

# Swindon Borough Council

## Health and Wellbeing Board

**Wednesday, 14 December 2016**

Committee Room 6, Civic Offices

At 2.00 p.m.

**Contact Officers:**

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### AGENDA

- 1. Apologies for Absence**
- 2. Declarations of Interest**  
Members are reminded that at the start of the meeting they should declare any known interests in any matter to be considered, and also during the meeting if it becomes apparent that they have an interest in the matters being discussed.
- 3. Public Question Time**  
Please refer to the explanatory notes below.
- 4. Minutes** (Pages 3 - 10)  
To receive the minutes of the meeting held on 12 October 2016.
- 5. Appointment of Vice-Chair**  
Members will be invited to nominate a representative to be appointed to the position of Vice-Chair of the Swindon Health and Wellbeing Board.
- 6. Swindon's Joint Health and Wellbeing Strategy Evaluation Report** (Pages 11 - 48)
- 7. Local Safeguarding Children Board Annual Report 2015-16** (Pages 49 - 132)
- 8. Ageing Well Joint Strategic Needs Assessment** (Pages 133 - 146)
- 9. NHS England National Commissioning Intentions** (Pages 147 - 234)
- 10. Sustainability and Transformation Plan - update** (Pages 235 - 250)

11. **Swindon Oral Health Strategy** (Pages 251 - 270)
12. **Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon** (Pages 271 - 282)
13. **Joint Commissioning Group - Minutes for Information and Comment** (Pages 283 - 298)
14. **Future meeting dates of the Board** (Pages 299 - 302)
15. **Any Other Business** (Pages 303 - 306)
  - To consider a letter regarding Police and Crime Commissioners and Health and Wellbeing Boards from The Rt Hon Amber Rudd MP, Home Secretary, and The Rt Hon Jeremy Hunt MP, Secretary of State for Health.

**Date of Despatch:** 05 December 2016

**Public Question Time** - Swindon Borough Council remains committed to increasing its accountability to the public and to promoting active citizenship. 15 minutes will be allowed at the start of all Council meetings for questions to the Chair from the public about the work of the Committee (except for confidential matters, and matters relating to planning and licensing applications). We will give priority to those who submit questions in writing at least two days before the meeting. Questions must be relevant, clear, and concise. You may not use Public Question Time as an opportunity to make speeches or statements.

Questions in writing should be sent to the Committee Officer whose contact details appear on the agenda above, or to the Director of Law and Democratic Services. We will publish it, along with the answer, alongside the Minutes. The process associated with asking a public question is set out in the "Public Question Time at Council Meetings Protocol and Guidance" available from the Committee Officer named above or on the Council's Website at:

<http://ww5.swindon.gov.uk/moderngov/ecCatDisplay.aspx?sch=doc&cat=13338&path=0>).

**Access Arrangements** - The venue is wheelchair accessible and an infrared receiver hearing system is provided. If you have any special requirements to enable you to attend the meeting, or would like to receive any of the pages contained in this agenda in a larger print size, please contact the Committee Officer as soon as possible prior to the date of the meeting.

**HEALTH AND WELLBEING BOARD**

**WEDNESDAY, 12 OCTOBER 2016**

PRESENT:- Brian Mattock (Lay Member) (Chair), Councillors Ray Ballman, Fionuala Foley, and David Renard (Swindon Borough Council), Mark Edwards (Healthwatch Swindon), Angus Macpherson (Police and Crime Commissioner), Gill May (NHS Swindon Clinical Commissioning Group), Nicki Millin (NHS Swindon Clinical Commissioning Group) and David Wray (Voluntary Action Swindon).

Also in attendance were: Doug Bale (Adult Safeguarding Manager, Swindon Borough Council), Diana Fulbrook (Independent Chair of the Swindon Local Safeguarding Adults Board), Cherry Jones (Director of Public Health, Swindon Borough Council), Karen Reeve (Director of Children's Services, Swindon Borough Council), Sue Wald (Director of Adult Social Services, Swindon Borough Council), Peter Nathan (Head of Education Services, Swindon Borough Council), and Ayoola Oyinloye (Consultant in Public Health, Swindon Borough Council).

Apologies for absence were received from Councillor Brian Ford and John Gilbert (Chief Executive, Swindon Borough Council).

**28. Declarations of Interest**

The Chair reminded members of the need to declare any known interests in any matters to be considered at the meeting. No declarations were made.

**29. Dr Peter Crouch**

Following the recent death of Dr Peter Crouch the Board wished to pass on its condolences to his family. It acknowledged the contribution of Dr Crouch as Vice-Chair of this Board and expressed its appreciation for his work both on the Board and within the wider community. It noted that his legacy in Swindon would continue through his achievements.

**30. Public Question Time**

No public questions were received prior to or during the meeting.

**31. Minutes**

Resolved – That the minutes of the meeting held on 13<sup>th</sup> July 2016, be confirmed and signed as a correct record.

**32. Safeguarding Adults in Swindon Annual Report 2015-16**

The Board considered a report reviewing (a) the Safeguarding Adults in Swindon Annual Report 2015/16, (b) progress made against the Local Safeguarding Board's Strategic Plan, and (c) details on activity in relation to safeguarding adults in Swindon.

Diana Fulbrook, Independent Chair of the Swindon Local Safeguarding Adults

Board (LSAB), and Doug Bale, Adult Safeguarding Manager at Swindon Borough Council, introduced the report and highlighted activities during the year in relation to the core 2015/16 priorities and Care Act requirements. The report also set out data collection throughout the year which supported the direction of travel for safeguarding adults and details on how the Care Act was embedded into the work carried out by the Board.

Following the introduction of the report by Ms Fulbrook and Mr Bale the Board discussed key issues raised including:

- The increase of 56% in the activity of the Adult safeguarding team in Swindon.
- That 38% of cases referred to the Adult Safeguarding Teams were investigated and 44% of cases required no further action.
- The source and nature of referrals during the 2015/16 reporting year.
- The impact of reduced resources and staff changes on work undertaken during the year.
- The furtherance of the following four strategic priorities for the Board during 2016/17;

1. Effective Governance (to develop the capacity of the Swindon LSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Swindon safe).
2. Performance and Quality ( to ensure that there are effective multiagency quality assurance and performance management processes in place which will promote the welfare of adults with care and support needs and will hold partners to account).
3. Communication and engagement (to ensure there is a consistent and co-ordinated approach to how the safeguarding message for adults is disseminated to all groups and communities in Swindon, and ensure that adults and communities of all backgrounds and makeup are engaged in the work of the LSAB).
4. Workforce Development (to ensure the workforce of all partner agencies have access to and have undergone robust training relevant to their role and that they understand how to apply the training to their role).

- Work undertaken in respect of domestic violence/abuse including joint work with partners on this major issue (54% of major case reviews involved domestic violence) including the Multi-Agency Risk Assessment Team.
- The effect of benefit changes on domestic violence.
- That domestic abuse had been added into the Board's guidance and that data was always collected in such cases.
- The LSAB's perspective of where safeguarding began and ended.
- The need to distinguish between care and support needs and adults being identified as vulnerable.
- Monthly training provided free of charge by the LSAB team Quality Assurance Manager for people with care and support needs.
- The need for partner organisations to better understand the referral criteria in order to reduce wasted time and costs involved in initial assessments to identify vulnerable adults that are not progressed by the LSAB (although some would be referred to other professionals where appropriate).

Resolved - That the Safeguarding Adults in Swindon Annual Report for 2015/16 be noted.



### **33. Implementation of the Special Educational Needs and Disability (SEND) Reforms**

The Board considered a report setting out the new joint local area Special Educational Needs and Disability Inspection under Section 20 of the Children Act 2004.

Peter Nathan, Head of Education Services at Swindon Borough Council and Councillor Fionuala Foley, Cabinet Member for Children's Services, introduced the report. It was noted that all areas in England will be the subject of a joint inspection from Ofsted and the Quality Care Commission, to judge the effectiveness of the area in implementing the disability and special educational needs reforms set out in the Children's and Families Act 2014, and that this inspection could be carried out at any time with only one week's notice. The Board was advised that Health and Wellbeing developments, including transition requirements, and the knowledge of Health and Wellbeing Board members of work in this area, would form part of the review.

Following the introduction of the report the Board discussed:

- The three key questions arising from inspections namely; (i) effectiveness in the identification of children and young people who have special educational needs and/or disabilities, (ii) effectiveness in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities, and (iii) effectiveness in improving outcomes for children and young people who have special educational needs and/or disabilities.
- The importance of achieving recognised outcomes and the role of the Special Education Needs Board to monitor provision in meeting needs and achieving improvements and promote learning.
- The percentage of young people with special educational needs and/or disabilities at Swindon (3.8%) which was one of the highest rates in the country.
- On-going work within the education team to focus funding to improve provision for these young people rather than funding through a system of statements of needs.
- The improvement in undertaking statement related work within a twenty week period which had risen from 30% to 94% in one year.
- Lessons to be learnt from how other Local Authorities operate in order to improve service provision.
- Work with parents and parent groups to ensure the child is at the heart of decisions made.
- The outcome of two Ombudsman cases in favour of the Local Authority.
- Work with the CCG on self-evaluation and to make processes more transparent.
- The need for the Board to monitor progress against the criteria laid down in the report.

Resolved – (1) That the arrangements for the forthcoming joint area Special Educational Needs and Disability Reforms inspection be noted.

(2) That a joint Swindon Borough Council and Clinical Commissioning Group progress report on the implementation of Special Educational Needs and Disability Reforms together with partnership arrangements to address the priorities of those

organisations, potential issues arising and how these will be addressed be submitted to this Board on a six monthly basis.

(3) That members of the Board be forwarded key facts relating to the top three developments for Swindon Borough Council and the Clinical Commissioning Group under the Special Educational Needs and Disability Reforms.

### **34. Oral Health Joint Strategic Needs Assessment**

The Board receive a report setting out the Oral Health Joint Strategic Needs Assessment for Swindon.

Ayoola Oyinloye, Consultant in Public Health, introduced the report and drew members' attention to the Oral Health Joint Strategic Needs Assessment recommendations namely:

- Develop an oral health strategy for Swindon.
- Tackle the causes of tooth decay in children and adults by reducing the consumption of sugar and alcohol and stopping the use of tobacco.
- Include oral health actions as the norm in strategies, programmes and services aimed at vulnerable adults and children, e.g. low sugar food policies, oral hygiene as part of individual care plans, signposting to NHS dental practices.
- Review current commissioning oral health interventions, using both universal and targeted approaches, to help people keep their mouths clean, use fluoride to strengthen their teeth, increase awareness of oral cancer and visit the dentist regularly. There is an opportunity to do this now as the contracts for oral health promotion is up for renewal in 2017/18.
- Address the historical high rates of hospital admission for tooth extraction in Swindon, to ensure that all admissions are appropriate.

Following Mr Oyinloye's introduction of the report the Board discussed the main issues including:

- The figures for dental care set out within the report and how dental care was affected by access to dental care.
- The current NHS dental capacity in Swindon.
- Local improvement to dental care for children within the context of the national position.
- The Swindon Oral Health Strategy and the expectation that this would be developed for the new financial year.
- The role of national policy in driving oral health care.
- The role of education in promoting good oral health and the role of schools within this work.
- How children with Special Educational Needs and/or disabilities were supported in finding dentists and subsequently in maintaining regular appointments to promote preventative work.

Resolved – (1) That the report be noted.

(2) That the recommendations of the Oral Health Joint Strategic Needs Assessment, as set out in paragraph 3.11 of the report be approved.

(3) That the development of an Oral Health Strategy for Swindon, to be led by Public Health, be supported.

(4) That the Oral Health Strategy for Swindon be submitted to this Board for future

consideration and approval.

### **35. Falls and Bone Health Joint Strategic Needs Assessment**

The Board received a report setting out the Swindon Falls and Bones Health Joint Strategic Needs Assessment, produced by a Swindon wide multi-agency group. The report set out a number of recommendations to support the work of the on-going work of the Swindon Falls and Bones Health Collaborative.

Cherry Jones, Director of Public Health, introduced the report noting that the Swindon Falls and Bones Health Joint Strategic Needs Assessment before the Board had updated its predecessor which was produced in 2014. The updated report reflected currently available data and the work of the Swindon Falls and Bones Health Collaborative.

A copy of a booklet “Steady Steps to Staying Active for Life” was circulated for Members’ information and comment.

Following Ms Jones introduction of the report the Board discussed the following issues:

- Falls as currently, the most common cause of death and their being a major cause of the loss of independence and also a major cost in medical care to the National Health Service.
- The implications of falls in relation to service provision for an ageing population.
- The recommendations of the Swindon Falls and Bones Health Collaborative together with progress in meeting these were set out in paragraph 3.8 of the report.
- The strength and balance of older people as a key health issue and a recent event on Falls and Bone health looked at how services could be better shaped to address needs in the future.
- The role of vitamin D deficiency and bone density in bone health and the strategy to improve bone health generally.
- The booklet “Steady Steps to Staying Active for Life” and how it would be distributed to its target audience.
- Strategies to improve Bone Health such as encouraging walking clubs.
- The use of intelligence and data collection to help prevent further accidents.
- The benefits of including a Swindon based short statistical summary in the “Steady Steps to Staying Active for Life” booklet when it is refreshed.

Resolved – (1) That The Swindon Falls and Bones Health Joint Strategic Needs Assessment, set out in Appendix 1 to the report, be approved and the on-going focus on falls prevention work in Swindon be supported.

(2) That the Swindon Falls and Bones Health Strategy be supported.

(3) That update reports on the Swindon Falls and Bones Health Strategy be added to this Board’s work programme.

### **36. Community Services**

The Board received a joint report of the Director of Adult Services, Executive Nurse (Clinical Commissioning Group) and Accountable Officer (Clinical Commissioning Group) setting out an overview of the procurement process for the award of adult

community services contracts and a summary of service issues at the time of the transfer of services.

Gill May, Executive Nurse at Clinical Commissioning Group, introduced the report setting out changes to services provision in respect of community services within the Borough which had been tested at public events. Contacts had gone out to tender in March 2016 but following capacity leadership and skills concerns at SEQOL community nursing service Swindon Borough Council brought some service provision back in-house. In addition the significant financial and staffing challenges facing SEQOL and analysis of complaints received and poor patient experience also meant that other work was taken over by the Great Western Hospital Foundation Trust and Avon and Wiltshire Partnership Trust. Service provision was continuing as usual under a new management team which had also supported staff since taking over responsibility on 1<sup>st</sup> October 2016.

Sue Wald, Director of Adult Social Services, Swindon Borough Council, confirmed that as a result of SEQOL's financial position all social care work had been transferred back to the Council on 1<sup>st</sup> October. This had resulted in the transfer of 400 staff back to the Council. Opportunities future social care service provision was being examined. This transfer had been successfully completed with community health and social work staff still being co-located. She thanked Nicki Millin for her hard work in transferring these services.

Following Ms May's introduction of the report the Board discussed the following issues:

- Due diligence and action planning for the transfer of services from SEQOL.
- The location of staff transferred to Swindon Borough Council and the Clinical Commissioning Group.
- Learning Disability and Autism services that had been transferred to the Avon and Wiltshire Partnership Trust.
- Patient benefits that it was hoped would be provided through the transfer of services.

Resolved – (1) That the report be noted.

(2) That the Board's appreciation for the speedy and successful transfer of services be recorded.

### **37. NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan**

Nicki Millin, Accountable Officer at Swindon Clinical Commissioning Group highlighted the following issues in respect of the NHS England Swindon Clinical Commissioning Group Sustainability and Transformation Plan:

- The NHS planning guidance had been received two weeks ago.
- The two year Sustainability and Transformation Plan was expected by 23rd December 2016.
- High level testing of the Sustainability and Transformation Plan.
- The resourcing of the development and staffing services to provide reliable service provision.
- Some service provision might be under a different model.
- Although the NHS England plans were still under embargo there was nothing

of concern for Swindon.

- Plans for public consultation were being considered and was expected to include, service provision, links to social care and the challenges facing the service.

The Board discussed:

- The national and local consultations undertaken in respect of NHS England Clinical Commissioning Group Sustainability and Transformation Plans.
- The need to identify service budgets at the earliest opportunity.
- That the local plan needed to reflect Swindon's Sustainability and Transformation Plan

Resolved – (1) That the report be noted.

(2) That the Accountable Officer at Swindon Clinical Commissioning Group be requested to report on the Sustainability and Transformation Plan draft response and submission to NHS England at the December meeting of this Board.

### **38. Autism Diagnostic Service**

With the agreement of the Chair and the Board, Councillor Ray Ballman, in her capacity as Chair of the Swindon Autism Board, raised local concerns that despite an increase in diagnostic service referrals to 6-8 per month that this service would be reviewed in December with a possible reduction in budget.

Gill May, Executive Nurse, Clinical Commissioning Group, responded that she had not requested any such reduction.

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## Swindon's Joint Health and Wellbeing Strategy: Evaluation Report December 2016

Health and Wellbeing Board

Date: 14 December 2016

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Author:	Cherry Jones - Director of Public Health, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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### 1. Purpose and Reasons

- 1.1 Swindon's first Joint Health and Wellbeing Strategy (JHWS): 2013-2016 was published in December 2013. It set out the vision and the long term improvements in local people's health and wellbeing that partners aimed to achieve in Swindon. It highlighted five priority outcomes for action (based on local need) and highlighted a range of indicators that would help measure progress.
- 1.2 Progress against the 2013 -2016 strategy priorities has been monitored and this report provides an evaluation and a rounded analysis of Swindon's performance on the supporting indicators.
- 1.3 The Joint Health and Wellbeing Strategy will be refreshed for 2017 informed by the latest JSNA (Joint Strategic Needs Assessment) and local priorities.

### 2. Recommendations

The Board is recommended to:

- 2.1 Note the Joint Health and Wellbeing Strategy Evaluation Report December 2016 attached at Appendix 1 to the report.
- 2.2 Consider the progress made against the priority outcomes and the areas where particular challenges still lie to achieve our long term aims and overall vision.
- 2.3 Review the refreshed Joint Health and Wellbeing Strategy 2017– 2022 informed by this report and reflecting the latest Joint Strategic Needs Assessment findings at its March 2017 meeting.

### 3. Detail

- 3.1 Swindon's Health and Wellbeing Board has a statutory duty, outlined in the Health and Social Care Act 2012, to produce a JHWS.
- 3.2 The Health and Wellbeing Board worked with local stakeholders including service users, residents, patients and carers, the voluntary and community sector, NHS,

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Further information on the subject of this report can be obtained from Tom Frost, 07884 733175, [tfrost@swindon.gov.uk](mailto:tfrost@swindon.gov.uk).

# Swindon's Joint Health and Wellbeing Strategy: Evaluation Report December 2016

Health and Wellbeing Board

Date: 14 December 2016

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local authority and One Swindon partners, to develop the first JHWS for Swindon, 2013-2016 and published in October 2013.

- 3.3 The JHWS vision is that Everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities.
- 3.4 The strategy outlines a three year ambition for improving health and wellbeing and addressing health inequalities across the borough. It identifies priorities and approaches for partners including the Clinical Commissioning Group (CCG), NHS and local authority, to take into account when developing their own plans and making decisions about spending money and planning services.
- 3.5 The JHWS for Swindon set out the vision and the long term improvements in local people's health and wellbeing that the partners wanted to achieve in Swindon. It also set out the priorities for action and a suite of indicators that would help measure progress.
- 3.6 The performance indicators agreed in the Joint Health and Wellbeing Strategy give an indication of how well Swindon's services are responding to local population need. Positive and negative changes in performance are influenced by more than just the local service provision in place, but it is important that the Health and Wellbeing Board is aware of the health and wellbeing trends of Swindon's population so it can plan for and develop services strategically and inform commissioning intentions.
- 3.7 This report (Appendix 1) provides a summary of final progress against the 2013-2016 JHWS to achieve the priority outcomes and a rounded analysis of Swindon's performance on the supporting indicators.
- 3.8 The strategy contains five priority outcomes with a series of indicators drawn from the Public Health Outcomes Framework (PHOF), NHS Outcomes Framework and Adult Social Care Outcomes Framework (ASCOF) to monitor progress.
- 3.9 The five priority outcomes are:
  - 1. Every child and young person in Swindon has a healthy start in life
  - 2. Adults and older people in Swindon are living healthier and more independent lives
  - 3. Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems, offenders)
  - 4. Improved mental health, wellbeing and resilience for all

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Further information on the subject of this report can be obtained from Tom Frost, 07884 733175, [tfrost@swindon.gov.uk](mailto:tfrost@swindon.gov.uk).



# Swindon's Joint Health and Wellbeing Strategy: Evaluation Report December 2016

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5. Creation of sustainable environments in which communities can flourish

3.10 The evaluation report looks at each outcome in turn and presents:

- An infographic summarising the indicators and providing an overview of outcomes in Swindon.
- A chart and table for each indicator showing how Swindon's outcomes have changed over time and how they compare to England, the South West, similar authorities (ONS cluster – New and Growing Towns (A)) and authorities experiencing similar levels of deprivation (3<sup>rd</sup> least deprived decile).

This style of presentation allows a much fuller analysis of progress than simply comparing a baseline value with current figures.

- A commentary on some of the actions and initiatives taken to tackle the challenges identified in delivering each outcome.

## Main findings and challenges

3.11 Swindon's outcomes on a number of indicators are significantly better than England and other comparator authorities, for example on childhood immunisations and breast cancer screening coverage.

3.12 Swindon's outcomes have significantly improved in a number of areas too, for example breastfeeding at 6-8 weeks, the number of 16-18 year olds not in education, employment or training and alcohol-related admissions to hospital (under 18's), people receiving social care who say they have advice and information, and successful completion of drug treatment by both opiate and non-opiate users.

3.13 In other areas, the indicators highlight that significant challenges remain, including:

- GSCE attainment
- Admissions of older people to residential and nursing care homes
- Physically inactive adults
- Cervical cancer screening
- Employment for those with learning disabilities compared to the overall population
- Reported domestic violence incidents

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Further information on the subject of this report can be obtained from Tom Frost, 07884 733175, [tfrost@swindon.gov.uk](mailto:tfrost@swindon.gov.uk).

# Swindon's Joint Health and Wellbeing Strategy: Evaluation Report December 2016

Health and Wellbeing Board

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- Suicide
  - Social isolation in adult social care users
- 3.14 In the majority of cases there are already initiatives underway to understand the issues connected with the indicators better and to tackle the problems themselves. This is underpinned by the JSNA framework which is the formal mechanism to analyse and interpret local and national data to establish need and service demand and how it is being met in Swindon. Since it was established in 2013 the HWB, which has a duty to develop the JSNA to identify local need and inform commissioning, has commissioned a number of JSNAs focused on specific topic areas.
- 3.15 JSNA's include recommendations for action to meet identified unmet need as well as how to improve service provision and tackle inequalities. All the JSNA's and supporting strategies can be found on the JSNA website <http://www.swindonjsna.co.uk/>.

## 4. Alternative Options

- 4.1 No alternative options are proposed.

## 5. Implications

### Financial and Procurement Implications

- 5.1 The JHWS 2013-2016: Evaluation Report is delivered within the current financial position. There are no financial or procurement implications arising from this report.

### Legal and Human Rights Implications

- 5.2 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

### All other Implications

- 5.3 There are no other implications arising from this report.

### Diversity Impact Assessment

- 5.4 A diversity impact assessment has not been completed at this stage for this report.

### Risk Management

- 5.5 No specific risks identified at this stage for this report.
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Further information on the subject of this report can be obtained from Tom Frost, 07884 733175, [tfrost@swindon.gov.uk](mailto:tfrost@swindon.gov.uk).

# **Swindon's Joint Health and Wellbeing Strategy: Evaluation Report December 2016**

**Health and Wellbeing Board**

**Date: 14 December 2016**

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## **6. Consultees**

- 6.1 The Corporate Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

## **7. Background Papers**

- 7.1 None.

## **8. Appendices**

Appendix 1 - Swindon's Joint Health and Wellbeing Strategy 2013-2016:  
Evaluation Report December 2016.

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# Swindon's Health and Wellbeing Strategy 2013 - 2016



## EVALUATION REPORT

Swindon's Health and Wellbeing Board

## Introduction

### JHWS 2013-2016

Swindon's first Health and Wellbeing strategy was published in 2013. It defined a vision that 'everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities'. It explained how this would be achieved by focusing on particular priorities. Five priority outcomes for action were identified based on local need, and a range of indicators suggested that would help measure progress.

The strategy was put together by the Health and Wellbeing Board working with people who use health and social care services, local residents, patients, carers, the voluntary sector, NHS, Swindon Borough Council and other interested organisations. The priorities in the strategy also informed the aims of individual organisations such as Swindon Clinical Commissioning Group and the Council when they were planning services and making decisions about spending money.

### JHWS 2013-2016: Evaluation Report

This report provides a summary of final progress on how we are doing in Swindon to improve health and reduce inequalities based on the five priority outcomes. The measures of progress are drawn from a range of national sources such as the Public Health Outcomes Framework (PHOF), NHS Outcomes Framework and Adult Social Care Outcomes Framework (ASCOF) to monitor progress. This is so we can be confident in the data and can compare Swindon against other areas and over time.

The five priority outcomes are:

1. Every child and young person in Swindon has a healthy start in life.
2. Adults and older people in Swindon are living healthier and more independent lives.
3. Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems, offenders).
4. Improved mental health, wellbeing and resilience for all.
5. Creation of sustainable environments in which communities can flourish.

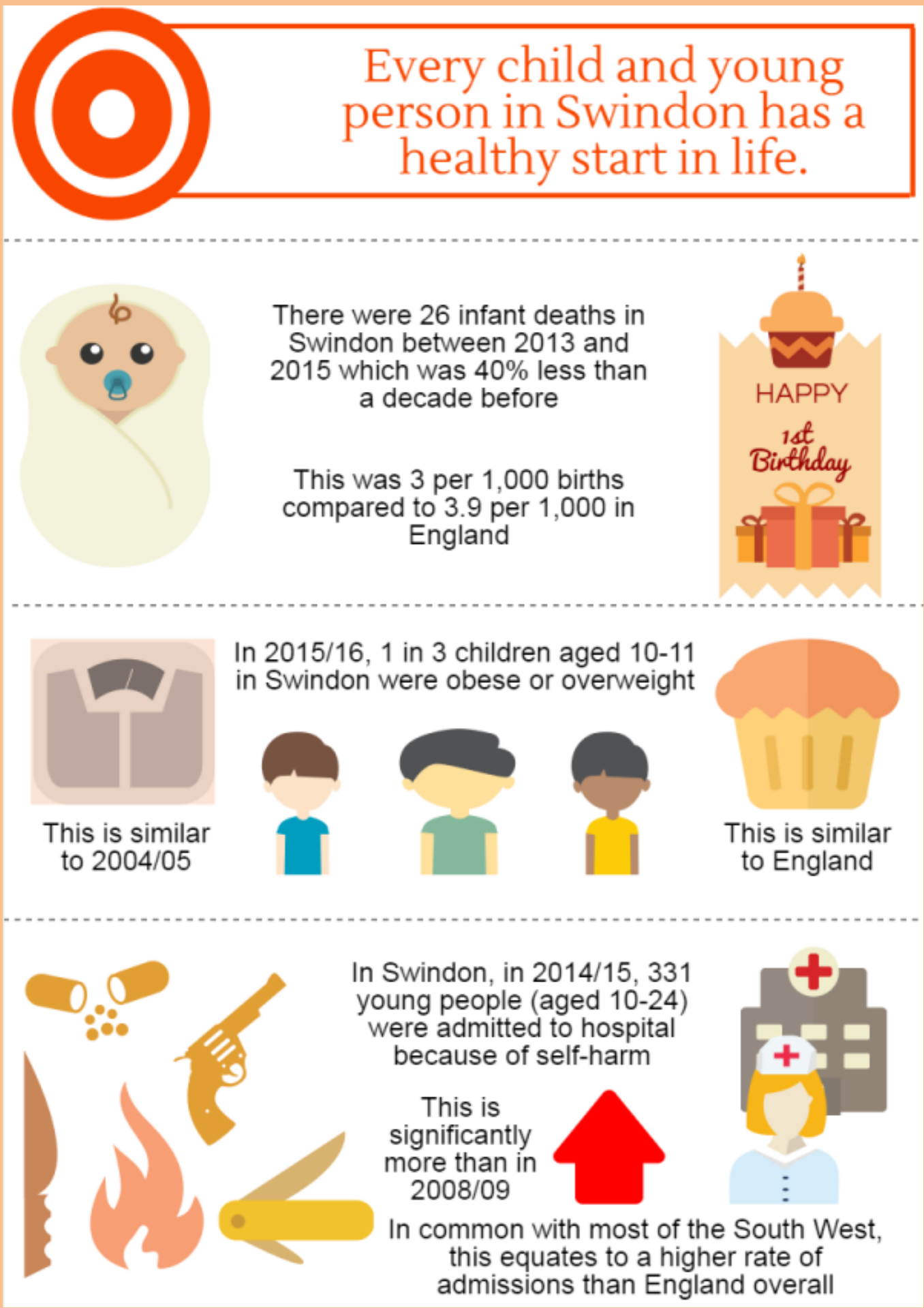
This update report looks at each of the five priority outcomes in turn and presents:

- An infographic highlighting some of the key indicators.
- A visual summary of the outcome trends showing where there have been statistically significant changes in the figures for Swindon.
- A commentary on what we have achieved, what is still a challenge for us, and what is happening now and in the future to continue to deliver the vision for Swindon.
- A chart and table for each indicator showing how Swindon's outcomes have changed over time and how they compare to England, the South West and similar authorities (including the group of 'Expanding Areas and Established Cities' which is defined by the Office of National Statistics).

This style of presentation allows a much fuller analysis of progress than simply comparing a baseline value with current figures.



Outcome 1: Every child and young person in Swindon has a healthy start in life



## Summary of outcome trends

**More babies  
breastfeeding**

**Fewer under 18s  
admitted to  
hospital because  
of alcohol**

**More children  
vaccinated**

**Fewer 16-18 year olds not in  
education, employment or  
training**

**Fewer young people entering  
the youth justice system**

**Similar numbers of  
children in care**

**Similar number of  
infant deaths**

**Similar numbers of  
overweight or obese  
10-11 year olds**

**Similar % of children gaining five  
good GCSEs including Maths and  
English**

**Similar % of pregnant women  
smoking around the time of  
giving birth**

**More people aged 10-24 admitted to hospital because of self-harm**

**It has not been possible to accurately assess whether there has been a significant change in the number of children with 2nd or subsequent child protection plans; the number of children in care or in the emotional wellbeing of looked after children.**

## JSNAs related to this outcome

Children and Young People's Needs Assessment (<http://swindonjsna.co.uk/dna/CYP-JSNA>) incorporating:

- Children aged 0-4 (Best Start)
- Children and young people's mental health
- Children and young people with complex and life limiting conditions

Impact of domestic violence and abuse on children and young people:

<http://swindonjsna.co.uk/dna/domestic-violence-and-abuse-needs-assessment>

Sexual Health Needs Assessment:

<http://swindonjsna.co.uk/dna/sexual-health-needs-assessment>

Child Sex Exploitation (CSE) – an evidence review:

<http://swindonjsna.co.uk/dna/child-sex-exploitation>



## **Commentary on progress and key challenges for the future**

Children in Swindon should have the best start in life and be safe, healthy and grow up in supportive, confident and resilient families and communities. Swindon community health professionals continue to work together to provide a strong community health service provision for children and young people. There has been a high uptake in relation to all immunisations for children and young people protecting them from illnesses such as measles, whooping cough, cervical cancer and meningitis. The implementation of the Healthy Child Programme continues, and ante-natal and post-natal checks take place routinely to support mothers and child health and wellbeing. This year Swindon achieved full accreditation of the UNICEF Baby Friendly Initiative in recognition of the good work carried out to support breastfeeding and parent infant relationships.

Children's Services face significant pressures from increased demand and the challenges of securing permanent, experienced and suitably qualified staff, which is mirrored nationally. The number of children looked after has increased, but historically numbers were lower than other areas. Latest performance data shows a reduction in the number of children being the subject of repeat child protection plans and fewer social care re-referrals.

Keeping young people safe and out of the criminal justice system is a priority. First time entrants (FTEs) into the justice system remain low in Swindon and continue to reduce. Whenever possible, low level offending is dealt through using Restorative Justice and Community Resolutions which avoids taking young people to court. The current re-offending rate is 10% which is very encouraging. However, it is important to remain vigilant in respect of FTE and re-offending rates as they are predicted to rise nationally.

Raising educational attainment is one of Swindon's corporate priorities in recognition of the need to continuously improve the standard of education in Swindon. The Council is working in partnership with schools and academies to do this. At the end of primary school, Swindon pupils meet the national average for reading, mathematics and grammar, including punctuation and spelling. Swindon pupils' results improved by 5% against a national improvement of 3% on the new headline measure of pupils obtaining an A\*-C grade in English and mathematics and are now just 2% below the national average.

Developing pathways to support routes to employment and encouraging local businesses to employ young people as apprentices is continuing. It is important to improve both the skill base and opportunities for young people beyond the classroom, particularly in the face of record youth unemployment. Latest figures show Swindon has a reduction in the youth unemployment rate (16-24s) and a slight improvement with NEET (Not in Education, Employment or Training) figures overall. An increasing number of young people are declaring work as their destination, but this is work without training and so does not count as EET (In Education, Employment or Training). The fact that they are working is positive and a preferable option to NEET, however further work needs to be done to increase jobs with training to build a sustainable future for these young people.

Good partnership working between Great Western Hospital and Swindon Young People's Substance Misuse Service, U-turn, has meant there continues to be fewer under 18s being admitted to hospital because of alcohol. However, hospital admissions for young people (10-24 years) as a result of self-harm remains too high. The self-harm training and guidelines, alongside the self-harm register, which has been introduced into the emergency department at Great Western Hospital, should help target vulnerable people and offer support earlier. The support provided to help mums-to-be to choose not to smoke during pregnancy had had a positive impact with fewer mothers now smoking at the time of delivery which puts Swindon similar to other areas.

## Outcome 1: Every child and young person in Swindon has a healthy start in life

### Key to charts

The top section shows how Swindon compares to (i) England, (ii) the South West, and (iii) a group of similar authorities (Expanding Areas & Established Cities)

<b>Green</b>	means Swindon is better than the comparator	<b>Yellow</b>	means Swindon is similar to the comparator
<b>Red</b>	means Swindon is worse than the comparator	<b>White</b>	means a statistical comparison is N/A

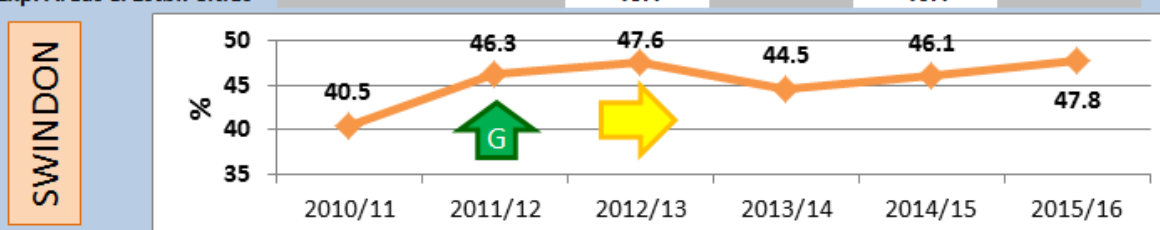
On the charts themselves **coloured arrows** show how Swindon's outcomes have changed over time

	<b>Significantly better</b>		<b>Significantly worse</b>		<b>No significant change</b>		<b>No change could not be evaluated</b>
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Statistical tests have been used to answer the question "how large is the change?" by comparing each change on an equitable basis. This is how the coloured arrows on the charts have been derived

### Percentage of babies breastfed at age 6-8 weeks

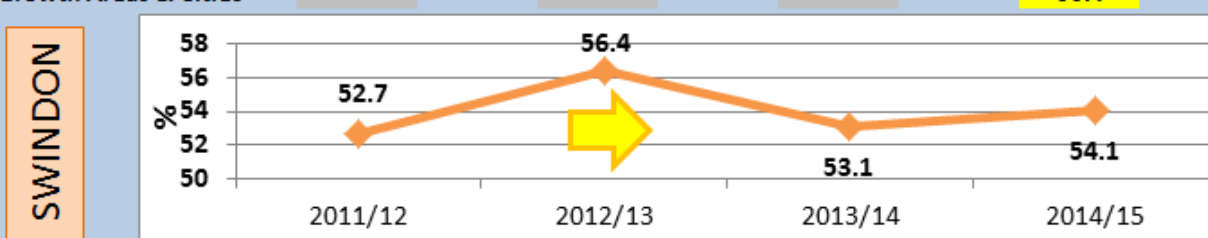
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	46.1	47.2	47.2	45.8	43.8	43.2
South West	48.7	49.7	49.3	49.3		
Exp. Areas & Estbl. Cities			48.1		43.1	



The Swindon figure for 2013/14 was not been officially ratified because of data collection issues

### GCSEs achieved (5A\*-C including English and Maths)

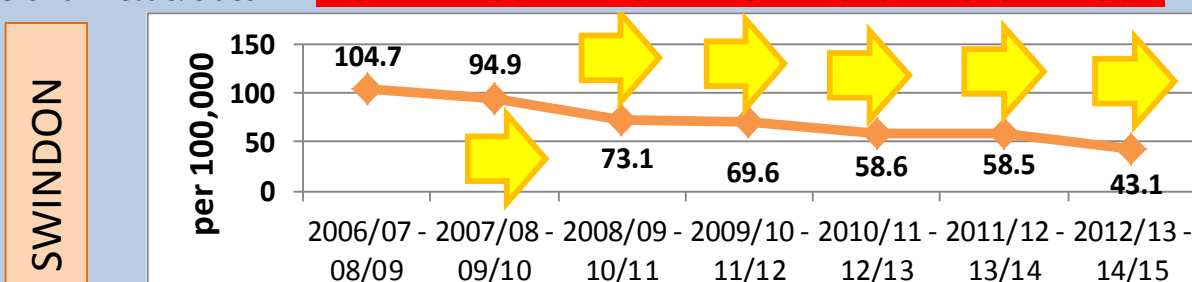
	2011/12	2012/13	2013/14	2014/15
England	59.0	60.8	56.8	57.3
South West	57.5	59.5	56.7	57.9
Growth Areas & Cities				55.1



The definition of this indicator changed in 2014 and results for 2014/15 are not comparable with previous years

### Under 18s admitted to hospital for alcohol specific causes (per 100,000)

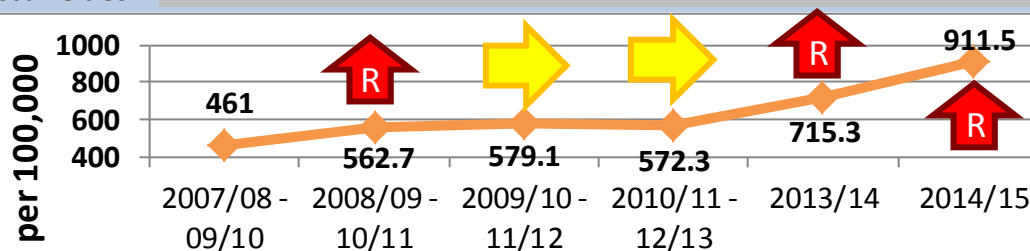
	2006/07 - 08/09	2007/08 - 09/10	2008/09 - 10/11	2009/10 - 11/12	2010/11 - 12/13	2011/12 - 13/14	2012/13 - 14/15
England	68.4	61.8	55.8	49.8	44.9	40.1	36.6
South West	76.2	67.5	62.0	57.7	52.9	47.7	44.8
Growth Areas & Cities	51.4	46.9	41.5	40	34.6	32.5	29.9



## Hospital admissions as a result of self-harm (10-24 years) (per 100,000)

	2007/08 - 09/10	2008/09 - 10/11	2009/10 - 11/12	2010/11 - 12/13	2013/14	2014/15
England	329.5	342.3	347.9	352.3	412.1	398.8
South West	368.9	388.6	399.8	418.4	520.8	537.9
Exp. Areas & Estbl. Cities						

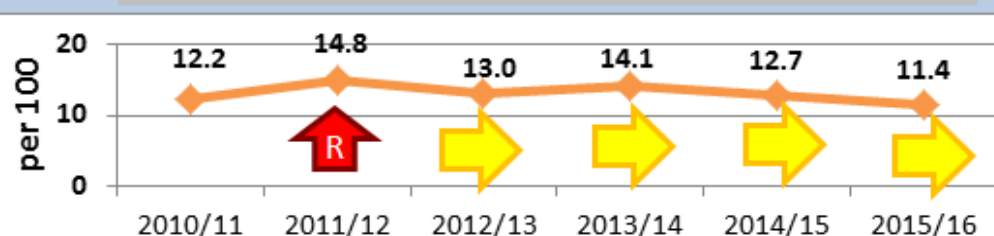
SWINDON



## Women smoking at time of delivery (per 100 maternities)

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	13.5	13.2	12.7	12.0	11.4	10.6
South West	13.5	13.1	13.3	13.0	11.9	11.2
Exp. Areas & Estbl. Cities						

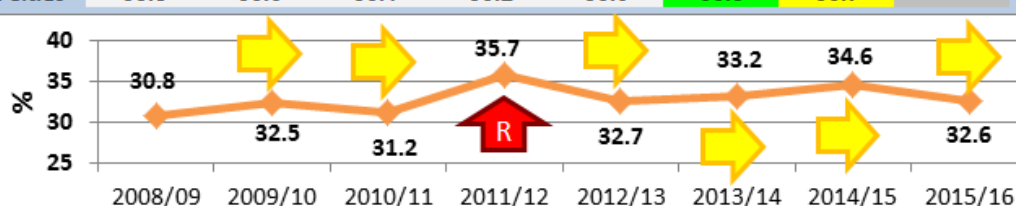
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## Percentage of children aged 10-11 classed as obese or overweight

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	32.6	33.4	33.4	33.9	33.3	33.5	33.2	34.2
South West	30.4	30.4	30.8	31.0	30.8	31.0	30.5	30.3
Exp. Areas & Estbl. Cities	33.8	35.0	35.1	35.2	35.0	35.3	35.7	

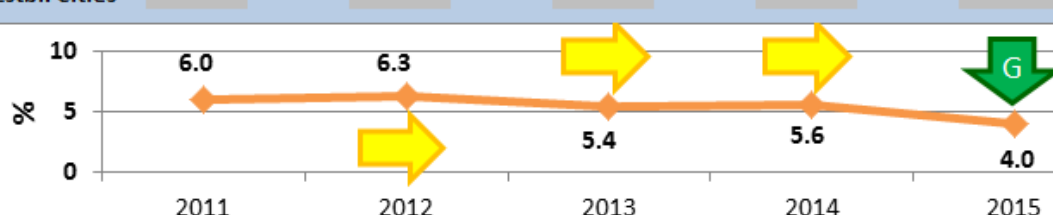
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## Percentage of 16-18 year olds not in education, employment or training

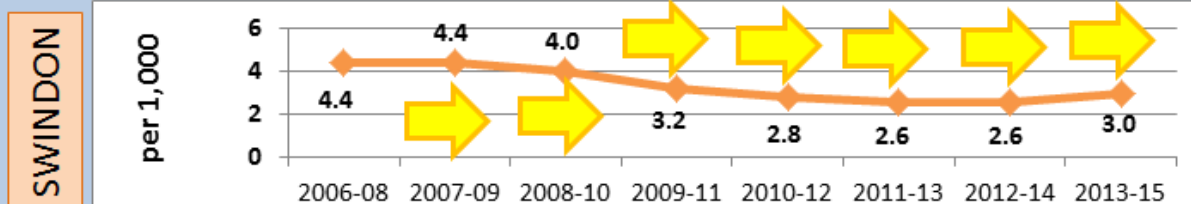
	2011	2012	2013	2014	2015
England	6.1	5.8	5.3	4.7	4.2
South West	5.7	5.5	5.2	4.5	4.1
Exp. Areas & Estbl. Cities					

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### Infant mortality (deaths under 1 year of age per 1,000 live births)

	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
England	4.8	4.7	4.6	4.4	4.3	4.1	4.0	3.9
South West	4.1	4.0	3.7	3.6	3.6	3.8	3.7	3.6
Exp. Areas & Estbl. Cities	5.8	5.7	5.6	5.3	5.0	4.8	4.6	4.5



### Childhood vaccinations

There are 11 current indicators in the Public Health Outcomes Framework (PHOF) on universal childhood immunisations.

In 2015/16, Swindon's coverage was statistically significantly HIGHER than England on all of these.

Swindon's coverage was also HIGHER than the South West on 9 out of the 11 indicators and SIMILAR on the other 2.

Public Health England also published target goals for these indicators and Swindon met and exceeded these in 6 cases.

Swindon's HPV coverage in 2015/16 was 96.1%; almost 7% higher than the England coverage.

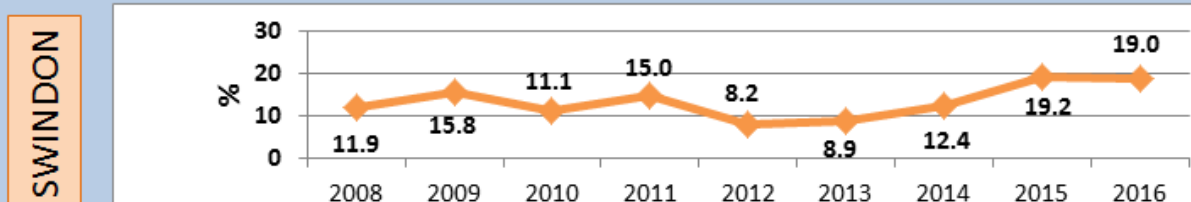
Swindon's flu vaccination in 2-4 year olds was only 40.1% but this was around 6% higher than the England coverage.

Swindon also had 100% coverage on targeted immunisations for hepatitis B, at age 1, in 2015/16 and 67% at age 2.

Where trend data is available it shows Swindon's coverage was higher for 9 out of 9 immunisations in 2015/16 compared to 2010/11. However, in 2015/16, coverage had fallen slightly for 5 indicators compared to 2014/15

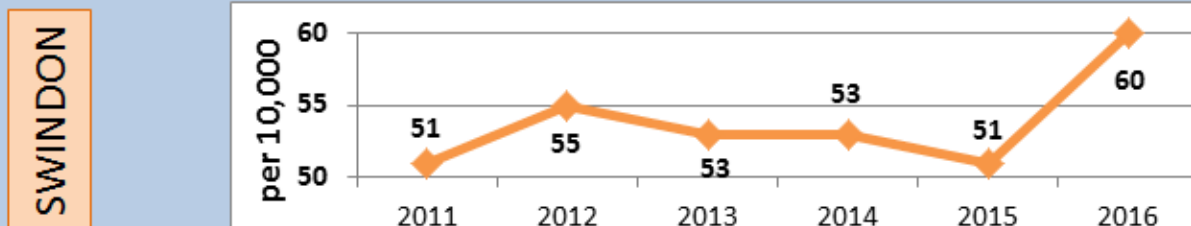
### Percentage of children with second or subsequent child protection plans

	2008	2009	2010	2011	2012	2013	2014	2015	2016
England	13.6	13.5	13.4	13.3	13.8	14.9	15.8	16.6	
South West	13.1	11.9		15.2	15.8	15.1	17.0	19.4	
OFSTED statistical neighbours	14.6	15.0	14.0	13.2	13.9	15.3	16.4	17.6	



### Number of children in care (per 10,000)

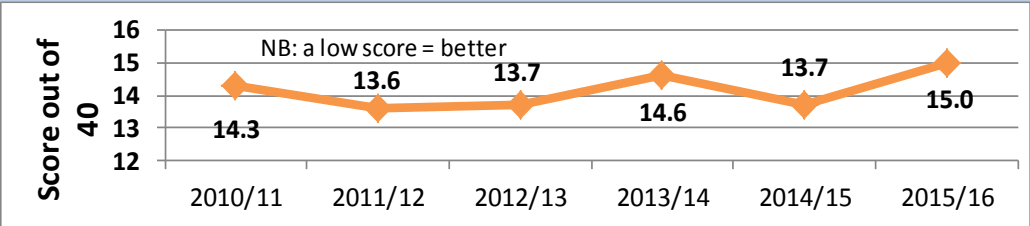
	2011	2012	2013	2014	2015	2016
England	58.0	59.0	60.0	60.0	60.0	60.0
South West	49.0	51.0	53.0	51.0	52.0	53.0
OFSTED statistical neighbours	55.9	57.9	57.0	56.7	57.5	60.7



Emotional wellbeing of looked after children (strengths and difficulties score)

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	13.9	13.9	14.0	13.9	13.9	
South West	15.0	15.1	15.2	14.8	14.8	
Exp. Areas & Estbl. Cities						

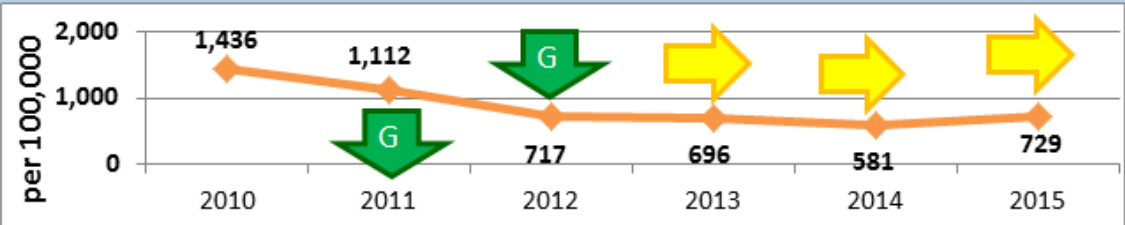
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First time entrants to the Youth Justice System (ages 10-17) (per 100,000)

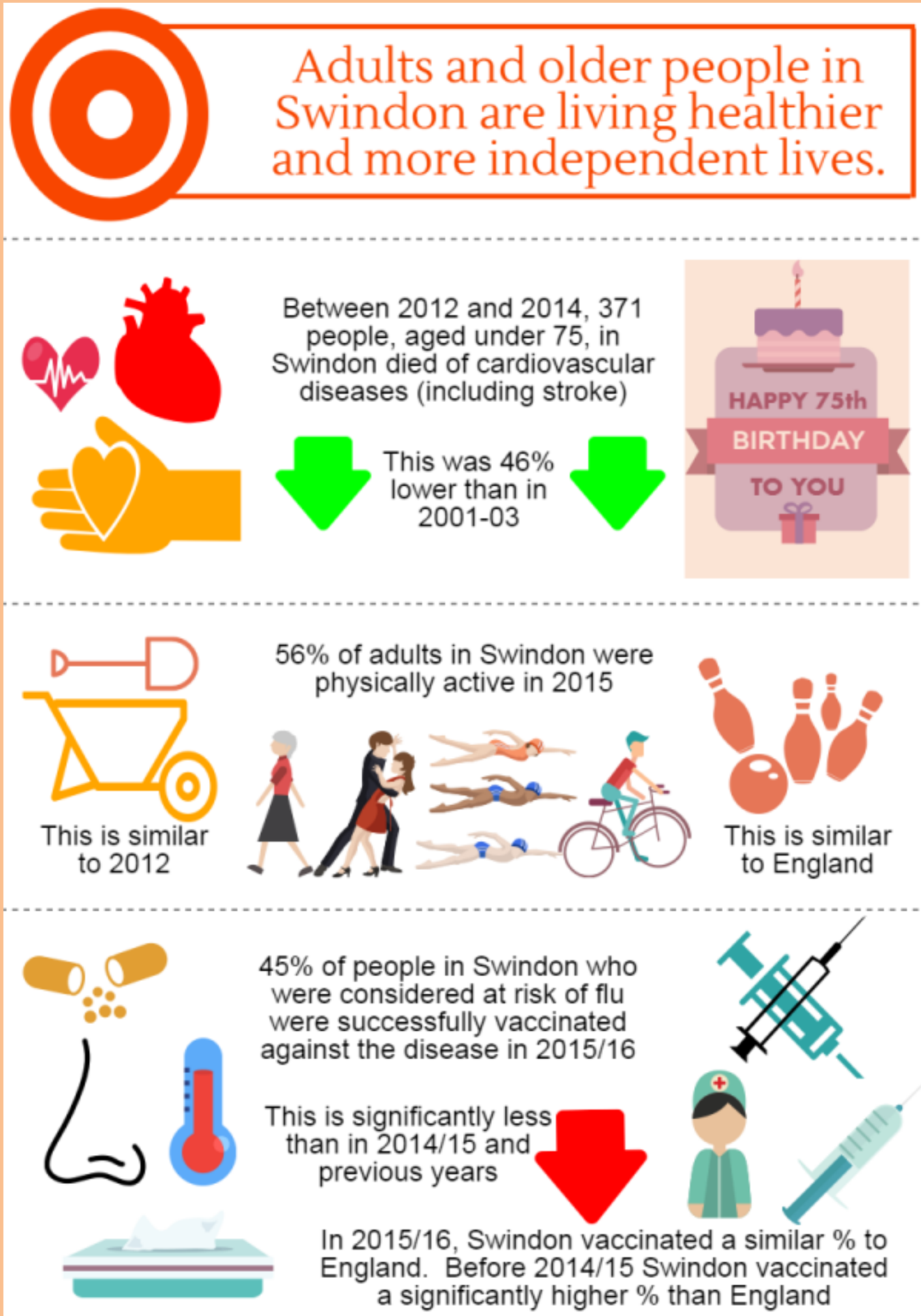
	2010	2011	2012	2013	2014	2015
England	902	726	556	448	409	369
South West	847	723	590	450	428	364
Exp. Areas & Estbl. Cities						

SWINDON





**Outcome 2: Adults and older people in Swindon are living healthier and more independent lives**



## Summary of outcome trends

**Fewer people under 75 died from cardiovascular disease  
(including heart disease and stroke)**

**Similar number  
of people over 65  
vaccinated  
against seasonal  
flu**

**Similar numbers of  
people admitted  
to hospital  
because of alcohol  
related harm**

**Similar number  
of people under  
75 died from  
cancer**

**Similar number of people  
under 75 died from  
respiratory disease**

**Similar number of physically  
active adults**

**Around 15,000 people have  
received an NHS Health  
Check**

**Similar number of adults who  
smoke**

**Fewer at risk people vaccinated against seasonal flu**

**It has not been possible to accurately assess whether there has been a significant change in the number of new admissions of older people into residential and nursing care or the proportion of carers having their needs assessed.**

## JSNAs related to this outcome

Diabetes JSNA:

<http://swindonjsna.co.uk/dna/diabetes-needs-assessment>

Adult Alcohol Needs Assessment:

<http://swindonjsna.co.uk/dna/adult-alcohol-needs-assessment>

Falls and Bone Health Needs Assessment:

<http://swindonjsna.co.uk/dna/falls-and-bone-health-needs-assessment>

Sexual Health Needs Assessment:

<http://swindonjsna.co.uk/dna/sexual-health-needs-assessment>

Pharmaceutical Needs Assessment:

<http://swindonjsna.co.uk/dna/pharmaceutical-needs-assessment>

The Healthy Weight and Get Swindon Active strategies are based on evidence from a number of JSNAs: <http://swindonjsna.co.uk/dna/healthy-weight>

## Commentary on progress and key challenges for the future

More people in Swindon are living longer but it is also important that people stay independent and safe and enjoy the best possible quality of life. Supporting adults to live healthier covers a wide range of issues and indicators. These include whether people choose to smoke, drink or take exercise and if and how people use health and social care services.

The aims of supporting people to make healthier choices are about reducing the risk of becoming ill, or managing a long term condition (e.g. diabetes, cardiovascular disease) better. In Swindon, there are now 46% fewer people dying from cardiovascular disease (including heart attacks and stroke) than in 2001-03. Following the successful introduction of a Community Health and Wellbeing Hub the focus is an integrated programme of public health activity that combines smoking support, alcohol reduction, increasing physical activity and a nutritious and balanced diet for everyone. Stop smoking services are available in a wide range of places including GP practices and pharmacies and are promoted at different events and workplaces to support people who want to quit. This has contributed to reducing the percentage of people who smoke in Swindon in recent years.

There are lots of opportunities in Swindon for physical activity. As well as the natural environment, this includes 16 free health walks, Dietbusters, exercise on referral, Park Run and commercial weight loss and gym sessions. Recent initiatives include the Tri Active Project and Football Fans in Training (FFIT). The Tri Active Project offers swimming, cycling and running sessions and has so far engaged over 2,000 previously inactive people. Football Fans in Training (FFIT) is a 12-week, weight management and healthy lifestyle programme designed to specifically appeal to men who are overweight and is run with Swindon Town FC. Both of these have had excellent results and engaged communities that would not access traditional weight management services.

Swindon Borough Council and NHS Swindon CCG have developed an active and thriving Falls Collaborative to deliver the recommendations from the Falls and Bone Health JSNA. This has engaged a wide range of partners including Dorset and Wiltshire Fire and Rescue Service, South West Ambulance Service, Great Western Hospital, SEQOL, Arriva and the voluntary sector. The Collaborative has reviewed existing services and developing a care pathway, development of a falls prevention booklet, Steady Steps, which was launched at the Swindon wide event in October 2016. It has developed a falls prevention strategy and action plan, piloted exchange of information between the Homeline service and GPs, and has set up a working group to examine the issues for those who frequently experience falls.

Swindon has higher admission rates for older people to residential and nursing care homes than other areas and this continues to be a major area of consideration for services in the borough. There continues to be a focus to improve and plan hospital discharge better and the Swindon Intermediate Care Centre continues to work to help people feel more confident to return home after spells in hospital. The Falls Collaborative is establishing another working group to look at falls among this group and the importance of strength and balance and raising falls awareness for staff who work in the caring professions.

One of the challenges for Swindon in terms of getting people active and making healthy lifestyle choices is how to make a population wide change. In a similar way to other areas in the country, local projects are effective with supporting small scale projects (between 10 and 500 people). However, as 70,000 adults in Swindon are overweight or obese increased effort is needed to engage with people more widely across Swindon.

Future JSNA work includes looking at long terms conditions and co-morbidities (where someone has more than one illness), and also substance misuse (alcohol and drugs). The diabetes JSNA and Pharmaceutical Needs Assessment are also being updated.



## Outcome 2: Adults and older people in Swindon are living healthier and more independent lives

### Key to charts

The top section shows how Swindon compares to (i) England, (ii) the South West, and (iii) a group of similar authorities (Expanding Areas & Established Cities)

**Green** means Swindon is better than the comparator  
**Red** means Swindon is worse than the comparator  
**Yellow** means Swindon is similar to the comparator  
**White** means a statistical comparison is N/A

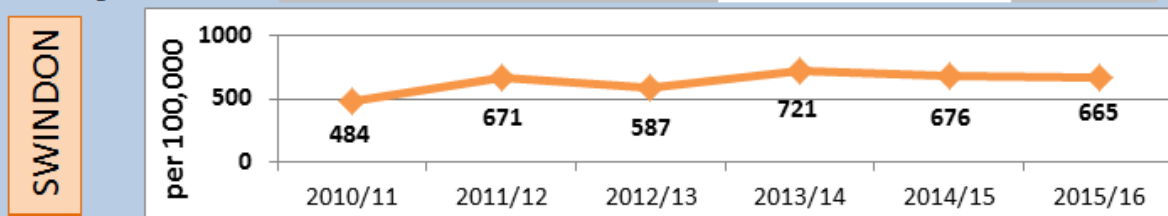
On the charts themselves **coloured arrows** show how Swindon's outcomes have changed over time

**Green G** Significantly better  
**Red R** Significantly worse  
**Yellow** No significant change  
**No arrow** = change could not be evaluated

Statistical tests have been used to answer the question "how large is the change?" by comparing each change on an equitable basis. This is how the coloured arrows on the charts have been derived

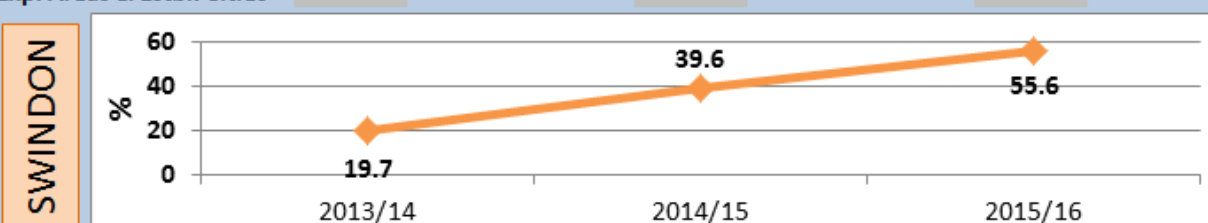
### New admissions (over 65s) to residential and nursing care homes (per 100,000)

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	687	696	697	651	659	628
South West	680	678	681	638	675	606
CIPFA neighbours				686	701	



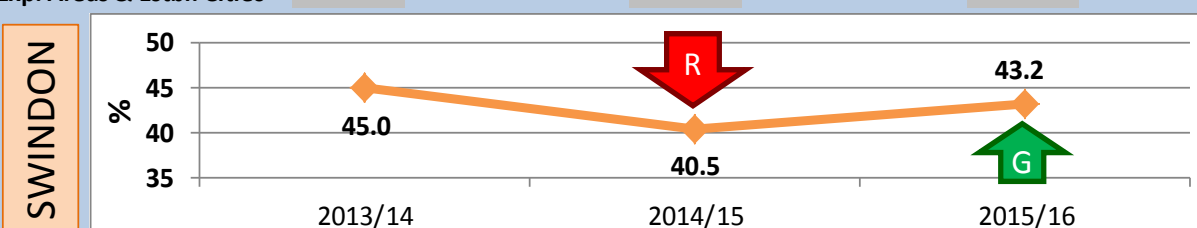
### Cumulative % offered an NHS Health Check (ages 40-74)

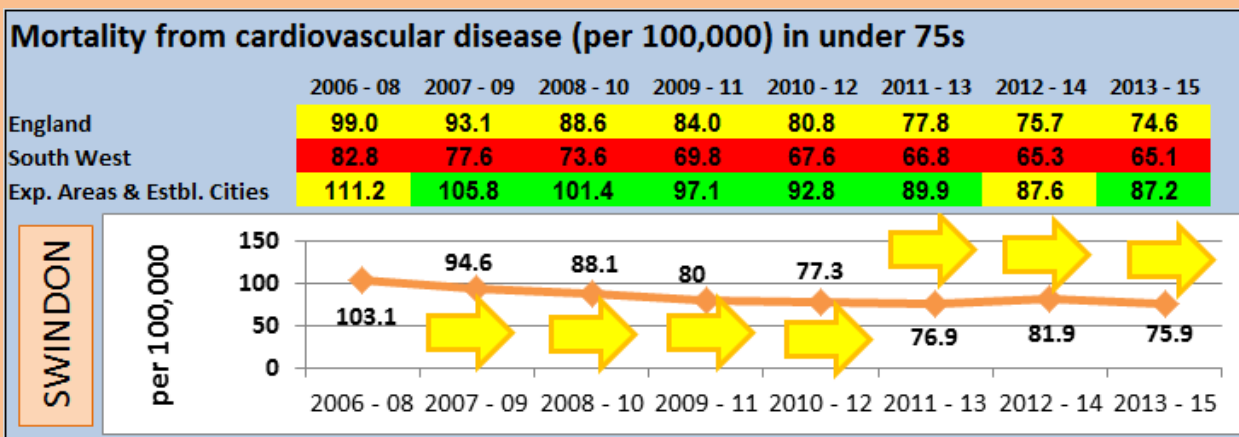
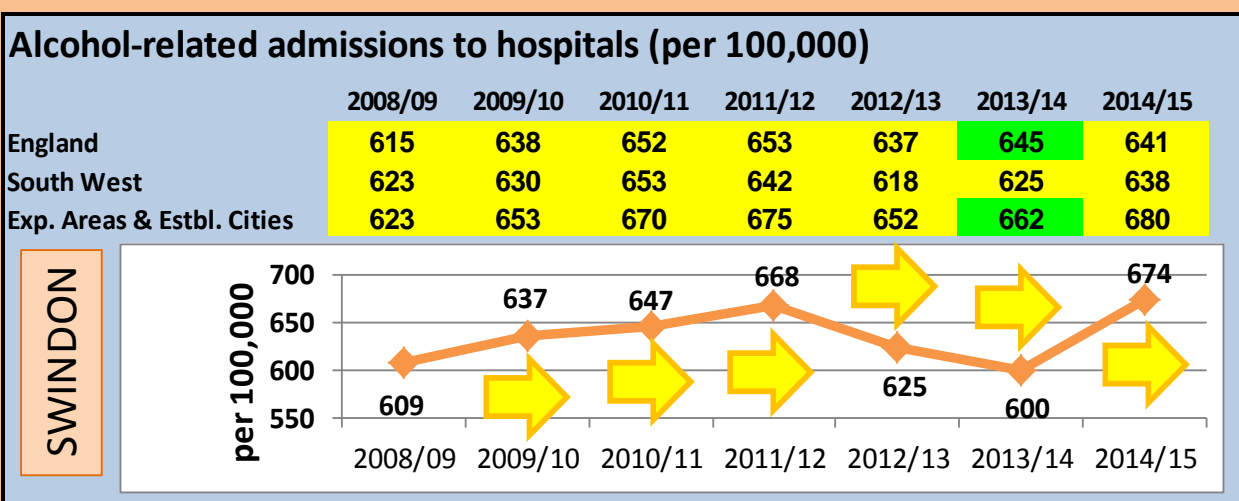
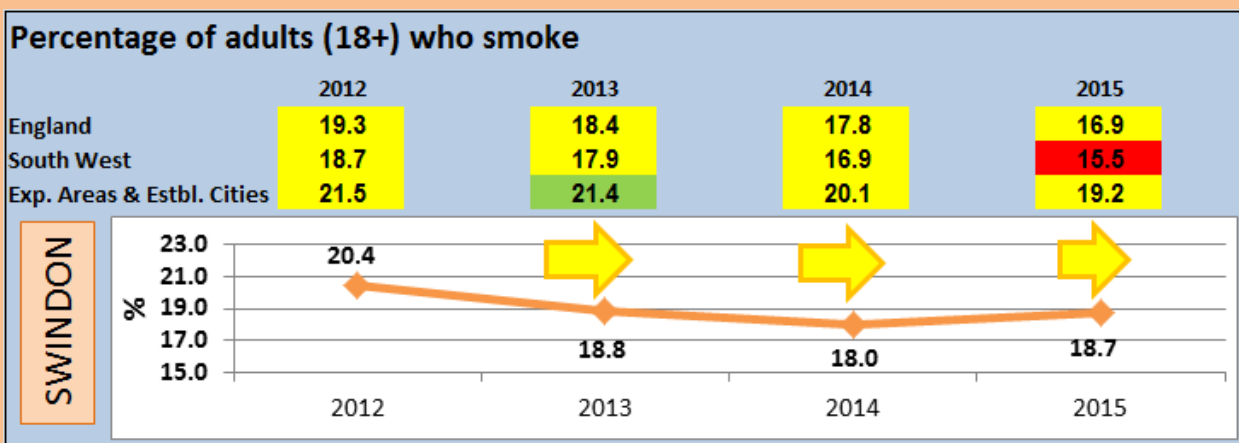
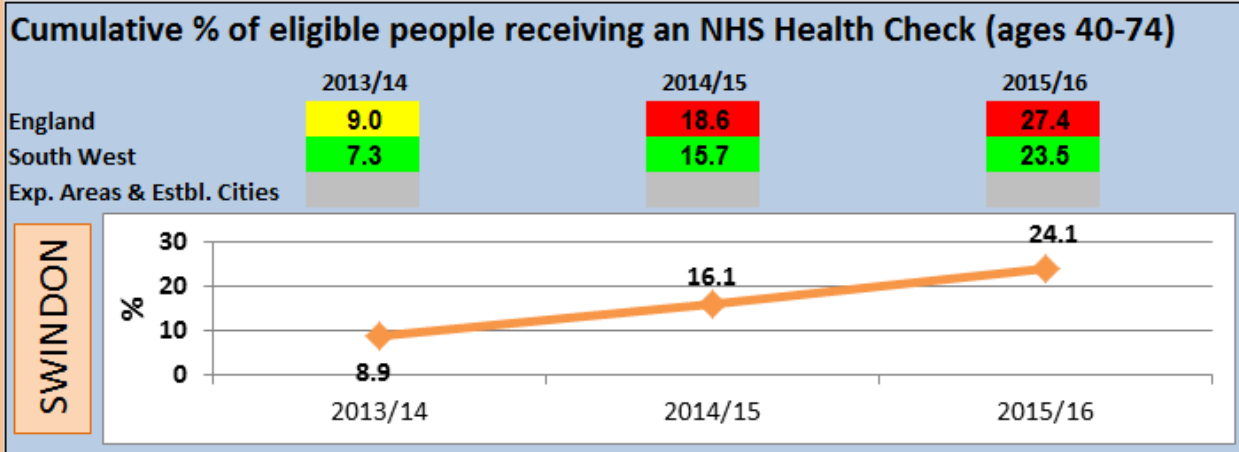
	2013/14	2014/15	2015/16
England	18.4	37.9	56.4
South West	16.2	33.7	48.8
Exp. Areas & Estbl. Cities			



### Cumulative % of those offered an NHS Health Check who received it (ages 40-74)

	2013/14	2014/15	2015/16
England	49.0	48.9	48.6
South West	45.4	46.6	48.2
Exp. Areas & Estbl. Cities			

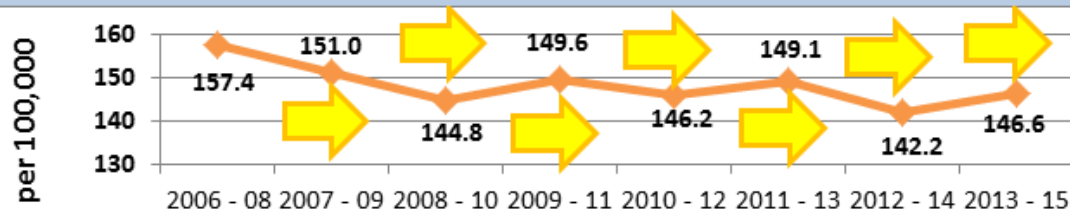




### Mortality from cancer (per 100,000) in under 75s

	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15
England	155.7	153.2	150.6	148.5	146.5	144.4	141.5	138.8
South West	142.9	140.5	139.4	138.4	136.8	134.3	130.5	127.8
Exp. Areas & Estbl. Cities	162.3	160.8	159.6	156.5	153.6	152.1	151.8	151.3

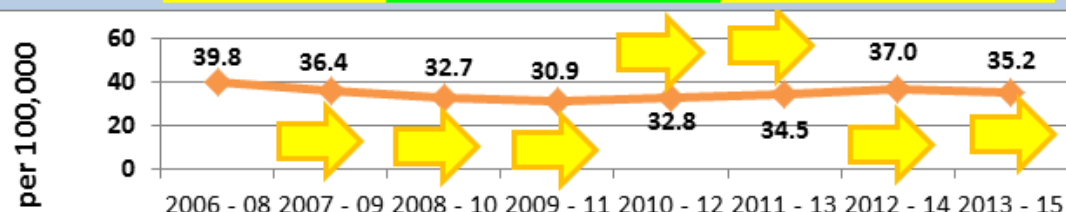
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### Mortality from respiratory disease (per 100,000) in under 75s

	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15
England	36.5	36.0	35.3	34.2	33.5	33.2	32.6	33.1
South West	27.9	27.5	26.9	26.7	26.3	26.8	26.4	26.9
Exp. Areas & Estbl. Cities	43.9	42.9	42.3	40.5	39.9	39.6	40.3	40.6

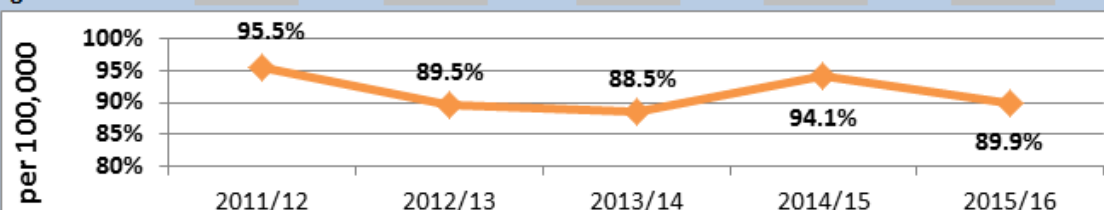
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### Carers who had their needs assessed (percentage of those receiving a service)

	2011/12	2012/13	2013/14	2014/15	2015/16
England				70.7%	
South West				67.8%	
CIPFA neighbours					

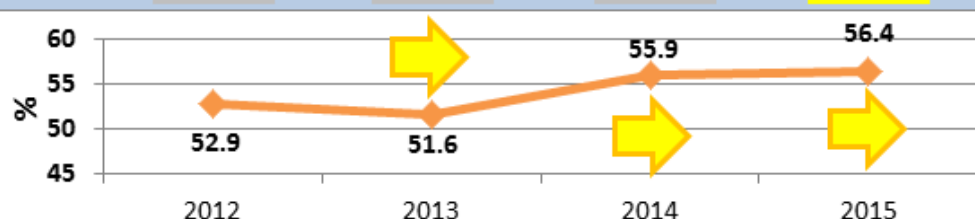
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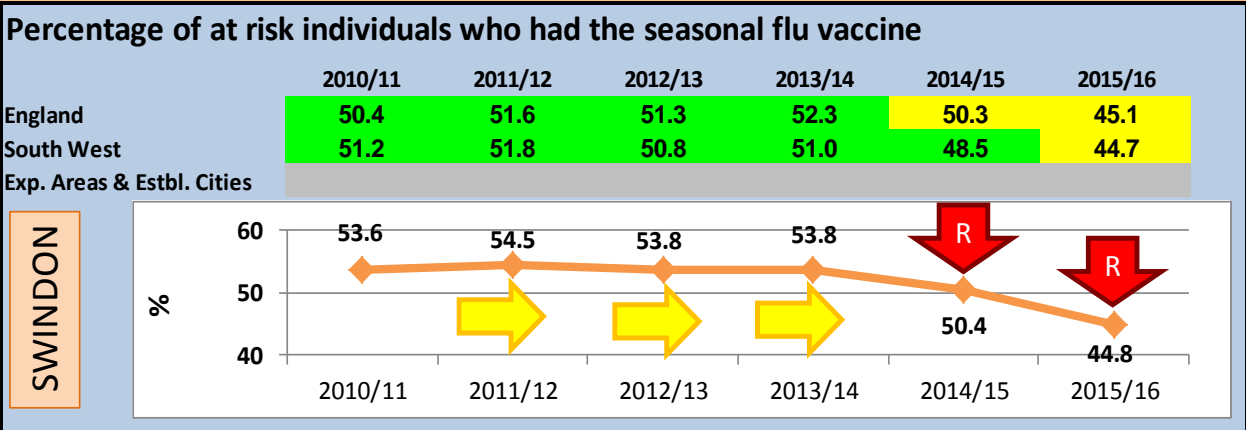
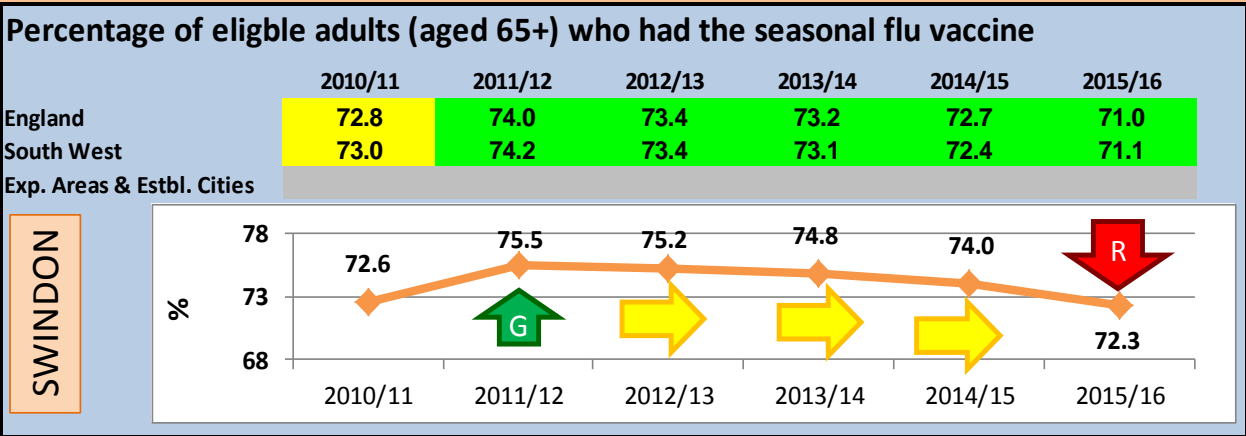


### Percentage of physically active adults

	2012	2013	2014	2015
England	56.0	56.0	57.0	57.0
South West	57.5	58.0	59.4	59.2
Exp. Areas & Estbl. Cities				55.2

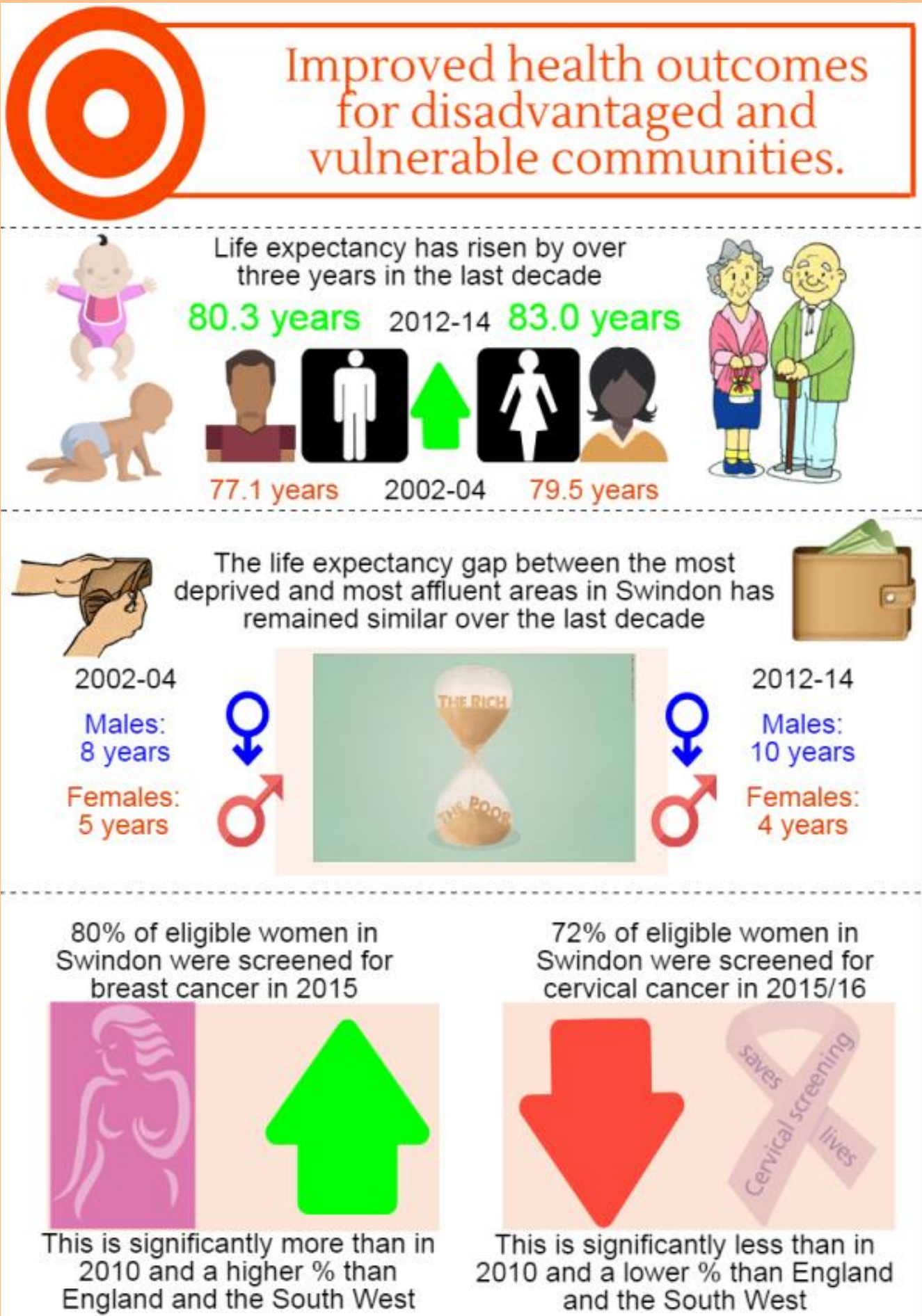
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**Outcome 3: Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems or offenders)**



## Summary of outcome trends

**Higher male life expectancy**

**Higher female life expectancy**

**More people who use social care services who feel safe**

**More women screened for breast cancer**

**Similar difference in male life expectancy between most and least deprived areas**

**Similar difference in female life expectancy between most and least deprived areas**

**Similar number of people receiving social care who say they find it easy to get information**

**Fewer women screened for cervical cancer**

**It has not been possible to accurately assess whether there has been a significant change in:**  
 (i) The number of new residential care admissions for people with learning disability  
 (ii) The difference in the employment rate between those with a learning disability and the overall population  
 (iii) The number of people with long term conditions feeling supported to manage them

## JSNAs related to this outcome

Learning Disability Needs Assessment:

<http://swindonjsna.co.uk/dna/learning-disability-needs-assessment>

Dementia Needs Assessment:

<http://swindonjsna.co.uk/dna/dementia-needs-assessment>

Indices of Deprivation reports:

<http://swindonjsna.co.uk/dna/ID>

Swindon Inequalities reports:

<http://swindonjsna.co.uk/dna/Inequalities>

Adult Autism Needs Assessment:

<http://swindonjsna.co.uk/dna/Adult-autism-needs-assessment>

Sight Loss Needs Assessment:

<http://swindonjsna.co.uk/dna/Sight-loss-needs-assessment>

Tuberculosis Needs Assessment:

<http://swindonjsna.co.uk/dna/TB>

## Commentary on progress and key challenges for the future

Overall, outcomes for Swindon around this priority are mixed. A man in Swindon has a life expectancy of 79.5 years and a woman 83.0 years and this represents a gradual increase over the last decade. However, the gap in life expectancy between the most and least deprived areas in Swindon has widened for both men and women. In the most deprived areas of Swindon, men live on average 14.1 years less in good health and women 12.1 years less than those in the least deprived areas.

Breast cancer screening coverage is improving and better than similar authorities however the opposite is true for cervical cancer screening. Work continues to raise awareness locally of the importance of attending for screening when invited. Population groups with low screening coverage rates have been identified and more targeted approaches to reach them are being developed with the aim to improve their access to screening programmes.

Joint working across the Council is resulting in the commissioning of a greater variety of supported living accommodation to reduce the reliance on expensive care home provision. Employment rates for people with a learning disability are relatively low and a Transitions Programme has been established to drive improvement around supporting more people with a learning disability into paid employment.

The number of social care users in Swindon who feel safe and feel they have access to advice and information is increasing. Carers are recognised for the regular and substantial support for service users they provide and Swindon is on target to ensure that 70% of carers have had an assessment or review of their needs. There are plans to develop an online tool for carers to assess themselves to ensure that people caring for patients are identified earlier and supported more quickly.

People's independence will be maintained and prolonged through improving their first point of contact with services. The Council's e-market place, [My Care My Support](#) (MCMS), provides extensive information around health and wellbeing, residential care, support at home, social groups and clubs and education across the voluntary, third and private sectors. Over the last year, a Google search facility has been integrated into the site to improve accessibility and community consultations have taken place to ensure the site includes the right information.

The Community Navigator project operates a referral based service through GP surgeries throughout Swindon. The scheme was successfully extended last year to all surgeries and 633 clients have accessed this service, all of whom have one or more long term health condition. The programme is being evaluated and has demonstrated significant improvements in people's health and wellbeing and is estimated to have saved over £400,000.

The multi-agency Swindon Dementia Steering Group has been set up to oversee the implementation of the recommendations from the Swindon Dementia JSNA and Dementia Strategy. Over 3,200 people who live in Swindon are now registered as dementia friends. A 'Living Well with Dementia' conference was held in Swindon in July 2015 and the Council have produced a dementia friendly housing policy and run dementia design sessions. NHS Swindon CCG have worked with Avon and Wiltshire Mental Health Partnership to reduce the waiting time for diagnosis to two weeks. Services post-diagnosis are also more widely available both in the voluntary sector (with memory cafes, lunch sessions and signing for the brain) and in terms of clinical support and information available.

The recently published Inequalities JSNA will inform further work and focus activity to reduce the difference in health outcomes between people living in different parts of Swindon or between different communities.

### Outcome 3: Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems or offenders)

#### Key to charts

The top section shows how Swindon compares to (i) England, (ii) the South West, and (iii) a group of similar authorities (Expanding Areas & Established Cities)

**Green** means Swindon is better than the comparator **Yellow** means Swindon is similar to the comparator  
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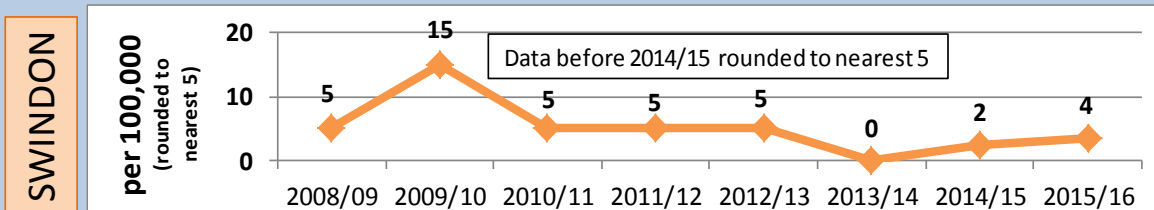
On the charts themselves **coloured arrows** show how Swindon's outcomes have changed over time

**Green G** Significantly better **Red R** Significantly worse **Yellow** No significant change No arrow = change could not be evaluated

Statistical tests have been used to answer the question "how large is the change?" by comparing each change on an equitable basis. This is how the coloured arrows on the charts have been derived

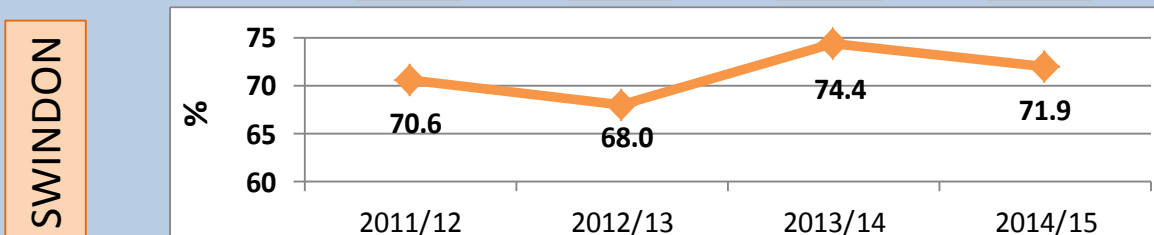
#### New admissions for people with learning disability into residential care (per 100,000)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	5	5	5	10	10	5		
South West	10	10	15	15	20	10		
Exp. Areas & Estbl. Cities								



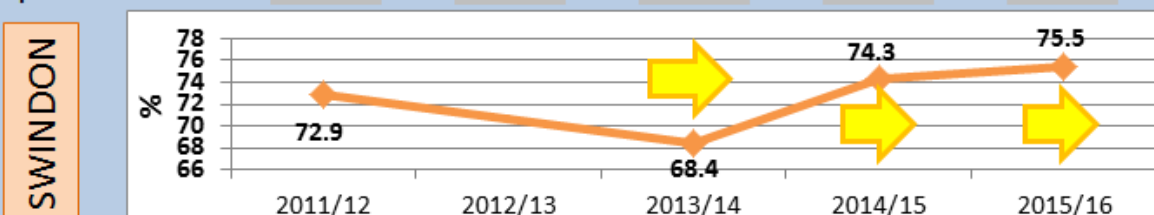
#### Gap between overall employment rate and people with a learning disability

	2011/12	2012/13	2013/14	2014/15
England	63.2	64.0	65.0	66.9
South West	67.6	66.7	66.8	70.3
Exp. Areas & Estbl. Cities				



#### Social care users who say they find it easy to get advice and information

	2011/12	2012/13	2013/14	2014/15	2015/16
England	73.8	74.1	74.5	74.5	73.5
South West	75.0	74.5	76.8	76.6	73.3
Exp. Areas & Estbl. Cities					

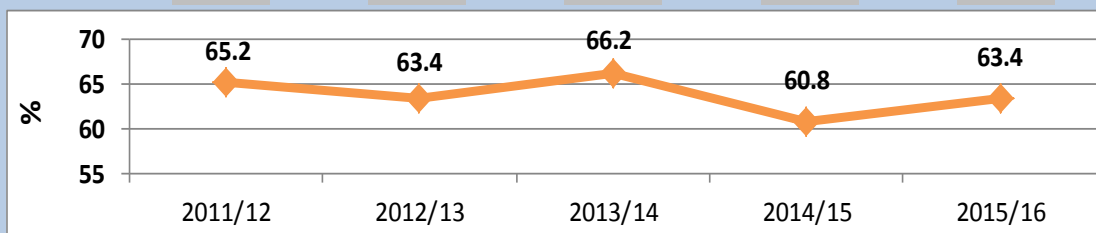




### Proportion of people feeling supported to manage their (long term) condition

	2011/12	2012/13	2013/14	2014/15	2015/16
England	66.7	65.6	65.1	64.4	64.3
South West	69.8	68.7	68.3	67.5	67.4
Exp. Areas & Estbl. Cities					

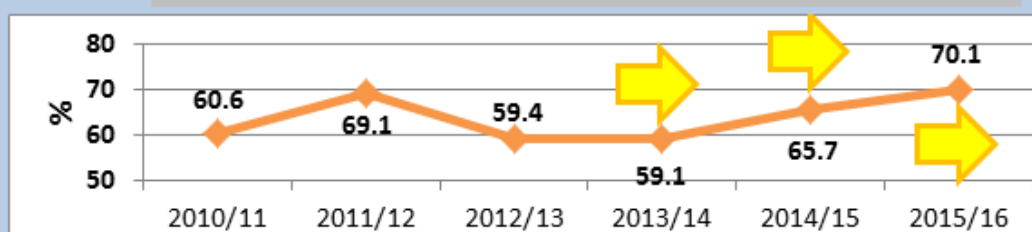
SWINDON



### Proportion of adult social care users who feel as safe as they want

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	62.4	63.8	65.1	66.0	68.5	69.2
South West	64.2	63.2	66.8	66.3	68.3	69.6
Exp. Areas & Estbl. Cities						

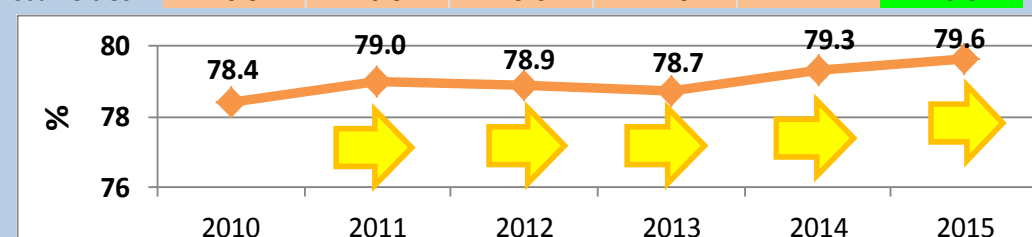
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### Breast cancer screening coverage

	2010	2011	2012	2013	2014	2015
England	76.9	77.1	76.9	76.3	75.9	75.4
South West	79.5	79.5	79.1	78.9	78.9	78.6
Exp. Areas & Estbl. Cities	76.5	76.5	75.6	74.9	74.7	73.5

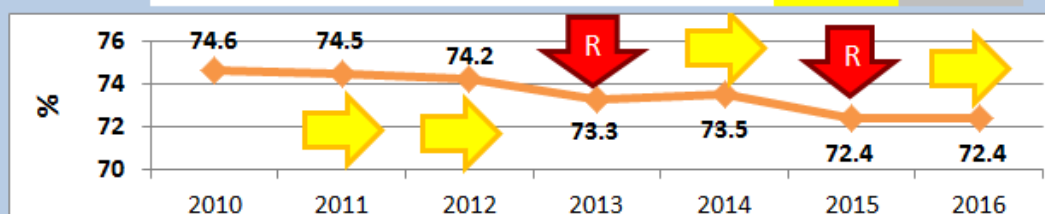
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### Cervical cancer screening coverage

	2010	2011	2012	2013	2014	2015	2016
England	75.5	75.7	75.4	73.9	74.2	73.5	72.7
South West	78.6	78.1	77.7	76.3	76.2	75.9	75.1
Exp. Areas & Estbl. Cities	75.5	75.3	74.9	73.3	73.1	72.5	

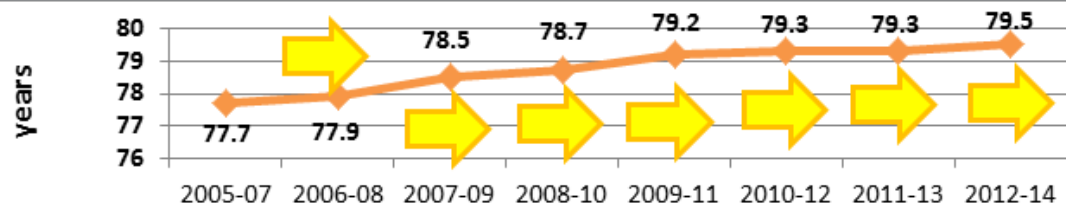
SWINDON



### Male life expectancy at birth

	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
England	77.6	77.9	78.2	78.5	78.9	79.2	79.4	79.5
South West	78.7	78.9	79.1	79.4	79.8	80.0	80.1	80.2
Exp. Areas & Estbl. Cities								

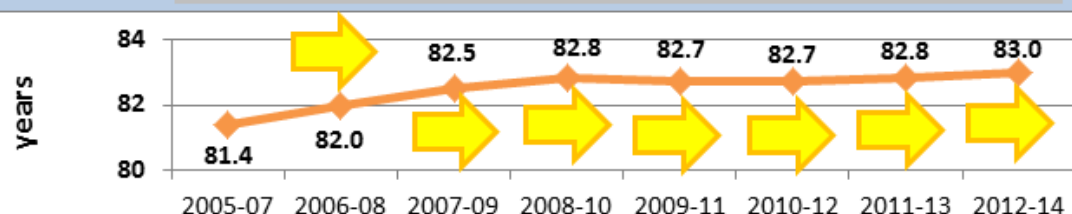
SWINDON



### Female life expectancy at birth

	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
England	81.8	82.0	82.3	82.5	82.9	83.0	83.1	83.2
South West	82.9	83.0	83.2	83.4	83.7	83.9	83.8	83.9
Exp. Areas & Estbl. Cities								

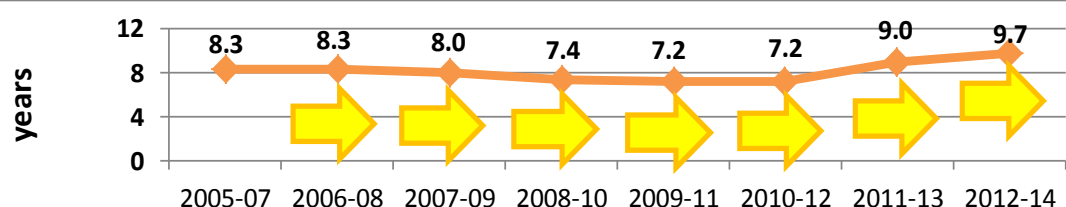
SWINDON



### Gap in male life expectancy at birth between most and least deprived areas

	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
England								
South West								
Exp. Areas & Estbl. Cities								

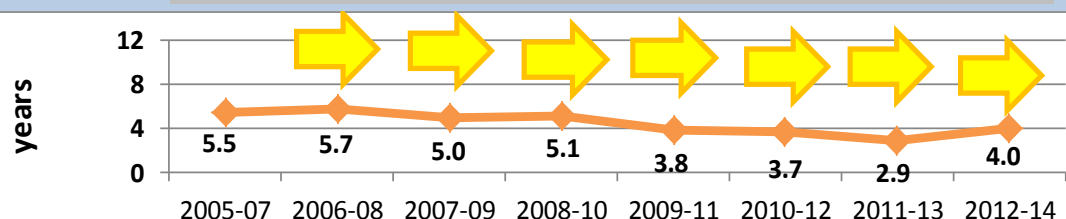
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### Gap in female life expectancy at birth between most and least deprived areas

	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
England								
South West								
Exp. Areas & Estbl. Cities								

SWINDON



Outcome 4: Improved mental health, wellbeing and resilience for all



Improved mental health, wellbeing and resilience for all.



In 2010, 289 Swindon juveniles received their first conviction, caution or youth caution.



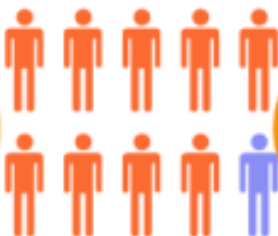
In 2015, this had fallen to 144.



This is still more than the England and South West averages.



Similar levels of self-reported happiness and anxiety in Swindon, in 2015/16, as in 2010/11.



1 in 10 people report a low happiness score

1 in 5 people report a high anxiety score

More reports of incidences of domestic abuse

In 2014/15, 18 domestic abuse incidents were reported to the Police for every 1,000 people in Swindon. This is double the 9 per 1,000 in 2010/11



These kinds of changes may in part be due to greater encouragement by the police to victims to come forward and improvements in police recording, rather than an increase in the level of victimisation.

### Summary of outcome trends

**Fewer young people entering the youth justice system**

**More opiate users  
successfully completing drug  
treatment**

**More non-opiate users  
successfully completing drug  
treatment**

**Similar number of  
suicides**

**Similar levels of  
self reported  
happiness**

**Similar levels of  
self reported  
anxiety**

**More reports of incidences of domestic abuse**

### JSNAs related to this outcome

Domestic Violence and Abuse Needs Assessment:

(<http://swindonjsna.co.uk/dna/domestic-violence-and-abuse-needs-assessment>)  
incorporating:

- Impact of domestic violence and abuse on children and young people
- Impact of domestic violence and abuse on adults

Adult Mental Health and Wellbeing Needs Assessment:

<http://swindonjsna.co.uk/dna/adult-mental-health-and-wellbeing-needs-assessment>

Swindon Suicide Audit:

<http://swindonjsna.co.uk/dna/Suicide-Audit>

Wiltshire Probation Trust Mental Health Needs Assessment:

<http://swindonjsna.co.uk/dna/Wiltshire-probation-trust-mental-health-needs-assessment>

A drug treatment needs assessment and associated treatment plan is completed in Swindon annually.

## **Commentary on progress and key challenges for the future**

Mental health and wellbeing is about how people are feeling, which may or may not be connected to physical symptoms or illnesses they have. Good mental health and resilience helps people get the best out of life but also cope with difficulties and challenges along the way. There are a number of different ways of measuring mental health and wellbeing and surveys are often used. It is also possible to measure actions that result from poor mental health such as suicide or committing crime, or experiences that may contribute to poor mental health such as domestic violence.

In the period 2010 to 2014 the suicide rate has risen in Swindon at a slightly higher rate than nationally. A Swindon Suicide Prevention Audit and Strategy were completed in 2016 with recommendations that have been implemented. These include focusing mental health promotion and treatment interventions at boys and men because 73% of deaths by suicide in Swindon were men. Additionally, suicide prevention training is being rolled out and learning through thematic reviews of deaths by suicide is being more widely shared.

An established care pathway has been put in place for those with substance misuse and mental health problems (dual diagnosis). A Swindon Street Drinkers Project has been established. This project provides a planned response to the needs of this high risk group with improved information sharing and cross agency working alongside the development of jointly owned coordinated planning. Already this is showing reductions in substance misuse and anti-social behaviour along with improved health outcomes for this group.

Additional mental health expert support to the police and emergency services has also been piloted through the Street Triage service. This aimed to improve the quality of care provided and improve the efficient use of emergency service resources. This should reduce the use of Section 136 under the mental health act and also hospital admissions for self-harm.

The levels of self-harm remain a concern in Swindon particularly for those between the ages of 15 and 24 years. The self-harm register is now embedded in the Avon and Wiltshire Mental Health Partnership (AWP) and is being used to inform service delivery with training delivered to Accident and Emergency staff at Great Western Hospital. Work is being undertaken on improving the transitions of those aged 18 from children's to adult services.

Swindon's drug and alcohol treatment services have seen marked increase in the numbers engaging in effective treatment, with over 790 drug treatment and 630 alcohol treatment client staying in effective treatment for more than 12 weeks in the past year.

There has been an increase in the number of domestic abuse incidents recorded by the police. Independent Domestic Violence Advocates (IDVA's) now support people who seek help at GP surgeries or the hospital as a result of domestic abuse. Qualified, specialist advisors provide a free and confidential service to victims considered to be at high risk of harm from their intimate partners, ex-partners or other family members.

The Adult Mental Health and Wellbeing JSNA explored the inequalities experienced by those with mental health problems and highlighted the need to raise awareness of the mental health problems and focus on prevention. This included recommendations to promote the Five Ways to Wellbeing, provide training and promote mental health in the workplace. Other key issues were the need to reduce risk to vulnerable groups such as those expressing emotional distress, those facing financial hardship, men and boys, those with dual diagnosis mental health and substance misuse and those who are social isolated. Support is available to people depending on their need: AWP Partnership provide residential mental health services, LIFT psychology support people in primary care, and the voluntary sector offer a range of support to different groups include advocacy services, therapeutic gardening, and social activities.



## Outcome 4: Improved mental health, wellbeing and resilience for all

### Key to charts

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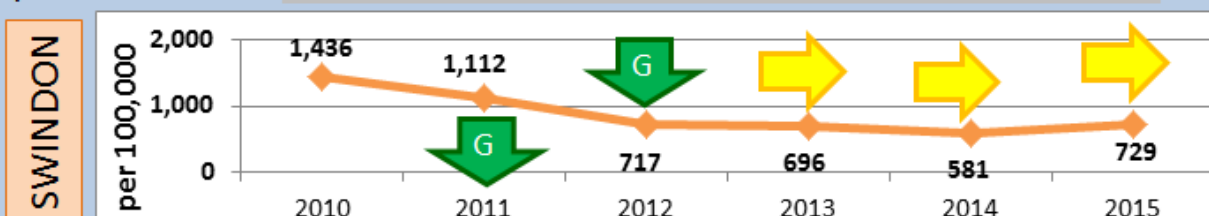
On the charts themselves **coloured arrows** show how Swindon's outcomes have changed over time

**Green arrow (G)** Significantly better  
**Red arrow (R)** Significantly worse  
**Yellow arrow** No significant change  
**No arrow** = change could not be evaluated

Statistical tests have been used to answer the question "how large is the change?" by comparing each change on an equitable basis. This is how the coloured arrows on the charts have been derived

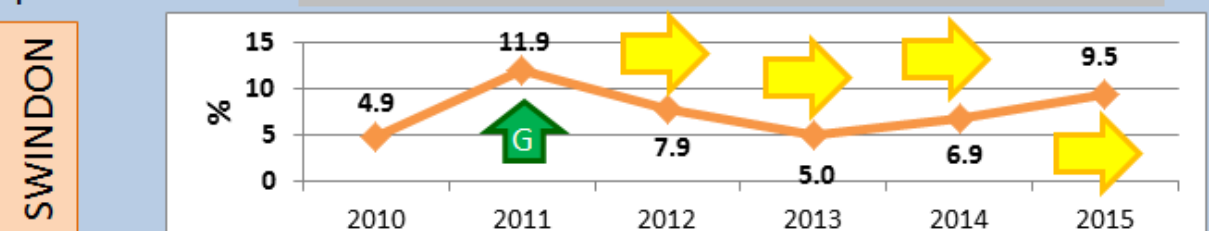
### First time entrants to the Youth Justice System (ages 10-17) (per 100,000)

	2010	2011	2012	2013	2014	2015
England	902	726	556	448	409	369
South West	847	723	590	450	428	364
Exp. Areas & Estbl. Cities						



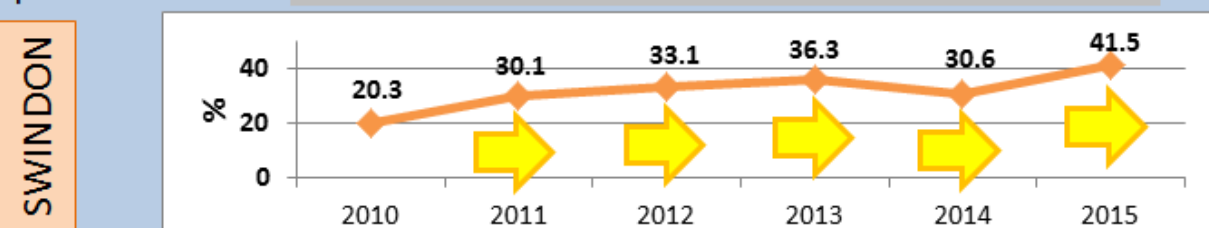
### Percentage of opiate drug users successfully completing drug treatment

	2010	2011	2012	2013	2014	2015
England	6.7	8.6	8.2	7.8	7.4	6.7
South West	7.1	10.2	9.9	8.5	7.9	8.0
Exp. Areas & Estbl. Cities						



### Percentage of non-opiate drug users successfully completing drug treatment

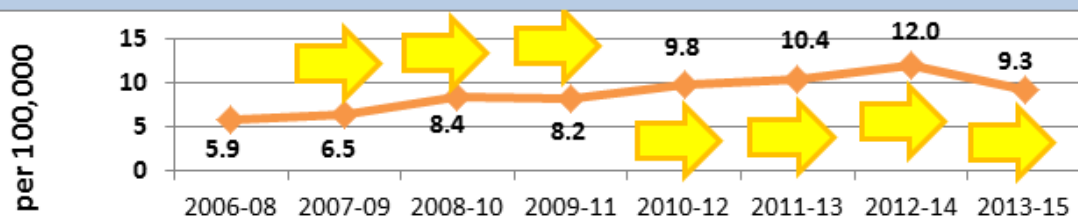
	2010	2011	2012	2013	2014	2015
England	34.4	36.6	37.7	37.7	39.2	37.3
South West	31.4	35.7	38.1	37.6	32.8	34.2
Exp. Areas & Estbl. Cities						



### Suicides (per 100,000)

	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
England	9.2	9.3	9.4	9.5	9.5	9.8	10.0	10.1
South West	9.6	9.9	10.5	11.0	10.9	11.3	11.3	11.0
Exp. Areas & Estbl. Cities	9.3	8.9	9.2	9.2	9.9	10.1	10.2	10.1

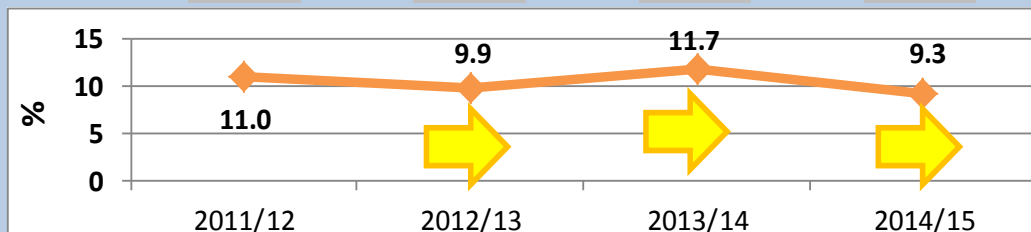
SWINDON



### Self reported wellbeing - people with a low happiness score

	2011/12	2012/13	2013/14	2014/15
England	10.8	10.4	9.7	9.0
South West	10.1	10.2	9.7	8.8
Exp. Areas & Estbl. Cities				

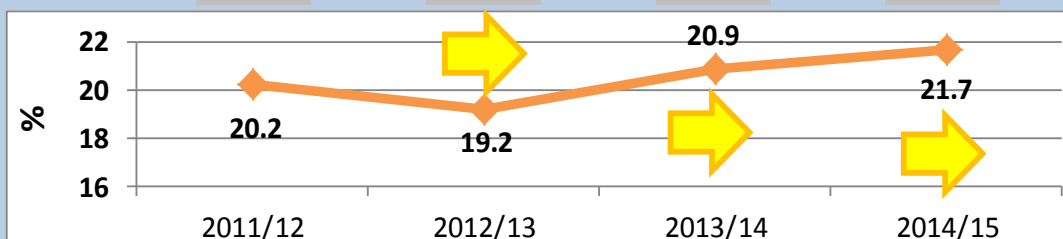
SWINDON



### Self reported wellbeing - people with a high anxiety score

	2011/12	2012/13	2013/14	2014/15
England	21.8	21.0	20.0	19.4
South West	20.2	20.3	19.3	18.8
Exp. Areas & Estbl. Cities				

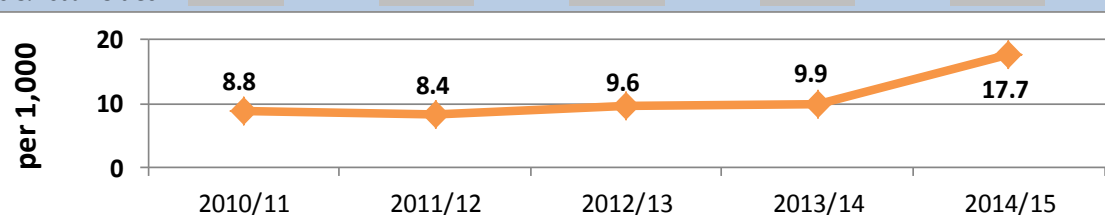
SWINDON



### Domestic abuse incidents recorded by the Police (per 1,000)

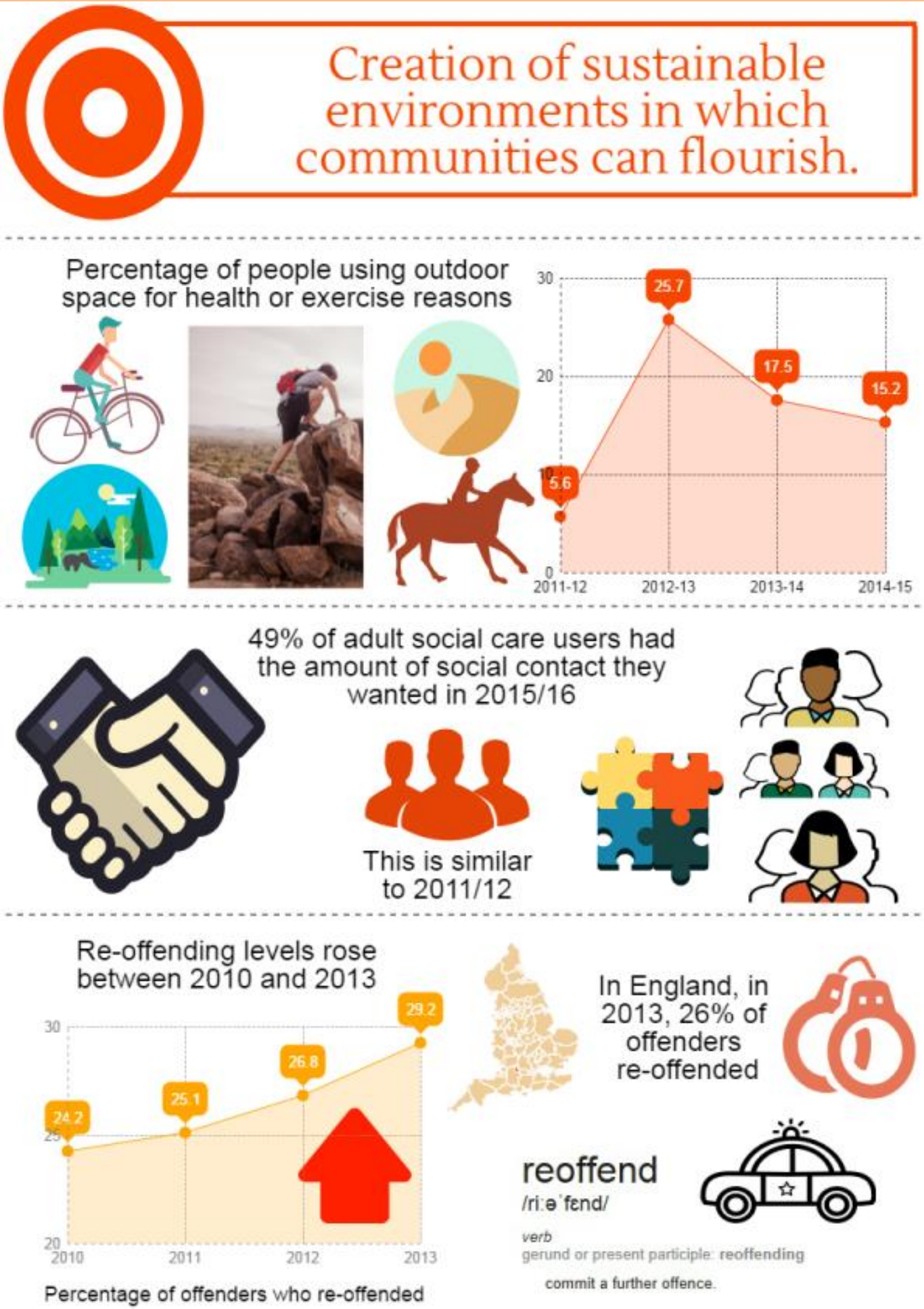
	2010/11	2011/12	2012/13	2013/14	2014/15
England	18.3	18.5	18.8	19.4	20.4
South West	14.3	14.2	14.2	15.2	17.6
Exp. Areas & Estbl. Cities					

SWINDON





**Outcome 5: Creation of sustainable environments in which communities can flourish**



## Summary of outcome trends

**Similar utilisation of green spaces for health or exercise**

**Similar numbers of adult social care service users who feel they have the amount of social contact they want**

**Similar levels of people feeling the things they do are worthwhile**

**Similar levels of self reported satisfaction**

**A higher % of offenders who re-offend**

**It has not been possible to accurately assess whether there has been a significant change in the number of reports of anti-social behaviour**

**There is no recent data to evaluate the current levels of volunteering in sport**

## JSNAs related to this outcome

The Swindon Get Active Strategy is based on evidence from a number of JSNAs:

<http://swindonjsna.co.uk/dna/healthy-weight>

Leisure Key Lines of Enquiry Report:

<http://swindonjsna.co.uk/dna/leisure-KLOE-report>

Libraries Needs Assessment:

[http://www.swindon.gov.uk/download/downloads/id/2293/libraries\\_needs\\_assessment.pdf](http://www.swindon.gov.uk/download/downloads/id/2293/libraries_needs_assessment.pdf)

## **Commentary on progress and key challenges for the future**

Good health and wellbeing is determined by a range of factors, many of them linked to the quality, accessibility and sustainability of our physical environment. Where people live, their social networks and the opportunity to feel part of a community, living, working and playing somewhere which is attractive, accessible, stimulating and giving people opportunities to give and receive from others is also important.

It is often difficult to measure what makes a community flourish. The indicators here capture a mix of how people feel generally, participation in volunteering, crime and safety, and use of green spaces.

A priority is to improve health and wellbeing for all by increasing and widening participation in sports, leisure and cultural activities and by supporting neighbourhoods, communities and voluntary organisations with initiatives.

An on-going challenge is to encourage people to use green space and sports activities more regularly. The Get Swindon Active Strategy 2015 includes a focus on making being active a routine part of everyday life and there are a number of successful programmes in Swindon that encourage this. The Swindon Tri Active Project offers swimming, cycling and running sessions; the Swindon Parkrun at Lydiard Park is one of the largest in the country and the Swindon Health Walks are weekly group walks that encourage enjoyment of the borough's parks and open spaces.

A Swindon Playing Pitch strategy is being written which includes consideration of several major sporting facilities and possible development of the Swindon Town FC County ground and Moredon recreation ground.

Levels of anti-social behaviour across the borough have declined over the last five years and delivery of the Anti-Social Behaviour (ASB) Reduction Strategy continues to focus on working with communities, victims and perpetrators to reduce the number and improve responses to incidents of ASB.

Engaging people in volunteering is a priority for Swindon Borough Council. Volunteering has the benefit of reducing social isolation both for volunteers and the people supported. Swindon Circles is a local service that offers local volunteers the opportunity to support an older person through social befriending to positively reduce loneliness and isolation amongst Swindon's older population. Volunteers encourage clients to be active mentally and physically, signpost to services or assist in problem solving in order to encourage safe and independent living. The service is currently working with 141 older people.

Currently, there is no national data collection on general volunteering that is available at local authority level. Local surveys can provide a partial picture but without benchmarking are hard to fully interpret.

Swindon was one of sixteen areas across the country shortlisted for the NHS England (NHSE) Healthy New Towns Programme. The principle of this initiative was for NHSE to work with areas that demonstrated an ambition to build strong communities and healthy places to live recognising that good urban and housing design promotes healthy lifestyles, can help prevent illness and keep older people independent and healthy, supported by the latest technology to live in their own homes rather than in care homes. Although Swindon did not make the final selection the working group continues to meet to drive this agenda forward.

Links are being strengthened between public health, planning, housing and transport and work continues towards becoming a Dementia Friendly accredited town.

## Outcome 5: Creation of sustainable environments in which communities can flourish

### Key to charts

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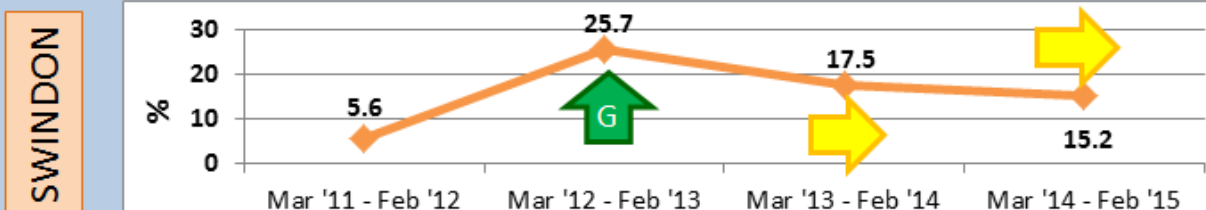
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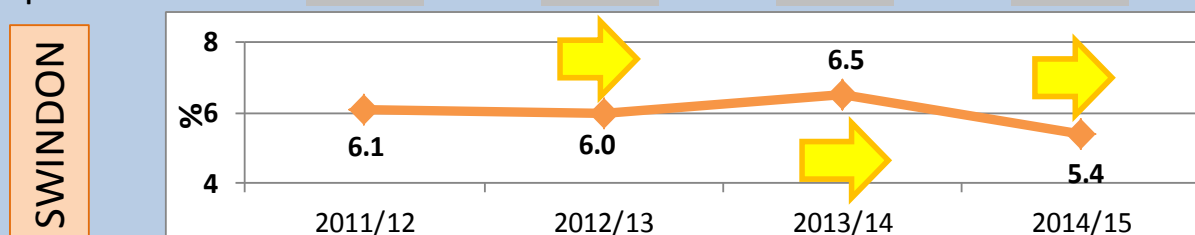
### Percentage of people using outdoor space for exercise or health reasons

	Mar 2011 - Feb 2012	Mar 2012 - Feb 2013	Mar 2014 - Feb 2015	Mar 2013 - Feb 2014
England	14.0	15.3	17.1	17.9
South West	19.4	21.2	22.2	25.4
Exp. Areas & Estbl. Cities				



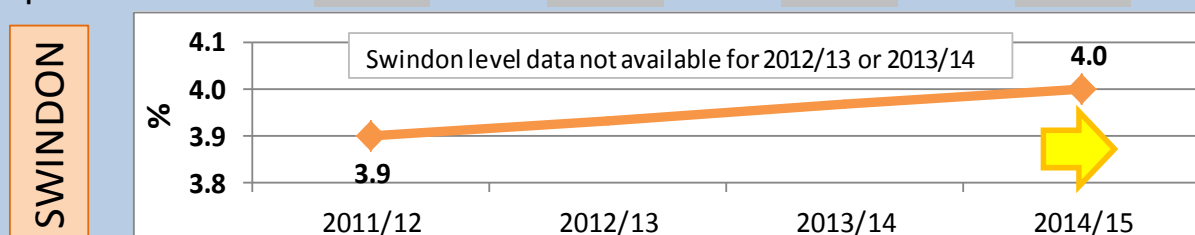
### Self reported wellbeing - people with a low satisfaction score

	2011/12	2012/13	2013/14	2014/15
England	6.7	5.8	5.6	4.8
South West	5.8	5.3	5.3	4.6
Exp. Areas & Estbl. Cities				



### Self reported wellbeing - people with a low worthwhile score

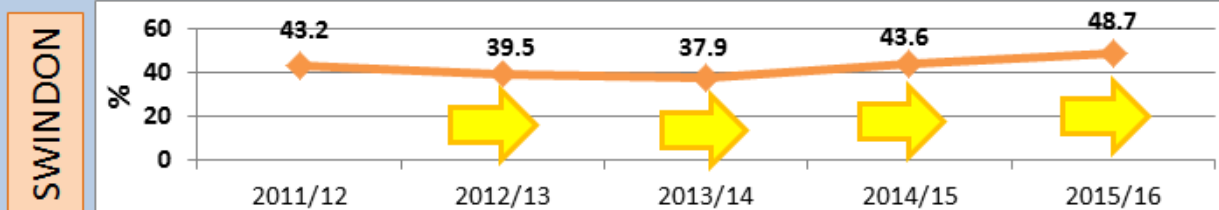
	2011/12	2012/13	2013/14	2014/15
England	4.9	4.4	4.2	3.8
South West	4.3	4.0	4.4	3.9
Exp. Areas & Estbl. Cities				





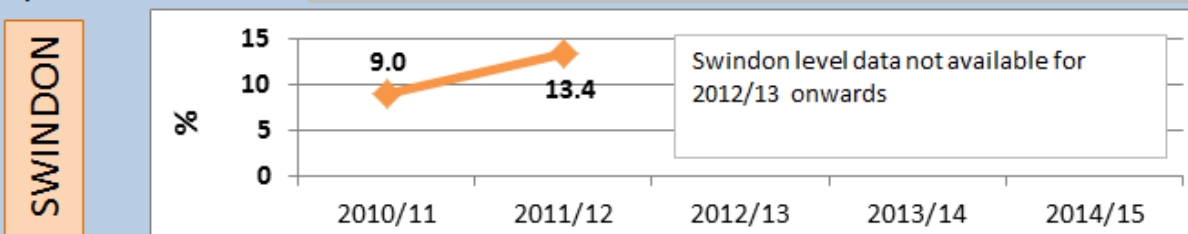
### Adult social care users who have the amount of social contact they want

	2011/12	2012/13	2013/14	2014/15	2015/16
England	42.3	43.2	44.5	44.8	45.4
South West	43.5	44.8	45.0	45.7	46.6
Exp. Areas & Estbl.					



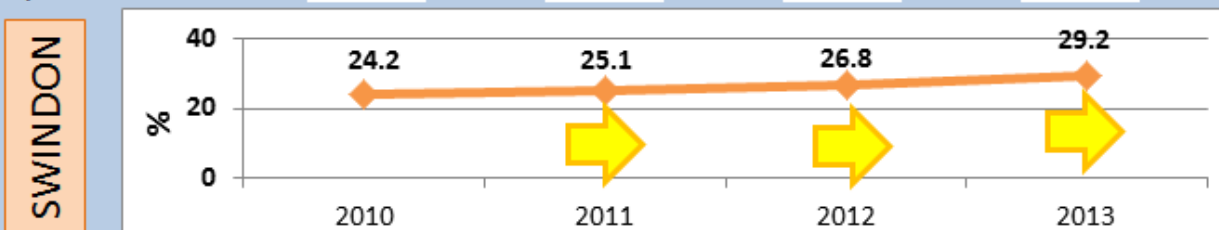
### Percentage of people volunteering in sport

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	13.6	14.0	12.0	12.5	12.7	12.6
South West	15.4	15.8	13.8	14.4	15.3	15.0
Exp. Areas & Estbl. Cities						



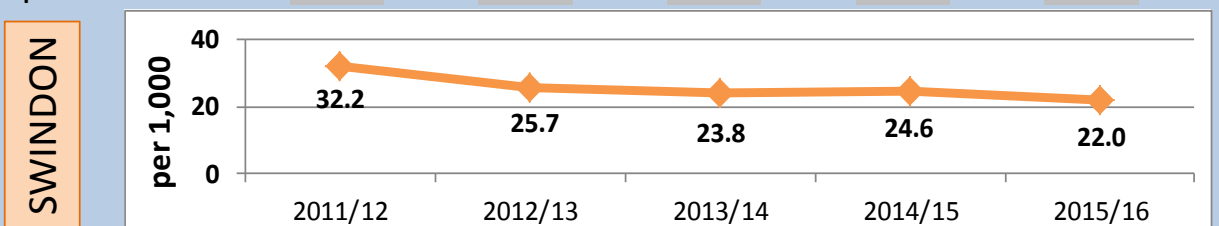
### Re-offending levels - percentage of offenders who re-offend

	2010	2011	2012	2013
England	26.8	26.9	25.9	26.4
South West	26.3	26.0	24.8	25.4
Exp. Areas & Estbl. Cities	25.8	25.6	25.4	26.1



### Anti-social behaviour incidents reported to the Police (per 1,000)

	2011/12	2012/13	2013/14	2014/15	2015/16
England and Wales	48.6	40.3	37.0	33.7	
South West region	44.6	35.7	34.4	31.5	
Exp. Areas & Estbl. Cities					



## Local Safeguarding Children Board Annual Report 2015/16

Health & Wellbeing Board

Date: 14 December 2016

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Author:	Cllr Fionuala Foley - Cabinet Member for Children's Services, Swindon Borough Council Karen Reeve - Director Children's Services, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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### 1. Purpose and Reasons

- 1.1 To present the Annual Report for Swindon Local Safeguarding Children Board (LSCB) 2015/16. The Annual Report is a statutory requirement and details progress towards the annual Business Plan for the Local Safeguarding Children Board.

### 2. Recommendations

The Board is recommended to:

- 2.1 Scrutinise and note the Local Safeguarding Children Board Annual Report 2015/16 attached at Appendix 1 to the report.

### 3. Detail

- 3.1 The Local Authority is responsible for establishing a Local Safeguarding Children Board and the Chief Executive is responsible for ensuring the effectiveness of the LSCB in consultation with LSCB statutory partners and the Cabinet Member for Children's Services. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. They co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and to ensure the effectiveness of what is done by each such person or body.
- 3.2 Statutory Guidance requires the Annual Report to be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board. In this instance the Lead Member for Children's Services has advised that it be presented to the Health and Wellbeing Board for its scrutiny, information and awareness. The Annual Report is attached at Appendix 1.
- 3.3 The Annual Report details the progress that has been made towards the four priority areas identified in the Board's Business Plan for 2015/16. A summary of the priority areas and headline achievements follows:

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Further information on the subject of this report can be obtained from Fiona Francis – Safeguarding and QA Manager, 01793 464366, [ffrancis@swindon.gov.uk](mailto:ffrancis@swindon.gov.uk).

# Local Safeguarding Children Board Annual Report 2015/16

Health & Wellbeing Board

Date: 14 December 2016

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## Priority Area 1 - Effective responses to specific safeguarding concerns

- 3.4 The LSCB has appropriate strategies and comprehensive approaches to specific safeguarding issues that keep children and young people safe and promote effective intervention with those who are at risk from:
- 3.4.1 Domestic Abuse: The LSCB continues to work with the Community Safety Partnership to ensure a joined up approach towards domestic abuse and violence against women and girls.
  - 3.4.2 Child Sexual Exploitation (CSE): The LSCB has a clear understanding of CSE in Swindon and work to identify children at risk is informed by partnership profiling, data on missing and absent children and the work of the Multi Agency Risk Panel (MARP).

## Priority Area 2 - Effective early intervention and safeguarding

- 3.5 The LSCB can demonstrate that children and young people in Swindon receive effective early intervention that meets a range of needs in different communities.
- 3.6 Work on this priority has focused on reviewing the use of Early Help Records and Plans and the development of the Multi Agency Safeguarding Hub.

## Priority Area 3: Communication and engagement

- 3.7 The LSCB and partner agencies communicate effectively with children and young people; their families; the community (including different sections of the Community); and staff at all levels from partner agencies.
- 3.8 The LSCB continues to look for opportunities to engage with all stakeholders. During 2015/16 the LSCB received presentations and reports from a number of groups working to promote the voice of children and young people including Young Carers, the Children in Care Council, Youth MPs and the Swindon Advocacy Movement.
- 3.9 Over 300 delegates from across all partner agencies attended the LSCB's Annual Conference which included presentations on 'Working with young people affected by CSE' and 'Trauma and Violence in the context of CSE and Radicalisation'.

## Priority Area 4: Performance management

- 3.10 The LSCB has an effective performance management framework which promotes different ways of knowing and learning about the effectiveness of early intervention, safeguarding and protection of children and young people in Swindon.



# Local Safeguarding Children Board Annual Report 2015/16

Health & Wellbeing Board

Date: 14 December 2016

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- 3.11 The LSCB continues to develop its performance and quality assurance functions and is working towards a theme-based approach to reporting which will inform more in depth work by both the Performance and Quality Assurance Sub-groups.
- 3.12 Quality Assurance work has led to the development of specific guidance to practitioners on working with adolescent neglect.
- 3.13 The LSCB had concluded a Serious Case Review (SCR) and one Local Case Review (LCR) during 2015/16. The learning from the reviews was and continues to be disseminated through training courses and published guidance. During 2015/16 the LSCB commissioned a further 2 SCRs and 2 LCRs.
- 3.14 The Annual Report also includes contributions from the Board's partners which provide information on particular safeguarding activity within their organisations and their contribution through the LSCB towards to multi-agency working.
- 3.15 The LSCB recognises the progress made by partners throughout the 2015/16 year. Through its business planning and review processes the Board identified the following 4 new priorities for inclusion in its Business Plan for 2016/17:
  - 3.15.1 Priority Area 1: Early Help: Evaluate the effectiveness of the Thresholds document to ensure that it is fit for purpose, well understood and used appropriately by professionals in partner agencies and identify any barriers to delivery of early help.
  - 3.15.2 Priority Area 2: Child exploitation: To undertake a partnership profile in order to better understand the nature and extent of CSE and related issues across Swindon and to evaluate the effectiveness of the multi-agency response to CSE and other forms of child exploitation.
  - 3.15.3 Priority Area 3: Strengthening the Voice of the Child and their families and practitioners: To develop the ways in which the LSCB can 'hear' the voice of the child and their families and also front line professionals when evaluating the effectiveness of services that support them and their families.
  - 3.15.4 Priority Area 4: Supporting the effectiveness of adults and children's services to work together to safeguard children: To identify and promote better outcomes for children through closer working between services that support children and the adults that care for them.

## 4. Alternative Options

- 4.1 Working Together to Safeguard Children 2015 requires the LSCB Chair to publish an Annual Report. The report should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

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Further information on the subject of this report can be obtained from Fiona Francis – Safeguarding and QA Manager, 01793 464366, [ffrancis@swindon.gov.uk](mailto:ffrancis@swindon.gov.uk).

# Local Safeguarding Children Board Annual Report 2015/16

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## 5. Implications, Diversity Impact Assessment and Risk Management

### Financial and Procurement Implications

- 5.1 There are no direct financial or procurement implications arising from this report.

### Legal and Human Rights Implications

- 5.2 All legal and human rights implications were taken into account in preparing this report. It is believed that the report's recommendations are compatible with Convention Rights.

### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 None.

### Diversity Impact Assessment

- 5.4 A Diversity Impact Assessment has not been completed for this report; however, Diversity Impact Assessments are completed by individual partner agencies where relevant to support strategic planning and development.

### Risk Management

- 5.5 The LSCB holds a risk register, which is reviewed through the LSCB Performance Sub Group and monitored quarterly through the LSCB Board.

## 6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

## 7. Background Papers

- 7.1 None.

## 8. Appendices

- 8.1 Appendix 1 – Local Safeguarding Children Board Annual Report 2015/16.



# Swindon LSCB Annual Report 2015/16

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## **INDEPENDENT CHAIR'S INTRODUCTION AND FOREWORD**

As the Independent Chair of Swindon Local Safeguarding Children Board (LSCB), I am delighted to present its Annual Report covering the period from April 2015-March 2016.

As a statutory partnership, the LSCB brings together organisations with a collective responsibility to safeguard and promote the welfare of children and young people. This report describes the achievements and challenges of the Board and its partners in their efforts to ensure the safety and wellbeing of children and young people within the Borough. During the period covered by this report, partners continued to make positive progress in strengthening local arrangements, but were not complacent as to the tenacity required to address the enduring issues affecting children and young people and the need for us to respond to emerging challenges.

I took up the position of Independent Chair in July 2015 and chair the full LSCB Board as well as the Chairs' Group which comprises the Chairs from the 8 LSCB sub groups. I also chair one of these sub groups-the Case Review Group (CRG) which oversees the Serious Case Review (SCR) and Local Case Review (LCR) functions.

### **The LSCB structure and budget**

Following appointment, my initial review focused on the current LSCB support team structure and how that could meet the key functions of the Board. Working with key senior leaders the structure was reviewed and a new LSCB Strategic Manager post was created (commencing work in May 2016) and the key LSCB functions of Quality Assurance (QA) and Training and Development were recognized and integrated into a new role. The LSCB budget was also revised to reflect the new staffing structure. I identified funding for functions which was being inappropriately coded to the LSCB budget which have been re-allocated to the LA and funding for CSE training for schools which is now being met from school's budgets.

### **Challenge and Scrutiny**

Challenge and scrutiny are the key functions of an LSCB and the LSCB has made a number of decisions to change and improve the overall improve the impact of learning.

Firstly, the CRG now oversees all SCRs and LCRs and does not have separate Review Teams which are costly in terms of staff capacity and don't at times allow for a timely and effective process. The new focus has already streamlined the process and improved ownership of recommendations. The CRG also reviewed 4 historical LCRs, which did not previously result in clear Action Plans in order to provide evidence of the progress, and improvements made and identify areas that still require improvement.

Secondly, the QA sub group reviewed its TOR and ensured that its multi-agency audit programme was achievable and addressed the areas requiring scrutiny informed by the priorities in the LSCB Business Plan, performance data and SCRs and LCRs

Thirdly, the Performance sub group reviewed and introduced significant improvements in the performance data received from partner agencies using exemplars from other LSCBs, the content of the overall data set and the quality of the narrative provided. This is to increase the LSCB understanding of the impact of work to safeguard children, particularly from Adult services.

Fourthly, I introduced the Challenge Log for the LSCB and its sub groups to record challenges around performance and practice which are identified and then presented to the LSCB. This is a live document providing evidence of challenge and transparency to enhance the LSCB collective responsibility to provide scrutiny and challenge. This Challenge Log will be published as part of the Annual Report in 2016/17.

### **Engagement of children & young people, their families and staff.**

The LSCB is working to further improve the engagement of children and young people and to ensure there are mechanisms to hear their voice. This is undertaken through a number of ways including the audit methodology, which includes direct feedback from children, young people and staff and more generalised survey activity. I have met with the Leads for children and young people's engagement and the LSCB agenda has been restructured to ensure there is a standing agenda item at each meeting to consider the views/input from children and young people. Participation of children, young people, families and practitioners has now been agreed as one of the four LSCB targeted priorities and the work is being led through the LSCB Strategic Manager and the revised LSCB Business Plan for 16/17.

### **Early Help.**

Early Help arrangements were discussed at the LSCB in September 15 and there was clearly further work needed to review and ensure that the Thresholds document, Early Help Pathways and training and support for partner agencies was appropriate. Agreement at the LSCB was reached to establishing a task and finish group to address these issues. This sub group is now chaired by the Clinical Commissioning Group (CCG) Safeguarding Lead and the initial meeting took place in February 16. The LSCB is keen to engage schools and Early Years sector and will also need to ensure this as an area, which is subject to multi-agency audit in 16/17.

There continues to be high levels of children subject to Child Protection Plans and concerns about the increase in contacts and referrals to the social care front door. There is no current evidence from performance data, case reviews, multi-agency and single agency audits, Independent Review Officer (IRO)/Local Authority Designated Officer (LADO)/Complaints/Child Protection (CP) Chair's reports that the quality of work has been affected. However, the additional capacity and focus this year on Quality Assurance by the LSCB will enable it to increase to ensure evidence of quality as well as the regular reporting of single agency auditing activity. The potential impact of any workforce challenges will need to be considered and continue to be monitored. The LSCB has also extended its scrutiny further for Looked After children and receives the Councils Corporate Parenting Board minutes' quarterly to allow scrutiny and to request areas of additional challenge. Proposed changes around the development of a MASH and Signs of Safety processes adopted in child protection conferences have been reported to the LSCB and further updates will be needed to ensure full understanding and ownership by all partners.

### **HEALTH**

I as Independent Chair arranged a meeting of key health leads to review current safeguarding arrangements and clarify governance and accountabilities in March 16. There was concern that there was no Designated Nurse and no Lead Safeguarding GP in 15/16, which impacted on safeguarding capacity. NHS England were providing support and the outcome was a revised and an enhanced job description for the post which was recruited to in August 2016, a peer review undertaken by a neighbouring CCG and additional funding from NHS England to support succession planning for designated and named health professionals. NHS England representation on the Board has also been secured.



## **Child Sexual Exploitation**

The LSCB is determined to ensure that the learning from case reviews concluded in 2015/16 is included in the current revision of the overarching CSE strategy. The planned CSE audit in 16/17 will evidence where there has been progress in the last two years and where more focus is required. It has undertaken robust scrutiny of arrangements for missing children to ensure that the statutory requirements for independent interviews of children on return are undertaken and the learning monitored by the CSE Strategy Group. Although there is evidence of much progress, there are still remaining challenges to ensure the operational links and processes are made and the multi-agency risk meetings and new operational teams are effective and the LSCB will continue to require assurance on these issues.

### **2016/17**

While reflecting on the work undertaken during this period, I am of course mindful of the important potential changes on the horizon following the government review of LSCBs published in May 2016 and the proposed legislative changes. The review confirmed the need for multi-agency safeguarding arrangements based on local need and will be the subject of future local discussions in 2016/17.

While recording my thanks to members of the Board and those supporting the work of its sub groups, I would like to state my gratitude to all those staff and volunteers within the local workforce for their commitment to safeguarding children and young people.

### **Alex Walters**

Independent Chair, Swindon Safeguarding Children Board.

## Progress on the LSCB Business Plan 2015-2016

The LSCBs Annual Business Plan sets out LSCBs priorities for the year ahead. The priorities are identified by Board members in response to performance data, case reviews, national and local drivers for change and local intelligence about the changing needs of children and young people in Swindon. The business plan for 2015/16 contained both overall objectives for the LSCB and four priority areas for focus.

### 1. Overall Objectives of the LSCB

To coordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area, and to ensure the effectiveness of what is done by each such person or body for these purposes (Section 14 Children Act 2004).

In order to achieve the above, specific objectives for the Business Plan 2015-16 have been developed and are divided into four main areas that directly relate to continuing to pursue the core purposes of the LSCB as given by statute. In addition, within priorities, there are particular areas of focus relating to local priorities for improvements in inter-agency service provision.

### 2. Core Priorities and areas of focus for 2015-2016

#### Effective responses to specific safeguarding concerns

- Detailed strategies and comprehensive approaches to specific safeguarding issues that keep children and young people safe and promote effective intervention with those who are at risk
- Consolidation of strategies and approaches to Child Sexual Exploitation that keeps children and young people safe

#### Effective early intervention and safeguarding

- The LSCB can demonstrate that children and young people in Swindon receive effective early intervention that meets a range of needs in different communities

#### Communication and engagement

- The LSCB and partner agencies communicate effectively with children and young people; their families; the community (including different sections of the Community); and staff at all levels from partner agencies

#### Performance management

- The LSCB has a performance management framework which promotes different ways of knowing and learning about the effectiveness of early intervention for and safeguarding of children and young people in Swindon

The following table is a summary of the actions the LSCB and its partner agencies have taken in response to the Priority Areas of Focus identified in the Business Plan. Additional detail is included in the reports from the Chairs of the Sub-groups later in this report.

**PRIORITY AREA 1 - EFFECTIVE RESPONSES TO SPECIFIC SAFEGUARDING CONCERNS**

Detailed strategies and comprehensive approaches to specific safeguarding issues that keep children and young people safe and promote effective intervention with those who are at risk

**Domestic Abuse**

- The Community Safety Partnership (CSP) commissioned a new Domestic Abuse Strategy (which also covers violence against women and girls) which was agreed by Swindon Borough Council (SBC) Cabinet and presented to the LSCB in December 2015.
- The LSCB is represented on both the CSP and the Domestic Abuse and Violence against Women and Girls Management and Quality Assurance Group to ensure a joined up approach to this work.
- The Domestic Abuse Pathway supports more effective and timely information sharing between partners.
  - Early Help and Social Care practitioners have an active role in the Multi Agency Risk Assessment Conferences (MARAC) to ensure the voice of the child and their 'lived experience' is considered in a multi-agency way.
  - The Professional Lead for Health Visiting reviewed the health input into MARAC and made improvements to facilitate more robust assessments and communication from health colleagues.
  - Governance and Quality Assurance arrangements for MARAC have been improved.
- The LSCB has continued to offer multi-agency training in the three areas that comprise the Toxic Trio – namely Domestic Abuse, Parental Mental Illness and Substance Misuse – but has yet to develop a dedicated course that focuses on supporting children living in families with multiple and complex needs.
- Working with partners the LSCB developed a Female Genital Mutilation (FGM) strategy which is forms one of the strands of work that the Community Safety Partnership oversees through its Domestic Abuse and Violence against Women and Girls Board.
- The LSCB worked with the Community Safety Partnership to provide multi-agency training in FGM and Honour Based Violence to 46 professionals from range of organisations.
- The LSCB is undertaking a multi-agency audit in the autumn of 2016 to consider evidence of good partnership working, clear pathways and sufficient and appropriate services for children experiencing domestic abuse.

**Child Sexual Exploitation (CSE)**

- The LSCB has a clear understanding of CSE in Swindon that is informed by Police and partner profiles, Missing and Absent data, the Section 11 audit and information gathered from the Swindon Multi Agency Risk Panel. Recommendations are implemented via the Child Sexual Exploitation & Missing Sub-group with its action plan informed by multi agency profiles, and

the recommendations from national and local case reviews.

- The effectiveness of the Councils Multi Agency Resources Panel (MARP) has been improved by: shifting the panel's focus to the pursuit and disruption of perpetrators as well as child protection; changing the chair's role to one of quality assurance and challenge; and, establishing a QA sub-group of MARP to evaluate the impact and effectiveness of the panel.
- Swindon Borough Council's CSE Strategy has strong corporate management and oversight of CSE across the Council, greater community engagement, and better identification and casework management by Council staff and schools.
- The Council appointed a CSE and Missing Manager to co-ordinate and oversee this area of the business and the Missing Children's protocol and Vulnerability Checklist have both been updated.
- The Partnership Profile for CSE has improved our understanding of those people who are at most risk in Swindon and enabled resources to be targeted more effectively.
- There has been strong partnership working to secure funding for the Opal Team which will provide a more co-ordinated response to CSE.
- The Quality Assurance Sub-group is to undertake a multi-agency audit of in summer 2016. Informed by the findings from case reviews the audit will consist of two parts: one to assess the level of knowledge of CSE amongst front line practitioner survey and the second a deep dive audit of a sample of case files to assess the progress made in multi-agency support for children and young people at risk of CSE.

#### **PRIORITY AREA 2 - EFFECTIVE EARLY INTERVENTION AND SAFEGUARDING**

The LSCB can demonstrate that children and young people in Swindon receive effective early intervention that meets a range of needs in different communities

- In order to ensure that children receive the right service at the right time the LSCB established an Early Help Working Group in 2015/16 to assess the use of Early Help Records and Plans and to review the LSCBs multi-agency thresholds document.
- The LSCB links well with other boards such as the Health & Wellbeing Board (HWB), the Local Adults Safeguarding Board and the Community Safety Partnership (CSP). The Business Plan and Annual Report are both presented to these groups and where appropriate, such as Domestic Abuse, Female Genital Mutilation and joint training, there are shared actions which promote safeguarding as "everybody's business".
- The LSCB has received regular reports on progress towards the development and implementation of a Multi-Agency Safeguarding Hub (MASH) in Swindon. Once the plans are finalised and the MASH is up and running the Board will want to undertake quality assurance activity to understand the effectiveness of the MASH in ensuring that children and young people get the support they need at the earliest opportunity.
- The LSCB's Online Safety Sub-group develops awareness campaigns on a range of e-safety topics. The annual online safety pupil survey of children's online experiences and attitudes obtained the views of nearly two thousand 8-10 year old children. The findings led to the

Sub-group organising and overseeing programmes to support children and young people and their parents/carers to be safe online. These programmes included:

- Online safety lessons to nearly 2800 children and young people including targeted work within the Junior Good Citizen and Young Warden’s programmes
- Training and awareness sessions to 80% of Swindon schools and colleges was attended by over 950 school staff and parents, additionally sessions have been delivered to GP’s and child-minders for the first time.
- The Wiltshire Police “Polite and Sexting” lessons has been delivered to just over 40% of primary and special schools and 35% of secondary schools and colleges respectively.

### **PRIORITY AREA THREE: COMMUNICATION AND ENGAGEMENT**

The LSCB and partner agencies communicate effectively with children and young people; their families; the community (including different sections of the Community); and staff at all levels from partner agencies

- The LSCB received presentations and reports from a number of groups working to promote the voice of children and young people in both the design of the services they receive and in the effectiveness of those services. For instance, the Board heard from Young Carers, Youth Forum, the Children in Care Council and Youth MPs.
- The Board also received reports from the Swindon Advocacy Movement (SAM) who support parents of children for whom there are safeguarding concerns and Coram Voice who provide an advocacy service for children who are the subjects of child protection case conferences. The Board was pleased to hear that both services were able to report good levels of engagement and positive feedback from their client groups and will look to develop additional ways of communicating with children and their families as part of an engagement plan within next year’s Business Plan.
- The LSCB website continues to host information for professionals, parents and children and young people on a range of safeguarding matters. It is also the home of the LSCBs training offer with online information about course availability and application information.
- With other LSCBs in the south west Swindon’s Board commissions a shared website hosting the South West Child Protection Procedures – a source of practice information and related research for those working with children and young people. The Policy & Procedures Sub-group will be working to develop the local resources that support the shared content so as to make it increasingly relevant to workers in Swindon.
- The Training & Development Sub-group distributes a quarterly newsletter called Newsbyte to highlight new and forthcoming courses and other related information.
- The LSCB’s Annual Conference was held in November 2015 and was very well attended by over 300 delegates from across all partner agencies. The theme was ‘Troubled or Troublesome’ with Keynote Speakers Dr Camille Warrington talking about working with young people affected by Child Sexual Exploitation, and Alyas Karmani who spoke about trauma and violence in the context of CSE and radicalisation.

- Education providers are well represented on LSCB training and representatives contribute to the work of many of the Boards sub-groups.
- The joint Wiltshire and Swindon Child Death Overview Panel (CDOP) met eight times in 2015/16 and reviewed 35 individual child death cases of which 18 were Swindon children. During this year the panel successfully launched the new CDOP quarterly newsletter (predominantly for health and social care professionals) highlighting issues and learning from cases reviewed locally and coordinated a media campaign to raise awareness amongst parents and carers on a range of issues including safe sleeping and water safety.
- In the coming year the LSCB plans to extend its awareness raising activity further by engaging with the voluntary sector and more directly with children, young people and the wider public. Work to facilitate this wider engagement with settings and workers is a priority strand for the LSCBs Lay Members in the Business Plan for 2015/16.

#### **PRIORITY AREA FOUR: PERFORMANCE MANAGEMENT**

The LSCB has a performance management framework which promotes different ways of knowing and learning about the effectiveness of early intervention for safeguarding of children and young people in Swindon

- The LSCB developed a data set of performance indicators designed to inform the Performance Sub-group's activity. Data relating to safeguarding activity and outcomes for children and young people is further enhanced by information relating to individual partner organisations and the strengths and challenges they experience in delivering their services. The data set is to be developed further in 2016/17 to provide for a more theme-based approach to reporting which will enable the Performance Sub-group to monitor performance on specific issues such as domestic abuse, CSE etc.
- As a result of its analysis of data relating to neglect and in line with the findings from case reviews the Performance Sub-group requested that an audit looking at the identification of and responses to adolescent neglect be undertaken by the Quality Assurance Sub-group which was undertaken in 2015/16.
- The LSCB's Quality Assurance Sub-group undertook an audit on the extent to which good practice on neglect was embedded within multi-agency working. As a result of this work the LSCB's guidance to professionals – The Neglect Framework – was revised to give specific guidance on working with adolescent neglect.
- The Quality Assurance Sub-group undertook a number of other multi-agency audits during the year and also received and reviewed single-agency audits on a range of issues including Children in Police Custody and Supervision within the Great Western Hospital Trust.
- The LSCB has concluded one Serious Case Review (SCR) and one Local Case Review (LCR) during 2015/16. The Case Review Sub-group had oversight of the review process and developed the multi-agency action plan in response to the findings and recommendations. The learning from the reviews was and continues to be disseminated through training courses and published guidance. During 2015/16 the LSCB commissioned a further 2 SCRs and 2 LCRs.



## **The Local Context**

### **Swindon Borough**

The Borough is 230km<sup>2</sup> (89 square miles) in area and is home to about 217,160 people. It consists of the town of Swindon itself, the market town of Highworth, the large village of Wroughton, and a number of smaller villages and hamlets. Swindon is at the heart of the M4 corridor and has excellent links to the rest of the UK and beyond, together with a superb natural setting.

### **The Population**

On the whole Swindon is an economically and socially successful town although there are some indicators which compare unfavourably with national trends such as harm from alcohol, self-harm, educational attainment at the ages of 16 and 19 and the number of young people aged 18 not in education, training or employment. The Health and Wellbeing Strategy 2013-2016 sets out the vision and long term plan for improvements in health and wellbeing of all and, whilst it focuses on health and social care issues, it recognises the wider factors that affect health and wellbeing including education, housing, employment and leisure.

Evidence from the Joint Strategic Needs Assessment (JSNA) suggests that in many ways the health of Swindon's population is similar to England as a whole, and this in itself can present many challenges. While average life expectancy and smoking levels are improving there are still wide inequalities across the population and very little sign that the health gap is being reduced.

Like other places across the country, Swindon people have been damaged by the economic recession and by growing problems of obesity and physical inactivity and the rise in Type 2 diabetes. The JSNA summary highlights some local issues such as the particularly large increase in numbers of older people projected into the future, incidents of domestic abuse, chlamydia screening in the 15-24 age group, and a worrying number of young people being admitted to hospital for reasons connected to alcohol, substance misuse and self-harm.

The increasing prevalence of long term conditions is also highlighted, in particular people having two or more conditions. The financial pressures facing the public sector in the coming years indicate a radically new approach is required, to be adopted by services and the public alike, to tackle this trend.

There is a growing realisation that health and wellbeing is everyone's business. Swindon has a thriving voluntary sector and wide acceptance that individual and community assets have a major role to play in meeting needs. People are more than passive recipients of services and, as the carers section shows, in reality most care is provided by individuals, families and friends themselves.

## **Children & Young People**

There are approximately 50,000 children under the age of 18. Children from Black and Minority Ethnic (BME) communities and diverse backgrounds account for 20% of all school age children. 117 languages are spoken in Swindon schools and Swindon has the highest proportion of children with English as an additional language in the South West.

There is fast growing population and the demand for support has increased over the past 3-4 years placing additional pressure on services. Higher numbers of teenagers are in need of additional help to address challenges such as mental health, exploitation, substance misuse and behaviours all of which can and do lead to family breakdown.

- At any time about 10% of children will be in receipt of early help services, and 3.1% (about 1,600 children) receiving specialist social care, or support following permanent exclusion or drug user treatment services. Children under five are supported by health visitors and the Family Nurse Partnership.
- At the end of 2015/16, there were 238 children subject to a child protection plan, an increase from 213 at the end of 2014/15.
- By the end of 2015/16 the number of children in care has risen to 292, an increase from 252 at the previous year.
- The percentage of children looked after for more than 2.5 years who have been in the same placement for at least 2 years or placed for adoption was 59.4% (38 out of 64 children).
- 18.8% of children looked after are placed more than 20 miles from home.
- 87.5% of care leavers live in suitable accommodation and 48.9% were in education, training or employment which is slightly higher than the England average in March 2015.
- The level of child poverty is better than the England average with 14.9% of children under 16 living in poverty in Swindon (2015/16). Beneath this overall statistic lies a more complex local picture. Five of Swindon's 20 wards have poverty levels which exceed the national average (Gorse Hill and Pinehurst; Liden, Eldene and Park South; Penhill and Upper Stratton; Rodbourne Cheney, and; Walcot and Park North) although despite the high concentrations of poverty in these wards, it is important to note that 69% of the children living in poverty do not live in these areas.

## **Joint Strategic Needs Assessment (JSNA)**

The Health and Wellbeing Board (HWB) has a statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Swindon. The JSNA is not an end in itself; it draws together key themes from available evidence and describes the current and future health and wellbeing needs of the people of Swindon and is the principal work stream to inform the Joint Health and Wellbeing Strategy (JHWS). The LSCB works closely as a partnership to ensure that its objectives are aligned with those of the HWB and that they are informed in part by the JSNA.

The [Health and Wellbeing Strategy 2013-2016](#) sets out the vision and long term improvements in local people's health and wellbeing that we want to achieve in Swindon. It focuses on health and social care issues for everyone living in Swindon, but also recognises the wider factors that affect health and wellbeing including education, housing, employment and leisure.

The JSNA highlights the importance of local partners working together to improve health and wellbeing and to reduce inequalities.

The JSNA:

- Provides a common view of health and care needs for the local community
- Documents current service provision
- Identifies gaps in health and care services, documenting unmet needs
- Provides evidence of effectiveness for different health and care interventions
- Looks at the health of the population, with a focus on behaviours which affect health such as smoking, diet and exercise.
- Identifies health inequalities
- Is concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment

The main audience for the JSNA are health and social care commissioners who use it to plan services. This includes partnership bodies such as the HWB and One Swindon, commissioning bodies such as Swindon Borough Council and NHS Swindon Clinical Commissioning Group and scrutiny bodies such as the LSCB.

The Joint Strategic Needs Assessment informs strategic planning for children and young people and is an integral part of the commissioning cycle. JSNA Bulletins provide more detailed analysis on specific issues in order to provide a more sophisticated analysis of our population of children which will ensure early and effective local interventions are commissioned to counteract the adverse impact of multiple risks throughout childhood which contribute to poor emotional, educational, economic, health and social outcomes.

During 2015/16 The JSNA produced needs assessments focussing on:

### **Children aged 0-4 (Best Start)**

This assessment focuses on the needs of around 15,000 children aged 0-4 in Swindon. Research tells us that pregnancy and a child's early years are a time of vital importance to a child's health and

wellbeing and that parents are central to this. The JSNA bulletin below provides a brief summary of the full JSNA which is a comprehensive and detailed analysis of all aspects of the first five years of a child's life and the influences on it.

- [Children and young people: Best Start needs assessment bulletin](#)

### **Children and young people's mental health**

This mental health needs assessment focuses on the needs of children and young people from 5 – 18 years but also includes transition to adult services up to the age of 25.

- [Children and young people's mental health needs assessment](#)
- [Children and young people's mental health needs assessment bulletin](#)

### **Children and young people with complex and life limiting conditions**

Children with a disability, complex need and/or life limiting condition are a diverse group. Some will need multi-agency support across health, social services and education whereas others will have little contact with services unless their condition deteriorates.

- [Children and young people with complex and life limiting conditions needs assessment](#)
- [Children and young people with complex and life limiting conditions needs assessment bulletin](#)

The assessments provide detailed information that helps us to better understand the needs of children and young people in these groups in Swindon. The recommendations arising from the assessments are considered alongside other performance data to inform the work of the LSCB and particularly the Performance Sub-group in 2016/17.

## Swindon Performance Information – the Child's Journey

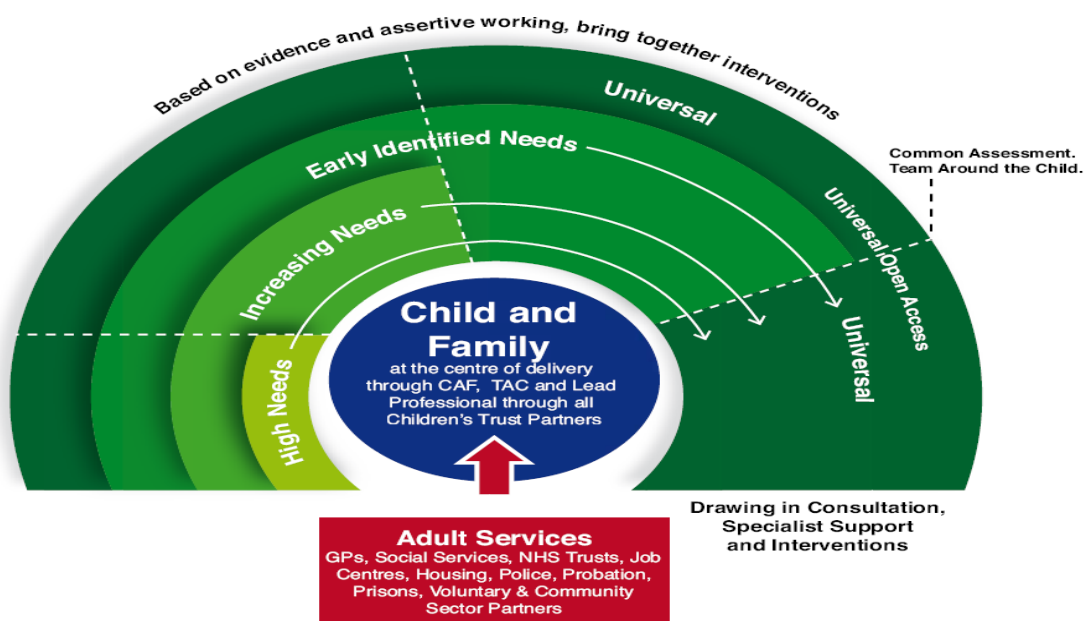
The intention of all those who work with children and young people in Swindon is for all children and young people, irrespective of their circumstances, to have the best start in life, to grow up safe, stable and healthy, to fulfil their potential and make a contribution to their community.

Children, young people and families experience a range of needs at different times in their lives. However, while all children and young people require access to high-quality universal services, some of them also have additional needs that may relate to their health, well-being, development and education. Parents/carers may also experience challenges in providing for their family. Some children will have complex needs and are supported by a number of services as part of a multi-agency response. A small number will be in need of protection because there are concerns that they are suffering or are likely to suffer significant harm.

The LSCB's Threshold Guidance helps workers to identify the appropriate level of response to a child's assessed needs and uses a Continuum of Need approach to guide practitioners in deciding, either at the initial screening stage or following an assessment, whether a child has additional needs and at what stage or by what agency those needs could best be met:

- Stage 1 Universal = Open access
- Stage 2 Early Identified Needs = Early Help
- Stage 3 Increasing Needs = Children with complex and long standing needs
- Stage 4 High Needs = Urgent/acute crisis and high priority needs.

The **Continuum of Need** (windscreen) illustrates how needs can change and by accessing advice and consultation, including the information contained in the assessment framework, it will help to identify what help is needed and by whom

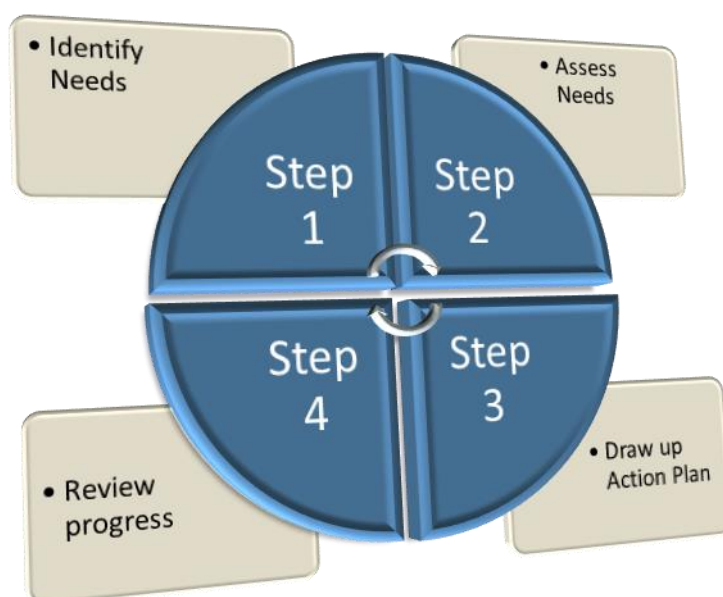


## Common Process & Single Assessment

The Early Help Record and Plan (EHR&P) is the common process in Swindon for supporting children, young people and families with additional needs. The aim is to consider the needs of the child or young person in four key areas: Health and Well-being; Development needs, educational attainment and achievement; Parenting/caring; and, Family and Community.

The Early Help Record is the first part of the single assessment process that aims to empower children, young people and their families and provide a timely, seamless service if needs escalate. This single assessment supports families through early help to escalating complex and/or urgent needs that require a statutory response from children's social care. Early Help Records and Plans should be used by any agency where they have identified a child or young person with additional needs. The following four step cycle should inform the work to draw up the record and plan. Additional guidance on the Early Help process is available at <http://schoolsonline.swindon.gov.uk>

### The Four Step Cycle of Single Assessment

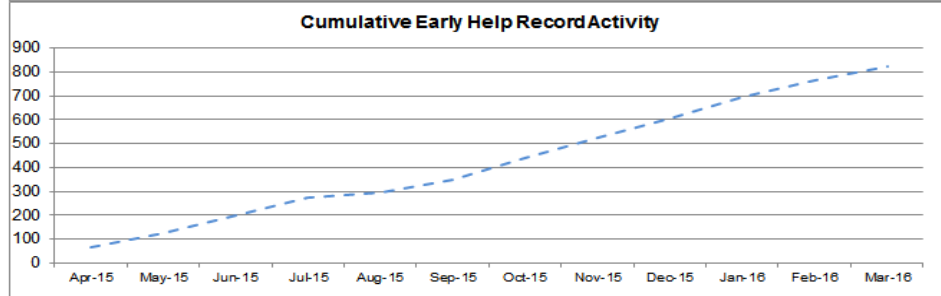
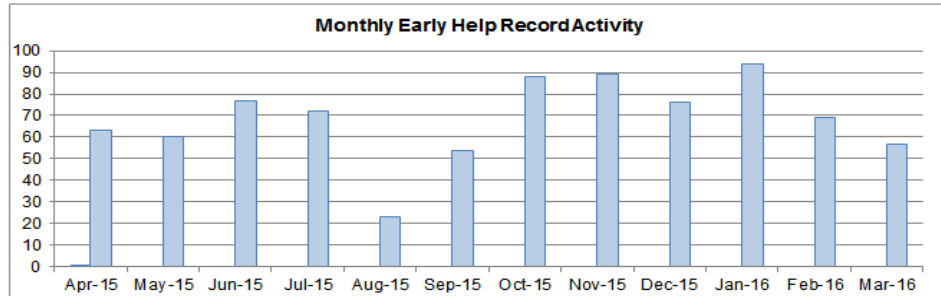


Once an Early Help Record and Plan has been completed it should be sent to Family Contact Point where it is held on file and available should there be any further referral or enquiries regarding that child. Any subsequent reviews of the Early Help Record and Plan should also be sent to Family Contact Point.

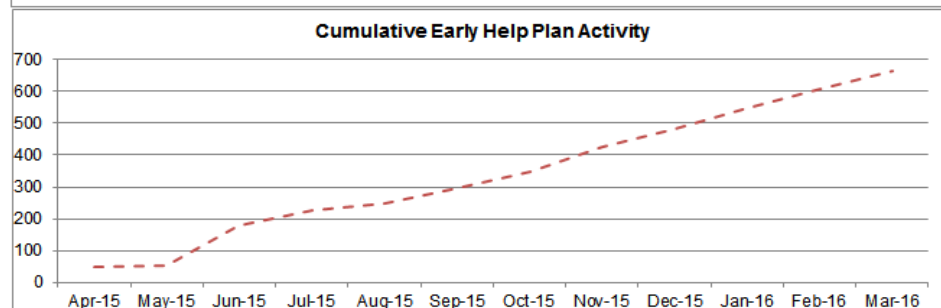
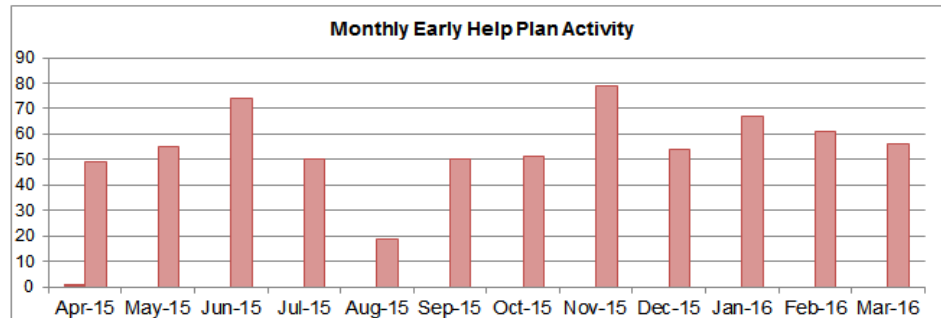
Management oversight and quality assurance of early help processes are the responsibility of individual agencies. For services provided by Children's Social Care there is an ongoing audit programme which supports service development.

The following charts show the numbers of new Early Help Records and the number of Early Help Plans received by Family Contact Point during 2015/16. The third chart shows the number of Records received in Family Contact Point broken down by originating agency.

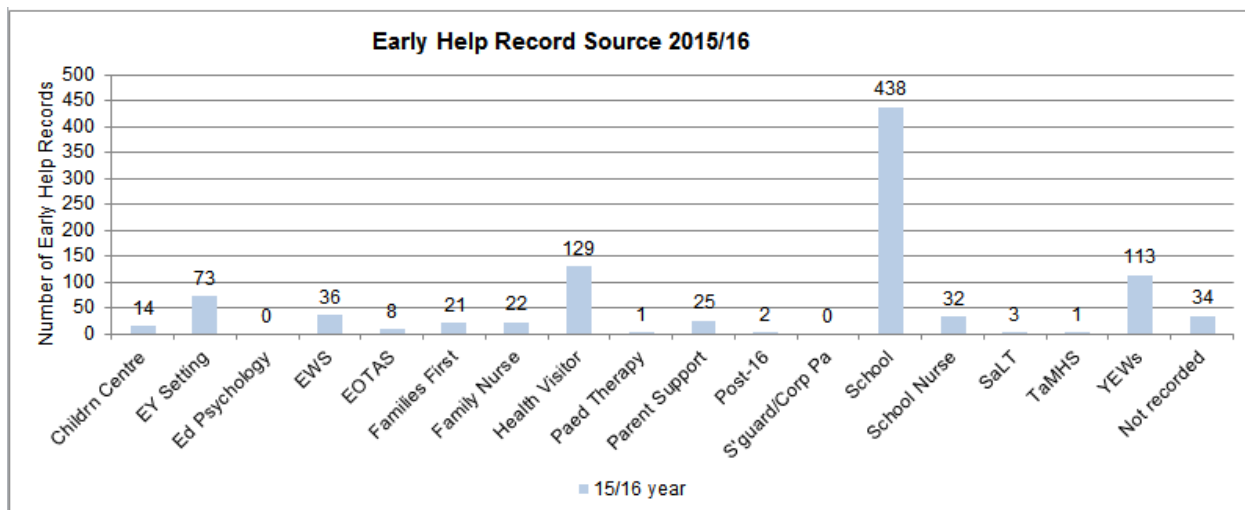
Early Help Record Activity												
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
New EHR	63	60	77	72	23	54	88	89	76	94	69	57
Cumulative New EHR	63	123	200	272	295	349	437	526	602	696	765	822



Early Help Plan Activity												
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
EH Plan in the month	49	55	74	50	19	50	51	79	54	67	61	56
Cumulative EH Plan	49	104	178	228	247	297	348	427	481	548	609	665



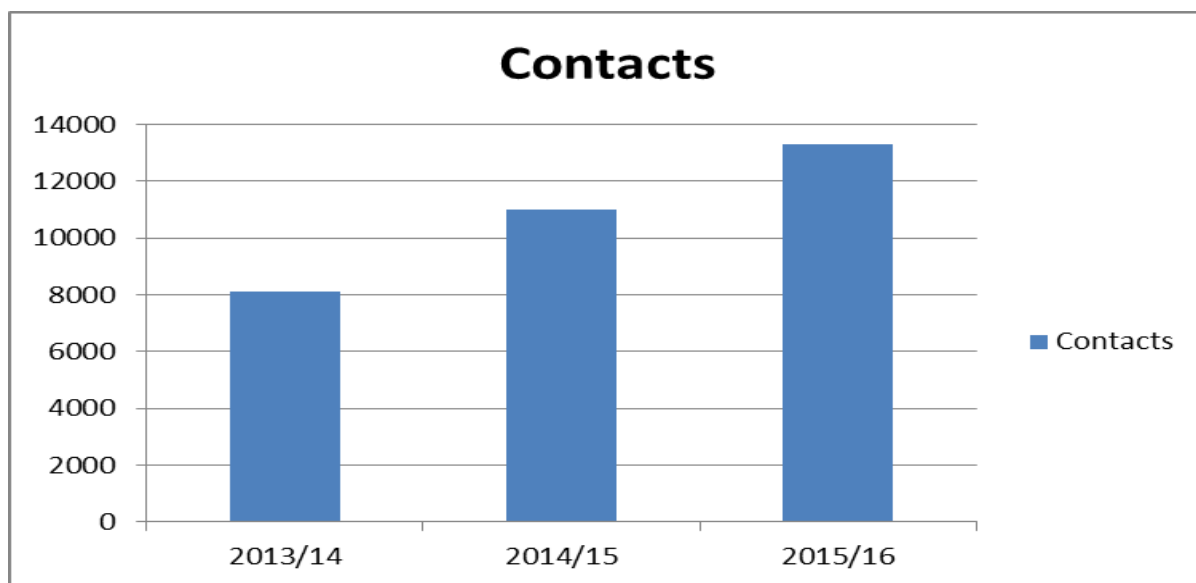




Where the child's needs are such that they are not able to be met through an EHR&P either because the needs have changed or were more complex on initial presentation or where the child is considered to be at risk of suffering significant harm, practitioners will want to contact Swindon Borough Council's Children's Services. The following paragraphs describe what happens when such a contact is made and is followed by some key statistics relating to this process and the different groups of children who are supported by children's social care teams.

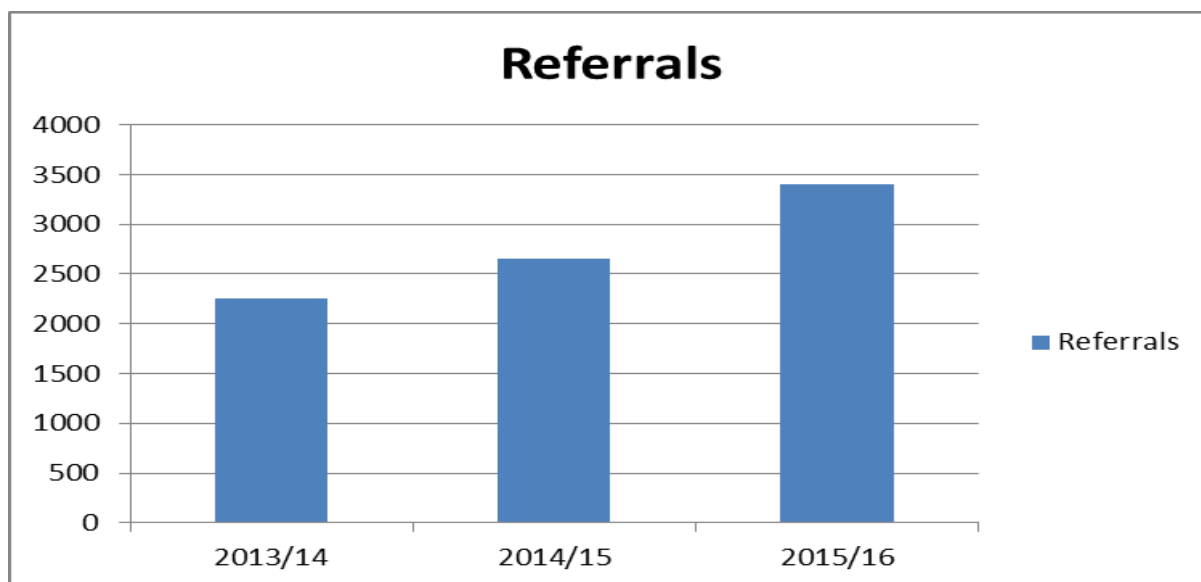
1. Each professional, family member and resident who gets in touch with Children's Services and is seeking advice on a potential safeguarding matter is counted as a **contact** by Family Contact Point (FCP). If the concern is of a child protection nature or further consultancy is needed to explore the degree of concern, then a caller can have direct contact either with social workers or an Assistant Team Manager, within FCP. In accordance with the Threshold document, and if a query details concerns which indicate that the child or family are in need of social care assistance, then the contact is passed as a **referral to Social Care** and referred to the Assessment & Child Protection Team.
2. A worker in FCP takes the details of the contact and if necessary makes further enquiries with other agencies about the child and family. This information is given to the Assistant Team Manager within FCP who makes the decision within 24 hours on, whether the case should be referred to another agency (Early Help) or universal services or whether the case meets the threshold of a child in need. The referrer is contacted in all instances to feedback what the decision was. If the case is referred, as a child in need, to the Assessment and Child Protection Team (ACP) for an assessment of need, then a social worker will complete a **Statutory Assessment** within 1 – 45 working days.
3. Following a Statutory Assessment, a case may be closed, or referred to another agency/service or allocated to a social worker for provision of a service if the child is deemed to be a child in need or in need of protection. If the manager decides that the child may be at risk of harm and this is a child protection referral, then a Strategy discussion takes place with the police and other agencies. The Strategy discussion decides whether an enquiry is required and whether this should be led by the Police or social care, or be undertaken jointly by both agencies. This is called a **Section 47 child protection enquiry**. If following the enquiry, the concerns are substantiated, the manager will decide whether a child protection conference is required which will be held within 15 days of the strategy discussion. The child protection conference decides whether the child should have a child protection plan.

## Contacts to Children's Services



Swindon receives around 1000 contacts a month. There were 10,996 contacts to children's services during the year 2014/15 compared to 13,313 in 2015/16, an increase of 21%. 3,405 of these contacts progressed to referral to social care. Although still significant, the percentage increase between 14/15 and 15/6, was lower than between 13/14 and 14/15. 25.6% of contacts were accepted as a social care referral. It is important to note that Family Contact point receives contacts for all children services queries, not specifically those for social care.

## Referrals

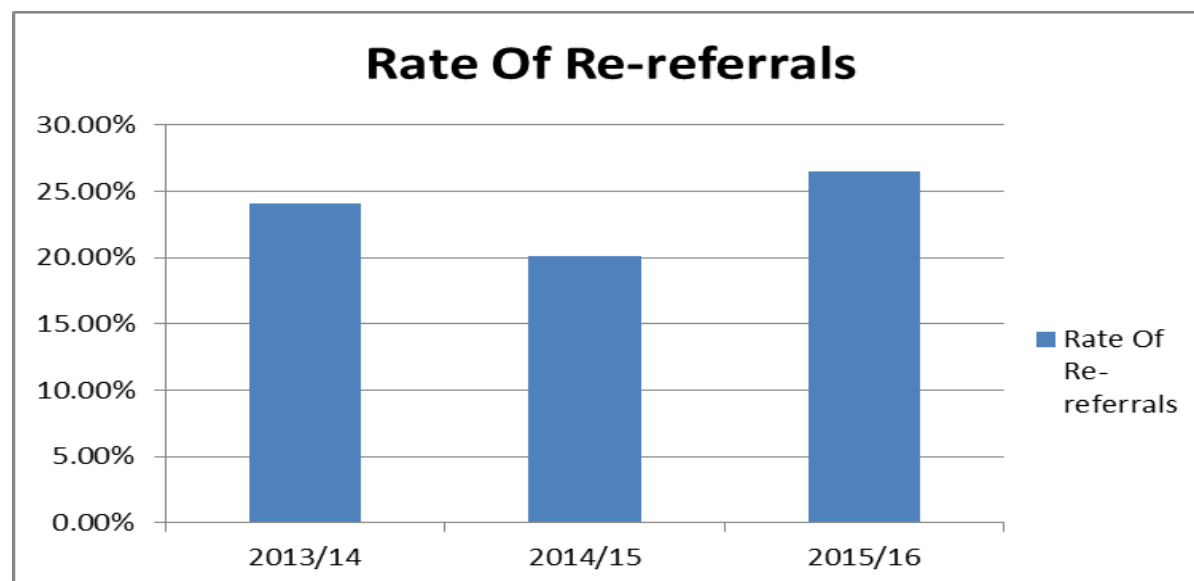


Demand at the "front door" of children's services continues to be at a higher level than in the previous year. The national trend reported a decrease from 571.7 per 10,000 population aged under 18 in 13/14 to 548.3 in 14/15. The national 15/16 comparator data will not be available until the Autumn, however our South East Benchmarking group provides us with some early 15/16 referral comparator data, and reports an increase in the South East average during the year.

During 2015/16, 3,405 referrals were received. Swindon has seen an increase from 553.2 (2650 referrals) referrals per 10,000 population in 14/15 to 700.6 per 10,000 population in 2015/16. This

translates to an extra 355 referrals. The average monthly number of referrals for 2015/16 is 284 compared to 220 in 2013/14, a 28.5% increase.

### Re-referrals



Of the 3,405 referrals received in 2015/16, 901 (26.5%) were re-referrals. This compares to 532 (20.1%) in 2014/15. The national average was 24% in 14/15. The re-referral rate will be closely monitored in 16/17 following the implementation of the MASH (Multi agency safeguarding Hub). An audit was undertaken in 15/16 following the increase in the re-referral rate, and it was established that all re-referrals coming back into the service were appropriate. It is anticipated that as the MASH is embedded and multi-agency decision making is strengthened at the contact point, this will lead to improved quality of information gathered to inform referral and will therefore ensure Assessment and Child Protection team have the right information in a timely manner to progress assessments as appropriate.

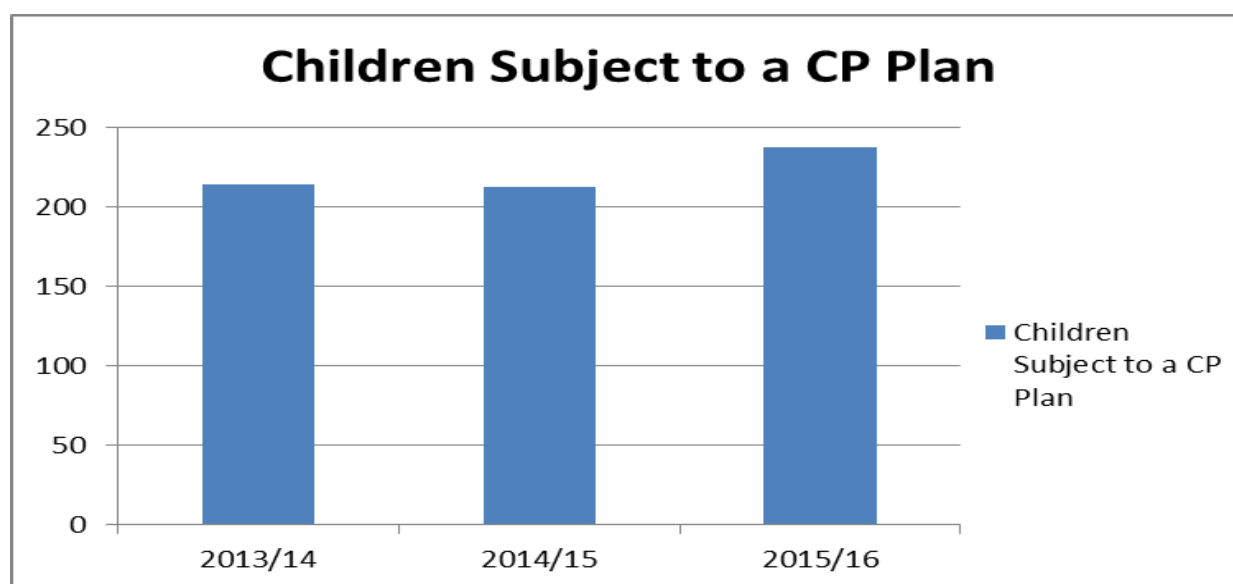
### Statutory assessments

3,146 Statutory Assessments were completed in 2015/16. This is an increase of 18.8% from 2649 in 2014/15. 65.1% of Statutory Assessments were completed within 45 working days, taking an average of 39 days. The national average was 28 days. One of the main reasons for Swindon being higher than the national average is that a number of assessment documents were not 'technically' shut down on the electronic system.. A data cleansing exercise has been undertaken to address this, but it has a negative impact on this measure. Regular auditing of case work ensured that the quality of assessments were sound. Performance should improve during 16/17.

### Children in need (section 17 social care)

There were 1283 children in need (this does not include children subject to a child protection plan or children in care) at the end of March 2016. This is above the national (1140) and statistical neighbour (943) average.

## Children subject to a child protection plan



238 children were subject to a child protection plan at 31<sup>st</sup> March 2016, above 2014/15 at 213. Swindon has a higher rate (50.4 per 10,000 population under 18) than the national average (42.8) and statistical neighbours (41.7).

Of these 213 children on child protection plans, 93.4% had their reviews completed on time compared to 98.4% at the end of 13/14. The national average for 13/14 was 94.6%.

### Children subject to a child protection plan by category of abuse

Category of abuse	2013/14	2014/15	2015/16
Neglect	64	77	92
Physical abuse	72	33	20
Sexual abuse	15	15	14
Emotional abuse	63	88	112
Total	214	213	238

Neglect and Emotional abuse are the two main categories leading to a child protection plan. Both of these categories saw an increase between 14/15 and 15/16. However, this needs to be considered in the context of an overall increase in the number of children on child protection plans. There has been a decrease in the number of plans with a main category of physical abuse.

### Percentage of children subject to a child protection plan for a second or subsequent time

For 2015/16, the rate of children starting a child protection plan for the second or subsequent time was 19.0% (55 out of 289). This is more or less static from 19.2% in 14/15, and is now higher than the national average of 16.6% and above the statistical neighbour average of 17.6%. This has been monitored via the Children, Families and Community Health performance reporting arrangements, and the percentage has reduced again in the first quarter of 16/17.

### Percentage of children ceasing to be subject of a child protection plan, who had been the subject of a child protection plan continuously for two years or more

In 2015/16, 3.1% (8 out of 256) of children ceasing a child protection plan remained on a plan for two years or more, compared to 1.5% in the previous year. This is below the 14/15 national average of 3.7% and below the statistical neighbour average of 3.6%.

## Children Looked After

292 children were in care/looked after by the Council at the end of 2015/16. This is higher than 252 at the end of 14/15 when this rate was lower than that of statistical neighbours.

90 children looked after (30.8%) were in Independent fostering or residential placements commissioned placements at end 15/16. This compares with 25.0% in 14/15. Swindon has a lower percentage of children in externally commissioned placements than nationally (35.9% in 2014/15).

Fostering capacity is strong, with the majority of children in care placed in in-house placements (63.7%). 81.2% (237 out of 292) of children in care live within 20 miles of home, ensuring minimal disruption to important networks of family, friends and school.

## Placement Stability

At the end of March 2016, 11.3% of children in care had 3 or more placements, compared to 10% nationally). This is an improved position from 2014/15 when 13.9% of children in care had 3 or more placements. Swindon has more adolescent young people in care than the average and we know this adds to placement stability issues, particularly in relation to placement sustainability with very complex teenagers.

## Private Fostering

The Local Authority has a responsibility under the Children (Private Arrangements for Fostering) Regulations 2005 and the National Minimum Standards for Private Fostering to ensure that we provide a proactive approach and commitment to safeguarding and promoting the welfare and needs of privately fostered children by everyone that works with children.

All Private Fostering referrals and records of visits are recorded on the Capita Integrated Children's System; with a clear process in place, from initial notification to allocation of case to the social worker. This has strengthened strategic oversight, and improved the case recording of and outcomes for privately fostered children.

During the 2014 Single Inspection Framework Ofsted inspection, inspectors commented on the low number of notifications and the potential under reporting of privately fostered children. Since then a new system has since been implemented that allows for all notifications to be recorded.

In June 2015 a private fostering social worker, with a borough wide lead on Private Fostering was appointed. The role also supports families of children who are subject to Special Guardianship Orders.

In 2015-2016 In Swindon there were 19 children under private fostering arrangements, this is an increase of 3 children on 2014-2015 when there were 16 children.

	2011/12	2012/13	2013/14	2014/15	2015/16
Number of Privately Fostered Children	15	9	20	16	19

The children that were under Private Fostering Arrangements in 2015-2016 were known to be attending Okanagen Ice Hockey Academy or privately fostered due to family breakdown or similar.

Challenges for the coming year are to continue to promote awareness of private fostering to the public and to professionals and to develop further the robust management and oversight of cases held by the Fostering & Adoption Team.

## Missing children

All reports of missing children from the police are received by Family Contact Point and those that do not reach the threshold for a social care assessment are referred for Early Help from the Integrated Locality Teams. The social care lead for missing children meets each month with the Wiltshire Police Missing Persons coordinator to monitor and review the data and ensure that actions have been put in place, including return interviews for each child where appropriate. Those children and young people at highest risk are also reviewed at the multi-agency risk panel.

The number of reports between 1<sup>st</sup> April 2015 and 31<sup>st</sup> March 2016 are detailed below; this includes repeat episodes of missing /absent and may relate to the same child who has been reported on more than one occasion over this period.

	2014/15	2015/16
<b>ABSENT</b>		
Number of reports missing & absent	874	1111
Number of absent reports	152	180
Number of episodes of absent looked after children	22 episodes (13 children)	34 episodes (23 children)
Number of individuals who have repeat absent episodes e.g. more than once.	15	35
Number of repeat absent children who were looked after	6 children	7 children
<b>MISSING</b>		
Number of reports of missing children	719	931
Number of episodes of missing children who are looked after children	286 episodes (54 children)	356 episodes (72 children)
Number of individuals who have repeat missing episodes e.g. more than once.	110	114
Number of repeat missing children who were looked after.	30 children	50 children

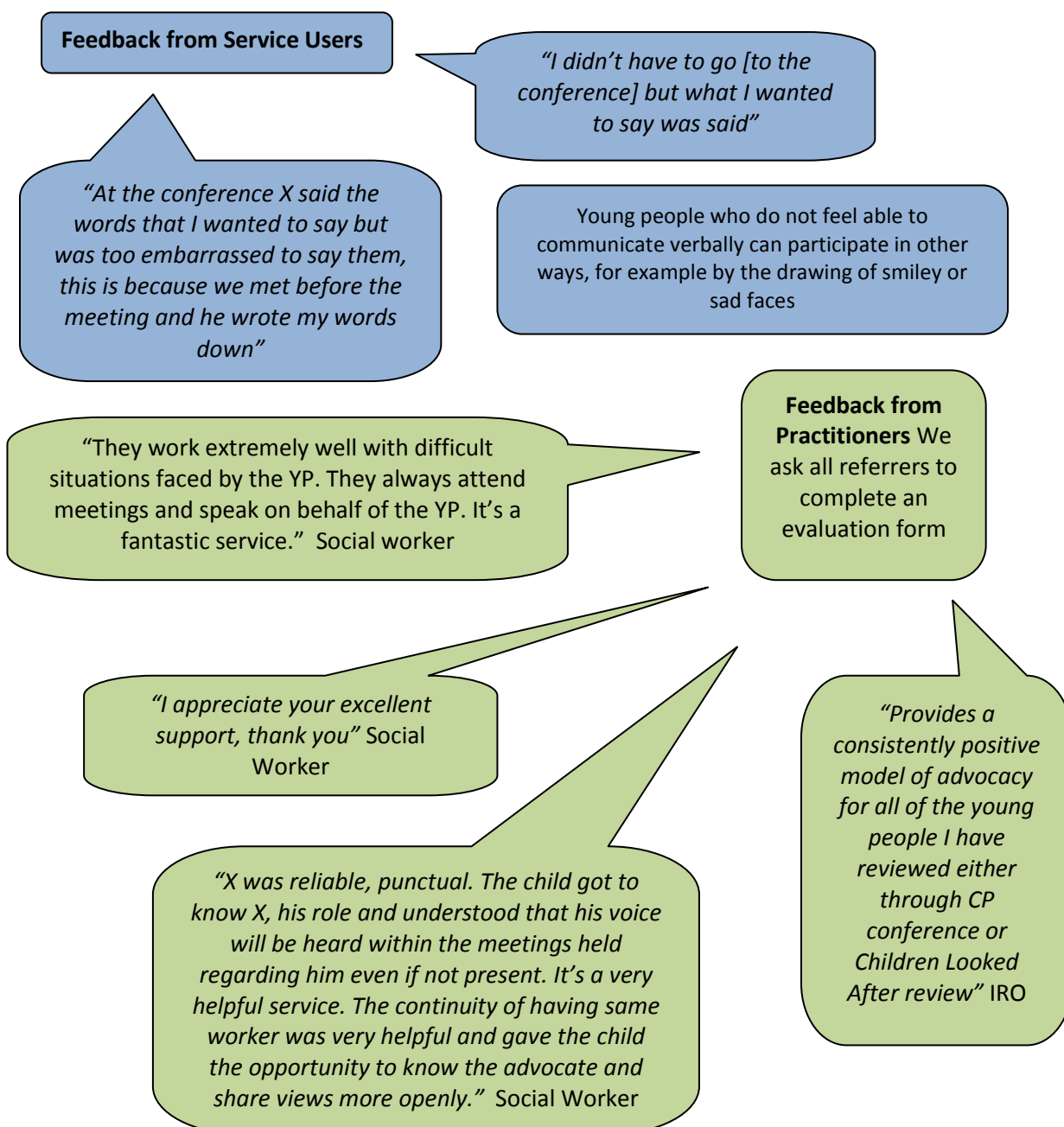
**Missing:** Anyone whose whereabouts cannot be established, and where the circumstances are out of character or the context suggests the person may be subject to crime or at risk of harm to themselves or another. **Absent:** A person is not at a place where they are expected or required to be and there is no apparent risk

The LSCB continues to collect and analyse data relating to the early help and child protection process through its Performance Sub-group and has constituted an Early Help Working Group to explore the existing early help model and the thresholds guidance with a view to making recommendations to the Board in 2016/17.

## Advocacy in the Child Protection System

Coram Voice has been commissioned by Swindon Borough Council Children's Services to provide an 'opt out' advocacy service to children and young people who are aged 7– 18 years and who are the subject of Initial Child Protection Case Conferences and/or review conferences.

The advocates support the children to attend and participate in the conferences or, if the child prefers, by gathering their views and presenting them at conference on their behalf. The advocates work on behalf of the young person only and, in order to ensure that as far as possible the views of the child are independent from those of the parents, the appointments take place at school rather than in the child's home environment.





The number of young people referred for child protection advocacy services from 1<sup>st</sup> April 2015 - 31<sup>st</sup> March 2016 was 201 with a percentage take up rate of 98%. The table below gives a comparison from 2014/15 to 2015/16:

Number of young people referred for CP Advocacy Support		1st April 2014– 31st March 2015	1st April 2015 – 31st March 2016
New cases	Quarter one	10	32
	Quarter two	49	43
	Quarter three	26	60
	Quarter four	21	66
Total carried over from previous year (ongoing advocacy support)		174	224
Total		280	425

### **Outcomes**

Coram Voice received 59 (31%) completed evaluation forms over this reporting year for child protection advocacy. All evaluation forms which were completed indicated a positive response/outcome in terms of being heard, someone to speak on their behalf and that they would recommend Coram Voice to their friends.

## Allegations Management

Over the last year the approach to allegations management has been significantly strengthened to include the completion of the actions agreed in the previous LSCB action plan and the LADO specific recommendation from the 2014 Ofsted Inspection.

Activity has included completion of a comprehensive diagnostic assessment of the LADO services which involved analysis of allegation trends over the last 4 years. Key stakeholders have been consulted about their views about the most effective way to manage allegations in future. This was used to create a successful business case for the recruitment of a dedicated LADO.

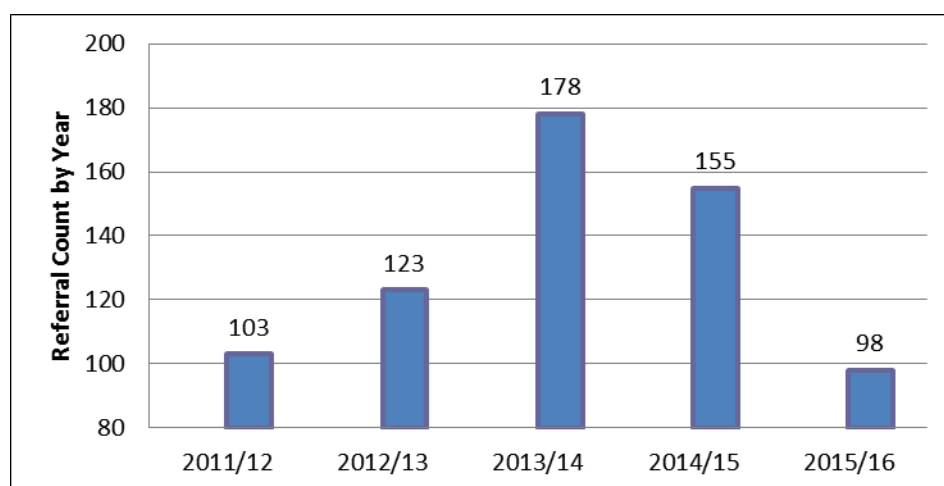
An audit process specifically for LADO cases has been designed and the first audit has been completed. This considered 12 cases concluded in the previous year (representing approximately 10% of all cases). The learning from audit has been used to develop and improve the local approach to allegations management. Specific examples include work to ensure greater consistency in the application of thresholds and processes for more frequent reviews of cases.

Allegations Management training has also been significantly updated and improved. The focus of this has been to equip professionals with the knowledge and skills to make effective safeguarding decisions in relation to allegations. Four cohorts have completed the new more interactive approach and it has been universally positively evaluated.

Work with partners to improve allegations management in relation to specific groups has been completed, an example includes working more closely with taxi licensing colleagues to identify and act upon the links between allegations and concerns in relation to the sexual exploitation of children.

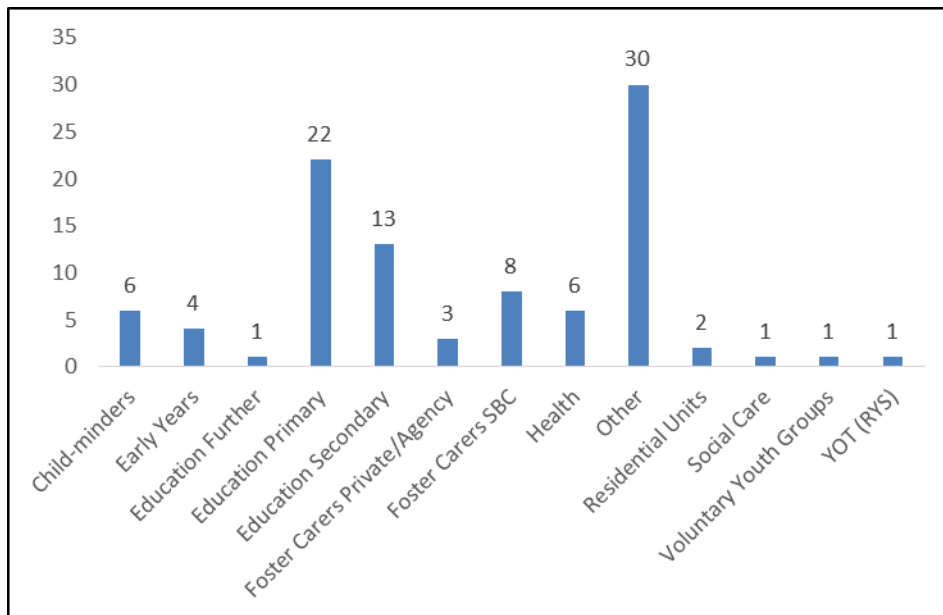
### Referral Numbers

The number of referrals has reduced in comparison with the previous 3 years; the reasons for this are thought to be related to a more robust application of LADO threshold, rather than a reduction in actual demand.



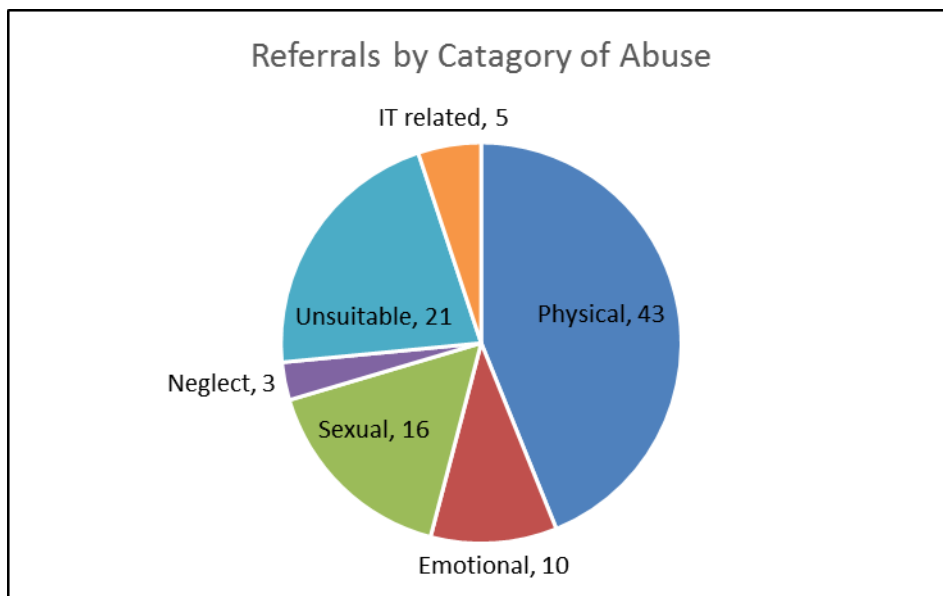
### Referrals by Agency

The pattern of referrals by the agency (of the person of concern) referred is reasonably consistent with previous years. Referrals involving education sector staff represent the single largest group (this is not surprising in light of the high numbers employed in this sector). The second largest group is 'other', this is made up of a wide range of different professional and volunteer roles (e.g. taxi drivers, leisure sector staff, sports coaches, carers etc.). Foster carers represent the third highest group and this probably relates to the challenging nature of this particular role.



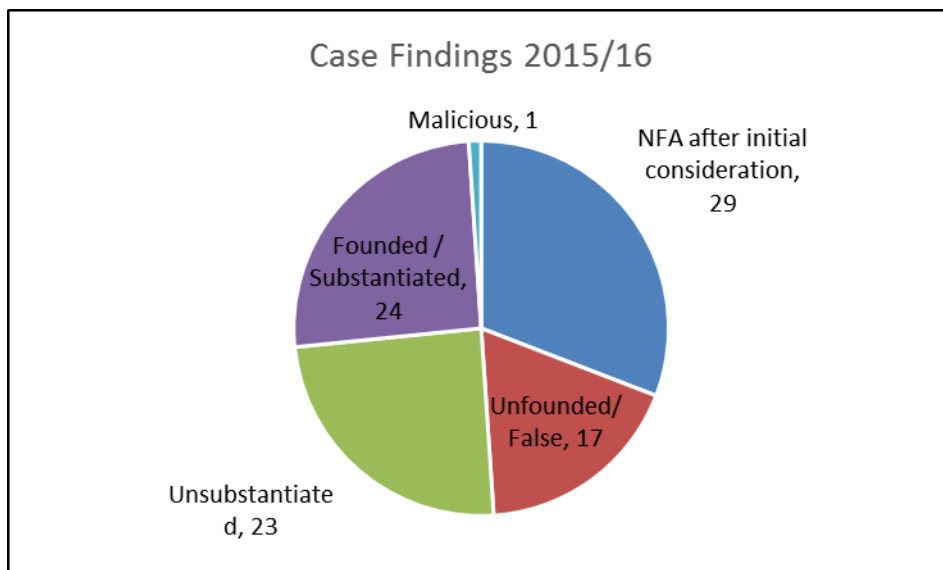
### Referrals by Type of Abuse

Again this is broadly similar to previous years with concerns about physical and sexual abuse making up the majority of LADO referrals.



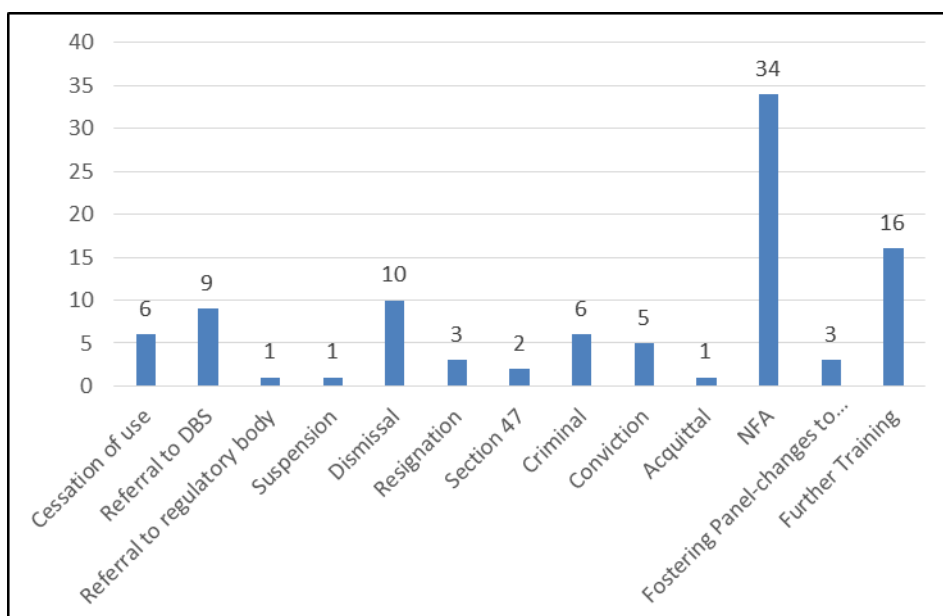
### Referral by Outcome

At the end of the LADO process professionals identify an appropriate outcome using the 'balance of probabilities' standard of proof as a test. Almost a third of referrals (31%) did not progress after initial consideration (information gathering, checks and possible consideration at an allegations management meeting) this is a reduction on the 44% figure from 2014/1. Just over a quarter of cases were founded/substantiated indicating the concerns in the original referral were correct. A further quarter was unsubstantiated, essentially neither proven nor disproven. Unsubstantiated cases often require further action or learning for individuals and organisations (e.g. changes in procedures or additional training). A fifth of cases were false or unfounded and only one case was thought to be malicious.



### Referral by Final outcome

One of the key purposes of the allegations management procedure is to ensure children are safeguarded when concerning behaviour/conduct is identified. In the most serious cases this is through criminal convictions and barring (through referral to DBS). The actions recorded in this graph identify that significant levels of activity have been taken to address concerns over the last year with 11 criminal sanctions (combination of convictions, cautions and community disposals), 19 staff leaving roles (combination of dismissals, resignations and cessation of use) and 9 referrals to the DBS. It also illustrates that organisations and individuals learn through the allegations management process (16 cases where the need for training was identified). N.B. multiple outcomes can relate to one case; the number overall is not the number of cases dealt with.



## Scrutiny and Challenge

### Learning and Improvement Framework

During 2015/16 the LSCB sought to further develop and embed its Learning and Improvement Framework. This work was overseen by three of the Board's sub groups- the Case Review Sub Group (CRG), the Quality Assurance (QA) and its Performance sub group who in accordance with the recently established requirements contained within Working Together (HMGov 2015) coordinated work in the following areas.

#### Routine analysis of data and information in respect of core safeguarding requirements

Throughout 2015/16 the Performance Sub-group continued to develop its core data set which provides both statistical and narrative information in relation to core, areas of safeguarding activities reported to members of the LSCB. In recognition of the importance of such data the sub group developed its agenda to allow increased scrutiny of emerging themes. This resulted in a number of challenges in respect of:

- Early Help - The link there may be between the numbers of children with Early Help Records and Plans and rising numbers of children in need cases.
- Deliberate Self-harm - The rise in numbers of incidents of self-harm and the quality of the joint work between AWP, CAMHS and GWH was the subject of a full report to the January 2016 meeting. CAMHS reported that young people have been involved in the development of a Deliberate Self-Harm booklet for parents and young people which will be used in emergency departments with all young people who self-harm. Further information on the findings are included in the contribution from Oxford Health CAMHS later in this report
- Adolescent Neglect – The Quality Assurance Sub Group Audit was asked to carry out an audit on neglect with a particular focus on adolescents. Following this the Neglect Framework was revised and has been incorporated into the training for frontline practitioners. Adolescent Neglect was the subject of a breakout session at a meeting of the full Board.
- Substance Misuse – in November 2015 the Performance Sub Group received a report giving headline performance information, and a guide to what substance misuse services do when working with adults who have children, and with children who are in treatment themselves. The group recommended that the report also go to the full board and that agencies be made aware of the range of services that support children and young people who misuse substances.
- School Exclusions – The data showing an increase in the number of fixed term exclusions in primary and secondary schools led to a report being requested for presentation to the LSCB at its September 2015 meeting.

Other issues which the Performance Sub-group considered were:

- The recognition of neglect within early help processes
- The vulnerability of children/young people affected by increased homelessness
- Service provision for children/young people effected by Domestic Abuse
- The processes to determine the safety of children/young people missing from Education
- The processes for ensuring the effective provision of 'return interviews' for missing children
- The increased use of fixed term exclusions by local primary and secondary schools.
- The processes required to ensure robust safeguarding responses in respect of older children/young people

The LSCB continues to refine the range and interpretation of the data it gathers and challenges partners to ensure delays in receiving information are kept to a minimum.

### **Regular reports on core safeguarding arrangements**

The LSCB received the following six monthly reports on core safeguarding arrangements and activity:

- Child Protection Conference Chairs and oversight of the Conference process
- Independent Reviewing Officers and oversight arrangements for Looked After Children.
- The Local Authority Designated Officer and Allegation Management
- The annual report on complaints regarding children's social care

These reports provide for scrutiny and analysis of the effectiveness of these key core components of the safeguarding system, both single agency and multi-agency and key challenges/recommendations for improvements. These reports provided evidence as to how well agencies are engaged and working together within the child protection process.

### **'Section 11' - scrutiny of local agencies / agencies commissioned by Swindon agencies**

The LSCB is required to monitor the effectiveness of organisations' implementation of their duties under section 11 of the Children Act 2004 to ensure that their functions, and any services they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Between May and July of 2015 Swindon LSCB and Wiltshire LSCB jointly facilitated the 2015/16 audit of each organisation's governance arrangements and their compliance with national standards for safeguarding. On completion of a self-assessment tool the two LSCBs convened a peer review meeting where authors could review each other's returns and share good practice.

Organisations were asked to complete action plans to address areas where standards are not being met with those plans monitored by the LSCB Performance Sub Group.

The section 11 audit provides evidence that Swindon agencies are compliant in discharging their functions with regard to the need to safeguard and promote the welfare of children.

The audit tool assessed compliance against the following national standards:

1. Senior management have commitment to the importance of safeguarding and promoting children's welfare
2. There is a clear statement of the agency's responsibilities towards children is available to staff
3. There is clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
4. Service development takes account of the need to safeguard and promote welfare
5. There is effective training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
6. Safer recruitment procedures are followed
7. There is effective inter-agency working to safeguard and promote the welfare of children
8. There is effective Information Sharing
9. There is effective Supervision
10. Processes to address Child Sexual Exploitation (CSE) are effective.

The audit tool used the assessment categories of 'Emerging' 'Developing' and 'Consolidating' to describe the level to which agencies are meeting the standards. The results of the assessments are set out in the table below.

Agency	Assessment of standard									
	E – Emerging; D – Developing; C - Consolidating									
	1	2	3	4	5	6	7	8	9	10
Swindon Children's Social Care	C	C	C	C	C	C	C	C	C	C
BGSW Community Reconciliation Company	C	D	C	C	C	-	-	C	C	E
Great Western Hospital	C	C	C	D	D	C	C	C	C	D
National Probation Service	C	D	C	C	C	C	D	C	C	E
Oxford Health	C	C	C	C	C	C	C	C	C	C
Avon & Wiltshire Partnership	D	C	C	D	D	D	-	C	D	D
SEQOL	D	D	D	D	D	-	-	-	-	E
Clinical Commissioning Group	C	C	C	C	C	D	-	C	C	D
Swindon Early Years	C	D	D	D	D	D	D	D	D	-
Swindon Youth Offending Team	C	C	C	C	C	C	C	C	C	D
Wiltshire Fire & Rescue	D	D	D	D	D	D	D	D	D	D
Wiltshire Police	C	C	C	C	C	C	C	C	C	D

In July 2015, and following the conclusion of the S11 audit, the LSCB also completed an audit of the safeguarding arrangements of a range of Swindon Borough Council services: Commissioning, Housing, Education Other Than At School (EOTAS), Leisure, Libraries, Licensing, Museums & Heritage, services commissioned from NSPCC, Placements, Special Educational Needs Assessment Team and the Plas Pencelli Outdoor Education Centre. A version of the multi-agency section 11 self-assessment tool was used with service leads taking part in a subsequent peer review panel meeting.

Feedback from services was that they found it a useful process, allowing them to focus on safeguarding especially at a time when services were being restructured. They considered the audit to be an effective challenge process raising a number of questions for example, who is responsible for safeguarding when services are commissioned? The LSCBs Performance Sub-group monitors the action plans arising from the audit process.

### Local Case Review Notifications

During 2015/16 the CRG sub group received a number of notifications from partner agencies where concerns had been identified in relation to the responses of professionals and the potential for learning to be identified that would improve practice. Notifications of incidents are viewed positively by the LSCB to encourage transparency and ensure that learning is identified and actions are taken to ensure improvements are made.

A Local Case Review (LCR) is initiated in circumstances where the LSCB Chair determines that criteria for a Serious Case Review (SCR) have not been met. An LCR adopts a methodology similar to that of an SCR in that an individual independent of any of the agencies involved in the case is appointed to oversee the review and write the report and by encouraging the involvement of the family in the review. The purpose is an inter-agency audit of partners' involvement to help identify learning and inform actions to improve practice and/or systems.



## Local Case Reviews

In 2015/16 there were two cases that had been initiated in 2014/15 as LCRs. One involved the sexual assault of a young person and the other involved child protection concerns around a disabled young person.

In the first case the report and the learning were disseminated to the CRG and the LSCB in December 2015 and it was considered alongside the SCR referred to later. An action plan was drawn up and the progress regularly monitored by the CRG Group.

The action plan was informed by the following key findings from the LCR:

**Recognise that it is very hard for a young person to see themselves as a victim:** 16 and 17 year olds particularly are often viewed as being more in control of their own choices and so less vulnerable to exploitation. Practitioners need to balance the young person's right to make their own decisions and assess their own risk, with the need to protect the young person from exploitation. Even if a young person is unaware or doesn't accept that they are at risk, or when risks to the young person's safety arise from their own behaviour and the decisions they make, professionals still need to intervene to prevent exploitation.

**Young people find it difficult to talk to adults about sexual issues:** The young people in this review said that they are unlikely to disclose sexual exploitation due to embarrassment about sexual experiences or fear of or loyalty to perpetrators. Young people may lack knowledge or acceptance that they are being exploited or have a lack of trust of or fear authorities. Messages from young people are that they want professionals including sexual health nurses and GPs to ask better questions, be more inquisitive particularly when prescribing contraception or treating STIs.

**Confusion about sexual activity and the issue of consent:** The case reviews found that there is confusion about adolescent sexual activity that can mean professionals struggle to distinguish between sexual abuse, sexual exploitation and/or underage sexual activity. This prevented concerns being identified and reported. In this review a 12 year old girl was seen as having sexual intercourse with number of 'boyfriends' rather than being a victim of abuse.

**Professionals in Health Services:** Professionals providing any sexual health services (including contraception) should consider the child protection implications of possible abuse or exploitation whenever they become aware of underage sexual activity. The fact that young people are engaged in what they view as consensual sexual activity does not mean that they are not being exploited.

In the second case the LCR concluded in 2016/17 and agencies are now working on implementing the recommendations. The learning and outcomes from this will be fed back in the 2016/17 Annual Report.

The Case Review Group also undertook to review Local Case Reviews undertaken by the LSCB over the previous 5 years. This process involved agencies completing and providing evidence of work undertaken and achieved and allowed the LSCB to take a view on whether the actions had been progressed or further work was required.

Where further work was insufficiently evidenced as robust, this was incorporated into the QA auditing programme for 2016/17.

## **Serious Case Reviews (SCRs)**

In 2015, the LSCB concluded one SCR. The detailed analysis and learning from this Review was presented to the LSCB and has subsequently been widely disseminated to LSCB sub groups, incorporated into the LSCB training programme and presented to groups of frontline professionals throughout 2015/16.

In 2015/16, the Case Review Group has considered two other cases in great detail with the Independent Chair subsequently agreeing two further SCR's - one in April 2015 and one in November 2015. Both of these SCR's have been overseen by the CRG and the Chair has formally recognized the impact in 2015/16 of undertaking 6 concurrent reviews (3 SCR's and 3 LCR's).

This impact has been significant for both the LSCB team and for partner organisations: Contributing information and reports to the reviews; enabling staff to attend meetings with the lead reviewers and then overseeing the process has absorbed enormous capacity.

However, there is no doubt that the learning gleaned from these processes has and will continue to be significant, providing rich evidence of how individual services and multi-agency arrangements to protect children can be improved.

## **Learning from multi-agency LSCB auditing**

The QA sub group has met on 9 occasions in 2015/16 and has reviewed its Terms of Reference and its interface with other sub groups within the Board. The work of the sub group has been guided by the LSCB Business plan and as directed by other groups.

The QA sub group has effectively undertaken a number of key multi-agency LSCB audits informed by concerns raised through performance data, previous audits/Local Case Reviews. The key audit multi-agency LSCB auditing activity for year 2015- 2016 included:

### **1. Children in Need**

The Performance sub-group identified there has been a considerable increase in the number of Children in Need cases and asked the QA group to investigate further. The audit scope included:

- What was the nature of the Early Help involvement before the child became a Child in Need?
- What is the evidence that the Common Assessment Framework (CAF) and/or Team around the Child (TAC) produced improvements in the life of the child and family?
- What was the nature of the link between Early Help and children's social care?
- Was there a connection between the issues identified in Early Help work and the subsequent referral to social care?
- What triggered the involvement by Children's Social Care?

The audit covered the impact of Early Help involvement on the outcomes for children who then became Children in Need. It also focused on non-engagement. The learning identified there were concerns about the advice given by the Family Contact Point in relation to appropriateness of referrals.

As a result, the LSCB identified Early Help as one of its priority areas of focus for 2016/17 and established a short-life working group to consider the issue further and to make recommendations regarding early help processes and the threshold guidance to the Board.

## 2. Adolescent Neglect

This significant piece of audit work was commissioned by the Performance Sub Group to be assured of the progress by the multi-agency network in relation to the Finding 1 of a Local Case Review which concluded that 'a lack of developed understanding and awareness of adolescent neglect across the multi-agency network leads to an uneven balance between 'troubled' and 'troublesome' adolescents which makes child centred practice less likely'.

- The strategic research question for the audit was agreed as: 'In open cases of young people over age 14, and where sexual exploitation, early pregnancy, anti-social behaviour, poor mental health, self-harm or poor school attendance has been a factor, is long term neglect also a contributory factor, and has this been recognised as such by professionals?'
- The purpose of this multi-agency quality audit was to support the LSCB action plan resulting from the Swindon Neglect LCR. The audit also sought to understand the extent to which the Neglect Practice Guidance is embedded across agencies and to understand and that the guidance addresses the links between adolescent neglect and wider safeguarding issues.

The learning identified:

- That the Neglect Practice Guidance was not well embedded; indeed, it highlighted a lack of understanding of the signs and symptoms of neglect in relation to adolescents.
- Chronology has different meanings and significance for different agencies.
- Importance of each agency understanding and assessing each young person in their own right, rather than taking the labelling from another professional i.e. schools to GPs.

The recommendations:

- Partner agencies to consider how to improve use of chronologies and genograms within the definitions contained in Working Together to Safeguard Children 2015 and how they can meet good practice standards.
- Professionals need to take responsibility for sharing their assessments and information with other involved professionals.
- Police and schools need to consider the cause of adolescents' behaviour, as well as addressing symptoms and always consider that neglect may be a factor.
- All professionals need to be mindful of symptoms of neglect and how they can identify them to make a robust and meaningful assessment.
- All agencies need to have a robust policy about non-attendance and information sharing protocol.

- LSCB to revisit and review the Neglect Framework.
- Further challenge by LSCB to partner agencies in relation to evidencing improved recognition and assessment of neglect and the inherent impact on adolescents.
- Participating agencies identified their own learning and recommendations which were developed into an action plan which the QA sub group monitors

The outcome of the Adolescent neglect audit:

- The QA Sub Group requested the Policy and Procedures sub group to review the Neglect Framework, with particular reference to adolescents.
- The LSCB Conference in November 2015 was titled 'Troubled or Troublesome' and the findings of this audit were incorporated in to the presentation from Research in Practice. There were over 300 practitioners from partner agencies who attended the conference.
- The sub group took time to analysis the LSCB Neglect training data. Information was circulated giving the take-up by agency of LSCB 'Working with Neglect' training for 2014 and 2015. There was good take-up by educational settings; mainly primary schools.
- The Training & Safe Workforce (T&SWF) Sub Group were asked to evaluate the impact this training has made on practice within agencies.

### 3. **Understanding the Journey of the Child: Response to Strengths and Difficulties Questionnaires (SDQ) Report.**

This audit looked at children and young people between the ages of 4 and 17 and their SDQ and the journey of a sample of looked after children who had a high SDQ in 2013/14 who are still in care. The audit sought to establish:

- Whether an intervention was put in place.
- The impact of any intervention.
- The evidence that the child's emotional wellbeing improved over time.

Audit findings and responses were:

- Little evidence recorded of intervention work.
- School and designated teachers appear to have little understanding of this process and their role in the process.
- There is a need for training which is due to start by September 2016 which will target social care, schools (incl. designated governors), CAMHs and TAMHs and commissioning personnel.
- Need for better understanding of the role of CAMHs in this process. Many children looked after do not reach the threshold for CAMHs work and sometimes the children are not always willing to engage. Extra capacity has been sourced for this team with one new post in April/May.
- Going forward, information gained from SDQs around children with high SDQs will be shared with all partner agencies where relevant and IROs will also be notified.
- Social Care Supervision will need to ensure there is a specific question around SDQs – it was recognised that more than half of the children in care will have emotional difficulties of some sort.

#### 4. Missing & Absent Evaluation-

The focus of the multi-agency audit was to clarify the consistency regarding the missing & absent young people who were reviewed by the Multi-Agency Risk Management Panel (MARP) to improve outcomes for these children.

- Recommendations for both Social Care and the Police.
- Action Plan went to MARP on the 11.12.15
- Updated Action Plan will be reviewed by the QA Sub Group meeting in February 16.
- The new Children Missing from Care Protocol has taken the findings into account.

#### 5. Learning from partner single agency audit and inspection

During the year the QA sub group worked with partners to ensure their single agency audit activities were objective and sufficiently self-critical. The subgroup worked hard to improve the reporting of audit activities and to establish the routine sharing of findings from service reviews and inspections. As a result, the sub group has gone on to develop a stronger culture of sharing critical information as well as celebrating the good practice identified.

There have been a number of single agency audits which have been completed. These include:

- **Custody Audit:** Identified through the Performance sub group, the scope was to understand better the story behind the data with regards to the number and time children and young people are held in custody across Wiltshire. The outcome was that a review of child detention times has already shown a reduction in the time that children are spending police detention and will continue to be monitored.
- **Safeguarding Children Supervision Audit (Acute)** Part of CQC Action Plan 2014-2105. To compare compliance/effectiveness against Trust Supervision at GWH policy.
- **Supervision Survey for CFCH** to get a benchmark after which it could measure the impact of the new Supervision Policy
- **Review of Child Protection Conferences (with professional & parental feedback).** To review the way in which Child Protection Conferences were being conducted and to gain feedback from professionals and service users regarding their experience of the conference model.

Outcomes include the development of the performance systems to report on parental and professional participation for Child Protection Conferences. The multi-agency report to conference was also reviewed via a task and finish group so that it mirrored the new refreshed conference model we had put in place.

- **Evaluation of Early Years' Safeguarding audit:**

The purpose was to evaluate the effectiveness of the Early Years' settings' early intervention and safeguarding policy and procedures. Information supplied by settings monitored/validated by Early Years Safeguarding Advisor as part of routine visits. The findings were positive however, very few audit documents returned from child-minders – only 20%. Of the 280 child-minders in Swindon, Ofsted rated only 5 as inadequate. This issue is being pursued in 216/17 to improve compliance.

- **Evaluation of Schools' Annual Safeguarding Audit to evaluate the effectiveness of the schools'/colleges' early intervention and safeguarding policy and procedures.**

The process involved an audit questionnaire very similar to that sent out to Early Years settings. All staff in schools circulated with questionnaire, not just the Safeguarding Leads and children/young people were also spoken to.

Areas for development include:

- Allegations – what to do if you are aware of an allegation.
- Online Safety – always a high priority with constant change.
- Child Protection Supervision-currently 71% have CP Supervision.



## Child Death Overview Panel (CDOP)

### Overview

We are fortunate that a child death is a rare event in our society, however; each death represents a tragedy for the family and the purpose of the Child Death Review process (CDR) is to identify potentially modifiable factors which may prevent deaths from occurring in similar circumstances in future.

### Achievements

The joint Wiltshire and Swindon Child Death Overview Panel (CDOP) met eight times in 2015/16 and reviewed 35 individual child death cases of which 18 were Swindon children.

Numbers of deaths notified by year 2011 to 2016 in Wiltshire and Swindon						
	2011-2012	2012-2013	2013-2014	2014-2015	2015-16	Totals
Wiltshire	36	39	32	28	17	152
Swindon	21	8	17	12	18	76

During this year we successfully launched the new CDOP quarterly newsletter (predominantly for health and social care professionals) highlighting issues and learning from cases reviewed locally

We coordinated a media campaign to raise awareness amongst parents and carers of issues relating to safe sleeping and water safety amongst others.

### Impact

Our main aim is to Influence practice through the follow up from the CDOP discussions and case reviews. We do this by communicating with respective agencies or providers regarding policies and protocols so that where possible we can reduce the likelihood of avoidable child deaths. Examples of actions taken as a result of the CDOP writing to the agency/body highlighting issues or concerns found as a result of the CDOP review include:

- Acute provider agreed to update their guidelines to include the use of oral anti-fungal agents when a premature baby is on antibiotics.
- CDOP recommended to the Home Office that a law be passed to ensure private pools are required to be fenced

### Challenges

Given that our main aim is to prevent future deaths we continue to explore how best to engage with the public in a way that will influence and change behaviours.

## Child Sexual Exploitation (CSE) and Missing Children

### Overview

The CSE and Missing children sub-group has been chaired by the Police for nearly two years providing consistency for this important area of work. Throughout this time the sub-group deputy chair has been provided by Swindon Borough Council.

There is good representation from across agencies. Representation at the group has been augmented recently, bringing Licensing and the CSE Opal Team manager into the group to provide additional impetus in relation to disruption and enforcement activity.

### Activity during 2015

- The Partnership Profile for 2014 was used to good effect by the group to help understand and develop the gaps in CSE response across agencies. Tactical information contained within the report was immediately used by Police and Local Authority to target prevention and enforcement activity at several locations around Swindon. The partner profile for 2015 has been used in the same way.
- In March 2015 the Sub-Group co-ordinated the activity of agencies for the National CSE Day of Awareness. All agencies embraced the day of awareness and increased their prevention/education activities. There was significant media interest and a number of press interviews were broadcast across the partnership which helped raise the profile of CSE in Swindon.
- Key agencies have now self-assessed their response to CSE and Missing by using a diagnostic tool. This took place in late 2015. The self-assessments and the Partnership Profile will help the group to identify the gaps in our combined approach to CSE, which will inform our 2016/17 plan.
- CSE Audit work has been commissioned, with the CSE Sub Group and the QA Sub-Group working closely to identify the most beneficial program of audit. This includes a CSE survey across the partnership to establish the level of understanding of CSE. The survey has had over 1000 responses from staff who work within a setting where safeguarding is a key part of their role. The Audit program will commence in July 2016.
- Oversight of the implementation of the co-located/integrated CSE Team (Opal Team), located within the SBC estate. Over the last 12 months the plans for the Opal team have developed at a pace and the foundations are now in place for a more effective and integrated service to support victims and target perpetrators.
- There has been significant engagement with the SCR sub-group in relation to SCR's and LCR's which have a CSE theme. Lessons learned through review are identified early and built into audit programs and action plans.

The most important current action for the Sub-Group is to refresh the CSE Strategy and Action plan. This will be developed once all self-assessments have been returned/scrutinised and aligned to the partner profile and results of the CSE survey.

### **Impact**

- Increased awareness to children and young people.
- Integrated Police/Social Care CSE team being implemented giving victims and those at risk from CSE more specialised and dedicated resources to work with and support.
- The Councils Multi-Agency Risk Panel has ensured that there is cohesive and co-ordinated partnership activity to support victims, but also to target perpetrators. 2015 has seen a shift towards identifying more offenders and targeting and disrupting them.
- There are much improved CSE flagging systems within both Police and Social Care, ensuring that both victims and offenders are recognised and recorded at the earliest stages. This is operationally beneficial, but also allows better analysis of the problem, which will help to ensure resources are targeted towards the most appropriate strategic threats. We now feel reassured that we have a stronger understanding of the scale and type of CSE taking place across Swindon.

### **Evidence**

- Self-assessments (diagnostics) conducted by agencies and scrutinised by the Sub-Group.
- Production of 2014 Partner Profile and 2015 Partner Profile.
- CSE and Missing Action plan, which shows the majority of 2014/2015 actions moving into green on the RAG status and becoming Business as Usual.
- Development and review of the MARP process (reports are submitted to the CSE/Missing sub-group).
- MARP reports are scrutinised by the CSE sub-group to ensure that CSE and Missing Children issues are being targeted effectively through this partnership forum.

### **Further action**

- CSE Audit Program to commence in July 2016
- Better understanding of the vulnerability of children with MH, autistic spectrum and ADHD required with Swindon. Current processes do not allow effective collection of data to understand if (and if there is what scale) there is a problem requiring more focus.

### **Key issues for Board**

- Commissioning of future Partner Profiles
- Overlap/connection with Dangerous Drugs Networks (drug gangs from metropolitan areas) which can often have links to CSE

## Online Safety

Over the last twelve months the Online Safety sub group has observed the age at which the typical child begins to actively engage in social networking has dropped from 11years old to 8-10. Such children are developing risky behaviours and are becoming more at risk of exposure to online sexual exploitation and other forms of abuse. This is evidenced from online pupil surveys undertaken in conjunction with Swindon schools and the direct interaction with children by members of the sub group.

The sub group has also noted an increase in the number of sexting incidents that is now occurring within this younger age group that is proving challenging for agencies and parents to deal with. Whilst the sexual exploitation teaching materials and advice for parents/young people does exist, it is clearly targeted at children in their teenager years. As a result, there is a need for appropriate preventative support and advice for these younger children. This has been recognised at the national level as reported to [UKCCIS](#).

Looking locally at this changing arena of online safeguarding, the sub group undertook an audit of staff training. The results showed a clear provision of annual training in many agencies most notably within the school's sector. The findings have enabled the sub group to put in place supplementary targeted training in addition to providing clear guidance to agencies in dealing incidents of sexting. In seeking the children's online experiences and attitudes, the annual online safety pupil survey obtained the views and trends of nearly two thousand 8-10 year old children. Some of the key findings in this year's survey have shown;

- Nearly 70% of boys stated they will not tell anyone they are being cyberbullied.
- Girls are more likely to tell a friend they are being cyberbullied compared to boys.
- 60% of boys stated their parents know nothing of what they do compared to only 40% of girls.

It is therefore evident that whilst parents provide a key role in safeguarding children online there is generally a disconnect occurring within this age group and particularly by boys.

The findings of the survey form the basis of the work for the sub group in helping agencies, parents and children to be safer online, below is some highlights of the sub group work during this year.

- Online safety lessons to nearly 2800 children and young people including targeted work within the Junior Good Citizen and Young Warden's programmes
- Training and awareness sessions to 80% of Swindon schools and colleges was attended by over 950 school staff and parents, additionally sessions have been delivered to GP's and childminders for the first time.
- The Wiltshire Police "Polite and Sexting" lessons has been delivered to just over 40% of primary and special schools and 35% of secondary schools and colleges respectively.

In looking forward, the challenge to the sub group is to identify advice and guidance for parents and agencies that will enable boys online to be more supported when dealing with cyberbullying.

Additionally, the focus of work will need to be around the raising of the awareness of sexting and the consequences of such behaviour by an ever increasingly younger age group.

To monitor and evaluate the impact of such work it is key that the sub group continues to obtain the voice of the children, enabling the monitoring of trends and challenge to agencies and parents in better safeguarding children online.

## Policy and Procedure

### Purpose

The main aim of the Sub-group is to develop, maintain and review inter-agency child protection procedures, protocols and practice guidance and to comment and advise upon whether procedures need to be reviewed as a result of practice developments arising from serious and local case reviews, new legislation, government reports, research findings and other relevant documents.

### Overview/Achievements

During the course of the year The Sub-group ratified a number of policies and guidance documents including:

- Swindon & Wiltshire Child Death Protocol
- Female Genital Mutilation
- Early Forced Marriage Guidance
- Policy for Bruising in Non-Mobile Babies
- Social Media Policy
- Additional Child Protection Procedures for Disabled Children
- Perinatal Pathway for Mental Health in Swindon (this pathway outlines the roles of all key agencies involved in the care of women during pregnancy).

In addition to this ongoing ratification and review of policies the sub-group has made good progress on the following two key of work:

At the request of the LSCB Board and following a local case review the Neglect Framework was revised so as to be more specifically inclusive of the needs of adolescents.

The Escalation policy was reviewed and in the light of comments received was revised so as to set clearer guidance to agencies in relation to timeframes for progressing concerns.

### Impact

The aim of all policies, procedures and guidance are to improve the wellbeing and outcomes for children and young people and improve safeguarding practice by professionals.

### Future challenges

The past year has seen the South West Child Protection Procedures move to a new platform managed by Tri-x. We have yet to determine the extent to which staff are finding these procedures useful and whether they are making use of the facility to receive automatic updates on new or revised guidance.

This past year there have been a number of Local and Serious Case reviews and following the completion of these reports consideration will be given to revising any current guidance or developing new guidance.

Quoracy of meetings has been a concern due to capacity of multi-agency members this has impacted on the timeliness of policy reviews. This has been raised as an item in the LSCBs Challenge Log.

For the coming year we will be implementing a formal feedback pro-forma for policy reviews to ensure that all agency members consult within their agencies and agree the policy

## Training and Safer Workforce

### Overview

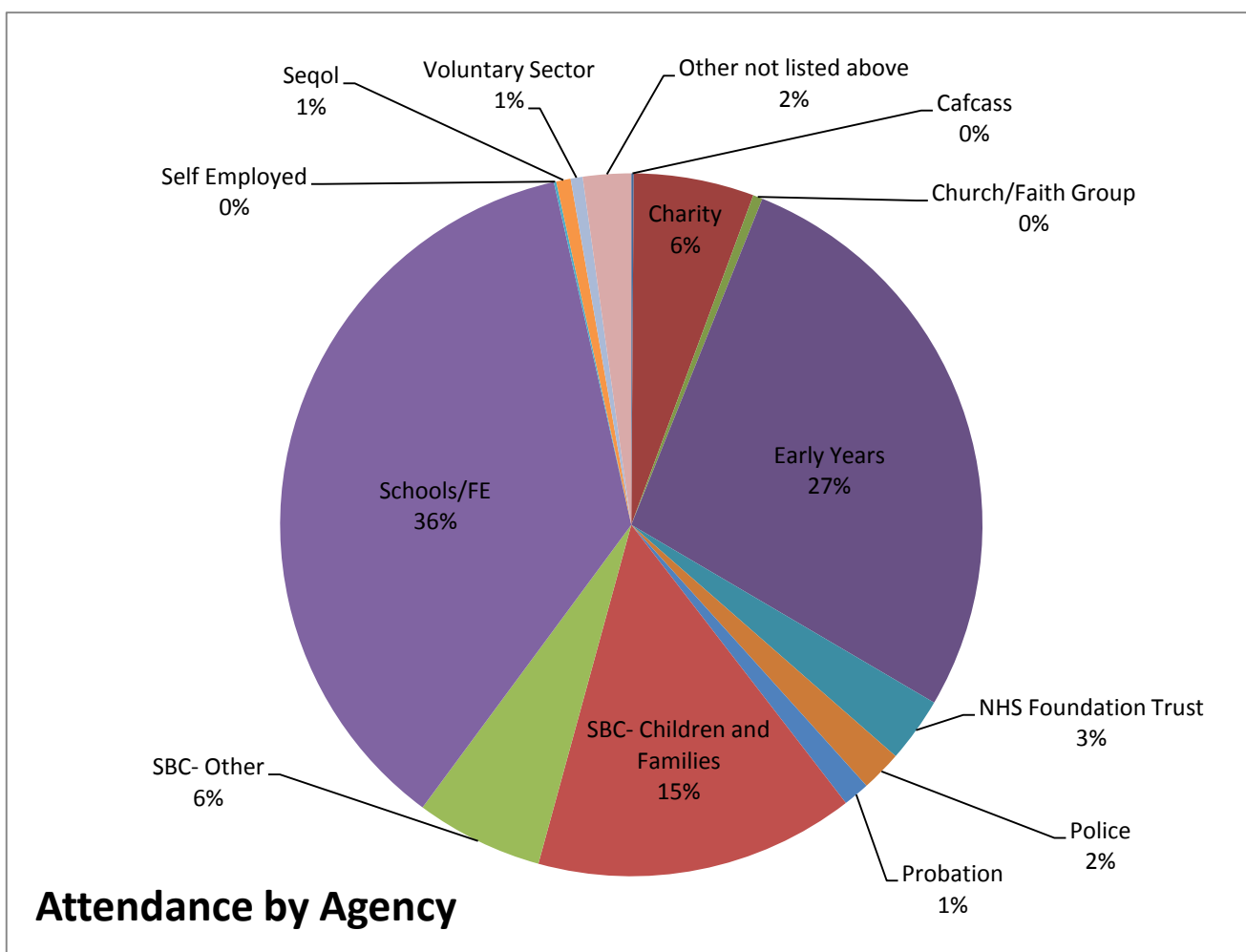
The Sub Group with refreshed membership has retitled itself the 'LSCB Training and Development Group' which more adequately reflects its focus on sourcing, facilitating and providing best quality, relevant and meaningful training and opportunities for all working with children and young people.

We continue to plan for and deliver a high quality and meaningful Annual Conference which last year (2015) had a primary focus on 'Troubled or Troublesome?' and this year, in October 2016 is entitled 'Laying the Foundations for Effective Safeguarding in Swindon'. This conference is traditionally very well attended by a diverse and wide-range of participants and 2015 was no exception.

### Achievements and Impact of Swindon LSCB Training Programme

- During 2015/16 the LSCB delivered 54 training courses.
- The 54 training courses reflect 14 safeguarding subject areas. These are all multi agency courses. Subjects include:
  - Child Sexual Exploitation
  - Safer Recruitment
  - Risky Behaviour in Adolescents
  - Parental Mental Health
  - Neglect
- Seven courses were cancelled due to low numbers. This mainly affected 'Keeping Safe Online' courses where, despite increased advertising, numbers continue to be low.
- There was a decrease in numbers attending LSCB training in 2015/16. 903 people attended LSCB training courses in 2015/16 compared to 1098 in 2014/15 a decrease of 17%.
- Figures are down across the board across all agencies and subjects, with the exception of 'SBC Other' and particularly seen in the Children, Families & Community Health figures with 117 fewer delegates than the previous year. Figures are due to be further scrutinised by the Training & Development Sub Group in September 2016.
- The increase in 'SBC Other' can be explained by the SBC S11 Audit that was completed in July 2015 and identified training needs in several teams in the organisation.
- Following the trend from previous years, the majority of training delegates are from schools and Early Years settings.
- The training pages of the LSCB website are regularly reviewed to provide guidance on training pathways and learning appropriate to staff roles and competencies. The LSCB Learning & Improvement Framework has been updated following the development of the LSCB Quality Assurance Framework.
- In 2015/16 the LSCB worked with Swindon Community Safety Partnership to support the FGM and Forced Marriage training commissioned by the CSP by advertising and administrating training applications. As a result, all courses ran at full capacity.
- Chelsea's Choice is a play performed to audiences of year 8 pupils by a theatre group. The play demonstrates how children can be groomed on line and in the real world and how they can then be exploited. A workshop which follows the performance addresses many other e-safety issues and safeguarding issues, like consent, relationships and grooming. In 2015/16 The LSCB organised, but did not fund, the programme of school visits tour of Chelsea' Choice drama in 2016. The play was offered to all secondary schools in Swindon with eight choosing

to host the production. An evaluation report of the tour showed that the vast majority of pupils surveyed said that their knowledge of CSE and grooming was greatly enhanced. Further feedback was provided to the LSCB CSE Sub Group for consideration.



### The Impact of the LSCB Annual Conference

- The theme of the annual conference was 'Troubled or Troublesome'
- Keynote speakers were Dr Camille Warrington talking about working with young people affected by Child Sexual Exploitation, and Alyas Karmani who spoke about trauma and violence in the context of CSE and radicalisation
- The conference was attended by over 300 delegates

Delegates were asked to complete an evaluation questionnaire at the end of the event and evaluations and comments were wholly positive.





### **Future challenges**

The ongoing challenge for the subgroup is to ensure that the training 'offer' remains relevant, pertinent and meets the needs of practitioners and other relevant partners. The Board will want to understand better the reasons for falling numbers at LSCB training and ensure that this is not adversely impacting on multi-agency safeguarding knowledge and practice.

Given that this year the LSCB has commissioned a number of reviews of cases the sub-group will want to ensure that the learning and key messages arising are understood, extrapolated and incorporated into the existing training offer or, where required, to commission bespoke provision of such training. To bring together all of the learning and ensure relevant messages and practice is disseminated to all.

Ensuring a timetable for group members to observe and quality assure the delivery of training undertaking for, by, and on behalf of the LSCB to ensure it is of sufficient quality, is up to date, and being delivered effectively. To redress any issues detected / reported by exception. To ensure, where possible, duplication is avoided should there be any detected (e.g. with the QA and Performance sub group).

## Lay Members

The Lay Member role continues to develop with the four members, between them, sitting on most of the sub and working groups. For the three new lay members, 2015-16 was their first full year of serving on the Local Safeguarding Children Board (LSCB) and as their experience increased so did their effectiveness in representing the public by challenging, questioning, and offering alternative perspectives on the work undertaken by the Board.

Much time has been spent in trying to ensure the published LSCB minutes are more accessible to the local community and member agencies' staff by reducing the amount of unexplained abbreviations and the greater use of plain language. This effort continues in the sub and working groups, particularly the work of the Policies and Procedures sub group.

Contact with the community continues to improve steadily, although more engagement work across the spectrum of the Board's activities still needs to be done and is included in the LSCB plan for 2016-17. Having said that some 2,745 young people and 948 adults (including Childminders, Doctors, Parents, Teaching and Support staff), have attended On-line Safety sub group sessions across the Borough, to name but one area of the Boards' outreach work.

Contact with other LSCB Lay Members is still being sought with a view to increase the effectiveness of the lay membership by sharing good practice and developing our involvement with both the Board and local communities.

Robin Stannard (Lay Member)

## LSCB Governance

The Children Act 2004 places a duty on all relevant authorities to make arrangements to safeguard and promote the welfare of children. Swindon Local Safeguarding Children Board has a statutory responsibility to co-ordinate and ensures the effectiveness of what is done by each agency/organisation on the Board for the purposes of safeguarding and promoting the welfare of children in the Borough. The LSCB is not accountable for operational work but holds partner agencies to account on the effectiveness of their safeguarding services for Swindon's children.

Swindon LSCB is composed of senior representatives nominated by each of its member agencies and professional groups.

Statutory & Other Partners, of whom 100% attendance at meetings is expected by the representative or nominated substitute:

- Swindon Borough Council, Director Children Services
- Swindon Borough Council (Service Director/ Head of Children, Families & Community Health; Head of Commissioning Children & Adults; Housing, Libraries & Leisure; Economy & Attainment)
- Wiltshire Police
- National Probation Service
- Bristol, Gloucestershire, Swindon & Wiltshire Community Rehabilitation Company
- NHS England
- Swindon Clinical Commissioning Group
- Public Health
- Designated Doctor, Child Protection
- Designated Nurse, Child Protection
- Great Western Hospitals NHS Foundation Trust
- Avon & Wiltshire Mental Health Partnership NHS Trust
- Oxford Health NHS Foundation Trust
- South West Ambulance Service NHS Foundation Trust
- CAFCASS
- Swindon Early Years
- NSPCC
- Swindon Youth Offending Team
- Wiltshire Fire & Rescue Service
- Adult Services
- SEQOL
- Swindon Healthwatch

Professional Representatives, who provide insights from and communication with their professional bodies but do not represent a single agency or organisation:

- Swindon Primary Schools
- Swindon Secondary Schools
- Swindon Colleges
- Swindon Special Schools
- Schools' Safeguarding Adviser
- GP Services
- Voluntary Sector
- Domestic Violence Representative
- Chair, Swindon Children's Trust Board
- the Chair of any LSCB sub-group not represented above

Partner agency representatives are of sufficient seniority to have control over or access to their agency's resources. They are given delegated authority to make decisions to an agreed level on behalf of their agency and have access to those responsible for making the decisions for which they do not have delegated authority.

Each representative on Swindon LSCB is responsible for disseminating information between the LSCB and their agency/professional body and for identifying any necessary actions.

The local authority's Cabinet Member for Children Services is a 'participating observer' of the LSCB, attending meetings and engaging in discussion but not being part of the decision making process. This enables the Cabinet Member to challenge, when necessary, from a well-informed position.

There are four Lay Members who in a voluntary capacity attend the Board meetings and serve on sub-groups. The remit of the Lay Members is to:

- Support stronger public engagement in local safety issues
- Contribute to an improved understanding of the LSCB's child protection work in the wider community
- Challenge the LSCB on the accessibility by the public and children and young people of its plans and procedures
- Help to make links between the LSCB and community groups

Alex Walters was appointed Independent Chair of the Local Safeguarding Children Board in July 2015, taking over from Mike Howard who had served as Chair since 2009. Alex is an active member of the Association of Independent LSCB Chairs and has used the skills, knowledge and experience she has gained as the chair of other LSCBs and before that from her work within Children's Services and Regional Government Offices to provide a well-informed level of support and challenge to the partnership.

A protocol has been agreed that sets out the relationships between the LSCB, the Local Safeguarding Adults Board (LSAB) and the Swindon Health & Wellbeing Board and these three boards work well together to ensure that their work is joined up and complementary.

Swindon LSCB is committed to safeguarding and promoting the welfare of children and young people and expects all staff and volunteers to share the same commitment.

Swindon LSCB believes that:

- The welfare and safety of the child is paramount
- We are stronger in safeguarding children if we all work together. This includes statutory and voluntary agencies and the wider communities
- We should support families in bringing up their children safely, engaging with them in the wider agenda for safeguarding
- We should provide an equitable, quality service to all children and their families
- Services should be provided which are appropriate to race, religion, culture, language, gender, sexual orientation and disability
- We need to be accountable for our actions, open to challenge, and to learn from practice in order to achieve continuous improvement
- Procedures and processes should be open and transparent

These principles should underpin everyone's approach to safeguarding children and promoting their welfare, regardless of the extent of their involvement.

Swindon LSCB will further ensure that:

- Personal information is held confidentially and only by those who need to know
- Safeguarding children is viewed in the wider context of their needs and rights

To enable it to fulfil its responsibilities, Swindon LSCB maintains the following Sub Groups:

- E-Safety (Now known as On-line Safety)
- Performance
- Policies & Procedures (links with the South West Policies & Procedures Group)
- Quality Assurance
- Case Review
- Child Sexual Exploitation & Missing
- Training & Safe Workforce

Each of these Sub Groups has defined its membership and terms of reference and works to an annual action plan developed with reference to the LSCB Strategic Business Plan.

There is a joint Swindon and Wiltshire LSCB Child Death Overview Panel.

A Chairs Group, consisting of the Chairs of all LSCB Sub Groups and working groups, as well as the Head of Children, Young People & Community Health, the Designated Doctor and the Chair of the Domestic Abuse Steering Group, and chaired by the LSCB Chair was established in February 2013 to facilitate communication between the various Sub Group chairs and to respond to their wish for greater direction from the Board.

Regular reports are presented to the Board for scrutiny relating to:

- Advocacy
- Allegations Management
- Awareness & Engagement
- Child Death Overview Panel
- Child Sexual Exploitation & Missing Children
- Domestic Abuse
- E-Safety
- Licensing & Gambling
- Looked After Children
- Performance
- Policies & Procedures
- Private Fostering
- Quality Assurance
- Safeguarding Disabled Children
- Safeguarding in schools
- Section 11 audit
- Serious Case Reviews
- Training & Safe Workforce

LSCB Board meetings continue to include interactive breakout sessions, to allow all Board members to participate in discussions and provide in depth challenge to the local authority and its partners on the effectiveness of the help and protection offered to children, young people and families locally. The LSCB held its business planning workshop/development session in April 2016, when members agreed the LSCB Strategic Business Plan for 2016/19. This three-year plan includes seven core functions for the Board and four key priorities which are the focus of work during 2016/17.

<b>LSCB BUDGET 2015/2016</b>	<b>Budget</b>	<b>Outturn Position</b>	<b>Variance</b>
<b>Expenditure</b>			
<b>Employment Costs</b>			
LSCB Posts	102,200.00	86,227.14	- 15,972.86
Independent Chair	16,500.00	18,964.40	2,464.40
	<b>118,700.00</b>	<b>105,191.54</b>	- <b>13,508.46</b>
<b>Multi-Agency Training</b>			
Training Programme	35,500.00	28,443.10	- 7,056.90
Events & Conferences	8,500.00	4,138.07	- 4,361.93
	<b>44,000.00</b>	<b>32,581.17</b>	- <b>11,418.83</b>
<b>LSCB Projects &amp; Statutory Agenda</b>			
Advocacy - Voice	28,000.00	28,000.00	-
Advocacy - SAM	21,500.00	21,500.00	-
CSE & Missing	15,850.00	4,070.00	- 11,780.00
Serious Case Review/Case Review	25,000.00	33,095.62	8,095.62
Procedures & Awareness	2,500.00	4,766.03	2,266.03
	<b>92,850.00</b>	<b>91,431.65</b>	- <b>1,418.35</b>
<b>Business Support</b>			
Staff & Member Development	1,500.00	514.00	- 986.00
General Supplies	300.00	76.97	- 223.03
Design & Printing	100.00	0.03	- 99.97
Meeting Venues	600.00	770.38	170.38
	<b>2,500.00</b>	<b>1,361.38</b>	- <b>1,138.62</b>
<b>Total Expenditure</b>	<b>258,050.00</b>	<b>230,565.74</b>	- <b>27,484.26</b>
<b>Funding</b>			
<b>Annual Contributions</b>			
CCG	- 44,150.00	- 44,150.00	-
GWH	- 17,699.00	- 17,699.00	-
Police	- 12,448.00	- 12,448.00	-
Probation - CRC	- 2,236.50	- 2,236.50	-
Probation - NPS	- 2,236.50	- 4,100.25	- 1,863.75
CAFCASS	- 550.00	- 550.00	-
	<b>- 79,320.00</b>	<b>- 81,183.75</b>	- <b>1,863.75</b>
<b>Local Authority Budget Allocation</b>			
Local Authority	- 94,600.00	- 91,100.00	3,500.00
Swindon Early Years Training	- 4,000.00	- 4,000.00	-
	<b>- 98,600.00</b>	<b>- 95,100.00</b>	<b>3,500.00</b>
<b>Training Income</b>			
Course Income	- 27,500.00	- 37,924.00	- 10,424.00
Events & Conferences	- 8,500.00	- 10,585.00	- 2,085.00
	<b>- 36,000.00</b>	<b>- 48,509.00</b>	- <b>12,509.00</b>
<b>Total Funding</b>	<b>- 213,920.00</b>	<b>- 224,792.75</b>	- <b>10,872.75</b>
<b>Total Balance</b>	<b>44,130.00</b>	<b>5,772.99</b>	- <b>38,357.01</b>
Reserves	82,307.00	82,307.00	
Reserves required to support in year budget	- 44,130.00	- 5,772.66	
<b>Remaining Reserves</b>	<b>38,177.00</b>	<b>76,534.34</b>	

## Partner Agency Reports

The following section contains reports from a number of partner organisations and services about their safeguarding activity and their contribution to the work of the Board over the course of the year.

### Swindon Borough Council

#### Introduction

Over the last 12 months, the Council has worked closely with partners in Swindon to support the delivery of the four strategic priorities set by the LSCB for 2015/16:

- Effective responses to specific safeguarding concerns
- Effective Early Intervention and Safe
- Communication and Engagement
- Performance management

Safeguarding Children, promotes the Council Vision, specifically Priority Four, “Help people to help themselves, while always protecting our most vulnerable children and adults”. Safeguarding is also an integral element of the Swindon Health and Wellbeing Strategy.

Swindon Borough Council plays a pivotal role in helping to keep children and young people safer from harm by empowering and supporting families to make changes, as early as possible, to create safety and stability for their children both at home and in the community. The Council is responsible for providing a broad range of universal, targeted and specialist provision which aim to promote healthy lifestyles, build capabilities and strengthen families. These include:

- Early Help, Youth Offending, Young Person Substance Misuse, Targeted Mental Health, Education Welfare, Educational Psychology, Youth Engagement, Services for Disabled Children
- Children’s Social Care
- Community Health Services including Health Visitors, School Nurses and Family Nurse Partnership, Paediatric Therapy Services, Speech and Language and Portage
- Education Services including, Provision for Early Years, LA Maintained Schools, Provision for children with Special Educational Needs and Disabilities

In this report we have highlighted some key achievements over the last 12 months linked to the LSCB priorities.



## Key Achievements and Impact

**Priority One:** To develop strategies and comprehensive approaches to specific safeguarding issues that keep children and young people safe and promote effective intervention with those who are at risk and consolidation of strategies and approaches to Child Sexual Exploitation (CSE) that keeps children and young people safe

**Priority Two:** To ensure the LSCB can demonstrate that children and young people in Swindon receive effective early intervention that meets a range of needs in different communities

Our key achievements in these areas are relevant to both priorities due to the synergies in the priority outcomes:

- Establishing Swindon Multi Agency Safeguarding Hub (MASH) to improve the front door response.
- Implementing a new framework to improve the effectiveness and rigour of Child Protection Conferences based on the principles of 'The Signs of Safety'. This has secured a better focus on danger and harm and the child's 'lived experience'. Initial feedback from professionals and parents is positive.
- Successfully filling our children's social care manager posts with permanent staff.
- Recruiting a dedicated social worker within the Fostering & Adoption Team which has improved practice in safeguarding and promoting the welfare and needs of privately fostered children.
- Successfully commissioning a new Domestic Abuse Strategy with partners that Cabinet have agreed, and introducing more robust governance arrangements to oversee strategy implementation. Recent changes to domestic abuse pathways have supported more effective and timely information sharing between partners.
- Early Help and Social Care practitioners having an active role in the Multi Agency Risk Assessment Conferences (MARAC) to ensure the voice of the child and their 'lived experience' are considered in a multi-agency way. The Professional Lead for Health Visiting reviewed the health input into MARAC and made improvements to facilitate more robust assessments and communication from health colleagues. Governance and QA arrangements for MARAC have been improved.
- Improving the effectiveness of our Multi Agency Resources Panel (MARP) by: shifting the panel's focus to the pursuit and disruption of perpetrators as well as child protection; changing the chair's role to QA and challenge; and establishing a QA sub-group of MARP to evaluate the impact and effectiveness of the panel.
- The Council's Child Sexual Exploitation (CSE) Working Group successfully progressing key deliverables of the CSE Strategy resulting in stronger corporate oversight and management of CSE across the Council, greater community engagement, and better identification and casework management by Council staff and schools. We appointed a CSE and Missing Manager to co-ordinate and oversee this area of the business and we have updated our Missing Children's protocol and Vulnerability Checklist.

- Council service areas contributing to The Partnership Profile for CSE which has improved our understanding of those people who are at most risk in Swindon and enabled resources to be targeted more effectively.
- Working with partners to secure funding for the Opal Team to provide a more co-ordinated response to CSE.
- Children's Social Care joining the Sex Workers Strategic Board and Forum which has improved multi-agency information sharing and risk planning to safeguard those children whose primary carer come to the attention of the forum.
- Contributing to a revision of the LSCBs Neglect Framework and Guidance to incorporate the needs of adolescents and offering School Nurse health assessments to all children and young people who are subject to a Child Protection Plan.
- Schools and colleges updating their safeguarding procedures in line with statutory guidance and no schools being identified by Ofsted as having unsatisfactory safeguarding procedures.

**Priority Three:** To communicate effectively with children and young people; their families; the community (including different sections of the Community); and staff at all levels from partner agencies

Our key achievements for this priority include:

- Providing safeguarding training and briefings on CSE, FGM, Forced Marriage, E-safety, and Prevent Duty (Radicalisation) for Council Workforce (including schools, colleges and some Trustees and Governors)
- Issuing letters to every taxi driver, bus driver, hotel and licence premises in Swindon to raise awareness and understanding of CSE.
- Launching a dedicated CSE webpage: [Say Something Swindon](#). and organising local activities for national CSE awareness day
- Issuing E-safety booklets to parents and schools.

**Priority Four:** To develop and maintain a performance management framework that promotes different ways of knowing and learning about the effectiveness of early intervention and safeguarding children and young people in Swindon.

Our key achievements for this priority include

- Embedding our Quality Assurance (QA) Framework and audit programme for Children, Families and Community Health which focuses on quality and evidence of impact.
- Continuing to develop a robust performance management framework for children's services which provides relevant and timely intelligence to inform policy, practice and decision making.

- Introducing a set of 'Obsession' Key Performance Indicators for closer scrutiny to support rapid improvement.
- Establishing a Quarterly QA Performance Board for Children's Social Care and Early Help which provides challenge and critic to audit work and oversees the implementation of the QA action plan.

### **Future Challenges**

Children's Social Care continues to face significant pressure from increased demand. Compared to last year, performance demonstrates a visible increase in front door activity, children subject to child protection plans and children in care. A number of children and families are experiencing repeat episodes of social care. There are still some practice concerns around Early Help and thresholds in relation to step up/down from Children In Need (CIN) and from CIN to Child Protection. Further work is underway to improve both the understanding and application of safeguarding thresholds.

Domestic abuse continues to be a complex and challenging priority and the reporting of domestic abuse is increasing. Work is required to improve the effectiveness of Multi Agency Risk Assessment Conferences (MARACs) to reduce the number of repeat referrals due to repeat incidents.

We need to ensure our recent success in recruitment and workforce stability is sustained so we can continue to be less reliant on agency and less experienced staff.

Better joint working between adult and children's services to safeguard children. Adult service agencies need to be encouraged to 'think family' and consider the impact of adult vulnerabilities on children living with the adult. Adult social care assessments and plans need to include an assessment of risk to any vulnerable child/children living with the adult. Children's workforce need a better understanding of adult services and thresholds.

For Adult Services, Housing, Children's Services, Commissioning and the Disabled Children's Team to work together more effectively to further embed our Transition Protocol and Pathway to support young people with a disability prepare for adulthood.

### **Schools & Colleges Safeguarding Adviser for Education (SAE)**

The Safeguarding Adviser for Education works closely with schools and colleges to support them in meeting their safeguarding responsibilities. By providing a link between Governing Bodies, Head teachers & Designated Safeguarding Leads and the Local Authority and the LSCB the SAE has been able to progress the following areas of work:

#### **Schools Safeguarding Policies and Procedures**

96% schools and colleges reported that they had reviewed and updated their policy and procedures in line with the updated statutory guidance 'Keeping children safe in education'. A recent review of Keeping Children Safe and subsequent draft publication (March 2016) will require schools and colleges to once again review their procedures and ensure that they are meeting statutory requirements.

All schools and colleges report that they are up to date and clear about the requirements which exist to safeguard children. Self- evaluation is quality assured by the SAE during monitoring visits. 17 out of 18 schools visited during 2015/16 had their self- evaluation judgements validated as accurate by the SAE.

Staff and volunteers are clear about the procedures to follow if they are worried about a child or have concerns about a member of staff from a safeguarding perspective. This is evidenced from responses from staff questionnaires which are completed as part of a monitoring visit, across all schools.

Termly briefings, delivered by the SAE, and attended by approximately 80% of Swindon schools, have ensured that education establishments are kept up to date with changes to statutory guidance.

### **Child Sexual Exploitation**

In 2015, every secondary school (including the pupil referral unit) in Swindon, took up the offer of hosting performances of 'Chelsea's Choice'.

1,500 Year 8 pupils watched the production. There were 3 additional performances, at Swindon College, a session for 150 workers and volunteers, and a session for parents held at a children's centre.

During the academic year there has been work on-going in schools to raise awareness of CSE. 56% schools report that whole staff training has been completed, with the remaining 44% reporting that whilst formal training has not been completed there has been an awareness raising opportunity to highlight the indicators and those at greatest risk of CSE. In February 2016 a well-attended CSE training session was delivered to school governors and trustees.

The staging of Chelsea's Choice has helped to raise awareness of the risks of CSE amongst pupils (55% of Year 8 pupils report that they have heard about CSE – SBC Feeling Safe Survey 2015). School staff have an increased awareness of the range of resources that available for use in schools.

Educating pupils about the risks of CSE continues to be a challenge for schools and colleges, as part of the wider Personal, Social and Health Education 'offer'. (46% of Year 8 pupils report that what they have been taught about healthy relationships is helpful – 'SBC Feeling Safe Survey 2015') Learning from recent case reviews of CSE highlights the issues around talking about sex and healthy relationships and the barriers which can exist when educating pupils.

### **Female Genital Mutilation**

During the summer term 2015, health professionals delivered a session at the safeguarding briefings about FGM and the indicators which could suggest that a child is at risk or has had FGM performed on them. 80% of schools and colleges attended these sessions.

The SAE notes that schools are certainly much more aware of FGM and there is evidence from conversations with schools that DSLs are considering FGM as a possible risk much more than previously. Two cases where children might be at risk of FGM were reported directly after the FGM sessions.

## Radicalisation

During the autumn term 2016, sessions were run as part of the safeguarding briefings to equip DSLs and Head teachers with a basic understanding of the Prevent Duty (June 2015) and the role education must play in identifying children and families who may be at risk of being radicalised. The SAE recommended that online training (referenced within the DFE Prevent duty guidance) should be completed. In addition, Head teachers attended a Prevent session, organised by the Director of Education. This was well attended.

54% of schools reported in this year's safeguarding audit that they have subsequently completed training with staff about the Prevent Duty. Staff are aware of the signs and indicators that may suggest that a pupil is being radicalised and are clear about the procedures to follow.

### **Prevent Awareness in New College, Swindon**

"In the Spring of 2016, our new full time Personal Tutors commenced a programme of prevent awareness raising using the 'Zak' resources produced by Kent University and Kent Police.

"Zak" is a social media based activity to raise and spread awareness of the Prevent agenda. It involves students reviewing various fictional social media pages related to a young man, Zak, who is leaving home to go to university. The students have to 'RAG' rate each message on the social media pages of Zak – Red for definitely worrying, Amber for slightly concerning and Green for no problem. They could then compare their ratings with those of the experts who had constructed the case study and discuss differences of opinion. It definitely kept students engaged and it was interesting to hear their perspectives. The exercise has 2 different concluding video clips which involve Zak in contrasting outcomes.

Tutors did the 45 minute activity as an individual, paired or group exercise according to the IT resources available for their sessions and were able to compare the pros and cons of each approach. The feedback from our students was positive, particularly in relation to the scenario being framed around social media and they were all able to reflect on the general dangers of online grooming related to sexual as well as radical extremist motivations.

We have been able to share our experience of using this resource with school and college colleagues from Swindon via the Prevent Education group formed this year to report to the Strategic Contest group."

Duncan Webster  
Head of Student Services & Safeguarding

Further information on this resource: <https://www.kent.ac.uk/spsr/ccp/game/zakindex.html>

## Early Year's Safeguarding Adviser (EYSA)

The Early Year's Safeguarding Adviser manages and supports the early year's sector to ensure robust safeguarding policy and procedures are in place across the service. The post is managed by the Quality and Reviewing Team Service Manager and works alongside the School's Safeguarding Adviser. The Early Year's (EY) sector includes nurseries, pre-schools, children's centres and child-minders.

### Achievements

- Annual Early Years (EY) Safeguarding Audit

An annual safeguarding audit was distributed to all Early Years (EY) providers.

Audits were returned by 95% of group settings and 20% of child-minders.

- Monitoring Visits

Thirty Early Years settings received a monitoring and support visit by the EYSA between May 2015 and May 2016

- Briefing Sessions

Termly briefing sessions, hosted by the EYSA, have kept providers up to date with local and national safeguarding news. 79% of settings have attended these.

- Newsletters

- All EY Providers and child-minders have received a termly safeguarding newsletter.

### Actions and Impact

#### Review of safeguarding training for child-minders:

The LSCB has historically recommended that child-minders attend Level 2 safeguarding training and that this should be refreshed every 3 years. A review of child protection training identified that there were areas covered in Level 3 training, not covered in Level 2, which were relevant to child-minders in their role as Designated Safeguarding Lead. The Training and Safer Workforce sub-group made the decision in February 2016, that a bespoke Level 2 plus training would be developed for child-minders. Level 2 plus training will include the areas from Level 3 training which have been identified as gaps in current Level 2 training.

#### Impact:

Level 2 Plus training for child-minders will be available from June 2016. All child-minders will have the relevant knowledge and skills to undertake their duties as Designated Safeguarding Leads in their settings.

#### Improving communication links between EY settings and Health Visitors

With the closure of Swindon Children's Centre, it has become even more important for EY settings to develop good communication links with Health Visitors. Health Visitors from the Central North Team met with Early Years managers at the Summer 2015 EY Briefing session. The result was an agreement about how communication links could be improved. An action plan was presented to the Health Visitors lead professional and this has been agreed that the action plan would be shared with all Health Visitor teams for rolling out. The Health Visitors lead professional is attending the EY Summer 2016 Briefing session to provide feedback to EY managers.

#### Impact:

Good communication links between Health Visitors and EY settings will lead to more effective sharing of information and will result in the effective identification and assessment of needs when there are emerging problems.

### **Online Safety**

Online safety is currently a focus for improvement in settings. An additional section was added to the annual safeguarding audit evaluating the safety of staff and children when using the internet. 60% of settings identified actions in relation to online safety. As a result, the Children's Services Manager for ICT presented an "Online Safety" update session at the Spring 2016 Safeguarding Briefing session (88% of settings attended). Settings have been encouraged to complete the SWGFL online compass which is a self-evaluation tool to support settings with online safety (about 50% of settings have completed this) The need for further EY training has been identified and single agency, online safety training, will be offered to Early Years Providers.

#### **Impact:**

Early Years (EY) professionals will have robust "Online Safety" policies and procedures in place to ensure all staff and children in EY settings are kept safe when using the internet.

### **PREVENT Duty training and awareness**

In June 2015 the Prevent Duty came into force for childcare providers. In order to make settings aware of this duty information was published in the EY summer term 2015 safeguarding newsletter. In addition, Providers have been signposted to "Channel" training, the Swindon Safeguarding Policy template for Early Years was updated to include the PREVENT duty and Avon and Somerset police delivered PREVENT training (January 2016) which 50% of settings attended.

#### **Impact:**

EY professionals will be aware of their responsibilities in relation to the Prevent Duty.

### **Refresh of CP conferences**

Early Years professionals have been kept informed of changes in relation to the refresh of CP conferences. In the Autumn Term 2015 Safeguarding Briefing the Service Manager for the Quality Assurance and Review Service made a presentation on writing good quality reports for child protection conferences (attended by 69% of settings). This was followed up in the Spring Term 2016 by the Team manager for the Quality Assurance and Review Service who informed Early Years managers of the changes to the structure of conferences (attended by 88% of settings). This information was repeated for all Early Years Providers in the March 2016 Safeguarding newsletter.

#### **Impact:**

EY professionals will provide an informative written report for conference which has been shared with parents. Professionals will be aware of the revised structure of conferences and will make a valuable contribution when invited to attend.

### **Future challenges**

- To get a higher percentage of child-minders to complete the annual safeguarding audit so that we have a better picture of the quality of safeguarding practice amongst child-minders (currently only 20% responded).
- To ensure that all EY providers receive a high level of safeguarding support in light of the current review of the Early Years Safeguarding support service provided by Swindon Borough Council.
- With the closure of Children's Centres in Swindon ensure that EY Providers, particularly child-minders, are able to access appropriate support for families.



## Child Protection and Disabled Children

### Achievements

There has been an increase in the number of disabled children and young people with a disability in need of protection being assessed within the Disabled Children's Social Care Team [DCT]. The Team is based at the Salt Way Centre, working alongside other professional groups who have a specific focus on providing a service to children and young people with a disability or additional needs and their families.

This team of staff have: -

- Specialist knowledge about disabled children's needs and circumstances;
- Skills in communicating with disabled children;
- Knowledge of and established relationships with other agencies working with disabled children;
- Specialist skills in recognising the vulnerability of disabled children to abuse and appropriate response to allegations.

In supporting the above, the Swindon LSCB Local Case Review 'Child N' found that only when the case of a young person with a learning disability was transferred to a specialist service [DCT] was appropriate action taken to ensure the young person's safety; the previous Social Work practitioners failed to recognise and address the added vulnerability of a child or young person with a disability who is at risk.

New criteria for the provision of a service from the DCT has been written and approved by the Council. The new criteria ensure that some more "hidden" disabilities are recognised i.e. ASD, ADHD and Asperger Syndrome. The young people with this type of disability can present with the most complex needs and slip through services.

The DCT take all referrals including those related to child protection at the point of referral from Family Contact Point/Multi Agency Safeguarding Hub. This is to make sure that the disability issues are addressed from the start. Traditionally, these would have been assessed in the Assessment and Child Protection Team and then transferred to DCT. The DCT receives approximately 3-4 referrals per week for assessment.

### Impact

Less child protection work with disabled children and young people is undertaken in the other Social Work Teams. This has meant that in the past 18 months the DCT has taken 40 cases of disabled children and young people from the non –specialist Social Care Teams.

Currently, approximately 70% of all referrals to DCT have safeguarding/child protection concerns.

There has been a change in the way all cases are managed or receive a service within the DCT so that the qualified Social Workers have the capacity to undertake the increased volume of work related to child protection.

### Overview

Children and young people with a disability in need of safeguarding and child protection receive a service from social care professionals with the skills, knowledge, experience and expertise to meet their needs.

All the staff within the service has received training above and additional to the Child Protection Level 3 training course.

### **Future Challenges**

Disabled children and young people remain under represented in the overall number of children subject to child protection plans – an audit will be undertaken to establish that we have not inaccurately defined or identified a child or young person who is disabled and on a child protection plan.

There are a higher number of young men being referred to the DCT presenting a risk of sexual harm to others – a specialist piece of work will be undertaken to understand how best to meet the needs of these young men.

To implement the actions from the findings of the Swindon Local Case Review on 'Child N'. This will include better joint working between adult and children's services to safeguard and protect children and young adults.

## Wiltshire Police

Vulnerability and the protection and safeguarding of children is a priority for Wiltshire Police.

Protecting the most vulnerable in society forms part of the Police and Crime Commissioners plan and Wiltshire Police has a number of delivery plans which drive forward improvements in this area.

Vulnerability is a cross cutting theme in the Wiltshire Police control strategy, with specific priority areas in Child Sexual Abuse Including CSE), Missing and Absent and Domestic Abuse. This ensures that the focus of Wiltshire Police targets all aspects of vulnerability, but in particular those areas that affect children.

Over the last 18 months there has been significant investment in the Public Protection Department. This has been in response to an increased demand in relation to sexual offences against children (a combination of historic offences and recent offences). Against a backdrop of austerity and a shrinkage across most business areas, there has been an increase in investment into the Public Protection Department of over 20%.

This includes the introduction of a new Assistant Chief Constable Post (Public Protection and Force Development) to provide additional focus on our response to vulnerability, over £150,000 of additional investment into the Swindon MASH hub, additional Child Protection Investigators, additional CSE investigators, additional Sex Offender Managers, additional investigators in the Child Internet Exploitation Team and additional Child Protection Conference Attendees. All these additional posts and investment illustrate Wiltshire Police's commitment to keeping children safe.

Our approach to Multi-agency working has become more integrated. The development of the Opal Team (the joint agency Child Sexual Exploitation Team based operating out of Swindon Borough Council estate) is an illustration of our commitment to innovative partnership working, learning the lessons from national thematic reports and Serious Case Reviews. This is further illustrated with the additional investment in MASH resources and the move to a co-located and integrated FCP/MASH again based within SBC estate.

Wiltshire Police continues to strive to focus activity on the most vulnerable in society, including children and has embraced the National Children's and Young Persons Strategy which seeks to improve engagement with children, reduce the time that children are kept unnecessarily in Police Custody and also reduce the unnecessary criminalisation of children and young people. A new Vulnerability Strategy has been developed which outlines Wiltshire Police's approach to vulnerability, putting safeguarding and protection of the vulnerable at the heart of decisions made by officers and staff.

A review of our child detention times (presented to the Board) as already shown a reduction in the time that children are spending police detention.

Significant work continues within Wiltshire Police to develop our response to Missing/Absent Children. Wiltshire Police is working more closely with SBC colleagues to reduce the number of repeat missing children improving the safety of vulnerable children often from within the care system.

We have reviewed our PPD/1 form (the form which enables us to share Police information with partners) to try and reduce unnecessary bureaucracy. Partners were a significant part of this review.

Historic reports of Child Sexual abuse continue to be a challenge for Wiltshire Police. The number of reports have increased over recent years and projections for continued reporting indicates this will increase over the

next few years. The initial increase has been as a result of the 'Saville effect', however the ongoing publicity into persons of public prominence and the Independent Enquiry into Child Sex Abuse (The Goddard Enquiry) is likely to increase continued awareness and give more victims the confidence to come forward. The Truth Project, which forms part of the enquiry is likely to result in a significant increase in referrals, increasing the demand on the Police Service.

## **NHS Swindon Clinical Commissioning Group (CCG)**

NHS Swindon CCG recognises safeguarding as a high priority for the organisation. In order to achieve this, we ensure we have arrangements in place to provide strong leadership, vision and direction for safeguarding. Swindon Clinical Commissioning Group has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of adults and children at risk of abuse and is a member of the Swindon Local Safeguarding Children's Board (LSCB).

### **Achievements**

- The CCG has reviewed and ratified the Safeguarding Children and Adults at risk policy during 2015/16.
- All CCG staff (100%) have completed relevant mandatory Safeguarding Adult and Children safeguarding training.
- The CCG have committed 70k investment into the Multi agency Safeguarding Hub (MASH). This will ensure health resource, including administration support is secured.

### **Progress and Priorities for 2016/17**

- The CCG is fully committed to ensuring the LSCB fulfils its strategic aims by discharging its core functions as defined in Working Together to Safeguard Children (2015). The CCG acknowledges that it is critical that the CCG discharges its commissioning and safeguarding responsibilities and fully engages with the LSCB.
- During 2015/16 the CCG Executive Nurse sought the support of Safeguarding and Designated leads from Wiltshire and Gloucestershire CCGs and NHSE to review the CCG's overall capacity and capability including contracts, processes and quality dashboards/indicators. The output of this review has resulted in a comprehensive action plan for the CCG.
- A Children's Services review has been planned and Terms of Reference agreed with key partners. The review will include all children's clinical pathways, and designated roles.
- The CCG recognises its obligations to the LSCB to provide appropriate resources and the need to maintain effective links with partner agencies such as the Community Safety Partnership and Health and Wellbeing Board. Engagement with domestic homicide reviews has highlighted actions for the CCG with regard supporting primary care and signposting to support services. As a result, the CCG is working in collaboration with NHS England to ensure a joined up approach to strengthening the safeguarding training agenda within primary care during 2016/17.
- During 2015/16 the CCG considered the need for a joint Designated Nurse / Adult Safeguarding Lead role. This followed a review of local structures and priorities, aligned to the Care Act Guidance and Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework. The CCG was successful in appointing to this post in August 2016, this post will further strengthen the safeguarding agenda and provide strong leadership for meeting CCG duties and priorities.

## Great Western Hospital NHS Foundation Trust

The Trust is committed to the well-being of all people using their services and takes the safeguarding of children very seriously. The Trust has dedicated Safeguarding Professionals who provide training, advice and support to all services within the organisation.

The Trust works in partnership with the Local Authority to safeguard children and is represented on the LSCB Sub-groups to ensure engagement, working towards our statutory duty under Section 11 of the Children Act 2004 to protect children from harm.

This means working in partnership with other agencies to: -

- Protect children from harm
- Identify health and development needs early to ensure the right level of support to safeguard children and young people
- Ensure children grow up in circumstances that are consistent with provision of safe and effective care
- Processes are in place to learn from events.

We aim to fulfil our commitment to safeguarding and promoting the welfare of children by: -

- Ensuring there is Senior Management commitment from the Organisational Divisions reporting to the Children's Safeguarding Forum.
- Having clear lines of accountability and structures
- Supporting a culture that enables safeguarding issues to be openly discussed and addressed.
- Ensuring staff receive adequate training to safeguard children
- Providing Safeguarding Supervision
- Regular safeguarding audit programme

### **Achievements:**

- We have increased the number of staff being trained at Level 3 to meet the "Inter Collegiate Document": Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014).
- The Swindon Multi-Agency Risk Assessment Conference (MARAC) meetings continue to be attended by representatives from the Emergency Department and Midwifery enabling identification of those at significant risk.
- The development of Safeguarding Simulation training.
- An increase in referrals to Children's Social Care as result of increased knowledge in relation to 'See the Adult, See the Child' protocol
- We are the first hospital within South West to introduce the CP-IS (Child Protection Information System).
- The development of Safeguarding Children's newsletter for staff.
- We have increased the number of Supervision sessions to encourage more staff to attend.
- Our Sexual Health Team attends the Multi-Agency Risk Panels.

### **Impact:**

Continue to see increase in advice sought from staff to the safeguarding professionals which identifies that there is learning from the various training programmes

### **Future challenges:**

- Medical attendance at Initial Child Protection Conference
- Increasing use of Initial CSE screening tool

- Developing safeguarding Dashboard.
- Raising awareness of 'Early Help'
- Rolling out the 'Blended learning' for the level 3 update training.

## **Oxford Health Child & Adolescent Mental Health Services (CAMHS)**

### **Achievements**

Safeguarding Children supervision is now established and available to all CAMHS clinicians within Swindon. This is provided in a group setting and is also available on an ad hoc basis for all staff during office hours, irrespective of their role. Safeguarding is also a standing agenda for all team meetings. Safeguarding Children Supervision is in addition to Clinical and Management Supervision.

CAMHS staff undertake Safeguarding Children training as part of their statutory/mandatory training, and have additionally undertaken NHS England CSE training, and PREVENT (anti-radicalisation training) during 2015/16.

### **Overview**

Oxford Health NHS Foundation Trust provides specialist child and adolescent mental health service (CAMHS) for young people under 18 years old in Swindon. Our services include;

- Specialist CAMHS for more severe mental health needs requiring longer term/intensive interventions for children/young people and their families
- Outreach work – for those requiring additional support across 7 days a week in the community
- Learning Disability CAMHS
- Emergency assessments – working closely with acute Hospitals and the Police where young people require immediate assessment 24/7
- Inpatient services at our acute psychiatric unit for adolescents in Swindon
- Safeguarding Children is inherent to all of CAMHS contact with children, young people and their families and Oxford Health NHS Trust have well established processes to ensure that Safeguarding Children is a key priority in the practice of every single member of the Trust.

### **Impact**

In September 2015, CAMHS were inspected by the Care Quality Commission as part of a Trust wide review involving over 100 inspectors. They formally reported that CAMHS were rated as 'Good' across all areas except the Caring domain which they rated as 'Outstanding'. The report stated:

- The workforce was positive about the young people and their families at every stage, even when dealing with difficult and challenging issues.
- Young people and their families and carers who used the service were effusive in their praise for the staff.
- Staff were highly motivated to offer care that met what young people wanted. Relationships between people who use the service and their families and carers and staff were very positive.
- We observed consistently positive interactions with young people and their families. This was reflected in how staff spoke about young people and their situations when they were not present as well.



- Other agencies who worked with the services commented on the positive nature of staff.
- Young people were involved in their care and also the design of service delivery and were valued for their voice by staff.

Swindon CAMHS Learning Difficulties team have also been regularly participating in meetings with 2 special needs schools where health, education and social care all come together to discuss complex cases which has helped improve communication and access to both CAMHS LD and the Disabled Children's team. This has recently been extended into another special school in order to establish the same process as it has shown to help teachers understand the role of social care and CAMHS when managing risk in school.

### **Future Challenges**

In August 2015, NHS England published guidance for developing CAMHS nationally, linked to a 5 year investment plan. There is wide recognition that the gap between services for young people with mental health need, and funding has widened. The CAMHS Transformation agenda is aimed at reducing those inequalities. In Swindon, two particular areas of need are a matter of concern:

### **Deliberate Self Harm (DSH)**

During 2015, CAMHS undertook a 12 month audit of DSH presentations at Great Western Hospitals. This coincided with the commencement of a DSH register, increased awareness for young people and their parents, and an initiative for longer follow up. Our audit findings told us:

- From January 2015-January 2016 inclusive there were 119 presentations made by young people aged 12-17 (mean 15.2yrs; median 15yrs). 45% of the individuals were known to be in current contact with mental health services. 92% were known to have been admitted to either a hospital or non-hospital bed (85% admitted to a hospital bed and 7% to a non-hospital bed).
- 7% (8/119) of the presentations during the year long period of data collection were repeat attendances (ranging from presenting twice to three times during this period). Furthermore, 71% of the cases were known to have had made previous attempts of self-harm in the past.
- Most patients' data was collected in January 2015 with a decrease as the year progressed with spikes in occurrences during June 2015 and at the start of the new academic year.
- An average of 2.8 presentations per week following self-harm (median = 2; range 1-10).
- Of the 8 cases that had multiple attendances in the sample, 6 were known to CAMHS and 1 was known to 'On track' (local Drug and Alcohol Service) and 1 was not known to services.
- Of the 85 instances where the young person had been known to have attempted self-harm in the past, 38 were known to CAMHS and 1 was known to 'another community team'. 46 were not known to services (or it was not known).

Oxford Health will continue to collate data through the DSH Register at GWH and introduce additional support strategies for young people including booklets for young people and their parents/carers about self-harm and helpful ways to manage feelings of distress more effectively. There is an agreed plan to provide training to ED and ward staff to enhance awareness and foster good working practice between services which will support young people to receive a high quality service and to ensure an effective treatment pathway remains in place. The register will be reviewed formally at the end of each year to understand the needs of young people more comprehensively in Swindon, identify trends, and develop support for young people at risk of self-harming.

Many more, present within schools, at GP surgeries and to other professionals including CAMHS. The multi-agency guidelines for professionals working with children and young people who self-harm remains in place. This remains a high level of concern across all agencies working with young people. Through CAMHS Transformation Plans, there is a clear intention for CAMHS to work with professional colleagues to improve confidence and competence in supporting young people wherever they seek help.

The planning of care for children and young people who self-harm has safeguarding children as a key area when considering the level of risk and harm. Management overview on all open cases provides an additional layer of supervision to keep risk and harm at the forefront of assessment.

### **Eating Disorders**

Nationally, the incidence of eating disorders is also increasing year on year. Swindon is no exception. Five year funding has been committed to improving access and waiting time standards for all young people as soon as a potential eating disorder is identified. Banes, Swindon and Wiltshire CCGs have joined up with CAMHS to create a specialist service to ensure full adherence to the new access and waiting time standards, increase the range of treatment and support for young people and their families, and reduce the need for inpatient admissions. Throughout 2016/17, the new service will be launched will also incorporate self-referral for young people and their families.

The concerns of significant harm to children and young people with Eating Disorders is well known, not least because of the increased risk of death and the need for families to participate fully in the ongoing support of the young person. Safeguarding Children is a key component of the planning of the care of these young people.

### **Workforce**

Nationally, recruitment and retention is a major challenge for all providers. Employing staff with the right values, skills and experience remains one of the major challenges in the year ahead.

The appointment of an experienced Senior Named Nurse Safeguarding Children will ensure that training, supervision and support for CAMHS staff is consistent and developed to skill up the CAMHS teams. A planned and audited service will ensure that the teams develop. Governance processes are in place to ensure that CAMHS is compliant with section 11 requirements and that evidence is provided to demonstrate this.

### **Our Objectives for 2016 – 2017**

During 2016/17, Oxford Health CAMHS are fully committed to working with partners to deliver system wide transformation for children and young people with mental health needs. This will require detailed planning and collaboration across the entire children's workforce to maximise the targeted investment to improve mental health services.

We are also committed to ensuring Swindon young people with eating disorders receive an outstanding service which ensures their outcomes are amongst the best in the country. Swindon CAMHS eating disorders service for young people is already cited nationally as a model of good practice. This will be further enhanced by faster access to assessment by increasing clinic capacity, specialist training for staff, self-referral and multi-family therapy.

The development of identification and working with children and young people who are at risk of, or experiencing Child Sexual Exploitation and exploitation generally, is a key objective for the next financial year

The Named Nurse and Named Doctor Safeguarding Children will run a series of workshops across the Swindon, Wiltshire; and, Bath and North East Somerset (BANES) areas to distribute key messages from local and national reviews, developing a practical action plan for each area to look at recommendations.

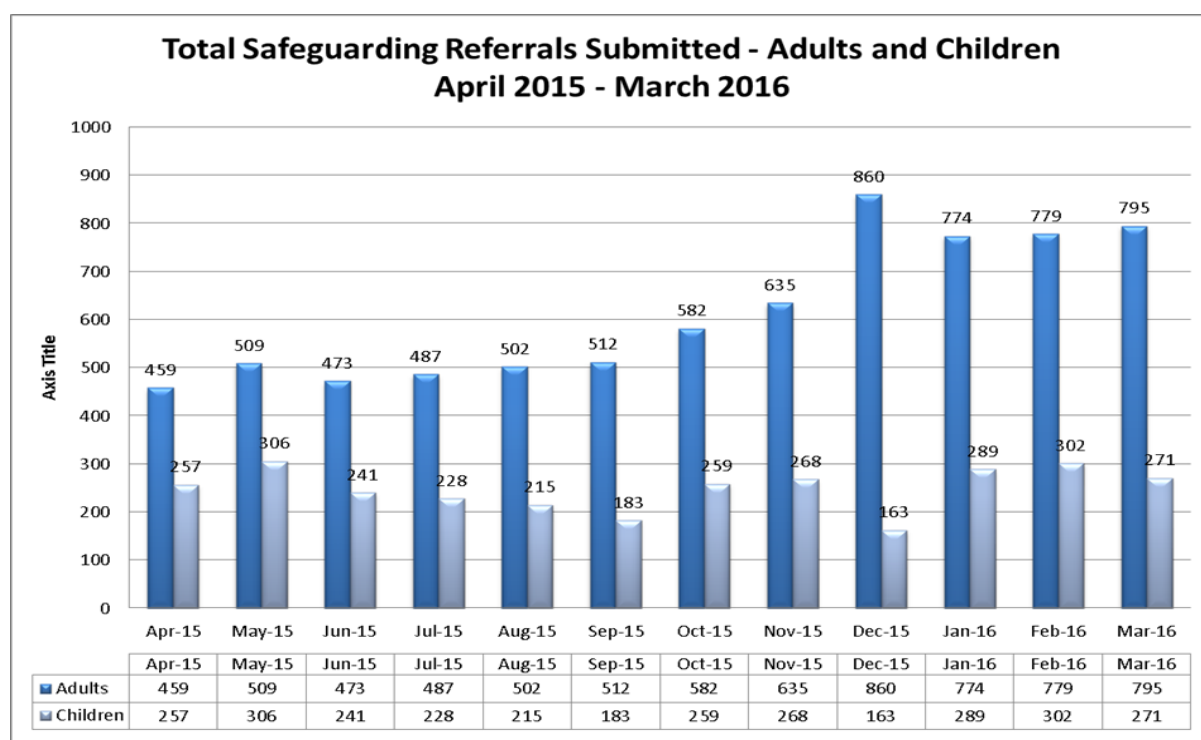
## South West Ambulance Service Foundation Trust (SWASFT)

To give an idea of SWASFT activity in Swindon, the trust has made 17 child referrals within the last 3 months of this financial year – Jan 1 – March 31 2016. Swindon accounts for 1% of the overall safeguarding activity in the trust.

Of the 17 referrals, 6 met the internal SWASFT threshold for safeguarding and the remaining 11 met the SWAST threshold for welfare.

Of the 6 safeguarding referrals 4 were for Neglect and 2 for physical abuse. The 11 welfare referrals include 5 for parental intoxication, 1 for child mental Health, 1 for inconsistent history, 1 for child on plan, 1 child alcohol, 1 child suicidal and 1 parental overdose.

The total numbers of Trust safeguarding referrals for both adults and children are as follows:



The SWASFT Safeguarding Team provides advice, training, ad hoc supervision and support to all frontline and support staff across the trust area. There are 3 Named Professionals that cover the 3 trust localities. The Named Professional for the Swindon area is Simon Hester and he reports to the Head of Safeguarding, Sarah Thompson.

## **Achievements this year**

- Analysis and Review of Referral Process for efficiency and Demand Management.
- Development of a standardised audit tool to review 40 randomised cases.
- Risk assessment of the referral process.
- Delegation of whole team to triage role due to long term absence of the Triager.
- Positive letter of support from Safeguarding Board for 111 CQC inspection
- Positive verbal feedback from 111 CQC inspections.
- IMR/SAR/DHR completed despite capacity issues.
- Recruitment to the administration position – referral triage processor to commence May 1 2016.
- First module of the NHS England Safeguarding Leadership course at Taunton completed by Named Professional North.
- TOR and Work plan for NASG (National Ambulance Safeguarding Group) agreed March 2016.
- Managing Allegations Policy updated and agreed at SOG.
- Prevent Policy agreed at SOG (Safeguarding Operational Group).
- PTS training quality assured and completed for all PTS (patient transport staff).
- Quality Assurance of CFR Safeguarding Training
- Positive action from North CDOP meetings including facilitating SWASFT Macmillan Nurses under the Palliative Care Response Times
- Facilitated OO abstraction to join Gloucestershire Safeguarding Fire Subgroup to look at joint working on hoarding
- Named Professional East achieved The Award in Education & Training enhancing the Service Training portfolio
- All team members received half day Emotional Resilience Training
- Quality Audit of Referrals with the 111 Service
- Production of an 'OO pack' for use by all Operational Officers related to Safeguarding by West Named Professional.
- SOP (Standard Operating Procedure) agreed for all frontline staff in relation to Child Death produced by Named Professional West.
- Launch of trust wide Welfare Service for staff – The Staying Well Service – 400 staff seen in first 5 months.

## **Future challenges**

The Fact that SWAST report to 30 safeguarding boards is a challenge in itself. It is a priority for the new Named Professional to build a relationship with this board in his area.

The increase in referral rate reveals a steady growth in the referral rate in an 18 month period with a significant rate of growth in the last 5 months. The general growth rate is most likely explained by improvement in safeguarding awareness by operational staff, the ease of access to safeguarding referral process through ePCR roll-out and changes in statutory duties (The Care Act).

This has led to a greater demand on the safeguarding team to triage and process the referrals

## **Objectives for 2016-2017**

- Respond to the imminent Care Quality Commission Inspection – June 2016
- Secure 2 seconded posts to permanent positions
- Increase capacity of safeguarding referral process

## Children and Family Court Advisory and Support Service (CAFCASS)

Cafcass (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and their families. It employs over 1,500 frontline staff.

The demand upon Cafcass services grew substantially in 2015/16 with a 13% increase in care applications and an 11% increase in private law applications. The grant-in-aid provided by the Ministry of Justice was smaller than the previous year. Notwithstanding this, Cafcass has met all of its Key Performance Indicators.

The following are examples of work undertaken by Cafcass in 2014/15 to promote the continuous improvement of our work and support reform of the Family Justice:

- Revision of both the **Quality Assurance and Impact Framework** and **Supervision Policy** which together set out the organisation's commitment to delivering outstanding services, and the ways in which staff are supported to achieve this and the quality of work is to be monitored. The Framework integrates the impact of the work on the child into the grade descriptors so that evidence of positive impact is to be present, alongside compliance with the expectations of Cafcass and the Court, for an outstanding grade to be achieved.
- Implementation of the **Equality and Diversity Strategy**. This entails: a network of Diversity Ambassadors who support the development of staff understanding and skill; the holding of workshops; a themed audit on the impact of diversity training on practice.
- Extending the **Child Exploitation Strategy** introduced in 2014/15 to include trafficking and radicalisation as well as sexual exploitation. Key elements of the strategy include: Ambassadors (at a service area level) and Champions at a team level to have a 'finger on the pulse' of local issues and to support learning; training and research (including a study of 54 cases known to Cafcass in which radicalisation was identified as a feature).
- Working with a **range of partners** across family justice, children's services and the voluntary sector for examples the judiciary, the Adoption Leadership Board and the Association for Directors of Children's Services with whom Cafcass has developed the social work evidence template for use in care cases, and with whom we are developing good practice guidance for children who are accommodated by the local authority. Cafcass also chairs the Wiltshire Family Justice Boards that covers the Swindon Courts,
- The development of **innovations** that are aimed at improving our practice and supporting family justice reform. These include: piloting the provision to our Family Court Advisers of consultations with a clinical psychologist; the extension of Family Drug and Alcohol Courts; *the supporting separated parents in dispute* helpline (a pilot across five service areas aimed at promoting out-of-court settlements of disputes where safe to do so).

- Contributing to the government **review of Special Guardianship Orders**, including a small piece of research that was included in the government's response to the consultation.
- A **Service User Feedback Survey**, which looked at the interim outcomes of children six to nine months after private law proceedings concluded. Specifically, the survey looked into whether arrangements ordered by the court had sustained; how effective communication was between parents before and after court proceedings; and whether participants believed that the court order was in their child's best interests.

The future challenge is to show continuous improvement in our performance and to deliver our services as effectively and as efficiently as possible within the resources available. Cafcass is also undertaking, on a national basis, a number of innovative projects designed to support reform in family justice.

## **Swindon LSCB Priorities for 2016/17**

The work of Swindon LSCB is varied and this report has highlighted areas of challenge, improvement and development over the previous year. Ensuring that safeguarding remains a priority for all those who have contact with children is at the heart of the Board's business and the strength of partnership working is the key to driving this forward to make a difference to the lives of children and young people.

The LSCB continues to strive to improve and develop its role in challenging and supporting the work of agencies involved in safeguarding children and in monitoring and coordinating the response to child abuse and neglect. This report provides evidence of the progress partners have made against the priorities identified in the 2015/16 LSCB Business Plan.

The Business Plan for 2016/19 was agreed by the LSCB in April 2016 and sets out the seven core functions of the Board and four key priorities for improvement in 2016/17. The key priorities are outlined below and the LSCB are on a journey in terms of developing strategic responses and demonstrating the impact of these.

The core functions are:

### **Policies and Procedures:**

Developing policies and procedures for safeguarding and promoting the welfare of children and young people in Swindon, including the publication of thresholds for intervention where a child's safety or welfare is compromised.

### **Communication and Safeguarding Awareness**

Communicate the need to safeguard and promote the welfare of children among both the professional and lay community, raising awareness of how this can be done and encouraging them to do so.

### **Performance Management**

Monitoring and evaluating the effectiveness of safeguarding and preventive strategies and the actions of partner agencies to the Board (individually and collectively) and setting standards for continuous improvement.

### **Serious Case Reviews**

Undertaking and commissioning reviews where abuse or neglect of a child is known or suspected and the child has died or has been seriously harmed and there is a cause for concern as to the way in which partners have worked together to safeguard the child. Consider and undertake local case reviews when the threshold for Serious Case Reviews is not met.

### **Quality Assurance Audits and Scrutiny (including Section 11 audits)**

Evaluating the effectiveness and efficiency of local actions to safeguard and promote the welfare of children, evidencing outcomes and challenging improvement.

## **Training and Staff Development**

To devise and deliver high quality innovative training programmes and initiatives that meets the training requirements of the local workforce and the priority safeguarding issues being progressed.

## **Child Death Overview**

To collect and analyse information on child deaths to identify opportunities to share learning, improve services and prevent further avoidable deaths.

The four priority areas for improvement during 2016/17 are:

### **1. Early Help**

Evaluate the effectiveness of the Thresholds document to ensure that it is fit for purpose, well understood and used appropriately by professionals in partner agencies and identify any barriers to delivery of early help

### **2. Child Exploitation**

To undertake a partnership profile in order to better understand the nature and extent of CSE and related issues across Swindon and to evaluate the effectiveness of the multi-agency response to CSE and other forms of child exploitation.

### **3. Strengthening the Voice of the Child and their families and practitioners**

To develop the ways in which the LSCB can 'hear' the voice of the child and their families and also front line professionals when evaluating the effectiveness of services that support them and their families.

### **4. Supporting the effectiveness of adults and children's services to work together to safeguard children**

To identify and promote better outcomes for children through closer working between services that support children and the adults that care for them.

The LSCB Sub and Working Groups continue to provide an effective way of addressing specific areas of safeguarding practice and will continue to develop practice in their particular areas of responsibility and keep the LSCB informed of the work they are undertaking and of any safeguarding issues requiring attention by the LSCB.



## Report Authorship & Availability

This report has been written with contributions from many different LSCB members, each writing about the work of their agency or the work of individual LSCB sub-groups. The LSCB Independent Chair and members of the LSCB Business Team have also written some sections of the report and have edited the final report.

This report was approved for publication by the Board of Swindon LSCB in September 2016.

The final report is a public document available on the Swindon LSCB website [www.swindonlscb.org.uk](http://www.swindonlscb.org.uk)

The LSCB Independent Chair will present the report at meetings with key strategic partners:

- Swindon Health & Wellbeing Board
- Wiltshire Police & Crime Commissioner
- Leader, Swindon Borough Council
- Chief Executive, Swindon Borough Council
- Cabinet Member for Children Services, Swindon Borough Council
- Director of Children Services, Swindon Borough Council

For information in relation to this report, please contact Swindon LSCB on:

[lscb@swindon.gov.uk](mailto:lscb@swindon.gov.uk)

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SN1 2JH

Tel: 01793 463803

## **What to do if you're worried a child is being abused**

Child abuse can take many forms, not all of which have visible signs. If you think that a child or young person under the age of 18 is being harmed and need to talk to someone about it, please contact:

### **Children Services Family Contact Point**

Tel: 01793 466903

### **Emergency Duty Service (out of hours)**

Tel: 01793 436699

### **Wiltshire Police**

Tel: 101

**In emergency, please call 999**

### **Allegations against staff and volunteers**

If you have concerns that a member of staff or a volunteer may have behaved in a way that has harmed a child or indicates that they may be unsuitable to work with children, you should contact the lead person for allegations within your organisation or seek advice from the Local Authority Designated Officer (LADO) for managing allegations.

Tel: 01793 466849

### **Child abuse on the web**

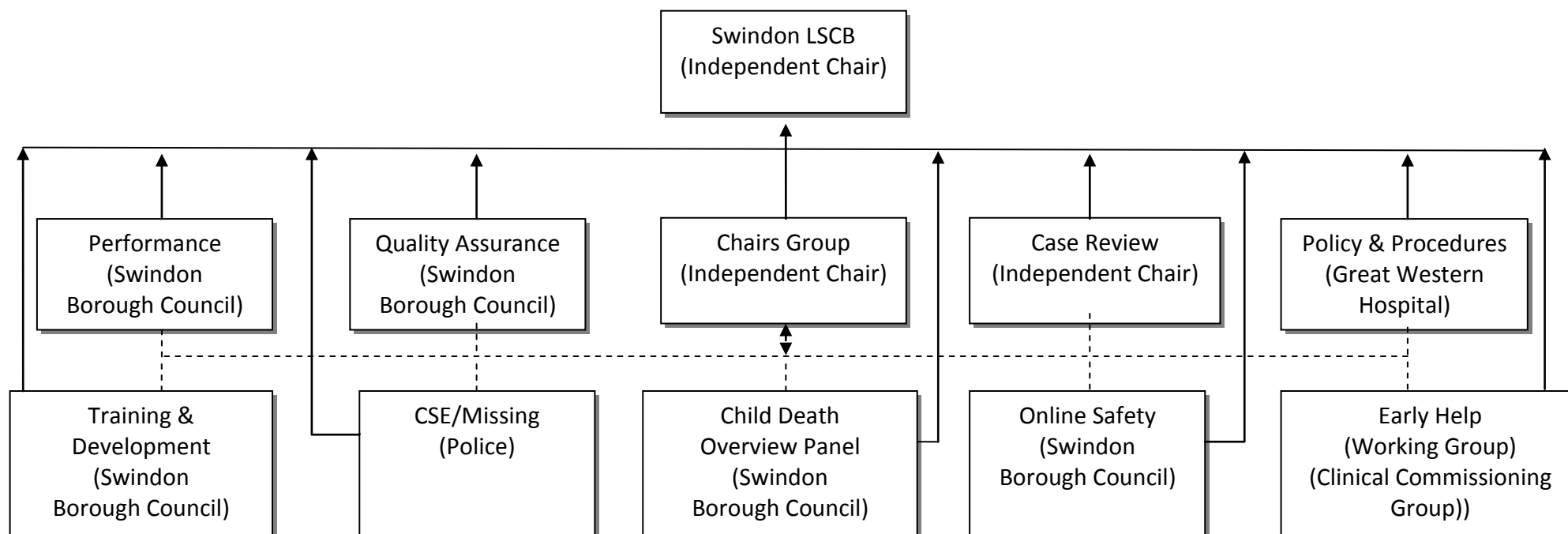
You can report online sexual abuse and content from the CEOP (Child Exploitation and Online Protection) website.

[www.ceop.gov.uk](http://www.ceop.gov.uk)

The site also has links for the reporting of other forms of online abuse including bullying, racism, spam and phishing.

For more detailed information, please refer to the South West Child Protection Procedures on

<http://www.proceduresonline.com/swcpp/>

**LSCB Structure Chart & Board  
Membership & Attendance**

BOARD MEMBER	ROLE & ORGANISATION	BOARD MEMBER	ROLE & ORGANISATION
Alex Walters	LSCB Independent Chair, Chair's Group & Case Review Group Chair	Amanda Murray	Area Manager, Gloucestershire/Wiltshire LDO, National Probation Service (NPS)
Bernie Brannan	Board Director, Service Delivery, Swindon Borough Council (SBC)	Catherine Clark	LSCB Quality Assurance & Training Manager
Cherry Jones	Director of Public Health, SBC & Chair of Child Death Overview Panel (CDOP)	Craig Holden	Detective Superintendent, Head of Public Protection, Wiltshire Police & CSE sub-group Chair
Deborah Murphy	Senior Service Manager, Children and Family Court Advisory & Support Service (CAFCASS)	Deidre Fitzpatrick	Swindon Association of Secondary Headteachers
Duncan Webster	Head of Student Services and Safeguarding, New College	Fiona Francis	Service Manager, Quality Assurance & Review Service, SBC & Quality Assurance sub-group Chair
Fionuala Foley	Cabinet Member Children's Services, SBC	Gill May	Executive Nurse, Swindon Clinical Commissioning Group (CCG) & Early Help Working Group Chair
Hilary Walker	Chief Nurse, Great Western Hospital (GWH)	Huw Ford	Children's Services ICT Manager, SBC & Online Safety sub-group Chair
Ingrid Anson	NSPCC Service Manager for Swindon	Janet King	Consultant Paediatrician and Designated Doctor, Swindon CCG
Joanne Smith	Named Nurse, GWH & Policies & Procedures sub-group Chair	Kathie Bryan	Association of Swindon Special School Headteachers
Karen Reeve	Interim Director of Children's Services (Interim) SBC	Lin Williams	Domestic Abuse Strategic Lead, SBC
Liz Hickey	Assistant Chief Officer, Community Rehabilitation Company (CRC)	Lyn Davis	Lay Member

Mark Edwards	Swindon Health Watch	Mark Scully	Head of Local Delivery Unit, Gloucestershire/Wiltshire LDU, (NPS)
Matt Bywater	Service Manager - Restorative Youth Services, SBC & Training sub-group Chair	Michelle Maguire	Head of Service: Oxford Health NHS Foundation Trust
Mike Ash	Head of Service: Housing & Community Safety, SBC	Newlands Anning	Interim Managing Director, Avon & Wiltshire Partnership
Pat Porter	Lay Member	Peter Nathan	Head of Education, SBC
Phillipa Lamb	Strategic Planning Manager, SBC & Performance sub-group Chair	Robin Stannard	Lay Member
Ruth Gumm	Principal Social Worker, SEQOL	Sarah Merritt	Divisional Director of Nursing, Women & Children's Division, GWH
Sarah Turner	Safeguarding Advisor for Education, SBC	Sarah Warne	Safeguarding Lead Nurse, NHS England
Simon Hester	Named Safeguarding Professional, South West Ambulance Service Trust	Simon Ratcliff	LSCB Strategic Manager
Spencer Allen	Swindon Association of Primary Headteachers	Stephanie Hathaway	Manager, Koalas Opportunity Group
Sue Wald	Director of Adult Services (Interim), SBC	Tanya Musty	Student Engagement Officer, Swindon College
Yasmine Ellis	Youth Development Manager, Dorset & Wiltshire Fire & Rescue Authority		
<b>LSCB BUSINESS TEAM</b>			
Christine Mister	Administrator	Lesley Boorman	LSCB Business Administrator
Catherine Clark	LSCB Training & Quality Assurance Manager	Simon Ratcliff	LSCB Strategic Manager

<b>Partner Attendance at Quarterly Local Safeguarding Children Board Meetings 2015/16</b>			
<b>Agency</b>	<b>% Attendance</b>	<b>Agency</b>	<b>% Attendance</b>
Adult Services	25	SBC - Children, Families & Community Health	75
AWP	25	SBC - Education Commissioning	75
CAFCASS	25	SBC - Housing & Community Safety	100
CSE & Missing Sub Group	100	SBC - Head of Commissioning, Children & Adults	100
Designated Doctor CCG	100	SBC - Cabinet Member Children Services	100
Designated Nurse CCG	50	SBC - Restorative Youth Services	100
E-Safety Sub-group	75	Case Review Sub Group	100
Early Years	0	Safeguarding Advisor for Education	100
CCG	100	Schools - Primary	25
GWH NHS Foundation Trust	75	Schools - Secondary	50
Lay Members	100	Schools - Special	75
NHS England	0	SEQOL	50
NSPCC	75	SW Ambulance Service	0
Oxford Health NHS	100	Swindon Colleges/FE	25
Policy & Procedures Sub Group	75	Swindon Health Watch	100
Probation CRC	25	Training & Safe Workforce Sub Group	75
Probation NPS	100	Voluntary Sector	75
SBC - Public Health	100	Wiltshire Fire Service	25
SBC - DV Strategic Lead	25	Wiltshire Police	100
SBC - Group Director, Children, DCS	50		

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## Ageing Well Joint Strategic Needs Assessment

Health & Wellbeing Board

Date: 14 December 2016

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Author:	Cherry Jones - Director of Public Health, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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### 1. Purpose and Reasons

- 1.1 To agree the recommendations of the Swindon Ageing Well Joint Strategic Needs Assessment (JSNA) and support the development of a multi-agency Ageing Well Strategy.
- 1.2 The population of Swindon is projected to increase over the next two decades due to the amount of homes that are being built and because people are living longer. The proportion of people over 65 years in Swindon is projected to increase by 89% from 29,069 in 2011 to 54,976 in 2031. However this is also in the context of a changing perception and reality of older age:
  - 1.2.1 People are living longer, often having a longer post retirement period in better health.
  - 1.2.2 People are also working longer and more flexibility.
  - 1.2.3 There are greater inequalities in old age in terms of years in good health linked to deprivation and income.
  - 1.2.4 There are more people living with conditions such as dementia because people are living to an older age, increasing demand on social care and other support services.
  - 1.2.5 Older people are more likely to live with co-morbidities and manage a range of conditions for longer.
  - 1.2.6 Older people are more technologically educated but there is also a widening gap between old and young in terms of the dominance of technology in their lives.
  - 1.2.7 People are wanting to live at home for longer and national and local policy is about helping people to help themselves rather than state intervention.
  - 1.2.8 Childhood experience for different generations is significantly different between those growing up in or between war years to born post war.
  - 1.2.9 There is conflicting rhetoric in the media of older people both as an asset but also a burden.

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Further information on the subject of this report can be obtained from Penny Marno, 01793 444711, [pmarno@swindon.gov.uk](mailto:pmarno@swindon.gov.uk).



# Ageing Well Joint Strategic Needs Assessment

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- 1.3 Understanding the needs of older people in Swindon via an Ageing Well JSNA will help give local context to these issues and also inform a whole range of Swindon Borough Council and partner policies and strategies including the development of an Ageing Well Strategy, the Adult Demand Programme, the Sustainability Transformation Plans, plans for the extensive new developments in Swindon, and the direction of health improvement work and long term condition support over the next few years.
- 1.4 It aligns to the Council vision by exploring older people's contribution to "a place of fairness and opportunity where people can aspire to and achieve prosperity, supported by strong civic and community leadership" and in developing the priority to "help people to help themselves while always protecting our most vulnerable children and adults".

## 2. Recommendations

The Board is recommended to:

- 2.1 Note and agree the recommendations identified in the Swindon Ageing Well Joint Strategic Needs Assessment as set out in the report in paragraphs 3.22 to 3.21.
- 2.2 Support the development of a multi-agency Ageing Well Strategy for Swindon.

## 3. Detail

- 3.1 The objectives of the JSNA are to:
  - 3.1.1 understand current population structure of older people in Swindon.
  - 3.1.2 understand future population projections for Swindon and what this may mean in terms of the needs of local older people and demand for services and activities.
  - 3.1.3 summarise aspects of ageing well relating to risky behaviours, mental health wellbeing and physical activity, and to understand the impact of housing and environment on older people's health.
  - 3.1.4 understand current health improvement services for older people in Swindon and current demand.
  - 3.1.5 understand what ageing well means to older people living in Swindon.
  - 3.1.6 understand people's perceptions of what would make Swindon a great place to grow old in.
  - 3.1.7 understand what the barriers are to ageing well and what would facilitate people achieving their aspirations for older age living.

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- 3.2 The profile combines both quantitative and qualitative research. The qualitative information is drawn from existing surveys but also focus groups commissioned specifically for this project and research from Swindon Borough Council's Community Research team who work in our localities and talked to people at lunch clubs and other social groups.
- 3.3 At Appendix 1 is a summary of the findings. Below are the key messages and then recommendations. A copy of the full draft JSNA is available on request. The draft report was presented at the JSNA Steering Group on 9<sup>th</sup> November and comments have been invited from interested stakeholders prior to presentation at the Health and Wellbeing Board.

## Key Messages

- 3.4 Older people are a diverse group with differing views, wants, desires and needs. Their physical and mental health, and their attitudes to life are shaped by their generation, life experience and work, family and retirement experiences. Planning for such a group requires the flexibility and variation to capture this diversity.
- 3.5 It is often difficult to get local level data in detail for older people as they tend to be grouped as 65+ which can potentially span 40 years of life and at least two generations including parents and children in the same family.
- 3.6 No one aspires to need care or move into a care setting; independence was a theme throughout the qualitative research and maintaining independence was a priority for most people.
- 3.7 There is evidence of increasing demand for social care: Swindon is not unique in this but work is ongoing to look at transition points between services and the role of the voluntary sector in supporting people earlier on. A review across the south west found that state support tends to lead to increased levels of dependency rather than decreased levels so keeping people supported by their own social networks and community if needed is more effective.
- 3.8 Older people are currently much less likely to live in the new developments in Swindon. In the future planning for more mixed communities and intergenerational living would have benefits for community integration, perceptions of ageing and reducing isolation at all ages as more people would be around during the day and using local services.
- 3.9 The significant increase forecast in the number of older people living alone has implications for the type and nature of housing needed in the future. There may also need to be more consideration of creating community where people can maintain independence (a strong message of what all older people want) but also facilitate the social networks and activities that are seen as key to ageing well and will reduce demand on social care.

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- 3.10 Inequality affects older people significantly. Looking locally the difference in the proportion of older people experiencing income deprivation varies from 4% in an area of Liden to 48.7% in a part of Central ward. Targeted work with the communities particularly in Central to ensure people are getting the benefits and advice they are eligible for could help address this.
- 3.11 There is some evidence nationally that people are drinking more often as they get older. Alcohol can increase the risk of falls and affect medication so increasing understanding of the effects of this is important.
- 3.12 Physical health itself wasn't seen as a barrier to ageing well; it became a barrier when it stopped people keeping mobile, accessing transport, seeing friends and family or doing what they enjoyed.
- 3.13 Ill health for older people occurs on a spectrum and the conditions that need the greater clinical intervention are not necessarily those that create the greatest barrier to ageing well. For example hearing loss and sight loss which affect around 40% and 20% of older people respectively can affect people's confidence in going out, using public transport, attending groups or social activities and seeing family and friends.
- 3.14 Projections of the number of people with ill health in the future all show increases as they are based on population forecasts. Unless there is a step change in behaviour, significant advances in treating chronic disease or a generational shift through population intervention, the number of people with chronic diseases and vulnerable to falls and limited mobility will increase even if prevalence stays the same as the number of older people will increase. To maintain the number of people who have say a long term illness that limits their day to day activities to the same level in 2030 as at present will require a reduction in the prevalence from 23.4% at present to 14.1% in 2030. Increases in long term conditions will also impact on the demand for social care.
- 3.15 Part of Ageing Well includes taking opportunities to protect against disease, detect illness early and get support when needed from a range of different sources. Promoting immunisation, screening, sight and hearing test accessibility allows people to maintain independence for longer and have treatment and support as appropriate.
- 3.16 There are different expectations at different ages: younger older people seem to have greater expectations of state support as they look to getting older. However older people themselves have a more positive view of getting older compared to younger older people.
- 3.17 Three quarters of people aged 85+ rate their health as fair, good or very good and nearly 50% consider day to day activities are limited a little or not at all in that age group. Promoting ageing well to raise expectations that it is possible to keep healthy and be active and fulfilled as people get older is important and will also

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# Ageing Well Joint Strategic Needs Assessment

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encourage people to strive for this in the future. There may be learning from the social norms work used in schools to encourage people to expect more from their bodies and minds and seeing looking after themselves as being achievable.

- 3.18 Wellbeing scores for older people suggest that whilst people can be happier and more satisfied as they get older, those over 80 have the lowest worthwhile scores. More should be done to look at how people are valued at all ages: there are examples within the Circles project of volunteers age 90+ and YOLO is a group of very active people living with dementia who contribute to a wide range of strategies and projects.
- 3.19 There are various opportunities when large numbers of older people access services and information or advice could be targeted. These include when people are immunised against influenza each year, initial contacts with social care, changes in council tax status, and when people are given their free bus pass.
- 3.20 There is no silver bullet for ageing well: the nearest is physical activity and opportunities to do this are most effective if built into day to day life. However having groups and classes which meet the whole spectrum of being physically active is important as they also have benefits in terms of social interaction.
- 3.21 Research suggests that a multi-faceted approach to prevention is needed including encouraging and improving the employability of older people, providing older people with opportunities to share and develop their knowledge and skills, providing opportunities for life-long-learning, and addressing isolation. When people do need low level care, providing this promptly or having a stepped intervention that draws in befrienders, signposting and lifestyle support whilst waiting for assessment or services can delay or even prevent increased demand later.

## Recommendations

- 3.22 To develop an ageing well strategy and action plan based on the findings and key messages from this report.
  - 3.23 Ensure there is joining up and reflection of ageing well in existing / developing strategies including:
    - 3.23.1 Joint Health and Wellbeing Strategy
    - 3.23.2 Swindon Falls and Bone Health Strategy
    - 3.23.3 Get Swindon Active Strategy
    - 3.23.4 Swindon Healthy Weight Strategy
    - 3.23.5 Alcohol Strategy
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# Ageing Well Joint Strategic Needs Assessment

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## 3.23.6 Oral Health Strategy

- 3.24 Promote the messages and insight from this report to relevant Housing and Planning boards to encourage intergenerational living in new developments and housing which reflects the aspirations and approach to living for older people now and in the future.
- 3.25 To develop a comprehensive strength and balance activity offer for people in midlife and as they get older as an integral part of Live Well Swindon, via signposting to and influencing existing community activities.
- 3.26 To continue to promote physical activity at a population level throughout the lifecourse and link more clearly to the long term benefits of physical activity linked to ageing well.
- 3.27 To develop a 'Valuing Older People' campaign which promotes Swindon as a great place to grow old in but embed positive ageing into Council communications and policies across the board.
- 3.28 To identify external funding to explore age-friendly environments, linking to the dementia friendly work already planned.
- 3.29 To work with partners to map out trigger points for ill health, social isolation and crisis and ensure interventions are targeted towards these. These will include retirement, bereavement, loss of mobility, changes in caring role, coming home from hospital and first access of formal care / support.
- 3.30 To work with Healthwatch to look at the feasibility of an Older People's consultation panel.
- 3.31 Review the evidence for intergenerational work to improve understanding of getting older and making the most of older people's experience and skills.

## 4. Alternative Options

- 4.1 To not take the Ageing Well work any further forward.

## 5. Implications, Diversity Impact Assessment and Risk Management

### Financial and Procurement Implications

- 5.1 There are no direct financial or procurement implications arising directly from this report.
- 5.2 Any service reviews or service requirements which are discussed as a result of this report will be reviewed and a business case developed accordingly.

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# Ageing Well Joint Strategic Needs Assessment

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## Legal and Human Rights Implications

- 5.3 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

## All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.4 There are positive implications on health from promoting ageing well. This will benefit both the health and social community as demands on adult social care from supporting older people have a significant economic and resource impact.

## Diversity Impact Assessment

- 5.5 A diversity impact assessment will be completed as part of the Ageing Well Strategy and will be available. The Ageing Well action plan will include actions to work on identified gaps or issues.

## Risk Management

- 5.6 No specific risks have been identified at this stage for this report.

## **6. Consultees**

- 6.1 The Corporate Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

## **7. Background Papers**

- 7.1 None.

## **8. Appendices**

- 8.1 Appendix 1 – Summary of findings from Draft Ageing Well Joint Strategic Needs Assessment.

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## **Appendix 1: Summary of Findings from Draft Ageing Well**

### **Joint Strategic Needs Assessment**

#### Population, Deprivation and Life Expectancy

There are about 33,000 people living in Swindon over 65, 15% of the total population. 1548 are aged over 90 with double the number of women than men in this age group.

Older people are not evenly across Swindon. The highest proportions are in Chiseldon and Lawn (26.6% of the population aged 65+) and Wroughton and Wichelstowe (25.3%) whereas the lowest are in Priory Vale (4.8%) and St Andrews (5.6%). Sometimes people can feel more isolated in areas which are predominantly younger as there are less facilities and services aimed at older people.

There are low proportions of older people in the new housing estates such as those in the north and west.

2011 Census data indicates 870 people in Swindon were living in care homes, a lower rate than in the south west and England. 88% of these are over 65.

Numbers of older people likely to live alone are projected to increase significantly between now and 2030 (52% increase for those aged 65 to 74 and 70% increase for those aged 75+).

The number of people in Swindon is likely to increase significantly over the next 20 years with the largest percentage increase seen in those over 65. The 85+ age group is projected to have the largest growth rate at 136% from 3823 in 2011 to 9039 in 2031.

Income deprivation affects nearly half of older people in the Manchester Road area of Central ward and Walcot East South West area of Walcot and Park North. Throughout Swindon there are likely to be around 1 in 3 older people eligible for pension credit who are not claiming it based on national rates.

Life expectancy at aged 65 is 18.5 years for men and 21.1 years for women on average. Women tend to live longer but spend more years after age 65 in poorer health.

2011 Census data on how good people rate their health shows 61% of those aged 65 to 74 rate their health as good or very good compared to 28% of those aged 85 and over. One in four people aged 85+ consider their health to be bad or very bad.

#### Lifestyle, Sexual, Oral and Mental Health

Lifestyle considers weight, alcohol, physical activity and smoking behaviours.

At national level around two thirds of women and three quarters of men aged 65+ are overweight or obese, increasing with age for men but decreasing for women. Swindon is unlikely to be significantly different. Issues around weight and nutrition are more complex as people get older however as being underweight is also a risk to health and medication, changes in appetite and chronic diseases can affect how much and what type of food people eat. Because of increasing numbers of older people in the future



the number of older adults likely to be obese is projected to increase by 53% by 2030. This has implications for both social care and health services.

Although people are less likely to drink alcohol as they get older, nationally the proportion who drink almost every day is increasing. 28% of 85+ men report drinking almost every day compared to 4% of those aged 25-34 although 22% have not drunk alcohol at all in the last 12 months (increasing to 42% of women). In Swindon the rate of hospital admission for alcohol related conditions for those aged over 65 years is higher than the England average, 224.8 admission episodes per 100,000 population against England average of 190.5. This is much higher for men than women.

As people get older they are less likely to be physically active: about one in five of those aged 65+ report taking part in sport in the last month and 47% of people over 65 are classed as inactive (less than 30 minutes of activity per week). Social care data shows people most commonly need help with physical support so maintaining strength and balance for as long as possible is valuable.

In Swindon in 2015 18.7% of adults were current smokers, which is likely to reduce to around 12% of those aged 65-69 and 3% aged 90+ according to national prevalence data. In 2015/16 around 200 people over 65 used local smoking cessation services in Swindon with around 58% achieving a four week quit target. Forecasts suggest less people will smoke in the future with only 4% of those aged 65-74 smoking in 20 years time.

0.6% of people attending a sexual clinic for the first time were over 65 in Swindon with double the number of men than women. National survey data found that 2% of people aged 65-74 had at least one new partner in the last year and there is some evidence that older people are less likely to use condoms than any other age group and that health professional do not perceive older people to be at risk of sexually transmitted diseases.

There is no locally collected data on the proportion of older adults with oral diseases although there is increasing national concern about oral health for people living in care homes. Tooth decay is most likely to affect those aged 25 to 34 and aged 75+ and in the south west 59% of the population experience some gum disease.

One in four people of all ages will experience a mental health problem at some point in life: risk factors such as caring responsibilities, life events, social isolation, lack of social networks and ill health are likely to be significant factors for older people.

Measures of wellbeing in the Annual Population Survey are similar for Swindon compared to England. National breakdowns show that whilst older people tend to have better satisfaction and happiness ratings than those in midlife those over 80 have the highest percentage reporting low worthwhile scores.

The national Opinion and Lifestyle Survey found that nearly one third of people report high levels of loneliness. Analysis of MOSIAC data in Swindon identified two types most likely to be lonely; people who experience anxiety and depression, and those who have limited contact and are less likely to use the internet.

### III health and use of Acute and Emergency Services

Older people are more likely to have multiple conditions with 50% of complex patients, identified by NHS England as those who make up the top 2% spend for a CCG, likely to be over 65+. The average complex patient is likely to have eight admissions per year for three different conditions.

Around 20,000 people in Swindon aged 65+ are likely to have high blood pressure which increases the risk of stroke and heart problems. Around 6000 are likely to have cardiovascular diseases and a similar number arthritis and rheumatism.

Hearing loss affects an estimated 14000 people aged 65+ and sight loss about half this amount. Older people can be reluctant to use sight and hearing aids.

For older men prostate cancer is the most common and for women breast cancer. More people are living with or beyond cancer and other illnesses and the long term effects of this as people live longer are not fully understood although they are likely to be both physical and psychological.

Developing a type of dementia is one of the greatest concerns as people get older both as an individual but also for a partner or loved one. In Swindon around 2200 people aged 65+ are estimated to be living with dementia, around half of which are 85+. Swindon has a dementia strategy focusing on the whole dementia journey from prevention to end of life and an active Dementia Action Alliance.

There were over 25,000 hospital admissions for those aged 65 and over in Swindon CCG in 2014/15, 36.6% of the total admissions. Cancer was the most common cause of admission for the 65 to 79 age group but for the 80 to 84 age group it was eye related conditions, for the 85 to 89 year olds it was circulatory disease and for those aged 90 plus it was respiratory disease.

In 2015/16 there were 11,268 attendances at GWH emergency department for people aged over 65 years who lived in the NHS Swindon CCG area. Half were due to known diseases or injury with the most common categories being 'Injury or other external cause', 'Diseases of circulatory system' and 'Diseases of the respiratory system'.

### Social Care

In 2015/16 there were 5543 people using adult social care services with 65% over 65. There is an upward trend in the number of contacts to social care from people of all ages (12898 in 2014/15 and 14068 in 2015/16), with around 50% of these leading to referral and assessment. 54% of all clients have one service with 23% having 3 or more: however a 'service' may also include pieces of equipment.

The most common type of care for people age 65 and over is personal care support where people find it difficult to do physical things on their own. This includes domiciliary care which is offered at home: on 31 March 2016, 742 clients over 65 received this service with highest numbers of people in parts of Wroughton and Highworth.

Social services data shows 337 people aged 65+ living in residential care and 184 living in nursing care: similar numbers to the previous year. However there is increasing demand to find beds, particularly for people on discharge from hospital.

### Prevention and Screening

There are a range of services provided by the Community Health and Wellbeing Team which are focused on supporting people to change behaviour and preventing isolation and ill health. These include health ambassadors, the circles of support project, and community navigators: 17%, 100% and 58% of clients respectively were aged over 65. Weight management support is also offered: between 16% and 21% of those who attend Dietbusters or are referred to Weightwatchers are over 65. There are no services specifically for older people although those available welcome all ages. People can also choose to attend Slimming World: 20% of attendees are aged 65 and over.

Older people are routinely offered immunisation against pneumococcal disease, influenza and shingles. Uptake of PPV vaccine for pneumococcal is lower than the England average in Swindon at 65% but update for influenza and shingles is similar to England.

Screening for abdominal aortic aneurysms (AAA), breast cancer and bowel cancer covers older people although for specific age ranges. Take up is similar to the English average for AAA, better for breast cancer and significantly worse for bowel cancer.

Sight tests are free for those over 60 and around half of people have an NHS test annually. People with hearing loss are less likely to seek help: on average people wait 10 years before seeking help and it is estimated three times as many people could benefit from hearing aids as have them.

### Staying Independent

Transport is very important for ageing well. The proportion of households without a car increases from 15% for those aged 65 to 69 to 66% of those aged 85 and over. People over 65 account for 85% of customers on the concessionary travel database and all people reaching state pension age are eligible for a free bus pass.

At the last census in 2011 two thirds of households aged over 65 owned their own home outright, reducing to 61% of those over 85. Nearly one in five households over the age of 85 years live in homes rented from Swindon Borough Council. People want different things from housing: adaptability is more important than type. Level access to showers and stair lifts are the most common disability facilities grant adaptations with council tenants having £900,000 worth of work in 2015/16 including showers, door widening, ramps, paths and conversions.

In Swindon, 90.4% of people have used the internet in the last three months and 9.3% have never used it or used it more than three months ago. National data found 56.5% of people over 75 never used the internet in 2016 but this has been falling year on year. Swindon Borough Council's primary source for information sharing is the MyCareMySupport website: 'Support at home' and 'Getting out and about' are the most frequently accessed pages in the marketplace.

Part of Ageing Well is about feeling valued and for some older people this is from providing care and/or volunteering. Around one in seven older people in Swindon are providing unpaid care according to the census. It is estimated that the 4520 people aged 65+ who provide unpaid care will increase to 7000 by 2030. This includes around 780 people aged 85 and over. Over 36% of people aged 65+ nationally participate in voluntary activities at least once a month: a significant workforce and valuable contribution to society and community.

17.4% of people aged 55+ take part in sport at least once a week in Swindon, and one in five had participated in any sport during the last 28 days which has been declining in recent years. Nationally the most popular sports for those aged 65 and over are swimming, fitness and conditioning, and golf. 29.3% of people over 65 said they would like to do more sport.

Swindon has a wide range of sports facilities including 21 swimming pools, and over 20 squash courts and tennis courts. There are also a range of walking groups aimed at different abilities, exercise on referral, balance and safety, gym sessions, chair based exercise and exercise aimed at people with different health conditions.

### Understanding People's Views

The Swindon residents' survey found that the most important things in making somewhere a good place to live for people aged 65+ were health services, clean streets, public transport and the level of crime.

28% of those aged 65 and over were very satisfied with their local area as a place to live and older people were more likely to be satisfied with services provided by the Council.

Focus groups across Swindon found that 'Ageing well' was perceived to be about maintaining mental health and wellbeing, watching out for your neighbours and being content.

Mental wellbeing was important to all age groups, but this evolved through the different life stages. For the youngest age group (50-64), mental wellbeing was about maintaining relationships through work, friends and family i.e. socialising, being busy. For those aged 65 to 79 there were similar themes but the concept of mental wellbeing began to shift towards mentally preparing yourself for old age, maintaining mobility to get out and about, and being positive about ageing. With the oldest age group (80+), mental wellbeing also focused on getting out and exercise but shifted even more to maintaining independence and accepting assistance.

Younger older people had some concern about the perception of growing older and how society views older people.

Views on Swindon varied significantly although a majority of people had good things to say about Swindon in general as a place to live. This ranged from good places to visit such as green spaces for walks, cycling, and shops, to Swindon being well connected.

There was a difference in views in terms of knowledge and participation in things going on in the town. This was less about there not being enough going on and more about lack of awareness and poor communication.

There was also a view that needs change over time and as people get older they need to both recognise that things may be more difficult but also that there should activities available that are at different levels.

## NHS England National Commissioning Intentions

Health and Wellbeing Board

Date: 14 December 2016

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Author:	Debra Elliott - Director of Commissioning, NHS England South (South Central)
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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### 1. Purpose and Reasons

- 1.1 The purpose of this report is to inform stakeholders of NHS England's commissioning intentions locally. The documents attached in the appendices provide the National Commissioning Intentions for the Direct Commissioning responsibilities for NHS England.

### 2. Recommendations

The Board is recommended to:

- 2.1 Note the commissioning intentions for Armed Forces and their Families for 2017/18 to 2018/2019 as attached at Appendix 1 to the report.
- 2.2 Note the commissioning intentions for Public Health Section 7a for 2017-2018 as attached at Appendix 2 to the report.
- 2.3 Note the commissioning intentions for Prescribed Specialised Services for 2017/2018 to 2018/2019 as attached at Appendix 3 to the report.

### 3. Detail

- 3.1 Attached at Appendix 1 - 3 are the national commissioning intentions for Armed Forces and their Families, Public Health Section 7a, and Prescribed Specialised Services.
- 3.2 These are national documents and so are for information only.

### 4. Alternative Options

- 4.1 Not Applicable.

### 5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 Financial planning completed as part of the development of commissioning intentions.

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Further information on the subject of this report can be obtained from Lorraine Richards, 01138 251501, [Lorraine.richards1@nhs.net](mailto:Lorraine.richards1@nhs.net).

# NHS England National Commissioning Intentions

Health and Wellbeing Board

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## Legal and Human Rights Implications

5.2 Not Applicable.

## All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 Not Applicable.

## Diversity Impact Assessment

5.4 Diversity impact assessment and risk management carried out as part of the development of commissioning intentions.

## Risk Management

5.5 Risk management carried out as part of the development of commissioning intentions.

## **6. Consultees**

6.1 As articulated in the Appendices.

6.2 The Corporate Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

## **7. Background Papers**

7.1 Not Applicable.

## **8. Appendices**

8.1 Appendix 1 – Armed Forces and their Families Commissioning Intentions 2017/18 to 2018/19.

8.2 Appendix 2 – Public Health Section 7a Commissioning Intentions 2017-2018.

8.3 Appendix 3 – Commissioning Intentions 2017/2018 and 2018/2019 for Prescribed Specialised Services.



# **Armed Forces and their Families Commissioning Intentions – 2017/18 to 2018/19**



## NHS England INFORMATION READER BOX

### Directorate

#### Medical

Nursing  
Finance

Operations and Information  
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Specialised Commissioning  
Commissioning Strategy

### Publications Gateway Reference:

05984

**Document Purpose** Strategy

**Document Name** Armed Forces and their Families Commissioning Intentions 2017/18 to 2018/19

**Author** NHS England

**Publication Date** 17 October 2016

**Target Audience** CCG Clinical Leaders, CCG Accountable Officers, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, GPs, Emergency Care Leads, Directors of Children's Services, Ministry of Defence

### Additional Circulation List

**Description** Our commissioning intentions for 2017 - 2019 outline the strategic intentions that plan to improve the way the services for Armed Forces and their families are commissioned.

### Cross Reference

**Superseded Docs**  
(if applicable) Armed Forces Commissioning Intentions 2016/17

**Action Required** NA

### Timing / Deadlines (if applicable)

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### Document Status

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Prepared by:

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Andy Bacon, Assistant Head of Armed Forces Health (Central Team)

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

Please contact 0300 311 22 33 or email [england.contactus@nhs.net](mailto:england.contactus@nhs.net)

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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## Executive summary

Our **commissioning intentions** for 2017 - 2019 outline the strategic intentions we are planning to improve the way we commission services for the Armed Forces and their families.

In summary to:

- Ensure **high quality services** are **accessible** to armed forces personnel and registered families to promote, protect and restore the health of the community.
  - We will work to meet the commitments of the **Armed Forces Covenant**
  - Improve access to **NHS screening programmes**
  - We will commission high quality, safe and effective healthcare in line with the NHS Constitution Standards
- **Improve the pathway** for service personnel and families as they leave the service with a particular focus on **mental health, prosthetics and continuing health care**
  - We will procure a new **veterans' mental health service**
  - We will work with the Ministry of Defence to implement the **Integrated High Dependency Care system**
- Improve **awareness** at local level by Clinical Commissioning Groups, providers and local authorities to ensure due consideration is given to veterans, reservists and service families
  - We will review our approach to **Armed Forces Networks**

## Purpose

1. These commissioning intentions provide notice to healthcare providers and give information to other commissioners of healthcare services about changes and planned developments in the commissioning and delivery of services for the Armed Forces and their families registered with a Defence Medical Services (DMS) practice by NHS England.
2. Together with planning guidance, the NHS contract, National Tariff system and CQUIN guidance they form a plan to be reflected in contracts, developments, service reviews and procurement opportunities for the two years from 2017/18 to 2018/19.
3. The prime purpose of these intentions is to enable healthcare providers to make early preparations, to engage with clinical leads and to make changes that benefit patients, with improved outcomes. These intentions should inform providers' plans at all levels.
4. These intentions also set out other planned changes related to the healthcare of the armed forces community that Clinical Commissioning Groups (CCGs) will wish to be aware of.

## Our population

5. NHS England has been commissioning services for the Armed Forces and those families registered with a DMS practice in England since 1 April 2013.
6. Our vision is to obtain the best health benefit within available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the NHS Mandate, Armed Forces Covenant and the NHS Constitution.
7. The following services are normally commissioned by the NHS England Armed Forces commissioning team for the DMS registered population (including DMS registered families) in England:
  - Secondary care services, including emergency care;
  - community services;
  - mental health services (only for families registered with DMS).
8. NHS England also provides lead commissioner or similar support arrangements for other services such as cervical screening for those DMS registered patients overseas, or out of hours primary care services.
9. DMS commissions or provides the following services in England:
  - Occupational health for military personnel;
  - primary care for serving personnel and GP services for DMS registered families;
  - all health care when on active operations and prior to return to UK;
  - rehabilitation services for musculoskeletal (MSK) and some neurological patients for serving personnel;
  - mental health in community and inpatient for serving personnel (but not families).
10. The following services are also commissioned for the Armed Forces community by NHS England:
  - primary care for families registered with NHS practices;
  - dental, pharmacy and optometry services for families;
  - secondary care dental services;
  - specialised services;
  - public health services covered by Section 7A.
11. Most services for veterans are commissioned locally by CCGs, with a veteran being defined as someone who has served a day in HM Forces. There is no definitive record of the number of veterans in England as there has been no systematic recording of veteran status in healthcare records. GPs are encouraged to ask patients registering at their surgery if they are a veteran and Read<sup>1</sup> code them as “military veteran” on the system. There are also Read codes for “Member of Military Family” which can be used to identify family members.

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<sup>1</sup> A coded thesaurus of clinical terms in use in primary care

12. There are two main estimates of the number of veterans in England. The Royal British Legion survey<sup>2</sup> estimated that there were approximately 2.8m veterans in the UK, whilst the recently published 2014 Annual Population Survey (APS)<sup>3</sup> which estimates that there are currently 2.6 million veterans in Great Britain (excludes Northern Ireland). The Annual population survey also provides a breakdown of the estimated number of veterans in each of the administrations in Great Britain. The APS estimates that there are 2.24 million veterans in England, 66% of who are over 65 years of age. There were over 800 very seriously or seriously injured personnel from recent conflicts such as Afghanistan and Iraq.
13. NHS England has specific duties and separate funding, including funding from LIBOR fines, to commission the following veterans' services:
  - Specific England wide veterans' mental health services, in response to "Fighting Fit". These are the services we are procuring for 2017.
  - On line psychological support services for veterans and families.
  - Post-traumatic stress disorder services for veterans
  - Veterans' prosthetic services including the Veterans' Prosthetics Panel (VPP) in response to "A Better Deal for Military Amputees".
  - Assisted conception services for those in receipt of compensation for loss of fertility.
14. Armed Forces personnel and families returning from overseas for treatment in the UK are covered by Overseas Visitor (OSV) regulations and are the responsibility of the local CCG in which the provider of the care that they receive is located, this is sometimes referred to as the Host CCG. Further information supporting this is can be found at: <https://www.england.nhs.uk/ourwork/tsd/data-services/>
15. A grid detailing the responsible commissioner is at the end of this document.

## Our priorities

16. To achieve our overall priority of ensuring that the armed forces community receive high quality, safe and effective healthcare, NHS England needs to work with both the Ministry of Defence and CCGs across a range of areas.

## Meeting the commitments of the Armed Forces Covenant

17. NHS England as the commissioner of health services for the Armed Forces and families registered with DMS needs to ensure that it upholds the commitments of the Armed Forces Covenant. Specifically this means that:
  - Armed Forces patients should not face disadvantage compared to other patients in the provision of healthcare.
  - Special consideration is appropriate in some cases, especially for those who have given most such as the injured

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<sup>2</sup> <http://www.britishlegion.org.uk/get-involved/campaign/public-policy-and-research/the-uk-ex-service-community-a-household-survey/>

<sup>3</sup> <https://www.gov.uk/government/statistics/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2014>

18. In practice this means that we:
- have a set of common access policies to ensure equity of access for service personnel and their families across England;
  - expect our providers to have due regard to the Armed Forces Covenant in managing their waiting lists and inter-provider transfers;
  - expect our providers to offer priority treatment to veterans, for service attributable conditions, subject to the clinical priorities of other patients;
  - commission some bespoke services for veterans, where we have been funded to do so – for example veterans’ prosthetics.

## **Procurement of a national veterans’ mental health service**

19. Whilst CCGs are the responsible commissioner for veterans’ services, NHS England has a system leadership role for veterans’ health service which includes commissioning some specified services. Towards the end of 2015/16 we began a programme of work to find out people’s views of NHS veterans’ mental health services, to ensure that feedback from veterans, family members and those involved in their care informed future service developments. The feedback is available at: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/09/veterans-mh-services-engagement-rep.pdf>
20. Feedback has highlighted the need to improve awareness of where veterans should go for help, raise the profile of NHS veterans’ mental health services and further increase understanding amongst health professionals of the unique issues faced by those from an armed forces background. It was also felt that more should be done to support a smoother transition from armed forces healthcare to the NHS to help ensure the right pathways of support are in place for veterans with mental health difficulties and the wider health needs of families are considered.
21. We will be undertaking a procurement exercise during the autumn of 2016 to commission veterans’ mental health services from April 2017, which more accurately reflect the needs of the people who use them. These “transition, intervention and liaison” services will offer:
- A service for those in transition - a transition / assessment and therapeutic mental health service for serving personnel who are in the process of leaving the armed forces and entering civilian life.
  - A service for veterans with complex presentations - A case management and co-ordination function for those veterans with complex presentations and particularly those who have suffered significant psychological trauma, where a military understanding would be beneficial, working alongside mainstream psychological and other mental health services.
  - A general service for veterans – a service for veterans who do not have complex presentation but would benefit from navigation and liaison support to other mental health services.
22. During 2017/18 we will review the current Post-traumatic stress disorder (PTSD) service using the principles of:
- Securing the needs of the people who use the services;

- Improving the quality of the services, and
- Improving the efficiency of the services.

## Access to NHS Screening Programmes

23. NHS Screening programmes for adults registered with a DMS practices are funded and commissioned by Public Health through the section 7A agreement. The numbers of patients eligible for access to these screening programmes are small due to the demography of our population and access to cervical screening is already in place. We will support our Public Health colleagues to ensure that from April access to NHS screening programmes for the Armed Forces population is improved for:

- Breast
- Bowel (scope and faecal occult blood)
- Diabetic Eye retinopathy
- Abdominal Aortic Aneurism

Further information on public health commissioning intentions is available at: [www.england.nhs.uk/](http://www.england.nhs.uk/)

24. Due to the mobile nature of the population, which affects patient access to testing in England and the IT systems used by the MOD there are differences, to the standard model, in how access to screening will be implemented. These differences mean that joint working across Armed Forces Health and Public Health teams at regional, national and local levels will be beneficial.

## Working together with the Ministry of Defence

25. During 2017 we will be reviewing our work plan with the Ministry of Defence to identify those areas where we can work together to maximise the outcomes for patients in the armed forces community.
26. Primary medical care services for the armed forces are provided by Defence Primary Healthcare (DPHC), but opportunities exist to work with DPHC to share learning and good practice, such as that from the Five Year Forward View for General Practice.
27. Additionally as part of the Army Basing and Estates programmes two areas have been identified as areas for joint (NHS and DPHC) primary care centres; these are in Larkhill and Catterick. Work is ongoing with NHS England (Primary Care) and local CCGs to progress these developments.

## Integrated High Dependency Care System

28. Over recent years the NHS and the MOD have worked together to improve the provision of services for veterans including prosthetic and mental health and smooth the transition process from serving to civilian life. For a very small cohort of service personnel with very complex physical, mental and neurological issues the transition into civilian life can be more challenging and we are working with the MOD to pilot an Integrated High Dependency Care System (IHDCS).



29. The objective of the IHDCS is to aid better assessment of integrated health and social care need and to provide focussed help to maximise the effectiveness and integration of services whether provided by MOD, NHS, Local Government or third sector. This improved management of funds, services and equipment aims to greatly improve the individual's quality of life.
30. Currently the services are funded and delivered from a number of sources including the NHS, MOD, Local Authority and a variety of Third Sector Organisations. This funding model will not change, however the new framework will enable and support individuals to improve the integration of these services, potentially through the greater use and management of Personal Health Budgets in order to deliver more holistic care to the individual.
31. The MOD is developing an options appraisal to consider the best way to take this work forward. Implementation is likely to begin in early 2017/18, subject to approval of the options appraisal.

## **Place and population based care**

32. The development of Sustainability and Transformation Plans (STP) has provided local communities the opportunity to develop greater collaboration across health and social care and deliver service transformation that results in long term sustainable health care. It is important, given the wide distribution of the armed forces population that we engage with STPs to ensure that we understand the impact of proposed changes, including new models of care, on our population.

## **Armed Forces Networks**

33. The Armed Forces Networks (AFN) offer an opportunity for commissioners and providers, as well as local authorities, MOD and charities to meet to consider the issues and needs of the armed forces community in their area. In addition to the networking capability that AFNs offer they provide an opportunity for dissemination and feedback, forming part of the Patient and Public Participation process. We will be review our existing models to develop a sustainable model with appropriate ownership to ensure they continue to be effective.

## **Public and Patient Participation**

34. Armed Forces commissioners are committed to establishing and implementing a new public and patient participation framework to inform and support our commissioning decisions and actions. The framework builds on the NHS England Patient and Public Participation (PPP) Policy, and has been co-produced with a mix of stakeholders including the Armed Forces PPP Group, and members of Armed Forces Clinical Reference Group (CRG).
35. Further engagement work is anticipated during the autumn of 2016 to strengthen our approach, with the final framework being in place to support our work from April 2017.

## Clinically driven change

36. We will be working with our CRG to review our activity to identify areas and pathways which, the Right Care methodology suggests may offer opportunities for improvement.
37. The following are key priorities in the CRG's work plan for 2017/18 and 2018/19:
  - Increase the profile and understanding of the Armed Forces community and especially veterans particularly in NHS general practitioners.
  - Improve the co-ordination of NHS services for patients with mental health problems for the Armed Forces Community including working with MOD for patients still serving, as they transition from being in uniform into civilian life and thereafter.
  - Improve the responsiveness of the NHS to musculoskeletal problems including rehabilitation
  - Improve the responsiveness of the NHS to Armed Forces issues by better integration with community in secondary care, possibly in partnership with vanguard sites, and in line with the intentions set out in the Five Year Forward View;
  - Improve the co-ordination and services of NHS care for family members of the Armed Forces Community
  - Improve the co-ordination of NHS services for members of the Armed Forces Community in contact with the criminal justice system.
  - Respond to changes in MOD provision following the Strategic Defence Security Review.
  - Improve the understanding of the requirements of the Armed Forces Covenant in partner organisations including NHS providers and CCGs

## Service developments

38. NHS England has a prioritisation framework to guide the work of its direct commissioning functions and a CRG, which enables decisions to be made regarding investment and if necessary dis-investment in services to best meet healthcare need within available resources. These proposals are assessed by the Armed Forces CRG which advises NHS England on all Armed Forces health commissioned services.
39. Investment in new services and interventions will be prioritised using the prioritisation framework. This will ensure that the range of services and interventions are optimised to best meet the needs of patients within available resources.
40. Service developments with a financial impact for existing providers of a given service will only be approved where they were initiated with NHS England's formal agreement. They will need to demonstrate measurable outcome and value improvements and will need to be agreed as part of the national prioritisation process and where resources have been released from elsewhere within an achievable balanced national financial plan. Where development or changes to the clinical eligibility policy for a treatment would warrant new

provider entry or revisiting the assessment of existing providers as the most capable to provide a significantly changed service, this will be managed through the service and commissioning review process with existing and potential providers considered for procurement.

41. For the avoidance of doubt, the regional commissioning team is unable to give support to cost increasing business case proposals outside of the national process. Providers should not initiate service changes or developments without prior commissioner approval.

## Our approach to contracting

### Practical arrangements

42. NHS England will normally only hold (or be party to) one NHS Standard Contract with any provider unless explicitly advised during any given procurement. Armed Forces health services requirements will be included as separate contract schedules within specialised service provider contracts, in a similar way that providers hold schedules for lead and associate CCG commissioners and, for those services, providers should invoice the South Central regional team.
43. NHS England has previously adopted a commissioner hierarchy amongst its directly commissioned services for the purposes of determining who the responsible payer is. This hierarchy has been developed into an algorithm and associated guidance (the Commissioner Assignment Method (CAM)). This is available at: <https://www.england.nhs.uk/ourwork/tsd/data-services/>
44. All contracts will use the following national standardised documents:
  - Indicative Activity Plan standardised formatted template
  - Local Prices standardised formatted template
  - Local Quality Requirements
  - Information Requirements (already in the NHS Standard Contract)
  - Service Specifications
  - Generic and clinical commissioning policies
45. To support continued reduction in local transaction costs further national standardisation of schedules will be considered over the next two years.
46. Increasingly as part of networked provider arrangements subcontracting will play an important role in commissioned services. In line with the NHS Standard Contract, providers will be expected to agree and obtain written approval in advance from the commissioner to enter into any material sub-contracts. This will include pharmacy services with particular reference to the Carter Review medicines optimisation recommendations. Existing sub-contract arrangements should jointly reviewed and documented within the 2017-19 contract as per the terms of the NHS Standard Contract. NHS England requires full transparency of sub-contracting pricing agreements including where these inform pass through payments, to be set out in the local price schedule. For the avoidance of doubt

providers cannot enter into agreements with an implication on reimbursement from NHS England without commissioner agreement.

47. NHS England will advertise intended contract awards and any market testing or procurement through the government 'Contracts Finder' website meeting the objectives of proportionality, transparency and non-discrimination for current or potential providers from the NHS, independent or third sector in line with the new Public Contract Regulations.
48. The introduction of HRG4+ and refresh of specialist top ups is a significant improvement in the accurate attribution of costs relative to patient complexity. NHS England does not expect to make payments above mandatory tariffs for services.
49. NHS England will only make payment where treatment complies with relevant published policies, and based on priced patient activity reflected in contracts. No resources are available for transitional financial payments. Providers will be expected to provide sufficient data to enable NHS England to validate invoices to ensure that all payments for armed forces health services are compliant with commissioning policy and are as per the rules of the National Tariff Payment System. The invoice validation process supports the delivery of patient care across the NHS and is vital to ensure NHS England fulfils its statutory duties of fiscal probity and scrutiny.
50. NHS England will operate in line with the National Tariff Document (NTD) when published.
51. Payments for high cost drugs and devices excluded from National Tariff should, if approved, be made on the basis of a pass through of the actual price charged to providers (prior to consideration of any contract level risk sharing mechanisms). Auditable information to validate payment of excluded drugs and devices will be required, in line with the NHS Standard Contract.
52. NHS England will also explore the opportunities for longer than 2 year contracts (including contract term and option to extend) with tier 1 and 2 providers where this affords opportunities for significant improvements in service quality and efficiency, and builds on effective existing contractual arrangements.

### **Capacity Planning and service developments**

53. Capacity planning to inform contract discussions will take place in the early autumn and should start from a 'no intervention'<sup>4</sup> basis. There are some demographic changes associated with the rebasing of service personnel and their families from Germany; these are not expected to be significant until the summer of 2018 and plans to manage the impact of these demographic changes with local CCGs and providers are at a mature stage. Commissioners will take responsibility for the final decision on these forecasts in line with their responsibilities to determine the level of care to commission.

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<sup>4</sup> Forecasting future activity with existing demand management and QIPP measures but prior to incorporating additional QIPP measures or initiatives

54. The regional team and providers will have early discussions to inform the affordable contract envelope for services, and develop solutions to ensure continued delivery of care within available resources.
55. Initiatives which impact on a 'no intervention' plan, with clear responsibilities and constructive engagement will be vital to ensure that contracts remain affordable. NHS England local offices will discuss a range of QIPP projects which have been developed by CRGs on a national basis, as well as locally identified projects. In many cases, provider clinical teams are in a good position to identify local opportunities and should add to the portfolio of planned change, to ensure that the volume growth and efficiency of pathways and episodes of care are addressed in plans
56. All new investment decisions will be subject to a prioritisation process. As set out in previous years providers should not initiate service changes and developments without prior commissioner approval as cost impacts will not be funded unless considered in advance through this process.

### **Prior Approvals and Individual Funding Requests**

57. There are a number of clinical commissioning policies that are subject to prior approval. These include the assisted conception policy and a number of policies for procedures that may be considered to be cosmetic. Treatments that have not secured prior approval will not be funded.  
[www.england.nhs.uk/commissioning/policies/ssp/](http://www.england.nhs.uk/commissioning/policies/ssp/)
58. Requests for prior approval should be made on the appropriate form and sent to [england.armedforcespriorapprovals@nhs.net](mailto:england.armedforcespriorapprovals@nhs.net)
59. Arrangements for Individual Funding Requests (IFRs) will continue in 2017/18 and 2018/19. Further details on IFRs, including the application form, are available at: [www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf)

### **CQUIN**

60. Armed Forces personnel and their families move home more frequently than the general population due to their military commitment. In seeking assurance that providers of NHS services are compliant with the Armed Forces Covenant in relation to 'no disadvantage' as a result of these moves, we focussed our 2016/17 CQUIN on ensuring the issues of mobility for armed forces community were reflected in access policies.
61. CQUINs for 2017/18 and 2018/19 will be developed in accordance with the planning guidance, to build upon the 2016/17 CQUIN.

### **Quality, Innovation, Productivity and Prevention (QIPP)**

62. There are a number of strands to our approach to QIPP. These are:
  - Ensuring we spend our resources in the most effective way.

- Working with CCGs to design and implement QIPP schemes that impact on the services we co-commission and ensuring that the elements of savings accrued from acute trust based QIPP schemes agreed with co-commissioners of the service are drawn down proportionate to the caseload.
- Working with MOD to ensure that there is a tax payer benefit to our actions, for example commissioning services to increase deployability.

63. We will work with our colleagues in DMS to consider what QIPP opportunities may exist through delivering care in a different or more efficient way:
- repatriation / movement of minor procedures to out of hospital settings where this is both clinically and cost effective
  - reduction in the ratio of follow ups to new out-patient appointments where clinically appropriate
  - increased work up / access to care in primary care settings to prevent hospital referral
  - direct access for diagnostic testing
  - improved immunisation and screening take up and recording.

## Key contacts

### Regional Team

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## Glossary

AFN	Armed Forces Network
APS	Annual population survey
CAM	Commissioner assignment methodology
CCG	Clinical Commissioning Group
CQUIN	Commissioning for quality and innovation
CRG	Clinical reference group
DMS	Defence Medical Services
DPHC	Defence Primary Healthcare
HRG4+	Health resource group v.4+
IFR	Individual funding request
IHDCS	Integrated high dependency care system
MOD	Ministry of Defence
MSK	Musculoskeletal
NTD	National tariff document
OSV	overseas visitor
PPP	Patient and public participation
PTSD	post-traumatic stress disorder
QIPP	quality, innovation, productivity and prevention
STP	sustainability and transformation plan
UK	United Kingdom
VPP	Veterans' prosthetics panel

## Responsible commissioners

	<b>Serving Armed Forces / Mobilised Reservists</b>	<b>Families with DMS</b>	<b>Families not with DMS</b>	<b>Non Mobilised Reservists</b>	<b>Veterans</b>
Primary Medical Care	DMS	DMS	NHS - 1° care	NHS - 1° care	NHS - 1° care
Out of hours	DMS	DMS	CCG	CCG	CCG
Primary Dental Care	DMS	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental
Operational Care (anywhere)	DMS				
Primary Medical Care (Overseas)	DMS	DMS			
Primary Dental Care (Overseas)	DMS	DMS			
Blue light ambulance	CCG	CCG	CCG	CCG	CCG
Emergency care	NHS - AF	NHS - AF	CCG	CCG	CCG
Emergency care (Overseas)	DMS	DMS			
Secondary care (dental)	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental
Secondary care (non-specialised)	NHS - AF	NHS - AF	CCG	CCG	CCG
Secondary care (specialised)	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec
Secondary care (delivered Overseas)	DMS	DMS			
Secondary care (Overseas returned to England)	CCG – OSV	CCG - OSV			
Community care	DMS & NHS - AF	NHS - AF	CCG	CCG	CCG
Community care (delivered Overseas)	DMS	DMS			
Mental health (non-specialised)	DMS & NHS - AF	NHS - AF	CCG	CCG	CCG
Mental health (delivered Overseas)	DMS	DMS			
Mental health (specialised)	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec
Rehabilitation (post injury)	DMS provision				
IVF (WIS cohort)	NHS AF & DH			CCG & DH	CCG & DH



	<b>Serving Armed Forces / Mobilised Reservists</b>	<b>Families with DMS</b>	<b>Families not with DMS</b>	<b>Non Mobilised Reservists</b>	<b>Veterans</b>
IVF	NHS - AF	NHS - AF	NHS - AF	CCG	CCG
Continuing Healthcare (CHC)	NHS - AF	NHS - AF	CCG	CCG	CCG
Public Health (Screening & Immunisations)	NHS - PH	NHS - PH	NHS - PH	NHS - PH	NHS - PH
Public Health (0-5)		local authority	local authority		
Occupational Health	DMS				
Prosthetics	DMS & NHS - VPP	NHS - Spec	NHS - Spec	NHS – VPP / NHS – Spec	NHS – VPP / NHS – Spec
Wheelchairs	DMS	NHS - AF	CCG	CCG	CCG

Key:

CCG	Clinical Commissioning Group
CCG OSV	CCG Overseas Visitor funding
DMS	Defence Medical Services
DH	Department of Health
NHS - AF	NHS England (Armed Forces Health)
NHS - Dental	NHS England (Dental)
NHS - 1° care	NHS England (Primary Care)
NHS – PH	NHS England (Public Health)
NHS – Spec	NHS England (Specialised Commissioning)
NHS – VPP	NHS England (veterans' prosthetics panel)

# **Public Health Section 7A**

## **Commissioning Intentions 2017-18**



**NHS England INFORMATION READER BOX****Directorate**

<b>Medical</b>	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
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## Public Health Section 7A

### Commissioning Intentions 2017-18

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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## 1 Purpose

This document sets out for commissioners and healthcare providers notice of NHS England's commissioning intentions for certain Public Health services for 2017/18, commissioned as part of the NHS Public Health Functions Agreement under s.7A of the NHS Act 2006<sup>1</sup>.

All commissioning intentions are subject to completion of the s.7A Agreement 2017/18.

The document supports NHS England's ambitions to improve health outcomes, tackle inequalities and secure the best value for money. It builds on the 2016/17 commissioning intentions and reflects the Five Year Forward View's vision and focus on prevention and public health.

## 2 Introduction

NHS England has continued to commission the services set out under the s.7A agreement to a high standard, offering continued protection to the public. Data and evidence demonstrates that public health protection remains world class and we have achieved real success. By implementing the ambitions in the s.7A agreement, approximately 30 million children, adolescents and adults have access to screening and immunisation programmes each year, which contributes significantly to wider prevention agenda and implementation of the Five Year Forward View (FYFV). Implementation of the Health and Justice Indicators of Performance (HJIPs), which include indicators piloting of Sexual Assault Referral Centres (SARCS) indicators of performance, has made a step change in the ability to measure service delivery and effectiveness, enabling better informed commissioning decisions, which will, in turn, lead to improved outcomes.

However, variation in performance across England remains a challenge across the public health services portfolio. The focus on improving access, quality, effective delivery and value needs to be relentless, supported by better business intelligence data and an improved understanding of the roles and responsibilities of commissioners and partners at all levels in the system.

The s.7A agreement is based on a shared commitment and a requirement to work in partnership with the Department of Health (DH), NHS England and Public Health England (PHE), to achieve the benefits of this agreement for the people of England to protect and improve the public's health. The s.7A is delivered in the context of the Five Year Forward View and the 2015 Spending Review.

In line with this requirement and the Five Year Forward View, we aim to:

- improve public health outcomes and reduce health inequalities, and
- contribute to a more sustainable public health, health and care system

In order to achieve this NHS England under the NHS Public Health Functions Agreement in 2017/ 2018 (s.7A) has two objectives:

<sup>1</sup> Exercise of Secretary of State's public health functions inserted by s. 22 of the Health and Social Care Act 2012

- 1) commission high quality public health services in England, with efficient use of s.7A resources, seeking to achieve positive health outcomes and reducing inequalities in health.
- 2) implement planned changes in s.7A services in a safe and sustainable manner, promptly and thoroughly.

### 3 Operating Model for Public Health Section 7A

Within the system for the delivery of public health services, partners including the DH, NHS England, PHE, local authorities (LAs), clinical commissioning groups (CCGs) and providers, will work together to deliver patient outcomes.

The Section 7A agreement for 2017/18 will describe the services that will be commissioned by NHS England in 2017/18 subject to agreement by the NHS England Board and Secretary of State for Health. The services are:

- Immunisation programmes
- Screening Programmes – cancer and non-cancer,
- Quality improvement to the Child Health Information Services (CHIS), including Child Health Records Department (CHRDs) and IT Systems according to the updated output based specification published in 2015;
- Public health services for people in prison and other places of detention, including those held in the Children & Young People's Secure Estate
- Sexual Assault Referral Centres (SARCs)

The programmes are underpinned by a set of service specifications, and national standards to support commissioning and contracting.

Outside of scope of the 2017/18 s.7A, PHE is working closely with NHS England to pilot services that may become part of the s.7A in future years subject to negotiation.

### 4 Improving Coverage and Uptake

The cancer strategy published in 2015, sets clear ambitions for improvement, with particular focus on presentation and early diagnosis. Due consideration and action is required to reverse the trend of declining uptake and coverage of the cancer screening programmes - in particular, the cervical screening programme and breast cancer screening programmes for vulnerable groups.

Performance indicators show that there has been a decline in uptake for some programmes and there is variation in performance. NHS England commissioners, PHE and local providers will be required to work together to reduce variation and bring all areas up to the performance of the best. Three programmes; cervical screening, breast screening and childhood immunisations (MMR) have been the focus of a tripartite spotlight. The tripartite spotlight brings NHS England, PHE, the DH and other stakeholders together to consider a programme in more detail and to recommend actions. NHS England local teams will be asked to act upon spotlight recommendations.

The delivery of s.7A services for armed forces personnel and their mobile families (registered with both NHS and Ministry of Defence GPs) are part of our

responsibilities for s.7A; and as part of the Armed Forces Covenant it is important that the armed forces community suffer no disadvantage from their service. Building on the developments and pathway changes delivered for cervical screening across Defence Medical Services (DMS) and NHS, there will be a focus on increasing access and integration for Bowel Cancer, Breast Cancer, Abdominal Aortic Aneurysm and Diabetic Retinopathy Screening Programmes. The exact way that this will be done will be jointly agreed due to the unusual demographics of this population (mainly young and male) that is also widely dispersed, mobile and has different security and IT interface issues.

The provision of the sexual assault referral centres (SARC) service were enhanced in 2016/17 including by the rollout of the Sexual Assault Referral Centres Indicators of Performance (SARCIPS). Services will be further enhanced by the amendments to include sign-posting enquiries for child sexual assault and or exploitation (CSA/ CSE), via collaborative relationships between NHS England, PHE, the police, Police and Crime Commissioners (PCCs), clinical commissioning groups (CCGs) and local authorities.

## 4.1 Equality and Health Inequalities

The objectives of screening and immunisation programmes should include:

Help to promote equality and reduce health inequalities through the delivery of the programme.

Key deliverables:

- Screening and immunisations should be delivered in a way which addresses local health inequalities, tailoring and targeting interventions when necessary.
- An [Equality and Health Inequalities Analysis](#) should be undertaken as part of both the commissioning and review of programmes, including equality characteristics, socio-economic factors and local vulnerable populations.
- Services should be delivered in a culturally sensitive way to meet the needs of local diverse populations so far as is lawful and reasonably practicable.
- User involvement should include representation from service users with equality characteristics reflecting the local community, including those with protected characteristics and inclusion health groups – homeless people & rough sleepers, gypsy and traveller groups, vulnerable migrants and sex workers.
- Providers should act reasonably and lawfully, and exercise high levels of diligence when considering excluding people with protected characteristics in their population from the programme and follow both equality, health inequality and screening guidance when making such decisions, ensuring any potential adverse or positive impact is appropriately recorded.

The provider will be able to demonstrate what systems are in place to address health inequalities and ensure equity of access to screening, subsequent diagnostic testing and outcomes. This will include, for example, how the services are designed to ensure that there are no obstacles to access on the grounds of the nine protected characteristics as defined in the Equality Act 2010.

Guidance on the Equality Act 2010 can be found here: <https://www.gov.uk/equality-act-2010-guidance>



The provider will have procedures in place to identify and support those persons who are considered vulnerable/ find services hard-to-reach, including but not limited to, those who are not registered with a GP; homeless people and rough sleepers, asylum seekers, gypsy traveller groups and sex workers; those in prison; those with mental health problems; those with drug or alcohol harm issues; those with learning disabilities, physical disabilities or communications difficulties.

The provider will comply with safeguarding policies and good practice recommendations.

Providers are expected to meet the public sector Equality Duty which means considering all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

It also requires that public bodies:

- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

## 5 Patient and Public Involvement

In upholding the NHS Constitution, NHS England is committed to ensuring that patients are at the centre of every decision that NHS England makes. Putting patients first needs to be a shared principle in all that we do. NHS England, through the local teams, will ensure that this is demonstrated in the way care is commissioned and provided and will monitor it through our formal contracting process with providers. It will be working to develop and improve the impact of patient and public involvement by implementing a new soon to be published framework for participation in commissioning of s.7a services.

It is essential that all providers of public health s.7A services demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making about their treatment and care.

Commissioners and providers are required to demonstrate real and effective patient participation, by working with local communities and groups including the voluntary and community sector, particularly in areas such as service improvement and redesign. Providers should commission and/ or deliver in house assessment of the quality of the patient experience, with expectations that this will be at least satisfactory with improvement plans in place as appropriate.

Providers of public health s.7A services should look to provide accessible means for patients to be able to express their views about, and their experiences of, services, making best use of the latest available technology and social media as well as conventional methods.

As well as capturing patient experience feedback from a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback.

Specifically providers should report outcomes of the Friends and Family Test for services specific to s.7A to identify levels of satisfaction every quarter and areas for potential improvement.

## 6 Training

Providers have the responsibility to ensure that service provision:

- is delivered and supported by suitably trained, competent healthcare professionals who participate in recognised ongoing training and development for example, as per PHE National Minimum Standards for Immunisation Training;
- is supported by regular and accurate data collection using the appropriate returns.

Providers must make provision to ensure all staff training is current and covers competencies required, and evidence to give assurance to commissioners of this as appropriate, allowing for appropriate annual CPD in line with s.7A programme requirements, such as study day or completion of e-learning as appropriate.

Providers are asked to promote engagement with the Level 3 Diploma for Health Screeners. The qualification is for non-professionally regulated screening staff in the NHS Diabetic Eye Screening Programme, NHS Abdominal Aortic Aneurysm Screening Programme and NHS Newborn Hearing Screening Programme.

## 7 Data Collection - Business Intelligence

Arden and Greater East Midlands Commissioning Support Unit (Arden & GEM CSU), as part of its contract with NHS England to deliver commissioning support for directly commissioned services, will lead the collection of business intelligence data for s.7A programmes. There is an expectation that there will be a consistent approach to data collection, with data flowing into centralised repositories.

To support the collection of business intelligence data for s.7A programmes as part of the contract for all directly commissioned services, we expect commissioner and providers to use the national information schedules for the following programmes;

- Breast Cancer Screening
- Diabetic Eye Screening
- Abdominal Aortic Aneurysm Screening

## 8 Data Collection – Screening Uptake and Coverage

PHE and NHS England have developed a Memorandum of Understanding (MOU) to describe the working relationship between the two organisations for the purpose of data sharing. The data allows identification of local good practice or areas to be improved, comparison with appropriate areas, assessment of improvement activities and active management of provider performance at a range of levels eg PHE centre footprint, NHS England local teams, and local authorities.

## 9 Planned Programme Changes 2017/18

The key planned additions to the existing s.7A programmes are:

- Influenza immunisation will continue to be offered to all children aged 2, 3 and 4; and to all children of appropriate age for school years 1, 2, 3 and 4.
- NHS England will continue to commission bowel scope screening centres to an agreed trajectory as part of the new NHS Bowel Cancer Screening Programme.
- NHS England will take responsibility for commissioning wave 3 bowel scope screening centres as at 1 April 2017 as part of the new NHS Bowel Cancer Screening Programme .

The majority of the existing s.7A programmes have a number of clarifications relating to the agreed models of delivery, quality assurance processes, training, and the equality responsibilities of providers. Details will be found in the s.7A service specifications to be published late in 2016

### Key Programme Change Deliverables

<b>Key deliverables (shown in bold)</b>
<p>NHS Newborn Blood Spot Screening Programme</p> <p><b>In 2017-18, NHS England will introduce Saturday morning checking of results and appropriate action for Medium-chain acyl-CoA dehydrogenase deficiency (MCADD), isovaleric acidaemia (IVA) and maple syrup urine disease (MSUD).</b></p>
<p>NHS Cervical Screening Programme</p> <p><b>In 2017/18 NHS England will:</b></p> <ul style="list-style-type: none"> <li>• <b>work with PHE to develop mitigation plans to ensure local service delivery during the development of planning to introduce HPV primary screening.</b></li> </ul>
<p>NHS Fetal Anomaly Screening Programme</p> <p><b>In 2017-18 NHS England will work with PHE to pilot a KPI to measure coverage of the screening for Down's, Edwards' and Patau's syndromes in order to improve the safety and quality of the programme so that women who have accepted the offer of screening do not miss screening.</b></p> <p><b>In 2017 – 18 NHS England will drive quality and improvement by implementing a change to the Down's Syndrome Screening Quality Assurance Service sonography flag allocation.</b></p> <p><b>In 2017/18 NHS England will work with PHE to develop education and training resources, standards and information development to prepare for the possible introduction of an additional test to the current screening pathway.</b></p>
<p>NHS Diabetic Eye Screening programme</p> <p><b>In 2017-18 NHS England will work with PHE on a framework around improvements in the quality of grading to support moving to extended intervals. Routine measures using available data will be needed to pro-actively support services and individual graders to improve the quality of their grading in preparation for moving to extended intervals.</b></p>

## NHS Newborn and Infant Physical Examination Programme

**In 2017-18, NHS England will work with PHE 2017/18 to plan and develop the standards/ pilot stages of an agreed model for delivering the 6-8 weeks examination.**

## NHS Bowel Cancer Screening Programme

**In 2017-18, NHS England will**

- **commission all bowel scope services from 1 April 2017 so each centre delivers an agreed level of activity and thus roll-out to include more general practices in the programme**
- **make efforts to improve uptake in bowel scope and FOBt in line with the recommendation of the independent Cancer Taskforce**
- **work closely with PHE to prepare for the implementation of the Faecal Immunochemical Test (FIT) to replace FOBt**

## MenACWY immunisation programme

**In 2017/18, NHS England will:**

- **continue to provide the MenACWY vaccine as part of the routine adolescent schools programme (school year 9 or 10).**
- **carry out a catch-up campaign for those students in school years 10-12 [Note: this will mainly be done throughout academic year 16/17 but some might be done in the summer term of 17 i.e. at the start of 17/18 financial year]**
- **carry out a catch-up campaign for those students in school years 13**
- **continue to offer immunisation to all first time university entrants ("freshers") up to 25 years of age**

*The MenACWY programme was introduced in August 2015 as an emergency programme to control a national outbreak of MenW disease. It will need to continue in 2017/18. The main aim of the programme is to control the rapid increase in MenW cases by interrupting transmission of MenW within the population. This is being done by targeting the teenage population, where the rates of transmission are highest, with vaccination. This will prevent onward transmission to susceptible children and adults, as well as providing direct protection to the teenagers themselves.*

## Improving MMR vaccination uptake

**In 2017/18 NHS England will:**

- **continue to ensure opportunities to improve MMR uptake**
- **ensure that local action plans are developed in response to the spotlight session on MMR uptake held in June 2016 and that progress is made in implementing these plans.**
- **improve MMR vaccination coverage for one dose (5 year olds) and for two doses (5 year olds).**

*Improvement of MMR vaccination coverage for one dose (5 year olds) and for two doses (5 year olds) will support the UK government's commitment to the WHO European regional target to eliminate both measles and rubella infections by 2020. An increase in MMR uptake could result in treatment savings elsewhere in the NHS system by reducing the risk of morbidity from measles, mumps and rubella and the risk of onward transmission.*

## Shingles immunisation programme

**In 2017/18, NHS England will:**

- **continue the rollout of the shingles vaccination programme. From 1 September 2017 shingles vaccine should be offered:**
  - **to patients who are aged 70 years on or after 1 September 2013 and they remain eligible until 80<sup>th</sup> birthday**
  - **as a catch up to those patients aged 78 years and they remain eligible until 80<sup>th</sup> birthday**

*Shingles immunisation was introduced into the national immunisation programme in September 2013. The first years of the programme are being run with a phased catch-up alongside a routine programme for 70 year-olds. The aim of the programme is to reduce the incidence and severity of shingles disease in older people.*

## Maternal pertussis programme

**In 2017/18, NHS England will:**

- **review the commissioning arrangements for maternal pertussis vaccination to consider extending the provision through maternity units, in order to improve coverage and timeliness of vaccination**

*The maternal pertussis programme was introduced in October 2012 in response to an increase in pertussis in infants too young to be protected by the routine programme. The programme has been highly effective with deaths and cases in infants reduced. Coverage in the programme is around 60% and of the 16 deaths in infants since 2012 only two have been born to vaccinated women - both were vaccinated late in pregnancy. In April 2016, based on new evidence, JCVI advised that recommended window for vaccination was changed to be at any stage after 16 weeks gestation, which offers more opportunity for undertaking this at the same time as other obstetric visits. The importance of maternity units communicating with primary care remains.*

## Childhood flu immunisation programme

**In 2017-18, NHS England will:**

- a) arrange provision of flu vaccination for all children 2, 3 and 4 years of age at 31 Aug 2017;**
- b) arrange provision for flu vaccination for all children eligible for schooling in years 1, 2, 3 and 4 (i.e. 5, 6, 7 and 8 year olds, including those who turn 9 on or after 1 September 2017); and**
- c) Continue to arrange provision for all primary school aged children in those areas included in the 2016-17 pilots for primary school aged children.**

*The best uptake of vaccination among 5 to less than 17 year olds is likely to be achieved through a predominantly school-based programme, with a limited provision and second opportunity sessions in other community settings in some localities.*

- *Ensure access for all children, including those not in mainstream school, or attending schools which do not participate in the programme*

## 10 Service Developments

NHS England commissioners will engage the national PHE Screening Division in discussions on local screening programme reconfigurations. This is to ensure that Quality Assurance and IT change issues are adequately considered and timescales are managed effectively.

### 10.1 Bowel Cancer Screening Programme

NHS England will continue to commission bowel scope screening centres to an agreed trajectory as part of the NHS Bowel Cancer Screening Programme.

To ensure operational deliverability and the continued affordability of the programme, commissioners are requested to work with bowel scope providers to review the existing roll-out plan for each provider. Commissioners and providers should consider the roll-out plan in the light of the provider's delivery of the first six months of the existing 2016/17 plan.

In addition, NHS England will take responsibility for commissioning wave three bowel scope screening centres as at 1 April 2017.

### 10.2 Diabetic Eye Screening - Centralised IT system

There is a requirement to embed national policy and consistently high standards of performance and safety within the local delivery of diabetic eye screening. Evidence suggests that the most cost-effective method is to implement a common national software solution. NHS England will support PHE in the implementation of the national software, to achieve standardised local programme operation through common IT system design and core functionality.

### 10.3 CHIS and the Children's Digital Health Strategy

NHS England commissioners of Child Health Information Services (CHIS) will work collaboratively with the team delivering the paperless 2020 vision; in order to realise the recommendations from the National Incident Report, and to assess and support future service redesign and the development of a five year roadmap. Contracts will be required to have specific break clause to accommodate the expected change.

NHS England will continue to commission CHIS in an affordable and operationally robust way, continuing support for the health visiting data flows to CHIS to meet service requirements outlined in S7a Service Specification 28, particularly during any period of transition where local authorities have procured health visiting services from new providers.



## 11 PHE Pilots and Developments

NHS England will support the development and delivery of the following screening and immunisation pilots programmes and developments, some of which are not currently part of s.7A but could be transferred into future s.7A agreements subject to negotiation and agreement on funding. This will ensure that planning and delivery fits with routine commissioning and development protocols within NHS England.

### 11.1 Breast Cancer Screening

The breast cancer screening 6 year age extension trial will continue until end 2020. Transfer and continuation is subject to favourable outcomes from the trial and policy agreement with commissioners.

### 11.2 Diabetic Eye Screening

The NHS DES programme is working on a framework around improvements in the quality of grading to support moving to extended intervals. Routine measures using available data will be needed to pro-actively support services and individual graders to improve the quality of their grading in preparation for moving to extended intervals. This work will require providers to undertake some performance improvement tasks based on factors identified through the development work.

### 11.3 Fetal Anomaly Screening

Fetal Anomaly Screening - Non-invasive pre-natal testing from anomalies in pregnancy (FASP) has an annual standard which measures coverage of the screening for Down's, Edwards' and Patau's syndromes. The data received from incidents in the NHS has identified that there is an on-going issue with women who have accepted the offer but miss screening, particularly at the interface between the first trimester combined screening and the Quadruple test. FASP will undertake a pilot process to ascertain the feasibility of this measure being reported quarterly as a Key Performance Indicator as a screening safety and quality issue.

To drive ongoing quality improvement, FASP and Down's syndrome quality assurance support service DQASS is consulting with sonographers regarding a change to the flag allocation to sonography datasets. The change will move the threshold for allocation of a red flag from the current 0.4mm to 0.3mm. The change would commence from the beginning of cycle 24 in 2017/18.

Non invasive pre-natal testing (NIPT). During 2017/18 PHE Screening Division will be developing education and training resources, standards and information development. The NHS will be asked to engage with the preparations for education and training, data and screening pathways.

### 11.4 HPV as Primary Screen

Following a review of results from the English HPV primary screening pilot sites and international evidence, the UK National Screening Committee recommended at its January 2016 meeting that HPV primary screening should be adopted by the

screening programme. Ministerial approval of HPV Primary Screening was announced by the minister in July 2016.

NHS England is working with PHE and an HPV primary screening implementation group has therefore been established with stakeholders. The group has representation from the various disciplines involved in the current cervical programme and sentinel (pilot) sites. HPV primary screening would affect all aspects of the programme pathway and would be a significant undertaking.

NHS England has been advised by PHE to take into consideration HPV primary screening when planning any cytology laboratory reconfigurations or procurements.

A full implementation plan has not yet been agreed; however, PHE and NHS England will continue to work in collaboration with clinical experts in the field. We are fully committed to working with the laboratory community and we look forward to continuing to receive clinical input and advice. Commissioners will continue to work with local laboratory providers during 2017/18 to mitigate any short term capacity issues.

## **11.5 Faecal Immunochemical Testing (FIT)**

The UK National Screening Committee recommended introducing faecal immunochemical testing (FIT) to replace the current (FOBt) test used in the bowel cancer screening programme. This is a more accurate test that should help identify and treat more cancers early in their development. Ministerial approval for the implementation of FIT has been announced. NHS England will work with PHE and other stakeholder during 2017/18 to develop plans for the implementation of FIT.

## **11.6 Newborn and Infant Physical Examination Programme**

In 2017/18 the PHE Screening Division will be planning and developing the standards / pilot stages of an agreed model and will need to engage with the NHS during this development phase. The PHE Screening Division will also be developing the work on IT Interoperability.

## **11.7 HPV vaccination for men who have sex with men (MSM)**

In 2016/17 NHS England will support PHE's pilot HPV vaccination programme for MSM. A pilot offering the human papillomavirus (HPV) vaccine to men who have sex with men (MSM) already attending participating sexual health clinics started in June 2016. It is being led by PHE. Up to 40,000 MSM will be offered the vaccine through the pilot and NHS England will use information from the pilot to inform future commissioning decisions related to this potential programme.



## 12 Collaborative Commissioning

NHS England directly commissions programmes under s.7A. Some flexibility and innovation is required in order to address specific challenges faced by some communities, and to ensure consistency of standards within available resource; this will help reduce inequalities and improve services across England.

Commissioners within the local health economies (CCGs, PHE, local authorities (LAs), Defence Medical Services, and NHS England) will work together across the whole pathway to develop evidence based pathways, e.g. bowel cancer and bowel scope screening to diagnosis, ensuring clarity of access for the relevant cohort across the commissioning landscape. These pathways can be used in contracting with providers, aligning incentives and accountability for outcomes. The approach of engaging commissioners will be the basis of future whole pathway commissioning.

## 13 Commissioning Resources

NHS England will commission and fund public health services directly following agreement between DH and NHS England of the Section 7A agreement. NHS England will set budgets at a geographical level for all programmes undertaken by providers within the allocation for the s.7A agreement. NHS England and providers working together will effectively manage high quality Public Health s.7A services within this finite resource.

Each region is responsible for ensuring the financial and quality performance of the contracts it holds for the whole population including relevant armed forces personnel based within England.

## 14 Contracts

### 14.1 NHS Standard Contract

NHS England mandates the NHS Standard Contract for use by commissioners for all contracts for healthcare services other than primary care.

National planning guidance to the NHS sets the expectation that commissioners will offer their high-value contracts with a term of at least two years with extension options in accordance with the [technical guidance](#).

### 14.2 Single Provider Contract

The intention for 2017/18 is that NHS England should normally only hold (or be party to) one NHS Standard Contract with any provider, which includes the five areas of direct commissioning with contract schedules.

### 14.3 Maternity Payment Pathway

The Aspects of the Maternity Pathway Payment for the Screening and Immunisations Programmes Guidance for Providers and Commissioners has been updated clarifying the payment mechanism for the new born blood spot programmes to

reduce administrative burden and the delivery of the BCG immunisation and Hep B immunisation.

## 15 Quality Assurance

All providers will participate fully in national quality assurance processes and respond in a timely manner to recommendations made, as appropriate. This will include submitting the following data to PHE Screening Quality Assurance Service (SQAS) who work alongside commissioners:

- data and reports from external quality assurance schemes
- minimum data sets as required – these may be required to be submitted to national external bodies
- self-assessment questionnaires / tools and associated evidence
- audits or data relating to nationally agreed internal quality assurance processes

Providers are expected to participate fully in the SQAS visit process where required and cooperate in undertaking ad-hoc audits and reviews as requested. Providers will respond to SQAS recommendations by the submission of action plans agreed by commissioners to address identified areas for improvement and any non-conformities / deviations from recommended performance thresholds.

Where a SQAS team believe there is a significant risk of harm to the population, they may recommend to commissioners to suspend a service.

## 16 Serious Incidents

The NHS England National Serious Incident Framework has been developed in partnership with providers, commissioners, regulators, and experts was refreshed and published in March 2015 and integrates with the Screening Serious Incidence guidance produced by PHE. In light of the potential impact of incidents in screening programmes on a large number of people, and the reputation of the programme, it is important that providers' are aware of and embed this guidance in all commissioned screening programmes.

## Appendix 1 - Services to be provided 2017-18

Programme category or programme	Services
Immunisation programmes	Neonatal hepatitis B immunisation programme
	Pertussis pregnant women immunisation programme
	Neonatal BCG immunisation programme
	Immunisation against diphtheria, tetanus, poliomyelitis, pertussis and Hib
	Rotavirus immunisation programme
	Meningitis B (MenB) immunisation programme
	Meningitis ACWY (MenACWY) immunisation programme
	Hib/MenC immunisation programme
	Pneumococcal immunisation programme
	DTaP/IPV and dTaP/IPV (pre-school booster) immunisation programme
	Measles, mumps and rubella (MMR) immunisation programme
	Human papillomavirus (HPV) immunisation programme
	Td/IPV (teenage booster) immunisation programme
	Seasonal influenza immunisation programme
	Seasonal influenza immunisation programme for children
	Shingles immunisation programme
Screening programmes	NHS Infectious Diseases in Pregnancy Screening Programme
	NHS Fetal Anomaly Screening Programme - Screening for Down's, Edwards' and Patau's Syndromes (Trisomy 21, 18 & 13)
	NHS Fetal Anomaly Screening Programme - 18+0 to 20+6 weeks fetal anomaly scan
	NHS Sickle Cell and Thalassaemia Screening Programme
	NHS Newborn Blood Spot Screening Programme
	NHS Newborn Hearing Screening Programme
	NHS Newborn and Infant Physical Examination Screening Programme
	NHS Diabetic Eye Screening Programme
	NHS Abdominal Aortic Aneurysm Screening Programme
Cancer screening programmes	NHS Breast Screening Programme
	NHS Cervical Screening
	NHS Bowel Cancer Screening Programme (including the Bowel Scope Screening Programme)
Child Health Information Systems	Child Health Information Systems
Public Health services for adults and children in secure & detained settings in England	Public Health Services for Children and Adults in Secure and Detained Settings in England
Sexual assault services	Sexual Assault Referral Centres



## **Commissioning Intentions 2017/2018 and 2018/2019 For Prescribed Specialised Services**

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## Executive summary

These commissioning intentions outline the strategic interventions to improve the way we commission and contract, review and transform specialised services. They build on progress already made to deliver consistent care standards across the country. They are based on the new strategic framework for Specialised Care set out in May 2016 which builds on the Five Year Forward View goals of a fully integrated health service delivering the best possible outcomes, within the resources available, for the population of England. To realise vision we will enable place and population-based care through much closer collaboration between NHS England and local commissioners on specialised service commissioning, as well as between commissioners and providers in the design and delivery of services. This new approach, to be reflected in all 44 Sustainability and transformation plans complements national clinical changes from Cancer, mental health, learning disability and maternity strategies and service reforms in the 6 specialised programmes of care including delivery of new, more networked models of care

This approach is delivered in a changing NHS context: Improvements for patients and sustainability of services have to be delivered within more constrained expenditure growth in the two years ahead. This provides a shared requirement for greater efficiency and productivity across the NHS for both commissioners and providers. The systematic year on year approach to productivity benefit realisation plans set out in the Carter review will form a key element of provider plans from 2017-2021. Specialised commissioning intentions support key areas of accountability for Trusts, ensuring they also deliver commissioning objectives for patients and tax payers:

- A clinical service redesign programme using operational practice and cost benchmarking will converge local prices to efficient levels and enable Trusts to deliver the planned reductions in resources per Weighted Activity Unit.
- Focusing support for our key providers as they progress implementation of clinical utilisation review and ensuring achievement together of multi-year benefit realisation plans using data to right size community services in STP footprints will enable providers to meet the Carter recommendations to deliver reduced length of stay and improved discharge and step down
- By April 2017 the NHS Supply Chain e-catalogue will be the single point of ordering for specialised high cost devices from all contracted hospitals, enabling leverage of the NHS purchasing power, with a clinically led review of the range and specification of devices from 2017 contributing to Carter procurement transformation plans, and improved performance on the purchase price index.
- Bringing together national work on cost-effective dispensing channels, high cost drugs optimisation, e-prescribing and work of the commercial medicines unit will ensure the NHS gets better value, with annual savings goals embedded in hospital pharmacy transformation plans, and reflected in CQUIN, planned contract expenditure and service development improvement plan milestones.



New specialised acute tariffs and top ups more accurately reimburse efficiently delivered complex care. The adoption of nationally consistent information rules provides a new enabler to systematically address unwarranted variation.

As NHS England supports the 'Getting it right first time' programme, a reduction in occasional practice and consolidation to expert centres will be reflected in updates to contract schedules. To maintain appropriate centres to achieve best quality for patients NHS England will only fund specialised services activity not reflected in contracted service lines by prior approval, and will only make payment where treatment complies with relevant published policies, and contracted datasets allow patient level validation of payment. NHS England will not make payments above national tariffs except where resulting from published national guidance.

The two year period of stability in tariff prices will be used to shadow and build evidence to support a range of changes to future reimbursement approaches, including service specific facility and infrastructure payments to reflect fixed costs, and alternatives to per-diem contracting for critical care and mental health. In secure Mental Health services, re-procurement following the current service review will enable transition to a new more recovery oriented payment model, with improved discharge and resettlement and user-led patient reported experience and outcome measures embedded in all contracts from 2017.

NHS England's single operating model will continue apply to all contracts. A provider specific CQUIN package with up to 10 nationally developed schemes will be offered to all contracted providers and will enable significant improvements in both quality and efficiency for patients. Existing ODNs funded through CQUIN monies will continue. Unless otherwise notified NHS England will normally only hold one NHS Standard Contract with any provider. Contracts will be for a minimum of 2 years with renewal options to support longer term transformation.

Substantial improvements in data quality are needed to drive the reforms set out in these intentions and the NHS has committed to driving compliance with national standards. There is continuity in contractually mandated formats for activity and local price plans. Provision of nationally defined datasets is a condition of reimbursement and accurate, patient-level itemised high cost drug expenditure is an immediate priority. Information flows are a key marker of and contribution to driving excellence in care that we expect from all those providing specialised services and contract sanctions will be applied systematically where needed to ensure all providers deliver on-time-in-full high quality data.

We are looking to achieve considered but prompt contractual agreement reflective of these priorities with clearly set goals for the coming years to ensure specialised services deliver the ambitions set out in the five year forward view for patients and provider service reforms achieve clinical excellence and financial sustainability.

## 1 Section 1: National Intentions

### 1.1 Purpose

These intentions provide notice to healthcare providers and partners about changes and planned developments in commissioning and delivery of prescribed specialised services. They should be read in conjunction with national planning guidance, the NHS standard contract, the National Tariff Payment System, and CQUIN guidance.

The aim is to enable providers to make early preparations and focus engagement with commissioners and clinical service leads for the 2017-19 planning process.

### 1.2 Context

#### 1.2.1 Strategic Framework

In May, NHS England set out a new strategic framework for specialised services. The framework articulated NHS England's vision for specialised services building on the Five Year Forward View goals of a fully integrated health service delivering the best possible outcomes for the population of England. Achieving our ambition will require changes in how services are commissioned and provided, with specialised care as a fundamental part of more integrated care for patients.

The framework sets out three key areas we will focus on for implementation:

- **Delivering place- and population-based care:** Local level collaboration to agree patient and service priorities, identify sustainable provider configuration and develop options for commissioning.
- **Providing national level support:** National support to enable local flexibility, including reform of clinical advice, improving data and information, support for innovation, and improving the prioritisation of new drugs and treatments.
- **Ensuring financial sustainability and value for money:** Putting in place financial controls in ways that provide clear incentives to transform provision and integrate specialised elements with the whole care pathway.

Over the last three months we have been working with a wide range of stakeholders to test and develop this framework. As part of this engagement we will also be closely working with four STP areas – South East London, Greater Manchester, Hereford and Worcester, and Cornwall – fast track progress in delivering this ambition.

Our Commissioning Intentions represent an important step in implementing the framework. They set out in particular how we will begin to move towards more place- and population based commissioning, supporting integrated care and promoting new models of provision, while also improving quality of care and ensuring financial sustainability.

### **1.3 Delivering place and population based care**

The development of Sustainability and Transformation Plans (STPs), local health and care strategies, provides us with the opportunity to develop greater collaboration and explore opportunities where local leaders can join-up the design and delivery of specialised services.

The transition to place and population based commissioning is challenging. Services are contracted directly by NHS England on a provider basis rather than population footprint, and the portfolio of 149 services is highly diverse in terms of both patient numbers and provider landscapes.

We are taking steps to strengthen the way in which services are commissioned, developing a more collaborative approach with local commissioners based on the shared priorities of the STPs. To support this more collaborative approach, we have been working with local commissioners to develop the approach, as set out in section 5.1. We are not expecting all services to use more collaborative commissioning arrangements from April 2017. However, we would expect to see progress on the national priorities of cancer, mental health and learning disabilities.

Some services will need to be commissioned on either a national or regional footprint. Although this means STPs will not systemically be invited to collaborate on the commissioning of those services NHS England will continue to work closely with STPs on achieving future provider landscape sustainability and enabling required transformation within those footprints.

### **1.4 Providing National Level Support**

To support place-based commissioning we will need to take action nationally:

- National clinical leadership –fundamental for all specialised services is providing national standards of quality and access. The recently revised remits of the national CRGs will mean our national clinical expertise can increasingly focus on setting standards on the outcomes that matter and highlighting models that deliver best quality and value;
- Information – central to driving service change and improving quality will be the better information on the cost and quality of services. A key part of the strategic framework will be improving information for commissioners, providers and for patients;
- Proactive management of new treatments pipeline - For population and place based approaches to be feasible, local health economy system leaders require stability and confidence in the resources they have available for the services they have planned to deliver; and

- Research & Development and Innovation – Innovation should be a systemic part of how specialised services are delivered. Major providers, most of whom have direct access to world-leading clinical research facilities, should be ‘designing in by default’ R&D to more of our care pathways and opening up new paths for innovation. This should include the use of “real world data” and quality improvement as well as formal clinical trials.

## 1.5 Ensuring financial sustainability and value for money

Underpinning the changes to way services are designed and delivered will be financial sustainability. Specialised services makes up over 15% of the NHS spending, and judicious stewardship will be crucial to meeting the financial challenges facing the NHS, both nationally and locally.

This document sets out how we will begin to meet the challenge over the next two years, in terms of managing new cost pressures and improve efficiency. It also sets out how we will put in place the foundations for service transformation.

## 2 Changes to the Scope of Specialised Services

Ministers have agreed that the following services should no longer be commissioned by CCGs; NHS England is working to put in place arrangements to commission these services on a national basis, including ensuring that an appropriate level of resource is transferred from CCGs:

- Some highly specialist adult male urological procedures (these are included in the revised Identification Rules and NHS England will contract for these procedures from April 2017);
- Primary ciliary dyskinesia management services for adults (the commissioning responsibility for this service will most likely transfer during 2017/18 through a contract variation);
- Some highly specialist adult haematology services, most likely services for patients with thrombotic thrombocytopenic purpura (the commissioning responsibility for this service will transfer between 2017 and 2019); and
- Patients with placenta accrete (the commissioning responsibility for this service will transfer between 2017 and 2019).

Ministers had previously agreed that there were certain additional elements of paediatric critical care services that should be commissioned by NHS England rather than by CCGs, including some aspects of patient retrieval. NHS England is in the process of undertaking a review of paediatric critical care services, the scope of which includes patient transport. Once this review is concluded, NHS England will put in place arrangements to enact any changes in commissioning responsibility as a contract variation after giving notice.

A service for patients with alpha-1 antitrypsin deficiency is being considered for prescription as a specialised service. If Ministers agree that the service should be commissioned by NHS England, a more detailed timetable for transfer of commissioning responsibility will be developed. Given that NHS England would need

to develop a service specification and select a small number of expert providers, it is unlikely that commissioning responsibility would transfer before 2017/18.

The Information rules (IR) baselining work undertaken in May and July 2016 will be used to secure the transfer of budget allocations to the appropriate commissioner. As a result all providers will be required to adopt in full the national identification rule set for contract activity from April 2017.

### **3 Strategic Intentions: Improving value for Patients from Specialised Care**

#### **3.1 Strengthen the way we commission**

Many services in the portfolio will need to be commissioned at a national or regional level. However, many would benefit from being planned on an STP or multi-STP footprint. Central to achieving the move to place-based commissioning will be maintaining both national service standards, outcomes and accountability for specialised services while providing local to flexibility in design and deliver services.

For contracts agreed for April 2017 NHS England is not intending to transfer commissioning responsibilities and budgets for any of the 149 services to CCGs. NHS England will remain accountable. However, we are looking for CCGs to take a greater role in planning and commissioning specialised services with NHS England.

For those services identified as potentially benefiting from being commissioned on an STP or multiple-STP footprint we are inviting STP leaders to explore how NHS England and STP partners can more formally collaborate on the commissioning of those services. To support this more collaborative approach, we have been working with local commissioners to develop:

- Clearer articulation of the services that might be most appropriate for locally led commissioning - See Annex B;
- Improved financial information at CCG level to support planning and monitoring;
- Governance options for greater collaborative commissioning, ranging from joint planning through to full devolution; and
- Continued financial incentives for CCGs to help drive efficiencies through collaboration on the whole patient pathway.

We are not expecting all services to use more collaborative commissioning arrangements from April 2017. For 2017/18 and 2018/19 we expect all STP footprints to focus on implementation of collaborative commissioning arrangements covering at least one of the following priority service areas: Cancer, Mental Health and Learning Disabilities.

We expect to see STP plans set out how the specialised commissioning spend can be increasingly joined up from April 2017 with the wider local health system spending to improve outcomes and value across the whole care pathway for those services. For more advanced and higher performing CCGs and STP footprints we will test feasibility of joint commissioning and delegation arrangements with NHS England

### 3.2 Reviewing and reshaping Specialised Services provision

Last year NHS England set out our approach to ensure that services are commissioned from the most capable providers through a rolling Strategic Service Review Programme with priorities published in commissioning intentions. This strategic programme complements regional and local programmes to address significant local service issues with collaborative commissioning colleagues.

From service reviews and from locally led change through sustainability and transformation plans, we expect there to be more networks of specialist providers and re-shaping supply models and contracting approaches to integrate care around patients. Service reviews will also provide opportunity for providers to propose sustainable solutions in line with clinically developed requirements. Service review implementation will also enable new payment approaches in order to incentivise improvement in care quality and patient experience.

Where the relationship between quality, value and patient volumes is strong we expect there to be consolidation of some services as a consequence of undertaking reviews.

NHS England will continue to undertake reviews using a structured programme methodology with provider selection carried out in an open and transparent way.

NHS England intends to use the service review programme to maintain and validate the assessment of commissioner requested services on a service line by service line basis, and as an input to the acute specialised service top up methodology, although as set out in national tariff payment system no changes beyond those announced for April 2017 are planned before April 2019.

Service reviews in progress that will have a transformational impact in 2017/18 include: Hyperbaric Oxygen Therapy, Prosthetics, Spinal Cord Injury, Paediatric Burns, Children's Epilepsy Surgery, Metabolic Medicine and Intestinal Failure. It also includes the Paediatric review of critical care & transport, surgery and ECMO which we expect to lead to a change of service specifications, formation of guidance and policy, revised quality metrics and an accompanying commissioning strategy. A further range of nationally and regionally led reviews planned for the coming year are set out in sections two and three

NHS England aims to build on the recommendations of the Cancer Taskforce and the progress already made to achieve its goals, such as changes to the Cancer Drugs Fund, Cancer Vanguard and the emergence of Cancer Alliances. Therefore, during the next two years an ambitious programme of cancer national service review will be completed. This will enable the development of innovative new care models and strengthened provider networks across the specialised commissioning cancer portfolio, closely linked to the Cancer Alliance population footprints. Our national service review programme will include radiotherapy, chemotherapy, cancer surgery, children's and young people's cancer services and a second phase of PET CT.

NHS England will build on the recommendations of the Mental Health Taskforce and will work with national, regional and local partners to ensure that we have a



consistent and integrated response to the 'Five Year Forward View for mental health'. Key areas of work will focus on the secure pathway, children's mental health services, perinatal services and the pathway of care for people with a learning disability. For all patient cohorts our intention is to ensure that people are cared for as close to home as possible in services that are as least institutional as possible. We will support the new models of care work that is delivered through the co-commissioning pilots and will stretch our ambition to move as swiftly as possible to integrated services near people's homes. We will continue our work on modernising how we pay for mental health services, ensuring that payment methodologies match clinical ambition for excellent care. Our work will be delivered through the Five Year Forward view for mental health ensuring that in policy development and service change we have a single way of monitoring progress and accelerating change.

### **3.3 Supporting the Development of New Models of Care**

Most of the initial STP plans submitted in July set out ambitions for more integrated approaches to the delivery of whole care pathways for these service areas. A number of plans also built on new models of care vanguards including development of 'whole population budgets' and 'lead provider contracts' with service providers, both inclusive of the specialised service element.

Such arrangements could enable both improved outcomes and improved value, and we will work with STP leaders to support transition in delivering their service priorities. In addition we would like invite groups of providers, who collectively deliver a specialised service across a whole national or regional footprint to develop proposals to ensure future sustainability and improve quality of that service. We would expect these proposals to build on models pioneered through the Acute Care Collaboration and other vanguard programmes i.e. moving to network, chain or franchise models.

Where groups of providers do come forward with collective and feasible proposals, NHS England will explore directly with them options around contracting and bespoke payment models, as well as how on we can assure again standards that are focussed more on the quality outcomes we expect to be delivered for out-patients.

### **3.4 Clinically Driven Change**

Two year commissioning intentions create a platform for a substantial programme of clinical service change. A refresh of the clinical advisory arrangements brings 42 new clinical reference groups combining national and regional clinical leadership, patient and public voice, the related colleges and associations, public health and commissioning leaders. The six national programmes of care are strengthened to lead and maintain the momentum of change.

National working groups are being established to deliver a series of clinical connections joining key organisations to the Forward View task of aligning national leadership. A 'Research' group will form links with NIHR to bring closer research strategies to service delivery strategies. A 'Guidelines' group will support the work of NICE helping inform their appraisal priorities and provide detailed service feedback on their work. A 'Data and Resource' group will forge effective links with NHS Digital and NHS Improvement as clinical service change thrives with high quality information and the enabling acceleration effects on change of well-constructed tariff. A 'Value'

group will link the innovation of Right Care, GIRFT, and other streams of work seeking enablers for at scale adoption.

NHS England will continue to prioritise potential new interventions for patients within available funding building on recent reforms to the policy and process, and will explore ways to align policy development more closely to the annual prioritisation process for future years.

We expect to see evidence that provider Executive Quality Leads are seeking to establish work programmes in their organisations in response to evidence of outlying performance from Quality Dashboards, self-declared service specification compliance, national audits and other sources of quality information such as surgeon specific outcomes. Provider derogations from service specifications will only be used to allow service contracts to be let if there is a well-defined work programme to achieve all service specifications approved by the Regional Clinical Director. In turn the national specialised commissioning team will establish a programme of simplifying service specifications.

Specialised services have a key role in the delivery of the World Class Outcomes in Cancer with a focus on the modernisation of radiotherapy equipment and workforce shortening treatment times and implementing care pathway changes including the impact of proton beam therapy will have particularly in children's cancer. Accelerating access to cost effective chemotherapy and guiding clinicians with algorithms that deliver best value, and taking action over occasional specialised cancer surgery that fail to deliver best patient outcomes are key changes we are implementing.

In Mental Health population based commissioning budgets will enable local decisions for care provision maintaining a national focus on the unfinished business of ensuring CAMHS capacity matches demand, seeking service development and payment reform in Adult Medium and Low Secure, and mobilise additional capacity in perinatal care.

Through the National Programmes of Care we continue to maintain attention on the broad portfolio of the services outside of published strategies in cancer and mental health. This includes enabling innovative medical interventions such as mitochondrial donation, developing commissioning through evaluation, forming access policies to new service developments, delivering commissioning plans for obesity surgery in children, and continuing to reduce the burden of liver disease caused by hepatitis C.

### **3.5 Reducing Unnecessary Variation**

The improving value programme brings together the actions of providers and commissioners to deliver improved value from our commissioning expenditure, and helping address the annual growth in costs of specialised services. The programme delivered £350m of efficiencies in 2015/16 and is on track to deliver a further £400m this year. The programme will need to deliver an additional £400m in each of the next two years.

Our CRGs will each have named clinical leads that act as champions for improving value and play a lead role in identifying and developing opportunities with the



potential to deliver significant improvements for patients, whilst achieving a reduction in the overall cost of services.

Variation is also substantial in the prices paid for, (and in some cases unit costs to deliver), specialised services where national tariff prices do not apply. A pre-requisite to contracts with local prices will be a provider-specific agreed plan for service reform of those services which are above the most efficient levels of cost. As recommended by the House of Commons Public Accounts committee, local prices agreed will reflect planned transition to reflect those lower costs over the 2 year period with an agreed programme of service areas and milestones for review. As well as being reflected in service development and improvement plans a dedicated CQUIN is being made available to ensure programme and specialist resources can be employed by trusts to enable local clinicians to benchmark practices and implement change. This programme will deliver efficiencies in commissioner spend, ensure prices cover provider cost, and deliver the improvements in cost per Weighted Activity Unit set out in the Carter productivity programme reflected in each provider's benefit realisation milestones.

We will continue to adopt and develop "RightCare" processes, delivering reform and improvement in a robust and systematic way, ensuring that our effort and that of our partners is focussed on transforming services to deliver improvement.

Existing Improving Value initiatives which will continue in 2017-18 include:

- Reducing variation in cost and activity associated with high cost devices and procedures, including complex cardiology devices and procedures;
- Delivering best value prices for the NHS for drugs and devices;
- Ensuring the delivery of radiotherapy for patients with prostate cancer is in line with the very latest published evidence;
- Expanding dose standardisation in chemotherapy;
- Working to ensure cost effective prescribing of Anti-Retrovirals and use of Intravenous Immunoglobulin;
- Implementing best practice across the spinal surgery pathway;
- Reducing delayed transfers of care in Critical Care services;
- Extending the use of Blueteq and securing benefits of Clinical Utilisation Review;
- Expanding Enhanced Supportive Care for patients with advanced cancer; and
- Standardising costs of Home Parenteral Nutrition.

We will also introduce new initiatives for 2017-18 including:

- Standardisation drug continuation criteria for patients with MS;
- Optimising value through appropriate use of new generics and biosimilars;
- Reducing Waste in Chemotherapy Services;
- Early Intervention in Premature Infants on Long Term Respiratory Support;
- Implementation of best practice in Anti-Fungal Stewardship; and
- Exploring reform in Renal services – including using technology to facilitate remote monitoring, and utilising shared decision making.

### 3.6 Clinical Utilisation Review

NHS England will continue to support the clinical utilisation review (CUR) programme, providing evidence-based clinical decision support to ensure patients are cared for in the setting most appropriate to their needs. Over the next two years we will focus support for the 5 Acute Early Implementer Sites and the 29 Acute providers who are now implementing CUR or currently undertaking a Local Learning pilot as they continue to access the multi-year CQUIN incentive payment to rollout the approach in admitted patient care and critical care,

Whilst NHS England is not actively further expanding the providers implementing CUR through the CQUIN scheme in the next two years, the expertise of the national programme support team and learning network will be made available where locally determined STP plans have included implementing CUR as an element of transformation across the wider health system. The national framework of 4 internationally proven CUR systems, from which providers can call off contracts for CUR technology, remains available to Trusts for this purpose. The use of evidence based decision support through recognised CUR systems provides strong assurance of consistent quality delivery ensuring providers are well placed to respond to future opportunities for service delivery.

Working with providers over the next two years provides a major opportunity to gather data to support a large scale evaluation of the benefits for patients commissioners and providers. As part of this approach an enhanced nationally standard patient level dataset will be incorporated at all commissioned sites. We are looking to agree 4 year benefit realisation plans with providers complementing and contributing to the approach set out in the Carter review. All Trusts and health communities implementing CUR will be supported to be able to evidence both financial and patient quality benefits. NHS England continues to build on the clinical learning community with national leaders and international practitioners to underpin this approach.

### 3.7 Improving Quality

#### 3.7.1 Better Information

Specialised services quality is underpinned by quality dashboards and a Quality surveillance system for providers and commissioners accessed via secure portals which will continue to be developed to deliver better information on patient outcomes, cost/value and quality to enable and inform change.

Current specialised services quality dashboard metrics covering 52 services are now available on the NHS England Internet site and following the CRG review in 2015/16 will be reviewed by exception in the next 2 years where doing so would provide significant benefit. The focus will be on extending dashboards to cover 80% of specialised services with clinical outcome data.

Providers continue to be required to have an overall registered gatekeeper and service level lead for each dashboard, and to continue to submit data via the portal in line with information requirements.

### **3.7.2 Service Specification Compliance**

The Quality Surveillance Team (QST) will work with the six Programmes of Care Boards to identify the priorities for quality indicator development, particularly where service specifications are introduced or revised. Where indicators have not yet been developed providers will be expected to continue to self-declare (using the Quality Surveillance Information System portal), against the key requirements from the service specification compliance process. The self-declaration, annual assessment and production of service profiles underpin the service specification compliance process and signposts commissioners to where they need to work with providers to address gaps in compliance.

### **3.7.3 Self-declaration**

Providers are required to complete by 30<sup>th</sup> June 2017 the self-declaration against a defined sub-set of indicators for all specialised services they are commissioned to provide with relevant approvals signed off by the chief executive of the provider.

### **3.7.4 Annual Assessment**

An annual assessment will be undertaken on services that are flagged as outliers as a result of either a declaration of non-compliance, or as a result of a flag from other data sources including local intelligence. This will be undertaken in collaboration with regional commissioners and the outcome recorded on the QSIS.

### **3.7.5 Quality Profiles**

A quality profile will be generated for each specialised service delivered by any given provider, summarising information from quality surveillance and identifying national outliers. The profile is updated in real time from in-year portal provider submissions. It is also captured at given point annually, as part of the annual assessment, and reviewed by QST and regional commissioners to determine the level of quality surveillance for the following year. Where the process identifies gaps in compliance a meeting will be held between commissioners and providers that will give rise to agreed resolution actions.

Where the process identifies gaps in compliance a meeting will be held between commissioners and providers that will give rise to:

- Agreement that a derogation should be sought and there is assurance that a time limited action plan will deliver compliance; OR
- Agreement that a gap in compliance exists and that this gap is not amenable to a time-limited action plan. Commissioner and provider discussion will continue to find a long-term sustainable solution to compliance gaps. The commissioner will, within six months of identification of the compliance gap, inform the provider of the action that they will take to ensure long-term sustainable compliance.

### **3.7.6 Peer Review Visits**

The annual programme of peer review visits takes into consideration the current priorities in the NHS England service review programme, services with significant compliance issues and where variation has been identified, either in quality or access.

The 2017/18 national programme is likely to include Neonatal Intensive care, Paediatric Intensive Care, Paediatric Surgery, Hepatitis C network providers, and Vascular services. The Neonatal Intensive care, Paediatric Intensive Care, Paediatric Surgery are one element of the wider service / transformation reviews being undertaken.

The national programme will be complemented by a regionally agreed programme and rapid response visits where regional commissioners identify significant risks which require urgent further investigation.

## **4 The single Operating Model**

### **4.1 Contractual Requirements**

NHS England will normally only hold (or be party to) one NHS Standard Contract with any provider unless explicitly advised during any given procurement. Prior approval should be sought for any elective specialised services activity not commissioned via a signed contract, reimbursement will be based on agreed contracts

Whilst pathway design work is increasingly aligned with CCGs, NHS England will remain the contracting body for all patients across England treated for services within the scope of specialised commissioning for Contracts awarded from April 2017. Such contracts would novate in whole or in part to reflect any legal changes in commissioner accountability implemented as a result of new governance options such as full devolution.

All contracts will use the following national standardised documentation:

- Indicative Activity Plan standardised formatted template;
- Local Prices standardised formatted template;
- Local Quality Requirements (Acute and MH respectively);
- Information Requirements (already in the NHS Standard Contract);
- Service Specifications; and
- Generic and clinical commissioning policies.

To support continued reductions in local transaction costs further national standardisation of schedules will be considered over the next 2 years.

Increasingly as part of networked provider arrangements subcontracting will play an important role in commissioned services. In line with the NHS Standard Contract providers will be expected to agree and obtain written approval in advance from the commissioner to enter into any material sub-contracts. This will include pharmacy services with particular reference to the Carter Review medicines optimisation recommendations. Existing sub-contract arrangements should jointly reviewed and documented within the 2017-19 contract as per the terms of the NHS Standard Contract. NHS England requires full transparency of sub-contracting pricing agreements including where these inform pass through payments, to be set out in the local price schedule. For the avoidance of doubt providers cannot enter into

agreements with an implication on reimbursement from NHS England without commissioner agreement.

NHS England will advertise intended contract awards and any market testing or procurement through the government 'Contracts Finder' website meeting the objectives of proportionality, transparency and non-discrimination for current or potential providers from the NHS, independent or third sector in line with the new Public Contract Regulations.

The introduction of HRG4+ and refresh of specialist top ups is a significant improvement in the accurate attribution of costs relative to patient complexity. NHS England does not expect to make payments above mandatory tariffs for services.

NHS England will only make payment where treatment complies with relevant published policies, and based on priced patient activity reflected in contracts. No resources are available for transitional financial payments. Providers will be expected to provide sufficient data to enable NHS England to validate invoices to ensure that all payments for specialised services are compliant with commissioning policy and are as per the rules of the National Tariff Payment System. The invoice validation process supports the delivery of patient care across the NHS and is vital to ensure NHS England fulfils its statutory duties of fiscal probity and scrutiny.

NHS England will also explore the opportunities for longer than 2 year contracts (including contract term and option to extend) with tier 1 and 2 providers where this affords opportunities for significant improvements in service quality and efficiency, and builds on effective existing contractual arrangements.

All new investment decisions will be subject to the national CPAG prioritisation process. As set out in previous years providers should not initiate specialised service changes and developments without prior commissioner approval as cost impacts will not be funded unless considered in advance through this process.

## **4.2 Contracting for Excluded Drugs and Devices**

Improving the value that the NHS gets from our significant investment in high cost drugs and devices continues to be a shared priority across the NHS. We have ambitious goals in terms of the contribution our high cost drugs and devices service reviews can make to the financial sustainability of services going forward. We intend to work closely with clinical colleagues and partners to bring forward system-wide benefits realisation through:

- Innovative procurement;
- Aggregation of demand;
- Clinical consensus underpinned by evidence based policies for the most effective and best value products;
- Optimisation tools and support;
- The promotion of effective new technologies and products; and
- Minimising unnecessary on-costs and levies on available investment resource

At the national level we are developing agile responses to improve cost effectiveness across the lifecycle of products, from market entry, through new indications and substitutes, to the end of patent. This will include a range of interventions from innovative procurements and supply chain arrangements, commercial access agreements, and clinical commissioning policies. However, the key-stone for improving value is local development, in particular hospital pharmacy transformation programmes, contract and Pharmex data quality improvement, policy compliance, best value from dispensing, clinical networking and the uptake of biosimilars and generics. In recognition of this we will be supporting local development through:

- Close alignment with the Carter Review recommendations, particularly in relation to hospital pharmacy transformation, reforming procurement and delivering purchasing price index improvements;
- Digital developments such as E-prescribing, E-catalogue supplies ordering, electronic prior approvals and standardised contract reporting;
- Completing the centralisation of the high cost device supply chain;
- Empowering clinically led efficiency improvements to maximise the benefits of new and existing technologies and reductions in unwarranted clinical variation including in the range and specification of devices; and
- Important CQUINs to support medicines and devices optimisation.

#### **4.2.1 Hospital Pharmacy Transformation Programme**

NHS England will continue to work closely with NHS Improvement to align priorities and to improve efficiencies relating to medicines optimisation and the Hospital Pharmacy Transformation Programme (HPTP). Trusts will be incentivised to undertake the work required by a medicines optimisation CQUIN during the two years of this contract, after which time it is expected that all schemes will be fully implemented.

#### **4.2.2 Aligning clinical and commercial priorities**

We are working alongside the Commercial Medicines Unit (CMU) to maximise the value for the NHS from drugs procurements going forward. This includes exploring the on-going relationship between the CMU, NHS England and the wider NHS.

Providers of specialised services that utilise high cost drugs will participate in CMU therapeutic tenders and comply with Pharmex data collection requirements as a condition of reimbursement.

NHS England is also working with NICE and the newly reformed CRGs to ensure that treatment algorithms for drugs commissioned by NHS England reflect optimal use of the most cost effective treatments. Trusts will be supported to address unwarranted variation.

#### **4.2.3 Commissioning from specialised centres**

In order to provide assurance that high cost drugs are being used appropriately and in line with commissioning policy, specialised centres will be required to act as gatekeepers to ensure appropriate use of resources and reduce unnecessary risk to patients. Where it may be more appropriate for drugs to be administered closer to



home, specialised centres will be required to establish formal clinical network arrangements with local services to provide appropriate assurances.

#### **4.2.4 Innovation**

NHS England is working with Pharmaceutical Industry colleagues to expedite early access to innovative medicines. Trusts will be required to comply with the commercial arrangements associated with each scheme.

#### **4.2.5 High cost drug data improvement**

Improving data quality associated with high cost drugs remains a priority for NHS England. A standard drugs minimum dataset (MDS) was introduced to all NHS England specialised services contracts in 2016/ 17 and work with NHS Improvement and NHS Digital on improving data quality will continue to allow improved benchmarking and identification of unwarranted variation. All patient access scheme rebates and all drugs supplied through homecare are required to be reported. Trusts will be required to provide dm+d drug codes as part of the MDS which aligns with the requirement for Trusts and system suppliers to implement the dm+d information standard by June 2017. Dashboards will be developed to monitor MDS data quality from each provider and these will be published on the NHS Improvement Model Hospital portal.

#### **4.2.6 Best value from dispensing**

Providers are expected to ensure VAT efficient dispensing methods (e.g. outsourced pharmacies, homecare etc.) are used where clinically appropriate in order to ensure maximum cost efficiencies and to align with the recommendation from the Carter Review to consider alternative supply routes. Following work undertaken in 2016/17 NHS England will propose a cost per item approach to recompense Trusts for work/ activity not reimbursed by the national tariff. This funding mechanism will ensure consistent reimbursement across providers, replacing various previous inconsistent arrangements regarding VAT savings (e.g. % gain sharing agreements).

#### **4.2.7 Medicines optimisation**

The Medicines Optimisation CRG will continue to develop and implement schemes to improve value from high cost medicines, e.g. reducing waste by increasing uptake of a standardised chemotherapy doses and standardised parenteral nutrition; purchase of standardised products as recommended by national advisory groups; development of incentive schemes; expediting implementation of biosimilar products; ensuring value from patient access schemes.

#### **4.2.8 Faster uptake of biosimilar and generic medicines**

In order to allow NHS England to continue to invest in new developments we will require all Trusts to use more cost effective generic and biosimilar products where these are available and in line with product licenses. We expect Trusts to have an active improvement programme to implement use of these products with all new patients being initiated on the biosimilar/ generic product within 3 months of them becoming available and all existing patients to have been moved to the biosimilar/ generic product within 12 months.

#### **4.2.9 Individual Funding Requests (IFR)**

IFRs for cancer-related treatments are now subject to the same process as non-cancer treatments. Trusts must ensure that appropriate internal governance arrangements are in place to assess appropriateness of requests prior to submission to NHS England. IFRs will be subject to an increased level of financial scrutiny to ensure that actual costs reflect those agreed.

#### **4.2.10 Chemotherapy**

Compliance with the SACT database is mandated and will be monitored. All Trusts must have fully implemented e-prescribing for chemotherapy by April 2017 (adults) and September 2017 (paediatrics). All Trusts will be required to report cancer drugs funded via the CDF using the drugs MDS taxonomy. No additional costs associated with the provision of cancer drugs funded by the CDF will be permitted. Trusts must purchase cancer drugs funded within the CDF at the confidential price/access agreement agreed between NHS England and the relevant pharmaceutical supplier.

#### **4.2.11 Reference Prices**

NHS England will continue its work with the NHS pricing team to identify drug categories where spend is predictable across a patient cohort which could be included in tariff from 2019. NHS England will be introducing maximum reimbursement rates in some specialities to reduce the data burden on Trusts and to ensure clinical engagement with use of cost effective medicines.

#### **4.2.12 Centralisation of the Supply Chain for High Cost Devices**

The centralised ordering, supply chain and procurements arrangements will be concluded during 2017/18 to deliver the full year impact of the efficiencies available from aggregating national demand. Further clinically led efficiency improvements will be realised through:

- Greater utilisation of the most effective and best value products;
- Improved service specifications;
- The adoption and spread of new technology;
- Reduced unwarranted variation; and
- Effective networking and consolidation.

The intention is to support clinicians to design the second phase of this initiative with partners and industry to utilise the centralised supply chain to deliver Right Care in high cost devices across the country. This will also include reviewing the options to extend the initiative to other high cost device category areas.

### **4.3 Resolving Significant Local Service Issues**

NHS England will continue to use the collaborative process detailed in the 2016/17 Commissioning Intentions in partnership with CCGs to address significant local service issues through a three step escalation process.



## 4.4 Reforming the Payment System

The adoption of the new Tariff and Top up payments in 2017 represents a significant change to the revenue flows associated with specialised care, more accurately reimbursing complexity. We have worked closely with providers to understand the impact on service line finances and to inform ongoing plans for efficiency and service redesign to ensure care can be delivered within nationally determined funding levels.

Following the adoption of HRG4+ and the associated revisions to specialist top ups, services will be eligible for top ups when the treatment provided attracts a top up and the provider is contracted to deliver it, unless otherwise stated.

Reforming the payment system for NHS services: supporting the five year forward view' published in December 2014 set out the long-term strategy for the payment system. This included an ambition "To develop a comprehensive set of currencies (units of healthcare for which a payment is made), including new currencies, particularly for specialised services." For those with long term conditions or extended treatment pathways this often involves introduction of year of care or pathway currencies. Adoption of such currencies is particularly helpful for services that have local prices, as they create the basis for benchmarking of prices and outcomes.

Objectives in more detail were set out in the 2016/17 commissioning intentions and developed in the Tariff engagement Document (TED) published by NHS Improvement and NHS England. NHS England intends to move forward with non-mandatory pathway currencies for Bone Marrow Transplant, Prosthetic services, and a year of care tariff for Cleft Lip and Palate services. For HIV and Spinal cord injury we aim to develop non-mandatory prices. We also intend to develop a solution, depending on evidence of the adequacy of HRG4+ for intestinal failure consistent with the current service review.

Further progress will be made in 2017/18 and 2018/19 in the development of these currencies, building upon the improvements in the collection of cost information and shadowing the impact of new payment approaches mandated in 2016/17. For services with a shadow currency it will be mandatory to collect and to report information on activity, costs and other metrics (including outcomes) as specified, and to estimate how payment would flow according to the payment mechanism associated with the currency. But it will not be necessary to pay for services according to the currency unless jointly agreed by commissioners and providers.

The two year period of stability in national tariff prices will be used to shadow and build evidence to support a range of changes to future reimbursement approaches, including service specific facility and infrastructure payments to reflect fixed costs. Work is continuing to improve currencies for adult critical care, paediatric critical care and neonatal critical care. In all these services, also, the option of facility and infrastructure payments to reflect fixed costs will be developed for 2019 but where earlier implementation is consistent with local health system goals there is opportunity to do so, with learning from early adopters informing national developments.

A two year CQUIN in 15/16 provided support to providers to expedite discharge, in year one within twenty four hour of patients being clinically ready, and in year two with four hours of patient clinical readiness in line with national standards with the intent that in future stays beyond this point would not attract reimbursement. In line with this direction, from 2017/18 stays beyond twenty four hours after patients are clinically ready for discharge from critical care will be reimbursed at an excess bed day rate. For 2018/19 this approach will apply to patients staying beyond four hours after clinically ready for discharge from critical care in line with national standards. Where bed days with zero organs supported are currently funded at critical care rates the intention is to revert to funding at excess bed day rates in the same way, as an element of the two year planned transition of local prices and costs.

In secure mental health services, re-procurement following the current service review will enable transition to a new more recovery oriented payment approach with improved discharge and resettlement and user-led patient reported experience and outcome measures embedded in all contracts from 2017.

The Tariff Engagement Document also provides details regarding the implementation of reforms to the payment for chemotherapy services (removing the link to individual regimens, and 're-weighting' the current chemotherapy delivery tariffs to better reflect clinical practice), and to more accurately reimburse automated red cell exchange in patients with sickle cell disease.

The objective in all cases is to provide funding that enables providers to optimize care across the patient's treatment pathway, to achieve best affordable outcomes, and that encourages benchmarking and accountability for outcomes. In secure mental health services, re-procurement following the current service review will enable transition to a new more recovery oriented payment approach.

## **4.5 Next Steps**

These national intentions for the commissioning of specialised services are complimented by the programme of care specific and regional intentions in the next sections, and will also be supplemented by provider specific notice communications where appropriate.

Please contact your nominated supplier manager if you require any assistance in contacting the relevant regional or programme of care lead about the programmes and initiatives outlined.

## 5 Section 2: National Intentions for Programmes of Care

### 5.1 Mental Health Programmes of Care

Plans for major reforms have been published with implications for Specialised Mental Health Services. The publication of the Mental Health Task Force report in February 2015 and “Building the Right Support for the people with Learning Disability” in October 2015 emphasise out-of-hospital care and the need for patients to have greater ability to determine the care they receive. Pathways of care are critical to the whole patient experience as they travel through specialised mental health services, and the role of local community based capacity is key to minimising use of specialised settings. Services need to be high quality and importantly the local capacity is there when needed. The commitment and investment at a CCG level into community services will strengthen the ability to deliver these objectives.

Our published commissioning intentions in 2016/17 signalled the intention to re-procure T4 CAMHS and Adult Low & Medium Secure Services with the expectation that this work needed to have local ownership and outputs embedded within local systems. NHS England has revised its approach to ensure local ownership under the umbrella of national co-ordination as a Strategic Service Review. This approach delivers commissioning interventions for the matters that need to change, such as location of beds, quality and financial requirements including new ways of reimbursing care. Right sizing capacity and care delivery in this way will ensure patients, their families and tax payers’ benefit and fewer patients have to travel for care due to local capacity mismatches. By autumn of 2016 the needs assessment and capacity modelling will be concluded. This work will require local commissioning hubs, CCGs, providers and other stakeholder support to reshaping service provision. 2017-19 will be years of transition and mobilization into new arrangements.

NHS England will further support the work of localisation by:

- Moving from 1<sup>st</sup> April 2017 to the 10 specialised commissioning hubs holding budgets for their resident populations, rather than provider geography;
- Ensuring where contracts (such as those with independent sector providers) cover large geographies each commissioning hub resident population will have their own activity schedule. These price and activity matrixes will covered under the overall terms and conditions of a nationally negotiated contract;
- Ensuring full compliance from all commissioned providers of the Mental Health Minimum dataset to support co-ordinated planning and delivery of services
- Concluding mobilisation plans resulting from the Service Reviews into CAMHS T4 and Adult Low and Medium Secure Services;
- Concluding transfer arrangements with the Transforming Care Partnerships for the specialised commissioning patients supporting the planned levels of reduction in patients within inpatient secure services;
- Conclude procurement and mobilisation process for the additional Perinatal Units as defined within the Task Force implementation plans;
- Continuing to actively support the roll out of the New Models of Care for tertiary mental health services and lessons learned;
- Continue to deliver against the approved business cases for the Offender Personality Disorder Programme;

- Working with the DH and the High Secure Services providers implement the changes resultant from the review into the Safety and Security Directions for High Secure Services, in line with the Ministerial time frame; and
- Working with the DH and the High Secure Services providers define the future clinical model for High Secure Services.

## 5.2 Cancer Programmes of Care

Linked to changes made during 2016/17 to centrally commission six molecular cancer diagnostics, the programme of care team are working with colleagues across NHS England to develop implementation plans for panel and genome testing, ensuring alignment with the genetic laboratory procurement and the 100,000 genomes programme.

During 2015/16, the Prescribed Specialised Services Advisory Group approved the transfer of three new procedures into Specialised Commissioning. The transfer is due to take place from 1 April 2017 and as a result the following procedures will be commissioned nationally as part of Specialised Urology Surgery service specifications and in accordance with nationally agreed clinical commissioning policies:

- surgical sperm retrieval for male infertility;
- urethroplasty for benign urethral strictures in adult men; and
- penile prosthesis for end stage erectile dysfunction.

Following work undertaken during 2016/17 to ensure greater alignment between the prescribed services manual and Identification Rules from 01 April 2017 the funding flows for prescribed cancer surgeries and cancer multi-disciplinary teams (MDTs) will sit with NHS England. Over the course of 2017/18 and 2018/19, we will use these changes to implement Cancer Taskforce recommendations, as follows:

- ensure optimally efficient delivery of cancer surgery across England, taking account of innovative surgeries such as robotics;
- implement recommendations for more efficient MDTs, as outlined within the Cancer Taskforce, alongside the development of consistent local pricing arrangements; and
- develop arrangements for national rare cancer MDTs.

As part of the two-year Tariff arrangements, the programme of care team are supporting the development of new chemotherapy delivery and radiotherapy planning and delivery prices as part of the on-going work to implement cancer Taskforce recommendations, such as enabling the replacement of linear accelerators where appropriate.

Work will also begin to support the implementation of a revised service specification for sarcoma. This will include a review of the current local pricing arrangements in order to ensure greater consistency in pricing and explore the potential to move to national arrangements.

Work will continue to be done to embed and enhance arrangements supporting the new Cancer Drugs Fund. In particular NHS England is now implementing plans for off-label cancer drugs and is working with Public Health England to strengthen the SACT database through the development of chemotherapy algorithms.

As part of the work to address the cancer taskforce recommendations 38 (MDT effectiveness) and 39 (30 day mortality) the QST, in partnership with a number of leading cancer providers and in alignment with Cancer Research UK work in this field, have been reviewing the current working practice of MDTs, identifying variation and best practice. This has culminated in the development of ten recommendations which have been endorsed by the Cancer Programme of Care. Over the course of 2017/19 these recommendations will be tested, refined and implemented.

With the opening of Proton Beam Centres in Manchester (The Christie) and London (UCLH), NHS England will begin to phase out the overseas service, eventually only commissioning activity from these two centres; in line with NHS England clinical commissioning policies. It is anticipated that the Manchester service will open during 2018/19 and the London service will open during 2019/10, however, because of the need to carefully ramp-up service provision, overseas activity is not expected to significantly decline until early 2020/21, with some exceptional cases potentially still being referred overseas.

## 5.3 Trauma Programme of Care

### 5.3.1 Service Review priorities

Three services are identified as priorities for review and may lead to changes in models of care and/or configuration in 2017/18:

- **Hyperbaric Oxygen Therapy** - NHS England is completing a review of Hyperbaric Oxygen Therapy and the current indications where it is used. The review is currently considering the feasibility of running a series of research projects to evaluate specific indications. It is anticipated that the outcome of the review will result in a procurement or tendering process where all providers will be asked to tender and assure compliance to the service specification to be able to continue to be contracted to provide the service.
- **Prosthetics** - A review of prosthetic service during 16/17 and the development of a shadow currency may impact on the future provision and configuration of prosthetic services.
- **Spinal Cord Injury** - Spinal Cord Injury services are facing particular challenges including delays in admissions and equity of access and this is having an impact on patient experience and also having an impact on other services such as Major Trauma and Critical Care. A review of SCI services is nearing completion and it is anticipated that during 2017/18 this will identify where there are capacity and demand issues. An option appraisal of solutions will propose ways to improve both the level and location of provision in some regions.
- **Paediatric Burns** - A national review of Paediatric Burns services is proposed to commence in 2017/18 this will consider issues around fragmentation of services, critical mass of patients, clinical interdependencies and co-location of PICUs and out of hours rotas. The service review will recommend the national configuration of services which addresses these issues.

### **5.3.2 Complex Rehabilitation Commissioning**

NHS England will commission according to the complex rehabilitation service specification all units are expected to be using the mandated currency with full Reporting to UKROC.

## **5.4 Women and Children Programme of Care**

### **5.4.1 Planned Commissioning Changes**

#### **Congenital Heart Disease**

Congenital Heart Disease services will be commissioned against the national service specification and standards and focus on early detection. This will include implementing any necessary service changes following consultation on proposals announced in July 2016; performance management of improvement plans for all Trusts that do not meet our requirements; and ceasing to fund occasional practice.

#### **Genetic lab procurement**

A revised service specification for NHS Genomic Laboratory Services has been agreed and through a planned procurement exercise we reconfigure genetic testing services to a nationally co-ordinated network of Genomic Central Laboratory Hubs partnered with local laboratories, Genomic Laboratory Hubs, providing a broad spectrum of tests.

### **5.4.2 Strategic Service Reviews**

#### **Paediatric Critical Care**

The recommendations arising from the national review of Paediatric Intensive Care services commencing in 2016/17 will likely progress to implementation in 2017/18. This review will encompass Extracorporeal Membrane Oxygenation, Paediatric Burns and Paediatric Transfer/Transport and will also be linked to the Specialised Surgery for Children review. This review also includes a review of pricing.

#### **Neonatal Intensive Care**

The case for change in Neonatal Services is linked to the combination to start NIC in the best place to promote survival and minimise morbidity, and to keep families as close to their home as possible. This review also includes a review of pricing.

#### **Specialised Surgery for Children**

To develop recommendations with stakeholders across specialised and non-specialised surgical services in order to ensure a sustainable network approach to paediatric surgery. The review will clarify procedures that should be defined as specialised and co-dependencies.

#### **Children's Epilepsy Surgery**

NHS England will make a decision on the proposed changes to the Children's Epilepsy Surgery Services (CESS) which would mean that surgery for all children would be undertaken in a designated CESS centre. If agreed, the proposed changes will be implemented from April 2017.



### **Adult Gender Identity Services**

In 2017/18 NHS England will adopt new service specifications for adult gender identity services. The specifications will address the various patient pathways from the point of referral into specialised gender identity clinics through to further treatment including surgical procedures. The process for developing the specifications will begin in 2016, including further stakeholder engagement and public consultation (building on the considerable engagement and consultation to date).

NHS England expects to implement the new service specifications via a process of national procurement, covering non-surgical and surgical providers.

### **Highly Specialised Services**

The programme of care team will support the work of the HSS team on services for Metabolic Services.

Lysosomal Storage Disorders – Drugs and Homecare for LSD services will be re-procured in 2017/18 for 2018/19.

### **Metabolic Medicine**

Policies for Wilson's disease and for the treatment of inborn errors of bile acid which are being developed in 2016/17 and will be implemented in 2017/18. A desktop review of metabolic services commenced in 2016/17 and will report in 2017/18.

### **Developing Payment approaches to best support patient care**

NHS England is working with its partners to develop a consistent and transparent national currency and payment system for neonatal services and paediatric critical care services across the whole pathway in support of the wider commissioning framework which encourages the right baby / child in the right place at the right time. It is also the intention during 2017/18 to shadow test a payment model along-side existing contract models. All providers of neonatal and/or paediatric critical care services (including critical care periods that are delivered outside of an ICU) must submit both the relevant data sets (NCCMDS and/or PCCMDS) to SUS as part of the Commissioning Data Set messages. This is a mandatory requirement under [Information Standards Notice 0092](#).

The work being undertaken to develop the next iteration of neonatal and paediatric critical care HRGs and progress these into tariff will require complete and high-quality data to be available in SUS.

### **Opportunities to work with STP footprints**

The programme of care team will work with STP footprints to agree service priorities and support achievement of those priorities for local populations over the next two years. Collaborative work with CCGs will focus on neonatal services and parts of the paediatric intensive care pathway and the team will support the collaborative commissioning vanguard to pilot joint working between CRGs and CCGs through the complex obstetrics work programme linked to the Cheshire and Merseyside Women's and children's services partnership, and input into the Maternity Review.

## **5.5 Internal Medicine Programme of Care**

### **5.5.1 Planned Commissioning Changes**

Procurements to commission services to meet the national caseload for Cytoreductive Surgery with HIPEC for peritoneal carcinomatosis and primary ciliary dyskinesia.

The commissioning plan for obesity surgery for children will be determined and taken forward in 2017/18.

A work programme of policy and service specifications will be undertaken.

### **5.5.2 Transformation and Strategic Service Reviews**

#### **Intestinal Failure**

The procurement process for Intestinal Failure will be taken forward and implemented in 2017/18.

#### **Cardiac Services**

A review of Cardiac Services is being scoped with a focus on commissioning for value and variation in quality.

#### **Liver transplant pathways**

A review of Liver Transplant Services is being considered with a focus on variation in access.

#### **Mechanically / Ventricular Assisted Devices**

A review of the approach to commissioning and pricing given the low availability of organs compared to need.

To support development of Urgent and Emergency Care Networks and 7 day working as part of the national work which include aspects of the specialised cardiac and vascular pathways.

### **5.5.3 Tariff / Currency / Pricing Developments**

#### **Complex Invasive Cardiology**

Consolidation of the procurement process following national review of the ICD / CRT devices for procedures within cardiology.

#### **Intestinal Failure**

Tariff arrangements remain under review, in parallel to the procurement exercise.

#### **Home Parenteral Nutrition**

The national framework was re-procured from 1 April 2016. The specification will be implemented fully with clearer criteria on the services provided for delivery of HPN services.



## **Renal Services**

The two work streams on renal dialysis and transplant tariffs will continue. For renal Transplant the aim is to recommend a tariff from 17/18 together with benchmark ref cost guidance to better reflect these costs by Nov 16.

## **CQUINS**

Internal Medicine Programme will be focusing on further development of the schemes for Rheumatology networks, appropriate use of cardiac devices, and enhanced supportive care for patients with advanced hepatopancreatobiliary disease, heart failure, respiratory disease and idiopathic pulmonary fibrosis. The programme will also be promoting Patient Activation in Cystic Fibrosis linked to the NIHR clinical trial and Shared Decision Measures as a tool to promote increasing patient engagement in service change and self-management.

## **Opportunities to work with STP footprints & Collaborative Commissioning**

The programme of care team will work with STP footprints and specifically with the four STP areas in Greater Manchester, SE London, Worcestershire/Gloucestershire and Cornwall to agree service priorities and support what they want to do to achieve those priorities for local populations over the next two years.

## **5.6 Blood and Infection Programme of Care**

### **5.6.1 Planned commissioning changes**

Work to enable progress on implementing changes in currency and pricing is a priority in Blood and Marrow Transplantation and HIV.

Work will continue to extend changes in drug procurement, stewardship and medicines optimisation across all of the clinical areas in the programme, with changes in commissioning arrangements as required. This will focus on algorithms for use of lowest acquisition cost clinically appropriate drugs (Hepatitis C, Haemophilia), switch programmes to allow greater use of generic drugs (HIV) and enhanced prior approval and outcomes reporting (immunoglobulin). In relation to immunoglobulin (IVIg), a comprehensive review of evidence of effectiveness in multiple indications will be undertaken to bring IVIg commissioning policy into line with NHS England's overall policy approach. In 2017/18, there will be a requirement to revise and enhance the role of provider IVIg Assessment Panels to demonstrate effective clinical oversight of usage in line with existing guidance. There will be changes to the mandatory requirements for reporting usage, such as weight related dosing, as well as outcomes data reporting via the national database. In line with previous years providers will be required to record all use of IVIg on the database. As a mandatory data requirement, non-payment for failure to comply will be enforced.

Pathway and network development will continue to ensure appropriate delineation of specialised and non-specialised activity, improve care for patients and improve value overall. This is particularly relevant to CRG areas such as Infectious Diseases, Immunology and Allergy and Haemoglobinopathies.

Supporting the implementation of treatments which improve outcomes and efficiency will be supported, such as automated exchange transfusion for people with sickle cell disease and thalassaemia.

Work will be completed to enable the transfer of commissioning responsibility for Thrombotic Thrombocytopenic Purpura (TTP). This is a very rare blood disorder and a service specification is being developed in 2016/17. Transfer to NHS England is expected to require a national procurement in 2017/18.

The Programme will continue to focus on using data on variation and outcomes to drive its work plan to secure improvements for patients and to drive improvements in value.

A work programme of policy and service specifications will be undertaken.

## **5.6.2 Transformation and Strategic Service Reviews**

### **Haemaglobinopathies**

This review aims to ensure the full implementation of networked care to address variations in access to specialist care for people with sickle cell disease and thalassaemia.

### **Infectious Diseases**

Building on and linked to the review of High Consequence Infectious Diseases, and taking into account the link with specialised HIV inpatient care, this review aims to better define tiers of infectious diseases care and improve the commissioning of specialised infectious disease centres.

### **Hepatitis C**

The implementation and development of Operational Delivery Networks supporting access to specialist care and treatment with new oral direct acting antiviral drugs will continue. With leadership from the Quality Surveillance Team, a programme of peer review visits is planned.

### **HIV**

At a national, regional and local level, work will continue to work collaboratively with local commissioners and providers to manage changes in sexual health and HIV pathways to safeguard improvements in outcomes. In terms of specialised HIV inpatient care, collaboration with specialised infectious disease is required to ensure pathways of care and sustainability of services and work force. The London HIV Service Review will continue.

Haemophilia care and BMT have also been identified by the Programme of Care as likely areas for service review in 2017/18 and further work is currently underway to confirm the scope and timing.

## **5.6.3 Tariff / Currency / Pricing developments**

### **HIV**

All Providers and commissioners must use the mandatory currency for HIV outpatient activity in contracts from April 2017. This will support the work to develop and begin the implementation of shadow pricing.

**BMT**

Workshops with providers will be held to confirm the issues of variation to be addressed by moving to a mandatory currency.

**Haemoglobinopathy**

With effect from April 2017 all providers will be required to use new procedure coding to distinguish automated and manual red cell exchange, which will be used to deliver new prices which are intended to replace the CQUIN in April 2019. This will ensure the NHS promotes best practice in the use of automated red cell exchange, within available resources.

**CQUIN**

The Blood and Infection Programme expect to implement the following CQUINs across relevant providers in 2017/18. These are an extension of existing multi-year CQUINs, the promotion of national generic CQUINs or the national roll out of relevant locally developed CQUINs:

- Hepatitis C Operational Delivery Networks;
- Haemtrack reporting for haemophilia patients;
- Haemoglobinopathy Networks;
- Automated red cell exchange;
- Patient Activation at existing providers extended to blood and infection patients, along with Shared Decision Making as a tool to promote increasing patient engagement in service change and self-management; and
- HIV drug switching for improved value within medicines optimisation CQUIN.

**Opportunities to work with STP footprints**

The programme of care team will work with STP footprints to agree service priorities and support key initiatives planned for local populations over the next two years. HIV, Hepatitis C, infectious diseases and haemoglobinopathy pathways would benefit from stronger links with commissioners of the non-specialised service elements. This may include supporting:

- Provider configurations – setting out the provider model and configuration required to deliver shared STP and NHS England priorities;
- Development of new service standards linked to outcomes; and
- Contract approaches such as multiyear contract options, collaborative commissioning arrangements with CCGs.

**5.7 Highly Specialised Services****5.7.1 Planned commissioning changes**

Building on the changes notified in the 2016/17 Commissioning Intentions, the Highly Specialised Commissioning Team (HSCT):

- Is considering the development of specifications for new models of care, which will likely involve provider selection to concentrate clinical expertise for: *in utero*

spina bifida surgery, urinary fistulae, thrombotic thrombocytopenic purpura and the management of corporea arteriovenous malformations in children;

- Is developing clinical commissioning policies, which will likely involve provider selection, to concentrate clinical expertise for: mechanical assist devices as destination therapy, balloon pulmonary angioplasty and interleukin 1 blockers.
- Is revising the service specification for the Vein of Galen malformation service in order to select a new, second provider of the service;
- Is revising the service specifications for the small bowel transplantation service to adequately describe the requirement to transition patients from paediatric to adult services;
- Will select provider(s) to deliver a service for patients with hypophosphatasia should NICE recommend the use of the drug asfotase alfa; and
- Is working with the Infectious Diseases CRG and other partners to scope the requirements for the treatment of high consequence infectious diseases (HCIDs). In particular, this will include the development of service specifications for airborne HCIDs and the selection of providers to deliver these services.

### **5.7.2 Developing payment approaches to best support patient care**

The HSCT is:

- Developing proposals for the repurchase of homecare for patients with lysosomal storage disorders. This will include the delivery of sebelipase alfa should this be recommended for use by NICE;
- Developing a market engagement process for potential providers of highly specialised services to ensure that clinical expertise, access, quality and value for money are optimised;
- Working with colleagues in the Department for Work and Pensions and the Department of Health to ensure that income from patients from other EU member states accessing highly specialised services in the UK is maximised; and
- In the extra corporeal membrane oxygenation (ECMO) service: is benchmarking existing services and reviewing variation in the contracting mechanisms and tariff; and continuing development of the integrated referral pathway, as part of the improving value programme.

### **5.7.3 Other service changes**

The HSCT is identifying and developing a sustainable position for the commissioning of transplant-aligned services such as cardiac ECMO and mechanical assist devices.

## **6 Section 3: Regional Intentions**

### **6.1 The South Regional Service Programme**

#### **6.1.1 South - Service Quality and Strategic Change**

The NHS South Specialised Commissioning team will work closely with STPs to ensure that services are planned at optimal population level.

We will continue to reduce pathway variation and will use the results of audit of NICE TA and commissioning policy audits to support reconfiguration through consolidation and networking.

#### **6.1.2 South - Internal Medicine**

Review of complex cardiology services with a view to consolidation of specialist work in fewer higher volume centres.

Working with providers to extend the enhanced supportive care approach beyond cancer to other life limiting conditions.

#### **6.1.3 South - Cancer**

We will work with regional cancer alliances to implement the recommendations of the national review of radiotherapy. We are aware of the time pressure to replace aging Linacs but need to ensure a consistent approach to assumptions about future capacity requirements to avoid a proliferation of services which may not be financially viable over the lifetime of proposed new Linacs.

We will be encouraging providers to adopt a number of levers to improve access, quality and efficiency including CQINS for Enhanced Supportive Care and Chemotherapy Dose Standardisation.

#### **6.1.4 South - Mental Health**

We will collaborate with providers to develop new contracting models and will be working to extend the New Models of Care Mental Health pilots to CAMHs services.

The NHS South team will explore the potential to develop a forensic outreach service in the Kent area, to support a diversion away from admission and an accelerated discharge pathway from secure care.

#### **6.1.5 South - Trauma**

Against a backdrop of high benchmarked reference costs and prices, we will work with providers and CCGs to consider new approaches to commissioning Critical Care services. Our intention is to move with a number of key contracted centres to a fixed facility payment from 2017/18 covering the bulk of costs, with a supplementary payment to cover variable costs and to work with providers to inform the national future work in this area. We will consider alternative proposals put forward by providers which contribute to a consistent regional pricing approach which incorporates the national approach to zero organs supported and delayed discharge from critical care to ensure funding flows facilitate improvements for patients.

#### **6.1.6 South - Women and Children**

We will work collaboratively with Neonatal ODNs to ensure consistent admission thresholds to avoid term admissions into Neonatal Units.

In anticipation of revised BAPM guidance we will review neonatal unit designation to ensure quality standards are met.

We will performance manage L1 Congenital Heart Disease centres and associated networks to ensure that standards relating to L1,2 and 3 congenital heart disease are met.

Linked to the IR exercise we will only commission Paediatric HDU services where there is a PICU on site.

#### **6.1.7 South - Blood and Infection**

Please see National section.

#### **6.1.8 South - Pharmacy**

We will be working, as part of the population based budgeting exercise, to identify variation in use and spend of specific National tariff excluded drugs and will work with providers to understand the variation.

We will continue to work towards improvements in the management of the use of immunoglobulin treatment with peer review supported IVIG Panels.

We will continue to support the work of clinical trials and to develop consistent processes for the agreement of any excess treatment costs which must be agreed with commissioners.

We will continue to review the role of the embedded pharmacist as a position that supports both provider and commissioner organisations.

We will work to support delivery of clinical treatment pathways utilising the most cost efficient drugs.

#### **6.1.9 South - 2017-19 Contracts**

We will review remaining block elements in contracts, particularly those supporting staffing only and will use price x activity contracts for 2017/18.

We will adopt a range of new contracting models, alongside CCGs and STPs, including prime provider models, supported by sub-contracting or partnership arrangements. We intend to pilot this approach with providers in 2017/18 and to roll these out across the South in 2018/19. Possible services include Cardiothoracic, Cancer, Cochlear Implants and BAHAs and specialist paediatric services. We welcome proposals from providers for other services and contracting models.

Linked to our strategic approach to reconfigure pathways and consolidate the supplier base, we will look to introduce differential funding approaches to support the changes we wish to see, including marginal rates or local tariffs where activity is consolidated or steps and costs are removed from pathways, which are covered by national tariffs.

We will review prices and costs for neonatal services, which compare highly with national benchmarks and will address high prices in the 2017/18 contract.

We will continue to strengthen our closed loop IFR process and will review the arrangements which providers have in place for ensuring that charges for overseas and private patients are not inappropriately passed on to commissioners.

We will not be funding in-year pathway changes without prior approval through an agreed process.

## **6.2 The London Regional Service Programme**

### **6.2.1 London – Service Quality and Strategic Change**

London Region will focus on improving the quality and effectiveness of services for patients, and ensuring resilient provision, by concentrating on five key themes which account for the majority of the financial sustainability challenge facing specialised services:

- Pathway inefficiencies;
- Ineffective prevention;
- Operational inefficiencies;
- Fragmented service provision landscape; and
- Inefficiencies due to patient flows.

London Region has established a Specialised Commissioning Planning Board, bringing together representatives from the 5 STPs, providers, NHS Improvement, the national specialised commissioning team and the two neighbouring NHS England regions. The Planning Board will identify and agree priorities for transformation in specialised services where there are significant patient flows across London and beyond. The initial improvement priorities for work across London and beyond are:

- Paediatrics;
- Cardiovascular;
- Specialist cancer; and
- Renal (led by each STP).

In addition, there is a programme of work focussed on options for the future configuration of specialised acute services across South London, and the patient flows into London from the South East.

We will continue to monitor all services against compliance with the service specifications. Work will continue in 17/18 on ensuring compliance, using information from the quality dashboards as well as the new quality information system (QIS) and reviews of the quality surveillance teams.

We will undertake a number of audits to ensure compliance with national policy for the use of high cost drugs and devices.

### **6.2.2 London - Internal Medicine**

London - Internal medicine - Undertake a review of paediatric cystic fibrosis services provided in London, working jointly with the South region.



### **6.2.3 London – Cancer**

We will work with the two cancer vanguards in London, and the cancer alliance in South East London, to ensure delivery of commitments for improved quality and cost effectiveness in relation to specialised services.

We will continue to address non-compliant cancer pathways which do not meet agreed activity thresholds.

We will work within the framework of the national strategy to address paediatric cancer services in London.

### **6.2.4 London – Mental Health**

We will support the implementation of the two new models of care pilots in London: North West London, focussed on CAMHS, and South London, focussed on adult secure.

We will continue our work with CCGs, providers and local authorities to improve the integration of CAMHS pathways.

We will continue our work with the London Transforming Care Partnerships to increase care and support provided to people with learning disability and autism in the community.

We will continue to work with the providers of Gender Identity services in London to improve waiting times, moving towards meeting constitutional standards; working with the national team and the other regions, we will reprocure gender surgery and Gender Identity services in London.

### **6.2.5 London – Trauma**

Adult ECMO: we will undertake procurement for the adult ECMO service covering West London and the South West, working jointly with South Region.

We will progress implementation of the London neuro-rehabilitation review to improve patient flow and joint working across the pathway.

### **6.2.6 London – Women and Children**

Congenital Heart Disease: we will ensure that contracts with all relevant providers include the new service specification and time limited derogations as necessary and work with providers to implement the outcome of the national review following public consultation.

We will progress implementation of the 2016/17 review into paediatric and neonatal transport services in London.

### **6.2.7 London – Blood and Infection**

We will progress implementation of the London HIV review.



We will continue to work with the National team to secure benefits from the new Hepatitis C Networks.

### **6.2.8 London – 2017-19 contracts and enablers**

We will assess what we need to do with respect to information sources and regular reporting to evidence changes and benefits of the above service changes. We will reflect these requirements into contract.

As in all regions CQUIN continues to be strategic enabler of change and quality improvement.

We will work across London with providers to address problems caused by referrals made without the required minimum data sets.

## **6.3 The Midlands and East Regional Service Programme**

### **6.3.1 Midlands and East – Service Quality**

We will continue to monitor all services against compliance with the service specifications. Work will continue in 17/18 on ensuring compliance, using information from the quality dashboards as well as the new quality information system (QIS) and reviews of the quality surveillance teams.

We will undertake a number of audits to ensure compliance with national policy for the use of high cost drugs and devices.

### **6.3.2 Midlands and East Internal Medicine**

Vascular Surgery: implementation of the outcome of the Midlands and East stocktake and complete designation of vascular networks and address non-compliant vascular service configurations.

### **6.3.3 Midlands and East – Cancer**

We will work with the new cancer alliances to deliver the national cancer strategy objectives relating to specialised services

We will continue to address non-compliant cancer pathways including:

- Complete the commissioning of IOG complaint specialised urology surgical centre for Essex;
- Complete the work to identify the optimal model for upper GI services in the East Midlands;
- Review of hepatobiliary pathways in the West Midlands;
- Review skin cancer pathways in the West Midlands to meet IOG standards; and
- Ensure oncology services for the Sandwell and West Birmingham population are compliant with service specification and peer review.

Review access to radiotherapy services for the Hertfordshire population.

### **6.3.4 Midlands and East – Mental Health**

We will reduce the capacity of Learning Disability/Autistic Spectrum Disorder secure services across the Midlands and East by a minimum of 10% in 2017/18. We will support the implementation of the Fast Track Programme to reduce reliance on inpatient beds in Coventry and Warwick, Nottinghamshire and Hertfordshire.

We will undertake a review of high cost packages of care and move towards a consistent pricing /banding structure across the ME.

We will complete the procurement of an additional perinatal service in the East of England.

We will increase the capacity of Gender Identity services in the East Midlands to improve waiting times, moving towards meeting constitutional standards.

We will undertake a review and reduce non-therapeutic lengths of stay.

We will work with and support the implementation of the New Models of Care pilot in the West Midlands.

We will complete the review of CAMHS and secure services looking to work with new models of commissioning collaboratively with CCGs and providers.

### **6.3.5 Midlands and East - Trauma**

Implement the national spinal pathfinder and improved RTT. Improve access to spinal services and reduce waiting lists in the West and East Midlands.

### **6.3.6 Midlands and East – Women and Children**

Congenital Heart Disease: we will ensure that contracts will all relevant providers include the new service specification and time-limited derogations as necessary and work with providers to implement the outcome of the national review following public consultation.

Complete the review neonatal services to ensure we have sufficient capacity in the most optimal network configurations.

Consideration of a new model of care to combine the commissioning and provision of neonatal and maternity services.

### **6.3.7 Midlands and East – Blood and Infection**

We will continue implementation of year of care tariff for HIV services.

We will complete the procurement of HIV services in the East of England.

## **6.4 The North Regional Service Programme**

### **6.4.1 North - Service Strategy**

In order to improve the quality and outcomes of specialised services across the North of England, we will focus on:

- Linking with STP footprints to develop a whole system, pathway led, approach to provision and commissioning of services, particularly where transformational change is required;
- Understanding the variation that currently exists across the region and identifying opportunities to challenge this in order to ensure equity of access, outcomes and experience for all patients. This will include working with other commissioners to ensure that care pathways work in a consistent way to support this in all areas;
- Building upon our knowledge of patient flows and the functional relationship between services to work with commissioners and providers to determine new and innovative ways of commissioning and providing services, in order to improve quality, safety and cost effectiveness;
- Piloting new innovations and evaluating the impact, where this is positive we will seek to spread best practice as quickly as possible; and
- At an STP level we will look at adopting one of the following with each footprint, depending on what is most appropriate in any given system:
  - New contracting model – Lead Provider / Alliance Contracting
  - Commissioning for one of the regional strategic clinical bundles
  - Pooling / delegating budgets for a particular pathway

As part of this work, during 2016/17 we undertook a specialised services sustainability audit in each of the North STP footprints. We will work with providers and CCG partners as part of STPs to address the findings of these audits and inform STP workstreams around future hospital configuration.

For 2017/18 and 2018/19, we will pilot new delivery models which will inform future contractual approaches to support our regional 2020 Vision of:

- Establishing one contract per strategic care bundle, per STP area (with the exception of for the West, North and East Cumbria STP);
- Moving to an approach that all Tier 1 (health economy) service lines for each bundle should be provided through a Lead Provider arrangement; and
- Establishing mechanisms so that Lead Providers in each STP area work across the sub region to coordinate access to Tier 2 (sub-regional) services.

In this way sustainability will be enhanced by:

- Reduced variation in cost and outcomes, driven by greater consistency of care and a coordinated pathway;
- Greater links to CCG commissioned pathways and prevention work;
- Better coordination and flexible use of scarce workforce;
- Improved access for all patients regardless of where they reside; and
- Potential for leveraging backroom costs and contributing to provider CIPs, as well as closing the financial gap across the health systems in the North of England.

#### **6.4.2 North - Mental Health**

We will work with CCGs and other partners to better integrate Specialised Mental Health services into place-based commissioning approaches and pathways.

We will reduce the capacity of Learning Disability secure services across the North of England, working in conjunction with CCG partners. In the North West, subject to consultation, we will commission a new service configuration of secure learning disability services. The North is aiming to reduce the numbers of patients in a specialised inpatient bed by 187 by March 2019. Trajectories have been set to achieve this as follows:

March 2016 Starting point	16/17	17/18	18/19
468 inpatients	411	349	281

We will undertake work to consider how best to meet the needs of patients requiring gender identity services in the North West.

#### **6.4.3 North - Cancer**

We will work with the new cancer alliances to deliver the national cancer strategy objectives relating to specialised services.

We will undertake local reviews of Pancreatic Cancer and Head and Neck Cancer services in Yorkshire and the Humber.

We will move towards a single MDT and subsequently single site of surgery for Upper GI Cancer in Merseyside.

We will review Specialised Kidney, Bladder, Prostate Cancer; Testicular Cancer; and Malignant Mesothelioma services in Cumbria & the North East.

#### **6.4.4 North - Blood and Infection**

We will address service specification and network issues in HIV services. Work will also be undertaken to harmonise contractual and pricing arrangements for this service; and in Lancashire and South Cumbria we will re-procure a single county-wide HIV service.

#### **6.4.5 North - Internal Medicine**

During 2016/17 we have undertaken work to examine variation across the North in Dermatology; Rheumatology; Respiratory; and Hepatobiliary services. We will implement changes that address these areas of variation.

We will undertake local reviews of Severe Asthma; ILD; and Cardiology services in the North West.

We will undertake local reviews of the Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy and Inherited Cardiac Conditions (All Ages) elements of Cardiology; and Endocrinology Services; Vascular Services; Colorectal: Complex Inflammatory Bowel Disease; and Faecal Incontinence services in Cumbria and the North East.

#### **6.4.6 North – Trauma**

We will implement a case-management model for Neuro-rehabilitation services, working with providers on complex rehab cases across the North.

We will undertake a regional review specialised Orthopaedics Services.

We will undertake a review of the National Artificial Eye Service hosted by Blackpool Teaching Hospital.

We will undertake a local review of Specialist Rehabilitation for Complex needs in Yorkshire & Humber.

#### **6.4.7 North – Women and Children**

Congenital Heart Disease: we will ensure that contracts will all relevant providers include the new service specification and time-limited derogations as necessary and work with providers to implement the outcome of the national review following public consultation.

We will implement a single Neonatal Transport service in the North West.

We will undertake local reviews in Yorkshire & Humber on Paediatric Medicine; Paediatric Oncology; and Paediatric Neurosciences services.

We will undertake local reviews in Paediatric Ophthalmology; Paediatric Gastroenterology, Hepatology & Nutrition; and Paediatric Palliative Care service in Cumbria and the North East.

#### **6.4.8 Devolved Specialised Services in Greater Manchester**

In Greater Manchester, Tier 1 (Health Economy) specialised services area commissioned on behalf of the Greater Manchester Health and Social Care Partnership. Jointly agreed priorities for Greater Manchester service reviews include:

- Vascular Surgery;
- HIV;
- Neurorehabilitation;
- Specialised Ophthalmology; and
- Specialised Orthopaedics.

## Annex A

The policies and specifications included within the work programmes are correct as of September 2016 but may be subject to change.

### Clinical commissioning policies as per 2016/17 work programme

Programme of Care	Intervention	Indication
<b>Internal Medicine</b>	Balloon pulmonary angioplasty	Non operable chronic thromboembolic pulmonary embolism
	Inhaled therapy levofloxacin	People with cystic fibrosis chronically colonised with pseudomonas aeruginosa
	Lung volume reduction	Severe emphysema
	Total pancreatectomy with islet autotransplant	Pancreatitis
	Rituximab	Systemic lupus erythematosus in adults
	Rituximab	Interstitial lung disease associated with connective tissue disease
	Infliximab	Refractory sarcoidosis
<b>Cancer</b>	Bortezomib	Relapsed Waldenstroms Macroglobulinaemia
	Clofarabine	Acute myeloid leukaemia as a bridge to transplant
	Stereotactic radiosurgery and radiotherapy	Pituitary adenoma
	Bendamustine	Relapsed mantle cell lymphoma
	Bendamustine	1 <sup>st</sup> line low grade lymphoma with rituximab
	Bendamustine	Relapsed chronic lymphatic leukaemia
	Bendamustine	Relapsed low grade non-Hodgkin's lymphoma
	Bendamustine	Relapsed multiple myeloma
	Dexraoxane for the prevention of cardiomyopathy	All children receiving cardiotoxic therapy with anthracyclines
	Arsenic trioxide	Primary therapy for acute promyelocytic leukaemia in children
	Bortezomib	Relapsed/refractory mantle cell lymphoma
	Bendamustine	1 <sup>st</sup> line mantle cell lymphoma
	Hypofractionated external beam radiotherapy	Prostate cancer
	Stereotactic ablative body radiotherapy	Non-small cell lung cancer
	Surgical correction	Pectus deformity (all ages)
	Dasatinib	Chronic myeloid leukaemia

Programme of Care	Intervention	Indication
<b>Trauma</b>	Total distal radio-ulnar joint replacement	Management of symptomatic instability and arthritis of the distal radio-ulnar joint
	Adalimumab	Adults patients with severe refractory uveitis
	Boston keratoprosthesis	Patients who are no longer suitable for a corneal transplant
	Deep brain stimulation	Tourette's Syndrome
	Intra-arterial thrombectomy	Proximal occlusion of the middle or anterior cerebral arteries
	Osseointegration	Transfemoral amputation
	Deep brain stimulation	Refractory Epilepsy
	Rituximab	Chronic inflammatory demyelinating polyneuropathy
	Hyperbaric oxygen therapy	Multiple indications
<b>Women &amp; Children</b>	Triethylenetetramine	Hepatic, neurological and neuropsychiatric sequelae of Wilson's Disease
	Rituximab	Acute and relapsing paediatric autoimmune encephalitis
<b>Blood &amp; Infection</b>	Anakinra and tocilizumab	Adult onset still's disease
	Canakinumab and anakinra	Hereditary periodic fever syndromes
	HSCT	Lymphoblastic lymphoma
	Immediate initiation of anti-retroviral therapy	HIV positive, any CD4 count, anti-retroviral therapy naive
	Lenalidomide	POEMs syndrome

### Service specifications as per 2016/17 work programme

Programme of Care	Title
<b>Internal Medicine</b>	Respiratory: Complex Home Ventilation
	Adults with Primary Ciliary Dyskinesia
	Specialised Colorectal: Selected Specifications
	Neuroendocrine Tumour Networks
	HSS Renal: Cystinosis
	HSS Small Bowel (Adults)
	Specialised Endocrinology
	Cardiac Surgery
<b>Cancer</b>	Service specifications will be revised as required through the Service Review programme and may involve: OG, Head and Neck, Chemotherapy, Radiotherapy, Paediatric Cancer, TYA Cancer
<b>Trauma</b>	Neurosciences - Neuropsychiatry
	Specialised Ears and Ophthalmology - Adult
	Specialised Ears and Ophthalmology - Children

Programme of Care	Title
	Neurorehabilitation
	Neurosciences
	Adult Critical Care
	Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS-TEN), all ages
<b>Women &amp; Children</b>	Clinical Medical Genetics
	DNA Repair
	Recurrent prolapse
	Recurrent Urinary Incontinence
	Urogenital and anorectal conditions
	Abnormally Invasive Placenta
	Urinary Fistulae / Vesico Vaginal Fistulae
	Congenital Anomalies
	Ciliopathies
	Leukodystrophy – Inherited White Matter Disorders
	Rare Hereditary Neuropathy
	Paediatric Onset Multiple Sclerosis
	ECMO for neonates, infants and children with respiratory failure
	Vein of Galen
	Small bowel transplantation (children)
<b>Blood &amp; Infection</b>	HSS: Thrombotic Thrombocytopenic Purpura
	Infectious Diseases
	Haemoglobinopathies
	Other service specifications will be revised as required to reflect changes in policy or pricing and may involve: HIV and BMT.



## Annex B: Commissioning Levels to support Place based STP planning

Commissioning Level	Service
National/Regional	Cryopyrin associated periodic syndrome service (adults)
	Diagnostic service for amyloidosis (adults)
	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)
	Severe combined immunodeficiency and related disorders service (children)
	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)
	Breast radiotherapy injury rehabilitation service (a discrete cohort of adult females)
	Choriocarcinoma service (adults and adolescents)
	Ex-vivo partial nephrectomy service (adults)
	Primary malignant bone tumours service (adults and adolescents)
	Proton beam therapy service (adults and children)
	Retinoblastoma service (children)
	Adult ataxia telangiectasia services
	Adult specialist pulmonary hypertension services
	Autologous intestinal reconstruction service for adults
	Behçet's syndrome service (adults and adolescents)
	Chronic pulmonary aspergillosis service (adults)
	Complex Ehlers Danlos syndrome service (adults and children)
	Encapsulating peritoneal sclerosis treatment service (adults)
	Epidermolysis bullosa service (all ages)
	Heart and lung transplantation service (including mechanical circulatory support) (adults)
	Insulin-resistant diabetes service (adults and children)
	Islet transplantation service (adults)
	Lymphangiomyomatosis service (adults)
	Pancreas transplantation service (adults)
	Pseudomyxoma peritonei service (adults)
	Pulmonary thromboendarterectomy service (adults and adolescents)
	Small bowel transplantation service (adults)
	Xeroderma pigmentosum service (adults and children)
	Atypical haemolytic uraemic syndrome service (adults and children)
	Adult highly specialist oesophageal gastric services in the form of gastro-electrical stimulation for patients with intractable gastroparesis

Commissioning Level	Service
	Liver transplantation service
	Mental health service for Deaf children and adolescents
	Secure forensic mental health service for young people
	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)
	Specialist mental health services for Deaf adults
	Veterans' post-traumatic stress disorder programme
	Diagnostic service for rare neuromuscular disorders (adults and children)
	Extra corporeal membrane oxygenation service for adults
	Hyperbaric oxygen treatment services (adults and children)
	Neuromyelitis optica service (adults and adolescents)
	Neuropsychiatry services (adults and children)
	Ocular oncology service (adults)
	Ophthalmic pathology service (adults and children)
	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)
	Spinal cord injury services (adults and children)
	Hand transplantation service (adults)
	Adult congenital heart disease services
	Alkaptonuria service (adults)
	Alström syndrome service (adults and children)
	Ataxia telangiectasia service for children
	Autoimmune paediatric gut syndromes service
	Bardet-Biedl syndrome service (adults and children)
	Barth syndrome service (male adults and children)
	Beckwith-Wiedemann syndrome with macroglossia service (children)
	Bladder exstrophy service (children)
	Complex childhood osteogenesis imperfecta service
	Complex neurofibromatosis type 1 service (adults and children)
	Complex tracheal disease service (children)
	Congenital hyperinsulinism service (children)
	Craniofacial service (adults and children)
	Diagnostic service for primary ciliary dyskinesia (adults and children)
	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure
	Gender identity development service for children and adolescents
	Highly specialist metabolic disorder services (adults and children)
	Lysosomal storage disorder service (adults and children)

Commissioning Level	Service
	McArdle's disease service (adults)
	Neurofibromatosis type 2 service (adults and children)
	Paediatric cardiac services
	Paediatric intestinal pseudo-obstructive disorders service
	Primary ciliary dyskinesia management service (children)
	Pulmonary hypertension service for children
	Rare mitochondrial disorders service (adults and children)
	Severe acute porphyria service (adults and children)
	Specialist genetic services (adults and children)
	Specialist paediatric liver disease service
	Stickler syndrome diagnostic service (adults and children)
	Vein of Galen malformation service (adults and children)
	Wolfram syndrome service (adults and children)
	Surgery for complex obesity in children
Sub Regional	Blood and marrow transplantation services (adults and children)
	Highly specialist services for adults with infectious diseases
	Specialist haemoglobinopathy services (adults and children)
	Specialist services for haemophilia and other related bleeding disorders (adults and children)
	Specialist services for children with infectious diseases
	Adult thoracic surgery services
	Radiotherapy services (adults and children)
	Specialist cancer services for children and young people
	Highly specialist adult urological surgery services for men
	Adult highly specialist respiratory services
	Adult highly specialist rheumatology services
	Adult specialist endocrinology services
	Cystic fibrosis services (adults and children)
	Highly specialist dermatology services (adults and children)
	Severe intestinal failure service (adults)
	Specialist cancer services (adults)
	Specialist services for complex liver, biliary and pancreatic diseases in adults
	Adult secure mental health services
	Adult specialist eating disorder services
	Child and adolescent mental health Tier 4 services
	Gender identity disorder services
	Specialist perinatal mental health services (adults and adolescents)
	Specialist services for severe personality disorder in adults
	Adult highly specialist pain management services

Commissioning Level	Service
	Bone conduction hearing implants (adults and children)
	Cochlear implantation services (adults and children)
	Specialist burn care services (adults and children)
	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)
	Cleft lip and palate services (adults and children)
	Fetal medicine services (adults and adolescents)
	Highly specialist adult gynaecological surgery and urinary surgery services for women
	Highly specialist pain management services for children
	Highly specialist palliative care services for children and young adults
	Mitochondrial donation service
	Paediatric and perinatal post mortem services
	Reconstructive surgery service for adolescents with congenital malformation of the female genital tract
	Specialist dentistry services for children
	Specialist ear, nose and throat services for children
	Specialist gastroenterology, hepatology and nutritional support services for children
	Specialist gynaecology services for children
	Specialist haematology services for children
	Specialist neuroscience services for children
	Specialist orthopaedic surgery services for children
	Specialist paediatric intensive care services
	Specialist plastic surgery services for children
	Specialist renal services for children
	Specialist surgery for children
	Specialist urology services for children
	Specialist immunology services for children with deficient immune systems
	Specialist maternity care for women diagnosed with abnormally invasive placenta
<b>STP/Multi STPs</b>	Adult specialist services for patients infected with HIV
	Specialist immunology services for adults with deficient immune systems
	Highly specialist allergy services
	Positron emission tomography-computed tomography services (adults and children)
	Adult specialist cardiac services
	Adult specialist intestinal failure services
	Adult specialist renal services

Commissioning Level	Service
	Adult specialist vascular services
	Specialist colorectal surgery services (adults)
	Adult specialist neurosciences services
	Adult specialist ophthalmology services
	Adult specialist orthopaedic services
	Complex spinal surgery services (adults and children)
	Major trauma services (adults and children)
	Specialist ophthalmology services for children
	Specialist rehabilitation services for patients with highly complex needs (adults and children)
	Specialist endocrinology and diabetes services for children
	Specialist neonatal care services
	Specialist respiratory services for children
	Specialist rheumatology services for children

## **Sustainability and Transformation Plan - update**

**Health and Wellbeing Board**

**Date: 14 December 2016**

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Author:	Nicki Millin – Accountable Officer, Swindon Clinical Commissioning Group
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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### **1. Purpose and Reasons**

- 1.1 The Health and Wellbeing Board is a key stakeholder in the Bath and North East Somerset, Swindon and Wiltshire (BSW) Sustainability and Transformation Plan (STP).
- 1.2 This report updates the Board on the progress of the BSW STP and provides the Summary version of the STP issued on 14 November 2016.

### **2. Recommendations**

The Board is recommended to:

- 2.1 Note the Sustainability and Transformation Plan Summary attached at Appendix 1 to the report.

### **3. Detail**

- 3.1 Health and care organisations across Bath and North East Somerset (B&NES), Swindon and Wiltshire have begun working together in an exceptional new way to meet the many challenges facing the health and care system.
- 3.2 Overall across B&NES, Swindon and Wiltshire the standard of health and care services is very good compared to other areas of England. However, there are still improvements that need to be made to make sure that these services are the best they can be – both now and in future years.
- 3.3 Additionally, there are increasing financial pressures. In the last financial year (2015/16), our combined spend on healthcare, across all our NHS organisations (such as GPs, hospitals, Clinical Commissioning Groups and mental health services), was approximately £1,570 per person. When we assess the additional needs that will be required from an older population – and of the growing numbers of people in our area based on national projections - then we estimate that by 2020/21 we will need to spend approximately £1,760 per person. This will exceed our expected budget of approximately £1,650 per person.
- 3.4 We therefore need to make choices over the next five years on how services are provided. We believe the only way to bridge the financial gap is to turn this into an opportunity to work smarter and more efficiently.

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Further information on the subject of this report can be obtained from Nicki Millin, Accountable Officer - Swindon CCG, 01793 683700

# Sustainability and Transformation Plan - update

Health and Wellbeing Board

Date: 14 December 2016

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- 3.5 At the time of preparing this report, the full STP plan is not in the public domain. As soon as this is published, we will provide the Board with a web link to the plan. For the purposes of this meeting, we will provide a verbal update on the summary version of the plan.

## 4. Alternative Options

- 4.1 No alternative options.

## 5. Implications, Diversity Impact Assessment and Risk Management

### Financial and Procurement Implications

- 5.1 Not identified in the Summary STP, but a detailed financial planning agreement is underway.

### Legal and Human Rights Implications

- 5.2 None identified at present.

### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 None identified at present.

### Diversity Impact Assessment

- 5.4 Not yet completed.

### Risk Management

- 5.5 Not yet identified.

## 6. Consultees

- 6.1 The Corporate Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

## 7. Background Papers

- 7.1 None.

## 8. Appendices

- 8.1 Appendix 1 – Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Plan Summary.

# Bath and North East Somerset, Swindon and Wiltshire

## Sustainability and Transformation Plan Summary



DRAFT  
November 2016



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## 1. Introduction

Health and care organisations across Bath and North East Somerset (B&NES), Swindon and Wiltshire have begun working together in an exceptional new way to meet the many challenges facing the health and care system.

Overall across B&NES, Swindon and Wiltshire the standard of health and care services is very good compared to other areas of England. However there are still improvements that need to be made to make sure that these services are the best they can be – both now and in future years.

Our Accident and Emergency (A&E) departments are under pressure, in some areas patients are waiting too long for GP appointments and there are gaps in quality with some parts of our region benefitting from better health and care services than others.

Additionally there are increasing financial pressures. In the last financial year (2015/16), our combined spend on healthcare, across all our NHS organisations (such as GPs, hospitals, Clinical Commissioning Groups and mental health services), was approximately £1,570 per person. When we assess the additional needs that will be required from an older population – and of the growing numbers of people in our area based on national projections - then we estimate that by 2020/21 we will need to spend approximately £1,760 per person. This will exceed our expected budget of approximately £1,650 per person.

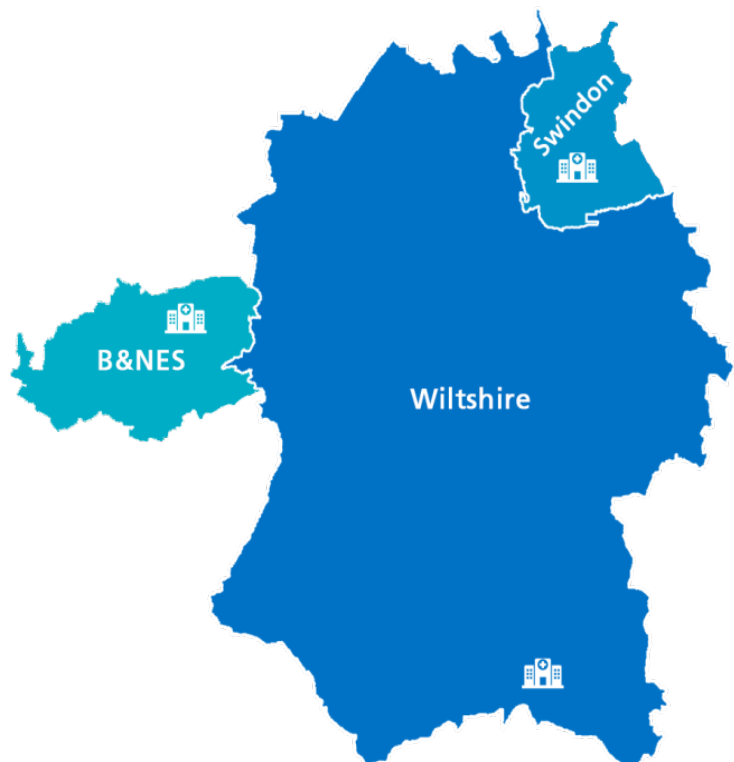
We therefore need to make choices over the next five years on how services are provided. We believe the only way to bridge the financial gap is to turn this into an opportunity to work smarter and more efficiently.

We need to support people to stay healthier and independent for longer.

We need to reduce the duplication, variation and potential gaps between the various health and social care organisations so that residents receive a consistent service and we make the best use of the available resource. We need to make better use of new technology to support people to monitor their own health and wellbeing with access to the right information and support to manage long-term conditions (such as diabetes) as an alternative to hospital-based care.

### What is our Sustainability and Transformation Plan?

This is why our health organisations have joined up with our local authority partners and other key stakeholders to agree a plan to improve local health and care services. This local plan for better health and care is known as a Sustainability and Transformation Plan (STP). It will support the delivery of a national plan called the Five Year Forward View. Published in 2014, it sets out a vision of a better NHS, and the steps we should take to get us there by 2020/21. This doesn't mean doing less for patients or reducing the quality of care.



It means working more closely with patients to help keep them healthier and well for longer and designing services to better meet their individual needs.

We recognise that the health and care needs of our local population are diverse and we are developing a joint approach that takes this local variation into account. And it will not stop all the great work already going on locally to improve services.

To succeed, our STP will need to build on where local health (NHS) services are already working together effectively with social care services provided by the local authority. This joined-up approach will help people manage long-term conditions better and will ease pressure on hospitals by providing improved home care services for those who need it. NHS leaders have begun working more closely with their local government partners to develop the STP and achieve a shared vision of care coordinated and centred around the needs of the individual.

This summary sets out our approach, emerging priorities and proposed activity so everyone can see and have their say on what is being proposed. Our STP needs to be developed with, and based upon, the needs of local people, patients, carers and communities and engage clinicians and other care professionals, staff and voluntary organisations.

We welcome your comments on this document and we also look forward to discussing and developing our ideas further with everyone over the coming months.

## **Our STP partners**

The following organisations are working together to develop our STP:

- Avon and Wiltshire Mental Health Partnership NHS Foundation Trust (AWP)
- Bath and North East Somerset Clinical Commissioning Group
- Bath and North East Somerset (B&NES) Council
- Great Western Hospitals NHS Foundation Trust (GWH)
- Health and Wellbeing Boards in B&NES, Swindon and Wiltshire
- Health Education England
- Healthwatch in B&NES, Swindon and Wiltshire
- Royal United Hospitals Bath NHS Foundation Trust (RUH)
- Salisbury NHS Foundation Trust (SFT)
- South Western Ambulance Service NHS Foundation Trust (SWASFT)
- Swindon Borough Council
- Swindon Clinical Commissioning Group
- Wessex Local Medical Committee
- West of England Academic Health Science Network (WEAHSN)
- Wiltshire Council
- Wiltshire Clinical Commissioning Group
- Wiltshire Health & Care

## 2. Our local area or 'footprint'

B&NES, Swindon and Wiltshire (BSW) have a population of approximately 874,000 people.

There are three local authorities, 110 GP practices, three Clinical Commissioning Groups (CCGs), three hospital trusts, a mental health provider, an ambulance trust as well as organisations providing community services and many voluntary and charitable organisations within our geographical area or 'footprint'. All the hospital trusts are located on the fringes of the STP boundary and patients are referred onto specialist centres outside of the BSW footprint for expert support and treatment, e.g. cancer services in North Bristol NHS Trust and ophthalmology at Oxford Eye Hospital. We have a combined health and care workforce of approximately 40,000 people.

B&NES, Swindon and Wiltshire all have growing populations and have local communities with very different health and care needs. For example:



Swindon is small but densely populated (221,000 people). This population is predicted to rise by 10 per cent to 243,000 by 2026. The STP footprint also includes Shrivenham.



Wiltshire, by contrast, has a much lower population density (483,000 people) spread across large rural areas with Salisbury Plain at its centre.



Wiltshire has a large armed forces presence and there are plans for a further 10,000 servicemen and their dependents to relocate to the area by 2021.



B&NES has a population of 182,000 people. Over 50 per cent live in Bath. The rest live in market towns or diverse rural communities.

There are an above-average number of people aged 20-24 years due to two universities in Bath.



In B&NES the local housing strategy is expected to create an extra 13,000 homes by 2029 and will increase the local population by 16 per cent. 22,000 homes are being built in Swindon between 2011 and 2026.



Across the BSW footprint there is a largely affluent population but there are pockets of deprivation – 6.4 per cent of people live in the most deprived areas of England.

### 3. Why do we need to change how we provide services?

The NHS's Five Year Forward View highlights three areas where fundamental change is urgently needed in order to ensure services meet the needs of the local population and are sustainable for the future. These areas are relevant to B&NES, Swindon and Wiltshire and reveals widening gaps between current resources and increasing demand:

#### Improving health and wellbeing

The majority of illnesses that the NHS treats are caused by obesity, smoking or alcohol. Many of these illnesses, such as heart disease or diabetes put significant pressure on health care services but are preventable. To improve everyone's health and wellbeing and for services to be sustainable, we need to get better at preventing disease, not just treating it. We need to strengthen collaboration between public health teams, other council departments and all our partner organisations and encourage everyone to take more responsibility for managing their own care. Local issues include:



Obesity rates that are higher than the national average in some parts of the BSW footprint.



A prevalence of obesity and smoking in Swindon.



Higher than average numbers of people in Wiltshire with hypertension (high blood pressure).



Long term conditions (LTCs) putting pressure on services. In Swindon, LTCs take up 50 per cent of all GP appointments.



5,700 people with undiagnosed diabetes across BSW.



Significantly worse admission rates for self-harm in B&NES and Swindon than the England average.

#### Improving the quality of care people receive

People are living longer and need a wider range of health and care services over a longer period of time. But care can be disjointed across different organisations and our workforce is not equipped or big enough to handle the increased demand. Local issues include:

- A 6.6 per cent population growth predicted across the footprint over the next ten years
- 40 per cent of the NHS budget being spent on the over 65s who currently make up nearly 19 per cent of the total population. This will rise to over 22 per cent by 2025/26
- Recruitment shortages and health professionals nearing retirement across all health and care sectors. This is a particular issue for GPs, nurses (in our trust hospitals, care homes and those based in the community) and midwifery

- In B&NES, for instance, ten extra GPs will be required for the increased population that will accompany housing growth. At time of writing, Swindon is short of 25 GPs compared to other areas with the same population size.

### Ensuring our services are efficient

The BSW health system will have a budget of £1.4 billion next year (2017/18) to commission or pay for services. Our local trust hospitals and partner organisations providing community and mental health services will receive an income of £1 billion.

Although the future challenges are considerable, we are in a better place to deal with them as our 2015/16 financial position was relatively strong when compared to the national position. The combined overspend that year, across all the NHS organisations within our footprint, was around 0.5 per cent of the total budget. In a national review of productivity and efficiency across NHS Trusts in England, the three hospital trusts in our footprint have been shown to be between eight and ten per cent more efficient (using average treatment costs) than similar hospitals elsewhere in England. Some of the ways we are already working smarter are by:



Improving communication between GPs and hospital doctors so that GPs can get specialist advice for individual patients without needing to refer them to hospital.



Sending out reminders about appointments via text to reduce the time a clinician wastes when patients do not show up to see them.



Providing alternative services that reduce the need for patients to stay in hospital overnight.



Introducing new IT systems that help reduce the amount of time clinicians spend on completing paperwork.

Our early focus is on ensuring that the innovative steps that are already underway in one organisation are taken forward in every organisation. The STP has already provided an unprecedented opportunity to bring teams together across a wider geography to share, learn and agree where what is working well in one area could be replicated in another area. This move towards standardisation and more joined-up planning will help us to improve the quality of services and better support the health and wellbeing of everyone living in B&NES, Swindon and Wiltshire.

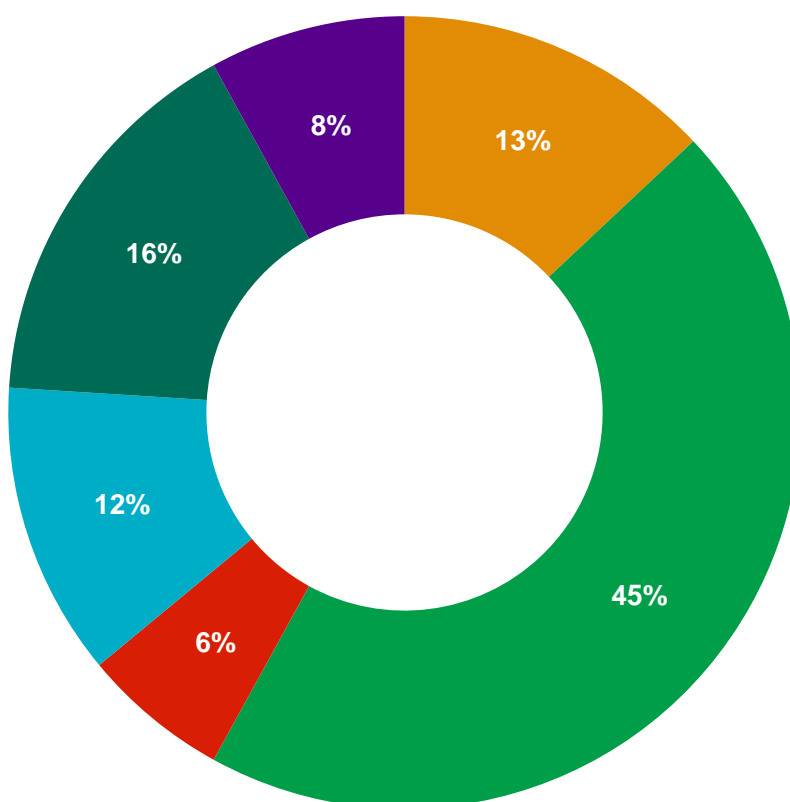
We also need to build on conversations already taking place with the public (through Clinical Commissioning Groups, Healthwatch and other partner organisations) on how we support them to stay healthier for longer. In the future, for example, we will face a choice whether to recruit more doctors and nurses (and potentially provide more hospital beds and clinical space) to manage the projected rise in type 2 diabetes or to work with our local population to improve everyone's diet and lifestyle and reduce obesity levels that causes the increase in diabetes. We know from national evidence that it is cheaper to prevent type 2 diabetes than to treat it so we have already committed in our plan to doing this.

This is just one example of the choices we face in planning our future health and care services. Our plan is at a much earlier stage of development than other STPs and we see this as an opportunity to engage our population in making these choices. Otherwise, if we do not continue to make efficiencies, then we know there will be a gap between our patient's needs and available health and care resources of approximately £300m by 2020/21.

We have started to identify where these savings need to come from as highlighted on the diagram below. It shows, for example, how we are developing local savings plans within each of our organisations and collectively to seek to achieve the amount needed. It also shows what additional NHS funding is available to us if we achieve certain criteria.

However, these plans are at an early stage of development. We will be working with our clinicians and local people to set out the choices we need to make and the potential financial consequences of those so we can develop our plan and monitor its potential impact.

#### How we plan to close the gap: 2017/18 to 2020/21



- |                              |                                |                               |
|------------------------------|--------------------------------|-------------------------------|
| ■ Additional NHS funding     | ■ Organisational savings plans | ■ Support services review     |
| ■ Clinical pathways redesign | ■ Local government gap         | ■ Specialist services volumes |



## 4. Our emerging priorities

Over the next five years we are planning to change services around five priority areas that will improve our population's health and wellbeing, improve the quality of care people receive and ensure our services are efficient:



### Priority 1: Transforming primary care

Our GPs and practice-based staff have a critical role to play in delivering our STP, particularly in terms of their contribution to support delivery of primary, community and mental health services that are joined-up and available to patients seven days a week. However, there are a number of challenges including recruitment, premises that are not fit for purpose and limited financial resources.

B&NES, Swindon and Wiltshire all have their separate plans to respond to these challenges. This includes groups of practices working closer together to share resources and practice-based teams of health professionals with a range of skills in a specific condition e.g. diabetes, who come together to work out the best treatment for a patient. Working together across the STP footprint presents an opportunity for GPs and practice staff to explore new ways to transform primary care services.

BaNES, Swindon and Wiltshire CCGs are progressing plans to take on more responsibility for commissioning (buying) primary care services from 1 April 2017. Until now the responsibility for this has fallen to NHS England alone. The three CCGs are working together to understand the opportunities to apply together for delegation from NHS England and share some of the responsibilities that accompany the new role.



### Priority 2: More focus on prevention and proactive care

There are a number of initiatives we are exploring as part of this priority and they include:

- A high impact, multi-media health awareness campaign across the footprint to promote flu and pneumococcal vaccinations. This will help protect those at risk of developing serious complications of flu such as pneumonia.
- Targeted support for older people with multiple long-term health conditions to improve their health and wellbeing.
- A new Fracture Liaison Service across B&NES, Swindon and Wiltshire based on the excellent service already being delivered in Salisbury to improve treatment for patients with osteoporosis.
- Roll out of a new Workplace Wellbeing Charter across every health and care organisation to support and improve all employees' health and wellbeing, improve productivity, decrease absenteeism and raise staff morale.
- A joined-up urgent care service across B&NES, Swindon and Wiltshire. Commissioners across the footprint are working together to develop new NHS 111 and GP out-of-hours services that will also include provision for a 'clinical hub' to provide timely, accessible and specialist advice to patients and health professionals.



- Increased capacity for ambulatory care as the alternative to A&E as this service offers a whole-system approach to treating the patient and supporting him/her to go home rather than being admitted to hospital.
- Standardisation of elective (planned) care pathways for patients to reduce variation in quality for patients. For example, there are plans for a new footprint-wide community pain management service so people in B&NES, Swindon and Wiltshire all have the same access to a high quality service closer to home.
- Improved access to psychological support for patients with mental health needs, for example through better signposting to community based services that can help people manage their own condition. This includes improved access to early, targeted and specialist mental support for children and young people including those in care and leaving care.



### Priority 3: Making best use of technology and our public estates

Digital technology has the potential to transform health and care delivery in B&NES, Swindon and Wiltshire. The STP presents an opportunity to accelerate adoption of new technology and further join up each organisation's information systems so people do not have to repeat their story over and over to the different health and care professionals involved in their care.

There are also opportunities to increase our use of telehealth tools and apps to promote self-care and deliver support remotely so, for example, there is no need to travel for treatment. We would also like to explore the potential to share our analytical data across organisations so we can better plan for future demand.

Across the footprint, our combined estate costs £175 million per annum to run. We are reviewing all our buildings to establish how we can make best use of our existing space whilst also reducing costs.



### Priority 4: A modern workforce

We know our collective workforce is a vital asset and that our emerging vision will not be delivered without their skills, expertise, commitment and passion.

We are exploring a number of workforce initiatives to support the STP and address some of the challenges we face, such as recruitment and retention of staff, particularly in the social care setting and domiciliary care in particular. These initiatives are being supported by funding provided by Health Education England and include:

- A joint approach to workforce modelling and planning
- A programme of activity to support staff health and wellbeing
- A joined-up approach to education and training across all our partner organisations. This will, for example, lead to more focus on helping to develop the skills of care home and domiciliary staff to build a more flexible workforce. And staff that work across more than one organisation will not have to complete two sets of mandatory training.



## Priority 5: Improved collaboration across our hospital trusts

The Great Western, Royal United and Salisbury Hospitals are currently facing high demands and limited capacity in common with other trust hospitals providing acute services. They are also challenged in terms of achieving NHS constitutional targets such as patients being seen within four hours in A&E and the maximum time patients should wait between referral to a specialist by their GP and treatment for planned care.

So the three hospitals are exploring ways to reduce costs by sharing some support services and through clinical collaboration. This could include joining up clinical out-of-hours services where practical to do so such as laboratories and pharmacies, developing footprint wide-booking and referral management systems and delivering enhanced seven-day services by joining up out-of-hours provision of areas such as radiology and specialist imaging.

### 5. How we are working together

Across the footprint we have established ways of working and a structure of governance.

As an STP, we have twice debated whether to establish mental health as a standalone stream of work. Instead we have decided to ensure mental health is a key part of each of three clinical work streams (prevention and self-care, planned and urgent and emergency care) and will develop separate collective mental health plans that are in line with national guidance such as the NHS Forward View for Mental Health.

We have established a Clinical Board (comprising public health professionals, nursing leads, GPs, care professionals, hospital doctors and Allied Health Professionals) that will help shape and drive our plans for transformation. It will ensure that proposals for new services and ways of caring for and treating patients have a strong evidence base and have been co-produced based on the insight and expertise of clinicians as well as patients and carers.

### 6. Get involved to help us solve the challenges we face

The STP offers our stakeholders a great opportunity to inform our plans for local health and care services.

Across our combined area, we already have a wealth of patient insight and useful information from recent consultation and engagement activity. We will build on this and draw on the experience and clinical expertise of our workforce and those who use health and care services, as well as their carers, to redesign services and develop new models of care that are sustainable.

We have strengthened our relationship with Healthwatch in B&NES, Swindon and Wiltshire and, as the independent body representing the voice of patients and public, the three local Healthwatch organisations are now acting in an advisory capacity for our STP as our plans begin to take shape. Healthwatch sits on the STP Board and communications work stream as 'critical friend' to health and care leaders and they will play an invaluable role in our approach to patient and public participation.

The workforce is a major focus for communications and engagement activity. Staff need to be briefed and mobilised to help champion, shape and implement future changes in services. Health professionals and academics were briefed on the BSW and neighbouring STPs at the annual meeting of West of England Academic Health Science Network on 13 October. A programme of engagement has also already begun within each partner organisation.

The voluntary and charitable sector is also a key participation partner for supporting delivery of our STP and developing prevention and wellbeing approaches. On 13 September we started the conversation about our STP with this key group and independent sector partners. Over 70 people attended our 'Time for Change' event in Devizes and emerging themes included how to make better use of local communities to support domiciliary provision and the importance of mental health and wellbeing across all work streams.

### How to get involved in our STP

Our programme of public engagement will commence early in 2017 and will be promoted via each partner organisation's website and other communication channels. In the meantime if you have any questions or feedback on the document, please get in touch by email to [ruh-tr.STP-BSW@nhs.net](mailto:ruh-tr.STP-BSW@nhs.net) or contact your local Healthwatch office.

Updates on our STP progress, emerging plans and thinking will be shared at partner Board meetings, patient forums and council meetings, so please check individual organisation websites for details of these if you would like to attend. These include:

- Swindon Health & Wellbeing Board on 14 December
- B&NES Health and Wellbeing Board on 7 December

Each STP organisation is also organising its own schedule of engagement with staff.

## 7. Glossary

### Acute care

Acute care is a branch of secondary health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or longer term care.

### Allied health professionals

Allied health professionals include dental hygienists, diagnostic medical sonographers, dieticians, medical technologists, occupational therapists, physical therapists, radiographers, respiratory and speech language therapists.

### Ambulatory care

Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

### Health and (social) care services

Social care is the extra support that helps people to stay independent and get on with their daily lives. This care may be practical or emotional and includes practical support in the home, home adaptations and home-visiting services. Social care is provided by local authorities, community providers and a host of charitable and voluntary organisations.

Health care relates to the treatment, control and prevention of a disease, illness, injury or disability and the patient or individual's after-care.

### Patient pathway

The patient pathway is the route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment.

### Primary care

As many people's first point of contact with the NHS, around 90 per cent of patient interaction is with primary care services. GP practices and community pharmacies are the key primary care services that are a focus for our STP.

### Secondary care

Secondary care services are usually based in a hospital or clinic as opposed to being in the community and patients are usually referred to secondary care by a primary care provider such as a GP.

### STP footprint

The geographical area covered by our local Sustainability and Transformation Plan (STP). In other words, B&NES, Swindon and Wiltshire.

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## Swindon Oral Health Strategy

Health and Wellbeing Board

Date: 14 December 2016

Author: Dr Rebecca Maclean – Public Health, Swindon Borough Council

Wards: All

Locality Affected: All

Parishes Affected: All

### 1. Purpose and Reasons

- 1.1 This Strategy builds on the 2016 Joint Strategic Needs Assessment (JSNA) on Oral Health in Swindon. It outlines the approach to improve the oral health of Swindon residents.
- 1.2 Significant improvements in oral health have been made. However, many adults and children still suffer from oral diseases. In order to improve oral health and give strategic direction a Swindon Oral Health Strategy is required.
- 1.3 This Strategy links to Swindon Borough Council's Priority Four: help people to help themselves while always protecting the most vulnerable children and adults. It also links to the Swindon Health and Wellbeing Strategy as follows: Outcome 1 - every child and young person in Swindon has a healthy start in life; Outcome 2 - adults and older people in Swindon are living healthy and more independent lives, and; Outcome 3 - improved health outcomes for disadvantaged and vulnerable communities.

### 2. Recommendations

The Board is recommended to:

- 2.1 Discuss and approve the Swindon Oral Health Strategy 2016-2021 attached at Appendix 1 to the report.
- 2.2 To recommend to Cabinet and the Clinical Commissioning Governing Body that they adopt the Swindon Oral Health Strategy for 2016-2021.
- 2.3 Support the establishment of an Oral Health Steering Group who will monitor this Strategy, and the Swindon Oral Health Action Plan.

### 3. Detail

- 3.1 The strategy built on the engagement in the Oral Health JSNA involving representatives from Great Western Hospitals Trust, Swindon Borough Council and Public Health England.
- 3.2 The five priority outcomes of the Swindon Oral Health Strategy are:
  - 3.2.1 Ensure oral health is a health and wellbeing priority

Further information on the subject of this report can be obtained from Ayoola Oyinloye, 01793 444674, Aoyinloye@swindon.gov.uk.

# Swindon Oral Health Strategy

Health and Wellbeing Board

Date: 14 December 2016

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- 3.2.2 Tackle social and lifestyle determinants of disease
- 3.2.3 Embed oral health into commissioning
- 3.2.4 Commission oral health improvement interventions
- 3.2.5 Ensure shared ownership of the oral health agenda
- 3.3 The Swindon oral health strategy (attached at Appendix 1) recommends the formation of an oral health steering group to monitor the action plan (attached at Appendix 2) and strategic outcomes.
- 3.4 The strategic target is to increase the proportion of 5 year old children free from dental decay to the same level or higher than the England average.
- 3.5 We will do this by increasing the knowledge of health professionals on oral health; ensuring that all residents of residential care settings have an oral care plan/protocol; ensuring NHS dental contracts deliver the recommended level of fluoride varnish to over 80% of children.

## 4. Alternative Options

- 4.1 Not commissioning oral health promotion. This is not a realistic option as oral health promotion is a statutory responsibility of Local Authorities.

## 5. Implications, Diversity Impact Assessment and Risk Management

### Financial and Procurement Implications

- 5.1 Swindon Borough Council (SBC) currently commissions the Oral Health Promotion Team of the Great Western Hospital to provide services to Swindon residents. SBC pays £28,000 a year for this service. The costs can be met from within existing public health ring fenced budgets. No additional funding implications are expected as a result of this report.

### Legal and Human Rights Implications

- 5.2 The Health and Social Care Act (2012) conferred the responsibility for health improvement, including oral health improvement, to Local Authorities.
- 5.3 Legal and Human Rights considerations have been taken fully into account in compiling this report. It is considered that the recommendations of this report are compatible with Convention Rights.

### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.4 No additional resources identified at this stage.

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Further information on the subject of this report can be obtained from Ayoola Oyinloye, 01793 444674, Aoyinloye@swindon.gov.uk.

# Swindon Oral Health Strategy

Health and Wellbeing Board

Date: 14 December 2016

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## Diversity Impact Assessment

- 5.5 A diversity impact assessment has been completed. No adverse or other significant issues were found. As part of the strategy we aim to specifically target groups at higher risk of oral health issues (children, older people, people living with learning disability, people living in poverty, people whose lifestyles increase their risk of oral disease and those who are dependent on others for support) and have not identified an adverse impact that this would have on others.

## Risk Management

- 5.6 No specific risks have been identified at this stage for this report.

## **6. Consultees**

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

## **7. Background Papers**

- 7.1 None.

## **8. Appendices**

- 8.1 Appendix 1 – Swindon Oral Health Strategy 2016-2021.  
8.2 Appendix 2 - Swindon Oral Health Action Plan 2016-2017.



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## Swindon's Oral Health Strategy 2016-2021

### 1. Why is oral health important?

A healthy mouth is a vital part of a healthy body. Oral health has been defined as an ability to eat, speak and socialise without active disease, discomfort or embarrassment, and refers to the health of people's teeth, gums, supporting bone and soft tissues of the mouth, tongue and lips. Having a healthy mouth allows us to speak, smile, kiss, taste, chew, swallow and cry<sup>i</sup>. These skills are fundamental to our daily living and are a key element of health and wellbeing.

Oral health problems include gum (periodontal) disease, tooth decay, tooth loss and oral cancers. Important risk factors for oral diseases are social determinants. In common with other common chronic diseases, the prevalence is significantly higher among poor and disadvantaged population groups. At a behavioural level, risk factors for oral diseases include poor oral hygiene from poor tooth brushing, insufficient exposure to fluoride, consumption of a diet that is high in sugar, tobacco use and harmful alcohol use. Three of these are also risk factors for the four leading chronic diseases – cardiovascular diseases, cancer, chronic respiratory diseases and diabetes – and oral diseases are often linked to chronic disease.

Having poor oral health can exacerbate existing health conditions and impact on people's mental well-being. An unhealthy mouth can make it difficult to eat a nutritious diet, drink enough fluids and socialise or communicate with confidence.

The burden of oral diseases disproportionately affects people who are already vulnerable in some way. For example tooth decay is strongly associated with socioeconomic deprivation. People from more deprived groups suffer from more severe decay, more urgent dental problems and are more likely to have no teeth at all.

At the level of individuals and families it is well known that oral diseases cause tooth loss, pain, sensitivity, infection and, in extreme cases, a threat to life. Figure 1 shows the impact to children, adults and families.

Figure 1: The impacts of an unhealthy mouth on children, adults and families

Impacts on children	Impact on adults and vulnerable adults	Impact on families
<ul style="list-style-type: none"> <li>• Reduced school readiness,</li> <li>• School absence,</li> <li>• Pain,</li> <li>• Embarrassed to smile,</li> <li>• Difficulties eating,</li> <li>• Difficulties socialising,</li> <li>• Problems speaking,</li> <li>• Reduced growth.</li> </ul>	<ul style="list-style-type: none"> <li>• Pain,</li> <li>• Problems eating healthy food,</li> <li>• Difficulty smiling,</li> <li>• Difficulty cleaning teeth, Difficulties working.</li> <li>• Reduced dignity,</li> <li>• Reduced confidence,</li> <li>• Problems communicating,</li> <li>• Problem hydrating,</li> <li>• Social isolation,</li> <li>• Increased dependency.</li> </ul>	<ul style="list-style-type: none"> <li>• Time off work,</li> <li>• Feeling stressed, anxious or guilty,</li> <li>• Sleep disrupted,</li> <li>• Family activities interrupted,</li> <li>• Financial difficulties.</li> </ul>

At a society level the impact of oral diseases is substantial, particularly the cost of treatment. The NHS spends £3.4 billion per year on dental care (plus an estimated £2.3 billion is spent on privately funded dental care)<sup>ii</sup>. Tooth decay was the most common reason for hospital admissions in children aged 5-9 years old in 2012/13, at a cost of almost £23 million<sup>iii</sup>.

This document should be read with in conjunction with the Swindon Oral Health JSNA which is a detailed assessment of the oral health needs of Swindon.

<http://www.swindonjsna.co.uk/dna>

## 2. Where do we want to be? Oral health strategy vision, aim and outcomes

The vision of this multi-agency oral health strategy is to improve the oral health of all people living in Swindon. It aspires to promote the best oral health and reduce oral health inequalities across the life course.

Our five priority outcomes are:

1. Ensure oral health is a health and wellbeing priority,
2. Tackle social and lifestyle determinants of oral disease,
3. Embed oral health into commissioning,
4. Commission oral health improvement interventions,
5. Ensure shared ownership of the oral health agenda.

### Strategic targets

- Increase the proportion of 5 year old children free from dental decay to the same level or higher than the England average.
- Reduce admissions rates for tooth extraction in children and young people (0-19 years) to the same rate or less than the England average.

#### Indicators of success

- Increase health professionals knowledge of oral health.
- Ensure that all residents of residential care settings have an oral care plan/protocol.
- Ensure NHS dental contracts deliver the recommended level of fluoride varnish to over 80% of children.

This strategy is designed to support each individual in Swindon to achieve the following:

- Keep sugar to a minimum (quantity and frequency),
- Clean their mouth daily,
- Use fluoride daily,
- Regularly visit a dentist for routine and urgent care,
- Quickly identify any changes in mouth health.

We recognise that many people will not need support for to achieve these outcomes but some will, particularly those who are vulnerable or disadvantaged in other ways.

### 3. Where are we now?

#### a. Oral health in Swindon

The Swindon Oral Health JSNA provides detailed information on the oral health of Swindon, the services available in Swindon and the key areas to improving oral health. The following are a summary of the findings:

- Oral health is integral to general health and should not be considered in isolation, as many of the key factors that lead to poor oral health are risk factors for other diseases and conditions including obesity, heart disease, stroke, cancer and diabetes.
- Oral diseases affects all ages and gender, but the burden of diseases disproportionately affects people who are already vulnerable in some way. This includes children, older people, people living with learning disability, people living in poverty, people whose lifestyles increase their risk of oral disease and those who are dependent on others for support.

- A significant proportion of Swindon 5 year olds (72.1%) are free from obvious dental decay. Almost 30% of 5 year olds however, have more than 3 decayed teeth each.
- The percentage of 5 year old children in Swindon with experience of tooth decay is similar to the England average, and the percentage of 12 year old children with experience of tooth decay (28.1%) is lower than the England average.
- Local data on oral diseases is less readily available for adults. The following estimates are based on South West data from a national survey in 2009:
  - 36% of adults have an average of 3-4 decayed teeth each,
  - 60% of adults have gum disease with around 11% experiencing severe disease,
  - People from more deprived groups suffer from more severe decay, more urgent dental problems and are more likely to have no teeth at all
  - Adults who do not attend a dentist regularly have fewer teeth and more decay.
- Tooth decay varies by age and prevalence is highest in adults aged 25-34 and 75 years and over. The percentage of children and young people (0-19 years) admitted to hospital for extraction of one or more decayed primary or permanent teeth is higher than the England average.
- Oral cancer incidence is relatively low in Swindon: 7.8 cases of oral cancer per 100,000 (age standardized rate) 2010-2012. Oral cancers are however an increasing public health problem. Across England incidence rates are rapidly rising and mortality is high with only a 50% 5 year survival rate. Mortality rates have also increased by around 10% in the last decade.

b. Current work to improve oral health in Swindon

There is a range of work underway in Swindon which addresses social inequalities which will influence oral health. For example the healthy cookery project are healthy cookery/ learn to cook classes for vulnerable adults including adult with a learning disability, and those with mental health problems. These promote low sugar and more savoury foods. In addition public health programmes around healthy weight, breastfeeding, tobacco and alcohol are tackling risk factors common to oral health like sugar, smoking, and so will influence people's oral health. Swindon. Furthermore there is an oral health promotion team which provides oral health training in schools and early years settings. Swindon is well served by a network of dental practices providing NHS dentistry to the residents of Swindon.

4. How do we get there? - Achieving the strategic outcomes

While the causes of oral diseases are well understood, tackling them is complex. A whole system approach is needed that combines universal with targeted action.

Targeted action needs to be focused on those groups who are more likely to experience poor oral health and less likely to access routine NHS dentistry.

This strategy has drawn upon recommendations from the Swindon Oral Health JSNA with the NICE evidence based guidance (NICE PH55; oral health: local authorities and partners, see appendix 2 for summary), Commissioning Better Oral Health for Children and Young People, PHE toolkit (PHE delivering better oral health, 2014) and PHE oral health return on investment tool to produce a strategy which aims for the improvement of oral health across the life course for the population of Swindon.

The Oral Health Strategy links to SBC Priority Four: help people to help themselves while always protecting the most vulnerable children and adults. It also links to the Swindon Health and Wellbeing Strategy Outcome 1: every child and young person in Swindon has a healthy start in life, outcome 2: adults and older people in Swindon are living healthy and more independent lives and outcome 3: improved health outcomes for disadvantaged and vulnerable communities.

#### **Outcome 1: Ensure oral health is a health and wellbeing priority**

- 1.1 Provide a regular report on delivery of Swindon's oral health strategy to the Joint Commissioning group.
- 1.2 Form a Swindon oral health steering group to monitor and review Swindon oral health strategy and action plan.

#### **Outcome 2: Tackle social and lifestyle determinants of disease**

- 2.1 Improve the environments in which people live and work by taking action on social determinants of ill health.
- 2.2 Making healthy choices easier with regard to healthy, sugar free foods and drinks by developing health supporting environments
- 2.3 Supporting reductions in alcohol misuse, tobacco use and substance misuse.

#### **Outcome 3: Embed oral health into commissioning**

- 3.1 Include oral health actions as the norm in strategies, programmes and services aimed at vulnerable adults and children.
- 3.2 Embed oral health within public health improvements such as the Swindon Community Health and Wellbeing Hub.

#### **Outcome 4: Commission oral health improvement interventions**

- 4.1 Ensure the most cost-effective oral health improvement interventions are being commissioned.
- 4.2 Ensure that oral health improvement interventions reduce inequalities by targeting those at greatest risk of poor oral health; including children, older

people, people living with learning disability, people living in poverty, people with lifestyle issues and those who are dependent on others for support.

4.3 Review the evidence for interventions that improve oral health including those that increase availability of fluoride.

### **Outcome 5: Ensure shared ownership of the oral health agenda**

5.1 Work with NHSE and other partners who manage the provision of dental services and dental professionals.

5.2 Ensure early years services and schools provide oral health information and advice, with tailored advice for those at high risk.

5.3 Work with care homes and care providers to raise awareness of oral health.

### **5. How are we going to get there? – Engagement and action plan**

Building on from the engagement that we undertook with the Oral Health Joint Strategic Needs Assessment the following organisations had the opportunity to participate in the shaping of this strategy:

- Swindon Borough Council,
- Public Health England,
- Great Western Hospital NHS Foundation Trust,
- NHS Swindon CCG,
- Primary care dentistry,
- Health Watch Swindon.

The Swindon oral health steering group will update and develop the action plan, monitor the strategic outcomes and targets of the strategy.

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<sup>i</sup> World Health Organisation website [accessed 20<sup>th</sup> November 2015] Available at [http://www.who.int/oral\\_health/policy/en/](http://www.who.int/oral_health/policy/en/)

<sup>ii</sup> NHS England. Improving dental care and oral health – a call for action 2014

<sup>iii</sup> Department of Health. National schedule of reference costs 2011-12 for NHS trusts and NHS foundation trusts. 2012

### Swindon Oral Health Action Plan 2016/17

This action plan is not exhaustive and will be updated and monitored as part of the Swindon oral health steering group.

<b><u>Objective</u></b>	<b><u>Action</u></b>	<b><u>Lead</u></b>	<b><u>Partners</u></b>	<b><u>Measurement and timescale</u></b>
<b>Ensure oral health is a health and wellbeing priority</b>				
Provide a regular report on Swindon's oral health to the joint commissioning group.	Oral health report	SBC	SBC, GWHFT, PHE	Completed report
Form a Swindon oral health steering group	Formation of Swindon oral health steering group	SBC	SBC, GWHFT, CCG, PHE, primary care dentistry.	6 monthly meeting of steering group, first meeting March 2017.
<b>Tackle social and lifestyle determinants of disease</b>				
Improving the environments in which people live and work by taking action on social determinants of ill health.	Discussion of oral health with the workplace wellbeing and attendance group.	SBC	SBC	Spring 2017
	Consideration and advocacy for wider changes which can have a positive impact on oral health e.g. developing healthier preschool settings, safe recreational areas (preventing dental trauma), removing sweets at supermarket checkouts and introducing planning policies that promote healthier food outlets near schools.	PHE	PHE, SBC	Ongoing



	Protocols for mouth care for people who are not able to live independently.	SBC	SBC, providers including care homes and domiciliary care providers	Oral care package as part of contract, April 2017
Making healthy choices easier with regard to healthy, sugar free foods and drinks.	This objective is a key part of the Healthy weight strategy. Examples of specific action within the Health Weight strategy which will impact on oral health include; healthy schools programme, health visitors work on weaning and healthy eating, Change4life.	See Healthy Weight strategy, 2016-21	See Healthy Weight strategy, 2016-21	See Healthy Weight strategy, 2016-21
Supporting reductions in alcohol misuse, tobacco use and substance misuse.	These objectives are a key part of the alcohol strategy and tobacco strategy and This includes reduction in chewing tobacco.	See relevant strategies.	See relevant strategies.	See relevant strategies.
<b>Embed oral health into commissioning</b>				
Include oral health actions as the norm in strategies, programmes and services aimed at vulnerable adults and children	Review which strategies and contracts are to be renewed which are aimed at vulnerable adults and children, to ensure that oral health can be considered. For example	SBC	SBC, PHE for advice	Addition to action plan of details of contracts/strategies which should be considered within this, 2016/17.

	breastfeeding, looked after children, carer centres.			
Embed oral health within public health improvements such as the Swindon Community Health and Wellbeing Hub.	<p>Ensure that there is awareness of oral health issues (e.g. self care, dental care and oral cancers) within public health improvements including healthy weight, tobacco, alcohol and substance misuse teams.</p> <p>Ensure that substance misuse teams are aware of oral health issues including the impact of substance misuse and methadone.</p>	<p>SBC</p> <p>SBC</p>	<p>SBC, PHE, GWHFT</p> <p>SBC, providers, GWHFT</p>	<p>Inclusion of oral health within key strategies (Ageing well, tobacco, healthy weight).</p> <p>Awareness of oral health issues following oral health training.</p> <p>Include oral health in reviews for methadone service users.</p>
<b>Commission oral health improvement interventions</b>				
Ensure the most cost-effective oral health improvement interventions are being commissioned.	<p>Review evidence base, local needs and current service to ensure cost-effective oral health improvement interventions are commissioned.</p> <p>Update service specification</p>	GWHFT, SBC	GWHFT, SBC, PHE, NHS England	Updated service

	for oral health promotion service and continue ongoing discussion with regards to collaborative commissioning on need.			specification for 2017/18  Regular review and monitoring of oral health promotion.
Ensure that oral health improvement interventions reduce inequalities by targeting those at greatest risk of poor oral health.	Ensure service specification for oral health promotion includes targeting to reduce inequalities by focusing on those at greatest risk of poor oral health including children, older people, people living with learning disability, people living in poverty, people with lifestyles that increase their risk of oral disease and those who are dependent on others for support.  Ensure provision of oral health promotion considers accessibility of information.	GWHFT, SBC	GWHFT, SBC, PHE, NHS England	Updated service specification for 2017/18
Review the evidence for interventions that improve oral health including those that increase availability of fluoride.	PHE recently concluded a review of water fluoridation. The oral health steering group will agree priorities from this for Swindon	Oral health steering group		

<b>Shared ownership of the oral health agenda</b>				
Work with partners who manage the provision of dental services and dental professionals	Liaise with NHS England about local needs and provision of outcome data to ensure equitable access to and provision of services.		SBC, PHE, NHS England	Ongoing
	Monitor admissions for tooth extractions in children, and continue to work with partners on this area.		SBC, GWHFT, PHE, CCG	Admissions for tooth extractions in children and young people (0-19 years), annual
Patient and public involvement	Capture the voice of service users and Swindon residents about dental services		NHS England, PHE, SBC, HealthWatch	Inclusion of patient voice in development of action plan
Oral health in schools and early years services	This will be included as part of the ongoing work provided by the oral health promotion service.	GWHFT, SBC	SBC, GWHFT, PHE	See above
	Ensure information on oral health is available electronically to schools and early years settings.	SBC	SBC, GWHFT	2017/18
	Consider oral health explicitly	SBC		2017/18

	as part of Healthy schools.			
Oral health for adults in care homes and adults receiving care at home	Review evidence base and local needs to develop a sustainable model.	SBC	SBC, GWHFT, care homes	2017/18
	Ensure oral health is included in Ageing Well strategy.		SBC	
	Deliver oral health presentation to care home forum.	PHE	PHE, SBC, providers	Early 2017
	All residents of residential care settings have an oral care plan/protocol	SBC	SBC, PHE, GWHFT, providers	March 2018
Oral health for people with dementia	Work with dementia steering group to review potential for dementia friendly dentists, and share existing tools for carers to maintain oral health.	SBC	Dementia steering group	Autumn 2017
Oral health for people with learning difficulties	Work with learning difficulties steering group and identify materials on oral health.  Include in oral health promotion service specification	SBC	Learning difficulties steering group	Autumn 2017
Oral health for looked after	Ensure looked after children	SBC	SBC, PHE, NHS	March 2017

children	have oral care plan as part of care package including access to dentist.  Ensure outcomes of looked after children are collected.	PHE	England	
Oral health for GWHFT inpatients	Oral health care package included for inpatients.	GWHFT	GWHFT, SBC	Autumn 2017
Data gathering	Work with PHE and NHE England to enable us to monitor oral health outcomes.	PHE	SBC, PHE, NHS England	Ongoing

### Appendix to action plan - What works to improve oral health

NICE PH guidance 55 includes the following recommendations:

- Ensure public service environments promote oral health.
- Include information and advice on oral health in all local health and wellbeing policies.
- Ensure frontline health and social care staff can give advice on the importance of oral health.
- Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health.
- Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health.
- Promote oral health in the workplace.
- Commission tailored oral health promotion services for adults at high risk of poor oral health.
- Early years settings:
  - Include oral health promotion in specifications for all early years services.
  - Ensure all early years services provide oral health information and advice.
  - Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health.
  - Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health.
  - Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health.
- Primary and secondary schools:
  - Raise awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools.
  - Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health.
  - Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health.
  - Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health.
  - Promote a 'whole school' approach to oral health in all secondary schools.

The PHE 'delivering better oral health' gives detailed guidance on advice dental health should give and actions they should take to prevent disease. The PHE return on investment tool looks at interventions for 0-5 year olds.

Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:



\*All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated

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## **Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon**

**Health and Wellbeing Board**

**Date: 14 December 2016**

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Author:	Cherry Jones - Director of Public Health, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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### **1. Purpose and Reasons**

- 1.1 Following the agreement of the Swindon Falls and Bone Health JSNA recommendations at the Health and Wellbeing Board it was agreed that the Strategy would be reviewed by the Board and commitment to the aims of the strategy sought.
- 1.2 A Falls and Bone Health JSNA was produced in 2016. One of the recommendations from this was to produce a Falls and Bone Health Strategy, owned and to be implemented by members of the Swindon Falls and Bone Health Collaborative and other partners.
- 1.3 The Collaborative is a Swindon wide multi-agency group lead by Public Health at Swindon Borough Council and NHS Swindon Clinical Commissioning Group. Membership include Great Western Hospital Foundation Trust, SEQOL, Primary Care, South West Ambulance Foundation Trust, Dorset and Wiltshire Fire and Rescue Service, Swindon Borough Council, Avon and Wiltshire Mental Health Foundation Trust, Age UK and Healthwatch.
- 1.4 A draft strategy has been produced as attached. The title reflects the 'Steady Steps to Staying Active for Life' branding which has been developed by the Collaborative and used for a raising awareness event in October 2016 and a booklet on Healthy Ageing, developing strength and balance and reducing the risk of falls which has been distributed across Swindon. The strategy recognises that a focus on falls prevention can result in a risk adverse approach where people are encouraged not to move around and to be inactive. The focus of the strategy is to promote mobility, independence and keeping active in a safe way to reduce harm from falls but developing good bone health throughout the lifecycle.

### **2. Recommendations**

#### The Board is recommended to:

- 2.1 To support the aims and outcomes of the Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon attached at Appendix 1 to the report.

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Further information on the subject of this report can be obtained from Penny Marno, 01793 444711, [pmarno@swindon.gov.uk](mailto:pmarno@swindon.gov.uk).

# Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon

Health and Wellbeing Board

Date: 14 December 2016

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- 2.2 To recommend to Cabinet and the Clinical Commissioning Governing Body that they adopt the Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon.

## 3. Detail

- 3.1 Falls and fall-related injuries are a common and serious problem for older people. Each year 30% of over-65s experience one or more falls and about 50% of people aged over 80 fall. Between 10 and 25% of such fallers will sustain a serious injury (NICE 2013, DH 2009). After a first fall people have a 66% chance of having another fall within a year. Falls are the most common cause of death from injury in the over 65s and cost the NHS over £2bn a year and over 4 million bed days. At an individual level, falls are the number one precipitating factor for a person losing independence and going into long term care.
- 3.2 Falls are not an inevitable part of growing old although the likelihood of a fall increases with age. There are clear risk factors for falling which include previous falls, fear of falling, balance problems, gait and mobility problems, pain, drugs, cardiovascular conditions, and cognitive impairment. External risk factors include poor or cold housing, poor footwear and home hazards: all of which can be modified.
- 3.3 The strongest evidence base for falls prevention is to promote balance and strength development throughout life and once someone has fallen to have an effective fracture liaison service. Strength and balance provision is part of the Government's physical activity guidelines which advise that over a week, people should do at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more, including exercises to improve balance and co-ordination on at least two days a week. Promoting strength and balance will be a key part of the Falls Strategy and also links to the Get Swindon Active Strategy. A fracture liaison service is one of the priorities from the Sustainability and Transformation Plans across the Swindon, Wiltshire and Bath and North East Somerset footprint.
- 3.4 Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon aims to:
- 3.4.1 Promote mobility, independence and improved quality of life for older people.
  - 3.4.2 Promote balance and strength as an integral part of ageing well.
  - 3.4.3 Prevent avoidable falls and reduce the number of hospital admissions due to a fall.
  - 3.4.4 Improve outcomes for people who have sustained a fracture.
- 

Further information on the subject of this report can be obtained from Penny Marno, 01793 444711, [pmarno@swindon.gov.uk](mailto:pmarno@swindon.gov.uk).

# Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon

Health and Wellbeing Board

Date: 14 December 2016

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- 3.5 The outcomes of the strategy will be:
- 3.5.1 Support for people to age well, develop strength and balance throughout their life;
  - 3.5.2 Early and effective identification of people at risk of a fall and early intervention to support them;
  - 3.5.3 A good pathway for people who do fall including preventing future fractures, increasing awareness of the services available and ensuring that treatment doesn't increase risk by reducing mobility when people are in hospital or residential care;
  - 3.5.4 Training and support for the workforce recognising the Making Every Contact Count model that everyone has a role in this.
- 3.6 This will be measured via monitoring of the number of fractured neck of femurs, number of admissions to hospital for falls over 65 years, number of inpatient falls, number of people accessing evidence based preventative exercise and strength and balance classes and number of providers engaging with training.
- 3.7 An action plan will be developed by the Collaborative with measurable actions, timescales and targets under six themes:
- 3.7.1 Early interventions to maintain independence and reduce the risk of falls.
  - 3.7.2 Preventing and managing falls amongst people who are at high risk of falling.
  - 3.7.3 Reducing the rate of inpatient falls and avoidable harm due to falls by April 2018 (this is a key target in Great Western Hospital's internal falls collaborative).
  - 3.7.4 Improving falls and promoting strength and balance in care homes.
  - 3.7.5 Improved bone health and reduced fragility fracture.
  - 3.7.6 Improve understanding of the prevalence and patterns of falls and injuries across Swindon and Shrivenham.

## 4. Alternative Options

- 4.1 The development of a strategy is an agreed outcome from the Swindon Falls and Bone Health JSNA and provides a framework and action plan for delivering falls work across partner agencies.

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Further information on the subject of this report can be obtained from Penny Marno, 01793 444711, [pmarno@swindon.gov.uk](mailto:pmarno@swindon.gov.uk).

# Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon

Health and Wellbeing Board

Date: 14 December 2016

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## 5. Implications, Diversity Impact Assessment and Risk Management

### Financial and Procurement Implications

- 5.1 There are no direct financial or procurement implications arising from this report.
- 5.2 Any service reviews or service requirements which are discussed as a result of this report will be reviewed and a business case developed accordingly.
- 5.3 There are no additional recommendations beyond those which were agreed previously.

### Legal and Human Rights Implications

- 5.4 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.5 There are positive implications on health from promoting falls prevention and bone health. This will benefit both the health and social community as falls have a significant economic and resource impact.

### Diversity Impact Assessment

- 5.6 A diversity impact assessment will be completed as part of the Swindon Falls and Bone Health Strategy and will be available on request. The falls and bone health action plan will include actions to work on identified gaps or issues.

### Risk Management

- 5.7 No specific risks have been identified at this stage for this report.

## 6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

## 7. Background Papers

- 7.1 None.

## 8. Appendices

- 8.1 Appendix 1: Steady Steps to Staying Active for Life: A Falls and Bone Health Strategy for Swindon.

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Further information on the subject of this report can be obtained from Penny Marno, 01793 444711, [pmarno@swindon.gov.uk](mailto:pmarno@swindon.gov.uk).

## **Steady Steps to Staying Active for Life**

### **A Falls and Bone Health Strategy for Swindon**

#### **Introduction**

Falls and fall-related injuries are a common and serious problem for older people. Each year 30% of over-65's experience one or more falls. About 50% of people aged over 80 fall each year. Between 10 and 25% of such fallers will sustain a serious injury. After a first fall people have a 66% chance of having another fall within a year.

Close to 95% of all hip fractures are caused by falls. 80% of people who break a hip are unable to shop, garden or climb stairs a year after a fracture, with implications for both health and social care need. It is estimated that in the UK it costs £6m per day in hospital and social care costs for hip fracture alone.

As well as physical impacts the human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall.

People can fall at any age, however the risk increases as people get older. In Swindon there are 33,000 people aged 65 and over and based on national estimates 11,360 people will fall each year with 4,900 falling twice. In 2015/16 there were 1757 admissions to hospital in Swindon due to falls for people aged 50 and over.

Reducing the risk of falling and effectively supporting people who do fall is a priority for Swindon and requires a multi-agency approach. This strategy aims to promote mobility and independence for people by reducing the number and the impact of harmful falls in Swindon. However it also recognises that falls will happen and that preventative work should not be at the expense of limiting mobility and reducing independence. The focus of the strategy is on developing strength and balance and good bone health throughout people's lifetime, supporting people who do fall in a timely and effective way, and to learn from when falls do occur to constantly improve services and information.

The strategy has been developed and is owned by the Swindon Falls and Bone Health Collaborative; a partnership of key organisations in Swindon who have come together to deliver the recommendations of the Swindon falls and bone health Joint Strategic Needs Assessment and improve quality of life for people living in Swindon.

A mapping exercise undertaken by the Swindon Falls and Bone Health Collaborative identified that there is a wide range of existing provision in Swindon but more could be done to raise awareness between different organisations and the public of what is available and a clearer pathway is needed to look at the transition between services.

#### **Impact, Aims and Objectives**

As a result of the strategy there will be:

- Support for people to age well, develop strength and balance throughout their life;

- Early and effective identification of people at risk of a fall and early intervention to support them;
- A good pathway for people who do fall including preventing future fractures, increasing awareness of the services available and ensuring that treatment doesn't increase risk by reducing mobility when people are in hospital or residential care. This will require inter-agency working to ensure that all Trusts and agencies work together and refer to one another appropriately to avoid fractures and reduce prevalence of falls.
- Training and support for the workforce recognising the Making Every Contact Count (MECC) model that everyone has a role in this. MECC is about taking every opportunity to have a conversation to improve health.

The Swindon Falls and Bone Health Strategy aims to:

- Promote mobility, independence and improved quality of life for older people;
- Promote balance and strength as an integral part of ageing well;
- Prevent avoidable falls and reduce the number of hospital admissions due to a fall;
- Improve outcomes for people who have sustained a fracture.

The outcome measures against which the strategy will be assessed are:

- Number of fractured neck of femurs;
- Number of admissions to hospital for falls over 65 years;
- Number of inpatient falls;
- Number of people accessing evidence based preventative exercise and strength and balance classes;
- Number of care homes accessing training.

### **Quality Improvement**

The Swindon Falls and Bone Health Collaborative will primarily utilise quality improvement (QI) methodology to identify and implement improvements across the falls pathway. QI is not just a method or model, but more an approach to personal or organisational learning, development and improvement. QI can be defined as the application of a systematic approach that uses scientific techniques to improve quality. There are a range of tools and approaches that fit under the QI title, but they all support the concept of a cycle of improvement which involve problem definition and diagnosis, tests of change, data collection and analysis, implementation and evaluation.

Further information on quality improvement can be found at:

<http://www.weahsn.net/news/1663/>

## **Key components of the strategy**

In order to deliver the aims of the strategy we will focus on the following areas.

### **1. Early interventions to maintain independence and reduce the risk of falls**

Preventing falls through earlier and more effective coordinated interventions in the community will improve the quality of life of individuals and families and reduce demand on health and social care services. We will therefore aim to:

- Enable the public of Swindon and Shrivenham to access relevant information about what they can do to maintain good bone health and improve their strength and balance throughout the lifecourse;
- Raise the awareness that falls are not an inevitable part of ageing;
- Promote the risk factors for falls including obstacles at home, alcohol, and other health conditions;
- Promote physical activity at all ages as part of the Get Swindon Active Strategy;
- Promote a healthy diet and, maintaining a healthy weight as part of the Swindon Healthy Weight strategy;
- Promote Vitamin D supplementation for those at greatest risk of deficiency;
- Equip service providers with the knowledge and skills to both reduce risk and manage patients through the falls pathways;
- Encourage patients at risk to have regular medication reviews;
- Offer or signpost to a range of evidence based preventative exercise and strength and balance classes e.g. Tai Chi and dance;
- Establish systems and processes for voluntary and community sectors to identify people at risk of falling and effectively refer them into the falls pathway;
- Provide community-based services to support safety at home.

### **Preventing and managing falls amongst people who are at high risk of falling.**

Timely, appropriate and coordinated management may lead to reduced emergency department attendances and admissions as a result of a fall. Managing falls is important as a focus only on falls prevention can result in a risk adverse approach where people are encouraged not to move around and to be inactive. Action will include:

- Developing a robust pathway to ensure that older people who are at high risk of falling, or have fallen or sustained a fracture, receive timely and appropriate interventions;
- Effective inpatient falls policies, procedures and training for staff, in all patient settings and other nursing and care settings. This will ensure falls risk assessments are carried out and evidenced based strategies and interventions are developed so as to balance the risk of a fall with maintaining mobility and long term health;
- Working collaboratively to ensure delivery of NICE clinical guidelines and quality standards relating to falls in older people;
- Review existing arrangements and implement an appropriate care pathway and clinical protocols for use by the South West Ambulance Service (SWASFT) where the person is not acutely unwell;



- Develop effective risk stratification in primary care for people at risk of falling;
- Recognising the increased risk of falls from sight problems and hearing loss and work with the Local Optical Committee to signpost to appropriate support;
- Link to the dementia pathway to understand the increased risk and appropriate support.

### **Inpatient falls**

People need to feel safe in hospital. However one of the key things that increase people's risk of falling is reduced muscle strength and poor balance. Sitting or lying for long periods of time can make someone more likely to fall and yet a busy hospital environment means it can be difficult to support people to move as much as they should. A loss of mobility whilst in hospital can make it more difficult for people to return to their own homes and increase the need for home support or residential care.

Great Western Hospital Foundation Trust (GWHFT) have an internal falls collaborative, with the following aim:

#### **To reduce the rate of inpatient falls and avoidable harm due to falls by April 2018**

GWHFT will report on the quality improvements undertaken within the acute setting to the Swindon Falls and Bone Health Collaborative.

### **Improving falls and promoting strength and balance in care homes**

We need to be clear why so many people need admission to hospital following a fall and work with the care homes in Swindon to reduce falls. It is clear that people with more complex needs are remaining in residential care homes and further work is needed to understand the most effective approaches to reducing risk of falls. To establish best practice we will:

- Use the data, including ambulance, GP and/or Community Nurse call outs for falls to target homes with the greatest number of falls and potential for reduction;
- Develop a sustainable approach to ensure that all staff in care homes have a fundamental understanding of falls awareness and knowledge of referral pathways for people who are at risk of falling or who have fallen;
- Promote training around maintaining strength and balance for all older people to help with preventing falls and minimising the impact when people do fall in care homes;
- Look at best practice from elsewhere including the use of technology.

### **Improved bone health and reduced fragility fracture**

By improving bone health we can reduce the risk of fracture and further falls for those people who have already fallen. This will be achieved by:

- Exploring the development of a fracture liaison service within Swindon as part of the Sustainability and Transformation Plan (STP);
- Implementing the NICE guidance for primary and secondary prevention of fragility fracture, including osteoporosis screening and management.

**Improve understanding of the prevalence and patterns of falls and injuries across Swindon and Shrivenham**

- Work with partner agencies to improve data collection processes and mechanisms;
- Regularly review information and data to assess implementation of the strategy and to inform future commissioning.

**Performance management and delivery of the strategy**

The multi-agency Swindon Falls and Bone Health Collaborative Group will develop a detailed implementation plan and oversee the implementation process.

Implementation will be phased to take account of the work required by a number of agencies and services across the pathway, and to ensure that the pathway is built on strong foundations.

## Appendix A: The 2014 Swindon Falls and Bone Health Profile: Progress to Date

In 2014 a Falls and Bone Health Profile for Swindon was written and agreed by the Swindon Health and Wellbeing Board. This has recently been updated but the recommendations are still relevant although progress has been made in each area. The Swindon Falls and Bone Health Collaborative is specifically focused on delivery of the recommendations and they will shape the Strategy and work programme going forward.

The recommendations together with a list of progress to date are listed below:

1. Review currently commissioned services that contribute to falls prevention, and care and support of those who fall, and explore opportunities for joined-up multi-agency approaches to commissioning to ensure that there is a clear evidence based falls and fracture care pathway in Swindon

*This work is part of the remit of the Swindon Falls and Bone Health Collaborative. A mapping exercise was undertaken by the group and a draft pathway produced. Developing this and identifying opportunities for more joined up approaches is a priority.*

2. Develop resources and training for health and social care professionals and the community and volunteers which promote falls and osteoporosis awareness, the importance of case risk assessment and case identification, existing falls services available in Swindon and appropriate referrals to these services

*A falls booklet has been produced and was launched at the Steady Steps to Staying Active for Life Event on 5th October 2016. The Swindon Falls and Bone Health Collaborative is a forum where agencies are working together to learn from each other and develop a consistent approach.*

3. Explore ways to increase capacity to undertake multifactorial falls risk assessment within health care services in Swindon. This may be through the existing community falls service or within Primary Care.

*Ongoing through the work of the Swindon Falls and Bone Health Collaborative. The group is looking at how risk is assessed for people at different levels of falls risk and also reviewing the services, particularly in terms of prevention, that are available to those who have not fallen but are at risk and those who have fallen without injury to reduce the risk of falling again.*

4. Improve referral pathways in to community falls clinic for repeat fallers attended to by the ambulance service or Homeline including redesign of current risk assessment forms used.

*A working group has looked at exchange of information between Homeline and Primary Care and developed a pilot project to improve this. A working group is also looking at frequent fallers. The STP work includes developing a consistent Fracture Liaison Service across the footprint.*

5. Identify ways to extend local provision of evidence based strength and balance training through group classes and home based interventions including building links with nursing and residential care, Primary Care, Health Ambassadors and the new Community Navigators project.

*Ongoing through the work of the Swindon Falls and Bone Health Collaborative and the redesign of the Community Health and Wellbeing Service and Live Well Swindon brand.*

6. Support national campaigns and deliver local campaigns to promote healthy ageing including physical activity and other healthier lifestyle choices and other protective factors for falls

and osteoporosis; advises older people and carers on what they should do in the event of a fall or fragility fracture; advises older people and carers about risk factors for falls and fractures and the steps they can take to reduce their risk.

*Ongoing via the Multi-agency Communications Team work and workplace health agendas across Collaborative organisations. There was a Steady Steps to Staying Active for Life Event on 5th October 2016 which promoted this and provided people with information and an opportunity to try different activities.*

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## Consideration of Joint Commissioning Group Minutes

Health and Wellbeing Board

Date: 14 December 2016

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Author:	Sue Wald – Director of Adult Services, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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### 1. Purpose and Reasons

- 1.1 To allow the Health and Wellbeing Board to consider the issues arising from the meetings of the Joint Commissioning Group held on 20 July, 15 September and 13 October 2016.

### 2. Recommendations

The Committee is recommended to:

- 2.1 To review the discussions held and issues arising from the meetings of the Joint Commissioning Group held on 20 July, 15 September and 13 October 2016, and where appropriate request additional information or reports in relation to issues raised.

### 3. Detail

- 3.1 The Health and Wellbeing Board is invited to consider issues arising from the minutes of the Joint Commissioning Group held on 20 July, 15 September and 13 October 2016 and to request additional information and/or reports on issues raised.

### 4. Alternative Options

- 4.1 None.

### 5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 This report has no financial or procurement implications.

Legal and Human Rights Implications

- 5.2 This report has no legal or Human Rights considerations.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 None.

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Further information on the subject of this report can be obtained from Sue Wald, 01793 465713, [swald@swindon.gov.uk](mailto:swald@swindon.gov.uk).

# Consideration of Joint Commissioning Group Minutes

Health and Wellbeing Board

Date: 14 December 2016

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## Diversity Impact Assessment

- 5.4 No Diversity Impact Assessment is required at this stage.

## Risk Management

- 5.5 No risk management issues have been identified at this stage.

## **6. Consultees**

- 6.1 This covering report presents the minutes of the Joint Commissioning Group at their meetings on 20 July, 15 September and 13 October 2016. The items discussed at that meeting were / will be consulted upon as appropriate, so no further consultation is required for this report.

## **7. Background Papers**

- 7.1 None.

## **8. Appendices**

- 8.1 Appendix 1 - Minutes of the Joint Commissioning Group held on 20 July 2016.
- 8.2 Appendix 2 – Minutes of the Joint Commissioning Group held on 15 September 2016.
- 8.3 Appendix 3 – Minutes of the Joint Commissioning Group held on 13 October 2016.

**Joint Commissioning Group**  
**Notes of 20<sup>th</sup> July 2016 Meeting**

**Present:**

Cherry Jones (CJ), Joy Kennard (JK), Thomas Kearney (TK), Sheila Baxter (SB), Lyn Frith (LF), Gill May (GM)

Item	Description	Action
1.	<p><b>Apologies</b></p> <p>Sue Wald, Caroline Gregory, Peter Nathan, Paul Bearman, Louise Tapper, , Angela Plummer, Jackie Walker, Sally Burnett, Matthew Hawkins.</p>	
2.	<p><b>Matters arising and Minutes</b></p> <ul style="list-style-type: none"> <li>• Sheila M to email Thomas with attendance list.</li> <li>• Terms of reference to be refreshed.</li> <li>• Nicki Millin and Peter Crouch to be removed from attendance list.</li> <li>• Lynette Glass has been asked to complete a weekly NHS England return for funded (looked after) placements from Children's Services. – Valerie Williams and Tina Meacham to send this to Lynette (JK emailed Tina during the meeting).</li> <li>• AWP – SB – still ongoing. Concerns about all options around 136 now renamed "Place of Safety". Will feedback at next meeting. AWP conducting consultation on places of safety which needs to be shared with SBC</li> <li>• Urgent Care working group and underutilisation of bridging services – GM has raised at Contract meeting.</li> <li>• Minutes from 24 June 2016 were agreed as an accurate record of the meeting.</li> </ul>	<p>SCM</p> <p>JK</p> <p>SB</p>
3.	<p><b>Better Care Fund Submissions</b></p> <ul style="list-style-type: none"> <li>• Our plan was approved by NHSE but all CCG's nationally have to resubmit.</li> </ul>	
4.	<p><b>Adults Social Care Performance Framework</b></p> <p>This performance framework is for adult social care only and does not cover Health or Children's data. Children's data to be presented bi-monthly</p> <ul style="list-style-type: none"> <li>• Slide 2 – Proportion of carers receiving direct payments – low</li> </ul>	



<b>Item</b>	<b>Description</b>	<b>Action</b>
	<p>performance and this indicator is part of contract discussions with SEQOL and AWP. The CCG are developing a Carers Strategy. Update to be provided on this indicator at next meeting and how it feeds into CCG strategy.</p> <ul style="list-style-type: none"> <li>• Slide 3 – delayed transfers of care from hospital are improving for social care but health delays and snapshot on a Thursday still need further improvement.</li> <li>• Slide 4 – Ensuring people have positive experience of care and support. AP attending weekly meetings and working with Seqol re capacity. DeTOC (Delayed Transfers of Care) programme board reports to SRG (the Swindon Resilience Group)</li> <li>• D40 adults receiving a service who have received an annual review –update to be provided at next month's meeting.</li> <li>• Slide 6, Key activities – agreed that it would be helpful to separate out health and social care for reporting purposes and to ensure that the issues can be clearly understood. To be actioned for next month's meeting.</li> <li>• Look to include health in this framework going forward so Adults, Health and Social Care Framework. Contact Graham O'Malley for health data and Esther for children's from CCG to inform this process; ES will be in post in September.</li> <li>• Final version of the framework to be circulated to all.</li> </ul> <p>Children's data to be presented separately.</p>	<p>PL</p> <p>Jo Ash</p>
<b>5.</b>	<p><b>Risk Commissioning – Adults</b></p> <ul style="list-style-type: none"> <li>• First draft of the risk register was circulated for comment around the measures. Consistency required on calculating risk levels.</li> <li>• Jackie Walker and Matthew Hawkins to review risk register</li> </ul>	JW/MH
<b>6.</b>	<p><b>SBC Quality Account Children's Community Health Service 2015-16</b></p> <ul style="list-style-type: none"> <li>• A Quality Account is an annual report that all providers of healthcare services must publish to inform the public about the quality of the services being provided. This requirement is set out in the Health Act 2009. The SBC Quality Account Childrens Community Health services 2015-16 has been</li> </ul>	GM

<b>Item</b>	<b>Description</b>	<b>Action</b>
	submitted to the Dept of Health and has also been circulated for information and comment to Swindon CCG, and the Patient and Public forum.	
<b>7.</b>	<b>PPV uptake</b> <ul style="list-style-type: none"> <li>Concern was raised about the relatively low uptake of the PPV (pneumococcal vaccine) to prevent respiratory disease in the elderly. Discussion was centred on how to increase uptake possibly through the winter campaign activity and linking with the seasonal flu vaccination activity. GM to take to Primary Care Team. Sharren Pells to be included in conversations around this.</li> </ul>	GM
<b>8.</b>	<b>SEND</b> <ul style="list-style-type: none"> <li>Swindon could be subject to a Local Area Inspection anytime during the next 5 years and we need to be prepared.</li> <li>CCG self evaluation underway - to come to Sept JCG meeting. LF meeting with GM to review.</li> <li>LF to circulate the SEND strategy to JCG members.</li> <li>Lynette Glass is the lead for the CCG from a Health perspective.</li> <li>LF will present comprehensive consolidated SEND report to JCG for discussion to identify any concerns and agree further actions</li> <li>Review the JCG terms of reference (September meeting) to ensure SEND 0-25 joint commissioning represented.</li> </ul>	LF
<b>9.</b>	<b>CAMHS</b> <ul style="list-style-type: none"> <li>Long standing Referral to Treatment non-compliance leading to increase in waiting times. Oxford health are working to an improvement plan to show improved performance in 2 months time</li> <li>Tender of tier 3 services coming back to CCG management. The new contract needs to be in place for March 2017. Wiltshire and BaNES have invited Swindon to join a joint tender for CAMHS. The impact of the integrated service in SBC needs to be looked at in the consideration of tendering. An urgent meeting is to be arranged for key people to understand the issues including with Nicki Millin and Karen</li> </ul>	TK JK

<i><b>Item</b></i>	<i><b>Description</b></i>	<i><b>Action</b></i>
	Reeve. <ul style="list-style-type: none"> <li>Hospices also need re-commissioning for next year. – JK will ask for the pricings to pass to legal in SBC.</li> </ul>	
<b>10.</b>	<b>Any other business</b> <ul style="list-style-type: none"> <li>CAMHs contract sign off - TK. JK will liaise with SBC legal team.</li> <li>Transforming Care Programme – LF. Visit on 27<sup>th</sup> July from NHS England (Cindy Gordillo). Involving both SBC and CCG and the transition for young people leaving residential care. LF to circulate documentation and coordinate a pre-meet with Lynette (CCG) and Elaine. LF to email letter to GM.</li> <li>The next round of bidding for the National Diabetic Prevention Programme is September 2016. Agreed a collaborative bid across our STP footprint. Draft submission to be circulated to JCG in September for comment prior to submission. CJ.</li> </ul>	JK  LF

**Joint Commissioning Group (JCG) Meeting****15<sup>th</sup> September 2016****Minutes****Present:**

Cherry Jones (CJ)	SBC – Director Public Health
Gill May (GM)	CCG – Executive Nurse
Sheila Baxter (SB)	CCG – mental Health Joint Commissioner
Thomas Kearney (TK)	CCG – Associate Director for Urgent Care
Graeme O'Malley (GO)	CCG – Community Contract Lead
Phillipa Lamb, (PL)	SBC – Strategy & Development Manager
Joy Kennard, (JK)	SBC - Head of Commissioning
Lyn Frith, (LF)	SBC - Strategic Commissioner SEND

<b>Item</b>	<b>Description</b>	<b>Action</b>
1.	<p>Apologies</p> <p>Apologies from Sue Wald (SW) Director Adult Social Services SBC, Angela Plummer (AP) Head of Adult Services SBC, Paul Bearman (PB) Executive Director of Corporate and Business Development, Karen Reeve (KR) Director of Children Services SBC, Peter Nathan (PN) Head of Education SBC, Jackie Walker (JW) Head of Finance Vulnerable People SBC, Matthew Hawkins (MH) Finance, CCG.</p>	
2.	<p>Minutes of the 20 July 2016 meeting &amp; matters arising</p> <p>Actions</p> <ul style="list-style-type: none"> <li>• AWP Place of Safety. AWP's draft consultation documents to be received and approved by SB. Consultation document will be circulated for comment to JCG in October</li> <li>• Adult Social Care Performance Framework – PL confirmed that she would contact KR to discuss JCG receiving regular performance reports for children's services</li> <li>• Risk Commissioning – Adults. JW/MH review risk register and bring to next meeting. PPV uptake – has been discussed with Primary Care Teams.</li> <li>• CAMHS Tier 3 Commissioning. Out to tender (joint BaNES, Swindon and Wiltshire).</li> <li>• Children's hospice commissioning - JK to update at next</li> </ul>	<p><b>SB</b></p> <p><b>PL</b></p> <p><b>JW/MH</b></p> <p><b>JK</b></p>

	<p>meeting.</p> <ul style="list-style-type: none"> <li>National Diabetic Prevention Programme (NDPP) draft submission under development for the STP. CJ to circulate when available.</li> <li>CAMHS contract - Meeting with LF and GM taking place.</li> <li>Minutes from 20 July 2016 were agreed as an accurate record of the meeting</li> <li>Minutes from 24<sup>th</sup> June have been amended: With an amendment to section 2, Matters arising and Minutes. Page 1. Point 3. Amendment to read "Speech and Language Therapy and Paediatric Therapy - The demand and subsequent business case put forward for additional funding has been considered by the CCG. This demand profile will be fully considered within the wider review currently being undertaken across Children's community provision and will fully inform commissioning intentions once completed to address this. This will be completed by the end of the financial year 2016/17."</li> </ul>	<p><b>CJ</b></p> <p><b>LF/GM</b></p> <p><b>JK</b></p>
3.	<p><b>SEND Inspection Report</b></p> <p>LF provided an update to the group on the implications of SEND area inspection framework and presented the SEND Strategic Plan.</p> <ul style="list-style-type: none"> <li>The implications of the Swindon SEND Strategic plan and the completed self-assessment (approved by the SEND Strategic Board) were discussed and considered. The SEND Strategic Board oversees the Strategic Plan and monitors the outcomes accordingly.</li> <li>The completed CCG self-assessment was circulated by GM and also discussed. Any further comments to be forwarded to GM.</li> <li>The Plan will be revised taking into account the CCG Self-Assessment.</li> <li>Dates to be added to the Strategic Plan</li> <li>Revised plan to come back to JCG November meeting.</li> <li>From May 2016 all local areas in England will be subject to a joint inspection from Ofsted and the Care Quality Commission (CQC) to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014</li> <li>The inspection will review how local areas support these children and young people to achieve the best possible educational and other outcomes, such as being able to live independently, secure meaningful employment and be well prepared for their adult lives.</li> </ul>	<b>LF</b>
4.	<b>Better Care fund quarterly return</b>	

	Quarterly return circulated for information.	
5.	<p><b>Adults Social Care Performance Quality Framework</b></p> <ul style="list-style-type: none"> <li>• Areas of improved performance especially around personalisation were noted. Members of JCG recommended reporting rolling year figures alongside year to date for adult and carers reviews to provide a more balanced assessment of performance. PL to follow up.</li> <li>• Following the Delayed Transfers of Care (DTOC) Summit, NHS England have withdrawn direct input to the DTOC programme as they are now assured robust plans are in place to continually drive improvement</li> <li>• It was noted the newly established Transition Programme would support improvements around employment for people with learning disabilities JCG requested 6 monthly updates on programme progress. PL to follow up.</li> <li>• Managing demand continues to be a challenge with hospital discharges and high demand for temporary nursing care presenting cost pressures</li> <li>• It was agreed for JCG to receive regular performance reports for Health services. GO to follow up.</li> <li>• Current pressures in Health Services – <ul style="list-style-type: none"> <li>○ Capacity issues regarding District Nurses – TK</li> <li>○ Capacity issues across community services – GO working with colleagues to address</li> <li>○ Oversight Transition Board in place with weekly intelligence call with NHS England to oversee the transfer of SEQOL services recognising it's ahead of schedule. Strong focus on quality and safety of all services with areas of concern addressed or escalated where appropriate.</li> </ul> </li> </ul>	<p><b>PL</b></p> <p><b>PL</b></p> <p><b>GO</b></p>
6.	<p><b>SBC Revenue Monitoring Reports (Finance)</b></p> <p>The July and August monitoring reports were reviewed</p> <ul style="list-style-type: none"> <li>• The forecast outturn position across Adults Social Care and Health Commissioning at the end of August was reported as a budget pressure of £2.718m.</li> <li>• The forecast outturn position across Public Health services at the end of August was a net saving of £150k.</li> </ul>	
7.	<p><b>Re-commissioning CAMHS (Children and Adolescent Mental Health Services) )</b></p> <p>The CAMHS tier 111 contract period has expired and been further extended under the Standing and Financial Instructions for SBC for 2017-18. Tier 111 services must be re-procured by the CCG for 2017-18.</p> <p>TK presented a report outlining the intention to re-commission the</p>	<b>TK</b>

	CAMHS with tier 111 procurement with STP partner CCGs. Tier 11 services remain provided by SBC. This option has been agreed by SBC Director of Adults Social Services and Director of Children's Services.	
8.	<b>AOB</b> <ul style="list-style-type: none"> <li>• <b>Terms of Reference.</b> To be reviewed. Comments to SM for collation and agreement at Oct meeting.</li> <li>• SM to create a forward plan and circulate for comment.</li> </ul>	<b>All</b>  <b>SM</b>

**JCG Meeting**  
**13<sup>th</sup> October 2016**  
**MINUTES**

**Present:**

Sue Wald (SW)	SBC – Director Adult Social Services
Cherry Jones (CJ)	SBC – Director Public Health
Gill May (GM)	CCG – Executive Nurse
Sheila Baxter (SB)	CCG – Mental Health Joint Commissioner
Graeme O'Malley (GO)	CCG – Community Contract Lead
Esther Schmidt (ES)	CCG/SBC – Joint Children's Services Commissioning Lead
Phillipa Lamb (PL)	SBC – Strategy & Development Manager
Joy Kennard (JK)	SBC - Head of Commissioning
Lyn Frith (LF)	SBC - Strategic Commissioner SEND
Karen Reeve (KR)	SBC – Director Children Services
Victoria Guillaume (VG)	SBC - Project development manager
Jackie Walker (JW)	SBC - Head of Finance
Angela Plummer (AP)	SBC – Head of Adult Services

1.	<b>Welcome &amp; Apologies</b>  Apologies	
2.	<b>Minutes of the last meeting &amp; matters arising</b>  The minutes from the meeting on 15 <sup>th</sup> September were agreed as a true record of the meeting.	
3.	<b>Review Terms of Reference for the Group</b>  CCG and SBC jointly commission services using the Section 75 and the Better Care Fund. This is overseen by The Joint Commissioning Group who report into The Health and Wellbeing Board and The CCG Governing Body. The terms of reference for JCG are part of the S75 agreement.  The role of JCG is to provide assurance that the joint commissioning and service priorities planned for 2016/17 are being delivered. This requires robust monitoring and reporting to track spend, demand, performance and cost pressures so issues can be escalated when appropriated. The joint commissioning responsibilities cover:	



	<ul style="list-style-type: none"> <li>• Adult social care</li> <li>• Public health</li> <li>• Children's social Care and Early Help</li> <li>• Children's health services</li> <li>• Mental health</li> </ul> <p><b>Agreed Action:</b> <i>Members of the group to familiarise themselves with the content and governance arrangements for S75 (check Health and Wellbeing website)</i></p> <p><b>Agreed Action</b> <i>The membership of the group to be reviewed to ensure there is senior representation from relevant business areas – send comments to Sheila Morley <a href="mailto:SMorley@swindon.gov.uk">SMorley@swindon.gov.uk</a> for collation for next meeting</i></p> <p><b>Agreed Action</b> <i>To review Terms of Reference providing clarity around what is in scope for the group to consider (send comments to Sheila Morley <a href="mailto:SMorley@swindon.gov.uk">SMorley@swindon.gov.uk</a> for collation for next meeting)</i></p> <p><b>Agreed Action</b> <i>To review the frequency of JCC meetings to ensure it meets business need (send comments to Sheila Morley <a href="mailto:SMorley@swindon.gov.uk">SMorley@swindon.gov.uk</a> for collation for next meeting)</i></p> <p><b>Agreed Action</b> <i>For JCG members to undertake a 6 month stake take of 2016/17 Commissioning Intentions and report progress and challenges. For this intelligence to be used to begin to shape the priorities for 2017/18</i></p>	<p>ALL</p> <p>ALL</p> <p>ALL</p> <p>ALL</p> <p>SW/V G</p>
4.	<p><b>Risk register</b></p> <p><b>Agreed Action:</b> <i>JW and GM to review and present to a future meeting.</i></p>	JW/G M
5.	<p><b>Performance Update</b></p> <p>It was agreed that although JGG needs assurance that the commissioning intentions are being progressed as planned, the group is keen to reduce the burden of monitoring and reporting and not duplicate effort. It was discussed that if information relating to the commissioning intentions is already being scrutinised and challenged by another Board or forum (covering spend, activity, performance and cost pressures), JCG will take assurance from that process. However, members of JCC will be required to provide an exception report to highlight the potential impact of key performance challenges and cost pressures. The following areas were brought to the groups attention:</p> <ul style="list-style-type: none"> <li>• DTOC continues to be a performance issue (off target) although performance has improved compared to</li> </ul>	JK

	<p>2015/16</p> <ul style="list-style-type: none"> <li>A&amp;E delivery board – need oversight of progress so recommend JCG has sight of the minutes of the meetings.</li> <li>Weekly meetings ongoing between SBC/CCG/GWH to manage the handover of services from SEQOL</li> </ul> <p><b>Agreed Action:</b> <i>to circulate minutes for A&amp;E Delivery Board to JCG</i></p> <p><b>Agreed Action:</b> <i>To map the forums and boards currently scrutinising and challenging data relating to joint commissioning intentions. Identify gaps and make recommendations for future reporting which ensures JCG is compliant with the S75 requirements.</i></p>	<p>SM</p> <p>PL</p>
6.	<p><b>Budget Update</b> – the following cost pressures were highlighted:</p> <ul style="list-style-type: none"> <li>SBC: Adults - current projected overspend of £1.6m</li> </ul> <p>Cost pressures relate to older people care packages and an additional 20 people who have been admitted to nursing care. Increased in nursing home, residential care and domiciliary care fees to meet increase in minimum wage have resulted in budget pressure of £1.7m. Funded Nursing care fee increase is passed to providers on top of fee increase until January 2017 when DH will review. There will be a review of how fees for nursing homes are negotiated for 2017/18.</p> <ul style="list-style-type: none"> <li>Children's – current projected overspend approx. £2m</li> </ul> <p>The service pressures continue to increase particularly in relation to commissioned placements, and additional staffing costs. Difficulties in recruiting staff and increasing workload demands have necessitated the use of agency social care staff across the service. There are a higher number of children coming into care and this inevitably impacts on legal costs, as legal services support the process of children coming into the care of the local authority.</p> <ul style="list-style-type: none"> <li>Public Health - projecting an under-spend</li> <li>CCG – projecting an overspend between £0.5m and £1m but high risk of further cost pressure related to the transfer of services from SEQOL.</li> </ul> <p>The savings delivered by SBC and CCG (QIPP savings plan) will contribute to the Sustainability and Transformation Plan (STP) savings.</p>	
7.	<b>Children's Hospice</b>	

	CCG will manage the contract from March 2017.	
8.	<p><b>AWP Place of Safety</b></p> <p>Still awaiting consultation document. Need to consult with children's services on the proposals.</p> <p><b>Agreed Action: <i>Consultation document to be shared with JCG</i></b></p>	SB
9.	<p><b>Inequalities Report</b></p> <p>The inequalities report has been endorsed by Health and Wellbeing Board Chairs Advisory Group and Health and Wellbeing Board. The report is available on the JSNA website. All commissioners need to be mindful of this document and use it to inform commissioning intentions and service development.</p>	
10.	<p><b>Integrated Personal Commissioning (IPC)</b></p> <p>Integrated Personal Commissioning (IPC) joins up health and social care funding for people with complex needs, so they can direct how it is used. IPC identifies the total amount of money spent on a person so they can have more control over how this money is used for their support, so that it may be spent in new ways. The aim is to improve the quality of life for people with complex needs and their carers by giving them greater flexibility in designing a service around their personal needs and circumstances. The aim is to have at least 250 adults and children with personal budget by 2020 (current performance is 6). Service users will need indicative budgets to be eligible for IPCs. Paul Davis (SEN/High Needs Finance Officer at SBC) is currently doing some modelling work around indicative budgets.</p> <p><b>Agreed Action: <i>SBC and CCG colleagues to work collaboratively to establish robust processes for implementing the use of IPCs and to ensure practitioners and finance colleagues are appropriately trained to manage the process including the timely payments of invoices</i></b></p> <p><b>Agreed Action: <i>SBC and CCG colleagues to identify potential users who may benefit from having an IPC and to target this cohort to improve uptake.</i></b></p> <p><b>Agreed Action <i>To resolve the outstanding monies due to SBC from CCG for previous PHBs and IPCs.</i></b></p> <p><b>Agreed Action <i>To share at the next JGG meeting the process for implementing IPCs more widely</i></b></p>	<p>GO/M G</p> <p>GO/M G</p> <p>GM/AP</p> <p>GO</p>
11.	<p><b>Sustainability and Transformation Plan (STP)</b></p> <p>Still in development – next submission due end of October 2016. The aim of the plan is to deliver significant savings through demand</p>	

	<p>management focussing on three key areas:</p> <ul style="list-style-type: none"> <li>• Preventative and proactive Care</li> <li>• Planned care</li> <li>• Urgent &amp; Emergency Care</li> </ul> <p><b>Agreed Action:</b> <i>To share STP with JCG once approved by NHS England and NHSE have released for publication</i></p>	SW
12.	<p><b>Children's Review update</b></p> <p>Initial meeting planned 2 November 2016. The group will be kept informed of progress.</p>	GM
13.	<p><b>My Care My Support update</b></p> <p><b>Agreed Action:</b> <i>Request that Caroline Gaulton provides regular updates for JCG on issues and developments.</i></p>	SM
14.	<p><b>Financial Planning 2017/18</b></p> <p>NHS planning guidance has been issued – 2 year plan is required by 23/12/16.</p> <p>SBC requires services to deliver a balanced budget for 2017/18 and beyond</p>	
15.	<p><b>Add to Forward Plan</b></p> <ul style="list-style-type: none"> <li>• Financial planning assessments for 2017/18 – informed by cost pressures and priorities</li> <li>• Children's review update</li> <li>• Sustainability and Transformation Plan</li> </ul>	SM
16.	<p><b>AOB</b></p> <p>None</p>	

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## Future meeting dates of the Board

**Health and Wellbeing Board**
**Date: 14 December 2016**

Author: Cherry Jones - Director of Public Health, Swindon Borough Council

Wards: All

Locality Affected: All

Parishes Affected: All

### 1. Purpose and Reasons

- 1.1 To provide an opportunity to members of the Board to discuss and agree the proposed meeting dates for the 2017 – 2018 Municipal Year.

### 2. Recommendations

The Board is recommended to:

- 2.1 Agree the proposed dates as set out in paragraph 3.3 of the report, subject to any changes made as a result of discussions held at the meeting.
- 2.2 Note that the final dates will be subject to sign-off by Full Council in May 2017 as part of the Meetings Calendar for 2017-2018.

### 3. Detail

- 3.1 The Terms of Reference of the Health and Wellbeing Board were revised at its meeting held on 25 May 2016. These set out the procedures for meetings of the Board.
- 3.2 Board meetings are held every two months, usually on the second Wednesday of the month (where possible) at 2.00pm. The five public Health and Wellbeing Board meetings are held on alternate months to the Chair's Advisory Group, which is a non-decision making forum used to brief Board members. The Chair's Advisory Group meeting is also usually held on the second Wednesday of the month at 2.00pm where possible.
- 3.3 The dates proposed for the meetings during the 2017 – 2018 Municipal Year are as follows:

Meeting	Date
Chairs Advisory Group	15 February 2017 (already agreed) (1.00pm start)
Health and Wellbeing Board	15 March 2017 (already agreed) (1.00pm start)

Further information on the subject of this report can be obtained from Vicki Yull, 01793 463603, [vyull@swindon.gov.uk](mailto:vyull@swindon.gov.uk).

## Future meeting dates of the Board

Health and Wellbeing Board

Date: 14 December 2016

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Meeting	Date
Chairs Advisory Group	12 April 2017 (already agreed)
Health and Wellbeing Board	24 May 2017
Chairs Advisory Group	14 June 2017
Health and Wellbeing Board	12 July 2017
Chairs Advisory Group	13 September 2017
Health and Wellbeing Board	11 October 2017
Chairs Advisory Group	15 November 2017
Health and Wellbeing Board	13 December 2017
Chairs Advisory Group	14 February 2018
Health and Wellbeing Board	14 March 2018
Chairs Advisory Group	18 April 2018

#### 4. Alternative Options

- 4.1 Alternative dates may be proposed during the discussion of this report. Final dates will be subject to sign-off by Full Council in May 2017 as part of the Meetings Calendar for 2017-2018.

#### 5. Implications, Diversity Impact Assessment and Risk Management

##### Financial and Procurement Implications

- 5.1 Not applicable.

##### Legal and Human Rights Implications

- 5.2 Not applicable.

##### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 Not applicable.

##### Diversity Impact Assessment

- 5.4 Not applicable.

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Further information on the subject of this report can be obtained from Vicki Yull, 01793 463603, [vyull@swindon.gov.uk](mailto:vyull@swindon.gov.uk).

## Future meeting dates of the Board

Health and Wellbeing Board

Date: 14 December 2016

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### Risk Management

5.5 Not applicable.

### **6. Consultees**

6.1 None.

### **7. Background Papers**

7.1 None.

### **8. Appendices**

8.1 None.



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TO:  
Chairs of Health and Wellbeing Boards  
Chief Constables  
Police and Crime Commissioners

15 November 2016

Dear All

**Police and Crime Commissioners and Health and Wellbeing Boards**

We are writing to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

The interface between crime and public health is well-documented – in the Department of Health’s public health outcomes framework, for example, which contains a number of indicators that recognise the links, including: entry to the youth justice system, people in prison with a mental illness, domestic abuse, violent crime, re-offending, drug treatment outcomes and perception of community safety.

In many areas of the country, police and health and care partners, in both the NHS and Local Government, are working collaboratively to deliver better outcomes for individuals, including the most vulnerable and local communities and there is potential for further joint working. For example, local authorities, the NHS and the police are required members of Safeguarding Adult Boards which help ensure a collaborative, inter-agency approach to the responses and prevention of abuse or neglect.

In addition, many health and wellbeing boards already include amongst their membership either their Police and Crime Commissioner (PCC) or representatives from their local police force or criminal justice agencies. This has enabled boards to take a broader strategic view of their area beyond health and social care, and through Joint Strategic Needs Assessments (JSNAs) provides boards with the opportunity to better understand the nature of public needs and demands on local services – which can in turn influence local commissioning strategies.

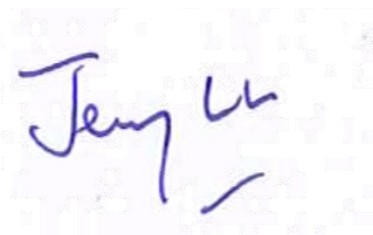
There are already a number of areas where greater collaboration has had positive outcomes including:

- Every area in England is now working to implement their local Mental Health Crisis Care Concordat action plans, involving NHS services, police forces and local authorities, and many of these local partnerships are using their Boards to ratify their plans and support progress. Local action plans and other helpful information on the Concordat can be found here: <http://www.crisiscareconcordat.org.uk/>
- In addition, around 30 police forces now have some form of street triage in operation. These models, often jointly commissioned by the PCC and Clinical Commissioning Groups, ensure mental health nurses staff support and advise police officers in their responses to people in mental health crisis. In some forces mental health workers and police officers provide joint responses in the community; in others mental health professionals work in emergency call centres in order to provide real time advice and support to frontline officers. The evaluation of nine initial pilot sites evidenced that the schemes contributed towards large reductions in the use of police custody as a place of safety for those vulnerable people detained under section 136 of the Mental Health Act.
- Around 25 police forces operate a drug intervention initiative which involves policing and health partners working together to identify, assess and refer users into appropriate treatment pathways. Investment in treatment is proven to reduce reoffending, with every £1 spent saving £2.50 for the Criminal Justice System, and with access to treatment reducing the impact of wider health harms including the spread of blood borne viruses and drug related mortality.
- A recent Home Office and Public Health England initiative in Middlesbrough brought together senior partners in policing, health and probation to consider the impact of heroin misusing offenders in their area and the wider implications this was having on individuals and the community. This has galvanised further collaborative working, including the development of a joint strategy to address their local needs and consider opportunities for developing a multi-agency commissioning approach for treatment services.
- The first phase of the local alcohol action areas programme, which ran until March 2015, saw police and health partners work closely together to reduce a range of alcohol-related harms. For example, Gravesham began a one-year pilot of a Make Every Adult Matter approach to street drinkers. An operational group is led by the area's alcohol and drug treatment provider with members including the police, third sector organisations, primary care providers, Jobcentre Plus and the Prison Service. Early indications are that the project is working well and that links between partner agencies are much improved and that better coordinated services for individuals with multiple needs are emerging. Invitations to apply to take part in the second phase of the programme were sent to PCCs, chief constables and all local authorities in England and Wales last month. The programme will begin in January and will again encourage active partnerships between local agencies to reduce alcohol harms.

Given the benefits outlined above, and the pressures on health and care services and police forces, we would like to ask Health and Wellbeing Boards and PCCs to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.

A handwritten signature in black ink, appearing to read 'Amber Rudd'.

**The Rt Hon Amber Rudd MP**

A handwritten signature in blue ink, appearing to read 'Jeremy Hunt'.

**The Rt Hon Jeremy Hunt MP**

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