a co-operative council

Telford & Wrekin COUNCIL

**Addenbrooke House Ironmasters Way Telford TF3 4NT**

# HEALTH AND WELLBEING BOARD

| | | | |
|---|---|---|---|
| Date | **Wednesday, 7 December 2016** | Time | **2.00pm** |
| Venue | **Room G3/G4, Ground Floor, Addenbrooke House, Telford TF3 4NT** | | |

**Enquiries Regarding this Agenda**:

| | | |
|---|---|---|
| Democratic Services | Jessica Tangye | 01952 382061 |
| Media Enquiries | Corporate Communications | 01952 382403 |
| Lead Officer | Jon Power | 01952 380141 |

**Committee Membership**:

| | |
|---|---|
| Cllr R A Overton **(Chairman)** | Cabinet Member – Housing, Public Health & Protection, TWC |
| Dr J Leahy **(Vice-Chairman)** | Chair, Telford & Wrekin CCG |
| Cllr K Tomlinson | Lib Dem / Independent Group |
| Cllr E A Clare | Cabinet Member – Leisure Services & Culture, TWC |
| J Chaplin | Healthwatch |
| Cllr A R H England | Cabinet Member – Adult Social Care, TWC |
| D Evans | Chief Operating Officer, Telford & Wrekin CCG |
| C Jones | Director: Children's & Adult Services, TWC |
| L Noakes | Director of Public Health, TWC |
| Cllr J M Seymour | Conservative Group, TWC |
| T Harding | Community Safety Partnership |
| Cllr P R Watling | Cabinet Member – Children, Young People & Families |
| R Woods | NHS England (North Midlands – Shropshire & Staffordshire) |

# AGENDA

Page

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes** Appendix **A**
   To confirm the minutes of the meeting of the Health and Wellbeing Board held on 7 September 2016.

4. **Public Speaking**

   **Strategic**

Continued ...

... Continued

5. **Sustainability and Transformation Plan (STP)** Appendix **B**
To receive the report from Dave Evans

6. **Dementia Strategy For Telford & Wrekin** Appendix **C**
To receive the report from Laura Thorogood and Frances Sutherland

7. **Health and Wellbeing Board Proposed Priority Work Streams** Appendix **D**
To receive the report from Liz Noakes

**Performance**

8. **Priority Update: Encouraging Healthy Lifestyles**
To receive the verbal report from Louise Mills

9. **Early Help Update Report** Appendix **E**
To receive the report from Louise Mills

**For Information**

**None**

**Future Meeting Dates:**
Wednesday, 8 March 2017

**A**

# HEALTH AND WELLBEING BOARD

## Minutes of a meeting of the Health and Wellbeing Board held on Wednesday 7 September 2016, at 2pm in the Meeting room G3-G4, Addenbrooke House, Ironmasters Way, Telford, TF3 4NT

**Present:**

Cllr R A Overton - Cabinet Member for Housing, Leisure & Health TWC **(Chairman),** Cllr E A Clare - Cabinet Member for Culture, Sports, Parks & Green Spaces TWC, J Chaplin - Healthwatch, D Evans - Chief Operating Officer: Telford & Wrekin CCG, Cllr J M Seymour Conservative Group TWC, C Jones - Director: Children's & Adult Services and Statutory Director of Children's Services TWC, L Noakes - Assistant Director: Health & Wellbeing and Statutory Director of Public Health TWC,

**Officers:**

### HWB-14 Apologies for Absence

Councillors A R H England - Cabinet Member for Adult Social Care & Older People TWC, K L Tomlinson, P R Watling – Cabinet Member for Children, Young People and Communities, and Dr Jo Leahy.

### HWB-15 Declarations of Interest

None declared

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### HWB-16 Minutes

**Resolved – that the minutes of the meeting of the Health and Wellbeing Board held on 15 June 2016 be confirmed and signed by the Chairman.**

### HWB-17 Public Speaking

No members of the public had registered to speak.

### HWB- 18 Sustainability and Transformation Plan Progress Update

The Board received the report from Dave Evans, which outlined the aim of the STP to develop a transformed system of care that would be high quality, financially sustainable, and efficient and delivered on national standards. Building resilience and social capital was central to this to ensure people have the knowledge and skills to help themselves to live healthier and happier lives.

NHS England had reviewed the STP submission on 30th June 2016, together with the Local Digital Roadmap. The Roadmap described how information technology would be used to support STP, to enhance patient care, such as through

telemedicine, remote monitoring and virtual consultations. Feedback on the STP was noted; in particular

- the need to include greater reference to mental health services;
- both local authorities needed to understand the interaction between their financial positions and the STP; and
- more detailed workforce plans were needed to clarify how the workforce gaps would be filled.

The Board noted that final submission of the STP and the Roadmap was 21st October, and that a revised financial template (and possibly an interim STP) would be required by 16th September. The STPs were not going to be publicly available until ratification by the NHS in October.

The local governance arrangements had been updated as appended to the report and it was noted that 500k would be made available to support the STP programme, although the precise use of this funding had yet to be determined.

The four priorities for the STP were outlined with regard to Neighbourhood working, reconfiguration of the hospital services, financial sustainability and reducing duplication; and maintaining standards of existing services.

The Board noted that good progress had been made in developing the Neighbourhood models of care for Telford and Wrekin and for Shropshire; best practice was beginning to emerge. The Neighbourhood workstreams would be assuming responsibility for work previously undertaken by the Community Fit and Rural Urgent Care groups. It was suggested that a presentation on the work of the Neighbourhood team would be valuable for the Committee to hear. The work of the neighbourhood workstream would be routinely reported to the HWB as part of the Health and Wellbeing strategic priority of developing community resilience and community based support.

The Board noted the priorities for the next month and that an early draft of the STP would be circulated to Board members.

**RESOLVED – that the progress to date on developing the Sustainability and Transformation Plan (STP) be noted.**

## HWB- 19 Mental Health Strategy and Improving Mental Wellbeing Priority

The Board received the report from Steph Wain and Francis Sutherland that provided an update on the work being undertaken across Telford and Wrekin to improve and support the mental health of local residents; including the Mental Health Strategy 2016-2019 and annual action plan of activity, appended to the report; and "Improving mental wellbeing" priority.

The report outlined the key pieces of work being undertaken in line with the five work streams developed to ensure the vision of the Mental Health Strategy was delivered.

It was reported that a new service for emotional health and wellbeing to include Child and Adolescent Mental Health Services (CAMHS), Learning Disability, eating

disorders and neuro-developmental conditions was to be in place in May 2017; this was open for tender.

Good progress was being made in the third year of the Drug and Alcohol Strategy. The newly commissioned substance misuse treatment services were now a year into delivery; key highlights of the service improvements were outlined. It was noted that the transformation of the substance misuse treatment services continued alongside the on-going expansion of prevention work.

As a key part of the implementation of the mental health strategy, a suicide prevention strategy and action plan was also being developed. The aim was to champion good practice in Telford and Wrekin and identify/ address any gaps in services. The Suicide Prevention Strategy for England 2012 had informed the initial development of the local plan and a multi-agency suicide network had been established for Telford & Wrekin, which included key stakeholders. Insights gained from the network, together with national level data and intelligence provided by the Coroner and partners from the emergency services, would be used to inform the key local priorities for the plan. There was agreement to share relevant data by the Coroner, West Mercia Police, Shropshire Fire and Rescue and British Transport Police. There would be quarterly meetings of a core group of the network to coordinate the work.

It was noted that Telford and Wrekin had done well to engage with the number of people making use of support services that it had done. The Board commended the work on the Suicide prevention strategy.

**RESOLVED – that the updates on the Mental Health Strategy and Improving Mental Wellbeing priority be noted.**

## HWB- 20 NHS Telford and Wrekin primary care strategic plans

The Board received the report on the Primary Care delegated commissioning strategic priorities for NHS Telford and Wrekin for 2016 – 2020. The priorities had been informed by

- a local Primary Care Needs Assessment (PCNA) which was undertaken during February and March 2016
- General Practice Forward View (Department of Health April 2016)
- NHS England Sustainability and Transformation plans
- Primary Care Estates plan

The aim of the priorities was to ensure the sustainability of excellence in the delivery of Primary Care responsibilities whilst meeting stakeholder expectations. It was noted that the vision for the primary care service was a GP led service, sufficiently resourced to provide appropriate and prompt access to excellent quality planned and urgent care. This would include:

- innovatively staffed multi-disciplinary teams across health and social care as well as Primary Care staff in community nursing teams.

- services designed around the needs of the population as mandated by patient groups
- maintaining the excellent reputation of Primary Care regionally and nationally to ensure Telford and Wrekin continued to attract Primary Care Clinicians.

The Board noted the report and agreed that it shed light on the current position; the Estates plan provided a good insight into this high priority area. It was noted that the Primary Care Needs Assessment appended to the report indicated that there was a "a longstanding aspiration for the NHS to focus as much on promoting wellness as managing poor health, and the NHS has a contribution to make to the prevention of disease and the promotion of health across populations, working in partnership with local public health services through Health and Wellbeing Boards". There was a question as to the scope of such proposed partnership working and how the Health and Wellbeing Board would gain access to information on the quality of provision of Primary Care.

Concerns were raised about how a 24/7 service 7-days a weeks could be implemented. Proposed models included clusters of practices working together on a rota system and digital/ telephone assessment and diagnosis services. It was also noted that mental health support was a crucial element of services going forwards, which had been identified by a survey to understand needs. The Board highlighted the importance of getting the neighbourhood model right as it was where most people would access services and it was essential to ensure the right community support was established to supplement services. Furthermore, engagement with the local communities would be vital and it was noted that there would be a communications plan.

**Resolved – that:**

a) **the Primary Care Strategic Priorities for 2016 – 2020 be noted; and that**

b) **these priorities are consistent with the wider Health and Wellbeing priorities.**

**HWB-21 Pharmaceutical Needs Assessment 2015/16- 2017/18 – Supplementary Statement 2016**

The Board received the report by Helen Onions which summarised the background to the PNA process, which had been used by the HWB, NHS England, the CCG and local contractors to determine that expanded dispensing provision was needed in South Telford. Agreement of the PNA Supplementary Statement would publically detail the expanded provision in the PNA. The Board noted the supplementary statement appended to the report that included the expanded provision in Madeley in South Telford and also covered the opening hours of the new pharmacy which opened in Lightmoor in July 2016. The Board reinforced concerns about the problems faced by residents in rural areas. It had been acknowledged that residents in some rural areas of the borough had equal or longer distances to travel to their nearest pharmacy, however, the Board had considered that limited transport facilities and low car ownership in South Telford placed residents at a disadvantage. It was

also noted that community pharmacy potentially faced some budget reductions but this had not been clarified by central government to date.

**RESOLVED – that**

a) **the extended evening and weekend dispensing provision in Madeley, which meets the need identified in the South Telford PNA review be noted.**

b) **the PNA Supplementary Statement for publication be approved.**

## HWB-22 Child and Adolescent Mental Health Services (CAMHS) Survey Update

The Board received the report from Kate Ballinger which provided an insight into the understanding and use of mental health services by young people in the borough. It also provided information about the types of matters that young people often found stressful and where they would look for support in times of crisis. A survey had been undertaken by local secondary schools, the headline results of which were presented to the Board by representatives from participating schools.

Further work had been proposed for 2017 with the Early Help Partnership Board and Healthwatch Telford and Wrekin to build a bank of evidence. The timing of the survey results was important in terms of informing the procurement of services for mental health by Telford and Wrekin Council and it was reinforced that input into the design of the service would continue to be sought from children and young people. It was clear that a range of services and professional programmes of support would be developed to address the range of needs. It was also noted that the survey and following work could assist West Mercia Police Force by providing insights into how to deal with young people in crises.

**Resolved that the report be noted.**

## HWB- 23 Health and Wellbeing Board Strategic Priorities: Performance Framework

The Board received the report from Helen Potter on the proposed performance framework to monitor progress against the Health and Wellbeing Strategy following approval of the delivery model in June 2016. The proposed performance framework appended to the report aimed to monitor progress against key deliverables highlighted within the strategy. It also provided a mechanism that would enable HWB to identify any risks/issues in a timely way in order to address any barriers to achieving the key outcomes identified within the strategy.

The proposed performance framework would be reported to HWB on an annual basis together with the more qualitative progress updates provided by CATPS. It was agreed that this would provide an additional layer of quantitative information for consideration by the Board in making proposals or challenging CATPs on progress. It was agreed that some areas needed to be expanded in the performance framework and any additional performance indicators identified by the Board could be included where necessary. It would be re-circulated following the meeting.

It was also noted that a Neighbourhoods Working Group had been established and would contribute to the priority of 'strengthen our communities and community based support'. The aim of the Group was to develop sustainable networks of informal care and support by developing people, community based projects, groups and organisations to improve outcomes for residents.

It was reported that a strategy delivery group consisting of the CATP leads would meet regularly to ensure links with other Boards and groups locally to ensure a wide range of organisations were involved in contributing to the delivery of the strategy. Progress in respect of new initiatives or areas of work being undertaken by partners/stakeholders would be reported via CATP update reports. The strategy delivery programmes would continue to be developed to take account of progress and new areas of work highlighted by the Board.

**Resolved – that**

a) **the proposed Health and Wellbeing Strategy performance framework be approved**

b) **current performance in relation to the proposed framework be noted.**

**HWB-24 Carers Health and Well Being Report**

The Board received the report from the Carers Commissioning Officer, Jill Tiernan, which provided an update on the progress being made on the HWB commitment to improving the lives of all age carers relating to health and wellbeing. Appended to the report was the Carer Outcome Pyramid; the Telford & Wrekin offer, and the Carer Narratives.

The Board acknowledged the principles outlined in the report that were described as critical to the successful delivery of eight key outcomes in the Carers Strategy, that the Carers Partnership Board had deemed relevant to the wellbeing and prevention agenda.

It was reported that the shared strategic ambitions for carers of all ages continued to be delivered through a pooled budget arrangement. From October 2015 the combining of young carer and adult commissioning responsibility allowed the transformation of all-age carer services across the borough to create a local offer.

The Board noted that this would provide a seamless pathway for carers of all ages and efficiency of resources whilst promoting a whole family approach. The Board noted the progress of work to improve adult and children's carers health, wellbeing and development of resilience, against eight outcomes in the strategy:

- Information Advice and Support
- Planning for the Future
- Promoting well being
- Time for yourself
- Meeting diverse needs
- A life outside caring
- Feeling financially safe and secure
- Having your say

The Board commended the 'all-age' approach to the carers service and the reshaping of the Carers Partnership Board to ensure better representation of a larger percentage of carers. Members acknowledged that it was important to continue to raise the profile, particularly to hard-to-reach groups.

The Board noted the activity and outcomes across the local offer and noted that there was a reduction in the numbers of people requesting support since 2015 which could be attributed to the work done to target the right people, to ensure that assessments were more effective and the support for people in their caring role was improved. The Board noted the areas for development that had been proposed for the forthcoming year, which included:

- expanding the community carer offer
- securing a permanent third Admiral Nurse (Dementia) support for family carers
- additional hours to enable the Moving and Handling Family Carer Adviser to address the increase in referral rates.
- Carers Indicative payments allocation
- broadening the range of respite/community opportunities for family carers.
- revision of an all age Carers Strategy and associated plans by the end of 2016
- continued co-production with carers to identify employment opportunities
- engagement with local people and communities to energise and enable communities to have greater resilience and self-efficiency.

**<u>Resolved</u> – that**

a) the developments and achievements since the last Board Report in September 2015 be noted

b) the strategic priorities and associated action plans considering the changing landscape (economic and commissioning) facing health and social care be supported

c) the significant and financial contribution family carers bring to the social and health local economy be supported

d) continued progress of the authorities in working towards raising carer awareness across the borough and local communities be noted.

**HWB- 25 Living Well Update**

The Board received the report from Louise Mills, Helen Onions, Stacey Norwood and Clare Harland which provided an update on the activity of the Living Well programme. The Living Well partners had continued to work collaboratively to deliver activity against the five work programme areas that were agreed as priorities and endorsed by the Health and Wellbeing Board. The priorities had been recognised by partners as areas that would benefit from greater collaboration and would contribute overall to improving population outcomes to reduce excess weight, increase physical activity levels and reduce smoking prevalence.

The key headlines for Telford & Wrekin from the most recent Public Health Outcomes Framework (PHOF) were detailed in the report and the programmes of work, highlighting all local activity, provided the Board with a comprehensive update.

The Board was assured that there were links between the work of a Living Well Network, plans for which were in place, and the Neighbourhoods workstream, evolving through the Sustainability and Transformation Plan. Work was ongoing with health partners to ensure health and care services were being built around needs of the local population.

The Smoke-Free update was noted by the Board which included detail about the network within Telford & Wrekin that had been working on the priorities set out in the smoke free plan. Key recent achievements and priorities for the remainder of the year were noted. The update provided recently released figures on smoking prevalence in adults and children, which followed the decline seen nationally and locally year-on-year since 2011/12. It was reported that analyses would be undertaken on the socio-economic background of local smokers in order to inform service developments and targeting in future, with a view to reducing health inequalities.

**Resolved – that**

**a) the progress for the five work programme priorities be endorsed**

**b) the key collective action being taken to reduce smoking across the Borough with partners be noted.**

**HWB-26 Healthwatch Annual Report**

The Board received the annual report 2015-16 from Healthwatch Telford and Wrekin from the Chief Officer, Kate Ballinger. The report provided the Board with an overview of the work undertaken by Healthwatch Telford and Wrekin in its third year of operation. It was noted that there had been significant changes during the 3 years including its establishment as a Not for Profit organisation and the removal of Parkwood Healthcare as host organisation, and a substantial reduction in budget.

Work by Healthwatch highlighted in the report included representation at the Future Fit Programme Board and the launch of a new Council funded feedback centre to encourage more effective engagement and to reach the people that needed the service. The Board noted that regular reports would be available and the priorities for future work were outlined, in particular, continued engagement with the public, raising awareness and recruitment of a new Engagement Officer.

**Resolved – that the report be noted.**

The meeting ended at 3.54pm

**Chairman:** .....

**Date:** .....

**B**

**TELFORD & WREKIN COUNCIL HEALTH AND WELLBEING BOARD**

**7th DECEMBER 2016**

**SUSTAINABILITY AND TRANSFORMATION PLAN (STP)**

**DAVID EVANS: CHIEF OFFICER, TELFORD AND WREKIN CCG**

## PART A) – SUMMARY REPORT

### 1. SUMMARY OF MAIN PROPOSALS

This report summarises the content of the Sustainability and Transformation Plan (STP) and explains the process for it to become public. It also contains an update on the Future Fit programme. Finally, it introduces the STP Compact – a cross-organisational commitment to joint working and seeks the Health and Wellbeing Board's endorsement for its way of working.

### 2. RECOMMENDATIONS

The Health and Wellbeing is requested to:

- Note the current position with respect to the STP and Future Fit programmes
- Endorse the STP Compact

### 3. IMPACT OF ACTION

The proposals in the STP are intended to help improve the health of the people of Telford and Wrekin and ensure local healthcare services become clinically and financially sustainable over the next 5 years

## 4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="5">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>➢ Strengthen our communities and community based support Priority</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>• improve the health and wellbeing of our communities and address health inequalities</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td></td><td>Yes</td><td>All members of the public, as potential patients, will be affected by the proposals for changes to health services that are set out in this Plan</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">The Plan sets out proposals for the development of health services up to 2020/21. Detailed implementation plans are still to be developed. The key milestones for Future Fit are set out in the main report</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>No</td><td></td></tr>
<tr><td>LEGAL ISSUES</td><td>No</td><td></td></tr>
<tr><td>EQUALITY & DIVERSITY</td><td>No</td><td></td></tr>
<tr><td>IMPACT ON SPECIFIC WARDS</td><td>Yes</td><td>The main focus of the STP is to enable people to become less dependent on healthcare that is delivered through hospitals. This will be achieved with the development of more resilient communities; the prevention of ill health and, wherever possible, the management and treatment of illness in local settings rather than the need to attend hospital.</td></tr>
<tr><td>PATIENTS & PUBLIC ENGAGEMENT</td><td>Yes</td><td>There has already been significant public engagement in the Future Fit programme and a formal consultation on hospital reconfiguration is planned to start shortly. A communications and engagement strategy will accompany the STP when it becomes a public document.</td></tr>
<tr><td>OTHER IMPACTS, RISKS & OPPORTUNITIES</td><td>No</td><td></td></tr>
</table>

## PART B) – ADDITIONAL INFORMATION

## 1. INFORMATION

### *1. Introduction*

Shropshire, Telford and Wrekin is one of 44 national 'footprints' that have been requested by NHS England to draw up 5 year plans to transform local health and care systems to create services that are professionally and financially sustainable. The local STP was submitted on 21st October but is not (as of the date of writing) in the public domain until authorised by NHS England. Proposals for the reconfiguration of hospital services (Future Fit) form one part of the STP.

### *2. Overview*

There is widespread consensus that our health and social care services need to change if they are to be sustainable in future. Demand continues to grow and funding is not keeping pace, placing increasing pressure on all services – particularly hospitals, general practice and social care. Some of the ways in which patients are cared for needs to change to reflect changes in technology, changes in practice, and changes in the financial situation. All organisations need to ensure their services are delivered as jointly and efficiently as possible. The STP sets out how we aim to achieve this in Shropshire, Telford and Wrekin over the next five years.

The causes of poor health are rooted in our communities and as such the solutions need to be community based. Making the most of the skills and assets of local people and organisations *(community resilience)*; supporting people to lead healthier lives *(prevention)*; and promoting self-care are beneficial in their own right as well as relieving pressure on the NHS and social care. The starting point for our Plan, therefore, is to focus on fifteen *neighbourhoods* and provide a consistent approach to preventing ill health, as well as promoting the support that these local communities already offer to individuals.

The same neighbourhood structure will be used as a basis for providing health and care services for people who need professional help but for whom hospital is not necessary. GPs, social care, community nurses and therapists, community mental health workers and learning disability practitioners will increasingly work together as a single team to provide a consistent range of services at a local level. These *Neighbourhood Teams* will be the first port of call for people with diabetes and other chronic conditions; for people who might otherwise have to go to hospital but who do not need emergency services; and for people who have recently been discharged from hospital.
For patients who do need hospital care, either because it is an emergency or because they need planned surgery or other treatment, the Plan creates two centres of expertise, one specialising in *emergency care* and the other in routine surgery or *planned care*. This aims to give better clinical outcomes by making best use of relatively scarce consultant time, as well as making financial sense. Specialist mental health and orthopaedic services will also be available locally.

Explaining all these changes to local people and involving them in the design of the new services will be crucial to their success. The focus of other work - on the use of technology;

the development of the workforce; and the use of the estate - must support the development of neighbourhoods and changes to hospital care.

All organisations have agreed to work together to implement the Plan in acknowledgement that it is in the best interests of local people. However, the financial position is sufficiently serious that these changes to services will not, on their own, solve the problem and so the Plan also has a range of other actions that will need to be taken.

## *3. Neighbourhood working in Telford and Wrekin*

A key focus in the latest iteration of the STP is the development of Neighbourhood working. In Telford and Wrekin, this has been led by Telford and Wrekin Council, working closely with Telford and Wrekin CCG and providers. An outline of the components of the local Neighbourhood work is attached as Appendix 1.

Neighbourhoods are based around General Practices and bring together health and care services, and physical and mental health. Three Neighbourhoods covering Telford have now been identified, with a number of practices still to be formally linked together. To ensure the system will work effectively, pilot sites are being established in the South Telford and Newport Neighbourhoods.

## *4. Future Fit*

4.1 Revised Decision Making Timeline Following the Options Appraisal September 2016.

The report summarising the outcome of the financial and non-financial options appraisal in September was submitted to Programme Board on 5th October. However, the decision was taken to postpone decision making on a preferred option by both Programme Board and CCG Boards for a month in order to give the Programme the opportunity to respond to concerns raised by Telford & Wrekin Council about the options appraisal process. Both CCG Boards have agreed to establish a Joint Committee for the purposes of receiving the recommendation from the Programme Board on the outcome of the option appraisal process and to identify a preferred option; terms of reference and membership has now been approved by both CCG Boards.

It is anticipated that both the Future Fit Programme Board and the CCGs Joint Committee will meet during November.

4.2 Pre-consultation Business Case (PCBC).

NHS reconfiguration programmes are subject to assurance and approval by NHS England before entering into a public consultation process. The aims of the PCBC are to make the case for changing acute hospital services in Shropshire and Telford & Wrekin; to describe the future model of care and how it has been developed; to give detail of the pre consultation engagement that has been undertaken with the public, clinicians, staff and other stakeholders in developing the future model of care; and to make the case to commence a formal public consultation process.

The Pre-Consultation Business Case (PCBC) also outlines how the proposals being put forward meet the four mandated Department of Health (DH) tests for service reconfiguration and are affordable in capital and revenue terms. The PCBC will be presented to the CCG Boards over the next month prior to submission to NHSE as part of the Stage 2 assurance process scheduled for December 2016.

The West Midlands Clinical Senate is currently undertaking as part of the NHSE Stage 2 assurance process, an independent clinical review over 3 days during October. This will include a review team visiting both acute sits. NHSE Stage 2 is a formal assurance checkpoint and involves assurance of the proposals against the 4 tests and best practice checks examining all aspects of the plans. These include clinical quality and strategic fit, finance, workforce, activity, programme management, travel impact, resilience, communications and engagement and use of IT. Stage 2 must take place in advance of any wider public involvement, formal consultation process or a decision to proceed with a particular option.

The Programme submitted a comprehensive and detailed set of documentary evidence to the Independent Review Panel in advance of the formal review dates. The Programme expects to receive the final report of the Clinical Senate Review late November. This information will form part of the Pre Consultation Business Case (PCBC) submission to NHSE in November as part of the Stage 2 Assurance Process.

4.3 Communications and Engagement

With an anticipated public consultation start date in December work continues to develop the consultation communications and engagement plan, as well as researching into different options for the consultation document.

## *5. Use of resources*

The health and care community faces very significant financial challenges. The combined health system alone would face a deficit of £131m by 2020/21 if nothing changed. A third of this deficit, however, will be recovered by providers achieving the same annual level of efficiency gains that have been achieved in recent years. Plans to reconfigure current expenditure to enable a financially sustainable position to be reached are still under discussion. Crucially, the aim of the STP focuses on the financial sustainability of the whole health system, not of individual organisations. Local work to review the organisation of back office functions also forms part of these discussions.

The financial challenges facing local authorities are acknowledged although national guidance excludes including them in the financial analysis.

## *6. Governance*

The governance arrangements for the STP programme are set out in Appendix 2.

A compact of Agreement between all the organisations involved has been drawn up by the Partnership Board for consideration by all Boards. This is attached as Appendix 3.

### *7. Next steps*

It is anticipated that NHS England will approve the STP to be made public by the end of November. A communications strategy has been developed to help explain the totality of the STP (and its relationship to Future Fit) to both internal and external audiences and to engage them in discussion about its content. The STP will continue to develop over the forthcoming months.

## 2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

None.

## 3. PREVIOUS MINUTES

9th March 2016 – Health and Wellbeing Board
15th June 2016 – Health and Wellbeing Board

## 4. BACKGROUND PAPERS

**Report prepared by David Evans, Chief Officer, Telford & Wrekin CCG**

# Appendix 1 Neighbourhood working – Telford & Wrekin


**The Telford and Wrekin Model of Care** aims to promote:

- Community resilience
- Teams working around the patient
- Intermediate care

## What is our approach to developing neighbourhoods?

- Building some prototypes around natural neighbourhoods.
- Optimising the total resource in the neighbourhood
- A community centred approach that increases access to community resources to meet health needs and increase social participation
- Supporting the development of strong neighbourhoods that can work collaboratively to take action together on health and the social determinants of health
- Needs to be locally determined and accept there are a variety of drivers for change and starting positions
- Incremental and organic change
- Support people properly to make the change (from front line staff to senior teams)
- Empower a broader spectrum of people to support the transformation, rather than the 'usual suspects'!
- Ensure we are embedding the principle of improved patient experience as one of our improved quality expectations

# Telford and Wrekin - Community Resilience

## Community Resilience

### Vision and aims

Telford will have strong and connected communities. The community will drive the development of local assets and people will :

- Have friends and support networks
- Feel empowered to improve their own and their families health
- Things to do
- A feeling of being safe and belonging to their community
- Confidence to go and help and ask for help
- Centres or 'connecting points' to go to

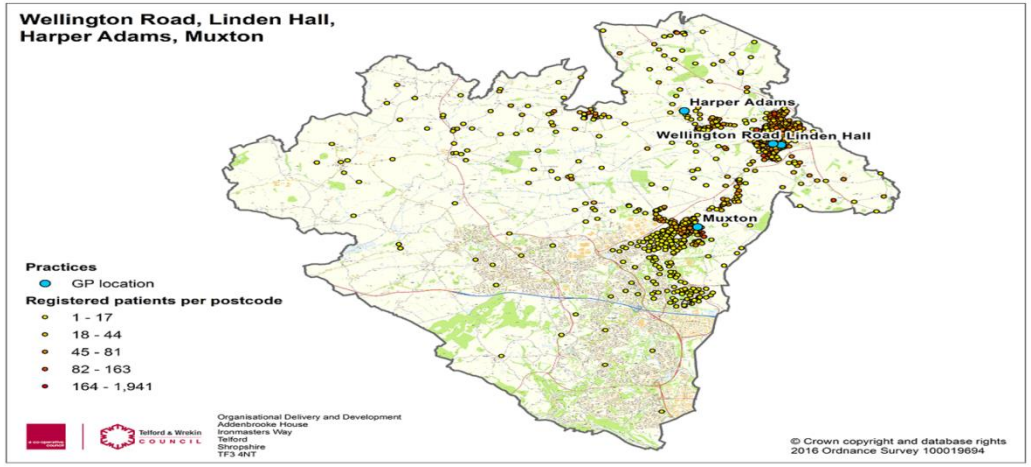
### Why?

- Traditional models of statutory services are no longer fit for purpose: They promote dependence, they are expensive and outcomes could be better
- There is a strong and growing evidence base about the importance of building confident and connected communities in improving outcomes for people
- Individuals benefit from contributing to the wellbeing of others
- Significant proof that poor health can be prevented or delayed
- Needs escalate and peoples health and wellbeing deteriorate because they don't have enough support in the community
- People depend on services because they have very limited alternatives in their own communities

# Telford and Wrekin - Neighbourhood Care Teams

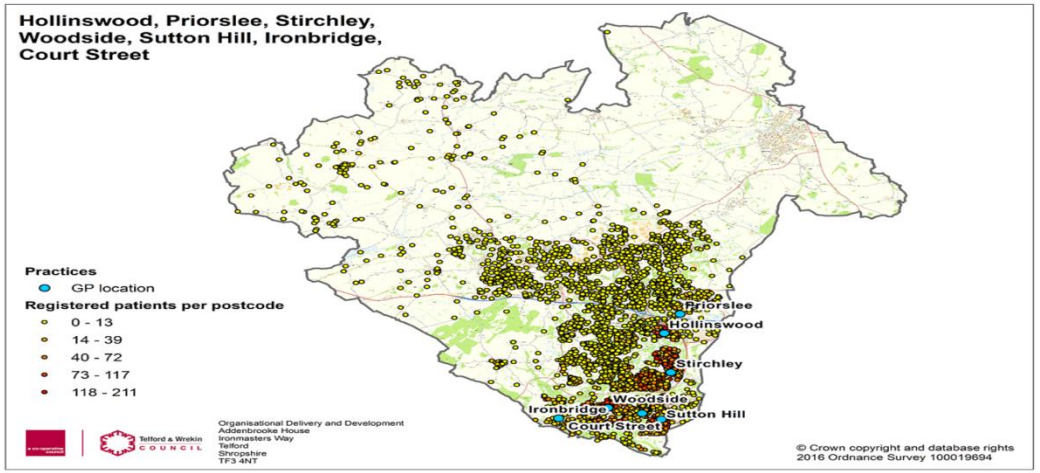
| Telford Neighbourhood Care Teams |
| --- |
| Vision and aims |
| People with an identified long term health condition will be supported to live their life to their full potential<br>• The notion of care 'from cradle to grave' will be reinvigorated<br>• Individual professionals will take responsibility for the delivery of as much care as possible, drawing on specialists where necessary<br>• Professionals will work together to seek out those who would most benefit from an intervention/support<br>• People will share their story once in a way that is right for them<br>• People will understand their condition and how to deal with it and people will self care/self manage where possible<br>• Carers will be supported |
| Why? |
| • We need a much greater focus on prevention<br>• We need to find people earlier in their disease progression so they can manage their condition better, earlier<br>• A greater number of people have become more dependent on statutory services<br>• Current services tend to do things to and for people, rather than promoting self-management<br>• Multiple individuals from different organisations are providing care for any one patient at any one time<br>• The current way of working is not the most effective way of supporting people<br>• We have lost a holistic nature of care by focusing on 'tasks' |

# Telford and Wrekin - Pilot sites




**Newport Neighbourhood (pop. 33,000)**
**Priorities:**

- Integration of nursing, therapy and care workforce and mental health and learning Disability professionals across a single area
- Utilise a different model of care based on Buurtzorg principles
- Align dementia related services with the practice and enhance early diagnosis
- Map and better utilise community assets (including local buildings)
- Develop the local offer within this market town, including range of diagnostics and outpatient clinics
- Better support to residential homes

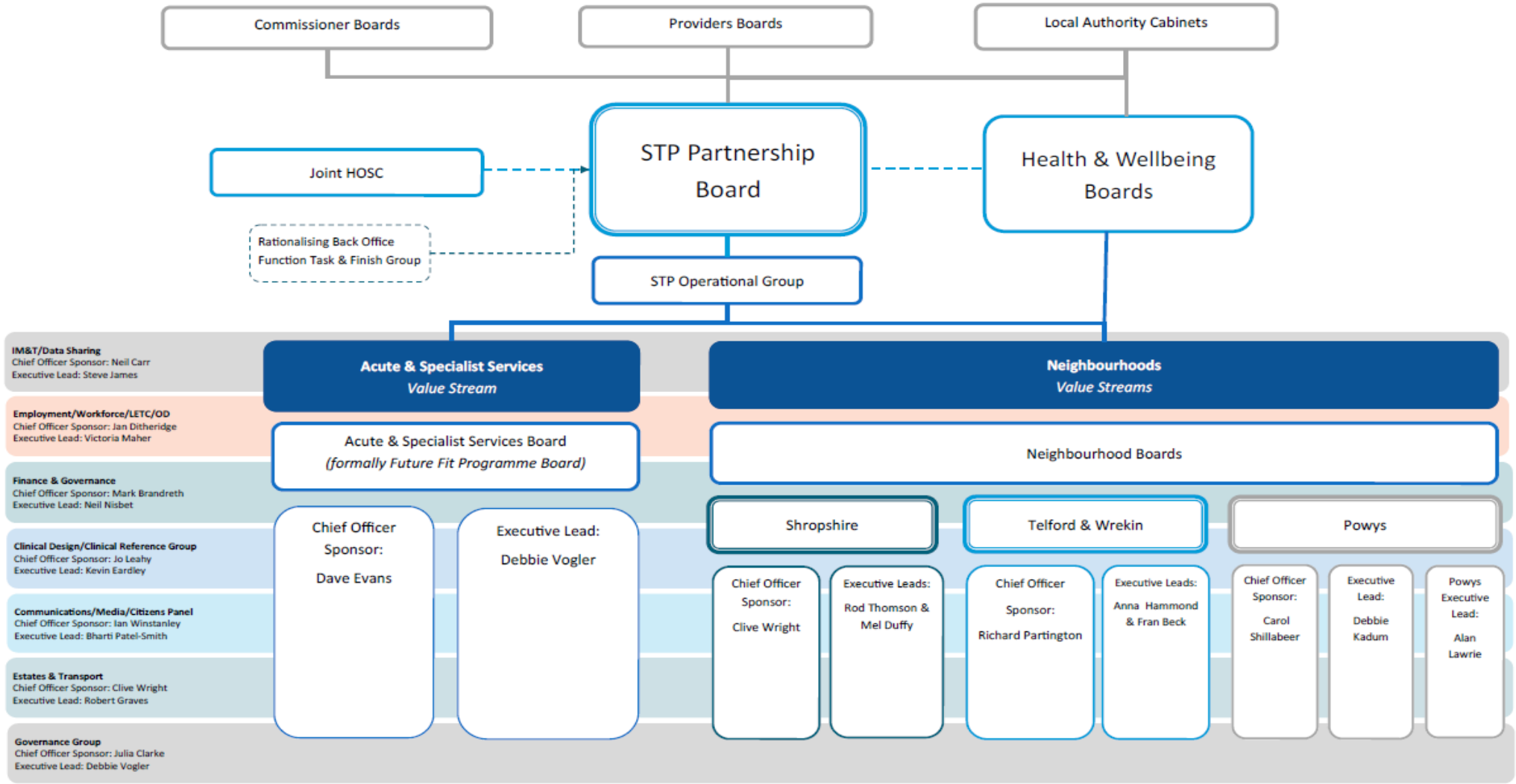



**South Telford Neighbourhood (pop. 44,000)**
**Priorities:**

- Integration of health and social care teams
- Greater involvement of drug and alcohol services
- Consideration of those aged 0-5, initially through improved alignment of health visiting
- Implementation of creative support planning and other links with local authority teams

| 4 Neighbourhoods | |
|---|---|
| TELDOC | 49,615 |
| South Telford | 45,427 |
| Newport | 27,412 |
| Group 4 | 59,155 |

# Appendix 2 Governance



# Appendix 3 – The STP Compact

- The overarching purpose of STP is to create a patient centered, sustainable system of health and social care. By implementing STP we learn how to collaborate to deliver care to an ageing population with less overall resource.
- We recognize the work that lies ahead will take discipline and a long-term commitment. In the end ***Shropshire, Telford and Wrekin will be the healthiest population on the planet.***
- We recognize achieving this vision will require unprecedented levels of trust, cooperation, collaboration, and working across traditional boundaries.

The purpose of our compact is to support this partnership way of working. The elements are:

**GIVE - In our work together, we all agree to:**

- Address hard issues [“lance boils”] in constructive ways
- Avoid defensive reactions – listen to feedback
- Say what we need to say in the meetings not outside
- Keep our commitments to this group
- Think and work upstream; invite participation, don’t hand others fully baked solutions
- Be transparent regarding data/finances
- When it comes to the money, align our behavior so that all organisations have positive bottom line within five years
- Share knowledge with each other
- Seek to understand the impact of decisions your organisation takes on others
- Demonstrate commitment to this work to our boards and staff. Inform them regularly using agreed-to talking points.
- Be disciplined about meeting start and stop time
- All take responsibility for successful meetings (not just the chair)

**We expect to GET:**

- Results including system surplus, 7 day/week care, the services our population needs delivered here
- Aligned outcomes
- Collective power and influence
- Robust meetings, constructive conversations
- Better decisions and greater confidence in our decisions
- More resilience and mutual support
- Trust that agreements we make to each other will be followed through
- Able to learn from failures or shortfalls and thereby accelerate progress

These outcomes should be indicators that our agreements are being lived and we are willing to modify our “gives” as necessary to make progress relative to these outcomes

# C

**TELFORD & WREKIN COUNCIL HEALTH AND WELLBEING BOARD**

**7th DECEMBER 2016**

**DEMENTIA STRATEGY FOR TELFORD & WREKIN**

**REPORT OF: Laura Thorogood, SDM, Commissioning (Vulnerable People) & Frances Sutherland, Head of Commissioning - Mental Health, Learning Disabilities and Children**

## PART A) – SUMMARY REPORT

### 1. SUMMARY OF MAIN PROPOSALS

This report provides an update on the development of the dementia strategy and describes the process we have been through to develop a vision for people living with dementia and their carers. It describes the present services; how we benchmark against other areas; the support provided including the spend; the future needs and the gaps. In addition it describes the work streams that have been set up to ensure the vision is delivered.

### 2. RECOMMENDATIONS

2.1 Board Members note the update and acknowledge progress of the development of the Dementia Strategy since receipt of the last Board Report in January 2015.

2.2 Board Members recognise that constant development is required and the strategy is to be updated with a 'live' Action Plan to include work activity in relation to prevention and as we develop Neighbourhood working.

### 3. IMPACT OF ACTION

Telford & Wrekin is an urban borough with an ageing population, with the percentage of people over the age of 80 projected to increase by 32% from 2014 to 2026. Approximately 7000 people over the age of 65 live alone in Telford, and many of these are income deprived and may be socially isolated. This would indicate we should expect more people to be living with dementia over the coming years. This number will be increased by the high levels of smoking, obesity and lack of regular exercise (which are risk factors for dementia).

The focus of the delivery of the Dementia Strategy and Action Plan:

- Improving public awareness of memory problems and addressing stigma will increase numbers of people visiting their GP, as the gateway for a diagnosis.
- Improving professional awareness of dementia will improve early identification of memory problems and ensure seamless transfer to appropriate services for a timely diagnosis, ensuring that people access care and support services, as early as possible. Improved professional training and awareness may also improve quality of care.

- Identifying and diagnosing people with dementia in the early stages of the disease will prevent crisis and the subsequent need for intensive services.
- Improving consistency and quality of end of life care will improve people's experience of health and social care services.

## 4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>• Encourage healthier lifestyles<br>• Improve mental wellbeing and mental health<br>• Strengthen our communities and community based support</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>Telford & Wrekin Council's Medium Term Plan for 2013/14 to 2015/16:<br><br>• Protect and support our vulnerable children and adults<br>• Improve the health and wellbeing of our communities and address health inequalities.</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>Dementia is mainly a disease of people aged over 65 years but its impact on families and carers is far-reaching and can affect people of all ages.</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">Dementia Strategy now complete - Action Plan to be further developed with targets for completion of delivery for individual workstreams to support prevention and support for those individuals living with dementia.</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>The national situation with regard to funding care is well versed. Government grant to the Council is reducing significantly to 2020 giving rise to further Council savings of £15-£20m by the end of 2019/20.<br><br>The Local Authority is experiencing significant financial pressure on it's current budget for the care of adults. Latest 2016/17 financial monitoring reports an overspend against the budget for the purchasing of care of around £4m. The factors influencing this</td></tr>
</table>

| | | |
|---|---|---|
| | | overspend include the rising costs of care and the additional pressures from having to provide more complex care.<br><br>The continued transformation to deliver care at home and to encourage direct payments continues and develops but residential and nursing care remain a fundamental and important part of the suite of care options available. Rising prices for the delivery of "traditional" care options and the increasing number of domiciliary care hours required will continue to challenge the Council given the current financial context.<br><br>The delivery of initiatives proposed in the dementia strategy forms a part of the overall strategy to deliver care within a budget which will have to deliver significant savings over the next few years. |
| **LEGAL ISSUES** | Yes | In relation to the work of the Health and Wellbeing Board (HWBB), which includes supporting people with dementia, Section 195 of the Health and Social Care Act 2012 requires the HWBB to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and to take the steps it considers appropriate to improve the health of the people in its area.<br><br>Dementia features in the current NHS Outcomes and Adult Social Care Outcomes Frameworks.<br><br>On 12 January 2016 Public Health England launched the Dementia Intelligence Network [DIN] to collect new and existing data.<br><br>On 6th March 2016 the Prime Ministers Challenge on Dementia 2020 Implementation Plan was published. |
| **EQUALITY & DIVERSITY** | Yes | Equality and diversity impact assessments will be undertaken when any service changes are developed. |
| **IMPACT ON SPECIFIC WARDS** | Yes | There is an estimated prevalence of 1,774 people living in the borough who are likely to |

| | | |
|---|---|---|
| | | have a diagnosis of dementia. |
| **PATIENTS & PUBLIC ENGAGEMENT** | Yes | Described within Dementia Strategy to include service users and carers. |
| **OTHER IMPACTS, RISKS & OPPORTUNITIES** | Yes | Dementia Strategy being developed to support more people with dementia in a community based setting as an alternative to more appropriate and less costly long term placements. |

## PART B) – ADDITIONAL INFORMATION

## 1. INFORMATION

### 1.1 Governance

Five work streams have been set up to take forward the work of the footprint. Each is led by either a person living with dementia, third sector or commissioner. These will be subgroups of the Health Economy Dementia Steering Group (HEDSG). The subgroups shall agree a model and then prioritise workload. The HEDSG will monitor the work and feedback to the Health and Wellbeing Board.

### 1.4 Development of Dementia Strategy

Telford and Wrekin Council and the CCG have worked together to develop this strategy to support people who live in the area who are living with dementia and their carers. The last joint strategy ran from 2009 until 2013 and achieved significant changes in the landscape to support people living with dementia (PLWD) and their carers.
**Please see attached - 'Dementia Strategy 2016-2019' at Appendix 1.**

### 1.5 What does this strategy aim to achieve by 2020 for people living with dementia and their carers?

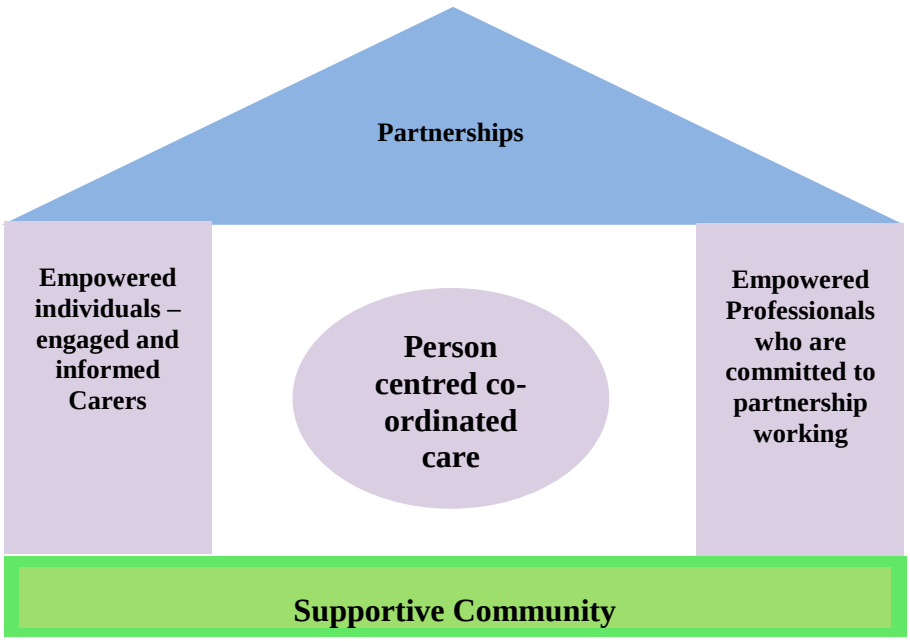
To enable people living with dementia and their carers to say:

**Me to stay me and live well, feeling secure in my communities**
**Me and the people around me, to feel confident, informed and to know where to go when we need help'**

### 1.6 How will we make this happen?

### House of Care

We have adapted the Kings Fund 'House of Care' model to create the Telford & Wrekin House of Care which describes a whole system approach. The ethos and principles that underpin this model can help to address many of our issues and mirrors what service users and professionals have told us. The House of care provides us with a model of care that puts individuals (whether that is the person living with dementia or their carer) at the centre of all care wherever delivered.



## 2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

### 2.1 Demographics - Telford & Wrekin

There is a forecast of increase in the older population and those living with dementia there are financial pressures that need to be taken into account.

Telford & Wrekin is an urban borough with an ageing population, with the percentage of people over the age of 80 projected to increase by 32% from 2014 to 2026. The Office of National Statistics mid year poulation estimates 1725 peole with dementia in the local authority area. The CCG prevalence figure is calculated with a different methodology ( CFAS 11) and indicates a prevalence of 1668.

### 2.2 What does this mean for the strategy?

- The population of older people is increasing at a greater rate and we need to build resilience and skills into services to ensure they are supported.
- We need to ensure we commission prevention and early intervention services that can support them at the earliest opportunity.
- We also need to consider the impact of caring on carers mental health and stress levels.

## 3. PREVIOUS MINUTES

- 21st January 2015 : Health and Wellbeing Board Priority Update: Support People with Dementia

## 4. BACKGROUND PAPERS

**Dementia Strategy 2016-2019**

**Report prepared by:**

**Laura Thorogood, Service Delivery Manager Commissioning (Vulnerable People)**
**Telephone: 01952 380793**

**Frances Sutherland, Head of Commissioning - Mental Health, Learning Disabilities and Children**

NHS
Telford and Wrekin
Clinical Commissioning Group

Telford & Wrekin COUNCIL

# TELFORD and WREKIN
# Dementia Strategy 2016-2020

NHS
Telford and Wrekin
Clinical Commissioning Group

Telford & Wrekin COUNCIL

**Telford and Wrekin Dementia Strategy**

**2016-2019**



NHS
Telford and Wrekin
Clinical Commissioning Group

Telford & Wrekin COUNCIL

## SECTION 1- Summary- Shropshire, Telford and Wrekin Dementia Strategy 2016-2020

### 1 Introduction

Telford and Wrekin council and the CCG have worked together to develop this strategy to support people who live in the area who are living with dementia* and their carers. The last joint strategy ran from 2009 until 2013 and achieved significant changes in the landscape to support people living with dementia (PLWD) and their carers. The plan achieved the following significant milestones

- A responsive memory assessment service with capacity to undertake the required assessments
- Dementia support workers in place
- Admiral nurses supporting carers
- A carers partnership board
- Health economy dementia steering group- stakeholders group across Shropshire, Telford and Wrekin
- Specialist dementia support in the local acute hospital

Work has continued to improve services to support people living with dementia and their carers. This strategy builds on the work completed locally; reviews what we have now; considers how people see the services; considers the latest evidence to support PLWD and their carers and provides a new vision for the next four years.

### 1.2 How has this strategy been developed?

The strategy draws on a range of different information and in producing it we have asked the following questions:

- *What have service users, professionals, carers, and volunteers told us about the current services, aspirations about services and what outcomes they would hope to achieve?*
- *What does the demographic information show us about our population needs now and how they will change in the future?*
- *What does the most recent evidence and research tell us about best practice?*

### 1.3 Why do we need to change?

#### 1.3.1 What local people have told us:-

Feedback from PLWD and their carers told us we are not getting it right- We were told that it isn't always easy to get a diagnosis. It can take many months to get a GP to understand there is a problem and carers find this very frustrating. Carers told us post diagnosis support is a lottery regarding what you can expect - it can be wonderful for some but frustrating and difficult for others. Reports regarding the Admiral nurse Service were very positive. We were also told that it is not always easy to know who or where to go for support. Carers found support groups helpful but wanted more places to go with their loved one as going without them caused more difficulty.

#### 1.3.2 Our demographic changes:-

Telford & Wrekin is an urban borough with an ageing population, with the percentage of people over the age of 80 projected to increase by 32% from 2014 to 2026. Approximately 7000 people over the age of 65 live alone in Telford, and many of these are income deprived and may be socially isolated. This would indicate we should expect more people to be living with dementia over the coming years. This number will

be increased by the high levels of smoking, obesity and lack of regular exercise (which are risk factors for dementia).

### 1.3.3 What does the research tell us that we can learn from?

Reducing the risk factors to develop dementia needs to be major element of any dementia strategy. This needs to be a key focus for Telford and Wrekin with its high level of smoking and obesity in the general population. Early diagnosis is important as some medication can be more effective in the early stages of dementia. Education programmes can support carers to understand the impact of dementia and how to manage challenging behaviours and thus helping to prevent carer breakdown. Cognitive stimulation therapy can improve the quality of life for PLWD and should be offered to all. Commissioners need to clearly defining services and then monitoring the quality and impact of the interventions, so we can improve the standard of care. (http://toolkit.modem-dementia.org.uk/database/)

### 1.3.4 What issues do we have with our present support?

The CQC inspection (2016) highlights our local memory service as outstanding taking into consideration safety, caring, effective, responsive and well led. The only issue raised was the high caseload of the home treatment team in Telford.

The diagnosis rate for Telford and Wrekin is at 63.7% but has a target of 66.9% by April 2017.

The demand on the dementia support workers and Admiral Nurses exceeds demand.

Little work has been done to support end of life care locally.

Overall cuts in funding mean there is less funding in the public sector and both commissioning organisations need to assure themselves, and the public of best value when using public funds.

### 1.4 What does this strategy aim to achieve by 2020 for people living with dementia and their carers?

To enable PLWD and their carers to say:

**Me to stay me and live well, feeling secure in my communities**

**Me and the people around me, to feel confident, informed and to know where to go when we need help'**

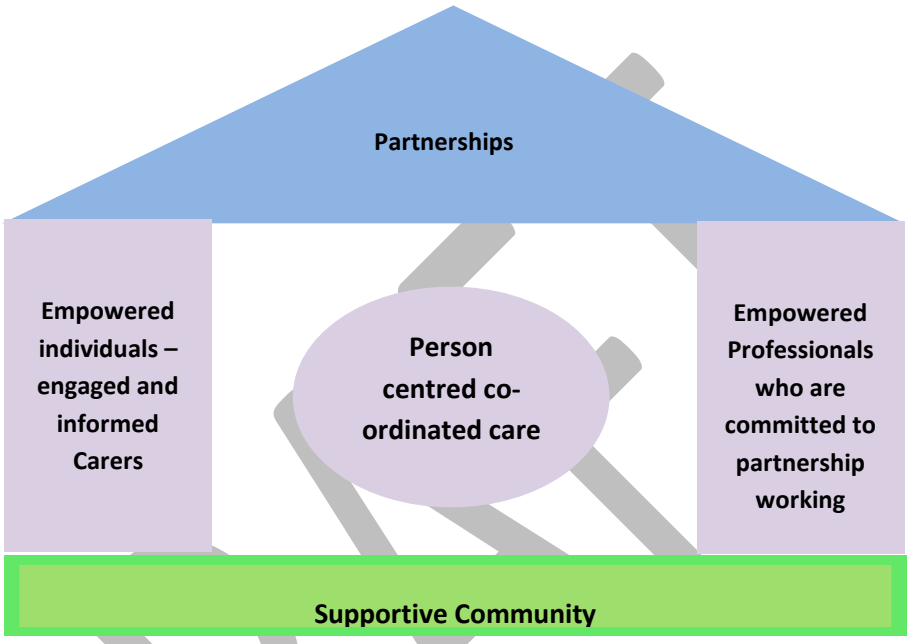
The key principles that will underpin all the work undertaken locally will:-

- Creatively build on an individual's strengths, skills and independence
- Support individuals to plan for their future
- Be honest about what can and can't be provided
- Support individuals to find someone who can help them when needed
- Ensure individuals can make timely and informed choices
- Work as one team to support individual's and their families
- With consent and when required, share an individual's story so they don't have to
- Reduce barriers to ensure individuals are able to get the help they need
- Work with individuals to find solutions to prevent a crisis
- Promote dementia friendly communities in Shropshire Telford and Wrekin
- Learn from what works well and what doesn't to improve the help what is provided.

## 1.5 How will we make this happen?

### 1.5.1 House of Care

We have adapted the Kings Fund 'House of Care' model to create the Telford & Wrekin House of Care which describes a whole system approach. The ethos and principles that underpin this model can help to address many of our issues and mirrors what service users and professionals have told us. The House of care provides us with a model of care that puts individuals (whether that is the person living with dementia or their carer) at the centre of all care wherever delivered




**Supportive Communities ('The Foundations'). The model will support:**

- Dementia friendly communities across the borough.
- Resilient communities where PLWD are welcomed and supported by all local networks and groups
- Increasing the role and value of the 3rd Sector to promote and develop assets in the community.

**Person-centred co-ordinated care is at the centre of the house and represents the following:**

- The recognition of what is both 'important to me' and what is 'important for me'.
- Support for people living with dementia and their carers in and by their own community.
- Support for people living with dementia and their carers to become more resilient and to plan for their future.
- Support for the people living with dementia and their carers to take control of their condition and develop self-management skills as far and as long as possible.
- The inclusion of the needs of Carers.
- A relevant key worker for each person with dementia and their carer.
- Provision of tailored information (including any risks and benefits) to assist the individual to make informed decisions.
- Support will be provided in the least restrictive environment.

**Empowered people – engaged and informed Carers ('Left Wall'). The model of care will:**

- Recognise people living with dementia and their carers, as 'Expert Care Partners'.
- Encourage self care and personal responsibility where safe and appropriate to do so, along with the information, education and support to enable this to happen.
- Ensure shared decision making becomes the 'norm' where and when possible, and to plan for a time when this is not a reality
- Use digital and assistive technologies to empower and support people where possible and reduce duplication.
- Provide Personal budgets where appropriate to support people to have more control over their life.

**Empowered Professionals who are committed to partnership working ('Right Wall'). The model will ensure that:**

- There will be a culture embedded across the workforce that promotes shared decision making, self-management and wellbeing of people living with dementia and their carers.
- Services will be integrated through multidisciplinary working with the voluntary and charitable sector playing key roles.
- Professionals at all levels will have the right competencies, capability and capacity to do their jobs to the highest standards.
- Professionals discuss the relevant risks of treatment/care with people living with dementia and their carers and support them with the decisions they make.
- Professionals will understand their local communities, use local assets to support people living with dementia and their carers and collaborate with the community to bridge any gaps.

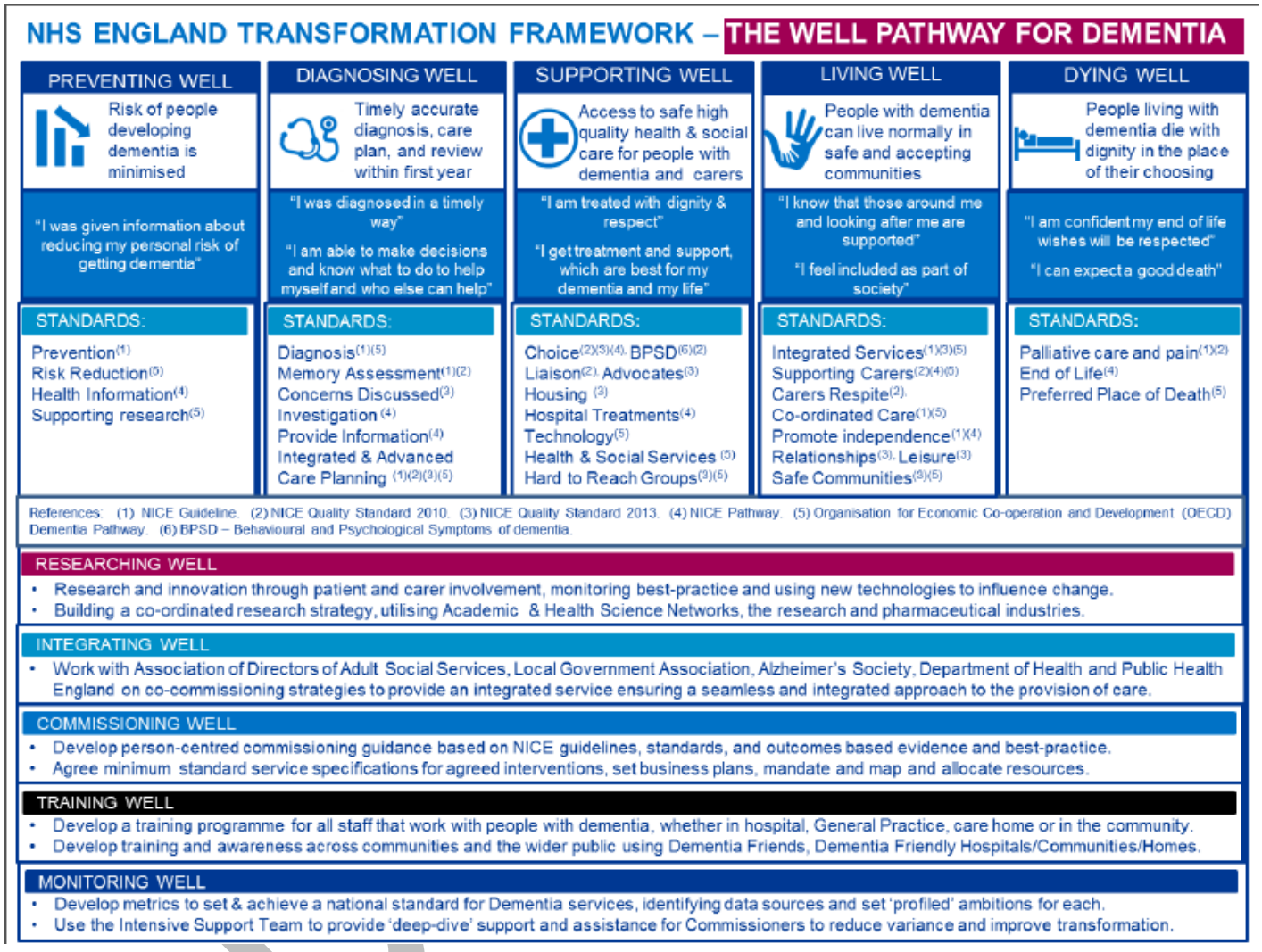
We will use partnerships as an enable to achieve our aspirations:-

**Partnerships including Joint Commissioning ('The Roof ')**

- We will work across local authority, NHS, other statutory organisations, voluntary sector, private sector and employers to ensure a joined up approach.
- We will include people living with dementia and carers in every stage of the commissioning cycle.
- We will explore opportunities for joint commissioning.
- We will focus on Social Value when undertaking commissioning.
- We will commission services on outcomes, including those identified by people living with dementia and their carers.
- We will ensure a robust voluntary sector in the borough.
- We will ensure that where possible there are systems that talk to each other to reduce bureaucracy and duplication and assist with record sharing.
- We will ensure service specifications include the delivery of shared decision making with service users.
- We will ensure soft intelligence; compliments and complaints inform commissioning decisions.

### 1.5.2 The Action Plan

NHS England has developed a 5-year transformation implementation plan called the `Well Pathway for Dementia` which covers preventing well, living well, supporting well and dying well. The plan supports the Prime Ministers challenge 2020. This plan will support the implementation of the vision for the Dementia strategy across the Shropshire Telford and Wrekin footprint and is based on this well pathway.




### 1.5.3 Governance

Five work streams have been set up to take forward the work of the footprint. Each is led by either a person living with dementia, third sector or commissioner. These will be subgroups of the Health Economy Dementia Steering Group(HEDSG). The subgroups shall agree a model and then prioritise workload. The HEDSG will monitor the work and feedback to the Health and wellbeing Boards.

## SECTION 2-REVIEW OF DEMENTIA SERVICES- What is dementia and what is its impact?

### 2.1 What is dementia?

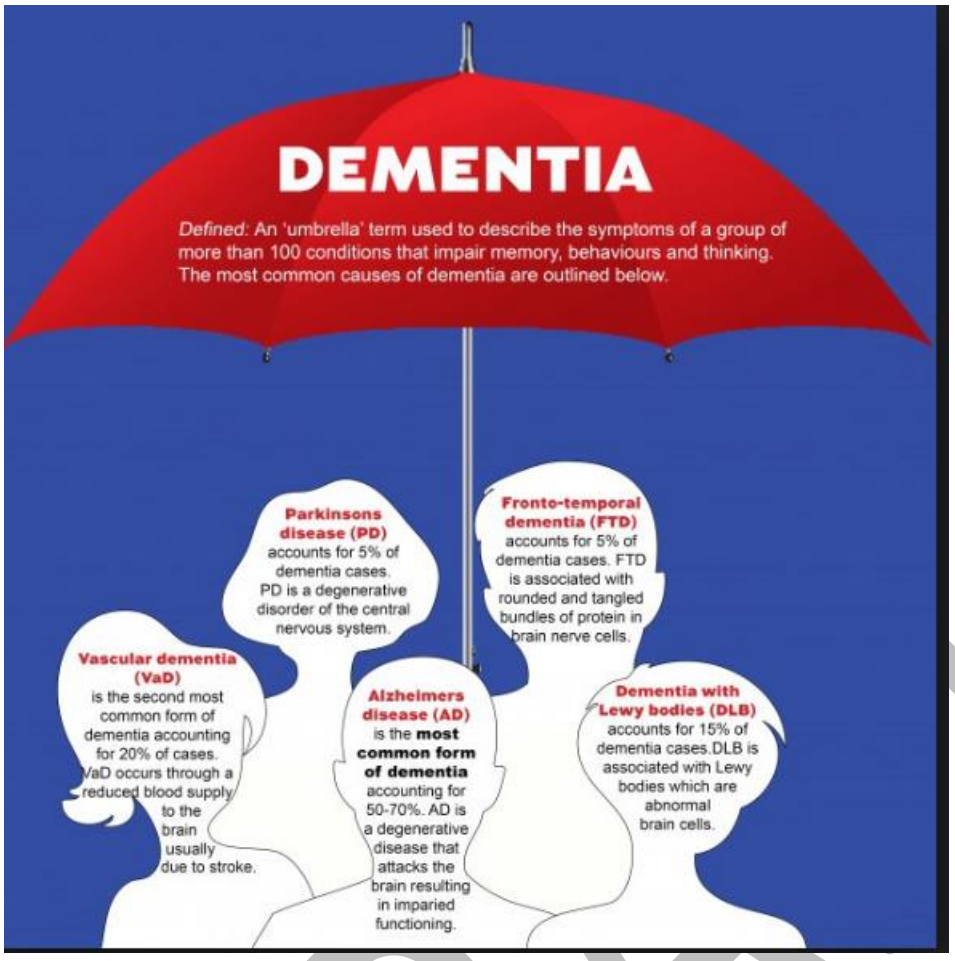
Dementia is a progressive condition, which means that the symptoms become more severe over time. People with dementia and their families have to cope with changing abilities such as the capacity to make decisions.Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years. Dementia can start before the age of 65, presenting different issues for the person affected, their carer and their family. People with young onset dementia are more likely to have active family responsibilities – such as children in education or dependent parents – and are more likely to need and want an active working life and income. Family members are more frequently in the position of becoming both the sole income earner, as well as trying to ensure that the person with young onset dementia is appropriately supported. The reality for many people with dementia is that they will have complex needs compounded by a range of co-morbidities. A recent survey by Alzheimer's Society found that 72 per cent of respondents were living with another medical condition or disability as well as dementia. The range of conditions varied considerably, but the most common ones were arthritis, hearing problems, heart disease or a physical disability.

### 2.2 How can it be treated?

Currently, dementia is not curable. However, medicines and other interventions can lessen symptoms for a period of time and people may live with their dementia for many years after diagnosis. There is also evidence that more can be done to delay the onset of dementia by reducing risk factors and living a healthier lifestyle. There is also a great deal that can be done to help people with dementia at earlier stages. If diagnosed in a timely way, people with dementia and their carers can receive the treatment, care and support (social, emotional and psychological, as well as pharmacological) to enable them to better manage the condition and its impact. For example, there is much that can be done to help prevent and ameliorate symptoms such as agitation, confusion and depression. Advanced dementia can be very difficult for the individual and their family and it is not always possible at this late stage of the condition to 'live well', but compassionate treatment, care and support throughout the progression of the condition is essential to enable people with dementia to one day 'die well'.

### 2.3 How many people are living with dementia?

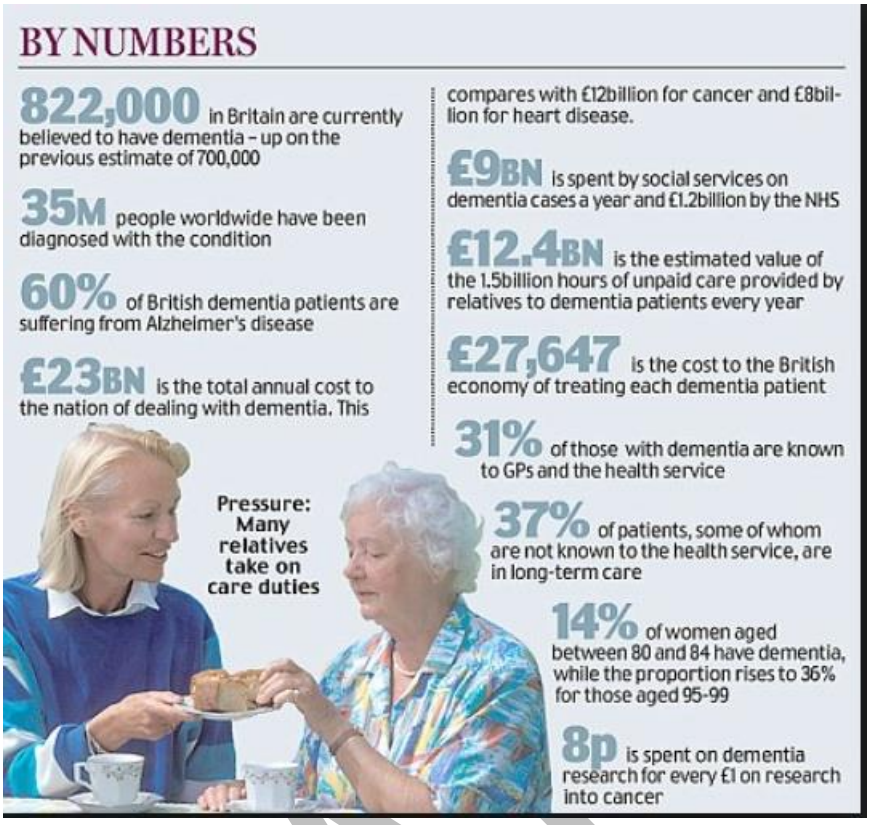
Estimating the prevalence of dementia in England is not an exact science. The Delphi approach is a consensus statement based on experts reviewing a series of international studies whereas the Cognitive Function and Ageing II Study (CFAS II) uses real data from three populations in England, allowing for more granular estimates of prevalence, for example at Clinical Commissioning Group level, and indicates that there are ranges. People with learning disabilities have an increased risk of developing dementia than other people and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s.




## 2.4 What is the impact of Dementia?

The Alzheimer's Society Dementia 2014 survey reported that 40 per cent of people with dementia felt lonely and 34 per cent do not feel part of their community. There is a similar impact on the carer.

- **Hospital care**
  People with dementia are sometimes in hospital for conditions for which, were it not for the presence of dementia, they would not need to be admitted. An estimated 25 percent of hospital beds are occupied by people with dementia. People admitted to hospital who also have dementia stay in hospital for longer, are more likely to be readmitted and more likely to die than patients without dementia who are admitted for the same reason.
- **Care homes and care at home**
  An estimated one-third of people with dementia live in residential care and two-thirds live at home. Approximately 69 per cent of care home residents are currently estimated to have dementia[21]. People with dementia living in a care home are more likely to go into hospital with avoidable conditions (such as urinary infections, dehydration and pressure sores) than similar people without dementia.




- **Costs**

  The total annual cost per person with dementia in different settings is estimated as follows: People in the community with mild dementia £25,723 People in the community with moderate dementia £42,841 People in the community with severe dementia £55,197 People in care homes with dementia £36,738. Two-thirds of people with dementia live in the community (Alzheimer's Society, 2007). Of these, one-third live alone in their own homes (Mirando-Costillo et al, 2010). The UK Homecare Association estimate that 60% of people receiving care at home have a form of dementia (UKHCA, 2013). Unpaid carers save the state £11 billion per year.

## SECTION 3- REVIEW OF DEMENTIA SERVICES 2016-2020- Commissioning, contracting and Investment

### 3.1 Commissioning responsibilities

3.1.1 The Clinical Commissioning Group (CCG) is responsible for commissioning specialist health provision provided including assessments and diagnosis services, post diagnosis support, support in a crisis in both acute and community settings. In addition it commissions generalist services that people living with dementia also access.

3.1.2 The Local Authority (LA) commissions and provides adult social care services as part of its statutory obligations under the Care Act, Mental Health Act and Mental Capacity Act. This includes commissioning services which promote wellbeing; reduce ill health and dependency; Advocacy; supporting carers; care packages and supported living.

### 3.2 Contracting

3.2.1 The main CCG contract is held by an NHS provider (South Staffordshire and Shropshire Foundation Trust). The CCG holds smaller contracts through the grant process to support PLWD and carers.

3.2.2 The LA commission a variety of providers ranging from large charitable organisations to small local private providers.

3.2.3 Contract monitoring:-

Both organisations have robust and regular contract monitoring processes in place to monitor spend and performance of its providers. The CCG has a quality monitoring process where quality and outcomes of services are monitored on a monthly basis. Quality Assurance processes are in place in the LA to ensure outcomes are delivered.

### 3.3 Investment

The spend on dedicated Dementia services across Telford and Wrekin CCG is £2.7M. Prescribing costs for dementia related drugs in the CCG are £98K.

3.3.1 **Spend by organisation**

| Commissioner | Budget 2015 / 16 £000 | Comments |
|---|---|---|
| **CCG** | **£6,889.094** | This is not an exact breakdown as the main element is part of a block contract and other contracts include spend on all older adults and Dementia spend cannot be identified |
| **LA** | **£11,540,866** | This includes spend on all older adults and Dementia spend cannot be identified |
| **Total** | **£18,429,960** | |

3.3.2 **Spend by contract type (CCG)**

| Contract type | Budget 2015 / 16 £000 | Number of providers | Comments |
|---|---|---|---|
| Cost and Volume | £2,411,686 | 1 | South Staffordshire and Shropshire Foundation Trust (SSSFT) |
| Block contract | £88,450 | 1 | Shropshire community for Admiral nurses |
| Individual packages | £4,227,688 | 273 | 273 patients over the age of 65 currently have in a service commissioned by the complex care team |
| Grant | £110,00 | 2 | Dementia advisors and support groups |
| Grant | £21,270 | 1 | Dementia worker |

3.3.3 **Spend by contract type (LA)**

| Contract type | Budget 2015 / 16 | Number of Providers | Comments |
|---|---|---|---|
| Spot purchase | £4,867,969 | Not known (Residential – 100 ongoing clients, nursing – 60 ongoing clients) | Nursing and residential EMI 2015/16 spend |
| | £164,796 | | Day care for older people* |
| | £648,319 | | Direct Payments for older people* |
| | £4,254,981 | | Homecare for older people* |
| Block | £1,604,801 | 2 | Nursing and residential EMI 2015/16 spend |
| Other<br>Our 2013/14 data tells us that at that time there were:<br>• 63 homecare providers operating in Telford and Wrekin, of these 14% offered a service to those with dementia. At that time just 2% of all homecare services were contracted via a block contract, all other homecare was spot purchased<br>• 10 daycare providers operating in Telford and Wrekin, of these 15% offered a service to those with dementia. At that time 17% of days purchased were contracted via a block contract, all other daycare was spot purchased | | | |

*Spend specifically on EMI residents not available

3.3.4 **Public Health contribution to promoting mental wellbeing**

Public Health (Part of the LA) funds a large range of services which provide a preventative approach to ensure people to stay as healthy as possible. Many of the interventions will be focused on improving or maintaining health and increasing activity. This budget is for population approaches and covers lifestyle interventions for all age groups and conditions.

3.3.5 **Carers Funding**

The LA and CCG pool budgets to support carers. The total carers pooled budget is £ 515.500. This is not specific funding for dementia carer support. It is not possible to calculate the % of care that is supporting those living with dementia. The funding covers a range of support including the provision of a Joint Carers Commissioning Officer which is central to driving forward the local carer agenda, Emergency Response Service, Carers Respite and a range of workshops which focus on promoting well being and carer resilience.

3.4 **Distribution of funding**

Investment from both organisations is focused on the highest cost and highest risk patients. These are service users who require hospital admission and social care packages to support them in activities of daily living.

**3.5 Challenges**

3.5.1 **Financial**

Both organisations are experiencing significant financial challenges with an increase in the populations' expectations of service provision; the demographic changes; national policy imperatives and reduced budgets.

3.5.2 **Systems and Processes**

There is no forum to discuss the contracts held across the economy as they impact on each other. Changes in one contract may have a knock on effect on another organisation. Both organisations have their own systems and processes for managing complex service users and contracts.

3.5.3 **Benchmarking spend on Dementia**

3.5.3.1 **CCG**

NHS benchmarking on health spend is complex. Programme budgeting has been used to benchmark CCGs against investment in specific disease areas but has significant problems setting the baseline for comparisons. In addition it does not differentiate dementia spends from mental health and therefore cannot be determined.

3.5.3.2 **LA Benchmarking Data –**

The local authority spend on a variety of the needs of the population and spend on dementia is not straightforward to extract. The authority often identify spend in relation to individuals or client groups e.g. older people, learning disabilities, mental health and someone with dementia may also have other conditions and so it is more difficult to extract spend on dementia specifically. However, we have commissioned some of our provision from nursing, residential, domiciliary care agencies, day opportunities who may specialise in supporting individuals with dementia and where possible we do identify commissioned spend. (See Spend by Contract Type).

As an authority we are also promoting personalisation and where appropriate we are enabling individuals and carers to have their own choice of purchasing rather than be limited to commissioned service provision which may also affect the monitoring of spend specifically on dementia.

**3.6 What does this mean for the vision?**

The main issues are:

- Opportunities to commission services jointly to improve integration and value for money should be considered
- Pressures from austerity need to lead to innovative ways to provide services and develop more community resilience.
- Increasing spend on prevention and lower level treatments may reduce the more expensive interventions in the future.
- Need to consider the development of pooled budgets

## SECTION 4- REVIEW OF DEMENTIA SERVICES - current dementia services

### 4.1 Introduction

This chapter describes the services that support People living with Dementia (PLWD) in Telford and Wrekin in 2015 and how we benchmark against national outcomes.

### 4.2 Service provision

#### 4.2.1 Health

Specialist Dementia services are in the main provided by South Staffordshire and Shropshire Foundation Trust (SSSFT) and the local authority. The Trust provides diagnostic, community services and inpatient services. General health services are provided by the local GP practices ( 20?) and the local hospital Princess Royal (part of Shropshire and Telford Hospitals). Community care ( nursing including Admiral nursing, therapy) are provided by Shropshire community trust

##### 4.2.1.1 Assessment and Diagnostic service

The service provides assessment in local GP surgeries as well as the trust facilities and service users own homes. People are seen on average within 2 weeks of referral to start to the assessment process. The service is staffed by Consultant Psychiatrists, Psychologists, Nurses, Occupational Therapists and Support workers. Prior to assessment the team ensures physical health checks have been completed. The assessment process involves pre-diagnostic counselling, informed consent about the assessment and information sharing, as well as the process of clinical history taking and analysis. Information regarding risk reduction with regards to dementia is given. Appropriate referrals are made for CT and SPECT scans.

##### 4.2.1.2 Community support post diagnosis

Post diagnostic support involves the commencement of medication, where appropriate and following the necessary ECGs and blood tests. Information is shared with regards to helping to understand the illness and manage some of the symptoms, getting peer support from voluntary agencies, other carers and service users and planning for the future decision making. Cognitive Stimulation Therapy (CST) reminiscence therapy, individual psychotherapy and neuropsychological testing is provided by the service. A home treatment team provides intensive support at times of increased need.
Those on medication are monitored in line with NICE Guidance and reviewed accordingly.

##### 4.2.1.3 In patient services

Specialist dementia Inpatient beds are provided at Redwoods hospital in Shrewsbury. There is one ward dedicated to older age adults which mainly caters for those people living with Dementia. 31 people from Telford and Wrekin were admitted in 2015/16 utilising 1673 bed days with an average of 54 day stay.
In addition PLWD are also admitted to the local acute hospital when they have physical health problems. The RAID team commissioned from SSSFT provide support to PLWD in both the Emergency Department and ward environments. They are able to screen people in those environments where there are concerns regarding memory loss and to offer advice and support where behaviours are more

difficult to manage. The acute hospital has staff that screen older people for memory problems and an advanced nurse practitioner to support staff who manage PLWD in the hospitals.

**4.2.1.4 Admiral Nurses**

The CCG and local authority commission Admiral nurses to support carers of people living with dementia. There are two whole time equivalent employed through Shropshire Community trust with a third part time worker funded non recurrently.

Referrals are taken by the team and these come from other service providers and self referrals. They hold caseloads of up to 60 people and case load is managed in the following way:

- Intensive support: One to One work for a targeted amount of time
- Moderate support: Regular support via face to face or telephone calls
- Holding: Carers contact the service when needs change and review is required

4.**2.1.5- Post diagnosis support**

This is provided by Alzheimer's Society and Age UK through a grant mechanism. The grant funds the Alzheimer's Society to provide three part time dementia support workers (1.5FTE) who provide 1:1 emotional and practical support to PLWD (diagnosed and carers), this includes coping strategies when PWD exhibit early stages of changing behaviours. On top of this additional hours currently provide a weekly Singing for the Brain group in Telford and two monthly peer support (for carers) & activity groups (for PWD) in Newport and Wellington. Alzheimer's Society provide regular education and training programmes across T&W which are funded by the Council. Age UK receive funding from the CCG towards the delivery of a number of Diamond Drop In Cafes which aim to reduce social isolation for PLWD. There are 4 of these, three of which operate on a fortnightly basis and one is monthly.

**4.2.2 Social care commissioned services**

The Care Act 2014 is being implemented by the Council which also impacts on how we commission more actively in commissioning for better outcomes in order to promote wellbeing and prevent, reduce and delay the deterioration of individuals and to assist carers and individuals to be supported having the right help, at the right time to live well and be supported well in their own homes as much as possible.

**4.2.2.1 Information, Advice and Advocacy**

The Council has taken into account the requirement for easier access to information and advice and in response has developed an 'Information Advice Strategy' which includes an electronic form of the collation of Information and Advice 'My Life' a web portal - http://www.telford.gov.uk.

The Council have recognised that some groups of the population to include carers and those people living with dementia may wish to talk to an individual rather than Internet access. As a result, from 1st October 2015, the Council has commissioned a consortium of the voluntary sector to provide an Information, Advice and Advocacy Service (My Choice). This service provides a single telephone access point for both carers and those living with dementia to seek more specialised support.

**4.2.2.2 Personalisation- Choice and Control**

We are supporting people to ensure that the people requiring longer term care can take as much control over their lives as their needs allow. We are working with the CCG and a variety of groups to include membership of Dementia Action Alliance to enable people to live well with dementia and going forward in development of this strategy identify community based services to include day opportunity

venues e.g Older People Enjoying Life Centres which assist in meeting the challenges of social isolation and social exclusion in understanding the requirements of those living with dementia and their carers as respite opportunities as well as services that enable people with dementia to take more control over their own lives and have links to the community.

**4.2.2.3 Community Based Solutions**

To assist people gaining the right help, at the right time and promoting independence, we have a selection of the care and support market that specialise in providing personal care and support services. We also have a specialist sector that provide services to people living with dementia that are very aware of the complexities of the condition and provide a sensitive service. We are aiming to help people continue to live in their neighbourhood and community, where this is feasible and affordable. We do commission a selection of nursing and residential provision across Telford and Wrekin. As we go forward residential care may only be explored where other options have been exhausted and have found that this is the only way to meet someone's care and support needs in a safe way.

We are supporting the person to safely meet their assessed needs in a community based setting and promoting independence in the person's own home and assisting resilience for carers together with carers commissioned services. Services may include arts and culture, to assist in living with dementia is supported as sensitively as possible with the individual at the heart of the provision.

Technology is developing rapidly, and we are ensuring that the interventions we offer people will focus on how we can promote their independence. This means we will always seek to use community based solutions including assistive technology and adaptations in the home, where these will enable people to remain safe and meet their care needs.

**4.2.3 Other Commissioning**

**4.2.3.1 Public health commissioning**

also sits within the local authority and commissions a range of interventions including supporting healthy lifestyles.

**4.2.3.1 Carers support-**

It is the identification and raising awareness of carers across Telford and Wrekin community which requires particular focus with a continued emphasis on prevention, promoting self help and ensuring a range of solutions are employed at an earlier stage in their caring lives in line with the Right Help, Right Time pathway which focuses on prevention and development of carer resilience.

Through the Prevention and Well Being Strategy, a collaborative approach requires everyone to be mindful of the emotional, physical and mental impact of caring. The Care Act 2014. At present the support provided is:-

- All ages Carers Information, Advice and Support Service where Carer Assessments are undertaken
- Emergency Carers Response Service providing replacement support for family carers in Crisis
- Moving and Handling Family Carer Adviser providing bespoke safe moving techniques in the family home.
- A range of workshops: Cookery , Creative: Arts/Painting/Drawing/Craft/Singing and Pottery where carers have time for themselves and receive peer support.
- Personalised Carer Support: Targeted support to give carers respite
- Pamper Sessions which focus on well being in conjunction with Health Trainers
- Specialised Dementia Workshops for family carers focussing on understanding dementia, managing stress , life planning

- Friend and Family Service providing support to those living with someone who has a drink or drug addiction
- Relationship Support for carers who are experiencing loss or finding change or relationships difficult to manage

The Carers Partnership Board is linked to the Health and Well Being Board and it provides an opportunity to influence service design promoting collaborative practices between carers, commissioners, voluntary organisations and statutory organisation.

### 4.3 Benchmarking of NHS services

The following tables are taken from the Public health profile fingertips. :-
http://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia
These profiles provide a rich source of data across a range of health and social care data to support commissioning.

#### 4.3.1 Prevalence

*Compared with benchmark:* Lower | Similar | Higher | Not compared

* a note is attached to the value, hover over to see more details

Export table as image

| Indicator | Period | England | West Midlands region | Birmingham | Coventry | Dudley | Herefordshire | Sandwell | Shropshire | Solihull | Staffordshire | Stoke-on-Trent | Telford and Wrekin | Walsall | Warwickshire | Wolverhampton | Worcestershire |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dementia: Recorded prevalence (all ages) | 2014/15 | 0.74 | 0.73 | 0.57 | 0.57 | 0.76 | 0.78 | 0.69 | 1.06 | 0.78 | 0.79 | 0.79 | 0.54 | 0.77 | 0.76 | 0.82 | 0.79 |
| Dementia: Recorded prevalence (aged 65+) | Sep 2015 | 4.27 | 4.10* | 4.34 | 3.82 | 3.75 | 3.42 | 4.30 | 4.61 | 4.14 | 3.92 | 4.81 | 3.39 | 4.47 | 3.86 | 5.05 | 3.78 |

This indicates that Telford and Wrekin is below the national figure for recorded prevalence which is a key area for the strategy to work on.

### 4.3.2 Preventing Well

Compared with benchmark: Lower | Similar | Higher | Not compared

* a note is attached to the value, hover over to see more details

Export table as image

| Indicator | Period | | England | West Midlands region | Birmingham | Coventry | Dudley | Herefordshire | Sandwell | Shropshire | Solihull | Staffordshire | Stoke-on-Trent | Telford and Wrekin | Walsall | Warwickshire | Wolverhampton | Worcestershire |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Smoking Prevalence in adults - current smokers (IHS) | 2014 | | 18.0 | 16.9 | 18.4 | 15.6 | 19.5 | 14.4 | 20.6 | 15.3 | 12.6 | 13.7 | 18.7 | 20.7 | 18.7 | 15.3 | 20.4 | 17.1 |
| Percentage of physically active and inactive adults - inactive adults | 2014 | | 27.7 | 29.1 | 31.8 | 27.2 | 33.2 | 22.7 | 35.2 | 24.0 | 23.5 | 28.5 | 35.4 | 28.1 | 32.8 | 28.2 | 29.3 | 24.8 |
| Excess Weight in Adults | 2012 | | 63.8 | 65.7 | 64.0 | 56.5 | 70.2 | 66.8 | 66.3 | 62.5 | 63.8 | 67.9 | 66.5 | 70.2 | 68.9 | 64.8 | 69.8 | 65.5 |
| Admission episodes for alcohol-related conditions (Narrow) | 2013/14 | | 645 | 697 | 678 | 810 | 780 | 546 | 751 | 621 | 629 | 703 | 983 | 681 | 730 | 620 | 851 | 598 |
| People receiving an NHS Health Check | 2013/14 Q1 - 2015/16 Q3 | | 25.0 | 27.3* | 36.7 | 33.5 | 26.2 | 25.7 | 19.6 | 22.3 | 28.9 | 23.7 | 33.6 | 21.0 | 41.9 | 20.8 | 18.1 | 28.8 |
| Hypertension: Recorded prevalence (all ages) | 2013/14 | | 13.7 | 14.8 | 12.3 | 13.6 | 17.7 | 16.0 | 15.6 | 15.7 | 15.2 | 15.4 | 16.6 | 13.7 | 15.7 | 14.8 | 15.3 | 15.2 |
| Stroke: Recorded prevalence (all ages) | 2013/14 | | 1.7 | 1.8 | 1.4 | 1.5 | 2.0 | 2.2 | 1.7 | 2.3 | 1.9 | 2.0 | 2.0 | 1.6 | 1.8 | 1.8 | 1.8 | 2.0 |
| Diabetes: Recorded prevalence (aged 17+) | 2013/14 | | 6.2 | 7.1 | 8.1 | 6.2 | 6.8 | 6.3 | 8.3 | 6.1 | 6.8 | 6.7 | 7.3 | 6.5 | 8.6 | 6.0 | 7.9 | 6.7 |
| CHD: Recorded prevalence (all ages) | 2013/14 | | 3.3 | 3.4 | 2.9 | 2.6 | 4.1 | 3.5 | 3.6 | 3.8 | 3.5 | 3.8 | 3.9 | 3.1 | 4.0 | 3.1 | 3.6 | 3.5 |
| Depression: Recorded prevalence (aged 18+) | 2013/14 | | 6.5 | 6.7* | 6.0 | 6.5 | 6.3 | 6.0 | 6.2 | 6.8 | 6.2 | 6.7 | 9.0 | 9.6 | 7.0 | 5.7 | 7.1 | 8.1 |

Telford and Wrekin has a mix of indicators that are either better or worse than the national figures. The strategy needs to ensure there is a focus on areas where we are poorly performing these include:-

- Smoking prevalence
- Obesity in adults
- The number of people receiving NHS health checks
- Management of diabetes
- Support for people who are depressed

### 4.3.3 Living Well

Compared with benchmark: Lower | Similar | Higher | Not compared

* a note is attached to the value, hover over to see more details

Export table as image

| Indicator | Period | | England | West Midlands region | Birmingham | Coventry | Dudley | Herefordshire | Sandwell | Shropshire | Solihull | Staffordshire | Stoke-on-Trent | Telford and Wrekin | Walsall | Warwickshire | Wolverhampton | Worcestershire |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social Isolation: % of adult carers who have as much social contact as they would like | 2014/15 | | 38.5 | 38.4 | 27.4 | 38.4 | 40.5 | 33.4 | 45.7 | 46.1 | 36.8 | 41.6 | 48.0 | 34.5 | 33.7 | 40.8 | 32.1 | 33.8 |

Telford and Wrekin has a lower % of adult carers who have as much social contact as they would like so a key area for community development

### 4.3.4 Supporting well

*Compared with benchmark:* Lower | Similar | Higher | Not compared

* a note is attached to the value, hover over to see more details

Export table as image

| Indicator | Period | England | West Midlands region | Birmingham | Coventry | Dudley | Herefordshire | Sandwell | Shropshire | Solihull | Staffordshire | Stoke-on-Trent | Telford and Wrekin | Walsall | Warwickshire | Wolverhampton | Worcestershire |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dementia: Ratio of inpatient service use to recorded diagnoses | 2013/14 | 65.1 | 72.7 | 78.9 | 79.5 | 75.3 | 57.9 | 75.7 | 53.7 | 71.9 | 80.9 | 61.7 | 63.6 | 74.8 | 71.7 | 76.5 | 68.3 |
| Dementia: DSR of emergency admissions (aged 20+) | 2013/14 | 779 | 832 | 996 | 1188 | 854 | 406 | 1136 | 543 | 865 | 798 | 1044 | 709 | 887 | 805 | 918 | 610 |
| Dementia: DSR of emergency admissions (aged 65+) | 2013/14 | 3046 | 3233 | 3822 | 4587 | 3298 | 1579 | 4366 | 2134 | 3401 | 3117 | 4114 | 2788 | 3465 | 3186 | 3574 | 2372 |
| Dementia: Short stay emergency admissions (aged 20+) | 2013/14 | 25.5 | 24.5 | 23.3 | 26.1 | 31.5 | 17.9 | 27.8 | 20.9 | 34.3 | 24.6 | 29.5 | 16.7 | 16.1 | 23.9 | 18.1 | 24.9 |
| Dementia: Short stay emergency admissions (aged 65+) | 2013/14 | 25.4 | 24.4 | 22.7 | 25.9 | 31.7 | 17.8 | 27.6 | 20.7 | 34.5 | 24.6 | 29.7 | 17.0 | 16.1 | 23.9 | 17.7 | 25.1 |
| Alzheimer's disease: DSR of inpatient admissions (aged 20+) | 2013/14 | 146.2 | 125.0 | 147.2 | 187.0 | 69.5 | 61.0 | 138.0 | 132.0 | 97.4 | 109.2 | 220.8 | 187.5 | 134.8 | 143.6 | 98.7 | 89.3 |
| Alzheimer's disease: DSR of inpatient admissions (aged 65+) | 2013/14 | 574.5 | 490.0 | 574.5 | 727.8 | 269.5 | 245.5 | 528.6 | 516.2 | 381.7 | 426.9 | 877.3 | 741.6 | 531.8 | 573.4 | 380.8 | 348.1 |
| Vascular dementia: DSR of inpatient admissions (aged 20+) | 2013/14 | 127.5 | 149.7 | 219.6 | 91.0 | 167.6 | 95.5 | 192.7 | 101.0 | 188.8 | 141.2 | 135.2 | 95.8 | 157.0 | 110.7 | 203.6 | 130.0 |
| Vascular dementia: DSR of inpatient admissions (aged 65+) | 2013/14 | 505.2 | 592.7 | 865.0 | 353.9 | 666.4 | 377.2 | 767.6 | 400.4 | 754.9 | 559.6 | 532.8 | 369.5 | 619.5 | 442.5 | 812.4 | 516.5 |
| Unspecified dementia: DSR of inpatient admissions (aged 20+) | 2013/14 | 336.1 | 357.7 | 397.2 | 432.9 | 357.5 | 202.6 | 411.5 | 271.4 | 341.1 | 382.1 | 480.3 | 318.6 | 365.3 | 364.7 | 392.6 | 280.3 |
| Unspecified dementia: DSR of inpatient admissions (aged 65+) | 2013/14 | 1327.3 | 1412.3 | 1560.9 | 1705.4 | 1415.4 | 789.2 | 1621.1 | 1081.6 | 1340.5 | 1513.2 | 1903.9 | 1266.0 | 1435.6 | 1448.1 | 1545.2 | 1104.7 |

Another mixture of good and not so good indicators for Telford and Wrekin. The action plan needs to focus on the following:

- Data for people living with dmentia who are admitted into an acute hospital- this needs reveiwing as we are higher for Alzhermeirs admsions but lower for vascular dementia.

4.3.5 Dying Well

Compared with benchmark: Lower | Similar | Higher | Not compared

* a note is attached to the value, hover over to see more details

Export table as image

| Indicator | Period | England | West Midlands region | Birmingham | Coventry | Dudley | Herefordshire | Sandwell | Shropshire | Solihull | Staffordshire | Stoke-on-Trent | Telford and Wrekin | Walsall | Warwickshire | Wolverhampton | Worcestershire |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Directly Age-Standardised Rate of Mortality: People with dementia aged 20+ | 2013 | 187.2 | 194.6 | 193.7 | 188.8 | 190.1 | 154.9 | 237.3 | 177.0 | 167.4 | 210.6 | 220.2 | 194.1 | 176.6 | 183.6 | 235.9 | 190.6 |
| Directly Age Standardised Rate of Mortality: People with dementia aged 65+ | 2013 | 746 | 776 | 774 | 756 | 758 | 619 | 946 | 703 | 662 | 839 | 877 | 775 | 702 | 730 | 942 | 761 |
| Deaths in Usual Place of Residence: People with dementia aged 65+ | 2013 | 66.6 | 62.5 | 56.2 | 64.3 | 64.9 | 70.5 | 54.5 | 74.1 | 58.2 | 63.0 | 62.0 | 68.9 | 51.6 | 63.6 | 49.9 | 72.9 |
| Place of death - care home: People with dementia aged 65+ | 2013 | 58.6 | 54.4 | 46.8 | 56.6 | 58.0 | 62.2 | 43.2 | 67.4 | 48.5 | 56.3 | 56.3 | 59.9 | 40.2 | 55.3 | 42.4 | 65.6 |
| Place of death - hospital: People with dementia aged 65+ | 2013 | 32.6 | 37.3 | 43.8 | 36.0 | 34.9 | 29.6 | 44.9 | 24.1 | 41.4 | 37.3 | 36.5 | 30.8 | 47.7 | 36.7 | 50.5 | 26.9 |
| Place of death - home: People with dementia aged 65+ | 2013 | 7.4 | 7.3 | 8.4 | 7.1 | 6.4 | 7.5 | 10.4 | 6.2 | 8.8 | 5.6 | 4.8 | 8.1 | 10.6 | 7.6 | 6.9 | 6.6 |

Telford and Wrekin benchmarks similar to England across all indicators

## 4.4 Governance

Oversight of the action plans and services to support PLWD is undertaken across Shropshire and Telford and Wrekin by the health economy dementia steering group (HEDSG). This is a group of stakeholders including PLWD. It brings providers together and is a forum for sharing information about services to support PLWD and their carers.

## 4.5 What does this mean for the strategy?

- Need to focus on increasing the numbers of patients diagnosed to ensure they get early treatment and support
- We need to focus on the lifestyle issues of smoking and obesity to reduce the risk for future generations and to increase NHS Health checks
- We need to facilitate the building supportive communities that support carers and PLWD, so they feel more included and have the social contact they would wish.
- We need to ensure we understand the data for hospital admission for other health related conditions in the acute general hospitals.

NHS
Telford and Wrekin
Clinical Commissioning Group

Telford & Wrekin COUNCIL

## SECTION 5- REVIEW OF DEMENTIA SERVICES -Engagement

### 5.1 Introduction

This section describes the work undertaken at both national and local level to understand the messages form PLWD and their cares. In addition it describes the engagement with local clinicians and their views of the services we have and the services we should provide.

### 5.2 National

#### 5.2.1 Outcomes – Dementia Action Alliance

In 2010, Alzheimer's Society worked with partner organisations to launch a National Dementia Declaration for England. This was developed by the Dementia Action Alliance (DAA), which brings together different organisations in England interested in delivering change. In the Declaration, people with dementia and carers described seven outcomes that are most important to their quality of life, many of which echo common themes from other research.

- I have personal choice and control over the decisions that affect me.
- I know that services are designed around me, my needs and my carer's needs.
- I have support that helps me live my life.
- I have the knowledge to get what I need.
- I live in an enabling and supportive environment where I feel valued and understood.
- I have a sense of belonging and of being a valued part of family, community and civic life.
- I am confident in my end of life wishes will be respected. I can expect a good death.
- I know that there is research going on which will deliver a better life for people with dementia, and I know how I can contribute to it.

### 5.3 Local process for engagement.

Local support groups where both PLWD and their cares have been attended. In addition one individual living with dementia also provided a view on the support and services available in the locality.

#### 5.3.1 Feedback with service users and carers

Themes from the local engagement were:-

- **Waiting times** - Took years to get diagnosis- 2-3 years for some people. Some waited for assessment appointment when were staff off sick. Waiting list for admiral nurses
- **Quality of services-** 6 monthly reviews just repeat of tests to see how deteriorated no other support. Some PLWD were assessed and reassessed- got use to the questions and could answer them easily. No support for a PLWD who wasn't sleeping- just brushed off. Other behaviour problems not really helped by Memory service- these were experienced carers and had tried most techniques needed more help/advice
- **Equity of services-**Service patchy- seems to depend on the clinicians involved in memory service. Luck of the draw what service you get
- **Post diagnosis support-**Some groups for carers can't take PLWD- need someone to sit or take them with them. Some PLWD wont accept anyone coming into their home-why cant they attend these groups. Nothing for a previous active man who doesn't like painting poetry etc. Still some discrimination re dementia- some local groups don't want PLD in their groups as they are too distributive

### 5.3.2 Feedback from Clinicians

GPs discussed dementia and the support services at the GP forum. They also felt there were problems with diagnosis especially for those with early stages of dementia or with Mild Cognitive Impairment. They felt that more support in the patient's own home earlier would be helpful with pre assessment being undertaken in the home. They wanted clear pathways with responsibilities for tests and diagnosis in place and structured post diagnosis support. They felt there need to be improved communications with services and the GP as the GP has to manage other clinical conditions of the patient. GPS wanted seamless support for patients particular in a crisis including out of hours support. Feedback regarding the Admiral Nurse Service was again positive with requests to increase the service.

### 5.4 Key items for the strategy

- Develop a clear referral pathway into the memory service with waiting time targets
- Develop an Mild Cognitive Impairment pathway
- Ensure crisis services are available across service providers
- Develop an equitable service for all people living with dementia that supports them when required
- Develop a model of dementia care that supports the above.
- Consider the range of support services in place to ensure both the PLWD and the carer is supported at the same time.

## SECTION 6- REVIEW OF DEMENTIA SERVICES -The evidence base

### 6.1 Introduction

This paper describes an overview of national documents that are available to support the development of a local strategy and relevant quality standards that need to be considered.

### 6.2 Prime Minsters challenge 2012

In 2012 the PMs Challenge was published. It focused on three key areas:-

- Driving improvements in health and care
- Creating dementia friendly communities that understand how to help
- Better research

This challenge has recently been updated. It sets out what this government wants to see in place by 2020 in order for England to be:

- The best country in the world for dementia care and support and for people with dementia, their carers and families to live
- The best place in the world to undertake research into dementia and other neurodegenerative diseases

It focuses on developing dementia friendly communities; providing early diagnosis; supporting people with information and choices; ensuring staff have an understandings of dementia and the needs of those living with dementia, and developing more research opportunities.

### 6.3 Five year forward view (2014)

There are three main themes in the 5 year forward plan- an ambition to improve quality; a greater focus on prevention and engaging communities. The focus on prevention includes the prevention of both physical and mental health problems. It also includes the promotion of employment which may affect those people with early onset dementia.

In addition the Five year Forward plan promotes engaging communities by increasing partnerships with charitable and third sector and by increasing and supporting volunteering. The Council and NHS locally need to ensure they are exemplar employers in promoting good mental health with their staff.

### 6.4 Dementia 2014: Opportunity for change- September 2014

People with dementia are frequent users of health and social care services. A quarter of hospital beds (Alzheimer's Society, 2009) and up to 70% of places in care homes are occupied by people with dementia (Alzheimer's Society, 2014a), and over 60% of people receiving homecare services have dementia (UKHCA, 2013). Unprecedented cuts to the care system and unco-ordinated reforms are leaving many people without access to the vital support they need to live well. Demand for services is increasing, as spend on social care in parts of the UK decreases (ADASS, 2014).

People with dementia and family carers can live well if they have access to good quality, integrated care that is affordable, and if they live in a housing environment that meets their needs. The rising cost of dementia to society can be attributed to the failure of our current health and social care services to appropriately deliver these requirements. Our survey found that fewer than one in five people thought they received enough support from the government. The gap is being filled by unpaid carers who are keeping the system afloat (Alzheimer's Society, 2014a). Action point's from the document are:-

**Action 1**: All statutory health and/or social care bodies in England, Wales and Northern Ireland to set targets for stepped yearly improvement in diagnosis rates up to 75% by 2017
**Action 2**: Twelve weeks from referral to diagnosis
**Action 3**: Establish a minimum standard of integrated post-diagnosis support for people with dementia and carers
**Action 4**: Governments to build on progress and commit to appropriately resourced national strategies in England, Wales and Northern Ireland
**Action 5:** An open debate with citizens on the funding of quality health and social care that meets the needs of people affected by dementia
**Action 6**: A fully integrated health and social care system that puts the needs of people first
**Action 7**: People with dementia and their carers must be involved in the commissioning, design and development of services
**Action 8**: High-quality mandatory training for all staff providing formal care to people with dementia
**Action 9:** All communities to become more dementia friendly
**Action 10**: Everyone should have improved awareness of dementia
**Action 11**: All businesses and organisations to take steps towards becoming dementia friendly
**Action 12**: Dementia research should receive a level of investment that matches the economic and human cost of the condition
**Action 13**: All people with dementia and carers should have access to the best evidence-based care and research
**Action 14**: People affected by dementia and their carers should be given greater opportunity to participate in dementia research

### 6.5 NICE guidance

NICE produces pathways, guidelines and quality standards to support the commissioning of dementia services. These are based on evidence and should be the basis for services specification development and delivery. Pathways include dementia diagnosis and assessment and treatment interventions.

NICE -Quality statements for people living with dementia

- Statement 1. People worried about possible dementia in themselves or someone they know can discuss their concerns, and the options of seeking a diagnosis, with someone with knowledge and expertise.
- Statement 2. People with dementia, with the involvement of their carers, have choice and control in decisions affecting their care and support.
- Statement 3. People with dementia participate, with the involvement of their carers, in a review of their needs and preferences when their circumstances change
- Statement 4. People with dementia are enabled, with the involvement of their carers, to take part in leisure activities during their day based on individual interest and choice.
- Statement 5. People with dementia are enabled, with the involvement of their carers, to maintain and develop relationships.
- Statement 6. People with dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing.
- Statement 7. People with dementia live in housing that meets their specific needs.
- Statement 8. People with dementia have opportunities, with the involvement of their carers, to participate in and influence the design, planning, evaluation and delivery of services.

- Statement 9. People with dementia are enabled, with the involvement of their carers, to access independent advocacy services.
- Statement 10. People with dementia are enabled, with the involvement of their carers, to maintain and develop their involvement in and contribution to their community.
- Other quality standards that should also be considered when commissioning and providing a high-quality service are listed in Related NICE quality standards.

### 6.6 Other documents

Over the past few years several documents and initiatives have highlighted the importance of the service users experience and the need to focus on improving these experiences where possible.

- Lord Darzi's report 'High quality care for all' (2008) highlighted the importance of the entire service user experience within the NHS, ensuring people are treated with compassion, dignity and respect within a clean, safe and well-managed environment.
- The NHS Constitution (2013) describes the purpose, principles and values of the NHS and illustrates what staff, service users and the public can expect from the service. Since the Health Act came into force in January 2010, service providers and commissioners of NHS care have had a legal obligation to take the Constitution into account in all their decisions and actions.
- The King's Fund charitable foundation has developed a comprehensive policy resource – 'Seeing the person in the patient: the point of care review paper' (2008).

### 6.7 What does this mean for the strategy?

- People living with dementia and their carers need to be involved at every stage of the development of the strategy and the services that are commissioned
- The prevention agenda must be considered within the action plan
- High quality training needs to be in place for all staff
- Communities need to be strengthen to support PLWD and their carers
- Services commissioned need to deliver quality standards.

## SECTION 7- REVIEW OF DEMENTIA SERVICES -Demographic profile

### 7.1 Introduction

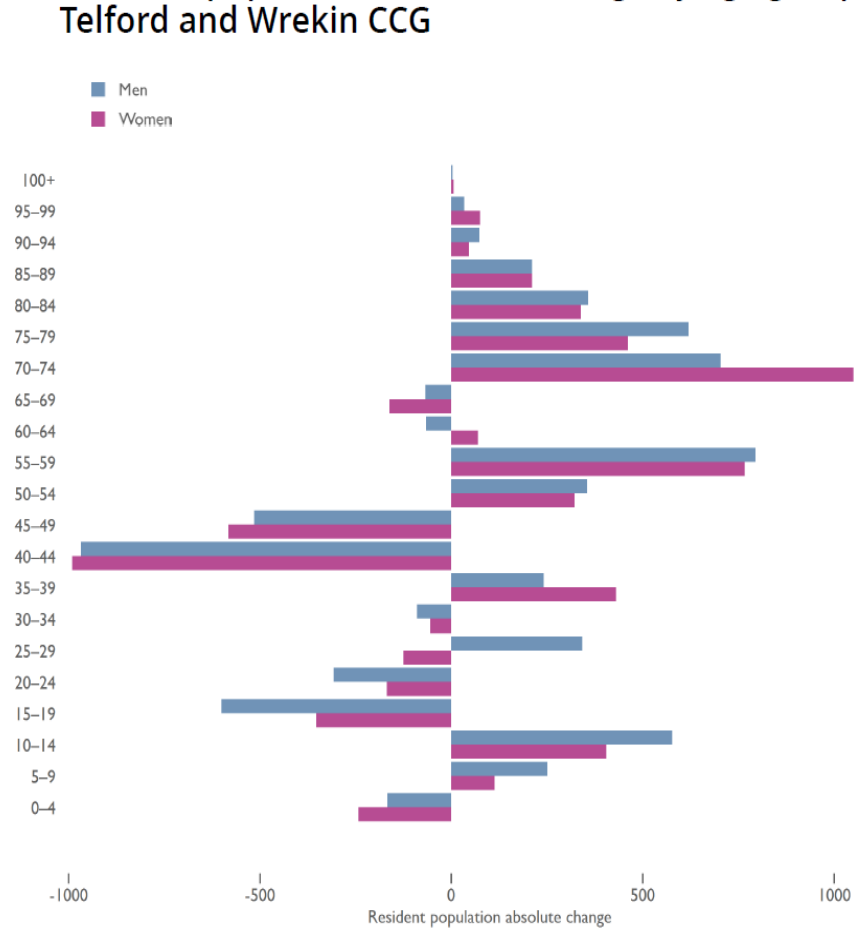
This paper describes a summary of the local demographic data for Telford and Wrekin. In addition it describes the different populations the two organisations commission.

### 7.2 Commissioning populations

This is joint strategy but the two organisations commission services on a different footprint. The local authority commission's services for people who live in the borough whilst the CCG commissions services for people registered with a GP in the organisation. The population of the borough is 166,641 whilst for the CCG it is 178,412.

### 7.3 General data

The 2011 Census population of Telford and Wrekin was recorded as 166,641 an increase of 5.2% from 2001. This strategy focuses on the adult population which in 2014 was approximately 136,000.
The age profile in Telford & Wrekin is changing, with the older age groups increasing most rapidly.




**Sources:**

Ons.gov.uk, (2015). Annual Small Area Population Estimates, 2013 - ONS. [online] Available at: http://www.ons.gov.uk/ons/rel/sape/small-area-population-estimates/mid-2013/mid-2013-small-area-population-estimates-statistical-bulletin.html#tab-Clinical-Commissioning-Group-Population-Estimates [Accessed 3 Sep. 2015].

Ons.gov.uk, (2015). 2012-based Subnational Population Projections for England - ONS. [online] Available at: http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html [Accessed 3 Sep. 2015].

### 7.4 Demographics for older people compared to England

| Population | Telford and Wrekin | England | What does this mean for us? |
|---|---|---|---|
| Over 65 year olds | 14.5% to total population | 16.4% | 7,113 are living alone. We have less older people in our community than England but this will increase |
| Households where all residents are over 65 | 18.5% | 20.7% | Lower than England average |
| Income deprived households over 60 years | 21.7% | 18.1% | As above |
| Estimated Future Population changes from 2011 | | | |
| 65-79 year olds | +19% | 2016 | This will increase the numbers of PLWD |
| 0ver 80 year olds | +32% | 2016 | As above |
| 18-64 year olds | +5% | 2020 | Smaller growth in adult population to support older people |
| Ethnicity | | | |
| BME | 10.5% | 20.2% | Much lower than England figure but rising and may rise more quickly with increases in asylum seekers. |
| Reported health | | | |
| Reporting bad health age over 65 years ( self reported) | 18.1% | 15.3% | 4,400 over 65 year olds say their health is bad or very bad- whilst we have lower numbers they are reporting more bad health- need to consider the impact of dementia and caring |
| Life expectancy Females | 81.7 years | 82.8 years | |
| Life expectancy males | 77.7 years | 78.9 years | |

This indicates that whilst we have lower numbers of older people in Telford and Wrekin as a % of the total population we have a greater number living in income deprived households and more reporting to be in bad health. These issues need to be considered as it is likely to make it more difficult for the PLWD and their carers to cope with the impact of the disease.

**Dementia Profile Data**

**3.10 People with Dementia (Estimated Prevalence)**

**Table 11: Estimated number of people with dementia**

| Locality | Area | Under 65 (early onset dementia) | 65-74 | 75-84 | 85+ |
|---|---|---|---|---|---|
| | | | | | |
| Hadley Castle | Donnington | - | 25 | 75 | 75 |
| | Hadley | - | 25 | 25 | 25 |
| | Newport | - | 50 | 100 | 125 |
| | Oakengates & St Georges | - | 50 | 100 | 100 |
| | **Area Total** | **25** | **125** | **300** | **325** |
| Lakeside South | Brookside | - | - | 25 | 25 |
| | Dawley | - | 25 | 50 | 50 |
| | Sutton Hill | - | 25 | 50 | 50 |
| | Woodside | - | 25 | 25 | 25 |
| | **Area Total** | **-** | **75** | **150** | **150** |
| The Wrekin | Arleston | - | 25 | 75 | 75 |
| | Malinslee | - | 25 | 50 | 25 |
| | Newdale | - | - | - | - |
| | Wellington | - | 50 | 100 | 100 |
| | Area Total | 25 | 100 | 225 | 225 |
| **Telford and Wrekin** | | **50** | **300** | **675** | **700** |

*Source: Prevalence rates have been applied to ONS Mid-year population estimates for age groups, all numbers have been rounded to the nearest 25*

The ONS mid year poulation estimates 1725 peole with dementia in the local authority area. The CCG prevalence figure is calculated with a different methodology ( CFAS 11) and indicates a prevalence of 1668. As the CCG has a national target to meet their figure will be used in the action plan.

**7.5 What does this mean for the strategy?**

- The population of older people is increasing at a greater rate and we need to build resilience and skills into services to ensure they are supported.
- Our population is reporting levels of poor health, so we need to ensure we commission prevention and early intervention services that can support them at the earliest opportunity.
- We also need to consider the impact of caring on carers mental health and stress levels.

**SECTION 8- REVIEW OF DEMENTIA SERVICES -References and Supporting Documentation**

| Document | Area of Impact on Strategy |
|---|---|
| Prime Ministers Challenge 2012 refreshed 2016 | National picture evidence base |
| National survey – The Five Year Forward View | Evidence |
| NICE quality standards | Evidence |
| Health and prevention strategy Telford and Wrekin LA (2015) | Evidence<br>Engagement |
| High quality care for all' (2008) | Evidence |
| NHS Constitution (2013) | Evidence |
| Seeing the person in the patient: the point of care review paper' (2008) | Evidence |
| The King's Fund developed a 'House of Care' | Model for strategy |
| http://toolkit.modem-dementia.org.uk/database/ | Evidence |

# D

**TELFORD & WREKIN COUNCIL HEALTH AND WELLBEING BOARD**

**7th DECEMBER 2016**

**HEALTH AND WELLBEING BOARD PROPOSED PRIORITY WORK STREAMS**

**LIZ NOAKES: ASSISTANT DIRECTOR HEALTH AND WELLBEING**

**PART A) – SUMMARY REPORT**

## 1. SUMMARY OF MAIN PROPOSALS

To present the Board with a proposal to focus its work on three key priority work streams in order to drive delivery against its strategy in areas where progress has not been as significant as anticipated.

## 2. RECOMMENDATIONS

That the Board approve:

- the proposed priority work streams for:

  - Developing community resilience: shaping the public narrative
  - Whole-systems approach to tackling excess weight
  - Collaborative approach to reducing harm caused by the "toxic trio" (domestic abuse, alcohol and drug misuse and mental health)

- The proposed reporting timescales and next steps highlighted at section 1.2 and 1.4

## 2. IMPACT OF ACTION

The proposed priority work streams will enable the Board to proactively drive action and improvements across three cross cutting areas of work where progress is required at pace. These areas have linkages to the wider HWBB priorities, but are not specifically addressed by the current CATP work programmes.

In driving this work, the Board can demonstrate added value and deliver tangible improvement in outcomes against the HWBB priorities.

## 4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="8">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>The priority work streams are relevant to and cut across all of the HWBB priorities as follows:-<br><br>➢ Encouraging Healthier Lifestyles<br><br>➢ Improve Mental Wellbeing and Mental Health<br><br>➢ Strengthen our communities and community based support</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>Contributes to all HWB priorities which link to Council priority objectives of:-<br><br>• put our children and young people first<br>• improve local people’s prospects through education and skills training<br>• protect and support our vulnerable children and adults<br>• improve the health and wellbeing of our communities and address health inequalities</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>The work streams developed to tackle excess weight and develop the public narrative for community resilience will be cross cutting, population-wide approaches.<br><br>However, the toxic trio work stream will impact on the most vulnerable children and adults in the borough.</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">The priority work streams progress will be reported to the Board and will be reviewed as part of this reporting process as outlined at section 1.2.</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>The delivery of this strategy and the detailed work programmes will need to be considered against the context of reducing resources. The Public Health grant allocation for</td></tr>
</table>

| | | |
|---|---|---|
| | | *2016/17 is £12.984m which includes a reduction of £300k with an additional reduction of £320k anticipated in 2017/18. This is on top of a 6.2% in year reduction in 2015/16. Further reductions and changes in this grant are expected in future years.*<br><br>*The budget for Excess Weight funded from Public Health Grant in 2016/17 is £0.613m. As part of the Council's 2017/18 Budget Strategy, savings of £0.046m have been identified. Further savings in 2018/19 and 2019/20, which have yet to be agreed, could impact on the funding for this element of the work stream.*<br><br>*The budget for Substance Misuse funded from Public Health Grant in 2016/17 is £2.528m. As part of the Council's 2017/18 Budget Strategy, savings of £0.070m have been identified. Further savings in 2018/19 and 2019/20, which have yet to be agreed, could impact on the funding for this element of the work stream.* |
| **LEGAL ISSUES** | Yes | *The HWBB has a statutory obligation to encourage integrated working and to encourage commissioners of health-related services to work closely with the HWBB (section 195, Health and Social Care Act 2012). Accordingly, the proposals in this report will assist the HWBB in meeting its legal obligations.*<br>*This continuing commitment to integrated working is also a requirement of the HWBB's terms of reference.* |
| **EQUALITY & DIVERSITY** | No | *None.* |
| **IMPACT ON SPECIFIC WARDS** | No | *None.* |
| **PATIENTS & PUBLIC ENGAGEMENT** | Yes | *Public consultation has already been undertaken in relation to the priorities – this was outlined in previous reports to the Board.* |
| **OTHER IMPACTS, RISKS & OPPORTUNITIES** | No | *None* |

## PART B) – ADDITIONAL INFORMATION

## 1. INFORMATION

### *1.1 Delivery of the Board's strategic priorities*

The Board received a report in June 2016 outlining an approach to delivering the HWBB Strategy and its associated priorities along with a work programme to deliver the strategy.

The HWB Strategy Delivery Group has since met to review the work programme and felt that this reflected work already planned by CATPS to deliver against the HWB priorities but did not necessarily demonstrate the impact of the Board in driving the priorities. Therefore, in order to proactively drive delivery of the strategy and demonstrate the impact the Board is having on delivering outcomes against the strategy, it is recommended that the Board focus' its efforts on areas of work:-

- Not already covered by the CATP work programmes
- Where improvements are not being made at the rate anticipated
- Which are cross cutting and cannot be allocated to one CATP to deliver alone

### *1.2 Priority Work Streams*

It is proposed that the HWBB identify a maximum of three key priority work streams which are key to the delivery of the HWB strategy but are not being addressed by other partnership boards. Priority work streams can be owned by the Board, who can drive and challenge in order to demonstrate added value and improved outcomes as a direct result of the Board's work. The proposed priority work streams are cross cutting therefore the Board can ensure that work is driven, joined-up, and effective across the local health and social care economy.

After reflecting on the current CATP work programmes and considering key performance measures, the Strategy Delivery Group propose the following priority work streams and leads:-

| Priority Work Stream | Link to HWBB Priority | Rationale | Lead | Reporting timescales |
|---|---|---|---|---|
| **Excess Weight** | Encouraging Healthier Lifestyles | Excess weight was a priority in the last HWB strategy – despite significant progress being made, performance in this area is still not where we would want it to be. A whole systems approach is necessary so that all strategic partners and organisations are aware of their role and the action they can take in promoting physical activity, good nutrition, and the benefits of a healthy weight. | Louise Mills | December 2016 Board to scope focus of this work stream. |

| | | | | |
|---|---|---|---|---|
| **Toxic Trio** | Improve Mental Wellbeing and Mental Health<br><br>Encouraging Healthier Lifestyles | The so called “toxic trio” of domestic abuse, drug misuse and alcohol misuse and poor mental health have been identified as a set of common features of families where harm to children has occurred. As such they are viewed as indicators of increased risk for causing potential harm to children and young people.<br><br>There is evidence that the overlap between these parental risk factors and cases of child death, serious injury and generally poorer outcomes for children across all ages.<br><br>More widely there is recognition that these areas are common presenting issues for the most vulnerable and complex residents of all ages in our communities, who create the greatest demands on our services.<br><br>Although we are aware of these issues locally in a strategic sense, we need to examine collaboratively our approach to addressing these issues together, joining up and connecting plans to deliver progress across all priorities. | Helen Onions, Jon Power, Paul Fenn | March 2017 |

| | | | | |
|---|---|---|---|---|
| **Community Resilience: The Public Narrative** | Strengthen our Communities and Community Based Support | Community resilience and building community capacity is a common challenge across all partnerships, as well as being a key priority for the Health and Wellbeing Board. However, work to date has focussed on delivery of services and engaging community/voluntary sector organisations in the planning and delivery of services. Key to making our communities more resilient is the key messages we give to our communities to ensure that they understand how they can help themselves. It is proposed that this becomes a key focus for the Board as this is not being addressed elsewhere but does have links to the Neighbourhoods Group which has been established under the STP and is being led by Richard Partington. | TBC | March 2017 |

### 1.3 *Commissioning and Transformation Partnerships (CATPS)*

The CATPs will continue to deliver against their own work programmes (which are closely aligned to the HWB priorities) and will report as planned to the HWBB on an annual basis – these update reports will highlight progress being made against the HWB priorities as well as the wider work of the group.

Similarly, (and as previously reported), progress against the Mental Health Strategy and action plan will also be reported to the Board on an annual basis.

### 1.4 Next Steps

It is proposed that the lead officers for each priority work stream will meet with relevant officers to scope their work stream and key deliverables and report progress to the Board in March 2017.

## 2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

No further impacts.

## 3. PREVIOUS MINUTES

- HWB Strategy Development and JSNA presented on 23rd January 2013
- HWB Strategy Development and JSNA (including sign off of final strategy) presented on 13th March 2013
- A progress update against the Health & Wellbeing Strategy priority 'asset mapping' process was presented to the Board on 13th May 2013.
- Joint Health and Wellbeing Strategy Performance and Partnership Framework presented on 17th July 2013 and 18th September 2013
- Joint Health and Wellbeing Board Strategy Performance presented 22nd January 2014
- Health and Wellbeing Board Strategy Refresh presented 10th June 2015
- Health and Wellbeing Board Strategy Update presented 9th December 2015
- Health and Wellbeing Strategy Update presented 9th March 2016
- Delivery of the health and Wellbeing Strategy 15th June 2016

## 4. BACKGROUND PAPERS

**Report prepared by Jo Winborn (Partnership & Planning Officer) and Helen Onions (Consultant in Public Health), Telephone: 01952 380672/ (01952) 381028.**

**E**

**TELFORD & WREKIN COUNCIL HEALTH AND WELLBEING BOARD**

**DATE: 7th DECEMBER 2016**

**EARLY HELP UPDATE REPORT**

**REPORT OF: LIZ NOAKES, ASSISTANT DIRECTOR: HEALTH & WELLBEING**

## PART A) – SUMMARY REPORT

### 1. SUMMARY OF MAIN PROPOSALS

This report summarises progress towards implementing the Early Help Strategy and priorities.

The Early Help Strategy sets out the programme of work that will be undertaken locally by the partnership (overseen by the Early Help Partnership Board) to provide early help to children and their families. The current strategy is due to be refreshed and updated to reflect the new priorities and to articulate the steps the Early Help Partnership Board will take with partners to support the development of other public sector universal services, the voluntary sector and communities to deliver early help and preventative services.

Performance against outcomes is routinely monitored by the Early Help Partnership Board. Current performance at month 6 is summarised in the main report.

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

The Health & Wellbeing Board is requested to acknowledge:

- The progress made by Early Help Partnership organisations towards improving outcomes for children and families
- The Early Help Strategy will be updated to reflect the new priorities of the board

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

Implementation of the Early Help Strategy and action plan will deliver improvements in the following outcomes:

- Improve the health and wellbeing of children, young people, families and carers
- Improve the educational attainment of children and young people
- Improve the emotional health and wellbeing of children, young people, families & carers
- Improve the prospects of children and young people in Telford & Wrekin
- Improve the engagement of children, young people, families and carers in services

## 4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>• Encourage healthier lifestyles<br>• Improve mental wellbeing<br>• Strengthen our communities and community based support</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>• Put our children and young people first<br>• Protect and support vulnerable children and young people<br>• Improve local people's prospects through education and skills training<br>• Improve the health and wellbeing of our communities and address health inequalities</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>Children and young people</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">N/A Work programme is ongoing</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>The work identified in this report is funded from various sources including the Council, NHS England/CCG and the Big Lottery Fund.<br>The Council holds a budget for Early Help funded from Public Health Grant in 2016/17 of £0.828m from which the delivery of this strategy and some of the detailed work programmes will be funded. As part of the Council’s 2017/18 Budget Strategy, savings of £0.03m have been identified against this budget as a result of a reduction in the expected Public Health grant. Further savings in 2018/19 and 2019/20, which have yet to be agreed, could impact on the funding for this element of the work stream.<br><br>The CCG has passported £99k of funding to the Council to support the delivery of the Telford & Wrekin Future in Mind Programme and other training initiatives as well as directly funding work at TCAT and other transformational activities.</td></tr>
</table>

| | | |
|---|---|---|
| | | Work is ongoing to establish the sustainability of some of these initiatives. The Big Lottery is fully funding the Parenting project through the national organisation HENRY with the Council providing a contribution in kind through the management of the programme co-ordinator. |
| **LEGAL ISSUES** | Yes | The work of the Early Help Partnership assists the council in meeting its public health obligations required by statutory provision such as those contained section 2B of the National Health Act 2006 (as amended).<br>This also includes specific services which the Secretary of State has arranged for local authorities to exercise under powers set out in section 7A of the National Health Services Act 2006 (as amended) such as health visiting. |
| **EQUALITY & DIVERSITY** | No | |
| **IMPACT ON SPECIFIC WARDS** | Yes | Borough-wide impact<br>Targeted activity within the localities |
| **PATIENTS & PUBLIC ENGAGEMENT** | Yes | Comprehensive engagement activities have taken place to commission the new emotional health and wellbeing service. This has included the consideration of local insights, over 100 interviews with people with lived experience and comparison of local to national insights. This has been evaluated and informed the service specification.<br><br>The joint Health overview and scrutiny committee signed off the engagement and communication strategy and have supported the work to date.<br><br>Parents, carers and young people have supported the procurement process<br><br>A significant programme of engagement is also underway to consider future provision for Family Nurse Partnership, Health Visiting and School Nursing Services |
| **OTHER IMPACTS, RISKS & OPPORTUNITIES** | No | |

## PART B) – ADDITIONAL INFORMATION

## 1. INFORMATION

## PROGRESS TOWARDS ACHIEVING OUR PRIORITIES

During the last 6 months significant progress has been made towards commissioning the new Emotional Health and Wellbeing Service for children and young people. The project team have undertaken comprehensive engagement activities. This has included the consideration of local insights, over 100 interviews with people with lived experience and comparison of local to national insights. This has been evaluated and informed the service specification. The joint Health overview and scrutiny committee signed off the engagement and communication strategy and have supported the work to date. A communication for partners on progress will be available in January 2017 inline with the procurement timescales and the formal decision making process.

Funding has been secured from NHS England to develop the Telford and Wrekin Future in Mind (Tackling Wellbeing) Programme - a school led multi-agency programme of training and development for emotional health and wellbeing. The programme launch was attended by 90 lead professionals from education, health and local authority services. Going forward, lead professionals will attend regular training and development opportunities and will be responsible for cascading the training within their own setting. The programme of work has been highlighted by NHS England for its innovation for engaging with the education sector. The programme will support professionals to:

- promote good mental wellbeing and resilience, by supporting children and young people and their families to adopt and maintain behaviours that support good mental health.
- take early action to prevent mental health problems from arising with those children, young people and their families who may be at greater risk.
- Swiftly identify when a child, young person or their family need help.
- Understand and own the value of inter-agency working and the benefits this brings to the child, family and society.

The programme is due to be extended early next year to include additional partners including GP's and the voluntary sector.

Additional resources have been secured from the Transformation funding to appoint a mental health practitioner to work across TCAT and New College, co-ordinating existing arrangements, up-skilling staff and ensuring available support is fit for purpose to align with the new Emotional health and wellbeing service due to launch in May 2017. This will include:

- Delivery of one to one and group interventions.
- Provide consultancy to the Learner Support Workforce.
- Focus on preparing young people for transition into life beyond college
- Liaison with Secondary schools for transition of students to college

The March update identified a number of service developments required to respond to the unmet needs of parents. Progress includes production of an on-line Parenting Handbook (developed by key partners and parents) and commissioning of a voluntary led parental befriending service which since contract award in October 2015 has provided support over the short term (up to 12 weeks) to 60 families. All families completing programmes have obtained higher levels of self-confidence, as measured through pre and post confidence assessments.

In response to providing additional support for parents of 0-2's, 23 health professionals across health visiting and midwifery and 2 Homestart volunteers have been trained to facilitate Antenatal Solihull, a 5 week 'Journey to Parenthood': Understanding pregnancy, labour, birth and your baby. The training has been resourced from CAMHS Transformation Funding. Courses will be delivered from January in community settings.

During July, the partnership received notification of a successful Big Lottery Fund bid to further develop the HENRY Parenting Project. Telford and Wrekin Council are one of three partners to work with the national organisation HENRY over the next 4 years (partnering with Leeds and Sheffield). The project is expected to provide training to 140 volunteers and has a target to retain 48 as active volunteers. It is expected that 260 families will receive support through the project. A Coordinator has now been appointed and over the next four years will recruit and train volunteers to deliver the HENRY Programme on a 1:1 basis with families in their own homes or community settings. HENRY is not a new approach to Telford and Wrekin – we have a long history of delivering the programme locally but in group settings. The first volunteer cohort has been trained and will provide support to families from January.

A particular success has been the work undertaken by the Health Visitors working with Children Centre teams and Early Years Consultants to better coordinate the 2 year progress review (Review@2). Although only small numbers of children participated in the pilot the workforce has seen the added value from attending joint training, working in a different way and improved data sharing. Plans are in place to embed the Review@2 into all early years settings over the next academic year, (by July 2017). All childminders will be supported via the Health Visitor helpline and settings are systematically being allocated their link Health Visitor and support to implement the Review@2. This will ensure consistency across Telford & Wrekin.

Developing and delivering effective early help universal services which prevent problems from arising in the first place is a priority for the Early Help Partnership Board. In the future a greater emphasis will be placed on supporting other public sector universal services, the voluntary sector and communities to deliver these services.

The restructuring of the newly designed Early Help and Support Service is underway within the local authority. The vision is that it becomes an all age service working alongside other partners and community members completely immersed in communities supporting adults, children and families. The primary purpose of the service will be to reduce demand on statutory higher tier more expensive services such as social care by targeting support to our most complex families whilst strengthening early help prevention working arrangements to ensure individuals are supported to get the "Right Help at the Right Time" to live active healthy independent lifestyles by utilising their own networks and community assets.

Working relationships with NHS England, the clinical commissioning group, public health, education services and voluntary, community and faith groups and town and parish councils are key.

Current contractual arrangements for the provision of Family Nurse Partnership, Health Visiting and School Nursing Services are due to end on the 31st August 2017. A programme of consultation and engagement activities are underway, led by public health as the lead commissioner. Included within this programme of work are discussions with the voluntary sector to better understand their contribution to delivering the Healthy Child Programme, Children Centre core purpose and activity to support children to be 'school ready'. Findings will inform commissioning intentions which will include activity and investment to build community capacity to deliver universal, preventative services. A number of early years settings, schools and voluntary sector organisations are working in partnership with the council to manage and deliver Children Centre activity as part of new arrangements going forward.

Performance against outcomes is routinely monitored by the Early Help Partnership Board. Commentary below has only been provided for indicators where there has been notable changes since the last report received by the board.

***Improve the health and wellbeing of children, young people, families and carers:***

Data for Q1 2016/17 shows an increase in the proportion of mothers smoking at the time of delivery (22.1%, compared to 18.1% in 2015/16)

Data to June 2016 shows an improvement in our teenage conceptions rate, with performance currently meeting the 2016/17 target (27.0 against a target of 30.2)

***Improve the attainment of children and young people:***

For Early Years Foundation Stage attainment levels have improved - the percentage of children achieving a good level of development is 69.1% (compared to 66.6% in 2015). This is higher than the West Midlands average (67.1%) and similar to the England average (69.3%)

**Improve the emotional health and wellbeing of children, young people and carers**

Latest data on the rate of hospital admissions as a result of self harm (10-24 year olds) shows a decrease (478.3 compared to 569.9)

The rate of hospital admissions for mental health conditions in 0-17 year olds is increasing from 43.6 at the end of 2014/15 to the current rate of 66.6

**Improve the engagement of children, young people, families and carers**

Figures for the first 6 months of 2016/17 show a continued increase in the

number of parents, carers and young people contacting Family Connect directly to request support (5,009 for the first 6 months of this year, compared to 8,179 for 2015/16)

## 2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

No further information

## 3. PREVIOUS MINUTES

## 4. BACKGROUND PAPERS

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