CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

28 June 2017

Time 2.00 pm **Public Meeting?** YES **Type of meeting** Oversight

Venue Committee Room 3 - 3rd Floor - Civic Centre

Membership

Councillor Roger Lawrence	Chair (Labour)
Councillor Sandra Samuels OBE	Cabinet Member for Adults
Councillor Val Gibson	Cabinet Member for Children & Young People
Councillor Paul Singh	Conservative
Councillor Paul Sweet	Cabinet Member for Public Health and Well Being
David Baker	West Midlands Fire Service
David Watts	Service Director - Adults
Elizabeth Learoyd	Healthwatch Wolverhampton
Ros Jervis	Service Director - Public Health and Wellbeing
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
David Loughton	Royal Wolverhampton Hospital NHS Trust
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Alistair McIntyre	Locality Director - NHS England (West Midlands)
Tracy Taylor	Black Country Partnership NHS Foundation Trust
Alan Coe	Wolverhampton Safeguarding Board
Chief Supt Jayne Meir	West Midlands Police
Bhawna Solanki	University of Wolverhampton
Helen Child	Third Sector Partnership
Tim Johnson	Strategic Director - Place
Dr Alexandra Hopkins	University of Wolverhampton
Linda Sanders	Strategic Director - People
Steven Marshall	Wolverhampton Clinical Commissioning Group

Information for the Public

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Some items are discussed in private because of their confidential or commercial nature. These reports are not available to the public.

Agenda

Part 1 – items open to the press and public

Item No. *Title*

NETWORKING OPPORTUNITY AND LIGHT REFRESHMENTS WILL BE AVAILABLE BEFORE THE MEETING AT 1:30PM IN COMMITTEE ROOM 3

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence**

2 **Notification of substitute members**

3 **Declarations of interest**

4 **Minutes of the previous meeting - 29 March 2017** (Pages 5 - 10)
[To approve the minutes of the previous meeting as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the previous meeting]

ITEMS FOR DISCUSSION OR DECISION - PART 2

6 **Health and Wellbeing Board - Forward Plan 2016/17** (Pages 11 - 14)
[Ros Jervis, Service Director – Public Health and Wellbeing, to present Forward Plan]

7 **Ideas for Development Day**
[Board to consider ideas for Development Day on 18 October 2017]

8 **Better Care Plan 2017/18** (Pages 15 - 102)
[Steven Marshall, Wolverhampton CCG and David Watts, Service Director – Adults, to present report]

9 **Sustainability and Transformation Plan (STP) - the Wider Perspective** (Pages 103 - 106)
[Dr Helen Hibbs, Wolverhampton CCG and Linda Sanders, Strategic Director – People, to present report]

10 **Quality and Safety Framework 2017-20** (Pages 107 - 156)
[Manjeet Garcha, Wolverhampton CCG, to present report]

11 **Overview of Primary Care Strategy and Estates Update** (Pages 157 - 162)
[Dr Helen Hibbs, Wolverhampton CCG, to present report]

12 **Perinatal and Infant Mortality in Wolverhampton** (Pages 163 - 168)
[Ros Jervis, Service Director – Public Health and Wellbeing, to present report]

13 **Draft People Directorate Commissioning Strategy** (Pages 169 - 230)
[Linda Sanders, Strategic Director for People and Paul Smith, Head of Commissioning to present report]

ITEM FOR INFORMATION

14 **Towards an Active City Strategy** (Pages 231 - 238)
[Ros Jervis, Service Director – Public Health and Wellbeing, to present report and presentation]

15 **Joint Strategic Needs Assessment - Programme Update** (Pages 239 - 248)
[Ros Jervis, Service Director – Public Health and Wellbeing, to present report]

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Agenda Item No: 4

Minutes - 29 March 2017

Attendance

Members of the Health and Wellbeing Board

Councillor Roger Lawrence	Leader of the Council (Chair)
Councillor Sandra Samuels OBE	Cabinet Member for Adults
Councillor Paul Sweet	Cabinet Member for Public Health and Wellbeing
David Baker	West Midlands Fire Service
David Watts	Service Director - Adults
Ros Jervis	Service Director - Public Health and Wellbeing
David Loughton	Royal Wolverhampton Hospital NHS Trust
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Chief Supt Jayne Meir	West Midlands Police
Bhawna Solanki	University of Wolverhampton
Helen Child	Third Sector Partnership
Linda Sanders	Strategic Director - People
Steven Marshall	Wolverhampton Clinical Commissioning Group
Alan Coe	Wolverhampton Safeguarding Board
Dr Helen Hibbs	Wolverhampton City Clinical Commissioning Group

Employees

Helen Tambini	Democratic Services Officer

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence**

Apologies were received from the following members of the Board:
Alistair McIntyre – Locality Director – NHS England (West Midlands)
Councillor Val Gibson – Cabinet Member for Children and Young People
Councillor Paul Singh – Shadow Cabinet Member for Public Health and Wellbeing
Dr Alexandra Hopkins – University of Wolverhampton
Tim Johnson – Strategic Director – Place
Tracy Taylor – Black Country Partnership NHS Foundation Trust

2 **Notification of substitute members**

Bhawna Solanki attended on behalf of Dr Alexandra Hopkins.

3 **Declarations of interest**

There were no declarations of interest.

4 **Minutes of the previous meeting - 15 February 2017**

That, subject to the amendments referred to below, the minutes of the meeting held on 15 February 2017 be confirmed as a correct record and signed by the Chair:

- The inclusion of Bhawna Solanki in the list of apologies.
- The deletion of Chief Supt Jayne Meir from the list of attendees and her inclusion in the list of apologies.

5 **Matters arising**

The Chair thanked the Board for its comments on the Early Years Strategy and confirmed that it had been approved by the Cabinet.

Linda Sanders, Strategic Director – People, referred to the Better Care Fund and confirmed that the Council was still awaiting Government guidance and once that had been received the Board would be updated.

The Chair referred to the Forward Plan and noted that several reports had been deferred. He referred to the need to ensure the effective management of the Forward Plan and noted that the issue would be discussed further under the Forward Plan item.

6 **Sustainability and Transformation Plan (STP) - Update and Local Health and Care System next steps**

Dr Helen Hibbs, Chief Officer, Wolverhampton Clinical Commissioning Group (CCG), David Loughton, Chief Executive, Royal Wolverhampton Hospital NHS Trust and Linda Sanders, Strategic Director – People presented the report.

The Strategic Director – People introduced the item and referred to the work already undertaken by the Transition Board and its evolvement into a Systems Development Board. She referred to the anticipated announcement by the Head of NHS England, Simon Stevens on Friday, 31 March, outlining future proposals for the health service and the implications that might have for Wolverhampton and the wider Black Country. She expected that there would be a renewed commitment to Sustainability and Transformation Plans (STPs), moving into a new phase with the appointment of a System Leader for the Black Country to drive change. Work was already ongoing with the Chief Officer and Chief Executive to ensure that local residents continued to receive the best service possible. It was vital that the service remained cohesive and resilient.

The Chief Officer referred to the ongoing attempts to reorganise the NHS and the difficulties ahead. Discussions locally had taken place looking at a place-based model of care to tie into the wider Black Country model. Information relating to the new System Leader post continued to change and it was unclear if an incumbent would take the post. A joint committee comprising the four Black Country CCGs had held its initial meeting and established several Task and Finish Panels.

The Chief Executive referred to the forthcoming great structural changes required to achieve the targeted reductions of £900 million. During this period of considerable change there was a great opportunity for Wolverhampton to take the lead, with so many significant changes taking place just outside Wolverhampton.

The Service Director – Public Health and Wellbeing referred to the uncertain future and the importance of regular dialogue as issues emerged to ensure that appropriate time was given to understand and support the development of the system for local people.

The Board was concerned about acute hospital bed provision in the region and sought assurance regarding its future.

Steven Marshall, Director of Strategy and Transformation, Wolverhampton Clinical Commissioning Group stated that although significant savings would have to be made and there was a great deal of speculation, there was no plan in place for hospital closures in the area.

The Chief Officer confirmed that as part of the STP there would be increased community care and to allow that, resources would need to be released from acute hospital beds. There would need to be economies, different working practices, and early intervention to allow that to happen.

Jeremy Vanes, Chair, Royal Wolverhampton Hospital NHS Trust stated that the Trust Board had spent time trying to prepare for future changes. The emphasis would be on sustaining health improvements rather than structure and although any changes would be orchestrated nationally, it would have to be delivered locally.

The Strategic Director – People referred to a press statement which had been drafted and asked the Board for guidance regarding a release date.

The Board acknowledged that until an announcement had been made, hopefully on Friday there would be many unanswered questions and until that announcement was made, it would be advisable to wait to make any announcements or release a press statement.

Resolved: The Board noted the issues connected to the development of care and health systems in the City of Wolverhampton in the light of the update on the next steps for the Black Country Sustainability and Transformation Plan.

7 **Health and Wellbeing Board - Forward Plan 2016/17**

Ros Jervis, Service Director – Public Health and Wellbeing introduced the report.

The Service Director – Public Health and Wellbeing referred to the letter from the Chair circulated to all members of the Board regarding proposed changes to how agendas for future meetings were set to ensure a strong strategic focus was maintained. It was proposed to establish an Agenda Group of core members which would meet a month before each meeting and members of the Board were encouraged to feed through any ideas which would be considered by that Group. Feedback to the proposals had been positive so far and any additional feedback was welcomed.

The Chair confirmed that there would be quarterly meetings and a development day in October. The Agenda Group would allow more effective planning for future agendas.

The Board referred to the forthcoming announcement by Simon Stevens on future proposals for the health service and suggested that an update report to reflect any possible impact from that statement on the Sustainability and Transformation Plan (STP) should be submitted to the next meeting in June.

Alan Coe, Chair of the Wolverhampton Safeguarding Board referred to how the phasing of the Safeguarding Boards would fit into the Plan and the Board suggested that those timings should also be considered.

Resolved:

1. The Board approved the current Forward Plan.
2. The Board requested a report on the STP detailing any updates in response to the forthcoming announcement from the Head of NHS England to be submitted to the next meeting of the Board in June.
3. The Board consider the timings for the phasing of the Safeguarding Boards into the STP at an appropriate time.

8 **NHS Capital Programme - Updates**

A request had been received prior to the meeting for the report title to be changed to Estates Update and for the report to be deferred to the next meeting.

Resolved:

1. That the report title be changed to Estates Update.
2. That the item be deferred to the next meeting of the Board in June.

9 **Evaluation Feedback on Living Well, Feeling Safe Event**

Ros Jervis, Strategic Director – Public Health and Wellbeing and David Watts, Service Director – Adults presented the report.

The Service Director – Public Health and Wellbeing introduced the report and stated that the event had proved extremely successful in engaging with both partners, community groups and local residents and had been very well received, with considerable positive feedback. Suggestions had also been received for any future events and it was important not to lose momentum and to consider the way forward.

The Service Director – Adults referred to the importance of engaging at a local level and working with local communities. The event had also highlighted local knowledge which had added valve to the event. In future events could be themed to target problems highlighted in specific areas.

The Board referred to large community events held annually in various locations, including Durham but considered that, smaller, more frequent, localised events were more beneficial as local communities and neighbourhoods could relate to them more. It was also important that the impetus between events was not lost, which could happen when annual events were held.

Alan Coe, Chair of Wolverhampton Safeguarding Board stated that it was important to help the socially isolated who were prone to vulnerability and it would be helpful to identify what local people found helpful when such events were held and any input from Stephen Dodd from the Wolverhampton Voluntary Sector Council would be advantageous.

Chief Supt Jayne Meir, West Midlands Police referred to the Active Citizens Funding of £80,000 to be awarded to community groups towards crime prevention and resilience and it was hoped in the future to become increasingly involved in community activities.

The Service Director – Public Health and Wellbeing confirmed that the Steering Group was Chaired by Stephen Dodd and a representative from the Police would be invited to the next meeting on 12 April.

In answer to a question regarding GP involvement, the Service Director – Public Health and Wellbeing confirmed that the Clinical Commissioning Group was well engaged and help would be given to improve engagement with GPs.

Resolved:

1. The Board noted the feedback from the Living Well, Feeling Safe Event.
2. The Board receive a range of options for further events at a future development session.

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Health and Wellbeing Board: Forward Plan

Updated 9th May 2017

Items in red are new or amended from the previous version.

Items are highlighted where no report was received and there is currently no arrangement to reschedule.

Items are in **bold** that are regular or standing items.

Date	Title	Partner Org/Author	JHWBS Priority	Format	Notes/comments
28 June 2017	Ideas for Development Day				Discussion item
	Better Care Plan 2017/18	CCG/Steven Marshall and CWC/David Watts		Paper	Discussion item
	Sustainability and Transformation Plan (STP) – the Wider Perspective	CCG/Helen Hibbs and CWC/Linda Sanders		Paper	Discussion item New item requested at meeting on 29 March 2017
	Mental Health Strategy 2017-19	CCG/Sarah Fellows		Paper and strategy	Removed from agenda of meeting on 28 June 2017 as not yet completed. To be deferred to a future meeting.
	Quality and Improvement Strategy 2017-20.	CCG/Manjeet Garcha		Paper	Last considered February 2016 Deferred from last meeting Title of report changed from Quality and Safety Framework

Key: JHWBS priorities

	Overview of Primary Care Strategy and Estates Update	CCG/Helen Hibbs		Paper	Discussion item Quarterly report Deferred from last meeting Title of report changed from NHS Capital Programme – updates
	Perinatal and Infant Mortality in Wolverhampton	CWC/Ros Jervis		Paper	New item agreed at Agenda Group meeting Discussion item
	Towards an Active City Strategy	CWC/Ros Jervis		Paper and 3 slide presentation	New item Information item
	Joint Strategic Needs Assessment – Programme Update	CWC/Ros Jervis		Paper	New item Information item
	Draft People Directorate Commissioning Strategy	CWC/Linda Sanders/Paul Smith		Paper	New item Discussion item
20 September 2017	Ideas for Development Day				Discussion item
	Director of Public Health Annual Report 2016/17	**CWC/Ros Jervis**		**Presentation**	
	Better Care Fund (BCF) Quarterly Report	**CCG/Steven Marshall and CWC David Watts**		**Paper**	**Discussion item** **Regular joint update paper** **Quarterly report**
	Future Commissioning across the Black Country	CCG/Helen Hibbs		Paper	New item requested by CCG Governing Body
	Place Based Commissioning (Social Care and Accountable Care System)	CCG/CWC/RWT (Various)		Paper	New item agreed at Agenda Group meeting
	Tackling Homelessness in Wolverhampton	CWC (TBC)		Paper	New item agreed at Agenda Group meeting

Key: JHWBS priorities

18 October 2017 **Development Day**					Items proposed so far: Combined Authority – opportunities Workforce in the health and social care sector Implications of Brexit
10 January 2018	Supporting families with no recourse to public funds	CWC/Paul Smith		Paper	Paper presenting findings from a six-month pilot by RMC to support families expedite their immigration claims (after Sept 2017 as evaluation due)
	Wolverhampton CCG Operational Plan 2017-19	**CCG/Helen Hibbs**		**Plan and paper**	**Annual item** **Last considered 15 February 2017**
11 April 2018					

Key: JHWBS priorities

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Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

28 June 2017

Report title	Better Care Plan 2017/18	
Cabinet member with lead responsibility	Cllr Roger Lawrence Leader of The Council	
Accountable director	David Watts, Service Director - Adults (City of Wolverhampton Council) Steven Marshall, Transformation and Strategy Director (Wolverhampton Clinical Commissioning Group)	
Originating service	People	
Accountable employee(s)	Paul Smith Tel Email	People Directorate 01902 555318 Paul.Smith@wolverhampton.gov.uk
Report has been considered by	Leaders Briefing People Leadership Team (PLT)	26 June 2017 12 June 2017

Recommendation(s) for decision:

Health and Well-Being Board is recommended to:

1. To note progress made during 2016-17 of the BCF programme.
2. To approve the BCF draft narrative plan 2017-19.

1.0 Purpose

1.1 To advise Health & Wellbeing Board of the progress made during 2016-17.

1.2 Approve the BCF draft narrative plan 2017-19 noting this may be subject to change following national guidance.

2.0 Background

2.1 The publication of National Planning Guidance is further delayed. It is anticipated guidance will follow the General Election. Submission dates have not been published and are expected within the guidance.

2.2 The new submission will be a two-year plan covering period 2017-19. There are four National Conditions attached. Those being; -

- A jointly agreed plan
- National Health Service (NHS) contribution to social care is maintained in line with inflation
- Agreement to invest in NHS-commissioned out-of-hospital services
- Implementation of the High Impact Change Model for managing Delayed Transfers of Care (DToC)

2.3 National Performance Metrics reported in the following areas; -

- DToC
- Non-elective admissions
- Admissions to residential and care homes
- Effectiveness of reablement

3.0 Performance & Progress to date on financial year 2016-17

3.1 DToC

Performance has improved significantly from the 2015-16 baseline with 2,656 fewer delayed days, which represents a reduction of 18%. However, this again falls short of the target of 6,430 fewer days, a reduction of 57%.

This has been affected by several long-term delayed patients from Mental Health settings & the increased proportion of delays caused by people waiting for a package of care in their own home, nursing home care or a residential placement.

The establishment of the Discharge to Assess project (D2A) to develop and implement an integrated D2A pathway is in place to improve performance in 2017-18.

3.2 Non-elective admissions

There has been a reduction of 1600 emergency admissions into RWT, of which 585 of the most complex and typically highest cost cases are directly attributed to BCF schemes.

3.3 Admissions to residential and care homes

3.3.1 Admissions have increased to 385 in the year against a target of 252. Admissions per month have been significantly higher than previous years. There was an average of 32 admissions each month in 2016-17 compared with 25 per month in 2015-16.

3.3.2 Numbers of admissions rose throughout 2016-17 and remained high in the first six months of 2016-17. The number of admissions each month has started to fall in the second half of the year, however, admissions remain higher than the same period in the previous year. The number of people admitted to permanent nursing care in the year has increased 45% from 93 to 135, whereas the number of people admitted to permanent residential care has increased by just 19% from 210 to 250. In total the proportion of admissions to nursing care has increased from 31% to 35% suggesting that those that are admitted to permanent care have higher care needs.

3.4 Effectiveness of Reablement

3.4.1 In 2016-17 the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services was 74.5% against a target of 80.3%. This is a slight reduction on the 2015-16 result of 75.6%. However, there has also been a significant reduction in the cohort that received reablement following discharge from hospital due to the ending of the joint funding agreement of the Community Intermediate Care Team which means that fewer people received reablement following a joint assessment.

3.4.2 Although there has been no increase in the proportion of older people who remain at home 91 days after discharge into reablement, the proportion of adults who have received a short term social care intervention designed to maximise independence who do not go on to need long term support has increased from 80.7% to 84.2% demonstrating that in Wolverhampton, earlier diagnosis, intervention and reablement is working to ensure that people and their carers are less dependent on intensive services.

3.5 It should be noted that continuous progress has been made in many other areas in the past 12 months, including; -

- Rapid Intervention Team (RITs) – Now operating as a seven-day admission avoidance service and is accepting referrals from West Midlands Ambulance Service.

- Risk Stratification – Community Matrons working with General Practitioners (GPs) to identify persons of high risk of admission and proactively manage their care. The next

phase will be to work with medium risk patients to stem the flow and dependency on acute care.

- Integrated Health and Social Care Multi-Disciplinary Team (MDT) working – three Locality based MDTs, meeting on a monthly basis to discuss an identified caseload of persons.

- Wound Care Pathway – Development of a multiagency Wound Care Pathway.

- End of Life Pathway – Development of a multiagency End of Life Care pathway.

- Mental Health – Development of Street Triage and a prevention focused service called 'Starfish'.

- Discharge to Assess (D2A) – Establishment of a D2A project to develop and implement an Integrated D2A pathway.

- Memory Matters – Establishment and rollout of Advice and Information clinics across the city for people who are concerned about memory issues and possible dementia delivered from non-health buildings.

- Dementia - A business case was agreed by the Accident & Emergency (A&E) Board to 'pump prime' service transformation by increasing the number of dedicated liaison and outreach dementia staff across Royal Wolverhampton Trust (RWT) and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT.

- Social Prescribing – Partnership working with Wolverhampton Voluntary Sector Council (WVSC) to deliver a 12-month Social Prescribing pilot.

- Wolverhampton Information Network (WIN) – Enhancement of the WIN to create a single information portal for health, social care, voluntary and community services.

- Data Sharing Agreement – City wide data sharing agreement approve to enable Integrated teams to work more effectively.

- Fibonacci – The implementation of an IT system allowing MDT members to view health and social care data.

3.6 The draft BCF narrative plan (2017-19) has been produced with new & updated work stream programmes developed as agreed by respective Senior Responsible Officers (SRO).

3.7 Expression of Interest for BCF Graduation has been submitted to NHS England. The panel has met and have shortlisted. A decision is currently awaited.

4.0 Better Care Fund Draft Narrative Plan 2017-19

4.1 The draft narrative plan (refer to appendix 1) has been developed in conjunction with 2017-19 Integration & BCF policy framework received & identified key lines of enquiry.

- The draft plan does not contain the breakdown & detail of all the National Metrics.
- Financial information is currently in draft awaiting final agreement.
- Following confirmation of final submission guidance and dates a final plan will be presented for final approval.

4.0 Improved Better Care Fund Quarterly Reporting Requirements

4.1 Department of Communities & Local Government (DCLG) wrote to Chief Executives on 26 May 2017 to set out the information they will require quarterly and when they expect to receive it.

4.2 A list of projects has been developed and agreed at Cabinet however further work is required on the detail on delivery. The guidance states plans will be jointly agreed with Wolverhampton Clinical Commissioning Group (CCG) and that A&E delivery boards will have oversight.

4.3 DCLG expect responses in accordance with the following timetable:

Q1 – template to be returned by 21 July 2017
Q2 – template to be returned by 20 October 2017
Q3 – template to be returned by 20 January 2018
Q4 – template to be returned by 21 April 2018

4.4 Local authorities are required to report on progress on the iBCF via a national template. Recommendation is that the template is signed off by BCF programme board prior to submission.

5.0 Financial implications

5.1 The 2016-17 revenue pooled budget was set at is £56.8 million, of which £21.6 million is a contribution from Council resources and £35.2 million from the CCG. The Section 75 (S75) agreement details the risk sharing arrangements for both organisations for any over / under spends with in the pooled budget. In addition to the revenue services pooled budget also includes a capital grant (Disabled Facility Grant) amounting to £2.4 million which are managed by the council.

5.2 The 2016-17 provisional revenue outturn is £59.5 million, representing an overspend of £2.7 million. This overspend was shared in line with the risk sharing arrangements detailed in the S75 agreement.

5.3 Negotiations are still taking place and national guidance is yet to be published therefore the draft pooled budget is subject to change. The current 2017-18 draft pooled revenue budget is £67.1 million, of which £29.2 million is a contribution from Council resources and £37.9 million from the CCG. The Council's contribution includes the improved Better Care Fund and the additional Adults Social Care monies announced in the Spring budget of which totals £7.6 million. It should be noted that the fund includes £6.5 million representing the NHS transfer to Social Care (S256). In addition to the revenue budget the fund includes a capital grant of £2.7 million (Disabled Facilities Grant). [AS/14062017/U]

6.0 Legal implications

6.1 A Section 75 agreement is in place for the delivery of the BCF plan 2016-17. A revised Section 75 agreement with the CCG in relation to the BCF is required for 2017-18/19. [RB/19062017/D]

7.0 Equalities implications

7.1 Each individual project within the work streams has identified equality implications, and a full equality impact analysis has been carried at work stream level.

8.0 Environmental implications

8.1 Each individual project within the work streams will identify environmental implications, such as the need to review estates for the co-location of teams and services.

9.0 Human resources (HR) implications

9.1 Each individual project within the work streams will identify HR implications. HR departments from both Local Authority and Acute Providers are already engaged in discussions regarding potential HR issues such as integrated working and change of base for staff.

10.0 Corporate landlord implications

10.1 Corporate Landlord (Estates Valuation and Disposals) meets regularly with the Task and Finish Team and is working with the Team to assist and evaluate if any of the assets within the existing NHS and Council Estate is suitable for reuse to support the BCF proposals. The BCF programme has an Estates task and finish group in place to consider accommodation options on a city-wide basis.

11.0 Schedule of background papers

Appendix 1, Wolverhampton Health & Care Economy BCF Draft Narrative Plan 2017-19 (v10).

Appendix 2, Q4 BCF Quarterly Data Collection Template.

CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Wolverhampton Health and Care Economy BCF

Narrative Plan 2017-2019

Black Country Partnership NHS Foundation Trust

The Royal Wolverhampton NHS Trust

Contents

1. Approval and Sign-Off

KLOE Ref.

1, 2

1.1 Summary of Plan

Local Authority	City of Wolverhampton Council
CCG	Wolverhampton CCG
Boundary Differences	None
Date submitted first draft	
Date submitted final plan	
Minimum required value of Pooled Budget	
Total agreed value of Pooled Budget	

1.2 Approval and signatures

Signed on behalf of City of Wolverhampton Council	
by	Linda Sanders
Position	Strategic Director
Date	
Signed on behalf of Wolverhampton CCG	
by	Dr Helen Hibbs
Position	Accountable Officer
Date	
Signed on behalf of Royal Wolverhampton Trust	
By	David Laughton
Position	Chief Executive Officer
Date	
Signed on behalf of Black Country Partnership Trust	
By	Lesley Writtle
Position	Director of Operations
Date	
Signed on behalf of Health and Wellbeing Board	
By	Cllr R Lawrence
Position	Chair/Leader of the Council
Date	

1.3 Completeness and Accuracy Check

36

2. Vision and Outcomes

13, 14

2.1 Vision Statement

- *'Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them live longer, healthier and more independent lives no matter where they live in the city. Health & Social Care colleagues will work better together, alongside local community organisations to deliver support closer to where individuals and families live and in line with their needs'.* **We have visualised this 'end-state' in** *Figure 1* below:-

Figure 1 – Wolverhampton's Vision/End State for 2020

- Our vision involves:-
  - **A fundamental transformation of health and social care in Wolverhampton** that will have a direct impact on reducing health inequalities and provide a better experience for the population of Wolverhampton.
  - **Care and support will be delivered closer to home and focus on promoting independence and prevention**, whilst providing a rapid health and social care response to persons where appropriate.
  - **Services being proactive in meeting population needs** and service developments that are evidenced based. Individuals will be empowered to take a more active role in managing their own care and support needs by making use of all assets available to them, not just those provided by statutory services.
- *Figure 15* in **Section 8 – Integration, p46** demonstrates our vision of what integration will look like in Wolverhampton with a number of examples described around how this is currently taking shape

2.2 What will success look like?

13, 14

Landscape Change	Demonstrated Through
People in Wolverhampton receive **seamless wrap-around services**	Through the delivery of **integrated, multi-disciplinary neighbourhood teams across three localities.** **An increase in the number of people with identified care coordinators**, a care plan, and contingency plan
Less people living permanently in Nursing & Residential care, with **more people receiving services in their own homes**	**Uplift in the number of services and support offered across 7 days and 24 hours** within the community
Those that remain in **Nursing & Residential Care will have a named GP** (1 GP per Home unless patients choose otherwise), with agreed care plans for their Long Term Conditions and services designed to wrap around them, including access to Specialist Services historically provided in a hospital setting	**Number of patients who are resident in a nursing or residential home with a named GP** – 100% **Clear transition of activity from hospital to the community**
A planned reduction in the number of acute medical beds, equivalent to 2 medical wards - one of which has already closed	Benefits realised through a **reduction in Delayed Transfers of Care (DTOC) and non-elective admissions**
A shift of workforce numbers from acute settings into community services	**Demonstrable activity shifts from hospital to community** **Access to more services across 24 hrs., and 7 days** per week in communities **Increase in self-management** and asset based community services being delivered in each neighbourhood
People 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	The **number of active personal budgets**
People with mental health problems identified early - in the primary care setting - and early intervention commenced	**Increase in dementia diagnosis** **Increase in self-help and early intervention** services for mental health

2.3 Outcomes and Expected Improvements to Person Experience

13

- In line with the vision **Wolverhampton has signed up to set of co-produced outcomes** that the programme is working towards across the life course of our population:-

- People will **live healthier lives for longer** and health inequalities will be reduced
- People will receive the **care and support they require closer to where they live**
- People will be **supported to stay at home for longer**, reducing reliance on residential and nursing care
- People will be **more in control of the care and support they receive** through the continued development of personal budgets and individual service funds
- People will have **one point of contact with a professional who will co-design the care plan with them**. The care / support will subsequently be **coordinated by a single professional** on behalf of the health and social care community neighbourhood teams
- People will have **self-care and self-management treatment plans** which focus on maximising the potential for good quality independence
- **More people will access community assets** to address fundamental wellbeing issues e.g. social isolation and depression

- In terms of the person experience we have engaged and listened to what matters (*Appendix 1 and 2*) and these are at the heart of our plans. *Figure 2* below outlines some of the significant findings. In addition, City of Wolverhampton Council has commenced a consultation on the Commissioning Strategy.

Figure 2 – Engagement Feedback

Source: Wolverhampton CCG 'You Said – We did' and Commissioning Intentions 2017-18'

2.4 Challenges

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- **Wolverhampton's vision is rightly ambitious and brave, but both achievable and measurable**. The challenges we have to achieve success are significant, not least because some of the underlying root causes of demand across the current health, care and housing systems are influenced by current economic, social and demographic factors.
- What we do know and can accomplish **is a partnership approach across the city that crosses organisational and sector boundaries and goes directly into the heart of communities**. This presents us with the best opportunity to achieve success. We see the most significant challenges of achieving this to be:-
- **Significant financial pressures** and constraints across the public sector
- Clarity of understanding that the shifts outlined in the vision will be **long term and require patience to see the impact**
- **Effecting the changes in the culture, lifestyle and behaviour** of the population that can lead to more complex health and social care needs in later life. See **Section 3 – The Evidenced Based Case for Change, p13**)
- **Creating a partnership culture and model across the health and care system that builds in the capability to flex over time** with shifting types of demand, growing populations and increased diversity
- **Creating a genuine partnership environment** within the context of often conflicting priorities, culture, financial constraints, political context, shifting public sector landscape and contractual arrangements
- **Alignment with STP** (See **Section 9, p51** of the plan for mitigation strategy)
- **Alignment with the emerging new models of Primary care in Wolverhampton**. The challenge here is that GPs have formed their models across locality boundaries and we need to continue working in partnership to ensure synergies with BCF model. To mitigate the above we have ensured a robust engagement strategy to ensure alignment and equity for the population of Wolverhampton and the GPs have agreed to move into localities.
- **This plan represents how we are beginning to meet these challenges in Wolverhampton and our plans to continue to do so going forward into 2017-19 and beyond**

16

2.5 Vision Narrative

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- In common with the rest of England, **Wolverhampton's health and social care economy is experiencing unprecedented demand and growth for services, with limited resources to meet those demands**. Despite progress in recent years, the resultant pressures are being reflected across the hospitals, GP surgeries, community healthcare teams and social services on a daily basis. **As the population grows and people live longer, the challenge to balance available resources and local needs will continue to grow**. Wolverhampton's starting point for responding to this challenge is to not regard it as simply a financial issue or view pressures in one part of its public services as being resolvable in isolation from others. **The vision for the next 3 years is therefore nothing less than a continuation of the fundamental transformation of the quality and experience of care**, across all elements of commissioning and provision on behalf of Wolverhampton's population.
- In line with the five year forward view, Wolverhampton CCG's Primary Health Care Strategy 2016-20 (*Appendix 8*) describes a number of emerging new models of care in Wolverhampton that **BCF will proactively seek to ensure synergy** with. There are two groups of practices that are established as Primary Care Homes (PCH) that represent circa 60,000 of the population. A larger group of practices, currently representing circa 120,000 of the population function in line

with a Medical Chamber model. The PCHs and the Medical Chamber group are all working towards MDT working. There are currently five GP practices representing a further 50,000 of the patient population who have subcontracted their General Medical Services (GMS) contract to the local acute and community provider. A further two practices are currently going through the due diligence process of aligning with the local acute and community provider. **From a person's perspective the Primary Care Home model describes that practices will offer "multi-speciality working through our 'Home', creating a 'one organisation' approach to delivering bespoke population health from a group of practices serving that community** – whilst ensuring we retain personalised care for individuals, and continue to identify at risk person groups."

- **Clearly the BCF programme will need to work closely with these models to ensure that care across the city is aligned**. It is the responsibility of current commissioners to ensure our services are developed and implemented in a way that makes them the preferred services for the new emerging organisations.

Within the programme we will:

- **Deliver holistic, person-centred care** *(Figure 3)* based on a population, place based approach. This ensures parity of esteem across physical, mental health and social care service.
- **Increase the diagnosis and management of people with Dementia** within a primary and community setting.
- **Deliver a range of services to support care closer to home**, promote confidence to enable **people to manage their own care** (this includes educating persons and carers of how to manage crisis situations) thus **enabling a reduction in A&E attendances and emergency admissions**. **See Section 5 – Delivery Model for details, p24**.
- **Actively promote a shared care approach with Primary Care professionals**, supporting Primary Care in the identification and case management of people identified at high/medium risk through MDTs and risk stratification
- **Be wrapped around Primary Care** based in our three localities supporting the emerging new models of care, to enable the delivery of a more localised approach to care closer to home.
- **Be multi-disciplinary across health and social care** in three localities to ensure equity of access and efficient use of wider community resources including the effective use of Information Technology
- **Work in collaboration with our Housing Partners to identify, scope out and develop any opportunities which would be enhanced by greater integration across Health, Social Care and Housing** that supports the outcomes and vision of the BCF Programme.

Figure 3: Person Centred Model of Care

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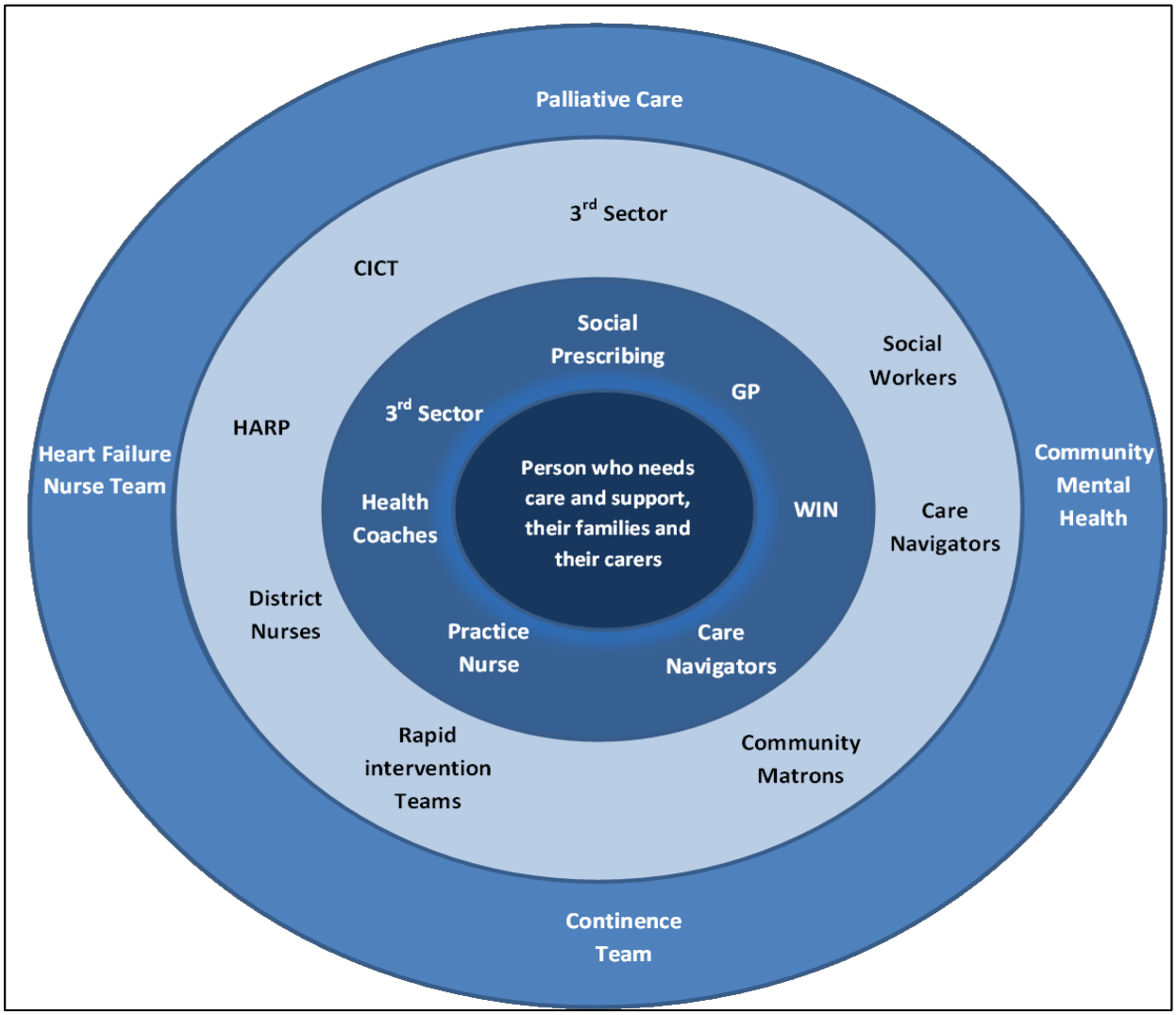

2.6 Whole System Change

- **Wolverhampton's vision for the future will require whole system change** e.g. how work is commissioned from providers to how providers interact with people and with each other. Wolverhampton is committed to effecting behavioural and attitudinal change in all areas by working together in partnership as a joint health and social care economy, with a central role for the voluntary, community sectors, and not least its citizens.

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- This document sets out the joint commissioning intentions and areas for development. **It explains how local authorities and CCGs, working with people and communities, will mobilise resources to target areas of need and deliver improved outcomes in 2017-2019 and beyond**. It captures why this is needed, what the expected outcomes are on both an individual and locality-wide basis and the current best estimates of the specific investments required to make this happen.
- In doing so Wolverhampton's plan is to go far beyond using BCF funding to back-fill existing social care budgets, preferring instead **to work jointly to reduce long-term dependency across the health and social care systems, promote independence and drive improvement** in overall health and wellbeing for local people.
- **The volume of emergency activity in hospitals will be reduced as will the planned care activity**

in hospitals. This will be achieved through the strengthening of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the Community Neighbourhood Teams (CNT's), will result in a minimisation of delays in transfers of care, reduced pressures in A&Es and wards, and ensure that after episodes of ill health, people are helped to regain their independence as quickly as possible.

- **Wolverhampton recognises that there is no such thing as integrated care without the inclusion of mental health services.** This in mind, the plans are designed to ensure that the work of community mental health teams is:-
  - Integrated with community health services and social care teams;
  - Organised around groups of practices;
  - Enables mental health specialists to support GPs and their persons in a similar way to physical health specialists.
- **In reviewing the Wolverhampton population demographics there are significant mental health needs for children and young people in the city**. On most indicators, the population of Wolverhampton scored significantly higher when compared to England averages. Measures include data on hospital admissions for self-harm, rate of children being looked after, first entrants into the youth justice system, and numbers of children living in poverty. Wolverhampton needs analysis data for CAMHS also describes under use of universal and targeted services at TIERS 1 and 2, causing over use of services at TIER 4. **Wolverhampton's vision is to re-balance activity across TIERS 1-4 by closing gaps, pump priming safe sound and supportive services whilst also increasing capacity and capability in early intervention and prevention services.** Future in Mind funding will be initially used to transform mental health services for children and young people by building capacity and capability mainly within specialist Child and Adolescent Mental Health Services at critical points, so that **by 2021 we can demonstrate measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people's mental health outcomes**
- **By improving ways of working with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care**. BCF will continue to be used to:
  - **Help people self-manage** and provide peer support working in partnership with voluntary, community and long- term conditions groups e.g. Dementia Cafes.
  - **Invest in developing personalised health and care budgets** working with persons and frontline professionals to empower people to make informed decisions around their care.
  - **Implement routine person satisfaction surveying** to enable the capture and tracking of the experience of care.
  - **Invest in reablement and the use of Telecare** reducing hospital admissions and the overall budget for nursing and residential care.
  - **Reduce delayed discharges**, through investment in neuro-rehabilitation services, strengthen 7 day social care provision in hospitals and implementation of the Discharge to Assess pathway.
  - **Integrate NHS and social care systems around the NHS Number** to ensure frontline professionals, and ultimately all persons have access to all of the records and information they need.
  - **Undertake a full review of the use of technology** to support primary and secondary prevention, enable self-management, improve access and service experience, and release professional resources to focus on those in greatest need. An example being the enhancement to the Wolverhampton Information Network (WIN) in the summer of 2017, which is a free web based signposting facility that enables the public and medical professionals to benefit from a comprehensive view of local services covering the entire

13

spectrum from health, through social care, and community. This can be either via self-service or through sign-posting by health care professionals.

- **Developing a new model of joined-up care will require a physical and cultural shift with new ways of working and new ways of thinking**. Previously, Wolverhampton's health and social care system has taken a reactive approach to managing the care of people in crisis often leading to a hospital admission and a journey in to long term care. **Since the implementation of the BCF Programme this has begun to change to a more positive and joined-up experience of care and a more proactive approach. We are aware, however, that much more improvement can be made.** The CCG Strategic Plan sets out its intent to put the health and care economy on a sustainable footing, through developing community-based services and addressing the default of receiving care in acute settings. This is also in the context of City of Wolverhampton Council (CWC) needing to save in excess of £54.2 million over the next 3 years. **To address this, both organisations will be working in partnership, with a CCG focus on increasing capacity in primary care and council focus on strengthening the community reablement offer.**

- The **BCF programme aims to reduce the number of people treated in hospital who could be treated more effectively in, or closer to their own homes**. It also **aims to reduce the number of people attending hospital at the point of crisis** by focusing on how to prevent the crisis happening. Wolverhampton wants to **encourage people to take control and lead healthier lives**. The assets of local communities will also play a big role in helping people to access different types of support closer to where they live. The mapping of community assets to ensure they can become part of how we plan care with people has begun and will continue up until 2020

2.7 Underpinning Support for our Vision

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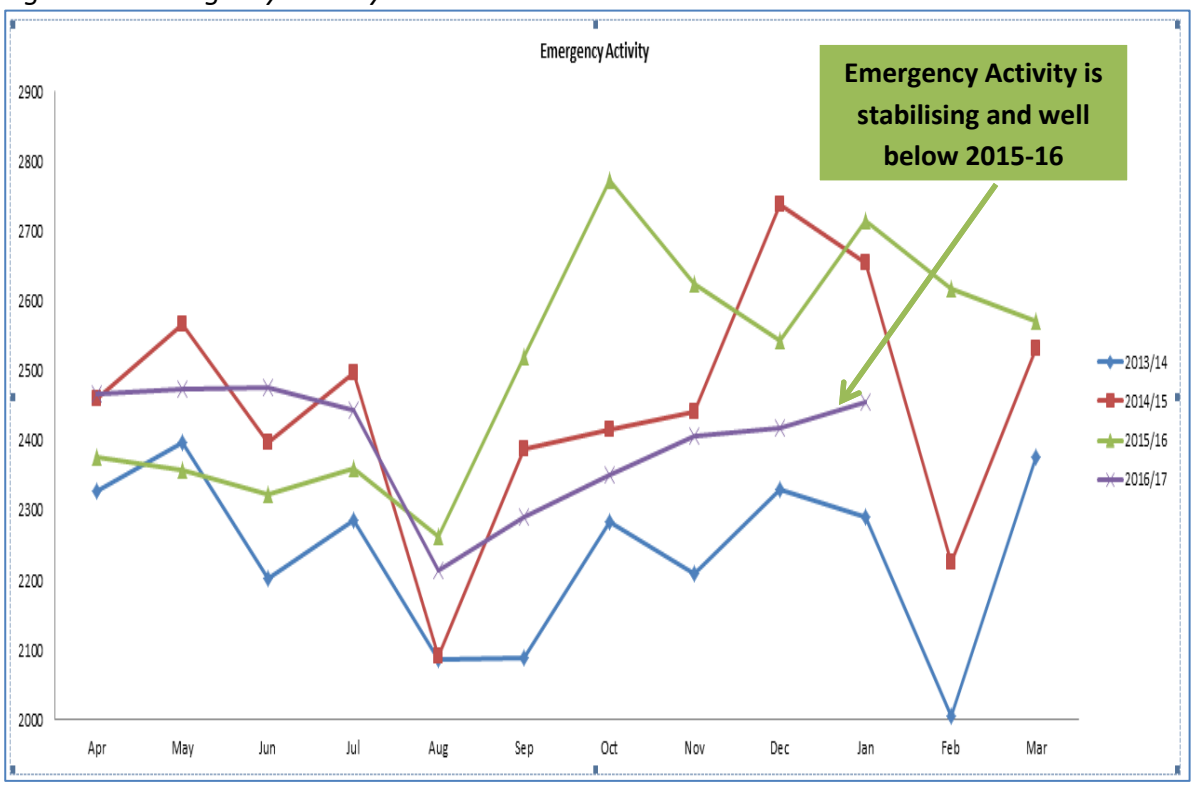
- Wolverhampton's vision for health and social care services for its community is **underpinned by**:
  - **The jointly agreed and developed Health and Wellbeing Strategy**. (Appendix 3)
  - **Effective engagement with the local community** and listening to what they have told us (Appendix 1 'Commissioning Intentions 2017-18' and Appendix 2 'You Said-We Did')
  - **Wolverhampton CCG Operating Plan 2015-2017** (Appendix 4)
  - **The Council's Corporate Plan and 'Our Vision Our City - Our Vision for the City of Wolverhampton in 2030'** (Appendix 5 and 6)
  - The evidence base regarding the future needs of the population of Wolverhampton through the **JSNA** (Appendix 7)
  - **Wolverhampton CCG** Primary Health Care Strategy 2016-2020 (Appendix 8)
  - **Neighbourhoods, Homes & People-Wolverhampton Housing Strategy** 2013-18 (Appendix 9)
  - **The Council also is consulting on a draft People Directorate Commissioning Strategy**. This brings together transformation activity across children and young people services, adult care services and public health. Commissioning intentions are proposed through which well-being, strengthening prevention, and ensuring care for all people are all promoted. Close partnership working is needed to deliver the commissioning intentions and the BCF has given us an environment in which to integrate further and align Council and CCG commissioning intentions.
  - **The Black Country Sustainability and Transformation Plan** 2016 (Appendix 10)

2.8 Progress and achievements over past 12 Months

- As outlined in the challenges to achieving the vision it will be take patience to see the full impact of the transformation, however **it is vital that we do measure, demonstrate and celebrate the progress** that Wolverhampton has made on the journey so far. Whilst more detail on this can be found in **Section 6 – Reflection on 2016-17, p31** significant aspects of our progress are:-

- **Reduction in emergency activity** and significantly less variation in the system **indicating greater system stability and control** has been established (*see Figure 4 below*)

Figure 4 – Emergency Activity over Time



- **Rapid Intervention Team** (RITs) – This service has moved from pilot phase to business as usual and is now operating as a 7 day admission avoidance service and is now accepting referrals form West Midlands Ambulance Service
- **Risk Stratification** – Community Matrons working with GPs to identify persons of high risk of admission and proactively manage their care. The next phase will be to work with medium risk patients to stem the flow and dependency on acute care
- **Integrated Health and Social Care Multi-Disciplinary Team working** – 3 Locality based MDTs, meeting on a monthly basis to discuss an identified caseload of persons.
- **Wound Care Pathway** – development of a multiagency Wound Care Pathway
- **End of Life Pathway** – development of a multiagency End Of Life Care pathway
- **Mental Health –** development of Street Triage and a prevention focused service called 'Starfish'
- **Discharge to Assess** (D2A) – Establishment of a D2A project to develop and implement an Integrated D2A pathway
- **Memory Matters** – Establishment and rollout of Advice and Information clinics across the city for people who are concerned about memory issues and possible dementia delivered from non-health buildings
- **Dementia** - A business case was agreed by the A&E Board to 'pump prime' service transformation by increasing the number of dedicated liaison and outreach dementia staff across RWT and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT
- **Social Prescribing** – Partnership working with Wolverhampton Voluntary Sector Council to deliver a 12 month Social Prescribing pilot
- **WIN – Enhancement of the Wolverhampton Information Network** to create a single information portal for health, social care, voluntary and community services

- **Data Sharing Agreement** – City wide data sharing agreement approve to enable Integrated teams to work more effectively
- **Fibonacci** – the implementation of an IT system allowing members of MDT to view health and social care data

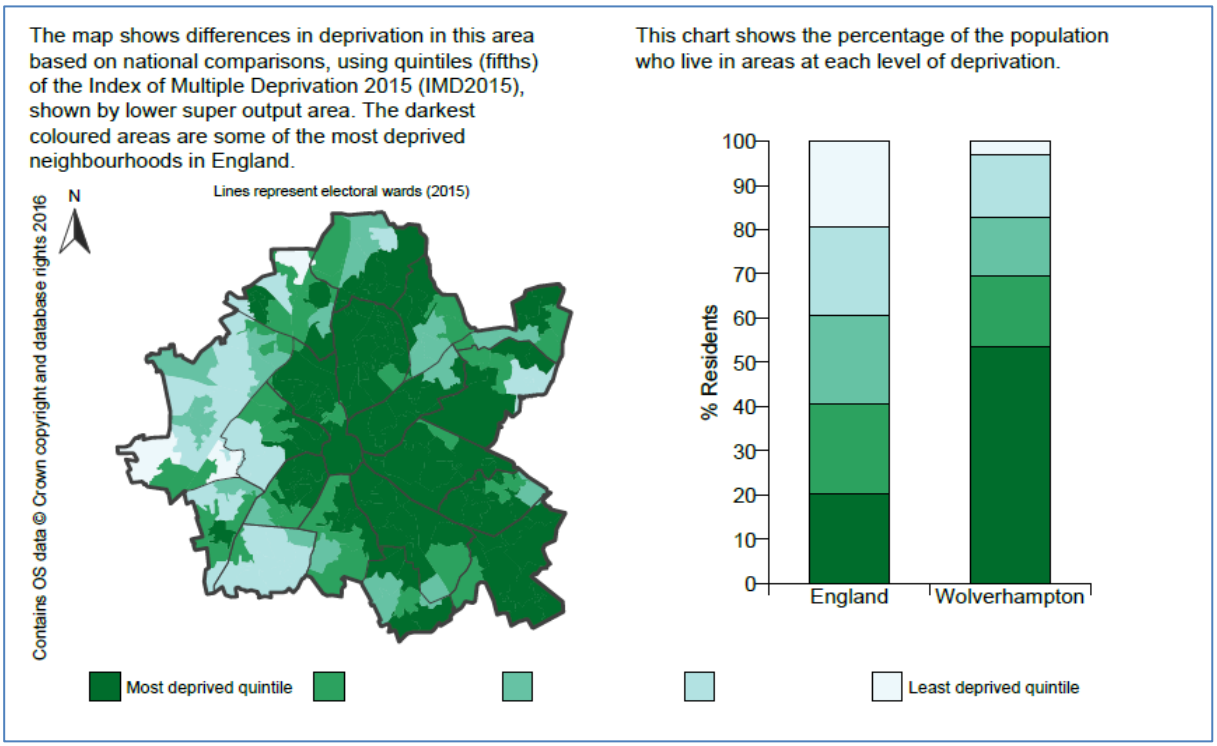
3. Evidenced Based Case for Change

17

3.1 The Economic Challenge

- **The Wolverhampton economy as a whole is financially challenged**. All key partners are experiencing significant financial challenges now and in forthcoming years. In the CCG the Quality Innovation, Productivity and Prevention (QIPP) delivery programme has a current 4 year plan of £35-40million savings that need to be made alongside the savings target for CWC over the next 3 financial years of in excess of £54 million.
- **Wolverhampton as a city area experiences more than twice the level of most significant deprivation than the national average, and proportionately much lower areas of prosperity**. As demonstrated in the wider determinants of health, those deprived are more likely to have lower life expectancies and earlier disease manifestations. *Figure 5* below shows the deprivation level comparator between Wolverhampton and the rest of England, the darker the green the more deprived.

Figure 5 – Deprivation in Wolverhampton



- The entire health and social care community in Wolverhampton understands that **in order to gain the most value from its joint investment, the BCF is the opportunity**, particularly around community based services, to pool its resources. For the CCG, this means enacting its strategic intentions to transfer appropriate elements of care from a hospital setting into the community as well as reviewing and transforming existing community based services to deliver the most significant demonstrable quality and value.

3.2 Drivers creating demand in Wolverhampton

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3.2.1 Executive Summary

- The evidence from Public Health, JSNA and clinical data sources indicate a **likely increase in demand for health and social care services in Wolverhampton** as a result of a forecast increase

in the numbers of older adults with comorbid health problems of a complex nature alongside challenging social care needs. The information depicts a current Wolverhampton population:-

- **Projected to increase,** including a **forecast 95% growth rate in the 85+ age range** rising from 6,000 in 2014 to 11,700 in 2039.
- With **over half falling amongst the most deprived** in the country. Wolverhampton remains the 21st most deprived Local Authority district in the country (*DCLG The English Indices of Depravation 2015)*
- With a greater than ever life expectancy **but no corresponding increase in healthy life expectancy** *(JSNA)***.** As they grow older, the longer people remain healthy, the less growth in demand for health and social care services there will be. **The pressure of an aging population is not in itself the key factor but rather how healthy people are.**
- That can **expect to live on average 2 years less** than the England average *(JSNA)*
- With a **Health Summary that is statistically amongst England's worst** *(Health Profile 2016, Public Health England)* where **31% are currently registered on a chronic condition register** and, **27.7% have one or more long term conditions** *(Moving care closer to home, Business Case)* and **over 64% of adults over 60 are living with frailty** *(Wolverhampton Frail Elderly Workshop, March 2017)*
- That has **significant health inequalities** across the city and ethnicities *(Health Profile 2016, Public Health England).*
- Where other than cancers of all types, **Cardiovascular Disease (CVD) remains the single greatest cause of lost life years** and although this is improving over time, mortality from CVD remains considerably higher than the national and west midlands average *(JSNA).*
- As of September 2016, the **recorded prevalence of Dementia in those aged 65 and over in Wolverhampton (4.94%) was significantly higher compared to England** (4.31%) and the West Midlands (4.14%) (JSNA).
- The **Dementia diagnosis rate in October 2016 was higher in Wolverhampton compared to the England average**. (JSNA) what is the dementia diagnosis rate? Andrew Woods
- The **rate of emergency admissions with a mention of Dementia in Wolverhampton were significantly higher compared to England and the West Midlands**, at the most recent data point (2015-16).(JSNA).

- Addressing these issues within the context of financial constraints and the local economic climate represents a significant challenge where **doing nothing is not an option**

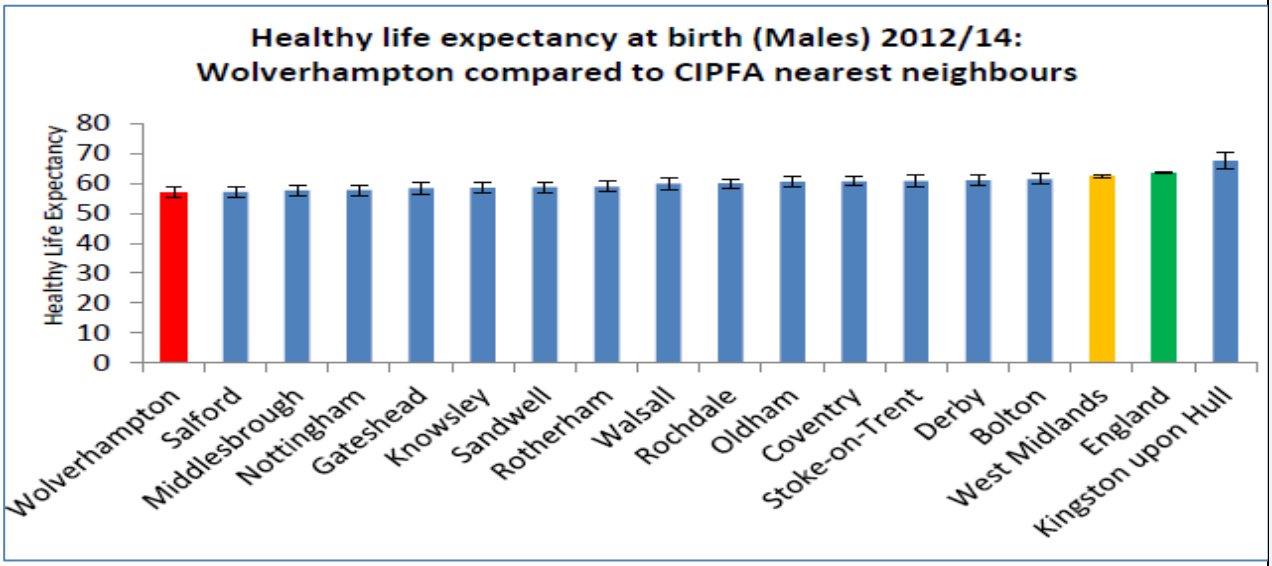
3.2.2 Population Forecast

- The Sub-National population projections to 2020 suggest an increase in the resident population with growth set to continue even further ahead to a projected estimate of Wolverhampton's population in 2039 as 288,000 with growth being most rapid in the child and older populations. These estimates show:
  - **The number of people aged 65 years or older is projected to grow** from 42,400 in 2014 to 60,500 in 2039: a gain of 18,100 (42.7% growth).
  - **The number aged 85 years or older is shown to grow by 5,700 (95.0% growth)**, from 6,000 in 2014 to 11,700 in 2039.
  - The number of children (aged 0 to 15 years) is projected to increase from 51,300 in 2014 to 59,000 in 2039. This is a net gain of about 7,700 (15.0% growth)
  - The number of people aged 16 to 64 years is projected to rise slightly from 159,400 in 2014 to 168,500 in 2039. This is a net gain of about 9,100 (5.7% growth).

3.2.3 Life Expectancy and Health Inequality

- The Joint Strategic Needs Assessment (JSNA) (Appendix 7) for Wolverhampton shows that although overall life expectancy in the city has improved over the last 12 years, **it is still some way below the national averages for both sexes with a significant health inequality gap** remaining in the city.
- Life expectancy in Wolverhampton is currently 77.6 years for males and 81.8 years for females, **which is almost two years less than the national average for both**.
- Healthy life expectancy in Wolverhampton **is almost six years less than the national average** for both sexes. Males can expect a healthy life expectancy of just over 56.9 years which i**s currently the worst of all our statistical comparators** *(See Figure 6)***.** Females have a healthy life expectancy of 58.3, which is also amongst the worst of all our statistical comparators.

Figure 6 – Healthy Life Expectancy for Males



- **The gap in life expectancy between the most and least deprived areas in the city is increasing.** The latest statistical information can be found below in (*see Figure 7)*

- **The Black Minority population is over represented in relation to emergency hospital admissions Ethnic (BME - using the definition of BME as non-White residents),** *see figure 8*. This suggests that some people are not accessing or receiving the care most suited to managing their condition, and are therefore further disadvantaged. 32% of Wolverhampton's residents are classified as being from BME backgrounds; the largest is Asian at 18%, followed by black and mixed race at 6.9% and 5.1% respectively. This diversity is higher than the national distribution where 14.6% of the population is classified from a BME community. In addition, Wolverhampton has an increasing growth population from Eastern Europe. Equality Lead – Juliet Herbert

- **The BCF plans to reduce health inequalities in the city by the implementation of the person centred model of *care*** *(Figure 3).* In addition each workstream is required to complete Equality Impact Assessments for any project work undertaken as an integral part of the governance processes

20

Figure 7 - Health In-equality – Life Expectancy Gap across the City

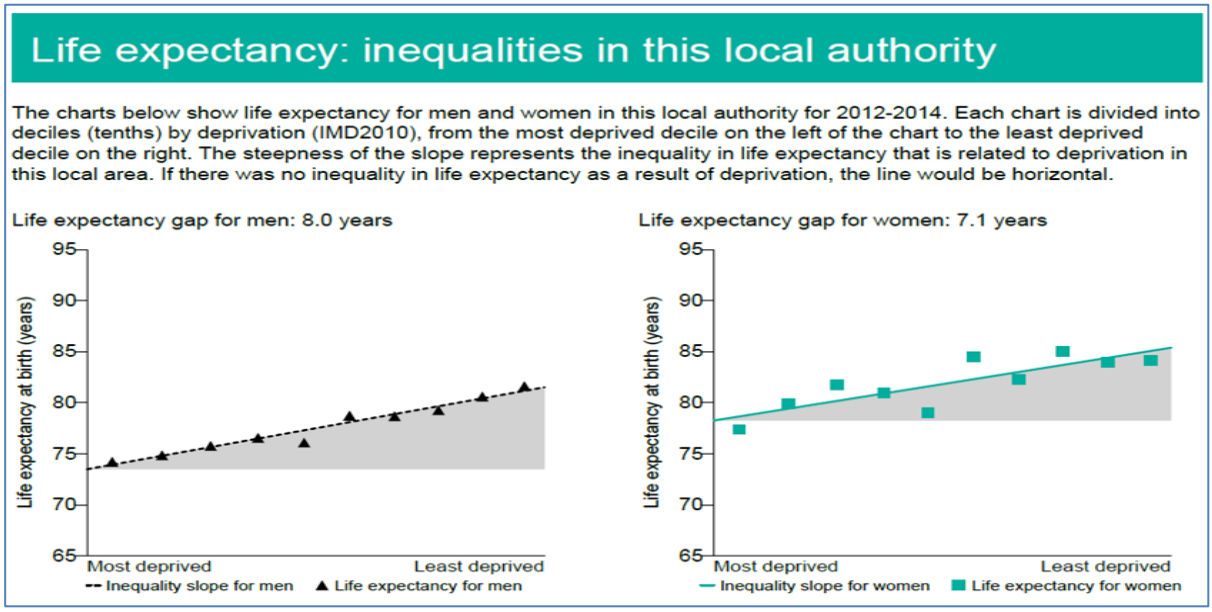
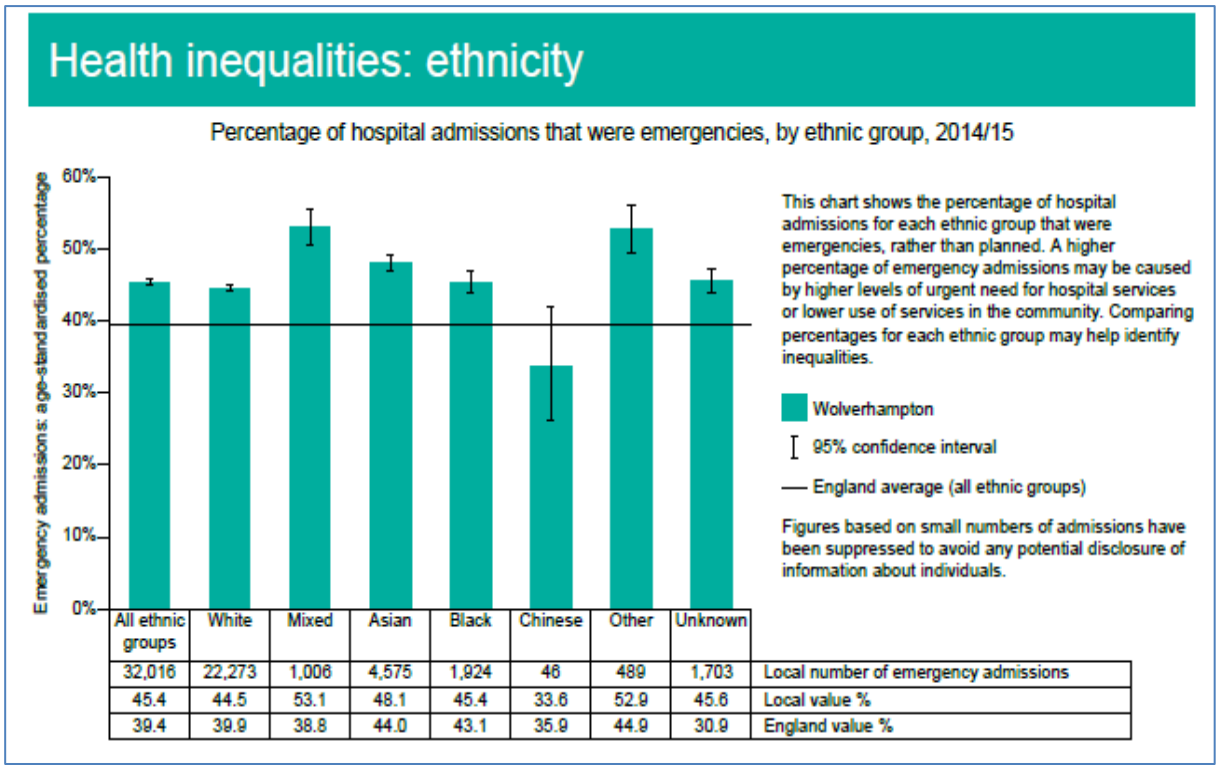


Figure 8 - Health In-equality – Ethnicity



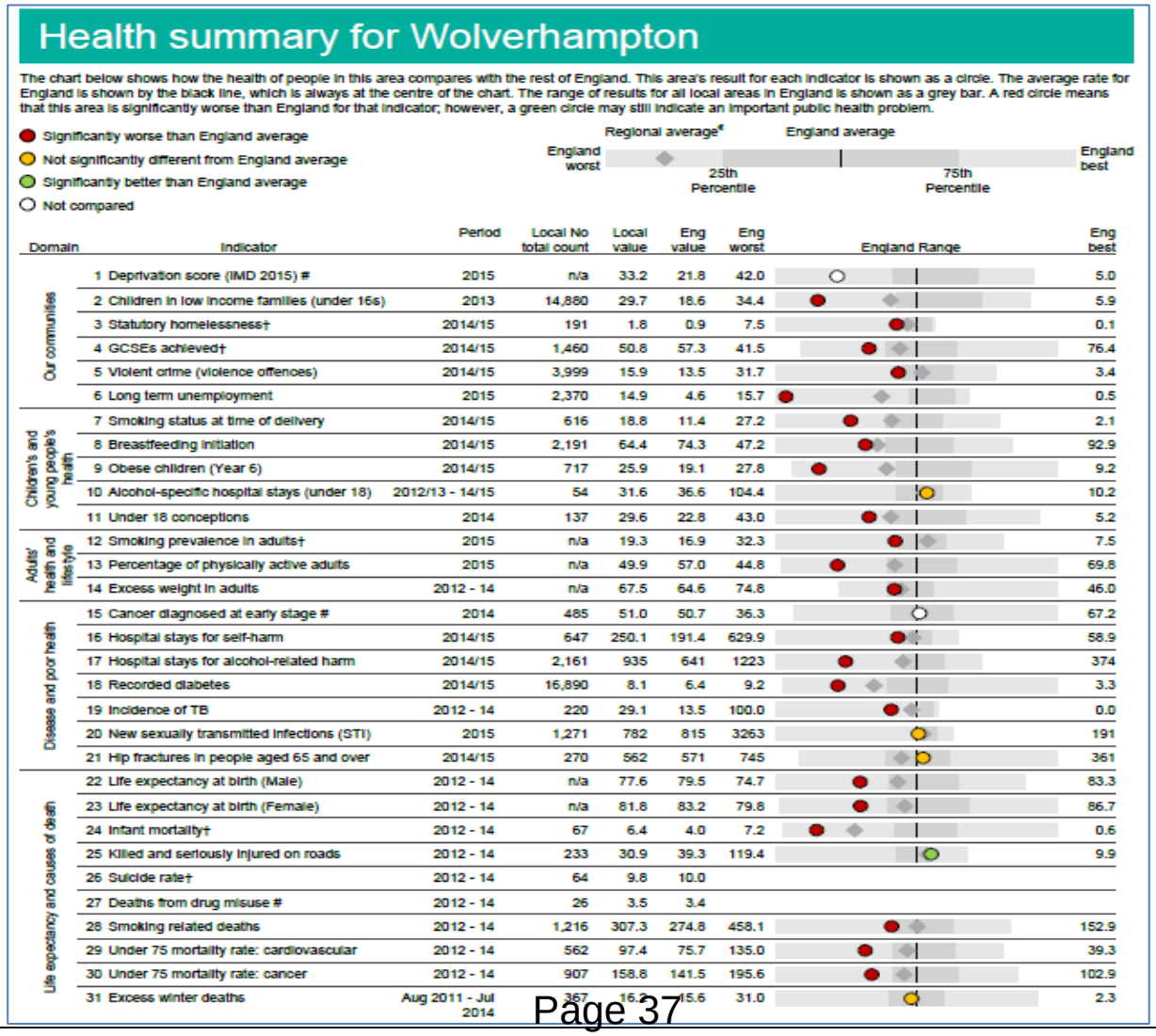
3.2.4 Health Summary and Long Term Conditions

- **Wolverhampton benchmarks very poorly against a number of significant health factors and the wider determinants of health** (See *Figure 9* below) that typically contribute to a life limiting illness, frailty and/or long term medical condition later in life e.g. smoking, obesity and alcohol consumption
- Highlighted areas of demand suggest **that a significant proportion of the Wolverhampton population – 16.1% - have a long term condition** *(See Figure 10, p18)*, with 11.6% having more than one long term condition; in total 27.7%, with 79% of those people with a single long term condition being within the 16-69 age range, and 53% of those with more than on long term condition are represented in this age range. Whilst this sits within the national average range,

the growth expectations regarding the over 85 population suggest that Wolverhampton will experience a potential increase in the numbers of older adults with comorbid health problems of a complex nature, and with challenging social care needs.

- A further indication of a likely increase in demand is suggested from information extracted from primary care clinical systems that currently indicates approximately **82,000 adults aged 18 and over (approximately 31% of total population) that are currently registered on a chronic condition register** which equate to nationally derived QOF cohort counts (including diabetes, asthma, heart disease, lung disease, dementia, stroke and arthritis) and an increasing number will develop these conditions as they grow older.
- Primary care data using the Electronic Frailty Index (eFI) indicates **over 64% (37,880 individuals) of the over 60 population in Wolverhampton are living with frailty** with a further 26.6% (18,437 individuals) aged between 49 and 60 (*Wolverhampton Frail Elderly Workshop, March 2017).*
- In reviewing the Wolverhampton population demographics **there are significant mental health needs for children and young people in the city.** On most indicators, **the population of Wolverhampton scored significantly higher when compared to England averages.** Measures include data on hospital admissions for self-harm, rate of children being looked after, first entrants into the youth justice system, and numbers of children living in poverty. **Wolverhampton needs analysis data for CAMHS also describes under use of universal and targeted services at TIERS 1 and 2, causing over use of services at TIER 4**.

Figure 9 – Health Summary



Health summary for Wolverhampton

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

Regional average[¶] England average

England worst — 25th Percentile — 75th Percentile — England best

Domain		Indicator	Period	Local No total count	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation score (IMD 2015) #	2015	n/a	33.2	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2013	14,880	29.7	18.6	34.4		5.9
	3	Statutory homelessness†	2014/15	191	1.8	0.9	7.5		0.1
	4	GCSEs achieved†	2014/15	1,460	50.8	57.3	41.5		76.4
	5	Violent crime (violence offences)	2014/15	3,999	15.9	13.5	31.7		3.4
	6	Long term unemployment	2015	2,370	14.9	4.6	15.7		0.5
Children's and young people's health	7	Smoking status at time of delivery	2014/15	616	18.8	11.4	27.2		2.1
	8	Breastfeeding initiation	2014/15	2,191	64.4	74.3	47.2		92.9
	9	Obese children (Year 6)	2014/15	717	25.9	19.1	27.8		9.2
	10	Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	54	31.6	36.6	104.4		10.2
	11	Under 18 conceptions	2014	137	29.6	22.8	43.0		5.2
Adults' health and lifestyle	12	Smoking prevalence in adults†	2015	n/a	19.3	16.9	32.3		7.5
	13	Percentage of physically active adults	2015	n/a	49.9	57.0	44.8		69.8
	14	Excess weight in adults	2012 - 14	n/a	67.5	64.6	74.8		46.0
Disease and poor health	15	Cancer diagnosed at early stage #	2014	485	51.0	50.7	36.3		67.2
	16	Hospital stays for self-harm	2014/15	647	250.1	191.4	629.9		58.9
	17	Hospital stays for alcohol-related harm	2014/15	2,161	935	641	1223		374
	18	Recorded diabetes	2014/15	16,890	8.1	6.4	9.2		3.3
	19	Incidence of TB	2012 - 14	220	29.1	13.5	100.0		0.0
	20	New sexually transmitted infections (STI)	2015	1,271	782	815	3263		191
	21	Hip fractures in people aged 65 and over	2014/15	270	562	571	745		361
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2012 - 14	n/a	77.6	79.5	74.7		83.3
	23	Life expectancy at birth (Female)	2012 - 14	n/a	81.8	83.2	79.8		86.7
	24	Infant mortality†	2012 - 14	67	6.4	4.0	7.2		0.6
	25	Killed and seriously injured on roads	2012 - 14	233	30.9	39.3	119.4		9.9
	26	Suicide rate†	2012 - 14	64	9.8	10.0			
	27	Deaths from drug misuse #	2012 - 14	26	3.5	3.4			
	28	Smoking related deaths	2012 - 14	1,216	307.3	274.8	458.1		152.9
	29	Under 75 mortality rate: cardiovascular	2012 - 14	562	97.4	75.7	135.0		39.3
	30	Under 75 mortality rate: cancer	2012 - 14	907	158.8	141.5	195.6		102.9
	31	Excess winter deaths	Aug 2011 - Jul 2014	367	15.2	15.6	31.0		2.3

Figure 10 – Long Term Conditions

Estimated Wolverhampton population breakdown based local data									
	Mostly healthy	1 LTC	Multiple LTCs	SEMI	Dementia	Cancer	Learning Disability	Physical Disability	Grand Total
Child	48,616	2,411	13	8	-	34	-	108	51,190
16-69	121,308	33,630	16,380	2,200	142	2,897	968	1,791	179,316
70+	5,234	6,169	14,070	361	1,725	3,257	45	413	31,274
Grand Total	175,158	42,210	30,463	2,569	1,867	6,188	1,013	2,312	261,780

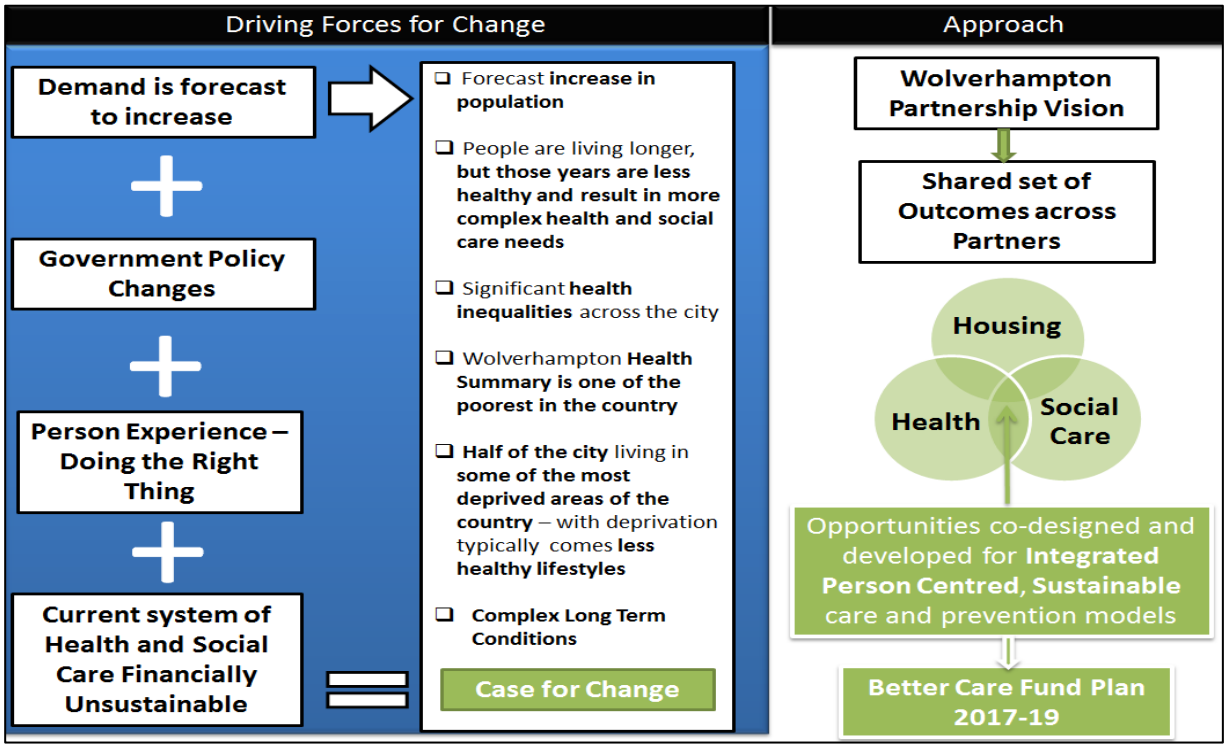
- The assumption from this data and the current data analysis regarding emergency admission activity is **that there is a need to plan for an increasingly health challenged aging population with complexity and co morbid conditions**. Alongside this is an **absolute need to adopt an early intervention, self-care management and prevention approach to support this population** over the coming years positively to live well and with general good health.
- As described in the CCG operating plan **our overriding aim is to enable people to live longer and more healthily.** Although life expectancy is increasing we need to ensure that people enjoy disability free years of live as well as having increasing longevity. **The increasing problem of the frail elderly population means that we have to look at specific services to support people to remain in their own homes and to receive care closer to home where appropriate**. We are working together as a health and social care economy to try to address these issues.
- In line with the seven NHS ambitions detailed in the NHS outcomes framework we **aim to improve the quality of life of people with one or more long term condition, including mental health conditions.**

3.2.5 Conclusion

17

- The insight that is available on the demographics, JSNA and Health Summary for Wolverhampton all provide a strong indication of the likely increase in demand for Health and Social Care services in the future. When reconciled with the economic challenges that are presenting both regionally and nationally this rise in demand will be unaffordable and unsustainable without significant transformation of the health and social care landscape *(see Figure 11 below*).
- As a component part of the wider public and voluntary sector system (and acting within those constraints) our BCF plan aims to redesign the model of health and social care delivery in Wolverhampton where our insight tells us that we can make the most difference in terms of person experience, preventing demand in the first place (where appropriate and right for the person) and where we can make the best use of our scarce resources once people need more complex health and social care needs. **It is on these principles that our plan to address the challenges are built and measured.**

Figure 11 – The Case for Change



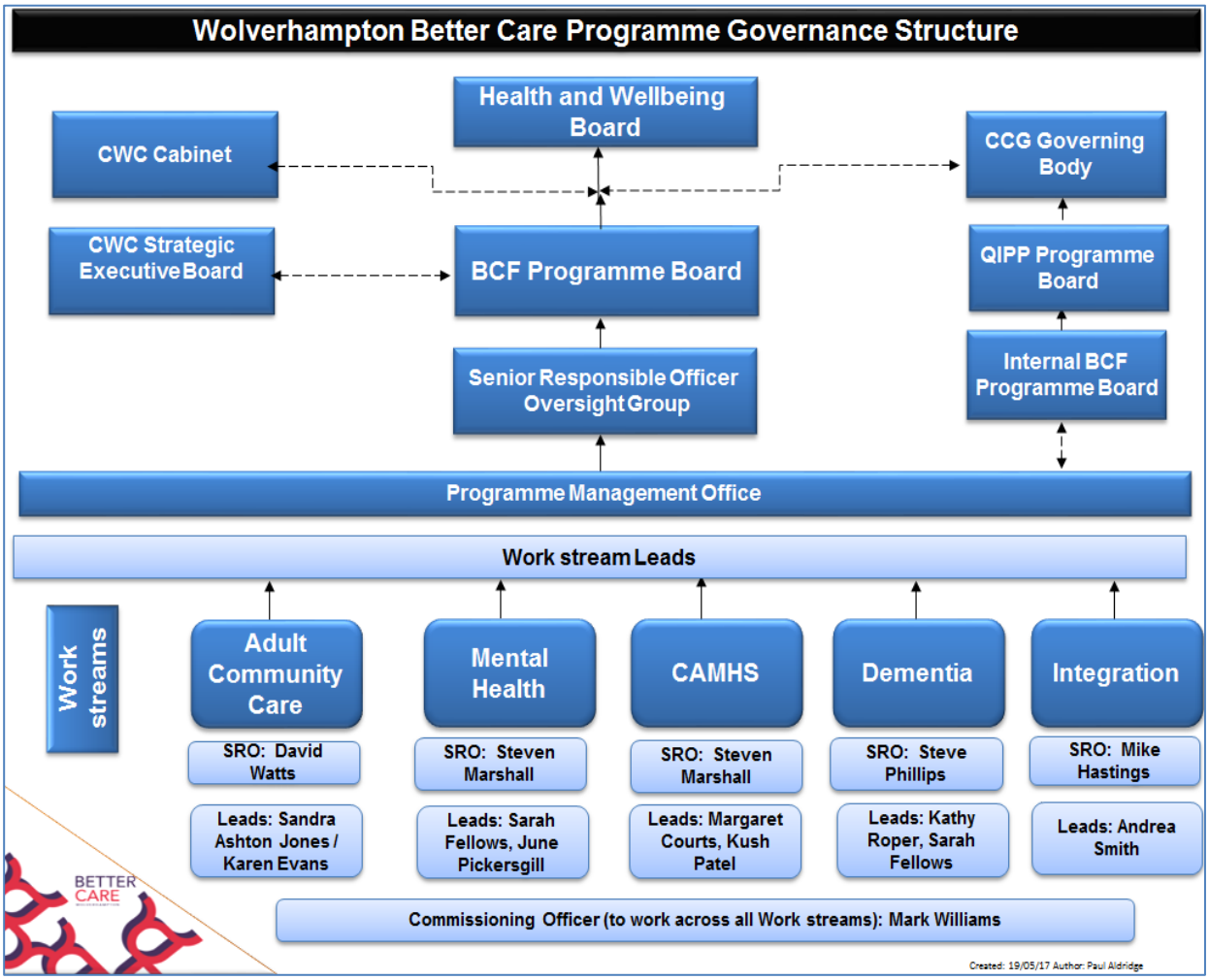
4. Programme Delivery Method and Control

19, 21

4.1 Overarching Governance Arrangements

- Wolverhampton's BCF is overseen by the HWB. The specific BCF programme of is managed through the BCF Programme Board which is co-chaired by the Accountable Officer at the Wolverhampton CCG and the Strategic Director (People Directorate) for CWC.
- The programme is underpinned by a refreshed formal Section 75 agreement between CWC and Wolverhampton CCG. Membership of the HWB will be reviewed in order to reflect the requirements of the Section 75 agreement and the robustness of approach it will need to take.
- The governance arrangements for the BCF are as streamlined as possible, bearing in mind the scale of the financial commitment involved and the scope of the overall project. Day to day operational management and oversight of the fund will be the responsibility of the BCF Programme Board. Each workstream within the Programme has an allocated Senior Responsible Officer and workstream leads from the key organisations involved in that work stream. Members of BCF Programme Board have delegated responsibility from both partner organisations to hold the Senior Responsible Owners to account and make necessary decisions from a planning and performance management perspective.
- The Senior Responsible Officers provide oversight and monitoring of the Pooled budget, supported by their respective organisation Finance leads.
- *Figure 12* below demonstrates the structure that provides the delivery mechanism and Governance to the Programme. CCG, LA and Provider organisations are represented at each of the levels of the structure except for the PMO which is a joint CCG and LA function. Both organisations resource a Programme and Project Manager and there is a jointly funded Project Support post.

Figure 12 – Wolverhampton BCF Governance Structure



4.2 Wolverhampton's Governance Flow Management and Oversight

- Wolverhampton CCG and CWC have co-terminus boundaries, and as such, have an element of already established oversight and management arrangements. Nevertheless, in relation to the BCF Programme, and in order to support the wide transformation agenda and current joint commissioning arrangements across the City, the two commissioning organisations have recognised the need to establish a clear and explicit governance framework which adds value to the existing partnership mechanisms.
- At the heart of the arrangements is the HWB, which, as mandated by the BCF Framework, has overarching accountability and oversight of the BCF Plan. Both CWC's Cabinet, and Wolverhampton CCG, have issued initial delegated authority to the Board for this oversight on behalf of the 2 organisations, with the HWB now being enhanced by additional elected membership.

4.3 Section 75

- Underpinning the management and oversight of the BCF Programme is the development of a Section 75 agreement. Wolverhampton currently has established joint commissioning arrangements in relation to mental health, learning disability, and all age disability. The Specific Section 75 agreement for BCF will cover:-
  - The complexity of the role of the HWB in relation to Section 75 oversight (i.e. the requirement for a change to Council constitution, and the Boards broader remit)
  - Risk sharing
  - Specific inclusion requirements

- These governance arrangements will ensure that there is sufficient authority to take appropriate decisions and scrutiny of those decisions and the operation of the arrangements generally. The governance arrangements have been developed over the last 12 months, and clearly articulate the reporting requirements. They will be set out in full in Schedule 2 of the Section 75 agreement. Existing contracts between the CCG and providers and the Council and their respective providers will not be affected by the continuation of a single host for the pooled fund.

4.4 Pooled Fund Management

- Each individual work stream where there is a pooled fund has designated pooled fund management from both a health and social care perspective (commissioner). This role is undertaken by existing commissioners within each of the statutory partners, with the following duties and responsibilities:
  - The day to day operation and management of the pooled fund
  - Ensuring that all expenditure from the pooled fund is in accordance with the provisions of the Section 75 agreement and the relevant scheme specification
  - Maintaining an overview of all joint financial issues affecting the Council and the CCG in relation to the services and the pooled fund
  - Ensuring that full and proper records for accounting purposes are kept in respect of the pooled fund
- Reporting to the Commissioning Executive Group (CEG) as required (this would be through SROs)
- Ensuring action is taken to manage any projected under or overspends relating to the pooled fund in accordance with the Section 75 agreement
- In conjunction with the overall pooled fund manager preparing and submitting to the HWB/Integrated Commissioning and Partnership Board quarterly reports (or more frequent reports if required) and an annual return about the income and expenditure from the pooled fund together with such other information as may be required by the HWB to monitor the effectiveness of the BCF and to enable the CCG and the Council to complete their own financial accounts and returns
- In conjunction with the overall pooled fund manager, preparing and submitting performance reports to the HWB on a quarterly basis (per Section 75 paragraph above)

4.5 Metrics and Performance Tools

- Wolverhampton's health and social care community acknowledges the need to respond to the scale and pace of the BCF Programme with a governance and management oversight infrastructure that is robust and has clear lines of accountability. Supporting the roles of the management and oversight infrastructure is a portfolio of metrics in a developing dashboard. This will provide 'at a glance' oversight of work stream delivery against programme objectives, risks, mitigations and benefits realisation on a programme wide basis. These are outlined in the table below:

Management Oversight Tool	Reporting To	When
Workstream Dashboard – Metric Impact	BCF Programme Board	Monthly
Programme Plan Highlight Report, Risks and Escalations	Programme Office	Monthly
Aggregated Performance Dashboard	BCF Programme Board and Health and Wellbeing Board	Monthly
Risk and Mitigations Exception Reports	Senior Responsible Owners	Monthly
Engagement and Communication Report	BCF Programme Board	Monthly
Performance report	Workstream	Monthly

4.6 Risks, Risk Share and Management of Risk

22

- Risks are identified (via risk log), analysed (typically using likelihood/impact matrix) and managed across the programme from individual project level through to workstreams and ultimately up to Programme level where significant risks are reported to and managed by the BCF Programme Board. Key stakeholders are represented at each of the levels.
- Alleviation of risk for providers relies heavily on understanding the commissioning intentions of the commissioning bodies. Wolverhampton commissioning intentions for both the council and the CCG are published in line with national timeframes and organisational requirements. Detailed discussions between commissioner and provider are undertaken during contract negotiations which fully address risk for providers.
- A comprehensive risk review has been undertaken across the 2017/19 programme. In each case where a risk was identified, thought was given to potential mitigations that would alleviate, assist or resolve the risk should it develop into an issue for any given provider. For the two NHS Trusts, much of this work has been addressed via contract negotiations, Commissioning for Quality and Innovation Payments Framework (CQUINS) and negotiated solutions using internal processes.
- The financial risk identified by the programme risk review are summarised below and can be confirmed as not putting any element of the minimum contribution to social care or iBCF grant at risk:-

23, 24

	CCG Risk%	Council Risk %
Adults Community Service	53	47
Dementia	90	10
Mental Health and CAMHS	65	35
Demographic Growth	56	44

- The 2017/19 pooled fund agreement has been achieved through a transparent process of sharing detailed projections, outturn information, and data and looking carefully at those areas of the whole Health and Social Care system that when pooled could create “cause and effect”. This approach has allowed both Wolverhampton CCG and the CWC to develop a shared incentive for overall agreement. As referred to earlier in the document the pooled fund for

Wolverhampton during 2017/19 will be £70.934m. This is broken down across the following work streams:

Work streams	CCG Funded services (£000)	Council Funded services (£000	Total Services (£000)
Adult Community Services **(Note: includes iBCF Funding within Council Funded services)**	29,086	25,644	54,730
Dementia	2,627	282	2,909
Mental Health	5,313	2,809	8,122
CAMHS	839	470	1,309
Ring Fenced Capital Grants – DFG	0	2,678	2,678
Care Act Funding **(TBC)**	964	0	964
Total	**38,829**	**31,883**	**70,712**

4.7 Risk Share – Underperformance

- The proposed revenue value of the pooled fund to be managed via the Section 75 agreement is £67.070m and consists of £37.865m of CCG funded services alongside £29.205m council funded services. The council contribution includes £6.513m for 17/18 and £6.637m for 18/19 representing the NHS transfer to social care (Section 256 funding). The pooled budget also includes a capital grant amounting to £2.678 m which is managed by the council.

4

4.8 Risk Share – Overspend

- The host organisation (CWC) will produce monthly financial reports and share these with the other party. The first reconciliation to recoup any overspend shall take place at quarter two (month six), and quarter three (month nine). Month 11 reporting will incorporate year end estimates on the pool fund.
- The BCF Programme Board shall consider what action to take in respect of any actual or potential overspends. The Board will take into consideration all relevant factors including, where appropriate the BCF Plan and any agreed outcomes and any other budgetary constraints and agree appropriate action in relation to overspends which may include the following:
  - Whether there is any action that can be taken in order to contain expenditure;
  - Whether there are any underspends that can be vired from any other fund maintained under this Agreement;
  - How any overspend shall be apportioned between the partners, such apportionment to be determined on the basis of the individual partner's contribution to the individual work stream as detailed in the table above.

4.9 Non-financial Risks

- The major areas of non-financial risk sharing specifically within the BCF largely relate to performance against targets, information governance and equalities. Each of these key areas were identified at the very start of the BCF journey.
- **Performance against targets.** The programme is well structured and managed. Work streams meet on a face-to-face basis fortnightly and management of activity and progress is documented and shared via the maintenance of comprehensive project management toolkits (critical paths, implementation plans, action, risk, issue and escalation logs) supplemented by highlight reports to programme board. Performance is measured against targets through

routine collections of data by each organisation's Business Intelligence team and reported to the programme board monthly. This allows for early identification of issues which enables proactive management at appropriate levels of the governance arrangements.

- **Information Governance and Equalities.** An overarching Information Sharing Agreement has been created to support the shared care approach we are working towards here in Wolverhampton. An agreement has been reached for the four main partners to install, gain access and utilise a software platform that allows frontline workers to comprehensively 'view' client data across all available systems for identified purposes. Given that this is a 'view only' solution that does not allow any changes to already stored data, this is a real step forward in the professional health and social care world. Existing information and data cannot be compromised and therefore the four BCF partners have each agreed a 25% financial cost and associated risk share arrangement. This ability for professionals to instantly access a person's health and social care information irrespective of their employing organisation will profoundly affect the timeliness of treatment and support available to those people in need, reducing the risk of duplication and gaps in service
- **With regard to equalities**, impact assessments are undertaken for each project and are continually reviewed and refreshed as required.
- **Other non-financial risk** sharing agreements sit largely across the BCF organisational partners as service level agreements rather within the Programme itself. These service level agreements relate to a variety of processes and practices across the health and social care economy the key ones relating to timeframes for:
  - Hospital discharge
  - Service response
  - Service quality

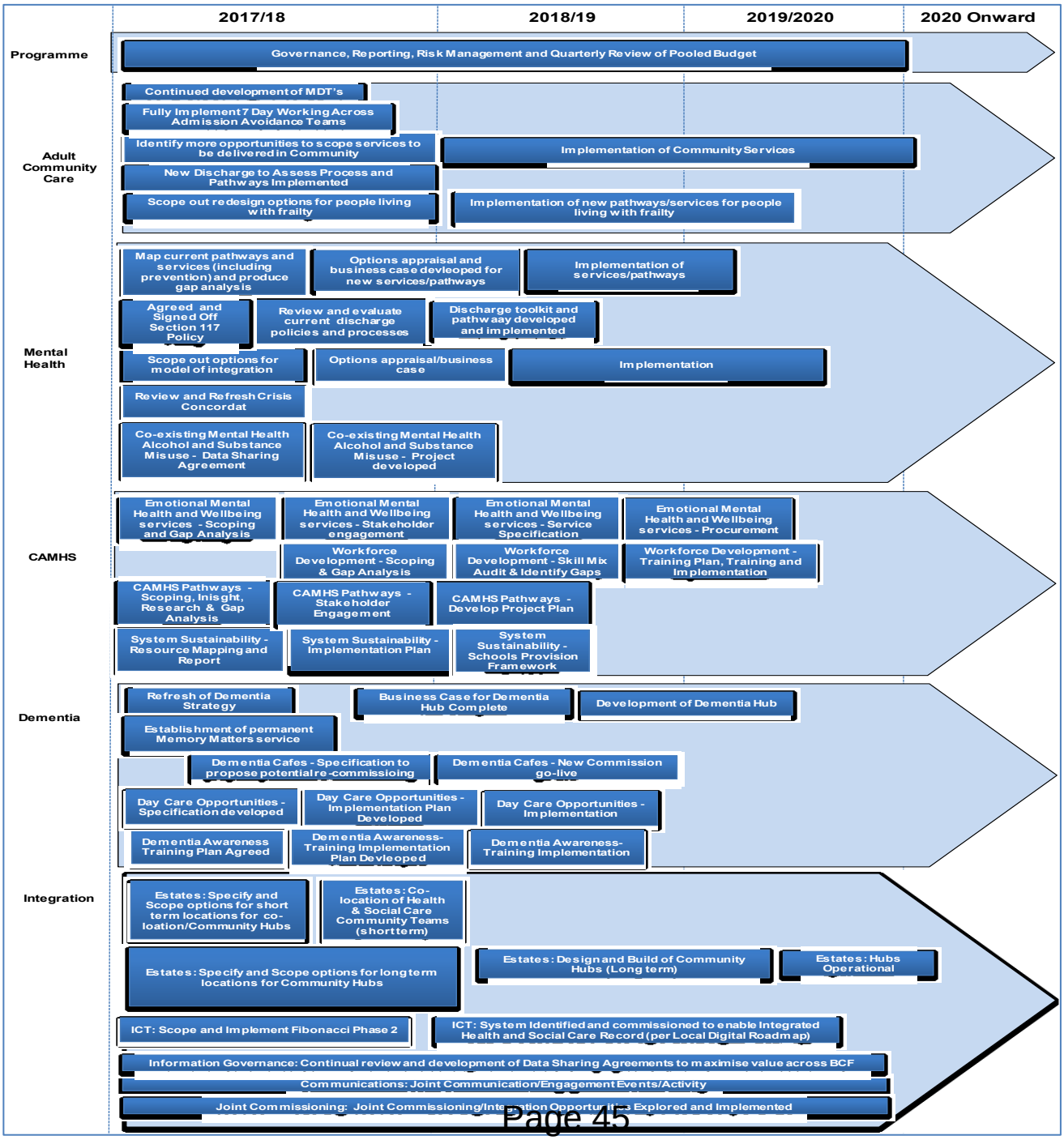
5. Delivery Model

5.1 Summary

- We have a number of programmes of work which are designing and developing services across Wolverhampton as part of our BCF approach (*see Figure 13 - Strategic High Level Roadmap*). These have been established over two years and have engaged health and social care provider organisations, commissioners, the voluntary sector, GPs, local forums and front line staff to contribute towards a review and redesign of services enabling us to deliver on the national performance metrics:- **16**
  - **Reducing emergency admissions** to hospital
  - **Reducing the number of delayed transfers of care** from hospital
  - **Improving the effectiveness of reablement**
  - **Reducing the number of people permanently placed in nursing and residential care**
- **Our aim is to have integrated health and social care teams, supported by Voluntary Sector and community groups, wrapped around GP practices and their individuals to provide place based co-ordinated proactive and reactive case management for people with medium to high level of need, long term conditions and who live with frailty.** They will be co-located in community hubs which will be developed to underpin this vision. The hubs will contain integrated health and social care teams working together to develop person centred interventions within the community they serve. The plan is for there to be one hub in each of the three localities across the city, however we are increasingly mindful of the emerging New Models of Primary Care and are working closely with the GP groups to ensure that development of the teams is also reflective of the Primary Care landscape.

- **These teams are currently working virtually and hold Multi-Disciplinary Team meetings on a monthly basis in all three localities** whereby the health and social care teams discuss in detail their caseload of people with complex and interdependent needs, ensuring that appropriate care is being co-ordinated and delivered.
- **The teams will work alongside the numerous stakeholders such as the individual's GP, Voluntary Sector, specialist teams, the Police, West Midlands Ambulance Service, West Midlands Fire Service and local pharmacies** delivering both proactive and reactive models of care depending upon the person's needs.
- **We aim to build a neighbourhood approach which generates self-care, early identification and screening, integration and resilience of communities**. Delivering a person centred focus to support for those who are living with frailty and/or complex health and care needs which maximises their independence and enables people to remain in the home they are ordinarily resident for as long as possible.

Figure 13 – High Level Strategic Roadmap 2017-2019



5.2 Proactive approach

- The proactive approach aims to identify those individuals presenting with high demand for services and at risk of attendance at A&E and emergency admission. **By identifying these people early we aim to provide support that educates and empowers them to understand and manage their condition more effectively** with the support of our community neighbourhood teams, Primary Care and Social Prescribing teams.
- **For Social Prescribing, Wolverhampton CCG in partnership with Wolverhampton Voluntary Sector Council, have launched a twelve month Social Prescribing Pilot** to provide an alternative to and compliment Primary Care. The service will work closely with other agencies in order to maximise the options available to individuals (i.e. voluntary sector organisations, Local Authority, and the local NHS provider Trusts). Each practice will have a named Social Prescribing Link Worker. The Social Prescribing Pilot will work very closely with Primary Care and aims to be anticipatory, preventive and proactive in its approach:-
  - To reduce demand on GP Primary Care (and potentially A&E attendances, admissions and readmissions to hospital for persons referred into the service) by improving their health and wellbeing.
  - To improve the health and wellbeing of individuals
  - To help improve the quality of life of individuals through education and low level support
  - To enable individuals to develop friendships and networks
  - To raise individuals awareness of available services
- **We utilise our Business Intelligence and analytical expertise to identify areas of need**, whether that is people with high numbers of A&E attendances and emergency admissions, areas of the city with specific condition prevalence, or to identify trends in activity.
- Persons are **identified through a number of routes but primarily between the GP and Community Matron utilising a Risk Stratification tool**. **Once identified the person is contacted to obtain consent for the Multi-Disciplinary team to case manage them**. (Multi-Disciplinary teams are made up of Community Matrons, District Nurses, Social Workers, Specialist nurses and link with the Persons GP, community mental health teams and voluntary sector when appropriate). **The person is then referred onto the MDT caseload where a joint (health and social care) plan is agreed and implemented**.
- **GPs will now also be identifying and monitoring the persons Frailty index** and these persons will also be case managed to reduce the risks associated with frailty.
- Now the **Fibonacci system (electronic shared record) has been successfully implemented across health and social care, it is used within the MDT environment to look at the person record** and can also be utilised by members of the team when they are with the person to ensure that they have the most up to date person information.
- **A robust Telecare offer has been created to support users to remain in their own homes and communities,** through the provision of technology based on individual needs and, where appropriate, provision of mobile response to a non-injury fall or instance of no response from the user, as provided by West Midlands Fire Service (WMFS). In 16/17 there were 2,219 response callouts, 57% relating to a fall, and only 14% of all callouts resulting in an ambulance intervention. Telecare is currently provided to over 5,000 people across the city, with a growth objective of 3,000 new users over a 3 year period through to end of 18/19. 2016/17 saw 1,150 new users supported. The development of the Telecare offer aims to support:
  - Reducing admissions due to falls
  - Rapid Hospital Discharges/Delayed Transfer of Care
  - Reduce, defer and delay the need for more intensive support
  - Reduced spend on delivery of care services both in care homes and at home

- Meeting needs of an ageing population with reducing budgets
- Promoting independence and self-management in the citizens of Wolverhampton

An example of the partnership with WMFS and the approach across Health and Social Care can be seen at: https://www.theguardian.com/healthcare-network/2017/apr/27/firefighter-falls-callout-service-easing-pressure-ambulances

- **For Dementia:-**
  - Using the pathway in the Joint Dementia Strategy the Memory Matters project has been developed to respond to a need for information advice and guidance to support early diagnosis.
  - Multi agency dementia awareness training is now being rolled out
  - The care market is being incentivised to support people with dementia
  - A revised commissioning model for clinical services has been commissioned that responds to the NICE guidelines

5.3 Reactive Approach

- Whilst much resource is aligned to managing people's conditions and preventing an acute crisis, some people will, at some time experience an exacerbation of their condition, either with their physical or mental health. We have implemented and continue to enhance a number of rapid response elements to the programme to further avoid emergency admissions to those persons in crisis

5.3.1 Mental Health Street Triage

- The mental health street triage care is a service jointly provided by CWC, BCPFT, WMAS and West Midlands Police. It is imperative that people with mental health problems get the right assessment, care and treatment they need as quickly as possible especially in emergency situations. This arrangement sees mental health nurses accompany officers to incidents where police believe people need immediate mental health support. The aim is to ensure that people get the medical attention they need as quickly as possible, thus preventing inappropriate use of police custody cells & and s136 suites
- Please see below link for media coverage of the Street Triage work and evidence of the Social Value of this way of working

  https://www.expressandstar.com/news/2017/05/19/black-country-triage-team-save-west-midlands-police-18m/#9AkYSmbseulSb5Sg.03

5.3.2 Community Rapid Intervention Team

- The purpose of the team is to **primarily prevent unnecessary hospital admission by providing a multi-disciplinary team approach for those experiencing an acute episode of illness or injury who are in a health and/or social care crisis.** *See Figure 14, p28 – Example of the co-designed integrated pathway for the Rapid intervention Teams (RiTs)*
- Once the acute episode of care has been managed, **the service will then work with a wide range of health, social care and voluntary sector professionals to identify and agree the on-going management of the persons** and the requirements of the person and carer, to be able to confidently manage their condition (where clinically appropriate) within their usual place of residence.
- The service will have the **following locally defined outcomes:**
  - A progressive reduction in attendances at A&E and all urgent care portals
  - A progressive reduction in emergency admissions to acute based care
  - A progressive reduction in preventable admissions

- A progressive reduction in readmissions for persons within a 90 day period
- Incremental increases in improvement in person experience
- All referrals will be responded to within the agreed timescales
- Delivery of care in the persons home or usual place of residence
- A comprehensive assessment of the health and social care needs of each person
- A progressive reduction in the delayed transfers of care for persons fulfilling the criteria for this service
- Support timely discharge from hospital
- Improvement in recovery from the acute episode of their illness
- Maximise independent, healthy living and build confidence to enable persons to self-care
- Utilise equipment including Telecare and telemedicine to enhance and support independence
- Working with Social care partners, prevent admissions to permanent nursing or residential care
- Working with Social care partners, prevent the need for high intensity social care packages of care
- Provide step up care to persons to avoid admissions to hospital
- Work in partnership with other agencies to provide a seamless service to all persons

Figure 14 – Co-designed integrated pathway for the Rapid intervention Teams (RiTs)

5.3.3 Reablement

- **The Bradley Reablement service** provides a short term residential reablement programme to enable a person's timely discharge from hospital, assessment of needs in a community environment, enable further recovery, encourage independence and facilitate a return to independent living at home as early as possible. The service has access to on site therapists and social care staff and referrals are made to equipment, Telecare and community based services where required to ensure a coordinated approach to returning home. Referrals are also received from the community for short term work to aid a person's return to on-going independence at home.
- **The Home Assisted Reablement Programme (HARP) Reablement service** provides a short term reablement programme in an individual's home, working together with the person and appropriate partners to maximise skills, independence and confidence to ensure on-going independent living at home. The programme supports people to be as independent as possible ensuring individuals continue with activities associated with daily living skills, personal care, kitchen skills, mobility skills and social inclusion. The HARP service will promote awareness and use of assistive equipment and technology to maintain a person's independence, reduce dependency on support services and promote safety within their home environment. The service receives people by way of hospital discharge or community referrals.

5.3.4 Evidence Based Approach

18

- **Integration is the key to delivering demonstrable improvements in quality, value and outcomes for the people of Wolverhampton**. There are a significant number of emerging case studies and papers which support the case for integrating services.
- **The case for developing integrated, person-centred services and the benefits to be derived from this is clearly articulated in the Kings Funds 'Making Best Use of the BCF" and "Making Our Health and Care Systems Fit for an Aging Population"**, the 9 components of which have been absorbed into Wolverhampton's planning.
- Evidence suggests implementing integrated care has shown that integrated health and social care services can support older people to maintain their independence longer. **This helps to prevent emergency admissions, reduces length of stay in hospital and as a result reduces demand on full social care, all core areas of focus in Wolverhampton.**
- **There is a strong emerging evidence base for the BCF plans and Wolverhampton is confident that by building on current and previous experiences, it can embed and deliver sustainable, resilient and responsive integrated services that are person-centred**. A recent example of this is the delivery of integrated discharge planning services, and the mutual benefits derived from them. There are also a number of case studies available from the schemes that are now up and running with a sample included at **Section 6.1, p37** that evidence the impact on the individuals and their families.
- Articulating what is meant by integration is equally important in supporting the case for change. **Wolverhampton has undertaken significant consultation, local evidence review and engagement prior to selecting the 5 work stream programmes that it proposes to take forward between now and 2020.** A summary of these is included at **Section 2.4, p6**, *Figure 1* with more detail in *Appendices 1 and 2*
- **Workshops have been held across the health and social care economy** with stakeholders across all areas, professions, providers and **communities. There have been public events for people and their carer's to talk about their experience of local community** as well as through GP locality events with our primary care providers.
- Themes have emerged that have become golden threads in the description of the **need to**

deliver integrated, person-centred services , in short Wolverhampton' services:-

- **Must be more explicit and coordinated across health and social care** in the targeting of resources, thereby removing the traditional boundaries in existence. **People only want to tell their story once.**
- **Must be sustainable, resilient and able to deliver better outcomes**, quality and value through behavioural and organisational change.
- **Must strengthen the way community and primary care facing services are constructed and delivered** in order to reduce the growing pressures on the local emergency and urgent care systems
- **Must maximise the value of return on investment** through activity shifts from hospital to community facing services as a means of successfully realising benefits
- **Must 'upstream' the focus toward asset based local community developments** for a redesigned model of integrated delivery of community facing services
- **Must encourage through design, living well, self-care, self-management and maximisation of choice**

- **The outcome of this process has been the identification of core work streams whose focus will be on transformational service redesign** that works towards the vision, outcomes and 'end state' as described and visualised in **Section 2, p4**. In doing so Wolverhampton has laid down the marker for its level of ambition and commitment to deriving maximum benefit from the BCF Programme.

- The core work streams are outlined in the table below, alongside the national and local evidence base for their inclusion in the programme;

Workstream	Evidence Base
Adult Community Care	Stepping up to the Place – NHS Confederation The Evidence Base for Integrated care – The Kings fund Delivering better services for people with long-term conditions - Building the house of care. The Kings Fund The Torbay Model – "Mrs Smith" Building bridges, breaking barriers, Care Quality Commission Making our Health & Care systems fir for an ageing population, The Kings Fund Efficiency opportunities through health & social care integration, Local Government assc Supporting integration through new roles working across boundaries, The Kings Fund Integrated care for older people with frailty – Royal College of General practitioners
Mental Health	The Five Year Forward View for Mental Health (NHS England) Bringing together physical and mental health" (March 2016), The Kings Fund No Health Without Mental Health Case Study: Sandwell Nurse Led Psychiatric Liaison
Dementia	JCPMH: Practical Mental health Commissioning - Dementia LGA Integrated Care Value Toolkit Dementia Map NICE Dementia Care Pathway – Dementia Interventions NICE Dementia Care Pathway - Diagram and Assessment NICE Dementia Care pathway - Overview
CAMHS	Future in Mind: Children and Young People's Mental Wellbeing (Department of Health/NHS England) Transforming Care Plan (The Black Country) Wolverhampton CCG CAMHS Transformation Plan What good could look like in integrated psychological services for children, young people and their families What really matters in children and young people's mental health Implementing the five years forward view for mental health

6. Reflection on 2016-17

The workstreams and projects within them were outlined in our plan for 2016/17. The table below demonstrates our progress and achievements against those projects.

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions
Adult Community Care	**The Continuing development of three locality based Integrated Health and Social Care Community Neighbourhood Teams, wrapped around Primary Care and supported by specialist teams and Voluntary Sector**	Working with partners to develop a Wolverhampton City Strategy to deliver the vision of the BCF ACC workstream. To ensure that our planning of services takes account of the opportunities to provide truly integrated care to our local population by wrapping services around our persons to deliver person centred, holistic care. To ensure we are commissioning services based on evidence of need including the complexity of conditions our population is presenting with. To continue to build good working relationships with our providers, co-producing services based on the holistic needs of the population working towards commissioning for outcomes. Providing both proactive and rapid response to our person's needs. Development of extensive Community Offer reducing demand on health and social care services and supporting citizens to become more independent	Reduction of A&E attendances Reduction of emergency admissions Reduce DToC Improve person experience Co-location of the H&S care teams Reduction in high cost demand by 5%	Jointly agreed plans Supporting 7 day services Better data sharing Joint approach to care planning and assessments Agreement on the consequential impact on providers Investing in out of hospital services Supporting plans for reducing delayed transfers of care

Achievements / Current Situation

Joint working:
The Community nursing teams and Social care colleagues now meet in each locality on a monthly basis for an integrated MDT supported by a newly developed electronic IT solution to capture individual care plans. This year has seen the introduction of mental health into the MDT and the work stream.

Admission Avoidance:
The admission avoidance team have commenced seven day working and continue to work in partnership with Primary Care, WMAS, Voluntary sector and the Local Authority reablement services avoiding admissions and conveyances to accident and emergency.

Step up beds:
The CCG has commissioned a small number of step up beds to pilot the impact on avoidable admissions. This pilot will be fully evaluated to measure the impact in terms of quality of person care and impact on emergency admissions.

Discharge to Assess (D2A):
This year has seen the introduction of a major programme of work on delayed discharges. Senior responsible officer for the programme is the Lead for Adult Social Care supported by the CCG Head of individual care. The programme has representatives from health and social care including our main acute care provider to ensure a whole system approach and the scope focuses on pathway redesign to promote and embed a 'home first' approach to hospital discharge.

The main objectives of the programme are:
- support admission avoidance where appropriate
- support timely discharge from hospital
- maintain independence wherever possible
- reduce the level of long term packages of care
- have a net neutral impact on the health and social care economy
- provide a 7 day service

Fibonacci:
This year saw the successful implementation of an electronic shared care record. This initiative supports the monthly integrated MDT's. Phase 2 will commence in May and this will bring online Mental Health and Primary Care.

Reablement:
Telecare - is offered by the City of Wolverhampton Council and supports people to live independently in their own homes by giving them a range of assistive technology, from emergency alarms and fall detectors to smoke and flood sensors. It aims to give peace of mind and reassurance 24 hours a day to people who are either living on their own or caring for someone else by providing support in crisis situations.

The Development of a Wound Care pathway	To provide a seamless 7 day service for persons who will receive treatment at the right time, in the right place by an appropriate health professional	New Wound Care pathway Improved person experience Efficiencies in reducing variance Standardisation of assessment for non-healing wounds	Jointly agreed plans Supporting 7 day services Better data sharing Agreement on the consequential impact on providers Investing in out of hospital services

Achievements / Current Situation

A multi stakeholder steering group has fully reviewed the current ambulatory wound care provision across Wolverhampton. This has included Primary Care, Community Care and domiciliary care. Some pathways within the acute hospital have also been reviewed to provide a more whole system approach. A new model of care has been developed to include a robust whole pathway approach including prevention and education that will deliver an optimal service for our population. The new model is a community based model with a clinical streaming element to ensure persons are treated by staff with appropriate capacity and capability. The model has a number of outcomes including quality of life outcomes for this person cohort.

We need to agree for community services the 7 day services e.g. weekend increase for DN to provide a 7 day service as only essential needs are met. Community Matron now 5 days how do we build this model and consider 7 day service around self-activation of PMP and support

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions
Dementia	**The development of a Dementia Hub for Wolverhampton**	The aim is to promote greater independence and choice for people with dementia, increasing their self- esteem and encouraging people to maintain good social and personal relationships. Amongst other things the hub model would host an Integrated dementia team, a Dementia Café, the Education and Awareness programme and the Dementia Pathfinders	A detailed specification for the hub and what it will provide.	Jointly agreed plans Supporting 7 day services Investing in out of hospital services Agreement on the consequential impact on providers
	Raising Awareness, information advice and guidance	The aim of this project is to ensure that all citizens and professionals have a relevant understand of dementia and can find information easily when required	Increase the number of people who are Dementia Friends Wolverhampton maintains its 'working towards being a dementia friendly community	Jointly agreed plans
	Memory Matters clinics	This is a community based 'pop up' information and advice service run by health and social care professionals (CPN/SW/CDWO) offered in a non-health and social care venue on the first Tuesday of every month across a twelve month	Reduced anxiety around memory concerns Family carers re more confident about supporting a	Jointly agreed plans

	period. The aim is to provide information and to signpost people towards support and early diagnostic services where appropriate The project received funds from The Big Lottery to co-produce information for the public. Co=production was undertaken with young people and people form BME groups	relative to seek diagnosis Increasing awareness of dementia and how to support someone with dementia	
Dementia Care pathway	• To 'pump prime' service transformation by increasing the number of dedicated liaison and outreach dementia staff across RWT and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT. • To align dementia care pathways across the 'whole system' across primary, secondary and tertiary care including residential and nursing care to improve care, clinical outcomes and quality of life from diagnosis to end of life and where possible, reduce unplanned admissions to RWT and BCPFT. All of the above provide an opportunity to develop and deliver a transformational plan	Analyse of HRG data and cluster data within BCPFT to identify admission causes for those with primary or secondary diagnosis dementia to inform service redesign. Dedicated PMO support will scope and describe current care pathways against best practice including NICE Guidance Reduce relapse, hospital admissions to RWT, numbers of people placed out of Wolverhampton in acute overspill and / or longer stay beds by keeping people well and responding pro-actively to periods of relapse / crisis.	Jointly agreed plans Better data sharing Agreement on the consequential impact on providers Investing in out of hospital services

Achievements / Current Situation

Joint Working

The group has established a strong ethos of joint working across CWC, CCG RWT BCPFT, carer services and the Dementia Action Alliance. The DAA is the local partnership board where representative form voluntary, community, and retail organisations work collaboratively to make Wolverhampton a dementia friendly community. The involvement of the DAA in the BCF programme ensures that the pathway re-design is co-produced at a number of levels.

Dementia Awareness

- BCPFT have trained all staff in dementia awareness at a level that is appropriate for the job they have
- Dementia is mandatory training at CWC
- The Dementia Action Alliance has been re-launched
- Alzheimer's Society did a dementia awareness session at the Team W event for GP's

Memory Matters

The first six sessions were centrally located and well attended but the service now moves around the city and pops up at relevant locations to rotate the sessions Dates and venue are being published on WIN Feedback to date indicates that the local people place a high value on receiving quality, informed and accurate information about concerns for their own or someone else's memory functions. The service is being formally evaluated with a view to moving from its current 'pilot' status into a permanent service

Dementia Hub

The new model and the business case are still in development. The BCF group have agreed to review the

	business case and undertake some research into other models of dementia hubs. The alternative models will include satellite surgeries in existing community resources. Professionals and members of the Dementia Action Alliance (DAA) are involved in developing the specification through feedback at the DAA. The dementia hub and alternative model will be included in the consultation plan and the final model will be developed following consultation in December 2017. **Dementia Care Pathway** Pathway agreed as specified in the Joint Dementia Strategy which improved access to specialist services, improved early diagnosis and more staff appropriately trained in dementia. Next steps are to develop the pathway to include all services available in each element of the pathway and to publish information in a single portal – probably utilising WIN			
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions**
Mental Health	**Street Triage**	The MH Rapid Response Triage care is a dedicated "blue light" ambulance vehicle deployed under guidance of Police / AMBO control rooms. It delivers a 7 day multi-agency response (Police, Ambulance and CPN) to appropriate 999 and 111 calls across the Black Country population of 1.2million. Planning is underway to further develop the service through the inclusion of AMHP expertise Expanded as per 15/16 service redesign and in 16/17 to include focus on dementia.	Options appraisal for inclusion of AMHP into rapid response car developed.	Jointly agreed plans Support of 7 day services Better data sharing Investing in out of hospital services.
	Hospital Discharge Pilot	Hospital Discharge pilot to include re-focus in 16/17 on Penn and RWT delays Dedicated social care mental health support to urgent care pathway to increase the number of AMHPs and provide dedicated support to Penn Hospital to reduce delayed discharges and facilitate mental health in patient flows with RWT and BCPFT.	Achievement of 7 day access to urgent health and social care services	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC.
	Mental Health Liaison Psychiatry	Service expanded as per 15/16 service re-design and in 16/17 to include re-focus on dementia	Achievement of 7 day access to urgent health and social care services	Jointly agreed plans Support of 7 day services Better data sharing
	Reablement and 1st Avenue	This will involve the implementation of a redesigned recovery and outreach service that includes:- Provision of a 2 bed crisis unit Integrated reablement / outreach recovery pathway An assertive outreach service Community recovery service – provides assertive outreach approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and / or relapse and readmission delivered from a range of bio-medico – psycho interventions, fully utilising NICE guidance	Operational 2 bed crisis unit in the community Operational social care assertive outreach service	Jointly agreed plans Support of 7 day services
	Resettlement	A two tier approach that will include:- The timely identification of	Operational access to 26 additional supported living	Jointly agreed plans Support of 7 day services

	individual needs through health and social care assessment and case review activity The development and implementation of additional supported living (50 units over a 3 year period) The development and implementation of a single floating support service	units Integrated reablement / outreach recovery pathway	Better data sharing Supporting plans for reducing DTOC.
Prevention	This will involve the recommissioning via a tender process of a single joint prevention service across health and social care	Commissioned single joint prevention service	Jointly agreed plans Investing in out of hospital services
Urgent Care Pathway	Delivers Wolverhampton Crisis Concordat for adults of all ages with a focus on compassionate and practice and responsive services and interventions, including starter schemes initiated in 2015/16 described above and also including single Point of Access and crisis resolution and Home treatment fully utilising NICE guidance	Redesign, develop implementation of interoperational implementation plan across AMHS and dementia Achievement of 7 day access to urgent health and social care services.	Jointly agreed plans Support of 7 day services Better data sharing Investing in out of hospital services
Community Recovery Service	Provides Assertive outreach approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and /or relapse and readmission delivered from a range of bio-medico – psycho interventions, fully utilising NICE guidance	Redesign, develop implementation of interoperational implementation plan across AMHS and dementia	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC. Investing in out of hospital services

Achievements / Current Situation

Street Triage: Discussions were held with Street Triage about the possibility of an AMHP being included into the car, however this was not considered necessary by stakeholders who believed this was an unnecessary use of resource.

Hospital Discharge Pilot: This pilot began in June 2016 and information was provided to the A&E board in February 2017 to evidence that the aims and outcomes were met. This resulted in an extension to this pilot for another 12 months. This is currently being fulfilled by an Experienced Social Worker/ AMHP who is seconded from the MH Social Work Team (Mon-Fri).

Reablement and First Avenue: Provision of 2 bed crisis unit achieved through a contract with P3. Social care 'assertive outreach' type service in place to support prevent crisis and promote independence and community inclusion for service users.

Resettlement: Social care case review completed and assessments on-going to support service users in moving to less restrictive environments, and therefore promoting independent living and community inclusion. 14 flat scheme (Woodhayes) projected to be completed in July 2017.

Prevention: Service with a prevention focus commissioned by LA called 'Starfish' and commenced April 2017. Further work is required to map and review all preventative services and to redesign, respecifiy and potentially re-procure on a city wide basis. This is reflected in our 2017/19 plan. Our mental wellbeing needs assessment has been completed and this will inform service development.

Mental health colleagues are now invited to the Community MDT that takes place in each locality when mental health input is required.

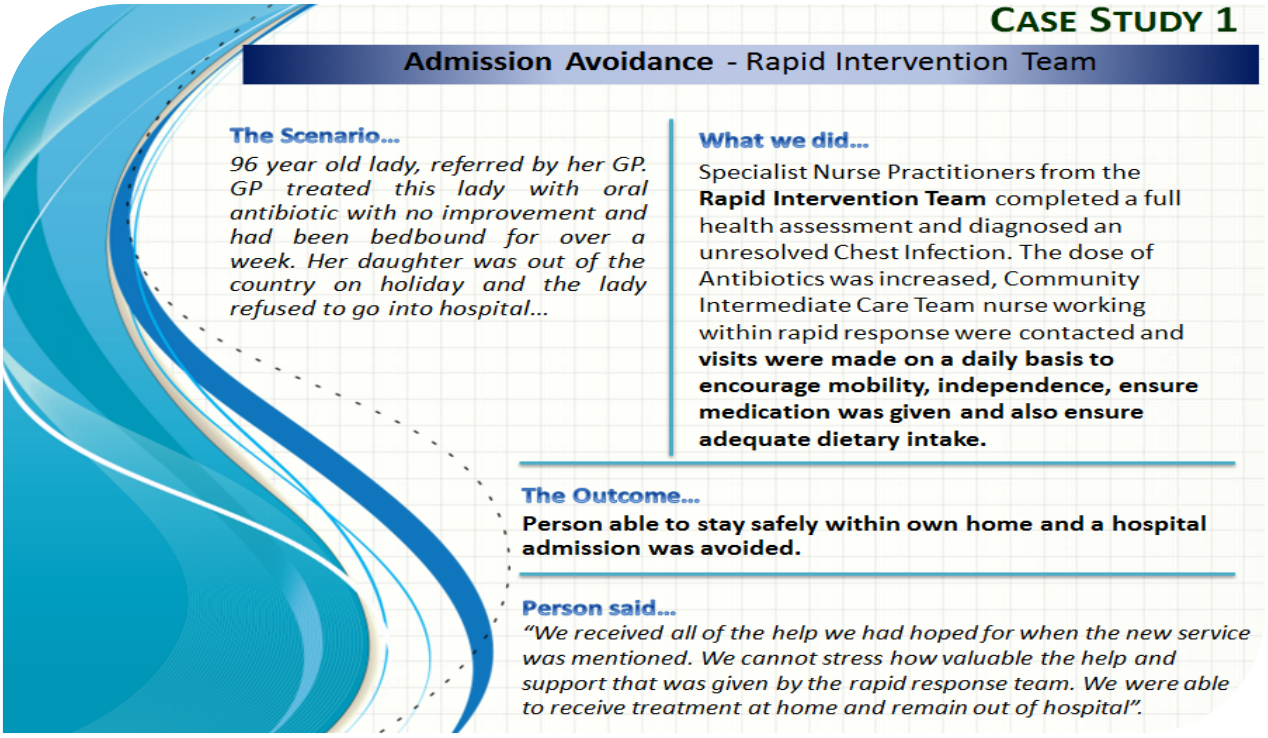
Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions
CAMHS	**Transformation of CAMHS services**	This work stream is to be included in the Programme for 16/17 in "shadow form". It will utilise the governance and joint working approach of the programme to deliver a review and transformational change of CAMHS services across Wolverhampton. The programme manager leading on this piece of work is a joint appointment between the CCG and Local Authority	An assessment and review of current CAMHS services. A transition plan of redesign of CAMHS services	Jointly agreed plans
	Achievements / Current Situation Following a review of the CAMHS services it has been identified that the main gap is the tier 2 services. Funding has been identified from WCCG and CWC to procure a service to meet these needs. These services to be managed under the BCF with a section 75 completed for a pooled budget to be agreed.			
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions**
Integration	**Estates**	To identify estates requirements for the programme as a whole and for individual projects. For example to support the co-location of Community neighbourhood teams, the moving of outpatient clinics from an acute to community setting, the development of a dementia hub and of developing dementia services in the community. To work with Estates colleagues to scope appropriate premises and to work towards the move to integrated health and social care teams	Estates specification produced Premises identified	Jointly agreed plans Supporting 7 day services Joint approach to care planning and assessments Agreement on the consequential impact on providers Investing in out of hospital services Supporting plans for reducing delayed transfers of care
	IT	To implement the Fibonacci system to enable health and social care staff to share information on a role-based access view only basis. To continue the exploration of open APIs for the economy with a long term view of developing integrated health and social care systems	Fibonacci implemented Integrated Health and Social Care record	Jointly agreed plans Better data sharing Joint approach to care planning and assessments Supporting plans for reducing delayed transfers of care
	IG	To ensure that pathways, processes and systems have robust and appropriate information sharing agreements at all stages and comply with Caldicott 2	Signed Data Sharing Agreement	Jointly agreed plans Better data sharing Joint approach to care planning and assessments Supporting plans for reducing delayed transfers of care
	HR	To ensure that in the move toward integration and the changes in person and service user pathways that change management processes are undertaken appropriately and fairly and all relevant policies and legislation is adhered to		Jointly agreed plans Supporting 7 day services Joint approach to care planning and assessments Investing in out of hospital services
	Achievements / Current Situation **Estates -** Work continues to progress in finding suitable accommodation for the co-location of Integrated Health and Social care teams and for the provision of services in the community. Whilst it has proved difficult to find suitable premises all key stakeholders are still committed to driving this forward. The Local Authority and CCG are jointly funding a Consultant to undertake a Service Strategy and Feasibility studies on potential estate across the City. This strategy will take into consideration the direction of travel in Primary Care and also work being undertaken within the STP.			

IT – We have successfully implemented an IT system "Fibonacci" that pulls health and social care data into one view for members of the Community multi-disciplinary team. This enables front line staff to manage persons more effectively understanding all of the contacts and interventions that the person has undergone, relevant to their care management. The system is co-commissioned by CCG/LA/RWT/BCPFT. We continue, through the Local Digital Roadmap Group to explore options for an Integrated H&SC record and for systems to provide H&S care data to holistically inform our commissioning decisions.

IG – we have a Data Sharing Agreement in place covering the functions of the BCF programme which is signed by CCG/LA/RWT/BCPFT ensuring our compliance with Caldicott 2.

HR – HR is a standing agenda item at the Integration Workstream. This enables us to identify any HR issues that may arise in relation to the integration of teams or Co-location etc.

6.1 Case Studies



CASE STUDY 2

Reablement - Telecare

The Scenario...

Couple signed up for Telecare after husband suffered a stroke which left the 83 year old with weakness in his left arm, mobility problems and susceptible to falls.

What Telecare did...

Each time a fall was reported the fire service came out to help him back onto his feet. They also checked him over to make sure he wasn't injured, and carried out a Safe and Well check with the couple on their home. **Each time, the presence of the mobile response service avoided the need to call an ambulance**

The Outcome...

Person able to stay safely within own home and a hospital admission was avoided.

Couple said...

"The Telecare service is such a reassurance. The fire service is able to help me up when I have a fall and carry out a thorough check to make sure I'm okay, and it's a big relief to know I can get help". "Everyone in Wolverhampton should know about this valuable service. It gives us freedom and provides our family the peace of mind that, if something does go wrong, we will be able to get the support we need."

CASE STUDY 3

Risk Stratification/Case Management

The Scenario...

Retired 67 year old gentleman was referred to Community Matron's via a local GP for management of his social conditions in relation to his alcoholic dementia. Patient is also a smoker. His Risk Stratification score was low. This was because the gentleman had not had any recent hospital admissions and so he wasn't registering on the electronic system as a high risk. **On the initial assessment by the Community Matrons there were several issues identified:**

- Lives alone and only has support of his ex-wife
- Had many episodes of forgetfulness.
- Had only had x 3 baths in a year.
- Had previously had a house fire
- Sleeping on sofa, hadn't been to bed for years
- Not taking any medications despite dementia diagnosis and blood pressure problems.
- Had extremely dry skin on his feet, unkempt nails (not washing)

What we did...

Referral to the Fire Brigade who performed a home visit and installed smoke alarms and provided full 'fire retardant' bed linen. The Matrons have helped to get a care company in after years of patient refusing help. The care company are from his multi-cultural background and he now really engages with them. He now has a weekly shower, has help with his cleaning (they encourage him) and they will take him out weekly for a walk, shopping etc. The Matrons also referred person to podiatry (chiropody) for foot health. The Matrons have worked closely with the GPs and have prescribed some medication for his blood pressure and requested some cream for his legs and feet. The Matrons have helped person to find a way to remember to take his tablets and his blood pressure is now a greatly improved. The Matrons and the GP are slowly considering medication to help with his alcoholism. They have made a referral to Telecare to request a Pivotel medication system (medication reminder machine) and a personal alarm in case he has a fall at home.

The Outcome...

Person received community based person centred support to prevent hospital admission

CASE STUDY 4

Admission Avoidance - Rapid Intervention Team

The Scenario...

Person taken ill in the night and too unwell to go to GP next morning. Husband went to local practice and the receptionist referred to Rapid Intervention Team (RiTS)...

What we did...

Within the hour a nurse arrived at the house, took her temperature (38.9) and her oxygen level which was very low. The nurse got patient to use her inhaler a few times and ensured she was using it properly, she explained that this was to increase her oxygen levels and open up her airways. She was also advised to open a window, take off the bedcover and sleep with just a sheet at night until her temperature was under control. The RiTS Nurse prescribed antibiotics and took sputum samples. From then on she had daily visits from the nurse from the Community Nursing Team who checked her temperature and oxygen levels. 5 days later a matron arrived who had the results from the tests and patient was diagnosed with Lung disease: Bronchiestis Pseudomonas – Aeruginosa (bacterial infection). Further medication was prescribed by the Rapid Intervention Nurse

The Outcome...

Person received care at home for 2 weeks and was discharged under the care of the community

Person feedback was...

"Very grateful and impressed with the quick response and wonderful service from both agencies, because it takes the worry out of being ill, it was wonderful to be at home in comfort and in the care of her husband and the health teams" Described the nurs as "a ray of sunshine"

CASE STUDY 5

Mental Health - Resettlement

The Scenario...

Individual aged 30 lived in a rehabilitation nursing home with 24 hour support for over 12 years. Had diagnosis of Schizophrenia Disorder and a speech impairment which made it very difficult for people to understand them. Clinically obese due to on-going poor eating habits and would drink 6 litres of fizzy pop per day. Weight condition impacted on physical health causing high blood pressure and cholesterol levels as well as breathing difficulties and sleep apnoea. Person lacked motivation and did not engage in any social activities, requiring 24 hour support to prompt and assist in all areas of daily living and did not participate in any physical activity. Sometimes they would display challenging behaviours and intimidate other people as well as self-harm.

What we did...

Social worker visited to complete an assessment of needs along with family, advocate and care provider . Everyone involved in the assessment felt person would benefit from living in a supported living scheme where they could develop independence, motivation and daily living skills. It was agreed that a culturally sensitive scheme would be beneficial and social worker identified an option. Individual and brother went to have a look at the scheme and both liked it there. Person supported by the outreach team to purchase my furniture and to move in. Staff supported to enable the person to overcome intial nerves around the move and helped them to develop a routine including support attend the day centre for lunch.

The Outcome...

Now been living in new home for 3 months, **preparing and cooking own healthy meals and snacks** with support from staff. **Socialises with the other tenants** who are all supportive. Gets on well with staff and developed a good sense of humour. **Laughs a lot and has not become upset or self–harmed.** Now **walks independently** to and from the day centre every day which is approximately 1 mile, attends a football session and a hearing voices group once a week. **Lost 4 stone and breathing, blood pressure and speech impairment have all improved.**

CASE STUDY 6

Mental Health – Resettlement (2)

The Scenario...

Individual aged 30 living in a nursing home for over 25 years - had never lived alone. All meals were prepared & cooked for person and staff in the nursing did laundry and cleaned bedroom. Suffers from chronic anxiety, OCD, an eating disorder and schizophrenia.

What we did...

Introduced person to social worker and advocate who both supported through the assessment process. They both worked with person to find out what they enjoyed to do, what they were good at and what the person needed help with. New places were visited, went out for lunch and the person was taught how to cook new things including making a shopping list and subsequent shopping for the ingredients . Social worker and cousin took person to look at lots of different houses and they chose their favourite which was in a very sheltered housing scheme. They were able to attend the day centre at the housing scheme before moving in in to help them to get to know the staff and residents

The Outcome...

Person has been living in their new home for 3 months now, getting help and support from the staff to cook their own meals and do laundry. Person is able to do their own cleaning but sometimes need reminding. They go shopping with the social care worker and chooses what they want to buy for meals. They go out most days and have learnt to know their way around their new community. Person visits cousin and she often now comes to their house too along with other friends and neighbours they have made.

Family said...

"'I would like to thank you very much for the excellent way you have handled the recent resettlement of my cousin. I hope that many more will have the pleasure of your dedicated work to enable them to move forwards with confidence and happiness"

CASE STUDY 7

Dementia – Memory Matters

The Scenario...

Mother and daughter attended Memory Matters session at the Local Library. Daughter was finding it difficult to approach the subject of her mother's memory for fear of upsetting her. Daughter felt mother was in denial of the extent that her memory was declining and mother would get very upset if it was mentioned and refused to get any help.

What Memory Matters did...

The Community Support Officer discussed memory decline which provided daughter (carer) the opportunity to voice her concerns to her mother. Mother admitted that she had tried to conceal her memory loss through fear of diagnosis and to prevent relatives from worrying, however it was a relief to get it out in the open.

Mother was encouraged to attend GP Surgery for a physical health screening and to talk about memory loss. Social activities were also suggested to keep her mind active and to increase her support network to reduce social isolation. Information leaflets were provided for Mother to read at her own leisure and to remain in control regarding choices going forward.

Daughter was provided with Carers assessment information.

The Outcome...

Mother chose to attend the GP surgery supported by her daughter. She also attends local activities to keep her mind active and to reduce isolation.

Feedback received...

Carer *" It was such a relief to be able to talk openly, to have someone to listen and to feel supported was very helpful, I'm hopeful that my mom will attend the surgery to have her memory looked into, Thank you for all your help"*

Mother *"I didn't realise the upset I was causing my daughter the friendly lady made it easy for me to admit I have been forgetting things quite a lot, I didn't feel judged made to feel I was going mad. With my daughters support I will attend the GP Surgery and the social group"*

7. 2017-19 Plan

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions (New and Maintaining Progress)	15, 16, 11
Adult Community Care	**People living with Frailty Programme**	Review and redesign of current pathways to ensure services are meeting the needs of our aging population. A revised model of care will place a stronger focus on prevention, aging well with the delivery of proactive care aiming to keep people living independently for longer.	• Gap Analysis working with NHS Right Care to inform direction • Define scope and plan for redesign based on gap analysis and best practice • Pilot Frailty Clinic in Primary Care (developed through Primary Care Home Model aligning to the new GP contract requirements) • Delivery of Prevention services, aging well agenda and proactive care	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	
	Review and Redesign of community services programme	In depth review of current Community Based services to establish effectiveness, efficiency and improve quality. To adopt a place based approach to the delivery of community based services ensuring where possible, persons are activated and encouraged to self-manage and remain in their usual place of residence where appropriate. Undertake a scoping exercise to identify acute based services that could safely be delivered within a community setting to achieve care closer to home Co-production of detailed plan and the development of a robust business case based on opportunities identified	• Full review of current services with recommendations and or options for redesign and or improvement • Implement new model of Ambulatory Wound care across the city • Analysis of acute based services that could potentially transfer • Options Appraisal and Business Case • Plan for implementation • Governance documents – Quality impact assessment, equality impact assessment, privacy impact assessment		
	Discharge to Assess Programme	This important programme of work is underway and working at pace to redesign pathways out of hospital to ensure a 'home first' culture is adopted and embedded when discharging persons from acute care. Workstreams have been identified, with named leads and project plans developed.	• Pilot and roll out across agencies of trusted assessor model • Pilot and roll out of D2A Hub • Redesign/Commission/ Procure new services to facilitate new pathways • Reduction in DTOC monitored and delivered		11
	Admission Avoidance Programme	Review and development of established Admission Avoidance capability to identify opportunities to improve current performance and further promote services to partners and stakeholders.	• Fully implement 7 day working across admission avoidance teams • Continue to work in partnership with Primary Care and other professionals delivering		

			Undertake modelling with Primary Care to ensure alignment with new models of care emerging across the City	proactive care to persons identified through risk stratification • Embed and further develop MDT across localities utilising electronic shared care record • Develop plan for further partnership working with West Midlands Ambulance Service (WMAS) • Evaluate Step up bed pilot and seek approval to roll out. • Development of robust business case for step up beds based on outcome of evaluation • Further roll out of redesigned CICT service			
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)		
Dementia	**Refresh of the Joint Dementia Strategy**	Clear direction of travel. Vision for dementia services in Wolverhampton	Dementia strategy signed by all key stakeholders with implementation plan – integrated approach (including an Integrated Care Pathway) involving Primary Care, Mental Health and Acute and Community Services A stakeholder mapping event with CCG, RWHT and social care professionals took place in April. A revised model with commissioning intentions is being developed. The revised model will be consulted on and take to health scrutiny – consultation to be completed by Dec 17.	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans		
	Establishment of permanent Memory Matters service	The service has been extended and is now a roaming clinic to ensure the service is reaching a wider audience Public health are completing an evaluation to support the establishment of permanent service.	Permanent service established, dementia awareness increased, increase in early diagnosis of people with dementia. Outreach Dementia Tool development to continue			
	Explore the potential Re-commissioning of Dementia Cafes	The aim of this project is to establish a well-functioning dementia café service that supports people with dementia and their family	Review of current service to be completed in June 17, this will include focus groups New specification developed by August 17 Tender timeline to commence in September			

			with a new provider in place for April 1st 18			
	Dementia Awareness Training	To develop a city wide multi agency training and awareness plan to increase awareness of dementia and support Wolverhampton becoming a dementia friendly community where all staff have appropriate dementia awareness training	Training Plan agreed by all key stakeholders with implementation plan			
	Dementia Hub to remain within the scope of work stream	Clear Vision and model for Dementia Hub is developed, consulted on and agreed	Service Specification signed by all key stakeholders with implementation plan			
	Dementia – Mental Health Liaison to become part of Core 24	As per CCG Operational Plan / NHS E Planning Guidance collaborative model across Acute and Mental Health Trust (pilot currently in place – focus on reduced non-elective admissions, greater support to nursing / residential care and reductions in hospital lengths of stay)	Service Specification signed by all key stakeholders with implementation plan			
	Day Care Opportunities	As per CCG / BCPFT SDIP and Operational Plan / NHS E Planning focus on NICE Evidence based care pathways for patients clusters 18-21 and also a focus on reduced non-elective admissions, greater support to nursing / residential care and reductions in hospital lengths of stay	Service Specification signed by all key stakeholders with implementation plan A review of Blakenhall has commenced.			
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)		
Mental Health	**Review of Preventative Services**	Identify and develop joint commissioning/integration opportunities that exist that may prevent escalation into more complex/acute services	• Cohort analysis • Map of current as is preventative services in Wolverhampton (including community and voluntary sector) • Gap Analysis • Produce business case for joint commissioning Intentions • Awareness of available services and how to access them	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes on the providers that are predicted to		
	Mapping of Current Services and Pathways	To map out all current pathways and services for Mental Health in Wolverhampton	• Cohort analysis • Map of current as is Pathways in Wolverhampton • Gap Analysis • Produce business case for joint commissioning Intentions/Options for new Pathways if appropriate • Awareness of available services and how to access them			
	Review and Development of Discharge	To review current Discharge policies / pathways and to produce an agreed Discharge	• Review / evaluation of current discharge policies to include review of			

	Planning and Pathways	pathway for patients with mental health needs	assessment and discharge planning under care planning approach (CPA) • Policy (Section 117) agreed and Procedure developed and signed off • Toolkit and Pathway developed and implemented • Alignment with the D2A Project • Evaluate Penn Hospital Discharge Pilot • KPIs developed	be substantially affected by the plans	
	Develop New Model of Integrated Mental Health Services/Offer in Wolverhampton	To identify and co-design opportunities for greater integration across partners	• Workshop to develop ideas and document what good integration would look like and benefits • Options appraisal and business case • Implementation Plan		
	Co-existing Mental Health, Alcohol and Substance Misuse	Development of a project to identify and manage high service users of Acute hospital services, a significant number of which have dependencies upon alcohol and substance misuse.	• Data Sharing Agreement finalised and approved • Project developed / Business case development • Implementation plan		
	Urgent Mental Health Care Pathway	Refresh CRISIS CONCORDAT. Continued focus on reduction of non-elective admissions to RWT for high volume service users.	• Review current Concordat • Refresh as appropriate		
	Mental Health Assertive Outreach Service	Review the requirement /gaps for a MH Assertive outreach service	• Gaps in service identified. • Options paper for Mental Health Assertive Outreach Service produced		
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)	
CAMHS	**Transformation of CAMHS Service**	Following a review of the CAMHS services it has been identified that the main gap is the tier 2 services. Funding has been identified from WCCG and CWC to procure a service to meet these needs. These services to be managed under the BCF with a section 75 completed for a pooled budget to be agreed.	Procurement of a suitable tier 2 service which reduces the number of referrals being sent through to specialist CAMHS. • **Emotional Health & Wellbeing** project scoping, gap analysis, service specification and procurement • **Workforce Development** project scoping, gap analysis, skill mix audit, training and implementation plan • **CAMHS pathways** project scoping, insight/research, gap analysis, stakeholder	**Plans jointly agreed**	

			engagement and development of project plan • **System sustainability** resource mapping/report, implementation plan and schools provision framework		
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)	
Integration	**Estates**	Identify and commission premises for integrated health and social care teams (Community Neighbourhood Teams) in the short term to allow more effective integrated working. 3 locality based teams Develop a service strategy to determine which services will be delivered in the community in which areas. This will influence the estates requirements Identify and undertake feasibility studies for premises for Community Neighbourhood hubs based on the needs identified in the Service Strategy. Identify Funding and commission Community Neighbourhood Hubs	Teams co-located in each of the 3 localities Wolverhampton wide Service Strategy produced Locations/premises identified Feasibility Studies produced Hubs operational	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	
	IT	Expand use of Fibonacci to Mental Health data and explore option of including Primary Care data Identification of a system to enable Integrated Health and Social Care record Agreement on a common system/s to provide secondary data to inform commissioning decisions	Mental Health data available in the system. Primary Care data available in the system System identified System/s commissioned		
	IG	Ensure the Data sharing Agreement is fit for purpose during the evolvement of the BCF Programme	Regular reviews and updates to DSA are undertaken		
	Communications and Engagement	Co-production events, jointly presented LA and CCG to work with public, persons and carers Development of a Communication and Engagement Plan for 2017-19 Internet/Intranet, Newsletters, GP Briefings updated regularly	Events planned and undertaken Revised Communication and Engagement plan in place Regular Updates		
	Developing joint commissioning	Develop a plan to further integrate staff across health and social care, either virtually or co located.	Options appraisal produced for collaborative commissioning/joint commissioning posts in the		

			future	
	HR	As the programme moves towards further integration and co-location of health and social care staff, and the moving of clinics from and acute setting into the community, ensure that HR issues are identified and addressed in a timely manner	HR involvement in Integration and Co-location plans	

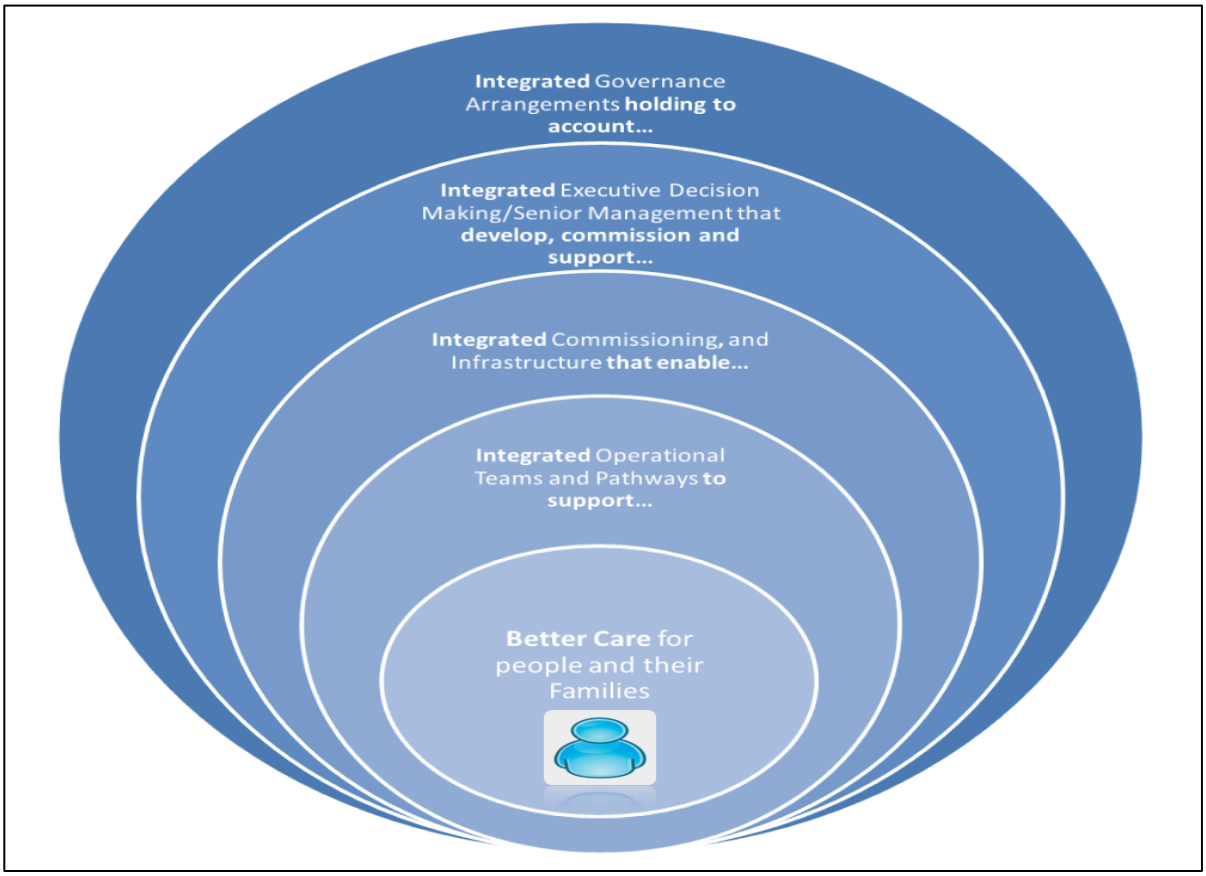
8. Integration

8.1 Our Vision and Model for Integration

14

- Wolverhampton's model of integration is based on the principle where individuals and organisations in the city work together, creating joined up care around individuals and their family's needs. This model of working is underpinned by the development of strong partnership governance arrangements that holds executive management across our organisational boundaries to account, as well as the continual building of integrated functions such as data sharing, information technology (e.g. Fibonacci), commissioning and the genuine co-design of new pathways and services. A summary of this model is included in *Figure 15* below

Figure 15 – Wolverhampton's Summary Model of Integration



- This model is being brought to life across health and care in Wolverhampton and some specific examples follow:-

8.2 Integrated Governance Arrangements

8.2.1 Section 75

- The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

- Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.
- The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will be able to pool funds and align budgets as agreed between the Partners.

8.2.2 Integrated Programme Structure

- The Better Care Fund Programme Structure demonstrates an integrated programme structure both in the PMO *(see figure 12, p20)* and in the Workstream structure. Each Workstream within the programme has a lead nominated form CCG, CWC and Provider organisation. These leads work together, to deliver the objectives of the work stream, redesigning pathways and in an integrated way. One example of a new integrated pathway co-designed by the Adult Community Care Workstream can be demonstrated in *Figure 14, p28.*
- Each workstream meets on a fortnightly basis and consists of members from the three key organisations (CCG, CWC, Provider) and other key stakeholders. *See Appendix 10* for an example of a Terms of Reference.

8.3 Integrated Executive Decision Making and Senior Management

8.3.1 Wolverhampton Transition Board

- Recognising the continued pace of change across the local health and social care economy, Wolverhampton CCG, The Royal Wolverhampton Trust, Black Country Partnership NHS Foundation Trust and the City of Wolverhampton Council have established a Transition Board. The Transition Board is made up of Executive leaders from across each organisation and acts as a joint forum to support system transformation across Wolverhampton to ensure that it delivers better health outcomes for residents across the city. Their vision statement is: '*To promote health and wellbeing for the Wolverhampton community, enabling them to live longer and healthier lives.'*
- The Transition Board will be responsible for setting the strategic direction for system transformation across the City and for making recommendations to the constituent organisations about actions to be taken to ensure transformation work helps to achieve the overall vision in the City's Joint Health and Wellbeing Strategy, Ensuring good health and a longer life for all in Wolverhampton.
- The board is working towards the following principles:-
    - Ensure the health and care needs of the people of Wolverhampton are at the heart of everything we do
    - See the whole person, recognising and respecting their life experience and views
    - Support people to receive care closer to home, improving the system so that hospital is the last resort
    - Be open and honest with the community and each other, about what we can achieve and what we cannot, and ensure we deliver what we promise
    - Work together locally and nationally, removing barriers to make people's use of services simpler and a more positive experience
    - Make Wolverhampton a great place to work in and maintain a quality sustainable workforce, fit for the future

8.3.2 Senior Responsible Officers (SROs)

- Each work stream within the programme is allocated an SRO as lead for the workstream. The SRO provides strategic direction and guidance for the work stream and reports highlights, risks and escalations to the Programme Board for their workstream. SROs are Executive level within their organisations and as such have the authority to make decisions and unblock issues at the most senior level.

8.4 Integrated Commissioning and Infrastructure

8.4.1 Joint Quality Assurance of Care Homes – Quality Nurse Advisor Team

- The Joint Quality assurance of care homes is undertaken by the Quality Nurse Advisors (CCG) and the Quality Assurance and Compliance Officers (CWC). **This integrated way of working aims to provide assurance that the care delivered in Care Homes is safe, high quality, effective and responsive to the needs of the individual.** The Quality Nurse Advisors assess care delivery by carrying out quality monitoring visits and analysing data received from care homes on the national safety thermometer and the monthly quality indicator submissions and involvement in conducting pressure ulcer root cause analysis investigations and supporting homes with implementing quality improvements and training. Information sharing is fundamental to promoting harm free care and best practice in Care Homes, and there are close working relationships with Regulatory Bodies, Partner Organisations and Statutory Agencies with the aim to reduce unnecessary hospital admissions by preventing avoidable serious incidents and enabling effective management of chronic conditions. **The integrated work programme includes:-**

Objective	Benefits/Outcomes
Revision of quality assurance visit tool for care homes	Collaboratively standardise the approach to quality assurance and compliance and develop a suite of reporting documents/best practice tools
Development of an on-line self-assessment tool for care homes and providers	Collaboratively standardise the approach to quality assurance and compliance and develop a suite of reporting documents/best practice tools
Development of a Risk Matrix for care homes	Standardise approach to quality assurance &compliance
Joint quality and sustained improvement visits	Standardise approach to quality assurance & compliance Universal approach to Quality Assurance and Compliance processes for the provider/care home and good customer experience for the service user/patient
Provide Health and Social Care support to facilitate management of failing Providers under LA Large-Scale Strategy	Collaborative approach to managing failing providers
3 Yearly Care Home/Domiciliary Registered Care Managers Development Events	Collaborative approach to developing care home managers Build good intelligence and rapport with Providers/care Homes Deliver three - six workshops in 2017/18 to improve quality of care
Provide health advice and investigations to MASH (Multiagency Adult Safeguarding Hub)	Collaborative approach to adult safeguarding providing daily clinical expert advice.
Co-chair CQC information sharing	Collaborative approach to adult safeguarding
Joint working for Pressure injury and falls prevention	Citywide approach to prevention of major harms The aim of the Scaling Up Improvement project is to introduce a tool that improves the prevention & management of pressure injuries and skin related conditions.

8.4.2 Communication, Engagement and Marketing

- Within the BCF Programme there is a dedicated Communications and Engagement lead that represents the four key partner organisations. Wolverhampton CCG's Communications, Engagement and Marketing team undertakes this role and regularly works with both commissioning and provider communications teams on a variety of both long and short term projects.
- Communication leads from Wolverhampton CCG, City of Wolverhampton Council, The Royal Wolverhampton NHS Trust and Black Country Partnership NHS Foundation Trust meet face to face at 6-8 week intervals, with a standing agenda item of Better Care Wolverhampton. As the agenda includes other areas such as STP, safeguarding, and city wide campaigns there is assurance that the communication around BCF is aligned with other Wolverhampton priorities.
- Both telephone and email contact is regular between these meetings and covers any joint press releases, such as the launch of the Fibonacci software. See link below for example of our integrated approach to press releases:-

  https://wolverhamptonccg.nhs.uk/news/320-wolverhampton-patients-benefit-from-pioneering-technology
- Not just targeting the general public and persons, all leads for communications share communications for use within existing internal channels and membership groups, to share information about integrated working and innovation within both their own organisations and those that they work closely with. Working jointly through sharing of local knowledge allows us greater flexibility within our limited resources.

8.4.3 Estates

- Estates are managed within the BCF via the Integration work stream which also includes Finance, Performance and IT. There are existing forums with their own terms of reference where collaborative estates strategic (Local Estates Forum (LEF)) and operational (CCG Capital Review Group (CRG)) work is carried out. There is representation from the Local Authority, the CCG, RWT and BCPFT at the LEF, supported by Community Health Partnerships (CHP) who also support the One Public Estate (OPE) work streams. At the CRG the lead is taken from the LEF and operational plans are discussed and actioned by operational managers from all organisations, including the BCF Programme leads.

8.4.4 Integrated Commissioning

- With the support of the BCF and the pooled budget we aim to jointly commission services where we can jointly influence service provision and make efficiencies both financially and in relation to service improvement and user experience. Examples of these are:-

  #### Community Equipment Service

  - The CWC and the CCG are commissioning an **integrated community equipment service** to meet health and social care needs across the City. One of the key strategic objectives is that care is delivered closer to home and that services are designed and commissioned in recognition of people's desire to remain at home.
  - The overarching intention is to help all people maintain as much control over their lives as possible and to promote their independence, health and wellbeing. Equipment can make a fundamental contribution to this agenda and can bring significant benefits to both social care and health partners, by:
    - Enabling all people to live in the community for longer
    - Reducing the need for and the level of domiciliary care packages
    - Reducing care home and avoidable hospital admissions

- Facilitating early discharge from acute care
- Reducing the amount of time people, including children and young people spend avoidably in hospital through better and more integrated care in the community
- Supporting persons approaching end of life to die in their preferred place of death

CAMHS

- The transformation of the emotional mental health and wellbeing service system involved the establishment of the CAMHS Transformation Partnership Board (CTPB). A place based care model has been co-designed with partners, and aligns with the establishment of Strengthening Family Hubs and HeadStart satellite sites. These co-located, multidisciplinary teams will be able to deliver care closer to home, as well as devise specific proactive interventions targeted to meet the needs of the neighbourhoods in which they work.
- The budgets for children and young people's Emotional Mental Health and Wellbeing service were managed in shadow form by the Better Care Programme Board during 2016/17. Some of the Mental health services for children and young people which are funded both by Wolverhampton CCG and City of Wolverhampton Council are proposed to be governed through joint arrangements with Wolverhampton Clinical Commissioning Group (WCCG) and City of Wolverhampton Council (CWC), and in a similar manner to adult mental health services. This will result in a joint approach to commissioning, contract management, and activity monitoring for this service. Further, by joining budgets for services that are funded by both CWC and WCCG, Emotional Mental Health and Wellbeing services can be more effectively aligned.

8.4.5 Local Digital Roadmap

- **The Wolverhampton Local digital roadmap was developed via a cooperative process between Health and Social Care organisations** that provide services within Wolverhampton. This plan is now incorporated within the Black Country Local Digital Roadmap. The key areas of development within Wolverhampton are:
- **Sharing information across sectors of care**: The development of a shared care record across the whole Health and Social Care economy, which will include primary, secondary, community, acute, mental health and Social Care. The CCG are deploying EMIS Remote consultation and mobile access to Clinical systems, enabling GP practices to utilise mobile working and access to patient records across primary care.
- **Empowerment:** The rollout of patient online services, allowing patients to access their own records, book appointments, view test results, letters and order repeat prescriptions. The expansion of e-referrals to social care and inclusion of child protection information within unscheduled care settings.

8.4.6 Joint Approach to Provider Failure

- There is a diverse market for care and support services in Wolverhampton including public, private and voluntary sector organisations. As in any market, some providers leave whilst new providers come in. Providers may leave the market for a number of reasons; examples include a provider selling on its property for residential use or a provider's business being taken over by a competitor. Most exits from the market are handled responsibly by providers who ensure that those receiving care services continue to do so in line with contractual obligations. This process is normally managed in an orderly way that does not cause disruption of services for the people receiving care. Occasionally, when care providers do exit the market in a way that adversely impacts on their ability to manage the closure of the service in a planned way, the agreed Provider Failure Policy is initiated. These procedures give clear guidelines on how any failures can be mitigated and managed to minimise the risk to people who use our services. In all circumstances a coordinated response between the Local Authority, Wolverhampton CCG, and

the care provider will be required. The CCG are a key stakeholder, their critical role is to work as part of the strategy group, review any clients who are funded by the CCG, take any relevant actions and respond within the timescales agreed by the strategy group. The CCG are also invaluable partners when assessing risk to residents and advising on clinical responses to these risks. **A close collaborative relationship between the LA and CCG supports effective management of provider failure and supports a holistic approach to supporting the residents affected.**

8.5 Integrated Operational Teams and Pathways

8.5.1 Mental Health

- **Adult Mental Health are considering options for progressing an integrated service** as part of the Better Care fund recommendations for improved service delivery.
- **Street Triage** – The mental health street triage care is a service jointly provided by CWC, BCPFT, WMAS and West Midlands Police. The service aims to ensure people with mental health issues are kept out of police custody and receive the right treatment and care. The service is mental health nurses and paramedics accompanying police officers where it is believed people need immediate mental health support.
- **Physchiatric Liaison** – Integration in as much as the team (? Who are they?) are embedded within ED at RWT

8.5.2 Integrated Health and Social Care Team

- The team operates an integrated set of functions across health and social care, incorporating patient flow, social work and community care assessment with administrative and management support wrapped around. They operate in a collaborative way that promotes communication and maximises the opportunity for effective discharge planning with appropriate outcomes using the following philosophy:-
  - To provide support and advice across the range of specialties within the Acute Trust and Step Down facilities.
  - Ensure that the patient/family receive the appropriate outcomes, providing information and support on services that they can access and promote choice and inclusion in their planning for discharge.
  - Provide additional, expert support as Health and Social Care Practitioners, interfacing between agencies to ensure that client receives the right support at the right time and in the right place.
  - To begin planning for discharge as early as possible to identify complex issues and ensure effective discharge arrangements in line with the medical plan for discharge including starting from pre-admission clinics.

8.5.3 Multi-Disciplinary Teams

- There are three locality based multi-disciplinary teams across Wolverhampton. They include Community Matrons, District nursing, social workers and therapists. Specialist teams such as heart failure nurses, palliative care consultants, community mental health teams, Home Improvement team or the patients GP are opted onto the MDT to discuss specific patients. The MDT is supported by a consultant geriatrician and the purpose of the meetings is to manage patients with complex needs in the community by care co-ordination and joint care planning.

9. Alignment with Sustainability and Transformation Plan (STP)

- We are fully aware of the interdependencies between BCF and the STP. Links across both programmes of work are maintained from SRO, Programme Management and Workstream lead

level. In Wolverhampton, wherever possible we utilise the BCF Programme Structure as the vehicle for the Place Based STP delivery. For example the review of Community Services and determining of services to be delivered in primary and community care is managed though the BCF Adult Community Care workstream. This then informs the development of the Wolverhampton STP place based model. Our work stream lead for Mental Health is also the STP mental health lead for the Black Country and therefore the two programmes of work are aligned with any duplication or contradiction identified at the earliest stage. The current Black Country Sustainability and Transformation Plan, is included in *Appendix 10*.

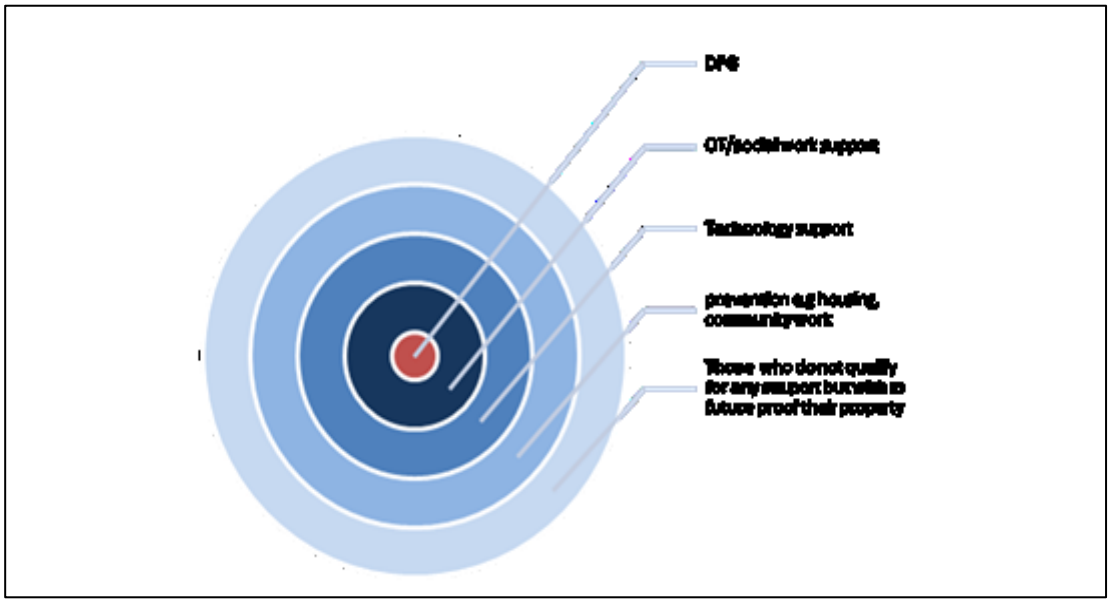
10. National Conditions

10.1 National Condition 1 – Plans to be Jointly Agreed

- Wolverhampton local health & social care economy is wholly committed to improving the health and wellbeing of its people. The principle of co-production is fully supported by the BCF partner organisations and is embedded in the overall governance structure of the programme. In 2016-17 partners agreed a set of principles about what the content of the pooled fund / BCF Programme should support and this agreement continues through to the 2017-19 plans. The principles are:- **2**
    - Co-production
    - Better Health Outcomes
    - Improved Well- Being
    - Promoting Independence
    - Identifying and utilising inter-dependencies between organisations
    - Moving intervention downstream
    - Targeted interventions by integrated teams
    - Working with Voluntary Sector
    - Care Closer to home

- The DFG budget sits within the housing capital programme for CWC (which is a single tier authority) and is included in the Pooled Fund **(See Section 4.6, p23).** The plan for spending the DFG monies is currently as per mandatory requirements and the existing discretionary policies (these support fast track installation of ramps and stair lifts). **2 & 3**
- Equipment and adaptations are a key enabler to maintaining independence and CWC will work in partnership with stakeholders to consider future actions required in delivering DFG's and adaptations. Colleagues from CW have been invited onto the BCF workstreams where appropriate and discussions are on-going around the shaping of further housing contribution to the current and future BCF plans including the potential for the co-design of a new DFG pathway. *Figure 16* below represents the current high level model for housing support in Wolverhampton through from prevention to the greatest of need (the DFG). BCF plans to explore opportunities that may exists across all of the tiers to enhance current and future plans

Figure 16 – CWC Model for Housing Support



- There is currently no official submission deadline for the 2017/19 plan but colleagues across partners are working proactively in line with the Policy Framework and latest Regional advice to produce a plan that will be a solid foundation upon which to amend quickly once official guidance is available.
- To mitigate against this 'delegated authority sign off' has been agreed by the CCG Governing Body on 11th April 17. The plan will then need to be presented to LA Senior Executive Board (SEB) on xxx for internal approval and will be presented to the Chair of the Health and Wellbeing Board *** and cabinet lead for Adult services on xxx, and the cabinet lead for children and young people on xx. Arrangements for formal acceptance and agreement of the BCF plan and content of the pooled budget are as follows:-
  - CCG Governing Body May 2017.
  - Health and Well Being Board 28th June 2017. Delegated Authority (Cllr Lawrence, Chair of Health and Well Being Board) for sign off prior to submission.

10.1.1 Involvement of stakeholders

- Through the CCG Clinical Reference Group, the plan has had oversight and input from Primary Care Colleagues. The Plan has also been shared with A&E Delivery Board, Health watch and Wolverhampton Voluntary Sector Council. Routine, regular, focused BCF meetings with the chair of the H&WB Board, other key elected members of the local council and the CCG Governing Body (made up of member elected GPs from each of the localities) have taken place throughout the duration of the programme and each body continues to approve and sign off planning at each stage of the implementation process.
- In the period prior to each submission phase, the development of the BCF plan (co-produced with work stream leads) is discussed with the Senior Responsible Officers and the BCF Programme Board each month. Executive representation from Health and Social Care providers (RWT, BCPFT and CWC) are full members of this BCF Programme Board. In addition, the Programme is supported by work stream groups (led by commissioning leads) who are pro-active in the planning and development of transformation plans. These work stream groups include operational managers from across Wolverhampton's health and social care commissioner/provider services.
- This co-production of transformation planning and implementation from strategic to operational ensures that all partners are cognisant of what the re-designed service will look like in the future and as a result, what the predicted impacts of changes to service delivery will

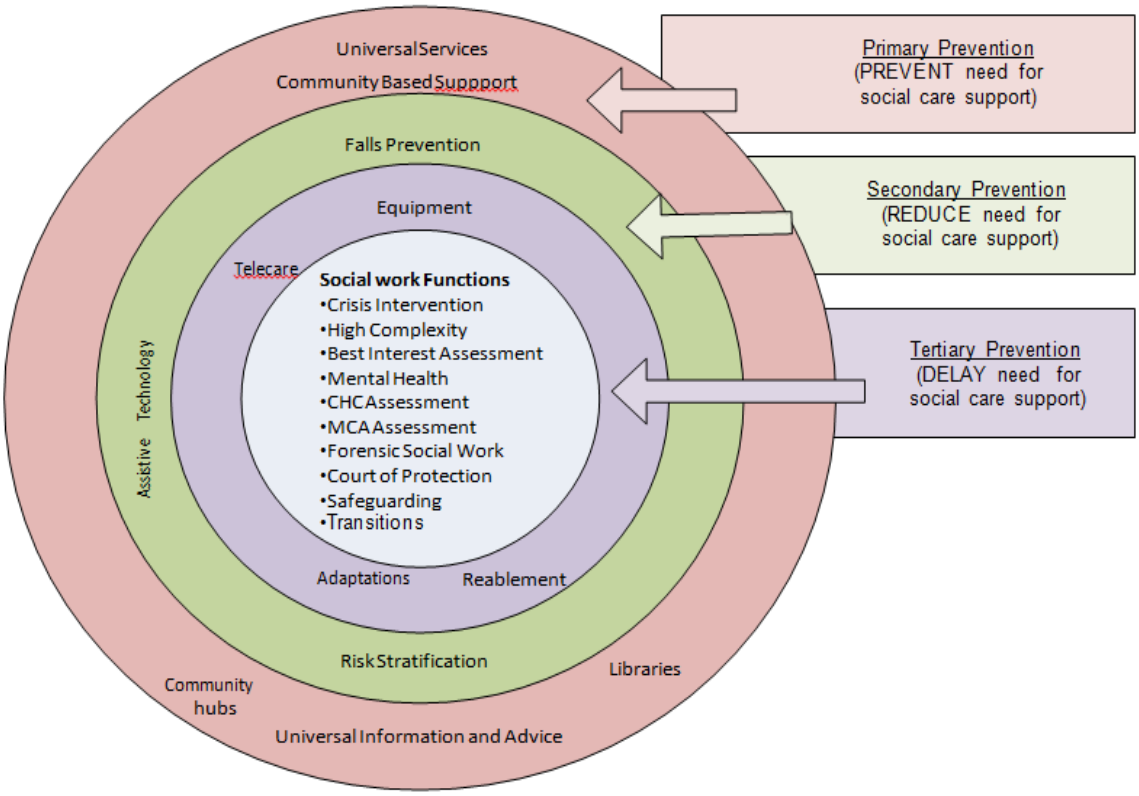
be. This approach is supported within health by discussions within the contract negotiation process which details the activity that will be impacted at HRG level and within social care through the established review monitoring and negotiation processes.

- In terms of wider stakeholders, Wolverhampton has always and continues to engage with stakeholders:-
- Design phase events included over 120 frontline Health and Social Care local professionals, individuals, users, carers, voluntary sector organisations and community groups.
- Engagement with the public has demonstrated that people want care closer to home.
- With regard to impacts for the voluntary sector, current grant recipients and other agencies are invited on a regular basis to the work streams to promote services, facilitate discussions and identify opportunities for closer working relationships. There is a Voluntary Sector forum that is held quarterly and is managed by the voluntary sector council. The LA and CCG attend the forum with a view to supporting VS organisations in capacity building (how to tender, financial stability, assistance with grant applications).
- The Local Authority is currently developing its community offer in conjunction with its stakeholders. Its aim is to provide an effective, targeted community offer, which helps citizens remain healthy, happy and independent for longer, and in so doing reduce, delay or prevent the social care needs of citizens. This is a key enabler of other projects looking to promote independence and reduce costs because it provides alternative support options. One element currently provided is the Social Prescribing pilot, which works a number of GP practices offering low level support regarding benefits, finance, housing etc. freeing up GP's time to deal with appropriate appointments. Wolverhampton Voluntary Sector Council (WVSC) are also running a 12 month pilot for Social Prescribing to support people with low level needs with the aim of improving people's wellbeing and reducing social isolation.

10.2 National Condition 2 – NHS contribution to Adult Social Care is maintained in line with inflation

- CWC Cabinet Report of 26/4/2017 *(see Appendix 11*) **4, 5, 6**
- The minimum CCG contribution for 2017/18 is £18.182m and £18.527m for 2018/19 which includes £964k **(note: still awaiting figure for 2017-18 £964 represents last years as a guide only)** Care Act monies and is in line with CCG overall budget inflation as notified by NHSE. The CCG can confirm that this minimum contribution is maintained and exceeded with the total CCG contribution being £37.865m. The development of integrated health and social care pathways and teams, including adult social care continues to be a priority within the programme, ensuring that there is no detrimental effect on the local health and social care system. *See Planning Template for detail.*
- Agreement on the high level plans for the allocation of IBCF money to ensure the local social care provider market has been attained.
- The Wolverhampton vision (see **Section 2, p4**) and delivery model (**Section 5, p24**) outline the plans for transforming and integrating the health and social care landscape in Wolverhampton and articulate the benefits, both and health and otherwise, to the population with the specific outcomes listed in **Section 2.4, p5**. The sample of case studies included at **Section 6.1, p37** outline how the BCF schemes are benefiting the people of Wolverhampton now. **7**
- The following protection of social care model (*Figure 17*) continues to be adopted across the BCF work streams, recognising that protection of social care is a key BCF objective.

Figure 17 - Protection of Social Care Model



10.3 National Condition 3 – Agreement to Invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care

- **NOTE – awaiting planning guidance around the minimum allocation for NHS commissioned out of hospital services.** 8
- The projects within the BCF Programme all support the movement of activity from acute to community, primary, social care, voluntary and general preventative services. An example is the work between GP's and community matrons to risk stratify people who are then case managed by the integrated health and social care teams and the development of the Community Rapid Intervention Team (see **Delivery Model, Section 5, p24 for details**)
- Risk stratification tool is currently being used which enables Community Matrons to work with GPs to identify patients at high risk of emergency attendance/admission. Individualised care management plans are developed for these patients with a view to managing their condition more proactively and reduce their risk of future health deterioration, maintaining people in the community. We continue to work with partners to redesign these proactive pathways with the ambition to move activity from secondary care to out of hospital services. We have worked closely with our local provider to agree the level of reduced emergency admission activity and to develop plans to further strengthen community working, investing further funding into the community contract this year.
- In line with the underlying principles of the BCF Programme the local area is committed to funding out of hospital commissioned services. This is demonstrated in the planning return expenditure plan. More detailed examples of these services are:-
- The CCG has negotiated with Providers a shift in funding streams from the funding of emergency admissions to the increased funding in community services. This has been possible as the demonstration of the impact of the schemes during 2016/17 has again instilled confidence in the future delivery of impacting going forward. **There has been an overall reduction**

in emergency admissions in Wolverhampton of 1,655 when compared to the previous year of which 35% at least can be directly attributable to the BCF Programme schemes. As a result of this we have agreed a BCF targets for 2017-18 of reduction in admissions of 1,677. Emergency admission performance data for 2016-17 is shown in the BCF dashboard extract *(Figure 18).*

Figure 18 – Current Performance – Emergency Admissions

BCF Monitoring	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Full year
Baseline (15/16 Activity)	1990	1960	1966	1992	1833	2100	2326	2228	2161	2187	2064	2035	**24842**
16/17 Actual Activity - Total Emergencies	1968	1954	1964	1953	1752	1855	1946	1996	1980	2072	1793	1954	**23187**
Variance	-22	-6	-2	-39	-81	-245	-380	-232	-181	-115	-271	-81	**-1655**
Variance (baseline v 16/17)	-1%	0%	0%	-2%	-4%	-12%	-16%	-10%	-8%	-5%	-13%	-4%	**-7%**
1617 Actual Activity - All Providers Total EM	2124	2139	2133	2163	1919	2035	2118	2160	2151	2243	1929	2102	

- The Programme is enhancing relationships with voluntary sector providers to support out of hospital services. Through a Grant Policy Framework a number of contracts have been awarded to voluntary sector organisations to support the teams in their delivery of support to the people of Wolverhampton. These schemes include a telephone befriending service with the aim of reducing social isolation, an advice and education Programme for persons with long term conditions, a support network for those at end of life and tailor made packages of support for targeted groups with aim of reducing subsequent need and dependency on NHS services and promote social inclusion.
- Two step up beds have been commissioned and are ring fenced for use by the Rapid Intervention teams for up to 7 days. These beds will increase the opportunity for avoiding emergency admission and retaining people in the community in a safe environment.
- The Street Triage/Mental Health crisis car is an example of collaborative working between organisations to provide care out of hospital.
- The Programme also commissions P3 a voluntary sector organisation that supports persons with mental health issues that are homeless so that when they hit emergency services help is given to identify suitable accommodation for the individual not in a hospital setting.
- Preventative mental health services – the council commissions Starfish to provide support to community groups outreach and one-one support for people with low level mental health provisions.
- For Social Prescribing, Wolverhampton CCG in partnership with Wolverhampton Voluntary Sector Council, have launched a twelve month Social Prescribing Pilot to provide an alternative to and compliment Primary Care (see **Delivery Model - Section 5, p24** for further detail).
- WCCG is working with colleagues in RWT and colleagues in Staffordshire in the delivery of a Research project around Health Coaching. Working with Health Navigator we are undertaking a project which sees persons with high Outpatient attendances, A&E attendances and emergency admissions being supported by Health Coached. These health coaches meet with the person and set up an individualised care management plan looking at their holistic health and care needs. The project will run for two years.
- Work is progressing with housing colleagues across sectors to shape and co-design the integrated process to access DFGs and other housing support and adaptions, enabling people to be as independent as possible and remain out of hospital wherever appropriate.
- **No additional target has been set for Non Elective Admissions** and therefore no contingency funds have been necessary to establish. **9, 10**

10.4 National Condition 4 - Implementation of the High Impact Model for Managing Transfers of Care **11, 12**

- **Wolverhampton is in the process of a robust self-evaluation against the High Impact model**

with the objective of ensuring that any gaps are identified and action plans are being developed to address. The self-evaluation is being jointly undertaken to ensure a Wolverhampton perspective and will be presented to both BCF Programme Board and A&E Delivery Board for assurance and approval of action plans.

- **There is a D2A programme that is working to develop and implement a Discharge to Assess model in Wolverhampton**. This is led by the Service Director for Adults at CWC with all key stakeholders being involved in the design and implementation. The focus of this work is to get people home from hospital as soon as it is clinically appropriate to do so. Where a person no longer needs acute care but does needs further assessment, rehabilitation and reablement this will happen in a community setting. Objectives are to:-
  - support admission avoidance where appropriate
  - support timely discharge from hospital
  - maintain independence wherever possible
  - reduce the level of long term packages of care
  - have a net neutral impact on the health and social care economy
  - provide a 7 day service

- **The D2A project will be achieved by two projects running concurrently to deliver the objectives. Project 1: Moving people out of acute care into a community health or social care setting.** Deliverables will include:
  - A Wolverhampton integrated discharge to assess offer
  - A trusted assessment screening tool for identifying on-going health and social care issues that will be assessed further in a community setting.
  - Simplified clear criteria for access to Pathway 1, 2 and 3 services
  - A single referral hub for all discharge to assess community health and social care services – this will involve a re-design of current services
  - Agreement and sign up from neighbouring authorities with regard to the implementation of the D2A pathways that all persons at RWT will follow
  - Clear pathways from ED into D2A services
  - New referral processes where necessary
  - Information for staff and persons about pathways and referral criteria
  - Engagement with mental health services to understand existing pathways into mental health and to identify gaps in provision
  - A reduction in delayed transfers due to medication or equipment not being available promptly.
  - Improved communication and information flows from acute care into community settings
  - An evaluation framework for the D2A programme

- **The Rationale for project 1 is-**
  - At present numerous professionals may be asked to assess a person before he or she is deemed ready to move. This can cause delay. This project will develop a single trusted assessment to identify issues to be resolved once the acute episode is finished.
  - Referrals for community services are made in a number of ways – through WUCTAS, through a social care referral point and between health and social care professionals. Ensuring the correct referral route to the most appropriate service relies on the individual knowledge of a range of services and professionals. This can slow down the process. The project will produce a business case for a single referral hub for D2A services which will describe the operating model. The project will also be responsible for the development and implementation of the hub.
  - Many persons attend ED and then have their hospital admission diverted. Some will need

on-going assessment and reablement in the community and should have access to D2A services. This project will develop the pathways from ED into these.

- The group is tasked with ensuring that persons receive the appropriate medication on discharge from hospital and that the provision of TTOs does not delay transfer and that the appropriate equipment and adaptations are available to persons in a timely manner on Pathway 1.
- This project will also be responsible for ensuring smooth information flows from hospital to the referral hub and out into community services. Wherever possible information should be collected once and shared with all relevant parties.
- It will be vital to demonstrate that the new D2A pathways are being used for the appropriate persons and that they are having a positive impact on outcomes and quality of life. This project will agree evaluation metrics, ensure that baseline information is available and that systems are in place for capturing data to support evaluation.

- **Project 2: Developing appropriate Discharge to Assess services utilising the pooled budget as per the section 75 agreement for the Better Care Fund.** *Deliverables will include:*
  - The development of jointly funded services in the community that facilitate the individual to return to his/her usual place of residence, as soon as possible, for people who do not require admission for acute care or have completed an acute episode.
  - Assessment(s) currently undertaken in an acute setting will now happen in the community.
  - All persons on the pathway receive a full assessment on arrival at the D2A service, have a care plan that identifies their rehabilitation and reablement potential with goals to achieve this and regular review
  - A reduction in the length of stay for persons across all D2A pathways
  - Services commissioned for each pathway with standard referral criteria and the same standard level of wrap around care.
  - Care homes commissioned that can demonstrate commitment to a cultural change to reablement and rehabilitation
  - All affected staff groups training needs identified and an on-going programme of workforce development is agreed and implemented.
  - A clear, co-produced communications plan to all stakeholders including a comprehensive information campaign to health and social care staff about the new pathways and how persons' are informed of and access them
- **The rationale for project 2 is:-**
  - One of the reasons persons are admitted/ delayed in New Cross is because of the range of services available and a lack of understanding about which is the most appropriate. There are 3 levels of care for persons on the discharge to assess pathways and the services that support them should have clear referral criteria consistent with the pathway and assessed needs of persons and be grouped in fewer places offering an equitable geographic spread. The purpose of this project is to ensure future provision reflects this. It will involve reviewing capacity to ensure the service can meet demand, refining the referral criteria and reviewing provision in residential and nursing homes for pathway 2 and 3. This may result in a change of service provision.
  - Persons on the D2A pathways will have a multi-disciplinary assessment of their needs undertaken in the community setting, an agreed care plan that identifies milestones and goals and a discharge date. There will be regular planned multi-disciplinary assessment of

progress against these goals. The purpose of this project is to ensure that these principles and culture are adopted in all services on the pathway and that staff receive the training needed to achieve this. The project will also look at whether there are any additional clinical skills needed to manage persons (often with increased complexity) in the community and identify training needs. This work will also focus on developing clear messages, in the most appropriate form, to persons and staff about the D2A referral pathways and criteria. Clear agreed messages to persons will explain the purpose of D2A i.e. of further assessment and rehabilitation in the community and will ensure all staff involved in the delivery of care to the persons place emphasis on its' short term nature.

- A significant proportion of the people who are delayed in hospital do not live in Wolverhampton. A medium term aspiration is to get agreement that these people are moved into their local area for assessment by the relevant authority. Alternatively there would need to be agreed agreement that out of area persons are transferred into a Wolverhampton D2A service as soon as they have become medically ready and assessed promptly by staff from the local authority covering the area where they live. This would involve charging the authority concerned.

10.5 Maintaining Progress on the 2016-17 National Conditions

10.5.1 Seven day services

15

- The Programme already has a number of services that support service delivery on a 7 day basis. The Community Intermediate Care Team (CICT), Home Access Reablement Programme (HARP), Bradley Reablement Service and Therapy Access Team services are available 7 days a week from 8.00am until 8.00pm. The Council's therapy led resource beds in the community and the nurse led rapid intervention beds at West Park Hospital can be accessed 7 days a week. These services all support the existing acute and emergency services and the developing community teams. We have commissioned 2 step-up beds that are accessible 7 days per week to support the admission avoidance agenda.
- Our Rapid Response pilot has now moved into an embedded 7 day admission avoidance service and is currently undergoing evaluation. The co-location of social care AMHPS in the Urgent Care Centre across weekends and bank holiday periods is now complete.
- As development of the programme progresses and in conjunction with provider colleagues, all new integrated services will have a phased approach to 7 day service delivery where appropriate in order to prevent avoidable admissions and support timely discharge.
- Wolverhampton is working with NHS England to be an early adopter of 7 day services and the BCF partners are working collaboratively to develop an implementation plan for delivery. A project group has been set up by RWT, which includes representation from: Wolverhampton CCG, CWC and BCPFT to collaboratively implement the plan.
- The programme will also explore how 7 day services can be supported by other organisations such as Primary Care and Voluntary Sector.
- There are now step up and step down beds being piloted with both offering a 7 day service

10.5.2 Data Sharing

- We now have a signed DSA to cover BCF in Wolverhampton, which has been developed and approved by CCG, LA, RWT and BCFPT. This enables front line staff to deliver more effective care to the population of Wolverhampton.
- The progress on data sharing has underpinned and enabled the successfully implementation of the "Fibonacci" IT system that pulls health and social care data into one view for members of the Community multi-disciplinary team. This enables front line staff to manage persons more effectively understanding all of the contacts and interventions that the person has undergone,

relevant to their care management. The system is co-commissioned by CCG/LA/RWT/BCPFT. We continue, through the Local Digital Roadmap Group to explore options for an Integrated H&SC record and for systems to provide H&S care data to holistically inform our commissioning decisions.

- Progress is also being made around enabling the use of the NHS number as the key data field. Social Care systems currently reporting a figure of 85% and plans in place to identify and resolve the issues connected to the unmatched 15%.

10.5.3 Joint Planning and Assessment

- Work is being undertaken by the emerging CNT's to identify a caseload for proactive case management. The proportion of the local population who receive case management and a named care coordinator will be the most vulnerable and this group will be identified via a risk stratification tool. This is being done by two methods:-
- A consolidated view of current health and social care caseload within each of the 3 localities to identify a cohort of persons that would benefit from a joint approach of care planning. This is undertaken during regular MDT meetings where health professionals and social care staff meet to agree a joint approach to assessments and care planning.
- Community matrons working with individual GP practices to identify a cohort of persons, based on risk stratification that would also benefit from a joint care planning approach from the integrated health and social care teams. People identified are either managed directly by the team of community matrons or referred into the MDT for a collaborative management plan to be developed.
- As we move forward we will be developing a more Primary Care MDT focus
- As the CNT's develop further and become more mature this approach will be embedded in their ways of working. This will be further enhanced when the teams become co-located. Work is underway with estates colleagues to identify available and suitable premises in each of the 3 localities and also to identify capital funding to enable this to happen. The opportunity to align to existing bids for new build premises within Primary Care is being explored as part of the longer term estate planning solution.
- The teams will develop an approach whereby each person is allocated a named accountable professional dependent upon their primary need.
- The CNT's are currently meeting on a monthly basis to discuss their caseload and a joint approach to care planning. The outcome of these meetings are recorded and updated accordingly into a care management plan. The next phase to have these available in a single person record. This is the first phase of development and our plans describe how these teams will be enhanced in the future.

11. National Metrics

11.1 Non-Elective Admissions

29, 30, 31

- **The non-elective admissions (NEL) target reduction for 2017/18 has been set at 1,677**. This figure has been reached through discussion with RWT community teams, contracts and clinicians (both primary and secondary care) who have reviewed the conditions that people are admitted with against the schemes that are in place through BCF and as an outcome have agreed on the potential impact (*see Figure 19 below*).

Figure 19 – Non Elective Admissions Plan 2017-18

BCF Monitoring - 2017-18 Plans	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Total NEL - BCF Related Plan	914	943	927	955	888	898	933	958	973	954	916	967	**11,226**
BCF Planned Reductions	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-139**	**-139**	**-139**	**-1,677**
Total NEL - Non BCF Related Planned	984	1,022	1,006	1,043	935	959	1,005	1,057	1,071	1,044	1,010	1,064	**12,200**
Total NEL	**1,758**	**1,825**	**1,793**	**1,858**	**1,683**	**1,717**	**1,798**	**1,875**	**1,904**	**1,859**	**1,787**	**1,892**	**21,749**

- **This will be a challenge**, and to contextualise in 2016/17 Wolverhampton achieved an overall reduction in NEL of 1,655, with 575 of the typically most complex cases directly attributable to the BCF Programme.
- The target for 2017/18 was set based firstly on evidence of deliverability of last year and whilst the target was not achieved last year a number of reasons are known for this (staff recruitment, influx of pneumonia in the winter months). **By continuing to work with our provider partners and with continued investment into community services we are confident that the set target, whilst challenging, is achievable if all plans are delivered.**
- **Secondly, the determination of the target has been very much clinically led**. Our community nursing teams, GPs and Consultant geriatrician have reviewed the conditions that people are being admitted for, alongside the interventions that we have and are planning to put in place, and have estimated the impact that the programme can, in theory, make on reducing emergency admissions.
- **No other reductions have been set for NEL admissions** in the CCG Operating Plan.

11.2 Admissions to Residential Care

- **The 'Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population' target has been set at 260 admissions** (an average of between 21 and 22 per month). The total number of admissions in 2016/17 was 385 – an average of 32 a month. **32**
- In 2015/16, Wolverhampton was in the top quartile among comparators with admissions of 299 – an average of 25 a month, but was in the lower-mid quartile regionally and nationally. Based on 2015/16 data, to be in the top quartile regionally there would need to be fewer than 234 admissions (an average of 19-20 a month) and to be in the top quartile nationally there would need to be fewer than 219 admissions (an average of 18 a month).

Graph to go here with new targets

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	644.8	638.0	698.8	581.9
	Numerator	273	273	299	252
	Denominator	42,338	42,787	42,787	43,307

- Service redesign to promote independence and strengthen access to treatment and support in the community is well underway, as is work to support the development of mechanisms to track it.
- The CWC is in the process of procuring the Care and Health Track system and is currently working to agree the content and delivery timescales. This will provide access to much more detailed information about health and social care needs across the City.

11.3 Effectiveness of Reablement

33

- **The proposed target for the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services is 80.3% - the same as 2016/17**. Although the target was not achieved, there will be additional reablement capacity with the introduction of the externalised service which it is proposed will be twin tracked with the internal HARP services as part of the IBCF monies. Further work will be done to understand the reasons why people do not remain at home following reablement to understand what else can be done to further maximise its effectiveness.
- The plans set out within this BCF submission to further increase the reablement offer to the citizens of Wolverhampton both within the community and on discharge from hospital further. Increasing the offer of reablement through a more widely encompassing selection and identification criteria for people who would benefit from the offer, often leads to a decline in overall reported effectiveness due a lessening of the 'cherry picking' effect that more stringent selection criteria can produce. It is therefore believed that maintenance of current performance against an increased reablement offer is realistic while providing a degree of ambition.
- The following metric has been selected:-

  'Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services'

  Need to update graph for targets

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	80.5%	94.3%	75.6%	80.3%
	Numerator	330	330	195	490
	Denominator	410	350	258	610

11.4 Delayed Transfers of Care

- The requirement for measuring delayed transfers of care has changed for 2017-19. There is a national target that has been set that by September, the number of delayed transfers of care should be no more than 3.5% of occupied bed nights. Although the detailed methodology has not been released for this, it is understood that the measure most likely uses the snapshot DTOC figure (number of people who are delayed at midnight on the last Thursday of the month) and the average daily occupied consultant led bed nights as published in the quarterly reports. Occupied bed nights are only available by Trust. Using data for the Royal Wolverhampton Trust, the figures for 2016/17 are as follows:

34, 35

Need DTOC graphs – then some narrative (none to bring over from last submission)

12. Budgets

25

26

TBC

27

28

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Better Care Fund Template Q4 2016/17

Data collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S.75 pooled budget, by Q4? If no, date provided?
Yes

3. National Conditions

	1) Plans to be jointly agreed	2) Maintain provision of social care services	3 i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3 ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken?	4 i) Is the NHS Number being used as the consistent identifier for health and social care services?	4 ii) Are you pursuing Open APIs (ie system that speak to each other)?	4 iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4 iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	7) Agreement to invest in NHS commissioned out-of-hospital services	8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. I&E (£'000's)

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
	Commentary	Yes				
	Commentary					

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	NEA	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	DTOC	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Local performance metric	Yes	Yes
	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Admissions to residential care	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Reablement	Yes	Yes

6. Year End Feedback

Statement:	Response:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Yes
2. Our BCF schemes were implemented as planned in 2016/17	Yes
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Yes
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Yes
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Yes
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Yes
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Yes

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response and category
Success 1	Yes
Success 2	Yes
Success 3	Yes

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response and category
Challenge 1	Yes
Challenge 2	Yes
Challenge 3	Yes

7. Additional Measures

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

8. Narrative

Brief Narrative	Yes

Cover

Q4 2016/17	
Health and Well Being Board	**Wolverhampton**
completed by:	andrea smith/
E-Mail:	andrea.smith21@nhs.net
Contact Number:	01902 441775
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Lawrence

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. I&E	19
5. Supporting Metrics	13
6. Year End Feedback	13
7. Additional Measures	67
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Wolverhampton

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Wolverhampton

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	Yes	Yes	Yes	Yes	
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes	Yes	Yes	
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be	No - In Progress	Yes	Yes	Yes	
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	No - In Progress	No - In Progress	No - In Progress	Yes	
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	Yes	
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - In Progress	No - In Progress	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	Yes	

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2016-17.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

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

3) Agreement for the delivery of 7-day services across health and social care to

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that,
Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may
Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.
This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Wolverhampton

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£14,419,190	£14,419,190	£14,419,190	£14,419,190	£57,676,760	£57,676,760
	Forecast	£14,419,190	£14,419,190	£14,419,190	£14,419,190	£57,676,760	
	Actual*	£14,419,190	£14,419,190	£14,419,190			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£14,419,190	£14,419,190	£14,419,190	£14,419,190	£57,676,760	£57,676,760
	Forecast	£14,419,190	£14,419,190	£14,419,190	£14,419,190	£57,676,760	
	Actual*	£14,419,190	£14,419,190	£14,419,190	£14,419,190	£57,676,760	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	N/A

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£14,419,217	£14,419,217	£14,419,217	£14,419,216	£57,676,867	£57,676,867
	Forecast	£14,419,217	£14,419,217	£14,419,217	£14,419,216	£57,676,867	
	Actual*	£14,419,216	£16,726,286	£12,440,949			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£14,419,217	£14,419,217	£14,419,217	£14,419,216	£57,676,867	£57,676,867
	Forecast	£14,419,217	£14,419,217	£14,419,217	£14,419,216	£57,676,867	
	Actual*	£14,419,216	£16,726,286	£12,440,949	£15,915,092	£59,501,543	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The pooled budget overspent this year due to pressures within various schemes within the fund. The manin pressure being Older People Care Purchasing support due to increased demand of support plans. This financial pressure was addressed by the CCG and Local Authority in line with the Section 75 agreement
Commentary on progress against financial plan:	see above

Footnotes:
*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board: Wolverhampton

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	In Wolverhampton we have seen a reduciton of 1600 emergency admissions into RWT. Whilst this is positive, only 585 of these can be direclty attributed to the work undertaken within the BCF Programme. This is however 585 fewer emergency admissions that 2015/16.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Performance has improved significantly from the 2015/16 baseline with 2,656 fewer delayed days, a reduction of 18%. This again falls significantly short of the target of 6,430 fewer days, a reduction of 57%.

Local performance metric as described in your approved BCF plan	New supported living placements for people with mental health issues
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	The plan has not fully achieved due to the abandonment of a building construction by a MH provider. However 6 people have moved into supported living in other schemes during this financial year.

Local defined patient experience metric as described in your approved BCF plan	Overall satisfaction of people who use services with their care and support
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	The result has fallen from 65.9% to 63% thi year. The target is 70%. Data is taken from the annual user survey and additional commentary is not currently possible.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)

Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Admissions have increased to 385 in the year against a target of 252. Tthe admissions per month have been significantly higher than previous years. This is an average of 32 admissions each month in 2016/17 compared with 25 per month in 2015/16.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Performance has fallen slightly from 75.6% to 74.5%. The underlying figures for this have seen significant reduction in numbers due to changes in the provision of post-hospital reablement.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board: Wolverhampton

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	All of our workstreams and projects are jointly led by CCG and LA representatives. Multi-agency, Multi-disciplinary project groups are in place for each project. Relationships and communication continue to improve.
2. Our BCF schemes were implemented as planned in 2016/17	Agree	The majority of schemes were implemented as planned. We have seen some delays with the development of CNTs and co-location of teams due to the identification and resourcing of suitable premises. Work is ongoing into 2017/18 to address this.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Agree	Operational teams work much more collaboratively and embrace the opportunity to co-locate to improve integration
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Agree	Whilst the reduction of emeregncy admissions has not met its target we have demonstrated 585 fewer emergency admissions than last year (directly attributable to BCF) and 1600 overall.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Neither agree nor disagree	Whilst we have not achieved our target for delayed transfers of care, the BCF Programme has enabled the D2A project to be initiated, with two multi agency project groups working to implement the new pathways.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	The concentration of reablement during 2016/17 has resulted in more visible activity data, an increase in productivity and a reduction of the time spent in reablement leading to more service users being reabled with the same resource.
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Neither agree nor disagree	Admissions have increased to 385 in the year against a target of 252. The admissions per month have been significnatly higher than previous years. This is an average of 32 admissions each month in 2016/17 compared with 25 each month in 2015/16.

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	Rapid Intervention Teams (RITs) moving to 7 days. Following a succesful pilot this service was built into the contract with our Community Provider on a permanent basis. Whilst there are still some recruitment issues the service is now running a 7 days service 8.00am - 8.00pm	10. Managing change
Success 2	DSA - A Data Sharing Agreement has been approved and signed by 4 key partners in the programme Wolverhampton CCG, City of Wolverhampton Council, Royal Wolverhampton Trust, Black Country Partnership Foundation Trust.	7. Digital interoperability and sharing data
Success 3	Implementation of Fibonacci - After some months of development the Fibonacci system was introduced to the MDT meetings. The system allows members of the MDT ot see bothhealth and social care information relating to patients on the MDT caseload.	7. Digital interoperability and sharing data

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Estates - We have still been unable to find suitable premises to co-locate the Community neighbourhood teams (community nursing and social care staff). The seatch for premises still continues and in the interim the teams are working in a more collaborative way with 3 locality based MDTs happening monthly across the City.	1. Shared vision and commitment
Challenge 2	Pace of change - Progress has been made in the delivery of the programme but the pace for change remians a challenge. Much of this relates to resources where it is the ssame individuals involved in numerous areas of work, most of which also have a "day job" to deliver. recruitment remians an issue and there are still vacancies within the RITs teams. The lack of pump prime money for new schemes / changes of pathways alos impacts upon the pace at which change can be implemented.	2. Shared leadership and governance
Challenge 3	Demonstrating impact - The target reduction of emergency admissions for 2016/17 was 1586. In total in wolverhampton we saw a reduction of 1600 emergency admissions. We can, however, only attribute 585, directly to the work undertaken within the BCF Programme. We suspect that the impact is much greater but cannot demonstrate this.	5. Evidencing impact and measuring success

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change

Other

Additional Measures

Selected Health and Well Being Board: Wolverhampton

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	No	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via interim solution	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via interim solution	Shared via interim solution
From Social Care	Shared via interim solution	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via interim solution	Shared via interim solution
From Mental Health	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	Installed (not live)	In development	Installed (not live)	In development	Installed (not live)
Projected 'go-live' date (dd/mm/yy)	[redacted]	31/07/2017	31/07/2017	31/07/2017	31/03/2018	31/10/2017

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot commissioned and planning in progress

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	26
Rate per 100,000 population	10

Number of new PHBs put in place during the quarter	0
Number of existing PHBs stopped during the quarter	6
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	92%

Population (Mid 2017)	257,344

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).

http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Wolverhampton

Remaining Characters	28,973

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Highlights and Successes---------- 2016/17 has been a positive year for the BCF Programme in Wolverhampton with the continued implementation of our plans and continued collaboration and integration across partner organisations. There has been a reduction of 1600 emergency admissions across the health economy, almost 600 of which are directly attributable to the schemes within the Better Care Fund Programme. The locality based MDT meetings have progressed throughout the year and have been significanlty enhanced by the implementation of the Fibonacci system that allows members of the MDT to view health and social care data applicable to the indiviuals on the MDT caseload. The Rapid Intervention Team service has moved to a 7 day service enabling people to be treated for exacerbation of condition in their own home rather than being admitted to hospital. Work is ongoing iwth housing colleagues across the sector to work in a collaborative way in managing home improvments, adaptions and other housing needs to support Managing Transfers of Care with the aim of reducing DTOC. We have worked closely with primary care,voluntary sector organisations and community groups in enabling low level support, tailored to individuals within a Social Prescribing environment. The dementia workstream has seen huge success in its Memory Matters project which provides information and advice for people wih dementia and their families and carers. The project began with an adhoc session in a locla library and has now been extended to regualr sessions across 7-8 locations across the City. There is also a Dementia Awareness Training programme in which we are working with ALzheimers Society to deliver Citywide. In mental health the Street Triage care continues to deliver impact. The BCF programe has embarked on an ambitious target of 600 new telecare installations during 2016/7 and over 1200 have actually being achieved. The concentration of reablment during 2016/17 has resulted in more visible activity data, an increase in productivity and a reduction of the time spent in reablement leading to more service users being reabled with the same resource. Challenges and Concerns---------- There a number of interdependencies that we are acutely aware of when delivering the BCF locally such as the STP, New models of care in primary Care, CCG collaborative commissioning, Combined Authority etc. the approach that we are taking in Wolverhampton is that we need to ensure that our plans are aligned wherever possible to these interdependencies whilst retaining a place based focus for the people of Wolverhampton. BCF wherever possible is utilised as the local delivery vehicle for wider agendas in an attempt to retain co-oridnation and consistency. We remain constrained in our development by the lack of suitable premises for both the co-location of integrated teams and also the delivery of servcies in the community. We are however undertaking a joint procurement to deliver a Service Strategy and subsequent feasibility studies over the next 12 months. Capaity within the teams to deliver transformational change is also a regular issue.

Potential Actions and Support---------- We are in the process of undertaking a self assessment against the High Impact Change model for Managing Transfers of Care. An outcome of this will be an action plan for implementation. As a health and social care economy we are committed to undertake the Integration self assessment tool "Stepping up to the Place" and would welcome support in the shape of faciliated sessions to deliver this.

Agenda Item No: 9

CITY OF WOLVERHAMPTON COUNCIL

Health and Well Being Board

28 June 2017

Report title	Sustainability and Transformation Plan – the wider perspective
Cabinet member with lead responsibility	Councillor Roger Lawrence Councillor Paul Sweet
Accountable director	Linda Sanders, City of Wolverhampton Council Strategic Director – People Dr Helen Hibbs, Chief Officer Wolverhampton CCG David Loughton CBE, Chief Executive, Royal Wolverhampton NHS Trust
Originating service	People Directorate
Accountable employee(s)	Linda Sanders — Strategic Director People Tel — 01902 553000 Email — linda.sanders@wolverhampton.gov.uk
Report to be considered by	

Recommendation(s) for action or decision:

Health and Well-Being Board is recommended to:

Note, comment and direct on any actions required in response to the wider perspective of the developing Black Country Sustainability and Transformation Plan (STP).

1.0 Purpose

1.1 For the Health and Well Being Board to receive an update on the developing Black Country STP and to debate the wider perspective and implications for the health and care system for the City of Wolverhampton.

1.2 For the Board to direct any actions arising from discussion.

2.0 Background

2.1 The Health and Wellbeing Board considered a report on 29 March 2017 on the next steps for the health and care system in the light of the current development of the Black Country STP.

2.2 The wider background of the STP process and its initiation through the Government's NHS Five Year Forward View of October 2014 was noted.

2.3 Following the Board meeting, a review of the Five Year Forward View was published on 31 March 2017. It reiterated the need for change in health and care systems in terms of:

(a) how different parts of the NHS work together – CCGs, Acute Hospitals, Mental Health and primary care; and
(b) how the NHS works together with partners such as local authorities who are also part of the system.

2.4 The review continued to emphasise the role of new "models of care" such as Accountable Care Organisations and Accountable Care Systems in delivering solutions to current challenges. "Place-based" solutions were also recognised as important because localities are different, therefore there may be different solutions in different places. Integration of services and the experience of people using those services was a key factor in this context.

3.0 Progress, options, discussion, etc.

3.1 There have been further meetings and contact between Black Country NHS Chief Executives and local government representatives since the last Health and Well Being Board. It is clear that the STP process is the route for continued improvement delivery and developments during this most recent phase include:

- Andy Williams (Sandwell and West Birmingham CCG Accountable Officer) has been confirmed as the STP lead for the Black Country.
- A draft "Memorandum of Understanding" has been developed to provide a framework for the developing Black Country STP partnership
- Black Country Clinical Commissioning Groups have agreed in principle to establish governance arrangements to allow greater joint-working between the CCGs at Black Country level.

- The four local authorities are in the process of developing a *Care and Support Closer to Home in Our Communities* – place based offer which will seek to articulate the Black Country Local Authorities contribution to care closer to home in our communities.
- A first "Assurance" process of the Black Country STP has been undertaken which included Council representation
- Next steps on the "Transforming Care Together" partnership agreement between Birmingham Community Healthcare NHS Foundation Trust (BCHC), Black Country Partnership Foundation Trust (BCPFT) and Dudley and Walsall Mental Health Partnership Trust (DWMH) which will affect the leadership and delivery of mental health and learning disabilities services amongst others in the City of Wolverhampton
- Early thinking on the development of an Accountable Care Model in the City of Wolverhampton health and care system. This would build on the developing models of care in the locality and has included recent discussions with GP's including those developing amongst GP's who would need to be an integral part of the system. There is broad agreement in principle now across the health and social care system, including public health, that the direction of travel should be to develop an accountable care system on a local collaborative alliance model.
- Overall interest and commitment to the importance of the principle of subsidiarity and collaboration in support of local decision-making and service delivery on a place basis / local authority footprint remains significant. Early discussions are underway in the City about the role and contribution of local authorities in making a vision of care and support closer to home in our communities a reality.
- The Transitions Board has been re-designated as a Systems Development Board to reflect the changing understanding of its purpose in the leadership of change in health and care systems in readiness for more change.
- Partners are working with Wolverhampton Healthwatch to begin engagement with the public in a variety of ways and over a period of time about the wider perspective arising from the Black Country STP. This will include information giving as well as developing the dialogue with people in the City so that our vision is co-produced.

3.2 Any further developments which have occurred between the submission of this Report and the Health and Well Being Board will be shared at the meeting for consideration about local implications in the City.

4.0 Financial implications

4.1 There are no direct financial implications arising from this report. Any actions arising from the Strategy and the associated plans will be delivered from existing budgets. AS/20062017/H

5.0 Legal implications

5.1 There are no legal implications to this Report at this stage but advice will be sought as needed when discussions develop. RB/20062017/W

6.0 Equalities implications

6.1 Equalities considerations will need to be at the heart of future development of care and health systems including with regard to addressing health inequalities and the role of the Health and Well-Being Board in improving the health of the local population.

7.0 Environmental implications

7.1 A key intention of the Sustainability and Transformation Plans was to ensure sustainability of health systems over the

8.0 Human resources implications

8.1 There are no human resources implications arising from this report at this time.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications at this stage.

10.0 Schedule of background papers

10.1 Not applicable.

Agenda Item No: 10

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

28th June 2017

Report title	Quality and Safety Framework 2017-20	
Cabinet member with lead responsibility		
Accountable director	Manjeet Garcha	
Originating service	Quality Safety and Risk Team	
Accountable employee(s)	Steve Forsyth Tel Email	Head of Quality, Safety & Risk 01902 446049 stevenforsyth@nhs.net
Report to be/has been considered by	Quality & Safety Committee Governing Body	13th June 2017 TBC

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Note Wolverhampton CCGs refreshed Quality Improvement Strategy 2017-2020.
2. Support the priorities and objectives outlined within the Strategy.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The CCGs Quality Improvement Strategy with particular attention to: the Plan on a Page (pg4), Mission Statement (pg4), team philosophy (pg4), quality objectives (pg5) and success measures (pg5).
2. Primary Care (pg6-11) particularly the Workforce Development Task and Finish Gup (pg9).
3. Care Homes and the work of SPACE (pg11).
4. EoL and Cancer work (pg12).
5. The CCG Quality Framework (pg16-24) which captures our key foundational elements of work in our Strategy for the coming years.
6. Equality, Inclusion and Human Rights (pg34).

1.0 Purpose

1.1 This paper is for information.

2.0 Background

2.1 The Quality Improvement Strategy is presented to provide assurance to the Health and Wellbeing Board that the services Wolverhampton CCG commission are quality assured in the domains of safety, patient experience and effectiveness; for the Board to be informed of the mechanisms in place to ensure robust monitoring and triangulation of information and intelligence which in turn informs our quality assurance framework. The Quality Improvement Strategy has been refreshed in light of the changing NHS architecture and it was a timely opportunity now to demonstrate how the CCG is visibly strengthening its approach to quality improvement. The CCG monitors its providers by working in partnership, providing a structured approach to quality and safety, taking into consideration the impact of the current economic environment, the necessary balance with quality and safety and the intention to continue to maintain safe services and improve quality. It identifies and prioritises a Quality Improvement Work Programme to ensure accountability and maximise governance which will hold the CCG to account to meet its statutory obligations but more importantly a commitment to the people of Wolverhampton.

3.0 Progress options discussion, etc.

3.1 To ensure our health economy network are clear on the CCGs Quality Assurance Framework and how we can work together in ensuring services commissioned in Wolverhampton are safe and effective.

4.0 Financial implications

4.1 N/A

5.0 Legal implications

5.1 N/A

6.0 Equalities implications

6.1 Please refer to pg. 34 of report for our EIHR plan

7.0 Environmental implications

7.1 N/A

8.0 Human resources implications

8.1 N/A

9.0 Corporate landlord implications

9.1 N/A

10.0 Schedule of background papers

10.1 N/A

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NHS
Wolverhampton
Clinical Commissioning Group

Quality Improvement Strategy 2017-2020

Quality@the❤&Safety@theMind

Contents: - **Page**

Statement from the Board

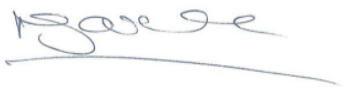
On behalf of Wolverhampton Clinical Commissioning Group we are pleased to introduce the second iteration of our Quality Improvement Strategy which identifies quality improvement priorities for 2017 - 2020. The strategy has been developed in consultation with staff and engagement from our lay members, patient representatives and HealthWatch at our Quality and Safety Committee. The work of the Quality team aims to further progress our ambitions identified within the Clinical Quality Strategy 2015 - 2017; continuing to ensure that our patients receive services that are safe, effective and positively experienced.
This work builds on the foundations of our three strategic aims:

1. *Improving the quality and safety of the services we commission*
2. *Reducing health inequalities in Wolverhampton*
3. *System effectiveness delivered within the CCG's financial envelope*

And our local objectives:

- Ensure on-going safety and performance in the system
- Improve and develop Primary Care in Wolverhampton
- Deliver new models of care that support care closer to home and improve management of Long Term Conditions.
- Proactively drive our contribution to the Black Country STP
- Greater integration of health and social care services across Wolverhampton
- Continue to meet our Statutory Duties and responsibilities
- Deliver improvements in the infrastructure for health and social care across Wolverhampton

Dr Helen Hibbs
Accountable Officer



Manjeet Garcha
Executive Director of Nursing & Quality

Jim Oatridge OBE
Interim Chair of the Governing Body

Pat Roberts
Lay Member for Quality

Introduction

In our previous version of the Clinical Quality Strategy 2015-2017 we stated that "significant progress has been made in developing the commissioning function, since the Health and Social Care Act 2012, in respect of increasing access to services, value for money and reducing waiting times and greatly improving on infection control targets. As Healthcare commissioners our motto is "quality at the heart and mind of everything we do" this is referencing our patients, our community, families, carers and everyone who requires healthcare from the services we commission in our great City of Wolverhampton."
Our mission statement is

- ***"Quality at the heart and Safety at the mind of the Organisation"***

Our focus has remained on assuring patient safety and the quality of services commissioned; engaging the public and improving the patient experience. This remains the same today as it did during its launch in 2015-2017, it is however time to raise our ambitions even higher with the launch of this new reenergised Quality Strategy to reduce unwarranted variation through the work of our Black Country Sustainability Transformation Plan and locally to prioritise the elimination of avoidable harm which includes eliminating avoidable deaths.
It is an exciting time in Quality and we are excited with the changes in Primary Care being more locally managed and the developments in our Promoting Safer Provision of Care for Elderly Residents (PROSPER) and now Safer Provision and Caring Excellence **(**SPACE) programme.

Our main areas in Quality include:

Safeguarding – Adults and Children including Looked After Children
Medicines Optimisation (Strategy 2016 – 2018 Version 2.0)
End of Life Care
Equality and Inclusion
Complaints

Quality (Safety, Experience and Effectiveness)
Improving Quality in Primary Care
Assuring Quality of Commissioned Services

Wolverhampton CCG is committed to continually improve, drive up quality and ensure that the patient's experience of care and treatment is sought and, heard and that this important information is utilised to improve services. The approach is to work in partnership with patients, public and all service providers whilst ensuring that evidence-based, safe, high quality services are delivered and sustained.

#Qualityattheheartandsafetyatthemindoftheorganisation
#Q&S@Heart&Mind
#QualityteaminWolvesCCG
#yourhealthandcarematter

Follow our hashtags - www. wolverhamptonccg.co.uk

Quality & Safety Team: Plan on a Page 2017/2018

Mission Statement : Quality at the heart and Safety at the mind of the Organisation

NHS Wolverhampton Clinical Commissioning Group

Quality Team Philosphy: Our team is quality driven providing commissioning outcomes that include outstanding care, improving health and lowering service costs, whilst ensuring equality, dignity and respect for all. We will work collaboratively maintaining that patients/service users are at the core of everything we do, in partnership to co-create consistency and seamless care, improving the quality of life for the population of Wolverhampton.

Wolverhampton Clinical Commissioning Group (WCCG) Strategic Objectives

1a. Ensure on-going safety and performance in the system
2a. Improve and develop Primary Care in Wolverhampton
2b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions.
3a. Proactively drive our contribution to the Black Country STP
3b. Greater integration of health and social care services across Wolverhampton
3c. Continue to meet our Statutory Duties and responsibilities
3d. Deliver improvements in the infrastructure for health and care across Wolverhampton

Safeguarding Vunerable Adults & Children/Looked After Children	Primary Care	Residential/Nursing Homes & End of life Care	Quality & Risk Team	Equality & Inclusion	Medicine Optimisation Team
• WCCG to ensure that they secure the expertise of a named GP for safeguarding adults, this is an essential role due to the delegated primary care commissioning arrangements. • Effective project management for NHSE allocated funding for Mental Capacity Act (MCA) and collaborative commissioning of continuation of the MCA project with other CCG's to include practitioners working with young people (16-18 year old). • Deliver key messages across our community regarding the voice of the child, think family and making safeguarding personals, commissioning specialist drama group to provide bespoke training • To progress commissioning outcomes, training, operational exposure and ensure all providers arrangements regarding prevent are robust. • To work with partner services to develop processes that differentiates between safety, safeguarding and quality. • To collaborate with multi agency colleagues to develop best practice adult safeguarding guidance for providers of healthcare in Wolverhampton, in order to eliminate confusion between safeguarding, safety and being safe. • That LAC placed out of City receive the same quality of health care as those placed internally. • Work with CCG Children's Commissioner to provide a reporting mechanism on the quality assurance measures relating to therapeutic placement providers for Looked After Children.	• Supporting the Primary Care Team in the CCG to develop the quality outcomes framework GP contract to ensure it reifects the health needs of the people of Wolverhampton. • Working with Public Health, GPs and the wider health economy to develop preventative health strategies • Working with the CCG Primary Care Team to ensure that full delegation is effective and quality remains at the forefront . • Developing the workforce to help increase numbers of staff and training opportunities for nurses, GPs and non-clinical staff to make primary care an attractive career progression. • Developing a one stop shop for health and social care, working with the Better Care Fund team and the Community Hubs to promote social prescribing and signposting people to improve and maintain their health and well being.	• Increased reporting of incidents, near misses and lessons learnt leading to a reduction in harms across the sector. • Achieving and delivering on the milestone of Safer Provision and Care Excellence (SPACE) • Driving up quality of care and safety culture through positive reporting and effective management of incidents leading to fewer serious incidents due to embedded learning. • Influencing the delivery of commissioning strategies such as care closer to home and admission avoidance agendas by supporting the development of care managers to build resilience across the care home sector. • Facilitate the use of advanced care plans with patients at the end of their Life.	• Embed the new Serious Incident contract regulations to ensure timely submissions. • NICE for all Providers. • Take forward Quality visits-table top reviews. • Sharing our learning on Serious Incidents & Root Cause Analysis and to remain as outstanding CCG. • Integrated Quality visits e.g. Healthwatch & patient reviewers engagement. • Develop new Serious Incident recording process (pilot & test). • Embed Serious Incident Scrutiny Group with providers attendance.	• Supporting the CCG to gain assurance from providers on their Equality Diversity Inclusion and Human rights (EIHR) compliance. • Embed Equality Diversity System2 (EDS2) in CCG business practice. • Update the Equality & Diversity Strategy and Policy For 2017 – 2020. • Refresh and embed equality objectives in CCG business practice. • Support the CCG to be a system leader of Workforce Race Equality Standard (WRES) • Provide expert advice and support to CCG decision makers through Equality Analysis (EA's)	• Re-procurement of GP Prescribing Support. • Right Care. • Quality, Innovation, Productivity and Prevention (QIPP) • Working with Regional Medicines Optimisation Committee. • Safer Prescribing of drink thickeners. • Cost effective respiratory prescribing. • Support for health economy Anti-Microbial Resistance program. • Increasing uptake of biosimilars.

Patient Reviewers and Representatives are involved and inclusive as an integral part of the Quality Team

Our Aim

Our Quality Objectives

Success Measures

Effectiveness	Safety	Patient experience
A commissioning and procurement process that actively involves members of the quality team. A highly skilled patient safety, quality and risk team that is capable of delivering our quality objectives and which demonstrates co creation, cohesiveness and a strong team dynamic. Reduction in Remedial Action Plans due to organisations learning the lessons and promoting innovation as opposed to reactive services. Reducing unnecessary duplication and unwarranted clinical variation for our patients and service users.	A reduction in the number of Hospital Acquired Infections occurring within the community and provider organisations. A health economy wide reduction in Pressure Injuries. Building on our foundations that safeguarding is considered as everyone's business. Develop a stronger relationship with our GP practices that encourages a culture of reporting and openness of incidents from Quality Matters to Serious Incidents. A reduction in Serious Incidents and Never Events with common themes.	We will ensure the continued use of high quality healthcare providers. That enable high levels of patient satisfaction from patients' experience. Fewer complaints with common themes. Patient feedback through patient stories, working with our patient reviewers and patient representatives to influence and shape continuous improvement in the safety and quality of care of we commission. Continuous quality improvement measured through surveys and contract KPI's Local service users check local services as their preferred choice of care delivery

Our key achievements in 2016/17

Increased rigour and developing our internal framework to Serious Incident Management
Outstanding rating as a CCG
Patient Safety Award – Molly Henriques-Dillon (Quality Nurse Manager)
Shortlisted for HSJ Patient Safety of the Year Award 2017
Sign upto Safety – (Appendix 1)

What we Commission

We commission services from a range of providers; both NHS and Independent Sector and we act as lead commissioners on behalf of CCGs for our main Acute Provider. The public has a right to choose treatment and care in the NHS and the choice of care and provider should be offered, depending on what is available locally.

An extensive list of contracts is held by the CCG and available from the Contracts Team. Our two main providers are:

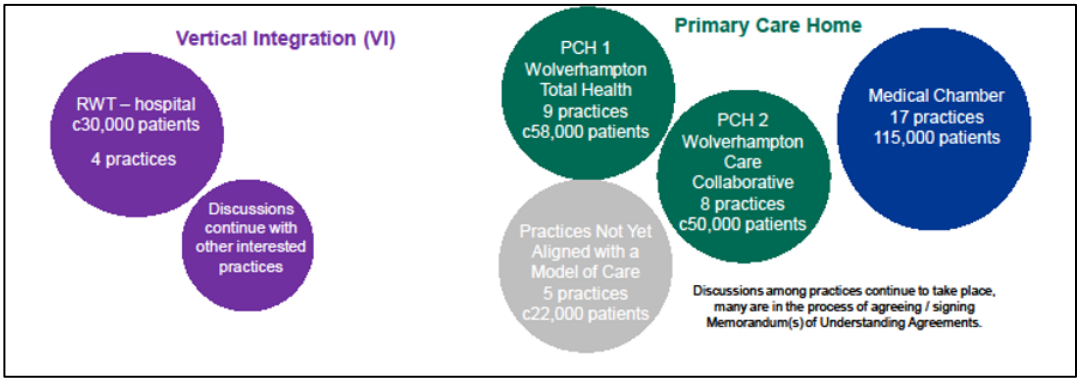
Royal Wolverhampton Trust http://www.royalwolverhampton.nhs.uk/
Black Country Partnership Foundation Trust http://www.bcpft.nhs.uk/
From the 1st April 2017 NHSE will handover Primary Care as part of 'full delegation.

The Quality & Risk Team actively support the development and review of service specifications and seek to ensure that once awarded, contracts are monitored routinely in line with the terms and conditions defined within the NHS contract.

Primary Care

New Models of Care

Wolverhampton practices are currently evolving into Primary Care Home Model and Vertical Integration with Royal Wolverhampton Hospitals Trust. The aim is to work collaboratively to address the challenges in primary care through improving access to services and optimising health. Governance will be provided via peer review, NICE Quality Standards, Information Management and Technology (IM&T) and Quality Assurance monitoring. The current model is shown below: *(this is subject to change)*



This model will continue to develop as the final groups align. More information about new models of care is available via NHS England.

Improving Quality Primary Medical Services

The CCG currently has a statutory duty to assist and support NHS England Area Team in securing continuous improvement in the quality of primary medical services and will therefore ensure that the core principles of NHS England Primary Medical Care are adopted locally through established lines of communication and joint working. This process will continue following full delegation with the CCG taking on more responsibilities within a Memorandum of Understanding with NHS England.

- To promote and prioritise equality including access and treatment for all patients across the full range of primary medical services and new models of care
- To focus on quality, outcomes and relevant patient experience as the main drivers for Improvement
- Primary care commissioning arrangements & plans
- To determine health outcomes
- To promote a clinically driven system in which GPs and other primary medical service clinicians are at the heart of the decision making process, driving quality improvement and commissioning decisions
- To facilitate strong and productive local contractor relationships based on proportionate and sensitive interaction
- Be responsive to and spread innovation
- To deliver a consistent national framework, which ensures fair and transparent interventions, implemented locally, with local discretion rooted in cultural and behavioural consistency
- Make commissioning decisions on the basis of firm data shared with CCGs, health and wellbeing boards and others and complimented by local intelligence
- To design systems that are fit for the future, allowing reform and operate within minimum bureaucracy. Such systems enable whole person patient care, with integrated physical, mental and behavioural services and facilitate shared best practice standards between primary care and specialists.
- To promote early engagement and collaboration with Local Medical Committees (LMC's) openly and transparently in the management of primary medical services

The CCG (with initial collaboration with the NHSE Area Team) will agree standards and quality indicators in service specifications in relation to Local Improvement Schemes and Directly Enhanced Services, where applicable. Review of clinical audits and quality assurance of performance data will determine the future delivery of services and provide continuous quality improvement.

Delivery of effective, safe and high quality primary medical services will require the CCG to play an active role in exercising its statutory responsibilities for member practices within its area once fully delegated. The CCG are already responsible and accountable for services commissioned locally through the standard NHS Contract i.e. Enhanced Services. A schedule of collaborative contracting visits with representation from the CCG Quality Team, Primary Care Team and Public Health is underway to provide assurance around contracting and quality requirements within general practice.

Additional support will be provided for practices via NHS England incentives such as Vulnerable Practices and Practice Resilience Programmes delivered by Primary Care Support England and the GP Development Programme as part of the GP Forward View. Work is also being undertaken collaboratively with other CCGs in the Black Country to develop the estates and IT infrastructure as part of the Sustainable Transformation Plan.

Primary Care Operational Management Group (PCOMG)

The current purpose of this group is to maintain an overview of and direct the work of Wolverhampton CCG with regards to Primary Care Commissioning following full delegation in April 17. This supports the work of Primary Care Commissioining Committee (PCCC),

The PCCC committee supports and acts upon information they are furnished with following these meetings and where necessary take on items requiring furtherance and in exceptional circumstances matters of concern will be raised with the CCG Executive Team. The PCOMG also supports the reporting to the Quality and Safety, Finance and Performance or Commissioning Committees on any issues that arise that fall within the purview of these committees. The Primary Care Quality Assurance Coordinator is be responsible for providing routine quality reports on activity in primary care to the committee as part of the overall Quality and Safety Report.

Meetings are held on a monthly basis and receive appropriate administrative support to ensure that a schedule of meetings is shared in advance for the respective year, a suitable venue is arranged and meeting papers are distributed at least one week prior to each meeting using the standard agenda as a minimum. Formal minutes and a corresponding action log are produced following each meeting and distributed to group members within 3 weeks of the meeting date.

Primary Care Workforce Development

In line with the national picture, a number of issues pertinent to primary care workforce in the City have been identified:

- Lack of General Practice Nurses and GPs
- Ageing workforce
- Retirements
- Lack of succession planning

A local Workforce Task and Finish Group are cited in the CCG governance structure and an attached workforce implementation plan with range of activities detailed within this programme of work, this comprises of four main areas:

- Attraction

  Workforce Scoping & Planning
  Wolverhampton - A Place to Work

- Recruitment

  Pilot mapping skills for new primary care service provision models

- Development

  Develop a primary care workforce development strategy
  Career Development for clinical and non-clinical staff
  Piloting new roles/new ways of working
  Developing a leadership culture within primary care
  Improving and implementing standards of practice
  Increase training capacity in primary care

- Retention

Local work will continue around practice nurse development in line with Health Education England GP Nurse Development Plan. The plan identifies a number of key areas that are aligned with the workforce implementation plan:

- Increasing the profile of General Practice Nurses (GPN's) to pre-registration students
- Increasing recruitment of newly qualified nurses to general practice by providing robust support
- Promoting professional development
- Standardisation of job descriptions
- Promoting non-medical prescribing
- Optimising the use of Advanced Nurse Practitioners (ANP's)
- Return to practice for GPN's
- Leadership skills (clinical and non-clinical)
- Promoting the development of support staff e.g. health care assistants and nursing associates
- Development of nursing apprenticeships

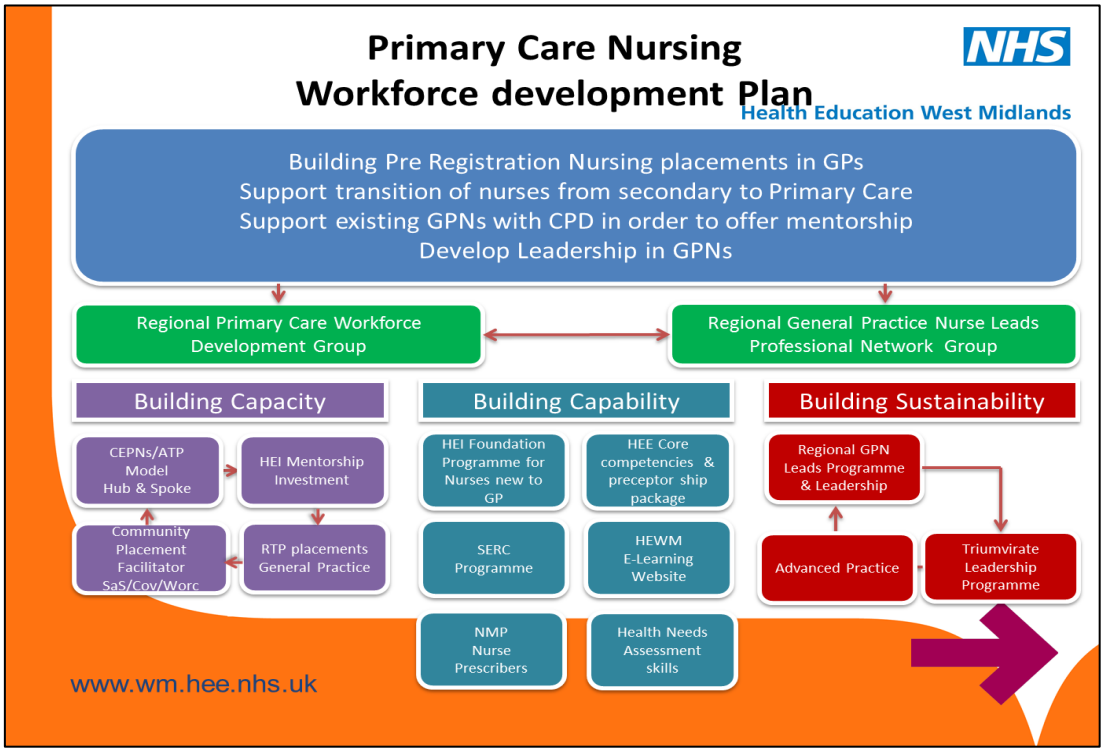
Funding support for the development of existing General Practice Nurses is released via HEE to local Community Education Provider Networks (CEPNs). CEPNs are independent bodies, currently funded by HEE who are responsible for local workforce planning and distribution of funding. Wolverhampton CCG is currently aligned to Walsall CEPN and works closely with the CEPN Project Manager to identify training needs and ensure appropriate and timely allocation of funds.

In addition to this alternative roles to support General Practices are:

- Physicians Associates
- Clinical Pharmacists
- Mental health therapists
- Paramedics

These will also be promoted in conjunction with Health Eduction England (HEE).

Representation from both the CCG and GPNs is in place at regional level, local arrangements were introduced during the summer of 2014 to manage the agenda and clinical skills development in Wolverhampton. The Primary Care Quality Assurance Coordinator continues to work with the Executive Nurse to monitor and develop this.



Wolverhampton CCG continues to work in collaboration with local Higher Education Institutes, Health Education West Midlands and NHS England to ensure that key priorities are met, as identified above.

In addition to this work, focus will also shift towards supporting recruitment and development of General Practitioners within Wolverhampton, this is supported by HEE and HEWM and the West Midlands Deanery. The concerns around GP workforce reflect those of GPNs, lack of numbers, aging workforce and difficulties in recruitment and retention of staff; coupled with high numbers of GPs opting to work as locums. Workforce implementation planning aims to increase numbers of partners and salaried GPs and support GP training.

The General Practice Forward View will also offer development opportunities for administrative staff via Care Navigator and Medical Assistant training. In addition to this practice manager development will also be offered as part of the overall GPFV. Leadership opportunities for all practice staff can be accessed through the Triumvirate Leadership Programme via HEE, and through the NHS Leadership Academy. Support for recruitment, development and retention of both clinical and non-clinical staff will also be provided by the GPFV.

Care Homes Sector

People living in residential and nursing homes should receive high quality compassionate care, expect to be treated with dignity and respect and protected from harm. Systems should be in place that identifies those people at risk and care will be tailored to individuals' needs and preferences. Care should be based on the best evidence and practice, centered on the person, supported by good governance and accurate record keeping. Staff working in the care home sector have a duty to ensure they have the appropriate level of knowledge and skills to deliver and promotes high standards of care and have the ability to respond to the complex and changing needs of the residents.

The Care Home improvement Plan implementation across the care home sector will be led by the Quality Nurse Advisor (QNA) team on behalf of the CCG. Through a programme of scheduled quality and sustained improvement visits the QNAs will be pivotal to monitoring, facilitating improvements and providing assurance to the Board of the quality of care delivered by commissioned services. Priority of quality visits will be determined on whether the Provider has health funded beds e.g. step down and/or whether quality concerns have been raised. Care homes with AQP and NHS contracts will be expected to participate in the quality framework by way of submitting monthly self-assessment quality indicator returns and subscribing to the Safety Thermometer data collection. Care homes not in the commissioning framework will also be encouraged to participate. Implementing best practice guidelines and promoting best practice in care homes will be the vehicle for navigating quality standards across the sector and standardising practice.

The SPACE (Safer Provision and Care Excellence) programme aims to drive up quality and safety culture through training and promoting the use of quality improvement tools and techniques. The QNAs in collaboration with the Local Authority will support the safeguarding agenda through involvement of section 42 enquires and quality concerns investigations in line with the Care Act 2014. The sharing of lessons learned and development of action plans will accelerate progress with care home managers achieving high quality harm free care for residents. The QNA team will promote positive reporting across the sector to achieve a culture learning from excellence and sharing of best practice.

Performance against the harm free care target of 95% will be monitored by the QNA team and under performance will trigger closer scrutiny and involvement by the team. Robust communication between the CCG, Wolverhampton City Council, MASH (Multi Agency Safeguarding Hub), health and the regulators will enable better partnership working and joint working towards achieving harm free care across the city.

End of Life Care and Cancer Agenda - Macmillan Primary Care Nurse Facilitator (MPCNF)

This is an innovative new post, supported by Macmillan, full time contract for a fixed term of 3 years, due to be reviewed in May 2019. WCCG and MPCNF will support primary care teams with respect to the Primary Care Strategy, Workforce Development and implementation Plan, incorporating the cancer agenda, specifically focusing on End of Life Care (EoLC), Cancer Awareness /Prevention, Early Diagnosis and enabling patients to live with alignancy as a long term condition (where possible), promoting optimal outcomes for patients thus promoting the Macmillan Survivorship Agenda within Wolverhampton.

The Commissioners and Providers of Health and Care services in Wolverhampton are dedicated to achieving integrated care predicated upon what really matters to their patients and local communities. They see an absolute requirement for all providers to work together in a co-ordinated and coherent manner to provide the best end of life care for every person, irrespective of where, or how, they access the system and supporting them in achieving their preferred place of care.

End of Life Care

WCCG has developed new EoLC Strategy in collaboration with RWT, Compton, LA, Voluntary sector, this is a large body of wor and the aim of this strategy is to detail Wolverhampton's integrated approach to the design and delivery of a person centred, integrated, end to end-End of Life care service.
To deliver a flexible, responsive, quality service to those approaching the end of their lives.
The strategy will encompass the following elements:

- Early identification of the dying person to ensure patients receive appropriate care
- Advance care planning to facilitate the person's needs and wishes
- Coordinated care to ensure people don't fall through gaps
- Optimum symptom control based on clinical need
- Choice to support preferred place of care and death
- Workforce fit for purpose

There are large programmes of work currently underway in relation to different elements of the EOL strategy namely, ACP (Advance Care Plan), EPaCCS, (Electronic Palliative Care Coordination System) Early identification of end stage disease, Education & Training with regard to Communication in Palliative Care, and Patient and User engagement. This work is ongoing alongside the ratification and publication of the Strategy and timeline.

There is continuing CCG engagement with Service User and Stakeholder representatives to understand what local people want from local End of Life and Palliative care services. The CCG hold several patient and user focus groups, including market place stalls at local Carer information sharing events.
The CCG and the MPCNF have developed an education and training need assessments across secondary and primary / community care, with engagement with local specialist palliative care providers of education to deliver relevant, tailor-made training packages which will address the needs identified in secondary, primary / community care. Acknowledging the need for place based learning, peer review and peer support, and an option to explore external facilitation of training & support.
WCCG has developed links with HEE (Health Education England) and local Hospice Association to explore options for support in educational sessions, Education and Training – (with links to the SPACE project) and Nursing Home education and training. As well as successful attainment of a Macmillan Funding bid to assist with Education and Training package, for the End of Life Strategy programme.
Encompassing in the roll out an ACP (Advance Care Plan) PILOT with local Nursing and Residential homes. Due for completion in May 2017.

Survivorship Agenda - The Recovery Package

National Cancer Survivorship Initiative(NCSI) were set up in 2008 to address these challenges, its aims to ensure that those patients living with and beyond cancer get the care and support they need to led as healthy and active a life as possible, for as long as possible.
Current Survivorship programme in Wolverhampton, involves the CCG working with the Cancer Leads within Royal Wolverhampton Hospital Trust (RWT), RWT currently have secured a CQUIN to provide H&WB (Health and Well Being) for breast care patients only. RWT are continuing to actively improve uptake of this service, by changing the model to engage with a larger cohort of patients.
H&WB Events / sessions should be offered to patients once they have completed initial treatment and include information on healthy lifestyle choices including physical health and healthy weight management, sign and symptoms of recurrence and potential consequences of treatment, and initially it was believed that to hold an annual Market Place Event, would be the preferred choice, and this model is currently due to be rolled out in June 2017.
WCCG hold regular consultation meetings with Cancer Leads at RWT and Cancer Peer Review team, reviewing service and progress on 31/62 day target and breaches, referral processes and appropriateness of GP Fast track referrals, and potential bottle necks in the systems that cause delay in the cancer pathway.
Also WCCG have completed review visits with Quality Team at RWT for the Oncology service.

Cancer Prevention, Early Diagnosis

WCCG and MPCNF have engaged with RWT, (the Bowel Cancer Screening Health Promotion Team) and CRUK to facilitate improvements on how locally Wolverhampton can improve the uptake for screening programmes, specifically the bowel screening uptake, breast screening and Ovarian screening.
WCCG in collaboration with PH, are committed to raising cancer awareness, by facilitating

Cancer awareness /promotion events – unmanned stands/ stalls for Breast awareness month October, and Pancreatic and Lung Cancer awareness in November. Literature, information and flyers and resources available during those months to highlight “Symptoms and what to look out for”

Working in Partnership

We currently commission Continuing Health Care(CHC) services within the CCG to arrange packages of CHC, funded nursing care and after-care from a range of providers. These include nursing homes, domiciliary care and supported living. Patients can have access to Personal Health Budgets and working with the Local Authority we monitor the quality of these providers and manage the market as both organisations (CCG and Local Authority) commission similar services.
The CCG also commissions services for people who have an Individual Funding Request approved, this is where people require a bespoke clinical service that is either rarely required, (or thus not regularly commissioned) or relates to exceptional circumstances. This is via Commissioning Support Unit for adults and directly by the CCG for children and young people under 18 and those adults with complex Mental Health needs leaving secure care settings.

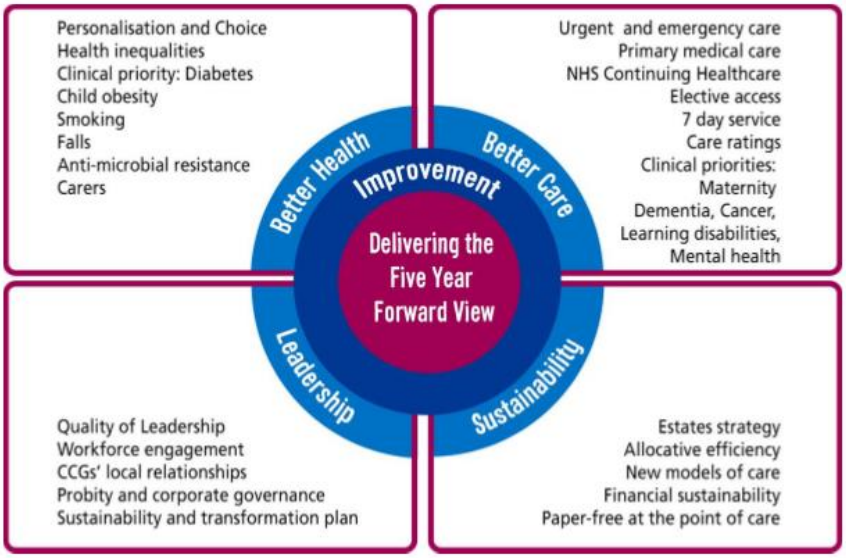
Furthermore, the CCG recognises that it cannot achieve these objectives working in isolation and in order to secure the necessary improvements we will work closely with partner agencies both at local and national level.

Our relationships include the following organisations (this is not a complete list)

https://improvement.nhs.uk/
https://www.england.nhs.uk/
http://www.healthwatch.co.uk/
https://www.gov.uk/government/organisations/public-health-england
http://www.wolverhampton.gov.uk/home
https://hee.nhs.uk/hee-your-area/west-midlands

Quality Improvement & Assurance

In order to improve quality in the NHS we have to be sighted on the needs and challenges presented both nationally and locally, the NHS Outcomes Framework enables us to achieve an overview that make up the outcomes framework and whilst they are designed to support commissioners in developing localised plans and establishing their levels of ambition ultimately quality improvement is the golden thread that should flow throughout the work of the CCG.

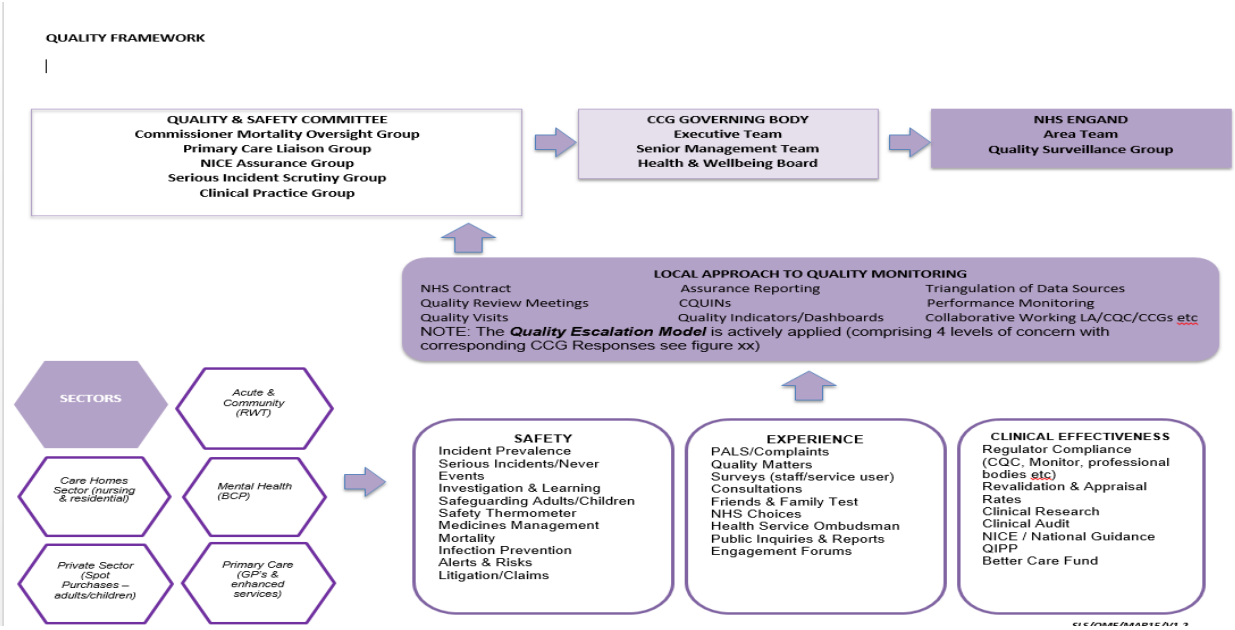


At national level there are many sources of guidance that have been developed and shared that help health care organisations to prioritise and align themselves with a vast array of priorities and areas of importance, some of those documents and initiatives are detailed below:-

Quality Framework

Our framework for monitoring quality demonstrates how we monitor clinical quality across all sectors where we have a responsibility or duty in accordance with the Health and Social Care Act 2012 and the NHS Constitution that clearly advocates the rights and pledges of staff working in the NHS and those patients receiving care. Each of the sectors we are responsible for are clearly defined and reliant upon a consistent focus on the three domains of clinical quality i.e. safety, experience and effectiveness as first set out by *Lord Darzi* in the NHS Next Stage Review (2008)* placing quality at the heart of everything the NHS does and emphasises the patients right to high quality care.

The framework is built upon the plethora of intelligence available to us about our providers and enables us to work closely with our providers through our local approach to quality monitoring that is underpinned by a contractual relationship that promotes mutual respect among peers and commitment to quality improvement.



We are responsible for the following:

- Monitoring delivery of standards and quality through the commissioning process
- A duty to require and monitor delivery of fundamental standards
- Ensuring there are resources to enable proper scrutiny of our providers' services, based on sound commissioning contracts
- Ensuring assessment and enforcement of fundamental standards through contracts and the development of alternative sources of provision if necessary.

** High Quality Care For All: Next Stage Review Final Report (NSR), which was led by LordDarzi and published on 30 June 2008.*
https://www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report

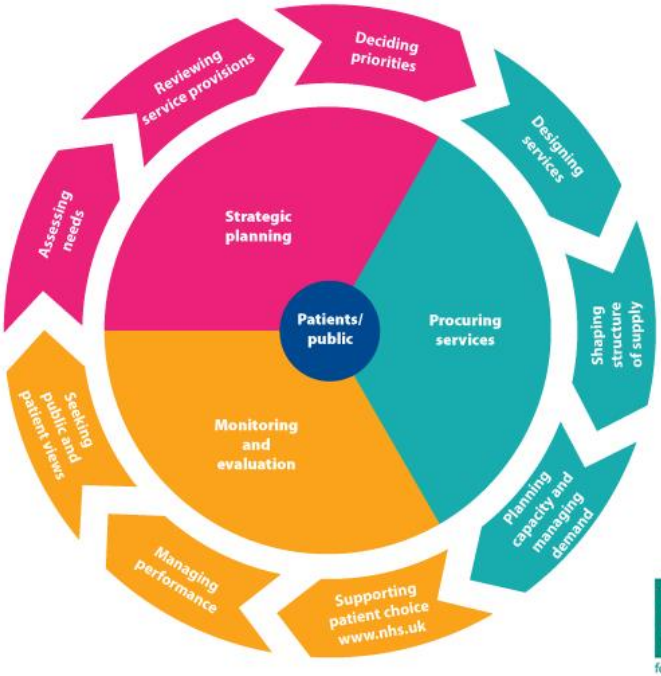
Quality in the Commissioning Cycle

High Quality care is defined in three equally important parts

The Three Dimensions of Quality

1. Clinical effectiveness, where high quality care is evidence based care
2. Safety, where high quality care is care delivered in a safe environment
3. Patient experience, where high quality care gives someone as positive an experience of treatment and recovery as possible including acknowledging people's wants or needs, and treating them with compassion, dignity and respect

The process for considering quality in the commissioning cycle is pictured below and demonstrates how we embed quality throughout our organisation and is dependent upon the identification and development of quality metrics incorporated into our planning and commissioning processes.



NHS
The Information Centre
for health and social care

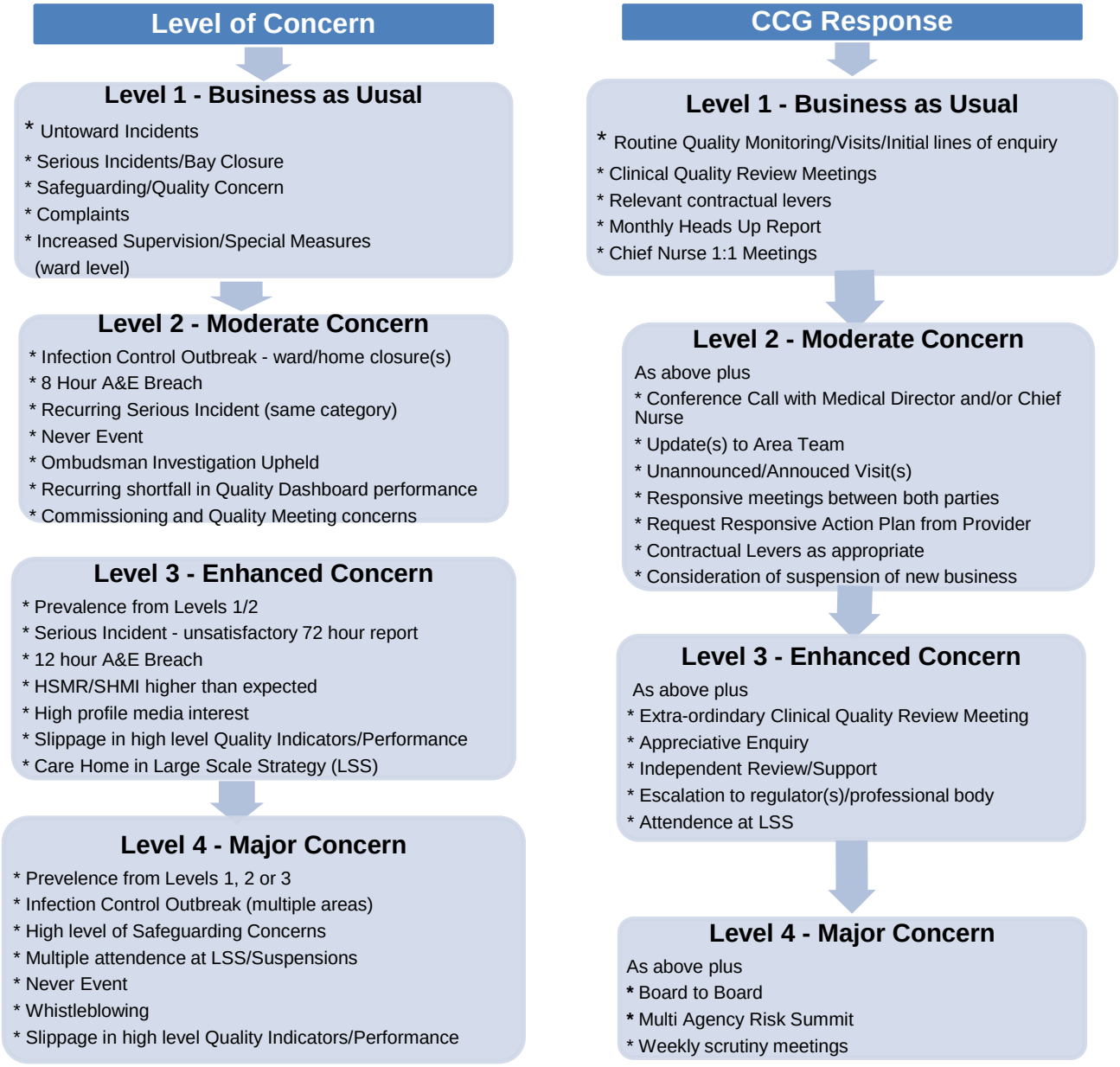
We work in partnership with providers whilst ensuring that evidence-based, safe, high quality services are delivered. Locally we continue to develop and improve the ways in which we are monitoring patient quality, safety, experience and the effectiveness of our service providers.

Assurance reporting based on our joint working with our providers through application of the NHS contract is reflected on a monthly basis via our Quality Assurance Report that is considered by the Quality & Safety Committee. The committee seeks to be assured that the framework is being applied with rigour, responsibilities are being fully realised and that the framework is being utilised to assist our providers to meet the demands of the high standard we want and need to achieve.

Escalation Model

Measurement of quality is achieved through correlation with the Quality Framework that seeks to ensure high standards of quality are sustained. However, there are occasions when circumstances change and providers will be challenged so that the CCG is assured of the robustness of quality information being afforded and the effectiveness of compensatory actions and control measures that have been put in place to address the exposed concern(s).

The escalation model defines four levels of concern that may arise and the corresponding actions that will be applied to seek assurance that circumstantial change has been appropriately managed and appropriate control measures have been put in place in response to the level of concern.



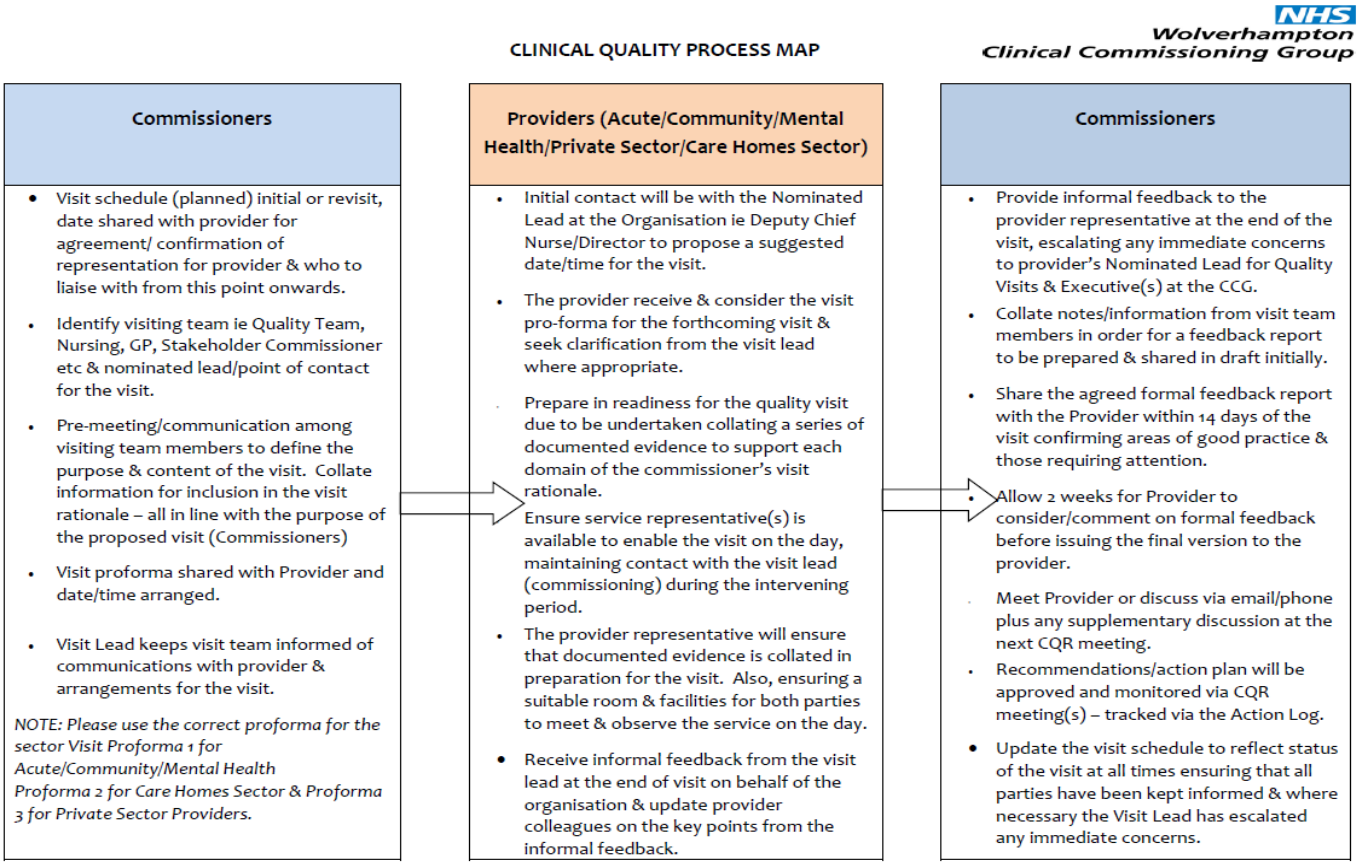
At operational level the escalation model will be assigned to each of the CCGs commissioned providers reflecting the level of concern and corresponding level of response that has been applied and will be reflected in assurance reports provided to the Quality & Safety Committee. It is important to note that the application of the model is underpinned by a collaborative approach to managing concerns pertaining to clinical quality that may be driven by activity and performance that constitutes concern about the quality of care patients may be receiving. A co-ordinated approach among teams within the CCG will be deployed to prevent replication and inconsistency of understanding and communication with the provider.

Quality Visits

There are many benefits attached to commissioners strengthening relations with their providers through visiting services to gain a greater understanding and where necessary assurance about commissioned services.

A program of planned visits is agreed with each provider. However, if there are any areas of concern, or a wish to focus on a topical issue for assurance, an unannounced visit will be undertaken.

These visits will be undertaken across each sector throughout the contract year – the number/frequency of visits will be determined by the number of services commissioned/contract value/level of concern using the following communication process:-



Each visit will be complimented by a suitably populated visit rationale using the CCGs visit pro-forma and will be used to document the findings from the visit. Visiting teams will comprise of staff members from the quality team, trained patient reveiwers and Healthwatch who will make observations, review documentation and where appropriate have discussions with staff and seek patient views.

Where deemed necessary an action plan will be developed if gaps, risks and areas where room for improvement have been identified. This will be routinely monitored until timely completion via the respective Quality Review Meeting or appropriate forum.

In the previous Clinical Quality Strategy we wanted to move forward, towards the recruitment and training of Patient Representatives to become reviewers and will accompany WCCG visiting teams in the future. We are pleased to confirm this recruitment has been achieved of patient reviewers and they will play a big part in our quality visits for this 2017 – 2020 Quality Improvement Strategy.

Quality Systems & Processes

There are many areas detailed within our framework that highlight the many areas of clinical quality that are invested in within the CCG. In this area of the strategy those areas are broken down to provide an overview of what they are and their content. Each area will have its own corresponding policy or procedure that should be read in conjunction with the information provided in this section.

Serious Incidents

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these and trigger actions that will prevent them from happening again.
There is no definitive list of events/incidents that constitute a serious incident but Serious Incident Framework (2015) has identified 34 categories of serious incidents which include a "pending review" category. However, a category must be selected before incident is closed.

All providers are expected that they report all serious incidents to the commissioners without delay and no later than 2 working days and all serious incident investigation reports are submitted to the commissioners within the contractually agreed timeframe. However, if required depending on the seriousness of the incident, the provider must inform the serious incident to other regulatory, statutory and advisory bodies, such as CQC, NHSE if appropriate without delay.

Wolverhampton CCG requires all providers to notify anyone who has been subject (or someone lawfully acting on their behalf, such as families and carers) to a 'notifiable incident' i.e. incident involving moderate or severe harm or death. This notification must include an appropriate apology and information relating to the incident as per regulation 20: duty of candour guidelines.

The 2015/16 Never Events List (NHS England 2015/2016) details 14 categories of Never Event. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. WCCG takes these

extremely seriously and ensures that contractual sanctions are applied should they occur.

Wolverhampton CCG supports the need to take a whole system approach to quality improvement, and will build on the fundamental purpose of patient safety investigation, which is to learn from incidents and not to apportion blame. The CCG continues to endorse the application of the recognised system-based method for conducting investigations – Root Cause Analysis (RCA) and its mechanism for driving improvement.
Providers hold responsibility for the safety of their patients, visitors and any others using their services. They must ensure that robust systems are in place for recognising, reporting, investigating and responding to serious incidents and for arranging and resourcing investigations.

Wolverhampton CCG Quality Nurse Advisor team provides support to Care Homes with the RCA process for serious incidents that occur within Care Homes, however the CCG are providing training for care home managers in order to improve their skills to complete the RCA process independently and more effectively.

The serious incident status for providers, commissioned services and the CCG are reported on a monthly basis to the Quality and Safety Committee, and lessons learned from serious incidents are reported on a quarterly basis. This information is used to provide intelligence for triangulation with other key performance indicators and any other areas of concern.

For services where Wolverhampton CCG is not the lead commissioner, we work with the lead commissioner to ensure that we are informed of incidents that affect our population.

Once RCA investigations are complete and submitted to the CCG for closure, WCCG holds a bi weekly Serious Incident Scrutiny Group. Recently, the SISG panel has invited providers to attend the SISG (Serious Incidents Scrutiny Group) to ensure an effective and a collaborative approach to scrutinising these SI's and to ensure that they are closed within recommended timeframes. There may be different outcome to the serious incidents presented to the SISG panel and it will depend on the nature of the incident, level of scrutiny and level of assurance provided to the WCCG through the RCA/Action plan etc. Any serious incidents not meeting these thresholds or lacking assurance will be deferred back to the provider.

All investigation reports are reviewed within this group and scrutinised prior to closure, ensuring that robust action plans are in place and all appropriate measures have been implemented to ensure that lessons learned are embedded in practice. Closure of an incident marks the completion of the investigation process only. It is possible to close incidents before all preventative actions have been implemented and reviewed for efficacy, particularly if actions are continuous or long term. Wolverhampton CCG ensures that mechanisms are in place for monitoring implementation of long term/on-going actions.

All of the above operates within NHS England's Serious Incident Framework – supporting learning to prevent recurrence (2015). Investigations within this framework are conducted for the purposes of learning to prevent reoccurrence. They are not inquiries into how a person died as this is a matter for the Coroner to determine. Neither are they conducted to hold any

individual or organisation to account – other processes exist for that purpose including:

- Criminal or civil proceedings
- Disciplinary procedures
- Employment law
- Systems of service and professional regulation – the Care Quality Commission, Nursing and Midwifery Council, Health and Care Professions Council and the General Medical Council

In circumstances where the actions of other agencies are required, WCCG will inform the relevant agencies.

Wolverhampton CCG aims to facilitate learning by promoting a fair, open and just culture, with robust application of duty of candour. The obligations associated with the statutory duty of candour are contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

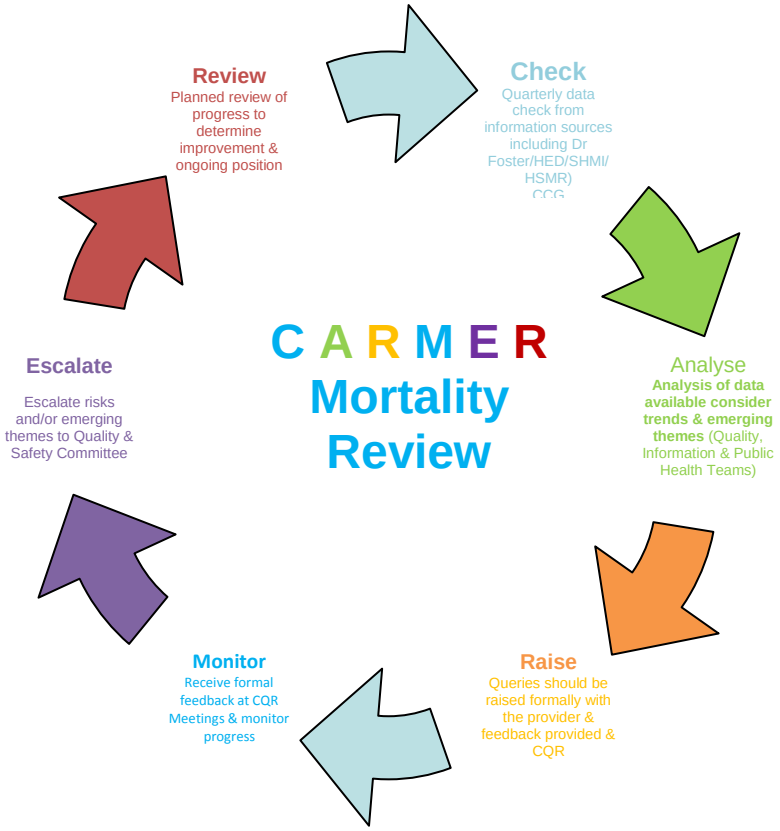
Mortality

A multi-agency approach to monitoring and reviewing mortality has been a key area of quality monitoring undertaken through triangulation of a range of information sources available to Public Health, Providers and the CCG. Consideration is given to the causal factors where greater prevalence is observed and may be above tolerance when benchmarked with other data sources including CQC, NHS England etc.

A locally developed model has been used to facilitate this work, the CARMER Mortality Review Process below demonstrates how inter-agency consideration of mortality information will be undertaken:-

CHECK	At quarterly intervals check information available from a range of sources including Dr Foster, HED, SMHI, HSMR, Public Health & MORAG to enable triangulation of intelligence.
ANALYSE	Analyse information available to consider trends & emerging themes & possible alerts on influencing factors/cause of death across the health economy. Stakeholders involved in quarterly checks include CCG, Public Health & CSU.
RAISE	Queries/outcomes from analysis of mortality data should be raised with the provider(s) and fed back to CMOG members and be included in the next Clinical Quality Review Meeting (mortality theme).
MONITOR	Receive formal feedback at respective Clinical Quality Review Meeting(s) following queries raised with providers following quarterly CMOG Meetings and continue to monitor progress.
ESCALATE	Risks and/or emerging themes should be not only raised with the provider(s) but also escalated to Quality & Safety Committee in order for them to be a) aware and b) kept informed and c) recorded on the CCG Risk Register, when deemed appropriate.
REVIEW	Planned routine review of progress should take place at CMOG as part of the agenda setting process to determine whether sufficient assurance has been proven to determine improvement or further deterioration.

Correlation with information provided by the Royal Wolverhampton Trust should coincide with other data sources reported upon by Public Health and the CCG to enable queries and ambiguities to be raised with the trust either at MORAG and/or CQR.



The Clinical Quality Review meeting(s) (Black Country Partnership and Royal Wolverhampton Trust) receive regular reports on mortality (quarterly intervals) initiated by the trusts Mortality Oversight Review & Assurance Group (MORAG). Mortality rates are considered to determine whether they are improving or deteriorating and assurance of mitigating actions being taken by the trust. The CCG routinely receive documentation and hold formal membership of MORAG, this is achieved via attendance of a CCG Board Member (Accountable Officer, Quality Lead or similar). Cross fertilisation of information between MORAG, CQR and Commissioner Mortality Oversight Group is undertaken at quarterly intervals providing assurance and risk information to the CCG Quality and Safety Committee and Local Authority Health and Wellbeing Board.

Infection Prevention

Reducing Health Care Associated Infections (HCAI's) remains high on the Governments safety and quality agenda and in the general public's expectations for quality of care. Antimicrobial resistance (AMR) concerns the entire world and requires action at local, national and global level. AMR cannot be eradicated, but a multi-disciplinary approach involving a wide range of partners will limit the risk of AMR and minimise its impact for health, now and in the future (DOH 2013).

To slow down the development of antibiotic resistance, it is important to use antibiotics in the right way – to use the right drug, at the right dose, at the right time, for the right duration. Therefore the CCG is working with our local partners where the aims are to:

- Reduced public expectation about receiving antibiotics
- Improved understanding of when antibiotics should and shouldn't be used
- Improved understanding of AMR
- Increase the local number of registered Antibiotic Guardians
- Targeting antibiotic therapy in the hospital
- Implementing a structured antimicrobial stewardship plans in the hospital
- Reviewing local surveillance and assessing microbiological data
- Implementing a quality prescribing scheme to enable antibiotic stewardship for prescribers working in primary care.

Quantifiable measurements are used to reflect the critical success of provider(s) with indicators and a target or plan. The quality requirements defined within our service specification serves as a benchmark improvement. The indicators facilitate Wolverhampton CCG to understand, compare, predict outcomes and improve care.

In achieving a reduction in the burden of Health Care Associated Infections, in particular Meticillin-Resistant Staphylococcus Aureus (MRSA) and C Difficile the CCG works collaboratively with their service provider and Public Health using training, audits and implementation of best practice from root cause analysis and also affords access to specialist advice and support. A key area of importance is to reduce the spread of infection and outbreaks not only in hospital but community care settings also.

Infection prevention and control is fundamental in improving the safety and quality of care provided to patients. Reducing Healthcare associate infections is high on the quality and safety agenda for the CCG. The aim is to prevent infections through provision of comprehensive, high quality and evidence based infection control support. Therefore the focus skill will be to reduce and sustain reductions in health care associated infections.

Through collaboration with the Royal Wolverhampton Trust there is a citywide improvement plan in place to combat the problems experienced across the city with infection prevention. Monitoring and review of the work plan is undertaken in conjunction with Public Health and reported to the responsible committee at quarterly intervals. A copy of the service specification will provide fuller detail on the provision of service.

WCCG supports local and national Infection Prevention Strategies, the overall aim being to deliver harm free care for those accessing health care in Wolverhampton. It is aimed at supporting 3 domains of the NHS outcomes framework:

- Preventing people from dying prematurely
- Ensuring that people have a positive experience of healthcare
- Treating and caring for people in a safe environment and protecting them from avoidable harm and should include reduction of Pressure Injuries, CDiff and MRSA.

The CCG has refreshed the Service Specification for Infection prevention, with particular

reference to specific gold standard IP indicators, adapted from the Infection Prevention and control commissioning toolkit (Infection Prevention Society and the Royal College of Nursing). This makes reference to UK's 5 year antimicrobial resistance strategy 2013 – 2018 (DOH 2013) and supports local and national Infection Prevention Strategies, the overall aim being to deliver harm free care for those accessing health care in Wolverhampton. It is aimed at supporting 3 domains of the NHS outcomes framework:

The Quality requirements within the Service Specification acknowledge the ambition to strive for 100 per cent compliance with the indicators. The aim of the infection prevention and control service is to prevent infections through provision of comprehensive high quality evidence-based infection control support. The focus of the service will be to reduce and sustain reductions in healthcare-associated infections. In particular, the service will aim to achieve a reduction in the rate of C Difficile infections, in line with national objectives and support the CCG to deliver on the requirement for zero tolerance of avoidable MRSA bacteremia.

Safeguarding – Children

The Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework 2015 was commissioned in order to set out clearly the responsibilities of each of the key players for safeguarding in the future NHS. The framework is intended to support NHS organisations in order to fulfil their statutory safeguarding duties as set out in;

- Working Together to Safeguard Children (2015)
- Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children (2015)

CCGs are statutorily responsible for ensuring that the organisation from which they commission services provide a safe system that safeguards children at risk of abuse or neglect. This includes specific responsibilities for Looked after Children and for supporting the Child Death Overview process, to include sudden unexpected deaths in childhood.

CCGs have a statutory duty to be members of the Local Safeguarding Children Board (LSCB) and the Corporate Parenting Board, working in partnership with local authorities to fulfil their safeguarding responsibilities.

CCGs should ensure that robust processes are in place to learn lessons from cases where children die or are seriously harmed and abuse or neglect is suspected. This will include contributing fully to Serious Case Reviews (SCRs) which are commissioned by the LSCB and also where appropriate, conducting individual management reviews.

Health providers are required to demonstrate that they have effective leadership and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the LSCB and their commissioners.

All health providers are required to have safe and effective arrangements in place to safeguard

vulnerable children and to assure commissioners that these are working. These arrangements include, safe recruitments, effective training of all staff, effective supervision arrangements, working in partnership with other agencies, and identification of a Named Nurse, Named Doctor (and a Named Midwife if the organisation provides maternity services) for both safeguarding and LAC.

CCG works with and ensures that all GP practices have a lead for safeguarding, who should work closely with named and designated safeguarding professionals.

Wolverhampton CCG Safeguarding and Looked after Children Team will continue to monitor WCCG compliance regarding its responsibilities for safeguarding and Looked after Children through regular self – assessments and implementation of action plans to address areas for development.

Wolverhampton CCG Safeguarding Team and Looked after Children Team will monitor that health providers have effective arrangements in place to safeguard vulnerable children through the development of effective professional relationships with the safeguarding and LAC leads in provider organisations to foster an open and transparent reporting framework in order to provide commissioners assurance at the appropriate forums and effective professional challenge as appropriate.

Wolverhampton CCG Safeguarding Children and Looked after Children Team will further develop processes to disseminate lessons learnt from the full range of reviews carried out by Wolverhampton Safeguarding Children Board to services commissioned by Wolverhampton CCG, and to monitor the implementation of the recommendations and the embedding of these into practice.

Wolverhampton CCG will continue to ensure appropriate representation is made at Safeguarding forums – including WSCB, Corporate Parenting Board and provider forums.

The designated professionals will continue to offer support and supervision for the named professionals in provider organisations and to work with the Named GP Safeguarding Children to support GPs and their staff to fulfil their roles and responsibilities to safeguard children.

Safeguarding – Adults

Safeguarding means protecting a person's right to live in safety, free from abuse and neglect. As commissioners, WCCG must demonstrate the aims of adult safeguarding:

- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives
- To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible
- To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect

There are fundamental requirements for effective safeguarding in the delivery of NHS care:

- NHS Wolverhampton Clinical Commissioning Group has responsibility to assure the quality and safety of the organisations with which contracts are held, and ensure that those contracts have explicit clauses that hold the providers to account for preventing and dealing promptly and appropriately with any example of abuse and neglect. The 2017/18 safeguarding contract information requirements have been strengthened to include a safeguarding dashboard and the requirement for providers to complete a quarterly and annual assurance report using a generic template developed by the WCCG Safeguarding Team
- To prevent safeguarding incidents arising through the provision of high quality NHS care. This includes the NHS Outcomes Framework which sets out the high-level national outcomes that the NHS should be aiming to improve
- Treating and caring for people in a safe environment; and protecting them from avoidable harm.
- To ensure effective responses where harm or abuse occurs through multi-agency adult safeguarding policies and procedures.

WCCG has worked in collaboration with City of Wolverhampton Council to ensure that the Safeguarding elements of the Care Act 2014 are implemented and have also supported the development of the Adult Multi Agency Safeguarding Hub.

The Care Act (2014) represents a landmark piece of legislation to modernise and consolidate social care law (which is based on thirty Acts including the 1948 National Assistance Act). It is the most significant piece of legislation in our sector since the establishment of the welfare state.

Underlining the reforms is a vision of a more integrated approach to the design and delivery of social, housing and health care services. The Better Care Fund is a vehicle for this. It is essential that there is clarity about responsibilities in relation to safeguarding within these new arrangements and how the new system can help drive continued improvement in practice and outcomes.

Adult Safeguarding is the process of protecting adults with care and support needs from abuse or neglect. It is an integral part of what many public services do, but the key responsibility is with local authorities in partnership with the police and the NHS.

From April 2015 each local authority must:

- Make enquiries, or ensure others to do so, if it believes an adult is subject to, or at risk of abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so by whom
- Set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the Police and the NHS (specifically the Clinical Commissioning Group/s) and

the power to include other relevant bodies. Wolverhampton CCG will be represented on the Safeguarding Adult Board by the Executive Director of Nursing and Quality
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them
- Cooperate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect

WCCG has the appropriate systems in place to manage requests for contributions towards Section 42 Enquiries and other safeguarding quality issues raised for WCCG's attention. The CCG's Joint Children and Adults Safeguarding Policy (2017) and the WCCG Safeguarding Strategy (reviewed 2017) will need to be read with reference to other CCG policies as indicated within the policy and:

- Adult Safeguarding: Multi- Agency policy and procedures for the protection of adults with care and support needs in the West Midlands (2016)
- NHS England – Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (2015)
- Wolverhampton City Council's Local Practice Guidance

WCCG is represented on the following by the Designated Adult Safeguarding Lead:

- Wolverhampton Safeguarding Adults Board
- Safeguarding Adults Review Committee
- Learning and Development Committee
- Quality and Performance Committee
- Domestic Homicide Review Standing Panel

Prevent: Wolverhampton CCG is a commissioning organisation and as such will have limited contact with members of the public or patients. There are, however, a number of potential interactions between the organisation and the public that could result in concerns being identified regarding the radicalisation of individuals. Radicalisation is a process by which an individual or group comes to adopt increasingly extreme political, social, or religious ideals and aspirations that reject or undermine the status quo.

The CCG also has a role to oversee how the organisations from which it commissions services are complying with the requirements of the National NHS Contract and the National Prevent Strategy. The CCG will also support and promote a Wolverhampton wide approach to Prevent, ensuring that there is one standard approach to information, awareness, training, and reaction/escalation to concerns.

WCCG will ensure that it is represented appropriately, and work collaboratively, in local Prevent partnership work including:

- Channel panel
- Wolverhampton CONTEST Steering Group
- Safer Wolverhampton Partnership

The CCG's Prevent Policy and Referral process (2016) should be referred to for further information and referral processes.

Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLs) – WCCG continue to support a project hosted by Walsall CCG (provided by Dudley and Walsall Mental Health Trust) which has raised awareness and provided training across the Black Country. Valuable resources have been developed; including scenario based video's which can be accessed via Dudley CCG's website.

NICE Assurance

There is a systematic process in place for planning, implementing, auditing and evaluating NICE guidance in the services it commissions. It accepts that NICE guidance is evidence based and represents good practice and effective use of resources.

There is an obligation to implement Technical Appraisal Guidance and consider NICE guidance issued by National Institute for Health and Care Excellence (NICE), which is the independent organisation responsible for providing national guidance and quality standards on the promotion of good health and the prevention and treatment of ill health.

NICE guidance is based upon the best available clinical evidence on what works and is cost effective evidence. There is an expectation that health professionals will take national guidance fully into account as part of their clinical practice, it is intended to support clinician's skill and knowledge.

WCCG has a responsibility for commissioning and delivering services that are compliant with NICE guidance and NICE Quality Standards in order to:

- ensure patients and service users receive the best and most appropriate treatment
- ensure the NHS resources are used to provide the most clinically and cost effective treatment
- ensure equity through consistent application of NICE guidance

Adherence to the policy will provide assurance that WCCG fulfils its responsibility to implement best practice as a matter of course and that it is working in partnership with other organisations. The principles to provide a systematic and transparent approach are:-

- Horizon scanning and forward planning
- Identification of clinical leads and service areas for dissemination
- Monitoring of local assessment and uptake
- Maintenance of WCCG data base to record actions

There are duties placed upon commissioners and providers of services, the policy defines the practical steps that should be taken to ensure treatment and practice are changed in light of new and emerging quality standards, guidance and technical appraisals. In order to obtain assurance the CCGs NICE Assurance Group (NAG) meets regularly to review progress and status with each of its commissioned providers and works closely with stakeholders including Public Health and Primary Care to enable an integrated approach to quality and care delivery.

Commissioning Quality and Innovation (CQUINs)

NHS England this year introduced a number of changes to the CQUIN scheme which were first introduced in 2009. All CQUINs for 2017-19 are nationally mandated and will be looking harder at each provider type, and designed schemes for specific provider settings.
The selection of CQUIN's for 2017-19 for our providers will fully support our strategic priorities to deliver quality and innovation. The quality team will work collaboratively to develop and monitor provider CQUINS.

The value of the CQUIN scheme will be 2.5% of Actual Contract Value as defined in the NHS Standard Contract. The percentage value earned will be dependent on provider performance.

Providers with agreed CQUINs in their contract will submit data to support performance on a monthly/quarterly basis which is then reviewed and challenged by the lead Quality Assurance Coordinator for that contract. Quarterly reconciliation meetings are held between the CCG and the provider to agree performance and identify any areas where CQUIN monies may be withheld due to performance issues. The quarterly performance is reported through the relevant CQRM and also to the Quality and Safety Committee via the Quality Report.

Commissioners may, in addition to CQUINs, offer additional incentives to providers and these are recorded as Local Incentive Schemes in the relevant schedule of the NHS Contract.

We are responsible for the following:

- Monitoring delivery of standards and quality through the commissioning process
- A duty to require and monitor delivery of fundamental standards
- Ensuring there are resources to enable proper scrutiny of our providers' services, based on sound commissioning contracts
- Ensuring assessment and enforcement of fundamental standards through contracts and the development of alternative sources of provision if necessary.

Our CQUIN selection for our main Acute and Mental Health providers for 2017-19 are:

Acute Provider	Mental Health Provider
NHS Staff Health and Wellbeing	NHS Staff Health and Wellbeing
Reducing the impact of serious infections	Child and young person Mental Health transition
E-referrals	Physical health for people with severe

	mental illness
Supporting proactive and safe discharge	Improving services for people with Mental Health needs who present to A/E
Improving the assessment of wound	Preventing ill health by risky behaviours –alcohol and tobacco
Personalised care planning	

Clinical Quality Review Meetings

Clinical Quality Review meetings will be maintained for all of our main providers of service. The lead commissioner takes responsibility for the management of these meetings. The frequency of these meetings will be at no longer than quarterly intervals for larger providers and no longer than annual intervals for smaller providers.

A collaborative approach to monitoring the quality of care provided by smaller providers who are commissioned by multiple associates is actively encouraged.

Terms of reference for all Quality Review Meetings and Quality and Safety Committee Meetings are routinely reviewed at no longer than 6 month intervals to ensure they are an accurate reflection of the responsibilities of the both forums.

Meeting schedules will be shared with members to enable efficiency and timely information distribution of a draft agenda issued 2 weeks prior, comments/papers received and distributed 1 week prior to the meeting and minutes issued 7-10 days later.

All Clinical Quality Review meetings will be chaired by a CCG Board Member wherever possible and supported by the Quality and Risk Team with attendance at senior office level from provider organisations.

In accordance with NHS National Contract clauses, the Clinical Quality Review meetings will be managed in accordance with clinical quality review and quality requirements focusing on the providers clinical quality performance report (monthly), progress made against CQUINs and Key Performance Indicators (KPI's) etc.

Quality Matters

Quality Matters launched in March 2012 and is a facility available to GPs, Contracted Providers and Associate Commissioners to enable concerns or requirements associated with an experience of a healthcare organisation and the impact on the quality of care received by the patient(s). There have been almost 1150 raised to date (March 2012 - March 2017).

The CCG Quality team currently receives and responds to traffic from one provider & another via the Quality Matters Communication Process. In the first instance the initial source will send a quality concern through the designated email address, where a member of the Quality Team checks emails on a daily basis. The concern(s) are then acknowledged and prioritised accordingly. Issues are evaluated and either escalated or a conclusion fed back immediately.

A response date is allocated to an individual concern and is identified by the severity of the concern raised.

Once the issue has been resolved, information is fed back to the initial source, the concern is then either closed, or the source replies with additional details that need discussion. Findings from all Quality Matters are reported on a monthly basis to relevant committees. Actions taken include changes to processes, pathways and working arrangements across all providers. The system is well used by both GPs and providers from Wolverhampton and other areas beyond the CCG boundaries.

Quality Governance

The Quality and Safety Committee, a subcommittee of the CCG Governing Body, will be responsible for receiving assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the clinical commissioning group does. This will include jointly commissioned services and supporting NHS England as regards the quality and safety of the healthcare services that it commissions on behalf of the local population.

Assurance Reporting

A range of reports are produced routinely and in response to specific requirements by the Quality and Risk Team that are considered by the Quality and Safety Committee and where necessary other groups/forums either within or sometimes outside of the CCG.

Quality Assurance is routinely reported at an aggregated level each month to the Quality and Safety Committee and subject to scrutiny where deemed appropriate by members in line with the committee's terms of reference.

Each of the forums within the Quality Framework will receive and consider reports and information pertaining to the expanse of quality monitoring that takes place. The following forums will consider and receive such information and take decisions on whether they accept or require further detail to support a particular area of importance:-

- Quality and Safety Committee
- Clinical Quality Review Meetings
- Commissioner Mortality Oversight Group
- NICE Assurance Group
- Serious Incident Scrutiny Group
- Primary Care

There are also exception reports generated on a weekly basis that confirm the CCGs position regarding new serious incidents, number open, number overdue and an overview of concerns across the cities care homes. The report provides a quick snapshot of activity and issues to be aware of over the past week.

In addition the CCG has a well-developed and embedded Quality and Safety Trigger and Escalation Model, previously mentioned in this document and will be used to communicate rising concerns with the Medical or Nursing Directors of the provider organisations. This is a formal, written process which requires an urgent investigation and response from the Directors. These are monitored at CQRM.

Equality, Inclusion and Human Rights (EIHR)

Context

The Equality Act 2010 simplified and harmonised equality law. Importantly, it also strengthens the law to help tackle discrimination and inequality. The Act applies to all employers and service providers in the United Kingdom.
The Act also introduces a new specific Public Sector Equality Duty (PSED), which means all public authorities must demonstrate proactive 'due regard' to:

- **eliminate** unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- **advance** equality of opportunity between people who share a protected characteristic and those who do not;
- **foster** good relations between people who share a protected characteristic and those who do not;
- (s149, Equality Act 2010)
- There are Specific Duties which require organisations to:
- **promote transparency** – public bodies are required to publish service delivery information to show compliance, and those that employ more than 150 staff, must also publish workforce profile information, at least annually in an accessible way;
- **setting equality objectives** – public bodies are required to set their own equality objectives based on evidence and data, at least every four years as part of their strategy and be able to measure their success against their equality objectives;

The Equality Act 2010 provides protection to the following groups of people based on the protected characteristics listed below:

- age
- disability
- gender reassignment
- marriage and civil partnership – only in respect of eliminating unlawful discrimination
- pregnancy and maternity
- race – this includes ethnic or national origin, colour or nationality
- religion and belief
- sex
- sexual orientation

Equality, Inclusion, and Human Rights

What are Equality, Inclusion and Human Rights (EIHR)?
Equality is about creating a fairer society where everyone can participate and have the opportunity to fulfil their potential; it is not about treating everyone the same. It is backed by legislation designed to address unfair discrimination based on particular protected characteristics.
Equality and Diversity are not inter-changeable but inter-dependent. There can be no equality of opportunity if difference is not valued and harnessed and taken into account.

Inclusion is about the combination of diversity and a positive vigour and striving to meet the needs of different people by creating an environment where everyone feels respected, properly involve and empower by creating the right environment to enable all to realise and their full potential. There is recognition that some individuals and groups, for a variety of differences and reasons, find it more difficult to have their voice heard in mainstream society.

Human rights are the basic rights and freedoms that belong to every person. They are the fundamental things that human beings need in order to flourish and participate fully in society. Human rights belong to everyone, regardless of their circumstances. They cannot be given or taken away – although some rights can be limited or restricted in certain circumstances. For example, your right to liberty (Article 5, Human Rights Act 1998) can be restricted if you are convicted of a crime, or subject to section under the Mental Health Act.

Having ‘due regard’ means consciously thinking about the three aims of the Equality Duty:

- **removing or minimising disadvantages** suffered by people due to their protected characteristic;
- **taking steps to meet the needs of people** from protected groups where these are different from the needs of other people;
- **encouraging people from protected groups** to participate in public life or in other activities where their participation is disproportionately low

Equality Analysis (EAs) is a process enabling managers to address fundamental questions in considering and understanding how a proposal for healthcare changes, can help them to meet all service users requirements including ensuring quality. It specifically seeks to address the following issues:

- Is there any direct discrimination?
- Is there any potential for indirect discrimination?
- What engagement and involvement has been carried out and who with?
- What was the outcome of any engagement and involvement? And how has this informed the decisions made?
- Is any group disproportionately affected?
- What are the potential adverse impacts?
- What actions will be taken to mitigate any adverse impact?
- Positive impact to be highlighted

The aforementioned considerations should also be considered during any quality and risk activities, paying specific attention to people from any protected characteristic as detailed within the Equality Act 2010.
The NHS has designed a reporting framework for all healthcare organisations to use to demonstrate progress in equality, inclusion and human rights area.
The main purpose of the Equality Delivery System2 (EDS2) is to help local NHS organisations, in discussion with local partners including local stakeholders, review and improve their performance for people with characteristics protected by the Equality Act 2010. There are key elements and outcomes of the EDS2 that are intrinsic with aspects of clinical quality.

The interface between the Quality Strategy and Equality, Diversity, Inclusion and Human Rights (EIHR)

The Golden Thread

To summarise, Clinical Quality prioritises assurance of quality of care for all patients regardless of their background or circumstance. A number of operational strategies are deployed to understand all patient needs, for example listening to patient feedback and experience and acting upon that feedback, as well as ensuring that patients' NHS Constitution rights are delivered and upheld.

EIHR prioritises the understanding of the diverse communities being served, dealing with principles of fairness, respect and dignity. The NHS Constitution details a duty to protect and promote equality, inclusion and human rights for everyone. Clinical quality and EIHR are interdependent to enable service to be safe and effective for sections of the community. There is a co-dependent relationship between Quality Impact Assessments and EAs in respect of all the principles mentioned.

The interface between clinical quality and EIHR, demonstrates the CCG's commitment towards dealing fairly and equitably with issues of equality as part of the quality and risk function.

Key points are:

- the importance of ensuring that all patients receive a safe high quality and equitable service regardless of age, sex, race, disability, sexual orientation, gender reassignment, religion and belief or any other personal characteristic;
- the importance to embed equality and human rights considerations as part of all quality and risk functions/activities;
- the opportunity to improve health outcomes and reduce health inequalities;
- meeting patients cultural and religious needs;
- the importance of embedding the NHS Equality Delivery System and the Workforce Race Equality Standards (where relevant), in core activities;
- carrying out EAs to demonstrate and evidence 'due regard' and from a potential and risk perspective, clinical quality and EA's are closely related and must be linked together.

Risk Management

The Quality Strategy is closely aligned with the CCGs Risk Management Strategy through applying equally as much rigour to the application of risk management to care quality therefore ensuring that risks are identified, recorded and duly reported. Within the scope of the risk management system care quality features strongly and is treated with all seriousness to ensure that robust mitigating actions have been identified and indeed implemented to reduce risks to patients and the services they access.

Risk Management is a key feature in the monthly assurance reports presented to the Quality & Safety Committee, also shared with Senior Management Team Meetings periodically and subject to scrutiny and oversight by a responsible director for each risk that enables ownership and furtherance of risk recording and scoring. Particular attention is paid to red risks to ensure that all reasonable action is being taken to reduce the likelihood of patients receiving care being unsafe, having a negative experience of care or care that is ineffective.

Annual Quality Report

We will produce an Annual Quality Report to provide an overview of both quality performance within the CCG during the year and the quality performance of provider organisations from which healthcare is purchased, together with details of any action taken to address identified quality related issues. Our priorities for the following year will also be set out within the report.
We will publish our Annual Quality Report on the CCG's website.

Summary

The CCG has a strong and effective quality function which works collaboratively with its providers and other organisations to deliver high quality services to the residents of Wolverhampton for whom it commissions health care.

Our Quality Strategy builds on these existing strengths and sets out our approach to quality over the next three years. It includes details of our specific objectives and planned programmes of work which support the CCG's overarching Strategy and will assist us to deliver our overall aim of improving individuals' quality of life and their experience of health care by commissioning high quality accessible services that reflect their needs.

Appendix 1

Sign up to SAFETY
LISTEN LEARN ACT

SIGN UP PACK (V1.5 Updated November 16)

Welcome to Sign up to Safety

Listen, Learn, Act

Listening to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

Our vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that each of our organisations undertake and aligning them with this single common purpose.

Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result.

As Chief Executive or leader of your organisation, we invite you sign up to the campaign by setting out what your organisation will do to deliver safer care

- Describing the actions your organisation will undertake in response to the five Sign up to Safety pledges (see page 3 to 5) and agree to publish this on your organisation's website for staff, patients and the public to see. You may like to share and compare your ideas before you publish – this support will be available to you.
- Committing to turn your proposed actions into a **Safety Improvement Plan** which will show how your organisation intends to save lives and reduce harm for patients over the next 3 years. Again, support will be available, if you wish to access it, to assist in the description of these plans.
- Within your Safety Improvement Plan you will be asked to identify the patient safety improvement areas you will focus on.

To officially sign up your organisation to the campaign, please complete the following sign up form and return via email to england.signuptosafety@nhs.net

Sign up to SAFETY

LISTEN LEARN ACT SIGN UP FORM

Organisation name: Wolverhampton CCG

In signing up, we commit to strengthening our patient safety by:

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges
- Committing to turn these actions into a Safety Improvement Plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.
- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community
- Make public our plan and update regularly on our progress against it.

Chief Executive or organisation leadership sponsor:

Helen Hibbs

Name	Signature	Date
Dr Helen Hibbs		15 06 17

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:	Mr	First name:	Steven	Last name:	Forsyth
Email:	stevenforsyth@nhs.net			Job title:	Head of Quality & Risk

The five Sign up to Safety pledges

1. Putting safety first. Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans

We will support our acute and mental health trust in reducing the number of avoidable pressures ulcers and falls causing harm through working collaboratively to learn from incidents and prevent recurrences.

Through implementation of the Sepsis CQUIN during 2015/16 seek to ensure our patients are treated in accordance with the prescribed pathway to prevent ill health in patients in an acute setting.

Prevent avoidable admissions from care homes through initiatives we have in place to provide care in the right place at the right time using our Hospital In-reach Team and other projects that enable care to be provided closer to home.

Promote the management long term health conditions in primary care and community setting to prevent admission to hospital.

Our pledges are summarised as follows:-

- ***Reduced Harm from Avoidable Falls***
- ***Reduced Harm from Avoidable Pressure Ulcers***
- ***Reduced Harm through implementation of Sepsis 6***
- ***Prevent Avoidable Admissions to Hospital***
- ***Management of Long Term Conditions in Primary Care & Community***

2. Continually learning. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are

We will promote the use of Quality Matters to share information and learn from feedback shared via primary care and/or our providers so that we are able to strive to continuously improve patient safety, patient experience and clinical effectiveness.

3. Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

We will be open and honest with our patient groups and the public through sharing our trend reports generated through Quality Matters and in response to feedback from patients and the public in line with our Patient Engagement Strategy.

4. Collaborating. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use

We will work with Healthwatch, providers and the Local Authority to ensure that so far as is reasonably practical we identify trends, identify learning opportunities and take action to prevent recurring themes continuing in the future.

5. Being supportive. Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress

We will strengthen information sharing with member practices to enable quality improvement and work to respond to the findings of the GP patient survey, patient surveys in hospital settings and in response to feedback from our Patient Participation Groups.

Glossary of Abbreviations

ACP	Advanced Care Plan
AMR	Antimicrobial Resistance
ANP's	Advanced Nurse Practitioners
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQR	Contract Quality Review
CQRM	Clinical Quality Review Meeting
CQUIN	Commissioning For Quality And Innovation
CSU	Commissioning Support Unit
DoLs	Deprivation of Liberty Safeguards
EA's	Equality Analysis
EDS2	Equality Delivery System2
EIHR	Equality Diversity Inclusion & Human Rights
EoLC	End of Life Care
GP	General Practitioner
GPFV	General Practice Forward View
GPN	General Practice Nurse
HEE	Health Education England
HEWM	Health Education West Midlands
HSJ	Health Service Journal
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LMC	Local Medical Committees
LSCB	Local Safeguarding Children Board
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MORAG	Mortality Oversight Review Assurance Group
MPCNF	Macmillan Primary Care Nurse Facilitator
NAG	NICE Assurance Group
NHSE	NHS England
NICE	National Institute for Healthcare Excellence
PCC	Primary Care Commissioning
PH	Public Health
QIPP	Quality, Innovation, Productivity and Prevention
QNA	Quality Nurse Advisors
RCA	Root Cause Analysis
RWT	Royal Wolverhampton Trust
SAB	Safeguarding Adults Board

SAR	Safeguarding Adult Review
SCR	Serious Case Review
SI('s)	Serious Incidents
SISG	Serious Incidents Scrutiny Group
SPACE	Safer Provision and Care Excellence
STP	Sustainability Transformation Plan
WCCG	Wolverhampton Clinical Commissioning Group
WRES	Workforce Race Equality Standard

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Agenda Item No: 11

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

14th June 2017

Report title	Overview of Primary Care Strategy and Estates Update
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Accountable director	Ros Jervis, Wellbeing
Originating service	Wolverhampton CCG
Accountable employee(s)	Adam Hadley — Group Manager – Democracy Tel — 01902 555043 Email — Adam.hadley@wolverhampton.gov.uk
Report to be/has been considered by	Health and Wellbeing Board

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Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Receive and discuss this report.
2. Note the continued achievements being realised by the CCG within Primary Care and Estates.

1.0 Purpose

1.1 Provide assurance on progress made to date in relation to achievements that have been realised from the programme of work attached to the CCGs Primary Care Strategy & Estates and confirm the work which is currently underway in the next phase implementation.

The report also confirms where assurance has been received from the CCG Primary Care committee in respect of new models of care demonstrating how practices have aligned with their preferred model & how working at scale is maturing.

The outcome of discussions at national level in respect of CCGs responsive plan that seeks to address the actions required to implement the GPFV is also confirmed.

2.0 Background

2.1 The CCGs Primary Care Strategy was ratified by the Governing Body in January 2016 in recognition of the changing demands in primary care. The programme of work was launched in the summer of 2016 and this report focuses on the achievements that have been realised since the programme of work commenced.

2.2 The CCGs vision is to achieve universally accessible high quality out of hospital services that promote the health and wellbeing of our local community, ensuring that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and also reduce health inequalities

3.0 PRIMARY CARE STRATEGY COMMITTEE

3.1 Since the programme of work was launched in the summer of 2016 a number of objectives have been achieved through the work of each task and finish group.

Task and Finish Groups

3.2 The individual Task and Finish Groups work programme are up and running and they each have identified priorities for the current quarter (April to June 2017). This includes milestones which are due to commence or are due to be completed within this quarter. It does not include any existing programmes of work which are currently in progress and have a completion date after June 2017.

3.3 Whilst there are risks attached to the delivery of this programme of work there are no red risks captured on the risk register at this stage, this was verified through discussions held at the Primary Care Commissioning Committee meeting in April.

4.0 NEW MODELS OF CARE

4.1 There are 45 practices within the membership of Wolverhampton CCG, almost all practices have aligned with like-minded practices to enable them to work together with a view to reviewing health care needs for their population(s) and where feasible exploring opportunities to share the workload through working at scale. Each group has identified the priorities they feel are most important for their population and comprise of some of the following:-

i. Improving access for patients with diabetes
ii. Improving access for patients during the evening & weekends
iii. Adopting pro-active management of patients with frailty
iv. Using a risk based approach to managing patients with long term conditions

4.2 The current practice groupings are largely attached to the Primary Care Home Model where practices work together to serve a population of in the region of 30-50,000 patients to provide population based complete care in conjunction with health and social care partners and the voluntary sector. This enables patients to receive the right care, first time, personalised to their needs through a strong focus on partnership working. The primary care home model is owned and lead by our general practitioners within each practice who continue to engage with their clinical peers to ensure they achieve a consistency of approach in the way care is provided to their patients.

Practice Group	Number of Practices	Population Size
Primary Care Home 1	9	58,388
Primary Care Home 2	8	50,266
Medical Chambers	21	130,500
Vertical Integration	5	30,350
Not Yet Aligned	2	5,477

Discussions are taking place with practice group leads to identify how those groups can be aligned within the boundaries of the three localities, this will enable the Primary Care Home Model to be further developed by all practices within Primary Care Home 1, 2 and Medical Chambers. Further discussions with practices not yet aligned and vertical integration will also take place to ensure equity of delivery of patient care.

5.0 GENERAL PRACTICE FORWARD VIEW

5.1 As a result of feedback from NHS England in relation to the CCGs second stage implementation plan for the GPFV a range of supplementary information was provided to the regional team in a revised plan. The plan has since been confirmed as fully assured and a programme of work is well underway to implement each of the projects detailed within the plan. The committee will receive formal reports on all live GPFV projects from May 2017 onwards, this information will be reflected in future reports of the committee to Governing Body.

6.0 ESTATES UPDATE

6.1 Better Care Fund (BCF) Hub Locality update - This programme of work is predicated upon the procurement of an external expert company to assess the estates needs of Wolverhampton as a whole from a health and social care point of view. The successful provider of the service is being tasked but not limited to scoping health and social care requirements across the city based upon **needs**. This will involve working with all organisations to gather data which can be overlaid to identify geographical health and social care requirements. The outcome from this succinct piece of work will be used to inform the requirement (or not) for potential 'Hubs' across the City. The work is being overseen by the Local Estates Forum (LEF) which is a strategic forum with executive representation from all organisations across health and social care in Wolverhampton. Other updates around BCF – BCF estates leads have been identified for each locality. The leads have been tasked with finding suitable locations for the co-location of multi-disciplinary teams (MDTs (administrative, not clinical at this stage)) – this group meets regularly under the direction of the BCF Programme Board.

6.2 BCF Hub Locality Next Steps - Awaiting outcome of the procurement of the Service Strategy provider and the recommendations from that work. A list of administrative bases for BCF MDT's will be presented to the next Programme Board.

6.3 Estates Prioritisation Update – The CCG has commissioned the completion of an independent prioritisation exercise, which is near completion. This has involved a review of all GP Practice buildings to include the current state of repair, room utilisation, cost, etc. Final areas being added include Infection Prevention, capacity and Primary Care Strategy support weighting. This will be presented to the Capital Review Group clinical representative for comments before being finalised and presented to the CCG Governing body with associated recommendations. The timescale for the document going to Governing Body is July 2017.

6.4 Estates Prioritisation Next Steps – The document is near completion; IP and Capacity have been included in the document. There are a few outstanding items of information which will be collated and added over the next two weeks. The document will then be reviewed by the CRG clinical lead before being finalised and readied for the Governing Body.

6.5 Primary Care Estates update - There are a number of practices within Wolverhampton working on proposed re-developments/relocations. The CCG is engaging with these practices to offer support where necessary, bearing in mind the imminent outcome from the independent prioritisation exercise. Draft papers have been developed for each locality that identify potential developments within each of the three localities.

6.6 Primary Care Estates Next Steps – To work with the identified practices so that the necessary background information is included in the paper. This will then be appended to the outcome of the prioritisation exercise as necessary. The full

documentation will be presented to the Governing Body for a direction in Primary Care Estates in line with the Primary Care Strategy.

7.0 CLINICAL VIEW

7.1 There are a range of clinical and non-clinical professionals leading this process in order to ensure that the leadership decisions are clinically driven. Clinical representation at many Task and Finish Groups takes place on a regular basis.

8.0 PATIENT AND PUBLIC VIEW

8.1 Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new models of care and the importance of patient and public engagement moving forward.

8.2 An update on Primary Care was provided to the Patient Participation Group Chairs in March, whilst this was welcomed they have requested further clarity regarding their involvement in the future in discussions with their respective models of care/practice groupings. Therefore, arrangements are being made for each group of PPG Chairs to meet with the CCG and the Group Lead(s) to discuss how this will be achieved and to ensure patients and the public are invited to share their suggestions on areas for improvement and take part in discussions about changes affecting patients.

9.0 RISKS AND IMPLICATIONS

Key Risks

8.1 The Primary Care Strategy Committee has in place a risk register that has begun to capture the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise with the Governing Body.

Financial and Resource Implications

8.2 At this stage there are no financial and resource implications for the Governing Body to consider, representation and involvement from finance colleagues at committee and tasks and finish group level will enable appropriate discussions to take place in a timely manner.

Quality and Safety Implications

8.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences of care. The CCG quality team will be engaged accordingly as service design takes place and evaluation of existing care delivery is undertaken.

Equality Implications

8.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Medicines Management Implications

8.5 The role of clinical pharmacist is an area of specific attention within the programme of work. A task and finish group has been established to ensure this role is utilised with maximum impact in the future.

Legal and Policy Implications

8.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

Agenda Item No: 12

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

28 June 2017

Report title	Perinatal and Infant Mortality in Wolverhampton	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Accountable director	Linda Sanders, People	
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Service Director Public Health and Wellbeing
	Tel	01902 550148
	Email	Ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team	12 June 2017

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The childhood mortality data for England and Wales and the current trend in infant mortality in Wolverhampton.

1.0 Purpose

1.1 The purpose of this report is to present a summary report of the childhood mortality data for England and Wales published in April 2017 and highlight the current trend in infant mortality in Wolverhampton.

2.0 Childhood Mortality in England and Wales 2015

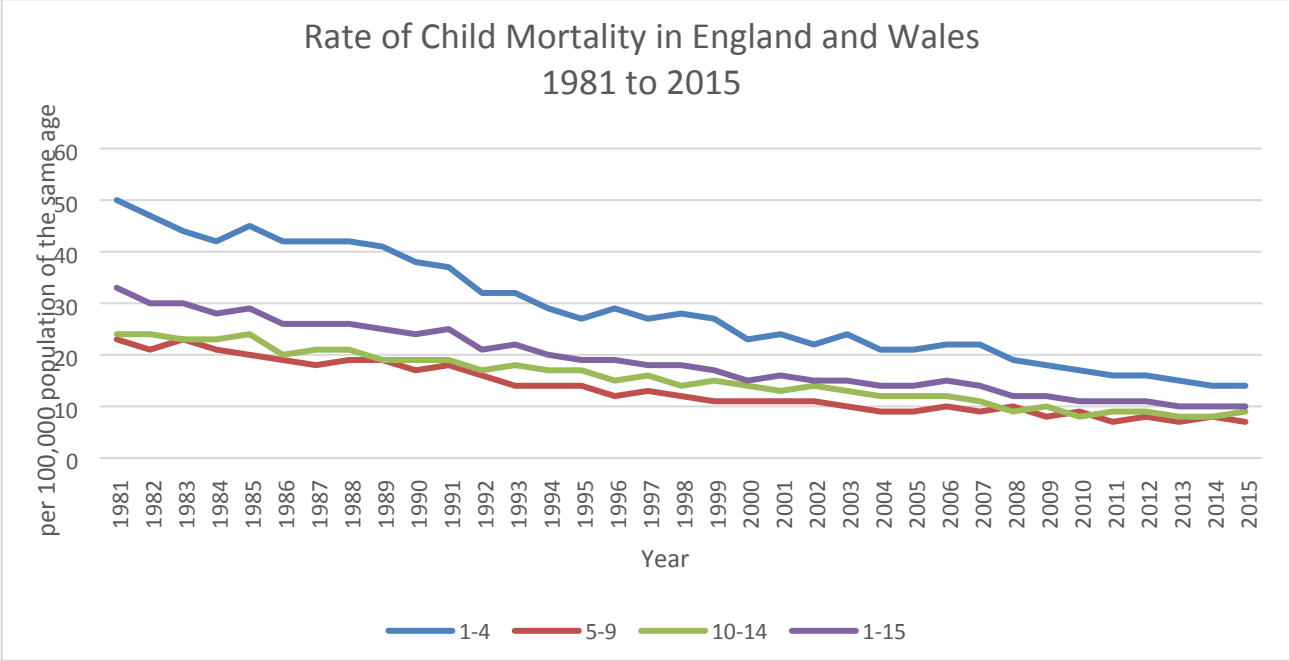
2.1 In April 2017, the Office of National Statistics (ONS) published the latest data on childhood mortality collected for all deaths to children under the age of 16 years from 1981 to 2015. Data on stillbirths (babies born after 24 weeks of pregnancy that show no signs of life) and infant deaths under the age of one year is available from 1921 to 2015.

2.2 The majority of the data is presented for all countries within the United Kingdom and there is one table on stillbirths and infant deaths by Region in England and Local Health Board in Wales. There is no data reported at a local authority level.

2.3 The dataset also provides comprehensive detail on stillbirths and infants in 2015 for:

- Causes of death
- Maternal age at time of infant/child death
- Maternal country of origin
- Marital status
- Previous children
- Birth weight
- Gestation (length of pregnancy in weeks)
- Socio-economic classification
- Place of delivery

Figure 1: Child Mortality in England and Wales



2.4 The steady decline in child mortality in England and Wales over the past 34 years is shown in figure 1, with the highest rate of deaths occurring in children aged one to four years.

3.0 Update on Infant Mortality in Wolverhampton

3.1 The information reported in the ONS dataset is collected locally by Royal Wolverhampton NHS Trust but is not routinely published and would only be accessible by a data sharing agreement for a specific purpose. Public Health receives data on relating to infant deaths only, which is used to support the Infant Mortality Working Group in the delivery of the delivery of the action plan.

3.2 The latest data on the rate of infant mortality in Wolverhampton indicates a decrease in the rate from 7.7 deaths per 1,000 live births in 2010-2012, when it was the highest in England, to 5.6 deaths per 1,000 live births in 2013-15.

3.3 This is a 27% reduction in the rate of infant deaths over the past three years, compared to a 9% reduction nationally (4.3 deaths per 1,000 live births ion 2010-2012 to 3.9 live births per 1,000 live births in 2013-2015).

3.4 Although, Wolverhampton still has a rate of infant mortality that is statistically significantly higher than the national average, there has been a greater improvement in the overall rate locally.

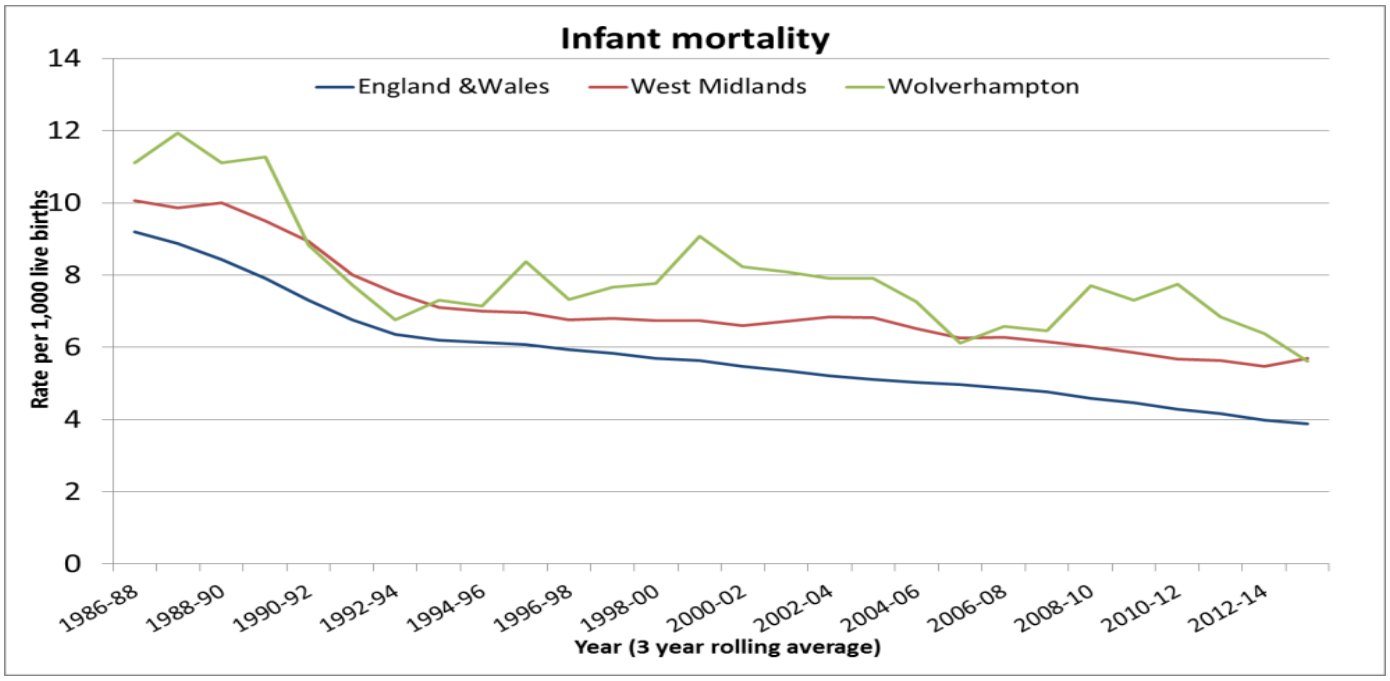
3.5 Table 1 below shows the local trend in infant mortality from 2003-2005 and 2013-2015 compared to the West Midlands and England this information is further illustrated in figure 2, dating from 1986-1988.

Table 1: Rate of infant mortality from 2003-2005 to 2013-2015

Rate per 1,000 live births	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015
England & Wales	5.1	5.0	5.0	4.9	4.8	4.6	4.5	4.3	4.2	4.0	3.9
West Midlands	6.8	6.5	6.2	6.3	6.2	6.0	5.9	5.7	5.6	5.5	5.7
Wolverhampton	**7.9**	**7.3**	**6.1**	**6.6**	**6.5**	**7.7**	**7.3**	**7.8**	**6.8**	**6.4**	**5.6**

Benchmark key	Similar to national	Significantly worse than national

Figure 2: Rate of infant mortality



4.0 Financial implications

4.1 There are no funding implications arising from this information only report. [GS/12062017/X]

5.0 Legal implications

5.1 There are no anticipated legal implications associated with the content of this report. RB/12062017/B

6.0 Equalities implications

6.1 There are no equalities issues arising from this information only report.

7.0 Environmental implications

7.1 There are no environmental implications related to this report.

8.0 Human resources implications

8.1 There are no anticipated human resource implications related to this report.

9.0 Corporate landlord implications

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

10.0 Schedule of background papers

10.1 There are no previous papers in relation to this specific report

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Agenda Item No: 13

CITY OF WOLVERHAMPTON COUNCIL

Health and Well-Being Board

28 June 2017

Report title	Draft People Directorate Commissioning Strategy	
Cabinet member with lead responsibility	Councillor Sandra Samuels	
Accountable director	Linda Sanders, People	
Originating service	People	
Accountable employee(s)	Linda Sanders Tel Email	Strategic Director People 01902 553000 linda.sanders@wolverhampton.gov.uk
	Paul Smith Tel Email	Head of Commissioning 01902 555310 Paul.smith@wolverhampton.gov.uk
Report to be considered by	Cabinet	19 July 2017

Recommendation(s) for action or decision:

Health and Well-Being Board is recommended to:

Note, comment and direct any actions based on the attached draft People Directorate Commissioning Strategy 2017-21 *Shaping Futures, Changing Lives* (attached as Appendix 1).

1.0 Purpose

1.1 For the Health and Well-Being Board to note, comment and direct any actions based on the content of the attached draft People Directorate Commissioning Strategy entitled *Shaping Futures, Changing Lives*.

2.0 Background

2.1 The Cabinet of 26 April 2017 approved the attached Draft People Directorate Commissioning Strategy for consultation during May and June 2017 with a view to seeking final Cabinet approval of the Strategy at its meeting of 19 July 2017.

2.2 The draft Strategy has been considered by the Scrutiny Board on 30 May 2017; the Adult and Safer City Scrutiny Panel on 13 June 2017; and the Children, Young People and Families Scrutiny Panel on 14 June 2017. Early versions of the strategy have also been shared with NHS colleagues and Wolverhampton Healthwatch in the context of overall work on care and health commissioning and integration.

2.3 The attached Draft People Directorate Commissioning Strategy explains the overall drivers, approach and content of the strategy for all parts of the service directorate.

2.4 The draft strategy is titled *Shaping Futures, Changing Lives.* It updates our approach in two ways.

2.5 Firstly, by bringing together in one place the wide-ranging activity already underway in the People Directorate through transformation initiatives.

2.6 Secondly, it shapes the direction for the People Directorate of the next stage of development in creating a single, simple narrative and model which will inform on-going engagement, service transformation and planning as part of one council and with partners. It also reflects the broad current stage of development and direction for care and health integration.

2.7 Updating a commissioning strategy also gives opportunity to incorporate developed approaches such as our approach to de-commissioning. It gives new focus to other initiatives such as the Health and Well Being Board priorities established in 2015/16. It also underpins the way in which commissioning is being harmonised within the People Directorate.

3.0 Progress, options, discussion, etc.

3.1 There has been significant engagement across all sections of the People Directorate as well as with colleagues in corporate procurement, finance, HR and workforce to develop the draft strategy to this stage. It may be that the content offers a template for application in other parts of the Council.

3.2 An early version of the draft was shared as evidence with OFSTED to support their positive view of the "leadership" element of the 2017 inspection.

3.3 The Cabinet of 26 April 2017 approved the draft strategy for consultation. A Communications / Engagement Plan was developed. At the time of the Panel meeting, this is now underway and a verbal update will be given to the Panel about any developing themes.

3.4 NHS partners have also had opportunity to comment and influence through their sight of earlier drafts.

3.5 The Board will note that the strategy is a wide-ranging document which makes links to many areas outside the People Directorate. Indeed, the success of the strategy will be linked to achievements elsewhere e.g. with NHS partners or continued joint-work on the development of skills and career pathways for care in the city.

3.6 The Health and Well-Being Board is invited to consider and comment on the attached draft Strategy with a view to ensuring that it is as rounded as possible.

4.0 Financial implications

4.1 There are no direct financial implications arising from this report. Any actions arising from the Strategy and the associated plans will be delivered from existing budgets.

4.2 A commissioning strategy and associated plans will be key instruments in managing the financial environment for the People Directorate over the coming period. (AS/23022017/B)

5.0 Legal implications

5.1 Details of law relevant to the development of a Commissioning Strategy are included in the draft strategy in Section 4.0 and include:

- The Health and Social Care Act 2012 section 192 (amending the Local Government and Public Involvement in Health Act 2007 section 116 (as amended by the Act – section 192) require a "responsible local authority" and each of its partner CCGs to prepare Joint Strategic Needs Assessment and Joint Health and Well Being Strategies; and section 116A (as inserted by the Act – section 193); Section 196 provides that these functions are to be exercised by the health and wellbeing board established by the local authority.

- The Care Act 2014 –
  - Section 3 establishes legal basis of integration of care and support with health services
  - Section 53ff. establishes requirements relating to market oversight

- Children's Act 1990 Section 22G creates a statutory requirement for a Sufficiency Strategy for accommodation of children looked after by the council under which is an important part of the commissioning

- Children and Families Act 2014 introduced new requirements including
  - those on adoption, special educational needs or disabilities
  - statutory requirements on integration with health and joint commissioning with health partners (Sections 25-26). RB28022017/V

6.0 Equalities implications

6.1 The draft Commissioning Strategy is underpinned by population needs assessment analysis and market shaping activity. These strands provide a framework for action to support all parts of the community in the City of Wolverhampton to allow specific market shaping as needed.

7.0 Environmental implications

7.1 A key intention of the draft Commissioning Strategy is to ensure sustainability for people needing support or care through sustainable resources management and service design. This augments the assets which people bring in their lives. The development of neighbourhood and locality approaches support more sustainable approaches to personal support with potential positive benefit for the environment.

8.0 Human resources implications

8.1 The Commissioning Unit has been re-organised and recruitment to vacant staff team roles is being finalised.

8.2. Any other activity which affects Council staff arising from this strategy will be managed through the relevant approved project plan and further advice sought as needed.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications at this stage.

10.0 Schedule of background papers

10.1 Not applicable.

CITY OF WOLVERHAMPTON COUNCIL

SHAPING FUTURES, CHANGING LIVES

PEOPLE DIRECTORATE COMMISSIONING STRATEGY 2017-2021

x

VERSION CONTROL		
30/01/17	V0.2	bc
14/02	V0.4	BC
20/02	V0.5	BC
22/02	V0.6 post PD PLT	BC
09/03	V0.7 SEB	BC
16/03	V0.8 post SEB	BC
28/03/17	V0.9 post Cabinet Leads	BC

Contents

1.0 People Directorate commissioning - Foreword

Shaping Futures, Changing Lives – our title for this new commissioning strategy states what we are doing through this first Commissioning Strategy for the People Directorate. Many factors influence the development of this new strategy:

- Continued and growing focus on prevention, strengthening families and using the assets and strengths which individuals, families and communities bring to their experience of life to promote their wellbeing and when they need more support
- *Care Act 2014* statutory duty for market shaping and development
- Renewed focus on collaboration rather than competition in NHS services
- Co-production – extending new understanding and actions
- Overall influence of changes in law such as the *Care Act 2014* and the *Children and Family Act 2014* SEND Reforms
- On-going statutory requirement of the role of Director of Adults Social Services, Director of Children's Services and Director of Public Health for commissioning [1] and
- Local factors such as:

    - One Council approach in the service of people in the City
    - Outcome of 2017 OFSTED Inspection of children's social care, our whole family approach and roll-out of Restorative Practice as an approach to working with families
    - Developing our local City of Wolverhampton *Community Offer*
    - People Directorate service re-design such as the Multi-Agency Safeguarding Hub (MASH) embracing a prevention and early help focus, revised early intervention model and specialist support service in children and young people's services
    - Outcome of the *Adult Social Care Peer Review* of March 2016 which recommended a more thematic approach to commissioning
    - Strengthening public health influence in and beyond the council
    - Re-structuring of adult social care operations under one Service Director
    - Working with partners including in the voluntary and community sector so that the experience of people using health and care services is more integrated in our community based approaches
    - Updating of other related strategies e.g. workforce, quality strategies; and need for coherence across strategies e.g. children's disability

This new Strategy will drive the recently established People Directorate Commissioning Unit, capturing current activity and informing future priorities.

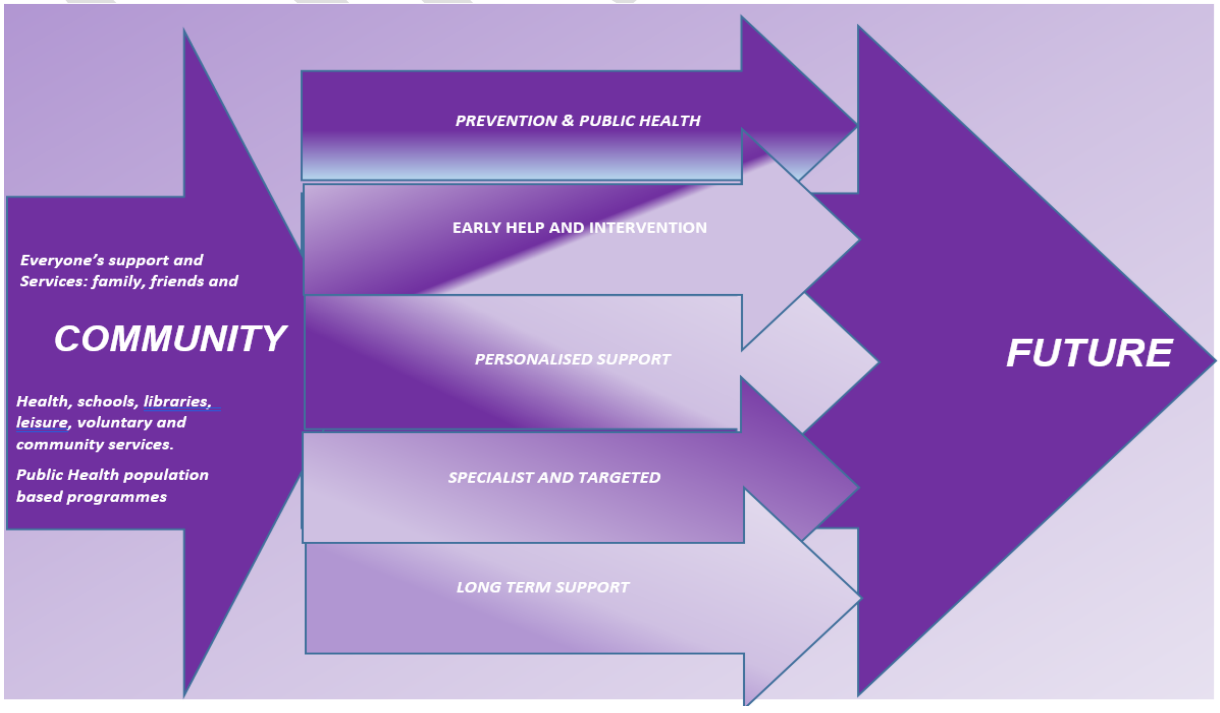
1.1 Vision

In this People Directorate Commissioning Strategy, on behalf of people living in the City of Wolverhampton:

- We embrace a positive, asset-based approach

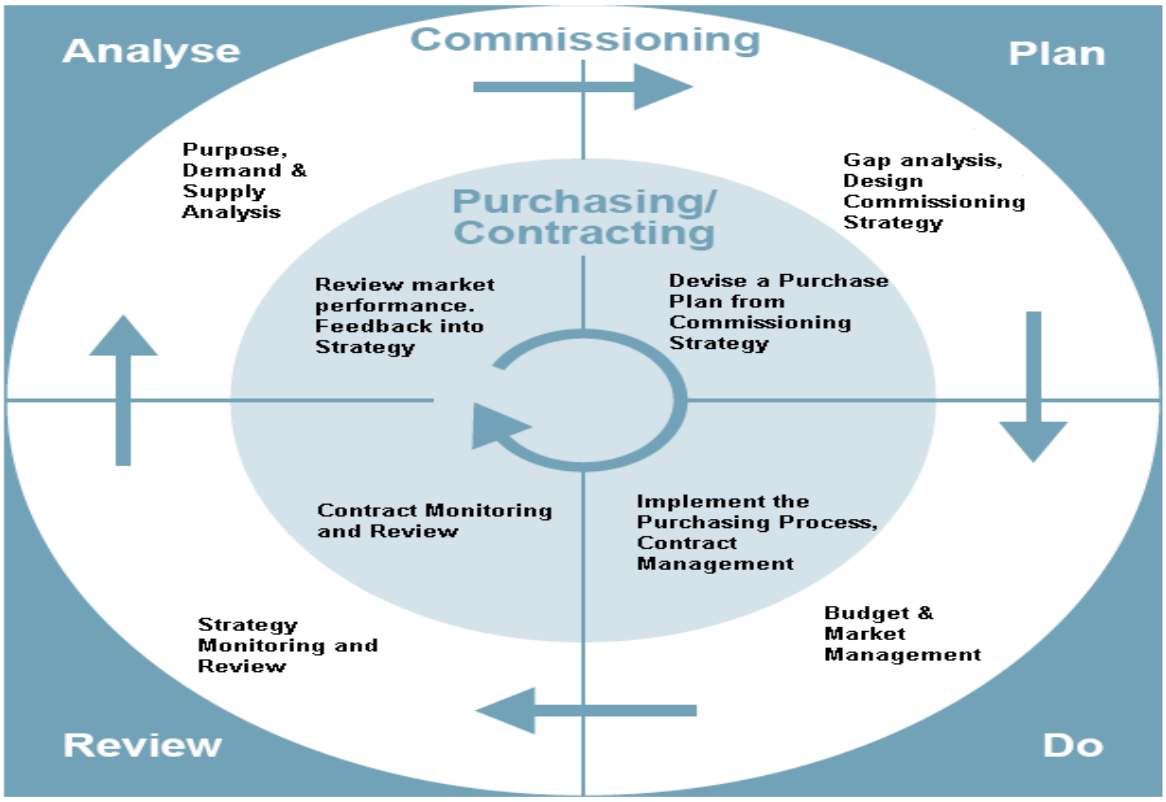
- We are using our resources to shape and investing in a better future.
- We know these are challenging times but we will not simply manage decline.
- Individuals will be at the centre of the commissioning process - Commissioning is for people
- We are working to ensure that people benefit from a well-shaped market where commissioned services are local, provide social value, high quality, capacity rich, citizen-led and cost effective
- We recognize the contribution of the voluntary and community sector to the successful delivery of our vision
- Our interventions are evidence-based and we will learn from best practice in other places
- We focus on delivery of care to people in their own homes or as close to home as possible.
- We will provide people with the skills to live safely and independently
- We will co-produce with citizens
- We will jointly commission with partner agencies where possible so that people's experience of support and care is integrated

In this strategy we adopt HM Treasury's approach used in the context of "value for money" work as *'…the optimum combination of whole-of-life costs and quality (or fitness for purpose) of the good or service to meet the user's requirement.'* [2] In other words, we want to maximise synergies, shared learning and action of being a People Directorate (examples include - telecare, work on loneliness, foster/shared care;) ensuring waste is eliminated and we learn from each other in relation to what works; adopt a future orientated approach, and promote innovation as we take our relationship with citizens and communities across the City of Wolverhampton to a new phase through our ***Shaping Futures, Changing Lives*** **model below** for our commissioning strategy.



1.2 Commissioning – overall thematic approach

The People Directorate has adopted the *"analyse, plan, do, review"* Institute of Public Care (IPC) "*commissioning cycle*." [3]



Our understanding and approach to commissioning in the People Directorate is that commissioning -

- is *everyone's responsibility*
- is a *process and continuum* - it includes many contributors working together – at all or some stages - the person seeking support and colleagues working to support the person / citizen
- requires *agreed strategic frameworks* such as Appendix 1 which shows our Commissioning Pathway
- is *not restricted* to or identified solely with the functional activity of the People Directorate Commissioning Unit who lead work with stakeholders to agree strategic frameworks with operational services
- *allows practitioners freedom* to focus on the assets of individuals, families and communities, applying the right intervention at the right level, purchasing services within an agreed strategic framework to meet need
- Is underpinned by the *values and principles* espoused by the City of Wolverhampton Council, People services and care /health professions
- promotes approaches which are *preventative, asset-based, whole-family, personalised and* focused on *well-being and safety*
- acknowledges *responsible use of resources* for all citizens and communities in the City

- must work closely with corporate colleagues in procurement and the Place directorate to ensure consistency and meet citizen need.

Amongst the factors included which have influenced the development of this new strategy, the March 2016 Adult Services Peer Review proposed a more thematic approach to People Services commissioning.

During 2016, the People Leadership Team led significant activity to embrace the opportunities offered by a thematic approach for People Services as a whole. Benchmarking was undertaken with a Council which had already developed a thematic approach. Refection was undertaken about informing concepts such as whole-life approaches. Local realities were also considered as a result of which five over-arching themes or categories were agreed:

- Public Health
- Early Intervention and Prevention
- Personalised Support
- Specialist Targeted Support
- Long Term Support

The rationale for these themes is underpinned by factors which include our overall commitment to prevention which the City Cabinet agreed is "everybody's business;" [4] strengthening families; supporting family, kinship or other forms of 'informal' care; an asset-based approach to individuals, families and communities; being effective and efficient in our use of resources including value for money; and using our staff resources to best effect.

These themes determine our ***Shaping Futures, Changing Lives*** model above (cf. p.6)

This approach strengthens our overall analysis as we take a more sustainable, longer-term view of support and needs and how commissioning can best be used to shape markets to promote wellbeing, respond to demand from people for care and meet those needs for which the Council is responsible.

After outlining our overall approach to commissioning, our strategy starts with our Commissioning Intentions which are the basis of a separate Action Plan. The background local and national context follows.

2.0 Commissioning Intentions

2.1 Commissioning Intentions

2.1.1 *Early Intervention and Prevention*

- Short Breaks- New contracts for Short breaks for children with disabilities were awarded in in 2016. It is our intention to conduct a review of the provision and the allocation of resource to ensure services are meeting needs. This will include project management of a new facility within Wolverhampton to provide overnight short breaks
- Domestic Violence - It is our intention to recommission accommodation based support for victims of domestic abuse and develop a city wide approach to commissioning that will look to draw funding from a wider range of sources including the Police and Crime Commissioners and Department for Communities and Local Government.
- "Floating Support" - Current provision is targeted at Learning Disabilities and Mental Health. It is our intention to commission generic floating support on outcomes basis. (Contract by May 2017)
- Mental Health Preventative Service - Commission new range of preventative services – In place at April 17
- Advocacy / Information, Advice and Guidance - it is our intention to review existing disparate advocacy arrangement and develop strategy for Information, Advice and Guidance including advocacy. By April 2018
- Carers - Monitor and update implementation plan for the Carers Strategy
- Young Carers- Review of provision for young carers (particularly 15-25) – recommendations on need and recommission. Collaborative – funding from other sources
- Telecare –
- No Recourse to Public Funds (NRPF) - Commission service to support NRPF by May 2017
- Reablement - To develop a comprehensive range of intermediate care services – linked to the Better Care Fund (BCF.) This will include outsourcing the current internal reablement service and developing a clear Discharge To Assess (D2A) process (linked to BCF) April 2017
- Review of Community Resources - Review of community based assets and development of seed funding programme to meet identified gaps.
- Money Management Services - Support with direct payments and welfare advice and guidance for self-funders.
- Community Equipment - To Jointly commission a new Community Equipment service in partnership with the CCG.
- Pathways to Support - More info needed
- Telecare – to be confirmed
- BCF – Guidance received w/e 31/03/17. Work on stream.
- Dementia – cross-refer to Long-Term Support Section
- Adult and Community

- Mental Health - Accommodation review
- CAMHS - Early intervention (Tier 2) work.
- Integration

2.1.2 Specialist and Targeted

2.1.2.1Children and Young People

Preamble - Mindful of the balance between meeting the needs of children and families and getting the best value for money the Integrated Commissioning Team will commission the following over the next five years:

Prevention – Supporting the development of family based early intervention services that help to keep families together where it is safe and reasonable to do so including;

- tendering for Therapeutic support services to support edge of care services and prevent children/young people coming into care
- supporting micro commissioning for the Strengthening Families Partnership Hubs to enable them to respond quickly to need
- tendering for Tier 2 CAMHS services to augment the CAMHS Transformation Programme
- supporting the development of solutions for families with *No Recourse to Public Funds* including the tendering of an accommodation framework

Placement – Ensuring that where children who must come into the care of the Council are in placements that most closely meet their needs including;

- retendering MSW Children's Home for Complex Needs
- developing a Regional Residential Block Contract
- reviewing options for future delivery of fostering services
- reviewing options for the procurement of residential and fostering placements
- supporting foster carer households in line with regulations
- reviewing the effectiveness of the intensive support pilot delivered by Family Action
- developing supported housing options with a view to tendering a range of services that meet identified needs and priorities

Permanence – Support the promotion of options for permanence where it is not possible to reunite children and young people with their families including;

- establishing and participating in a Regional Adoption Agency

Leaving Care/Transition – Supporting the development of services which help in:

- returning young people home as soon as possible in the right circumstances
- ensuring that when young people reach adulthood they achieve a successful transition to adult life

2.1.3.2 Adults

Preamble - Specialist and targeted services work with the client groups with the highest level of need due to their mental health, learning disabilities or other related social care needs. Historically, many of this service user group would have been institutionalised in residential or hospital settings but it is now recognised that it important for the quality of life of these people that all efforts are made to ensure they are able to access the support they need in a community setting as soon as possible, where appropriate.

- Promote and expand supported living arrangements and provision to enhance life choices and quality of life for service users.
- We will be reviewing the current Supported Living Framework which will include reviewing current provisions and referrals, evaluating the reasons for any failures in the framework placements, liaising with providers, social workers, and family and carers and garnering feedback about what is currently successful. Following the review a decision will be made about either extending the current contracts on the framework or going back out to tender for part or the whole of the Supported Living Framework.
- extend our Shared Lives provision enabling more service users to live in a family setting and developing their life skills in the community. This service will be going out to tender in 2017.
- We are also working with residential care home and nursing providers who wish to deregister with Care Quality Commission for this type of provision and register as Supported Living providers. A number of providers have already an interest in going through this process and the Specialist and Targeted services commissioning team are supporting them with this endeavour.

2.1.4 Long Term Support

Preamble - We are committed to delivering quality outcomes for people. This means changing the way in which we commission care and support for those people who need long term support. The Council is committed to working with our partners to develop care and support that will deliver quality outcomes though truly promoting independence in a safe environment.

- Childrens - shape the quality of provision in the local market through work with Providers to develop a new Quality Assurance process (short-term
- Older People - New models of care provision – we will continue to develop more housing options for people so that they can age in the same place with increased levels of support available to them e.g. Extra Care Housing projects (“pipeline housing developments”)
- Remodel the provision of long term support to enable people to achieve independence, choice and control
- Reduce the number of residential placements and the proportion of spending on residential care. The reduction in residential care will enable the Council to

divert resources to deliver personalised care such as supported and very sheltered housing.

- Work with providers to develop a new business model that includes supported living, very sheltered housing and extra care models instead of residential care.
- Provide Wolverhampton citizens who have long term support needs and who currently live out of the City, the opportunity to move back, into services that meet their individual neds and circumstances.
- Support the development of a range of new housing and support options for people within the city for people who need long term support.
- *Workforce - As demographic trends indicate, people in the UK are living longer and their needs are becoming more complex. This need reinforces the growing demands on social care services and the changing expectations of service users who require a workforce which is highly skilled and supported, and able to work in flexible ways.*

    - Commission services from organisations that evidence that they have an appropriately skilled and trained work force e.g. Through the Better Care Fund we are seeking to make sure that all staff have received dementia training at a level that is relevant to the job they are doing.

- Dementia - Take an integrated approach across health, social care and the third sector to respond to the need for; appropriate information advice and guidance, early diagnosis, living well with the condition, support when a person's needs change, access to quality secondary care and dignified end of life care.

- *Long term support needs – living with Long Term Support should not mean living a poor quality of life. It is our intention to ensure that people live well, are active members of their community, maximise their independence and receive high quality services.*

2.1.5 Public Health and Well Being

- The Healthy Child programme; 0-5 (Family Nurse Partnership and Health Visiting) and 5-19 (School Nursing) is currently out to tender and mobilisation will commence with the successful bidder from April 2017**.** The new service commences on 1 August 2017
- Health Protection services; Tuberculosis and Infection Prevention. Planning commences between Public Health and Wellbeing and the CCG in February 2017. Progress will be reported to the Commissioning Executive Board in June 2017 for further discussion around contract and procurement options.
- A drugs and alcohol prevention, treatment and recovery system commissioning programme commenced in December with a scoping meeting held between Public Health and Wellbeing and Wolverhampton CCG. A multi-agency steering group met for the first time in January. Engagement and consultation processes will run

between March – June. All drug and alcohol services commissioned by Public Health and Wellbeing and expiring in March 2018 are currently in scope. A tender will be published during Autumn 2017 with a new service commencing in April 2018.

- A registration process for revised Primary Care sexual health services ended in January (YEAR?) , a number of accredited practices will be offering contraception and screening services from 1 February 2017. Practices that were transferring to new organisational arrangements via practice groups or alignment with the Royal Wolverhampton NHS Trust were given the opportunity to register an interest in delivering these services on a phased implementation so as not to disadvantage any interested GPs.
- Joint / collaborative
    - Health Protection; Tuberculosis and Infection Prevention services will be redeveloped as a joint pathway with the WCCG. Currently both organisations commission elements of these pathways separately. Alongside this arrangements for joint contracting and pooled or aligned resources will be developed.
    - Substance misuse services (drugs and alcohol) will be re commissioned during 2017. This programme will require input across NHS, Council and Community and Voluntary sectors. Public Health and Wellbeing and the WCCG are working collaboratively to ensure primary care, mental health and acute responses to substance misuse are developed to support earlier identification and reduce admissions. Alignment with children, young people and family services are fundamental to this model and the multi-agency steering group includes representation from both Council and WCCG on this area. Programme costs are being developed and a review of current investment to support joint resource planning is proposed.
    - The development of the children and families 0-19- Healthy Child Programme and SWITCH; Befriending service for women at risk of having children taken into care have been jointly undertaken by Public Health and Wellbeing and Children and Family services within the City of Wolverhampton Council. This has led to the development of integrated models of delivery, featuring colocation shared infrastructure and joint pathways. The perinatal mental health offer and a review of maternity pathways is also being jointly undertaken between Public Health and Wellbeing the WCCG, Royal Wolverhampton NHS Trust and Black Country Partnership NHS FT in relation to mental health pathways.
    - The Infant Mortality Plan has initiated a number of collaborative commissioning arrangements with the CCG and Royal Wolverhampton NHS Trust. This has focused on increasing the uptake of breastfeeding, and a successful, targeted neonatal programme [STORK] commenced in 2016 and is being continued

and developed this year. Smoking cessation activity within maternity has increased the numbers of women and families receiving support and pregnant women who misuse substances have a dedicated pathway and treatment programme between maternity and Recovery Near You. Aligned to this is the distribution of healthy start vitamins for under 5's supported by children's centres, strengthening family hubs, the health visitor service, maternity, RMC and the healthy lifestyles service.

- Migrant health needs have been a key focus for Public Health and Wellbeing, the WCCG and RMC during 2016 17. A number of joint initiatives have been collaboratively developed. A new Public Health and Wellbeing service offer is now available to cover the enhanced aspects of clinical care of patients newly arrived in the Country and who register with Wolverhampton GPs. This service is also aligned to the Wolverhampton Refugee and Migrant Centre (RMC).
- Public Health and Wellbeing contributes to the housing initiative 'Rent with Confidence' scheme. The scheme aims to transform the way the Council works with private sector landlords and tenants to ensure people have access to high quality, secure tenancies in the private sector. Public Health and Wellbeing also adds value by helping to shape this support it so that people who may find it hard to access for a range of different reasons and/or vulnerabilities also are enabled to participate and inequalities in access are not widened.
- Collaborative GP practice quality visits have been undertaken with the WCCG since October 2016. The Public Health and Wellbeing team are part of the review group and any relevant Public Health and Wellbeing service contracts are also quality assured at the time of the visit.

2.1.6 Personalised Support

- Care homes – we believe that there is an over-supply in the City and accessible at city border locations. *To be inserted*
- Domiciliary support – *to be inserted*

2.1.7 Workforce

- Ensure recruitment and retention to all posts, especially Social Work posts
- Support continuing professional development of all staff to meet current and future needs
- Work proactively through the *Careers into Care* partnership with the wider care sector to ensure sufficiency of supply of well qualified and skilled staff across all disciplines and sector serving Wolverhampton people

2.1.8 Quality – to ensure equality is part of the overall approach to quality

2.1.9 Co-production – we will strengthen our approach to co-production including better use of social media through:

- the recruitment of two Commissioning Support Officer posts in early 2017 to work with corporate colleagues and all stakeholders
- co-operating with new Council capacity to deliver stronger engagement

3.0 Commissioning and People Directorate Service areas

3.1 Commissioning for Public Health and Well-Being
3.2 Commissioning for Children and Young People
3.3 Commissioning for Adult Social Care

3.1 Commissioning for Public Health and Well-Being

The Public Health and Well-Being Service brings together a range of services including the statutory responsibilities of the Director of Public Health for the City of Wolverhampton.

Analysis – The wider JSNA described above (cf p XX) impacts on the Health and Well-Being service area. Some further, indicative items include:

- infant mortality rate of 6.4 per 1,000 (2012-14) one of the highest in E&W compared to 4.0 per 1,000 for England and Wales.

- statistically significant worse than average levels of obesity[5]:
  - In 15/16 the rate of obesity for children aged 4-5 years is 12.2% (Nat. Ave. in 14/15 was 12.3%)
  - In 15/16 the rate of obesity for children aged 10–11 years is 26.8% (Nat Ave 14/15 was 19.1%)

- Under 18 conceptions age 15-17 years (2014) is 29.6 per 1,000 - a 6% reduction in the 2013 reported rate of 31.5 per 1,000 and consistent reduction since 2007

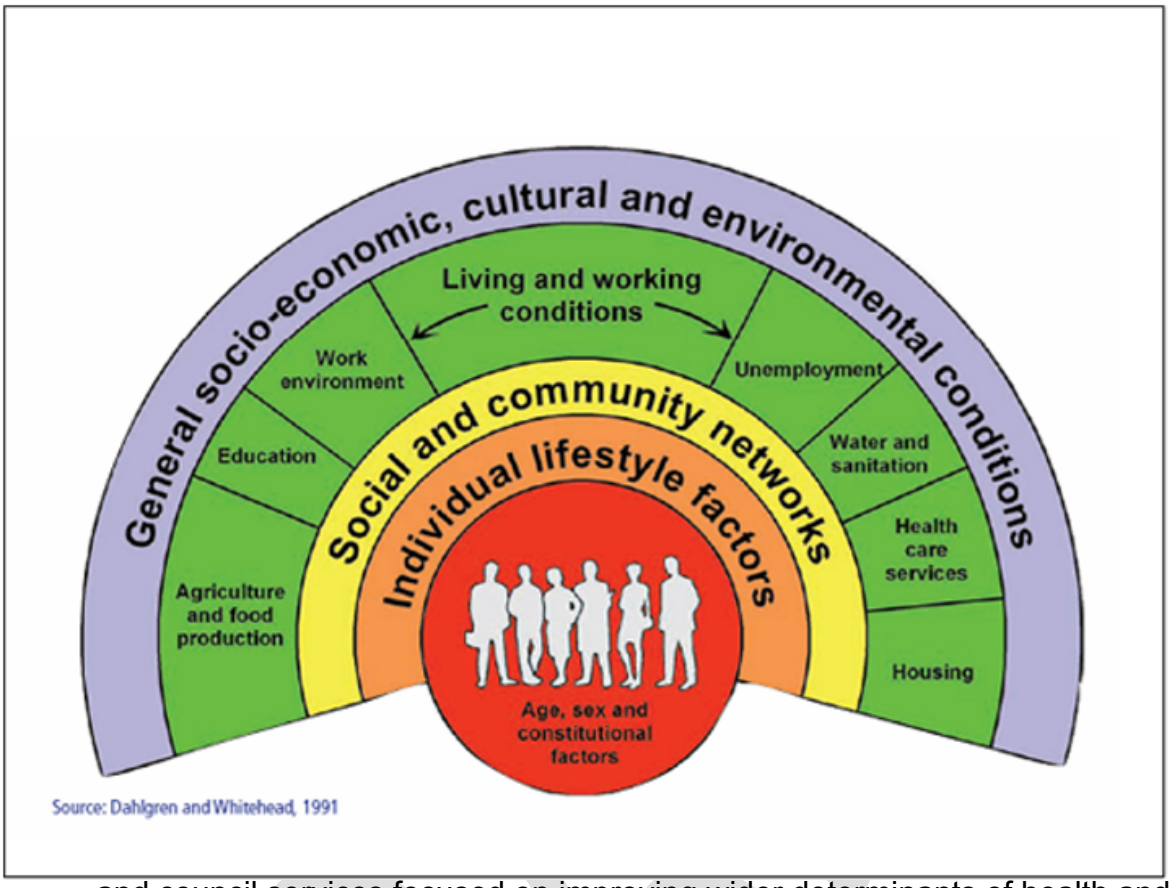
Plan and Do -

Using a whole-systems approach, we week to influence action across a range of factors in the life of individuals and communities through their whole life. This encompasses prevention, accommodation and employment to those more traditional lifestyle aspects such as smoking or weight as shown in the “rainbow” diagram below.

This approach supports our commitment to exploit synergies in the People Directorate and beyond to focus on vulnerable groups in more targeted ways through individual casework and whole-population interventions.
For the Public Health and Well Being Service, the focus for this over-arching Commissioning Strategy is on the influence which the service can bring to bear on a range of activities undertaken by the Council and its partners to help improve the health of the City population

The Service area has established principles of effective commissioning which are consistent with this over-arching strategy:

- alignment of services to meet need
- to achieve the best public health outcomes from public health interventions



and council services focused on improving wider determinants of health and reducing inequalities
- impact on the delivery of public health outcomes framework,

Moreover, for the Public Health and Well-Being Service, in commissioning the focus is on

- outcomes and evidence based practice supported by strong information and intelligence systems.
- joined up commissioning at a local level with the Wolverhampton CCG and other NHS services through the JSNA and health and wellbeing board
- a business model used in collaborative commissioning which integrates stakeholder consultation, citizen involvement and empowerment into commissioning process.

The vision for the Public Health and Well Being Service is to influence the whole Council, the NHS and other partners in transformation activity to bring about improved health and reducing inequalities.

Overall, people in Wolverhampton are living longer than ever before and the gap between life expectancy in the city and the national figure is closing. We know that socio-economic factors affect life expectancy. In Wolverhampton and similarly disadvantaged communities, the determinants of health such as skills, jobs and housing, are well below the national average.

Knowledge of the six conditions which account for over half of the difference in life expectancy that exists between Wolverhampton and England informs our overall

strategy. These are: heart disease, stroke, infant mortality, lung cancer, suicide and alcohol. This is seen disproportionally in the most disadvantaged communities. Deaths due to alcohol and those occurring in infancy are the major reasons why life expectancy has not improved.

Therefore, there will be a rigorous focus on public health and wellbeing strategic ambitions, local priorities and action to support people throughout their lives to ensure a preventive approach is embedded in the local system.

The established Public Health Commissioning, Procurement and Project Management process (overleaf) is consistent with the IPC approach adopted through this Strategy.

Fig 2.

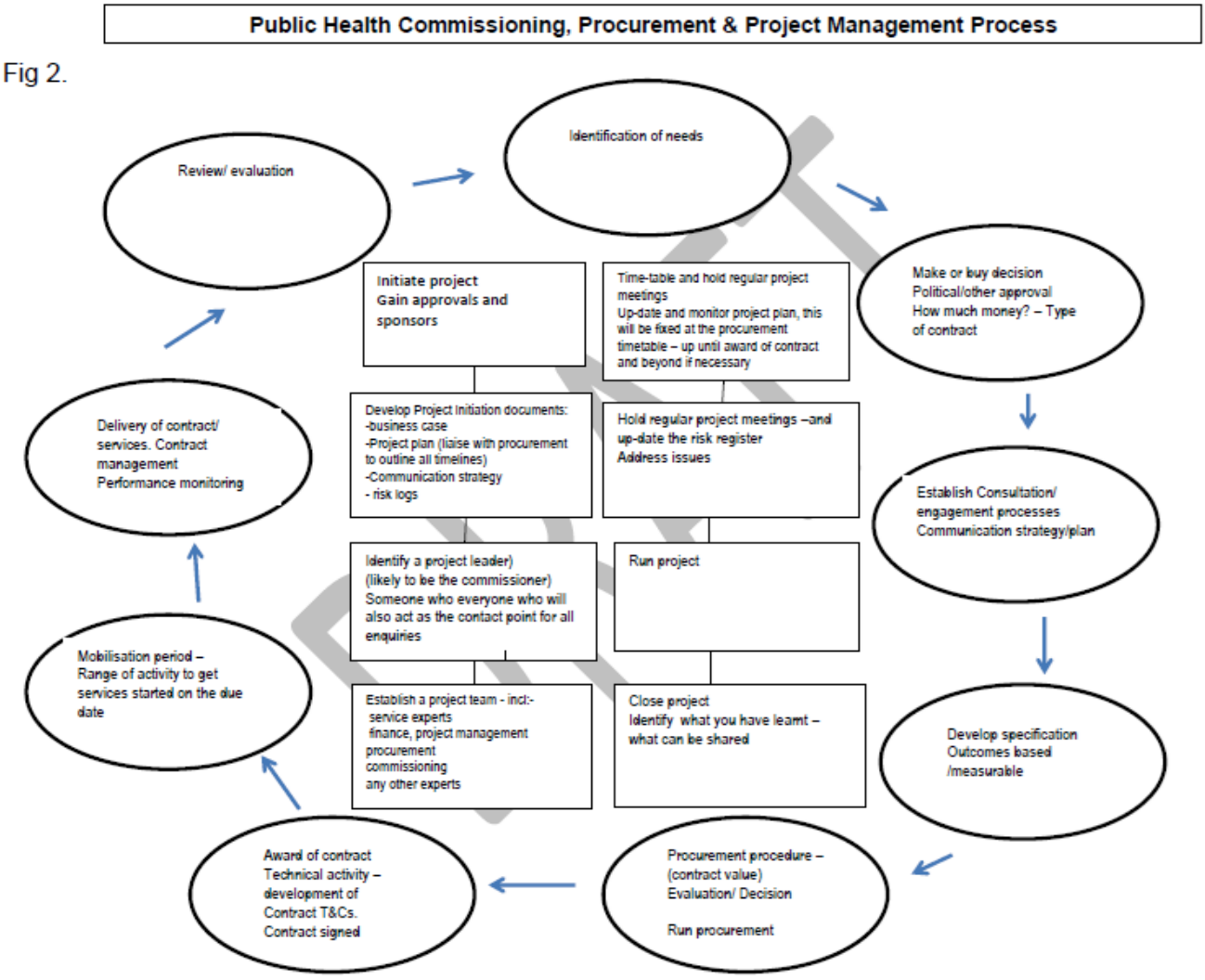


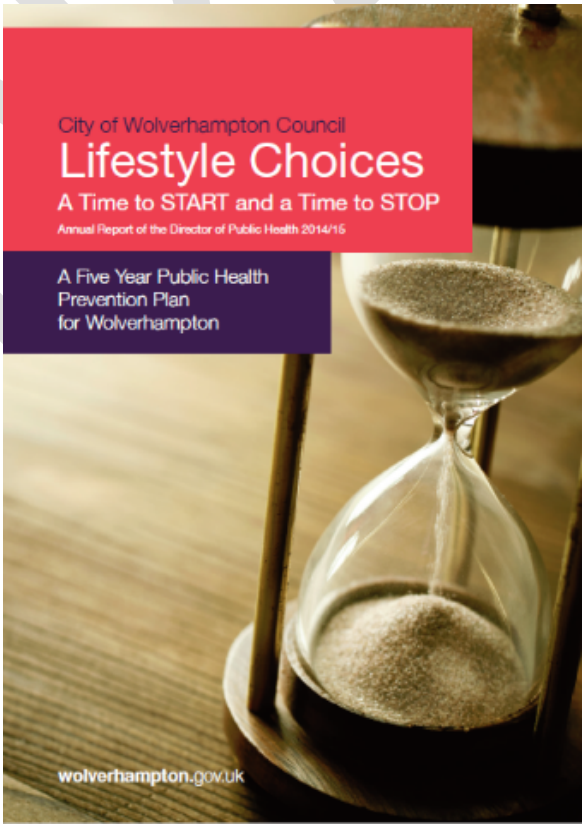
Figure X ***Public Health Commissioning, Procurement and Project Management process***

The first focus of our *Shaping Futures, Changing Lives* model is prevention (cf. 2014/15 Annual Report of the Director of Public Health – "*Lifestyle Choices"* – below right) is led by, amongst other contributions, continued public health focus on influencing the behaviour of the whole population as well as activity aimed at specific segments e.g. on smoking cessation, etc.

Priorities for public health and well-being up to 2019 are:

- *embed public health into local authority organisation and embed processes that will ensure public health outcomes are in the centre of improving the wider determinants of health.*
- *Focus contract monitoring and commissioning improvements on the services that perform significantly lower or worse than the England value as measured on the public health outcomes framework*
- *Continue securing quality and performance of legacy and new public health contracts*
- *To develop the future commissioning business plans for the big six priorities Healthy weight and keeping active, smoking, mental wellbeing, health inequalities and life expectancy, alcohol and substance misuse and sexual health*

A "Prevention Pledge" signed by the Health and Well Being Board in 2015 supports activity across all service areas to embrace a preventative, asset-based approach. To deliver its aims and transform activity through influence and direct delivery, the Public Health and Wellbeing portfolio has been assimilated into six core work streams covering the healthy child programme, health protection, drugs, alcohol and community safety, healthy lifestyles, sexual health and workforce.

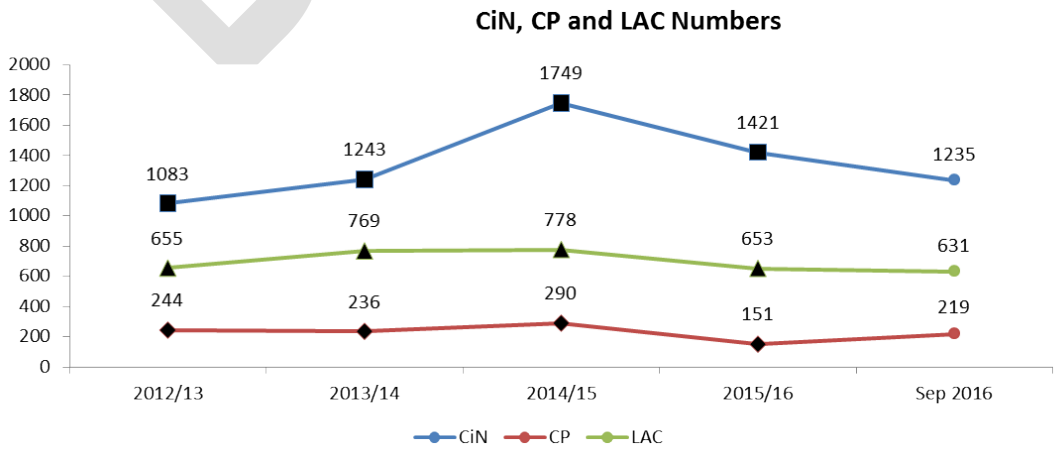


3.2 Commissioning for children and young people

Analysis – key facts on children and young people in the City of Wolverhampton include:

- 58,167 children and young people under the age of 18 years live in Wolverhampton – about 22.9% of the total population. 40,798 pupils on roll in 114 schools.
- Approximately 31.5% of Wolverhampton's children and young people (aged 0 – 17) are living in poverty [6]; this rises to 50% in 10 Lower Super Output Areas.
- Children and young people from BME groups account for 41.6% of all children living in the area compared with 21.5% in England. Approximately 42.7% of children aged 5-17 are from a BME group compared with 24% in England.
- 60 (53%) primary and secondary schools in Wolverhampton are in the most deprived quintile nationally as defined by Ofsted. The proportion of children and young people with English as an additional language: (a) Primary schools - 27.2% (Nat Avge 20.1%); and (b) Secondary schools - 22.5% (Nat Avge 15.7%)
- 6,935 pupils receive SEN provision of which 5,782 (83%) received SEN support, 972 (14%) received a SEN statement and 181 (2.6%) received an EHC plan in 2015/16. 851 children with SEN or EHC Plans have accessed social care services (04/15)
- In 2014, significantly higher prevalence of moderate (59.2 per 1,000) and severe (5.34 per 1,000) learning difficulties (England prevalence is 28.6 per 1,000 and 3.8 per 1,000 rsp.
- 1,030 children and young people in Wolverhampton with learning disabilities (04/15)
- 4668 referrals to childrens social care 19/15 - 09/16 – a 16.4% increase on the number received in 2015/16. Prior to 2015/16 the number of referrals had remained relatively static over the past four years fluctuating by just 4.5%. The increase in referrals coincides with the introduction of the MASH and will continue to be monitored.

- Adoptions have increased by almost 30% in 2012-2015 to 137 in comparison to 106 in 2011-2014. This is also an increase of 80% from 2010-2013 where just 76 adoptions occurred.
- 14% of the YOT caseload is looked after children
- Numbers of children in need, those on child protection plans and looked after children are as follows:



Planning and Doing – In response to the overall analysis, our overall service model starts with a focus on early help and prevention. We are ensuring families are strong, resilient and can create an environment in the home and community in which children and young people can flourish and be kept from harm.

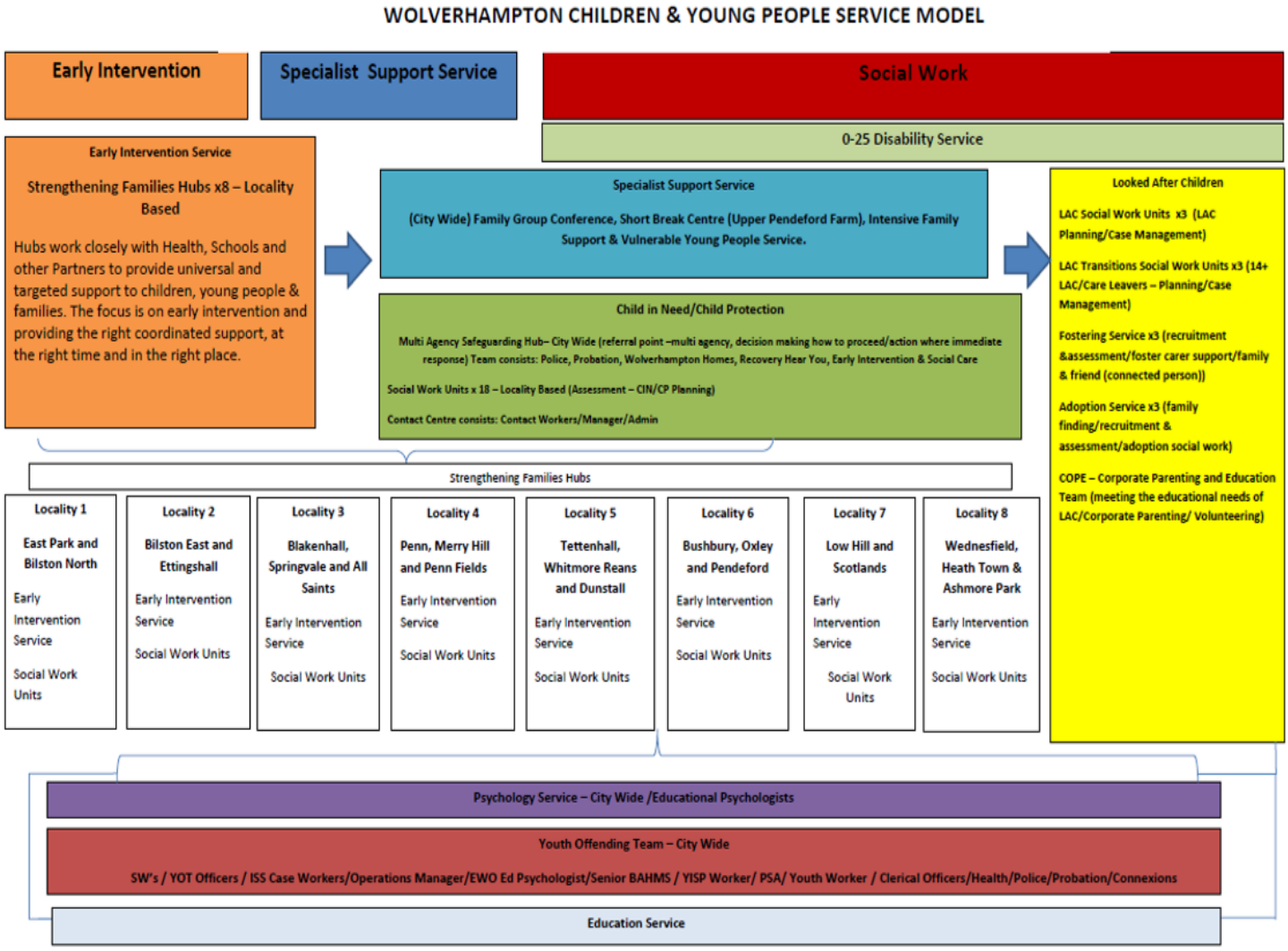


Fig XXX xxxx

The Children and Young People's Service area has been very focused on delivering the right outcomes at the right cost to ensure that we provide good value for money with our commissioning and contracting arrangements within our overall service model.

Our underpinning approach of restorative practice and our approach to thresholds (below,) is ensuring that preventative services are available to identify and support children and families early and reduce escalation into specialist support services.

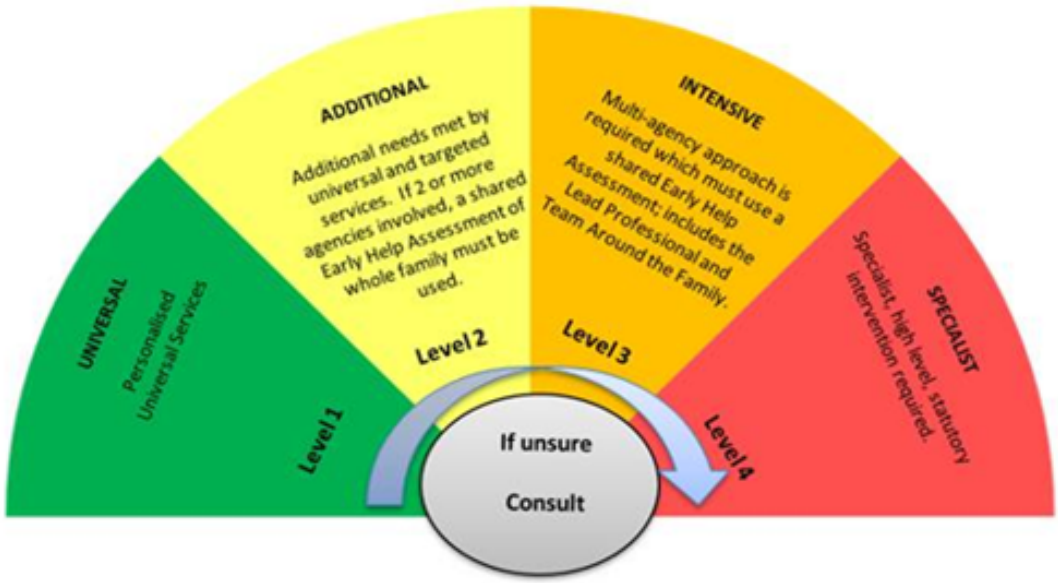


Fig XXXXX XXXXXXXXXXX

In seeking to balance Cost and Quality, a “paying for what we need and getting what we pay for” approach is adopted. Current specific initiatives include:

- A micro-commissioning framework for use by Family Support Workers in localities providing swift access to interventions as need arises
- project on residential and fostering placements for looked after children, we are improving market shaping, getting a better understanding of need and business intelligence. This enables improved matching and scrutiny of placements reducing unnecessary placement spend.
- Our overall Sufficiency Strategy is an outcomes based action plan covering the main themes of residential, fostering, edge of care etc.
- Regional and sub-regional framework agreements for residential and foster care have been reviewed and renewed and the sufficiency strategy implementation plan has recently been extended to include specialist support services.
- New services have been commissioned to support both prevention of admission to care, e.g.
    - establishment of a short break residential service,
    - to promote placement stability, e.g. the introduction of Safe Haven, which is a specialist intensive support service to work with young people
- planning for re-commissioning domestic violence service
- currently procuring a single provider of therapeutic support for the specialist support service.
- Analysis of the split between “internal” and “external” providers which varies across different service areas, for instance (September 2016 figures):
    - foster care placements ratio of 57.44% external, 42.56% internal
    - residential provision has been more evenly balanced over recent years but the review (and subsequent changes to “internal” provision means

that in future the proportion of external residential placements may well increase (albeit against a background of falling proportions of Looked After Children in this type of placement).

- New services have been put in place to prevent admissions to care including the establishment of a short break residential service.
- Possible use of an Outcomes Based Commissioning framework through Outcome based Tenders / changing relationship with partners
- Regional and sub-regional framework agreements for residential and foster care have been reviewed and renewed and the sufficiency strategy implementation plan has recently been extended to include specialist support services.
- Strengthen the capacity of Social Workers and other professionals working with families to ensure that they can access the right level and type of services at the right time

The Transforming Children Services programme (below) seeks to ensure that there is a whole system approach. Service re-configurations are key ways in which we seek to make the commissioning continuum better for children, young people and families more efficient

- the establishment of the Multi-Agency Safeguarding Hub (MASH) for children and young people in January 2016,
- re-design of Early Intervention to support commissioning including use of locality budget.
- the Specialist Support Service supported by the therapeutic commissioning framework

We are using an integrated locality approach with staff deployed across 8 localities, co-located in multi-disciplinary teams - social care, early intervention, police and health. This provides the environment for effective joint case management across social care and early intervention and enables more effective application of “step-up/down” processes Successful delivery of the children’s transformation programme is underpinned by a stable and skilled workforce together with robust commissioning arrangements.

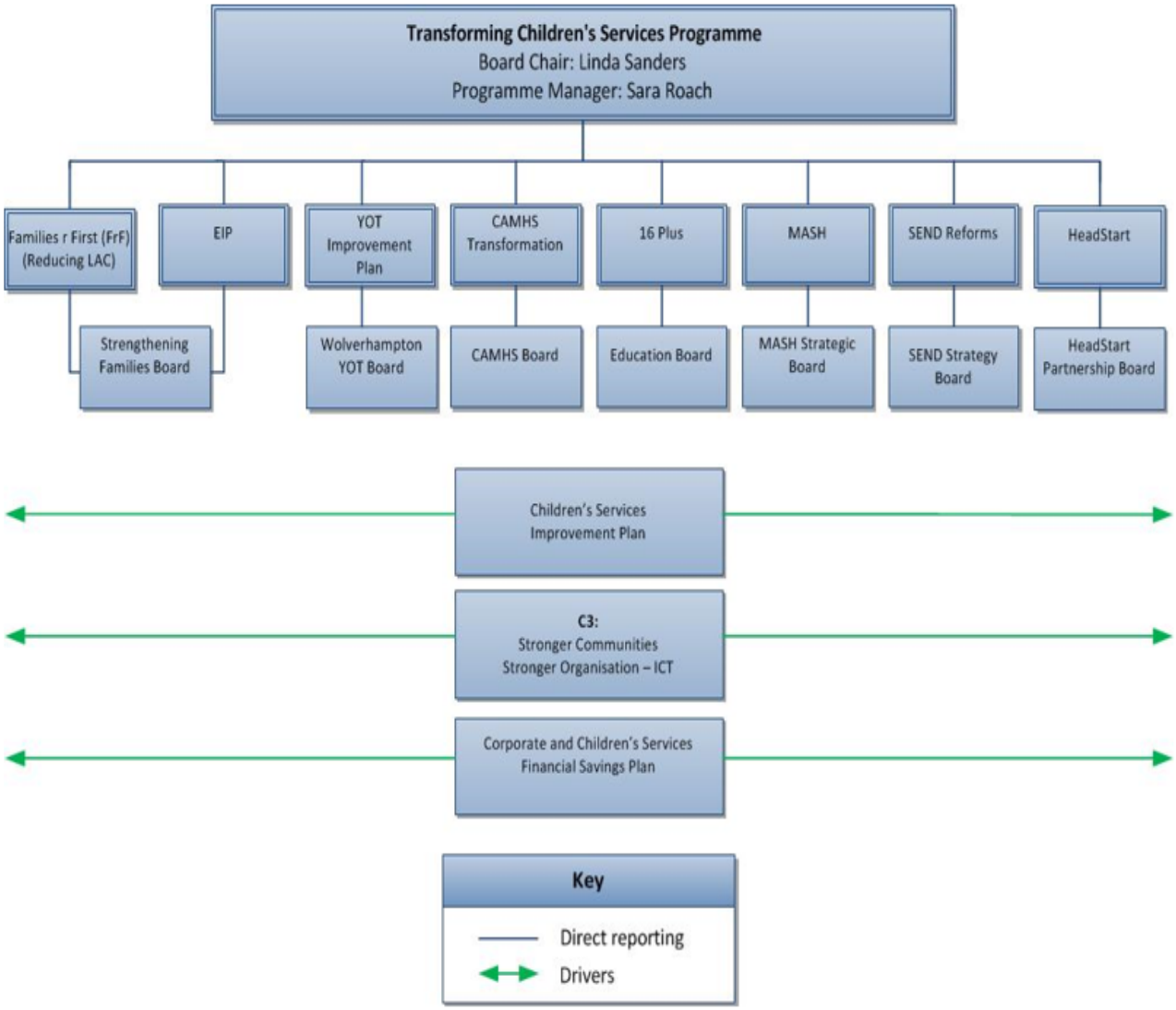


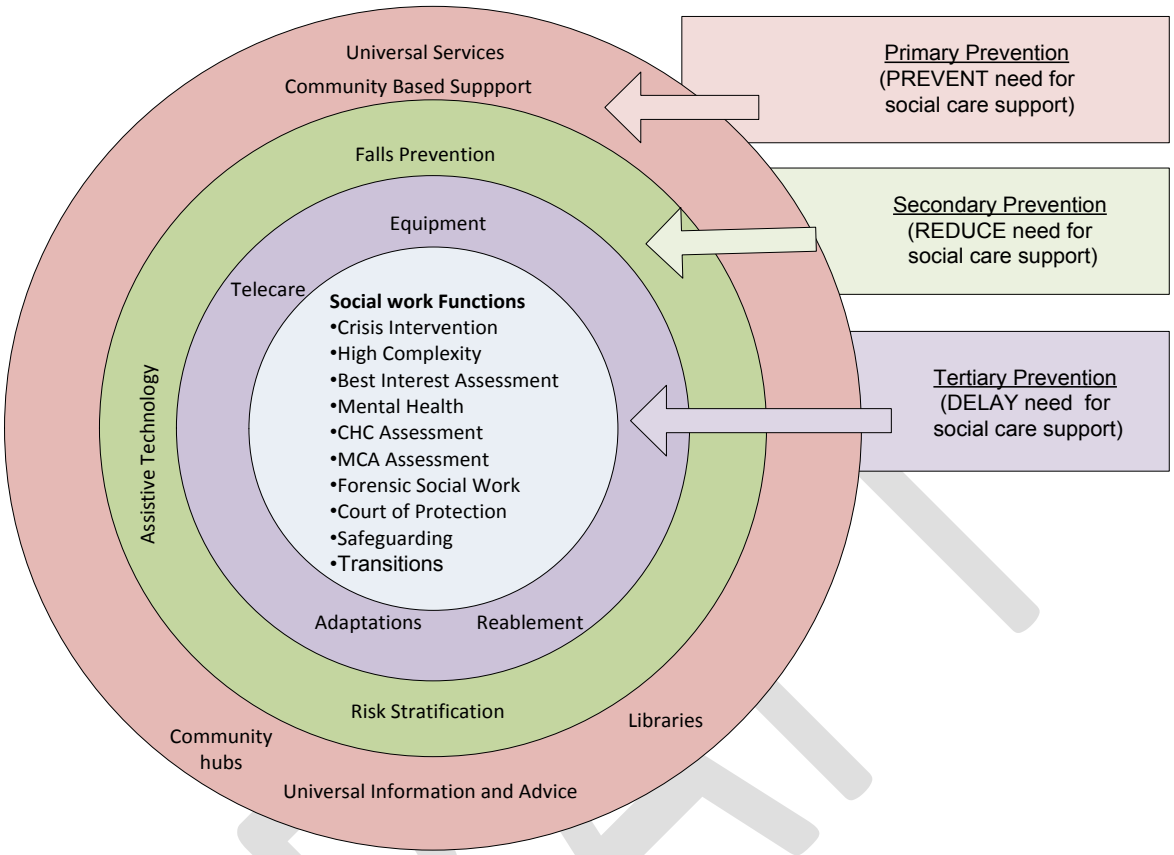
Fig XX - XXXXXXXXXXXXXXX

3.3 Commissioning for adult social care

Analysis: – key facts on adults in the City of Wolverhampton include:

- The numbers of older people in the City Wolverhampton are projected to rise from 41,400 in 2012 to 59,900 in 2037, a net gain of 18,500 people, or 44.7% growth
- Over 27,136 people in the City of Wolverhampton identified themselves in the 2011 Census as "Carers" who provide unpaid care in the locality
- 3,100 living with dementia
- 850 working age adults with moderate to severe learning disability
- 5.2% have a long-term mental health problem
- 60% of people with a disability living in Wolverhampton are over the age of 60
- Nearly 10,000 City of Wolverhampton citizens have their ability to be more economically active promoted through their eligibility for the Disabled (Blue) Badge Scheme
- Estimated 500 "self-funders"
- 2,895 people in the City of Wolverhampton have Personal Budgets paid directly to service providers for their social care.
- 644 Personal Budgets taken as Direct Payments in the City who may be buying in micro-enterprises to provide a service
- About 800 people living in care homes supported by the Council

Plan and Do - a target operating model [7] for adult social care based on LGA approaches including *Commissioning for Better Outcomes* was agreed by the Council's Cabinet based on a prevention approach at their meeting of 15 April 2015 as follows:



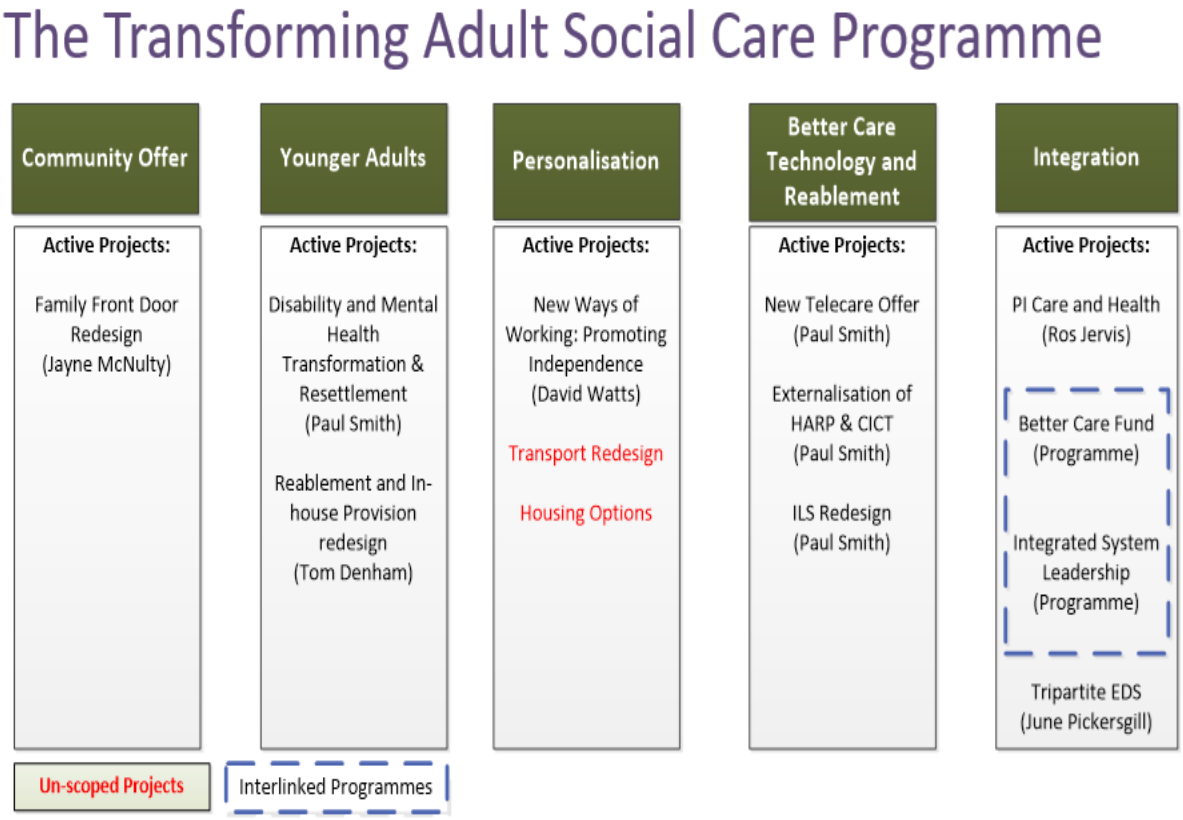
This model informs and shapes our approach to commissioning for adults. Some key features of the "*Promoting Independence*" model informing our commitment to personalisation and commissioning encompasses duties for Councils to:

- promote the well-being of individuals
- provide a range of preventative services
- provide adults and carers with information about care and support
- ensure that the eligible needs of self-funders are met
- integrate services with the NHS

The model for adults starts with the positive principle that public services should support the individual citizen and communities in the responsibility which they have for their own lives, using individual strengths and assets as well as those of the wider community. Mental capacity and safeguarding concerns are always paramount.

The model requires on-going change to be led in the organisation and the wider community. For instance, change is required to recognise that the role of adult social care has been changing from assessing and delivering services to one which supports individuals to meet their own outcomes, often without the need for publicly procured service provision using community-based solutions. This has been a move away from assessment and care management to engaging in partnership roles with individuals, families and carers so as to best 'promote independence.'

A Community Offer is being developed ranging from the provision of information through the Wolverhampton Information Network (WIN), community-based services. A wide-ranging Transformation programme is in place with a range of workstreams as follows



Close work with the NHS in both commissioning and provision is key to adult social care as more integrated approaches are developed. The Adult Social Care Transformation Programme incorporates the programme to develop the community-based approach.

The opportunities for people in the City are:

- continued focus on assets, reablement and recovery, supporting people at home will lead to a reduction in people using Care Homes and long term care;
- supporting the Promoting Independence agenda will result in reduction in dependency on care and support services;
- ensuring a sustainable provider market and avoiding market failure; [8]
- encouraging providers to focus on quality and so help retain care workers
- having an integrated commissioning approach will ensure resources are used effectively and will reduce or eliminate duplication of redesigns/provision
- service design linked to 'need and outcome' rather than age specific
- leading culture change in our own and partner's services

A continued shift to a clearer "community offer" is being made and further analysis as a basis for the next stage of planning and action has been made during 2016/17 by *"impower"* to support the next stages of transformation.

4 Commissioning contexts

4.1 Commissioning and the corporate context

Our People Services Commissioning Strategy is established within our overall local Democratic commitment – commissioning for and with people in the City of Wolverhampton represented by their Elected Members.

The voice and leadership of Elected Members provides overall direction for this strategy as part of the Council's 2030 Vision.

The City of Wolverhampton "one-Council" approach provides a supportive and enabling corporate framework through which our People Services strategy is delivered.

In taking its lead from the Council's 2030 Vision, success will be based on collaboration across the city and beyond, using an approach which recognises that we are far more effective when we pool our resources, ideas and work together.

The Council's strategic approach to address its challenges is to:

- Manage demand for core services by using early intervention to help families and individuals of all ages to live unsupported, safe, independent lives;
- Improving educational attainment and skills;
- Work together to make sure that every child in their early years has the opportunity to be the best they can be
- Encouraging enterprise and business, and private sector employment; and
- Stimulating economic activity through capital investment;

People Services contributed to shaping the priorities of the Corporate Plan (HYPERLINK) in collaboration with the Corporate Procurement function which include:-

- **Promoting and enabling healthy lifestyles -** Tackling lifestyle issues will improve quality of life, reduce the time spent with illness and have a positive effect on life expectancy in the city.

- **Promoting independence for older people -** Older people in the city are able to live full and active lives, with support where necessary to promote independence and choice.

- **Strengthening families where children are at risk -** Targeting effective early help and support will strengthen families, keep children and young people safe and improve their life chances.

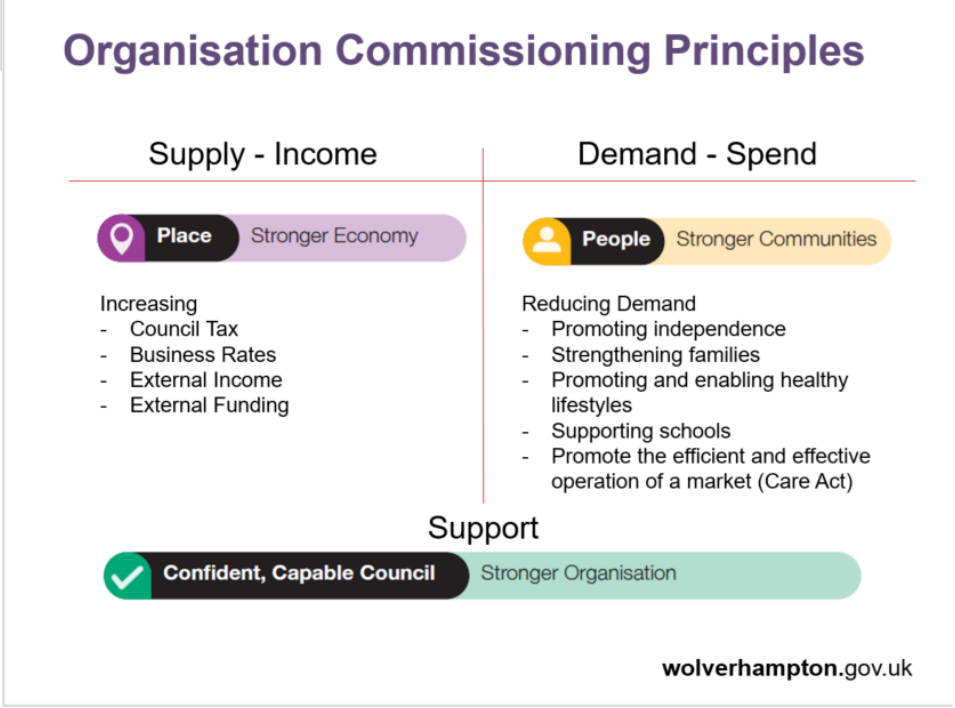
- **Enabling communities to support themselves -** Supporting communities to develop local support will build resilience in the city.

- **Keeping the City Safe -** A safe city creates a stable economic climate and a vibrant night time economy which improves the experience of residents, workers and visitors

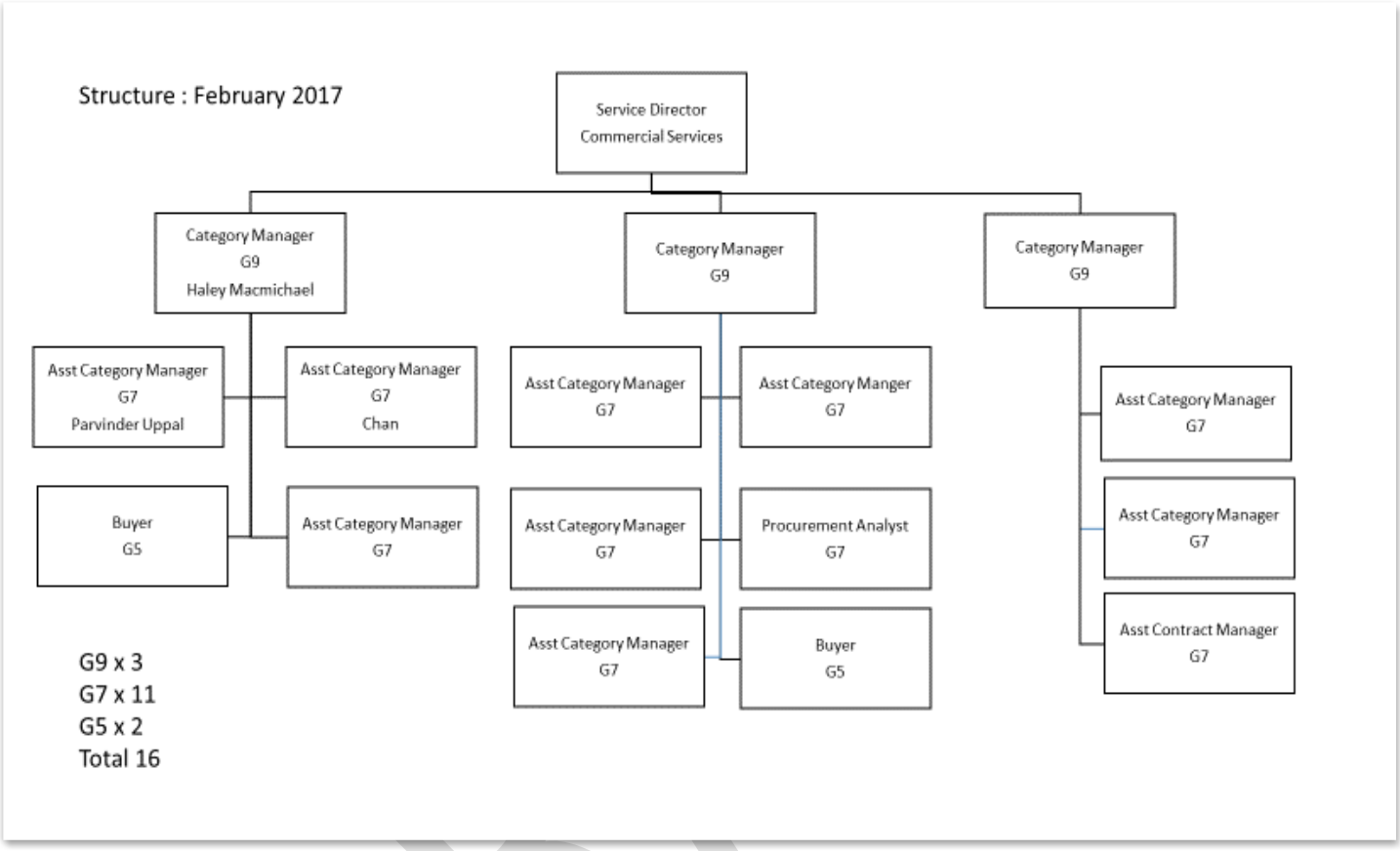
- **Challenging and supporting schools to provide the best education -** Raising expectations, securing swift school improvement and ensuring sufficient school places and resources to support children's learning is essential to providing the best education for our young people.

- **Adults and children are supported in times of need -** Safeguarding people in vulnerable situations; and Strengthening families where children are at risk

4.2 **Corporate Procurement links** - In this context, People Services strategy as part of the Council drives the process adopted for procurement. People Services work closely with corporate procurement colleagues and a **Corporate Procurement Plan 2015-2018** (HYPERLINK) sets the framework which is in turn driven by the commissioning strategy. The Public Services (Social Value) Act 2012 and the Public Contracts Regulations [9] provide a significant element of the framework. The organization commissioning principles (below) apply for the People Directorate as part of one Council. Other strategies and principles which affect People Directorate practice at this time - such as integration between care and health and the context of the family and community offers of children's and adult services - all provide added context for service-specific development as outlined later in this document. People Services and corporate procurement are using the opportunity of developing this strategy to work more closely together on specific issues e.g. contract management and engagement with citizens, providers and staff.

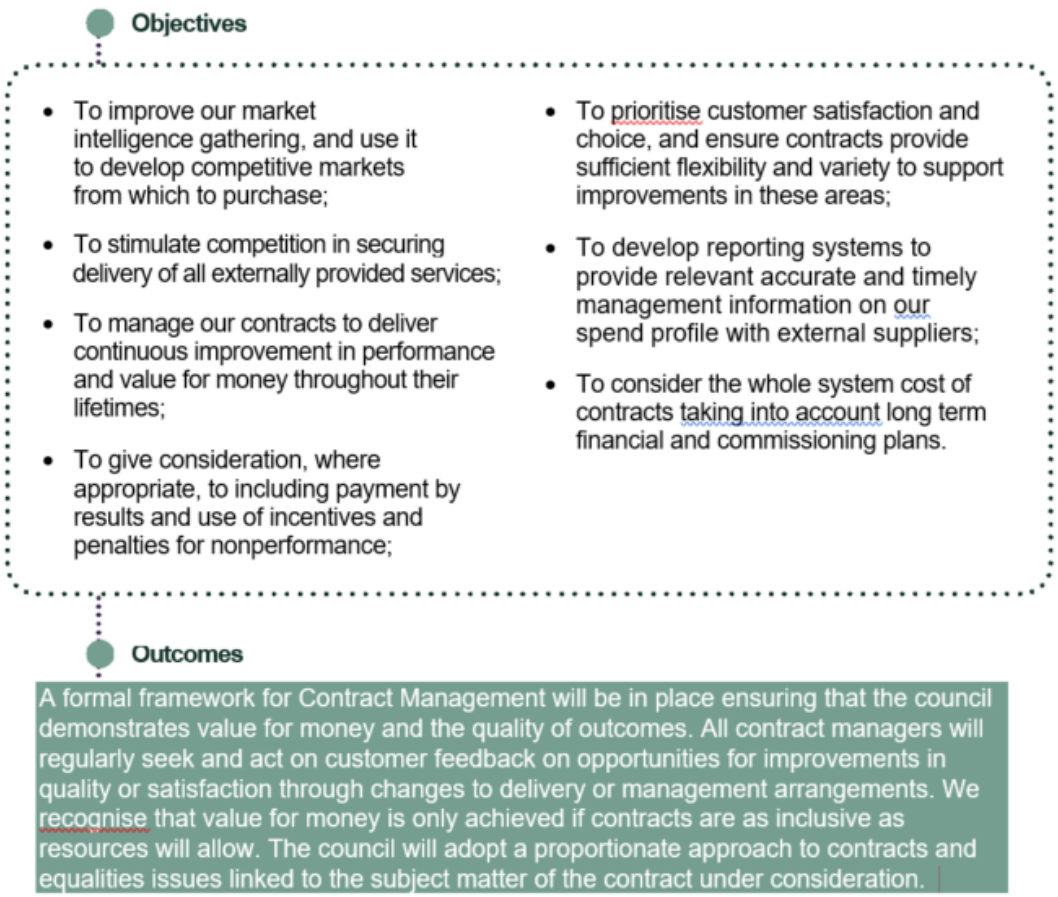


The structure of the corporate procurement team and the new People Services Commissioning structure (see below p x) are the practical arrangements for closer working.



4.3 Commissioning and value for money

The City of Wolverhampton's Corporate Procurement Plan states that "*Achieving value for money and being able to demonstrate it are essential as the resources we have must be used in the most effective manner to provide high quality services*." It includes a set of objectives / outcome through which we work as follows:



Our commissioning intentions (see Section xx) include actions to address current known challenges across our service areas in terms of value for money.

4.4 Evidence-based commissioning

Knowing our challenges is key to our success. Great leadership and management is being self-aware and knowing what our challenges are. For that we use evidence and colleagues work closely across a range of activity to make this happen including:

- *Public health and wellbeing* – provide whole population needs analysis and assessment. This analysis and assessment supports improvement in evidence-based commissioning and co-ordination of activity for our whole family and prevention focus.

- *Business Intelligence* – the provision of dashboards, performance reports and information governance / freedom of information advice are all key areas in which co-working on a range of commissioning issues is required

- *Finance Services* - our work on value-for-money is supported by the business partner model of the City which allows colleagues to work together on areas of shared interest. Finance analysis and support is used for all commissioning projects. The stated commissioning intentions (section xx) use financial data so that commissioning plans are rooted in available resources as part of our commitment to our values and principles.

- *Corporate procurement team* – using frameworks and processes as outlined above promotes evidence based commissioning through the procurement element of the commissioning cycle (see section xx) .

- *Workforce* – ensuring all practitioners are skilled and have access to good evidence. This also encompasses the role and contribution of the Principal Social Worker. (see p xx on engagement)

4.5 Commissioning and the legislative context

Amongst the law relevant to the development of our People Directorate Commissioning Strategy are:

- The Health and Social Care Act 2012 section 192 (amending the Local Government and Public Involvement in Health Act 2007 section 116 (as amended by the Act – section 192) require a "responsible local authority" and each of its partner CCGs to prepare Joint Strategic Needs Assessment and Joint Health and Well Being Strategies; and section 116A (as inserted by the Act – section 193); Section 196 provides that these functions are to be exercised by the health and wellbeing board established by the local authority.

- The Care Act 2014 –
  - Section 3 establishes legal basis of integration of care and support with health services
  - Section 53ff. establishes requirements relating to market oversight

- Children's Act 1990 Section 22G creates a statutory requirement for a Sufficiency Strategy for accommodation of children looked after by the council under which is an important part of the commissioning

- Children and Families Act 2014 introduced new requirements including
  - those on adoption, special educational needs or disabilities
  - statutory requirements on Integration with health and joint commissioning with health partners (Sections 25-26)

- Health and Social Care Act 20XX INSERT PHWB items c/o RJ

- Public Contracts Regulations 2015 [10] updated the context for procurement for Councils

- Public Services (Social Value) Act 2012 requires public authorities to have regard to economic, social and environmental well-being in connection with public services contracts and connected purposes

- The Transfer of Undertakings (Protection of Employment) (or "TUPE") Regulations 2006 [11] as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014" for business transfers and service provision transfers.

4.6 Commissioning and the community context

In March 2016, the Council approved the City of Wolverhampton Charter with other partners working in the City.[12] This confirmed our joint approach to procurement and commissioning.

This aimed to help "increase the levels of local expenditure with local businesses and other local agencies and to increase the impact of public expenditure on the Wolverhampton City Strategy priorities to increase local jobs, increase economic activity and employment, reduce child poverty and health inequalities."

The City of Wolverhampton Charter

The Charter establishes five principles that will underpin the commissioning and procurement activities of key partners in the City. These are set out below along with the measures to be used annually by the City Board to monitor progress. The City Board have committed to using their commissioning and procurement processes to:

Develop and grow a skilled workforce through: *Creating employment and training opportunities for local residents including supporting people into work and providing work experience placements; mentoring and supporting personal development and, where appropriate incorporating provision within contracts to offer training and employment opportunities for local people*

Encourage healthy lifestyles and independence by: *Encouraging the adoption of workplace health initiatives which keep people in work, reduce sickness and also create a workplace that is more conducive to good health. Promoting active travel such as walking, cycling and public transport use*

Support more people to be active within their communities by: *Building the capacity of local voluntary and community organisations and schools through the provision of resources and expertise in areas with the greatest need e.g. mentoring and the provision of meeting facilities etc.*

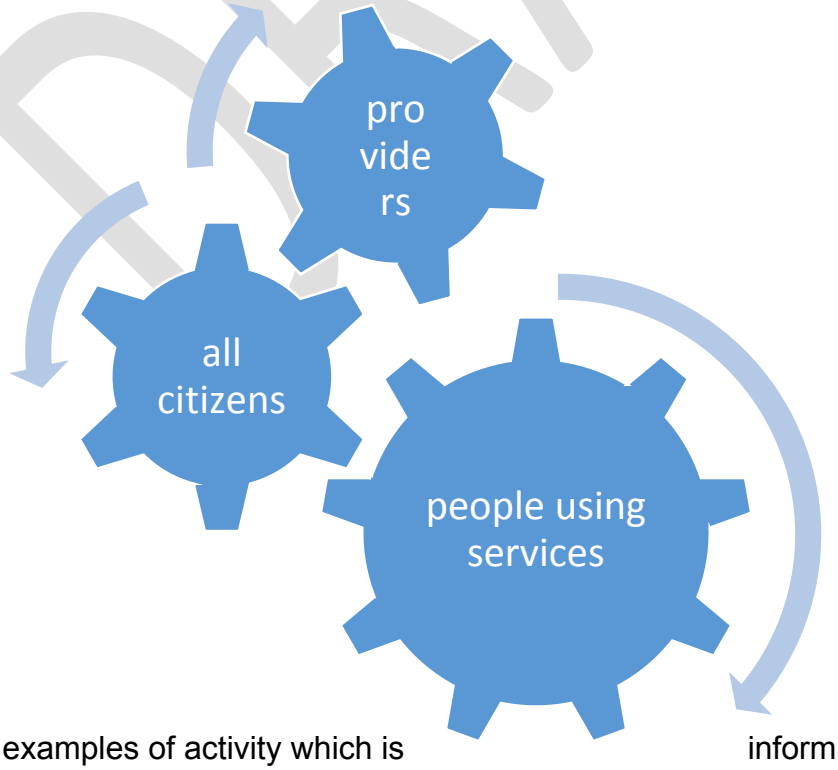
Support business to develop and grow by**:** *Having a preference to buy locally on the condition that a suitable supplier exists and that this provides value for money.*

Support the reduction to the carbon footprint and eliminate unnecessary waste by: *Specifying good and services on the basis of whole life costing and which minimise the use of resources and the creation of pollution and greenhouse gases*

4.7 Commissioning, engagement and co-production

Engagement with citizens, providers and staff are recognised as key activity in the JSNA, market shaping and subsequent commissioning so that current needs are understood, changing needs identified, and problems responded to.

To take previous achievements forward into the next stage of development and building on best practice, the City of Wolverhampton agreed a new focus to engagement and co-production in December 2016. This will be an important contributor to the success of our Commissioning Strategy.



Some examples of activity which is informing our developing commissioning strategies across a range of groups include:

ELECTED MEMBERS – the Council's Cabinet sets direction for policy. Local democracy process ensures decisions are made through relevant Committee or Decision by Cabinet Members for People Directorate Service Areas

PEOPLE USING SERVICES & CARERS / Citizens – Forums used to maintain dialogue with specific groups include (*1) Corporate Parenting group; (2) Over 55's Forum; etc.*

Specific strategies in which engagement undertaken are:

- Consultation on the draft Joint Autism Strategy 2016 – 2021 07/06/16 – 30/08/16 **130 engaged**
- Joint All Age Carer Strategy 2016 – 2020 Exec Summary *identified themes to shape strategy*
- Consultation - proposed new service model/ options for Community Based Preventative Mental Health Services 05/05/16 – 28/07/16 - Shaped the model. **419 engaged**
- Wolverhampton Children and Young People's Health Related Behaviour Survey 2016 HRBS 2016 was completed by a total of **7930 pupils**
- Consultation on proposed options for the future for Recovery House 11/15 – 02/16 - **90 people engaged**
- Proposals: Regarding Services for People at Risk of Violence and Abuse 11/08/16 – 03/11/16 **75 engaged** in shaping proposals
- Redesigning Day Opportunities Review 11/15 – 03/16 **92 engaged**
- Special Educational Needs 09/12/15– 14/02/16 Strategy amended as a result of consultation

Planned events:
Transition Board Events 2017
Early Years Strategy Consultation Plan Jan-Apr 2017

Staff – dialogue maintained by:

- Supervision & line management
- Service Area Events e.g. Childrens Services
- Directorate Events (800 attendees 11/16)

CARE PROVIDERS

Routine meetings bring care providers and commissioners together to maintain dialogue on issues of mutual interest.

"Foster Talk" – nearly 500 contacts

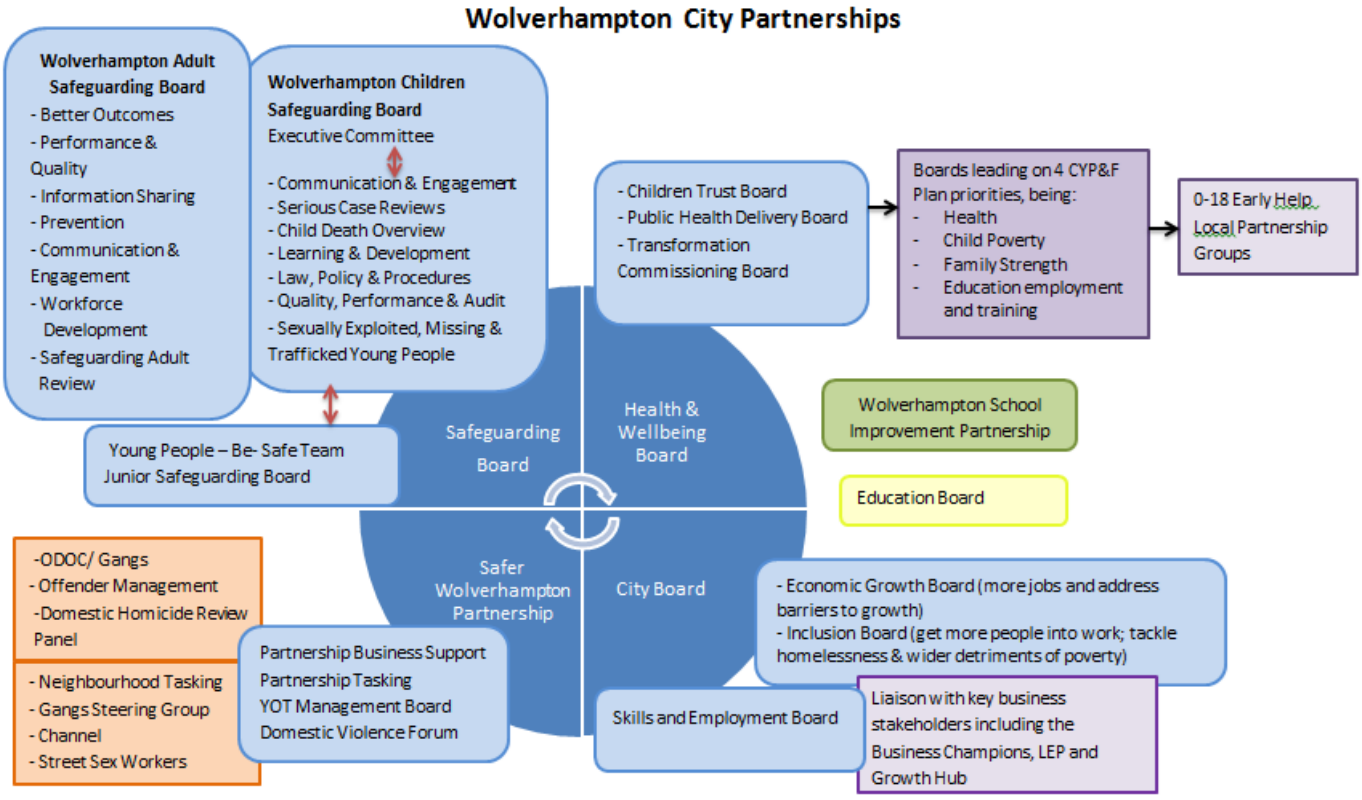
The role and wider contribution of the voluntary and community sector in relation to engagement and consultation is valued especially the offering of Healthwatch

Wolverhampton. Collectively, they generate their own contribution to our knowledge for analysis of the City.

Two Commissioning Support Officers are being recruited in early 2017 to develop the wider co-production process including use of social media to ensure increased consumer-driven responsiveness in the commissioning process

4.8 Commissioning, partnerships and integration

The need and importance of local democratic leadership is reflected in many ways in the City of Wolverhampton e.g. through the Council's Leader chairing the Health and Well-Being Board. This shows how the Council is committed to act as a good partner to ensure that the Council represents the best interests of the citizens in the City of Wolverhampton in a variety of ways.



The overall partnership environment shown above is the current way in which the Council acts in partnership with colleagues to ensure vulnerable people are kept safe and positive outcomes are achieved.

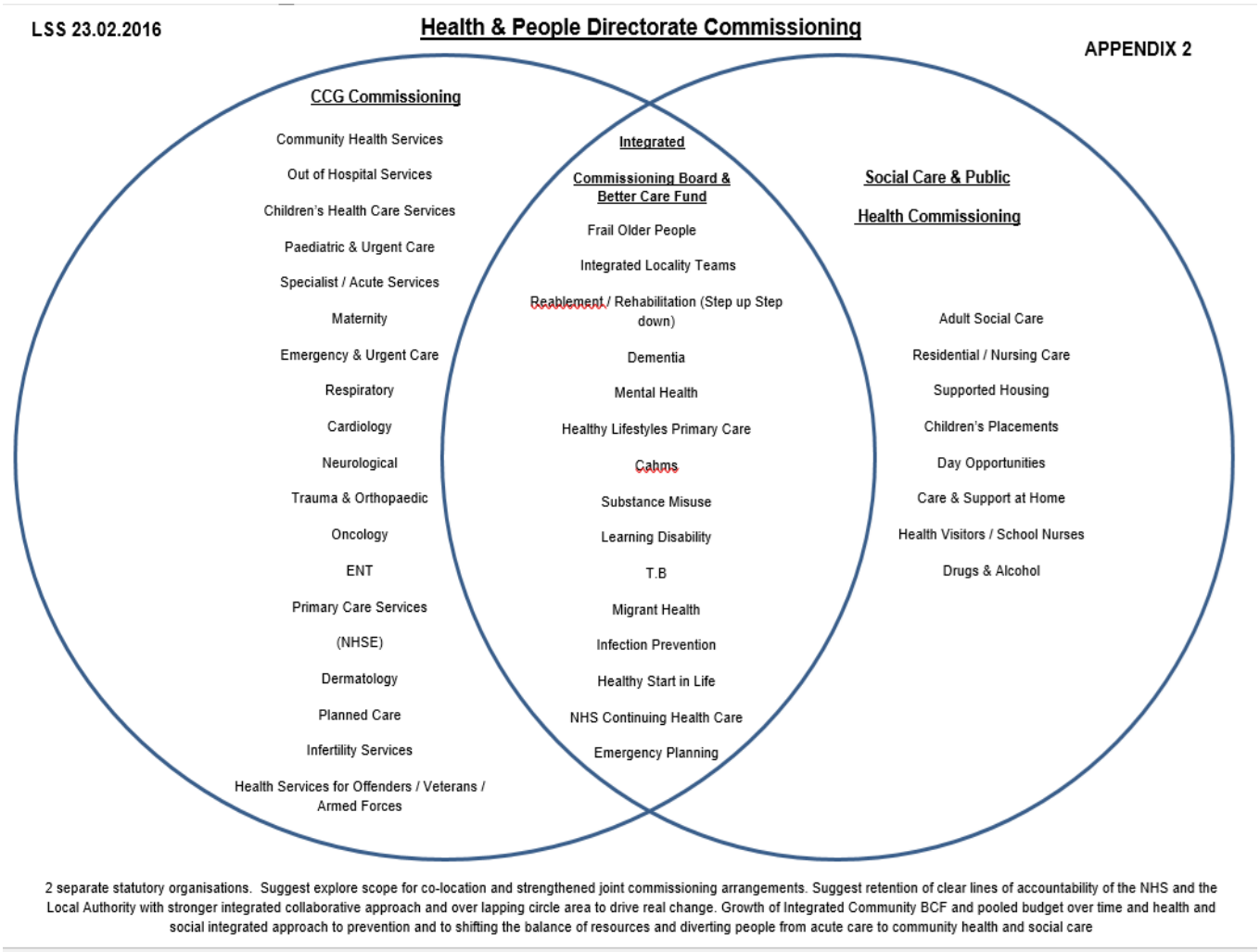


Figure XX

In order to ensure that local people benefit from closer integration of health and care commissioning and services, the Council has proposed the approach outlined in Fig XX above. This has been developed through the successful experience of the Better Care Fund arrangements in the period leading up to the launch of this Commissioning Strategy. It reflects an understanding where one partner is best placed for leadership on designated activity or for commissioning on a single agency basis. The model assumes the benefit of pooling activity and interest where it is agreed that such pooling is required. This may result in the use of a Section 75 Agreement or other agreed approach e.g. budgets for the Better Care Fund or children with disabilities [CHECK]

It is also important to note that XX% (CHECK) of the activity of public health and well-being services is dedicated to supporting NHS commissioning. This reality supports all activity in which the Council exercises its statutory responsibility to improve the health of the local population and the CCG's statutory responsibilities for the quality of health services. This links to clinical governance responsibilities.

In this context, People Services have worked closely with Wolverhampton CCG to define a person-centred model of delivery represented below. This reflects our

shared view that community assets best support many people in the first instance. It supports our vision that expensive public sector resources are best provided within an overall asset-based, preventative approach. Given a preventative approach, people should then be able to access services easily to step-up or step-down with or without support.

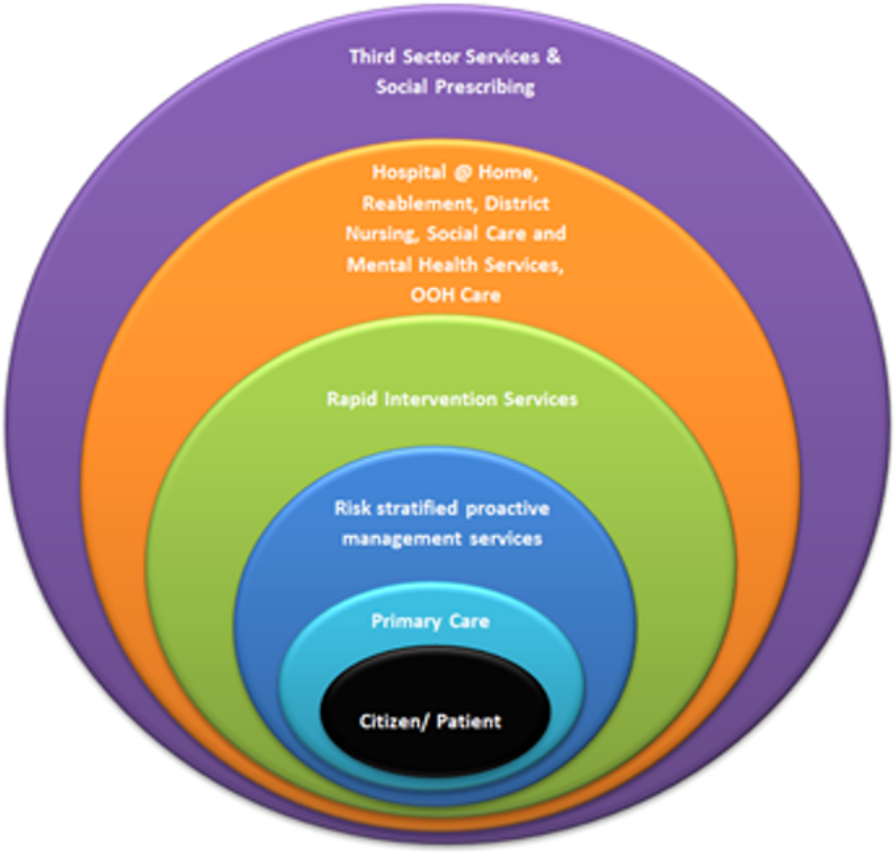


Fig XXXX XXXXX

A locality-focus is a key part of the model. During 2016, based on the achievements of our Better Care Fund approach, a series of Workshops resulted in the formation of a Transitions Board to oversee a range of work programmes to support overall integration. Work clarifying how geography and estates will be best used is underway.

4.9 Commissioning and workforce context

This strategy takes the view that commissioning is "everybody's responsibility." However, what is required of staff will be different according to their role. 1369 people work within the People Directorate. Types of role occupied by staff include leadership and management; social work; direct care provision; family support; and administration. Everyone's contribution makes a difference to efficient use of our resources in supporting people and communities to use their own strengths and ensure council contribution is efficiently allocated based on local priorities, values and statutory requirements.

Our overall commissioning approach needs a well-skilled workforce for all people working in the wider sector. In 2016, the Council undertook work under the heading of "*Care and the Economy."* [13] This showed the economic contribution of the workforce within and connected to the People Services as part of the Council's overall contribution to regeneration strategies. This found that: [14]

- there are 8,190 businesses in the City
- 80% of these businesses are "micro" i.e. with 1-9 employees
- There are about 110,00 jobs in the City with approximately 16,300 of jobs in the care and health sector
- Between 1996 - 2006, there was a 120% growth in "health and social work" reflecting changing patterns of commissioning and greater diversification in the social care sector
- There are about 6,500 jobs in the adult social care sector in Wolverhampton where there are about 1500 vacancies (2016)
- the wider children's workforce who are strengthening families (in childrens centre, school class; nursery; pre-school playgroups; childminders; etc.) nationally amount to 350,000 in that sector (08/09.)

Social Work recruitment and retention is a key activity so that the continuum of commissioning is effective. Social Workers work at the cross-section of preventative and asset based work with individuals as well as commissioning specialist, targeted services. A Social Work Development Group (CHECK – LINK?) oversees recruitment and retention strategies and activity. A Principal Social Worker role has been established to support wider practice quality improvement. The wider strategic commissioning framework needs to be supportive and responsive in this context as part of a mutual responsibility for excellence in practice.

A partnership between the People and Place Directorate with local care and training providers has established a "*Careers Into Care*" initiative in 2016/ 17 to support recruitment into the wider adult care workforce. Our Commissioning Strategy will add force to leadership on this important activity and will also use national tools. [15]

4.10 Commissioning – quality and clinical governance context

An updated People Services Quality Strategy is giving renewed focus to quality. [INSERT LINK]

That Strategy embraces the positive approach to quality adopted in the City of Wolverhampton as well as the requirements of external regulators and inspectors such as the Care Quality Commission (CQC) and OFSTED or the role of Public Health England (PHE.)

For children's services – (NB THEME LINK) Quality Assurance and Compliance officers work in partnership with providers and stakeholders to ensure agreed outcomes are being delivered. Levels of risk and quality of provision in care and support services for children and adults purchased by the council are monitored with the aim of:

- monitoring the quality and compliance of care services in accordance with agreed strategies, priorities and systems;
- inform commissioners and stakeholders of issues relating to services and make recommendations for improvement;
- advise and support services to enable them to achieve required levels of quality.

For adult social care services, likewise, there is a commitment to quality services and support through the responsibility of the DASS for the wider workforce and therefore, the quality of provision.

At the strategic and monitoring level, we work with partners in the CQC and CCG to monitor quality of provision in care home and domiciliary care environments.

For public health and wellbeing, the council's overall involvement and contribution to **clinical governance** is a key issue. The link between NHS services and the role of public health and well-being is a vital connection in the local arrangements for integration.

- Collaborative GP practice quality visits have been undertaken with Wolverhampton CCG since October 2016.
- The Public Health and Wellbeing team are part of the review group and any relevant Public Health and Wellbeing service contracts are also quality assured at the time of the visit

We use wider partnerships to maintain quality and appropriate sharing of information such as in our routine liaison with the Care Quality Commission.

Likewise, the quality of the **workforce** in the Directorate and beyond is supported by our internal Quality Assurance Framework, routine liaison with partners such as the CQC and our "Careers into Care" partnerships through which we are promoting values-based recruitment cf. Section XX above.

The Directorate Equalities Group lead equalities work which feeds to commissioning processes as required in terms of analysis or action.

5.0 Commissioning Unit

5.0 Commissioning Unit

5.1 Commissioning Unit - functional design

A £2 million budget is allocated to the Commissioning Unit to develop and maintain the overall strategic framework for the People Directorate.

Embracing the opportunities offered by a thematic approach and responding to other drivers such as the recommendation of the March 2016 Adult Services Peer Review, the Commissioning Unit has been re-organised on a thematic basis (see p.XX.)

This supports leadership of a Families First and personalised approach, supporting individual and communities to improve their capacity and resilience with access to graduated levels of support linked to assets and needs. The Commissioning Unit's themed approach supports a preventative, whole-family and life-long approach.

The Commissioning Unit restructure was undertaken with an objective of assessing the visible effectiveness, potential efficiencies available, value for money, resources available, and opportunities for collaboration and general approach to commissioning projects. The intention is to remove areas of duplication, reducing waste and exploiting potential synergies across adults and children.

The new model moves People Commissioning to a thematic model with lead commissioners for the following themes and service approaches:-

- Early Intervention, Prevention and Public Health
- Personalised Support
- Specialist Targeted Support
- Long Term Support

It is further intended that all commissioning activity will be underpinned by a common set of principles: personalisation; citizen led service design and co-production; maximisation of the use of Better Care technology; and Delivery of the corporate savings objectives

For practical reasons, a functional design for staff who are delivering the strategic thematic element of the "*analyse, plan, do, review*" model is required to achieve success as shown right.

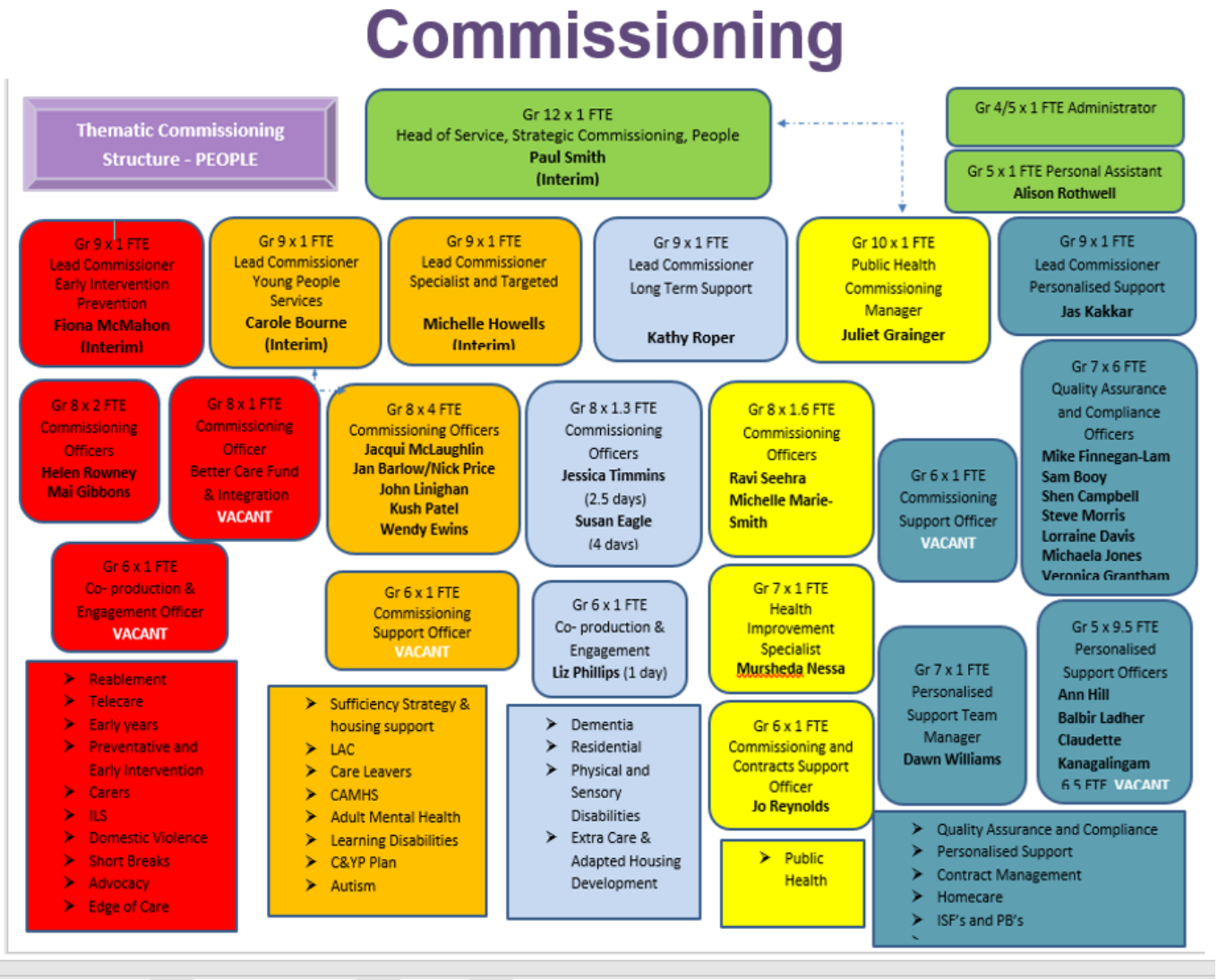


Fig X *Commissioning Unit Structure*

In terms of overall g**overnance** of commissioning a Commissioning Pathway Model is included at Appendix 1. This is the basis for governance of the overall framework approach to the "*analyse, plan, do, review*" commissioning cycle. It shows the way in which the Unit works to develop strategic commissioning frameworks which are required in support of People Services aims and objectives.

As noted elsewhere (see p. XX) commissioning is everybody's responsibility across a continuum. The capacity of the Commissioning Unit is best used to provide the strategic framework activity required of People Services and partners work. In this context, strategic commissioning is not the same as casework.

5.2 Analysing

5.2.1 Joint Strategic Needs Assessment (JSNA.) - The IPC Commissioning Cycle begins with analysis. The main source for Commissioning Unit analysis in the City of Wolverhampton is the process and product of the Joint Strategic Needs Assessment (JSNA.) [16] Illustrative analysis includes:

CITY OF WOLVERHAMPTON TODAY…

- 254,406 (2015 MYE) population - Gender: 50.5% female; 49.5% male
- Average Age – 39 yrs. 196,239 (77%) are 19+. 58,167 aged under 18. 6,000 85+
- Ethnicity - 64.5% white; 35.5% BME. 42.7% of 5-17 years from a BME group
- About 31.5% of children and young people (0 – 17) living in poverty
- About 20% of children are entitled to free school meals in primary and secondary schools
- Population density (2011) increase to 36 people per hectare (PPH), (34 PPH in 2001)
- Unemployment rate double the national rate
- Life expectancy lower than England average, 20th out of 326 local authority areas in the Indices of Deprivation 2010
- 27,136 Carers (Census 2011)
- 21% retired. 43000 economically inactive of whom 11200 are long-term sick
- 3,100 living with dementia
- 850 working age adults with moderate to severe learning disability
- 5.2% have a long-term mental health problem (GP Survey)
- 60% of people with a disability living in Wolverhampton are over the age of 60
- 4668 referrals to childrens social care (09/15-09/16)
- 631 LAC, 1235 CiN and 219 CP
- 104,000 dwellings (housing, flats, etc.) - 75,900 private dwellings (65,000 owner occupied, 10,900 privately rented;) 21,700 Council owned, 2080 Council owned with TMO; 4,320 rented from housing associations

Moreover, the JSNA includes f**orecasts** based on analysis which help us show what the City of Wolverhampton might look like in the near-future. Issues include:

IN CITY OF WOLVERHAMPTON TOMORROW - THERE WILL BE…

- More people overall - growth of 8.9% by 2037, to 273,300
- more older people (aged 65+) 44.7% increase to 59,900 residents.
- more younger people – U19's increase by 7%.
- fewer working age people.
- more Dementia - 44% rise in next 20 years i.e. extra 75 people per year
- impact of socio-economic factors on people's health, resilience, family and community bonds
- more people – young and old – living longer with complex conditions and disabilities

The JSNA is more than data. It is also a process. This process incorporates the outcome of "softer" data available through engagement with the public and people directly using our support (see section xx.) Some **emerging issues** based on this and wider analyses feeding into this strategy for the people of the City and its leaders therefore are:

- People living for more years with significant health issues ("long term conditions") and many conditions together ("co-morbidities") requiring more complex support
- Housing – sufficiency of nature and supply
- Employment - effects of austerity or other issues on resilience of individuals and families
- potential increased tax burden to support care provision and/or
    - individuals / families / communities to do more
    - market opportunity for private sector to deliver products and services
- continued support for parents and carers under pressure
- making the care system more flexible and integrated through personalisation and more outcome-focussed contracts
- creating more options for people to meet their own support needs
- *Life expectancy is an overarching measure of health and wellbeing within the City and all commissioning activity should be aligned to identifying services with an ultimate aim of improving this measure.*
- *Healthy Life expectancy is key summary measure of population health and all commissioning activity should be aligned to identifying services with an ultimate aim of improving this measure.*
- *The relationship between personal wellbeing and local circumstances is complex and can influence health and social care outcomes. Commissioned services should consider how the overall wellbeing of the population can be improved through the services provided.*
- *HRQoLis a multi-dimensional concept that goes beyond direct measures of population health, such as life expectancy and mortality, and focuses on the impact of health status on the quality of life.*
- *Commissioned services should aim to assess how the service provided has improved the quality of the life of the service user.*
- *Commissioned services should aim to assess how the service provided has have met the needs of the service user and how unmet needs can be identified and addressed.*
- *Improving the risk factors through various commissioned services including*
    - *promoting early booking and attendance for antenatal care*
    - *preventing poor lifestyle choices including smoking during pregnancy, obesity and teenage conceptions*
    - *improving outcomes for premature births, low birth weight babies and babies from deprived areas of the City*
- *Overall, premature mortality rates for the majority of conditions in Wolverhampton is worse than the England average. Lifestyle risk factors such as smoking, obesity and alcohol misuse are major contributors to the rate of premature mortality. Commissioned services need to focus on promoting healthier lifestyles and preventing the development of long term conditions that lead to premature mortality.*
- *This can be achieved through training service providers to Make Every Contact Count across health, social care and the voluntary sector*

5.2.3 Joint Health and Well Being Strategy 2013-18

The Joint Health and Well-Being Strategy (JHWBS) [17] is based on the wide analysis of the JSNA product and process. Informing perspectives for the JHWBS included from the outset *Knowledge-led decision making; innovation; integration; being outcome focused; and value.*

Health and Well Being Board Key Priorities agreed in 2014 were re-focussed during 2016 in an updated Mission and Vision and focus on three areas:

- Childhood obesity
- Mental health of children and young people
- Dementia and care closer to home

Mission

Promoting health, wellbeing and resilience across the life course

Vision

- Best start in life
- Supporting positive transition into adulthood
- Promoting wellbeing throughout adulthood
- Supporting a good healthy life expectancy

Each Service area within People Services has a Transformation workstream or Business Plan (outlined below – see pp xxx.) These bring together its work on key improvement areas based on engagement with the public and people using our support, analysis, local and national policy and best practice requirements.

Our Commissioning Strategy takes forward previously agreed delivery arrangements which are being updated as a result of this strategy.

Other sources: An indicative list of documentary sources of information and strategies for all thematic areas of the Commissioning Unit includes:

- Law: e.g. Care Act 2014, *Children and Family Act 2014* SEND Reforms

- Best Practice:
  - Local Government Association - Commissioning for Better Outcomes[18]
  - Think Local Act Personal - Making it Real Plan
  - SCIE

- External provided Data
  - POPPI and PANSI
  - National Minimum Data Set for Social Care - NMDS-SC

- Internal – Council
  - Corporate Plan/Priorities
  - Finance information

- Internal – People Services data and Strategies
  - JSNA 2016 – 2020
  - JHWBS 2013-17
  - All Age Disabilities Strategy 2013-2016
  - Early Years Strategy 2017-2021;
  - CYP Sufficiency Strategy
  - Children, Young People & Families Plan 2015-25
  - Early Intervention and Prevention Strategy
  - Balancing Cost and Quality
  - Public Health Commissioning Strategy / Contracting Plan 2014 -2019
  - Children, Young People & Families Plan 2015-25
  - Refresh Joint Reablement and Intermediate Care Strategy 2014 -2016
  - Joint All Age Carer Strategy 2016 – 2020
  - Living Well In Later Life 2013- 2015
  - Joint Dementia Strategy: 2015-2017
  - All Age Autism Strategy 2016 – 2020
  - Joint Learning Disability Strategy 2011 – 2015
  - Obesity Call to Action
  - Prevention Strategy

- Internal – Commissioning Unit

  - Market Position Statement for Care and Support for Adult Services in Wolverhampton 2015-2017
  - Market Position Statement for Adults with Disabilities and Mental Health 2015-17
  - Providers/Suppliers
  - Contract Finder
  - CM2000 – Electronic Home Care Monitoring system

- West Midlands ADASS
    - Commissioning Network
    - Balanced Score Card metric for measuring progress with personalisation

Co-production takes the task of analysis further in debating and coming to conclusions together with people using our support or services as well as the wider voice of all citizens in the City of Wolverhampton.

5.3 Planning

5.3.1 Market Position Statements

Building on acquired previous experience in social care, the Care Act 2014 made market shaping a statutory duty for Councils. Therefore, People Services commissioners have been working on "market shaping" activity for sometime. This duty also builds on the responsibility of People Services through the statutory duties of the Director of Childrens Services (DCS) and those of the Director of Adult Social Services (DASS.) In the City of Wolverhampton, these are combined in the post of Strategic Director:

- *The DCS is responsible for securing the provision of services which address the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers…. The DCS is responsible for ensuring that effective systems are in place for discharging these functions, including where a local authority has commissioned any services from another provider rather than delivering them itself* [19]
- *(The DASS is) "…responsible for the management, welfare and professional development of all local authority staff involved in planning, commissioning and/or providing social services. This includes shared responsibility for staff appointed to jointly funded posts between the local authority and other agencies/organisations involved in adult social care or healthcare."* [20]
- (*The DPH) …is the principal adviser on all health matters to elected members and officers (on) health improvement, health protection and healthcare public health…. contribute(s) to and influences the work of NHS commissioners, … take steps to improve the health of the people in its area"* [21]

People Services Commissioning Unit already have three Market Positon Statements either complete or in an advanced stage of development and available at: https://www.wolverhampton.gov.uk/mps for:

- children and young people
- children and young adults
- older adults

The content of those documents is not repeated here but they are an important part of the "architecture" to make this Commissioning Strategy a success. This strategy is initiating work to ensure that the Market Positon Statements are developed in their next stage to reflect the thematic approach to commissioning now being taken.

This Commissioning Strategy will also inform the ***Children and Young People's Services - Sufficiency Strategy.*** The Sufficiency Strategy recognises commissioning *as " the process for deciding how to use the total resource available for children, parents and carers in order to improve outcomes in the most efficient, effective, equitable and sustainable way*" states national guidance aimed at looked after children. [22] It is part of the wider commissioning approach with specific focus on looked after children. In updating the strategy, there will be renewed emphasis on (1) engaging service users / co-production in the strategy and commissioning services which prevent admission to care and promote placement stability and (2) Good use of regional and sub-regional framework agreements for residential and foster care and specialist support services.

5.3.2 Opportunities across thematic areas

Opportunities created for people in the City of Wolverhampton across the thematic areas include the following:

Early intervention

- needs based interventions rather than service led interventions.
- driving culture change through the Early Intervention focus
- Co-produced commissioning with broad range of individuals, organisations and specific user groups.
- For children and young people:
    - Developing a family based approach.
    - Minimising / eliminating challenges at transition to adult services
    - Not replicating effort and money by addressing issues in themes

Specialist targeted support

- real improvements to communities and the lives of people most in need
- The opportunity to identify and address deep rooted social issues that affect the majority of people who use our service in an efficient way rather than tackling them by client group.
- (FOR TEAM) Increased learning and an enhanced collective understanding leading to improved skills and confidence of commissioners with regards to the development of generic commissioning skills.

Long term support

- whole city approach to the market,
- ensuring equality of access regardless of a person's needs.
- enabling People Services commissioning work closely with council priorities such as regeneration, placing "pipeline" housing schemes into city wide housing developments context
- Develop Extra Care schemes to respond to the needs of vulnerable, integrating disabled people into bigger extra care developments.
- Use extra care schemes focus to achieve better use of residential and nursing market

- engaging with the market to be solution focused
- support a whole -family approach linked to the City's regeneration plan
- Develop integration with health colleagues
- support engagement with the third sector

Personalisation

- continued focus on assets, reablement and recovery, supporting people at home will lead to a reduction in people using Care Homes and long term care;
- supporting the Promoting Independence agenda will result in reduction in dependency on care and support services;
- ensuring a sustainable Provider market;
- encouraging providers to focus on quality and so help retain care workers
- having an integrated commissioning approach will ensure resources are used effectively and will reduce or eliminate duplication of redesigns/provision
- service design linked to 'need and outcome' rather than age specific
- leading culture change in our own and partner's services

Public Health and Well-Being

- Six health conditions account for over half of the difference in life expectancy that exists between Wolverhampton and England - heart disease, stroke, infant mortality, lung cancer, suicide and alcohol.
- This is seen disproportionally in the most disadvantaged communities. Deaths due to alcohol use and those occurring in infancy are the major reasons why life expectancy has not improved.
- People in Wolverhampton are living longer than ever before and the gap between life expectancy in the city and the national figure is closing. We know that socio-economic factors affect life expectancy.

5.4 The Commissioning Pathway and Unit Governance

To support overall **governance** and increased consistency of commissioning processes within the People Directorate as part of one Council, a "commissioning pathway" (see p. xxx) below establishes general guidelines for the commissioning cycle process.

Some generic aims for the integration of the Commissioning Unit include:

- Standardising commissioning approach e.g. contract monitoring
- Understanding spend and making it smarter
- Outcomes -based commissioning / impact
- Smart PBR
- Agreeing strategic approach to SIBs

- Synergy with children's and adult transformation programmes
- Shared understanding of the model and alignment across themes
- Stakeholders - communicating change externally: maintaining dialogue with those affected by our activity and sharing decisions with directorate and corporate Stakeholders
- budgets/finance and thematic scheme synergy
- Innovation, working differently
- utilising/growing internal skills,
- public health access to health (NHS) intelligence
- Business intelligence gap; data management, monitoring and analysis is weak
- Regional opportunities – making best use of wider frameworks and starting them where agreed helpful
- Digital information and communications

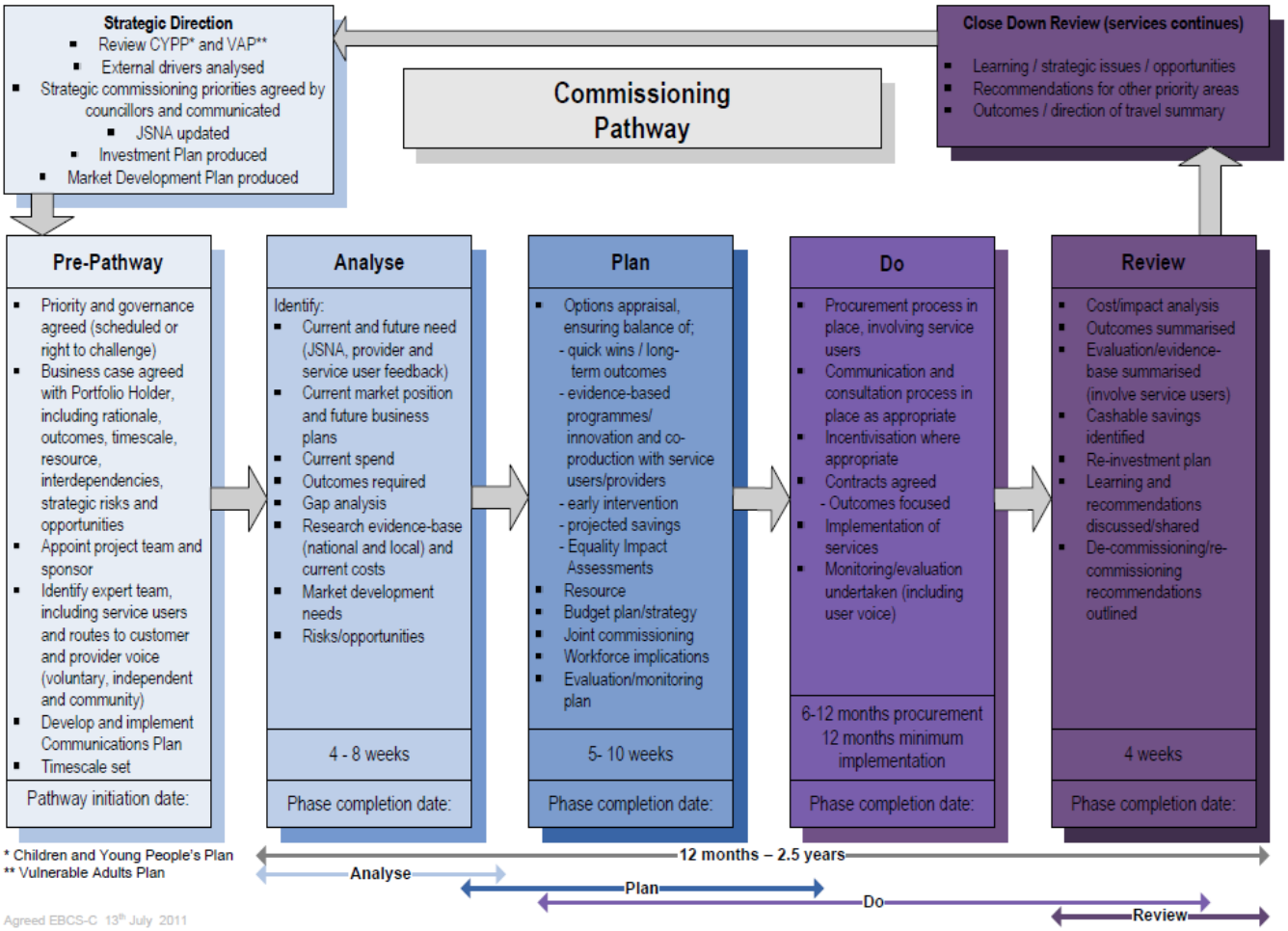


Fig XXXX XXXXX

5.5 De-commissioning – our approach

The *"analyse, plan, do, review"* commissioning cycle approach is a dynamic process. It allows us to be more responsive to change. Change may include:

- developing needs and aspirations of people living in the City of Wolverhampton
- overall direction determined by the Council's Cabinet
- responding to changes to the way other agencies deliver their services
- improved ways of working e.g. through provision of new evidenced based approaches or more efficient process design
- change in commissioning resource allocation
- market failure [23]
- Council decision to terminate poor quality provision
- provider decision to terminate local activity
- overall analysis of population need e.g. JSNA
- end of agreed contract

Where such changes occur, it may be right to de-commission existing activity. However, the procurement and contract process allows some commissioned services to end naturally as the time period covered by the contract expires.

Where appropriate, a key part of de-commissioning is the need for effective engagement, scrutiny and challenge. Appropriate engagement with all concerned may be required given all the circumstances of the possible decision. This will be determined in dialogue between all leaders and managers using the relevant procedures. Where required, impact analysis will focus on professional judgement which weighs up various factors such as:

- Defined need of individual or community
- quality
- Budget requirements
- Statutory basis
- Elected Member views and leadership
- Staff deployment and views
- Public perception
- Media interest

For example, a decision may be small from the perspective of budget allocation but high in potential impact on individuals or on the reputation of the council.

Decisions will be made according to the agreed de-commissioning procedures as relevant to the circumstances with leadership from the Cabinet, engagement with Elected Members, people using services, members of the public, providers, partners and any other relevant stakeholder. In particular, our de-commissioning processes will cohere with frameworks established by corporate framework which in turn will respond to practice realities. De-commissioning procedures are available at: [INSERT HYPERLINK – DE-COMMISSIONING PROCESS..]

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Endnotes

[1] Department of Health *(2006) Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services;* Department for Education (2013) *Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services or local authorities;* Department of Health *(2013) Directors of Public Health in Local Government - Roles, Responsibilities and Context*

[2] HM Treasury (2006) *Value for money guidance,* p11. http://www.hm-treasury.gov.uk/d/vfm_assessmentguidance061006opt. pdf The quote continues: "*Value for money is not the choice of goods and services based on the lowest cost bid."*

[3] http://ipc.brookes.ac.uk/ accessed 20/02/17

[4] City of Wolverhampton Health and Well Being Board July 2016 *Making prevention everyone's business*

[5] *Wolverhampton Child Health Profile, March 2016*

[6] *Wolverhampton's Child Poverty Strategy 2013-2018*

[7] http://www.local.gov.uk/care-support-reform//journal_content/56/10180/6520234/ARTICLE and *LGA Commissioning for Better Outcomes 2015* http://www.local.gov.uk/documents/10180/5756320/Commissioning+for+Better+Outcomes+A+route+map/8f18c36f-805c-4d5e-b1f5-d3755394cfab

[8] https://www.adass.org.uk/ncasc-2014-market-oversight-and-provider-failure

[9] http://www.legislation.gov.uk/uksi/2015/102/contents/made

[10] Available at: http://www.legislation.gov.uk/uksi/2015/102/contents/made accessed 20/02/17

[11] Available at: http://www.legislation.gov.uk/uksi/2006/246/contents/made accessed 20/02/17

[12] https://wolverhampton.moderngov.co.uk/documents/s22708/City%20of%20Wolverhampton%20Procurement%20Charter.pdf

[13] Available at: http://www.investwolverhampton.com/assets/pdf/care-and-the-local-economy.pdf

[14] From: "*Care and the Local Economy"* City of Wolverhampton Council

[15] For instance, Skills for Care's *Workforce commissioning – workforce shaping and commissioning for better outcomes* at: http://www.skillsforcare.org.uk/Documents/Leadership-and-management/Workforce-commissioning/Workforce-shaping-and-commissioning-for-better-outcomes.pdf accessed 20/02/17

[16] Available at: http://www.wolverhampton.gov.uk/article/3647/Joint-Strategic-Needs-Assessment-JSNA

[17] Available at: http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=2944&p=0

[18] http://www.local.gov.uk/care-support-reform/- /journal_content/56/10180/6520234/ARTICLE

[19] Department for Education (2013, April) *Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services or local authorities* p.5 para 1

[20] *Department of Health (2006) Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services* Para 18 p5

[21] Department of Health *(2013) Directors of Public Health in Local Government - Roles, Responsibilities and Context*

[22] *Sufficiency Statutory guidance on securing sufficient accommodation for looked after children* - Department P.16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273812/sufficiency_-_statutory_guidance_on_securing_sufficient_accommodation_for_looked_after_children.pdf

[23] ADASS & LGA - *Adult social care, health and wellbeing: A Shared Commitment - 2015 Spending Review Submission* September 2015

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Agenda Item No: 14

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

28 June 2017

Report title	Towards an Active City – A physical activity framework
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing
Accountable director	Linda Sanders, People
Originating service	Public Health and Wellbeing
Accountable employee(s)	Richard Welch — Head of Healthier Place Tel 01902 552162 Email Richard.welch@wolverhampton.gov.uk Andrea Fieldhouse — Active People and Places Manager Tel 01902 556224 Email Andrea.fieldhouse@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team — 17 October 2016 Education Leadership Team — 5 December 2016 Obesity Programme Board — 6 December 2016 Place Leadership Team — 12 December 2016 Senior Executive Board — 20 December 2016 Cabinet — 18 January 2017 Health Scrutiny Panel — 27 April 2017 People Leadership Team — 12 June 2017

Recommendation(s) for action or decision:

Health and Well-Being Board is recommended to:

1. Note the principles adopted within the physical activity framework but consider how the City best utilises its assets to improve health and well-being for residents.

1.0 Purpose

1.1 To provide an overview of the adopted principles within 'Towards an Active City – a physical activity framework' which has been developed to encourage the population to be active every day. In addition to this, to consider how the city best utilises its assets to improve health and well-being.

2.0 Background

2.1 Our Vision, Our City 2030' (2016) outlines an ambition for "a city which is serious about health and wellbeing" but with only half of the population undertaking regular physical activity, we are unlikely to achieve the levels of health improvement we require. If we are to achieve this ambition, we must turnaround rising levels of physical inactivity, and in doing so address some of the health inequalities that exist.

2.2 The framework is consistent with national strategy and is influenced by both Government's 'Active Nation' strategy (2015) and Sport England's 'Towards an Active Nation' strategy (2016). The framework also aligns to other relevant Black Country and West Midlands plans, particularly the emerging "West Midlands on the Move 2016-2030: Physical Activity Strategy" being developed by the West Midlands Combined Authority (WMCA). This calls for "active citizens", developed through a mixture of mass participation initiatives, behavioural change schemes and structural improvements.

2.3 The Public Health Outcomes Framework for Wolverhampton illustrates that 35.2% of the local population are inactive and only 49.9% are taking part in 150 minutes of physical activity in line with the Chief Medical Officers (CMO) guidelines for physical activity. The remaining 14.9% do some activity but do not achieve 150mins per week therefore, 64.8% of residents are undertaking a minimum of 1 x 30 minutes' activity per week. (Source: Public Health England - Public Health Outcomes Framework. Measure: percentage of physically active and inactive adults. Time period(s): 2015)

2.4 The City has a range of assets at its disposal which lend themselves to providing physical activity opportunities; these include a stock of physical assets such as community buildings, parks and open spaces but also human resources in the form of community groups and social enterprise based organisations. Walking for Health is a good example of a part subsidised, volunteer led sustainable physical activity programme which takes place at various sites across the city. Similarly, Parkrun is a national movement with local weekly provision in West Park and is self-sustainable. Further work is required to understand the dependency thresholds of such provision if this is to be replicated across the City on an industrial scale.

2.5 The Public Health function within the Council is mid-way through a re-design of the Healthy Lifestyle Service. This exercise aims to transform the recently transferred service to become more modernised and efficient whilst maximising the impact upon public health outcomes.

3.0 Progress

3.1 'Towards an Active City - a physical activity framework' has been developed to help the city to encourage the population to be active every day. A Toward an Active City Plan on a Page has been devised (appendix one) with a more detailed framework that can be accessed in the following Towards an Active City

3.2 The intention of the framework is to root physical activity into the city's plans and priorities, which have a profound impact on the planning of health and physical activity including the perceptions of the people, the place, and its business competitiveness. It also aligns with the WMCA vision to ignite a social movement that makes physical activity and active citizenship the norm.

3.4 The work of key stakeholders has steered the framework such as West Midlands Police, University of Wolverhampton, schools, and other education providers. Consultation was undertaken during the development of the framework. The framework is based on data, intelligence and insight provided both by national, Black Country and local partners who have a vested interest in the city including for sport and physical activity. It is also influenced by key national, Black Country and local strategies and policy documents.

3.5 The framework concentrates on those who are currently inactive and offers approaches that can be taken to make physical activity a normal part of everyday life.

3.6 The framework recommends that an independent Active City Board, with an independent chair should be established to bring together health, physical activity, and economic stakeholders to deliver and implement the framework and ensure physical activity is considered as part of the major plans and policies across the city. The board will be responsible for producing an action plan that will set out how the immediate People, Place and Business strategic priorities should be implemented over the next three years with longer term actions up to 2030.

3.7 The action plan will assist the board in determining the resource implications for each priority and how this will be measured.

3.8 The Active City Board will align to established strategic boards within the city including the Council's Cabinet, Health and Well Being Board and Obesity Programme Board.

3.9 The framework recognises that this is a starting point to delivering the size and scale of change which is needed by 2030.

3.10 The framework is supported by a suite of supporting documents which advise on playing pitches, built facilities and open spaces where sport and physical activity can take place.

3.11 Sport England recommends that all Local Authorities produce a Built Facilities Plan which is a technical document that enables us to take an asset based approach. A Built Facilities Plan on a Page which highlights the key issues can be found in Appendix two. The more detailed summary document can be found at the following Built Facilities Plan This, in conjunction with the published Playing Pitch Strategy and Open Space Strategy

and Action Plan will inform the framework for future investment that will assist us in achieving our ambition of everybody active every day.

3.12 Building upon the success of volunteer led programmes such as Walking for Health and Park run

4.0 Financial implications

4.1 There are no direct or immediate financial implications for the Council arising from adoption of the framework. However, it is envisaged that there will be financial benefits arising from the adoption of this framework in the form of capital and revenue funding programmes for the city, social value and future savings that can be made from reduced demand on health and social care services.

4.2 Whilst there will be cost implications identified when the action plan is developed, delivery of these actions will be the responsibility of the partners attending the board alongside the Council. Any projects that fall under the Council responsibilities will follow the appropriate governance procedures for approval. [GS/19062017/L]

5.0 Legal implications

5.1 There are no immediate legal implications from this report.

[Legal Code: TS/14062017/T]

6.0 Equalities implications

6.1 The consultation undertaken with strategic partners was integral to the development of this framework.

6.2 The framework recognises that one of the City's strengths is its diversity and to ensure that there is equality and fairness for all. In this regard, the Active City Board will be challenged to adopt an inclusive and locality driven approach when formulating the action plan.

7.0 Environmental implications

7.1 There are no immediate environmental implications.

8.1 There are no human resources implications.

9.0 Corporate landlord implications

9.1 There are no immediate corporate landlord implications.

10.0 Schedule of background papers

10.1 Playing Pitch Strategy and Assessment Report – Cabinet Meeting, 13 January 2016

10.2 City of Wolverhampton Open Space Strategy and Action Plan – Cabinet Meeting, 24 February 2016

10.3 Towards an Active City – a physical activity framework - Cabinet Meeting, 18 January 2017

Appendix One

Towards an Active City
Our Ambition is clear: we want every resident to be active everyday

Principles and values

Committed to:

- Root physical activity into the city's plans and priorities
- Continually creating, learning, and improving opportunities to encourages everyone to be active every day

Leadership

- Independent Active City Board accountable to the Health & Wellbeing Board
- Active City champions and ambassadors
- Co-ownership – as shared city wide responsibility
- Collating evidence and monitoring impact

Evidence

- 35.2% of the city's population are inactive
- Only 49.9% achieve recommended 150 minutes' activity per week
- 14.9% do some activity but do not achieve 150mins per week therefore, 64.8% of residents are undertaking a minimum of 1 x 30 minutes' activity per week
- Physical inactivity is 4th biggest global killer (WHO)

Our Priority Outcomes

People

- Reduced levels of obesity and inactivity
- Improved levels of mental wellbeing and a reduction in social isolation
- Grow school sport and PE to build lifelong activity habits
- Develop the skills of the workforce, both paid and voluntary

Place

- A better connected city which enables everyone to be active everyday
- Increased community use of school sites
- Identified investment priorities through alignment of Playing Pitch Strategy, Open Space Strategy and Action Plan and Built Facilities Plan to secure future funding
- A wider leisure, play and recreation offer that provides attraction for residents and visitors

Business

- Increase profitability for businesses as a result of a healthier workforce
- Digital technology will be used to maximise physical activity opportunities
- Extended coverage of the workplace charter for Wolverhampton businesses

What success looks like

- By 2030, the proportion of Wolverhampton residents that are achieving at least 1 x 30 minutes of activity per week is equal to the national average (71.3%)

Appendix two

Built Facilities Plan

Our ambition is clear: we want every resident to be active everyday

Principles and values

Committed to:

1. Developing sustainable participation in sport and physical activity
2. Development of an audit and assessment of sports facilities to inform future investment
3. Look further than high quality sports & leisure facilities as alone they will not address sedentary behaviour

Governance

The built facilities plan will be owned and maintained by the City of Wolverhampton Council and progress will be reported into the Active City Board

Swimming pools

1. City's pools are reasonably well located
2. Impact of growth is not significant
3. Closure of school pools albeit in the short term is putting pressure on full stock
4. Present stock should be maintained and retained
5. Invest to increase capacity at WV Active Central
6. Review pool programming
7. Scope joint venture with Black Country Neighbours if capacity can't be increased

Sports Halls

5. Total supply meets demand and no further provision is needed
6. Nearly 88% of sports halls are owned or managed by educational institutions
7. Community centres provide critical local flexible indoor opportunities
8. Review halls programming
9. Protect and modernise existing stock
10. WV Active to consider off peak activities that meet Towards an Active City priorities
11. Support improved community use of school sites

Gymnastics

(1) Absence of gymnastics provision for males
(2) Consultation needed with Black Country Partners and British Gymnastics re feasibility study on provision of gymnastics centre

Bowls

- Important facility type for city demographic
- Increasingly seen as activity for health intervention
- Work with facilities to provide short and long mat bowls

Health and Fitness

1. Ranked high is facility type to increase participation
2. Range of modern and large scale good quality facilities
3. No need to increase provision
4. Interventions and action is more people than facility based

Studios

- Ranked as important facility type, particularly for women
- Represents an activity that can address balance between male and female participation
- Facility provision and location is good

Indoor Tennis

- Well accommodated at Wolverhampton Lawn Tennis and Squash Club but casual participants must be considered

Outcomes

- **By 2030 the % of Wolverhampton that was physically inactive will have reduced to the national average**
- **Suitable and sufficient facility provision in place to achieve our ambition of everybody active everyday**

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Agenda Item No: 15

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

28 June 2017

Report title	Joint Strategic Needs Assessment – Programme Update	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Accountable director	Linda Sanders	People
Originating service	Public Health	
Accountable employee(s)	Ros Jervis Tel Glenda Augustine Email	Director of Public Health 01902 558662 Consultant in Public Health - Evidence Glenda.augustine@wolverhampton.gov.uk
Report to be/has been considered by	Joint Strategic Needs Assessment Steering Group Public Health Senior Management Team People Leadership Team	09 May 2017 18 May 2017 12 June 2017

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to note:

1. The completion of the Joint Strategic Needs Assessment (JSNA) Overview Report 2016-17.
2. The topics prioritised for the next year to be developed into topic-specific JSNAs.
3. Progress on developing an interactive interface for the JSNA products.

1.0 Purpose

1.1 The purpose of this paper is to provide the Health and Wellbeing Board (HWBB) with an update on the completion of the Joint Strategic Needs Assessment (JSNA) Overview Report 2016-17. It will also outline the topics prioritised for topic-specific JSNAs within the next year and highlight the need to develop an interactive interface for the JSNA products.

2.0 Background

2.1 The JSNA is an integral part of improving population health and well-being and reducing local health inequalities. It aims to provide an assessment of the current and future health and social care needs of the local population. The identification of health and social care need will inform strategic planning alongside the commissioning of services across the whole system to address unmet need. The JSNA will also support the monitoring of trends and evaluation of performance data in relation to commissioned services.

2.2 In October 2015 the HWBB approved a large-scale review and redesign of the JSNA including an interactive interface for JSNA products. Updates on the progress of these products were provided throughout 2016 and this paper presents developments since November 2016.

3.0 JSNA Overview Report

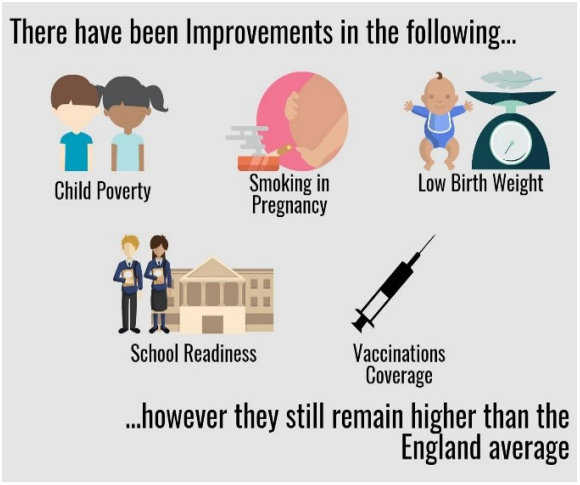
3.1 The JSNA overview report is now complete and includes a section on 'Wolverhampton City' and sections based on the life-course approach as listed below:

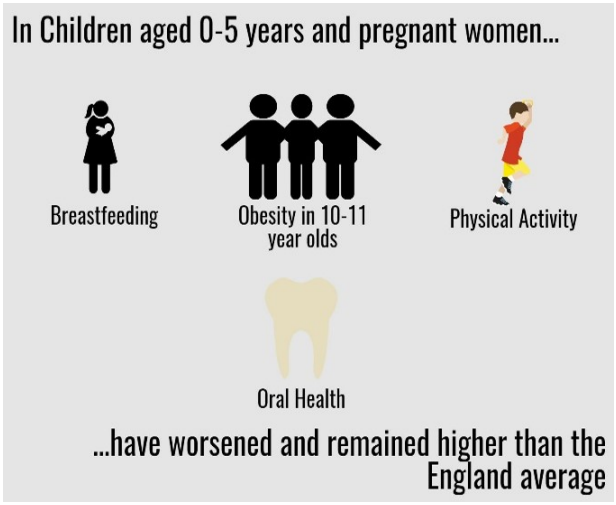
- How long do people live?
- Causes of Early death
- Start well
- Develop Well
- Live, work and stay well
- Age Well

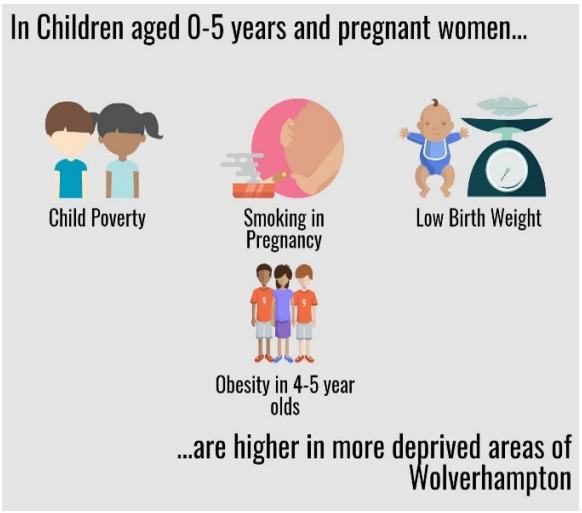
3.2 These sections include data on the current prevalence, trend analysis, national and regional comparisons including statistical neighbours. Information is also available on identified inequalities in terms of age, gender, ethnicity, deprivation, alongside variation between wards in Wolverhampton (where available). An explanation of the findings and the indicative commissioning needs, on the basis of the data available, are also presented.

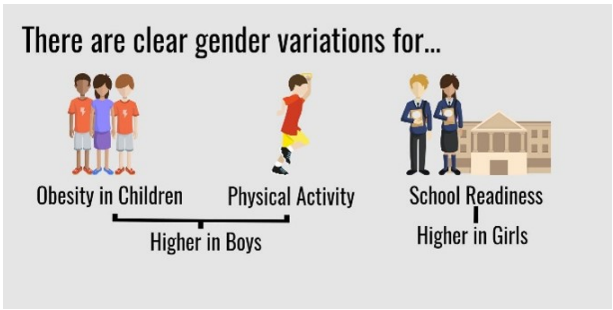
3.3 A summary of key findings in each new section added since November 2016 to complete the overview report is presented below.

- Key findings for Start well section:

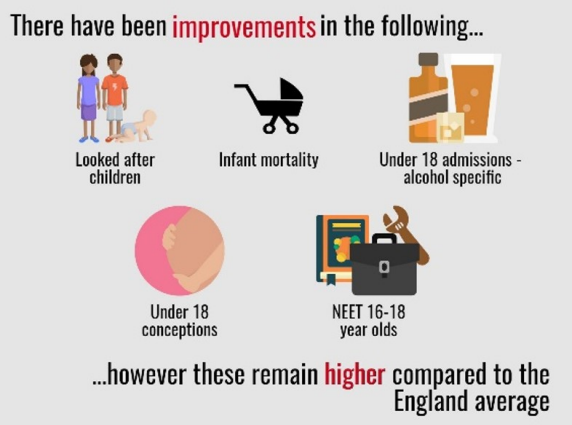


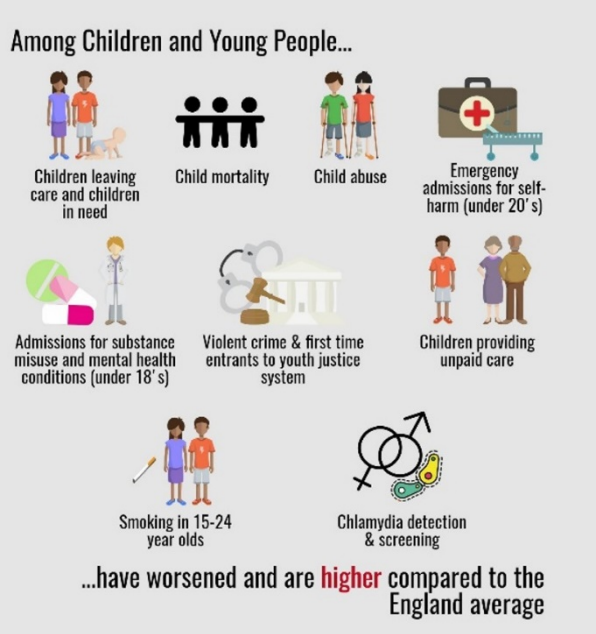


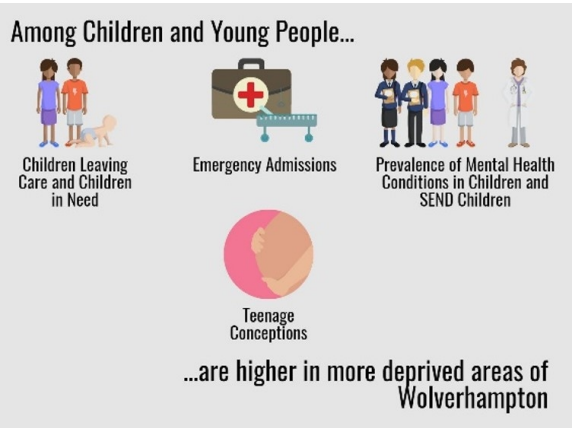


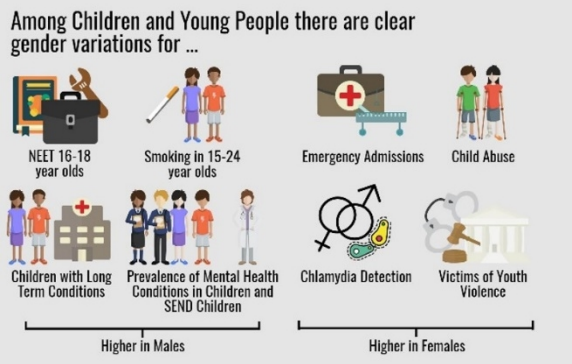


- Key findings for Develop well section

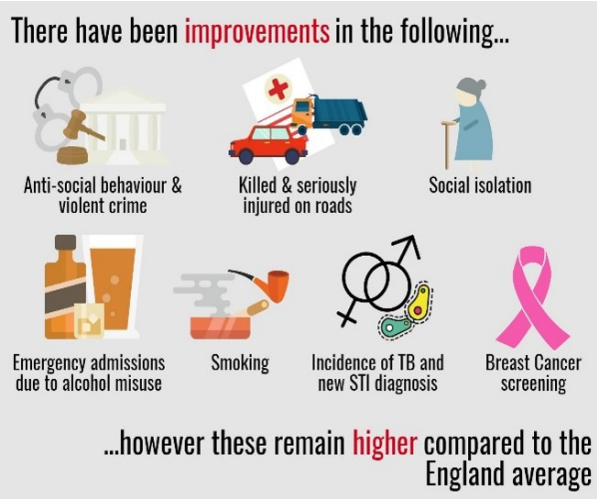


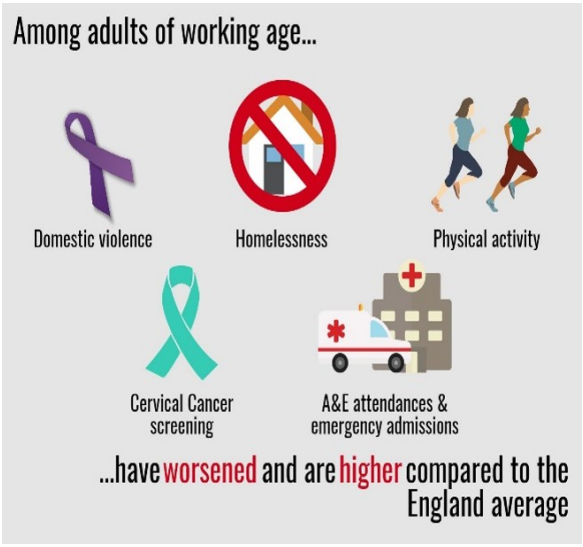


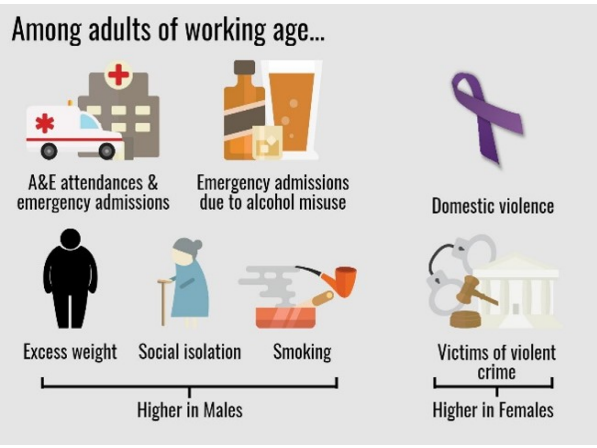


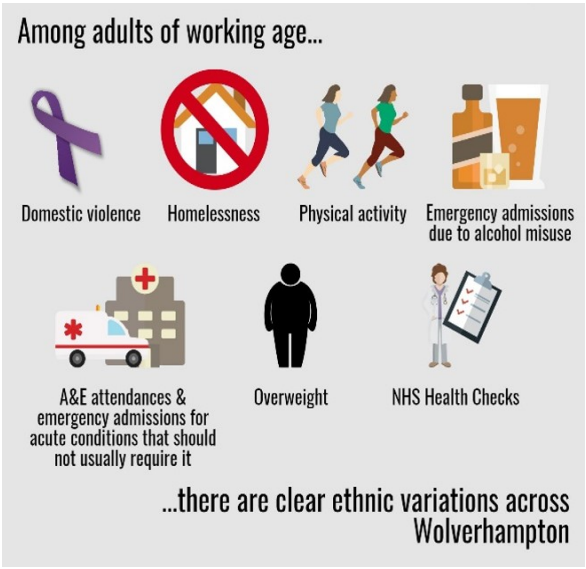


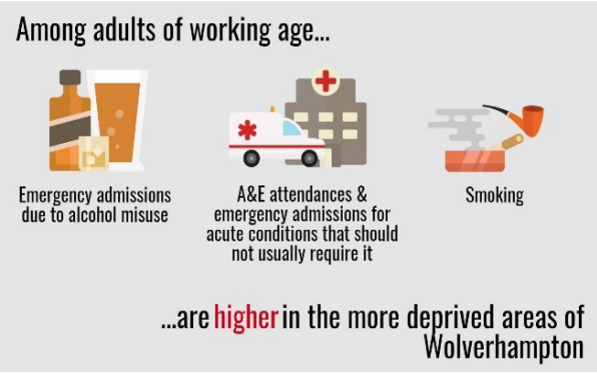
- Key findings for Live Work and Stay Well section



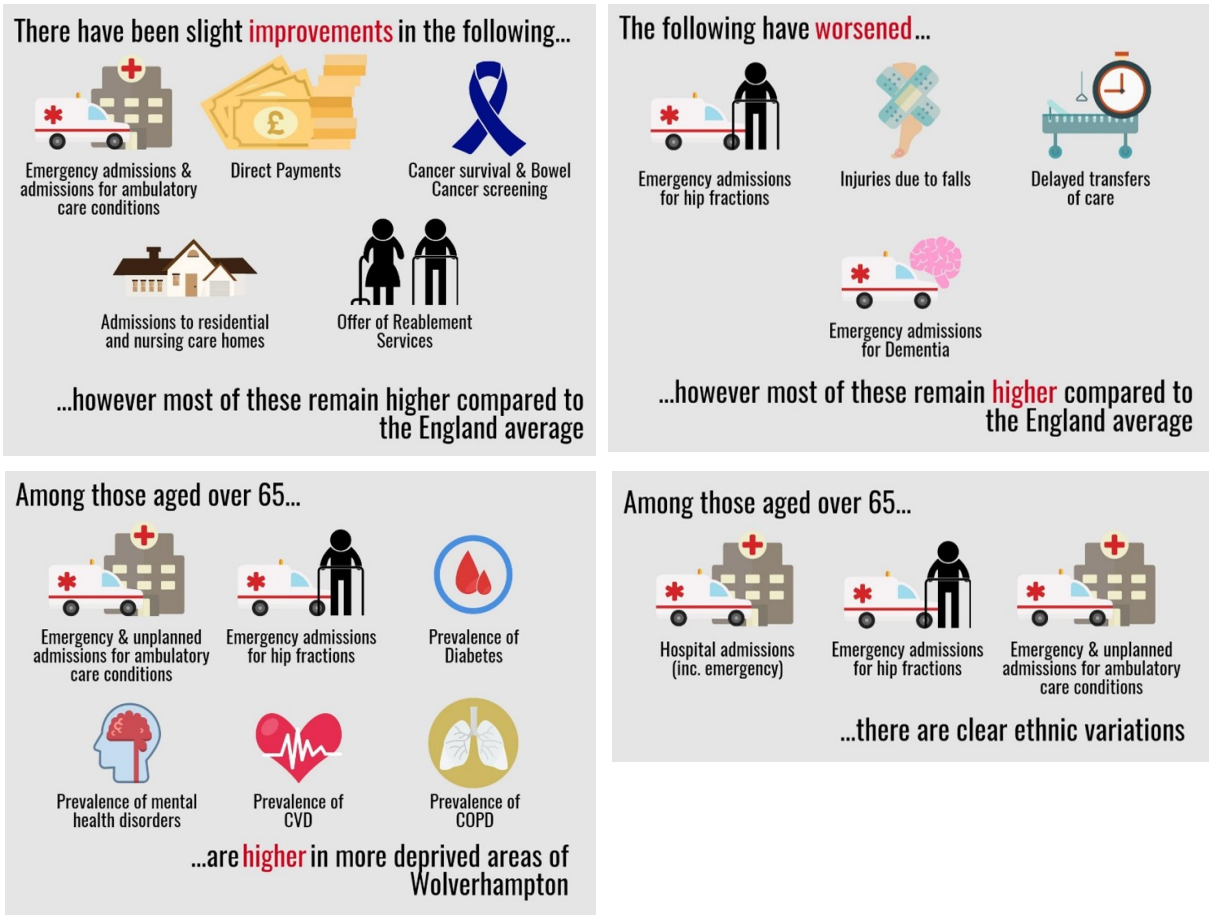




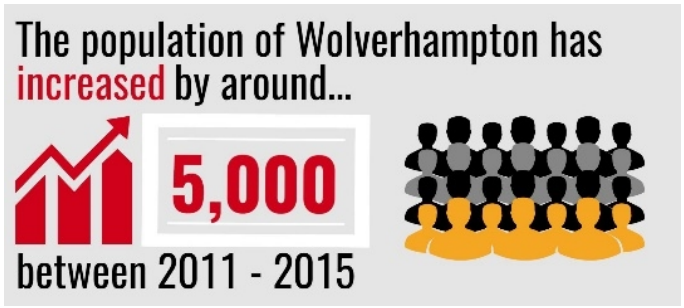


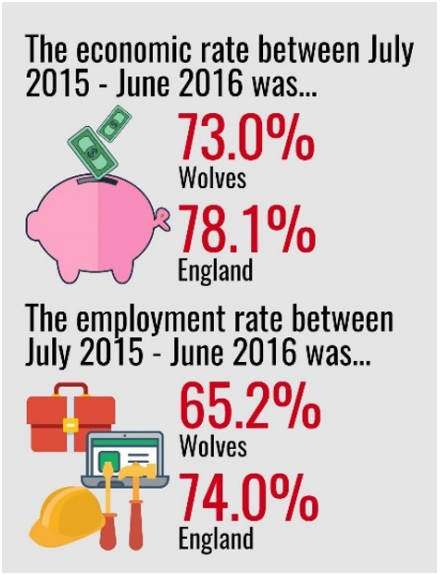


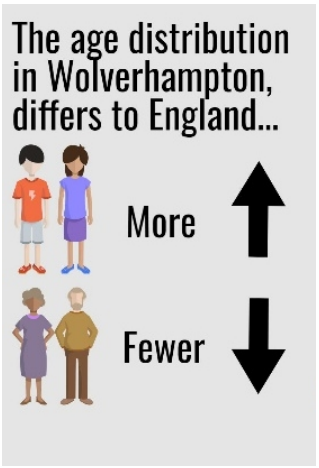
- Key findings for Age Well section

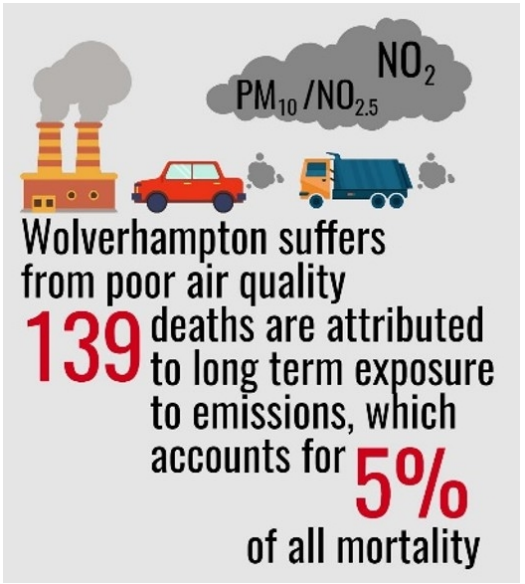


- Key findings for Wolverhampton City section









3.4 Over the last year, various organisations including the Wolverhampton CCG, Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust, University of Wolverhampton, Police and various departments within Wolverhampton Council such as public health, social care, education, housing, transport and business intelligence have been involved in providing data and developing the JSNA. We would like to continue with this participatory approach to the JSNA across the whole system of health and social care.

4.0 Topics prioritised for topic-specific JSNAs

4.1 A comprehensive topic prioritisation process was undertaken to identify the priorities to be developed into topic-specific JSNAs for the coming year. This process included completion of prioritisation templates that estimated population need based on a range of criteria such as severity, trend, benchmarking as well as influence of national/ local policy drivers. The templates were completed by Wolverhampton CCG, Social Care, Public Health and wider determinants such as Spatial Planning and NEET.

4.2 A topic prioritisation survey was undertaken with the public and members of staff of various organisations including City of Wolverhampton Council, Wolverhampton CCG, Royal Wolverhampton NHS Trust, Black Country Partnership Foundation NHS Trust, University of Wolverhampton and businesses within Wolverhampton. A total of 229 survey responses were received.

4.3 The results of the completed topic prioritisation templates and the topic prioritisation survey were considered by the JSNA Steering group on 9 May. The topics were categorised on the basis of the lead organisation/department for the topic previously agreed by the Steering Group – Public Health, CCG, Social Care and Wider Determinants.

4.4 Following discussion and a Steering Group voting exercise the following topic areas were prioritised for the development of topic specific JSNAs over the next year:

- Social Care – Currently being reviewed by social care
- Public Health – ‘Violence (including children, domestic abuse, violent crimes)’ and ‘Falls’
- Wolverhampton CCG – ‘Chronic Ambulatory care sensitive conditions’ and ‘Dementia’
- Wider Determinants – ‘Employment and Health and Homeless People’ and ‘Rough Sleepers’

5.0 Future development of the JSNA

5.1 Currently, the JSNA products are available as a PowerPoint or Excel portable document format (PDF) which does not allow the user to search the various sections for specific information.

5.2 An interactive interface for the presentation of JSNA products was agreed by the HWBB in October 2015. As the JSNA is a partnership of health and social care agencies consideration needs to be given to how an interactive platform will be developed, funded and placed to ensure access to relevant, up to date information to inform health and social care commissioning.

5.3 In addition, we are planning to develop 'Live summary updates' which would include up-to-date data on key health and social care indicators which can support commissioning decisions.

6.0 Access to the JSNA

All JSNA documents are now available on the Council website on the following link http://www.wolverhampton.gov.uk/jsna

7.0 Financial implications

7.1 The interactive platform to be developed for the JSNA will cost approximately £10,000. The HWBB is to discuss and advise on how this is funded as the JSNA is a partnership of health and social care organisations. [GS/05062017/N]

8.0 Legal implications

8.1 There are no anticipated legal implications to this report. RB/22052017/V

9.0 Equalities implications

9.1 The process of analysing health and social care need may highlight inequalities in service access or provision which could adversely affect people differently or not meet the needs of certain groups. There will be specific recommendations made regarding commissioned services, where applicable, to address any inequalities identified

10.0 Environmental implications

10.1 There are no environmental implications related to this report.

11.0 Human resources implications

11.1 There are no anticipated human resource implications related to this report.

12.0 Corporate landlord implications

12.1 This report does not have any implications for the Council's property portfolio.

13.0 Schedule of background papers

13.1 HWBB paper presented in November 2016, Wolverhampton Joint Strategic Needs Assessment: Policy and Process 2016 presented at JSNA Steering Group on 1 February 2016 and HWBB paper presented in October 2015