HEALTH AND WELLBEING BOARD

10 September 2015

Present:-

Devon County Council
Councillors Barker, Davis (Chairman), Clatworthy and McInnes.
Dr V Pearson (Director of Public Health)

District Council Representative
Councillor Sanders

Environmental Health
Mr R Norley

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

Joint Engagement Board
Ms C Brown

Health Watch
Mr D Rogers

Apologies:

Mr T Hogg (Police and Crime Commissioner)
Ms J Stephens (Devon County Council)
Dr D Greatorex (South Devon and Torbay Devon Clinical Commissioning Group (CCG)
Mr J Wiseman (Probation Service)
Ms L Scott (NHS England)

*181 Minutes

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

RESOLVED that the minutes of the meeting held on 11 June 2015 be signed as a correct record.

PERFORMANCE AND THEME MONITORING

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

The Board considered a report from the Director of Public Health, presented by Mr S Chant (Public Health Specialist – Intelligence), on the performance for the Board, which monitored the priorities identified in the Joint Health and Wellbeing Strategy for Devon 2013-2016.

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.

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 characteristics and trends over time. The indicators relating to Teenage Conception Rate, 2014 Q1, Hospital Admissions for Self-Harm, Aged 10 to 24, 2013-14, Proportion of Physically Active Adults, 2014, Alcohol-Related Admissions, 2014-15 (narrow and broad definitions), Incidence of Clostridium Difficile, 2014-15 and Feel Supported to Manage Own Condition, 2014-15 Q3-Q4 had all been updated since the last report to the Board.

Following approval at a previous meeting, a Red, Amber, Green (RAG) rating was included in the indicator list and a performance summary on page 2 of the full report. Areas with a red rating included hospital admissions for self-harm, aged 10-24.

The report also highlighted that, in due course, it would contain a summary of emerging themes from the Devon Child Sexual Exploitation (CSE) scorecard. The scorecard was being developed by the CSE sub-group of the Devon Safeguarding Children Board (DSCB), with input from relevant partners. A senior information analyst from the Public Health Intelligence Team had been seconded to act as lead analyst for CSE data. The first version of the scorecard had just been drafted and would be available in late September and produced thereafter on a quarterly basis.

The outcomes report was also available on the Devon Health and Wellbeing website www.devonhealthandwellbeing.org.uk/jsna/health-and-wellbeing-outcomes-report

The Board, in discussion,

- clarified reasons for the lower level of dementia diagnosis rates;
- noted that the measures for dementia diagnosis rates were under national review;
- considered the importance of appropriate care and support, post diagnosis, which was critical;
- questioned the gender disparities in relation to hospital admissions for self harm and whether any further breakdowns were available; and
- whether there were any plans by commissioners to address the gender differences highlighted by the figures.

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

RESOLVED

(a) that the performance report be noted and progress with the Child Sexual Exploitation scorecard be welcomed; and

(b) that Members of the Board be sent a further breakdown of statistics in relation to the gender figures and self harm hospital admissions.

***183 Theme Based Report – Good Health in Older Age**

The Board considered a report from the Director of Public Health on the promoting good health and wellbeing in older age priority, as detailed in the Joint Health and Wellbeing Strategy.

The importance of promoting good health and wellbeing in older age is well known and of particular importance in Devon due to the higher proportion of older people living and working in Devon. The Devon Joint Strategic Needs Assessment (2015) highlighted forward projections of future growth in the older population and the reduction in the younger working age population. This had major implications for care and support.

Analysis of the Joint Strategic Needs Assessment identified the priorities of reducing falls and fractures in older people, raising awareness of dementia in communities and identifying hidden carers. In addition, the Joint Health and Wellbeing Strategy update in

2013 added the additional priority of end of life care and the following additional actions of, producing an end-of-life care integrated pathway, promoting healthy lifestyle advice for people with dementia, implementation of the carers strategy and the undertaking of a sight loss/ visual impairment health needs assessment.

In terms of progress against outcomes, the report contained an analysis of relevant outcomes measures from the Devon health and wellbeing outcomes report and was set out in table form and included performance measures of incidences of clostridium difficile, injuries due to falls, dementia diagnosis rate, feeling supported to manage own condition, reablement services (effectiveness), reablement services (coverage) and re-admissions to hospital within 30 days.

In summary, the report outlined that Devon was expected to experience the greatest population growth in the older age groups and for this reason 'Good Health and Wellbeing in Older Age' was an important priority locally. There were approximately 181,600 people aged 65 and over in Devon, of which 15,600 were supported by social care (JSNA 2015).

The focus of prevention in older age was around healthy active ageing and supporting independence so that older people were able to enjoy longer healthy lives, felt safe in their homes and were connected to their community.

The Board also viewed a short film, produced by Teignbridge District Council, which highlighted the emotional and psychological effects of falls, spoken by those in the film, outlining impacts on confidence levels and general wellbeing.

The Board discussed the following in terms of

- the role of the new Prevention Board, being chaired by Dr Norrey (Chief Executive of Devon County Council);
- the work being done to avoid admissions to hospital;
- the role of care plans and understanding patient / people preferences to help avoid admissions;
- clarification on the systems that paramedics had access to (for example patient preferences) and whether this was appropriately 'joined up';
- whether any analysis had been conducted on the correlation between slips, trips and falls and poor housing conditions and / or areas of deprivation;
- the current work by Healthwatch, with hospices and in conjunction with Cornwall, on end of life care;
- whether there was a role in Devon with regard to Admiral nurses for dementia;
- the current pilot with Devon Fire and Rescue, combining fire advice with a home check, particularly focusing on those issues that could cause falls and slips; and
- the key themes arising from the discussion that pointed towards investment in community services, reablement and demand management (to help people help themselves) and the transparency of records;

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

RESOLVED

(a) that the future format of themed reports be discussed at the Health and Wellbeing Board Development Day on 8 October 2015; and

(b) that further information be brought to the Board in respect of any work or analysis on the correlation between housing, deprivation and slips, trips and falls.

BOARD BUSINESS - MATTERS FOR DECISION

***184 Joint Commissioning in Devon, the Better Care Fund (BCF) and Governance Arrangements)**

The Board considered a joint report from Mr T Golby (Head of Social Care Commissioning, Devon County Council) and Mr P O'Sullivan (Director of Partnerships, NEW Devon CCG) on current progress with the Better Care Fund.

The purpose of this fund was a drive towards integration and a seamless service user / patient experience being at the forefront of developments around health and social care. The key areas of focus were prevention and independence, crisis response and regaining independence.

The report outlined that the Better Care Fund 2015 /16 First Quarter Return had been submitted to the national BCF programme. The return built on the previous return that the Board had agreed at its last meeting. It provided data and details in relation to a number of items including the National conditions, Performance information regarding Non Elective Admissions and the Pay for Performance target, an update on how Income and Expenditure was being handled and a progress report on Dementia Diagnosis.

The quarterly data collection also required submission of a written narrative that contained any additional information regarding progress against the plan. The narrative was included as part of the Board papers.

In addition, each month a summary performance report was produced for the whole of Devon and the latest version was also attached to the papers.

The Board was asked to note that the BCF Delivery Group had open actions in place intended to address the issues related to delayed transfers of care and non-elective admissions. both of which were supported by the current operational plans of both NEW Devon and South Devon & Torbay CCG.

The Board was further asked to endorse the Chairs recent delegated decision to sign off the latest data validation return for Better Care Fund (Min 168b).

In signing off the return the Board agreed to the use of NHS Monthly Activity Report (known as MAR), that no Quarter 4 payment was due, that no Quarter 4 Payment was made and the difference between the CCG Operational Plans including QIPP savings and the BCF Performance Target was less than 2% and, as such, national guidance states that the original BCF performance target of 3.5% should not be changed.

The Board discussed and asked questions on the following;

- whether delays in TTA's were still happening (medication "to take away" on discharge from hospital) and what actions were being taken to address this, for example delays in dispensing by hospital pharmacies etc;
- the work of the Strategic Resilience Group in assuring internal processes were operating as they should, including the issues raised with TTA's; and
- the role out of the computerisation programme within the NHS which should see improvements, especially with electronic prescribing.

It was **MOVED** by Councillor Sanders, **SECONDED** by Councillor McInnes, and

RESOLVED

(a) that recent delegated decision made by the Chairman to sign off the latest data validation return for Better Care Fund (Min 168b), be endorsed; and

(b) that the quarterly reports, required by the Board, be welcomed.

***185 Annual Health Protection Report**

The Board considered a report from the Director of Public Health which provided a summary of the assurance functions of the Health Protection Committee and also the actions taken in relation to the programme of health protection work priorities for 2014 to 2015.

The report considered the following domains of health protection:

- Communicable Disease Control and Environmental Hazards (which included information and actions around organisational roles/responsibilities, surveillance arrangements, outbreak of E.coli VTEC, tuberculosis incident in a Devon School, norovirus 2013-14, scarlet fever 2014-15 and seasonal influenza);

- Immunisation and Screening (considering organisational roles/responsibilities, surveillance arrangements, immunisation activity and changes to the National Immunisation Programme 2014-15, screening, information sharing and seasonal influenza); and

- Health Care Associated Infections (including the work of the Health Care Associated Infection Programme Group, clostridium difficile infection (CDI), MRSA, other outbreaks, other bacteraemias, exercise Cygnus and also national issues such as the Ebola virus disease).

The report concluded with an outline of the Work Programme for 2015-16, which included a Tuberculosis strategy, Influenza immunisation, Hepatitis C strategy review, Screening, Bacteraemias and Emergency planning including a further pandemic flu exercise in the autumn, Exercise Mallard.

The Board discussed and asked questions on the following;

- the welcome news that Local Authorities had been working with Public Health England to produce guidance for the hospitality industry (following a recent norovirus investigation);
- the low take up of the flu vaccination for pregnant women and the forthcoming campaign to address this issue; and
- the need to recognise the large scale co-ordination required by GP's surgeries to conduct immunisation programmes to all eligible people, including newer vaccinations such as the one for shingles.

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

RESOLVED that the report and forthcoming work programme be welcomed.

***186 Adult Safeguarding - Vulnerable Adults Mental Health Crisis Care**

The Board considered a report from the Head of the Adults Safeguarding Board which outlined a summary and key learning points in relation to the recent thematic review into vulnerably adults mental health crisis care.

The review was commissioned by the Safeguarding Adults Board to consider any underlying or cross cutting themes that existed within three cases that had occurred within six months of each other but were otherwise unrelated (a suicide, a murder and a dispute on arranging safe transport).

A number of themes were identified during the review which included the quality and timeliness of assessment at the point of crisis, inter-agency communication, sharing of risk information, co-location and informal information exchange, mental health services discharge processes, joint agency training and understanding, multi agency participation in root cause analyses and duty of candour and clarity of RCA reports for service users and families.

Since the review (and during the progress) some of the identified issues had started to be addressed by developments in national or local policy and practice. The report then outlined the further progress since the review, linked to each of the themes identified above.

The Board discussed

- that feedback from the review raised information governance issues with regard information sharing and the need for pro-active sharing of information across agencies and professionals; and
- the huge human impact of the cases, demonstrating the need to 'get it right'.

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

RESOLVED that the review, learning points and subsequent action plan be welcomed.

***187 Transformation Plans (CAMHS)**

The Board received a joint presentation from NEW Devon CCG and South Devon and Torbay CCG in relation to the CAMHS Transformation Plans. All the CCGs, local authorities and service providers were adopting a system wide approach to transformation and, in doing so, were recognising current services and needs would be different in different parts of the geography, whilst also looking to achieve a consistent system vision and outcomes over the course of the plans.

The presentation outlined the key messages received from children and young people which raised consistent themes around spanning information, preventing crisis, help in a crises, easy access services and a workforce that listened and treated people with respect. It also presented the Board with the needs and considerations locally, outlining the geographical issues in delivering services. In the last year, there had been 3709 referrals to CAMHS and there were approximately 115 young people with eating disorders.

The CAMHS agenda was reported as very important as a local agenda and there was much good practice to build upon. However, the presentation outlined the aspirations for the future which included evidence based models designed around children, a whole systems approach, the wider workforce as a focal point for transformation, clear outcomes and the use of interventions that were both effective and evidence based.

The presentation then outlined the main priorities, highlighted as:

- Early intervention (working with partners and peers, early intervention with support at Tier 1 and 2 and working with adult providers for all age pathways)
- Crisis response (implement the requirement of MH Crisis Concordat, timely front door response in acute crisis 24/7 and assertive outreach over extended hours)
- Children in care (remodelling the CiC (Children in Care) pathway, enhanced evidence based therapeutic interventions and multi-agency support for children on the edge of care); and
- Specific services (embed the self harm evidence pathway and extending eating disorders model across Devon and Plymouth in line with the evidence base)

The presentation concluded with the Governance Plans and expectations of what young people should expect in terms of timely access, choice over support, control over the services received, integrated support, services in line with best practice, involvement in planning and the opportunity to influence.

(a) South Devon and Torbay CCG

The Board considered a report from South Devon and Torbay CCG outlining that Clinical Commissioning Groups had been given funding allocations by NHS England to support transformational change in local CAMHS services.

The SDT CCG had been working with CAMHS providers, patients/ parents and NEW Devon CCG to outline the changes needed. Plans were for 5 years and had to show a distinct service for eating disorders as well as looking to meet the priorities outlined within 'Future In Mind'. As part of the assurance process, the support of the Board was sought to confirm agreement to the proposed priorities and also the anticipated outcomes.

The report outlined the ambitions of the CCG which were;

- reduce the number of presentations to A&E for those in crisis (would be predominately those with significant self harm);
- reduce the number of admissions to secondary care for eating disorders and for those in crisis (would be predominately those with significant self harm);
- reduce and maintain shorter treatment times for those with eating disorders by increasing dietetic and paediatric support, building on the existing nationally recognised good practice pathway;
- reduce the number of admissions to Tier 4 beds for all conditions;
- support core CAMHS services with recognition that transformational change had already taken place by drawing on core funding; and
- work with schools to build resilience, to more effectively support children between the ages of 2-5 years and look at more robust autism assessment services (dependent on financial capacity and resources)

The report also outlined further plans in relation to eating disorders and the existing hub and spoke model, the crisis and intensive home intervention service and how resilience might be provided through a peer support service (via Young Devon) and also to improve the offer to Looked After Children in line with the new NHSE guidance.

The Board expressed concern over the potential development of a peer support service and increasing online counselling through Young Devon, given the Council had just co-commissioned a new service with schools which was needs- and evidence-based and had been developed with a considerable amount of work over the last 18 months. The Board requested this was reconsidered as there could be potential duplication and also result in inequality in service provision across Devon. It was also noted that of the existing CAMH service provision, there was still a gap at tier 2/3 level (Primary Mental Health Workers) which should be addressed by the additional NHS funding and which would consequently reduce the pressure on tier 3 and 4 (specialist) CAMH services.

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

RESOLVED that, subject to reconsideration of the peer support proposal, the Board endorse the outline priorities, as outlined in the report, and also give delegated authority to the Chair of the Board to approve the final plan, which was required to be signed off by 16th October 2015.

(b) NEW Devon CCG

The Board considered a report from NEW Devon CCG which, firstly, outlined the initial objectives, by NHS England, of the transformation programme which included developing

eating disorder services for children and young people, rolling out the Children and Young People's Improve Access to Psychological Therapies Programme (IAPT) and improving access to perinatal care. As part of the programme, local Transformation Plans for each Clinical Commissioning Group (CCG) area had to be developed.

The local Transformation Plans had to be underpinned by the input of children and young people themselves and also partnership working across the system which included the completed plans being signed off by Health and Wellbeing Boards.

The report described the planning requirements, including assurance processes, set out the scope, design features and resource framework, outlined the local process for developing the Transformation Plan and proposed an approach for Health and Wellbeing Board engagement and sign off.

There were a whole host of criteria which CCG's needed to demonstrate in terms of producing their plans. These were outlined in detail in the report and included, inter alia, having been built around the needs and mental health needs of children and young people, evidence of effective joint working, reference to other improvement initiatives, promoting collaborative commissioning approaches within and between sectors, include spending and investment by all partners, publication of the plans on relevant websites, demonstrate how health inequalities would be addressed, include workforce information, have measurable KPI's and must have been costed and aligned to the funding allocation.

It was noted by the Board that both NEW Devon and Southern Devon and Torbay CCG's had to submit local Transformation Plans and they were looking at areas within the plans where there were benefits of working together.

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

RESOLVED that the proposed priorities, framework and assurance mechanisms be endorsed and the Board agree that delegated authority be given to the Chair to authorise the final sign off in order to meet the submission date of 16 October 2015 (noting that the plan is a 'living document' and would continue to be updated).

***188 NEW Devon CCG Update (including Transforming Community Services)**

The Board received a presentation from NEW Devon CCG which updated Members on the following issues:

- the Monitor investigation and the findings of the CCG's Eastern Locality community services procurement (Monitor launched its investigation in January 2015, following a complaint by Northern Devon Healthcare NHS Trust (NDHT) over the CCG's decision to name the Royal Devon and Exeter NHS Foundation Trust (RD&EFT) as its preferred provider);
- Sidwell Street (Exeter) Walk in Centre and Urgent Care review (whilst the public support for walk-in centre in Exeter was acknowledged, the review was on hold pending national guidance);
- Improving Quality, Innovation and Productivity (there were 29 active projects within the 2015/16 Quality, Innovation, Productivity and Prevention (QIPP) programme and also an update on the Right Care initiative – major initiative for continuous service review and improvement);
- Success Regime (preparatory work was under way for the start of the Success Regime and the CCG were one of three health systems involved in the first wave of SRs);
- NHS England directions (the directions were issued following the quarter three review in 2014/15 and came into effect on 10 August 2015, giving NHS England a greater support / monitoring role over the CCG's performance and financial recovery. The majority of the actions in the directions had been completed)

- Accessing patient information at the point of care (the CCG had 73 GP practices signed up to share records digitally which meant GPs could electronically share information with fellow clinicians outside their surgery, which avoided time consuming phone calls and paper chases).

There was also an open invitation for members of the Board to attend the annual general meeting of the CCG, on Wednesday 30 September 2015 at the Westpoint Centre in Clyst St Mary.

The Board discussed

- how potential links could be made with medical providers and personal care providers;
- how public health and the social care sector would be involved in the success regime; and
- whether clarification could be given in relation to the current position with North Devon, the Community Hospitals Consultation and provision in other parts of the County.

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

RESOLVED that Dr Burke be thanked for his presentation and that a copy be made available to Board Members.

OTHER MATTERS

*189 References from Committees

Nil

*190 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.

*191 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 12 November 2015 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Strong and Supportive Communities) **Business / Matters for Decision** Better Care Fund Care Act Implications CCG Updates Joint Commissioning Strategies – Actions Plans (Annual Report) Prevention Strategy Update (Minute 169) Children's Safeguarding annual report (Annually September – moved from Sept) Child Sexual Exploitation – Multi-Agency Working (DT / JS) Adults Safeguarding – Annual Report NEW Devon CCG – Personal Medical Services

	Other Matters Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 14 January 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Children, Young People and Families) **Business / Matters for Decision** Better Care Fund CCG Updates Delivering Integrated Care Exeter (ICE) Project – Annual Update **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 10 March 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Healthy Lifestyle Choices) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 9 June 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Review / Joint Health and Wellbeing Strategy / JSNA) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 8 September 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information

Thursday 10 November 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 12 January 2017 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 9 March 2017 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Items to Add	Equality & protected characteristics outcomes framework Winterbourne View (Exception reporting)

RESOLVED that the Forward Plan be approved, including the items approved at the meeting.

***192 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, events, consultations, campaigns and other correspondence. Details were available at; http://www.devonhealthandwellbeing.org.uk/

Items of interest included;

(a) a briefing note regarding the 'All the Moor Butterflies' project, on Dartmoor, by Butterfly Conservation, which highlighted links between the project and the

Health and Wellbeing Strategy and identified the Board as a consultee for the work; and

(b) a letter from Torridge District Council's External Overview & Scrutiny Committee meeting which had included a recent resolution from that Committee to *'contact all those involved in providing the 'care closer to home' service including third sector and other providers; to seek assurance that the 'care' element be put in place as a complete health care package; and to recommend that all sections of care and health providers work closely together to provide a holistic integrated seamless service'*

RESOLVED that the items of correspondence be noted.

***193 Dates of Future Meetings**

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

Thursday 12th November 2015 @ 2.00pm

Thursday 14th January 2016 @ 2.00pm
Thursday 10th March 2016 @ 2.00pm
Thursday 9th June 2016 @ 2.00pm
Thursday 8th September 2016 @ 2.00pm
Thursday 10th November 2016 @ 2.00pm

Thursday 12th January 2017 @ 2.00pm
Thursday 9th March 2017 @ 2.00pm

***194 Dates of Future Seminars**

Thursday 8th October 2015 @ 1.30pm – 4.00pm (**Note revised start time**)

Thursday 11th February 2016 @ 10.30am – 4.00pm
Thursday 13th October 2016 @ 10.30am – 4.00pm

Thursday 9th February 2017 @ 10.30am – 4.00pm

The Chairman reminded the Board that an LGA facilitator would be attending the Development Session on 8th October 2015.

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

The meeting started at 2.00pm and finished at 4.47pm.

NOTES:
1. Minutes should be read in association with any Reports or documents referred to therein, for a complete record.
2.The Minutes of the Board are published on the County Council's website at http://www.devon.gov.uk/index/councildemocracy/decision_making/cma/index_hwb.htm
3. *A recording of the webcast of this meeting will also available to view for up to six months from the date of the meeting, at http://www.devoncc.public-i.tv/core/portal/home*

Devon Health and Wellbeing Board
12th November 2015

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 November 2015 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. The local authority comparator group has been updated to reflect the latest designations (Cambridgeshire and Hampshire have been removed, and Staffordshire and Suffolk added). The updated indicators are:

- Children in Poverty, 2013
- Alcohol-Related Admissions, 2015-16 Q1 (narrow and broad definitions)
- Re-ablement Services (Effectiveness), 2014-15
- Re-ablement Services (Coverage), 2014-15
- Self-Reported Wellbeing: Low Happiness Score, 2014-15
- Social Contentedness, 2014-15
- Carer Reported Quality of Life, 2014-15
- Stable and Appropriate Accommodation: Learning Disabilities, 2014-15
- Stable and Appropriate Accommodation: Mental Health, 2014-15

2.2 In Devon 15,215 children live in households dependent on benefits or tax credits, which is 12.4% of the population compared with 14.8% in the South West and 18.6% nationally.

2.3 Using the narrow definition of alcohol-related admissions covering more immediate harm, the direct age standardised rate of admissions (628.3 per 100,000) is broadly in line with the South West (635.5) and England (634.7) rates but significantly above the local authority comparator group rate (603.2). Using the broad definition of alcohol-related admissions covering longer-term impacts of alcohol, the direct age standardised rate of admissions (1825.6 per 100,000) was below the South West (1984.8), local authority comparator group (1854.8), and England (2128.7) rates.

2.4 In 2014-15, re-ablement services were effective for 88.8% of older people who received the service in Devon, which was significantly higher than the South West (84.0%), local authority comparator group (82.8%) and England (82.1%). In terms of coverage, 1.4% of older people discharged from hospital in Devon were offered re-ablement services, which was significantly lower than the South West (3.5%), local authority comparator group (2.8%) and England (3.1%) rates.

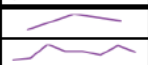
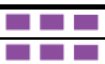
2.5 Within Devon in 2014-15 6.28% of the population had a low happiness score compared with 8.79% for the South West, 8.05% in the local authority comparator group and 8.95% in England overall.

2.6 In 2014-15, 42.8% of social care users surveyed in Devon reported being satisfied with their social situation. This was significantly below South West (45.7%), local authority comparator group (45.4%) and England (44.8%) rates.

2.7 Carer reported quality of life in Devon is slightly above the South West, local authority comparator group and national average.

2.8 In 2014-15 65.6% of adults with a learning disability in Devon (known to the council) were living in their own home or with their family, compared with 69.5% in the South West, 69.9% in the local authority comparator group and 73.3% nationally. In 2014-15 60.9% of adults in contact with a secondary mental health service in Devon were in stable and suitable accommodation. This is higher than the South West (53.8%), local authority comparator group (55.2%), and England (59.7%) rates.

Table 1: Indicator List and Performance Summary, November 2015

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		
	G	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 (Narrow Definition) *	Watch		
	A	Alcohol-Related Admissions (Broad Definition) *	Watch		
	G	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		
	A	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, November 2015

Priority	Summary
1. A Focus on Children and Families	Child poverty levels continued to fall in 2013. Recorded levels of child development are above the South West and England averages. Rates of smoking at delivery are falling over time. Teenage 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 alcohol-related admissions (narrow definition) 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 aligns with South West and national rates. The gap between Devon and the South West and England for the detection of dementia has narrowed significantly. Devon has relatively low levels of injuries due to falls. A higher proportion feel supported to manage their long-term condition in Devon. Re-ablement 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 consistently above the national average. There is a smaller gap in life expectancy between the most and least deprived communities in Devon than nationally. Self-reported wellbeing in Devon tends to be better than the national average. The proportion stating that they have as much social contact as they would like is below the national average. Quality of life for carers is in line with the national average. Devon had lower levels of people with learning disabilities in stable and appropriate accommodation than the national average, but higher rates for people with mental health issues.

Table 3: Devon compared with the Local Authority Comparator Group for all Health and Wellbeing outcome measures, November 2015

Measure	Rates			Significance		LACG Rank / Position	
	Devon	LACG	England	LACG	England	Rank	Position
Life Expectancy Gap in Years (Male)	5.2	7.2	8.4	Better	Better	1 / 16	
30 Day Readmissions to Hospital (%)	10.3	11.0	11.8	Better	Better	1 / 16	
Early Years Good Development (%)	67.0%	60.0%	58.0%	Better	Better	1 / 16	
Feel Supported to Manage own Condition (%)	68.9%	64.2%	63.3%	Better	Better	1 / 16	
Reablement Services Effectiveness (%)	88.8%	82.8%	82.1%	Better	Better	1 / 16	
Life Expectancy Gap in Years (Female)	3.3	5.4	6.2	Better	Better	2 / 16	
Physical Activity (%)	60.3%	58.9%	57.0%	Similar	Better	3 / 16	
Carer Reported Quality of Life	8.100	7.806	7.900	Better	Better	3 / 16	
Cancer Deaths, under 75	130.9	134.3	144.4	Similar	Better	5 / 16	
Child Poverty (%)	12.4%	14.1%	18.6%	Better	Better	5 / 16	
Smoking at Time of Delivery (%)	12.2	12.3	12.0	Similar	Similar	6 / 15	
Circulatory Disease Deaths, under 75	63.8	66.7	78.2	Similar	Better	6 / 16	
Admission Rate for Accidental Falls	1766.1	1809.9	2011.0	Similar	Better	6 / 16	
Teen Conception Rate per 1,000	18.5	19.5	23.4	Similar	Better	6 / 16	
Excess Weight in Year Six (%)	30.3%	30.8%	33.5%	Similar	Better	7 / 16	
Adult Smoking Rate (%)	16.4%	16.7%	18.4%	Similar	Better	7 / 16	
Stable Accommodation - MH (%)	60.9%	55.2%	59.7%	Better	Better	8 / 16	
Alcohol Admission Rate (Broad Definition)	1825.6	1854.8	2128.7	Similar	Better	9 / 16	
Dementia Diagnosis Rate (%)	56.5%	56.5%	60.8%	Similar	Worse	9 / 16	
Low Happiness Score (%)	8.5%	8.6%	9.7%	Similar	Similar	9 / 16	
Excess Weight in Reception Year (%)	23.4%	22.3%	22.5%	Worse	Similar	10 / 16	
Alcohol Admission Rate (Narrow Definition)	628.3	603.2	634.7	Worse	Similar	11 / 16	
Social Connectedness	42.8%	45.4%	44.8%	Worse	Worse	12 / 16	
Stable Accommodation - LD (%)	65.6%	69.9%	73.3%	Worse	Worse	12 / 16	
Incidence of Clostridium Difficile	30.8	27.4	26.3	Worse	Worse	12 / 16	
Hospital Admission Rate for Self-Harm	501.8	463.1	412.1	Worse	Worse	12 / 16	
Suicide Rate	10.4	9.5	8.8	Similar	Worse	13 / 16	
Reablement Services Coverage (%)	1.4%	2.8%	3.1%	Worse	Worse	15 / 16	

3. Child Sexual Exploitation

3.1 A CSE scorecard is being developed by the Child Sexual Exploitation (CSE) sub-group of the Devon Safeguarding Children Board (DSCB). A senior information analyst from the Public Health Intelligence Team has been seconded on a fixed term, part-time basis to act as lead analyst for CSE data. This secondment is focused on completing the work to develop the multi-agency CSE scorecard. The analyst will work to ensure the production of qualitative information, analysis and reporting, combining information and intelligence from across all DSCB partner agencies. The first version of the scorecard has been drafted and will be produced thereafter on a quarterly basis. The intention is that further detail will be added to the scorecard as new processes for gathering data are established and the improved CSE risk assessment tool is implemented.

3.2 The new CSE Assessment has been developed locally and is in the process of being rolled out. This assessment will be completed for all referrals to the MACSE (Missing and Child Sexual Exploitation) Panel to allow the multi-agency panel to respond more effectively to the needs of the young person. This information will also be used to create develop intelligence for us and partners around CSE in Devon as currently the evidence base is limited. Devon and Cornwall Police are developing an Organised Crime Local Profile on CSE which will further improve the evidence base and will be used by them to improve their response to CSE across their area. Early intelligence suggests that a 'boyfriend' model of CSE is more common in Devon than the organised gang activity that has been observed in other parts of the country. In common with other parts of the country, the identified victims have been predominantly female and in their mid-teens with some vulnerability prior to being exploited.

4. Legal Considerations
There are no specific legal considerations identified at this stage.

5. Risk Management Considerations
Not applicable.

6. Options/Alternatives
Not applicable.

7. 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.

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Background Papers
Nil

Devon Health and Wellbeing Board
12th November 2015

Strong and Supportive Communities

Report of the Director of Public Health

Recommendation: It is recommended that the Devon Health and Wellbeing Board note the report and discuss in conjunction with the presentations on health inequalities and housing and health.

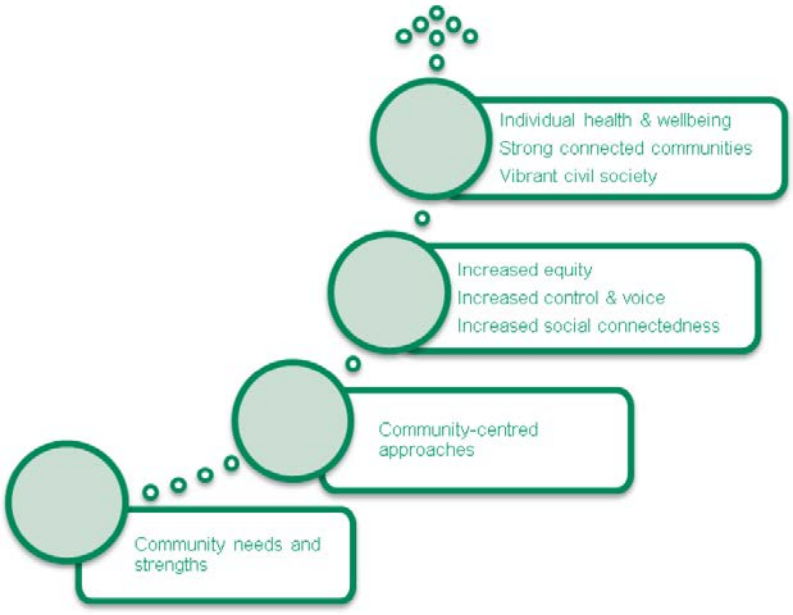
1. Context

The 2015 update to the Joint Health and Wellbeing Strategy refreshed the ambition for the Strong and Supportive Community Theme:

"We want people to thrive in supportive communities, with people motivated to help one another. Our communities are strong, vibrant places to live, where people are not anxious about criminal activity and social disorder, and where a positive attitude to mental health and wellbeing is fostered."

The capacity of communities, both geographical and of people with shared interests, to support themselves has become an increasing focus of national policy over recent years. Devon County Council's "Better Together" vision for 2020 and beyond reflects the changing expectations of Devon's citizens and communities. The recent Public Health England and NHS England guide to community-centred approaches to health and wellbeing concluded that at an individual level, joining social activities, connecting to others and taking part in local decisions help keep us healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary to help people to flourish. Figure 1 illustrates the importance of individual and community empowerment to improve the population's health and reduce health inequalities.

Figure 1 Building Healthier Communities



Source: A guide to community-centred approaches for health and wellbeing. Full report. Public Health England and NHS England. February 2015.

Improving life expectancy is an outcome measure for the Strong and Supportive theme. The Director of Public Health's latest Annual Report (2014-15 report) is focused on health inequality, and highlights progress since the annual report first considered the topic in 2007-08 with particular reference to Ilfracombe.

2. Priorities – what and why?
Analysis of the Joint Strategic Needs Assessment identified the following priorities for this overarching objective. Some examples of local developments for each one are as follows:

Mental health and emotional wellbeing; In July Public Health announced a new support service to improve the emotional, psychological and social wellbeing of children and young people. The Early Help for Mental Health (EH4MH) service supports the drive for early-intervention services and fosters cultural change in the ways schools tackle mental health problems. ASIST (Applied Suicide Prevention Skills Training) has been commissioned with funding from Public Health England, 15 trainers have been recruited to deliver a number of training courses across Devon and Torbay, and this is supported by an evaluated and evidence based 'Safe to Talk about Suicide' leaflet. This will support removing barriers about discussing suicide. An additional agenda item covers the progress on the Joint Commissioning Strategy for Mental Health.

Improving living environments; The attached background paper supports the living environment and housing priority and considers some aspects related to housing and health in Devon. Further work is being undertaken to utilise data to target energy efficiency measures, increase uptake of renewable energy, reduce fuel poverty and inform housing strategies.

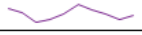
Housing and homelessness; To support work related to homelessness a collaborative approach is being developed working towards a 'whole system change' so that people with a range of complex health and social care needs receive more coordinated support and healthcare that is delivered away from an acute care setting. MEAM (making every adult matter) is the approach that will be used to test and change the system.

Social isolation; A number of programmes have been commissioned or are in place across Devon to support individuals to connect with local communities and services and work is underway to develop a framework to inform future commissioning in support of Care Act responsibilities and in response to the Commissioning for Prevention Strategy.

Offender health; The Devon Health, Wellbeing and Justice Group has meet twice and is currently developing two work themes: (1) mental health commissioning and pathways in the criminal justice system and (2) the needs of victims of sexual abuse. There is a peninsula criminal justice and mental health meeting which is working on implementing the Section 135 protocol relating to places of safety.

Protected characteristics; The Devon Joint Strategic Needs Assessment Overview (2015) has detailed consideration of the health needs of the protected characteristic groups to inform commissioning plans and decision making.

3. Commentary on progress against outcomes
An analysis of relevant outcomes measures from the Devon Health and Wellbeing Outcomes Report is set out in the following table:

Priority	RAG	Indicator	Type	Trend	Dev/SW/Eng
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.	Improve		
	G	Stable/Appropriate Accommodation (Mental	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

A more detailed analysis of the indicators reveals the following points:

- **Suicide Rate** – Around 65 deaths per annum are registered as suicide or injury undetermined (open verdict), with a direct age standardised rate of 10.4 per 100,000. This was above the South West (10.1), local authority comparator group (9.5) and England (8.8) rates. Within the county, rates are similar between districts, with no significantly higher rates. Whilst year-on-year variations are seen due to the small numbers involved, rates in Devon have typically remained around or slightly above the national rate.
- **Life Expectancy Gap** – The Slope Index of Inequality compares life expectancy in the most deprived and least deprived communities within an area's population, revealing the gap in life expectancy in years. For males in Devon the gap is 5.2 years which is significantly lower than the gaps for the South West (7.5), the local authority comparator group (7.2), and England (8.4). For females in Devon the gap is 3.3 years which is significantly lower than the gaps for the South West (5.0), the local authority comparator group (5.4), and England (6.2).
- **Self-Reported Wellbeing** – Low happiness score is one of four self-reported wellbeing measures in the Public Health Outcomes Framework, with others covering life satisfaction, feeling worthwhile and anxiety. Within Devon, 6.28% of the population had a low happiness score (ranked 0-4 on a scale of 10) on the index compared with 8.79% for the South West, 8.05% in the local authority comparator group and 8.95% in England overall. The percentage with a low happiness score is falling over time.
- **Social Contentedness** – 42.8% of social care users surveyed in Devon in 2014-15 reported being satisfied with their social situation. This was significantly below South West (45.7%), local authority comparator group (45.4%) and England (44.8%) rates. Within Devon whilst there is some variation in responses at district level, smaller sample sizes mean the differences are not statistically significant. Rates decreased significantly on 2013-14 levels (47.5%).
- **Carer Reported Quality of Life** – This measure gives an overarching view of the quality of life of carers based on outcomes identified through research by the Personal Social Services Research Unit. This is the only current measure related to quality of life for carers available, and supports a number of the most important outcomes identified by carers themselves to which adult social care contribute. The carer reported quality of life in Devon is slightly above the South West, local authority comparator group and national average.
- **Stable and Appropriate Accommodation (Learning Disability)** –The nature of accommodation for people with learning disabilities has a strong impact on their safety and overall quality of life and the risk of social exclusion. In 2014-15 65.6% of adults with a learning disability in Devon (known to the council) were living in their own home or with their family, compared with 69.5% in the South West, 69.9% in the local authority comparator group and 73.3% nationally. Rates decreased on 2013-14 levels.
- **Stable and Appropriate Accommodation (Mental Health)** – Stable and appropriate accommodation is closely linked to improving safety and reducing the risk of social exclusion. In 2014-15 60.9% of adults in contact with a secondary mental health service in Devon were in stable and suitable accommodation. This is higher than the South West (53.8%), local authority comparator group (55.2%), and England (59.7%) rates. Rates have increased on 2013-14 levels.

4. Summary

Strong and Supportive Communities is a wide ranging theme area with a range of outcome measures to track progress. The principle of working with individuals and communities to improve health and wellbeing is important but sometimes difficult to measure or evaluate but this should not deter action. There are local examples of communities working with the Local Authority to develop new approaches to delivery of services at a local level with success; for example library developments.

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5. 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.

6. Legal Considerations

There are no specific legal considerations identified at this stage.

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

8. Public Health Impact
The Devon Health and Wellbeing Board will be central to overseeing the commissioning of services which address public health and other relevant health and wellbeing outcomes

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Background Papers
Housing and Health – Background Paper

Public Health Devon

Devon County Council

Housing and Health – Background Paper

1. Introduction

1.1 The standard of accommodation is a major contributory factor in attaining and maintaining good health. Conversely, poor housing can precipitate a range of physical and mental health conditions. Minimising the adverse effects of poor housing remains a challenge for health, local government and voluntary agencies.

1.2 Arguably, the development of Public Health functions in the 19th Century were a response to the growth of industrial towns and cities; improving housing conditions and stopping the spread of disease through provision of clean water and adequate sanitation. House-building and slum clearance in the post war period led to a further improvement in housing conditions; however, there are still a range of health conditions which are exacerbated by the condition of the dwelling and the environment in which it is placed.

1.3 This report highlights the importance of safe, decent housing for human health. It provides an overview of housing needs in Devon summarises what is known to be effective in addressing those needs and, based on the available evidence, makes observations as to how health outcomes can be improved through a range of initiatives which can improve the quality and safety of housing.

1.4 Although it is acknowledged that there are wider issues of concern this paper will focus upon two main areas; excess cold and accidents in the home, as available data suggests that these have the potential to make the biggest impact upon health in Devon.

2. Devon Overview

2.1 Devon has an older population profile than nationally, particularly in those aged 50 to 70 years of age, reflecting significant in-migration in this age group, and those aged 85 years and over, reflecting an ageing population and longer life expectancy Over the next 20 years Devon will experience more significant growth in those aged 70 and over, and a more significant proportionate reduction in those aged 40 to 65. The population aged 85 and over is set to increase from 28,300 in 2015 to 64,900 in 2035. (Source: Devon JSNA Overview 2015).

2.2 The Joint Health and Wellbeing Strategy update for 2013 to 2016, under the heading 'Strong and Supportive Communities', identifies housing as a priority in Devon with a focus on taking effective action to address homelessness and improve the quality of the housing stock across Devon.

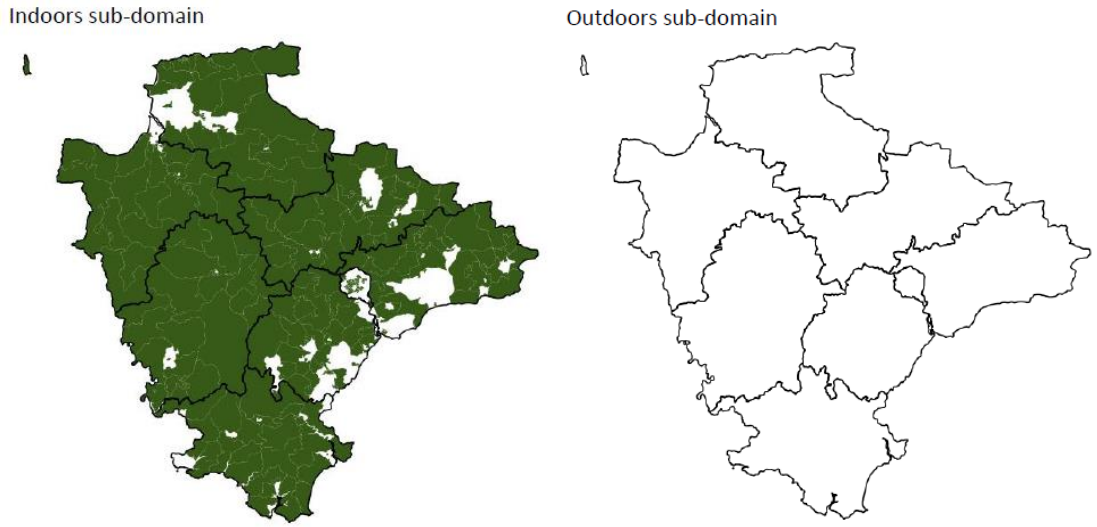
2.3 The Joint Strategic Needs Assessment Devon Overview 2015 highlights the impact of housing on health, with excess cold or heat, trips and hazards identified as significant risks to health. Cold homes also present trip risks, especially for older people, so, in some cases, one type of risk may be significantly increasing another. The affordability of housing in Devon is also an issue on account of relatively high house prices and relatively low wages. Levels of homelessness in the county are relatively high, and are associated with a range of physical and mental health problems.

2.4 Whilst the Joint Strategic Needs Assessment also highlights overcrowding as an issue, data shows that levels of overcrowding are significantly lower in Devon than the national average. It may be that overcrowding disproportionately affects particular groups within the general population, such as migrant workers, or that overcrowding is linked to affordability; however, this will not be covered in any depth within this report. It is worth noting that home ownership has become less affordable across England and Wales over the last 15 years and especially in some areas of Devon: the average house in South Hams now costs almost 12 times the average income for that area. On average, homes in Devon cost 8.42 times the average wage (ONS and HM Land Registry 2014). Arguably, high house prices have an impact upon rent levels in the private sector. For those on low incomes, this can restrict their options of places to rent, lead to overcrowding and contribute towards fuel poverty.

2.5 The 2015 Indices of Deprivation were released in September 2015 and also highlight additional challenges in relation to housing in Devon. The overall index of multiple deprivation highlights that 5% of the Devon population live in areas which are in the top 20% nationally, indicating a less extreme pattern of deprivation in the county which is reflected in most of the domains. However, the two domains where this is reversed are the barriers to housing and services domain, which covers geographic access to services and housing accessibility/affordability (27% of Devon population in most deprived 20% nationally), and more significantly the indoor environment sub-domain, which

covers the quality of housing (54% of Devon population in most deprived 20% nationally). The following maps compare Devon areas in the most deprived group for the 'indoor' and 'outdoor' environment sub-domains (the latter relating to air quality and road traffic accidents), highlighting that within a county with no areas identified as highly deprived in terms of the outdoor environment, significant challenges exist in terms of the indoor environment.

Figure 1, Devon areas in the most deprived national quartile for the Indices of Deprivation 2010, Living Environment



Source: Indices of Deprivation, 2015

2.6 In Devon, just below 20% of the population living in the private rented sector is classed as 'vulnerable households'. This definition is given to households which are in receipt of at least one of the principal means-tested benefits and is intended to include low income groups most susceptible to health risks as a result of poor property condition; the elderly, long-term sick, disabled and families with children.

2.7 There is no longer a legal requirement for local housing authorities to have a housing strategy. There is, however, the Devon Private Sector Housing Group which comprises representatives from all eight districts and two unitary authorities. Their mission statement is to promote and deliver better private sector housing in Devon through collaborative working. The aim is to reduce inequalities in health through:

- improvement of housing conditions in the private rented sector
- improving energy efficiency of homes and reducing fuel poverty
- supplying relevant data for the Joint Strategic Needs Assessment

3. Housing and Health Priority Issues

Excess Cold

3.1 Excess cold in the home can exacerbate a number of health conditions and can arise from the property being hard to heat because of its design or poor state of repair, or it can be because the occupants do not have enough income to heat their home adequately.

3.2 A household is said to be in fuel poverty if they have required fuel costs that are above average and were they to spend that amount of money they would be left with a residual income below the official poverty line This is referred to as the 'low income, high costs' definition. [1]

3.3 Just above one in eight people in Devon live in fuel poverty (12.55%) which is above the South West (11.54%), local authority comparator group (9.27%) and England (10.39%) rates. Within Devon, the highest levels of fuel poverty are in Torridge (14.03%) and the lowest in East Devon (11.02%). Levels of fuel poverty have increased over recent years, and are highest in more deprived areas.

3.4 Five percent of all households in Devon (16,470) lack central heating compared to 4% in the South West and 3% in England and Wales. Those living in the private rented sector and on a low income are the most likely to be living without central heating. Households without central heating also have a stronger likelihood of dampness and condensation than other homes. Lack of central heating also reflects the need for modernisation of housing stock. (Mitchell A (2014) Cosy Devon Partnership)

3.5 Excess cold is closely linked to circulatory and respiratory diseases. Circulatory diseases are responsible for around 40% of excess winter deaths nationally and accounted for around 160 excess winter deaths each year in Devon between 2004 – 2013 (source: Primary care Mortality database). This is because the cold increases blood pressure; every 1 degree Celsius lowering of room temperature is associated with a rise of 1.3mmHg blood pressure. A rise in blood pressure during the cold increases the risk of heart attacks and strokes.

[1] Hills, J. (2012) Getting the measure of fuel poverty final report of the Fuel Poverty Review. CASE Report 72. London: DECC [online] available from : https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/48297/4662-getting-measure-fuel-pov-final-hills-rpt.pdf (Accessed 7th August)

3.6 Respiratory illnesses cause around 33% of excess winter deaths, which accounts for around 140 excess winter deaths each year in Devon. The cold lowers the resistance to respiratory infections. Being cold impairs lung function and can trigger broncho-constriction in asthma and chronic obstructive pulmonary disease (COPD).

3.7 Another health condition affected by excess cold is arthritis, which can become worse in cold and/or damp houses. Strength and dexterity can also decrease as temperatures drop, especially in the elderly, increasing the risk of injuries, trips and falls.

Hard to Heat Homes

3.8 An example of a dwelling that is hard to heat due to its design is a park home or caravan, which can be especially challenging to keep warm and dry. This is a particular issue for Devon as 3,282 (0.9%) households live in caravans, park homes or temporary structures (Census 2011). The highest rate is in Teignbridge at 2% (five times the rate for England and Wales, 0.4%) with the lowest rates (0.6% of households) found in Mid Devon and East Devon.

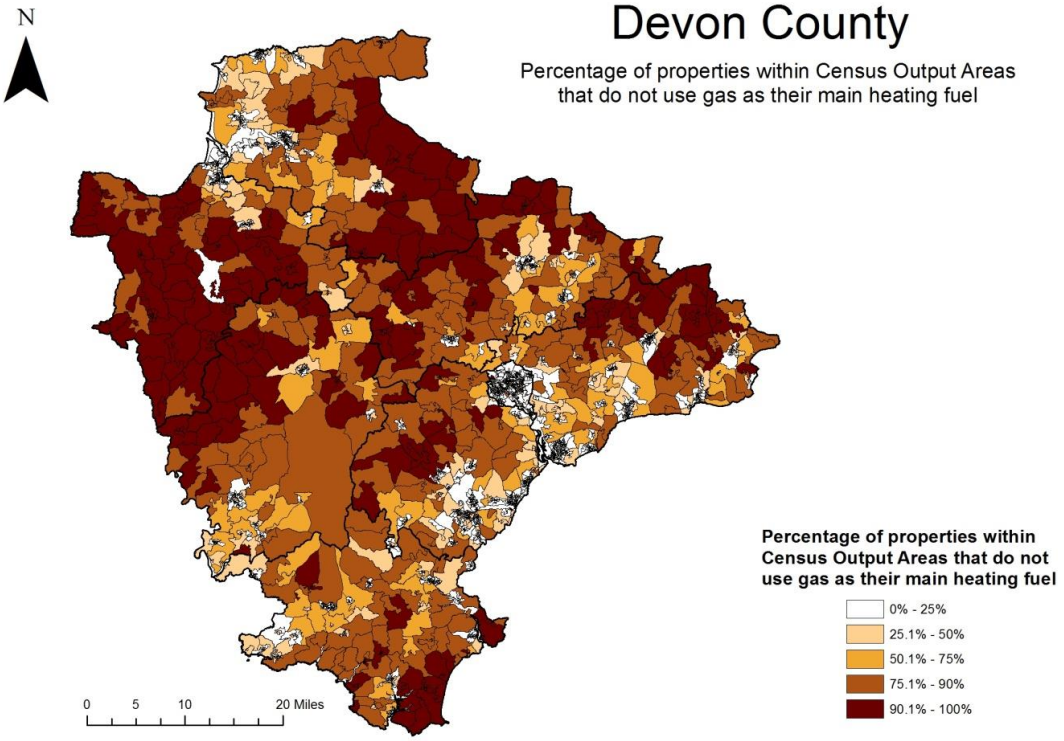
3.9 Fuel costs are high as they are typically off gas and by their construction the homes are poorly insulated. Residents in park homes tend to be older people on low incomes and, whilst park home ownership is a lower cost housing option for some people, housing conditions are generally poor with excess cold, damp and potential trips and falls as the main hazards in and around their home.

3.10 Whilst park home owners can benefit from ECO assistance, by the nature of their construction and the lack of any tools to assess their energy rating, it is currently difficult for owners to access this funding. Some local authorities do offer loan assistance to help improve the energy efficiency park home but this funding is limited.

Rural Housing

3.11 In Devon, the urban centres predominantly comprise dwellings constructed with solid walls, which are difficult to heat and expensive to make more energy efficient. The rural housing stock is also older “difficult to treat” construction and this problem is further exacerbated by the absence of gas supplies, meaning dwellings require heating with expensive oil, LPG or electric systems and need much higher levels of insulation to make them fuel efficient

Figure 2 Percentage of properties within Census Output Areas in Devon that do not use gas as their main heating fuel.



Source: Mitchell A (2014) Cosy Devon Partnership

3.12 Properties that are not on the mains gas grid are predominantly in rural locations, with pockets of higher incidence in specific urban locations such as town centres. The highest instances of properties not on the mains gas grid (close to 100%) occur in west Torridge, pockets of Mid and North Devon.

3.13 Considering the districts in their entirety, the predominantly rural districts of Torridge, West Devon, Mid Devon, South Hams, North Devon, East Devon and Teignbridge exceed the average for England of 15.2%.

3.14 Devon County Council, the Devon districts and Torbay, working with EON, will ran a Cosy Devon scheme in 2014/15, targeting energy efficiency measures across the county. Through the scheme loft and cavity wall insulation was primarily free for all, the promotion of this scheme sought to concentrate in areas where there are higher levels of fuel poverty.

3.15 Green Deal funding through Department of Energy and Climate Change (DECC) assisted residents in North Devon, Torridge and Teignbridge take up Green Deal plans to improve the energy efficiency of the housing stock in these areas, as well as some councils offering assistance through loans.

Evidence of Effectiveness

3.16 Housing investment which improves thermal comfort in the home can lead to health improvements, especially where the improvements are targeted at those with inadequate warmth and those with chronic respiratory disease. Best available evidence indicates that housing which is an appropriate size for the householders and is affordable to heat is linked to improved health and

may promote improved social relationships within and beyond the household. In addition, there is strong evidence that provision of adequate, affordable warmth may reduce absences from school or work. [2]

3.17 NICE guideline (NG 6) entitled *'Excess winter deaths and morbidity and the health risks associated with cold homes'* makes a number of recommendations relating to cold homes for a range of stakeholders. The evidence review for the guidance identified a lack of UK evidence on how to prevent cold-related deaths (particularly relating to interventions). The review did not identify any urban or rural differences but noted that rural properties are more likely to be 'off grid' and so reliant on more expensive forms of fuel and there may be more installation difficulties. The economic evaluation did conclude that providing home heating and insulation interventions to households where someone has COPD, heart disease or is older than 65 was found to be cost effective from a health perspective, it makes an important distinction that if ventilation is poor and this leads to health problems, the intervention will not necessarily be cost effective. Fuel subsidies may be more cost effective for short term interventions. The evidence review and economic analysis does not relate to specific interventions but provides a guide to the relative merits of broad interventions.[3]

Examples of Good Practice

3.18 Oil buying collective (Community Council for Devon): This is a community-based countywide oil buying syndicate that gets a lower price for heating oil through a social enterprise which buys in bulk. It is membership based, links to the warm and well scheme and can ensure that people on low incomes are supported with membership fees.
http://www.devonrcc.org.uk/c/63/the-devon-oil-collective

3.19 In Devon a range of fuel poverty initiatives have been undertaken including 'Warm and Well' a Department of Health funded programme, fuel energy saving initiatives though Cosy Devon. In 2015, the Cosy Devon Partnership (led by Teignbridge) successfully bid for £1.1 million through the Department of Energy and Climate Change's 'Central Heating Fund. Match funding brings the total up to £2.3 million. The fund will install central heating into 350 homes (and 16 flats), that are currently not connected to the mains gas. Public health are working with the Cosy Devon Partnership to identify vulnerable households that meet the eligibility criteria and are more likely to have on – going health problems. Public health money will also be used to train health professionals that visit people in their own home and fire officers who carry out home fire safety checks, to identify thermal discomfort and then signpost or refer people into the relevant scheme. Teignbridge District Council undertook a whole house approach to tackling fuel poverty as described in the case study.

[2] Thomson H; Thomas S; Sellstrom E; Petticrew M (2013) Housing improvements for health and associated socio-economic outcomes. Cochrane Database Syst Rev. 2013 Feb 28;2:CD008657 [online] available from : http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008657.pub2/abstract [Accessed 7th August 2014]

[3] NICE NG6 (2015) Excess winter deaths and morbidity and the health risks associated with cold homes. London. NICE

Case Study:

Miss R, who lives in a spacious two-bedroomed maisonette with her partner and four year old son, applied for help to improve the energy efficiency of their home. An energy assessment was carried out in the property and recommendations were made to Miss R on how they could reduce the energy usage in their home through behavioural changes and installation of energy measures.

A full income check was carried out to ensure that Miss R was receiving any benefits the family were entitled to and an assessment was also carried out to ensure that the energy supplier that Miss R was currently with provided the best deal. Through the advice and works to the property Miss R was able to make savings of £165 per month on her energy bill.

Summary

3.20 Energy efficiency intervention can lead to improvements in health and wellbeing, increased comfort levels in the home and a reduction in the use of health services. Some households, however, remain in fuel poverty after having full central heating installed, reflecting the significant contribution of low income on the production of fuel poverty, therefore initiatives to alleviate fuel poverty also need to focus upon income maximisation.

Accidents in the Home

3.21 Preventing accidents in the home is a priority in the Health and Wellbeing Strategy, which states that the risk of accidental falls increases with age and that people living alone, with existing medical conditions or living in deprived areas, are at greater risk. There is also a need to reduce accidents among children under the age of five as, every year, about 500,000 children under the age of five go to hospital because of an accident in the home and accidents are a main cause of death among children aged between one to five years old.
http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/safety-under-fives.aspx#close

3.22 There were 2,560 hospital admissions in people aged 65 years and over following an accidental fall in the home in Devon in 2013, at an estimated cost of £8.4 million to the National Health Service. (Devon Public Health Intelligence Team 2014)

3.23 There were 260 hospital admissions for all accidents in the home in children aged under five in 2013, at an estimated cost of £250,000. (Source: Secondary Uses Service Commissioning Dataset: Inpatient 2014).

3.24 Devon & Somerset Fire & Rescue Service attended 747 dwelling fires across Devon, Torbay and Plymouth in 2013/14 in which 58 people were injured. The service has identified seven factors that increase the risk of a dwelling fire injury or death: smoking; living alone; limited mobility; alcohol; drugs (both prescription and illegal); mental health and poor housekeeping. (Source: Devon and Somerset Fire and Rescue Service internal reporting 2014).

Evidence of Effectiveness

3.25 An Italian study found that the living room was the place where 33% of the accidents occurred. Eighty-seven percent of the accidents were falls and 33% of the accidents were the immediate consequence of sudden malaise. One-half of the cases reported one or more leg fractures. The variables that were independently associated with household injuries were: poor household illumination; poor emotional status; regular physical activities and housekeeping activities.[4]

3.26 Healthy housing conditions for older persons are important to maximise the supportive capacity of one's home, to stimulate an active and healthy lifestyle, and to avoid unnecessary institutionalisation.[5]

3.27 A literature review was undertaken to look at the relation between the design and condition of dwelling features and accidents and between human behaviour and accidents. The results showed that little work has been done in most areas on the different degrees of the contribution made by human behaviour and building conditions.[6]

3.28 Injuries in the home are very common and most of the injuries to older people and children under five occur at home. Many people are encouraged to alter their home to try and reduce injury and injury risk. Common alterations include the fitting of locks on cupboards, installing stair gates, improvement of lighting in halls and stairways, and the removal of trip hazards. The review found that there is insufficient evidence from studies to show that such changes reduce the number of injuries in the home but does not conclude that these interventions are ineffective. Home alterations need to be evaluated by larger and better designed studies which include injuries and their outcomes. [7]

[4] Camilloni L, Farachi S, Rossi PG, Chini F, Di Giorgio M, Molino N, Iannone A, Borgia P, Gausticchi G (2011) A case control study on risk factors of domestic accidents in an elderly population. International Journal of Injury Control and Safety Promotion. 18 (4) pp269-276

[5] Braubach M, Power A (2011) Housing Conditions and Risk: Reporting on a European Study of Housing Quality and Risk of Accidents for Older People. Journal of Housing for the Elderly 25(3) pp288--305

[6] Moore R, Ormandy D (2004) Home Safety in the UK: review of the influence of human and housing factors. Reviews on Environmental health 19(3) pp.253-270

[7] Turner S, Arthur G, Lyons RA, Weightman AL, Mann MK, Jones SJ, John A, Lannon S. Modification of the home environment for the reduction of injuries. *Cochrane Database of Systematic Reviews* 2011, Issue 2. Art. No.: CD003600. DOI: 10.1002/14651858.CD003600.pub3

Examples of Good Practice

3.29 Devon County Council: Devon Falls Prevention Pathway: Well UK was awarded a grant to devise an innovative falls prevention pathway for people at risk of falls and fractures, as well as those who have already experienced a fracture. The aim is to integrate community-based services with NHS delivered exercise groups, one-to-one work, fracture liaison and home safety programmes. http://welluk.org/programmes/devon-falls-prevention-pathway/

3.30 Teignbridge Council worked with the Design Council's public service programme to meet key challenges by using the design process. It gave the Council an opportunity to look at fresh methods of working and to explore new collaborations with health, the voluntary sector and social care. An ageing local population, resulting in high hospital admissions due to trips and falls, prompted the Council to look at how it could deliver a more customer focused, effective and efficient service.

3.31 Different joined up projects were trialled with partners to establish an understanding and awareness of the issues; these included working with older people to create a video of their experience, developing hands on awareness programmes in GPs' surgeries, mapping the customer's journey and creating home health checks in people's homes.

https://vimeo.com/86094693

Housing Standards

3.32 Decent housing is measure using the Housing Health and Safety Rating System (HHSRS). This is a risk-based evaluation tool to help local authorities identify and protect against potential risks and hazards in identified dwellings: https://www.gov.uk/government/publications/hhsrs-operating-guidance-housing-act-2004-guidance-about-inspections-and-assessment-of-hazards-given-under-section-9

3.33 The underlying principle of the HHSRS is that any residential premises should provide a safe and healthy environment for any potential occupier or visitor. The HHSRS risk assesses different types of hazard in the home and provides them with a rating, based on the level of physical and psychological risk they pose to occupants; from minor and short term ill health to death or chronic

illness. A Category 1 hazard is one where the risk of injury/chronic illness/death is more likely.

3.34 In Devon, local house condition surveys indicate over 60,000 Category 1 hazards with an average of 20% of owner occupiers living in unsafe housing with one or more Category 1 hazards present. This increases to 25% in the private rented sector and, in the most deprived areas, the number of dwellings with one or more Category 1 hazards rises to 40%. The most commonly encountered Category 1 hazards are those associated with excess cold, arising from inadequate or inefficient heating and/or thermal insulation, often in combination with the secondary hazards of damp and falls in or around the home. Local authorities in Devon reduced over 600 Category 1 hazards in 2012/13 through direct intervention.

3.35 Funding for housing condition surveys is restricted, so update surveys are not being carried out across Devon. Each district is required to make returns to the government estimating how many Category 1 hazards it has addressed in the year. There has also been a decline in the number of home improvements grants and loans, such as the private sector renewal grant, however, councils can still insist on private landlords providing a decent and safe standard of accommodation by enforcing their legal powers through HHSRS. Clearly, the scale of the problem is above the resources available to local authorities.

3.36 A local survey across health visitor teams in Devon of all families visited in November 2012 (4,136 families were surveyed containing 7,296 children) found that 10% of families and 11% of children under the age of five were living in poor housing which was having a detrimental effect on their lives. The survey also found that 7% of families and 6% of children under the age of five were living in temporary accommodation rather than a settled home. (Public health Intelligence Team 2014)

3.37 The HHSRS data provides evidenced-based information on housing condition and can be useful for commissioners to identify households, geographical areas or populations of interest where support such as 'Warm and Well' or accident prevention schemes may need to be targeted.

Evidence of Effectiveness

3.38 Public health England, in partnership with The Chartered Institute of Environmental Health have developed 'Housing and Health' resource that aims to inform a local shared understanding of the relationship between the home environment, physical and mental health and wellbeing and the population groups that may be most at risk. The resource will better equip local decision makers and practitioners to improve health and wellbeing and reduce health inequalities.
http://www.cieh-housing-and-health-resource.co.uk/

4. Helping People to Stay in Their Own Homes

4.1 EVOLVE is a tool for evaluating the design of housing for older people. It is used to assess how well a building contributes to the physical support and personal wellbeing of older people. Developed from research into extra care housing, it can be used for a variety of building types, including sheltered housing and individual private houses. The tool can be used by architects, housing providers, commissioners, researchers and individual tenants or home owners.

4.2 Individualised environmental intervention plans were implemented to the extent possible through home modifications and assistive technology**.** Pre and post-modification task performance and self-report revealed the positive impact that home modifications and assistive technology can have. The study demonstrates the need for ongoing evaluation and assessment, sensitive to the needs of people with developmental disabilities and the unique characteristics of supported living settings.

5. Summary

5.1 In 2010 a Building Research Establishment Trust report quantified the cost benefit of housing interventions by local authorities and suggested that undertaking basic improvements and reducing hazards could the save the National Health Service £600 million per year. If comprehensive improvements to the heating and insulation of cold homes are undertaken then this saving could be doubled. [8]

5.2 This report has outlined how excess cold and accidents in the home impact on the health of both young and ageing people in Devon. It also makes observations about the need for a co-ordinated response from Social Care, Public Health, Housing and Planning authorities and a range of support agencies to deliver housing improvement interventions in Devon that are effective in removing the health hazards and reducing the risks.

5.3 Interventions such as 'Staying Warm and Well'; the Community Council for Devon's oil buying collective and seeking funding to tackle fuel poverty e are examples of good practice to improve energy efficiency, thermal comfort and income maximisation which lead to health improvement. Against a background of restricted funding and much reduced survey work interventions such as the EVOLVE tool; home modifications; safe and well schemes and parenting skills programmes, show how the needs identified by the Housing Health and Safety Risk Rating System can be tackled.

Nicola Glassbrook - Senior Public Health Officer (Health Inequalities)
Martin White - Public Health Specialist
Alison Dolley - Private Sector Housing Team Leader Teignbridge District Council on behalf of Devon Private Sector Housing Officers Group
Updated October 2015

[8] Nicol S, Roys M, Davidson M, Ormandy D, Ambrose P (2010). Quantifying the Cost of Poor Housing. Warwick. BRE

DEVON MISSING AND CHILD SEXUAL EXPLOITATION ACTION PLAN PROGRESS UPDATE AUGUST 2015

1. Introduction and background

1.1 In March 2015 the Devon Safeguarding Children's Board (DSCB) set up a new Missing and Child Sexual Exploitation (CSE) Sub Group. The Sub Group is accountable for the delivery of the Devon Child Sexual Exploitation Strategy and Action Plan 2015-16.

1.2 The Sub Group has agreed a detailed Missing and Child Sexual Exploitation Action Plan which lays out a substantial programme of work across the Prevent, Protect and Disrupt strands of the Strategy.

1.3 The Action Plan includes actions to address all the recommendations that were made in the People's Scrutiny Committee Child Sexual Exploitation Task Group's report of 8th January 2015.

1.4 This report updates on the progress made against each area of the plan and in addressing the recommendations made in the Scrutiny Committee report.

2. Progress in delivering the Devon CSE Action Plan

2.1 Overall progress against the CSE Action Plan

i) Prevent - CSE Awareness raising:

- The County Council's Reducing Exploitation and Absence from Care or Home (REACH) team and the Youth Service held a conference for groups of young people from 4 Exeter schools in early June, following which pupils from each school are delivering awareness raising action plans for their school. The REACH team and Youth Service Youth Workers are providing follow up support to each school, and will be reviewing the outcomes from the Exeter conference with the students concerned in September, so that their feedback can be taken into account in the plans that are being made for working with more schools around the County.

- Babcock Learning Development Partnership (LDP) have sent CSE Fact sheets to all schools and Safeguarding Newsletters have included information about the Missing and Child Sexual Exploitation Locality Groups (MACSEs) and how to refer to them. Schools have attended the MACSEs to contribute to discussions on individual cases, and Babcock LDP also attend to represent the schools. Plans are being made to re-publicise the work of the MACSEs with schools in November, after the current MACSE model and working processes have been reviewed and improved.

- Babcock LDP, in collaboration with the DSCB Education Sub Group, have written a “CSE guidance” document for schools, which includes guidance on training to be provided to children, staff and parents and minimum standards for schools to follow. These standards have been woven into the safeguarding audit process which is completed by all schools in Devon. The guidance document has been distributed to schools during the summer term and will be distributed again in the autumn. A complementary document entitled 'A Whole School Approach to CSE’ has been provided to secondary schools and a similar document is being written for primary schools.

- Babcock LDP will be delivering ten CSE workshops for schools across Devon during the autumn and spring terms. South West Grid for Learning have been commissioned to deliver online safety workshops with specific reference to CSE, starting in September. All of the Child Protection workshops which Babcock LDP run for schools include information about the work of the MACSEs and CSE.

- ‘Chelsea's Choice’ is a 40-minute long, hard-hitting theatre production that has proven highly successful in raising awareness of the issues surrounding Child Sexual Exploitation amongst young people and has been very positively received by schools. In Spring 2015, 34 performances were delivered in 22 different school settings, and 5,858 young people saw the play during that time. Further performances of “Chelsea’s Choice” have now been commissioned for September, in order to ensure that those schools who haven’t already hosted the production are given the opportunity to make it available to their pupils. The Head of Education & Learning also has plans to commission the production for the Youth Service’s Chance Educational Support Service.

- The Police are continuing to roll out their CSE training programme to all Officers, staff and Special Officers.1379 officers and staff have been trained at the time of writing and another 1188 have been booked to attend the training, including Devon and Cornwall Police Chief Officers Group. 270 spaces have been arranged for Special Officers, with another 337 to be trained once additional courses have been scheduled. Plans are also being made for including CSE awareness training into the induction programme for all new staff after the current training programme is complete.

- The DSCB runs a multi-agency training programme about CSE. During 2014/2015, 158 staff attended across the partner agencies, with the largest groups of attendees coming from Health and Social Care. The majority of attendees on the courses run during 2015/2016 have also come from Health and Social Care. Devon and Cornwall Police are working with the DSCB to strengthen the College of Trainers who deliver the Group 3 core inter-agency safeguarding training.

- All DCC elected members will have received CSE awareness training by the end of August.

- A CSE awareness raising and discussion event was held with residential providers on June 23rd. 30 people attended, representing almost half of our residential providers. Very positive feedback was received from those who attended, and further events are being planned for the rest of 2015/16 to confirm the detailed processes for providers to engage with the MACSEs.

- The 2015/2016 training programme for foster carers in Devon includes a number of courses targeted at raising awareness of child sexual exploitation and influences on young people, including the Child Exploitation and Online Protection Centre (CEOP) "Think U Know" Education programme.

- The Youth Service have planned the delivery of 20 x 2 hour workshops (each for up to 20 participants) to voluntary and community groups across Devon during 2015/16.

- The Safer Devon Partnership have committed to working through the District Community Safety Partnerships (CSPs) to deliver training and awareness to local businesses including hoteliers and taxi drivers during 2015-2016, using the National Working Group "Say something if you see something" materials. Each CSP will take a different approach to briefing staff and awareness raising with businesses and dates for delivery are in the process of being confirmed. Exeter CSP is already working with licensed trade and taxis through existing routes. Other CSPs will be picking up good practice from Exeter. The Devon Licensing Group will also share learning from Exeter CSP.

- A Task & Finish Group led by the Senior Manager for Safeguarding has been set up to ensure that parents are fully involved in the CSE awareness raising strategy. South West Grid for Learning and Babcock LDP are participating in this work.

- The Sub Group have agreed to develop a "base lining" questionnaire to assess the current level of CSE awareness across all sectors. The questionnaire will go out to Health agencies during August 2015, and then to all agencies in late autumn 2015.

ii) Prevent and Protect - multi agency data sharing and identification of children at risk of CSE

- A Task & Finish group has been set up to design a multi agency CSE "scorecard", and to ensure that it is populated and published on a monthly basis. The DSCB office has now appointed a part-time data analyst from Public Health to lead on the work to complete the score card and ensure that data collection processes are embedded in working practice.

- Improved forms and processes have been implemented for social work teams and the REACH team to record information on missing children and Return Home Interviews.

- New chairs have been appointed to the MACSEs from the Youth Service, YSMART and social care. A full-time coordinator to support the work of the MACSEs is starting in post in mid August, and this will address the issues raised by previous chairs about the need for administrative support of the meetings.

- Work is in progress to agree data collection and data gathering processes to support the MACSEs. At the last CSE Peninsular group meeting Devon & Cornwall Police Force Intelligence Centre (FIC) attended to lead a discussion on bringing together CSE intelligence from partner agencies with Police systems, in order to provide a detailed multi agency data set. It was agreed a process will be designed to support the submission of data from the MACSEs and partners directly to the FIC. The FIC intend to pilot this in Devon before the end of 2015.

- Work is in progress to review and combine the work of the MACSEs and the Vulnerable Children's Panel (VCP), with a plan now agreed for implementation of monthly MACSE meetings from November. The VCP was set up to share information about CSE risks for children open to social care, but it has been agreed that risks will be better assessed and managed by reviewing the cases of children open to social care and those not open through a single forum. The revised MACSE meetings will combine the current functions of both the MACSEs and the VCP and will share information and assess risk to children both above and below the threshold for social care.

- All missing from education data is collated weekly and children of most concern are RAG rated. Weekly meetings take place with representatives from Education and Social Care to plan for these children, who are also cross referenced against the MACSE lists. Those children identified as most at risk are referred to the Vulnerable Children's Panel. When the work of this Panel is merged with the MACSE's they will be referred into the MACSE meetings.

- Devon and Cornwall Police plan to implement a process for "flagging" children who may be at risk of sexual exploitation, suspected perpetrators of child sexual exploitation, and locations connected to CSE on the Force Crime and Intelligence IT system. This will ensure these individuals and locations are immediately identifiable to staff searching the system, and will also improve analytical capabilities.

iii) Prevent and Protect - assessment and management of risk

- The DCC REACH team has been expanded with additional social worker and business support capacity, enabling it to work with a larger number of children and young people.

- The REACH Team is working to ensure a clear service specification and referral route is communicated to other Social Care teams and other agencies.

- A Task and Finish group has been set up to develop and agree a single CSE risk assessment tool and ensure that it is clearly communicated to all agencies. This work is due to deliver final recommendations in August, with the tool to be implemented and publicised in September. The Peninsula CSE Steering Group, chaired by the Head of Devon and Cornwall Police Public Protection, has agreed that a single risk assessment tool will be implemented across the Peninsula.

- An implementation schedule has been agreed for the establishment of Devon and Cornwall Police Central Safeguarding Teams (CST) to cover the whole force area. These units will sit within the jurisdiction of the Public Protection Unit and will play a key role in the collection, research, and assessment of CSE reports.

- The REACH team will be implementing a consultation line for professionals from the start of September, offering advice about child sexual exploitation for professionals working with children.

iv) Disrupt

The Devon and Cornwall Police FIC analyse data from across their IT systems to identify possible CSE offenders. These potential offenders are being risk assessed so that Police resources can be assigned to investigate their activities.

In July the Devon and Cornwall Police Force published a Child Sexual Exploitation & Child Sexual Abuse (CSE/CSA) Peninsula Overview, written to inform the development of Organised Crime Local Profiles in support of the Home Office commissioned Serious & Organised Crime Local Profiling Process. The Force is currently developing CSE/CSA Local Profiles for Torbay, Devon, Plymouth, and Cornwall & the Isles of Scilly.

The DSCB CSE Sub Group will be agreeing the detailed plan for the strands of the CSE Action plan related to disrupting perpetrators, and improving interventions and therapeutic services during autumn 2015.

Health and Wellbeing Board
12 November 2015

BETTER CARE FUND – 2015/16 PERFORMANCE REPORTING

Recommendation:

That the Board note the report.

The Chair is given delegated approval to sign off the BCF return due on 29th November 2015

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1. Introduction

Regular reports are provided on the progress of the Devon Better Care Fund Plan to enable monitoring by the Health and Wellbeing Board. Performance and progress is reviewed on a monthly basis by the Joint Coordinating Commissioning Group through the high level metrics reports (Item 3) and progress overview (Para 4).

On a quarterly basis the Health and Wellbeing Board is also required to formally report, using the template supplied by the national Better Care Fund Programme support team (Item 2).

2. BCF 2015/16 Second Quarter Return

The BCF 2015 /16 Second Quarter Return is due for submission on 27th November 2015. There is an action plan for its completion and the JCCG is monitoring its progress, which is currently on track. The completed return will be reported to Health and Wellbeing Board at the meeting in January 2016.

3. BCF Monthly Performance Reports

Each month a summary performance report is produced for the whole of Devon.
The latest is attached and called “Devon Better Care Fund Outcomes Report - 21 October 2015 Updates”

Devon Better Care Fund Outcomes Repo

4. Performance Summary

The table below summarises the BCF activity in terms of the work towards the National Conditions.

Health and Wellbeing board are asked to note that JCCG and the BCF Delivery Group have open actions in place that are intended to address those areas in Amber.
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National Condition	Target
Are Joint Plans Agreed	On Track
Are Social Care Services being protected	On Track
Are 7 day services in place	At Risk
Is the NHS Number fully adopted and in use	On Track
Are Open API's being pursued	On Track
Are IG controls in place and in line with Caldicott 2	On Track
Is a joint approach to assessments and care planning in place	On Track
Is there agreement upon the impact of changes to the acute sector	At Risk

Figure 1: National Condition performance update.

Outcome	Target	Previous Month		
		-1	-2	-3
Non Elective admissions	Behind			
Residential admissions	Behind			
Patient and service user experience	On track			
Reablement effectiveness	Behind			
Dementia diagnosis	Behind			
Delayed transfers of care	Behind			

Figure 2: BCF performance summary table.

Dementia Diagnosis was selected as our local metric for the Devon BCF plan with an additional emphasis on access to support services. NHS England has recently published the revised definition for the indicator; however there have been issues in collecting appropriate data from a number of GP surgeries throughout Devon. Internally measurement at a CCG level continues to suggest that we likely to achieve the ambition of 66.7%.

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Permanent admissions to residential and nursing care (ASCOF 2A part 2); Due to a change in the national data definition and extraction criteria performance against this indicator has declined and continues to be under review. 2014-15 performance (616.2) remains above the provisional England average (658.5). As the baseline and local targets reflect the old definition, these will be revised to reflect the national changes, when they are announced.

91 days Reablement effectiveness (ASCOF 2B part 1); The national definition changed for this indicator to a snapshot looking a discharges from hospital between 1 October and 31 March 2014 with outcomes tracked 1 January to 31 March 2015. Performance has been maintained against the new definition with Devon benchmarking with other authorities well.

Health and Wellbeing board are asked to note that the BCF Delivery Group have open actions in place that are intended to address issues related to Delayed transfers of care and Non Elective admissions which are supported by the current operational plans of both CCG's.

Tim Golby
Devon County Council
Paul O'Sullivan
NEW Devon CCG

Electoral Divisions: All

Strategic Director, People: Jennie Stephens

Contact for Enquiries: Andy Goodchild, Programme Manager, The Annexe, County Hall, Exeter. andy.goodchild@devon.gov.uk
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DEVON BETTER CARE FUND OUTCOMES REPORT 21ST OCTOBER 2015 UPDATES ONLY VERSION

OVERVIEW

This report monitors Better Care Fund Indicators for the Devon County Council area. The report format is based on the outcomes report for the Devon Health and Wellbeing Board and includes the following sections:

- Overview and indicator summary on page 1
- A dashboard showing current monthly in-year performance will be added on page 2
- Detailed indicator reports providing breakdowns comparing Devon to other South West local authorities and similar local authorities, as well as comparisons with the South West and England rates over time. Where available breakdowns are also provided by local authority district withing Devon, by Clinical Commissioning Group and localities and by inequality characteristics such as deprivation from page 3 onwards. This is dependent on national comparator data being available, so will not be as timely as the dashboard data.
- Supplementary monthly dashboards for localities.

Within Devon, non-elective admission rates of non-elective admission are above national and regional averages. The rate of permanent admissions to care homes in older age groups is below regional and national averages and is falling over time with in-year data for 2013-14 suggesting further falls. Re-ablement service effectiveness at 91 days is currently above regional and national rates and remain around the 90% mark at the end of 2013-14. Higher levels of delayed transfers of care are seen in Devon, although rates have fallen over recent years. During 2013-14 delayed transfers peaked in May to October and are currently slightly above trajectory. Rates of avoidable emergency admission are below England and comparator group levels, but have increased during 2013-14. The dementia diagnosis rate has increased over recent years but is still below regional and national average. The patient/service user experience indicator is broadly in line with national and regional averages.

Updates this month

Permanent admissions to care homes, re-ablement services (effectiveness), non-elective admissions, avoidable emergency admissions and delayed transfers of care (August 2015). Dementia diagnosis rate delayed due to change in methodology and calculation tool nationally.

Joint Commissioning Indicator List and Summary

Theme	RAG	Indicator	Latest Month	2013-14	Annual Trend	Comp*
Overarching	R	Non-Elective Admissions (rate)	2681.4	2695.1		
Supporting	A	Care home admissions	522.9	556.4		
	A	Re-ablement (effectiveness)	81.2%	89.8%		
	-	Re-ablement (coverage)	-	2.0%		
	R	Delayed transfers of care	698.6	360.4		
	-	Avoidable emergency admissions	1602.8	1787.8		
	-	Patient/service user experience	-	66.7%		
Local	R	Dementia Diagnosis Rate	56.5%	44.9%		

* Devon, South West and England compared

RAG Rating Definition (based on latest month)

Red	R	Failing to meet Better Care Fund target trajectory, statistically significant difference
Amber	A	Failing to meet Better Care Fund target trajectory, difference not statistically significant
Green	G	Meeting or exceeding Better Care Fund target trajectory

RAG rating based on latest reported position (monthly), current RAG rating thresholds shown on page 2.

Detailed indicators reports which have been updated since the last report are marked as:
UPDATED INDICATOR

This report is produced in collaboration between the Devon County Council Public Health and Social Care Commissioning Teams and the NEW Devon CCG Business Intelligence Team.

Any queries on this report should be directed to the Devon Public Health Intelligence Team at publichealthintelligence@devon.gov.uk

NHS Northern, Eastern and Western Devon Clinical Commissioning Group

Devon County Council

Public Health Devon

NHS South Devon and Torbay Clinical Commissioning Group

DEVON BETTER CARE FUND OUTCOMES REPORT

MONTHLY ACTIVITY DASHBOARD: DEVON

RAG Rating Key 2015-16 (Q2 2015-16 for all admissions)

RAG Rating	Care Adm	91 Day E	All Adm	Avoidable Adm	DTOC	DT-S	DT-H	Dem
Green	<514.8	>81.52%	<2442.8	No Longer an official target	<280.4	Not currently set	Not currently set	>67.0%
Amber	between	between	between		between			between
Red	>540.5	<77.44%	>2564.9		>294.4			<62.0%

Activity								
Month	**Care Adm**	**91 Day E**	**All Adm**	**Avoidable Adm**	**DTOC**	**DT-S**	**DT-H**	**Dem**
Apr-13	654.9	88.8%	2625.8	1760.1	339.8	55.7	281.7	42.1%
May-13	662.5	88.6%	2652.3	1763.9	375.4	63.9	306.0	42.4%
Jun-13	652.5	88.6%	2588.1	1745.0	380.5	74.7	305.2	42.6%
Jul-13	655.5	86.1%	2611.6	1746.3	360.2	61.1	288.4	42.9%
Aug-13	653.1	83.3%	2692.2	1750.7	376.6	75.2	280.2	43.1%
Sep-13	620.4	81.6%	2740.2	1757.5	378.9	65.5	295.9	43.4%
Oct-13	601.1	80.8%	2721.6	1744.5	383.8	56.7	292.9	43.6%
Nov-13	609.1	90.7%	2616.4	1752.6	345.9	72.7	253.7	43.9%
Dec-13	579.0	90.7%	2651.0	1761.0	234.3	66.2	147.7	44.1%
Jan-14	572.8	91.3%	2661.6	1767.4	341.6	89.7	243.4	44.4%
Feb-14	543.3	89.9%	2623.2	1783.2	311.4	71.4	230.0	44.7%
Mar-14	548.4	89.8%	2631.0	1802.7	337.2	97.0	240.0	44.9%
Apr-14	532.0	88.9%	2599.6	1809.1	283.4	62.8	204.2	50.2%
May-14	521.3	89.3%	2666.4	1826.4	357.8	74.1	270.1	50.5%
Jun-14	523.5	90.5%	2603.5	1863.9	425.6	129.0	294.7	50.9%
Jul-14	527.5	89.2%	2645.5	1881.8	361.1	89.2	256.4	49.6%
Aug-14	513.9	90.2%	2624.9	1892.6	366.6	122.3	231.3	49.5%
Sep-14	506.6	88.6%	2666.4	1886.3	418.0	108.2	285.2	50.4%
Oct-14	491.2	87.4%	2663.3	1897.6	367.7	97.3	246.1	51.0%
Nov-14	458.7	88.4%	2680.8	1847.2	444.9	112.4	310.1	52.2%
Dec-14	446.6	90.9%	2755.4	1845.2	515.2	123.3	376.0	52.3%
Jan-15	440.0	91.8%	2822.6	1825.5	470.2	123.9	342.1	53.0%
Feb-15	430.1	89.9%	2774.7	1818.2	451.4	104.9	342.6	54.3%
Mar-15	441.1	87.5%	2740.4	1782.1	604.7	169.7	403.1	56.5%
Apr-15			2650.8	1748.6	572.9	134.0	366.7	
May-15	443.3	83.6%	2672.4	1714.7	489.1	136.2	313.1	
Jun-15	516.4	84.2%	2636.6	1674.6	615.3	117.7	445.1	
Jul-15	521.2	83.1%	2691.1	1638.9	597.6	88.3	458.8	
Aug-15	522.9	81.2%	2681.4	1602.8	698.6	115.7	520.0	
Sep-15								
Oct-15								
Nov-15								
Dec-15								
Jan-16								
Feb-16								
Mar-16								

Care Adm	Permanent Admissions to Care Homes (over 65), crude rate per 100,000
91 Day E	Re-ablement Services (Effectiveness), percentage
All Adm	All Non-Elective Admissions, quarterly moving rate per 100,000 (Monthly Activity Return)
Em Adm	Avoidable Emergency Admissions, crude rate per 100,000
DTOC	Delayed Transfers of Care, crude rate per 100,000
DT-S	Delayed Transfers of Care (Social Care Attributable), crude rate per 100,000
DT-H	Delayed Transfers of Care (Health Care Attributable), crude rate per 100,000
Dem	Dementia Diagnosis Rate, percentage

Health and Wellbeing Board
12 November 2015

Care Act

Report of the Head of Social Care Commissioning

Recommendations: that the Board

a) Note the progress with the Care Act programme 2014
b) Acknowledge the readiness of Devon County Council for the new Care Act duties.

1. Background/Introduction

1.1. Devon's Care Act Programme 2014 was established in September 2014. Guidance for phase 1 requirements was published in October 2014.

1.2. Following publication of the guidance the programme team focused its efforts on meeting the requirements of the act for April 2015.

1.3. Devon is compliant in our new 1 April 2015 Care Act duties, these include:

- Duties on prevention
- Duties on wellbeing
- Duties on information and advice (including advice on paying for care)
- Duty on market shaping
- National minimum threshold for eligibility
- Assessments (including carers assessments)
- Personal budgets and care and support plans
- New charging framework
- Safeguarding
- Universal deferred payment agreements
- Advocacy

1.4. Today, the programme continues to improve and further embed some of the changes that have been put in place for phase 1 of the act.

1.5. Partnership working and engagement with carers, users, staff and providers has been a focus for the Care Act 2014 programme in Devon.

The care act user and carer reference group and provider reference group meet each month to discuss and develop different elements of the programme. The Staff reference group have also had a care act specific slot on their agenda each month.

1.6. The NHS have been engaged in the programme since its inception and the community and voluntary sector have supported areas of the work, such as the co-production of information networks.

1.7. On 17 July 2015 the Department of Health notified the LGA of plans to defer the Care Cap and other phase 2 Care Act 2014 changes until 2020 including the duty for local authorities to arrange residential care for self funders when requested.

1.8. The Care Act 2014 is already in legislation so the authority will continue to deliver those elements that are currently in place or are being developed and improved further; these

include a comprehensive information and advice service, delivery of the joint commissioning strategy for prevention, responsibilities relating to market sufficiency and market shaping, support for a greater percentage of carers and also a deferred payments scheme.

The duties and responsibilities of the LA are also redefined in relation to a number of areas of practice – including safeguarding, preparing for adulthood, supporting advocacy, and supporting people to engage fully in assessment and support planning.

1.9. In light of the announcement in July, we have reviewed our plans and adjusted them accordingly.

2 Prevention and information and advice

2.1 Prevention and information and advice have been particular challenging areas of focus for Devon and for many other local authorities, mostly due to the nature of these topics being wide ranging and all-encompassing.

2.2 A separate paper on prevention has been prepared for this months Health and Wellbeing board; therefore this paper will focus on other areas of work within the programme.

2.3 The Key principles set out in our information and advice strategy are:

- **Being digital by design** – to make the best use of digital and mobile technology
- **A strong partnership approach** – working with all key strategic partners to ensure the most comprehensive possible information and advice system and that these work together seamlessly
- **Empowering others** – ensuring the voluntary and community sector, independent providers and others are all able to work together to develop the widest possible local information and advice network as a 'trusted source'

2.4 Work to date in developing our information and advice offer has included:

- The development of an information and advice strategy for Devon.
- Development of our digital information offer which includes a care and support self checker and an online self assessment form and various other tools to help people make informed choices about their care and support.
- Co-production of information networks to enhance the co-ordination of information and advice in the voluntary sector.
- Refresh of all adult social care web content
- Development of a 'my journey to be healthy and well' diagram to help individuals to understand where they can go for information and advice and what they should expect should they need to navigate through the adult social care pathway

2.5 Future work will include:

- Launch of our supported self assessment online form and care and support self checker.
- Development of a carers online supported self assessment.
- Construction of Staff guidance on our asset based approach for care management staff.
- Implementation of an assisted digital programme – helping people to use the internet and various tools online.

- Launch of a refreshed signposting platform where individuals can search for local care and support services.
- Creation of a PA finder tool to allow people wanting to work as Personal Assistants (PAs) to advertise their availability, and people wanting to hire a PA to find appropriate candidates.

3. Market shaping

3.1 Devon County Council has new responsibilities to ensure a sufficient market for Adult Social Care, applicable to all Devon businesses and organisations caring for private and publicly funded clients. To meet our statutory market sufficiency duties under the Care Act DCC have focused on the development and implementation of the following strategies, tools and plans.

I. **The Market Position Statement (MPS).** Demand profile & supply side assessment. What DCC intends to commission from the Adult Social Care sector market to inform providers to enable business development in relation to self-funders and people with Direct Payments.

II. **The Market Facilitation Strategy (MFS).** How we will work with providers to ensure that our commissioning strategies and plans for provider support are sustainable.

III. **The Market Sufficiency Plan (MSP).** What actions we will take to support the market, that are additional to the commissioning strategies already outlined in the MPS.

IV. **Addressing Provider Failure.** Early Actions including Provider Intelligence Database and Risk/Quality Profiling Tool to identify issues and Business Support to prevent provider failure, and an Operational Plan outlining how we will meet our responsibilities if a provider does fail or exit the market.

V. **Business Support for Providers** is currently being delivered through the Rural Growth Network (RGN) until December 2015. A new contract to deliver targeted support for social care providers will be commissioned by Economy from January 2016, and this will include provision for a bespoke package for struggling business and those in a position to grow, develop, diversify or innovate

VI. **Action Learning pilots to test the potential for Collaborative working in the sector** are underway in the areas of South Molton, Moretonhampstead and Teignmouth/Dawlish. Learning from these pilots will also be applied to future business support and workforce development tenders to support to Adult Social Care providers.

VII. **Employment and Skills support** is being provided through a range of existing mechanisms, including DCC Workforce Development, the NHS and through national organisations such as Skills for Care..

4. Other areas of the Care Act Programme

4.1 Other areas of the programme include:

- The development of the new carers offer in Devon.
- new policies relating to self funders, charging, and fair and affordable care
- Assessments and peer support for prisoners
- Increased access to independent advocacy

- Universal deferred payments scheme

4.2 The duty to arrange care for self funders for the community came into place in April 2015. Devon already arranges care for community based self funders and therefore meets this duty.

4.3 The duty to arrange care for self funder in a residential setting (S18.3 of the Care Act) formed part of the phase 1 duties to be introduced in April 2016 and has now been delayed until 2020.

5. Summary and Conclusion

5.1 The Care Act programme has enabled a considerable amount of change over the past year. Partnership and council wide engagement have been a key focus of the programme, along with a strong emphasis on user, carer, staff and provider engagement.

5.2 DCC and its partners have delivered the Care Act 2014 and we are compliant with the legal requirements of the Act.

Considerations

There are no financial, sustainability, carbon impact issues arising from this report.

The full Care Act Equalities Impact Assessment available to view on DCC's website https://new.devon.gov.uk/impact/care-act-implementation-impact-assessment-updated-september-2015/

Tim Golby
Head of Social Care Commissioning

Health and Wellbeing Board
12 November 2015

Report on the progress of the implementation plans of the joint commissioning strategies for Dementia, Learning Disabilities, Mental Health and Carers

Report of the Head of Social Care Commissioning (DCC), Managing Director (Partnerships) (New Devon CCG) and Director of Commissioning (South Devon and Torbay CCG)

FOR THE Board to note progress against the objectives and indicate further action to be taken.

Recommendations:

That the Board notes the content of each report and comments on the implementation plans as required.

Key messages:

The four joint commissioning strategies were presented to the Board in March 2015 and it was requested that progress be reported annually to the Board in autumn each year.

This is the first update report on the implementation of the strategies.

Each strategy has key areas for achievement and each implementation plan has set out what actions are to be taken. The reports detail the major achievements and areas for further action.

Purpose:

To enable the Health and Wellbeing Board to note
(1) Achievements and risks against planned actions
(2) Comment on the content of the plan
(3) Advise on changes in reporting they may consider appropriate.

1. Background/Introduction

1.1 At its meeting of 12 March 2015, the Health and Wellbeing Board received the three joint commissioning strategies for partner agencies across the DCC footprint

1.2 The three strategies presented at that meeting complemented the existing Dementia Strategy.

1.3 The Board noted:

(a) The Joint Commissioning Strategies for Learning Disability, Mental Health and Carers, be welcomed;

(b) That the common themes identified at Appendix 1 of the report, be noted;

(c) The delivery of the strategies, as outlined in the implementation plans, be welcomed; and

(d) The intention to report progress annually to the Board be welcomed and be added to the Boards forward plan for the Autumn.

1.4 This report is the action referred to in 1.3 (d) above.

1.5 Appendices 1 to 4 are the updates on implementation of the Joint Commissioning Strategies.

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Appendix 1

Dementia Strategy Implementation update November 2015

1. Implementation of the Dementia Strategy in Devon

1.1 This summary reviews progress in delivering the Dementia Strategy in the Devon County Council area under 4 main headings to reflect the key messages and commissioning intentions:

- Risk reduction
- Raising awareness and understanding
- Early diagnosis and support
- Living well with dementia

2. Risk Reduction and prevention

The diseases that lead to dementia are complex, and there is still a lot to learn about the risk factors. In most cases, it is likely that our age, genes, medical history and lifestyle all contribute to our risk of the condition. Risk factors for cardiovascular disease are also risk factors for dementia.

2.1 Progress

Devon has a living well and ageing well prevention strategy which seeks to promote healthy lifestyles and ageing well**.** A number of programmes are commissioned through public health to support individuals and identify individuals who may be developing health conditions.

- The NHS healthcheck programme has delivered healthchecks to residents to identify individuals who may be at risk of vascular disease and offer evidence based support (25,000 in the DCC area). Individuals over 65 are also given information about dementia.
- In Devon and Torbay a new outreach service has been commissioned to reach those most at risk of cardiovascular disease.
- Stop smoking services, healthy weight services and substance misuse services provide support and are supported by media campaigns such as Dry January, Stoptober and Stop smoking day.
- The walking for health programme now covers the whole area.

2.2 Priorities for next year

- The health check programme needs to be effective at reaching individuals at greatest risk of cardiovascular disease
- Commissioning a new lifestyle service offer to more effectively reach individuals who need information, advice and support to make changes through a digital, face to face and 1:1 offer
- Professionals and services need to ensure every contact counts
- Support national and local campaigns including ‘One You’ to embed a mid-life approach to prevention

3 Raising awareness and understanding

In 2009 the National dementia Strategy set an objective in relation to improving public and professional awareness and understanding of dementia. This encompassed information about the benefits of timely diagnosis and care, reducing the risk of dementia, and reducing social exclusion and discrimination. It aimed to encourage behaviour change in terms of appropriate help-seeking and help provision.

In addition to the risk reduction messages described above, there are a range of examples in Devon of how awareness raising is being tackled.

3.1 Devon Dementia Partnership

The Devon Dementia Partnership was established in early 2013 and is committed to improving the lives of people with dementia and their families living in Devon by sharing, learning and collaborating across our diverse organisations and communities and the many organisations providing services within them.

The Partnership has been recognised at a national level as an exemplar of good practice by the Civil Society and Voluntary Sector group of the Prime Minister's Champion Group on dementia-friendly communities.

Examples of the impact of the Devon Dementia Partnership include the facilitation of 2 highly regarded local conferences: **Living with Dementia in Devon** in May 2014, and **Living Independently and Well with Dementia** in May 2015.

The Partnership have also coordinated other events including Memory Café network events and facilitated the appointment of a Partnership Development Officer to support ongoing development of dementia friendly communities in Devon.

Priorities for next year: to review the current structure and role and explore involvement of people with dementia

3.2 Dementia Roadmap

The Dementia Roadmap provides information about understanding dementia, the diagnostic process, post-diagnosis support, living well with dementia, carer health and planning for the future.

3.2 **Progress:** Headline information tells us that the most popular pages have related to:

- Cognitive impairment testing
- The diagnostic process
- Post diagnosis support
- The dementia pathway, carer health and living well have also been popular.

3.3 **Priorities for next year:** To ensure appropriate links to existing websites and the emergent Care Act information

3.4 **Dementia friendly communities**

A Dementia Friendly Community is a place where people living with dementia and their carers and families feel confident and supported to continue with their every day lives and included in a community.

3.5 **Progress:** Supported by the Devon Dementia Partnership, a Partnership Development Officer is now employed within DCCs Services for Communities Directorate. This 18 month post is designed to help communities develop their local steering groups, share practice and ideas and stimulate other communities to join up. Information about the Devon towns and parishes working towards becoming dementia friendly is available here on the Dementia Roadmap.

3.6 **Priorities for next year:** To continue support through network activities, supported by the Devon Dementia Partnership, encouraging organisations to improve their awareness of dementia.

3.7 **Schools activity**

Seven Devon schools were involved in a national pilot to test different approaches to educating children and young people about dementia awareness. The pilot schools have developed a whole school approach through the curriculum and through music. 'A Good Practice Guide to delivering effective Dementia Awareness in schools', describes the lessons learnt and examples of projects undertaken. This programme has also benefitted from the involvement and support of Devon Senior Voice in developing an intergenerational focus through school based Memory and Reminiscence Cafes.

3.8 **Books on prescription**

Reading Well Books on Prescription for Dementia book collections are available and free to borrow in every library across the county and can either be 'prescribed' or found on library shelves. The scheme is run nationally by The Reading Agency and supported by Public Health Devon, The Alzheimer's Society along with other national organisations working in dementia research, treatment and care.

The collections include 25 titles recommended by health professionals covering:

- normal ageing and memory problems
- background information about dementia
- living well with dementia
- support for relatives and carers and personal stories

http://reading-well.org/books/books-on-prescription/dementia

4. Early diagnosis and support

The National Dementia Strategy emphasises the importance of good quality early diagnosis and intervention for all. The descriptions below illustrate our local pathway which is well developed in the early post diagnosis phase.

4.1 Devon Memory Service

The Devon Memory Service offers a 'one stop' diagnostic service –It delivers a referral to treatment time of 30 days on average – probably higher than any other area in the country. This model has been very well received by patients and their families. The memory assessment process has also been adjusted to ensure that people with a learning disability have access to more timely diagnosis.

4.2 Post Diagnosis follow up

Carried out within a month of receiving a diagnosis, these sessions, delivered jointly between the Alzheimer's Society Dementia Support Service and Devon Partnership Trust, started in January 2015.

4.3 Progress: 193 people have had appointments across 100 sessions. 179 of those appointments became referrals for the Devon Dementia Support Service (98%), and 62 referrals were made to 'Memory Matters'.

4.4 Priorities for next year: To ensure that people diagnosed outside of the usual Memory assessment Service route are receiving a similar follow up appointment and introduction to the Support Service.

4.5 'Memory Matters'

'Memory Matters' Workshops are delivered on a time limited basis to people who have received a diagnosis along with family carers in a partnership between Devon Partnership Trust and the Alzheimer's Society. The main objectives are:

- To provide a comprehensive education package to people with dementia and their families
- To provide information and guidance to those with a diagnosis of dementia
- To support people with dementia and their carers to understand which organisations are able to provide support to ensure needs are met across the lifetime of the individual.

4.6 Progress

People attending the courses report significant improvement in their knowledge, understanding and awareness of the condition, coping strategies,

support services available and value the opportunity to meet others in a similar position.

4.7 Peer support groups (Memory Cafes)

There are now 38 Memory Cafes aligned to each of the market and coastal towns plus Exeter city. Memory Cafés offer an informal setting for those affected by memory problems and their carers to access support and information.

People attending Memory Cafes value:

- Social contact and sharing experience
- Access to information about dementia
- Being able to speak to professionals
- Getting support from others who come to the café

4.8 Progress

Demand in some areas is significant and a number of cafes are extending their activities and moving to more frequent sessions i.e. from once a month to twice a month, or even weekly

4.9 Priorities for next year

Develop a sustainable model of support for memory cafes recognising they have a key role in the dementia pathway. Consider complementary models of peer support.

4.10 Dementia support service

Based on the dementia adviser roles described in the National Dementia Strategy, the Dementia Support Service in Devon is provided by the Alzheimer's Society.

4.11 Progress: Over the 3 year lifetime of this contract the following impacts should be noted:

- Since the service started, **3504** people have received support and advice from this service
- Currently **2042** people are being supported by the service
- **76.6%** of carers who responded said they would recommend the service
- **67.6%** of people with dementia who responded said they would recommend the service
- **57%** of GPs who responded have indicated that the service has increased their confidence in pursuing a dementia diagnosis
- Carers and people with dementia will have benefitted from structured and professionally facilitated courses (Memory Matters)
- **98%** of people diagnosed go on to receive the dementia support service

4.12 Priorities for next year: Develop a specification for a new tender for the service during 2016.

4.13 Diagnosis rates

Current diagnosis rate information is as follows as at March 2015:

NEW Devon CCG	55.2%
South Devon & Torbay CCG	61.5%
Devon County Council	56.5%

More recent data is anticipated, bringing us closer to the NHS England target of 67% but latest data is not available at this point. In order to make more rapid improvement on diagnosis rates an action plan has recently been developed which focuses on some key areas:

- Ensure follow up of people identified as part of the Acute Trust Commissioning for Quality and Innovation
- Clear information for GPs about the Memory Assessment process and post diagnosis pathway.
- Raise the profile of post diagnosis services
- Care homes case finding
- Medicines Optimisation teams to review all practices where dementia drugs are being prescribed in Devon to see if they have also coded the patient correctly as having dementia.

4.14 Priorities for next year:

- develop a toolkit for GPs to develop dementia friendly GP practices and
- build on award winning care home support examples to improve identification/outcomes for people with dementia in care homes

5 Living well with dementia

Enabling people to live well with dementia depends on all organisations across statutory, private, voluntary and independent sectors working together to make sure they provide properly co-ordinated services to people with dementia and their carers.

5.1 Direct payments

At the end of December 2014 there were 2,327 people in receipt of a direct payment. Based on the information in ‘My plans’, 14.6% of these related to people with dementia.

5.2 Dementia as a long term condition

Information drawn from a subset of the data collected from a Healthwatch Devon survey in to long-term conditions indicated the following:

- In general people with dementia had a less active role and less confidence in taking care of their own health, and experienced less control over their care.

- The survey also illustrates huge variation in people's experience – not only in managing dementia but also managing co-morbid conditions alongside dementia.

5.3 Promote closer integrated working between primary, community and secondary care and between statutory, voluntary and independent sectors

The Older People's Mental Health Steering Group brings together those who use, provide and commission services to make improvements in outcomes for complex patient pathways using an integrated, whole system approach. The dementia pathway has been enhanced through detailed work undertaken via this group.

In addition, examples of integrated working projects include the Budleigh hub; Hospital@Home and the ICE (Integrated Care Exeter) project.

Priorities for next year: Develop the emergent Health and social care collaborative as a focus for good practice in the integration of Health & Social Care services, using the OPMH Steering Group as a reference group for dementia specific activity and to ensure the needs of people with dementia are incorporated in service redesign.

5.4 Ensure the needs of carers for people with dementia are encompassed within a refreshed carers strategy, including access to regular and reliable respite options

Block contract arrangements are now in place to enable bookable respite in some local care homes. Progress on the implementation of the Care Act is reported in the Carers Strategy update.

5.5 Maintain a focus on quality of care for people with dementia in acute and community hospitals

Acute and community hospitals have undertaken a range of improvements to environment, staff training and improved understanding in the identification and involvement of carers.

5.6 Drive up quality and dementia specific capacity within care homes; extra care housing; domiciliary care

5.7 Care homes

The greatest focus needs to be on ensuring a sufficient supply of care home provision suitable for people with dementia. The latest available demand and supply information in relation to dementia care homes is available at https://new.devon.gov.uk/providerengagementnetwork/files/pdf_cache/adults-market-position-statement.pdf

5.8 Progress

Sector led improvements continue through the Devon Care Kite Mark movement with over 50 homes involved. The Health and Social Care Collaborative and quality team are now established to support good practice in all areas of care.

5.9 Priorities for next year: Continue work with providers to adapt the existing available supply by encouraging a greater proportion of beds to be remodelled to support the needs of older people with dementia. The Market Position Statement is being refreshed and a commissioning plan for care homes is being developed.

5.10 Extra Care Housing (ECH)

All ECH schemes developed to meet our commissioning priorities must be capable of accommodating people with complex care needs, including dementia, at their initial point of occupation, and support people with those conditions as they develop. More information is available at:
https://new.devon.gov.uk/providerengagementnetwork/files/pdf_cache/adults-market-position-statement.pdf

5.11 Living Well @ Home Strategy

This strategy covers all funded care and support delivered to people through their own door (regulated and unregulated) and encompasses the needs of people with dementia.

5.12 Improved end of life care

NEW Devon CCGs Advance Care Planning (ACP) guidance is now available. Opportunities for people to discuss this in the earlier stages of dementia can be helpful in preparing for the future.
http://www.newdevonccg.nhs.uk//information-for-patients/planning-for-your-future-care/101638

5.13. Antipsychotic Prescribing

The most recent audit of antipsychotic prescribing shows.

- Improved recall/review systems in primary care
- Secondary care reviews 12 monthly
- Reviews stopping/decreasing doses as symptoms improve
- Decreased prescribing despite increased diagnosis of BPSD
- Read coding of unlicensed prescribing from secondary care

5.14 Research

A number of positive developments are taking place with regard to dementia research with increasing opportunities to get involved. The National Institute for Health Research has launched 'Join dementia research' www.joindementiaresearc.nihr.ac.uk is a new service which allows people to

register their interest in national dementia research. It helps people with dementia, their carers, or anyone interested in dementia research to be matched to studies.

Locally, the South West Peninsula NIHR Clinical Research Network has been very active in promoting Join Dementia Research (JDR) and it is starting to prove successful.

A total of 13 clinical trials are supported locally - either in follow up, open to recruitment, or in the process of being set up. There are also strong and growing links with academics from a wide range of academic backgrounds at both the Universities of Plymouth and Exeter. The University of Exeter is prioritising dementia as an area it wishes to grow and lead research in.

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Appendix 2

Learning Disability Strategy Implementation update November 2015

Update Report on "Living well in Devon, A joint strategy for People who have a Learning Disability".

1. Introduction

1.1 This report provides an update on the current strategy being implemented regarding adults who have a learning disability living within Devon County Council footprint area.

1.2 Each of the stated commissioning intentions has been considered and a brief update has been outlined with these in mind. The Current position has been grouped into key themes, as follows

- Personalisation,
- Integration,
- Staying Healthy
- Keeping Safe
- Living Well
- Prevention and Transforming Care

2. Personalisation

Within learning disability services we have 32% of our known population of people who have a learning disability utilising direct payments, this is benchmarked as comparable to local authorities similar to Devon in profile. Support to use budgets is made accessible through organisations like Disability Focus, and having a direct payment can enable improved choice and control for individuals.

People are also now made aware of what their indicative budget is following review ensuring transparency of information to help people make decisions about how they may want their care to be delivered. Transparency is also enhanced by the implementation of a revised offer for Supported Living across Devon, which enables individuals to know how much their services cost and what choices they have.

In addition NEW Devon CCG has also been implementing Personal Health Budgets from April 2015 approximately 15 people so far utilising a personal health budget.

In the future it would be helpful for the Council and CCG to look at how Education, Health and Care plans are developed for young people preparing for adulthood. There is opportunity to look at "braided funding" to maximise choice and control for this group.

3. Integration

The last year has seen the implementation of “Changing Directions” (with Devon Partnership Trust) and also the integration of LD staff into the 14 Complex care teams across Devon.

Such active strategic development has enabled some positive changes such as a single point of access for Social Care, and the clarification of roles across our services, particularly in respect of case management.

Three Disability Lead posts have been aligned to support the Complex Care teams and this includes having a focus and oversight of the needs of those individuals who have a learning disability in our wider population.

It is still early to see the ongoing impact of the changes to service configuration, and close monitoring will happen via the newly established Learning Disability Partnership Group, where health and social care performance and quality indicators are reviewed side by side with commissioners and operational leads across health and social care.

4. Staying Healthy

2015-16 has seen the implementation of a robust plan to increase the numbers of Learning Disability Primary Care Liaison Nurses from 4 to 20 across Devon. Although only in place since April they are already having an impact and very positive feedback has been raised at the Learning Disability Partnership Board and also at DPT’s CQC inspection as a result.

Their role is to improve access to GP practices speeding up diagnosis and treatment. They liaise closely with the existent Learning disability Acute Care Liaison nurses, smoothing admission into and out of secondary care. As a result people get to hospital promptly and also get out as soon as they are ready, with developed knowledge about their individual needs communicated across services ensuring a safe discharge.

Three new Learning Disability Neurology Liaison posts have also been introduced into our hospitals to ensure that people who have a learning disability and epilepsy are well supported with their treatment.

Further work has also been undertaken to improve monitoring of and information for people who have a learning disability who take anti-psychotic medication. DPT nurses have recently been shortlisted for the Learning Disability Community Nursing Times Award for this work. Information for carers and primary care staff will also be published shortly in a “Purple Book” which will improve awareness about what needs to be in place for safe and successful medication of individuals.

Work to focus on obesity is commencing, this will require collaborative working across a range of services to ensure it has a positive impact.

This past year we also worked to develop reasonable adjustments in relation to dementia and people who have a learning disability, for example the memory assessment process has also been adjusted to ensure that people with a learning disability have access to more timely diagnosis

5. Keeping Safe

This last year saw the refreshing of the “Safe Places” scheme across Devon with active engagement from advocates and people who have a learning disability in engaging proprietors and the public. This is a place that is identified in the community that people can go to if they feel vulnerable- staff in the public place know who to call and how to respond to get the right help for the person.

There are now over 200 safe places across 26 towns and villages in Devon. This work has happened in conjunction with Devon and Cornwall Police and Devon Link-Up, and was communicated using leaflets, stickers in the windows of public places and also DVDs.

There has also been ongoing support to ensure that the Mental Capacity Act is properly implemented ensuring that all staff are trained in its use and are aware of Deprivation of liberty safeguards. There is a high level of awareness demonstrated across providers, however demand for Court of Protection services and Deprivation of Liberty Safeguard decision making has created some challenges as a result and delays have occurred in planning for individuals due to waiting for court judgements.

The independent sector received funding to raise awareness of mate crime. Mate Crime is where people befriend vulnerable individuals and go on to abuse or exploit them. Videos, role play and workshops were used to get the message across to people who have a learning disability about how to recognise and report mate crime.

An “Autism Card” is also being developed that will benefit a significant number of people who have a learning disability. It is a card people can carry to tell others they have additional needs and where help can be sourced as needed.

6. Living Well

We have raised the needs of women who have a learning disability within the wider maternity strategy for Devon ensuring that reasonable adjustments are supported to help them with their pregnancy and early motherhood. This is supported by the improved access to learning disability primary care nurses and acute care liaison nurses.

The preparing for adulthood pathway has been recently reviewed and refined and sits within the revised strategy which has been extended in timescale by one year, which will start from November 2015. The pathway will be implemented through the work of the four new preparing for adulthood workers, three of whom have been recruited in September 2015.

Accommodation is still a challenge when we are planning to support people with very complex needs. In early 2015 we were successful in securing £800,000 to help with a shared ownership project for people with very complex needs. The project enabled a small number of people to become home owners.

The work of the enabling team has contributed to helping people live more independently, assessing individuals at review stage and providing targeted support where it is needed. This work has been complemented by the "Just Right Project" which involves using assistive technology for people who have a learning disability using systems such as "just checking" in people's homes to track the assistance they require over a period of time. Data can be used to ensure that the correct levels of support are supplied to the person. So far six kits have been used and will be extended to thirty, by working in collaboration with five providers of services.

In terms of employment for people who have a learning disability some limited progress has been made in this area .a good example is "Project Search" . A scheme that offers varied work placements within our acute hospital trusts across the whole of Devon. Approximately 60% of people using this achieving paid work of 16 hours or more after their placements.

Further work is needed in relation to widening the work opportunities within our community in Devon. This will rely on improved working with the Department of work and Pensions.

7. Prevention and Transforming Care

Transforming Care is the response to reducing the numbers of people placed in hospital. In the past they stayed far too long in inappropriate placements.

The "Blue Light" protocol was developed in Devon to support creative and fast decision making to keep the right support in place in the community at a point of crisis. As a result NEW Devon CCG we has prevented 26 admissions into hospital over the last two years, -the majority of these were in Devon local authority. This protocol is now part of the response nationally to Transforming Care.

In the past two years there have been no new admissions in hospitals out of our area, the last one taking place in August 2013 for a Devon citizen.

The numbers of people who were placed out of area by Devon have fallen steadily. Currently NEW Devon CCG has11 people from Devon placed in hospital, but four of these are in the county, leaving seven people out of area. Four people, (two in Devon and two out of Devon) are due to move into the community in the next 6-10 weeks.

All individuals are regularly reviewed and care and treatment reviews have taken place to make sure each person who is in hospital is receiving active care and treatment or has a plan for discharge.

Six people from Devon are in secure hospital placements currently, and their services are commissioned by NHSE, however we support the planning and return to the community when the person is ready for discharge.

As part of “Changing Directions” DPT reorganised their services to ensure that care closer to home was available. Part of this work was refocussing the support for people who have very complex needs being supported by Intensive Assessment and Treatment Teams. These teams work to help people who have a learning disability and behaviours that challenge.

The use of Care and Treatment reviews (Implemented in 2015) has challenged the use of hospital placements ensuring that they are always only ever used for active assessment and treatment, when this cannot be provided within the community. Family carers can use a “Right to challenge” if their son or daughter is placed in hospital.

Further work is needed to bolster our provider market, develop better provision for short breaks and also improve our joint working with Children’s services and NHSE. A proposal to develop a Transforming Care Partnership has been put forward to build on the work to date, address the further work we need to do and ensure we are able to deliver the requirements of the national Transforming Care Plan due to be published on 28th October 2015.

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Appendix 3

Mental Health Strategy Implementation update November 2015

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1. Introduction

This report provides an update to the Health and Well-being Board on progress with achieving the priorities identified in the Mental Health Commissioning Strategy for Devon. The strategy has an intended life span from 2014 to 2017 and it will be subject to periodic review, particularly from people with lived experience of mental illness who were the core consultation group when the strategy was initially drafted.

The key priorities identified in the strategy were:

- Prevention
- Personalisation
- Integration
- Improving health and wellbeing
- Supporting recovery
- Access to services

Each of these priorities cannot be seen in isolation from the others and indeed several programmes of work have been addressing these priorities together.

It is worth noting that national priorities have changed since the publication of this strategy, primarily with the publication of the Mental Health Crisis Care Concordat and the passing into law of the Care Act 2014. Both of these drivers were anticipated in the strategy but as was inevitable there has been a shift in understanding and priority as organisations and stakeholders have become engaged in implementation. This will be visible in the work programmes for strategy implementation.

2. Prevention

The prevention work stream is an immediate priority but also an area for long term planning. Current priorities are focusing on secondary and tertiary prevention, i.e. prevention work that seeks to prevent the onset of serious symptoms, for example early intervention services, and relapse prevention services, e.g. the crisis services being developed as part of the Crisis Care Concordat[1]. These represent a service based approach to prevention and makes use of professionals with substantial experience to work with people vulnerable to serious mental illness.

There will be an investment of resources into early intervention services in this year. This will expand both capacity and the speed at which people can access services.

The Crisis Care Concordat has increased the focus onto improving the response of crisis services to mental health crises. Whilst this is crucial to

[1] www.crisiscareconcordat.org.uk

deliver an effective service it is also recognised that preventing crisis is more effective and gets better outcomes. There are two strands of work underway to address this:

- Improving the function of Crisis and Home Treatment Teams in working with known patients to ensure there are clear crisis and relapse prevention plans
- Improving access to 24 hour crisis services that mean people (including those not previously known to services) can get swift access to advice, support and treatment.

The Concordat action plan for Devon can be accessed at the Crisis Care Concordat website.

http://www.crisiscareconcordat.org.uk/areas/devon/

A longer term piece of development work is happening via the Early Help for Children and Families Strategy which heavily overlaps with the mental health commissioning strategy. This piece of work focuses on targeted support for families and young people where there are known risk factors for the development of long term mental illness – worklessness in the family, frequent address changes, non-attendance at school, substance misuse within the family and exposure to domestic abuse. As such it is an attempt to deliver primary prevention, i.e. services that intervene with vulnerable people and communities to provide the skills and resilience to respond to these negative circumstances as well as direct interventions to address the risk factors. This strategy is crucial to the whole prevention agenda as it concentrates on the groups of young people most vulnerable to long term mental illness in adulthood. The work is supported jointly by Devon County Council (DCC) and Devon Partnership Trust (DPT) but the impact and capacity is limited at the moment. This will remain a long term priority and central to the future plans for investment in services.

3. Personalisation

The agenda on personalisation tends to focus on the use of personal budgets and direct payments. The process of giving control to people over the allocation of resources for support and, increasingly, treatment is a key approach. Indeed there are three pieces of work happening in Devon to support this:

- Personal Health Budget Scheme (NEW Devon CCG)
- Integrated Personal Care Project (NEW Devon CCG)
- Direct Payment Programme (Devon County council)

However it should be noted that personalisation of care and treatment is at the heart of improving services, preventing crises and reducing the use of out of area placements.

A focus on detailed person centred planning is becoming the basis of new approaches to complex care in mental health, especially with those either in

hospital and or at risk of an expensive hospital placement. Approaches that have been developed in the learning disability world are now being adapted to help plan for those with long term dependence on hospital placement and institutional care.

4. Integration

The current provision of specialist mental health services in Devon is subject to a formal agreement between Devon County Council and Devon Partnership Trust. This agreement is currently subject to a review to ensure that it remains fit for purpose and addressing the priority issues for both the commissioners and provider. The primary object for the review is to ensure that health and social care intentions from commissioners are delivered by the provider in Devon – the crucial requirements for effective recovery and sustained well-being are factors like housing; employment; relationships; a place in the community and these are not areas that are particularly susceptible to treatment (therapy or prescribing) but instead

Whilst the integration of health and social care provision is a prime area for improved efficiency and effectiveness this is not the only area of integration that is being implemented. As part of the Mental Health Crisis Care Concordat there is a concerted move to rationalise processes and ensure that mental health expertise is available across systems and processes. For example the development of Street Triage and Liaison and Diversion services with the Police and Courts or the expansion of Psychiatric Liaison in the acute hospitals. The priority for commissioners is to use integration processes to improve the experience of using the service, primarily by rationalising processes, speeding up responses and removing wasteful repetition from the system.

The impact of integrated approaches like this can be seen in the evaluation of the Street Triage pilot which operated from April 2014 to March 2015. During the operational hours of the service:

- The use of Police custody for detentions under s.136 of the Mental Health Act fell by an average of 25%. This number has been improving since the service went into full operation (validated figures will be available shortly).
- The use of s.136 was averted on 76 occasions
- 9 suicides were prevented[2]

These data provide hard evidence of the impact of well integrated services and are the model for future collaboration within the Crisis Care Concordat plan. The proposed new model for crisis care is based on highly integrated approaches involving the NHS, Police and Ambulance service with shared resources, integrated service delivery and joint response. Examples of this are:

- S.12 Doctor rota to ensure comprehensive medical cover for Mental Health Act duties

[2] Devon Street Triage Pilot Project 12 Month Review and Evaluation March 2014-April 2015

- Development of psychiatric liaison services in emergency departments – investment to deliver 7 day 24 hour services in a partnership between acute hospital services and DPT.
- Developing a Crisis single point of contact in partnership with the Police, 111 and Ambulance service – with the potential to share control centre resources.

5. Improving Health and Well-being

The unacceptable variance in mortality and morbidity rates for people with mental health problems is a key inequality in the health and social care systems. The causes of this variance are varied – for example stigmatisation; consequences of medication; poor lifestyle choices (especially smoking); poor housing and poor access to health care. We have prioritised a number areas for action:

- Smoking cessation – both in inpatient and community settings
- Enhanced psychiatric liaison services in the acute hospitals
- Development of improved relationships between primary and secondary care services
- Specific health checks and screening on psychiatric inpatient units
- Medicines optimisation programme to reduce poly-pharmacy
- Commissioning for Quality and Innovation contract incentive to support improved approach to mental health in the emergency departments.

All of these work strands are in operation and delivering improved outcomes and experiences for people but the long term effects on morbidity and mortality will take time to register an impact. Evidence of the importance of this has been provided by the Parity of Esteem programme from the Department of Health and research like QualityWatch[3].

6. Supporting Recovery

Sustaining the recovery of people with mental health issues is a task that goes beyond compliance with treatment and attendance at appointments. There has been variable progress with this priority with projects like the Devon Recovery Learning Community thriving and increasing its output but with on-going challenges around the provision support for housing and employment. There are significant programmes of work in these areas but as yet performance indicators remain at a low level. Addressing this is part of the previously mentioned work on enhancing the Partnership Agreement between DPT and DCC.

It is fundamental to the success of recovery programmes that mental health and well-being is seen as a natural part of treatment in primary care and as a core requirement to successful employment, education and to a life outside specialist mental health services.

[3] QualityWatch Focus on: People with mental ill health and hospital use
Exploring disparities in hospital use for physical healthcare

A positive example of this is the Partners2 research programme which is trialling new ways of working in primary care that will develop confidence and skill in primary care and will provide direct input to GPs and primary care teams to manage and treat people with more complex and long standing needs.[4] This project is a model of an approach that supports long term recovery by siting it in the community making it part of routine primary care.

7. Access to Services

Limiting access to services is a source of frustration for people who use services. When we have spoken to people with lived experience one of the most significant concerns was that services were not available when they felt they needed them.

The main referrers to mental health service are general practitioners and they report similar concerns to patients, they are unable to gain access to services for their patients and they are unable to get access to advice and support for their own clinical practice.

Partners in other agencies, especially the Police and acute hospital providers are frequently required to deal with people who have significant mental health issues and they have routinely struggled to get the support they require and access to services for the people they are working with.

These issues have driven a significant piece of work that focuses on acute care in mental health and how key partners can improve their working relationships and improve services. The early focus has been on:

- Availability of health based places of safety
- Improving the s.12 Doctor rota
- Enhancing the availability of psychiatric liaison services, especially in A&E
- Developing local psychiatric intensive care facilities
- Redesigning mental health services using the “Smart Recovery” methodology
- Reviewing the provision of the AMHP service and the EDT service
- Implementing a Street Triage service
- Developing liaison and diversion services in Police Custody and the Court Service

All of these strands of work are linked to a wider programme to utterly rethink the acute care pathway and shift resources and expertise to the very front of the system by developing a single point of contact for all mental health activity. This gives direct access to expertise and, crucially, ensures that people experiencing a crisis get a response. This represents a significant transformation of service and major step towards achieving the strategic intentions of the commissioners in Devon.

[4] PARTNERS2: development and pilot trial of primary care based collaborative care for people with serious mental illness

8. Summary

As is clear there is substantial work underway involving a variety of providers and partners in delivering the aims of the Mental Health Commissioning Strategy. Progress is occurring at different speeds across the system and is often linked to the strength of pre-existing partnerships.

There are two key tasks that are outstanding with the strategy:

- A review against the “I Statements” by people with lived experience
- A series of Strategy update events across the whole County to refresh the document and reaffirm the support of stakeholders and people with lived experience.

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Appendix 4

Carers Strategy Implementation update November 2015

Implementing the Joint Strategy for Carers: Update Report November 2015.

1. Scope

The scope of the Joint Strategy covers all the commissioning and providing activities of the partners- NHS Northern Eastern and Western Devon CCG and South Devon and Torbay CCG for the Devon County Council area (excludes Torbay and Plymouth).

2. Key Priority Areas of the Strategy

Care Act 2014 requirements:

Progress has been **good but progress is still being made**. Devon County Council was compliant with the Act in the key particulars of having:-

- A refreshed carer offer, new online information resources and a compliant carer assessment available through Devon Carers on the due date of April 1st.
- Carers personal budgets were available as carer support plans were completed

Since April 2015:

- significant work has been undertaken to improve the effectiveness, usability and compliance of Carer Support Management and underpinning business processes and systems;
- staff have worked very hard to address need while building capacity in the early months; since then work has been focussed on improving quality and timeliness of assessments.

2.3 However, the challenges of implementation have been significant:

- Circa 50 GP Practices have withdrawn from direct delivery of Care Health and Wellbeing Checks which are now being provided by Devon Carers; around 20 Practices remaining have all worked hard to stay with the project. In 2015/6 work will be required to define a new offer to and through Primary Care.

- The demands of the Care Act 2014 were not clear when other commitments were made in the Strategy document; therefore some delays in achievement of other priorities with milestones within the period 2014/16 have been delayed and mitigations are described below.

- For Devon, very substantial systems changes were necessary to move from the previous offer, based as far as possible on open access, to the nationally prescribed model of assessment and provision on the basis of eligibility. These changes have produced challenges for the extraction of Management Information making reporting difficult.

- Referrals for assessments for carers have been on an upward though uneven trend since April, total so far 2,741. Completion of assessments has been slower than desired but improvements in completion rates are now evident.

3. Other Preventive Commitments

Carer identification remains the key priority for prevention; without this carers cannot be provided with support, and may well not realise what is available to them until too late. Improvements in carer identification continued last year consistent with recent years to reach 19,079 at the end of 2014/5 (approximately 22.7% of the last Census figure), including 3,527 young carers (greater than the Census suggested, but the Census is considered unreliable on the number of young carers). In the first quarter of 2015/6 the figure for identification of all carers dipped slightly to 18,853, (young carers 3,265) which we believe is mainly a result of the changes to the Carer Offer and publicity relating to Care Act 2014 and Children and Families Act 2014 changes.

Progress on other specific preventive commitments in the Strategy is described below:-

- Improve access to bookable respite (highest priority for carers) {due date of June 2015 not achieved}. This is a complex issue as market sufficiency issues are involved. Work continues to understand root causes and solutions, to test voluntary cooperation among carers and non-standard forms, exploring the potential of breaks based on holiday accommodation to provide alternative style respite. A new date of September 2016 has been provisionally set.

- Review emergency support for carers {due date September 2015} incomplete but in hand.

- Review the training offer for carers {due date December 2015} on track.

- Pilot a Carer Recognition Tool delayed; pilot sites, e.g. Hospital and Community services being negotiated}

- Changes to commissioned carers services to improve reach and preventive focus, are likely to be partially complete by the due date of end 2015/6.

- Work to analyse the causes of carer breakdown resulting in emergency/urgent demands on services has commenced and an initial report is anticipated in March 2016.

- Work to align commissioned carer services with hospitals and health and social care hubs as well as GP Practices is being scoped and will result in development plans, anticipated in late 2016.

Our commitment to deliver carer assessments as Carer Health and Wellbeing Checks continues. In 2014/5, 2255 CH&WBC's were delivered, 1368 by GP Practices and the remainder by Devon Carers (a handful by Pharmacies). By the end of September 2015/6, GP Practices had contributed only 360 (for the half year), 110 of which were delivered by Practices which subsequently

withdrew. This increases pressure on Devon Carers in particular. A telephone "light touch" assessment giving more rapid access to simple services introduced in-year is now being taken up at a rate of about 80 per month, and the ratio of completed CH&WBC's to completed "light touch" assessments is currently 7:4. Developments in online access to assessment/self-assessment and full assessment by telephone are planned and it is currently unclear what the overall picture of carer assessment will be in future, in response to carer choice and the potential scale of future demand.

4. Broader system-wide commitments

The Strategy committed the Health and Social Care community as a whole to improvements based on good practice exemplified in the "Triangle of Care" – mainly around inclusion and treating carers as expert partners in care. These are difficult improvements to track and measure system-wide.

Carers continue to raise with us service interfaces in health and social care, particularly between social care and mental health services. To address such issues will require system-level commitment.

However, there are encouraging examples of progress in some areas, including:-

- DPT have introduced a Carers Charter and involve carers in monitoring it.
- In adult mental health, improvements in the acute care pathway have been informed by carer input, particularly by a carer who had been unable to access emergency mental health services for an acutely ill relative. These improvements will be piloted from April 2016.
- In relation to the people most at risk of hospitalisation or already in hospital, the Transforming Care programme has ensured that carers are included in the new Care and Treatment reviews in Learning Disability services.
- Torbay Hospital has free parking for carers, and has lifted some visiting restrictions for them.

5. Young Carers

"No Wrong Door" Memorandum of Understanding:

This evidences our commitment to joint working across adults and children's services to support young carers. The action plan is overseen by a group including Devon Partnership Trust, Public Health, Integrated Children's Services, adult services (including drug and alcohol services) and provider organisations. We are focusing on implementing the "Think Family Protocol" to achieve this commitment. All adult health and social care services need to take responsibility for identifying young carers and ensure that we: support young carers to achieve positive outcomes; recognise and reduce to appropriate levels their caring responsibilities. The Think Family guidance is explicit about young carers and its implementation will further increase all agencies' awareness of their duties.

6. Specific actions in support of the Strategy:

- Devon is one of 6 local authorities which are part of a "trailblazer for step change" project, led by the Carers Trust and The Children's Society.
- Young carers may be at additional risk of being NEET (Not in Employment, Education or Training) - Careers South West is developing specific support for them.

- Young carers may have particular mental health needs - they have been given priority group status for specific support services.

- We must better understand the needs of young carers - we have focused on our early help assessment processes ("Devon Assessment Framework") and improved training for young carer services and adult services where young carers maybe identified.

- Working with Young Carers, Devon Carers has developed The "Triple A Check" (Assessment, Analysis and Action Plan) booklet for young carers.

- The role of schools is key: Devon Carers are part of a national pilot to develop awards for schools; we have increased the input of our school support services; the Education Welfare Team is championing young carers in schools, encouraging schools to identify them and taking forward a bullying in schools project; we are reviewing and developing our schools resource pack to be more relevant to primary schools and colleges.

5 Young Carers Council

The Young Carers Council's input is important in achieving our ambition to be more carer-led. Their priorities are: education support; rural and social Isolation; health care services; raising aspirations.

6 Parent Carers

We have taken forward a number of improvements in support for Parent Carers.

- Engagement with families is more regular (two series of events this year)

- We have been working to increase the choice available in our "local offer" including better access to community based activities close to home, improving information and increasing the control families have over the resources available to them.

- We are improving coordination of services and support through early help assessments and improved interagency coordination.

- We continue to improve assessment of the needs of carers that focuses on meeting needs and achieving outcomes through the principles and values of personalisation, self directed support and person-centred thinking.

- We are continuing to develop integrated services to support both early help and specialist support for families.

- We have increased the take up of Direct Payments and will continue to promote the take up of personal budgets.

7 Transitions to adulthood for young carers and for parent carers of children with additional needs

Progress in these areas has been prioritised in-year and a project established to produce the following to the timescales identified:-

- Preparing for Adulthood Strategy Consultation – October - December 2015
- New processes, protocols and practice guidance – by January 2015
- Communication and workforce development – January to March 2016

8 Conclusion

The original Strategy document stated:- “In presenting this strategy to the Devon Health and Wellbeing Board we are inviting all partners to think about how the needs of carers can be better met through their services and activities” (p9). In presenting this report we invite all partners to consider further the contribution of their own organisations can make to the achievement of our agreed objectives and priorities, particularly those outside the direct scope of strategic commissioning of carers services – for example in acute and community health and care services.

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Devon Health and Wellbeing Board
12th November 2015

Joint Commissioning for Prevention Strategy – Progress Report

Report of the Head of Social Care Commissioning, Managing Director (Partnerships) NEW Devon CCG and Director of Commissioning (South Devon and Torbay CCG)

Please note that the following recommendations are subject to consideration and determination by the Committee before taking effect

Recommendations: that the Board**:**

1. Note the progress taken to develop the implementation of the Joint Commissioning for Prevention Strategy
2. Endorse the Strategy action plan for 2015/16

1. Context

The Joint Commissioning for Prevention Strategy was endorsed by the Health and Wellbeing Board in June 2015 and the Board requested a progress report for the November meeting.

2. Background

The Devon Prevention Strategy 2011-13 focused on adults, but had a particular focus on interventions for older people. A forward policy for older age should promote successful ageing from middle age onwards, rather than simply aiming to support elderly people to prevent worsening of chronic conditions. The Joint Commissioning for Prevention Strategy seeks to shift the focus to earlier prevention and intervention. The vision is "**To support local people to remain active, healthy and independent for as long as possible with local services focussed on those who have the greatest need"**

The objective of the strategy is to reduce premature mortality and morbidity; prevent, reduce and delay demand on (statutory) and prevent high and unmanageable costs.

3. Progress

The joint prevention workstream currently reports to the Care Act Programme Board and has developed an action plan for implementation of the strategy for 2015/16. The work links closely with information and advice and carers workstreams to address the wider Care Act responsibilities. The Care Act User group have been consulted regarding the approach which has been shared widely within partner organisations. A shift to prevention requires a joined up approach and to reflect this there are proposals to set up a Prevention Board chaired by Phil Norrey, Chief Executive to drive the work.

In July 2015 the ADASS/LGA Peer review of Adult Social Care considered the Prevention Strategy as part of the review and recommended that the Local Authority

should ‘harness the approach to community resilience and focus on prevention and build that on an industrial scale.’

The current prevention offer includes a wide range of services and support including interventions to support lifestyle change such as stop smoking support and healthy weight services though to crisis response to support individuals in need of short-term support to return to independence or avoid an emergency hospital admission and extra care housing to maintain supported but more independent living.

Areas for an improved offer have already been identified including:

- social care reablement; increased coverage is proposed following a review of the service and increased Devon County Council investment (tertiary prevention)
- rapid (crisis) response; increased coverage is proposed across the County (through the Better Care Fund) to provide early intervention for individuals to seek to avoid a hospital admission (tertiary prevention)
- lifestyle service review; a new service is to be tendered to reach more residents (with extra support through those most in need) and support them with lifestyle change. (primary prevention)

The secondary prevention offer is less well defined and includes support for people at risk due to particular health and social care needs (although support is available). The action plan for 2015/16 identifies areas for further development including:

- further development work to identify the groups, individuals and places to focus or target prevention activity
- development of a common approach to community connecting/navigating roles and services to support individuals to find their way to the right support (in some cases without the need for statutory services)
- refining the commissioning approach to embed prevention
- developing the workforce and supporting providers to make every contact count and direct individuals to the right support –whether on-line, face to face, in the local community or through a commissioned service

4. Next steps

Prevention needs to be an integral part of the new model of care to manage future demand and match need with the right support and this requires a system wide change and a commitment to making every resource deployed and every contact count. This requires a shift to reaching individuals with mild need as well as supporting those with complex needs. Individuals and communities are an essential component of the new approach.

5. Summary/ Conclusion/Reasons for Recommendations

The strategy supports the wider joint commissioning strategies and wider integration journey and endorsement is sought from the Board on progress.

6. Financial considerations

The strategy represents a direction of travel and therefore financial considerations form part of organisational delivery plans.

7. Legal Considerations
There are no specific legal considerations identified and the Strategy was developed in line with national legislation (including the Care Act) and national guidance.

8. Equality Considerations
The strategy was prepared in line with partners' Public Sector Equality Duty. It recognises the importance of targeting and meeting the needs of particular groups.

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Background Papers
Living Well and Ageing Well in Devon –Draft Commissioning Strategy for Prevention (link to be added)

"Living Well and Ageing Well" – Getting Serious about Prevention

Priorities	Approach	Actions for 2015/16	By when	Lead
People and Communities				
Principles: • Engage communities in the debate and be honest about future challenges **Remember the importance of the wider determinants of health including:** • Reducing poverty and fuel poverty. • Supporting people to access or return to employment, education and volunteering. • Preventing falls • Reducing housing related health issues • Preventing social isolation and loneliness and overcoming barriers to inclusion	• **Identify the focus for prevention activity work** Identify risk profile Understand demand Agree places, communities and groups of focus Agree cohort to target secondary prevention (signed off by partners) Develop profiles and/or personas • **Develop a joint approach to working with communities** Agree a joint approach to target priority groups, places and individuals with secondary prevention Work with communities to develop resilience and create opportunities recognising current assets (This will be different for different areas and will not be everywhere)	**1: Define and quantify the individuals and groups that would benefit most from prevention services and support linking to the Carer Prevention work and considering the Public Sector Equality Duty** **2: Develop a process to define the risk cohort(s) to target for secondary prevention at an individual level** **3: Develop a community navigator's framework outlining the different tiers of connectivity into prevention services.** **The framework should include:** **a) definitions of the tiers (ie: Community level, CDP/CCT, Professional/primary care level) and what we currently have in place across the whole system** **b) a blueprint outlining what we want to achieve** **c) identification of gaps in provision to inform the development of a plan** **d) Make recommendations around preferred models of connectivity**	**March 2016** **June 2016** **Phase 1 December 2015** **Phase 2 March 2016**	**Task group: Public Health, Health and Social Care information teams, Information and advice workstream ICE programme** **Adult Social Care and Services for Communities**
Commissioning Approach				
Principles: • Focussing on where the problems are greatest to make sure the health of the poorest improves fastest to close the inequalities gap • Focussing preventive action from mid-life • Supporting people to change their lifestyle behaviour if they want to • Preventing abuse, neglect or loss of dignity	• **Define what good preventive offer looks like (community offer, commissioned service, information and advice, technology and digital offer)** • **Develop a new integrated approach to preventive commissioning that is outcome based** • **Model benefits across the system**	**4: Define the current prevention offer using the mapping of grants and contracts within Devon County Council, NEW Devon CCG and South Devon and Torbay CCG and link to the evidence base to identify gaps and areas where things could be developed or decommissioned. Use this to inform our future approach.** **5: Develop the future prevention offer which includes a blue print for commissioned services and the wider non-commissioned approach which includes new ways of working at a system level.** **6: Develop the approach to embedding prevention and early intervention in care pathways (particularly long-term conditions and mental health) utilising the 'Right Care' model**	**Phase 1 Nov 2015** **Phase 2 June 2016** **March 2016**	**Prevention workstream linked to information and advice** **CCG leads**

Workforce and Providers of Services				
Principles: • Making every contact count • Intervening early and take action when problems first arise	• **Selling the vision and sharing what works** • **Being clear on the outcomes wanted** • **Develop an enabling role and co-produce future activity** • **Having the right infrastructure and workforce skills** • **Recognising and harnessing the value of the voluntary and community sector, social enterprises, social investors and community interest companies and business**	**7: Develop the tools to enhance the wider workforce skills needed to support a shift to prevention and develop a workforce plan which will include training, information and support to deliver the new model of prevention eg. Brief intervention, asset based staff guidance, guided conversations**	**June 2016**	**Social Care Business change team and prevention workstream**

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Review of Personal Medical Services (PMS) Process Going Forward

1. Background

1.1 NHS England has set out a requirement for a review of PMS contracts. Through the process all funding identified over and above equity is to be reinvested in general practice. In this instance the movement to equity is in relation to the monies paid to general practice by NHS England for the core services they provide. Overall the process is designed to ensure fairer funding across primary care for the provision of core services.

1.2 Further detail is available in the draft briefing note that has been produced by NHS England locally in conjunction with local CCGs; Appendix A - Draft Briefing PMS Contract Reviews.

1.3 The process for PMS contract reviews is running parallel to the movement to equity, and the removal of the Minimum Price Income Guarantee (MPIG) for General Medical Services (GMS) contracts. The movement to equity across GMS practices has been the catalyst for the movement to equity across PMS practices.

The diagrams in, Appendix B – NEW Devon CCG Practices Movement to Equity, show the movement to equity for both GMS and PMS practices over the period of change. The diagrams also show reinvestment of the PMS Premium equitably across all practices. It should be noted that presently the overall PMS Premium figure is indicative and could reduce. Also, equitable reinvestment of the PMS Premium is for illustrative purposes only and it is unlikely that such reinvestment would be absolutely equitable.

1.4 The movement to equity of the ‘core’ contractual requirement for PMS is the responsibility of NHS England. This process will identify monies over and above the core funding which will be defined as the PMS Premium. The Premium is identified at CCG level and must be reinvested within that CCG area on services from general practice. CCGs will be responsible for commissioning services from general practice with these monies. The associated guidance is quite clear that the monies must be reinvested in general practice so the services must be commissioned from GP practices.

1.5 There has been discussion in NEW Devon CCG about whether the PMS Premium monies should be ring fenced at Locality level as otherwise monies would move across localities. The proposed way forward is that the process is undertaken across the whole CCG. Through the commissioning intentions the CCG would then look to invest across all practices in relation to services that you would expect all patients to be able to access. There will also be a specific amount of monies identified from the Premium for investment in GP services in line with Public Health priorities. For further information see the section below on commissioning intentions.

1.6 Reinvestment of the PMS Premium through offering all practices the opportunity to provide the services the CCG wishes to commission will result in these monies be invested on a more equitable basis. This will result in a more equitable distribution of these monies across NEW Devon CCG. Currently the largest proportion of the PMS Premium is linked with the practices in the Eastern Locality. Modelling work is currently underway to provide more detail in relation to the potential impact.

1.7 The first call on available funding will be to replace provision currently delivered within an equivalent PMS contract but covered by existing DES and LES agreements or LA contracts for other practices e.g. IUCDs

1.8 As part of the process of identifying the Premium and movement to equity practices will be asked to identify

- Services formally commissioned within PMS contracts above and beyond those within GMS contract terms.
- Services provided by PMS providers above and beyond those within GMS contract terms, but which are not formally commissioned.

1.9 Once the services above are identified NEW Devon CCG will be required to make decisions on whether it wishes to commission the services identified from the process above. If it does decide it wishes to commission such services then it will be required to offer all GP practices the opportunity to provide these services. These services will be the first priority for use of the PMS Premium so the information obtained from practices will be crucial for setting commissioning intentions.

1.10 Further detailed information is available in Appendix C – PMS Review: Principles, process and timeline.

1.11 The pace of change is over a 5 year period so any commissioning intentions will need to be on the basis of 5 years. There will be challenges around potential time lag between disinvestment and reinvestment. The CCG should minimise such reinvestment issues and maximise the monies going back into general practice.

1.12 The PMS Premium will be in the region of £4 million for NEW Devon CCG. The actual amount for reinvestment may drop as the initial review process with practices will identify services which need to be commissioned on a continued basis but were not previously documented eg TR’s LES/DES etc

2. Risks for NEW Devon CCG

2.1 NEW Devon CCG has no option regarding its role in the PMS Review. The national process of movement to equity identifies an amount of money for investment in services over and above core general practice – PMS Premium. The CCG is required to invest the PMS Premium in general practice in line with the guidance to the best of its ability.

2.2 The PMS Review process represents a significant risk to NEW Devon CCG. Whilst acknowledging the fairness in a movement to equity of core funding at an individual practice level the removal of funding, at a time when the CCG requires sign up for activities included in the 'turnaround plans' represents a significant risk. For this reason the first priorities for investment will be aimed at those services that you would expect all CCG member practices to have the ability to provide and so earn the associated monies.

2.3 Also, there is a significant risk in relation to services that are currently provided in general practice. The PMS Review process has led to GP practices examining the services they currently provide in relation to whether they are currently remunerated for those services. If practices are remunerated, they are reviewing whether such remuneration covers costs of providing the service for patients. The CCG will need to work closely with member practices when reinvesting the premium to minimise any such risk.

3. Governance

3.1 The PMS Premium for NEW Devon CCG will be in the region of £4.2 million. This is a significant amount of money that will be reinvested in general practice. NEW Devon CCG will need to ensure that a robust process is in place to facilitate the reinvestment of these monies, whilst ensuring that we avoid any potential conflicts of interest. Presently, NEW Devon CCG is at Level 1, greater involvement in the commissioning of primary care. If NEW Devon CCG progresses to the level of either 'Joint' or 'Delegated' commissioning of primary care then it will be required to set up appropriate governance arrangements, sub-committee, to facilitate taking on those responsibilities whilst ensuring it complies with conflicts of interest guidance.

3.2 The requirement to invest these monies wisely whilst avoiding conflicts of interest was discussed at NEW Devon CCG Primary Care Development Group. Identifying appropriate members for such a group, especially clinicians, whilst avoiding potential conflicts of interest is problematic. It was also noted that there was an immediate need to set up a group in relation to the reinvestment of the PMS Premium, which would then make recommendations to the Governing Body.

3.3 This issue was also discussed at the CCG Executive and it was agreed that a PMS Review group should be set up. In the longer term this might become a sub-committee of the Governing Body but that would be dependent on future co-commissioning arrangements.

Outlined below is the composition of a proposed PMS Review group;

- Lay Chair
- Lay member

- Specialist Doctor Member of Governing Body
- CCG Executive for Northern and Eastern Planning Unit
- CCG Executive for the Western Planning Unit
- Director of Commissioning, NHS England
- Director of Patient Safety and Quality (or representative)
- Director of Public Health, Devon County Council
- Director of Public Health, Plymouth City Council
- Finance Representative
- Head of Primary Care Commissioning
- GP from neighbouring CCG (1)

May wish additional experts to attend meetings on an ad hoc basis

(1) To be identified through recruitment process

Recommendation: The Governing Body is asked to approve the Governance arrangements detailed above for the conduct of the PMS review.

4. Commissioning Intentions for Reinvestment of Premium

4.1 NEW Devon CCG is required to identify Commissioning Intentions for reinvestment of the PMS Premium. The reinvestment of the PMS Premium must be in GP services and will be over a 5 year period.

4.2 Until further information is available in relation to services formally commissioned within PMS contracts above and beyond those within GMS contract terms and Services provided by PMS providers above and beyond those within GMS contract terms, but which are not formally commissioned the CCG can only allude to high level commissioning intentions

4.3 Outlined below are the different Commissioning Intentions for NEW Devon CCG

Services from all Practices for their Patients
These services will be identified through the PMS Review process and the CCG will need to make a decision regarding what services it wishes to commission.

Principles

- Continue to commission services that you would expect all practices in NEW Devon to be providing. Link this with the existing services to CCG currently commissions from practices and create a NEW Devon core + we would expect all practices to provide.
- Commission services that we would want all patients of practices in NEW Devon to be able to access (might not be provided by the patients' own practice)

Service from GP Practices in line with CCG Priorities (Turnaround plans)
Work through the Turnaround Steering Group and Commissioning Control centres to identify priority areas for investment in general practice in line with CCG strategic priorities

Services from GP Practices that reduce Health Inequalities

Task the Public Health Teams with identifying services that could be commissioned through general practice that will reduce health inequalities across the CCG.

Appendix A

NHS England South (Southwest)

Briefing note PMS Contract reviews

1. Introduction and background to the national PMS contract review process:

NHS England has set out a requirement for a review of PMS contracts. All funding will continue to be invested in GP practices and the review process is designed to ensure fairer funding. In England GP practices hold one of three types of contract and these are used to calculate their payments from NHS England for delivering the 'core service' to their patients. These main contracts are supplemented with a range of other contractual payments from NHS England, CCG's and Local Authorities related to specific services or requirements.
The types of contract available to practises are:

- General Medical Services (GMS) contract
- Personal Medical Services (PMS) contract
- Additional Personal Medical Services (APMS) contract

The GMS contract is negotiated on a national basis whilst the PMS contract is negotiated locally. APMS contracts tend to be used for specific purposes (for example walk-in centres) and those contracts will be reviewed as part of planned re-procurement processes. Many aspects of the national GMS contract are replicated in the PMS contracts and over time the original rationale for some additional payments made to PMS practices has been eroded and significant equity issues have arisen.

On a national basis it is estimated that the premium element of PMS expenditure is £325 million. That is the value of how far PMS expenditure exceeds the equivalent items of GMS expenditure. This means that NHS England pays, on average, a premium of £13.52 for patients registered with PMS practices. The premium will reduce to around £235 million over the seven years to 2021/22, as the GMS Minimum Practice Income Guarantee (MPIG) is gradually phased out. This reduces the average premium per registered PMS patient to £9.80. The national data collection exercise also showed that of the £325 million, around £67 million was identified as linked to specific enhanced services or key performance indicators (KPIs). The remaining £258 million may be associated with enhanced services or populations with specific needs, but it has not been notified as such. Analysis of the data revealed there is no obvious relationship between current PMS expenditure and deprivation.

It is essential to apply the principle of equitable funding by moving towards a position where it can be demonstrated that all practices (whether on GMS, PMS or APMS) receive the same core funding for providing the core services expected of all GP practice. Any additional funding above this must be clearly linked to enhanced quality or services or the specific needs of a local population, and all practices should have an equal opportunity to earn premium funding if they meet the necessary criteria. It is however important to state that whilst the concept of a core contract is understood that this has never been defined nationally or locally.

2. The PMS contract review process in South West England:

Appendix A

Across NHS England South West 55% of GP practices hold PMS contracts and the 'premium' associated with those contracts is estimated to be £xx million. The pattern of PMS to GMS contracts at a CCG level is variable as demonstrated in the table below:

CCG	Number of practices, patients and % of population covered by GMS contracts	Number of patients and % of population covered by PMS contracts	Number of patients and % of population covered by APMS contracts
Kernow	48 GP practices 408,389 (69.2%)	18 GP practices 169,763 (28.8%)	3 GP practices 12,102 (2.0%)
NEW Devon	31 GP practices 160,115 (17.3%)	86 GP practices 743,989 (80.6%)	5 GP practices 18,814 (2.1%)
S. Devon and Torbay	9 GP practices 61,986 (21.0%)	25 GP practices 233,653 (79.0%)	-
Somerset	52 GP practices 363,305 (64.4%)	22 GP practices 196,430 (34.8%)	1 GP practice 4,092(0.8%)
North Somerset	6 GP practices 52,232 (24%)	16 GP practices 156,974 (72.2%)	2 GP practices 8,086 (3.8%)
S Gloucestershire	1 GP practice 2,328 (1.0%)	23 GP practices 227,402 (95.7%)	1 GP practice 7,964 (3.3%)
Bristol	7 GP practices 63,468 (13.6%)	45 GP practices 396,099 (84.9%)	2 GP practices 6,892 (1.5%)

The local process for review of contracts will reflect the national expectations:

- NHS England is moving to a position where all GP practices, whether GMS, PMS or APMS contracted, can expect to receive the same core funding for providing the core services expected of all GP practices.
- Any additional funding NHS England chooses to invest over and above this core funding, for example through PMS contracts, will need to be clearly linked to enhanced quality or services or the specific needs of a particular population.
- NHS England want to move to a position where there is equal opportunity for GP practices (regardless of which type of contract they hold) in a CCG to earn this additional funding if they are able to satisfy the locally determined requirements.
- Core funding for GMS practices is increasing over the seven years from April 2014. This is because Minimum Practice Income Guarantee payments to GMS practices are being reduced by one-seventh every year and the subsequent savings added in to core (global sum) funding. Changes in payments to PMS practices for core activity will be made over the same time period (ie between 2016/17 and 2021/22
- For PMS practices, NHS England are working with CCG's to review local contracts to ensure additional investment paid over core funding (i.e. equivalent to GMS core funding) is used in a way that is clearly linked to enhanced quality or services or the specific needs of a particular population.
- Information is currently being provided to each practice holding a PMS contract setting out details of any 'premium' funding which is understood to be in place and giving practices an opportunity to provide information about additional services provided for that funding.

- CCG's will be responsible for deciding whether they wish to re-commission any 'additional service' which a PMS practice considers to be covered by the 'premium' payment. In making that decision the CCG will be mindful of its obligation to offer the same earning opportunity to other eligible practices in its area. So for example if a practice argues that the payments reflect the additional costs of delivering a service to a deprived population or running branch surgeries in a rural area the CCG would need to consider whether additional payment is applicable; ie are local GMS practices delivering a similar service within the core contract value.
- It is anticipated that many practices will accept that there is no substantive basis for the 'premium' payment in which case the 5 year pace of change will be applicable from April 2016. This would mean that the 'premium' payment would be reduced 20% each year but this would of course be off-set by annual inflation uplifts to the contract value.
- In reviewing local arrangements, area teams will also ensure PMS contracts meet the national legislative requirements and have terms and conditions that are properly recorded. To achieve this NHS England will be using a single set of standard PMS contract documentation.

3. The key actions required and expected timelines are:

a. NHS England to finalise the review the funding for each PMS practice and identify the amount that is paid over and above the GMS rate. (this sum is described as the 'premium')
b. NHS England will share the financial information with each practice at the same time the practices will be told that this funding will start to be reduced from 1st April 2016 and it will be for CCGs to decide how to reinvest this money. (May/June 2015)
c. Practices will be asked to identify what services they provide to justify this additional funding (by end of June 2015)
d. Where practices have identified a service that is funded through the additional funding the details will be shared with the CCG who will make recommendations on whether they will continue to fund these services or whether they will invest in other areas (July/August 2015)
e. Where the CCG decides that they do not wish to commission a service and this might impact on service delivery for local people it may require a stakeholder engagement process. It is recommended that all CCG's alert Health Overview and Scrutiny Committees of the background to the PMS review process as soon as possible and commence formal engagement on any consequent changes to service delivery (where applicable) by September 2015
f. In April 2016 the changes will be implemented. It should also be noted that the intention is to move all PMS practices on to the new standard PMS contract that has been produced by NHS England from April 2016. This will ensure that all PMS practices are on the most up to date contract which reflects all the recent changes.

g. Where a practice considers that the changes will have a destabilising impact and that it is unable to deliver its core service it may wish to propose changes to practice boundaries, closure of a branch surgery or ultimately give notice of contract termination. In such situations the existing NHS England processes and timelines will be applicable.

4. **Communication and engagement**

CCGs have an on-going process of engaging with patient's that is embedded in their organisations and which is used to inform their general practice primary care strategic/commissioning plans. It is important to recognise that patient engagement is not a one off exercise; rather it should be an on-going process whereby the commissioner is consistently listening to the patient voice so that the needs of the population may be reflected in the service delivery and the commissioning intentions ultimately decided upon.

As commissioners of general practice primary care services NHS England has the same statutory duty placed upon them as the CCGs to engage with patients and the public where there is to be a change to existing service provision and to ensure that services current or planned meet patient need within the financial envelope available.

NHS England will work with the CCGs and their communications teams to ensure patient opinion is taken account of and reflected in local commissioning plans and to facilitate this with the timely sharing of information. CCG's have been requested to brief Health Overview and Scrutiny Committees, through this paper, on the background to the PMS review process. This is in preparation for any more detailed engagement which might be required if there is a proposed change to service delivery. It is intended that the funding released from PMS review and MPIG will be reinvested in general practice primary care service provision and this will be reflected in the commissioning intentions of individual CCG's.

5. Principles which will inform CCG re-investment planning:

a. All funding released must be reinvested in general practice primary care provision and be in line with the general practice primary care strategy for the CCG. CCG strategies for investment in general practice primary care services will reflect the 5 Year Forward View including the expectation that general practice primary care will need to work at scale to deliver a wider range of services and improved access.

b. The first call on available funding will be to replace provision currently delivered within a PMS contract but covered by existing DES and LES agreements or LA contracts for other practices within the CCG. This funding will be excluded from the calculation of the 'premium'.

c. The next priority will be for CCG's to review the 'additional services' identified by practices. Where there is a wish to re-commission such services GGG's will need to plan to utilise funding released taking account of the requirement to ensure equality of opportunity except where it can be demonstrated that the additional service reflects the unique needs of a practice population. Where a CCG decides that it does not plan to commission an

'additional' service this will be reflected in published commissioning intentions and practices will be given a 6 month notice period.

d. NHS England has recommended that CCG's use a proportion of the available funds on a non-recurrent basis in order to resource the change process or other one-off investment required to deliver the 'at scale' solutions agreed for the local area.

e. NHS England will retain an oversight and governance role in assuring that planned CCG investment meets the criteria set out in this document and where used recurrently is funding specific additional services over and above core.

6. Governance arrangements and timeline for the PMS Review process in the South West:

The NHS England South West Executive Team will retain overall accountability for implementing the PMS review process and ensuring fairness and consistency in line with national and South of England objectives and guidance.

The Primary Care Oversight Groups for DCIOS and **Primary Care and Public health Commissioning Forum** for BNSSSG will provide more local oversight and act as **the Project Boards** for the review process. The operational aspects of the review will be undertaken by sub-committees through the **PMS Review Steering Group** (already in place in DCIOS and to be established for BNSSSG)

It is important that the review process proceeds in a timely manner so that individual practices have a clear understanding of the changes in expected income and earnings opportunities at the earliest date. CCG's will need information about the income available for redistribution, together with current non-core contractual commitments where a future re-commissioning decision will be required. Practices also need to be given an opportunity to set out details of other services which are not specified in current contracts nor covered by existing LES specifications which they would like CCG's to consider re-commissioning

NHS England South West Primary Care contracts team will ensure that it provides timely information about the anticipated financial impact of the PMS review to each CCG and constituent practices. This will include schedules of any additional services specified in current contracts about which a decision on re-commissioning or otherwise is required. NHS England South West will also provide a template for completion by each practice where they can set out details of any additional services not specified in contracts nor covered by an existing LES or DES which will require a CCG commissioning decision. The Primary Care contracts team will work with CCG's to establish an appropriate in year reporting and monitoring process.

Each CCG will develop (or update current) their **Strategy for investment in General Practice Primary Care** which will inform the decisions about the targeting of the funds available for reinvestment. NHS England will provide CCG's with copies of the completed templates re additional services so that CCG's can determine their future commissioning intentions in respect of those services.

CCG's will publish their commissioning intentions in relation to additional services and communicate with practices setting out details of services which are being de-commissioned and will not be part of contracted activity from 1 April 2016 or a specified later date. CCG's will commence an engagement process (followed by formal consultation where indicated) where a practice population

might be expected to experience a reduction in local service delivery/access as a result of such decisions.

Where **CCG's** wish to commission a specific service within the transition period to 2021 but are only able to fund the development in other practices once funding has been released it will legitimate to plan a phased roll-out commencing with full or partial reinvestment against the new specification in those PMS practices who would otherwise have to curtail a service and then recommence it at a future date.

Appendix A

Appendix 1 Example
PMS Premium Proforma:

L83* name**		£		
Weighted List Size at 1/04/2015	16,500.00			
At				
GMS rate at 1/4/2015	£71.74	1,183,710		GMS rate £73.57 plus ? £2.21 less OOHs £4.04 CHECK
Current Contract Rate	£79.00	1,303,500		At individual rate at 2015/16 values
Excess Over GMS Contract:		£119,790	**A**	
Temporary Residents Fixed Amount		**10,164**	**B**	Crystalised Amount
Items that are included in PMS Contract that are paid outside GMS Contract				
Childhood Imms - target payments		26,015		These are 13/14 amounts but need to be moved to 14/15
PA Dispensing Fees		13,245		ditto
Minor Surgery		0		This needs to be calculated at 14/15 activity level
IUCD		0		Assume this is nil as paid by Council (or if for health reasons by CCG)
NHSE Items to be paid as item of service	Total	**39,260**	**C**	Check no other NHSE payments included in the baseline

Appendix A

Estimated Figure to match MPIG reinvestment				
over next 5 years	**£2.50**	**41,250**	**D**	This to be reconciled at end of period.
Excess Available		**£29,116**	**(A minus B, C and D)**	
Less:				
Contractual items paid "in error"		**£4,116**		eg Trade Waste, Excess Premises costs etc
PMS "Premium"		**£25,000**		

Services that Practice Consider should be paid out of the above

Service 1	x
Service 2	x

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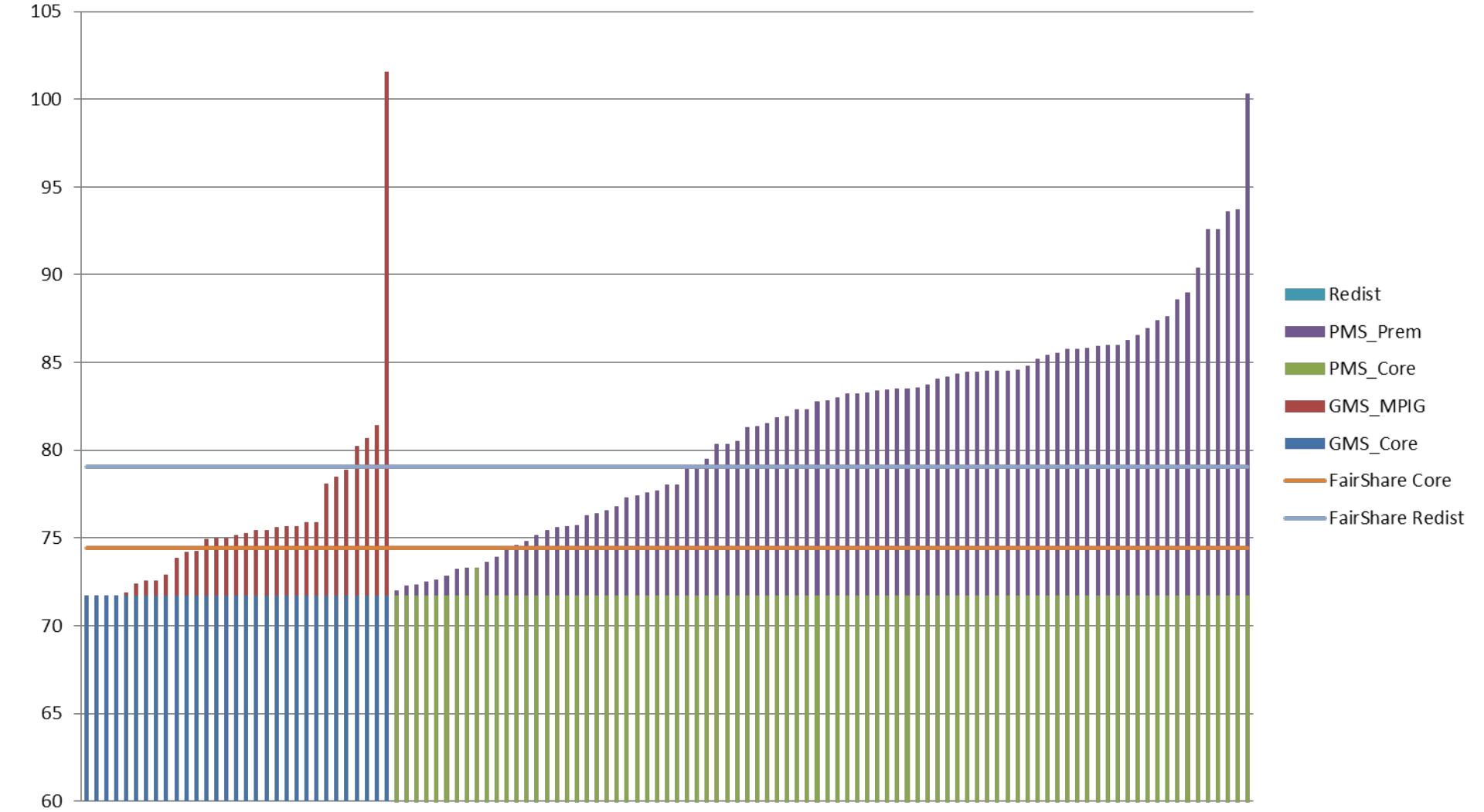
Appendix B

PMS Review – NEW Devon CCG Practice Movement to Equity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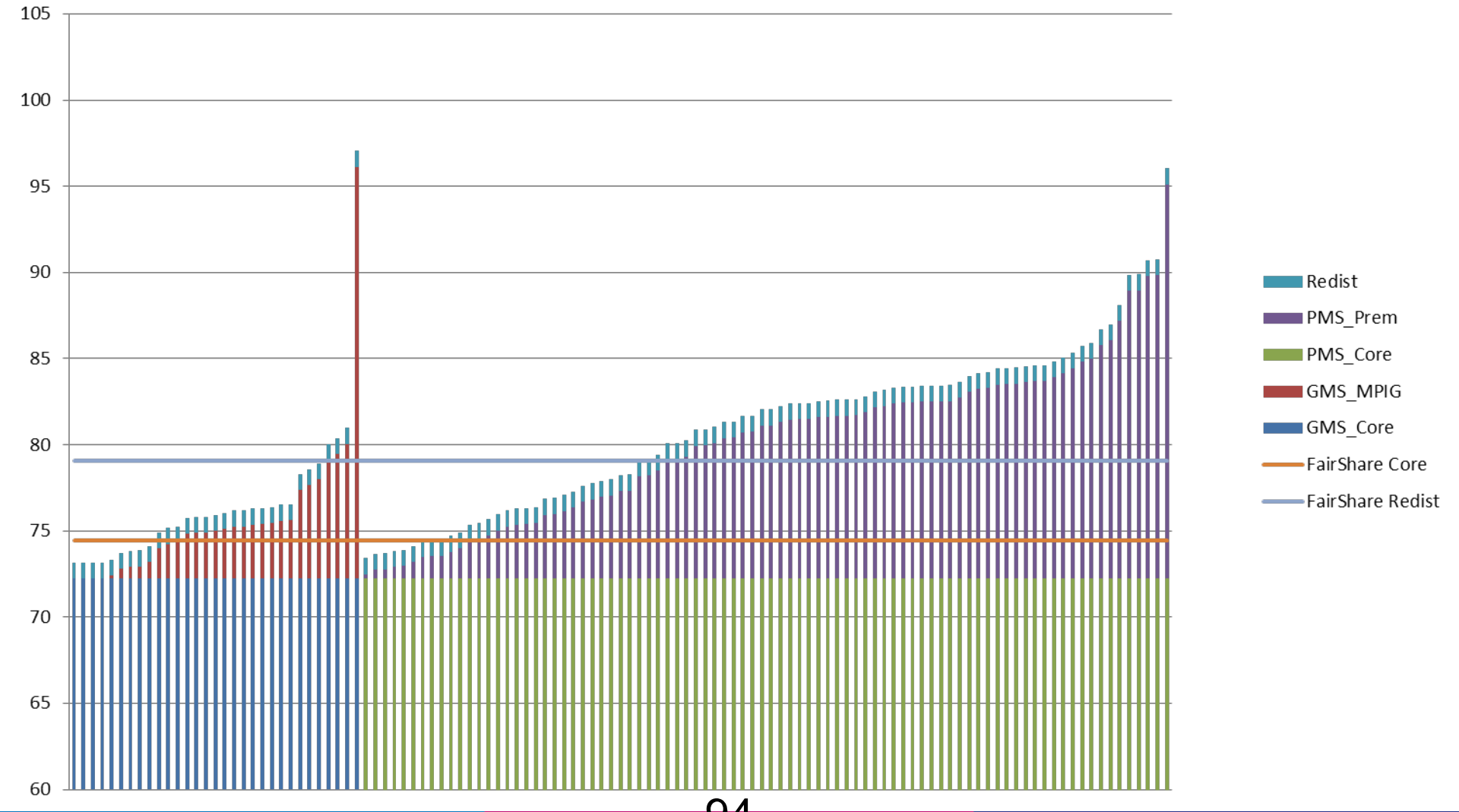
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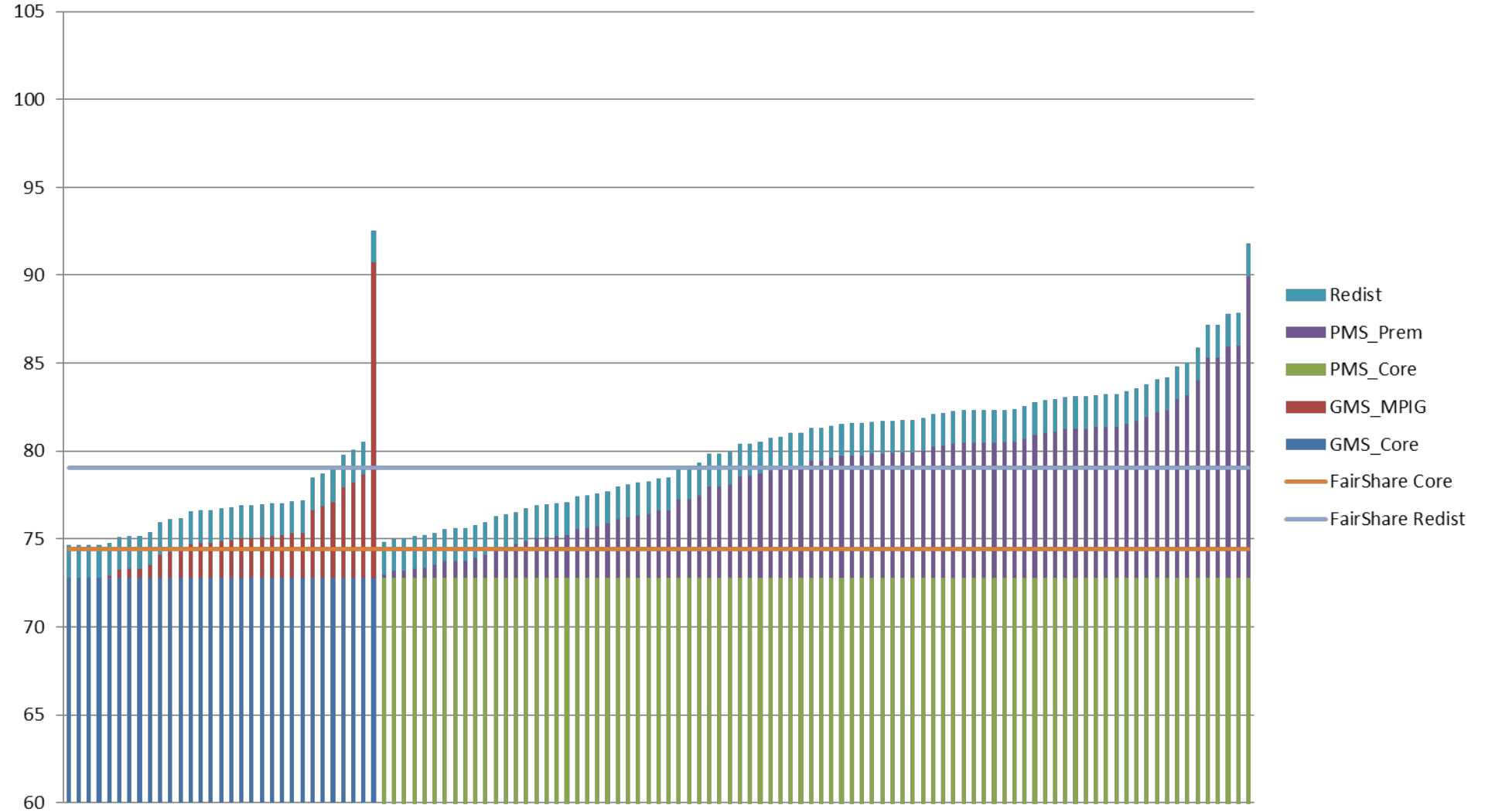
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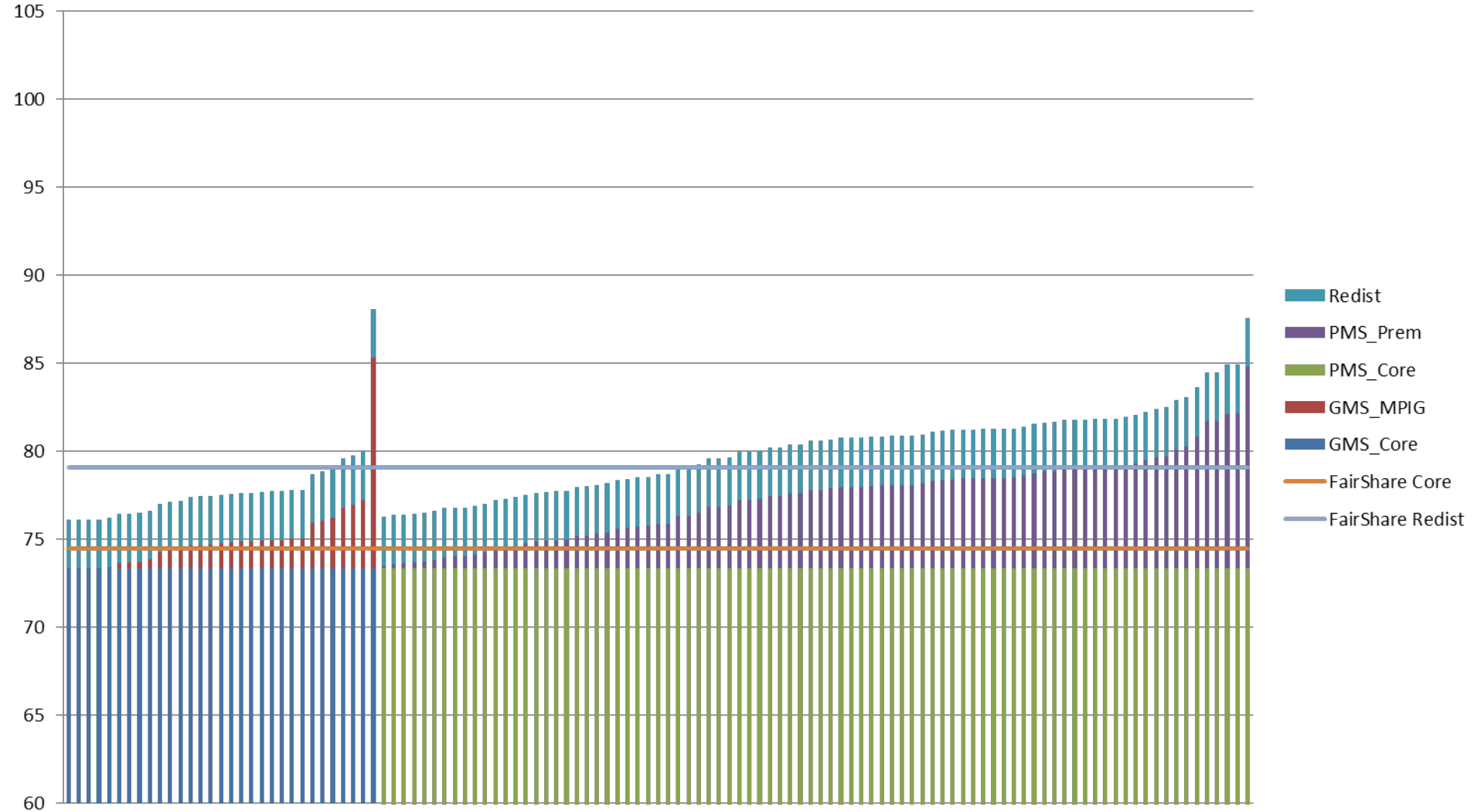
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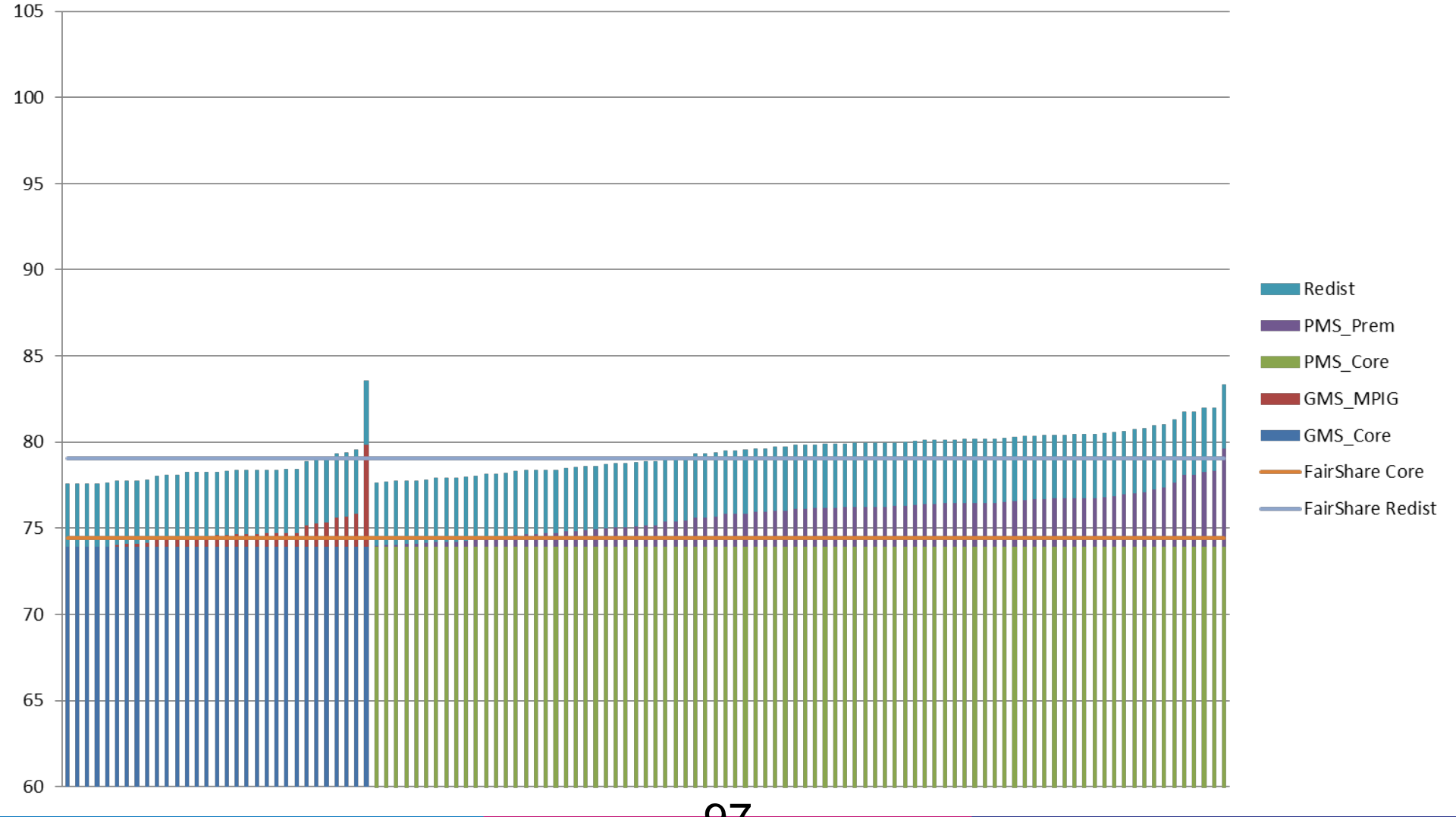
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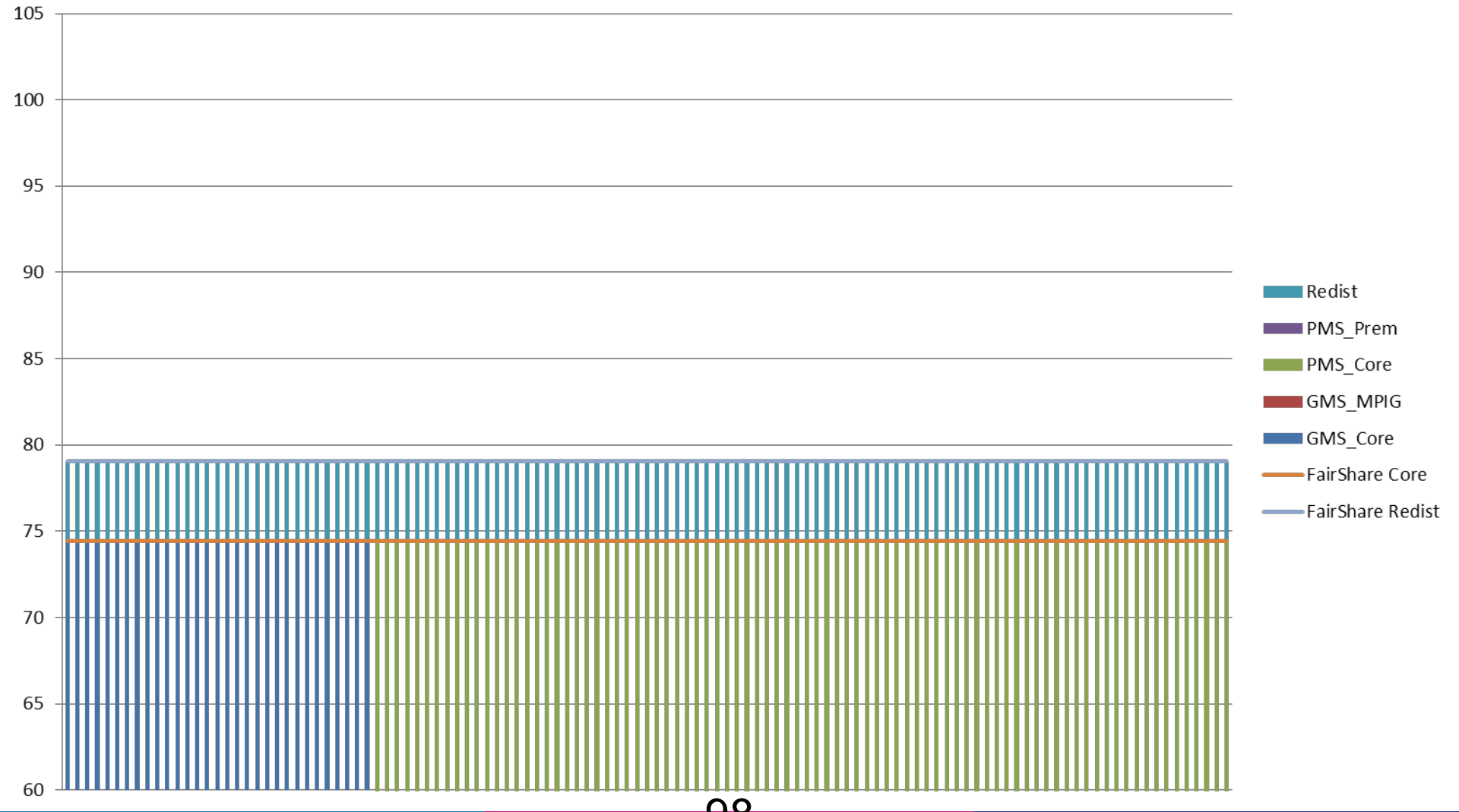
2020/21

Item 14



Appendix C

NHS England South (Southwest)

PMS Review: principles, process and timeline

1. Introduction:

This paper sets out the arrangements which will operate across NHS England South West to undertake the contract changes associated with the national requirement to review PMS contracts. The PMS review is to ensure a mirroring of GMS payments in an equivalent PMS contract model. Any commissioning outside of this is the responsibility of the CCG.

The February 2014 national guidance provides the strategic context for the review process. The process should also be seen alongside the move towards delegated commissioning of general practice primary care so that any non-contracted essential services reflect the priorities of individual CCG's and enable them to re-shape the wider local health and care system. The review process is designed to ensure that NHS England together with individual CCG's are able to secure best value from future investment of the premium element of PMS funding. In implementing the PMS review process we will ensure that there is an open and transparent process with no surprises for practices. We will also ensure that no practice is worse off on a PMS contract than if they returned to GMS. Specifically the guidance states that the review process is designed to ensure available resources for investment over and above core funding for contracted essential and additional services expected from all GP practices meets the following criteria:

Extract from February 2014 guidance:

Reflect joint NHS England/CCG strategic plans for general practice primary care. *The use of any premium funding over and above funding for core services should reflect strategic plans for primary care that have been developed jointly between NHS England and CCGs and support a more integrated approach to delivering community-based services, including general practice. This should include joint or collaborative commissioning arrangements between NHS England and CCGs including pooling of funding where appropriate.*

a. ***Secure services or outcomes that go beyond what is expected of core general practice or improving primary care premises.*** *There should be no premium funding that is not tangibly linked to providing a wider range of services, or providing services to higher quality standards or providing services for a population with specific needs that are not adequately captured by the Carr-Hill formula. Funding could also be used to support improving the quality of general practice primary care premises, for example, to support delivery at scale.*

b. ***Help reduce health inequalities.*** *Premium funding should be used as far as possible to help reduce health inequalities. This may include, for example, providing funding for practices that provide services for populations with specific needs, e.g. homeless people.*

c. ***Give equality of opportunity to all GP practices.*** *In line with the principles of equitable funding, all GP practices should have the opportunity of earning premium funding if they are capable of meeting the required standards. The only exception to this is when the funding is being used to reflect a specific population served by a particular practice. For instance, where a basket of services is defined that practices have to provide – and KPIs that they have to meet – in order to earn additional funding, the opportunity to provide these services should not be restricted to current PMS practices. Equally if premium funding is intended to improve the quality of primary care premises this should also not be restricted to current PMS practices.*

d. ***Support fairer distribution of funding*.*** *Premium funding should be used in a way that, where possible, supports fairer distribution of overall funding. The publication by NHS England of general practice primary care funding at an illustrative CCG[1] level will give a clearer sense of the total resources for a local health community and support moving towards a fairer allocation of those resources.*

2. The key actions required are:

a. NHS England needs to review the funding for each PMS practice and identify the amount that is paid over and above the Global Sum Equivalent. (this was previously known as the premium). Over the 5 year period it is the intention that no PMS practice will have an income below that which it would receive if it returned to a GMS contract.
b. NHS England needs to share the financial information with each practice at the same time the practices will be told that this funding will start to be reduced from 1st April 2016 and it will be for CCGs to decide how to reinvest this money
c. Practices will be asked to identify what services they provide to earn this additional funding
d. Where practices have identified a service that is funded through the premium the details will be shared with the CCG who will make recommendations to NHS England about whether the CCG wishes to continue to fund these services or whether they will invest in the wider provision of the service from other GP practices. As the contract holder NHS England will be responsible for giving a practice six months' notice if it is not intended to continue to commission a supplementary service.
e. Where the CCG decides that they do not wish to commission a service and this might impact on service delivery for local people it may require a stakeholder engagement process. NHSE will work with each CCG to alert Health Overview and Scrutiny Committees of the background to the PMS review process as soon as possible and

[1] * National guidance indicates that fairer distribution of funding should be achieved at a CCG level

commence formal engagement on any consequent changes to service delivery (where applicable)

f. In April 2016 the changes will be implemented. It should also be noted that the intention is to move all PMS practices on to the new standard PMS contract that has been produced by NHS England from April 2016. This will ensure that all PMS practices are on the most up to date contract which reflects all the recent changes.

g. Where a practice considers that the changes will have a destabilising impact and that it is unable to deliver its core service it may wish to propose changes to practice boundaries, closure of a branch surgery or ultimately give notice of contract termination. In such situations the existing NHS England processes and timelines will be applicable.

3. NHS England South - Common principles and processes to be applied to PMS Reviews

Across NHS England South agreement has been reached on a common set of principles and some processes which will be followed to ensure fairness and consistency of approach. These principles reflect the developments since publication of the 2014 guidance about the review process and in particular reflect the increasing role of CCG's in commissioning general practice primary care.

a. **Overall aim of PMS review –** The PMS review is to ensure a mirroring of GMS payments in an equivalent PMS contract model. Any commissioning outside ofthis is the responsibility of the CCG. Regions may have regard for national funding streams such as growth for general practice primary care, should it become available, which must be applied in accordance with the accompanying guidance. In some cases it may be considered that a contractor could deliver a service that falls outside of contracted essential services because it is in line with the joint commissioning intentions of NHS England and CCG and is demonstrated to meet the needs of the population. However the agreed contractual mechanism for the provision of this service should be outside of the PMS agreement.

b. **End point –** this was confirmed as 2021 for all PMS practices in that all negotiations are complete and monies recovered in full, regardless of the size of impact of the PMS review on individual practices.

c. **Right of return to GMS –** any practice has a right of return from a PMS contract to a GMS contract. This may be particularly relevant to PMS practices whose income is below that that would be applicable if they held a GMS contract.

d. **Pace of change –** the pace of change to be flexible this is to allow sub regions to recognise earlier decisions and commitments. A request for a shorter timescale can also be received from the practice outside of the regions plans and this was an option the regions would support. However the default position will be that any

premium funding received by a practice will be reduced in five equal instalments commencing from April 2016. In each year the reduction will be set against the annual growth allocation for GMS contracts.

e. **Calculation of premium** – The regions agree that the calculation should match the funding and services that are available under the GMS contract. Any other funding streams can be documented as separate lines but should not form the basis of the premium payment.

f. **Reinvestment of funds** – in line with national guidance all of the returned premium funding will be made available to the CCG where the PMS practice sits.

g. **Payment method** - the PMS review calculations would be based on weighted patients rather than actual patients to account for variation in population need, recognising this will create differences in the impact the review will have on some practices than others. Where contracts are currently based on raw population data they will be moved to reflect the weighted population before April 2016

h. **Information to be shared –** The initial baseline assessment reflecting current income paid via the PMS agreement will be shared with practices. There are a number of options for doing this and agreement will be reached locally on the most appropriate. It is important that the practice recognise the figure presented and understand the information provided to ensure negotiations can be productive and time efficient. Options considered include:

    a. Individual meetings with each practice where information could be tabled at the meeting or information could be provided in advance.

    b. Larger meetings to set out principles under which negotiations would be held, which could be followed up with individual practice information being shared. Supplemented by arrangements to meet with individual practices as necessary

i. **Contract documentation –** The regions will take this opportunity to move all providers to the nationally published PMS contract documentation and consideration given to any requirement to move from a health body status to non-health body status and vice versa.

j. **Financial wording and schedule** -the regions will work together to create a standard financial schedule to include detail of weighted patients, list size changes and so forth. Some NHS England payments for example immunisation fees will be removed from the contract and be replaced by Item of Service payments from April 2016 (see appendix 1 for worked example of how such changes impact on an example practice). The minor surgery DES is a historic anomaly as an NHS England commissioned service and will be treated along-side LES's to enable CCG's to make locally appropriate commissioning decisions.

k. **Prioritisation of reviews –** The prioritisation of reviews should be agreed with CCGs. Where the impact is deemed by the region to be large early discussions will be undertaken to allow the revised funding arrangements to be transitioned over the maximum period. The regions agreed that it will be the gross sum that is deducted from practices in each financial period. This sum will be returned to the relevant CCGs to allow them to outline their commissioning strategy and re-commission services in line with this and the funding available in that year.

l. **Support tools** – As a result of the PMS review it is possible that some practices will be or consider themselves to be destabilised as a result of the re-basing of their funding. NHS England South West has commissioned a GP Sustainability and Transformation project. Whilst related to the wider changes impacting on GP practices this may also be helpful to those who regard their practice as adversely affected by the outcome of the PMS review process. This project is focused on developing and offering a range of support resources to General Practices across the South West. The overarching aim is to support General Practices in achieving and maintaining sustainability as business units, and offer assistance in their individual and collective attempts to explore and adopt business change and transformation through collaboration with each other.

The project will offer the following:

- Business 'Health Check' tool – a set of questions aimed at enabling a General Practice to reflect and consider their current status as a sustainable entity
- Guided facilitation to enable Practices to actively consider options and ways forward, as well as help explore how to reach consensus
- Resource materials which will describe a range of options and introduce a 'next steps' approach
- Project management expertise and mentoring to enable initiation, management and delivery of desired outcomes
- Documented examples of 'good practice' in General Practice innovation and transformation

m. Regions will also consider what toolkits or guidance (e.g. the national framework for step-in arrangements) might support the practice and the NHS England team in these circumstances to reach the best solution.

n. **Working with practices where it has not been possible to reach agreement** – The region agreed that in such circumstances the current PMS agreement would need to be terminated. If the practice wishes to retain is contractual relationship with NHS England it would need to accept the terms of the PMS review or consider reverting to GMS contract arrangement. Regions should give consideration to contingency plans for practices not going forward with either a PMS or GMS contract for future provision of primary care services. The regions should consider what contingency would like depending on where the practice is located within the regions geography.

o. **Communication and engagement -** As commissioners of general practice primary care services NHS England has the same statutory duty place upon them as the CCGs to engage with patients and the public where there is to be a change to existing service provision and to ensure that services current or planned meet patient need within the financial envelope available. CCGs will have an on-going process of engaging with patients that is embedded in

their organisations which should be used to inform their general practice primary care strategic/commissioning plans. It is important to recognise that patient engagement is not a one off exercise; rather it should be an on-going process whereby the commissioner is consistently listening to the patient voice so that the needs of the population may be reflected in the service delivery and the commissioning intentions ultimately decided upon. There is a need for NHS England to work with the CCGs and their communications teams to ensure patient opinion is taken into account and reflected in local commissioning plans being facilitated with the timely sharing of information. NHS England will ask individual CCG's to support it so there is an NHSE led joint briefing of each Health Overview and Scrutiny Committees on the background to the PMS review process in preparation for any more detailed engagement which might be required if there is a proposed change to service delivery. It is intended that the funding released from PMS review and MPIG will be reinvested in general practice primary care service provision and so must be reflected in the commissioning intentions.

p. **Consultation** – Where following the review process a CCG decides it does not wish to re-commission a service and this would impact on local patients there may be requirements for stakeholder and/or public consultation. NHSE is clear that as the contract holder it is responsible for giving notice of any such change. NHSE and the relevant CCG is unlikely to be able to begin a public engagement process about specific service changes until the CCG has a fuller understanding of the services they may wish to re-commission and the premium funding that will become available. Further clarity is currently being sought in relation to the relevant legal requirements and guidance a further update will be provided in due course.

4. Principles to inform CCG re-investment planning:

a. All funding released must be reinvested in general practice primary care provision and be in line with the primary care investment plan for the CCG. CCG strategies and associated primary care investment plans will reflect the 5 Year Forward View including the expectation that general practice primary care will need to work at scale to deliver a wider range of services and improved access.

b. The first call on available funding will be to replace provision currently delivered within an equivalent PMS contract but covered by existing DES and LES agreements or LA contracts for other practices within the CCG. This funding will be excluded from the calculation of the premium.

c. The next priority will be for CCG's to review the 'supplementary services' identified by practices as currently delivered. Where there is a wish to re-commission such services GGG's will need to plan to utilise funding released taking account of the requirement to ensure equality of opportunity except where it can be demonstrated that the supplementary service reflects the unique needs of a practice population. Where a CCG decides that it does not plan to commission an 'supplementary' service this will be reflected in published commissioning intentions and practices will be given a 6 month notice period by NHS England.

d. Whilst policy objective to secure fairer funding remains the review process for investment above core needs to reflect local circumstances and minimise the potential disruption and destabilisation to PMS practices. The predecessor PCT's for some CCG's had undertaken recent PMS contract reviews and in consequence a CCG may take the view that the benefits of a further review of investment in 'supplementary services' are likely to be outweighed by the potential risks. CCG's taking this view will however need to ensure that this approach carries the support of their member practices and be mindful of the requirement to ensure that all practices have an opportunity to earn the additional income associated with 'supplementary services' that are not related to meeting the needs of a specific population.

e. NHS England recommend that CCG's use a proportion of the available funds on a non-recurrent basis in order to resource the change process or other one-off investment required to deliver the 'at scale' solutions agreed for the local area.

f. NHS England will retain an oversight and governance role in assuring that planned CCG investment meets the criteria set out in this document and where used recurrently is funding specific supplementary services over and above core.

5. Governance arrangements and timeline for the PMS Review process in the South West:

The NHS England South West Executive Team will retain overall accountability for implementing the PMS review process and ensuring fairness and consistency in line with national and South of England objectives and guidance.

The Primary Care Oversight Groups for DCIOS and **Primary Care and Public Health Commissioning Forum** for BNSSSG will provide more local oversight and act as **the Project Boards** for the review process. The operational aspects of the review will be undertaken by sub-committees through the **PMS Review Steering Group** (already in place in DCIOS and equivalent arrangements to be established for BNSSSG)

It is important that the review process proceeds in a timely manner so that individual practices have a clear understanding of the changes in expected income and earnings opportunities at the earliest date. CCG's will need information about the income available for redistribution, together with current non-core contractual commitments where a future re-commissioning decision will be required. Practices also need to be given an opportunity to set out details of other services which are not specified in current contracts nor covered by existing LES specifications which they would like CCG's to consider re-commissioning

NHS England South West Primary Care contracts team will ensure that it provides timely information about the anticipated financial impact of the PMS review to each CCG and constituent practices. This will include schedules of any additional services specified in current contracts about which a decision on re-commissioning or otherwise is required. NHS England South West will also provide a template for completion by each practice where they can set out details of any supplementary services not specified in contracts nor covered by an existing LES or DES which will require a CCG commissioning decision. The Primary Care contracts team will work with CCG's to establish an appropriate in year reporting and monitoring process.

Appendix C

Each CCG may need to update their current strategy including setting out a **Primary Care Investment Plan** which will inform the decisions about the targeting of the funds available for reinvestment. NHS England will provide CCG's with copies of the completed templates re supplementary services so that CCG's can determine their future commissioning intentions in respect of those services.

CCG's will publish their commissioning intentions in relation to supplementary services and communicate with practices setting out details of services which are being de-commissioned and will not be part of contracted activity from 1 April 2016 or a specified later date. NHSE working with each CCG will commence an engagement process (followed by formal consultation where indicated) where a practice population might be expected to experience a reduction in local service delivery/access as a result of such decisions.

Where **CCG's** wish to commission a specific service within the transition period to 2021 but are only able to fund the development in other practices once funding has been released it will legitimate to plan a phased roll-out commencing with full or partial reinvestment against the new specification in those PMS practices who would otherwise have to curtail a service and then recommence it at a future date.

Appendix C

ACTION PLAN AND TIMETABLE

ACTION	TIMESCALE	RESPONSIBLE FOR DELIVERY	COMMUNICATION AND DECISION
NHS England to establish a Steering Group or equivalent for BNSSSG	**By 29 May 2015**	**Lesley Woakes**	Rationale and reporting arrangements to be notified to Primary Care and Public Health Commissioning Forum
NHS England needs to review the funding for each PMS practice and identify the amount that is paid over and above the GMS rate. (this sum was previously known as the premium)	**By 30 April 2015 (DCIOS)** **By 29 May 2015 (BNSSSG)**	**Primary Care Finance Leads** **Michael Stone** **Rebecca Bull**	**PMS Steering Group** to agree dates and arrangements for local briefing meetings to take place by end of June 2015
NHSE will share preliminary information about the premium for practices in BNSSSG and meet with CCG's before the information is shared with individual practices	**Between 29 May 2015 and 20 June 2015**	**Pam Smith/Clive Coleman/Rebecca Bull**	Ensure local knowledge is utilised so that initial queries can be resolved and there is joint ownership of the figures being circulated to practices
Prepare letter to practices including template re supplementary services	**By 29 May 2015 (DCIOS)** **By 3 June 2015 (BNSSSG)**	**Heads of Primary Care**	Draft to be shared with CCG's and LMC
NHS England needs to share the financial information with each practice. At the same time the practices will be told that this	**By 29 May 2015 (DCIOS)** **By 30 June 2015 (BNSSSG)**	**Heads of Primary Care** in conjunction with CCG Primary Care Leads	NHS England send letters to individual practices sent **including dates of briefing meetings**

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ACTION	TIMESCALE	RESPONSIBLE FOR DELIVERY	COMMUNICATION AND DECISION
funding will start to be reduced (net of growth) from 1st April 2016 and it will be for CCGs to decide how to reinvest this money.			
CCG's to review and where necessary refresh their Strategy including outline setting out a Primary Care Investment Plan showing priorities for re-investment of funding released	**By end of July 2015**	**CCG Heads of Primary Care**	**CCG Governing bodies** to approve and publish Primary Care Investment Plans ensuring this is made available to all constituent practices and to **PCOG**
Practices will be asked to complete template to identify what services they provide to earn additional funding	**By 10 July 2015 (DCIOS)** **By 10 August 2015 (BNSSSG)**	**PMS Practices**	Explanatory notes with template plus briefing meetings
Where practices have identified a service that is funded through the additional funding the details will be shared with the CCG who will make recommendations on whether they will continue to fund these services or whether they will invest in other areas	**Confirmation of funding for services covered by an existing LES or DES** **CCG decide whether it wishes to re-commission other supplemenary services by 31 August 2015 (DCIOS) and 15 September 2015 (BNSSG)**	**CCG Primary Care Leads** with input from **NHS England** re services covered by NHS England payments	**NHS England** to confirm future NHS England payments (excluded from the premium) **CCG's** to write to practices to confirm which services are covered by an existing LES or DES together with information re specification and

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ACTION	TIMESCALE	RESPONSIBLE FOR DELIVERY	COMMUNICATION AND DECISION
			funding **CCG Governing body** to decide on re-commissioning or cessation of other 'supplementary services' and notify NHSE and practices of intent
Using the outcomes from the CCG review process NHSE will prepare a risk and impact assessment for discussion with CCG's and other key stakeholders in order to inform decisions about consultation requirements and CCG commissioning plans	**September 2015 onwards**	**NHSE with CCG input and support**	**NHSE and CCG's to advise local steering Group and PCOG** of review outcome including the risk and impact assessment NHSE and CCG's to develop specific engagement and communication plans in line with local decisions/expected impact in each CCG area
NHSE supported by CCG's to commence engagement process re outcome of their review of 'supplementary services' and where necessary plan formal consultation	**Initial briefing about PMS review process to each HOSC June/September 2015** **Follow up engagement and where appropriate formal consultation September 2015 onwards**	**NHSE supported by CCG Primary Care Leads** with support from Heads of Primary Care	**NHSE and individual CCG' s with LMC, HOSC and other stakeholders**

Appendix C

ACTION	TIMESCALE	RESPONSIBLE FOR DELIVERY	COMMUNICATION AND DECISION
NHS England to offer support to practices and where necessary develop contingency plans to step-in/re-provide services if practices give notice or are given notice in the event of failure to agree	**September 2015 and on-going**	**Heads of Primary Care** with support from NHSE SW General Practice Sustainability and Transformation project and CCG Primary Care Leads	**Steering Group and PCOG** to provide strategic oversight and ensure solutions are aligned with strategic intent
CCG's to publish commissioning intentions for reinvestment from April 2016 including continuation of services, new LES opportunities and non-recurrent investment	**CCG's** to publish commissioning intentions by **30 November 2015** **Practices** to confirm their intent re take up the LES or other investment opportunities by **31 December 2015**	**CCG's**	**PCOG** to confirm plans re in line with principles set out in this document
Move all PMS practices on to the new standard model PMS contract that has been produced by NHS England. This will ensure that all PMS practices are on the most up to date contract which reflects all the recent changes.	**By April 2016*** *Subject to national timescales and progress to develop the new standard model contract	**Heads of Primary Care**	Revised contract documentation to be circulated as soon as available for information

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

Recommendation: For information

1. Integrated Care Organisation relationships / collaboration

On 1 October 2015, a number of the senior team attended the official launch of the new ICO, Torbay and South Devon NHS Foundation Trust (TSDFT), the first single organisation in the country responsible for acute and community health and social care.

The executive teams continue to work closely together, and a Board to Board meeting is being arranged for January 2016 to strengthen collaborative working further. A number of key meetings continue to support the transformation work detailed within the full business case.

2. Vanguard (Urgent and Emergency Care)

Following the successful bid for additional support, work is on-going to increase access and choice of urgent and emergency services. The senior team have decided to focus on five high impact workstreams, with their aspirations, summarised below:

Workstream	By April 2016 we said we would achieve ...
111	Increased integrated 111 services. Increased calls to 111.
Mental health	Trialling models for all age crisis response, risk stratification and measures of performance (timescale to be agreed).
Self-care	Increase self-care services locally, including NHS Choices, targeting resources where 999 and A&E activity is highest, in areas of deprivation. Targeted patient and public engagement events in Torquay, an area of significant deprivation, to promote self-care and 111 as A&E alternatives.
Shared records	Primary care records shared with Out of Hours providers.
Urgent care centres	Rapid development of UCC facilities in at least two centres, prioritising areas of higher deprivation to reduce inequalities. Co-located primary care facilities with A&E / Urgent Care Centre facilities in at least two locations.

The local System Resilience Group oversees the management of the Vanguard objectives. Simon Tapley (Director of Commissioning and Transformation) and Liz Davenport (Chief Operating Officer, TSDFT) have been nominated as the executive leads for this work, and Christine Branson (Head of Unplanned Care) is the senior manager driving this work forward for the CCG.

On Wednesday 21 October 2015 a meeting is planned for the wider Vanguard representatives including the national Vanguard team, clinical leads, subject matter experts, patient representatives, the regional

tripartite lead and members from the new care models team. Individuals will agree how improvements in patient care locally will be achieved within one, two and three years. An in-depth understanding for year one will include:

- The aims, objectives and clinical and non-clinical outcomes for the new care model;
- The progress to date and the current position against the objectives;
- Best practice / shared learning across all the vanguard sites;
- The support required to overcome identified barriers and accelerate delivery;
- The partnership agreement between the new care models team and the Vanguard.

3. Pioneer

Funding has been secured for a dedicated individual to manage the final parts of the Pioneer project as it transitions into ICO workstreams. An evaluation of how the ICO was formed, what worked well etc. will be included, and outcome reports will be shared with the JoinedUp Board.

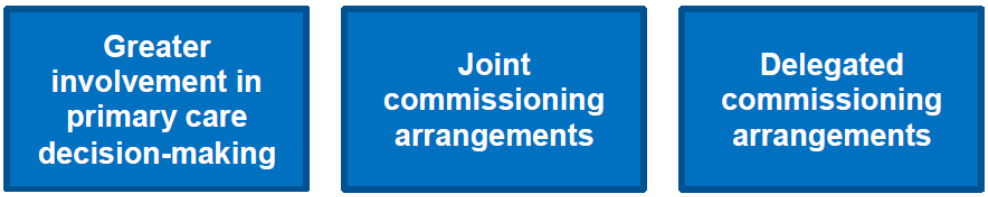
A further bid is in train to fund work to enhance patient support packs and engagement with patients about the new care model.

Leadership support funding has already been allocated to develop locality leads, in the form of delivery of a bespoke Foundation Leadership programme.

4. Primary Care Co-Commissioning

Engagement with GPs

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems. There are 3 primary care co-commissioning models CCGs could take forward:



On the 1 and 7 September, our CCG primary care leads hosted engagement events with member GPs to:

- Recap the 3 models above;
- Discuss our successes at level 1 and examples of frustrations at this level;
- Debate why now is the time to move to level 2 and the planned due diligence surrounding this.

The feedback from these sessions was positive, and there was a consensus that joint commissioning is the right thing to do. People felt it would:

- Provide further insight into the implications of fully delegated commissioning;
- Facilitate whole-system change and pooled funding with NHSE where appropriate.

Primary Care Co-Commissioning Committee

Monthly meetings commenced in shadow form this August, going live in October. The remit is to:

- Jointly commission primary medical services for the population of South Devon and Torbay;
- Make primary care commissioning decisions;
- Oversee the development and implementation of the primary care strategy / work-plans;
- Oversee the implementation of the CCG statutory duty to improve primary care quality.

5. Future Models of Care

Following community services consultation in our Coastal locality late 2014 / early 2015, further engagement is planned for the New Year. We were initially hoping to commence this exercise pre-

Christmas 2015 although work is currently on-going to ensure all the necessary information is available to help inform this process.

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

14 October 2015

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 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 4.30am 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 Councils Website at (http://www.devon.gov.uk/dcc/committee/mingifs.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					
16 Nov 2015 Joint Member Development with Place SC	*Performance*	*Understand and interpret performance information for scrutiny purposes*	*Head of Services for Communities*	*Briefing*	*Member Development Session*
23 Nov 2015	In-Year Budget Briefing	Delivery of the 2015/16 budget	All Heads of Service	Report	Committee meeting only
	HR future developments	Involvement of scrutiny in the changes to the HR service	Cabinet member and HR Manager	Report	Committee meeting only
Member Development	*Sickness absence and stress*	*HR Policy for managing sickness absence and stress incl. performance*	*HR Manager*	*Presentation / workshop*	*Possible task group / spotlight review*
	Redundancy	*Changes to Redundancy Policy and impact on the Council and staff*	*HR Manager*	*Presentation / Workshop*	*Member Development Session*
	Budget	*To equip Members with the knowledge they need to be able participate in the development of the budget and engage in meaningful budget Scrutiny*	*Deputy County Treasurer*	*Presentation/questions and answer session*	*Member Development Session*
22 Jan 2016	2016/17 Budget	Scrutinise 2016/17 budget proposals for Corporate Services	All Heads of Service	Report	Committee meeting only
29 Jan 2016	Joint Scrutiny Budget Day	2016/17 budget proposals across services, their implications and recommendations to Cabinet & Council	All Heads of Service	Report	Committee meeting only
24 Mar 2016	Scrutiny & Commissioning Task Group Report				
Member Development	*Open Data*	*Role of Members as champions of open data*	*Head of Services for Communities*	*Presentation / workshop*	*Member Development Session*

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
Place Scrutiny Committee					
16 Nov 2015	In-Year Budget Briefing	Delivery of the 2015/16 budget, incl. update on Waste Task Group recommendations and impact of electricity prices on street lighting	All Heads of Service	Report	Committee meeting only
	Civil Parking Enforcement	Cost-neutrality and approach to parking on pavements/footpaths (see Minute *42)	Head of Highways, Capital Development & Waste	Report	Committee meeting only
	Flooding Task Group Update	Recommendations, including progress with flood alleviation schemes	Head of Planning, Transportation & Environment	Report	Committee meeting only
	Future Library Service	Update – standing item	Head of Services for Communities	Report	Committee meeting only
	Rollout of Connecting Devon and Somerset superfast broadband	Update – standing item	Head of Economy & Enterprise	Report	Committee meeting only
Member Development	*Peninsula Rail Task Force (PRTF)*	*Progress since February 2014*			
	Performance	*Understand and interpret performance information for scrutiny purposes*	*Head of Services for Communities*	*Briefing*	*Member Development Session*
7 Jan 2016	Future Library Service	Update – standing item	Head of Services for Communities	Report	Committee meeting only
	Rollout of Connecting Devon and Somerset superfast broadband	Update – standing item	Head of Economy & Enterprise	Report	Committee meeting only
Member Development	*Connecting Devon & Somerset Superfast Broadband*				
21 Jan 2016	2016/17 Budget	Scrutinise 2016/17 budget proposals for Place Services	All Heads of Service	Report	Committee meeting only
29 Jan 2016	Joint Scrutiny Budget Day	2016/17 budget proposals across services, their implications and recommendations to Cabinet & Council	All Heads of Service	Report	Committee meeting only
7 Mar 2016	Department of Transport 20mph Speed Limits, incl. Police representation	National guidance and discussion following Sept 2015 meeting	Head of Services for Communities	Report	Committee meeting only

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
Member Development	*Corporate Energy Manager*	*Meet and Greet*			
Jun 2016	Rail infrastructure	Possible future rail routes and resilience of the rail infrastructure	Head of Services for Communities	Report or task group	Committee meeting or Task Group
Possible Future Topics	Community Transport Review (Task Group)	See Minute *79			
People's Scrutiny Committee					
18 Nov 2015	In-Year Budget Briefing	Delivery of the 2015/16 budget	All Heads of Service	Report	Committee meeting only
	Children's Standing Overview Group	Update	Chair/Vice-Chair	Verbal Report	Committee meeting only
	Adult's Standing Overview Group	Update	Chair/Vice-Chair	Verbal Report	Committee meeting only
	Children's Centres Task Group	Update on progress	Task Group	Report	Committee meeting only
	Residential Homes	Outcome of residential homes closure programme	Head of Adult Social Care	Report	Committee meeting only
	Devon Safeguarding Children Board Annual Report 2014/15	Review the Annual Report	DSCB Chairman	Report of the DSCB Chairman	Committee meeting only
	Devon Youth Service	Update on progress of the establishment of a new organisation to deliver the Youth Service from April 2016.	Head of Children's Social Work and Child Protection	Report	Committee meeting only
	Performance Dashboard	Summary of performance	All Heads of Service	Report	Committee meeting only
8 Jan 2016	Children's Standing Overview Group	Update	Chair/Vice-Chair	Report	Committee meeting only
	Adult's Standing Overview Group	Update	Chair/Vice-Chair	Report	Committee meeting only
	Educational Outcomes Task Group	Review on school exclusions and issues relating to those academies which have not signed up to the *Eliminating Exclusions Protocol*	Scrutiny Officer	Report	Committee meeting only
	Care Leavers Task Group	Report of the Task Group	Scrutiny Officer	Report	Committee meeting only
	Safeguarding Adults Board Annual Report 2014/15	Review the report	DSCA Chairman	Report	Committee meeting only

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
	Deprivation of Liberty Safeguards	Review the safeguards in place, and the way in which risk is managed for those adults deprived of their liberty	All Heads of Service	Report	Committee meeting only
	LDP Performance	Review work to address underperformance and gap measures	Head of Education & Learning	Report	Committee meeting only
	Performance Dashboard	Summary of performance	All Heads of Service	Report	Committee meeting only
19 Jan 2016	2016/17 Budget	Scrutinise 2016/17 budget proposals for People's Services	All Heads of Service	Report	Committee meeting only
29 Jan 2016	Joint Scrutiny Budget Day	2016/17 budget proposals across services, their implications and recommendations to Cabinet & Council	All Heads of Service	Report	Committee meeting only
21 Mar 2016	Children's Standing Overview Group	Update	Chair/Vice-Chair	Report	Committee meeting only
	Adult's Standing Overview Group	Update	Chair/Vice-Chair	Report	Committee meeting only
	Internal Audit Plan 2016/17	Review the report	Head of Devon Audit Partnership	Report	Committee meeting only
	Performance Dashboard	Summary of performance	All Heads of Service	Report	Committee meeting only
June 2016	Children's Standing Overview Group	Update	Chair/Vice-Chair	Report	Committee meeting only
	Adult's Standing Overview Group	Update	Chair/Vice-Chair	Report	Committee meeting only
	Commissioning Domestic Abuse Support Services	Update	Director of Public Health	Report	Committee meeting only
	Performance Dashboard	Summary of performance	All Heads of Service	Report	Committee meeting only
Future topics	Social Care: Direct Payments and Personal Budgets	For details see Minute *93b	Scrutiny Officer and witnesses	Written and oral evidence	Task Group with report back to Committee
Health & Wellbeing Scrutiny Committee					
10 Nov 2015	Success Regime	Appointment of Lead Officer and progress	NEW CCG/Success regime	Report	Committee Meeting
	North Devon Consultation: 'Safe and Effective Care within our budget'	response to committee's comments at last meeting	NDHT	Report	Committee meeting

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
	Coastal Transforming Community Services	Review of the S Devon and Torbay Board decisions	S Devon/Torbay CCG	Committee report	Committee meeting
	Transforming Community Services (TCS)	Latest position	NEW Devon CCG	Report of CCG	Ongoing consideration
	Mortality Rates throughout Devon	Concerns raised by Cabinet member	Care Quality Commission/CCGs	Dashboard?	Committee meeting only
	Devon Partnership NHS Trust is making some transformational changes	Changes to St John's Court in Exmouth	DPT	Report	Committee meeting only
	2015/16 Budget	in-year review	Director of Public Health	Report	Committee meeting only
Jan 2016	Torrington Community Hospital	Ascertain if there are grounds to make a referral to the secretary of state for Health	NEW CCG NDHT	Previous committee reports	Task Group report
	Dentistry and appointment system	Difficulty to access NHS dentists and appointment waiting times		Report	Committee meeting only
20 Jan 2016	Joint Scrutiny Budget Day	2016/17 budget proposals across services, their implications and recommendations to Cabinet & Council	All Heads of Service	Report	Committee meeting only
	Axminster Community Hospital – reinstatement of inpatient beds	Task Group to review the local solutions and identify lessons learnt	NDHT	Reports	Task Group

HEALTH AND WELLBEING BOARD – FORWARD PLAN

Date	Matter for Consideration
Thursday 12 November 2015 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Strong and Supportive Communities) **Business / Matters for Decision** Better Care Fund Care Act Implications CCG Updates Joint Commissioning Strategies – Actions Plans (Annual Report) Prevention Strategy Update (Minute 169) Children's Safeguarding annual report (annually in September – moved from Sept) Child Sexual Exploitation – Multi-Agency Working (DT / JS) Adults Safeguarding – Annual Report NEW Devon CCG – Personal Medical Services **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 14 January 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Children, Young People and Families) **Business / Matters for Decision** Better Care Fund CYPF Alliance Plan *Cranbrook Health and Wellbeing Strategy (Tentative)* CCG Updates Delivering Integrated Care Exeter (ICE) Project – Annual Update **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 10 March 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Healthy Lifestyle Choices) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 9 June 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (Review / Refresh of Joint Health and Wellbeing Strategy / JSNA) **Business / Matters for Decision** Better Care Fund CCG Updates

	Other Matters Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 8 September 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 10 November 2016 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 12 January 2017 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Thursday 9 March 2017 @ 2.00pm	**Performance / Themed Reporting** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Report (TBC) **Business / Matters for Decision** Better Care Fund CCG Updates **Other Matters** Scrutiny Work Programme / References Board Forward Plan Briefing Papers, Updates & Matters for Information
Items to Add	Equality & protected characteristics outcomes framework Winterbourne View (Exception reporting)