Health and Wellbeing Board

4 March 2015

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

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence (if any)**

2 **Notification of substitute members (if any)**

3 **Declarations of interest (if any)**

4 **Minutes of the previous meeting** (Pages 5 - 10)
[To approve the minutes of the previous meeting held on 7 January 2015 as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the meeting held on 7 January 2015]

6 **Summary of outstanding matters and Chair's update** (Pages 11 - 14)
[To consider and comment on the summary of outstanding matters and to receive remarks from the Chair]

7 **Health and Wellbeing Board Forward Plan 2014/15** (Pages 15 - 18)
[To consider and comment on the items listed on the Forward Plan]

8 **Obesity Call to Action - Update and progress made towards developing an action Plan to tackle obesity in Wolverhampton** (Pages 19 - 26)
[To receive an update on progress and to note the obesity summit, significant other initiatives and progress made towards developing the city wide action plan]
[Sue Wardle]

9 **Working Well Week**
[To receive a verbal update on the arrangements for Working Well Week to be held as part of the City Conference Season]
[Heather Ernston]

10 **Draft Infant Mortality Action Plan** (Pages 27 - 46)
[To consider an overview of the Infant Mortality action plan developed by the multi-agency infant mortality working group to address the high rate of infant mortality in Wolverhampton]
[Ros Jervis]

11 **Funding transfer from NHS England to Social Care 2014/15** (Pages 47 - 58)

[To consider the approval of allocation of the funding transfer from NHS England to Social Care 2014/15]

[Sarah Carter / Noreen Dowd / Viv Griffin]

12 **Joint Strategic Needs Assessment (JSNA) Qualitative Chapter: Patient Safety** (Pages 59 - 64)
[To receive a collated summary of patient safety derived from local assessment in response to the Francis Inquiry and the Safeguarding and Winterbourne View reports for Wolverhampton produced by Wolverhampton Clinical Commissioning Group and Wolverhampton Safeguarding Board respectively]

[Ros Jervis]

13 **Wolverhampton City Clinical Commissioning Group and Wolverhampton City Council Mental Health Strategy** (Pages 65 - 114)
[To receive a an update regarding the implementation of the Mental Health Strategy, including amendments made to address the needs and requirements of key vulnerable groups and associated key next steps]

[Sarah Fellows]

14 **Wolverhampton City Clinical Commissioning Group (WCCCG) - Decommissioning and Disinvestment Strategy** (Pages 115 - 144)
[To receive the WCCCG's Decommissioning and Disinvestment Strategy]

[Dr Helen Hibbs]

15 **Better Care Fund - Update** (Pages 145 - 158)
[To receive an update on the Better Care Fund]

[Sarah Carter]

16 **Feedback from Sub Groups** (Pages 159 - 186)
[To receive feedback from the following Sub Groups]

(i) Children's Trust Board (Emma Bennett)
(ii) Transformation Commissioning Group (Viv Griffin)
(iii) Public Health Delivery Board (Ros Jervis)

17 **Exclusion of the press and public**
[To pass the following resolution:

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

Part 2 – exempt items, closed to the press and public

18 **NHS Capital Programme**

[To receive a report on the present position]

Information relating to any individual. Para (1)

[Dr Kiran Patel]

Health and Wellbeing Board

Minutes - 7 January 2015

Attendance

Members of the Health and Wellbeing Board

Cllr Sandra Samuels (Chair)	Cabinet Member for Health and Wellbeing
Maxine Bygrave	Chair, Healthwatch Wolverhampton
Alan Coe	Independent Chair, Wolverhampton Children's Safeguarding Board
Cllr Steve Evans	Cabinet Member for Adult Services
Cllr Val Gibson	Cabinet Member for Children and Families
Dr Helen Hibbs	Chief Officer, Wolverhampton City Clinical Commissioning Group
Christine Irvine	Wolverhampton Voluntary Sector Council
Ros Jervis	Director of Public Health
Tim Johnson	Strategic Director, Education and Enterprise
Prof Linda Lang	University of Wolverhampton
Sarah Norman	Strategic Director, Community
Cllr Paul Singh	Shadow Cabinet Member for Health and Wellbeing

By invitation

Cllr Roger Lawrence	Leader of the Council

Council employees and representatives of partner organisations

Viv Griffin	Service Director - Disability and Mental Health
Maxine Bygrave	University of Wolverhampton
Sarah Carter	Programme Director - Better Care Fund, Wolverhampton Clinical Commissioning Group
Sarah Fellows	Mental Health Commissioning Manager
Alan Coe	Chair Wolverhampton Safeguarding Board

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence (if any)**
No apologies were received

2 **Notification of substitute members (if any)**
None

3 **Declarations of interest (if any)**
None

4 **Minutes of the previous meeting**

Resolved:

The minutes of the previous meeting (5 November 2014) were agreed as a correct record and signed by the Chair

5 **Matters arising**

It was noted that the quality chapter of the Joint Strategic Needs Assessment would be reported to the March meeting of the Board

6 **Chair's remarks (if any)**

The Chair reported that on12 December she had attended a meeting of the National Health and Well Being Board. Next week she would be attending the National Health Scrutiny meeting and would report the outcome to the next meeting.

7 **Summary of outstanding matters**

Resolved:

That the summary of outstanding matters be received and noted.

8 **Health and Wellbeing Board Forward Plan 2014/15**

The Forward Plan had been updated. The March meeting would receive reports on the Better Care fund, the Learning Disability Strategy and the infant mortality action plan.

There would be a need to plan the range of items that would be submitted to future meetings later in the year once dates had been agreed.

Resolved:

That the Forward Plan, as now updated, be received and noted.

9 **Wolverhampton Safeguarding Children's Board Annual Report 2013 - 14**

Alan Coe introduced the Safeguarding Children's Board Annual Report. He had just completed his first year as Chair of the Board. The annual report had attracted press coverage which indicated the high level of public interest in safeguarding issues.

There had been 20 changes to the membership of the Board during the year which reflected the widespread reorganisations. This had affected the ability of the Board to adopt a consistent approach to partnership working.

The Board had formal links to the Health and Wellbeing Board and other appropriate committees. The forward to the report outlined the main challenges facing the Board and in particular he drew attention to the funding of the Board and the inter relationship between the work of the Board and social care. He also spoke about the role of the Board in engaging with schools which at times could be difficult because they were often seen as remote and autonomous. However, work was ongoing to improve links with the schools.

Mr Coe sought assurance that all Health and Wellbeing Board members knew who their representatives on the Safeguarding Board were.

Dr Helen Hibbs noted that there was a need for more engagement with GPs regarding safeguarding issues. All GPs were required to have been trained to level 3

on safeguarding issues. A GP had been appointed with particular responsibility for safeguarding issues.

The level of engagement with the Be Safe initiative and with young people would be significant part of the forthcoming year. Young people were not currently as engaged with the Board as they could be but engagement was increasing.

The Be Safe initiative was engaging with vulnerable people. An intermediary was asking what impact safeguarding had on young people who had been the subject to safeguarding measures.

The Domestic Violence Health Adviser at Accident and Emergency at New Cross Hospital was an effective service. For 2014/15 the service was funded by the CCG and would be funded by the Hospital Trust after that.

Consideration was given to ensure all agencies represented at the Board had internal assurance mechanisms that could demonstrate their role and performance in relation to safeguarding arrangements for children and young people. The assurance mechanisms included the fact that the same agencies who attend the Safeguarding Board also attended the Health and Wellbeing Board.

It was noted that the Board was working with faith groups regarding safeguarding issues and looking to understand what help could be provided.

The profile of the board would be raised through greater use of social media.

Resolved:

That the report be noted.

10 **Health and Wellbeing Board - Governance arrangements including updated Terms of Reference and amendments to membership**

Consideration was given to a report on the governance arrangements for the Health and Wellbeing Board which included revised terms of reference and revisions to the membership of the Board.

It was noted that the CCG was reviewing its constitution which may result in changes to their representation on the Board. A GP would be elected to fulfil the role on behalf of the CCG.

The terms of reference of the Board had been amended to include specific reference to the Better Care Fund

It was noted that it would be for the Royal Wolverhampton NHS Trust to decide if their representative would be the Chair of the Trust or the Chair of the Trust Board

Resolved:

That the updated Terms of Reference and revised membership of the Health and Wellbeing Board be endorsed and implemented with effect from the

beginning of the 2015/16 Municipal Year subject to the approval of the Special Advisory Group, Standards Committee and Council.

11 **Mental Health Strategy/ Mental Health - Crisis Concordat**

A report was received which provided an update on the implementation of the Mental Health Strategy, including the key next steps. The Strategy included a number of key priorities and outlined the vision to develop integrated health and social care pathways care pathways as part of the Better Care Fund .

It was noted that the crisis concordat action plan needed to be submitted by end of March.

The aim of the Strategy was to improve clinical outcomes and to provide a focus on young people.

It was noted that some mental health and safeguarding placements were away from the city. Where this was the case and where mental health was and element in the placement there was a need to embed it into the care approach. The Board was informed that placements outside the city received robust case management. Work was underway to provide services within the city which would enable those placed outside the city to be brought back to area.

It was felt that the strategy needed specific reference to safeguarding and interaction with hard to reach groups. There was agreement that early intervention on mental health issues for children and young people was vital so they could access services.

Resolved:

1. That the development and implementation of the Mental Health Strategy, including submission of the Wolverhampton Crisis Concordat Declaration be noted
2. That a report be submitted to the next meeting of the Board with on how the strategy would include reference to safeguarding issues and engagement with hard to reach groups

12 **Implementation of Action Plans following the Francis Report - Update**

A report was received on the progress made to with recommendations of the Robert Francis QC report into the Mid Staffordshire Foundation NHS Trust. The appendix to the report detailed the work undertaken to date by the Wolverhampton City Clinical Commissioning Group

It was noted that in addition to the outcome of the Francis report there were a range of other national drivers which brought change at a local level. There was recognition that greater emphasis needed to be placed on openness and transparency.

A framework was in place to ensure that the CCG were meeting the recommendations of the Francis report and progress was being monitored. It was felt that regular progress reports should be made to the Health and Wellbeing Board.

Concern was expressed that the report made no reference to listening to staff especially whistleblowers. The Board was informed that the outcome of a national review was awaited.

It was noted that the pressures on accident and emergency were growing. 11% more people had been admitted and 20% more were attending accident and emergency which was unprecedented. It was felt that people were attending accident and emergency because they were unable to get GP appointments. Concern was expressed that when the frail and elderly were admitted it was often difficult to find places for them outside of the hospital to enable their release

Resolved:

1. That the report be noted
2. That progress reports be submitted to the Board every six months.

13 **Better Care Fund - Update including Primary and Community Strategy and Primary Care Co-Commissioning Strategy**

The Board was informed that the health economy needed to work differently or the CCG would run out of money in around a year to 14 months if spending continued at the current level. The importance of good outcomes was stressed. An efficiency review group had been established to look at where and how savings could be achieved. A report on the progress made by the review group would be submitted to the March meeting of the Health and Wellbeing Board.

The most important action was to achieve ministerial approval for the Better Care Fund plan. The Section 75 agreement was being considered and developed by the Governance Core Group and would be reported to the March meeting of the Board

It was noted that 6 performance metrics relating to the Better Care Plan that were emerging and would build system resilience and create alternatives to emergency admission. Workstream proposals regarding new service delivery models had been developed in draft, with further financial, metric, and activity analysis in progress, alongside the exploration of internal governance and decision making arrangements. Individual implementation plans were being developed which were very detailed and would be supported by the overarching programme plan. The initial draft primary and community strategy would be submitted to the next meeting of the CCG governing body and copies would be circulated to Health and Wellbeing Board members

It was reported that NHS England had offered a range of options for CCGs to become much more involved in the commissioning of primary care and this would present a number of issues which the Health and Wellbeing Board may need to consider. All the options would require increased involvement from both Health and Wellbeing Board and Health Watch. It would provide opportunities for the development of new systems and models of primary care. However it was noted that it was unlikely to be cost neutral.

The CCG, at its meeting on 14 January would consider the range of options and which the approach which should be taken.

Resolved
That the report be noted

14 **Proposals to deliver planned care for Wolverhampton residents at Cannock Chase Hospital - Update**

A report was received Proposals to deliver planned care for Wolverhampton residents at Cannock Chase Hospital.

The report detailed the responses received to consultation on the proposals. A total of 664 responses had been received together with a petition relating to breast care services.

Five main areas had been identified as raising concerns

- Transport/Travel
- Car parking
- Accessibility
- Clinical Standards
- Communications

An action plan had been developed to respond to the concerns raised especially transport.

The importance of ensuring consistency of clinical standards across the site was highlighted. It was noted that importance was being placed on patient engagement throughout the process. Details of the proposals would be sent to all GP practices within the next two weeks. The first transfer would take place in mid February and would be for orthopaedics

A meeting had been arranged for later in the month between the petitioners concerned with breast care and clinical leads, breast care services were not planned to move until later in the programme.

Resolved:

That the report be noted.

15 **Feedback from Sub Groups**

The Transition Group had met and the minutes reflected the clear focus of the Group on the Better Care Fund

The Children's Trust Board had finalised its terms of reference but had agreed to review them if circumstances changed. Work was ongoing with the voluntary sector to provide better outcomes for children. The Board had given consideration to a frontline case study discussion on obesity.

Agenda Item No. 6

Health and Wellbeing Board

4 March 2015

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 Director	Viv Griffin – Service Director – Disability and Mental Health
Originating service	Disability and Mental Health
Accountable officer(s)	Viv Griffin Service Director Tel 01902 55(5370) Email Vivienne.Griffin@wolverhampton.gov.uk

Recommendation

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

MEETING	TOPIC	LEAD OFFICER
4 MARCH 2015 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Obesity Action Plan	Ros Jervis (WCC)
	Plans for Working Well Week – March 2015	Heather Ernston (WCC)
	Infant Mortality	Ros Jervis (WCC)
	Better Care Fund including Section 75 Agreement and transfer of funds from NHS England to Social Care	Sarah Carter /Noreen Dowd (WCCCG)/ Tony Ivko (WCC)
	NHS Capital Programme – Update	Dr Kiran Patel (NHS England – Local Area Team)
	Joint Strategic Needs Assessment (JSNA) – Qualitative Chapter: Patient Safety	Ros Jervis (WCC)
	Mental Health Strategy – Safeguarding and Hard to Reach Groups	Sarah Fellows (WCCCG)
	Wolverhampton City Clinical Commissioning Group – Report back from Efficiency Review Group	Noreen Dowd (WCCCG)
	Wolverhampton City Clinical Commissioning Group – Decommissioning and Disinvestment Strategy	Helen Hibbs (WCCCG)

June 2015	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Integrated Commissioning	Sarah Carter (WCCCG) / Noreen Dowd (WCCCG) / Viv Griffin (WCC)
	Joint Strategy for Urgent Care – Equality Analysis	Steve Corton (M&LCSU)
	Better Care Fund	Sarah Carter (WCCCG)
	Learning Disability Strategy including Winterbourne	Kathy Roper (WCC)
	Obesity Action Plan	Ros Jervis (WCC)
September 2015	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Primary Care Commissioning	Noreen Dowd (WCCCG)

To be added at some appropriate point: Youth Offending Team input Joint Strategic Needs Assessment

Update on progress following Francis Inquiry to July and January meetings and 6 monthly thereafter

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Agenda Item No. 7

Health and Wellbeing Board

4 March 2015

Report Title	Summary of outstanding matters
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Director	Viv Griffin – Service Director – Disability and Mental Health
Originating service	Governance
Accountable officer(s)	Carl Craney — Democratic Services Officer Tel — 01902 55(5046) Email — carl.craney@wolverhampton.gov.uk

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

1.0 Purpose

1.1 The purpose of this report is to appraise the Board of the current position with a variety of matters considered at previous meetings of the Health and Wellbeing Board.

2.0 Background

2.1 At previous meetings of the 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)	Progress report to this meeting
8 January 2014	Children's Safeguarding Action Plan – New approach	Emma Bennett (WCC)	Report to a future meeting (via Children's Trust Board report)
8 January 2014	Better Care Fund	Sarah Carter (WCCCG)	Report to this meeting
31 March 2014	Health and Well Being Strategy – Performance Monitoring	Helena Kucharczyk (WCC)	Quarterly reports
31 March 2014	NHS Capital Programme – NHS England – GP practices in Wolverhampton	Les Williams / Dr Kiran Patel (NHS England)	Quarterly reports
3 September 2014	Joint Strategy for Urgent Care – Equality Analysis	Delivery Plan	Report to this meeting
7 January 2015	Mental Health Strategy – Crisis Concordat	Inclusion of safeguarding issues and hard to	Report to this meeting

		reach groups	
7 January 2015	Implementation of Action Plans following Francis Inquiry – Update	Six monthly updates	Reports to July 2015 and January 2016 meetings and six monthly thereafter

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

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Agenda Item No. 8

Health and Wellbeing Board

4 March 2015

Report title	Obesity Call to Action – Update and progress made towards developing an Action Plan to tackle obesity in Wolverhampton
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Ros Jervis - Public Health and Wellbeing
Originating service	Public Health
Accountable employee(s)	Sue Wardle — Locum Consultant in Public Health Tel 01902 558666 Email sue.wardle@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Delivery Board — 3 February 2015

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Where appropriate, nominate representatives to be part of the individual work streams and overarching strategic group that make up the Call to Action.

2. Support the 'whole systems' approach by agreeing that members act as enablers and 'unblockers' should problems arise.

The Health and Wellbeing Board is asked to note:

1. The progress made and proposed content of the Action Plan to tackle obesity in Wolverhampton.

1.0 Purpose

1.1 The Health and Wellbeing Board received and endorsed the Public Health Annual Report 'Weight, We can't Wait', A Call to Action to tackle obesity in Wolverhampton, at its meeting on 9 July 2014. Significant progress has been made since the publication of the report and this update highlights the successful obesity summit; significant other initiatives – e.g. the member obesity champions and 'million' campaigns and progress made towards developing the city wide action plan.

2.0 Background

2.1 The board has already been asked to note 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. The Annual Report set out our aspiration to make Wolverhampton a less obesogenic place to live by adopting a whole systems approach, using our assets and showing how life events influence behaviour and how influential times in life can be used as catalysts for change. The board also pledged its support for an obesity summit which was held at Dunstall Racecourse on 10 November 2014.

3.0 Progress to date

3.1 Obesity Summit held at Dunstall Racecourse on 10 November 2014

The obesity summit was attended by nearly 300 representatives from statutory and voluntary organisations, faith groups, business and community leaders. The aim was to start a locally led movement for change that will impact upon our 'obesity epidemic' by making Wolverhampton a healthier city by being a more healthy place to live and work, with an environment that encourages physical activity and enables healthy eating. The summit aimed to inspire the audience with ideas based on evidence and best practice from elsewhere by including expert speakers; a 'marketplace' of local Wolverhampton services and initiatives and many opportunities for delegates to undertake physical activity themselves. The summit was widely covered by local TV, radio and the press . Photos from the event are available here .

3.2 Summit Pledges

All delegates at the obesity summit were asked to make pledges of support - both individual and organisational - to commit to practical actions, however small, that collectively will make a difference. The summit's programme was designed to motivate the delegates to make their pledge. Commitment to tackling the problem was demonstrated by close to 300 pledges, of which 145 were organisational pledges and 146 were individual pledges. A wide variety of pledges were made - from schools, organisations and workplaces. The Wolverhampton Public Health Team pledged to provide feedback and support where necessary on the pledges made, and all pledges

were followed up. The pledges will form an important element of the city-wide action plan to tackle obesity in Wolverhampton. (See section 3.6)

3.3 Wolverhampton member champions

The member champions are a cornerstone of the Wolverhampton Call to Action – Cllr Simpkin, Sweet and Warren have signed up to a high profile public facing weight loss challenge, charting their progress through the local press and TV and using social media including at twitter.com/wecantw8.

3.4 Wolverhampton 'million' challenges

The summit also launched two large scale Wolverhampton wide challenges:

- A million miles for Wolverhampton and
- Shed a million pounds for Wolverhampton.

These initiatives are primarily community challenges and will be publicised widely and our residents will be encouraged to be more active and to either run, walk, cycle or swim and to record their physical activity (miles) and any associated weight loss (pounds shed) on a web based 'totaliser' which can be found at wolverhampton.gov.uk/wecantw8 All the initiatives are supported by distinctive 'Weight? We Can't Wait' branding.

3.5 Visit from Duncan Selbie, Chief Executive, Public Health England

Duncan Selbie, Chief Executive, Public Health England (PHE) is conducting a series of visits to public health teams in local authorities. His visit to Wolverhampton was on 4 February 2015 where a range of public health work was showcased, including the obesity Call to Action. His follow up comments were extremely positive – and in relation to the obesity work he was particularly impressed and motivated by our whole City wide focus and the personal leadership being shown by city Council leaders and members – including the obesity member champions.

This visit was followed up by Professor Kevin Fenton, National Director Health & Wellbeing at Public Health England (PHE) who was asked by Duncan Selbie to find out more about our approach so this can be used as an example in his evidence to the House of Commons Health Select Committee on obesity, diet and physical activity. This will be followed up by a further visit.

In addition, Wolverhampton's obesity work was singled out and showcased in Duncan Selbie's 'Friday message' on 6 February 2015:-

> *I see lots of innovation and lots of problems that some might say are intractable but which local politicians, clinicians and managers are getting on with addressing (…..). they are the natural leaders for making things happen. For example, that is exactly what they are doing in Wolverhampton where their population experiences a number of health problems and none more compelling than obesity. (…..) the City council is tackling this as a whole city priority. Led by Ros Jervis, their Director of Public Health, everyone across*

the city is getting involved including the Acute Trust and the CCG. I was met at the station by three councillors, two of whom had between them lost a number of stones and they have all been sharing their experiences with their communities through tweets and blogging. They are not just 'warning and informing', they are actually leading from the front and they are determined to turn things around.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401940/DS_Friday_message_6_February_2015_final.pdf

3.6 Wolverhampton Action Plan to tackle obesity

The detail of the action plan is still being finalised, and a draft plan will be presented at the June meeting of the board. However, the high level content of the action plan is given below:

Aim of the action plan
The overall aim of the action plan is:
'

To deliver a whole systems, asset based approach to make Wolverhampton a place that helps to prevent people of all ages from gaining weight and supports them to lose weight'.

Strategic 5 year aspiration
The action plan itself will be for a one year period. However, this is set within an overall strategic timeframe of five years to achieve (for example) the following outcomes:

- To halt the rising trend in childhood obesity in reception year children
- To slow down the rapid rise in childhood obesity from reception year to year six
- To reduce the number of inactive adults in Wolverhampton so that those who do no physical activity begin to be more active
- To increase physical activity amongst children and young people

It is proposed that the annual action plan will be refreshed and updated yearly and that the board will receive an annual update based on evaluation of evidence and lessons learnt.

Underpinning principles
The action plan will be based on and reflect the following principles

- A whole systems approach – a city wide, inclusive plan
- An asset based approach - using our assets better and differently to achieve better outcomes
- A life course approach – to benefit all ages, sustained as people grow up and grow older
- Use behaviour change approaches – finding out what works for our residents

Main elements of the action plan
As noted above, the pledges are a key element of a city wide action plan to tackle obesity in Wolverhampton. Following the summit, a number of key work streams have now been identified and these will form the backbone of the plan. These are:

1. Workplace health
2. Communication and engagement
3. Community call to action – this work stream includes the Call to Action involvement with Working Well Week in March
4. Development of a physical activity and weight management pathway across the life course

A Call to Action Strategic Group oversees the work stream task and finish groups. The Health and Wellbeing Board is invited to nominate members to attend this group and the task and finish groups, although each work stream task and finish group has a wide membership across Wolverhampton organisations, including input from businesses and the voluntary sector.

Outcomes and Outputs
The action plan will contain outputs and outcomes that are realistic within the timescale of 12 months, but set within the context of a 5 year strategic framework. The action plan will seek to develop measures, both qualitative and quantitative, and including the development of local tools, to record progress in the following areas:

- Increases in physical activity/ reducing levels of inactivity
- Weight loss and better health outcomes
- Childhood obesity and physical activity
- Indicators relating to work stream outcomes. This will include a range of intelligence and social marketing insights, including barriers and enablers related to each of the work streams

Governance
- The governance structure for the Call to Action programme is shown in Figure 1:

Figure 1:

4.0 Financial implications

4.1 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.

4.2 Any costs incurred for the initiatives commissioned by Public Health will be met from within this allocation.

[NM/18022015/T]

5.0 Legal implications

5.1 The report contains no legal implications

[Legal Code: TS/16022015/Q]

6.0 Equalities implications

6.1 The obesity priority will consider equalities implications and especially the impact of obesity on those in poverty, on different ethnic groups and social class. A full equality impact assessment is not considered necessary at this stage but will be considered as the action plan takes shape.

7.0 Environmental implications

7.1 The obesity action plan will consider the environmental implications of making Wolverhampton a less obesogenic place to live.

8.0 Human resources implications

8.1 There are no human resource implications.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications.

10.0 Schedule of background papers

10.1 Weight? We can't wait. A Call to Action to tackle obesity in Wolverhampton. Public Health Annual Report 2013/14 Health and Wellbeing Board, 9 July 2014

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Agenda Item No. **10**

Health and Wellbeing Board

4 March 2015

Report title	Draft Infant Mortality Action Plan
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Linda Sanders People
Originating service	Public Health
Accountable employee(s)	Ros Jervis Director Public Health Glenda Augustine Consultant in Public Health Tel 01902 554211 Email ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Senior Management Team

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Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1.1 Approve the draft Infant Mortality Action Plan for 2015 - 2018.

1.0 Purpose

1.1 The purpose of this report is to provide an overview of the Infant Mortality action plan developed by the multi-agency infant mortality working group to address the high rate of infant mortality in Wolverhampton.

2.0 Background

2.1 The National Child Health Profiles published in March 2014 indicated that Wolverhampton has the highest rate of infant mortality (death of a live born infant within the first year of life) in England. The average rate of infant mortality between 2010 and 2012 is 7.7 deaths per 1,000 live births compared to the England average of 4.3 deaths per 1,000 live births

2.2 The high rate of infant mortality raised concerns across health and social care organisations and resulted in the convening of a multi-agency infant mortality working group in May 2014.

2.3 The multi-agency infant mortality working group has held four focused meetings to identify the causes of infant mortality that are modifiable and how these issues can be addressed to halt preventable death of infants in Wolverhampton. The final meeting in November 2014 resulted in the production of the draft infant mortality action plan.

3.0 Draft Infant Mortality Action Plan

3.1 The infant mortality action plan consists of 15 individual recommendations within six specific areas (full details in Appendix One):

- Strengthening Local Understanding and Awareness of Infant Mortality
- Addressing smoking cessation in pregnancy and after pregnancy for the whole family
- Low Birth Weight Infants
- Maternal and Infant Nutrition
- Reducing Sudden Unexpected Death in Infancy
- Addressing vulnerability pre-pregnancy and beyond

3.3 The draft action plan provides an integrated partnership approach to addressing the consistently high rate of infant mortality in Wolverhampton.

3.4 There is one potential, but significant risk associated with the monitoring of infant mortality in the future. The new information governance rules implemented in April 2013 will make the detailed identification of the local causes of infant mortality impossible in the future unless local solutions are found to ensure the re-instigation of this data sharing. It is important for key partners within the city to recognise the value of sharing data in a secure and timely manner to enable a composite review of issues that can reduce local inequalities and improve health and social care outcomes for local residents.

4.0 Financial implications

4.1 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 of which £15.2 million is allocated to Public Health Commissioning.

4.2 Should any financial implications arise as a result of this report then they will be contained within the Public Health Commissioning Budget.

[NM/04022015/T]

5.0 Legal implications

5.1 There are no anticipated legal implications to this report.

RB/03022015/J

6.0 Equalities implications

6.1 This report does address inequalities as the action plan has been drafted taking into account the needs of the population at risk. This action plan will directly impact on service delivery and an equalities analysis will be an integral part of any commissioned services.

7.0 Environmental implications

7.1 There are no anticipated environmental implications related to this report.

8.0 Human resources implications

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

9.0 Corporate landlord implications

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

10.0 Schedule of background papers

10.1 The infant mortality briefing paper produced for the health scrutiny review is included for information in Appendix Two.

APPENDIX ONE: Draft Wolverhampton Infant Mortality Action Plan 2015 - 2018

Strengthening Local Understanding and Awareness of Infant Mortality					
Recommendation		**Action**	**Key Stakeholders**	**Resources**	**Time Scale**
1	Establish a process for identifying and reviewing the causes of infant mortality in Wolverhampton	• Data sharing agreement required to link Public Health Mortality data and Maternity dataset • Annual Public Health intelligence briefing on infant mortality • Annual review of Sudden Unexpected Deaths in Infancy Syndrome (SUDIs) for children under one year derived from the Child Death Overview Panel • Produce action plans to address the preventable and modifiable risk factors identified from the annual reports • Bi annual Infant Mortality Multi- agency working group to review Progress on action plans • Task and finish group to create an infant mortality dashboard to monitor proxy measures	• Public Health • Royal Wolverhampton NHS Trust • Child Death Overview Panel • Wolverhampton Clinical Commissioning Group	From existing resources	• Data sharing agreement to be completed by March 2015 • Annual Public Health intelligence briefing completed by May 2015 • Annual review of SUDI report completed by May 2015 • Infant Mortality Working Group to meet in May and November each year, commencing May 2015 • Infant mortality dashboard completed with baseline data for review in May 2015
2	Review of the variation in Infant mortality rates	• Comparison of health and social care factors at ward level	• Public Health • Royal Wolverhampton NHS Trust	Investment may be required	• Tier 3 data sharing agreement completed by March 2015

	across Wolverhampton	• Task and finish group established and qualitative research conducted to identify contributory and protective factors for infant mortality within and between wards.	• Child Death Overview Panel • Wolverhampton Clinical Commissioning Group • Adult and Children's Social Care		• Summary report of variation in infant mortality by ward completed by November 2015
3	Raise awareness of the details of the Infant Mortality Action Plan amongst all Key Stakeholders	Develop a communications plan to promote the key actions that are most likely to contribute to improving outcomes for mothers and babies	• Royal Wolverhampton NHS Trust • Wolverhampton Local Authority • Wolverhampton Clinical Commissioning Group	From existing resources	• Communications plan to be agreed and 'signed off' by Wolverhampton Health and Wellbeing Board by March 2015
Address smoking cessation in pregnancy and after pregnancy for the whole family					
1	Reduce the proportion of women smoking during and after pregnancy	• Offer Carbon Monoxide (CO) monitoring of all pregnant women at each antenatal contact with printed advice related to the outcome given to the mother and recorded in the maternity records. • Opt-out referral of all pregnant women who smoke to the smoking cessation service with follow-up of non-attenders. • All smoking quitters 'followed-up' by the smoking cessation service at 3 months, 6	• Stop Smoking Service • Royal Wolverhampton NHS Trust: Midwifery Services. Health visiting services • Wolverhampton Clinical Commissioning Group	Public Health will fund additional CO monitors	• CO monitoring at all antenatal visits implemented by March 2015 • Review of CO monitoring available at each Infant Mortality Working Group Meeting • Follow-up of smoking quitters implemented by April 2015 • Referral pathways for pregnant women who smoke reviewed at May 2015 meeting of the Infant Mortality Working Group • Number of women smoking at booking and

		months, 9 months and 12 months after quit date to provide support to maintain and sustain a successful quit. • 6 monthly review of CO monitoring to inform Infant Mortality Working Group Meetings • Develop referral pathways for pregnant women to Smoking Cessation Service through other sources e.g. Pharmacists, Dentists • Establish a system of midwifery notification of a successful quit to the health visiting service for ongoing support to prevent relapse			delivery recorded in Infant Mortality dashboard by May 2015 alongside initial 4 week quit and follow up data.
2	Ensure a smoke free hospital stay through the implementation of a smoke free hospital site	• Develop and implement a local NHS Trust smoke-free policy during hospital stay as recommended by NICE Public Health Guidance on quitting smoking in pregnancy (NICE PH 26) and smoking in maternity services (NICE PH 48) • Scope the feasibility of ultrasonographers	• Stop Smoking Service • Royal Wolverhampton NHS Trust, to include Trust side representative • Wolverhampton Clinical Commissioning Group	Existing Resources	• Outcome of service audit of against Nice Guidance presented at November 2015 meeting of the Infant Mortality Working Group

		offering brief interventions at booking and subsequent scans • Map pathways of frontline staff groups to promote Making Every Contact Count.			
3	Promote a smoke free home environment	• Assessment of the family environment of all pregnant women and the offer of smoking cessation services to all smokers within the household • Scope the potential pilot of a neonatal unit programme on risks to the neonate on discharge from hospital • Assess smoking status of parents with children on the Neonatal Unit and refer to smoking cessation services • Record smoking status at home following discharge at key contacts by midwife and health visitor	• Royal Wolverhampton NHS Trust: Maternity, Neonatal, Paediatric and Health Visiting services • Stop Smoking Service • Wolverhampton Clinical Commissioning Group • Children's Centres • Public Health	Investment required for neonatal pilot	• Collated data on family environment, smoking status of parents with children on the neonatal unit and smoking status at key intervals post discharge reported at the May 2015 Infant Mortality Working Group. This data reporting will be a standing agenda item for the Group as part of the Infant Mortality Dashboard • Discuss the piloting of the neonatal unit 'risk' programme at May 2015 Infant Mortality Working Group.
4	Ensure a whole school approach to smoking prevention and smoking cessation	• Deliver evidence based age appropriate smoking prevention interventions in schools to effectively prevent smoking	• Public Health, School Health Nursing • Stop Smoking Service	Existing resources	• Implementation of evidence based smoking prevention interventions by November 2015 • Audit of School Health

	to decrease smoking initiation and maximise referral to smoking cessation services for school children	initiation • Brief interventions and referrals to smoking cessation to be delivered by School Health Nurses • Audit of school based contacts and referral to smoking cessation services			Nurse contacts and referrals to Smoking cessation services to be presented at May 2016 Infant Mortality Working Group
5	Promote a smoke free population	• Local marketing campaign to promote smoking prevention and cessation	Public Health	Public Health investment made	• Local marketing campaign to promote smoking prevention and cessation to commence by March 2015 • Evaluation of marketing campaign to be reported to the May 2016 Infant Mortality Working Group.
			Low Birth Weight Infants		
1	Improve antenatal detection of foetal growth restriction	• Scope the feasibility of implementing the use of customised growth charts	• Royal Wolverhampton NHS Trust: Maternity, Neonatal and Paediatric	Existing Resources	• Scoping report on customised growth charts presented at the May 2015 Infant Mortality Working Group meeting
			Maternal and Infant Nutrition		
1	Improve maternal nutrition during and after pregnancy	• Healthy choices on a budget information provided to all pregnant women • Universal offer of Healthy start vitamins to pregnant women • Targeted weight	• Royal Wolverhampton NHS Trust: Healthy Lifestyles Team; Maternity , Neonatal, Paediatric, and Health Visiting • Public Health • Children's Centres	Investment will be required for maternal weight management programme	• Scoping report on the offer of free swimming for all pregnant women presented at May 2015 Infant Mortality Working Group meeting • Review outcome data from weight management

		management programmes for women with a BMI over 30 during and after pregnancy • Promoting physical activity during pregnancy • Scope the feasibility of offering free swimming sessions to all pregnant women			programmes at May 2016 Infant Mortality Working Group, and a standing agenda item at subsequent meetings. as part of the Infant Mortality Dashboard
	Promote exclusive breastfeeding in the first 6 months of life	• Local social marketing campaign to promote exclusive breastfeeding as part of the Obesity Call to Action • Develop an infant feeding pathway to ensure on-going support for breastfeeding mothers • Scope the feasibility of increasing community support for breastfeeding • Collect data on breastfeeding status at 6 months	• Public Health • Royal Wolverhampton NHS Trust: Maternity, Neonatal, Paediatric and Health Visiting services • Children's Centres • Wolverhampton Clinical Commissioning Group	Investment may be required	• Local marketing campaign to promote breastfeeding to commence by March 2015 • Review of rates of breastfeeding initiation and at 6-8 weeks as part of the Infant Mortality dashboard baseline data in May 2015 • Evaluation of marketing campaign to be reported to the May 2016 Infant Mortality Working Group. • Breastfeeding status at six months should be reported in the Infant Mortality dashboard from November 2016
Reducing Sudden Unexpected Death in Infancy (SUDI)					
1	Promote the risk factors for SUDI to prevent	• 'Back to Sleep' campaign promoted by all relevant front-line	• Royal Wolverhampton NHS Trust: Maternity, Neonatal, Paediatric and Health Visiting	Existing Resources	• Annual review of modifiable risk factors for SUDI in Infancy included in

	postpartum deaths up to one year	professionals • Revision of the reducing SUDI page in the Personal Child Health Record (PCHR) • Audit health visiting use of the revised SUDI page	services • Wolverhampton Clinical Commissioning Group • Children's Centres • Public Health		report to the Infant Mortality Working Group in May 2015 • Revised SUDI page in the PCHR to be implemented by August 2015 • Audit of the health visiting use of the revised SUDI page to be reported at the May 2016 meeting of the Infant Mortality Working Group
Addressing vulnerability pre-pregnancy and beyond					
1	Assess the effectiveness of gender specific pregnancy prevention programmes	• Scope the feasibility of a gender specific sexual health education programmes for teenage girls to build personal resilience and reduce the rate of unintended pregnancies	• Public Health • Royal Wolverhampton NHS Trust: School Nursing • Children's Centres	Investment may be required	• Evidence-based review of gender specific teenage pregnancy programmes Infant Mortality Working Group in May 2015
2	Ensure all mothers under 19 years are supported to make 'healthy' choices during pregnancy and beyond	• Referral of eligible 'mothers' to the Family Nurse Partnership Programme (FNP) • Provision of targeted support to 'vulnerable' young mothers not eligible for the FNP programme	• Royal Wolverhampton NHS Trust: Maternity, Neonatal, Paediatric and Health Visiting services • Wolverhampton Clinical Commissioning Group • Children's Centres • Public Health	Existing Resources	• Update of FNP referrals reported to the Infant Mortality Working Group as a standing agenda item • Outcomes of under 19 years contacts with 'vulnerable women's' midwife reported at each Infant Mortality Working Group
3	Ensure all 'vulnerable' mothers are	• Scope the feasibility of a targeted programme for vulnerable women,	• Royal Wolverhampton NHS Trust: Maternity, Neonatal, Paediatric and Health Visiting	Existing Resources	• Scoping report on the targeted provision of a programme for vulnerable

	supported during pregnancy and beyond	commencing antenatally • Audit of the referrals to the 'vulnerable women's ' midwife • Establish a pathway of care for vulnerable women following discharge from maternity services	services • Wolverhampton Clinical Commissioning Group • Children's Centres • Public Health		women discussed at the May 2015 working group meeting • Audit report of referrals to the 'vulnerable women's ' midwife presented at the May 2015 working group meeting • Report on the development of the pathway at the May 2015 working group meeting

APPENDIX TWO: Infant Mortality Briefing

Public Health Intelligence Briefing for the Health Scrutiny Review Panel: Infant Mortality in Wolverhampton

Last Updated: 2nd September 2014
Public Health Wolverhampton Intelligence and Evidence Team

Introduction

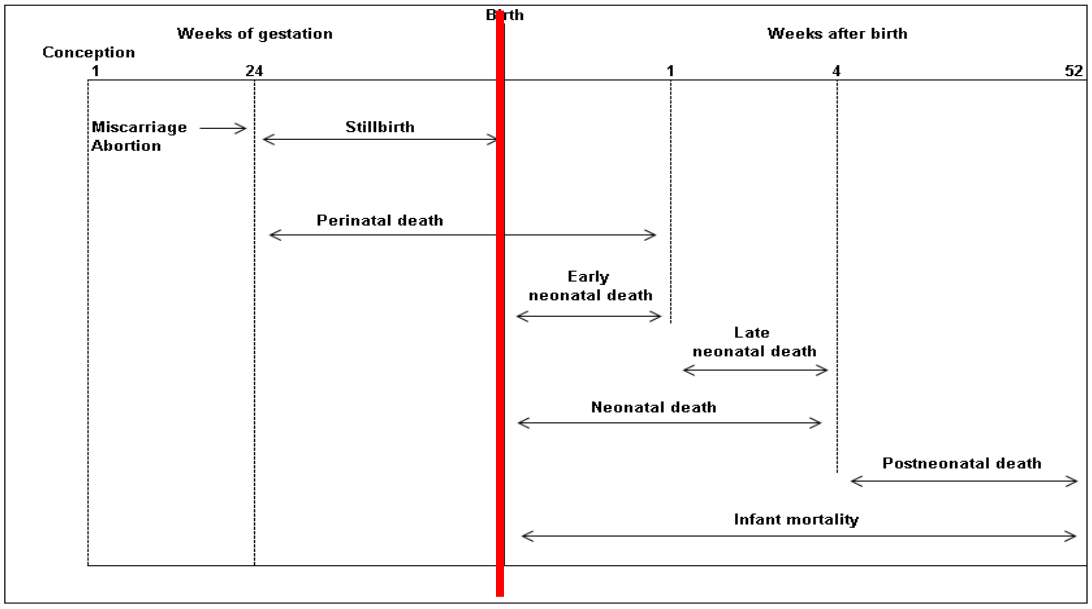
The National Child Health Profiles published in March 2014 indicate that Wolverhampton has the highest rate of infant mortality in England. The average rate of infant mortality between 2010 and 2012 is 7.7 deaths per 1,000 live births compared to the England average of 4.3 deaths per 1,000 live births. This briefing will aim to define infant mortality and the importance of addressing this major local issue by highlighting factors that can be addressed, modifiable factors, to reduce the rate of infant deaths in Wolverhampton.

What is Infant Mortality?

Infant mortality is defined as the death of a live born baby within the first year of life. This period of time is further subdivided based on the length of time from birth to death and illustrated in Figure 1:

- Early neonatal: death occurring up to 7 days after a live birth
- Late neonatal: death occurring from 7 days and up to 28 days after a live birth
- Post neonatal: death occurring after 28 days following a live birth
- Infant: death occurring in the first year of life following a live birth (includes all three time periods above)

Figure 1: Illustration of time periods for deaths occurring during pregnancy and within 1st year of life

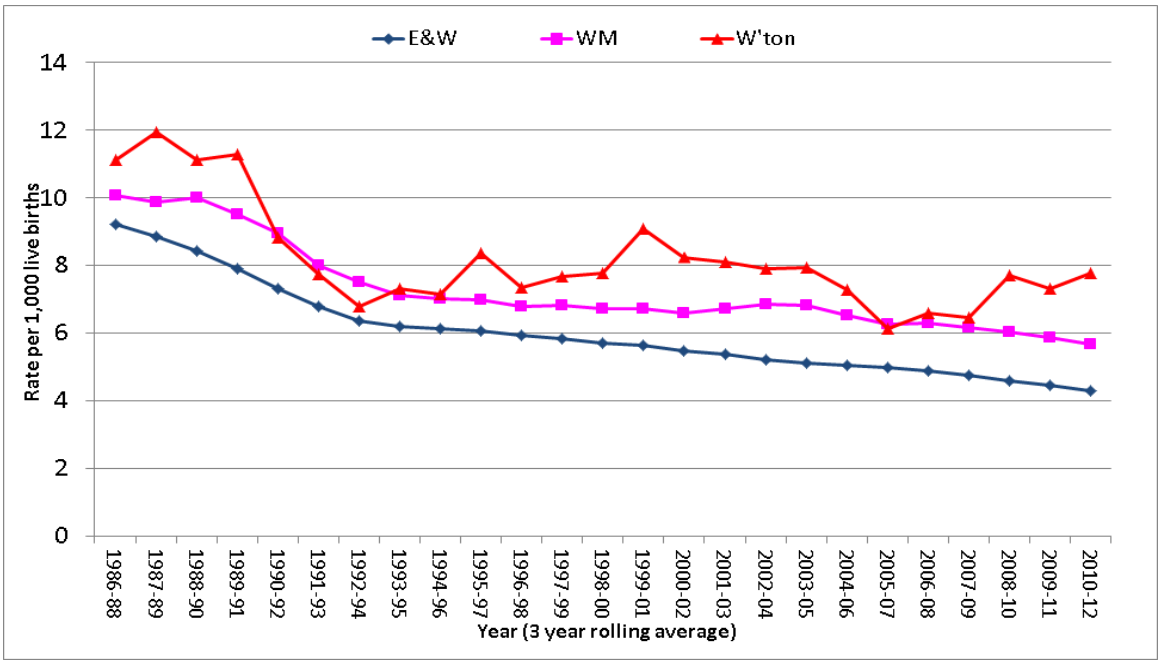


Why is Infant Mortality Important?

Infant mortality is an important indicator of the health of the present population reflecting current factors that impact on population health, such as general living conditions, social wellbeing and the quality of the environment. Historically, the rate of infant mortality in Wolverhampton has been almost double the current rate, with an average of 14 deaths per 1,000 live births between 1987 and 1989.

Whilst the infant mortality rate in Wolverhampton has steadily decreased over time, as shown in Figure 2, there has been a greater decline in the national infant mortality rate. Over the past 30 years there has been a 33% decrease in the national infant mortality rate. However, in Wolverhampton the infant mortality rate has fluctuated, with a fairly static average rate of 7.5 deaths per 1,000 live births throughout this period.
Infant mortality is a major contributor to the difference in life expectancy between Wolverhampton and the national average, accounting for the greatest number of years of life lost[1]. Therefore, it is important to address infant mortality to improve the outcomes for babies born in Wolverhampton and reduce the inequalities that exist between local and national measures. Reducing infant mortality will also have an impact on overall life expectancy for residents of Wolverhampton.

Figure 2: Wolverhampton infant mortality rate time trend compared to regional and national averages



[1] Years of life lost (YLL) provides a summary measure of premature mortality, defined as the years of potential life lost due to premature deaths (that is, before age 75 years). YLL takes into account the age at which deaths occur, giving greater weight to deaths at a younger age and lower weight to deaths at an older age

What are the risk factors for Infant Mortality in Wolverhampton?

A review of primary care mortality data linked to data from the maternity information system at Royal Wolverhampton NHS Trust (RWT) from 2004 – 2012 was conducted in February 2014. This review relates to Wolverhampton residents and highlighted the following key issues:

- *Smoking during pregnancy*: there is a 54% increased risk of infant death for women who smoke during pregnancy, as recorded at the time of delivery, compared to women documented as non-smokers. This indicates a strong association between smoking in pregnancy and infant death.
- *Prematurity*: prematurity is defined as birth after less than 37 completed weeks of pregnancy, which usually lasts 40 weeks. Whilst most premature births occur between 34 weeks and 37 weeks of pregnancy, a small proportion of babies are born under 34 weeks. Almost 65% of infant deaths occurred in babies born under 34 weeks of completed pregnancy, whereas premature infants were only 3% of all births. This indicates that prematurity is a high risk factor for infant death.
- *Very Low birth weight*: a birth weight under 1,500g is classified as a very low birth weight. 60% of infant deaths in Wolverhampton occurred in very low birth weight infants, whereas very low birth weight infants accounted for only 1.5% of all births. This indicates that a very low birth weight is a high risk factor for infant death.
- *Maternal age*: although the highest number of infant deaths occurred in mothers aged between 20 and 34 years, the proportion of deaths was similar to the proportion of births within these age groups. However, 7.9% of infant deaths occurred in babies born to mothers aged 40 to 44 years, whereas births to mother aged 40-44 years were only, 2.5% of all births. This indicates that later maternal age is a high risk factor for infant death.
- *Ethnicity*: the proportion of infant deaths compa5red to total births is broadly similar across ethnic groups with the exception of babies born to black mothers. 16.4% of infant deaths occurred in babies born to black mothers, whereas births to black mothers were 9.8% of all births. Preliminary findings from the review suggest a link between ethnicity and prematurity, with a higher proportion black mothers delivering premature babies, under 34 weeks. Overall, this indicates that black ethnicity is a higher risk factor for infant death than other ethnic groups.
- *Deprivation*: most of the infant deaths occurred amongst the 20% most deprived mothers within the city, a slightly higher proportion of 69.4% compared to total births to mothers in this group, 65.1%. This indicates that deprivation is a high risk factor for infant death.
- Other known risk factors for infant mortality, maternal obesity[2] and late booking in pregnancy[3], did not appear to be associated with the local infant deaths reviewed. However, consideration is still required to address these particular risk factors locally.

There are other potentially modifiable environmental risk factors that contribute to infant mortality recorded as 'sudden unexplained death in infancy' within the first year of life in

[2] Tennant PGW, Rankin J, Bell R (2011) Maternal body mass index and the risk of fetal and infant death: a cohort study from the North of England *Human Reproduction*, **26**:6, 1501–1511

[3] attending for first antenatal appointment after 13 weeks and 6 days of pregnancy

Wolverhampton. A review of modifiable risk factors for sudden unexplained death in infancy in Wolverhampton was conducted between 2009 and 2012[4]. The top four major modifiable risk factors are:

- exposure to environmental tobacco smoke which was recorded in 55% of cases
- co-sleeping environment (bed sharing/sofa sharing) which was recorded in 44% of cases
- alcohol use within the last 24 hours which was recorded in 35% of cases
- and over-heating[5] which was recorded in 32% of cases

How can we reduce the rate of infant mortality in Wolverhampton?

Substantial research evidence is available regarding the risk factors associated with infant mortality, many of which are potentially modifiable and, if addressed, will assist in the reduction of the infant mortality rate[2,6].

Smoking during and after pregnancy

Smoking is the single cause of preventable disease and death. The smoking status of pregnant women is recorded at the first antenatal booking appointment and repeated at the time of delivery. Unfortunately, the difference between the proportion of women smoking at booking and at the time of delivery is marginal. This indicates that the majority of women who are smoking at the beginning of the pregnancy continue to smoke, and few women quit smoking during pregnancy. The most recent data on the proportion of women smoking during pregnancy, as recorded at delivery, indicates that 18.6% of women who deliver in Wolverhampton are smokers. Although smoking status at delivery in Wolverhampton has decreased over the years, it still remains higher than the regional (14.2%) and national (12.7%) average.

It is logical to assume that women who smoke during pregnancy will continue to smoke following delivery, increasing baby's exposure to environmental tobacco smoke which is a major risk factor for infant mortality. It should also be noted that babies born to women who have never smoked or have stopped smoking during pregnancy may also be exposed to environmental tobacco smoke within the home if others in the household smoke.

The National Institute of Health and Care Excellence has produced two public health guidelines[7, 8] with a total of 19 maternity specific recommendations to promote smoking cessation in pregnancy and the adoption of smoke-free homes. Implementation of these recommendations and rigorous promotion of the smoking related harm will assist in reducing the rate of infant mortality in Wolverhampton.

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[4] Moore A (2014) Modifiable risk factors in infant deaths in Wolverhampton 2009 -2012: Presentation at Wolverhampton Infant Mortality Working Group 8th May 2014

[5] This includes room temperature, baby clothing, bedding and mattress

[6] Allen F, Gray R, Oakley L *et al* Inequalities in Infant Mortality Project Evidence Map Report 3: The effectiveness of interventions targeting major potentially modifiable risk factors for infant mortality: a user's guide to the systematic Review evidence. National Perinatal Epidemiology Unit, University of Oxford 2009

[7] National Institute of Health and Care Excellence (2010) Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26. NICE June 2010

[8] National Institute of Health and Care Excellence (2013) Smoking cessation in secondary care: acute, maternity and mental health services. NICE public health guidance 48. NICE November 2013

Prematurity and very low birth weight infants

Whilst not all premature infants have a very low birth weight, there is a strong relationship between prematurity, very low birth weight and infant death. There are many causes of both premature birth and very low birth weight infants related to either mother, baby, environmental exposures or a combination of all these factors.

There are guidelines for the delivery of routine antenatal care during pregnancy[9] and obstetric and neonatal policies/protocols are in place for managing complications during pregnancy and caring for the baby following delivery. Adherence to the guidelines, policies and protocols will optimise the care received and assist with improving outcomes for premature and very low birth weight babies. Promotion of smoking cessation and smoke free homes by neonatal staff will also enhance outcomes for these babies.

It should be noted that death of some very premature (less than 32 completed weeks of pregnancy) and extremely premature (born between 23 and 24 weeks of pregnancy) is expected as a result of the severity of their clinical condition. Unfortunately these deaths cannot be prevented and will always contribute to the infant mortality rate.

Maternal age

There is national evidence that suggests older mothers are potentially more likely to have a baby that dies in infancy[10]. The Royal College of Obstetricians and Gynaecologists made a statement on later maternal age[11], indicating that 'later maternal age is an emerging public health issue.' It highlights that pregnancy in women over 40 years is at high risk of pregnancy related complications and there may be also issues for the baby. Whilst it advocates that women should be 'supported rather than constrained in their life style choices', the statement calls for better public information for women on the issues surrounding later pregnancy.

The care received by these women during pregnancy and following delivery will be in keeping with current antenatal care guidelines[8] and adherence to local policies/protocols as complications arise will assist in the reduction of infant mortality.

Ethnicity

The inequalities that exist between the rate of infant mortality by ethnic group is well documented and described as multi-factorial and complex[12]. There appears to be an intricate inter-relationship between socio-economic, physiological and behavioural factors, alongside access to and uptake of services. The review suggests that black mothers had a higher proportion of premature deliveries, 34 weeks and under, compared to other ethnic groups. Further work is required to investigate this finding in more detail. Greater local understanding of the reasons why babies within specific ethnic groups are at greater risk of infant mortality will assist in the development of a targeted approach to addressing the issues identified.

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[9] National Institute of Health and Clinical Excellence (2008) Antenatal care. NICE clinical guideline 62. NICE March 2008

[10] Office of National Statistics (2013) Gestation-specific Infant Mortality in England and Wales 2011. *Office of National Statistics Statistical Bulletin* 10 October 2013

[11] RCOG (2009) RCOG Statement on later maternal age http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-later-maternal-age

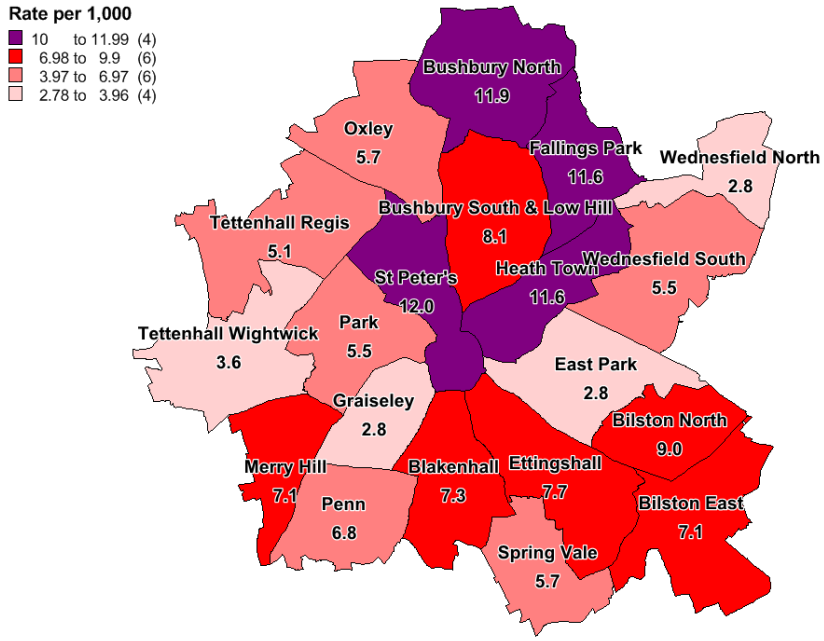
[12] Ray, R. Headley, J. Oakley, L *et al* (2009) Towards an understanding of variation in infant mortality rates between different ethnic groups in England and Wales. Inequalities in Infant Mortality Project Briefing Paper 3. National Perinatal Epidemiology Unit, University of Oxford

Deprivation

The map depicted in figure 3 shows the distribution of infant mortality across the city by ward. There are some higher concentrations of infant mortality in certain areas of the city, for example, in the Centre and North of the city running from St Peter's to Fallings Park and Bushbury North. These ward rates of infant mortality are higher than the average rate for Wolverhampton. Targeted care for women and infants in these areas will assist in the reduction of infant mortality.

It should be noted that although there is a higher proportion of infant deaths in areas that are most deprived, infant deaths also occur in areas of Wolverhampton where there is the least deprivation. Therefore, a universal approach to the delivery of maternity care and support during the first year of life is required across the city.

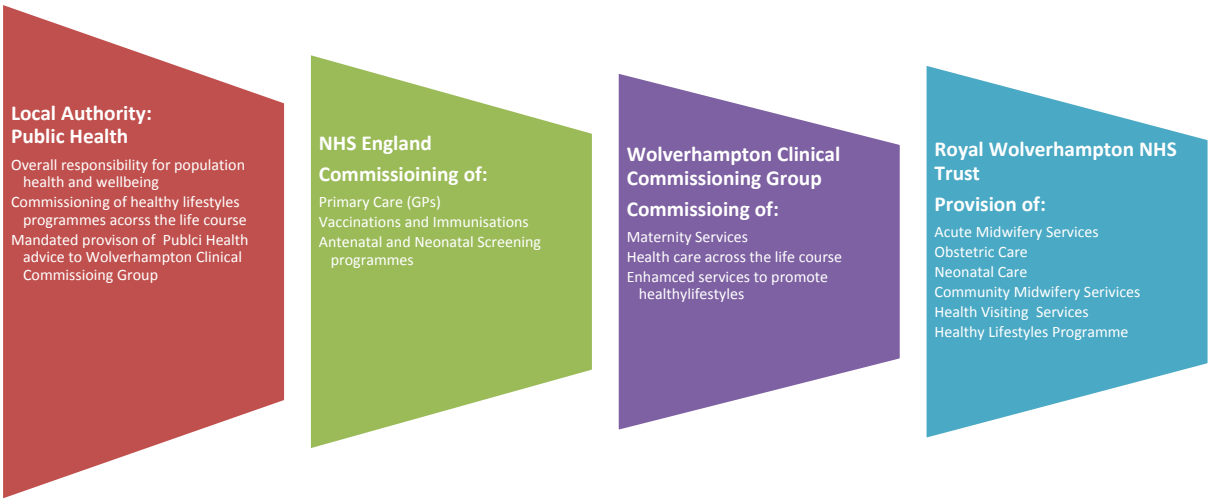
Figure 3: Map of Infant mortality by electoral ward in Wolverhampton 2003-2012



Organisational Responsibilities

There are a number of organisations that are responsible for the commissioning and provision of services that will contribute to reducing the rate of infant mortality in Wolverhampton as shown in Figure 4. A strategic overview of organisational function with a detailed understanding of service delivery will support the achievement of improved outcomes for local women, children and families.

Figure 4: Local organisations that may contribute to reducing the rate of infant mortality



Conclusion

The current rate of infant deaths is a significant issue in Wolverhampton which can be addressed through tackling the modifiable factors that are associated with an increased risk of infant death. Primarily the promotion of smoking cessation and smoke free homes will have a substantial impact on the unborn infant with benefits realised not just in the first 12 months following birth, but throughout life for the child and their family.

It is acknowledged that the issue of prematurity with subsequent very low birth weight babies, maternal age, ethnicity and deprivation present a complex clinical, psychosocial and socioeconomic picture in the context of infant mortality. Therefore, there will be no single intervention that will be the panacea. There will need to be a targeted approach to meet the needs of specific groups such as older mothers, black mothers and mothers from the most deprived areas of the city. However, a universal approach is also required to deliver routine care and identify potential changes that may indicate an increased risk of infant mortality.

Action to reduce the rate of infant mortality in Wolverhampton will require concerted multi-organisational commitment across acute and community service provision with the ultimate aim of improving outcomes for children and their families.

Caveat

This report highlights the comprehensive review that can be produced through linking datasets across the city. It provides enhanced understanding of the factors behind major public health issues to enable a reduction in inequalities and improve maternal, foetal and infant outcomes. It should be noted, however, that the new information governance rules implemented in April 2013 will make this work impossible in the future unless local solutions are found to ensure the continuation of this data sharing. It is important that key partners within the city recognise the value of sharing data in a secure and timely manner to enable a composite review of issues that can reduce local inequalities and improve health and social care outcomes for local residents.

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Agenda Item No.11

Health and Wellbeing Board

4 March 2015

Report title	Funding Transfer from NHS England to Social Care 2014/15
Decision designation	AMBER
Cabinet member with lead responsibility	Councillor Steve Evans Adult Services
Key decision	Yes
In forward plan	Yes
Wards affected	All
Accountable director	Linda Sanders
Originating service	People
Accountable employee(s)	Steve Brotherton Head Of Commissioning Older People Tel 01902 555318 Email Steve.brotherton@wolverhampton.gov.uk Helen Rowney Commissioning Officer Tel 01902 555495 Email Helen.rowney@wolverhampton.gov.uk
Report has been considered by	Cabinet Resources Panel 21 October 2014 Wolverhampton Clinical Commissioning Group Governing Board 9 December 2014

Recommendation for decision:

The Health and Wellbeing Board is recommended to:

To approve the allocation of the funding transfer from NHS England to Social Care 2014/15

Authority is delegated to the Cabinet Member for Adult Services in consultation with the Strategic Director of People and Assistant Director Finance, to approve the detailed allocation of this funding to services

To approve the Council entering into an agreement under Section 256 of the NHS Act 2006 to document the transfer of the funds to the Council.

1.0 Purpose

1.1 The purpose of this report is to provide information and to seek approval for the allocation of the funding transfer from NHS England to Social Care 2014/15.

2.0 Background

2.1 For the last three financial years, NHS Support for social care funding has been transferred from the Wolverhampton Primary Care Trust to the Council in order to support adult social care services, delivering health benefits in the process. These funding transfers had been agreed under Section 256 of the NHS Act 2006.

2.2 For 2014/15 this funding transfer for Wolverhampton will be £6.3 million and will be transferred from NHS England to the local authority again via an agreement under Section 256. This funding transfer consists of an integration payment and main allocation.

2.3 There are a number of national conditions within the agreement for the integration payment and the main allocation.

- The payments are to be made under section 256 of the 2006 NHS Act
- The funding must be used to support adult social care which also has a health benefit
- The funding may be used to support existing services or transformation programmes, where such services or programmes are of benefit to a wider health and care system, provide good outcomes for service users, or would be reduced due to budget pressures in local authorities without this investment
- There must be a local agreement between health and social care partners about the use of the funding and the outcomes to be delivered – this will be mandated through the Health and Wellbeing Board
- It is a condition that the local authority and the clinical commissioning group must have regard to the Joint Strategic Needs Assessment for their local population and existing commissioning plans for health and social care in how the funding is used
- As part of its agreement with local authorities, NHS England must ensure that it has access to timely information on how the funding is being used locally, in order to be able to account for this expenditure and assure itself that the conditions for each funding transfer are being met

- In relation to the integration payment a condition of the transfer is that the local authority must agree with its partner clinical commissioning group a plan for establishing and maintaining a Better Care Fund (BCF) pooled budget in the financial year 2015/16 and that the integration payment must be used for purposes related to preparing for implementing BCF .

2.4 Within the local context for Wolverhampton this funding will focus on the delivery of an integrated approach to reablement; rehabilitation; prevention and early intervention, ensuring a joined up all-encompassing philosophy and approach, which delivers greater independence and choice for all customers. The table below includes current metrics

Service Area
Bed Based Intermediate Care There are 49 beds across the City which equates to 17,885 bed nights available
Integrated Domiciliary Based intermediate Care HARP/CICT There have been 302 unique people from 1 April 2014 that have benefited from the HARP service
Independent Living Service This service currently supports approx 27,000 people
Assistive Technology (Telecare) This service currently supports approx. 942 people
Supporting Hospital Discharge (Hospital Team)

3.0 Current Situation

3.1 The Joint Wolverhampton Reablement and Intermediate Care Strategy 2014 - 2016 was approved by Wolverhampton City Council's Cabinet in June and approved at Health and WellBeing Board in July 2014.

3.2 In October 2014 Cabinet Resources gave approval to enter into an agreement under S 256 of the NHS Act 2006 for the transfer of this funding.

3.3 The governance arrangements for this funding will be through the Health and Wellbeing Board – see appendix one.

3.4 Through the BCF, the Intermediate Care and Reablement work stream is in the process of redesigning the model and pathways. The strategic objective of this work stream is the development and delivery of Wolverhampton's approach to effective alternatives to admission, effective discharge, and early discharge programmes.

3.5 The design principles that underpin the modelling include;

- Building on the current approach to discharge planning and delivery, enhanced community facing discharge liaison function, risk stratification and planning approaches
- An integrated approach to asset based community development, and building community capacity to improve health and reduce social isolation around the person as part of the whole person approach to reablement and intermediate care
- A material shift from care and support being delivered on an episodic basis to support and interventions being wrapped around the individual to maximise the potential for independence
- Fully integrated approach to intermediate and reablement care which is community facing and supports person centred care, providing both alternatives to admission that are community facing and accelerated discharge with intensive, needs based support. This support will be delivered and coordinated on an integrated basis in the community
- Effective support in a crisis
- Robust support to residential and nursing care

3.6 This funding will deliver the following short, medium and long term priorities:

- Addressing additional pressures that would impact on the health and social care community
- Through early intervention within communities;
- Supporting integrated hospital discharge
- The delivery of bed based intermediate care
- The delivery of an integrated approach to domiciliary reablement

3.7 This funding will contribute towards the delivery of the outcomes detailed in appendix two but will focus on the following priority outcomes and measures:

National Metric	Impact measure
Reduction in non-elective admissions:	180
Reduction in permanent residential admissions	8
Reduction in delayed transfers of care:	46
Increased effectiveness of reablement:	9

3.8 In addition NHS support for social care funding for this year will focus on the delivery of an integrated approach to the on-going development of reablement and rehabilitation, better preparing the health and social care market to deliver a value for money response to the increasing demographic pressures that have already emerged.

3.9 These services outlined in 2.4 are described below:

Bed Based Intermediate Care

Residential rehabilitation is provided from two Wolverhampton City Council resource centre's and delivers the following:

- Up to a six week residential rehabilitation intervention with input from both occupational and physio therapy in order to maximise and maintain independent living

Integrated Domiciliary Based Intermediate Care

This service delivers the following:

- A six week intervention with patients in their own home either following discharge from hospital or to prevent hospital admission as an alternative or extension to inpatient rehabilitation

- A range of health and social care support to patients including nursing support (e.g. pressure ulcer management, wound care management, monitoring of medication, continence

- A range of support activities that include exercise, posture, balance re-education, mobility, enable meal preparation, support with personal care, sign posting to other agencies for on-going support on discharge and support to carers as part of the reablement element

Home Assisted Reablement Programme is Wolverhampton City Council service and delivers the following:

- A planned six week intervention to customers in their own home either following discharge from hospital, review of care packages or where there is potential for the customers situation to improve through reablement

- A range of support activities that include mobility, meal preparation, support with personal care, sign posting to other agencies for on-going support on discharge (Age UK, church groups bereavement support) and support to carers

Assistive technology – Telecare service delivers the following :

- The provision of an alarm and equipment system. It supports vulnerable people who may need help in a crisis situation

Telecare equipment can provide:

- smoke and flooding alarms
- temperature control detectors
- Inactivity monitors or fall detectors that monitor a fall or no movement for a long time
- automated pill dispensers a reminder to take medication
- alarms that alert relatives or the control centre that help is required

Independent Living Service

This service delivers the following:

- The provision of social care and health equipment to people in the community in order to maximise independent living

Both the independent living service and telecare service enable people to remain or return to living independently focusing on optimising people's independence with the lowest appropriate level of on-going care and support.

Supporting Hospital Discharge

This service delivers the following:

- The provision of a health and social care integrated team to deliver an appropriate and timely patient discharge from New Cross Hospital and West Park Hospital.

4.0 Current Actions

4.1 The Clinical Commissioning Group and the City Council will work together in order to quantify both the baseline and performance improvement measures against a number of these outcomes. This work will not delay the overarching agreement or transfer of the funding.

4.2 In summary, the Section 256 Fund meets the national conditions in the following way;

National Condition for Use	Wolverhampton's Approach
The payments are to be made under section 256 of the 2006 NHS Act	The payment will be made and managed via the agreed governance arrangements for the BCF pooled budget, via a Section 75 agreement and Partnership Board, with oversight from the Health and Wellbeing Board
The funding must be used to support adult social care which also has a health benefit	The funding is embedded within the Intermediate and Reablement work stream of the BCF programme. The work stream is

	developing a revised approach to intermediate and reablement care pathways which integrates health and social care delivery with health and social care metrics, and achieves performance against the BCF metrics.
The funding may be used to support existing services or transformation programmes, where such services or programmes are of benefit to a wider health and care system, provide good outcomes for service users, or would be reduced due to budget pressures in local authorities without this investment	The funding will deliver the following short, medium and long term priorities: Addressing additional pressures that would impact on the health and social care community through early intervention within communities; Supporting integrated hospital discharge The delivery of bed based intermediate care pathway which supports effective integrated intervention The delivery of an integrated approach to domiciliary reablement
There must be a local agreement between health and social care partners about the use of the funding and the outcomes to be delivered – this will be mandated through the Health and Wellbeing Board	The Health and Wellbeing Board has oversight of the BCF programme. Primary outcomes to be delivered through this programme are the nationally mandated metrics which are; Reduction in emergency admissions Reduction in delayed transfers of care Improvement in the effectiveness of reablement Reduction in permanent nursing and residential placements Improvement in patient experience Increase in the number of patients diagnosed with dementia (locally agreed)
It is a condition that the local authority and the clinical commissioning group must have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used	The BCF has utilised the JSNA to focus the planning of the intermediate and reablement care workstream. The treatment of the funding reflects the jointly held strategic priorities in relation to the BCF Programme, and driving integration across health and social care.
As part of its agreement with local authorities, NHS England must ensure that it has access to timely information on how the funding is being used locally, in order to be able to account for this expenditure and assure itself that the conditions for each funding transfer are being met	The fund will be overseen through the integrated governance structure for the BCF. Performance against agreed metrics will be monitored through the Partnership Board, and included in the performance reporting against the BCF .

In relation to the integration payment a condition of the transfer is that the local authority must agree with its partner clinical commissioning group a plan for establishing and maintaining a Better Care Fund pooled budget in the financial year 2015/16 and that the integration payment must be used for purposes related to preparing for implementing Better Care Fund.	The BCF Plan has been agreed across the Clinical Commissioning Group and City Council. The plan has been approved with support via NHS England. Development of a Section 75 agreement is in progress, and is collaboration and partnership across both organisations is driving this forward. The Section 75 will be subject to the approval of both organisations in February

5.0 Financial implications

5.1 The proposed use of the Section 256 funding for 2014/15 is set out in the following table.

Service Area	Amount £000
*Bed based intermediate Care (Staffing and support Costs)	2,255
Integrated domiciliary based Intermediate Care HARP / CICT (Staffing and support Costs)	1,074
Independent Living Service (Staffing and support Costs)	1,704
Assistive technology (Telecare) (Staffing and support Costs)	176
*Supporting Hospital Discharge (hospital team)	1,100
TOTAL	**6,309**

* Service areas identified for the integration payment

5.2 All values in 5.1 above are appropriately contained within the Social Care budget for 2014/15.
[AB/23022015/G]

6. Legal Implications

6.1 In order for the relevant NHS England to provide the Council with the sum of £6.3 million the Council will need to enter into an agreement under S 256 of the NHS Act 2006. The agreement will oblige the Council to ring fence the funds for the provision of social care services. The Council will also be obliged to provide evidence that funds have been used for social care and may be subject to audit.

6.2 Section 256 NHS Act 2006 (as amended) permits NHS England to make payments to local authorities towards expenditure incurred or to be incurred by it in connection with any social services functions. Also, payments can be made in connection with the performance of any of the authority's function, which have an effect on the health of any individual or on and NHS functions or are connected with any NHS functions. The payments may be made in respect of expenditure of a capital or of a revenue nature or in respect of both kinds of expenditure. The payments may be subject to such Directions as may be issued by the Secretary of State.

6.3 This element of funding is absorbed within the overall contribution to the pooled Better Care Fund budget which will be managed under a formal Section 75 agreement between the two commissioning organisations, Wolverhampton Clinical Commissioning Group and Wolverhampton City Council. A Partnership Board has been established to facilitate joint agreement and collaboration regarding the development of the BCF programme.

[Legal Code: TS/16022015/G]

7.0 Equalities implications

7.1 There are no obvious equality implications that arise from this report and an initial screening has been undertaken.

8.0 Environmental implications

8.1 There are no obvious environmental implications that arise from this report.

9.0 Human resources implications

9.1 There are no human resource implications that arise from this report.

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications that arise from this report

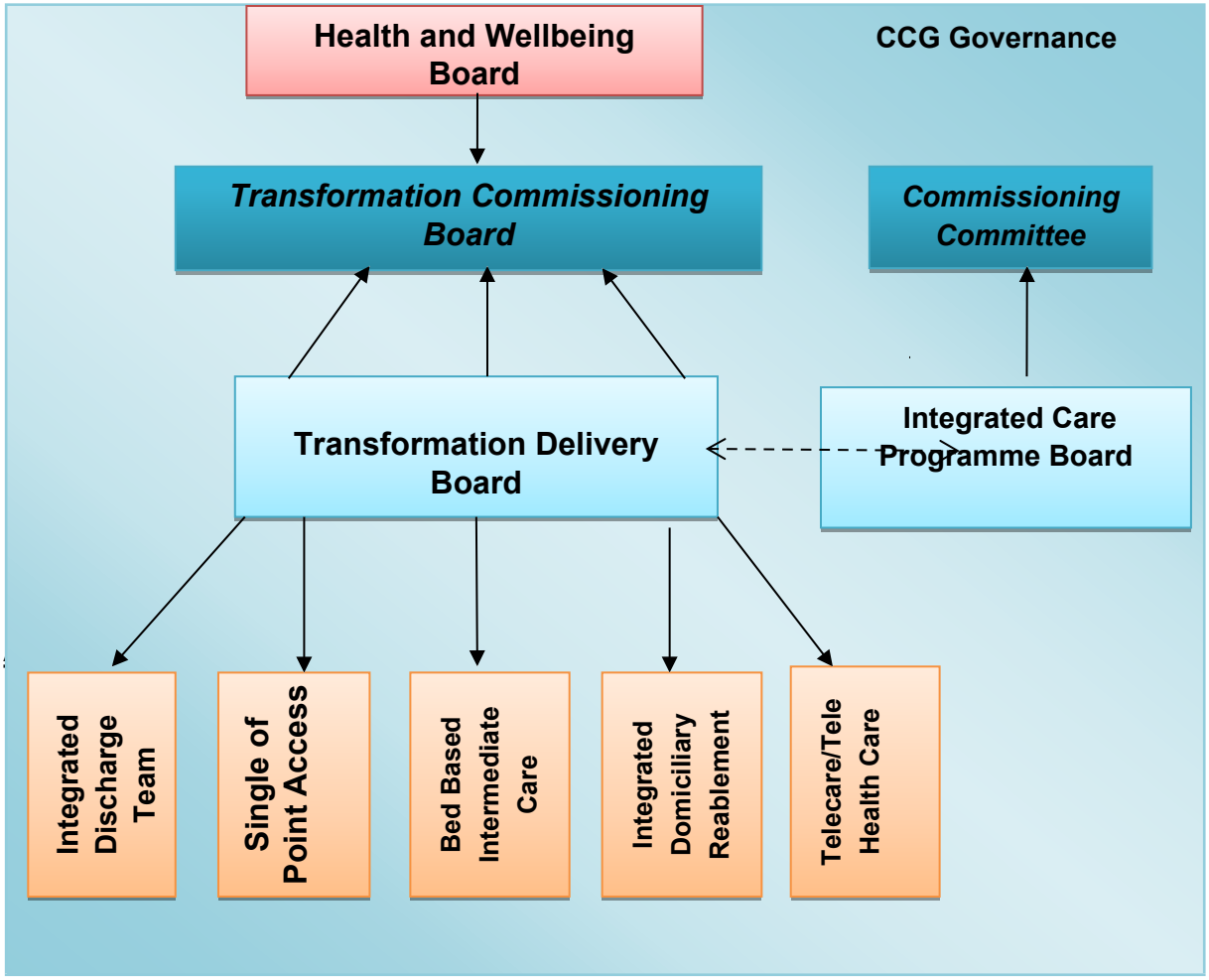
9.0 Schedule of background papers

N/A

10.1 Appendices

1. Governance
2. Hierarchy of Outcomes

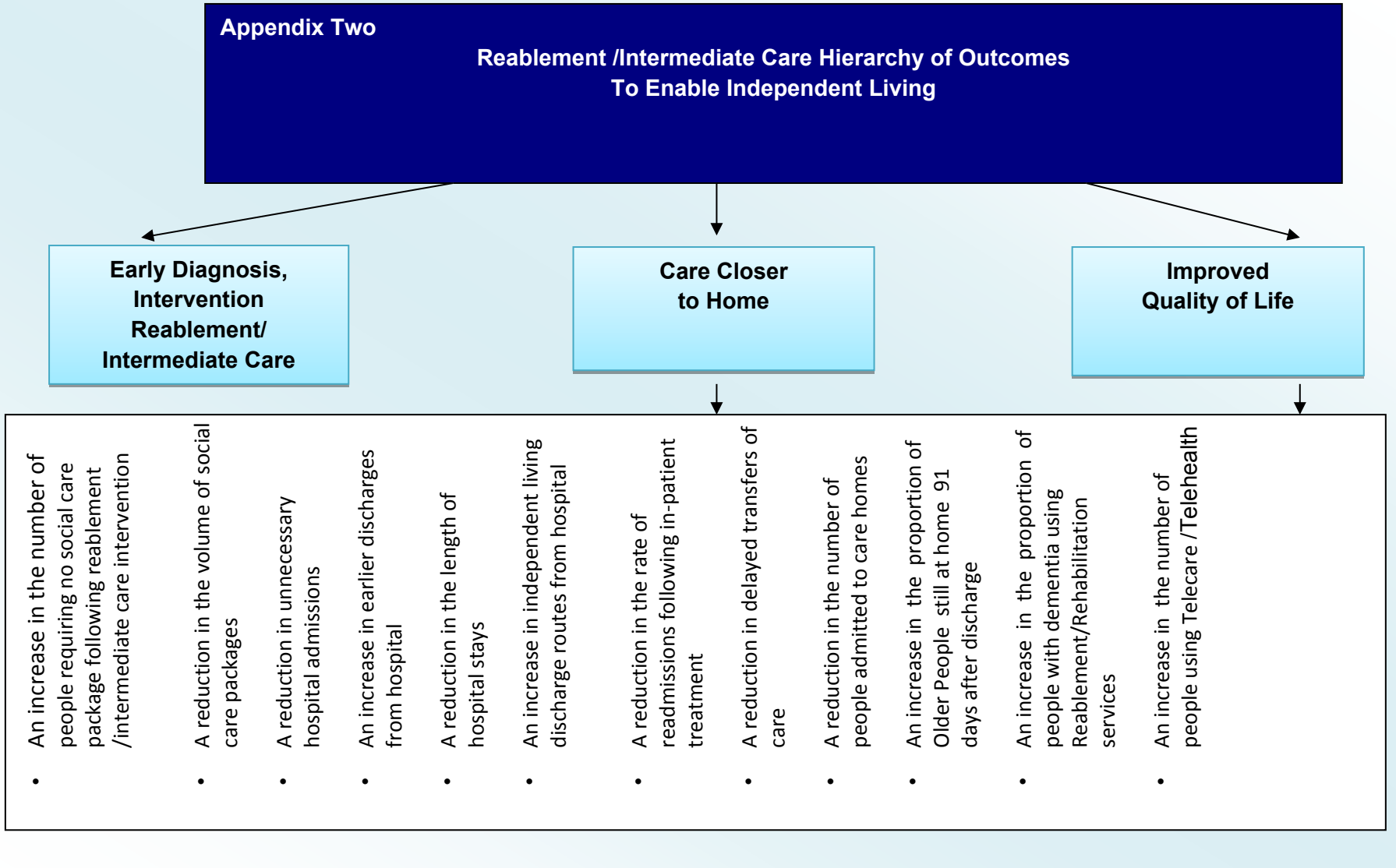
Appendix One – Governance



This Joint Reablement and Intermediate Care Strategy for Wolverhampton 2014 - 2016 programme will be driven by the following high level strategic outcomes:

Appendix Two

Reablement /Intermediate Care Hierarchy of Outcomes To Enable Independent Living



Agenda Item No. **12**

Health and Wellbeing Board

4 March 2015

Report title	Joint Strategic Needs Assessment Qualitative Summary: Patient Safety	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders	People
Originating service	Public Health	
Accountable employee(s)	Ros Jervis Glenda Augustine Tel Email	Director Public Health Consultant in Public Health 01902 554211 ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Note the Joint Strategic Needs Assessment qualitative summary on patient safety and quality.

1.0 Purpose

1.1 The purpose of this report is to provide a collated summary of patient safety derived from local assessment in response to the Francis Inquiry and the Safeguarding and Winterbourne View reports for Wolverhampton produced by Wolverhampton Clinical Commissioning Group and Wolverhampton Safeguarding Board respectively.

2.0 Background

2.1 The Health and Wellbeing Board agreed that the refresh of the Joint Strategic Needs Assessment for 2014 should include a desktop qualitative review of patient safety and quality for 2013/14. This topic was chosen because it is a theme that is relevant to the whole health and social care economy and has been raised in a number of reports and work streams.

2.2 The aim of this qualitative paper is to provide the Health and Wellbeing Board with assurance regarding patient safety and the quality of care delivery in the city, in relation to the Francis Inquiry, generic safeguarding of children and adults and the review of Winterbourne Review.

2.3 This paper will not replicate the content of the reports previously presented at various boards, but will provide a composite overview of patient safety and quality issues. Primarily this paper will highlight compliance with recommendations and any risks alongside proposed mitigation. Further in depth details can be found in the original reports.

2.4 *The Francis Inquiry*

2.4.1 The Francis Inquiry February 2013 made 290 recommendations aimed at improving the quality of patient care through cultural change, with the focus on the patient not the business of the organisation. The key recommendations include the delivery and monitoring of standards of care, a system built on openness, transparency and candour, stronger healthcare leadership and improved support for compassionate, caring and committed nursing

2.4.2 Wolverhampton Health Scrutiny Panel received update reports on the Francis Inquiry from Wolverhampton Clinical Commissioning Group (WCCG), the Royal Wolverhampton NHS Trust (RWT) and the Black Country Partnership Foundation Trust (BCPFT) in January 2015.

2.5 *Safeguarding Children and Adults*

2.5.1 There are two safeguarding boards within Wolverhampton, Children and Adults,

who co-ordinate a partnership approach to protecting and promoting the welfare of children and adults. Each board is required to produce and publish an annual report demonstrating the effectiveness of safeguarding in Wolverhampton.

2.5.2 The Wolverhampton Safeguarding Adults Board annual report was presented to the Health and Wellbeing Board in November 2014 and the Safeguarding Children Board annual report was presented in January 2015.

2.6 *Review of Winterbourne View*

2.6.1 The Department of Health review of Winterbourne View resulted in a Concordat Programme of actions for implementation by June 2014. The Concordat required commitment from health and care commissioners to transform services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them.

2.6.2 There is national leadership and local support for implementation of the Concordat. An update on the programme actions related to the review of Winterbourne View in Wolverhampton was presented to Wolverhampton Strategic Executive Board (SEB) in January 2015.

3.0 Qualitative Summary Findings: Francis Inquiry

3.1 The summary of the Francis Inquiry provided by RWT and BCPFT indicate that there has been investment in staff training and education to improve the standard of care delivered, increased staffing ratios, regular quality and safety reporting and a robust system for dealing with complaints.

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3.2 There are 102 of the 290 Francis Inquiry recommendations that are relevant to RWT with over 70% compliance reported. There is partial compliance of remaining recommendations with the assurance that full compliance would be achieved by March 2015. It would appear that the process of embedding the recommendations into core business with reporting and monitoring through the governance framework for the Trust will support achievement

3.3 The BCPFT report indicated that 84 of the 290 recommendations are applicable to their practice. Although there was no explicit quantification of the level of compliance, the narrative on progress to date and the implementation of automated monitoring of actions, indicates partial compliance and increased assurance for the BCPFT Board.

3.4 The WCCG report indicates that the commissioning organisation is monitoring the standard and quality of care delivered by provider units with tracking of patients receiving care outside Wolverhampton. An example of future plans to improve quality and safety is the arrangement of quality visits with the Care Quality Commission at night and weekends.

3.4 There were no specific risks highlighted regarding the implementation of the Francis Inquiry recommendations across provider and commissioning organisations in Wolverhampton. The collective reports provide assurance that there is compliance with the recommendation to ensure improving quality and safety in the delivery of patient care.

4.0 Qualitative Summary Findings: Safeguarding Children

4.1 The annual report on safeguarding for children presented to the Health and Wellbeing Board in January 2015 was for the reporting year 2013/14, describing partnership objectives and achievements up to March 2014.

4.2 The report indicates that this multi-agency partnership is committed to prioritising safeguarding and has articulated a determination to strengthen prevention and early intervention, underpinned by staff training and education. This is despite reduced funding, new structures and commissioning arrangements impacting on the partnership structure. Further development of preventatives strategies using combined resources is planned for the coming year.

4.3 All partner agencies have documented achievement against objectives and details of improvement plans have been provided where barriers may impact on attaining the set objectives. Resources and capacity appear to be the main challenge, however, there is no evidence that this poses a major risk to the quality of service delivery that will significantly impact on the safeguarding of children in Wolverhampton.

5.0 Qualitative Summary Findings: Safeguarding Adults

5.1 The peer review of the adult safeguarding service in September 2013 highlighted a number of strengths and areas for consideration with an overall positive conclusion. This review provides assurance that there is strong partnership working arrangements which will enable significant progress in adult safeguarding in Wolverhampton. The 2013/14 annual report indicates that an action plan has been developed to address the areas of consideration highlighted within the peer review, enhancing the assurance process.

5.2 The annual report demonstrates a clear focus on staff education and training alongside raising awareness within partner organisations and through community groups.

5.3 Whilst challenges to achieving the priorities of the adult safeguarding board have been highlighted, there appear to be no specific risks to patient safety or the quality of service delivered.

6.0 Qualitative Summary Findings: Winterbourne View

6.1 The Winterbourne View update presented to SEB indicates that there is appropriate placement of patients in WCCG funded high and low secure hospital care as demonstrated by comprehensive Care and Treatment Reviews. The reviews assess safety, quality of care, discharge planning and appropriateness of hospitalisation.

6.2 This report indicates that there is compliance with the Winterbourne View recommendations in relation assessment of patient safety, quality of care and the provision of care within an appropriate setting.

6.3 There were no risks associated with patient safety or quality of care highlighted within this report.

7.0 Qualitative Summary Findings: Conclusion

7.1 In summary, the qualitative review of various reports provides assurance that the children and adult services across health and social care for 2013/14 are delivering quality care that strives to maintain patient/citizen safety through the achievement of set priorities and objectives and structured plans to mitigate against identified risks.

8.0 Financial implications

8.1 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

8.2 This report has not identified financial implications for the Public Health budget.

8.3 There are no additional financial implications for the Local Authority that have not previously been highlighted in the original reports presented to the Health and Wellbeing Board and Health Scrutiny Committee.

[NM/18022015/E]

9.0 Legal implications

91 There are no anticipated legal implications to this report.

[Legal Code: TS/19022015/G]

10.0 Equalities implications

10.1 There are no anticipated equalities implications to this report

11.0 Environmental implications

11.1 There are no anticipated environmental implications related to this report.

12.0 Human resources implications

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

13.0 Corporate landlord implications

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

14.0 Schedule of background papers

14.1 Links to the Health Scrutiny Panel updates on the Francis Inquiry and the Wolverhampton Safeguarding Board annual reports for children and adults are listed below:

14.1.1 Francis Inquiry Update
http://wolverhampton.moderngov.co.uk/ieListDocuments.aspx?CId=146&MId=223&Ver=4

14.1.2 Wolverhampton Safeguarding Children Annual Report
http://wolverhampton.moderngov.co.uk/documents/g4278/Public%20reports%20pack%2007th-Jan-2015%20Health%20and%20Wellbeing%20Board.pdf?T=10 page 29-112

14.1.3 Wolverhampton Safeguarding Adults Annual Report
http://wolverhampton.moderngov.co.uk/documents/s5357/Item%2010%20-%20Adults%20Safegaurding%20Annual%20Report%202013-14.pdf

http://wolverhampton.moderngov.co.uk/documents/s5333/Item%2010%20-%20Adults%20Safeguarding%20Board%20-%20Final%20Annual%20Report%2013-14.pdf

14.1.4 Wolverhampton Safeguarding Adults Peer Review: September 2013
http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=3309&p=0

Agenda Item No. 13

Health and Wellbeing Board

4 March 2015

Report title	Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Noreen Dowd, Interim Director, Strategy and Solutions, WOLVERHAMPTON Clinical Commissioning Group.
Originating service	Commissioning – Wolverhampton CCG
Accountable employee(s)	Sarah Fellows Mental Health Commissioning Manager Tel 01902 442573 Email sarahfellows2@nhs.net
Report to be/has been considered by	Wolverhampton Health and Well-Being Board - 7 January 2015

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. The purpose of this report is to provide members of the Health and Wellbeing Board with a further update regarding the Commissioning Mental Health Strategy, specifically regarding the actions required to address the needs and requirements of key vulnerable groups.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The development and implementation of the Mental Health Strategy, including amendments made to address the needs and requirements of key vulnerable groups.

1.0 Purpose

1.1 The purpose of this report is to provide members of the Health and Well-Being Board with an update regarding the implementation of the Mental Health Strategy, including amendments made to address the needs and requirements of key vulnerable groups and associated key next steps.

2.0 Background

2.1 Following discussion at Health and Well-Being Board on January 7 2015 the amended Wolverhampton Clinical Commissioning Group and Wolverhampton City Council Adult Mental Health Commissioning Strategy which covers the period 2014 – 2016 is attached as Appendix 1. The Strategy has been amended to specify how our health and social care economy will work with all stakeholders to address the needs of vulnerable groups and difficulties that arise from the wider determinants of mental ill-health.

2.2 Development of the Mental Health Strategy responds to the recommendations of the Mental Health Strategy review and key national and local drivers including the CCG's Operational and Strategic Plans, the WOLVERHAMPTON City Council and WOLVERHAMPTON Clinical Commissioning Group Emotional and Psychological Health and Well-Being Strategy for Children and Young People (2013-2016) the Suicide Prevention Strategy for England (2013) and Closing the Gap (2013), the National Crisis Concordat (2014) and our health and social care economy's Better Care Fund plans.

3.0 Progress, options, discussion, etc.

3.1 A number of key priorities are outlined in the Mental Health Strategy. The priorities are aligned with the revised stepped care model and are outlined as follows:

STEPS 0-5 - Develop an all age approach across the whole service model that incorporates the needs of people under 18 years and over 65 years.
STEP 0 – Develop a local Resilience Plan (Mental Health Promotion, Early Intervention and Prevention) and include within in this actions regarding the assessment and mapping and scoping of people with key vulnerabilities, actions required to address the broader determinants of mental ill-health and, improved information, marketing and communication to support parity of esteem and end stigma.
STEP 1 Develop a local Suicide Prevention Strategy.
STEP 1 – Develop Primary Care Pathways.
STEP 2 – Review Commissioning Model of Integrated Access to Psychological Therapies (IAPT).
STEP 3 – Commission the Young Person's Service for young people aged up to 25 years.

STEP 3 – Review the Commissioning Model of the Community Well-Being Service.
STEP 3 – Commission an integrated urgent mental health care pathway.
STEP 4 – Review the commissioning model of the complex care service.
STEP 4 – Commission and implement an integrated re-ablement and recovery care pathway.
STEP 4 – Review the commissioning model of local specialist care pathways.
STEP 5 – Review the commissioning model of Female PIC and out of area admissions for urgent and planned mental health care.
STEP 5 - Review the commissioning model of Pond Lane and other Learning Disability In-patient Services.

3.2 As outlined in Appendix 1 the Wolverhampton 2011 census outlines the following points:

- Our City's resident population is 248,470.
- The average age in Wolverhampton is 39 years.
- Wolverhampton has a slightly higher proportion of children aged under 16.
- In terms of ethnicity, 68% Wolverhampton residents are from a white ethnic background with the remaining 32% of residents belonging to black minority ethnic backgrounds (BME).
- Wolverhampton has high numbers of new arrivals arriving into the City each year including traveller families (estimated 2700 families in 2012).
- In terms of levels of deprivation in our 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.
  Deprivation is disproportionate across the city, with the more affluent wards in the west of the city.

3.3 As outlined in Appendix 1 a number of sources of evidence suggest that a number of in-equalities and demographic factors can have a significant effect on the local need and uptake of mental health services. This information has been validated by local data capture which includes the experiences of our City's stakeholders including service users and carers and providers. As highlighted in Appendix 1 key vulnerabilities include matters arising as a result of:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse

- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

3.3 On 7 January 2015 the Health and Well-Being Board members requested that the Mental Health Strategy be amended to specifically outline how the needs and requirements of key groups will be addressed moving forward. The Strategy has been amended to include within the document the outline Resilience Plan and to propose how a Community Development Work model will deliver the associated required actions.

3.4 As outlined in Appendix 1 the necessary actions and interventions that are needed to deliver the Wolverhampton Mental Health Resilience Plan across the Stepped Care Model described will require developing our community development work approach which has previously focussed in Wolverhampton on initiatives such as those outlined in '*Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett' (HM Govt. 2005)*.

3.5 The key building blocks of our refreshed approach will include:

- **More appropriate and responsive services –** achieved by improving services and up skilling the workforce across the stepped care model to better respond to the needs of key groups to enable all members of the population to access all of our services equally and by working with all key stakeholders to that ensure that together we have a joined up approach to challenging and addressing the broader determinants of mental ill-health and stigma and discrimination and promote parity of esteem, compassion, equality and respect diversity and human rights. .
- **Wider community engagement –** achieved by extending stakeholder engagement to capture agencies, voluntary groups and organisations that can have a strategic and day to day influence on the wider determinants of mental health and embedding agreed key deliverables into the Resilience Plan and Implementation Plan. Supported by our Community Development Workers.
- **Better information, communication and marketing -** achieved by improved data collation, capture and analysis of the City's vulnerable groups, mapping their needs and requirements and monitoring agreed actions via the implementation plan. This will include a regular census of mental health patients and public mental health needs across the City and delivery of a pro-active marketing campaign aligned to parity of esteem and national campaigns such as Beat Bullying, Time to Change, Health Poverty Action, and Child Sexual Exploitation of the NSPCC.

3.6 Next Steps are proposed as follows:

- Stakeholder Event supported by Health and Well-Being Board members to develop key actions and associated timelines within the outline Resilience Plan that can be embedded into the Strategy Implementation Plan and aligned with the Crisis Concordat

declaration and action plan and other key initiatives especially including HeadStart Wolverhampton.

- Review of the integrated commissioning current Community Development Work to scope how the bullet points identified in 3.5 will be developed within the existing model including a gap analysis of the current programme of community development work.
- Scoping following delivery of the above actions to explore the QIPP opportunities that could be delivered across mental health and the wider health, social care and criminal justice system on delivery of the Resilience Plan.
- Alignment of the above initiatives with mental health KPIs and dashboards to support monitoring and performance management of key outputs and collation, measurement and aggregation of benefits across the 'whole system'.

4.0 Financial implications

4.1 The Mental Health Strategy will be delivered within the current financial envelope which includes cost efficiency requirements and current and any future QIPP plans and opportunities. Delivering improved mental health early intervention and prevention across our City's resident population and targeting key vulnerable groups however provides opportunities to re-align spending from secondary and tertiary services to primary, community and voluntary services within the medium to longer term as key initiatives deliver and this should be further explored and under constant review as part of the Resilience Plan and the Strategy Implementation Plan and any associated commissioning intentions.

5.0 Legal implications

5.1 There are currently no outstanding legal implications that should be highlighted in relation to this report.

6.0 Equalities implications

6.1 Section 149 of the Equality Act 2010 outlines the Public Sector Equality Duty to engage with relevant individuals regarding key decisions. As previously identified a period of consultation will be required regarding any proposed changes to mental health services locally.

7.0 Environmental implications

7.1 There are currently no outstanding environmental implications that should be highlighted in relation to this report.

8.0 Human resources implications

8.1 There are currently no outstanding environmental implications that should be highlighted in relation to this report.

9.0 Corporate landlord implications

9.1 There are currently no corporate landlord implications that should be highlighted in relation to this report.

10.0 Schedule of background papers

10.1 The amended Mental Health Strategy is attached as Appendix 1.

Wolverhampton City Council

Community
Health, Well Being and Disability

NHS
WOLVERHAMPTON
Clinical Commissioning Group

MENTAL HEALTH COMMISSIONING STRATEGY

2014-2016

CONTENTS

1. INTRODUCTION

Commissioning and delivery of safe, sound and supportive mental health services and care pathways is a key strategic priority for our health and social care economy and is aligned with a number of other key deliverables such as reducing health inequalities, reducing the impact of long term conditions upon quality of life and improving patient experience as outlined in our Wolverhampton Health and Well-Being Board Strategy, the CCG's Operational Plan and the CCG's 5 Year Strategic Plan.

The Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016 is a joint commissioning re-fresh of the Wolverhampton City Primary Care Trust and Wolverhampton City Council Adult Mental Health Commissioning Strategy 2011 – 2015 wherein we outline our commissioning plans to develop our mental health whole system model and to deliver improved outcomes for the people of our City in line with local needs and local and national priorities.

This follows a review period and responds to key local priorities highlighted as an outcome of the review and other local imperatives including plans that form part of the Better Care Fund initiative, and the implementation plans for the Wolverhampton Mental Health and Psychological Wellbeing Services Strategy for Children and Young People 2013-2016.

National statistics show that mental illness is the largest disease burden upon the NHS, up to 23% of the total burden of ill health and the largest cause of disability within the United Kingdom (Royal College of Psychiatry 2010). There are significant personal,

social and economic costs (the latter estimated as £105 million per annum for England alone), with particular risks from birth, into childhood and as young people move into adulthood and as they enter periods of physical and psychological change and development. There is a strong economic case to provide early intervention and prevention mental health services for children and young people especially, to prevent up to 25-50% of adult mental illness (Kim-Cohen et al 2003). We know that physical health is inextricably linked to mental health. Poor mental health is associated with obesity, alcohol and substance misuse and smoking, and with diseases such as cardio-vascular diseases and cancer (HM Government, 2011).

In 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget. Treatment costs are likely to double in the next 20 years as by 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million(Royal College of Psychiatry 2010) .

In Wolverhampton our current annual joint commissioning health and social budget for Mental Health services is £35.7 million. Benchmarking data suggests that in Wolverhampton investment in mental health services is comparable with the England average. Our Strategy implementation plan will align our service re-design and development with our plans to ensure value for money across the system however and re-align our investment in services to improve early intervention and prevention, urgent care and re-ablement and recovery. This is to achieve 'parity of esteem' for mental health compared with physical health in terms of access to services, quality of service user and carer experience and service user outcomes within an 'all age' context.

The strategy re-fresh includes a wider all age mental health approach to improve outcomes for all people requiring support from mental health services. This is in keeping with the cross government mental health outcomes strategic guidance for people of all ages detailed in 'No Health without Mental Health' (2011), 'Preventing suicide in England' (HM Government, 2012), 'Closing the Gap' (HM Government 2014), which adopt a life course approach.

Our strategy prioritises the delivery of the 6 key outcomes of 'No Health without Mental Health' (2011) as overarching themes. These are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Our mental strategy re-fresh outlines the required commissioning actions to achieve all of the 6 key outcomes described above.

2. INFORMATION REGARDING PREVALENCE AND NEED

Our commissioning priorities outlined in this strategy re-fresh will respond to the critical issues and factors that exist in Wolverhampton in terms of levels of social and health inequality and also address our knowledge and understanding of local levels and type of mental health need and our response to tackling inequalities and preventing mental health difficulties occurring wherever possible.

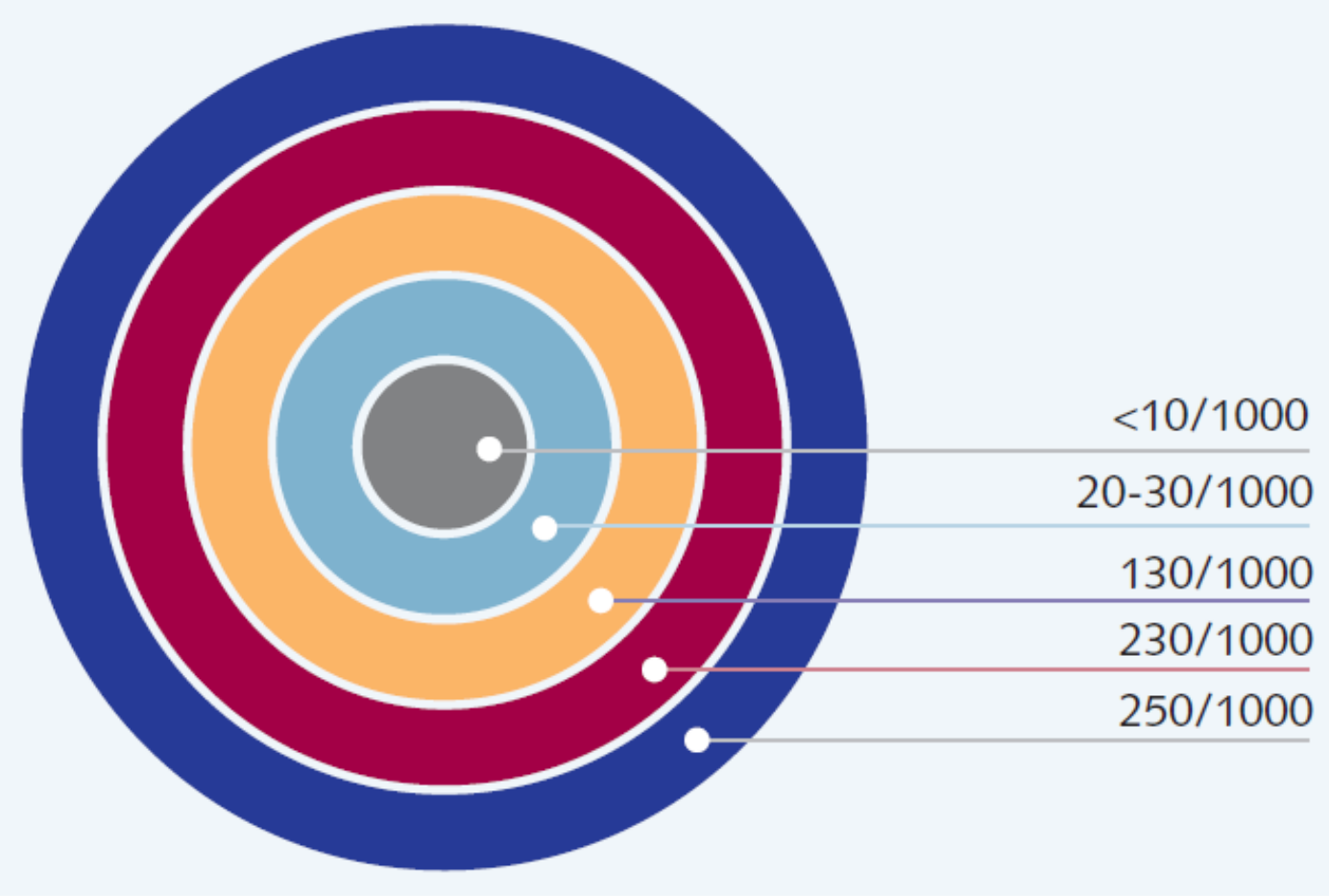
'No Health without Mental Health' (HM Government, 2011) describes three aspects to reducing mental health inequality:

- tackling the inequalities that lead to poor mental health

- tackling the inequalities that result from poor mental health such as unemployment, poor housing, and poor levels of educational achievement and poorer education and physical health
- tackling the inequalities in service provision – in access, experience and outcomes

The illustration below is taken from the Joint Commissioning Panel for Mental Health guidance 'Practical Mental Health Commissioning' (2011).

Numbers of people affected by mental health problems



Mental health problems affect about one in four people – that is, 250 per 1000 at risk (see figure 4). Of those 250 people, the vast majority – about 230 – attend their general practice. Of these 230, about 130 are subsequently diagnosed as having a mental health problem, only between 20 and 30 are referred to a specialist mental health service, and fewer than 10 are ever admitted to a mental health hospital.

A summary of some key demographic and local and national prevalence related data is described below.

The Wolverhampton 2011 census describes our resident population as 248,470. The average age in Wolverhampton is 39 years, which is similar to the England average; however Wolverhampton has a slightly higher proportion of children aged under 16. In terms of ethnicity, 68% Wolverhampton residents are from a white ethnic background with the remaining 32% of residents belonging to black minority ethnic backgrounds (BME). Wolverhampton has high numbers of new arrivals arriving into the City each year including traveller families (estimated 2700 families in 2012). In terms of levels of deprivation in our 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. Deprivation is disproportionate across the city, with the more affluent wards in the west of the city. A number of sources of evidence suggest that a number of equalities and demographic factors can have a significant effect on the local need and uptake of mental health services, including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism

- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

Interventions to support the specific needs and vulnerabilities of key groups should include disabled people, people with learning difficulties and older people both in terms of social isolation and self-efficacy and barriers to accessing appropriate levels of support (including barriers to communication in the case of people with sensory impairments for example). Particular focus should be placed upon the needs of people of all ages with conditions such as Autism and Attention Deficit Disorder who are at risk of falling between gaps in services, ('No Health without Mental Health', 2011). Mental health services and care pathways and services should also specifically consider and address the mental health needs of pre and post natal mothers, people with co-morbid substance misuse and people with learning disabilities (national prevalence of people with learning disabilities with co-occurring mental health problems is estimated to be 25–40%, 'No Health without Mental Health', 2011).

The over representation of people from BME groups has locally and nationally focussed upon the need to commission culturally sensitive services particularly for particular groups of men and women including new arrivals. In Wolverhampton we need to continue to address over representation of key groups specifically in relating to formal admission under the Mental Health Act 1983. The relatively low prevalence of numbers of children from BME groups referred to Tier 2 and Tier 3 CAMHS (less than 20% of referrals, compared with 41% of the population of children and young people in our City) suggests that prevention and early intervention should include a focus upon targeted interventions for children and young people and their parents and carers from BME groups and communities of new arrivals.

Learning from the needs analysis from our Wolverhampton Emotional and Psychological Well-Being Strategy for Children and Young People has also identified the following key issues in 2012/13:

- An under use of universal and targeted services, an over use of specialist services and a significant increase in the use of in-patient hospital provision.
- Requests for hospital admissions rose by over 100% (75 % of in-patient admissions were related to self-harm)
- The Crisis Support and Home Treatment Service received a 25% increase in routine referrals.

A recent survey of Wolverhampton's LGBT community highlighted significant mental health difficulties and concerns amongst respondents, in excess of what is understood nationally regarding higher levels of suicide, depression and self-harm within this group (LGBT Wolverhampton, 2013). The survey highlighted the prevalence of self-harm, suicidal ideation, depression and experience of bullying amongst the LGBT community locally and the important role of peer support in terms of improving outcomes and facilitating access to care pathways and services within the City.

Data highlighted in 'No Health without Mental Health' (2011) identifies that although women are at greater risk of childhood sexual abuse and sexual violence (an estimated 7–30% of girls), 3–13% of boys have also experienced childhood sexual abuse. Whilst we need to understand more about the impact of sexual violence locally, nationally it is understood that 1 in 10 women have experienced some form of sexual victimisation, including rape and some studies have shown that 50% of female patients in psychiatric wards have lifetime experience of sexual abuse 'No Health without Mental Health' (2011).

The Community Mental Health Profile 2013 for Wolverhampton identifies that Wolverhampton is **'significantly worse'** than the England average in the following key factors in terms of deprivation and indicators of mental health prevalence and performance against key outcomes:

- Working age adults who are unemployed
- Percentage of the relevant population living in the 20% most deprived areas in England
- Episodes of violent crime
- Statutory homeless households
- Percentage of 16-18 year olds not in employment, education or training
- Percentage of the population with a limiting long term illness
- Percentage of adults (18+) with learning disabilities
- Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders
- Rate of Hospital Admissions for alcohol attributable conditions
- Percentage of referrals entering treatment from Improving Access to Psychological Therapies
- Numbers of people on a Care Programme Approach, rate per 1,000 population

The Community Mental Health Profile 2013 for Wolverhampton identifies that Wolverhampton is **'significantly better'** or **'not significantly different'** than the England average in the following key factors:

- Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population **(significantly better)**
- First time entrants into the youth justice system 10 to 17 year olds
- Percentage of adults (16+) participating in recommended level of physical activity
- Percentage of adults (18+) with dementia
- Ratio of recorded to expected prevalence of dementia
- Percentage of adults (18+) with depression **(significantly better)**
- Directly standardised rate for hospital admissions for mental health **(significantly better)**

- Directly standardised rate for hospital admissions for unipolar depressive disorders
- Directly standardised rate for hospital admissions for Alzheimer's and other related dementia **(significantly better)**
- Allocated average spend for mental health per head
- In-year bed days for mental health, rate per 1,000 population **(significantly lower)**
- Number of contacts with Community Psychiatric Nurse, rate per 1,000 population **(significantly better)**
- Number of total contacts with mental health services, rate per 1,000 population **(significantly higher)**
- People with mental illness and or disability in settled accommodation **(significantly better)**
- Indirectly standardised mortality rate for suicide and undetermined injury
- Improving Access to Psychological Therapies - Recovery Rate
- Excess under 75 mortality rate in adults with serious mental illness **(significantly better)**

3. Vision

Our vision for mental health services in Wolverhampton is an integrated 'whole system' of health and social care pathways and services that will deliver early intervention and prevention, assessment, treatment and intervention and re-ablement and recovery across the life course.

Our aim is to prevent people entering statutory services where possible and to provide care pathways into and through services to provide the right type and level of intervention, when this is required, including within primary care and non-statutory services and with a focus upon public mental health as part of our Resilience Strategy.

Our commissioned model will support the delivery of aligned health and social care outcomes to promote independence, improve physical health, optimise recovery and increase social inclusion at all stages of the care pathway and across the 'whole system' of integrated care.

Our vision is based on national and local prevalence and risk issues as well as local and national policy and strategic priorities and imperatives have informed our commissioning mental health strategy for Wolverhampton. This includes the 2013 Mandate to NHS England sets the Government's commitment to give mental health parity of esteem with physical health, including a commitment to:

- Removing the stigma attached to mental illness.
- Implementing access and/or waiting times standards for mental health services in 2015.
- A specific focus on mental health and wellbeing from Public Health England.
- A dedicated transformation programme for children and young people's services to enhance access to evidence-based therapies.

- Providing settled accommodation for people with mental illness to support their recovery.
- Support for CCG's commissioning Mental Health services from NHS England to commission evidence based services locally that are compliant with NICE Guidance and Quality Standards.
- Pro-active crisis support.
- Initiatives to reduce the inequalities in life expectancy for people with severe mental illness.
- Further roll out of improving access to psychological therapies.
- Improved offender mental health.
- Using the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services.

The vision outlined above includes all elements of commissioned service delivery, including Health, Social Care, Education, Voluntary and Community and Third Sector and Independent Sector Services, Specialised and Secure Services and 'out of area' placements. The service development changes outlined in our priorities and implementation plan will increase capacity and capability within services locally to improve individual, familial and community resilience by increasing protective factors and promoting independence, increasing self-efficacy, reducing risk and enabling recovery.

For our local Wolverhampton 'whole system' to work effectively each service will have a clear role; understand how it relates to other elements of the system and work to a set of clear care pathways and specified outcomes to meet the needs of our population. This will involve commissioning to increase the effectiveness and efficiency of services, improve care pathways and communication across the whole system and reduce duplication across service providers. This will include increasing capacity and capability locally to support people with severe and enduring and / or complex mental health needs and ensure effective and robust care coordination using the Care Programme Approach guidance 'Refocusing the Care Programme Approach Policy and Positive Practice Guidance' (HM Government 2008).

It will also include interventions and actions that support the needs and requirements of people in Wolverhampton that have particular vulnerabilities and these include those vulnerabilities highlighted on page 8 and detailed again below:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

Responding to the specific needs and requirements of key vulnerable groups will form a key element of the Wolverhampton suicide prevention plan and the Wolverhampton Crisis Concordat Declaration and Wolverhampton Crisis Concordat Action Plan. The Wolverhampton suicide prevention plan is known as the Wolverhampton Mental Health Resilience Plan and describes those

interventions highlighted within the Wolverhampton Health and Well-Being Strategy that focus upon mental health promotion, early intervention and prevention and are detailed within the table below and which will be aligned with the Mental Health Strategy Implementation Plan and our local Crisis Concordat Action Plan and Declaration:

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	**WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN** **Action Required**
1. DEVELOP LOCAL SUICIDE PREVENTION GROUP.	Mental Health Stakeholder Forum will develop small working group to take forward key actions. (Could meet immediately before as discussed). **<u>The local suicide prevention group needs to:</u>** • Map current practice and service provision with any gaps forming the basis of a WOLVERHAMPTON Suicide Prevention Action Plan. • Ensure all WOLVERHAMPTON mental health, suicide and self-harm data is captured. • Link with the WOLVERHAMPTON Health and Well-Being boards and feed into local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Well-Being Strategies (JHWSs). • Link with the Mental Health, Dementia, and Neurology Intelligence Network to map, understand and address mental health issues in WOLVERHAMPTON. • Ensure data mapping includes the needs and requirements of key vulnerable groups including vulnerabilities related to: ▪ Age and gender ▪ Black and minority ethnic communities ▪ Persons in prison or in contact with the criminal justice system

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
	▪ Service and ex-service personnel ▪ Deprivation ▪ Unemployment ▪ Housing and homelessness ▪ Refugees and asylum seekers (new arrivals) ▪ People with long term conditions or physical and or learning disabilities including autism ▪ Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ) ▪ Substance misuse ▪ Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying
2. DEVELOP LOCAL ACTION PLAN.	• Develop a suicide prevention action plan • Monitor data, trends and hot spots • Engage with local media • Work with transport to map hot spots • Work on local priorities to improve mental health Include • Assessment of impact on equalities • Prompts for local leaders on suicide prevention • Statistical update (September 2012) / **plan by March 2015** • Sources of information and support for families **Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives.**

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
Page 88	Working with: • CCGs • Local Authority • Public Health • Mental health Trusts / Providers • West Midlands Police • West Midlands Ambulance Service • Coroners • Families bereaved by suicide • The Voluntary and Community Sector • National Suicide Prevention Alliance • Mental Health, Dementia, and Neurology Intelligence Network **6 Key Action Areas** 1. Reduce the risk of suicide in key high-risk groups 2. Tailor approaches to improve mental health in specific groups 3. Reduce access to the means of suicide 4. Provide better information and support to those bereaved or affected by suicide 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour 6. Support research, data collection and monitoring.
3. ALIGN WITH HEALTH AND WELL-BEING BOARD MENTAL HEALTH PRIORITY AREA.	This draws heavily on The Joint Commissioning Panel for Mental Health *'Guidance for Commissioning Public Mental Health Services' (JCP-MH, 2012)*, identifies that mental well-being is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour such as, better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life.

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
Page 89	http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=2944&p=0 Ensure data mapping includes the needs and requirements of key vulnerable groups including vulnerabilities related to: • Age and gender • Black and minority ethnic communities • Persons in prison or in contact with the criminal justice system • Service and ex-service personnel • Deprivation • Unemployment • Housing and homelessness • Refugees and asylum seekers (new arrivals) • People with long term conditions or physical and or learning disabilities including autism • Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ) • Substance misuse • Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying
4. ANALYSE AND AGGRAGATE AND MONITOR DATA, TO IDENTIFY TRENDS,	Data Analysis Needs Assessment Hotspots • Focus Vulnerable Groups • Identify hotspots / areas of vulnerability

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
OT SPOTS AND VULNERABILITIES IN TERMS OF MENTAL ILL HEALTH AND SUICIDE.	• Work with transport police to map hot spots • Reduce access to the means of suicide • Focus on cyber bullying • Focus on education providers, employers and un-employed
5. WORK ON LOCAL PRIORITIES TO IMPROVE MENTAL HEALTH INTERVENTIONS.	Focus on: • Medication Management and Prescribing • Better Care Fund Care Pathways • Clinical Interventions • Learning from LPS, CRISIS CAR and CAMHS CHRT and EIS pilots • IAPT and Primary Care Depression Care Pathway • Development of Community Hub • Improved Care Pathways complex Care and Well-Being • Focus on monitoring outcomes • Help lines • Single Point of Access
6. FOCUS ON SELF-EFFICACY AND LOCUS OF CONTROL.	• Align with HeadStart • Scope Tier 1 and Tier 2 • Develop Mental Health Education, Information and Awareness and Psycho-education and Self-Help • Develop Public Health campaign • Identify potential sources of revenue
7. DEVELOP CRISIS CONCORDAT.	• Make Wolverhampton Declaration by December 2014. • Submit Local Wolverhampton Crisis Concordat Plan by March 2015. **Mental Health Crisis Care Concordat principles:** **A. Access to support before crisis point.** A1. Early intervention – protecting people whose circumstances make them vulnerable. **B. Urgent and emergency access to crisis care.**

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
	B1. People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery.
	B2. Equality of access.
	B3. Access and new models of working for children and young people.
	B4. All staff should have the right skills and training to respond to mental health crises appropriately.
	B5. People in crisis should expect an appropriate response and support when they need it.
	B6. People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the police must be supported by health services, including mental health services, ambulance services and emergency departments.
	B7. When people in crisis appear (to health or social care professionals, or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect.
	B8. People in crisis should expect that statutory services share essential 'need to know' information about their needs.
	B9. People in crisis who need to be supported in a health-based place of safety will not be excluded.
	B10. People in crisis who present in emergency departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right on-going support.
	B11. People in crisis who access the NHS via the 999 system can expect their need to be met appropriately.
	B12. People in crisis who need routine transport between NHS facilities or from the community to an NHS facility will be conveyed in a safe, appropriate and timely way.
	B13. People in crisis who are detained under Section 136 powers can expect that they will be conveyed by emergency transport from the community to a health-based place of safety in a safe, timely and appropriate way.
	C. Quality of treatment and care when in crisis.
	C1. People in crisis should expect local mental health services to meet their needs appropriately at all times.
	C2. People in crisis should expect that the services and quality of care they receive are subject

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
	to systematic review, regulation and reporting. C3. When restraint has to be used in health and care services, it is appropriate. C4. Quality and treatment and care for children and young people in crisis. **D. Recovery and staying well / preventing future crises.**
8. DEVELOP SERVICE USER AND CARER INVOLVEMENT.	Provide better information and support to those bereaved or people affected by suicide. • Establish self-help group – support learning. • See Focus on Self-Efficacy and Locus of Control • Align with Community Hub and PA4MH
9. WORK ON LOCAL PRIORITIES TO IMPROVE MENTAL HEALTH BY FOCUSSING ON VULNERABILITIES AND THE BROADER DETERMINANTS OF MENTAL HEALTH.	Use Community Development Work model to engage with local groups, stakeholders and partners to focus on: • Housing • Employment • Debt Counselling • Benefits • Bullying • Leisure • Dual Diagnosis • Parents • Employers • Schools Develop Stake Holder Forum to engage with and involve local groups, stakeholders and partners so that agreeing interventions that improve mental health are embedded in al key strategic deliverables across our City.
10. WORK ON LOCAL PRIORITIES TO IMPROVE THE PHYSICAL HEALTH OF PEOPLE WITH MENTAL HEALTH	• Physical Health • Parity of Esteem • 5 Ways to Well-Being

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
DIFFICULTIES.	
11. COMMUNICATION AND MEDIA.	Develop a communication strategy regarding mental health which supports mental health awareness, promotion, early intervention and prevention and anti-stigma campaigns locally and also supports the media in delivering sensitive approaches to suicide and suicidal behaviour: Include focus on: • Help lines • Twitter • National campaigns
12. TRAINING.	Identify suitable stakeholder training Consider Peer Support Model Align with HeadStart Resilience training

The necessary actions and interventions that are needed to deliver the plan outlined above across the Stepped Care Model described on page 25 will require a community development work approach which has previously focussed in Wolverhampton on initiatives such as those outlined in 'Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett' (HM Govt. 2005).

The key building blocks of our refreshed and broader approach will include:

- **More appropriate and responsive services –** achieved by improving services and up skilling the workforce across the stepped care model to better respond to the needs of key groups to enable all members of the population to access all of our services equally and by working with all key stakeholders to that ensure that together we have a joined up approach to

challenging and addressing the broader determinants of mental ill-health and stigma and discrimination and promote parity of esteem, compassion, equality and respect diversity and human rights. .

- **Wider community engagement –** achieved by extending stakeholder engagement to capture agencies, voluntary groups and organisations that can have a strategic and day to day influence on the wider determinants of mental health and embedding agreed key deliverables into the Resilience Plan and Implementation Plan. Supported by our Community Development Workers.

- **Better information, communication and marketing -** achieved by improved data collation, capture and analysis of the City's vulnerable groups, mapping their needs and requirements and monitoring agreed actions via the implementation plan. This will include a regular census of mental health patients and public mental health needs across the City and delivery of a pro-active marketing campaign aligned to parity of esteem and national campaigns such as Beat Bullying, Time to Change, Health Poverty Action, and Child Sexual Exploitation of the NSPCC.

Stepped Care Model

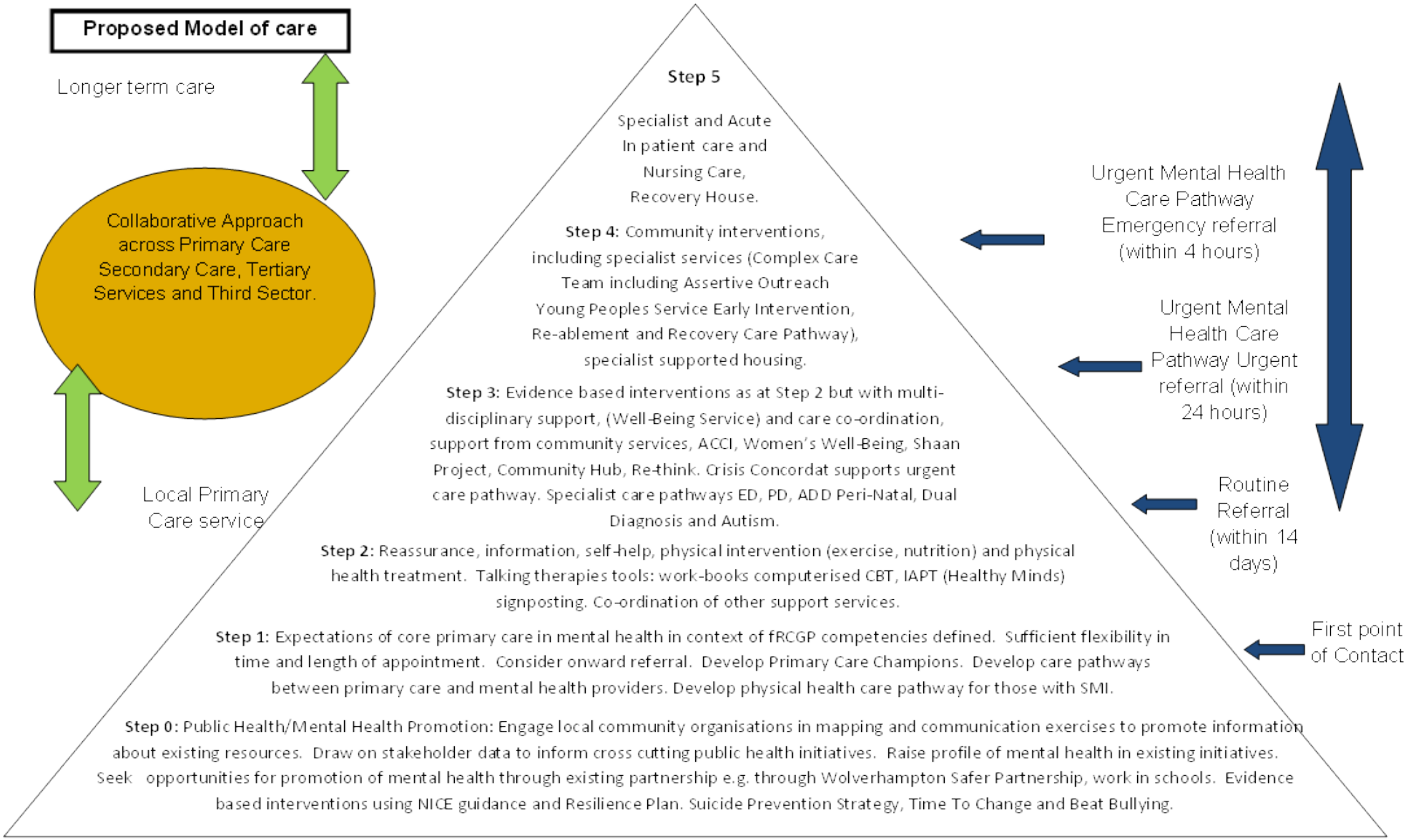
Mental Health services will be commissioned across the 'whole system' using the 'Stepped Care' Model which has formed the basis of previous service re-design in Wolverhampton.

The 'Stepped Care' model allows service users to transition through and into and out of secondary mental health services and into primary care, and re-enter components of the system if / as required. Fundamental principles underlining this approach will include:

- A 'whole system' of services and providers delivering recovery orientated interventions and support.

- Improved integrated health and social care pathways within existing services using the Better Care Fund.
- Improved communication between primary care, secondary and tertiary mental health services.
- Clear access and / or referral criteria.
- Transition into and out of services as appropriate and in keeping with the Care Programme Approach.
- Access to services 24/7 and improved urgent care.
- Greatest level of service provision for those with the highest levels of need.
- Promoting independence and improving recovery rates across the whole service model.
- Increased flexibility regarding the application of the care cluster model in terms of access to and treatment with health services.

The refreshed Stepped Care Model is described in the diagram below.


Proposed Model of care
Longer term care
Collaborative Approach across Primary Care Secondary Care, Tertiary Services and Third Sector.
Local Primary Care service
Step 5
Specialist and Acute In patient care and Nursing Care, Recovery House.
Step 4: Community interventions, including specialist services (Complex Care Team including Assertive Outreach Young Peoples Service Early Intervention, Re-ablement and Recovery Care Pathway), specialist supported housing.
Step 3: Evidence based interventions as at Step 2 but with multi-disciplinary support, (Well-Being Service) and care co-ordination, support from community services, ACCI, Women's Well-Being, Shaan Project, Community Hub, Re-think. Crisis Concordat supports urgent care pathway. Specialist care pathways ED, PD, ADD Peri-Natal, Dual Diagnosis and Autism.
Step 2: Reassurance, information, self-help, physical intervention (exercise, nutrition) and physical health treatment. Talking therapies tools: work-books computerised CBT, IAPT (Healthy Minds) signposting. Co-ordination of other support services.
Step 1: Expectations of core primary care in mental health in context of fRCGP competencies defined. Sufficient flexibility in time and length of appointment. Consider onward referral. Develop Primary Care Champions. Develop care pathways between primary care and mental health providers. Develop physical health care pathway for those with SMI.
Step 0: Public Health/Mental Health Promotion: Engage local community organisations in mapping and communication exercises to promote information about existing resources. Draw on stakeholder data to inform cross cutting public health initiatives. Raise profile of mental health in existing initiatives. Seek opportunities for promotion of mental health through existing partnership e.g. through Wolverhampton Safer Partnership, work in schools. Evidence based interventions using NICE guidance and Resilience Plan. Suicide Prevention Strategy, Time To Change and Beat Bullying.
Urgent Mental Health Care Pathway Emergency referral (within 4 hours)
Urgent Mental Health Care Pathway Urgent referral (within 24 hours)
Routine Referral (within 14 days)
First point of Contact

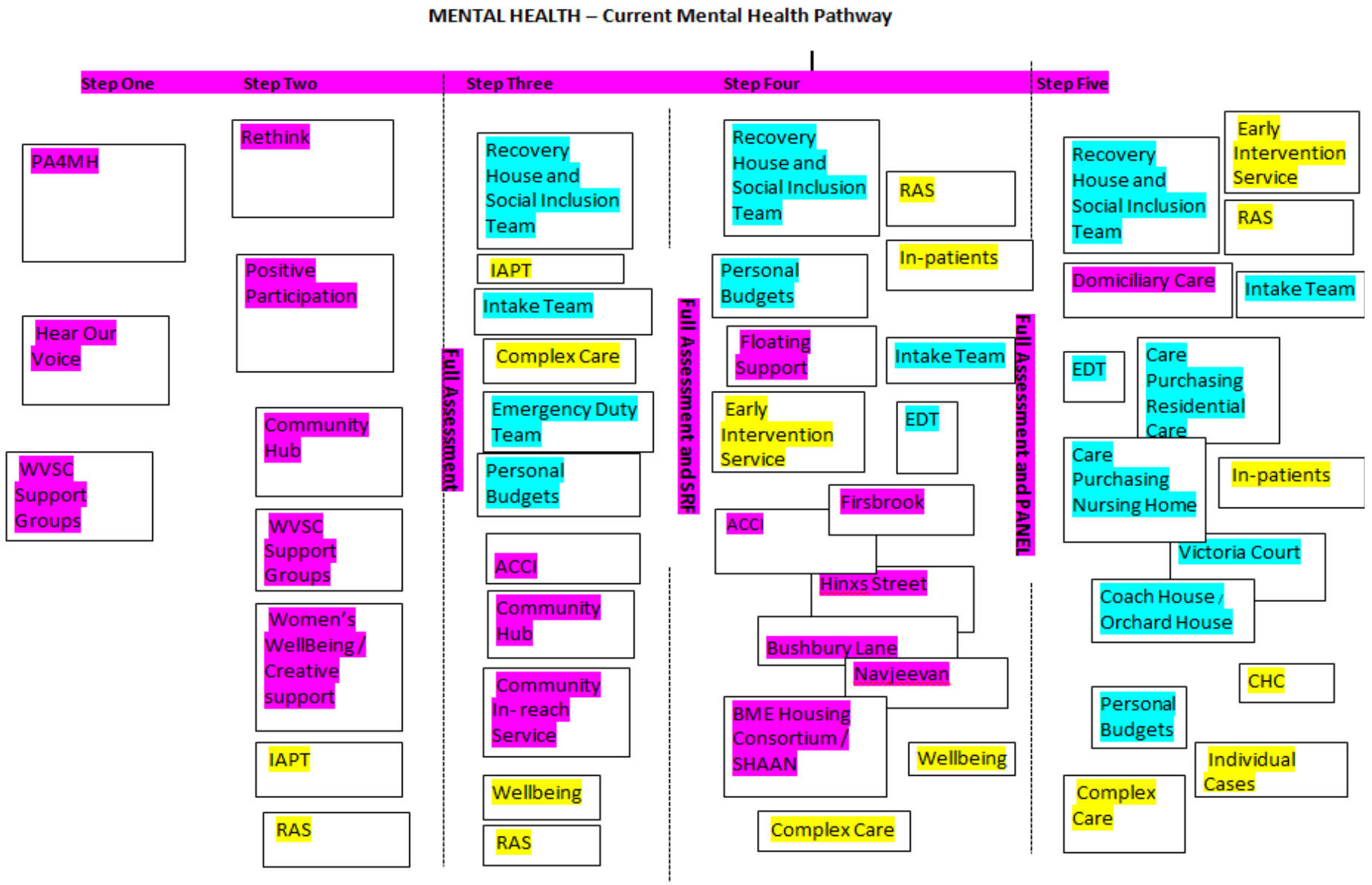
The Better Care Fund

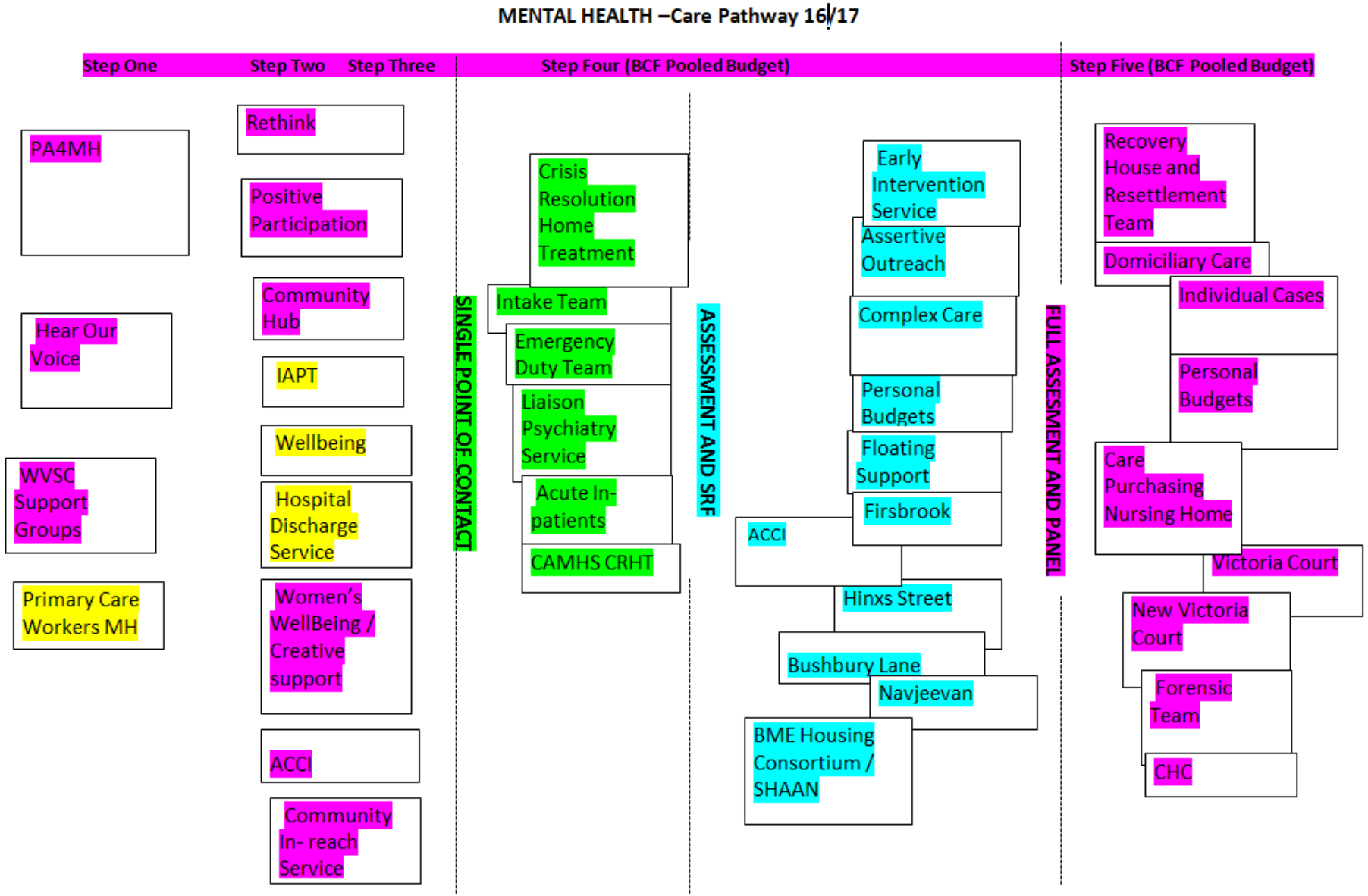
The Better Care Fund provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for mental health services in Wolverhampton. Wolverhampton's Better Care Plans include two integrated care pathways in mental health services, the Integrated Re-ablement and Recovery Care Pathway and the Integrated Urgent Mental Health Care Pathway.

The integrated Mental Health Re-ablement and Recovery Care Pathway will provide specialist re-ablement and recovery focussed assessment, interventions and support for adults with severe and enduring mental illness (SMI). This will include nursing and residential care, step-down, specialist community support and intervention, specialist mental health supported accommodation and floating support and day services and also individualised packages of care for people with high levels of need.

The integrated Urgent Mental Health Care Pathway 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.

Illustrations describing the current and future service mental health 'whole system' models are described below.


MENTAL HEALTH – Current Mental Health Pathway
Step One
Step Two
Step Three
Step Four
Step Five
PA4MH
Hear Our Voice
WVSC Support Groups
Rethink
Positive Participation
Community Hub
WVSC Support Groups
Women's WellBeing / Creative support
IAPT
RAS
Full Assessment
Recovery House and Social Inclusion Team
IAPT
Intake Team
Complex Care
Emergency Duty Team
Personal Budgets
ACCI
Community Hub
Community In- reach Service
Wellbeing
RAS
Full Assessment and SRF
Recovery House and Social Inclusion Team
RAS
In-patients
Personal Budgets
Floating Support
Intake Team
Early Intervention Service
EDT
ACCI
Firsbrook
Hinxs Street
Bushbury Lane
Navjeevan
BME Housing Consortium / SHAAN
Wellbeing
Complex Care
Full Assessment and PANEL
Recovery House and Social Inclusion Team
Early Intervention Service
RAS
Domiciliary Care
Intake Team
EDT
Care Purchasing Residential Care
Care Purchasing Nursing Home
In-patients
Victoria Court
Coach House / Orchard House
CHC
Personal Budgets
Individual Cases
Complex Care


MENTAL HEALTH –Care Pathway 16/17
Step One
Step Two
Step Three
Step Four (BCF Pooled Budget)
Step Five (BCF Pooled Budget)
PA4MH
Hear Our Voice
WVSC Support Groups
Primary Care Workers MH
Rethink
Positive Participation
Community Hub
IAPT
Wellbeing
Hospital Discharge Service
Women's WellBeing / Creative support
ACCI
Community In- reach Service
SINGLE POINT OF CONTACT
Crisis Resolution Home Treatment
Intake Team
Emergency Duty Team
Liaison Psychiatry Service
Acute In-patients
CAMHS CRHT
ASSESSMENT AND SRF
Early Intervention Service
Assertive Outreach
Complex Care
Personal Budgets
Floating Support
Firsbrook
ACCI
Hinxs Street
Bushbury Lane
Navjeevan
BME Housing Consortium / SHAAN
FULL ASSESMENT AND PANEL
Recovery House and Resettlement Team
Domiciliary Care
Individual Cases
Personal Budgets
Care Purchasing Nursing Home
Victoria Court
New Victoria Court
Forensic Team
CHC

4. KEY ISSUES / PRIORITIES

The final report of the adult mental health strategy review is attached as Appendix 2. The priorities for implementation will be aligned with those outlined in the CCG Operational Plan, the CCG Five Year Strategic Plan, Wolverhampton City Council Strategic Plan and the Joint Health and Well-being Strategy. Key priorities for future mental health commissioning have been drawn from the strategy review recommendations and key other local and national imperatives. In summary the key issues and priorities include the following:

- Integrated and / or aligned health and social care pathways are required across all stages of the service user journey, including primary, secondary and tertiary care. This will require remodelling some aspects of the commissioned service provision.
- Clear pathways for engagement with primary care are also needed to support the mental and physical health needs of people with differing requirements to achieve parity of esteem. This will require dedicated mental health support in primary care and primary care champions in all secondary and tertiary services.
- Consultant Psychiatry and medical support and expertise require re-focussing and balancing across the secondary, tertiary and primary care facing elements of the system. Our re-commissioned model will require increased access to Consultant Psychiatry expertise across the 'whole system' to improve access to assessment and treatment interventions and to achieve parity of esteem.
- Greater flexibility is needed regarding the application of the care cluster model (this is the model that is the framework for the payment system that is mental health payment by results). This is required both in terms of access to and treatment with health services so that the unique and specific needs of people are adequately supported and to allow greater alignment between services where the cluster model does not apply such as CAMHS, Learning Disabilities and Neurological Disorders.

- Achieving and sustaining recovery within the health model for patients of all clusters and especially for those patients clusters 3 and above experiencing non-psychotic conditions should re-focus to move include treatment support and interventions beyond an IAPT model of care and to provide continuing support as required.
- The application of the Care Programme Approach must be re-focussed across the 'whole system' to ensure appropriate levels of community support, relapse prevention and crisis plans and support for carers. Our re-commissioned must achieve an approach to CPA locally that is consistent with national guidance.
- An 'all age approach' is required in keeping with national guidelines so that there is flexibility regarding transition into age specific services and the unique needs of individuals are recognised and to achieve parity of esteem across the life span.
- There is a need to improve access to assertive support and treatment at home, and increase capacity and capability within day services and step-down services, to increase recovery rates, support sustained recovery and reduce relapse and prevent admission to hospital wherever possible.
- Access to care pathways including those providing access to specialised services must be un-impeded by and differing commissioning arrangements for different elements of the care pathway (i.e. into and out of secure and specialised care).
- Further development of local care pathways for people with Autism, Attention Deficit Disorder, Eating Disorders, Personality Disorders and Peri-Natal Mental Health is required to provide access to specialised assessment and treatment that is co-ordinated with across primary, secondary and tertiary care.
- Access to services and support across providers of re-ablement and rehabilitation services should be commissioned using a care pathway approach that improves access to the correct level of support and allows transition through services to services to promote independence and facilitate recovery and optimise effective and efficient use of resources within the market locally.

- To achieve parity of esteem improved waiting times and improved patient and carer experience in terms of emergency, urgent and routine response times and improved access to multi-disciplinary support in a crisis are required. This will involve some service re-modelling to provide dedicated support within the Acute Urgent Care Pathway at RWT. This will require local development of the Crisis Concordat with key local partners.
- Access to local female psychiatric intensive care is required.
- A refreshed approach to both the stepped care and the care cluster model is required to allow greater flexibility across the service model and to ensure that people receive the right level of continuing support and achieve sustained recovery.
- A collaborative approach with other local commissioners of mental health services is required, to pool resources and provides economies of scale.
- Improved access to information and communication for service users and carers and all key stakeholders regarding all matters pertaining to mental health and emotional wellbeing is required. This should harness and optimise the potential of the internet and social media and simple tele-health.
- In line with the Mental Health and Psychological Wellbeing Services Strategy for Children and Young People 2013-2016 there is a requirement re-commission services for children and young people to extend the upper age limit to 25 years where appropriate to provide access to care pathways and services that are age sensitive to prevent or facilitate transition to adult services as required.
- Improved access to and recovery rates within IAPT for people of all ages and specifically for children and young people aged 14-25 years and for people aged over 65 years is required. This should include re-commissioning to deliver value for money and improved access to e-CBT.

- Improved joint working across adults and children's services is required to ensure that the needs of families in contact with mental health services are addressed in entirety, and that the needs of children and young people are assessed and monitored when parents / guardians are experiencing mental health difficulties and vice versa.
- Improved and co-ordinated commissioning approaches with substance misuse commissioning colleagues is required to ensure clearly commissioned care pathways between and across mental health and substance misuse services, and to co-ordinate health promotion campaigns.

In response to the above identified key issues an implementation plan is included as Appendix 3.

5. IMPLEMENTATION

For the purposes of delivery of a 'whole system' model the implementation plan attached as Appendix 3 is structured across the stepped care model, as described below.

STEPS 0-5 DEVELOP AN ALL AGE APPROACH ACROSS SERVICE MODEL THAT INCORPORATES THE NEEDS OF PEOPLE UNDER 18 YEARS AND OVER 65 YEARS

We will develop a commissioning plan / care pathway/s that align all initiatives within the implementation plan with existing and future plans regarding CAMHS and Older People's Services so that services are consistent, seamless, age related and inclusive. This will also be aligned with simple tele-health and FLO and the Emotional and Psychological Health and Well-Being Strategy (2013-2016) and Dementia Strategy re-fresh.

STEP 0 - DEVELOP A LOCAL RESILIENCE PLAN (MENTAL HEALTH PROMOTION, EARLY INTERVENTION AND PREVENTION)

We will develop a local multi-agency Resilience Plan with key stakeholders described in Wolverhampton's Health and Well-Being Strategy. This will help us to deliver targeted mental health promotion and early intervention and prevention interventions cross our commissioned services, and to work with partners involved in education, employment, leisure and housing, for example to focus initiatives upon the wider determinants of health . This will include initiatives to address the broader determinants of mental ill-health including issues pertaining to:

- Parental mental health
- Mental Health Promotion
- Physical health and disability
- Leisure and physical activity
- Bullying
- Mental Health in the work place
- Self-harm
- Substance misuse
- Improved information and communication
- Targeted Interventions for carers
- Targeted interventions for at risk groups (BME, LGBT/Q)
- Debt Advice
- Un-employment
- Educational attainment

- Ending stigma attached to mental health

In addressing those issues highlighted above the Resilience Plan will incorporate the Suicide Prevention Plan and will assess, map and scope the needs of the City's key vulnerable groups people affected by vulnerabilities related to and including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

This will be taken forward using a Community Development Work model as out lined on page 23.

STEP 1 DEVELOP A LOCAL SUICIDE PREVENTION STRATEGY

We will develop a local multi-agency Suicide Prevention Strategy with key stakeholders. This will be aligned with the local Crisis Concordat and will respond to local needs across each of the National Suicide Prevention Strategy areas for action:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

This will incorporate learning from the Preventing Suicide in England: One year on First Annual Report (2014), and local data regarding current trends and new messages from research, including the use of social media, learning regarding 7 day follow up, health and social care assessments, treatment and clinical interventions for people with depression and people at risk of self-harm, and specific vulnerabilities related to age, gender and ethnicity and the specific needs of the LGBT/Q community and people who misuse substances.

STEP 1 - DEVELOP PRIMARY CARE PATHWAYS

To ensure best practice in terms of early intervention and prevention, improving the physical health of people with mental health difficulties and improving care pathways into and out of secondary services for people of all ages, we will commission mental health care pathways in primary care supported by primary care champions and workers in primary care facing and secondary services.

This will include pathways of care for people with specialised mental health needs such as autism, attention deficit disorder, eating disorders, peri-natal mental health, depression and personality disorder and the primary care support needs of people taking anti-psychotic medication. This will include review of all of our well-being and support services commissioned from community and voluntary sector organisations and third sector organisations to strengthen early intervention and prevention initiatives and deliver the resilience plan as described above.

STEP 2 - REVIEW COMMISSIONING MODEL OF INTEGRATED ACCESS TO PSYCHOLOGICAL THERAPIES

We will review our current commissioning model of IAPT services for patients clusters 1-3 to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days for those patients meeting 'caseness' and within 28 days for those who do not. This will include increasing the accessibility of the service for targeted groups and to extend provision to children and young people aged 14-25 years and older people and people with co-morbid mental and / or physical health needs. We will look for opportunities to commission on an economies of scale basis and will seek to achieve cost efficiency savings for re-investment elsewhere in the mental health system and to balance the proportion of spend across the mental health 'whole system'. We will look for opportunities to commission E-CBT packages, with access to peer support and signposting and information and communication online. The model will also be reviewed to include primary care gateway workers to facilitate pathways for engagement with primary care to support the mental and physical health patients with differing levels and types of need.

STEP 3 – COMMISSION THE YOUNG PERSONS SERVICE MODEL

We will work with the providers of health and social care services to implement the service model changes required to complete implementation of the Young Person's service which will extend children's services and pathways to accommodate young adults up to 25 years. This will allow young people to receive dedicated treatment and support from a designated team of clinical experts supporting their transition from CAMHS to adult services and care pathways up to the age of 25 years if required.

STEP 3 – REVIEW COMMISSIONING MODEL OF THE COMMUNITY WELLBEING SERVICE

We will review our current commissioning model of the Community Wellbeing Service for patients clusters 4 and above to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days. This will include reviewing the capacity and capability of the service to offer support and interventions beyond a psychological based therapies service and to increase access within the service to multi-disciplinary and Consultant Psychiatry expertise. The model will be reviewed to allow patients to receive on-going support from the service and for services users in the service to receive care planning support and intervention that are compliant with the national guidance regarding the Care Programme Approach. The model will also be reviewed to include primary care gateway workers to facilitate pathways for engagement with primary care to support the mental and physical health patients with differing levels and types of need. This will be aligned with the review of the complex care service (as per Step 4).

STEP 3 – COMMISSION AN INTEGRATED MENTAL HEALTH URGENT CARE PATHWAY

As part of our Better Care Fund development plans to implement the Integrated Mental Health Urgent Care Pathway we will review the health components of the current model. We will re-commission Liaison Psychiatry to provide an all age model. We will review the current model of Crisis Resolution and Home Treatment to provide an integrated Crisis Resolution / Home Treatment Team.

We review pathways and referral criteria into each service within the health system to improve waiting times so that waiting times (not including Wolverhampton Healthy Minds) are up to 4 hours (emergency), up to 24 hours (urgent) and up to 14 days (routine). We will review the capacity and capability of the health and social care urgent mental health care pathways to increase the capacity and capability of the service to meet the needs of people of all ages outside normal working hours and respond to requests for assessment under the Mental Health Act. We will commission a service model and care pathway that provides an integrated collocated and aligned approach to mental health urgent care within a multi-disciplinary context, including access in an emergency to specialist medical and Consultant Psychiatry support that is consistent with Royal College guidelines and the Care Programme Approach.

STEP 4 – REVIEW COMMISSIONING MODEL OF THE COMPLEX CARE SERVICE

We will review our current commissioning model of the Complex Care Service, for patients clusters 5 and above to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days. This will include reviewing the capacity and capability of the service to offer support and interventions of an assertive outreach model, the function of the personality disorder hub and the forensic team. This is to increase the capacity and capability of local services to support people with the highest levels of need, and provide step-down from secure care and specialised services locally and 'out of area' and reduce relapse and re-admission/s. The model will also be reviewed to allow patients to receive on-going support from the service and for services users in the service to receive care planning support and interventions that are compliant with the national guidance regarding the Care Programme Approach.

STEP 4 – COMMISSION AND IMPLEMENT AN INTEGRATED RE-ABLEMENT AND RECOVERY CARE PATHWAY

We will re-commission and implement an integrated re-ablement and recovery pathway as part of Better Care Fund plans. This will promote independence, facilitate recovery and allow service users to progress along the care pathway and prevent relapse and re-admission. The integrated pathway will also allow pooled and effective deployment of and efficient use of resources across the 'whole system' that responds to local need and demand management. This will facilitate step-down from in-patient, specialised and secure care, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches for people requiring continued support in supported housing, nursing and residential care and hospital placements into an aligned care pathway of continued support. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery, and will allow the re-allocation of resources from acute, specialised, 'out of area' and complex care to recovery and re-ablement in the mid to long term.

STEP 4 – REVIEW COMMISSIONING MODEL OF LOCAL SPECIALIST CARE PATHWAYS

We will work with providers of health and social care services to commission and implement specialist care pathways for the following:

- Eating Disorders
- Personality Disorder
- Peri-natal Mental Health
- Dual Diagnosis (Substance Misuse)
- Attention Deficit Disorder
- Autism

This will increase capacity and capability, providing specialist assessment and intervention within mainstream mental health services within the local system and facilitating effective liaison with specialist services commissioned by NHS England.

STEP 5 – REVIEW COMMISSIONING MODEL OF FEMALE PIC AND OUT OF AREA ADMISSIONS FOR URGENT AND PLANNED MENTAL HEALTH CARE

We review of our current commissioning of all out of area mental health admissions to identify opportunities to maximise the resources available within local services as alternatives to out of area admissions and to identify 'preferred providers' for Female Psychiatric Intensive Care (PIC) in the short term, whilst liaising with local providers and commissioners regarding a medium to longer term solution. We will optimise the available capacity within re-ablement and recovery services within our local health and social care economy both with the public sector and independent sector services as an integral part of the local 'whole system' as required. We will realise cost efficiency savings by reducing the numbers of all types of out of area placements and reducing lengths of stay. We will work with local providers to develop capacity and capability of locally commissioned services to meet the needs of people who are discharged and / or transferred from secure and specialised services, so that we can optimise deployment of and efficient use of resources across the 'whole system' that is consistent with local need, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches sub –specialisms including hospital placements for rehabilitation. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery.

STEP 5 - REVIEW THE COMMISSIONING MODEL OF POND LANE AND OTHER LEARNING DISABILITY IN-PATIENT SERVICES

As part of the mental health strategy implementation plan we will review the current commissioning of all LD in-patient admissions to optimise resources available within local services as alternatives to admissions to BCPFT In-patient services and out of area

admissions. We will also commission to optimise the available capacity and capability within community services within our local health and social care economy both with the public sector and independent sector services as an integral part of the local 'whole system' as required. This will be to develop the capacity and capability of locally commissioned services to meet the needs of people with LD who are discharged and / or transferred from secure and specialised services. Identify opportunities for collaborative commissioning. We will identify opportunities for collaborative commissioning (e.g. SWBCCG) and others and align our commissioning plans with Autism Strategy and Winterbourne Plans.

Summary

The priorities outlined in our re-freshed joint commissioning mental health strategy have been developed from our knowledge of local need and national best practice and policy implementation guidance. The priorities outlined above will commission a 'whole system' of integrated health and social care fit for the future which operates across the stepped care model to offer parity of esteem and the right care, in the right place at the right time. This will include targeted supportive and preventative interventions to strengthen community resilience and a programme of investment in evidence based services, care pathways and initiatives to deliver improved access to early intervention and prevention, urgent and crisis care and re-ablement and recovery. This will achieve 'parity of esteem' for mental health services and care pathways in comparison with physical health services in terms of access to services, quality of service user and carer experience and service user outcomes.

6. LIST OF APPENDICES

- Appendix 1 - Final Report of the Strategy Review
- Appendix 2 – Strategy Implementation Plan

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Agenda Item No. 14

Health and Wellbeing Board

4 March 2015

Report title	Wolverhampton Clinical Commissioning Group Decommissioning And Disinvestment Policy
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Linda Sanders, Community
Originating service	Wolverhampton City Clinical Commissioning Group
Accountable employee(s)	Dr Helen Hibbs Chief Officer Tel 01902 443075 Email Helen.hibbs@nhs.net
Report to be/has been considered by	WCCG Public Governing Body Meeting on the 9th December 2014

Recommendations for noting:

The Health and Wellbeing Board is asked to note; review and comment as applicable.

1.0 Purpose

1.1 The purpose of this report is to provide the board with the Wolverhampton Clinical Commissioning Group (WCCG) Decommissioning and Disinvestment Policy.

2.0 Background

2.1 At the private WCCG Governing Body (GB) meeting on 11th November it was agreed that a WCCG Efficiency Review Group' (ERG) would be established on a task and finish basis to review expenditure, this work would be completed in as short a timescale as possible.

2.2 To ensure that resources are consistently directed to the highest priority areas, the CCG has developed a "Decommissioning and Disinvestment Policy".

The policy sets out the agreed principles that the CCG will follow when decommissioning or disinvesting a service(s).

2.3 WCCG faces financial pressures and must act accordingly to protect health care service and ensure that the tax payer funding is as affectively used as possible.

3.0 Progress, options, discussion, etc.

3.1 The policy was approved at the WCCG Public Governing Body meeting on the 9th December 2014. A WCCG communications approach has begun to ensure that all stakeholders are aware of the policy, and the impact of the current procedures that the CCG will be undertaking to review expenditure.

3.2 By documenting the decommissioning and disinvestment process, the CCG is:

- Setting out the agreed principles for decommissioning / disinvesting a service (so that funds can be redirected where appropriate).
- Clearly defining the process that will be followed, when approval has been given to decommissioning / disinvesting a service(s).
- Defining the clear lines of accountability and responsibility throughout the process.

3.3 The disinvestment and decommissioning policy is to be applied when making both clinical and non-clinical disinvestment and decommissioning decisions.

4.0 Financial implications

4.1 The CCG has a strategic plan that is transformational in its intentions; however this level of change will take time. The establishment of the ERG has prompted immediate actions to protect the resources of the CCG, so that short term stability can be achieved whilst longer term change is initiated and embedded

4.2 There is an immediate and substantial risk that the CCG will fail to meet its financial targets for 2015/16 and will overspend in a number of its budget areas. This undermines the foundation for the financial position in future years and potentially destabilises the CCG's commissioning strategy.

4.3 Whilst the CCG is forecasting that it will meet its 2014/15 expenditure limit, in doing so it will consume a significant amount of its recurrent reserves. This carries increased pressures into future financial years and impacts on sustainability in the medium to long term

5.0 Legal implications

5.1 Consultation and engagement will be undertaken in line with the decommissioning and disinvestment process and in line with our legal duties.

6.0 Equalities implications

6.1 Equality Impact Assessments will be completed with each ERG recommendation to the Governing Body.

7.0 Environmental implications

N/A

8.0 Human resources implications

N/A

9.0 Corporate landlord implications

N/A

10.0 Schedule of background papers

10.1 The attached policy was agreed at the WCCG Public Governing Body on the 9th December 2014.

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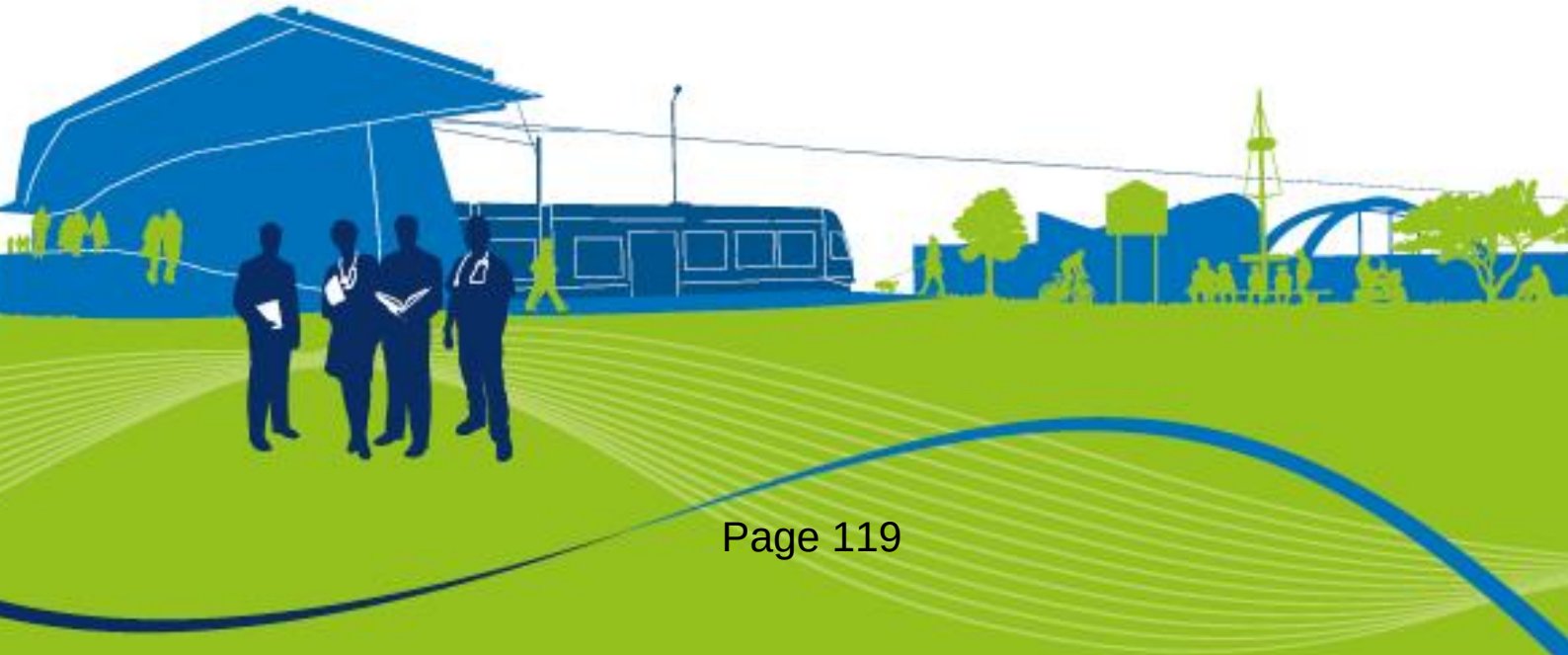
NHS
Wolverhampton
Clinical Commissioning Group

Decommissioning & Disinvestment Policy
Version 1.2



DOCUMENT STATUS:	**Approved**
DATE ISSUED:	**9th December 2014**
DATE TO BE REVIEWED:	**December 2015**

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
1.0	**02/12/14**	**First Version**
1.1	**09/12/14**	**Version Presented to Governing Body**
1.2	**09/12/14**	**Final Version Approved by Governing Body**

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Tim Rideout	Interim Turnaround Director	26/11/14	1.0
Claire Skidmore	Chief Finance and Operating Officer	27/11/14	1.0

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Efficiency Review Group	02/12/14	1.1
WCCG Governing Body (Public)	09/12/14	1.2

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REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION

Contents Page

Executive Summary

Due to the current challenging financial climate, it is important for the CCG to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources, and in order to deliver our statutory responsibilities, and meet the needs of the Wolverhampton population.

To achieve this, effective contracting arrangements and strong performance management are essential to meet these challenges, and secure the best possible healthcare for our local population.

The CCG will ensure that our commissioning decisions are fully informed and based on health outcomes data by utilising all reliable data sources combined with public health data and clinical analysis.

To ensure that limited resources are consistently directed to the highest priority areas the CCG has identified the need to develop a Decommissioning and Disinvestment policy that sets out the agreed principles for decommissioning a service, so that funds can be redirected where appropriate.

There is also a need to ensure that when approval has been given to decommission, or disinvest a service that a clearly defined process is followed, with clear lines of accountability and responsibility.

For the purpose of this policy the following definition have been applied:

- **Decommissioning:** This relates to the withdrawal of funding from a provider organisation that is subsequently re-commissioned in a different format.

- **Disinvestment:** This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.

In the event that decommissioning or disinvestment is proposed, the CCG will need to recognize that a number of steps will be required prior to a final decision being taken by the CCG Governing Body.

These include consideration as to whether a consultation exercise is required with partner organizations, patients, public and the Health Overview and Scrutiny Committee.

1. Introduction

The CCG's long term commissioning strategy and financial challenges has inevitably led to the need to clarify the circumstances of when services should be decommissioned, and the need to describe the approach and processes, that will be adopted to ensure decommissioning and disinvestment decisions are fully informed and managed.

Following any service review a number of options will be available to the CCG.

These will include:

- The need to re commission part of the service,
- Amend the threshold / restrict access to a service or
- Provide a modified service to ensure that there are no gaps in healthcare delivery.

In line with best practice the CCG has identified the need to describe the approaches that will be used to identify services that require review, describe how the 'Case for Change' for service decommissioning will be produced and how disinvestment decisions will consulted upon, Furthermore, the roles and accountability of decision making have been set out.

The disinvestment and decommissioning policy is to be applied when making both clinical and non-clinical disinvestment and decommissioning decisions.

2. Our approach to Decommissioning and Disinvestment

The aim of this policy is to:-

1. Provide a rationale and process to allow services to be identified for review prior to any decision to decommission or disinvest.

2. Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.

3. Ensure all commissioned services are monitored in terms of performance, health outcomes, efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding the continuation of that service.

4. Contribute to the delivery of the CCG's commissioning plan and QIPP agenda, to ensure that resources are directed to the highest priority area in order to achieve the best possible health outcomes for the local population against available resources.

5. Ensure all decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the CCG Governing Body.

6. Ensure the safety of patient remains paramount.

3. Structure and Accountabilities

3.1 CCG Governance Processes

3.1.1 Clinically-led structure

The CCG's Operating Plan 2014-16 sets out our two-year roadmap and explains how the CCG will start to transform local care for the better, the plan describes the structure for the planning and delivery of the CCG's commissioning strategy through the delivery of QIPP priorities and the release of benefits associated with assuring and improving quality, harnessing innovation, improving productivity and reducing demand for services.

The Operating Plan 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 deliver QIPP improvements and therefore improved health outcomes for the Wolverhampton CCG population.

3.1.2 Locality ownership and accountability

The broad role of the CCG localities within this planning and delivery framework is two-fold. Firstly, localities are required to work with Delivery Boards in order 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 their constituent practices), to deliver against QIPP benefits targets which contribute to improved health outcome.

The overarching Commissioning Business (delivery) Plan for the CCG is therefore chiefly a composite of Locality Business Plans and Better Care Fund plans.

3.1.3 Wolverhampton CCG Commissioning Strategy

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 outcomes.

3.1.4 Commissioning Committee – Strategic Planning

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 commissioning plans - Operating Plan, locality plans and Better Care Fund plans - are aligned to the strategic objectives of the CCG.

3.1.5 Finance and Performance Committee – strategic delivery

The Finance & Performance Committee (FPC) is accountable to the Governing Body and its remit is to provide assurance on issues related to the finances, including financial health, of the CCG and the achievement of performance objectives and targets.

Part of the remit of the committee is to review plans for and delivery of initiatives under QIPP and any subsequent programme of that nature; and to make recommendations as necessary to the Governing Body on the remedial actions to be taken with regard to finance and performance issues and risks, including in-year changes to budgets.

3.1.6 QIPP Portfolio Board – operational planning and delivery

The QIPP Portfolio Board has a dual function within this structure and is the fulcrum upon which effective commissioning business planning and delivery is balanced.

The QIPP Portfolio Board will report on progress on delivery to the Finance & Performance Committee and the localities using standard reporting formats.

The QIPP Portfolio Board is a high level board which oversees the CCG's delivery of QIPP programme by holding the lead Executive directors of each Programme Delivery Board to account for performance against their QIPP target. Chaired by the DCFO and supported by Business and Performance and Quality, the Board receives exception reports for schemes which are not delivering to plan or are no longer viable.

The QPB acts as an escalation vehicle to ensure delivery of schemes are not compromised and the PDBs deliver their target. It is for the PDBs to operationally manage the QIPP delivery within their areas identifying new schemes as appropriate.

The Board also oversees the whole QIPP planning cycle (over 5years in line with the LTFM) and takes the strategic view of QIPP schemes (over 5years in line with the LTFM), including their fit with the CCG strategic direction including Better Care Fund.

3.1.7 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.

They will act as the key decision-making bodies for their sector of care; they will include primary care clinicians in agreeing optimum means by which the challenge of QIPP and 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 and a number of QIPP work streams

3.2 Efficiency Review Group.

3.2.1 Role

The Governing Body, as the legally accountable body in Wolverhampton, will ultimately take the decision with regard to the decommissioning of any service following the criteria and process set out in this policy.

The vehicle for managing the task of reviewing expenditure and making recommendations to the Governing Body will be the 'Efficiency Review Group' (ERG). The group will report directly to the Governing Body and whilst it will not have delegated responsibility to make disinvestment decisions it will be required to make clear recommendations to the Governing Body.

The ERG will be established on a task and finish basis with challenging deadlines for the review of expenditure in order that benefits can be realised in as short a timescale as possible.

Once recommendations are made and the Governing Body have agreed actions to be implemented the CCG will follow all necessary steps for consultation; notice periods and transition to alternative services where necessary and appropriate. At this point the ERG will refocus its work to oversee delivery of the work programme.

3.2.2 Principles

The following principles will be adopted throughout the ERG process.

These are as follows:

4. Roles and Responsibilities of the CCG & of the wider teams

The following describes the role and responsibilities within the CCG, and how each role will influence and interact in the disinvestment / decommissioning process.

4.1 Accountable Officer

The Accountable Officer is accountable for the actions undertaken by the CCG Heads of Service, as noted below.

4.2 CCG Heads of Service

The CCG Heads of Service are responsible for the commissioned service and are required to undertake the following actions when considering disinvestment / decommissioning proposal:

- Secure any appropriate legal advice through discussions with the Chief Finance Officer and Corporate Operations Manager.
- Assess the benefits the service has realised and assess the potential for any further improvement to the services effectiveness.
- Inform the relevant department(s) of the benefits identified; and plan with them how to obtain valid evidence of positive progress.
- Review the monitoring of the benefits realised.
- Undertake an initial service impact analysis.
- Prepare a case to be considered by the ERG in respect of decommissioning / disinvestment of the Service.
- Adopt a programme management approach to manage the processes to inform the ERG of the development of a “Disinvestment Impact Assessment” document that will be used to consult and ultimately be presented to the Governing Body.

  The case for change will include:-

  - The evidence behind why the case for the case is being proposed for a decommissioning / disinvestment decision.
  - Undertake all appropriate impact analysis prior to these being presented to the CCG Quality Committee / QiPP
  - Keep log of the risk and issues identified.

4.3 Quality

The CCG Quality Committee is a key forum to notifying commissioners when concerns are raised in terms of the quality and safety of the services provided.

The team utilizes information from a variety of sources to assess the safety, efficacy and service user experience of clinical commissioned services. This information along with site visits and other intelligence is used to assess the relative quality of services commissioned or contracted by the CCG.

The Heads of service will work with the Quality Team, proposing the decommissioning of service(s) to ensure that a reduction in services does not have a direct or indirect negative impact on patient safety or the quality of any other related service.

The availability of good quality information is important to the decision making process in commissioning, NICE guidance and commissioning guides are used to inform all relevant commissioning decisions.

4.4 Contracting

The CCG is responsible for ensuring that providers who have been commissioned to provide health care services have a contract with the CCG that specifies the services to be provided, the value of that service and the means by which the CCG will be able to hold the provider to account for the delivery of the service.

The contracting team works with our providers to ensure day to day operational issues that affect the service delivery are resolved effectively.

In most cases the contracting team will assess the performance of a particular contract or contractor by the use of monthly monitoring data, by contract meetings with the commissioned providers; these would typically take place on a monthly basis.

Any remedial actions required would be clearly agreed in an action plan and a follow up meeting, where necessary providers will be recompensed for unavoidable costs incurred following the cessation of services.

4.5 Strategy and Solutions

The Strategy and Solutions teams are a key part to reviewing the services against health outcomes and identifying service / programme areas to be reviewed prior to more in depth analysis to identify specific commissioned services.

Areas for review will be identified using the following tools:

- Analysing trends by care setting e.g. Acute Care, Primary Care, community services, mental health etc. and comparing these trends of spend with other areas, to identify the reasons for the difference in trends between PCTs.

- Expected and current prevalence figures to understand the population demographics.

4.6 Finance Team

Our Finance team are key to reviewing expenditure against health outcomes and identifying service areas to be reviewed.

Reviews are done using the following tools:

- Programme Budgeting Results: Using the programme budgeting benchmarking tool to identify how much is spent by the organisation for each programme compared with similar CCGs. It also analyses the relationship between spend and the health outcomes, and investigates variances to understand the reasons for investing these resources.

- Various other benchmarking tools: Using various benchmarking tools to analyse the trends in activity over time in comparison to national, regional and local benchmarks on activity/spending trends.

4.7 Performance Team
The CCG's Performance Team are responsible for providing key performance information to commissioners to ensure that services are appropriately reviewed.

The information behind a decision to decommission must be of high quality, be auditable and able to be presented as evidence which can withstand challenge should the decision be disputed.

The tools referred to in section 5 are utilised by the team to identify areas for further consideration by commissioners.

The team look for areas of:

- Poor performance against targets
- Poor health outcomes
- Poor value for money
- Inequality of service provision
- Reduced impact on health outcomes and identify potential areas for resources to be redirected to achieve better health outcomes for the population we serve.

4.8 Public Health Team
When considering service for decommissioning or disinvestment the Wolverhampton County Council Public Health team will be able to help assess the effectiveness of the intervention(s) provided by the service and contribute to the health impact assessments required in making informed decommissioning / disinvestment decisions.

The Public Health team have the skills and ability to add to the interpretation of population based data that are used to highlight areas for decommissioning, such as benchmarking tools which compare the cost and / or outcomes of services compared to other CCG and previous PCTs.

The Public Health Team are a core member of the ERG.

4.9 Human Resources Advice
HR expertise will be sought should the decommissioning of services be confirmed, to ensure all legal obligations and any potential workforce planning issues are appropriately managed.

4.10 Communications Engagement Team
If decommissioning or disinvestments is proposed due to the introduction of a new service model, then the commissioner needs to seek expert advice from the communications team in relation to whether any engagement / consultation exercise is required to comply with Section 242 of the NHS Act (2006).

This advice must be sought at the earliest possible opportunity due to the length of time required for informal engagement and public consultation.

Health Scrutiny Panels / Committees, Key Stakeholders and Health Watch should be advised and involved from the outset.

The timescales required plus other guidance on engagement/ consultation criteria can be found through national best practice guidance.

4.11 Procurement Lead
Specialist Procurement advisors within the CSU and the CCG Procurement lead will ensure that the rules and principles relating to any decommissioning (and disinvestment) activity will follow the principles and rules of cooperation and competition.

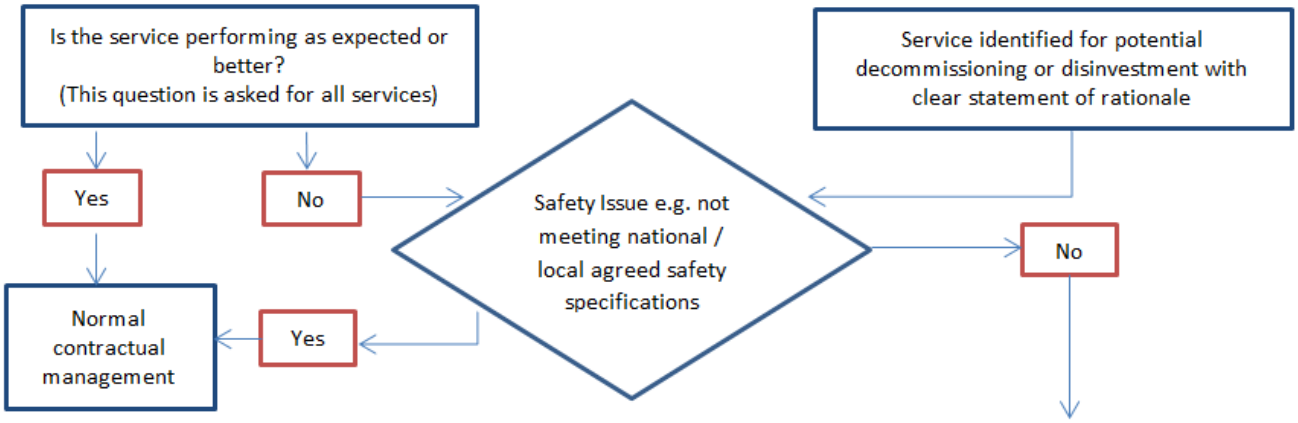
Monitor Guidance must be considered to ensure that no sector of the provider market is given any unfair advantage during the decommissioning process, and the CCG will retain an auditable documentation trail regarding all key decisions around procurement law. The Procurement advisors will also ensure market assessments are completed to analyse any impact on the provider market.

5. Decommissioning and Disinvestment Processes for Commissioned Services

5.1 Process Flow Chart

The Disinvestment / Decommissioning tool flow chart (appendix one) provides at a glance the agreed process for commissioners to follow prior to commencing decommissioning / disinvestment discussions.

5.2 Step One



5.2.1 Identification of service for review

The Process for identifying services for review and potential decommissioning / disinvestment needs to be systematic and there are a number of mechanisms utilised to evidence the need for review.

In line with commissioning best practice there is a need to ensure that WCCG apply performance and contract management principles to all contracts and subsequently service reviews.

Each commissioned service, shall be initially reviewed to confirm if the “service is performing as expected or better?”

The CCG can then identify commissioned services that:

1. Do not meeting the needs of the population (as identified through the Joint Strategic Needs Assessment, Enhanced JSNA and demand analysis);

2. Of low quality and do not demonstrate value for money.

3. Of high expenditure and low outcomes.

4. Has continued poor performance identified through the contract monitoring process and / or feedback from patients, public and partners.

5. Are not meeting the health needs of the population (as demonstrates via a health needs Assessment

6. Do not maximise the health gain that could be achieved by reinvesting the funding elsewhere.

7. Do not meet the standards of a modern NHS as defined by:
    - Professionally driven change i.e. provider driven business case which delivers modern innovative service.
    - Nationally driven change i.e. National policy or guidance requires change in service delivery.
    - The service is one with limited clinical evidence, quality or safety.

5.2.2 Tools to be used to Identifying Service Review Areas

The CCG is committed to ensuring that our local population receives the best care, for the best value and subsequently ensures that there is a continual review of CCG contracts and expenditure against measurable health outcomes.

As a matter of policy the CCG will prioritise those areas where high expenditure and low outcomes are identified to enable / undertake further analysis into the provision of commissioned services .

- **NHS Comparator**

NHS Comparators data provided analysis of quarterly inpatient activity and expenditure data by programme budget at England, a SHA, previous PCT and Practice level. Prescribing expenditure and volume data linked to programme budget are also available. NHS Comparators allow commissioners to track expenditure and outcomes over time.
https://nww.nhscomparators.nhs.uk/

- **Programme Budgeting**

Programme budgeting information is used to examine the current deployment of resources, and to make decisions on how resources should be invested to achieve better value outcomes. There are a number of tools that can be used to consider areas for review including the Department of Health benchmarking toolkit below:
http://www.networks.nhs.uk/nhs-networks/health-investment-network/news/2011-12-programme-budgeting-data-now-available

The above toolkit provides a means of considering our expenditure compared to other Trusts both locally and nationally.

- **The Spend Outcomes Tool**

The Spend and Outcomes tool (SPOT) was developed by the Association of Public Health Observatories.

The tool allows comparison between expenditure and outcome data for each of the Programme Budget disease categories on a single page. It is interactive and allows the selection of different outcome measures and different views of the data, including a comparison with any other organizations therefore enabling the ability to identify areas of expenditure that warrant further investigation. Data is at previous PCT level.

- **Ssentif Benchmarking System**

The Ssentif benchmarking website which enables benchmarking outcomes and expenditure against other Trusts / Providers both locally and nationally

- **Programme Budgeting Atlases**

Programme budgeting expenditure has also been linked to health outcomes, Quality Outcomes Framework (QOF) data and Hospital Episodes Statistics (HES) activity in the Programme Budgeting Atlases.

These interactive atlases present programme budgeting expenditure data alongside clinical and health outcome indicators in a user friendly graphical format that can be used to support commissioners when considering areas for service review.

The following link http://www.rightcare.nhs.uk/index.php/nhs-atlas takes the user to the Information Centre website where the interactive atlas can filter and benchmark outcome indicators

- **Mosaic**

Mosaic is a national geo-demographic segmentation that splits the UK population into 11 groups and 61 types based on national characteristics. Mosaic enables us to gain a greater understanding of the differing health need of the local population and supports commissioners to consider whether services are placed in appropriate locations, are being advertised appropriately and are being accessed by those that need it.
The utilisation of services by their target population groups will be a consideration when making decommissioning or disinvestment decisions.

- **Contract Register**

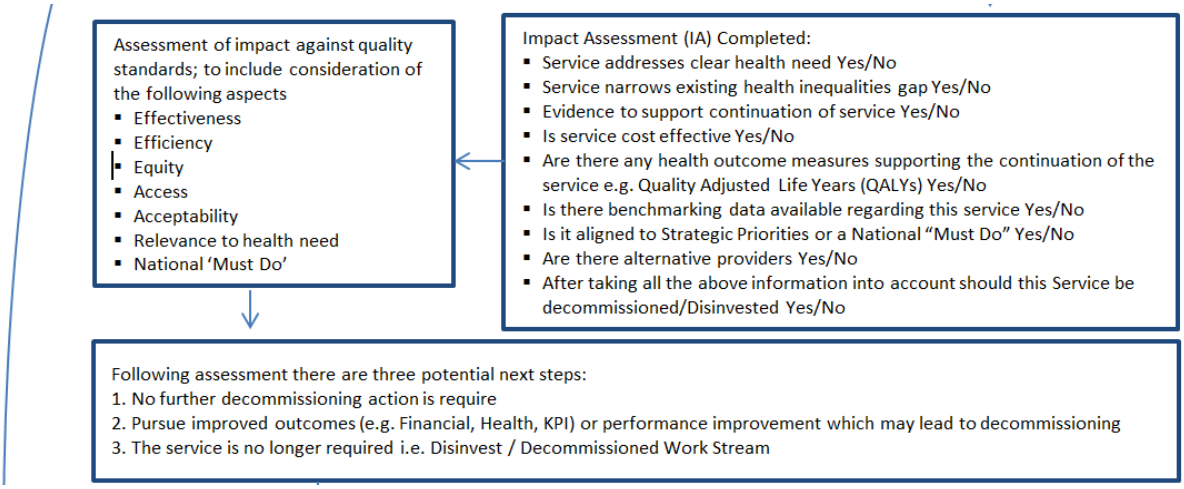
The contract register holds records of all contracts currently held by the CCG. The register will be able to provide information on all providers delivering services and contractual information to support decommissioning decisions and the procurement work stream.

- **Service Users**

A key mechanism for identifying potential services for review is feedback from service users via, complaints, compliments, the CCG's Patients Groups, patient survey results and Healthwatch.

The CCG Executive Nurse will also proactively seek views from relevant community groups and feedback from patients who have been service users, or are likely to be service users in the future.

5.3 Step Two



5.3.1 Initial Assessment and Assessment of impact

In the event that a case for change is validated by sufficient supporting evidence, the lead identified via the ERG will be responsible for developing an impact assessment (IA) (appendix two).

The impact assessment (IA) will identify the anticipated or actual impacts of any disinvestment / decommissioning on health, social, economic and workforce.

The impact assessment will also include reference to: -

- Health outcomes – the effect on health outcomes will be assessed to identify potential adverse consequences of disinvestment or decommissioning and what might to done to minimise them.

- Quality of services – to ensure that the quality of services will not deteriorate following any proposed changes. The CCG will use its agreed Quality Impact Assessments tools to carry out the reviews.

- Equality and diversity implications – underpinned by the principle that people should have access to health care on the basis of need. However enshrined in law there are a number of identified protected groups, categories of the population that require specific consideration

In addition to the above, the leads will consider the following areas when completing a IA:-

- Workforce implications
- Market implications
- Geographic implications e.g. impact on transport links etc.
- Value for money
- Impact on partner organisations e.g. Sustainability including impact on partners.

5.3.2 Preparing the case for change

Once the IAs have been prepared they will be presented to the ERG for review, The ERG will review each IA fully.

The following will be considered by the ERG when developing the case for change for services under the review for disinvestment or decommissioning:

- Gaps in care created by disinvestment or decommissioning the service
- Managing the negative impact on the services identified for potential disinvestment or decommissioning and mitigated against them.
- The patient experience need must be paramount in informing any decision, action should be taken to minimize the impact of gaps in service provision once the service is decommissioned or disinvested.
- The outcomes of the Quality and Equity Impact assessments must be considered in order to quantify and clarify and positive or negative impact on patient care and the wider community (i.e. carers)
- The potential destabilising effect on other service and organisations e.g. third sector, of a decision to decommission/disinvest should be fully considered.
- The clinical impact of decommissioning or disinvesting from the provision

All proposed changes will be communicated clearly back to the leads as part of the process to create the final case for change.

All IA's must be approved via the ERG prior to being presented to the Governing Body; The ERG will not have delegated responsibility to make disinvestment decisions, only recommendations to the Governing Body.

The CCG is committed to engaging patients, carers, the public and wider stakeholders at all stage of commissioning, As part of this the CCG will communicate clearly, fully and continuously with all stakeholders before, during and following any decision to disinvest in or decommission services.

5.3.3 Decision making framework

Making good decisions regarding health care priorities involves the exercise of fair and rational judgment and at times discretion.

Although there is no single objective measure on which such decisions can be based, decisions will be fully informed taking into account the needs of individuals and the community, Whilst recognising the CCG need to achieve a financial balance its discretion will be affected by factors such as the NHS Constitution, national Planning Framework, NICE technology appraisal guidance and Secretary of State Directions to the NHS.

The CCG will adopt a robust approach to its decommissioning / disinvestment decisions by ensuring decisions are lawful and consistent.

This will be achieved by:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered prior to decisions being made.

- Promoting fairness and consistency in decision making and with regard to different clinical topics, reducing the potential for inequity.

- Providing a means of explaining the reasons behind the decisions made.

- Reducing risk of judicial review by implementation of robust decision-making processes that are based on evidence of clinical and cost effectiveness and adopting a decision making framework so that decisions are made in a manner which is fair, rational and lawful.

- Ensuring the Vision, values and goals of the CCG are reflected in business decisions.

- Providing a consistent approach for the development of strategy and plans across the whole health care system.

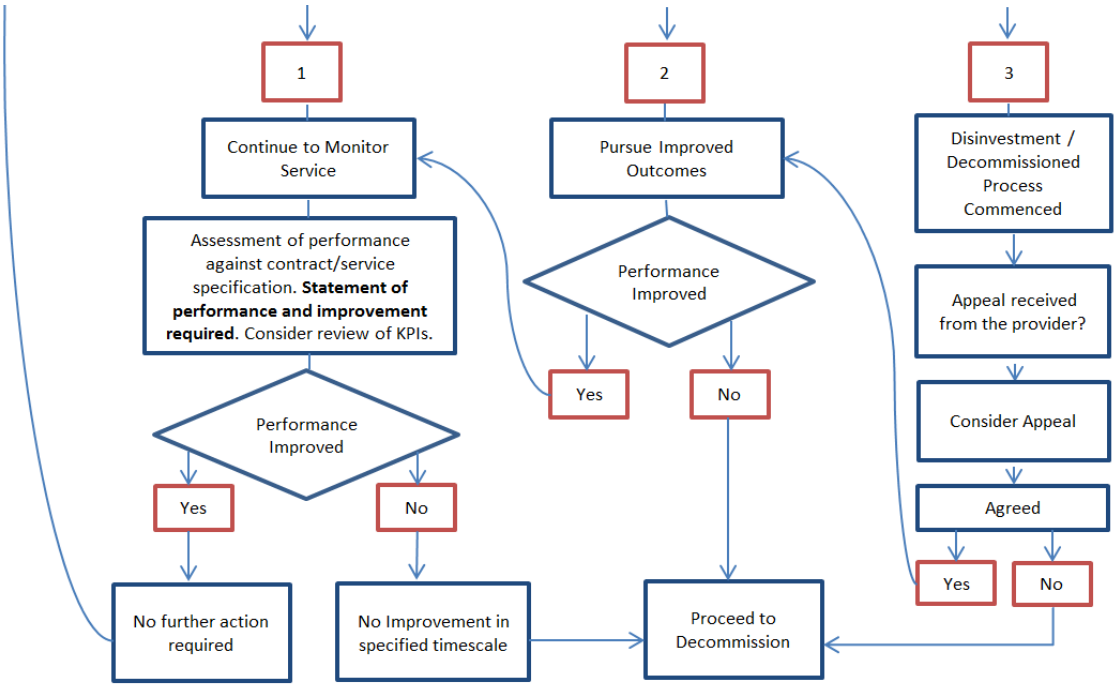
- Ensuring any potential or actual conflicts of interest are managed effectively in line with established policies

5.4 Step Three

The Governing body will review the recommendations presented by the ERG and it's supporting Impact Assessments.

The ERG will make one the following three recommendations to the Governing Body on the services reviewed:

1. Continue to monitor the service
2. Purse improved Outcomes
3. Disinvest or Decommission the service



5.4.1 Monitor the service

If the recommendation of the ERG is to continue to monitor the service, the service will be notified and a statement of performance and improvement will be developed with the service. The service will have a set timescale to improve the service and achieve key KPIs.

5.4.2 Pursue Improved outcomes

The service will be informed by the CCG, that improved outcomes are to be completed within a set time, failure to achieve the required outcomes within the timescale confirmed, will result in the CCG recommending to the Governing Body that the service is decommissioning or disinvesting.

The service will receive an action plan of improvement and will provide updates to the CCG at key points with the timescale. A full report will be presented to the Governing Body at the end of the agreed timescale.

5.4.3 Decisions to Decommissioning or Disinvesting

The CCG Governing Body will use the following criteria to inform its decisions to decommissioning or disinvesting from services:

- The recommendation(s) of the CCGs ERG.
- A needs assessment demonstrates existing services are not meeting the health needs of the population.
- There is a clear and objective reason for the decommissioning of a service that is based on assessment of the current providers' performance, value for money and the need for service redesign to improve services for patients.
- The original decision to fund a service was made on assumptions that have not realised.
- There are demonstrable benefits for the decommissioning of a service.
- There is inability to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract.
- Service does not deliver value for money, as demonstrated through financial review, utilising programme budgeting tools such as the Spend and Outcome Tool and other similar modelling tools.
- The investment in a service does not maximise the health gain that could be achieved by reinvesting the funding elsewhere.
- Service fails to meet the standards of a modern NHS as defined by the NHS constitution, professionally driven change and nationally driven changes.
- The service is unable to demonstrate clinical and cost effectiveness.
- The service provided is no longer the statutory responsibility of the CCG.
- The service is no longer shown to be a component of the CCGs core provision.
- The service is unsafe or of poor quality.

Where decommissioning is a direct result of the provider's breach of contract, a service must be maintained in the short to mid-term - options for recovering any excess cost shall be pursued via the contractual terms and conditions.

Where a service is decommissioned but the health need for a service remains - this should be recorded in the IA and the funding ring-fenced for on-going investment in meeting that health need. This should be approved at the point of ratification.

Where decommissioning is the result of an insufficient health need, the funding should be identified as a QIPP saving and any reinvestment in alternative services as per the current investment planning and prioritisation process(es).

5.5 Principles of Decommissioning / Disinvestment
Following the governing body's approval, The Decommissioning / Disinvestment Process will commence.

The CCG will communicate clearly, fully and continuously with all stakeholders following any decision to disinvest in or decommission services. **10 operational days** will be allowed for this communication and queries from stakeholders to be dealt with before notice is served on the provider. The responsibility for serving notice on the provider is with the contract manager or as otherwise determined by the CCG Accountable Officer.

For any substantial service change an appropriate period of consultation will be undertaken before any decision to disinvest or decommission is made. The feedback from all statutory and non-statutory consultation will be fully reviewed and analysed and will be used to assist in the decision making process.

Formal public consultation in line with "Overview and Scrutiny Committee" guidelines must take place where the decommissioning of the service or contract results in a material change to the delivery of the re-commissioned service (except when the service is recommissioned by Any Qualified Provider procurement), or where the service will not be recommissioned. https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services

This occurs where:

- There is insufficient need/demand to warrant the current volume of service and/or number of providers,
- The service is no longer a clinical priority and is classed as 'non-essential',
- A mismatch is demonstrated between need and the current profile of services following a health needs assessment.

The CCG in line with the approach for transparency and openness will provide intelligence to the provider (as part of the notification letter) as to why the service has been decommissioned or ceased through disinvestment, i.e. the decommissioning / disinvestment of a service has been based on assessment of the current providers' performance, value for money and the need for service redesign to improve services for patients.

Following the stakeholder communication, the provider will be notified in writing of the plan to Decommission / Disinvest the service.

The CCG will communicate clearly and fully why the service, as to the reason to Decommission / Disinvest, and the "next steps" that will be undertaken in the process.

The provider (following notification of decision to decommission) will provide the commissioner with an 'Exit Plan' outlining actions required by both parties for smooth service cessation.

The plan will cover a minimum

- Patient continuity of care
- Patient records
- Staff
- Estate
- Equipment
- Stock (where funded by the commissioner)

The commissioner will ensure mechanisms are in place where, in conjunction with the provider, execution of the exit plan is actively managed.

Decommissioning of any service will be managed in line with the “Principles and Rules for Co-operation and Competition” regulation (2012) and related Monitor Guidelines. https://www.gov.uk/government/publications/principles-and-rules-for-cooperation-and-competition

Disinvestment of any decommissioned service will also be processed in line with NHS Wolverhampton Standing Orders and Prime Financial Polices. In addition an assessment of potential contestability should be undertaken in line with the CCG procurement strategy.

5.6 Recordkeeping

An auditable record/trail of decision making and all communication relating to each decommissioning decision and contract termination will be kept by the CCG.

This is vital, both to demonstrate that the decommissioning process was robust and transparent, and as evidence in the event of any challenge, legal or otherwise.

5.7 Decommissioning or Disinvestment review process

A decommissioning or disinvestment review process will be put in place so that any affected stakeholder can request a review of the decision making process, in line with the approach to transparency and openness.

In the event of a service being decommissioned or ceased through disinvestment, the service will have the opportunity to provide evidence to appeal against the decision.

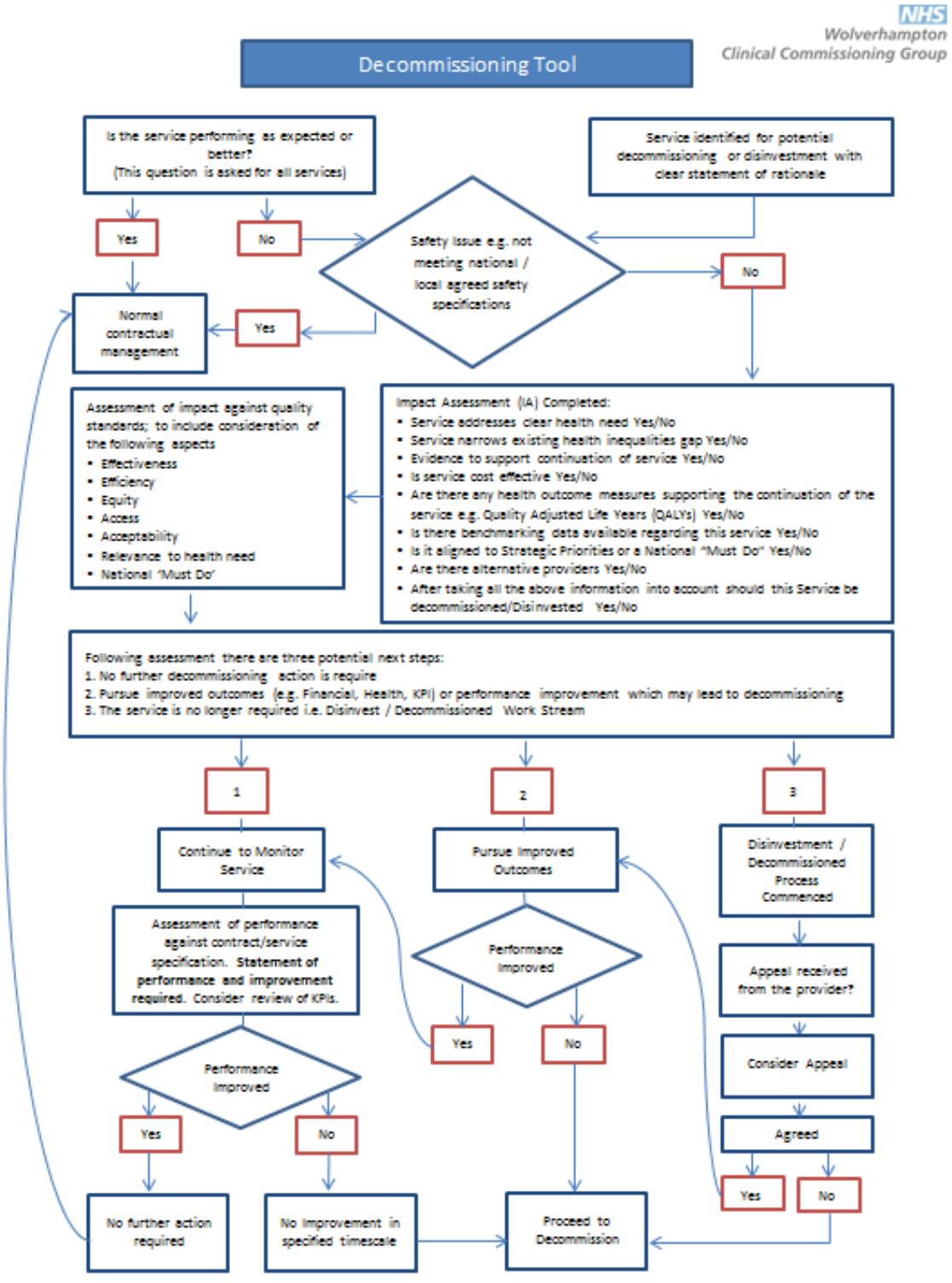
An appeal against the decision will be accepted from the provider if the appeal is received within **10 operational days of the notice being given.**

The ERG will review the evidence presented by the provider along with the supplementary evidence of the IA and ERG review, to re-examine the decision process made.

If the ERG concludes at the end of the review process, that the decision is valid, the CCG will provide further intelligence to the provider as to why the CCG advocates its decision.

If the ERG concludes that the provider’s evidence supports a further review, then the ERG will report its evidence to the Governing Body for final decision.

Appendix One



Appendix Two

Impact Assessment Template

IMPACT
ASSESSMENT (IA) Te

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Technology Centre
Wolverhampton Science Park
Glaisher Drive
Wolverhampton
WV10 9RU

Email: wolccg.wccg@nhs.net

Telephone: 01902 44487

Agenda Item No. 15

Health and Wellbeing Board

4 March 2015

Report title	Better Care Fund Programme Update
Decision designation	AMBER
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Key decision	Yes
In forward plan	Yes
Wards affected	All
Accountable director	Linda Sanders, Community Helen Hibbs, Chief Officer, CCG
Originating service	Health, Wellbeing & Disability

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to formally approve:

1. The next steps of the plan programme
2. Its support for the Section 75 agreement between NHS Wolverhampton CCG and Wolverhampton City Council

3. The delegated approval authority on behalf of the Health and Wellbeing Board, of the cabinet member for Health and Wellbeing (and chair) to formally agree the detailed Section 75 agreement prior to 31st March 2015.

The Health and Wellbeing Board is recommended to consider the note:

1. A performance and update report will be presented to the next Health and Wellbeing Board outlining key updates including activity, financial and implementation plan.

1.0 Purpose

The purpose of the report is:

- To brief Board members on the proposed arrangements for the Section 75 agreement for the management of the Better Care Fund
- To appraise Board members of progress against workstreams and the overall programme since the last update
.

2.0 Background

2.1 Section 75

A Section 75 (S.75) Agreement is an agreement made under section 75 of the National Health Services Act 2006 between a local authority and an NHS body in England (in this case Wolverhampton CCG). S. 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

The Better Care Fund arrangements require a pooled fund, and the Care Act 2014, Section 121provides for this. The S.75 agreement governing the creation and management of the pooled fund must be in place before the beginning of the 2015/16 financial year (the year to which it applies).

The pooled funds need to be hosted by one 'accountable' organisation – it is recommended that this is Wolverhampton City Council. This does not affect the current commissioning and contracting arrangements, but will require health and social care commissioning to work more closely together through an integrated commissioning approach to ensure strategic alignment moving forward.

NHS England announced on 22 December 2014 that Wolverhampton's BCF plan had been 'fully approved ', clearing the way to begin delivery of the proposals contained within the plan and agreeing between the two partners the terms of the S. 75 agreement.

2.2 Better Care Fund Programme

The Better Care Fund Programmes focus is the delivery of integrated and sustainable health and social care services in Wolverhampton. Previously referred to as the Integration Transformation Fund, the programme was announced in June 2013 as part of the 2013 Spending Round. The fund incorporates a substantial level of existing 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 builds on existing work the Council and Clinical Commissioning Group have undertaken in relation to joint development of programmes, and support the sustainable delivery of community facing, neighbourhood health and social care services to the people of Wolverhampton.

At the centre of the governance process for the Better Care Fund submission and programme is the Health and Wellbeing Board, who are mandated to approve and jointly agree the plan prior to submission, and oversee planning and performance post implementation.

The governance infrastructure has been established for a number of months, and the programme is overseen by a Transformation Commissioning Board. This reports to the Health and Wellbeing Board via the Programme Director. Reporting to the Board are;

- Transformation Delivery Board, which includes all partners and stakeholders,
- Finance and Information Core Group,
- Quality and Risk Core Group,
- Governance Core Group

3.0 Progress, options, discussion, etc.

3.1 Section 75

Wolverhampton City Council and Wolverhampton Clinical Commissioning Group have been working collaboratively to explore the details of a proposed S. 75 agreement. A report has been provided to Cabinet and the Clinical Commissioning Groups Governing Body which proposes the structure, content and management arrangements of the pooled budget and agreement.

Key elements of the proposed Section 75 agreement include;

- **Governance** - Day to day operational management and oversight of the fund will be the responsibility of the Adults Transformation Commissioning Board (TCB), whose members will have delegated responsibility from both partner organisations to hold the Executive work stream leads to account and to make necessary decisions from a planning, and performance management perspective. The scope of these powers will be within the existing limits set by both organisations schemes of delegation in relation to BCF, particularly from a financial and procurement perspective. Beyond these limits, decision making will remain within the responsible bodies in the individual organisations (Cabinet and the CCG's Governing Body), to whom the members of the TCB will be accountable for the operation of the fund. The Health and Wellbeing Board will [continue to] oversee both organisations for the performance of the fund against the objectives set out in the BCF plan and the Health and Wellbeing strategy
- **Commissioning** - There is not a formal requirement to make commissioning arrangements as part of the S.75 agreement, though in practice, the BCF has developed a codesigned vision and plan which maximises opportunities for effective commissioning approaches. As such the Council and the CCG will continue to have the flexibility to continue to take their own decisions with the arrangements supporting effective co-ordination and shared planning and development, and overseen by the Health and Wellbeing Board.
- **Contracting** - Existing contracts between the CCG and providers and the Council and providers will not be affected by the creation of a single host for the pooled fund. Future contracts are linked to the discussion about commissioning options, above.
- **Financial Value** - The proposed value of the pooled fund consists of services totalling £70.7 million revenue (final figure to be confirmed); of which £22.8 million are council funded services (inclusive of £6.3m S256 monies) and

£47.8 million are CCG funded services. The fund also includes £2.1 million capital grant which is managed by the council.

- **The Health and Wellbeing Board Role -** The Health and Wellbeing Board will operate as the strategic lead with natural oversight and supporting facilitated discussions between NHS England, Wolverhampton CCG and Wolverhampton City Councils on how the pooled budget should be spent, as part of their wider discussions on the use of their total health and care resource. The HWB moves from plan support to provide the following in support of the S. 75 agreement -

  - Leadership – providing strategic support to the developing relationship between the CCG and council, developing a shared vision of future services, holding a helicopter view of resources across the whole system, oversight of the impact of transformational change and risk management
  - Public, patient/user & community engagement
  - Professional & administrative support – engagement of public health in assessing need, deriving evidence, and harnessing opportunities for fuller approaches to integrated commissioning, support to the integrated commissioning process and its fit with existing programmes of integrated care, agreement and use of performance metrics for BCF, oversight of organisational capacity
  - Plan delivery – oversight and exception reporting via the Transformation Commissioning Board

3.2 **Better Care Fund Programme**

Since the last Board, the workstream proposals have been developed significantly and a number of activities have been undertaken across the collaboration as follows;

- Partner agencies including RWT and BCPFT have continued to be engaged and involved as key partners in the BCF work streams, design and implementation planning.

- Engagement sessions have been held with the Wolverhampton Voluntary Sector through the 3rd Sector Partnership, Over 50s Forum, Locality GP meetings, multi partner workshops, and individual voluntary sector groups.

- Primary and Community Care Workstream – has met on a weekly basis and is in the process of finalising its proposal, phasing, and implementation plans. A number of design and impact workshops have been facilitated which have had comprehensive clinical, voluntary sector and operational representation – these workshops have been focussed on the core areas, with a clear mandate regarding designing interventions, which in the view of clinicians and practitioners would move activity away from non-elective admissions and into community facing planned interventions. Workshops have included the following themes; Management of Long Term Conditions, Admission Avoidance, Improving Health and Wellbeing and Wound Care Pathway

- Intermediate and Reablement Care work streams have met on a weekly basis. The workstream has presented its outline proposal and is in the process of developing its implementation plan and phasing approach. Scoping and activity/capacity modelling has been undertaken in relation to both the community and bed based element of the service.

- Mental Health – This workstream continues to meet on a weekly basis, and has developed its proposals significantly with workforce and activity modelling since the last HWB. The mental health workstream continues to focus on the areas of planned and urgent care, with broad and effective engagement across the sector.

Workstream	Impact Narrative
Primary and Community Care Workstream	
Programme	
Support into Residential Care Homes Support– GP Watch	**Why** Of the 44 residential care homes in Wolverhampton, the 12 (27%) in the pilot represent 38% of all ambulance call outs, with a conservative 54% admission rate. The primary reasons for attendance at A&E are abdominal pain, UTI, falls, and chest pain. **Primary KPI target** - Reduction of emergency admissions into acute care, improved health and wellbeing **How:** Hard targeting UTI management, bowel care, medicines optimisation by ANPs. Rapid response (within 2 hrs) to home call out. Care planning clinics. Crisis contingency plans for all residents (420)
Eclipse Medicines Management System creating alerts to GPs for medicines optimisation	**Why** To reduce unnecessary emergency admissions for older people with medication matters. Eclipse is defined as the risk stratification tool within the NHS England 'Any town' toolkit . It supports the safe and appropriate use of medicines in the community. Wolverhampton has an increasing no of emergency admissions relating to medicines management **Primary KPI Target:** Reduction in the number of gastro intestinal emergency admissions, reduction in no of permanent nursing and residential home placements **How:** 49 GP practices engaged with risk stratification and alert Eclipse System relating to gastro intestinal medication alerts. Medical and/or pharmacy medicines review of high risk patients.
UTI Community Care Pathway Redesign through consolidation of the Community Matron function	**Why** Non care home emergency admissions relating to UTIs are at very high in Wolverhampton per annum of which 72% are those in the over 50 age group. This equates to 86% of the total spend on UTIs. **Primary KPI Target:** Reduction of emergency admissions relating to UTI conditions by 8%, reduction in DTOCs, reduction in number of permanent nursing and residential home placements **How** Implement community nurse led UTI care pathway. UTI discharges will have community nurse follow up for contingency planning/dip test advice in a risk stratified system. Wolverhampton wide UTI awareness campaign – early identification and intervention.
Community	**Why**

and Primary Care Redesign	To develop a seamless approach to the management of long term conditions, community and neighbourhood integration of services, and to maximise opportunities for early intervention, prevention and crisis management **Primary KPI Target** Reduction in emergency admissions Reduction in non elective readmissions in the over 65s by 10% Reduction in no of permanent nursing and residential home placements **How** Integrated health and social care community neighbourhood teams x 3 Wound Care Pathway Redesign and implement change for Wound Care services in Wolverhampton (locality facing designed solution) – reducing the numbers of patients using WIC and acute hospital for wound care services Implement single risk stratification system across primary and community services Establishment of crisis care plans across Wolverhampton for over 75s and High Attenders Establishment of Liason Meeting Community Matrons and Hospital Discharge Team Primary Care Model development - increasing capacity and availability across Primary Care through schemes such as Dr. First, weekend/ extending hours.
Intermediate Care	
Programme	
Nursing Home Support - Home Inreach Team	**Why** A significant number of patient's are admitted to Acute services from Nursing homes, with the majority discharged back to the nursing home. A significant number of these patients can be treated and supported in the nursing home reducing the number of admissions to ED and AMU and reducing in-hospital deaths. An audit of the admissions by the Consultant Community Geriatrician has found that an additional 55 attendances at ED and admissions could be avoided if a 7 day model was implemented with the inclusion of IV Therapy for the Home Inreach team, **Primary KPI Target**: Reduction in Emergency Admissions from nursing homes **How** Full implementation of a 7 day HIT service and additional provision of a rapid response to prevent admissions at weekends. IV Therapies administration in nursing homes Weekend clinical review

Intermediate Care Pathway Redesign	**Why** To improve development maximising capacity, impact and effectiveness of intermediate and reablement care, reducing the need for residential and nursing home placements, accelerating discharge, and admission avoidance scheme development. **Primary KPI Target:** Reduction in no of permanent nursing and residential home placements, improvement in reablement **How** Integrate CICT and HARP services into a Community facing Intermediate Care Team with enhanced functions Implement acute inreach/rapid response/intensive home support function (admission avoidance/early discharge) in Intermediate Care Team. Implement Community Matron Flow Coordinator role (pathfinding all proposed bed based acute discharges) Maximise current bed usage across the current 3 provider units Review intermediate care bed requirements and consolidation potential on 1 site Implement ICT managed residential respite bed.
Mental Health	
Programme	
Psychiatric Liason Crisis Car Urgent Care redesign	**Why** To remove inappropriate admissions via the acute sector To enhance the development of fully integrated care pathways for mental health, including responsive services where crisis and urgent care needs occur, which ensure care is delivered as close to home as possible, delivers the best possible clinical outcomes, achieves parity of esteem, provides the highest levels of care to those with the greatest levels of need whilst promoting mental health awareness and anti-stigma self-help and resilience development for all. **Primary KPI Target** Reduction in emergency admissions of any age with a primary mental health disorder diagnosis, Crisis Contingency plans for all regular attenders, assertive outreach and CP service users, Parity of Esteem **How** Redesign of urgent care pathway implementing Crisis resolution and Home Treatment Team, Psychiatric Liason, Crisis Car, and Discharge Team
Planned Care	**Why**

Redesign	Designed services which support recovery, keep people well and prevent crisis the planned mental health care pathway will deliver integrated health and social care specialist resettlement and recovery support and intervention delivering case management and care co-ordination that enables transition through the community care pathway, from in-patient and nursing and residential care into step down and supported housing services with integrated wrap around personalised support. **KPI Target** Reduction in emergency admissions of any age with a primary mental health disorder diagnosis Reductions in high cost care by 30% packages through improved step-down and reablement services leading to resettlement into shared Lives, sheltered accommodation and 'group homes' Improved reablement support with young people in transition **How** Fully integrated community mental health services across health, social care and the voluntary sector Integrated community recovery and reablement services driving crisis planning, CPA implementation and community alternatives to admissions Redesign of recovery house service Non-institutional accommodation and support development impacting upon high cost or acute placements A suite of preventative services
Dementia	
Programme	
Integrated Care Pathway Redesign	**Why** To provide an efficient and effective fully integrated dementia service which focusses on living well with dementia, early identification and support, alongside advance planning and decisions **KPI Target** No of advance plans undertaken Reduction in emergency admissions **How** Dementia Hub development Fully integrated service delivery model across health and social care Introduction of advance planning and advance decisions

- Dementia – The workforce and activity modelling for this workstream is almost complete, with the design proposal complete. Workshops have been held which have engaged a broad range of stakeholders, and have

focussed on the development of integrated approaches, the primary care role, assessment and diagnosis and the role of the specialist team.

Key elements of the programme plans, and their areas of impact are outlined in the table below:

4.0 Financial implications

4.1 The current proposed BCF revenue pooled fund for 2015/16 is £70.7 million, of which, £22.8 million is made up of services that are managed by the council. This includes £6.3 million representing the NHS transfer to social care ('Section 256 funding), which is ringfenced. In addition to the revenue services the bid includes capital grants amounting to £2.1 million (Dedicated Facilities Grant and Social Care Capital Grant).

4.2 The pooled fund requires efficiencies to be realised to fund the council's demographic growth of £2.0 million and care act implementation funding of £964,000. The council's medium-term financial strategy (MTFS) currently assumes that these pressures will be funded in full from the BCF.

4.3 The receipt of a proportion of the BCF funding in 2015/16 (£1.6 million) will depend on meeting agreed performance targets, specifically the reduction in the number of non-elective emergency admissions by 3.5%. The CCG are required to withhold these monies from the Pool until such time as delivery has been demonstrated. In the event that admissions are not achieved, the CCG will bear 100% of this risk for 2015/16.

4.4 Each organisation will make equal monthly payments to the pooled budget. The actual contributions paid into the pooled by each party will be net of demographic growth, care act monies for the council and net of the performance payment for the CCG.

5.0 Legal implications

5.1 The Planning Guidance for the Better Care Fund confirms that the Fund will be allocated to local areas where it will be put into pooled budgets under Section 75 NHS Act 2006 ("Section 75 Agreements").

5.2 The S.75 agreement is a vehicle for the delivery of the BCF plan, which was approved in December 2014. This plan was developed jointly across the CCG, City Council and involving other lay partners and providers and aims to support the delivery of the Councils and CCGs strategic vision, supporting the achievement of effective, efficient and integrated community and neighbourhood facing services.

5.3 The section 75 agreement must be in place for the start of the 2015/16 financial year.

5.4 Section 75 of the NHS Act 2006 (the "Act") allows local authorities and NHS bodies to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. Section 75 of the Act permits the formation of a pooled budget

made up of contributions by both the Council and the CCG out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health-related functions of the local authority. The Act precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of certain laser treatments and other invasive treatments and emergency ambulance services.

5.5 Prior to signing both partners will secure independent legal review of the final agreement

5.6 The notice period for ending the Section 75 agreement, by negotiation, is 3 months.

6.0 Equalities implications

6.1 There are no equalities implications specifically relating to the current status of the BCF programme.

7.0 Environmental implications

7.1 There are no environmental implications.

8.0 Human resources implications

8.1 Some transformational change outcomes may require TUPE arrangements to apply between providers if procurement is utilised to enhance provide a more mixed health and social care economy. This will not have a direct impact other than in relation to procurement advice and support.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications.

10.0 Schedule of background papers

10.1 Cabinet Meeting Report – January 2015

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WOLVERHAMPTON CHILDREN'S TRUST

CHILDREN'S TRUST BOARD

Minutes of meeting held on 17th December 2014

Civic Centre

Item	Notes	Action
	Present Councillor Val Gibson (Chair) – WCC Noreen Dowd (Vice – Chair) - CCG Emma Bennett - WCC Gillian Ming – WCC Safeguarding Children Ian Darch – Voluntary Sector Council Dr Cathy Higgins – Royal Wolverhampton NHS Trust Ros Jervis – WCC, Public Health Jeremy Vanes – Royal Wolverhampton NHS Trust Kush Patel - WCC Kevin Pace - WCC Mary C Keelan –Our Lady and St Chad Catholic Sports College Gabrielle Sewell (Minutes Secretary) - WCC Safeguarding Children	
1.	**Welcome, Apologies, Introductions** Apologies were received from: Chief Supt Simon Hyde – West Midlands Police Tim Johnson - WCC Councillor Evans – WCC	
2.	**Declarations of interest:** <u>Kevin Pace WCC – Head Start, Programme Manager</u> • Wolverhampton City Council has successfully won a bid from the Big Lottery, to target support for the mental health and wellbeing of young people aged between 10 - 14yrs of age. They were awarded £10,000 to put towards scoping work. Kevin Pace became involved in the project in March 2014. • At the end of July 2014 a further £500,000 was secured that will carry the project through until December 2015. The local authority has had to adopt a flexible and progressive approach to this work. 19 partnership schools are engaging in the Stop Understand Move On (SUMA) programme. • The Pennsylvania Resilience Programme also began in September 2014. A	

	further £100,000 is being allocated to local organisations, feedback was highly positive. Straight after Christmas, the Big Lottery will be deciding who has won the funding and which organisation is most appropriate in helping young people. Head Start want to ensure as many colleagues as possible are involved in the Head Start Governance arrangement • Kevin advised that further bidding will take place in 2016 for a larger award of £10 million. April 2016 will be when the bidding starts. May 2015 will be when the planning of stage 3 begins; details will be put on www.headstart.fm. • The structure of the Headstart Partnership was questioned. It was reported that Big Lottery sits at the top of the Partnership Board and the shadow board consists of the young people that Headstart works with. • Noreen updated the Board in relation to a recent successful bid submitted By the CCG to look at Tier 4 work across the Black Country.	
3.	**Minutes of the meeting held on 30th September 2014** • Agreed as a true record **Matter Arising** • Emma Bennett provided an update on the successful DCLG Transformational Challenge bid for £900k. This is being progressed under the FrF programme. • It was agreed the Health Behaviour Survey action can be closed.	
4.	**Early Help Plan** <u>Kush Patel</u> • Kush Patel presented the final version of the Early Help Plan, which is intended to be delivered across the partnership. The Early Help Plan will be a three year plan with an annual review. This plan sits under the Children and Young People's Plan. **Action:** Balance score card to be developed and other agencies to contribute to the work under the Early Help Plan.	
5.	**Updated Structure & Terms of Reference of CTB** • It was agreed that the terms of reference are to be amended to reflect Gillian Ming's membership to the Children's Trust Board. Gillian is Manager of the WSCB. Alan Coe is now a member for the Health and Wellbeing Board. **Action:** Terms of reference are to be revised as suggested in report and Gillian	

	Ming's membership to CTB to be updated.	
6.	**WSCB Annual Report** • Gillian Ming presented the Annual report for 2013 – acknowledged this is quite out dated and so was presented for noting. Gillian is to present the 2014 report at the next meeting. • Gillian Ming stated that all acronyms in the glossary of the new report are to be explained for clarity as this would be particularly useful for schools within the LA. **Action:** Agreed to receive the report.	
7.	**Progress with Families r First** • Emma Bennett presented update on the work taking place under the FrF programme, highlighting the progress made and challenges. **Actions:** Agreed the recommendations.	
8.	**Voluntary and Community Sector Issues** • Ian Darch presented report on Steve Dodd's behalf. Ian highlighted 4 themes: asset transfer, collaboration, best value and structures. • It was suggested that the CTB tasks the Early Help Board to take this forward. The issues raised need to be considered against the wider arena of what our priorities are. **Actions:** Report to be presented to the Early Help Board in January for progression. A progress report to be presented to CTB in March regarding all issues discussed.	
9.	**Frontline Practice Discussion** • The group heard and discussed at length a case study in relation to obesity. **Actions:** It was agreed as a group that early intervention needs to take place and somebody needs to take responsibility. At this point the Chair thanked everyone for their attendance and authors of reports; Cathy Higgins was also thanked for her case study. The chair left the conference at 3:50 pm	
10.	**Topic for discussion at the next meeting:** • Mental Health – Tier 2, focus around Mental Health Support, Sarah Fellowes and Mai Gibbons to identify a case for discussion	

11.	**AOB** Teenage Pregnancy Rates • Ros Jervis confirmed that teenage pregnancy rates in Wolverhampton have fallen considerably. The rate fell from 66 per 1000 to 42 per 1000 from 1998 – 2012. The most recent figure is 30 per 1000; the reason for this is that interventions have been highly successful. The West Midlands are currently following the national trend. • Kush Patel confirmed the CYP Plan launch at 09:30 am – 12:30 pm, Wednesday 25th February 2015, Bilston Town Hall – Looking for potential speakers, can all CTB members hold in their diaries. Formal invitations are to be sent out ASAP. • Sarah Norman was thanked for all of her hard work and wished every success at her new position in Dudley. Date of next meeting – **Wednesday 18th March, 14:00 pm – 16:00 pm, Committee Room 2, Civic Centre** Close	
12.	**Date of Next Meeting** Wednesday 18th March, 14:00 pm – 16:00 pm, Committee Room 2, Civic Centre	

Action	Responsibility	Completion date
Balance score card to be developed and other agencies to contribute to the work under the Early Help Plan.		
Terms of reference are to be revised as suggested in report and Gillian Ming's membership to CTB to be updated.		
Report to be presented to the Early Help Board in January for progression. A progress report to be presented to CTB in March regarding all issues discussed.		
It was agreed as a group that early intervention needs to take place and somebody needs to take responsibility.	Dr. Cathy Higgins	

WOLVERHAMPTON HEALTH AND WELL BEING BOARD

TRANSFORMATION COMMISSIONING BOARD

Minutes of meeting held on Thursday 29th January 2015
at the Civic Centre

PRESENT:	**Helen Hibbs**	- WCCG **(Chair)**
	Linda Sanders	- WCC Strategic Director, People
	Tony Ivko	- WCC Service Director
	Viv Griffin	- WCC Service Director
	Sarah Fellows	- WCC Head of Commissioning
	Steve Brotherton	- WCC Head of Commissioning
	Kathy Roper	- WCC Head of Commissioning
	Ros Jervis	- WCC Service Director
	Noreen Dowd	- WCCG
	Sarah Carter	- WCCG
	Claire Skidmore	- WCCG
	Darren Pandaal	- WCCG
	Angela Parkes	- WCCG
	Andrea Smith	- WCCG
IN ATTENDANCE:	**Amrita Sharma**	- WCC Regulation & Business Support Officer
	Emma Dart	- WCC Quality Assurance & Business Support Admin Officer
APOLOGIES:	**Maxine Bygrave**	- HealthWatch Wolverhampton

		ACTION
1.	**Notes of previous meeting** Notes of the meeting held on the 5th November 2014 were accepted as a true and accurate record of the meeting subject to the following clarification: **3. Urgent Care & Emergency Services** *The figure of 98% recorded for the Wolverhampton Accident & Emergency Department was a snapshot of that particular day.*	
2.	**Better Care Fund Update** • Lots of work has been carried out across the four workstreams and there has been engagement from the community and GPs to take the care pathways forward. • SC currently developing a performance dashboard for the Board which will be shared with the Board at the next meeting. Board members were invited to forward any suggestions on any business critical measures they would like to see included to SC. • The Board were informed of an expression of interest being developed for submission to become a registered Vanguard site, implementing	**SC** **All members**

	support around primary care, community care and the voluntary sector. This will need to be signed off by members as an integrated model. • SC reported there may be an element of provider anxiety which will need to be managed in the workstreams; A voluntary sector modelling and engagement event is planned for the end of February 2015 which will include workshops covering all four workstreams within the BCF. • On the 18th February 2015 a leadership event is to be held to review the robustness of the implementation plan and ensure deliverability. • ND emphasised the need to ensure the Implementation Plan clearly identifies new proposals for reducing emergency admissions otherwise we may run the risk of arbitration.	
3.	**Workstream Proposals** Presentations were received from the respective Lead Officers for each of the Better Care Fund workstreams and the following points highlighted in respect of each of the areas: **a) Primary and Community Care – presented by Andrea Smith** • The current system map illustrated numerous access points working independently. • The vision is to have a single access point, with locally developed and integrated care. • There are plans to address issues around admissions to A&E, access to final care. • This is a significant piece of work with multiple stakeholders; time needs to be invested at the start to plan and design the system and to ensure that the IT is aligned. • On 4th March 2015 this will be taken to the Health and Wellbeing Board. • There have been many opportunities for stakeholders to get involved in workshops and there has been good engagement from GPs and clinicians. • AS is optimistic that the timescales are realistic with the ultimate aim to improve patient experience. • A number of 'quick win' elements e.g. wound care may be addressed ahead of schedule. • LS said it is important to not make assumptions around IT systems as this may lead down unhelpful pathways. • The Board was in agreement about the direction of travel of the workstream. **b) Intermediate Care and Reablement – presented by Angela Parkes** • The drive is for home based as opposed to bed based care with a culture shift towards reablement. • Focus is home is hub • Need more detail around definitive goals e.g. how many beds do we want in the future. There are opportunities for bed rationalisation in the next few months.	

	• Working towards the ability to rapidly assess and support patients at home • SC said patients' independence is often diminished following admittance to hospital; a new enablement team would address this by rapidly assessing and supporting the patient at home if possible. • The reablement strategy has been refreshed. • CS concerned that the bulk of the savings would be backloaded which would take away opportunities for flexibility and about whether having one point of entry for the system would create bottlenecks. • These considerations will form part of the design models for triage, admissions and assessments. • One of the challenges will be the competing demands on the individuals involved, but that even through the majority of individuals cannot give the project full time commitment, it should be part of the day to day role. **c) Dementia – presented by Steve Brotherton** • Lots of GPs have been fully involved with this workstream. • Different patient experiences exist for different geographical regions. • Currently a quarter of hospital beds and a third of care home beds are used to accommodate dementia patients. • 21 organisations have signed up to the Alliance, seeking to increase commercial sector involvement. • Plan is to introduce bespoke locality hubs with third sector involvement e.g. Alzheimer's Society, Age UK. • There are currently six Dementia Cafes. • In order for GPs to better recognise the condition, lead GPs will be supported by a consultant. • There is not currently an agreed signed up dementia strategy. • SC said in order to mainstream dementia, dedicated time and attention is required. The workstream will then be embedded to business as usual. **d) Mental Health – presented by Kathy Roper and Sarah Fellows** • If a quicker diagnosis is achieved with young people, there is a better chance of those patients being able to stay in their own home. • Feedback from stakeholder events suggested that they felt an integrated relapse crisis plan was not always available and may need readmission. • The mental health car is able to see people in their homes. • The hospital discharge pilot has been very successful. ***[Darren Pandaal, Angela Parkes, Sarah Fellows, Kathy Roper, Andrea Smith, Steve Brotherton left the meeting]***	
4.	**Integrated Commissioning – Future Proposals** • SC proposing to pilot integrated comissioning across Health & Social	

	Care over the next few months in alignment with the BCF proposals. The Board were presented with an outline proposal for the future governance arrangements. Feedback from partners will be used as learning points to look for a permanent and agreed approach. • LS stated she was unconvinced that a Director of Commissioning was the correct role in the context of the shift towards micro-commissioning. • VG suggested it was important to maintain close relationships, a high level of leadership, engagement with contract and procurement leads and to install governance for the future. • ND suggested the Board would probably benefit from some evaluation of the effectiveness of the pliot from the commissioners; senior leadership and accountability would be crucial to the successful implementation of the BCF programme. • It was agreed that the members of the Board would re-group on the 2nd March 2015 to further evaluate the governance proposals and consider feedback from commissioners involved in the delivery of the BCF programme.	**SC/VG**
5.	**Section 75 Cabinet Report** • SC confirmed that Section 75 reports were currently being prepared for Cabinet and the CCG Governing Body and would include details around financial implications and risks for both the CCG and the council.	
6.	**Any Other Business** Nil	
7.	**Date of Next Meeting** To be confirmed	

ADULT DELIVERY BOARD

ACTIONS LOG

[Appendix.1]

Summary of key Actions

Ref	Date	Action	Owner	Status	Notes
~~057a~~	~~5.11.14~~	~~Finalised Terms of Reference to be presented to Board at next meeting for ratification.~~	~~VG~~	~~Closed~~	**29/1/15** - Signed off at the Health and Wellbeing Board.
~~059~~	~~10.9.14~~	~~Work be undertaken around the wider determinants of health i.e. employment etc. to encourage more of a geographical focus on these issues; update on specific initiatives that are achievable to be presented to a future meeting of the Board.~~	~~SF~~	~~Closed~~	**29/1/15** - The plan is CCG led with Public Health involvement. Copy of Plan to be circulated with next minutes.
~~060~~	~~10.9.14~~	~~Work to be undertaken with NHS England Areas Team to look at how to reduce numbers of children stepping down from Tier 4 and maintaining an integrated approach. Update report to be presented to future Board meeting.~~	~~SF~~	~~Closed~~	**29/1/15** – funds have been granted and a project manager has been appointed. A survey monkey will be circulated next week to support the scoping stage. There will be an engagement event at the end of the month.
~~061~~	~~10.9.14~~	~~Dementia Strategy to be further developed to provide more strategic direction and relevant information.~~	~~AI / ND~~	~~Closed~~	**29/1/15** – Board updated on development of strategy as part of the BCF workstream updates.
~~062~~	~~10.9.14~~	~~Revised draft Dementia Strategy to be presented to next Board meeting.~~	~~SB~~	~~Closed~~	
063	10.9.14	Update on the development of the refreshed Autism Strategy to be presented to future meeting of the Board.	**KR**	**OPEN**	**29/1/15** – Agreed refreshed Autism Strategy be presented to next Board meeting.
~~064~~	~~5.11.14~~	~~Proposals in respect of future integrated commissioning arrangements to be presented to next Board meeting.~~	~~ND~~	~~Closed~~	**29/1/15** – Outline draft proposals presented to the Board; to be further considered on 2.3.15
~~065~~	~~5.11.14~~	~~Representations to be made to the Council's Planning Committee and Cllr Steve Evans in respect of proposals concerning the development of a medium/secure unit in the near vicinity of New cross Hospital.~~	~~HH / AI~~	~~Closed~~	**29/1/15** – This has been raised through several channels.
066	29.01.15	A small group to be created to connect and drive system change to support initiatives around National CAMHS	**VG**	**OPEN**	

		task forces.			
067	29.01.15	A performance dashboard will be brought to the next meeting. The board have been asked to forward their thoughts on any business critical measures they would like to see included.	**All**	**OPEN**	
068	29.01.15	Members of the Board to re-group on the 2nd March 2015 to further evaluate the governance proposals and consider feedback from commissioners involved in the delivery of the BCF programme.	**SC/VG**	**OPEN**	

Public Health Delivery Board

Notes of meeting held on 3rd February 2015

Present:

Ros Jervis - Chair (RJ)	**Director of Public Health**
Jane Fowles (JF)	**Speciality Registrar in Public Health**
Sue Wardle (SW)	**Locum Consultant in Public Health**
Katie Spence (KS)	**Consultant in Public Health**
Juliet Grainger (JGr)	**Public Health Commissioning Manager**
Kerry Walters	**Public Health Governance Lead Nurse**
Andy Jervis (AJ)	**Head of Regulatory Services**
Neeraj Malhotra (NM)	**Consultant in Public Health**
Chris Hale (CH)	**Head of Housing**
Karen Samuels (KSm)	**Head of Community Safety**
Andrea Smith (AS)	**Modernisation Manager, CCG**
Richard Welch (RW)	**Head of Healthier Place Service**
Sue McKie (SM)	**Healthy Start to Life Programme Manager**
Glenda Augustine (GA)	**Consultant in Public Health**
Neil Rogerson (NR)	**Resilience Manager**
Tessa Johnson (TJ)	**Graduate Management Trainee**

Item No	*Title*	*Action*
1.	**Welcome, introductions and apologies**	
1.1	RJ welcomed Karen Samuels and Neil Rogerson to the Board	
1.2	Apologies were received from:- Donald McIntosh, Jo Birtles, Ian Darch	
2.	**Minutes of the last meeting and minutes**	
2.1	Page 1 – Tessa Johnson – Trainee Public Health to read *Graduate Management Trainee.* Page 4 – Action around Care Homes – Care Homes to be brought back to future PHDB meetings. Report to be circulated bringing together all the work done across all the different organisations. The document to be forwarded to Jas for circulation. Minutes were agreed as a true record of the last meeting.	**Jas**
3.	**Management Restructure and Changes to Public Health (verbal update)**	
3.1	Verbal update provided by RJ; Keith Ireland has been appointed to the post of Council's MD and management changes are being developed to include; • Community Directorate being called People Directorate - Public Health will be Public Health and Wellbeing within this Directorate • Education and Enterprise being known as Place Directorate. • Parks (Development) has transferred from public health to the City Environment Team; a close working relationship will be retained to ensure strategic alignment with public health outcomes.	

	• Safeguarding services remain with Public health and these functions will be more widely integrated across the service area.	
4.	**Partnership and wider links: summary reports (ad-hoc basis)**	
4.1	There was no presentation at this meeting.	
5.	**Performance: Updates relating to:-**	
5.1	<u>Working Well Week – Neeraj Malhotra</u> NM presented a briefing paper the purpose was to update members of the PHDB on Working Well week which is to take place from 23rd to 27th March 2015. Working Well is one of three events in the year that is organised by the City Board as part of its actions to deliver the city strategy. The aim of the week is to boost employment for local people by bringing together residents and employers in a range of activities. It also seeks to promote healthier lifestyles for the people of Wolverhampton. NM advised that a steering group had been established which meets on a weekly basis. The Group is made up of representatives from PH, Communications, the City Board and the Healthy Lifestyles Team. Members of the Steering Group are putting on a lot of different events. PH will have a stand with Healthy Lifestyles Team and communities will be invited to come and take part. It was emphasised that WVSC will be engaged in helping to contribute to the Working Well Week. NM stated that we had to get more creative with dialogue with the businesses and advised RW was leading on this piece of work. In terms of engagement AJ suggested approaching small businesses and emphasised that we had good relationship with some businesses. The Board were requested to let NM have any creative ideas particularly around demonstrating the benefits for businesses.	
5.2	<u>Transformation Fund – Neeraj Malhotra</u> Briefing paper was presented by NM the purpose of which was to update the PHDB members on the transformational fund. The fund was established for a two year period to support the Council and partner organisations to try new ways of working that seek to improve the health of the population and wherever possible, save money. Due to many challenging issues that needed to be addressed in 2014, delay has been experienced with regards to the allocation of some of the funds. Some of these issues were to do with internal processes and others were to do with staff turnover and as a result some of these specification amendments have not happened as quickly as we would have liked. Some projects however are progressing well. RJ reflected that the programme had been aspirational for the first year of public health within the LA and learning had been gained. RJ stated that some interim results were however expected from the 9 projects that have been awarded funding totalling £1.187m over a period of 2 years. RW suggested programming a show case event.	

	Financial profiles will be discussed and developed for decision on continuation reviewing the funding period and progression of the projects. It was felt that dialogue was required in relation to what options were available in the case of money running out. NM and AJ to have a conversation outside of the meeting re the environmental health enhanced nutrition project. SW asked to see the MH Community Hub project for an update around implementation.	
5.3	<u>Pharmacy Needs Assessment – Dr Jane Fowles</u> The purpose of the briefing paper was to provide a progress report on the development of the Wolverhampton Pharmaceutical Needs Assessment (PNA) for publication prior to April 2015. The PNA is a structured approach to identifying unmet needs for pharmaceutical services. JF advised that 60 day period of consultation closed at the end of January. No major changes were required to the document. The report was deemed to be an excellent piece of work and was well received by the HWBB. Conversations are happening with the members of the public. RJ queried how it would be promoted and used. AJ stated that the PNA could take some of the pressures off the GP services. KSm advised that people could be encouraged to access pharmacies rather than A&E and stated that if we were to invest resources then we should get return back. CH Asked the Board to think about what sort of information Pharmacies needed to hold in terms of signposting, the absolute key things that they hold. CH to feed through to JF. The final PNA will be signed off by the HWB Chair on behalf of HWBB. Noted: The Board noted the progress.	
5.4	<u>Infant Mortality – Glenda Augustine</u> The purpose of the briefing was to provide a progress report on the draft action plan developed to address the rate of infant mortality in Wolverhampton. The National Child Health Profiles published in March 2014 indicated that Wolverhampton has the highest rate of infant mortality in England. This raised concern across health and social care organisations and resulted in the convening of a multi-agency infant mortality working group in May 2014 and the production of an action plan to address the underlying causes of infant mortality. The action plan consists of 15 individual recommendations within six specific areas. The Plan will be presented at the HWBB on 4th March and if accepted, reported to the Royal Wolverhampton NHS Trust Board and Wolverhampton CCG Governing Body.	

	RJ invited thoughts/concerns/issues from the Board.	
5.5	<u>Violence Reduction – Dr Jane Fowles</u> Dr Jane Fowles presented the briefing paper the purpose of which was to update the PHDB on public health support to the violence reduction agenda in Wolverhampton. Local review of the WM Force area violence profile and Wolverhampton Spotlight identified two priorities for local action - youth violence and violence against women and girls (VAWG). Both are current priorities for the Safer Wolverhampton Partnership (SWP) and are reflected in the current Crime Reduction, Community Safety and Drugs Strategy. Wolverhampton Public Health is contributing to the violence reduction partnership with a focus on these two priority areas: • Supporting the SWP in the allocation of the 2015/16 Community Safety grant – proposals have been agreed by the SWP board and will now be presented to the Police and Crime Commissioners Office. • Strengthening local understanding of youth violence and VAWG. • Developing the 2015-2018 VAWG strategy in partnership with the Wolverhampton Domestic Violence Forum (WDVF) and SWP. • Re-profiling the Hospital Youth Service around mental health and youth violence. Prevention of both youth violence and VAWG is underpinned by wider PH work and links with a range of local authority programmes such as Early Help and Families r First. RJ invited thoughts and feedback from the Board.	
5.6	<u>Health Visiting Transition Update – Neeraj Malhotra</u> The purpose of the briefing paper was to update PHDB members on the transfer of commissioning responsibilities for the 0-5 Healthy Child Programme from the NHS to the Local Authority. Responsibility for commissioning 0-5 children's public health services is transferring from NHS England to Local Government on 1 October 2015. This joins up the commissioning for children under 5 with the commissioning for 5-19 year olds and other public health functions. An internal transition group has been established within the local authority to oversee a smooth transition. The group is made up of representation from Public Health (transformation, NHS facing, commissioning), legal, finance, procurement as well as early years services and is accountable to the PHDB. Contractual arrangements need to be resolved by mid-March. At its inaugural meeting on 28th January the group agreed to proceed with the NHS contract some queries have been raised and responded to at the internal transition group about can we use the NHS contract and what it	

	means for the Council. Legal and procurement advice has been sought and the process for approval is underway. Communications with the stakeholders will be undertaken. Future service development to include a 0-19 years programme integrating school nursing. AJ suggested that this would link very closely with the work on the Pharmacy. RJ recommended that a briefing note to be produced (one side of A4) highlighting priorities for a forward plan.	
6.	**Joint Health and Wellbeing Strategy Update – verbal (RJ)**	
6.1	JSNA Refresh GA produced for HWBB to be circulated. No major changes to the document. Membership of the HWBB has been extended with the Leader now joined as a core member. Two main providers have been invited RWT and BCPFT. Positive step forward. But Strategy needs to be a lot more cross cutting with some of our ideas. Conversations need to be had around HWBB and greater partnership working and that the individual organisations can do. Trying to get all sectors contributing. JG raised issues around the need to raise the profile of alcohol. Health data and intelligence from across the health economy suggest that this need a partnership focus. Work is required on key priorities and these will be fed back in the first instance under the alcohol strategy refresh.	JG
7.	**Business Plan: summary reports from:**	
7.1	<u>Effective Commissioning JG</u> JG presented a table outlining progress to date on the Public Health Business Plan, priority one – Effective public health commissioning. It was noted that the contracting strategy had been approved in December by Cabinet Resource Panel for procurement planning over the next 3 years. Equality and Analysis reviews will be done as part of each programme. The drugs and Alcohol service is not included in the list as this will be part of an Options Appraisal process to decide if the available 2 year contract extension is applied post March 2016. RJ informed that it has taken two years to change from one model to another for our main programmes of redesign, substance misuse and sexual health.	
7.2	<u>Effective Process – KW</u> Progress of the Public Health priority 2 development of public health business systems and processes. There has been significant progression in terms of setting up the framework for the department governance arrangements however due to vacancies and team structure not all of the work has been able to be progressed.	

	Priority 2 will be business as usual and therefore not routinely reported unless there is an exception.	
7.3	Integrating Healthier Place Team – RW Progress to date on the Public Health Business Plan Priority 3 – Integrating Healthier Place Team into Public Health. Healthier Place project plan update: • Strategic influence on the distribution of S106 monies related to 30 schemes within the last 6 months (with an emphasis on health related provision). • Production of a school based health related behaviour survey (in 66 schools with 7790 respondents) with analysis being used to help determine future commissioning of services and also utilised by a range of local partners and stakeholders to address current issues. • £1.1m external funding secured for Sport and Physical Activity Capital schemes with the opportunity to lever a further £900k.	
7.4	Obesity (SW) The Board is requested to note the summary report of the Obesity Summit held at Dunstall Racecourse on 10th November 2014 and note the work streams that make up the Obesity Action Plan. SW advised that an action plan was being developed. In addition to the work being undertaken to develop the Action Plan, work streams have been identified and task and finish groups are being established. SW invited ideas for membership for the task and finish group. It was suggested Heads of Service should be approached for ideas. The Board were asked to support SW in the delivery of the action plan. In terms of this Board RJ confirmed that she along with the team would be happy to decide on the workstream and that it would be a good idea to focus on one of the workstreams at each of the future PHDB meetings. NM stated that further conversations need to take place regarding overlapping work and what is distinct. RJ invited the Board to direct comments to SW.	
7.5	Healthcare Advice (KS) The Board were asked to note the progress to date on the Public Health Business Plan Priority 5: Healthcare Advice. KS advised the Plan was on target. There were some issues around the SEND data. In terms of the Prevention Strategy there has been some slippage on the delivery and a new target for completion is March. Agreement being reached about what data we can provide. Suggestion was made to ask Linda Sanders to be a champion to support unblocking data barriers and enabling development.	
7.6	Smoking (SMc) The purpose of the report was to provide the Board with an overview of	

	performance against priority 6 – smoking as identified in the Public Health Strategy. SMC advised that the Council have now signed up to The Local Government Declaration on Tobacco Control. Smoking is still the biggest cause of preventable illness and premature deaths in the country – accounting for over 80,000 deaths in England a year. People will carry on smoking while the cigarettes are cheaper. A number of escalation plans are underway to target smoking populations in particular around pregnant women and smoke free homes. JG asked that support for people who smoke cannabis is also integrated. RJ asked for the Position Statement to be circulated.	
7.7	<u>Health Protection /EPRR (KS)</u> The purpose of the report was to outline progress on Priority Seven within the Public Health Business Plan. KS advised that with the successful appointment to the Health Protection Lead Practitioner post, the Health Protection work has taken off over the past five months. The Wolverhampton ConOps for the management and response to public health incidents was agreed at the Health Protection Forum in May. A Communications Plan is now being developed to support this document. Neil Rogerson is joining Public Health focussing on Health Protection and EPRR and Resilience Board.	
8.	**Any Other Business**	
8.1	RJ gave a brief update on the visit to Wolverhampton on 4th February by Duncan Selbie, and stated that the visit would include a tour of the Incident Room, Civic, Refugee Migrant Centre and Contraception and Sexual Health Service. RJ said feedback of the visit will be provided at the April meeting of PHDB. Corporate Plan – RJ confirmed that by the time of April meeting our Corporate Plan will have been delivered with the 3 objectives and will discuss how we take this programme forward.	
9.	**Date and Time of Next Meeting**	
9.1	The next meeting will be held on 14th April 2015 at 10.00 am, Committee Room 4.	

Attachment: Appendix 1 – Business Plan Summary

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Appendix 1: Public Health Business Plan: Priority One - Effective public health commissioning

Activity	Performance Measures	Target	Progress to Date (January 2015)
1. 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	• Final draft commissioning strategy document completed • Contracting strategy approved by CRP December 2014
2. 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 completed by March 2015	• Health visiting transfer; Finance and budget transfer agreements are agreed in principle. • 0-5 transition group being established to manage shadow contract/commissioning arrangements and service development
3. Define clear healthy lifestyles outcomes for Wolverhampton incorporating our obesity call to action and reducing harm from smoking and smoking related activities.			• Obesity reported separately. • Smoking cessation service development, NHS health check audit and extension of child weight management interventions to complete with any contracting implications identified by March 15.
4. Prioritise contracts requiring retender and review during 2014-15 and develop and implement the frameworks in order to undertake these programmes.			• Consultation on the sexual health service model will close January 15 interim findings reported • School nursing development plan drafted. • Needle exchange award of contract to CRP January 2015.
5. Contract management process established against all specifications/minimum data sets/targets and outcomes in place.			• Contract notifications, commissioning intentions and governance checklist to be issued to all providers during Jan/Feb 15

Appendix 1: Public Health B*u*siness Plan: Priority Two - Developing public health processes to support transformation

Activity	Performance Measures	Target	Progress to Date (January 2015)
1. 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	• Public Health risk register, incident log and incident management processes complete • Work commenced to develop governance and quality assurance processes for each contract. • Risk management framework drafted to be finalised and signed off at SMT
2. Establish Public Health Communications plan that addresses internal and external communication needs	The Public Health communications plan is agreed and established by December 2014	100% of the communication needs identified in the plan are delivered by March 2015	• There is some slippage in development of the communications plan but there is progress with external communications mapping
3. 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 December 2014	100% of all eligible staff will have an induction, appraisal and personal development plan by March 2015	• Slippage means new timescales have been agreed • Partial completion of the induction packs
4. 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	• Activation anticipated as services are commissioned • Work to commence on identifying specific quality components required for the new service level agreements
5. 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	• There is evidence that the Local Authority is aware of Public Health research governance function • Further work is required to develop formal programmes and an ethical review panel

Appendix 1: Public Health Business Plan: Priority three - Integrating the healthier place team into Public Health

Activity	Performance Measures	Target	Progress to Date (January 2015)
1. Implement restructure for Healthier Place team following disaggregation of budgets for Sport Development / Healthier Schools / Parks Development	Creation of a project plan, revised structure and work programmes for individual teams.	Completed by 31/3/15	Budgets realigned for all three teams. Further restructure work to be undertaken to include the obesity call to action, Urban environment development, and wider City Council reorganisation.
2. Complete Asset Mapping Profile for the City to include Physical and non-physical assets and develop an electronic database.	Production of a database.	Completed by 31/12/14	All profiles have been developed. Gap analysis to be undertaken regarding geographical hot spots (i.e. those areas with little provision or support).
3. Refresh the Sport Development and Investment Strategy	Production of document.	Completed by 31/05/2015	Radical change in approach has been made as document is to be revised (as opposed to being refreshed) to take into account obesity priority for the City. Refresh of Playing Pitch strategy is to also feed into the strategy. Due to these factors Officers are working with Sport England and Governing Bodies with a revised completion timescale of May 2015.
4. Implement Savings proposal for Parks (Development) and Countryside Service.	Savings of £295k and introduction of new health related schemes, initiatives and services within parks, open spaces and countryside areas of the City.	Completed by 31/07/2018	Savings achieved for 2013/14.
5. Contribute towards review of healthy lifestyles related commissioned contracts and development of a savings programme.	Savings of £300k to be achieved.	Completed by 31/09/2014	Commissioning intentions document includes direction of travel reference in relation to healthy lifestyles related contracts. Further work required to decommission / re-commission existing contracts.

Appendix 1: Public Health Business Plan: Priority Four - Reducing obesity across the life course

Activity	Performance Measures	Target	Progress to Date (January 2015)
1. 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 focuses on a 'call to action' to kick-start Wolverhampton wide action on the important health issue of obesity.	Completed by May 2014	Completed • Report now completed and published and presented to Health and Wellbeing Board in July 2014. • The report has been presented to internal and external committees and boards and these presentations will continue to promote the 'Call to Action'
2. To follow up the Annual Report with a whole health economy summit to agree a Wolverhampton wide approach	Summit organised and held	Completed by end of October 2014	Completed • Summit held on 10th November at Dunstall Racecourse. • Over 300 delegates attended • Nearly 300 pledges to tackle obesity in Wolverhampton were made • The event launched the 'million' challenges, 'A million miles for Wolverhampton' and 'A million pounds (shed) for Wolverhampton' • The event attracted significant media coverage
	Action plan agreed by the Health and Wellbeing Board	Action plan agreed by December 2014	• A first draft of the Action Plan will be presented at the Health and Wellbeing Board in March 2015.

3. Community involvement in the obesity call to action	**Establishment of members obesity challenge** **Launch of Million Miles for Wolverhampton challenge and associated Million Pounds Lost challenge**	**Launched in the media on 22nd September 2014** **To be launched at the Obesity Summit**	**Completed** • **Cllrs. Sweet, Simkin and Warren are participating in the challenge and using social media to chart their progress** • **Progress with the member champions was highlighted at the November Obesity Summit** • **'Million' Challenges were launched at the summit.**
4. Links to Healthier Places Priority	**Complete an asset map of the city**	**To be completed by October 2014**	• **Raw data complete with further work to be undertaken regarding a gap analysis and publication via corporate website.**

Appendix 1: Public Health Business Plan: Priority Five - Healthcare advice: delivering mandated function

Activity	Performance Measures	Target	Progress to Date (January 2015)
1. 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	• Work plan is being delivered. 6 monthly review with CCG is due. • Infant mortality draft action plan completed awaiting Health and wellbeing Board approval in March 2015
2. Development of a prevention strategy for Wolverhampton to support the reduction in long term conditions. database.	Prevention strategy output informs Primary Care and Public Health commissioning	100% of the Prevention Strategy is completed by March 2015	• There has been slippage on the completion of the prevention strategy which was previously due in December 2014, but is now due to be delivered by March 2015.
3. 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	• This objective is currently under review due to change in CCG plans
4. 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	• The draft PNA is now out for consultation until 30th January. • The PH Pharmaceutical Lead post has now been advertised.

Appendix 1: Public Health Business Plan: Priority Six – Tackling Health Inequalities: reducing smoking

Activity	Performance Measures	Target	Progress to Date (January 2015)
1. 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	• Mapping of good practice in other local Authorities has been undertaken and this will feed into commissioning intentions. Consideration is being given to undertake some work with Dudley PH dept. and the Arts with the opportunity of some match funding.
2. 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 August 2015	• Tobacco control peer assessment is being planned for May. This needs to be completed to identify gaps to inform the strategy. Commissioning of smoking services is currently under review.
3. Develop a strategy to reduce infant mortality	Multi-agency strategy group continues to meet.	100% of interventions commissioned to reduce infant mortality are evidence based and have robust evaluation plans	• Infant mortality draft action plan completed awaiting Health and wellbeing Board approval in March 2015

Appendix 1: Public Health Business Plan: Priority Seven – Health Protection and Emergency Planning and Preparedness: delivering mandated function

Activity	Performance Measures	Target	Progress to Date (January 2015)
1. Develop the Health Protection Forum Work Plan 2014-15.	Work plan agreed within six months	100% of the work plan delivered by March 2015	• Data dashboard to aid prioritisation agreed by Health Protection Forum • HP Lead appointed • Slippage to deadline due to need for Ebola preparedness, and winter pressures.
2. 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	• Developed a suite of methods, including the HPF data dashboard, the screening and immunisation assurance framework, a quarterly report from PHE on cases reports and incidents, and care homes infection surveillance group • Governance structures established for incident logging and tracking within public health team. Whole team training delivered. • Work has commenced on developing a contractual assurance framework for PH commissioned services.
3. 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	• PH EPRR lead providing a service to CCG from 1st June 2014 until 31st March 2015 • Preferred option for BC joint EPRR service out for consultation • Sandwell Public Health calling a BC meeting to finalise agreement on future service.
4. Develop and integrate Public Health incident response into WCC	Plans agreed by Health Protection Forum by October	100% of the Incident Plan established and	• Wolverhampton ConOps for PH incident response agreed

Incident Plan and conurbation plans	**2014**	**fully operational by December 2014**	**at Health Protection Forum.** • **Need to develop process for testing plan** • **Communications Strategy development has commenced.**

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