Health and Wellbeing Board

9 July 2014

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

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

Information for the Public

If you have any queries about this meeting, please contact the democratic support team:

Contact Carl Craney
Tel/Email 01902 555046 carl.craney@wolverhampton.gov.uk
Address Democratic Support, Civic Centre, 2nd floor, St Peter's Square, Wolverhampton WV1 1RL

Copies of other agendas and reports are available from:

Website http://wolverhampton.cmis.uk.com/decisionmaking
Email democratic.support@wolverhampton.gov.uk
Tel 01902 555043

Please take note of the protocol for filming and recording of, and use of social media in, meetings, copies of which are displayed in the meeting room.

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*

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence**

2 **Notification of substitute members**

3 **Declarations of interest**

4 **Minutes of the previous meeting (7 May 2014)** (Pages 1 - 6)
[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 meeting held on 7 May 2014]

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

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

8 **Better Care Fund - progress report** (Pages 15 - 22)
[To receive an update on progress regarding the development of the Better Care Fund]
[Noreen Dowd]

9 **Urgent Care Strategy - update** (Pages 23 - 26)
[To receive an update on the Urgent Care Strategy prior to the commencement of the public consultation exercise]
[Noreen Dowd]

10 **Joint Re-ablement and Intermediate Care 2014 - 16 - update** (Pages 27 - 48)
[To consider the Joint Re-ablement and Intermediate Care Strategy 2014 – 16]
[Tony Ivko]

11 **Director of Public Health Annual Report - Obesity Call to Action** (Pages 49 - 76)
[To consider the Director of Public Health's Annual Report 2013/14]
[Ros Jervis]

12 **Local Government Declaration on Tobacco Control** (Pages 77 - 84)

[To receive details on the Local Government Declaration on Tobacco Control and to consider becoming a signatory to the Declaration]

[Ros Jervis]

13 **Care Act 2014** (Pages 85 - 94)

[To receive details of the Care Act Implementation and Personalisation Programme Board]

[Emma Bennett]

14 **Wolverhampton City Clinical Commissioning Group - 5 Year Strategic Plan** (Pages 95 - 164)

[To consider the 5 year Strategic Plan for the Wolverhampton Health and Social Care Economy]

[Noreen Dowd]

15 **Feedback from Sub Groups** (Pages 165 - 190)

[To receive feedback from the following Sub Groups]

(i) Children’s Trust Board

[Emma Bennett]

(ii) Adults Delivery Board

[Viv Griffin]

(iii) Public Health Delivery Board

[Ros Jervis]

16 **Exclusion of press and public**

[To pass the following resolution:

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

Part 2 – exempt items not open to the public and press

17 **Capital Programme Projects - NHS England**

[To receive a report on the current position]

[Dr Kiran Patel]

This page is intentionally left blank

Health and Wellbeing Board

Minutes - 7 May 2014

Attendance

Members of the Health and Wellbeing Board

Cllr Mrs Sandra Samuels (Chair) – Cabinet Member for Health and Wellbeing
Cllr Val Gibson - Cabinet Member for Children and Families
Ch. Sup. Simon Hyde - West Midlands Police
Christine Irvine - Wolverhampton Voluntary Sector Partnership
Ros Jervis - Director of Public Health, Community Directorate
Bob Jones - West Midlands Police and Crime Commissioner
Sarah Norman - Strategic Director for Community, Community Directorate

Employees

Glenda Augustine	Consultant in Public Health, Community Directorate
Noreen Dowd	Chief Operating Officer, Wolverhampton City Clinical Commissioning Group
David Kane	Head of Finance, Delivery Directorate
Michael Murphy	Interim Assistant Director, Older People and Personalisation, Community Directorate
Carl Craney	Democratic Support Officer, Delivery Directorate
Observer	
David Elliot	Public Health England (Observer)

DRAFT

Part 1 – items open to the press and public

Item No. *Title*

1. **Apologies for absence**
Apologies for absence had been received from Cllr Steve Evans (Wolverhampton City Council), Viv Griffin (Wolverhampton City Council), Professor Linda Lang (University of Wolverhampton) and Dr Kiran Patel (NHS England – Local Area Team).

2. **Notification of substitute members**
Professor Linda Lang had indicated that either Angela Clifford or Ranjit Khutan might represent her at the meeting, subject to availability.

3. **Declarations of interest**
No declarations of interest were made in relation to items under consideration at the meeting.

4. **Minutes of the previous meeting**

Resolved:

> That the minutes of the meeting held on 31 March 2014 be confirmed as a correct record and signed by the Chair subject to the addition of "Sarah Norman – Director of Community" in the list of members present.

5. **Matters arising**

There were no matters arising from the minutes of the meeting held on 31 March 2014.

6. **Summary of outstanding matters**

Carl Craney reported that the report relating to the Summary of outstanding matters had been omitted from the papers circulated for this meeting and undertook to ensure it was included in the published Document Pack and circulated separately to Members.

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

Carl Craney reported that the report relating to the Health and Wellbeing Forward Plan 2014/15 had been omitted from the papers circulated for this meeting and undertook to ensure it was included in the published Document Pack and circulated separately to Members.

8. **Wider Determinants of Health**

Ros Jervis presented a report which outlined progress on the Joint Health and Wellbeing Strategy priority relating to Wider Determinants of Health. She referred to the inequalities in Wolverhampton, the key strands that made up the wider determinants, and the progress to date with key issues, including:

- Obesity;
- Looked after Children prevention;
- Establishment of a Healthier Place Team;
- Transformation Fund and
- Challenges to delivering the wider determinants priority.

With regard to the key work strand in respect of Obesity, she reminded the Board of the challenge which had been posed to Wolverhampton by Dr Liam Donaldson on 28 June 2013 at the launch of Wolverhampton Healthwatch to target one of the many problems facing the local population. Following this challenge obesity had been selected as a target and would form the key topic of the Annual Public Health report for 2014. This would include a call to action to all partners to respond to the problem.

With regard to the key challenge regarding prevention of Looked after Children she reported on a multi- agency summit which had been held on 6 May 2014 with a view to all partners working together to address the issue of the increasing Looked After population which had long term effects on the outcomes for those children. A further Summit was planned for 25 June 2014 at which partners would be invited to sign up to an Action Plan.

A further 8 strands for action had been identified and a report on progress would be submitted to the next meeting of the Public Health Delivery Board and to this Board at the July meeting. She also advised the Board of the expansion of the Public Health service with the integration of the Sports Development Team, the Parks and Countryside team and the Healthy Schools team. This would not only increase the

capacity of the Public Health Team but would also bring an additional perspective to addressing the various issues.

Christine Irvine reminded the Board of the role of the Voluntary Sector in addressing many of the topics now under consideration and enquired as to whether the subject of healthy eating was still addressed within schools and, in particular, through Children's Centres. Ros Jervis reported that Healthy Eating and the "Food Dudes" initiative continued to be very popular in schools but emphasised the need for families as a whole and not just children to be targeted if long term success and/or progress was to be achieved. Increasingly, there was a demonstrable need to target children at an earlier age as it was now not uncommon for children to enrol at Reception Class with obesity issues. Children's Centres continued to play an important part in communicating the importance of healthy eating and the nutritional value of particular food. She opined that the return of responsibility to for Health Visitors to local government in October 2015 would also assist in the provision of a whole systems way of working with the associated benefits.

Cllr Val Gibson referred to the approach being adopted through the Families First initiative and on the work being undertaken with Essex County Council with a view to reducing the Looked after Children population within the City. She enquired as to any progress on working with the Planning and Environmental Health Services to address the issues relating to the proximity of fast food establishments to schools, and in particular, secondary schools, where pupils were often to be seen using these establishments during lunch breaks. Ros Jervis explained that this issue was addressed specifically within the Public Health Annual report and that use was being made of the Transformation Fund to encourage the proprietors of such establishments to offer healthy alternatives and / or to increase the nutritional value of food offered.

The Chair, Cllr Sandra Samuels, commented on the production by the Local Government Association on the role of Health and Wellbeing Boards in town and country planning matters including steps to reduce the proliferation of fast food establishments close to school premises. She also enquired as to whether any targets had been set with regard to the prevention of children entering care. Sarah Norman advised that targets for this subject were not set as the needs of the child were always paramount and if being taken into local authority care was the most appropriate action that is what would occur. Work was, however, being undertaken to establish the reasons behind the high level of children in care in the City and the Family is First Team were working with colleagues from Essex County Council on this issue. Accordingly, "ambitions" rather than "targets" would be established. Emma Bennett was leading the work in this area. Viv Griffin informed the Board of the dangers of setting targets in this field and outlined the experiences of the London Borough of Lambeth.

Resolved:

1. That the workstreams that made up the wider determinants of health priorities of the Joint Health and wellbeing Strategy be noted and endorsed;

2. That further consideration be given to the challenges to working and ways of enhancing these workstreams, including formulating suggestions on how to promote "whole systems" approach to reduce traditional "silo" working which can hinder the partnership working needed to improve health and tackle health inequalities through the wider determinants of health;
3. That the selection of obesity as the subject of the Director of Public Health's 2013/14 Annual Report, which can only be tackled successfully through an approach that has the wider determinants of health at its heart, and receives a presentation on the Annual Report at the July 2014, meeting be noted;
4. That a report be presented to a future meeting which investigates further reasons for the increasing health inequalities gap in life expectancy in Wolverhampton.

9. **Joint Strategic Needs Assessment (JSNA) for 2014/15**

Ros Jervis presented a report which recommended priorities for updating the Joint Strategic Needs assessment (JSNA) in 2014/15.

Resolved:

That the themed update for 2015 focus on children and young people and especially the following vulnerable groups:

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

10. **Health and Social Care Strategic Overview Group to inform local intelligence**

Glenda Augustine presented a report on Terms of Reference and governance arrangements for the Health and Social Care Information Group to inform local intelligence in relation to performance reports for integrated initiatives which had been established at the meeting held on 31 March 2014.

Ros Jervis advised the Board that the governance arrangements for the Better Care Fund were still under discussion. Dr Helen Hibbs commented that she was confident that these arrangements would be formalised by the next meeting of the Board.

Resolved:

That the Terms of Reference and governance arrangements for the Health and Social Care Information Group, as detailed in the report, be approved subject to a further report to the next meeting on the governance arrangements for the Better Care Fund.

.

11. **Better Care Fund - Finalised Submission**

Noreen Dowd presented the final submission in relation to the Better Care Fund which had been subject to a number of minor amendments since the last meeting of

the Board. She reported that the submission had been signed off by the Local Area Team of NHS England and that Wolverhampton was now classified as a "low risk health economy". She reported that the first meeting of the Interim Delivery Board had been held and that leads and governance issues had been identified. Interviews for the post of Programme Manager were due to be held on 7 and 8 May 2014.

Sarah Norman drew to the attention of the Board an article which had appeared in that morning's edition of The Guardian newspaper with regard to proposals abolish the Better Care Fund. This assertion had been refuted by Brandon Lewis from the Department of Communities and Local Government. She also advised the Board that the submissions of some neighbouring authorities had either not yet been signed off or had been "red" rated.

Dr Helen Hibbs acknowledged that the metrics would be difficult to deliver in the short term but would have long term benefits. Maxine Bygrave enquired as to the steps proposed to engage with the public in respect of the proposals contained within the submission. Noreen Dowd advised that one public engagement event had been held and further similar events were planned. A Communications Plan was being developed and the voice of the patients were integral and essential to the success of the proposals. Public Engagement would form part of the Delivery Plan.

Resolved:

1. That the final submission in relation to the Better Care Fund and the feedback and recommendations of the Local Area Team of NHS England be noted that the submission be approved be noted ;
2. That the next phase of work to ensure the delivery of the Plan be noted.

12. **Feedback from Sub-Groups**

- **Children's Trust Board**

No meetings of the Children's Trust Board had been held since the last report.

- **Children's Delivery Board**

The Board was advised that the Children's Delivery Board reported to the Children's Trust Board to this Board.

- **Public Health Delivery Board**

Ros Jervis presented a report which informed the Board on the current work of the Public Health Delivery Board and, in particular, matters arising from the meeting held on 8 April 2014.

Maxine Bygrave enquired as to whether there were any areas with a similar profile with regard to Infant Mortality and as to whether any examples of good practice could be utilised to address this issue. Ros Jervis cited a number of possible comparator Authorities but explained the reasons that such comparisons would not be meaningful. She advised that a more realistic approach would be to adopt a regional approach within the West Midlands for meaningful comparisons to be made.

The Chair, Cllr Sandra Samuels, referred to the Black Country Emergency Preparedness and Resilience and Response service and enquired as to any steps taken with regard to Scarlet Fever and Polio. Ros Jervis advised that Polio was an international issue and that Wolverhampton had a good record on immunisation. In

relation to Scarlet Fever, Wolverhampton was currently suffering from a high level of cases and that joint working with Public Health England was being undertaken to address the concern.

13. **Chair's Announcement**

The Chair, Cllr Sandra Samuels, advised that in the absence of Dr Kiran Patel, Medical Director, Local Area Team, NHS England and in the absence of a report it would not be possible to consider the current position on Capital Programme Projects – NHS England.

Resolved:

That consideration of this matter be deferred to the next meeting of the Board.

This report is PUBLIC
[NOT PROTECTIVELY MARKED]

Agenda Item No. 6

Health and Wellbeing Board
9 July 2014

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

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

1.0 Purpose

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

2.0 Background

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

DATE OF MEETING	SUBJECT	LEAD OFFICER	CURRENT POSITION
1 May 2013	Child Poverty Strategy – Timelines, Six Target Wards And Membership Of Stakeholder Workshop	Keren Jones (WCC)	Report to 3 September 2014 meeting
8 January 2014	Certification of Deaths	Ros Jervis (WCC)	Report to a future meeting
8 January 2014	Primary Care Strategy	Richard Young (WCCCG)	Report to a future meeting
	Children's Safeguarding Action Plan – New approach	Emma Bennett (WCC)	Report to this meeting (via Children's Trust Board report)
8 January 2014	Better Care Bill / Special Educational Needs of Children	Anthony Ivko (WCC)	Report to a future meeting
8 January 2014	Primary Care Strategy	Richard Young (WCCCG)	Report to a future meeting
8 January 2014	Local Government declaration on tobacco control	Ros Jervis (WCC)	Report to this meeting
8 January 2014	Report back from	Viv Griffin (WCC)	Report to a future

	SEND Sub Group		meeting
31 March 2014	Health and Well Being Strategy – Performance Monitoring	Helena Kucharczyk (WCC)	Quarterly reports
31 March 2014	Children's Trust Board – future structure, membership, frequency of meetings and terms of reference	Emma Bennett (WCC)	Report to July 2014 meeting (via Children's Trust Board report)
31 March 2014	NHS Capital Programme – NHS England – GP practices in Wolverhampton	Les Williams / Dr Kiran Patel (NHS England)	Quarterly reports
7 May 2014	Wider Determinants of Health	Further consideration of challenges to ways of working to promote "whole systems" approach.	Report to future meeting
7 May 2014	Director of Public Health Annual Report – Tackling Obesity	To receive the DoPH Annual Report	Report to this meeting
7 May 2014	Better Care Fund	To receive proposals in relation to the governance arrangements	Report to this meeting

3.0 Financial implications

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

4.0 Legal implications

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

5.0 Equalities implications

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

6.0 Environmental implications

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

7.0 Human resources implications

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

8.0 Corporate landlord implications

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

9.0 Schedule of background papers

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

Agenda Item No. 7

Health and Wellbeing Board

9 July 2014

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

Recommendation

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

MEETING	TOPIC	LEAD OFFICER
9 JULY 2014 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Better Care Fund – progress report	Noreen Dowd (WCCCG)
	Urgent Care Strategy – update	Noreen Dowd (WCCCG)
	Intermediate Care update	Anthony Ivko (WCC)
	Public Health Annual Report (Obesity Call to Action)	Ros Jervis (WCC)
	Local Government Declaration on Tobacco Control	Ros Jervis (WCC)
	Care Act 2014	Simon Nightingale (WCC)
	Wolverhampton Clinical Commissioning Group – 5 Year Strategic Plan	Noreen Dowd (WCCCG)
	Capital Programme Projects – NHS England	Dr Kiran Patel (NHS England)
3 SEPT 2014 (1230 HOURS)	**YOUNGER ADULTS THEMED MEETING**	
	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Drugs and Alcohol priority update	Ros Jervis (WCC)

	Child Poverty Strategy	Keren Jones (WCC)
	Dementia Care update	Anthony Ivko (WCC)
5 NOVEMBER 2014 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Joint Strategic Needs Assessment (JSNA) – Refresh	Ros Jervis (WCC)
	Implementation of Action Plans following Francis Report – Update	WCCCG / RWHNHST
7 JANUARY 2015 (1230 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
4 MARCH 2015 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)

To be added at some appropriate point: YOT input JSNA

This page is intentionally left blank

Agenda Item No. **8**

Health and Wellbeing Board
9 July 2014

Report Title	Better Care Fund - Update	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Wolverhampton Clinical Commissioning Group Wolverhampton City Council	
Accountable officer(s)	Sarah Carter Tel Email	Programme Director – BCF 01902 445941 sarah.carter21@nhs.net
	Viv Griffin	Assistant Director Health, Wellbeing and Disability Wolverhampton City Council
	Tel:	01902 555370

Recommendations for noting:
The Health and Wellbeing Board is asked to note and comment on:

1. The progress that has been made since the last report
2. The planned activity for the next 3 months
3. The changes to the governance and assurance structure
4. The process to achieve multi agency agreement of the workstream transformational change programmes

1.0 Purpose

1.1 The purpose of this report is to update the Health and Wellbeing Board on progress regarding the development of the Better Care Fund Programme, ensuring that the requirements of the programme are fully known and understood, and that the Health and Wellbeing Board are fully sighted on the current position, and next steps.

2.0 Background

The Better Care Fund Programme (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. The fund encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability, and is an important enabler to take forward the agenda of integration (both service delivery and commissioning) at scale and pace. The programme will build on existing work the Council and Clinical Commissioning Group have already undertaken in relation to joint development of programmes, and support the sustainable delivery of services to the people of Wolverhampton.

3.0 Progress, options, discussion, etc.

The initial submission of the Better Care Fund Programme was made to NHS England in April. A further iteration is expected to be made on the 1st August 2014. This is a single plan jointly agreed across health and social care, and incorporating public engagement. Governance arrangements have been established which include a Transformation Delivery Board, a Transformational Commissioning Board, and direct reporting into the Health and Wellbeing Board for formal agreement. Please see Appendix 1.

There are national conditions and national metrics associated with the development of the BCF programme. They are articulated below, alongside the current collaborative BCF response to them;

National Conditions	**BCF Programme Update**
Jointly agreed plans between health and social care	Agreed and submitted to NHS England, a further iteration to be submitted on 1st August 2014. The Health and Wellbeing Board is the approval group for this submission
Protection of social care services (to be locally agreed)	The DFGs/Carers Grant and Community Capacity Grant (which form part of the scope of the programme, are passported automatically into the local authority, in addition demographic growth has been factored into the financial commitment to the value of £2m, alongside a £989k commitment to support the Care Bill implementation and section 256 monies, all contribute towards the mandate of protecting social care services.
7 day services in health	There are currently 4 workstreams operating in support of the transformational change programmes required from

and social care to support discharge and prevent unnecessary admissions	the implementation of the programme, they are; mental health, dementia, nursing and residential care homes, and intermediate care. 7 day services is a core component of these workstream programmes
Data sharing should be developed across the health and social care agencies	This is an enabling strategy to support the improved integrated health and care services delivery, and a shared understanding of the current profile of Wolverhampton; as such a business case is under development for the development of a shared IT system in collaboration with local providers.
Joint approach to assessment and care planning	There are currently 4 workstreams operating in support of the transformational change programmes required from the implementation of the programme, they are; mental health, dementia, nursing and residential care homes, and intermediate care. Further developing a joint approach to assessment and care planning is a core component of the workstream programmes. Each workstream has an executive sponsor from both commissioning organisations, and named workstream project leads. Health and social care provision is represented on the workstream programmes, however further work needs to be undertaken to ensure effective inclusion and engagement from the voluntary sector in each of the workstreams.
Agreement of the impact on the acute sector(provider by provider breakdown and analysis) + public, patient and service user engagement in planning	This analysis has been undertaken and submitted as part of the BCF programme

National and Local Metrics	**BCF Programme Update**
DTOCs	These are being measured between April and December 2014 for reduction achievement
Avoidable emergency admissions	These are being measured between April and September 2014 for reduction achievement
Admissions to residential	These are measured within the 2015/16 programme

and nursing care homes	
Effectiveness of reablement	This metric is measured within the 2015/16 programme
Patient/service user experience	Consideration is currently being given to the way in which experience can/should be captured to demonstrate improvements
Dementia diagnosis (local)	A focus on improving diagnosis rates for dementia in primary care is aligned to both the PCIS and the national planning guidance. Underpinning this is the alignment of the development of the dementia care pathway to provide earlier community focussed support to those diagnosed with dementia.

During July each workstream will participate in a facilitated all day workshop, to develop and consolidate the programme, and ensure we have a consistent approach to programme discipline and delivery. Membership of the workstream project groups includes representation across health and social care provision and commissioning.

Future areas of consideration for the further development of the BCF programme plan include;

- Full integrated care pathway development
- Joint outcomes based commissioning approaches
- Development of joint approaches to the delivery of efficiency
- Further workstreams including primary/community care and early impact analysis of options

4.0 Financial implications

4.1 The Health & Well-Being Board are requested to note the following potential implications:

The plans have been approved as financially deliverable through the NHS England process, however, a question remains whether they are ambitious enough to take forward whole system transformational change of health and care delivery over a significant programme lifecycle. This will be a consideration of the transformational Commissioning Board moving forward.

The plan is delivered within 85% currently committed resources, and is dependant upon the ability of the system to transform in order to reduce activity in acute care (unplanned emergency admissions, length of stay, and reduced readmissions), reduce spend into long term care placements, and deliver earlier intervention and prevention.

Both commissioning organisations are operating within austere economic conditions with challenging efficiency programmes. The CCGs financial position has worsened since the previous report, and the local authority faces significant budgetary challenges. The programme needs to ensure that benefit delivered is only counted once, and that joint approaches are developed to strategic commissioning and service development transformation that support achieving sustainable delivery models and the requirements of each organisations financial challenge.

In mitigation, the governance structure which has been implemented will continue to ask core questions of the programme which include;

- Does the proposal deliver against the metrics?
- How will benefit be extracted?
- Where will the benefit be deployed?
- What are the timeframes for benefit delivery?
- Is the transformation iterative over a number of years?
- Are there any hidden financial risks?
- Is the transformation sustainable?

Core to the effective delivery of the programme is ensuring that proposals do not destabilise the health and social care system, as this could have significant financial impact. Workstreams continue to develop individual sensitivity analysis with regard to financial impact, and a systematic approach to ensuring financial impact is managed.

As mentioned earlier in this report, protection of social care services has been incorporated into plans and jointly agreed.

5.0 Legal implications

5.1 In 2015/16 the fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements.

6.0 Equalities implications

6.1 Each work programme and proposal for transformational change will have an equality impact assessment in order to demonstrate that the changes have no adverse impact on the protected characteristics.

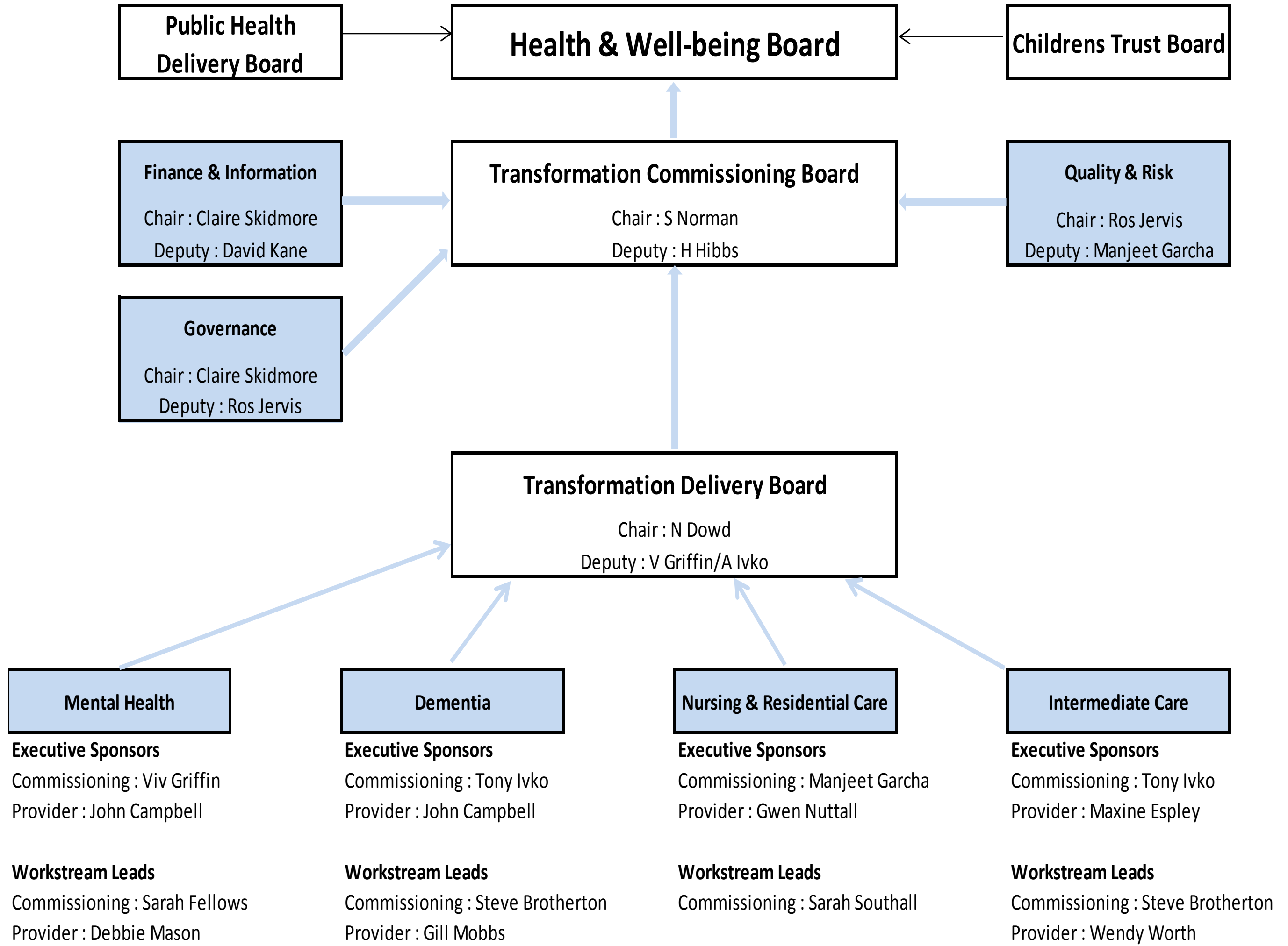
7.0 Environmental implications

7.1 No direct implications at this stage.

8.0 Human resources implications

8.1 Transfer of Undertakings for the Protection of Employment (TUPE) will apply for those staff currently working on existing contracts where services are affected by procurement approaches.

Appendix 1.



Mental Health	Dementia	Nursing & Residential Care	Intermediate Care
Executive Sponsors	**Executive Sponsors**	**Executive Sponsors**	**Executive Sponsors**
Commissioning : Viv Griffin	Commissioning : Tony Ivko	Commissioning : Manjeet Garcha	Commissioning : Tony Ivko
Provider : John Campbell	Provider : John Campbell	Provider : Gwen Nuttall	Provider : Maxine Espley
Workstream Leads	**Workstream Leads**	**Workstream Leads**	**Workstream Leads**
Commissioning : Sarah Fellows	Commissioning : Steve Brotherton	Commissioning : Sarah Southall	Commissioning : Steve Brotherton
Provider : Debbie Mason	Provider : Gill Mobbs		Provider : Wendy Worth

This page is intentionally left blank

Agenda Item No. **9**

Health and Wellbeing Board
9 July 2014

Report Title	Urgent Care Strategy - Update	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Wolverhampton Clinical Commissioning Group	
Accountable officer(s)	Noreen Dowd	Interim Director
	Tel	01902 445797
	Email	Noreen.dowd1@nhs.net

Recommendations for noting:
The Health and Wellbeing Board is asked to note and comment on:

1. The progress that has been made since the last report in November 2013
2. The outcome of the three month patient consultation process
3. The process to secure sign off of the final Joint Urgent and Emergency Care Strategy
4. The process to monitor the implementation of the Strategy
5. The Equality Analysis for the urgent and emergency care proposals is brought to a future meeting of the Board.

and to provide feedback on when the Health and Wellbeing Board would require further updates on the implementation of the strategy

1.0 Purpose

1.1 The purpose of this report is to provide an update on the progress since presenting the draft Urgent and Emergency Care Strategy to this Board in November 2013, prior to going out to public consultation.

2.0 Background

The Draft Joint Urgent and Emergency Care Strategy was initially presented to Clinical Commissioning Group (CCG) Governing Body back in May 2013. The Governing Body supported the principles behind the strategy but required the support of Health and Well-being Board before it was signed off.

The revised version of the strategy was presented and supported by Health and Well-being Board and Health Scrutiny in/around November 2013.

A three month public consultation commenced in Dec 2013, concluding in March 2014. On 8 April 14, CCG Governing body accepted the communications and engagement report which; set out the methodology of the urgent care consultation; the level of public support for the strategy and; gave the CCG and Urgent Care Working Group (UCWG) themed insight into patient worry areas which will be built into our implementation plans.

3.0 Progress, options, discussion, etc.

The draft Joint Urgent and Emergency Care Strategy has now been finalised with the only major changes being the reflection on the engagement process and the implications locally from the Sir Bruce Keogh review found within the publication ""Transforming urgent and emergency care services in England – DH 2013". Minor changes included changes in tense.

The Joint Urgent and Emergency Care Strategy was approved at the Urgent Care Working Group on 13/06/14. It is on the agenda for RWT Trust Board for sign off on 30/06/14 and CCG Governing Body on 08/07/14.

Once approved, it will be publicly available.

4.0 Financial implications

4.1 The Health & Well-Being Board are requested to note the following potential implications:

The Joint Urgent and Emergency Care Strategy outlines the overarching vision for the system. There is no additional resource available therefore the system described within the strategy has to be delivered within the existing financial envelope.

However, the vision requires large scale system change required by more than one organisation simultaneously. To mitigate against this, the Urgent Care Working Group will monitor activity and progress across organisations.

Due to the scale of change it may be difficult to predict the activity numbers of patients who are likely to use the services in future

Financial implications may arise, especially if demand continues to increase at its current rate.

5.0 Legal implications

5.1 The system change detailed within the strategy will require the CCG to follow stringent procurement processes in line with current guidelines.

6.0 Equalities implications

6.1 An equality analysis has been undertaken and is currently in draft form pending the inclusion of local data on interpreting and language support. The assessment for the proposed changes was that "the demographic information available suggests that the health inequality gap between different groups is unlikely to be widened by the proposals". The analysis also includes 21 recommendations for the Health economy in Wolverhampton relating to strategic and operational matters. It is suggested that the Board consider the equality analysis at a future meeting

7.0 Environmental implications

7.1 The environmental implications will arise from the building of a new Emergency and Urgent Care Centre on the Acute Trust site at New Cross Hospital. The Acute Trust have submitted a Full Business Case to the Trust Development Agency (TDA) which includes a full environmental impact assessment. The TDA have approved the new build

8.0 Human resources implications

8.1 Transfer of Undertakings for the Protection of Employment (TUPE) will apply for those staff currently working on existing contracts where services will be affected by the changes

This page is intentionally left blank

Agenda Item No. **10**

Health and Wellbeing Board

9 July 2014

Report title	Joint Reablement and Intermediate Care Strategy for Wolverhampton 2014- 2016
Cabinet member with lead responsibility	Councillor Steve Evans Adult Services
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	Commissioning
Accountable employee(s)	Steve Brotherton Head Of Commissioning Tel 01902 555318 EmailSteve.brotherton@wolverhampton.gov.uk Helen Rowney Commissioning Officer Tel 01902 555495 Email Helen.rowney@wolverhampton.gov.uk
Report has been considered by	Cabinet 25 June 2014

Recommendation(s) for decision:

The Health and Wellbeing Board is recommended to:

1. Approve the Joint Reablement and Intermediate Care Strategy for Wolverhampton 2014-2016.

1.0 Purpose

1.1 The purpose of this report is to seek approval from the Health and Well Being Board for the Joint Reablement and Intermediate Care Strategy 2014 -2016.

2.0 Background

2.1 In 2011 Wolverhampton launched its first Reablement Forward Plan, articulating its commissioning intentions with regard to reablement activity. Over the last two years there have been significant changes across the health and social care economy, not least the implementation of the Health and Social Care Act 2013.

2.2 In response to these changes and through discussions at the Adult Delivery Board, health and social care partners identified the need to expand the reablement plan to include health based intermediate care services.

2.3 This joint strategy has been presented to Adult Delivery Board in December 2013 and February 2014. Members of Adult Delivery Board were invited to comment and which have been reflected in the final version.

2.4 The implementation plan linked to the joint strategy with timescales will be delivered through the individual work streams identified on page 16 of the joint strategy.

2.5 This joint strategy will be presented to relevant boards /committees of the Health and Social Care partners as appropriate.

3.0 Progress, options, discussion, etc.

3.1 In June 2013 Helen Sanderson and Associates facilitated a workshop with front-line operational staff from across the health and social care economy. This workshop delivered the following headlines:

- Reablement requires ownership by all partner agencies
- The current governance arrangements need to be revisited to reflect the joint ownership
- An outcomes framework needs to be agreed across all partner agencies with a robust monitoring framework
- Both quantitative and qualitative data needs to be reported – this will ensure that any quality of life outcomes will be captured
- Success stories should be celebrated and disseminated through social media – this will help facilitate a wider cultural shift in relation to aspirational change
- More work is needed with the external market to change culture and practice

3.2 The headlines from this first workshop formed the basis of the opening presentation at a second workshop in July 2013 facilitated by the Institute of Public Care. This was a high level strategic workshop attended by Senior Responsible Officers from key partners

across the health and social care economy. This workshop delivered the following headlines:

- There is a recognition that reablement delivers improved quality of life outcomes for individuals and financial savings for the public sector
- Health and social care organisations need to align their reablement and intermediate care intentions and work in an integrated way to deliver these outcomes
- More evidence and better understanding is needed about the longer-term benefits of reablement
- More work is needed with the wider market to incentivise reablement and intermediate care activity

4.0 Financial implications

4.1 There are no direct financial implications from this report.

4.2 There will be financial implications resulting from the implementation of the strategy. As the detailed plans are developed they will need to work within the parameters of the available budgets.

[AS/11062014/X]

5.0 Legal implications

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

[RB/13062014/K]

6.0 Equalities implications

6.1 This report has equality implications. This strategy details the reablement and intermediate care intentions in order to maximise opportunities for independent living for vulnerable people. An equality analysis has been completed and will be reviewed as part of the implementation plan.

7.0 Environmental implications

7.1 There are no environmental implications.

8.0 Human resources implications

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

9.0 Corporate landlord implications

9.1 There are no implications for the Council's property portfolio.

10.0 Schedule of background papers

10.1 There are no additional supporting documents.

Joint Reablement and Intermediate Care Strategy for Wolverhampton

2014- 2016

Wolverhampton City Clinical Commissioning Group

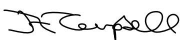
Foreword

This strategy details the reablement and intermediate care intentions of Wolverhampton's health and social care economy.

Our aim is for the principles, outcomes and metrics to instil a preventative philosophy, which will require a change of investment and approach in order to maximise opportunities for independent living.

The plan describes our key development areas in response to this changing landscape and supports the ambition of our Better Care Fund, which is to deliver the Right Care in the Right Place at the Right Time.

Wolverhampton City
Clinical Commissioning Group



Introduction

In the summer of 2011, Wolverhampton launched its first Reablement Forward Plan, articulating its commissioning intentions with regard to reablement activity over the following two years. Over this time, there have been significant changes across the health and social care economy, not least the implementation of the Health and Social Care Act 2013.

In response to these changes and through discussions at the Adult Delivery Board, health and social care partners have identified the need to expand the reablement plan to include health based intermediate care services.

The purpose of this refreshed document is to expand the scope of the original plan by including intermediate care; updating the governance and outcomes framework to reflect the changing priorities, and set the framework for the construction and delivery of work programmes going forward. The document also highlights a number of best practice examples and articulates a Principles Framework that will guide reablement and intermediate care activity in Wolverhampton for the next two years.

What is Intermediate Care?

The Department of Health released the original Intermediate Care guidance in 2001 and released updated guidance, Intermediate Care – Halfway Home, in 2009 which sets out the national requirements for intermediate care. This guidance provides the following definition for Intermediate Care:

> "Intermediate Care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long term residential care, support timely discharge from hospital and maximise independent living"

Intermediate care services can be defined as meeting the following criteria:

- They are targeted at people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS inpatient care
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home
- They are time limited, normally no longer than six weeks and frequently as little as one to two weeks or less

What is Reablement?

The term reablement defines the use of timely and focussed intensive therapy and care in a person's own home in order to enable them to remain or return to living independently. This

approach focusses on optimising people's independence with the lowest appropriate level of ongoing support and care.

National and Local Guidance and Research

In the context of a 26% contraction of public sector budgets, there are a number of factors driving the further development of reablement and intermediate care activity.

First and foremost, maximising independent living is a vital component of improving the health and wellbeing of the population and raising the quality of services people receive. Intermediate care and reablement activity is seen as being central to providing timely, appropriate, enabling and empowering care to individuals

The conclusions reached by the Care Services Efficiency and Delivery Programme from their national studies (CSED, 2007 & 2010) have had the biggest influence on the development of reablement activity. These can be summarised as follows:

- Domiciliary reablement delivers a 60% reduction in on-going social care service usage (and cost)
- Two thirds of reablement users required a reduced or no service response after their reablement intervention.
- Two thirds of reablement users were still managing without a service two years after their reablement intervention
- One third of those who needed an on-going package had reduced or maintained that package.

In addition, the Social Care Institute for Excellence (SCIE 2012) reached the following conclusions from its review of the reablement research:

- Reablement leads to improved health and wellbeing
- Reablement improves outcomes and reduces expenditure on on-going support
- There is no single leading delivery model
- Government investment in reablement could lead to more joint working and funding between health and local government
- Assessment and goal planning are integral to people achieving their individual aims
- Occupational therapists have a key role in the provision of reablement and can assist in on-going reablement activity for people with complex conditions
- More evidence is needed on how reablement influences outcomes in different models of delivery
- Research suggests that customer satisfaction can be high from a well-run reablement service

In January 2013, the University of Birmingham hosted a Social Care Evidence in Practice workshop on the topic of reablement. This workshop reported on the first phase of an academic study, which included a survey of Directors of Social Services followed by interviews with identified intervention leads. It delivered the following research headlines:

- 4 out of 9 studies available nationally have been produced or commissioned by CSED - the national promoter of reablement
- There is much repetition of data from key studies and the volume of research is extremely limited
- The long-term nature of the studies is very limited – a 2 year follow up was never carried out
- There has been very little focus on a variety of user target/sub groups: for example, people with dementia
- The cost impact for carers has not been considered in any of the studies

The overarching conclusions from this workshop were:

- Reablement activity has large upfront costs
- Reablement is more expensive than traditional home care but leads to reduced service usage and better individual outcomes
- Reablement is potentially cost effective over time but more research is needed

For such a visible intervention this lack of research evidence highlights a challenge for practitioners in using an evidence base to inform current practice and develop services.

Demography

This driver can be summarised as more people to serve with less money. The value of reablement and intermediate care lies in the potential to decrease the demand for publically funded services, whilst at the same time delivering positive quality of life outcomes for service users and patients - in short, doing the right thing for the right reasons.

Older people are by far the largest user group of publically funded services, and this population is growing.

Wolverhampton population aged 65 and over					
	2012	**2014**	**2016**	**2018**	**2020**
People aged 65-69	11,400	11,500	11,900	11,500	11,300
People aged 70-74	9,600	9,800	9,900	10,500	10,700
People aged 75-79	8,200	8,400	8,400	8,400	8,600
People aged 80-84	6,500	6,400	6,400	6,600	6,800
People aged 85-89	3,800	4,000	4,200	4,300	4,400
People aged 90 and over	2,000	2,300	2,500	2,800	3,100
Total	**41,500**	**42,400**	**43,300**	**44,100**	**44,900**

POPPI (2012)

The 2012 National Audit of Intermediate Care shows that users had an average age of 81 with over 42% of the sample being over 85 years of age. An increase in the population for this age group is therefore going to have a significant impact on demand for intermediate care services

According to the last ONS ethnicity estimates, the majority of those aged 65 and over are from a white ethnic background, with very few from a black minority ethnic background (BME) and these are predominantly Asian. Census 2011 data suggests that 32% of the population are from a BME background, 18.1% Asian, more than previous estimates.

In addition, there are 3,100 people with dementia living in Wolverhampton – this figure is set to increase to 3500 people by 2020.

Wolverhampton population aged 65 and over predicted to have dementia					
	2012	**2014**	**2016**	**2018**	**2020**
People aged 65-69	141	145	148	143	141
People aged 70-74	262	267	271	287	293
People aged 75-79	481	493	493	493	504
People aged 80-84	781	768	768	788	811
People aged 85-89	767	783	822	861	878
People aged 90	597	684	742	829	915
Total	**3,028**	**3,139**	**3,243**	**3,401**	**3,542**

POPPI (2012)

Responding to the reablement/intermediate care needs of people with dementia crystallises the level of challenge facing the health and social care economy. For people with dementia living in an institution can be a daily reality. Several observations can made through the extrapolation of national studies

- A third of people with dementia live in care homes
- Two thirds of the care home population are people with dementia
- One quarter of hospital beds at any one time are occupied by people with dementia
- The inpatient experience for people with dementia has a negative effect on well-being; dementia symptoms and physical and mental health, resulting in poorer quality outcomes when compared to the general population
- One third of people with dementia who are admitted to a general hospital ward never return home and are usually admitted to a care home

Ref
Wolverhampton Joint Dementia Strategy (2011)
Alzheimer's Society (2009)
CSCI (2008)

Intermediate Care Best Practice One– Dementia

Central Lancashire PCT

Ten beds commissioned in a residential home for intermediate care for people with dementia who have been transferred from acute hospital wards. A multidisciplinary team provides support, OT and other therapies, aiming to reskill people to become independent. The team also provides outreach support when people leave linked with a community resource centre providing enhanced day care, drop in, open access and voluntary organisation.

All of this needs to change as articulated in the Joint Dementia Strategy, people with dementia are people first and are entitled to the same rights and opportunities as everyone else. This includes rights and opportunities which maximise the likelihood of regaining or retaining independent living.

Whilst most reablement activity has focussed on older people, the number of people under 65 years of age with moderate and serious disabilities is also projected to increase steadily over the next 20 years (PANSI 2011). This is due to a range of contributing factors: for example, medical advances enabling people to survive life threatening incidents from stroke, road traffic accidents, serious assault, and people living longer with more complex long term impairments,. In addition, many younger disabled people have an increased expectation that they will receive rehabilitation and reablement as part of their journey to recovery or as part of the maintenance of their long term impairment, and want to live more independently and reduce their dependence on care services.

Best Practice Two

The **START** (Short Term Assessment and Reablement Team) service in Shropshire provides a short term period of intensive assessment and reablement to people who want to remain living in their own home. The service is managed centrally and delivered from five locations across the county.

Consultation & Outcomes

In June 2013 Helen Sanderson and Associates facilitated a workshop with front-line operational staff from across the health and social care economy. This workshop delivered the following headlines:

- Reablement requires ownership by all partner agencies
- The current governance arrangements need to be revisited to reflect the joint ownership
- An outcomes framework needs to be agreed across all partner agencies with a robust monitoring framework
- Both quantitative and qualitative data needs to be reported – this will ensure that any quality of life outcomes will be captured
- Success stories should be celebrated and disseminated through social media – this will help facilitate a wider cultural shift in relation to aspirational change
- More work is needed with the external market to change culture and practice

The headlines from this first workshop formed the basis of the opening presentation at a second workshop in July 2013 facilitated by the Institute of Public Care. This was a high level strategic workshop attended by Senior Responsible Officers from key partners across the health and social care economy. This workshop delivered the following headlines:

- There is a recognition that reablement delivers improved quality of life outcomes for individuals and financial savings for the public sector
- Health and social care organisations need to align their reablement and intermediate care intentions and work in an integrated way to deliver these outcomes
- More evidence and better understanding is needed about the longer-term benefits of reablement
- More work is needed with the wider market to incentivise reablement and intermediate care activity

Best Practice Three
Sandwell Reablement Model

STAR (Short-Term Assessment and Reablement) is a support service that is provided in your own home and focuses on short-term assessment and reablement. The aim is to improve the ability to live independently. We can provide this service to you for a maximum of six weeks until you are able to manage once again, or we have supported you to receive other appropriate services.

Local Market

The Department of Health White Paper 'Caring for our Future: reforming care and support' proposed a new duty on local authorities to promote diversity and quality in the provision of services. This duty includes the requirement for all local authorities to publish a Market Position Statement (MPS) by March 2014. A key part of Wolverhampton's MPS is to deliver the following:

- Worked with the Wolverhampton Clinical Commissioning Group (CCG) to issue a statement about future joint commissioning of integrated health and social care services

- Refreshed the Reablement Forward Plan to provide more details about further developing reablement and prevention in partnership with providers

- Produced a more detailed paper based on the joint health and social care strategy for dementia, which will outline specific expectations and requirements of the market when delivering a range of opportunities for people with dementia and their families

In 2012 Wolverhampton City Council along with Wolverhampton Primary Care Trust (PCT) commissioned Community Gateway to undertake a data gathering exercise with the purpose of understanding the scope of both health and social care reablement and intermediate care locally, regionally and nationally. The following conclusions were identified from this research:

- The external market locally and nationally is still in embryonic form and the economic, effectiveness and efficiency benefits of outsourcing in-house services are far from proven

- The national market is relatively underdeveloped the longest externalisation has been four years and some local authorities have experienced serious difficulties in achieving the quality and reliability outcomes they were seeking from externalisation

- There was considerable variation in the hourly price for externalised reablement services

- In those local authorities that had externalised services, the decision was made either for cost reduction reasons and/or part of a wider Council strategy of commissioning /provider separation

The overarching recommendation from this report is that priority should be given to the development of an integrated reablement/intermediate care model with health and social care Providers. There are clear opportunities within this model for cost reduction, duplication avoidance and improved outcomes for patients and service users.

Best Practice Four

Home care reablement service in Leicestershire found that 58−62 per cent of reablement users had their care package discontinued at first review, compared with 5 per cent of a control group; 17−26 per cent had their care package reduced at first review, compared with 13 per cent of a control group (Kent et al, 2000).

Best Practice Five

Hertfordshire Council's Model

A review of the rehabilitation model which although was performing well was high in costs, led to service changes that included payment by results and improved outcomes. Investment was also made in commissioning a new electronic home care monitoring system. A new service specification tied into payment by results was to ensure that hourly cost was reduced along with improved contact time

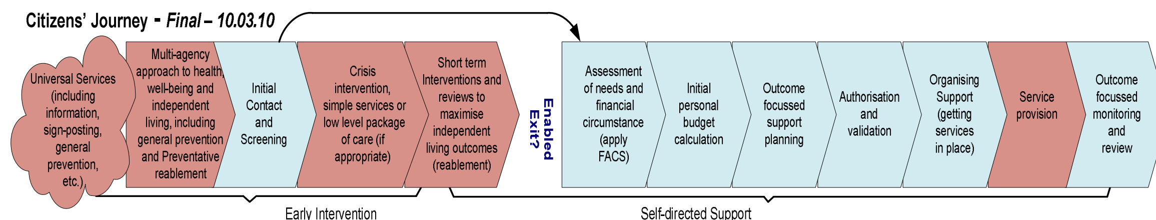
68% of referrals from community and hospital go through rehabilitation

65% of people have no on-going needs

Hourly cost has reduced from £70 to £45

Citizens and Patients Journey

Through its Putting People First Programme, Wolverhampton has developed a Citizen's Journey, which embraces a broader definition of reablement and embeds independent living principles at every stage.



PPF_Citizens Journey_DR_V1.0 (Final)_100310.vsd

Underlining the continuum link between reablement and prevention, a broader strategy approach for reablement has been developed that takes into account all aspects of the Citizens Journey and includes three aspects of a prevention definition:

- ***Universal Prevention/Promoting Wellbeing***

This is aimed at people who have no particular social or health care needs. The focus is on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health, social inclusion and active lifestyles, delivering practical services etc. These activities form part of Universal Services outlined in the Wolverhampton Citizens' Journey

- ***Targeted Prevention/Maintaining Independence and Social Inclusion***

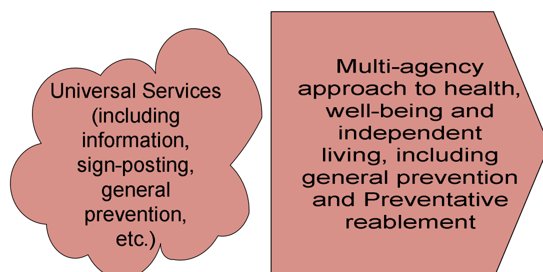
This is aimed at identifying people at risk in the community through targeted prevention to halt or slow down any deterioration and actively seek to improve their situation. Interventions include community support and case finding to identify individuals at risk of specific conditions or events or that they have existing low level social care needs.

- ***Reablement Prevention/Independent Living***

This is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus is on maximising people's functioning and independence through interventions such as rehabilitation/reablement services and joint case management of people with complex needs.

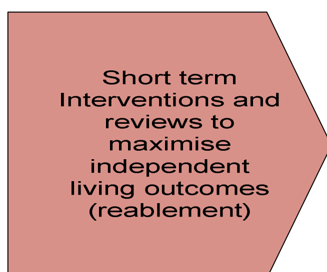
Supporting this broad continuum approach, CSED identified the importance and benefit of delivering bursts of reablement activity at transition points in people's lives in order to enable (re-able) independent living to be maintained or regained (2007; 2010). This Strategy has utilised the Citizen's Journey identified the critical transition Blocks most likely to deliver independent living outcomes:

Citizen's Journey; Blocks 1 & 2



Blocks 1 & 2 are identified as critical early stage intervention reablement opportunities. These have been overlooked by most local authorities in their single strand domiciliary reablement response, but delivering a reablement philosophy and approach at this earlier stage reduces and minimises the likelihood of crisis situations developing in the first place and the subsequent need for on-going service interventions.

Citizen's Journey; Block 5



Block 5 is important because it is at this point that citizen's potentially become customers and users of services. This Block represents a short-term targeted reablement intervention that has been the focus of most local authorities. This Strategy advocates that this intervention is offered before or as a core part of the assessment process. This pre-assessment intervention will be delivered free of charge.

Intermediate care fits into block 5 of the Local Authorities citizens journey but focusses on people who have a health need. "Halfway Home" states that the services that might contribute to the intermediate care function include:

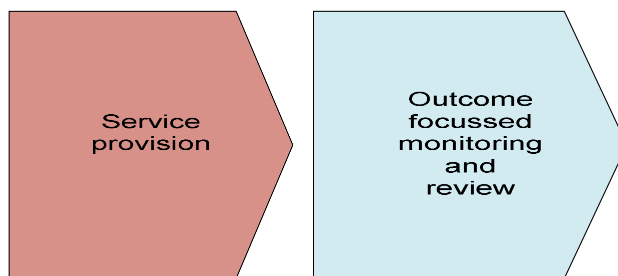
- Rapid response teams to prevent avoidable hospital admissions for patients referred from Primary Care, A&E and other sources
- Acute care at home from specialist teams including some treatment such as administration of intravenous antibiotics
- Residential rehabilitation for people who do not need 24 hour consultant led medical care but do need a short period of therapy and rehabilitation ranging from one to eight weeks
- Supported discharge in a patient's own home with nursing and/or therapeutic support to allow recovery at home
- Day rehabilitation for a limited period in a day hospital or day centre possibility in conjunction with other forms of intermediate care support.

Wiltshire developed their 'Home to Live at Home Service' for older people and others who remain at home. Wiltshire has focused on outcomes that older people may wish to gain while at home. The responsibility for delivering an outcome based service has been driven by Personalisation agenda. The model created was a single entity that comprises of integrated equipment and telecare service and an out of hours response service.

A key aspect of this approach is to view the care delivery as a function which can be provided by a wide variety of community services and not stand alone teams.

Ideally the intermediate care and reablement activity across Wolverhampton would be integrated health and social care services. As a minimum the services will need to be aligned across health and social care and partnership agreements will need to be in place to ensure effective flow between the agencies preventing delays in transfer of care. The aim is to move towards a broader view of intermediate care with specialist health care services falling under an umbrella of bridging services between hospital and home and from illness to recovery.

Citizen's Journey; Blocks 11 & 12



Blocks 11 and 12 are identified as critical reablement intervention points.

Assertive outcome focussed reviews that are timely and include the potential for targeted reablement intervention are critical to the successful application of a person centred reablement philosophy and approach.

Developing a broader perspective, this plan also incorporates a range of health outcomes:

- An avoidance of unnecessary hospital admissions
- An increase in earlier hospital discharge
- Reduction in the length of hospital stay
- Increase in the number of independent living discharge route
- A decrease in the rate of readmissions following in-patient treatment
- The diversion away from hospital admissions
- An alignment to other strategies

In line with national evidence, numerous reviews have been undertaken which recognise that:

- A number of acute hospital beds are inappropriately occupied for long periods by a relatively small number of predominately older people who frequently have complex needs which could be more appropriately met in different care settings
- There is an increasing demand from people themselves that, wherever possible, care should be provided at home or as close to home as possible

Intermediate Care Best Practice Seven – Third Sector Involvement

British Red Cross's Care in the Home scheme is a third sector voluntary scheme that has a number of strands. The emergency admissions avoidance strand works with people who have a long term condition and need support to be able to stay in their own home.

Volunteers on the A&E discharge programme transport patient's home from hospital, settle them in, make a risk assessment, tell neighbours and relatives that the person is home, check on pets and help prepare a meal. A follow up home visit is made the next day. (HSJ, 2011)

Intermediate Care Best Practice Eight– Co-ordinated Care
Bristol

The Intermediate Care service is managed under one umbrella and includes:

- Rapid response team to prevent admission to acute care
- Rehabilitation in peoples own home
- "Reconnect service" to facilitate discharge for people who need short term input but no therapy
- "React teams" working at the front of the hospital to prevent admissions
- In reach nurses to wards to identify patients who could be discharged to intermediate car
- Access through a single point of access.

Following the intervention 80% of people remained in their own homes.

(Halfway Home, 2009)

In summary, this plan promotes an all en-compassing philosophy and approach, including all adults and advocates that the single strand time limited domiciliary reablement focus applied by most local authorities is unnecessarily limiting and fails to recognise the true experience and needs of potential customers.

Intermediate Care Best Practice Nine – Joint Commissioning
Tameside and Glossop

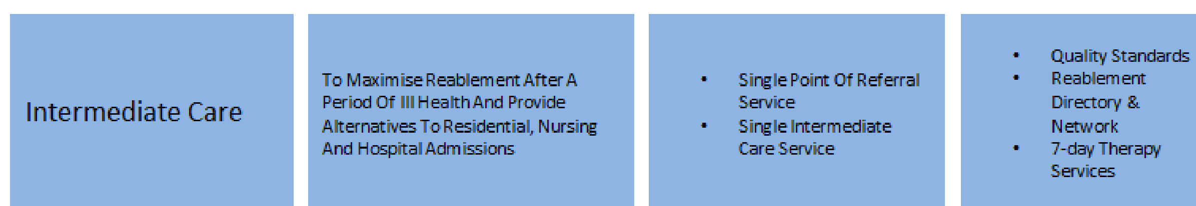
There is a jointly commissioned intermediate care service with a single point of access, 7 days a week between 8am and 10pm. The service receives over 200 referrals per month which are associated with avoiding hospital admissions and facilitating hospital discharge. 85% of those who received a service were discharged to their own homes and 60% required no further support.

(Halfway Home, 2009)

Better Care Fund

The Better Care Fund will ensure that the Wolverhampton health and social care economy is working in an integrated way to deliver the most efficient and effective response to the needs of all users and patients. It recognises and protects early stage interventions and the contribution they make to restoring and maintaining independence; reducing unnecessary hospital admissions; facilitating discharges back home and improving the quality of care for all.

Health and Social Care partners have agreed a vision for the delivery of the Better Care Fund under the heading ‘Wolverhampton, One Ambition, Working as one, for Everyone’.



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

This vision will be delivered through the Plan on the Page shown in Appendix Three, including the following focus on intermediate care:

Intermediate Care	To Maximise Reablement After A Period Of Ill Health And Provide Alternatives To Residential, Nursing And Hospital Admissions	• Single Point Of Referral Service • Single Intermediate Care Service	• Quality Standards • Reablement Directory & Network • 7-day Therapy Services

Principles Framework

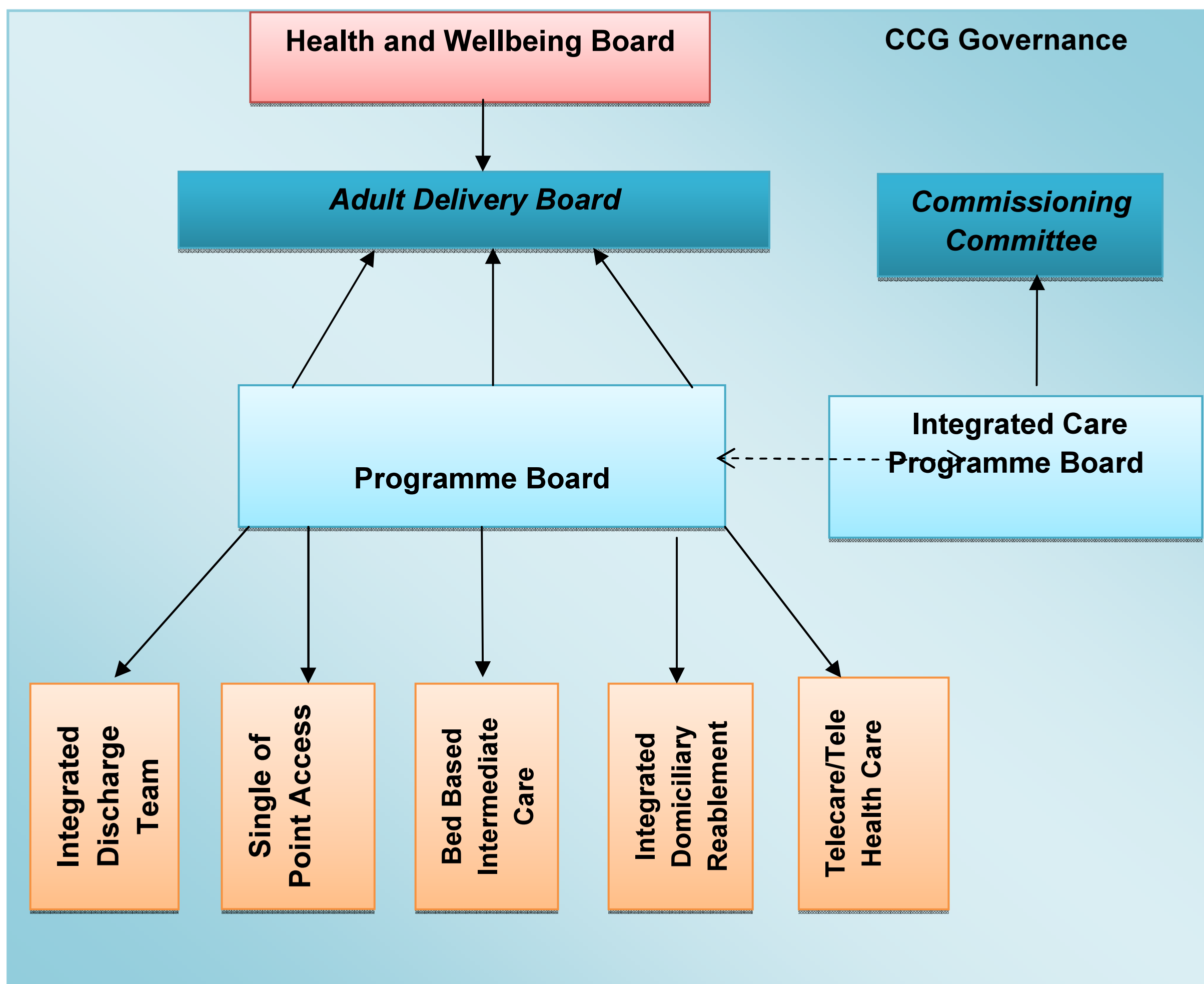
In order to deliver this Reablement/ Intermediate care strategy the Adult Delivery Board has agreed the following principles framework:

Principle One People with dementia will have full access entitlement to all reablement /intermediate care services and opportunities	***Principle Two*** This reablement / intermediate care strategy plan will apply to all adults with reablement/intermediate care needs
Principle Three Providers of care from all sectors are recognised as partners in the delivery of reablement and intermediate care activity, and engagement will take place with these partners at all stages of the commissioning process	***Principle Four*** Reablement and Intermediate Care will be an aligned, integrated, all-encompassing philosophy and approach that is reflected in all customer pathways and journeys
Principle Five Reablement and intermediate care will focus on building, improving and maintaining self-esteem and wellbeing	***Principle Six*** Reablement and intermediate care activity will be a way of delivering person centred outcomes
Principle Seven No long term decision will be made for an older person when they are in a crisis. Help and support will be provided to work through the crisis before determining any longer-term outcomes	***Principle Eight*** Reablement and intermediate care activity will be regarded as business as usual or, in short, it’s ‘what we do around here’
Principle Nine Reablement and intermediate care will focus on delivering greater independence and choice for all	

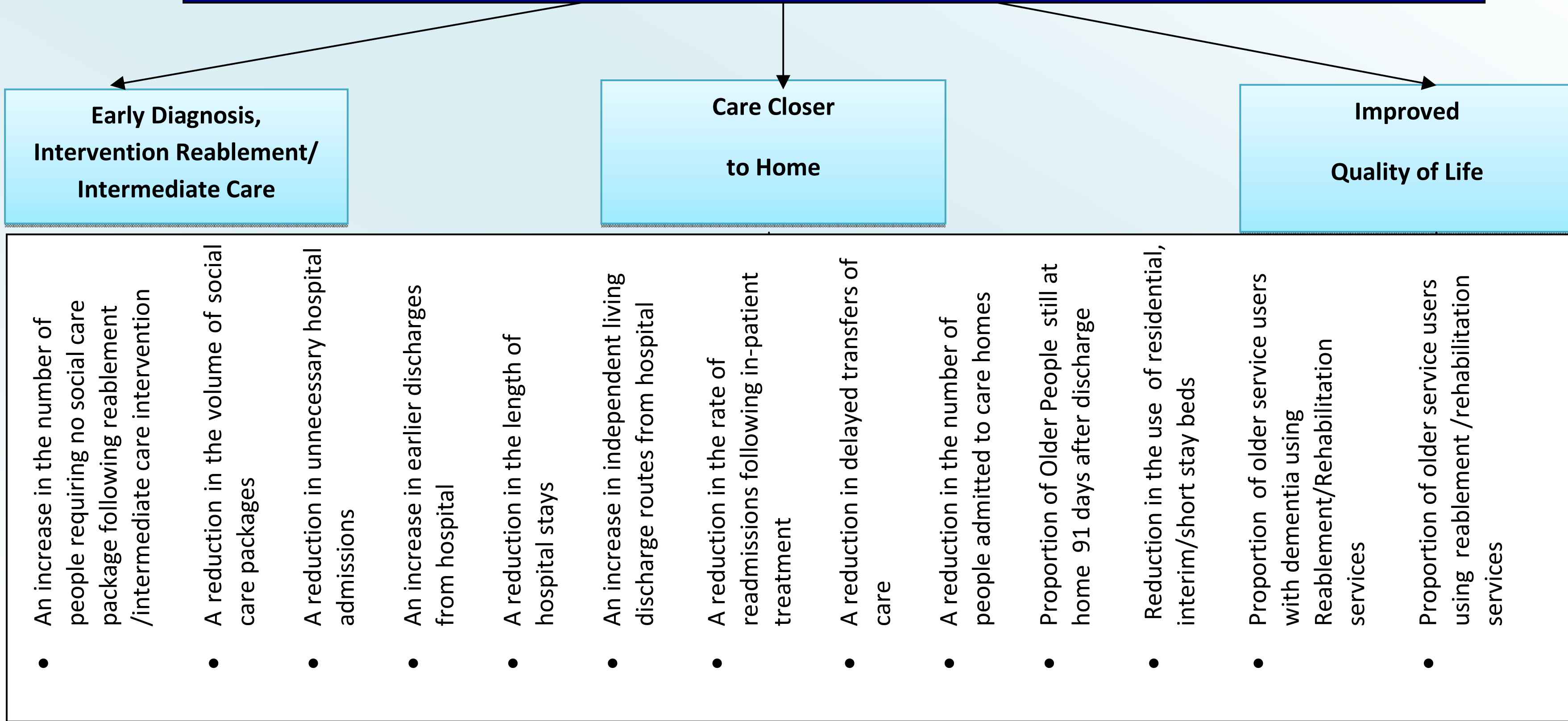
Governance and Next Steps

As shown in the governance structure below, the responsibility for delivering the overarching work programme will rest with the Intermediate Care Programme Board, which will be made up of subject matter experts from across all agencies and chaired by the Joint Commissioning Unit (JCU). The work programme will be broken into key projects and delivered through a project management approach by a number of Task and Finish Groups. The Intermediate Care Programme Board will work alongside the Integrated Care Programme Board within the CCG. Clear channels of communication will be put in place to ensure no duplication of work occurs.

Appendix One



Both the programme and the projects will be delivered in line with the overarching messages from the refresh workshops and the agreed hierarchy of outcomes framework – see Appendix Two.



[NOT PROTECTIVELY MARKED]

13 Metrics

- An increase in the number of people requiring no social care package following reablement/intermediate care intervention
- A reduction in the volume of social care packages
- A reduction in unnecessary hospital admissions
- An increase in earlier discharges from hospital
- A reduction in the length of hospital stays
- An increase in independent living discharge routes from hospital
- A reduction in the rate of readmissions following in-patient treatment
- A reduction in delayed transfers of care
- A reduction in the number of people admitted to care homes
- An Increase in the number of Older People still at home 91 days after discharge
- Reduction in the use of residential, interim/short stay beds
- An increase in the number of people with dementia using Reablement/Rehabilitation services
- An increase in the number of people using Telecare/Telehealth

Reablement /Intermediate Care - Plan on a Page

Principles of Framework

Principle One
People with dementia will have full access entitlement to all reablement /intermediate care services and opportunities

Principle Two
This reablement / intermediate care strategy will apply to all adults with reablement/intermediate care needs

Principle Three
Providers of care from all sectors are recognised as partners in the delivery of reablement and intermediate care activity, and engagement will take place with these partners at all stages of the commissioning process

Principle Four
Reablement and Intermediate Care will be an aligned, integrated, all-encompassing philosophy and approach that is reflected in all customer pathways and journeys

Principle Five
Reablement and intermediate care will focus on building, improving and maintaining self-esteem and wellbeing

Principle Six
Reablement and intermediate care activity will be a way of delivering person centred outcomes

Principle Seven
No long term decision will be made for an older person when they are in a crisis. Help and support will be provided to work through the crisis before determining any longer-term outcomes

Principle Eight
Reablement and intermediate care activity will be regarded as business as usual or, in short, it's 'what we do around here'

Principle Nine
Reablement and intermediate care will focus on delivering greater independence and choice for all

[NOT PROTECTIVELY MARKED]

Agenda Item No. **11**

Health and Wellbeing Board

9th July 2014

Report title	Weight? We can't wait. A Call to Action to tackle obesity in Wolverhampton Public Health Annual Report 2013/14
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	Public Health
Accountable employee(s)	Ros Jervis — Director of Public Health Tel — 01902 551372 Email — ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	Strategic Executive Board — 26th June 2014 Community Directorate Management Team — 23rd June 2014 Public Health Delivery Board — 10th June 2014

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Endorse and support the Public Health Annual Report 2013/14 'A Call to Action' on obesity in Wolverhampton.
2. Pledge the Board's support for the Autumn Obesity Call to Action Conference.
3. Individual partner agencies to make pledges of support to take action as part of their commitment to a partnership 'whole systems' approach to tackling obesity and to attend the Autumn conference.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The serious health issue that obesity presents for the health of the city and that rates of excess weight in Wolverhampton are significantly worse than national and comparator areas.

1.0 Purpose

1.1 Each Director of Public Health is required to produce, and the local authority to publish, an annual report on the health of the local population. The health issue of obesity has been selected as the theme for the 2013/14 Public Health Annual Report for Wolverhampton – the first public health annual report in the new local authority setting. The report takes the form of a 'Call to Action' to tackle this multi-dimensional problem in a partnership 'whole system' way by outlining the part that local statutory organisations, businesses, the voluntary sector, communities, individuals and families can play.

1.2 The report picks up the challenge made by Sir Liam Donaldson at the 2013 Healthy, Wealthy and Wise, Wolverhampton Debate, to 'choose one thing, and do it well'. The report and its recommendations provide the public health response to this challenge.

2.0 Background

2.1 Obesity is one of the most important health issues facing Wolverhampton, with estimates showing that nearly 70% of the adult population is either overweight or obese (41% overweight, 28.5% obese) and that 13% of children enter primary school being obese - this almost doubles to nearly 25% by the time they reach year 6 (aged 10 to 11).

2.2 However, obesity is a complex problem and can only be impacted on by the whole range of partners and the community itself working together to adopt a partnership 'whole system' approach. This is why the 2013/14 Annual Report is a 'Call to Action' for statutory and voluntary partners, businesses, communities and individuals to work together – to address lifestyle behaviours, community influences, living and working conditions and to promote a less 'obesogenic environment' which we define as 'an environment that promotes the gaining of weight and makes it difficult to lose weight'

3.0 Content of the report

3.1 The annual report gives many practical examples of what can be done. It adopts a life course approach by showing how life events influence behaviour and how influential times in life can be used as catalysts to change behaviour. It also makes suggestions of how to create an environment in Wolverhampton that supports individuals to sustain healthy eating and physical activity and gives practical examples of how this can be done. The report makes clear that this is not just a health issue or a matter of an individual's choice alone and that there is no easy fix.

3.2 Further detail on the content of the report and the actions required to make Wolverhampton a less 'obesogenic place' to live will be given in the accompanying presentation to the Board by the Director of Public Health.

4.0 Financial implications

4.1 The costs of the initiatives outlined in the report will be met from within existing Public Health budgets, which are funded by Public Health Grant of £19.3 million in 2014/15.

[DK/26062014/C]

5.0 Legal implications

5.1 The report contains no legal implications

[RB/24062014/E]

6.0 Equalities implications

6.1 The report considers the impact of obesity on those in poverty, on different ethnic groups and social class.

7.0 Environmental implications

7.1 The report considers environmental implications of making Wolverhampton a less obesogenic place to live.

8.0 Human resources implications

8.1 No implications.

9.0 Corporate landlord implications

9.1 No implications.

10.0 Schedule of background papers

10.1 No previous background papers.

This page is intentionally left blank

Health Annual Report Obesity_Layout 1 16/06/2014 15:27 Page 1

If you require this information in an alternative language or format (for example large print, braille or audio tape) please contact City Direct on 01902 551155

ਜੇਕਰ ਤੁਸੀ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਬਦਲਣਾ ਚਾਹੁੰਦੇ (ਜਿਵੇ ਪ੍ਰਿੰਟ,
ਵੱਡੇ ਅੱਖਰਾ ਵਿਚ ਜਾ ਆਡੀਉ ਟੇਪ ਵਿਚ)ਤਾ ਕ੍ਰਿਪਾ ਕਰਕੇ City Direct ਦੇ ਨੰਬਰ
01902 551155 ਤੇ ਸੰਪਰਕ ਕਰੋ ਜੀ ।

Jesli potrzebuja Panstwo tych informacji w innym jezyku lub formacie (na przyklad chcielibyscie je otrzymac w pismie punktowym dla niewidomych, lub jako tekst duzym drukiem) prosimy o kontakt City Direct pod numerem 01902 551155

ئەگەر ئەم مەعلوماتانەت بە وبانێکی تر یان بە شێوەیەکی تر (خەتی گەورە یان خەتی بزماری یان بە
دەنگ) دەوێت تکایە پەیوەندی بکە بە ﴿ستی دایرێکتەوە﴾ بەم ژمارە تەلەفۆنە 01902 551155

إذا كنت بحاجة الى هذه المعلومات باللغة أخرى أو بالشكل إخر (خط عريض أو طريقة برايل او تسجيل
صوتي) إتصل على ستي داريكت بهذا الرقم 01902 551155

如果你需要这些信息的另一种语言 或格式(例如大型印刷,盲文或音频磁带)请联系01902 551155

જો તમને આ માહિતી બીજી કોઈ અન્ય ભાષામાં અથવા બંધારણમાં જ
ોઇતી હોય તો(ઉદાહરણ તરીકે મોટા પ્રિન્ટ ,બ્રેઇલ અથવા બોલતી કસેટ)
મહેરબાની કરી સીટી ડાયરેક્ટને 01902 551155 પર સંપર્ક કરશો.

فارمیٹ میں درکار ہوں (مثلاً بڑے الفاظ، بریل، آڈیو ٹیپ یا کسی دوسری
01902 551155 اگر آپ کو یہ معلومات کسی اور زبان یا
زبان میں)، تو برائے مہربانی سٹی ڈائریکٹ سے اس نمبر پر رابطہ کریں

"Jei jums reikia šios informacijos kita kalba arba formatu (pvz., dideliu šriftu, Brailio raštu arba garso juosta), prašome susisiekti su City Direct telefono numeriu 01902 551155

Ja Jums nepieciešama šī informācija alternatīvā valodā vai formātā (piemēram, lielā drukā, Braila rakstā vai audio ierakstā), lūdzu, sazinieties ar City Direct pa tel. 01902 551155

اگر شما به این معلومات به زبان دیگر یا در فورمات مختلف و (چاپ بزرگ یا خط بریل یا نوار صوتی)
نیاز دارید لطفاً با این شماره تماس بگیرید. 01902 551155

Kana muchida ruzivo urwu nerumwe rurimi kana manyorerwo mamwe kana kuziviswa neimwe nzira, (mavara mahombe, kana manyorerwo emapofu, kana mazwi akatapwa) tapota ridzayi runhare rwunoti 01902 551155 kuCity Direct

WCC 1111 06/14

Weight? We can't wait
A call to action to tackle obesity in Wolverhampton

Annual Report of the Director of Public Health 2013/14

www.wolverhampton.gov.uk

Wolverhampton City Council

Bluebells in Wolverhampton

Contents

Foreword

Councillor Sandra Samuels, Cabinet Member for Health and Wellbeing, Wolverhampton City Council . . 4
Ros Jervis, Director of Public Health, Wolverhampton City Council 5

Contributors and Acknowledgements 6

Part I Why obesity? 7
1. Introduction 7
1.1 Why is obesity the subject of the DPH Annual Report for 2013/14? 7
1.2 What do we mean by obesity? 8
1.3 Why is obesity important? 10
2. What do we know about the obesity challenge in Wolverhampton? 14
2.1 Children 14
2.2 Adults 15
2.3 Physical activity in Wolverhampton 16
2.4 Impacts and financial effects 18
2.5 Future predictions 19
2.6 Summary 19

Part II We need a new approach 20
3. What has led to our obesity crisis? 20
3.1 The impact of poverty and welfare reforms 21
4. What does the evidence say about what works? 22

Part III Action against obesity in Wolverhampton 24
5. Adopting a life course approach 24
6. Opportunities to make Wolverhampton a less obesogenic place to live 29
6.1 Opportunities in the NHS and general practice 29
6.2 Opportunities in schools 30
6.3 Opportunities in local business and workplaces 31
6.4 Local authority opportunities 29
7. Significant behaviour change is needed 40
7.1 Individual behaviour change 40
7.2 Organisational behaviour change 41

Part IV Recommendations and Actions 42
8. Pledge your support 42
9. Priority Actions 44
10. Action Cards 46

Foreword

Councillor Sandra Samuels, Cabinet Member for Health and Wellbeing, Wolverhampton City Council

Councillor Sandra Samuels

Cabinet Member for Health and Wellbeing

As Wolverhampton's Cabinet Member for Health and Wellbeing I welcome the practical and joined up approaches tackling the serious challenges of obesity affecting the City's population. We must however utilise local initiatives, promote good practice and work in partnership to develop local and national solutions to address what is a rising trend across Wolverhampton - the National Child Measurement Programme twelve months ago classed 24.2% of the City's year six children as obese.

It is now just over a year since public health returned to the Local Authority after a forty year absence. This report not only demonstrates the value of embedding our public health functions into local communities, but crucially highlights the role we all play as public health advocates in promoting a healthier City and preventing ill health within our families and communities. We must liaise with our businesses, public and private sector to enhance some of the excellent initiatives Wolverhampton has in place.

The Health and Wellbeing Board fully endorses the report and encourages other stakeholders to support us through making a practical pledge in helping to make a difference to the wellbeing of the citizens throughout the City.

Councillor Sandra Samuels

Foreword

Ros Jervis, Director of Public Health, Wolverhampton City Council

Ros Jervis

Director of Public Health, Wolverhampton City Council

Each Director of Public Health is required to produce, and the local authority to publish, an annual report on an important public health issue. This year, my first annual report as Director of Public Health for Wolverhampton City Council seeks to tackle one of the most important and difficult health issues facing our generation – the rising levels of overweight and obesity in our society. The popular view of the issue of obesity all too often draws on stereotypes, presents simplified descriptions of the problem, and presents an unrealistic assessment of the solutions. However, these oversimplifications do not reflect the current state of scientific evidence and understanding, nor do they help us to develop a sustained response to a problem that will have profound long-term consequences for health and well-being and major costs to the health budget and the wider economy.

Obesity is also a global problem – so how can Wolverhampton tackle what is a problem of modern life – fast food, two for the price of one offers, increasingly sedentary lifestyles, inactivity and ever available high calorie foods? This is what this annual report is all about. It will not be a quick fix – the evidence shows that this issue will need sustained action over the long term and from all partners and sectors, and in particular, the community itself.

So our 2013/14 Public Health Annual Report – our first in our new local authority home – is a call to action for all organisations and communities in Wolverhampton to make sure that we are all aware of the public health threat that faces us, but that we are all equally aware of the response that is needed to tackle it and that we are prepared to make the collective commitment that is needed in order to make a difference.

Ros Jervis

Contributors and Acknowledgements

I would like to thank the public health team for their contributions to this annual report and to other colleagues in Wolverhampton City Council who also contributed pictures, information and ideas. I would also like to thank Karen Saunders from Public Health England for being a 'critical friend' and providing invaluable input to our early drafts.

Contributors

Public Health team:
Sue Wardle
Glenda Augustine
Katie Spence
Juliet Grainger
Richard Welch
Jo Birtles
Jason Gwinnett
Karla Bailey
Sandra Squires
Sue McKie
Margaret Liburd
Andrea Fieldhouse
Louise Sharrod
Dawn O'Brien

Other contributors:
Andrew Clarke
Parampreet Tamber
Tina Clark
Helen Heywood
Communications and Marketing Team
Karen Saunders, Public Health England

Northycote Farm and Country Park Wolverhampton

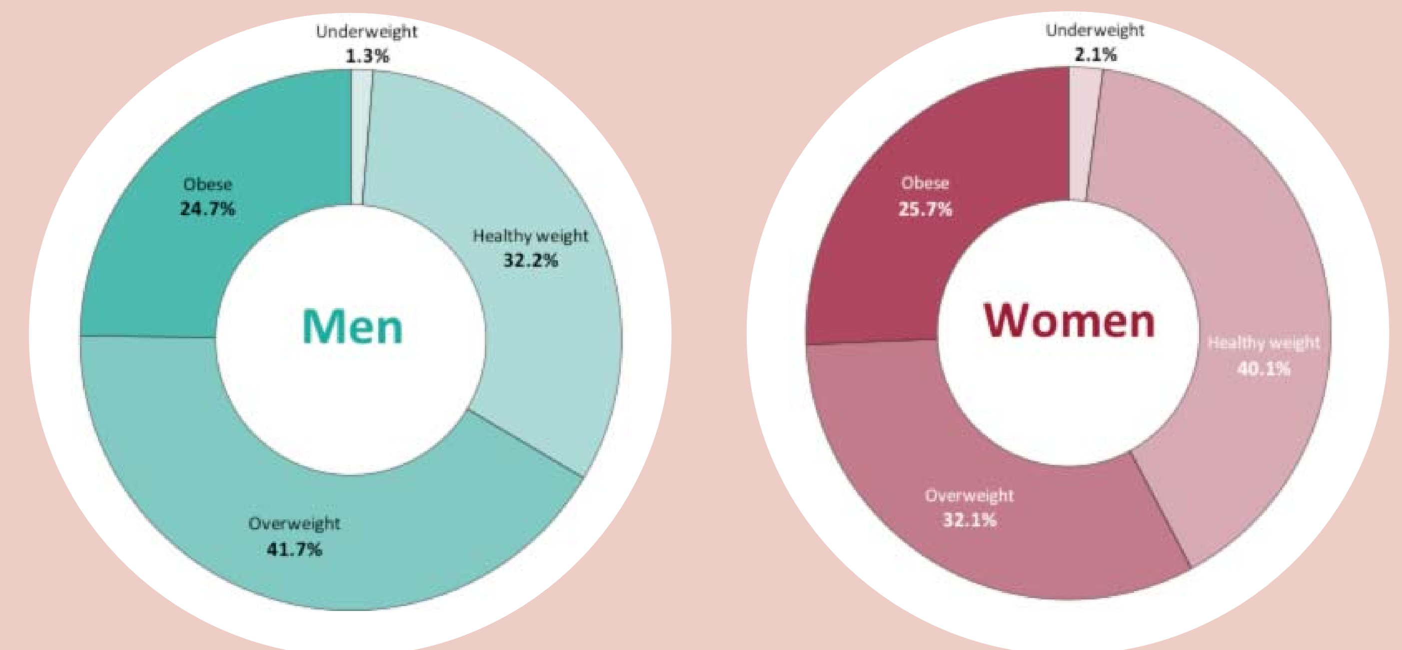
Part I Why obesity?

1. Introduction

1.1 Why is obesity the subject of the Director of Public Health Annual Report for 2013/14?

Obesity has been chosen as the subject for the 2013/14 Director of Public Health (DPH) Annual Report because the data available on obesity for children and adults in Wolverhampton indicates that levels of obesity are increasing year on year, with projected continual increase in the future. However, the population of Wolverhampton is not unique as across the UK the rates of obesity have more than doubled in the last 25 years. In fact, **being overweight is now the norm for adults as more than 6 out of 10 men (66.5%) and more than 5 out of 10 women (57.8%) are either overweight or obese** [1] (Figure 1). Healthy weight prevalence is much lower for men than for women, even though obesity prevalence is marginally higher for women than for men. This is because there is a much higher recorded prevalence of overweight in men than in women.

Figure 1: Adult BMI Status by Sex (Health Survey for England 2010 – 2012)



Source: Public Health England

The number of people who are overweight and obese has increased to such an extent that analysis by the government's Foresight programme [2] estimated that 60% of the population could be obese by 2050. This means that if things continue at the same rate **we are in real danger of obesity ultimately becoming the norm**. The increase in overweight and obesity is seen in virtually all age groups, including most worryingly pre-school and primary school age children.

1 Health Survey for England 2012

2 Foresight – Tackling Obesities – Future Choices Project 2007
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_079713

Therefore, our Annual Report sits alongside the national **Call to Action** [3] which is the Government's national approach to reducing excess weight in both children and adults by 2020. Similar to our Wolverhampton Call to Action, it sets out how, by working together, a wide range of partners - local authorities, businesses, charities, health professionals and individuals can make a difference to this complex problem.

1.2 What do we mean by obesity?

Obesity is a term used to define someone who is very overweight, with a high degree of body fat that may have an adverse effect on health and wellbeing, so it is more than an issue of appearance. The Body Mass Index (BMI) gives a measure which provides an indication of whether a person is a healthy weight for their height, and allows categorisation of weights into what is normal and healthy, overweight, or obese for someone of a particular height and gender. This allows for trends in population levels of obesity to be tracked over time.

The measure uses weight as measured in kgs divided by height in metres squared (m²) i.e.:

$$\text{BMI} = \frac{\text{weight (kg)}}{\text{height(m)} \times \text{height (m)}}$$

BMI can be measured more simply by using a BMI calculator.[4]

Box 1 provides the classification of the BMI range and what it means for each individual. However, BMI can in some cases need careful interpretation and can be unreliable on an individual basis, for example:

- BMI can be overestimated in very athletic people who may have a lot of muscle
- Pregnancy will increase weight, therefore pregnant women will have an increased BMI
- Black, Asian and other minority ethnic groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population (see section 1.3.4).
- In children, the relationship between BMI and being overweight or obese is more complex. As children are still growing, their age, height and gender need to be taken into account. Being overweight or obese must therefore be defined by referring to reference charts that take both age and gender into account. However, these measures are only a guide, as every child is different and grows at different rates.

3 Healthy Lives, Healthy People: A call to action on obesity in England' https://www.gov.uk/government/news/department-calls-for-action-on-obesity

4 An example of a BMI calculator can be found at: http://www.nhs.uk/Tools/Pages/Healthyweightcalculator.aspx or by using a height/weight chart to look it up, for example http://www.nhs.uk/Livewell/healthy-living/Pages/height-weight-chart.aspx

Box 1: Body Mass Index Ranges

Classification	BMI range (kg/m²)	What it means for you
Underweight	under 18.5	Being underweight is not healthy. If you have a BMI under 18.5 this may mean that you need to build your weight up. Discuss with your GP how to do this in a healthy way.
Healthy weight	18.5 to 24.9	Being a healthy weight means you are at a lower risk of heart disease, stroke and type 2 diabetes than someone who is overweight or obese
Overweight	25.0 to 29.9	If you are overweight, you are at higher risk of diseases such as heart disease, stroke and type 2 diabetes. You should think about whether you need to lose weight to improve your health
Obese	30.0 to 39.9	Being obese or morbidly obese means you are at a greater or increased risk of health problems and should discuss with your GP how to lose weight the healthy way
Morbidly obese	40 and over	

It is also important to think about where the weight is located on the body, for example, a person who has a lot of weight around the middle may be unhealthy, even if BMI appears to be within normal range. In this case there are alternative ways to look at healthy weights, for example, to measure waist circumference or to look at the ratio between waist and hips as these measures may be more accurate predictors of disease in some groups. Over the years, the prevalence of raised waist circumference has also shown an increase. Since 1993, both average waist circumference and the proportion of people with a raised waist circumference have increased for both men and women. Raised waist circumference is higher among women than men (Figure 2).

Figure 2: Adult (aged 16 years and over) waist circumference (Health Survey for England)*

Key: - Year of survey
- Mean waist circumference (cm)
- % with raised* waist circumference

* Raised waist circumference is taken to be greater than 102cm in men and greater than 88cm in women
% with raised waist circumference is a three year average for 1993-95 and 2010-12

Source: Public Health England

Many parents of obese children underestimate their weight. Research in the United States[5] found that nearly 51 percent of parents with overweight or obese children tended to underestimate their child's excess weight. In addition, one in seven parents of normal-weight children worried that their child might be too thin. This suggests that parents could have difficulty assessing their child's weight because childhood obesity has become so commonplace. Although this research was conducted in the United States, it is likely that a similar situation may exist in Britain and indicates a need to educate parents about healthy weights.

From a young person's perspective, more than half of 12 to 16 year-olds surveyed by the British Heart Foundation thought that parents are responsible for rising childhood obesity. This survey also revealed a lack of cooking skills among teenagers with more than one in 10 (13%) unable to complete basic tasks, such as scrambling eggs, make a fruit scone, spaghetti bolognaise, homemade pizza or preparing a fruit salad by themselves. Guidance from the British Nutrition Foundation and the National Curriculum for England suggest that all 13 year-olds should be able to do these. While children can learn these skills at home, the findings reinforce the need for basic cooking lessons as part of the national curriculum.

1.3 Why is obesity important?

1.3.1 Relationship between obesity and physical illness

A number of severe and chronic medical conditions are associated with overweight and obesity, including type 2 diabetes, hypertension, coronary heart disease, stroke, osteoarthritis and some cancers (Figure 3). In addition, Body Mass Index (BMI) is a strong predictor of premature mortality among adults. Overall, moderate obesity (BMI 30-35 kg/m^2) was found to reduce life expectancy by an average of three years, while morbid obesity (BMI 40-50 kg/m^2) reduces life expectancy by 8-10 years. This 8-10 year loss of life is equivalent to the effects of lifelong smoking. Box 2 reports some statistics on the effects of being overweight or obese. Not only do medical conditions adversely affect people's health and quality of life, but they create serious and rising financial and social care burdens which are not sustainable into the future.

5 http://www.philly.com/philly/health/kidshealth/HealthDay684400_20140203_Many_Parents_of_Obese_Children_Underestimate_Their_Weight.html#rtyFl2JSrUsl0PqX.99

Wolverhampton City Centre

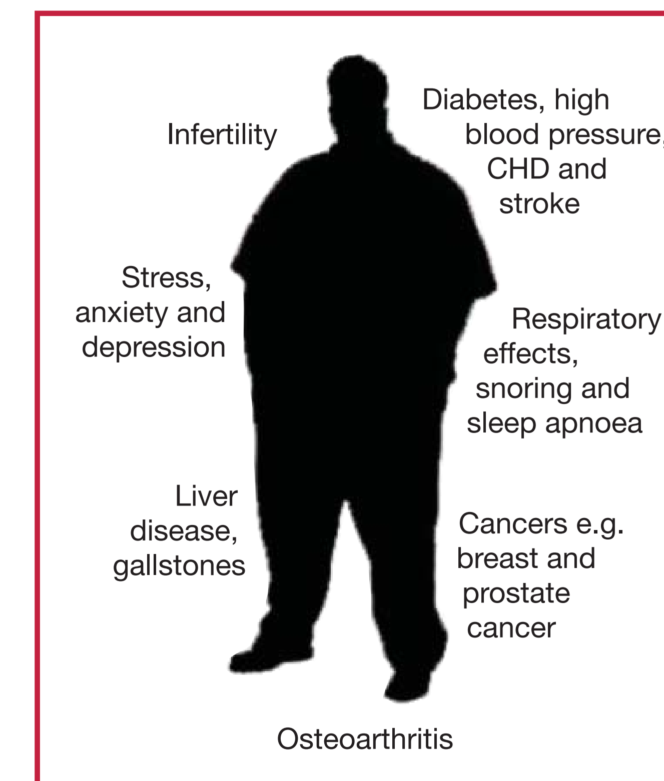
1.3.2 Relationship between common mental health disorders and obesity

A report from the National Obesity Observatory[6] highlighted that there is not enough emphasis on the association between mental health, emotional wellbeing and obesity. The relationship is complex with some researchers suggesting that obesity can lead to common mental health disorders, whilst others have found that people with mental health problems are more prone to obesity. Results from a recent review of the evidence found a relationship between obesity and depression and a less strong link between obesity and anxiety disorders.

Obese persons had a 55% increased risk of developing depression over time, whereas depressed persons had a 58% increased risk of becoming obese.

- Reasons why obesity causes mental health disorders in adults include low self-esteem, stigma, the cycle of dieting and gaining weight, medication, and hormonal imbalances.
- Reasons why mental health disorders cause obesity in adults include unhealthy lifestyles, medication and reduced support.
- There is strong evidence to suggest an association between obesity and poor mental health in teenagers and adults

Figure 3: Obesity is associated with serious medical complications.



6 http://www.noo.org.uk/uploads/doc/vid_10266_Obesity%20and%20mental%20health_FINAL_070311_MG.pdf

1.3.3 Social care implications and obesity[7]

Adults with severe obesity may have physical difficulties which inhibit activities of daily living and this can have resource implications for social care services including:

- housing adaptations such as specialist mattresses, doors, toilet frames, hoists and stair lifts
- specialist carers (trained in manual handling of severely obese people) for people who are house bound and have difficulties caring for themselves
- provision of appropriate transport and facilities (such as bariatric patient transport and specialist leisure services).

Box 2: Some statistics on the effects of overweight and obesity:

- 90% of type 2 diabetics are borderline overweight or obese
- 85% of higher blood pressure is linked with overweight or obesity
- Obese men and women under 50 years have increased risk of coronary heart disease and stroke
- A neck circumference of greater than 43 cm in men and greater than 40.5 cm in women is associated with obstructive sleep apnoea
- 10% of all cancer deaths among non-smokers are related to obesity – higher for some cancers
- 6% of infertility in women is attributable to obesity and impotency and infertility are frequently associated with obesity in men
- Risk of disability in the elderly attributable to osteoarthritis is equal to that of heart disease and greater than any other medical disorder of the elderly
- There are links between mental health problems and obesity, with levels of obesity, gender, age and socioeconomic status being key risk factors
- The mental health of women is more closely affected by overweight and obesity than that of men

Source: Foresight Report/National Obesity Observatory

7 http://www.local.gov.uk/documents/10180/11463/Social+care+and+obesity+-+a+discussion+paper+-+file+1/3fc07c39-27b4-4534-a81b-93aa6b8426af

1.3.4 Obesity and ethnicity

The National Institute for Health and Care Excellence (NICE)[8] has issued guidelines that suggest that millions of people from ethnic minority groups, who may be at risk of weight-related diseases, are not showing up as obese under current BMI guidelines. NICE is suggesting that BMI obesity and overweight thresholds could be lowered, as for good health, ethnic minority groups need to be slightly slimmer for their height than people who are White.

Type 2 diabetes, heart disease and stroke are potentially life-threatening conditions, which people of African, Caribbean and Asian descent and other minority ethnicities are significantly more likely to develop than the wider population. People from these ethnic backgrounds are up to six times more likely to be diagnosed with type 2 diabetes, and they are 50% more likely to die from cardiovascular disease. They also suffer from these conditions at a younger age.

This is an important consideration given the ethnic makeup of the population in Wolverhampton where 68% of the population is White and the remaining 32% is made of up of people from Asian (18.1%); Black (6.9%); Mixed (5.1%); and Other (1.1%) ethnic groups.

8 http://guidance.nice.org.uk/PH46

Health Annual Report Obesity_Layout 1 16/06/2014 15:27 Page 15

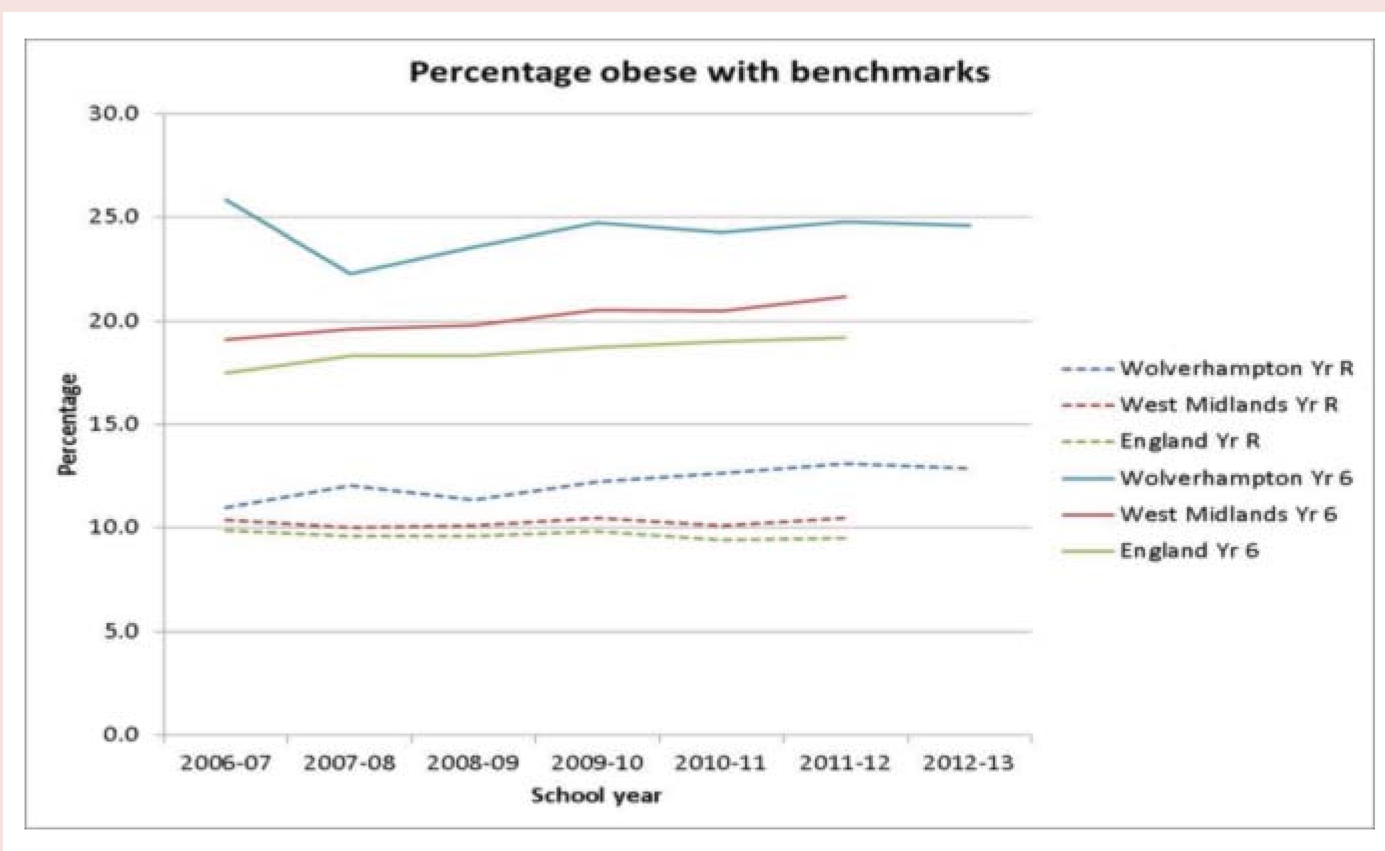
2. What do we know about the obesity challenge in Wolverhampton?

2.1 Children

Most of what we know about obesity in Wolverhampton comes from the data we collect in schools from the National Child Weight Measurement Programme (NCMP). This programme assesses the height and weight of primary school children in England and gives an accurate and almost complete picture as the data is collected in all schools by school nurses. The data tells us that obesity is a considerable local issue in Wolverhampton, 12.9% (372 children) and 24.6% (612 children) of children in Reception (age 4-5 years, year R) and year 6 pupils (age 10-11 years) respectively, are obese, compared to the England averages of 9.5% and 19.2%.

Figure 4 below shows the trend in Years R and 6 obesity rates since the NCMP programme began. From this chart we can see that year R obesity rates have risen in Wolverhampton, increasing the gap to the West Midlands and England average figures. Year 6 obesity rates have persistently been higher than the England and West Midlands averages, in recent years the upward trend in Year 6 obesity has slowed in Wolverhampton but remains high in comparison to England as a whole.

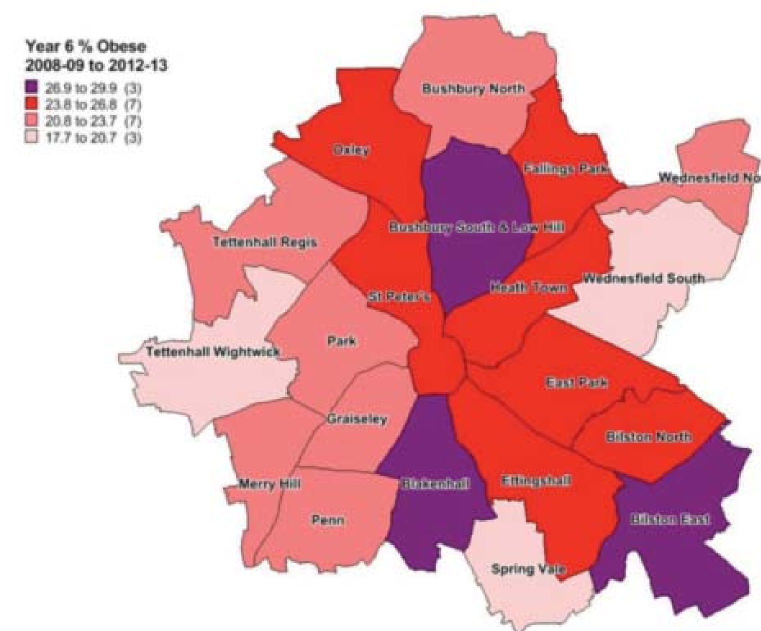
Figure 4: Percentage of children obese at year R and year 6 in Wolverhampton



Source: Public Health England

Figure 5 shows how childhood obesity rates vary across wards in the city. We can see that rates are broadly higher in those areas with higher deprivation levels although this relationship is not as strong as for other public health needs. The highest rates of obesity in children are found in Bushbury South & Low Hill, Blakenhall and Bilston East. Only Tettenhall Wightwick has rates of obesity below the England average.

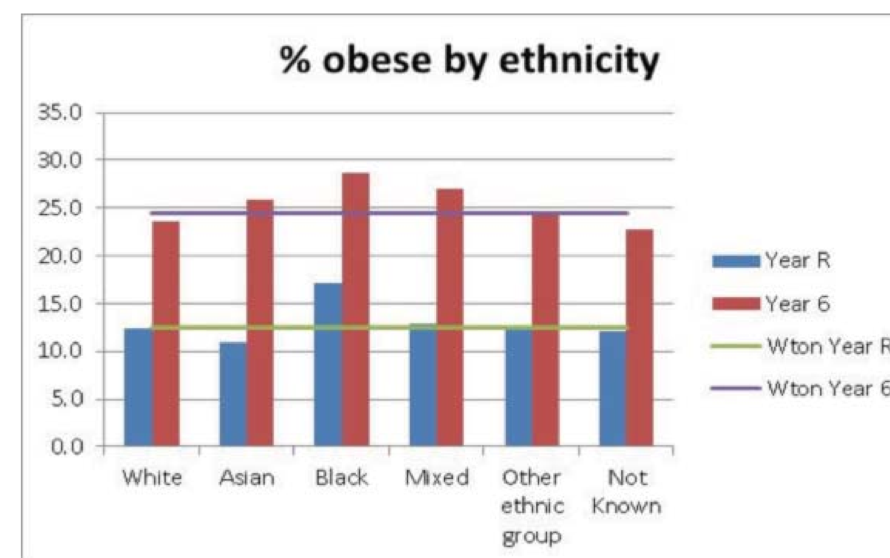
Figure 5: Percentage of children obese at year 6 in Wolverhampton by electoral ward



Source: National Child Measurement Programme

Obesity rates do vary by ethnic group within the city at year R and year 6. Higher rates are found amongst black children and this may be partly explained by differences in physiological make up amongst black children. Asian children observe the biggest increase in obesity from year R to year 6, with rates below average at year R but above average at year 6. (Figure 6).

Figure 6: Percentage of children obese at year R and 6 by ethnicity



Source: National Child Measurement Programme

2.2 Adults

The data we have on obesity levels for adults comes from the 2012 Active People Survey (see section 2.3) produced by Sport England. Unlike the data we have to monitor childhood healthy weights, this survey data uses self reported information on heights and weights and so may be less accurately measured. Sport England analysts then compare this data with the Health Survey for England and adjust the figures to give the best estimates of BMI ranges in our population. This is the data that is used to monitor obesity in the Public Health Outcomes Framework.

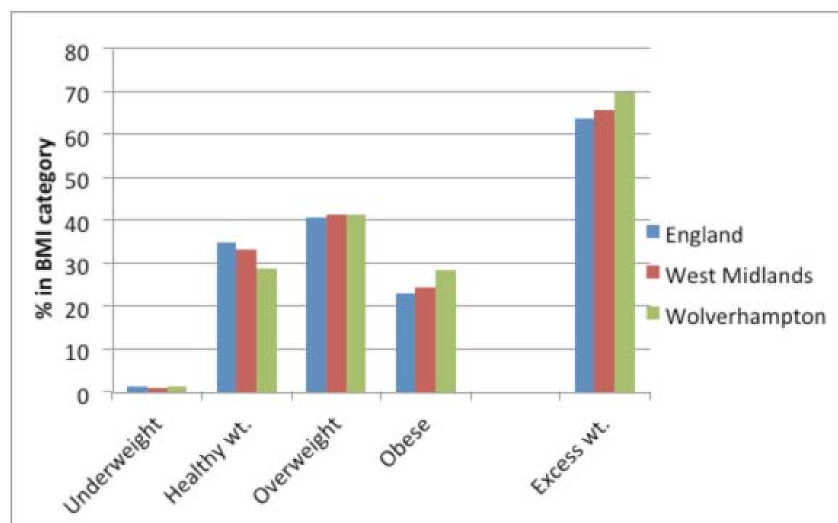
Table 1 and Figure 7 show that compared to England and the West Midlands, Wolverhampton has a smaller proportion of its population who are of a healthy weight; a similar proportion who are overweight (at 41%), but at 28.5%, a much higher percentage of its population who are obese compared to England (23%) and the West Midlands (24.5%). **This means that nearly 70% of the adult (16 and over) population in Wolverhampton is estimated to be either overweight or obese**.

	England	West Midlands	Wolverhampton
Underweight	1.2	1.1	1.5
Healthy weight	35	33.2	28.7
Overweight	40.8	41.2	41.3
Obese	23	24.5	28.5
Total excess weight	63.8	65.7	69.8

Table 1: Adult (16+) Body Mass Index in Wolverhampton, 2012 (%) Adjusted prevalence of underweight, healthy weight, overweight and obesity in adults in England 2012

Source: Active People Survey http://www.noo.org.uk/LA/obesity_prev/adults

Figure 7: National, regional and local % BMI in adults, 2012



Source: Active People Survey

Local obesity estimates can also be found from GP Quality and Outcomes Framework data (QOF) which requires GPs to keep a register of obese patients. These data show that in 2012-13, 13.4% of patients over 16 were recorded on an obesity register. This is less than half of the Sport England best estimates of 28.5% and indicates that there are a large number of obese patients not being picked up by GPs and whose weight is likely to be causing health problems but who are not recorded on their GP's register. There are an even larger number of people who are overweight who would also benefit from advice about their weight before the onset of health problems as outlined in section 1.3.

2.3 Physical activity in Wolverhampton

Levels of physical activity are closely linked to the prevalence of obesity with fewer people taking enough exercise to maintain a healthy weight. Physical activity includes all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organised and competitive sport.

Start Active, Stay Active, the joint report from the Chief Medical Officers in England, Scotland, Wales and Northern Ireland[9] outlined the need for each person to aim to participate in an appropriate level of physical activity for their age. These age appropriate guidelines are set out in Box 3.

Unfortunately, measures of physical activity to monitor the Start Active, Stay Active recommendations are not routinely available at a local level. An alternative measure is however provided by the Active People Survey which continuously measures the number of people taking part in sport and active recreation (which includes activities such as recreational walking and cycling) across the nation and in local communities[10]. The survey is carried out annually from October throughout each year and in each local authority a minimum of 500 interviews are carried out.

A key measure in the survey is the '1 x 30' indicator. This is the percentage of the adult population participating in sport and active recreation, at moderate intensity, on average at least once a week. Higher levels of physical activity are also recorded, for example on average three times a week.

Table 2 shows that, although fluctuating, the numbers of adults participating in sport and active recreation nationally and also in Wolverhampton appear to be increasing slightly since 2005/6 which is an encouraging trend to build upon. However, nationally just over a third of adults are undertaking sport and active recreation at least once a week, and less than this number in Wolverhampton.

Table 2 : Adult (16+) participation in sport and active recreation at least once a week, by year

Year	Wolverhampton	West Midlands	England
2005/06	27.9%	31.9%	34.2%
2007/08	25.9%	33.4%	35.8%
2008/09	30.9%	33.6%	35.7%
2009/10	31.2%	32.9%	35.3%
2010/11	33.2%	32.7%	34.8%
2011/12	31.0%	31.2%	33.5%
2012/13	33.3%	36.0%	35.7%

1 session a week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days)

Source: Sport England Active People Survey

9 Start Active, Stay Active A report on physical activity for health from the four home countries' Chief Medical Officers http://www.bhfactive.org.uk/userfiles/Documents/startactivestayactive.pdf

10 Sport England Active People Survey http://www.sportengland.org/research/about-our-research/active-people-survey/

When broken down by age and gender, it is apparent that whilst all groups show increasing activity, women have particularly low levels of participation in sport and active recreation compared to men, and activity levels also decrease with age. Therefore, activities need to be planned that appeal to women and older age groups (Table 3).

Table 3 : Adult (16+) Participation in sport and active recreation - at least once a week by population group

	2005/06	2012/13
Male	33.8%	35.2%
Female	22.4%	26.9%
16 - 25	45.6%	*
26 - 34	36.0%	*
35 - 54	31.0%	37.0%
55 and over	12.9%	14.4%
White	27.3%	34.1%
Non white	30.4%	*
All	27.9%	31.2%

** data is suppressed due to small sample size leading to issues of confidentiality and reliability*

1 session a week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days)

Source: Sport England Active People Survey

Table 4 shows participation in sport and active recreation at higher levels, i.e. on average 3 times per week. Once again, participation levels have increased over time for all groups, but numbers participating overall are significantly lower – 21% undertaking sport and active recreation 3 times per week in 2011/13 compared to 31% doing so at least once a week. A worrying trend is that activity levels for non white groups appear to be declining in Wolverhampton. Fewer people participate in sport and recreational activities more than 3 times a week – figures for 5 times a week show that 16% of men do so and 8% of women.

Further information can be found about Wolverhampton residents' participation in physical activity from Sport England's Sport and Active Recreation Participation Profile http://www.sportengland.org/our-work/local-work/local-government/local-sport-profile/

Table 4 : Adult (16+) Participation in sport and active recreation – at least 3 times per week by population group

	2005/06	2012/13
Male	20.9%	27.9
Female	11.6%	15.2%
16 - 25	22.7%	28.1%
26 - 34	23.2%	*
35 - 54	16.1%	23.7%
55 and over	9.9%	12.1%
White	15.7%	23.7%
Non white	17.6%	15.5%
All	16.1%	21.1%

** data is suppressed due to small sample size leading to issues of confidentiality*

3 sessions a week (at least 3 x 30minutes of moderate intensity activity

Source: Sport England Active People Survey

Wednesfield Bowling Club

Box 3: Physical activity guidelines for each age group

Early Years (under 5s)	Children and Young People (5 - 18 years)
Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments. Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day. All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).	All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week. All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

Adults (19 - 64 years) and Older Adults (65+ years)

- Adults and older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
- Alternatively, or for those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
- Adults and older adults should also undertake physical activity to improve muscle strength on at least two days a week.
- All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.
- Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
- Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.

2.4 Impacts and financial effects

As already stated, obesity is a contributing factor to a number of chronic illnesses most notably heart disease and diabetes. We know that there is expected to be an increase in the percentage of people with diabetes in the city from 9.5% in 2013 to 12.4% in 2030 and that increasing adult obesity rates are a significant factor behind this projected increase.

Research suggests that for each unit of increase in BMI, annual health care cost is increased by £16 with a doubling of annual healthcare costs for a BMI of 20 to 40. These costs add up to considerable sums. The cost to the UK economy of overweight and obesity was estimated at £15.8 billion per year in 2007. The Foresight report looked at the estimated costs of treating overweight and obesity to the NHS alone. In 2007 they estimated this cost in Wolverhampton to be £73.8 million rising to £81.9 million in 2015. The cost of inactivity alone is estimated to be £22.5 million per year in Wolverhampton according to the report "Turning the Tide of Inactivity". [11]

11 www.ukactive.com/downloads/managed/Turning-the-tide-of-activity.pdf

2.5 Future predictions

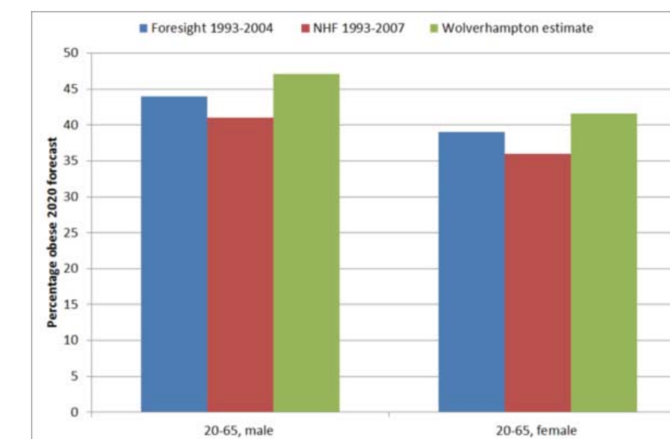
Obesity levels are predicted to rise in the near future although there is less clarity around future childhood obesity levels. Adult obesity estimates for England were published as part of the Foresight review and this predicted by 2020, 20 to 65 year olds would have an obesity prevalence of 44% for males and 41% for females. This has been backed up further by a UK Health Forum report[12] using more up to date data from the Health Survey for England that estimated corresponding rates for 20 to 65 year olds of 41% for males and 36% for females by 2020. Both sets of predictions can be used as a proxy for what might happen in Wolverhampton in the next 7 years. With obesity rates already higher than the England average **it would be prudent to expect adult obesity rates to be around 45% for men and 40% for women in 2020**. (Figure 8)

Figure 8: Forecasted obesity prevalence in 2020 for adults aged 20 to 65

Source: Foresight, UKHF and Wolverhampton Public Health Department

In 2007 when the Foresight report was published, childhood obesity rates for England were expected to increase significantly by 20% for boys and 14% girls. Updated research from the UK Health Forum has now revised these figures downwards as a result of the slowing in obesity trends in recent years. The obesity levels for England are expected to remain similar to today's values at 13% for boys and 10% for girls. Even if this were the same for Wolverhampton and rates of obesity remained stable over the next 7 years this will still mean that **around 13% of year R and 25% of year 6 pupils will be obese in Wolverhampton in 2020.** (Figure 9)

Figure 9: Forecasted obesity prevalence in 2020 for children aged 2-11



Source: Foresight, NHF and Wolverhampton Public Health Department

2.6 Summary

This section has shown that we have considerable knowledge, particularly about childhood obesity which is related to age, ethnicity and where people live in Wolverhampton which should allow targeting of interventions and policies in the most appropriate way. Estimates of excess weight and levels of physical activity in adults outline the scale of the problem and the fact that obesity and overweight prevalence is higher in Wolverhampton than in other areas. However, the next section begins to look at some of the reasons for increasing weight and what we can do in Wolverhampton to take action.

12 http://nhfshare.heartforum.org.uk/RMAssets/NHFMediaReleases/2014/Statement%20from%20UK%20Health%20Forum%20on%20NOF%20report.pdf

Part II We need a new approach

3. What has led to our obesity crisis?

The average daily calorie intake for men, women and children is given in Table 5 below, but more and more people are exceeding these limits and the population is slowly getting fatter. This is true worldwide, nationally and in Wolverhampton.

Table 5: Recommended daily calorie intake

Men	Women	Children aged 5-10
2,500	2,000	1,800

Source: NHS England

The causes of obesity are relatively well understood from the scientific evidence base[13]. The common view is that if overweight people ate less and did more exercise then this would solve the problem. However, it is not just an issue of personal willpower. Individuals have less choice in the matter of their weight than we might assume. The current epidemic of obesity does not solely arise from individual over-indulgence or laziness. Instead, human biology has become out of step with society. This is because humans evolved to respond to hunger by eating and we are only weakly able to notice when we have had enough and stop eating. The ability to stop was effective when food was scarce and hard to find, but now high energy cheap food is all around and easy to access. In addition, many people lead more sedentary lifestyles with less and less physical activity. The combination of access to cheap, high energy and high calorie foods with low nutritional value, together with the lack of physical activity conspire to create an 'obesogenic environment'. We are defining an 'obesogenic environment as:

Fast Food

'an environment that promotes the gaining of weight and makes it difficult to lose weight'

A key message is that while physical activity is important, for most of us, reducing the amount of calories we consume is key to weight loss and to stay within a healthy weight, most people would have to override their instincts, habits, upbringing, and all the triggers in their day to day lives that enable and encourage the consumption of food. Fewer and fewer people manage to do this.

13 Foresight Tackling Obesities: Future Choices project is the most comprehensive investigation into obesity and its causes. The aim of the Foresight programme is to build on the scientific evidence base to provide challenging visions of the future to help inform government strategies, policies and priorities

3.1 The impact of poverty and welfare reforms

Children from low income backgrounds are more likely to be overweight and obese and also face health problems and poorer educational attainment - children can feel the stigma of their health problems and this can impact on their school attendance and behaviour[14].

Research from the consumer group Which?[15] shows that for families on low incomes food is costing more of their household spending. The economic downturn, falling incomes and cuts to welfare have coincided with a steep rise in food prices.

A Food Ethics Council report[16] highlights that the cost of a 'minimum' basket of food has gone up significantly more than general inflation with those on the lowest incomes hardest hit. They report a wide range of coping strategies including eating cheaper products and buying (and eating) less food. They found that the lowest income households also reduced their fruit and vegetable purchases by an average of 20% between 2007 and 2010, down to an average of just 2.7 portions per person of their 5 A Day allowance in 2010. This also means that in some low income families, children might not eat a balanced healthy diet, but understandably, parents would prefer their children to eat something they like rather than risk buying something that their children might not eat (which might be wasted), not having the luxury of being able to offer an alternative if their child doesn't want to eat the meal put in front of them. Thus, people can be 'forced' into negative choices ('40 frozen sausages for 85p' kind of deal), which is a temptation to eat unhealthily but very cheaply. Therefore, cheap food 'deals' can often point people in unhelpful directions.

While some parents do need to get better at making sure their children get a healthy diet - some families also have additional difficulties that present further barriers to being able to buy and cook fresh food. Being homeless or living in temporary accommodation, mental health difficulties, disabilities and living with little social support make it harder for some parents to buy good food and create a household routine around meals.

Over half (51%) of all households in Wolverhampton live in the most deprived (poorest 20%) households in England and this includes 55% of children and young people (under 16). Therefore our approaches need to reflect the differing financial circumstances of families in the city.

Meal deal offers in the city centre

14 Family Action 2014: http://www.family-action.org.uk/standard.aspx?id=23263

15 Cutting back and trading down: the impact of rising food prices. Which? Consumer Report November 2013 http://www.staticwhich.co.uk/documents/pdf/which-report-cutting-back-and-trading-down-the-impact-of-rising-food-prices-341023.pdf

16 Affordable food: getting values into the value range. How can we make healthy, fair, sustainable food affordable to all – including those on low incomes? Food Ethics Council. A report of the Business Forum meeting on 22nd January 2013 http://www.foodethicscouncil.org/system/files/130122-Report-FINAL.pdf

Health Annual Report Obesity_Layout 1 16/06/2014 15:27 Page 23

4. What does the evidence say about what works?

Fast Food

The research evidence shows that the increasing prevalence of obesity is a consequence of modern life and there is no easy fix. It is also a complex problem and there is no single intervention or agency that can tackle this alone. Any response needs to be multifaceted and aimed at different stages in life, in particular how to promote healthy weights during pregnancy, establish appropriate child growth through healthy eating and physical activity in childhood and throughout life. Therefore, there is a clear need to bridge the gap between awareness of the problem and practical implementation of the necessary environmental and lifestyle changes for the population.

Given this complexity we need to recognise that tackling a multi-factorial problem like the rising levels of overweight and obesity in society requires an equally multi-factorial, long term solution. This must be our starting point in tackling this issue together as agencies, individuals and communities.

The evidence relating to obesity mostly concentrates on the causes and treatment of obesity rather than its prevention. Few interventions have been shown to be successful in reducing the prevalence of obesity at a community level and even the most promising research conducted (amongst children)[17] needed 8 years before a decline in prevalence was apparent and this was achieved only by all local agencies working together with local communities and required real commitment to tackling the problem. This illustrates why we need this 'Call to Action' to bring together Wolverhampton City Council, Wolverhampton Clinical Commissioning Group, local NHS Trusts, local businesses, the voluntary sector and other partners and local communities to take action to start the long journey that will be needed to make a difference to this difficult problem.

However, even in the absence of a robust evidence base, there is a pressing need to act, for the health of our population and because of the cost of obesity to public services. As a starting point, there is a growing body of evidence to show what approaches have been successful on a smaller scale and what individual organisations can do.

We already have some universal services that target the whole population to promote healthy weights and some services that target those who are overweight or obese. These are mapped out in Figure 10 for different age groups. However, we have few services that we have clear evidence will actually impact on weight. Therefore a useful approach is to:-

- make our existing resources and what we currently have in place work better, and
- undertake more work to tackle the underlying causes of overweight and obesity and promote healthy weights.

We will need to accept that our local approach may need to include interventions for which the evidence is incomplete and this requires accepting the risk that some interventions may fail or need to be refined and enhanced as their effects become better understood.

17 Fleurbaix Laventie Ville Santé (FLVS) Study. Epode European Network
http://www.epode-european-network.com/en/background/epode-background.html?start=1

Figure 10: Current interventions available to promote healthy weight in Wolverhampton

Pregnancy and Healthy Pre-School (under 5s)

Adventure Playgrounds
Change 4 Life Pre-School Clubs
Children Centres
Leisure Centres
Parks, countryside and greenspaces

Healthy Schools (5 -18 yrs)

Healthy Schools Team
Free Swimming (under 17s)
Change 4 Life Sports Clubs (primary & secondary)
Health & Well Being Schools
Let's Get Cooking
School nursing
Food Dudes
National Child Measurement Programme
School Food Action Plan
Partnership and school sports

Healthy Families

Child Weight Management (Family Clubs, Inc. Family Learn to Swim)
British Heart Foundation Hearty Lives
Adventure Playgrounds
Leisure Centres
Parks (orienteering)
Bikeability
Community Hubs and community centres
Parks, countryside and greenspaces
Allotments

Healthy Adults (19 – 64 yrs)

Adult Weight Management (GP/Weight Watchers/Health Trainers)
Fit for a Fiver
Leisure Centres
Sports Clubs
Community Hubs and community centres
Parks, countryside and greenspaces
Allotments

Healthy Ageing (65+ yrs)

Health Trainers
Walking for Health, Strength & Balance Programme
Leisure Centres
Parks, countryside and greenspaces
Age UK Young at Heart Programme
Allotments
Community Hubs and community centres
Older people's gyms

Health Annual Report Obesity_Layout 1 16/06/2014 15:27 Page 25

Part III Action against obesity in Wolverhampton

Now we understand that an obesogenic environment is one that makes it easy to gain weight but difficult to lose weight, how do we make Wolverhampton a less obesogenic place to live? Can we create an environment that better suits our bodies and supports individuals to develop and sustain healthy eating and physical activity habits and behaviours? If we treat obesity as simply a health issue, or a matter of individual choice we will fail to make an impact. Therefore, this section looks at some practical actions, firmly focussed on prevention and opportunities that could be developed locally, to halt the rise of obesity in adults and children.

5. Adopting a life course approach

Existing evidence highlights a number of points across an individual's life course where there may be specific opportunities to influence behaviour, related to life or health events. Early life, pregnancy, menopause or spontaneous changes in behaviour such as leaving home or becoming a parent, alongside periods of significant shifts in attitudes like peer group pressures, or the diagnosis of ill health all have an impact. There is no one point where an intervention is particularly successful, but progress through life offers a number of naturally occurring opportunities where intervention can be successful. However, while it is important to use these critical opportunities, the most significant predictor of a child becoming obese is parental obesity.

Table 6 shows these trigger points in more detail and looks at some practical examples of what would be needed to turn these opportunities throughout life into practical actions to create a less obesogenic environment in Wolverhampton. This table provides a blueprint for an action plan for Wolverhampton, further developed in the Action Cards in Part 4.

Further work is needed to develop a multi-agency action plan to enable all agencies to work together to realise this vision.

Phoenix Park Sensory Garden

Table 6: Critical opportunities for intervention during an individual's life course – A 20 point Action Plan for Wolverhampton

Age		Stage	Issue	Examples of what we can do to make Wolverhampton a less obesogenic place to live
Pre conception and early infancy		Preconception in utero	Healthy lifestyles programmes focus on mother and foetus and wider family	1. Promote advice and support to maintain a healthy weight during pregnancy and quitting smoking during pregnancy 2. Give advice on postnatal and nutrition during early years
	0 – 6 months	Post-natal	Breast feeding	3. Encourage breastfeeding and support
	6 – 24 months	Weaning	Low sugar foods	4. Improve parenting skills to prevent an obesogenic home environment and encourage behaviour change
School age	2 – 5 years	Pre school	Low sugar foods, introduce '5 a day' fruit and vegetables Active Play	Improve parenting skills to prevent an obesogenic home environment and encourage behaviour change 5. Review effectiveness of existing programmes and scale up lifestyle programmes aimed at promoting healthy weights in both children and families
	5 – 11 years	Primary school	Development of physical skills and food preferences	6. Develop evidence based physical activity and healthy weights programmes in schools
	11 – 16	Secondary school	Development of individual behaviours	7. Ensure that the National Child Measurement Programme (NCMP) is performing well and that support and follow up is provided where necessary. 8. Maximise opportunities through the School Food Action Plan[18] 9. Report the findings from NCMP data collection to the Health and Wellbeing Board to inform strategic decisions 10. Work in partnership with schools and nurseries to address issues relating to overweight and obesity by promoting healthy eating plans and active lifestyles
Early adulthood/ Adulthood	16 – 20	Leaving home	Exposure to alternative cultures/ behaviour/ lifestyles patterns (e.g. work, living with friends etc.)	11. Encourage workplace health programmes with an emphasis on healthy food choices and promotion of physical activity in the workplace (starting with Wolverhampton City Council and other public sector workplaces)

18 http://www.schoolfoodplan.com/

Health Annual Report Obesity_Layout 1 16/06/2014 15:27 Page 27

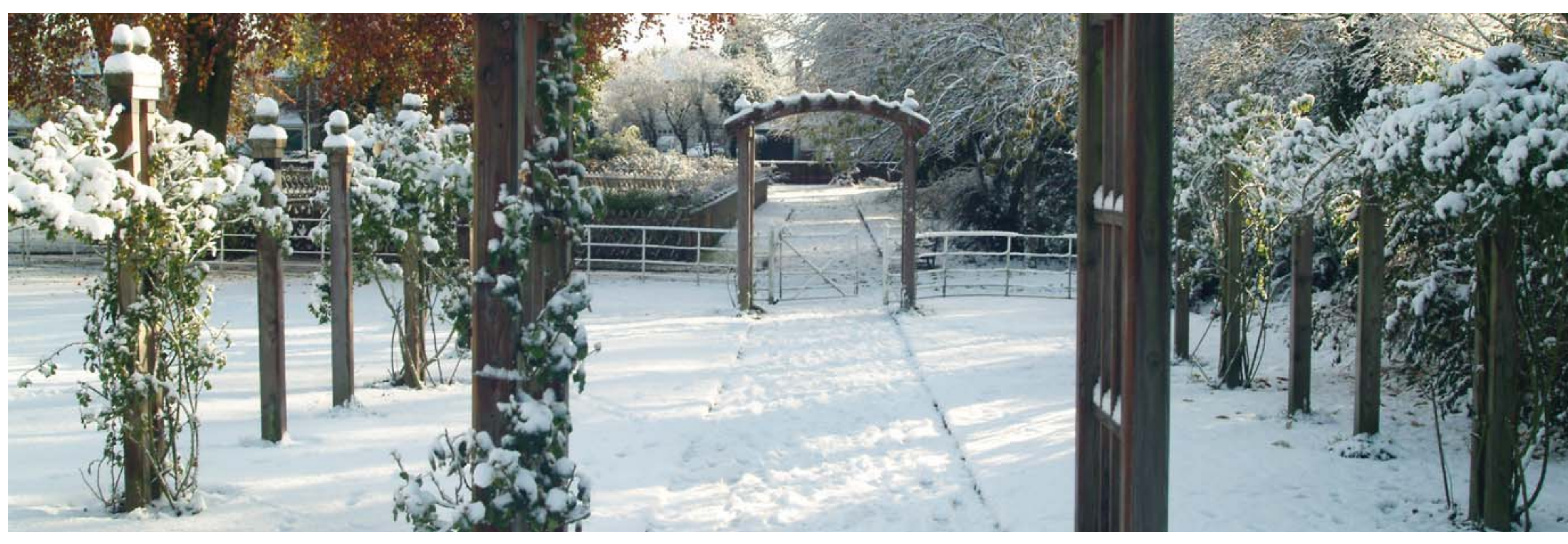
Table 6: Continued

Age		Stage	Issue	Examples of what we can do to make Wolverhampton a less obesogenic place to live
	16 and over years	Becoming more health aware	Health awareness prompting development of new behaviours eg decision to quit smoking	12. GPs increased recording of BMI to increase number of people 'diagnosed' as obese and referred to healthy lifestyle service 13. Encourage walking and cycling 14. Work with local food retail businesses and restaurants /retail food outlets (See point 1 re health in pregnancy)
	16 – 40 years	Pregnancy	Maternal nutrition	
Later adulthood	45 – 55 years	Menopause	Biological changes	As above
	60 + years	Ageing	Growing awareness of physical health prompted by diagnoses of disease in self or others Lifestyle change prompted by changes in time availability, budget, work life balance Occurrence of ill health	15. Management of overweight and obese adults in NHS settings to diagnose co-morbidities earlier and prevent complications
All ages				16. Establish a multi-agency partnership programme of work which addresses healthy eating, overweight and obesity 17.Smart commissioning • Coordinate commissioning across organisations and make sure pathways are integrated • Optimise Making Every Contact Count (MECC) approaches • Explore opportunities to join up small scale initiatives to provide a whole population approach to tackling obesity

Table 6: Continued

Age		Stage	Issue	Examples of what we can do to make Wolverhampton a less obesogenic place to live
All ages				18. Use of evidence • Use an evidence approach to target those areas where there is most need • Use a consistent branding informed by social marketing and using behavioural insight. 19. Explore opportunities to develop programmes with other partners/organisations – for example transport, planning, environment, education, social care 20. Utilise local assets, for example leisure and community facilities, green and open space and community groups, and use the Health and Wellbeing Board to promote healthier communities.

Some examples of how to achieve this life course approach are given in section 6 overleaf.



A winter walk in Bantock Park

Springvale Park Wolverhampton

6. Opportunities to make Wolverhampton a less obesogenic place to live

6.1 Opportunities in the NHS and General Practice

The current Quality and Outcomes Framework (QOF) Primary Care indicator on obesity only requires GPs to register their obese patients and there is no requirement to take any further action – to discuss weight issues or take appropriate action on a patient's weight, even though in many cases the condition that the patient is presenting with is clearly weight related. This is a missed opportunity. Identifying overweight and obese adults in general practice and other NHS settings and taking steps to control or reduce weight will enable better management of the condition and also early diagnosis of co-morbidities to prevent complications from hypertension, diabetes, CHD and stroke. Addressing weight issues, even when a patient does not present with a weight related issue, is still an opportunity to prevent ill health in the future and improve quality of life.

It is not only GPs who have a responsibility to identify and refer patients – this is an opportunity for all health and care staff to promote healthy weights and good nutritional standards. The case study below shows how seriously the medical professions take this issue, with a specially commissioned report by the Academy of Medical Royal Colleges on obesity[19]. Professor Terence Stephenson, a paediatrician and chair of the Academy, said:

"As health professionals, we see it across all our disciplines – from the GP's surgery to the operating table and everything in between. So it is no exaggeration to say that it is the biggest public health crisis facing the UK today. Yet too often, vested interests dub it too complex to tackle."

"It's now time to stop making excuses and instead begin forging alliances, trying new innovations to see what works and acting quickly to tackle obesity head on - otherwise the majority of this country's health budget could be consumed by an entirely avoidable condition."

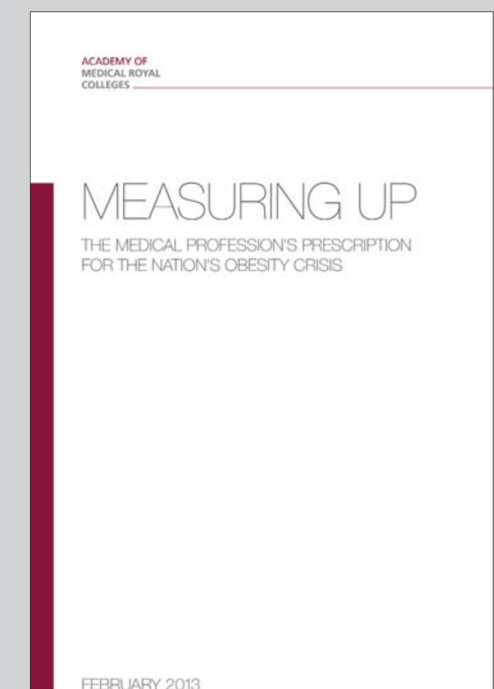
Case Study: Doctors Unite to deliver 'prescription' for UK Obesity epidemic

A recent report produced by the Academy of Medical Royal Colleges (AoMRC) which comprises medical professionals from surgeons and psychiatrists to paediatricians and GPs – has set out their joint recommendations for tackling obesity entitled, 'Measuring up: the medical profession's prescription for the nation's obesity crisis'. The report presents 10 key recommendations falling into three areas:

- *Actions to be taken by health care professionals*
- *Changing the obesogenic environment*
- *Making the healthy choice the easy choice.*

Actions to be taken by healthcare professionals are:

- *Education programmes within the next two years to ensure 'making every contact counts' becomes a reality*
- *Investment in weight management services*
- *Nutritional standards for food in hospitals*
- *Increasing support for new parents to increase basic food preparation skills and guide appropriate food choices.*



19 http://www.aomrc.org.uk/doc_details/9673-measuring-up

6.2 Opportunities in Schools

Schools present a range of opportunities to tackle obesity and increased physical activity, for example

- through healthy school meals and a whole schools approach to diet and nutrition,
- through the curriculum to promote knowledge of healthy eating and knowledge of how to cook – See School Food Plan[20]
- through participation in physical activity
- schools also provide an opportunity to work closely with families and communities
- schools have a range of facilities and open space that can be utilised by the wider community

Multi Use Games Area at Phoenix Park

Case Study: Primary PE and Sports Premium

The Primary PE and Sports Premium is a direct funding scheme for school sport, announced as a two-year initiative to run until 2015-16, is now expected to run for another five years. Each year primary schools will continue to receive £8,000, plus £5 per pupil. The funding is meant to improve sports lessons, such as paying for specialist coaching, equipment or to help after-school clubs.

East Park Children's Playground

Case Study: Community Uses of School Sites

Schools are essential to provision of sustainable high quality sport and leisure facilities. Education-based provision accounts for 64.5% of overall provision in Wolverhampton. This is very high compared to West Midlands (51%) and national (46%) averages and reinforces the importance of community access to schools.

In a nutshell, the efficient, effective programming and use of school indoor and outdoor sports facilities (plus associated changing accommodation and on-site parking) for community benefit is vital to increasing physical activity and sustaining participation levels.

For sports halls, the position is more extreme. Most capacity in the city is provided at schools, with very little provided directly by the Council or commercial sector. Therefore, gaining access to school provision to cater for sport and physical activity is a vital component of improving physical activity levels amongst the whole population.

20 http://www.schoolfoodplan.com/

6.3 Opportunities in local business and workplaces

Businesses and workplaces also present ideal opportunities to make Wolverhampton a less obesogenic place. The Public Health Responsibility Deal[21] was established to encourage businesses (including food and drink manufacturers and retailers) to do their part in reducing obesity levels by making it easier for individuals and families to make healthy choices. The Department of Health and the Local Government Association has produced a toolkit to localise the Public Health Responsibility Deal which sets out a menu of simple, effective actions which a range of local businesses could take to support their customers and staff make healthier choices. Examples relating to obesity are:

- encouraging physical activity in the workplace for example by signposting employees to local opportunities to be physically active and promoting the use of stairs rather than lifts
- promoting active travel, i.e. walking, cycling and running, for example by providing secure cycle storage, and changing and showering facilities
- where food and drinks are available to staff (including through vending machines), ensuring that there are healthier choices and appropriate portion sizes.
- for catering outlets, making products healthier by using healthier oils, less salt and more fruit and vegetables

The Responsibility Deal has a collection of pledges that (at a local level) small to medium sized business are encouraged to commit to. However, if local businesses and workplaces do not want to sign up to the pledges in the Deal, they can still take action on the above areas and greater attention should be given to the role of business and workplaces in promoting physical activity and healthy eating - with public sector organisations taking a leadership role here. Some case studies follow – further examples are available on the website.

Cycle Storage

21 https://responsibilitydeal.dh.gov.uk/category/showcase/

Case Study: Eat Out, Eat Well – Surrey County Council Trading Standards Service

Surrey County Council developed The Eat Out Eat Well Award to reward caterers throughout Surrey who make it easier for their customers to make healthy choices when eating out. It has three levels – Bronze, Silver, and Gold, and it is open to all types of catering establishments including cafes, takeaways, sandwich shops, private schools and staff restaurants that are 'broadly compliant' in relation to food safety and food standards.

Case Study: Salt and saturated fat reduction in fish and chip shop's project in Stoke-on-Trent

Stoke on Trent City Council environmental health and trading standards officers have helped local fish and chip shop owners to reduce salt and saturated fat levels in their products as part of a drive to help promote healthier eating.

6.4 Local authority opportunities

Local authorities are very large organisations and have a range of legislative and policy levers at their disposal that can help create places where people are supported to maintain a healthy weight in their role as commissioner, regulator and community leader. The treatment of obesity has traditionally been viewed as an NHS issue yet all areas of the council have an important role in supporting individuals and communities to achieve and maintain a healthy weight. Virtually all council services have something to contribute to the reduction of obesity levels in Wolverhampton.

Obesity is an issue that should be of special interest to officers and elected members, especially portfolio holders for health, social care, planning, transport, regeneration, business, and this section highlights some of the significant areas that can make a difference.

6.4.1 The role of planning

The move of public health from the NHS to local authorities provides a great opportunity to produce an environment which really promotes health and this is vital to making progress on tackling complex health issues such as obesity and there is now a wealth of guidance available on how to promote healthy communities. For example:

The recent report by the **Town and Country Planning Association and Public Health England** 'planning healthier places – report from the reuniting health with planning project' has emphasised the role of health in planning and planning in health and in the desirability of developing an integrated health and planning work programme and the need to enhance competence and share knowledge. It produced a series of findings and recommendations in relation to health and planning, i.e:

- Economic growth requires places that promote good health – the focus on short term financial viability threatens to undermine this.

tcpa | Public Health England

planning healthier places –

report from the reuniting health with planning project

Andrew Ross, with Michael Chang

- Public health priorities and evidence must be better linked to places and planning processes
- Tackling local health inequalities needs to be emphasised more strongly in local planning processes
- Raising the design quality of developer schemes would create incentives to improve health
- Local plans should be flexible enough to facilitate placed-based innovations that could improve health and wellbeing.

Unless action is taken, the cost of obesity has the potential to derail the goals of achieving sustainable economic growth and a healthier Wolverhampton.

Messages for localities

- Local authorities should drive an integrated work programme to support health promoting environments
- Local authority partners should be encouraged to work more closely together around shared objectives
- Developers must fulfil their role in creating health-promoting environments.

Messages for planning, public health and relevant practitioners

- Think laterally and work collaborative
- Build shared knowledge and competencies on the role of planning

Allotments

Wolverhampton skyline

A report from the **Royal Institute of British Architects** draws parallels with the public health pioneers and urban reformers in the 19th and early 20th centuries, who helped overcome infectious diseases like cholera and TB by improving our buildings, streets and neighbourhoods. The report 'City Health Check: How design can save lives and money'[22] examines how in the 21st century the design of our cities can play a crucial role in combating some of the new public health epidemics – in particular obesity and related chronic diseases such as diabetes and heart disease whilst at the same time delivering savings of £900 million a year for the NHS. The report looks at London and England's eight Core Cities - Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield – examining three major health problems and comparing the amount of green and public space available. The results were clear – **the areas of our cities with the poorest health outcomes had the least amount of green space**.

The report outlines a series of actions that developers, councils and the Government can take to help make them healthier places.

The role of Health and Wellbeing in Planning - In March 2014, the Department for Communities and Local Government launched its planning practice guidance as a web-based resource which includes guidance on the role of health and wellbeing in planning.[23]

The guidance states that local planning authorities should ensure that health and wellbeing is considered in local and neighbourhood plans and in planning decision making in order to promote healthy communities and emphasises that the built and natural environment are major determinants of health and wellbeing. The importance of the role of planning in promoting health and wellbeing is emphasised in the promoting healthy communities section of the guidance and links are also found in guidance on transport, good design, and the natural environment.

In relation to the promotion of healthy weights, planning guidance states that development proposals should be subject to the following considerations:-

- Proposals should 'help create healthy living environments which should where possible include making physical activity easy to do and create places and spaces to meet to support community engagement and social capital'.
- Proposals should have considered opportunities for healthy lifestyles e.g. planning for an environment that supports people of all ages in making healthy choices, helps to promote active travel and physical activity and promotes access to healthier food, high quality open spaces and opportunities for play, sport and recreation'.

Therefore, the Health and Wellbeing Board can provide a valuable forum through which partners can help ensure that planning proposals have a positive impact on the health and wellbeing of communities.

22 http://www.architecture.com/TheRIBA/AboutUs/InfluencingPolicy/CityHealthCheck.aspx/#.Uyntvfl_snU

23 http://planningguidance.planningportal.gov.uk

Case Study: Making it happen – Recommendations from 'City Health Check: How design can save lives and money'

In ***2013*** *responsibility for public health was handed over to local authorities across England, bringing with it new possibilities to join up housing, planning and health strategies in order to encourage healthier lifestyles through healthier* ***local environments****. The report calls on local authorities to integrate public health considerations into planning policies and programmes and to have a truly joined-up approach to improve their city's health through the following steps:*

Recommendations for local authorities

1. Local authorities that are comprised of less than 50% green space and/or have a housing density of over 5% ***must produce a Healthy Infrastructure Action Plan as part of their Local Plan in conjunction with Health and Wellbeing Boards****. They must outline their strategy for making streets and parks safer and more attractive and they must outline the principles they expect new developments to meet in order to gain planning permission.*

2. Local Authorities that are comprised of less than 50% green space and/or have a housing density of over 5% should ***redirect a proportion of their Community Infrastructure Levy (CIL) receipts to fund their Healthy Infrastructure Action Plan.***

Recommendations for central government

3. Planning guidance must include ***guidance as to how planners and developers can aid healthy lifestyles by ensuring places are safe and attractive, to encourage people to walk and cycle more safely.***

4. Seven of the 10 city local authorities with the worst health performance have not received the higher growth rate (10% or above) of ring fenced grants to spend on public health services. These ***local authorities should be prioritised in the next round of grants and should use the increase to invest in actions specified in their Health Infrastructure Investment Plan.***

Recommendations for developers and architects

To truly transform our cities and make them healthier places, we need to think about how we design and build in health from the outset. ***Developers and architects*** *need to recognise the responsibility they have in creating healthier environments. We recommend that:*

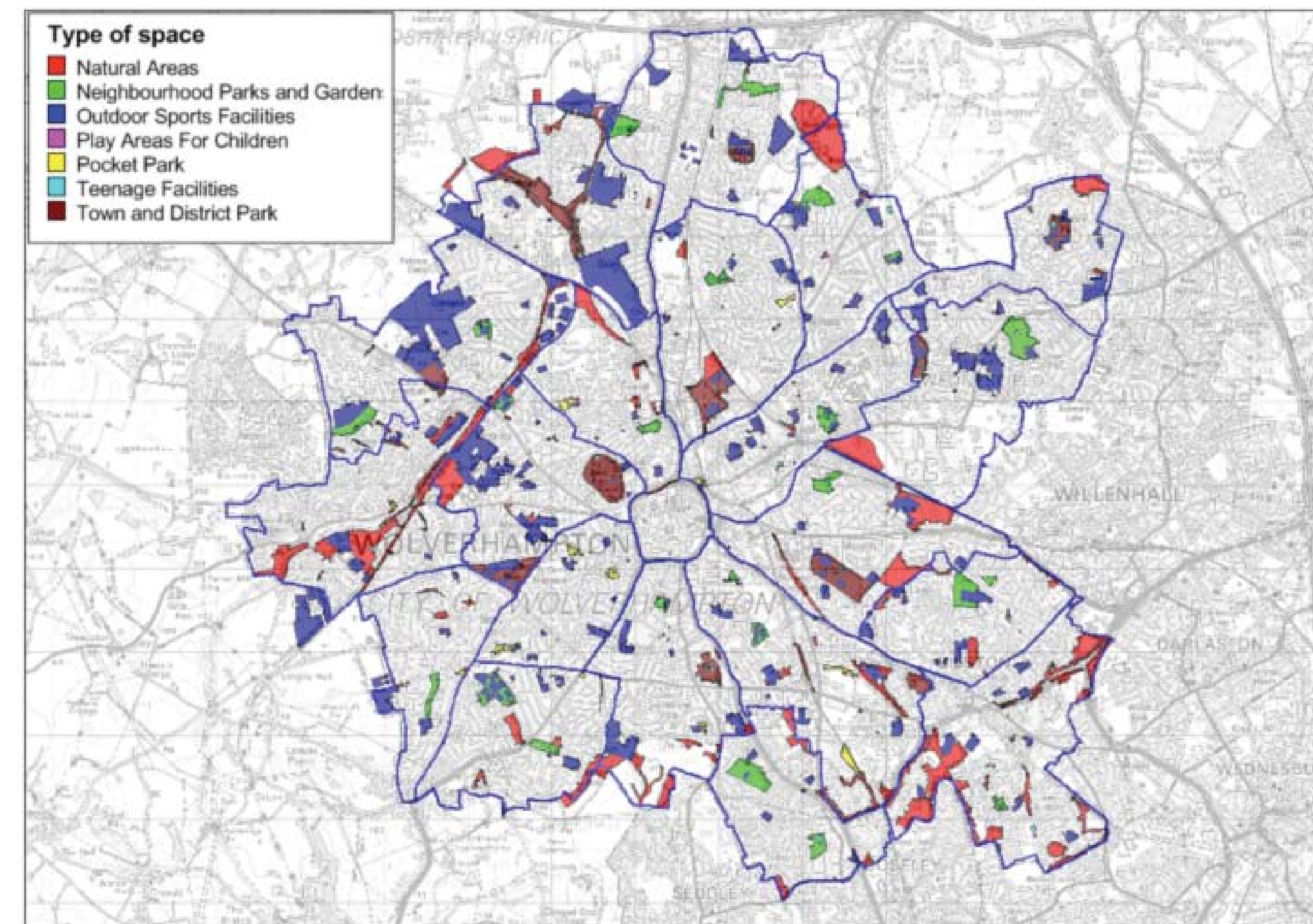
5. Built environment organisations, in particular ***housing developers and architects should commit to pledges 3 and 4 of the Responsibility Deal Physical Activity Network.***

6. Developers should ***use the Design and Access Statement to prove how their new developments will benefit public health though their design of the public realm*** *and its links to existing infrastructure. They should identify characteristics of the local area and the view of local people as to what constitutes beautiful architecture and public space.*

6.4.2 Sport and leisure facilities

Nowhere in Wolverhampton is far away from a park or leisure facility of some kind (Figure 11) and there are a wide range of green space and facilities to suit all ages and abilities and in particular provide opportunities for walking, cycling and outdoor play.

Figure 11: Sport and Leisure Facilities



Source: Wolverhampton Public Health

Table 7 shows the number and type of sports and leisure facilities in Wolverhampton which highlights a range of opportunities available to enable participation in sport and fitness activities. An existing example of a successful scheme in Wolverhampton is the case study on community gyms, highlighting the successful use of some of the local community facilities mapped out in Figure 11.

Table 7: Sport and Leisure Facilities

Facilities	Number in Wolverhampton
Athletics Tracks	3
Golf	4
Grass Pitches	86
Health & Fitness Suites	18
Indoor Tennis Centre	1
Sports Halls	39
Squash Courts	4
Swimming Pools	18
Artificial Grass Pitches	10

Source: Wolverhampton Public Health

Transit Trix Winners at Phoenix Park

Case Study: Fit for a Fiver – Community Gyms

The concept of 'Community Gyms' is that sessions for local people will be delivered by local people in facilities within local communities. Community members don't have to worry about travelling too far to access affordable activity as Community Easy Line Gyms are available on their doorsteps and are being delivered by real people from within their areas who have been empowered to become deliverers.

Within these community gyms, we currently deliver a Fit for a Fiver programme aimed at people with a high Body Mass Index (BMI) – 30 or more, diabetes or any other long-term medical condition, and enables them to enjoy 12 weeks of exercise. The programme costs just £5 and provides vouchers enabling participants to use Easyline gyms over a 12-week period.

An example of the impact of the scheme can be seen in Bob of Bilston. Bob was referred to the scheme by his health trainer after suffering bouts of depression and has been on the programme for 20 weeks. He works out at the Easyline Gym at Lower Bradley Community Centre and has already lost two-and-a-half stone. Bob completed the initial 12-week programme and has made such good progress that he has been given a second set of vouchers so that he can continue his improvement.

A resident enjoys the benefits of the Trim Trail at Phoenix Park.

*He said: **"My health trainer recommended that I take up the Fit for a Fiver programme and I haven't looked back."***

"I love the sessions – they've not only helped me lose weight and feel better physically but they have also made me feel better in myself."

"The hardest part was getting the courage to come through the door that first time but I'm so glad that I did. The sessions are a social get-together as much as a fitness class and that's what makes them work so well."

The community gyms have made a noticeable impact within the community. This is due to the joined up approach adopted for the development of the community gyms and the implementation of schemes linked to them.

6.4.3 Walking and cycling

Walking for Health at Graiseley Recreation Ground

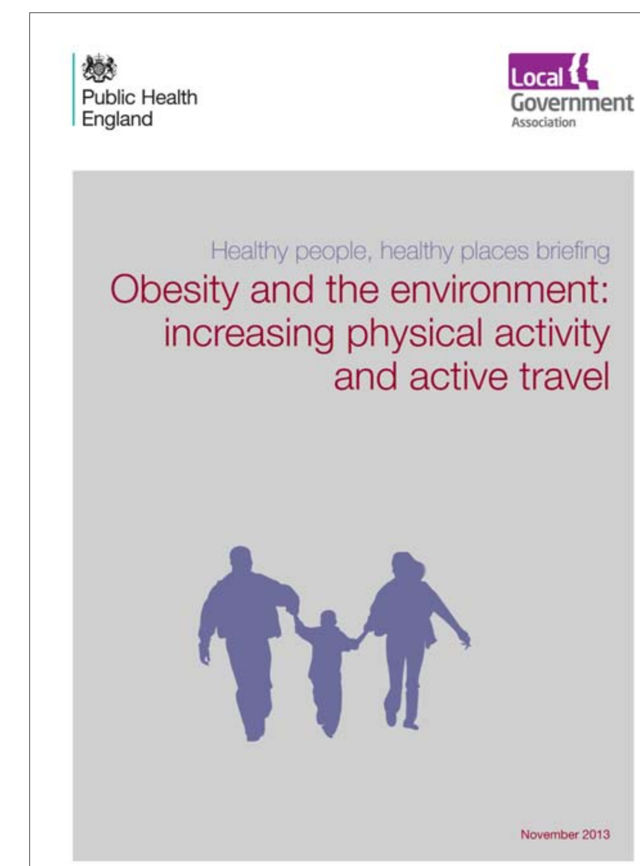
An important part of any action to counter rising obesity levels is to increase overall exercise across all levels of society and all ages. Broader environment considerations such as travel to work distances, distance to shops, schools, perceived safety, greenery and aesthetics and upkeep of neighbourhoods and paths all encourage walking. The appeal of buildings themselves is an important factor, for example having prominent and appealing staircases rather than escalators and lifts. Increased attention to community safety may be needed which can be a barrier to people being more active.

As stated above, planning authorities can influence the built environment to improve health and reduce the extent to which it promotes obesity and health should be an important consideration of planning policy decisions, for example through a health impact assessment. Creating an environment where people actively choose to walk and cycle as part of everyday life can have a significant impact on the public's health and is an essential component of a strategic approach to increasing physical activity and may be more cost effective than other initiatives that promote exercise, sport and active leisure pursuits[24].

Similarly, safe, accessible and pleasant outdoor spaces can enhance children's active outdoor play, and initiatives on road safety are key opportunities to create better conditions for walking and cycling. Moving to a default 20 mph speed limit for streets where people live, work and shop may be the most effective approach available at present.

Public Health England have produced a briefing paper 'Obesity and the environment briefing: increasing physical activity and active travel'[24] which addresses the issue of creating environments where people are more likely to walk or cycle for short journeys.

The briefing summarises the importance of action on obesity and a specific focus on active travel, and outlines the regulatory and policy approaches that can be taken together with examples of what can be achieved – See Case Study.



24 Obesity and the environment briefing: increasing physical activity and active travel. Public Health England. https://www.gov.uk/government/publications/obesity-and-the-environment-briefing-increasing-physical-activity-and-active-travel

East Park - Walkers

Case Study: 20 mph: saving lives while creating space for cycling, walking and play

More than four-fifths of child casualties occur on roads with a 30 mph speed limit. The North West Public Health Observatory undertook a modelling exercise to investigate the impact of implementing 20 mph traffic speed zones in residential areas (other than main roads) across the North West. This showed that 140 killed or seriously injured children could have been prevented in the region each year between 2004 and 2008

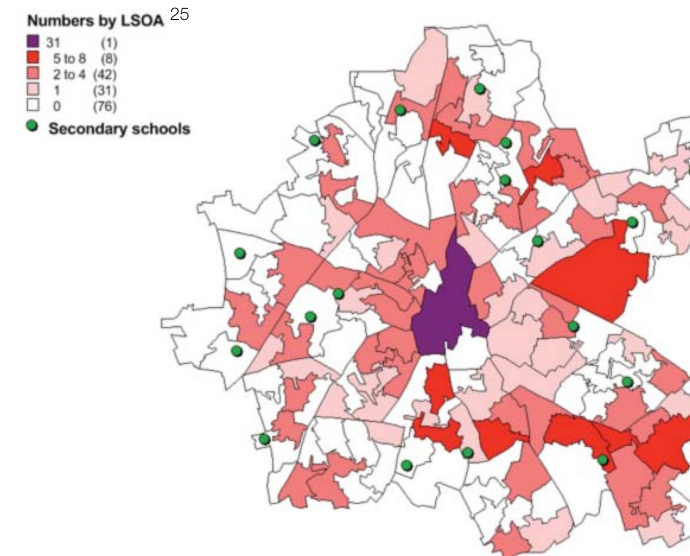
Source: Obesity and the environment briefing

6.4.4 Regulating the growth of fast food outlets

One of the trends in recent years has been an increase in the proportion of food eaten outside the home, including in hot food takeaways, which tend to sell food which is more likely to be high in calories, fat and salt, and low in fibre, fruit and vegetables. Research on a causal link between food availability and obesity is still underdeveloped but a clear relationship exists. Public Health England has produced analysis that shows the density of fast food outlets varies between 15 and 172 per 100,000 population and that there is a clear association with deprivation in that there is a higher density of fast food outlets in the most deprived areas, potentially contributing to increasing health inequalities.

Improving the quality of the food environment around schools has the potential to influence children's food purchasing habits, potentially influencing their future diets. However, taking action on hot food takeaways is only part of the solution to improving children and young people's diets and does not address sweets and other high calorie food that children bring to schools and can buy in shops near schools.

Figure 12: Fast food outlets: density in Wolverhampton

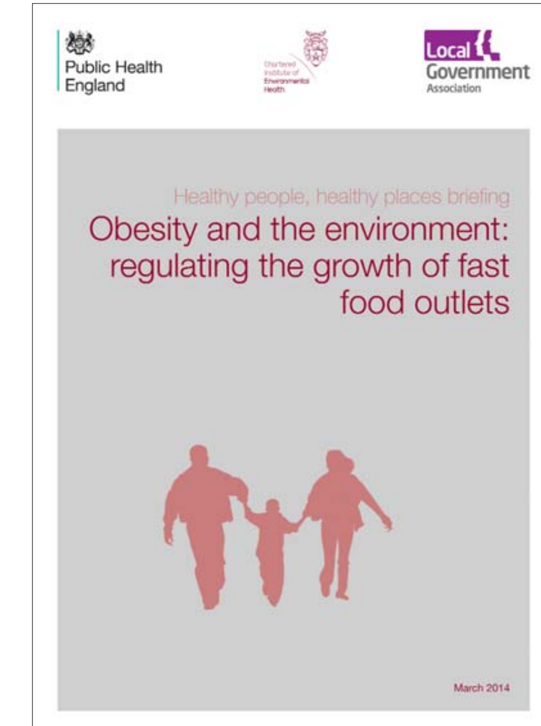


Source: Wolverhampton Public Health Department

Figure 12 maps the density of fast food outlets in Wolverhampton which shows the highest density in the city centre, but that there are high concentrations in many parts of the city. The map also shows the distribution of secondary schools in Wolverhampton.

The Local Government Association (LGA) and the Chartered Institute of Environmental Health (CIEH) have produced a briefing 'Healthy people, healthy places briefing Obesity and the environment: regulating the growth of fast food outlets'[26].
It addresses the opportunities to limit the number of fast food takeaways (primarily hot food takeaways, especially near schools) and ways in which fast food offers can be made healthier. The report provides numerous case studies and outlines the regulatory and other approaches that can be taken at local level. For example, there are three broad approaches that could be used by local authorities to address the problem of hot food takeaways in city centres or near schools:

1. Working with the takeaway businesses and food industry to make food healthier
2. Working with schools to reduce fast food consumed by children
3. Using regulatory and planning measures to address the proliferation of hot food takeaways.



Reviews of the evidence suggest that although specific actions can sometimes be useful, without overall coherence in policy and clear political drivers, they are most unlikely to deliver the required change. Even at a micro level, this appears to be the case. Usually, reviews of interventions in school settings suggest that a 'whole school' approach e.g. meal services, vending machines, class teaching, physical education, out of school activities is more likely to be successful than one targeting individual children.
In principle, the greater the environmental change, the more chance of a sustainable change in health behaviour.

25
A Lower layer Super Output Area (LSOA) is a geographic area generated to give a consistency of population size to improve reporting of statistics for small areas. the minimum population is 1,000 with an average of 1,500.

26
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/264914/Briefing-OBESITY-FASTFOOD-FINAL.pdf

7. Significant behaviour change is needed

None of these opportunities can make any difference to levels of overweight and obesity in Wolverhampton unless significant behaviour change takes place. This is needed to enable individuals, communities and agencies to make the changes required to reduce the obesogenic environment within Wolverhampton. Commitment is needed from all organisations having an influence on individuals' lives and behaviour as well as the personal motivation needed from individuals themselves. Insights into understanding behaviour (for example from social marketing) will lead to new opportunities and approaches to use in the new health and care landscape.

7.1 Individual behaviour change

Evidence from social marketing research suggests it is unlikely that large scale information giving campaigns on physical activity and healthy eating will be enough to address obesity. Interventions that do more than just giving information, for example, programmes that simultaneously inform, shift motivation and provide the necessary skills to enable change are more likely to lead to actual changes in behaviour. Particularly important in Wolverhampton is that any promotion or education campaigns or services need to take into account cultural diversity and be equally accessible to low income groups. Locally targeted social marketing campaigns can help in this aspect.

Achieving behaviour change also needs to deal with the different consequences of helping that change in behaviour; for example tackling obesity involves challenging attitudes to diet, changes in shopping behaviour, increases in exercise, different choices of transport, reduction is alcohol consumption, changes in shopping/eating habits etc.

Considerable psychological effort is needed to combat the temptation of an unhealthy lifestyle and freedom of choice can sometimes make it more difficult to resist temptation when unhealthy options are so abundant in modern life. Choice, stress and habit make it hard to resist unhealthy options. Long term effectiveness depends on appropriate environmental changes and strategies that help sustain new behaviour as evidence shows that promoting healthy behaviour to individuals is unlikely to succeed if not supported by environmental change otherwise old environmental cues will trigger old habits.

St Christopher's Park in Low Hill - demonstrating pedal power to make a fruit smoothie

Case Study: Football Fans in Training

Football clubs can be a catalyst for weight loss amongst children, as demonstrated by Wolverhampton's 'Wolfie's Workout'. However, research evidence shows that they can also be a great place to engage older men who are overweight or obese who are the most reluctant group to join organised weight loss programmes. Professional football clubs are popular venues for (mostly) male fans and have the potential to be appealing places for men who want to lose weight and live more healthily. This is demonstrated by a large scale (over 700 participants) randomised controlled trial called 'Football Fans in Training' which was undertaken amongst overweight and obese Scottish football fans (men aged 35 to 65 years) who were at a very high or extremely high future risk of obesity related ill health. [27]

The results showed that those men who took part in a programme of 12 weekly group sessions at the football club they supported lost, on average, nearly 5kg (11 lbs) more weight than those who did not take the programme which is enough to improve their health and reduce their risk of diseases such as type 2 diabetes, high blood pressure, heart disease and stroke.

The draw of the football club was very important in getting men to attend when they would otherwise be reluctant and the style of the sessions fostered team spirit and the men appreciated being with other men 'like them' who were overweight and unfit but who shared an interest in the football club.

"I've struggled with my weight since, maybe, early-twenties and I've tried various diets, various things, and you seem to get to a stage where you're successful, then you fall back out the way again. So, when I seen this advertised in the paper... the main thing that drew us to it was because it's (Club07). You're going to be involved at (Club07) whether it just be at the ground, stadium.... That was what really attracted me to it". [28]

Therefore, this study shows that it is possible to engage overweight and obese men in weight loss programmes and that they can lose the amounts of weight that can make a difference to their health and that this can be sustained.

7.2 Organisational behaviour change

Public health gains can only be sustained if the behaviour change can be maintained by encouraging and promoting organisational and environmental change that encourages the healthy behaviour and sustains and makes the healthy choice, the easy choice. The examples given in section 6 shows some of the ways that this can be done.

27 Football Fans in Training (FFIT): a pragmatic randomised controlled trial of a gender-sensitised weight loss and healthy living programme delivered to men aged 35-65 years by Scottish Premier League football clubs. The Lancet. www.thelancet.com/protocol-reviews/11PRT8506

28 Do weight management programmes delivered at professional football clubs attract and engage high risk men? A mixed-methods study BMC Public Health www.biomedcentral.com/1471-2458/14/50

Part IV Recommendations and Actions

8. Pledge your support

Recommendation 1 – Hold an Obesity Summit in October 2014

On 28th June, 2013, Professor Sir Liam Donaldson, former Chief Medical Officer for England, gave a special lecture entitled 'Healthy, Wealthy and Wise' – the third event in the series of Wolverhampton Debates. Sir Liam discussed some of the challenges facing the city, the impact of lifestyle choices and the consequences for the future prosperity of cities. He shared his experiences as the Royal Physician and as Chief Medical Officer during the Swine Flu epidemic and his current role in the international efforts to eradicate polio. His challenge to the audience to improve the health of the city was 'to choose one thing and do it well'.

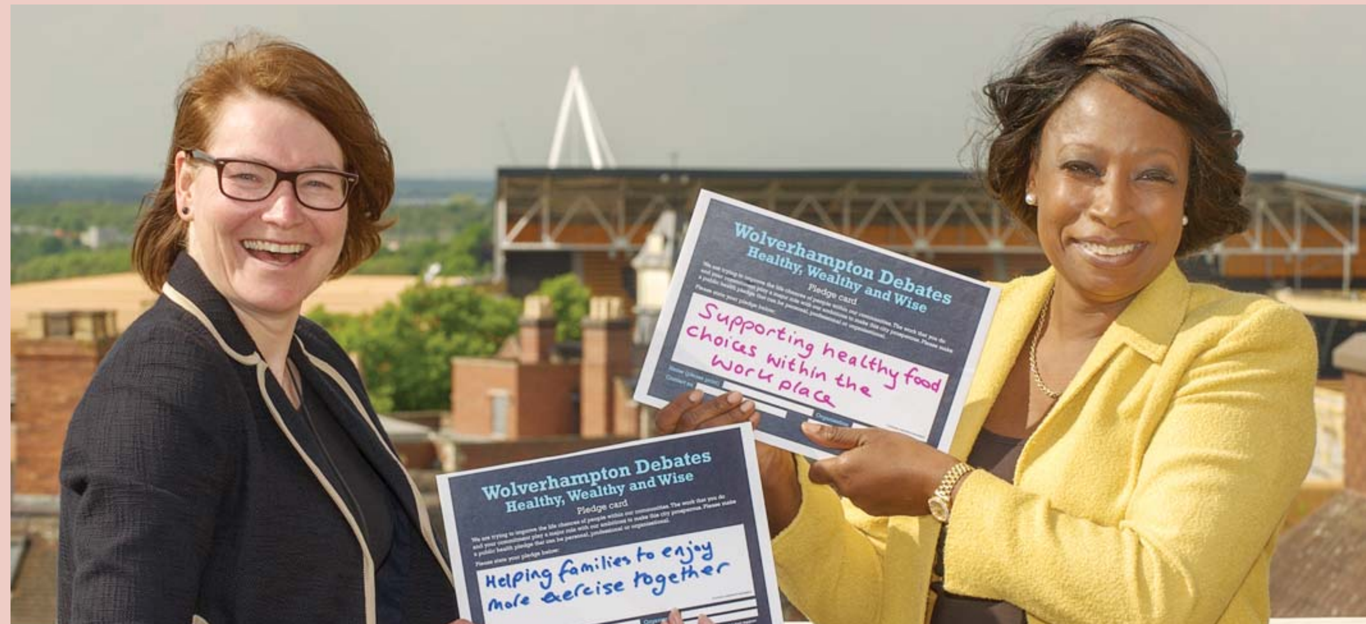
One year on, this annual report, with its focus on tackling obesity, picks up Sir Liam's Challenge and makes the recommendation to hold an Obesity Summit in October 2014, with the remit to develop a Wolverhampton wide action plan.

Recommendation 2 – Pledge your support

At the 'Healthy, Wealthy and Wise' Wolverhampton Debate, participants were also asked to pledge their support to improving the health of Wolverhampton residents, either for themselves, or on behalf of the organisations and communities they represented. In preparation for the Autumn Obesity Summit, recommendation 2 asks readers to sign up to the Summit and make a pledge to contribute to the obesity challenge. Sign up and pledges can be made at www.wolverhampton.gov.uk, or by returning the proforma overleaf.

Wolverhampton City Council makes the first pledge of organising a workplace health pilot with the remit of promoting healthy eating and physical activity amongst the City council employees.

Ros Jervis, Director of Public Health for Wolverhampton and Councillor Sandra Samuels, Portfolio holder for Health and Wellbeing, supporting pledges from the 2013 Healthy, Wealthy and Wise Wolverhampton Debate.



What can I Do?

Recommendation 3 highlights what are considered to be the 6 priority areas for action to tackle obesity in Wolverhampton. These are given in Section 9, Table 8, in addition Section 10 provides some handy Action Cards.

These are all based on best evidence and may help you think about what you or your organisation can do, but innovation and knowing the local community is important too, so pledges of support can reflect this.

I would like to express an interest in the Autumn Obesity Summit and wish to receive further information when available.
Organisation Name:
Address:
Postcode:
Telephone:
Email:

Organisation Name:
Our Obesity Pledge

Please return to: **Public Health, Civic Centre, St Peter's Square, Wolverhampton WV1 1RT**

9. Recommendation 3 - Priority Actions

Table 8: Priority action to tackle obesity in Wolverhampton.

Priority		Rationale	Take action by:
Priority 1.	Encourage and support breastfeeding	There is strong evidence to support the maternal and child benefits associated with breastfeeding in both the short and long-term. However, it is not enough to encourage breastfeeding, as whilst it may increase initiation, adequate on-going support is required to sustain breastfeeding for the recommended length of time during infancy	• Promote the breastfeeding session at New Cross hospital to encourage all pregnant women to attend • The importance of breastfeeding incorporated in the healthy schools programme • Peer support for breastfeeding mothers
Priority 2.	Improve parenting skills to prevent an obesogenic home environment and encourage behaviour change	Parenting skills are key to the development of family health and wellbeing, providing the opportunity to promote healthy lifestyle choices	• Health visitor and schools based programmes to support parenting skills which include raising awareness of the importance of healthy eating and encouraging physical activity for the family
Priority 3.	Develop evidence based physical activity and healthy weight programmes in schools	The school food agenda has been a primary focus and it is equally important to address the need for promoting and improving levels of physical activity to support the achievement and maintenance of a healthy weight	• Review current service provision and ensure commissioned services are evidence based and provide effective outcomes that improve physical activity and support maintaining a healthy weight
Priority 4.	Establish a multi-agency partnership programme of work which addresses healthy eating, overweight and obesity and which focus on the wider social determinants of health to tackle the obesogenic environment.	Addressing the obesogenic environment cannot be achieved in isolation and will require multi-agency partnership commitment to support the Call to Action.	• Establish a multi-agency partnership forum to drive the programme of work and ensure organisational commitment to achievement of outcomes. • Make full use of the planning practice guidance to ensure that health and wellbeing is considered. The Health and Wellbeing Board has a key role to play in ensuring that planning proposals are likely to have a positive impact.

Table 8: Continued

Priority:		Rationale:	Take action by:
Priority 5.	Encourage workplace health programmes with an emphasis on healthy food choices and promotion of physical activity in the workplace (starting with Wolverhampton City Council and other public sector workplaces)	There is evidence that improving the health outcomes of local employees has the potential to have a significant impact on families and the community with additional tangible benefits for the employer. Workplace health initiatives need to support employees to make healthier choices.	• Workplace survey on food choices at work, and desire for support regarding healthy weight and physical activity • Review food choices within the workplace and make recommendations on improving proportion of healthy options if required. • Offer employees the opportunity to have an NHS health check.
Priority 6.	Develop and promote the universal offer around physical activity across the life course. Focus on availability of local facilities to support accessible and sustainable opportunities for play.	A huge opportunity exists to exploit social media, digital marketing and mobile devices (information, apps & exercise videos) to motivate people and encourage physical activity amongst the less active. This approach has already begun to be promoted nationally. For example, the Change 4 Life 'Couch to 5k' app.[29]	• Developing a healthy lifestyles brand, perhaps building upon the Change4Life brand; known and trusted. • Review and re-align the content and purpose of web pages for Public Health and or other service websites in Wolverhampton. (Nottingham Public Health's home page may be a good example to help shape thinking and ideas for developing a model for Wolverhampton. http://www.nottinghamcity.gov.uk/article/24176/Public-Health)

29 Couch to 5k' app, http://www.nhs.uk/Change4Life/Pages/couch-to-5k.aspx

10. Action Cards

Action Card

Encourage healthy eating

- Encourage awareness of eligibility for welfare benefits and other schemes that supplement the family food budget.
- Use existing powers to control the number of take-away and other food outlets in a given area, particularly near schools.
- Ensure healthier choices are included in catering contracts and are promoted through pricing and educational initiatives.
- Encourage Food Co-ops and local growing projects

Action Card

Encouraging physical activity

- Work in partnership to create and manage more safe spaces for incidental and planned physical activity, addressing any concerns about safety, crime and inclusion. Audit and amend bye laws that prohibit games.
- Plan local facilities and services to ensure they are accessible on foot or by bicycle.
- Ensure leisure services are affordable, culturally acceptable and accessible by public transport or by safe 'active travel' routes. Ensure provision is made for women who wish to breastfeed.
- Consider pedestrians and cyclists when designing, developing or maintaining streets or roads, for example, by introducing traffic calming measures.

Action Card

Promote workplace health

- Support employees to make healthier choices.
- Set an example by ensuring on-site catering offers healthier choices.
- Encourage physical activity by improving the decor and signposting of stairs and by providing showers and secure cycling parking to encourage active travel.
- Offer lifestyle weight management services for overweight or obese staff who would like support to manage their weight.
- Promote Change 4 Life through websites.
- Offer employees an NHS Health Check.

Action Card

Local businesses and social enterprises

- Local organisations and businesses promote health and wellbeing. For example, ensuring the range and content of the food and drink sold does not create an incentive to over-eat and gives people the opportunity to eat healthily. Provide information, such as the calorie content of meals, on menus.
- Venues frequented by children and young people to resist sponsorship and product placement from companies associated with foods high in fat, sugar and salt.
- Encourage breastfeeding, for example by local businesses being more supportive of breastfeeding mothers
- Use food labelling

Action Card

Involving the community

- Local people, groups and organisations to decide what action to take. Use community engagement and capacity-building methods to identify networks of local people, champions and advocates who can help. Council leaders and elected members raise the profile of obesity prevention initiatives through informal and formal meetings with local people.
- Use NCMP to engage schools and parents.
- Address local people's concerns about issues such as the cost of eating more healthily or being more physically active and the perceived dangers of children playing outside. Monitor the number of Food Banks in local areas
- Train lay or peer workers from black and minority ethnic communities and lower socioeconomic groups to promote physical activity and healthy eating.

Action Card

Organisational development and training

- Ensure all relevant professionals are trained to be aware of the health risks of being overweight and obese and the benefits of preventing and managing obesity.
- Ensure all relevant staff who are not specialists in weight management or behaviour change can give people details of local services that can help them maintain a healthy weight.
- Ensure the links between nutrition and health are an integral part of training for catering managers. See Healthier and more sustainable catering: a toolkit for serving food to adults https://www.gov.uk/government/publications/healthier-and-more-sustainable-catering-a-toolkit-for-serving-food-to-adults

Action Card

Promote healthy lifestyles in and through schools

- Gain whole school support for improving the food and physical activity environment and ethos in school, including that from SLT, teachers, support staff, governors and parents.
- Review food and physical activity provisions ensuring a 'whole school approach' where consistent healthy messages are received by all.
- Support staff CPD through access to appropriate training on nutrition, health, physical education and school sport.
- Implement the new food based standards in school from January 2015, for all school provided throughout the school day.
- Increase school meal uptake, particularly for those entitled to free school meals.
- Ensure breaktime and lunchtime arrangements facilitate healthy choices and a positive dining environment.
- Support parents to make healthier choices for themselves and their families, including in the provision of healthy choices for school food that is provided from home.
- Ensure pupils are provided with opportunities to learn about the importance of healthy eating and excerise through a broad, comprehensive PSHE education curriculum.
- Provide cooking as a curriculum entitlement for key stages 1 to 3 from September 2014.
- Consider the need for a breakfast club to ensure provision of a healthy breakfast.
- Effective use of the PE and School Sports Premium to improve opportunities for pupils.
- Ensure curriculum entitlement of two hours quality PE per week striving towards three to four hours when including extra-curricular provision.
- Offer a breadth of activity clubs for all pupils ensuring provision across age, gender and ability levels.
- Involve the whole school community, including pupils and parents.

Agenda Item No. **12**

Health and Wellbeing Board

9 July 2014

Report title	Local Government Declaration on Tobacco Control	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service	Public Health	
Accountable employee(s)	Martyn Sargeant Tel Email	Democratic Services Manager 01902 555043 martyn.sargeant@wolverhampton.gov.uk
Report has been considered by	Public Health Delivery Board 3 December 2013	

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Propose the signing of the Tobacco Control Declaration by the leading Council Executives and the Director of Public Health (as referenced in Appendix 1)

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The background paper

1.0 Purpose

1.1 To provide the Board with background information about the Tobacco Control Declaration and set out why Wolverhampton should be one of the early signatories.

2.0 Background

2.1 The Government Declaration on Tobacco Control within Local Authorities was developed by Newcastle City Council early in 2013 as a way of securing high level, local authority commitment to the importance of tackling issues relating to smoking. It is based on the successful Nottingham Declaration on Climate Change and has been endorsed by the Health Minister, Chief Executive of Public Health England and the Chief Medical Officer

2.2 The Declaration includes a number of specific commitments which will enable Councils to take a strong leadership approach and champion the importance of tackling smoking right across local communities. Locally these can be translated into commitment to:

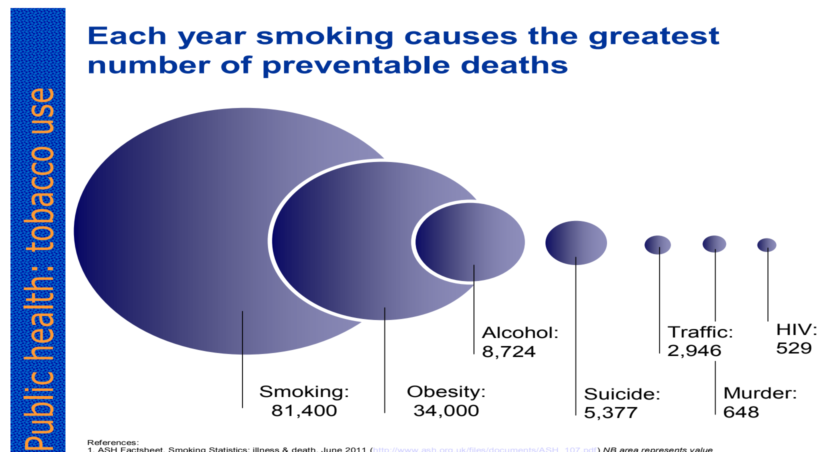
- Reduce smoking prevalence e.g. enabling staff to access smoking cessation services at work, enforcing a smoke free area by entrances and exits to Council buildings.
- Lead on the development of tobacco control plans and strategies with partners and local communities and monitor the progress of these plans
- Participate in local and regional networks and join up to the Smokefree Action Coalition
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry

2.3 An increasing number of local authorities have signed or are about to sign the declaration.

2.4 Smoking is one of the main contributory factors to premature death and disease in Wolverhampton, and the single largest factor in health inequalities, a major driver of poverty. The move of public health to local government presents an opportunity for local authorities to lead local action to tackle smoking, and to ensure that the tobacco industry is not able to influence local tobacco control policy.

2.5 From local data it is clear that smoking rates are disproportionate across different ages and deprivation groups. Smoking in pregnancy remains an issue with younger mothers more likely to smoke during pregnancy as are mothers from the more deprived areas.

2.6 The Impact of Smoking: Every year in England more than 80,000 people die from smoking related diseases. This is more than the combined total of the next six causes of preventable deaths. Smoking accounts for one third of all deaths from respiratory disease, over one quarter of all deaths from cancer, and about one seventh of all deaths from heart disease. On average a smoker loses 10 years of life.



2.7 Reducing smoking in our communities significantly increases household incomes and benefits the local economy: The annual cost of smoking to the UK national economy has been estimated at £13.7 billion. A smoker consuming a pack of twenty cigarettes a day will spend around £2,500 a year. Poorer smokers disproportionately spend more of their weekly household budget on smoking than do richer smokers. Smokers who quit are more likely to spend money saved in their local communities.

2.8 Reducing smoking amongst the most disadvantaged is the single most important means of reducing health inequalities: About half of all smokers in England work in routine and manual occupations. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles. The poorer and more disadvantaged you are, the more likely you are to smoke.

2.9 Smoking is an epidemic created and sustained by the tobacco industry: The tobacco industry (outside China) is dominated by four multinationals which are some of the most profitable in the world: the global tobacco market is worth about £450 billion a year. The industry needs to recruit 200,000 smokers a year in the UK to maintain current levels of consumption replacing those smokers who have quit or died. It is the only industry in the UK that produces and promotes a product that has been proven scientifically to be addictive and it is looking at e-cigarettes for its growth market.

2.10 Smoking is usually an addiction of childhood and adolescence, not an adult choice, with two out of three lifelong smokers hooked before they are legally allowed to purchase cigarettes. Although current evidence on the impact of e-cigarettes on this population is still emerging, marketing of these products is very clearly aimed at young people with strawberry and cream flavours. In addition there is evidence that some young people are also using the devices to get high substituting the liquid for cannabis.

2.11 The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco: HM Revenue and Customs estimate that in 2010/11, the illicit market in cigarettes and hand-rolled tobacco accounted for about 9% and 38% of the UK market respectively. The total amount of revenue lost to the Exchequer was estimated at £1.20 billion for cigarettes and £0.66 billion for hand-rolled tobacco. (All figures are mid-range estimates).

3.0 Progress.

3.1 Over the last 15 years, efforts have been taken to reduce smoking rates. The “Smokefree Law” (that is to say the Health Act 2006 and Smoke-free (Premises and Enforcement) Regulations 2006) , removed smoking from nearly all enclosed public spaces; age of sale for tobacco has increased from 16 to 18 and there are now wide ranging bans on almost all aspects of tobacco advertising. Tobacco control measures like these have helped to protect millions from the harm of second hand smoke and there are over 2 million fewer smokers than there were a decade ago.

3.2 Wolverhampton City Council already plays an important role in reducing tobacco use. The Environmental Health team enforces the Smokefree Law across the city and the Trading Standards department work to reduce the availability of smuggled and counterfeit tobacco as well as ensuring local shops are not allowing under-age sales. This role increased in April 2013 when it took over Public Heath responsibilities - part of which includes the commissioning of the city's Stop Smoking Services.

3.3 However, despite huge progress in some areas, rates of smoking remain high in Wolverhampton and numbers coming through smoking services are reducing, possibly as a consequence of the increasing use of e-cigarettes.

3.4 Smoking prevalence is higher than the national average as shown in Appendix 2 as is smoking in routine and manual groups. Of increasing concern in light of Wolverhampton having the highest infant mortality rate are the smoking in pregnancy rates which remain stubbornly high in comparison to our statistical and local neighbours and the England average.

3.5 Data from the Health Related Behaviour Study 2011/12 shows that the number of young people smoking is about 3% but as this is based on self report it is likely to be an underestimate. It is clear that more work is required to better understand the impact not only of smoking in young people but what the impact of Shisha and e-cigarettes are in this population.

4.0 Financial implications

4.1 This report has no financial implications.

[DK/26062014/A]

5.0 Legal implications

5.1 There is no risk to either signing or not signing this Local Government Declaration on Tobacco Control. The role of the Council in enforcing the "Smokefree law" (the Health Act 2006 and Smoke-free (Premises and Enforcement) Regulations 2006) is described above.

[KR/27062014/X]

6.0 Equalities implications

6.1 Public Health continues to work towards reducing the smoking prevalence and use of tobacco products in Wolverhampton. By reducing the smoking prevalence, particularly in the most disadvantaged areas, we will have the greatest impact on improving the health of the community and reducing the gap in life expectancy between the richest and poorest in our society. As well as improving the health of the community it will impact on the local economy by increasing income into the community. An Initial Equality Analysis has been completed and there are no equalities implications from this proposal.

7.0 Environmental implications

7.1 Reducing smoking prevalence will reduce the environmental impact from cigarette litter.

8.0 Human resources implications

8.1 There are no direct HR implications arising from the report.

9.0 Corporate landlord implications

9.1 There are no direct implications for the Council's property portfolio.

10.0 Schedule of background papers

Public Health Delivery Board 3 December 2013

Local Government Declaration on Tobacco Control

Appendix 1

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

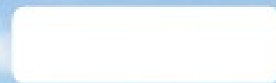
We commit our Council from this date ....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories

Leader of Council

Chief Executive



Director of Public Health

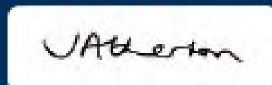
Endorsed by

Anna Soubry, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Professor Dame Sally Davies, Chief Medical Officer, Department of Health

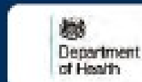
Dr Janet Atherton, President, Association of Directors of Public Health

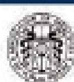


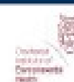
Dr Lindsey Davies, President, UK Faculty of Public Health

Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute

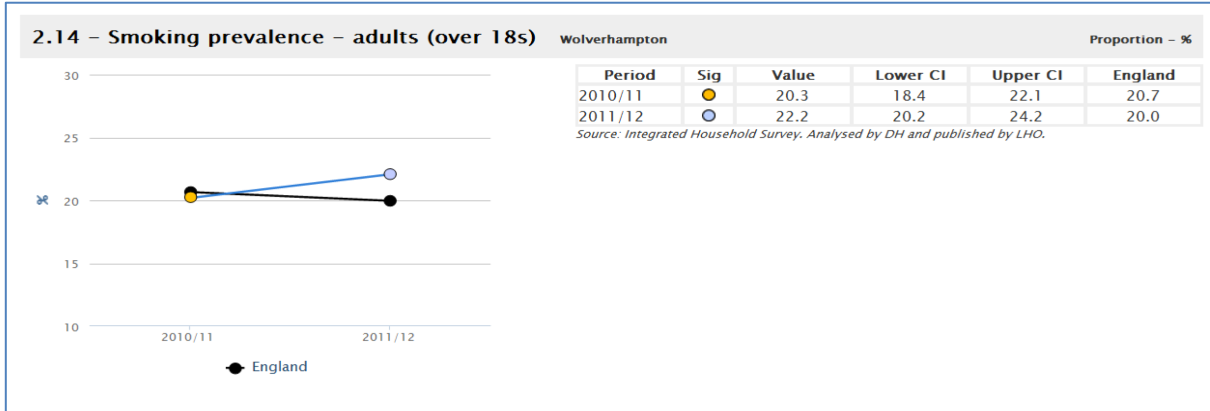






Appendix 2

Fig. 1



2.14 – Smoking prevalence – adults (over 18s) Wolverhampton Proportion – %

Period	Sig	Value	Lower CI	Upper CI	England
2010/11		20.3	18.4	22.1	20.7
2011/12		22.2	20.2	24.2	20.0

Source: Integrated Household Survey. Analysed by DH and published by LHO.

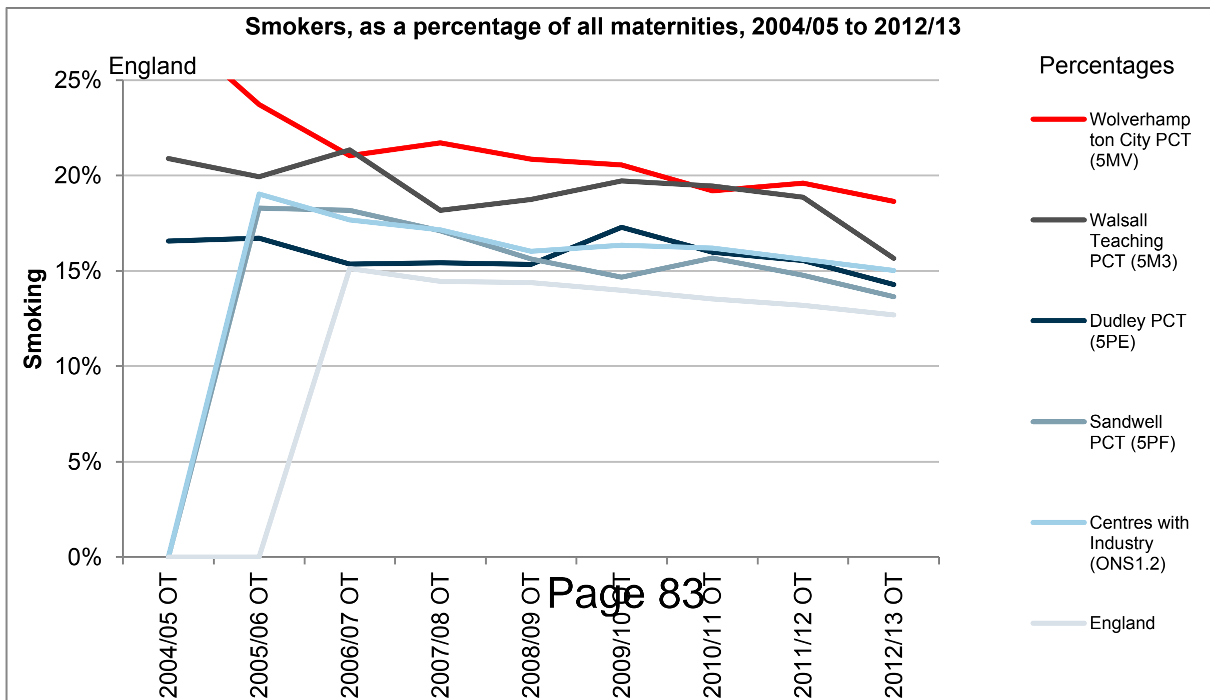
Fig. 2

2.14 - Smoking prevalence - routine & manual Wolverhampton Proportion - %

Period	Sig	Value	Lower CI	Upper CI	West Midlands	England
2011		31.6	26.9	36.3	28.5	30.3
2012		31.7	27.1	36.3	28.1	29.7

Source: Integrated Household Survey. Analysed by the Department of Health and published by Public Health England

Fig. 3



Agenda Item No. **13**

Health and Wellbeing Board

9 July 2014

Report title	Care Act Implementation	
Cabinet member with lead responsibility	Cllr Steve Evans	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service	Transformation Programme	
Accountable employee(s)	Simon Nightingale Tel Email	Transformation Programme Team 01902 550285 simon.nightingale@wolverhampton.gov.uk

---

Recommendation(s) for noting:

The Health and Wellbeing Board is recommended to:

1. Note the Council's progress to date in response to implementing the Care Act and future integration working.

1.0 Purpose

1.1 To inform members of the Health and Wellbeing Board of the work of the Care Act Implementation and Personalisation Programme Board.

2.0 Background

2.1 The Care and Support Bill published in July 2012 was developed into the Care Bill, which was announced in the Queen's Speech on May 9 2013 and published on 10 May 2013. It brings into a single statute all legislation on adult care and support, the government's response to the Dilnot Commission into the funding of adult care and support services,

as well as the findings of the Francis Inquiry into the failings of Mid-Staffordshire Hospital. The Care Act 2014 received Royal Assent on 14 May 2014.

2.2 The Department of Health has summarised the aims of the Care Act, it:

- ensures that people's well-being, and the outcomes which matter to them, will be at the heart of every decision that is made;
- puts carers on the same footing as those they care for;
- creates a new focus on preventing and delaying needs for care and support, rather than only intervening at crisis point;
- puts personal budgets on a legislative footing for the first time, which people will be able to receive as direct payments if they wish.
- reforms the funding system for care and support, by introducing a cap on the care costs that people will incur in their lifetime.
- will ensure that people do not have to sell their homes in their lifetime to pay for residential care, by providing for a new universal deferred payments scheme;
- provides for a single national threshold for eligibility to care and support;
- gives new guarantees to ensure continuity of care when people move between areas, to remove the fear that people will be left without the care they need;
- includes new protections to ensure that no one goes without care if their providers fails, regardless of who pays for their care;
- has new provisions to ensure that young adults are not left without care and support during their transition to the adult care and support system.

2.3 The main changes to the Care Bill prior to Royal Assent were:

- Right to independent advocacy for those needing most support to engage with key processes such as assessment.
- Ensure focus on prevention in assessment process by signposting to other services in the community.
- Stronger emphasis on importance of housing.
- Local authorities to take a more active role on financial advice.
- Commissioning must take account of well-being of individuals.
- New appeals system to challenge decisions.
- Secretary of State must have regard to well-being principle when issuing regulations and guidance.

2.4 The reforms within the Care Act will be implemented through:

- Primary legislation – the Care Bill
- Secondary legislation – the regulations
- Statutory guidance
- Practice guidance/implementation support

2.5 The consultation process on the Care Act guidance and regulations began on 6 June and will run until 15 August 2014. Responses under the consultation will be used to clarify

and improve the guidance and regulations. The Councils' response is likely to be submitted as part of a West Midlands Regional Group.

3.0 The Care Act Implementation and Personalisation Programme

3.1 In response to the Care Act 2014 the Council has initiated a Programme, with a named Programme Manager, to oversee the implementation of the Act including ensuring its Personalisation agenda is aligned with the Programme objectives. The Programme utilises existing Council resources across its Directorates supported by the Community Transformation programme Team. The structure of the Programme is shown at Appendix A.

3.2 The initial workstreams established within the Programme are currently working on defining their objectives and deliverables but much of this detail will be dependent on future regulations and guidance. The structure of the Programme will need to adapt to the requirements of the regulations and guidance in that workstreams may be subject to change.

3.3 The structure includes a two way relationship between the Care Act Implementation and Personalisation Programme and the Health and Wellbeing Board. Within the Act the general wellbeing duty places the individual at the heart of any judgements and decisions about them. The wellbeing principle is intended to establish what the Law Commission called a 'single unifying purpose around which adult social care is organised'. The duty also emphasises the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist. In preventing needs for care and support the Council must provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will:

- contribute towards preventing or delaying the development by adults and carers in its area of needs for care and support;
- reduce the needs for care and support of adults and carers in its area.

This is not just about what the Council does itself, but also how it works with other local organisations to provide preventative information, build community capacity and make the most of the skills and resources already available in the area. Whilst these provisions set out the council's duties, it is clear that 'promoting wellbeing' and 'preventing needs' are dependent on all parts of the system acting with these objectives in mind. The duty to promote integration deals explicitly with well-being and prevention.

3.4 To promote integration of care and support with health services etc. the council must exercise its functions under this Part with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would:

(a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area,
(b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or
(c) improve the quality of care and support for adults, and of support for carers, provided in its area.

The duty to integrate also extends to some of the other general duties within the Care Act – for example, the duty to provide information and advice, the duties to assess and meet needs and the duties to co-operate generally and in specific circumstances, etc. Councils need to ensure that their operations and workforce are aligned to the promotion of well-being and prevention.

3.5 It is proposed to provide a fuller report to this Board in the Autumn as consultation will have ended and a clearer picture of the work required will be vailable.

4.0 Financial implications

4.1 Implications for the Council are huge, multiple and, as yet, not fully defined. Within the Care Act Implementation and Personalisation Programme is a workstream focused on understanding the financial implications of the Care Act.

4.2 The most significant changes to be introduced by the Act from a financial perspective are the introduction of a cap on the total lifetime cost of care for any individual, anticipated to be at £72,000 for those of state pension age, and lower for working age adults (although the amount is yet to be announced), and increases in capital thresholds used in calculating client contributions. The effect of these changes is to transfer a significant portion of the total cost of care from individual care recipients to local authorities. These changes will take effect from 1 April 2016.

4.3 The Act is also expected to introduce a wide range of other changes, including a national eligibility threshold, a universal entitlement to request a deferred payment, additional assessments, and a duty on councils to provide advice and information. Most of these changes take effect from 1 April 2015. See Appendix B for a summary of changes and timescales.

4.4 The position on funding for the costs of the Care Act remains unclear. The Government has announced £335.0 million of funding nationally, as set out below. It is not clear how much of this will be 'new money'.

- £145.0 million for early assessments and reviews.
- £110.0 million for deferred payment (cost of administering the loans and the loans themselves).
- £20.0 million for capacity building including recruitment and training of staff.
- £10.0 million for an information campaign.
- £50.0 million for capital investment, including IT systems (which sits in the Better Care Fund).

4.5 For the costs arising in 2015/16, funding has effectively been taken from Wolverhampton's Better Care Fund allocation (£989,000). A breakdown of this £989,000 is provided at Appendix C (these are Government estimates of the cost to the council, and it should be noted that they include a deduction of £71,000 for 'savings from staff time and reduced complaints and litigation').

4.6 One-off funding has been announced (4 June 2014) by the Minister of State of £125,000 to each local authority in England to provide adequate provision for programme management to implement the requirements of the Care Act.

[AS/30062014/A]

5.0 Legal implications

5.1 The Care Act will change the legislative framework for care, as outlined above. In particular the legislation will have a major impact on local authorities in relation to their adult social care responsibilities. The Care Act places new duties and responsibilities on local authorities as well as extending existing responsibilities. The Act also seeks to introduce new regulations in relation to people's eligibility for care and support services, and in changing the existing charging regimes. RB/27062014/K

6.0 Equalities implications

6.1 This report has no equalities implications. The wider Care Act work, including the implementation of the changes, will require an equality analysis in due course.

7.0 Environmental implications

7.1 No direct implications at this stage.

8.0 Human resources implications

8.1 No direct implications at this stage.

9.0 Corporate landlord implications

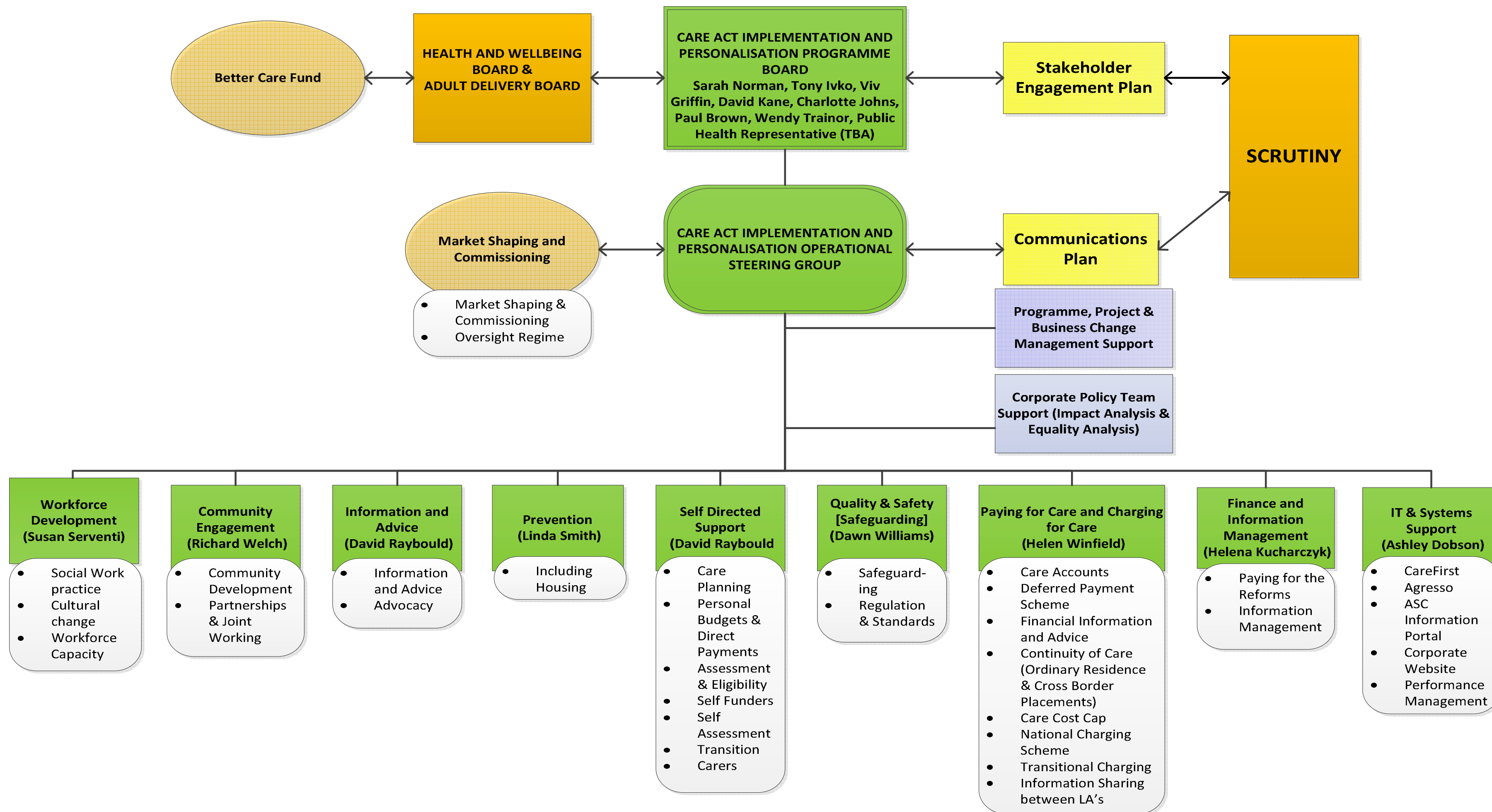
9.1 No direct implications at this stage.

10.0 Schedule of background papers

10.1 References:
- Care Act Briefing Note – Executive Team 25 June 2014

Appendix A

CARE ACT IMPLEMENTATION AND PERSONALISATION PROGRAMME – GOVERNANCE @ MARCH 2014 (Version 3)



Appendix B

Care Act Implementation and Personalisation Programme – Key Events Timeline

****New in Law and Practice - Will have an impact on Local Authorities****

Area	01/04/2015 Care Act Provisions in Force (excl. Funding Reforms)	01/04/2016 Care Act Provisions in Force (inc. Funding Reforms)
Information and Advice	Duty to provide universal information and advice service Duty to provide an independent advocacy	
Legislation, Governance and Law Reform	Care Bill Provisions in Force (excl. Funding Reforms) Statutory Wellbeing Principle Duties and powers to meet needs Power to delegate provision Delayed Discharge provisions Mental Health after care Duty to promote integration Duty to co-operate Duty to maintain sight register Clarification re. care and support for people in prison and bail accommodation	
Paying for Care and Charging for Care	Universal Deferred payment agreements and loans to be available Charging Framework (regulations and guidance in force) Power to charge for care and support Duty to carry out financial assessment Recovery of charges, transfer of assets Right to choice of accommodation and extension to provision of top-up payments	Cap on Care Costs in Effect Duty to Provide Care Accounts Duty to provide independent personal budgets
Prevention	Duty to ensure the provision of preventative services	
Quality and Safety	Statutory Duty to establish Safeguarding Adults Board Responsibility to ensure enquiries into cases of abuse and neglect Information Sharing Protocols	
Care Planning & Personalisation	Duty to provide and review care and support plan in force Right to Direct Payments (inc. for authorised persons) Personal Budgets (as defined) Expanded scope of ordinary residence principle New arrangements in place to make placements in DA's	
Assessment and Eligibility	Duty to determine eligible needs Duty to conduct needs assessment Duty to provide continuity of care Legal duty on transition assessments Duty to provide carers' assessments in force Duty to meet carers' needs	
Care Markets	Duties on market shaping in force Duties in case of provider failure	

APPENDIX C

Care Bill implementation funding in the Better Care Fund (£135m nationally)	**W'ton allocation,**

		£000
Personalisation	*Create greater incentives for employment for disabled adults in residential care*	*16*
Carers	*Put carers on a par with users for assessment.*	*86*
	Introduce a new duty to provide support for carers	*172*
Information advice and support	*Link LA information portals to national portal*	*0*
	Advice and support to access and plan care, including rights to advocacy	*129*
Quality	*Provider quality profiles*	*26*
Safe-guarding	*Implement statutory Safeguarding Adults Boards*	*42*
Assessment & eligibility	*Set a national minimum eligibility threshold at substantial*	*208*
	Ensure councils provide continuity of care for people moving into their areas until reassessment	*23*
	Clarify responsibility for assessment and provision of social care in prisons	*34*
Veterans	*Disregard of armed forces GIPs from financial assessment*	*13*
Law reform	*Training social care staff in the new legal framework*	*24*
	Savings from staff time and reduced complaints and litigation	*-71*
Total		***702***
IT	***Capital investment funding including IT systems (£50m nationally)***	*287*
Grand Total		***989***

Agenda Item No. **14**

Health and Wellbeing Board
9 July 2014

Report title	Five Year Strategic Plan for the Wolverhampton Health and Social Care Economy	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Wolverhampton Clinical Commissioning Group	
Accountable officer(s)	Noreen Dowd Tel Email	Interim Director 01902 444878 Noreen.dowd1@nhs.net

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Support and approve the Five Year Strategic Plan for the Wolverhampton Health and Social Care Economy

Recommendations for noting

The Health and Wellbeing Board is asked to:

2. To Note and Receive the Five Year Strategic Plan for Wolverhampton Health and Social Care Economy

3. To Note that if there are any further changes to the plan (subject to Area Team feedback), they will be represented to the Health and Well-Being Board for final approval.

1.0 Purpose

1.1 To present and discuss the five year strategic plan for the Wolverhampton Health and Social Care Economy.

2.0 Background

2.1 The five year strategic plan has been under discussion with key stakeholders across the health and social care economy over the last few months with particular focus early on in the process on the Two Year Operational Plan. The five year plan builds on the level of detail provided in the two year plan. Key discussions have been held with senior staff across the Local Authority, Royal Wolverhampton NHS Trust and the Black Country Partnership Foundation Trust. Further Board to Board discussions are also due to take place shortly with RWT.

2.2 The production of the five year strategy is a requirement from NHS England for all health and social care economies and sign off to the plan is required by the Health and Well-Being Board.

3.0 Progress, options, discussion, etc.

3.1 The formal submission of the five year plan was submitted to the local Area Team on the 20th June subject to final approval of the Health and Well-Being Board. However, further iterations may be required depending on feedback from the Area Team which is due on the 14th July.

4.0 Financial implications

4.1 There are significant financial challenges for the health and social care economy over the five year period which are detailed in the five year plan.

5.0 Legal implications

5.1 The five year strategic plan takes into account all key statutory and legal implications across all key partner agencies.

6.0 Equalities implications

6.1 The five year strategic plan has been developed and supported by Public Health who have been members of the operational and strategic planning group. This group has had managerial responsibility for the production of the final plan. The plan is based on Wolverhampton's Joint Strategic Needs Assessment (JSNA) including the latest needs assessment updates. In this context, at it's core is the focus on tackling health inequalities and improving health and social care outcomes for our local population.

7.0 Environmental implications

7.1 Over the five year period, new services and technologies will be developed. The drive to have care closer to home, as well as new telehealth and telecare options, should provide the opportunity to reduce the carbon footprint. Any new buildings will be environmentally friendly using the latest design and environmental improvements possible.

8.0 Human resources implications

8.1 Workforce capacity and design across all sectors will be crucial in order for the shift to be made to more community based services.

9.0 Corporate landlord implications

9.1 The transformation of services, particularly in relation to the Better Care Fund, may have implications for the property portfolio across the whole sector. However, at this stage, there are no specific implications that have been identified.

10.0 Schedule of background papers

10.1 Previous Health and Well-Board meetings have discussed the Two Year Operational Plan and the Better Care Fund (as key elements of the five year strategic plan)

This page is intentionally left blank

This Unit of Planning covers the population of Wolverhampton and concerns the commissioning and delivery of health and social care, comprising the statutory organisations of Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, Black Country Partnership Foundation Trust and The Royal Wolverhampton NHS Trust.

In 5 years time we will have a streamlined health economy with reduced reliance on the acute sector and increased capacity in primary and community care with accessible high quality services. By 2018/19 significant progress will have been made towards making sure that within the available resources, people in Wolverhampton will receive

the right care, in the right place, at the right time

Outcome Ambition 1 : To decrease Potential Years of Life Lost (PYLL) from causes amenable to healthcare by 13.2% in 5 years

Outcome Ambition 2: To improve the health related quality of life for people with long term conditions by 1.7% in 5 years

Outcome Ambition 3: To reduce avoidable admissions to hospital by 15% in 5 years

Outcome Ambition 4: To increase the proportion of older people living independently at home following discharge from hospital by at least 5% in 5 years

Outcome Ambition 5: To increase the number of people having a positive experience of hospital care by 5% in 5 years

Outcome Ambition 6: To increase the number of people having a positive experience of out of hospital care by at least 9.6% in 5 years

Outcome Ambition 7: To have parity in weekend mortality (no higher than any other day in the week) in our hospital

Primary Care Development to include: Workforce development; improve IT and Estates; enhance productivity; improve integrated working with other sectors.

Community Care Development: to include Community Nursing Service and Telecare and Telehealth provision.

Better Care Fund: To act as catalyst for whole system change which includes collaboration for health and social care planning and service delivery; prevention focus; person centred care

Reconfiguration of Urgent and Emergency Care System to include streamlining of services; highly responsive urgent care system; emergency patients directed to emergency centre with relevant expertise and equitable 7 day access.

Modernisation Programme to include shift of activity to the community and implementation of enhanced recovery and discharge planning projects

Specialised services: To collaborate and engage with West Midlands partners to align with the national direction of travel.

Mental Health: Focused on parity of esteem and early intervention to prevent people from entering secondary and tertiary services wherever possible and provide an integrated system of assessment and intervention with social care partners to enable recovery, promote independence and prevent relapse.

Tackling Health Inequalities: to work with health and social care partners to analyse key problems, set common goals, identify, implement and measure high impact interventions including preventative measures

Governance arrangements

- Coordinated through HWBB
- Clinically driven and designed for clinical expertise and decision-making
- Combined with the rigour of Programme Management
- Commissioning cycle approach

Success criteria

- Achievement of Outcome Ambition Targets
- Integrated Quality Assurance across the system
- Sustainability and Financial Stability
- Reduction in Health Inequalities

System values and principles

- Respect and value; listen and engage with local people
- Work proactively and in partnership
- Ensure clear accountability and transparency
- Act in fairness and with equity
- Focus on Quality and Innovation
- Prevention: Promote health and wellbeing
- Productivity: monitor the effectiveness of our services ensure the best use of our resources

This page is intentionally left blank

Draft Five Year Strategic Plan for the Wolverhampton Health and Social Care Economy

Draft for submission to NHS England
20th June 2014

Draft Five Year Strategic Plan for the Wolverhampton Health and Social Care Economy

Contents

Page

1.	Introduction	Page 4
2.	Vision	Page 5
2.1	What will the Wolverhampton health and social care system look like in 2018/19	Page 5
2.2	Values and Principles	Page 7
2.3	Improving quality and outcomes	Page 8
2.4	Characteristics of the high quality and sustainable service models	Page 12
3.0	The case for Change	Page16
3.1	Population	Page 16
3.2	Health Inequality	Page 18
3.3	Joint Strategic Needs Assessment	Page 20
3.4	Lifestyle	Page 20
3.5	Current Performance	Page 21
3.6	Assessment of future demand	Page 22
3.7	The opportunities	Page 25
3.8	Cost pressures and QIPP opportunities	Page 28
3.9	Financial Plan	Page 31
4.0	Strategic Programmes to achieve the vision	Page 34
4.1	Primary care development	Page 36
4.2	Tackling health inequalities	Page 37
4.3	Children's Agenda	Page 38

4.4. Disease and Risk Modification Page 40

4.5 Urgent Care System Page 41

4.6 Community services development Page 43

4.7 Mental Health Strategy Page 45

4.8. Better Care Fund Page 47

4.9 Modernisation Programme Page 49

4.10 Specialised Commissioning Page 50

4.11 Strategic Enablers Page 51

5. Governance: how all partners will ensure this happens Page 59

6. Next Steps Page 63

1. Introduction

In ‘Everyone counts: planning for patients 2014/15 to 2018/19’ published by NHS England, there is a requirement on Clinical Commissioning Groups and partner organisations to develop five year strategic plans.

The five year strategic plan for Wolverhampton sets out:

- a vision for what the health and social care system should look like in 2018/19
- the values and principles underpinning this vision
- the case for change, that is, the reasons why we need to transform the current system
- the main transformational programmes of work to deliver this vision
- the governance structure to ensure progress is made.

The Unit of Planning covers the population of Wolverhampton and concerns the commissioning of health and social care, comprising the following statutory organisations: Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, Black Country Partnership Foundation Trust and The Royal Wolverhampton NHS Trust.

There are a number of key documents on which this five year strategic plan draws upon and is aligned with including:

- Joint Strategic Needs Assessment
- Health and Wellbeing Board strategy
- Two-year Operational Plan
- Better Care Fund.

2. The Vision

2.1 What will the Wolverhampton health and social care system look like in 2018/2019?

In 5 years time we will have a streamlined health economy with reduced reliance on the acute sector and increased capacity in primary and community care with accessible high quality services. By 2018/19 significant progress will have been made towards making sure that within the available resources, people in Wolverhampton will receive the right care, in the right place, at the right time.

- There will be a marked improvement in the health outcomes for those people in Wolverhampton who currently have relatively poor outcomes.
- Resources will be directed to helping people to stay healthy for as long as possible.
- People will receive the right care and particular priority will be given to the very young, the very old and those people with life limiting conditions.
- Services will be delivered to the right standards; they will be safe and reliable, and the people of Wolverhampton will have confidence in them.
- Patients will be seen by the appropriate professional at the right time.
- Quality will be at the heart commissioning decisions and the focus of service delivery will be the patients and their needs.

The system vision is shown in the diagram below and in Wolverhampton this translates to strategic priorities of:

- **More primary care:** a developed/expanded primary care provision which is proactive and central to the coordination of the integrated health and social care system. This also includes standardisation of primary care services with longer opening times and full use of skill mix with the offer of more diagnostics and minor procedures as add on services.
- **Less but more streamlined secondary care:** the acute hospital sector focuses both on its specialist functions, reduces its general bedded activity and develops its integration with the community
- **More community care**: increased activity in community-based settings
- **More third sector provision**: an expanded role focusing on supporting patients
- **More integrated care**: social care is central to the integration with the acute/mental health sectors, third sector, primary, and community based services especially for those with long term conditions. the Better Care Fund is the mechanism for driving integration
- **Improved services for children**: Commissioning of services will adhere to care centred around the child using the new SEND reforms and children's continuing care framework.
- **Improved services for older adults**: availability of a named GP and possibly a patient advocate to ensure there care is patient centred and not just disease specific. They will have personal health budgets where appropriate
- **Improved services for mental health**: easily accessed and providing the correct model of care at the correct time. A reduction in bedded activity to focus on early intervention in the community.

  Improved quality: integrated quality assurance is wrapped around the whole system

Strategic Vision

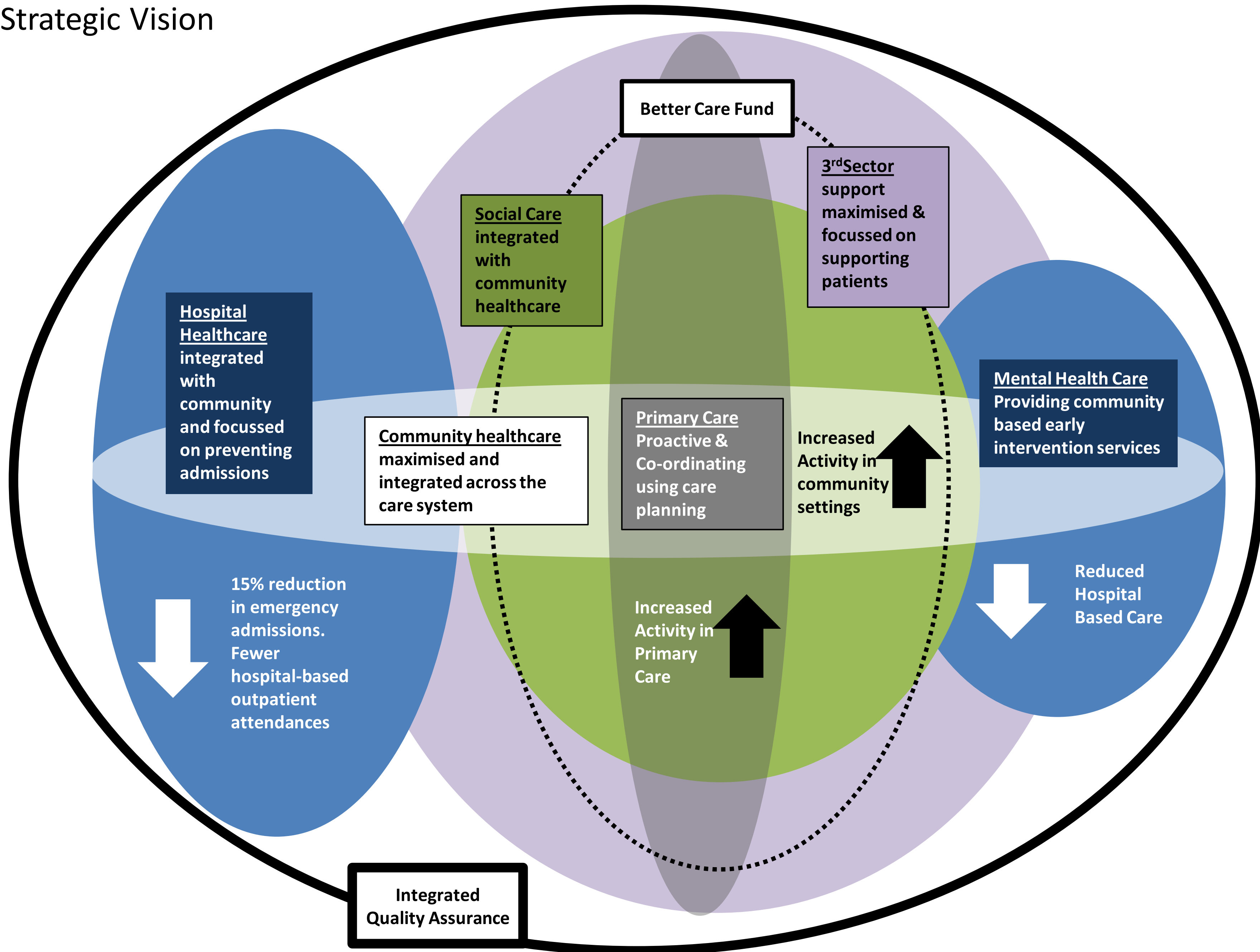


Figure 1: Wolverhampton CCG Strategic Vision

2.2 Values and Principles

The values and principles which underpin and drive our vision of are:

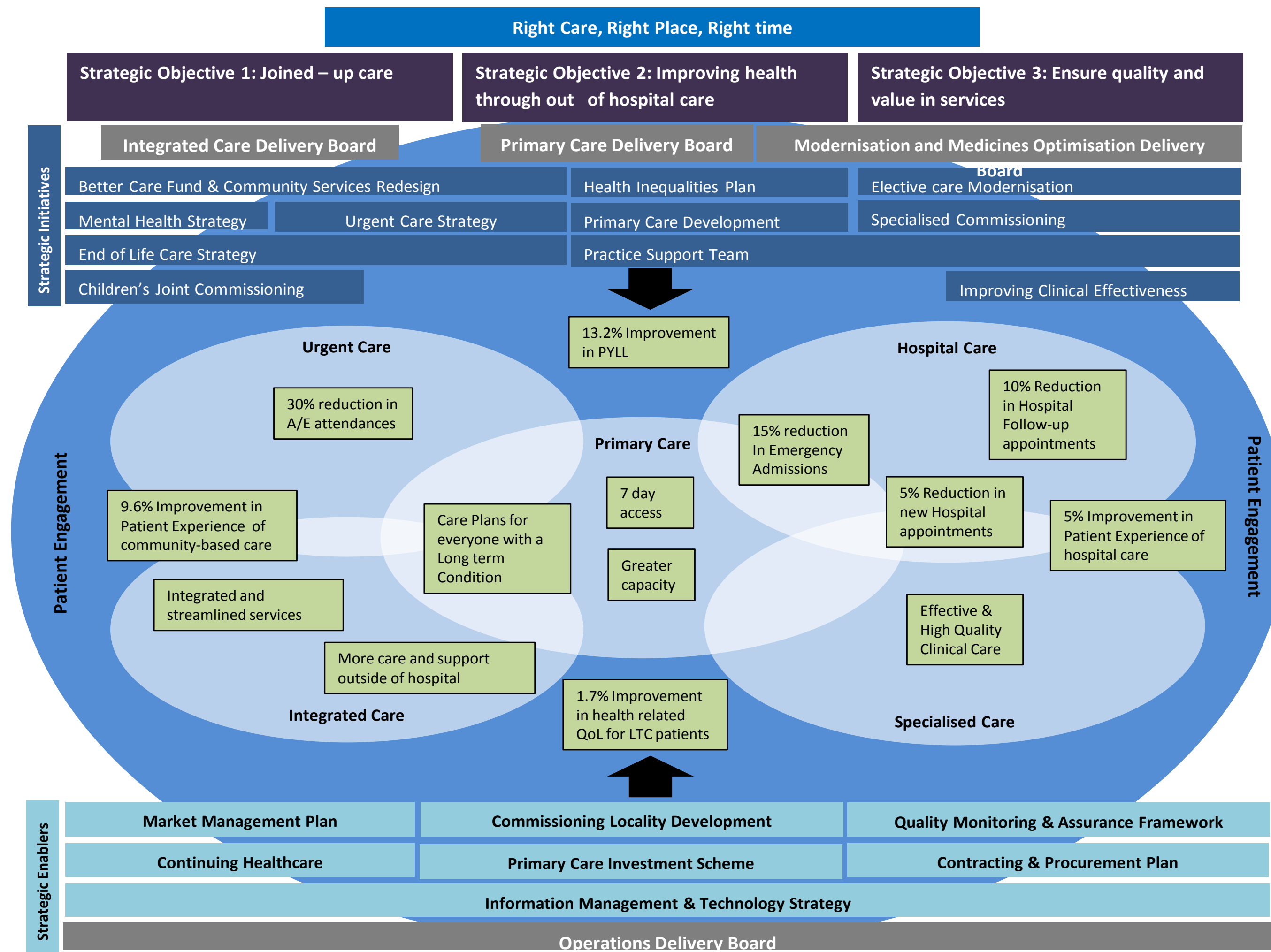
- Respect and value people – personalisation of service and choice are at the core of the delivery agenda
- Listen and engage with local people – we are committed to involving patients, carers, clinicians and communities in the design and improvement of their services
- Ensure clear accountability and transparency – we value feedback and a clear sense of accountability and responsibility for our decisions. We intend to strengthen the links between our decision making and the views of local people
- Fairness and equity – we will maintain a focus on disadvantage in communities ensuring that they have genuine opportunities to access health services. We intend to promote a sense of right of entitlement within our communities, in line with the NHS constitution
- Drive clinical leadership – we recognise the need for and will develop and support clinical leadership in service planning, redesign and delivery in order to ensure the highest levels of quality and efficiency
- Quality – We will continuously improve the quality of the services that we commission and demonstrate improvements to the public
- Innovation – we will make best use of all the best ideas available, in order to be a dynamic, responsive and innovative organisation
- Prevention - we will work to prevent poor health starting early, before birth, and working through the whole life cycle
- Partnership and collaboration – we will work closely with our partners in the health, local authority and third sectors in an integrated way in order to ensure a holistic approach to promoting health and equality in the community
- Productivity – we will monitor the effectiveness of our services and the impact on outcomes to ensure the best of our resources
- To have a proactive, inclusive, equitable and professional approach that will secure best value for money and high quality in all that we do.

2.3 Quality and outcome ambitions to deliver the vision.

NHS Outcome Framework Domains	NHS Outcome Ambitions	Local Rationale	Baseline	Target 2015/16 (Year 2)	Target 2018/19 (Year 5)
Domain 1: Preventing people from dying prematurely	**1. Securing additional years of life for the people of England with treatable mental and physical health conditions** Measure: Decrease Potential Years of Life Lost (PYLL) from causes amenable to healthcare	The process for setting this target has been to take the data available from 2010-2013 (from ATLAS) and apply a logarithmic progression (R^2=9.001) up to 15 years. This gives ambitious targets initially, levelling out as successes reduce the cohort of patients. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.	2511 (2012/13 ATLAS Data)	2295	2180
Domain 2: Enhancing quality of life for people with long-term conditions	2.**Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions** measured using the EQ5D tool in the GP Patient Survey	The process for setting this target has been to take the data available from 2011/12 – 2012/13 (from ATLAS) and apply a linear trendline (R^2=1) up to 15 years. This takes into account the continuing programme of improvement over a long period – an essential requirement for LTCs. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits.	69.9 (2012/13 ATLAS Data)	70.5	71.1

NHS Outcome Framework Domains	NHS Outcome Ambitions	Local Rationale	Baseline	Target 2015/16 (Year 2)	Target 2018/19 (Year 5)
Domain 3: Helping people to recover from episodes of ill health or following injury	**3.Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital** Composite of all emergency avoidable admissions (indirectly standardised)	The CCG has taken into account previous performance to set a trend line for the long term target. This was transposed to current baseline to set a start point; QIPP intentions were added for Y1 & Y2 targets; 15% ambition for reducing emergency ambitions added for Y5 target; Series extended to meet long term 15Y target based on 2009-2012 trend line data. The 2014/15 and 2015/16 targets have then been calculated from this data. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.	2641.0 (2012/13 ATLAS Data)	2466.1	2246.2
	4.Increasing the proportion of older people living independently at home following discharge from hospital BCF metric of: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services sourced from the Adult Social Care Frameworks Indicator	The process for setting this target has been to take the data available from 2008/09 – 2012/13 and extend the graph to a 5% increase in the metric over the next 2 years. This is seen as an stretch target due to recent years of decline in performance. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.	85.6 (2012/13 ATLAS data)	89.9	tbc
Domain 4: Ensuring that people have a positive experience	**5.Increasing the number of people having a positive experience of hospital care** Patient experience of inpatient care (Friends and Family)	WCCG are projecting 2% reduction in those patients reporting a poor experience of inpatient care. WCCG will continue to monitor performance of the combined FFT data via contracts as a monthly measure to performance manage. Projects are already in flight via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH,	114.5 (2012 ATLAS data)	112.0	108.8

NHS Outcome Framework Domains	NHS Outcome Ambitions	Local Rationale	Baseline	Target 2015/16 (Year 2)	Target 2018/19 (Year 5)
of care		Provider etc.) listed below have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.			
	6.Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community Composite indicator comprised of (i) GP services, (ii) GP Out of Hours. Patient Survey	Due to the lack of national data, WCCG are proposing a 10% improvement (reduction) in negative responses for the patient experience of primary care over 2 years. Failing this data being available WCCG will define a more readily available performance measure.	Baseline: 7.3 (2012 ATLAS Data)	6.6	TBC with data availability
Domain 5: Treating and caring for people in a safe environment & protecting them from avoidable harm	**7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care**	The measure used is that weekend mortality should be no higher than any other day in the week. This is measured using 18 month's worth of comparison data from CISU. The CCG uses mortality data from the HED tool which contains the UHB's version of HSMR and SHMI (their SHMI is almost identical to the Information Centre's SHMI). The CCG are able to look at the difference between weekday and weekend mortality figures for RWT and plot the rate of change. To have this under control, the rolling average change in the difference between mortality at weekends compared to weekday needs to be a flat series. We are proposing that we use this information to monitor the outcomes of projects that are in flow or being set up to reduce mortality and specifically the differential between weekday and weekend rates – i.e. 7 day working initiatives etc.	18 month's worth of comparison data from CISU	1. Difference between wkday and wknd per month (0 indicates parity) 2. Change between the differences from month to month 3. Rolling average in change in difference (same as 2 but uses a 6 month average).	



The main features in delivering the vision in the context of outcome ambitions.

2.4 Characteristics of the high quality and sustainable service models

2.4.1 Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

We have a comprehensive framework for engagement, the outcome from which is robust gathering, triangulation, reporting and responding to insights received from patient and community groups. Through this framework, which comprises a range of forums that meet quarterly, the CCG is able to collaborate with a diverse range of representative groups – residents, PPGs, patient/community groups, clinicians and allied health professionals, and Healthwatch. The groups are able to report their experiences, but also scrutinise and influence the CCG's plans and strategies, which are taken by CCG leaders to these groups. All reported insights are reviewed and discussed at the CCG's Joint Engagement Assurance Group which has multi-agency representation. An Assurance Framework comprising key risks around communications and engagement is overseen by the group ensuring both the performance of and confidence in our engagement framework is maintained.

We use a range of creative methods to engage with the wider community. Our call to action round tables in Autumn 2013 invited members of the public to discuss the challenges facing the NHS and opportunities for meeting their needs more effectively. We have continued this momentum with the Your Future NHS event, held in May of this year, attended by over 80 members of the public, patients and professionals; more than a quarter of those attending have expressed an interest in continuing to work with us on plans as they progress. We also work with the city's Equality and Diversity Forum to reach the seldom heard and we evaluate our self-selecting Patient Partner membership against the city's demography statistics (Census 2011) to ensure they are representative. Our forthcoming communications and engagement strategy aims to strengthen engagement with under-represented members of our community.

Our vision for engagement over the next 5 years is focused on 3 areas:

1. Listening to patient's views
We will put patients at the forefront of the decision-making process. We will do this by involving the population in regards to the planning and delivery of services and we will engage and empower patients to manage their own health condition and the care that they receive individually.

2. Delivering better care through the digital revolution
The CCG aims to review and assess the digital options available with the view to implementing solutions that offer both improved and directed care to patients, while improving efficiency of staff and reducing the cost of care provision. The key strands of this strategy will be to support patients through assisted living at home by implementing self-management of treatment and remote monitoring. The CHC nurses are being issued with tablet devices in order to increase the efficiency of their assessments out with patients. We are looking at implementing mobile clinical systems via tablets/smartphones for GP' to assist with home visits. The Shared Care Record being delivered via BCF will be available to all clinicians with a direct clinical relationship with patients via a mobile platform. This will also allow patients access to their own records to assist them with self - management. We would like to pilot consultations via webcam to test for appropriateness - this is

happening already in England and we will investigate this. This is all subject to appropriate funding for Telehealth and telemedicine via IM&T.

3. Transparency and sharing data

The CCG has a short and long term strategic plan to implement a solution that will enable interconnectivity across disparate clinical systems creating a fully populated and clinically complete Electronic 'Longitudinal' Patient Record. This is an economy wide plan involving all Health Care Provider Organisations and Social Care. It is the aim of the CCG to use this as a vehicle to improve transparency between Health Care professionals across all settings as well as empowering patients through access to their own health records. The CCG is actively involving key staff to ensure adherence to Information Governance requirements related to data sharing at all points through this process.

2.4.2 Wider primary care, provided at scale

The development of primary care is critical to the achievement of our vision. We will facilitate the transformation and development of Primary Care so that it is able to:

- Maximise the capacity, capability, flexibility of GP primary care in order that greater levels of access, healthcare and support activity can be undertaken outside of hospital in order to prevent unnecessary and avoidable hospitalisation.
- Improve health outcomes by focusing on primary and secondary prevention strategies in order to prevent ill-health in the whole population and improve the quality of life and management of patients who have a long-term and/or complex condition. This involves ensuring that high risk patients are identified and targeted for intervention that ensure the each individual patient's care is planned and encompasses a range of health improvement strategies, from education and self-care, through to treatment and beyond.
- Maximise the quality and productivity of services in order to ensure maximum value for money for care provided and that the highest standards of care are maintained and delivered to the population of Wolverhampton.

2.4.3 A modern model of integrated care

A range of services provided in the community are led by nursing and professions allied to medicine. Our vision focuses on these services to maximise their potential and impact on health outcome by ensuring integration with and coordination across other health and social care services. In particular, services will target patients with a long term condition and/or those are over 75.

We will establish the process of care planning for these patient groups in order to ensure there is a named senior clinician responsible for each patient and a care plan in place which has been initiated by the patient's GP. This will be aimed at disease and risk modification in order to proactively manage the patient's healthcare needs, concentrating on care outside of hospital and avoiding unnecessary requirement for emergency admission where appropriate.

We will deliver our model of integrated care through the following key initiatives:

- the Better Care Fund to maximise the potential of health and social care support in the community to facilitate the delivery of patient care plans.

- the GP contract changes for over 75s and the enhanced service to provide proactive case finding and care review for vulnerable people
- the £1m allocation for our Primary Care Investment Scheme.

We will:

- link each of these initiatives and associated services by the golden thread of a personalised patient care plan initiated by the GP in partnership with the patient.
- redesign community nursing services so that they are focused on supporting primary care in the delivery of out of hospital care
- ensure that other clinical support supports and professions allied to medicine are focused and integrated in order to support both the QIPP and health outcome challenges.
- maximise the support and potential of the third sector and voluntary agencies across health and social care in order to support patients in the community.

2.4.4 Access to the highest quality urgent and emergency care

Wolverhampton health economy has a strong history of networking across the local health economy. On a regional basis, Wolverhampton's acute hospital is part of the network of Trauma units in the Black Country which are networked with the Major Trauma Centres in the West Midlands in Stoke, Birmingham and Coventry. Working partnerships is evident in the work around critical care and the recent development work relating to mass casualty planning across the region. The Area Team have agreed to facilitate sub regional discussions to establish robust emergency care networks which Wolverhampton is fully committed to participating in.

Locally, the principles of the approach of networks to ensure the patients receive the right care, at the right time, in the right place is fully supported. The city has a history of separate organisations forming one urgent care system in the city. The Wolverhampton Urgent Care Working Group (UCWG) was established in order to develop an integrated system across the system involving primary, community, acute and social care. The UCWG has representation from the CCG, RWHT, LA and neighbouring CCG. Our vision for the urgent and emergency care system is built around the recommendations of the national review undertaken by Sir Bruce Keogh. The delivery of this vision will be interdependent with our vision for the development of primary care.

The Urgent Care Working Group is the key engagement mechanism across local, regional and national stakeholders and networks. This local network of individual providers (Acute, Community, WMAS, Local Authority, Public Health and Commissioners) has overseen the development of the Wolverhampton Urgent and Emergency Care Strategy. The three key principles of the strategy are:

- Firstly, working with Primary Care to improve access and ensure sharing of clinical information is enabled and maximised across the system in order facilitate consistent, high quality care.
- Secondly, to reduce duplication in service and minimise the confusion in the system for patients who felt that there are too many access points into the current urgent and emergency care system
- Thirdly, to ensure the infrastructure supports the integration of care provision. This will involve the building of a new Emergency and Urgent Care Centre. The new ED will be future proofed against increased emergency activity from both predicted surge and major incidents. A newly

established urgent care centre will be based above the ED with a signposting service at the front door to ensure that patients are seen in the right part of the system. This will include increased information to support patient self-care/management.

The UCWG also works with the Black Country Network in order to ensure the right co-ordination in both commissioning and provision across Wolverhampton, Dudley, Walsall and Sandwell. The UCWG will also engage with the NHS England, Critical Care and Stroke Services networks to the same end.

2.4.5 A step-change in the productivity of elective care

For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error, maximise quality, and achieve a major step – change in productivity.

We will work with our providers to deliver high quality care, treating adequate numbers in order to retain the required levels of skills, training, education and workforce, and with the most modern equipment available.

We will work with primary care in order to manage demand for services, to ensure those in the greatest need receive the right care, in the right place and at the right time. We will also develop a greater number of providers, particularly those that can be based in a community and/or purpose-built setting in order to provide greater choice and competition for elective care

International comparisons suggest that, as well as quality improvements, there are significant productivity gains to be made if we can change our model of delivering elective care – giving us the opportunity to treat even more patients at the same or lower cost.

2.4.6 Specialised services concentrated in centres of excellence

Specialised services are those services that are provided in relatively few hospitals to a catchment population of more than one million people. The number of patients accessing these rarer services is small and a critical mass of patients is needed in each centre in order to deliver the best outcomes. In addition a concentration of skills and expertise by the clinical team undertaking the treatment also benefits the standard of care delivered. These services are commissioned directly by NHS England and locally this is undertaken through the Birmingham, Solihull and Black Country Area Team for the West Midlands.

Specialised services are currently being delivered out of too many sites, with too much variety in quality and at too high a cost in some places. Nationally, and as outlined in NHS England planning guidance, the vision for these services is to concentrate them into a smaller number of centres for excellence. This will ensure that commissioners are able to maximise the quality, effectiveness and efficiency of these services because the providers are able to work at critical mass volumes while remaining integrated with research and teaching activity. The detailed strategy for Specialised Services will be developed and delivered within the timescales of this strategic plan and it is expected that care will be concentrated within 15-30 centres for the majority of specialisms, supported by the new Academic Health Science Networks.

3. The case for Change

3.1 Population

The Wolverhampton CCG registered population is 262,000 (the resident population is 250,000). Population projections to 2018 suggest a further increase in the resident population to 257,000. There is a five percent difference between the resident and registered population of Wolverhampton. It is estimated that the registered population will be 274,850 in 2018 if this difference maintained. Wolverhampton's predicted population growth rate is below the national, regional and Black Country averages.

Diversity

The majority of residents in the city belong to the white ethnic group (68%), with the remaining 32% from black minority ethnic backgrounds (BME). The largest of the BME groups is Asian at 18.8%, followed by black and mixed race at 6.9% and 5.1% respectively. This is quite different to the national distribution with only 14.3% from a BME background. The south east of the city has the highest proportion of BME residents. It is anticipated that the projected increase in the population will increase diversity in the City in 2018, but it is not possible to predict proportions in particular ethnic groups

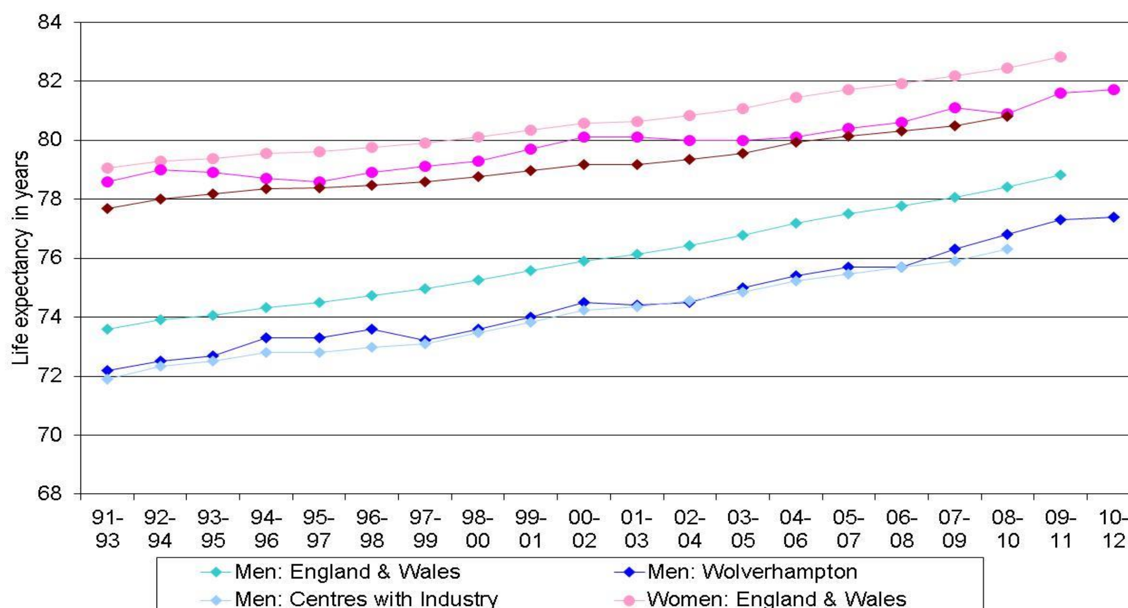
Deprivation

Deprivation is a fundamental determinant of poor health and dependence. There are significant levels of deprivation in the city. Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. This indicates that over half of Wolverhampton's population live in the poorest areas in England, which impacts on life expectancy and premature mortality rates in the city. Deprivation is disproportionate across the city, with the least deprived wards in the west of the city and the most deprived located in the north east and south east of the city (see figure above). This level of deprivation is unlikely to change over coming years and may worsen by 2018 due to the current levels of austerity.

Life expectancy

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

Table 1: Trend in male and female life expectancy in Wolverhampton



There are also considerable inequalities in the experience of life expectancy and healthy life expectancy (disability-free) across Wolverhampton. Local analysis shows that there is a gap of approximately seven years for males and four years for females between those who are least and most deprived in Wolverhampton. This gap has remained fairly consistent over time.

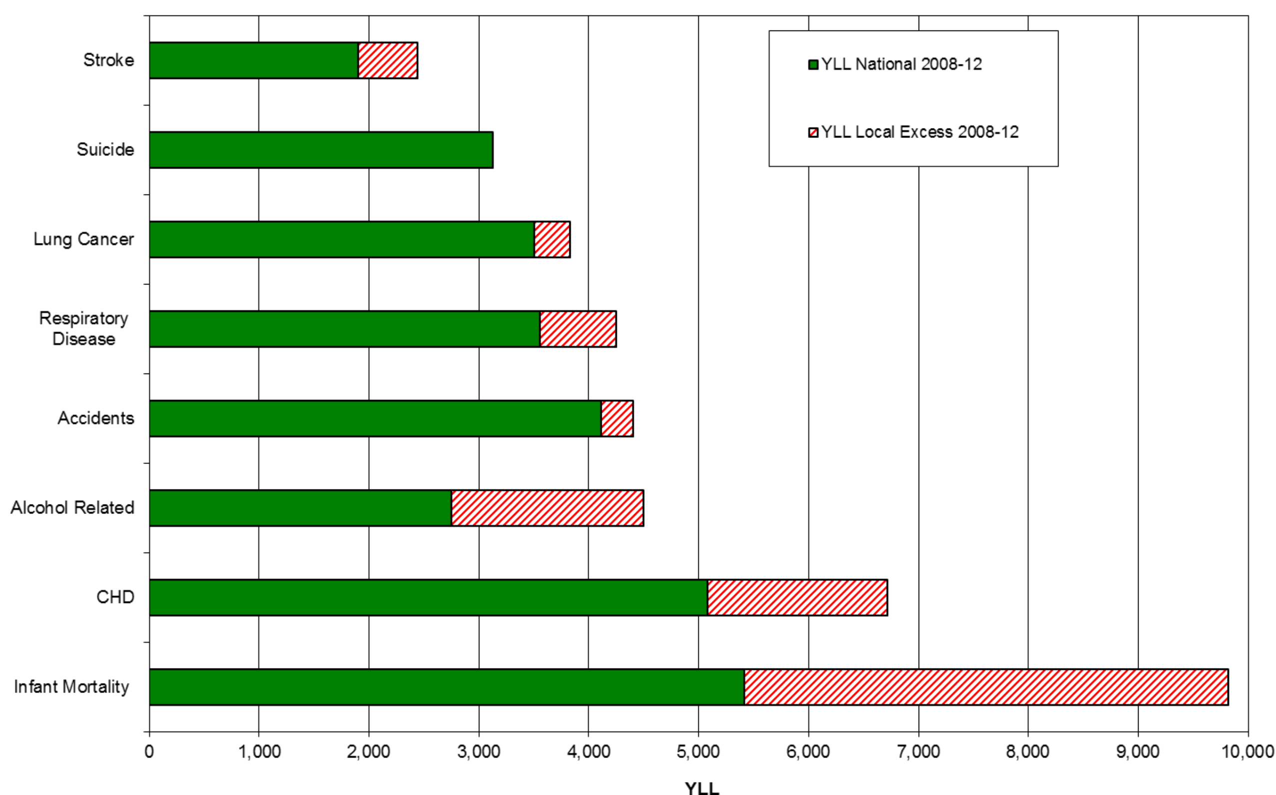
The analysis of these key health problems has been shared across the local health and social care economy. This is an emerging area of development in this domain of the commissioning for prevention framework. There is collaborative work in place to understand and act upon performance with anticipated improvement in outcomes by 2018.

The top six conditions that drive low life expectancy in Wolverhampton have been identified. These are the conditions causing the most avoidable life years lost (i.e. the number of years of life lost below the age of 75). The six conditions are:

1. Infant mortality
2. Alcohol related mortality
3. Coronary heart disease (CHD)
4. Accidents
5. Respiratory disease
6. Lung cancer

The graph below shows the number of life years lost from the top six causes mortality between 2008 and 2012. The length of the full bar (including green block and red and white striped block) show the total years of life lost in Wolverhampton. The green bar shows the numbers of life years lost if our mortality rates were the same as England. The red and white striped bar shows the local excess years of life lost and therefore the years of life Wolverhampton could potentially gain if death rates were similar to the national average.

Figure 2: Causes of Excess Years of life lost - persons under 75 years 2008-2012



The implementation of this strategic plan supported by various Public Health initiatives will deliver significant gains in these top six conditions, increasing life expectancy, reducing inequalities and improving quality of life by 2018.

3.2 Health Inequality

The delivery of the aims of this strategic plan will have a high impact on tackling local health inequalities through the commissioning of services and interventions to:

- address the high risk lifestyle choices that are strongly correlated to deprivation
- target specific population groups at greater risk of poor health and wellbeing
- ensure improved access to local high quality services
- focus on primary prevention.

There will also be a requirement to provide universal services to ensure that the needs of small pockets of 'more deprived' populations located in the 'less deprived' areas of the City are not neglected. This includes meeting the needs of local populations just above the threshold for poverty. These sections of the population are often difficult to identify and as a result, are at greater risk of inequitable service provision.

The inclusion of Equality Impact Assessments in the commissioning of services will highlight potential inequalities that may arise so that they can be addressed prior to service implementation. Therefore, more detailed work will be undertaken to promote the use of Equality Impact Assessments for commissioned services, supported by relevant Health Impact Assessments and

Health Equity Audits. Outcome-focused, needs-led commissioning and realistic target setting, combined with robust performance management and service evaluation will also inform the effectiveness of services in reducing health inequalities and improving the health of the local population.

Male and female life expectancy by ward 2008 to 2012

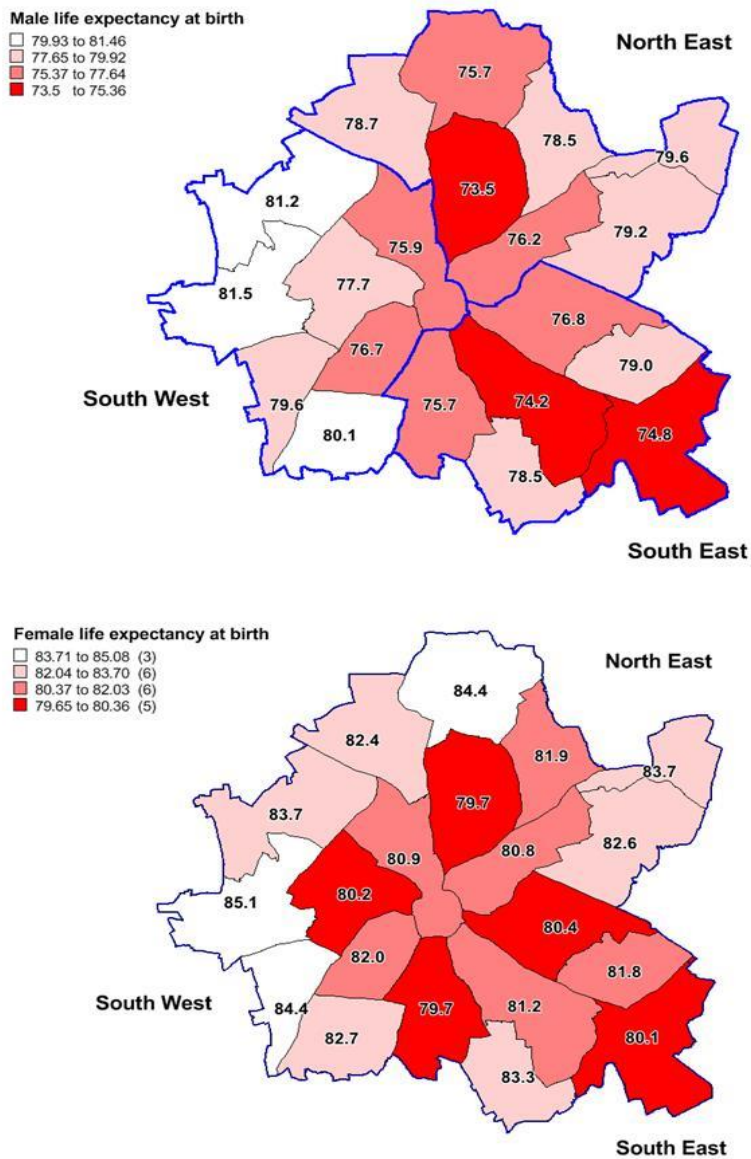


Figure 3: Male and Female Life Expectancy by ward 2008 to 2012

3.3 Joint Strategic Needs Assessment

Wolverhampton's Joint Strategic Needs Assessment (JSNA) has focussed on the outcomes contained in the three national outcome frameworks: Public Health (PHOF), NHS (NHSOF) and Adult Social Care (ASCOF). An additional locally developed outcomes framework for children and young people has been included. The key health needs identified from these frameworks highlight the priorities for commissioned services to improve health and reduce inequalities.

The JSNA process has informed the development of the Wolverhampton Joint Health and Wellbeing Strategy, produced by the Health and Wellbeing Board. The health and wellbeing priorities listed below have been selected to provide a number of high level evidenced-based priorities that are a challenge to resolve and span organisational responsibilities. The strategic outcomes for the strategy are aimed at increasing life expectancy, improving quality of life and reducing child poverty. Therefore, the top five priorities identified to achieve these outcomes are:

- Wider determinants of health
- Alcohol and drugs
- Dementia (early diagnosis)
- Mental Health (diagnosis and early intervention)
- Urgent Care (improving and simplifying).

This partnership approach to the setting of these priorities and the development of common goals demonstrates a predominantly mature approach to commissioning for prevention in this domain of the framework.

3.4 Lifestyle

Wolverhampton current performance against latest lifestyle indicators alongside the regional and national average is shown in table XX. Wolverhampton is significantly higher than the national average for all of the risk factors listed. The table also includes data on the performance of the NHS Health Check programme offered to the population aged between 40 years and 74 years. Wolverhampton has a statistically significant lower offer and uptake of this programme compared to the national average and there is a plan to increase this.

Table 2: Lifestyle risk factors performance measures for Wolverhampton

Indicator	Wolverhampton	West Midlands	England Average
Excess weight in children age 4-5 years (2012/13)	27.0%	22.7%	22.2%
Excess weight in children age 10-11 years (2012/13)	40.6%	35.5%	33.3%
Excess weight in adults (2012)	69.8%	65.7%	63.8%
Physically inactive adults (2012)	34.4%	31.8%	28.5%
Smoking Prevalence (2012)	22.9%	18.9%	19.5%
Offer of NHS Health Checks (2012/13)	10.9%	17.4%	16.5%
Take-up of NHS Health Checks (2012/13)	40.9%	45.8%	49.1%
Alcohol attributable alcohol admissions (2010/11 – All Age DSR /100,000)	2073.1	1910.3	1895.2

Source: Public Health Outcomes Framework http://www.phoutcomes.info/
Local Alcohol Profiles for England: http://www.lape.org.uk/data.html

Whilst there are interventions in place to address these lifestyle risk factors, obesity has been chosen as the subject for the Director of Public Health Annual report. The data available on obesity for children and adults in Wolverhampton indicates that levels of obesity are increasing year on year, with projected continual increase in the future. A number of severe and chronic long-term medical conditions are associated with overweight and obesity, including type 2 diabetes, hypertension, coronary heart disease, stroke, osteoarthritis and some cancers. Not only do medical conditions adversely affect people's health and quality of life, but they create serious, rising financial and social care burdens, which are not sustainable into the future. We know that obesity is related to age, ethnicity and where people live in Wolverhampton which should allow targeting of interventions and policies in the most appropriate way.

The Director of Public Health Annual Report is a call to action for Wolverhampton presenting multi-organisational local opportunities to make a difference to this difficult problem. The outcome of this call to action should deliver a significant change in the proportion of children and adults with excess weight and in physically inactive adults by 2018.

3.5 Current Performance

The drive in the strategy to relieve pressures on the acute hospital sector, should help to overcome the areas of concern about current performance.

The key performance indicators the CCG uses to monitor performance both at CCG and Provider level are taken from the, NHS Constitution, NHS Outcomes Framework, NHS Outcomes Indicator Set, Everyone Counts (Planning for Patients), NHS Operating Framework and Wolverhampton CCG Operating Plan Ambitions.

Performance is assessed against the baseline and/or target set by the Information Centre or set locally by the CCG, using historical data and forecast modelling. RAG ratings are applied to each performance indicator to enable the CCG to effectively monitor performance and the KPI's are reported on monthly, quarterly or annually.

Highlighted are a selection of KPI's which the CCG has recognised as particularly challenging and has focussed efforts on driving improvements.

- A&E 4 Hour Wait Targets – Supporting provider to meet 4 hour wait performance
- Cancer Waits – 62 day cancer waits
- Patient Experience Indicators (Friends and Family Test)
- MRSA – targeting zero breaches
- C Difficile – Reducing the number of instances
- Elective Activity – Reducing activity
- Non Elective – Reducing activity
- First Outpatient Attendances – Reducing activity.

These KPI's are performance managed within the terms agreed within the CCG/Provider contract and where applicable, fines and other sanctions can be imposed on Providers for breaches against performance.

3.6 Assessment of future demand

The longer people remain healthy as they grow older, the less growth in demand for healthcare services there will be. The pressure of an aging population is not in itself the key factor but rather how healthy people are, in particular whether they have a life limiting illness and/or long term medical condition as they grow old, in most cases these are typically driven by lifestyle factors eg smoking, obesity and alcohol consumption.

We have modelled the potential growth in demand for healthcare services by assessing changes in population size, the age profile and age specific health status over the next 5 years. Understanding how changes in demand is driven by changes in population size, age profile and age specific age status helps to identify what our objectives should be in terms of how we should respond to the predicted growth in demand for health services and what type and range of services we should commission.

We have undertaken work with the Wolverhampton Public Health team in order to understand the impact of demographic change and health status on hospital utilisation. This particularly focussed on the concept of *disability free life expectancy* and the analysis demonstrates that small changes in the health of the general population, linked to their overall life expectancy, will have a significant impact on the demand for healthcare services.

Cost pressures are commonly split into those that are associated with population change (demographic pressures), and those that are broadly independent of demography (non-demographic pressures). The drivers of non-demographic cost pressures include new medical technologies, new clinical guidelines and changes in patient expectations.

Guidance produced by NHS England for the Call to Action exercise suggests that non-demographic cost pressures for acute health services commissioned by CCGs will vary between 0.5% and 0.3% per annum over the 5 year planning period.

Table 3: Non-Demographic Cost Pressures

	Non-Demographic Cost Pressures £000	% cost pressure
12/13	-	-
13/14	1,126	0.4%
14/15	2,343	0.4%
15/16	3,871	0.5%
16/17	5,406	0.5%
17/18	6,332	0.3%
18/19	7,260	0.3%

It should be noted that in the CCGs five year financial plan, additional resources have been profiled over and above the national percentage assumptions shown above, which reflect the pressures of recent years, the local circumstances and defined areas of development.

Levels of healthcare utilisation are strongly associated with age, with costs rising as patients approach the end of their lives. To estimate demographic cost pressures we calculated PbR costs for the CCG by gender and single year of age. These were multiplied by ONS interim 2012-based subnational population projections.

This approach to estimating demographic cost pressures assumes that age specific healthcare costs are static. There is evidence to suggest however that age specific health status is improving and therefore this approach may overstate the demographic cost pressures.

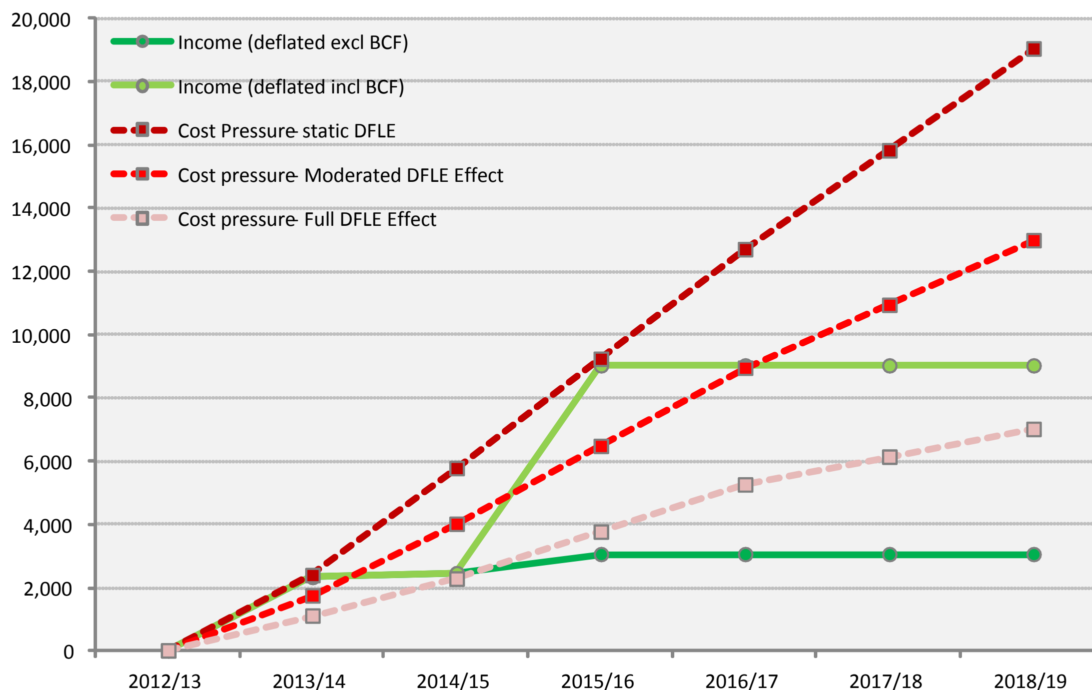
Two further estimates of demographic cost pressures have been produced:

- Full DFLE effect – this estimate assumes that age specific health status will improve by two years over the 5 year planning period (i.e. that an average 82 year old in 2018 will have the health status of an 80 year old today). These improvements are in line with recent trends in disability free life expectancy.
- Moderated DFLE effect - this estimate assumes that age specific health status will improve by one year over the 5 year planning period.

Table 4: Demographic Cost Pressure (£'000s)

	Demographic Pressure Static Age Specific Health Status	Demographic Pressure Moderated DFLE Effect	Demographic Pressure Full DFLE Effect
12/13	-	-	-
13/14	1,256	609	-28
14/15	3,420	1,659	-75
15/16	5,350	2,594	-117
16/17	7,279	3,530	-160
17/18	9,479	4,597	-208
18/19	11,772	5,709	-258

Table 5: The Gap between Forecast Income and Expenditure



Please note that since the publication of the CCG allocations used in the diagram above, adjustments have been made and the updated allocations are shown in section **3.9** The Financial Plan.

3.7 The opportunities

Anytown model

We have also analysed future demand using the NHS England *Anytown Model.* The Anytown Lite Model has been applied to Wolverhampton CCG and identifies that demographic and demand growth would add £39m by 2018/19 if there is no change to how the health care system works now.

The Anytown model shows how the implementation of a range of high impact interventions can help to address the challenge of growing demand for healthcare services.

The model shows the impact of 2 sets of interventions based on a set of case studies. These are:

- High Impact Interventions
- Early Adopter Interventions.

The model uses a set of population sub-groups in order to model changes in demand and the impact of the interventions in mitigating that demand.

Of the £39m demographic and demand growth £ 11.7 m (30%) can be tackled by implementing the High Impact Interventions as illustrated in the figure below

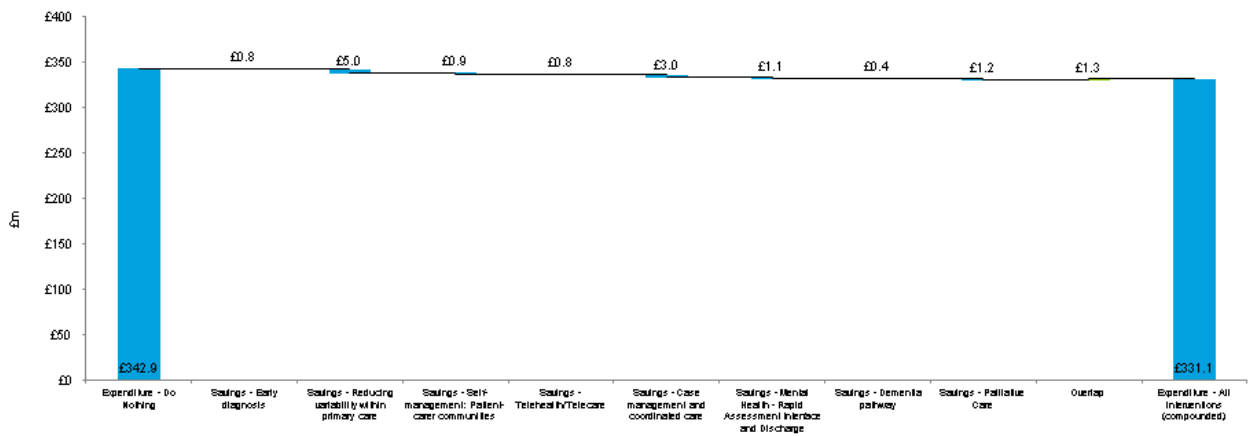


Figure 4: High Impact Interventions

A further £12.5m (32%) can be addressed by implementing the Early Adopter Interventions as demonstrated in the fig below

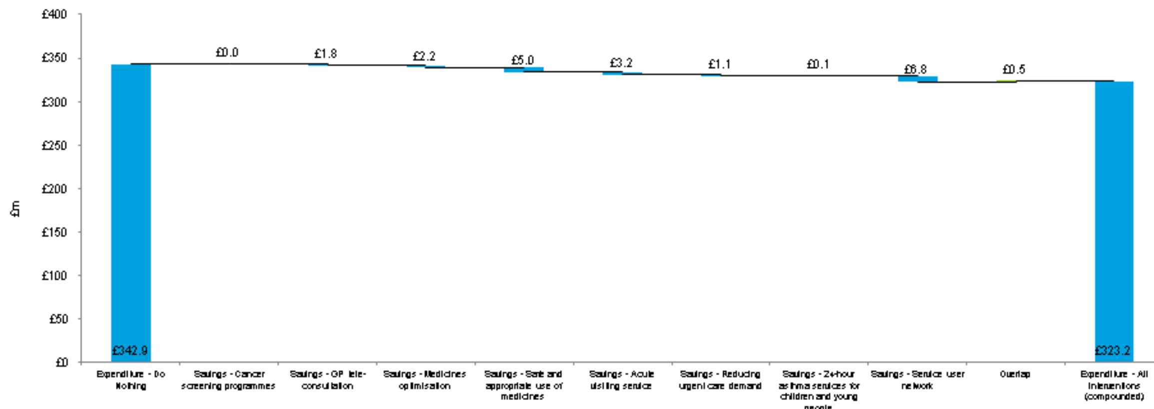


Figure 5: Early Adopter Interventions

Implementing all the High Impact and Early Adopter Interventions will save £24m (60%) of the predicted demand growth.

It should be stressed that , to the extent that in Wolverhampton some of these interventions have already commenced implementation, the levels of saving shown above may overestimate what can be achieved because these are calculated from a zero baseline and achieving 100% of savings.

Other opportunities to improve both quality and value by doing things differently have been assessed and compared with current local practice. In order to gauge the potential impact of our plans we have reviewed the following:

- Commissioning for Value
- Central Midland Commissioning Support Unit - Identifying Potential QIPP Opportunities
- Central Midlands Commissioning Support Unit - Future Impact of Demographic and Health
- Status Change on Hospital Utilisation
- NHS Rightcare - Commissioning for Value
- NHS Rightcare - Programme Budget Comparisons
- Public Health England - Spend and Outcomes Tool
- Wolverhampton City Council - Joint Strategic Needs Analysis
- NHS England Call to Action
- NHS England CCG outcomes tool
- NHS England Level of ambitions atlas
- NHS England operational planning atlas.

The table below provides a summary of the key areas of our commissioning expenditure where there is a significant variance in how the CCG benchmarks against other CCGs. It identifies that there are further opportunities for maximising the impact of our allocated resource in order to improve the health outcomes of our population across the QIPP spectrum.

Table 6: Summary Table QIPP Opportunities vs Commissioning for Value

Summary Table - QIPP Opportunities vs Commissioning for Value		Average	Top Quartile	Top decile
Alcohol	Marginally Attributable	£445,344	£1,872,692	£2,875,143
	Somewhat Attributable	£240,546	£375,417	£530,955
	Wholly Attributable	£25,080	£175,151	£247,927
Obesity	Marginally Attributable	£191,572	£234,468	£294,433
	Somewhat Attributable	£73,971	£148,706	£209,968
	Wholly Attributable	£1,871,176	£2,762,734	£3,176,958
Smoking	Marginally Attributable	£0	£0	£0
	Somewhat Attributable	£0	£10,599	£34,791
	Wholly Attributable	£1,282,580	£2,726,010	£3,346,966
ACS		£595,212	£358,338	£413,366
Medicines related		£0	£89,002	£186,170
Vaccine Preventable		£0	£0	£152,096
POLCV	Relatively ineffective	£0	£0	£5,611
	Probably aesthetic	£0	£0	£57,543
	Close benefit to harm ratio	£411,440	£702,646	£790,741
	Lower cost alternative	£156,109	£313,265	£576,173
Frail Elderly	Probable non-acute alternative	£0	£131,931	£1,316,556
	Possible non-acute alternative	£40,202	£230,956	£611,727
Admissions via A/E with primary MH diagnosis		£1,405,298	£3,282,944	£4,161,741
Readmission		£0	£1,112,936	£2,197,904
End of Life	3-5 days	£120,829	£286,217	£393,539
	Less than 3 days	£9,951	£72,809	£96,412
Medically unexplained symptoms		£0	£305,639	£343,624
Zero LoS, no procedure, discharged alive		£707,228	£1,508,472	£2,040,224
Cancelled procedures		£100,671	£142,225	£191,566
Falls related admissions		£0	£0	£358,023
Admission for self-harm		£0	£0	£0

QIPP Opportunities

Potential commissioner savings have been drawn from the 'QIPP Opportunities' packs produced by Central Midlands CSU for local CCGs in 2013. These packs identify a wide range of opportunities to reduce CCG expenditure on acute services (inpatients, outpatients and A&E).

Three savings estimates are calculated for each opportunity and CCG as the difference between the current level of expenditure per head of population and

- the West Midlands CCG average
- the West Midlands CCG best quartile
- the West Midlands CCG best decile.

These calculations assume no overlap between the opportunities and so may overstate the potential savings.

Table 7: QIPP Opportunities

Point of Delivery	West Midlands Average £000	West Midlands Best Quartile £000	West Midlands Best Decile £000
Inpatient	5,225	11,728	19,868
Outpatient	934	2,816	4,363
A&E	284	2,387	2,569
Total	**6,443**	**16,931**	**26,800**

The above analyses combined with our long term commissioning model, the Wolverhampton JSNA and the performance scorecard analysis, enable us to assess the relevant importance and priority of different initiatives. The purpose of this prioritisation is to identify those initiatives which:

- Focus on the delivery of strategic objectives and prioritised health outcomes
- Achieves significant QIPP impact
- Achievable within the acceptable planning timescales.

The conclusions that we draw from the analyses are that:

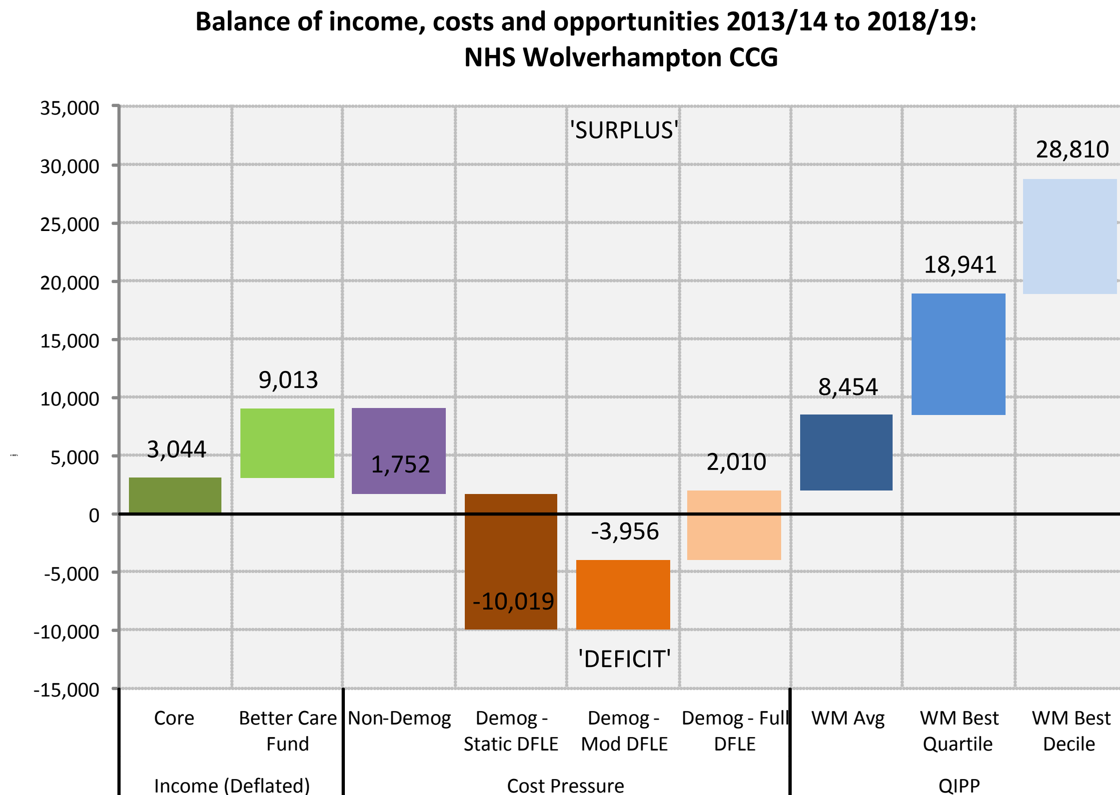
- The predicted growth in demand will contribute to a substantial increase in costs over the next 5 years
- Activity and cost growth can be mitigated through a range of interventions and QIPP initiatives
- Without introducing transformational change in the way that healthcare is delivered in Wolverhampton, a substantial gap between the cost of demand and allocated resource will ensue
- Our Strategic Plan will address the way that services are delivered as well as the way demand for those services are generated
- The impact of lifestyle choice and health inequality are key factors in the demand for services
- The management of patients with long term conditions and/or who are elderly is key to meeting the challenge of growing demand for healthcare services
- We will commission for maximum productivity for elective care services in order that we are target our resources effectively on those who are elderly and/or have a chronic health condition
- The demand for hospital services can be reduced and the quality of the care received improved through the development of more services provided outside of hospital by primary and community care
- The quality, health outcome and patient experience can be improved if services, across the local health and social care system, are better co-ordinated and integrated.

3.8 Cost pressures and QIPP opportunities

Taking the projections of cost pressures which arise from both demographic and non demographic increases in demand alongside the QIPP opportunities to save resources we can look at different scenarios over the period to 2018/19.

In the optimistic scenario, shown in a bridge diagram for the period below, the full impact of DFLE is assumed combined with achieving the top decile performance (in the West Midlands) on QIPP, which leads to a significant surplus in 2018/19.

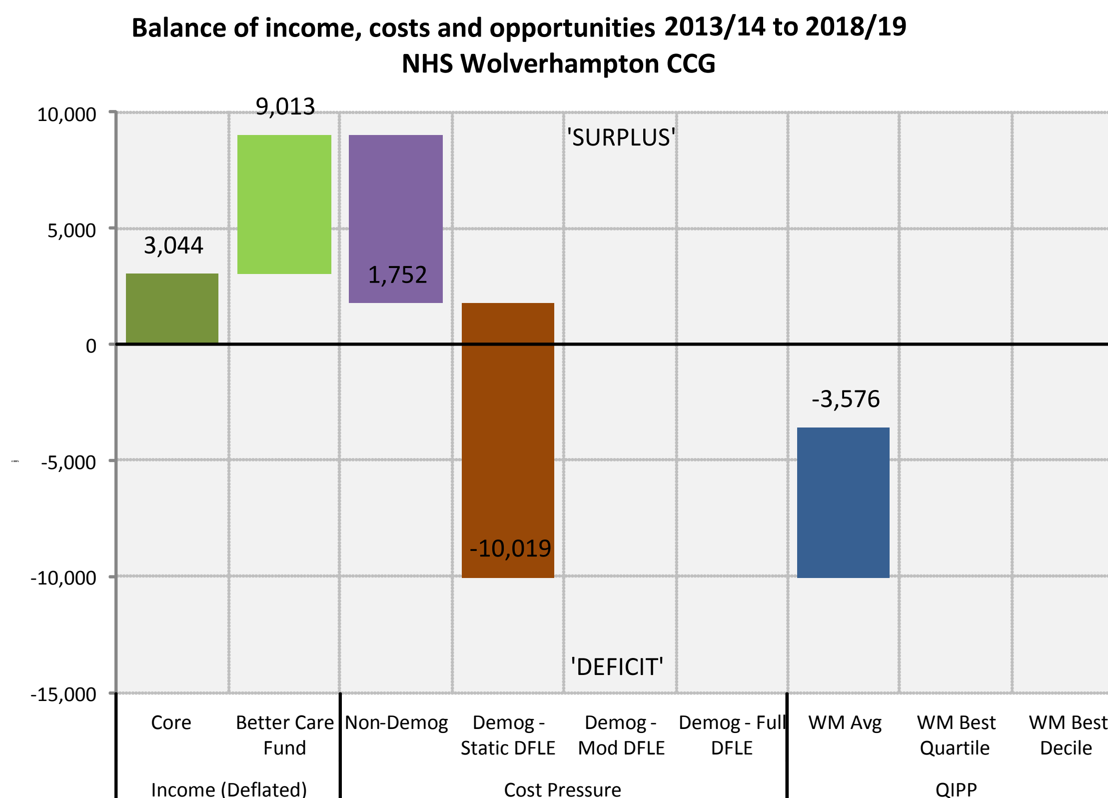
Figure 6: Cost Pressures and QIPP Opportunities (£'000s) – optimistic scenario



Figures on bars are cumulative surplus or deficit

In the pessimistic scenario, shown in a bridge diagram for the period below, there is no benefit from DFLE assumed and only average performance (in the West Midlands) is achieved on QIPP resulting in a deficit in 2018/19.

Figure 7: Cost Pressures and QIPP Opportunities (£'000s) – pessimistic scenario



Figures on bars are cumulative surplus or deficit

The table below shows the potential gap between forecast income and expenditure in 2018/19 given different QIPP saving and demographic cost pressure scenarios. In all but the most pessimistic scenarios, the CCG would have sufficient income and QIPP savings to cover the cost pressures if it were able to fully achieve the projected DFLE position *and* deliver all of the savings opportunities.

Table 8: Demographic Cost Pressure Scenario

	Gap (£'000s) @21/13 prices	Static DFLE	Moderated DFLE Effect	Full DFLE Effect
QIPP Savings Opportunity	**WM Average**	-3,576	2,487	8,454
	WM Best Quartile	6,912	12,975	18,941
	WM Best Decile	16,780	22,843	28,810

3.9 The Financial Plan

The CCG has produced a long term financial model (LTFM) which includes key assumptions for:

- demographic projections
- inflationary pressures
- efficiencies
- other factors impacting on contract growth.

For each of these key assumptions, three scenarios have been produced for the period, which include, 'best case', 'worst-case' and 'most likely'.

These assumptions, in the three scenarios are applied to the following budget categories:

- Prescribing
- Reserves
- Mental Health and Learning Difficulties
- Continuing Health care
- Secondary and tertiary care
- Running costs
- other PCT commissioning spend.

In the 'most likely scenario' challenging QIPP schemes are required to deliver financial balance.

The financial plan for the five year period shows that the predicted growth in demand cannot be afforded if the system continues to operate as it is currently because the additional allocations could not cope with those cost pressures. Significant efficiency gains are required in all sectors alongside the delivery of the QIPP programme.

The table below provides the summary level position for the CCG including:

- Recurrent and non-recurrent allocations
- Planned Programme expenditure
- Planned Running Cost expenditure
- QIPP.

The Revenue Resource Limit reflects the published figures for both Programme and Running Costs. In both 2014-15 and 2015-16 the CCG remains at c 3% Distance from Target which equates to spending of around £1,220 per head of registered population of around £39 per head over target spend .

Planned expenditure on running costs is in line with the published levels and reduces in 2014-15 from £24.73 per head to £21.53 in 2018-19.

The Acute Services portfolio continues to dominate the Commissioning profile being 53% of total Commissioning spend in 2014-15. QIPP levels as identified below have been incorporated into income and expenditure and are spread across all service areas. QIPP targets are extremely challenging but deliverable as transformation change occurs across the whole Health Economy.

Table 9: Commissioning and Sustainability Profile

Revenue Resource Limit

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent	317,590	320,162	331,237	336,397	342,040	347,778
Non-Recurrent	9,267	8,999	9,000	4,000	4,000	4,000
Total	**326,857**	**329,161**	**340,237**	**340,397**	**346,040**	**351,778**

Income and Expenditure

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Acute	172,394	164,908	168,413	168,356	167,555	166,498
Mental Health	35,328	33,674	34,473	34,166	33,871	33,574
Community	34,828	34,055	34,020	34,604	34,878	35,153
Continuing Care	10,800	11,788	14,608	16,278	17,932	19,775
Primary Care	47,111	51,795	51,225	53,604	56,079	58,672
Other Programme	11,147	15,923	26,142	22,056	24,414	26,818
Total Programme Costs	**311,608**	**312,144**	**328,881**	**329,065**	**334,730**	**340,490**
Running Costs	6,249	6,201	5,556	5,532	5,510	5,488
Contingency	-	1,816	1,800	1,800	1,800	1,800
Total Costs	**317,857**	**320,161**	**336,237**	**336,397**	**342,040**	**347,778**

Net QIPP Savings (included in figures above)

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	7,330	10,600	9,000	6,800	7,000	7,000

There are a range of risks to the five year financial plan, two significant risks need to be highlighted. First is the loss of £125m from Local Authority budgets over the next five years plus the impact of the Care Bill that will increase hardship for a large number of people in Wolverhampton and therefore place further pressure on the health and social care system. Second is the move to the Better Care Fund pooled budget in 2015/16. The Better Care Fund model will bring together health and social care budgets and deliver joint services across the City. There are a number of risks relating to this work which are recorded in the operating plan however in the context of the finance plan there is a significant risk that as the fund develops it will draw funds out of the CCG that it does not have freely available to allocate hence increasing the cost burden to the organisation.

The detailed planning of the transformation programmes in the Strategic Plan will drive and determine the long-term financial plan. It is fully understood by all partners that QIPP schemes cannot be regarded simply in terms of financial savings, but have to be the means by which the shift of care away from the acute sector and into preventative interventions and primary/community based services, is achieved. The financial plan will therefore be revised as part of the planning of the transformation programmes, and it is anticipated that the agreement and implementation of schemes, will show an increase in the funding of primary and community services. Currently the five year financial plan, post 2015/16, (in the 'most likely scenario', of the LTFP), over and above increase spend to meet demographic and non-demographic pressures, shows additional resources in three

areas: growth across all contracts (between £2.8m and £3.0m pa); expenditure on high cost drugs; the phased investment in the emergency care centre, including CDU. The investment profile which is relatively flat across the range of service areas will change to reflect the strategic vision. It is important to maintain realism concerning the level of QIPP savings (as currently profiled over the five year period) therefore within the limited financial flexibility, all parties must be committed to the innovation required to achieve the redistribution of resources for the new models of care.

We are committed to focusing on the investment planning (which will require disinvestment and redistribution of resources) to meet the requirements in each of the transformation areas illustrated in the diagram below in the overlapping spheres of activity covering: urgent care; integrated care; primary care; hospital and specialised services.

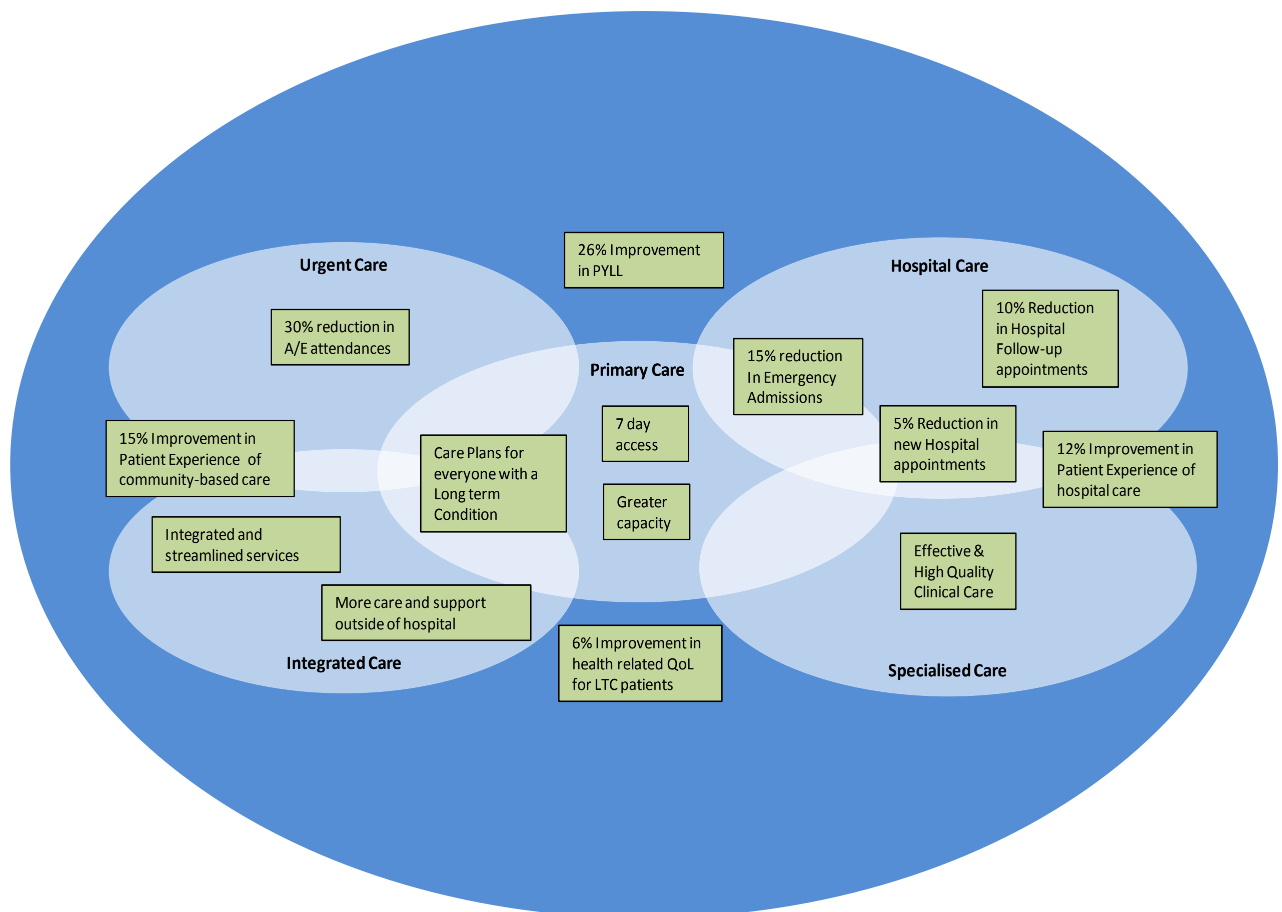


Figure 8: Transformation areas and Strategic programmes required to deliver the Vision

The CCG's business planning cycle and business case production will be reinforced in a way to ensure prioritisation is given to delivering these outcomes and service improvements.

4. Strategic Programmes to achieve the vision

During years 1 and 2, we will focus on building the foundations to prepare for the significant and transformative change planned for years 3 to 5. Specifically, the first 2 years will centre on:

- Delivery of agreed QIPP schemes in order to:
    - Release efficiency
    - Manage demand
    - Maximise quality
- Development of integration strategies and plans
- Building capacity and capability in primary and community care

During years 3 to 5, our plans will address:

- Major reconfiguration and transformation
- Harnessing integration
- Harnessing technology and innovation
- Risk modification, health inequalities and prevention agenda

Figure 9 below provides an overview of our strategic initiatives and enablers, mapped to our system objectives and outcome ambitions.

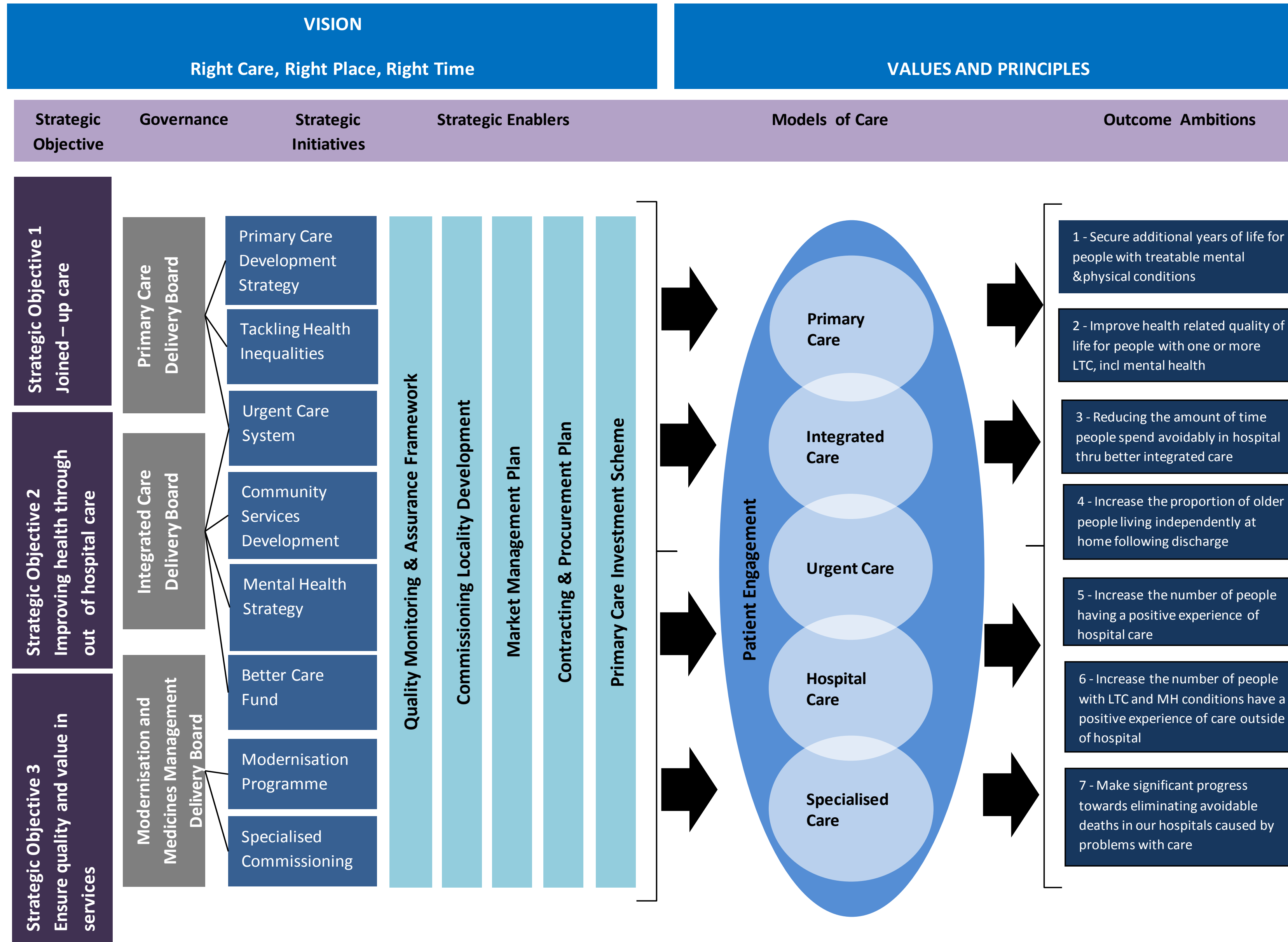


Figure 9: Strategic initiatives and enablers required to deliver the Vision

4.1 Primary care development

Our strategy for primary care development focuses on 8 key objectives:

1. Develop the primary care workforce so that it is more flexible and able to undertake a greater range healthcare interventions as part of a model of integrated delivery across health and social care;
2. Improve the primary care estate and IT infrastructure in order to facilitate improved access, healthcare delivery and information flows;
3. Facilitate and provide clinical training and education in order to maintain high clinical standards and skills within the primary care workforce;
4. Maximise primary care productivity by providing practice operational and business support;
5. Seed an approach to the federation of practices, which meets GP expectations and requirements that facilitates greater capacity and flexibility across primary care;
6. Develop clinical functional support and peer review in order to help target support where it is most required in order to reduce unwarranted variation;
7. Integrate service delivery at GP practice level with the provision of all other out of hospital services across community, social and voluntary sector care
8. Work in collaboration with the NHS England Area Team, its developing strategic framework, and the Local Professional Networks to develop collaborative approaches to service delivery across GP, Optometrists, Dentists and Pharmacies

Operational costs will be met within CCG management overheads. Development will be funded through the Primary Care Investment Scheme and supporting incentive schemes based on QIPP delivery and the transfer of activity from the acute to the primary, community and voluntary care sectors.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
• Workforce review undertaken and plan developed • Estate review undertaken and plan developed • Review of practice business federation options undertaken •Increased access piloted to reduce emergency admissions	• Workforce development plan implemented • Estates development plan implemented • Shared business service plan implemented	• Primary care based services designed and developed • Federation support plan implemented • Workforce training and development plan in place • Single assessment process implemented in alignment with BCF plans • Community nursing service (focused on practice support) commissioned • 7 day working, 8-8 services	• Primary care based services implemented • GP practices using a federated model to support practice business function • Appropriately trained workforce in place	• Enhanced primary care commissioned from federations of GP practices which offer: o 7 day access o Diagnostics o Community-based acute services • Integrated virtual teams delivering health and social care services based around clusters of federated practices

It is recognised that a number of critical success factors need to be put in place to achieve our objectives:

- Sufficient provider engagement and support to deliver the strategy, including our Primary Care Support Team;
- Investment and resourcing via the Primary Care Investment Scheme and other means to facilitate the required levels of development and activity;
- Establishment of a sustainable investment and incentive scheme which integrates with QIPP delivery;
- Development of locality commissioning structures.

Expected outcomes

- A more flexible primary care workforce, able to undertake a greater range healthcare interventions as part of a model of integrated delivery across health and social care;
- High clinical standards and skills within the primary care workforce, maintained through clinical training and education;
- Improved primary care estate, facilitating improved access, capacity and healthcare delivery;
- Increased primary care productivity through practice operational and business support;
- An agreed approach to the federation of practices, meeting expectations and requirements and increasing capacity and flexibility;
- A collaborative approach to service delivery across general practice, optometry, dentistry and pharmacy, working in collaboration with the NHS England Area Team and local professional networks; for example, pharmacist-led interventions to support optimal prescribing and the use of medicine.

Progress will be monitored through the following KPIs: emergency admissions rates/health outcomes for LTC and over 75s/benchmarking against national quality measurement tools/workforce skill-mix benchmarks/GP referral rates/cost & productivity ratio benchmarks/A&E attendance rates.

4.2 Tackling health inequalities

Our approach to health improvement, ill-health prevention and tackling health inequalities is embedded throughout this plan and reflects significant joint working that we have undertaken with the Wolverhampton Public Health team. Our initial priorities are to ensure that the Wolverhampton population enjoy equity of access and high quality of care in the services that we fund. We will focus awareness, access, availability and acquisition. Our joint planning with Public Health is characterised by the recommended 5 steps for commissioning for prevention:

- Analysing key health problems at population level – we have undertaken joint work with Wolverhampton Public Health involving the Joint Strategic Needs Assessment, long-term demand modelling
- Working together with partners and community to set common goals – we have undertaken joint priority setting sessions with Governing Body, Executive team and the Public Health team
- Identifying high impact programmes focused on top causes of premature mortality and chronic disability – we have specifically set out on a journey to implement disease and risk modification programmes and will work together to develop joint intervention programmes to support the latter in the long term. This will include a consideration of the drivers of health inequality for each vulnerable group and how their attribution will be identified and interventions tailored to address them e.g. smokeless tobacco use in

ethnic populations to address oral cancers and CVD. We will look at how we can target income, education and deprivation and thereby help to address the social determinants of health
- Planning resource profile to deliver prevention goals – we have set aside funding to support disease modification through the Primary Care Investment Scheme, and the GP Enhanced Service for care reviews for vulnerable people as part of this plan
- Measuring impact and experiment rapidly - We will evaluate the impact year on year and adjust our priorities and plans in order to reflect our learning, working in partnership with Public Health and other key stakeholders.

In order to contribute to this aspect of our vision, and to the delivery of each of our strategic objectives as a whole, we will also engage the population, jointly with Wolverhampton Public Health, in the commissioning for prevention agenda in order to target health inequality across the city.

We will focus in particular on:

- Infant mortality and teenage pregnancy
- Disease and risk modification.

4.3 Children's Agenda

We plan to deliver the requirements of the Children and Families Act (2014) by an evidenced active collaboration with children, young people, parents and carers and between health, social care, education and third sector agencies and providers in order that children and young people have a range of services based on local choice and individual need and this is delivered in a planned and co-ordinated way. We also plan to improve transition arrangements between child and adult health services to support a seamless pathway for young adults with the most complex health needs and to align this with social care, education and other third sector provider arrangements.

As part of commissioning for children's services, our main aims are to: significantly reduce infant mortality, focus on improving the lives of children and young people with special educational needs and disabilities (SEND) and reduce teenage pregnancy in Wolverhampton.

The CCG is also committed to meeting its statutory safeguarding responsibilities for all children including Looked After Children (LAC). There has been a significant rise in the number of LAC in Wolverhampton. Since 2009 the number has risen from 374 to 800 in 2014. We are working with the Local Authority and Provider Trust to meet the statutory requirements to provide medical assessments to all LAC. There is ongoing work with the LA to establish a 'Charter' which will address the numbers of children going into looked after care, this will be agreed at end of June meeting. The CCG will ensure that there is adequate commissioning to address the health needs of these children.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**

<table>
<tr><td>Review and develop Children’s Commissioning Strategy with PH/LA

JSNA refresh

Multi agency action plan agreed</td><td>Implement plan and commission services

Monitor KPIs

Transfer of Health Visiting Services to PH</td><td colspan="3">Performance manage delivery of commissioning plan jointly with PH/LA</td></tr>
<tr><td>Infant mortality Working group established

Maternity specifications for commissioning reviewed and aligned with PH

FPNs programme commenced</td><td colspan="4">The clinically led Infant Mortality Working Group will confirm further implementation plans on the 20th of June 2014. Expected workstreams include:

Addressing high levels of growth retardation/restriction including smoking in pregnancy

Early Intervention/Warning system for chaotic families

Understanding ‘vulnerability’ in Wolverhampton</td></tr>
<tr><td>Plan for SEND in the context of the requirements of the Children and Families Act (2014).</td><td>Local offer agreed across all sectors

Adult (14+) framework implemented

Complex care database for children implemented

Patient partnership forum to co-produce consultation on health offer

Young People/Changing Lives Governing Body and Consultation event

Named GP for safeguarding in each practice, trained to level 3

Database established for Safeguarding leads and training

Case conferences for Safeguarding to include GP reports</td><td>Review, evaluation and revision (where required) of frameworks

Joint appeals and complaints process in place

EHCP planning process in place for new entrants

Personal Budgets offered in EHCPs

Patient Partnership voice embedded within systems and processes and driving commissioning plans</td><td>Directory of Services - open and transparent publication of in-service provision and how to access it

Young people with LDAs transferred to new system

Transfer of funding and complex care commissioning service to the Better Care Fund

Single complaints process within BCF covering all services including voluntary sector

Advocacy arrangements embedded within systems and processes

GPs routinely submitting reports 48 hours before case conferences</td><td>Children and young people with statements transferred to the new system

Integrated provision of services

Transition health plans established at16 for smooth transition into adult services

Diversity of provision, wrapped around the child, offering patient control and choice</td></tr>
</table>

	Training for GPs on Complex care assessments (key worker) and Children and Families Act		Key workers (primary care) actively managing transition and complex care	

Expected outcomes*:*

- Reduce infant mortality to below benchmarked average for CGG comparator groups;
- Reduce teenage conception rates to below benchmarked average for CCG comparator group.
- Reduce SEND emergency admissions with greater efficiency and effectiveness in the use of allocated budget envelopes, better co-ordinated and integrated care, improved patient and carer experience of care, and deliver improved health outcomes

The programme will be delivered through existing management costs and Progress will be monitored through the following KPIs: infant mortality rates; smoking in pregnancy rates; teenage conception rates, experience of services, EHC plans completed and emergency admission rates decreased for SEND children.

Effective joint commissioning arrangements will underpin this work as part of a joint health inequalities plan, agreed with the local authority. In particular, alignment will be needed with commissioning plans for family nurse partnerships, maternity and other joint commissioning plans.

4.4 Disease and risk modification

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

This long term approach will facilitate, either directly or indirectly, the local review, development and implementation of the following high impact and early achiever innovations:

- Early detection and diagnosis

- Optimisation of medicines use
- Case management and co-ordinated care
- Self-management
- Cancer screening programmes
- Integration of health and social care for older people

An investment of £1m has already been identified for 2014/15. Additionally, this will be supported through the Enhanced Scheme for LTC management.

Milestones	
Years 1-2	**Years 3-5**
Implement care planning for all over 75s and those with a long term condition in order to modify disease progression	• Implement risk stratification, targeting and care planning for patients at early disease stage and/or high risk of LTC. Extend care planning to over 65s • Implement joint commissioning plans with Wolverhampton Public Health team for health promotion, lifestyle management, self-care, early detection & diagnosis and screening programmes (cancer or other)

Expected outcomes

- Improved health outcome
- Reduced burden of demand on healthcare services, particularly in terms of emergency admissions
- Lower heath inequality
- More care delivered outside of hospital
- Greater focus on delivering proactive, co-ordinated and integrated care
- Increased engagement and empowerment of people to become involved in the management of their condition and the care they receive

Progress will be monitored through the following KPIs: Care planning rates/emergency admissions rates/QoF indicators & registers/Patient and stakeholder experience and feedback.

This programme of work is dependent on a number of other key strategic initiatives, notably: the primary care investment scheme; the GP enhanced service for LTC management; the Better Care Fund; and the primary care development strategy. Investment and development support will be needed to deliver alternative models in primary care.

4.5 Urgent care system

Our 5 year vision for the Urgent and Emergency Care System comprises 6 main themes:

1. Supporting Self Care – The urgent care centre will be designed in such a way that patients will be supported to manage their conditions through accessible support via face to face or telephone and information that gives greater confidence to manage their condition themselves

2. Helping people with urgent care needs to get the right advice or treatment in the right place, first time – we will streamline services into one urgent care system that is accessible 24/7 and will ensure patients entering the urgent care system are appropriately sign-posted to the right service. We will work across organisational boundaries, in order to ensure that the services patients need are on hand (Social Care, Mental Health, diagnostics) regardless of who the provider is. The urgent care centre will be the portal for both NHS111 referral (telephone or face to face) as well as the central hub for health care professionals to access the necessary services that have potential to reduce emergency ad missions (diagnostics - xray, scans, Social Care and community services). Urgent care centre staff will be able to access key historical medical history, medication and care plans, to ensure that the patient receives the most appropriate care. We will ensure a wide range of professionals can access appropriate advice and guidance to reduce the need to enter into the urgent and emergency care system.
3. Providing a highly responsive urgent care service outside of hospital so that people no longer have to queue in A&E. – By integrating the Urgent and Emergency Care Centre, patients will have access to various levels of clinical advice and input. They will be signposted to the appropriate part of the system based on clinical need. This will reduce the levels of primary care type activity that adds to the delays in care in our A&E department. This will be supported by the development of a Primary Care Strategy which will include harnessing the minor ailment scheme for pharmacies.
4. Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise – We will work with the Black Country network and wider West Midlands engagement, the local acute trust, WMAS and to ensure, where appropriate, patients have access to right emergency care provider that best meets their needs. A particular focus for ensuring this will be emergency planning/mass casualty and the critical care network engagement.
5. Implement the findings of the NHS services 7 days a week forum – We have implemented pilots during winter 13/14 with practices across the city to deliver extended access. This varies from extending appointments at traditionally busy times (Monday mornings) to additional evening clinics, Saturday and Sunday opening. In addition there is already a strong focus on 7 day working across health and social care within the urgent care system. We will expand and strengthen the intermediate care system developing alternatives to A&E/UC and in doing so further strengthen the availability of 7 day service provision.
6. Connecting the whole urgent and emergency care system together through networks – The CCG will work through local, regional and national networks, involving both commissioners and providers in order to ensure that the local configuration of services integrates effectively with the west midlands footprint. A key aspect of this will be the implementation of the Keogh Review whereby the national number of major emergency and urgent care centres will be rationalised to between 40 and 70, supported by networks of emergency and urgent care centres. We will work through the Urgent Care Working Group, the Black Country Network and the Area Team in order to agree local and regional plans, engage with patients and the public and sign-off development and implementation plans.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Local resilience planning continue through UCWG delivered refreshed plans by summer 2014, detailing the use of retained 70% from marginal	Urgent care Centre opened Implementation phase for Emergency care Review commenced	Urgent Care Hub implemented, integrated with primary Care, incorporating telephone/111 access and a home visiting service	Electronic patient Record implemented, shared across the local health community Fully developed	

tariff. Wolverhampton Urgent Care Centre & Out of Hours Service implemented Stakeholder engagement and local implementation plan developed	40 to 70 Urgent and Emergency Care centres, supported by emergency centres and urgent care facilities.		local clinical network established Evaluation phase for Emergency Care Review commenced	

Expected outcomes:

- Implementation of the Wolverhampton Urgent Care Centre;
- Reduced emergency attendances in A/E;
- Shorter waiting times in A/E;
- Increased access in primary care.

The specification for the Urgent Care Centre will include:

- Redesigned pathway for A/E activity;
- Out of Hours Service;
- Care Home Support Service;
- GP Home Visiting Service;
- NHS 111;
- Social care support (linked to BCF).

Progress will be monitored through the following KPIs: A/E attendances, A/E waiting times, Patient experience and feedback, Access rates in primary care.

In order to support the delivery of an effective urgent and emergency care system, we recognise that it is important to improve the range, flexibility, capacity and access to primary care. Feedback from the public on the Urgent and Emergency Care Strategy indicated that pressure on urgent care services could be alleviated by improving access to primary care services throughout the day as well as outside of normal working hours. The delivery of our Primary Care Development Strategy will be a contributor to improvement across the urgent care system.

4.6 Community services development

As part of the delivery of our Operating Plan, we will undertake a review and commence the process of redesign and transformation of community based services. This will initially focus on Community Nursing Services but will, in the course of this Strategic plan, encompass the delivery of all healthcare services based in a community setting. As part of this work we will seek to maximise the potential for Telehealth and telecare in the delivery of personalised support to patients.

The vision is of delivering care at the right care, right time, right place, building on the momentum of the Better Care Fund to deliver seamless care and co-ordinated care. The key characteristics are:

- Central hub that anyone can contact
- Care planning
- Single IT system
- Providers that are fully engaged and involved
- Early detection and screening facilitating better prevention
- More care closer to home
- Co-ordination of medication (less wastage)
- Single budget
- One team of commissioners (local authority / health)
- Multi-disciplinary care delivery teams
- More community based clinics
- More community hubs for information, signposting and support
- Better support in mental health (walk in centres)
- Public health play a key role
- Third sector involvement (awareness, communication, provision and delivery of services)
- Same care for everyone
- Equality of access
- Outcome focused
- Better value for money (more effective)
- Co-ordinated care with a key worker
- Voluntary sector involved with CHC patients (personal health budgets).

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Phase 1: Service review, stakeholder engagement, strategy and plan development. Review West Park provision as a priority	Phase 2: Transition phase incorporating procurement planning, service transformation, commissioning intentions. Implement West Park project.	Phase 3: Implementation of Integrated Primary and Community care Nursing Services	Phase 4: Implementation Therapy Services	Phase 5: Implementation Therapy Services & Other

Expected outcomes:

- Greater productivity and efficiency
- Improved support to GP practices
- Increased integration with voluntary sector and social care
- Reduced unplanned hospitalisation
- Improved patient experience of care
- Reduced lengths of stay

- Improved patient outcomes.

Progress will be monitored through the following KPIs: delayed transfers of care; admissions to Nursing Homes; patient/user experience; proportion of older people who are still at home 91 days after discharge from hospital; and health related quality of life for people with a Long Term Condition.

Interdependencies:

This programme will require strategic leadership and oversight by the CCG and Social Care on a single vision of integrated care delivery alongside effective stakeholder communication and engagement. GP leadership of the commissioning process within CCG will be essential. The programme will be closely aligned with the primary care development strategy and the Better Care Fund plan.

4.7 Mental health strategy

The CCG's over-arching aim regarding mental health services is to commission a system that:

- Prevents people from entering secondary and tertiary services wherever possible via early intervention initiatives delivered in primary care and universal services.
- Provides an integrated system of assessment and intervention with social care partners to enable recovery, promote independence and prevent relapse within secondary and tertiary care.

The vision for all-age mental health services is that by 2018/19 we will have transformed service user and carer experience and outcomes by commissioning an evidence based system of integrated care pathways and services for people of all ages that will achieve parity of esteem and deliver:

- Using the Friends and Family test improved transparency and quality across the whole system including CAMHS;
- Integrated Access to Psychological Therapies within CAMHS and younger people's services;
- Early intervention and prevention initiatives and services including those provided for children and young people in Tier 2 CAMHS and a dedicated Young Person's service that operates a resilience building model;
- Early intervention in Psychosis services for those aged 14-35 years that meet recommendations highlighted in 'Schizophrenia the Abandoned Illness; and the relevant NICE Guidance;
- An Acute Care system that includes an integrated care pathway with social care regarding urgent mental health care using Better Care Funds;
- Local mental health crisis concordat;
- Local multi-agency suicide prevention strategy;
- Access to services and waiting times that are equitable with standards for physical health;
- Improved access to information, support and advice for people of all ages and local marketing campaigns regarding #beatbullying and #timeforchange.

Using Better Care Funds, the CCG will commission integrated care pathways for people with the highest level of need and co-morbidities / vulnerabilities including dual diagnosis, to improve quality of life and life expectancy for people with multiple long-term conditions and clinical risk factors. The CCG will commission services across the system that encourage self-management, reduce the numbers of people on sick pay and benefits, and increase the numbers of people with mental health problems receiving community support. Detailed plans are currently being developed in our revised Commissioning Strategy for Mental Health 2014. The detailed financial

model behind the strategy development will outline our intentions to re-align the CCG spend on mental health as part of QIPP plans locally to deliver system and service re-design, deliver cost efficiency savings and increase value for money. This will include:

- An integrated care pathway to deliver reablement, self-management and recovery
- Increased dementia diagnosis in primary care
- Single assessment and care planning processes for people with dementia
- Physical health care pathway for people with mental health difficulties across primary and secondary care
- Integrated care pathways for people with dual diagnosis.

The CCG will commission an integrated mental health urgent care pathway which provides 24/7 pro-active health and social care interventions and support for people of all ages including CAMHS. This will provide emergency and urgent assessment, treatment, intervention and care and support within an integrated health and social care model for adults and children with acute and severe mental health difficulties who require high levels of care and support in urgent and / or emergency situations.

The CCG will develop a local Suicide Prevention Strategy by supporting those with the highest levels of acute risk and reduce self-harm and suicide. The all age mental health urgent care pathway will include an embedded all Liaison Psychiatry Service (LPS), providing a dedicated function to the wards and departments within the Acute Hospital and primarily A&E for patients who require mental health assessment, intervention and support. In 14/15 and 15/16 the above initiatives will be developed in line with our local Better Care Fund Mental Health plans which focus on the following key outputs / success factors:

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

We will commission services and care pathways to support self-management of patients taking anti-psychotic medication and prevent relapse wherever possible. We will align these initiatives with locally developed care pathways and procedures regarding dual diagnosis to ensure that the mortality risks of people with mental illness who misuse substances such as alcohol and drugs are pro-actively managed and reduced. We will align this care pathway development and implementation with plans in 2015 / 2016 to develop Recovery Colleges as part of the Better Care Fund initiative.

- Integrated care pathways for people with a learning disability;
- Utilisation of digital technology i.e. simple Telehealth across the system.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
• Delivery of agreed QIPP schemes as part of Operating Plan. • Development of Mental Health Strategy	• Delivery of agreed QIPP schemes as part of Operating Plan	• Implementation of Mental Health Strategy		

Note: 2 year objectives for Mental Health are identified within the Operating Plan. This includes the requirement to undertake a refresh of the Mental Health Strategy which mental health strategy will be completed by July 14. Key objectives of the strategy will be:

- Early intervention and support
- Community based services
- Integrated services.

Expected outcomes

- Delivery of early intervention which facilitate avoidance of disease progression
- Improved CAMHS
- Service integrated around the patient
- Improved quality of life
- Improved life expectancy
- Reduction in suicide rates
- Improved self-management
- Improved patient experience.

Progress will be monitored through the following KPIs: admission rates; length of stay; suicide rates; patient experience; referral rates; transfer between service tiers; usage rates of residential and hospital care; and community activity rates.

Interdependencies

We will work with local partners and key stakeholders to deliver quality improvements regarding our application of the Mental Capacity Act locally, by ensuring access to training and support, cross cutting performance management and audit initiatives across agencies and organisations. We will involve service user and carer groups in this process. We will bench mark performance standards against national prevalence and best practice data and provide annual reports vs the local safeguarding board.

4.8 Better care fund

The Better Care Fund (BCF) programme is regarded by the Local Health & Care Economy as a catalyst and microcosm of a much larger and fundamental long-term transformation strategy. To this end, key stakeholders have embarked upon an ambitious journey of whole system change. The Wolverhampton Whole System Change and Improvement Programme is focused around enabling adults in Wolverhampton to live fulfilling lives by enhancing their independence, health and quality of life through seamless, efficient action that strives to improve experiences and outcomes. This transformation project will provide the basis of the longer term Health & Care Strategy for Wolverhampton and will be a key plank in this Strategic Plan. The key partners for the Better Care Fund are: Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, Black Country Partnership Foundation Trust and The Royal Wolverhampton NHS Trust.

Within 5 years, the BCF programme will have:

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

The Wolverhampton Health & Social Care economy have, over a series of events, developed a Better Care Fund Plan based on 4 workstreams : Mental Health De-Escalation, Intermediate (Reablement/Rehabilitation) Care, Nursing & Residential Homes and Dementia. Within each of these workstreams there are a series of projects designed to achieve the mandated National Metrics.

In order to identify the financial contributions from the CCG Commissioning Budget analysis of areas to be included in individual projects against CCG budget line has been undertaken - this has resulted in a value above the minimum requirement identified. A transitional fund of £3m (referred to as 'Call to Action' monies in the NHSE Operating Framework) has been set aside to facilitate any change in practice that requires pump-priming or double running during 2014/15.

Plan development work has included in excess of 120 stakeholders - drawn from frontline professionals (health & social care), patients, users, carers, voluntary and 3rd Sector Organisations. A number of these stakeholders have identified a wish to take part in the workstreams and projects and will form part of individual project teams going forward.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Establish Single Assessment Process for Dementia Establish memory clinics for Dementia Establish community database Establish step-	Establish step-down facility Health and social care integration (CICT/HARP) Establish care home in-reach service	Establish Dementia Hub Introduce 7 day therapy services	Specify and develop health and social care telehealth/telecare support services	Implement health and social care telehealth/telecare support service

down framework Review CICT/HARP Establish care homes training and education Establish care homes quality standards				

Expected outcomes:

- Reduce emergency admissions
- Improve patient experience of services
- Reduce permanent admissions to residential & care homes
- Increase effectiveness of reablement services
- Reduced delayed transfers of care
- Optimise independent living post-discharge
- Maximising independence
- Avoid preventable hospital admissions
- Maintain / improve personal well-being
- Optimise GP managed care
- Support the management of Long Term Conditions in the community
- Maximise self-care
- Dramatically improve the dementia diagnosis rate
- Pooled Better Care Fund budget, in excess of the minimum requirement.

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

4.9 Modernisation programme

The vision is to ensure patients are seen in the right place at the right time by the most appropriate healthcare professional. Also that if they do need to be seen in secondary care that their stay is not prolonged by either delays in treatment or delays in discharged. Improving productivity by 20%. For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error, maximise quality, and achieve a major step – change in productivity.

The modernisation programme is currently funded. CCG non-recurrent transitional funds will be made available to support transformational change.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
As per QIPP schemes outlined in Operating Plan		• Shift of activity into community settings • Implementation of enhanced recovery and discharge planning projects.		

Expected outcomes

- Reduced length of stay
- Discharge planning upon (or prior to) admission
- More care closer to home
- Near patient testing instead of attendance at community clinics leading to patient self-testing
- Increased patient choice by increasing competition into the market
- Care delivered in primary or community settings, where appropriate
- Continual review and enhancement of POLCV policy
- Continual review of pathways to ensure that patients are experiencing the most efficient pathway
- 20% improvement in productivity.

This programme will build on the collaborative working between primary and secondary care facilitated by the primary care development strategy; locality development commissioning; and our market development analysis.

4.10 Specialised commissioning

It is important for the CCG (and the local unit of planning) to align its local strategy to the direction of travel nationally for specialised services over the next five years as:

- The focus on planning across the entire patient pathway is the vital .i.e. Any changes to a patients pathway considered by the CCG/Local Authority/specialised team for a service such as Child Adolescent Mental Health Services(CAHMS) will impact on the whole pathway.
- Historically Specialised Services account for £12.2 billion per annum of the NHS allocation. Historically, the growth in cost exceeds other parts of healthcare by as much as 4% per annum. We are planning to look at how we work together with NHS England to review and achieve better value for money and improved quality is a key priority. Specialised services will be developing a robust QIPP challenge of its own and the CCG will need to work with the Area Team to understand the impact of their QIPP agenda on the local health economy.
- The national strategy being developed for specialised services is in the early stages of its development but it is clear the direction of travel is towards fewer centres concentrated in centres of excellence (around 15 to 30 centres). The CCG will need to work closely with NHS England to understand the implications of the strategy and work together on how to implement the transformational change required.
- There will be joint opportunities for maximising research and teaching opportunities to encourage innovation and change.

The CCG will therefore work with Specialised Commissioning Team over the duration of this Strategic Plan to ensure:

- Strong engagement in the development of the national strategy for specialised services through the call to action programme completing in July 2014.
- Active participation in the proposed West Midlands governance arrangements for the strategy development which will be considered and discussed at the 5th February Call to Action event.
- Identification of opportunities for joint planning and development of care across the whole patient pathway within local plans. Supporting the need for change within an agreed case for change.

- Close contract management arrangements with specialised commissioners for providers.
- Supporting the development of the local service priorities and/or reconfigurations currently being considered by the Area Team plan which include CAHMS Tier 4, Cancer services, Cardiology, Paediatric Intensive Care and High Dependency services and neuro-rehabilitation services.

4.11 Strategic enablers

4.11.1 Quality monitoring and assurance framework

We are committed to commissioning high quality services that both improve patient experience and the quality of care. We recognise that a quality agenda must be implicit in everything that we do. We believe that a robust and systematically embedded approach to safety and quality will be a key enabler in delivering our required outcomes and other associated targets. Refer to Figure X for an overview of our quality assurance framework.

The Quality & Safety Committee monitors the outcomes and recommendations made from national reviews and inquiries and will endeavour to be assured that all appropriate learning is recognised and acted upon by commissioned providers. Providers are required to submit ongoing progress reports and updates on changes and improvements made to the quality of services. Quality visits are also used to monitor practice and continuous improvement at service level. The implementation of the Quality Assurance Framework in Primary Care will identify patient safety improvement indicators focused on needs and outcomes, in particular relating to safety, experience and effectiveness. Further development of patient safety reporting in primary care via the CCGs teams will enable practice level learning and sharing of information to identify learning opportunities at practice and locality level, and reduce the likelihood of recurring incidents. Safeguarding duties are and will be discharged in all local plans and continuous assurance will be sought on this matter via CQR reports (quarterly exception reports on progress against safeguarding plans), quarterly themed reports to Quality and Safety Committee and onward reporting to the Governing Board.

Overarching approach to quality improvements		
Quality Components		**Actions**
Bring clarity to Quality	By being clear about what high quality care looks like in all specialties/services and reflecting this consistently when setting standards and quality indicators in specifications and contracts	Use National Guidelines to support setting standards for good practice. Commission for Quality and Effectiveness by ensuring clinically recognised best practice is used as the benchmark for new services. Establish defined standards and evidence based commissioning
Measure Quality	By gathering and using information that shows providers and their clinical teams where they most need to improve on key measures and enables them to track the effect of changes they implement via clinical quality review and contract monitoring	Use Clinical Audit as a key mechanism to monitor clinical performance, quality of services and demonstrate continuous quality improvement. Review and take appropriate action on the five domains from the National Outcomes Framework, including Hospital Standardised Mortality Ratio indicators, never events, HCAIs, RTT times, cancer waits, A&E waits, patient experience and ambulance quality. Monitor and performance manage providers using the CQC Essential Standards, Clinical Quality Review Groups, as part of the contracting process, use a single quality dashboard, and patient experience feedback to bring providers to account.
Publish Quality	By making data available so that patients and their carers can make better informed choices, clinical teams can benchmark, compare and improve their performance, commissioners/providers agree priorities for improvement by using information from the quality observatory and the development of quality accounts/board reporting	Use Quality Accounts in conjunction with financial accounts in order to help test compliance. Work in partnership with the Care Quality Commission to seek assurance that providers are compliant
Recognise and reward Quality	By ensuring the right incentives are in place to support quality improvement by using commissioning for quality and innovation	Develop CCG CQUIN schemes to incentivise improvement against a number of clinical practice indicators.
Raise standards through clinical	Through stronger clinical leadership and engagement in commissioning, Strategic Planning and service/pathway development, using stronger clinical engagement with	Recognise that strong clinical leadership and engagement is paramount to the process of quality improvement. GPs are engaged at every level of the commissioning process in Wolverhampton.

transformation	CCGs and through networks	
Safeguarding Quality	Through regulation of professions and services and collaboration with the SHA and regulators such as the Care Quality Commission.	The processes for monitoring and managing Serious Untoward Incidents (SUI) is part of the provider contract monitoring process.
Stay ahead	By supporting innovation to foster a pioneering NHS through the promotion of quality innovation and providing initiatives	Engage and work in partnership with Health Innovation and Education Clusters, Academic Health Science Centres and NHS Improvement Agencies to develop and implement innovation, new learning and tools and techniques within the Wolverhampton health system.

4.11.2 Commissioning locality development

The 5 year strategy is to develop the GP membership and localities in the commissioning agenda of the CCG through the creation of a supporting governance, accountability, business planning and delivery structure. Our vision is that our localities will drive the commissioning agenda, working at a local level to maximise QIPP while helping to shape the strategic direction of the CCG. The cost of this programme will be managed within existing CCG management cost envelopes.

Alongside the components of the Better Care Fund, the Primary Care Investment Scheme and the Enhanced Service for Unplanned Admissions, the CCG will task its localities to develop schemes for the frail and elderly population of Wolverhampton. These will be designed to enables the elderly population to receive maximum care and support within their own homes and/or the community, reduce the reliance on urgent and emergency care, improve their quality of life, improve their experience of care and maximise the integration of health and social care services.

It is expected that the CCG will adopt a co-production approach with localities to deliver on CCG system objectives and QIPP targets. A key benefit will be enhanced patient and public engagement through practices and patients working at a local level on service improvement.

4.11.3 Whole system approach to community based prevention

The CCG is a partner in a successful bid to the Public Health Transformation Fund, to develop a whole systems approach to community based prevention. This project seeks to make a step change in the delivery of preventative activity and services and to refocus efforts around the delivery of health and social care away from acute care and towards preventative and early intervention services which have been identified as priorities in the City Strategy
(http://wolverhamptoncityboard.org.uk/UserFiles/File/WCC%20101%20Full%20City%20Strategy%20a.pdf) following extensive engagement. This will be achieved by:

- Bringing together representatives from the Clinical Commissioning Group, The Royal Hospital Trust, the Council (including Public Health) and the community and voluntary sector to map current provision and how it could be delivered differently.
- Supporting and promoting localised provision by piloting new ways of commissioning and supporting services which enable grass roots delivery of services within local communities to grow and sustain. This will build on these emerging foundations outlined above whilst also seeking to open up the market in terms of personalisation services to grass roots providers.
- Ensuring that any developments are informed by community networks

In the long term, the project will result in:

- Improved outcomes for local people i.e. less illness;
- Better value for public money through a whole systems approach;
- An increase in community based preventative services in the city e.g. walking programmes designed to address obesity and lifestyle programmes designed to address coronary heart disease incorporating nutritional advice, exercise and smoking cessation;
- A strategy for sustaining these activities beyond the life of the project funding through mainstream funding.

4.11.4 Reshaping the secondary and tertiary hospital sector in the West Midlands

As described in several sections of the Strategic Plan (section 2.4 Characteristics of high quality and sustainable services models, and section 4 Strategic Programmes) to achieve the vision there are a number of drivers both national and local, which will change the nature and scale of the hospital sector throughout the West Midlands. Some of the most important of these factors are described below:

'Keogh' Review of the urgent and emergency care: this will bring greater standardisation and clarity for patients, public and staff concerning the provision of the urgent and emergency care provided by networks of providers, which can deal with the minor illnesses/accidents up to the most complex and life threatening conditions which require highly specialist interventions;

Review of stroke services throughout the Black Country and Birmingham and Solihull: this review involves all seven CCGs and six provider trusts in examining the best way to provide the whole continuum of care to people on the stroke pathway. One component of the review is to determine which trusts should provide the immediate interventions in Hyper Acute Stroke Units (HASU). Depending on the outcome of this review there may be significant implications for both patient flows and capacity required at different trusts.

Specialised services review: this is a national review being undertaken by NHS England and the timescales are not yet fixed. The basic driver of the review has been to achieve a range of benefits from greater concentration of these specialised services. Royal Wolverhampton NHS Trust provides specialised services therefore could be significantly affected by the outcome of the review.

15 % reduction in emergency activity: nationally there has been a drive to support integrated care outside of hospital s to help prevent patients having crises which lead to attendance at A&E and admission to hospital on an emergency basis, as well as promoting a timely return to the community as soon as an acute episode of care is completed. The 15% reduction in emergency activity is therefore a national norm which underpins the scale of resources which is expected to be invested in alternative services. Over time therefore the hospital sector will restructure its provision and costs to reflect lower levels of emergency activity.

Seven day working: there are major benefits to the whole health and social care system operating on a seven-day basis. Within the acute sector there are safety and quality gains to be made however the costs incurred in providing different services on a seven-day basis requires Trusts to restructure their services to ensure that they are clinically and financially sustainable in the long term.

All health and social care economies are considering these factors in the strategic planning. The scale of the implications goes beyond Wolverhampton and we are particularly affected by potential service reconfiguration in neighbouring areas. We will be active in making links with different decision-making groups but in particular the following are important:

- CCG Accountable Officers group in the Black Country
- CEO forum for the Unit of Planning in Birmingham, Black Country
- the West Midlands clinical Senate and Strategic Clinical Networks
- all relevant local clinical Senates

The potential strategic service changes, many of which are linked to the main driver is described above, may have implications locally:

- the dissolution of Mid Staffordshire Hospitals Foundation Trust, and the development of elective services at Cannock Hospital under the management of Royal Wolverhampton hospitals NHS trust
- Future Fit plans for the restructuring of the acute hospital and community hospitals provision in Shropshire and Telford; depending on the outcome for services in Telford, there may be implications for patient flows between the Black Country and Telford
- across the Black Country, Birmingham and Solihull, the Stroke services review, the Keogh review on urgent and emergency care, and specialised services, require a mechanism for coordinating planning.

It has to be recognised that if the outcome of these different reviews, and work streams leads to the planning of significant service change, there will need to be appropriate levels of engagement with patients and public ultimately leading to public consultation. The geographical areas covered by such public consultation, will need to be determined as part of the planning process given that this may be much wider, than Wolverhampton; it is the case however that the CCG would play a key role in the engagement and consultation on behalf of its population.

4.11.5 Market management

The provider market within the Primary, Integrated, Urgent and Hospital models of care are relatively rigid, characterised by large single providers in respect of integrated, urgent and hospital based care in mental health and acute care, and small, isolated providers within a rigidly controlled market in the case of primary care. It is likely that primary care will need to be able to develop economies of scale within the context of a federated approach to service delivery in order to respond to the challenge of increasing demand. In respect of hospital, urgent and integrated care there are both advantages and disadvantages in relation to the current configuration of providers which the CCG will need to resolve through the development of an effective market plan within each of these models of care in order to effectively address demand and the needs of the population.

As part of the delivery of this plan, the CCG will implement a process for analysing in detail our provider markets within each of the 6 models of care. The output of that analysis will then inform a market strategy and development plan that supports the delivery of our strategic objectives.

In order to deliver our strategic objectives we will need to develop the right mix of providers, market conditions and management plans in order to ensure that care is integrated, of sufficient capacity, of the highest quality and delivered in the most effective and efficient way. It is likely that this will require investment in the development and capacity of providers, the involvement of new entrants into healthcare markets and the greater involvement of the voluntary and third sector organisations. We will also need to ensure that we performance manage our existing contracts in order to maximise the quality and value that is delivered by those providers. We will need to undertake this work in close collaboration with the local authority, particularly in relation to the Better Care Fund and in such a ways to ensure that care remains co-ordinated and integrated. In 5 years we aim to have developed a health market whereby the appropriate levels of competition, choice and performance management are deployed in order to maximise care outside of hospital, ensure that the experience of care is positive, integrated and co-ordinated and that we ensure that maximum value and quality is gained from our commissioning budgets.

During 2014/15, a detailed market assessment will be undertaken to inform the development of a market plan, which will set out the detailed plans for 2015 onwards.

4.11.6 Contracting and procurement

It is nationally stipulated that the NHS Standard Contract must be used by CCGs for all their clinical services contracts, it is through the use of NHS Standard Contract a key lever for commissioners to secure improvements in the quality and cost-effectiveness of the clinical services they commission.

The fundamental aim of for 2014/15 has been to create greater flexibility for commissioners to vary, by local agreement, national rules which were sometimes seen as obstacles to major service redesign and improvement. So, for 2014/15, the CCG has greater flexibility to:

- determine the duration of the contract they wish to offer, within the framework of national guidelines and regulations on procurement, choice and competition, with the option of longer contract terms than previously;
- move away, by agreement with providers, from rigid national prices, using the Local Variation flexibility set out in the National Tariff guidance, potentially developing different payment models based more on quality and outcomes and less on activity; and
- utilise innovative contracting models such as the prime provider approach

Together, these new flexibilities should enable the CCG to be equipped with the tools to employ longer-term, transformational, outcomes-based commissioning approaches.

This in conjunction with the principles for Cooperation and Competition offer a variety of procurement options which ensure fair and transparent cooperation and competition to obtain best value for money, encourage innovation and promote patient choice

4.11.7 Primary care investment scheme

The Primary care investment scheme is a scheme for investment in GP provider services in order to facilitate development within primary care providers in Wolverhampton, working in conjunction with the Avoiding unplanned admissions enhanced service, and supporting the delivery of the objectives stated within The Mandate. This will:

- Enable personalised care planning for patients that have a long term condition that is not already provided through QOF or an Enhanced Service
- The facilitation of practice development in relation to the management of patients with a long term condition.
- Enable locality engagement to recommend how the population can be efficiently and effectively targeted
- Enable Locality Management to develop business plans in order to facilitate:
    - Ownership and delivery of QIPP
    - Delivery of reduction in unplanned admissions.

In the longer term we will evolve the scheme from a disease modification to a risk modification focus in order to support our approach to tackling health inequalities, ill-health prevention and improving health outcomes.

There will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and

will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:

- Improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission
- Ensure that other clinicians and providers (eg A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions
- Carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management
- Provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator
- work with hospitals to review and improve discharge processes
- undertake internal reviews of unplanned admissions/readmissions.

4.11.8 Clinical Research Network

Following the reorganisation of Topic specific and Comprehensive Local Research Networks across England, from 1st April 2014 Royal Wolverhampton NHS Trust (RWT) became host to the Clinical Research Network: West Midlands. This provides an excellent opportunity for Wolverhampton CCG and primary care to ensure clinical research becomes embedded as a standard treatment option.

As Commissioners we will ensure organisations are active in delivering National Institute for Health Research (NIHR) trials, supporting translation into practice, designing patient pathways and working with primary care where appropriate. We will support the CRN: WM promoting research and harnessing enthusiasm in the community through encouraging engagement with member practices and the Research teams at neighbouring Trusts. Within the next two years we will look to expand the number of research-active GPs and increase the number of patients actively recruited into trials; our patients should be offered the opportunity to be part of research. We will be actively engaged with the CRN: primary care speciality and will support the national 'Ok to Ask' campaign so that our citizens are able to choose to take part in research. Within 3-5 years we would expect to see clinical research offered in primary care as a standard treatment option.

5. Governance: how all partners will ensure this happens

All partners have participated in the process of debating the major issues encapsulated in the Five Year Strategic Plan for the Wolverhampton health and social care economy. There is sign up to the vision, values/principles, and the work programmes which have to be implemented to achieve our objectives. The dialogue concerning the development of the Strategic Plan has occurred within the formal structures of the main providers as well as the Health and Wellbeing Board as initiated by development of the BCF. The formal sign off of the Strategic Plan is scheduled for July when there will be a formal board to board between the Royal Wolverhampton NHS Trust and the CCG, and final approval will be sought from the Health and Wellbeing Board. It is acknowledged that further work is required on the Strategic plan, including taking into account the feedback from NHS England planned for 14 July, therefore further iterations of the plan, will be submitted for approval.

The existing accountability structure for the BCF is being used for the oversight of the Strategic Plan.

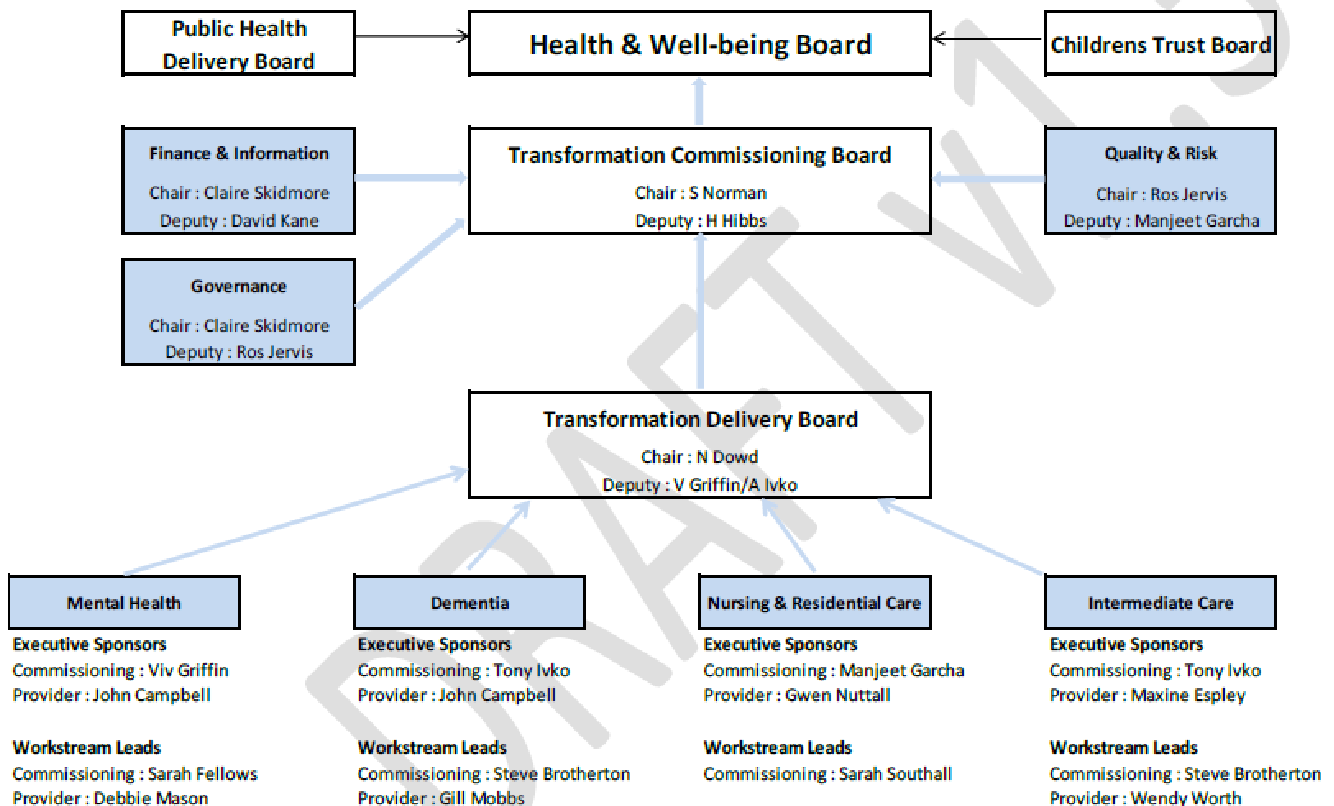


Figure 10: BCF Proposed Reporting Structure

This governance structure is in place to ensure partners sustain their commitment to the Strategic Plan and ensure delivery. The health and well being governance structure will provide system oversight of the plan and the CCG delivery board structure is clinically driven and designed so that clinical expertise and decision-making can be combined with the rigour of Programme Management using a commissioning cycle approach to the improved health outcome for the Wolverhampton CCG population.

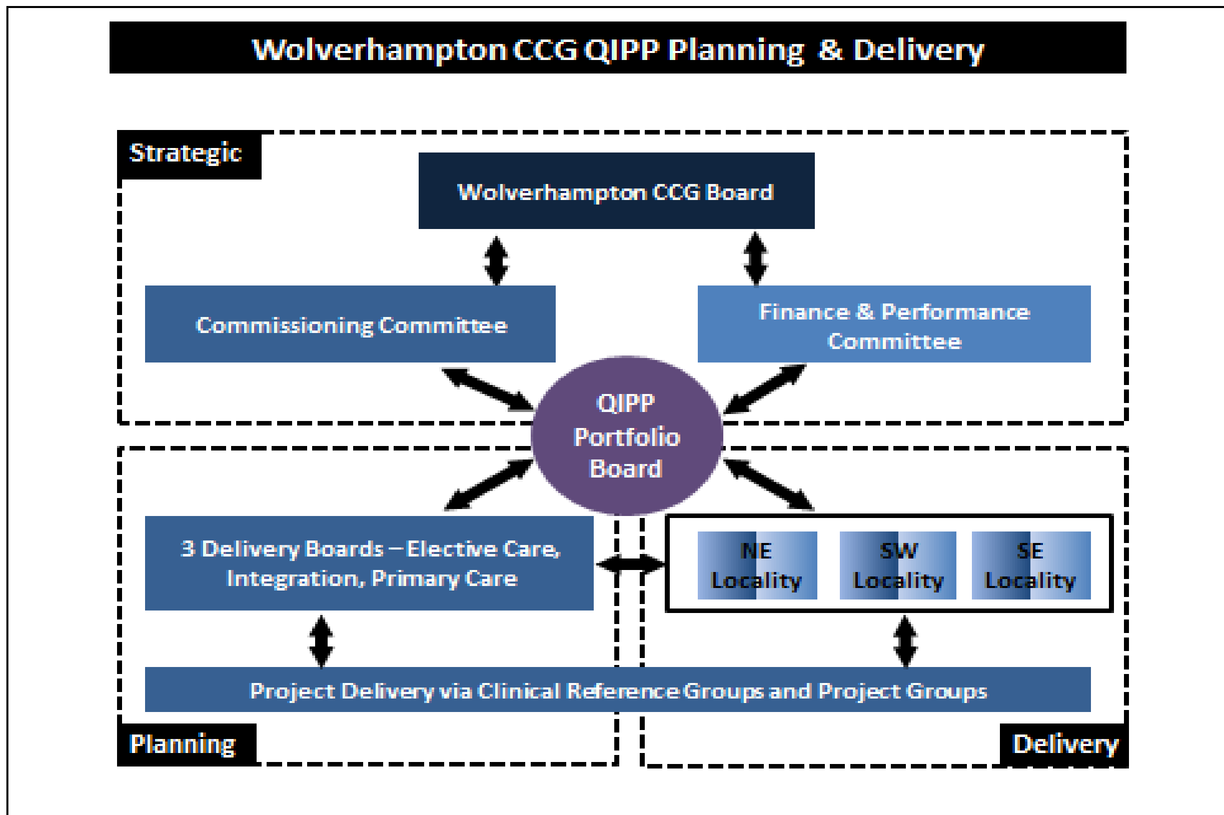


Figure 11: Planning and Business Delivery Structure

Note: Elective Care delivery board above is now the Modernisation and Medicine Optimisation Delivery Board

Local ownership and accountability

The Business Planning Framework is informed by and developed within the context of the CCG's Strategic Plan. The Strategic Plan identifies how the organisation intends to shape the commissioning and provision of health care for the Wolverhampton population over the next 5 years in order to improve health outcome.

The role of the CCG localities within this planning and delivery framework is two-fold. Firstly, localities are required to work with Delivery Boards to design service transformation, integration and quality improvement strategies and plans. Secondly, localities will have delegated responsibility for delivering QIPP benefits for the segment of the Wolverhampton population for which they are responsible. This will involve an operational business planning process whereby individual localities will agree the most appropriate way (for its constituent practices), to deliver against QIPP benefits targets which contribute to improved health outcome.

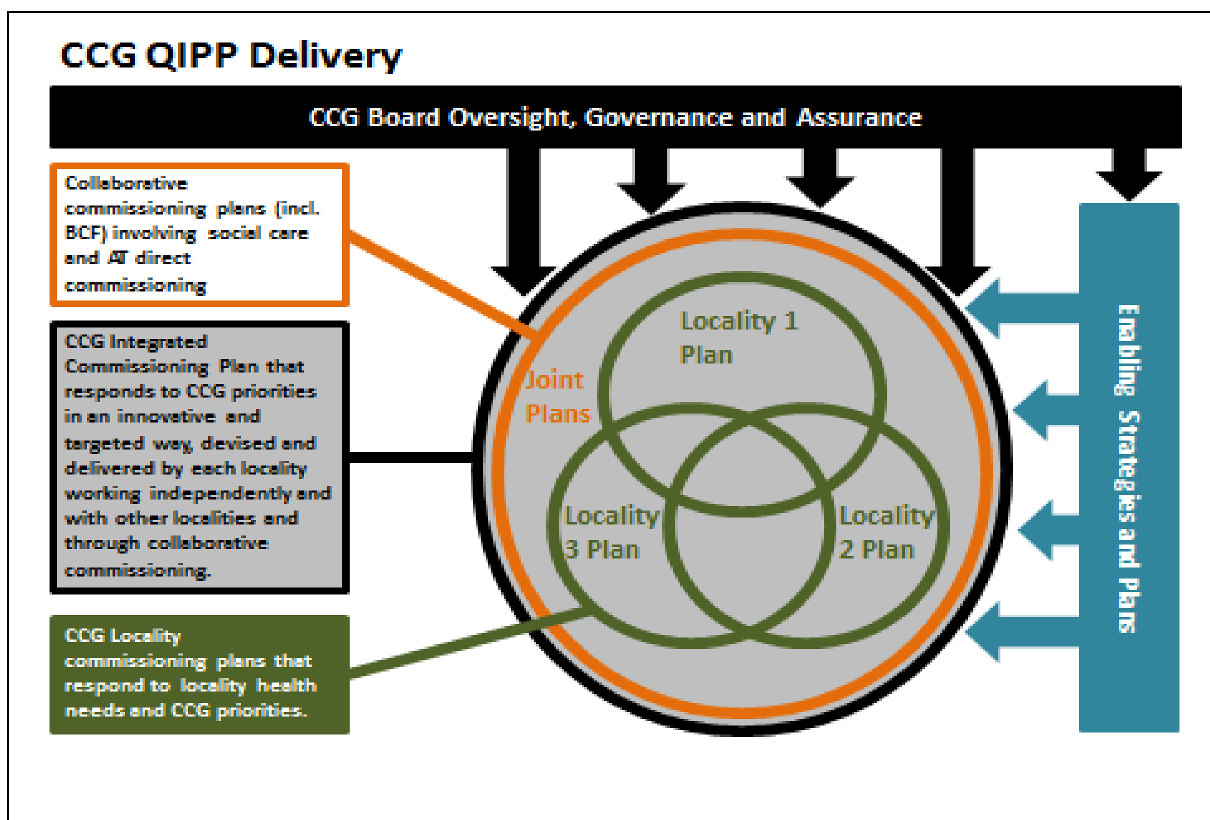


Figure 12: Integrated Planning and Delivery

Commissioning Committee

The delivery of the CCG's Commissioning Strategy plan is overseen by the Commissioning Committee which has a strategic, governance and assurance remit and is composed of the senior managerial and clinical leadership of the CCG. The Commissioning Committee is a decision-making body which is supported by the CCG's programme management structure. It will oversee the development of the CCG Strategic Plan, ensure all commission plans – Operating Plan, Locality plans and Better Care Fund plans - are aligned to the strategic objectives of the CCG.

The Finance & Performance Committee (FPC)

The FPC is accountable to the governing body and its remit is to provide the governing body with assurance on issues related to the finances and the achievement of performance objectives and targets.

QIPP Portfolio Board

The role of the QIPP Portfolio Board is to oversee and co-ordinate the activities of the Delivery Boards in order to maximise impact through integrated working. The QIPP Portfolio Board is chiefly concerned with how the benefits and outcomes for each of the Delivery Boards are to be achieved over time and in a co-ordinated way.

Delivery Boards

Delivery Boards are the key mechanism for clinical discussion and agreement regarding the delivery of effective and efficient care which improves health outcomes across the local health community. They are key engagement mechanisms for local stakeholders, clinical or otherwise and are chiefly concerned with how the benefits and outcomes for their portfolios are to be achieved, and will act as the key decision-making bodies for their sector of care. They will include primary and secondary care clinicians in agreeing optimum means by which improvement in health outcomes can be met. The Delivery Boards are chiefly concerned with the development and evaluation of strategies and plans that are delivered through localities.

Locality Plans

Locality plans are the responsibility of each of the CCG constituent localities. The locality plan will be the key delivery mechanism for QIPP. It will identify how the locality intends to achieve QIPP benefits and contribute to the strategic objectives of the CCG and improve health outcomes for locality populations.

6. Next steps

We are clear about the major transformational programmes of work which are needed to achieve the vision and we will drive the implementation now.

There are areas of work which need further development:

Within Wolverhampton for the whole system planning including clarity of financial projections of income and expenditure across all of the partners is needed given the range of scenarios based on different assumptions (optimistic/pessimistic). This will inevitably lead to the reprofiling of investment in the 3 years 2016/17 to 2018/19.

The reshaping of the health and social care system which relies less on bedded care, means that there will be a reshaping of the hospital sector. As described in this plan, the reshaping of the hospital sector is to take into account the following:

- the Keogh review on urgent and emergency care
- NHS England's review of specialised services
- the outcome of the stroke review including the designation of hyper acute stroke units
- the impact of a 15% reduction in emergency activity
- seven day working
- improvements the productivity of elective care

This cannot be achieved within Wolverhampton alone therefore we will use the available collaborative structures to develop an agreed approach across our borders in the following way:

- the Black Country meeting of CCG Accountable Officers
- Linking with the leaders forum for the Unit of Planning covering Sandwell, Birmingham and Solihull.
- Continued dialogue with the Staffordshire CCGs and Royal Wolverhampton NHS Trust concerning both the development of Cannock hospital and the future patient flows into and out of Wolverhampton.

Although there is important work to be undertaken on the most intensive part of the health and social care system in terms of bedded care in the secondary and tertiary centre, our main focus will continue to be transforming services outside of hospital, based in the community with primary care transformation at its core. It is only by achieving this transformation that the whole of the health and social care system can provide and sustain, safe and high quality services, which improve people's experiences of services and produce the health outcomes our population deserves.

This page is intentionally left blank

Agenda Item No. **15(i)**

Health and Wellbeing Board

9th July 2014

Report title	Children's Trust Board progress report
Cabinet member with lead responsibility	Councillor Val Gibson Children and Families
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	Quality & Safeguarding
Accountable employee(s)	Emma Bennett — Assistant Director Tel — 01902 556101 Email — Emma.bennett@wolverhampton.gov.uk
Report to be/has been considered by	N/A

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Agree to the drafting of a protocol between the Health & Wellbeing Board and the Children's Trust Board in order to support an effective working relationship between the two.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. Recent activity at the Children's Trust Board.

1.0 Purpose

1.1 To keep members of the Health & Wellbeing Board informed of the work of the Children's Trust Board (CTB).

2.0 Background

2.1 The Children's Trust Board is a partnership of agencies from all sectors working together to ensure the alignment of strategic priorities for children and young people in the city. It currently meets on quarterly basis.

3.0 Present position

3.1 The Children's Trust Board most recently met on 18th June 2014.

3.2 A review of the Board took place earlier this year and a number of recommendations have been agreed by the Board, in order to ensure its work is relevant and focused. This includes a standing agenda item to consider learning from frontline practice, along with ensuring that children, young people and families remain a significant part of the agendas of other partnership Boards in the city.

3.3 In order to achieve this, the CTB has committed to putting in place protocol agreements with a number of Partnership Boards, to include the Health and Wellbeing Board. The Health and Wellbeing Board are accordingly asked to agree to the development of a protocol with the CTB.

3.4 At its meeting, the CTB received a paper to confirm its revised terms of reference, structure following the rationalisation of sub Boards and to identify named representatives for each organisation. In addition, a Partnership Agreement document was presented, to outline the vision, aims and objectives for the CT Board and the responsibility of Board members. Board members agreed the content of the partnership agreement and committed to signing the Partnership agreement document

3.5 A discussion about the development of a work programme for the CTB took place. The Board were asked to agree and approach to the development of a work programme, to ensure it was owned by all Board partners. The Board were in agreement that the Work Programme needed to align with the Children Young people and Families Plan and that the areas of difficulty in terms of the delivery of the Plan would need to be signposted from the Children's Trust Delivery Board. In this respect the work programme will need to continue to evolve when the CYP&F Plan is in place.

3.6 The need to ensure the voice of the child is at the centre of all the work of the Children's Trust Board was raised and it was agreed that this needs to be reflected in Work Programme.

3.7 An update on progress with the development of the Children, Young People and Families Plan 2014-2024 was received. Work is continuing to identify measures from a range of agencies which will be used to monitor the impact being made against the priorities and headline outcomes. This work is nearly complete. Targets for short, medium and long term are being set; stakeholders have found it challenging to set medium term (5 years) and long term (10 years) targets, so it has been agreed that these will be set once the plan is in place. This will ensure that the document is kept 'live' and will ensure its relevance throughout its lifetime.

3.8 The Board agreed to the proposed timescales for completion of the Children, Young People and Families Plan and will therefore receive the final document with the strategic framework and other associated documentation at its meeting on 24th September.

3.9 The CTB received an update report from the Families r First (FrF) programme, which is the programme to support children living safely within their families and as such reduce the need for children to become looked after and reduce the current numbers of Looked After Children in the city. The FrF multi-agency steering group will regularly report progress with the programme to the Children's Trust Board as part of the agreed governance arrangements.

3.10 A number of work streams are operational under the FrF programme within the framework of targeted intervention, early help support and a committed partnership with all agencies. There is a multi-agency steering group in place to support the programme.

3.11 A summit event to raise awareness of the challenges faced by services took place in May and this will be followed up with an event on 25 June to develop a charter. The Board agreed to the governance arrangements for the programme and requested to receive a more detailed report about what exactly their role will need to be at their meeting in September.

3.12 An information item to provide the Board with an update on preparation for the Ofsted inspection of services for children in need of help and protection, children looked after and care leavers was submitted. This included a briefing note with an update on changes to the inspection framework, along with an overview of the response to the Ofsted Thematic Inspection in relation to Neglect, which took place last June. This has included revisions to the Neglect Strategy. The role of partners in the inspection was highlighted in regard to the multi- agency audit and also with Ofsted speaking to all agencies which have been involved in cases.

4.0 Financial implications

4.1 There are no direct financial implications to this report.

[JF/27062014/Q]

5.0 Legal implications

5.1 There are no direct legal implications to this report.

[TS/19062014/K]

6.0 Equalities implications

6.1 There are no direct equalities implications to this report, as it is an update on progress at the Children's Trust Board, rather than referencing specific programmes of work in relation to the delivery of Children's Services.

7.0 Environmental implications

7.1 There are no direct environmental implications to this report.

8.0 Human resources implications

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

9.0 Corporate landlord implications

9.1 There are no Corporate Landlord implications to this report

10.0 Schedule of background papers

10.1 None

Agenda Item No. **15(ii)**

Health and Wellbeing Board

9 July 2014

Report title	Adult Delivery Board – Progress Report	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service		
Accountable employee(s)	Vivienne Griffin Tel Email	Assistant Director 01902 555370 Vivienne.griffin@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The feedback received against the Wolverhampton Better Care Fund submission and the subsequent engagement of NHS IQ to support the further development of work streams; and

2. The development of the Reablement Intermediate Care Forward Plan and Adult Mental Health Strategy.

1.0 Purpose

1.1 To keep members of the Health and Wellbeing Board informed of the work of the Adult Delivery Board in regard to the Board's work plan for 2013/14.

2.0 Background

2.1 The Board received updates on the progression of the Better Care Fund (BCF) and the Reablement Intermediate Care Forward Plan.

It also received a presentation from Wolverhampton Clinical Commissioning Group (WCCG) on the Local Health Economy (LHE) Sustainability Plan and Operating Plan.

The Board also considered the key findings from the Adult Mental Health Strategy Review conducted by Rubicon Consulting, which would help inform the new Mental Health Strategy.

Board Members were also made aware of the preparations pertaining to the forthcoming unannounced OFSTED inspection of Children's Services and its likely impact on partner agencies. Particular attention was also drawn to the findings of the recent thematic OFSTED inspection on 'Neglect' and the need for more effective working across adults and children's partner organisations when assessing and agreeing plans for children experiencing neglect.

The Board was also presented with a set of proposals outlining future governance arrangements to support the delivery of the Better Care Fund Plan moving forward; these would impact on the way the Adult Delivery Board currently operated and its membership.

3.0 Progress, options, discussion, etc.

3.1 Wolverhampton Better Care Fund Plan (BCF)

The BCF proposals had now been submitted to NHS England and an overall rating of 'amber' had been awarded to Wolverhampton's BCF submission however; no clarification had been provided on the criteria used to establish this rating. The Board were informed that NHS IQ had been commissioned to support the further development of the BCF proposals and will be offering practical support and training to workstream leads; all of whom had been asked to do a sufficiency check by revisiting their initial metrics and finances to ensure the BCF proposals remain deliverable.

3.2 Local Health Economy (LHE) and Operating Plan

The Board received a presentation on the LHE Sustainability Plan and WCCG Operating Plan, outlining the key objectives and new governance arrangements for delivering the 7 key ambitions of the Operating Plan. It was reported that WCCG would be using data

analysis to evaluate the impact of last year's schemes and measure the effectiveness of care planning. Moving forward, it would be looking to set up a Practice Improvement Team who will work alongside General Practitioners (GPs) to review effectiveness of plans and quality assure work through audits, peer reviews and service user feedback via patients from GP Practices.

The governance structure underpinning the Operating Plan will be supported by locality based structures to tackle any inequalities; these will include representation from General Practitioners, Practice Managers, Governing Body members covering the North East, South East and South West of the City.

3.3 Reablement Intermediate Care Forward Plan

The Board noted that the refreshed Forward Plan was currently progressing through Cabinet and would be presented to the Health & Well Being Board in July 2014 following sign off by all partner organisations. The refreshed Forward Plan would then be officially launched in August 2014.

3.4 Mental Health Stock-take

The Board received an overview of the key findings, implications and recommendations arising from the Adult Mental Health Strategy Review conducted by Rubicon Consulting on the following areas:-

- The referral and Assessment Service (RAS)
- Changes to inpatient services
- Medical staff resourcing across the system
- The secondary care / primary care interface
- The Section 75 Agreement
- The Healthy Minds and Wellbeing Service
- Cross cutting themes

Rubicon Consulting have provided a series of recommendations for each of the above areas described as 'do now', 'do soon' and 'do later'; these will help inform the structure and content of the new Mental Health Strategy.

The Board approved the next key steps detailed within the report and agreed that the draft Mental Health Strategy be presented to the next Board meeting in September 2014.

3.5 Future Governance Arrangements

The Board considered proposals outlining future governance arrangements to support the delivery of the BCF Plan moving forward which involved the following:

- changing the name of the Adult Delivery Board to the 'Transformation Commissioning Board' with revised Terms of Reference and membership; and

- establishing a 'Transformation Delivery Board' for the purposes of setting the commissioning agenda for the BCF Plan and overseeing implementation.

Whilst the Board supported the development of the Transformation Delivery Board, in principle, it was agreed that further work needed to be undertaken to establish the membership of partner organisations who currently served on the Adult Delivery Board. An update on these considerations would be presented to the next Board meeting in September 2014.

4.0 Financial implications

4.1 There are no direct financial implications to this report, at this stage. [AS/23062014/F]

5.0 Legal implications

5.1 There are no direct legal implications to this report, at this stage. [RB/20062014/J]

6.0 Equalities implications

6.1 There are no direct equalities implications to this report, at this stage. Any reference to savings has been subject to individual equality impact assessments completed by the respective service areas.

7.0 Environmental implications

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

8.0 Human resources implications

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

9.0 Corporate landlord implications

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

10.0 Schedule of background papers

10.1 None

Agenda Item No. **15(iii)**

Health and Wellbeing Board
9 July 2014

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

---

Recommendation(s) for action or decision:

That the Health and Wellbeing Board (HWBB) notes the newly agreed key work streams of the Public Health Delivery Board (PHDB) which will form the Boards work programme for 2014/15.

1.0 Purpose

1.1 To inform the HWBB of the new work streams of the PHDB, as agreed through the Business Planning Cycle and matters arising from its meeting of 10 June 2014.

2.0 Background

2.1 A key focus of the June meeting was to present the public health business plan for 2014/15 and seek approval of the seven priorities and work streams for the PHDB for the forthcoming year.

2.1.1 The seven priority areas identified on which the Public Health business plan is based are:

- Effective commissioning
- Effective process
- Integrating the 'Healthier place' team into Public Health to support work across the wider determinants of health
- Obesity
- Healthcare advice
- Smoking
- Health Protection/Emergency Preparedness, Resilience & Response (EPRR)

Sexual Health, Drugs and Alcohol and Mental Wellbeing remain key public health services but these will be enshrined in core public health services rather than requiring dedicated work streams during 2014/15. The approved business plans can be found in Appendix A.

2.1.2 Sarah Norman, Director of Community, has approved the business plan and further work will now take place to build a portfolio of project plans to deliver these priorities with specific, measurable, achievable, realistic and timely processes.

3.0 Joint Health and Wellbeing Strategy

3.1 The wider determinants priority of the Joint Health and Wellbeing Strategy was the subject of an update paper presented to the Board at its last meeting. This highlighted that a key strand of this work is the focus on obesity which is the theme of the Annual Report of the Director of Public Health 2013/14 and represents a ‘call to action’ for all partners to address this area of local concern. This report was discussed in some detail at the Public Health Delivery Board June meeting and is the subject of a separate agenda item for presentation to this Health and Wellbeing Board meeting.

4.0 Partnership and wider links – Social Inclusion Model

4.1 Keren Jones, Assistant Director Partnerships Economy and Culture, presented a report identifying the biggest challenges to delivering the City's economic and social objectives, and the Council's own Corporate Plan objectives is to achieve both economic and social inclusion. Priorities include:

- Supporting more people into the world of work,
- Supporting financial and digital inclusion.
- Encouraging healthier lifestyles and independence at all stages of life
- Supporting more people to be active within their communities

4.1.1 To deliver on these priorities the Council works at a number of levels:

- Partnerships at the Black Country level
- Partnerships at the City level

4.1.2 The council have a new Neighbourhood Services Team which is to be renamed as the Community Enterprise Service is being transformed into to a smaller more agile team focused on co-ordinating grass roots economic inclusion and community enterprise activities across the Council, working closely with the voluntary and community sector and other local partners.

5.0 The Public Health Delivery Board Work Programme (final update)

5.1 The PHDB agreed that its key work streams for 2014/15 would mirror the Public Health Business Plan for 2014/15.

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

5.3 **Transformation Work Stream**

5.3.1 The panel overseeing the Transformation Fund working with Councillor Samuels as Chair of the Health & wellbeing Board have together selected a total of nine projects for funding. A full report of all projects supported through this fund was presented to the Public Health Delivery Board. The complete list can be found at appendix B.

5.4 **Health Protection Work Stream**

5.4.1 A verbal update was received as all key items were very recent and as a result missed the report cycle.

5.4.2 A public health incident involving needlestick injury at Moreton Community School generated a significant amount of media interest, locally, regionally and nationally. The incident was dealt with effectively with good multi-agency working, and the incident management team have a further meeting planned to ensure all actions have been completed.

5.4.3 Wolverhampton Public Health gave a presentation to the Local Health Resilience Partnership (LHRP) on the progress made within Walsall and Wolverhampton in relation

to public health emergency planning and resilience. This included sharing the recent development of contractual assurance with the main providers, through an agreed service specification. This work was received very positively, and is seen as a model that could be developed in other areas across the LHRP footprint.

5.4.4 Wolverhampton Public Health presented a draft Concept of Operations (CONOPS) for managing public health incidents at its Health Protection Forum. After thorough discussion subject to a few amendments the CONOPS was agreed.

5.5 **Sexual Health Review**

5.5.1 The sexual Health review highlighted that local sexual health delivery has grown organically with additional changes and responses being "bolted on". The national specification states that CASH and GUM should be available together at one site. The current service does not have an integrated specification therefore service delivery has been disparate, lacking co-ordination and data highlights that overall sexual health outcomes in Wolverhampton are poor compared to both regional and national averages.

5.5.2 Sexual Health contracts expire in April 2016, so it makes sense to start the commissioning processes in order that services are ready to deliver a new model of integration from April 2016.

5.5.3 Retaining the status quo is not an option because the Council is bound by a number of regulations, not least its own Constitution and EU Procurement Laws. The principles of these ensure that we are seen to be open fair and transparent in all contracts we let. It is advised that we test the market (tender) in order to demonstrate this, particularly given that is well above the EU procurement financial threshold.

5.5.4 Public Health delivery Board agreed and approved that a locally determined, integrated sexual health model is developed led by Public Health and developed in partnership with key stakeholders. The impact of this piece of work will require that the new service model is competitively tendered.

6.0 Additional Papers

6.1 Research Governance

6.1.1 A report to inform the Board of proposals to deliver Research Governance (RG) for the Council and support a Research and Development (R&D) culture within Public Health, the Council and the wider research community was presented. This will be managed through the Public Health Intelligence and Evidence Service area with clear lines of communication with the Office of the Chief Executive.

6.1.2 A proposal for the Research Governance process via a web-based system is to include:

- Flow chart of process
- Standards, including response times
- Check list for researchers to complete

Research & development opportunities both internally and external to the Council were discussed.

7.0 Financial implications

7.1 This report has no direct financial implications. Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2014/15 is £19.3 million. The work streams set out in this report will be funded from this allocation.

[DK/26062014/P]

8.0 Legal implications

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

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

[KR/27062014/C]

9.0 Equalities implications

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

10.0 Environmental implications

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

11.0 Human resources implications

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

12.0 Corporate landlord implications

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

13.0 Schedule of background papers

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

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

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

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

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

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

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

Health & Wellbeing Board 7 May 2014 Public Health Delivery Board – Progress Report

COMMUNITY DIRECTORATE - EMPOWERING PEOPLE AND COMMUNITIES

2014/15 BUSINESS PLAN (Public Health 1)

OUR AIM:

Enabling all communities, families and individuals to thrive. Closing the gap in social, health and educational outcomes for disadvantaged children and adults

Service Delivery Activities: Effective Commissioning

Activity:	Performance Measures:	Targets:
• Develop Public Health strategic commissioning plan in line with the Public health Outcomes Framework and Local Priorities.	• 100% of milestones against development and production of plan achieved.	• Commissioning Plan completed by December 2014
• Identify joint commissioning priorities with the Local Authority and CCG. To include Children's Public Health, 0-5 years, health visiting function transfer from NHS England.		• Contract reviews and tender preparation complete by March 2015
• Define clear healthy lifestyles outcomes fro Wolverhampton incorporating our obesity call to action and reducing harm from smoking and smoking related activities.		
• Prioritise contracts requiring retender and review during 2014-15 and develop and implement the frameworks in order to undertake these programmes.		
• Contract management process established against all specifications/minimum data sets/targets and outcomes in place.		

Transformation Activities Including The Delivery Of Savings:

Activity:	Outcomes:	Milestones:
• Review and develop PH contracts procurement plan for application of efficiency savings.	• An identified PH allocation available for re profiling in 2015-16.	• Proposals for projected allocation agreed by Public Health Budget Development Group May 2014.

Our Purpose:

We are passionate about delivering great services and making life better for all. This is underpinned by a strong sense of public service, which guides all we do and how we are expected to behave.

'Serving Wolverhampton, Securing Prosperity, Delivering Value'

COMMUNITY DIRECTORATE - EMPOWERING PEOPLE AND COMMUNITIES	2014/15 BUSINESS PLAN (Public Health 2)

OUR AIM:

Enabling all communities, families and individuals to thrive. Closing the gap in social, health and educational outcomes for disadvantaged children and adults

Service Delivery Activities: Process

Activity:	Performance Measures:	Targets:
• To provide a robust Governance framework to support Public Health functions.	• A Governance Framework is agreed by September 2014.	• 100% of all components of the Governance processes in place with agreed audit criteria by March 2015.
• Establish Public Health Communications Plan that addresses internal and external communication needs.	• The Public Health Communications Plan is agreed and established by September 2014.	• 100% of the communication needs identified in the plan are delivered by March 2015.
• A comprehensive Public Health Workforce Development Plan is in place to ensure effective delivery of Public Health function.	• All eligible Public Health staff will have a work plan by June 2014.	• 100% of all eligible staff will have an induction, appraisal and personal development plan by March 2015.
• Establish a quality audit programme to maintain and improve the quality of commissioned services.	• A Quality Assurance process has been identified for all commissioned services by December 2014.	• 100% of all commissioned services to have an audit programme by March 2015.
• To provide a comprehensive research governance service across the Council that ensures all research is robust and of high quality.	• A research governance framework is established by September 2014.	• 95% of all research governance requests are responded to within the agreed timescale.

Transformation Activities Including The Delivery Of Savings:

Activity:	Outcomes:	Milestones:

Our Purpose:

We are passionate about delivering great services and making life better for all. This is underpinned by a strong sense of public service, which guides all we do and how we are expected to behave.

'Serving Wolverhampton, Securing Prosperity, Delivering Value'

COMMUNITY DIRECTORATE - EMPOWERING PEOPLE AND COMMUNITIES	2014/15 BUSINESS PLAN (Public Health 3)

OUR AIM:

Enabling all communities, families and individuals to thrive.
Closing the gap in social, health and educational outcomes for disadvantaged children and adults

Service Delivery Activities: Integrating the Healthier Place Team into Public Health/Wider Determinants

Activity:	Performance Measures:	Targets:
• Implement restructure for Healthier Places Team following transfer and disaggregation of budgets for Sports Development / Healthier Schools / and Parks (Development) and Countryside.	• Creation of project plan, structure and work programmes for individual teams.	• Project plan to be developed by May 2014. • New Structure to go live by end of September 2014.
• Complete Asset mapping profile for the City to include physical and non-physical assets and develop an electronic database.	• Production of database.	• Database to be established by October 2014.
• Refresh the Sport Development and Investment Strategy.	• Refresh of document.	• Document to be politically endorsed by November 2014.
•		
•		

Transformation Activities Including The Delivery Of Savings:

Activity:	Outcomes:	Milestones:
• Implement Savings Proposal for Parks (Development) and Countryside Service.	• Achievement of £280k over a four year period.	• Submission of checkpoint returns on a monthly basis.
• Contribute towards review of Healthy Lifestyles commissioned contracts and development of a savings programme.	• Achievement of significant savings circa £200k for savings programme for 2015-16.	• Establishment of project group. • Production of project plan.

Our Purpose:

We are passionate about delivering great services and making life better for all. This is underpinned by a strong sense of public service, which guides all we do and how we are expected to behave.

'Serving Wolverhampton, Securing Prosperity, Delivering Value'

COMMUNITY DIRECTORATE - EMPOWERING PEOPLE AND COMMUNITIES	2014/15 BUSINESS PLAN (Public Health 4)

Wolverhampton City Council

OUR AIM:

Enabling all communities, families and individuals to thrive. Closing the gap in social, health and educational outcomes for disadvantaged children and adults

Service Delivery Activities: Obesity

Activity:	Performance Measures:	Targets:
• To produce an Annual Report of the Director of Public Health for 2013-14 on the health of the population in Wolverhampton.	• A report produced which focusses on a 'call to action' to kick-start Wolverhampton wide action on the important health issue of obesity.	• Completed by end May 2014.
• To follow up the Annual Report with a whole health economy Summit to agree a Wolverhampton wide approach.	• Summit organised and held. • Action plan agreed by the Health and Wellbeing Board.	• Completed by end of October 2014. • Action plan agreed by December 2014.

Transformation Activities Including The Delivery Of Savings:

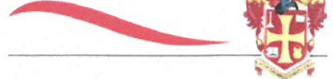
Activity:	Outcomes:	Milestones:

Our Purpose:

We are passionate about delivering great services and making life better for all. This is underpinned by a strong sense of public service, which guides all we do and how we are expected to behave.

'Serving Wolverhampton, Securing Prosperity, Delivering Value'

Wolverhampton City Council



COMMUNITY DIRECTORATE - EMPOWERING PEOPLE AND COMMUNITIES	2014/15 BUSINESS PLAN (Public Health 5)

OUR AIM:

Enabling all communities, families and individuals to thrive.
Closing the gap in social, health and educational outcomes for disadvantaged children and adults

Service Delivery Activities: Healthcare Advice

Activity:	Performance Measures:	Targets:
• Agreement and delivery of the Core Offer Work Plan with a focus on infant mortality and child health and wellbeing.	• Work plan agreed and completed.	• 100% of the Core offer is delivered by March 2015.
• Development of a prevention strategy for Wolverhampton to support the reduction in long term conditions.	• Prevention strategy output informs Primary Care and Public Health commissioning.	• 100% of the Prevention Strategy is completed by December 2014.
• Work with Wolverhampton Clinical Commissioning Group and Central Midlands Commissioning Support Unit apply a risk stratification tool to the local population.	• A valid risk stratification tool is agreed and the process for implementation finalised by August 2014.	• 50% of the population has been included in the risk stratification process by December 2014.
• Establish a Public Health pharmacy work stream to include the production of the pharmaceutical needs assessment.	• Work plan agreed by October 2014.	• 100% of the pharmacy work plan is completed by March 2015.

Transformation Activities Including The Delivery Of Savings:

Activity:	Outcomes:	Milestones:

Our Purpose:

We are passionate about delivering great services and making life better for all. This is underpinned by a strong sense of public service, which guides all we do and how we are expected to behave.

'Serving Wolverhampton, Securing Prosperity, Delivering Value'

COMMUNITY DIRECTORATE - EMPOWERING PEOPLE AND COMMUNITIES

2014/15 BUSINESS PLAN (Public Health 6)

OUR AIM:
Enabling all communities, families and individuals to thrive.
Closing the gap in social, health and educational outcomes for disadvantaged children and adults

Service Delivery Activities: Smoking

Activity:	Performance Measures:	Targets:
• Develop a plan for prevention in schools to increase tobacco control activities in schools.	• Education prevention plan evaluated and disseminated by July 2014.	• 100% of schools informed of education prevention.
• Develop a local Tobacco Control Strategy that includes E Cigs.	• Tobacco Control Strategy completed with partners.	• Tobacco Control Strategy completed and partners signed up by December 2014.
• Develop a strategy to reduce infant mortality.	• Multi-agency strategy to reduce infant mortality developed by September 2014.	• 100% of interventions commissioned to reduce infant mortality are evidence based and have robust evaluation plans.

Transformation Activities Including The Delivery Of Savings:

Activity:	Outcomes:	Milestones:

Our Purpose:
We are passionate about delivering great services and making life better for all. This is underpinned by a strong sense of public service, which guides all we do and how we are expected to behave.

'Serving Wolverhampton, Securing Prosperity, Delivering Value'

COMMUNITY DIRECTORATE - EMPOWERING PEOPLE AND COMMUNITIES	2014/15 BUSINESS PLAN (Public Health 7)

OUR AIM:

Enabling all communities, families and individuals to thrive. Closing the gap in social, health and educational outcomes for disadvantaged children and adults

Service Delivery Activities: Health Protection/EPRR

Activity:	Performance Measures:	Targets:
• Develop the Health Protection Forum Work Plan 2014-15.	• Work plan agreed within six months.	• 100% of the work plan delivered by March 2015.
• Develop robust Health Protection monitoring and surveillance systems.	• Monitoring and surveillance systems operational by June 2014.	• 100% of cases reported and recorded within the system.
• Establish Joint Clinical Commissioning Group/Public Health Emergency Planning Resilience and Response function (EPRR).	• Agreed function operational by September 2013.	• 100% recruitment to the EPRR function.
• Develop and integrate Public Health incident response into WCC Incident Plan and conurbation plans.	• Plans agreed by Health Protection Forum by October 2014.	• 100% of the Incident Plan established and fully operational by December 2014.

Transformation Activities Including The Delivery Of Savings:

Activity:	Outcomes:	Milestones:

Our Purpose:

We are passionate about delivering great services and making life better for all. This is underpinned by a strong sense of public service, which guides all we do and how we are expected to behave.

'Serving Wolverhampton, Securing Prosperity, Delivering Value'

This page is intentionally left blank

Round 1

title	council partner	other partner	names
Pathway Development Post	Community- joint commissioning MH	Black Country Partnership Foundation Trust	Viv Griffin (WCC) Qadar Zada BCPT
Inspire Wolverhampton (employment)	Education and Enterprise- skills	Uni W-ton The Workplace	James McElligott (WCC) Simon Brandwood (Uni)
Wellbeing and Community Support Hub	Community- joint commissioning MH communtiy services	WVSC, Rethink, ACCI, BME Consortium, Creative Support, +ve participation	Susan Eagle (WCC) Creative Support

Round 2

Community-based prevention: H&SC	Education and Enterprise	WVSC	Sheila Collett
Universal Services: Dementia Awareness and Information Pilot	Community- commissioning, older people	Uni of W-ton:	Steve Brotherton , Angela Clifford
Working with New Communities and professionals to reduce Health Inequalities	community- older people and personalisation	RMC and Lea Rd Church	Anthony Walker, Pam Gill
Enhanced Takeaway Nutrition	Education & Enterprise, Regeneration	Take away places plus potentially NHS Healthy Lifestyles	Oliver Wassall
Supporting Self-Reliant Communities	Community Recreation / Public Health	Community Associations	Richard Welch

Round 3

Wolverhampton Active Travel Strategy	Regen, Enterprise & Education	Centro; Wolverhampton Cycle Forum; Staffs, Stoke & Wolverhampton	Keith Rogers

Appendix B

topics	yr 1	yr 2
1/2 post for 12 months: clear referral criteria for AMH, SC, social inclusion, CAMHS, A&E	25000	0
employability of gradutes from W-ton Uni or elsewhere returning to W-ton	62500	25000
specialist services into generic hub for preventative and wellbeing services for MH clients *	107000	107000
* project may increase by £70,000 each year for city centre rent	70000	70000
Round 1 Total	264500	202000
Grass roots dev and provision of preventative H&SC activity	30000	30000
Pilot posters with smart phone tags for dementia	21527.5	
migrants needs, strategy and implementation of action	193741	193641
improving nutrition in takeaway foods	47145	47460
health outcomes in community hubs	90741	77996
Round 2 Total	383154.5	349097

Active travel in Wolverhampton	10000	20000
Round 3 Total	10000	20000
GRAND TOTAL	657654.5	571097