HEALTH AND ADULT CARE SCRUTINY COMMITTEE

Minutes of the meeting of the Health and Adult Care Scrutiny Committee held on 12th August 2013 in Meeting Room 3, Darby House, Lawn Central, TF3 4JA

PRESENT:
Councillors D. White (Chair), F. Bold , R. Evans V. Fletcher , J. Greenaway, A. Meredith, J. Minor, Co-optees R. Shaw, J. Gulliver, D. Davies and R. Perkins.

Also Present**:** Cllr. A. England, Cabinet Member Adult Social Care, P. Taylor (Interim Director Adult Care, Heath and Wellbeing), K. Kalinowski (Assistant Director Care and Support), C. Heaven (Shropshire and Telford and Wrekin Age UK) and F. Bottrill (Scrutiny Group Specialist)

HACSC-50 MINUTES

RESOLVED - The minutes of the previous meetings of the Health and Adult Care Scrutiny Committee held on 3rd May 2013 be agreed as an accurate reflection of the meetings and signed by the Chairman subject to the deletion of 'to' page 3, paragraph 11, line 3.

HACSC-51 APOLOGIES FOR ABSENCE

None

HACSC-52 DECLARATIONS OF INTEREST

Cllr. R. Evans declared her employment in a social care provider organisation that has contracts with the Local Authority.

HACSC-53 RESPONSE TO THE SCRUTINY REVIEW OF CONTINUING HEALTHCARE

The Chair invited Cllr. A. England, Cabinet Member for Adult Social Care, to give a verbal response to the Scrutiny Committee's report on Continuing Healthcare (CHC).

Cllr. England made some initial comments on the report setting out the reduction in the level of CHC funding and the impact that this has had on the Local Authority's Adult Care budget. He noted the approach that the Scrutiny Committee had taken in looking

at the quality of the assessment process. He highlighted the findings of the report that set out that the local interpretation of the assessment process was unfair and that in some cases care provision was not meeting the needs of individuals. He commented that he would like further evidence of this. He also commented on the finding of the Committee that it would be impossible to produce a single document that would explain to patients and their families what care the patient being assessed would need and how this related to CHC funding. Cllr. England said that this reflects the complexity of the system. He added that the assessment process has to be fair and it should not be based on patients who ‘shout the loudest’ getting the most support.

Cllr. England commented on the findings of the Committee that the Council is not meeting the full cost of people’s needs. He responded that private Care Homes make a profit but he recognised that there are not-for-profit care home providers. He was glad that the report identified the implication for the Adult Social Care Budget which has resulted in additional costs of £8 million. If this continued there is a risk that the threshold for eligibility for local authority funded care could be raised to critical.

The Chair requested that the Cabinet Member respond to the recommendations in the report. He added that the Committee also had concerns regarding people who are self funding and the appeals process. C. Heaven confirmed that the appeals they had supported over the last 3 years had not been successful and that a patient who appealed last month was still waiting to hear. Cllr. England responded that he wanted to ensure that the Committee understood the difficult issues and the Interim Director for Adult Care, Health and Wellbeing suggested he could update the Committee on the work that has been undertaken with the Clinical Commissioning Group.

Cllr. England provided the following response to the recommendations in the Scrutiny Report:

Recommendation 1
The CCG put systems in place to ensure that all patients and their families are appropriately involved in the assessment process. The CCG must ensure that the assessment is patient centred and that the assessment is carried out in a caring and compassionate manner in line with the Francis Report.

CCG to respond to this recommendation

Recommendation 2
All patients who are assessed using the Initial Check List and their families should be given written information about independent advice and advocacy services with specialist knowledge of CHC BEFORE the checklist is initiated. The information should provide the contact details for the advocacy services

CCG to respond to this recommendation

Recommendation 3
This advocacy service must be adequately resourced to respond in a timely manner and provide the necessary support to individuals and their families throughout the CHC process. The Committee recommend that the CCG contribute toward the cost of this service in line with the National Framework Practice Guidance (p.98)

Accepted: The Council currently funds advocacy services and patients and their families going through the CHC process can access these. The issue of advocacy services for CHC was discussed at the CHC workshop on 20 June with the CCG and this has been built into the follow up action plan. This will be carried out jointly with the CCG

Recommendation 4
The Multi-disciplinary working can only be delivered through a successful partnership approach both at organisational level and practitioner level where all the people involved in the care of an individual feel that their views are valued. The views of all professionals in the MDT must be evidenced in the decision making process.

Accepted: The Local Authority would like to work with the CCG towards a more integrated assessment approach. A joint Steering Group is being set up (first meeting in September) and will take forward an action plan following the joint externally facilitated workshop on 20 June.

Recommendation 5
All the organisations involved in the care of an individual being assessed for CHC must be included in the Personal Details section of the DST (p. 53 of the draft Operational Arrangement Document). All these organisations must be contacted to provide evidence for the assessment including mental health services.

CCG to respond to this recommendation

Recommendation 6
Joint training is undertaken (including role play) ensuring that all professionals from the different organisations involved in CHC understand the full implications of the decisions that are made from the perspective of the patient, their colleagues from other organisations and the implications for wider health and social care economy.

Accepted: The Local Authority CHC Team Leader has and continues to carry out training for LA staff to raise awareness of CHC following the recent revision of the

framework. Training has also been undertaken with Care Homes in partnership with SPIC. There is also a commitment for follow up joint training as discussed at workshop as part of the action plan

Recommendation 7

Domiciliary care providers and their care staff are involved in this training so that they can engage in the CHC process to contact the relevant professionals to request and contribute to a check list and contribute towards the Full Assessment.

Accepted; This is included in the training as set out above. It is hoped in future training will be delivered jointly with the CCG

Recommendation 8

The CCG record and monitor the number of people who have an Initial Check List and the outcome of this i.e. how many of these are referred for a Full Assessment.

Accepted :The CCG have responded that this information is collated in a database which is already in place. The Local Authority is looking to see what information it can record on Care First, our client record system, but this would only include people known to us and not self funders .

Recommendation 9

All staff who carry out the Initial Check List must be appropriately qualified professionals and have had training on how to carry out the assessment, what information to provide to patients and their families and how to promote the advocacy support that is available. The information provided to patients should include health care and financial implications for patients and their families in the event of the range of outcomes of the assessment process.

CCG to respond to this recommendation

Recommendation 10

The CCG should work with the Hospital Trust to review the Integrated Health Assessment Form which incorporates the CHC Checklist to ensure that all information is clinically appropriate – of specific concern is the current instruction that patients who have not had previous cognitive impairment and have suffered a stroke must not be referred to mental health services.

CCG to respond to this recommendation

Recommendation 11
That as part of the agreement of the Operational Arrangements document the CCG, Local Authority and other partners agree to a local protocol on the interpretation of the revised Decision Support Tool guidance on the eligibility of patients who do not have a Priority Need but do have needs that meet indicative guidance set out on p.14 and 15 of the revised guidance.

Partially Accepted: The Local Authority has agreed with the CCG to work to the national guidance in establishing a primary health need. Therefore a local protocol should not be necessary as the detail is sufficient in the national guidance. Processes for local implication are being agreed e.g. Disputes Process. The Local Authority is committed to working with the CCG to provide the assurance to the Scrutiny Committee that the Indicative Guidance is being implemented appropriately.

Recommendation 12
The CCG should work with partner organisations including the Local Authority, SPIC, the Community Health Trust, the Hospital Trust, Age UK and other advocacy services to establish a panel that will consider the MDT assessment and make recommendations to the CCG regarding CHC eligibility. The terms of reference and operation of the panel should be reviewed annually to ensure that it is adding value to the process.

CCG to respond to this recommendation

Recommendation 13
The CCG and Local Authority work together to agree a dispute process as set out in the National Framework (p. 136) and jointly monitor the number and outcome of the assessments disputed by the Local Authority

Accepted : This recommendation has already been agreed and implemented.

Recommendation 14
As part of the Operational Arrangements document the CCG must include information on the re-assessment process. This must include a local policy on the interpretation of the principle of well managed needs as set out in the 2012 Department of Health Framework (p. 61) agreed by the CCG, Local Authority, Community Health Trust, SaTH, SPIC and the local advocacy services.

Partially Accepted: The Local Authority has agreed with the CCG to work to the national guidance in establishing the well managed need. Therefore a local protocol is not necessary. The Local Authority will work with the CCG to seek evidence that the National Guidance on well managed need is being implemented appropriately.

Recommendation 15
The CCG records and monitors the number of appeals / review and their outcomes.

CCG to respond to this recommendation

Recommendation 16
All patients and their family / representatives should be offered independent advice and advocacy before and during the appeal / review process. Patients should also be made aware of independent legal advice available e.g. free 15 minute appointments with a solicitor through Age UK and other specialist legal advice.

CCG to respond to this recommendation

Recommendation 17
The CCG ensures that it is adhering to the Framework when the patient or their family dispute the outcome of a re-assessment where funding is withdrawn.

CCG to respond to this recommendation

Recommendation 18
The Membership of the appeal panel should reflect the good practice established by the regional appeal panel (previously at the SHA) which included an independent chair. All communication from the Panel should come from the independent Chair.

CCG to respond to this recommendation

Recommendation 19
The Committee has not made any specific recommendations regarding the level of CHC funding as the funding inequality is a product of the failings in the CHC assessment process.

CCG to respond to this recommendation

Recommendation 20
The CCG and Local Authority work together to explore the option of Joint Funding Packages for patients who are not eligible for CHC in line with the National Framework.

Accepted: This has been agreed with the CCG and an initial meeting to establish appropriate policies and procedures was held in July.

Recommendation 21
The Committee does however recommend that the number of CHC cases, the level of funding and the number of jointly funded care packages made following a CHC assessment and the total funding contributions by partner organisations is reported quarterly to the Health and Wellbeing Board.

Accepted: The Local Authority will work with the CCG to bring this information to the Health and Wellbeing Board.

Recommendation 22
The Local Authority should ensure that any staff who report bullying or harassment are appropriately supported – this should include policies and procedures to cover partnership arrangements.

Accepted: The Local Authority has put in place training for staff so that they understand more fully their roles and responsibilities when representing the needs of their client at an MDT meeting.

The CHC Team leader also provides support in specific cases.

The dispute process is in place and staff are informed how they can use this.

The Council does have policies and procedures to support staff who are feeling stress as a result of bullying and harassment though a range of mechanisms.

Further discussion with People Services around procedures to raise issues with partner organisations.

Councillor England asked for clarification of the comments made in the Scrutiny Report in relation to bullying. Paul Taylor stated that at no time had any staff formally raised concerns in relation to bullying or such allegations.

Recommendation 23
In line with the Framework (p. 21) should the Initial Check List or full assessment identify a carer they should be informed of their right to a carer's assessment and advised to contact the Local Authority or, with their permission, refer them for this purpose.

Accepted: The Local Authority, as a matter of course, will inform a carer of their right to an assessment.

The Local Authority are committed to working with partner organisations to ensure this happens through out the assessment process.

Recommendation 24
Further work is carried out to clarify the number of patients assessed as eligible for CHC funding and receiving CHC funding and the age profile of people receiving CHC funding.

Recommendation 25
The Operational Procedure Document that was presented to the Scrutiny Committee is an opportunity for the CCG to have genuine dialogue with partner organisations. The Committee recommend that the concerns expressed by the local authority regarding this document are taken into account and that SPIC and Age UK and other advocacy organisations are also given the opportunity to comment on the Operational Procedures for CHC.

Reject
The Local Authority has agreed with the CCG to work to the national guidance as it is sufficiently detailed to be adhered to without the need for local guidance. Local processes are being agreed. The Local Authority will work with other organisations to monitor whether National Guidance is being implemented appropriately.

The Chair asked the K. Kalinowski, Assistant Director for Care and Support if she had anything to add.

K. Kalinowski responded that a Joint Workshop had taken place on the 20th June, facilitated by the Department of Health CHC Lead and the Association of Directors of Adult Services CHC Lead. The draft action plan is being drawn up and can be shared with Scrutiny. A Joint Group will oversee the implementation of this action plan and joint training will be essential. Within the Local Authority we have carried out training

for our staff and it is hoped that this will be done jointly in the future. The Joint steering Group has been established and will meet in September. This will be jointly chaired by the Assistant Director for Adult Services and the CCG's Executive Nurse Lead for Quality and Safety.

The Interim Director for Adult Care, Health and Wellbeing, added that there are discussions with the Chief Operating Officer and Chair of the CCG regarding the ongoing transfer of funds. It had been acknowledged that the Council had previously not been funding enough and after the rate of CHC funding had reduced the PCT had recognised the financial pressures this created for the Local Authority and had transferred funds. The CCG has agreed to passport £2.4 million funds to benefit the council. He recognised that the issues for patients and service users are different since NHS care is free at the point of delivery while the Local Authority does not fund care for people with over around £23k disposable capital. For 2012/13 the cost for self funders was £2.4 million. The CCG have continued to recognise the need to passport money to the Local Authority in 2014 but there needs to be further discussion regarding the number of people in the CHC system – the CCG and Local Authority have different views on this. We need to have an open dialogue about this and the impact if decisions regarding CHC.

The Chair commented that the CHC Guidance issued by the Department of Health in 2012 was much clearer. He added that the issue with the CCG transferring one-off funds was that this could change in the future. The Committee want to see the National Guidance implemented correctly. The guidance is open to local interpretation and the Committee concluded that it was not being interpreted fairly. If there is a primary health need – there must be a fair assessment and the care must be funded by the NHS. The Committee want the Council and CCG to work together to resolve this.

The Interim Director for Adult Care, Health and Wellbeing added that there has been agreement to adhere to the National framework. There has been disagreement in the past but we have agreed to work together in the future and there will need to be some compromise on both sides. We need to be clear what the processes are and it was recognised that it can be difficult for people to be clear what is the roles of the NHS and Local Authority social care.

The Chair responded that there has to be a fair system and that this should include jointly funded packages of care.

The Assistant Director for Care and Support agreed that Joint Care packages should be a matter of routine. There was a meeting in early July to take this forward.

The Interim Director for Adult Care, Health and Wellbeing clarified that the legislation

is clear that if there is a primary health need the NHS meets the cost of health and social care needs. If a person is not eligible for CHC there may be other health needs that the NHS should meet above the Registered Nursing Care contribution. There is no national system for care in a non nursing home setting e.g. at home nursing input above and beyond district nursing.

The Chair commented on the specialist care provided by care staff in nursing homes e.g dementia care.

Cllr. England agreed that it is important to provide continuity of care.

Cllr. Minor asked if there was anything in the National Framework that can be used to refuse care? He added that the current position seems to be “ them and us” and there is something wrong of Age UK have not won an appeal for 2 years.

The Interim Director for Adult Care, Health and Wellbeing responded that the CHC and Continuing Care legislation sets out who should fund the care, but neither legislation sets out the level of care – this has to be a judgement of need. There are difficulties for both organisations with their respective budgets.

The Chair said that there were a number of solicitors who were involved in challenging decisions and that this was something the Committee were very concerned about.

Cllr. Fletcher said that the Committee had not got information on the specifics on the different levels of funding and how this is decided.

The Interim Director for Adult Care, Health and Wellbeing responded that he can provide the numbers for continuing healthcare and continuing care.

These figures were confirmed following the meeting. The national figures for 2013/14 quarters have not been released yet.

- Continuing Healthcare (funded by T&W CCG): 56 people (as at 3 March 2013), equivalent to 15 per 50,000 head of population, compared to England average of 52 per 50,000 and Shropshire CCG 64 per 50,000 of their population
- Continuing Community Care (funded by T&W Council): 2060 people (as at July 2013)

It was recognised that we need to do more work with the CCG to agree the number of people who should be in the CHC system. National Figures show that we should be nearer 150.

J. Gulliver stressed the importance of dementia training in hospital. She had been in the hospital that morning and was told by a nurse that it was not happening.

The Interim Director for Adult Care, Health and Wellbeing highlighted that CHC does not apply to people in a hospital setting. When long stay hospitals closed more people were supported in the community.

The Chair added that it is important to recognise that people have different care needs and this includes religious requirements that should be provided in different settings.

The Interim Director for Adult Care, Health and Wellbeing responded that the legislation determines the funding responsibility – but the level of care is determined within the budget.

R. Shaw commented that the Department of Health Framework Guidance for CHC was better.

The Chair asked if the CCG representative would like to comment on their response. This was declined as she was attending as a member of the public.

Cllr. Fletcher said she was concerned that the CCG response says that the Scrutiny Committee had been biased. She confirmed that in her view the Committee has looked at this issue objectively.

The Chair said the Committee had identified that there had been a change in the level of funding – something had changes. The evidence presented to the Committee showed that the assessment process was unfair. The Committee did not have a set aim for this review.

Cllr. Fletcher said that she had met someone recently who did not know about CHC and was funding his own care.

R. Perkins said the Committee were looking for a balanced approach. The Committee had heard that people were not given the opportunity to contribute to the assessment.

Cllr Minor said that it is important to consult people. With information technology it is possible for people to get together through facebook, twitter. He gave the example of Stafford Hospital where local campaigns have made a difference.

The Chair said that we have a good relationship with the NHS. The NHS is in a process of change and the Committee has called the Local Authority and NHS to work together. The Chair said he was sure that they will work together to resolve this.

The Assistant Director of Adult Care, Health and Wellbeing said that there is a lot of good joint working between the Local Authority and CCG. This has been recognised by the Peer Challenge that has recently been carried out. People who are not receiving CHC are continuing to receive care funded by the Local Authority unless they are self funding. It is our view that very few people are not receiving the care they need. CHC impacts on our budget and the Local Authority will get to the point where we can't fund everyone so we do not bankrupt the Council.

Cllr. England said that the Council must work with the CCG and the Health and Wellbeing Board has a role in bringing health and social care together. He saw this as very positive and as an Elected Members his role is to question and challenge.

The Chair said that he had been involved in Scrutiny for a long time and that the Council is very lucky to have this CCG in Telford and Wrekin. The Council and Local Authority must continue to work together and Scrutiny will continue to ask questions.

The Scrutiny Group Specialist said that the responses to the Scrutiny report discussed at this meeting were initial responses from both organisations. A formal joint response has been requested from the Health and Wellbeing Board and this will be submitted to the Committee following the Health and Wellbeing Board meeting in September.

Cllr. England asked who will be presenting the response from the Health and Wellbeing Board?

The Interim Director for Adult Care, Health and Wellbeing responded that he has been tasked to work with the Chief Operating Officer of the CCG to bring a joint response to the Health and Wellbeing Board. It is also important to make sure that the voice for self funders is being heard. He explained that the Care and Support Bill, which is expected to take effect from 2015 will give Local Authorities responsibility for everyone in the care system – this does not mean that everyone will be funded. There will be a maximum amount that individuals will have to pay for their care.

The Cabinet Member for Adult Social Care, Interim Director for Adult Care, Health and Wellbeing and the Assistant Director, Care and Support left the meeting.

The Committee confirmed the views expressed by the Chair regarding the CHC report.

Cllr. Fletcher commented that the CCG response stated that legal advice had been sought. She asked if the Scrutiny Committee should seek legal advice?

The Chair responded that it would not be necessary.

HACSC-54 SHROPSHIRE AND TELFORD AND WREKIN SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2012/13

The Chair informed the Committee that this item had been deferred to the next meeting.

HAC SC- 55 HEALTH AND ADULT CARE SCRUTINY COMMITTEE WORK PROGRAMME

The Scrutiny Group Specialist outlined the work programme for the Scrutiny Committee.

Review of the Meals on Wheels / Community Meals Service
The meeting with the RVS volunteers had taken place and interviews with service users will be arranged.

Autism Strategy – it was agreed that a report on the autism strategy should come to the Committee in October

Mental Health – The Joint HOSC has decided to look at the provision of Mental health services. The South Staffordshire and Shropshire Healthcare Foundation Trust will be invited to the September meeting of the Joint HOSC.

Transfer of Public Health – the new Director of Public Health has been appointed and will be invited to future meeting of the Committee.

It was reported that the capacity of the Scrutiny Group Specialist to support this work will be affected by the work load of the Joint HOSC.

Cllr. Fletcher suggested that the Committee should scrutinise the cost of the new hospital at Ludlow and how this is being funded.

The Chair responded that this will be incorporated in the work of the Joint HOSC.

HAC SC- 56 CHAIR'S UPDATE

The Chair updated the Committee on the work of the Joint Health Overview and Scrutiny Committee with Shropshire Council and the outcome of the meeting held on the 8th August 2012. The Chair reported that he and the Shropshire Chair of this Committee has held meetings with the Hospital Trust, CCGs and NHS England Area

Team regarding the concerns about services at the Princess Royal Hospital and the Royal Shrewsbury Hospital. The Trust faces a number of issues:

- Low patient satisfaction
- Capacity issues at SaTH
- Ability of Trust to meet targets
- Concerns about sustainability of A&E services
- Staff survey – low morale and difficulty recruiting in key areas
- Financial issues resulting from requirement to make efficiency savings and duplication of services across both sites.

These issues are in the public domain and there are discussions taking place but as Chairs of the Joint HOSC they were concerned that no solutions for the longer term problems has been put forward. If these issues are not resolved important services may be lost by the Trust or it could be taken over. It important that the discussion about the future of hospital services is debated in public. The Joint HOSC Chairs held a meeting with representatives from the Clinical Commissioning Groups, Shrewsbury and Telford Hospital NHs Trust, Community HealthTrust, both Local Authority Cabinet Members for Adult Services and Chairs of the Health and Wellbeing Boards and the NHs England Area Team. At this meeting the Chairs expressed their concern and set out their expectations for the Joint HOSC meeting on the 8th August. The NHS organisations attended this meeting and set out the issues that the health organisations face and the need for change. The Hospital Trust was open about the problems they face. The Joint HOSC recognised that the services are not sustainable as their are currently configured. This has started the debate about the future of services, including A&E and the Joint HOSC recognised that all options must be considered. As far as he was aware, this is the first time that a Joint HOSC has taken this proactive approach to start a public debate about hospital services and there is no guarantee what the outcome of this process will be. The local NHS organisations have been asked to plan the public consultation. The role of the Joint HOSC is not to develop the solutions but to ask the questions. The Chair explained that it had not been possible in the timescales to update this Committee before now. He asked if the Committee support the approach taken by the Joint HOSC Chairs and the work undertaken by the Joint HOSC.

J. Gulliver commented that one issue that need to be addressed is that Walk in centres are referring patients to A&E

R. Perkins commented that access to GP is an issue and if people cannot get an appointment they will go to A&E.

The Chair said that doctors in Primary Care should perform minor surgery rather than

referring to A&E.

R. Perkins said it is important to educate the general population about how to use the NHS.

Cllr. Minor congratulated the Chair on the work the Joint HOSC Chairs had undertaken.

The Chair said that the Joint HOSC recognised that services need to be consolidated. As Chair he will not allow the discussions at the Joint HOSC to become politicised. Some people will have to travel further to get the best service – but it is not acceptable that the current situation where there are two understaffed and disorganised hospitals. The Joint HOSC has started this process and at the meeting on the 8th August it was set out that any decisions about the future reconfiguration of services will be made within 12 months.

Cllr. Fletcher commented on the need to locate children's services with other specialities.

Cllr. Greenaway said that it is important to look at the bigger picture if there is a risk of losing services. She asked who will manage the consultation and how this information will be recorded.

The Scrutiny Group Specialist responded that it is usually the Commissioners who are responsible for managing the consultation on changes to NHS reconfigurations.

The Chair added that the consultation will not be restricted to hospital services but will include community hospitals as well. All health professionals, the CCGs and the Health and Wellbeing Boards will have to be involved.

Cllr. Greenaway said that any consultation will involve a lot of responses which will include anecdotal evidence. This is an important part of the consultation.

Cllr. Fletcher said that the option to build a new hospital had been discussed in the media.

The Chair said that this was unlikely given the funding that would be required – but at this stage nothing should be ruled out.

The Scrutiny Group Specialist said that the Joint HOSC had responded to the recommendations of the Francis Report and was being proactive in addressing concerns about local services.

R. Perkins supported the work of the Joint HOSC and the timescales discussed.

The Committee supported the work of the Joint HOSC and the Joint HOSC Chairmen.

The Meeting ended at 17.33pm

Chairman: ....

Date: ....

HEALTH AND ADULT CARE SCRUTINY COMMITTEE
Notes of the meeting of the Health and Adult Care Scrutiny Committee held on 4th November 2013 in Severn Meeting Room, Business Development Centre, Stafford Park 4 , TF3 3BA

PRESENT:
Councillors D. White (Chair), V. Fletcher , Co-optees J. Gulliver, R. Shaw, J. Gulliver, and R. Perkins.

Also Present: Cllr. A. England, Cabinet Member Adult Social Care, Cllr. J. Seymour, P. Taylor (Interim Director Adult Care, Heath and Wellbeing), D. Robson, (Service Delivery Specialist (Safeguarding & Quality) D. Saunders, (Chair of Healthwatch Telford and Wrekin) , K. Ballinger (Manager, Healthwatch Telford and Wrekin) and F. Bottrill (Scrutiny Group Specialist)

The Chair opened the meeting, but as the meeting was not quorate it was agreed that the discussion would continue as an informal working group and the notes of the meeting would be received by the Committee at the next meeting.

APOLOGIES FOR ABSENCE

Apologies had been received from Cllr. R. Evans, F. Bould and Co-optees R. Shaw , D. Davies.

DECLARATIONS OF INTEREST

None

VERBAL UPDATE ON MENTAL HEALTH SERVCIES
The Chair updated the Committee on discussions that had taken place regarding mental health services. The Joint HOSC has been informed that the community service at Dawley, provided by the South Staffordshire and Shropshire Healthcare Trust, had been closed on a temporary basis for 6 months due to low usage. There has been no consultation regarding this change in service and it had been made clear at the Joint HOSC meeting that this was not acceptable. It also became clear that the information provided by the Trust on their performance did not reflect what community organisation were experiencing in relation to mental health services.

A meeting has been held with the MP, Cabinet Members, Clinical Commissioning Group and SSSFT where it was agreed that a review of mental health services would

be carried out. J Gulliver commented that it is important that this review also includes service to people with mental health issues who are in hospital because they have a physical illness. She raised particular concern about support for patients with dementia.

The Chair also reported that Members of the Joint HOSC had had a very useful visit to the Redwood Centre in Shrewsbury. Cllr. England said that he had been appointed to the SSSFT Board and had asked how he should raise concerns as the issue regarding Castle Lodge in Dawley had been raised shortly after his appointment.

Cllr. Fletcher said she was concerned that during the visit to the Redwood Centre Members had been informed that services Telford and Wrekin was in effect subsidising services for Shropshire. She referred to a report from Walsall on the provision of mental health services.

The Chair said he had spoken to a representative of a mental health organisation in Shropshire who raised concerns about the provision of community services.

K. Ballinger said she had become aware that there was a redesign of talking therapies and that this would affect people who are half way through their treatment. She questioned what consultation had been carried out.

The Interim Director, Adult Care, Health and Wellbeing said that there has been a increase in the use of talking therapies several yeas ago which aimed to prevent people developing more serious mental health problems. The had resulted in the IAPT (Improved Access to Psychological Therapies) team being developed locally. He was not aware of any cut backs to this service but was aware there was a waiting list. The strategy for mental health services was based on reducing the number of inpatient beds and developing community services. The health and wellbeing board should oversee changes to mental health services.

Cllr. Seymour expressed concern that the development of the Redwood Centre has been based on the improvement of community mental health services and asked how the Commissioners had been involved.

The Interim Director, Adult Care, Health and Wellbeing said that previously the local Authority had had joint commissioning arrangements with the PCT but when the CCG was created this was separated out. In the Council the services were led by K. Kalinowski as the Assistant Director and C. Harrison as the Service Delivery Manager. At the CCG F. Beck was the lead Director and M. Bennet was still a commissioner but no longer in mental health services.

Cllr. Fletcher said that she was concerned that during the visit to the Redwood Centre

the manager did not seem to be aware that maintaining the service at Castle Lodge was part of the strategy to improve community services in Telford and Wrekin.

The Chair said there had been discussions with Scrutiny in Staffordshire who have the role in commenting on the SSSFT Quality Account. the review of mental health services must make it clear what the services have been, what they will be and the reasons why.

Cllr. England said that there is an important role for the SSSFT Governors.

The Interim Director, Adult Care, Health and Wellbeing said that it important for the Governors from Telford and Wrekin to hold the Trust to account.

RELATIONSHIP WITH HEALTHWATCH

The Chair introduced K. Ballinger and D. Saunders from Healthwatch.

D. Saunders updated the Committee on the development of Healthwatch since the service was commissioned from Parkwood Healthcare. Healthwatch had been launched officially on the 24th October. Healthwatch was not a legal entity and arrangements were being put in place to appoint local directors in the next few weeks. The Board was currently working in Shadow form. The staff are in post and volunteers are being recruited. Healthwatch has a place on the Health and Wellbeing Board and there is a national body – Healthwatch England.

With regard to the relationship with Scrutiny Healthwatch has the opportunity to be the eyes and ears for a number of organisations and to feed into Scrutiny. Healthwatch will particularly work with people who are not usually heard e.g. people whose language is not English or deprived communities. Scrutiny could say – we are looking at this – can you do some work on this issue for us?

D. Saunders welcomed the opportunity to have a representative from Healthwatch on the Scrutiny Committee.

The Chair said that J. Gulliver would remain on the Health and Adult Care Scrutiny Committee and the Healthwatch representative would have a place on this Committee and the Joint HOSC. He said he would welcome someone from Healthwatch joining Scrutiny and will share the priorities and work programme for the Scrutiny Committee.

D. Saunders asked how Scrutiny's relationship with NHS England was developing.

The Chair said that NHS England had attended the meeting called by the Joint HOSC to resolve the issues faced by the Acute Trust.

The Interim Director, Adult Care, Health and Wellbeing said that NHS England was also responsible for commissioning GP services and specialist services.

Cllr. Fletcher asked if it was necessary to check the Council's Constitution if the number of co-optees changed.

The Chair said this was not necessary – it would be reported to the Scrutiny Management Board.

The Scrutiny Group Specialist said that an amendments would be needed in the Scrutiny Handbook which set a maximum limit of the number of co-optees to elected Members on a Scrutiny Committee.

SHROPSHIRE AND TELFORD & WREKIN SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2012/13

D. Robson presented the Adult Safeguarding Board Annual Report for 2012/13. He highlighted that the Board does not currently have ant statutory or legal basis and is separate from the Children's Safeguarding Board. The legal basis of the Board will change as part of the Care and Support Bill which sets out that the Local Authority must have a Board and this will have a duty to investigate. Across the West midlands there is a new safeguarding procedure which has been adopted by 11 of the 14 authorities.

The Annual Report identifies that the number of referral has increased year on year. This could indicate that there is an increase in the incidence of abuse – but there is a better awareness of abuse and this may have resulted in the increase in referrals.

The Adult Safeguarding Board has established a new sub-committee structure. The increase in referrals have not related to large institutional abuse but more to poor outcomes and cultural issues within an organisation.

Public awareness has been raised through talks to community groups, the website is hosted by Telford and Wrekin Council however this takes time to maintain and so it has not reached its full potential.

D. Robson also explained that there has been a move towards a performance framework which focuses on outcomes not just activity. The Department of Health requires activity data. This data is submitted in May and published in July.

D. Robson said that another priority for the Safeguarding Board is to have an independent chair. To achieve this the Board will have to become an independent entity and have income streams.

F. Bottrill said that it had been brought to her attention that there was an error on page 41 or the report. The number of staff in Telford and Wrekin who had received Adult Safeguarding Training was 437 not 34.

The Chair commented that there was more activity in Shropshire than Telford and Wrekin. He highlighted that for many areas of training this was identified as non-applicable and he queried if this was correct.

The Interim Director, Adult Care, Health and Wellbeing said that there are more care homes in Shropshire and there are also more domiciliary care agencies so there are more staff requiring training. the figures provided were for in house staff providing care and due to restructures there were no new starters.

K. Ballinger suggested it might be helpful to show information on the percentage of staff who have been trained.

Cllr. Fletcher asked about the 42 staff who have yet to receive the minimum training. She commented that the report said that this is 10% of the work force.

The Chair asked if the CQC had expressed a view on this.

The Interim Director, Adult Care, Health and Wellbeing said that the Council has two care homes but that provider organisations will have done this training with their staff.

D. Robson said he can confirm this.

The Interim Director, Adult Care, Health and Wellbeing said he would come back to the Committee on this issue.

The Chair asked how the safeguarding service will be maintained with the financial improvement plan?

D. Robson said there is a small team which has remained more or less untouched over 2 years. The senior social workers who carry out the investigations are not part of this team. The costs of the investigations are included in the Council's budget. IT was highlighted that investigations are time consuming.

The Interim Director, Adult Care, Health and Wellbeing said that the savings targets have not been based on reducing social work staff. 90% of the budget is spent on care not staff. There is a need to protect the number of assessment staff.

The council is the lead safeguarding agency. All organisations are responsible for their

own services but the local authority is responsible for investigation.

The Chair asked about powers regarding deprivation of liberties.

The Interim Director, Adult Care, Health and Wellbeing explained that this is relatively new since the Mental Health Act 2005 and implemented in 2008. This was the first time that individuals lacking mental capacity were recognised by the law and some cases are going though the courts It is taking time to embed the law and develop the knowledge in the health and social care community. The powers only apply to people in hospital or residential care. For people at home it applied at the time of a decision if there is no body else who can take the decision on their behalf . there is national recognition that there are differences in the use of the powers across the country. This would suggest that there are different interpretations by professionals not that there are different levels of capacity. The legislation came from one specific case where the patient who lacked capacity was in hospital and it was the view of the health professionals that this was in the person's best interest but the family wanted the person to come home. The legislation in place mean that to make this decision now there is a complex process – this is a legal requirement.

Cllr. White said that it is important that care staff have the training to understand the legislation.

UPDATE ON ADULT SERVICES

Cllr. England informed the Committee that Adult Services had a £4 million overspend and must make £5million savings. This requires the service to find £9 million by the end of the next financial year. He explained the 3 approached to addressing the financial issue:

1) 3 or 4 years ago NHS Continuing Healthcare funding in Telford and Wrekin had been £13.1 million but this had reduced to £3 million. this reduction in funding was being addressed with the CCG and discussions were also taking place with NHS England and the Minister if necessary.
2) A central issue is to ensure that adult service are lean and this is reflected in the organisational structure
3) Care provider costs –this accounts for 80% of the adult services budget/ some local authority care costs have not increased. In Telford and Wrekin if we can reduce costs by 5% this will save £2million, if we can save 10% this will save £4 million.

The Interim Director, Adult Care, Health and Wellbeing said that Adult services has been reviewed though a the peer challenge that had taken place over the summer. The feedback was set out in the report. The reviewers had been asked to look at the

Council's approach to personalisation. This is set in the context that there is less money available but more people needing support. It has therefore been identified that we must:

- Help people help themselves
- Help communities help themselves
- Prevention work
- Provide high level support without creating dependency

Social care is the largest spender accounting for 36-37% of the Council's budget. Our approach is to:

- Reduce the number of people needing support
- Reduce the amount of support
- Review all care packages to ensure people are not getting more help than they are entitled to
- Addressing the issues of CHC funding with the NHS

Cllr. England added that Telford and Wrekin is underfunded and when making comparisons we should look at the average funding in other authorities.

The Interim Director, Adult Care, Health and Wellbeing said that Telford and Wrekin is not a high spender on Adult Social Care but costs have gone up by 10% over the last few years. We appear to be paying a higher rate for domiciliary care and adults with learning difficulties. This is linked to CHC funding as the Council has assumed responsibility for high care costs. It was also explained that there is a consultation on New Options which accounts for £60 million of which £5million is in-house provision.

Cllr. England explained that shared lives is a scheme where by people who need support can live with another person. This meets their care needs but also reduces social isolation.

K. Ballinger said that the New Option consultation is being well done and the Council is ensuring that people understand. She said that Shared lived can work very well – but it is not for everyone.

Cllr. White added that it may address some of the issues resulting from the 'Bedroom Tax'.

The Interim Director, Adult Care, Health and Wellbeing explained that there are two huge pieces of change that the Council need to prepare for.

Care and Support Bill – this sweeps all care and support in one piece of legislation and

sets out how much individuals will pay for care.

Integration of Health and Social Care – It has been announced that by 2016 the Council will have to place a significant amount of funding in a joint integration fund. A first draft of an integration plan has to be submitted on February 2014. This will involve the Council, Health and Wellbeing Board and CCG
The Government will prescribe the minimum amount of funding that has to be put into the integration fund.

Cllr. Seymour asked if this would include some of the CHC money

The Interim Director, Adult Care, Health and Wellbeing responded that the amount of £3.8 billion nationally has been announced but this is not new money. There is an expectation that the NHS will free up money from the acute sector to support people on the community. From a council perspective this will create pressure on Adult Care.

R. Perkins said that there are a lot of patients who go to A&E instead of going to their GP. Previously as a PCT Board member this was something he had raised but one of the issues is that GP service is not available 24 hours.

The Interim Director, Adult Care, Health and Wellbeing said that as part of the integration work 1 billion of the 3.8 billion will be performance related and one of the conditions is that there will be 7 day working.

The Chair asked if this will include doctors and social workers?

The Interim Director, Adult Care, Health and Wellbeing responded that there has been some debate that 7 day working should not cost more – it will mean that staff time is spread over the 7 days.

The Chair said that given the scale of the saving that have to be made in the adult care budget it will mean giving less care to fewer people. He gave the example of Birmingham where they tired to raise the threshold for care but this was over ruled in court – not because it was the wrong decision but because the consultation had not been carried out properly.

R. Shaw said that you cannot put off making a difficult decision because you may be challenged.

Cllr. England responded that it is not possible to have a generic consultation. New Options covers a lot of services,

The Interim Director, Adult Care, Health and Wellbeing explained that if you aim to cit

a service this cannot be cut without taking the needs of individuals into account. the Council still needs to meet their eligible needs. The Cut cannot be made without reviewing on an individual basis. We must be able to demonstrate we have done it in the right way. If we do not do it in the fright was we will face challenge.

The Chair said that families will challenge if services are taken away. He supported the use of special guardianship – the Council needs to work with people and this can be much cheaper. Helping people to live at home will also involve aid and adaptation.

The Interim Director, Adult Care, Health and Wellbeing said that the disabled facilities grant will be part of the integration fund.

Cllr. England said that assistive technology has a role and can be a prompt however it does take away the individual contact.

The Chair said it is important that the Council talks to all service users and this will require additional resources. Scrutiny wants to be involved in this – but this was in issues in the Meals on Wheels review. Only Members were able to interview service users and this took a long time to agree.

The Chair also asked t if the budget that is being prepared for 2014/15 will be achievable or if it will be based on savings that have not been fully worked through?

The Interim Director, Adult Care, Health and Wellbeing responded that Adult Social Care budget has been reduced – and it has been recognised that the service has not previously delivered against the budget.

Cllr. England said that in September there was a £4million overspend reported and that the overspend is currently £0.5 million per month. A Panel has been put in place and considers every request for new resources. He gave the example of his experience of managing the budget for 3 sports centres. The difference is that Adult Service is demand led. Service delivery managers will now also report to the Cabinet Member.

The Chair asked if the panel will result in more people getting less care?

Cllr. England responded that the care funded by the local authority will be based on need nit wants or desires.

The Interim Director, Adult Care, Health and Wellbeing said that one of the issues is that the number of people receiving care has reduced but there are still more people coming into the system.

Cllr. Seymour asked how the Resource allocation system will help?

The Interim Director, Adult Care, Health and Wellbeing explained that the assessment equates that a persons needs requires this sum of money and it is up to the person and their family to determine how to sue this. He explained that he thought the Council will need to amend the community care policy which will require a report to Cabinet. The Resource allocation system will be implemented in the new year, initially with new people but this will also need to be used for people already receiving care.

The Chair asked if there is an appeals process?

The Interim Director, Adult Care, Health and Wellbeing said there is a statutory appeals process.

The Chair said that the council can end up on the position of defending a decision in court.

K. Ballinger said that this highlighted the importance of advocacy services.

Cllr. England said that the Council does fund advocacy services.

The Chair gave an example of someone who was receiving domiciliary care. They received care for 15 minutes – but the carer had spent longer travelling.

The Interim Director, Adult Care, Health and Wellbeing said that the carer will not be paid for the travel time. The Council does have an in house service – but this is at great cost. There is an issue for the care industry to provide a livable wage.

F. Bottrill asked if there had been discussion about reviewing the care threshold?

The Interim Director, Adult Care, Health and Wellbeing explained that the councils can set their threshold for care and are then required to provide care to meet the bottom if that level. Fro Telford and Wrekin the level is currently severe. He explained that when the Care and Support Bill becomes law in April 2015 the new threshold will be set nationally and this will be at the current severe level. Also there is national evidence that if the threshold is raised to critical, people who have a severe level of need deteriorate quickly and then become critical.

D Saunders said that the funding allocation for CCGs is changing and this will favour rural areas.

The Interim Director, Adult Care, Health and Wellbeing said that the reason given for this is that rural areas tend to have a higher proportion of older people.

The Chair said that the Committee is waiting for the formal response to the Scrutiny report on CHC funding.

Cllr. Fletcher said that it is essential that CHC assessments are carried out correctly.

The Chair said that the Committee will be involved in the consultation on the Council's budget proposals and will work jointly with the Budget and Finance Scrutiny Committee.

The Meeting ended at 12.35pm

TELFORD & WREKIN COUNCIL

HEALTH AND ADULT CARE SCRUTINY COMMITTEE – 27 MAY 2014

BETTER CARE FUND HEALTH & SOCIAL CARE INTEGRATION

REPORT OF THE ASSISTANT DIRECTOR FAMILY, COHESION AND COMMISSIONING

LEAD CABINET MEMBER CLLR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 This report sets out the requirements placed upon the Council and CCG to move towards the integration of health and social care services, with particular reference to the requirements to have a Better Care Fund (BCF) agreed and in place by April 2015.

1.2 This report also sets out the proposed integration vision, principles and funding that need to be developed and agreed, to allow relevant budgets to be freed up during 2014/15 for inclusion in the Better Care Fund and an initial planning template had to be submitted by 14 February 2014, signed off by the Council, CCG and Health and Wellbeing Board.

2. RECOMMENDATIONS

2.1 The Health and Adult Care Scrutiny Committee note requirements to put in place a Better Care Fund and consider the plan attached.

2.2 The Committee agrees any further scuriny of the Better Care Fund.

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	From April 2014	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The Government have identified £3.8bn nationally in 2015/16 for the Better Care Fund (BCF). This

		includes the continuation of the £200m of additional national funding in 2014/15 to assist local authorities in the implementation of the BCF. The Council's share of this is £645k. In 2015/16 the BCF will be created from £1.9bn NHS funding and £1.9bn based on existing funding in 2014/15. The Government have stated that nationally £135m of the BCF is available to resource the implications of the Care Bill, additional Carer's assessments and the Adult Safeguarding Board. This will need to be reflected in the Plan but will potentially require a reallocation of funding to allow the Council to meet these requirements. In 2015/16 the Telford & Wrekin Better Care Fund (T&W BCF) minimum allocation by Government is £11.690m of which £10.410m is revenue. The Fund also includes capital funding - Disabled Facilities Grant (£849K) and the Social Care Capital Grant (£431k). The financial template included within the report sets out the proposed value of the T&W BCF for the next two financial years. This demonstrates a significant variation to the minimum allocation to an overall total of £16.674m. It should be noted that this amount of funding is dependant on the CCG and the Council working together through the BCF to ensure a shift of resources from Acute, Emergency and Inpatient Care to the community Further work is planned to review current spending on the voluntary sector and a value still to be determined will then be added to the BCF. The financial template to be completed not only requires the costs of the individual schemes to be identified but also indicates an expectation of financial benefits arising. Until the more detailed work is carried out on the plan a monetary value cannot be identified but the areas from which these savings will arise are identified within the **Better Care Fund planning template – Part 1** £1bn of the £3.8bn will be performance related - linked to achieving outcomes. Further clarification of the implications of failing to satisfy performance requirements is needed before any financial implications can be fully assessed. This funding will be retained by the Department of Health and released in staged payments according to our performance as measured against the BCF plan. The Telford & Wrekin performance related funding

		will be approximately £2m. The template requires the identification of funding required for contingency if targets are not achieved. It is not possible to identify figures at this stage before further detailed work is completed on the overall plan. The significant shifting of resources from one sector to another will potentially carry significant risks for both the CCG and the Council if the planned outcomes are not achieved in terms of the additional costs that may arise for all organisations. As the pooled budget consists of funding already committed and does not include any new funding the requirements of the fund may well exceed the existing budget arrangements. The full financial implications of the BCF will need to be fully assessed as work towards implementation progresses. The Council is undertaking a significant transformation program in Adult Social Care which the BCF plan will complement. The Council and CCG, however, must also consider their own budget strategies and the need for significant savings delivery when considering the content and implementation of this plan. More detailed financial information is contained within the body of the report.
LEGAL ISSUES	Yes	The NHS England planning guidance (attached at Appendix 2) sets out the recommended process and format for developing a plan for the Better Care Fund. If the guidance is not followed at any point there needs to be a justifiable reason for doing so as this may jeopardise the award of funding (as outlined in the guidance). There will be standards for the plan which are national requirements. However, there will also be the Council's and CCG's own requirements which should be in place to ensure good governance, effective contract management and the protection of sensitive data. Further, if the plan results in any possible changes to existing service provision to people, consideration needs to be given as to whether further equalities impact and consultation work needs to be undertaken. The new integration provisions will bring significant changes to the commissioning of some Council and

		Clinical Commissioning Group (CCG) services. As the plan moves from being a strategic to a more operational process , officers will identify specific areas where changes to existing commissioning processes will be needed to incorporate the integration required. If the changes effect the Council's and CCG's commissioning plans it may require separate reports elsewhere such as Cabinet and CCG Governance Board. For example, changes to existing delegated powers may need to be made to undertake the new joint commissioning. There is reference to the potential legislative changes proposed in the Care Bill which, if implemented, will need to be complied with as part of this process. This will be monitored by officers. 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 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.
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	The timeframe for submitting a draft plan by 14th February 2014 is challenging, and will require a rapid joint effort by the Council and CCG. The existing information governance data sharing challenges in the NHS, caused by the introduction of the Health and Social Care Act 2012, may delay implementation of data sharing to support the integration of health and social care.
IMPACT ON SPECIFIC WARDS	No	

PART B) – ADDITIONAL INFORMATION

4. INFORMATION

4.1 As previously communicated, 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 spending review at the end of June 2013 set out the requirement to set up an Integration Transformation Fund, renamed the Better Care Fund (BCF) by April 2015, with at least a minimum value of CCG and Council monies included in the ITF. The national value of this funding in 2015/16 is £3.8bn and it includes the continuation of the national 2014/15 NHS transfer to local authorities. The spending review announced an increase to this transfer in 2014/15 by £200m to help local authorities prepare for the implementation of the BCF and make early progress on priorities.

4.2 On 17th October, NHS England and the Local Government Association jointly released a letter titled "Next Steps on implementing the ITF". There is an expectation that Health and Wellbeing Boards will oversee the development of a shared plan for the totality of health and social care activity within their area and that over time the level of total funding the CCG and LA will commit into the BCF will increase. The letter suggests that a fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. A further letter and guidance together with a final template was received on 20th December 2013. See Appendix 1 and 2.

4.3 The Council and CCG are required to put their share of £11.690m, identified as the minimum amount to be included, in the BCF. This money is not new money but there is an expectation the Council and CCG will agree to use the money to take forward a new shared approach to health and social care.
The table below summarises the elements of the Spending Round Announcement on the Fund:

<table>
<tr><th colspan="2">The June 2013 spending round set out the following:</th></tr>
<tr><th>2014/15</th><th>2015/16</th></tr>
<tr><td>A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned</td><td>£3.8bn to be deployed locally on health and social care through pooled budget arrangements</td></tr>
<tr><th colspan="2">In 2015/16 the fund will be created from:</th></tr>
<tr><td colspan="2">£1.9bn of NHS funding(some new funding included for new LA responsibilities in relation to Community Care)</td></tr>
<tr><td colspan="2">£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise:

• £130m Carers' Break funding
• £300m CCG reablement funding
• £354m capital funding (including £220m Disabled Facilities Grant)
• £1.1bn existing transfer from health to adult social care (includes £200m transfer from the NHS to Social Care)</td></tr>
</table>

The local value of our proportion of the is set out in the table below:

Better Care Fund Proposal

	Expenditure			Expenditure			Expenditure		
	LA	**CCG**	**Total**	**LA**	**CCG**	**Total**	**LA**	**CCG**	**Total**
	£k13/14	£k13/14	£k13/14	£k14/15	£k14/15	£k14/15	£k15/16	£k15/16	£k15/16
Reablement & Prevention	3,953		3,953	4,731		4,731	206	4,525	4,731
Support for Carers	523		523	523		523	328	195	523
Bed based Intermediate care	327		327	327		327	50	277	327
Developing Integrated Community Enablement					3,000	3,000		5,413	5,413
To support the transformation of healthcare and the Council's Community Care functions.	2,800		2,800	3,800		3,800		4,400	4,400
Review of Voluntary Sector Services to build community capacity						TBD			TBD
Sub Total	7,603	0	7,603	9,381	3,000	12,381	584	14,810	15,394
ICT investment/Service transformation	430		430	431		431	431		431
Disabled facilities Grant	702		702	702		702	849		849
Total	8,735	0	8,735	10,514	3,000	13,514	1,864	14,810	16,674

4.4 The fund will be allocated to local areas where it will be put into a pooled budget under joint governance between the CCG and Council, with a condition that they must have a jointly agreed plan which meets certain requirements set nationally. There are 6 national conditions:

- Plans to be jointly agreed.
- Protection for social care services (not spending).
- 7 day services in health and social care to support patient discharge from hospital and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care based on the NHS number.
- Joint approach to assessments and care planning, funding used for integrated packages and a named accountable professional in all cases.
- Agreement on the consequential impact of changes in the acute sector.

The opportunity has been taken to enhance the contribution to this fund to support the transformation of some of the Council's Community Care Services. It needs to be recognised that the resources that the CCG are to invest in out of hospital care (circa £9.8m in 2015/16) will have implications on the acute care sector. There is also a potential risk to the Council's financial position if outcomes are not achieved and more complex needs have to be met by Social Care.

4.5 Elements of the BCF will be performance related amounting to £1billion of the national £3.8billion total. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

4.6 The CCG, Council and Health and Wellbeing Board returned the first cut of the completed Better Care Plan template by **14 February 2014**. The revised version of the BCF plan should be submitted to NHS England, as an integral part of the CCG's Strategic and Operational plans by **4 April 2014**. A detailed draft report has been developed with the CCG.

4.7 A task and finish group has been set up with nominated officers from both the CCG and Council to complete the planning template to meet the deadline set (see Appendix 3 for completed draft submission planning template part 1 and 2). Discussions continue between Officers of the CCG and Council to develop this plan for the integration of health and social care locally.

4.8 **Proposed Local Vision**

To empower people in Telford & Wrekin to take control of their own health; to support them in caring roles, and to keep everyone as healthy and as independent for as long as possible'.

To achieve this we will work in partnership with our communities to commission and deliver high quality integrated health and care services. The service model must address the growing demand of an ageing population and people living with long term conditions.

The 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.

Our Better Care Fund will be focused on two key themes:-

1 Building Community Capacity (Prevention). To develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self help groups, and individuals in both 'patient' and 'caring' roles.

2 Enhanced community services as an alternative to hospital provision (Integration)To deliver a viable alternative to in-patient hospital care for people who can be cared for closer to home. We will build on our existing integrated community health and social care Enablement/Rehabilitation model by transferring capacity from the acute sector so that we offer a viable alternative community service rather than hospital bed based care.

The BCF will also be used to support adult social care services locally by helping the Council to protect Adult Social Services and make a "positive difference to social care services and outcomes for service users" linked to a "health benefit" , which otherwise would not be possible "in the absence of the funding transfer".

4.9 **Local Proposed Objectives for the BCF**

It is proposed that we base our BCF plan on the existing joint and integrated work currently in place between the Council and CCG with the following objectives within each theme

Using Theme 1, we will pilot arrangements in 2014/15, seeking a minimum reduction of £400k in acute care costs to fund care in a community setting.

Theme 1: Building Community Capacity –prevention, self-help.self-care, support to carers and building community capital

1. To review current spend by both organisations on voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
2. To support improvements in the infrastructure of the voluntary sector
3. To collaborate on commissioning a range of support services that can be delivered by voluntary and community organisations.
4. To work through a robust engagement process with self help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
5. To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.

Theme 2: Enhanced community services – maximising independence through integration of out of hospital services

1. To review how existing services funded by the resources being pooled in the BCF can improve to enhance quality, value for money, and outcomes.
2. To complete modelling to confirm how many people can be supported in Out of Hospital care, what staff are required and what the costs will be.
3. To establish an enhanced and expanded integrated and multi-disciplinary 'Out of Hospital Service' which will provide a comprehensive continuum of services from admissions avoidance to end of life care.
4. To bid for an element of the transformation monies in the CCG allocation for 14/15 to 'Invest to save' in staff to allow a longer term transfer of acute staff to the community in line with modelling completed by the CCG
5. To establish processes for referrals/access/assessment and support by the enhanced integrated service including the establishment of a Single Referral Point.

4.10 **Future scope of integration**

Whilst the Better Care Fund task and finish group are focusing on developing a plan that builds upon the integrated work currently in place particularly around adults – it recognises that the approach to commissioning and delivery being developed could be extended further in the future to encompass children and young people.

5. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

n/a

6. PREVIOUS MINUTES

None.

7. BACKGROUND PAPERS

7.1 Letter inviting expression of interest for Health and Social Care Integration Pioneers - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198746/2013-05-13_Pioneers_Expression_of_Interest_FINAL.pdf

7.2 Health and Wellbeing Board report 13th November 2013 Health and Social Care Integration

7.3 Cabinet Report 12th December 2013 Health and Social Care Integration

7.4 CCG Board Report 14th December 2013

7.5 Cabinet Report 30th Janaury 2014 Better Care Fund Health and Social Care Integration

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Department
of Health

Department for
Communities and
Local Government

Dear colleagues,

2 0 DEC 2013

Better Care Fund

The way we deliver health and social care services needs to change. One in three children born today expect to live to 100, so demand is only going to increase and we need to make major changes now to create seamless services fit for future generations , and to focus more effectively on preventing ill health and preventing a deterioration to health.

That is why, in June, we announced £3.8 billion worth of pooled budgets between health and social care, starting from April 2015. This will be a multi-year fund, as confirmed by the Autumn Statement, and is the biggest ever financial incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018.

Many places are already working collaboratively and redesigning services to meet the needs of users and communities, but we want to see faster and more widespread change. We have therefore provided an extra £200m in the pool for the transfer from health to social care in 2014/15 to streamline the process. This means that you should be well placed to take maximum advantage of the first full year of the fund in 2015/16. The £3.8 billion fund is the minimum amount to be pooled; some areas may wish to go further.

We call on every area to start planning now, with a view to having plans drafted by February 2014. We know the deadlines are tight – this is reflective of the urgency of this work. We need your plans to be innovative and ambitious – the end goal is radical transformation to provide better care.

We have come together in Whitehall so that you can work together at a local level. We need you to link your local plan to those wider determinants of health, and ensure housing and public health priorities and programmes support and enrich this work.

We are pleased to enclose full guidance and allocation information to enable you to make the most of the Better Care Fund.

NORMAN LAMB

BRANDON LEWIS

Annex to the NHS England Planning Guidance

Developing Plans for the Better Care Fund

(formerly the Integration Transformation Fund)

What is the Better Care Fund?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care "pioneers" initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

What is included in the Better Care Fund and what does it cover?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	**2015/16**
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.

7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance[1] from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

8. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

9. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*

10. *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

11. *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

12. Councils should use the additional £200m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.

13. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement

14. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.

    i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.

    ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will be the statutory framework for the Fund?

15. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75[2] joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

16. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

17. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

18. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local

[2] Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

19. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

20. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

21. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

How will local Fund allocations be determined?

22. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.

23. In 2014/15 the existing £900m s.256 transfer to councils for adult social care to benefit health, and the additional £200m, will continue to be distributed using the social care relative needs formula (RNF).

24. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

25. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £200m will be transferred directly from NHS

England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

26. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

27. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the Fund?

28. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

29. Where the unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

30. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:

- aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
- assure that the national conditions have been achieved; and
- understand the performance goals and payment regimes that have been agreed in each area.

31. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is attached as a separate Word document and Excel spread sheet. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

32. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and

the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

33. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.

34. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

What are the National Conditions?

35. The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

National Condition	Definition
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

How will Councils and CCGs be rewarded for meeting goals?

36. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.

37. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

38. The performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: • delayed transfers of care; • avoidable emergency admissions; and
October 2015	£500m	Further progress against all of the national and local metrics.

National and Local Metrics

39. Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

40. The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

41. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

42. Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

43. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two of these metrics, on admissions to residential and care homes and the

effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential and care homes	N/A	Apr 2014 - Mar 2015
Effectiveness of reablement	N/A	Apr 2014 - Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan - Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient / service user experience	N/A	Details TBC

44. For the metric on patient / service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient / service user experience should be measured specifically for the purpose of the Fund.

45. In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

46. A menu of possible local metrics selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life
Public Health Outcomes Framework	

1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as "inactive"
2.24i	Injuries due to falls in people aged 65 and over

47. Local areas must either select one of the metrics from this menu, or agree a local alternative. Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

48. Each metric will be of equal value for the payment for performance element of the Fund.

49. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

50. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

51. In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

How will plans be assured?

52. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

53. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.

54. The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

55. The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers. The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).

- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.

- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.

- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG, HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.

- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.

- Ministers will give the final sign-off to plans and the release of performance related funds.

What will be the consequences of failure to achieve improvement?

56. Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such

a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

57. If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

58. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

59. If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

60. If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

61. Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

Support for BCF Planning

62. CCGs and councils can access additional support for Better Care Fund planning from the same routes as for NHS operational and strategic plans: local support via CSUs or external providers, workshops and webinars, and specific tools and resources. Links to these, and contact details can be found on NHS England and the LGA’s websites.

When should plans be submitted?

63. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs’ Strategic and Operational Plans by **14 February 2014**, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.

64. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs’ Strategic and Operational Plans by **4 April 2014**.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Telford and Wrekin Council**
Clinical Commissioning Groups	**Telford and Wrekin Clinical Commissioning Group**
Boundary Differences	**Co-terminous boundaries**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Telford and Wrekin CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	Telford and Wrekin Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

DRAFT

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

There is a close partnership between all health and social care providers in the Local Health and Social Care Economy, who have worked together to improve integrated care for several years.

Various formal partnerships including all local organisations have been involved in steering the development of the plan to date, and these will continue to be closely involved:

- Health and Wellbeing Board
- Urgent Care Working Group
- Winter planning group
- Optimising capacity group
- Stakeholder partnership groups led by the Council/CCG involving users, carers, independent and voluntary sector providers

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Over recent years a number of strategic exercises have engaged the public, service users, carers, clinicians and providers to steer the planning of future services.
These include:

1. A range of joint strategies in place for several years, driven by a joint commissioning approach
2. Development of the Urgent Care Strategy where key patient messages and expectations of local services included:
   - Be joined up and responsible for my care
   - Help me understand my (urgent care) needs
   - Assess and treat me promptly and in the right place
   - Admit me to hospital only when necessary
   - Try to care for me at home, even when I am ill
3. A council led ‘Thinking Ahead’ project working group established to steer and coordinate the health and social care review of the Rehabilitation and Re-ablement Strategy.
4. 'Optimising capacity' - a work stream led by a management consultancy agency ATOS which designed a model to support early discharge/better rehabilitation. Stakeholders highlighted the need for any model to support alternatives to admission and admission avoidance.

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5. A review of the Multi-Agency Carer’s Strategy led by the Carer's Partnership.
6. A major conference as part of 'The Call for Action' on local healthcare provision. This served as the culmination of several months consultation informed by over 3,000 of the Shropshire/Telford & Wrekin population, and over 200 clinicians. .
7. Our Local Health Economy has just launched the next stage to respond to 'A call for action' - a 'Strategic Clinical Review' which will specifically focus on configuration of hospital based care, but which will be informed by progress of this plan to provide out of hospital care wherever appropriate.
8. This may lead to recommendations for further reconfiguration of hospital services and there will be ongoing and extensive engagement in accordance with the statutory engagement requirements of the 2006 NHS Act, and the so called 'Lansley' tests.

Common messages have emerged from consultative exercises to date:

- People want care close to home.
- They want it personalised to meet their specific needs
- There is currently insufficient 'joining up' between services that leads to confusion and potential duplication and/or fragmentation which is not cost effective.
- There is too much variation across parts of Telford and Wrekin particularly for access to services and/or patchy co-ordination.
- Discharges are far too slow - from user experience

No additional specific engagement has been completed at this stage for BCF. We will build on the above and expect to engage people in an iterative process over coming months as this plan will inform the Strategic Clinical Review of hospital care and vice versa. It is essential that we clarify 'what' can be provided out of hospital, and 'how much of it', at the same time as determining how to reconfigure acute services

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

The draft Implementation Plan is attached. Local strategies linked to integrated working are also summarised and included.

Document or information title	**Synopsis and links**
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment (JSNA) informs the development of priorities across the economy. The process brings together and explores a wide range of data, performance information and intelligence to identify those issues where the Borough is doing well and also those which remain a challenge and where more needs to be done. The JSNA is not one single document - individual parts of the JSNA can be found on our facts and figures page. The latest analysis from the JSNA process has been used to help identify local health and wellbeing needs,

Health & Wellbeing Strategy	This strategy sets out our commitment to working in partnership to improve the health and wellbeing of people living in Telford and Wrekin. The Telford and Wrekin Health and Wellbeing Board is responsible for delivering the strategy and addressing health inequalities. http://www.telford.gov.uk/downloads/file/4123/hwb_priorities_consultation_may_2012
Urgent Care High Level project Optimising Capacity proposal supported by Chief Officers Group, approved by CCG Board.	The project reviewed issues faced by the economy in managing urgent care demands. It showed that the current network of bed capacity, resources, care pathways, teams and skills were not optimised, thus creating inefficiencies. The project set out an integrated health and social care model of working to support discharge. Key features included: Discharge home to assess as the norm; a Single point of access and referrals mechanisms; integrated triage, co-ordination and management; a shared record, rapid access to advice and 7 day working. http://www.telfordccg.nhs.uk/board-papers-9-july-2013
Multi-agency strategy for Carers 2013- 2016	This multi-agency strategy sets out the ambition for local Carer services as well as, new national priorities identified by Government. The strategy's priorities will be supported by an action plan which will inform how these priorities will be met. The monitoring of the plan will be undertaken by the Carers Partnership Board where carers actively contribute to discussions and debates. From a grass roots level, continued engagement with the Carers Forum will ensure carers have the opportunity to influence and shape future services, which affect both carers and the person for whom they care for. http://www.telford.gov.uk/downloads/file/5201/carers_strategy-draft
Older Adults strategy 2006-2016	This Joint Strategy sets out the health and social care commitment to working with older adults in Telford & Wrekin, and our partners, to ensure that every older adult can access information when they need it, is valued as a citizen and as a member of their local community, always

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	has opportunities to improve his or her health and wellbeing, receives the care and support he or she needs to live as independently as possible and has personal choice and control over how the care and support they need is organised and provided. http://www.telford.gov.uk/downloads/file/2686/older_adults_strategy_refreshed_2010-2014
Multi-Agency Living Well with Dementia Strategy	This Joint Commissioning Strategy seeks to change the shape and quality of existing services to address the objectives in the National Dementia Strategy, 2009 (NDS). The purpose of the document is to drive the development of an equitable, seamless and coordinated dementia service of a good quality, using an agreed pathway served by agreed protocols and staffed by a trained, competent workforce. Implementation of the Strategy is through and Health and Social Care Economy Group for Dementia and accountable to the Health and Wellbeing Board. Dementia Pathway - Living with Dementia S
Rehabilitation and Reablement strategy 2010-13	This strategy sets out the proposed developments and changes to rehabilitation and re-ablement services in Telford & Wrekin. The overall aim is to provide a range of services that improve the quality of life for people and enable them to live as independently as possible. To achieve this, services must be timely, accessible and organised to meet individual needs. Rehabilitation and Reablement Strategy Rehab Action Plan 2012.doc
Integrated Community Enablement model	This paper sets out an approach to supporting frail elderly people with complex care needs through an Integrated Community Enablement model. It seeks to reduce admissions and length of stay through increased community capacity. The paper was supported by the CCG Governance Board http://www.telfordccg.nhs.uk/board-papers-12-november-2013

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2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Telford & Wrekin Health & Wellbeing Board has developed a 3 year Health & Wellbeing Strategy to improve health and wellbeing of our communities and address health inequalities.
The board recognises that effective commissioning and design of services is central to delivering against priorities and has agreed that key principles of equity, accessibility, quality, financial sustainability, positive experience, safeguarding, engagement and early intervention & prevention will underpin our approach to improving health and wellbeing.

The Telford & Wrekin vision for the Better Care Fund is:-
'To empower people in Telford & Wrekin to take control of their own health; to support them in caring roles, and to keep everyone as healthy and as independent for as long as possible'.

To achieve this we will work in partnership with our communities to commission and deliver high quality integrated health and care services. The service model must address the growing demand of an aging population and people living with long term conditions (a summary of needs analysis from the JSNA)

The 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

The Fund provides an opportunity to do something radically different given 'Doing more of the same' is not in line with stakeholder views or affordable. Our proposals must make better use of combined resources for service users, communities and tax payers.

Local user feedback constantly reinforces messages about the need for better information to enable people to manage their own long term conditions as far as possible, better support for carers, and services that promote independence

An audit completed in 2013 which was commissioned as part of our Urgent Care Project Group 'Optimising Capacity on Discharge' highlighted that 48% of patients in a hospital non-elective bed could have been supported with 'lower levels' of care in a community setting.

Reducing reliance on use of acute hospital beds, with increased investment in community services, is in line with feedback from our public, service users and clinicians. If we can

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design a service model that both strengthens community capital and delivers public services that are integrated, efficient, and 'skill mixed', we will achieve a more cost effective, sustainable option for delivering care in the future.

Our initial approach will focus on the themes outlined below. Both organisations recognise that greater integration of commissioning, management & administrative support and ‘all age’ service provision is possible in the future, where we can demonstrate that this would be in the interests of the population of our Borough and both our organisations.

Our Better Care Fund will be focused on two key themes:

1. To develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self help groups, and individuals in both 'patient' and 'caring' roles.

2. To deliver a viable alternative to in-patient hospital care for people who can be cared for closer to home. We will build on our existing integrated community health and social care Enablement/Rehabilitation model by transferring capacity from the acute sector so that we offer a viable alternative community service rather than hospital bed based care.

In five years time, we will have:

Theme one – Building Community Capacity in Telford and Wrekin

- A strong voluntary sector infrastructure, with strong links with our 'Teams around Practices'
- A significant increase, based on modelling data, (*tbc as a target*) in people volunteering
- Community networks in every locality in the Borough offering support as a wider Telford and Wrekin 'Extended Family'
- More Self Help groups for people with Long Term Conditions to help them manage their own health.
- Access to information through a wide range of traditional and modern social media mechanisms.
- Access to Advice and Guidance from health and care professionals when required.

With a view to reducing the number of people who need to access ongoing care support and/or treatment

Theme two – Enhanced community services for Telford and Wrekin as an alternative to hospital provision

- Fewer hospital wards for non-elective care as we transfer capacity and activity into the community service.
- This will strengthen the ability of hospitals to focus on patients that need hyper-acute care, for example strokes and heart attacks, and to focus increasingly on planned operations.
- An Integrated Enablement/Rehabilitation Service that has a full complement of

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clinicians and skills, including acute Doctors, Nurses and Therapists, in addition to existing Social Care and Community health professionals able to in-reach into existing residential and social care settings.

- Access to care to support people in the community
- This service will operate 7 days a week.
- A 'Single Referral Point' for Integrated 'Step up/Step down' with patients identified by the NHS number to facilitate better information/data sharing.
- Single triage and assessment processes will be well established.

There is significant evidence, particularly for older people, that hospital based care can have a negative impact; reducing confidence, exacerbating dementia, confusion, increasing risk of falls, and eroding levels of independence.

With improved technology, enhanced capacity and greater skill mixing in community services it is possible, and in line with patient feedback to offer more care out of hospital and reduce dependence on continuing care in the community.
We expect to see the following outcomes:

- Improved levels of confidence in self care
- Fewer avoidable admissions through better management of long term conditions
- Carers feeling better supported
- Enhanced Community involvement
- Reduced unnecessary emergency admissions
- Reduced delayed transfers of care
- Improved, expanded and effective support services facilitating more people in independent living
- Delayed admission to residential care/nursing home care
- Better end of life care experiences, with more people able to die in a place of their choice.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

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 aims are:

- Delivering the best possible health and social care outcomes
- Promote 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

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Five performance measures will be used to monitor progress :

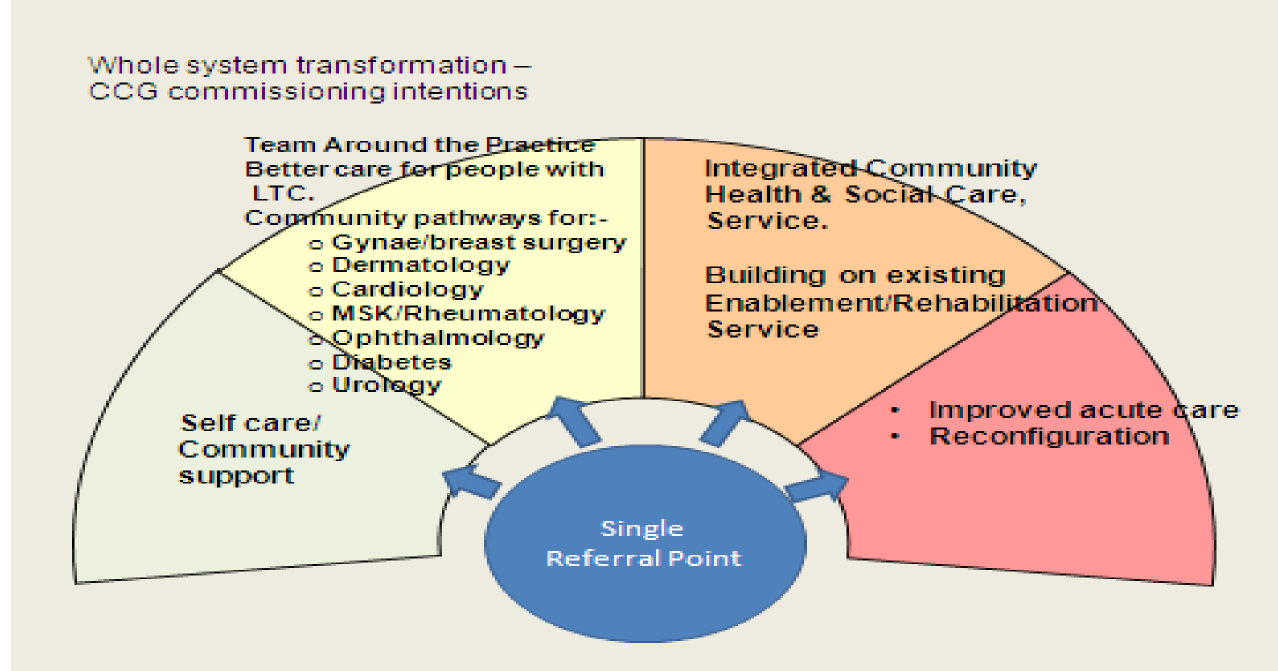
- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.

This has been driven by the national personalisation agenda in Adult Social Care which recognises that the traditional ways of delivering community care services are unsustainable against a background of budget constraints and increasing numbers of people needing support. There is evidence that the historic approach can disable people, is risk averse and leads to an over prescription of support, whilst discouraging innovative, personalised and more cost effective interventions.

Therefore the Council's commissioning intentions are based around a more personalised approach with the person and their family taking greater control themselves through access to:

1. Universal Information, Advice & Living Well
2. Community Support to facilitate self-help
3. Single point of access for specialist advice & support
4. Prevention & Enablement to maximise independence and avoid or reduce need for ongoing care and support
5. Personal budgets to give greater choice & control for those who need ongoing support

Similarly the CCG demonstrates its 'high level' commissioning intentions through the model below:-



The four elements in the CCG commissioning strategy include:

1. Stronger communities – to strengthen communities, develop greater capacity for patients to 'self-care', and to offer support to families and carers.
2. A Team around the GP Practice – to strengthen primary care with a multi-disciplinary approach to proactive support of patients with Long Term Conditions, particularly those who are vulnerable.
3. Enhanced Integrated Enablement Team – to build on the existing Home from Hospital and Enablement Services and to broaden the remit to include a community based Falls Service, all admission avoidance; all discharge of rehabilitation and enablement and End of Life Care.
4. Improved Hospital care– ensuring acute hospital services have effective processes from ED attendance, admission, treatment pathway to discharge to ensure quality and efficiency.

The greatest synergies between the discrete council and CCG plans is in the shared aspirations for:

- *Prevention, self-help/self-care and building Community Capital*
- *Maximising Independence through the Integration of Out of Hospital and Enablement Services.*

To deliver these aims we have the following objectives:

Theme 1 - Building Community Capacity in Telford and Wrekin

1. To review current spend by both organisations on voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
2. To support improvements in the infrastructure of the voluntary sector
3. To jointly design and procure a range of support services that can be delivered by voluntary and community organisations
4. To work through a robust engagement process with self help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
5. To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.

Theme 2 – Enhanced community services for Telford and Wrekin as an alternative to hospital provision

1. To review how existing services funded by the resources being pooled in the BCF can improve to enhance quality, value for money, and outcomes.
2. To complete modelling to confirm how many people can be supported in Out of Hospital care, what staff are required and what the costs will be.
3. To establish an enhanced and expanded integrated and multi-disciplinary 'Out of Hospital Service' which will provide a comprehensive continuum of services from admissions avoidance to end of life care.
4. To bid for an element of the 1.5% transformation monies in the CCG allocation for 14/15 to 'Invest to save' in staff to allow a longer term transfer of acute staff to the community in line with modelling completed by the CCG.
5. To establish processes for referrals/access/assessment and support by the enhanced integrated service including the establishment of a Single Referral Point.

The measures of benefits in terms of health gain and/ or personalisation and independence can be summarised in two categories – Non-Financial and Financial Benefits

Non-Financial Benefits

- More people are empowered to manage their own condition
- More people are supported to meet their urgent care needs in the community
- People get the help they need when they need it
- More people benefit from Intermediate care
- People only spend the time in hospital that is needed
- People are enabled to recover and regain their independence
- Improved transfers of responsibility of care – 'passing the baton', ensuring a smoother and more coordinated journey.
- More people are enabled to recover and regain their independence
- Improved patient experience of the quality of care received
- Improved end of life care outside hospital
- Reductions in admissions due to falls and long term implications of falls
- Reduction in the number of patients leaving acute hospital who are admitted to residential or nursing home care
- Achieving cultural change within our community, encouraging and supporting self help and self care
- Increased engagement of volunteers
- Maintaining people in employment longer

Financial benefits

- Increase in uptake of carer assessments and support services
- Reduced duplication, through single points of access, assessment and potentially, intervention.
- Reductions in hospital admissions
- Reductions in zero length of stay
- Reductions in 1-5 day length of stay
- Reductions in excess bed days in acute hospitals
- Reductions in admissions to care/nursing homes from hospital
- Reductions in admissions due to falls/falls in hospital
- Reduction Delayed Transfers of Care
- Reduction in need for longer episodes of more intensive care.
- Maximising flow through enablement, monitoring periods of intervention, which may be less than 6 weeks, to maximise capacity of the service.
- Reduction in domiciliary care packages or reduce the rate of cumulative costs increase

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c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery

- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Planned changes for theme one- *Building Community Capacity in Telford and Wrekin*

Prevention enables people to maintain good physical and mental health and live independent and fulfilling lives. A key element of our integrated model is to strengthen communities, develop greater capacity for patients to 'self-care', and to offer support to families and carers.

We plan to develop the ability of people and communities to manage their own care, by ensuring that there is good information and support available to people and their carers. We will build community capacity by supporting the development of, and improving links with mutual support organisations. We will ensure education and better information for early support to prevent more costly interventions in the future.

There is no new money for this, but by combining the resources of the two organisations we will improve service specifications, procurement and rigour around contract monitoring to ensure optimal delivery. Through this focus we will provide facilitation to communities and strengthen the ability of Self-Help groups in providing information, support and guidance.

Care of long term and other conditions will increasingly be based on a shift of responsibility from professional to citizen. The ideas of self-care and expert patient are not new, and as personal health budgets and appropriate assistive technology emerge we will explore opportunities to take the principles of self-care to the next stage.

Investment in relevant housing related support including physical building related adjustments as well as low level support will remain an important preventive component.

This work stream is being progressed through the positive interface with the voluntary and community sectors, through the Chief Officer's Group and an existing Local Authority -led Information and Advice project. There is productive engagement with Advocacy and User-led organisations to ensure robust service user and carer involvement.

Although still to be explored we envisage a key role for Healthwatch Telford & Wrekin and the CCG Roundtable in supporting this theme.

Planned changes for theme two: *Enhanced community services for Telford and Wrekin as an alternative to hospital provision*

Integrated teams have been established to deliver effective rehabilitation and enablement services in the community. Re-ablement focuses on preventing or delaying a downward spiral of increasing dependence, declining physical and mental health and poorer quality of life. Interventions address physical aspects (e.g. mobility, physical functioning, pain management etc) and mental health and the factors which promote it (e.g. social relationships and support, self-esteem, self-efficacy).

Re-ablement not only helps individuals to recover and achieve their full potential but is also a good investment for health care and social care, including, preventing decline. Rehabilitation enables individuals the interventions to return to the level of function prior

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to illness or surgery. After rehabilitation and enablement, it may be possible to remove the need for on-going care, and to establish independence and coping skills more effectively so future crises can be avoided.

The existing integrated Enablement Team in Telford & Wrekin already includes Social Workers, Domiciliary Carers, Nurses and Therapists, with a local authority management lead. The proposed model is to enhance the service by integrating elements of other existing services to create additional capacity. MCAP audit data will be used to inform this work.

The most critical action for this plan to work is to model exactly what capacity is needed to provide a viable 'out of hospital' service which will enable the CCG to reduce activity levels in the acute contract to divert both money and staff into the new service.
This must include the social care component which has yet to be fully modelled and costed. We are exploring what support the Central Midlands CSU can provide to help with this.

We now have access to detailed benchmarking data for District Nurses and will use this for modelling community nurse capacity.

The development of the Joint Health and Wellbeing priorities were determined from JSNA evidence and activity trends including rates of child obesity and demographic changes for older people. The development of strategies earlier including for Rehabilitation and Reablement, Dementia and Carers all include JSNA analysis and projected increases in demand. The analysis supported the action plans from the strategies.

Activity assumptions related to Theme Two include projected numbers of people 65+ who need will need health and social care services and associated increased in demand. This was recognised within the Urgent Care High Level Projects in 2013. The economy agreed a model for Optimising capacity on Discharge to reduce length of stay in hospital; giving additional acute capacity. This model has been developed through Commissioning plans for the CCG and Council to the Enhanced Community model.

The JSNA also highlights likely numbers in need of some level of support for LTCs that may, in the future, need enhanced health and social care services. This information will support the demand and capacity modelling for Theme One.

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d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The plan proposes reduced activity within the acute sector. These include reduced admissions and length of stay. Current modelling (to be further revised within the action plan) highlights 845 reduced admissions (utilised MCAP audit data) 1500- 2000 early discharges. This includes reduced admissions related falls and End of Life care within the community from enhanced services. Most NHS rehabilitation will be community based

rather than within the acute setting.

Indicative saving are £2.1 – £4.5m full year effect on activity reductions. Commissioning intentions for 2014/15 include a £3m reduction to the acute hospital to be included within the BCF.

The model within Theme Two includes acute clinical capacity working within the community – medical, OT, physiotherapy – to ensure sufficient specialists skills are available to avoid emergency admissions. This will also develop further community capacity to support planned care reductions within the acute sector where possible.

Risks associated with savings not being realised are highlighted within the risk matrix.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The CCG is accountable to NHS England for performance, and the council to the population through elected members and the Cabinet. We are actively exploring a more significant role for the Health and Wellbeing Board. We will be suggesting that the Board prioritises the Integration agenda and the management of what will become a significant pooled budget.

It is proposed that the Programme Management Group for the Better Care Fund will report into the Strategic Commissioning Group which in turn will report into the Health and Wellbeing Board.

The H&WB will provide strong joined up governance for the formal pooled BCF budget. The BCF will be delivered through a strong Programme Management approach. The PM Group will have clear goals, a robust plan, work-streams and clearly identified resources. The H&WB will receive assurance on progress from the PM Group.

The Health & Wellbeing Board will be responsible and accountable for monitoring the spend of pooled budget, scrutinising delivery of programmes plans, and performance managing progress.

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3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

Social Care have statutory duties including carrying out statutory assessments and meeting eligible needs in a person centred way. We will maintain the availability and quality of services which keep people safe. The focus will be to ensure, as far as possible, that people remain independent within their own home.

From carrying out the of statutory assessment of need, a range of options will be utilised: accessing a range of voluntary and community resources; signposting to partner agencies including Council services, housing and by providing a range of interventions to meet assessed eligible need.

We will increase the level of self-help and low level prevention to support the whole population This includes prevention programmes, reablement and assistive technologies, practical support in the home, equipment and adaptations, carer services and support where necessary to access residential and nursing home provision.

Without this approach the need for primary and secondary care need will increase. Therefore, front-line support must be adequately resourced within a climate of reduced resources.

Please explain how local social care services will be protected within your plans.

The BCF will be used to support adult social care services locally by helping the Council to protect Adult Social Services and make a "positive difference to social care services and outcomes for service users" linked to a "health benefit" , which otherwise would not be possible "in the absence of the funding transfer".

The BCF is to redistribute resources to reduce the over reliance on acute services and place more emphasis on earlier help and prevention services. This will maximise the use and impact of resources to reduce costly services.

The plan builds on the existing integrated working of Enablement team who will find care solutions that meet identified needs in the cost effective way, where resources are directed to maximum benefit and impact at lowest cost.

Social Care services will be protected by understanding their statutory duties; the development of integrated models of care which will reduce duplication, streamline assessment and maximise independence and more joint commissioning focusing on outcomes; pooled resources and a reduction in the duplication of effort. Individuals will be healthier for longer before they need more extensive care packages.

Current expenditure on re-enablement and prevention through the s256 agreement provides resources for

- Community Equipment and adaptations
- Telecare

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- Integrated Crisis and rapid response services
- Maintaining eligibility criteria
- Enablement services
- Bed-based Intermediate Care services
- Early Supported Discharge schemes
- Other preventative services

These will be revised and enhanced to maximise independence and self-help. Developing community capacity as set out above will delay the demand for and reduce the level of extensive care packages – being person-focused with care delivered in the right place at the right time by the right people.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

All organisations have developed 7 day working in response to our current Winter Plans. The local Hospital Provider SaTH (Shrewsbury and Telford Hospitals Trust) is developing 7 day services, including medical cover. Social Care has extended Hospital from Home Service and the Community Trust is in the process of extending key services, e.g. Community Equipment.

Proactive discussions with the Care/Nursing Home sector are underway as our analysis demonstrates delays. A more consistent approach is needed to the transferring of patients at weekends.

Within the new model people will be able to be discharged from hospital at the weekend through the staff medically approving, planning and initiating discharge. This includes the link-up with suitable providers if there are on-going care needs. This will involve SaTH and SCT changing their staffing patterns and rotas.

The integrated Enablement service already operates 7 days a week, although health input tends to be limited to Monday- Friday - this will be addressed through the planned expansion. Further modelling and pilots will be considered to ensure the optimum effectiveness and efficiency.

Strategic commitment has been demonstrated through the following papers:

- Health & Wellbeing Strategy
- Urgent Care High Level project Optimising Capacity proposal supported by Chief Officers Group , approved by CCG Board.
- Joint Rehabilitation and Reablement Strategy 2010- 2013
- Older Adults strategy 2006-2016
- Multi-Agency Living Well with Dementia Strategy
- Multi-agency strategy for Carers 2013- 2016

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c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

We are not using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Currently the NHS number is used inconsistently across social care, although the council database 'Care First' does include a field for it. We are currently reviewing the Information Sharing protocols (which had been signed by the PCT so out of date) with the intention of re-signing these in early 2014. A robust project plan to include training to facilitate cultural change for the systematic recording of the NHS number by social care professionals is being developed. This includes clarification of the implementation timescales for the use of the NHS number as the primary personal identifier. This is a specific requirement of the BCF. The plan will develop processes to share activity and performance data on key services and we need to ensure the same data sets are being shared across the partnership. If there is a change to existing sharing of data sets or sharing of new data sets then this will need to be mapped and privacy impact checklists completed alongside completion of individual data sharing agreements for each data set. This is potentially very large piece of work that service areas would need to complete and a risk is being added to the risk register that without a framework this may not be adequately completed. The project team is exploring the implications of extending data sharing to more voluntary organisations as the sector is currently challenged by lack of capacity and technical knowledge. Plus there is a risk that the voluntary sector may not be compliant with Local Authority or NHS Information Governance standards

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

There is commitment to allow information to be exchanged between systems through open standard interfaces, supported by open Application programming Interfaces where necessary.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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There is commitment to ensure appropriate IG controls are in place. Both the Council and the CCG have IG teams that provide guidance and awareness on related matters and are also the key people in completing IG Toolkit requirements.

The IG team liaise with both the Caldicott Guardian and SIRO regularly providing assurance that adequate IG controls are in place. The CCG's IG team is purchased through the Commissioning Support Unit.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The current integrated Enablement team have a lead professional to case manage based on identified need.

Within the enhanced model the lead professional will be determined by a Single Assessment Process - this will identify the most appropriate individual to take that role. This assessment will also determine levels of risk and the support plan. Consultant medical capacity and additional OTs, physiotherapy, social work and nursing will be within the team.

Changes to the GP contract will require us to build on existing risk stratification and develop robust care plans for high risk groups. Our health economy has been targeting support for residents of care and nursing homes including a Care Home Advanced Scheme completing care plans for patients at high risk of hospital admission. This work will inform approaches to risk stratification. GPs will therefore support the identification of those high risk patients who need a joint care plan and lead professional.

Through BCF we will also focus resources on people living in the community to provide 'step up and step down' support.

The 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
- Discharged with a need for rehabilitation and/or enablement

All people who are identified as high risk of admission will have an agreed accountable lead professional.

The target population has not been reduced further. This is to ensure this is inclusive of

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all who are at risk or may need enhanced health and social care needs. This approach maximises the potential and impact of self-help; support to primary care for LTCs, reducing admissions and supports early discharge. This approach also provides further opportunities for joint planning and integrated working.

A significant target group is the 5383 admissions for 65years+ (in 2012/13). This will be reduced through self- help from building community capacity and enhanced Community services (building on the 1400 Enablement episodes in 2012/13).

RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

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System: Better Care Fund (BCF)	**Assessment Conducted by:** Michael Bennett and Lezli Feeney
Vision: 'To empower people in Telford & Wrekin to take control of their own health; to support them in caring roles, and to keep everyone as healthy and as independent for as log as possible'	**Date:** 04/02/14 **Review Date:** 01/04/14

Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor (*T&W Council risk grading in italics and brackets)*	Actions	Residual Risk	Responsible Person/ Implementation Date
£3m of capacity must be moved from SaTH during 2014/15 to provide the financial resources for the BCF. Reduce reliance on acute hospital beds by community investment.	Failure to release this funding, e.g. by failure of SaTH to reduce activity, will mean that sustainable service change in the community cannot be delivered.	Commitment in principle to the BCF BCF Project Plan Local health and social care economy BCF Steering Group Call for Action – Strategic Clinical Review Defined contract activity changes	Possible x catastrophic = high 13 *(High x likely = key risk 8)*	Development and in year activity of the BCF Steering Group Further innovations as part of the action plan within year to further reduce admissions and LoS	Catastrophic and Unlikely = High 12 *(High x likely = key risk 8)*	Michael Bennett

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Effective change management achieved at SaTH, SCT and Council Trust to facilitate reduction of activity at SaTH and create the capacity and skills to undertake additional work in the community.	Teams within organisations may continue to work in existing patterns; cultural change will not be achieved and patients will not receive joined up, personalised care closer to home. This risk may be exacerbated by 'change fatigue'.	As above	Major x possible = high 11 *(High x medium = key risk 7)*	Skills audit of SaTH, SCT and Enablement Re-deployment of SaTH and SCT into the Virtual team as part of integrated model Some redeployment of staff from SaTH to the Community Trust to TAP Recruitment of additional staff Further innovations to promote new ways of evidence-based interventions	Major x unlikely = Moderate 8 *(High x Unlikely = key risk 6)*	Michael Bennett
Inconsistency of interpretation between the Council and CCG relating to the levels of CHC funding.	The BCF template will not be approved by the HWB Board. Financial pressures remain highlighted and unresolved	DH guidelines for CHC BCF financial modelling Negotiations between the Council and CCG re: funding for people in their own homes and care	Moderate x possible = moderate 8 *(medium likelihood 5)*	Continued negotiations related to the level of the BCF pooled budget	Moderate x unlikely = Low 6 *(medium x unlikely = 3)*	David Evans

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		homes					
Programme management capacity	Insufficient resource to effectively manage the BCF programme will exacerbate challenges to its success. This risk is exacerbated by reduced management structures across the local health and social care economy. Other responsibilities cause distraction.	Council lead: SDM Transformation/ CCG lead: Head of Commissioning, Integrated Care	Major x possible = high 11 *(High x medium = key risk 7)*	Proposed programme management structure and staff being considered. Steering group bring developed	Major x possible = high 11 *(High x medium = key risk 7)*	Fran Beck/ Clive Jones
High level technical modelling and analytical skills to model activity and provide monitoring data.	There is insufficient assurance that the available data, national metrics and skills resource are sufficient to ensure meaningful modelling and monitoring of activity flows to define proposed and actual activity. The urgency to address this risk is exacerbated by the need to include meaningful data in the programme submission to the Area Team.	CM and SL CSUs and Council data analysts Project Group	Major x possible = high 11 *(High x medium = key risk 7)*	Understanding of the available data and an evidence base of activity will develop over time. Therefore close data monitoring must be maintained.	Major x unlikely = Moderate 9 *(High x Unlikely = key risk 6)*	Michael Bennett

Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor	Actions		CCG Responsible Person/ Implementation Date
Insufficient capacity within the local community, principally the voluntary sector, to support self help/ self care. There is a need for significantly more community capacity in this area Current providers include: Red Cross, Age UK and Community Service Volunteers (CSV)	Self care will not form an effective element of service redesign to provide care closer to home, self help intervention, community support and move activity from specialist to prevention and self help. Increased financial risk	Contracts with current voluntary sector providers Call for Action Working together Events in Telford and Wrekin	Major x possible = high 11 *(High x medium = key risk 7)*	Provide support to the voluntary sector to develop the leadership, capacity and skills to fulfil their role in the delivery of the BCF. Establish voluntary sector links to 'Teams Around Practices' Implement communication and engagement strategy as identified within the Implementation plan	Major x unlikely = Moderate 9 *(High x Unlikely = key risk 6)*	Michael Bennett
Patients and the wider community need to feel that service delivery under the BCF effectively meets	Failure to 'win hearts and minds' will result in failure by patients to engage with care provided under the BCF programme. Failure to implement the	BCF Project Plan Call for Action – common messages	Major x possible = high 11 *(High x medium = key risk 7)*	Patient and public engagement in the BFC programme. Meaningful communication	Major x unlikely = Moderate 9 *(High x Unlikely = key*	Michael Bennett

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their needs.	BCF will challenge the CCG's ability to address the common messages of consultative exercises.			and engagement, including the use of social media, to inform the Strategic Clinical Review and BCF. Establish community networks within the Telford 'Extended Family' and self help groups for people with Long Term Conditions. Reduce negative impacts of care on people.	*risk 6)*	
Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor	Actions		CCG Responsible Person/ Implementation Date
Integrated care pathways that empower patients and address the needs of the local demographic.	Failure by partner organisations, including the voluntary sector, to embrace cultural change and work in a truly integrated way will challenge the quality and timeliness of services	BCF Project Plan BCF Steering Group JSNA CCG and the Council's commissioning	Major x possible = high 11 *(High x medium = key risk 7)*	Joint working within the Steering Group to inform change in partner organisations Act upon the findings of the	Major x Unlikely = Moderate 9 *(High x Unlikely = key risk 6)*	Michael Bennett and David Evans

		intentions		‘Optimising Capacity on Discharge’ audit Implement ‘Single Referral Point’ and single triage and assessment		

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Risk Grading Matrix

	Consequences				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Almost certain	LOW 6	LOW 7	MODERATE 10	HIGH 13	HIGH 15
Likely	LOW 5	LOW 6	MODERATE 9	HIGH 12	HIGH 14
Possible	VERY LOW 4	LOW 5	MODERATE 8	HIGH 11	HIGH 13
Unlikely	VERY LOW 3	VERY LOW 4	LOW 6	MODERATE 9	HIGH 12
Rare	VERY LOW 2	VERY LOW 3	LOW 5	MODERATE 8	HIGH 11

Qualitative Measures of Likelihood:

Likelihood	Example
Almost certain	Will undoubtedly happen or recur, possibly frequently
Likely	Will probably happen or recur but it is not a persistent issue
Possible	Might happen or recur occasionally
Unlikely	Do not expect it to happen or recur
Rare	Will probably never / happen or recur

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Association

DRAFT Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority Telford & Wrekin	N	10,514,000	*1,280,000*	*1,864,000*
CCG Telford & Wrekin	Y	3,000,000	*10,410,000*	*14,810,000*
BCF Total				

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD
Outcome 2	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Reablement & Prevention		4,731,000		TBD	TBD	4,731,000	TBD	TBD	TBD
Support for Carers		523,000		TBD	TBD	523,000	TBD	TBD	TBD
Bed based Intermediate care		327,000		TBD	TBD	327,000	TBD	TBD	TBD
Developing Integrated Community Enablement		3,000,000		1,308,000	TBD	5,413,000	TBD	TBD	TBD
To support the transformation of healthcare and the Council's Community Care functions.		2,400,000	1,400,000	400,000	TBD	2,400,000	2,000,000	2,000,000	TBD
Review of Voluntary Sector Services to build community capacity		TBD		TBD	TBD	TBD	TBD	TBD	TBD

Association England

DRAFT Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent Admissions This is a reduction of admissions from 166- 149 people (17 less)out of a denominator that has increased by 8%. Expected outcomes include financial and non-financial benefits including: reduced admissions; reduced residential and nursing care costs; increased independence, choice and control; more people supported within the community. This will benefit a wider target population of those who need health and social care services who are under 65 years. Other benefits of the scheme include development of the integrated Community Enablement service which will also impact on mitigating upward presure on the domiciliary care budget.

Proportion of Older People at home 91 days discharge

Increasing the number of people who remain at home for 91 days (not including those under 65 years, palliative care or those within the community who receive enablement). This indicator monitors a cohort from Oct - Dec 2014 of those starting Enablement and followed for 91 days. Financial and non-financial benefits include: reducing admissions to residential care due to more Enablement interventions available; more people regaining independence; increased engagement with volunteers to support self care; reduced admissions to SaTH through more effective Enablement (thus maintaining the current denominator has not increased); reductions in care needs post Enablement.

Delayed Transfer of Care

The baseline data shows an average 158 days of delays per month. The target is to reduce to an average of 151 days delays per month eg reduced DTOCs by 7 days a month across each identified time period. Financial and non-financial benefits include: reduced costs dut to length of stay such as reduced excess bed days; reduced LoS; more people benefit from Enablement; more people regain independence. Enhancing the Integrated Enablement servies also enables ereduced need for longer and more costly care.

Avoidable emergency admissions

The baseline metric has been identified as 3879 admisisons from April 2012 - March 2013 across all ages. April 2015 payment metric is to reduce by 138 admissions during the identified 6 month period (275 admissions for the year). The October 2015 payment is a reduction of 106 admissions during the 6 month period (212 over the year). These relate to admissions of all ages. The CCG target group is primarily 65 years + (16% of the population). Financial and non-financial benefits include: reductions in admissions faciliated by the enhanced Integrated Community Enablement team with associated cost reductions; more self-help and prevention; more people supported to meet their urgent care needs in the community; reduced admissions to care homes

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

The intention is for the local economy to use the National Metric. In addition to the National Metric, which is being developed we will also gain patient experience from the Health Roundtable (a sub-group of the CCG Board), the Patient Participation Group Network (4 members of which sit on the Health Roundtable), the Long Term Condition Reference Group (a member also sits on the health Roundtable), Soft Intelligence Collection System (DATIX), Patient Membership Scheme and the PALS and Complaints received by the CCG.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Permanent Admissions This will be monitored through monthly reporting by the Council to the Programme Management Board. **Proportion of Older People at home 91 days discharge** evidence of achieving this metric is through the analysis at the end of the 91 days monitoring period. Monitoring in real time will be developed. Development of the Enhanced Integrated Community model with additonal capacity is essential and the increase in community capacity for self help and preventative support. Assurance for the development of these will be through the monthly Programme Management meetings. **Delayed Transfers of Care** This will be monitored through monthly summaries of daily reports presented at the monthly Programme Management Board **Avoidable Emergency Admissions** - this composite indicator will be monitored by replicating the 4 underlying indicators from the SUS data and reporting on a

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

NA

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	652.4	N/A	542.4
	Numerator	166		149
	Denominator	25445		27471
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	53.3	N/A	63.7
	Numerator	72		86
	Denominator	135		135
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	121.3	114.8	114.2
	Numerator	1890	1355	905
	Denominator	130149	131102	132097
		April 12- March 13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2305	2211.14	2152.14
	Numerator	3897	1811	1842
	Denominator	169065	0	171177
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

Report of the Health and Adult Care Scrutiny Committee

Review of the Meals on Wheels Hot Meals Service

(Community Meals Service)

May 2014

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Chair's Foreword

This has been a challenging piece of work in a number of ways but I am satisfied that the conclusions and recommendations from this review will improve the services that are available for vulnerable older people in Telford and Wrekin. The benefit of the hot meal service is so much greater than the provision of food. The interviews Councillors carried out with people who use the Hot Meals Service found that people do value the meals that are provided but the regular contact with someone coming to their home was just as important. This provided reassurance both to the person receiving the meals but also to their relatives and it was reported that this enabled family members to work because they feel confident that some will be visiting their relative during the day. The review also demonstrated that service users understand the pressures the Council is facing and we should not be afraid to talk about the costs of services when consulting service users. All the service users who discussed an increase in price during the interviews said that they would continue to use the service if the price was increased.

I have been extremely impressed by the commitment and dedication of the RVS volunteers and the way the RVS have responded to our review. Our conclusion has been that rather than reduce the service provided by RVS volunteers this is an opportunity to expand the services. While this will involve some ongoing cost to the Council I believe that if the hot meals service ceased the additional care costs to the council would be far greater than the savings made.

I want to thank everyone who has contributed to this review. The Scrutiny Committee has made sure that the views of service users and volunteers have been heard as part of the wider review of the Community Meals service. As a Scrutiny Committee we cannot make decisions but this report will be considered by Cabinet when making the decision about the future of the service

Cllr. Derek White

Chair of Health and Adult Care Scrutiny Committee

Background

During the scrutiny of the service and financial planning 2012/13 to 2014/15 (budget proposals) the Budget and Finance Scrutiny Committee recommended that the Health and Adult Care Scrutiny Committee review the proposals relating to the Community Meals Service. This issue was included in the work programme for the Health and Adult Care Scrutiny Committee in August 2012.

When planning the Scrutiny Work programme it was a agreed that the Scrutiny Committee would take a policy development approach to this piece of work so that it would run in parallel to the Service Review.

The Scrutiny Committee held the scoping meeting when the work commenced on the Service Review in February 2013.

Membership of the Scrutiny Committee

Cllr. Derek White (Chair)

Cllr. Veronica Fletcher

Cllr. John Minor

Cllr. Roy Picken

Cllr. Adrian Meredith

Cllr. Jacqui Seymour (2012/13)

Cllr. Chris Turley (2012/13)

Cllr. Jackie Loveridge (2012/13)

Cllr. Jayne Greenaway (2013/14)

Cllr. Rae Evans (2013/14)

Cllr. Francis Bold (2013/14)

Dilys Davies - Co-opted member

Jean Gulliver - Co-opted member

Cllr. Ralph Perkins - Town Council Co-optee

Richard Shaw - Co-opted member

Scope of the Scrutiny Review

The Scrutiny Committee met with the Council officers tasked with carrying out the service review to deliver the £57,000 savings agreed within the Council's budget. A summary of the evidence presented at this meeting and the work agreed by the Scrutiny Members is given below.

Any person over the age of 65 who lives in Telford and Wrekin Borough can use the Community Meals (Meals on Wheels service). There are two organisations with contracts to deliver the Meals on Wheels service.

The Royal Voluntary Service (RVS) provides a Hot Meal Service – the frequency of this service varies across the Borough from 2 to 5 days a week . Service users can choose to have 1-5 hot meals delivered daily. The RVS also offers a service to provide frozen meals for the 2 days they do not deliver hot meals. The meals are prepared at a number of locations across the Borough some are freshly prepared and some are regenerated frozen meals. There was some discussion about the choice available with the hot meal service – it was recognised that while special dietary and religious requirements are met the choice is limited. The Council owns and maintains some vehicles that volunteers use to deliver the meals. Some volunteers use their own vehicle and claim mileage (this may be at peak demand there are not enough 'fleet' vehicles or the volunteers preference to drive their own car)Members asked about implications of tax on mileage claims and ensuring that vehicles were insured for business use.

Appetito provides the frozen meal service – This service includes the provision of a table top freezer (if required) and serve therm to heat food. This ensures that the meal is heated to the correct temperature without the need to defrost first. Most meals are currently delivered fortnightly (some are delivered weekly). It was recognised that while many people with a sensory or physical disability can use this equipment people with dementia will require additional support.

When using the frozen meals service the service user is offered a menu they can order from. When the meals are delivered the service user pays cash for the meals provided. It was recognised that this may cause problems for the service user ensuring the correct money is available, it can delay the person delivering who is running on a tight schedule and the associated risks with cash handling.

Appetito work to national standards to ensure quality of the food. This 5 year contract will end in April. It was recognised that when the contract is renewed the increase in food priced and transport costs will have to be included. The Council has previously been successful at keeping the price down.

During 2011/12 there were approximately 439 people who used the service including hot and frozen meals. It was reported that there has been a drop in the number of people accessing the service. The is a standard charge for the meals - £2.65 per meal (£2.10 for a main meal and £0.55 for a pudding). It was reported that approximately 100 people receive hot meals. (The Committee recognised that the number of service users changes on a daily basis. At the time of producing the report there were 70 service users. The numbers changed on a daily basis and it was highlighted that there were 8 service users who were temporarily cancelled the service due e.g. due to a stay in hospital)

The table below shows the service provision and costs for 2012:

2012 - Meal Activity	**Hot Meals (WRVS)**	**Frozen Meals (WFF)**	**Total**
Meals sold:	15212 (of which 3691 frozen)	31094	46306
Income from clients @ £2.65 per meal:	£40,312	£82,399	£122,711

Information about services in some other authority areas was provided:

West Midlands

- Shropshire CC- frozen £3 per meal
- Staffordshire CC-hot £3.55 per meal, frozen£2.52
- Birmingham CC- sign post to provider list

Other Authorities

- Gloucestershire CC- hot £3.50 per meal, frozen £2.50
- North Somerset C-Hot £3.80 per meal
- Wiltshire / Norfolk CC's- no meal service just sign post

When considering the costs it was highlighted that service users pay the same price for hot and cold meals (hot meals are more expensive to provide) reported that the price has not increased for a number of years. It was recognised that the hot meal service is subsidised and further work is being carried out to investigate this further. Work will also be carried out on the price sensitivity of the service – what are people able / prepared to pay for this service?

Members discussed a number of other organisations that provide a meals service – e.g. Donnington Learning Centre, local churches and religious organisations the Salvation Army and Pub clubs. It was suggested that another option could be to sign post people to these other providers.

It was also commented that some people may only need meals delivered for a short period of time e.g. following discharge from hospital or a bereavement. If the appropriate support is provided people may gain the confidence to shop independently or learn cooking skills. It was also recognised that there is an opportunity to link to other services that people may receive in their home. Other service models were also discussed that could provide greater choice for service users:

Options could include:

- Contact Register
- Pub clubs

- Cafe / Restaurant
- Cooking Club
- Group Takeaway
- Shopping assistance
- Cooking Assistance/ skills support

It was reported that the RVS is keen to engage in the review and consider alternative models of service delivery.

The issues identified regarding the hot meal service were:

- Time / Temperature Control – Delivery
- What time people choose to consume their meals is limited on the hot service
- No/ limited choice of Hot Meals (special diets and religious and cultural meals are provided.
- Small Delivery Window- 90 mins
- Cash Collection and Handling
- Inequity of service delivery of hot meals across Borough

Members agreed that a fundamental part of the review must be understanding the needs of the service users – both the long term and short tem users. It was discussed that in any change management process it is important to consider the individual need – this service cannot be delivered using a 'blanket approach'. It was also recognised that while the review must provide the savings required it must be carried out taking service users views into account – if this does not happen then the service will fail or a second review will be necessary.

It was discussed that there is no means testing for the service and the greatest costs for the service are:

- Provision of the hot meals (subsidy)
- Service Level Agreement with RVS
- Running and maintaining vehicles and volunteer expenses
- Overheads (further work is being carried out to identify admin costs for the service)

The opportunity to link this work to 'My Life' portal were discussed. It was suggested that Members might want a demonstration of this system at a future meeting.

Following this presentation and discussion Members identified the following key issues as the focus for the Scrutiny Review:

- Equity of Service Provision
- Getting the views of service users who receive the hot meal service
- Getting the views of RVS and volunteers who currently provide the service

- Ensuring quality and nutritional content of food

Following the Scoping Meeting RVS have provided information on how the Meals on Wheels Service is linked to the Good Neighbours Service. It was also highlighted that the RVS provides continuity for support for service users from the community and into hospital and on their return to the community through the RVS volunteers at PRH. It is a priority for RVS that the work of the volunteers continues – in total there are 262 volunteers involved in these schemes. (Meals on Wheels 103, PRH Volunteers 110, Newport Helpline 44 and Luncheon Club 5)

Views of RVS Volunteers

Members of the Health and Adult Care Scrutiny Committee met with RVS volunteers on 14th June 2013. The volunteers supported both the Community Meals Service and the Good Neighbours Service. A summary of the key points from the volunteers is given below:

- The Meals on Wheels service delivered hot 1000 meals in May 2013 to over 200 people across Telford and Wrekin. For some people this is the only person who comes to the house providing social contact, meals and checking on health and safety.
- The Good Neighbours Service is managed from Shropshire Council – this service needs to be developed in Telford.
- If any issues that volunteers identify are reported to RVS and recorded. Volunteers have a delivery sheet and make notes on this and return to RVS – if the issue is urgent the volunteer will phone the office where it is followed up. Clients rely on RVS volunteers with help addressing anti-social behaviour problems.
- The volunteers get to know the clients well and know their likes and dislikes. The volunteers also make links with other services that can support the client and can provide practical support for people with disabilities e.g. opening cartons
- The people the RVS volunteers deliver food to have hot meals – one man needed pureed food and this was delivered as a frozen meal. Wiltshire farm food deliver frozen meals every 2 weeks . Volunteers expressed concern that the drivers do not follow up if someone does not answer to receive the food – where as RVS volunteers will contact the office who can phone the house or family. There was a case the previous week - after a call from the RVS a family member visited and found the person had fallen and could not get up.
- While the frozen meal service meets the need of some service users – there are some people who would have difficulty using a microwave to heat up meals.
- Volunteers expressed frustration at the bureaucratic processes around the payment of expenses paid by service users on the good neighbours scheme. The volunteer has to collect the money from the service user – deliver this to the office which involves another journey. The volunteer then receives a payment from RVS for this amount. The volunteers recognised the need to be able to account for the money and audit this – but felt that this was too complicated and would put people off volunteering.
- Volunteers were not opposed to putting up the cost of food – but not increasing the cost of a meal to more than £3.50

- The van is expensive – the cost of the service can be reduced if volunteers use their own vehicles. Using the van also involves additional time for volunteers to collect the van and return it to the depot.
- Develop wider usage of the service – this could include other vulnerable individuals e.g. adults with learning disabilities, families with children with special needs, family emergencies and discharge from hospital.
- Need to promote the service more widely – meals on wheels and Good Neighbours service. The Good Neighbours Service does not get referrals from Telford – most of the clients for the Good Neighbours Scheme are in Bridgnorth, Albrighton and Shifnal.
- All organisations need to work together – including Council and NHS. The RVS has an Emergency Resilience Team – this needs to be linked in to the work of the Council.
- It is important to encourage people to volunteer with RVS . There was positive feedback about the volunteer centre at Meeting Point House but there should be other ways to find out about volunteering e.g. to include information about volunteering when staff are planning retirement.
- The Good Neighbours Scheme is more time intensive. It was discussed that ideally the referral would be made to a volunteer who lived near by – however this also has to fit with volunteers availability. If there were more volunteers then it would be easier to match people who lived close to each other – this would make the service more efficient as there would be less travel time and it would be easier for the volunteer to make more frequent visits.
- It is essential that the clients needs are at the centre of the service – not budgets. It was recognised that there is a budget to run the service – but the volunteers did not see that it was their role to understand the detail of this. The primary concern for the volunteers is for the client.
- Many of the service users are very vulnerable and some RVS clients have a lot of problems with phones and volunteers help with this.
- Volunteer reported that some clients with dementia so not recognise the volunteers but let them in to their home.

Volunteers asked how the views of services users about the service they receive is fed back to the Council. Further information was provided by the RVS on work in other areas. A summary of this information and the implications for this report are attached at Appendix 1.

Views of Hot Meals Service Users

The Members of the Health and Adult Care Scrutiny Committee met with 12 people who used the community meals hot meals service. These people had responded to an invitation to talk to a member of the committee when completing the questionnaire that had been sent as part of the wider service review or had been asked by the RVS if they would like to take part in the interviews. Seven of the service users were male and five were female. There were two married couples (4 service users) included in these numbers. The age range of 9 of the service users was recorded – this was 76 years to 93. The average age was 85.5 years. The service users lived in the following areas:

- Donnington
- Dawley

- Leegomery
- Madeley
- Wellington
- Oakengates
- St. Georges

Frequency of Meals and Length of Service Provision

The length of time people had received the service was between a few months to 20 years. Most service users had received the service for a couple of years.

Not all the service users said how they found out about the service. Of the 7 interviews where this information was recorded 6 said they found out about the service from family / friends / neighbours. One service user had been referred by a professional (diabetic nurse)

The majority of service users had hot meals delivered 5 time a week. One service user commented that he /she would like the service 7 days a week. 2 service users said they had frozen meals over the week end (one service user said that a carer heated this in the microwave for her), 2 others has meals provided by family / carers, one person went to a church club once a week that provided a hot meal and others catered for them selves e.g. jacket potato or sandwiches or a fish and chip dinner from the shop.

What do Service users think of the Service?

The majority of service users were very pleased with the service – the comments from 7 service users indicated they were very happy and the comments from 3 more indicated they were happy but some aspects of the service could be improved. The positive comments were about the meals but equally about the reassurance that the visits by the volunteers provide to the service user and their family. The positive comments covered the following issues:

- Quality of the meals is good / excellent. Service users were not given a choice of meals but the two service users who commented on this said were happy with the meals provided
- Enables the person to remain independent in their home.
- Helping recovery following illness. One service users said that following an illness she had lost her appetite and had lost weight. Since receiving the service she had regained both
- There is a good selection of veg and meat
- The people delivering the meals are nice / the staff are excellent.
- Service users are re-assured that they are seen every day and if some thing is wrong it will be reported. One service users had required assistance from the emergency services.
- One service users said that he daughter was able to go to work because she know that someone would visit during the day
- Don't have to spend time shopping and cooking which would be difficult and enables a couple to spend more time together
- Several off the service users said they had recommended the service to others
- Two service users said that volunteers did other tasks e.g. buying magazines and posting letters or delivering a prescription

The following comments were made by 5 service users:

- The meals are "not too bad but they do vary.... meals are bland"
- The meals were "generally not very good and not good value for money..... some of the meals have been burnt"
- Meals are luke warm
- Two service users commented that they was not able to cut up food due to weak wrists. Some of the volunteers did cut up food– but not all. One service users said that if it was not cut she had to tear it with her fingers.
- Two service users said that they do not have much conversation with the volunteers who deliver the meal. One service users said the volunteers are very pleasant but "just plonk the meal on the table and go"
- The ready meals from the supermarket – there is more choice.

How service could be improved

While the majority of service users seemed to be happy or very happy with the service when further questions were asked they did identify things that could be improved. These comments included:

- The vegetables are not adequate- too many potatoes
- I would like more fish products, particularly on a Friday
- A weekly planner would be nice
- Someone to come and chat with the service user

The issue regarding the quality of the meals is difficult to analyse further as meals are provided by different organisations. Meals also varied for individual service users – it was identified that this may related to school holidays. It was also identified that two service users who lived close to each other did not have the same range of meals (one had fish the other did not).

Value for Money

Of the 12 service users interviewed 11 responded to the question whether the meal was value for money. 8 of the 11 responses said it was good value for money and 3 service users said it was not good value for money or it was "not too bad."

Of the 12 service users interviewed 10 responded to the questions increasing the price of the service. All 10 said they would pay more if the price was increased. The comments in relation to any increase in the cost of the meal varied:

- One service user made the comparison that you would not be able to get a two course meal at a restaurant for less than £10.00.
- One service user said she wouldn't mind paying extra as the quality of the food / people is high.
- Another service user said he would pay more – but be had no alternative.

- One service users did express concern that if the price did increase it would be difficult and another service users said that an increase might make the service that this may make it unaffordable for some service users.
- One service user said that the meals were not good value for money and sometimes he / she throws the meal away.

Only two of the service users were aware that the Council subsidises the service

Other Help

All of the service users who were interviewed were had some level of support. For 4 of them this was low level support which included:

- Family member shopping
- 2 reported that they had pendent alarms
- Milkman delivering other food
- Chemist delivering prescriptions
- Using aids and adaptations e.g. stair lift and walkers

8 of the service users had a higher levels of support:

4 service users had paid carers coming into their home. The number of visit by carers varied (twice a day, once a day and twice a week). Some of these service users also had support from family, friends or neighbours. One service user reported needing regular healthcare and, on occasions, needed to be admitted to hospital. Two of the service users who had a higher level of support also had additional help cleaning or gardening (one couple reported that this was through Age Concern). One service user lived in warden supported accommodation and had family support.

There were two married couples who supported each other in their home. One couple were particularly independent and had previously turned down personal care support.

One service users was very isolated and the only help reported was that a family member did the shopping.

Alternatives to the Hot Meal Service

This was discussed in three of the interviews if the service user would consider the frozen meals service. Two of the service users said they would use either but one said he wanted to retain the hot meals service.

Quotes from Service Users

Some of the comments that highlight the views of the service users are:

- “ Do not attempt to guild fine gold”
- “Each individual person is different and each person should be treated as such. It shouldn’t be assumed that everyone’s need are the same”
- “The whole point is that the (the meals) are delivered each day..... that is the pleasure. You’re seen by somebody. If anything goes wrong , they (the volunteers) will report it.”

- "100% for service of food, chat to workers, cooking of food"
- "It is an essential service and ensures that old people are seen once a day."
- "Some one comes to say 'hello'. First class people."
- " It saves such a lot of work"

Frozen Meals Service

Members of the Health and Adult Care Scrutiny Committee met with a representative of frozen meal provider, Appetito. It was explained that once a person is referred to the service a member of staff from the company will visit them in their home and explain the service and how the equipment works. The service user can order using the order form or meals can be ordered online. All the meals meet the nutritional standards for the National Association of Care Catering. As part of the service Appetitio provides a table top freezer and a smart microwave. Each meal is labelled with a number code – the service user does not have to set the microwave power and timer. Once this code is used the microwave will heat the meal in the required way including the 'pause' during the heating process.

The contract with the Council sets out how the service is provided. All the delivery drivers are trained and work to the company policy manual. This sets out what to do in different situations. E.g. if the delivery driver does not get an answer when the meals are being delivered there is a procedure to follow to contact next of kin, the local authority or emergency services. The drivers deliver to their customers in their area and so get to know them well - it was recognised that for many of the service users this contact with the delivery driver is important. The drivers all receive dementia awareness training and the company has procedures in place to support service users. E.g. a photograph of the driver can be left in a prominent place in the house so if the service users is confused and does not recognise the driver or remember that meals have been ordered this can be used as a prompt. It was discussed that the Council and other organisations can work with Appetito so that the delivery drivers can provide information to service users e.g. key messages during severe hot or cold weather.

There is no net cost to the Council for the provision of this service and all service users are charged the same rate for their meals. The charge to the service users covers the full cost of the service. Some of the meals are more expensive to produce such as special dietary requirements and pureed meals – but this additional cost is balanced across the service. Service users can use this service on a long term basis or for short term respite or rehabilitation. Appetito want to work with other organisations to encourage people to access the service a part of their rehabilitation. Members were informed that if a service user has not paid for the service, after 4 weeks Appetito will contact the Council.

Appetito can also provide a hot meals service where the frozen meals are heated in specifically designed vehicles that heat the meals in different 'chambers' that come on at different times so that the meal has been heated for the right length of time and is still hot when it is delivered. Examples were given of how this service operates in different authorities. However service this would be more expensive than the standard frozen meal service.

Members asked if the Local authority areas worked together if this would reduce the cost of the service and were informed that this would be the case. It was also discussed that Town and Parish

Councils may want to contribute towards the service if it can be demonstrated that there is an uptake in their area.

The Committee were informed that the national estimate of the cost of malnutrition in the UK is about 6.5 billion in the UK e.g. the increased risk of slips, trips and falls. This would equate to around 4 million in Telford and Wrekin.

Members commented that the meals once heated in the microwave were very hot. It was reported that there had been no incidents reported to Appetito where this had been an issue. Members tested some of the meals including the pureed meals. It was noted that the meals were presented to look like a standard meal e.g. the pureed carrots were shaped like carrots. It was discussed that the appearance of food is an important part of the eating experience.

Financial Information on the Community Meals Service

Members received evidence on the financial information for the Community Meals Service (this included the income and expenditure for both the hot and frozen meals service.)From this information it was difficult to determine the exact income and expenditure for the hot meals service. However based on the figures provided it was found that cost to the Council for the hot meals service minus the cost of the meals is around £58,000. This figure includes costs for Council employees, Council premises, Council transport, Council Supplies and Services, Support services and the RVS Service Level Agreement.

The Older Population in Telford and Wrekin

The Telford and Wrekin population profile provides statistical information about the local population. The full report is available on the Council's website at http://www.telford.gov.uk/downloads/file/3825/telford_and_wrekin_population_estimates_and_projections_2011

Some of the key statistics relating to older people in Telford and Wrekin from this document are:

- Around 8,800 people aged 65+ are living alone (2010) (p.5)
- The 65+ cohort accounts for 14.5% of the population compared to 16.5% nationally (p.6)
- In terms of the older population, females significantly outnumber males with 1,900 females aged 85+ compared to 900 males. (p. 6)

There are a number of key findings from the ethnicity projections:

- The BME population of Telford and Wrekin is younger than the overall population, with 25.5% aged under 16 (20.1% Borough wide) and just 7.2% aged 65+ (14.5% Borough wide).
- By 2026 the BME population is projected to have grown by some 6,700 people from15,200 to 21,800, an increase of around 43%. In overall terms BME groups will account for 11.1% of the total population by 2026, an increase from 8.9% on 2010. (p. 8)

Nutrition and Health

The Committee were aware of the general advise regarding the benefits of a balanced diet on health and wellbeing. In addition to this the Committee received evidence on the specific effects of malnutrition in older people.

Malnutrition Task Force Report
The Malnutrition Task Force is an independent group of experts across Health, Social Care and Local Government united to address the problem of avoidable and preventable malnutrition in older people. The report Prevention and Early Intervention of Malnutrition in Later Life sets out the issues regarding malnutrition, identifies best practice and guidance. The full report is available from:

http://www.bda.uk.com/news/130509GuideLocalCommunityApproach.pdf

Some of the key information in this report is set out below:

What is malnutrition?
According to NICE (National Institute for Health and Care Excellence) guidance in Nutrition support in adults (CG32),6 malnutrition is defined as:

- a body mass index (BMI) of less than 18.5 kg/m2
- unintentional weight loss greater than 10% within the last 3–6 months
- a BMI of less than 20 kg/m2 **and** unintentional weight loss greater than 5% within the last 3–6 months

Those who have eaten little or nothing for more than five days and/or are likely to eat little or nothing for five days or longer are at risk and should also be considered for nutrition support.

Malnutrition is both a cause and consequence of disease and illness and there can be many contributing factors. Whilst some causes of malnutrition might be the result of underlying ill health, disease or the body's inability to absorb nutrients, malnutrition can also be linked to other experiences or factors in a person's life. These include depression or anxiety, social exclusion, poor access to transport or mobility difficulties, poverty, difficulties with shopping, dental problems or the influence of medication on appetite. This list is not meant to be exhaustive but highlights many of the contributing factors. Malnutrition can be a result of one or a combination of factors.

Scale of the challenge
- At any given time, more than three million people in the UK are either malnourished or at risk of malnutrition
- The vast majority of these (approximately 93%) are living in the community, with a further 5% in care homes and 2% in hospitals
- It is estimated that 1 in 10 people over 65 are malnourished or at risk8 The population of people over 75 is at highest risk of malnutrition and is projected to double in the next 30 years
- As many as 33% of older people are already malnourished or at risk on admission to hospital and 37% of older people who have recently moved into care homes are at risk too
- It is imperative to identify and treat people as quickly as possible. If we do not put mechanisms in place now to address malnutrition, the numbers of malnourished people and the associated human and financial costs could spiral in the future. (p.9)

Consequences of malnutrition

- Research has found that individuals who are malnourished will experience: increased ill health, increased hospital admissions, increased risk of infection and antibiotic use, longer recovery time from surgery and illness and increased risk of mortality11 12 13
- When compared with well nourished people, malnourished individuals in the community saw their GP twice as often, had 3 times the number of hospital admissions and stayed in hospital more than 3 days longer14
- Malnutrition in care homes has been linked to increased hospitalisation, readmission and long term ill health11 15

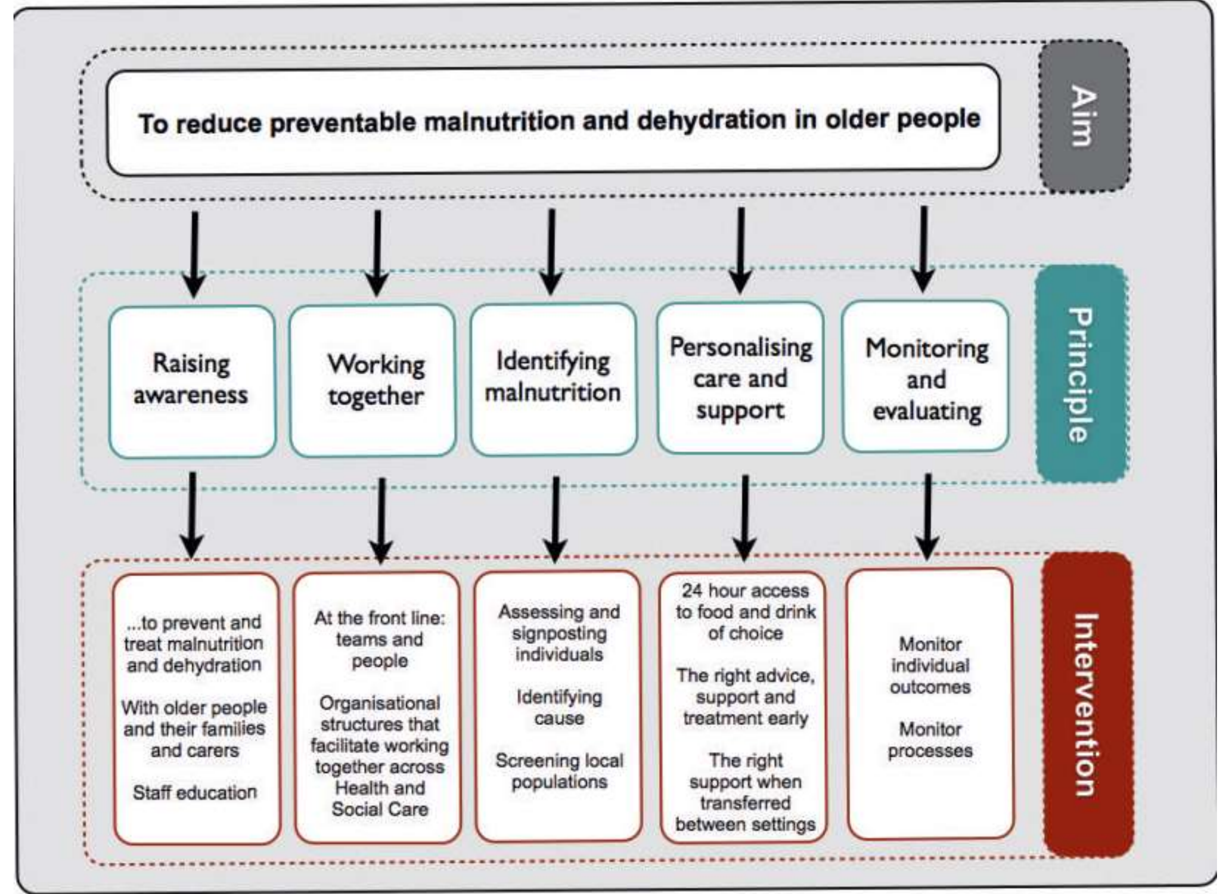
Cost of malnutrition

- Malnutrition leads to increased use of health and care services and the national estimated costs run into billions of pounds.1 Addressing it could lead to really significant savings
- Severely malnourished patients identified in general practice incur additional health care costs of £1,449 per patient in the year following diagnosis14

Carers

- Carers UK found that, out of 2,000 carers providing substantial care to frail, ill and disabled people, one in four carers were looking after someone who was underweight.24
- one in six carers were looking after someone at real risk of malnutrition
- but were receiving no nutritional support.24

The diagram from the Malnutrition Task Force report shows the model developed to reduce malnutrition and dehydration in older people. While the scope of this Scrutiny Review did not cover all aspects of this model it does illustrate the role and opportunities for the community meals service to reduce the risk of malnutrition and dehydration.



From Prevention and Early Intervention of Malnutrition in Later Life p. 28

Royal College of Nursing

Further information about the financial cost of malnutrition is available on the Royal College of Nursing Website which set out:

- Disease related malnutrition costs in excess of £13 billion per annum, based on malnutrition prevalence figures and the associated costs of both health and social care (Malnutritionpathway.co.uk 2012, p 4.).
- Malnourished inpatients stay in hospital longer (National Institute for Health and Clinical Excellence 2006). A saving of just one per cent of the annual health care cost of malnutrition to the NHS would amount to £130 million annually (NHS Institute for Innovation and Improvement 2010

From: http://www.rcn.org.uk/development/practice/nutrition/key_challenges

National Institute for Health and Clinical Excellence (NICE)
The importance of preventing, identifying and addressing malnutrition in older people within the NHS has been identified in two sets of guidance produced by NICE that relate to nutrition and malnutrition in older people:

Guideline to help the NHS identify patients who are malnourished or at risk of malnutrition.

http://www.nice.org.uk/niceMedia/pdf/2006_006_nutrition_guideline_launch.pdf

Nutrition support in adults

http://publications.nice.org.uk/quality-standard-for-nutrition-support-in-adults-qs24

Telford and Wrekin Health and Wellbeing Strategy
While nutrition for older people was not a specific priority identified within Telford and Wrekin's Health and Wellbeing Strategy the service provided by the Community Meals Services does contribute towards the following priorities and principles of the strategy:

- Priority 7: Improving Carers Health and Wellbeing
- Priority 9: Supporting People to Live Independently
- Priority 10: Supporting People with Dementia

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

Conclusions

Members found this a very valuable piece of work in a number of ways. It has provided an opportunity to meet with people using the community meals service who may other wise not have the opportunity to meet with Elected Members and to consider how the Council is working with other organisations and volunteers to meet the needs of some of the most vulnerable people in the Borough. This work has also been inline with Scrutiny's approach to contributing to policy development and while the timescales have been challenging this work demonstrates the value Scrutiny can add.

The main findings of the Committee were:

The provision of food to people in their home for those who would otherwise be unable to provide food for themselves and do not have carers who can provide this for them is a fundamental service. The Committee concluded that many service users depend on this as their main meal and benefit from it. Having a nutritious meal is a basic requirement for physical and mental wellbeing for the individual and is key part of any preventative and re-ablement support provided by the Council and NHS. Members also specifically recognised the importance of access to healthy meals at home following hospital discharge.

Service users value the hot meals service and that the regular contact with someone who comes to their home is as important as the meal itself

The frozen meal service is a valuable service for people who are able to manage heating the meals them selves or have support to do this and do not need the reassurance of a regular contact with someone calling to their house. The Committee recognised that the frozen meal service provided a greater range of meals and were assured that the delivery drivers do receive appropriate training to meet the needs of vulnerable service users. There are opportunities to work with the frozen meals provider to get key information to people who may other wise be isolated.

Any change to the community meal service must be based on the needs of the service users. Members recognised the need to make savings but concluded that any short term savings could be lost by longer term care costs. Members did consider the feasibility of providing a frozen meal only community meals service but concluded that this would not be in the best interest of the service who are have physical / sensory disabilities and would not be able to use the microwave. Other service users may have dementia and would have difficulty in remembering to heat the meals. While the Members of the Committee are not trained to assess the specific needs of the service users they visited, they concluded that there is a high risk that some of the older people currently receiving the hot meal service would struggle to be able to live in their own homes if they had to rely on a frozen meal service. In addition to the risk for the individual service users, the Committee also identified the longer term cost implications for the Council if they were unable to remain at home and the Local Authority was responsible for the cost of their care. Members concluded that this was a significant risk that should be seriously considered in any future planning for the hot meal service. If the service did change to a frozen service , if this resulted in two people no longer being able to live at home and needing residential care that was funded by the local authority this would negate the savings made by the transition to a frozen only meal service. When the hot meal service was withdrawn in another local authority area the RVS reported that, of the people who had previously

received the hot meal services, about 30% were able to manage with the frozen meal service, 30% were 'boarder line' and struggled to manage with the frozen meal service and 30% required additional support in the home which included local authority funded care.

There is an opportunity to develop the Community Meals service and make it work more efficiently. This will be described in the service model set out below. This will provide choice and personalisation for service users, support existing local food outlets, fit with the co-operative model for service delivery

It was identified that, while the it was reported that the number of people using the Community Meals service has declined, Members noted that of the 12 service users interviewed only 1 referral had been made by a professional . Based on the statistics for the older population (see p 13) Members concluded that there is an opportunity to develop and expand the service ensuring that all health and social care professionals know how to recommend the Community Meals service and the Good Neighbours Service as it develops. The Committee support the continued open access to these services so that family and individuals can access the services directly without a referral from a professional.

While the Community Meals Service is currently available to any one over the age of 65 Members recognised that are other groups and individuals who could benefit from this service either on a long term (e.g. some people with learning disabilities living independently) or a temporary basis (e.g. people of any age who require some support when recovering at home after an operation.)

Within the scope and timescales for this review it was not possible to explore in detail how the local NHS organisations work with and support the community meals service. However, given the strength of evidence of the health benefits of a ensuring older people living at home have good nutrition the Committee believe that there is an opportunity to gain greater synergy through the Community Meals service through partnership working with the NHS.

Members were pleased to have the opportunity to engage with the RVS in this review and have the opportunity to meet with volunteers. The Committee commend the dedication and commitment of the RVS volunteers enabling some of the most frail and vulnerable people to live independently in their home through the Community Meals Hot Meals Service (Meals on Wheels) and the Good Neighbours Service. It was recognised that Telford and Wrekin has an excellent volunteer base and the work of the volunteers is supported by an organisation that had effective systems to monitor the service provided. When the Chairman met with RVS staff he was impressed with the approach that the RVS had taken to seek opportunities to develop their services and meet the individual needs of their service users.

Having considered all the evidence the Committee concluded that there is an opportunity to develop a different model for the provision of hot meals as part of the Community Meals Service which fits with the Council's co-operative values, enables the development of a Good Neighbours Service and develops a truly person centred service. The model, set out below, will require financial resources, but the Committee believe that the investment in this service will avoid increased care costs for people at home and reduce the residential care costs in the long term.

Proposed Model for Community Meals Service

The current costs to the Council for the hot meals service should not be taken as a saving but re-invested in developing a Good Neighbours Service. This would involve ceasing the use of Council fleet vehicles . Volunteers will use their own vehicles and it will be essential that arrangements are put in place to ensure appropriate car insurance cover is maintained.

The procurement of the frozen meals service continues as agreed by Cabinet in September 2013.

In the process of developing this new service model all existing and future community meals service users should , where possible, be given the opportunity to choose to between the following services:

- Receive the frozen meal service without additional support
- Receive the hot meal service delivered by the RVS through the Good Neighbours Service *
- Receive a hot meal service provided by a local provider
- Receive the frozen meal service with additional support from the RVS to heat the meal and maintain social contact.

*the Committee recognise that the hot meal service does not currently operate in all areas of the Borough, however based on the evidence received in this report the Committee concluded that there is a demand and need for this service and an opportunity to expand.

Encourage local food providers including cafes, pubs and schools to consider developing a local hot meal service (an example that the Committee has considered is the service provided by the Donnington Life Long Learning Centre)The Council should support these providers to develop a high quality service by developing a service standard. This would not form a contract with the Council but ensure that local providers are aware of the necessary health and safety requirements etc and that service users know what level of service to expect. This service standard should include methods of payment e.g how to pay by direct debit / standing order or how cash collection will be managed.

The options for the future provision of Community Meals and the potential for the RVs is set out below:

Meal Service	Potential Role for RVS
Frozen meal delivered in line with contract arrangements agreed through procurement of this service	None
Frozen meal delivered in line with contract arrangements agreed through procurement of this service	Through Good Neighbours Service where a service users needs support to heat a frozen meal this could be provided by RVS volunteers
Hot Meals service delivered through RVS Good Neighbours Service	Building on the good practice of the current Community Meals Hot Meals Service delivered by the RVS hot meals would be delivered
Hot Meals Service provided by local food provider	There may be an opportunity for the local food provider to work with the RVS to deliver the meals

The Committee recognise that the options set out above are a significant expansion on the current services provided by the RVS. The exact scope of the service and the contract arrangements will have to be agreed though a commissioning process. The commissioning process may identify other efficiencies that could reduce the cost of the service e.g. the suggestion from RVS volunteers to reduce the transport costs by removing the use of fleet cars and volunteers using their own vehicles. The Committee also recognise that there are significant costs of the community meals service that are outside the RVS contract. The frozen meal service contract is currently going through a procurement process and the Committee expect that when other contracts relating to the hot meal service come to the end of their term they will go through a procurement process that will ensure value for money.

Recommendations

The Health and Adult Care Scrutiny Committee recommend that:

1. The Council works with RVS to develop the Good Neighbours Service model as set out above which will include the continuation of a hot meal service based on service users need and demand. This will involve negotiating a realistic cost and contract / SLA for this service though a commissioning process.
2. Town and Parish Councils should be encouraged to promote, and where possible, financially support the Community Meals Service.
3. Opportunities for sponsorship for the Community Meals Hot meals service should be explored.
4. The current service should continue until a robust and sustainable service model is developed and can be implemented by all necessary partners.
5. The Council and RVS explore opportunities to work with the NHS to develop the Community Meals Service as part of the Good Neighbours Service.
6. The price of the hot meals procured by the Council should be increase by up to 50 pence to around £3.15 and annually thereafter inline with the increase in the State Pension. The Committee recognise that the price of hot meals provided by independent local providers will not be determined by the Council.
7. Under the new service model the RVS would be responsible for promoting the service to the public and ensuring up to date information is available to health and social care professionals to increase the number of people referred to the service. Other organisation should support the promotion of the service through websites, leaflet displays etc. Increasing the number of service users, and the number of meals provided combined with the proposed increase in price can, in the future, reduce the reliance on Council funding. It may be possible to work with the RVS to develop this longer term service model.
8. Information about the Community Meals service should be available on the Council's Care First system and My Life Portal. Information about the Good Neighbours Services should be included in the Adult Care Assessment Process and Resource Allocation Management System. Access to the Good Neighbours Service should not be means tested and should be available to people who are eligible for local authority funded care and people who are self funding.
9. The Council and NHS work in partnership with the frozen meals provider to ensure that key messages are communicated to service users. This should include key public health messages e.g. flu jabs.
10. When other contracts that relate to the Community Meals Service come to the end of their term they should go through a procurement process to ensure value for money for the Council and service users.
11. The Committee feel very strongly that a hot meal service should continue. However, if the Council's Cabinet decide to remove the hot meals service and provide a frozen meals service alone, then the Committee set a clear expectation that all hot meals service users are individually assessed to ensure that their needs are met and their risk of social isolation and poor nutrition is not increased.

Appendix 1

Developing a Good Neighbours Service with RVS in Telford

During the review on the Community Meals Service the Health and Adult Care Scrutiny Committee have also considered the RVS Good Neighbours Service.

There is an opportunity for the Council to re-invest the funding currently used to fund the Community Meals Service and develop a Good Neighbours Service in Telford. The Committee has concluded that this would improve the service for the people of Telford and Wrekin and also in the medium and long term save the health and social care economy a significant amount of money.

- Telford and Wrekin has an excellent volunteer base. The RVS currently has over 260 volunteers in the Borough – 103 of these volunteer with the community Meals Service.
- Telford and Wrekin currently does not have a full Good Neighbours Service. The RVS are funding a Good Neighbours Service to some service users in Telford. Telford volunteers are keen to develop a Good Neighbours Service and are currently supporting some service users who live outside Telford and Wrekin.
- Working with voluntary organisations is an essential part of the co-operative Council's approach to meeting the financial challenges – the Good Neighbours Service is an opportunity to put this into practice within Adult Services.
- When the RVS Hot Meals service was withdrawn and replaced with a frozen meals service in another local authority area the RVS reported that of the hot meal service users about 30% were able to manage with the frozen meals service, 30% were 'boarder line' and struggled to manage with the frozen meals service and 30% required additional support in the home to which included local authority funded care.
- The figures above reflect the views of the Members in relation to the service users they interviewed as part of the Scrutiny work.
- When establishing the Good Neighbours Service in another authority it was agreed that social workers would be the primary referral route. In Telford & Wrekin there is an opportunity to link the Good Neighbours Service to the Assessment Process that will inform the Resource Allocation System. People who are not eligible for Council funded services can be referred to the RVS Good Neighbours Service.
- When developing the model for a Good Neighbours Service in Telford this can include an element of the Hot Meals Service for service users who need it but can also incorporate good practice from the RVS Hospital to Home service in Leicestershire.
- The Hospital 2 Home service in Leicester received 603 referrals in the first year and over this time 5600 interactions with older people were carried out, 448 referrals were made to other organisations, readmission rates for older people was 7.5% (half the national rates)
- The Red Cross currently provide time limited support (6 weeks) to people on hospital discharge. There is no time limit on the Good Neighbours Service
- There is an opportunity to raise the benefits of a Good Neighbours Service with local NHS organisations
- The RVS works in partnership with other 3rd Sector organisations which supports the Cooperative model for the Council.

Response to: Health and Adult Care Scrutiny Committee **Appendix 2**

Draft Response of : Cabinet Member: Adult Social Care

Scrutiny Review Meals on Wheels Hot Meals Service in Telford and Wrekin

May 2014

Recommendation	Response	Date by which action will be taken	Person responsible (name and title)
The Council works with RVS to develop the Good Neighbours Service model as set out above which will include the continuation of a hot meal service based on service users need and demand. This will involve negotiating a realistic cost and contract / SLA for this service.	The Council will extend the existing arrangement for providing a hot meal to allow more time to evaluate options for meeting any unintended consequences of replacing the current hot meal option, including evaluating the need and identifying options for providing a Good Neighbours Scheme. We will also proceed with a tender for frozen meals which will have the capacity to incorporate increase of the Frozen meals, and also, the potential to expand to incorporate hot meals. Any option will need to save £57k in line with the budget strategy for 2013/14.	Existing contract extended to October 2014.	Commissioning Team – Vivianne Service Delivery Manager
Town and Parish Councils should be encouraged to promote, and where possible, financially support the Community Meals Service	The Council will work with other organisations including Town and Parish Councils to identify options for continuing with a community hot meals service for those that require one and for schemes like “befriending” to meet the unintended consequences of withdrawing the current daily service. If hot meals is provided as part of the Frozen meals contract, we will still seek to encourage befriending both through local Town and Parish councils and the RVS.	By Oct 2014	Commissioning Team – Vivianne Manager, Service Delivery Manager
Opportunities for sponsorship for the Community Meals Hot meals service should be explored	The Council will continue to investigate opportunities for seeking sponsorship to support a community hot meals option and/or alternative (as above), including working with large and smaller local retailers.	By April 2015	Commissioning Team – Vivianne Service Delivery Manager

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The current service should continue until a robust and sustainable service model is developed and can be implemented by all necessary partners	Agreed		
The Council and RVS explore opportunities to work with the NHS to develop the Community Meals Service as part of the Good Neighbours Service.	The Council and Telford & Wrekin Clinical Commissioning Group is currently looking at options for building community capacity and enhancing community services as part of its commitment to the greater integration of health and social care through the Better Care Programme. This will include working with a range of voluntary sector organisations including the RVS. The programme is currently in the "start up" phase with a number of meetings planned over coming months.	Plans will be in place by June 2014 to implement in December 2014	Clive Jones, Assistant Director and Kit Roberts, Commissioner
The price of the hot meals procured by the Council should be increase by up to 50 pence to around £3.15 and annually thereafter inline with the increase in the State Pension. The Committee recognise that the price of hot meals provided by independent local providers will not be determined by the Council.	The Council will consider the need to increase charges when reviewing options above and take account of the rates charged for hot meals in other parts of the Region.. The Council will also consider and take into account any impact that this would have on service users.	By October 2014	Commissioning Team – Vivainne Manager, Service Delivery Manager
Under the new service model the RVS would be responsible for promoting the service to the public and ensuring up to date information is available to health and social care professionals to increase the number of people referred to the service. Increasing the number of service users, and the number of meals provided combined with the proposed increase in price can, in the future, reduce the reliance on Council funding. It may be possible to work with the RVS to develop this longer term service model.	The Council will consider this recommendation when reviewing options for extending the existing arrangements and in making proposals for any alternative option. The intention to increase the supply of meals will also apply to Frozen meals.	By October 2014	Commissioning Team – Vivainne Service Delivery Manager
Information about the Community Meals service should be available on the Council's Care First	Once ongoing arrangements have been extended and any revised arrangements have been put in place the Council	actioned	

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system and My Life Portal.	will ensure that these are advertised via the Council's Care First system and My Life portal.		
The Council and NHS work in partnership with the frozen meals provider to ensure that key messages are communicated to service users. This should include key public health messages e.g. flu jabs	The Council will explore with the existing and any future frozen meals provider the opportunity for key messages to be communicated in this way.	Ongoing	Vivainne McKay and Louise Mills (public Health commissioing lead)
When other contracts that relate to the Community Meals Service come to the end of their term they should go through a procurement process to ensure value for money for the Council and service users.	The Council will follow best practice in terms of value for money to go through a procurement process. This process assists to test the market place with regard to other options and obviously price.		
The Committee feel very strongly that a hot meal service should continue. However, if the Council's Cabinet decide to remove the hot meals service and provide a frozen meals service alone, then the Committee set a clear expectation that all hot meals service users are individually assessed to ensure that their needs are met and their risk of social isolation and poor nutrition is not increased.	The Council agrees that those who have an eligible need should receive meals. For those who are eligible; the Council would like to offer them meal options whether it be hot or cold. In introducing any changes the Council will review need of individuals to ensure we provide a service for those who are eligible. The Council will continue to work with the voluntary sector to support people who are socially isolated	Reviews will be undertaken between now and October Ongoing	Adults Social Care

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TELFORD & WREKIN COUNCIL

HEALTH AND ADULT CARE SCRUTINY COMMITTEE - 27 MAY 2014

RELATIONSHIP BETWEEN SCRUTINY AND HEALTHWATCH IN TELFORD AND WREKIN

REPORT OF SCRUTINY GROUP SPECIALIST

1.0 PURPOSE

1.1 To enable the Health and Adult Social Care Scrutiny Committee to consider the relationship with Telford and Wrekin Healthwatch.

2.0 RECOMMENDATIONS

2.1 That the Committee:

- Considers the working arrangements with Telford and Wrekin Healthwatch.
- Agrees the co-option of a representative from Healthwatch on to the Health and Adult Care Scrutiny Committee and the Joint Health Overview and Scrutiny Committee for Shropshire, Telford and Wrekin.

3.0 PREVIOUS MINUTES

3.1 None

4.0 BACKGROUND INFORMATION

4.1 The Health and Social Care Act 2012 not only reformed the arrangements for NHS organisations – but also the local accountability structures for health and social care services. This included:

- Establishing Healthwatch organisations as local consumer champions for health and social care
- Conferring the health scrutiny powers on the Local Authority rather than a Health Overview and Scrutiny Committee and extending health scrutiny powers to all NHS providers.
- Establishing Health and Wellbeing Boards to encourage integrated working between the NHS, Public Health and social care advancing the health and wellbeing of the local population.

4.2 The Act came into force on the 1st April 2013 and following consideration by Council Constitution Committee, Full Council has agreed the necessary arrangements to discharge the health scrutiny function effectively. The contract for Telford and Wrekin Healthwatch was awarded by the Local Authority to Parkwood Health Care and the official launch event was held on 24th October 2013. The Chair of the Health and Adult Care Scrutiny Committee attended a workshop on 24th September arranged by Shropshire Council and Shropshire Healthwatch which considered the roles and relationship of different health and social care organisations, HOSC and regulators with Healthwatch.

5.0 SCRUTINY AND HEALTHWATCH

5.1 The Health and Adult Care Scrutiny Committee and Telford and Wrekin Healthwatch both have roles in the accountability arrangements for health and social care services. The Centre for Public Scrutiny had contributed to the ‘Smart Guide to Engagement’ document which sets out the roles of Healthwatch and Scrutiny in holding NHS commissioners and providers to account.

Council Scrutiny	Healthwatch
Councillors as Community Leaders	Local people and groups
Have a broad overview of local health and social care issues	Ask local people what they think about local health and social care and suggest ideas to help improve services
Scrutinse priority areas, including impact of council services	Investigate specific issues of concern to the community
Have no powers to enter and view	Authorised representatives able to enter and view premises to see if services are working well
A right to require information and attendance from Cabinet Members, senior council officers and NHS staff	Ask for information and get an answer in a specified amount of time
Define substantial developments and variations of health services and require to be consulted	May help NHS develop options for service changes and may submit views during public consultation
Refer proposals for health service changes to the secretary of state in specific circumstances	Refer relevant issues to council scrutiny
Make recommendations and require a response from NHS bodes and council executive	Make reports and recommendations and receive a response
Have a non-executive role to hold decision makers to account	Take decisions through role on Health and Wellbeing Board

5.2 In relation to children’s services the Telford and Wrekin’s Health and Adult Care Scrutiny Committee can scrutinise the commissioning and provision of NHS services for children and young people (this may be

carried out jointly with the Children and Young People Scrutiny Committee where appropriate). Local authority scrutiny of children's social care services is carried out by the children and young people's Scrutiny Committee. Healthwatch's role includes children's and young people's NHS services but does not include children's social care services that are regulated by OfSted.

5.3 In considering Scrutiny's relationship with Healthwatch is it also important to recognise the role of the Joint Health Overview and Scrutiny Committee with Shropshire Council as this has the formal role to Scrutinise County wide services including acute hospital services, community health services and mental health services.

5.4 The Department of Health has not yet published the guidance on Health Scrutiny arrangements or how the relationship with Healthwatch will work in practice (other than the right of the Healthwatch to refer an issue to Scrutiny).. However, Scrutiny in Telford and Wrekin had a good working relationship with the Local Involvement Network and the relationship with Healthwatch can build on this good practice.

- Co-opted representatives on the Health and Adult Care Scrutiny Committee and Joint HOSC (co-optees on the Joint HOSC have voting rights)
- Sharing work planning process and agreed work programmes
- Informal meetings of the Scrutiny Chair with Healthwatch Members / officers
- Ongoing communication between supporting officers

5.4 When considering the option to co-opt a Member of Healthwatch on the Scrutiny Committee Members are asked to consider the relevant elements of the Terms of Reference for the Scrutiny Committee and the Co-optee protocol. The current Scrutiny Handbook sets out that, with the exception of the Children and Young People Scrutiny Committee, the number of co-optees will not exceed 50% of the Elected Members membership of the committee. If a Member of Healthwatch were invited as a co-optee on the Health and Adult Care Scrutiny Committee in addition to existing co-optees this exemption would need to be extended to this Committee as there would be 8 Elected Members and 5 Co-opteed Members. The terms of reference for the Joint Health Overview and Scrutiny Committee set out that there are 3 Elected and 3 co-opted Members from each authority on the Joint HOSC. It is not possible for the Health and Social Care Scrutiny Committee to unilaterally change the number of co-opted Members on this committee.

5.5 The Health and Social Care Act also sets out that Healthwatch must have a place on the Health and Wellbeing Board which encourages integrated working and prepare the Joint Strategic Needs Assessment and Health and Wellbeing Strategy. Issues regarding any conflict of interest for Healthwatch representatives are outlined in the legal comment in Section 8 of this report.

6.0 EQUAL OPPORTUNITIES

6.1 There are no specific equal opportunity impacts arising from this report.

7.0 ENVIRONMENTAL IMPACT

7.1 There are no specific environmental impacts arising from this report.

8.0. LEGAL COMMENT

8.1 In addition to the legal issues outlined in the report, it would be necessary to ensure co-optees did not act when a conflict of interest arose. The Healthwatch representative nominated to sit on Health and Adult Social Care Scrutiny Committee would need to be different from the representative from that organisation that sits on the Health Wellbeing Board. Also, when the Health and Adult Social Care Scrutiny Committee was scrutinising any Healthwatch related matter, the Healthwatch representative would need to ensure they did not participate in that item.

9.0 LINKS WITH CORPORATE PRIORITIES

9.1 Establishing an effective working relationship with Healthwatch will contribute to the corporate priority to improve the health and wellbeing of our communities and address health inequalities

10. OPPORTUNITIES AND RISKS

10.1 It is important that Scrutiny and Healthwatch have a good working relationship to ensure that appropriate information is shared and avoid duplication.

11. FINANCIAL IMPLICATIONS

11.1 If a member of Healthwatch is co-opted on to the Scrutiny Committee they will be entitled to claim an allowance of £260 per annum. This could be accommodated within the current revenue budget for member allowances. TAS 23.10.13

12. WARD IMPLICATIONS

12.1 There are no specific ward implications arising from this report.

13. BACKGROUND PAPERS

13.1 None

Report prepared by Fiona Bottrill, Scrutiny Group Specialist 01952 383113

TELFORD & WREKIN COUNCIL

HEALTH AND ADULT CARE SCRUTINY COMMITTEE - 27 MAY 2014

SCRUTINY COMMITTEE COMMENTS FOR NHS QUALITY ACCOUNTS

REPORT OF SCRUTINY GROUP SPECIALIST

1.0 PURPOSE

1.1 To note the comments submitted to the NHS providers for inclusion in their Quality Accounts.

2.0 RECOMMENDATIONS

2.1 The Scrutiny Committee note the comments set out in Sections 5-8 of this report.

3.0 PREVIOUS MINUTES

3.1 None

4.0 BACKGROUND INFORMATION

4.1 A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

4.2 The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

4.3 NHS trusts are required by regulation to share their Quality Report with NHS England or relevant clinical commissioning groups Local Health Watch organisations and Overview and Scrutiny Committees. The Scrutiny Committee can submit comments based on the work undertaken by the Committee. The scrutiny of the NHS provider organisations has been carried out by the Joint Health Overview and Scrutiny Committee. The Telford and Wrekin membership of this Committee is a sub-committee of the Health and Adult Care Scrutiny Committee. Due to the tight timescale comments were circulated to members by email and submitted to the Trusts. Any additional

comments from Members at the meeting will be forwarded to the relevant Trust.

5.0 COMMENTS FOR SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

5.1 The Telford and Wrekin Membership of the Joint Health Scrutiny Committee is a sub-committee of the Health and Adult Care Scrutiny Committee. The main focus of the work of the Joint Health Overview and Scrutiny Committee during 2013/14 has been the need to reconfigure health services to reduce the demand on the acute hospital and the role of the community hospitals in achieving this. During the summer of 2013 the Committee raised concerns about the sustainability of some services across the two hospital sites in the county.

5.2 The Committee has welcomed the approach of the local health economy which has resulted in the Future Fit Programme. The Shrewsbury and Telford Hospital NHS Trust has engaged particularly well with the Committee and has responded constructively to both being held to account for the services currently provided and the process to plan services for the future. The Committee has sought assurance that the plans being developed through Future Fit are aligned to other strategic programmes for example the Better Care Fund.

5.3 The Committee has been assured that the outcomes for stroke patients has improved following the temporary centralisation of stroke services at the Princess Royal and had received an update on the transfer of women's and children's services.

5.4 An ongoing concern for the Committee has been to ensure that patients with mental health issues who are receiving care at in an acute setting for a physical illness receive appropriate care and therefore welcome that this has been identified as a priority for 2014/15. The Committee has recommended that better partnership working between the Royal Shrewsbury Hospital NHS Trust and the South Staffordshire and Shropshire NHS Trust would improve outcomes for these patients and their families. The Chair of the Committee has been informed of the Mental Health Crisis Care Concordat which will inform the Committee's scrutiny of this issue.

5.5 When considering the Trusts Travel and transport plan the Committee has also recommended that this includes transport to the acute mental health facility at the Redwood Centre.

5.6 The Chair of the Scrutiny Committee recognised that the target set to reduce the number of falls should be challenging but achievable.

6.0 COMMENTS FOR SHROPSHIRE COMMUNINTY HEALTH TRUST

6.1 The Members are aware that there has been significant change in the senior management team at the Community Health Trust. It has taken some time to arrange a meeting with the new Chief Executive and following this discussion the chairmen and the Committee will determine the focus of any future work regarding the Community Trust.

6.2 The Telford and Wrekin membership of the Joint Health Overview and Scrutiny is a sub-committee of the Health and Adult Care Scrutiny Committee. The main focus of the work of the Joint Health Overview and Scrutiny Committee during 2013/14 has been the need to reconfigure health services to reduce the demand on the acute hospital. The Committee has welcomed the approach of the local health economy which has resulted in the Future Fit Programme. The Community Trust has been a key partner in the process.

7.0 COMMENTS FOR SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE TRUST

7.1 NHS organisations are legally required to request comments from the Scrutiny Committee in which the Trust's headquarters is located. However, following discussions with the Trust is was agreed that Telford and Wrekin's Health and Adult Care Scrutiny Committee will be invited to provide comments. The Telford and Wrekin Membership of the Joint Health Scrutiny Committee is a sub-committee of the Health and Adult Care Scrutiny Committee.

7.2 The Committee recognises that the South Staffordshire and Shropshire Mental Health Trust provides services across the country. However Members want to ensure that appropriate accountability mechanisms are in place for the services provided in this area.

7.3 Members of the Joint HOSC visited the Redwood Centre in September 2013 and were impressed with the facility and the dedication of the staff. However, Members have a number of concerns that have been raised with the Trust both informally and formally:

7.4 Members of the Shropshire and Telford and Wrekin Joint HOSC raised serious concerns regarding the temporary closure, without consultation, of the only inpatient mental health facility in Telford and Wrekin. The Chairs of the Shropshire and Telford and Wrekin Joint HOSC have discussed these concerns with the Chair of the Staffordshire HOSC.

7.5 The Trust has reported on the performance of community mental health services at the Joint HOSC meeting on the 23rd September 2013.

However, the positive performance of community mental health services presented was not reflected by the information received by Members in Telford and Wrekin from service users and local voluntary organisations. Following this discussion the Committee welcomed the review of community mental health services and assurance that this would be brought to the Joint HOSC and would include proposals for the future of the temporarily closed facility in Telford. At the Joint HOSC meeting on the 24th Match 2014 it was agreed that a report would be brought Committee in June 2014 to update on the review of community mental health services.

7.6 The Committee welcome Priority 2 set out in the Quality Account – Access to Physical Healthcare. For many years the Scrutiny Committee has requested that the acute trust and healthcare trust work together to ensure that patients who have mental health needs receive appropriate care to meet their physical health needs. Discussions have included training for front line acute hospital staff on the needs of patients with mental health issues and including the South Staffordshire and Shropshire Healthcare Trust in the Acute Trust Travel. The Chair of the Committee has been informed of the Mental Health Crisis Care Concordat which will inform the Committees scrutiny of this issue. One area of joint working that has been highlighted by the Committee is that the Redwood Centre should be included in the travel and transport plan being developed by the Shrewsbury and Telford Hospitals NHS Trust.

7.7 The Telford and Wrekin Health and Adult Care Scrutiny Committee has recently started work on the implementation of the Alcohol strategy. The work of the South Staffordshire in providing community services and inpatient treatment will be scrutinised as part of this work.

8.0 COMMENTS FOR THE WEST MIDLANDS AMBULANCE SERVICE

8.1 The Telford and Wrekin Membership of the Joint Health Scrutiny Committee is a sub-committee of the Health and Adult Care Scrutiny Committee. The main focus of the work of the Joint Health Overview and Scrutiny Committee during 2013/14 has been the need to reconfigure health services to reduce the demand on the acute hospital and the role of the community hospitals in achieving this.

8.2 The Committee has welcomed the approach of the local health economy which has resulted in the Future Fit Programme and the West Midlands Ambulance service is represented on the programme Board.

8.3 The Committee has received the monitoring reports from provided by the Trust. No formal issues have been raised with the Trust based on this information however there have been discussions through the West Midlands Regional Scrutiny Network.

8.4 The Committee has received update reports from the CCG on the performance of the WMAS 111 service.

Improving General Practice

March 2014

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	**Commissioning Development**
Finance	Human Resources	

Publications Gateway Reference:	**01258**
Document Purpose	Resources
Document Name	Improving general practice – phase one report
Author	Ben Dyson, Director of Commissioning Policy & Primary Care
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Additional Circulation List	Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, Allied Health Professionals
Description	This report focuses on the central role we want general practice to play in wider systems of primary care, and it describes our ambition for greater collaboration with CCGs in the commissioning of general practice. Transformational change will be led locally, but we outline the work underway nationally to support it.
Cross Reference	Improving general practice – a call to action The NHS belongs to the people: a call to action
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	
Contact Details for further information	Clare Coughlan Primary Care Strategy Team Skipton House, 80 London Road London SE1 6LH 020 7972 5845

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Introduction

1. General practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day. NHS England has responsibility for commissioning these core primary medical services, and spends in the region of £7 billion a year across England.

2. Last August, we launched "*Improving general practice – a call to action*" to support action to transform services in local communities and to stimulate debate as to how we can best support the development of general practice to improve outcomes and tackle inequalities, both for today's patients and for future generations. It echoed the case for change made by other organisations, such as the *Royal College of General Practitioners*' report "*A Vision for General Practice in the Future NHS*" (May 2013). We supported our engagement with a national online survey and a national stakeholder event.

3. Our stakeholders had much to tell us. A report of an independent analysis of responses submitted by individuals can be found here* and the submissions made by organisations can be found here** and here***.

4. We have also published "*Improving community pharmacy*" (December 2013) and "*Improving dental care and oral health*" (February 2014) to stimulate similar action and debate for other parts of primary care. We will bring together the outcome of all of these calls to action, together with a fourth on eye health, in the autumn of 2014 when we will publish our strategic framework for the commissioning of primary care – covering the total £13 billion of primary care services directly commissioned by NHS England.

5. This report focuses on general practice and the central role we want it to play in wider local systems of primary care. It sets out our emerging thinking on the commissioning of general practice services. It describes the kind of general practice we want to see in the future, and the work needed to develop the necessary clinical and organisational models. It sets out the key ways in which this will be led locally, and then outlines the work underway nationally to support it.

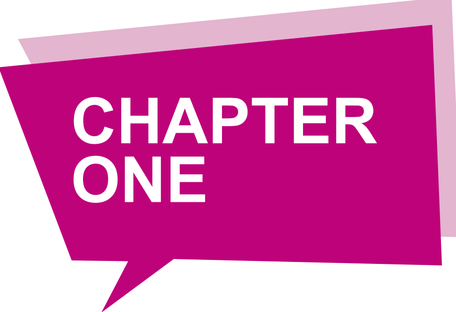
6. This is still subject to further engagement at national and local level. This report is therefore intended to provide an update on the work so far.

7. In particular:
   - We want to test our emerging ambitions for general practice, and the work we have started to support local communities in achieving these ambitions.
   - We want to explore further how our national partners can help us deliver the vision – and how we can support our partners.
   - We want to test further whether we have identified the right priorities for the national work to promote and remove barriers to local innovation.

* Independent analysis of responses report: http://www.england.nhs.uk/wp-content/uploads/2014/03/imp-gp-cta-analysis.pdf

** Organisation responses 1: http://www.england.nhs.uk/wp-content/uploads/2014/03/resps-2013-1.zip

*** Organisation responses 2: http://www.england.nhs.uk/wp-content/uploads/2014/03/resps-2013-2.zip



Does general practice need to change?

8. The wider context facing England in the provision of health care was set out in NHS England's "Call to Action". This summarised the challenges associated with demographic changes, growing public expectations and the economic and financial context, and the scope to improve outcomes and tackle unwarranted variation and inequalities across England through the way that we respond to these challenges.

9. Demographics: The population in England is growing and people are living longer. Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older[1]– the most intensive users of health and social care. The health care needs of the population are changing. In England 53 per cent of people report that they have a long-standing health condition, including mental health conditions, and the number of people living with more than one long-term condition is set to rise from 1.9 million in 2008 to 2.9 million in 2018.[2] These are very different needs from twenty years ago, and to meet these changing needs the current pattern of services and models of care will need to change.

10. Outcomes: General practice has a key role to play in securing better outcomes for the population, but there are unwarranted variations in the services that patients currently receive which can impact on the outcome of their care. We heard from the first inspection report from the Chief Inspector of General Practice in December 2013 that there are a small minority of practices where there are serious failings in the provision of care. Overall satisfaction with general practice services remains high – 86 per cent of respondents to the GP Patient Survey say that their overall experience is good or very good.[3] However there are growing challenges in relation to patient experience of access to care. A quarter of patients do not rate the overall experience of making an appointment as "good"; 26 per cent of people do not find it easy to get through to the surgery by telephone and this figure varies from 8 per cent to 48 per cent in different parts of the country.

11. Financial constraints: The NHS faces a projected funding gap of £20 billion by 2021/22.[4] Primary care potentially has a key role in helping reduce this gap by providing more personalised, accessible community-based services for patients that help improve community health and reduce avoidable pressures on hospital resources. This will involve changing the way care is provided and prioritising the services that patients need and want within the available resources.

12. Impact on other parts of the system: Between 2003/04 and 2011/12 the number of emergency admissions for acute conditions that should not usually require hospital admissions increased by 34 per cent.[5] The causes for this are complex and multi-factorial and will certainly be a reflection of the rising acuity of some patients' needs. But it may also partly reflect the perception of the ability to access wider out of hospital services, whether community, primary or social care, and the extent to which these services are able to support individuals before they need emergency care.

"We need to invest in primary care by offering relaxation of rules that stifle innovation"
response to engagement

1. ONS National Population Projections, Table A2-4, Principal projection, England population in age groups, 2012 based
2. Long Term Conditions Compendium of Information https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition
3. Ipsos MORI, GP Patient Survey, December 2013: http://www.gp-patient.co.uk/
4. NHS England (2013), The NHS belongs to the people: A call to action: http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
5. HSCIC indicator portal, 2003/04 to 2011/12
6. NHS staff 2002-12, General Practice. Table 7.

13. Workforce: While the numbers of full time equivalent GPs has grown over the past ten years, the GP workforce has grown at only half the rate as other medical specialties and has not kept up with population growth. A gradual increase in the proportion of GPs working part time is creating longer-term sustainability pressures: the peak age band for female GPs leaving the workforce is currently 35 - 39 years whereas the peak age band for males leaving is 55 - 59 years.[6] Within the wider general practice workforce there has been only a marginal increase in the number of practice nurses.

Factors affecting change in general practice

14. In addition to these wider drivers, there are several factors which shape how NHS England can support and drive improvement in general practice.

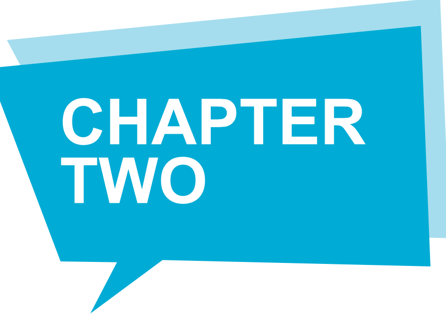
15. Local services, national contractual frameworks – general practice is above all a local service, provided by around 8,000 independent contractors. However, through the national GMS (General Medical Services) contract and the associated PMS (Personal Medical Services) contracts, all contracts are based on nationally developed contractual frameworks. Our national approach to commissioning general practice needs to strike the right balance between, on the one hand, national consistency and, on the other hand, providing space for local innovation, local leadership and sensitivity to local needs.

16. Integrated services, different legal framework – the rise in the number of people with long-term conditions, including those with mental health needs, has significant implications for how general practice organises itself, and co-ordinates the services it provides with other services provided in the community. Yet there is a different statutory basis for our commissioning of general practice and for CCGs' commissioning of other community services. We are committed to working collaboratively with CCGs to commission integrated services for the individual, and enhance the central co-ordinating role that the general practice can play in supporting people and their families.

17. CCGs as clinically led membership organisations – for the first time in the history of the NHS, every practice is formally a member of a local clinical commissioning group, led by clinicians, with expert management support. Whilst NHS England is the statutory commissioner of core primary medical services, CCGs have a duty to improve the quality of primary medical care. CCGs have a major opportunity to use their clinical leadership and relationships with member practices – if given the right tools, information and incentives – to help transform primary care.

18. Retaining the strengths of the generalist system – Most of the population is registered with a general practice, and this is recognised internationally as a powerful tool in the co-ordination and continuity of care. Coupled with the highly systematic use of technology to support the management of long term conditions and track changes in health status, general practice can play the central role in providing support for people with chronic disease, and in identifying those at risk of developing ill health. It also plays a key role in enabling effective population health interventions such as screening and immunisation.

19. In summary, there are four key reasons why we need to support changes in general practice: to meet the changing needs and expectations of our population; to improve outcomes and tackle inequalities; to maximise limited resources across the system, and to secure a sustainable service for the next decade. There are particular factors that will shape how we approach that – ensuring that we build on the many strengths of the current system of general practice in this country.



Our ambitions for general practice and wider primary care

20. Our initial findings, from both this phase of engagement and from the national survey and the comments and complaints received more generally, have highlighted five areas where we believe we need to improve services, both for today's population but also to ensure we have excellent services for the future. Much of this is built on great work already happening in general practice, but not consistently across the country.

21. These are:

Ambition one: proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.

Ambition two: holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

Ambition three: fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.

Ambition four: health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.

Ambition five: consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

Responsive to the needs of all – and reducing inequalities

22. These ambitions are designed to meet the varied needs of all our communities across the country. We want to ensure that everyone gets access to the same excellent high quality services. This is as true for general practice services and wider out-of-hospital services as any other. It also needs to be sensitive to the different requirements of different parts if the population. For example:

- more proactive, coordinated care will be of real benefit for frail older people and other people with complex needs;
- more person-centred care for people with long term health conditions and people with mental health problems;
- responsive care for the general population, including same-day access to services for people with urgent care needs; but also different ways of accessing services may benefit other groups such as young people;
- preventative care, advice and interventions that will support communities and individuals to better manage their own health to avoid becoming ill, and prevent unnecessary interventions.

"Be more open and listen to what people are saying, respond with simple language; start from the assumption that you do not have the answers"
response to engagement

Frail older people and other people with complex needs

There are 4.2 million people aged over 75 years in England. Although only 8 per cent of the population, they account for around 30 per cent of emergency admissions to hospital, and they have more than twice as many GP consultations as the rest of the population. The majority of people aged over 80 years have one or more long term conditions. Population forecasts predict a significant rise in the number of people aged over 75 in the next 20 years and in the prevalence of long term conditions. We need to strengthen and redesign primary care services to enable us to meet these major demographic challenges. The changes agreed to the GP contract for 2014/15 include ensuring that everyone aged 75 years or over has a named, accountable GP to oversee their care – and that practices provide a tailored programme of proactive, personalised care and support for those patients with the most complex health and care needs (to include at least two per cent of each practice's registered patients). We are planning further work with the *Department of Health* and with patient and professional groups to look at how to extend this approach more widely.

People with mental health problems

A quarter of the population will experience mental health difficulties this year, and around 90 per cent of them will be managed in primary care. The incidence of people with mental health difficulties is expected to rise to reflect an ageing population and an increase in the number of people with long term physical conditions. People with long-term physical conditions, people from more deprived areas and unemployed people are more likely to need longer term care for mental illness than the general population. Area teams and CCGs will explore innovative ways to provide care and support for mental health needs that build on the distinctive role of general practice in providing continuity of care. At national level we will establish a development programme to share examples of successful innovation, including how non-medical interventions such as social prescribing can contribute to primary care teams meeting the physical, psychological and social care needs of an individual in the round.

Children and young people

Children and young people account for nearly a quarter of the population, and account for up to 40 per cent of consultations in general practice. In many parts of the country around half of GPs have had no formal training in paediatrics[7]. Yet there is compelling evidence of how tailoring general practice services to the needs of children and young people can dramatically address the sustainability issues facing the NHS and improve health outcomes. A national review in 2010[8] identified that children, young people and their parents or carers are often unwilling or unable to gain access to the care of a GP and that they choose to go instead to the A&E department of a hospital. The *National Children's Bureau* has highlighted that nearly a quarter of all those attending A&E services are under 16 years of age, and that the number of attendances and emergency admissions are rising for this age group[9]. This creates obvious pressures on hospital services and exposes children and young people to acute hospital settings unnecessarily. We will work with CCGs to help make general practice and wider primary care more suitable for the health needs of children and young people . On *Children's Takeover Day* in November 2013 the NHS England Executive Team heard directly from young people about how they thought general practice could be more responsive to their needs by allowing them to email their concerns in advance, rather than have to tell their story out loud for the first time to the GP.

People with long term conditions

The 15 million people in England with long term conditions have the greatest healthcare needs of the population (15 percent of all GP appointments and 70 percent of all bed days).[10] It is clear that current models of dealing with long term conditions are unsustainable. Rather than people having a single condition, multimorbidity is becoming the norm.[11]

People have told us that they want person-centred coordinated care to manage their long term conditions. This will enable individuals to make informed decisions which are right for them, and empower them to manage their health in partnership with health and care professionals.

NHS England and partners are using the 'House of Care' model as a framework to help deliver high quality person-centred coordinated care. The House relies on four key components: commissioning; engaged, informed individuals and carers; organisational and clinical processes; and health and care professionals working in partnership.

7. "Getting It Right for Children and Young People" (p6); Professor Sir Ian Kennedy; 2010
8. "Getting It Right for Children and Young People"; Professor Sir Ian Kennedy; 2010
9. "Opening the Door to Better Healthcare", May 2013
10. Department of Health (2011) Ten things you need to know about long term conditions. Available at: www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm
11. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012) Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet, 380:37-43.

23. But it's not just about responding to the varied health needs of our communities. It's also about putting equality at the heart of the NHS, its values, processes and behaviours. People have a right to high quality services, irrespective of who they are, their social status, where they live, or what needs they have. In commissioning primary care services, we are committed to ensuring a particular focus in improving access to high-quality services for:

- people from more deprived backgrounds with poorer health outcomes;
- people from black and minority ethnic communities;
- people with physical or learning disabilities.

24. We also need to improve access for groups who face particular difficulties in accessing services including homeless people; sex workers; gypsies and travellers; and people in prisons and offender institutions. For these groups, experience of general practice is often worse than for the population at large because it is not sufficiently tailored to their specific needs. So our ambitions for primary care are particularly important for making sure that we meet the needs of these groups in society.

25. Our area teams are working with CCGs to develop primary care strategies that draw on the insights and experience of people across all these different groups and support a more integrated approach to providing care and support across primary care, community health services, social care, the voluntary/charitable sector and specialised services. We will use the *Equality Delivery System* to guide us in helping make services more responsive to people's individual needs and promote more equitable health outcomes.

26. In developing joint plans with CCGs, area teams are working with *Health and Wellbeing Boards* to ensure that plans are based on a clear understanding of access and health outcomes across different population groups, including gaps in life expectancy and their causes, incidence of 'killer' diseases at local community level and inequalities across the most and least well off neighbourhoods.

27. In order to reduce inequalities, we are also reviewing the formula used to weight the capitation payments made to general practice. The formula already includes adjustments to reflect the age of registered patients, relative levels of deprivation, and rurality factors. We are working with the *British Medical Association's General Practitioners Committee* to improve the weighting given to deprivation factors and help ensure that there are appropriate incentives to improve access to people from more deprived communities.

"Involving GPs and other healthcare professionals in care pathway re-design, as is now happening through CCGs, is creating clinically-led innovation"

response to engagement

Wider primary care, delivered at scale – future models of care

28. In order to support delivery of our ambitions, we believe that general practice will need to operate **at greater scale and in greater collaboration** with other providers and professionals and with patients, carers and local communities. At the same time, general practice will need to preserve and build on its traditional strengths of providing personal continuity of care and its strong links with local communities.

29. Many practices in England are already looking to adopt new approaches to self care, communications technologies and clinical collaboration. They are also exploring ways of improving clinical effectiveness, safety and patient experience. These often involve looking more broadly at primary care and other community-based services. This is about a bigger perspective and ambition, and a step change in partnership working, both across practices and with their community partners.

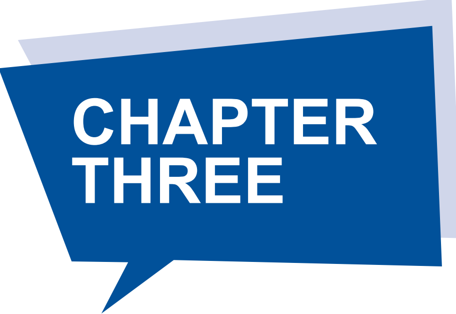
30. This does not necessarily have to involve a change in organisational form. It can be achieved through practices coming together in networks, federations or 'super-partnerships', or as part of a more integrated model of provision. It is likely to have a range of benefits including:

- **Better outcomes**
  - pooling of clinical expertise, offering a greater range of generalist and more specialist services delivered by a larger multidisciplinary team
  - improved patient access, including greater availability of consultations outside traditional opening hours, and consultations outside of the surgery
  - local systems of extended primary care that work to prevent unnecessary hospital admissions and support safe hospital discharge seven days a week
- **Better partnerships**
  - a more innovative approach to planning and delivering services by way of shared learning and ideas
  - a more systematic approach to governance and risk assessment
  - opportunities for innovative diagnostic, treatment and care pathways
- **Better value**
  - economies of scale in administrative and business functions
- **Better for the workforce**
  - better development opportunities for GPs, practice nurses, practice managers and other staff and ability to support students
  - more effective peer support and mentoring

31. We plan to work with national and local partners to identify the best emerging examples of service models that deliver these outcomes and improvements. Service models need to be locally designed and need to be sensitive to local needs, priorities and circumstances: what may be suitable for a very transient community in an inner city may not be right for a very stable population dispersed across a large rural area. There can be therefore no single blueprint. We will publish emerging examples of these potential models to help support those leading change at a local level, and to ensure that we are clear about the clinical, patient and economic benefits of different ways of organising care, and the workforce implications. Some early examples are set out in Appendix A.

32. We believe our ambitions for general practice will not be met simply by local strategies alone. The combination of factors affecting general practice set out in chapter one highlight the need for some national enabling work to support the champions of change, and to build the foundations nationwide for better primary care to deliver great outcomes for everyone. This is covered in our next chapter.

NHS
England



Meeting our ambition

33. This chapter sets out the ways in which we are already taking steps to enable general practice to meet these ambitions, and the work we have planned for the future.

34. NHS England commissions primary medical care through 27 area teams across England. Each of these area teams has been engaging with local communities, CCGs and other stakeholders to discuss how we can respond to A Call to Action. It is at this local level that plans translate into real changes for patients.

35. For example, in London we have worked with CCGs and other community partners to develop "Transforming Primary Care in London: General Practice – A Call to Action"[12]. This includes new ambitions for primary care in London, built from patient and public views, led by clinicians and focused on more proactive, coordinated and accessible care for all.

36. In Greater Manchester we have worked with CCGs and other partners to develop a five-year strategy to develop new quality assurance systems, give people the information and choice they need to manage their own health, provide integrated care teams for people with long term conditions, develop new forms of rapid response to urgent care needs, and enable people to access a wider range of out-of-hospital services in their local community.

37. All of our area teams are working with local communities to translate the general ambition into specific concrete strategies for their populations. This reflects the different starting points and the different needs of communities; but is set within our overarching ambitions for improved outcomes for all.

38. To support these locally-led transformations in primary care, we are focusing at national level on seven main areas of work. These are:

I. Empowering patients and the public: 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.

II. Empowering clinicians: ensuring high-quality support for innovation and improvement, developing networks to allow more rapid spread of innovation, supporting general practice in developing new models of provision, and releasing time for patient care and service improvement.

III. Defining, measuring and publishing quality: improving information about quality of services both to strengthen accountability to the public, clarity on what the public can expect, and to support clinical teams in continuous quality improvement.

IV. Joint commissioning: working with CCGs to develop a joint, collaborative approach to commissioning general practice services, with a stronger focus on local clinical leadership and ownership and allowing more optimal decisions about the balance of investment across primary, community and hospital services.

12 http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf

V. Supporting investment and redesigning incentives: supporting a shift of resources towards general practice and 'wrap-around' community services, developing the national GP contract to support our five ambitions, and developing innovative new forms of incentives that reward the best health outcomes.

VI. Managing the provider landscape: ensuring that all general practices meet essential requirements, responding effectively to unacceptably low quality of care, and enabling new providers to offer their services to the public.

VII. Workforce, premises and IT: working with national and local partners to develop the general practice workforce, promote improvements in primary care premises and sustain improvements in information technology services.

39. In the pages that follow, we set out some of the work that will follow in each of these seven areas.

(1) Empowering patients and the public

Enabling patients and carers to participate fully in managing their own health care needs, and in developing personalised care plans, lies at the heart of our vision for health care, not just general practice. Patient, public and carer voices will be central to the planning and commissioning of general practice services and wider primary care.

40. By April 2015 all patients, who wish to do so, will have online access to their own records in general practice, including test results.

41. We will make sure that patients who manage their own care have access to high quality information, such as expertise in the interpretation of diagnostic tests, through our strategy for "information as a service" and through our "shared decision making" toolkits.

42. We will publish a *best practice standard* in the summer of 2014 that describes a good personalised care planning process, to support implementation of proactive coordinated care planning for frail older people and other people with complex needs.

43. We will provide guidance by the summer of 2014 on how the primary care team can use peer support and social prescription services to support patients in achieving long-term behaviour change and building social networks of support.

44. We want to promote innovative forms of patient participation that reflect the specific needs of local communities. We will work with the *National Association of Patient Participation* and other partners such as *Healthwatch* to support practices to develop inclusive and insightful approaches to building participation.

45. We will provide more opportunities for patients to give feedback on general practice services: from December 2014 the *Friends and Family Test* will be extended to general practice services.

"Involve patients in the design of services. It is not rocket science to look at the best customer service in the outside world and apply those lessons across the NHS"
response to engagement

We will give people greater freedom to choose the GP practice that best meets their individual needs.

46. We will ensure clear information about the choices already available to members of the public through *NHS Choices* by publishing an increasing range of information to support patient choice and by working with the *Care Quality Commission* to support its new work around the rating of individual practices.

47. From October 2014 practices will be able to accept patients onto their registered lists from outside their traditional boundary or catchment areas (with alternative arrangements in place where patients need urgent care closer to home); this will particularly benefit people who move house and want to stay registered with their existing general practice, and people who want to register with a general practice near their place of work. We will explore new forms of online patient registration to ease the process of switching practice.

48. We will more fairly reward practices that take on more patients by continuing to increase the proportion of funding that follows a patient when they switch practice – for instance through phasing out the Minimum Practice Income Guarantee and seniority payments and recycling these resources into the capitation payments that all practices receive to reflect the numbers of patients on their registered list, weighted by age, morbidity and other factors.

We will enable patients to access services in ways that better reflect their needs and preferences – whilst ensuring that patients access the most appropriate service, at the right time and in the most appropriate location

49. Over 2014/15 we will develop quantifiable ambitions for improving overall patient experience of general practice services. This will focus on improving experience of access to services, which we know in turn is particularly linked to convenience of getting an appointment, ease of getting through on the phone and the helpfulness of receptionists.

50. We will use the £50 million made available under the Prime Minister's Challenge Fund to enable groups of practices around the country to pilot new ways of working that transform patient access to services. In December 2013 we began the process for identifying a number of pilot practices, and a rolling programme of pilots will commence from April 2014 that will test how to improve access to general practice, which could include:

- access between 8am-8pm on weekdays and at weekends
- flexible access including consultations by telephone, email, and Skype; electronic prescriptions and online booking of appointments
- easier, online registration and choice of practice
- joining up of urgent care and out of hours care
- greater flexibility in how people access general practice, including freedom to visit a number of GP surgery sites in their area
- better access to 'telecare' to help manage patients in their own homes, as well as promoting healthy living 'apps'.

51. From April 2015, all practices will offer patients the opportunity to book appointments online, order repeat prescriptions online, and have access to their medical records online.

52. We are working with CCGs to develop primary care strategies that address barriers to access for vulnerable populations, such as the homeless, and access to treatment for hard to reach communities who are often not engaged in proactive long term management of their conditions.

URGENT AND EMERGENCY CARE

The initial conclusions of NHS England's review of Urgent and Emergency Care are that the NHS must do better to help patients with urgent care needs to get the right advice in the right place, and that we must provide highly responsive urgent care services close to home so that people no longer choose to queue in A&E. Our current model for providing urgent and emergency care is not sustainable.
General practice and other primary care services are well placed to respond to the challenge of ensuring safe and sustainable urgent care services outside hospital that are responsive to the needs of individual patients. However, at the moment patients contacting their general practice with an urgent problem receive a variable response, and may be directed elsewhere inappropriately.
In some cases patients do not even think to approach primary care services in urgent situations, and instead choose to queue at A&E services. This is particularly true of parents seeking urgent care for infants and children.
We will support general practice in working innovatively with out-of-hours providers, community health teams, acute hospitals and NHS 111 to deliver a better service that ensures that patients with more urgent care needs receive prompt attention at all hours of the day or night. CCGs are already developing strategic plans for improving urgent care, and the proposals set out in this document will help us work alongside CCGs to implement the eventual recommendations of the Urgent and Emergency Care review.

(2) Empowering clinicians

To make sure we drive up improvement across general practice for each of our ambitions, we will support the development of networks to allow more rapid spread of innovation. We will support practices in releasing time for patient care and service improvement. We will make more data available to support clinicians in continuous quality improvement.

53. We will reduce unnecessary burdens on general practice and support more efficient ways of working so that practice teams can devote the maximum possible time to patient care. We are simplifying the Quality and Outcomes Framework from 2014/15 to reduce bureaucracy and to free up time for GPs and practice staff to provide more proactive, person-centred care, with an initial focus on frail older people and other patients with more complex needs.

54. We are exploring how the wider primary care and community workforce can support capacity in general practice. *"Improving patient care through community pharmacy – a call to action"* highlights the potential for community pharmacy teams to play a bigger role in supporting patients with long-term conditions.

55. The call to action – and the responses we have received – has identified a pressing need to invest in the ability of general practice to release capacity and implement innovative service models for wider primary care.

56. We are considering a range of measures to support the spread of innovation, for confirmation in April 2014.

"Integration will come from better understanding of the whole – more shadowing of roles across disciplines"
response to engagement

SOCIAL PRESCRIBING

In order to make general practice more sustainable we need to ensure that people get the most appropriate help at the right time, and this includes making more use of non-clinical interventions when this is appropriate. Social prescribing is an innovative approach that harnesses the unique expertise and resources within the voluntary and community sector for people with non-clinical needs and is particularly effective as an intervention for people with mild to moderate mental health issues. It is also effective for groups who are at risk of social exclusion and who consequently are frequent attenders at their local practice. Common examples are self-help groups, education classes, clubs, discussion groups and other hobby-related activities. Current provision of social prescribing is variable, and we want to disseminate great practice where it exists and is shown to deliver better outcomes and better value. We will work with our voluntary and community sector partners to encourage a move to social prescribing and to develop pathways that enable people with non-clinical needs to access voluntary services and community groups.

(3) Defining, measuring and publishing information on quality

We will turn our ambitions into clear standards, and work with partner organisations to define more clearly what patients and the public should expect from high-quality general practice and develop a better range of measures that can be used to gauge how well practices are meeting these standards.

57. In collaboration with the CQC, NICE, the *Health and Social Care Information Centre* and other organisations across healthcare, NHS England has established the *National Network of Quality in Primary Care* to define and promote quality in primary care.

58. Through this network, we are bringing together in one place – and continuing to develop – standards that describe the key characteristics of high-quality primary care in the following domains:

a) clinical effectiveness, including (i) reducing avoidable mortality; (ii) improving quality of life for people with long term conditions; (iii) providing swift and effective responses to acute illness or injury;

b) patient experience, including experience of access;

c) patient safety.

59. We will also ensure that for each of these areas there is a consistent set of metrics that enable us to provide comparative information for GP practices, CCGs, and patients and the public as to how well practices – or groups of practices – are performing against these standards.

60. These quality standards will draw on pioneering work already taking place around the country between CCGs, our area teams and local communities to define better what to expect from high-quality primary care and to develop more stretching ambitions for what can be achieved from wider primary care, delivered at scale.

We will improve information about the quality of general practice services to: strengthen accountability to the public; support clinical teams in continuous quality improvement; support patients in decisions about their care and in exercising choice; and increase transparency of health information for the benefit of patients and the public.

61. We will publish accessible and meaningful information so that patients are able to make better decisions about their health and care, and citizens are able to participate more fully in conversations about the design and quality of local services and hold them to account. Publishing this kind of data also enables expert third parties to contribute to the transparency and quality agendas by scrutinising the data in novel ways and publishing their analyses. Together with other sources of data, it also has the potential to provide GPs themselves with the analytical tools to understand and improve their own practice.

62. New data on general practices was added to a special ‘accountability’ section of the *NHS Choices* website in December 2013. We will engage further with key stakeholders to identify and publish more information.

We are taking particular steps to help improve patient safety in primary care

63. To support our proactive approach in monitoring safety we have established a *Primary Care Patient Safety Expert Group* to provide senior clinical advice on patient safety issues and provide advice and guidance for commissioners and providers. The Expert Group is developing a strategy for improving patient safety in primary care, including improving patient safety incident reporting, improving culture and improving the safety of the discharge process from acute care. This will support everyone working in general practice to undertake improvement activity and increase their use of information to drive continuous reductions in harm.

64. In response to the Francis and Berwick reports, we are investing £12 million on a major programme of patient safety improvement through the creation of around 15 patient safety collaboratives covering every part of England. These collaboratives will be locally led and nationally supported to spread best practice and build safety skills. The collaboratives will:

- bring together frontline teams, experts, patients, commissioners and others to tackle specific patient safety problems, develop and test solutions, and learn from each other to improve safety;
- address patient safety issues across acute, community and primary care services.

65. This will require the full involvement of general practice providers and will support the whole primary care sector in addressing patient safety issues.

(4) Joint commissioning of general practice services

To deliver our ambitions, we have heard that a collaborative approach to commissioning general practice services between NHS England and CCGs would be more effective.

66. We have heard consistently that to meet the needs of a population with an increasing rise in long term conditions general practice wants to – and needs to – play a stronger role at the heart of more integrated networks of community-based or 'out-of-hospital' care. At its best, general practice already plays a pivotal role in connecting people to other community services that help them stay healthy and manage long term health conditions – and in working with a range of partner organisations to improve the health of local communities.

67. Developing more integrated services will depend ultimately on the leadership and cultures of the different provider organisations involved – and we are already seeing great examples of general practice starting to come together with community health services, social care and specialist services to do this. To support these changes, however, we need to ensure that we commission services in a holistic way, based on the needs of a given locality.

68. To do this, NHS England intends to move towards joint arrangements with CCGs for commissioning general practice services. This will:

- allow NHS England and CCGs to pool resources, where appropriate, and make more optimal decisions about how resources are allocated between primary care, community health services and hospital services;
- strengthen local clinical leadership and ownership of plans to transform general practice services, and ensure they are aligned with the wider strategic plans for that community;
- strengthen the links between in-hours general practice services and wider out-of-hours services;
- support development of more integrated arrangements for providing general practice and community health services (for example in linking the work of general practice, district nurses and palliative care nurses in end of life care);
- allow a more cohesive approach to incentives for general practice and other local health organisations, so that providers are held to account for – and rewarded for – similar outcomes, e.g. for population health;
- support joint working with local authorities to commission more integrated health and social care for local communities and support outcomes that address social and economic disadvantage (such as housing and education) to improve community health and wellbeing;
- provide greater confidence that, where local plans require additional investment in general practice services, this investment is being made in ways that do not give rise to perceived conflicts of interest for GPs involved in clinical commissioning.

69. To support this approach, we are expressing primary care allocations at a CCG population level. This will enable CCGs and NHS England to look at the resources available to spend on general practice alongside resources for hospital and community services in each locality.

70. We are also developing a national governance framework to enable this to happen at a pace that can be led locally and is appropriate to local circumstances.

"Part of the problem is that CCGs do not commission primary care, they cannot, due to conflict of interests. Before you can get integrated care you need to have integrated commissioning"

response to engagement

We shall use new forms of collaborative commissioning to help tackle health inequalities

71. Joint commissioning offers the potential to:

- commission services focused on vulnerable populations with high health-care needs but who traditionally have poor access (such as the homeless and migrants);
- involve communities in co-designing services that meet their wider health and social care needs;
- commission integrated primary care as a gateway to non-clinical and community services that address the social determinants of health.

(5) Supporting a move of resources and re-designing incentives

To deliver our ambitions, we believe we need to see a shift of resources from the acute sector towards general practice and 'wrap-around' community services

72. We have heard a strong view that, if we are to develop a more sustainable health service that helps to keep people healthy, there needs to be a significant shift of resources from acute services to out-of-hospital care. The *Better Care Fund* - a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities - will provide significant opportunities for CCGs and local authorities to work together to effect this change.

73. We have also heard that there needs to be local flexibility as to how far this is achieved. CCGs are already developing strategic plans that place a much greater emphasis on care outside hospital, and many intend to use general practice as a major component of more accessible and integrated systems of care.

74. NHS England's planning guidance for 2014/15 describes how CCGs will provide additional funding of around £5 per head to support practices in transforming the care of patients aged 75 or over and in reducing avoidable admissions. This funding could be used to commission new services from general practices or invested in community services to improve integration with primary care. Practices should have the confidence that, where these initial investment plans successfully reduce emergency admissions, it will be possible to maintain and potentially increase this investment on a recurrent basis.

75. This local shift of investment, combined with more collaborative working between CCGs and area teams, will increasingly allow us to set more stretching ambitions for primary care.

76. In support of joint commissioning and a more specific focus on the needs of local communities we will provide greater clarity about the different ways in which area teams and CCGs can make safe, controlled investments in general practice services, including:

- services commissioned by CCGs under the NHS Standard Contract;
- services commissioned as variations to General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contracts, managed by NHS England but potentially drawing on funding that has been pooled with CCGs.

"First of all we need to work out how to disinvest money from secondary care without destabilising the hospitals we need"

response to engagement

We will continue both to develop the national GP contract and to develop innovative new forms of incentives that reward the best health outcomes.

77. This is not just about new investment. The forecast funding gap for the NHS of £20bn by 2021/22 means that we urgently need to use existing resources more effectively. We have heard considerable frustration from CCGs and general practice about the number of current incentive schemes, the need for greater cohesion and the desirability of adapting incentives to reflect local priorities.

78. To allow a more cohesive approach to incentives, we will:

- continue to develop the national GMS contract framework so that it provides equitable funding for the essential services that all general practices should be expected to provide and helps drive continuous improvements in quality of care and value for money;
- continue to develop the *Quality and Outcomes Framework* with a view to a stronger focus on outcomes rather than processes of care and a continued push to remove unnecessary bureaucracy;
- review local PMS contracts to ensure that, where NHS England is providing extra funding for primary care services locally, it is invested in services that go beyond what is expected of core general practice and supports locally agreed plans for developing primary care;
- use PMS or APMS arrangements to stimulate innovation and quality improvement to meet local needs and reduce health inequalities, based on local CCG strategies and, where appropriate, using pooled funding.

79. We will also develop and test innovative approaches to incentives, for instance by:

- using PMS or APMS flexibilities to design more holistic incentives that reflect local needs and support integration;
- developing practical tools to support area teams and CCGs in innovative forms of contracting that support greater integration in the provision of general practice and other services.

(6) Managing the provider landscape

Our ambition to ensure that everyone, wherever they live, can access consistently high quality care means that we need to set clear expectations for the standards that patients should be able to expect from all general practices; respond effectively to poor quality of care; and enable new providers to offer their services to the public, particularly where current services are not providing good quality.

80. *Monitor's* recent report[13] set out a number of recommendations for how we can best manage our relationship with existing and potential future providers of primary care services to improve quality for patients. Those recommendations have informed these emerging findings, and we will continue to work with *Monitor* and other partners to take forward the action described below.

We will take a more consistent, rigorous and risk-based approach to monitoring quality

81. Every general practice is required to meet essential national standards around quality and safety in order to maintain its registration with the *Care Quality Commission* (CQC). We are working with the CQC to ensure a shared approach to monitoring, maintaining and improving quality in general practice.

82. NHS England has a key role to play in ensuring safety and quality, working alongside the CQC. Our risk-based assurance process for general practice enables us to monitor practice performance against a range of outcome standards and performance indicators and to take action where there are concerns about performance. Our approach reflects the five key questions that the CQC asks about each general practice:

Questions		Actions
Is it safe?	➡	Assurance
Is it effective?		
	➡	Support where possible
Is it caring?		
	➡	Intervention
Is it responsive?		
Is it well led?	➡	Closure if necessary

83. To complement the CQC's plan to have inspected and rated every practice in England by 2016, each area team will during 2014/15 identify those practices in each locality that cause most concern in terms of quality and work with those practices to determine the most appropriate action for improvement.

13 "Discussion document following Monitor's call for evidence on GP services", February 2014

We will work with the CQC to take a more rigorous and coordinated approach to respond to evidence of poor quality

84. Reporting on the CQC's first 1,000 inspections of GP surgeries in December 2013, the Chief Inspector of General Practice concluded that a minority of practices (around one per cent) present serious failings in the provision of care. Where a practice is providing poor quality care, we will take the following action, working as appropriate with the CQC:

- Where the CQC has judged a practice to be "inadequate" but has not removed registration we will work with the practice to determine the action that is needed to improve quality of care within a stipulated time frame and monitor progress.
- We will support practices, where necessary and appropriate, in accessing external support to help them make the necessary improvements.
- We will ensure that patients are informed of other practices that they could choose to join, if they have concerns about quality following a CQC assessment.
- Where appropriate, we will work with practices to consider if quality of care for patients could be improved by joining a network or federation of other practices, or through merger with another local provider to create a single management structure.
- Where there is a serious risk to patient safety, we will halt the provision of services at that practice.

Where practices close, we will either bring in a new provider or seek to consolidate services with another local practice, whichever is in the best interests of patients

85. There are a number of scenarios in which GP practices are unable to carry on providing services to patients. This could be because a practice chooses to close, or because – in the event of serious failure – the CQC removes their registration or NHS England removes their contract.

86. In these circumstances, our immediate priority will always be to ensure that local patients have continued access to services, typically by arranging for another provider to take over the practice on a short-term basis to provide continuity and by ensuring that patients have information about other practices with which they could choose to register if they wish.

87. The longer-term approach to replacing services will depend on the local circumstances. Where the practice serves a relatively small population, we will, where possible, make arrangements for an existing provider to take over the practice on a permanent basis, in line with our view that general practice is more likely to deliver high quality, cost effective services when operating at greater scale. Where the provider serves a larger population we will generally look to commission a new provider through an open and transparent procurement process.

We will bring in new providers on a targeted basis where this will have the greatest impact in improving quality and choice for patients

88. In addition to bringing in new providers to replace any failing practices, we will work with *Health and Wellbeing Boards* to assess current and future needs and to assess how well these needs are being met through existing services.

89. In order to improve quality and reduce inequalities in access, we will take targeted action to bring in new providers in two main circumstances:

- first, where new services are needed to respond to growing population, particularly where existing practices are unlikely to be able to absorb this growing demand;
- second, in those specific localities where there are comparatively low numbers of GPs and primary care staff per head of population, where CQC inspections have indicated poor quality of existing services and where patients have limited choice (i.e. significant numbers of closed lists).

90. Wherever we are considering bringing in new provision in this way, we will also work with existing providers to help identify how they can better meet demand or improve quality, for instance through introducing new service models.

91. We will ensure new providers are introduced through open and transparent procurement processes designed to identify the providers that will offer the highest quality services within the standard price for GP services. In the past, contracts for APMS have tended to be for about five years, but we intend to introduce longer-term contracts, where possible, for new providers in the interests of long-term continuity of care and value for money.

(7) Developing infrastructure

Our ambitions cannot be realised without the right people and the right tools. We will work with national and local partners to develop the general practice workforce.

92. We face four key challenges in relation to workforce:

i. we need to help address the short-term pressures that many general practices are facing in recruiting and retaining GPs and practice nurses;

ii. there is a pressing need to improve recruitment to some elements of the community health workforce, particularly district nursing;

iii. we need to address long-standing inequalities in numbers of GPs and practice nurses per head of population

iv. we have heard consistent calls for developing a fresh approach to how we plan and train the future community workforce to support more proactive, coordinated and accessible care.

93. These are system-wide training challenges that will rely particularly on the leadership of *Local Education and Training Boards* and *Health Education England* (HEE) to address.

94. We are working with HEE and other partners including the national professional bodies to determine how we can best support these workforce improvements. Our current focus is on working with CCGs to ensure that HEE and *Local Education and Training Boards* have a sufficiently clear view of future service plans to be able to translate these into longer-term plans for growing the primary care workforce. We will publish a toolkit in spring 2014 to support CCGs and area teams in working with LETBs to translate plans into workforce strategies.

"NHS England and CCGs have to work together to decide to plan premises based on future requirements in terms of size of population and how services are to be commissioned"

response to engagement

95. Whilst others have the leading role in supporting training, recruitment, retention and return to practice, we will prepare a detailed plan by summer of 2014 that describes our own specific role including:

- improving the recruitment of GPs and practice nurses in communities where this has been challenging;
- promoting safe, effective and proportionate routes for GPs wishing to return to practice;
- supporting the retention of the existing GP workforce;
- supporting the development of community, district and practice nurses through our *Community Nursing Strategy Programme*;
- encouraging more effective use of skill mix in general practice and encouraging practices to make the best use of community assets; and
- supporting practices to be good employers

We will promote improvements in primary care premises.

96. We want to ensure that patients receive care in safe, accessible and suitable premises that offer value for money for the taxpayer. Investment in primary care estate has lagged behind investment in secondary care capital expenditure. As a consequence general practice is often still working from inadequate buildings which offer limited facilities and a poor environment for patients and staff. Under-developed premises have inhibited development of primary medical care and its integration with other community providers. Much of the primary care estate is out of date, under developed and no longer provides an appropriate environment for modern clinical care.

97. We have heard consistent messages about the importance of developing new approaches to primary care estates, both to enable a greater range of services to be provided in community settings and to support members of multidisciplinary teams (who may be drawn from different provider organisations) to work alongside each other more closely.

98. In order to release resources to allow additional revenue funding for premises, the two most critical factors will be our ability to support more efficient and effective use of existing community assets and the ability of CCGs to release revenue funding from other sources to support the move towards wider primary care.

99. In order to support new solutions we will:

- work with CCGs, *Health and Wellbeing Boards* and other local partners to ensure that joint strategic plans for developing primary care and wider community-based services identify where premises developments are needed to support these strategic plans and how the capital and revenue consequences of these premises developments is going to be met;
- work with CCGs to support them and providers in making more rational use of existing community-based estates, working with LIFT companies, *Community Health Partnerships*, local authorities and NHS Property Services;

- support practices in working at greater scale (through federations or networks) to facilitate a more effective and cost-efficient use of estates;
- publish a new framework to underpin decisions on general practice premises reimbursement, ensuring more effective prioritisation of any new revenue funding and better alignment with local CCG strategies for out of hospital care;
- work with the Government to review the current system of general practice premises reimbursement to identify opportunities for improving value for money and promoting more innovative use of estates;
- work with the *Care Quality Commission* to help ensure that there is a consistent approach in its inspection criteria and our criteria for general practice premises.

We will sustain improvements in the use of information systems to improve patient care.

100. We are working with the *Health and Social Care Information Centre* to ensure that we continue to develop high-quality information systems in general practice and that we make more effective and consistent use of systems that allow information to be shared between health and care providers to improve quality of care for patients. Shared and summary care records are being developed to support the sharing of information between different health care providers. The 'NHS number' is key to the sharing of information between healthcare providers and NHS England is working to ensure it is consistently used across primary care healthcare providers.

101. We have already taken steps to ensure more consistent information sharing between providers through changes to the GP contract that will improve patient safety, support more joined-up care, and make NHS services more efficient. Under these new arrangements, all practices will:

- use the NHS number in all clinical correspondence
- upload information onto the Summary Care Record each working day to support the sharing of up-to-date information between different healthcare providers
- transfer records electronically when patients change their general practice.

102. The new framework for providing GP clinical IT systems (the *General Practice Systems of Choice* replacement framework) will be designed to enable general practice in this country to extend its world-leading position in the use of electronic systems. It will also be designed to allow increasingly rich online services for patients, helping patients to become more closely involved in their own care and in shared decision-making with GPs.

103. We have delegated responsibility for local operational management of general practice IT services to CCGs. This enables local clinical leaders to play a stronger role in developing patient online services and in improving information-sharing with other providers to support joined-up care.

104. In the summer of 2014 we will publish a revised operating model called "*Securing Excellence in General Practice Information Technology*" which will:

- provide a strategic direction for the development of general practice IT systems
- set technology standards
- introduce, over a two-year period, a more equitable distribution of investment between CCGs to support more consistently high quality of IT services
- give CCGs freedom to innovate to support service redesign
- simplify processes for allocating resources and providing assurance about how they are spent.

Next steps

105. We have set out here:

- The drivers that mean general practice will need to change and develop; and the particular factors that pertain now to the way in which that will happen
- Our five ambitions for improvement, which will help to secure high quality care for all, now and for future generations
- Our proposed work programme at a national level to put in place some of the important enablers for local leadership to take forward their ambitions for local communities.

106. Our area teams are already working with CCGs to reflect the direction of travel set out here in local strategies for primary care services, as described in our NHS planning guidance for 2014/15, *Everyone Counts.*

107. But we know there is more work to do to build the national foundations for sustainable primary care, delivered at scale. We want to continue our discussions with key stakeholders on our emerging views. This period of engagement will run from March to June 2014. We intend to publish the resulting strategic framework for commissioning primary care in the autumn of 2014, covering not just general practice but wider primary care services including dental services, community pharmacy and eye health services.

108. General practice, at its best, has been described as the jewel in the crown. But without change, and without support, it will not be fit for purpose or sustainable for the next decade. And there is much to do now to tackle current unwarranted variation. We welcome further thoughts on how we can work with you to create a consistently high quality, effective and sustainable service for the future.

Timeline

FURTHER STAKEHOLDER ENGAGEMENT

Date	Action
April 2014	Introduce new GP contract arrangements, including new enhanced service to provide proactive, tailored care for patients with the most complex needs
April 2014	Begin to roll out the *Prime Minister's Challenge Fund* pilots for improving access to general practice
April 2014	Commission general practice development programme to support the Prime Minister's Challenge Fund
April 2014	Commence collaborative work with CQC, NICE and other stakeholders to improve range of metrics for quality and outcomes in general practice and wider primary care
May 2014	Publish practical toolkit (with *Health Education England*) to support CCGs and area teams in working with *Local Education and Training Boards* to translate five-year strategic visions into workforce development plans
June 2014	Publish framework, supported by practical guidance and resources, on joint commissioning, CCG investment in primary care services, flexibilities for area teams/CCGs to design local alternatives to national contract arrangements, and other innovative forms of contracting
June 2014	Area teams deliver 5-year strategic plans for primary care
June 2014	Publish GP IT strategy
July 2014	Publish guidance on practice mergers and new market entry
July 2014	Publish policy on responding to concerns highlighted by CQC assessments
July 2014	Review outcomes of 'calls to action' for dental services, community pharmacy and eye health
September 2014	Publish strategic framework for commissioning primary care services
October 2014	Publish potential models for wider primary care at scale
October 2014	Implement new arrangements to extend patient choice
December 2014	Implement Friends and Family Test for general practice
April 2015	Implement arrangements for patients to have on-line access to records
April 2015	Freeing up time in general practice study - identifying how we can go further in freeing up clinical time to provide more proactive, person-centred care and improve access

APPENDIX A

WIDER PRIMARY CARE DELIVERED AT SCALE

There a number of elements which providers include as they create wider primary care at scale. The choice of specific solutions will depend on the needs of local people, the features of existing primary care services and other aspects of the local health and care system. We expect the process of designing the future primary care system to be a collaboration involving local people, commissioners and providers.

Listed here are some of the approaches practices may consider. They are not mutually exclusive. Many are already being employed or considered by providers and commissioners in England.

Improved access and resilience

- **Extended hours.** A group of local practices establish a rota system for providing consultations outside of current opening hours. This makes it easier for working people to see a GP, and for acutely unwell patients to receive a general practice consultation rather than attend A&E. While the patients may not see their own GP, they will benefit from consulting an expert generalist who has access to their full record and who is able to arrange ongoing investigations and care.
- **Responsive urgent care.** A group of local practices operate a rota for providing immediate appointments for acutely unwell patients. Patients from all of the participating practices are able to access the appointments. A broader skill-mix may be deployed, including creating a minor illness service for rapid access to appropriate advice and treatment.
- **In-house staff bank / emergency cover.** A group of local practices pool their resources to provide emergency relief for one another in the event of staff sickness. This may involve clerical staff working in another practice for a short period, or patients from one practice being able to access appointments with clinicians at another. Cover can often be arranged at very short notice, and patients are able to access help without needing to attend A&E if their own clinician is unwell.
- **Business economies of scale.** A group of practices collaborate in the procurement of services and supplies, and delivery of back office functions. This may include clinical administration, business planning, HR, finance, information and legal services. In addition to the financial benefit, there will often be more direct benefits for patients resulting from greater inter-practice communication and collaboration, and the establishment of common procedures, including a greater standardisation of certain care processes.

Integrated care

- **Care coordinators.** One or more specialist care coordinators work across a group of local practices to support patients with multiple complex health and social care needs. The coordinators act as a resource for patients, carers and staff; support patients and carers to make choices about their care; and coordinate the contributions to patient care made by the inputs from different agencies.
- **Multi-professional integrated community team.** Local practices collaborate with community nursing, social care, voluntary/ charitable providers and other local partners to create a common system of coordinated health and social care, based on shared working practices and shared records.
- **Community hospital / virtual ward / intermediate care.** Local practices are able to provide rapid access to intensive out-of-hospital nursing care and therapy services, provided in the patient's own home, care home or another neighbourhood facility. Practices may use a rota system to ensure round-the-clock medical cover, supported by video technology.

New services in the community

- **Advanced skills.** GPs who have developed more specialist skills provide advanced diagnosis and treatment without patients needing to attend hospital. The 'specialist GP' has access to the patient's' records, thus improving safety, reducing delays and providing more seamless care.
- **Community diagnostic services.** Local practices collaborate to arrange diagnostic services in the community, reducing travelling for patients and speeding access to results. These may include blood tests, adult and children's phlebotomy, ultrasound and, skin biopsy. and INR testing.
- **Enhanced access to care professionals and therapists.** Mental health, occupational therapy, community nursing or social care staff are directly attached to practices, enabling patients to receive a wider range of services as an integral part of the services at their local surgery or health centre.
- **Access to specialist advice.** Practices are able to obtain rapid remote advice or on-site consultation from medical specialists without the patient needing to travel to hospital or have their care handed over.
- **Patient (and family) support and education.** Local practices collaborate with community health services, social care and voluntary and community services to provide group support and education sessions for patients and families. This may include visits to school and community groups, as well as targeted group consultations for people living with long term conditions.

Community development

- Local practices, pharmacies, community health services, voluntary agencies and the local authority work as a group to engage with their community, collaborating with them in asset-based approaches to improving health and wellbeing.

Quality improvement

- **Peer-to-peer challenge and learning.** A group of practices establishes a learning network to share and test ideas and compare performance. This facilitates the development of new ways of working and, the spread of successful innovation. With a continual focus on improvement it provides practices with a supportive professional framework in which to test and promote new ideas and a continual focus on improvement.
- **Service improvement capacity.** A group of practices, not necessarily in a single geographical area, share a common pool of expertise in service redesign and improvement. This may include the use of common processes and protocols, supported by in-house experts in improvement science and change management. Economies of scale also make it easier to invest in information and analysis infrastructure for strategic planning and continuous quality improvement.
- **Continual professional development.** A group of practices pool their resources to plan and deliver relevant professional development for their staff. This can easily be aligned with existing priorities for service improvement, and integrated into wider moves to establish a culture of continual learning and improvement. It is easier to ensure it is relevant to the needs of primary care and may be cheaper and more convenient than external CPD opportunities.

These options represent a range of potentially radical changes to how general practices collaborate with each other and with other health and social care providers, helping general practice to fulfil more of its potential as part of more integrated systems of care outside hospital.

We will promote these innovations and help spread examples of best practice in improving care for patients and local communities.

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