

HEALTH AND WELLBEING BOARD

6 March 2014

Present:-

Devon County Council

Councillors Davis (Chairman), Barker, Clatworthy and Mumford, Ms J Stephens (Strategic Director, People) and Dr V Pearson (Director of Public Health)

District Council Representative

Councillor J McInnes

Northern, Eastern & Western (NEW) Devon Clinical Commissioning Group (CCG)

Dr T Burke

Environmental Health

Mr R Norley

Health Watch

Dr H Ackland

Apologies:

Dr D Greatorex (South Devon and Torbay Devon Clinical Commissioning Group (CCG))

Ms C Williams (NHS England)

Ms C Brown (Joint Engagement Board)

***72**

Minutes

RESOLVED that the minutes of the meeting held on 16 January 2014 be signed as a correct record.

MATTERS FOR DECISION

***73**

HealthWatch

Mr Sibley (Executive Director of Health Watch) attended the meeting and gave a presentation on the role of Health Watch and how they might engage with future service provision. This outlined the current shift in health and social care provision and the need to move towards empowered citizens and consumers.

Health Watch was not a complaints organisation, but rather a 'consumer champion'. Complaints could be perceived as reactive and individually focused, rather than proactive and community focused. Research had also shown that nearly 61% of people didn't feel they had a clear way of providing feedback on a service and that when concerns were raised, many were not confident that action would be taken.

In essence, it was felt that 'having your say' was key to raising the bar and pushing health and social care services to continually innovate and evolve.

Mr Sibley finally updated the Board on other Healthwatch Devon projects which included the Engagement Gateway, CAB Healthwatch Advisers and an increase to the Volunteer base.

The Board discussed the role of the CAB Healthwatch Advisers and the progress of this project and also that the role of Health Watch was welcomed in commissioning activities to move towards a culture of learning from failures and / or negative experiences.

RESOLVED that the presentation and current activities of Health Watch be welcomed.

*74

Clinical Commissioning Groups'

(a) NHS Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group

The Board considered a report (with supporting papers) from the Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG) which provided an update in relation to their five year Strategic Plan and Commissioning Framework for 2014/16. A presentation also accompanied the reports outlined the planning timeline, planning highlights and an overview of both the commissioning framework and the strategic plan.

The supporting papers (full copies of the Draft Strategic Plan and Commissioning Framework Modules summary) were also circulated.

The Strategic Plan looked ahead to 2018/19 outlining the strategic ambitions and commissioning intentions for 2014-2016. Work had been undertaken within communities across the three localities and the plans had been discussed with large numbers of the public and other member practices. There was a vision of Healthy People, Living Healthy Lives, in Healthy Communities, with a mission to attain high-quality sustainable services that promoted wellbeing and cared for people when they were unwell. Also five Strategic Priorities of Personalisation and integration, General practice as an organising unit of care, a regulated system of elective care that delivered efficient and effective care for patients, a safe and efficient urgent care system and the CCG as an effective and engaging partner.

In respect of the Commissioning Framework 2014/16, the Modules summary gave a high level overview of each Commissioning Framework (CF) module. These modules related to, inter alia, the Plan, commissioner priorities, contracting principles, financial commissioning framework, activity planning principles, better care fund and ethical frameworks. These modules continue to be circulated to providers and were available on the website;

<http://www.newdevonccg.nhs.uk/who-we-are//what-is-clinicalcommissioning/commissioning-framework/100925>

The Board discussed;

- the indicators for the NEW Devon geographical area and how these related to the Board;
- clarification of the £5 per head of population funding figure and where this funding was from (new funding or redirection of funds);
- the importance of moving towards quality indicators, in line with the high quality of locally collated indicators; and
- the need to take care over language and terminology (as the same term often meant different things to different organisations), and that a glossary of terms would be welcomed.

It was **MOVED** by Councillor Davis, **SECONDED** by Councillor Clatworthy, and

RESOLVED that the update be noted and the views expressed above be considered as part of the planning process.

(b) NHS South Devon and Torbay Clinical Commissioning Group (CCG)

The Board considered the report of the South Devon and Torbay Clinical Commissioning Group, presented by Dr C Daniels on the draft CCG Strategic Plan, which had been circulated with the papers. The Plan had been refreshed in-line with national planning guidance which extended the Plan to 2019, with a more detailed 2 year Operating Plan contained within. The main changes were highlighted as;

- that it had been informed by recent engagement events which focused on community services, mental health and learning disabilities;
- the 3 overall transformational aims were clearly articulated as 'Prevention & Self-care, 'Community Hubs' and 'Integrated Care Organisation'
- there was also a stronger focus on co-ordination of care, mental health, children's services and prevention.

The Board were asked for comments and feedback on the Plan.

The report also updated on activities being undertaken by the CCG, including progress with the Joined-Up (Integration Pioneer) bid where plans for community hubs were being developed, an update on the Integrated Pioneers Study Tour, the Time to Talk Day, discussions at the Primary Care Commissioning Oversight Group, Acquisition of Torbay and Southern Devon Health and Care NHS Trust and the role of the Academic Health Science Network (AHSN) Best Practice Stocktake.

The Board welcomed the emphasis on children and childrens' services within the plan and discussed how they might best provide influence and provide support to the Pioneer Bid. They also noted that further comments on the plan could be submitted via email, in line with the process outlined within the report.

It was **MOVED** by Councillor Davis, **SECONDED** by Councillor Clatworthy, and

RESOLVED that the CCG's update be noted and that the overall strategic direction of the plan be endorsed.

***75 Joint Commissioning in Devon and the Better Care Fund (formally the Integration and Transformation Fund)**

(Councillor Davis declared a personal interest in this matter by virtue of being a Carer)

The Board considered the joint report of the Head of Social Care Commissioning (Devon County Council), Managing Director Partnerships (NEW Devon CCG) and the Director of Commissioning (South Devon and Torbay CCG) ([SCC/14/14](#)) on current progress with the Better Care Fund. The purpose of this was a drive towards integration and a seamless service user / patient experience being at the forefront of developments around health and social care.

At the last meeting of the Board, members received the national guidance for the Better Care Fund and an early draft of the submission. This was discussed in conjunction with a wider "Integration Plan".

A copy of the submission was included with the papers, as well as a finance summary, list of schemes and an outcomes and metrics précis. Members of the Board were asked to comment on the order to inform the next iteration of the Better Care Fund and plans for its implementation. As part of the next phase, health and social care commissioners would be working in partnership with the NHS and other providers to deliver the agenda through the co-production of plans.

The Board noted that NHS England had undertaken an assurance process of the draft Better Care Fund submissions and had advised local areas accordingly. The advice received had reinforced the original assessment.

A revised version of the Better Care Fund was due to be submitted to NHS England on 4th April 2014.

The Board discussed the following;

- the role of the current county wide survey (nationally agreed) analysing user experiences;
- that Devon was starting from a strong position as provider teams had been co-located and integrated for some time;
- performance in relation to personal budgets was also in the top quartile;
- clarification of funding flows, as outlined at page 17 of the report;
- the importance of capturing the patient experience and that the relevant performance indicator was awaited from NHS England;
- that Devon had an extensive advocacy service and this could be better reflected in the documentation;
- the importance of acknowledging there would be winners and losers in pooled budget arrangements and savings needed to be recycled; and
- provider engagement was a key principle for both the NHS and the Local Authority and this needed to be robust and fit for purpose.

It was **MOVED** by Councillor Clatworthy, **SECONDED** by Mr Norley, and

RESOLVED

(a) that the template return for the Better Care Fund submitted to NHS England on 14th February 2014 be noted;

(b) that the comments made above be noted and taken into account for the next version;

(c) that authority be delegated to the Chair of the Health and Wellbeing Board to endorse the revised submission (in order to meet DH timelines of 4th April 2014);

(d) that the Board receive an update on the Better Care Fund at the next meeting; and

(e) that a briefing be organised for Members of the Board, giving further detail on the Better Care Fund and future operations.

***76 Devon Local Nature Partnership**

The Board considered the report of Chair of the Devon Local Nature Partnership on the compact agreement (which described the relationship between the Devon Health and Wellbeing Board and the Devon Local Nature Partnership).

The aim of this was to maximise the health and wellbeing impact of the natural environment in Devon through shared strategic approaches. These included;

- the natural environment of the County offered many opportunities to produce social, economic and environmental, as well as physical and emotional, benefits to health and wellbeing;
- that the Board and the Partnership committed to making explicit strategic objectives in both the Devon 'Joint Health and Wellbeing Strategy' and the Devon Local Nature Partnership's prospectus and subsequent delivery plan;
- through the joint strategic needs assessment process, data and the evidence of effectiveness of interventions would be shared and promoted; and
- the commissioning plans of the members of the Board and Partnership would set out relevant actions as appropriate.

The Board then witnessed the signing of the compact agreement, which had already been approved by the LNP Board.

The Prospectus for Natural England 2014-2019 was circulated as part of the papers and could be found at <http://www.naturaldevon.org.uk/wp-content/uploads/2014/01/Final-DLNP-prospectus-jan20141.pdf>. The Strategy had seven priority themes which were Naturally Healthy, Green Connections, Outdoor Learning, Farming with Nature, Wood for Good, Resilient Wetlands and Sustainable Seas.

Members were further asked to note that news / newsletters were available on the website <http://www.naturaldevon.org.uk/news> and members could be added to distribution lists if required.

The Director of Public Health reported that the Partnership had established many new networks and work had been undertaken, using some of the public health grant funding, with National Parks and other partners which were starting to reap benefits.

It was **MOVED** by Councillor Davis, **SECONDED** by Dr Pearson, and

RESOLVED that the signing of compact be welcomed.

MATTERS FOR INFORMATION

***77 Safeguarding Adults Board – Performance and Monitoring**

The Health and Wellbeing Board received the report of the Chair of the Safeguarding Adults Board on the performance, monitoring and priorities of the Safeguarding Adults Board.

The Board noted that the Safeguarding Adults Board was an independently chaired Board (organised by Devon County Council) to provide multi agency strategic coordination and agreed strategic governance arrangements to safeguarding vulnerable adults from abuse in Devon.

The report outlined that the new Care Bill was expected to go through Parliament in Summer 2014 and would put the Safeguarding Adults Board on a statutory footing for the first time. The Bill also required Boards to provide a Business Plan and Annual Report, both of which were already published and available on the Safeguarding web pages at <http://www.devonsafeguarding.org/adults/index.html>

The report further provided an update on progress (at appendix 1) with the Safeguarding Adults Board's Business Plan, which included progress on each of the four strategic objectives;

- prevention of abuse and neglect, through commissioning, provision and monitoring of high quality and personalised care;
- communication, engagement and Involvement;
- learning, improvement and training; and
- ensuring good governance as a statutory body

The report also included an example of the awareness raising work (appendix 2) which had been developed in consultation with the Service user and care group, for distribution throughout their organisations.

***78 Devon Safeguarding Children Board – Performance Monitoring, Multi-Agency Working and Opportunities for Improvement**

The Health and Wellbeing Board considered the report of the Chair of the Devon Safeguarding Children Board which summarised the activities of the Safeguarding

Children Board over the past six months and raised issues that it wished the Health and Wellbeing Board to consider.

In terms of progress to date, the report outlined the changes in structure and the creation of an Executive and a main Board. A self-assessment of the progress and priorities for the Board had been undertaken and would form the basis of the business plan for 2014/15. The self-assessment was based on the OFSTED framework criteria for Safeguarding Children Boards and was appended to the papers. Further work included the exploration of joint working with the Torbay Safeguarding Children Board, the launch of a new website (April) and the undertaking of three serious case reviews.

The report then outlined some areas where the Board could provide an input. These included Early Help which was a key priority for the Board. It was stated this would only work effectively with senior management involvement and ownership. The second area was Compliance with Section 11 of the Children Act 2004. 'Working Together 2013' expected all organisations to be compliant with this section of the Act, although results of a recent survey showed gaps in a number of areas for many organisations. Third, in a review of Child and Adolescent Mental Health Services and Adult Mental Health, issues had been raised regarding the lack of availability of tier 4 CAMHS beds, gaps in provision of providing mental health services for very vulnerable young people earlier in the system and a real difficulty for some young people accessing the Tier 3 service.

Other matters raised included the importance of the support of all agencies in implementing the Child Sexual Exploitation Strategy.

The Board discussed the following;

In respect of Early Help, the new system was being implemented and training was due to be rolled out over the next 4 – 6 weeks.

Regarding Compliance with Section 11 of the Children's Act 2004, it was suggested the relevant part of 'working together' and the relevant legislation was recirculated to partners to ensure awareness (page 47 of the link refers)
http://www.teescpp.org.uk/Websites/safeguarding/images/Documents/Working_Together_March_2013.pdf

Partners needed to ensure that providers understood the requirements and this needed to form part of the commissioning process.

The issues outlined in the report on Child and Adolescent Mental Health Services were a cause for concern. Early intervention was paramount and a 'safe place' when needed for the young person. This issue should be discussed at the next meeting of the Devon Health and Wellbeing Board Chairs and also it was agreed that the Chair write to NHS England regarding provision levels and the concern about tier 4 CAMHS placements many miles from the young persons' home.

The Board would receive a further report at the next meeting in relation to the Child Sexual Exploitation Strategy (outcomes and findings of the review).

The issues relating to the Child Death Overview Panel would be considered at the next JSNA refresh. There was also a joint piece of work on suicide prevention, with Exeter University, that would be disseminated in the near future.

It was **MOVED** by Councillor Davis, **SECONDED** by Councillor Clatworthy, and

RESOLVED that the Board's comments, as outlined above in respect of Early Help, Compliance with Section 11 of the Children's Act 2004, CAMHS, Child Sexual Exploitation Strategy and the Child Death Overview Panel, be taken forward to improve the safeguarding children practice of staff in Devon.

***79** **Winterbourne Review Concordat**

The Board considered a report from the Managing Director of Partnerships (NEW Devon CCG) outlining the progress against key winterbourne view concordat commitments. The stocktake exercise had been presented to the Board at every meeting since September 2013 and it had been agreed that regular progress reports be presented to the Board.

This national Concordat plan was developed in response to a Panorama investigation which had showed abuse of patients at Winterbourne View and, as a response, six separate reports were developed nationally. These had generated a multitude of recommendations for many services, including regulators, providers and health and social care commissioners.

The final Concordat was clear about the key aims of preventing further placements of people away from their homes, and supporting those in current services to move back to their community. The end goal was moving people into appropriate community placements by 1st June 2014.

Within Devon, (and as a response to Winterbourne View), a 'seven step pathway' had been developed for returning people to appropriate community support arrangements.

The report outlined the current position in Devon as at February 2014 and progress to date of the number of people returning to appropriate community placements.

It was **MOVED** by Councillor Davis, **SECONDED** by Dr Pearson, and

RESOLVED that the progress be noted and welcomed.

***80** **Devon Joint Health and Wellbeing Strategy: Priorities and Outcomes Monitoring**

The Board considered a report (PH/14/6), on the performance for the Board, which monitored the priorities identified in the Joint Health and Wellbeing Strategy for Devon 2013-2016.

The Board received an 'updates only' version of the Health and Wellbeing Outcomes Report. The report was themed around the four Joint Health and Wellbeing Strategy 2013-16 priorities and included breakdowns by local authority, district, clinical commissioning group, inequalities and trends over time.

The indicators relating to Early Years Foundation Score (2012-13), Adult Smoking Prevalence (2012), Under 75 Mortality Rate – All Cancers (2012), Under 75 Mortality Rate – Circulatory Diseases (2012), Suicide Rate (2012), Self-Reported Wellbeing – Low Happiness Score (2012-13) had all been updated since the last report to the Board.

Following approval at the November 2013 Board meeting, a RAG rating had been added to the indicator list and performance summary on page 2 of the full report, Areas with a red rating included Hospital Admissions for Self-Harm, aged 0 to 17 and the Dementia Diagnosis Rate.

The indicator list and performance summary within the full report set out the priorities, indicators and indicator types, and included a trend line, highlighting change over time, and a Devon, South West and England comparison chart for benchmarking purposes.

It was **MOVED** by Councillor Davis, **SECONDED** by Dr Pearson, and

RESOLVED that the Health and Wellbeing Outcomes Report be noted.

***81 Joint Engagement Board (JEB) Update**

The Board received a report on the current work and progress of the Joint Engagement Board.

The report outlined that service users and carers had recently been involved in the Council's Day Services and Residential Homes Review engagement events and also an engagement event for families of children with disabilities co-hosted by DCC, the CCGs and Devon Parent Carer Voice.

The JEB's Expert Panel had also been working with project managers on the Direct Payments Card, changes to the Social Care assessment process and associated forms, developments of social care webpages and factsheets; and also the adult social care Market Position Statement.

The work of the Service Delivery Monitoring Group (SDMG) had also been involved in tender evaluations, joint commissioning work and supplying independent volunteers to help support service users affected by the day service reviews.

OTHER MATTERS

***82 Board Membership 2014 - 2016**

The Chair of Board reported at the last meeting of the Board that the Membership had been static for the previous twelve months, in order to consolidate working practices and settle into its role.

It was resolved that;

that members of the Board be invited to make representations regarding its future composition.

The Chair reported back on those representations and the Board further discussed how it might better monitor its key achievements, rationalise processes and work to avoid duplication.

It was **MOVED** by Councillor Davis, **SECONDED** by Councillor Clatworthy, and

RESOLVED that the Board ask Devon County Council to consider the future composition of the Board and include representation from the Police and Crime Commissioner, Probation Service and a nomination from the Local Enterprise Partnership.

***83 Scrutiny Work Programme**

The Board received a copy of Council's Scrutiny Committee work programme in order that it could review the items being considered and avoid any potential duplications.

***84 Forward Plan**

The Board considered the contents of the Forward Plan, as outlined below (which included the additional items agreed at the meeting).

Date	Matter for Consideration
Thursday 12th June 2014 2.00pm @	CCG Updates Better Care Fund (formally ITF) Establishment of a Devon Children, Young People and Families Alliance Children's Safeguarding – Annual Report (BF from Sept - request of DCSB) Child Sexual Exploitation – Outcomes of Review Health & Wellbeing Strategy Priorities and Outcomes Monitoring Oral Health Strategy – Peter Howard Williams Topic based report (Housing) Joint Ambitions (CCG and NHS England) Winterbourne View (Standing Agenda Item) Engagement and Communications – TBC Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 11th September 2014 2.00pm @	CCG Updates Adults Safeguarding – Annual Report Better Care Fund (formally ITF) Topic based report (Frailty) (new topics to be identified) Health & Wellbeing Strategy Priorities and Outcomes Monitoring Winterbourne View (Standing Agenda Item) Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 13th November 2014 2.00pm @	CCG Updates Health & Wellbeing Strategy Priorities and Outcomes Monitoring Better Care Fund (formally ITF) Winterbourne View (Standing Agenda Item) Topic based report (topic tbc) Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 15th January 2015 2.00pm @	CCG Updates Health & Wellbeing Strategy Priorities and Outcomes Monitoring Better Care Fund (formally ITF) Winterbourne View (Standing Agenda Item) Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 12th March 2015 2.00pm @	CCG Updates Health & Wellbeing Strategy Priorities and Outcomes Monitoring Better Care Fund (formally ITF) Winterbourne View (Standing Agenda Item) Topic based report (topic tbc) Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme

	Briefing Papers, Updates & Matters for Information
Items to Add	Equality & protected characteristics outcomes framework Devon Pharmaceutical Needs Assessment - review/refresh Children's Safeguarding annual reports (annually in June) Engage Project – possibly as a topic based report

RESOLVED that the Forward Plan be approved.

***85** **Briefing Papers, Updates and Matters for Information**

Members of the Board received regular email bulletins directing them to items of interest, including research reports, policy documents, details of national / regional meetings and events and consultations. Details were available at;
<http://www.devonhealthandwellbeing.org.uk/>

Items of interest from the February 2014 bulletin included;

- an update on the signing of the Local Government Declaration on Tobacco Control;
- reports and briefings including the JSNA Devon Overview, JSNA Profiles, Public Health Devon Outcomes Report, District Public Health Plans 2013-14 and a Partners section added to the website;
- campaigns and activity updates including a breast cancer awareness campaign targeting the over 70s, Be there tomorrow (smoking campaign) and skin cancer.

***86** **Dates of Future Meetings**

RESOLVED that future meetings of the Board will be held on.....

Thursday 12th June 2014 @ 2.00pm
Thursday 11th September 2014 @ 2.00pm
Thursday 13th November 2014 @ 2.00pm

Thursday 15th January 2015 @ 2.00pm
Thursday 12th March 2015 @ 2.00pm

***DENOTES DELEGATED MATTER WITH POWER TO ACT**

The meeting started at 2.00pm and finished at 4.07pm.



Northern, Eastern and Western Devon
Clinical Commissioning Group

Transforming Community Services

Report for Devon Health and Wellbeing Board Meeting: June 2014

Recommendation

The Board is invited to engage and contribute views in relation to the proposed strategic direction for community services as set out in the strategic framework.

Over the last year the co-production phase of the Transforming Community Services programme has been discussed at previous Health and Wellbeing Board meetings.

The Transforming Community Services Programme commenced in May 2013 to establish the strategic direction and delivery arrangements for community services. Now the initial co-production phase of this programme is complete, the strategic framework for community services sets out the proposed way forward.

A short summary version of this framework (Integrated, personal and sustainable: Community services for the 21st century) is attached. This, and further information including the full draft strategic framework document is also available on:

<https://www.newdevonccg.nhs.uk/involve/community-services/101039>

This will be accompanied by a short presentation for discussion at the Health and Wellbeing Board meeting on 12th June 2014 to engage and invite Board views ahead of the next Clinical Commissioning Group Governing Body meeting in July 2014.

Attachments:

1. Integrated, personal and sustainable: Community services for the 21st century
2. Powerpoint presentation

Integrated, personal and sustainable



Community Services for
the 21st Century -
A Strategic Framework



Foreword

We have a tremendous opportunity to help people improve their health and wellbeing, maintain their independence, and experience more appropriate care outside of large and busy hospitals and closer to - or in - their homes and communities. *Integrated, personal and sustainable: community services for the 21st century* sets out our proposed direction for community services and invites your views on this.

This strategic framework exists within the pillars of the Clinical Commissioning Group's overarching strategy. It is also in the context of our co-commissioning of primary care; the role of General Practice as the organising unit of care and our work with local authorities to advance integration of health and social care.

During the last year we have heard from hundreds of people about what they think is most important about community services - what is good now and what could be better. We have heard from patients, carers and communities - we have heard from bodies and organisations that represent them - and we have heard directly from senior and clinical leaders in health and social care. This has greatly influenced our thinking.

What is clear is that community health, and integrated health and care services, are highly valued. They are also ideally placed to make an impact on the whole pattern of care, shifting the emphasis of services - from acute to community settings, from hospital to home, and from care delivery to prevention of ill health. This is what people want to see, a change to the way services are delivered.

Advances in care mean there are more possibilities than before to improve, maintain and recover health. At the same time the age of the population is rising as is the complexity and scale of health need. Austerity is a reality - money is limited and costs are ever increasing - so we need to make every pound count. And, in doing so, we must keep improving quality and experiences of services.

Now we are translating many of the local views and insights we have heard so far accompanied by our understanding of health needs and information from national and local policy, into a proposed way forward - so that we can and do achieve integrated, personal and sustainable community services which are right up to date.

Getting this right requires a partnership approach. Community services benefit from the commitment of staff, carers, leagues of friends, a range of volunteers and many others. We see these existing vital partnerships - and new ones to be established with communities - as pivotal to the development and design of future services.

We would welcome your views and comments. We know future plans and services will be even better and stronger as a result. Thank you.

Dr Tim Burke

Chair, NHS NEW Devon Clinical Commissioning Group

Rebecca Harriott

Chief Officer, NHS NEW Devon Clinical Commissioning Group



21st century community services for individuals, families and communities

Facts about us

- We are the largest CCG in the country
- We have an overall budget of £1.1 billion
- We serve a total population of 898,523
- We cover a total area of 2,330 square miles
- Our CCG chair is **Dr Tim Burke** and there are three locality chairs:
 - North Devon – Dr John Womersley**
 - East Devon – Dr David Jenner**
 - West Devon – Dr Paul Hardy**
- Our Chief Officer is **Rebecca Harriott**

This strategic framework has been developed for the areas of Devon that are covered by NHS Northern, Eastern and Western Devon Clinical Commissioning Group, which leads the commissioning of the majority of local healthcare. Approximately 11 per cent of the overall £1.1 billion resource is spent on community services - those health and integrated care services that take place in or close to people's homes and communities. Community services have a key role now and in the future.

As we look ahead we want to build on the many strengths of current services and to develop them further so that they can and do stand the test of time. This is why we have engaged so many local people in thinking about their future – and why we are checking our proposed way forward again through 'Integrated, personal and sustainable: community services for the 21st century'. We know that there are important decisions to make now to set the path for the coming years.

In addition to our local engagement there is national policy and guidance that is relevant to community services. This sets a direction of clear and simple pathways of care, focusing on outcomes and quality for patients whilst achieving the efficiency and effectiveness that will enable sustainable care and support.

Community services are of course part of a much wider system of health and social care and in looking at community services we have also been paying attention to this. The role of General Practice, the value of connections with acute and specialist healthcare, the possibilities for extending the integration of health and social care, the role of all agencies in adopting a greater health and wellbeing focus - have all been at the centre of our thinking.

In this framework we describe how community services could be, an approach to making this happen, and the inputs that will be needed to make a difference. We also set out the important experiences that people should be able to expect as a result of this work, and a number of guiding principles that have been identified as important.

Integrated, personal and sustainable - how this could be

People told us they wanted 'healthcare which does not stop at the boundaries', services that 'see me as a person, not a condition' and 'safe and secure services with future proofing in mind'. These and many other views and insights set a vision for 'integrated, personal and sustainable' community health and integrated health and care services. These views also framed the following six strategic priorities.

Help people to stay well

As well as a focus on caring we would expect the emphasis of community services to move increasingly towards prevention and maintenance of health. This includes recognising the importance of support for people with complex needs to help them to live well and to maintain independence.

Integrate care

The need for care and support to be wrapped around individuals and their families has been stressed time and again in local discussions. This means we would expect services to be joined up and integrated - removing and minimising the impact of organisational boundaries on great care.

Personalise support

Personalisation, choice and control over individual care was highlighted as important. Personalisation includes, and is much more than, personal health budgets and means advancing a flexible model of support which can increasingly be tailored to individuals.

Co-ordinate pathways

The value of pathway-based approaches to care with co-ordination through prevention to crisis and ongoing care has been identified time and again. This includes paying particular attention to pathways which reflect the natural flows of patients through different health and care services.

Think carer, think family

The key role of carers and the need to support carers' health and wellbeing - in addition to that of patients and the population is essential as more services are focused in people's homes and in the community. We want to commission mainstream services which are fully carer-aware.

Home as the first choice

There is growing understanding of the need to shift the model of services with less inpatient beds but a greater number of more responsive care packages at home. There is now a clear impetus for action to progress this at an early point to enable new models of community services to develop.

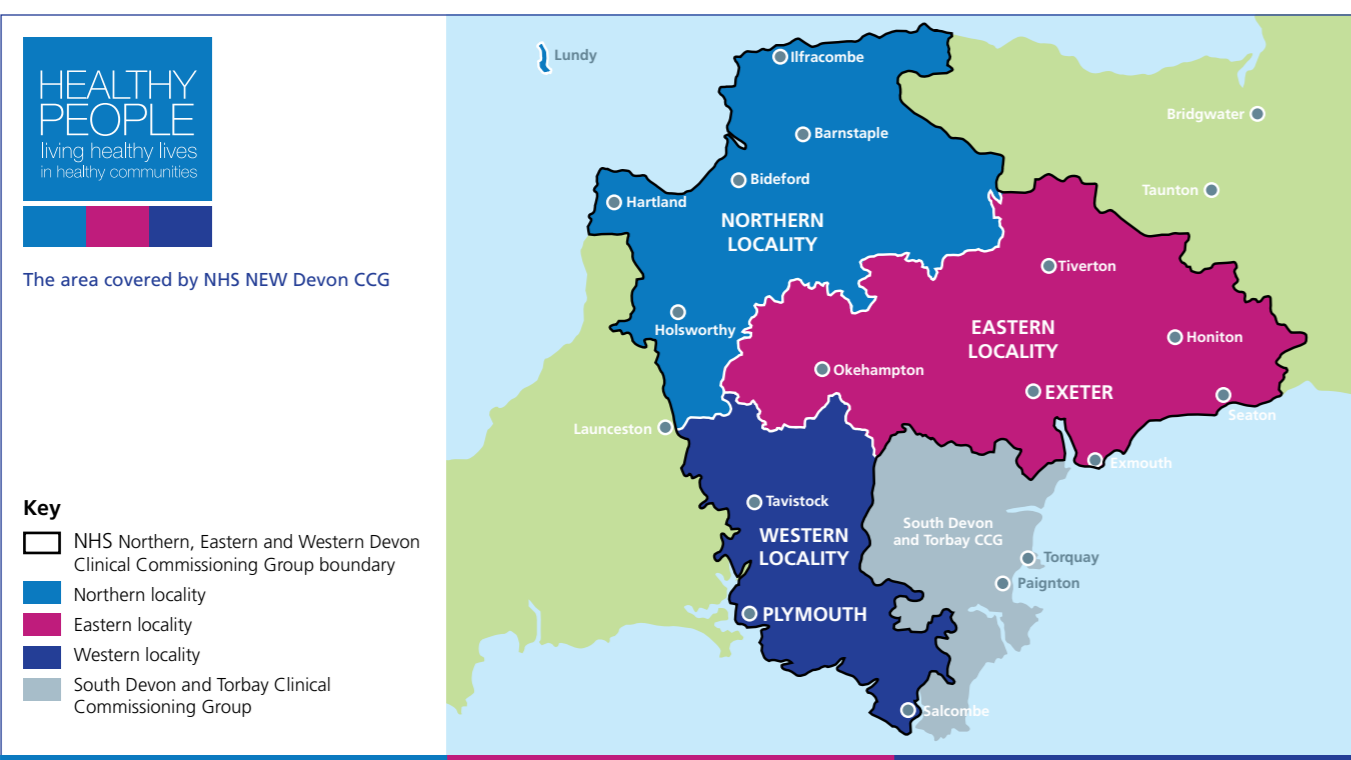
A shared direction

Over the last year in Northern, Eastern and Western Devon we have been:

- Listening to views of patients, carers, communities and their representatives
- Engaging with clinical and senior leaders involved in health and social care
- Reviewing needs, evidence and other details relevant to community services

This has been central to our community services programme which is designed to set the direction and delivery arrangements for the future - so that community services can and do realise their true potential for individuals, families and communities.

We are now ready to propose a way forward. 'Integrated, personal and sustainable: community services for the 21st century' is a summary of extensive work on community services. A more detailed document and further information is available on <https://www.newdevonccg.nhs.uk/involve/community-services/101039>.



Designing community services for the population - how this could be



Community services are those services which take place at home or nearby. They include nursing care and support, multi-disciplinary and integrated teams that help people with complex needs and a range of clinical and other services in community hospitals and local care settings. There are many good services but we know that more can be achieved if community services are to realise their true potential.

The latest health and wellbeing profile for NHS NEW Devon CCG shows that compared to England there are:

- Fewer children below age of 14
- More young adults aged 20-24
- Fewer working age adults 25 -50
- More older adults over age 60

The proportions of older adults are already higher than England and rising. By 2021, the population in the NHS NEW Devon CCG area is expected to grow by 6 per cent with a 9 per cent rise in 60-74 year olds and a further 26 per cent increase (over 22000 people) in those aged 75 and over. There are new houses and communities being developed too. We need to plan ahead.

Social isolation is an issue raised in many conversations and we know that in both urban and rural settings this can be a real issue, especially for older people. This can impact on health and wellbeing. Community services of the future have a role towards addressing this.

'As more people live into older age we need services which support people to remain as well as possible for as long as possible in their own homes and communities. The ambition is to increase the healthy years of life and reduce the social isolation.'

NHS England chief nursing officer

Locally relevant plans

In looking ahead, it is essential that we plan and prepare now for an increasing older population and their carers.

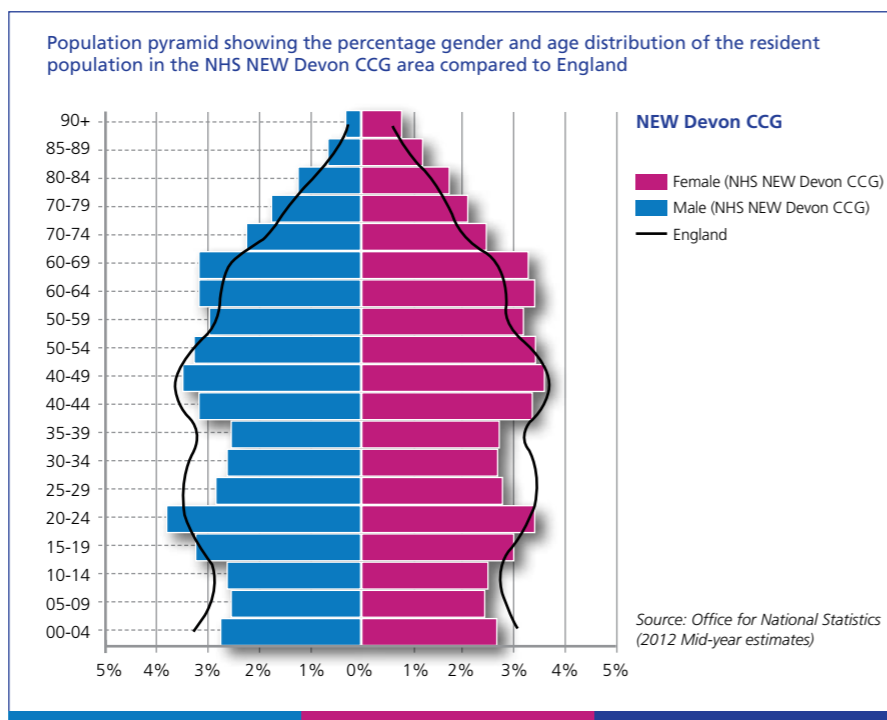
Age can bring an increased complexity of physical and mental health needs and frailty affecting the pattern of services required - especially in the oldest age groups.

We know that already people over 65 years in the NHS NEW Devon CCG area account for 72 per cent of all unscheduled days in a hospital bed (this is 10 per cent higher than the rest of England).

We also know that the impact of aging in the population is likely to bring an increase of up to 2 per cent a year extra activity in already busy acute hospitals locally.

Local Public Health audits have shown that around one third of people in community hospitals were fit and waiting for discharge.

Yet many older people would prefer to be at home. We need to plan and design services that will support this with home as the first choice for care.



Achieving the best from national and local policy - making it happen

There is a wealth of national and local policy which sets the foundations for excellent services - achievable even in the face of rising needs and the realities of financial austerity. The best care is not always the most expensive care. There is increasing evidence and examples of improving services for people while strengthening quality, efficiency and effectiveness too. This is how we can make it happen.



A view from here

Views gathered through local engagement in community services compare well with national and local policy direction.

Hundreds of people took part in discussions over the last year including:

- Attending local health summits to directly give their views
- Joining focus discussions such as a long term conditions event
- Participating through bodies that represent a range of groups
- Joining senior leaders in events and workshops
- GP Member Practice and clinician to clinician discussions.

We heard that: prevention services are as important as crisis services; the person needs to be put first; we need to remember personalised care is not - one size fits every person. Further information is available on:

<https://www.newdevonccg.nhs.uk/involve/community-services/101039>.

Integrated

We are already well on the path to integration of health and social care in Devon and Plymouth. The national Better Care Fund announced in 2013, is a pooled health and social care budget and is a helpful catalyst for taking this integration to the next level.

Starting this year and scaling up from 2015/16 onwards this is set to unlock the true potential of 'out of hospital' care and therefore community services - and to positively shift resources to where they can bring most benefit.

Locally we are looking to this pooled fund to enable integrated multi-disciplinary teams in each locality, to strengthen home care and to move more care out of hospital.

Personal

The King's Fund's recent review of community services in England described the important role of these services in transforming care. The report noted a range of changes are necessary including: simplifying community services; building multi-disciplinary teams supported by new models of specialist input; and reaching out to the wider community to improve prevention, supporting isolated people and to create healthy communities.

Our local engagement reflected the value of services that are tailored to enable personalised approaches to care and support.

Sustainable

Creating services that are strong and ready to stand the test of time is of utmost importance. It is recognised that change cannot wait and we need to prepare now for quality and affordable services in the future. Community services have a clear part to play in responding to the growing scale and complexity of needs, and in shifting from a focus on buildings to designing services around people - and engaging communities in sustainable services.

'...it is more important than ever that commissioners, providers and citizens are open and honest with one another about what can be achieved and work together to find solutions.' Think Local, Act Personal Partnership.

Preventive and personalised support - making it happen

Making an impact

The management of complex long term conditions needs to happen every day at home and in the community to help people to live well. This needs a new approach by all services to 'make every contact count' and embed prevention into day to day activities.

Thinking differently

'We need pathways which start and end with wellness'

Outcomes

- Enhancing quality of life for people with long term conditions and care and support needs
- Helping people recover from episodes of illness
- Reducing emergency admissions to hospital and delayed discharges from hospital.

Community health and integrated health and care services are ideally placed at the heart of communities to tailor care and support services to the people who use them; and to harness the true power of communities in wellbeing, the maintenance of health, and mobilising community assets to support people to live well and at home.

Many more people are living with one or multiple long term conditions and complex health needs. In this section we are focusing on targeted support to prevent or delay deterioration of health and wellbeing, address health inequalities and reduce the risk of admission to hospital or residential care. This will need the following key changes:

- Build on existing targeted services that support people at high risk through information, self-management, 'making every contact count' towards prevention and establishing named clinical leadership throughout the whole pathway of care
- Use technology effectively to enable preventive and personalised support. Bring this into mainstream services where the benefits of technology are known and are relevant to the needs being addressed.

To fully make a difference to community wellbeing, particularly in the older age groups, there are real benefits in harnessing the power of communities. We want to explore innovative opportunities with communities as a key part of taking this programme forward.

- Change the way facilities are used, with some community hospitals becoming hubs for health and wellbeing rather than maintaining their traditional inpatient focus. This new approach would bring more prevention, wellbeing and pro-active support into localities
- Develop personalised care planning for people with complex needs which include plans for prevention, self-management and support to maintain independence and, wherever possible, avoid a crisis
- Establish a framework for services that enables increasingly flexible and bespoke support so that individuals can be more in control, including through personal health budgets as these become established



Pathways for people with complex needs - making it happen

Making an impact

NHS England advocates a pathway approach especially for older people who are most likely to suffer problems with co-ordination of care and delays in transitions between services.

Thinking differently

'See me as a person - not as a condition'

Outcomes

- Enhancing quality of life for people with long term conditions and care and support needs
- Helping people recover from episodes of illness
- Reducing emergency admissions to hospital and delayed discharges from hospital
- Improved patient and service user experience.



With more people living with multiple long term conditions and complex needs, it is essential to design the right model of care and treatment. It is increasingly recognised that all elements of care and organisations providing this are interdependent and that services and a pathway approach will achieve the best outcomes and reduce or avoid fragmentation and gaps in care that are sometimes experienced.

As well as personalised and preventive approaches to pro-active care already described, the pathway addresses help in a crisis and ongoing care with a focus on much of this care being community based and helping people to remain at home or nearby. We propose the following key changes:

- Create a model of service that offers a robust alternative to hospital stays both in preventing admission and reducing length of stay with effective community interventions including early specialist assessment when necessary
- Establish clinically led integrated multidisciplinary teams wrapped around a cluster of general practices that have a role in the whole pathway extending the skill base of teams to support more people out of hospital

- Design a small number of strategically located enhanced community hospitals, offering clinical assessment, inpatient care, outpatient care and diagnostics to enable more people requiring hospital appointments or admission to receive this in the community
- Arrange a consistent approach to supporting people living in care homes when they need healthcare to help them to remain in their care home where possible, rather than being moved or admitted to hospital
- Ensure strong co-ordination of the pathway with mental health expertise, particularly in the care of older people with dementia and other mental illness who require physical healthcare; and similarly with end of life expertise.

There are a number of local examples of strengthened community services including hospital at home, the development of local specialist clinics, and the use of technology to reach out to people at home. We want to build on the current work of complex care teams and see health and social care teams as part of a co-ordinated pathway within each locality geography.

Urgent care in the community - making it happen



Urgent care in community settings needs to be a consistent, high quality and resilient service which can be and is used as a first choice for routine urgent care. As part of a wider network of expertise it needs to be designed so that the majority of patients can be seen, treated and their care completed in a single attendance.

People with urgent needs can be supported in a range of ways. National review information indicates that patient priorities include: quick access and simplicity, being in control, and local services which are high quality and safe. Yet the reality is often an unclear system with variations in terms of service, name, location, opening hours which is thought to be increasing overall urgent care demand all over the country. In the NHS NEW Devon CCG area we propose a redesigned model with the following key changes:

- Facilitate prevention and a range of approaches to take services to patients including the use of technology, home visiting and other routes to accessing urgent support such as NHS 111 and near patient testing
- Establish a small number of hospital-based urgent care centres, replacing the current pattern of minor injuries provision, where possible within 30-40 minutes' drive time of communities accompanied by appropriate outreach support. Different approaches would need to apply in rural and urban centres

- Align the urgent care centres with primary care out-of-hours services including co-locating these on the same site where this is achievable, ideally linked with other facilities such as x-ray, to deliver a more comprehensive community service
- Arrange expert senior clinical leadership of the community service within the urgent and emergency care network arrangements in each locality plus shared information technology; protocols and governance for the most effective care.

This is a very different community model from that presently in place in that it enhances urgent care outside of large hospitals, and does this in a way which is connected to emergency and urgent care expertise to bring a convenient and reliable service that meets the needs of our population.

Making an impact

NHS England highlighted four improvements in urgent care: consistent, high quality and safe services; simplicity which enables good choices by patients and clinicians; right care in the right place with the right skills; efficient delivery of services.

Thinking differently

'I want healthcare which does not stop at the boundaries'

Outcomes

- Right care, first time with care completed in one visit
- Reducing emergency admissions to hospital
- Patient and service user experience.

Community specialty services – making it happen

Making an impact

We propose an in-depth piece of work designed to map the full scope of these services in Northern, Eastern and Western Devon.

It will also engage with professionals, commissioners, clinicians, patient and stakeholder representatives to consider current and future needs, the opportunities and challenges ahead and the relevant policy frameworks. This will provide a basis for proposing the strategic direction and future pathways for these services.

Outcomes

- Reducing emergency admissions to hospital and admissions to care
- Effectiveness of reablement
- Patient and service user experience.

There are a whole host of community specialty services. These are typified as those uni-professional services that take place in clinics or home. They particularly support people who may be vulnerable due to age, whose conditions require more specialist input. Working with patients in the community and linking with all parts of the health and care system, these services have an important role.

Specialty services include services such as: podiatry; tissue viability; musculo-skeletal physiotherapy; bladder, bowel and pelvic floor services; specialist nursing such as cardiac nursing and others. Generally, these services have many distinct individual features while also some core features in common including:

- Their role in supporting individuals who require specialist professional input due to specific needs from a patient group who are also often

vulnerable due to age, long term conditions or following an episode of ill health

- Some services are small in volumes but complex in the nature of what is delivered, for example chronic fatigue services. Co-working in a networked approach with other specialty, acute, primary and community services is essential to assist the small resource to spread further
- The ethos of promoting and maintaining health and wellbeing is important in these services and most have established education strategies and support arrangements to reduce the impact of risk behaviours on the individuals themselves and others.

It is important these services are taken into account in this community service programme.

We will be undertaking further co-production work to look at these services in more depth. This will take place from the point of publishing this document and with a report on initial proposals available in July 2014.



A new model of care - making a difference

This programme builds on the strengths and proposes change to improve community services. It is centred on getting care in the right place at the right time and to the right standard for individuals, families and communities. It covers personalised and preventive support, pathways for adults with complex needs, community urgent care and specialty services in the community. The notes below describe some of the differences we would expect.



Community hospitals

Community hospitals/local care centres have an important role in the future although we expect this role to be different.

We see a number of hospitals becoming hubs for health and wellbeing - largely without beds but with a range of innovative services including clinics, prevention and wellbeing support, tailored particularly for people with complex needs.

We see a small number of others as clinical care facilities that offer enhanced outpatient services such as urgent care and diagnostics; with inpatient care consolidated into fewer settings than at present. Some may provide more specialist services.

In progressing change of this nature as it is agreed in principle, we would wish to discuss detailed implementation with primary care, providers, clinicians, partners and communities.

At home: integrated care and support every time

Home - and a person's own bed - becomes the focal point of care. Fully integrated multi-disciplinary teams - supported by specialists working in a co-ordinated way - enable more people to remain in their own homes and with the right mix of care and support in communities to achieve this. The role of district nursing, therapists, clinicians and others reflects latest national policy and skills are deployed to maintain more people at home. Learning from current successes - such as hospital at home and complex care teams - enables the spread of this learning and rapid implementation.

In each community

New partnerships in communities become established - beyond health and social care. These partnerships involve patients, primary care, community leaders, the voluntary sector, local charities and business. They also include other key departments and agencies at a local level for example education, police, fire and rescue services. They focus on harnessing the assets and power in communities to shape future care. In some areas community hospitals will also change their role to community health and wellbeing hubs while in others a more networked approach may be developed.

In each locality

The model of urgent care and pathways for adults with complex needs includes a range of Better Care Fund schemes and the development of a small number of strategically located enhanced clinical and integrated care facilities across the geography. This would bring more care out of busy acute hospitals and nearer to people's homes - and work to current day quality standards and outcomes. Strong networks and connections reflecting patient flows would support this.

Supporting future change - making a difference



To support change and transformation we need to take into account a range of important factors. These include: quality standards, the money, the workforce, technology and facilities for services, the actions and governance which will achieve transformation and the support during the period of transition to maintain quality safe services in the interim.

Quality and outcomes

There is something very powerful in describing community services as the 'golden thread' which holds seamless and high quality pathways together. Involving communities in defining this high quality can enable services and their delivery to reflect the experiences and outcomes that are important to people. Our engagement in co-production has helped us to progress this with six strategic priorities as described earlier. We have also been developing principles and experience outcomes to act as a guide to commissioning decisions.

The money

We spend 11 per cent of our commissioning resource on community services and the Clinical Commissioning Group has stated in its 2014/15 plan that the proportion of spend on community care and support will increase, showing a commitment to this model of care. However, as we all know, costs are rising and pressures on care are greater so we need to make every pound count. Add to that the fact that the local health economy is identified as one of 11 challenged communities nationally in relation to financial sustainability, anything new we do must, of course, be affordable.

Community services workforce

The workforce is central to the delivery of good care and we would wish to engage and work with the many community services clinicians, professionals and staff in the detailed design for the future. There is a need to consider new guidance and policy such as: the exciting developments in nursing roles; the benchmarks and staffing levels that will be required for the future; and the most effective ways of maintaining workforce skills. New models of care will bring new opportunities for skills development in the areas of wellbeing and prevention as well as clinically enhanced care.

The role of facilities and technology

During the stakeholder engagement phase, we were urged to make the best use of community hospitals and this framework aims to achieve this by thinking differently about the role of these important facilities. The clinical commissioning group does not own the buildings but would wish to see them used imaginatively and will work with providers, property services and communities in relation to this.

Technology is another feature yet to be fully embraced. Access to patient records by different teams, remote consultations, alarms and sensors to assist people at home, electronic appointment bookings, and many other developments all bring possibilities. We will be interested in innovative approaches to the use of technology in the delivery of effective home based and local care.

Towards a future pattern of provision



In addition to preparing community services for the future, we need to consider the arrangements for their provision. These arrangements will need to deliver the ambition of integrated, personal and sustainable care and support already described. Our proposed pattern of provision from 2015/16 until 2018/19 is described here for each of the making it happen sections of this framework.

We want to give current and prospective providers, local authorities, commissioners, key stakeholders and the public locally an opportunity to express their views before decisions are made on procurement (contract award) approach at the meeting of the Clinical Commissioning Group Governing Body on 16th July 2014. We have used the sound basis of NHS Procurement, Patient Choice and Competition (no 2) Regulations and associated guidance by Monitor to underpin our approach.

Current community services contracts in the Eastern Locality, South Hams, West Devon and Plymouth in the Western Locality, are all due to end in 2015/16. We therefore must plan ahead for provision of services in these areas from 2015/16 until no earlier than 2018/19.

- It is clear that we need to design community services with integration high on the agenda. We are therefore committed to ensuring that the future pattern of provision supports our drive towards integration with both Devon and Plymouth local authorities

- Breaking down barriers and simplifying and streamlining care for patients, particularly older people, across a patient's pathway is also crucial. We are therefore proposing to commission patterns of provision centred on locality geographies where appropriate for maximum care pathway co-ordination
- There are clear benefits of enabling enhancement of community services through clinical specialist input so that more care can and does take place outside of large hospitals. This requires taking positive steps working with the acute sector to maximise the shift of care to community settings
- We need to start now to fundamentally re-design towards a sustainable system that is centred on, and extends beyond, traditional health and social care. This includes adopting approaches which harness the power of communities and the voluntary sector and positively enable personalisation and flexible provider responses to flourish.

Towards a future pattern of provision

Personalised and preventive support

This is a developing set of services that will promote greater flexibility and innovation. We propose a competitive approach to facilitate a range of providers including the community and voluntary sectors to best serve needs.

Services for adults with complex needs

Integration and co-ordination of services with clear pathways of care centred on natural locality geographies. This underpins a no-competition proposal for these services, and re-procurement in each locality geography.

Community urgent care services

For community urgent care services we are proposing competition to achieve an alliance approach to harness the range of relevant expertise into a single arrangement for Northern, Eastern and Western Devon.

<https://www.newdevonccg.nhs.uk/involve/community-services/101039>

Next steps and your views

Starting now we will:	In the first 12 months we will:
Communicate the contents of 'Integrated, personal and sustainable: community services for the 21st century' widely and invite and obtain feedback on the proposed direction for services by 8th July 2014.	As we know there is a clear impetus for action we will ensure an early focus on implementation on areas already in progress and also on more specific options and proposals as these are developed and agreed.
Engage local Health and Wellbeing Boards and local Healthwatch in Devon and Plymouth and consult with Devon Health and Wellbeing Scrutiny Committee and Plymouth Scrutiny Committee.	Some work is well advanced already and we are working with a number of communities to shape new models. This co-production will continue to develop, grow and guide local change in relation to this framework.
Further involve clinicians, commissioners, partner organisations, providers and their staff particularly through engagement of CCG localities, member practices, clinically focused care design groups and local authority colleagues.	Advance our work with local authorities on integrated health and wellbeing, commissioning and delivery to progress the model of integration Northern, Eastern and Western Devon.
Engage key groups who have an interest in this work including: carers, lay and professional stakeholder reference groups, council members, the voluntary sector, equality contacts, safeguarding leads and others.	Implement changes already underway with the support of communities, including the first of the new Health and Wellbeing hubs that are currently being designed.
Conduct in-depth work during the period between now and 8th July 2014 in relation to the contents of this framework including outcomes, impact assessments and the proposed approach to future provision.	Work towards early release and shifts of resources from current to new models of care with a clear and transparent programme, implementing this from the second half of 2014/15 and through 2015/16.
Review responses and decide the next steps towards 'Integrated, personal and sustainable: community services for the 21st century' at the Clinical Commissioning Group Governing Body meeting on 16th July 2014.	Progress the work to achieve sustainable delivery of services once decisions are made in July 2014 regarding the scope and nature of contract award processes.
In relation to future work as regards specific proposals we will begin a staged programme of publication - between June and September - for each of the care sections and localities - each with an eight-week period for comment.	Act on other changes that reflect national policy such as advancing our work on personalisation and personal health budgets, implementation of the Better Care Fund and greater integration.

Principles that will act as a guide

Early on in this programme, we established a large stakeholder reference group bringing together leaders and clinicians to add their experience and expertise. Taking into account the initial public engagement, this group set out ten principles for commissioning of community services. These have since been interpreted as 'I' experience statements and provide a framework for improvement through community services.

Community services commissioning principles

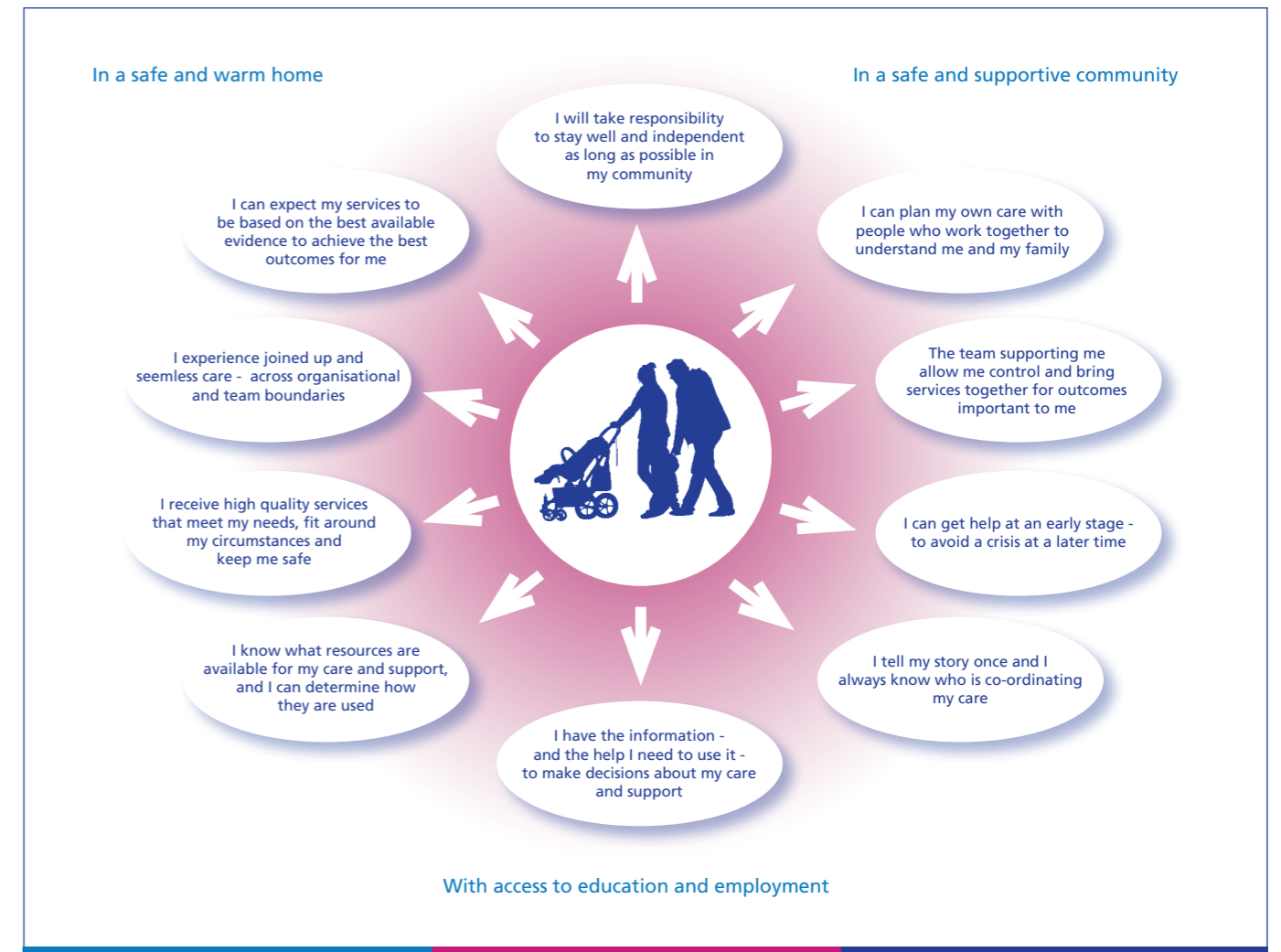
These principles will be an important marker to guide planning and decision making on the strategy and delivery arrangements for community services - and then at key milestone points in this journey of transformation so future services achieve the desired results:

- Integrated and seamless delivery
- Clear pathways and access

- Consistent outcomes
- Evidence-based foundations
- Individuals and carers at the centre
- Personalised and localised models
- Honest and open relationships
- Care which reflects health needs
- Sustainable, agile and flexible responses
- Shifts of resources and innovation.

Implications for experience

Built from these principles and the themes from engagement, these 'I' statements set out what individuals should be able to experience. They were developed with colleagues in Devon County Council and Plymouth City Council, and South Devon and Torbay Clinical Commissioning Group. Localities have also developed more detailed 'I' outcomes to reflect specific locality priorities identified through engagement. All of this will guide our work.



Please tell us your views

We would like your views to share with the Clinical Commissioning Group Governing Body and locality boards. At this stage we are asking you to comment on a strategic framework. Our approach to local implementation will be through co-production and should it be required for a specific change, further engagement and consultation. This means there will be opportunities to influence community services as more specific details become available.

Our questions for you

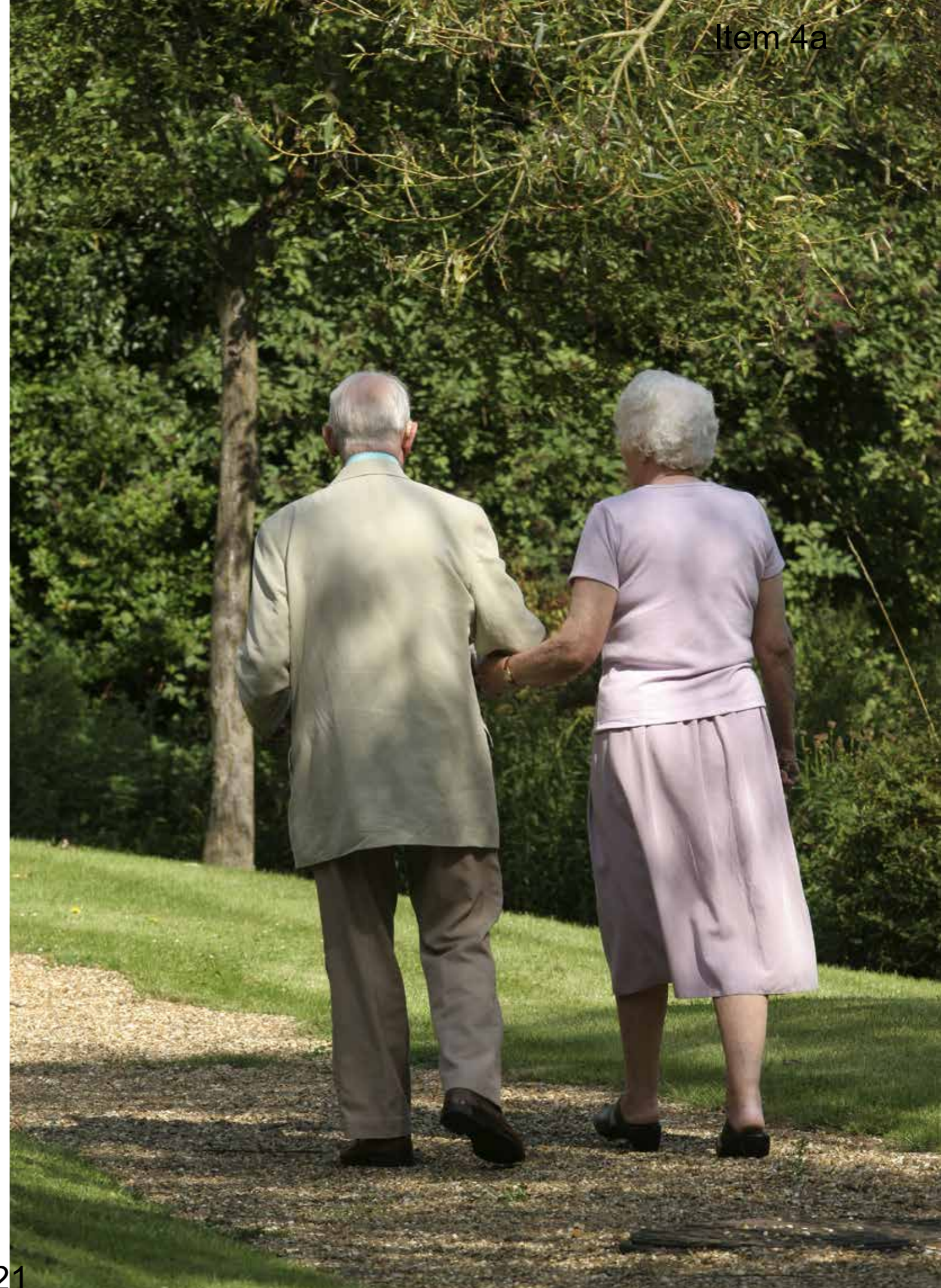
General questions:

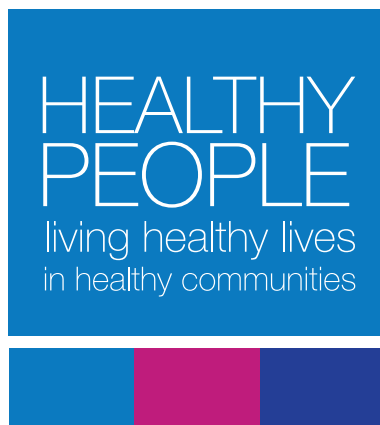
- What are your views on the direction of travel?
- What are your views on the level of ambition in this framework?
- What do you like most about the proposed way forward?
- What is your main concern about the proposed way forward?

We would particularly welcome your responses to these questions for the framework overall as well as in relation to the following sections:

- Preventive and personalised support
- Pathways for adults with complex needs
- Urgent care in the community
- Community specialty services
- Towards a future pattern of delivery

When and how to comment	
When?	Anytime during the eight weeks from now until 8th July 2014 - although it would be helpful if we could have your comments as early as possible in this time period.
How?	<p>There are a number of ways you can comment:</p> <p>Fill in the online form on https://www.newdevonccg.nhs.uk/involve/community-services/101039 or send an e-mail or written response to:</p> <p>Community Services, NHS NEW Devon Clinical Commissioning Group, County Hall, Topsham Road Exeter, D-CCG.Community@nhs.net</p> <p>Telephone one of our community relations managers to discuss your views by contacting Keri Ross on 01392 267680 or Sally Parker on 01752 398737</p> <p>Join in meetings or focus discussions that will be held over this time period as published on https://www.newdevonccg.nhs.uk/involve/community-services/101039</p>
Need any help?	If you need this document in a different format or language then please let us know using the contact details above.





Integrated,
personal and
sustainable

NEW Devon - Glossary of Terms

[A&E – Accident and Emergency](#)

ADVA - Against Domestic Violence and Abuse

[AQP – Any Qualified Provider](#)

[AT – Area Team \(NHS England\)](#)

[BID – Be Involved Devon](#)

[BMA – British Medical Association](#)

BME – Black, Minority and Ethnic

[BNF – British National Formulary](#)

C2C – Clinician to Clinician

[CAMHS – Child and Adolescent Mental Health Service](#)

[CCD – Community Council for Devon](#)

[CCG – Clinical Commissioning Group](#)

CD - Controlled Drug

CDAO - Controlled Drug Accountable Officer

[C-Dif – Clostridium Difficile](#)

CET – Clinical Executive Team

[CHC – Continuing Healthcare](#)

CIC - Community Interest Company

CIP – Cost Improvement Programme

CMO - Chief Medical Officer

COF – Commissioning Outcomes Framework

[CQC – Care Quality Commission](#)

CQUIN – Commissioning for Quality and Innovation

CYP – Children and Young People

DAAT – Drug and Alcohol Action Team

[DACVS - Devon Association of Councils for Voluntary Service](#)

[DART – Devon Access and Referral Team](#)

[DCC – Devon County Council](#)

DDA - Disability Discrimination Act

[DDOC – Devon Doctors on Call](#)

DH - Department of Health

[DPA – Data Protection Act](#)

DPH – Director of Public Health

[DPT – Devon Partnership Trust](#)

DRSS - Devon Referral Support Service

[EDDC – East Devon District Council](#)

[EDP - Exeter Drug Project](#)

[EDS – Equality Delivery System](#)

EDS - Eating Disorder Service

[EDVSA – East Devon Volunteer Support Agency](#)

EMSA – Eliminating Mixed Sex Accommodation

EOL - End of Life

[EPP – Expert Patient Programme](#)

[FOI – Freedom of Information](#)

[GMC - General Medical Council](#)

[GP – General Practitioner](#)

GPSI – GP Special Interest

[HCAI – Health Care Associated Infection](#)

HCG - Healthwatch Consultation Gateway

[HPA – Health Protection Agency](#)

HR – Human Resources

[HSJ – Health Service Journal](#)

HWB - Health and Wellbeing Board

[HWD – Healthwatch Devon](#)

[HWE - Healthwatch England](#)

IFR – Individual Funding Request
[IG – Information Governance](#)
IPAM – Integrated Performance and Assurance Meeting
[JSNA – Joint Strategic Needs Assessment](#)
KPIs - Key Performance Indicators
[LGBT – Lesbian, Gay, Bisexual and Transgender](#)
LIG – Local Implementation Group
[LMC – Local Medical Committee](#)
LTC – Long-Term Conditions
MDT – Multi-Disciplinary Team
[MHRA - Medicines and Healthcare Products Regulatory Agency](#)
[MIU – Minor Injury Unit](#)
[MP – Member of Parliament](#)
[MRSA – Meticillin Resistant Staphylococcus Aureus](#)
[NDDH – North Devon District Hospital](#)
[NDHT – Northern Devon Healthcare Trust](#)
[NE – Never Event](#)
[NEW DEVON – Northern, Eastern and Western Devon Clinical Commissioning Group](#)
[NHS – National Health Service](#)
[NICE – National Institute for Health and Care Excellence](#)
[NRLS – National Reporting and Learning System](#)
OOH - Out of Hours
OPMH – Older People’s Mental Health
[OSC – Overview and Scrutiny Committee](#)
PA – Personal Assistant
[PACT – Patient Advice and Complaints Team](#)
[PALS – Patient Advice and Liaison Service](#)
[PbR – Payment by Results](#)
[PCC – Plymouth City Council](#)
[PCH – Plymouth Community Healthcare](#)
[PEAT – Patient Environment and Assessment Team](#)
[PFI – Private Finance Initiative](#)
[PHE – Public Health England](#)
[PHNT – Plymouth Hospitals NHS Trust](#)
PPE – Patient and Public Engagement
[PPG – Patient Participation Group](#)
PRG – Patient Reference Group
[QIPP – Quality, Innovation, Productivity and Prevention](#)
[QOF – Quality and Outcomes Framework](#)
RAMP – Resource Allocation for Mental Health and Prescribing
[RCA – Root Cause Analysis](#)
[RD & E – Royal Devon and Exeter Hospital](#)
RTT – Referral to Treatment
[SD & T CCG – South Devon and Torbay Clinical Commissioning Group](#)
[SDHCT – South Devon Healthcare NHS Foundation Trust](#)
[SEA – Significant Event Audit](#)
[SIRI – Serious Incident Requiring Investigation](#)
[SWASFT – South West Ambulance Service Foundation Trust](#)
TCS – Transforming Community Services
[TDA – NHS Trust Development Authority](#)
TDRP – Treatment Decision Review Panel
TEP - Treatment Escalation Plan
[TRAC – Tamar Referral and Appointments Centre](#)
Wakley – Axminster, Honiton, Ottery St Mary, Seaton and Sidmouth
WEB – Woodbury, Exmouth and Budleigh
[WIC – Walk in Centre](#)



Northern, Eastern and Western Devon
Clinical Commissioning Group

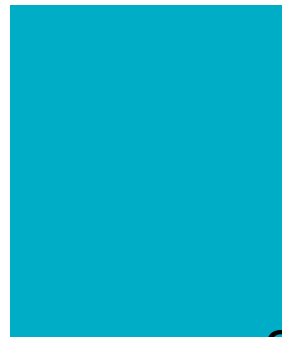
Item 4b



Shared Ambitions – NEW Devon and NHS England joint working



Dr Tim Burke and
Carol Williams



Objectives

- Describe Call to Action on Primary Care Phase 1 Report
- Describe current interface/joint working initiatives between NHS England & CCG
- Use Integrated Frailty pathway as an example of joint working

Primary Care Call to Action – Why does general practice need to change?

- **Demographics:** The population is growing and people are living longer. Those with more than one long-term conditions will rise from 1.9 million in 2008 to 2.9 million in 2018.
- **The GP workforce** is also ageing and insufficient graduates have been choosing General Practice over recent years. Numbers of GP's has grown at only half the rate of other medical specialties and has not kept up with population growth. More GPs are also working part time.
- **Outcomes:** There are variations in the general practice services that patients currently receive that impact on their care. There are growing challenges in relation to patient experience of access to care.
- **Financial constraints:** The NHS funding gap of £30 billion by 2021/22. Primary care potentially has a key role in helping reduce this gap by providing more personalised, accessible community-based services for patients to reduce avoidable pressures on hospital resources.

Wider primary care, delivered at scale

Item 4b



Northern, Eastern and Western Devon
Clinical Commissioning Group **England**

- General practice will likely need to operate **at greater scale and in greater collaboration** with other providers and professionals, and with patients, carers and local communities.
- At the same time general practice will also need to preserve and build on its traditional strengths of providing personal continuity of care and its strong links with local communities. We need to remember 90% of patient contacts are in Primary Care local to where people live.
- GP Practice populations as units of planning for services in communities.
- This does not necessarily have to involve a change in organisational form. It can be achieved through practices coming together in networks, federations or super partnerships, or as part of a more integrated model of provision.
- Developing a modernised Primary Care aligns with CCG strategies for shift of services into the community and maintaining people at home.

- General practice, at its best, has been described as the jewel in the crown. But without change and without support it will not be fit for purpose or sustainable for the next decade.
- To support locally-led transformations in primary care, there is a focus at national level on seven main areas :
 - i. Empowering patients and the public
 - ii. Empowering clinicians
 - iii. Defining, measuring and publishing quality
 - iv. Joint commissioning
 - v. Supporting investment and redesigning incentives
 - vi. Managing the provider landscape
 - vii. Workforce, premises and IT

Key national work (1/4)

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Empowering patients and the public

1. **Describing care planning:** work with National Voices and other partners to provide guidance on how to deliver personalised care planning
2. **Promoting innovative forms of patient participation:** work with the National Association of Patient Participation and other partners to support practices to develop inclusive and insightful approaches to building participation
3. **Enabling patients to access services in ways that better meet their needs and preferences:** use the Prime Minister's Challenge Fund to enable groups of practices around the country to pilot new ways of working that transform patient access to services

Empowering clinicians

4. **Reducing unnecessary burdens on general practice:** identify how to free up clinical time to provide more proactive, person-centred care and improve access
5. **Supporting the spread of innovation:** implement a range of measures to support the spread of innovation in general practice during 2014/15

Key national work (2/4)

Defining, measuring and publishing information on quality

6. **Defining quality:** work with CQC to develop national quality standards for wider primary care and general practice in the following domains:
 - clinical effectiveness
 - patient experience, including experience of access
 - patient safety
7. **Measuring quality:** lead work with NICE, CQC, PHE and other partners to improve metrics for quality and outcomes in general practice & wider primary care
8. **Publishing quality:** publish a greater range of comparative data for patients and the public, working with PHE and other partners

Joint commissioning of general practice services

9. **Joint commissioning:** develop framework for joint or collaborative commissioning of primary care by Area Teams and CCGs, including governance models.

Key national work (3/4)

Supporting a move of resources and redesigning incentives

- 10. Investment in general practice:** provide clarity about the different ways in which area teams and CCGs can make safe, controlled investments in general practice services
- 11. Develop and test innovative approaches to incentives:** develop practical tools to support the commissioning of 'general practice plus', e.g. integrated general practice & community health services
- 12. Primary care contracts 2015/16:** continue to develop the GMS contract and review local PMS contracts

Managing the provider landscape

- 13. 'Special measures' regime for failing practices:** define response to practices assessed by CQC as providing inadequate care
- 14. Policy on market entry and practice mergers:** refine policy on criteria/process for bringing in new providers, including policy on contract length for new APMS contracts, and merger of existing providers

Key national work (4/4)

Northern, Eastern and Western Devon
Clinical Commissioning Group

Supporting infrastructure

- 15. Premises:** develop a new framework for improving the quality of primary care premises, developing new premises solutions and making more cost-effective use of existing estates
- 16. Workforce:** support HEE in developing the future primary care workforce, including a practical toolkit to support CCGs/area teams in working with LETBs to translate 5-year strategic plans into workforce plans and action to support retention and return to practice
- 17. IT and business intelligence:** publish a revised operating model for general practice IT and support more consistent information sharing between providers

Co-Commissioning Agenda

	NHS England	CCG	LA	Specialist Commissioning
CAMHS	✓	✓	✓	✓
Primary care (medical, dental, pharmacy, eye health)	✓	✓	✓	
Frailty	✓	✓	✓	
Practice Nurse and Community Nurse Development	✓	✓		
Strengthening the voice of the public in	✓	✓ 34	✓	✓

Co-Commissioning for Quality

	NHS England	CCG	LA	
Safeguarding Children & Adults	✓	✓	✓	
Sepsis	✓	✓	✓	
Tackling variation in Primary Care	✓	✓		
Learning from Significant Events in Primary Care	✓	✓		

Local Primary Care Co-Commissioning Initiatives

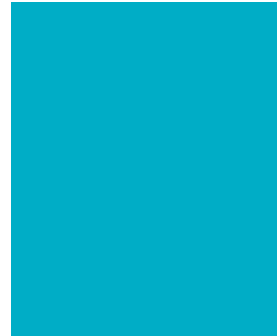
- Establishment of the Peninsular Primary Care Commissioning Oversight Group (PCOG) Membership: AT, CCGs, LMCs, PHE
- Successful Peninsula bid for the Prime Minister's Challenge Fund. (£3.5m to pilot innovative access to GP Services)
- Appointment of chairs for the Pharmacy, dental, eye health Local Professional Networks (LPNs)
- Implementation of each LPN and agreement of annual work plan

Local Primary Care Co-Commissioning Initiatives

- Call to action events:
- Medical (July 2013)
- Pharmacy (February 2014) <http://youtu.be/7Egj6sf9hwk>
- Dental (April 2014) <http://youtu.be/V6y41dlE3sY>



Safe, Compassionate Care for Frail Older People using an Integrated Care Pathway



Helen Lyndon Nurse
Consultant Older People.
Clinical Lead Frailty
NHS England Devon, Cornwall
and Isles of Scilly Area Team





An overview of our session today

- Introduction to frailty and multimorbidity
- An update on the NHS England Frailty Guidance
- Changes to the General Practice contract to focus on older people living with frailty
- The elements of a pathway of care
- Interventions at all stages of the pathway



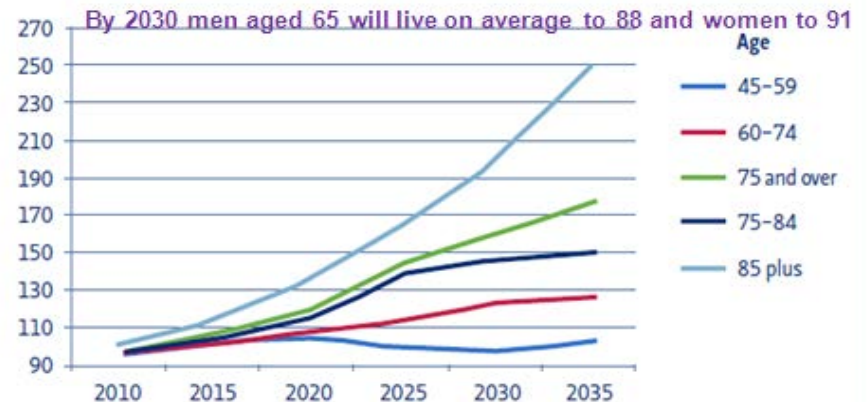
Long Term Conditions and an Ageing Population

‘Death is no longer an event, it is a long, drawn out process’

Brown 2008

- Each day between 2011 and 2030, an average of 10,000 people will turn 65
- On average, death is now preceded by 10 years of chronic ill health and figure is rising
- Those aged over 100 years will grow from 10,000 now to 1 million by 2030

Figure 1. Projected population by age, United Kingdom, 2010–35 (2010 = 100)



Source: Office for National Statistics (Oct 2011) National Population Projections 2010-based Statistical Bulletin.



The ageing population – a success story for society and healthcare

Contrary to stereotypical, ageist attitudes...

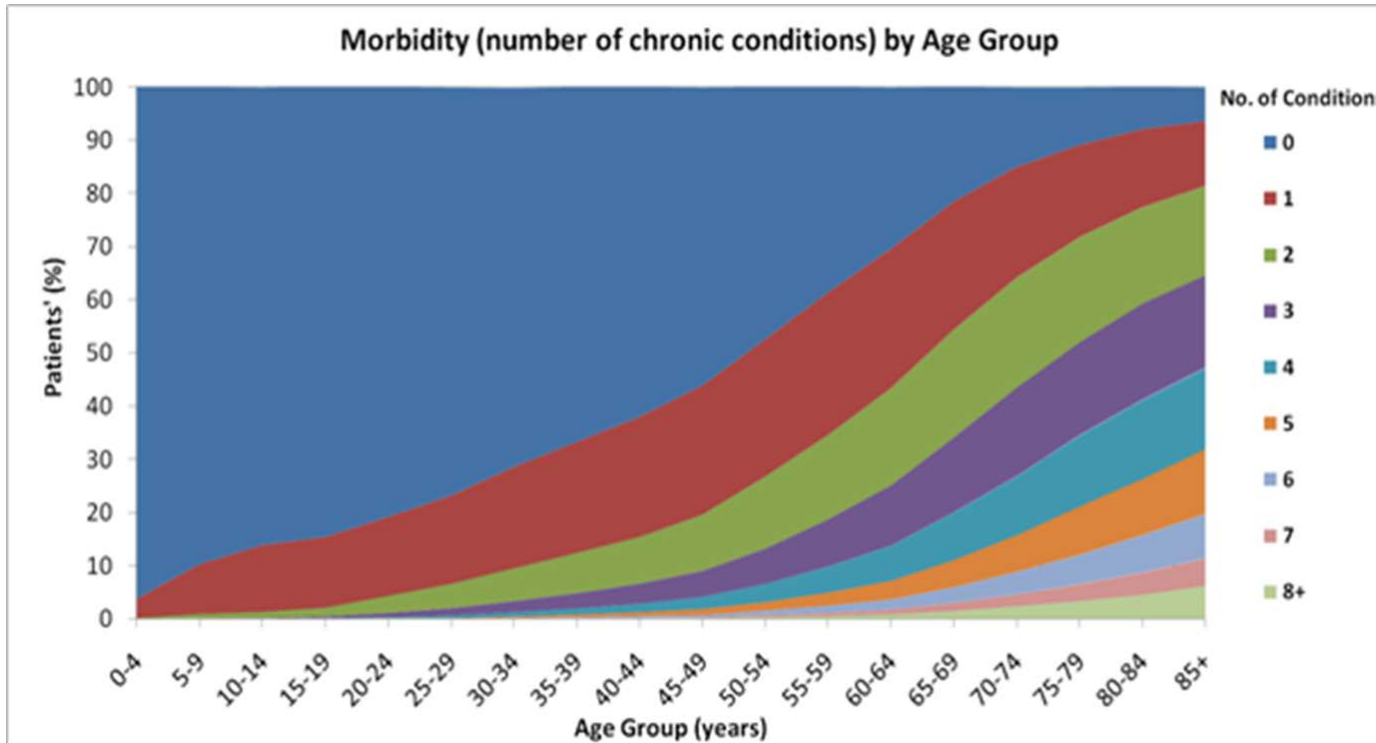
- Most older people are **not** ill, unhappy, dependent, isolated etc.
- Many stay active, working, volunteering, contributing
- Let's stop labelling
- Need more focus on prevention (primary and secondary) across the life-course
- Help to age well “in place” and support unpaid carers.



Thanks to David Oliver



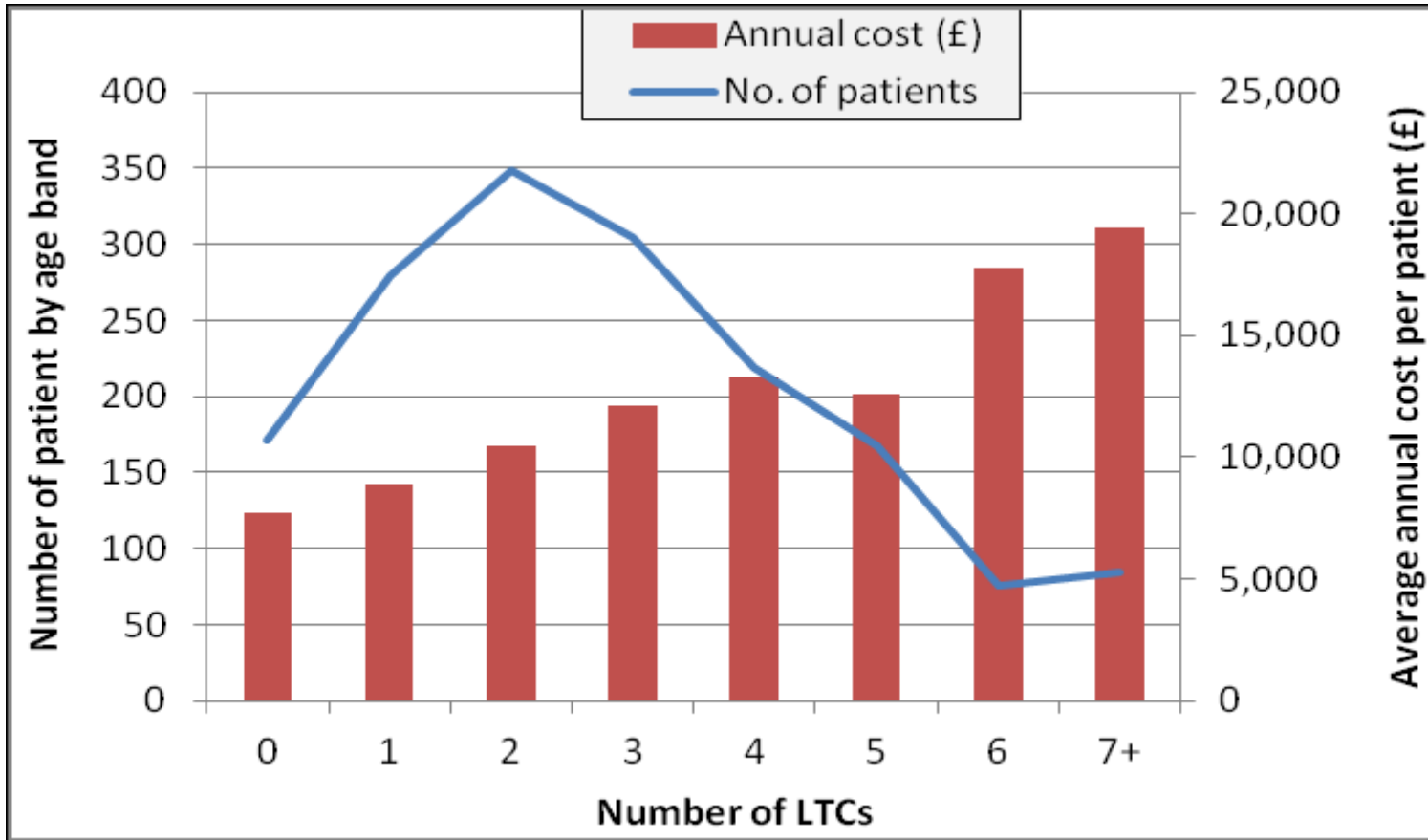
Multimorbidity is the norm



The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions
More people have 2 or more conditions than only have 1



Relationship between number of long-term conditions and cost





Frailty & Current Health Care Policies House of Lords Report April 2014

Old Age ain't for sissies'

- Bette Davis

- 'Nor will the UK be if we fail to act now'
- Report illustrates two possible futures for older people in the UK – best and worst case scenario





Frailty & Current Health Care Policies House of Lords Report April 2014


Recommendations:

1. Long-termism, end thinking in 5 year electoral cycles – need to think 25 years ahead.
2. Working on a cross-party political basis to reform pensions, NHS and social care, housing, public transport.
3. Inclusivity – young and older people working together for a better future





UK Health care: a “PERFECT STORM”

- Increasingly clumsy health & social care system
- Changing population
- Simple needs  highly complex (frailty)
- The Austerity Years



*Health & Social Care System
needs to be fit for purpose*



Frail Older People in Urgent Care Settings

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“when we design services for people with one thing wrong at once but people with many things wrong turn up, the fault lies not with the users but with the system, but all too often we label these patients as inappropriate and present them as a problem”

Rockwood 2005



*“**Systems** designed to treat occasional episodes of care for normally healthy people are being used to deliver care for people who have complex and long term conditions. The result is often that they are passed from silo to silo without the system having ability to co-ordinate different providers”*

Stephen Dorell MP 2012



The evidence

- 43% increase in mortality at ten days after admission through an overcrowded emergency department (ED) (Richardson 2006)

Length of stay in an ED is a predictor of inpatient length of stay (Liew et al 2003):

- An ED stay of 4-8 hours increases inpatient length of stay by 1.3 days and an ED stay of more than 12 hours increases length of stay by 2.35 days.
- For patients who are seen and discharged from ED, the longer they have waited to be seen, the higher the chance that they will die during the following seven days (Guttmann et al 2011)



The evidence

Levels of avoidable harm among older people are considerably higher than in younger age groups:

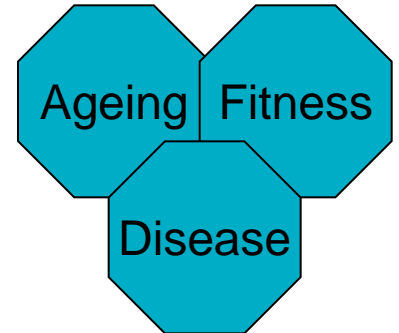
- A higher likelihood of polypharmacy in the older population, who may be more susceptible to adverse effects
- Falls: falls in care among patients over 70 is 2.77%, compared with 1.26% in patients 70 or younger (NHS Safety Thermometer, 2013).
- Pressure ulcers: 6.24% of patients over 70 recorded as having a pressure ulcer, compared with 3.41% in all other age groups (NHS Safety Thermometer, 2013).
- It is established that frail older people can suffer harm from receiving care in an acute setting when this is not absolutely necessary.



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A definition of frailty



Frailty is not a disease but a combination of the natural ageing process and a variety of medical problems:

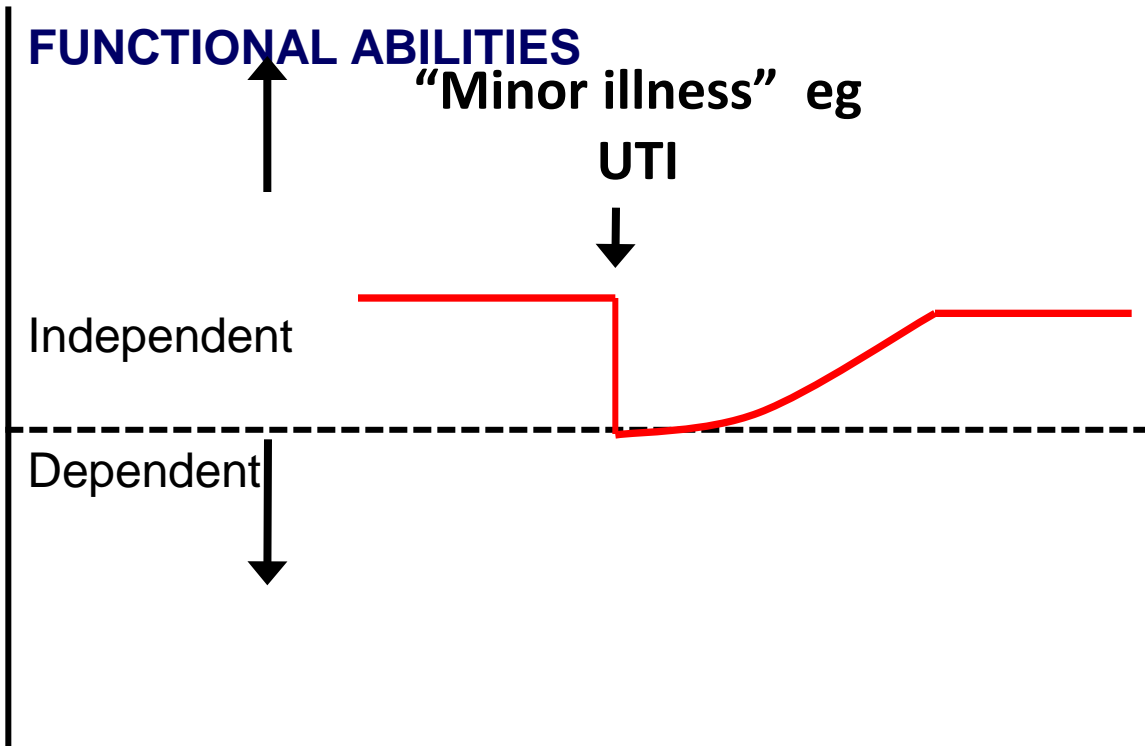
- It is characterised by loss of reserve, energy and wellbeing.
- It increases the risk of adverse outcomes, including falls, delirium and disability.
- A useful definition is: “Multidimensional loss of reserves - energy, physical ability, cognition and health”

Rockwood et al (2005)



Frailty is a loss of physiological reserve

Frailty syndromes present in crisis



Hyper-acute Frailty syndromes:

- Immobility
- Falls
- Delirium
- Fluctuating disability
- Incontinence



Impact of increasing frailty on patients and carers from their perspective



“No, you think you’re going to go on the same way, at least I think most people do, don’t they? I never thought one day I should be sitting here, can’t do anything - never even thought of it.”



And then he doesn’t seem to be so strong: once we got nearly as far as nearly the pillar box (on a walk) but now I don’t know he doesn’t want to go as far as that. I’m just terrified he’s going to die.”



“But my confidence in life in general has gone, you know because you can’t do things...I haven’t got the confidence anymore.”



Frailty, Social Isolation and Loneliness

Windle et al (2011) Preventing loneliness and social isolation: interventions and outcomes. Social Care Inst for Excellence Research Briefing 39

Key messages:

- Frail older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income.
- Social isolation and loneliness impact upon quality of life and wellbeing, adversely affecting health and increasing use of health and social care services.

Lonely older adults have a 14% increased risk of dying early than their peers who have strong social ties.

Cacioppo et al 2014



Indicators of Frailty

- Reduced mobility
- Muscle weakness/lack of strength
- Poor balance
- Deficits in motor processing
- Cognitive decline
- Poor nutrition/weight loss
- Lack of endurance/reduced stamina
- Limitation of physical activity

Ferrucci et al (2004)

[Designing Randomized, Controlled Trials Aimed at Preventing or Delaying Functional Decline and Disability in Frail, Older Persons: A Consensus Report.](#) Journal of the American Geriatrics Society, Vol52, Issue 4, pp: 625-634. Available at www.ncbi.nlm.nih.gov/pubmed/15066083 (accessed 17 April 2013)



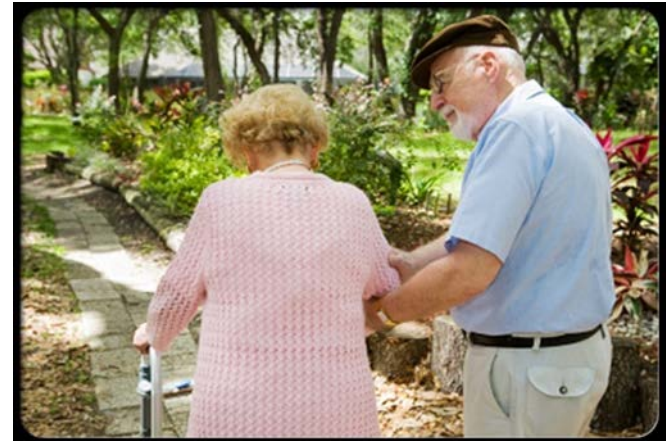
Why worry?

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Frailty is a reliable predictor of a general decline in health. The frail face an immediate future of:

- Falls
- Deteriorating mobility
- Disability
- Hospitalisation
- Death.



Frailty is also highly associated with cardiovascular disease, low education and poverty.

Fried et al (2001) *J Gerontol A Biol Sci Med Sci*

Song et al (2010) *J Am Geriatr Soc*

Frailty

Can we manage it in Primary Care as a long term condition?



‘Frailty is an enigma: it surrounds us in health and social care and we recognise it when we see it – but it is, paradoxically, invisible because we do not regard it as a diagnosis or formally record it. Indeed, we tend to use the term as an adjective – “the frail elderly” – rather than considering it more properly as an abnormal health state, like a long term condition.

This is important because frailty absolutely behaves like a long term condition: it has a high prevalence; it is progressive; it impacts adversely on life experience; it is expensive; and it has acute exacerbations.’

Prof John Young, Clinical Director for Frailty and Integrated Care, NHS England



Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders



If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm.



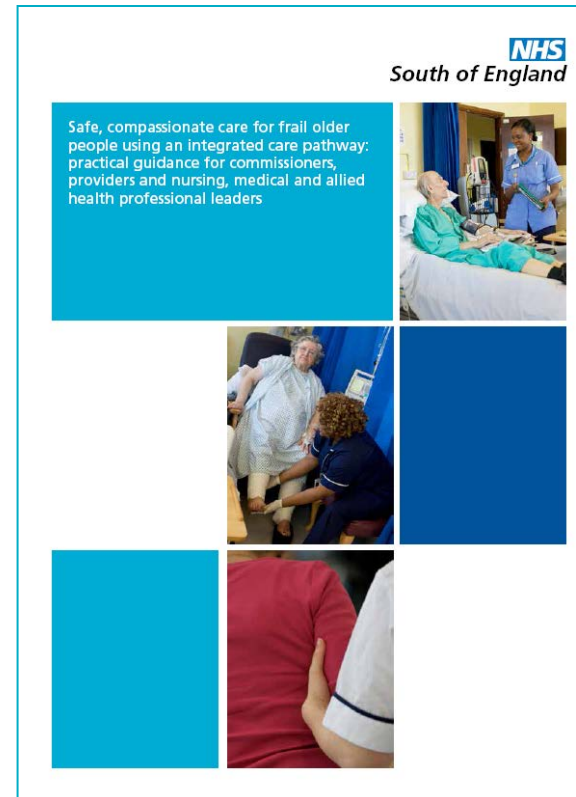
This document summarises the evidence of the effects of an integrated pathway of care for older people and suggests how a pathway can be commissioned effectively using levers and incentives across providers.

<http://www.england.nhs.uk/ourwork/pe/safe-care/>



The Guidance....

- Summarises the standards and interventions at all elements of the care pathway
- Suggests some levers and incentives to support CCGs in implementing a pathway of care
- Suggests some areas for CQUINs for providers
- Suggests outcome measures for measuring success





QOF Changes 2014/15



- 40 QOF indicators retired
- These changes are intended to reduce bureaucracy, allow GPs and practice staff more time to focus on the needs of individual patients



New Unplanned Admissions Enhanced Service

“ a new agreed ES places emphasis on practice availability to patients at risk of hospital admission through the proactive case management of at-risk patients and will require coverage of 2% of the practice population over 18 years of age”

Could these be frail patients? They are:

- The highest users of services
- Hospital admission can be avoided in 20-30% of frail patients aged 75 years and over (Mytton et al 2012)

Providing proactive care and avoiding unplanned admissions for vulnerable people:

A PROGRAMME OF **ACTION** FOR GENERAL PRACTICE ↗



The new enhanced service about to be introduced in general practice – together with new opportunities for clinical commissioning groups (CCGs) to shift funding into primary care services and community health services – are designed to bring about a step change in the quality of care for frail older people and other patients with complex needs.

The cohort of patients that you identify as having the greatest need will be enrolled onto a new, more proactive programme of care, tailored to their individual needs and overseen by a named, accountable GP. This short guide sets out how you and your CCGs can work together to ensure that we achieve the greatest possible benefits for patients – and how NHS England will support you.

Background

As we all know, unplanned admissions to hospital are often distressing and disruptive for patients, carers and families and they are a significant and unnecessary cost to the NHS. Many unplanned admissions are for those who are frail or have complex physical and/or mental health and care needs; almost 30% of emergency admissions¹ and over 30% of emergency readmissions² are for people aged over 75. Multi-morbidity and poly-pharmacy increase clinical workload, so doctors, nurses and pharmacists need to work coherently as a team with a balanced clinical skill-mix. (For example, we know that around five to eight per cent of hospital admissions are due to preventable, adverse effects of medicines).

We are confident that many unplanned admissions can be avoided through freeing up more time for general practice to provide proactive care –

¹ HSCIC (2013) HES Admissions Statistics

(<http://www.hscic.gov.uk/catalogue/PUB10584/ccg-ind-to1-mar-13-v4.pdf>).

² HES, HSCIC (2012/13). Analysis of finished emergency admissions by age at start of admission episode (acute & geriatric specialties) (www.hscic.gov.uk/hes)



Components of the ES...

- Improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
- Ensure that other clinicians can easily contact the practice by telephone to support decisions relating to hospital transfers or admissions;
- Regular risk profiling to identify at least two per cent of adult patients – and any children with complex needs – who will benefit from more proactive care management and to enrol them onto the new programme of proactive care;
- One-to-one discussions with patients on the programme to agree and regularly review a holistic care plan that reflects their individual needs and wishes;



Components of the ES...

- Provide proactive care and support for patients on the programme, including ensuring that patients have a named accountable GP and care coordinator;
- Provide timely follow up by an appropriate professional in the practice team when a person is discharged from hospital, so that they receive coordinated care upon discharge;
- Take part in internal reviews of unplanned admissions and/or readmissions and notify any serious incidents to the CCG and/or area team as appropriate.



Implementing frailty in primary and community care services – CCGs

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EVERYONE COUNTS:

PLANNING FOR PATIENTS 2014/15 TO 2018/19



NHS SERVICES 7 DAYS A WEEK



Specific focus during 2014/15 on patients aged 75 and over and those with complex needs.

CCGs will be expected to:

- support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans.
- provide additional funding to commission additional services which practices have identified will further support the accountable GP in improving quality of care for older people.

The funding of £5 per head of population for each practice, equates to £50 for patients aged 64 and over.

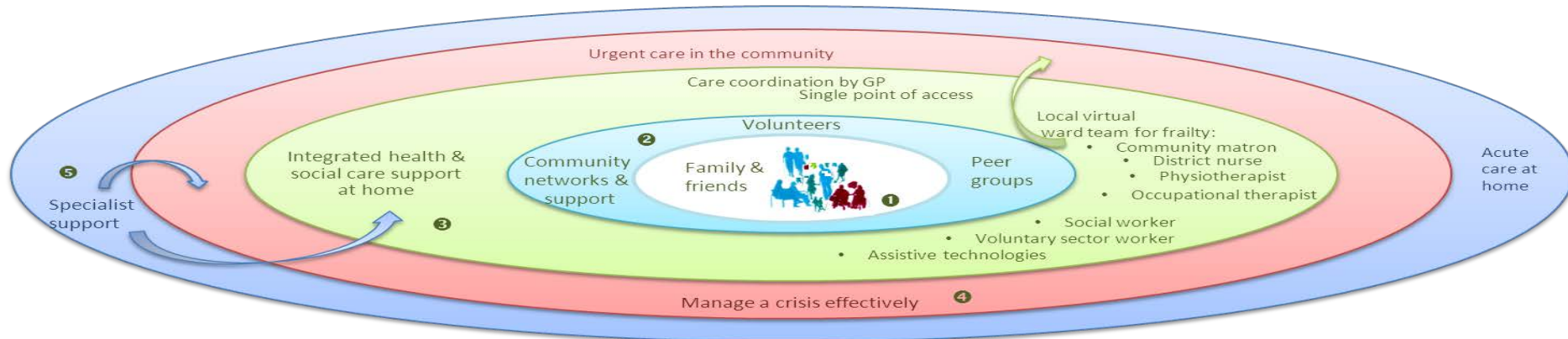


Implementing frailty in primary and community care services – CCGs

Suggested services to support general practice in delivering the DES:

- rapid response community nursing;
- additional support from mental health service providers;
- designated district nursing;
- additional discharge coordinator services;
- additional support for carers;
- targeted social care services;
- additional services from voluntary and charitable organisations;
- additional use of services from pharmacy.

A model of care for those who are frail or who have complex care needs



Elements and standards of a 'Home-to-Home' Frailty Care Pathway





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So what interventions work?



Oliver D, Foot C, Humphries R (2014).
Accessed at: <http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population>



Elements of the pathway (1)



Healthy active
ageing and
supporting
independence

Goal

- Older people should be able to enjoy long and healthy lives, feeling safe at home and connected to their community.



Elements of the pathway (1)

Interventions we know can work:



Healthy active
ageing and
supporting
independence

- Life-course approaches to health and wellbeing that address the wider determinants of health
- Housing for older people
- Preventing social isolation and promoting age-friendly communities
- Cold weather planning
- Promoting healthy lifestyles and wellness
- Adequate treatment for 'minor' needs that limit independence
- Vaccination



Elements of the pathway (2)



Living well with
long term
conditions

Goal

Older people with simple or stable long-term conditions should be enabled to live well, avoiding unnecessary complications and acute crises.



Elements of the pathway (2) Interventions we know can work:




Living well with
long term
conditions

- Continuity/care co-ordination
- Population risk stratification
- Case management delivered through integrated locality-based teams
- Involving older people and their families in planning and co-ordinating their care
- Personal care budgets
- Telehealth
- Support and education for family and volunteer carers
- Ensuring that older people receive the same care and support as younger people with the same condition



Elements of the pathway (3)



Living well with complex comorbidities and frailty

Goal

Health and care services should support older people with complex multiple comorbidities, including frailty and dementia, to remain as well and independent as possible and to avoid deterioration or complications.



Elements of the pathway (3)

Interventions we know can work:



Living well with
complex
comorbidities
and frailty

- Recognising the importance of frailty
- Frailty risk assessment and case-finding
- Proactive comprehensive geriatric assessment and follow-up for people identified as frail
- Exercise for frail older people
- Falls prevention
- Providing good care for people with dementia
- Reducing inappropriate polypharmacy



Elements of the pathway (4)

Goal

When the health or independence of older people rapidly deteriorates, they should have rapid access to urgent care, including effective alternatives to hospital.



Rapid support
close to home
in crisis



Elements of the pathway (4)

Interventions we know can work:



Rapid support
close to home
in crisis

- Continuity of primary care
- Urgent access to primary care
- Urgent, co-ordinated social care
- Ambulance services implement shared care strategies with other services
- Hospital At Home services
- Virtual or community wards
- Telecare for older people at risk
- Discharge-to-assess models
- Access ambulatory care clinics
- Community and interface geriatrics



Elements of the pathway (5)



Good acute
hospital care
when needed

Goal

- Acute hospital care must meet the needs of older patients with complex co-morbidities, frailty and dementia.
- Services should provide adequate access to specialist input, minimise harms and ward moves, and provide care that is compassionate and person-centred.



Elements of the pathway (5)

Interventions we know can work:



Good acute
hospital care
when needed

- Comprehensive geriatric assessment
- Focusing on dignified person-centred care
- Specialist elderly care units and wards
- Liaison and in-reach services for frail older people under other medical and surgical specialities
- Maximising continuity of care
- Improving safety and preventing avoidable deaths
- Minimising harms of hospitalisation
- Improving care for inpatients with dementia and mental health problems



Elements of the pathway (6)



Good discharge
planning and
post-discharge
support

Goal

- Discharge planning needs to start at first contact with the hospital and be standardised and embedded in practice, with older people and their carers fully and promptly involved.
- The NHS and social care should work together to ensure that patients can leave hospital once their clinical treatment is complete, with good post-discharge support in the community.



Elements of the pathway (6) Interventions we know can work:



Good discharge
planning and
post-discharge
support

- Early senior assessment, assertive discharge planning, and a clear focus on patient flow
- Concerted focus on discharge planning throughout hospital stay, and the ability to discharge seven days a week
- Involving older people and their carers in discharge plans
- Integrated information systems and structured multi-professional communication
- Effective post-discharge assessment and support
- Reducing delayed transfers of care



Elements of the pathway (7)



Good
rehabilitation
and reablement

Goal

Older people should receive adequate rehabilitation and re-ablement to prevent:

- permanent disability
- greater reliance on care and support
- avoidable admissions to hospital
- delayed discharge from hospital

And to provide adequate periods of assessment and recovery before any decision is made to move into long-term care.



Elements of the pathway (7)

Interventions we know can work:



Good
rehabilitation
and reablement

- Shared and comprehensive assessment of needs and personalised plans
- Implementing evidence-based best practice
- Commissioning for patient outcomes
- Home-based rehabilitation and re-ablement
- Community hospital-based rehabilitation and re-ablement
- Using alternative providers
- Workforce training in re-ablement
- Successful ending of and transition from rehabilitation and re-ablement.



Elements of the pathway (8)



High quality
nursing and
residential care
home care

Goal

- Though some people make a positive choice to enter long-term care, older people should only generally move into nursing and residential care when treatment, rehabilitation and other alternatives have been exhausted.
- Residents should consistently receive high-quality care that is person-centred and dignified, and have the same access to all necessary health care as older people living in other settings.



Elements of the pathway (8) Interventions we know can work:

NHS
England



High quality
nursing and
residential care
home care

- Preventing avoidable admissions to long-term care
- Active commissioning of health and mental health care for care home residents
- Information-sharing
- Conducting holistic assessments and developing personalised care plans
- Providing support and training for care home staff



Elements of the pathway (9)



Choice, control
and support
towards the end
of life

Goal

- Older people who are nearing the end of life should receive timely help if they want or need it, to discuss and plan for the end of life.
- End-of-life care services should provide high-quality care, support, choice and control, and should avoid over-medicalising what is a natural phase of the ageing life course.



Elements of the pathway (9) Interventions we know can work:



Choice, control
and support
towards the end
of life

- Identifying people in the last year of life
- Effective assessment and advance care planning
- Adequate provision of specialist palliative care services
- Supporting care home residents to die in the care home rather than in hospital
- Home-based services
- Improving end-of-life care for people with dementia
- Management of the dying phase and the crucial importance of involving patients and families.



And finally....

- Integrated care, joining it all up...



<http://www.kingsfund.org.uk/audio-video/joined-care-sams-story>



Some questions for you...

1. How far have you progressed with implementing an 'end to end' pathway of care for older people living with frailty?
2. What support do you need?
3. What are the challenges?

And finally... What happens next?



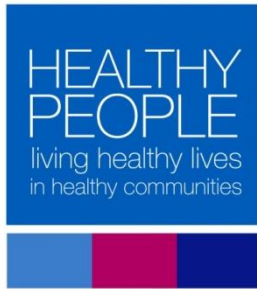
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Helen Lyndon
Nurse Consultant Older People
Clinical Lead, Frailty

helen.lyndon@pch-cic.nhs.uk

Tel: 07919891065



Northern, Eastern and Western Devon
Clinical Commissioning Group

Co-commissioning of Primary Care Services

Report for Devon Health and Wellbeing Board Meeting: June 2014

Recommendation

The Board is invited to engage and contribute views in relation to the potential new arrangements for co-commissioning of primary care services.

NHS England has asked CCGs to submit expressions of interest to develop new arrangements for co-commissioning of primary care services.

The Expressions of Interest should include information on the following areas:

- At individual CCG or group of CCGs level
- Scope
- Nature of co-commissioning
- Governance
- Monitoring and evaluation
- Engaging Member Practices and Stakeholders

To complete the Expression of Interest NEW Devon CCG would like to include the views of member practices, patient groups, provider organisations and local authority colleagues.

Publications Gateway Ref. Number 01599

Commissioning Development Directorate
Room 4N28, Quarry House
Quarry Hill
Leeds LS2 7UE
Barbara.hakin@nhs.net
Rosamond.roughton@nhs.net
0113 825 0919

9 May 2014

To: CCG Clinical Leads
Area Directors, NHS England

Copy: CCG Chief Officers

Co-commissioning of primary care services

We are writing to set out:

- how CCGs can submit expressions of interest to develop new arrangements for co-commissioning of primary care services, following Simon Stevens' announcement on 1 May (see annex A);
- the work proposed to be done through the NHS Commissioning Assembly to support CCGs and area teams in developing co-commissioning arrangements.

We are inviting CCGs to submit expressions of interest by 20 June. We would encourage CCGs to work with area teams in developing proposals.

Expressions of interest should include at least this information:

A. CCG(s) involved

Proposals may be submitted by an individual CCG or by a group of CCGs that wishes to propose co-commissioning arrangements to cover their combined localities.

B. Intended benefits and benefits realisation

Expressions of interest should set out how the proposals fit with five-year strategic plans and, in particular, how they will help:

- achieve greater integration of health and care services, in particular more cohesive systems of out-of-hospital care that bring together general practice,

community health services, mental health services and social care to provide more joined-up services and improve outcomes;

- raise standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices;
- enhance patient and public involvement in developing services, for instance through asset-based community development;
- tackle health inequalities, in particular by improving quality of primary care in more deprived areas and for groups such as people with mental health problems or learning disabilities.

C. Scope

Commissioning of primary care encompasses a wide spectrum of activity, including:

- working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;
- designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHS England);
- approving 'discretionary' payments, e.g. for premises reimbursement;
- managing financial resources and ensuring that expenditure does not exceed the resources available;
- monitoring contractual performance;
- applying any contractual sanctions;
- deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.

The expression of interest should indicate which aspects of commissioning fall within the scope of the proposed arrangements. CCGs may wish to propose that they take on delegated or joint responsibilities for some aspects, whilst NHS England continues to discharge other responsibilities directly.

We envisage that arrangements for managing the Performers List, revalidation and appraisal would fall outside the scope of any co-commissioning arrangements.

NHS England cannot delegate responsibility for commissioning of community pharmacy services or dental services. CCGs may wish to make proposals for how better to align decisions made by area teams in commissioning of community pharmacy services with CCGs' strategic objectives, provided that NHS England retains its statutory decision-making responsibilities and that there is appropriate involvement of local professional networks.

NHS England could in principle delegate responsibility for commissioning of primary eye care services, but the main services commissioned by NHS England (NHS sight tests) are essentially a demand-led service governed by national regulations.

D. Nature of co-commissioning

There is a spectrum of potential forms that co-commissioning could take, for instance:

- greater CCG involvement in influencing commissioning decisions made by NHS England area teams;
- joint commissioning arrangements, whereby CCGs and area teams make decisions together, potentially supported by pooled funding arrangements;
- delegated commissioning arrangements, whereby CCGs carry out defined functions on behalf of NHS England and area teams hold CCGs to account for how effectively they carry out these functions.

Expressions of interest will need to indicate the form that CCGs would like co-commissioning to take and how they would like this to evolve, including the proposed relationship with any current or proposed joint commissioning with local authorities.

CCGs will be expected to ensure that their proposals take advantage of synergies with existing areas of CCG activity and enable functions to be discharged within existing CCG running costs as far as possible. Expressions of interest will need to indicate where proposals would rely upon area team staff working under the supervision of CCGs.

E. Timescales

Expressions of interest will need to indicate the proposed timescales for applying the new arrangements, including any proposals for phasing (e.g. where some elements of co-commissioning are introduced during 2014/15, followed by a more developed form of co-commissioning during 2015/16).

Any proposals that rely upon setting primary care budgets at a locality level (below that of an area team) would have to be implemented from 2015/16 onwards.

F. Governance

CCGs already have powers to commission services from general practice (or from other primary care providers) in their own right. Where commissioning services from general practice, or from any organisation in which their members or offers have a

material interest, CCGs have a statutory duty to manage conflicts of interest and to have regard to the statutory guidance on managing conflicts of interest published by NHS England¹. CCGs would need equally to meet these duties and follow the statutory guidance in relation to any functions that they were to carry out jointly with, or on behalf of, NHS England.

Expressions of interest should set out any additional proposed safeguards for managing conflicts of interest.

G. Engaging member practices and local stakeholders

Expressions of interest should set out how CCGs have engaged their member practices in developing the proposals and any key issues raised by member practices, together with proposals for how they will further involve member practices.

Expressions of interest should provide any initial views of local stakeholders, together with proposals for engaging stakeholders more fully in developing the proposed arrangements more fully. This should, for instance, cover:

- patient groups;
- local authorities and Health and Wellbeing Boards;
- other local provider organisations, e.g. community, mental health, acute trusts.

H. Monitoring and evaluation

Expressions of interest should set out initial proposals for how to monitor and evaluate the impact and effectiveness of the proposed co-commissioning arrangements, in order to ensure that CCGs and area teams can adapt

NHS Commissioning Assembly project

The primary care working group of the NHS Commissioning Assembly will undertake a rapid piece of work to identify the key issues that will need to be resolved to support successful co-commissioning, with the aim of supporting area teams and CCGs in working together to refine the proposals that come from expressions of interest and to help spread innovative thinking.

This will include:

- identifying likely success factors for effective co-commissioning;

¹ <http://www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf>

- identifying the different forms that co-commissioning could take – and its potential scope – and the considerations that would need to be applied locally in choosing between them;
- developing a checklist that could guide CCGs and area teams through the steps involved in setting up new arrangements.


The project will also look, among other issues, at:

- how NHS England can assure itself that delegated functions are being discharged effectively and that any conflicts of interest are being managed appropriately;
- how associated financial resources would be allocated, managed and accounted for;
- any national decisions or approvals that would be needed in relation to information sharing;
- any implications for the public health offer to support primary care commissioning from Public Health England and local authorities.

Conclusion

CCGs are asked to submit expressions of interest, covering the factors set out above (paragraph 8), by 20 June. Please submit expressions of interest to england.co-commissioning@nhs.net.

The relevant Area Team will then discuss each proposal with the applicant CCG(s) and subsequently make a recommendation for approval through the Board governance of NHS England.



Rosamond Roughton
National Director: Commissioning Development



Dame Barbara Hakin
Chief Operating Officer

NHS ENGLAND PRESS NOTICE (1 May 2014)

LOCAL HEALTH PROFESSIONALS TO GET MORE POWER TO IMPROVE NHS PRIMARY CARE

Stevens announces new option for local Clinical Commissioning Groups to co-commission primary care in partnership with NHS England

England's 211 clinically-led local Clinical Commissioning Groups will get new powers to improve local health services under a new commissioning initiative announced today by NHS England Chief Executive Simon Stevens.

Speaking to GPs and other NHS health professionals at the Annual Conference of NHS Clinical Commissioners in London, Simon Stevens said:

"England has now taken the bold step – unique in the western world – of putting two thirds of its health service funding under the control of local family doctors and clinicians.

"If we want to better integrate care outside hospitals, and properly resource primary, community and mental health services - at a time when overall funding is inevitably constrained - we need to make it easier for patients, local communities and local clinicians to exercise more clout over how services are developed.

"That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations. As well as new models for primary care, we will be taking a hard look at how CCGs can have more impact on NHS England's specialised commissioning activities.

"So today I am inviting those CCGs that are interested in an expanded role in primary care to come forward and show how new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond.

"CCGs are still young organisations at different stages of development, and with different local needs. So rather than specifying a one-size-fits all solution, and having listened carefully to what CCGs have been saying, I'm keen to hear from CCGs themselves about what next steps they would like to explore."

Mr Stevens announced that NHS England will be writing next week to all CCGs in England with details of how to submit expressions of interest in taking on enhanced powers and responsibilities to co-commission primary care.

Applications will need to describe the additional powers and responsibilities the CCG would like to assume. They will need to meet a number of tests, including showing

they will help advance care integration, raise standards and cut health inequalities in primary care.

They will also need to show how they will ensure transparent and fair governance - with a continuing oversight role for NHS England to safeguard against conflicts of interest - all in the context of the CCG's five-year plan for its local NHS services.

NHS England will work with the NHS Commissioning Assembly, NHS Clinical Commissioners and other stakeholders to advance this agenda.

CCG expressions of interest should be developed by June 20, the same date that CCGs will complete their initial five-year 'Forward Views' for local NHS services.

Each proposal will be discussed by the applicant CCG and the local Area Team of NHS England, which will subsequently make a recommendation for approval by the Board of NHS England.

NOTES TO EDITORS

England's 211 CCGs are statutory bodies led by local GPs, alongside hospital doctors, nurses and other health professionals, managers, and independent lay members of the public.

NHS Clinical Commissioning Groups (CCGs) now control £67 billion of NHS funding – about two thirds of NHS spending in England.

Giving CCGs the ability to better influence and shape primary care services requires no further structural reorganisation, and the necessary enabling powers are already included in current legislation.

In accordance with national legislation, NHS England (and its Area Teams) will in all parts of the country continue directly to discharge specific primary care responsibilities, including in respect of community pharmacy, primary dental and ophthalmic services, as well as certain responsibilities in respect of primary medical services.

NHS South Devon & Torbay Clinical Commissioning Group (CCG) Update report from Dr Derek Greatorex, Clinical Chair, CCG

Recommendation: Section 1 (Strategic Plan) - for comment
From section 2 onwards - for information

1. Draft CCG Strategic Plan (appended)

The SDTCCG Strategic Plan 2014-19 has been signed-off by the SDTCCG Governing Body in April, and subsequently submitted to NHS England. The plan sets out the high level priorities for our organisation and our partners, and commissioning managers are following work plans for the next two years which will ensure the first stage of our five year plan is achieved.

In conjunction with submitting our five year plan, the CCG are also required to submit improvement trajectories for the indicators within the Quality Premium. **The Health & Wellbeing Board are asked to review the list (at appendix A), giving particular attention to the 'local determination' indicators, to ensure themselves they are content with the responses.**

2. Care Quality Commission

The CCG was involved in the CQC's visit 19-23 May to review the quality of health services for children in care, and the effectiveness of safeguarding arrangements for all children. The review evaluated the experiences and outcomes for children, young people and their families who receive health services within the boundaries of Torbay.

3. NEW Devon CCG Community Services

NEW Devon CCG has issued a strategic framework for community services, proposing:-

- Services for adults with complex needs (community and hospital) in West Devon will be transferred from South Devon and Torbay Health and Care Trust to Plymouth Community Healthcare in April 2016, with no competitive tender.
- Urgent care services will go out to tender
- Personalised and preventive services will go out to tender.

Comments on the proposals are welcome until July, and more information can be found at <http://www.newdevonccg.nhs.uk/involve/community-services/101039>

4. Musculoskeletal Service

The CCG's planned care team is currently reviewing the musculoskeletal pathway, alongside colleagues in primary care, physiotherapy, podiatry and consultant-led secondary care services. The key workstreams include:-

- Prevention, self-care and shared decision making
- Patient experience
- Service re-design
- Referral Management

5. Community Hub Developments

The 21 CCG led community engagement events throughout 2013/14 identified that people value joined-up care closer to home, continuity of care, and access to services through a single contact point. To help meet these needs, the CCG is working with provider organisations to develop community hubs to provide:-

- A central point for children and adults to access:-
 - Primary care
 - Social care
 - Mental health
 - The Integrated Care Organisation

- The voluntary sector
- The hospice
- A reduction in emergency admissions and long-term placements
- A reduction in inequalities
- An increase in people feeling supported to manage their conditions

The CCG plans to have 2 community hubs in place in 2014/15, currently planned in:-

- Torquay – for children and young people aged 0-25, their families and carers
- Newton Abbot – for frail older people, their families and carers

A further 3 community hubs (for the other localities) will be introduced in 2015/16.

6. **Joined-Up / Pioneer**

We continue to attend and contribute to discussions on important functional parts of Pioneer, such as creating an integrated workforce, modelling costs, contract changes and how to ensure that the patient experience forms a key part of our measurements. There's great value in being able to share learning nationally, as well as in influencing change for the future.

Our national senior sponsor, Jon Rouse (Director General, Social Care, Local Government and Care Partnerships), visited our pioneer site at the end of April, and heard all about the two community hubs being created in year one as part of our Joined-Up plans. He complimented us on our progress but reiterated the need to be clear about setting measurements which will really demonstrate what we're trying to achieve through integrated services.

The first edition of JoinedUp News (including the video, which creatively expresses our plans) can be found <http://us3.campaign-archive1.com/?u=6bbe2062414e4e29e92c68c76&id=529c1d2eb0&e=0913199447>

Options/Alternatives

N/A

Consultations/Representations/Technical Data

N/A

Financial Considerations

N/A

Sustainability Considerations

N/A

Carbon Impact Considerations

N/A

Equality Considerations

N/A

Legal Considerations

N/A

Risk Management Considerations

N/A

Public Health Impact

N/A

Electoral Divisions: All

Cabinet Member for Health & Wellbeing: Councillor Andrea Davis

Strategic Director People: Jennie Stephens

Item 4d

National Quality Premium Measures

Indicator	Measure	Response	Local determination? Y/N	Rationale for ambition
i) Potential years life lost (PYLL) from amenable causes in 2014/15	Potential Years of Life Lost (rate per 100,000)	Baseline 1843 in 2012, ambition 1777 in 2014/15	Y	Minimum required annual reduction of 3.2%. Data for 2012, so reduction at 2014/15 increased to 3.7% (as time period more than one year)
ii) What trajectory are you aiming for in the composite avoidable emergency admissions indicator in 2014/15?	Emergency admissions composite indicator	Baseline 1915.2 - ambition 1915.1 in Q4 2014/15	N	Aiming to move up by one quintile nationally
iii) For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16?	People receiving psychological therapies as a proportion of people with depression and/or anxiety disorders	Baseline 13% - ambition 15% by end of 2014/15, and 15.5% in 2015/16	N	National target of 15% in 2014/15
iv) a) Do you plan meet the nationally set objective for the Friends and Family Test in 2014-15 and 2015/16?	Yes/No	Yes	N	National requirement
iv) b) Which Friends and Family patient improvement indicator have you selected for an improved average score to be achieved between 2013/14 and 2014/15.	Select either: a) Improve GP out of hours patient experience, b) hospital care experience, or c) do not improve either	b) Patient experience of hospital care	Y	Area for most potential improvement
v) Have you agreed (in conjunction with your Health and Wellbeing Board and NHS England area team) a specified increased level of reporting of medication errors from specified local providers between Q4, 2013/14 and Q4, 2014/15?	Yes/No	Yes	Y	If we agree to improve reporting we have a better chance of understanding the issues and making an improvement

Quality Premium Local Priorities

Indicator	Measure	Response	Local determination? Y/N	Rationale for ambition
Dementia diagnoses	Diagnosis rate for people with dementia	Baseline: 45% in 2012 - ambition 50% by 14/15 and 67% by 15/16	Y	This indicator was selected as our local indicator as it is an area where the CCG has potential for significant improvement. It also has potential knock-on positive impacts for society as a whole and has also been selected as our local Better Care Fund indicator.

Adult Inpatient Services Survey – 2013 Results

Update report from Dr Derek Greatorex, Clinical Chair, South Devon & Torbay CCG
Dr Tim Burke, Clinical Chair, NEW Devon CCG

Recommendation: *For information / a verbal update will also be provided at the meeting.*

Appendix A: Inpatient Survey - National Summary

Appendix B: Inpatient Survey Results: Northern Devon Healthcare NHS Trust

Appendix C: Inpatient Survey Results: Plymouth Hospitals NHS Trust

Appendix D: Inpatient Survey Results: Royal Devon and Exeter NHS Foundation Trust

Appendix E: Inpatient Survey Results: South Devon Healthcare NHS Foundation Trust

Options/Alternatives

N/A

Consultations/Representations/Technical Data

N/A

Financial Considerations

N/A

Sustainability Considerations

N/A

Carbon Impact Considerations

N/A

Equality Considerations

N/A

Legal Considerations

N/A

Risk Management Considerations

N/A

Public Health Impact

N/A

Electoral Divisions: All

Cabinet Member for Health & Wellbeing: Councillor Andrea Davis

Strategic Director People: Jennie Stephens

National findings from the 2013 Inpatients survey

Introduction

This report details the key findings from the 2013 survey of adult inpatient services. This is the eleventh survey and involved 156 acute and specialist NHS trusts. We received responses from just over 62,400 patients, a response rate of 49%.

The questionnaire asks people about their experiences from hospital admission to discharge. This briefing note highlights any statistically significant differences from 2012 (the last time the survey was carried out). A “statistically significant” difference means that a change in result is very unlikely to have occurred by chance. Where comparisons are not shown, this is either because there has not been a statistically significant change, or because a question is new or has been changed.¹ A set of tables showing the year on year results for each question is available on the CQC website, along with the results for each NHS trust.

Summary

It is encouraging that there have been improvements in the results for many questions, with very few questions having a decline. However, a number of questions have remained stable meaning scope for continued improvement remains in some key areas such as involving patients in their care and treatment, information provision and discharge arrangements.

Information provision has been highlighted as an area of concern over repeated surveys of hospital inpatients. It is encouraging that there have been improvements in many of the questions asking about this across all areas of stay from arriving at hospital, to the ward and discharge:

There were increases in the proportion of respondents who say they were given the “right amount” of information about their condition or treatment: 75% of those who went through A&E said that they were given the “right amount” of information in A&E, up from 74% in 2012; and 80% of all respondents said were given the “right amount” of information on the hospital ward, up from 79% in 2012.

Improvements were also seen in some questions asking about information provision for operations and procedures: of those respondents who had an operation or procedure, 82% said that beforehand, a member of staff “completely” explained the risks and benefits in a way they could understand (up from 81% in 2012) and explained what would be done during the operation or procedure (76%, up from 74% in 2012). Sixty eight percent said

¹ If a question has been changed, it is not possible to present comparisons as it is not known if the change in result is caused by a change in patient experiences, or the change to the questionnaire.

that afterwards, a member of staff “completely” explained how it had gone in a way they could understand (up from 66% in 2012).

Information provision at discharge has improved in *some* areas: 69% were given written or printed information about what they should or should not do after leaving hospital (up from 67% in 2012) and 72% were “completely” given clear written or printed information about medication to take home (up from 71% in 2012). Sixty four percent received copies of letters sent between hospital doctors and their family doctor, up from 61% in 2012.

However, whilst improvements have been seen in some questions asking about respondents experiences of leaving hospital, this remains an area where further improvement is needed. There is scope to involve patients more in decisions about their discharge from hospital - although 54% “definitely” felt involved, an improvement from 53% in 2012, this still leaves a large proportion not feeling fully involved. Responses to the survey also suggest that scope remains for improvement in providing information about medication side effects as less than two-fifths of respondents (39%) reported that they were “completely” told about medication side effects to watch out for when they went home (up from 38% in 2012). Less than half (43%) were “completely” told about any danger signals they should watch out for at home (up from 41% in 2012). Half (50%) said that that doctors or nurses “definitely” gave their family or someone close to them all the information they needed to help care for them (up from 48% in 2012).

Delays to discharge from hospital remain a problem: results are unchanged from 2012 with 41% saying their discharge was delayed. Of these, a large proportion (62%) were waiting for medicines. Almost a quarter (24%) said that their discharge was delayed by four hours or more.

Questions asking about communication with staff have also seen improvements: 69% said that doctors “always” answered their questions in a way they could understand (up from 68% in 2012) and 76% said that doctors did **not** talk in front of them as if they were not there (up from 75% in 2012). Sixty nine percent were **not** given conflicting information by hospital staff, up from 68% in 2012. More than half (57%) “definitely” got enough emotional support from staff during their stay, if they needed this, up from 56% in 2012. However, less than half (40%) were “definitely” able to find someone on the hospital staff to talk to about their worries and fears, if they wanted to, though this is an improvement from 38% in 2012.

There have been improvements in questions asking about cleanliness with 69% describing the hospital room or ward they were in as “very clean” (up from 68% in 2012), and 62% describing the toilets and bathrooms as “very clean” (up from 61% in 2012).

There have been improvements in questions asking about privacy: 78% of those who went through A&E were “definitely” given enough privacy when being examined or treated there (up from 76% in 2012) and 75% of all

respondents were “always” given enough privacy when discussing their condition or treatment on the hospital ward, up from 74% in 2012.

There have also been improvements in questions asking about transitions out of hospital and between other services, if this was applicable: 61% said that hospital staff “completely” took their family or home situation into account when planning their discharge, up from 60% in 2012. Eighty five percent said that hospital staff discussed with them if they needed any further health or social care services after leaving hospital, up from 84% in 2012.

When asked to rate their overall experience on a scale of 0 to 10, most people responded positively with 71% rating their overall experiences as “8” or above. Over a quarter (27%) rated their overall experience as a “10” which was up from 25% in 2012.

Though results have improved from 86% in 2012, a large majority of respondents (79%) said that during their stay in hospital, they were **not** asked to give their views on the quality of their care.

Results from the Survey

Admission to Hospital

The majority of respondents (61%) said that their hospital stay was an emergency (for example, they were admitted after attending the Accident and Emergency Department) an increase from 59% in 2012. There has been a corresponding decrease in the proportion who had a planned admission (following referral by a healthcare professional), from 38% in 2012 to 36% in 2013.² The remaining 3% responded “something else” (for example, they may have been transferred from another hospital).

The Accident & Emergency Department (A&E)

Of those who were admitted as an emergency, the majority went through A&E when they arrived at hospital (84%, down from 88% in 2012).

Information Provision

The majority of respondents (75%, up from 74% in 2012) were given the “right amount” of information about their condition or treatment while they were in A&E. Nine percent said that they were not given any information and 16% said that they were not given enough.

Privacy

Just over three quarters of respondents (78%) were “definitely” given enough privacy when being examined or treated in A&E, up from 76% in 2012. There

² It should be noted that respondents tend to report different experiences dependent upon their method of admission (emergency or elective). Those who had an emergency admission tend to report less positive experiences than those who had an elective admission. This is taken into account when comparing results between NHS trusts in the scored data. .

was a corresponding decrease in the proportion to respond “to some extent” from 22% in 2012 to 20% in 2013. The remainder (2%) said they were not given enough privacy.

Waiting List or Planned Admissions

Choice

Over a quarter (27%) said that when they were referred to see a specialist, they were offered a choice of hospital for their first hospital appointment. Eleven percent said they were not offered a choice, but would have liked one. The majority (61%) were not offered a choice but said they did not mind.

Waiting to be admitted

Respondents were asked how they felt about the length of time they were on the waiting list before they were admitted to hospital. The majority (76%) said that they were “admitted as soon as I thought was necessary”. Fifteen percent said they “should have been admitted a bit sooner” and 8% that they “should have been admitted a lot sooner”.

Just under a fifth said that their admission date was changed by the hospital, either once (16%) or two or three times (3%). The majority did not have their admission date changed by the hospital (81%).

Transition between services

Respondents were asked if, in their opinion, the specialist they saw in hospital had been given all of the necessary information about their condition or illness from the person who referred them. The majority (82%) said “yes, definitely” with the remainder responding “yes, to some extent” (15%) or “no” (3%). This question is not comparable to 2012 due to changes made to the response options.

The Hospital and Ward

Waiting to get to the ward

All respondents were asked if, from the time they arrived at the hospital, it felt like they had to wait a long time to get to a bed on a ward. Most (66%) said “no” which is a statistically significant increase of less than one percent from 2012 (66%). The remainder said “yes definitely” (13%) or “yes, to some extent” (21%).

Single sex accommodation

It is a goal of the Department of Health and the NHS to “eliminate mixed sex accommodation, except where it is in the overall best interest of the patient or reflects their personal choice” and this is set out in the operating framework for the NHS.³ This is a complex area to assess using patient experience surveys as patients’ reporting can be influenced by:

- The purpose of the ward they stay in.

³www.gov.uk/government/uploads/system/uploads/attachment_data/file/216590/dh_131428.pdf

- Their journey around the hospital - many stay in more than one area.
- Their personal perceptions of what constitutes 'mixed-sex accommodation'.

To understand some of these effects, the survey results are presented separately for respondents who had emergency and those who had planned admissions, and they distinguish between sharing before and after moving to other wards. Sixty-two percent of respondents stayed in just one ward with 30% staying in two wards and 8% three or more.

We also exclude any respondents who stayed in critical care areas (such as Intensive Care, High Dependency Unit or Coronary Care Unit) as the majority of these areas are exempt from the mixed sex accommodation guidelines due to the necessity for clinical needs to be prioritised. In 2013, 22% said they stayed in a critical care area (up from 21% in 2012).

Single sex accommodation: when first admitted

Respondents were asked if, when they were first admitted, they shared a sleeping area (for example, a room or bay) with patients of the opposite sex. The majority of respondents said they did not: 92% of those who had an emergency admission and 94% who had a planned admission (though this is down from 95% in 2012 for planned admissions).

Single sex accommodation: after moving wards

Respondents who stayed in more than one ward were also asked if they shared a sleeping area with patients of the opposite sex after they were moved. Again, the majority of respondents said they did not: 95% of those who had an emergency admission and 96% who had a planned admission.

Single sex accommodation: bathroom areas

The NHS is required to monitor any mixed sex use of bathrooms⁴. Respondents were asked if they ever used the same bathroom or shower area as patients of the opposite sex. The majority (86%) said they did not. This leaves 13% who said they did and 1% who said they did because the bathroom had special bathing equipment that they needed to use.

Noise at Night

Almost two fifths of respondents (39%) said that they were bothered by noise at night from other patients. A fifth (20%) said that they were bothered by noise at night from hospital staff, a statistically significant decrease of less than one percent from 2012 (20%)

Cleanliness

Over two thirds of respondents (69%) described the hospital room or ward as "very clean", up from 68% in 2012. There was a corresponding decrease in the proportion who said it was "fairly clean" from 29% in 2012 to 28% in 2013. Two percent said it was "not very clean" and 1% "not at all clean".

⁴ www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/MSA-Stats-Press-Notice-January-2014.pdf

Sixty two percent of respondents described the toilets and bathrooms that they used in hospital as “very clean”, up from 61% in 2012. There was a corresponding decrease in the proportion who responded “fairly clean” from 33% in 2012 to 32% in 2013. Five percent said they were “not very clean” and 1% “not at all clean.”

Hand hygiene by patients and visitors is essential to control the spread of infection within hospitals. Most respondents (96%) said that hand-wash gels were available for patients and visitors to use. The remainder said they were empty (2%, up from 1% in 2012) or that they did not see any (3%).

Security

Most respondents (97%) said that they did not feel threatened during their stay in hospital by other patients or visitors, leaving 3% who said that they did.

Food

Respondents were asked how they would rate the hospital food. Twenty one percent said it was “very good,” a statistically significant increase of less than one percent from 2012 (21%). Thirty six percent described it as “good”, a statistically significant decrease of less than one percent from 2012 (36%). Twenty nine percent described the food as “fair,” down from 30% in 2012, and 14% described the food as “poor,” an increase from 13% in 2012.

The majority of respondents (79%) were “always” offered a choice of food, a statistically significant increase of less than one percent from 2012 (79%). Fifteen percent were “sometimes” offered a choice of food, leaving 6% who said they were not. As may be expected, responses to this question may reflect differences in the length of stay by patients: those patients having a stay of one day are more likely to say that they were **not** given a choice of food (11%, down from 12% in 2012%) compared with those who had a longer stay (3%).

Around a quarter of all respondents to the survey needed help from staff to eat their meals. Of this group, 64% said that they “always” got enough help. This leaves over a third who did not always get the help they needed, responding that they either only “sometimes” got enough help (19%) or that they did not get enough help (17%).

Doctors and Nurses

Communication

The majority of respondents (69%) said that doctors “always” answered their questions in a way they could understand, up from 68% in 2012. Twenty six percent said they “sometimes” did and 5% that they did not (6% in 2012).

The majority of respondents (69%) said that nurses “always” answered their questions in a way they could understand. Twenty seven percent said they “sometimes” did (26% in 2012) and 4% that they did not.

Just over three quarters of respondents (76%) said that doctors did not talk in front of them as if they were not there, an improvement from 75% in 2012. Nineteen percent said that this “sometimes” happened which is a statistically significant decrease of less than one percent from 2012 (19%). The remainder said this “often” happened (5%).

The majority of respondents (81%) said that nurses did not talk in front of them as if they were not there. Fifteen percent said that this “sometimes” happened and 4% that this “often” happened.

Respondents were asked whether one member of staff ever told them one thing and another told them something quite different. The majority (69%) said this did **not** happen, an improvement from 68% in 2012. There was a corresponding decrease in the proportion to say that this “sometimes” happened from 25% in 2012 to 24% in 2013. Seven percent said that this “often” happened.

Confidence and Trust

Eighty one percent said that they “always” had confidence and trust in the doctors treating them. The remainder responded “sometimes” (16%) or “no” (3%).

Over three quarters (77%) said that they “always” had confidence and trust in the nurses treating them. The remainder responded “sometimes” (20%) or “no” (3%).

Availability of Staff

Just under three fifths of respondents (59%) said that there were “always or nearly always” enough nurses on duty to care for them in hospital. Thirty percent said that there were “sometimes” enough nurses leaving 11% who said that there were “rarely or never” enough nurses, a statistically significant increase of less than one percent from 2012 (11%).

Two fifth of respondents (40%) “definitely” found someone on the hospital staff to talk to about their worries and fears, if they wanted to, up from 38% in 2012. There was a corresponding decrease in the proportion to respond “yes, to some extent” from 38% in 2012 to 36% in 2013. Almost a quarter (23%) said they were not able to find anyone to talk to about their worries and fears.

Fifty seven percent of respondents said that they “always” got enough emotional support from hospital staff, if they wanted this, an improvement from 56% in 2012. There was a corresponding decrease in those responding “yes, sometimes” from 30% in 2012 to 29% in 2013. The remaining 14% said they did not receive enough emotional support from staff.

Respondents were asked how long it usually took for them to receive the help they needed after they used the call button: 14% said this was “0 minutes /right away.” Most said this took between one and two minutes (38%) or between three and five minutes (29%). Seventeen percent said this took more

than five minutes and 1% said they never got help when they used the call button.

Patient care and treatment

Involvement in decisions

Providing the right amount of information to each patient in an understandable way is essential for them to be able to make informed decisions about their care and treatment.

Over half (56%) said that they were “definitely” involved as much as they wanted to be in decisions about their care and treatment, an improvement from 55% in 2012. There was a corresponding decrease in the proportion to respond “yes, to some extent” from 35% in 2012 to 34% in 2013. Ten percent said that they were not involved as much as they wanted to be.

The majority (80%) were given the “right amount” of information about their condition or treatment, up from 79% in 2012. A fifth (20%) were not given enough, a statistically significant decrease of less than one percent from 2012 (20%). The remainder (1%) said they were given “too much” information.

Privacy

Three quarters (75%) were “always” given enough privacy when discussing their condition or treatment, up from 74% in 2012. There has been a corresponding decrease in the proportion responding “yes, sometimes” from 19% in 2012 to 18% in 2013. Six percent said they were not given enough privacy.

Most (90%) said that they were “always” given enough privacy when being examined or treated. Eight percent said this was “sometimes” the case and 1% were not given enough privacy.

Pain management

When asked if they were ever in any pain during their stay in hospital, 64% of respondents said that they were. Of those who experienced pain, 71% said that staff “definitely” did everything they could to help control their pain, up from 70% in 2012. There has been a corresponding decrease in the proportion who responded “yes, to some extent” from 24% in 2012 to 23% in 2013. Six percent thought that staff did not do everything they could to help control their pain.

Operations and Procedures

Just over three fifths of respondents (61%) reported that they had an operation or procedure during their stay in hospital (down from 62% in 2012). These respondents were asked a number of questions about their experiences.

Before the Operation or Procedure

Most of the respondents who had an operation or procedure responded positively to questions asking about the information they received.

Just over four fifths of respondents (82%) said that a member of staff “completely” explained the risks and benefits of the operation or procedure in a way they could understand, up from 81% in 2012. Fifteen percent said this was explained to them “to some extent,” a statistically significant decrease of less than one percent from 2012 (15%). Four percent said this was not explained to them in a way they could understand.

Over three quarters of respondents (76%) said that a member of staff “completely” explained what would be done during the operation or procedure, an improvement from 74% in 2012. There was a corresponding decrease in the proportion to respond “yes, to some extent” from 21% in 2012 to 20% in 2013. Five percent said this was not explained to them.

The majority (78%) said that a member of staff “completely” answered any questions they had about the operation or procedure in a way they could understand. Nineteen percent responded “yes, to some extent” and 4% “no.”

Fifty seven percent said that they were “completely” told how they could expect to feel after the operation or procedure. However, this leaves over two fifths who were either not told this (15%) or told “to some extent” (28%).

Eighty five percent of respondents said that before the operation, they were given an anaesthetic or medication to put them to sleep or control their pain. Of these, 84% said that the anaesthetist or another member of staff “completely” explained how they would be put to sleep or have their pain controlled in a way they could understand. Eleven percent said this was explained “to some extent” and 4% that this was not explained in a way they could understand.

After the Operation or Procedure

Over two thirds of respondents (68%) said that a member of staff “completely” explained to them how the operation or procedure had gone in a way they could understand, up from 66% in 2012. There have been corresponding decreases in the proportions responding “yes, to some extent” from 23% in 2012 to 22% in 2013, or “no” from 11% in 2012 to 10% in 2013.

Leaving the Hospital

Preparing to leave hospital

Over half of respondents (54%) said that they “definitely” felt involved in decisions about their discharge from hospital, up from 53% in 2012. This leaves more than two fifths who did not feel they were involved enough, responding either “yes, to some extent” (30%) or “no” (16%, a statistically significant decrease of less than 1% from 2012).

Respondents were asked if they were given enough notice about when they were going to be discharged from hospital. Over half (56%) said they “definitely” were, 32% said they were “to some extent” (up from 31% in 2012) and 13% that they were not.

Respondents were asked if hospital staff took their family or home situation into account when planning their discharge. Of those for whom this was necessary (around three fifths of all respondents) 61% said hospital staff “completely” took their home or family situation into account when planning their discharge, up from 60% in 2012. There was a corresponding decrease in the proportion to say “no” from 19% in 2012 to 18% in 2013 with the remainder responding “yes, to some extent” (21%).

Delays to discharge

Forty one percent of respondents said that on the day they left hospital their discharge was delayed.

Of those who were delayed, most (62%) said this was caused by “waiting for medicines.” The remainder said this was due to “waiting to see a doctor” (14%), “waiting for an ambulance” (10%) or another reason (14%).

Respondents were also asked about the length of the delay: 15% were delayed by an hour, 28% between one and two hours, 33% between two and four hours, and 24% longer than four hours.

Medication

Respondents who were prescribed medication to take home were asked a number of questions about their experiences.

Three quarters (75%) said that a member of staff “completely” explained the purpose of medicines they were to take home in a way they could understand. Sixteen percent responded “yes, to some extent” leaving 8% who said “no.”

Less than two fifths of respondents (39%) said that a member of staff “completely” told them about the medication side effects to watch out for when they went home, though this was up from 38% in 2012. Nineteen percent responded “yes, to some extent” leaving over two fifths (42%) who said that a member of staff did not tell them about medication side effects to watch out for when they went home, though this is an improvement from 43% in 2012.

Just over three quarters (76%) said that they were “definitely” told how to take their medication in a way they could understand. Fifteen percent responded “yes, to some extent” and 9% “no.”

Seventy two percent responded “yes completely” when asked if they were given clear written or printed information about their medicines, up from 71% in 2012. There was a corresponding decrease in the proportion to respond “no” from 13% in 2012 to 12% in 2013. The remainder responded “yes, to some extent” (16%).

Information provision

Over two thirds (69%) said that they were given written or printed information about what they should or should not do after leaving hospital, up from 67% in 2012. This leaves 31% who said they were not given this information, though this is an improvement from a third (33%) in 2012.

Less than half of respondents (43%) said they received a “complete” explanation from a member of staff about any danger signals they should watch for after they went home, though this is up from 41% in 2013. There was a corresponding decrease in the proportion to say “no” from 38% in 2012 to 36% in 2013. The remainder said “yes, to some extent” (21%).

Half of respondents (50%) said that doctors or nurses “definitely” gave their family or someone else close to them all the information they needed to help care for them, if this was necessary, up from 48% in 2012. There were corresponding decreases in the proportion to respond “yes, to some extent” (24% in 2012 and 22% in 2013) or “no” (29% in 2012 and 28% in 2013).

Over three quarters (77%) said that hospital staff told them who to contact if they were worried about their condition or treatment after leaving hospital, leaving 23% who were not told this.

It is good practice that patients receive copies of letters sent between the hospital and the patients’ family doctor (GP)⁵. This year 64% of respondents said they received copies up from 61% in 2012. Of those who received copies, just over three quarters (76%) said that the letters were “definitely” written in a way they could understand. The remainder said “yes, to some extent” (22%) or “no” (2% in 2013 and 3% in 2012).

Transition from hospital

Two questions were included in the survey asking respondents whether hospital staff discussed transitions between other services with them when leaving hospital, if this was necessary.

Of those respondents for whom this was necessary, 81% said that hospital staff discussed with them whether they would need any additional equipment in their home, or any adaptations made to their home, after leaving hospital. This leaves 19% who said that staff did not discuss this with them, but they would have liked them to.

Eighty five percent said that hospital staff discussed with them whether they needed any further health or social care services after leaving hospital (such as services from a GP, physiotherapist, community nurse, or assistance from social services or the voluntary sector), up from 84% in 2012. This leaves 15% who said that staff did not discuss this with them, but they would have liked them to, though this is down from 16% in 2012.

Overall Impression

Eighty one percent of respondents reported that, overall, they were “always” treated with respect and dignity while they were in hospital, up from 80% in 2012. There was a corresponding decrease in the proportion who said this was “sometimes” the case from 17% in 2012 to 16% in 2013. Three percent said they did not feel they were treated with respect and dignity.

When asked to rate their overall experience, most people responded positively. On a scale of 0 to 10, 71% of respondents scored their overall experiences as “8” or above. Over a quarter (27%) rated their overall experience as a “10” which was up from 25% in 2012.

Over a fifth of respondents (21%) said that during their hospital stay they were asked to give their views on the quality of care they received, up from 14% in 2012. This leaves 79% who were not asked this (down from 86% in 2012).

It is important that patients understand how to complain if they are unhappy with the care they receive while in hospital. The majority of respondents (75%) did not see, or were not given, any information explaining how to complain about the care they received in hospital, though this is an improvement from 78% in 2012.

Next Steps

This report has presented the results from the 2013 inpatient survey, making comparisons with the 2012 survey where possible. The detailed survey results have been provided back to NHS trusts who are expected to take action based upon the results. The results will be used by the Care Quality Commission as part of its Hospital Intelligent Monitoring.

NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The Trust Development Authority will use the results to inform the quality and governance assessment as part of their Oversight Model for NHS Trusts.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):

www.cqc.org.uk/Inpatientsurvey2013

The results for the adult inpatient surveys from 2002 to 2012 can be found at:

<http://www.nhssurveys.org/surveys/425>

Full details of the methodology of the survey can be found at:

<http://www.nhssurveys.org/surveys/705>

More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information on CQC's Intelligent Monitoring is available on the CQC website at:
<http://www.cqc.org.uk/public/hospital-intelligent-monitoring>

Children's Partnership Governance

Report of the Strategic Director (People)

Recommendation: that the Health and Wellbeing Board be asked to endorse the draft Governance Proposals, as outlined in the report, and be invited to make any comments as appropriate.

Background

1.1 Devon is currently operating under an improvement notice in its provision of Child Protection services. As a result a Safeguarding Improvement Board (SIB) is meeting monthly which includes representation from Health, the Police, Schools and Devon County Council. The board has an independent chair in Professor Ray Jones.

1.2 The stated purpose of the SIB is to ...

... oversee the implementation of a Child Protection Improvement Plan and to monitor its impact and effectiveness ensuring,

- *That clear improvement outcomes are set*
- *That a clear plan is in place for the delivery of those outcomes*
- *That improvement outcomes are delivered*

1.3 Children's Trust arrangements in Devon came to an end circa 2010, however recent visits to good or outstanding authorities have highlighted the benefits of such a group, with most if not all those visited having a senior high level multi-agency governance group focussing on outcomes for Children and Young People in a broad sense.

1.4 Furthermore the MASH and Early Help Strategy - Implementation Plan recommends the creation of a Strategic Partnership Group accountable to the Health and Well Being Board

1.5 This view is supported by the latest OFTSED inspection guidance which states that to be ...

a) Outstanding Authorities should be able to demonstrate ...

Professional relationships between the local authority and partner organisations and commissioned service providers are mature and well developed. Accountabilities are embedded and result in confident, regular evaluation and improvement in the quality of help, care and protection that is provided.

b) And that to be Good authorities should be able to demonstrate ...

Leadership, management and governance arrangements deliver strong, strategic local leadership that measurably improves outcomes for vulnerable children. The local authority works with partners to plan and deliver early help, to protect children and young people, to improve educational attainment and narrow the gap for the most disadvantaged and it acts as a strong and effective corporate parent for children looked after and those leaving or who have left care.

There is a clear and up-to-date strategy for commissioning and developing services and there are sufficient resources to meet the needs of children and young people in the local authority area. Leaders, both professional and political, drive continuous improvement so that the local authority is consistently effective as both the lead agency for the protection and care of children and as a corporate parent.

1.6 The formation of a high level strategic multi-agency 'Children's Alliance' was tabled at Devon's joint Corporate Leadership Team and Cabinet meeting on the 24th February with members supporting the proposal. It was also recommended that it should not be a formal committee of the council but rather a

Item 6

strategic alliance, owning and ensuring delivery of a multi-agency Children and Young People's plan on behalf of that wider partnership and reporting to the Health and Well-Being Board

- 1.7 The proposed 'Alliance' would operate in the public domain aligning with the Health and Well-being board, and meeting on a quarterly basis. They would be responsible for strategic direction and ownership of the Children and Young People's Plan with delivery undertaken either through single agency operational management or multi-agency delivery boards such as the current Troubled Families and Early Help. It is recommended that one of the first actions of the 'Alliance' be to rationalise the number of sub-groups, focussing joint work into a small number of focussed groups.
- 1.8 Recommendations are due to be presented to the next Health and Well-being board on the 12th June, however it is hoped that development work between partners will start ahead of that date.
- 1.9 Short Terms of reference together with a diagrammatic representation of proposals are included as an appendix to this paper.

Appendix

CHILDRENS ALLIANCE – DRAFT GOVERNANCE PROPOSALS

Terms of Reference

1. Purpose

- To be accountable and responsible for better outcomes for children and young people by -
 - Giving strategic leadership and direction
 - Acting collectively as a partnership
 - Driving change

2. Function

- To be responsible for developing, publishing, reviewing, revising and monitoring the implementation of the Children and Young People's Plan (CYPP)
- To ensure that the CYPP is informed by the views of children, young people, their families and the Joint Strategic Needs Assessment (JSNA)
- To develop an integrated commissioning approach with pooled or aligned budgets, shared data and other information and set the direction for the joint commissioning strategy
- To act as 'children's champions' by engaging partner agencies and local communities in the promotion of better outcomes and better life experiences for children and young people
- To ensure all partner agencies are aware of their shared responsibility for improving outcomes for children and young people and to provide joint strategic leadership to secure the necessary changes to culture and practice
- To exercise shared responsibility for the performance of services to children and young people and review, on at least an annual basis, a detailed analysis of outcomes for children and young people in Devon
- To ensure that arrangements are in place to gather the views of service users on the appropriateness and quality of services. To keep these arrangements under review and alongside the extent to which their views have informed the development of services
- To oversee the implementation of effective approaches to workforce development across the whole of the children's workforce
- To ensure appropriate links between the work of the Alliance and other key strategic partnerships
- Enable an alignment between strategic and operational focus
- Ensure the involvement of service users and communities in the development of commissioning arrangements

3. Core Membership

3.1 Alliance membership will comprise

- Cabinet Member for Children, Schools and Skills - Chair
- Devon County Council - Chief Executive
- Devon County Council - Strategic Director People
- Devon County Council - Director of Public Health
- Head of Children's Social Work Service and Child Protection
- Chief Executive of Devon Partnership Trust
- Chief Executive of NEW Devon CCG
- Chief Executive of South Devon and Torbay CCG
- Senior Police representative
- Secondary Heads representative
- Primary Heads representative
- Independent chair of the Safeguarding Board
- Police and Crime Commissioner
- NHS clinical representation
- Voluntary sector representation

3.2 The Alliance will be quorate provided 6 members are present.

3.3 Administrative support will ensure information and papers are compiled and distributed in advance of meetings, take minutes and chase any required actions

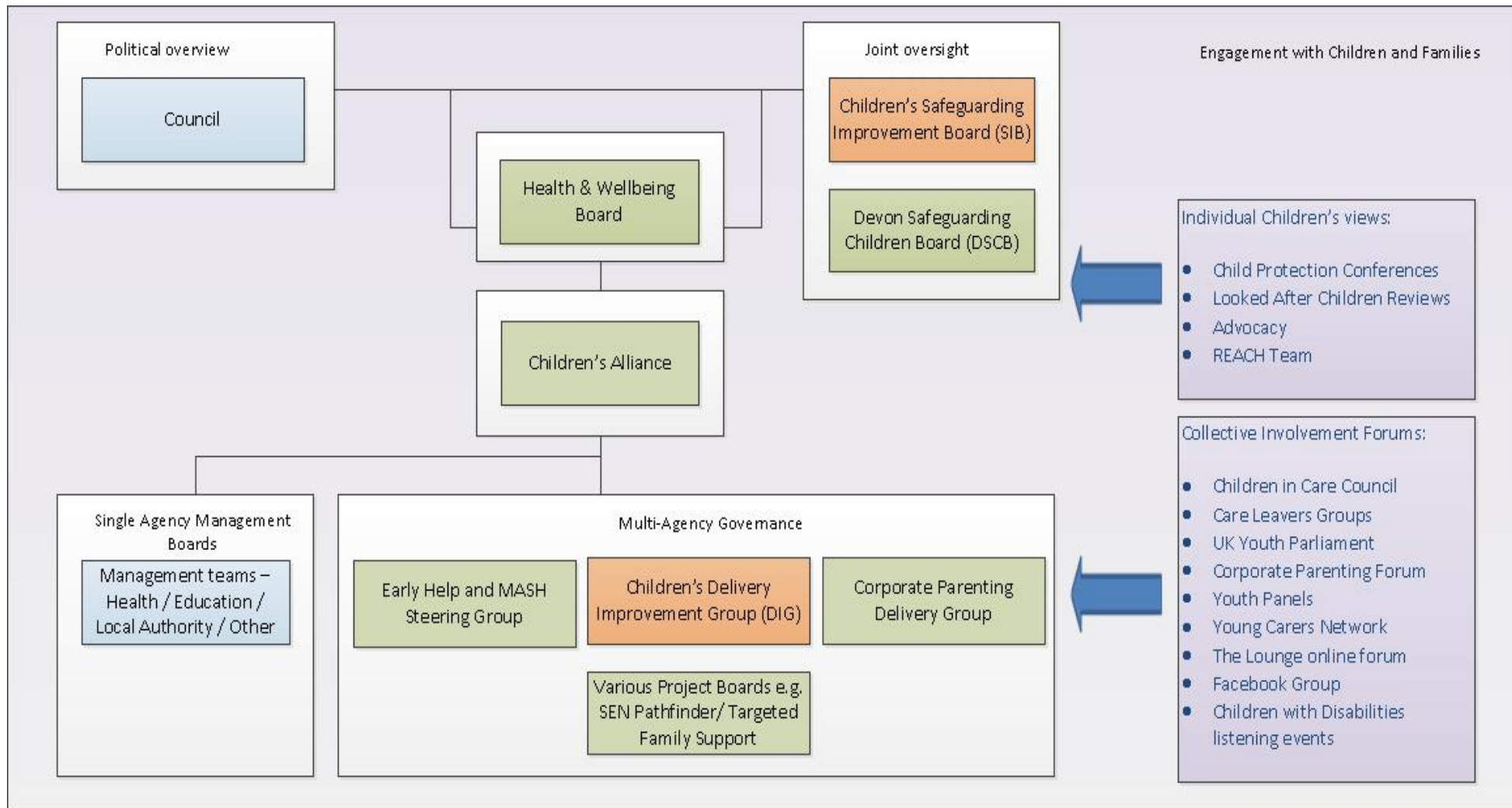
3.4 The agenda, with attached meeting papers will be distributed at least five working days before the next scheduled meeting.

3.5 The format of the Alliance minutes shall be as agreed decisions and actions.

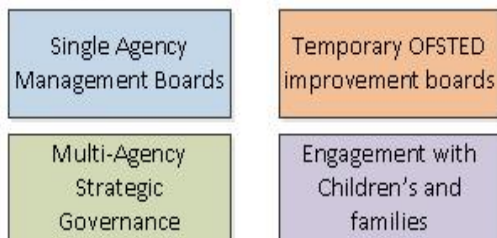
3.6 Full copies of the minutes, including attachments, shall be provided to all Alliance members no later than five working days after each meeting.

3. Frequency of Meetings

3.1 The first meeting will take place in September 2014 and The Alliance shall meet quarterly



Key



Pharmaceutical Needs Assessment

Report of the Director of Public Health

Recommendation: It is recommended that the Devon Health and Wellbeing Board endorse the approach proposed to produce the Pharmaceutical Needs Assessment (PNA) for Devon.

1. Context

1.1 The Devon Health and Wellbeing Board has a statutory duty to ensure the production of a Pharmaceutical Needs Assessment for Devon.

1.2 The Health and Social Care Act 2012 transferred responsibility to develop and update PNAs from Primary Care Trusts (PCTs) to Health and Wellbeing Board s. Whilst responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

1.3 The NHS Act (the "2006" Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health (DH) powers to make regulations:

- (i) Each Health and Well-being Board must in accordance with regulations--
 - (a) assess needs for pharmaceutical services in its area, and
 - (b) publish a statement of its first assessment and of any revised assessment.

- (ii) The regulations must make provision--
 - (a) as to information which must be contained in a statement;
 - (b) as to the extent to which an assessment must take account of likely future needs;
 - (c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;
 - (d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

- (iii) The regulations may in particular make provision--
 - (a) as to the pharmaceutical services to which an assessment must relate;
 - (b) requiring a Health and Well-being Board to consult specified persons about specified matters when making an assessment;
 - (c) as to the manner in which an assessment is to be made;
 - (d) as to matters to which a Health and Well-being Board must have regard when making an assessment

2. A Pharmaceutical Needs Assessment for Devon

2.1 Work has been initiated by Public Health teams in Devon, Plymouth and Torbay working closely with NHS England to agree a consistent but locally relevant format which complies with the regulations.

2.2 The proposed structure of the needs assessment is:

1. Introduction and context for the Pharmaceutical Needs Assessment
2. Process followed for the production of the Pharmaceutical Needs Assessment
3. Geography and population
4. Localities
5. Local health needs
6. Current provision of pharmaceutical services
7. Gaps or overlaps in current provision of pharmaceutical services (including access, acceptable travel times)
8. Outcomes of the consultation process
9. Future needs of pharmaceutical services

10. The Health and Wellbeing Board's vision for pharmaceutical services in Devon
11. Conclusion
12. References
13. Glossary
14. Appendices
15. List of tables and statistics

Appendix One has more detail of what will be included in each section.

2.3 A draft document would be consulted on through October to November 2014 with the revised Pharmaceutical Needs Assessment being presented to the Board in January 2015.

3. Summary

3.1 The approach proposed complies with national regulations and timescales for sign off by March 31st 2015

4. Equality Considerations

The needs of people and communities, particularly those most vulnerable or disadvantaged, will be made explicit in the Devon Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. Integrated Impact Assessment will be undertaken on specific thematic, condition or population based health and wellbeing related strategies. It will be important for the Health and Wellbeing Board to consider all individuals in shaping policy and have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out its activities.

5. Legal Considerations

There are no specific legal considerations identified at this stage.

6. Risk Management Considerations

The Devon Health and Wellbeing Board is subject to all necessary safeguards and action being taken safeguard the Council's position. The corporate risk register will be updated as appropriate.

7. Options/Alternatives

The Health and Social Care Bill required all upper tier authorities to establish a statutory Board by April 2013.

8. Public Health Impact

The Devon Health and Wellbeing Board is central to overseeing the commissioning of services which address public health and other relevant health and wellbeing outcomes

Dr Virginia Pearson
Director of Public Health
DEVON COUNTY COUNCIL

Electoral Divisions: All

Cabinet Member for Health and Wellbeing: Councillor Andrea Davis

Contact for enquiries: Ian Tearle
Room No 141, County Hall, Topsham Road, Exeter. EX2 4QU
Tel No: (01392) 386386

Background Papers
Nil

PHARMACEUTICAL NEEDS ASSESSMENT (PNA) DRAFT CONTENTS

Version control

Acknowledgements

Executive summary

- 1. Introduction and context for the Pharmaceutical Needs Assessment**
 - In this section cover: Why undertaken? How will it be used? (informing short term and long term strategic plan for pharmacy)
 - Duty for LAs to produce a PNA (legislative background and wider context)
 - Undertaking the PNA through the HWB
 - Contents of a 'good' PNA (information that must be in the PNA)
- 2. Process followed for the production of the Pharmaceutical Needs Assessment**
 - Introduction
 - Establishment of Peninsula wide PNA steering group (members) – streamlining of process and PNA across Peninsula
 - PNA project plan and timetable (Gantt chart)
 - Stakeholder identification and engagement
 - Linked strategic priorities (PNA developed in accordance to JSNA/HWB strategic priorities)
 - Understanding local needs (reference to Peninsula wide PNA steering group, role of KIT(?) and focus on local needs)
 - Assessing current pharmaceutical services provision – describe data collections method(s) (PharmOutcomes Tool, user views???)
 - Mapping of pharmaceutical services provision – role of KIT(?)
 - Determining adequacy of assessment (statement outlining how adequacy of service provision was assessed)
 - Identification and management of gaps in service provision
 - Consultation process (60 days)
 - Approval process (LPN, LPC, HWB)
- 3. Geography and population**
 - Geography and population
 - Economics
 - Discussion of specific population groups (focus on those with greater needs/most disadvantaged)
 - Inequalities and deprivation
 - Travel
- 4. Localities**
 - Definition and description of localities used
- 5. Local health needs**
 - Current local health needs (key health issues)
 - Known future health needs over lifetime of PNA
 - Local and national priorities - link with JSNA
- 6. Current provision of pharmaceutical services**
 - Definition of pharmaceutical services
 - Providers of pharmaceutical services
 - May want section on rurality here if relevant
 - Current service provision

- Current provision of local commissioned services by PCC and the CCG – NHS England
- 7. Gaps or overlaps in current provision of pharmaceutical services (including access, acceptable travel times)**
- 8. Outcomes of the consultation process**
- 9. Future needs of pharmaceutical services**
 - Including dispensing doctors and appliance contractors
 - Future improvements or better access
 - Unforeseen benefits
 - Future demands on pharmaceutical services e.g. planning, housing developments
 - The changing direction of pharmaceutical provision locally
- 10. The Health and Wellbeing Board's vision for pharmaceutical services in Devon**
 - Focus on assessment of potential for community pharmacy to contribute to improving local health and wellbeing
- 11. Conclusion**
- 12. References**
- 13. Glossary**
- 14. Appendices (suggested items below)**
 - Terms of reference for PNA Steering Group
 - List of stakeholders
 - PharmOutcomes Tool data capture questionnaire
 - PharmOutcomes Tool results
 - Any user feedback captured (complaints etc)
 - Formal consultation report
 - Specification of all essential services
 - Specification of advanced services
 - Map showing locations of pharmacies
 - Map showing locations of GP practices
 - Map showing drive times to pharmacies
 - Pharmacy opening hours
 - List of enhanced and advanced services provided by pharmacy
 - Local case studies???

ALSO INCLUDE:
Enhanced services
Consultation areas
Disabled access
Numbers of staff

- 15. List of tables and statistics**

Devon Safeguarding Children Board Report

Report of the Independent Chair of the Devon Safeguarding Children Board

Recommendation: that the Health and Wellbeing Board agrees to contribute to the proposals as outlined in the body of this report to improve the safeguarding children practice of staff in Devon

1. Introduction

In March 2014 the Devon Safeguarding Children Board conducted an in-depth review of the safeguarding child sexual exploitation (CSE) system within Devon. This report sets out the findings of this review and progress since then.

2. Peninsula Child Sexual Exploitation Structure

The Devon Safeguarding Children Board has collaborated with the three far South West Local Safeguarding Children Boards (LSCB) and developed a Peninsula CSE Steering group, a sub group of each LCSB. The focus of the Steering group over the next 12 months will be review how each LSCB is delivering against the Peninsula CSE strategy under four categories, prevention, safeguarding, bringing offenders to justice and raising public confidence.

In Devon there are four 'Missing and Child Sexual Exploitation', (MACSE) forums operational in North Devon, Exeter, East and Mid Devon and South Devon. These multi-agency forums seek to identify and manage CSE risk to children at an early stage. Over the next 12 months each forum will be reviewed using data and feedback from children, on the impact they have had on protecting children.

A Devon strategic CSE forum translates and implement actions from the Peninsula Steering group to local areas. It aims develop and monitor the MACSE's ensuring good practice is shared and improvements are made. The Chair of the Devon strategic forum represents the DSCB on the Peninsula Steering group.

Devon has developed services to support the CSE strategy. The REACH team continue to see all 'child missing' reports and complete return home interviews where the child is not receiving services from social care. Part of their return home interview includes the completion of a CSE risk indicator, allowing for escalation of any concerns.

3. Delivering improvements.

The Peninsula CSE working protocol has been reviewed and re-written based on feedback from professionals and members of the Peninsula steering group. The following improvements have been made:

- Uses the Association of Chief Police Officers definition of CSE
- Incorporates 'Missing'
- Sets Objectives for the Steering Group
- Provides a standard Terms of Reference for the Strategic Group

- Provides a data set
- Sets responsibilities regarding training and awareness
- Provides direction on the use of risk assessment 'tools'
- Provides clear referral pathways
- Provides flexibility for each Local Authority to deliver CSE and Missing provision based on their needs.

The protocol was presented for a final consultation at the Peninsula Steering Group on 29th April and the completed document will be presented to the Devon Executive in July 2014.

4. DSCB in-depth review March 2014

In March 2014 the Devon Safeguarding Children Board conducted an in-depth review of the safeguarding child sexual exploitation system within Devon and how CSE was being tackled in Devon. The session was facilitated by a number of colleagues involved in both developing the strategy but also those dealing with referrals and operational engagement with vulnerable young people.

The key priorities agreed by the Board were:

- **Joining up operational and strategic functions**

The Chair of the Strategic CSE Forum will report to the Executive on a regular basis providing information on the performance of the local Missing and Child Sexual Exploitation forums, police investigations, how missing children are managed, MASH activity and allegations made against staff of partner agencies. The REACH team will also provide feedback from children who have gone missing, reporting on their experiences to enabling partners to assess their services based on the needs of the children. A data set has been developed with the Peninsula working protocol to support this requirement and will be used in Devon to support the next iteration of the Joint Strategic Needs Assessment for Safeguarding Children.

The Board is asked to support the data collection for the JSNA in line with the recommendations from the Children's Commissioner to create a strategic overview on the likelihood of CSE and the vulnerabilities within Devon to CSE. Whilst the incidence of CSE in Devon can not be measured, providing demographic information compared against other national information (empirical data/ socio-economic mix) and the level of expected CSE will provide a broad understanding of our vulnerabilities.

- **Roll-out of awareness training re: CSE**

It was agreed that an important part of tackling CSE was the awareness of professionals and knowing enough about CSE to ask questions and link with other agencies if necessary.

A working group will be established to develop and deliver a training and awareness strategy. Initial focus will be to deliver E-learning packages through the DSCB website and to review national campaigns like 'Say Something if you See Something' to raise CSE awareness.

- **Information sharing governance**

It is vital professionals feel confident and understand the importance of information sharing in order to identify possible incidence of CSE. Information sharing will form part of key messages sent through targeted communication and displayed on the DSCB website. Partners in key agencies will be expected to ensure that staff are trained and have guidance about the necessity to share information where there are safeguarding concerns.

The revised CSE Peninsula working protocol provides new guidance on information sharing to assist professionals. The DSCB has re-circulated the 'Golden Rules' on information sharing and published this on the website.

- **Early Intervention: Sex Education – 9 to 13 years (vulnerable children)**

A critical issue in relation to CSE was children and young people understanding what constitutes a healthy relationship and this should be a key area in sex education. The DSCB will be working with schools, governors and education agencies about how this is delivered to the most vulnerable children and young people and the emphasis put on this in the curriculum. In addition the DSCB are promoting the offer of free sessions run by the NSPCC about younger children's understanding of their bodies and appropriate relationships with others.

- **Looked after Children (commissioning)**

The DSCB have identified the high instances of looked after children in the Authority who are going missing on more than one occasion. The Local Authority will be reviewing this to determine who these children are, the setting in which they are being placed and the reasons for them going missing and develop proposals to tackle this issue.

- **Developing the operational pathway**

The complexity for individual practitioners of dealing with and recognising CSE was noted by the Board. The new Peninsula CSE working protocol includes referral pathways for professionals and will be linked to the Threshold Tool. The DSCB will look to agree how this will work in Devon at the July DSCB Executive. The protocol will be available to all professionals through their agencies and the DSCB website.

- **Missing children (education and runaways)**

There is not a clear tie up between the monitoring of children and young people missing from education and those who go missing from home. The DSCB have asked the police and education to review their data along with other agencies to see how this information can be assessed and presented in a more joined up way. In particular the DSCB are interested in looked after children who are persistent absentees from school and whether these are also part of the cohort who go missing from placement.

- **Online safety - SWGFL**

South West Grid for Learning are contracted to give support in respect to on-line safety in schools. The Board would like to see how the expertise of this organisation particularly in relation to understanding the risks but also educating parents and young people, might most effectively be used.

The DSCB will fund the South West Grid for Learning to attend the Peninsula on-line safety meetings.

5. Managing CSE investigation

The Police have led one complex criminal investigation in response to child sexual exploitation. Supported by partner agencies a high number of children were seen and safeguarded and a person was arrested. This action disrupted criminal behaviour which was putting children at risk and prevented children becoming victims of sexual abuse.

A number of specific strategy meetings have been held to review risk and protect children within South Devon who through information and intelligence had been identified as being at risk of CSE. Whilst no criminal investigations were completed, agencies worked together to safeguard children and disrupt behaviour putting the children at risk.

The DSCB are asking for regular information from the police about the level and nature of this activity and use this as one proxy measure of success in respect to other activity that is happening of a preventative nature.

Conclusion

The DSCB seeks support from the Health and Wellbeing Board to improve the safeguarding children practice of staff in Devon as outlined in the main body of the report.

David Taylor
Independent Chair
Devon Safeguarding Children Board



Northern, Eastern and Western Devon
Clinical Commissioning Group

Update report regarding Winterbourne view for Devon Health and Wellbeing Board.

12th June 2014.

1. Background and Context.

The Winterbourne View hospital abuse occurred at Winterbourne View, a private hospital in South Gloucestershire England, owned and operated by Castlebeck.

A Panorama investigation broadcast on television in May 2011, exposed the physical and psychological abuse suffered by people with learning disabilities at the hospital.

Eleven people pleaded guilty to criminal offences of neglect or abuse as a result of evidence from the programme "Undercover Care". After prosecution six members of staff were given custodial sentences.

Immediately after the eleventh person pleaded guilty, the Serious Case Review was published, revealing hundreds of previous incidents at the hospital and missed warnings.-The hospital has been shut down as a result of the abuse that took place.

On the 25th June 2012 CQC issued its report regarding services for people who have a learning disability. - The national summary report of their focused inspection programme of 150 hospitals and care homes for people with learning disabilities. Whilst the inspections did not find abuse on the scale of Winterbourne View, the CQC report highlights concerns about the poor quality of care provided to people with learning disabilities.

Many of the failings identified in the report are a direct result of care that is not centred on the individual or tailored to their needs.

On the 4th July the Department of Health responded to the findings of the CQC investigation on it identified a number of national objectives, these were to:

- improve commissioning across health and care services for people with behaviour which challenges with the aim of reducing the number of people using inpatient assessment and treatment services
- clarify roles and responsibilities across the system and support better integration between health and care
- improve the quality of services to give people with learning disabilities and their families choice and control
- promote innovation and positive behavioural support and reduce the use of restraint
- establish the right information to enable local commissioners to benchmark progress in commissioning services which meet individuals' needs, improve the quality of care, and reduce the numbers of people in in-patient services for assessment and treatment

A wider action plan was developed with the sign up of a range of government departments, charities and key stakeholder groups. It was titled "DH Winterbourne View Review , *Concordat: Programme of Action*" and was published in late December 2012.- Key actions included the following;-

- Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014:
- Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care There will be national leadership and support for local change (Mainly via ADASS and DH)
- Planning will start from childhood.
- Improving the quality and safety of care:
- Accountability and corporate responsibility for the quality of care will be strengthened:
- Regulation and inspection of providers will be tightened
- Progress in transforming care and redesigning services will be monitored and reported:

2. Introduction.

This paper outlines our local progress relating to the Winterbourne View Concordat. It focuses on the actions undertaken regarding local services immediately after Winterbourne and the number of people we are seeking to return to appropriate community placements and the current actions steps and issues we are engaged in to achieve this.

The figures focus on people in patient care outside of Devon, and inside Devon in independent sector settings. The figures include known people with a learning disability in secure settings who have a learning disability.

The paper describes the recent and on-going scrutiny arrangements and reflects upon our learning so far and identifies further recommendations for local improvement.

3. Actions taken to date.

By the time the Concordat action plan was published we had undertaken independent reviews of all of our inpatient settings in Devon. Teams of trained individuals including carers, staff from a range of services, commissioners and people who had experienced services investigated and developed recommendations for improvement where required. No safeguarding issues were identified.

A list of the people we knew were in hospital was collated gathering information across Devon Partnership Trust, NEW Devon CCG and Devon County Council. This information was submitted to the Department of Health. People placed in specialist commissioned services (Secure hospitals) are commissioned via NHS England since 1st April 2013 is reported separately by NHS England. We identified that Devon had high numbers compared to other local authorities.

We also utilised Section 256 funding and set up an out of area reviewing team who ensured all people funded across health and social care placed out of area had a review, and where appropriate plans to return to the community. The team complete an annual report summarising their activities and findings, and updates are provided to the Devon Learning Disability Partnership Board.

We have designed a pathway that supports effective “Returning home” of individuals. It follows seven simple steps that care managers and commissioners have to complete to help the person move out of institutional care.

The seven step model is being used to monitor the people who are moving through the pathway and the performance of the services responsible. In short, it helps us understand how well we are doing in achieving the aims of the Concordat.

The pathway was developed with supported living as the main model. Most people are returned to supported living but a small number have moved to residential care (Mainly in Devon) where there are single flats designated as residential care or very small numbers of people living together. Individualised services are required to enable tailored support to each person.

The pathway is attached as Appendix 1.

4. The historical position for Devon.

The reason for the historically high numbers may be related to a number of factors, such as a historical problem of having a previously fragmented number of PCT's operating across a wide geography leading to underdeveloped local services. Over time the admission to people into services outside of our local area may have contributed to a diminishing capacity of local skills within services to manage people with very complex needs.

Other reasons for people being placed away relate to a loss of local control in some cases arising from use of the mental health act. This is because most people in specialist hospital beds will have been sectioned under the Mental Health Act, once this happens a hospital bed in a specialist unit needs to be found - if local services had no available beds, or if the local services had not managed to provide an effective service, - a person would have been placed elsewhere.

Additionally if a person was deemed to have very high levels of risk they may be subject to Ministry of justice restrictions. Once legal frameworks are applied it is very difficult for local clinicians and commissioners to move someone out of hospital as psychiatrists who work for the provider service or the Ministry of Justice has to agree the transfer or discharge.

We have learned that people placed far away received less reviews than those locally, a situation that was exacerbated by the need to travel long distances. In turn this delayed the usual prompts to get planning happening and get the person home. This distance also has a very negative impact on families and also creates a loss of connection with the person's home, community and relationships.

Sometimes people end up in a hospital if they have become an adult and are still in services away from home having been placed as a child. Similarly secure hospitals may be used as a referral point from prison if courts or decision makers feel this is appropriate.

During this work we identified that it is far easier for a person to be placed in a hospital away from services than it is to get them home.

The key is to avoid placements away from Devon in child and adult services, as well as making sure that repatriation of the current population takes place.

Despite the stated Winterbourne Concordat aspirations of having all individuals who are able to be in a community placement by 1st June 2014, the national average of people returned home to date following the introduction of the Concordat stands at 7%.

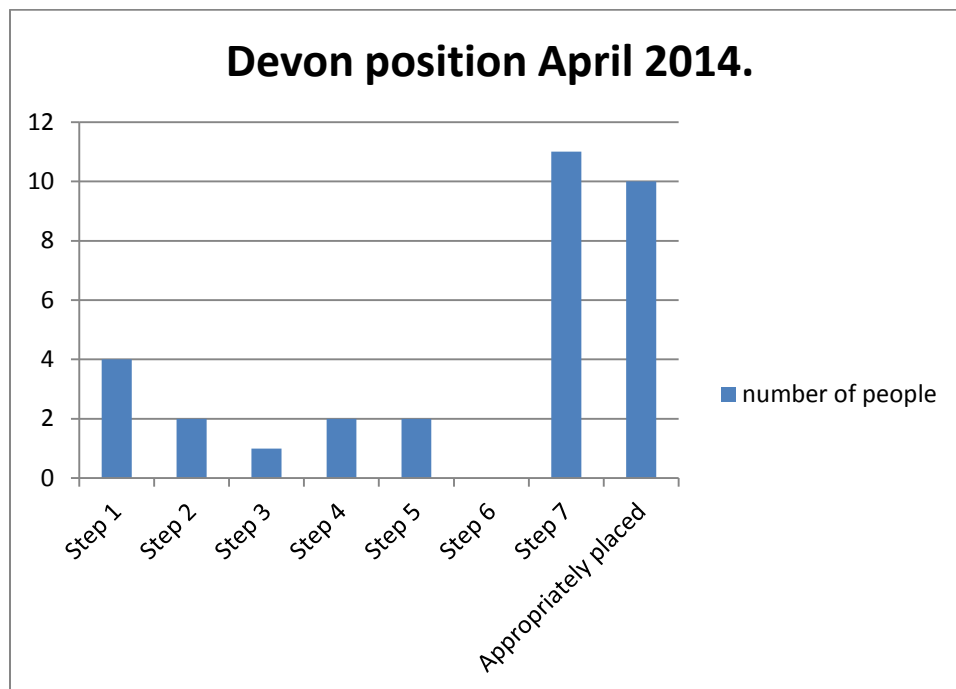
5. Updated Figures.

Devon had two people placed at Winterbourne view, both people are now living locally with support. However there were other people who were place out of area, in hospital who were affected by the implementation of The Winterbourne View Concordat Programme of action.-For Devon our current position is as follows,

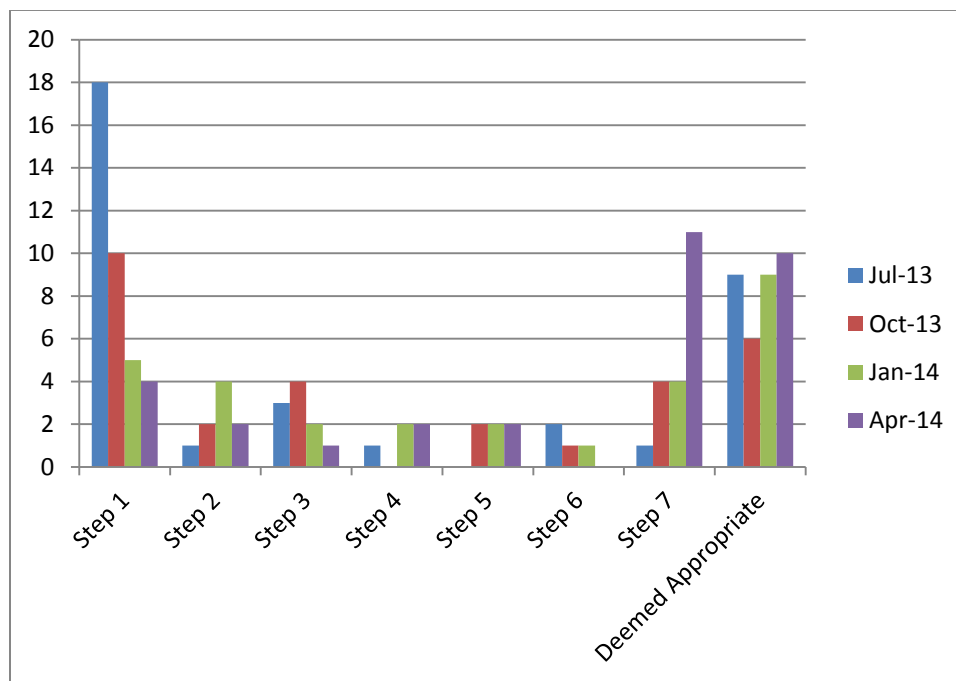
Eleven people have returned to live in the community with support. (Approximately 34.5% of the total)

A further eleven have plans in place and are progressing through the pathway to return home within 12 months (Approx 34.5%)

Ten people are deemed to be currently “Appropriately placed” in hospital following a review of their current needs and risks. (Approx 31%) Justification reports have been received for this stance on each individual and reviews continue. A small number of individuals have had a change in their provider when we have been dissatisfied with the lack of progress for the person.



Over time we have tracked progress which can be seen below;-



6. Outcomes for individuals.

As people return back into their community we aim to ensure that the service is built around the person and is an individualised as possible.

Given that this is the case we are finding that people are increasing what they are doing in their everyday lives, developing new skills, and making new friends. Over time if the package of support is working well support can be safely reduced.

We have just introduced a way of measuring outcomes using the Health Equalities Framework, (HEF). This gives us a baseline measure of what life is like for the person, looking at a range health determinants. All people returned will have this measure undertaken so we can monitor the outcomes for each person in a quantifiable way.

Over seventy staff members have been trained in this approach across Devon and Plymouth services.

7. On-going monitoring of placements.

Once a person has returned to the community, life can feel very strange or overwhelming at first. Providers especially will need to be able to spot and manage risks, understand what behaviours mean and make sure that staff members employed respond appropriately.

Our clinical teams work closely with each provider in an extended team,- monthly meetings between the commissioner and the extended team for the most complex individuals are now developing. This is required to ensure that assurance is in place for commissioning authorities but also acts as a supportive framework to discuss dilemmas, reflect and learn and identify key actions to keep individuals progressing.

Terms of reference have been devised and quality checking will be an inherent part of that process. The method to check quality will be based on the methodology developed by the national improving lives team, key areas of focus are;-

- 1) To ensure that individuals are safe now.
- 2) To ensure the persons current care arrangements are appropriate.
- 3) To ensure that appropriate plans are in place for the person's future.

8. Scrutiny Requirements.

Currently there are exceptionally high levels of scrutiny regarding the work we are undertaking relating to Winterbourne view.

Devon initially had higher numbers of people placed out of area compared to other authorities, which has led to greater involvement of the Winterbourne Improvement Team that otherwise would have been the case.

The following table provides an overview of the on-going reporting both nationally and locally.

Type of Report	Who to	Frequency	Detail
Snapshot report of inpatient care, for people who have LD and or autism both within and outside of Devon.(This also included Mental Health inpatient beds in Devon)	Winterbourne view joint improvement team	Quarterly Last deadline was 14 th April.2014	To complete 30 questions about each person.
Reports on people who were actually at Winterbourne view.	Winterbourne view joint improvement team- Improving Lives.	Quarterly Last Deadline was the 18 th April.2014	Specific questions about the 2 Devon people, who live in the community now.

In depth reviews on individuals who were actually at Winterbourne view.	Improving Lives team	The two Devon placed individuals had their in depth reviews. The date of these reviews was 20th and 21 st May. Each person took at least a full day to review.	Each person will have a report following the visits which has recommendations to implement. These have only been verbally reported so far and we await the formal report.
Devon Outlier in depth area review. This is happening because at the start of the process Devon had high numbers of out of area placements reported in our initial stocktake.	Winterbourne view joint improvement team	This was a single visit so far where commissioners were interviewed. The date was the 16 th April.2014 Requests have been made to interview the Devon Director of Social Services and the Chief Executive of the CCG.	This took a half day with some follow up requests for detailed information. A report will follow with recommendations and on-going support is available from the person undertaking the review.
Winterbourne view stocktake status report	Goes to Ministers via the Winterbourne view Joint improvement team.	Possibly a one off but related to the Winterbourne View Stocktake we did last summer. The deadline was the 5 th May. 2014, but a further update was requested and responded to by the 30 th May 2014.	This is a report about where each person is and where they are moving or have moved to, and relates to the 1 st June deadline set within the Concordat Action plan. In addition we are required to submit our area action plan which originally had recommendations from 5 national reports related to Winterbourne view and then the concordat action plan. More local recommendation incorporating the follow up from the in depth individual reviews are part of this.

Winterbourne view position report, for Devon	Health and Wellbeing board.	Every Devon HWBB. board.	This provides progress regarding the seven step model and how many people are progressing through the process.
	Safeguarding Boards.	Reports are given to Devon SAB approximately six- nine monthly.	We also have a list of people who are deemed to be appropriately placed in hospital and have individual justification reports from care managers to say why this is so.
	The CCG Partnerships commissioning Board.	The CCG Partnerships Board receives a Report Quarterly.	
	LD Partnership Board	Updates are provided at least six monthly	

9. Feedback from the individual reviews.

The initial feedback from the in-depth reviews for individuals from the “improving Lives” team identified that the work they saw was encouraging, they felt that the model was very person centred and value based executed with high levels of creativity and innovation.

They felt that there was good cohesion between the strategic commissioning role and the members of the community team with a very inclusive approach to planning and risk management around each individual.

However there were inconsistencies of approach in some areas across teams in Devon. This will be addressed within the new Devon Partnership Trust redesign of services, and the development of new specifications.

Other recommendations about individuals care packages were made that are confidential to each person.

The Team asked for

- Copies of the Seven Step model (Attached as Appendix 1).
- The Blue Light Protocol (Appendix 2) This has saved us at least £750k and nine out of area placements.-Clinicians and staff report feeling supported by commissioners during a crisis when this has been used.

- The developing Police Passport. This last piece of work was something that we developed with the police regarding people who are more likely to be in contact with officers who need a helpful and consistent approach to communicating with individuals. This requires widespread implementation across services by Devon and Cornwall Constabulary.
- We also have developed an advanced hospital passport for individuals who are likely to be high users of A&E or other departments.

Some support was also given to our strategic stance of not rushing to get everyone into any placement into the community to simply meet the 1st June deadline, rather than risk failed placements and distress to individuals.

On-going work in “out of hours” services is required to ensure 24/7 adjusted support other than Emergency Duty Team input.

10. Key barriers and issues.

In Devon we have very good integrated working however applying S117 funding agreements in line with local protocol will be required for those people returning in the longer term. It is important to note that for those people returning from secure hospitals funding is not transferred to the local Clinical Commissioning Group (CCG) from the specialist commissioning budget, and whilst care packages are less in cost than inpatient care, for the CCG and local authority this could be perceived as a new cost. This has not acted as a barrier to decision making to date but it needs to be acknowledged as a cost pressure.

We also need to widen the out of hours crisis service for Mental health to include people who have a learning disability should it be needed. The Winterbourne view review team identified that any short term crisis in a placement had been managed through the commitment and good will of staff but queried the sustainability of this position. A paper has been drafted to take to the NHS Contractual meetings with Plymouth Community Healthcare, a similar paper is being developed for Devon Partnership Trust.-Individual crisis support plans will be developed around individuals for staff to refer to in order to bolster contingency arrangements.

In addition there are strategic issues and risks that we must address regarding this programme of work, they are;-

- i) The engagement of children’s services in a clear action plan regarding those young people placed out of area. This needs to establish shared principles and values, an agreed model of working, sound local procurement plans that enrich our local provision so children are not sent out of area, and some improved financial planning.-The model we have developed has

- demonstrated that people with very challenging needs can be cared for in the community and that in doing so challenges diminish and risks are managed, and outcomes improve. This requires some challenge to traditional models of risk management and the cycle of containment and increased reaction in individuals.
- ii) We also need to question the perpetuation of views about people who are labelled as having “Severe Reputations” or “Challenging Behaviour”.
In the past there may have been instances where that label legitimised the high charges for services. In future we will need to challenge the provider’s clinical views when required, and accept that much of the challenge presented by individuals is a form of communication; - Perhaps even communication distress or a response to being contained, far from home with little or no personal control or say in what happens.
 - iii) Improved strategic planning with specialist commissioning and links with the Ministry of Justice. There currently is no systematic means of looking at out total population and knowing what plans are in place to help people move out of secure settings wherever possible. Additionally the Ministry of Justice is not party to the Winterbourne View Concordat, and some of the difficulties we have faced getting people off their restrictions has created delays in progress.- This has been communicated to the Winterbourne View Improving Lives team.
 - iv) Lack of suitable housing creates a problem; this is also exacerbated by the limits on housing benefit. We sometimes find ourselves paying for the additional rent within our budgets as most accommodation classed as social housing is not always appropriate for the people we seek to support, and housing benefit is not enough to cover the costs of suitable housing. We have learned that people have very specific housing needs and that they need to be cared for in capable environments.-We also sometimes have to consider neighbours, proximity to community services and other environmental factors that can impact on timely planning.
 - v) Delays in the Court of Protection decision making process for people requiring tenancies who lack capacity. This can currently take six months. We envisage this will become a worsening situation following the impact of the Cheshire West ruling.

Other strategic planning is in place such as the DPT redesign of Learning Disability services titled “Changing Directions” this includes work regarding the “Green Light” Audit and Toolkit which looks at how universal mental health services supports people who have a learning disability. The Changing Directions work has been developed also to address the health inequalities of people who have a learning disability (following research we were involved in regarding the Confidential Inquiry into the premature

deaths of people who have a learning disability) and has been presented at a national NHS Conference. Dr Dominic Slowie, the National Clinical Director for Learning Disability said that “It is most reassuring to see the changes planned in Devon in response to the Confidential Inquiry”. There is a second phase of the Changing Directions plan which seeks to develop intensive support and treatment teams, and reviews the efficacy of local learning disability inpatient services.

The joint strategic plans that include actions related to Winterbourne view are

- An updated local area action plan that is reviewed through the Partnerships Commissioning Group. It has also been shared with Safeguarding Adults Board
- A Learning Disability overarching commissioning strategy that spans Devon, Plymouth and Torbay.
- Stated commissioning intentions.

11. Conclusion and Recommendations.

Health and social care services in Devon are making good progress with the current population and has now more people placed in the community. Most of the people have required very high levels of planning and coordination to get them home and maintain them safely in their community.

The challenge for the health and social care commissioners is to create a sustainable position that also addresses the young people we currently have out of area. This required a real cultural shift and changed practice throughout our system as a focus solely on adult services will not solve the issue. Effective planning is needed to ensure that the cohort of people we are returning is not simply replaced by children who are placed out of area now and then become adults.

We need to develop robust plans with the specialist commissioning teams nationally, to know our population and sign up to an agreed model of delivery and direction of travel. This is likely to require robust challenge to the providers of existing services.

The reporting process regarding Winterbourne View is onerous, and takes scarce resource away from the delivery of the action plan. Nationally it would be helpful if the Winterbourne view team could streamline the reporting requirements to avoid duplication.

Planning is required around housing to help secure the right properties, and some consideration needs to be made regarding contingencies of payment of rental if people become ill and spend time in hospital in the future.

Good providers of community support are becoming saturated with work and we need to energise the market with further procurement, utilising an accredited list of providers. Given the very specialised needs people have this will take place outside of the existing frame work, it would be helpful if this provision spanned those young people preparing for adulthood.

Helen Toker-Lester.

30th May 2014.

APPENDIX 1. Seven Step approach to People placed out of area- Concordat Action Plan Response.

Appendix 2.

Blue Light Protocol.**Introduction.**

As part of the aspiration to keep people cared for in their own home or as close to home as possible it is necessary to avert crises and support each other , across services to deliver our aim.

It is written into the NEW Devon CCG contract with DPT that no placement should take place out of area without the agreement of the commissioner.

Crises should be avoided by effective planning for a person with good contingency arrangements in place, but occasionally there are times when a multi-disciplinary discussion, usually by conference call at short notice, in order to help solve problems is useful.

This protocol describes when this “Blue Light” response is needed. Who should attend and what discussions should take place.

The process.

This process is instigated by a senior manager within the provider service (DPT) ***when an individual has been identified who is at risk of being placed out of area, or is at risk of losing their home, due to an unmet clinical or social need creating crisis.***

The senior manager within the provider organisation will usually have been alerted to the need through a member of staff within the service who is managing the care of an individual in crisis.

The list of invitees could include the following people, but this is not prescriptive-

Role	Involvement
Psychiatrist	To provide feedback on assessed needs and risks.- Role in MHA processes.
Named Nurse	Care management and coordinating role, provider of clinical information.
Social worker	Care manager, involvement in assessment and care planning.
Modern Matron	To provide expertise and support.
IMHA/IMCA	As required
Commissioner	To provide support to fund alternatives to institutional care.
GP	To ensure effective support around health needs as required

Advocate	As required to support the individual.
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Conference call details.

The chair is likely to be the person who identifies the problem and they should manage the conversation using the format below.

It is recommended that a text is sent to prospective blue light participants at least 30 minutes prior to the time that the full call commences. The Text should state

BL call at (time) and then it should include the contact numbers above.

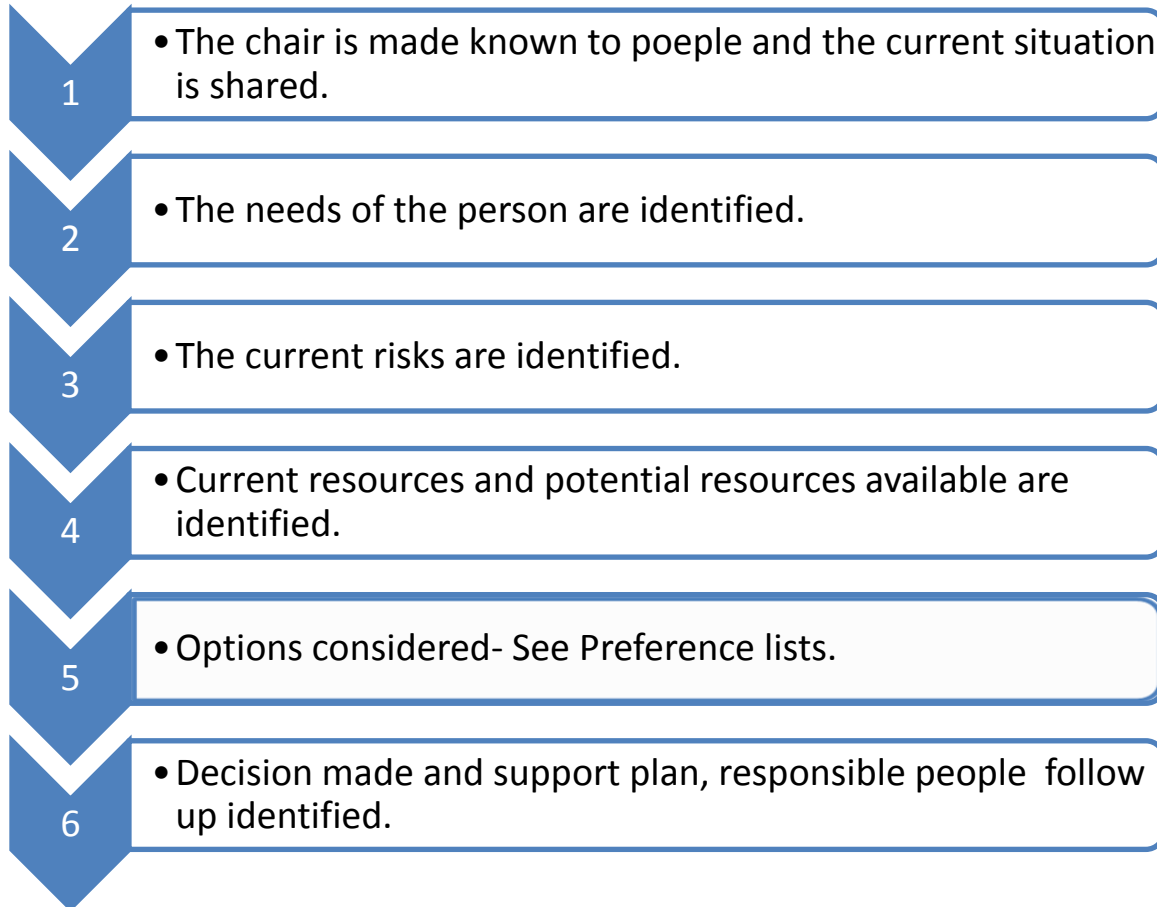
Sign up to availability for Blue Light.

Participants of Blue Light discussions need to sign up to agreeing to short term interruptions, and they will need to explain that they have an up and coming call in order to participate in the Blue Light meeting.

A list of Blue Light contacts is attached at the back of this protocol- This will be reviewed and updated every six months.

Call process.

The process for the call is outlined below, and is useful as a guide. The chair should ensure that the call is recorded and the file saved. Participants should be made aware that the call is being recorded.



Preference list.

The preference of support arrangements are as follows-

1st preference- Support the person at home with the relevant help taking place there. Additional support packages will be considered favourably by commissioners.

2nd preference- the person is supported in a local non inpatient unit, using residential nursing, or short breaks services.

3rd preference- a local inpatient service in the NEW Devon area- Please note that Mental health needs should be met in acute mental health services and underlying physical health needs in acute hospitals- Inpatient LD units should not be inappropriately used.

-Finally, out of area placements should be avoided at all costs. If an out of area placement is suggested it needs to be approved by the commissioner in line with the

contracting process, and would only ever be considered when the move is clinically justified and all other avenues have been exhausted.

Any gaps in local delivery should be reported to the relevant commissioner if needs cannot be met locally.

Follow up.

The placement will require constant review from the care manager to ascertain effectiveness and quality. Additional supports should be stepped down safely when no longer needed in order to avoid dependency. A full face to face review will need to take place as soon as practically possible to enable longer term planning within normal care pathways.

Health and Wellbeing Outcomes Report

Report of the Director of Public Health

Recommendation: It is recommended that the Devon Health and Wellbeing Board note the updated Health and Wellbeing Outcomes Report.

1. Context

This paper introduces the current detailed outcomes report for the Devon Health and Wellbeing Board, which monitors the priorities identified in the Joint Health and Wellbeing Strategy for Devon 2013-2016.

2. The Health and Wellbeing Outcomes Report

2.1 An 'updates only' version of the Health and Wellbeing Outcomes Report for June 2014 is included separately. The report is themed around the four Joint Health and Wellbeing Strategy 2013-16 priorities, and includes breakdowns by local authority, district, clinical commissioning group, inequalities characteristics and trends over time.

2.2 The following indicators have been updated since the last report:

- Teenage Conception Rate (2013 Q1)
- Hospital Admissions for Self-Harm, Aged 10 to 24 (2012-13)
- Alcohol-Related Admissions (2012-13)
- Injuries Due to Falls (2012-13)
- Dementia Diagnosis Rate (2012-13)
- Male Life Expectancy Gap (2010 to 2012)
- Female Life Expectancy Gap (2010 to 2012)

2.3 The latest teenage conception rate for Devon (25.6 per 1,000) is the lowest on record. Stronger decreases in the rate nationally mean that Devon remains above the South West (23.5) and local authority comparator group (22.6) rates.

2.4 The hospital admissions for self-harm in young people indicator has been altered to cover the age group 10 to 24 years to reflect changes to the national indicator. The admission rate in Devon (419.5) remains above the England average (346.3).

2.5 The alcohol-related admissions indicator has also been changed nationally, and now reflects a more narrow range of conditions with an alcohol-attributable primary diagnosis or an alcohol-related external cause. Admission rates in Devon (631.1) are broadly consistent with the South West (618.0) and England (636.9) rates.

2.6 The rate of admission for injuries due to falls in Devon (1672.8) remains significantly below the South West (1875.6), local authority comparator group (1809.9) and England (2011.0) rates.

2.7 The dementia diagnosis rate for Devon stood at 41.9% in March 2013. Whilst the rate in Devon has continued to improve over recent years, this is significantly below the diagnosis rates in the South West (46.5%), local authority comparator group (45.2%) and England (48.1%).

2.8 The gap in life expectancy between the most and least deprived communities in Devon (4.9 years for males, 3.2 years for females) has remained consistently below South West (male 7.1, female 4.8), local authority comparator group (male 7.1, female 5.1) and England (male 9.2, female 6.8) levels.

2.9 The outcomes report is available on the Devon Health and Wellbeing website www.devonhealthandwellbeing.org.uk/jsna/health-and-wellbeing-outcomes-report. This includes a full report, a two page summary report, the 'updates only' report, individual two page indicator specific reports, and this briefing paper.

Table 1: Indicator List and Performance Summary, June 2014

Priority	RAG	Indicator	Type	Trend	Dev/SW/Eng
1. A Focus on Children and Families	A	Children in Poverty	Chall		
	G	Early Years Foundation Score	Chall	-	
	G	Smoking at Time of Delivery	Watch		
	A	Teenage Conception Rate *	Watch		
	-	Child/Adolescent Mental Health Access Measure	Improve	-	-
	R	Hospital Admissions for Self-Harm, Aged 10-24 *	Improve		
2. Healthy Lifestyle Choices	G	Proportion of Physically Active Adults	Chall	-	
	A	Excess Weight in Four / Five Year Olds	Chall		
	A	Excess Weight in 10 / 11 Year Olds	Chall		
	A	Alcohol-Related Admissions *	Watch		
	A	Adult Smoking Prevalence	Watch		
	G	Under 75 Mortality Rate - All Cancers	Improve		
	G	Under 75 Mortality Rate - Circulatory Diseases	Improve		
3. Good Health and Wellbeing in Older Age	A	Incidence of Clostridium Difficile	Chall		
	G	Injuries Due to Falls *	Chall		
	R	Dementia Diagnosis Rate *	Chall		
	G	Feel Supported to Manage Own Condition	Watch		
	G	Re-ablement Services (Effectiveness)	Watch		
	A	Re-ablement Services (Coverage)	Watch		
	A	Readmissions to Hospital Within 30 Days	Improve		
4. Strong and Supportive Communities	A	Suicide Rate	Chall		
	G	Male Life Expectancy Gap *	Chall		
	G	Female Life Expectancy Gap *	Chall		
	G	Self-Reported Wellbeing (low happiness score)	Watch		
	A	Social Contentedness	Watch		
	G	Carer Reported Quality of Life	Watch	-	
	A	Stable/Appropriate Accommodation (Learn. Dis.)	Improve		
	G	Stable/Appropriate Accommodation (Mental Hlth)	Improve		

RAG Ratings

Red	R	Major cause for concern in Devon, benchmarking poor / off-target
Amber	A	Possible cause for concern in Devon, benchmarking average / target at risk
Green	G	No major cause for concern in Devon, benchmarking good / on-target

Table 2: Priority Area Summaries, June 2014

Priority	Summary
1. A Focus on Children and Families	Child poverty levels fell slightly between 2010 and 2011. Recorded levels of child development are above the South West and England averages. Rates of smoking at delivery are falling over time and are amongst the lowest in the South West. Conception rates have fallen over time, particularly in more deprived areas. Self-harm admissions in younger people are above the national average.
2. Healthy Lifestyle Choices	Higher levels of physical activity are seen in Devon. Levels of excess weight in children are above average at age 4/5 and below average at age 10/11. The narrow alcohol-related admissions rate is similar to England. Adult smoking rates are below the national average. Mortality rates are falling.
3. Good Health and Wellbeing in Older Age	Clostridium Difficile incidence is above South West and national rates. Devon is below South West and national rates for the detection of dementia, although detection is improving. Devon has lower levels of injuries due to falls. A higher proportion feel supported to manage their long-term condition in Devon. Reablement service effectiveness is above average, but recorded coverage is low. Readmission rates are below average but are increasing over time.
4. Strong and Supportive Communities	Suicide rates in Devon are consistent with the national average. There is a smaller gap in life expectancy between the most and least deprived communities in Devon. Self-reported wellbeing in Devon tends to be better than the national average. Lower levels of people reported as much social contact as they would like. Quality of life for carers in Devon was broadly in line with the national average. Devon had lower levels of people with learning disabilities in stable and appropriate accommodation than the national average, and similar rates for people with mental health issues.

3. Legal Considerations

There are no specific legal considerations identified at this stage.

4. Risk Management Considerations

Not applicable.

5. Options/Alternatives

Not applicable.

6. Public Health Impact

The Devon Health and Wellbeing Outcomes Report is an important element of the work of the board, drawing together priorities from the Joint Health and Wellbeing Strategy, and evidence from the Joint Strategic Needs Assessment. This report and the related documents have a strong emphasis on public health and other relevant health, social care and wellbeing outcomes. A number of the outcomes indicators are also drawn from the Public Health Outcomes Framework. The report also includes a specific focus on health inequalities.

Dr V Pearson
DIRECTOR OF PUBLIC HEALTH
DEVON COUNTY COUNCIL

Electoral Divisions: All

Cabinet Member for Health and Children: Councillor Andrea Davis

Contact for enquiries: Ian Tearle
Room No 255, County Hall, Topsham Road, Exeter. EX2 4QU
Tel No: (01392) 367761

Background Papers
Nil

Report to: Devon Health and Wellbeing Board
Report date: Tuesday, 27 May 2014
Report Purpose: Healthwatch Devon Update

Introduction

This report sets out the main activities and focus of Healthwatch Devon over the period since the last Health and Wellbeing Board meeting.

Board members are invited to:

- Note the contents and to contact Healthwatch Devon for further detail on any items of particular interest.
- Note and respond to the headline items which we have raised below.
- Comment on the general form and content of this report, and its usefulness to the Board in its task of overseeing health and wellbeing strategy.

Headline items - for special consideration by the Health and Wellbeing Board

Devon County Council Residential Care Homes and Day Services

Feedback from service users and their relatives/carers indicates high levels of anxiety about possible DCC care homes and day centres closures. Concerns (including possible safeguarding issues) have been raised with Healthwatch Devon, logged, and fed back to relevant managers as part of the consultation process.

DCC has made a good start in organising a series of meetings with service users and providers. We have no doubt that plans are being put in place at various levels to help manage possible closures and transitional arrangements. But in the interests of achieving best outcomes for people affected by this service transition, we believe that there should be:

- An on-going information, advice and practical support service for the large numbers of people affected. This could include help with tackling worries about alternative services including wider issues of affordability, travel, access to social contact etc.
- An on-going means of tracking the experience of service users and their relatives/carers through the transition. This would enable monitoring - at the strategic level - of the impact of this transition on the wellbeing of those at the sharp end of the change.

The Health and Wellbeing Board is invited to:

- Note that Healthwatch Devon has a forthcoming meeting with Cllr. Stuart Barker to discuss these issues
- Note that Healthwatch Devon has outlined a possible set of services and solutions linked to the issues raised above
- Accept a report at the next meeting of the Health and Wellbeing Board to consider outcomes of the meeting between Healthwatch Devon and Cllr. Barker

Transforming Community Services

We will, in the coming weeks, submit our response to the NEW Devon CCG "Integrated, personal and sustainable" strategic framework for community services. We will be looking for assurances that the consumer voice is central to the proposals, and that the strategy will tackle historic issues (throughout the NHS) of fear of speaking out and/or lack of confidence that feedback will be heard.

The Health and Wellbeing Board is invited to:

- Note that Healthwatch Devon is preparing a response to the community services strategic framework, and
- Accept a summary of the Healthwatch Devon submission for debate at the next meeting of the Health and Wellbeing Board

Mental Health Services

For some time we have been hearing from people about their experiences of using mental health services. Concerns have been raised to us about access to care at times of crisis, delays in accessing psychological therapies, a lack of inpatient intensive care beds in Devon leading to patients being placed out of county and a lack of continuity when people are discharged from hospital back into the community. These concerns have been shared with Devon Partnership NHS Trust and Care Quality Commission and we are pleased to be involved in the multi agency Quality Improvement Plan, so that these experiences can contribute to driving service improvement.

Healthwatch Devon is due to report its year one report and recommendations in relation to mental health and wellbeing services, based on the experiences it has captured since Healthwatch came in to being.

The Health and Wellbeing Board is invited to:

- Note that Healthwatch Devon is preparing a report based on peoples experiences of mental health and wellbeing services in Devon
- Accept the report at the next meeting of the Health and Wellbeing Board

Access to Non Urgent Care

A recent survey carried out by Healthwatch Devon, which received over 500 responses and feedback received through 'Speak Out' revealed that many people find it difficult to access GP appointments in Devon and many are unsure what services are available to them locally if non urgent treatment is required.

Healthwatch Devon is due to report its findings imminently to NHS England and Commissioners, which will explain why people find it difficult to make GP appointments, what people do if they cannot get an appointment when they need one and what choices people make when considering which local service to use. Key findings already indicate that people want:

- Better access to GP appointments and shorter waiting times for appointments
- More choice as to when they can access a GP appointment –i.e. longer opening times at evenings , weekends
- Better access to their own GP

- More information about what services are available to people in their local area, should they require non urgent medical attention
- More consideration given to those with particular access needs e.g. if they have a physical disability, sensory impairment, mental health condition or if English is not their first language

The Health and Wellbeing Board is invited to:

- Note that Healthwatch Devon is due to publish a report focussing on access to non-urgent care
- Note the key points highlighted above in relation to what Healthwatch Devon has found
- Accept a summary of the report at the next meeting of the Health and Wellbeing Board

Current work plan

Getting the *Community Voice* into the JSNA

Healthwatch Devon is currently working with the Public Health Intelligence Team (PHIT) to develop a process for including the community voice in Devon's Joint Strategic Needs Assessment. We are working with PHIT on upcoming topic based needs assessments (Long Term Conditions and Eye Health) and we have developed a volunteer support framework and training package to help maintain a team of community / locality researchers to gather information to feed into the JSNA process.

Unsafe Discharge

We are due to launch our next survey which will run throughout June, focusing on people's experiences of being discharged from hospital or care setting, as part of a national Special Inquiry entitled "Then What?" being led by Healthwatch England into unsafe discharge. This Inquiry has a specific focus on the experiences of vulnerable people, those with mental health conditions, older people and homeless people and Healthwatch Devon and partners are planning targeted engagement activities to enable us to capture experiences from people in Devon. Healthwatch England aim to report their findings in September. More information can be found [here](#) We will produce a report of our local findings in August

Latest Reports

Our *Care. Data* survey report can be found [here](#)

We have had a reply from the NEW Devon CCG to our "Torrington 200" report, and will publish the report and the reply imminently.

Health and Wellbeing Board 12 June 2014

Joint Engagement Board representative report from Carol Brown

The Joint Engagement Board contains representatives from service user networks covering: carers, people with physical & sensory disabilities, people with learning disabilities, people with mental health issues, older people and parents of children with disabilities.

Tough Choices consultation

Members of the networks were pleased to have been involved in relevant engagement and consultation activities for the Tough Choices reviews, in particular the day centre and care homes projects. We particularly welcome the open way in which DCC was prepared to share the real costs of these services and the scale of the financial and demographic challenges facing the authority. We are, however, concerned about the following issues...

Headline feedback from that involvement is:

- Concern over the appropriateness of alternative provision presented to service users and stakeholders, when reviewed by service users many of the options being presented were simply not fit for purpose for vulnerable people, especially those with complex needs.
- Concern over the gap between the People part of DCC which is withdrawing from providing services and the Place part of DCC which has to encourage community take-up of services where possible.
- Concern over the way in which individual service users will be transferred from existing services to alternative provision – will this be carried out in a sensitive enough way and will the financial pressure mean this has to be done too quickly for suitable support to be in place?

Other user network activity

As well as Tough Choices consultation, since the last Health & Wellbeing Board the user networks have participated in high volume of involvement activities to help the planning and delivery of health and social care services. This includes:

Adults Safeguarding Board service user sub-group
Devon Carers strategy Board
NHS out of hours services consultation
Focus groups on Stroke services
Devon Partnership Trust target-setting
Devon Partnership Trust work with Care Quality Commission
Metnal Health commissioning strategy development
Care Direct mystery shopping exercise
Care Closer to Home events
Community Equipment Service consultation
RD & E carers survey
Independent care homes CCG quality focus group
NHS England national learning disability consultation on pharmacy services

SEND Pathfinder involvement
Listening events for parents of children with special needs
Creation of DCC and NHS staff training DVDs

Our networks have also been working on some non-health and social care issue, including:

Physical access meetings with District Councils, including access to polling stations
Welfare benefit reform work with Citizen's Advice Bureaux
Dear Awareness sessions
Learning disability community safety work with the police.



*From Jane Ellison MP
Parliamentary Under Secretary of State for Public Health*

*Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 4850*

29th April 2014

To: Health and Wellbeing Chairs and Members

In the last year, public health has undergone some of the biggest changes in generations. Our public health reforms have radically shifted power to local authorities, empowering them to invest and innovate to improve the health of their communities. I am confident that local communities are best placed to respond to local needs.

To mark the first anniversary of the birth of this new system and the establishment of Health and Wellbeing Boards, I wanted to write to you to thank you for all your hard work to for improve your local population's health in creative and innovative ways. I also want to highlight some of my priorities and recent work in and out of Parliament, as well as some of the public health issues that have been of particular interest to my parliamentary colleagues in recent months.

Recognising local excellence in promoting health and wellbeing

The public health changes we have seen over the last year are unleashing great creativity and local innovation as, local leaders rise to the challenges they face in their area.

I wanted to recognise, in Parliament, those people that have gone the extra mile to change the world around them for the better. That is why earlier this month I hosted a celebration event, in Parliament, to recognise those people who have been working hard to make a difference to the health and wellbeing of the people in their area.

It was fantastic to meet so many dedicated individuals at the event and to hear of the diverse and exciting initiatives and projects that people are engaged in such as the Wisbech Market Stall Project which provides health information such as advice about

diet and alcohol through a market stall or the 'Lose Weight Feel Great' initiative at Wigan Borough Council which helped 8000 people to lose weight.

The response to the call for nominations and attendance at the event was superb, reflecting the level of pride and ambition in around the country. I was heartened to see that some MPs put forward the people they know are making a difference in their constituency.

I hope that the event will serve to inspire the next wave of public health heroes and I look forward to hearing more about their achievements. You can download the summary booklet featuring all the nominated individuals and groups from www.dh.gsi.gov.uk. I would also be very interested to hear from you about innovative examples of public health work going on in your area, so please do contact me at publichealth.minister@dh.gsi.gov.uk

Tackling TB

The Collaborative Tuberculosis Strategy for England 2014 to 2019 was launched for consultation at a well-attended meeting organised by the All Party Parliamentary Group on TB in Parliament on 24 March 2014. The Strategy aims to learn from successful TB control programmes internationally, and adapt the learning to our specific epidemiological situation and health care structures.

The focus is to build on the assets already in the NHS and the public health system, to support and strengthen local services in tackling TB in areas of high incidence, to ensure clear lines of accountability and responsibility throughout, and to provide national support for local action.

The Department will continue to support Public Health England in giving national policy leadership, ensuring that there is a co-ordinated approach to TB. If you would like to read the strategy and/or take part in the consultation you will find it [here](#).

FGM

As some of you may know, before becoming Public Health Minister, I campaigned strongly against female genital mutilation (FGM), setting up the All Party Parliamentary Group on FGM. Since taking office, I have been taking action to ensure health services do all they can to combat this illegal and abusive practice.

Since 1 April 2014, all healthcare professionals are now required to record in a patient's healthcare record if it is identified that she has FGM. All professionals including GPs, hospital doctors, nurses, and midwives must follow this, across all healthcare sectors with immediate effect. We have done this by introducing a new

information standard. This also requires that all Acute NHS Trusts (Foundation and Non-Foundation) must report to the Department of Health on the prevalence of FGM within their patient population, and the total number of patients who have been treated for FGM. The monthly collection must be implemented by September 2014.

All queries on this and the wider programme of work can be directed to FGM@dh.gsi.gov.uk

Can I also take this opportunity to remind you that if any frontline staff identify a child they consider to be at risk of FGM, or who has already undergone FGM, they must respond appropriately by involving social services and/or the police.

I have urged the NHS to ensure the information standard is implemented in their organisation with immediate effect. They should review the [Multi-Agency Guidelines](#) to ensure their organisation is meeting the responsibilities in relation to safeguarding and to engage with the FGM Prevention programme as further standards, activities, improved training and other measures are introduced. I think it is of particular note that all NHS healthcare providers are now involved in the recording of FGM within personal healthcare records, so would encourage you to circulate this through staff communication cascades.

I would also ask that you consider whether this is a matter that needs attention in your area and whether it needs to be considered as part of the Joint Strategic Needs Assessment. The Multi-Agency Guidelines provide useful information about practising communities, prevalence etc that should assist you in this regard.

PUBLIC HEALTH IN PARLIAMENT ROUND UP

Headsmart campaign on brain tumours in children

An important awareness campaign, Headsmart, has been raised with me a number of times recently in Parliament to promote the early diagnosis of brain tumours in children. Last year there was a full debate stimulated by a successful e-petition. A key part of the campaign is the distribution of pocket sized awareness cards and I would ask that you look at how best these could be deployed in your area. Some local authorities, for example, have circulated them to schools.

As well as improving the chances of survival, early diagnosis reduces the likelihood of a child or young person with the disease developing a long-term disability.

The campaign has a dedicated website <http://www.headsmart.org.uk> which provides a range of materials on symptoms of brain tumours in children and teenagers for the public and for health professionals, including the pocket size awareness cards.

Public Health England has also agreed to contact all directors of public health about the campaign, which is also funding research into this condition.

Debates on cancer

Over the last few months, there has been a great deal of parliamentary interest and debate about cancer services. The All Party Parliamentary Group (APPG) on Cancer has recently published a report into cancer services, which includes recommendations for every level of the NHS. I will be responding to the APPG formally on the recommendations for this Department, but you may wish to consider its recommendations for your areas. You can read the report [here](#).

I have also responded to a number of debates on different types of cancer. The overarching theme between each case has been the overwhelming importance of the patient experience, and often the ‘non-medical’ aspects of caring for people. I am pleased that the annual Cancer Patient Experience survey is continuing to provide excellent feedback to trusts and commissioners, and I would urge you to consider all of its suggestions about how individual local services can give patients the best possible care.

I’d also like to make you aware that we’re running a range of regional “be clear on cancer” campaigns this year and during 2015, as well as our rolling national campaigns. These are great opportunities to consider how they could work in your area or complement local activity, you may be planning. For more information, [click here](#).

Let’s get physical

In February, the Government published ‘Moving More, Living More – the Olympic and Paralympic Physical Activity Legacy for the Nation’. Getting the nation to engage in more physical activity is a key priority for this Government. Healthy, active lifestyles not only benefit the individual by reducing the likelihood of developing over 20 chronic conditions, including coronary heart disease and stroke, but they can also contribute to the community as a whole. I am especially conscious of the positive role physical activity can play in tackling social isolation.

We all have a role to play in helping people to exercise more, and it is in the collective power of Health and Wellbeing Boards’ to bring together public health commissioners, the NHS and local authorities to achieve this ambition. Public Health England is currently running a national consultation to develop its National Implementation Framework for Physical Activity. When finished, this document will provide advice and examples of good practice in how to design physical activity back into everyday life. More information on the consultation can

be found at www.gov.uk by searching for ‘Healthy Lives, Healthy People: our strategy for public health in England’, and I would encourage your Health and Wellbeing Board to take part in it. The interim consultation summary will be published in the autumn with the intention of helping LA’s plan for 2015/16.

Delivering on the promise of the new public health system

We still see stark and stubborn differences in the health and wellbeing of people depending on where they live in the country and their social economic background. There is a wealth of data that shows in detail key health and wellbeing indicators broken down by local authority areas. This data should serve as a driver to implement local solutions to address particular local problems, for example on obesity or smoking. Your Director of Public Health and PHE Director can assist you in accessing this information.

I truly believe that although national action and legislation plays an important part in some key areas of improving public health, such as tobacco control, giving local authorities the mandate and money to design and deliver public health initiatives locally is the right approach. I have already heard and seen fantastic local examples, up and down the country. However, if 2013-14 was about embedding the new public health system and building up strong relationships, the real test this year will be measurable, real and sustained improvements in local public health outcomes for people within their communities. I wish you every success.

A handwritten signature in black ink that reads "Jane Ellison". The signature is written in a cursive style and is underlined with a single horizontal line.

JANE ELLISON MP
PARLIAMENTARY UNDER SECRETARY OF STATE FOR HEALTH

DEVON COUNTY COUNCIL

SCRUTINY WORK PROGRAMME

The Scrutiny Work Programme identifies those areas of activity or work proposed to be undertaken by individual Scrutiny Committees over the coming months, notwithstanding the rights of County Councillors to ask for any matter to be considered by a Committee or to call-in certain decisions in line with the Council's Scheme of Delegation (Part 3 of the Constitution) and the Scrutiny Procedures Rules.

Co-ordination of the activities of Scrutiny Committees is undertaken by the Chairmen and Vice-Chairmen of Scrutiny Committees to avoid duplication of effort and to ensure that the resources of the Council are best directed to support the work of Scrutiny Committees.

The Work Programme will be submitted to and agreed by Scrutiny Committees at each meeting and will be published on the Council's website 'Information Devon', (http://www.devon.gov.uk/index/councildemocracy/decision_making/scrutiny/scrutiny_programme.htm) as soon as possible thereafter.

An up to date version of this Plan will also be available for inspection from the Democratic Services and Scrutiny Secretariat at County Hall, Topsham Road, Exeter (Telephone: 01392 382296) between the hours of 9.30am and 4.30pm on Mondays to Thursdays and 9.30am and 3.30pm on Fridays, free of charge.

Where possible Scrutiny Committees will attempt to keep to the timescales/dates shown in the Plan. It is possible, however, that some items may need to be rescheduled and new items added as new circumstances come to light.

Please ensure therefore that you refer to the most up to date Plan.

Copies of Agenda and Reports of Scrutiny Committees of the County Council referred to in this Forward Plan area also available on the Council's Website at (<http://www.devon.gov.uk/dcc/committee/minqifs.html>)

SCRUTINY WORK PROGRAMME

Date for Consideration	Matter for Discussion	Scope of Investigation or Purpose of Report	Contributors or Heads of Services to be involved	Documents to be considered	Likely timescale for Investigation or Consideration
Corporate Services Scrutiny Committee					
23 Sept 2014	Police and Crime Panel update on work	Programme of work and how scrutiny might input	Chair of the PCP	Verbal report	Committee meeting only
	Search and Rescue service	Concern over the privatisation and relocation of the service Details	Scrutiny Officer and witnesses	Written and oral evidence	Task Group with report back to Committee
25 Nov 2014	Community resilience task group	Changing nature of the councils relationship with communities in Devon and identify ways of supporting them	Scrutiny officer and witnesses		Task Group with report back to committee
Suggested future topics	Commissioning/ benefit realisation of contracts	Scrutiny's role in commissioning	All Heads of Service	Report back to committee	Spotlight review/seminar
	Armed Forces Covenant	18 months on – review progress and impact	Scrutiny Officer and witnesses	Report	Spotlight Review with report back to Committee
Place Scrutiny Committee					
12 Sept 2014	Energy Reduction and Generation Initiatives	County Council schemes, and the potential for energy generation through tidal and river power	Head of Planning, Transportation and Environment	Report	Committee meeting only
	Winter Service: Review of Winter 2013/14	Overview of the winter service 2013/14 and the associated costs	Head of Highways, Capital Development & Waste	Report	Committee meeting only
	Road Traffic Collisions and Casualties 2013	Report annual statistics	Head of Highways, Capital Development & Waste	Report	Committee meeting only
	Performance Data	Quarter 4 report	All Heads of Service	Report	Committee meeting only
15 Nov 2014	2014/15 Budget: In Year Briefing	Report on progress with delivery of the current year's budget against the Council's agreed priorities and objectives	All Heads of Service	Report	Committee meeting only

Item 16

Date for Consideration	Matter for Discussion	Scope of Investigation or Purpose of Report	Contributors or Heads of Services to be involved	Documents to be considered	Likely timescale for Investigation or Consideration
15 Nov 2014	Fuel Poverty	Focus and activities on fuel poverty at district level and with Health and Wellbeing	Head of Planning, Transportation and Environment	Report	Committee meeting only
	Performance Data	Quarter 1 report	All Heads of Service	Report	Committee meeting only
10 Jan 2015	LEP Strategic Economic Plan	Update report on LEP Strategic Economic Plan (incorporating the EU Strategic Investment Framework)	Head of Economy & Enterprise	Report	Committee meeting only
	Performance Data	Quarter 2 report	All Heads of Service	Report	Committee meeting only
People's Scrutiny Committee					
19 Sept 2014	Safeguarding Children Task Group	Further interim report	Scrutiny Officer	Report	Committee meeting only
	Educational Outcomes Task Group	An evaluation of educational outcomes for children and young people with a particular focus on Children in Care.	Scrutiny Officer	Report	Committee meeting only
	Devon Safeguarding Children Board (DSCB) Annual Report	Review the 2013/14 Annual Report	DSCB Chair	Report	Committee meeting only
	Meals Service	Update	Head of Social Care Commissioning	Report	Committee meeting only
	Public Health Annual Report	Review the 2013/14 Annual Report	Director of Public Health	Report	Committee meeting only
20 Nov 2014	2014/15 Budget: In Year Briefing	Report on progress with delivery of the current year's budget against the Council's agreed priorities and objectives.	All Heads of Service	Report	Committee meeting only
	Safeguarding Children Task Group	Update	Chair	Verbal report	Committee meeting only
8 Jan 2015	Support for Carers / Young Carers Task Group Update	Review of implementation of recommendation 5	Scrutiny Officer	Report	Committee to consider / Task Group
	Devon Safeguarding Adults Board (DSAB) Annual Report	Review the 2013/14 Annual Report	DSAB Chairman	Report of the DSAB	Committee meeting only
Suggested future topics	Social Care: Direct Payments and Personal Budgets	For details see (see Minute *93b)	Scrutiny Officer and witnesses	Written and oral evidence	Task Group with report back to Committee

Item 16

Date for Consideration	Matter for Discussion	Scope of Investigation or Purpose of Report	Contributors or Heads of Services to be involved	Documents to be considered	Likely timescale for Investigation or Consideration
Suggested future topics	Accommodation for 16-25 year olds in transition from care to independent living	For details see Minute *21	Scrutiny Officer and witnesses	Written and oral evidence	Task Group / Spotlight Review with report back to Committee
	Safeguarding Adults	New Task Group	Scrutiny Officer and witnesses	Written and oral evidence	Task Group with report back to Committee
	Children's Centres	Refresh	Scrutiny Officer and witnesses	Written and oral evidence	Committee meeting only
Health & Wellbeing Scrutiny Committee					
16 Jun 2014	Voice of the Vulnerable	Developments since Francis Report into Mid Staffordshire NHS Trust	County Solicitor	Spotlight review report	Spotlight Review
	Transforming Community Services – particular look at the strategic plan (include Torrington CH and Budleigh CH,)	Strategic direction of community services particularly changes from bed based models of care to those in community settings	NEW Devon CCG	Report	Spotlight Review – TBA and then discussion at committee
	Veterans accessing Primary Health Care	To explore barriers which have been experienced by veterans in the healthcare system	CCGs	Health Checks Task Group Report	Spotlight review?
	Future of Community Health and Social Care Services in South Devon	Draft plans and proposals following community engagement	South Devon and Torbay CCG	Report	Committee meeting only
	North Devon Maternity Service changes	Scope of the changes and anticipated impact	Northern Devon and NEW Devon CCG	Report	Committee meeting
	Better Care Fund	Fund creation and distribution			Committee meeting
	CAMHs	To investigate concerns about the service s			Spotlight review
18 Sept 2014	Discharge rates at the RD&E	To investigate concern over discharge	RD&E	Report	Committee meeting only
	Mortality Rates – possible quality surveillance dashboard from CQC	To examine cause for concern	Care Quality Commission	Dashboard?	Committee meeting only follow up as necessary
	Community Hospital Task Group	Progress against recommendations	NHS Commissioners/ Providers	Task Group Report	Spotlight review if necessary
	Psychological Services(See 6 Mar 2013 Minutes)	To report progress on reducing waiting lists	CCG/DPT	Previous Report Report	Committee meeting only

Item 16

Date for Consideration	Matter for Discussion	Scope of Investigation or Purpose of Report	Contributors or Heads of Services to be involved	Documents to be considered	Likely timescale for Investigation or Consideration
Suggested future topics	JSNA Priorities and the contribution that scrutiny can make to them				

HEALTH AND WELLBEING BOARD – FORWARD PLAN

<u>Date</u>	<u>Matter for Consideration</u>
Thursday 12th June 2014 @ 2.00pm	CCG Updates Better Care Fund (formally ITF) Establishment of a Devon Children, Young People and Families Alliance Child Sexual Exploitation – Outcomes of Review Health & Wellbeing Strategy Priorities and Outcomes Monitoring Oral Health Strategy – Peter Howard Williams Joint Ambitions (CCG and NHS England) Winterbourne View (Standing Agenda Item) Engagement and Communications – TBC Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 11th September 2014 @ 2.00pm	CCG Updates Adults Safeguarding – Annual Report Children’s Safeguarding – Annual Report (BF from June - request of DCSB) Better Care Fund (formally ITF) Topic based report (Housing) Topic based report ((Frailty) to include Frailty Guidance (Carol Williams) Health & Wellbeing Strategy Priorities and Outcomes Monitoring Winterbourne View (Standing Agenda Item) Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 13th November 2014 @ 2.00pm	CCG Updates Health & Wellbeing Strategy Priorities and Outcomes Monitoring Better Care Fund (formally ITF) Winterbourne View (Standing Agenda Item) Topic based report (topic tbc) Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 15th January 2015 @ 2.00pm	CCG Updates Health & Wellbeing Strategy Priorities and Outcomes Monitoring Better Care Fund (formally ITF) Winterbourne View (Standing Agenda Item) Topic based report (topic tbc) Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Thursday 12th March 2015 @ 2.00pm	CCG Updates Health & Wellbeing Strategy Priorities and Outcomes Monitoring Better Care Fund (formally ITF) Topic based report (topic tbc) Winterbourne View (Standing Agenda Item) Topic based report (topic tbc)

January 2014

Item 17

	Healthwatch Update Joint Engagement Board Update Scrutiny Work Programme Briefing Papers, Updates & Matters for Information
Items to Add	Equality & protected characteristics outcomes framework Children's Safeguarding annual report (annually in June / September) Engage Project – possibly as a topic based report