Health and Wellbeing Board

7 May 2014

Time 12.30 pm **Public Meeting?** YES **Type of meeting** Executive

Venue Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence**

2 **Notification of substitute members**

3 **Declarations of interest**

4 **Minutes of the previous meeting** (Pages 1 - 6)
[To approve the minutes of the previous meeting as a correct record]

5 **Matters arising**

6 **Summary of outstanding matters** (Pages 7 - 10)
[To consider and comment on the summary of outstanding matters]

7 **Health and Wellbeing Board Forward Plan 2014/15** (Pages 11 - 14)
[To consider and comment on the items listed on the Forward Plan]

8 **Wider Determinants of Health** (Pages 15 - 26)
[To consider the key work strands, the latest inequalities position, progress to date and to explore the challenges experienced to date]

9 **Joint Strategic Needs Assessment (JSNA) for 2014/15** (Pages 27 - 30)
[To seek approval on the recommended priorities for updating the JSNA in 2014/15]

10 **Health and Social Care Strategic Overview Group to inform local intelligence** (Pages 31 - 36)
[To consider the Terms of Reference and governance arrangements for the Group]

11 **Better Care Fund - Finalised Submission** (Pages 37 - 78)
[To receive, for information, the finalised submission, supporting documentation and templates]

12 **Feedback from Sub-Groups** (Pages 79 - 86)
[To receive feedback from the following Sub Groups]

Children's Trust Board
Children's Delivery Board
Public Health Board

13 **Exclusion of press and public**

[To pass the following resolution:

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following items of business as they involve the likely disclosure of exempt information on the grounds shown below.]

PART 2 - EXEMPT ITEMS, CLOSED TO THE PRESS AND PUBLIC

14 **Capital Programme Projects - NHS England**

[To receive details of the latest position]

Information relating to the financial or business affairs of any particular person (including the authority holding that information) Para (3)

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Health and Wellbeing Board
Minutes – 31 March 2014

Attendance

Members:
Cllr Sandra Samuels (Chair) – Cabinet Member for Health and Wellbeing
Maxine Bygrave – Chair, Wolverhampton Healthwatch
Cllr Steve Evans – Cabinet Member for Adult Services
Cllr Val Gibson – Cabinet Member for Children and Families
Ranjit Khutan – Wolverhampton University (substitute for Professor L Lang)
Chief Superintendent Simon Hyde – West Midlands Police
Cllr Paul Singh – Shadow Cabinet Member for Health and Wellbeing
Ros Jervis – Director of Public Health, Community Directorate

Staff:

Glenda Augustine	Consultant in Public Health, Community Directorate
Jill Canning	Programme Manager, Royal Wolverhampton NHS Trust
Helen Carter	Consultant in Public Health, Public Health England
Noreen Dowd	Interim Chief Operating Officer, Wolverhampton CCG
David Elliott	Service Lead for Health and Wellbeing, Public Health England
Viv Griffin	Assistant Director, Health, Wellbeing & Disability, Community Directorate
Helena Kucharczyk	Acting Business Intelligence Manager, Community Directorate
Michael Murphy	Interim assistant Director, Older People and Personalisation, Community Directorate
Dr Kiran Patel	Medical Director, Local Area Team, NHS England
Richard Young	Director of Strategy and Solutions, Wolverhampton CCG
Les Williams	Operations & Delivery Director, Local Area Team, NHS England
Carl Craney	Democratic Support Officer, Delivery Directorate

Part 1 – items open to the press and public

Item No. *Title*

1. **Apologies for Absence**

Apologies for absence had been received from Dr Helen Hibbs (Chief Officer, NHS Wolverhampton), Christine Irvine (Wolverhampton Voluntary Sector Partnership), Professor Linda Lang (Wolverhampton University) and Tim Johnson (Strategic Director for Education and Enterprise).

2. **Notification of Substitute Members**

Ranjit Khutan attended as a substitute for Professor Linda Lang. (Wolverhampton University)

3. **Declarations of interest**

No declarations of interest were made relative to items under consideration at the meeting.

4. **Minutes of the meeting held on 8 January 2014**

Resolved:

That the minutes of the meeting held on 8 January 2014 be approved as a correct record and signed by the Chair subject to Maxine Bygrave (Chair, Wolverhampton Healthwatch) being included in the list of Members rather than employees.

5. **Matters arising**

There were no matters arising from the minutes of the meeting held on 8 January 2014.

6. **Minutes of the meeting held on 5 February 2014**

Resolved:

That the minutes of the meeting held on 5 February 2014 be approved as a correct record and signed by the Chair subject to Maxine Bygrave (Chair, Wolverhampton Healthwatch) being included in the list of Members rather than employees.

7, **Matters arising**

There were no matters arising from the minutes of the meeting held on 5 February 2014.

8. **Summary of outstanding matters**

Resolved:

That the summary of outstanding matters be received and noted.

9. **Chair's update**

The Chair, Cllr Sandra Samuels advised that she did not have anything to update the Board upon as all relevant matters were included on the Agenda for consideration.

10. **Health and Wellbeing Board Forward Plan 2014/15**

Viv Griffin presented the Health and Wellbeing Board Forward Plan for 2014/15.

Resolved:

That the Forward Plan 2013/14 be received and noted subject to the report on "Obesity call to action" scheduled for consideration at the

meeting on 7 May 2014 being slipped to the meeting on 9 July 2014.

11. **Better Care Fund – submission**

Richard Young presented a report and gave a PowerPoint presentation in connection with the work undertaken to date towards drafting the better Care Fund (BCF) Plan, creating the programme of work for 2014/15 and 15/16 and to create a pooled budget as an enabler for change within the local health economy from 2015/16 onwards.

He explained the difficulties in co-ordinating with the planning cycles of all partner organisations and, for that reason, work would be continuing on finalising the submission up to the deadline of 4 April 2014. Consequently, it was not possible for a final version of the Plan and submission to be considered at this meeting but undertook to ensure that these documents were circulated as soon as possible following finalisation. He assured the Board that the information now presented was very nearly complete and would only be subject to minor amendment and clarification. He responded to various points of detail and acknowledged the requirement to amend slightly certain elements to avoid double counting or over/under estimating the financial implications.

Resolved:

1. That the presentation and updates now made be received in order to enable the penultimate draft of the BCF Plan and submission of the relevant templates;
2. That the penultimate draft Plan be received subject to the incorporation of amendments as appropriate;
3. That, subject to 2. above, the Plan together with the associated supporting documents be approved for submission;
4. That the programme of work set out in the Plan be approved;
5. That the provisional allocations and expenditure set out in section 4 of the report be approved;
6. That the metrics and targets contained within the Plan, subject to minor amendments, and in particular, the local metric for recording of Dementia diagnosis within Primary Care as the BCF Local Measure, be approved;
7. That delegated authority be granted to the Chair of the Board in consultation with the Assistant Director, Health, Wellbeing and Disability and the Director of Strategy and Solutions to sign off the final version of the Plan, supporting documentation and templates for submission.

12. **Health and Wellbeing Strategy – 2013 -2018 – Performance Monitoring Report Quarter Three 2013/14**

Helena Kucharczyk presented the quarter three performance monitoring report which provided the Board with a comprehensive overview of performance against the five key priorities identified in the Health and Wellbeing Strategy 2013 – 2018. She suggested that the Board receive an updated performance monitoring report on a quarterly basis.

Sarah Norman enquired as to whether future reports would include the local

metric for recording of Dementia diagnosis within Primary Care as the BCF Local Measure. Helena Kucharczyk undertook to include this information in future reports.

Maxine Bygrave suggested that quantitative data collected by Wolverhampton Healthwatch in respect of "Patient Experience" be included in future iterations of the report. Helena Kucharczyk offered to include this data in respect of Mental Health patients on an annual basis and to explore options to update this type of data on a more regular basis with it being included as a separate section of the report.

Resolved:

1. That the report be received and the format be approved;
2. That the performance and issues raised as part of the Quarter three 2013/14 performance report be received and noted;
3. That future iterations include the local metric for recording data of Dementia diagnosis within Primary Care as the BCF local measure and quantitative data in respect of "Patient Experience" relating to Mental Health patients;
4. That a report in connection with the Joint Dementia Strategy be submitted to a future meeting of the Board.

13. **Health and Social Care Strategic Overview Group to inform Local Intelligence**

Glenda Augustine reported on proposals for the development of a strategic Health and Social Care Group to support the delivery of the priorities outlined in the Joint Health and Wellbeing Strategy 2013 – 2018 and the implementation of other integration initiatives, in particular, the Better Care Fund. The Board discussed the problems encountered to date in respect of data sharing protocols, the need for a simple but wide ranging agreement which could acknowledge exceptional circumstances to protect the position of all Partners and the proposal to include an Information Governance professional on the Group.

Resolved:

1. That the development of a strategic Health and Social Care Group, with a focussed overview on local intelligence, to support delivery of the priorities outlined in the Joint Health and Wellbeing Strategy 2013 – 2018 and the implementation of other integration initiatives, in particular, the Better Care Fund, be approved subject to a report on the proposed Terms of Reference and Governance structure being submitted to the next meeting of the Board;
2. That the formal title of the Group be determined by the Group itself.

14. **Feedback from Sub Groups**

- **Children's Trust Board(CTB)**

Cllr Val Gibson reported on the proceedings of the most recent meeting of the Children's Trust Board when the future structure, membership, frequency of meetings and Terms of Reference had been considered. A further report on these matters would be considered at the next meeting of the CTB with a report to this Board at the July meeting.

Resolved:

That the report be received and noted.

- **Adults Delivery Board(ADB)**

Viv Griffin presented a report on the work of the Adults Delivery Board in regard to the work plan for 2013/14.

Resolved:

1. That the report be received and noted including progress made across the Board's key priority areas;
2. That the progression of the City's bid for funding from the Better Care Fund in partnership with key partners from the CCG and the Acute Trusts be noted

- **Public Health Delivery Board (PHDB)**

Ros Jervis presented a report which advised the Board on the work of the Public Health Delivery Board and in particular matters arising from its meeting on 4 February 2014. She drew specific attention to the work undertaken in respect of "Obesity" which posed a major challenge for all partners. She advised that this topic would be the subject of the Public Health Annual Report which would be presented to the July meeting of this Board.

Resolved:

That the report be received and noted.

15. **Primary Care Development – "Engagement Session" – NHS England**

The Board received a PowerPoint presentation from Dr Kiran Patel in relation to Primary Care Quality from the perspective of the Birmingham, Black Country and Solihull Area Team of NHS England, in particular insofar as it related to Wolverhampton.

Cllr Steve Evans referred to the slide which drew particular attention to the age breakdown of General Practitioners (GP's) in Wolverhampton and enquired as to the steps proposed to address this issue. Dr Kiran Patel reported that the number of training places for GP's had been increased by Health Education England but that this would take up to seven years to have an effect. He commented that there was a need to seek the views of those GP's as to their future intentions and on the need to consider the increased use of Nurse Practitioners and Nurse Prescribers. Les Williams suggested that there was also a need to consider the current organisational structure of some GP practices, given the number of sole practitioners or two member practices. Ros Jervis confirmed this suggestion as some 63% of practices were comprised of one or two GP's. Dr Kiran Patel reported on the need to also have regard to the move to seven day working and the implications of the European Working Time Directive.

Maxine Bygrave queried the information relating to GP access and patient satisfaction as, in her opinion, it was at variance with the information held by Wolverhampton Healthwatch. Dr Kiran Patel acknowledged that there were several sources of patient experience data and that the information held by Wolverhampton Healthwatch could be more up to date than that held by NHS England. He emphasised the need to improve access at primary care level in order to avoid escalation up to acute level care.

The Chair, Cllr Sandra Samuels enquired as to the methodology for the assessment of suitability of the condition of GP premises. Dr Kiran Patel explained that such surveys would be undertaken through the CCG Capital

Priorities Premises Group.

The Chair, Cllr Samuels enquired as to the views of NHS England on the engagement with Healthwatch / Health and Wellbeing Boards / Health Scrutiny Panels. Dr Kiran Patel reported that NHS England worked closely with Healthwatch and Health and Wellbeing Boards but that the engagement with Health Scrutiny Panels was less well developed. In response to a further question from the Chair, Cllr Sandra Samuels, Les Williams reported that the Local Area Team worked closely with Healthwatch Wolverhampton and that data sharing also took place.

Resolved:

That the presentation be received and noted.

16. **Exclusion of press and public**

Resolved:

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following items of business as they involve the likely disclosure of exempt information contained in paragraph 3 of the Act, namely information relating to the financial or business affairs of any particular person (including the authority holding that information).

17. **Capital Programme Projects – NHS England**

Les Williams presented a report which outlined organisational changes within the NHS particularly relating to NHS Property Services and the present position with regard to the following GP premises in the City:

- Bradley;
- Bilston Urban Village;
- The Scotlands; and
- Heath Town.

He responded to questions relating to particular GP premises. Ros Jervis enquired as to whether the membership of the CCG Capital Priorities Premises Group included a representative from the Council's Property Team especially having regard to the Council's Corporate Landlord position. Les Williams advised that the membership was currently confined to NHS bodies only but undertook to investigate the possibility of such an invitation being extended.

Sarah Norman queried strategic the use and allocation of capital resources within the NHS insofar as it related to improvement and/or provision of GP premises. Les Williams explained that this issue was being addressed currently and that details could be included in future reports.

Resolved:

That the report be received and noted and future reports be submitted on a quarterly basis.

Agenda Item No. 6

Health and Wellbeing Board

7 May 2014

Report Title	Summary of outstanding matters
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Delivery
Accountable officer(s)	Carl Craney — Democratic Services Officer Tel — 01902 55(5046) Email — carl.craney@wolverhampton.gov.uk

Recommendations for noting:
The Health and Wellbeing Board is asked to consider and comment on the summary of outstanding matters

1.0 Purpose

1.1 The purpose of this report is to appraise the Board of the current position with a variety of matters considered at meetings of the former Shadow Health and Well Being Board and the inaugural meeting of the Health and Wellbeing Board.

2.0 Background

2.1 At previous meetings of the Shadow Board /Board the following matters were considered and details of the current position is set out in the fourth column of the table.

DATE OF MEETING	SUBJECT	LEAD OFFICER	CURRENT POSITION
1 May 2013	Child Poverty Strategy – Timelines, Six Target Wards And Membership Of Stakeholder Workshop	Keren Jones (WCC)	Report to a future meeting
8 January 2014	Certification of Deaths	Ros Jervis (WCC)	Report to a future meeting
8 January 2014	Primary Care Strategy	Richard Young (WCCCG)	Report to a future meeting
	Children's Safeguarding Action Plan – New approach	Emma Bennett (WCC)	Report to May 2014 meeting
8 January 2014	Better Care Bill / Special Educational Needs of Children	Anthony Ivko (WCC)	Report to a future meeting
8 January 2014	Primary Care Strategy	Richard Young (WCCCG)	Report to this meeting
8 January 2014	Local Government declaration on tobacco control	Ros Jervis (WCC)	Report to this meeting
8 January 2014	Report back from SEND Sub Group	Viv Griffin (WCC)	Report to a future meeting

31 March 2014	Better Care Fund – final submission	Richard Young (WCCCG) / Viv Griffin (WCC)	Report to this meeting
31 March 2014	Health and Well Being Strategy – Performance Monitoring	Helena Kucharczyk (WCC)	Quarterly reports
31 March 2014	Health and social Care Strategic Overview Group – Terms of Reference and Governance arrangements	Glenda Augustine (WCC)	Report to this meeting
31 March 2014	Children's Trust Board – future structure, membership, frequency of meetings and terms of reference	Emma Bennett (WCC)	Report to July 2014 meeting
31 March 2014	NHS Capital Programme – NHS England – GP practices in Wolverhampton	Les Williams / Dr Kiran Patel (NHS England)	Quarterly reports

3.0 Financial implications

3.1 None arising directly from this report. The financial implications of each matter will be detailed in the report submitted to the Board.

4.0 Legal implications

4.1 None arising directly from this report. The legal implications of each matter will be detailed in the report submitted to the Board.

5.0 Equalities implications

5.1 None arising directly from this report. The equalities implications of each matter will be detailed in the reports submitted to the Board

6.0 Environmental implications

6.1 None arising directly from this report. The environmental implications of each matter will be detailed in the report submitted to the Board.

7.0 Human resources implications

7.1 None arising directly from this report. The human resources implications of each matter will be detailed in the report submitted to the Board.

8.0 Corporate landlord implications

8.1 None arising directly from this report. The corporate landlord implications of each matter will be detailed in the report submitted to the Board.

9.0 Schedule of background papers

9.1 Minutes of previous meetings of the former Shadow Health and Well Being Board and associated reports and previous meetings of this Board and associated reports

Agenda Item No. 7

Health and Wellbeing Board

7 May 2014

Report Title	Health And Wellbeing Board – Forward Plan 2014/15
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Communities/Health, Wellbeing and Disability
Accountable officer(s)	Viv Griffin — Assistant Director Tel — 01902 55(5370) Email — Vivienne.Griffin@wolverhampton.gov.uk
Report to be/has been considered by	

Recommendation

That the Board considers and comments on the items listed in the Forward Plan

MEETING	TOPIC	LEAD OFFICER
7 MAY 2014 (1230 HOURS)	**OLDER PEOPLE THEMED MEETING**	
	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Wider Determinants of Health	Ros Jervis (WCC)
	JSNA priorities for 2014/15	Viv Griffin / Ros Jervis (WCC)
	Health and Social Care Strategic Overview Group to inform local intelligence	Ros Jervis (WCC)
	Better Care Fund – final submission	Richard Young (WCCCG) / Viv Griffin (WCC)
	Capital Programme Projects – NHS England – GP premises in Wolverhampton	Les Williams (NHS England)
2 JULY 2014 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Drugs and Alcohol priority update	
	Obesity 'call to action'	Ros Jervis (WCC)
	Children's Trust Board Review of Terms of Reference	Emma Bennett (WCC)
	Public Health Annual Report	Ros Jervis (WCC)
	Dementia Priority Care update	Anthony Ivko (WCC)
	Intermediate Care update	Anthony Ivko (WCC)
	Dementia Care Strategy	Anthony Ivko (WCC)

3 SEPT 2014 (1230 HOURS)	**YOUNGER ADULTS THEMED MEETING**	
	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
5 NOVEMBER 2014 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
7 JANUARY 2015 (1230 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
4 MARCH 2015 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)

To be added at some appropriate point: YOT input JSNA

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Agenda Item No. **8**

Health and Wellbeing Board

7 May 2014

Report title	**Progress Update on Joint Health and Wellbeing Strategy Priority: Wider Determinants of Health**	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service	Community/Public Health	
Accountable employee(s)	Ros Jervis Tel Email	Director of Public Health 01902 55(1372) ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Delivery Board Public Health Delivery Board	4th February 2014 8th April 2014(verbal update)

Recommendation(s):

The Health and Wellbeing Board is recommended to:

- Note and endorse the workstreams that make up the wider social determinants of health priority of the Joint Health and Wellbeing Strategy;
- note the challenges to working, and considers ways that the Board can enable and enhance these workstreams, including suggestions on how to promote the transformational 'whole systems' approach to reduce traditional 'silo' working which hinders the partnership working needed to improve health and tackle health inequalities through the wider determinants of health;
- note the selection of obesity as the subject of the Director of Public Health's 2013/14 Annual Report which can only be tackled successfully through an approach that has the wider determinants of health at its heart and receives a presentation on the Annual Report at the July 2014 meeting;
- receive a report at a future meeting which further investigates reasons for the increasing health inequalities gap in life expectancy in Wolverhampton.

1.0 Purpose

1.1 It is nearly twelve months since widespread NHS restructure saw the transfer of the public health function from the NHS (Wolverhampton PCT) to become part of Wolverhampton City Council in April 2013. One of the key public health functions is to improve health and reduce health inequalities by working through the wider social determinants of health that impact on an individual's life and consequent health chances, for example, education, employment, housing, environment, transport, financial security and socio economic status. The transfer, therefore, better places public health to be able to support and influence these factors to benefit population health.

Since the transfer to local authority, this key public health function to improve health and reduce health inequality through the wider determinants of health has been adopted as one of the key priorities in Wolverhampton's Joint Health and Wellbeing Strategy (JHWBS) 2013-18, approved by the Health and Wellbeing Board (HWBB) at its September 2013 meeting.

This 'one year on' update on this strategic priority seeks to:

- Outline the key work strands and delivery mechanisms that make up this priority area
- Update the board on the latest inequalities position for Wolverhampton
- Update on progress to date.
- Explore some challenges experienced to date

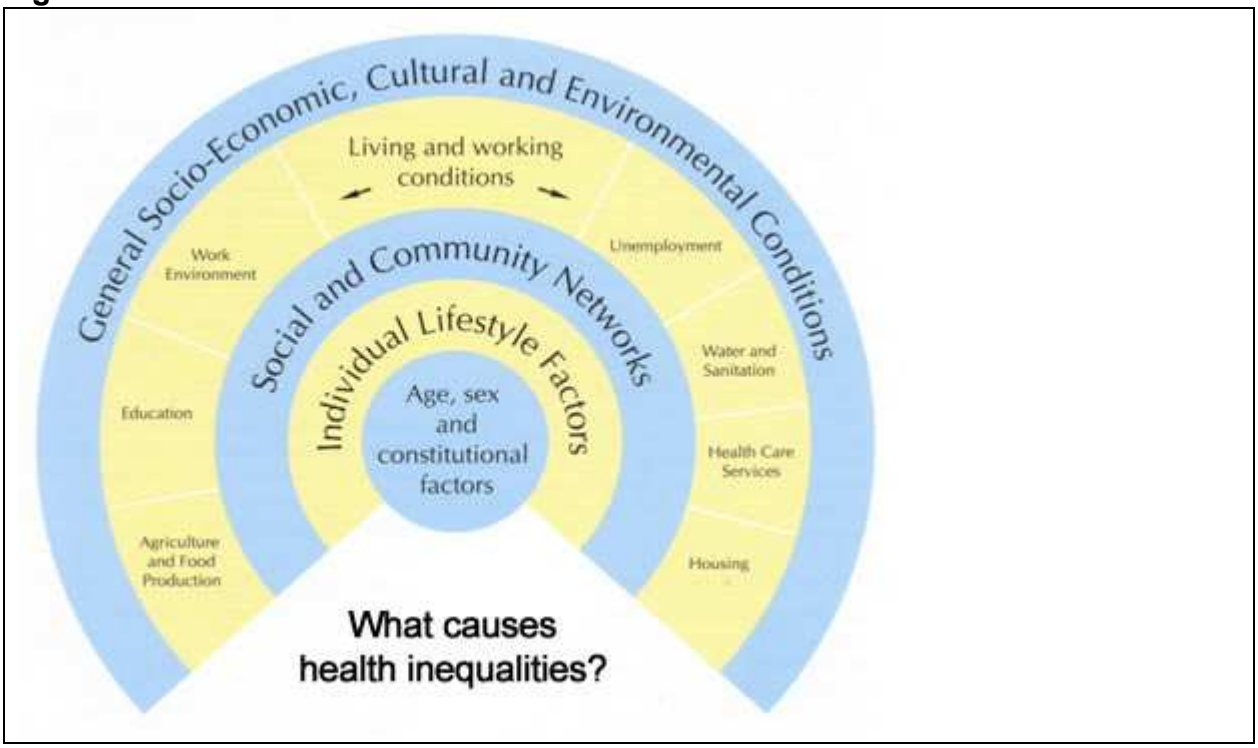
2.0 Background

2.1 What are the wider social determinants of health?

Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, and result in those people who are worst off experiencing poorer health and shorter lives.

Some differences, such as gender, genetic make-up or ethnicity, are fixed. Others are caused by social or geographical factors and can be avoided or mitigated. Local Authorities are uniquely placed to tackle health inequalities, as many of the social and economic determinants of health, and the services or activities which can make a difference, fall within their remit. It is now widely accepted that these social determinants are responsible for significant levels of unfair health inequalities. If we focus on supporting improvements across these wider social determinants for those most in need, across council services and other organisations and communities, together we can try to reduce the inequalities in health outcomes across our City. Figure 1 illustrates the different layers and components that make up the wider determinants of health.

Figure 1: The wider determinants of health



The challenge is to reduce the difference in mortality (death rates) and morbidity (ill health) rates between richer and poorer and to increase the quality of life and sense of wellbeing of the whole local community.

2.2 Inequalities in Wolverhampton

Effective interventions to improve health and reduce health inequalities can be measured in various ways by comparing data on mortality (deaths) and morbidity (ill health) with a measure of a person's social position (usually a measurement of how deprived the area is in which they live). One of the most common ways of measuring inequalities is to use life expectancy – which is a measure of how long a baby born today would be expected to live, on average, if they experienced the current death rates for their area. In the UK, the more deprived an area is, the worse health is likely to be, and life expectancy will be shorter.

In Wolverhampton, as in England as a whole, life expectancy continues to increase, thanks to improved social conditions, advancing medical and scientific knowledge, a highly trained professional workforce and continued investment in a free and universal healthcare system. However, even with these advancements, life expectancy in Wolverhampton is below the national average and masks a widening gap between the health outcomes of our wealthiest and most deprived communities.

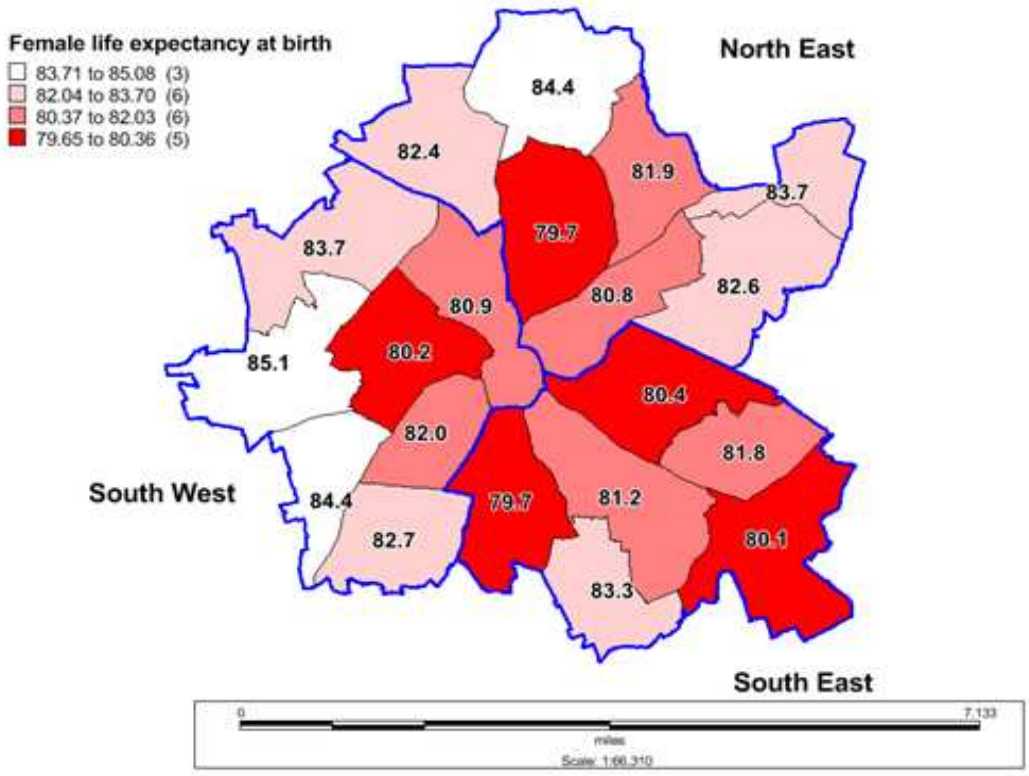
Using latest available data on life expectancy (between 2008 and 2012), the gap in life expectancy between a man living in the most and least deprived areas of Wolverhampton is eight years of life – increased from a six year gap previously measured using data for 2007 – 09. This means that a man living in Tettenhall Wightwick can expect to live on

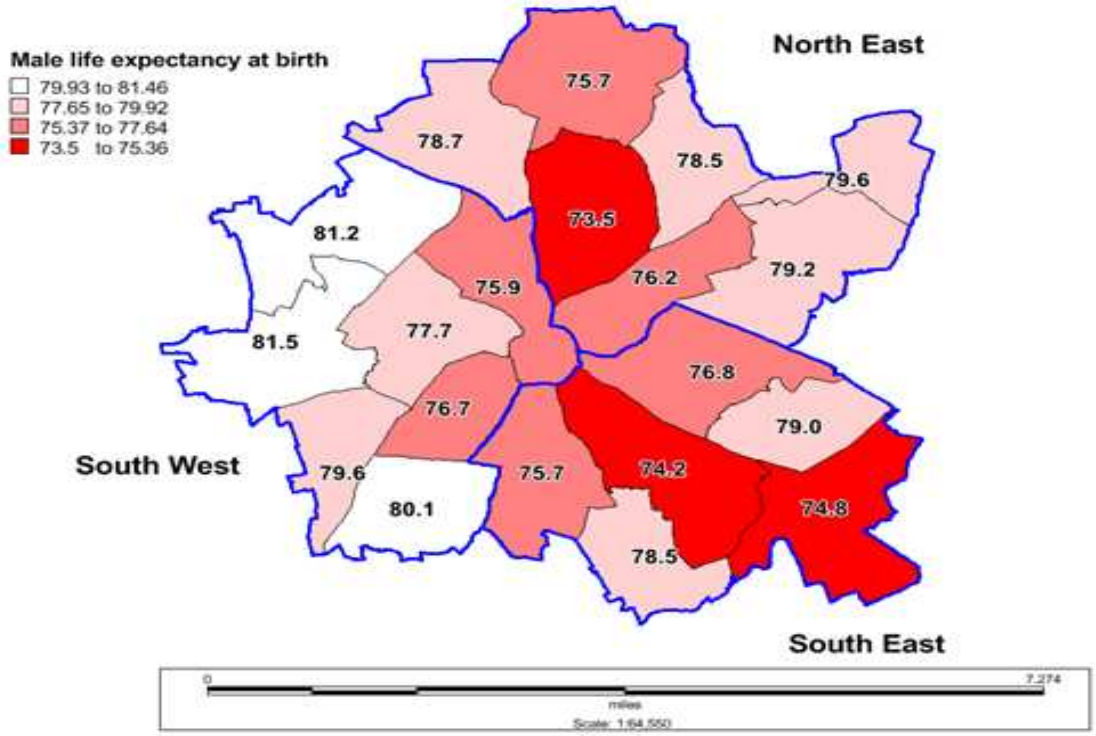
average to be over 81 years while only a short distance away, men in Bushbury South and Low Hill can expect to live until they are 73 years.

For women, life expectancy is higher and the gap between those living in the most and least deprived areas is not so wide, at 5 years but the gap is also increasing. A women living in Tettenhall Wightwick can expect to live on average to over 85 years compared to a women living in Bushbury South and Low Hill and Blakenhall who can expect a life expectancy of nearly 80 years. See Maps 1 and 2, and Appendix 1.

Further analysis is needed to investigate the reasons for this widening inequalities gap in life expectancy in Wolverhampton.

Maps 1 & 2: Life Expectancy by wards in Wolverhampton 2008 – 2012: Female/Male





2.3 **Key work strands that make up the wider determinants health and wellbeing priority area**

There are several strands of work that currently make up this priority work area. However, two current key areas of work describe both the scope and the scale of the partnership work required to improve health and reduce health inequalities across the wider determinants of health. These are:

- Obesity;
- Prevention of looked after children

These workstrands illustrate the 'golden thread' or 'whole systems' nature of improving health through working on the wider determinants of health. This means that by focussing collective joined up partnership action on an agreed issue of concern (the golden thread) it is possible to make a difference that would not be possible through individual organisations acting independently.

This paper also updates on other significant work strands that relate to this priority area, i.e.

- Establishment of a Healthier Place Team
- Update on the Transformation Fund

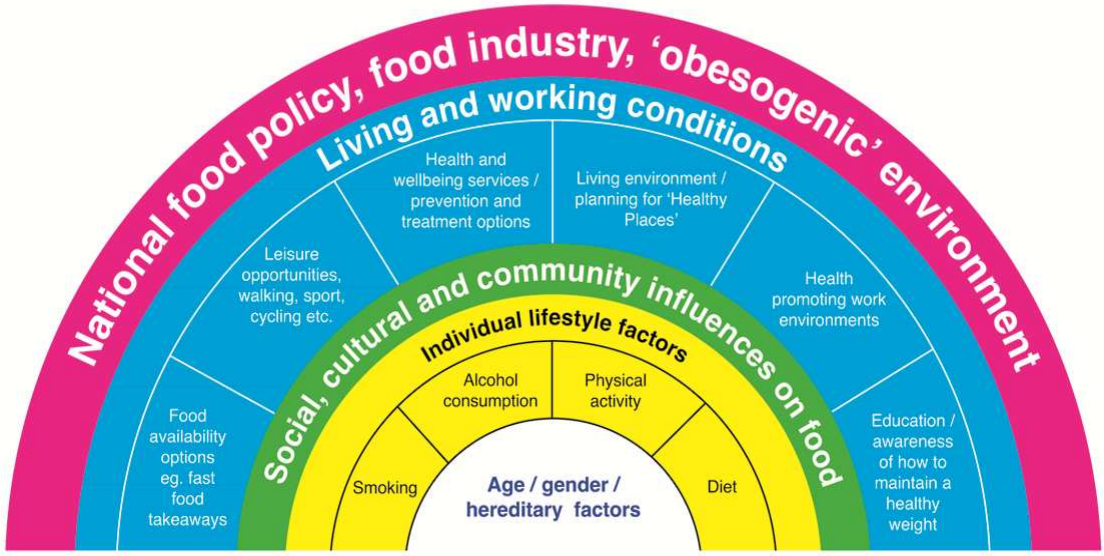
3.0 Progress to date

3.1 Golden Thread' issues:

3.1.1 Obesity

The 2013/14 Public Health Annual Report is the first public health report in the new local authority setting and takes the form of a 'Call to Action' to tackle this multi dimensional problem in a partnership 'whole system' way encompassing local organisations, businesses, the voluntary sector, communities, individuals and families. Obesity is an issue which is impacted on by the whole range of wider determinants outlined in Figure 1 – which is interpreted in relation to the factors impacting on obesity in Figure 2. This demonstrates the different layers of factors and influences that need to play a part in tackling this complex issue.

Figure 2 – the impact of the wider determinants of health on obesity



The report will comprise three sections:

Why obesity?	Gives background to the issue and outlines the current situation in Wolverhampton
The case for a new approach	• Describes what has led to the rising levels of obesity and what the evidence says about effective approaches • Outlines what is already in place in Wolverhampton
Action against obesity in	• Outlines a series of critical opportunities across the life course and shows what

Wolverhampton

departments and agencies can contribute, illustrated with case studies.

- Organisations will be asked to pledge their support and attend an 'Obesity Summit' in the autumn of 2014.

3.1.2 **Looked After Children Prevention**

This workstrand is concerned with a collective response to prevent children coming into the care system, following a rapid rise in numbers resulting in Wolverhampton having one of the highest LAC rates in the country. A Prevention of Looked After Children Task and Finish Group met for the first time on 12th November 2013, this is now referred to as Families First. This multi-agency group has the overarching aim to support children and families to live together where safely possible, as opposed to becoming looked after. Key objectives are to:

- systematically identify early those families that are starting to struggle;
- look for rapid and effective interventions (help for families) to support the de-escalation of need wherever possible
- promote and embed a shared response offering preventative and targeted family support services

Representatives include officers from council directorates, i.e. children's welfare, social inclusion, housing, education and enterprise and public health as well as representation from domestic violence services, CCG, police, Royal Wolverhampton NHS Trust, mental health and the voluntary sector.

A further meeting was held on 7th March 2013 and agreement made to hold a multi-agency summit to take place on 6th May to raise awareness and agree a series of actions and workstreams to meet the above key objectives and develop a partnership approach.

It was agreed to set up task and finish sub-groups to coordinate and deliver the summit and also to look at triggers to becoming looked after, 'unblockers' to help families and governance issues. In addition, part of the work will be about looking at best practice in other local authorities.

3.2 **Other issues related to wider determinants workstream**

3.2.1 **Establishment of a Healthier Place Team**

This workstream concerns the development of a new and dynamic 'Healthier Place' team within Public Health. From April 1st several staff groups or small teams transferred into the public health workforce; the three most relevant to the development of a 'Healthier Place' team being:

- The Sports Development Team
- The Healthy Schools Team
- The Parks (Development) and Countryside Team

In order to maximise the potential these three staff groups can deliver in terms of positive public health outcomes across the wider determinants of health, the aim is to develop a programme of collaborative working across council departments, other public and voluntary sector organisations and private industry in an attempt to halt, and ultimately reduce, health inequalities across the city. This will focus on programmes that cut across education, housing, transport, un/employment, living and working conditions as well as the environment. As part of wider organisational change within the Council (e.g. the establishment of a Corporate Landlord model), it is anticipated that a small Community Development team be transferred to the service to further support this agenda.

This programme will utilise the raft of local, regional and national policy documents and guidance and how this all fits together for Wolverhampton, - for example: The Wolverhampton Open Space Strategy & Action Plan, the Open Space, Sport and Recreation Supplementary Planning Document (SPD), the TCPA planning guides and more recently the RIBA City Health Check document.

Models and approaches that may be right for Wolverhampton can then be developed with some practical actions to inform a work programme for the new team to take forward.

3.2.2 **Transformation Fund**

In September 2013 The Health & Wellbeing Board (HWBB) agreed the funding and bidding process for transformational projects up to the sum of £1 million for two years. The public health transformation fund (PHTF) made available grants of up to £250,000 per year for two years to support the development and implementation of initiatives which improve the health and wellbeing of the population. Its primary aim is to support the embedding of public health outcomes into directorates across the Council so that improving the health of the population is everyone's business within the Council. This represented a new opportunity to improve the health of the population particularly the health of the more vulnerable in our society.

Progress to date:

Two bidding rounds have identified eight successful projects. These eight projects include schemes that:

- Improve mental health pathways
- Improve employment opportunities (Inspire Wolverhampton)
- Improve wellbeing through a new Wellbeing & Community Support Hub
- Will trial new approaches to community based prevention
- Trials a new concept of awareness raising with a dementia pilot

- Works with new communities to reduce health inequalities
- Improves nutritional standards in takeaways
- Supports the development of self-reliant communities

3.3 **Challenges to delivering the wider determinants priority**

Promoting and delivering a transformational agenda that works across the wider determinants of health is the only real way to make significant inroads to improving health and reducing heath inequalities. - however, this represents a new way of working and therefore is challenging and progress over the last 12 months has not always been smooth, for example:-

3.3.1 working in a whole systems way is challenging

The public health agenda and in particular improving health through the wider social determinants of health requires the commitment and collaboration of many agencies, both across the council and other organisations in order to make an impact. It requires a commitment to work in a whole systems way. However, there can be a tendency to see these issues as standalone public health issues, when in fact they are much more complex than what can be tackled by a single agency or team. The issues of obesity and LAC prevention outlined above are key examples of how organisations need to work together in a different way.

3.3.2 focus on outcomes not issues

An approach that focuses on single issues and with single leads can be a hindrance to working in new ways across the wider determinants. A whole systems approach focuses on outcomes, rather than individual issues. An example of this was that many of the bids received for consideration by the transformation fund were concerned with the continuation of funding rather than refocusing spending on delivering public health outcomes.

3.3.3 understanding the role of public health

The role of public health in the Council is still relatively new and its role in supporting a transformational agenda may be as yet poorly understood. Public health's role can be to provide support at various stages of the commissioning cycle – for example in the development of strategy, or the development of an evidence base to support new transformational commissioned activity in other council teams. However, as the cycle moves into a commissioning phase, this requires a subsequent handover to the appropriate team/directorate to operationalise. Additionally, the public health team have been working to understand the roles and responsibilities of other council teams and to embed effectively.

4.0 Financial implications

4.1 This report has no direct financial implications, however the work streams and priorities set out in this report should make a positive contribution to the council's financial position in the medium- and long-term. The strands making up the priority area rely on partners working closely together and therefore call on a variety of funding streams.

[DK/24042014/A]

5.0 Legal implications

5.1 There are no direct legal implications arising from this report.

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[RB/24042014/H]

6.0 Equalities implications

6.1 The public health service seeks to ensure equality of opportunity as it delivers its core functions and aims to reduce health inequalities. Tackling health inequalities thorough the wider determinants of health means that the needs of those most vulnerable in society are considered.

7.0 Environmental implications

7.1 Environmental issues impact on health and this workstream aims to utilise the environment in a positive way to improve the health of Wolverhampton residents.

8.0 Human resources implications

8.1 There are no direct human resource implications arising from this report.

9.0 Corporate landlord implications

9.1 There are no direct corporate landlord implications arising from this report.

10.0 Schedule of background papers

10.1 Health and Wellbeing Strategy Mark 2 - Health and Wellbeing Board, 4th September 2013

Appendix 1: The Life Expectancy Gap in Wolverhampton is widening

Males

	Ward	***LE 2007-09***	***Ward***	***LE 2008- 12***
Highest	Tettenhall Wightwick	79.2	Tettenhall Wightwick	81.5
Lowest	Ettingshall	72.9	- Bushbury South and Low Hill	73.5
Difference		6.3 years		8.0 years

Females

	Ward	***LE 2007-09***	***Ward***	***LE 2008- 12***
Highest	Wednesfield South	83.0	Tettenhall Wightwick	85.1
Lowest	Blakenhall	78.1	- Bushbury South and Low Hill - Blakenhall	79.7
Difference		4.9 years		5.4 years

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Agenda Item No. **9**

Health and Wellbeing Board

7 May 2014

Report title	Joint Strategic Needs Assessment (JSNA) Update 2014/2015	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service	Health and Wellbeing	
Accountable employee(s)	Viv Griffin Ros Jervis Tel Email	Assistant Director Director of Public Health for Wolverhampton 01902 555370 / 01902 551372 vivienne.griffin@wolverhampton.gov.uk ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendation for action or decision:

The Health and Wellbeing Board is recommended to:

1. Endorse the recommended priority areas for updating the JSNA in 2014/15.

1.0 Purpose

1.1 To seek approval from the Health and Wellbeing Board on the recommended priorities for updating the JSNA in 2014/15.

2.0 Background

2.1 The JSNA for Wolverhampton 2013-2018 was approved by the Health and Wellbeing Board on 4 September 2013. The JSNA is a process that identifies the current and projected health and wellbeing needs of the community. It is a statutory responsibility of the Wolverhampton Health and Wellbeing Board to work together to improve the health and wellbeing of the local community and reduce health inequalities.

2.2 The JSNA is a key tool in understanding the needs of local people where the aim is to improve services in order to make a real difference to the health and wellbeing of the people of Wolverhampton.

2.3 The JSNA uses reliable and robust information to understand local needs and underpin the commissioning priorities and strategic plans of the local authority and the local NHS. Specifically it will be used to inform the Joint Health and Wellbeing Strategy 2013 - 2018. Needs change over time and therefore the JSNA will need to be updated on a yearly basis to make sure that priorities continue to be right and to enable us to monitor progress.

3.0 Progress, options, discussion, etc.

3.1 The overarching JSNA focusses on high level outcomes in the national outcomes frameworks for the NHS, adult social care and public health, to provide an overall strategic view of health in Wolverhampton. However in order to provide a more in depth focus on important issues, it has been agreed to produce themed reports. The themed report agreed on for 2014 (September) is on the theme of patient quality and safety. The suggestion for the 2015 themed update is that it should focus on children and young people, and especially the following vulnerable groups:

- Children in Need / Child Protection and Looked After Children
- Troubled Families
- Special educational Needs
- Children with Disabilities
- Youth Offending
- Children and Adolescents with Mental Health Needs.

4.0 Financial implications

4.1 There are no direct financial implications to this report, at this stage.
[AS/24042014/N]

5.0 Legal implications

5.1 There are no direct legal implications to this report, at this stage.

[RB/24042014/K]

6.0 Equalities implications

6.1 There are no direct equalities implications to this report, at this stage.

7.0 Environmental implications

7.1 There are no direct environmental implications to this report, at this stage.

8.0 Human resources implications

8.1 There are no direct human resources implications to this report, at this stage.

9.0 Corporate landlord implications

9.1 There are no direct Corporate landlord implications to this report, at this stage.

10.0 Schedule of background papers

10.1 None.

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Agenda Item No: **10**

Health and Wellbeing Board

7 May 2014

Report title	Health and Social Care Strategic Overview Group to inform Local Intelligence: Terms of Reference and Governance Arrangements
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	Public Health
Accountable employee(s)	Ros Jervis — Director Public Health Tel — 01902 554211 Email — ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1.1 Approve the proposed Terms of Reference and governance arrangements for the Health and Social Care Strategic Group to inform local intelligence.

1.0 Purpose

1.1 The purpose of this report is to seek approval from the Health and Wellbeing Board for the proposed Terms of Reference and the governance arrangements for the Health and Social Care Strategic Group to inform local intelligence.

2.0 Background

2.1 The Health and Wellbeing Board discussed the establishment of a Health and Social Care Information group to inform local intelligence in relation to performance reports for integrated initiatives on 31st March 2014.

2.2 This approval was subject to submission of a report highlighting the proposed Terms of Reference and governance arrangements for the 'Group' for consideration by the Health and Wellbeing Board in May 2014.

3.0 Proposed Terms of Reference for the Health and Social Care Strategic Group

3.1 The proposed Terms of Reference (ToR) for the Health and Social Care Strategic Group is outlined in Appendix A.

3.2 The ToR refers to the Health and Social Care Information and Metric Oversight Group, however the precise name of the group will be decided at the inaugural meeting proposed for mid-May 2014.

3.3 The governance arrangements include reporting to the Health and Wellbeing Board and the Interim Board of the Better Care Fund as a standing agenda item.

3.4 Failure to reach consensus within the group on issues that impact on performance will be escalated to the Health and Wellbeing Board for resolution as an exceptional item within the standing quarterly report.

3.4 The ToR also acknowledge the commercial sensitivity surrounding the commissioner - provider relationship, indicating that it may not always be appropriate for all partners to be present for the entire meeting on some occasions. The decision regarding the need for a closed section of the meeting will be made by the chair of the 'Group' based on the agenda items for discussion or submissions made by other partners. Therefore consideration will be given to identifying core group members at the inaugural meeting.

4.0 Financial implications

4.1 The council's participation in the group will be resourced by existing budgeted staff; there are therefore no direct financial implications.

4.2 This group will have oversight of the performance of the Better Care Fund which will be introduced in full in 2015/16, and will draw together £20.0 million of NHS and local authority funding in Wolverhampton. Approximately one quarter of this funding will be subject to meeting a number of performance targets.

[DK/25042014/I]

5.0 Legal implications

5.1 There are no anticipated legal implications to group and the Terms of Reference outlines the need for all partner agencies to adhere to Information Governance policies and data sharing agreements.

[TS/17042014/R]

6.0 Equalities implications

6.1 This proposal does not directly impact on service delivery or employment therefore does not have any explicit equalities implications. However, if the review of performance indicates that there is inequitable service provision action will be taken to ensure that all inequalities highlighted are addressed. The group will ensure that decisions and processes follow the requirements of the Public Sector Equality Duty, reflected in the Terms of Reference, to endure compliance with the law and the best outcomes for Wolverhampton.

7.0 Environmental implications

7.1 There are no anticipated environmental implications of this proposal.

8.0 Human resources implications

8.1 There are no anticipated human resource implications of this proposal.

9.0 Corporate landlord implications

9.1 This proposal does not have any implications for the Council's property portfolio.

10.0 Schedule of background papers

10.1 The Health and Social Care Strategic Overview Group to inform Local Intelligence report was presented to the Health and Wellbeing on 31st March 2014

Appendix One

Draft Terms of Reference:
Health and Social Care Information and Metric Oversight Group

Purpose
To support delivery of the priorities outlined in the Joint Health and Wellbeing Strategy 2013-2018 and the implementation of other integration and partnership initiatives, in particular the Better Care Fund.

Background
Integrated working has been necessary in the development of performance reports to support the delivery of the Joint Health & Wellbeing Strategy and the preparation work for the implementation of the Better Care Fund. This has highlighted the need to think more proactively about how performance and information management is handled across partner agencies in order to better monitor delivery of joint initiatives in a timely manner.

The proposal to establish a strategic Health and Social Care oversight group was approved by the Wolverhampton Health and Wellbeing Board on 31st March 2014. The principal aim would be to provide a strategic overview of performance and information management for joint working and integration initiatives and agendas.

Governance
The Health and Social Care Information and Metric Oversight Group will report directly to the Health and Wellbeing Board and will be a quarterly standing item on the Health and Wellbeing Board agenda. The group will also report to the Interim Delivery Board of the Better Care Fund.

If consensus on a particular issue cannot be achieved within the usual business of the group, the matter will be escalated to Health and Wellbeing Board for resolution via an exceptional item within the standing report.

Membership
To be confirmed

Due to the commercial sensitivity surrounding the commissioner provider relationship, it may not always be appropriate for all partners to be present for the whole of every meeting. The decision regarding the need for a closed section of the meeting will be made by the chair based on the agenda items for discussion or submissions made by other partners. Therefore consideration should be given to identifying core group members.

At least one senior performance or information lead from each organisation or service area and nominated deputy with commitment to attend all meetings

Suggested Organisations and Service Areas:
- *Public Health*
- *Social Care*
- *Wolverhampton Clinical Commissioning Group*

- *Royal Wolverhampton NHS Trust*
- *Black Country Partnership Foundation*

Information Governance representation for discussion

Frequency of Meetings

The meetings will be held bi-monthly and *ad hoc* meetings may also be convened to respond to identified information requirements.

Remit of Health and Social Care Information and Metric Oversight Group:

- To establish a collaborative, outcome focused approach to Health and Social Care performance in Wolverhampton

- To support the Joint Health and Wellbeing Strategy and the Better Care Fund performance reports; other partnership work may also require support

- To produce consistent and robust information to provide co-ordinated analysis, monitoring and prediction of integrated outcomes

- To facilitate timely information and data sharing across Health and Social Care in line with Information Governance requirements with resolution for information sharing issues

- To provide early identification of areas where unmet targets or under performance may impact on strategic outcomes which may subsequently require more in-depth review or action

- To develop an 'Information Directory' to increase awareness of data held and metrics available within each organisation

- To provide a forum for shared learning and promotion of best practice in performance reporting and the production of Information Management reports

- To ensure that decisions and processes follow the requirements of the Public Sector Equality Duty in compliance with the law to achieve the best outcomes for Wolverhampton.

Date of Review:
Six Months following Inaugural meeting and twelve monthly thereafter.

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Wolverhampton City Council

NHS Wolverhampton Clinical Commissioning Group

Wolverhampton Health & Care Economy

Better Care Fund Planning Template – Part 1

April 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

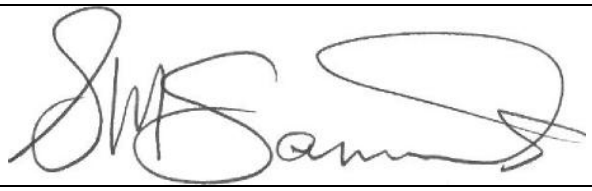
a) Summary of Plan

Local Authority	**Wolverhampton City Council**
Clinical Commissioning Groups	**Wolverhampton CCG**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**31/03/2014**
Date submitted:	**04/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£6,309,000**
2015/16	**£20,024,000**
Total agreed value of pooled budget: 2014/15	**£20,496,174**
2015/16	**£24,621,362**

b) Authorisation and signoff

Signed on behalf of Wolverhampton Clinical Commissioning Group	
By	Dr Helen Hibbs
Position	Accountable Officer
Date	4th April 2014

Signed on behalf of Wolverhampton City Council	
By	Sarah Norman
Position	Strategic Director of Community Services
Date	4th April 2014

Signed on behalf of the Wolverhampton Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr S Samuels
Date	4th April 2014

c) Service provider engagement

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

In June 2013, the four major statutory agencies and stakeholders in the local health &social care economy agreed to come together to find opportunities for better integrated working between the agencies. This initially culminated in an 'Integrated Pioneer' project based around dementia services. Whilst this bid for funding was unsuccessful, all partners resolved to continue the work. This partnership has evolved into the basis of the Integration Transformation Fund / Better Care Fund.

This work has produced a whole series of events across the health and social care economy and also across the widest range of participants and staff. These events have included front line staff and all four CEO's from the major agencies. All of this work has been underpinned by a core planning group comprised of the operational, planning and finance directors from each organisation with support from a small team of programme support management.

In the Autumn of 2013, the Chief Executives of the Provider Trusts (The Royal Wolverhampton NHS Trust and The Black Country Partnership Foundation Trust), the Accountable Officer of Wolverhampton Clinical Commissioning Group (CCG) and the Strategic Director of the Community Directorate of Wolverhampton City Council set up a structure to develop the response to the requirements of the Better Care Fund, implement the plan and deliver the wider transformational agenda.

Below this leadership level, an Interim Development Board (IDB) has been established.

This is a group of executive directors from each of the key stakeholder organisations including the Directors of Finance (or equivalent) and Directors of Planning / Chief Operating Officers (or equivalents) plus the Director of Public Health.

The IDB has hosted and facilitated a number of whole system events designed to co-produce the BCF programme vision, priority workstreams and projects.

The key events and outputs are set out below:

- Workshop - 20.06.13 – Identification of workstreams

- Leadership Alignment Event - 28.11.13
    - Senior representatives from all four organisations (RWT / BCPFT / WCCG / WCC)
    - Revision of the BCF workstreams

- Front Line Staff Event – 17.12.13 :
    - 60 plus staff representing : patients, carers, voluntary sector, health & social care (commissioners & provider) staff
    - Work & successes to date
    - Opportunities from what we have now
    - Opportunities in what we do
    - Under what circumstances – present assets & new opportunities
    - Opportunities in what we have lost
    - Immediate, practical, actions
    - Opportunities for transformation

- Whole System Event – 28.01.14
    - 70 delegates representing patients, carers, voluntary sector, health & social care (commissioner & provider – acute, mental health & primary care)
    - Develop vision for BCF and Sign off of Better Care Fund Plan workstreams & project ambitions.

- Leadership Alignment Event – 18.02.14
    - Review of the outputs of the Whole System Event
    - Sign off of the Wolverhampton Story
    - Wolverhampton Change Model & Pathway going forward.

A series of further events is planned over the first half of 2014 to establish and bed-in the vehicles for the whole system transformational change required.

d) Patient, service user and public engagement

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

As set out in 1c) above, the Wolverhampton Health &Social Care economy has used an inclusive approach to planning the BCF programme. Some of the above events had a specific focus to identify and develop patient, carer and public aspirations for the BCF Plan and the wider transformational agenda.

The key events have included:

- Front Line Staff Event – 17.12.13
- Whole System Event – 28.01.14
- Health & Well-Being Board – 05.02.14
- Adult Delivery Board – 11.02.14
- Wolverhampton Health Summit – 12.03.14
- Health & Well-Being Board – 31.03.14
- Patient Engagement Event –1.04.14

All of these events had patient, patient representative, carer and voluntary sector representation.

Planned future events and opportunities for engagement include:

- CCG Patient Engagement Groups / locality sessions: various.
- WCC Over 50's Forum
- WCC Learning Disability Parliament
- WCC SEN/D Reform Board

The Wolverhampton Adult Social Care Annual Report has a clear outcome on ensuring that people have a positive experience of care. To this end there is a hierarchy of engagement with service users ranging from information giving to co-production. The personalisation agenda puts service users at the centre of service provision and increasingly dominates future planning.

In terms of the mechanics of the plan construction, Wolverhampton Healthwatch have been significantly involved in developing the programme and its "story" or vision, in particular, Wolverhampton Healthwatch have requested to be included in the regular updates and development sessions via the local Health & Well-Being Board sub-structures / delivery boards. (Healthwatch declined an offer be to part of the IDB).

e) Related documentation

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

Document or information title	Synopsis and links
Initial Workshop	Outputs of the initial whole system workshop in June 2013 that identified transformational workstreams.  June Workshop Action Notes.pptx
Leadership Alignment Event 28.11.13	Initial Leadership Alignment Event with Chief Executives/Accountable Officers and Directors from Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, The Black Country Partnership NHS Foundation Trust, The Royal Wolverhampton NHS Trust. Confirmed the transformational workstreams, commenced work on leadership alignment.  Outputs of 281113.pptx
Front Line Event 17.12.13	Delegates made up of frontline staff from health & social care, carers, users and voluntary/3rd Sector. Using the 4 workstreams as the subjects, identifying opportunities from current practices, what could be changed. Practical, work that could start immediately.  Front Line Staff Event Feedback.pptx  Workstream 1.pptx  Workstream 2.pptx  Workstream 3.pptx  Workstream 4.pptx
Whole System Event 28.01.14	Developing the Wolverhampton 'Story' and identifying what needs to happen to ensure transformational project success.  Setting Up for Success Summaries.p  BCF one wolverhampton.pptx

Better Care Fund Plan on a Page	This document provides an overview in graphical representation of the Better Care Fund Projects within each workstream and the strategic fit.  BCF on a page V7 1.pptx
Better Care Fund Timeline	Graphical overview of the timeline for workstreams& projects.  BCF Timelines v5.2 310314.pptx
Better Care Fund Project Summary	This document provides summary details from the individual Project Initiation Documents, the strategic objective and which metric the project contributes to.  Project Summary v1.1 240314.docx
Better Care Fund Target Setting	The document provides the detailed calculation of the National and Local Metrics – part of Template 2 - a summary of which project contributes to which metric and metric targets in graphical form.  Better Care Fund Target Setting.pptx
Wolverhampton Interim Development Board Terms of Reference (draft)	Terms of reference for the Interim Development Board, which will provide strategic direction for and monitoring of the Better Care Fund until such time as the governance arrangements have been agreed.  Interim Development Board TOR v2 19031

Wolverhampton Transformational Change Programme Roadmap	Graphical representation of the Wolverhampton Transformation Change Programme of which the Better Care Fund is a significant part.  Wolves LSI Pathway v2Feb14.doc
BCF Risk Register	Better Care Fund Risk Register, complied from high level and initial project risks.  Risk Log 040414.xls

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

Wolverhampton Local Health & Care Economy is wholly committed to improving the health and wellbeing of our population. We will achieve this by placing patients at the centre of our decision making and deliver care through the newly established model of integrated commissioning and provision. This clinically-led model of care will bring about real integration of services delivering measurable benefits for the health of our population and their experience of services.

We have to deliver transformational change in order to realise an efficient and effective health and social care system in Wolverhampton, which is both affordable and provides the highest service standards, which our population rightly expects and deserves. Our programme of change will be led by clinicians and social care experts at the front-line; will operate in collaboration across all stakeholders (including people, practices and voluntary / third sector organisations) and is deliberately flexible in order respond to emerging circumstances.

At the Whole System Event in January 2014, representatives from key stakeholders, partners and our local community agreed a vision statement. The vision for our local Health & Care Economy vision for 2014-19 is:

Wolverhampton:

One Ambition, Working as One, for EveryOne.

This statement not only captured the will to change and transform - so energetically expressed by all participants on the day - but also has a high degree of synergy with the CCG vision (as expressed in its authorisation documents) for the ***Right Care*** in the ***Right Place*** at the ***Right Time*** for all of our population. A sentiment strongly echoed in the BCF guidance. The following will be yardsticks by which we will judge the results of our plan:

- Patients will feel confident that the **right care** is provided to the standard that they expect;
- Local health and care services will co-ordinate, collaborate and communicate in order to ensure that care is delivered in the **right place;**
- Care delivery and advice will be proactively planned and provided in order to ensure care is provided at the **right time.**

As a result of the Better Care Fund and it's workstreams and projects - over the next five years - we will see:

- Patients and service users receiving services that are wrapped around them, that are seamless and with no duplication.
- Less people living, permanently, in Nursing & Residential care with more people receiving services in their own homes.
- Those that remain in Nursing & Residential Care will have a named GP (1 GP per Home), with have agreed care plans for their Long Term Conditions and services designed to wrap around them, including access to Specialist Services historically provided in an acute hospital setting.
- A planned reduction in the number of acute medical beds, equivalent to 2 medical wards.
- A shift of workforce numbers from acute settings into community services.
- Patients living with Long Term Conditions managing their own conditions – with the appropriate support, taking control through personalised health and social care budgets and enjoying a better quality of life.
- Patients and service users with mental health problems identified early - in the primary care setting - and early intervention commenced.

b) Aims and objectives

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

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

We believe that this vision statement will be central in how the local partnership continues to develop the BCF programme. It has meaning on a number of levels and, as the table below sets out, the vision statement illustrates the ambition of a single plan for all partners – instead of the multiple (and sometimes conflicting) plans of the key stakeholders.

Strategic Objective	One Ambition	Working as One	For Everyone
What Are We Trying To Do?	Single Plan Sharing everything Prevention & Recovery	Integrated Pathways All Partners Working Together Shared Sustainable Outcomes	Each Individual Keeping People Well Self-caring Communities
	Right Care	Right Place	Right Time

We will share information (within the appropriate imperatives of safeguarding and good governance), facilities and resources. We will focus on preventing ill health rather than treating illness, but, when people are ill, we will strive to enable the best recovery to as full and high quality life as possible.

We will work together, implementing new integrated pathways and deconstructing the silos. We will find new solutions for our city and its community that provide effective and efficient use of resources – optimising the skills and strengths of our combined workforce.

This will deliver the outcomes required to deliver financial sustainability and improve the lives of our patients and citizens.

This programme will have meaning for everyone: staff, patients, public and organisations. We will put the person at the heart of our thinking, planning and delivery. It will support the personalisation agenda and focus on to services tailored to individual need. Our main focus will be to keep people well thereby reducing demand and improving lives. Part of our ambition will be to create cultures where people are able, and incentivised, to take responsibility for their own care wherever practical and optimise self-care for many conditions.

Within 5 years, the BCF programme will have:

- A single plan or a single over-arching framework covering the necessary suite of strategic plans from each partner which will be collaborative, complementary and assist partners in the delivery of agreed common goals.
- Routinely shared information, resources and facilities.
- Delivered a re-configured series of integrated services with single providers where appropriate.
- Embedded new ways of working ensuring that service users interact with fewer professionals, with fewer hand-offs between services, creating more seamless care and continuity of care.
- Shifted the focus on care planning from treatment to prevention.
- Moved the focus of Clinical Pathways and care services to be patient / service user centred – not organisationally orientated.
- Achieved clinical, financial and social outcomes which are sustainable.
- Made personalisation available to all.
- Kept more people well – maximising individual quality of life / independence and reduced need for unplanned care.
- Many more people taking increased responsibility for their own care and managing their own health & well-being.

In particular, the Wolverhampton BCF plan will:

- Reduce emergency admissions
- Improve patient experience of services
- Reduce permanent admissions to residential & care homes
- Increase effectiveness of re-ablement services
- Reduced delayed transfers of care
- Optimise independent living post-discharge
- Maximising independence
- Avoid preventable hospital admissions
- Maintain /improve personal well-being
- Optimise GP managed care
- Ensure improved, more co-ordinated services across the health and social care pathway, including patients with mental health problems

- Support the management of Long Term Conditions in the community
- Maximise self-care
- Dramatically improve the dementia diagnosis rate

The over-arching measure of health gain will be fewer hospital bed-based interventions.

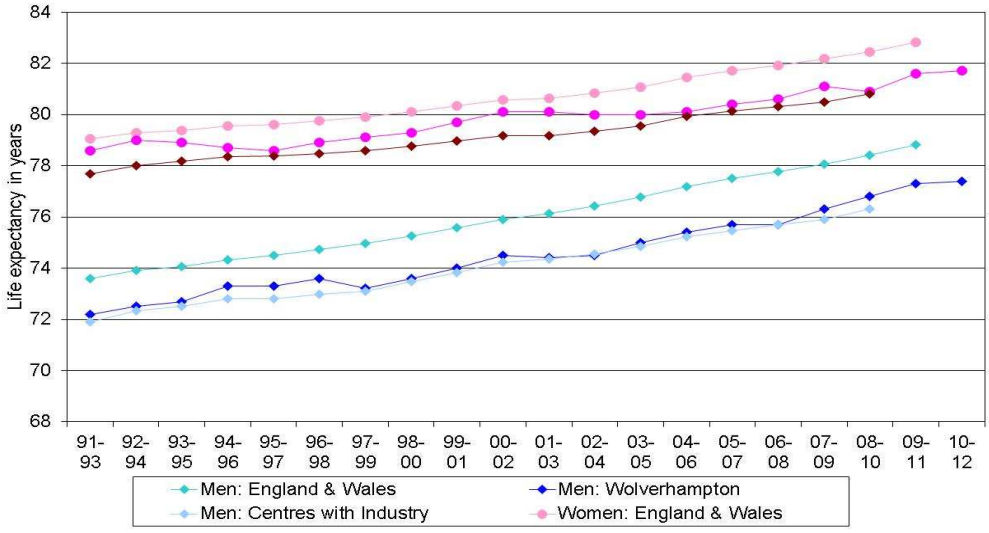
c) Description of planned changes

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

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

The JSNA for Wolverhampton shows people in Wolverhampton are living longer than ever before, however, the gap between life expectancy in the city and the national figure is not closing. Nevertheless, both males and females in Wolverhampton experienced lower overall life expectancy in 2010-12; 77.4 years for males and 81.7 years for females. This is almost two years less than the national average for both males and females. In addition, a male in Wolverhampton can expect to live just over 58 years free of any disability which is almost three years less that the national average. Women can expect to live almost 61 years free of any disability which is two years less than the national average. Therefore, not only do Wolverhampton residents live shorter lives but they also spend more of their lives experiencing ill health and disability.

Trend in male and female life expectancy in Wolverhampton



The analysis of key health problems has been shared across the local health and social care economy.

Social Care Dimension

What does the data tells about services for older people

- 80+ population will increase by 63% over the next 20 years
- 50% of Wolverhampton wards are amongst the most deprived nationally
- Too many resources are tied up in long term care
- We need to shift the balance towards community based intervention
- The spend per person is high
- There is a high unit cost, specifically relating to in-house services

What does the data tell us for younger adults?

- Reduced bed capacity within the Health provision for people with mental health needs
- Increased demand for Mental Health Act assessments
- We have too many young adults in residential and nursing care
- We pay too much for these services especially for disabled adults
- We like to look after people and can take away individual and family responsibility which doesn't support personalised support

The Plan for Older People

- To take an outcomes based approach to domically care
- To review external day care contracts
- Put re-ablement before assessment
- Have a focus on independence
- Review the Very Sheltered Housing Model

The Plan for younger adults

- Enablement and reablement before assessment
- Refresh the Mental Health reablement forward plan
- Work with the special schools to get the independence message across
- No one goes into residential care and everyone is given a ‘care in your own home’ option
- Everyone currently living in residential care is supported to move into their own homes
- Minimise the use of residential care for disabled children and adults for short breaks

The prioritised workstreams& projects have been developed through the series of whole system events and are based upon JSNA, the Health & Well-Being Strategy, CCG ICP and Local Authority strategic plan.

These workstreams are:

- Mental Health De-escalation
- Nursing & Residential Care
- Intermediate Care (Reablement/Rehabilitation)
- Dementia.

Mental Health De-escalation Workstream

Outcomes:

- To Maximise Recovery And The Support Of People With Mental Health Problems Within The Community
  - To improve patient experience and outcomes, supporting care as close to home as possible to reduce unplanned admissions

Project(s) :

- Urgent Mental Health Care Pathway including Liaison Psychiatry
  - Finalise Service Specification; Identify resources & funding; develop and implement action plan
  - Ensure patients are identified in Primary Care, with early referral to mental health services.
- Reablement Pathway
  - Agree the pathway; Finalise Service Specification; Review & align Service Specifications
- Co-production Recovery College
  - Adopt as a good process and sign up; Info & education re : 'What it is'; Review existing services

Success Factors :

- More people in recovery
- More people with mental health problems being managed within the community
- Less use of residential & hospital care

Nursing & Residential Care Workstream

Outcomes:

- To keep people well and prevent avoidable hospital admissions
  - To support Nursing & Residential Homes by providing in-reach support and education to reduce unplanned admissions

Project(s) :

- 1 GP Practice per Home
- Implement Single Commissioning & Contracting Arrangements
  - reflect analytical work; based on need; outcome focused specifications; monitoring & performance measurement
- Quality Standards
- Training & Education for Nursing & Residential Home Staff
- In-reach Services
  - covers training, chronic disease management & acute deterioration

Success factors:

- Less admissions to acute hospital from nursing & residential care
- Enhance capacity to look after people where they live
- Living life to the end of life

Intermediate Care (Reablement/Rehabilitation) Workstream

Outcomes:

- To maximise reablement after a period of ill health and provide alternatives to residential, nursing and hospital admissions
  - To deliver a single Intermediate Care Service that is easily accessible to all

Project(s) :

- 7 day therapy services
  - CICT proposal for OT/PT Sat/Sun; Rapid Response Services; To develop access to ILS; Explore therapy resources centres & West Park
- Single Intermediate Care Service including single point of referral
  - Develop work on clarifying boundaries/ease transitions; Clarity of referral process to external agencies; flagging CICT involvement on to Local Authority; Care First – review of assessment process (HARP)
- Single Assessment Process
  - Develop the process and act as the pilot for the Single Assessment Process prior to roll-out across Wolverhampton
- Community re-enablement network & directory
  - Earlier intervention – partnership

Success factors :

- Less A&E attendances
- Less emergency hospital admissions
- Speedier discharge (reduction in Length of Stay)
- Maximise re-ablement/rehabilitation
- Increase in the numbers returning to independent living

There is a significant challenge with the metric target of 89.5% for the 'Proportion of Older People who have undergone reablement or rehabilitation who are still at home 91 days post discharge'. Wolverhampton is already performing well in this area with our 2012/13 performance in the upper mid-quartile nationally and within our comparator group and significantly higher than both national and comparator averages.

Wolverhampton also offers reablement and rehabilitation to a much higher percentage of older people upon discharge from hospital due to the success of our current CICT and HARP services, with 2012/13 performance metrics showing that we offer reablement to 5.8% of people compared with a 3.7% average nationally and a 4.9% average amongst comparators. This puts us in the top quartile nationally and amongst our comparators.

Additionally, the project plans outlined in the submission aim to widen the criteria for people who are offered reablement or rehabilitation services post discharge and there is a risk that as the emphasis on offering these types of services to those who will benefit the most is reduced in favour of offering the services to more people in general, the success rate will naturally and not unexpectedly decline.

The current restrictions on the people who can be counted within this indicator based on the requirement that they must have undergone a social care or multi-disciplinary or social care assessment, excluding those that have received a health assessment only, may also prove a challenge with the relevant project streams needing to ensure that appropriate processes for multi-disciplinary assessments are implemented as part of the development of services. It is understood that the Department of Health are considering changes to this indicator so that health based reablement can be included, however this will not be in place for 2014/15.

Dementia Care Workstream

Outcomes:

- To provide holistic services that keep people with dementia well and independent
  - To deliver a dementia friendly city through agreed and implemented Dementia pathway across Health & Social Care

Project(s):

- Improve diagnosis rate and recording in Primary Care
- Single assessment process
- Increased Access to Resource Centres for patients with Dementia
- Dementia Hub
  - range of services; communication base; sign posting, etc..

Success factors:

- Improve the way care & support to people with dementia is provided
- Development of single assessments
- Use of named Lead Professionals
- Reduce crisis events
- Maintain independence
- Improve patient/user & carer satisfaction
- Learning to inform work on other Long Term Conditions

Initial Project Initiation Documents (PIDs) have been produced, these will be further developed as part of the next phase of the project, and will include:

- Service Vision – defining what the transformed service will look like, what this will mean for patients and users,
- Evaluation of existing services – value for money and quality,
- Implications for workforce,
- Quantification of contribution to metrics, targets and savings,
- Identification of any transitional (investment/pump-priming/double-running) costs for year 2014/15 – this will be funded from the transitional funding set-aside in the 2014/15 Operating Plan.

Further detail on each of the projects - from the initial PIDs - is included as related documents, together with the Better Care Plan on a Page and BCF Timeline summary documents.

d) Implications for the acute sector

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

This Integrated Better Care Fund Plan (the Plan) clearly displays the programmes and tactics for achieving our vision of meeting the health needs of the residents of Wolverhampton. Whilst acknowledging that we are yet to fully develop our approach and that we are working with a number of challenges, the Local Health & Care Economy has recognised that the integration of key services centred around the patient and citizen will deliver quality services; reduce or eliminate duplication and service gaps; and deliver efficiencies and financial savings.

As a result, we have split the creation and development of the BCF plan into two distinct phases:

- Establishment phase (Years 1 & 2):
    - To undertake the initial scoping work, develop governance structures, establish pooled budget arrangements and the scope of those arrangements.
    - Agree and embed the vision for the emergent partnership and set out detailed plans for the first two years of the programme.
    - During this phase, the scoping and detailed planning of the following stage will be undertaken to enable the significant expansion of the programme (and pooled fund).
    - This BCF Plan is largely concerned with this phase.
- Development phase: (Years 2 – 5)
    - Having created the foundations and infrastructure required for the ambition of the plan, The intention of the Wolverhampton Health & Care Economy is to further develop the programme.
    - Potentially including significant elements of spending and services currently locked into NHS contracts to enable transformational change across traditional health & social care boundaries.

This means that in Years 1-2, the focus will be on a review of existing services (including ensuring value for money & achievement of quality standards), establishing alternative services, testing the market for new or radically re-configured services and integrating care pathways. Together with other demand management initiatives in primary and secondary care, this will reduce demand for hospital based services, producing cash savings that can be transferred into other support and early intervention services via the BCF.

Both of the secondary care service providers – The Royal Wolverhampton Hospital Trust and The Black Country Partnership NHS Foundation Trust – have been actively involved in the development of the Better Care Fund Plan and the vision for service transformation.

Analysis has been undertaken to quantify the potential benefits associated with the Metric targets. At this stage the assumptions made are still to be finalised but the BCF is anticipating benefits accruing in the first year of c£4,807m. The gross benefits accruing have been identified as follows:

Permanent admissions of older people to nursing & residential care £'000	Delayed Transfers of Care £'000	Avoidable Emergency Admissions £'000	Total £'000
2,467	1,875	465	4,807

The figures pertaining to a reduction in permanent admissions of older people to nursing & residential care are based on the full savings – this level of savings will be realised however, there will be a need to re-invest a significant proportion to fund increased domiciliary services to support people in the community and their own homes. These monies would therefore not be invested in the BCF Pool they would instead be retained by the Local Authority in their capacity as commissioner for these services.

The impact on the acute sector primarily relates to the reduction in preventable admissions to be achieved from within the projects in order to hit and surpass the metric targets. Specifically we expect to reduce the number of unplanned admissions to the equivalent of £500k to be taken out of acute contracts (mostly RWT).

Reductions in avoidable emergency admissions have been discussed with the Royal Wolverhampton NHS Trust with consideration being given to 2014/15 and 2015/16 in particular. These assumptions are incorporated within the CCG's LTFM.

In addition, the work around developing intermediate care and reducing / maintaining DTOCS at a low level will drive system efficiencies, through reducing excess bed-day spend in the acute sector.

As stated in Section 2a – Vision for health & care services – in 5 years there will be a reduction in acute medical beds equivalent in numbers to 2 wards and a transfer of workforce numbers from acute to community services.

In developing the schedules of metrics and associated costs and benefits we have identified a number of queries and concerns relating to the data used. For the purpose of this return metrics have been articulated as provided via NHS England, however, data validation and subsequent costings will form a key task for the Information and Finance Workstream to focus on. These refinements to our figures will be reported and reviewed over the coming months.

The table below illustrates the value of the proposed transfer of CCG commissioning budgets into the BCF Pooled Budget by sector/organisation for 2015/16. For 2014/15 these budgets will remain with their originating organisation but will be operated in shadow form.

Organisation		
BCP		3,287,489
RWT		4,801,887
CCG/Reablement		2,266,000
3rd Sector		2,395,798
		12,751,174

Sources of funding – CCG Allocations

It should be noted that the CCG governance for the delivery of both the BCF and the Mental Health Strategy falls under the remit of the Integration Delivery Board. The Board will be responsible for ensuring that BCF and mental health plans are co-ordinated and complementary in order to avoid any duplication of activity, minimise any negative impact on the level and quality of services and achieve maximum integration of service delivery.

e) Governance

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

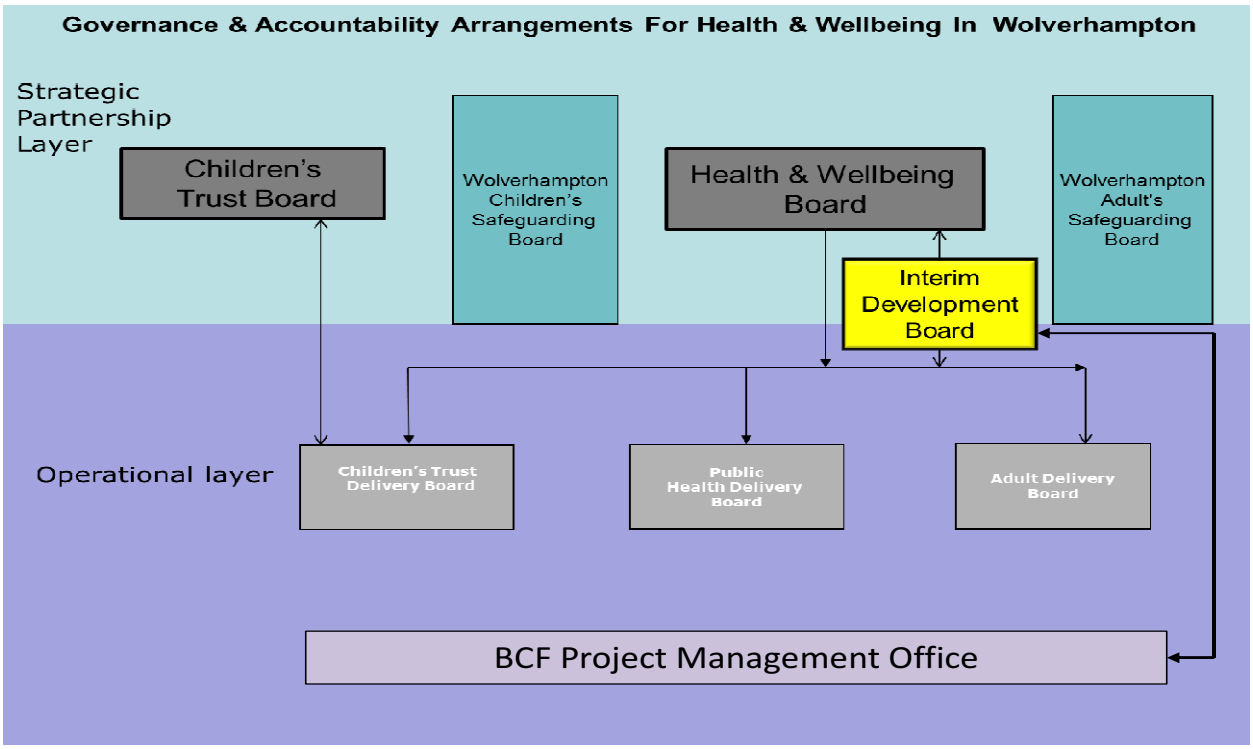
The Chief Executives / Accountable Officers of the key stakeholder organisations - The Royal Wolverhampton NHS Trust, The Black Country Partnership Foundation Trust, Wolverhampton Clinical Commissioning Group and the Local Authority [Community Directorate of Wolverhampton City Council] - have set up a structure to develop the response to the requirements of the Better Care Fund and implement the plan.

An Interim Development Board (Terms of Reference attached) has been established as a short term multi-agency governance body comprised of a group of senior executive directors from each key stakeholder organisation including the Directors of Finance (or equivalent) and Directors of Planning / Chief Operating Officers (or equivalents) plus the Director of Public Health.

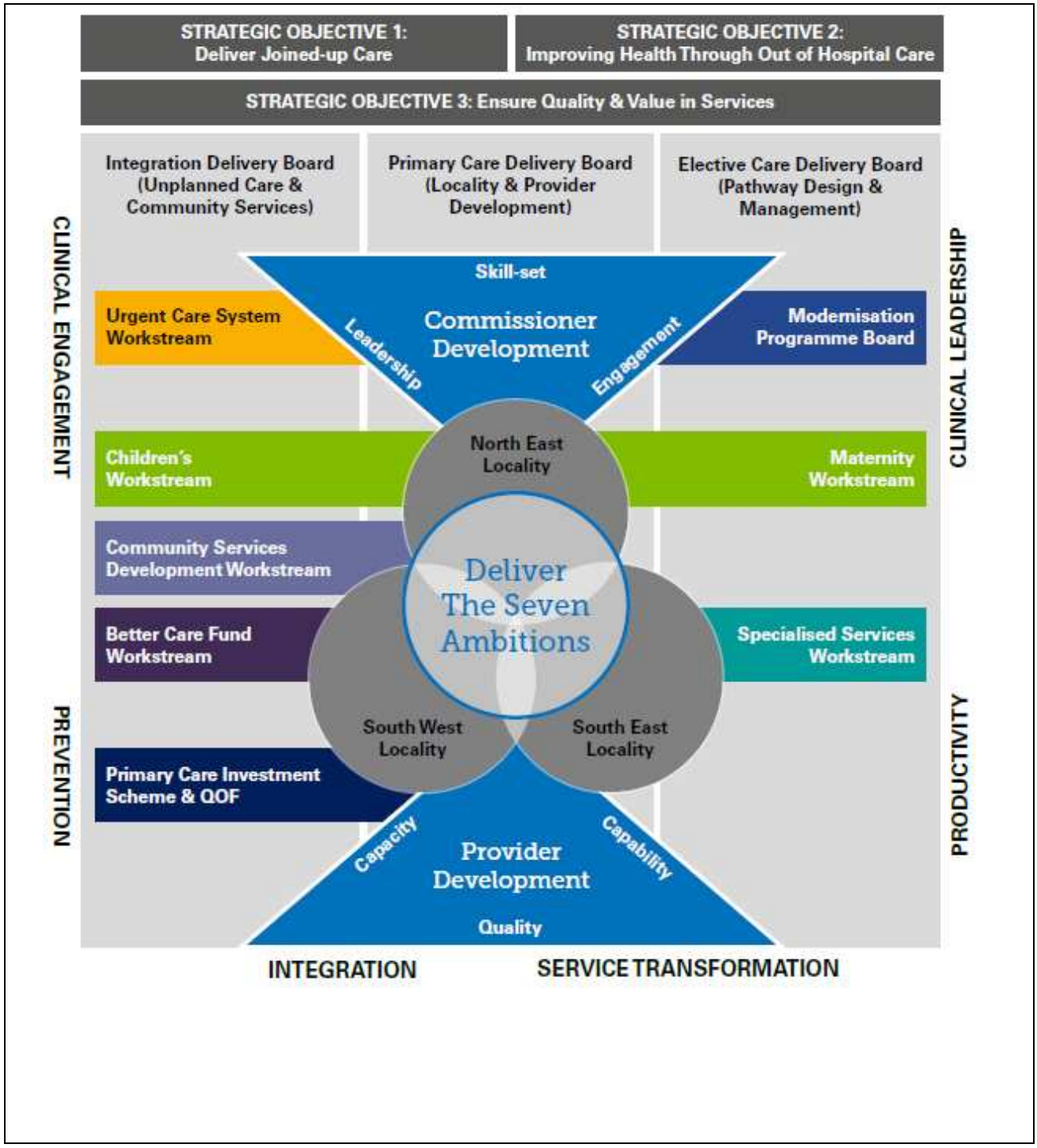
This Interim Development Board will report directly to the Health & Well-Being Board until such time as the existing structures of the Health & Well-Being Board have been constitutionally altered to provide overall governance and management of the proposed pooled budget and the work programme associated with the Better Care Fund Plan – planned for Quarter 1: 2014/15. In due course, operational and executive layers within the Health & Well-Being Board structures will assume the routine management and

accountability for the workstreams. The Health & Well-Being Board itself will remain the sovereign body accountable for the newly stabled pooled budget arrangement.

The graphic below illustrates the current Health & Well-Being Board governance arrangements.



Whilst the Health & Well-being Board will remain the sovereign body accountable for the Better Care Fund. The programme will also form a key part of the CCG Governance structure – shown below – and as such the individual projects will report into QIPP Portfolio Board via the relevant Delivery Board – this will ensure operational oversight of the individual projects and allow early identification of emerging risks and challenges.


STRATEGIC OBJECTIVE 1:
Deliver Joined-up Care
STRATEGIC OBJECTIVE 2:
Improving Health Through Out of Hospital Care
STRATEGIC OBJECTIVE 3: Ensure Quality & Value in Services
Integration Delivery Board (Unplanned Care & Community Services)
Primary Care Delivery Board (Locality & Provider Development)
Elective Care Delivery Board (Pathway Design & Management)
CLINICAL ENGAGEMENT
CLINICAL LEADERSHIP
PREVENTION
PRODUCTIVITY
Skill-set
Commissioner Development
Leadership
Engagement
Urgent Care System Workstream
Modernisation Programme Board
Children's Workstream
Maternity Workstream
Community Services Development Workstream
Better Care Fund Workstream
Specialised Services Workstream
Primary Care Investment Scheme & QOF
North East Locality
South West Locality
South East Locality
Deliver The Seven Ambitions
Capacity
Capability
Provider Development
Quality
INTEGRATION
SERVICE TRANSFORMATION

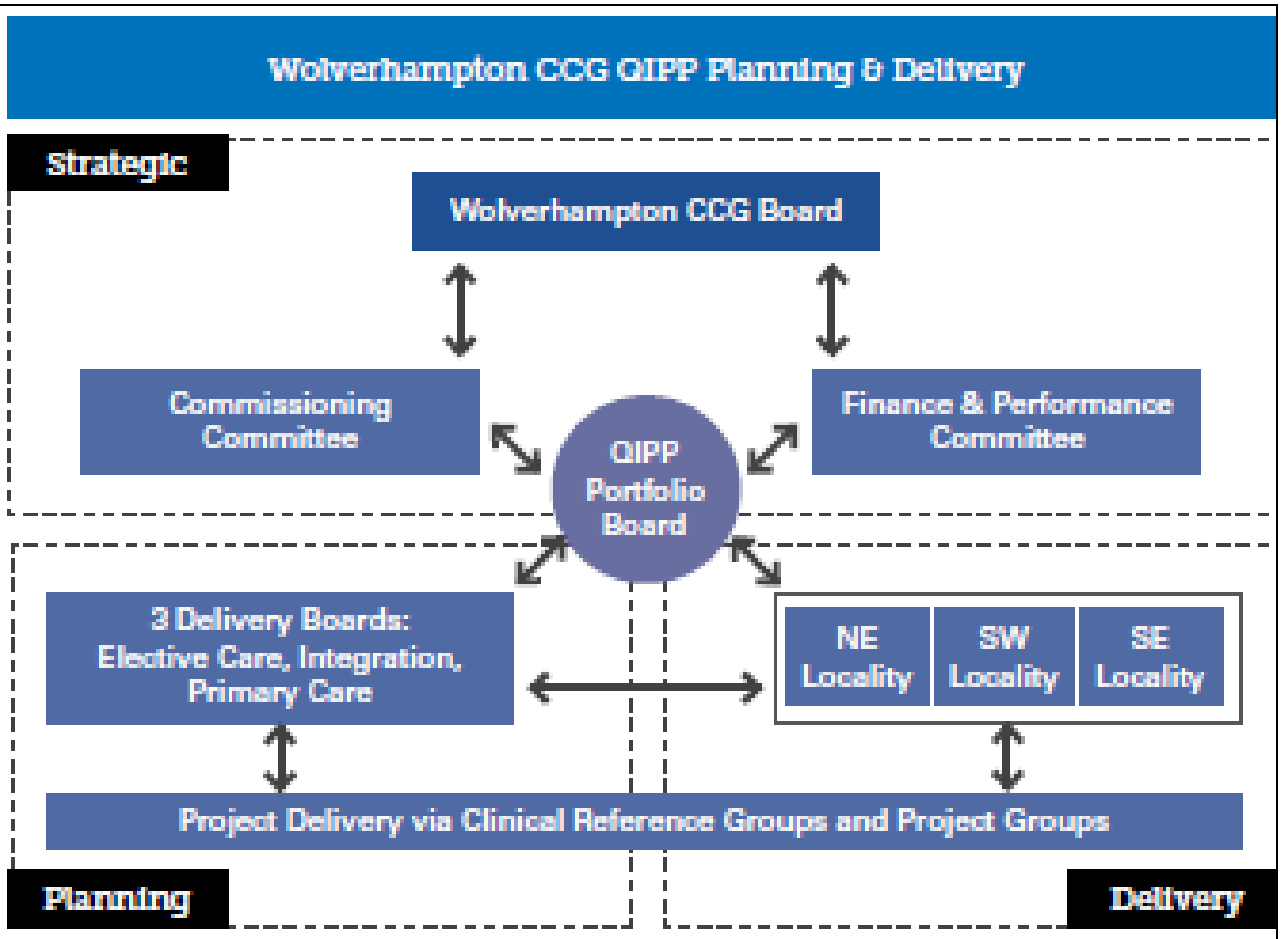
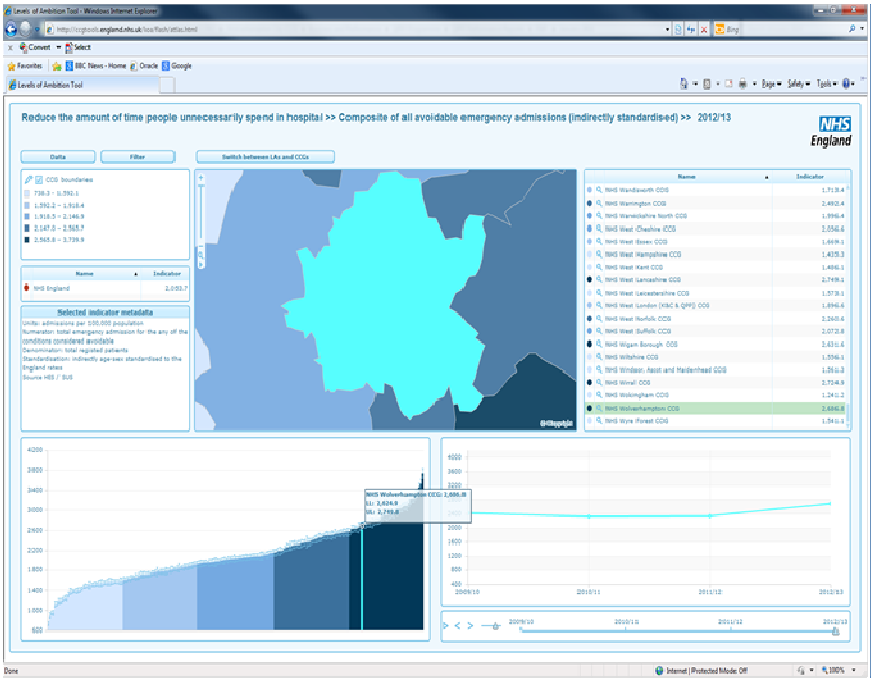


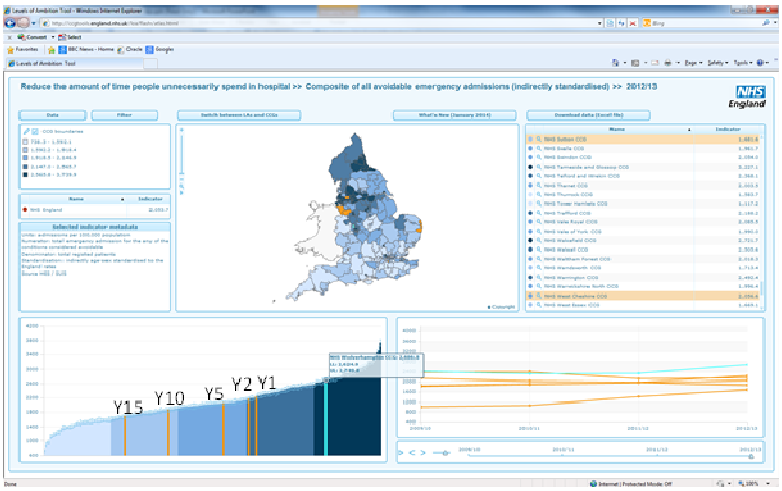
Fig 34

The following dashboard will be used in conjunction with the metric target graphs (see related documentation) will be used to monitor performance.

Metric 4 – Avoidable Emergency Admissions



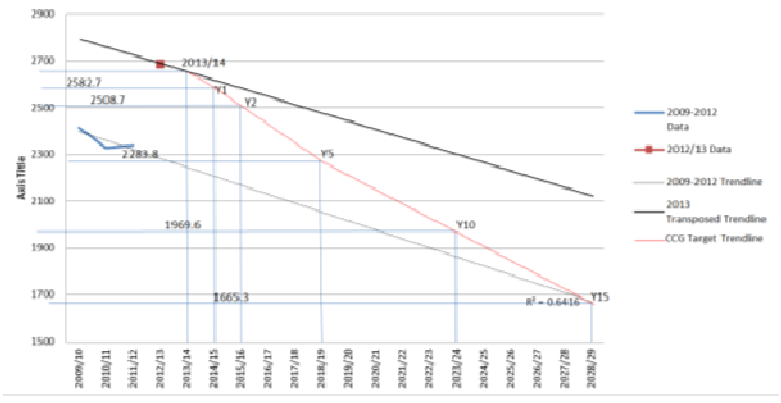
Contributing Projects
UC - Frequent Service Users
UC - Rapid Falls (now WMAS convenience)
UC - GP (or ANP) alongside A&E
UC - Paediatric Hot Clinic
UC - Dr First
UC - Assisted Visiting Service (AVS)
UC - Development of the Urgent Care Centre (UCC)
Meds Opt - Prescribing
LTC - Respiratory Hot Clinic
LTC - Primary Care Investment Scheme
LTC - High Impact Users (Health & Social Care Data)
LTC - Assistive Technology
LTC - Anticoag
LTC - Link with IC Nursing Homes Project
IC - Wrastons Bed Based Intermediate Care
IC - Review of Step Down Provision
HPB - Calprotectin
HPB - Endoscopy Outpatient Project
BCF - Liaison Psychiatry (Mental Health)
BCF - Reablement Pathway (Mental Health)
BCF - Recovery College (Mental Health)
BCF - Physical Health of Mental Health Patients
BCF - 1 GP practice per Nursing/Residential Home
BCF - 7 day therapy services
BCF - Single Point of Referral for Intermediate Care
BCF - Single Intermediate Care Service
BCF - Dementia Hub
Community Services Development
COUIN - Supporting Safe & Early Discharge from Hospital
COUIN - Patient Ward Moves
COUIN - Urgent & Emergency Care Services and their supporting diagnostic services



The process for setting this target has been:

1) The CCG has taken into account previous performance to set a trendline for the long term target;
2) This was transposed to current baseline (from ATLAS) to set a start point;
3) QIPP intentions were added for Y1 target;
4) 15% ambition for reducing emergency ambitions added for Y5 target;
5) Series extended to meet long term 15Y target based on 2009-2012 trendline data.
6) Triangulation with BCF Statistical Significance Calculator and CSU data.

Composite of all avoidable emergency admissions Linear trendline (R^2=0.6416) 2009 to 2012 transposed to 2012/13 (actual = 2686.8)



Financial Governance – relates to Part 2 completion

Presentation of Contribution to the Pool
The finance template (part 2) has been populated with information collated from both CCG and Local Authority budgets and the NHS related figures exceed the minimum values required by national guidance. Budgets for those services currently jointly commissioned by the CCG and Local Authority have been included within the template. In addition, the Local Authority's HARP service has been included due to the interdependency between this and the CCG-commissioned intermediate care services included in the figures.

There are a further series of Local Authority funded services - related to the Better Care Fund workstreams - which it would appear reasonable to include within the pooled budget, again, due to their interdependence with CCG-commissioned services. These have been included in the template position and presented as forming part of the pooled budget however this position will need to be reviewed subject to the appropriate governance and constitution changes being made within the Local Authority.

14/15 Figures
In 2014/15 the CCG and Local Authority will not operate a formal pool. Instead we will function with shadow arrangements; working jointly to prepare for and support services into transition. The figures included in the 14/15 columns of the finance template reflect the totality of budgets to be managed under the shadow arrangements.

15/16 Figures
Where benefits are captured in 2015/16 figures it should be noted that the figures presented represent the total benefits captured. This is not fully reflective of the value of monies to be reinvested into the BCF Pool. In most cases there will be a direct investment of the benefit numbers into the Pool however there may also be agreement between the CCG and Local Authority to retain monies within the commissioning organisation where they are realised.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

The Wolverhampton BCF (and its partner organisations) recognises the challenges for social care – and its need to protect statutory and essential preventative services – and will protect funding for the Care Bill and demographic growth in its financial planning.

The BCF partners are taking the following steps to protect short term expenditure.

I. DFGs/Carers Grant and Community Capacity Grant are automatically passported through to Local Authority social care;
II. Demographic growth of £2m a year is built into the budget.
III. Allocation of £989,000 to fund the Care Bill is built into the Better Care Fund.
IV. NHS transfer (section 256 / NHS support for social care) is seen as a key component of social care's contribution to the Better Care Fund and the protection of social care services.

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

The Wolverhampton Better Care Fund journey will build upon the strong existing work on integration of services. Our research and forecasting/commissioning has identified demand management, maximising people' independence and limiting the impact of any unpredicted decline to be the key components of this work and we already know a considerable amount about what can work in this area.

Our existing strong, collaborative, working in the field of intermediate care/ resource centres and joint Learning Disability and Mental Health provision form a firm foundation for future action.

The BCF action plan seeks to take each of these key theses to the next phase of operation by developing models which are predicated on one emphasis on outcomes, one process and one journey for the individual through the system.

This aspiration will cross All Adult Social Care groups and include all elements of service commissioning and provision.

Two key issues that are currently being picked up are the use of one identified lead professional between the services and 7 day a week working.

Protection for Social Care and Reducing Hospital Admissions - achieving both at the same time

The Council in Wolverhampton had made a commitment to maintain the current level of eligibility at critical and substantial. The opportunity to redesign services in ways that have a proven impact on reducing demand is a critical part of the approach. We know that if our reablement and intermediate care services were better aligned we would meet peoples' needs at a lower level, so improving outcomes for the person as well as reducing the reliance on beds and using resources more efficiently. We have already identified that a discontinuous system allows us to increase peoples' dependencies and we need to set up systems that stop this happening. This is inherent in each workstream.

The evidence from recent research undertaken by the Council is that demand reduction by both reablement and prevention offers the only sustainable service options for the future and the synergy and waste avoidance that can be captured by integrating this across the whole health and social care community offers the only solution for resource viability across the public sector.

In addition, we will :

- work together to ensure services are joined up and not duplicated or working in silos
- find alternative models of care to reduce the need for long term residential care and to support people to stay in their own homes where possible
- reduce the reliance on acute hospital care which will release funding to provide more low intensity interventions.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy).

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

A significant number of the schemes and projects contained within this BCF programme will introduce or (more frequently) extend 7-day services in health & social care to support patients being discharged or provided with alternative and clinically appropriate care. Intermediate care workstream plans will further develop a range of social care and therapy based services to augment existing 7 day services.

Within The Royal Wolverhampton Hospital Trust, staffing levels and skill mix are reviewed each year as part of the annual planning round. Where professional bodies provide guidance on staffing this is used to inform plans. Over the last year there were increases in consultant staffing to ensure provision of onsite presence of senior consultants' 7-days a week. Nurse staffing is reviewed using the AUKUH (Association of UK University Hospitals) model, most recent changes include making Band 7 Ward Managers supervisory and approval to recruit c.150 ward nurses in recognition of the rapidly changing dependency of our patients in acute wards and the need to increase the

number of weekend discharges.

Corporate services and back office functions will be market tested against industry levels over the next few months to ensure they are competitive on value and quality.

7-day working is already established in many aspects of the Wolverhampton LHE – within the next six months there will be a social work presence in the acute hospital seven days per week and the Integrated Discharge Team will be an integral part of 7 day discharge processes.

Within Primary Care the CCG is piloting weekend working and additional hours working for GP Practices, this will be evaluated and form part of the trajectory to achieving 7 day services in Primary Care. The CCG 5 year Strategic Plan clearly sets out an ambition to work towards practices in Wolverhampton opening 7 days per week for 12 hours per day.

The development of these services will be co-ordinated with the identified workstreams within the current BCF Programme.

Intermediate care workstream plans will further develop a range of social care and therapy based services to augment existing 7 day services and prevent un-necessary admissions at weekends.

Within the CCG SDIP with its main providers, the CCG has specific actions relating to 7-day working. This has been developed by the CSU and is the same in all contracts across Black Country. (see below).

Each provider of acute services must agree with local commissioners, and detail within an SDIP, action that it will take during 2014/15 to implement the clinical standards set out in the *NHS Services, Seven Days a Week Forum* review into seven-day services	Subject to General Condition 9 (Contract Management)	Provider to work up plans for the adoption of ten clinical standards that describe the standard of urgent and emergency care that patients should expect to receive, seven days a week. The standards include: 1. Patient Experience 2. Time to consultant review 3. MDT review 4. Shift handover 5. Diagnostics 6. Intervention/ key services 7. Mental Health 8. On-going review 9. Transfer to community. Primary and/ or social care 10. Quality improvement Implementation of the clinical standards as per the action plan agreed for full rollout by end of Q4	Plans to be made available to and agreed with the CCG by end of Q1 Q2-Q4

c) Data sharing

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

Better data sharing is a key component of the vision for BCF in Wolverhampton and work is progressing well on this – going forward the NHS Number will become the core identifier across all workstreams and services.

The NHS services are achieving the standards required for the use of the NHS number.

The city council have 70-75% of NHS numbers in CareFirst for current service users, people who have received a service in the past 2 years or people who have received an assessment in the past 12 months and continue to undertake regular batch matching exercises with the Acute Trust.

The next phase of work will be to embed the collection of the NHS number in social care assessment, review processes and systems over the coming months, alongside system and process changes to support the implementation of the Zero Based Review of Adult Social Care returns.

There is some initial work being undertaken with the CCG and CSU to link health and social care data via the CSU to understand the health and social care 'footprint' across the city – based on work undertaken in Birmingham and which Walsall, Solihull and Sandwell are commencing. This is currently with Information Governance Teams for sign off.

At its April meeting the Wolverhampton Health and Wellbeing Board approved the formation of a Health and Social Care Indicator and Information Group - made up of information and performance experts from across the partner organisations - in order to consolidate and improve the levels of sharing of information and data (using NHS number).

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

N/A

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

Robust information sharing is recognised by Wolverhampton as being key to successfully delivering the aims and plans of the Better Care Fund. Social Care have already begun to collect and record NHS number in the primary Social Care System (with over 70% of clients now having NHS number recorded) and work is being undertaken to embed the collection of NHS number within the assessment and care management process.

The Local Authority will lead on implementing processes for more robust information sharing and will work with the shared IT project stream to begin to look options for developing interfaces and API's between health and social care systems. This work is currently in its infancy, however, the development of a cross-partnership Health and Social Care Metric and Information Group has recently been approved by the Health and Wellbeing Board to take this work forward in line with embedded IG principles and agreements.

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

See above.

The work of the Health and Social Care Metric and Information group will ensure that any data sharing that takes place will fall within IG frameworks incorporating the IG Toolkit and Caldicott 2 :

- Staff receive training related to information security, the use of information and their personal responsibilities.
- Adequate security and working procedures are put in place.
- Systems are in place to monitor all aspects of information security.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Care Planning for Disease and Risk Modification

Currently, all practices in Wolverhampton are engaged with the 2013/14 Primary Care Investment scheme which was initiated at the beginning of December 2013. The scheme uses a technical solution built on GP data that identifies and risk stratifies diabetic patients. GP practices, supported by the CCG and other providers (in acute and community care), develop and deliver proactive care plans for individual patients which places the emphasis on patient as well clinician management of the condition.

In 3 months - 7000 care plans have been produced for diabetic patients, using a process of patient targeting, risk stratification and care planning. Positive feedback has been received from clinicians (both primary and secondary care) and patients. The system has been designed in order to deliver improved health outcome, better co-ordination of care, improved patient self-management and reduced emergency admissions through the proactive modification of disease.

<u>Short – Medium Term Objectives for Disease and Risk Modification for the elderly and /or those with a Long term Condition</u>

In accordance with national guidance, our local priorities and the key messages from the Wolverhampton JSNA, we recognise that the proactive care management for the elderly and those with a long term condition is key to delivering our strategic objectives over the next 5 years.

Through disease and risk modification we intend to:

- Improve health outcome
- Reduce the burden of demand on healthcare services, particularly in terms of emergency admissions
- Address health inequality
- Focus on delivering care outside of hospital
- Focus on delivering proactive, co-ordinated and integrated care
- Engage and enable people to become involved in the management of their condition and the care that they receive

<u>Target patient population</u>

The CCG commissions significant levels of service and activity for patients with a long term condition and the elderly. With better planning and co-ordination, we predict that greater levels of service and quality can be provided with the resource that we have

available.

There are 193888 people over 75 registered with a Wolverhampton GP.

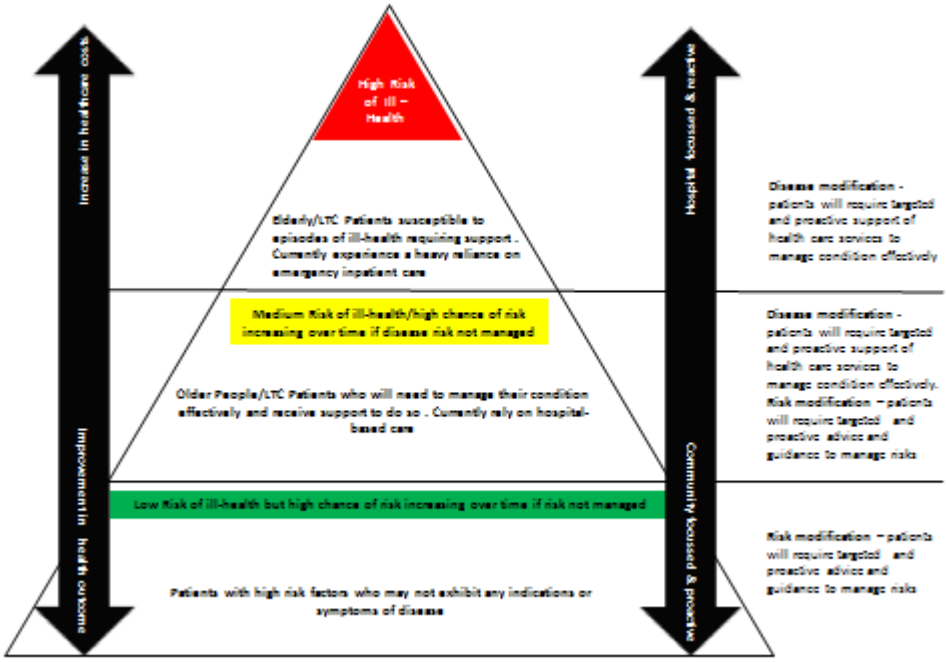
Sample LTC Prevalence in Wolverhampton, based on QoF registers (figures do not account for multiple LTCs)

- 20473 with respiratory disease
- 16340 with diabetes
- 9462 with CHD
- 4663 with stroke
- 39885 with hypertension
- 5057 with cancer

Strategic Intention

Our approach to developing disease and risk modification is built upon the systems and processes that we have developed as part of the Diabetic Optimal Management Index, Integrated Care Pathway and the implementation of care planning via the Primary Care Investment Scheme.

We intend to use the Optimal Management Index technical infrastructure, combined with clinical and managerial support, and the Primary Care Investment Scheme in order to target specific patient cohorts for, initially, disease modification, graduating to risk modification intervention over the course of this 5 year plan. In this way we will target those within the care system currently at greatest immediate health risk in order to proactively plan their care in order to improve their health outcome and reduce the need for emergency services. We will modify their disease risks so that they can live healthier and more fulfilling lives. As we do so, we will also start to shift our attention to those patient cohorts who are either at early, maybe undetected stages of disease or those who exhibit high risk factors. Using the same approach as our disease modification plans, and working in partnership with the Local Authority Commissioning and Public Health teams we will target patients and invite them to become involved in risk modification interventions using a proactive care planning approach, co-ordinated in primary care.



<u>High Level Development Milestones</u>

Our initial focus of activity in the next 2 years is to implement disease modification using care planning as the cornerstone in order to improve the health outcome and reduce emergency admissions for those at highest risk of ill-health. We will do this by targeting, risk stratifying and developing care plans for all long term condition patients and those over 75. This will be enabled using the Primary Care Investment Scheme and the national GP Contract for Enhanced Service for LTCs. In the longer term, years 3-5 of our Strategic Plan, we will target patient groups for risk modification interventions working in partnership and alongside the Public Health team from Wolverhampton City Council.

<u>Key Delivery Vehicles</u>

As part of the development of the Optimal Management Index and the Primary Care Investment Scheme, the CCG has developed the technical architecture, tools, support processes, supporting teams and care plans in order to support the delivery of care planning in primary care for risk stratified target patient cohorts. The CCG has made significant progress in delivering this for the care of Diabetic patients in 2013/14. We intend to use these processes for care planning in order to deliver disease modification in the short term graduating to proactive risk modification in the medium to long term.

Lead Professional

There are specific projects in two workstreams – Intermediate Care and Dementia – that focus on single, multi-disciplinary, assessment and allocation of lead professional, by their very nature these projects will include plans for the integration of community based multi-disciplinary health, mental health and social care teams.

Rather than re-inventing the wheel, work on single assessment and lead professional will utilise research on existing models and piloting to determine the best 'fit' for Wolverhampton.

The lessons learnt in these workstreams will allow single assessment and lead

professional allocation to be rolled out to all long-term conditions.

Models used in other parts of the country accept referrals into the named service – either as admission prevention or supported discharge; identify which professional – from the content of the referral – would be the most appropriate to undertake the assessment on behalf of the service. Once the assessment is complete the service then discusses which professional will take the lead and which elements of the service will be applicable to the patient.

In the interim, people at high risk of hospital admission will have an agreed accountable lead professional.

In addition to the single assessment process - as an enabler project - the CCG is working collaboratively with the CSU and the Local Authority to map social care data across health services to inform BCF projects moving forward. There is a requirement to agree a true health and social care virtual ward model focussing on emerging risk groups for the future.

One of the aims for the BCF is joined up care planning. Scoping work is underway to explore existing or new systems that extract data from GP systems and creating programmes around those moderate to high risk groups. This risk stratification approach would be replicated with social care data (using NHS numbers and single assessment process) to identify vulnerable people across the broadest range of factors that cross traditional silos.

4) RISKS

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

A risk register has been compiled from the initial Project Initiation Documents and is attached to this template, this register will be updated as work on the individual projects commences and proceeds. An up to date copy of the risk register will be reviewed by the Interim Development Board at its monthly meetings.

Set out below are the systems risks.

	ID No.	Risk	Possible Outcome	Consequence (Initial)	Likelihood (Initial)	Rating (initial)	Mitigation	Owner	Residual risk score
System Risks	1	Failure to reduce Avoidable Emergency Admissions	Avoidable Emergency Admissions continue current trends	Possible	Major	12	BCF Projects : MH Urgent Care Pathway, MH Reablement Pathway, MH Recovery College, Single Intermediate Care Service, 7 Day Therapy Servies, Training for Care Home Staff, 1 GP per Care Home, In-reach Specialist Services, Single Commissioning (NH/RH) Arrangements, Dementia Hub	All workstreams	9
	2	Financial risk of failure to reduce Avoidable Emergency Admissions	Finaicial risk to CCG under PbR/Tarriff	Likely	Major	16	CCG Contingency Funds	CCG	16
	3	Increase in resources (financial and staffing) required to facilitate 7 day therapy working	Unable to implement	Likely	Major	16	Use BCF Transitional funding until such time as other projects delivery savings. If necessary recruit via agency.	Intermediate Care Workstream/Pooled budget holder	6
	4	Financial regime of the Local Authority in light of the reduction in budget & spend	Savings identified as accruing to BCF may be required to contribute to WCC plans. This would threaten the financial viability of the BCF.	Likely	Major	16	Finance and Information workstream to monitor and work together for early identification and mitigation of risks arising.	WCC	12
	5	Destabilistation of health care providers	Commissioning of services to deliver financial viability of BCF may require radical changes to services and potentially have a detrimental impact on provider income streams.	Possible	Major	12	Full engagement in BCF by provider units with early sharing of commissioning plans to identify risks and mitigations.	All workstreams	6

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NHS
Wolverhampton
Clinical Commissioning Group

Better Care Fund

Health & Well-Being Board 7th May 2014

Noreen Dowd
Interim Chief Operating Officer

NHS
Wolverhampton
Clinical Commissioning Group

Update

- BCF Plan submitted on 4th April
- Clarification required on 1 point
- Plan resubmitted on 16th April
- Initial feedback :
  - No 'Red' rated sections on the template
  - Overall Financial Assessment – Amber
  - Plan is not deemed High Risk
  - Local Area Team recommend plan to be approved
- Next phase is to :
  - Move into more detailed project planning to ensure desired outcomes are achieved
  - Review programme support & project team development
  - Finalise infrastructure & support for operational workstreams
  - Identify team members , & set up meetings, for core function workstreams

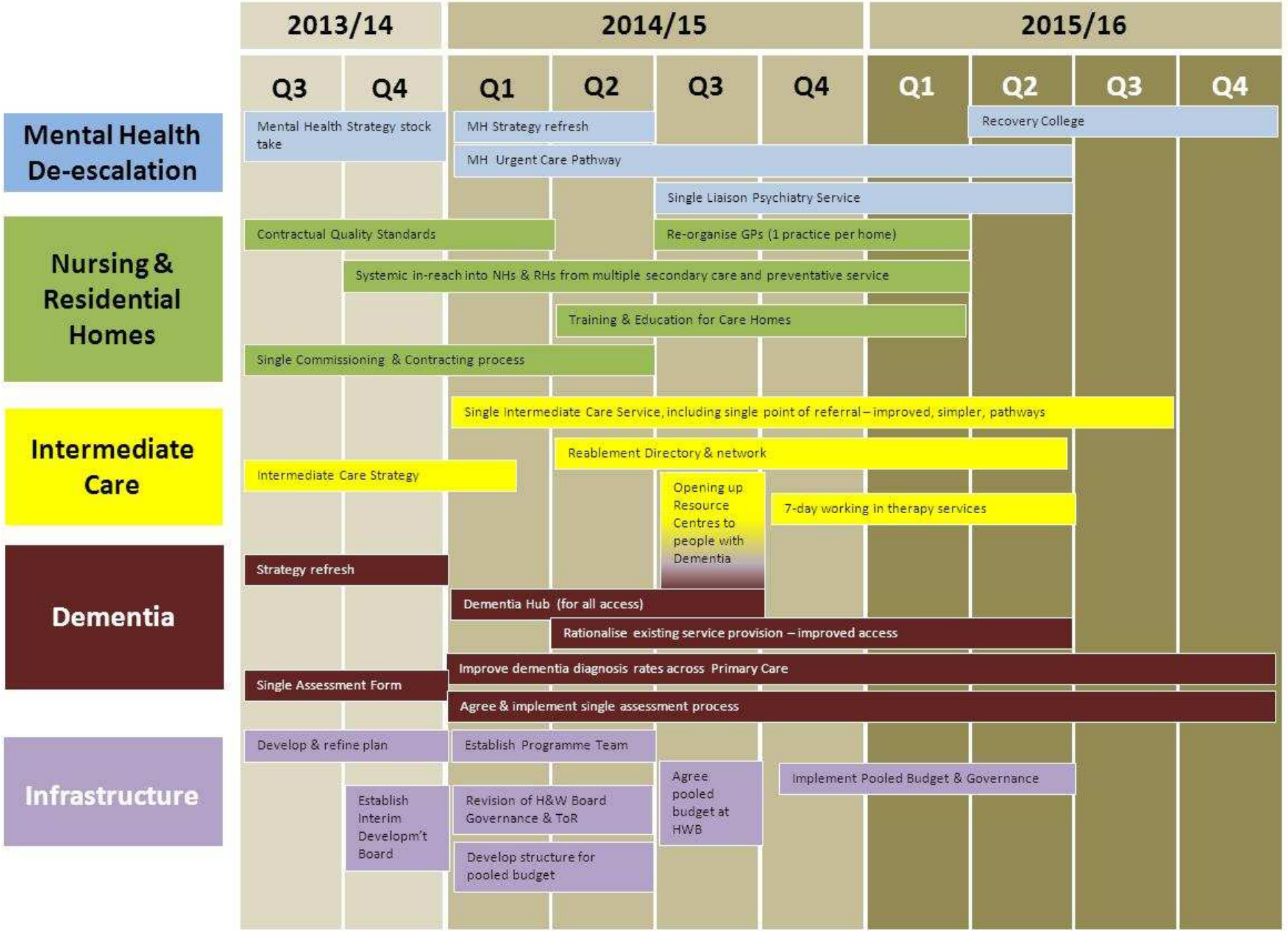
Better Care Fund: Plan on a Page

V7.1

Vision: **Wolverhampton One Ambition, Working as One for EveryOne.**

Strategic Objective	One Ambition	Working as One	For Everyone
What Are We Trying To Do?	Single Plan Sharing everything Keeping People Well	Integrated Pathways All Partners Working Together Shared Sustainable Outcomes	Each Individual Prevention & Recovery Self-caring Communities
Priority Areas			
Mental Health De-escalation	To Maximise Recovery And The Support Of People With Mental Health Problems Within The Community	• MH Urgent Care Pathway • MH Reablement Pathway • Single Liaison Psychiatry Service	• Recovery College
Intermediate Care	To Maximise Reablement After A Period Of Ill Health And Provide Alternatives To Residential, Nursing And Hospital Admissions	• Single Intermediate Care Service to include single point of referral • Single Assessment Process	• Reablement Directory & Network • 7-day Therapy Services
Nursing & Residential Care	Keep People Well & Prevent Avoidable Admissions	• Quality Standards • Single Commissioning Arrangements	• Training For NH & RH Staff • 1 GP Per Care Home • In-Reach Specialist Services
Dementia Services	To Provide Holistic Services That Keep People With Dementia Well And Independent	• Single Assessment Process • Increased access to Resource Centres	• Dementia Hub • Improved diagnosis & recording rate in Primary Care
Outcomes Sought	• Increase in effectiveness of these services whilst ensuring that those offered service does not decrease • Reduced Hospital Admissions	• Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.	• Older people (65+) continue to live in their own home. • Local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience.
	• Reduce Emergency Admissions Which Can Be Influenced By Effective Collaboration Across The Health And Care System.		
Outcome Targets (see Metrics table)	• Increase proportion of older people still at home 91 days after discharge from hospital into reablement services	• Reduce delayed transfers of care from hospital per 100,000 population • Increase diagnosis and recording rate of Dementia in Primary Care	• Reduce Permanent admissions of older people (65+) to residential and nursing care homes, per 100,000 population
	Reduce Emergency Admissions		

Better Care Fund – Timeline chart



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Recommendations to Health & Well-Being Board

1. Note the feedback and recommendation of the Local Area Team – for the plan to be approved.
2. Note the next phase of work to ensure delivery of the plan.

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Agenda Item No. **12**

Health and Wellbeing Board

7 May 2014

Report Title	Public Health Delivery Board: Chairs Update
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Community / Public Health
Accountable officer(s)	Ros Jervis — Director of Public Health Tel — 01902 551372 Email — ros.jervis@wolverhampton.gov.uk

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Recommendation(s) for action or decision:

That the Health and Wellbeing Board (HWBB) notes the progress of the key work streams of the Public Health Delivery Board (PHDB) work programme for 2013/14.

1.0 Purpose

1.1 To inform the HWBB of the current work of the PHDB and in particular matters arising from its meeting of 8 April 2014.

2.0 Background

2.1 A key focus of the April meeting was to explore links between Public Health and the Voluntary Sector. Ian Darch, Chief Executive of Wolverhampton Voluntary Sector Council, presented a paper on the voluntary sector services. The Better Care Fund was discussed as a potential vehicle for integrated working between the voluntary sector community and health & social care in order to achieve better health outcomes of the people of Wolverhampton. There was a request from the VSC to public health in terms of how may be able to facilitate an agile/flexible approach by the VSC and how could we best support action within primary care in relation to social prescribing. These initial discussions will require further work and investigation however this paper generated a lot of positive discussion.

2.2 One of the Transformation Fund projects is to strengthen the voluntary sector council to specifically develop a model to engage the statutory sector and communities and focus on one particular theme or issue. Particular examples of issues to address are establishing and maintaining a healthy weight and building the capacity for Wolverhampton Clinical Commissioning Group to test community commissioning. The areas which will be targeted as part of this pilot are two of our most deprived wards, Health Town and Bilston East.

3.0 Joint Health and Wellbeing Strategy

3.1 The wider determinants priority of the Joint Health and Wellbeing Strategy highlights two key areas of work to illustrate both the scope and the scale of the partnership working. These co-ordinated partnerships are required to improve health and reduce health inequalities across the wider determinants of health in the following areas:

- obesity
- the prevention of looked after children

3.2 An update paper on the Wider Determinants priority is being presented to the HWBB as a separate agenda item providing further details including the work being done on the prevention of looked after children. This paper will also provide details of the establishment of a healthier places team alongside other related initiatives.

3.3 Obesity is the theme of the Annual Report of the Director of Public Health 2013/14 and represents a ‘call to action’ for all partners to address this area of local concern. This report will be the subject of a paper which will be presented to the Health and Wellbeing Board in July 2014.

4.0 The Public Health Delivery Board Work Programme

4.1 A review of the defined Public Health work streams within this year's (2013/14) work programme was undertaken as usual with consideration of how this may be affected as the work programme is adapted to address the priorities identified for 2014/15. The final Public Health Business Plan 2014/15 will be presented to next Public Health Delivery Board on the 10 June 2014.

4.2 The PHDB received update papers in relation to the following key work streams for 2013/14:

4.3 Transformation Work Stream

4.3.1 The panel overseeing the Transformation Fund have selected five projects for funding in round two. One project the panel recommended for funding was above £100,000 threshold. The process approved by the Health & wellbeing Board in September 2013 requires all projects over the £100,000 threshold receive ratification from the Health and Wellbeing Board (or Chair delegate). This project has now been ratified by Councillor Sandra Samuels, Cabinet Member of the Health & Wellbeing Board. A full report of all projects supported in both rounds will be presented to next Public Health Delivery Board on the 10 June 2014.

4.4 Health Protection Work Stream

4.4.1 The Director of Operations of the NHS England Area Team and Co-Chair of the Local Health Resilience Partnership asked the Health Protection Forum to undertake a process with key partners to establish local arrangements for dealing with incidents and outbreaks. An initial template was completed by key local stakeholders which were subject to discussion and challenge at the Forum meeting, during which local partners and Public Health England (PHE) reached agreement on local processes.

4.4.2 It was agreed that a Wolverhampton Concept of Operations (CONOPS) would be developed and a draft presented at the next Forum meeting. A draft Memorandum of Understanding for managing incidents and outbreaks across the Area Team footprint of Birmingham, Solihull and Black Country has also been circulated for comments. Wolverhampton submitted a detailed commentary, which was formally acknowledged.

4.4.3 Wolverhampton CCG and Public Health are leading on the development of a Black County Emergency Preparedness Resilience and Response service. An initial options appraisal paper has been developed for consideration by the four Black Country CCGs and Walsall, Sandwell and Wolverhampton Public Health departments.

4.4.4 A national consultation has been launched on the development of services to tackle options for the delivery of Tuberculosis (TB) services. The consultation is pertinent to Wolverhampton as it is recognised that rates in urban areas of the West Midlands are

challenging. The strategy recognises the need to ensure new entrants are screened for TB as a priority. There are also proposals to consider the optimum arrangements for commissioning TB services. Wolverhampton public health will be coordinating a multi-agency response to the strategy.

4.5 Public Health Commissioning Work Stream

4.5.1 This update confirmed that all current contracts have either been extended into 2014/15 or completed as per contract agreement.

4.5.2 Service reviews for four service areas are planned for 2014/15:

- school nursing
- healthy lifestyles
- TB services and
- Substance misuse.

The aim will be to ascertain quality and performance outcomes and cost effectiveness. This may initiate some procurement activity commencing in 2014/15 where revised specifications and rebased services have been agreed. Any new service contracts would commence in 2015/16.

4.6 Sexual Health Review

4.6.1 The aim of this review is to inform a commissioning approach for sexual health which ensures that all sexual health information and services are effective in meeting the needs of the local population as well as delivering value for money.

4.6.2 Delays in receipt of specific data and the subsequent level of activity and analysis has impacted on the timely delivery of the final report which should now be completed in May 2014.

4.6.3 The activity data and service mapping indicate that sexual health is complicated in terms of service delivery at all levels. Broadly these cover; advice, prevention, pregnancy testing, sexually transmitted infection (STI) screening and testing, long acting contraception insertion and fitting, treatment and follow up. There is a correlation emerging between poor sexual health, teenage pregnancy and deprivation.

4.6.4 The scope of the review has focused on population needs particularly targeting (but not exclusively) young people and vulnerable groups such as: people with learning difficulties, people with drug and alcohol issues, sex workers and people with mental health issues.

4.6.5 The analysis highlighted a number of equality issues in terms of access, availability and appropriate interventions being offered such as universal coverage available to the population of Wolverhampton. The need to develop more local, targeted approaches to service delivery for vulnerable groups; particularly young people, migrant populations and Black and Minority Ethnic groups has also been highlighted.

4.7 Children's Public Health Services

4.7.1 Health visiting work continues to identify gaps in local service provision and priority areas for review. This will inform the development of an action plan to ensure readiness for the handover of Health Visitor Commissioning to the Local Authority in October 2015.

4.7.2 Public Health is working closely with PHE and NHS England (NHSE) to ensure early and seamless transition of health visitor commissioning to Local Authorities. It has been agreed that a meeting between the three organisations would be held in the near future.

4.7.3 The transition arrangements will also be taking into consideration commissioning responsibility for the transfer of the Family Nurse Partnership (FNP) Programme. FNP is a Department of Health licensed preventive programme for vulnerable first time young mothers on low income and with low psychological resources, focussing on adaptive behaviour change. The supervisor post was successfully recruited to in mid-February and there is currently an advert in place for 4 FNP nurses.

4.7.4 Infant Mortality is featured in The Public Health England National Child Health Profiles published on Tuesday 25th March 2014 and indicates that Wolverhampton has the highest rate of infant mortality in the country.

4.7.5 Wolverhampton has consistently had a higher rate than the England average for Infant Mortality for a number of years, always featuring in the lowest quintile (20%).It should be noted that infant mortality is a fluctuating rate related to small number variation year on year.

4.7.6 However, a recent review of infant mortality in Wolverhampton indicates some risk factors, such as preterm and low birth weight births and smoking in pregnancy. These provide potential areas for positive intervention to support improved outcomes for this indicator.

4.7.7 A multi-organisational forum has been convened and the first meeting is scheduled for 8th May 2014 to proactively plan to address this area of major concern.

4.8 **CCG Work Programme**

4.8.1 A workshop to review the core offer was held on the 6th March with key staff from the CCG and public health. The first half of the workshop reviewed the Core Offer of 2013/14. It was agreed that the core offer for 2013/14 had been delivered, including the production of two deep dives: diabetes and dementia. Furthermore it was agreed that there was a need to focus on how completed work is best disseminated, for the highest impact. Attendees suggested additional meetings throughout the year would be useful to share learning and ensure a focus on priorities.

4.8.2 There was general agreement from attendees on the key areas to be included in the core offer for 2014/15. A key priority is Children's services, in particular infant and maternal health and the needs of children with Special Educational Needs and Disabilities. Other proposed areas to be supported are the development of a Prevention Strategy, the coordination of 'Risk Stratification' across primary care and continued support to the CCG's 2 year operating plan/5 year strategic plan.

4.8.3 The final areas for Public Health support within the core offer are yet to be agreed alongside the requirement for additional Public Health support. Senior members of the Public Health management team recently attended another CCG Governing Body Educational event, to facilitate a session on prioritisation within the CCG key work streams of Planned Care, Urgent Care and Primary Care. This will help inform the 5 year Strategic Plan.

5.0 Financial implications

5.1 This report has no direct financial implications. Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2013/14 was £18.8 million.

[DK/28042014/T]

6.0 Legal implications

6.1 There are no direct legal implications arising from this report.

6.2 Governance arrangements for health and wellbeing are regulated by statute and secondary legislation. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Health and Wellbeing Board is constituted as a Committee under section 101 of the Local Government Act 1972 with power to appoint sub-committees.

[AS/23042014/X]

7.0 Equalities implications

7.1 The Public Health Service seeks to ensure equality of opportunity as it delivers its core functions and aims to reduce health inequalities. By taking a needs based approach to all commissioned services including the use of equality impact assessment tools we aim to ensure that the needs and rights of equalities groups are considered.

8.0 Environmental implications

8.1 There are no direct environmental implications arising from this report.

9.0 Human resources implications

9.1 There are no direct human resource implications arising from this report.

10.0 Corporate landlord implications

10.1 There are no direct corporate landlord implications arising from this report.

11.0 Schedule of background papers

10.1 Health & Wellbeing Board 3 July 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 4 September 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 6 November 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 January 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 4 February 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 April 2014 Public Health Delivery Board – Progress Report

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