procurement support
Improving Access (transactional)	**Access**	To have only 5% of practices with half day closing once a week	YES	Regional and national picture of the status quo would be useful	Regionally to agree core data sets required for effective performance management of access with providers?	
Improving Access (transformational)	**Access**	7 Day Access	Partially	National Guidance	Learning from PM Challenge fund process	Funding
QIPP Delivery	**Efficiency**	To achieve a DC QiPP of 2.5%	YES	NHS England DC Business Rules 2014/15-2015/16	Allocation issues to be resolved to understand scale of challenge	

Pharmacy Objectives

DRAFT Primary Care Pharmacy Strategic Plan 2014-16

To commission high quality, patient centred services which focus on delivering improved clinical outcomes through medicines optimisation, reducing health inequalities and safety risks associated with medicines.

System Priority Objectives

1. Underpin the pharmacy strategy with the views of patients, the public, commissioners and providers
2. Utilise available technologies to gain assurance on the quality of services commissioned
3. Utilise the LPN to engage with local clinicians to help develop improved services contributing to better outcomes
4. Better integration of pharmacy within the health economy to allow first port of call for self care and expert advice on med
5. Develop robust mechanisms to allow pharmacists to contribute to and manage long term conditions to help capacity
6. Develop and improve communication mechanisms across interface to reduce medication errors and improve safety
7. Utilise the pharmaceutical needs assessment to inform local commissioning decisions

Governance – Primary Care Quality Committee, LPN, LPC, Pharm. Contracts Committee

Operational Plan 2014/15

- Ensure the Pharmacy Call for Action themes and feedback are used to develop the two and five year strategy
- Implement the NHS England's proposed IT solution for managing and monitoring the Pharmacy Assurance Framework
- Finalise and agree service priorities into signed off business cases for implementation and monitor outcomes
- Take forward workstream initiatives developed by the Pharmacy LPN to help deliver local priorities
- Utilisation of community pharmacy to help improve flu vaccination uptake rates
- Evaluation of the Minor Ailment Scheme & Emergency Supply and commissioning if outcomes are favourable
- Findings of the Pharmaceutical Needs Assessment to be utilised in future commissioning decisions
- Develop an outline strategy for health promotion in pharmacy based on existing best practice
- Review historical commissioning of enhanced services to improve outcomes within the context of available resources
- Develop an integration pathway for community pharmacy to deliver services around long term conditions and medicines optimisation

Operational Plan 2015/16

- Monitor outcomes from newly commissioned services to identify areas of efficiencies or under performance
- Targeted Medicines Use Reviews in certain priority therapeutic areas in consultation with local CCGs
- Implement pathways allowing greater integration of community pharmacy with other providers such as GPs, hospitals, community clinics such to deliver improved management of long term conditions and medicines optimisation
- Working with CCGs and hospital providers to implement safer systems of communication across the primary /secondary care interface to reduce medicine errors and improve patient safety around medicines.
- Implement a clear programme of work to maximise public health campaigns and working with Public Health utilise Healthy Living Pharmacies to deliver improved outcomes
- Working with the LPN and LETBs support the training needs of the community pharmacy workforce

Measuring success

-5 Year Strategy in place - 100% pharmacies visited within 3 years – up to date/ robust IT data for CPAF – Improved flu vaccination by at least 5% - Pharmacy becomes first port of call for Minor Ailments - Improved uptake and delivery of NMS via Refer to Pharmacy Scheme - Demonstrable impact on crisis aversion for mental health patients – Improved clinical outcomes for patients utilising inhalers - 10% Reduction in pharmaceutical waste and improved patient outcomes by targeted MURs – Improved patient satisfaction with service and improved range of services – 10% Increase in patients utilising Healthy Living Pharmacy for advice – 10% reduction in number of medicine errors – Commissioned Pharmacy Service to manage/support at least one long term condition – Implementation of IT systems sharing information – Electronic Summary Care Records - Standard Accreditation

Dental Objectives

Operational Milestones for 2014/15

- Compliance with NHS England Dental Assurance Framework.
- Established programme of contractual visits.
- Undertake equilibrium analysis to understand demand and capacity for secondary dental care on a factual basis.
- Ascertain case mix in secondary care oral surgery and ascertain level of coding compliance.
- Complete orthodontic needs assessment and develop an action plan to address recommendations.
- Systematic quality assurance process for primary care orthodontics established to support DAF for orthodontics.
- Work with key partners and stakeholders to ensure sustainability of hospital led orthodontic services.
- Complete vulnerable adults oral health needs assessment in Stoke on Trent and consider whether to replicate across the Area Team geography.
- Identify potential providers to develop the preventative role of dental nurses in Shropshire.
- A fully established LPN seen as an integrated part of the wider commissioning system.
- Ensure local stakeholder involvement in the national Call to Action exercise.
- Ensure that access to out of hour's urgent dental care is equitable.
- Develop a system-wide approach to patient safety in dentistry by ensuring systems and processes are in place between Area Team directorates to ensure appropriate and relevant information sharing.

3.2 Operational Milestones for 2015/16

- PDS Orthodontic service procurement.
- Implementation of national care pathways when published.
- Prepare primary care providers for the dental contract reform process.
- Quantify the need for secondary care dental services not currently adequately provided within the Area Team geography
- Establish mechanisms to ensure that the commissioning of community prevention and primary care dental services are coordinated between NHS England and Local Authorities.

OPTOMETRY OBJECTIVES

- Improving Optometry and Eye Health, A Call to Action, is due to be produced in May 2014, which will provide feedback from the key eye health stakeholders and the findings will help to formulate the local strategy around eye health.

- Embed the Eye Health Local Professional network at the heart of the Area Team, enabling clinical leadership and patient participation to drive our plans

- To complete an Area Team eye care needs assessment, in conjunction with the local EHNA, to understand what the hotspots are around eye care in the area and to develop an action plan.

- Primary Eye care practitioners could be used to deliver far more community services, enabling the secondary eye care practitioners to see the patients with more serious conditions that need to be treated within the hospital environment. The Eye Health LPN will work with the Area Team, CCGs, LAs, the voluntary sector and patient representatives to ensure that the appropriate pathways are developed and services commissioned.

- To focus upon vulnerable groups and identify ways to increase the uptake of sight tests.

- Compliance with NHS England primary eye care assurance mechanism

- To commence a review to understand the levels of Age-related Macular Degeneration (AMD), Glaucoma, & Diabetic Retinopathy that cause avoidable sight loss. Preventable sight loss is now part of the Public Health Outcomes Framework, and links in with other wider Public Health Strategies, including smoking, obesity and diabetes.

There are strong links between sight loss and dementia, depression and falls, and so Eye Health is definitely part of the wider Health and Social Care agenda, and eye health promotion is of paramount importance in order to prevent avoidable sight loss. The Eye Health LPN will support the Area Team, alongside Public Health to promote the value of eye examinations.

	HEALTH AND JUSTICE COMMISSIONING		
	National and Local Priorities 2014-16	**Expected Outcomes**	**End State Ambition**
General Prison Healthcare	• Procurement strategy implemented to embed prime provider model. • Long term condition services NSF audit across all 12 prisons. • Learning disability annual health checks. • Section 117 aftercare plan. • Prison inpatient model and pathways. • Access to specialist mental health services.	• Implementation of the prime provider model and standard contracts. • Compliance against NSFs assessed and improvement plan implemented. • Assessment of annual health check implementation completed and improvement plan implemented. • Continued achievement of section 117 aftercare plan target. • Prison inpatient demand and capacity assessed, service model proposal developed and negotiated with providers and NOMS. • Pathways into specialist mental health services defined and supported through clear commissioning arrangements.	• Integrated services operating under a single contracting structure. • All prisoners with long term conditions receive care to the standards required within the NSF. • All prisoners with an identified learning disability receive an annual health check. • All prisoner returning from a mental health act inpatient stay are accompanied by a section 117 aftercare plan. • Clear West Midlands inpatient model, capacity and pathways in place. • Prisoners are able to assess specialist mental health services on a needs led basis.

Secondary Care (prisons)	• Accurate prisoner secondary care data routinely received. • Redesign of secondary care pathways. • Capacity constraint identified with NOMS.	• Waiting times performance and prisoner activity understood and informing service delivery and underpins secondary care redesign activities. • Capacity constraints recognised by NOMS and NHS England, remedial actions and long term national strategy agreed.	• Assurance that prisoner access to secondary care services is in line with national expectations. • Increased healthcare delivered within the prison. • Prisoner escort capacity constraints do not restrict access to secondary care services.
Public Health Section 7a (prisons)	• Performance against national targets on Hep B, Hep C and TB (Xray)	• Services deliver the public health targets within the section 7a agreement, with improvement plans and support provided where action required.	• Prisoners access public health services which meet national standards and expectations and which support prevention and improve health
Sexual Assault Services	• Regional paediatric support for SARCS. • Consistent SARC service provision.	• Paediatric services commissioned which meet expected national standards. • Local SARC services reflect the emerging NHS England single operating model for SARCS.	• Children have appropriate access to paediatric services following a sexual assault. • Equity of service provision is available across the West Midlands.
Liaison & Diversion	• Trial site development. • Revolving door offenders project.	• Selected trial sites are supported. Other local projects continue to develop ready for possible trial site selection including schemes to support the 2 new super custody blocks. • Targeted work undertaken to	• The new national liaison and diversion service model is rolled out across the West Midlands in line with the national project timetable. • Frequent attendees in

		identify and proactively work with the top 100 offenders.	police custody are targeted for healthcare engagement, supporting reduced reoffending.
Police Custody	• Transition of commissioning responsibility to NHS England. • Pathways into community services	• Police healthcare contracts transferred to NHS England. • Pathways agreed and developed which support access to community services from police custody	• NHS England ownership and delivery of commissioning responsibilities. • Patients supported to access community services where a need identified in police custody
Patient and Family/Carer Engagement	• Commissioner developed patient and carer engagement systems.	• Patient and family engagement mechanisms are utilised by commissioners across health and justice settings	• Commissioners have a range of mechanisms to ensure patient and carer views are reflected in the commissioning and development of services.

Public Health Commissioning

Immunisations programmes	Screening programmes
• Immunisation programmes • Neonatal Hepatitis B • Pertussis pregnant women • Neonatal BCG • Respiratory syncytial virus (RSV) • Diphtheria, tetanus, poliomyelitis, pertussis and Hib • Rotavirus • Meningitis C (MenC) • Hib/MenC • Pneumococcal • DTaP/IPV and dTaP/IPV • Measles, mumps and rubella (MMR) • Human papillomavirus (HPV) • Td/IPV (teenage booster) • Seasonal influenza • Seasonal influenza immunisation programme for children • Shingles	• NHS Infectious Diseases in Pregnancy • NHS Down's Syndrome Screening (Trisomy 21) • NHS Foetal Anomaly • NHS Sickle Cell and Thalassemia • NHS Newborn Blood Spot • Newborn Hearing • NHS Newborn and Infant Physical Examination • NHS Diabetic Eye Screening • NHS Abdominal Aortic Aneurysm • Breast • Cervical • Bowel Cancer

Other responsibilities:

- Healthy Child Programme and Health Visiting (universal offer) (from pregnancy to age 5)
- Family Nurse Partnership (nationally supported targeted offer)
- Child Health Information Systems
- Public health services for people in prison and other places of detention, including those held in the Young People's Secure Estate
- Sexual assault referral services
- New developments for 14/15
- Men C University / further education entrants
- Bowel scope

Shropshire and Staffordshire Area Team and Public Health England Screening and Immunisations team are working in partnership with local authorities, providers and clinical commissioning groups to improve the public health and well-being of our population now and for future generations by delivering the S7a public health agreement and commissioning universal and targeted, high quality, value for money services (14/15 – 15/16)

System Objective One
Deliver the requirements of S7a agreement in line with best practice.

System Objective Two
Commission breast age expansion for the South Staffordshire and Shropshire programmes

System Objective Three
Reduce health inequalities across commissioned programmes by improving uptake across commissioned programmes

System Objective Four
Reduce premature mortality by improving uptake across commissioned programmes

System Objective Five
Ensure people have a positive experience of care

System Objective Six
Reduce variation across programme performance and strive for continuous improvement.

Delivered through effective commissioning and service development

- Commission value for money services as required in S7a.
- Undertake service specification gap analysis and develop action plans to address gaps (July 2014)
- Monitor programme performance (KPIs and standards) and address issues
- Deliver HV and FNP fte requirements (March 2015)
- Work in partnership with LAs to ensure safe transition of HCP to Local Authorities (October 2015.)
- Implement action plan for delivery of age expansion(April 2014)
- Develop a strategy for the CHIS across the Area Team in line with national requirements. (xxxx)
- Commission school age based community immunisations service (September 2014)
- Commission childhood flu programme
- Commission high risk breast screening in line with national requirements (December 2015)
- Develop CQUIN to incentivise providers to understand health inequalities within and across programmes and work with CCG / LAs to develop plans to address (April 2014)
- Work with Quality team and primary care on GP practice visits to improve vaccination and screening rates (April 2014)

Delivered through patient / public engagement

- Develop processes to systematically engage with patients / public on commissioning of services and to obtain patient experience feedback to inform commissioning (June 2014)
- Raise public awareness of programmes plan (May 2014)

Delivered through continuous improvement

- Share best practice with providers to reduce variation in performance and sustainably achieve highest practicable performance across all programmes (2016)

Measured using the following success criteria

- Number of FTE HV and FNP recruited to deliver HCP requirements (14/15 – HV 11.18 fte)14/15 FNP 150 families)
- Maintenance of / continuous improvement towards 95% population vaccination coverage rates
- Breast age expansion implemented
- Family history screening implemented
- Continuous improvements in uptake rates of screening programmes.
- Sustainable delivery of KPIs to highest standards
- Delivery of financial balance

Overseen through the following governance arrangements

- Systematic application of robust financial and contract management monitoring and review
- Regular monitoring of programme delivery through programme boards.
- Quarterly assurance reports to Local Authorities
- Area Team Quality Surveillance and Intelligence sharing meetings and risk register
- Area Team Clinical Team GP practice visits
- LA and CCG Children's Commissioning Boards
- Monthly finance meetings (inc. QIPP)
- Monthly programme management meetings
- QA monitoring and peer review visits

System values and principles

- High quality care for all, now and for future generations
- We prioritise patients in every decision we take
- We listen and learn
- We are evidence based
- We work in collaboration with partners to achieve best outcomes to
- Respect, consent, dignity and confidentiality
- Commission value for money services

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

NHS FUTURE FIT PROGRAMME REPORT

REPORT OF DAVID EVANS, CHIEF OFFICER, TELFORD & WREKIN CLINICAL COMMISSIONING GROUP

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The attached report seeks to provide an update on the current progress and forward plans of the NHS FutureFit Programme.

Appended to the report are the Programme's Case for Change, its Principles for Joint Working and its Interim Clinical Report.

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

The Board is invited to:
a) Endorse the Programme's Case for Change;
b) Endorse the Programme's Principles for Joint Working;
c) Note the current progress made by the Programme, and its future plans;
d) Note the Interim Clinical Report (including the extent of its alignment with the Council's Health and Wellbeing Strategy); and
e) Consider how alignment between the Programme's Clinical Model and the Health and Wellbeing Strategy might best be demonstrated.

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

The Programme is focused on acute and community hospital services in Shropshire and Telford & Wrekin. It involves all communities who use those services, particularly across Shropshire, Telford & Wrekin and mid Wales. The aim is to develop a clear vision for excellent and sustainable acute and community hospitals – safe, accessible, offering the best clinical outcomes, attracting and developing skilled and experienced staff, providing rapid access to expert clinicians, working closely with community services, focused on those specialist services that can only be provided in hospital.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	No	Please refer to attached report.
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	No	Please refer to attached report.
	Will the proposals impact on specific groups of people?	
	No	Please refer to attached report.
TARGET COMPLETION/DELIVERY DATE	Please refer to attached report.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes/No	Please refer to attached report.
LEGAL ISSUES	Yes/No	Please refer to attached report.
EQUALITY & DIVERSITY	Yes/No	Please refer to attached report.
IMPACT ON SPECIFIC WARDS	Yes/No	Please refer to attached report.
PATIENTS & PUBLIC ENGAGEMENT	Yes/No	Please refer to attached report.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes/No	Please refer to attached report.

PART B) – ADDITIONAL INFORMATION

Please refer to the attached report: "Programme Update Report".

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Programme Update Report

Report to:	**Telford & Wrekin Council Health & Wellbeing Board**
Subject:	**Programme Update Report**
Report by:	**Joint Senior Responsible Officer – David Evans**
Date:	**14th May 2014**

1 PROGRAMME PROGESS

1.1 Programme Plan

1.1.1 Phase 1 - Programme Set-up & High-Level Vision

Phase 1 of the Programme has now been completed. Following the approval of the Programme Execution Plan (PEP) at the January 2014 Programme Board, the PEP has since been received by sponsor Boards as follows:

- Shrewsbury & Telford Hospital NHS Trust – approved 30th January 2014;
- Shropshire Community Health NHS Trust – approved 20th March 2014;
- Shropshire CCG – approved 12th February 2014;
- Telford and Wrekin CCG – approved 11th March 2014, and;
- Powys LHB – to be confirmed.

Key elements of the PEP are the positive Case for Change (Attachment A) and the Programme's Principles for Joint Working (Attachment B). **The Board is invited formally to endorse these key documents**.

The work of the Programme is overseen by a multi-stakeholder Board (containing the two local Directors of Adult Social Care and observed by a Joint HOSC Chair) and is managed by a Programme Team. In addition, a core group of Programme Sponsors is being formed to improve the speed and pace at which the Programme can operate.

Under the Programme Team the detailed work of the Programme is conducted by the following five workstreams:

- Clinical Design;
- Activity & Capacity;
- Engagement & Communications;
- Finance, and;
- Assurance (attended by HOSC Officers and a Joint HOSC Chair).

1.1.2 Phase 2 - Development of Models of Care

The key task in Phase 2 of the Programme is to further develop the high level clinical models and to build activity and capacity projections which reflect those models. This will then enable a range of options to be identified in Phase 3.

The clinical work completed in Phase 1 is far more ambitious and wide ranging than had been anticipated. It is greatly to the credit of local clinicians that they have devoted such time and energy to leading the design process. There have been major concerns that a clinical design that focuses simply on hospitals will not be radical enough to deliver a sustainable solution. Thus the notion of painting the full canvas has emerged, out of which the FutureFit Programme will take forward the elements within its scope and, in relation to elements outside of its scope, will define the critical dependencies to be taken forward in parallel by commissioners.

A report on the emerging clinical models is appended to this report (Attachment C) and the Board is invited to note the work to date.

Further extensive work to test and develop these models is underway leading to a meeting of the Programme's Clinical Reference Group on May 28th to which some 200 local clinicians have been invited (all of whom have been contributing to the design work). This work includes:

- Iterative testing of the model against specific patient/clinical scenarios and cross-cutting themes (e.g. Mental Health, Social Care, IT);
- Further defining the evidence base for the proposed model;
- Demonstrating alignment with JSNAs and Health and Wellbeing Board strategies;
- Increased patient and public engagement, and;
- External Clinical Assurance through the West Midlands Clinical Senate.

To do justice to the emerging models, and to maintain and extend the engagement we have had to date, will require several more months of work. Without this there is the risk of moving too quickly towards a decision that will not stand up to subsequent scrutiny and, indeed, will not finally deliver the radical change that local patients and clinicians believe to be necessary. It is extremely important that we get the process right. This is truly a once-in-a-generation opportunity.

The Future Fit process is one of genuine discovery. Nothing has been predetermined so, in order to produce for our patients a clinical model that is fully owned and understood (and that we are confident can be delivered), it will be essential to work through the emerging models in detail and to test them through several iterations, facilitated by extensive engagement with the public and with clinicians. The new timeline includes a major extended public engagement in October/November 2014.

2 FURTHER STAGES

2.1.1 Phase 3 - Option Development & Appraisal

The purpose of Phase 3 is to develop and appraise a range of options for how the clinical model could be delivered, leading to the identification of a preferred option.

2.1.2 Phase 4 – Outline Business Case & Public Consultation

Following the appraisal of options an Outline Business Case will begin to be constructed in parallel with formal Public Consultation on the proposed solution.

3 ALIGNMENT WITH HEALTH AND WELLBEING BOARD PLANS

Guidance from NHS England - *Planning and delivering service changes for patients* (NHSE 2013) – states that:

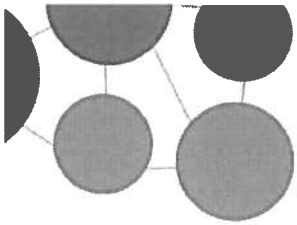
Local authorities are essential stakeholders in the reconfiguration process, both through the local authority health scrutiny functions, but also the joint and integrated working between the NHS and local government through health and wellbeing boards.

It is good practice that NHS commissioners work proactively with health and wellbeing boards, so that service change proposals can reflect joint strategic needs assessments and joint health and wellbeing strategies.

The Programme invites the Board to consider how best to achieve this and to demonstrate alignment between the Programme's Clinical Model and the Council's Health and Wellbeing Strategy.

David Evans

Joint Senior Responsible Officer



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Attachment A
Case for Change

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The Case for Change

Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

This then is the positive case for change.....

.....the opportunity to improve the quality of care we provide to our changing population.

The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

Changes in our population profile - The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

Changing patterns of illness - Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

Higher expectations - Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

Clinical standards and developments in medical technology - Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

Economic challenges - The NHS budget has grown year on year for the first 60 years of its life .....in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy and the UK economy within that is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

Opportunity costs in quality of service - In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

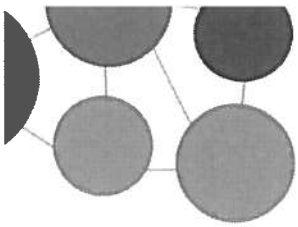
Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities - In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

Call to Action

In November 2013 we ran a major consultation exercise with public and clinicians under the national Call to Action for the NHS. The response was very clear in saying that the public wanted full engagement in thinking through options for the future and that nothing should be predetermined. Nevertheless, in the light of the factors described above, there was real consensus between public and clinicians about the following:

- An acceptance of there being a case for making significant change;
- A belief that this should be clinically-led and with extensive public involvement;
- A belief that there were real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;
- An agreement that hospitals are currently misused. This is not deliberate but as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives;
- A belief that it is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of the rural and urban populations of this geography - but if we are to succeed we must avoid being constrained by history, habit and politics.



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Attachment B
Principles for Joint Working

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Our 'Moral Compass' - Principles for Joint Working

Given the 'Case for Change' and the goals and objectives of the Programme, it is recognised by all parties that complex and difficult decisions lie ahead if this Programme is to succeed in delivering the improvements to care and to health that we seek for the populations we serve. There are several potential trade-offs which cannot be avoided. In every one of these there will be a balance to be found, but one which can never satisfy every individual interest:

- The 'common good' (for all who look to services in this geography for their health care) versus the individual or locally specific good (the preferences of sub groups);
- The present versus the future;
- Organisational interest versus public interest;
- One priority versus another when resources are limited.

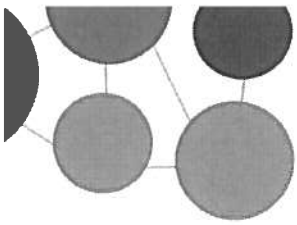
It is the role of leaders to reach decisions on these, and to do so transparently and objectively.

The Programme is a collective endeavour because all who are party to it - sponsors and participants - recognise that this is the only way that the scale of the challenge and opportunity for this whole geography can be met. But working collectively, whilst still acting as separate statutory organisations, requires agreement on what we have called a 'Moral Compass' - ways of working designed to help navigate through when it gets difficult and when the 'trade-offs' have to be decided jointly.

We have agreed the following principles for our Programme - we will hold ourselves to account against them, and would ask others to do the same:

- We are concerned with the interests of all of the populations in England and Wales who use hospital services provided within the territories of Shropshire and Telford and Wrekin. We desire to maximise benefit for that whole population. Whilst our decisions seek to deliver the greatest benefit to the whole population we serve, we will always consider the consequences of any options for either specific local populations or for the needs of minority and deprived groups and will be explicit about how we weight these and our rationale for so doing.
- Participant organisations will individually sign up to the single version of the Case for Change and, at the appropriate point, to a single shared strategic vision and high level clinical model that arises out of the Programme and its response to the Call to Action and other engagement processes. This will be in addition to the collective sign-up represented by the Programme Board agreeing the Programme Execution Plan.
- The Programme will agree, in advance of its key decision–making on the selection of options, an objective set of criteria that will be employed, and these will also be signed-up to by individual constituent organisations at that stage. These will explicitly address the basis for considering the trade-offs referenced earlier.
- We will make shared decisions on which innovations to roll out at scale, recognising that any one might not always favour all parties and that some sacrifice for the common good will be necessary.

- We will openly consider all options that can enhance our ability to reach collective decisions on key issues, including governance arrangements which are designed to bind our respective boards together.
- We will work collectively with our stakeholders, including politicians, to invite agreement from them to the case for change, the clinically –led model and the principles for decision making.
- We recognise that we will need to find ways that can meet our programme objectives within current levels of overall expenditure. We cannot add costs, instead we need to redistribute resources to achieve a better overall outcome for the populations we serve.
- We will ensure that we develop a shared financial model so that any plans or changes can be assessed on whether they deliver authentic economic benefit i.e. we will not plan to deliver savings in one part of our system if the inevitable consequence is (unplanned) cost increases in another.
- We will develop ways to share the financial risk when implementing major change...we recognise that national payment formulae may not support what we are agreeing to do and we will adjust for that where appropriate.
- We will share all information necessary to allow the Programme to deliver our objectives and will do so in line with the laws and guidance on Information Governance.
- We will share organisational plans and be transparent re budgets.
- We will deliver our individual contributions to the work of the Programme to the highest quality possible and on-time.
- We will all use a single version of documents pertaining to the Programme and these will be prepared for us by the Programme Office. We will coordinate consideration of key documents so that we avoid the issues (of fact and perception) that can arise when key considerations or decisions are taken sequentially rather than simultaneously.
- We will work together to ensure that public and patient engagement in our Programme is extensive, timely and meaningful and that we engage in the formulation of options as well as in response to recommendations on them - we want this Programme to be characterised by co-production with patients and public.
- The response to Call to Action told us that the public, whilst wanting full engagement at all stages and no predetermination of outcomes, want and respect clinically-led development of strategies and options. We will ensure that this happens.
- Whilst partnership and collective working on the Programme is essential, so too at times will be the need for organisations to pursue their own objectives (e.g. in relation to competition amongst service providers). Where this is felt by any constituent to be the case, then we agree to making that explicit to our partners, to explain our position, and to work with the Programme to enable continued collective decision making to continue.
- The response to the Call to Action asked us to avoid being constrained by history, habit and politics and to look to do 'the right thing'. We will explain any decisions we make clearly and in that light.
- Being part of the CSR Programme represents a clear commitment, and we will take collective responsibility for making progress towards a shared vision for improved services and health.



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Attachment C
Emerging Clinical Models of Care

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Clinical Design Workstream

A Report of Output
November 2013 -March 2014

Contents

1. Introduction

The Clinical Design workstream was established in November 2013 and used the results from the patients' and clinicians' Call to Action survey and meetings as a starting point for its work. From this, it has established an approach to ensure that the future of hospital and community services is considered within the context of the whole system. It has embedded a process which maximises patient and clinician engagement and co-creation, and agreed that there is a compelling case for change. It has also considered the clinical and design principles applicable to the whole system and key components within it, examined the national and international evidence base and formulated high level models of care across the whole system which have undergone some initial testing.

The output up to this point, together with a summary of next steps, is described fully in the following report.

2. Scope of the Clinical Design workstream

The design of high quality, safe, efficient and sustainable hospital services must be done within the context of a coherent and deliverable whole system plan. So, although the scope of the FutureFit programme is confined to the future of acute and community hospital services, the clinical design work stream is required to consider the health and social economy as a whole and establish models of care which fully integrate all services within it. The success of FutureFit is likely to depend on achieving whole system transformational change. This has significant implications for commissioners as well as the organisations, services and workforce that currently lie beyond the scope of this programme.

3. Process

Following the Call to Action surveys and events, a Clinical Reference Group comprising 50 senior clinicians from health and social care, along with patient representatives, met on November 20th 2013 to receive the results, from which a case for change was established and whole system design principles were debated and agreed.

The Clinical Reference Group met again on January 29th 2014, during which it confirmed the output from the first meeting, suggested what success would look like and how to measure it and discussed the clinical and design principles applicable to the three main areas of health care delivery:

- Acute and Episodic Care;
- Long Term Conditions / Frailty, and;
- Planned Care.

Three subgroups were formed to consider these areas further; each subgroup comprising approximately 30 clinicians from health and social care along with patient representatives. They each met for six hours during February 2014 to add more detail to the design and clinical principles, to establish high level models of care in each area and to begin a process of sense checking, testing and refinement of the models.

The core Clinical Design workstream, reporting to the Programme Team, has planned and overseen this process and will remain responsible for the next steps described at the conclusion of this report.

4. The Case for Change

4.1 Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
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They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

This then is the positive case for change - the opportunity to improve the quality of care we provide to our changing population.

4.2 The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

4.2.1 Changes in our population profile

The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

4.2.2 Changing patterns of illness

Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

4.2.3 Higher expectations

Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

4.2.4 Clinical standards and developments in medical technology

Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult

to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

4.2.5 Economic challenges

The NHS budget has grown year on year for the first 60 years of its life .....in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy, and the UK economy within that, is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

4.2.6 Opportunity costs in quality of service

In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

4.2.7 Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities

In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

5. Acute and Episodic Care

5.1 Key Principles

5.1.1 Care close to home

An enhanced and integrated education and prevention programme, driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim, without which the sustainability and quality of services in the future will be seriously threatened. This is discussed further in the LTC section.

Easy access to understandable and trustworthy information about self care options and local services, combined with clear signposting to points of access appropriate for the level of urgent or emergency care required.

A single point of access for professionals to navigate patients to a wider range of integrated and community based services.

Urgent (not emergency) care delivered by expert community generalists as a default, with prompt access to specialist advice and opinion when required.

5.1 2 A needs led service

Patient access to urgent and emergency care should be dependant on the level of care they require. Quality, safety and achieving the best outcomes will come before choice. Services will be rationalised so they are more consistent in their quality and the services they offer. This will make it easier to effectively triage, signpost and brand to ensure more appropriate attendances at the right point of care, which should be the least intensive level required to fully meet every patient's needs in order to maximise efficiency and reduce iatrogenic harm.

5.1.3 Integrated care

Integrated care records are a necessary component of an integrated health and social care system and their development should be of the highest priority. Patients regard them as a reasonable proxy for continuity of care.

Agreed pathways of care should run seamlessly across the whole system and span whole patient journeys. They should be consistent across all localities, 7 days a week. Local variation due to rurality should not obstruct integration.

There should be smooth transitions between levels of care. Providers should define their transitions as carefully as their core business.

Holistic assessments should be the default in all care settings.

5.1.4 Care by experts

An early expert opinion should be available from senior clinicians in all settings. A principle of right care first time: 'triage – diagnose – treat / palliate' should be the default.

An education, training and workforce review will be required and new roles developed in order to provide expert opinions in all settings 7 days a week.

5.1.5 Consistent and consolidated services

A single high acuity emergency centre, providing expert specialist and generalist led services, will provide multiple clinical benefits. It will consolidate resources, improve teamwork and integration, improve quality and safety, allow more effective generalist support in lower acuity settings and provide an economy of scale and high volumes of care to maximise expertise and improve outcomes.

'Some' community based urgent care centres, staffed by expert generalists with easy access to specialist support, will provide services closer to home but at a sufficient scale to ensure consistent, effective and sustainable 'modular' services.

5.1.6 Sustainable systems

The 'critical mass' of urgent and emergency care delivered by one emergency centre and 'some' urgent care centres will enhance recruitment and retention of staff.

Continuous monitoring and learning should be embedded to allow service evolution and improvements and to develop predictive forward planning.

Commitment to this model of care should be long term.

5.2 Model of Care for Acute and Episodic Care

5.2.1 Patient Flows

An internet 'patient portal', available on all platforms, will provide easy, trustworthy and localised information regarding self help, advice and signposting. This will include and integrate health, social and voluntary sector information.

A 'Smart' Single point of telephone access (111) will intelligently triage all requests for urgent care (defined as requests for same day assessment) and signpost patients to the right point of care, including the capacity to make appointments at their GP practice if less urgent, or at one of the urgent care centres. This service will be linked to a live demand and capacity management system to improve patient flow.

As a default, LTC urgent care should be 'planned' as active case management will detect exacerbation at an early stage.

There will be increased signposting to local pharmacies for low level urgent care advice and treatment. Pharmacies will 'cluster' with GP practices and develop closer working relationships.

5.2.2 One Emergency Centre

A single, fully equipped and staffed high acuity emergency centre with consolidated technical and professional resources delivering high quality emergency medical care 24hrs 7 days a week. A combination of expert generalists (Acute physicians, COE consultants and new roles etc) and specialists (ED consultants and specialists) will provide early expert opinions at all times. It will serve as a trauma centre with a co-

located critical care unit. Other adjacencies include facilities for ambulatory care and assessment units with multi-disciplinary teams (including mental health) specifically dealing with patients suitable for 0 day length of stay (LOS) pathways (ambulatory care) and <3 day length of stay (LTC and frailty syndromes). There will be also be full and immediately accessible diagnostic facilities, blood bank and pharmacy.

Access will be via 999 ambulance or co-located urgent care centre.

A single emergency centre will improve safety and quality of care and focus resources to improve teamwork. Integration and consolidation of the workforce will promote better working practices both within the unit and in providing support to generalists in lower acuity settings. Improved trust and relationships across different care settings will be embedded through partnership care and rotating / posts, some in new roles designed to promote integrated care and whole system pathways.

5.2.3 'Some' Urgent Care Centres

Multiple units provided at 'cluster' GP practice level of 'modular' and consistent design to provide low and medium levels of urgent medical and care input. Some diagnostic facilities and a pharmacy will be available on site. Co-located with a range of mental health, community and voluntary sector services, GP Out of Hours, and in some centres medium acuity beds. Timely expert generalist opinion available 7 days. One Urgent Care Centre (UCC) will be co-located with the Emergency Centre and receive all the 'walk in' patients who will not be able to access the Emergency Centre unless transferred by a clinician from the UCC. Urgent Care Centres will be staffed by a combination of advanced practitioners and GPs from the 'cluster' of practices surrounding it. From a GP practice perspective, urgent care will be provided at cluster level, whilst LTC management and other non urgent work will remain at practice level. Continuity of care at urgent care centres will be achieved through integrated care records, whilst continuity of care for patients with LTCs will be through a named clinician or keyworker (in addition to integrated care records).

5.2.4 Partnership Care

Specialist support will be easily and quickly available to support generalists in lower acuity care settings, including urgent care centres. This will be in the context of the development of partnership care across all care settings with a re-definition of generalist and specialist roles to include a greater teaching and learning component to increase generic skills and improve the consistency of care. Communication between professionals will be frequent and direct (not via a third party) which will improve working relationships, feedback and learning. This model is described in more detail in the LTC section.

5.2.5 Professional Navigation

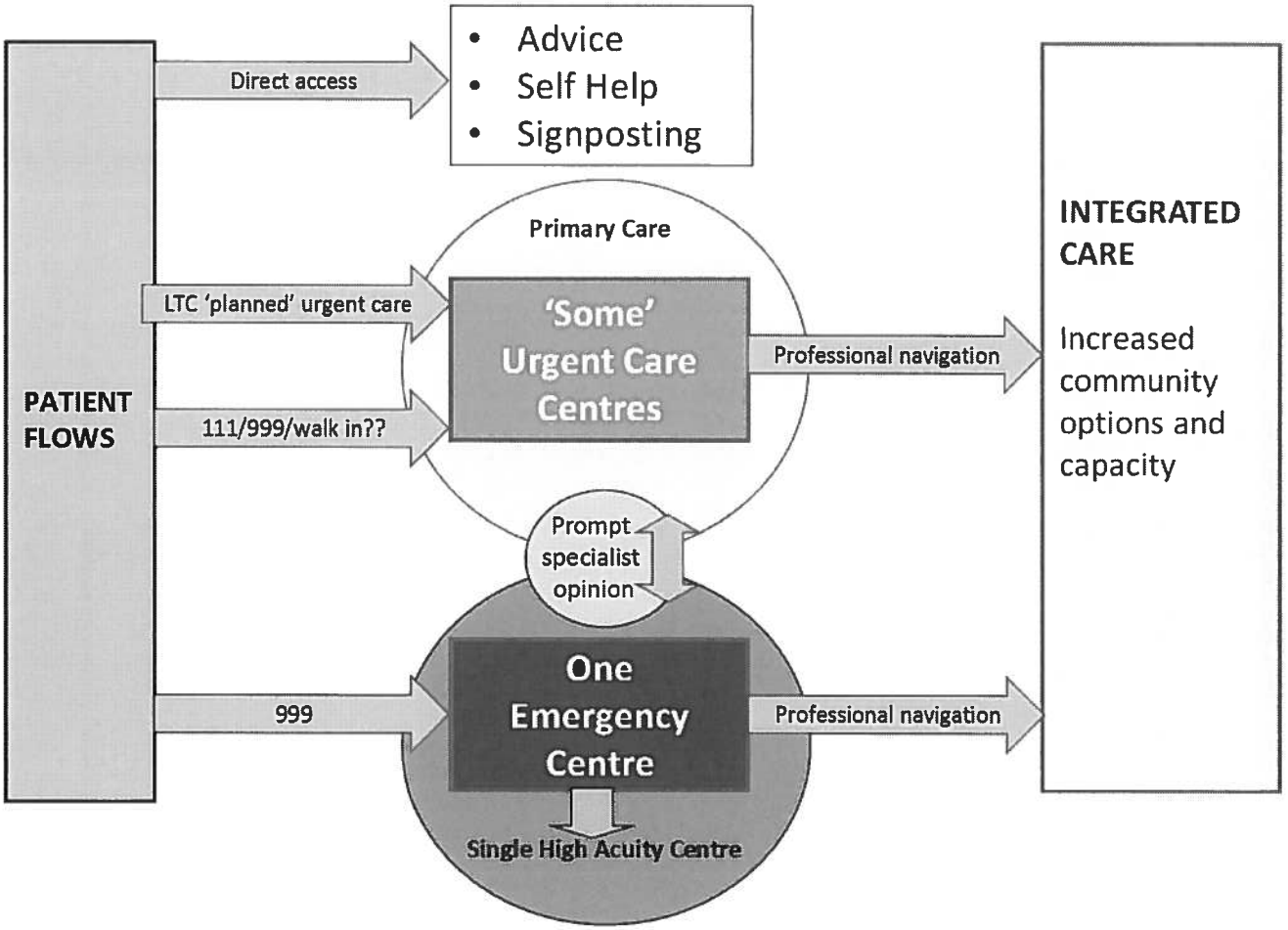
There will be a single point of access (SPA) for professionals to arrange further care and support for patients following their urgent or emergency care contact. This SPA will act as a portal to a wide range of community based integrated care options. For complex care issues, the SPA will initiate contact but care planning will then be finalised through direct conversation between professionals. For simple care issues,

a 'handover' will be managed through the SPA service with integrated care records serving as a valid proxy for continuity of care.

5.2.6 Integrated Community Care

Urgent and emergency care will be delivered in the context of whole system integration. Services will be provided by teams around the patient, not by a series of independent professionals working within their own organisations and professional boundaries. Community capacity will be built to keep people at home and out of hospital, deliver reablement in the community, enhance the role and involvement of primary care and consistently deliver the right care in the right place by the right staff. Access to these services will be available from all points of patient contact via the SPA. This is further discussed in the LTC section.

5.3 Diagrams of the Acute and Episodic model of care



'Some UCCs'

'One EC'

6. Long Term Conditions and Frailty

6.1 Key Principles

6.1.1 Enable patient responsibility for prevention, self care, maintenance and accessing appropriate care

Enabling patient responsibility should be embedded in all models of care. Although there is mixed evidence of short term impact on admissions and cost, there is an overwhelming case for empowering citizens and communities to be co-responsible for managing their lives and social environment, whatever their health status.

Many long term conditions are preventable and systematic secondary prevention shows improved outcomes. The medium and long term potential for reduction in health and social care demand is great.

Targeted prevention activities in social care have demonstrated impact although there is currently no statutory obligation for Local Authorities to invest in prevention.

Public Health and all other stakeholders must be involved and particular focus is required for hard to reach groups. The prevention agenda should form part of the school curriculum.

Behaviour change, education and support will often be more effective and sustainable if delivered by peers rather than professionals.

Self management of Long Term Conditions is at an early stage of development with little hard evidence as yet to support significant investment. It is the view of the clinicians locally however that it is aligned with the principles of citizen empowerment and community mobilisation as well as the emergence of assistive technology, self care should be a central component of LTC management.

People with co-morbidities and who are frail have less capacity for self management and require a different approach, especially when they are ill. Frailty syndromes are now recognised as an independent risk of worse outcomes and do not fit well into pathway driven care which the patient can be co-responsible for. They require a named key worker or responsible clinician with whom they can share decisions and who can act as their advocate. This is also the case for other vulnerable groups such as people with learning difficulties.

6.1.2 Generalist care as a default, with partnership care between generalists and specialists and clearly defined indications for specialist care

Generalists perform holistic assessments as a default and should be available in all care settings. Workforce planning and redesign will increase the number of generalists, many of whom will also develop specialist skills. This includes GPs, community health professionals and acute care clinicians. They will be responsible for initial assessment as well as the co-ordination and continuity of care for the majority of patients.

Specialists will offer timely response to support generalist care. They will assume greater responsibility for education and learning to improve the generic skills of generalists in all care settings. They will continue to be responsible for the care of the most complex patients.

Partnership care between generalists and specialists will become the norm with a more dynamic and greater range of options to share the care of patients through meaningful and direct conversation, interaction and information flow. This will allow the care of a greater proportion of patients to be managed by generalists in a community setting with targeted specialist input when required. Resources must shift to support this.

Partnership care will be developed across the whole health and social economy. The integrated health and social care of a patient will be provided 'in parallel' (not 'in series' as is currently the case) with shared risk management.

Better relationships will allow 'honest feedback' and more effective mutual and case based learning.

Age transitions, especially in mental health and paediatric care are currently a problem which will be resolved when continuity of care is managed by a community generalist working across all age groups.

Integrated care records are a key requirement for partnership care.

6.1.3 Provide a better match between needs and levels of care through a systematic shift towards greater care in the community

People prefer to be cared for in their own home whenever possible, even when they are ill.

Too much care is currently provided at levels of care which are higher than patients require to meet their needs. This is not only resource inefficient, but also increases the risk of iatrogenic harm. Up to 30% (?) of people admitted to acute hospitals could be managed safely and effectively in a different care setting and at a lower level of care.

Patients cared for at home remain connected to their family and carers. Community support remains continuous and the patient is less likely to 'decompensate' by being cared for in a bed based acute environment which is also much more stressful. Individualised care can be delivered more easily by integrated teams. The potentially difficult and harmful transitions from home to hospital and back again are removed. Performing an accurate and holistic assessment of needs is much more difficult when a patient is not in their usual living environment.

Home will not be the right place to care for everyone who is ill. Some of course require high levels of care in an acute hospital bed, but other alternatives must be provided that offer a 'medium' level of care.

Community capacity must be built to accommodate this shift. The required shift in resources to achieve this poses a challenge. It is not necessarily cheaper to provide care at home when intensive input is required.

6.1.4 Move from reactive to proactive care, including risk stratification, care planning, early detection and intervention and 'planned' urgent care

The evidence base supports the provision of proactive care for a number of specific conditions but does not yet show improved outcomes for people with multiple co-morbidities and frailty. Nevertheless, the new GP contract and local clinician consensus both support a move to providing more proactive care. Clinical experience strongly suggests that it reduces the number and severity of crises and gives reassurance to patients, families and carers that they know what to do and who to contact in the early stages of exacerbation.

There is uncertainty about what percentage of the 'at risk' population would benefit from active case management. It is important not to shift resources into ineffective interventions and targeted proactive care will remain preferable until the evidence base is clearer.

6.1.5 Provide timely response to exacerbation and ensure enhanced recovery and rapid reablement with a minimum time spent in acute care settings

Integrated multi-disciplinary teams are needed to address all the issues, both in community and acute settings and care must remain joined up at all times.

An exacerbation related to an existing LTC should not require admission, but may require diagnostics.

Once in hospital, the LTC tends to be ignored in preference to the exacerbation and the patient has an 'asymmetric' experience of their assessment and care because of this. Holistic assessment as a default will address this.

Discharge planning must start at the time of admission, and patients think this should be done by the ward staff caring for them, not a separate team. Provide Estimated Dates of Discharge for all patients soon after admission.

Standardise simple discharge processes and provide bespoke planning for complex discharges.

Employ strategic operational planning to maximise 0 day length of stay (ambulatory care and <3 day length of stay (frailty teams) in acute settings.

'Discharge to assess' as default once medical condition stabilised. Reablement at home where possible and in community setting if not. Aim to return patient to original level of care.

Resolve governance issues around free NHS and assessed social care which currently inhibit integrated care.

6.1.6 Diagnose and plan the last year of life and stop sending people to hospital to die.

Once fully embedded, End of Life (EOL) care will become part of 'the day job' but this will require care co-ordination and equity of care for all terminal conditions. EOL care is currently unstructured and patchily commissioned. To improve this, a consolidated EOL package will provide better care and reduce costs. A roving palliative care team would be effective and cost efficient.

6.2 Model of Care for LTC

6.2.1 Prevention

An economy wide prevention strategy driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim.

Targeted primary prevention across all health and social care settings employing 'make very contact count' and upskilling the workforce in behavioural and motivational change techniques.

Systematic secondary prevention.

6.2.2 Partnership Care

Primary care generalists (mainly GPs) retain continuing responsibility for care and co-ordination with rapid access to specialist support as required.

A menu of options to facilitate timely and personal communication between generalist and specialist to share decisions and improve care planning for patients at all levels of acuity: routine, urgent, emergency and end of life.

Clinical conversations, mutual learning and honest feedback will improve working relationships and the quality of care.

Direct access for generalists to pathway driven diagnostics to reduce unnecessary secondary care referrals.

Specialists will continue to manage and be responsible for the continuing care of a smaller number of the most complex patients, but with a greater responsibility for education and upskilling the generalist workforce.

6.2.3 Self Management and Care Planning

Upscale self management programmes and combine with care planning as a routine for anyone with an LTC.

Active case management for those at high risk, targeted initially to those conditions where benefit is evidenced.

Upscale peer and community support programmes

6.2.4 Integrated teams

Integrated multi-disciplinary teams providing case management, timely response to exacerbation and facilitating discharge.

Strong links with primary care, 'teams around the practice' aligned with 'teams around the patient'.

Specialist skills linked to and augmented by integration with acute care specialists.

Sustainability achieved through generic upskilling across professional boundaries, using individual specialist skills as the teaching resource.

Embed continuous learning and review within the teams to ensure maximum effect from integration

6.2.5 Increased Levels of Care

Timely and appropriate response to exacerbation through a 'tiered' increase in level of care:

- Low medical input provided by a 'hospital at home service' for minor exacerbations where short term additional care and rehabilitation at home allows the patient to continue living independently. With effective case management and early detection of exacerbation, this level of care will be appropriate for an increasing proportion of people with LTC exacerbations.

- Medium medical input provided in a community setting, but not in the patient's home. 'Step up' higher intensity care and rehabilitation can be combined with more frequent and expert medical input to hasten recovery with the aim of returning to the original level of care. Integration of care in these settings with care provided in acute settings will improve quality and flow.

- High medical input provided in a single high acuity unit with a consolidated and integrated workforce as described in the key principles.

6.2.6 Reablement and rehabilitation

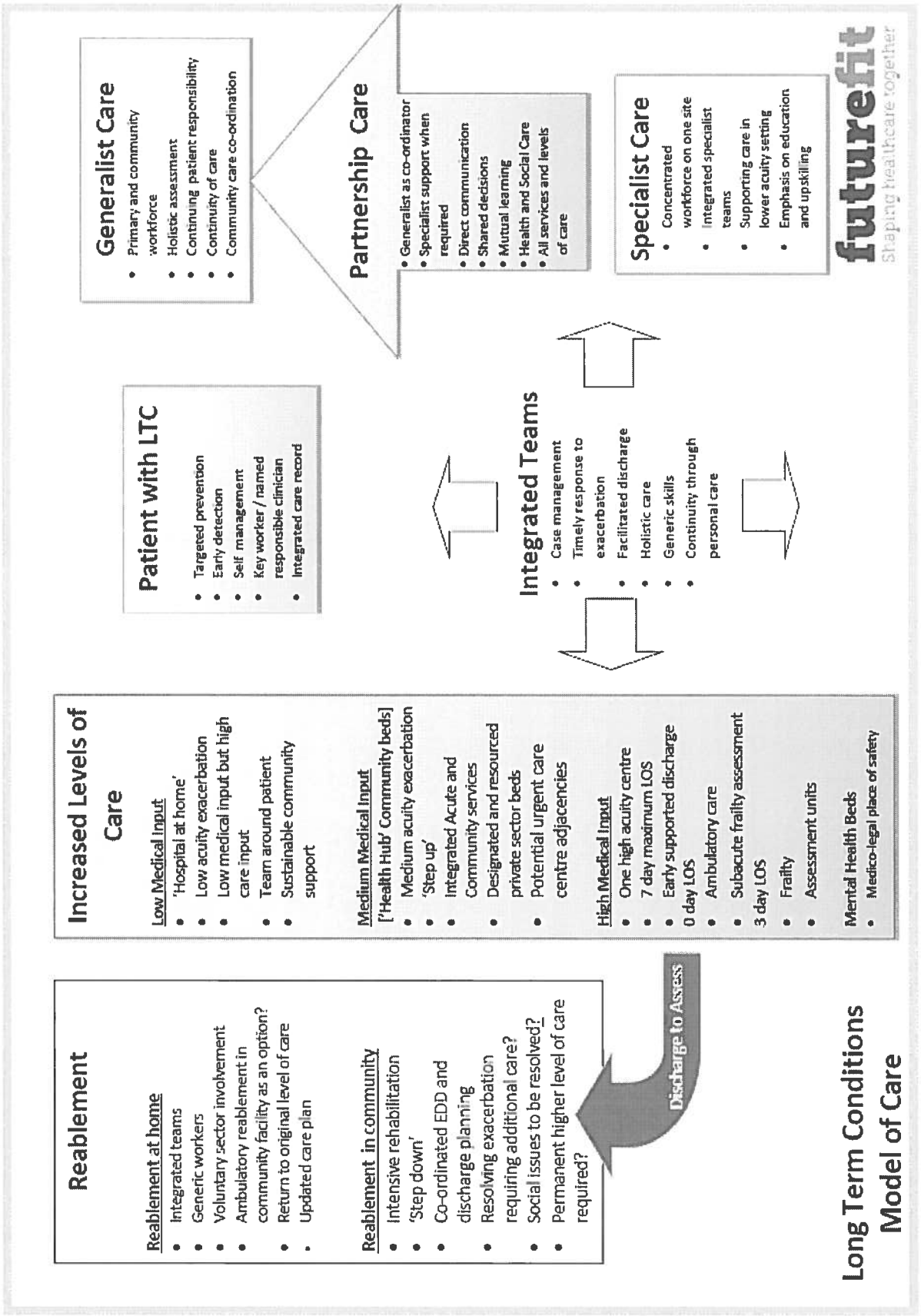
Discharge to assess as the default from acute care settings.

Reablement at home as the preferred option with the aim of a rapid return to the original level of care and the withdrawal of additional care and support.

Reablement in a community setting but not at home for those patients with slow to resolve exacerbations, people who will not return to their original level of care, including those awaiting care home placements. Aligned with 'step up' processes, an EDD and discharge planning will be standard for 'step down', using the same or similar criteria to those employed in acute care settings.

Identify and fill gaps e.g. neuro rehabilitation.

6.3 Diagram of the Long Term Conditions model of care



7. Planned Care

For the purposes of this report, planned care is defined as care that is non urgent and accessed either directly by the patient or through referral from a generalist to a specialist. LTC management includes much planned care and some urgent care is 'planned' if it is referred to a next day clinic.

7.1 Key Principles

7.1.1 Patient empowerment and navigation

The current planned care system is complex, fragmented and difficult to navigate. It disempowers and frustrates patients who then seek professional help to signpost and navigate when this should not be necessary. The initial referral has benefitted from the Referral Assessment Service (RAS) and the Telford Referral and Quality Service (TRAQS) but their roles do not extend beyond making the first appointment.

Patients want easy access to understandable and trustworthy information about self care options and local services to which they can gain direct access, as well as to information that guides them to seek professional help when necessary.

Patients find it understandably hard to distinguish 'want' from 'need' and, although clear information will resolve some of this, they often require professional expertise to distinguish between the two.

Once referred, patients want clear information about what is going to happen next and the timescale they should expect.

Navigation through the planned care system should be patient focused and facilitate self navigation wherever possible

Professional or peer advocacy to assist in navigation should be the exception rather than the rule.

Some patient groups (e.g. people with learning disabilities) should be offered pro-active advocacy.

7.1.2 Pathways

Planned care should be largely pathway driven, with as few stages as possible to minimise error and delay.

Pathways will vary in type and complexity depending on the degree of diagnostic uncertainty and treatment options. Patients should be able to gain access to the simplest 'out of hospital' and diagnostic pathways without the need for a professional referral, whilst the most complex will require expert specialist decision making at an early stage because of diagnostic uncertainty.

7.1.3 Partnership care

Aligned with the principles described in acute and LTC care, a richer and more dynamic conversation between referring generalist and specialist will result in higher quality referrals, better outcomes and mutual learning.

7.1.4 Levels of care

In planned care, this is about 'who does what where?' There is a compelling evidence base for a tiered arrangement of treatment centres, with the most complex and risky surgery being performed in a site co-located with a critical care unit, but the majority not requiring this. Separate treatment centres for routine surgery can also benefit from being designed and delivered through a different business model.

There is a 'critical mass' issue to consider when planning the number of treatment centres. For minor surgery, this is less of an issue, although the skill of the operator still influences the outcome, whereas for intermediate treatment centres outcomes are influenced by volumes – the larger the number, generally the better the result.

7.2 Model of care

7.2.1 Patient portal

Facilitated self management through a web based patient portal which provides trustworthy localised information about common conditions, when to seek professional help, options for self management and direct access to simple therapies and diagnostics

7.2.2 Pathways

Systematic design, approval and implementation of whole system pathways driving the majority of planned care. A tiered model:

- patient self referral and self management
- diagnosis or symptom complex known with direct GP / generalist access to the pathway
- diagnosis or symptom complex unknown requiring expert specialist decision making early in the pathway.

Reduce stages in all pathways to improve quality and safety and reduce errors. 'Optimise' patients prior to referral as a routine. Referral made by most appropriate professional (e.g. could be physio for arthroplasty). Patient choice expressed at time of referral assisted by navigator and / or Patient Recorded Outcome Measures (PROMS) data. Eliminate duplicated diagnostics. Provide expert opinion at first out patient appointment, preferably from the surgeon who will be performing the procedure. Date of surgery agreed immediately after first out patient appointment. Single multi-disciplinary pre-op assessment to include anaesthetist, physio and social worker. Admit on day of surgery. Enhanced recovery with the shortest possible LOS. Out patient follow up in the community as appropriate.

7.2.3 Navigation

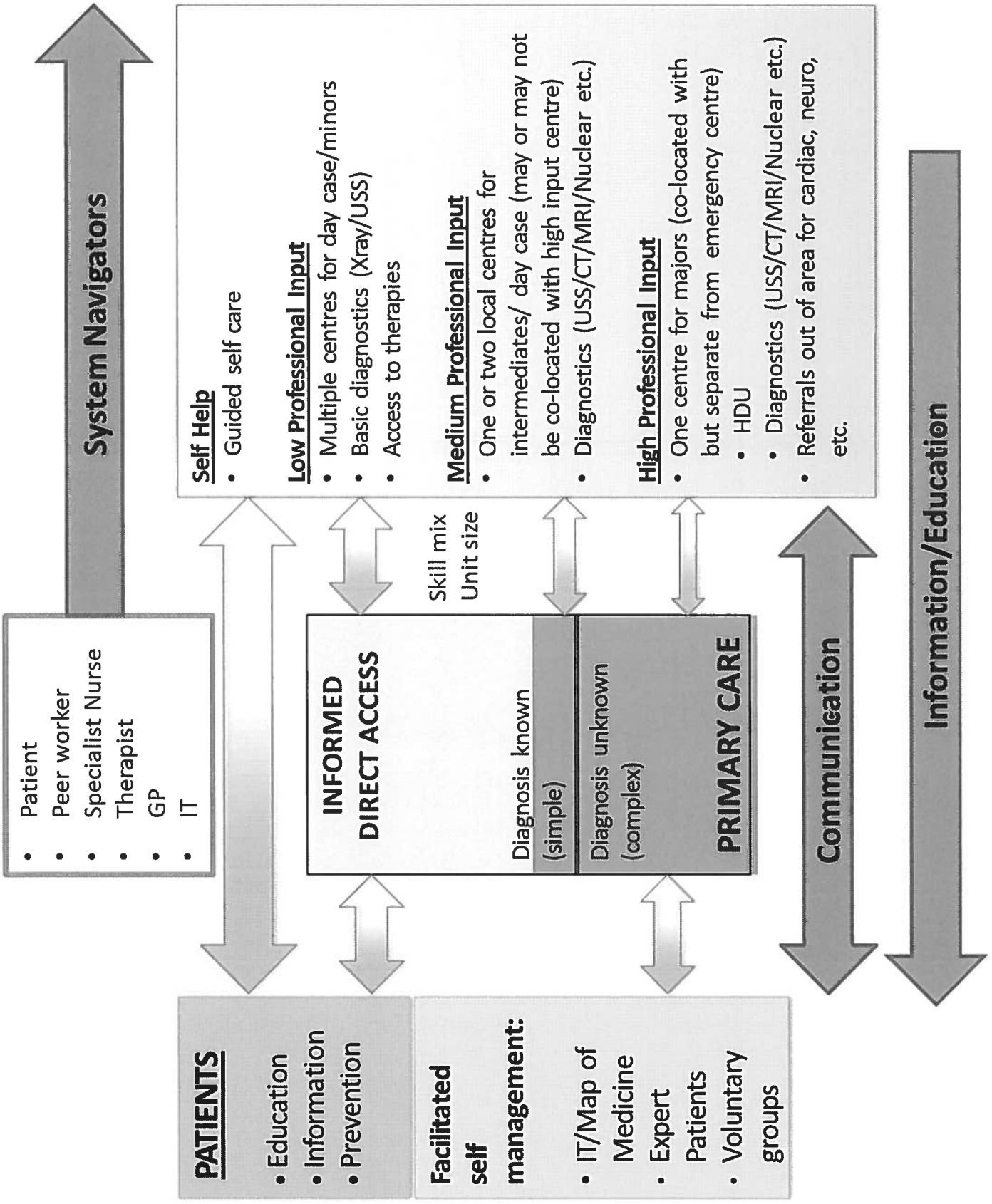
A simpler planned care system requires less navigation. Patients should have access to updated information about their stage of the planned care journey and be able to self navigate as a default. Some advocacy will be required which the RAS and TRACS teams may be able to provide. In more complex and serious situations, or when a patient has special needs, then a navigator / advocate will be required. This could be a peer group volunteer, specialist nurse, therapist, GP or other professional.

7.2.4 Levels of Care

Three tiers of treatment:

- Low professional input. Multiple centres for day case / minors, basic diagnostics and access to therapies
- Medium professional input. One or two centres for intermediates / day case. Beds available for low / medium risk orthopaedics. May or may not be co-located with high input centre. Advanced diagnostics (USS/CT/MRI/Nuclear etc)
- High professional input. One centre for majors, co-located but operating separately from single emergency centre. Co-located HDU. Advanced diagnostics. Potential for repatriation of elements, at least, of out of area specialist surgery (e.g. cardiac, neuro). Whilst it is appropriate that some work goes to specialist tertiary centres, there is opportunity to develop shared care models in which a concentrated local centre might provide pre- and post-operative care.

7.3 Diagram of Planned Care model of care.



8. Cross Cutting Themes

A number of important cross cutting themes have emerged in all the clinical meetings thus far. The following is a summary of discussion from different clinical meetings.

8.1 Embedding compassion and healthy relationships

Although compassionate care requires the right attitude, this must be translated into action and supported in system design and team working practices. Every member of a team must have clearly understood roles and responsibilities, especially when working within complex systems and environments. However, over-definition of roles, especially when restricted to one care setting, can prevent professionals 'going the extra mile' to ensure compassionate care and seamless patient journeys.

Named key workers or responsible clinicians will improve co-ordination of care for vulnerable people.

Values based recruitment will become the norm and compassionate attitudes, behaviours and relationships will be more visible throughout the whole organisation.

8.2 Rural and Urban solutions

The problems of providing equality of access and quality of care to rural populations will be partially mitigated by achieving greater care in the community. Care provided by teams around the patient with home as the default can be provided equitably in both urban and rural settings. Access to services that require travel clearly require better transport solutions, but there is also a balance to be achieved between the advantages of providing truly local services for all levels of care and the better outcomes and reduced cost of providing care at larger scale in fewer units.

8.3 Workforce issues

Many parts of the health and social care workforce are in crisis. A full workforce review and plan is required as part of, or alongside the FutureFit programme in order to resolve this. 7 day working is a requirement across the whole system and brings additional workforce challenges.

Local clinicians expressed some strong views about potential components of the solution:

- Consolidate services to make posts more attractive by improving the quality of work, gaining more experience working in larger units, offering better rotations through fully staffed co-located departments and services, all in an improved working environment.

- Fill medical rotas to fit the available workforce and fill the gaps with new roles (Advanced practitioner, Emergency Nurse Practitioner, Physicians assistant etc.).

- Prototype and implement rotating (and split) posts through different care settings to improve mutual learning, understanding and trust, provide better risk management, encourage better use of shared protocols, pathways, training opportunities and shared documentation and improve consistency and quality of care through generic upskilling.

- Improve recruitment and retention of staff through more effective succession planning and better role development and CPD

- Gain academic status by establishing an economy wide link to university and other education and training programmes to attract people to come to Shropshire to train and work.

8.4 Co-ordination, integrated and consistency across the whole system

There is universal agreement that improving the co-ordination, integration and consistency of care delivered across the whole economy is a necessary precondition for achieving sustainable improvements in quality and safety. The will to do this is evident; it is the barriers to it that require systematic identification and removal. These include a fragmented organisational structure, multiple incompatible IT systems, 'old fashioned' commissioning mechanisms and an overwhelming administrative burden. Where any pathway components are supplied under the 'Any Qualified Provider' system or through private sector tendering, these will need to be commissioned in a way which supports improved integration.

'Siloed' care does not incentivise clinicians to 'go the extra mile', and professionals are increasingly reluctant to fill gaps in care if it is not within their defined role. Clinicians should have more control over appointment systems.

8.5 Delivering effective high quality care with no extra money

Financial austerity is one of the key drivers for radical change. There is a need to move beyond organisational interests so that funding follows the patient. Pragmatism is required to find the 'key enablers' of change to concentrate our limited resources.

Currently, the status quo is incentivised with the need for organisations to show a surplus contributing to this.

'Disruptive' change is required to overcome the NIMBY (not in my backyard) problem.

From the clinical perspective, there was a clear case for unifying health and social care funding and to integrate acute and community care.

8.6 Social Care

Health and social care are clearly interdependent and should be designed to reflect this. There is currently an anomaly which makes closer integration difficult in that social care is means tested whilst health care is always free. To achieve integrated working, health and social care should run parallel and share risk, not run in series as is mostly the case at the moment. No-one enters the social care system without a health problem and currently both systems focus on those most in need and pay much less attention to prevention and self care. Although there is no statutory obligation for Local Authorities to invest in prevention, there was a clear consensus that health and social care must tackle prevention, education and patient empowerment to increase self reliance together. The Better Care Fund is a potential vehicle for this, but concern was expressed that, because its not new money, the opportunity would be missed.

The financial challenge in social care provision attracted specific comment and some suggestions to mitigate its effect were made:

- Increase community and carer input
- ensure more patients return to the same rather than a higher level of care
- manage patient and public expectations
- provide more education and information about options
- incorporate the voluntary sector as a core component of care provision
- implement the models of care described in this report which deliver timely response and intervention, enhanced recovery, early supported discharge and reablement

8.7 Mental Health

There was unanimous agreement that mental health should be integrated with primary, community and acute health care. The models of care described in the three main areas of Acute, LTC and Planned Care were all contributed to by mental health professionals and further detailing will demonstrate more clearly the potential for closer integration.

Partnership care in particular was felt to be a model which was equally applicable to mental health services. Psychological management of all LTCs should be 'part of the day job' and, within the context of partnership care, mental health specialists should have a greater role in education and upskilling of generalists. Young people have particularly stressed the need for support for problems with stress and self harm.

The RAID model of liaison in the acute sector was felt to be a good one, but it needed further development, especially in regard to education and training (the RAID effect)

8.8 Children

This area needs further exploration, but initial comments are: there is a lack of psychological and family support. There are big gaps, such as Autism (now 1:80) and age transitions. Obesity is not being systematically tackled. GPs and others are become more and more risk averse around children, Paediatric training for GPs should be mandatory. Partnership care is an excellent model for Paediatrics.

8.9 Therapeutics

Clinicians recognised that a whole system and strategic approach to therapeutics was required and that the importance of this was mostly under-estimated. Community pharmacies are not clustered with GP practices and do not have a defined working relationship with them. Community pharmacies can take a bigger role in minor urgent care and also in routine / repeat prescribing. They would need access to integrated care records to do this. Their impact in minor urgent care would be increased if some OTC medicines were free to stop unnecessary diversion to GPs. All pharmacies should have consistent and longer opening hours. In the acute sector, everyone should have a medication review <24hrs after admission. Evidence that if they are on 4 or more meds then 2 need changing due to acute presentation. These reviews should also apply to lower risk groups – often only the highest risk patients get them. More work with patients at home (e.g. the HARMS scheme) would add value (hoarding, poor compliance etc). There are too many admissions for technical therapeutics which could be done at home or in a community setting. There is little co-ordination of medication across care settings, dressings are a particular example.

9. Whole system synergies

There are a number of key principles and components of models of care which were repeated in slightly different but synergistic forms across all three care areas:

Reablement	Increased Levels of Care for LTC	Levels of Care Planned care	Acute and Episodic Care
Reablement at home • Integrated teams • Generic workers • Voluntary sector involvement • Ambulatory reablement in community facility as an option? • Return to original level of care • Updated care plan	**Low Medical Input** • 'Hospital at home' • Low acuity exacerbation • Low medical input but high care input • Team around patient • Sustainable community support	**Low Professional Input** •Multiple centres for day case/minors •Basic diagnostics (Xray/USS) •Access to therapies	
Reablement in community • Intensive rehabilitation • 'Step down' • Co-ordinated EDD and discharge planning • Resolving exacerbation requiring additional care? • Social issues to be resolved? • Permanent higher level of care required?	**Medium Medical Input** **['Health Hub' Community beds]** • Medium acuity exacerbation • 'Step up' • Integrated Acute and Community services • Designated and resourced private sector beds • Potential urgent care centre adjacencies	**Medium Professional Input** •One or two local centres for intermediates/ day case (may or may not be co-located with high input centre) •Diagnostics (USS/CT/MRI/Nuclear etc.)	**'Some' Urgent Care Centres**
	High Medical Input • One high acuity centre • 7 day maximum LOS • Early supported discharge **0 day LOS** • Ambulatory care • Subacute frailty assessment **3 day LOS** • Frailty • Assessment units **Mental Health Beds** • Medico-legal place of safety	**High Professional Input** •One centre for majors (co-located with but separate from emergency centre) • HDU • Diagnostics (USS/CT/MRI/Nuclear etc.) •Referrals out of area for cardiac, neuro, etc.	One Emergency Centre

	Acute Care	LTC / Frailty	Planned Care
Prevention	Make every contact count	Targeted prevention	Information / Self care
	Whole economy long term strategic prevention programme		
Patient Empowerment	Access to reliable info about signposting and self care.	Self management. Care and EOL plans with shared decisions.	Access to reliable info re self care, local services and direct access
Advocacy and Continuity	Integrated care record	Key worker	Pathway navigation
Partnership Care	Timely specialist support to generalist in Urgent Care Centre	GP led care with specialist support and education	Tiered pathway driven care with GP and specialist at defined points. Feedback and education as the norm
Levels of Care (see diagram)	One Emergency Centre 'Some' Urgent Care Centres	Low, medium and high medical input care settings	Low, medium and high professional input care settings for procedures
Integrated Teams	SPA to access integrated community services	Integrated multi-disciplinary teams	Teams integrated around service

10. Next Steps

This report details the output of the Clinical Design workstream over the first 3 months of its activity. The models of care are emerging but are still at a high level.

A process of refinement will continue through a number of cycles where they will be repeatedly tested using patient scenarios, patient characteristics and flow volumes and financial impact.

A further detailed review of the evidence base around each component of the model will be undertaken.

External clinical assurance will be sought from an expert clinical team overseen by the West Midlands Clinical Senate.

Clinical engagement will be deepened, both by continuing involvement of the clinicians in the clinical reference group and subgroups, and through events, such as

webinars and meetings, designed to reach 2/3 of the clinical workforce of Shropshire and Telford & Wrekin.

Patient representatives and patient groups will continue to be involved and co-creating at every stage of the process.

TELFORD & WREKIN COUNCIL

HEALTH AND WELLBEING BOARD – 14TH MAY 2014

IMPLICATIONS OF THE CARE BILL: IMPLEMENTING THE CARE AND SUPPORT REFORMS – PROGRAMME START UP

REPORT OF THE INTERIM DIRECTOR: HEALTH, WELLBEING AND CARE, T&W COUNCIL

LEAD CABINET MEMBER – CLLR ARNOLD ENGLAND

PART A – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 This report updates members on the implications of the Care Bill and sets out the requirements to effectively put in place a change management programme to deliver the changes necessary, arising from the Bill when it becomes law:

- To fully understand the proposed changes, the impact of these changes and ensure robust programme management is in place to deliver the changes.
- To analyse the resource implications for the Council's budget.

1.2 Once the Bill becomes law it will place significant additional responsibilities on the Council and increase the cost of delivering community care services to those eligible for public support, at a time when the resources available are already under pressure.

1.3 The Council will need to profile the likely additional costs into its budget planning process for 2015 and beyond, whilst continuing with the transformation programme aimed at reducing care costs to the Council and exploring the benefits of further integration with our main partners.

1.4 The emphasis moving forward will be on person centred, asset based care. In future people's care and support needs will be expected to be met by:

- harnessing existing capacity within neighbourhoods and families to provide support;
- addressing people's needs at an earlier stage and before the need for formal services;
- the provision of high quality state support based on clear national entitlements;
- It also envisages that care and support will be more effectively joined up across all local services (particularly health and housing) and will work more collaboratively across local authorities, providers and other statutory organisations.

2. RECOMMENDATIONS

2.1 HWB Board Members note the implications and risks of the Care Bill and Reforms and the plans being put in place to ensure we are prepared to implement the Act when it becomes law.

2.2 HWB Members consider whether the Care Bill and its implications be the focus of the next HWB Development session in October.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Co-operative Council priorities?	
	Yes	*Vulnerable Children & Adults* *Health and Wellbeing*
	Will the proposals impact on specific groups of people?	
	Yes	Will impact on people who are ill or disabled, who need support and on their family carers.
TARGET COMPLETION/DELIVERY DATE	2013 – 2015/16	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The Spending Review announced £335m, both capital and revenue funding, to cover the costs of implementation of the Care Reform Bill with a further £135m contained within the Better Care Fund. The Local Government Association (LGA) have provided all Council's with indicative allocations and the areas to be funded based on their information, it should be noted these have not been published by the Government. LGA's indicative figures for T&W are shown in 4.8.1 below. In April 2014 the Government announced a further £23m would be made available for LA's to help with preparation for Care Bill Implementation, no further information on how this has been distributed has been made available. Whilst the Government have estimated the costs for the implementation of the national eligibility criteria and the additional assessments required as £34.4m and £16.5m respectively, it is unclear as yet whether , locally, the funding will be sufficient to meet the requirements identified in this report. In addition to the specific Additional Burdens Grant of £919k identified within our provisional settlement for 2015/16 further discussions are

		required with the CCG to ensure the release of £407k of revenue funding from within the Better Care Fund pooled budget. Any failure to release the funding for the purposes identified will present the Council with a significant risk to the implementation of the Care Reforms. In terms of ongoing cost implications the Government estimated that 1 in 5 self funders would become eligible for funded support but early work by some Councils has identified that the number of people who will be affected by the changes is greater than this. Depending on the national picture it is likely that the £1bn per year extra cost estimated by the Government will be insufficient to meet the increased costs to Councils. This work was fed into the responses to the Funding consultation. More detailed work is currently being undertaken, with a limited number of authorities, by Association of Directors of Adult Social Services (ADASS) to model the cost implications of the Bill and so it is not possible to evaluate the local impacts except to say that the costs of care locally will continue to rise in the light of demographic changes. The current strategy being pursued in Telford & Wrekin is to improve and enhance preventative services via it's own transformation agenda and via the Better Care Fund (BCF). This is in order to avoid a reactive approach to providing care when a client has costly high needs. This strategy, should prove to be successful in helping to contain cost increases in future but unlikely to reduce care costs overall. Therefore, cost pressures are likely to remain and will require additional Government resource. It is expected that additional funding will be allocated to local authorities using a new Adult Social Care formula which is currently being developed by the Department of Health. Delay in the implementation of funding reform and the placing of Social Care funding on a sustainable footing will result in the continuation of increasing pressure on Local Authority care budgets. It is important, however, to set these changes; increased integration with Health via the BCF and the Care Bill, against the context of potential

		savings to be released from the Health acute sector, decreasing LA budgets and consequent savings targets and locally the financial impact of Continuing Health Care on the Council. In 2013/14 the anticipated overspend against Adult Social Services is around £4.2m some of which results from the impact of CHC on the Council's costs; the savings required to meet available funding for Social Services in 2014/15 are £10.5m. All of these issues have the potential to put significant financial pressure on a reducing Adult Social Service budget if current plans and outcomes are not achieved. TAS 30.4.14
LEGAL ISSUES	Yes	The Care Bill was introduced in the House of Lords on 9th May 2013. The Bill contains provisions relating to adult care and support, care standards, health education and research. Most of the clauses in Parts 1 (Care and Support) and 3 (Health) of the Bill were published in draft form in July 2012 (as the Draft Care and Support Bill) for consultation until October 2012 and pre-legislative scrutiny. The Joint Committee's report following pre legislative scrutiny containing 107 recommendations was published on 19th March 2013, with the Government's response published in May 2013. The Bill currently contains 127 clauses, in five Parts, and eight Schedules. Factsheets and a glossary were published by the Department of Health on 10th May 2013 to accompany the Bill and these were last updated on 10 January 2014. The Bill [as at 29 April 2014] has concluded all stages in the House of Commons and amendments are due to be considered in the House of Lords on 7 May 2014. The Bill is intended to give effect to the policies requiring primary legislation that were set out in the White Paper *Caring for our future: reforming care and support* (July 2012), to implement the changes put forward by the Commission on the Funding of Care and Support, chaired by Andrew Dilnot, and to meet the recommendations of the Law Commission in its report on Adult Social

		Care (May 2011) to consolidate and modernise existing care and support law from over a dozen Acts into a single framework. The Bill also gives effect to elements of the Government's initial response to the Mid Staffordshire NHS Foundation Trust Public Inquiry that require primary legislation. The Bill also takes forward the necessary legislative measures for the proposals outlined in *Liberating the NHS: Developing the Healthcare workforce - From Design to Delivery*, the establishment of Health Education England as a non-departmental public body; and those in relation to health research that were set out in the Government's *Plan for Growth*, and the establishment of the Health Research Authority as a non-departmental public body. The main issues for the Local Authority arising from the Bill are set out within the body of this report. The Bill and subsequent Statute, once it receives Royal Assent, will be accompanied by relevant Statutory Instruments and Guidance. These will be issued for consultation first, in accordance with the timeline set out in paragraph 4.2 of the report [from the Local Government Association website].This timeline may alter, with the Bill not having received Royal Assent in April as anticipated. KF 29.4.14
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	Any other risks and opportunities will be appropriately managed and reported if necessary.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact

PART B – ADDITIONAL INFORMATION

4. INFORMATION

4.1 Health and Wellbeing Board and Cabinet received a report in September 2012 providing information about the Care and Support White Paper, the draft Care Bill and a Government update on Funding Reform.

4.2 The Bill is currently going through the parliamentary process with a view to becoming law by 2015 with phased implementation from 2015 through to April 2017.

Timeline for passage of Bill and regulations:

Royal Assent of Care Bill	1st April 2014
Consultation on guidance and regulations	Late May 2014
Publication of regulations and guidance coming into effect in 2015	1st October 2014
Regulations laid before Parliament for provisions coming into force in April 2015	1st October 2014
Care Bill part 1 provisions (excluding funding reform) coming into force	1st April 2015
Care Bill part 1 funding reform provisions coming into force	1st April 2016

4.3 All of the proposed changes will take place at a time of increasing need as a result of our demography, raised expectations and reduced budgets. It is therefore important that we fully understand the changes being proposed, the impact of these changes and ensure that we develop a structured programme and transformation plan including a full analysis of the resource implications for the council's budget planning from April 2015 and wider health and social care integration plans.

4.4 Clearly the Act will place increased emphasis on preventative initiatives delivered in the community by the community or local voluntary sector organisations, to support families to carry on caring. This in itself will be challenging as resources are reduced and all agencies will need to consider how they continue to prioritise preventative initiatives and support to the community. All of this is at a time when the health agenda is looking to reduce the number of people requiring acute care, which in turn increases the number of people with health needs requiring support in the community, provided by the local authority. However this is consistent with our joint health and social care commitments set out in the Better Care Fund plan.

4.5 Integration is already high on the agenda, given the principles underpinning the Health and Social Care Act, 2012 and the responsibility of the Health and

Wellbeing Board to oversee the development of "integrated" approaches. The Care Bill promotes "integration" too and paves the way for the Better Care Fund to promote closer working between the NHS and Care & Support.

4.6 Fact Sheets explaining the changes are available at:

https://www.gov.uk/government/publications/the-care-bill-factsheets

4.7 Clause Analysis is available at:

http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/5761381/ARTICLE

4.8 **Key proposed changes** arising from the Care and Support reforms are detailed in Appendix A. They are:

- Clarification of entitlement to care and support
- Development of national eligibility criteria
- Family carers to be treated equitably with the person they care for
- Reform of funding of care and support
- Focus on prevention and wellbeing rather than crisis intervention
- Guarantee of service continuity between local authorities and should a service provider fail
- Simplification of system and flexibility for greater integration to achieve better outcomes
- Adult safeguarding put on a statutory footing

4.9 Summary of the **Funding of Care and Support** when the funding reforms come into effect in April 2016 are detailed in Appendix B. Key details include:

- Separation of accommodation and care costs
- Accommodation costs payable by individual up to £12k a year
- £72k cap (no current cap) on total amount an individual will have to pay for care across life time
- £123k upper capital threshold for means tested care (currently £23.5k)
- Right to deferred payment arrangement

4.10 **Implications and risks** of the changes and new charging rules are detailed in Appendix C. They include:

- Loss of income from current service users
- New duty to pay for self-funding people once they reach the cap
- Additional assessment activity for carers and self funders
- Under estimation of full costs at a national level and formula distribution
- Capacity to complete assessments
- Process and IT system change and state of readiness
- Unintended consequences – for e.g. additional complaints, disincentives to family care, impact on the market through self funders, etc
- Implementing the Care Bill at the same time as dealing with budget reductions and the integration agenda

4.11 **Programme Structure, Approach and Governance:**

A programme management approach to deliver the transformation required has recently been established. The approach will involve the formation of a Care and Support Reforms Programme Team, reporting (ultimately) to the Council's Cabinet. Workstream leads will report progress to the Programme Team/Board, membership of which to include the Director of Health, Wellbeing and Care and AD's with responsibility for Adult Social Services and Commissioning. The Programme Team will be supported by a number of workstreams, tasked with development and implementation of relevant sections of the Care Bill Implementation project plan. We are looking to identify dedicated additional capacity for this purpose.

4.11.1 **Programme Organisation:**

See Appendix D detailing Programme Governance and Officers

- **Priority Programme Workstreams:**

See Appendix E – further work streams may need to be added, as the programme develops. The key workstreams identified are:

- Deferred Payments
- Funding Reform
- Assessment
- Advice & Information
- Commissioning
- Adult Safeguarding Board

We will also need to ensure we address cross cutting themes including Workforce Development, IT Systems, etc

Each work stream lead officer will ensure an action plan is in place with key actions and milestones for delivery, risks, and interdependices with other workstreams and support services. Regular highlight reports will be produced to monitor progress by the Programme Team/Board.

- **Programme Resources**

See Appendix F. Funding identified for implementing the change:

- £335m nationally in 15/16, £50m of which is capital funding within the Better Care Fund. T&W's local provisional allocation of the remaining £285m is £919k (The methodology for allocating funding for these burdens is under development, so the illustrative figures are based on an assumption that the funding will be distributed according to the Relative Needs Formula. This could mean the figure may drop)(see Table below)
- £407k in 2015/16 from BCF for Carers assessments and Adult Safeguarding Board, etc. (see Table below)

- £2.7m across 9 regions of which £282,895 for West Midlands region to be administered by ADASS through Worcestershire County Council, for the purpose of ensuring successful delivery of the care and support reforms but this will have the additional benefit of creating capacity to support closely-related activity for the Better Care Fund. It is expected that regions will want to organise their activities to fit with existing regional structures and other related programmes of work to support sector-led improvement.
- at the ADASS Spring Conference in April - Norman Lamb announced that £23m of funding would be made available for LA's to help with preparation for Care Bill Implementation in 2014/15 - this would work out at an average of around £150,000 per authority - although there is no detail as yet on how the £23m will be distributed.

Whilst these resources have been identified, the major additional costs associated with the outcome of more assessments resulting in more eligibility for public support and the funding reforms themselves, has not been quantified at a local or national level. Work is currently underway to quantify the financial impact of the funding reforms to inform the Treasury's assessment of the amount of additional funding required at the national level. Original estimates "in excess of £1billion" may prove to be conservative and their are significant risks of the total sum being under estimated and the distribution formula not being accurate for individual LA areas.

- **Key Stakeholders – Communication Plan and engagement and consultation planning:**

  Key to implementation is engagement and communication. Nationally work is underway to develop a media campaign informing the general public of the changes for launch in the Atumn 2014.

  Locally we will need to enage with existing service users, carers, general public (potential new service users & carers), care providers, voluntary organisations, advocacy, NHS colleagues, Health & Wellbeing Board, Council Cabinet Members & Senioe Management Team, Scrutiny, Council Adult Social Services Change Management Board, Adult Social Services Teams, Children's Services, People Services, Finance, ICT, legal, Business Support, Co-operative Council Team (Performance and Communications), Audit, Public Health, Housing, etc.

  Presentations have already been given to raise awareness of the Care Bill and its implications at the 'Working Together Event' in January and more recently at the Carers Partnership Board in April. This activity will need to be stepped up over the coming months.

- **Risk and Issue Identification and Management**

  To be incorporated at both Programme Board and workstream group level

- **Workforce and Organisational Development**

  Recruitment, retention, structure, culture supportive of person centred, asset based care, training (and e-learning), policy and procedure review, business support, etc. will be linked to the Transformation workforce development strategy and plan.

5. PREVIOUS MINUTES

5.1 Health and Wellbeing Board – 12 September 2012 – Care and Support White Paper and Bill

5.2 Cabinet – 20 September 2012 – Care and Support White Paper and Bill

6. BACKGROUND PAPERS

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

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

6.3 Care and Support Bill – HM Government, 11 July 2012, https://www.gov.uk/government/publications/draft-care-and-support-bill-published

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

6.5 Integrated Care and Support: Our Shared Commitment – National Collaboration for Integrated Care and Support – May 2013 https://www.gov.uk/government/publications/integrated-care

6.6 Policy statement on care and support funding reform and legislative requirements https://www.gov.uk/government/publications/policy-statement-on-care-and-support-funding-reform

6.7 The Care Bill explained: including a response to consultation and pre-legislative scrutiny on the draft Care and Support Bill - http://www.official-documents.gov.uk/document/cm86/8627/8627.asp

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APPENDIX A

Adult Social Care Law – proposed changes

The Bill modernises over 60 years of care and support law into a single statute, built around people's needs and what they want to achieve in their lives. The aim is to ensure that people receive the support they need but this will only be fully achievable if resources are increased accordingly. The single statute will:

- **Clarify entitlement to care and support** – creating a legal expectation of consistency from one local authority to another irrespective of the level of resource available

- **Develop a national eligibility criteria** – this will reduce our local flexibility to raise thresholds as a means of reducing legal responsibility and demand

- **Treat carers as equal to the person they care for** – this will raise expectations and lower the threshold of support for carers, potentially meaning more people will expect support

- **Reform how care and support is funded by creating a cap on care costs payable by every individual** – this will mean that all "self-funders" will need to be assessed at an early point by the local authority, requiring greater assessment capacity. In addition more people will qualify for Council funded support at an earlier point, requiring increased community care spend with the risk that this will not be fully funded nationally

- **Support a focus on prevention and wellbeing rather than crisis intervention** – Positive though this will increase the pressure to support preventative initiatives at a time when budgets supporting people with intensive needs are under pressure

- **Provide guarantees regarding service provision between local authorities and should a service provider fail** – Welcomed in light of some major national failure of providers but increased responsibility for Local Authorities

- **Simplify the system and providing flexibilities for greater integration to achieve better results for people** – Will increase pressure for transformational change in partnership with key local stakeholders, which in itself could be positive if we can develop an integrated relationship with T&W CCG and T&W GP Practices in particular, but with possible pressure to look to a pan Shropshire approach based on the configuration of local health services

APPENDIX B

Funding of Care and Support

In summary when the funding reforms come into effect in April 2016 there will be a:

- Separation of care and accommodation costs, with everybody expected to pay their own accommodation costs if they enter residential or nursing home care, out of their own income, estimated at 2017 prices to be around £12,000 a year
- £72,000 cap on the total amount an individual has to pay out of their own money to meet their eligible care and support needs, across their life time
- £123,000 upper capital threshold for means tested support in residential care, including value of their home in specific circumstances (currently the threshold is £23,500 above which an individual has to pay the full cost – care and accommodation costs)
- £17,500 lower threshold for means tested support, below which no additional contribution will be made from the individual's capital (currently the threshold is £14,250)

These reforms will need to be considered alongside other recommendations also to be implemented including the introduction of a national minimum threshold for eligibility and deferred payments which should come into effect from April 2015.

Implementing the cap and the extended means test will have a cost. This includes the additional cost of services for all adults, the cost of local authorities carrying out more assessments and a change in the amount of disability benefits payments we can use towards the cost of care (since people receiving state-funded residential care are not eligible for some disability benefits).

Alongside these changes the Government have announced a review of the funding formulae for Adult Social Care which would be used to distribute additional resources for social care between local authorities from 2015 onwards to implement these changes. The additional costs nationally are predicted to be in excess of £1billion. A sub-group of the National Transformation group has been created to support the practical delivery of funding reform. This sub-group, called the Dilnot implementation group exists to develop an approach to the implementation of funding reform, including the capped cost model, Deferred Payment Agreements, information and advice, and engagement on the legislative framework for funding reform.

APPENDIX C

Risk and Issue Identification and Management

Key Risks include:

- **Loss of income from current service users**: The council currently collects income from people living in care homes and income from people living in their own home who receive social care input and who have been assessed as having the financial means to contribute. The change in rules will result in a loss of direct income from people who use services who reach the £72,000 cap or who fall below the new higher upper capital limit threshold of £118,000. The government have pledged to meet this income gap from general taxation through an increase in local authority grant but it is unclear how this funding will be allocated to councils.

- **New duty to pay for self-funding people who have reached the cap**: A large number of people who pay privately for their own care and support and who have not approached the council before will become eligible for funding when they reach the £72,000 cap. These people are not expected to be a cost pressure to councils for up to four years after the new rules come into effect (until they reach the £72,000 care cap from a 2016 start date). Future demographic pressures and cost inflation will exacerbate financial pressures. The government have also pledged to meet this new burden from general taxation.

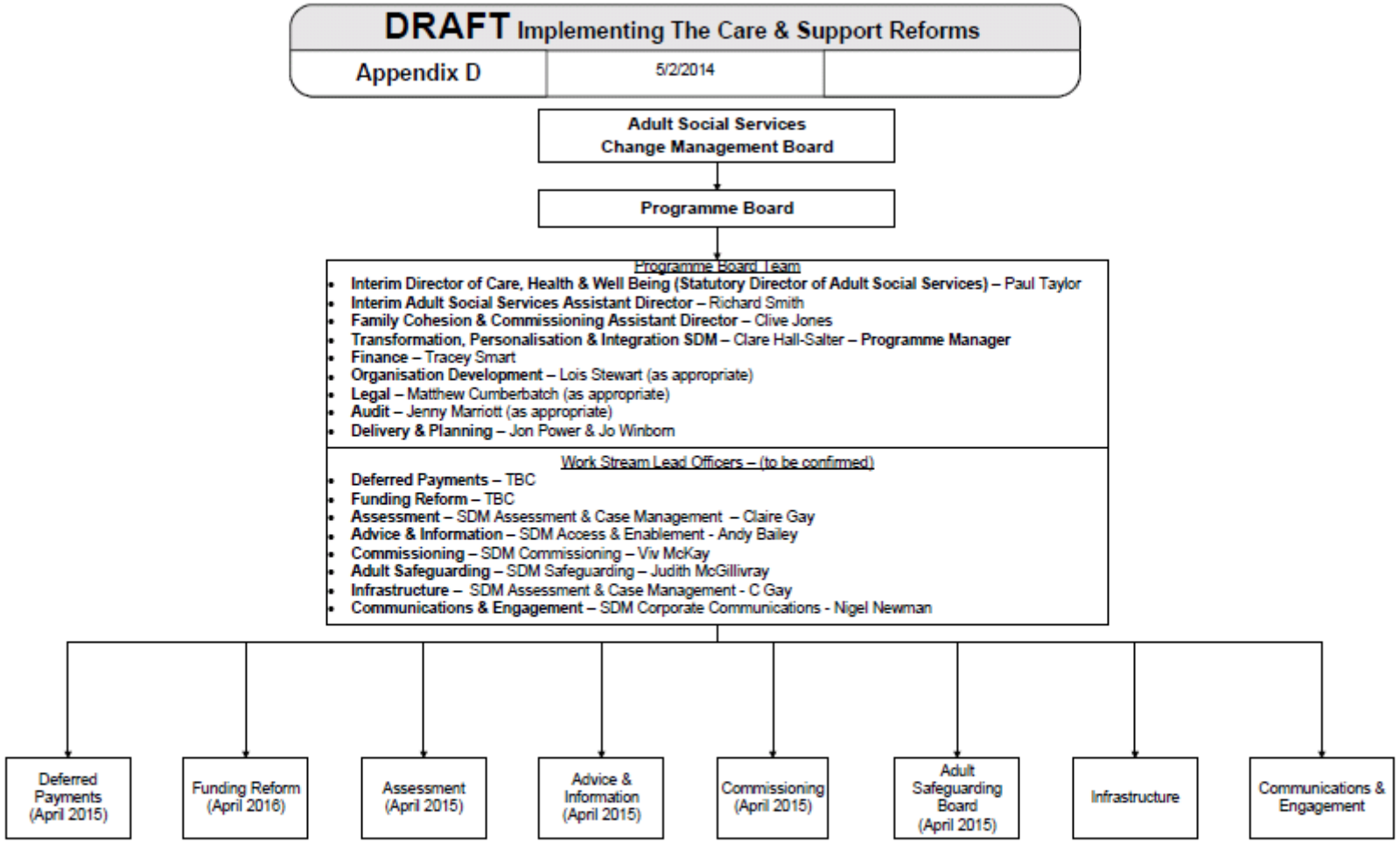
- **New care assessment activity:** Given that any spending on care does not count towards the £72,000 cap until a formal community care assessment has been carried out by social services, there are likely to be a large number of people who are currently funding the cost of their own care who will approach the council for an assessment when the new rules come into effect. It has been estimated by the Department of Health that 30-35% of people in receipt of care are funding the full cost and have not approached the local authority. This will present recruitment difficulties as additional staff will be required for the year 2016 to undertake these one-off assessments.

- The new rules will also lead to a **significant permanent increase in the total number of community care assessments requested by self-funders** who wish to start recording eligible care costs counting towards their £72,000 cap after 2016. Similarly more people who have assets of less than the new upper capital limit of £118,000 will present for assessment and care services. This staffing cost will need to be projected. There will also be significant training and recruitment costs and difficulties to sourcing large numbers of newly trained staff. The Association of Directors of Social Services (ADASS) is lobbying the government to meet the costs of this new burden from taxation.

- **Additional complaints:** Due to the new financial implications of determining 'eligible' care needs by social services, it is expected that there will be an

increase in the number of appeals and complaints about the outcome of these assessments, particularly from people who have been funding their own care but whose needs are not deemed as being 'eligible' using national eligibility criteria.

- **Loss of unpaid family carers:** The new system introduces a significant financial disincentive for the family of vulnerable adults to provide informal care. As family care is not covered as an expense and would therefore not count towards the cap, this care provision would lengthen the time that an individual would need to fund their own care. Unless the service user was paying the full cost of their support, it would ultimately result in a worse financial situation. This anomaly has been identified to the Department of Health but as a significant risk both in financial terms to individuals but also in terms of the potential need for an increased social care workforce in the medium-term.


DRAFT Implementing The Care & Support Reforms
Appendix D
5/2/2014
Adult Social Services Change Management Board
Programme Board
Programme Board Team
Interim Director of Care, Health & Well Being (Statutory Director of Adult Social Services) – Paul Taylor
Interim Adult Social Services Assistant Director – Richard Smith
Family Cohesion & Commissioning Assistant Director – Clive Jones
Transformation, Personalisation & Integration SDM – Clare Hall-Salter – Programme Manager
Finance – Tracey Smart
Organisation Development – Lois Stewart (as appropriate)
Legal – Matthew Cumberbatch (as appropriate)
Audit – Jenny Marriott (as appropriate)
Delivery & Planning – Jon Power & Jo Winborn
Work Stream Lead Officers – (to be confirmed)
Deferred Payments – TBC
Funding Reform – TBC
Assessment – SDM Assessment & Case Management – Claire Gay
Advice & Information – SDM Access & Enablement - Andy Bailey
Commissioning – SDM Commissioning – Viv McKay
Adult Safeguarding – SDM Safeguarding – Judith McGillivray
Infrastructure – SDM Assessment & Case Management - C Gay
Communications & Engagement – SDM Corporate Communications - Nigel Newman
Deferred Payments (April 2015)
Funding Reform (April 2016)
Assessment (April 2015)
Advice & Information (April 2015)
Commissioning (April 2015)
Adult Safeguarding Board (April 2015)
Infrastructure
Communications & Engagement

APPENDIX E

Key Priority Programme Workstreams and key actions/responsibilities:

1. **Deferred Payments (April 2015)**

    a. Estimate increase in requests for a deferred payment
    b. Review existing arrangements for Deferred Payments (work force capacity, ICT, Finance)
    c. Estimate implementation costs (average length of stay in residential placements, average client contribution)
    d. Estimate related costs (properties subject to a DPA may be exempt from council tax)

2. **Funding Reform (Cap on Costs) (April 2016)**

    a. Identify local self funders
    b. Estimate time needed to assess self funders ahead of go live
    c. Estimate cost of meeting care costs for self funders locally
    d. Impact on current work force (skills, capacity, configuration)
    e. Putting in place arrangements for "care accounts", including monitoring of spend up to the cap; this will include separation of care costs from general living expenses
    f. Consider ways of conducting proportionate assessments (including via third sector or self-assessment
    g. Calculate costs of implementation (excluding costs of the cap)
    h. Review financial processes, information and advice systems and IT
    i. Dialogue with local providers about potential impact

3. **Assessment (April 2015)**

    a. Needs assessments for all carers
    b. Assessments of young people and carers of children (to plan for adult care before they reach 18yrs)
    c. New national eligibility threshold

4. **Advice and Information (April 2015)**

    a. Review existing advice and information (adequate capacity and funding)
    b. Review locally advice, advocacy and brokerage services
    c. Financial information and advice available (independent of the authority)

5. **Commissioning (April 2015)**

    a. Review commissioning arrangements (capacity, skills and leadership)
    b. Develop market position statements
    c. Review engagement with local providers and service users

d. Use of Better Care Fund – focus on early intervention and prevention

6. Adults Safeguarding Board (April 2015)

a. Responsibility to ensure enquiries into cases of abuse and neglect
b. Establishment of Safeguarding Adults Boards on a statutory footing,
c. Puts Safeguarding Adults Reviews on a statutory footing
d. Information sharing

APPENDIX F

Adult social care new burdens funding (£335m nationally)		£000s
Assessment & eligibility	*Funding for early assessments and reviews*	*468*
IT	*Capital investment funding including IT systems*	*161*
Capacity	*Funding for capacity building, including recruitment and training of staff*	*65*
Deferred payments	*Year 1 funding for the implementation of the universal deferred payment scheme*	*355*
Information	*Funding for a national information campaign*	*30*
Total		***1,079***

Care Bill implementation funding in the Better Care Fund (£135m nationally)		£000s
Personalisation	*Create greater incentives for employment for disabled adults in residential care*	*9*
Carers	*Put carers on a par with users for assessment.*	*50*
	Introduce a new duty to provide support for carers	*100*
Information advice and support	*Link LA information portals to national portal*	*0*
	Advice and support to access and plan care, including rights to advocacy	*75*
Quality	*Provider quality profiles*	*15*
Safe-guarding	*Implement statutory Safeguarding Adults Boards*	*24*
Assessment & eligibility	*Set a national minimum eligibility threshold at substantial*	*121*
	Ensure councils provide continuity of care for people moving into their areas until reassessment	*13*
	Clarify responsibility for assessment and provision of social care in prisons	*20*
Veterans	*Disregard of armed forces GIPs from financial assessment*	*8*
Law reform	*Training social care staff in the new legal framework*	*14*
	Savings from staff time and reduced complaints and litigation	*-41*
Total		***407***
Grand Total		***1,486***