Health and Wellbeing Board

7 January 2015

Time 12:30 p.m. **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 - 14)
[To approve the minutes of the previous meeting held on 5 November 2014 as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the meeting held on 5 November 2014]

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

7 **Summary of outstanding matters** (Pages 15 - 18)
[To consider and comment on the summary of outstanding matters]
[Viv Griffin]

8 **Health and Wellbeing Board Forward Plan 2014/15** (Pages 19 - 22)
[To consider and comment on the items listed on the Forward Plan]
[Viv Griffin]

9 **Wolverhampton Safeguarding Children's Board Annual Report 2013 - 14** (Pages 23 - 112)
[To consider the Wolverhampton Safeguarding Children's Board Annual Report 2013 – 14]
[Alan Coe]

10 **Health and Wellbeing Board - Governance arrangements including updated Terms of Reference and amendments to membership** (Pages 113 - 120)
[To consider proposed revisions to the Terms of Reference and membership of the Health and Wellbeing Board]
[Viv Griffin]

11 **Mental Health Strategy/ Mental Health - Crisis Concordat** (Pages 121 - 170)
[To receive an update on the implementation of the Mental Health Strategy including the next key steps]
[Noreen Dowd]

12 **Implementation of Action Plans following the Francis Report - Update** (Pages 171 - 178)

[To receive an update on the work undertaken to date by the Wolverhampton City Clinical Commissioning Group in response to the Francis Inquiry]

[Manjeet Garcha]

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

[To receive a position statement on the Better Care Fund and the Primary and Community Strategy and Primary Care Co- Commissioning Strategy]

[Sarah Carter / Noreen Dowd]

14 **Proposals to deliver planned care for Wolverhampton residents at Cannock Chase Hospital - Update** (Pages 179 - 234)

[To receive the final report on the joint consultation undertaken by the Royal Wolverhampton NHS Trust and the Wolverhampton City Clinical Commissioning Group]

[Maxine Espley]

15 **Feedback from Sub Groups** (Pages 235 - 240)

[To receive the minutes of the meetings of the following Sub Groups]**[TO BE CIRCULATED]**

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

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Health and Wellbeing Board

Minutes - 5 November 2014

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
Prof Linda Lang	University of Wolverhampton
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

Glenda Augustine	Consultant in Public Health, Community Directorate
Sarah Carter	Programme Director - Better Care Fund, Wolverhampton Clinical Commissioning Group
Heather Clark (Economics)	Manager Strategic Projects/Funding
Carl Craney	Democratic Support Officer
Noreen Dowd	Chief Operating Officer, Wolverhampton City Clinical Commissioning Group
Maxine Espley	Director of Planning and Contracting, Royal Wolverhampton NHS Trust
Jane Fowles	Public Health Speciality Registrar
Viv Griffin	Assistant Director - Health, Well Being and Disability
David Johnston	Project Lead - Primary Care Regeneration, NHS England Local Area team
Kathy Roper	Head of Young Adults Commissioning

Part 1 – items open to the press and public

Item No. *Title*

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

Apologies for absence had been received from Chief Superintendent Simon Hyde (west Midlands Police), Tim Johnson (Wolverhampton City Council), Sarah Norman

(Wolverhampton City Council) and Dr Kiran Patel (NHS England – Local Area Team).

2 **Notification of substitute members (if any)**
No notification of substitute members had been received.

3 **Declarations of interest (if any)**
No declarations of interest were made relative to items under consideration at the meeting.

4 **Minutes of the previous meeting**
Resolved:

That the minutes of the meeting held on 3 September 2014 be confirmed as a correct record and signed by the Chair subject to the following amendments:

Minute No. 9

Deletion in the second paragraph of the preamble of "(2015/16)" and "(2016/17)" and the substitution therefor of "(2014/15)" and "(2015/16)";
Deletion in the third paragraph of the preamble of "QUIPP" and the substitution therefor of "QIPP".

5 **Matters arising**
There were no matters arising from the minutes of the meeting held on 3 September 2014.

6 **Summary of outstanding matters and Chair's update**
Carl Craney presented a report which appraised the Board on the current position with a variety of matters considered at previous meetings.

The Chair, Cllr Mrs Sandra Samuels, provided feedback on the matters discussed at the Away Day held on 15 October 2014 including:

- Self-Assessment Stocktake;
- Purpose of the Board;
- The need for the "Better Care Fund" to become a strong priority for the Board;
- Changes that needed to be made.

The Chair, Cllr Mrs Sandra Samuels sought the views of the Board on the desirability or otherwise of a Vice Chair of the Board being appointed.

Resolved:

1. That the reports be received and noted;
2. That the appointment of a Vice Chair of the Board be supported.

7 **Health and Wellbeing Board Forward Plan 2014/15**
Viv Griffin presented the Health and Wellbeing Board Forward Plan for 2014/15. She informed the Board on the outcome of a recent meeting held with a view to populating the Agenda's for the January and March 2015 meetings as follows:

7 January 2015 – Theme "Younger Adults"

- Learning Disability Strategy

- Safeguarding Children's Board Annual Report 2013/14;
- Joint Strategic Needs Assessment (JSNA) – Update – Quality

4 March 2015 – Theme "Wider Determinants of Health"

- Obesity Action Plan;
- Plans for Civic Week – March 2015

Reports in relation to the Better Care Fund would be submitted to all future meetings. She invited the Board to indicate any further reports to be considered at these meetings. Noreen Dowd suggested that an update in relation to the proposals to deliver planned care at Cannock Chase Hospital should be considered at the January meeting together with the Primary Care and Commissioning Strategy.

Resolved:

That the Forward Plan, as now amended be approved and a copy be circulated to members of the Board.

8 **Proposals to deliver planned care at Cannock Chase Hospital for Wolverhampton patients - Outcome of Consultation Exercise**

Maxine Espley gave a PowerPoint presentation and circulated copies of slides in connection with the proposals to deliver planned care at Cannock Chase Hospital. The presentation covered the following areas:

- Update on the consultation process and emerging themes;
- Equality Impact Assessment;
- Actions taken to date and future plans and
- Next steps.

She advised the Board that a report would be considered at the meeting of the Health Scrutiny Panel scheduled for 20 November 2014 which would provide an overview of consultation feedback, address the Equality Impact assessment and provide an Action Plan responding to the various issues and concerns raised through the recent consultation exercise. She reported that a trial had taken place that morning of the proposed transport arrangements between New Cross Hospital and Cannock Chase Hospital at which five Members of the Health Scrutiny Panel together with two Wolverhampton City Council employees had been in attendance. She reminded the Board that the planned transfer would be phased in over an 18 month period, that users of individual services would be engaged with at the appropriate stage and of plans to continue discussions with Wolverhampton Healthwatch in relation to the proposals.

Maxine Bygrave welcomed the approach which had subsequently been adopted by the Royal Wolverhampton Hospitals NHS trust and the Wolverhampton City Clinical Commissioning Group with regard to the proposals and consultation arrangements. She suggested that there was a need for a very clear message to be communicated that the transfer of services would be undertaken on a phased basis rather than all at once. She also suggested that further consideration needed to be given to the proposed transport arrangements between the two Hospitals having regard to likely delays which could be experienced during the rush hour periods. Maxine Espley acknowledged the points now made and assured the Board that the transport

arrangements were being planned in a true partnership manner with the transport operator.

The Chair, Cllr Mrs Sandra Samuels, enquired as to the proposed charging regime for the transport arrangements. Maxine Espley reported that the transport would be at no charge to patients, carers' and those over the age of 65. The charges for other users was currently being considered but was likely to be at a subsidised level.

Resolved:

That the presentation and report be received and noted.

9 **Implementation of Action Plans following Francis Report - Update**

Noreen Dowd advised that the report in connection with implementation of Action Plans following the Francis Report was not currently available and undertook to ensure it was presented to the next meeting.

Dr Helen Hibbs reported that there was not a specific Action Plan currently used by the Wolverhampton City Clinical Commissioning Group as the recommendations contained within the Francis Report were an integral part of all activities of the Group. There was a focus on the quality of services provided and a Clinical Quality Review had been undertaken with all providers. Work was also being undertaken with all Care Homes in the City and patients receiving care outside the City were also being tracked.

Resolved:

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

10 **Wolverhampton Safeguarding Adults Board - Annual Report - 2013 - 14**

Alan Coe presented the Wolverhampton Safeguarding Adults' Board Annual Report 2013/14 including the Executive Summary which informed the Board of safeguarding activity and detailed progress made against the priorities identified for 2013/16. He reminded the Board that the Safeguarding Children's Board would become a statutory body from 1 April 2015.

He highlighted a number of areas of concern including the levels of consistency between partners on issues such as training. He also referred to the significant difference in the level of referrals between Wards. This could be explained in part by the location of Care Homes / Hospitals etc. With regard to the forthcoming statutory role he advised that the official guidance had only been received within the last two weeks.

Sarah Carter enquired as to the planned circulation for the Annual Report. Alan Coe explained that it was for individual partners to make appropriate arrangements for the circulation of the report. In response to a question from Christine Irvine, Alan Coe confirmed that it was the responsibility of Commissioners to ensure that the providers complied with all the appropriate safeguarding requirements. Dr Helen Hibbs acknowledged the points now made but reminded the Board that a number of care placements were self- funding and thus responsibility with regard to safeguarding fell

to the provider. Alan Coe assured the Board that the Care Quality Commission was aware of the situation.

Ros Jervis suggested that there was a need for the Board to have in place a Framework to ensure that all Agencies had internal mechanisms that could demonstrate their role and performance in relation to safeguarding arrangements for adults at risk.

Resolved:

1. That an assurance be provided to Wolverhampton Safeguarding Adults Board that the respective agencies represented on the Health and Wellbeing Board report annually to their respective Boards on adults safeguarding;
2. That the Health and Wellbeing Board and the Wolverhampton Adults Safeguarding Board work together on the preparation of an appropriate framework to ensure that all Agencies had internal mechanisms that could demonstrate their role and performance in relation to safeguarding arrangements for adults at risk;
3. That Board members representing key agencies mentioned in Statutory Guidance dated 23 October 2014 take the necessary steps to ensure that the new statutory Board was in place and properly constituted and funded by 1 April 2015;
4. That the report be noted.

11 **Child Poverty Strategy**

Further to Minute No. 11 of the meeting held on 3 September 2014 Keren Jones presented a report which addressed the following elements pertaining to the Child Poverty Strategy:

- Governance arrangements;
- Performance measures to be used by the Board to measure progress;
- How responsibility for priority actions were allocated and/or apportioned and
- How a “call for action” might be delivered.

She referred to a diagram within the report which outlined the inter-relationship between the various Boards and responsibility for particular themes.

Cllr Val Gibson welcomed the report and the explanation of performance management measures. Christine Irvine endorsed the comments now made but stressed the need to ensure that all partners were aware of the work being undertaken. She also expressed concern on behalf of the Third Sector with regard to the use of the term “Civic Week”. Keren Jones acknowledged the these points but explained that work was still at an early stage and would be subject to ratification by all the individual Boards before the term was finalised.

Resolved:

That the report be received and endorsed.

12 **Joint Strategic Needs Assessment (JSNA) - Refresh**

Glenda Augustine presented a report which provided the Board with an update on the changes to the health and wellbeing of the residents of Wolverhampton as indicated by a review of the outcomes frameworks which had informed the Joint Strategic Needs Assessment (JSNA). She drew to the attention of the Board the

decrease in the incidence of teenage pregnancy by 25% albeit that this was a national trend. She also referred to a number of key areas of concern in Wolverhampton, namely:

- Excess weight of children;
- Breast cancer screening;
- MMR immunisation levels;
- Infant mortality rates.

She reminded the Board that whilst progress had been made a dramatic change could not be reasonably expected in the short term.

Alan Coe referred to the Peer Review of Adult Safeguarding inasmuch as the review had been critical of the lack of a reference within the JSNA to safeguarding. He anticipated that similar comments would be made by Ofsted at the time of the children's safeguarding inspection. Ros Jervis assured the Board that safeguarding was referred to in the qualitative chapter of the JSNA. She also advised the Board that at the recent "Away Day" it had been agreed that there was a need to review the priorities contained within the JSNA to confirm their continued relevance and on the need for all partners to act more collectively on wider determinants of health.

Resolved:

1. That the annual change in the health and social care indicators that informed the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy be noted;
2. That publication of the Joint Strategic Needs Assessment Refresh for 2014 be approved.

13 **Pharmaceutical Needs Assessment: Update**

Dr Jane Fowles presented a report which informed the Board of the findings of the Wolverhampton Pharmaceutical Needs assessment and which sought endorsement of the draft document for the statutory 60 day consultation. The report recommended, inter alia, that authority be delegated to the Chair of the Board to receive a summary of the feedback received during the consultation and the ratification of the final Pharmaceutical Needs Assessment for publication by 1 April 2015.

Maxine Bygrave reported that Wolverhampton Healthwatch had been involved in the process and that this was an area which generated very few complaints or concerns from the public. Dr Helen Hibbs commented on the opportunities to make greater use of community pharmacies to address issues which did not require GP or hospital consultations. Sarah Carter reported that there was also an opportunity to include the use of community pharmacies in the re-design of the Community Care Programme as part of the Better Care Fund.

Resolved:

1. That the findings of the draft Wolverhampton Pharmaceutical Needs Assessment be noted;
2. That the draft Wolverhampton Pharmaceutical Needs Assessment be endorsed for the statutory 60 day consultation;
3. That authority be delegated to the Chair of the Board to approve the final Wolverhampton Pharmaceutical Needs Assessment for publication by 1 April 2015 following consideration of feedback after the conclusion of the consultation period.

14 **Wolverhampton Healthwatch - Annual Report**

Kathy Roper and Maxine Bygrave presented the Healthwatch Wolverhampton Annual Report 2013/14 which outlined the range of community engagement undertaken, how Healthwatch Wolverhampton had influenced local decision making and which detailed the priorities for 2014/15.

Noreen Dowd commented on the improvement in organisation and prioritisation within the local health economy in the face of limited resources. Christine Irvine enquired as to the proposed financial arrangements post April 2015. Kathy Roper opined that funding was anticipated for the 2015/16 financial year but with a General Election scheduled for May 2015 future years funding was unclear. Alan Coe commented on the need to avoid duplication of inspections and of the balancing act required to ensure that Healthwatch Wolverhampton maintained its independence whilst fulfilling the expectations of both the Council and the Clinical Commissioning Group. Maxine Bygrave assured the Board that every effort was made to avoid duplication of work and of the need to respond to local priorities. The Chair, Cllr Mrs Sandra Samuels, advised the Board of the role played by Healthwatch Wolverhampton in the transfer of services from New Cross Hospital to Cannock Chase Hospital.

Professor Linda Lang reported that the work undertaken by Healthwatch Wolverhampton was very appreciated by the University of Wolverhampton. She enquired whether contact had been made with the “Volunteering Programme” operated by the University. Maxine Bygrave advised that contact had been established and discussions were on-going.

Resolved:

That the report be noted and the work undertaken by Healthwatch Wolverhampton, including the community engagement undertaken and the priorities identified for 2014/15 be acknowledged.

15 **Better Care Fund - Update**

Sarah Carter presented a report which provided the Board with an update on progress made in relation to the development of the Better Care Fund Programme in Wolverhampton and which outlined the next steps to be taken with regard to the next steps required for the sign off of the Better Care Fund Plan. She explained to the Board that since the report had been produced the submission had been rated by the Department for Health in the category as “Approved with Support”. This meant that, overall the Review Team and the Modification Panel had confidence in the Plan. There were, however, some items of evidence or information that would need to be submitted to provide full assurance. The Team would want to review these particular areas before the Plan could be approved fully. Areas in this category would be assigned a Relationship Manager from the Task Force to agree a plan to provide the further information identified through the National Consistence Assurance Review (NCAR) process. This would be a straightforward and light touch process and the aim was for all Health and Wellbeing Board’s in this category to have their Plans approved fully before December 2015.

She reported that a report in connection with “Pooled Budget” arrangements

Would be submitted to the meeting scheduled for 7 January 2015 with the proposals being signed off at the meeting scheduled for 4 March 2015. A number of issues needed to be addressed before the official sign of including:

- Whether responsibility for monitoring the Better Care Fund expenditure would be undertaken by the Health and Wellbeing Board;
- The level of oversight of the Programme required by the Health and Wellbeing Board.

Viv Griffin reminded the Board that it had been the practice to stage two "Away Days" each Municipal Year and suggested that arrangements be made for such an event in order that consideration could be given to the issues now referred to. This suggestion was supported.

Sarah Carter reported that the final Better Care Fund submission would be uploaded shortly on the Websites of both the City Council and the Wolverhampton City Clinical Commissioning Group. Maxine Bygrave requested that an "Executive Summary" be provided to Healthwatch Wolverhampton and that she would arrange for it to be uploaded to the Website. Alan Coe suggested that if an "Executive Summary" document was not available information pertaining to the Better Care Fund should be provided in a format that was easily understandable and in a "what does this mean for me/ my relative" format. Sarah Carter assured the Board that these issues were being addressed by the Communications and Engagement Team.

Resolved:

1. That the next steps of the plan programme be approved;
2. That delegated authority be granted to the Chair of the Board for the final Better Care Fund detailed scheme descriptions and submission to the Department for Health;
3. That arrangements be made for a further "Away Day" event to consider the responsibility for operational oversight and financial and performance monitoring, metrics and plans associated with the Better Care Fund;
4. That further reports be submitted to future meetings on the "pooled Budget" arrangements and the Section 75 proposed draft agreement.

16 **Feedback from Sub Groups**

(i) Children's Trust Board

Viv Griffin presented the minutes of the meeting of the Children's Trust Board held on 30 September 2014.

Resolved:

That the minutes of the meeting of the Children's Trust Board held on 30 September 2014 be received and noted.

(ii) Transformation Commissioning Board

Viv Griffin reported on the deliberations of the Transformation Commissioning Board at the meeting held on 10 September 2014.

Resolved:

That the report be received and noted.

(iii) Public Health Delivery Board

Ros Jervis presented a report which informed the Board of the new work streams of the Public Health Delivery Board, as agreed through the Business Planning Cycle and matters arising from the meeting held on 9 October 2014.

Resolved:

That the report be received and noted.

17 **NHS Capital Programme**

David Johnston presented a report on the present position with negotiations and discussions between NHS England, the Wolverhampton City Clinical Commissioning Group, NHS Property Services and Wolverhampton City Council in connection with Council and NHS development plans with a view to understanding how these plans could be best co-ordinated in relation to the following sites:

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

The Chair, Cllr Mrs Sandra Samuels enquired as to the likely timescale for The Scotlands scheme. David Johnston advised that work would commence shortly. Ros Jervis enquired as to whether the various parties were satisfied with the proposed timescale for the Bilston Urban Village scheme. David Johnston confirmed that to be the case. Ros Jervis expressed concern that the new premises proposed for this site would be adjacent to a Public House and a fast food take way restaurant. David Johnston acknowledged the point but advised that there was no alternative site available.

Cllr Roger Lawrence enquired as to whether the scale of proposals for Wolverhampton were comparable to other local authorities in the West Midlands. He also enquired as to whether this Officer Group was also looking at pipeline schemes. David Johnston confirmed that the scale of proposals planned were comparable against other local authorities covered by the Local Area Team and that Wolverhampton was receiving significant investment. Noreen Dowd opined that Wolverhampton had done well when compared to some other authorities. Dr Helen Hibbs reminded the Board that the scale of investment was at a much lower level than that discussed under the “LIFT” initiative but nevertheless Wolverhampton had done well in the allocation round albeit that the estate was in a poor condition. She assured the Board that work was on-going to ensure that priorities of the various parties were aligned. David Johnston reported that whilst the Council did not have a direct feed in to securing NHS finance the relevant bodies were aware of the requirements.

Resolved:

That the report be received and noted.

Agenda Item No. 7

Health and Wellbeing Board

7 January 2015

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

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

1.0 Purpose

1.1 The purpose of this report is to appraise the Board of the current position with a variety of matters considered at 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 4 March 2014 meeting
5 November 2014	Proposals to deliver planned care at Cannock Chase	Final outcome of public consultation exercise	Report to this meeting

	Hospital for Wolverhampton patients		
5 November 2014	Implementation of Action Plans following the Francis Report – Update	Report on progress	Report to this meeting

3.0 Financial implications

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

4.0 Legal implications

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

5.0 Equalities implications

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

6.0 Environmental implications

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

7.0 Human resources implications

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

8.0 Corporate landlord implications

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

9.0 Schedule of background papers

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

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Agenda Item No. 8

Health and Wellbeing Board

7 January 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 Strategic Director	Linda Sanders, Community
Originating service	Communities/Health, Wellbeing and Disability
Accountable officer(s)	Viv Griffin — Assistant Director Tel 01902 55(5370) Email Vivienne.Griffin@wolverhampton.gov.uk

Recommendation

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

MEETING	TOPIC	LEAD OFFICER
7 JANUARY 2015 (1230 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Wolverhampton Safeguarding Children's Board Annual Report 2013 -14	Alan Coe (WSCB)
	Health and Wellbeing Board – Governance arrangements including updated Terms of Reference and amendments to membership	Viv Griffin (WCC)
	Mental Health Strategy / Mental Health – Crisis Concordat	Noreen Dowd (WCCCG)
	Implementation of Action Plans following Francis Report – Update	WCCCG (Manjeet Garcha)
	Better Care Fund	Sarah Carter (WCCCG)
	Proposals to deliver planned care for Wolverhampton residents at Cannock Chase Hospital – outcome of consultation	Maxine Espley (RWNHST)
	Child Poverty Action Plan – Delivery Strategy	Keren Jones (WCC)
4 MARCH 2015 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Joint Strategy for Urgent Care – Equality Analysis	Steve Corton (M&LCSU)

Obesity Action Plan	Ros Jervis (WCC)
Plans for Civic Week – March 2015	Heather Ernstons (WCC)
Better Care Fund including update on Community and Primary Care Workstream and Primary Care and Commissioning Strategy together with 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) Noreen Dowd (WCCCG)
Learning Disability Strategy including Winterbourne	Kathy Roper (WCC)
Joint Strategic Needs Assessment (JSNA) – Quality Chapter	Ros Jervis (WCC)

To be added at some appropriate point: YOT input JSNA

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Agenda Item No. 9

Health and Wellbeing Board

7 January 2015

Report title	Safeguarding Children's Board Report 2013-14 Report of the Independent Chair
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Linda Sanders, Community
Originating service	Children's Safeguarding
Report to be/has been considered by	Wolverhampton Safeguarding Children's Board — 11 December 2014

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Provide assurance to Wolverhampton Safeguarding Children Board that the respective agencies represented on the Health and Wellbeing Committee report annually to their respective boards on children's safeguarding;
2. Ensure all agencies represented at the Board have internal assurance mechanisms that can demonstrate their role and performance in relation to safeguarding arrangements for children and young people.
3. Note the report

1.0 Purpose

1.1 The Wolverhampton Safeguarding Children Board and the Health and Wellbeing Committee represent the aspects of the partnership agenda of the City and have a responsibility to hold one another to account. This is represented by a formal agreement recently signed by the Chairs of both Boards and is included in the schedule of background papers. The annual report of the Safeguarding Children Board offers a formal opportunity to ensure that this relationship in practice operates in accordance with the protocol. From the perspective of the Children's Safeguarding Board it provides an arena for challenge and an opportunity to seek assurances from members of the Health and Wellbeing Board that their constituent organisations discuss and review safeguarding at their respective Boards and, where relevant, scrutiny committees.

2.0 Background

2.1 Safeguarding Children's Boards are statutorily required to publish an annual report on the effectiveness of children's safeguarding and promoting the welfare of children in the local area. The Board is a broad partnership of key agencies who have a collective responsibility for safeguarding children and providing mutual assurance that the practice of safeguarding reflects jointly agreed policies and protocols. The board meets four time a year with much of its business conducted through a range of committees that report into the Board. It is expected that annual reports are presented to the Chief Executive (Managing Director in Wolverhampton's case), the Leader of the Council, the chair of the Health and Wellbeing Board and the local Police and Crime Commissioner. The annual report describes the combined activities made in respect of children safeguarded at a local level.

2.2 This report relates to the year 2013-14. It was signed off by the Safeguarding Children Board in December. There has been far less delay in the production of this report but it is intended that in future we shall be setting a deadline of the September of the reporting year concerned. Report to the Health and Wellbeing Committee would then follow accordingly.

3.0 Progress since last report

3.1 Board and membership and priorities have been reviewed and a revised Business Plan produced. An Executive of the Board has been established to help ownership of each priority and ensure the full Board is quickly appraised of any emerging risks and challenges in meeting our targets. The four key priorities are led and owned by different Board members. They are:

- Governance – Emma Bennett – Assistant Director Children's Services – Wolverhampton Council
- Front Line Delivery and Impact – Manjeet Garcha – Director of Nursing – Wolverhampton CCG
- Safeguards for particularly vulnerable children and young people – Supt Angela Whittaker – West Midlands Police – supported by Inspector Michaela Kerr

- Communication and Engagement – Stephen Dodd – Youth Opportunities Wolverhampton (YOW)

3.2 Although a list of key achievements is contained on Page 23 of the report I want to draw attention to the following areas of progress which will impact on our joint capability for keeping people safe:

3.2.1 There is now an established programme of multi-agency case file audits linked with briefing papers on lessons learned sent to local staff.;

3.2.2 There are clearer lines of communication with maintained schools through the establishment of Schools and Safeguarding Group with representation from the learning communities of Wolverhampton Schools Improvement Partnership. This ensures more schools and their staff can raise concerns about any safeguarding issues relating to the wider partnership and head teacher representatives on the Board are better able to communicate with the institutions they represent.

3.2.3 The Board, through the CCG is requiring an improved contribution from GPs to children's safeguarding and has taken steps to improve this;

3.2.4 Children are better protected by operational and strategic partnerships that oversee strategies and organise actions to prevent, disrupt and intervene in cases of child sexual exploitation. This has been achieved through a reconstituted and improved committee to oversee this area of work;

3.2.5 There continues to be a well-established multi-agency training programme which equips a range of staff to better identify the signs of possible abuse and respond appropriately to them. Take up of training is high and improvements to evaluate effectiveness of training are planned; and

3.2.6 Through the *BeSafe* initiative we have started a programme to engage young people directly in order to determine what causes them to feel unsafe and to determine when professionals have formally intervened they feel safer as a consequence.

3.3 Although new governance and board arrangements have established a firmer platform for safeguarding children I consider more could have been achieved last year but for the significant levels of turmoil within many partner organisations. At a time of significant public sector budget reductions many organisations have undergone significant change. Not only has the Board had to respond to new and updated national guidance on safeguarding Children –in *Working Together 2013* it has had to do so when Board membership has changed significantly. Nationally the Probation Service has been completely restructured and divided in two. Similarly the NHS has changed both locally – with the introduction of Clinical Commissioning Groups (CCGs) but also regionally. West Midlands Police have completely restructured its safeguarding arrangements both for children and adults. Wolverhampton Council has also changed aspects of its management arrangements and both the West Midlands Fire and Ambulance Services have changed the way they organise themselves in relation to safeguarding. In each case this has led to a change of Board representation and in the case of the Police service more than once. This has been a challenge both in terms of continuity but also in terms of identifying how to do more with less. I am now more confident in the stability of membership and am working with colleague chairs in neighbouring safeguarding board to see how we can form alliances that recognise

we need to be smarter in how we tackle similar problems and issues together rather than separately.

4.0 Financial implications

4.1 By the end of the reporting period the Board was becoming increasingly aware that funding to deliver the Board's priories was a challenge. In the short-term member the CCG has agreed to increase financial support while a review of how we meet our priorities going forward and the resources required to do so is undertaken.

5.0 Legal implications

5.1 Health and Wellbeing Boards (HWBB) were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and Wellbeing of their local population and reduce health inequalities.

5.2 The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and to ensure that these agencies are effective. It operates under guidelines known as 'Working Together to Safeguard Children'; the latest version came into effect from 15th April 2013.

5.3 Outlined in Working Together is the responsibility of the Chair to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. As stipulated in the related guidance, the annual report will be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and is presented here for the attention of members of the health and wellbeing board.

5.4 Following discussions between the Independent Chair of both Wolverhampton Safeguarding Adults and Children Boards, and the Chair of the Health and Wellbeing Board, it was agreed that there should be a formal agreement outlining this relationship.

5.5 The attached protocol sets out the distinct roles and responsibilities of the Boards, the interrelationships between them in terms of safeguarding, and wellbeing and the means to ensure effective co-ordination between the all Boards.

6.0 Equalities implications

6.1 Within this report covering the period 2013 -14, there are no specific equality implications. However the Board's work programme for the current year includes a significant focus on ensuring we obtain greater assurance about the level of understanding of safeguarding children among the multiplicity of organised religious groups in the City

7.0 Environmental implications

7.1 There are no specific environmental implications.

10.0 Schedule of background papers

10.1 Annual Report of the Wolverhampton Safeguarding Children Board 2013-14

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WOLVERHAMPTON SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2013 - 2014

CONTENTS

WSCB Value

Wolverhampton Safeguarding Children Board is committed to the following values and expects all staff and volunteer to share the same commitment.

1. All people of Wolverhampton have the right to:
- dignity, choice and respect
- protection from abuse and/or neglect
- effective and co-ordinated work by all agencies to ensure an holistic child/person centred response
- support to achieve the best possible outcomes, regardless of their age, sex, ability, race, ethnicity, religion, sexual orientation and circumstances
- high quality service provision

2. Safeguarding the wellbeing of children, young people and adults is a shared responsibility held by all agencies represented on the Board.
3. Openness, transparency and sustainability will underpin the work of the Board.
4. Participation by children, young people is essential to inform services, policies, procedures and practices.
5. Services to meet the individual needs of children, young people and families aspire to reach the highest standards.
6. Constructive shared learning to protect children and young people will be integral to the Board's business.
7. Celebration of strengths and positive achievements is important to the Board, as is the commitment to a process of continuous development and improvement.

Acknowledgments

A special 'Thank you' to all colleagues, young people involved in the Be-Safe Team who have contributed to the work of the Board, including the art work illustrated throughout this report, and finally special appreciation to Jane O'Daly. I hope you find the report of interest.

Foreword from the Independent Chair: Alan Coe.

We respond with horror and incredulity when we hear reports of children being abused neglected, sometimes murdered. We rightly ask: 'How did this happen?' When we hear the phrases 'More could have been done,' or 'We have learnt the lessons' we are both sceptical and angry. Each year there are cases that hit the

headlines nationally and names such as Rochdale, Rotherham or Coventry become associated with horrendous failings of professionals to protect children. In the past year Wolverhampton Safeguarding Children has published the findings of two Serious Case Reviews. They did not show continuous and systematic failings but they did identify things that professionals could have done better. A safeguarding board has a responsibility to assure the public that we are driving improvements in practice and prevention that will increase the safety and wellbeing of the children of this City. Much is done already to train and support staff in identifying and intervening where abuse is happening as well as promoting a better awareness among the local community of what they can do to better protect children. Increasingly we ask children how they think we can help keep them safe. You can read about it in the report.

We constantly challenge one another to be open about how we can do better and identify the weaknesses of local systems and practice that could place children at risk. We both review our risks and take action to reduce them. I wish to mention briefly three of them and what we are doing about them:

- Schools often feel isolated in their efforts to protect and support the children in their care. We are taking action to improve the help available to schools to spot the early signs of distress and encourage early help. A child who suddenly is frequently absent or appears withdrawn requires us to ask questions and seek support. We want greater assurance that schools are intervening early and with the support of health and social care staff.

- Family doctors can also feel isolated and not wholly aware how best to intervene in circumstances where they have concerns about the care of children. Through Wolverhampton Clinical Commissioning Group we are working to better equip GPs to recognise the signs of neglect and abuse and contribute more to our shared information about a child who may be at risk.

- We don't know enough about how many children are at risk of organised sexual abuse and maybe at risk of being trafficked. With the Police and other safeguarding Boards in the West Midlands we are determined to do more to preventing this happening, protecting those most at risk and pursuing and prosecuting the perpetrators.

We will be in a position by the next report to assure residents of the City that the risks identified above will have reduced. What we will never say is that we are satisfied that we have done all we can.

Introduction

Wolverhampton Safeguarding Children Board (WSCB) advocates that 'Safeguarding Children is everyone's responsibility'. It is crucial that partners from all agencies who work with children, young people and families across Wolverhampton work together to ensure that they are safeguarded and are given the opportunity and appropriate level of support to achieve the best possible outcomes.

WSCB has a statutory duty to co-ordinate how agencies work together to safeguard and promote the well-being of children and young people in Wolverhampton and to ensure the effectiveness of local partnership safeguarding arrangements.

WSCB has had a very busy year, with a new Independent Chair, a recently appointed Business Manager, a new Head of Safeguarding Service for the Local Authority and a number of new representatives to replace the resignation of some of the boards long standing members.

The outcome from a review of the board and all sub-groups very early in to this reporting year, resulted in a number of significant changes which were undertaken at difference stages and realistic pace throughout the year.

2013, we also saw the revised publication of the government guidance on safeguarding within Working Together 2013. This retained the emphasis on safeguarding being everyone's responsibility and the essential requirement for agencies providing services to both children and adults to work together to safeguard children and promote their welfare. The guidance re-affirms the role of LSCBs for ensuring that all agencies work effectively together.

For the role of the Chair, Working Together 2013 requires the Chair of LSCB publish an annual report on the effectiveness of safeguarding arrangements which should clearly outline how well agencies work together to promote the welfare of children in the local area. This report aims to provide an overview of the performance and effectiveness of local services. It identifies areas for improvements, and what actions are being implemented to address these areas as well as other areas for developments. The report will be presented to the Chief Executive of Wolverhampton City Council, the Lead Member, Chair of the Health and Well-Being Board and the Police and Crime Commissioner. It is intended for a wide audience including the professional workforce and local communities
Wolverhampton is fortunate as it benefits from strong partnership commitment to safeguarding, and there is good understanding of the benefits and importance of early intervention and prevention in relation to safeguarding. These are key to effective practice and WSCB will continue to strive to strengthen the importance of this aspect as it is developed further.

Each agency has been asked to provide an evaluation of its own performance; these are summarised in the Report, along with the contributions from WSCB Committees, the individual groups who undertake

the much valued work on behalf of the Board.

This report provides a mixed picture, as many of the member agencies including the Local Authority are facing reduced funding resulting in many having to implement new structures to accommodate for loss of key posts and experienced post holders. New commissioning arrangements are in place in many service areas and the Board is aware that any period of major organisational change presents additional risks. There is however the continuing commitment among all agencies to prioritise safeguarding and to ensure WSCB is an effective board.

Background.

This report provides an insight in to the work of Wolverhampton Safeguarding Children Board (WSCB) from 1st April 2013 through to 31st March 2014. It highlights the main achievements in safeguarding Wolverhampton's children and young people, and identifies the priority areas for improvement for the following year and beyond.

This is the 6th Annual report for WSCB. However, the format, layout and branding throughout has changed in part with many other changes that were deemed necessary following the evaluation of the effectiveness of the board at the end of the previous year and continues throughout this reporting year. Under a new leadership, multiple changes in membership, reaching the end of the 2010 – 2013 Business Plan, feedback from a Peer Review, and the publication by DfE of the revised statutory guidance, Working Together (March 2013), dictated the need for WSCB to take a new direction and to ensure a clear and transparent focus is maintained on the safeguarding arrangements across the City.

In Working Together 2013, the Government made a commitment to strengthen the role of LSCBs to monitor and scrutinise the effectiveness of all safeguarding arrangements in their local area. It has also changed much of the framework in which we work, and has given more authority to LSCBs in monitoring both child protection and early help services. A Review of WSCB was undertaken during development day (April 2013); this identified the need to strengthen some of the existing arrangements to ensure that the board can deliver against the requirements as outlined in Working Together 13. This led to:

- A revision in the governance and membership arrangements.
- The introduction of an Executive Committee with members of the main board nominated as leads to oversee each area of the priorities
- A revised Constitution requiring signature of each board member.
- An agreed set of priorities with designated leads for each priority who are the members of the newly form executive committee.
- A business plan

WSCB is supported by a range of sub-groups that enables it's functioning, a review of each group led to the formation of:

- An change in terminology in line with Working Together 2013, from sub-group to 'Committees
- The introduction of an additional Communication & Engagement Committee
- The former 'Missing and Compromised sub-group was retitled to; Sexually Exploited, Missing and Trafficked (SEMT) Strategic Committee.
- Revised Terms of reference
- An overhaul of the memberships of each group.

This report provides details of the range of work undertake during a year, including what is done to ensure that the children and young people of Wolverhampton are appropriately safeguarded, their welfare is promoted through services delivered locally and how partner agencies are held to account on the effectiveness of their safeguarding arrangements.

Throughout this report we have captured many areas of good practice and there is a sense of the many strength across the WSCB partnership, there is also evidence that WSCB is not a stagnant but a developing board, and while we can celebrate what we do well, we are fully sighted on the areas where arrangements need to be more robust, therefore, where further developmental work is necessary to enable an effective and fully functioning board.

Within this report, we can see some evidence of children being central in the works and activity of the board, if we keep the same focus on keeping children safe in the coming year and ensure the infrastructure and resources are adequate to deliver against the ever evolving and challenging agenda, we can expect to provide better services for all children and young people, whilst ensuring too that the most vulnerable children can be seen and have their voices heard.

It has been a challenging year for all agencies with the result of a huge cut in public sector funding leading to major reorganisation and cuts in services, and a continuing squeeze on resources which is felt by all agencies; this all impacts on staff and equally on children and families who are also facing increased pressure from the downturn in the economy. Despite all of this, WSCB will continue to strive to improve and develop its role in challenging and supporting the work of agencies involved in safeguarding children and in monitoring and coordinating the response to child abuse and neglect. The recent Business Plan for 2013-6 introduced at the end of the last reporting year, outlines the four strategic priorities and the desired outcomes as we move forward, aiming to go from strength to strength.

Wolverhampton in Context

With a population of 250,970, Wolverhampton is one of the largest cities in England and one of the most compact, covering just 27 square miles.

The number of Wolverhampton's Layer Super Output Areas (LSOA's) is in the 20% most deprived nationally is 82 (out of 158). This equates to 52% of Wolverhampton LSOAs now in the 20% most deprived in England, a rise of 3 percentage points from 2007.

The latest Indices of Deprivation (2010) indicates that Wolverhampton is more deprived than it was in 2007. This represents a relative decline, from the 28th most deprived to the 20th most deprived (out of 326 local authorities) and moves Wolverhampton from being in the 8% most deprived authorities to the 6% most deprived. Compared to that of the other Black Country authorities, only one being more deprived than Wolverhampton (9th most deprived).

There were 12,127 people aged 16-74 who said they were unemployed, which represents 7.8% of the total 16-74 cohort. This compares to 4.4% unemployed in England for the same age group.

The number of persons in the city aged 0 – 18 inclusive is 59,789 against a population of 250,970. Of these, 30,648 (51.3%) are male and 29,141 (48.7%) are female. This represents 23.8% of the total population. The highest individual age of children between 0 – 18 is <1 year (3,646 persons).

In total 39,199 children are currently being education in Wolverhampton state maintained schools (Nursery, Primary, Secondary, Special Schools). An additional 32 children are currently enrolled in a Pupil Referral Unit and 1751 by independent schools in Wolverhampton.

The total number of children deemed to be living in poverty is 17,920. 87% of these children are under the age of 16 (15,635 children). In total, 14,810 children are in families who claim IS or JSA; 1,000 are in families who claim WTC and CTC, and 2,110 are in families who claim only CTC. Of the 17920 children, 11870 belong to a 'lone-parent' family, whilst 6050 belong to a 'couple' family.

The percentage breakdown all children by ethnicity in Primary, Secondary and Special Schools are:

- White 57.5%
- Mixed 10.1%
- Asian 22.0%
- Black 8.7%
- Chinese 0.2%
- Any Other Ethnic Group 1.0%

(0.5% ethnicity information refused or

What are Safeguarding Children Boards?

Safeguarding Children Boards are the key statutory mechanisms for agreeing how the relevant organisations in each local area work together and co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.
The Children Act 2004 required each local authority to establish a local Safeguarding Children Board by 1 April 2006.

What are the statutory objectives of Local Safeguarding Children Boards?

The functions of Local Safeguarding Children Boards are set out in primary legislation (Section 14 and 14A of the Children Act 2004), and Regulation 5 of Local Safeguarding Children Regulations 2006 (SI 2006/90), and was reproduced in (2010), and more recently in April 2013. This statutory guidance outlines the core objectives of the Board as follows:

- To co-ordinate what is done by each person or body represented on the board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and
- To ensure the effectiveness of what is done by each such person or body for that purpose.

Safeguarding and promoting the welfare of children is defined for the purposes of this annual report (as detailed in appendix A in Working Together Guidance 2013) as:

- Protecting children from maltreatment;
- Preventing impairment of children's health or development;
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Undertaking that role so as to enable those children to have optimum life chances and enter adulthood successfully.

Wolverhampton Safeguarding Children Board will therefore ensure that the duty to safeguard and promote the welfare of children is carried out in such a way as to contribute to improving the outcomes for every child.

Safeguarding and promoting the welfare of children includes protecting children from harm. Ensuring that work to protect children is properly co-ordinated, effective and remains a primary focus of Wolverhampton Safeguarding Children Board.

What is the remit of Wolverhampton Safeguarding Children Board?

The remit of Wolverhampton Safeguarding Children Board (WSCB) includes safeguarding and promoting the welfare of children in three broad areas of activity:

- Activity that affects all children and aims to identify and prevent maltreatment, or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care.
- Proactive work that aims to safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population (eg. Children living away from home, children who are missing from home, school or care, children in the youth justice system, including custody, disabled children, children being, or at risk of sexual exploitation, trafficked children, children who may be forced into marriage or are possible to Female genital mutilation, and children and young people affected by gangs).
- Responsive work to protect children who are suffering, or are likely to suffer significant harm

Where particular children are the subject of involvement with the agencies represented on the Board, then safeguarding work should aim to help them to achieve the planned developmental outcomes and to have optimum life chances. It is within the remit of the local safeguarding children board to check the extent to which this has been achieved as part of its monitoring and evaluation work.

What are the functions of Local Safeguarding Children Boards?

The core functions of a local Safeguarding Children Board are set out in primary legislation and regulations. They are:

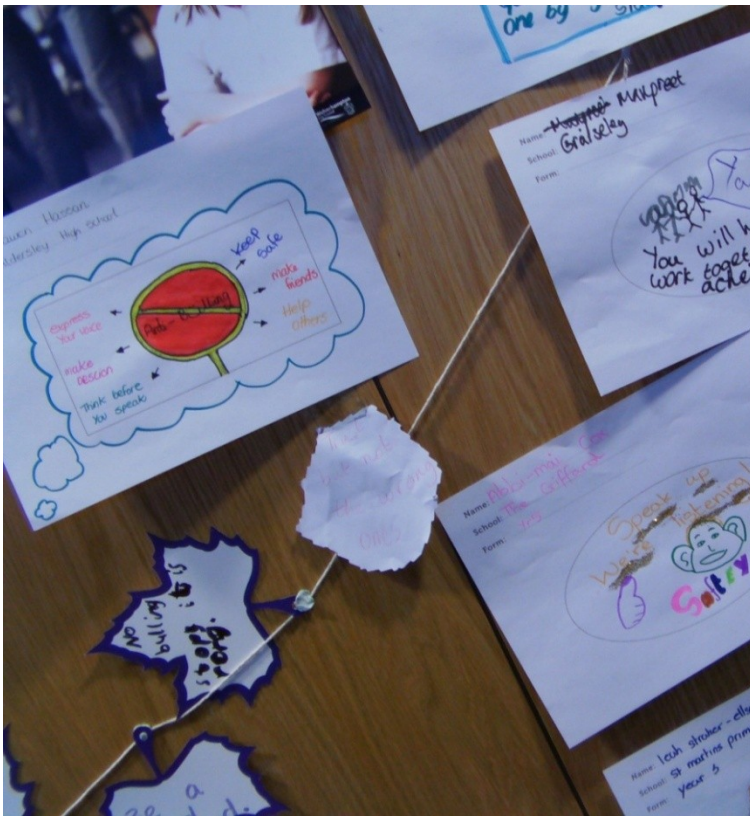
- developing policies and procedures for safeguarding in the area of the authority, including policies and procedures in relation to:
  - ✓ the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
  - ✓ training of persons who work with children or in services affecting the safety and welfare of children;
  - ✓ recruitment and supervision of persons who work with children;
  - ✓ investigation of allegations concerning persons who work with children;
  - ✓ safety and welfare of children who are privately fostered;
  - ✓ cooperation with neighbouring children's services authorities and their Board partners;
- communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this

can best be done and encouraging them to do so;
- monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- participating in the planning of services for children in the area of the authority; and
- undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

As stated in Working Together 2013, in order to fulfil its statutory function under regulation 5 an LSCB should as a minimum:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

WSCB does not have a power to direct other organisations.
The roles and responsibilities of local Safeguarding Children Boards and the agencies that are represented on them are set out in the government guidance "Working Together to Safeguard Children" (2013).

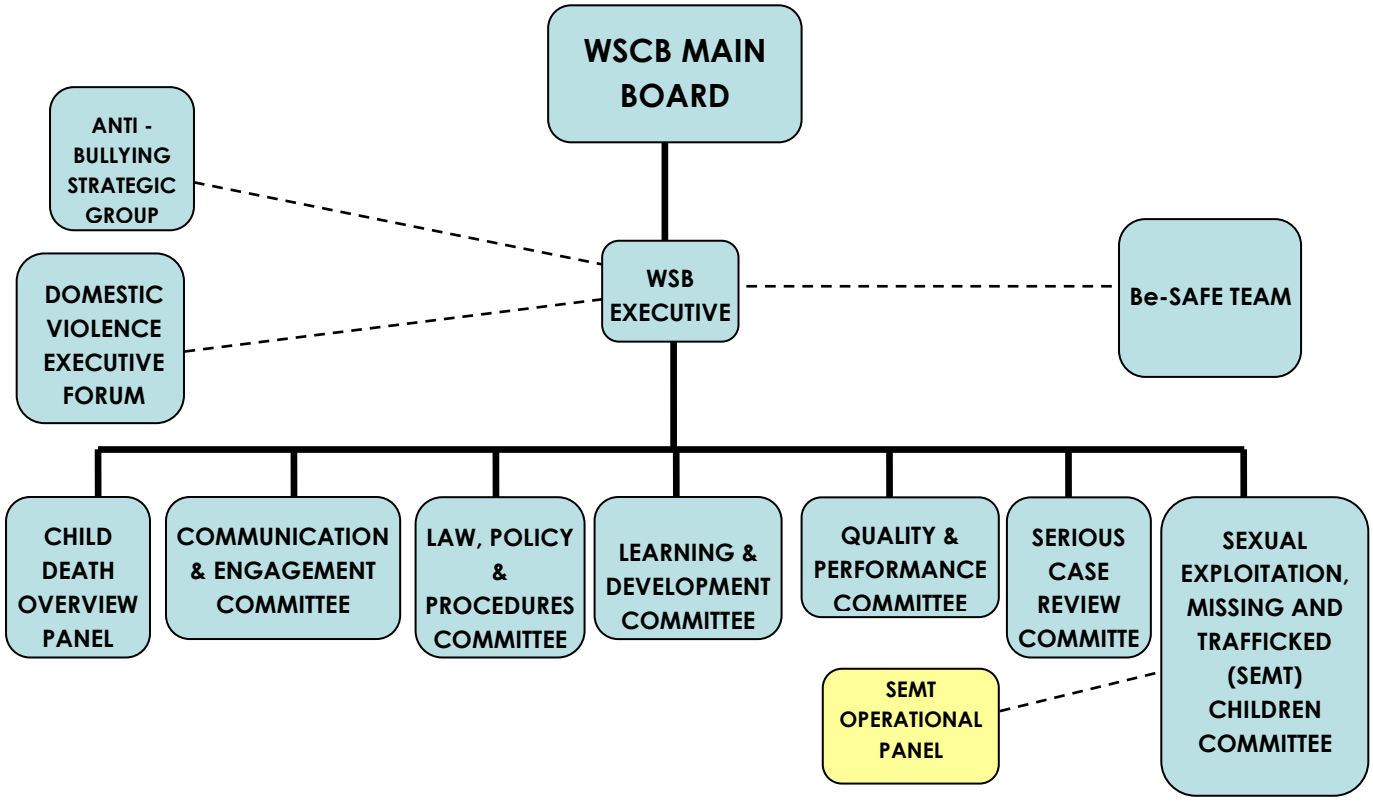


Wolverhampton Safeguarding Children Board structure

WSCB is composed of senior representatives nominated by each of its member agencies. The board is independently chaired by Alan Coe, and with the exception of an extraordinary meeting and the annual development day, the board met five times during the reporting year.

To enable it to fulfil its responsibilities, the main Board is supported by a range of committees. Within the review of the governance and membership arrangements in April 2013 led to the formation of an executive committee, whose purpose is to effectively manage the business and operation of the Board, in addition, a further committee was established to address the communication and engagement aspect of work on behalf for the board.

WOLVERHAMPTON SAFEGUARDING CHILDREN BOARD STRUCTURE CHART



A review of the former 'Missing and Compromised sub-group identified the need to strengthen the arrangement and processes of this group, to ensure better understanding and response to vulnerable groups of young people. The creation of the SEMT strategic Committee, with a subsidiary Operational Panel reporting directly to it ensures that Wolverhampton has a robust process for safeguarding particular vulnerable young as illustrated below.

Each committee has redefined its membership, terms of reference, and have provided a summary of the activities for this period which are featured further on in this report.

The executive committee is responsible for overseeing the activities under each area of the board's priorities, as well as, work undertaken by the following three distinctive groups;

- The work and remit of Wolverhampton Domestic Violence Executive Committee, overlaps across both adults and children safeguarding agendas, the task for the executive committee is to ensure that the local strategy pertaining to 'Violence Against Women and Girls' is not lost, but remain firmly rooted in to the business of the board.
- Listening to the children & young people of Wolverhampton, bullying, including via technology is their greatest concern. For many years Wolverhampton, within the area of its social inclusion services have an Anti-bullying Strategic Group; WSCB through the executive committee will be closely monitoring the arrangements, effectiveness and activities of this group.
- Towards the end of the last reporting year, WSCB established a Junior Safeguarding Board. The day to day management of this group is commissioned out to the Peer Network Group to ensure a sustainable and fully functioning initiative for the City. The Executive group along with its other duties holds the responsibility for overseeing and monitoring the pace of this area of the business.

Each of the above group have provided a commentary of the years' activities which features further on in this report.

Who are the representatives of WSCB April 2013 – March 2014?

WSCB Members

Independent Chair - Alan Coe

N Appleby	Probation - Vice Chair
J Ashby-Ellis	WM Ambulance Service
E Bennett	WCC- ADCS
J Blakeman	WM Fire Service
A Brown	WCC - Secondary School
H Crampton	CAFCASS
L Cross	Wolverhampton College
V Darby	Independent Schools
K Deeny	NHS – England
A Dill-Russell	Wolverhampton College
S Dodd	Wolverhampton VS
L Fieldhouse	Health
M Garcha	Health
S Hay	Primary, Schools Rep
M Heywood	Independent Schools
J Leadbeater	CAFCASS
S Marshall	Health
S Nash	YOT
S Norman	DSC WCC
J Parry	WMP – PPU
J Skyrme	WMP- PPU
J Thomas- West	WMP - Local
J Welsby	WCC - C&F
R Willoughby	WCC- ADCS

Professional Advisors

A Campbell	WCC - CiN/CP
T Christies	WCC – Legal
K Cole-Evans	WDVF – VS
L Millard	Health – CCG
R Robbins	Connexions
K Samuels	WCC – SWP
M Viggers	Health
C Thomas	Named Dr -
D Williams	WCC – Safeguarding
K Martin	WCC – SSL
A Wolverson	WCC - Early Years

Lay Members

R Bhagat
A Salmon

Observers

Councillor S Constable
Councillor V Gibson

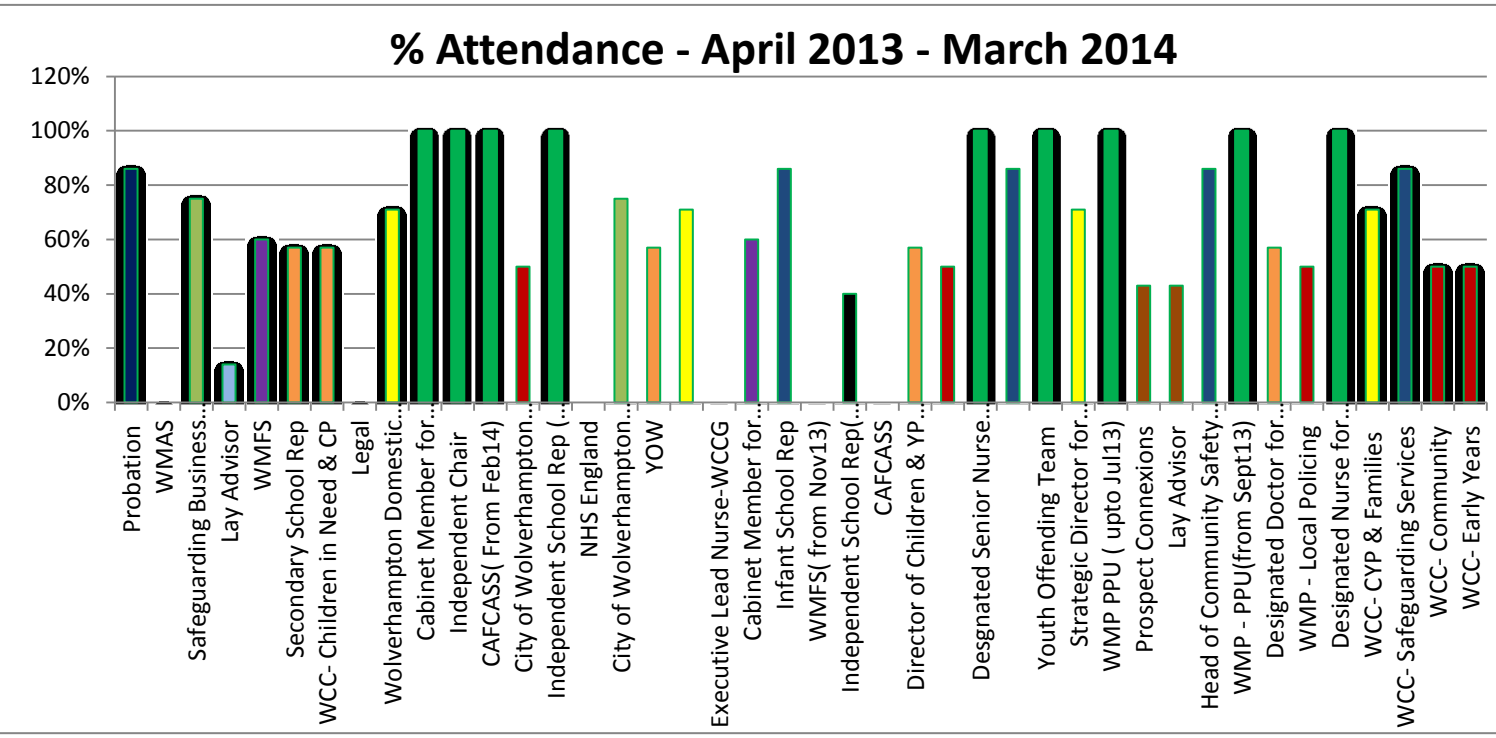
WSCB Business Support

Gillian Ming	Business & Training
Beverley McCalla	Administrator

There have been a number of membership changes over the past year. Strenuous efforts have been made to ensure appropriate representation and continuity.

WSCB members have a responsibility to attend all meetings and disseminate relevant information within their agency. Membership records are monitored to ensure attendance is regular and at an appropriate level. These records are monitored on an annual basis as part of the boards quality assurance process.

The table below represent the attendance figures by agency, based on five meetings held from April 2013–March 2014.



Achieving what was set out in the Business Plan and Priorities

The three year Business Plan 2013-2016 was agreed at the Board development day (April 2013), it outlines the following priorities to be implemented and addressed during this year and represents work from most board partners.

	PRIORITY AREA	WSCB LEAD	ACTIVITY
1	**EFFECTIVE GOVERNANCE**	**J.WELSBY** WCC. AD – CHILDREN AND FAMILIES	We will develop the capacity of WSCB and its infrastructure to effectively deliver the core functions of the Board to help keep children and young people in Wolverhampton safe.
2	**FRONT-LINE DELIVERY AND THE IMPACT OF SAFEGUARDING**	**M. GARCHA** CCG EXECUTIVE LEAD NURSE	We will develop challenging and rigorous approaches to monitoring and evaluating the impact of services on safeguarding and promoting the welfare of children & young people; and will hold partners to account.
3	**SAFEGUARDING FOR PARTICULAR VULNERABLE CHILDREN & YOUNG PEOPLE**	**J. PARRY** WM POLICE DCI-PPU	We will ensure that everything we do promotes improved practice to help safeguard and meet the needs of those children and young people who are particularly vulnerable, or are at increased risk of harm and improves outcomes for them.
4	**COMMUNICATE & ENGAGE**	**S.DODD** PROJECT COORDINATOR - YOW	We will ensure that we engage children, young people, families and communities of all backgrounds and make up, in the work of WSCB.

A copy of the Business Plan is available on the WSCB website: www.wolvesscb.org.uk

HOW DID WE DO AGAINST THE 2013/14 KEY PRIORITIES?

Priority Area	The priorities set for 2013/14	Performance against the agreed priorities
1	Review of the governance arrangements	WSCB has revised the governance arrangements for the board and all its associated committees.
2	Through the provision of training and development opportunities, ensure that staff have the requisite skills and experience to intervene effectively to safeguard children.	WSCB has maintained a an multi-agency training programme
3	Improved provision of the range of services for particular young people: 11 – 18 year olds to safeguard and promote the welfare of young people.	The revised responsibilities of the SEMT Committee, includes oversight and management of its subsidiary Operational Panel which monitors services for particular vulnerable young people.
2	Further improve the quality, and consistency, of interventions, assessment, planning and interagency working to safeguard children and young people.	Monitoring of continuous progress in interagency activity across the partnership is on-going through the Quality and Performance Committee.
4	Engage the wider community in safeguarding children.	WSCB has raised the profile of safeguarding within the community through its 'Promoting Safeguarding Week occurs on an annual basis',
1	Utilise the combined resources of WSCB member agencies to underpin preventative strategies and services in challenging budgetary conditions.	This area of work is in its infancy and is intended to be developed further in the coming year and beyond
2	Establish a transparent line of communication with schools and GPs in safeguarding children – including Academies.	Work to establish a Safeguarding Education group has commenced. The CCG has been challenged to strengthen the understanding, commitment and involvement of GPs in safeguarding activity.
4	Raise the profile of WSCB and its safeguarding agenda through effective communication and media strategies.	WSCB has raised the profile of safeguarding within the community through its 'Promoting Safeguarding Week occurs on an annual basis', This area of work is developing
1	Ensure that the potential impact on safeguarding and outcomes for children arising from service changes due to challenging budgetary conditions are closely monitored by WSCB, and that agencies share information and cooperate to minimise the short and long term impact of changes in safeguarding children.	The board receives reports on the impact of reduced services and constantly seeks reassurance from service areas in respect of
2	Ensure that messages from the Serious Case Review processes informs local practice and	During the year, a series of sharing the learning from local, regional and

	service development.	national SCR's briefings has been disseminated via the SCRC committee.
4	Raise the profile of WSCB and its safeguarding agenda through effective communication and media strategies.	This area of work is developing

Activities of WSCB Committees

Committee Title	**Learning and Development Committee**
Chair	**Lorraine Millard**
Agency	Wolverhampton Clinical Commissioning Group
Agencies represented on this Committee:	WCCG WSCB Education (Student Services) BCPFT (Named Nurse Safeguarding Children) RWT (Named Nurse Safeguarding Children) Youth Organisations Wolverhampton Co-ordinator Project Co-ordinator- Base 25 Children Social Care

Brief Terms of Reference

- To support the identification of training needs of the service users.
- To prioritise those needs when planning and commissioning the safeguarding inter-agency training programme and the development of the training strategy, ensure that where possible, training can be influenced and/or directed by service users.
- Develop the annual Safeguarding & Child Protection training programme according to the local needs ensuring it is informed by current research, lessons from local and national serious case reviews, and local and national developments, while work within the budgetary requirements of the Board.
- Identify and agree a robust evaluation process for each training programme to ensure the standard, quality, and delivery is at a high level and meets agreed learning outcomes
- Provide an annual report to WSCB.

Objectives for 2013/14

PRIORITY	OBJECTIVES	PROGRESS
1	➢ To support WSCB's business priorities and to ensure that the committee has the infrastructure to effectively address the specific elements of work that relate to the learning and development of the children's workforce.	A re-formed committee met for the first time in November 2013 following a time lapse in face-to-face meetings. The committee has new Terms of Reference, the format for the agenda and has devised a template for the other committees to referral into the L&D Committee.
2	➢ To ensure the representatives on the committee contribute to the learning, development and education of a multi-	The Committee has effectively contributed to the development of a streamlined training programme that reflects the priorities of WSCB

	agency work-plan for Safeguarding Children that reflects the identified priorities.	
4	➢ To liaise with the community & engagement committee on the overlapping areas of work ensuring that a strategy is devised to manage each area of competing tasks.	In order to improve communication between WSCB and its partners the L&D committee have develop multiple ways of disseminating information. Work going forward includes; ❖ a quarterly WSCB news- letter ❖ a series of posters developed by the Be-Safe Team to be distributed and displayed in both professional and public arenas to increase public awareness of the existence and work of the board; and ❖ plans to update the current WSCB leaflets.
1	➢ To ensure there are clear communication route between the Learning and Development Committee and other committees to furnish the programme of activities.	The L&DC has devised a template for the other committees to referral areas identified for learning into the L&D committee.
2	➢ To ensure the learning from the findings of local and outside-of-area case reviews are disseminated to the workforce to enhance city-wide practices.	WSCB have developed, and delivered a series of 'Learning from SCR's briefing sessions during 2013/4. This has been transferred to the L&DC to be added to the training programme of 2014/5 and beyond.
4	➢ To develop a robust relationship with Adults Safeguarding in terms of aligning learning event which crosses over both areas of work	A joint approach between WSCB and WSAB has been developed in the associated areas of the safeguarding agendas. This includes some areas of training; eg. the joint Force Marriage Roadshow in 2013 is one example
2	➢ To continue to monitor the impact of multi-agency training through a series of pre and post course evaluation process to ensure both value for money and there is an identifiable impact on practice.	A review of the feedback forms completed by attendees following previous courses over a twelve month period has taken place, including a review of the current method of evaluation was led to some recommendations which will be implemented during the next 12 months.

Additional evidence of progress made during 2013/14

- The L&D Committee, on behalf of the Specialist Midwife for Vulnerable Women, requested the Law, Policies and Procedure Committee considered the development of a Pre -birth plan to ensure clarity of arrangements. This has now been developed and disseminated for use. This highlights good collaborative working between committees.
- In order to ensure the face-to-face training offered by WSCB meets the needs of the workforce a review of the feedback forms completed by attendees following previous courses over a twelve month period has taken place. At the same time the current method of evaluation was reviewed leading to recommendations to develop the current process, with the expectation that future methods would evaluate both the quality of the training and the impact the training has had on practice.
- The L&D committee supported the development of Local Safeguarding Children Board's Learning and Improvement Framework, and will support its implementation planned for 2014/15.

Evidence of the Voice/Contribution of Children and Young People

- The Be-safe team developed the WSCB Raising Awareness of WSCB posters.

Impact for Children and Young People

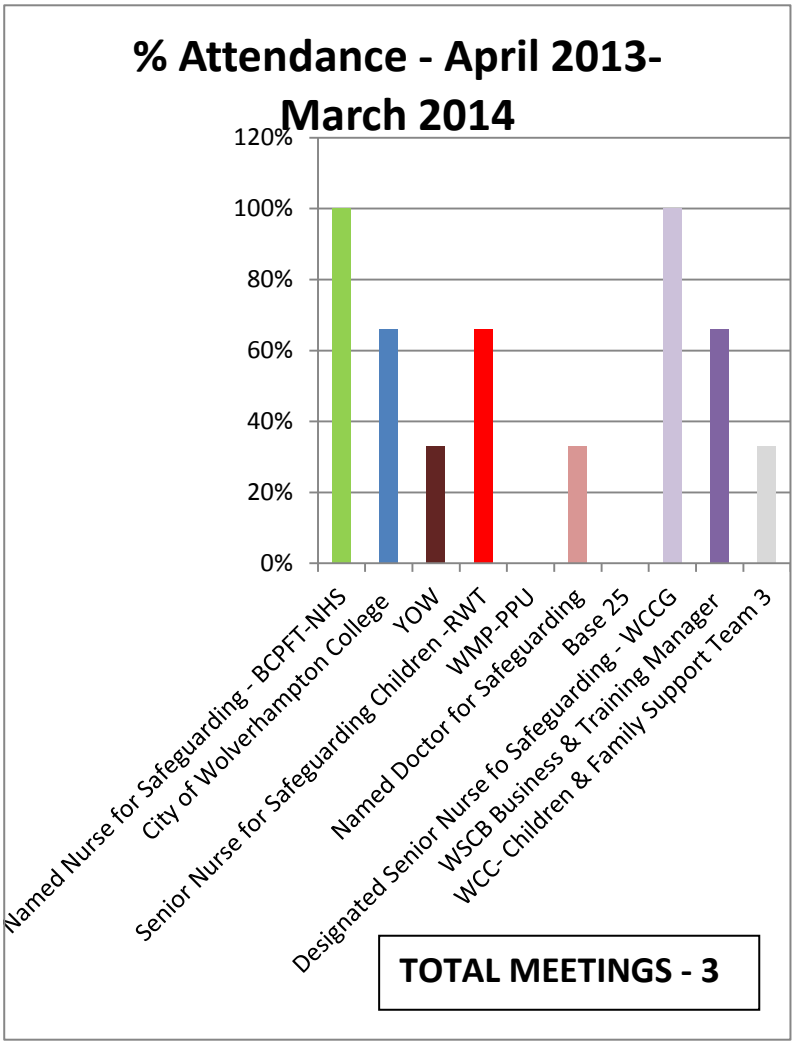
- There is currently no data available which demonstrates the impact of current training currently being delivered by WSCB.
- Transfer-related outcomes-relating to skills, knowledge, attitudes and behaviours that have contributed to improve practice is difficult to measure, but is recognised as important and meaningful. The L&D committee have prioritised further development in this area of the Evaluation Framework for 2014-2015.

Looking forward brief overview of work anticipated for 2014/15

- A number of key WSCB Business Plan priorities relate directly to the L&D Committee. Front line services and workers, including non-statutory organisations, in particular independent schools, must have access to better information on safeguarding delivered in ways that enables them to keep abreast of new developments. This will require the implementation of an auditing and monitoring process of both single and multi-agency training, and development of a number of different ways of disseminating information. In addition, WSCB multi-agency training programme must be redesigned continuously assessed to ensure it is of the highest quality,

and increases the awareness of individuals who are particularly vulnerable, or are at increased risk of harm.

- In order to ensure WSCB can continue to deliver an effective training programme with a limited and reducing budget there are plans to develop a training pool. This will ensure local expertise and experiences are fully utilised to improve local practices. However for this to be effective and consistent, partners will need to identify appropriate personnel to have protected time to attend the initial train the trainers course, and then to commit to delivering a number of sessions throughout the year.
- A number of training courses are relevant to both adult and child practitioners and it is envisaged that the Learning and Development committee of both the Adult and Children Safeguarding Boards are aligned.



Committee Title	**Communication and Engagement Committee**
Chair	**Stephen Dodd**
Agency	Youth Organisations Wolverhampton
Agencies represented on Working Group	▪ Age UK ▪ Children's Society (Black Country Advocacy Service) ▪ Wolverhampton College ▪ HealthWatch ▪ Wolverhampton Interfaith and Regeneration Network ▪ Staffordshire and West Midlands Community Rehabilitation Company ▪ Links to WSCB's B-Safe Team ▪ WSCB Business & Training Manager ▪ WSAB Business Manager

Brief Terms of Reference

- Identify and share key messages around safeguarding adults and / or children including:
  - How to recognise different forms of abuse
  - What help and support is available
  - How to raise a concern
- Develop city-wide communication channels (websites, social media, press coverage, leaflets posters)
- Develop constructive and mutually respectful relationships with communities; making sure that equality and diversity is appropriately considered in all communication and engagement activity.
- Undertake targeted engagement – evidence-led, on request, by theme, by community (based on geography or shared interest / characteristic/s)
- Liaise and collaborate with WSCB and WSAB, relevant committees, partnership forums and service users in the above activities

PRIORITY	OBJECTIVES set for 2013/14	PROGRESS made in 2013/14
1	Establish this committee	Joint WSCB & WSAB Communication and Engagement Committee established. Terms of Reference, work-plan devised and quarterly meeting schedule agreed.
4	Identify and promote key messages	Key messages from WSCB & WSAB meetings compiled in a monthly newsletter and disseminated to voluntary and community groups.
4	Develop shared branding	Work in this area is underway in partnership with Wolverhampton

		College who is a member of WSCB and is represented on the committee.
4	Develop shared adults' and children's safeguarding website	Work begun on shared 'Safeguarding Across the Generations' website
4	Strengthen links with faith groups	Representation expanding Links made with Wolverhampton Interfaith and Regeneration Network (WIFRN)
1 & 4	Identify partners resources to support this area of work	Marketing and promotion resources (skills and time identified
4	Build on good practice from other areas	Links made; and some joined up activities and events undertaken with neighbouring LSCB's

Additional evidence of progress

- Safeguarding in Faith event held 20-04-13
- Promoting Safeguarding 2013 included a week of activities and engagement with the general public and community groups, raising the profile and awareness of Safeguarding.
- DBS event held for voluntary and Community groups
- A bespoke event; addressing and implementing Safeguarding Standards for small groups

Evidence of the Voice and Contribution of Children and Young People

- Links initiated with the B-Safe team

Impact for Children and Young People

- Due to the fact that this group is newly established, it is too soon to comment on measure its impact on children and young people.

Looking forward - brief overview of work anticipated for 2014/15

- Decide on joint branding for WSCB and WSAB
- Shared website launch in autumn 2014
- Links to be formalised with WIFRN
- 4 x engagement activity with public and community groups

- Key messages identified from data and community engagement
- Public safeguarding campaigns x 2
- Communication & Engagement committee and Learning & Development committee to agree specific responsibilities and areas of joint working in regard to communication and engagement with public and community groups on the one hand, and the children's / adults' workforce on the other

Committee Title	**Quality and Performance Committee**
Chair	**Heidi Crampton**
Agency	Cafcass
Agencies represented on Working Group	Cafcass Service Manager DI WM Police: Public Protection Unit Third Sector: Youth Organisations, Wolverhampton Name Nurse for Safeguarding - BCPFT Name Nurse for Safeguarding - RWT Name Nurse for Safeguarding - CCG WCC Head of CiN/CP Probation – Safeguarding Lead WCC Head of Safeguarding WCC Senior Information Officer WSCB Business & Training Manager

Brief Terms of Reference

The Committee is a multi-agency forum which exists to develop a clear understanding of the safeguarding profile of the Wolverhampton Safeguarding Children Board (WSCB) and how the respective partners are performing to meet those needs.

The Quality and Performance Committee (Q&PC) is responsible for reviewing data, trends, safeguarding key performance indicators and the results of audits that have been carried out. To quality assure practice, including through joint audits of case files and practitioners and identifying lessons to be learned.

To achieve its purpose the committee will:

- Develop and maintain a performance management dataset for WSCB
- Review performance management information, identifying themes and areas requiring action and reporting these to the Board
- Ensure key messages includes areas to recognise and celebrate good practices as well as areas identified for further development are distributed to WSCB members with a specific requirement of disseminating to the wider workforce/frontline practitioners
- The Q&PC will have a particular focus on ensuring that partners with a duty to co-operate under s11 of the Children Act 2004, or s175 of the Education Act 2002, are fulfilling their statutory obligations for safeguarding and promoting the welfare of children
- Ensure ownership and accountability for performance and quality standards at the highest level.
- Provide challenge to Board members, holding them to account for the quality of practice to ensure agreed standards are met
- Consider the outcomes from relevant audits undertaken by partners, to ensure findings are disseminated across the partnership and to assess impact and implications for improving practice
- Monitor members' feedback and attendance across all Committees.

PRIORITY	Objectives for 2013/14	Achievements for 2013/14
1	On-going development of a WSCB multi-agency safeguarding dataset and pursuit of lines of enquiry based on the data presented.	Identified and agree a multi-disciplinary data set that is user friendly and is inclusive of key indicators for all partners. To review and analyse data for the Board to ensure that any patterns are identified and acted upon.
1	Introduce and embed a quarterly series of a multi-agency case file audit process.	✓ Multi-Agency Case file Audits undertaken during 13/14 and lessons learnt cascaded in relation to the following themes: ▪ Children with Disabilities ▪ Hidden harm
1	Oversight of section 11 review for all constituent agencies, designed to audit and then improve their safeguarding capabilities.	A new model has been identified by the Q&PC and presented and approved by WSCB members during development day 2014. The cross agency audit will be distributed to members in July 2014

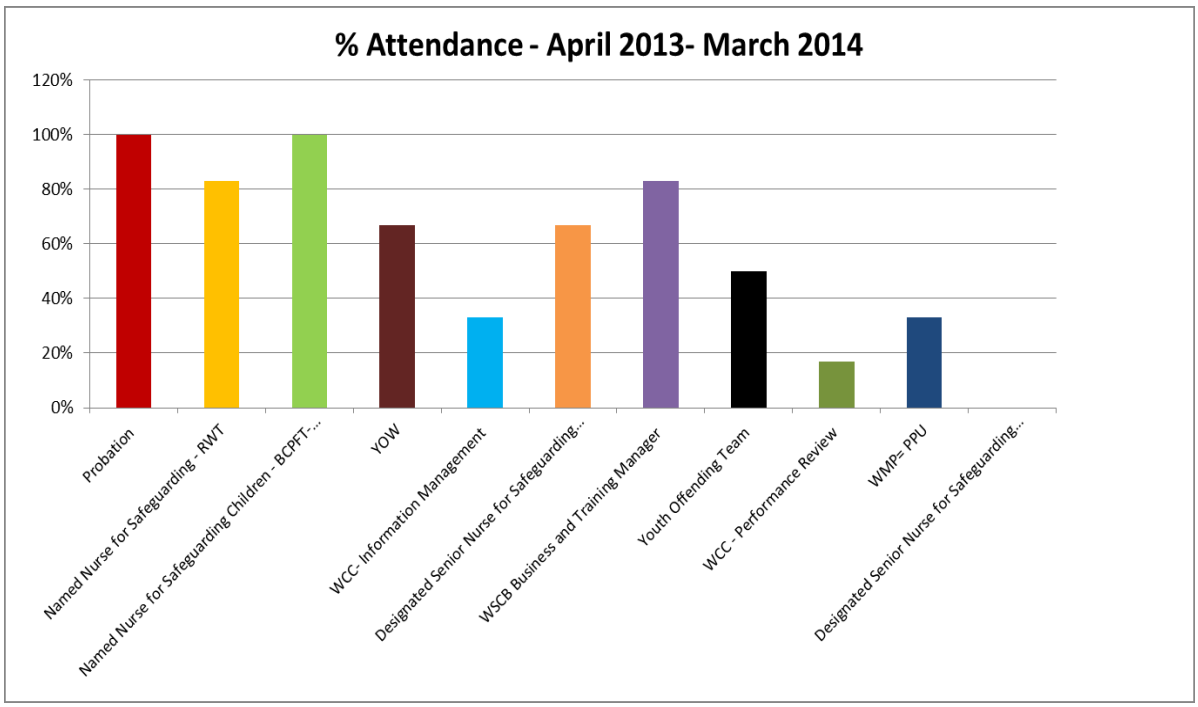
Impact for Children and Young People

- Greater focus on missing children, reasons for them being missing and a focus on return interviews.
- Children with Child Protection Plans have an up-to-date plan and regular statutory visits are recorded and monitored.
- The need for improved understanding and information gathering in respect of ensuring the child's voice is heard in all safeguarding work.

Looking forward brief overview of work anticipated for 2014/15

- To have a quarterly Multi-agency Case file audit. Themes to include: Children on the edge of Care, Teenage Suicide and Self-Harm, Missing children, Children at risk of child sexual exploitation, children and young people at risk of involvement in gangs and pre-birth assessments.
- To ensure that lessons learnt from Multi-agency case file audits, including good practice are disseminated and acted upon.
- To continue to scrutinise the Section 11 audit and monitor the safeguarding duties of all partners.

- To continue to provide appropriate challenge and be
- the critical friend to the board and its members.



Number of Meetings 6

Committee Title	**Law, Policy & Procedure Committee**
Chair	**Dawn Williams**
Agency	Wolverhampton City Council (WCC)
Agencies represented on Working Group	WCC Head of Safeguarding – Adult & Children Third Sector: Base 25 Service Manager Name Nurse for Safeguarding - RWT WCC Early Help 0 – 5 Provision Manager WSCB Business & Training Manager

Brief Terms of Reference

The Committee is a multi-agency forum which supports the statutory function of WSCB's role to develop policies and procedures to support safeguarding work, with this, the group manages and oversee the multi-agency Child Protection Policies and Procedures, undertake revisions as and when necessary and ensures that each respective partner member is consulted on any proposed changes / developments.

Within its core functions, the group reviews, amends and develops safeguarding procedures in response to lessons learned from Serious Case Reviews, it also monitors the publication and circulation of national, regional and local practice guidance to ensure knowledge is kept abreast of regulatory changes for best practice in relation to frontline delivery and performance, as well as local and national issues, changes in legislation and any gaps emerging from practice.

The Head of Safeguarding (Children & Adults) took over the chairing of this group from February 2013.

The group reviewed of the Boards Child Protection Procedures to ensure that the latest guidance and procedures were included; this resulted in successfully agreeing a work-plan, with some of the following results:

To achieve its purpose the committee will:

- Scrutinise each section of the existing Policy and Procedural website
- Review the threshold guidance to ensure it fits with the introduction and shift to early help.
- Ensure that policy and procedures exist to support the workforce to operate both appropriately and confidently with the business priorities of the board
- Liaised with all other committees and strategic groups to support in the development of local policy and procedures in line with their core business and activities.
- Connected with Wolverhampton Safeguarding Adults Board (WSAB) on areas of joint concerns where, including when policies reflect a 'whole' family agenda.
- Ensure the information produced by this committee it that which the workforce can rely upon, trust and be confident in applying, whilst it maintains a high standard.

PRIORITY	Objectives for 2013/14	Achievements for 2013/14
1	Review relevant policy and procedures in line with local and national influences; including the release of Working Together 2013	✓ Produced/revised and the website practice guidance for the following: ✓ The changes from *Working Together 2013 was* agreed, and the Procedures updated ✓ Supporting Children and Young People Vulnerable to Violent Extremism ✓ Cross Border Child Protection Cases under the 'Hague Convention' ✓ Safeguarding Children & Young People who may be affected by Gang activity ✓ There were agreed updates to the management of allegations, which involved working with the Local Authority Designated Officer.
1	Overhaul all current policies, identify priorities, revise, publish and promote updates in policy guidance	✓ Wolverhampton Threshold policy ✓ Neglect – addendum ✓ Addition added to introduce ✓ 'New Operating Model (Early Help) information. ✓ Escalation Policy ✓ Hidden Harm Practice guidance ✓ Forced Marriage practice guidance.
1	Ensure the work of this committee is aligned with other committees and strategic groups	✓ Devise and disseminate a referral template for other committees and groups to utilise for referring any multi-agency policy/procedure for attention. ✓ Ratify multi-agency safeguarding policies devised by other committees and groups
	Identify where work should be pooled together to support a 'whole family agenda'.	✓ Work with (WSAB) to ensure policies reflect family approach ✓ Consider where policies can operate across borders.

Impact for Children and Young People

- All revised local policies are constructed with children and young people at the centre of actions to be taken.
- Greater focus is on both seeing and hearing the child and taking the child's view in to consideration. In this way, children will be more inclusive in decisions made for/about them which in turn should result in

improved outcome and impact.

Looking forward brief overview of work anticipated for 2014/15

- To continue to scrutinise and localise all WSCB policy and procedural guidance to increase the support of local practice
- Maintain a close eye on new ways of working alongside the introduction of 'early help' support services and the associated 'new operating model', and ensure practice guidance, policies, procedures and protocols are revised accordingly.
- The ensure policy updates are widely circulated across all agencies
- To provide launch events to ensure key practice related messages involving changes in delivery are shared
- To ensure all updated policies are transferred to the Learning and Development Committee to be included in training, to ensure implementation.
- The committee is has set a work-plan with timescales to review key areas, some of which include: Children on the edge of Care, Teenage Suicide and Self-Harm, Missing children, Children at risk of child sexual exploitation, safeguarding practice and arrangement for Children with Disabilities and pre-birth assessments.

Committee Title	**Serious Case Review Committee**
Chair	**Claire Thomas /Dawn Williams**
Agency	Wolverhampton Clinical Commissioning Group (CCG)
Agencies represented on Working Group	CCG Designated Dr; Safeguarding WCC Head of Safeguarding – Adult & Children Third Sector: YOW Project Coordinator Head of Service – CiN/CP WCC Head of Service - Early Help 0 – 5 Provision WSCB Business & Training Manager Senior Officer – Probation YOT – Head of Service BCPFT RWT

Serious Case Reviews (SCRs) - rationale

Working Together 2013 states that when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected to be a factor in the death, then local organisations must consider whether there are any lessons to be learned about the ways in which they worked together to safeguard and promote the welfare of children. Additionally, LSCBs should always consider whether a SCR should be conducted whenever a child has been seriously harmed and the case gives rise to concerns about interagency working to protect children from harm.

Brief Terms of Reference

- To function within the framework set out in 'Working Together';
- To examine serious cases of child abuse, neglect or death where a formal Serious Case Review may be appropriate, with a view to commissioning such a review if the criteria are met;
- To undertake the management of any Serious Case Reviews that are commissioned according to the agreed protocol, and to scrutinise the quality of the content and recommendations of single agency reports;
- To organise or commission other forms of case or management review where the criteria for a Serious Case Review are not met, but where in the opinion of the Committee such a case review would have benefits;
- To review its own processes, practices and terms of reference, thereby ensuring continuous quality improvement;
- To provide assurance to the board, that recommendations arising from Serious Case Reviews have been actioned.
- To identify issues of policy, training or quality that will be passed on to the appropriate WSCB committee.

To achieve its purpose the committee will:

PRIORITY	Objectives for 2013/14	Achievements for 2013/14
2	To examine child abuse, neglect or death where a formal Serious Case Review may be appropriate. Commission reviews where the criteria are met	✓ Commissioned and published a single serious case review during this reporting year, ✓ Publicised the executive summary from a serious case review undertaken in the previous reporting year.
1	Keep the board informed and assured of all issues including the monitoring of recommendations /actions arising from Serious Case Reviews.	✓ Extraordinary meeting of WSCB members held to inform on new information which delayed the timescale for publication. ✓ WSCB receive a written report form this committee on an annual basis. ✓ Recommendations made as a result of SCR's have been monitored by the SCR committee and the action plan which included all partner agencies has been signed off by the board.
2	Organise or commission other forms of case or management review where the criteria for a Serious Case Review are not met	✓ Undertook a SCIE review on a case that did not meet the threshold for a full review. ✓ 8 cases investigated by SCR committee during the reporting year including 2 SCR which met the criteria for a full review, 2 case reviews undertaken by YOT and a further 4 being investigated critiqued further through the committee. ✓
2	Review its own processes, practices and terms of reference, thereby	✓ The committee had a full review and revised its terms of reference to ensure

	ensuring continuous quality improvement	a clear focus is maintained ✓ Serious Case Review Toolkit developed September 2013 which includes overarching explanation of the SCR process and how to notify the SCR subgroup of a case for consideration, series of tools for administration of SCR's, including those for business unit, SCR committee, SCR panel, IMR authors, families and young people and staff. ✓ The SCR toolkit also includes a quality assurance module and audit tool and information around learning lessons.
2 /4	Consider whether there are lessons to be learned about the ways in which partners worked together to safeguard and promote the welfare of children. Ensure there a range of avenues used to share learning arising from SCR's, this should be applicable to the various cohort of audience including children and parents	✓ Multiagency "SCR Lessons Learned" Training sessions arranged for 2013 and will continue in 2014 on a rolling schedule to ensure local and national lessons from SCR's are embedded in local practice ✓ Lessons learned papers developed for all below the threshold investigations to be disseminated to the work force by the members of the WSCB and included in SCR training ✓

Impact for Children and Young People

Learning from SCR's are used to shape and improve practice, with much emphasis on the importance of communicating, Information sharing, reporting concerns in a timely manner and on recording information, these areas are not unique to the findings of local SCR's however, they are regular recommendations threading through most SCR's. This is something that Wolverhampton are keen to improve and will monitor progression going forward, to ensure that intervention pertaining to safeguarding concerns are identified and acted upon at the right time.

A great deal of specific learning from locally commissioned SCR, together with the broader findings of research undertaken has been

shared through a series of presentations and workshops. The audiences have covered an extensive range of professional groups, senior leadership and management teams in a range of agencies and strategic partnerships including the Safeguarding Adults Board.

Looking forward brief overview of work anticipated for 2014/15

There was a need to commission a SCR at the beginning of 2014. The board has required that in addition to the sharing the learning from this review, agencies will be tasked to demonstrate how the broader aspects of activities identified will be reflected up on within the agencies staff professional development. This area of work will be monitored jointly with the quality and performance committee.

This committee will also:

- Reinforce the messages of safeguarding being everybody's responsibility, by providing advice to parents/carers in regard to responding to safeguarding concerns which ultimately can contribute to the prevention of significant harm.
- Ensure that messages from regional and national SCR's and associated research appropriately shared to a wide audience and by way of various methods.
- Continue to scrutinise incidents which do not meet the threshold for the commissioning of a full SCR, but where there are clearly lessons for learning; in these cases, the committee will explore, identify and apply a model to conduct case reviews.
- Organise a development day in addition to the bi-monthly meetings, to evaluate progress against the board business plan and to schedule the activities going forward in to 2014/15 and beyond.

Wolverhampton's Be-Safe Team

Brief Terms of Reference

- To establish a sustainable, fully representative Junior Safeguarding initiative for the City
- To provide opportunities for children and young people to engage with safeguarding related activities to increase awareness and understanding
- To provide opportunities for young people who have been subject to a Child Protection Order to contribute to discussion about the 'system' and influence the Board
- To ensure that safeguarding is included within a joined-up approach to the engagement and education of children and young people across the City

Objectives for 2013/14

- To re-launch Peer Zone to include new Crime, Anti-bullying and Safety teams.
- To consult with groups of young people to establish and brand and identity for a Junior Safeguarding Board (renamed as 'B-Safe Team') as the vehicle for engagement with wider groups of young people to raise awareness and understanding of safeguarding.
- To begin the process of establishing a standing group of B-Safe ambassadors, able to directly feed into WSCB and its activities.
- To raise awareness with voluntary sector partners, and the B-Safe initiative amongst the City's young people through social and other media.
- To pilot safeguarding related workshops in schools, PRUs, youth/community sectors, linked to existing peer mentoring and peer support training.

Achievements for 2013/14

- The new structure for Peer Zone to incorporate the Be-Safe Team was launched in October 2013. The event attracted 80 young people. A diary booth captured their thoughts on being safe, anti-bullying and other issues that affect them.
- Since the launch event, a group of young people have continued to meet with the Peer Support Coordinator at the Youth Café and have contributed to discussions around activities and a work plan for the B-Safe Team.
- During Anti-bullying week, in November 2013, two days of Anti-bullying conferences were held; one day for primary and one day for secondary and special schools. The invitation only conferences attracted over 170 young people and 40 staff. Conference workshops included Bullying, Crime and Gangs, Confidence and Resilience and activities

designed to establish data on the use of the internet by young people to develop a Cyber Safe strategy for the City.

- A video booth gave young people and staff an opportunity to discuss issues that concern the safety of young people.
- In March 2014, a 'B Safe' Event consisted of two half-day sessions, the morning for primary schools and the afternoon for secondary's, and included a number of practical workshops for the young people to engage in, including radio broadcasting, digital music, drama, graphic design and art. The workshops all focused around safeguarding themes including bullying, cyber-safety, crime, resilience and messages for adults about staying safe. 180 young people took part in the event.
- During the B-Safe Event, a graphic designer worked with groups of young people to design a brand for the B-Safe Team which was unveiled at the WSCB development day in April, when a group of young people delivered a presentation based on their 'hopes and fears'.
- Delivery of peer mentoring and peer support training to 560 young people across the City now includes additional safeguarding-related content and has included some pilot activities which will lead to increased roll out during 2014/15.
- A specific safeguarding emphasis was given over to training delivered to pupils at the Orchard Centre, and some of the programmes delivered to community groups.
- Meetings has commenced with the Independent Review Officers to discuss a mechanism for accessing, consulting with, and recruiting young people who have or are the subject of a safeguarding intervention or support.

Evidence of the Voice/Contribution of Children and Young People

- The engagement and co-production with the City's young people is a key driver for the B-Safe initiative. Young people have named and branded the B-Safe Team and designed the logo and strap line. The direction of travel for the team has been consulted widely with schools and professionals.

Impact for Children and Young People

- Over 1,000 young people have been directly impacted by the B-Safe initiative, through the Peer Zone, B-Safe and Anti-bullying events and through the peer mentoring and peer support training. As well as raising awareness of safeguarding issues, the events and activities had provided young people with opportunities to contribute to the direction of travel for the B-Safe team.

Looking forward brief overview of work anticipated for 2014/15

- To progress the establishment of B-Safe ambassadors, representative of Wolverhampton's young people, able to directly feed into the Safeguarding Board and its plans and activities.
- To calendar a number of events and activities to continue to raise awareness of safeguarding and the B-Safe initiative amongst the City's young people, including through social and other media.
- To continue to pilot safeguarding related workshops in schools, PRUs and the youth/community sectors, linked to existing peer mentoring and peer support training, and school curriculum activities.
- To complete the production of a questionnaire for young people on or completing a child protection order, and with the Independent Reviewing Officers, target a group of young people who have been subject to a child protection order to secure their views and provide them with opportunities to inform the Safeguarding Board.
- Complete the collection, analysis and reporting of safeguarding-related evidence and report to the Board.

WSCB 2013 – 2014 Income & Expenditure

Income 2013/14		Expenditure 2013/14	
CCG	26,812	Staffing	99,127
West Midlands Police	14,775	Independent Chair	19,372
Probation Service	3,000	SCR's	3,809
CAFCASS	550	Training	30,061
Prospects Connexions	750	Website	5,551
Courses	660	Room Hire	2,230
Wolverhampton CC Contribution	126,723	Subscriptions	5,200
Partnership Fund Brought Forward from 2012/13	52,395	Refreshments	1,672
		Serious Case Review	14,689
		Travel & Parking	2,692
		Printing & Stationary	3,577
		Junior Safeguard Board	11,000
		Healthy Schools Hidden Harm Officer Practitioners Guide Other	1,000 24,395 1,000 290
	225,665 15,550		225,665

2014 – 2015

Income 2014/15		Expenditure 2014/15	
CCG	32,470	Staffing	109,210
West Midlands Police	14,770	Training	31,600
Probation Service	3,000	Hire of Facilities	2,000
CAFCASS	550	Car Allowance	2,160
Prospects Connexions	750	Refreshments	2,000
Wolverhampton CC Contribution	153,090	Printing & Stationary	4,640
		Computer Software	4,800
		Consultants	24,000
		Insurance	220
		Child Death Review	24,000
Total Partnership Funding Brought Forward from 2013/14	204,630 15,550		204,630

Member agency contribution:

Name	Dawn Williams
Position	Head of Service – Safeguarding Adult & Children
Agency	Wolverhampton City Council

Local Authority, including Child protection activity
Contacts and Referrals – At 31 March 2014:

- 7134 contacts were received.
- 3492 (49%) of contacts were closed no further action; or were signposted/referred to another organisation.
- 3642 (51%) of contacts resulted in referrals being opened.
- Approximately 68% of open referrals are converted to assessment (against a regional average of 71% and a national average of 75%).

Child Protection - At 31 March 2014:

- 2249 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1982 at March 2013.

- 236 children and young people were the subject of a Child Protection Plan. This is a decrease from 244 at 31 March 2013.

- 8 children lived in a privately arranged foster placement. This is decrease from 11 at 31 March 2013.

Children Looked After - At 31 March 2014:

- 769 children are being looked after by the Local Authority (a rate of 137 per 10,000 children). This is an increase from 661 (118 per 10,000 children) at 31 March 2013; equivalent to a 16.3% increase. It is acknowledged that these numbers are too high and this is being addressed through the Families r First Programme; which is discussed in detail later in this document.

- Approximately 55.3% of children live out of the authority area, with 84.3% of children placed within 20 miles of their home address.

- 57 (7.4%) live in residential children's homes, secure units or hostels, and 1 child lives in a residential special school.

- 598 (77.8%) live with foster families including friends and family placements, 53 children live with parents or persons with parental responsibility.

- 3 children are unaccompanied asylum-seeking children.

- 122 (15.9%) of looked after children have a decision that they should be adopted; 89 had a placement order granted and with 33 (37%) of those children currently being placed with their adoptive parents.

- 14 (7%) children out of 201 school age children placed with the fostering service changed educational placement because of a foster placement change; as compared to 49 children (21.2%) out of 231 school age children in 2012/13.

    - In 2013/14:

- 224 children have ceased to be looked after.

- There have been 50 adoptions.

- 24 children became subject of Special Guardianship Orders and ceased to be looked after.

- 32 children and young people have moved on to independent living.

- 331 children became looked after; of whom 39 (11.8%) had been previously looked after.

- In the period 2013-14 Wolverhampton made 24.7 care applications per 10,000 children; significantly higher than the national figure of 9.2 care applications per 10,000 children. Wolverhampton has the highest rate of care applications nationally.

What were the agreed safeguarding objectives for 2013/14?	**Achievements against the above Objectives :-**
Families approach to safeguarding	• Creation of Head of Safeguarding for both adults and children has meant closer collaborative work with WSAB • There is also joint working with Adult Social Care, this has particularly strengthened relationships and improved areas of work including; undertaking household assessments • There has also been an much better relationship with addiction Services
Implementation of Munro	• Created Community Hub Social Work approach in CSC • Improved working with health partners and children social care across the board to improve early help offer to families of Wolverhampton • Creation of Single assessment to replace Initial/Core • Extended Social Development will refocus an outcomes for children
To continue to enhance number of timely adoptions	• Wolverhampton success in adoption of siblings groups and BME placements, as a result the targeted approach, the number of adoptions has slowed due to this specialist focus
To reduce the number of LAC	2013/14 saw continuing increase in LAC due to National and local drivers. 2014/15 will see further drives to reduce numbers

Name	**Lynne Fieldhouse on behalf of Jayne Hopewell Named Nurse**
Position	**Head of Safeguarding**
Agency	**The Royal Wolverhampton NHS Trust [RWT]**

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

- The Chief Nurse who is also Deputy Chief Executive holds safeguarding in her Executive Director portfolio.
- The Trust Board receive an annual child safeguarding report.
- The Trust Board members receive an annual child safeguarding educational update
- A Quality Governance Assurance Group receives assurance reports quarterly.
- A Commissioning Quality Assurance Group receives assurance reports quarterly.
- The RWT Safeguarding Children's team comprise of a Senior Named Nurse, two Named Nurses, a Named Nurse for Domestic Abuse and a Named Nurse for Looked After Children. There is a named Doctor for RWT.
- The Trust's Joint Safeguarding Children Group[JSCG] exist to develop and monitor the safeguarding arrangements of the Trust with the aim of increasing awareness of safeguarding and implementing processes to ensure adherence with the safeguarding policies of the City and to reflect national legislative strategic direction. The group has an annual work schedule to monitor compliance to actions required by audit findings, peer reviews, CQC, NHSLA,OFSTED, DoH & Home Office standards, and priorities for the organisation agreed with the Wolverhampton Safeguarding Board.

What were the agreed safeguarding objectives for 2013/14?	**Achievements against the above Objectives :-**
Admission flagging system to be rolled out to other emergency admission or treatment centres	1. This has been delayed due to technical I.T. issues however 'Flagging' system of children on child protection plans continues to be utilised by the Emergency Department (ED) which ensures timely communication with social care. The Phoenix Walk in centre and all acute areas have access to this information on the Portal computer system and by September 2014 the System One computer system will be populated and utilised. The JSCG monitors the ED system and the progress of the Walk-in centre initiative.
2. To develop and implement a system[s] to consult with children and	2. The Policy for the 'Management of Deliberate Self-Harm in Young People' was authored in partnership with the local mental health Trust (BCPFT). It is now

young people parents and carers about their needs and opinions in relation to safeguarding and act on those findings.	utilised by RWT staff and is available on the Trust's website. The validity and reliability of this policy will be determined by audit in July 2014. The pathway for referral to community school nurses and CAMHS is clearly identified utilising the Health Visitor Liaison service which is based in ED. Discharge planning meetings are convened when there has been intentional self-harm and a discharge check list is available to ward staff to ensure a comprehensive assessment is completed before discharge home. The implementation of this policy and audit will be monitored by the JSCG
3. To act on any CQC and serious case reviews action plans	3. Young people's experience of their health assessment was determined by a questionnaire that was distributed to young people aged from 5-18 years. The format of the questions was young people focused and a 40% (47 young people) return rate was ascertained. 38% of the children surveyed said that the experience of having a health medical was excellent, followed closely by a further 23% who said it had been a 'very good' experience. A further 5% said that it was 'ok'. The medicals were completed by a wide range of RWT staff including School Nurses, the LAC Nurse, Advanced Nurse Practitioners and Paediatricians and took place in a variety of settings including The Gem Centre and School premises.
	4. Action plans from reviews are actively monitored via JSCC.

Improvement Plans where barriers have existed.

- Work undertaken to minimise IT technical issues for multi-site working.
- Safeguarding Training is monitored monthly by the Trust training team. The current levels are as follows:
  - ✓ Safeguarding Children Level 1 - eligible 6431, trained 6292 = 97.8%
  - ✓ Safeguarding Children Level 2 – eligible 3066, trained 2717 = 88.6%
  - ✓ Safeguarding Children Level 3 - eligible 751, trained 639 = 85.1%
- Level 1 and 2 percentage of uptake has improved significantly from last year's figures,
  - Level 3 training is currently delivered as part of the RWT training program but in the future the Level 3 training provided by the Safeguarding

Board multi-agency training resource.

- The commitments of ward staff and the need for 24 hour health services make training a complex issue. Safeguarding Children Training is delivered flexibly to ensure that ward areas have access to all levels of training. The E-Learning Level 1 package reflects the Working Together to Safeguard Children (2013) guidance and is interactive.

- Health Visiting teams are now based in Children's Centres
- which ensures the opportunity for enhanced communication with local authority colleagues. This will ultimately lead to an enhanced seamless service for children and their parents. Regular Early Intervention meetings are convened to ensure that information is shared.

- In January 2014 a Health / Social care event was held at The Medical Institute New Cross Hospital. Staff from the acute hospital: children's, ED and maternity services met with social workers for a case study discussion which increased understanding of roles between both groups. This event was valued by both groups of staff and will enhance perceptions, understanding and respect of each other professions roles.

Name	Fay Baillie
Position	Director of Nursing and Quality
Agency	NHS England, Birmingham, Solihull and The Black Country Area Team

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

The NHS England guidance Safeguarding Vulnerable People in the Reformed NHS: Assurance and Accountability Framework was published in March 2013. This framework clearly sets out the responsibilities of each of the health partners for safeguarding in the future NHS. It articulates how the performance of the wider NHS with respect to the duties and priorities defined elsewhere will be assured. The framework aims to:

- Promote partnership working to safeguard children, young people and adults at risk of abuse, at both strategic and operational levels
- Clarify NHS roles and responsibilities for safeguarding, including in relation to education and training
- Provide a shared understanding of how the new system will operate and, in particular, how it will be held to account both locally and nationally
- Ensure professional leadership and expertise are retained in the NHS, including the continuing key role of designated and named professionals for safeguarding children
- Outline a series of principles and ways of working that are equally applicable to the safeguarding of children and young people and of adults in vulnerable situations, recognising that safeguarding is everybody's business.

NHS England, as a single organisation, has developed a national Safeguarding Policy – formal sign off is anticipated by 16 July 2014.

NHS England, via its area teams, is responsible for the co-coordinating and funding of safeguarding training for GPs and potentially other primary care professionals.

Local Arrangements for NHS England membership of Safeguarding Boards has been agreed with Safeguarding Board Chairs; this reflects the approach suggested in correspondence between CQC and the Chief Nursing Officer.

What were the agreed safeguarding objectives for 2013/14?

The Mandate from the Government to the NHS England for the period April 2013 to March 2015 (published in November 2012) set NHS England a specific objective of continuing to improve safeguarding practice in the NHS. Both CCGs and NHS England are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect.

Although the structure of the NHS has changed, it remains the responsibility of every NHS funded organisation and healthcare professional to ensure that people in vulnerable circumstances are not only safe but also receive the highest possible standard of care.

Both CCGs and the NHS England have a statutory duty to be members of Local Safeguarding Children Boards and are expected to be fully engaged with local Safeguarding Adults Boards working in partnership with local authorities to fulfil their safeguarding responsibilities.

During 2013-14 it was established that NHS England, via its area teams, is responsible for the co-coordinating and funding of safeguarding training for GPs and potentially other primary care professionals.

Achievements against the above Objectives :-

The Birmingham, Solihull and The Black Country Area Team has established a Joint Safeguarding Forum. A key focus of the forum is to explore opportunities for commissioners to share resources across CCGs to develop consistency of specification in contracts and consistency in training. The membership of the Area Team joint safeguarding forum includes leads for safeguarding children and adults, domestic violence and Prevent. This system level approach is designed to promote a 'think family' and collaborative system level perspective to shared learning and improvement.

The CQC and NHS England Chief Nursing Officer have agreed that Area Teams should agree with their Safeguarding Board Chairs the best way for the Area Teams to establish and maintain an effective connection with respective Safeguarding Boards. For the Birmingham, Solihull and the Black Country, the Area Team Director of Nursing has agreed with Safeguarding Board Chairs a system of delegated responsibility to provide effective assurance of safeguarding and attendance at all twelve local Safeguarding Children and Safeguarding Adults Boards. As part of this arrangement Fay Baillie, Director of Nursing and Quality is a member of the Birmingham, Wolverhampton and Walsall Safeguarding Children and Safeguarding Adult Boards.

It has been noted through the Birmingham, Solihull and the Black Country Area Team Safeguarding Forum that there is wide variation in the delivery of safeguarding training across the area. The intention is to maximise the impact of limited resources through stream lining training with a view to delivering levels 1 -3 safeguarding children training through e-learning with a focus on scenario based learning to enhance this from level 3 onwards. A task and finish group to take this forward was

established at the June meeting of the Area Team Safeguarding Forum; this group includes membership form all CCGs.

The Child Protection – Information Sharing (CP-IS) project is gathering momentum; CP-IS is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings. All Safeguarding Children Board Chairs have been asked to support and encourage local health and social care partners to engage with this important work programme. By connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings, CP-IS will enable local authorities to share child protection information with the NHS. This will improve the safeguarding of children subject to a Child Protection Plan (including unborn babies) as well as children supported through looked after services. Health and social care teams responsible for the treatment and care of these groups of children will benefit from access to better supporting information; this is designed to ultimately lead to improved interventions and to prevent the on-going abuse or neglect of a child

NHS England has procured an Executive Safeguarding Leaders Programme and a

Designated Professionals Programme. Publication of the programmes is anticipated shortly.

The NHS England National Safeguarding Steering Group has established sub-groups to progress and lead on national priorities across NHS England. The Child Sexual Exploitation sub-group held its initial meeting on 03 June 2014. It is made up of representatives from across CCGs; providers and NHS England area teams. The group is tasked with reviewing and implementing the relevant recommendations contained with the DH Child Sexual Exploitation report.

A National NHS National England Looked After Children (LAC) and missing families subgroup has also been established.

The Royal Colleges have signed off a set of competencies to ensure the NHS fulfils its responsibilities in tackling Female Genital Mutilation in the UK. The report has been presented at the National Steering Group in February 2014, and a sub-group will be established in the near future.

A national analysis of named GP capacity has been undertaken by NHS England centrally, and the findings were presented to the NHS England Executive Management Team in January 2014. A decision was made for Area Teams to fund the function of a Named GP.

The Safeguarding Vulnerable People in the Reformed NHS: Assurance and Accountability Framework (2013) acknowledges the critical role performed by the Named GP in local leadership and early family engagement. It recommends that all Clinical Commissioning Groups within England secure the services of a Named GP at a minimum of 2 sessions per 220,000 population. Where these areas include higher levels of deprivation, significant geographical challenge and a great number of

local providers, CCGs have been encouraged to consider whether additional capacity is required to effectively manage these additional complexities.

Within Birmingham, Solihull and the Black Country, it has been agreed that named GPs will be employed by CCGs and funded by NHS England. A model job description has been endorsed centrally, has been adopted locally and is in the process of being implemented across CCGs.

It is acknowledged that in some areas across the country, recruitment of named GPs has been difficult. A model job description for a named professional has, therefore, been developed where a skill-mixed approach to managing the named GP role is considered to be more deliverable, sustainable and effective. The current named capacity for each CCG has also been established and CCGs asked to review this and identify local approaches to addressing any shortfall.

The Area Team has established a Quality Surveillance group for health services across Birmingham, Solihull and The Black Country. The Quality Surveillance Group acts as a virtual team across the health and care economy, bringing together organisations and their respective information and intelligence gathered through performance management, commissioning and regulatory activities, to identify potential and actual quality problems at an early stage. Information and intelligence about safeguarding is an integral part of this. In addition to the QSG, the Area Team has established a Quality and Safety group where CCGs and Area Team Commissioners routinely share a wide range of

Improvement Plans where barriers have existed.

It is acknowledged that during the process of the new NHS organisations taking on their statutory duties from April 2013, detailed operational systems and recruitment of some key staff have taken time to be embedded locally, regionally and nationally. During this period of transition it has been critical for all staff to remain vigilant and raise any concerns regarding risks appropriately.
Although the NHS is changing, it remains the responsibility of every NHS funded organisation and healthcare professional to ensure that people in vulnerable circumstances are not only safe but also receive the highest possible standard of care. Clarifying the roles and relationships of NHS provider and commissioning organisations has been a key priority for our work with Safeguarding Boards.

Impact for Children, Young People and Families

The Child Protection – Information Sharing (CP-IS) project is designed to ultimately lead to improved interventions and to prevent the on-going abuse or neglect of a child.

The membership of the Area Team joint safeguarding forum includes leads for safeguarding children and adults, domestic violence and Prevent. This system level approach is designed to promote a 'think family' and collaborative system level perspective to shared learning and improvement.

Named GPs take a professional lead to support General Practice (including Unscheduled Care services and Out of Hours Services), to meet their responsibilities

to safeguard children. Named GPs work closely with the Designated Safeguarding Professionals and the strategic leads for safeguarding children across the area they serve.

In relation to safeguarding children, what are your priorities/objectives for 2014/15

The refreshed NHS England mandate for 2014 - 15 was published in November 2013; and sets out specific priorities for Safeguarding as follows:

- Safeguarding
- Looked after Children
- Adoption
- Full participation in local safeguarding arrangements
- Children and young peoples' views of services
- Working in partnership for children with disabilities and special educational needs.
- Care planning and personalised budgets.
- Community safety
- Immediate Access to Psychological Therapies

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The Birmingham, Solihull and The Black Country Area Team of NHS England has established, in agreement with Safeguarding Board Chairs how it will deliver its responsibility for membership of Safeguarding Boards. In support of delivery against the NHS England specific objective of continuing to improve safeguarding practice in the NHS, the Area Team has established a Local Joint Safeguarding Forum. The membership of the Area Team joint safeguarding forum includes leads for safeguarding children and adults, domestic violence and Prevent. This system level approach is designed to promote a 'think family' and collaborative system level perspective to shared learning and improvement.

The Area Team is represented on the NHS England National Safeguarding Steering Group and will continue to ensure that the priorities, risks and initiatives discussed around agreed through this group inform and respond to local priorities and risks.

Name	Jamie Ann Edwards
Position	Head of Probation NPS – Walsall & Wolverhampton
Agency	National Probation Service (formerly SWMPT)

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

SWMPT has been an active member of the WSCB. Both strategically and operationally there is a presence at local safeguarding forums.

SWM has a commitment to ensuring that all staff work to keep children safe, make assessments around risk of harm to children and work with families and partners in the City to ensure communication about and for families is effective and timely.

What were the agreed safeguarding objectives for 2013/14?

- Local Management team are confident that all staff are familiar with the agency safeguarding policy and how this links with local authority processes. That all staff know HOW to refer when needed.
- Local management are confident that safeguarding training is available for all operational staff.
- Local systems are in place for making referrals and checks to the police where there is evidence of domestic abuse and there are children in the household.

In relation to safeguarding children, what are your priorities/objectives for 2014/15

To ensure a continuing focus on the delivery of excellent practice to achieve our core objectives - protection of the public, reductions in reoffending and rehabilitation of offenders.

- To continue to deliver 'Green' Performance against all Service levels To continue to ensure the protection of the public through defensible decision-making in the assessment and management of risk.
- To continue to work to reduce crime and improve re-offending rates in LDUs
- To continue to develop and embed Effective Practice across the Trust/CRC, including placing the delivery of interventions at the heart of offender supervision
- To continue to work with strategic partners at a Trust (CRC) and District/County level to reduce crime and improve public confidence in the criminal justice system
- To ensure initial risk assessments pre- and post-sentence are accurate and appropriate
- To improve the quality of risk management plans and their implementation in the conduct of supervision
- To improve the quality of inter-agency work in Child Safeguarding

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

Local management sit on both the Board and Serious Case Review Committee regularly throughout the year. The previous Head of Probation for SWM Trust Chaired the Quality and Assurance Committee.

Name	Stephen Dodd
Position	Co-ordinator
Agency	Youth Organisations Wolverhampton

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

YOW prioritises a role for its Co-ordinator around children's safeguarding by providing a lead on safeguarding for the voluntary and community sector in the city. This has been demonstrated by: regular attendance at and contribution to WSCB board meetings; chairing the Communication and Engagement Committee; active involvement in developing and 'Learning from Serious Case Review' training; and active participation in the following committees: Quality and Performance, Learning and Development, Law Policy and Procedures, Serious Case Review.

YOW also provides safeguarding training for voluntary and community groups; informs the VCS about safeguarding developments and promotes messages from WSCB; and represents views from the sector in safeguarding decision-making forums.

What were the agreed safeguarding objectives for 2013/14?

1. Lead on communication and engagement for WSCB
   a) Make links with, and provide support to, a wider range of faith groups
   b) Develop VCS safeguarding forum
   c) Develop broader involvement of VCOs in safeguarding
2. Continue to promote Safe Network Standards and support VCOs to work towards them
3. Provide safeguarding information across the VCS
   a) DBS briefing events
   b) Regular safeguarding updates
   c) VCO responsibilities under Working Together 2013

Achievements against the above Objectives :-

1. **Lead on communication and engagement for WSCB**
   - See Communication & Engagement Committee report
2. **Make links with, and provide support to, a wider range of faith groups**
   - Safeguarding in Faith event held on 20th April 2013 attended by representatives of 13 different faith groups although only 2 different faiths (Christian and Hindu)
   - Links initiated with Wolverhampton Interfaith and Regeneration Network
3. **Develop VCS safeguarding forum**
   - No progress on this to date, although there is interest from YOW member

groups to progress this in 2014-15.

4. **Develop broader involvement of VCOs in safeguarding**
   - Work on links with Faith Groups and around Safe Network Standards has broadened engagement with safeguarding agenda
   - New reps on WSCB committees from voluntary sector
5. **Continue to promote Safe Network Standards and support VCOs to work towards them**
   - Promoted at Safeguarding In Faith, and DBS briefing events. At latter, 43% said they would definitely use the Safe Network Standards to support their work around safeguarding
   - Development of template for Safeguarding Children Policy and Procedures and training session to promote this
   - One-to-one work with a number of groups including: training around e-safety; introduction to safeguarding; and revising safeguarding policy and procedures
   - Continued contact with regional Safe Network forum
6. **Provide safeguarding information across the VCS**

   a) **DBS briefing events**
      - 5th and 6th November 2013 to 43 participants. Information shared to all YOW members and wider VCS

   b) **Regular safeguarding updates**
      - Monthly updates from June 2013

   c) **VCO responsibilities under Working Together 2013**
      - Circulation of Working Together 2013
      - Reference to Working Together in all training delivered to the VCS
      - Updates on, and links to Ofsted Inspection of safeguarding

Improvement Plans where barriers have existed

Capacity has been the main barrier, improvement plan is to:

- prioritise the development of VCS Safeguarding Forum from Oct 2014
- Use links with WIFRN to begin to establish links with individual Faith groups

Impact for Children, Young People and Families

- No evidence of direct positive impact for children, young people and families
- However, voluntary and community organisations are better informed, more confident in their safeguarding roles and responsibilities, better able to provide a safe environment for their work with children and young people.

In relation to safeguarding children, what are your priorities/objectives for 2014/15

- Establish a VCS safeguarding forum
- Promoting VCS involvement in demonstrating their safeguarding effectiveness via Safe Network Standards and Section 11
- Continuing to develop and build on links with faith groups
- Improve safeguarding information to the VCS
- Increase the numbers of VCS reps on WSCB committees

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

YOW has brought a breadth of perspective to the Board and Committee discussions. This from the perspective that safeguarding is an important element of the work of voluntary and community organisations (not the focus for their work). The Co-ordinator has also played an active role in all committees he is a member of.

The effectiveness of this contribution can be measured by: the measurements from the 'Learning from Serious Case Reviews' training; the quality of the policies and procedures contributed to; the increased engagement of VCOs with safeguarding agenda; and improved policies and procedures within VCOs.

Name	Rosemary Robbins
Position	Operations Manager
Agency	Prospects Services [Connexions]

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

Prospects Corporate safeguarding Management group meets quarterly to review safeguarding practice and policy. Chaired by Managing Director and attended by non-executive Director of Prospects main board. The company have also contracted with a Senior Consultant from the NSPCC appointed to provide support and act as a critical friend on the organisations work on

Locally the Operations Manager sits on the Wolverhampton Safeguarding Children Board and attends the SEMT strategic group with a team leader attending the SEMT operational group.

Staff locally attend a range of Safeguarding training events and courses.

We are committed to engaging with audits and serious case reviews.

What were the agreed safeguarding objectives for 2013/14?

- Ensure safeguarding continues to be a priority focus in all work with young people and respond effectively to any disclosures and concerns.
- Ensure all cases and concerns are regularly reviewed with staff members in supervision and that good practice is disseminated.
- Ensure that appropriate links are established with the new Social Care Operating Model in particular for young adolescents
- Ensure that the delivery of the Connexions early intervention service delivery model, using the RONI tool, embraces safeguarding as a central theme.
- Ensure that safeguarding is central to our developing work with Families in Focus and to address issues/concerns through supervision and internal training as appropriate.
- Ensure that our PAs, working with young people in Transition who have learning difficulties and/or disabilities, are clear about their safeguarding responsibilities and the role they play in ensuring the best interests of their clients..
- Revision of all corporate documentation to reflect latest guidance on vetting and barring requirement and update service from the DBS – September 2013
- Development of corporate risk management processes to manage high risk clients/customers – always in conjunction with local partners – by Spring 2014
- Development of corporate safe recruitment e learning and training opportunities – Spring 2014
- Launch of new corporate site to track referrals – by December 2013

Achievements against the above Objectives :-

- Policy on DBS launched and supplemented by a programme of road shows for managers across the company delivered by Head of Quality and Corporate HR Business Partner
- Related documents and forms all revised
- On-going monitoring of DBS checks and rechecks with report to the Prospects Safeguarding Management Board
- New systems to monitor corporate referrals launched Jan – March 2014. Trial has led to modification and new approach in 2014/2015
- Attendance at local briefing sessions on the new Operating Model and service delivery model has been developed to reflect changing local structures.
- RONI tool has been embedded and safeguarding issues raised where appropriate
- Extensive work has been undertaken with Families in Focus work and case workers have been made aware through training and supervision of the wider safeguarding issues in working with the whole family.
- Staff attended the Meeting Family Need conference in February 2014, Threshold training, Adolescents training and Subs and alcohol support and risk training.
- Person Centre planning has been embedded within the work carried out with young people who have SEN. Issues raised and discussed through supervision as appropriate.
- Operations Manager attended the LSCB development day and attended 60% of the Safeguarding board meetings.

Improvement Plans where barriers have existed.

All staff have been prepared for the introduction of the new Early Help assessment. Targets have been agreed to support this.

All staff have been involved in a service review to raise awareness of the "Family" and the need to be taking a holistic approach to family issues and concerns in particular any safeguarding concerns.

Impact for Children, Young People and Families

Personal Advisers are better able to deal with family issues and concerns and to make appropriate referrals.

In relation to safeguarding children, what are your priorities/objectives for 2014/15

Launch of corporate self-assessment process to inform internal risk management. Initial assessment to be launched by Autumn 2014

- Safeguarding Management group to devise and approve internal risk matrix and monitor high risk contracts more closely
- Development of procedures to bring safeguarding work into company quality procedures currently certified under ISO9001
- Review Allegation Management procedures and devise code of conduct for

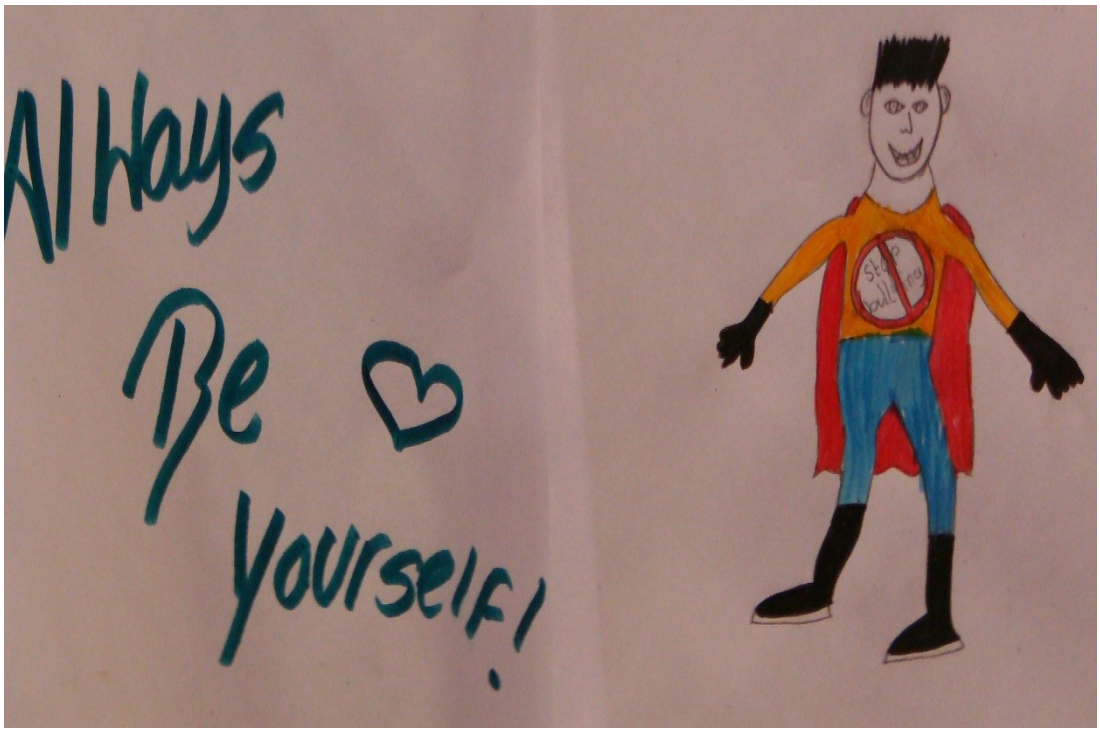
delivery staff by September 2014

- Embed the Early Help assessment into PA practice
- Attend relevant safeguarding training within the city
- Contribute to multi-agency case file audits and any other audits/reviews/inspections.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The Operations Manager attended 60% of the Safeguarding Board meetings in 2013/14 and 66% of the strategic SEMT meetings.

Prospects continues to support the local safeguarding board and to ensure that local strategies and policies and procedures are embedded within the locally delivered service.



Name	Andrea Dill-Russell
Position	Director of Student Services
Agency	City of Wolverhampton College

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

The College is highly committed to safeguarding children and the work of the Board, it has taken huge strides this year in order to develop processes and engage key stakeholders both internally and externally. The College can demonstrate its commitment through the work it has undertaken to have:

- A Safeguarding policy in place for reporting concerns, suspicions and allegations
- A dedicated safeguarding team at the college with a presence on all three campuses
- Named senior designated safeguarding person
- Named safeguarding Governor
- Termly reports and monitoring at Executive Management Team (EMT) meetings
- Safer recruitment and selection process in place
- Revised DBS policy and procedure
- Single central register in place
- Safeguarding training for all staff
- Safeguarding linked to personal appraisal
- Close working relationships with statutory and voluntary organisations that support children, young people and adults at risk (i.e. Social Services, Police, YOT and LAC)

What were the agreed safeguarding objectives for 2013/14?

- Review all policies and procedures within the College in order to ensure they are fit for purpose
- Restructure the safeguarding team to ensure flexibility and delivery on all college campuses
- Revise and implement Human Resources policies on safer recruitment
- Deliver 11 safer recruitment training sessions
- Update DBS policies and procedures for whole college
- Provide online training material for all teachers in order to embed safeguarding in tutorial/stretch and challenge activities
- Review protocols with Youth Offending Team (YOT)
- Review protocols with Looked After Children's Team (LAC)
- Update marketing material to ensure whole college approach to safeguarding

Achievements against the above Objectives :-

- Safeguarding policies and procedures reviewed, completed and due to go to Governors 7th July for Resource Committee
- Increased referrals to the Safeguarding Team following a revised referral process and awareness training
- Safeguarding Awareness training to all staff will be completed by July 2014
- Bespoke training developed and implemented for specialised central teams (Additional Learning Support, Advice and Guidance and Attendance Monitors)
- Safer recruitment training is in progress (4 of the 11 completed)
- YOT protocols are now in place, we have received written positive feedback on our new processes
- LAC protocols are now in place
- New marketing materials have been developed and are in use

Improvement Plans where barriers have existed.

The College undertakes an annual self-assessment process. Areas for improvement are integrated into an improvement plan (QIP). The QIP is monitored and evaluated termly.

Impact for Children, Young People and Families

Students, parent and carers have a named person (Safeguarding Officer) in College who they can contact for support and advice. Safeguarding Officers attend and support students in external agency meetings and/or reviews (i.e. Child in Need, PEP or housing). An improved referral service has seen an increase in referrals to the team; this is due to a more effective process and awareness of all staff.

In relation to safeguarding children, what are your priorities/objectives for 2014/15

Development of bespoke training for the remainder of cross college and curriculum teams for September 2014, matching cross college and curriculum specialism's to safeguarding requirements

- Safer recruitment training to be completed
- All new staff to receive Safeguarding Awareness training as part of induction
- Monitoring and evaluating the effectiveness of policies and procedures
- Monitoring the impact of the new Safeguarding Team.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

City of Wolverhampton College acknowledges the duty of care to safeguard the welfare of students and staff and is fully committed to ensuring safeguarding practice reflects statutory responsibilities and government guidance.

The Director of Student Services has been a Board member since September 2013.

The college now has named representatives on all Boards within the City; information from the Boards is triangulated by the Safeguarding Management team within the College to inform our strategic planning. The Director of Student Services is an active

member of two sub committees;

Learning and Development Committee – worked on the audit of training delivered within the City over the last twelve months, supported the identification of outcomes of the training and areas for development for future training. I have attended all but one of the meetings and provide knowledge of training; delivery and evaluation.

Joint Communication and Engagement Committee –recently invited to attend, attended first meeting and agreed to develop a new marketing logo for the joint boards website, marketing support from within the college (to be in attendance at the next meeting) to develop a campaign for the launch of the website.

ENGAGING WITH THE PUBLIC 'SAFEGUARDING WEEK 2013'

Name	Michaela Kerr
Position	Detective Chief Inspector: Public Protection Unit (PPU)
Agency	West Midlands Police

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

Dedicated Senior Officer lead for Safeguarding Children identified (Assistant Chief Constable) with senior operational lead (Detective Superintendent)

Delivery Plan developed for Child Safeguarding across West Midlands Police (WMP). (Voice of the Child being key consideration in every aspect of agreed plan)

- WMP Child Abuse Investigation policy reviewed in line with Working Together
- Recent restructure of WMP PPU and investigative functions (STT project, delivered June 2014) included additional resources being allocated to child investigation teams based at Wolverhampton (including additional supervisor)
- Problem Profile delivered across all local authorities identifying Child Sexual Exploitation threats, risks and issues
- Dedicated staff member allocated to support and attend joint screening meetings across all Local Authorities (including Wolverhampton)
- Dedicated 'vulnerabilities' team created including Female Genital Mutilation, Forced Marriage and CSE experts
- Internal audit completed in April 2014 of a wide range of child matters: including non – crime reports, Domestic Abuse incidents where children were present, on – line offences against children, sexual offences against children assessment criteria based on 'voice of the child' and 'working together' document
- Dedicated member of the West Midlands Police (WMP) Senior Leadership team attends Wolverhampton Safeguarding Children Board
- Local Senior officer for child protection at Wolverhampton chairs Wolverhampton CSE steering group
- Detective Inspector from Wolverhampton Child Abuse Team chairs monthly CSE operational group
- WMP have invested in and delivered Regional CSE pathways work
- Daily Management meetings held within both the PPU and Local Policing Command Unit where incidents (crimes and non-crimes) involving children are reviewed, discussed and actions agreed
- Central Referral Unit created to receive, assess and support all referrals regarding children at risk daily, conduct immediate review of risk, commence strategy discussions and refer to operational investigators within the PPU based at Wolverhampton for necessary strategy meetings and joint visits
- Monthly Tactical Tasking meeting for PPU includes data regarding offences against children, perpetrators of harm against children and intelligence concerning children at risk.
- New role of Police Staff Case Conference Attendee created, 2 full time staff based at Wolverhampton and dedicated to attending all case conferences

- Regular review of training needs of police officers and staff engaged in **Child** safeguarding
- Lessons learnt from DHR and SCRs captured and cascaded to ensure improved future practices in safeguarding families

Improvement Plans where barriers have existed.

- Specific improvement plan generated regarding CSE (regional task and finish group set up)
- Barriers regarding resourcing numbers allocated to safeguarding roles addressed via STT project (including new posts created for professional case conference attendees)

Impact for Children, Young People and Families

- 'Voice of Child' priority consideration leading to better understanding of needs of individual children and impact on them and their families in both single and joint agency response / decision making
- Improved processes for identifying CSE, supporting victims and bringing offenders to justice (including increased number of referrals for CSE)
- Increased sharing of information regarding children / young people at risk leading to more appropriate, comprehensive , timely and effective plans to reduce harm and support families
- Better support for children, young people and families throughout criminal justice process (from report to court)
- Improved understanding, processes and pathways around most vulnerable child/ young person victims (especially around DA, CSE, FGM, Forced Marriage)

In relation to safeguarding children, what are your priorities/objectives for 2014/15

- WMP are currently completing a strategic assessment document which will identify force priorities and specific objectives around safeguarding children. Pending the outcomes of this assessment process, the delivery plan attached details our current priorities and objectives.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

WMP is a key contributor to the Wolverhampton Safeguarding Children board as detailed above. Not only does the organisation provide the chair for the CSE committee and for the CSE Operational group, the PPU Chief Inspector based at Wolverhampton also leads on priority area 3 (Safeguards for particularly vulnerable children and young people).

The WMP representation on the LSCB has changed over the last 12 months and it is recognised that consistency is an issue which the organisation needs to address: not just in ensuring a thorough understanding of the board's priorities but also in building effective relationships with other members and delivering the board's objectives.

The CSE agenda has been heavily influenced by the regional work, in which WMP has been a key contributor. The regional pathways agreed have been reviewed for Wolverhampton and we have changed practice locally to reflect those standards

The CSE delivery plan for Wolverhampton is being amended to reflect the regional delivery plan, this work is still in progress and a priority for the next year will be to ensure that this delivery plan translates into effective action in Wolverhampton.

ENGAGING WITH THE PUBLIC 'SAFEGUARDING WEEK 2013'

Name	Sally Nash
Position	Head of Service
Agency	Youth Offending Team

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

Safeguarding is a key requirement of YJB practice and integral to all our work. All service users are assessed in relation to risk including public protection, offending, safeguarding and vulnerability and their intervention plans reflect this assessment.

The YOT is strongly committed to the work of the board attending WSCB and various sub groups.

What were the agreed safeguarding objectives for 2013/14?

- Reducing first time entrants to the YJ system(FTE)
- Reducing reoffending
- Reducing custody
- Reducing remand episodes
- Increasing educational engagement

Achievements against the above Objectives :-

The YOT continues to perform at a high level in respect of the three national indicators of FTE, reoffending, and use of custody.

There is continued work to mitigate the need for remand outcomes and the lack of suitable accommodation/placements remains a key feature

Educational engagement for young offenders remains stubbornly low in Wolverhampton, and these issues are on the WSCB agenda

Improvement Plans where barriers have existed.

The YOT has an ETE improvement plan which is regularly reported into the Management Board

Impact for Children, Young People and Families

CYP in Wolverhampton benefit from a very strong 'Intensive Surveillance and Supervision' programme (ISS) which provides a robust alternative to custody and is heavily utilised by the courts.

The engagement of children in meaningful education is a significant safeguarding challenge as it is their key point of universal engagement, and those who are not engaged/attending are vulnerable to a variety of risks during core school hours.

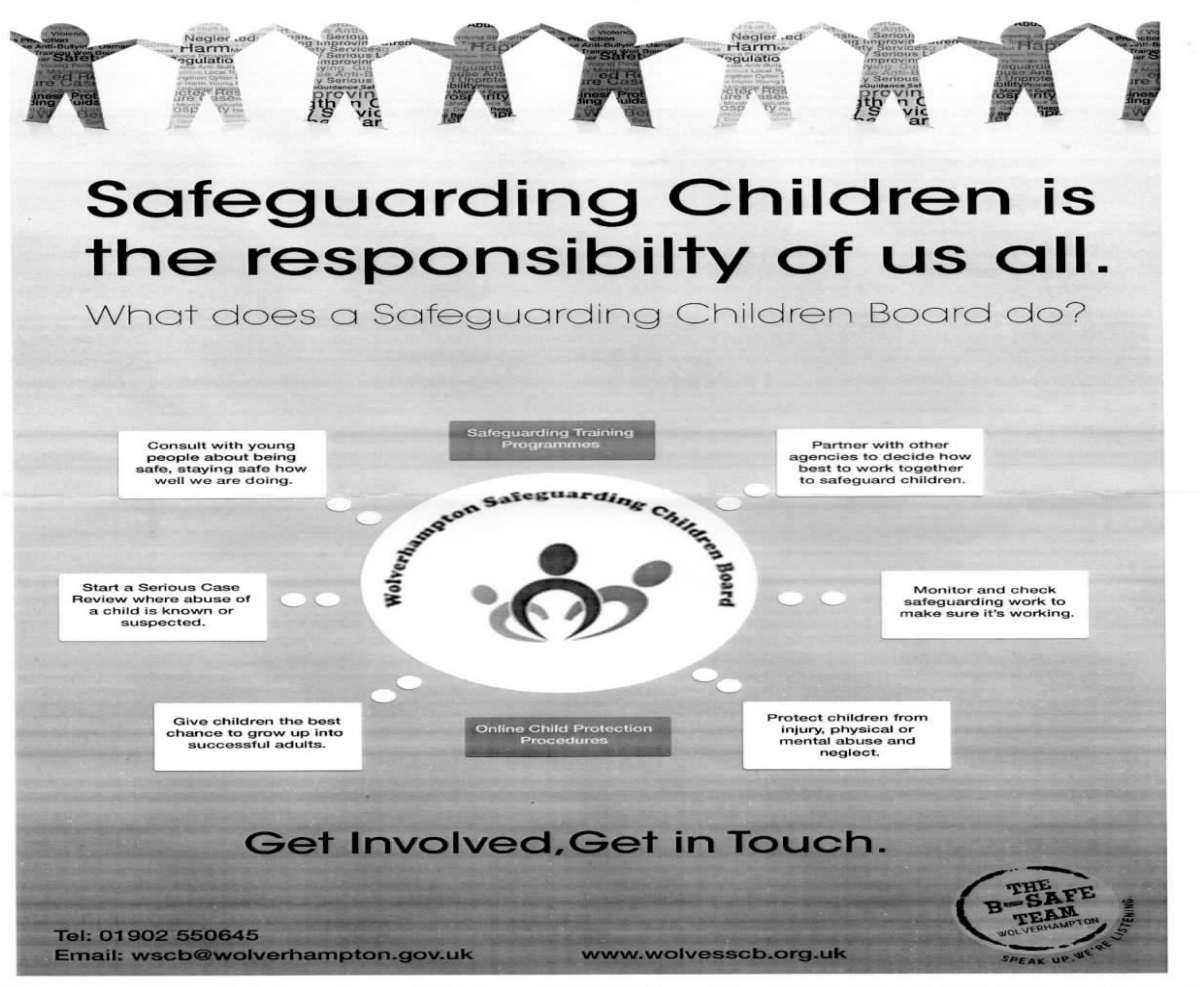
In relation to safeguarding children, what are your priorities/objectives for 2014/15

- FTE
- Custody
- Reoffending
- Remand rates
- ETE engagement
- CSE issues – we are aware of an increasing number of young (particularly) women who are being exploited
- Gangs
- The 'Prevent' agenda

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The YOT is a reliable attender and fulfils its obligations at WSCB. Q &P , SEMT

We have a current section 11 audit and action plan



Name	Heidi Crampton
Position	Service Manager
Agency	CAFCASS A12

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

Specific to the Wolverhampton Safeguarding Children Board, a designated service manager sits on the board and makes an active contribution in the following ways:

- Chair of the Quality and Performance Committee from 16th May 2014. I have updated the terms of reference, set dates and themes for multi-agency case file audits, the committee is developing a bespoke set of standards against the regional key performance indicators and I have participated in the latest MACFA.
- Attendance at and contribution to SEMT.
- Cafcass has escalated a number of children via the Chair to ensure that lessons are learnt.
- I provided a report to the Board to clarify Cafcass' safeguarding role and bring to the Board's attention any difficulties Cafcass' experience in fulfilling its safeguarding role.
- Learning from MACFA and SCRs are disseminated to all staff.
- Cafcass' has offered staff to assist in facilitating LSCB training.
- All Wolverhampton Safeguarding Children Board training is cascaded and I am aware that representatives of Cafcass attend.

What were the agreed safeguarding objectives for 2013/14?

Cafcass is a non-departmental public body, sponsored as of April 2014 by the Ministry of Justice. Its **principal functions are to safeguard and promote the welfare of children** who are subject to family proceedings, and to provide advice to the family courts. It employs about 1870 staff, over 90% of whom are frontline.

In 13/14 a total of 9,680 care applications (public law) were received, which is a decrease of 12% compared with the number received in 12/13. Similarly there has also been a decrease in private law cases where a total of 42,888 applications were received in 2013/14 - a 7% decrease compared to 12/13. Shorter case durations (within s31 cases), together with proportionate working and more efficient working practices have led to the stock of open cases reducing in both private and public law.

Achievements against the above Objectives :-

The following are examples of activities undertaken by Cafcass in 13/14 to improve practice, better safeguard children and make a positive contribution to family justice reform:

- ✓ Working with partners in family justice e.g. the Family Justice Board, Local Family Justice Boards (11 of which are chaired by Cafcass), judges; the Family Justice Young People's Board; and the ADCS, to promote family justice reform in preparation for the implementation of the Children and Families Act (April 2014).
- Contributing to the development of the Public Law Outline and Child Arrangements Programme (Practice Directions 12A and 12B respectively); and working with partners to reduce the duration of care cases (35 weeks as of quarter 3).
- Setting up demonstration projects designed to accelerate family justice reform e.g. a telephone helpline service in the North-East to divert from court cases where there are no safeguarding issues.
- Strengthening the workforce through a number of measures including: the talent management strategy; 'My Work' (a mechanism by which staff can understand and regulate their own performance); development of a health and wellbeing strategy.
- Revising the Child Protection Policy, Operating Framework and Complaints and Compliments Policy.
- Drafting service user minimum standards which will be joined with our work-stream on child outcomes.
- Undertaking a number of pieces of research into the work of Cafcass and family justice including research into: expert witnesses in s31 cases; the work of the Children's Guardian; learning derived from Cafcass submissions to serious case reviews (Cafcass having contributed to 30 such reviews in 13/14).

Improvement Plans where barriers have existed.

In 2013/2014, Cafcass nationally and locally developed Achieving Good plans, in line with Ofsted guidelines and expectations.

Cafcass undertakes an annual review of IMRs where Cafcass were involved.

- The review sets out learning about the case dynamics derived from 35 Individual Management Reviews (IMRs) undertaken between 2009 and 2013 and data provided by serious incident notifications, specifically in respect of incidents of child and parental suicides from 2009 to 2013.
- The term **'Toxic Trio'** is used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred.

In order to address these, Cafcass launched a set of tools, e-learning and classroom training.

Impact for Children, Young People and Families

Ofsted found that:

- Cafcass is good at identifying any risks to children and young people and writes good quality letters to the court before the first court hearing
- Children and young people are successfully helped to express their wishes and feelings and Cafcass makes sure the court understands them.
- Family court advisers have good tools to help their work understanding children's wishes and feelings and assess families' strengths and this assists them to write good reports which help the courts make the right decisions for children.
- When a child needs to come into care Cafcass quickly appoints a Children's Guardian who quickly gets to know the child and their family and gives good quality advice to the court. This is helping to avoid delay in children's lives.
- Children's Guardians are good at helping local authorities understand what is best for children.
- Cafcass has supported young people who have been involved in family courts to form the Family Justice Young People's Board. This Board has been very effective in making sure Cafcass, judges and government listen to what young people think is most important.

In relation to safeguarding children, what are your priorities/objectives for 2014/15

As set out in the Children Act and the Children and Families Bill 2014, Cafcass' principal functions are to safeguard and promote the welfare of children who are subject to family proceedings, and to provide advice to the family courts

Cafcass is piloting a number of projects to:

- Ensure a more efficient, child focused service to children and their families.
- Work more effectively in reducing the time children are subject of private and public law proceedings.
- Prevent delay in outcomes for children.
- Prevent unnecessary involvement in family law proceedings.
- Making parental responsibility work.

The Wolverhampton Safeguarding Children Board could assist by:

- Including a business objective specific to children subject of Private Law Proceedings i.e. Ensuring that children subject of private law proceedings are protected by improved communication between the Local authority and Cafcass.
- Including a business objective specific to children subject to Public Law proceedings i.e. Ensuring effective working between the IRO (as set out in national guidance), Children's Services and Cafcass.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

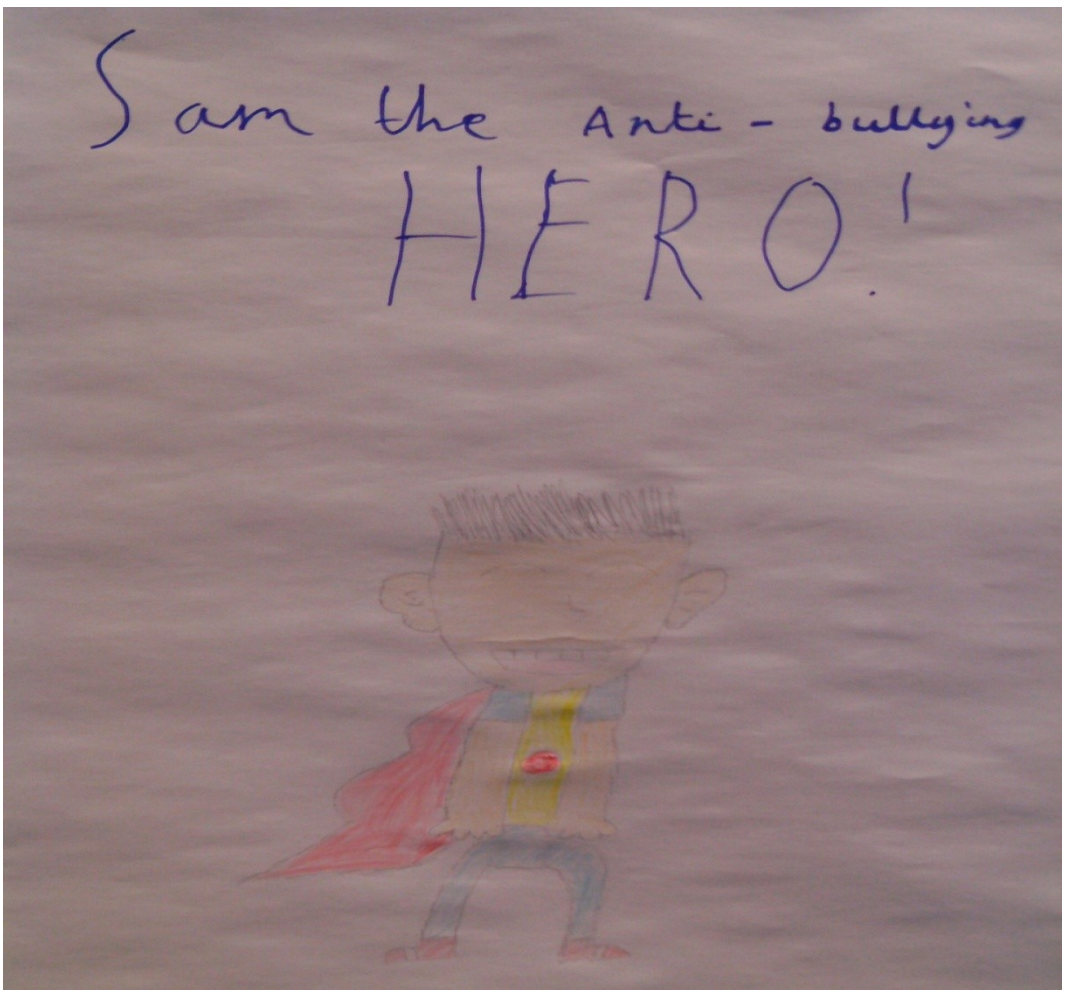
All of the Key Performance indicators, relating to the allocation of work and filing of reports, have been met.

The National Ofsted inspection took place in February and March 2014. Both private law and public law practice were judged to be good as was the management of local services. National leadership was judged to be outstanding.

The four judgements of the Ofsted inspection were as follows:

- The quality and effectiveness of Cafcass private law practice with families: **Good**
- The quality and effectiveness of Cafcass public law practice with families: **Good**
- The leadership and governance of the national organisation: **Outstanding**
- The leadership and management of local services: **Good**

Cafcass has evidenced its commitment to the board and sub-committees through regular attendance, sharing expertise and knowledge and actively contributing to the Quality and Performance Committee, SEMT, Policy and Procedure sub group and consistent communication with partners.



Name	Jennie Watton, Jason Dudley
Position	Empower Co-ordinator (Safeguarding lead), Young Person & Volunteer Development Co-ordinator
Agency	Base 25

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

Base 25 offers early intervention projects (e.g. Empower, Inspire, SAFE) that enable the identification of children and young people at risk. Base 25 demonstrates its commitment to safeguarding through implementing safer recruitment processes, safeguarding policy, multi agency working and contributing to strategic and operational SEMT.

What were the agreed safeguarding objectives for 2013/14?

- To improve the early identification of young people at risk.
- To increase self-esteem of young people.
- To increase self-confidence and emotional resilience
- To improve young people's ability to make informed decisions
- ❖ To increase self-awareness and sense of identity
- ❖ To minimise harm to self and others.

Achievements against the above Objectives :-

To improve the early identification of young people at risk.

- Increased number of referrals made to projects
- Increased number of agencies referring to projects (increase in the number of referrals from 'mothers')
- There has been an increase across the projects with regards to lower risk young people, this demonstrating that young people are being identified at an early stage of intervention. This has also enabled preventative work to be delivered with those identified and where necessary, their siblings.

To increase self-esteem of young people.

- Utilising a range of assessment tools, there has been an increase demonstrated in self-esteem with young people accessing the projects. Percentage increases ranging between 20% and 30%.

To increase self-confidence and emotional resilience

- Emerging themes from professionals, parents and young people involved in the projects have included: comments, observations and reflections around perceptions of the young person's level of increase in their confidence and self-esteem and what that looks like: an improved ability to communicate more positively with peers, parents and professionals; Increased involvement in positive activities and an improved ability to manage emotions more effectively.

To improve young people's ability to make informed decisions

- Reduction in the risk indicators for young people assessed now making safe/better decisions
- Parent and/or professional perspective has shown an improvement in the decisions made by young people.
- Increased knowledge around healthy relationships, staying safe, identifying risk and risky situations, sexual health, around protective behaviours and utilising this knowledge when making decisions.

- **To increase self-awareness and sense of identity**
- Through the programmes developed through the projects, concepts of self and identity have been explored at all stages across all of the thematic areas. Young people have been able to locate themselves within the context of their own lives and have demonstrated an awareness of those that have influence on them and how they influence and impact on others. This has also impacted on their confidence, self-esteem and their ability to make decisions. Young people have shown ability to empathise with others and an understanding around their own emotional literacy with regards to how others make them feel.
- A lot of work developed with young people was around de-constructing concepts around negative beliefs and values. Young people have demonstrated an understanding of the realities of their negative lifestyle and have identified alternative perspectives on positive change.
- **To minimise harm to self and others.**
- Decrease in the assessed risk factors.

A lot of the thematic work has been delivered around sexual health, exploitation, grooming, drugs and alcohol misuse, crime, violence and engaging in gang related activity. This has positively impacted on the behaviour of the young people involved in the projects. Most have demonstrated a change in attitude and a more confident approach towards staying safe.

Improvement Plans where barriers have existed.

- There has been an increase in referrals as a consequence of local funding cuts and a need to generate future funding for projects.

Impact for Children, Young People and Families

- Positive feedback from young people, parents and professionals
- Positive feedback from schools regarding behaviour and attendance
- Children and young people achieving the objectives of the various projects
- More accessible information to enable referrals for children and young people

Case Study 1 - Lucy aged 17 came to Base 25 with concerns around displaying violent and controlling behaviours towards mum, Lucy had previously witnessed domestic violence from dad to mum. Lucy had anxieties around how she managed conflict and would became angry at herself for demonstrating behaviours of violence. She would isolate herself in her bedroom to avoid any conflict. Through intervention with Base 25 she was able to identify safer ways to manage conflict which led to her feeling less anxious, this resulted in her having a better relationship with mum and spending less time in her bedroom. By the end of the work, Lucy increased her well-being score from 22% to 36% and her risk factors decreased from 39% to 28%.

Case Study 2 - Andrew is 22, has special educational needs, estranged from his parents and living in a hostel. He was being negatively targeted by a criminal gang who were influencing him to smoke drugs. The Base 25 worker spent time developing trust with Andrew and was able to identify with the difficulties that he was experiencing. The worker liaised with his hostel to put strategies in place to keep him safe there. A supported referral was also made for him to see a drugs worker. The Base 25 worker meet with Andrew on a regular basis to work with him around his decision making and

risk taking behaviours in a way that Andrew could understand. As Andrew looked up to the worker as a 'role model' the worker was able to use his influence to encourage Andrew away from the negative choices he was making around his friendships and supported him to access a local training provider and to volunteer for a community radio station. Andrew now lives in different supported accommodation and has a new, more positive friendship group. He is doing a level 2 qualification and has his own radio debate show.

Case Study 3 - Robert, currently at school had been exposed to sexual activities through being manipulated into performing a sexual act on a girl of a similar age, by the girl's brother after watching pornography on the internet. The worker developed a programme of work around relationship building, emotional resilience, safer relationships and protective behaviours. After engaging with the programme the young person was able to identify with

healthy relationships and expressed an increased awareness around the negative influence of pornography and unhealthy sexual relationships. He is now at secondary school and has a positive network of friends.

In relation to safeguarding children, what are your priorities/objectives for 2014/15

To develop new early intervention programmes in school

- To identify and generate new funding for projects
- To continue developing partnerships with other organisations
- To offer more external training opportunities for professionals around the thematic areas of the various projects, to raise awareness and increase referrals

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

Base 25 continues to support young people in shaping their lives through the early identification of young people at risk and providing projects that offer both prevention and intervention to ensure that children and young people are safeguarded.

Joint Adult and Children Safeguarding Board's Forced Marriage Conference 2013

Name	Daphne Atkinson
Position	Senior Consultant Social Worker
Agency	Wolverhampton City Council

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

"all our children and young people should be successful, healthy, safe and contributing to the communities in which they live, work and play" Children and Young People Plan (2011-14)

Wolverhampton City Council Child and Families Services ensures that it works within the Children Act 1989, Private Fostering Regulations 2005, and the National Minimum standards 2005, which sets out how the welfare of privately fostered children is to be safeguarded and promoted. The duties of Local Safeguarding Children Boards were also extended in an attempt to ensure that the interests of children who live within a Private Fostering arrangement are protected.

- The local authority Fostering service has a written Statement of Purpose which sets out the role and function regarding Private Fostering (PF).
- Relevant staff are suitably qualified and experienced to respond effectively to the local authority duties and functions in relation to private fostering
- The Fostering service promotes awareness of the notification requirements and ensures that professionals who may come into contact with privately fostered children understand their role in notification and can responds effectively to notifications; and deals with situations where an arrangement comes to their attention.
- The Fostering team carries out full screening of the private fostering situation to effectively determine the suitability of all aspects of the private fostering arrangement.
- Private foster carers and parents of privately fostered children receive advice and support to assist them to meet the needs of privately fostered children.
- Privately fostered children are able to access information and support when required so that their welfare is safeguarded and promoted.

What were the agreed safeguarding objectives for 2013/14?

- The targeting of professionals to assist in identifying children who may be in a private fostering arrangement continues to be the focus of the Fostering service.
- To include private fostering information/presentation as part of the Induction training for new workers to the city.
- Progress the marketing strategy and action plan for 2013-15
- Continue the multi-agency briefing sessions throughout the year. This could involve linking in with nearby authorities and the Private Fostering Special Interest Group (PFSIG).
- Progress the work required to ensure compatibility of all the Private Fostering processes with Care First.
- Further work required to ensure that the timescale for completing the suitability assessment is not hindered by delay in obtaining all the

required statutory checks within the 42 days statutory timeframe.

- The Fostering Service to continue to negotiate with Education to try and obtain the information they collate on the admissions forms relating to private fostering, and also to try to amend the schools admissions process at 4 and 11 to enable them to refer any arrangements that come to light.
- To actively recruit or involve individuals to become 'Champions' for Private fostering, receiving and disseminating information within their specific service areas and with partner agencies

Achievements against the above Objectives :-

There were 13 referrals to Children Services during 2013-14. However a number of these were not converted to a private fostering arrangement for the following reasons:

- Young people reaching the age of 16 years.
- Young People returning to other family members.
- Disqualification of the arrangement due to the criteria for Private Fostering being compromised.
- The placement did not meet Fostering Regulations.
- One carer obtained Special Guardianship for the young person
- The Foster Carers had a number of issues that caused concern for both the Fostering Social Worker and also the Child's Social Worker
- Foster Carer was the great-grandmother of her 15 year old great granddaughter, who lived with her. A neighbouring Local Authority placed the grand-daughter's boyfriend in the home.

We currently have 3 Approved Private Fostering households and 2 Prospective Private Fostering arrangements in the process of assessment. They are at varying stages of the process.

There continues to be an online section on Private Fostering on the Council's Website.

Following changes to the Fostering Forms on Care First, there is now a Private Fostering Initial assessment document. All new assessments are completed using this Care First form.

Recently, contact has been made with the School's Admission Team, the newly appointed Virtual School Head and the LAC Nurse, with a request for the Private Fostering leaflets to be cascaded to both staff and service users to raise awareness of the related issues and associated process.

In addition to the above, a Marketing Plan has been completed and the profile of PF amended on the council's Web site.

Work is underway and will continue to develop a joint working protocol. This is to ensure that if there is an increase of privately fostered children joining, e.g. Wolves Academy Host Families, there will be a smooth transition and the regulation can be effectively applied. Information leaflets are now available for all involved parties in Private Fostering

Arrangements, parent, child and private foster carer. PDF versions of the above leaflets are also available and these are used when disseminating Private Fostering with other professionals.

Representatives from the Fostering Service continue to attend the Private Fostering Special Interest Group (PFSIG). The group is co-ordinated by British Agency for Adoption and Fostering (BAAF). The group is made up of other specialist private fostering social workers from around the West Midlands regions. The PFSIG looks at the development of services, offers support to specialist workers, relate practice to legislation and currently advises on Ofsted inspection and best practice in raising awareness on Private Fostering. The last meeting was in December 2013.

Improvement Plans where barriers have existed.

In January 2014, the Private Fostering lead e-mailed all a list of people who were identified as potential Private Fostering champions by the Safeguarding Board. Included in the e-mail were the PDF leaflets on Private Fostering and an offer to come and deliver a short presentation on Private Fostering. Unfortunately only 1 person responded (S. D.) to this e-mail. An appointment was offered for April 2014, but S. had no availability.

Also in January 2014, the Private Fostering lead sent an information e-mail to all of the following education providers in Wolverhampton:

- Pupil Referral Units
- Specialist Schools
- Nursery Schools Infant Schools
- Children's Centres
- Primary Schools
- Junior Schools
- Secondary Schools

In the e-mail were 3 Private Fostering Leaflets, a short description of a Private Fostering arrangement, how to make a referral, a request to cascade the information and also an offer to deliver a short presentation on Private Fostering. It is extremely unfortunate that only one of the above organisations acknowledged the e-mail (Ashmore Park Nursery) and no other providers have requested for us to attend their school, nursery or Children's Centre to present on Private Fostering.

The restructuring of the Children Services in 2013-14

Impact for Children, Young People and Families

We have continued to raise awareness within the various professionals groups and the wider community by providing direct information about Private Fostering and how to notify the local authority of such arrangements. Where we have been notified of such situations we have carried out comprehensive assessments to ensure children welfare are safeguarded

In relation to safeguarding children, what are your priorities/objectives for 2014/15

We will continue the targeting of professionals to assist in identifying children who may be in a private fostering arrangement.

- The impact of the restructure of Children Services (NOM) has meant that there has been some slight delay in some aspect of the work .However the focus of the work will now be managed by a dedicated group of workers which will provide enhanced focus and timeliness.
- We plan to continue the joint Private Fostering Information Sessions which will now incorporate Rachel Warrender, policy officer.
- We are in the mid phase of the marketing strategy and action plan for 2013-15. This will continue to be progressed.
- We will continue to try to build relationships and engage with the Language Schools in the City.
- We will continue to try and engage with groups and services for the Black, Asian and other minority ethnic groups in the City.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

We have strived to work within the statutory framework to ensure that where children are unable, for whatever reason, to live within their own birth family, a range of services and resources are provided designed to assist families in resuming the care of their children. Where this is not appropriate the Fostering Service have assessed private fostering families who can promote the child's best interest, well-being and development by providing the highest possible standards of care according to the child's individual assessed needs.

Name	Kathy Cole-Evans
Position	Strategy Coordinator & General Manager
Agency	Wolverhampton Domestic Violence Forum

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

As part of our contribution in kind to the Safeguarding Boards, WDVF is committed to attending and participating at Board meetings as a professional adviser to the Board, and providing input to various sub-groups of the Board to contribute to the joint Board targets. In addition, WDVF delivers domestic violence and safeguarding training as part of the Board's multi-agency annual training programme.

WDVF's objectives, outcomes, policies, procedures, and working practices focus on making children and adults safer.

Staff are trained in safeguarding arrangements.

What were the agreed safeguarding objectives for 2013/14?

To increase the early identification of, and intervention with, victims of 'violence against women and girls' subject areas and including men and boy victims, by utilising all points of contact with front line professionals

Objective 2: To build capacity to provide effective advice and support services to victims of 'violence against women and girls' subject areas and including men and boys

Objective 3: To improve the criminal justice response to 'violence against women and girls' subject areas and including and men and boys

Objective 4: To support victims through the criminal justice system and manage perpetrators to reduce risk

Achievements against the above Objectives :-

WDVF leads on developing & performance managing successive multi-agency Wolverhampton Violence Against Women & Girls Strategy (VAWG) & Action Plans via WDVF's Executive Board, the Safeguarding Boards, and through the Safer Wolverhampton Partnership Board and its structures. The current strategy and action plan focuses on victim and perpetrator services, and requires refreshing after March 2015.

WDVF provides independent challenge at statutory Domestic Homicide Review (DHR) panels, chairs the Standing DHR panel, leads on specific DHR strategic recommendations on behalf of the Safer Wolverhampton Partnership, and contributes to local, regional, and national DHR research.

In response to previous domestic homicide review recommendations, WDVF has developed and agreed through the Safeguarding Boards a new Over-Arching Domestic Violence Protocol for the city that sets out minimum expectations on organisations to reduce serious harm and homicide, including to have in place appropriate training, policies, routine questioning, risk assessment capability, pathways to Multi-Agency Risk Assessment arrangements for high risk cases, and signposting information.

WDVF has contributed to two recent joint Safeguarding Board forced marriage and honour based violence conferences, and in developing Wolverhampton's multi-agency protocol for forced marriage and honour based violence, the first in the UK to be a joint policy for adults and children. As part of its contribution to the Board and amongst other training commitments, last year WDVF also delivered domestic violence and safeguarding training as part of the Safeguarding Children's Board multi-agency training programme.

WDVF's co-located team jointly screens and initiates action with cases where children and pregnant women are identified. Last year there were 2016 cases involving children and pregnant women jointly screened by a Social Worker, Specialist Nurse, Child Protection Police Officer, and an Independent Domestic Violence Adviser. There were 403 cases assessed at high risk of serious harm and homicide last year with 520 associated children. These cases were jointly assessed and intervention plans developed through Multi-Agency Risk Assessment arrangements and twice weekly crisis intervention meetings. During the year WDVF's Executive Board has agreed to take responsibility for governance of Multi-Agency Risk Assessment Conference arrangements.

WDVF continues to employ specialists such as an Independent Criminal Justice Domestic Violence Adviser, and a Sexual Violence Adviser, both of which roles assist in improving the attrition rate through the criminal justice system.

WDVF used its own reserve funds to successfully pilot a much-required Independent Health Domestic Violence Adviser service at our local Accident & Emergency department. This pilot is in line with good practice elsewhere, facilitating domestic violence and safeguarding awareness raising and training to health staff. It also provides a clear care pathway for victims of domestic violence presenting with injuries at A&E to be assessed using a common domestic violence risk assessment tool, and signposted to specialist help depending on the level of risk.

WDVF raised external funding to develop and run a pilot community based perpetrator programme over the last two years. There is huge demand for such a programme with referrals being made by Social Care, Children and Family Centres, Family Court, Police, etc, and directly by service users. The pilot will be evaluated shortly.

WDVF's work focuses on evidence based institutional advocacy, and participation at regional and local boards, scrutiny panels, and strategic meetings, in particular around shortfalls in the criminal justice response to violence against women and girls. WDVF

chairs and performance manages Wolverhampton's Specialist Domestic Violence Court Steering Group, is an active participant at the Black Country Criminal Justice Area Delivery Group, West Midlands Criminal Justice Board's Victim, Witness & Domestic Violence Group, the Crown Prosecution Service Violence Against Women & Girls Scrutiny Panel, the West Midlands Violence Against Women and Girls Strategic Group,

Improvement Plans where barriers have existed.

The significant barrier to the sustainability of work and services around violence against women and girls remains the considerable and on-going funding cuts to services. WDVF is a small independent organisation and charity that, without Local Authority or partnership funding for its core service after March 2015 will be unsustainable, which will result in the loss of the organisation, its statutory, strategic and coordination work, the external funding it attracts, and the additional services it develops and oversees that contributes to the joint outcomes.

Impact for Children, Young People and Families

Reduced harm resulting from violence against women & girls subjects (including for men and boys) including homicide prevention

Reduced prevalence of violence against women and girls

Reduced rate of repeat domestic violence incidents

Increased offences brought to justice

In relation to safeguarding children, what are your priorities/objectives for 2014/15

Objective 1: To increase the early identification of, and intervention with, victims of 'violence against women and girls' subject areas and including men and boy victims, by utilising all points of contact with front line professionals

Objective 2: To build capacity to provide effective advice and support services to victims of 'violence against women and girls' subject areas and including men and boys

Objective 3: To improve the criminal justice response to 'violence against women and girls' subject areas and including and men and boys

Objective 4: To support victims through the criminal justice system and to manage perpetrators to reduce risk

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

WDVF is a small independent organisation and charity with a specific and unique perspective on multi-agency working around violence against women and girls subject areas. We work closely alongside Wolverhampton's Safeguarding service and from this perspective we play an active professional advisory role at Safeguarding Boards.

2014/15 Summary of Activities & Challenges Ahead for 2014/15

The contents of this report demonstrates that during the reporting year, there has been a much activity across the WSCB partnership in regards to keeping children safeguarded alongside actions to be taken when specialist interventions are needed and the mechanisms to evaluate the overarching arrangements through the duties of the board.

The national context on how LSCB's work means that going forward, we will be actively considering how to measure the impact of our work on outcomes for children – i.e. how have we made a difference? Whilst this increased accountability is welcome, the work of moving WSCB to this new self-challenging position will be significant.

WSCB will continue to strive to improve and develop its role in challenging and supporting the work of agencies involved in safeguarding children and in monitoring and coordinating the response to child abuse and neglect. Going forward, the Business Plan 2013 -2016 keeps the same four key strategic priorities but within them outlines additional outcomes and activities for the year ahead.

Consideration must also be given to the addition role for LSCB's80 within Working Together which now require boards to influence and assess the development of early intervention services, as these are critical in improving the safeguarding of children, and in ensuring that only those in highest need receive specialist intervention form children social care services. WSCB will also need to monitor the interfaces between preventative and statutory services to ensure that thresholds are clear and consistent.

We have a challenging work plan, but, whilst all require attention, this report also tells us that attention is also required in the following areas:

NATIONAL DRIVERS

- Working Together 2013 requires LSCBs to monitor the provision of early help to children and young people. There are a range of local services available, however, WSCB will need to ensure that the pathways into services are clearly understood and a strategic overview is necessary to identify gaps and to ensure that services are confident in delivering effective services despite any reduction in future funding.
- Ensuring that the potential risks to safeguarding practice and arrangements are kept under review in response to increasing demand for services and on-going reshaping of public services.
- WSCB need to be clear of the expectations for LSCB's in safeguarding across inspection frameworks
- WSCB will need to assure itself that child sexual exploitation is properly addressed; this may require a mapping exercise of the area to establish whether the current

arrangements in place are effective and that work is properly co-ordinated across agencies.

- There have been changes in the external inspection regime carried out by Ofsted. The new framework recently introduced will focus very much on Council services for children in need of protection, who are looked after, or who are care leavers. It will include a judgement on the board. However, the attempts to create a genuine multi-agency inspection have so far failed, so other agencies will not be adequately represented in the process, this then raise a question as to whether the board can be adequately inspected for the effectiveness of it safeguarding arrangements as a multi-agency partnership under this methodology.

LOCAL DRIVERS

- WSCB relies heavily on it committees to carry out much of its activities, ensuring there is adequate membership and resources from partner agencies to carry out this work will be a significant challenge in this current climate.
- Ensuring safeguarding arrangements across the partnership is a core function for WSCB, the quality and performance committee support this process via quarterly audits.
- The performance data to date has been draw from children social care, this requires further development to ensure all partner agencies are providing reliable data;
- There is a need to ensure Board members disseminate information throughout their agencies;
- In response to Working Together 2013, WSCB has produced a learning and improvement framework, this will need to be maintained to ensure appropriate local effective multi-agency work
- The board needs to seek assurance that there are effective local arrangements in place to safeguarding disabled children.
- The board will need to assure itself that Safeguarding of children in Wolverhampton schools, and early years centres are secure, and that the structures for identifying children at risk are robust and exist in all schools and centres irrespective of their status: Community, Academy, Faith, Free or Independent. In addition, the board should agree a mechanism for ensuring safeguarding policies exists, are regularly reviewed, practice is monitored and data is used to inform development work.
- The board has through the year been better able to assess the quality of practice through the use of multi-agency case file audits (MACFA). This has been in the main However, this needs to be further developed into a fully comprehensive quality assurance framework.

An evaluation of the progress against the priorities alongside the assessment of the effectiveness of local safeguarding arrangements, consideration of relevant national issues will influenced the main priorities moving forward, it is important that WSCB continues to keep as its focus, improving safeguarding arrangements and activities as a main priority during 2014-15 and beyond.

Acronyms Explained

A & E	Accident & Emergency
BCPFT	Black Country Partnership Foundation Trust
BME	Black and Minority Ethnic
CAFCASS	Children and Families Court Advisory Support Service
CDOP	Child Death Overview Panel
CP	Child Protection
CPP	Child Protection Plan
CiN	Child in Need
CP-IS	Child Protection Information Sharing
CRH	Central Referral Hub
CRU	Central Referral Unit
CSE	Child Sexual Exploitation
CYPS	Children and Young People's Services
DBS	Disclosure & Barring Service
DHR	Domestic Homicide Review
FGM	Female Genital Mutilation
FM	Intensive Surveillance and Supervision'
FTE	Forced Marriage
IRO	Full-time Equivalent
IMR	Independent Review Officer
ISS	Independent Management Review
JSCG	Joint Safeguarding Children Group
LAC	Looked After Children
LADO	Local Authority Designated Officer (Allegations)
LSCB	Local Safeguarding Children Board
MARAC	Multi-agency Risk Assessment Conference
MACFA	Multi-agency Case File Audit
PFSIG	Private Fostering Special Intervention Group
PPU	Public Protection Unit
RWT	Royal Wolverhampton Trust
SCR	Serious Case Review
SEN	Special Education Need
SEMT	Sexual Exploitation, Missing and Trafficked
SWMPT	Staffordshire & West Midlands Probation Trust
VAWG	Violence Against Women & Girls
VCO	Voluntary & Community Organisations
WCC	Wolverhampton City Council
WDVF	Wolverhampton Domestic Violence Forum
WIFRN	Wolverhampton Inter-Faith & Regeneration Network
WMP	West Midlands Police
WSAB	Wolverhampton Safeguarding Adults Board
WSCB	Wolverhampton Safeguarding Children Board
YOW	Youth Opportunities Wolverhampton
WTSC	Working Together to Safeguard Children
YJB	Youth Justice Board
YOT	Youth Offending Team
YOW	Youth Organisations Wolverhampton

Agenda Item No. 10

Health and Wellbeing Board

7 January 2015

Report title	Health and Wellbeing Board – Updated Terms of Reference	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, Director of People	
Originating service	Health and Wellbeing	
Accountable employee(s)	Viv Griffin	Service Director – Disability & Mental Health
	Tel	01902 555370 / 01902 551372
	Email	vivienne.griffin@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendation for action or decision:

The Health and Wellbeing Board is recommended to:

1. Endorse the attached updated Terms of Reference and revised membership of the Health and Wellbeing Board with effect from the 2015/16 Municipal Year, for the Special Advisory Group, Standards Committee and Council as appropriate.

1.0 Purpose

1.1 To seek approval from the Health and Wellbeing Board for the updated Terms of Reference and revised membership

2.0 Background

The Terms of Reference for the Health and Wellbeing Board were last updated at its meeting held on 1 May 2013. Since that date the role of the Board has continued to evolve and as a result of a number of levers the Board now needs to reconsider its Terms of Reference and membership.

3.0 Statutory Responsibilities

The Health and Social Care Act 2012 Act prescribes a core statutory membership of Health and Wellbeing Boards of at least one elected representative, nominated by either the Leader of the Council, the Mayor, or in some cases by the local authority, a representative from each Clinical Commissioning Group whose area falls within or coincides with, the local authority area, the local authority directors of adult social services, children's services, and public health and a representative from the local Healthwatch organisation. In addition the NHS Commissioning Board must appoint a representative for the purpose of participating in the preparation of the Joint Strategic Needs Analysis and the Joint Health and Wellbeing Strategy and to join the Health and Wellbeing Board when it is considering a matter relating to the exercise, or proposed exercise, of the NHS Commissioning Board's commissioning functions in relation to the area and it is requested to do so by the board.

The guidance states that beyond the core statutory membership Health and Wellbeing Boards can add members, to the board beyond that set out in the legislation. This could include representatives from other groups or stakeholders who can bring in particular skills or perspectives, or have key statutory responsibilities which can support the work of boards, such as those from the criminal justice agencies or relevant District Councils, or local representatives of the voluntary sector, clinicians or providers (whilst seeking to avoid potential conflicts of interest in relation to providers).

Wolverhampton's current Terms of Reference (May 2013) include the following Membership:

Cabinet Member – Health and Wellbeing (Chair)
Cabinet Member – Children and Families
Cabinet Member – Adults
Shadow Cabinet Member – Health and Wellbeing
Strategic Director - People
Strategic Director - Place
Director of Public Health

Chair of Local Healthwatch
Wolverhampton Clinical Commissioning Group (3 representatives)
West Midlands Police and Crime Commissioner (or representative)
NHS Commissioning Board / Local Area Team
University of Wolverhampton – School of Health and Wellbeing
West Midlands Police – Wolverhampton Local Policing Unit
Third Sector Partnership

4.0 Levers for Change

Under the Health and Social Care Act 2012 Health and Wellbeing Boards were given the specific statutory duty to encourage integrated working between health and social care commissioners (including promoting pooled budgets and / or integrated provision). As a result of this duty Health and Wellbeing Boards have been given the responsibility to sign off the Better Care Fund Plans and to have an executive over view of the resultant pooled budgets.

The Better Care Fund (BCF) was introduced in June 2013 as a way to provide an opportunity for local areas to transform local services so that people could receive better integrated care and support. The Wolverhampton Health and Wellbeing Board subsequently established a number of working groups, for each key work stream, who have developed the detail of the local Better Care Fund plan. This system transformation role has involved all key partners across health and social care including both commissioners and major service providers. Acknowledging this wider systems transformation and integration role the Rt Hon Jeremy Hunt MP, Secretary of State for Health wrote to all Health and Wellbeing Boards in October 2014 requesting that service providers be invited to join Health and Wellbeing Boards.

This wider remit of the Health and Wellbeing requires a review of the Membership and terms of reference of the Board.

Attached in Appendix 1 are the suggested revised Terms of Reference and membership.

5.0 Financial implications

5.1 There are no direct financial implications to this report.
[AB/11122014/M]

6.0 Legal implications

[RB/10122014/Q]

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

7.0 Equalities implications

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

8.0 Environmental implications

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

9.0 Human resources implications

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

10.0 Corporate landlord implications

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

11.0 Schedule of background papers

11.1 None.

TERMS OF REFERENCE HEALTH AND WELLBEING BOARD (REVISED JANUARY 2015)

1. CORE MEMBERSHIP

Cabinet Member – Health and Wellbeing (Chair)
Leader of the Council and Chair of Cabinet
Cabinet Member – Children and Families
Cabinet Member – Adults
Shadow Cabinet Member – Health and Wellbeing
Director of People
Director of Place
Director of Public Health
Representative of Local Healthwatch
Wolverhampton Clinical Commissioning Group- Senior Responsible Officer (Vice Chair)
Wolverhampton Clinical Commissioning Group (2 clinical representatives)
West Midlands Police and Crime Commissioner (or representative)
NHS Commissioning Board / Local Area Team
University of Wolverhampton – School of Health and Wellbeing
West Midlands Police – Wolverhampton Local Policing Unit
Third Sector Partnership
The Royal Wolverhampton Hospitals NHS Trust
Black Country Partnership NHS Foundation Trust

2. MEETINGS

Frequency of meetings:

The Board will meet every other month.

An extraordinary meeting can be called when the Chair considers this necessary and or/ in the circumstances where the Chair receives a request in writing from 50% of the membership of the Board.

The Board may hold informal focus days / sessions on specific issues of interest to the Board.

Meetings of the Board will be conducted in public.

The quorum for meetings will be 50% of the membership. There must be at least one local authority and one health Board Member at each meeting.

3. STATUTORY RESPONSIBILITIES OF THE HEALTH AND WELLBEING BOARD

The statutory health and wellbeing board will focus on the following functions:

• To prepare and publish a joint strategic needs assessment

• To prepare and publish a health and wellbeing strategy based on the needs identified in the joint strategic needs assessment and to oversee the implementation of the strategy

• To promote and encourage integrated working including joint commissioning in order to deliver cost effective services and appropriate choice. This includes providing assistance and advice and other support as appropriate, and joint working with services that impact on wider health determinants

4. FUNCTIONS OF THE BOARD

(a) To provide leadership and democratic / public accountability to improve health and wellbeing and reduce inequalities.

(b) To promote integration and partnership working between the NHS, social care, public health and other commissioning organisations.

(c) To assess the robustness of the Joint Strategic Needs Analysis (JSNA) Plan for the local population and to ensure that key commissioning decisions reflect local needs analysis.

(d) To receive the Annual Public Health Report and agree and performance manage the forward plan for Public Health priorities and to review progress.

(e) To develop in the light of the JSNA, a joint Health and Wellbeing Strategy, setting out how the health and well-being needs of the community will be addressed. To set an action plan to take forward the key priorities from the Health and Wellbeing Strategy and to performance manage progress against defined targets.

(f) To support and challenge, as appropriate joint commissioning integrated care and management and pooled budget (Section 75) arrangements as a means of delivering service priorities. This will include pooled budget arrangements established to deliver the Better Care Fund Plans.

(g) To determine appropriate partnership structures required to deliver the Board's responsibilities. To oversee and performance management the work programmes of the Board sub-groups (Children's Trust Board / Transformation Commissioning Board / Public Health Board).

(h) To oversee major partnership service transformation programmes such as the Better Care Fund and to monitor the QIPP (Quality, Innovation, Productivity & Prevention) Programme and other savings programmes which impact on all partners.

(i) To consider options for the development of Local Healthwatch in Wolverhampton ensuring that appropriate engagement and involvement with patient and service user involvement groups takes place. To monitor the continued development of Local Healthwatch and receive regular reports on work undertaken by Healthwatch.

(j) To oversee the governance and partnership arrangements for both Adults and Children's Safeguarding Boards.

(k) Lead on the Joint Strategic Needs Assessment and ensure coherent and co-ordinated commissioning.

(l) Produce a Health and Wellbeing Strategy and an Annual Health Improvement Plan monitor and review these documents on a regular basis.

(m) Ensure decisions of Clinical Consortia and other Commissioners fit with the Health and Wellbeing Strategy and hold them to account for delivery.

(n) To oversee the work of Public Health on health promotion and ill-health prevention campaigns.

(o) Support local voice and patient/ service user and choice by ensuring that the views of local people are used.

(p) To respond to major Government launched Inquiries into Health and Wellbeing issues.

(q) To have an overview of major service reconfiguration by providers of relevant services and make recommendations to those providers to enable improved and integrated service delivery.

(r) To maintain on overview of delivery of outcomes within the NHS, Public Health and Adult Social Care outcomes frameworks.

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Agenda Item No. 11

Health and Wellbeing Board
7 January 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, Wolverhgampton 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	Adult Delivery Board - 10th September 2014

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 an overview of the Mental Health Strategy, including key next steps.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The development and implementation of the Mental Health Strategy, including submission of the Wolverhampton Crisis Concordat Declaration.

1.0 Purpose

1.1 The purpose of this report is to provide members of the Governing Body with an update regarding the implementation of the Mental Health Strategy, including key next steps.

2.0 Background

2.1 The 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 developed following a period of review and has been presented to the CCG Governing Body.

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 (2013-2016) the Suicide Prevention Strategy for England (2013) and Closing the Gap (2013).

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).
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 The Strategy outlines the vision to develop integrated health and social care pathways care pathways as part of the Better Care Fund. The mental health Better Care Fund Care Pathways that ar in development are urgent and planned mental health care.

3.3 A key national driver rergarding the strteafgy development and implementation and the development of the urgent mental health care pathway is delivery of the local Crisis Concordat Declaration and Action Plan. This supports national and local initiatives to prevent people with mental health difficulties developing or entering crisis and moving to recovery in a timely manner if this cannot be avoided. The Wolverhampton Crisis Concordat has been submitted to the National Programme website. A copy of the declaration is attached as Appendix 1. A Wolverhampton Crisis Concordat Action Plan is in development with local key stakeholders and partners. This must be submitted to the National Programme by end March 2015. This is aligned with the draft Wolverhampton Suicide Prevention Plan, a copy of this is attached as Appendix 3.

3.4 Negotiations and discussions with Sandwell and West Birmingham CCG regarding an aligned health model and jointly developed service specifications continue. To date this has focussed potentially joint / aligned models in terms of:

- Eating Disorder Services / Care Pathways.
- Early Intervention in Psychosis Services.
- Children and Yong People's Services.

There are however many other opportunities for collaborative commissioning and these are being explored with Sandwell and West Birmingham CCG and will be developed as appropriate via the Mental Health Strategy Core Group. Collaborative commissioning approaches provide an opportunity for improved patient experience, improved and increased productivity and value for money cost efficiencies by increasing the capacity and capability of services through improved economies od scale.

4.0 Financial implications

4.1 The Strategy outline financial plan utilises some non-recurrent funds to pump prime service model changes and transformation to transition to the new service/s. Starter schemes under the Better Care Fund include Liaison Psychiatry Service and Street Triage. Other non recurrent funds have been used to increase capacity and capability develop the CAMHS Crisis and Early Intervention in Psychosis Services.

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. A period of consultation will be required regarding any proposed changes to mental health services locally, with a requirement to take the revised Strategy to Health Scrutiny Panel.

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 Mental Health Strategy is attached as Appendix 1. This has previously been presented to Adult Delivery Board.

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.

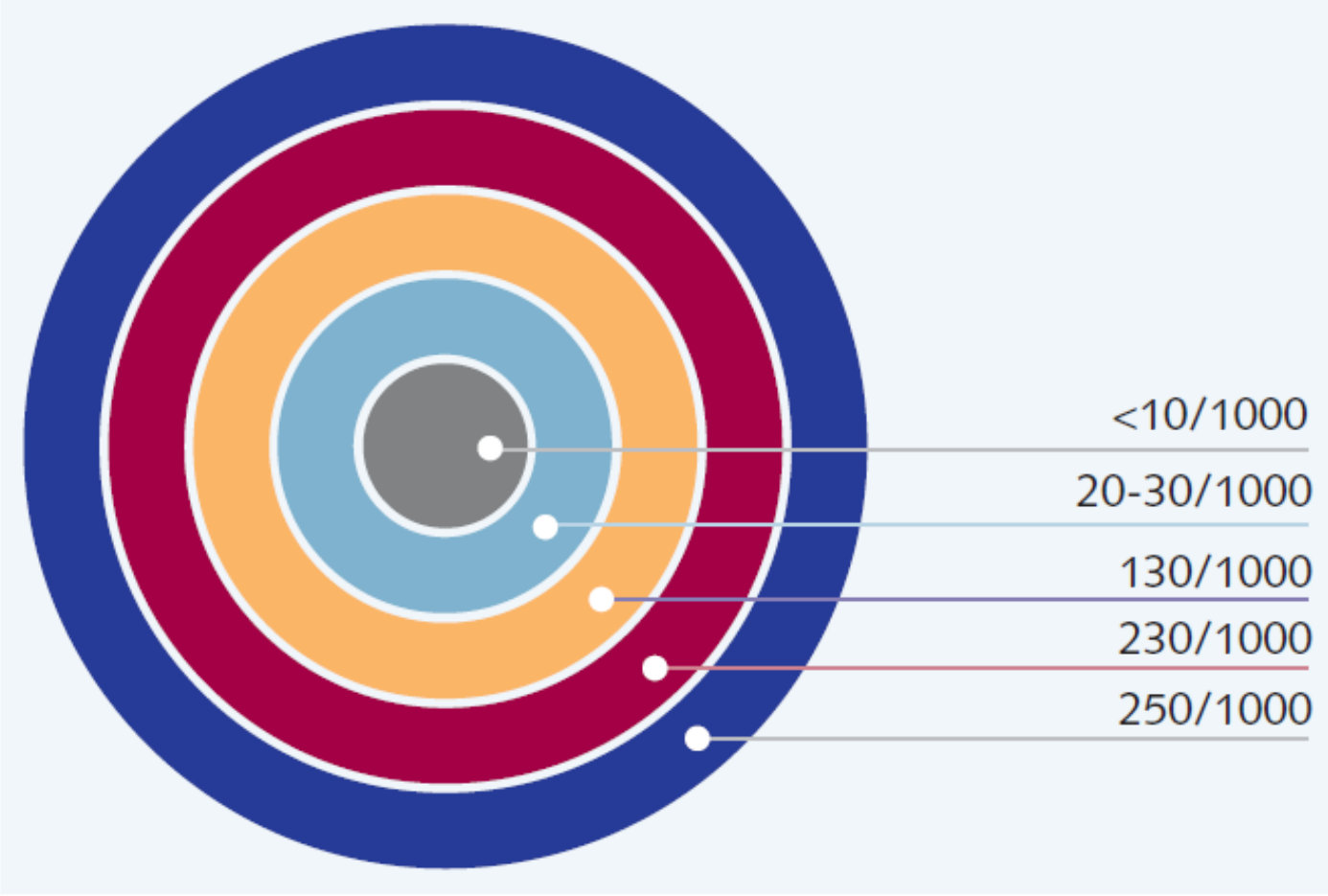
'No Health without Mental Health' (HM Government, 2011) describes three aspects to reducing mental health inequality:

- 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
- 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

- Substance misuse
- Victims of violence, abuse and crime

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
- Numbers of people using adult & elderly NHS secondary mental health services (significantly lower)
- 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)
- Directly standardised rate for emergency hospital admissions for self-harm (significantly better)
- Indirectly standardised mortality rate for suicide and undetermined injury
- Hospital admissions caused by unintentional and deliberate injuries in <18s
- 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 recommendations and actions of the key reports that have informed the development of our Strategy are detailed in Appendix 1.

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).

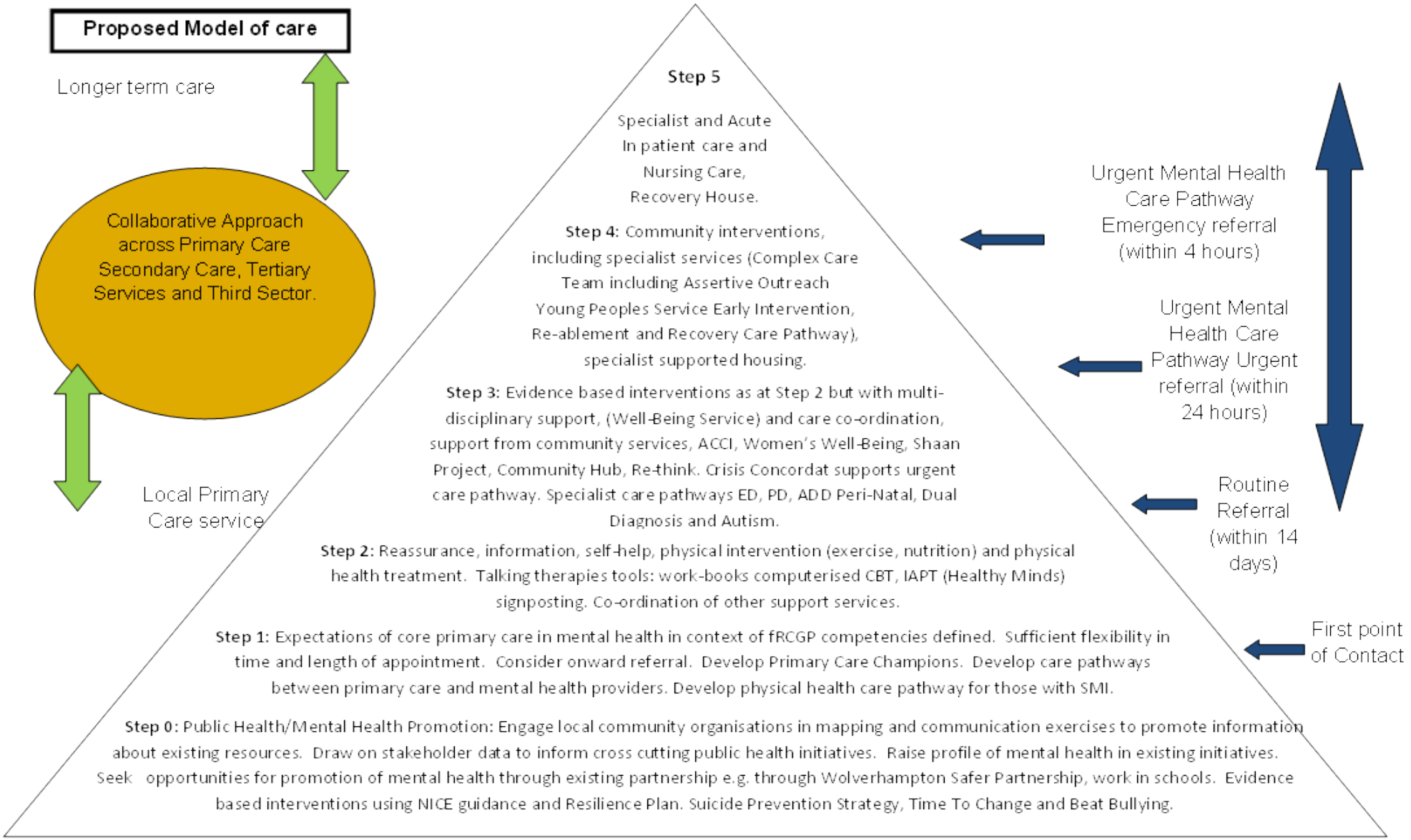
Stepped Care Model

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

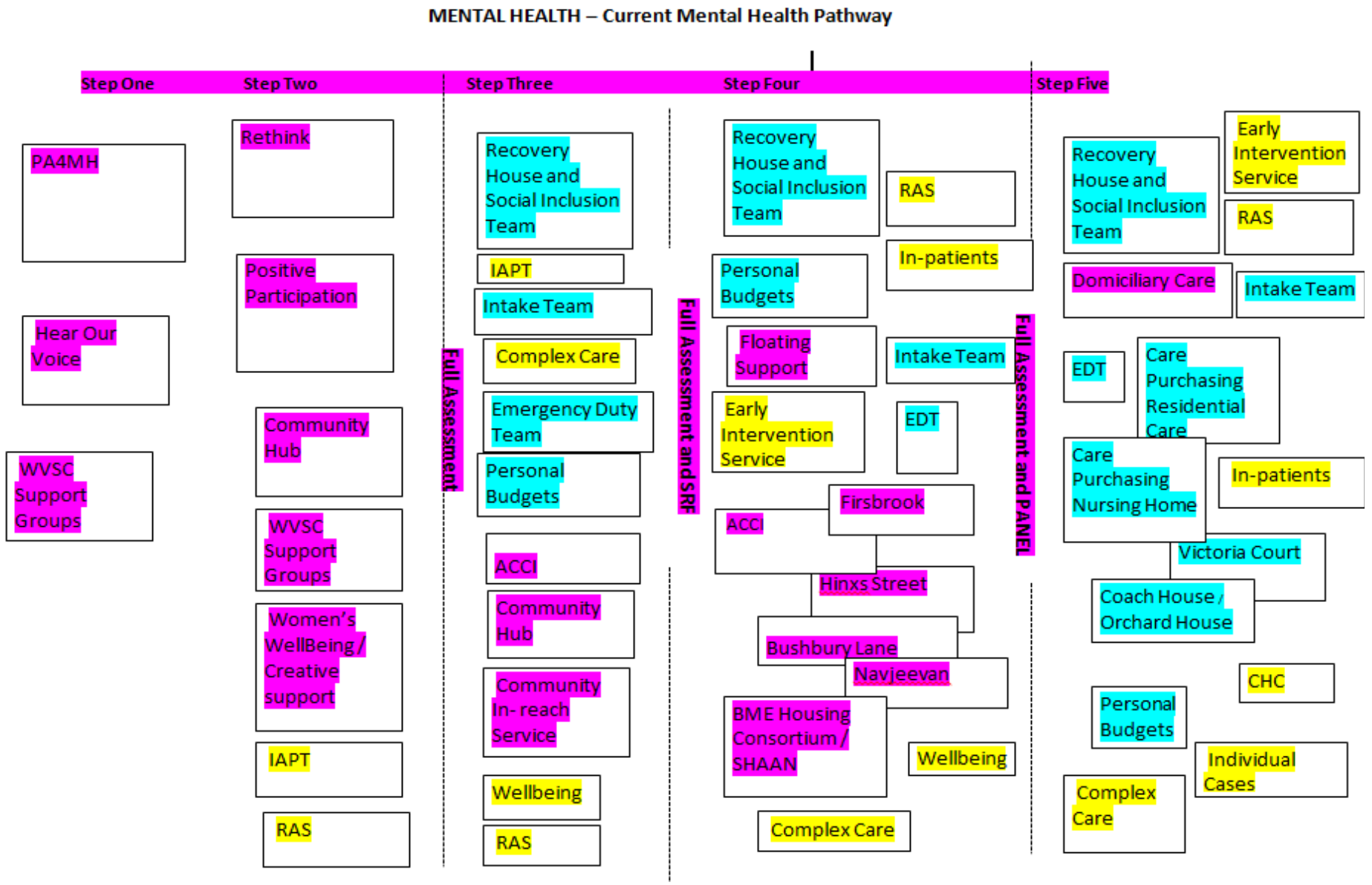
The Better Care Fund

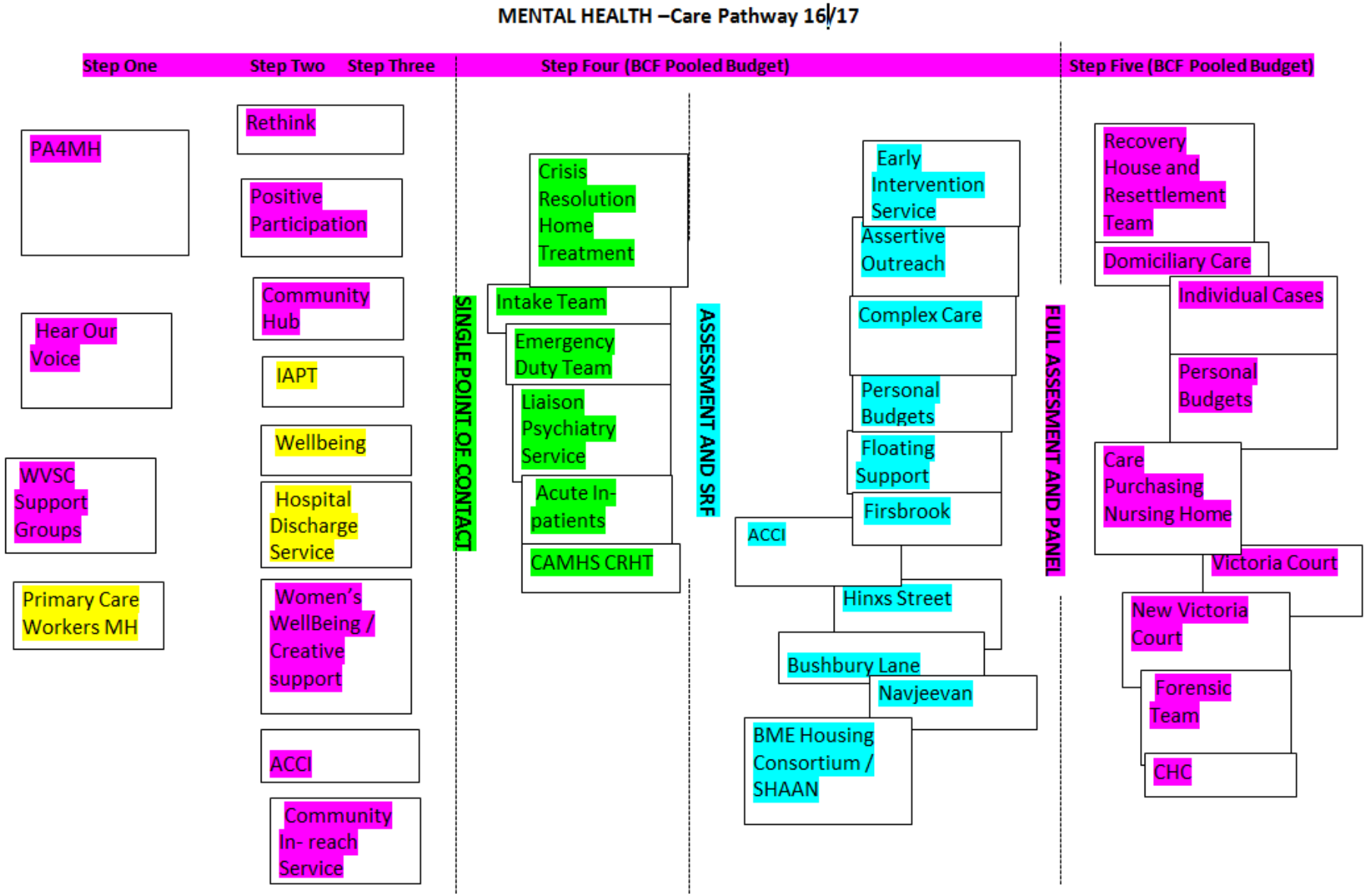
The Better Care Fund provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for mental health services in Wolverhampton. Wolverhampton's Better 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 requires 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 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

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 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

Crisis Care Concordat
Mental Health

WOLVERHAMPTON Declaration statement

The 2014 WOLVERHAMPTON Declaration on improving outcomes for people of all ages experiencing mental health crisis NOVEMBER 2014.

We, as partner organisations in WOLVERHAMPTON will work together to put in place the principles of the National Concordat to improve the system of care and support so that people of all ages in crisis as a result of a mental health difficulty are kept safe and well supported. We will help them to find the help they need whatever the circumstances and from whichever of our services they turn to first.

We will work together to prevent crises occurring whenever possible. We will do this by intervening to support people at risk of mental health crisis an early stage and by ensuring that all of our interventions focus on helping people experiencing mental health difficulties to achieve recovery and stay well.

We will support individuals, families and communities who are particularly vulnerable or at risk and we will ensure that targeted interventions in terms of mental health promotion and crisis prevention and support reach people and communities with the greatest levels of need and vulnerability.

We will respond with awareness and sensitivity to our City's diverse demographic in terms of culture and ethnicity and acknowledge the unique needs of seldom heard groups and communities such as the LGBT community.

We will work together to make sure that we focus on mental health prevention and the development of personal resilience skills across the lifespan.

We will work together to co-ordinate our responses to meeting the needs of vulnerable people in urgent situations. We will ensure that our services work together to make sure that people of all ages receive the right care at the right time from staff who respond with professionalism and compassion to ensure the best possible outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. We will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in WOLVERHAMPTON by putting in place reviewing and regularly updating an action plan.

We will do this working in partnership with service users and carers and working across agencies and with a focus upon the broader determinants of health and mental health.

This declaration supports 'parity of esteem' between physical and mental health care in the following ways:

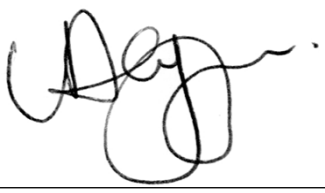
- By agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in WOLVERHAMPTON for help in a crisis. This will result in the

best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.

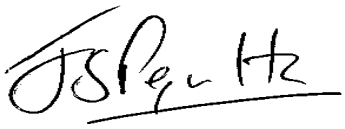
- By working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there are safe and effective services with clear and agreed policies and procedures in place for people in crisis, and that organisations can access services and refer people in the same way as for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to patients and service users, their families and carers, the staff that work in our services and the wider community and by working together to support people of all ages to recover and achieve improved quality of life and wellbeing.

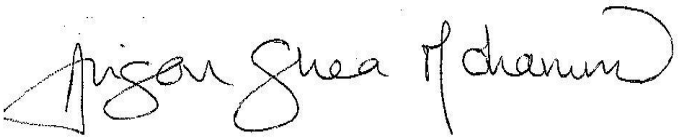
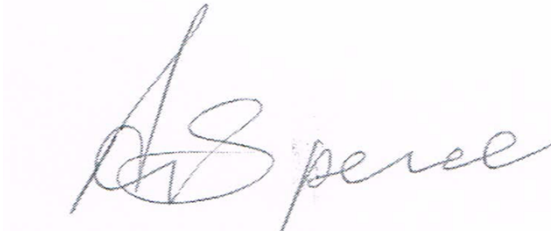
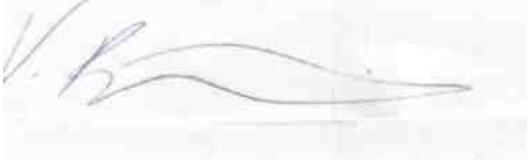
We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in WOLVERHAMPTON**.**

Electronic signatures of Chief Executive Officers and Directors of concordat partners

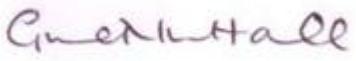
Name	Signature
Helen Hibbs Chief Accountable Officer NHS Wolverhampton Clinical Commissioning Group.	
Noreen Dowd Interim Director Strategy and Solutions, NHS Wolverhampton Clinical Commissioning Group.	
Vivienne Griffin Service Director – Disability & Mental Health, Wolverhampton City Council.	
Sarah Norman Strategic Director – People Wolverhampton City Council.	

Name	Signature
Emma Bennett **Service Director – Children & Young People.**	
Councillor Sandra Samuels - **Cabinet Member for Health and Well Being.**	
Ros Jervis **Director –** **Public Health and Wellbeing.**	
David Ashford **Head of Clinical Practice – Mental Health** **West Midlands Ambulance Service NHS Foundation Trust.**	
Superintendent Allan Gregory **Midland Sub-divisional Commander** **British Transport Police.** BRITISH TRANSPORT POLICE	

Name	Signature
Jas Pejatta **Head of Walsall & Wolverhampton Probation – SWM Community Rehabilitation Company.** Staffordshire & West Midlands Community Rehabilitation Company PROBATION	
David Jamieson **West Midlands Police and Crime Commissioner.** west midlands police and crime commissioner	
Dave Edwards **Operations Commander** **West Midlands Fire Service.** WEST MIDLANDS FIRE SERVICE	
Anna Lunts **Chief Executive** **Creative Support**	 creative SUPPORT

Name	Signature
Mr Melvin Passmore **Wolverhampton Mental Health Stakeholder Forum.**	
John Wade **Managing Director for Support, Innovation & New Ventures Bromford Housing Association.**	John Wade Bromford.
Alison Shea Mohammed **Chief Operating Officer** **Rethink.** Rethink Mental Illness.	
Alicia Spence **Afro-Caribbean Cultural Initiative.**	
Vanessa Biddulph **Service Manager** **Voiceability.** **Black Country** VoiceAbility	 Advocacy Q P M Quality Services

Name	Signature
Lesley Roberts **Chief Executive Officer** **Wolverhampton Homes.** Wolverhampton Homes	
Janet Meredith, Project Co-ordinator **Base 25.** base 25	
Jamie Edwards **National Probation Service**	

Name	Signature
Mike O'Hara **Superintendent – Local Policing** **Wolverhampton LPU**	
Karen Dowman, Chief Executive	
Gwen Nuttall **Chief Operating Officer** **Royal Wolverhampton NHS Trust**	

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe
Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: "Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 1993) Further information http://www.imroc.org/

Action Area	Action Required	Next Steps	Date	Lead/s
1. Develop Local Suicide Prevention Group	Suggest use Stakeholder Forum for this purpose with 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.	Develop Plan	By March 2015	SF
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	Develop Plan	By March 2015	SF

Action Area	Action Required	Next Steps	Date	Lead/s
Page 166	• 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.** Working with: • CCGs • Local Authority • Public Health • Mental health Trusts / Providers • Police • 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.			

Action Area	Action Required	Next Steps	Date	Lead/s
3. Align with Health and Well-Being Board MH Priority Area (Resilience Plan))	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. http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=2944&p=0	Align detail in H+WB STRATEGY (MH Priority Area) with Plan	By January 2015	SF
4. Monitor and analyse data, trends and hot spots	Data Analysis Needs Assessment Hotspots • Focus Vulnerable Groups • BME Groups LGBT / LGBTQ Self-harm, Veterans, Un-employed, Peri-natal Mental health, victims of abuse CAMHS Older People Dual Diagnosis People with SMI and Bullying • Focus Hotspots	Identify and analyse all sources of relevant data to inform plan.	By January 2015	Public Health and CDWs
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	Align detail in Mental Health Strategy with Plan Identify key action areas	By February 2015	SF / MG / SS /BCPFT

<table>
<tr><th>Action Area</th><th>Action Required</th><th>Next Steps</th><th>Date</th><th>Lead/s</th></tr>
<tr><td></td><td>• Single Point of Access</td><td></td><td></td><td></td></tr>
<tr><td>6. Focus on Self-Efficacy and Locus of Control</td><td>• 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</td><td>Align detail in Mental Health Strategy with Plan

Identify key action areas</td><td>By February 2015</td><td>SF / MG</td></tr>
<tr><td>7. DEVELOP CRISIS CONCORDAT</td><td>• Make Wolverhampton Declaration by December 2014.
• Submit Local Wolverhampton Crisis Concordat Plan by March 2015.

<table><tr><td>Mental Health Crisis Care Concordat principles:</td></tr><tr><td>A. Access to support before crisis point.</td></tr><tr><td>A1. Early intervention – protecting people whose circumstances make them vulnerable.</td></tr><tr><td>B. Urgent and emergency access to crisis care.</td></tr><tr><td>B1. People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery.</td></tr><tr><td>B2. Equality of access.</td></tr><tr><td>B3. Access and new models of working for children and young people.</td></tr><tr><td>B4. All staff should have the right skills and training to respond to mental health crises appropriately.</td></tr><tr><td>B5. People in crisis should expect an appropriate response and support when they need it.</td></tr><tr><td>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.</td></tr><tr><td>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.</td></tr><tr><td>B8. People in crisis should expect that statutory services share essential ‘need to know’</td></tr></table></td><td>Align detail in Mental Health Strategy

Identify key action areas</td><td>By December 2014 and March 2015</td><td>SF / All</td></tr>
</table>

Action Area	Action Required	Next Steps	Date	Lead/s
	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 ongoing 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 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	Identify key action areas	By February 2015	SF / MG PA4MH
9. Work on local priorities to improve mental health (broader determinants)	Focus on: • Housing • Employment • Debt Counselling • Benefits	Identify key action areas	By February 2015	SF / MG Local Authority Colleagues

Action Area	Action Required	Next Steps	Date	Lead/s
	• Bullying • Leisure • Dual Diagnosis • Parents • Employers • Schools			
10. Work on local priorities to improve mental health (physical health)	• Physical Health • Parity of Esteem • 5 Ways to Well-Being	Identify key action areas	By February 2015	SF / Public Health Colleagues
11. Hotspots	• Identify hotspots / areas of vulnerability • Work with transport to map hot spots • Reduce access to the means of suicide • Focus on cyber bullying • Focus on schools	Identify key areas of vulnerabilities and action areas	By February 2015	SF / All
12. Communication and Media	Support the media in delivering sensitive approaches to suicide and suicidal behaviour Include focus on: • Help lines • Twitter	Identify key action areas	By February 2015	SF /All
13. Training	Identify suitable stakeholder training Consider Peer Support Model Align with HeadStart	Identify key action areas	By February 2015	SF / All

Agenda Item No. 12

Health and Wellbeing Board

7 January 2015

Report title	**Update from the Wolverhampton Clinical Commissioning Group in response to the Francis Inquiry**
Cabinet member with lead responsibility	Councillor Sandra Samuels Chair Health and Wellbeing Board
Wards affected	All
Accountable director	Linda Sanders - People
Originating service	Wolverhampton City Clinical Commissioning Group
Accountable employee(s)	Manjeet Garcha Tel:01902 442476 Email:Manjeet.garcha@nhs.net
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Note and comment on the content of the report.

1.0 Purpose

1.1 The purpose of this report is to update the Health and Wellbeing Board on the progress with recommendations of the Robert Francis QC Mid Staffordshire Foundation NHS Trust Public Inquiry.

2.0 Background

2.1 Sir Robert Francis was commissioned in July 2009 to chair a non-statutory inquiry into the happenings at Mid Staffordshire. The primary purpose of this being to give a voice to those who had suffered and to consider what went wrong. This initial report was published in February 2010.

3.0 Progress, options, discussion, etc.

3.1 Attacheed as an Appendix is the current position on the work undertaken to date by the Wolverhampton City Clinical Commissioning Group in response to the Francis Inquiry.

4.0 Financial implications

4.1 None arising directly from this report.

5.0 Legal implications

5.1 None arising directly from this report.

6.0 Equalities implications

6.1 None arising directly from this report.

7.0 Environmental implications

7.1 None arising directly from this report.

8.0 Human resources implications

8.1 None arising directly from this report.

9.0 Corporate landlord implications

9.1 None arising directly from this report.

10.0 Schedule of background papers

10.1 None.

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Update from the Wolverhampton Clinical Commissioning Group in response to the Francis Inquiry

To Health and Wellbeing Board 7 January 2015

Executive Summary

Sir Robert Francis was commissioned in July 2009, to chair a non-statutory inquiry into the happenings at mid Staffordshire. A recommendation was made that there needed to be an investigation into the wider system to consider why issues had not been detected earlier and to ensure that the necessary lessons were learned. The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry made 291 recommendations, grouped into themes. It was recommended that all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations and decides how to apply them to their own work.

Recommendation

The Board is requested to note and comment on the work undertaken so far.

Background

Sir Robert Francis was commissioned in July 2009 to chair a non-statutory inquiry into the happenings at Mid Staffordshire. The primary purpose of this being to give a voice to those who had suffered and to consider what went wrong. This initial report was published in February 2010.

Key themes of the report included:

- Lack of basic care
- A culture not conducive to providing good care
- Management focus was on financial pressures and achieving Foundation Trust status
- Management failed to remedy deficiencies in staff and governance
- Lack of urgency in response to problems, complaints
- Focus on systems and not outcomes
- Lack of internal and external transparency

A key issue raised was the role played by external organisations which had oversight of the trust.

A recommendation was made that there needed to be an investigation into the wider system to consider why issues had not been detected earlier and to ensure that the necessary lessons were learned. As such, another inquiry was commissioned and the report of the *Mid Staffordshire NHS Foundation Trust Public Inquiry*[i] was finally published in February 2013 with 291 recommendations, grouped into themes. Where possible, recommendations identified the organisation which it suggested should take them forward. It was recommended that all commissioning, service providers, regulatory and ancillary organisations in healthcare consider the findings and have an action plan to apply and monitor in own areas of work.

The Governments initial response, *Patients First and Foremost*[ii], set out plans to prioritise care, improve transparency and ensure that where poor care is detected, there is a clear action and clear accountability. *Hard truths – the journey to putting patients first, the government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry*[iii] builds on this to provide a detailed response to the 291 recommendations the Inquiry made across every level of the system.

Key Drivers

National Reports published since 2001 have resulted in a minimum of 911 recommendations.

Year	Key Report	No of Recommendations
2001	The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995	198
2002-5	The Shipman Inquiry	190
2009	Mid Staffs Review- Dr David Colin Thome	24
2009	Mid Staffs Review- Professor Alberti	23
2010	Colin Norris Inquiry 2010	32
2010	RF 1 March 2009 (Robert Francis QC)	18
2010	The Airedale Inquiry (Kate Thirwell QC)	6
2012	Winterbourne Review	56
2012	Morecambe Bay	35
2013	RF2 Feb 2013 (Robert Francis QC)	290
2013	Don Berwick- a promise to learn	10
2013	Bruce Keogh- Review of 14 NHS Trusts	8
2013	Ann Clwyd MP & Professor Tricia Hart- Review of NHS Hospitals Complaints Systems	4
2013	Cavendish Review- Healthcare assistants and support workers in NHS settings	2
2014	Hard Truths- Government Response to RF2	5
2014	Kennedy Breast Care Review	10
2015	Awaited Robert Francis review of Whistleblowing	tbc
Total		911

Current Position

Amongst the plethora of reports and hundreds of recommendations, there is a consistent theme for all commissioners, service providers and regulators in Wolverhampton. These are:

Theme	Monitoring Already	Further/ongoing work planned
Preventing Problems	Patient Safety, openness & candour, listening to patients.	Culture & Safe Staffing
Detecting Problems Quickly	Expert inspection teams, mortality outliers & Quality Surveillance Group. Cross triangulating softer intelligence with local authority safeguarding teams and making a timely decision to suspend further admissions into care/nursing homes if there are concerns.	CCG/CQC visits taking place at night & weekends, embedding the new CQC inspection standards and framework
Taking Action Promptly	Timely and appropriate challenge to the person/persons with authority to respond accurately	Aspiring FTs will be required to achieve good or outstanding to be authorized.
Ensure Robust Accountability	CCGs focus on Quality & Outcomes. Clinical Quality Review Meetings Contract meetings, escalation and governance processes. NHS England assurance	Recognising the new criminal offence(s) wilful or reckless neglect or mistreatment of patients.
Ensuring Staff are Trained & Motivated	Staff engagement/feedback. Right staff with the right skills in the right place. Recruitment and workforce development strategies	Implementation of new Staff Engagement Guidance – essential for creating positive cultures of safe & compassionate care.

Safety and openness	Transparent, monthly reporting of ward by ward staffing levels and other safety measures. Quarterly reporting of complaints data and lessons learned by provider along with better reporting of safety incidents Statutory duty of candour on all providers and professional duty of candour on all individuals. Providers are liable if they have not been open with patients	Ongoing monitoring to ensure changes are sustained. Changes to professional codes of practice awaited and Plan for 5000 safety fellows to be trained and appointed in next 5 years Dedicated provider safety websites awaiting to be developed for the public

National Drivers

National movement since RFII includes:

- A new Chief Executive for the NHS
- Ongoing Sir Bruce Keogh and Sir Mike Richards Mortality Reviews
- CQC Chief Inspector of Hospitals recruited
- a new criminal offence for wilful neglect, with a government intention to legislate so that those responsible for the worst failures in care are held accountable
- a new fit and proper person test, to act as a barring scheme for senior managers
- every hospital patient to have the names of a responsible consultant and nurse above their bed
- a named accountable clinician for out-of-hospital care for all vulnerable older people.
- more time to care as all arm's length bodies and the Department of Health have signed a protocol in order to minimize bureaucractic burdens on trusts
- a new care certificate to ensure that healthcare assistants and social care support workers have the right fundamental training and skills
- a new fast-track leadership programme to recruit clinicians and external talent to the top jobs in the NHS in England
- safer staffing levels declared monthly with evidence of board updates
- a new patient safety alert system
- overhaul planned for the current serious incident system
- Establishment of Quality Surveillance Groups

Report Author

Manjeet Garcha
Director of Nursing and Quality
Wolverhampton Clinical Commissioning Group

[i] The Mid Staffordshire NHS Foundation Trust Public Inquiry. Chaired by Robert Francis QC. House of Commons Feb 2013

[ii] Putting Patients First: government publishes response to Francis Report. DOH. 26th March 2013

[iii] Hard Truths: The Journey to Putting Patients First. Vol One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry. DOH. January 2014

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Agenda Item No. 14

Health and Wellbeing Board

7th January 2015

Report title	Provision of planned care services by The Royal Wolverhampton NHS Trust at Cannock Chase Hospital – public consultation final report	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, Community	
Originating service	The Royal Wolverhampton NHS Trust and Wolverhampton Clinical Commissioning Group	
Accountable employee(s)	Maxine Espley Noreen Dowd Tel Email	Director of Planning & Contracting, RWT Interim Director, WCCG 01902 695944 Maxine.espley@nhs.net
Report to be/has been considered by	Health Scrutiny Panel	November 2014

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Note the final report and the action plan responding to the recent public consultation exercise

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. Note the final report from the public consultation, the Equality Analysis report, the detailed survey analysis and the Action Plan responding to the public feedback.

1.0 Purpose

a. To provide the Health and Wellbeing Board with the final report on the joint consultation undertaken by The Royal Wolverhampton NHS Trust (RWT) and Wolverhampton Clinical Commissioning Group (WCCG) between 18 July and 17 October on proposals to move some planned care services to Cannock Chase Hospital. This will follow the transfer of Cannock Chase Hospital to RWT as part of the acquisition of services and estate from Mid Staffordshire NHS Trust.

b. The previous reports to the Board have outlined the clinical model for Cannock Chase Hospital which was developed and endorsed by the clinical teams within the Trust and was subject to scrutiny and approval from the National Academy of Royal Colleges during the Trust Special Administrator approval process and is consistent with a number of models across the country. The opportunity to develop this model has arisen due to funding made available to the Trust as part of the solution for services that were delivered by Mid Staffordshire Foundation Trust. This financial support would not have been available to the Trust under normal operating and would not have been affordable within the contracting arrangements with the CCG.

c. The Board has also received previous updates on the consulattion exercise, the mechanisms to communicate with the public and the interim feedback and themes.

2.0 Background

2.1 Consultation events

Four local 'round table' events were held across Wolverhampton's three localities (SE, SW and NE) and the city centre, each comprised approximately 50 places. The sessions gave people the opportunity to learn about the proposals and take part in a discussion exercise that led to completion of the survey questions. The events, held from 6-8pm, were as follows:

- Wednesday 6 August, Mercure Wolverhampton, Penn Road.
- Tuesday 12 August, The Workspace, All Saints Road, Wolverhampton.
- Tuesday 2 September, Wolverhampton Science Park.
- Wednesday 8 October, The Molineux.

2.2 Communications

Raising awareness of the proposals and the opportunities people have to get involved was of prime importance. To ensure this happened there was a comprehensive communications schedule (shown below) that supported promotion of the consultation and ensured that as many people as possible had the opportunity to comment on the proposals:

Type of	Description	Took place

communication		
Website	A consultation website was established in order to provide information about the consultation. Contained documents translated in a range of community languages.	18 July 2014
Letter to councillors, MPs, Healthwatch, GPs, providers	This provided notice of the consultation (outline proposals had already been shared with some of these bodies).	18 July 2014
Staff message within RWT/WCCG	This provided notice of the consultation.	18 July 2014
Joint press briefing and/or news release – launches consultation	Brief provided to the media with a follow-up option of a face-to-face briefing.	18 July 2014
Announcement on the start of the consultation sent to all stakeholder groups	Sent by email with a link to the web resources. Added to the Wolverhampton One City database.	18 July 2014
Poster and copies of the consultation document sent to GP practices, hospital waiting areas and other community venues	Summarised the consultation process and set out how people could get involved.	18 July 2014
Email	Consultation information sent to relevant groups	18 July 2014
News release – round-table events	Invited residents to have their say, messaging about reasons for consultation, why it's important people get involved. Where and when. Highlighted other ways people could get involved if they couldn't attend on the day.	28 July 2014
Email reminder	Reiterates key messages. Sent to: • Healthwatch • WVSC • Staff/members within WCCG/RWT/Wolverhampton City Council • RWT patient members • CCG patient members	28 July 2014
Email to carers' groups	A reminder of key messages sent to recipients of the carers' newsletter.	30 July 2014
Signal radio interview	Maxine Espley took part in a 5 minute	30 July

(Maxine Espley)	interview on Signal 107 radio to promote key messages and opportunities to get involved.	2014
Information stall at Family Fun Day event, Lowhill	This was an opportunity to meet with local residents at Low Hill to share/discuss proposals and promote the engagement events.	7 August 2014
Email reminder for open events	Reiterated key messages. Sent to: • Healthwatch • WVSC • Staff/members within WCCG/RWT/SESSPCC/ Wolverhampton City Council/ • RWT patient members • CCG patient members To update people on the consultation.	13 August 2014
BBC WM radio interview	Gwen Nuttall took part in a live radio interview to promote key messages and opportunities to get involved.	15 August 2014
Update media release	To update people on the consultation.	w/c 18 August 2014
Wolverhampton Today (social media)	A story added to the council's Facebook page having over 30k followers (see measures below).	w/c 18 August 2014
Follow up calls to patient and public groups	Courtesy call to check receipt of document, respond to any queries and offer meetings.	w/c 18 August 2014
Pop up event – Mander Centre	Opportunity to promote key messages and opportunities to get involved	28th August 2014
Consultation documents	Further consultation documents sent to all practices, libraries, community clinics, pharmacies and dentists. A new poster was shared to promote the new event date and consultation documents were redesigned to include the new consultation end-date.	1 September 2014
Health & Wellbeing Board meeting	RWT/WCCG directors presentation to the H&WB on the proposals	3rd September
Signal 107 radio campaign	A radio campaign that ran with one minute messages played out multiple times per day took place on Signal Radio	15 September – 17

	(107 FM) to highlight the consultation and opportunities to get involved.	October
wcfFM – radio interview	Addressed questions/comments highlighted by the community to the radio station.	w/c 15 September
Email reminder for open events	Reiterated key messages. Sent to: • Healthwatch • WVSC • Staff/members within WCCG/RWT/SESSPCC/ Wolverhampton City Council/ • RWT patient members • CCG patient members Updated people on the consultation.	15 September
Equality survey	To seek views from hard to reach groups and those with protected characteristics	15 September – 17 October 2014
WCCG AGM	Opportunity to promote key messages and opportunities to get involved	16th September 2014
Healthwatch meeting	Executive teams from RWT/WCCG to meet Wolverhampton Healthwatch Board members to discuss the proposals	22nd September 2014
City Carer Magazine – Autumn edition	An article on the consultation featured in the local authority's newsletter aimed at carers in the city.	w/c 22 September
Practice Managers' meeting	Requested that PMs continue to promote the consultation.	24 September
Healthy Lungs pop-up shop	This saw the CCG meet over 700 shoppers at a pop-up shop in the Mander Centre. A stall on the consultation allowed people to take consultation documents, ask questions and have their say.	26 – 27 September
RWT AGM	Opportunity to promote key messages and opportunities to get involved	29th September 2014
Media release	Highlighted that people had just under three weeks to get involved.	w/c 29 September

2.3 Communication reach

During the consultation period the Trust and CCG used a range of methods to get the greatest coverage across the City and across the population to increase the number of

people engaging with the consultation and giving their feedback. The table below outlines some of the activities:

Twitter (Wolverhampton CCG)	**33 posts sent to 2,437 followers** 34,831 followers – many more reached through shares
Facebook	28 August Post – 53 likes, 90 comments, 134 shares Themes from comments: services should stay within Wolverhampton; travel concerns; new facilities should be built in Wolverhampton if New Cross cannot accommodate all services necessary; concerns around Dermatology and Rheumatology clinics moving to Cannock.
	16 October Post – 2 likes, 5 comments, 1 share Themes from comments: travel concerns; positive move that reduces pressure on New Cross Hospital.
Consultation web page (CCG/RWT)	More than 2769 visits
Number of consultation documents printed and distributed	**5000**
Paper feedback forms received	**318**
Electronic feedback forms received	**346**

A campaign ran with Signal107 Radio during which street teams attended a number of local places to share information and speak to people about the proposals. This programme covered the locations below:

- Bilston – Thursday 25 September
- Wolverhampton & Willenhall – Friday 26 September
- Tettenhall – Saturday 27 September
- Bilston – Thursday 9 October
- Penn – Thursday 9 October
- Migrants' Centre – Monday 13 October

2.4 Media coverage

We achieved six stories in the local media, some of which were planned, some were reactive i.e. in response to an enquiry. The reporting was generally factual and

neutral/positive – conveying the consultations key messages. The items were also fairly prominent in the publication.

2.5 Equality and diversity research methodology

As part of the equality impact assessment, an Equality Survey was undertaken with key equality and diversity groups. The survey report is attached at appendix 1. The recommendations from the survey findings are encompassed within the Action Plan.

3.0 Overall summary of findings

There were 664 formal responses to the survey. In addition Wolverhampton Breast Care Action Group collected a petition of around 8,000 signatures which was primarily focussed on retaining all breast surgery at New Cross Hospital. The points below provide the summary of the findings, the detailed analysis is shown at appendix 2.

- The survey recorded a high level of concern regarding the proposals to move some planned care services from New Cross Hospital to Cannock Chase Hospital, with two thirds of respondents scoring their level of concern as a 5 or 4 out of 5 for all three different types of planned care. It became evident during the consultation that there was misunderstanding about the proposals and also some misinformation which is likely to have contributed to the level of concern. Steps to address this are detailed in the action plan
- There was marginally more concern about ‘Day case surgery’ than ‘In-patient surgery’ and least concern about ‘Day case treatment’.
- Concern was highest amongst those whose mobility was limited a lot by a health problem or disability, those without access to a car and those that live alone. The Trust has already put plans in place to mitigate these concerns, detail is described in the action plan, the Equality Analysis report and elsewhere in this report
- Travel issues were overwhelmingly the most common concern. Frequent travel concerns included the distance/ time, and accessibility and the transport arrangements**.** There was a great deal of concern about the use of public transport by those without access to cars, and the elderly and disabled; particularly to get to the hospital in time for an early appointment and going home on a bus after an operation. There was also frequent concern expressed about the cost of travel and visitor access. The Trust has already put plans in place to mitigate these concerns described in the action plan
- Many stated a preference to keep all care ‘local / at New Cross/ Wolverhampton’ and did not want change. Many felt it was their right to be treated at a local hospital, or expressed preference for New Cross. They were concerned about Cannock’s facilities and reputation, and did not want to go to an unfamiliar hospital.
- The biggest specific care concern was about the lack of Emergency Care facilities at Cannock- there was concern for what would happen if there were complications and the patient needed emergency care, or an unplanned post operative stay.

- There was also concern about the logistics of splitting care over two hospitals. This included concern about patient records not being available at both sites, and access to consultants.

4.0 Responding to the Consultation findings

Whilst the overall number of responses to the survey is relatively small when compared with the population of Wolverhampton they have provided the Trust and CCG with important information which must be taken account of during the detailed planning of individual specialty service changes. The timeline for changes has been staggered to ensure that there can be learning from service changes as the happen and remedial actions taken as they apply to each patient group.

An action plan has been developed and is attached at appendix 3. It identifies actions to be taken primarily by the Trust in response to the themes identified within the survey responses and has been grouped as follows:

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

It is proposed that the Trust and CCG provide an update on progress to the Board on a regular basis to give assurance that areas of concern are being addressed and mitigated.

The Trust and CCG are clear that clinical services delivered at Cannock Chase Hospital will be consistent with those approved by the National Clinical Advisory Group. As with all service changes there will be an ongoing evaluation of the changes .

5.0 Why are we doing this – A reminder

- A better experience for all patients
- Improved quality of clinical services and health outcomes
- Keeping local services safe - a clinically and operationally sustainable service model
- Treatment in an improved environment
- More effective use of public resources

Change is difficult for everybody – we need to work with our patients and their families to make these changes work for them.

Midlands and Lancashire Commissioning Support Unit

Proposals to deliver some planned care at Cannock Chase Hospital for Wolverhampton patients

Survey Analysis

NHS Wolverhampton Clinical Commissioning Group

The Royal Wolverhampton NHS Trust

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Proposals to deliver some planned care at Cannock Chase Hospital for Wolverhampton patients

Survey Analysis

1. Introduction

The Royal Wolverhampton NHS Trust (RWT) and Wolverhampton Clinical Commissioning Group (WCCG) propose to move some planned care services from New Cross Hospital to Cannock Chase Hospital. This will follow the transfer of Cannock Chase Hospital to RWT on 1 November 2014 as part of the transfer of services from Mid Staffordshire Foundation Trust.

A public consultation was held from 18 July to 17 October 2014.The consultation included four public events around Wolverhampton, an information stall at local events, a website, radio and press coverage, posters at GP surgeries, and direct communication with key stakeholder groups including, Healthwatch, NHS staff , RWT/CCG patient members, and carer groups.

Feedback was collected via a consultation survey, email, letters, Facebook and a petition. This report summarises the response to the survey. A total of **664 responses** were received, of which 318 were paper copies, the rest were entered directly via the Survey Monkey web survey.

This document provides the detailed analysis of the responses to the consultation. It provides no comments in relation to the responses and observations made by those responding to the survey. The report to Health Scrutiny Panel and the Action Plan describe actions to be taken primarily by the Trust in response to the themes identified within the survey responses which have been grouped as follows:

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

The Trust and CCG would like to thank those who responded to the survey and attended meetings for taking the time to share their views on the proposals

2. Survey Findings

2.1 How concerned were people about the proposals?

Concern expressed by total sample

The questionnaire asked about the level of concern regarding the provision of some planned care services at Cannock Chase Hospital for adults. The same question was asked for three different types of planned care, which were described as follows;

	Q1- Day case surgery	**Q2- Inpatient Surgery**	**Q3- Day Case treatment**
This means...	" Surgery with operating theatre facilities and/or a general anaesthetic where you will visit the hospital for up to one day and won't stay there overnight"	" Operations where you need to remain in hospital overnight or longer after the surgery is completed, for care or observation"	"Medical treatment where you will stay at hospital for up to one day and won't stay overnight"
Examples;	• **General surgery** (examples include hernia repair and gall bladder surgery) • **Orthopaedics** (includes hip, knee, foot, ankle and upper limb surgery) • **Breast surgery** • Urology (includes bladder and kidney) • **Dermatology/plastic surgery** (removal of lumps and lesions)	• **General surgery** (examples include hernia repair and gall bladder surgery) • **Orthopaedics** (includes hip, knee, foot, ankle and upper limb surgery) • **Breast surgery** • Urology (includes bladder and kidney) • **Dermatology/plastic surgery** (removal of lumps and lesions)	• **Endoscopy** (examples include colonoscopy and gastroscopy) • **Rheumatology** (includes day care and intravenous treatment for conditions such as rheumatoid arthritis) • **Dermatology** (includes phototherapy, intensive topical skin treatments)

The responses indicated a high degree of concern with all three areas, with about half those who responded scoring their level of concern as 5 out of 5 in each case. A further 16-17% scored their concern at 4.

Q. To what extent do these proposals concern you? ('1' being not at all concerned and '5' being very concerned)			
Score out of 5	**Q1- Day Surgery**	**Q2- Inpatient Surgery**	**Q3- Day Case treatment**
Base (Number responding)	*647*	*594*	*573*
5	53%	53%	49%
4	17%	16%	16%
3	12%	12%	13%
2	7%	5%	7%
1	11%	13%	15%
Mean Score	**3.94**	**3.90**	**3.76**

There was minimal difference in the responses to the three areas with marginally more concern about 'Day case surgery' than 'In-patient surgery' and least concern about 'Day case treatment'. This was reflected in an increasing percentage scoring 'In-patient surgery' and 'Day case treatment' as '1' indicating they were not concerned by these at all. But the % scoring their concern as 1 out of 5 was at a low level for all three areas. The response about daycase surgery illustrates the misunderstanding about the proposals – the Trust has clearly stated that for the majority of patients (c.90%) day surgery will continue to be delivered at New Cross.

The number of people responding to each question reduced with each question- this may be due to 'survey fatigue' or it may reflect less concern for the provision of 'In-patient surgery' and 'Day case treatment' at Cannock.

Concern expressed by key sub-groups

The following table shows that concern was greatest amongst those whose mobility was limited a lot by a health problem or disability, those without access to a car and those that live alone. Older people (aged 65+) were slightly less concerned than the total population, suggesting that it is not age alone that creates concern about these proposals, but factors which limit mobility and access to Cannock Chase Hospital.

	Q. To what extent do these proposals concern you? ('1' being not at all concerned and '5' being very concerned)			
Sub-group	**Base***	**% Scoring 5/5= Very concerned**		
		Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case treatment**
Total Sample	**647**	**53%**	**53%**	**49%**
Activities limited a lot by health/disability	103	70%	73%	70%
Activities limited a little by health/disability	129	51%	52%	48%
Without access to a car	193	59%	58%	52%
Age 65+	162	51%	48%	39%
Live alone	147	59%	56%	53%

** Number answering Q1. (Bases for Q2 and Q3 are less)*

What were the reasons for concern or lack of?

Overview of reasons for concerns/ no concern

After each question respondents were invited to 'briefly list up to three reasons why you are concerned or not concerned'. Most took advantage of this opportunity listing several reasons for each question. (Many gave more than three reasons) The number of responses and reasons given was as follows:

Q. Briefly list up to three reasons why you are concerned or not concerned'.				
	Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case**	**Total**
Number of responses	1325	1008	897	3230

'Reasons' given	1459	1075	944	3478

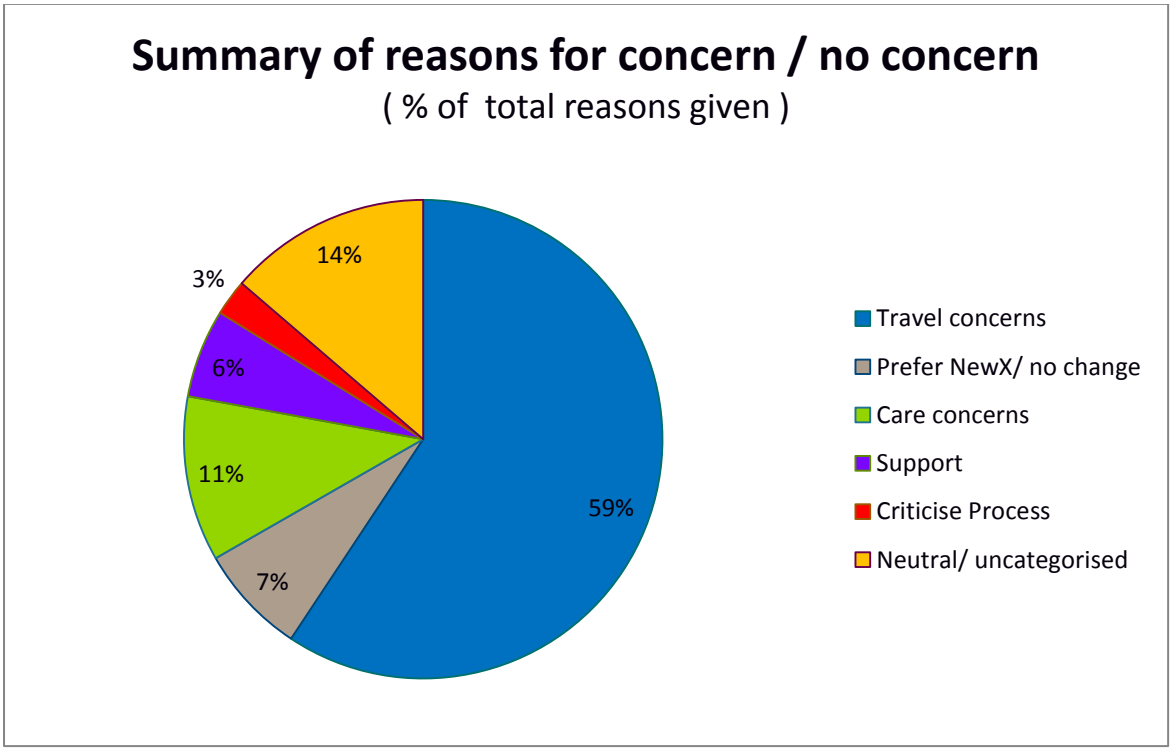
The responses and reasons given reduced for each question, probably suggesting 'survey fatigue' as the responses were often repetitive, listing the same reasons each time; some wrote in "same as previous question" or similar. However it may also reflect less concern for the provision of 'In-patient surgery' and 'Day case treatment' at Cannock.

All the responses made were analysed and all reasons given were 'coded' to identify the most frequently mentioned reasons. The table below shows how the responses split into reasons for concern (negative to proposals), reasons not concerned (positive to proposals), and neutral or uncategorised responses.

Q. Briefly list up to three reasons why you are concerned or not concerned'.				
	Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case**	**Total**
Number of reasons	1459	1075	944	3478
Reasons concerned	85%	79%	74%	80%
Reasons not concerned	8%	5%	4%	6%
Neutral or uncategorised	7%	16%	22%	14%

80% of reasons given were reasons for concern, with only 6% of reasons for being 'not concerned'.

The following pie chart shows how these reasons were categorised at a macro level. Travel issues were overwhelmingly the most common concern, accounting for almost 60% of all reasons given. Other key reasons for concern were a preference for New Cross/ no change and concerns about care. These reasons are all explored in detail in the next sections.



Travel concerns

By far the most frequent reason for concern was the extra travel involved in getting to Cannock Chase Hospital. This was referred to in a number of ways;

Q. Briefly list up to three reasons why you are concerned or not concerned'. (Number of mentions)				
	Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case**	**Total**
Number of reasons	1459	1075	944	3478
Concerns about travel:				
Distance/time/travel	372	240	**279**	**891**
Access/ transport	255	123	**137**	**515**
Cost of travel	92	70	**62**	**224**
Visitor access	47	142	**18**	**207**
Inconvenient	45	28	**15**	**88**
Difficult for elderly/ disabled	40	17	**13**	**70**
Appointment time	12	6	**6**	**24**
Stress to patient	14	7	**11**	**32**
Not concerned re travel	24	8	3	35

A quarter of all concerns simply referred to 'Travel' or the distance or time taken. There were also comments that appointments in Cannock would result in more time off work, and create problems for parents who need to pick children up from school.

"Travelling/distance involved"

"Time consuming - children to get from school"

"I would not be able to take more time of work to travel the extra distance"

The other very frequent concern was about accessibility and the transport arrangements. There was a great deal of concern about the use of public transport for those without access to cars. In particular there was concern about using public transport to get to the hospital in time for an early appointment and going home on a bus after an operation.

"Getting to Cannock chase with Orthopaedic issues is going to be difficult for me as I live alone and do not drive. It would make getting to an appointment nearly impossible"

"Inconvenience to Wolverhampton residents with regards to travel - provision of a shuttle bus does not cover this - how early will pts need to start a journey in order to have an operation!"

"Do not think that travelling on a bus is suitable for patients who have had a general anaesthetic"

The cost of travel was frequently mentioned. People mentioned the cost of buses, petrol, car parking and in particular the cost of taxis, as it was felt that public transport wasn't suitable after an operation.

""Day cases are the worst to move, people won't be able to get there & back, you can't drive after surgery, taxis will cost a fortune."

"Nearing pensionable age and I am afraid I would not be able to afford travelling expenses"

Access for Visitors was another area of concern. This was a particular concern for Inpatient surgery where an overnight stay would be involved.

"Family will not be able to visit so easily"

"Visiting times would be impossible as extra travel means can't just take a break and visit for half hour; it would take half hour just travelling"

The extra travel was seen as particularly **difficult for the elderly, infirm and disabled.**

"If elderly people have hip ops etc how are they expected to travel the extra distance

"My paraplegic wife uses three of these services at New Cross which is accessible to us whereas Cannock proves to be an obstacle too much."

"My mom is always at New cross with rheumatology, she can't drive, can't get on to a bus, would definitely not be able to get up of bus seats"

General inconvenience and stress to the patients were also mentioned frequently

"The distance to travel there and back after a procedure is going to be extremely stressful"

Some responders were unconcerned by the travel to Cannock, and expressed this thought in the survey.

"Can drive; not a major concern"

"Closer to home so less travel"

"Good access by bus"

Preference for New Cross/ no change

A significant number of responses stated a preference to keep all care 'local / at New Cross/ Wolverhampton' and did not want change.

Q. Briefly list up to three reasons why you are concerned or not concerned'. (Number of mentions)				
	Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case**	**Total**
Number of reasons	1459	1075	944	3478
Concerns about change				
Prefer Wolv/New X/local	94	29	39	162
Unfamiliar hosp& staff	12	14	10	36
Praise New Cross	15	9	7	31
Prefer no change	9	5	13	27

Many felt it was their right to be treated at a local hospital, or expressed preference for New Cross.

"When people have an illness or medical condition they expect and deserve to be treated at the nearest hospital to their home and family, not to have to travel a distance"

"Local facilities for local people"

"Have a good hospital in Wolves why should We travel?

"Does this mean that people out of our area will now be catered for at NX rather than local people?"

Some praised New Cross and wanted to keep going there,

"Perception - service/care in Wolverhampton is top notch, not so good in Cannock. I want the best care I can get."

"Breast Care in Wolverhampton is excellent and I do not see why this excellence should be watered down by shipping very vulnerable patients to Cannock"

"I prefer the back-up of a major hospital"

And others didn't want to go to an unfamiliar hospital.

"Elderly/vulnerable patients having to go somewhere they are unsure of"

"Out of familiar environment"

"Unfamiliarity to the Cannock area"

Concern about quality of care

A variety of concerns were mentioned about the quality of care that would be received. Some concerns were about Cannock Chase Hospital itself, and others about the logistics of splitting care over two hospitals.

Q. Briefly list up to three reasons why you are concerned or not concerned'. (Number of mentions)				
	Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case**	**Total**
Number of reasons	1459	1075	944	3478
Concerns about care				
Cannock facilities/ staff/care	37	46	19	102
Criticise Cannock	3	11	6	20
Need more info on Cannock	8	7	4	19
Care split across 2 sites	22	12	5	39
Concern about consultant access/ patient records	12	3	4	19
Patient care/safety	22	5	4	31
Post-op/ emergency care	46	15	13	72
Aftercare	12	8	7	27
Lack of patient choice	10	5	8	23
Waiting times	4	3	3	10
General concern	13	7	4	24

Concern was expressed about the facilities/staff and care they would receive at Cannock. Some thought Cannock had a bad reputation (linked to Stafford hospitals), and others felt they needed to know more about it.

"Facilities not as advanced"

"Staff at Cannock have no experience of looking after acute patients"

"Poor reputation of Staffordshire hospitals in the press"

"Bad conditions and increased risk of infection at Cannock hospital"

"We are used to certain standards in Wolverhampton & would not trust to get the same in Cannock"

"New cross had state of the art equipment services staff etc we know nothing about Cannock"

"Don't know anything about Cannock chase hospital or its standards"

The main concern about care was the lack of specialist facilities at Cannock- there was concern for what would happen if there were complications and the patient needed emergency care or an unplanned post operative stay. This was a particular concern for the proposal to move Day Surgery to Cannock.

"What critical care facilities available if any problems?"

"What if there are complications, how will these be managed?"

"If patient needs over night bed due to unforeseen circumstances"

"If I m not well enough to go home, will I be made to leave?"

"Isn't the chance of moving a patient after surgery at risk of infection?"

Others were concerned about the logistics of splitting care over two hospitals. This included concern about patient records not being available at both sites, and access to consultants.

"Breast surgery being undertaken by a team split across two sites"

"The procedure and after care are not in the same location therefore surgeons are not as easily consulted post op and the service becomes less consistent."

"Concern that Patient Record will be mislaid."

"If I'm ill, my consultant would not be around"

There was also concern about where After Care appointments would be.

"Long way to travel for follow up's, will physio be at New Cross?"

There was concern about patient care and safety.

"I would prefer to have surgery on an acute site, not in a little cottage hospital."

"I feel it's totally unsafe"

"Continuity/standard of care"

And a feeling that patient choice had been removed

"I understood that it's patient choice where you had your treatment Closer to home!! "

"Patient choice: if services are moved, you are not giving us choice."

Conversely, there were some very positive comments about Cannock from those who had used the services in the past or were current patients

"Service was good at Cannock"

"Cannock Chase hospital have been wonderful to me"

"Previous experience very favourable"

"Professional all areas"

Support for proposals

There was some support for the proposals. Most was at a general level, with some praising Cannock Chase Hospital and others keen to see a reduction in waiting times and cancellations.

Q. Briefly list up to three reasons why you are concerned or not concerned'. (Number of mentions)				
	Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case**	**Total**
Number of reasons	1459	1075	944	3478
Support for proposals				
General support	**39**	**30**	**17**	**86**
Criticise New Cross	**2**	**0**	**3**	**5**
New Cross too busy	**8**	**2**	**0**	**10**
Not concerned re travel	**24**	**8**	**3**	**35**
Praise Cannock	**14**	**4**	**2**	**20**
Reduce Cancellations	**5**	**0**	**1**	**6**
Reduce waiting times	**22**	**10**	**13**	**45**

"If it improves the service to patients then I don't see a problem"

"Seems a good use of an under used hospital"

"I would rather travel for non-urgent than urgent need"

"It's good to at last reduce new cross waiting times"

"More concerned about cancelled op than travel to Cannock"

"More facilities mean faster appointments and care"

Criticism of Consultation process

There was some criticism of the process; suggestions that the changes were all a result of Mid Staffordshire Foundation Trust's problems, that other services may follow and some alternative suggestions.

Q. Briefly list up to three reasons why you are concerned or not concerned'. (Number of mentions)				
	Q1- Day Surgery	**Q2- Inpatient Surgery**	**Q3- Day Case**	**Total**
Number of reasons	1459	1075	944	3478
Criticism of Process				
Criticize Consultation	**17**	**9**	**10**	**36**
Result of Staffs problems?	**9**	**9**	**5**	**23**
Alternative Suggestion	**10**	**9**	**1**	**20**
Other services may follow	**2**	**3**	**0**	**5**

Criticisms of the consultation process suggested that the Trust had already decided to implement the proposals irrespective of the consultation findings.

"You will do whatever suits the needs of the Trust"

"You are refusing to listen to the views of the Community

" Building started on theatres at Cannock - why when you say it is not definite yet?"

"No information given about what other options were looked at and why this is the best option for Wolverhampton residents."

"Equality Implications - this will disproportionately affect people with protected characteristics"

Alternative suggestions included building more capacity in Wolverhampton.

"Why not create additional beds at New Cross Hospital to meet the need?"

"If the NHS was efficient and sustainable, New Cross would have the capacity to deal with these cases and so would not have to resort to moving them to Cannock Chase"

There was annoyance that Wolverhampton people were being affected by problems with Mid Staffordshire Foundation Trust.

"Failure of Stafford Hospital should affect adversely affect New Cross patients"

"New Cross losing out because of Stafford troubles"

"Why are New Cross taking on Stafford hospitals work if they cannot cope with their own"

Other feedback

The CCG captured further feedback on the consultation via email and through the post from members of the public, a local MP, Healthwatch Wolverhampton, conversations on social media (Twitter), as well as a petition from a local breast cancer charity. We would like to thank the group for this and the efforts of its members to help shape local NHS services.

The petition contained over 8,000 signatures from people under the statement: "[We] are opposed to the proposal… to move some breast surgery to Cannock Chase Hospital". While petitions can give a sense of general sentiment, it is difficult to discern more detailed insights into people's concerns so that we may address or mitigate them.

Main views shared through other methods echoed those who fed back via the formal consultation survey, and centred mainly on concerns about patient choice, as well as logistics and access to Cannock Chase Hospital for local people. There was concern for elderly patients who may need multiple appointments, and the suitability of a shuttle bus as a mode of transportation especially for those who may have undergone surgery.

Credibility of the consultation was also questioned, with some perceiving plans to be a "fait accompli". Healthwatch had expressed concerns about the consultation methodology earlier in the consultation. The CCG and Trust responded by strengthening the process – improving communications and awareness raising, through development of a campaign to run on Signal Radio, an extension to the consultation duration, and developing versions of the consultation document in different community languages – shared via the website and across the Healthwatch Wolverhampton membership.

4.0 Demographics of respondents

The survey asked a range of demographic questions designed to check that the respondents were representative of the Wolverhampton borough and to identify whether any populations were over or under represented. The following is a summary of the findings.

- 95% of the respondents who gave their postcode gave a **Wolverhampton postcode**.

- 72% of respondents were **female** and 26% **male.** The dominance of women responding is probably linked to higher female involvement in caring for relatives, a greater use of health service themselves.

- The majority of the sample said they were heterosexual (88%). 7% preferred not to say, 3% were homosexual, and 2% Bisexual. Less than 1% said they were transgender.

- The sample was **older** than the Wolverhampton adult population, but slightly under represented those over the age of 80. The age groups of 45-65 and 65-80 were the most strongly represented in the survey. This probably reflects the fact that these age groups are heavier users of planned care services, and it maybe difficult to motivate the over 80s to take part in a survey.

Q8. What is your age?			
	Total Sample	Wolverhampton Population 2011 census	Wolverhampton Population 2011 excluding under19s
Base	(567)	(249,500)	(187,125)
Under 18	1%	25%*	0
19-24	3%	8%*	11%
25-44	25%	28%	37%
45-64	42%	23%	31%
65-80	26%	11%*	15%
81 or over	4%	6%*	8%

**Estimated as age brackets do not match census data.*

- 43% of the sample respondents had **limited activity due to long term ill health or disability**. This group is more likely to use the planned care services affected by the proposal, and are therefore more motivated to take part.
.
- 36% of the sample **did not have access to a motor vehicle**, compared to 26% of Wolverhampton households. This sector of the population may be over-represented as people without their own transport are likely to be more concerned about the proposals and travel implications, and so motivated to respond to the survey.

- The sample under represented ethnic minorities. 89% of the sample was White British compared to only 65% of the Wolverhampton population. The Indian, Pakistani and Black populations of Wolverhampton were not well represented on the survey.

Q15- 19. What is your ethnic origin?		
	Total Sample	Wolverhampton Population 2011 census
Base	(540)	(249,500)
Any White	91%	68%
(English/ Scottish/ Welsh/ NI/ British)	*(89%)*	*(65%)*
Any Asian	5%	18%
(Indian)	*(3%)*	*(13%)*
(Pakistani)	*(0%)*	*(2%)*
Any Black	3%	7%
Any Mixed race	2%	5%
Any Other	0%	2%

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Appendix 2

NHS Wolverhampton Clinical Commissioning Group

The Royal Wolverhampton NHS NHS Trust

Report on Equality Analysis

Joint consultation on proposals to deliver some planned care at Cannock Chase Hospital

November 2014

Contents

Summary

Wolverhampton CCG and The Royal Wolverhampton NHS Trust have undertaken a joint consultation on proposals to deliver some planned care at Cannock Chase Hospital for Wolverhampton patients. This equality analysis focuses on the impact of these changes for patients in Wolverhampton

This document presents the analysis along with reasons for the conclusions reached, and makes evidence based recommendations to inform equality approaches in the transfer of some planned care services to Cannock chase Hospital for Wolverhampton patients

The Equality Analysis considers two key areas:

1. **The equality impact of the new clinical model which sees the transfer of planned care from New Cross Hospital to Cannock Chase Hospital for some patients**

The transfer of service to Cannock Chase Hospital will benefit some residents and disadvantage others. The demographic information available suggests that the health inequality gap between different groups is unlikely to be widened by the proposals however responses to the survey highlight a perception that older people and people with a long-term limiting disability feel disproportionately affected by the proposals. Proxies for deprivation discussed in the report such as no car ownership or receipt of Disability Living Allowance suggest that a greater proportion of low income households with mobility disadvantages may be impacted by these changes. The proposed benefits described in the consultation document should deliver an improved quality of service for all patients including all protected characteristic groups. In response to the most significant concern relating to transport the Trust has already commissioned a dedicated bus service as described elsewhere in this report.

2. **A consideration of how *operationally*, planned care services can adopt an equality approach towards different protected characteristic groups.**

Commissioners can ensure that robust equality considerations, sensitive to the particular needs of each protected characteristic group, are built into the commissioning contract. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services. The operational impact for each of the different protected characteristic groups will be considered as part of the detailed service planning and is referenced in the Action Plan accompanying the final report.

Recommendations are offered in the analysis as part of the overarching action plan in response to the consultation and are shown at section 7.

1. Introduction

Delivering some planned care at Cannock Chase Hospital – the case for change

The Trust's priority is to deliver safe and effective services for its patients and to increase the certainty for delivery of routine elective surgery. Over the last couple of years the Trust has faced increasing pressure on all services due to the rise in unscheduled care including admissions from A&E and other emergency portals. This has resulted in an increase in cancellations of patients about to undergo elective surgery. As part of its bid for the services from MSFT RWT proposed a clinical model which will enable the Trust to more effectively schedule elective care and prevent cancellations resulting from unscheduled admissions. The Trust presented its clinical model to the National Clinical Advisory Group (comprising the chairs of all the Royal Colleges and Associations). The proposals that have been included in the consultation were approved by this Group as being clinically safe.
The Trust has presented to the Health Scrutiny Panel and other forum on a number of occasions regarding the pressures on its services. Most recently the Panel has heard about the City wide Urgent & Unscheduled Care Strategy. WCCG has discussed the Trust's plans and agree that the proposed model seeks to address the current pressures on elective care and give patients a better experience.

The current constraints on capacity at New Cross Hospital driven by a number of factors including increasing demand on unscheduled (emergency and unplanned) care have resulted in the need to implement a clinical model that separates elective (planned surgery and medical treatment) and unscheduled/ complex care. The Trust is unable to make suitable changes on the New Cross site due to the financial cost and space constraints therefore delivering this model on the New Cross site is not an option. The consultation document and presentation material describe the current situation with continuing uncertainty for patients arising from:

- Delays in admission from the Emergency Department
- Moves between wards
- Delays in discharge
- Cancellation of operation
- Delays in having planned operations including after admission to hospital
- And, sometimes the Trust doesn't get it right leading to poor care and experience

The Trust has clearly stated that for the majority (c.90%) of patients there will be no change for outpatient and day case surgery, unless patients choose to go to Cannock Chase Hospital, as these services have little impact on the inpatient bed stock. Introducing this element of choice means that patients who live equidistant to the two hospitals can go to the most convenient. Additionally there will be some patients who choose Cannock Chase Hospital for personal reasons.

The Trust has undertaken analysis to show the number of patients likely to be impacted by the change. This information was included in the joint consultation document and is shown in the table below. These numbers represent around 1.3% of the Wolverhampton population (assumes that every patient in each category is a "new" contact ie no patient has an appointment in more than 1 category and that no patients choose to go to Cannock under Choice)

	Total Activity at New Cross 2013/14	Proposed Transfer to Cannock	Remaining activity at New Cross	% proposed to transfer
A&E attendances	109305	0	109305	0
Inpatient/Daycase	45835	9849	35986	21.5
Unplanned admissions	47419	0	47419	0

Outpatient attendances (including procedures)	519592	22766	496826	4.4

The Consultation document summarised the proposals for each element of planned care and invited respondents to indicate if they were supportive of them

The Trust and CCG have stated that the provision of services at Cannock Chase Hospital will be to the same standards as the rest of the Trust with the same policies and procedures and the same staff on rotation between the Trust sites. Regulators such as the Care Quality Commission will assess Cannock Chase Hospital as part of any inspection of the Trust's services and will expect it to be delivering services to a consistent standard. This should provide assurance to patients

The Trust and CCG identify two main benefits related to elective service transformation:

1. A target of no last minute cancellations by hospitals for non-clinical reasons due to separation of elective and emergency activity (there have been no cancellations for non clinical reasons at CCH since 2003)

2. There will be a reduction in waiting times, meeting the pledge to patients in the NHS constitution. The Trust is currently breaching the 18 week target for orthopaedics and general surgery (including urology and breast) due to pressures at New Cross Hospital.

There is research suggesting that separating emergency and elective services can prevent the admission of emergency patients, both medical and surgical, from disrupting planned activity and vice versa, thus minimising patient inconvenience and maximising productivity for the Trust (The Royal College of Surgeons of England 2007). This research suggests that health outcomes may be enhanced by the transformation of noncomplex inpatient elective procedures by removing the possibility of emergency patients disrupting planned activity.

Separating emergency and elective services can also lead to a reduction in healthcare acquired infections through avoiding admissions from the emergency department and transfers from within/outside the hospital (The Royal College of Surgeons of England 2007).

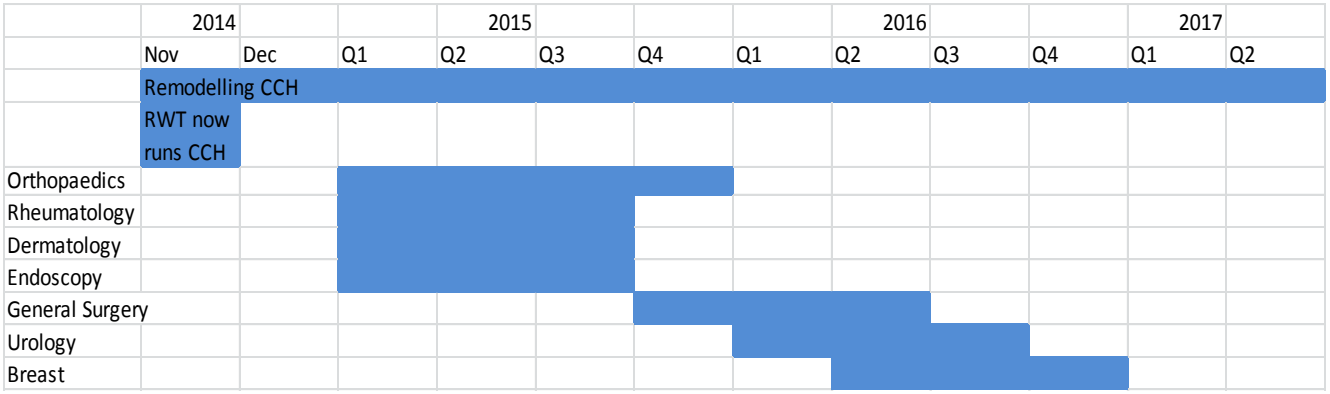
Recent evidence is demonstrated by the South West London Elective Orthopaedic Centre (SWLEOC) which has developed as a centre of excellence, and analogous to the proposed model, is associated with improvements to health and patient outcomes.

There are also some anticipated impacts on patient experience resulting from the proposed transformation of elective services. Research suggests there are potential improvements to patient experience from establishing a non-complex elective inpatient centre. The proposed transformation impacts three distinct components of the NHS Patient Experience Framework (NHS 2012).

- Welcoming the involvement of family and friends. There are proposals to review the car parking arrangements at CCH. This could facilitate the involvement of family and friends of patients undergoing non-complex inpatient elective procedures. Particularly, the proposed changes will make it easier for friends and family to come and visit patients. In doing so, the changes could enhance patient experience.
- Access to care. Lower waiting times and fewer cancellations both enhance patient access to care and thus patient experience. Testimonials from patients using SWLEOC have highlighted that it provides a good patient experience, as they are able to meet with their consultant locally but receive an efficient and high quality service for their operation (EOC 2010). The plans described by the Trust offer outpatients and preoperative assessment at both sites which increases the choice for patients.
- Physical comfort. The Trust has embarked on an extensive remodelling and refurbishment programme at CCH which will improve physical comfort for patients and visitors and support easy navigation of the hospital.

The timetable for change

The Trust takes over the management of Cannock Chase Hospital on 1st November 2014 and will continue to deliver care for the Wolverhampton patients who currently go there. The indicative timeline is shown in the table below:



Responses to the Consultation

The consultation was undertaken between 18 July and 17 October 2014. The methodology for the consultation and a summary of the responses will be presented in a final report to Wolverhampton Health Scrutiny Panel at its meeting in November.

Key themes emerging from the responses include:

- Transport – how will people get to and from Cannock Chase Hospital, and the cost of public transport and taxis. This was the main concern of around 50% of responders. The Trust has already taken steps to address this with the provision of a shuttle bus.
- Standards of care – will they be the same as New Cross
- Staff – will there be enough staff and will patients see the same team
- Improved experience – reducing delays and cancellations

The Trust and the CCG have stressed the importance of on- going involvement of patients in the detailed development of the service changes.

In addition to the individual responses the Trust and CCG received a petition of c.8000 signatures collected by Wolverhampton Breast Care Support Group. A formal response was also received from Healthwatch Wolverhampton which focused primarily on the consultation process

Equality and diversity research methodology

664 individuals responded to the consultation survey which was, given the reach of the consultation process and some of the publicity, a low response level. Equality questions were included on the survey form (questions on disability, ethnicity etc). Analysis shows a slight under representation of young people and those over the age of 80. There was also under representation from ethnic minorities with 89% of the sample being White British compared to 65% of the Wolverhampton population. Concern was also expressed by some responders regarding the provision of their postcode. There are lessons here for providing clarity and reassurances to the public about why the information is being collected, and how it is to be used and the benefit of undertaking targeted work in parallel to the main consultation process.

However there was significant coverage through a range of media, and a very wide range of stakeholders included in the consultation process in efforts to ensure that the vast majority of Wolverhampton residents had an opportunity to access the materials and to respond if desired.

Survey of Organisations

A separate short survey ran from 22 September to 17 October targeted at voluntary and community organisations who work with protected characteristic groups as defined by the Equality Act 2010. This survey was distributed by the Trust to 25 organisations or individuals using their Equality and Diversity database. It was also made available to individuals and groups through an online survey. This survey was designed to be complementary to the consultation questionnaire, and to capture any information, through the knowledge and understanding of representative groups, about how the current provision of planned care services are viewed. The questions, a summary of which is attached at appendix 1, were focused on planned care and asked about:

- Positive experiences of services
- Any difficulties experienced
- Improvements which could be made
- Whether services understand (or don't understand) the particular needs of different groups
- Whether people feel listened to
- Whether privacy and dignity are respected by services

Two specific issues which arose during the consultation and in the survey responses:

1. Concerns of people with a long-term or limiting disability and how those reliant on 3rd party transport will be affected
2. The under-representation of Indian and Pakistani respondents

Actions to address these issues have been described elsewhere in this report

2 The Context for Equality Analysis

2.1 Strategic Commitment

The Trust and CCG are fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity, so that we can remove or minimise disadvantages between people who share a protected characteristic and those who do not.

The clinical model the Trust will implement mirrors that in place in a number of places across the country and will ensure that services are appropriate and do not discriminate on the basis of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex and sexual orientation.

The fact that outpatient and daycase surgery will be available on both sites means that there will be no negative impact for any of the groups with protected characteristics in terms of entering the secondary care system (first outpatient appointment) and day case surgery. Those patients who, on clinical assessment are deemed to be complex, will continue to be treated at New Cross and therefore there is no negative impact arising from these proposals.

2.2 The Public Sector Equality Duty

The **Public Sector Equality Duty** (PSED) is made up of a general overarching equality duty supported by specific duties intended to help performance of the general equality duty. The general equality duty is set out in section 149 of the Equality Act 2010.

In the exercise of functions, healthcare providers and commissioners have to give due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are often referred to as the three aims of the general equality duty.

Advancing equality of opportunity involves in particular, having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

This includes taking into account the needs of disabled people and treating some people more favourably.

Personal Protected Characteristics

The ‘protected characteristic groups’ are defined in Part 1 of the Equality Act 2010 and cover people who are specifically offered protection by the Act. Before the Equality Act, all NHS organisations were required to demonstrate that they were treating people of different races, people with a disability, and men and women fairly and equally. The 2010 Act has added groups of people to the equality duty. These are set out in the table below

Protected Characteristic	Definition
Age	This refers to a person having a particular age (for example, 52 years old) or being within an age group (eg 18-30 year olds; 'older people' or 'children and young people'. Specific discussions about age will usually be given context by the nature of the services under consideration.
Sex	Someone being a man or a woman
Disability	A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
Race	Race refers to a group of people defined by their colour, nationality (including citizenship), ethnic, cultural or national origins. 'Ethnic group' is another descriptive term often used. This may refer to a long, shared history and common cultural traditions; a common geographical origin, language, literature, or religion may also be factors to consider.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex (homosexuality), the opposite sex (heterosexuality), or to both sexes (bisexuality). The terms 'Lesbian', 'Gay', 'Bisexual' (LGB) are commonly used when describing the particular health experiences, prejudices, and challenges encountered by people whose sexuality differs from the majority heterosexual state.
Gender reassignment	People who are transitioning from one gender to another. A person who is Transgender is someone who expresses themselves in a different gender to the gender they were assigned at birth. Although the legislation covers gender reassignment, the term 'trans' better encompasses the wider community and has wide currency. Gender reassignment may also include people who are considering a sex change, but an intention to change sex is not a necessary requirement to be considered as trans.
Religion or belief	People with a religious or philosophical belief, (or people without a religion or belief e.g. Atheism). Generally a belief should affect your life choices or the way you live for it to be included in the definition. Political beliefs are not afforded protected characteristic status.
Pregnancy and maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in an employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
Marriage and Civil Partnership	People who are in a civil partnership or are married. Marriage is recognised between same sex couples as well as the 'union between a man and a woman'. Same- sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same way as married couples on a wide range of legal matters

2.3 Scope of the Equality Analysis

The Equality Analysis considers two distinct but related areas:

1. The equality impact of the new clinical model which sees the transfer of care from New Cross Hospital to Cannock Chase Hospital for some patients

2. A consideration of how *operationally*, planned care services can adopt an equality approach towards different protected characteristic groups.

The focus of the analysis has been on the impact for residents of Wolverhampton. The impact for residents of Staffordshire was covered within the extensive work undertaken as part of the Trust Special Administrator's consultation into changes for the provision of services at Mid Staffordshire Foundation Trust

The impact on staff working for the Trust will be considered internally within the existing framework for

Method

Both the Trust and the CCG have published documents outlining how they will seek to comply with its Public Sector Equality Duty. Both organisations have action plans in place and local tools to support Equality Impact Assessments for all change including clinical services. Further information can be accessed via the links below:

- WCCG
- RWT

This equality analysis has considered the potential impact of the transfer of some services to Cannock Chase Hospital and considers the information from the public consultation and a targeted survey of voluntary and community organisations which deal with protected characteristic groups

A wide range of information and transferable learning from equality analyses of similar service changes in other parts of the country were used as part of this analysis. A full list of these appears at the end of this document. The conclusions and inferences made in this analysis have been made using these materials.

Assumptions

In undertaking this work it is assumed that:

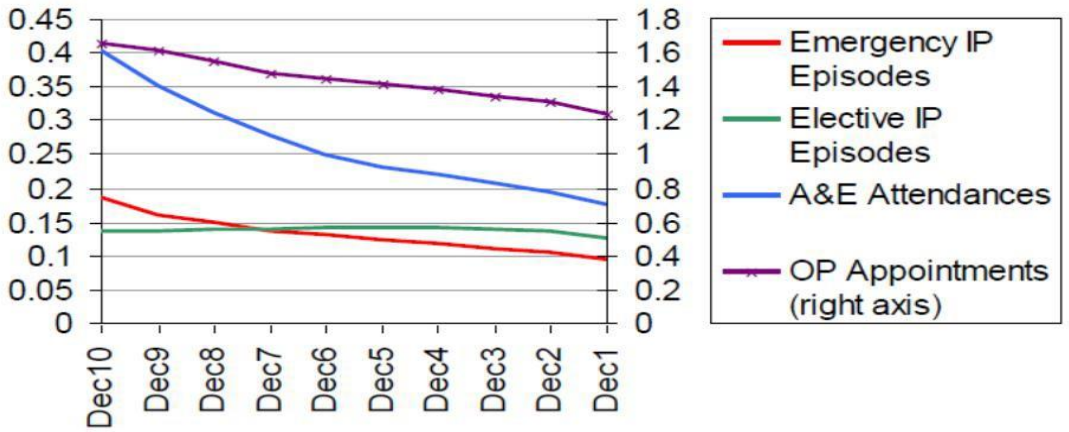
- No planned diminution of service has been identified either by withdrawing services, or restricting eligibility for existing services. The drivers for change emphasise the intention to enhance services and improve efficiencies by reducing unnecessary duplication, and offering clinicians and patients alike greater clarity along the treatment pathway.
- The Trust, in pursuance of meeting its own Public Sector Equality Duty under s149 Equality Act 2010 will conduct further analysis to cover workforce and service impacts arising from implementation plans.
- Further engagement opportunities for patients and their families, and other stakeholders will continue throughout the transition phase and the detailed service planning. These opportunities will be receptive to the perspectives of different protected characteristic groups, including targeted outreach work where relevant

3. Equality Impact of the reconfiguration of services

Accessing Services

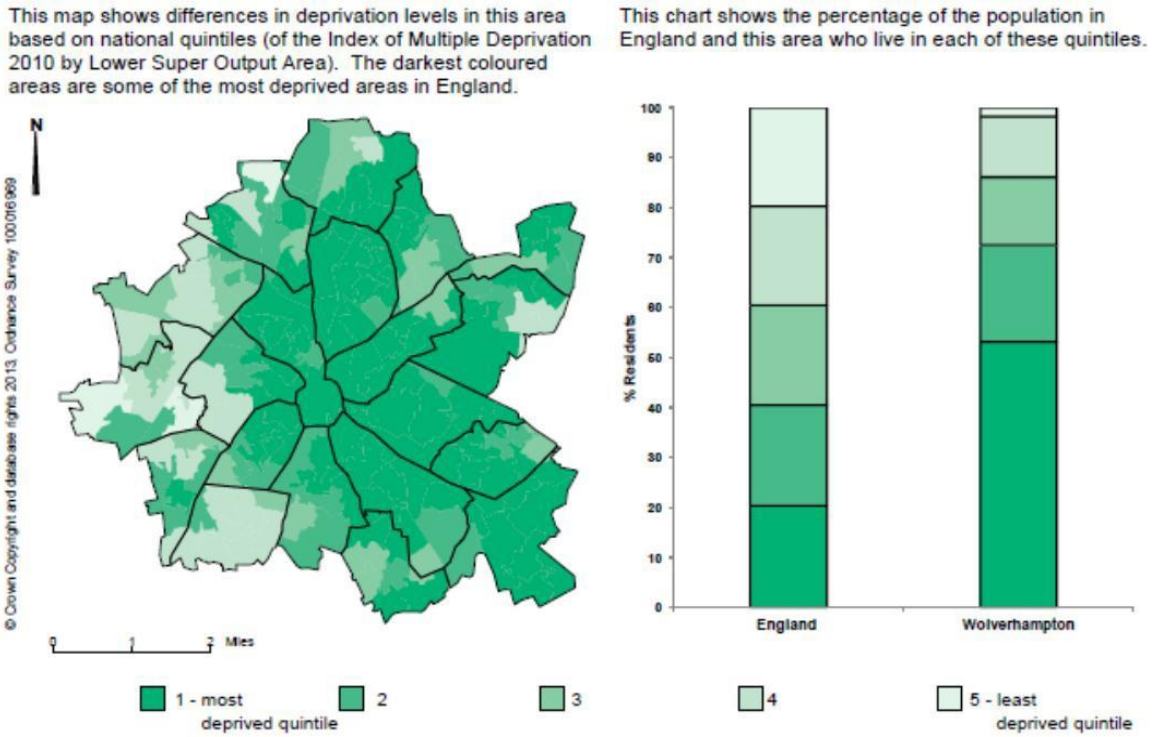
The figure below shows that the number of elective admissions per head is broadly similar across all deprivation deciles. Although these figures are for England in 2012 the authors contend that this finding is stable year on year, and it is reasonable to conclude that the pattern in Wolverhampton is highly likely to be similar.

Figure 1: Emergency and elective inpatient episodes for England, A&E attendances and outpatient appointments per head of population by deprivation decile (10 is most deprived, 1 is least deprived), patients of all ages (McCormick et al; 2012)



Demographic Information

Figure 2: Map of Deprivation in Wolverhampton (Public Health England 2013)



The following maps highlight some of the indicators of health and wellbeing which may have a contributory effect on the impact of transferring some planned care to Cannock Chase Hospital

Figure 3: Percentage of households with no car or van – 2011 (Wolverhampton City Council 2013)

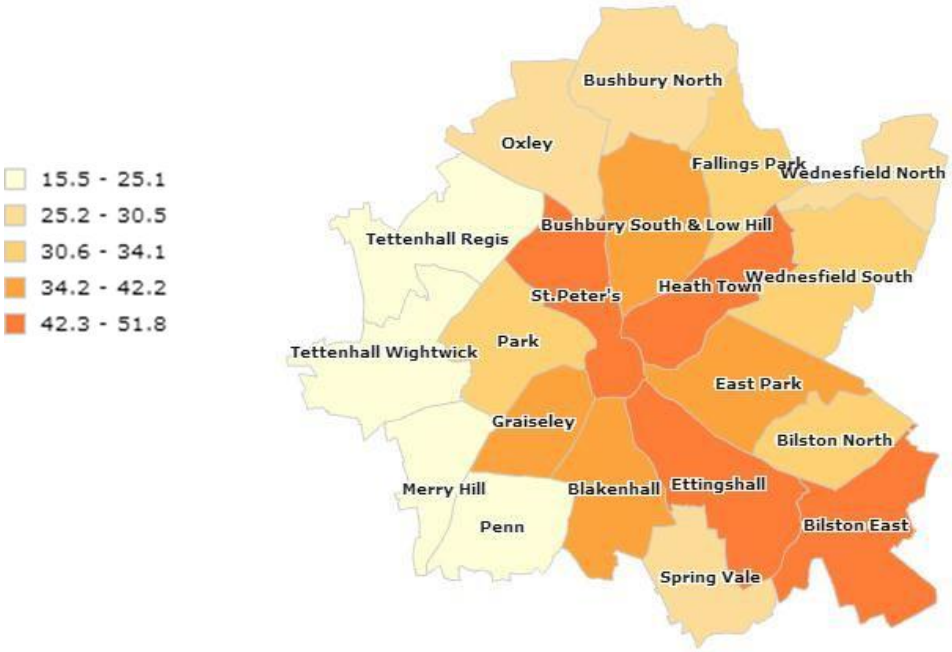


Figure 3 shows the percentage of households with no car or van. People in areas with greatest reliance on others for transport are likely to have been those who expressed most concern about the proposals. As the current service provision for outpatients and daycase surgery remains unchanged this is unlikely to have a negative impact on people accessing services.

Figure 4: Number of people who claim Disability Living Allowance (DLA) (Feb 2013) (Wolverhampton City Council 2013)

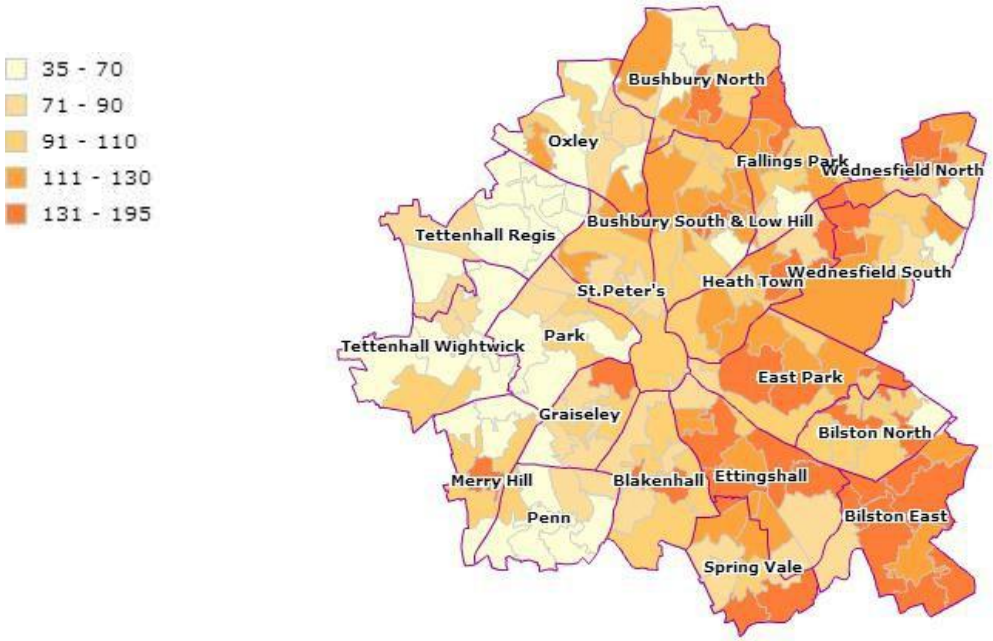
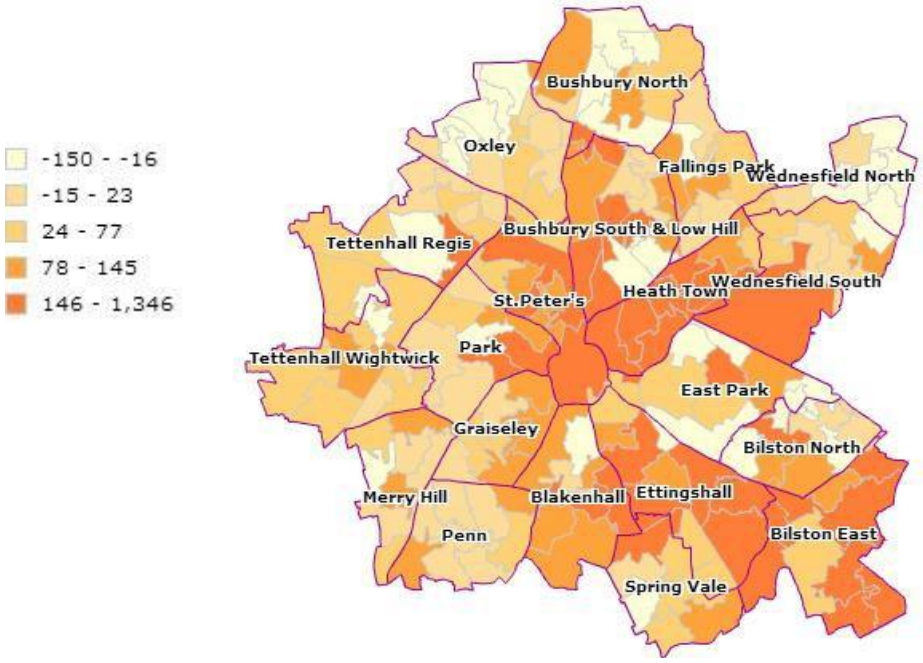


Figure 4 above shows the pattern for people who claim DLA (Personal Independence Payment (PIP) for over 16s and under-65s). DLA provides some money to eligible claimants as a contribution to extra costs caused by long term ill-health or disability. People needing DLA are less likely to be independently mobile, and more reliant on carers.

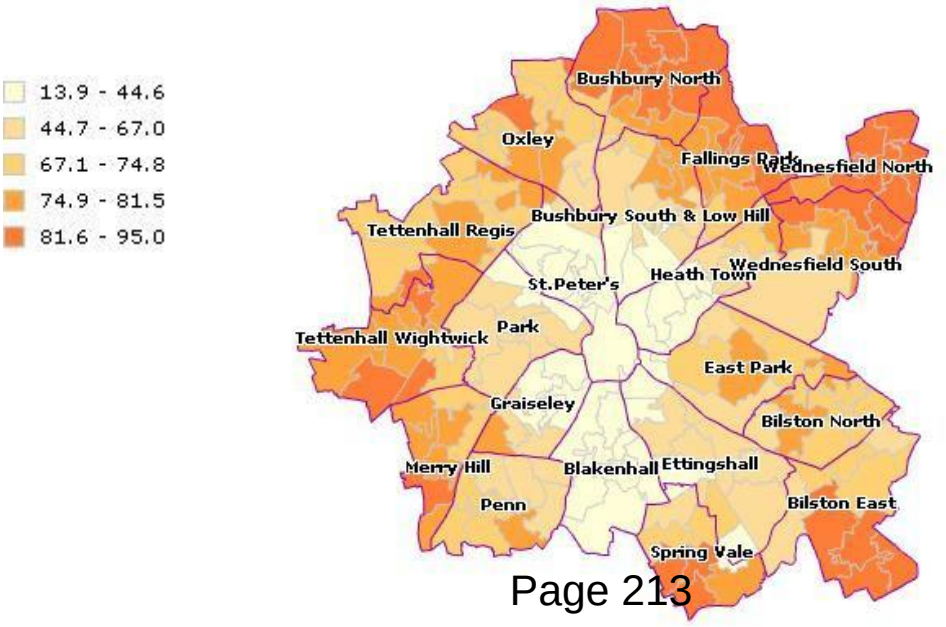
The figure below shows the total change in population in the 10 years between the last two censuses (in 2001, and 2011) and indicates significant increases in the south-east and the east of the City. This would suggest that the current pressure on services at New Cross will continue to rise.

Figure 5: Change in total population between 2001 and 2011 (Censuses 2001, 2011)



The figure below shows the pattern of minority ethnic groups in the City area, based on Census 2011 information and using the descriptor of 'the % of residents who are White British'. In this map therefore, the ***darker*** the shaded area, the greater the proportion of White British people who are resident in the area. The pattern for minority groups correlates closely to the map of deprivation in Figure 1 above.

Figure 6: Population percentage of residents who are White British (Census 2011)



Travel times

There are no nationally established databases of journey times to hospital or recognised standards for what length of journey should be regarded as safe or reasonable. In the absence of a clear indication on thresholds the measure of the median distance to a District General Hospital which nationally is 12 km, with a maximum of 50 km and a corresponding travel time of 13 – 48 minutes was used. The distance between New Cross Hospital and Cannock Chase Hospital is about 13.5km (8.7 miles) with an average drive time of 19 minutes (AA Routeplanner).

Given the elective nature of the service, adverse health outcomes are not identified as a result of potentially increased travel time. People know in advance that a certain procedure is required and they book the procedure for a certain date. As such, whilst there may be an increase in travel time for some patients and the resulting inconvenience, this may suggest a less material impact on accessibility for the majority of patients travelling by public transport

Whilst physical and geographical barriers have been discussed, the main focus has been on journey times. However, stakeholders also noted the potential impact of service transformation on journey complexity. Complexity involves the route that patients have to take to reach a certain hospital, the number of changes that have to be made and the walking distance from a bus stop and train station to a hospital.

In response to early concerns during the consultation about travel to and from Cannock Chase Hospital the Trust has already committed to providing a regular bus service which will make it much easier for patients living in those wards where there is an apparent reliance on other people for their transport needs – either public transport or lifts from friends, relatives. In addition there are a number of public bus routes details are shown at appendix 3. Implementation plans will include a review of the proposed bus route and its connections with public transport across the city. The proposed service will run at sufficient frequency to enable patients to get to CCH in time for scheduled appointments including admission for surgery. The buses that the hospital will run are easy access, low-floor type buses with kneeling mechanism making easy access for people with walking difficulties and wheelchair users. There is also an open out ramp to assist with boarding and alighting which the teams of drivers are fully trained in using. The Trust has also commenced discussions with the respective council departments on the use of bus passes across borders.

Although travel time would increase for patients going to CCH for surgery/ day case treatments there would be no increase in travel time for outpatient/daycase surgery unless the patient chose to go to CCH. As previously described the Trust has plans to reduce journey complexity through the provision of a shuttle bus and through work with the council on the reorganisation of car parking outside the hospital. These actions are included within the overarching action plan.

Equality considerations for services

This section of the report set out in **Table 2** below considers the impact of the service changes on different protected characteristic groups to demonstrate how a consideration of diverse needs in preparing the detailed service plans can offer much improved experiences and outcomes for patients, as well as improving the working environment for staff.

Following a consideration of the challenges for service provision for each protected characteristic group in an planned care context, this section then considers the challenges in the care of other groups not covered by the Equality Act 2010, and the key structural challenges to service reconfiguration which have an impact on all

patients.

Key to Table 2

Protected Group = *Group as defined by the Equality Act 2010*	
Potential Impact	**Opportunity/Risk Mitigation**
Impact as discerned from available evidence. Bibliography is given at back of this document.	*The opportunities available in service design and operations, and the potential for reducing risks through acknowledgement of the needs of different protected characteristic groups.*

Table 2 - Protected Characteristic Groups

Protected Group	**AGE – Older People**
Potential Impact	**Opportunity/Risk Mitigation**
The number of older people (65 year and above) living in the city has increased to 40,600 from 40,000 in 2001, a +1.5% increase. This represents 16.2% of the population, close to the English average of 16.5% but lower than that for the West Midlands (17.2%). The growing elderly population and the prevalence of long term conditions represents a significant challenge to health and social care services. Older people are higher users of orthopaedic and rheumatology services Additionally, the older people are high users of elective services and the impact of changes to these services on this group is of particular relevance. **Potential impact related to travel which may be greater than in other groups. This needs to be considered during the detailed service planning**	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. The refurbishment of the site will improve accessibility as will the ground level entrance at each floor. The smaller site and calmer environment may also be beneficial for patients who are confused. Travel can cause additional anxiety for patients which will be mitigated to some extent by being on a Hospital bus rather than public transport. Discussions are also taking place about the use of bus passes across county boundaries for those who choose public buses.
Protected Group	**AGE – Younger People**
Potential Impact	**Opportunity/Risk Mitigation**
Younger people may find it difficult to take additional time off work to attend appointments. Those with young children could experience difficulties with travel on public transport. **No negative differential impact identified at this stage. However this will need to be reviewed further during service planning to determine any specific requirements**	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. The refurbishment of the site will improve accessibility as will the ground level entrance at each floor. The Rheumatology Unit will offer an enhanced service for this group of patients including access to a hydrotherapy pool
Protected Group	**DISABILITY - General Issues**
Potential Impact	**Opportunity/Risk Mitigation**
The coherent integration of pathways across health and social care is a recurring concern nationally for patients with a disability and for carers. Physical access to facilities, and the availability of suitable equipment to meet the specific needs of people with different disabilities also figures prominently. For people with disabilities, the change in travel time and distance is particularly relevant and may act as a barrier to access for elective services. Depending on the nature	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. The refurbishment of the site will improve accessibility as will the ground level entrance at each floor The buses that the hospital will run are easy access, low-floor type buses with kneeling mechanism making easy access for people with walking difficulties and wheelchair

of the impairment, people with disabilities may rely on family and carers to transport them to the hospital where the procedure will be performed. However, pre- and post-operative care could be provided in locations close to the home and this should entail a reduction in travel time and cost. As described for race and age, patients, carers and relatives of people with disabilities may benefit from the development of further parking at CCH **Potential impact related to travel which may be greater than in other groups. This needs to be considered during the detailed service planning**	users There is also an open out ramp to assist with boarding and alighting which the teams of drivers are fully trained in using. There is an opportunity to consult people with disabilities – both directly and through representative organisations as part of the detailed service planning to consider specific requirements for visually impaired people (colour schemes, and signage already provided for to a great extent as there is an ophthalmic unit on site); Hearing impaired people and communication options generally.
Protected Group	**DISABILITY – Learning Disability**
Potential Impact	**Opportunity/Risk Mitigation**
Having a learning disability can increase anxiety and distress (adding to the patient's vulnerability) as the individual may not understand why they are there or what to expect. Therefore it helps to make the situation as predictable as possible for the person – always letting them know what is happening. Consideration should be given to the appropriate reception and treatment for patients with a learning disability who are undergoing planned treatment and to whether staff are sufficiently trained to safely discern the person's needs; to communicate effectively with the patient and their carer(s); and to ensure the best possible patient experience. **No negative differential impact identified at this stage. However this will need to be reviewed further during service planning to determine any specific requirements**	The RCN publication Dignity in Healthcare for People with Learning Disabilities (2nd edition) offers excellent and useable examples of good practice. Commonly reported experiences for people with learning disabilities include: • Discrimination • Assumptions being made about individuals with no assessment • Lack of communication with the individual and their carers • Difficulty in accessing services • Staff with a lack of knowledge and skills in learning disabilities • Abuse and neglect This document can be used to pose questions for people with a learning disability and to consider specific scenarios relating to this group. The Trust has made a number of changes to the ways in which it supports this group of patients and their carers and should ensure that this work is replicated at CCH Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. However, there is the opportunity to create better packages of care in a calmer environment for this group. Travel can cause additional anxiety for patients which will be mitigated to some extent by being on a Hospital bus rather than public transport
Protected Group	**Mental Health**
Potential Impact	**Opportunity/Risk Mitigation**
Based on the proposals no negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with mental health problem	
Protected Group	**Race**
Potential Impact	**Opportunity/Risk Mitigation**

Wolverhampton's Black and Asian Minority Ethnic (BAME) population has increased significantly since the 2001 Census and now represents over one third of the population at 35.5%. Nationally, the Afiya Trust suggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities". (Afiya Trust 2010) Impact analysis is hampered by the lack of good equality monitoring information for ethnicity. **No negative differential impact identified at this stage. However this will need to be reviewed further during detailed service planning**	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. Travel can cause additional anxiety for patients which will be mitigated to some extent by being on a Hospital bus rather than public transport. The survey sample under represented ethnic minorities. 89% of the sample was White British compared to only 65% of the Wolverhampton population. The Indian, Pakistani and Black populations of Wolverhampton were not well represented on the survey. The Trust should take steps to engage with these groups during the detailed service planning to ensure that their views are considered
Protected Group	**Religion**
Potential Impact	**Opportunity/Risk Mitigation**
No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase	Religion is increasingly being recognised as an important signifier of customs and traditions which may have a bearing on health and prevalence of ill-health (for example dietary habits). It can also help, in consideration alongside data on race (ethnicity), to identify physical, cultural, or behavioural barriers to accessing health and social care services. There are sometimes concerns expressed about the work required to capture and analyse such information and whether or not it is proportionate. However, provider organisations are subject to the public sector equality duty and need to demonstrate that they are eliminating discrimination, and minimising disadvantage across all protected characteristic groups. This information can also usefully be compared to a provider's workforce data (for race and religion) to demonstrate if the composition of the workforce reflects the communities it serves. The absence of any robust local data here does not allow for any form of analysis.
Protected Group	**Sexual Orientation**
Potential Impact	**Opportunity/Risk Mitigation**
Although no specific issues have been identified with the case for change in Wolverhampton; Issues have been identified nationally with same sex partners not being included in consultations in the same way that heterosexual couples/married partners would. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase**	Opportunity to gather further evidence from Lesbian, Gay, and Bisexual and Transgender (LGBT) groups locally/regionally to see if anecdotal reports of poor experiences can be addressed.
Protected Group	**Gender Reassignment**
Potential Impact	**Opportunity/Risk Mitigation**
Based on research the Gender Identity Research and	There are concerns in trans communities about recording

Education Society (GIRES), it is estimated that 12,500 adults have presented for medical treatment of gender dysphoria with around 7,500 having now undergone transition in the UK (Gender Identity Research and Education Society 2011). GIRES also notes that there is an upward trend with the number of people presenting doubling every six and a half years No specific issues have been identified in Wolverhampton, but anecdotal issues raised nationally with trans groups around courtesy of treatment, respect and dignity issues for a person's preferred identity. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase**	gender reassignment status and the potential for identifying people where postcode information is also identified. Opportunity to engage further and for Providers to review policies for reception and treatment for patients and carers; and training for staff**.** **ICD 10 (WHO International Statistical Classification of Diseases and Related Health Problems 10th Revision ICD-10)** still lists at **F64 Gender identity Disorders** including F64.0 Transexualism and F64.1 Dual-role transvestism, whereas the APA DSM-V - the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders ' which may well influence the release of ICD-11 in 2017 has now moved away **from 'disorder' to 'dysphoria'**. This may have a positive impact on the treatment of transgendered individuals by removing the stigmatism of individuals having a 'disorder'. A diagnosis of Gender identity Disorder implies that the problem lies within the patient, suggesting and setting a context for treatment that the patient needs to be cured or 'fixed' emotionally or mentally. The reclassification in DSM-V recognises the mental state that accompanies being transgendered within a society that stigmatises the condition. – ie the problem to be addressed is not the person's identity but rather the distress that is often experienced by those who need access to medical transition care.
Protected Group	**Sex**
Potential Impact	**Opportunity/Risk Mitigation**
No negative differential impact identified	
Protected Group	**Pregnancy & Maternity**
Potential Impact	**Opportunity/Risk Mitigation**
No negative differential impact identified	Recommendation: Access and mobility issues should be considered for visitors and ability for mothers to breastfeed; for parents to change babies as part of Providers' consideration of service use.
Protected Group	**Marriage & Civil Partnership**
Potential Impact	**Opportunity/Risk Mitigation**
No negative differential impact identified	No specific issues with plans for change. Issues have been identified nationally with same sex partners not being included in consultations in the same way that heterosexual couples/married partners would.

5. Groups not protected by the Equality Act 2010

There are some key groups which are not covered by the Equality Act but are vulnerable, often marginalised,

and have a significant impact on health services.

Homeless people

Wolverhampton City Council's Homelessness Strategy 2011-2014 identified that:

- 1 in 5 people suffer from mental health problems
- The suicide rates of homeless people are 34 times greater than the population as a whole
- 80% of street homeless people are addicted to drugs or alcohol
- The life expectancy of someone who is street homeless is 42.
- Rough sleepers are 13 times more likely to be a victim of violent crime.

The number of homeless households in Wolverhampton is significantly worse than the England average (Public Health England Community Mental Health and general Health profiles 2013) despite successful homelessness intervention strategies adopted by the City Council.

Detailed planning of the service changes should ensure that the specific requirements of this group are considered.

Travelling Communities

The Equality and Human Rights Commission has stated:

"There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown."

(EHRC 2010)

Detailed planning of the service changes should ensure that the specific requirements of this group are considered.

Migrants and Asylum Seekers

The Faculty of Public Health briefing (2008) states that:

"Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health" (p1)

Newall (2013) explains that information on migrant populations can be obtained from a range of data sources, "however no one source is able to provide a detailed picture of all new migrants to the UK that have settled in the City." He suggests that 3.8% of Wolverhampton's population arrived from outside the UK in the past 5 years. This compares to 2.9% for the West Midlands Region. In 2011, 22.9% of primary school aged children and 18.5% of secondary school pupils in the City have a non-English first language (Regional averages are 18.9% and 13.8% respectively).

The Social Care Institute for Excellence (2010) publication 'Good Practice in social care for asylum seekers and refugees' though targeted at social care, has a useful set of principles which should be considered in the detailed service planning:

- A humane, person-centred, rights-based and solution-focused response to the [health] care needs of asylum seekers and refugees
- Respect for cultural identity and experiences of migration.
- Non-discrimination and promotion of equality

- Decision-making that is timely and transparent and involves people, or their advocates, as fully as possible, in the process.

Carers

Carers are not a specific equality characteristic but are considered given their importance to overall patient experience where relevant. The impacts on this group are considered particularly in relation to their ability to continue to provide support to patients as travel times could increase for some patients. Also, the support of carers can be critical to the fast recovery of patients from procedures and illnesses. It is important to note that carers are not considered in the same detail as each of the protected groups.

6. Data Considerations

The collation of equality data is a pivotal stage in developing any equality analysis work in support of strategic decision making because from this, we can begin to build a picture of how responsive planned care services are to patients from the different protected characteristic groups. In preparing this report it is apparent that a limited amount of information is currently available about protected characteristics.

NHS Trusts are bound by the public sector equality duty in s149 Equality Act 2010 which requires them to eliminate discrimination and show due regard to minimising disadvantage for the protected characteristic groups: age; disability; race; religion/belief; sex; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership. In order to demonstrate compliance with these provisions the Trust will need to understand something about the different patients it serves, and so collection of equality information is a necessary first step.

7. Recommendations

There are a number of recommendations arising from the responses received during the consultation. Some of these have already been translated into actions and are included in the overarching action plan. The recommendations are listed below:

1. The Trust should establish a mechanism for measuring patient experiences of cross site journeys that will complement existing patient surveys such as the Friends and Family Test.
2. The Trust should establish a mechanism for evaluating the impact of the service changes on those patients with mobility issues and therefore a greater reliance on carers to support them and those without a car or van who have a greater reliance on others for transport
3. The Trust should ensure that it makes specific reference to these service changes and the consultation and subsequent actions in both its Annual Report and Quality Account

In addition to the recommendations arising from this survey there are a number of additional recommendations linked to the joint work on the provision of Urgent & Unscheduled Care services which have been endorsed by the relevant Boards and are relevant to these service changes and should be taken account of by both the Trust and CCG. These are:

DATA - to improve on the routine collection of equality information from patients, and by staff, using collection methodologies that ensure comparative statistics are available (eg by using Census 2011 classifications but with flexibility to enable patients to self-define where this is possible). This should include staff training approaches (see Recommendation 21), and the joint promotion (across health and social care agencies) of equality monitoring with users of services. 'Equality monitoring progress 'is now a standing item at each Data Quality Review Meeting.

CONTRACTS - The Trust should implement and publish internal reviews of their use of equality information for services, and for their workforce and to assess their compliance with the Public Sector Equality Duty (s.149 Equality Act 2010). Action plans to be published which allow for discernible improvement in equality approaches (this work has commenced)

CONSULTATION AND ENGAGEMENT - Opportunities to engage across the protected characteristic groups should be built in to any engagement and consultation work and should form part of the detailed service planning

The CCG and the Trust should ensure that representatives from the Wolverhampton People's Parliament (part of the Changing Our Lives charity which supports people with disabilities of all ages see www.changingourlives.org) and the Wolverhampton Equality and Diversity Forum are consulted and involved in any planned engagement work.

OPERATIONS and STANDARDS - The Trust should ensure that it can provide appropriate assurance that the same standards in relation to quality of care and access to services are in operation on all its sites. The CCG and the Trust should monitor the ongoing effectiveness of the prioritisation plans reported to CQC in September 2013 for people with learning difficulties and autism, and evaluate through further listening events to inform improved practice. The Trust should include user groups in the detailed service planning

Access and mobility issues should be considered for all visitors to Cannock Chase Hospital including the topography of the area (eg to avoid inclines for people with mobility difficulties); internal colour schemes (to enable visually impaired users of services to discern between different surfaces); internal fire doors (to enable wheelchair users to move independently through public areas of a building); appropriate signage; facilities for parents to change babies and ability for mothers to breastfeed – all as part of a Provider's consideration of service users.

STAFF TRAINING - The CCG and Trust should ensure that equality and diversity training is included in the mandatory training elements for each organisation. Where possible, agencies are recommended to share training opportunities, particularly where patient pathways necessitate involvement with different organisations. This would allow for consistency of approach, and highlight areas of complementary (or dissonant) practice. For all, training content should include information about all the protected characteristic groups; the public sector equality duty and the three aims; the significance and importance of equality monitoring; and the values, principles and pledges within the NHS Constitution as a minimum.

Staff involved in the design of surveys or questionnaires; in their distribution or completion with respondents should receive a comprehensive and timely briefing beforehand which covers: the significance and value of equality questions; the importance in ensuring a high percentage of completion from respondents; and how to confidently respond to respondents' questions in a way which is tactful, sensitive, and reassures people about the confidentiality of the information they share.

8. Conclusion

Marmot's (2010a; 2010b) concern was with the 'social determinants' of ill-health or the 'causes of the causes' of health inequalities – those fundamental social and economic conditions which have been shown to have an impact on how healthy a person will be during the course of their life. This includes the conditions in which people are born, grow, live, work and age. It includes an individual's education and employment opportunities in life and their earning potential; it can include belonging to a minority group or being socially excluded from mainstream society. Inequalities in the social determinants of health act as barriers to addressing health disparities. The equality approaches identified in this analysis, and included in the recommendations above, are crucial complementary elements to any Health and Well Being strategy which is concerned with a person's 'life course', and in minimising the disadvantages each citizen may encounter during this life course.

The clinical case for a change for planned care services at Cannock Chase Hospital has been clearly articulated. The intention to separate routine planned care should offer a positive and beneficial impact for all patients, including the statutorily protected characteristic groups. There is no planned diminution of existing services. In this context there are no negative differential impacts identified at this stage for any of the protected characteristic groups covered by the Equality Act 2010.

Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services, with regular (eg quarterly) reports submitted to the commissioner which are required to demonstrate statutory compliance with s.149 of the Equality Act 2010. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty).

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Wolverhampton CCG and The Royal Wolverhampton NHS Trust Wolverhampton NHS Trust, A Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17

Appendix 1

Summary of questions in the Equality Survey September – October 2014

NB. These are shortened forms of the questions asked.

Q1: Name and address of your organisation (please include website if any).

Q2: Contact details for someone we can keep informed of progress

Q3: Please tell us a little about what your organisation does and who it helps?

Q4: Which protected characteristic groups do you work with/represent?

Q5: Positive experiences of planned care services provided by RWT?

Q6. Difficulties experienced?

Q7. Improvements you would wish to see?

Q8. Do providers of services understand the needs of the people you work with?

Q9. Does the group/community feel that their views are listened to by providers?

Q10. Does the group feel that their privacy/dignity as patients is respected?

Q11. Please tell us three things you would like the NHS in Wolverhampton to change for the better for this group?

Appendix 2

Access Facilities at Cannock Chase Hospital

- **Braille Translation service** – same provision as other RWT sites
- **Disabled parking** – provision at all levels of the Hospital and in the adjacent car parks. Drop of points and 30 minute parking at Level 1 of the Hospital. *The Trust has confirmed that it will make plans available as soon as they are agreed with the Council*
- **Disabled WC** – provision throughout the hospital
- **Signing service** – same provision as other RWT sites
- **Translation services -** same provision as other RWT sites
- **Wheelchair access** – at all levels of the Hospital
- **Step free access** – at all levels of the Hospital

Bus routes – Wolverhampton to Cannock

All buses go via New Cross Hospital

ROUTE NUMBER	DAY OF SERVICE	OPERATING SERVICE	DEPARTURE POINT WOLVERHAMPTON	ARRIVING IN CANNOCK	TIMES OF DEPARTURE	LENGTH OF JOURNEY
*67	MON - FRI	Select Bus Service	Salop Street	Town Centre, Bus Station	0950 1140 1405	1 hour “
67	SAT	SBS	Salop Street	Town Centre, Bus Station	0950 1140 1405	1 hour “
*68	MON - FRI	Arriva Midlands	University of W’ton, Stafford St.	Town centre, Bus Station	On the hour between 0835-1835, and then 2055 2255	1 hour 1 hour
68	SAT	Arriva Midlands	University of W’ton, Stafford St.	Town Centre, Bus Station	On the hour between 0835- 1835 and then 2055 2255	1 hour 1 hour
70	MON - FRI	Arriva Midlands	Art Gallery, Lichfield Street (Stop2) Wulfrun Centre (Stop1)	Town Centre, Bus Station Town Centre, Bus Station	0625, 0655, 0803, 0905 Then 5 minutes past each hour 0630, 0700, 0805, 0910, then 10 minutes past each hour 0635, 0705, 0735, 0810,	1 hour 1 hour

			University of W'ton Stafford Street, (Stop 2) University of W'ton Stafford Street, (Stop 2)	Town Centre, Bus Station Town Centre, Bus Station	0845, 0915 and then 15 minutes past each hour Until; 1745, 1815, 1855, 1945. 2035, 2135, 2235	1 hour Approx. 1 hour
70	SAT	Arriva Midlands	Art Gallery, Lichfield Street (Stop 2) Wulfrun Centre (Stop 1) University of W'ton Stafford Street (Stop 2)	Town Centre, Bus Station " " " " "	0735, 0805 then 5 minutes past each hour 0740, 0810 and then 10 minutes past each hour 0745, 0815 then 15 minutes past each hour, until; 1845, 1945, 2035, 2135, 2235	1 hour 1 hour Approx. 1 hour
70	SUN	Arriva Midlands	University of W'ton Stafford Street (stand 5)	Town Centre, Bus Station	0940, 1140, 1340, 1540, 1740, 1940, 2200	Approx. 1 hour

Appendix 3

The Royal Wolverhampton NHS Trust Wolverhampton NHS Trust and Wolverhampton CCG

Proposal to Deliver some Planned Care Services at Cannock Chase Hospital

Post consultation action plan

Theme	Issue	Action	Lead	Evaluation/comments
Transport/Travel	How do I get to CCH?	• Finalise the route and timetable with the bus company and communicate details • Clarify arrangements for patients entitled to free transport including the process for booking transport • Ensure details of options for transport are available in outpatient areas and preoperative assessment • Explore the provision of cross border volunteer transport for older people and those with mobility issues • Evaluate the impact of the service changes on those with mobility issues/lack of transport	RWT Chief Operating Officer	The bus service will be reviewed at 3 months to ensure the timings are working and amended if required. There will be a more formal review at 6 months which will include feedback from users. Indicators that will be monitored from Day 1 are: • Utilisation of shuttle bus
Car parking	Where can I park at CCH?	• Continue work with Cannock Chase Council on the reorganisation of current car parking and the provision of additional spaces • Continue to explore arrangements for alternative car parking within 5-10 minute walk of CCH	RWT Chief Financial Officer	Car park provision will be subject to regular review as services move to CCH. Indicators that will be monitored from Day 1 are: • Car park utilisation

		• Publicise arrangements for parking and drop off on the Trust website and make available in outpatient areas and preoperative assessment		
Accessibility	Will I be able to get around CCH?	• Continue the remodelling/refurbishment programme for CCH – this has been designed to be DDA compliant • Review all entry points to the site for accessibility • Continue with the current or similar provisions for support with hearing and visual disability	RWT Chief Financial Officer	
Clinical standards	Will the care be safe and to the same standards as New Cross?	• Reaffirm the approved clinical model through information available on the Trust and CCG websites • Confirm specialty plans for service transfers • Engage with patient groups and share plans as they are developed • Ensure that clinical policies and procedures are standardised across sites as soon as is practical and safe for patients • Consider the needs of patients within the Protected Characteristic groups as they relate to individual services • Ensure that all required staff training is available • Publish details of the patient pathway for each service as soon as they are agreed on Trust/ CCG websites and in GP practices • Ensure clinical criteria for CCH are widely available in outpatients and preoperative assessment areas	RWT Medical Director	The Trust is required to provide a range on information on the quality and safety of services much of which is reported in the public domain. This information will provide evidence in relation to service provision at CCH. Some of the indicators that will be monitored from Day 1 are: • Nurse staffing levels by ward • Friends and Family test • Healthcare Acquired infections • Referral to Treatment times • Medical staff revalidation • Cancelled operations • Clinical standards for CCH

Communication	How will I know what is happening and what will happen to me/my family if they need treatment?	• Reaffirm the proposed service changes to address misunderstanding/mis information • Provide regular updates on the Trust/CCG website • Provide a regular patient facing bulletin to GP practices • Provide information on Choose and Book regarding the patient journey at sub specialty level including criteria for CCH where relevant • Publicise the outcome of the consultation and the action plan on the Trust and CCG websites • Provide regular updates to Health Scrutiny Panel • Provide regular updates to Health & Wellbeing Board and Healthwatch • Use the Trust and CCG patient groups and for a to cascade information • Provide information on the connections with public bus routes to the Bus Station and New Cross Hospital • Publicise pubic bus routes and timetable on the Trust website • Ensure the 2014/15 Annual Report and Quality Account describe the consultation and its outcomes	Director of Planning & Contracting	Indicators that will be monitored include: • Range of up to date information available on the website • “mystery shopper” calls to ensure information is available in GP practices • Regular checks of information availability in Trust areas • Number of press enquiries about service changes

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WOLVERHAMPTON HEALTH AND WELL BEING BOARD

TRANSFORMATION COMMISSIONING BOARD

Minutes of meeting held on Wednesday 5th November 2014
at the Civic Centre

PRESENT:	**Helen Hibbs**	-	WCCG **(Chair)**
	Tony Ivko	-	WCC Assistant Director
	Viv Griffin	-	WCC Assistant Director
	Sarah Fellows	-	WCC Head of Commissioning
	Steve Brotherton	-	WCC Head of Commissioning
	Kathy Roper	-	WCC Head of Commissioning
	Ros Jervis	-	WCC Assistant Director
	Noreen Dowd	-	WCCG
	Sarah Carter	-	WCCG
	Maxine Bygrave	-	HealthWatch Wolverhampton
IN ATTENDANCE:	**Amrita Sharma**	-	WCC Regulation & Business Support Officer
APOLOGIES:	**Sarah Norman**	-	WCC Director of Community Services
	Claire Skidmore	-	WCCG

		ACTION
1.	**Notes of previous meeting** Notes of the meeting held on the 10th September 2014 were accepted as a true and accurate record of the meeting subject to the following amendment: **3. Better Care Fund** *The first draft of revised proposals will be presented to the TCB in January 2015* ***not*** *November 2014.*	
2.	**Better Care Fund** • SC confirmed the Wolverhampton BCF application had now received approval from NHS England and was not required to undergo any further approval processes via this route. • A Relationship Manager would now be allocated to work with Wolverhampton here onwards. • Next steps would include developing a corresponding Communications Plan to ensure all stakeholders and partners are kept informed of progress and engaged in the development of the BCF delivery plan. • SC formally thanked all partners for their support and contribution in developing the Wolverhampton BCF.	

3.	**Urgent Care & Emergency Services** • ND reported that Wolverhampton Accident & Emergency (A&E) Department had been under significant pressure and whilst failing to reach their 95% target earlier had now managed to climb to 98%. • Systems in plan have now been signed off and are being received well; all key schemes have now been put into action, which involve developing primary care models for the future and reducing emergency admissions to hospitals. • Scenario testing workshop to be held on 21st November 2014; invited representation from all partners. • Procurement plan to be presented to the CCG Governing Body seeking approval to go out to tender to provide additional beds for Cannock. • Board were also advised that the Psychiatric Liaison Service in A&E commenced in October 2014; a specialist Doctor would now be helping to transition work to nurses beyond the end of November 2014. This had already resulted in much improved response to dealing with patients and throughput.	
4.	**Community and Primary Care** • Board noted that the workshop held on the 6th October had been well attended by stakeholders with over 44 representatives taking part. The workshop provided an opportunity to map current services across the city and identify further opportunities for delivering community and primary care. • SC reported that the emerging model of three points of entry within three individual neighbourhoods across the city was very much a community project. The operational model had already received a very positive response from the LMC (Local Medical Committee). • HH reported that NHS England were also in the process of developing a heat map to help identify where new models of primary care were being developed across the region. NHS England's 'Forward View' document further sets out the direction of travel in reference to community and primary care; this would prove helpful in assisting us to develop our own strategy.	
5.	**Mental Health** • The Board were updated on events and developments underpinning the Mental Health Strategy. SF confirmed that the Crisis Care online facility was on target to go live by mid November 2014. • A regional Mental Health Crisis Concordat event is also planned for the 14th November 2014; this serves to provide an opportunity to share good practice guidance for our local plans. The Concordat is about preventing crisis by ensuring we are more responsive across the whole pathway. • SF also reported on the recent opportunity to apply for funding from the NHSE Area Team for a proportion of £1.4(m) available across the region to support work around the Concordat; early indications	

	suggested that Wolverhampton had been successful in securing £300k, but awaiting formal confirmation.	
6.	**Intermediate Care** • SC reported on work being undertaken to map current pathways of service users; this was providing some very insightful information which would assist in the design and development of our recovery, primary care and intermediate care pathways. Proposals for the re-design model would be considered over the forthcoming weeks.	
7.	**Dementia Strategy** • AI reported that work progressing on the Dementia Strategy refresh and development of the Dementia Pathway.	
8.	**Future Integrated Commissioning arrangements** • ND advised the Board on the re-design of future joint commissioning arrangements to support the delivery of the Better Care Fund, potentially via four integrated commissioning teams. Detailed proposals will be shared with the Board and stakeholders in the near future. • A working group of lead officers from both the CCG and WCC have been meeting on a fortnightly basis to progress these proposals with a view to rolling out a six month pilot with effect from November which will be reviewed in March 2015. Finalised proposals will be presented to the next meeting of the Board. **ACTIONS** • Proposals in respect of future integrated commissioning arrangements to be presented to the Board at their next meeting.	**ND**
9.	**All Age Disability Services Strategy** • KR Presented the Board with an update on the implementation of the All Age Disability Strategy which serves to provide an overarching framework to support the delivery of key legislation and local policy in reference to children, young people and adults who have particular disabilities. • The focus of the strategy is centred around the following key areas: - lifelong learning - Family and Friends - Achieving Independence with Choice and controls - Being Economically Active - An Accessible City - Health and Wellbeing • Work is currently underway to develop the 'Local Offer' and will be looking to engage young people in this process. • There remains a need to improve links into the Adult Education Service to increase pathways into employment for people with learning	

	disabilities.	
10.	**Any Other Business** • The Board were alerted to proposals concerning the development of a medium/secure unit opposite New Cross Hospital. It was noted that no consultation had been undertaken with either the CCG or WCC as part of the wider planning application. HH agreed to write to the Planning Committee expressing the Boards disquiet over these proposals; AI to also share these concerns with Councillor Steve Evans.	**HH / AI**
11.	**Date of Next meeting** Wednesday 21st January 2015 at 11.00am	

ADULT DELIVERY BOARD

ACTIONS LOG

[Appendix.1]

Summary of key Actions

Ref	Date	Action	Owner	Status	Notes
~~057~~	~~10.9.14~~	~~Refreshed Terms of Reference to reflect the new Board membership and roles to be presented to next meeting.~~	~~ND/VG~~	~~Closed~~	***05.11.14*** – Draft ToRs shared with Board for consideration and feedback to VG by end November.
057a	5.11.14	Finalised Terms of Reference to be presented to Board at next meeting for ratification.	**VG**	**OPEN**	
~~058~~	~~10.9.14~~	~~Board to be presented with regular updates on the performance of the Mental Health Strategy and Implementation Plan.~~	~~SF~~	~~Closed~~	***05.11.14*** – Update on Mental Health Strategy presented to 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**	**OPEN**	
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**	**OPEN**	
061	10.9.14	Dementia Strategy to be further developed to provide more strategic direction and relevant information.	**AI / ND**	**OPEN**	
062	10.9.14	Revised draft Dementia Strategy to be presented to next Board meeting.	**SB**	**OPEN**	
063	10.9.14	Update on the development of the refreshed Autism Strategy to be presented to future meeting of the Board.	**KR**	**OPEN**	***05.11.14*** – 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**	**OPEN**	
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**	**OPEN**	

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