Worcestershire County Council

Agenda

Health and Well-Being Board

Wednesday, 28 January 2015, 2.00 pm
County Hall, Worcester

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Health and Well-Being Board
Wednesday, 28 January 2015, 2.00 pm, Council Chamber, County Hall

Membership:

Full Members (Voting)

Cabinet Member for Health and Well-being	Marcus Hart (Chairman)
Cabinet Member for Adult Social Care	Sheila Blagg
South Worcestershire CCG Accountable Officer	Dr Carl Ellson
Cabinet Member for Children and Families	Liz Eyre
NHS England – Director of Finance	Brian Hanford
Redditch and Bromsgrove / Wyre Forest CCG Accountable Officer	Simon Hairsnape
Leader of the County Council	Adrian Hardman
Director of Adult Services and Health	Dr Richard Harling
South Worcestershire CCG Clinical Chair	Dr Anthony Kelly
Chief Executive, WCC	Clare Marchant
Chair of Healthwatch	Peter Pinfield
Director of Children's Services	Gail Quinton
Wyre Forest CCG Clinical Chair	Dr Simon Rumley
Redditch and Bromsgrove CCG Clinical Chair	Dr Jonathan Wells

Associate Members

South Worcestershire District Councils	Hannah Campbell
Voluntary and Community Sector	Carole Cumino
North Worcestershire District Councils	Anne Hingley
Westmercia Police	Supt. Mark Travis

Agenda

Item No	Subject	Presenter	Page No
1	**Apologies and Substitutes**		
2	**Declarations of Interest**		
3	**Public Participation** *Members of the public wishing to take part should*		

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Date of Issue: Tuesday 20 January 2015

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	notify Legal and Democratic Services in writing or by e-mail indicating the nature and content of their proposed participation on items relevant to the agenda, no later than 9.00am on the day before the meeting (in this case 9.00am on 27January 2015). Enquiries can be made through the telephone number/e-mail address below.		
4	**Confirmation of Minutes**		1 - 12
	For Decision		
5	**Worcestershire Public Health Annual Report**	Richard Harling	13 - 18
6	**Implementing the 2015/16 Better Care Fund Plan-Section 75 Agreement**	Frances Martin	19 - 26
7	**Pharmaceutical Needs Assessment**	Frances Howie	27 - 36
8	**Dementia Action Alliance, Carers Call to Action**	Frances Martin	37 - 44
9	**Crisis Care Concordat**	Richard Harling	45 - 56
10	**Local Government Declaration on Tobacco Control**	Chairman	57 - 62
	For Consideration		
11	**Access to Services for Deaf People**	Peter Pinfield	63 - 68
	For Information and Assurance		
12	**Health Protection Group**		69 - 74
13	**Autism Strategy**		75 - 76
14	**Carers Strategy**		
15	**Future Meeting Dates 2015** **Public Meetings** Wednesday 28 January Tuesday 3 March		

Item No	Subject		Page No
	Tuesday 12 May Wednesday 15 July Tuesday 30 September Tuesday 3 November All meetings start at 2.00pm. Venues to be arranged. **Development (Private) Meetings 2015** Tuesday 10 February Tuesday 14 April Tuesday 16 June Tuesday 13 October Tuesday 8 December All meetings start at 2.00pm and will be held at County Hall.		

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Health and Well-Being Board
Tuesday, 4 November 2014, 2.00 pm, Council Chamber, County Hall

Minutes

Present:

Mr M J Hart (Chairman), Dr C Ellson (Vice Chairman), Mrs S L Blagg, Mrs E A Eyre, Mr S Hairsnape, Mr A I Hardman, Richard Harling, Dr A Kelly, Clare Marchant, Mr P Pinfield, Gail Quinton, Dr Simon Rumley, Mrs C Cumino and Mrs A T Hingley

Also attended:

Frances Howie, Frances Martin and Richard Keble

261 Apologies and Substitutes

Apologies were received from Cllr. Hannah Campbell, Brian Hanford, Superintendent Mark Travis and Dr Jonathan Wells.

Cllr. Phil Grove attended on behalf of Cllr. Campbell.

262 Declarations of Interest

None.

263 Public Participation

There were two public participants.

Anne Duddington spoke on behalf of the three carers involved in the Carers Strategy Working Group and made the following main points about the Carers' Strategy Refresh:

- The working group only actually involved carers in person at one meeting and the document that was being presented to the Board bore little resemblance to the last version they saw,
- Carers and carers' organisations had been asking for updates on the strategy for over a year but the paper had only become available when the Board agenda was published,
- The vision, principles and outcomes were discussed in very broad terms at a meeting in March but no discussions had taken place since and even the definition of carer had changed since that early meeting,
- The term 'we' was used throughout the document without reference to whom this term refers,
- A small group of carers had looked at the document last week and felt it lacked evidence and used terminology that was not accessible. The carers on

the strategy group felt insulted by the document and felt it did not give the impression that their roles were valued,
- Good examples of strategies developed in partnership were the Learning Disability Strategy and the previous Carer's strategy.
- Finally carers were very unclear about what would happen next as the document did not state what type of support and services carers could expect from April 2015.

Colin Archer made a statement as a Board member of Carers Action Worcestershire which was a consortium of the four main carer focussed organisations in the county. He felt the Carers Strategy Refresh did not 'reaffirm the commitments originally made' as was claimed. He went on to make the following points:

- Early drafts of the strategy covered carers of all ages so it was a disappointment to find that the young carer's strategy would now be a separate document,
- They had concerns about the lack of health partner involvement and the fact that there was no mention of the NHS Commitment to Carers,
- 6 weeks was too short for the consultation period,
- They would like to know what approach would be taken to charging for services for carers which are currently provided free and there was no indication of the level of funding to be committed to supporting carers,
- The definition of a carer had been changed and they wanted to know why,
- Finally they disagreed with the statement that the 'statutory and voluntary sector partners would nominate a main contact to develop a detailed action plan and oversee implementation' because they felt that should be the role of the commissioner.

The Chairman thanked the public participants and stated that the Carers Strategy refresh would be discussed at item 6 on the agenda.

264 Confirmation of Minutes

The minutes of the meeting of 23 September 2014 were agreed to be a correct record of the meeting and were signed by the Chairman.

265 Autism Strategy Update

Richard Keble explained that following the Autism Act 2009, the National Strategy for Autism required local authorities to develop a local Autism Strategy and to appoint a lead commissioner which in Worcestershire was Elaine Carolan.

The strategy had been developed by the Autism Strategy Partnership Group which included adults with autistic spectrum conditions, family carers, third sector partners, Worcestershire Health and Care Trust, the Council and CCGs. The strategy gave the commitment by all partners to comply with national requirements.

Due to different legislative frameworks it was proposed that there be a separate Autism Strategy for Children and Young People and for an all age strategy to be developed over time.

It was proposed that there be a six week consultation with the outcome being brought back to the Board in January.

In the following discussion the following points were made:

- That although there were some different drivers for Adults and Children's strategies, in the long term the aim should be an integrated strategy. It was suggested that further work be carried out and then following an update in January one integrated strategy be produced, perhaps in March 2015.
- It was agreed that a longer consultation period would be preferable,
- It was queried whether any schools were included in the Strategy Partnership Group. When informed that that Schools were not specifically included in the consultation the Board requested for them to be included,
- The Board wished to know if employers and further education providers had been included in the production of the Strategy. It was pointed out that the Strategy was at present concentrating on adults so education providers were not included, but it was agreed that when they considered whether the adults and children's strategy could be better integrated they would look at options of including employers and educational establishments,
- It was confirmed that input had been received from the Health and Care Trust but CCG input could be improved and further training for staff around autism needed to be addressed. It was pointed out that the voluntary sector was likely to have an important role in supplying training.

In summary the Chairman explained that further work was required to integrate the Children's and Young People's Autism strategy with the adult strategy. The consultation would go ahead as planned but a progress report would be required at the January HWB meeting with a view to sign off one combined strategy in March.

RESOLVED that the Health and Well-being Board:

a) **Considered and discussed the content of the Draft Autism Strategy for Adults in Worcestershire;**

b) **Authorised consultation on this strategy and requested a progress report on the integration of the adults with the children and young people's strategy be brought back to the Board in January 2015 for consideration,**

c) **Request that the integrated strategy be brought back for consideration and sign off in March 2015.**

266 Carers Strategy Refresh

Richard Keble explained that the Carers strategy was being refreshed in the light of various policies and the Care Act 2014. The strategy covered adults aged 18 and over. A Young Carers' strategy would be brought to the Board meeting in January.

In response to comments already made by Board members regarding consultations it was suggested that the planned six week consultation could be extended and the final strategy would then return in March 2015.

The Chairman moved the motion that a twelve week consultation period would be more appropriate than six weeks. This was agreed by the Board who felt the extra time would be required to adequately consult with the number of carers' organisations in Worcestershire.

In answer to the question put by the public participants about the definition of a carer which had been changed in the refreshed strategy, it was explained that the definition now matched the definition in the Care Act.

Again following previous comments the strategy would be looked at to see if it would be possible to integrate the Adult and the Young People's strategy.

A Board member suggested that the strategy should be re-worked before it went out to consultation but generally

Board Members felt that if the process and what was being consulted on were clarified, the consultation should go ahead.

Worcestershire was a well-connected pioneer so should ensure it worked well with partners. The last carers' strategy had been considered a Worcestershire Strategy rather than a Council Strategy.The Chairman agreed it should be a Worcestershire Strategy and that the consultation should go ahead, but with a longer consultation time that allowed the Council to listen and be prepared to amend the strategy.

RESOLVED that the Health and Well-being Board:

a) **Considered and discussed the content of the Draft Adult Carers' Strategy for Worcestershire;**

b) **Authorised consultation on this strategy and requested that a progress report on the extended consultation and the integration of the adults with the children and young people's strategy be brought back to the Board in January 2015 for consideration,**

c) **Request that the integrated strategy be brought back for consideration and sign off in March 2015.**

267 The Better Care Fund

Frances Martin confirmed that the Better Care Fund (BCF) Plan had been approved with no conditions.

In the summer the Board had signed the agreement for the Better Care Fund forecast overspend. The Board had approved the use of £500,000 from winter pressures contingency monies, but had asked that action be taken to try to reduce the overspend. Action had been taken to mitigate the overspend and it had improved to a forecast £232,000 underspend taking into account the winter pressures contingency money.

Now the BCF plan was in place a huge amount of work was needed to ensure delivery.

When asked how it was planned to engage with the public it was explained that a plain language version of the plan was being developed which would then be distributed more widely.

RESOLVED that the Health and Well-being Board:

a) **Noted the full Better Care Fund Plan submitted on 19 September 2014,**

b) **Noted the current forecast position of 2014/15 Better Care Fund schemes and the further measures put in place to manage demand,**

c) **Supported the ongoing work (through the Well Connected programme) to implement the Better Care Fund Plan for 2015/16 in the context of the Worcestershire Five Year Health and Care Strategy. This would include development of an appropriate Section 75 agreement,**

d) **Would consider any proposals for redesign and re-commissioning of services funded by the Bettter Care Fund as they arose, including as they relate to integrated health and adult social care re-ablement and rehabilitation services.**

268 Health Improvement Group - Bi-annual Report

Frances Howie gave an overview of the Health Improvement Group (HIG) which was set up in March 'to lead, co-ordinate and ensure progress of action to improve health and well-being, focussing on health inequalities and the wider determinates of health and well-being in Worcestershire.' Members of the group have met three times and include District Councils, the Police, Housing, Voluntary Sector Representatives, CCGs and the University of Worcester.

The HIG supported and monitored the delivery plans of three of the four HWB priorities, the alcohol plan, the mental well-being and suicide prevention plan and the obesity plan. The HIG also considered District health and well-being plans. The HIG Annual Report would be presented to the HWB in May 2015.

Board Members queried what impact the HIG had and what outcomes were achieved. It was explained that this report was just an introduction to the work of the HIG and outcomes would be included in the individual plans which would be reported in the annual report.

In his '5 year View of the NHS' Simon Stevens looked to local leaders to take action about alcohol and obesity issues. Board members wished to know what actions

Worcestershire were taking. It was clarified that the plans for the priority areas were focussed and dealt with specific actions such as assessing planning applications for fast food outlets close to schools.

Each District Council had Health and Well-being Groups who had the support of Public Health consultants. Each area looked at issues which were relevant to the local area for example Malvern Hills had a project which looked at the high number of falls in their area.

RESOLVED that the Health and Well-being Board:

a) **Considered and commented on progress made between March and September 2014, and**

b) **Requested that the Health Improvement Group Annual Report be presented to the Board in May 2015.**

269 Consumer Experiences of the Health and Social Care Complaints System

Peter Pinfield explained that Healthwatch Worcestershire had produced a report about consumer experiences of the health and social care complaints system. The report had been well received by central government and Health and Social Care Organisations and he hoped that all HWB members could ask their organisations to look at their own complaints procedures and ensure that they were simple, compassionate and responsive to patients and service users.

He hoped that the possibility of a Worcestershire wide complaints model could be considered. As Worcestershire was a Well Connected Pioneer he wondered whether it could sit within the communication and engagement work stream and take place over the next 12-18 months.

Board Members were happy to consider a common set of standards rather than one combined complaints policy. They wished to ensure that Children's issues were included as well as adults and also to consider the impact on staff who were complained about.

RESOLVED that the Health and Well-being Board:

a) **Received and took note of the Healthwatch England Report "suffering in**

Silence…listening to consumer experiences of the health and social care complaints system,"

b) Asked the key stakeholders to raise the contents and recommendations of the report with their respective Boards, and

c) Should look at the possibility of developing a Worcestershire wide complaints model that incorporateed some commonly owned basic principles. This model would sit within the well connected communication and engagement work stream that was currently being developed as part of our integration of services strategic aim. A future report would then be provided to the HWB outlining a plan for change.

270 Adults Safeguarding Board Annual Report 2013/14

Pete Morgan, the former Independent Chair of the Worcestershire Safeguarding Adults Board, presented the Annual Report for 2013-14.

During the last six months the number of alerts increased but that was due to a change in the recording procedures. The number of alerts which were converted into referrals did not increase. Some of the alerts were found to be non-safeguarding issues. The outcome of the Francis report may mean that there was an increase in in-patient referrals.

During 2013/14 a lot of work had been carried out to ensure that the Safeguarding Board was Care Plan compliant and some groups were held in abeyance. The new structure was beginning to bed down and a virtual network had been created.

The Board was urged to think about resourcing for the Board which currently had a budget of £70,000 compared to the Children's Safeguarding Board which received £140,000. In some areas the two boards did work together and as the Council encouraged people to Think Family the Board was reminded not to forget that families were often made up of three or more generations not just parents and children.

A Board member asked how cases were selected for a serious case review. It was explained that it was detailed in the Care Act that a particular case had to give multi agency learning where abuse or neglect had caused a death or serious harm. A referral would then be made to a sub-group where an independent Chairman would

decide if it should become a serious case review. Councillors and MPs could refer cases directly and members of the public could make referrals through an agency.

Mr Morgan wished to leave the meeting with the thoughts that there should be lower levels of bureaucracy in place to enable people to be able to learn lessons more easily and also to be better at celebrating good practice.

The Chairman and Board Members thanked Mr Morgan for the work he had done with the Safeguarding Adults Board.

RESOLVED that the Health and Well-being Board noted and endorsed the Worcestershire Safeguarding Adults Board Annual Report 2013/14.

271 Analysis of safeguarding in Worcestershire in response to the Francis Report

Pete Morgan and Diana Fulbrook (Independent Chairman, Worcestershire Safeguarding Children's Board, explained that even though there was no direct reference to safeguarding in the Francis Report the provided reports gave details of the implicit recommendations concerning adult safeguarding.

For Adult safeguarding details were given regarding:

- Safeguarding Alerts,
- Reporting processes understanding,
- Complaint procedures,
- Commissioning activities, and the
- Relationship between the Worcestershire Safeguarding Adults Board and the Care Quality Commission.

For Children's safeguarding details were given surrounding:

- Quality and safeguarding assurance
- Culture
- Voice of the Child and Family/User feedback
- Openness, transparency and candour
- Information

It was confirmed that there were not any outstanding issues but it was pointed out that the report represented a snapshot in time and organisations could not afford to be complacent. Pete Morgan was concerned at the lack of respect that some agencies showed for Safeguarding

adults by not providing their reports when requested. He felt the onus was on the HWB to ensure that engagement and positive management of these issues continued. Further assurances would be included in the next annual report.

RESOLVED that the Health and Well-being Board:

a) **Noted the Worcestershire Safeguarding Children's and Safeguarding Adults analysis of Safeguarding in Worcestershire,**

b) **Supported the WSAB in implementing its proposed actions in response to the Francis Inquiry, and**

c) **Noted the progress of WSCB's assurance process in response to the implications of the Francis Inquiry review and requested further updates through the WSCB annual report as necessary.**

272 Future of Acute Hospital Services in Worcestershire

Simon Hairsnape explained that the assurance process was proceeding with the Clinical Sennate assessing the preferred option. However with the election coming up in May 2015 it would not be possible to consult during the purdah period leading up to the election. Consultation would therefore be starting in late spring 2015. Decisions would then be made in Autumn 2015 and implementation would be likely in early 2016. In the meantime the programme board would continue to work to ensure that acute services were safe.

RESOLVED that the Health and Well-being Board noted the update regarding the Future of Acute Hospital Services in Worcestershire.

273 Future Meeting Dates

Development Meetings all at County Hall
Wednesday 3 December 2014 2.00pm

Dates 2015

Public Meetings 2015
Wednesday 28 January 2.00pm
Tuesday 3 March 2.00pm
Tuesday 12 May 2.00pm
Wednesday 15 July 2.00pm
Tuesday 22 September 2.00pm
Tuesday 3 November 2.00pm

Development Meetings 2015
Tuesday 10 February 2.00pm
Tuesday 14 April 2.00pm
Tuesday 16 June 2.00pm
Tuesday 13 October 2.00pm
Tuesday 8 December 2.00pm

The meeting ended at 3.45pm

Chairman …….

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Worcestershire
Health and Well-being Board

Worcestershire Public Health Annual Report

Agenda item 5

Date	28 January 2015
Board Sponsor	Dr Richard Harling
Author	Dr Richard Harling – Director Adult Services & Health Peter Fryers – Consultant in Public Health
Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — Yes Obesity — Yes Alcohol — Yes Other (specify below) — No **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — Yes
Item for	Decision
Recommendation	**1. That the Health and Well-being Board:** **a) Note the contents and endorse recommendations of the Annual Report;** **b) Disseminate the key messages and recommendations within their own organisations and seek further endorsement;** **c) Request that member agencies work through the Health Improvement Group and Children's Trust to develop a single action plan to address health inequalities based on the recommendations and priorities for action in the Annual Report.**
Key Messages	2. The key messages from the report are: • Inequalities in the main health outcomes in Worcestershire have reduced since 2008.

- Overall health has improved and the biggest improvement has been in the most deprived areas.
- Long-term inequalities in outcomes still persist.
- Inequalities in health affect everyone and are a drain on the County economy and resources.
- The causes of inequalities in health outcomes are wide and tackling them requires all organisations working together to address them.
- Deep-rooted inequalities require new approaches to break the link between deprivation and health.

Background

3. Public health annual reports have been a statutory requirement of Directors of Public Health (DsPH) for many years and this has not changed with the move of Public Health back into Local Authorities under the Health & Social Care Act 2012. The annual report is not a statement about the policy of the organisation for which they work, but is a personal assessment of the health of the population they serve. It is there to raise concerns about health problems or poor outcomes in the local area, to assess progress against local Public Health objectives and inform local multi-agency action.

4. According to guidance from the Faculty of Public Health, DPH annual reports should:
   - Contribute to improving the health and well-being of local populations.
   - Reduce health inequalities.
   - Promote action for better health, through measuring progress towards health targets.
   - Assist with the planning and monitoring of local programmes and services that impact on health over time.

5. A previous report in 2008 looked at the issue of health inequalities and the identification of "health hotspots" in the County. This report re-examines the issues and assesses progress since then.

Why do health inequalities matter?

6. There is a sound economic case for tackling inequalities. Those extra years of life and more importantly the greater extra years of disability free life would have an economic benefit both in terms of increased productivity and reduced costs to health and social care. The estimated costs of the additional limiting illness suffered by the most deprived nationally is £31-32 billion in productivity, with loss of tax and increased welfare in the region of £20-32 billion and the healthcare costs estimated at £5.5 billion.

7. Reducing health inequalities is also a matter of fairness and social justice and the argument for doing so could

also be regarded as a moral one. People on the lowest incomes lose up to 17 years of disability free life expectancy compared to those on the highest incomes due to worse living conditions and this alone is reason enough to try to address some of the factors that lead to this situation.

8. Action taken to reduce health inequalities will benefit society in many ways. It will have direct benefit to individuals lives both in quantity and quality. It will benefit local and national economies through increased productivity and reduced welfare costs and it will benefit wider society through having a healthier more active population better able to engage in society, especially in older age. Inequalities in health also result in a disproportionate use of resources by people in disadvantaged groups, which is both inefficient and impacts the whole population.

Report Recommendations

9. The recommendations in the report focus on 5 areas under which a number of actions have been recommended:
    - Intensive ongoing support for vulnerable families
    - Intensive focus on early years development in priority areas
    - Employment opportunities in priority areas
    - Change to a place & asset-based approach to commissioning.
    - Strengthen and improve prevention of ill-health

Health inequalities in Worcestershire

10. Overall health in Worcestershire is on the whole better than the national average. Life expectancy and healthy life expectancy, especially for men are significantly better in the County than for England and mortality from common conditions and those considered preventable are consequently lower than average.

11. However theses overall figures mask some differences across the County and as with all Local Authority areas there are inequalities that persist.

12. In general health inequalities in Worcestershire are no worse than other similar places across the country, but the problems associated with health inequalities are wide and far reaching. This report is an assessment of where we currently stand on health inequalities and in particular how things have progressed since this issue was last looked at in an Annual Report in Worcestershire, in 2008.

13. Since then the Marmot report on health inequalities has been published and made specific recommendations on how to address them. We have followed the Marmot

chapters in the layout of this report and at the end of each chapter we have assessed our own progress against the Marmot recommendations and then identified priorities for local action to address these recommendations.

14. In terms of overall health inequalities on the broad outcome measures of differences in life expectancy and mortality, the picture is a positive one, with inequalities having reduced in absolute terms whichever way they are measured. However, underneath this there remain many inequalities both in health outcomes and in the factors which in the long-term affect life chances and health.

15. As part of addressing this issue we have identified the areas in Worcestershire which have the worst health outcomes as being health hotspots. These are largely the same as they were when the exercise was last done in 2008, but there are some that are expanded and a couple of different areas, in particular two rural areas have been identified as having worse health outcomes.

Give every child the best start in life

16. Health inequalities and particularly those factors which lead to them can be identified right from the beginning of life and even before birth. So, for example babies from deprived areas are more likely to have been born to younger mothers and their mothers are more likely to have smoked or be overweight, all things which mean that the baby starts life with a disadvantage. Then through their early development these disadvantages are widened as they are less likely to be breastfed, their language development is more likely to be delayed and they are more likely to have poor levels of development by the time they get to school.

17. While progress has been made in this area, Worcestershire has a worse than average number of children who have a good level of development by the end of reception year and more needs to be done across all agencies to implement a multi-faceted approach to addressing early years development in disadvantaged areas and families.

Enable all children, young people and adults to maximise their capabilities and have control over their lives

18. Once children get to school the inequalities are there from the beginning and only get wider as time goes on. Differences in level of achievement that are about 25% at Key Stage 1 are 4-500% by Key Stage 5, whilst those living in deprived areas are far more likely to have special educational needs, be excluded or be subject to child protection plans. They are also more likely to have excess weight, attend A&E more often and more likely to

require emergency hospital treatment. Children from the most deprived areas are also the most likely to have mental health problems and be in contact with mental health services.

19. Although much has been done to try to address these gaps, they are very persistent and an increased focus on intensive support and parenting advice to vulnerable families throughout the children's time at school is required to build on what has already been done. A more joined up approach to dealing with problem behaviours is needed along with schools and colleges doing more to promote health & wellbeing.

Create fair employment and good work for all

20. Although unemployment in Worcestershire is relatively low at 2.2%, there are individual wards where it as high as 6.6%. Also, whilst the rate of those unemployed for less than a year has not changed significantly, the rate of those who have been claiming for over a year has gone up. There is a strong association between areas of high unemployment and high mortality and other poor health outcomes.

21. Local initiatives like Worcestershire Works Well are aimed at encouraging healthy workplaces, but more could be done to develop work opportunities across the social gradient aimed at reducing the gap and for disadvantaged groups.

Ensure a healthy standard of living for all

22. There is an association between income and health outcomes and although Worcestershire has generally relatively low levels of low income households compared to other areas, these are fairly concentrated. In the 20% most deprived areas 37% of children are classed as living in poverty compared to just 5% in the 20% least deprived areas. In addition in Worcestershire the proportion of households in fuel poverty is higher than the national average.

Creating Healthy and Sustainable Communities

23. Worcestershire as a County offers good access to green space and has good air quality, although there are small pockets of poor access and poor air quality in the urban areas. These same areas also have the highest levels of deprivation. They also have lower levels of satisfaction with the area and the lowest levels of feeling of belonging to an area. In order to address these multiple issues a change is needed to an asset-based approach to commissioning, which involve local people, skills and resources in the planning and process of commissioning and decisions which affect the local area.

Strengthen the role

24. A small number of conditions cause the majority of

and impact of ill health prevention	premature mortality and morbidity, and these are all linked to health related behaviours, smoking, poor diet, physical inactivity and drinking too much alcohol, on the part of the individual, which can be changed. Recent improvements in these have almost all been in the higher socio-economic groups. Worcestershire follows this pattern, with people in the most deprived areas most likely to have one or more of these unhealthy behaviours. In order to maximise the potential for health improvement across the County the targeting of prevention and use of Public Health and other resources needs to be strongly evidenced and linked to reducing the health gap.

Worcestershire Health and Well-being Board

worcestershire county council

Implementing the 2015/16 Better Care Fund Plan – Section 75 Agreement

Agenda item 6

Date	28 January 2015
Board Sponsor	Dr Richard Harling, Director of Adult Services and Health
Author	Frances Martin, Integrated Commissioning Director
Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — Yes Obesity — No Alcohol — Yes Other (specify below) — Yes Partnership working through integrated commissioning **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — Yes
Item for	Decision
Recommendation	**1. That the Health and Well-being Board:** **a) Approve revision of the Section 75 Agreement to reflect the 2015/16 Better Care Fund Plan and other emerging partnership priorities, operating models and commissioning intentions; and** **b) Note the current budgetary position for the 2014/15 Better Care Fund.**
Background	2. Worcestershire's Better Care Fund Plan for 2015/16 was signed off by the Health and Wellbeing Board at the meeting on 23 September 2014. The mandatory contributions to the Better Care Fund were agreed as:

Disabled Facilities Grant	2,358
Capital Spending Social Care	1,328
NHS South Worcestershire CCG	16,866
NHS Wyre Forest CCG	6,572
NHS Redditch and Bromsgrove CCG	10,069
BCF Total	**37,193**

3. The allocation of the funding was agreed as:

Summary	**2015/16 (£'000)**
Admission Prevention	11,796
Facilitated Discharge	8,254
Independent Living	7,459
Payment for Performance and ring-fenced fund	9,684
BCF Total	**37,193**

4. The full list of agreed schemes is provided in Annex A

5. To implement the Better Care Fund Plan for 2015/16, partners are required to establish a Section 75 Agreement.

6. The overall purpose of any Section 75 Agreement is to formalise partnership arrangements designed to jointly improve outcomes for patients and service users. A formal agreement under Section 75 of the NHS Act 2006 has been in place in Worcestershire since 2008. The current Section 75 includes elements relating to adults and children (the Better Care Fund Plan is adults only). As well as the services commissioned under the Section 75 Agreement, the Council and CCGs include funding for staff to commission the services in the Agreement.

7. It is proposed to revise the current Section 75 Agreement to reflect the Better Care Fund Plan. The Agreement would also be amended to reflect emerging partnership priorities, operating models and respective commissioning intentions. This would also provide the opportunity to review the commissioning arrangements for services.

Reporting

8. As is currently the case, reporting against the Section 75 Agreement would be to the Health and Wellbeing Board, via the Integrated Commissioning Executive Officers Group (ICEOG). Developing a single Section 75 Agreement would enable a single reporting format to Health and Wellbeing Board.

Timetable

9. The timetable in place revision of the Section 75 Agreement is:

Health and Wellbeing Board	28/01/14
Line by line review of services for inclusion in S75	February
Review at ICEOG	09/02/15
NHS contracts agreed	24/02/15
Health and Wellbeing Board	03/03/15
Further amendments	March
2015/16 section 75 in place	31/03/15

2014/15 BCF Monitoring

10. The 2014/15 Better Care Fund is monitored through Integrated Commissioning Executive Officers Group and reported to Health and Wellbeing Board. Annex B shows the budgetary position at Period 8. The overall BCF position is an underspend of £292,338, before the use of any Winter Pressures funding (agreed as a contingency to support demand). The forecast underspend after the use of the Winter Pressures funding is £792,338.

11. Note that the underspend has been possible because of use of NHS System Resilience funding to support BCF schemes, specifically Discharge to Assess beds. Note also that health and adult social care services have been under unprecedented pressure so far this winter and therefore the forecast underspend at Period 8 may not be reflected at year end. The Board will be updated on the position in March and asked to agree the disposition of any remaining underspend.

Annex A

Services included in the 2015/16 BCF Plan

Category	Service
Admission Prevention	Short-stay Care Setting with Specialist Inreach - Urgent and Unplanned beds
Admission Prevention	Intensive Support at Home - SW Intermediate Care Night Sitters
Admission Prevention	Intensive Support at Home - Night Sitters and Discharge after Dark workers
Admission Prevention	Intensive Support at Home - Urgent and Unplanned Domiciliary Care
Admission Prevention	Intensive Support at Home - Recovery Project - Urgent Homecare
Admission Prevention	Extended Hours for Professional Response - Rapid Response Social Work Team
Admission Prevention	Extended Hours for Professional Response - Extended Nursing Hours to Access Service
Admission Prevention	Extended Hours for Professional Response - Extended Hours to Access Service
Admission Prevention	Extended Hours for Professional Response - Dementia/RMNs in Intermediate Care
Admission Prevention	Extended Hours for Professional Response - Single Point of Access/Rapid Response Nurses
Admission Prevention	Extended Hours for Professional Response - SW Enhanced Care Team
Admission Prevention	Extended Hours for Professional Response - SW Practice-based Social Workers
Admission Prevention	Extended Hours for Professional Response - WF/RB Virtual Ward
Facilitated discharge	Short-stay Care Setting with Specialist Inreach - Plaster of Paris Placements
Facilitated discharge	Short-stay Care Setting with Specialist Inreach - Discharge to Assess Beds
Facilitated discharge	Reablement at Home - Enhanced Interim Packages of Care
Facilitated discharge	Short-stay Care Setting with Specialist Inreach - Health Worker to Support Discharge to Assess
Facilitated discharge	Reablement at Home - ICES 24 hr fast-track Delivery
Facilitated discharge	Reablement at Home - Recovery Project - ICES
Facilitated discharge	Short-stay Specialist Care Setting - ASWC in Community Hospitals, Resource Centres and DtA Beds
Facilitated discharge	Short-stay Specialist Care Setting - Timberdine Nursing and Rehabilitation Unit
Facilitated discharge	Short-stay Specialist Care Setting - Stroke Rehabilitation
Facilitated discharge	Short-stay Specialist Care Setting - Resource Centres
Facilitated discharge	Short-stay Specialist Care Setting - Recovery Project - Resource Centres

Category	Service
Facilitated discharge	Short-stay Specialist Care Setting - Therapy Support to Resource Centres and WICU
Facilitated discharge	Reablement at Home - Recovery Project - PI
Facilitated discharge	Reablement at Home - Winter Pressures
Facilitated discharge	Short-stay Care Setting with Specialist Inreach - CCG Winter Pressures
Independent living	Pivotell
Independent living	Demographic Pressures in Domiciliary Care
Independent living	Home Care
Independent living	Integrated Community Equipment Service Demographic Pressures
Independent living	Carers
Independent living	Implementation of Care Act
Independent living	Care Bill (Capital)
Independent living	Disabled Facilities Grant
Independent living	Social Care Capital
Payment for performance	Held Centrally against 3.5% reduction in Admissions

Annex B

Better Care Fund					
Budget Monitoring Statement No. 8	**8 months to 30th November 2014 (66.7% of year)**				
Scheme	**Annual Budget**	**Annual Outturn**	**Annual Variance**		**Change In Variance**
UUPs placements	500,000	571,396	71,396		117,048
PoP Placements	442,000	546,996	104,996		-33,308
DtA	667,500	486,363	-181,137		-339,983
Pivotell	40,000	40,000	0		0
Enhanced Interim Packages of Care	92,800	150,000	57,200		0
Dementia/RMNs in Intermediate Care	310,000	310,000	0		0
Timberdine Nursing and Rehabilitation Unit	1,805,000	1,650,472	-154,528		-125,500
WHASCAS Extension	220,700	220,700	0		0
Health Support for Step-down	61,200	61,200	0		0
Therapy Support to Resource Centres and WICU	128,000	110,000	-18,000		0
SPOA/Rapid Response Nurses	235,400	208,000	-27,400		0
Discharge after dark	85,000	85,000	0		0
Night sitters	50,000	50,000	0		0
Reimbursement of 1314 Overspend	219,972	123,000	-96,972		-4,972
Resource Centres	1,000,000	1,000,000	0		0
Home Care	1,000,000	1,000,000	0		0
Stroke rehabilitation	220,000	220,000	0		0
WCC Domiciliary	1,120,000	1,120,000	0		0
WHASCAS Extension	131,300	131,300	0		0
ICES: 24 hr fast-track delivery	57,000	57,000	0		0
Urgent and Unplanned Dom Care	141,400	141,400	0		0
Rapid Response Social Work Team	665,000	617,106	-47,894		-6,643
ASWC: Comm Hosps	118,500	118,500	0		0
ASWC: Resource Centres	79,800	79,800	0		0
ASWC: Step-down	38,780	38,780	0		0
ICES	300,000	300,000	0		0
Recurrent Schemes	9,729,352	9,437,014	-292,338		-393,358
Winter Pressures					
Winter Pressures County-wide	1,200,000	700,000	-500,000		0
Winter Pressures WHACT	0	0	0		0
Winter Pressures CCGs	0	0	0		0
Winter Pressures WCC	0	0	0		0

Winter Pressures WCC	0	0	0		0
Recurrent Schemes	1,200,000	700,000	-500,000		0
BCF expenditure	10,929,352	10,137,014	-792,338		-393,358
BCF Income - Main Allocation	-10,929,352	-10,929,352	0		0
TOTAL	0	-792,338	-792,338		-393,358

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Worcestershire Health and Well-being Board

Worcestershire Pharmaceutical Needs Assessment

Agenda item 7

Date	28 January 2015
Board Sponsor	Dr Richard Harling, Director of Adult Services and Health
Author	Janette Fulton, Information Analyst Principal, Public Health Intelligence
Relevance of Paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — Yes Obesity — Yes Alcohol — Yes Other (specify below) — No **Groups of particular interest** Children & young people — No Communities & groups with poor health outcomes — Yes People with learning disabilities — No
Item for	Decision
Recommendation	**1. That the Health and Well-being Board:** **a) Approve the pharmaceutical needs assessment for publication and dissemination;** **b) Approve key messages to accompany the PNA's publication:** • **The evidence shows that there is no fundamental unmet pharmaceutical need in Worcestershire;** • **There is a high level of satisfaction with the pharmaceutical provision available to the public; and** • **There is an opportunity for community pharmacies to contribute to implementing the joint health and wellbeing strategy.** **c) Consider comments and recommendations made**

by the PNA Working Group; and

d) Consider what further actions may be required.

Background

2. The Health and Well-being Board has responsibility for developing and updating pharmaceutical needs assessments (PNAs) under the Health and Social Care Act 2012 and the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

3. The Board must:

   a. Publish its first PNA by 01 April 2015.

   b. Consult the following about the contents of the PNA:
      i. any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);
      ii. any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);
      iii. any persons on the pharmaceutical lists and any dispensing doctors list for its area;
      iv. any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;
      v. any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and
      vi. any NHS trust or NHS foundation trust in its area;
      vii. the NHSCB; and
      viii. any neighbouring HWB.

   c. Publish an update on the PNA within three years of the first.

Consultation

4. A first draft PNA was presented to the Board in September 2014 and approved for consultation. Consultees, including those listed above, were given 60 days to respond.

5. The main issues raised during consultation were:

   a. Responses from members of the public indicated difficulties accessing information about pharmaceutical services including the range of services and when and where they are available.

   b. Pharmacies could play a role in supporting the

implementation of Worcestershire's urgent care strategy and developments in primary care.

6. A full report on the consultation is available in Appendix 6a and 6b of the final draft of the PNA.

Final draft of the PNA

7. The responses were reviewed by a PNA Working Group and changes made where appropriate. A final draft of the PNA is now presented to the HWB for approval.

8. The key messages are:
   - The evidence shows that there is no fundamental unmet pharmaceutical need in Worcestershire;
   - There is a high level of satisfaction with the pharmaceutical provision available to the public; and
   - There is an opportunity for pharmacies to contribute to implementing the joint health and wellbeing strategy.

Next steps

9. The Board, through commissioners will:

   a) Ask pharmaceutical service contractors to provide an action plan setting out how they will respond to the points raised in the PNA "Strategy to Reduce Barriers to Access Highlighted in Public and Service User Engagement".

   b) Ensure that community pharmacies are aware of the opportunities to contribute to implementing the joint health and wellbeing strategy by tendering for work through the 'any qualified provider' process, and that they are fully engaged as key stakeholders in service redesign.

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worcestershire county council

Worcestershire Health and Wellbeing Board's Pharmaceutical Needs Assessment

April 2015

Specialist solutions at the heart of healthcare

NHS
Arden Commissioning Support

Executive Summary

Background – What is a Pharmaceutical Needs Assessment (PNA)?

A PNA presents a comprehensive picture of current pharmaceutical service provision, which includes dispensing of prescriptions by community pharmacies, dispensing doctors and other providers, as well as a range of other services provided by community pharmacies.

Community pharmacies are based in the heart of local communities, in rural as well as urban areas, where people live, work and shop. With the significant contribution that community pharmacy can make to improve healthcare, it is important to ensure that there are an appropriate number of pharmacies, that they are in the right places and offer an appropriate range of services. The PNA helps to achieve this.

The responsibility for PNAs transferred from Primary Care Trusts (PCTs) to Health & Wellbeing Boards (HWBs) in 2012. The *NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (The 2013 Regs)* of April 2013 state that HWBs must produce their first PNA by no later than 1st April 2015.

Process – how has the PNA been developed and what happens now?

The pharmaceutical services delivered by Worcestershire contractors (including community pharmacies and dispensing doctors) have been evaluated. Each contractor has contributed a service profile and opening times and locations have been mapped.

A number of key documents have been considered and reviewed that examine the health needs of the local population with the aim of improving health and wellbeing and reducing inequalities.

The views of the public, local patients and service users have been sought. A public and patient engagement programme has sourced the views of over 1000 contributors from Worcestershire.

The picture of current service provision is presented in **Part A** of the PNA. The next section, **Part B,** looks at the local health needs and priorities that have been identified and prioritised by the Health and Wellbeing Board for each of the six defined localities that make up Worcestershire. **Part C** considers the summary of current provision of pharmaceutical services alongside the health needs of the localities and identifies where current service provision may be deemed to be inadequate. This highlights potential gaps or “pharmaceutical needs”.

The PNA then considers how the needs and service gaps that have been identified could be met by the provision and development or extension of existing pharmaceutical services. In this way the PNA acts as a steer for planning and commissioning of relevant future services including whether new pharmacies should be allowed to open or GPs allowed to dispense.

HWBs must consult during the process of developing the PNA for a minimum period of 60 days. The responses received during this period have been considered and incorporated into the final version.

Findings

The PNA has concluded that the level of access to pharmaceutical services currently commissioned across Worcestershire generally meets the needs of the population. A pharmaceutical service in Worcestershire is provided by a cohort of contractors that are appropriately located, to meet the needs of the vast majority of the population.

The total opening hours that contractors cover, provides access from early morning to late evening, during the working week and at weekends. Whilst access is more extensive during normal working hours over the working week, reflecting the rise and

fall in demand that normally occurs, access is still considered adequate outside of normal hours and at weekends.

The dispensing pharmaceutical service provided by pharmacies is complemented by the service provided by dispensing GPs in the more rural areas reducing the distance that users have to travel to access the service.

It was noted that there is still some capacity within the existing service profile for community pharmacy to provide further support to help meet the needs and address the priorities of the HWB. There are also opportunities for service development. The developing specialist public health advisory role for community pharmacy particularly within the structure of the Healthy Living Pharmacy programme offers further opportunity for community pharmacies to support the HWB.

The public patient process revealed a high level of satisfaction on the part of respondents:

- 84% state that they have easy access to services with no problems
- Almost 70% did not identify any barrier to access to services
- Just under 40% need to travel less than a mile to reach a pharmacy
- 70% need to travel less than 2 miles to access a pharmacy
- Over 76% need to travel for less than 15 minutes to reach a pharmacy
- 83% are very or fairly satisfied with opening hours when pharmaceutical services are available

A lack of awareness of the range of services available from pharmacies and more general information about times of availability and access was highlighted by the public/patient engagement process.

Conclusions

There are some serious challenges to overcome in the drive to improve health and well being in Worcestershire. To meet these challenges there will need to be a much greater emphasis on prevention, early intervention and early help to preserve

people's health and independence. Community pharmacies have close links with their communities and are therefore well placed to support the HWB to deliver their priorities.

1. Community pharmacies should fully utilise the current service profile to maximise the contribution they can make to improving healthcare. For example;
    - Each pharmacy should fulfil their full quota of Medicines Use Reviews and the New Medicines Service by targeting appropriate patients who will benefit from these interventions
    - Further uptake of the Healthy Living Pharmacy Programme should be encouraged
    - The public/patient engagement programme has highlighted a number of areas where further improvements in service delivery can be made. All contractors are encouraged to consider and reflect on the range of comments received

2. A process to allow access by the public to general information about location and times of availability of pharmaceutical services must be developed.

3. The dispensing of prescriptions remains the cornerstone of pharmaceutical service provision and is a vital local service, clearly valued by patients in Worcestershire and delivered by a range of contractors, including community pharmacies and dispensing GPs. The term "*pharmaceutical services*" however incorporates a range of services that can be commissioned from community pharmacy and it is acknowledged that the PNA presents an opportunity for representatives of community pharmacy and service commissioners to explore together how the development of "*pharmaceutical services*" can further help to deliver the priorities of the HWB in Worcestershire.

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Worcestershire Health and Well-being Board

Dementia Action Alliance – The Carers Call to Action.

Agenda item 8

Date	28 January 2015
Board Sponsor	Dr Richard Harling
Author	Jenny Dalloway – Lead Commissioner Mental Health and Dementia
Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — Yes Obesity — No Alcohol — No Other (specify below) - Carers — Yes **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — Yes
Item for	Decision
Recommendation	**1. That the Health and Well-being Board is asked to:** **a) Sign up to the Carer's Call to Action (CC2A); and** **b) Note the ambition for two thirds of Health and Wellbeing Boards, CCGs and Local Government to recognize the importance of support for carers of people with dementia (by signing the CC2A).**
Background	2. The Rt Hon Jeremy Hunt MP Secretary of State for Health wrote to all Health & Wellbeing Boards recently: 'I want to encourage you to sign up to the Call to Action. The Department of Health, Public Health England and NHS England have all signed up and together we can improve the lives of over half a million

carers of people with dementia'

3. It is estimated that one in three people will care for a person with dementia in their lifetime and the number of people with dementia is set to double in the next 30 years. The Prime Minister made his personal commitment to improve the lives of people living with the condition including their families in his Challenge on Dementia (DH, 2012).

4. Two thirds of people with dementia are cared for at home by family or friends. The challenge recognises that unpaid carers of people with dementia save the economy £7 billion a year, yet the evidence shows that carers struggle to care for the person with dementia leading to avoidable crises in care, hospital admissions or early entry into a care home which are very costly (World Alzheimer's Report, 2013).

5. With a push to increase diagnosis rates we must also prioritise post diagnosis support. The diagnosis is given not just to the individual but their spouse, family and friends.

Call to Action

6. A number of organisations within Worcestershire have signed up to the Dementia Action Alliance, developing their own action plans for implementation. The Dementia Friends campaign, supported by public health, also has growing support.

7. There now needs to be a focus on the needs of carers of people with dementia. Carers have the right to expert advice, information and support in their own right, if they receive these then their own health and wellbeing will be maintained for longer as well as benefit to the person they care for.

8. The Board is asked to sign up to the campaign and the five aims of the shared vision to demonstrate that we will consider the needs of family carers of people with dementia in Worcestershire. The campaign wants to empower families living with dementia to have a voice to support local meaningful engagement to work with us to find the most appropriate and pragmatic local solutions.

Five aims

9. The five aims of the campaign are below that carers of people with Dementia;

- have recognition of their **unique experience**
- are recognised as **essential partners** in care - valuing their knowledge and the support they provide to

enable the person with dementia to live well

- have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the **person with dementia**

- have assessments and support to identify the on-going and changing needs to maintain **their own health and well-being**

- have **confidence** that they are able to access good quality care, support and respite services that are flexible, culturally appropriate, timely and provided by skilled staff **for both the carer and the person for whom they care.**

Action already underway

10. We are already commissioning services with a specific remit of supporting carers of people living with dementia including;
    - Onside - young onset Dementia support service
    - Age UK - Dementia Advisor service
    - Admiral Nursing Service - specialist dementia nurses who give practical and emotional support to family carers
    - Alzheimer's Society - Peer support services through Dementia Cafés.

11. There are a number of training and support programmes available for carers provided by AgeUK and the Alzheimers Society.

12. The Worcestershire Association of Carers helpline is able to provide support to people supporting individuals living with dementia.

Impact of signing up the Carer's Call to Action

13. Signing up to the Carer's Call to Action will provide a checklist for commissioners to adopt to ensure that carers are supported throughout the care pathway of the person living with dementia. This will form an improvement plan to support full implementation of the local Dementia Strategy.

Appendix 1

Carers' Call to Action Overview

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Dementia Action Alliance

The Carers' Call to Action – Overview

What is The Carers' Call to Action?

- Leading national charities, public bodies, family carers and private providers came together in 2013 to address the intolerable situation that many people experience when a loved one is diagnosed with dementia.

- ***'A diagnosis of dementia is given not just to one person – it is given to a spouse, a partner, a child, the extended family and friends. It is important to remember that every time a diagnosis is made it is life changing. It is therefore vital that everyone has timely access to bespoke post diagnosis support and information on an on-going basis.*** 'Alistair Burns NHS England National Clinical Director for Dementia

- Support across England continues to fall far short of what is needed – There are approximately 3,000 Macmillan nurses compared to about 102 Admiral Nurses – one in three people will be diagnosed with cancer in their lifetime (Cancer Research UK). It is estimated that one in three people will care for a person with dementia in their lifetime (Carers Trust).

- ***"I was falling apart, trying desperately to think up new ways of coping and feeling really isolated. We were not on a pathway, we were stumbling. I needed support but had no idea how to get it or what it would look like."***

- Mounting research demonstrates the value of supporting carers both to the person with dementia and to the efficient use of scarce public resources - ***'including and supporting carers of people with dementia will lead to better outcomes for patients, carers and ultimately the professionals supporting them'*** (Triangle of Care Carers Trust & the Royal College of Nursing 2013)

- Carers save the economy £119 billion a year. Properly identifying and supporting carers will prevent escalation and demand on statutory services (Carers Trust 2013)

- The new Care Bill, Better Care funds, Health & Social Care Integration, Health & Wellbeing Boards, 'meaningful local engagement with patient voices' and The Dementia Movement provide new opportunities to engage and for commissioners to fund and deliver better early intervention and support.

- We have created 5 aims supported by a 20 point checklist of what good support for the needs and rights of family carers must look like.

'our shared vision'

Aim One –

Family carers of people with dementia have recognition of their unique experience - 'given the character of the illness, people with dementia deserve and need special consideration... that meet their and their caregivers needs' (World Alzheimer Report 2013 Journey of Caring)

Aim Two -

Family carers of people with dementia are recognised as essential partners in care - valuing their knowledge and the support they provide to enable the person with dementia to live well

Aim Three –

Family carers of people with dementia have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the person with dementia

Aim Four-

Family carers of people with dementia have assessments and support to identify the on-going and changing needs to maintain their own health and well-being

Aim Five –

Family carers of people with dementia have confidence that they are able to access good quality care, support and respite services that are flexible, culturally appropriate, timely and provided by skilled staff for both the carer and the person for whom they care

What we need you to do

- **Encourage others to SIGN UP** at: www.dementiaaction.org.uk/carers - we can only do this together!
- Please **download the 'We Support' logos** http://www.dementiaaction.org.uk/carers/download_cc2a_logos and add to your website and printed materials
- We MUST **engage with Health and Wellbeing Boards and Commissioners** to bring about change.
- Please **tweet on twitter** – our hash-tag is #DAACC2A and our user name is @DAAcarers
- If you are able to offer anything practical for example fundraising, social media, time, experiences, stories, money! Please get in touch.
- Write to your GP/Clinical Commissioning Group/Health and Wellbeing Board/MP/Local Authority/ District Council/ etc. highlighting The Carers' Call to Action and five aims of **our shared vision.** Template letters are available at: http://www.dementiaaction.org.uk/carers
- Let The Carers' Call to Action team know about examples of carer's support that works well in

your area

- Embed the five aims of **our shared vision** in your own service development strategy.
- Work within your local community to increase awareness of the needs and rights of carers of people who have dementia – this may include fundraising for carers support groups, talking to local groups etc.
- Make everyone within your strategic networks aware of the needs of carers and The Carers' Call to Action.
- Work locally to collate an overview of services and identify where there are strengths and gaps.
- Share your story to highlight the need for The Carers' Call to Action
- Commit to time to speak to people/organisations/commissioners about The Carers' Call to Action (slides are available to download from the website)
- If you have experience of caring for someone with dementia and you would be happy to talk about it at meetings, events or conferences we can support you to do this!
- Slide templates are available on the website, which we encourage you to use to present at every possible opportunity the aims of our shared vision.
- If you need copies of our leaflets let us know.

What good support looks like - Do you commission?

1) **Pre-diagnosis support** from the point of GP referral to Memory Clinic.
2) **Post diagnosis education** for the family and person with dementia.
3) A **dementia adviser/support worker/Admiral Nurse/** to provide on-going & timely access to local, face to face, **personalised, dementia expertise** and practical advice as well as psychological & emotional support.
4) On-going & timely access to dementia specific **local information**, **resources and support** in a variety of accessible formats.
5) Support for family carers that provides a clear, **collaborative pathway of action and plan of care** once **GPs** have identified a family carer (QOF April 2014.)
6) **Carer Peer Support Groups** specifically for family members/carers/friends of people living with dementia, which meets the cultural needs of the local population and age range of those affected.
7) Health and social care staff (including third sector services) who have **knowledge & expertise in dementia** to complete personalised assessments of a person who has dementia and their family carer's.
8) An **expert clinician in dementia** to support and supervise Care Co-ordinators/Social care staff/Health Care Practitioners with their role in assessing, treating and managing the impact of co-morbidities of the person with dementia and thus supporting the family carer.
9) **Support to remain active and integrated** in the local community thus reducing impact of loneliness and social isolation of both the person with dementia and their carer e.g. dementia friendly communities, health prescriptions, community transport, age appropriate activities.
10) Access to appropriate and timely **respite** opportunities by the hour, day or week in a range of settings.

11) Age appropriate support for the impact of **young onset dementia** e.g. supporting younger family members, loss of income and roles.
12) Culturally appropriate, accessible information and support for people with dementia and their family carers from **Black and ethnic minorities** communities.
13) Culturally appropriate, accessible information and support for people with dementia and their family carers from **Lesbian, Gay, Bisexual and Transgender** communities.
14) Dementia **advocacy** services – e.g. to capture the wishes, values and beliefs of a family carer and strategies to ensure people living with dementia have a person-centred assessment, support for completing legal and financial issues.
15) Community **Health & care services** that are delivered by those who have training & expertise in dementia (not just dementia awareness) e.g. dentist, nutrition, opticians, podiatry, hairdressers who specialise in dementia and offer domiciliary visits.
16) **Training in dementia care** for Health & Social Care professionals.
17) **Glossary/overview/Jargon buster** concerning what professions/services mean and what they can do for you.
18) **Dementia awareness** promotion within local communities and businesses including Dementia Friends, Dementia Friendly Communities/Environments, Local Dementia Action Alliance initiatives.
19) Support for **employers** to enable carers to continue working.
20) Support, and training as necessary, for family carers and people living with dementia to **have a voice** to influence and support change locally. This requires a **'meaningful community engagement'** so that commissioning services is based on the evidence of need of the local population.

Essential Reading:

Alzheimer's Disease International, BUPA (2013) *World Alzheimer Report 2013 Journey of Caring An Analysis of Long-Term Care for Dementia (Alzheimer' Disease International, London)*

Alzheimer's Society (2013) *Dementia 2013: the Hidden Voice of Loneliness (London, Alzheimer's Society)*

British Institute of Human Rights (2012) *Your Human Rights - A Pocket Guide for Carers* (British Institute of Human Rights, London)

Carers Trust (2013) *A Road Less Rocky – Supporting Carers of People with Dementia* (Carers Trust, London)

Carers Trust, Royal College of Nursing (2013) *The Triangle of Care – Carers Included: A Guide to Best Practice for Dementia Care* (Carers Trust, London)

Carers Trust (2013) Carers' Hub Toolkit for Commissioners

Carers UK (2014) Supporting employees who are caring for someone with dementia

Red & Yellow Care (2014) A Good Life With Dementia

Email: admin@dementiaaction.co.uk Follow us on **Twitter** @DAAcarers #DAACC2A
Follow us on **Facebook** DAA The Carers' Call to Action
Visit our **webpage** www.dementiaaction.org.uk/carers
Telephone: 020 7423 5185

NB: To Follow: Examples of good services

Worcestershire Health and Well-being Board

Mental Health Crisis Care Concordat

Agenda item 9

Date	28 January 2015
Board Sponsor	Dr Richard Harling, Director of Adult Services and Health
Author	Jenny Dalloway, Lead Commissioner Mental Health and Dementia
Relevance of paper	**Priorities** Older people & long term conditions — No Mental health & well-being — Yes Obesity — No Alcohol — No Other (specify below) — No **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — No
Item for	Decision
Recommendation	**1. That the Health and Well-being Board:** **a) Note that all local organisations have signed up to Mental Health Crisis Concordat;** **b) Request that relevant officers develop an action plan for sign off by the Chair and submission before 01 March.**
Background	2. The Mental Health Crisis Concordat is a government policy priority for partner agencies to commit to working together to deliver better outcomes for people experiencing mental health crisis. 3. The Concordat covers; • Access to support before crisis point; • Urgent and emergency access to crisis care; • The right quality of treatment and care when in

crisis;
- Recovery and staying well, and preventing future crises; and
- Has 46 actions for national and local agencies to enable delivery of the shared goals of the concordat.

4. The national Concordat was published in February 2014, with the requirement for local agencies to sign a **declaration** by 31 December 2014, and then produce an **action plan** by 1 March 2015. The local lead is the Office of the Police and Crime Commissioner West Mercia, who are co-ordinating these requirements across both Warwickshire and West Mercia.

Progress

5. The declaration has been signed by the main commissioning and provider organisations in Worcestershire and can be viewed on the public facing website http://www.crisiscareconcordat.org.uk/ Worcestershire is currently rated as amber, along with the rest of England. Additional signatories can be added as the action plan is developed.

6. A group including officers from these organisations has been established to develop an action plan, with involvement of Healthwatch Worcestershire and local service user forums, and reporting to the Systems Resilience Group.

7. The timescale to develop and agree the action plan is challenging to meet the submission date of 1 March 2015. The plan will then be published on the crisis concordat website, and Worcestershire rated as green. The Board are therefore asked to delegate authority for sign-off to the Chair on the advice of the project group and the System Resilience Group.

Appendices

- West Mercia Crisis Concordat Declaration
- Crisis Care Concordat: Local declaration and beyond' letter from Norman Lamb

The 2014 Warwickshire and West Mercia Declaration on improving outcomes for people experiencing mental health crisis Wednesday 3rd September 2014.

We, as partner organisations in Warwickshire and West Mercia, will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

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

We are responsible for delivering this commitment in Warwickshire and West Mercia by putting in place, reviewing and regularly updating the attached action plan.

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

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in Warwickshire and West Mercia for help in a crisis. This will result in the best outcomes for people with illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people using services at time of crisis, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals and wider community.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to patients, service users, carers, wider community, staff and to support people's recovery and wellbeing.

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

Who should sign a local Declaration?

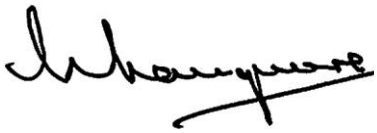
Many local organisations want to support the Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the action plan for continuous improvements.

In addition, certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis:

- Clinical Commissioning Groups
- NHS England Local Area teams (primary care commissioners)
- Commissioners of social services
- The Police Service
- Police and Crime Commissioners
- The Ambulance Service
- NHS providers of Urgent and Emergency Care (Emergency Departments within local hospitals)
- Public / independent providers of NHS funded mental health services
- Public / independent providers of substance misuse services

David Shaw
Chief Constable
West Mercia Police Headquarters

West Mercia POLICE



Bill Longmore
West Mercia Police and Crime Commissioner

Office of the Police and Crime Commissioner West Mercia

Tom Currie
Assistant Chief Officer
Head of Service NPS West Mercia

National Probation Service

Neil Carr
Chief Executive Officer
South Staffordshire and Shropshire Healthcare NHS Foundation Trust

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust
A Keele University Teaching Trust

Clive Ireland
Chairman
Shropshire Mind

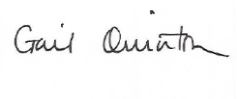
mind for better mental health Shropshire

Simon Hairsnape
Chief Officer
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS Wyre Forest Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

Dr Richard Harling
Director
Adult Services and Health
Worcestershire County Council



Gail Quinton
Director of Children's Services
Worcestershire County

worcestershire countycouncil

Simon Trickett

Chief Operating Officer
NHS South Worcestershire Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

Peter Herring
Chief Executive
Shrewsbury and Telford Hospitals (SATH)

The Shrewsbury and Telford Hospital NHS
NHS Trust

Sarah Dugan
Chief Executive
Worcestershire Health and Care NHS

Worcestershire Health and Care NHS
NHS Trust

Caron Morton
Accountable Officer
Shropshire Clinical Commissioning Group

NHS Shropshire Clinical Commissioning Group

Clive Wright
Chief Executive
Shropshire Council

Shropshire Council

Liz Stafford
Chief Executive
Warwickshire and West Mercia Community Rehabilitation Company

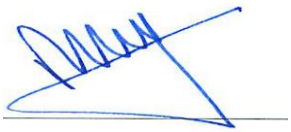
Warwickshire & West Mercia Community Rehabilitation Company PROBATION

Paul Taylor
Director: Health, Wellbeing & Care
Telford & Wrekin Council

a co-operative council | Telford & Wrekin COUNCIL

Sue Price
Director of Commissioning
Arden, Herefordshire and Worcestershire Area Team NHS England

NHS England



Richard Kelly
Executive Director
Herefordshire Mind

mind for better mental health Herefordshire

David Evans
Chair & Chief Officer
NHS Telford and Wrekin Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

Dr Ken Deacon
Medical Director/ Interim Director of Commissioning
Shropshire & Staffordshire Area Team
NHS England

NHS England

Penny Venables
Chairman and Chief Executive
Worcestershire Acute Hospitals NHS Trust

Worcestershire NHS Acute Hospitals NHS Trust

Steven Gregory
Director of Nursing and Operations
Shropshire Community Health NHS Trust

Shropshire Community Health NHS NHS Trust

Jo Whitehead
Chief Officer
Herefordshire Clinical Commissioning Group

NHS Herefordshire Clinical Commissioning Group

Richard Beeken
Chief Executive Officer
Hereford Wye Valley Trust

Wye Valley NHS NHS Trust

Sam Joyce
Chief Executive Officer
Telford Mind

mind for better mental health Telford

David Ashford
Head of Clinical Practice – Mental Health

West Midlands Ambulance Service NHS NHS Foundation Trust

Helen Coombes
Herefordshire Council Adults and Wellbeing

Shaun Clee
2gether NHS Foundation Trust (Herefordshire)

Allan Gregory
Superintendent
British Transport Police

Jo Davidson
Herefordshire Council Childrens and Family

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Department of Health

From the Rt Hon Norman Lamb MP
Minister of State for Care and Support

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

POC3000911110

14 JAN 2015

To: All Crisis Care Concordat local leaders

Dear Colleague,

CRISIS CARE CONCORDAT: LOCAL DECLARATIONS AND BEYOND

I am writing to sincerely thank you all for your hard work in ensuring that your local Crisis Care Concordat Declaration was signed before the end of 2014 by all the agencies in your area that work to respond to people in mental health crisis.

I am pleased to inform you that all localities in England succeeded in signing Declarations before the end of 2014. I believe this reflects a hugely significant development in improving the provision of mental health crisis care across the country. I was very pleased to follow your progress through the online map managed by Mind, and to watch this map turn amber in its entirety (with shades of green) was extremely encouraging. I know that this means that new and existing partnerships are coming together and will work to improve service responses.

I am grateful to you for the leadership you have shown to date in galvanising local partners and bringing together the various different agencies to have these vital discussions. It is clear to me how much energy and willingness there is out there to drive and deliver true change on the ground. I have heard many genuinely moving personal stories from both service users and professionals, up and down the country, and these have been inspirational for me.

Action plans

Whilst local declarations are a critical first step, the action plans represent the substantive vehicles for transforming crisis care for the better. I now want us to build on declaration sign-up and invest intensive efforts in ensuring that the local action plans that you and your partners produce are robust, of high quality and prove to be the catalyst for longer-term change.

In order to maintain the momentum you have generated, I am therefore setting an expectation that you will have an action plan in place by the end of March 2015. This will allow local partners who are members of System Resilience Groups to integrate relevant elements of their operational resilience and capacity plans within action plans and will allow partners to give due regard to contractual arrangements in advance of the new financial year.

I know some areas have already uploaded their action plans to the Mind map and I congratulate local partners in those areas for their ambition; I am also aware of many more of you who are currently progressing well in developing your plans. I know this reflects your appetite to build on solid foundations. Existing action plans are available for anyone to view on the Concordat website at www.concordat.org.uk by clicking on green areas, and there are further resources also available on the website to assist local partners in drawing up their action plans under the 'Resources' and 'Get Inspired' tabs.

I suggest that we all view action plans as 'continuously improving' – so local areas should revisit, revise and update their plans as circumstances change, further challenges arise and results and solutions emerge. Action planning should therefore be viewed as a work in progress, and action plans that are on the website should be updated as necessary.

The focus should be, above all else, on developing plans that will deliver real change. We expect to see the involvement of local declaration signatories in developing relevant actions that seek to identify and address weaknesses in local service provision. Areas are welcome to add to the list of existing declaration signatories if they wish to do so, with new signatories contributing their own actions, as is the case in Gloucestershire, for example, with several third sector organisations becoming involved. The central national Concordat team, consisting of officials from my Department and colleagues from Mind, is putting in place an action plan quality review process which will help guide local partners.

NHS England planning guidance

In designing action plans, local partners should pay particular attention to NHS England's planning guidance for the next financial year, 'The *Forward View* Into Action: Planning For 2015/16' (http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf); paragraph 4.17 makes specific reference to the Crisis Care Concordat action plans, which should enshrine "the actions required of commissioners and providers to ensure that those experiencing a mental health crisis are properly supported", including "the provision of mental health support as an integral part of NHS 111 services; 24/7 Crisis Care Home Treatment Teams; and the need to ensure that there is enough capacity to prevent children, young people or vulnerable adults, undergoing mental health assessments in police cells."

Local governance & accountability

It is also important that areas have governance structures in place to ensure strong local accountability in monitoring the delivery of actions. The national Crisis Care Concordat works on the basis that all national signatories are jointly accountable to one another and I would encourage partners to consider adopting a similar approach to ensure that the spirit of collaborative working towards a mutual goal is maintained.

Care Quality Commission (CQC)

As you may know, as part of its thematic review into crisis care, CQC is carrying out local area inspections of services that respond to people experiencing a mental health crisis between November 2014 and February 2015 in up to 15 localities. As part of these local

area inspections, CQC is asking Trusts whether they already have a local Crisis Care Concordat action plan in place. CQC will provide feedback to those localities; this will be very helpful in identifying areas for improvement which can in turn be addressed through action plans. In addition, the final report will outline the plans for inspecting regulated providers that respond to people experiencing a mental health crisis so that key issues are routinely considered within their regulation of services, alongside recommendations for partners across the health and social care sector who have a responsibility towards people in crisis. CQC is seeking to publish the report later in 2015.

Crisis Teams and Health-based Places of Safety have been defined as core services under CQC's new inspection model for mental health services, and will be rated by CQC as part of the comprehensive inspection process. As a key partner to the national Crisis Care Concordat, CQC will take into account the Concordat's principles as part of this process.

Use of police cells for places of safety for u18s

You will hopefully now be aware that on 18 December, the Department of Health and Home Office published a joint Review into the operation of sections 135 and 136 of the Mental Health Act 1983. The Review recommends that the law be amended so that the use of police cells as places of safety is ended for under-18s, and occurs only in very exceptional circumstances for adults. Whilst next steps are subject to a detailed funding and implementation plan, the recommendations of the Review chime with the Government's existing position on this matter and with the standards set out in the Crisis Care Concordat.

As you may know, nationally, the use of police cells has reduced by 24 per cent so far this financial year for adults and children. While I hope to see this trend continue, there is significant variation across the country, which is why Mike Penning, the Minister for Policing, Criminal Justice and Victims, and I have recently written jointly to all areas where police cells are still being used as places of safety to make clear that we want to see rapid progress towards significantly reducing overall numbers and ending the practice for under 18s. We expect local action plans to address, for example, the need to end the use of blanket exclusion criteria restricting access to health-based places of safety on account of someone in crisis being intoxicated, and the need to ensure that there are clear protocols to enable under-18s to access crisis services on a 24/7 basis.

Improving the urgent response to people in crisis is one of many important elements of this work. Another I would encourage partners to consider is suicide prevention, with one local example being 'Project Zero', led by the South West Regional Suicide Reduction Collaborative, which aims to reduce suicides in the south west region to zero by 2018 (http://www.mentalhealthalliancesouthwest.org.uk/resource/project-zero-south-west-regional-suicide-reduction-collaborative/).

Moving forward

Please do ensure this letter is cascaded to everyone involved in drawing up your declaration. I do hope you all had a refreshing and enjoyable festive break and I look forward to pressing ahead with our collaborative work in 2015 with new energy and impetus. As ever, departmental officials with our colleagues at Mind are on hand to assist you in the next phase of this crucial task. Congratulations once again for your work to date and thank you for your ongoing efforts. I am sure you will all agree it is fundamental that we remember that we are doing this to improve the lives of individuals. We should all therefore give this the paramount priority it deserves, and be excited about the transformation we can achieve.

Yours sincerely,

NORMAN LAMB

Worcestershire Health and Well-being Board

Local Government Declaration on Tobacco Control

Agenda item 10

Date	28 January 2015
Board Sponsor	Marcus Hart, Chair and County Council Cabinet Member for Health and Well-being
Author	Dr Frances Howie, Head of Public Health
Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — No Obesity — No Alcohol — No Other (specify below) — No **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — Yes
Item for	Decision
Recommendation	**1. That the Health and Well-being Board:** a) **Support Worcestershire County Council (WCC) in signing the Local Government Declaration on Tobacco Control and support implementation of the Declaration through a partnership approach; and** b) **Encourage members to also consider signing the declaration (District Councils) or the sister declaration that has been launched for NHS organisations - the NHS Statement of Support.**
Background	2. Tobacco use remains the primary cause of preventable illness and premature death, accounting for approximately 80,000 deaths a year in England. There is clear evidence that through reducing smoking prevalence we will improve the overall health and life expectancy of

many people.

3. Smoking prevalence among adults has declined from just under 50% in the 1970s to approximately 19% in 2013. There are many reasons for this decline, including tobacco control legislation, evidence based NHS Stop Smoking Services and national educational campaigns.

4. Two thirds of smokers start before the age of 18.

5. Smoking is a crucial factor in health inequalities and is the single biggest cause of inequalities in death rates between the riches and the poorest communities.

6. Illicit trade in tobacco remains a problem in the UK, with 9% of cigarettes consumed being illicit, and the proportion of illicit hand rolled tobacco being around 36%.

7. Reducing smoking prevalence significantly increases household income and benefits the local economy. The annual cost of smoking to the UK national economy has been estimated at £13.7 billion.

8. The cost of smoking to the National Health Service in England is estimated to be £2 billion a year. It is estimated that smoking costs the NHS in Worcestershire approx. £27 million each year.

9. Smoking prevalence in Worcestershire was 14.7% in 2013. However, smoking harms not only the smoker but those who inhale their smoke too.

Tobacco Control Alliance

10. The Health Improvement Group (HIG) approved the Tobacco Control Plan 2014-2017 for Worcestershire, and will continue to monitor the progress of the plan. The Plan has set out the following three aims with a detailed action plan setting out how they will be achieved:
    - To prevent young people from becoming smokers;
    - To empower every smoker to stop; and
    - To protect families and communities from smoking-related harm

11. Implementation of the Tobacco Control Plan will be led, co-ordinated and monitored by the Tobacco Control Alliance (TCA) with annual reports to the HIG and up to the Board. The TCA includes a range of partners who have an influence on tobacco control and will operate as a virtual network with an annual workshop focused on updating knowledge; reviewing/mapping actions against the plan; and updating priorities for action in the next

planning period.

Local Government Declaration on Tobacco Control

12. The Local Government Declaration on Tobacco Control (Appendix 1) is a response to the enormous and ongoing damage that smoking does to our communities. It is a statement of a local authority's commitment to ensure that tobacco control is given a high priority and to take action to reduce harm from smoking.

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

14. The Declaration commits local authorities to:
    - Reduce smoking prevalence and health inequalities;
    - Develop plans with partners and local communities;
    - Participate in local and regional networks;
    - Support Government action at national level;
    - Protect tobacco control work from the commercial and vested interests of the tobacco industry;
    - Monitor the progress of plans;
    - Join the Smokefree Action Coalition.

15. The Council intends to sign the Declaration, and will ensure implementation through the Tobacco Control Plan. The Declaration is relevant for District Councils, who also have the opportunity to sign, and a sister document to the Declaration, the NHS Statement of Support, has been launched to allow NHS organisations to show their support for tobacco control.

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Local Government Declaration on Tobacco Control

We acknowledge that:

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

As local leaders in public health we welcome the:

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

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

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

Signatories

Leader of Council	Chief Executive	Director of Public Health

Endorsed by

Jane Ellison, Public Health Minister, Department of Health	Duncan Selbie, Chief Executive, Public Health England	Professor Dame Sally Davies, Chief Medical Officer, Department of Health
Dr Janet Atherton, President, Association of Directors of Public Health	Dr Lindsey Davies, President, UK Faculty of Public Health	Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute

Department of Health | Public Health England | Association of Directors of Public Health | Faculty of Public Health | Chartered Institute of Environmental Health | trading standards institute

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Worcestershire Health and Well-being Board

Access to Services for Deaf People

Agenda item 11

Date	28 January 2015
Board Sponsor	Peter Pinfield
Author	Jo Ringshall, Director Healthwatch Worcestershire
Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — Yes Obesity — No Alcohol — No Other (specify below) — No **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — Yes
Item for	Consideration
Recommendation	**1. That the Health and Well-being Board:** **a) Consider the Access to GP Services for Deaf People report and its recommendations; and** **b) Encourage the implementation of the recommendations of the report by all commissioners and providers of GP services particularly to reflect their Public Sector Equality duty**
Background	2. One of the issues consistently raised with Healthwatch Worcestershire (HWW) has been that Deaf people and their families were likely to experience difficulties accessing GP services. Information received locally combined with the experiences of Deaf Direct, a local charity that serves Worcestershire and national data confirmed this was a national problem which is reflected in the local experience across the County.

3. Deaf people experienced issues such as missed appointments due to a lack of visual prompts in the waiting room, friends and family being relied up to interpret and difficulty in making appointments due to 'telephone only systems'.

4. It was decided to survey GPs to ascertain what services they offered to deaf and hard of hearing patients and what adjustments were made to ensure they received a good experience when accessing their local GP services.

5. The procedure was:
   - Devise survey and distribute to all GP surgeries across Worcestershire
   - Collate responses
   - Discuss responses with local Deaf Charity and provider of BSL and other interpreter services with a view to assessing the quality and accuracy and appropriateness of the responses
   - Compile report, conclusions and recommendations
   - Report reviewed by Task and Finish Group from Healthwatch Worcestershire's Reference and Engagement Group.
   - Report reviewed by Board of Directors and co-opted members of the Board and approved for distribution
   - Distribute report.

6. All 68 surgeries were surveyed of which 28 responded which equates to a 41% return rate. Some surgeries were reluctant to provide detailed information and wrote back with the minimum response. Further details of the responses received can be seen within the report. Some Surgeries told us they did not record whether patients were deaf or hard of hearing so could not respond.

7. The response rate to the survey was relatively low and therefore the results are only indicative of the provision of services across the County however this is supported by the evidence accumulated by HWW and the Deaf Health Charity Sign Health for their "Sick of It" campaign. The responses do, however, show an inconsistent approach across the County.

Conclusion

8. The GP survey has highlighted a number of issues experienced by Deaf and Hard of Hearing people when accessing GP services across Worcestershire. A distinction should be drawn between patients who are profoundly deaf and whose first language is often BSL and hard of hearing patients who have developed hearing loss often later in life and who depend upon hearing loops and do not use BSL. Many of the basic

issues such as difficulty making appointments do affect both groups but there are very specific issues affecting the profoundly deaf.

- Difficulty making appointments where the appointment system is by telephone only and consequent reliance on family and friends to communicate with the Surgery
- Lack of visual prompts in the surgery to ensure that patients are aware when they are called for their appointment
- Triage systems which do not make adequate allowance for patients who are deaf or hard of hearing
- Inconsistent access to BSL interpreters and a lack of awareness of other methods of communication available such as on line interpreting for the profoundly deaf
- Reliance on family and friends to interpret or on written communication which may not be the patients preferred method of communication.

9. There were also some areas of good practice which were highlighted by the survey:
    - Surgeries where appointments could be made by email and SMS
    - Visual prompts in surgeries for appointments
    - Surgeries where double appointments were routinely made for patients with hearing difficulties to allow time for effective communication
    - Clear and obvious procedures for booking BSL interpreters

10. What is clear from the survey is the provisions made by GPs surgeries to improve access to health care for Deaf people is inconsistent across the County. This could be in breach of the duties outlined in the Equality Act 2010 which requires service providers to avoid unlawful discrimination and to make reasonable adjustments to ensure equality of service. Under the Equality Act it is considered a reasonable adjustment for organisations to book appropriate communication support.

11. The report recommends:

    1) Review how Deaf patients book appointments and how appointments are confirmed, making sure a range of options are available; email, on-line, text, Typetalk, fax and face to face.
    WHO – GP practices

    2) Mark patients records quite clearly that the patient is deaf and set up a clear and simple process for

ensuring the patient is aware when it is their turn.
WHO – GP practices

3) Provide Deaf Awareness Training for all staff who have contact with the public, including Receptionists and Practice Managers. The training should be delivered by an accredited trainer.
WHO – Health and Social Care service providers. Key agencies in Worcestershire such as CCGs, NHS England, Area Teams, County and District Councils

4) Advertise and promote interpreting provision by
   - Displaying posters in surgeries, hospital and council offices to remind staff to book an interpreter
   - Making a checklist or leaflet available to all staff as a reminder of their responsibilities to Deaf patients and how to book interpreters

   WHO – Health and Social Care service providers and service providers for BSL and other interpreters

5) Review how providers become aware of the preferred language or preferred method of communication of their patients and carers who are Deaf.
WHO – Health and Social Care providers

6) Adopt simple visual indicators in waiting rooms and reception areas. For example give everyone a number when they arrive and display the number on a screen when it is their turn.
WHO – Health and Social Care providers

7) Consider access to services for deaf people when tendering and reviewing contracts.
WHO – Commissioners of health and social care services

8) When the patient is referred on to other services ensure letter/notification includes highlighting the patient is deaf as this information is sometimes lost.
WHO – GP practices

12. HWW will circulate their report widely to all commissioners and providers of GP services asking for the recommendations to be implemented where appropriate. HWW will be revisiting the survey in the summer of 2015 to monitor outcomes and actions arising from the report.

13. NHS England is creating a standard of 'Making Health and Social Care information Accessible. This information standard would require all NHS and Social Care Organisations – including GPs and Dentists to:
    a) Identify and record whether a patient or service user has different information needs or communication support because they have a disability, impairment or sensory loss;
    b) Share and record needs
    c) Provide support/meet needs

14. Healthwatch Worcestershire will be using the results obtained from their survey to feed into the creation of this information standard.

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Worcestershire Health and Well-being Board

Update from Health Protection Group

Agenda item 12

Date	28 January 2015
Board Sponsor	Cllr Marcus Hart, Cabinet Member with Responsibility for Health and Well-being.
Author	Frances Howie, Head of Public Health, Directorate of Adult Services and Health.
Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — No Obesity — No Alcohol — No Other (specify below) — No **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — Yes
Item for	Information and assurance
Recommendation	**1. The Health and Well-being Board is asked to:** **a) Note the work of the Health Protection Group during 2014;** **b) Ask that a report be made annually to it for assurance, and by exception for escalation of any key issues; and** **c) Ensure their own organisations contribute to improvement where needed.**
Background	2. The Health Protection Group (HPG) was set up in 2013 as a sub-group of the Health and Well-being Board, with the purpose "to provide assurance that adequate multi-agency arrangements are in place to protect the public from major threats to health and well-being in

Worcestershire."

3. The full terms of reference are attached and detail the objectives of the Group. These include assurance around Emergency Preparedness, Resilience and Response (EPRR); immunization and screening programmes; health and social care acquired infections; and other major threats to health and well-being.

4. Membership includes CCGs; NHS England; Public Health England; District Councils; Worcestershire Health and Care Trust; Worcestershire Regulatory Services; Worcestershire Acute Hospitals Trust; and the County Council.

Work during 2014

5. The HPG met three times in 2014 (January, April, and October). Although the intention is to meet quarterly, the July meeting was cancelled due to the lack of agenda items. Several of the items of business have an annual cycle and the frequency of meetings will be under constant review. Six-monthly will be the core requirement. Meetings have been well-attended by all partners.

6. A summary of work during 2014 is included below. The HPG will continue to meet in 2015, receiving exception reporting and annual summaries, and ensuring that improvement plans where necessary are implemented.

Emergency Preparedness, Resilience and Response.

7. The HPG received and discussed reports on the Cold Weather Plan, and the Joint Outbreak Response Plan. Following the structural reforms of 2013, the focus of discussion was on clarifying where responsibilities lie and this is now clear and agreed between all parties. The Cold Weather Plan did not require activation in the Winter of 13/14.

8. At its October meeting, a presentation on Ebola was received from Public Health England. This stressed the low risk to UK populations, and the processes in place for dealing with suspected and possible cases. A local table-top exercise on Ebola took place on 28 October and this, and a subsequent exercise on 27 November was attended by many members of the HPG and other partners. Plans were tested and understanding was improved and shared.

Immunisation and Screening

9. Performance reports have been received on screening programmes for breast cancer; cervical cancer; diabetic retinopathy; abdominal aortic aneurysm; bowel cancer; and new-born. The Area Team has introduced a financial incentive CQUIN scheme to improve reach to

vulnerable population groups. Overall, coverage and uptake in Worcestershire are in line with national averages.

10. Performance reports were given on immunisation programmes on influenza, and childhood immunisations. It was noted that pockets of low take-up could be masked by overall good figures and an on-going discussion about sharing practice level data is now nearing resolution, and this will help local take-up initiatives. An expanded influenza immunization programme is now in place, offering the vaccine to children aged 2, 3, and 4 years for the first time, and to years 7 and 8 as part of a national pilot. Overall, uptake is in line with national average.

11. Due to organisational change, plans to improve uptake were not been fully developed at the start of 14/15, but this work is now in place and receiving full focus. Local roles and responsibilities were discussed and agreed by the HPG. Public Health England have agreed to involve the Health Improvement Group where appropriate in supporting these plans at local level.

Health and Social Care Acquired Infection (HCAI)

12. At the January meeting the Chair of the County Infection Prevention Committee received a report from a recent and well-attended Health Care Acquired infection workshop, and the County strategy. In April the final version of the 3 year Strategy was welcomed and endorsed. Monitoring of the Strategy will be through the County Infection Prevention Committee and the HPG will receive annual update. The low rates of infection were noted.

Other threats to Health and Well-being

13. During the year, three general items have been brought to the Group. The first dealt with Air Quality, and has been reported previously to Health and Well-being Board members at the July meeting of the Board. Ten Air Quality Management Areas (AQMA) are in place across the county and are managed through Worcestershire Regulatory Services. Poor air quality is intermittent and linked to congested streets in peak traffic times, where there is minimal air flow and residential properties close to the curbside. All are linked to traffic emissions. This is not seen as a major threat to health at this stage and District priority actions for each AQMA are in place, reporting to a Steering Group. The HPG will receive further updates.

14. The second general item dealt with the impact of reductions to Worcestershire Regulatory Services (WRS) and the HPG was reassured that the cumulative impact of service reduction had not presented a significant threat

to health and well-being at this stage. Funding reductions were being managed but there was very limited capacity now for any proactive or work. There were still some concerns about this, and about surge capacity in the event of an outbreak. Discussion in the October meeting asked for future reports on the effectiveness of risk mitigation to come to the HPG.

15. Thirdly, the HPG received a confidential update report from Public Health **England** on health protection, summarizing outbreaks and incidents, and it was noted that there had been nothing to suggest unusual levels, and also that outbreaks and incidents had been well managed. Although the emerging threat of Ebola has a great deal of national coverage, the risk of infection to our population is extremely low. The transition to new systems as a result of NHS reform has been carefully managed and all processes and capacity are now embedded.

Worcestershire Health and Well-being Board

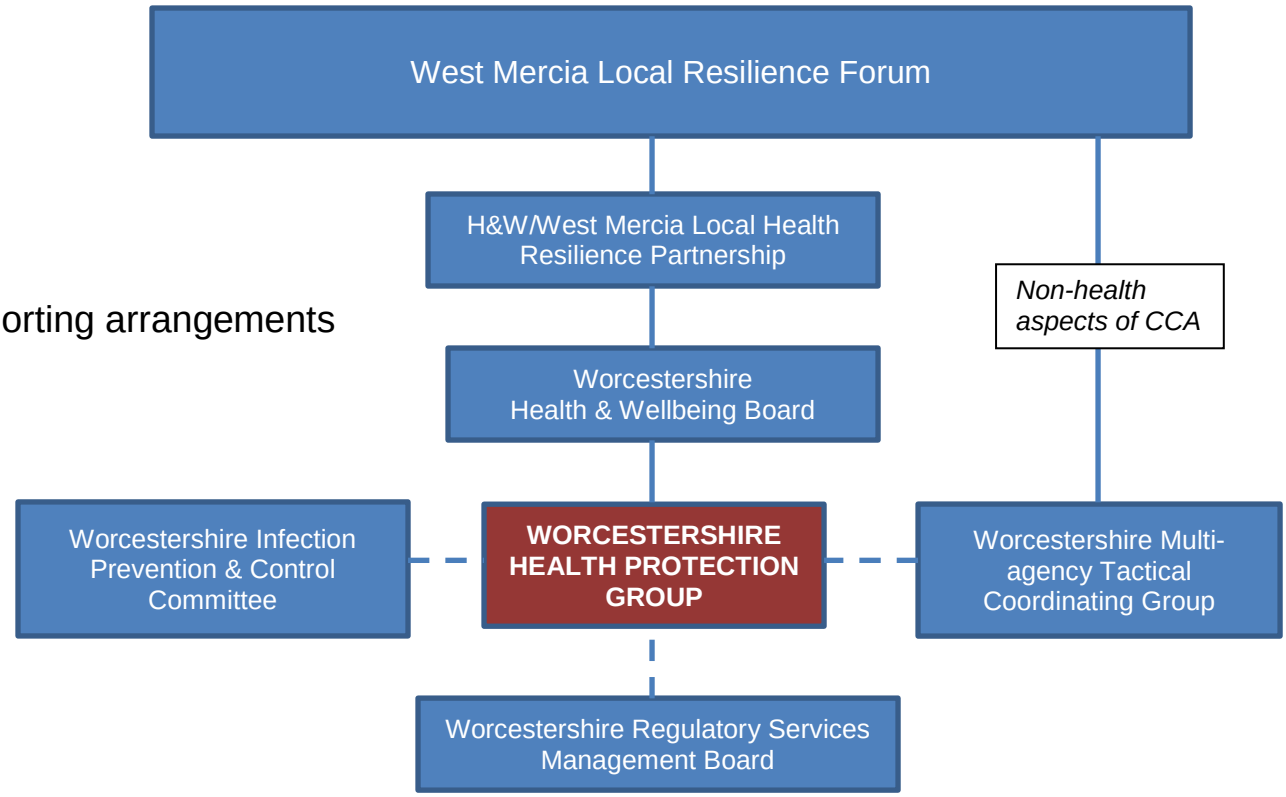
Health Protection Group

Terms of reference

Purpose	To provide assurance that adequate multi agency arrangements are in place to protect the public from major threats to health and well-being in Worcestershire.
Objectives	1. To ensure that Worcestershire County Council, District Councils, NHSCB and PHE (as category 1 responders) and CCGs (as category 2 responders) deliver their responsibilities for Emergency Preparedness, Resilience and Response (EPRR) under the Civil Contingencies Act, and where relevant for health protection under the Health and Social Care Act. 2. To identify major threats to health and well-being and ensure that comprehensive, up to date and tested plans are in place, working with the West Mercia Local Health Resilience Partnership and West Mercia Local Resilience Forum. 3. To ensure that robust arrangements for leading and co-ordinating the response to specific incidents and emergencies are in place. 4. To ensure that adequate procedures are in place to manage and prevent health protection incidents from occurring. 5. To review the response to serious incidents and emergencies and make recommendations to inform improvements to planning and response to future events. 6. To raise concerns to the Health and Wellbeing Board where deficiencies in the preparation, resilience and/or response to threats to health and well-being are identified. 7. To develop an integrated partner approach to ensure that public health messages are received by residents, businesses and other stakeholders in a relevant and timely manner as part of a rolling programme. 8. To review immunization coverage, overall and in specific groups, and to oversee the development and implementation of plans for improvement where necessary. 9. To review the coverage and quality of national screening programmes, overall and in specific groups, and to oversee the development and implementation of plans for improvement where necessary. 10. To review the incidence of health and social care acquired infections, and oversee the development and implementation of plans to reduce these where necessary.
Accountability	The Group is accountable to the Health and Well-being Board.

Membership	• County Council lead Member(s) [Chair] • County Council (DASH HoS) • NHS England (HO EPRR & HO Public Health) • Public Health England • Member from District Councils – South • Member from District Councils – North • WAHT (Emergency Planning Officer) • Head of Worcestershire Regulatory Services • CCG Chief Operating Officers • Chair Worcestershire Infection Prevention & Control Committee • WCC Emergency Planning Manager • Consultant in Public Health (Health Protection) • WHCT (Emergency Planning Manager)
Regular attendees	To be decided.
Arrangements for deputies	Each member to nominate one deputy to attend in their absence.
Quoracy and decision making	Meetings will be quorate if at least five members or substitutes are present including at least one elected Member from the County or District Council and one GPCC representative. It is expected that any decisions of the HPC will generally be by consensus, otherwise by a majority of those members present.
Frequency of meetings	Quarterly. Agenda items to be added via DASH HoS.

Reporting arrangements



Worcestershire Health and Well-being Board

Autism Strategy for Worcestershire

Agenda item 13

Date	28 January 2015
Board Sponsor	Dr Richard Harling, Director of Adult Services and Health
Author	Richard Keble, Head of Joint Commissioning
Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — Yes Obesity — No Alcohol — No Other (specify below) — No **Groups of particular interest** Children & young people — Yes **Communities & groups with poor health outcomes** — Yes **People with learning disabilities** — Yes
Item for	Information and assurance
Recommendation	**1. The Health and Well-being Board is asked to note progress of development and consultation of the Autism Strategy.**
Background	2. Health and Well Being Board received a report about the proposed Autism Strategy for Worcestershire in November 2014. This strategy is set in the context of the National Strategy for Adults with Autism and the Statutory Guidance for Autism, which requires Local Authorities and their NHS partners to have such a strategy in place. 3. The Autism Act 2009, "Fulfilling and Rewarding Lives: The Strategy for adults with autism in England (March 2010) and subsequent documents issued by the Department of Health focus on adults with autism, therefore the previously presented draft strategy focused on adults only.

4. The Health and Well Being Board discussed the advantages of turning this adult strategy into an all age strategy, incorporating not only recent legislation in the Children's and Families Bill. It would also offer the basis for a more integrated service for children, young people and adults.

5. The Health and Well Being Board
   - Authorised consultation on this Strategy and requested a progress report be brought back to the Board in January 2015 for consideration, along with a progress report on consultation on a children and young people's Autism Strategy; and
   - Requested that an all age Strategy be developed and brought back for consideration and sign off in March 2015.

6. That the Strategy has now been amended to include reference to children and young people's and we are now consulting on an all age Strategy.

Next Steps

7. Consultation has now commenced. A report about the outcome of the consultation and the finalised Autism Strategy for Adults and Children will be presented to the Health and Well Being Board in March 2015.