Swindon Borough Council

Health and Wellbeing Board

Wednesday, 24 May 2017

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. **Minutes** (Pages 3 - 10)
   To receive the minutes of the meeting held on 15 March 2017.

4. **Public Question Time**
   Please refer to the explanatory notes below.

5. **Carers Memorandum of Understanding** (Pages 11 - 58)

6. **Joint local area SEND update** (Pages 59 - 68)

7. **Long Term Conditions Joint Strategic Needs Assessment** (Pages 69 - 82)

8. **Police and Crime Plan 2017-21** (Pages 83 - 90)

9. **Development of Accountable Care in Swindon** (Pages 91 - 130)

10. **Better Care Fund 2017-2019** (To Follow)

11. **Joint Commissioning Group - Minutes for information and comment** (Pages 131 - 142)

Date of Despatch: 16 May 2017

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, 15 MARCH 2017

PRESENT: Brian Mattock (Chair) (Lay Member), Councillors Ray Ballman, Fionuala Foley, and Brian Ford (Swindon Borough Council), Mark Edwards (Project Coordinator, Healthwatch Swindon), Dr Peter Mack (Vice-Chair) (Clinical Chair, NHS Swindon Clinical Commissioning Group), Gill May (Executive Nurse, NHS Swindon Clinical Commissioning Group), and David Wray (Voluntary Action Swindon).

Also in attendance were: Cherry Jones (Director of Public Health, Swindon Borough Council), Peter Nathan (Head of Education Services, Swindon Borough Council), Tom Frost (Public Health Senior Information Analyst, Swindon Borough Council), Ross Miller (Commissioning Support Officer – Growth and Regeneration, Swindon Borough Council) and Emma Gee (Strategic Commissioner – Growth and Regeneration, Swindon Borough Council).

Apologies for absence were received from: John Gilbert (Chief Executive, Swindon Borough Council), Sue Wald (Director of Adult Services, Swindon Borough Council), Karen Reeve (Director of Children's Services, Swindon Borough Council), Nicki Millin (Accountable Officer, NHS Swindon Clinical Commissioning Group) and Angus Macpherson (Police and Crime Commissioner).

53. 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.

54. Minutes

Resolved – That the minutes of the meeting held on 14 December 2016 be confirmed and signed as a correct record.

55. Public Question Time

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

56. Health and Wellbeing Strategy Refresh 2017

The Board considered a report setting out how Swindon's Health and Wellbeing Strategy has been refreshed for 2017 – 2022 informed by the Swindon Joint Strategic Needs Assessment (JSNA). The report set out how the Health and Wellbeing Board has a duty to produce a Health and Wellbeing Strategy, in accordance with the Health and Social Care Act 2012, informed by the needs of its population outlined in its JSNAs, and also how the Swindon Clinical Commissioning Group, NHS England, and Swindon Borough Council plans for commissioning services are expected to be informed by the Health and Wellbeing Strategy and the JSNA.

Cherry Jones, Director of Public Health at Swindon Borough Council, introduced the report and referred to the five priorities previously identified for the Strategy when it

was first created in 2013, as detailed in paragraph 3.8 of the report. There are two areas which will be made more explicit within the Strategy following the refresh: ensuring that all adults have the opportunity and support to sustain paid employment or volunteering, and; to reduce the incidence of domestic abuse.

Following the presentation of the report, and the refreshed Health and Wellbeing Strategy for 2017 – 2022 attached at Appendix 1 to the report, Board members discussed the matters raised, including:

- The targets contained within the Borough Council's Vision regarding increasing the numbers of adults with learning disabilities being in paid employment, and how the refreshed Strategy will help to achieve this.
- The different options available to raise awareness of the refreshed Strategy.

Resolved – (1) That the refreshed Health and Wellbeing Strategy for 2017 – 2022, attached at Appendix 1 to the report, be adopted.

(2) That the proposal to engage further with local communities and residents to ensure our shared vision and proprieties are relevant and proportionate to local opinions be supported.

(3) That the Cabinet and the Governing Body of the Swindon Clinical Commissioning Group be recommended to adopt the refreshed Health and Wellbeing Strategy for 2017 – 2022.

57. Joint Strategic Needs Assessment Summary 2016/17: An overview of Health and Wellbeing in Swindon

The Board considered a report setting out how the Health and Wellbeing Board has a statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Swindon. The JSNA must describe 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. The report also set out how the Swindon JSNA is an on-going iterative process led by Swindon Borough Councils public health team and involving a wide range of stakeholders, and informs decision about how services are commissioned and designed.

Tom Frost, Public Health Senior Information Analyst at Swindon Borough Council, introduced the report and confirmed that the JSNA website, which contains signposts to other sources of information, is being reviewed by subject matter experts to ensure its accuracy and will be updated by the end of March 2017. Mr Frost also referred to the Key Facts from the JSNA Summary, which were set out in detail in paragraph 3.9 of the report.

Following the presentation of the report, and the JSNA Summary for 2016/17 attached at Appendix 1 to the report, Board members discussed the matters raised, including:

- The options for communicating the key messages from the JSNA Summary to a wider audience.
- The differences between data concerning the length of life in good health, and life expectancy figures, and how more focus is being placed on having good health whilst ageing.
- The report coming to a future Board meeting concerning people having more

than one long term condition, and the differences with how chronic illnesses are dealt with between deprived and less deprived areas.

Resolved – (1) That the 2016/17 Joint Strategic Needs Assessment Summary report, attached at Appendix 1 to the report, be noted.

(2) That its use in commissioning and strategy preparation, including the Joint Health and Wellbeing Strategy, be endorsed.

58. Swindon Substance Misuse Joint Strategic Needs Assessment

The Board considered a report setting out how Swindon Borough Council is responsible for reducing the harm caused by substance misuse and, as such, how it is important to review the needs of drug and alcohol users and assess the impact their substance misuse is having on themselves, their families and their communities. This information is used to inform the strategy and commissioning of a range of services that aim to impact on substance misuse.

The report also highlighted the purpose of the Joint Strategic Needs Assessment (JSNA) for substance misuse, and how it will lead to the development of a substance misuse strategy which will outline how key partners in Swindon will work together to reduce the number of people who misuse substances, reduce the harm caused by substance misuse, and support those recovering from substance misuse thereby addressing health inequalities.

Frances Mayes, Senior Public Health Manager at Swindon Borough Council, introduced the report and referred to the four priorities around which the recommendations from the JSNA have been grouped (as set out in the Substance Misuse JSNA Bulletin attached at Appendix 1 to the report). These are: early intervention with young people and their families; prevention of substance related harms for adults; treatment services deliver effective harm reduction and sustained recovery, and; reduce substance misuse related crime and anti-social behaviour.

Following the presentation of the report, and the Substance Misuse JSNA Bulletin attached at Appendix 1 to the report, Board members discussed the impact of the integration of the drugs and the alcohol provision, and the impact on the Swindon and Wiltshire Alcohol and Drugs Service (SWADS).

Resolved – (1) That the findings of the Substance Misuse Joint Strategic Needs Assessment, as set out in the Bulletin attached at Appendix 1 to the report, be noted.

(2) That its use in the commissioning of substance misuse services in Swindon be endorsed.

(3) That the development of the Substance Misuse Strategy 2017 – 2022 based on the recommendations of the Joint Strategic Needs Assessment be endorsed.

59. Diabetes Joint Strategic Needs Assessment 2017

The Board considered a report on the incidence of diabetes in the UK and its emergence as a major health problem requiring urgent action. In particular, the report highlighted the increased prevalence of diabetes in Swindon. It was noted that outcomes for people with diabetes remain poor and spend on diabetes and its

complications are high. The Joint Strategic Needs Assessment (JSNA) provides evidence to help understand diabetes prevention and care in Swindon, building on the diabetes profile completed in 2013. The report also set out how there has been significant improvement in diabetes care since the 2013 profile, however the number of people who develop diabetes remains high while some outcomes remain poor.

Cherry Jones, Director of Public Health at Swindon Borough Council, introduced the report and referred to the high number of lower limb amputations taking place in Swindon due to patients not managing their condition well. Mrs Jones referred to the recommendations set out in the JSNA Bulletin, attached at Appendix 1 to the report, which will be taken to the Swindon Diabetes Transformation Board for action.

Following the presentation of the report, and the Diabetes JSNA 2017 Bulletin attached at Appendix 1 to the report, Board members discussed the matters raised, including:

- How type 2 diabetes is formally diagnosed, and the varying symptoms that can be checked for.
- The potential reasons behind why there is a low uptake of structured education for people with type 2 diabetes in Swindon.
- The new National Diabetes Prevention Programme being developed across the Sustainability and Transformation Plan (STP) footprint (Wiltshire, Swindon and Bath and North East Somerset) whereby patients who are identified by GPs as pre-diabetic will be sent a letter to offer them a chance to learn how to avoid developing the full condition. This will target between 3 – 4000 people a year across the STP footprint.
- Prevention being the key to this disease in future, by ensuring that both adults and children learn about maintaining a healthy weight and having an active lifestyle, and that activities are designed in to new housing estates.
- The focus on educational achievement and standards within education settings at the moment, rather than promoting a more holistic approach which targets physical education as well.

Resolved – That the recommendations identified in the Swindon Diabetes Joint Strategic Needs Assessment, as set out in paragraphs 3.6.1 to 3.6.7 of the report, be noted and approved.

60. Update on Swindon's Economic Strategy

The Board considered a report presenting the evidence base that underpins the draft Economic Strategy. Formulation of the Strategy resulted in the identification of four key themes, and the suite of recommendations set out in the Joint Strategic Needs Assessment (JSNA) Bulletins associated with each of these four themes (attached at Appendix 1 – 4 of the report) will help to accelerate Swindon’s economic growth.

Ross Miller, Commissioning Support Officer – Growth and Regeneration at Swindon Borough Council, introduced the report and confirmed that the draft Swindon Economic Strategy for 2016 – 2026 (attached at Appendix 5 to the report) was being rewritten and therefore withdrawn from consideration by the Board at this meeting.

Following the presentation of the report, and the JSNA Bulletins attached at Appendix 1 – 4 to the report, Board members discussed the matters raised, including:

- The need for easily accessible green open space within the town to help promote physical activity, and how this could be built into infrastructure planning.
- How the approach to solving some health problems can be designed in to projects, such as helping to promote the falls agenda by removing trip hazards for the elderly in a given space.
- The reasons why the levels of CO2 in Swindon are comparatively high, focussing on the high reliance on cars in the area, and the high level of manufacturers based within the town who are producing emissions.

Resolved – That the findings of the Economic Strategy Joint Strategic Needs Assessment, as set out in the Bulletins attached at Appendix 1 to 4 to the report, be noted.

61. Swindon Tobacco Control Strategy 2017-2022

The Board considered a report presenting the Swindon Tobacco Control Strategy for 2017 – 2022. The Strategy sets out how, over the next five years, partners will work together across Swindon to reduce the number of people who smoke and the harm caused by tobacco use and create a smokefree Swindon. The Strategy will also ensure that partners continue to work collaboratively to protect and improve the health of the population and future generations in the creation of a smokefree Swindon.

Chris Woodward, Public Health Programme Manager at Swindon Borough Council, introduced the report and advised that smoking prevalence in Swindon is above the England average of 16.9% at 18.7%, and smoking rates from workers in routine and manual jobs in the town (25%) are higher than the smoking rates of adults in general. Smoking rates are also much higher in our population with mental health conditions and in our areas of highest deprivation.

Following the presentation of the report, and the draft Swindon Tobacco Control Strategy for 2017 – 2022 attached at Appendix 1 to the report, Board members discussed the matters raised, including:

- The increase in the numbers of people using e-cigarettes, and whether there is evidence to suggest that the use of them encourages people to move on to normal cigarettes.
- The confusion surrounding e-cigarettes, and whether they are healthier or not to use. The latest studies suggest that they are 95% less harmful than normal cigarettes.
- ‘Vaping’ figures are not identified separately within the statistics in the report. E-cigarettes are still an unlicensed product, and the National Institute for Health and Care Excellence has not indicated that funds should be invested in this area yet.
- The potential for workers in the health services to be ‘role models’ for members of the public, and for organisations to go completely smokefree on

their sites.
- That Swindon has the lowest uptake of smoking amongst teenagers across the south west.
- The 'Make Every Contact Count' initiative which incorporates stopping smoking.
- The potential for spatial planning and transport to incorporate the principal of smokefree areas in to the design stage, which helps to promote healthy environments from the beginning.
- Other ideas such as smokefree children's play areas, smokefree school gates which could help assist teachers to stop smoking and be role models for their pupils, and potential fosterers and adopters being required not to smoke.
- How organisations will be approached to see what they could pledge to help deliver the Strategy.

Resolved – (1) That the Swindon Tobacco Control Strategy 2017 – 2022, attached at Appendix 1 to the report, be approved and the ongoing focus on tobacco control work in Swindon be supported.

(2) That the Cabinet and the Clinical Commissioning Group Governing Body be recommended to adopt the Swindon Tobacco Control Strategy 2017 – 2022.

(3) That the development of the action plan associated with this Strategy, which will be monitored by the Swindon Smokefree Alliance (the Swindon tobacco control partnership of key stakeholders), be supported.

62. Sustainability and Transformation Plan - update

The Board considered a report setting out how the NHS in England is required to produce place-based Sustainability and Transformation Plans (STP), driving the Five Year Forward View over the period October 2016 to March 2021. The report set out how Swindon Clinical Commissioning Group (CCG) are working with Bath and North East Somerset and Wiltshire CCGs to develop a footprint plan, and provided an update on the development of this plan across the footprint.

Gill May, Executive Nurse at Swindon CCG, introduced the report and referred to the STP short guide, attached at Appendix 1 to the report, which is a public facing document setting out the purpose of the STP, highlights areas for action over the next five years, and seeks feedback from the public on those proposals.

Following the presentation of the report, and the Sustainability and Transformation Plan short guide attached at Appendix 1 to the report, Board members discussed the matters raised, including:

- How there are no plans to close departments at the Great Western Hospital in Swindon as part of the STP proposals.
- How the consultation is going to be rolled out to seek as many views as possible across the board, and the perceived lack of consultation to date.
- How the project is moving towards the implementation phase of the Swindon approach, and how members of the public can help co-design what services will look like at stakeholder events.
- The work that will be undertaken over the next few months to ensure that a coherent and compelling message is communicated to Swindon residents about future service delivery.

- The Board noted that the report to its July meeting will contain more comprehensive information on the consultation process.

Resolved – That the content of the Sustainability and Transformation Plan short guide, attached at Appendix 1 to the report, be noted.

63. Healthwatch Swindon Update - Winter 2016

The Board received a report which provided an update on the activities of Healthwatch Swindon during the period October to December 2016.

Mark Edwards, Healthwatch Swindon, introduced the report and confirmed that the Board will receive the Annual Report from Healthwatch Swindon at its next meeting in May. Mr Edwards also referred to the work plan priorities that the Healthwatch Swindon advisory group have been asked to consider for 2017/2018 which include the Sustainability and Transformation Plan, the mental health and wellbeing of young people, ageing well, and the new Community Health contract.

Following the presentation of the report, Board members discussed the survey of 500 young people commissioned by the Swindon Ten to Eighteen Project, and how Healthwatch Swindon have been working with them on the issues around the mental health of young people.

Resolved – That the report and the work completed by Healthwatch Swindon during October to December 2016 be noted.

64. Update on Mental Health Crisis Care Concordat

The Board considered a report which provided an update on the Swindon Mental Health Crisis Care Concordat.

Gill May, Executive Nurse at Swindon Clinical Commissioning Group, introduced the report and reflected on how the Concordat is about supporting people in crisis, and also helping them to access support before reaching a crisis point. Ms May referred to the Crisis Care Concordat Action Plan, attached at Appendix 1 to the report, and highlighted the commitment already obtained from partner agencies to deliver the actions against the areas identified in the Plan, and the progress made to date.

Resolved – That the update provided on the Swindon Crisis Care Concordat be noted.

65. Joint Commissioning Group - Minutes for information and comment / Better Care Fund update

Resolved – (1) That the minutes of the Joint Commissioning Group meetings held on 16 November 2016, 8 December 2016, 12 January 2017 and 7 February 2017 be noted.

(2) That the update provided on the Better Care Fund Quarter 3 2016-2017 data be noted.

66. Any Other Business

At the invitation of the Chair, Cherry Jones, Director of Public Health at Swindon Borough Council, addressed the Board and advised that there is an opportunity for 10 areas to bid for up to £10m each from Sport England to run local delivery pilots which address physical inactivity.

Sport England has acknowledged that there is not yet a solution to achieving a population shift in activity levels and so are offering a unique experimental opportunity for a population shift approach to 10 areas across England. The purpose of the Local Pilot Fund is to create a whole system approach to tackle stubborn inequalities through reducing inactivity among the underrepresented.

Resolved – That a Swindon Expression of Interest for this Pilot be supported.

Carers Memorandum of Understanding

Health and Wellbeing Board **Date: 24th May 2017**

Author: Susanna Jones, Chief Executive - Swindon Carers Centre

Wards: All

Locality Affected: All

Parishes Affected: All

1. Purpose and Reasons

1.1 NHS England and its partners have developed a toolkit to help health and social care organisations work together in identifying, assessing and supporting the wellbeing of carers and their families.

1.2 This toolkit covers new duties on NHS organisations brought about by the Care Act 2014 and the Children and Families Act 2014, and includes numerous examples of positive practice that are already making a difference to Carers and their families.

1.3 The toolkit also includes a template Memorandum Of Understanding (MOU) that local partners can use to help us work together in supporting Carers of all ages and their families.

1.4 This links to the Health and Wellbeing Strategy priorities under the following headings:
- Every child and young person has a healthy start to life.
- Adults and older people in Swindon living healthier and more independent lives.
- Improved health outcomes for disadvantaged and vulnerable communities.
- Improved mental health, wellbeing and resilience for all.
- Creation of sustainable environments in which communities can flourish.

2. Recommendations

The Board is recommended to:

2.1 Support the intentions of the Carers Memorandum of Understanding, and encourage partner organisations to sign up to the principles in it.

3. Detail

3.1 Swindon Borough Council (SBC) and Swindon Carers Centre (SCC) are setting up a quarterly meeting of Carers Leads in the following partner organisations: SCC, SBC, Swindon Clinical Commissioning Group, Avon and Wiltshire Mental Health Partnership, Great Western Hospital, Prospect Hospice, Swindon Healthwatch. In time, this group may expand to include Carers Leads at major employers and education provisions in the town. We will be sharing best practice on the integrated approach to identifying and supporting the health and wellbeing

Further information on the subject of this report can be obtained from Susanna Jones, 01793 401098, susanna.jones@swindoncarers.org.uk.

of the 21,000 carers in Swindon, who currently save our economy £395 million per year. *(Source, Carers UK, Nov 2015).*

4. Alternative Options

4.1 None considered. This is about sharing resource, knowledge, expertise and best practice across key organisations to encourage an integrated approach to supporting unpaid carers.

5. Implications, Diversity Impact Assessment and Risk Management

5.1 Swindon Carers Centre has reviewed its equality and diversity policy and annual statement, following a six-month inclusion action plan. Results of this action plan include increased engagement from socially isolated carers e.g. Young Adult Carers and growth from 4 to 9 BME groups accessing and engaging support for their caring roles. Swindon Carers Centre has also reviewed the Young Carer Award standards for schools, to ensure they are inclusive, non-discriminatory and ensure all school young carer leads delivering the award enable all young carers to be identified and supported.

Financial and Procurement Implications

5.2 At this time there are no risks considered. It should encourage shared dialogue and joined up working to meet the principles identified in the NHSE toolkit for carers.

Legal and Human Rights Implications

5.3 There are no legal and human rights implications arising as a result of this report.

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

5.4 There are no other direct implications arising as a result of this report.

Diversity Impact Assessment

5.5 No Diversity Impact Assessment is required at this stage.

Risk Management

5.6 Issues will be covered in the Terms of Reference in the new quarterly Carers Leads group.

6. Consultees

6.1 Swindon Borough Council, Swindon Clinical Commissioning Group, Great Western Hospital, Avon and Wiltshire Mental Health Partnership, Prospect Hospice, and Swindon Healthwatch.

Further information on the subject of this report can be obtained from Susanna Jones, 01793 401098, susanna.jones@swindoncarers.org.uk.

6.2 The 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 – NHS England Carers Toolkit.

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NHS England

An integrated approach to identifying and assessing Carer health and wellbeing

carersUK

carerstrust action · help · advice

The Children's Society

directors of adass adult social services

Standing Commission on Carers

NHS England INFORMATION READER BOX

Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance	Specialised Commissioning	

Publications Gateway Reference:	**05231**
Document Purpose	Tools
Document Name	An integrated approach to identifying and assessing Carer health and wellbeing
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Publication Date	May 2016
Target Audience	CCG Accountable Officers, Directors of Adult SSs, CCG PPI Lay Members
Additional Circulation List	Health and Wellbeing Board Chairs, local Carer Support Organisations
Description	
Cross Reference	NHS England Commitment to Carers, NHS England/RCGP Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers'
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	
Contact Details for further information	Dave Ross Patient Experience Team Room 5W33 Quarry House, Leeds LS2 7UE 0113 825 5579 https://www.england.nhs.uk/ourwork/pe/commitment-to-carers/

Document Status

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1 Introduction

1.1 The purpose of this paper

This paper builds on the work started by the NHS England *Commitment to Carers* that was published in May 2014, and which sought to give the five and a half million Carers in England the recognition and support they need to provide invaluable care for loved ones.

In December 2014, NHS England and the Royal College of General Practitioners published '*Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers'*, to help Clinical Commissioning Groups (CCGs) better identify and help Carers to stay well and to deliver the best outcomes for Carers.

Copies of the *Commitment to Carers* and *Commissioning for Carers* can be accessed at https://www.england.nhs.uk/ourwork/pe/commitment-to-carers/ .

This paper addresses changes to the way in which Carer health and wellbeing need is identified, assessed, and supported, as a result of changes introduced by the Care Act 2014 and the Children and Families Act 2014. It is, essentially, a resource to help promote working together between Adult social care services, NHS commissioners and providers, and third sector organisations that support Carers, of all ages, with a specific focus on developing an integrated approach to the identification, assessment and support of Carers and their families across health and social care. To support this joint working, a template Memorandum of Understanding, to be discussed and agreed locally, is included at Appendix One.

A secondary purpose of this paper is to provide clarity and ensure consistency around the language of care and caring. We understand that, in some cases, different sectors of care are not clear about their duties under the relevant legislation, that the duties of co-operation between agencies are not clearly understood, and that there are variations in understanding of some of the terms used.

An additional purpose of this paper is to identify positive practice in supporting Carers, with a particular focus on Carers from vulnerable communities or at key transition points, in order to reduce health inequalities.

The Better Care Fund (BCF) was launched in 2014 and aims to transform local health and social care services so that they work together to provide better joined up care and support, through CCGs and local authorities agreeing joint plans and agreeing to pool elements of their budgets.

Local Health and Wellbeing Boards are responsible for overseeing agreement of the joint plan and for ensuring that funds are used in accordance with the agreed plan. There is a requirement that plans outline the support that would be made available to Carers, reflecting the retention of £130m to fund Carers breaks in 2016/17.

Given the above responsibilities, it is suggested that all partners on the local Health and Wellbeing Board sign the Memorandum of Understanding at Appendix One in order to demonstrate commitment to the duties of co-operation and promotion of wellbeing, as well as the wider commitment to identifying, recognising, assessing and supporting Carers.

It is recognised that the template Memorandum of Understanding may need to be varied to reflect local circumstances and policies. The important thing, here, is that any such local variation should be discussed and agreed to by all parties on the Health and Wellbeing Board.

Nothing in this paper seeks to amend or replace statutory guidance or accepted best practice. Statutory guidance, *Care and Support Statutory Guidance (DH, 2014)*, on implementation of the Care Act 2014 can be accessed at:

https://www.gov.uk/guidance/care-and-support-statutory-guidance

A template Memorandum of Understanding for supporting Young Carers and their families can be accessed at:

http://adcs.org.uk/early-help/article/no-wrong-doors-working-together-to-support-young-carers-and-their-families

Established best practice and examples of positive practice are included in Appendix Two to this document.

1.2 Acknowledgements

The development of this paper was informed by the invaluable contributions of members of ADASS (the Association of Directors of Adult Social Services) and its regional Carers Policy Network meetings, the support and advice of the Department of Health and NHS England, the Standing Commission on Carers, NHS England regional nursing staff, members of individual clinical commissioning groups, and the many national and local carer support organisations we have met with and spoken to.

We also wish to acknowledge the individual and collective contributions made by Young Carers and Carers from vulnerable communities.

2 The new framework for Carer health and wellbeing

2.1 Understanding the duty of co-operation

The Care Act 2014 introduces a number of reforms to the way that care and support for adults with care needs are met. It requires local authorities to adopt a whole system, whole council, whole-family approach, co-ordinating services and support around the person and their family and considering the impact of the care needs of an adult on their family, including children.

In several places, the Act makes provision for all Carers, including Young Carers and Older Carers. This “whole system” approach bestows a duty of co-operation on local authorities and all agencies involved in public care.

What is the duty of co-operation?

The Care Act 2014 now makes integration, co-operation and partnership a legal requirement on local authorities and on all agencies involved in public care, including the NHS, independent or private sector organisations, some housing functions, and the Care Quality Commission (CQC).

Section 6 of the Act provides for a general duty to co-operate. Section 7 of the Act provides for co-operation in specific cases and includes caveats for specific cases when co-operation is not possible.

Further, Section 15.22 of the statutory guidance provides for “the local authority…consider what degree of co-operation is required and what mechanisms it may have in place to ensure mutual co-operation (for example, via contractual means)”.

Who has the duty to co-operate?

Relevant partners of a local authority include any other local authority with which they agree it would be appropriate to co-operate and the following agencies or bodies who operate within the local authority’s area, including:

- NHS England
- Clinical Commissioning Groups
- NHS trusts and NHS Foundation Trusts
- Any NHS-funded service
- Job centres

- Justice - the Police, prisons and probation services
- Housing – officers who exercise the local authority functions in relation to housing for adults with needs of care and support, or local authorituy functions in respect of Carers and, in some cases, private registered providers of social housing
- Education services

Source: *Care and Support Statutory Guidance*, Chapter 15

The 2015/16 Planning Guidance for the NHS, *Five Year Forward View into Action*, set out how the NHS will seek to implement its duties under the above acts, including a clear expectation that, "CCGs alongside local authorities…draw up plans to identify and support carers and, in particular, working with voluntary sector organisations and GP practices, to identify young carers and carers who themselves are over 85, and provide better support".

Further, "In developing plans, CCGs should be mindful of the significant changes to local authority powers and duties from April 2015 under the Care Act 2013 [*sic*]. Plans should focus on supporting young carers and working carers through the provision of accessible services, and services for carers from vulnerable groups".

Copies of the 2015/16 Planning Guidance for the NHS can be accessed at:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/forward-view/

2. 2 Understanding the duty to promote wellbeing

The general duty of a local authority towards individuals, under Section 1 of the Care Act 2014 is "to promote that individual's well-being". Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person, and that person should be enabled to participate as fully as possible in decisions at every stage in their care.

What is "wellbeing"?

Wellbeing is a broad concept and it is described as relating to the following areas in particular:

- personal dignity, including treatment of the individual with respect
- physical and mental health and emotional wellbeing
- protection from abuse and neglect

- control by the individual over day-to-day life (including control over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society

Source: *Care and Support Statutory Guidance*, Chapter 1

There is no hierarchy to these areas, and all should be considered of equal importance when considering "wellbeing" in the round, for the individual concerned.

Further, wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs from developing and escalating, and on supporting people to live as independently as possible for as long as possible.

It is recognised that social care and voluntary sector care practitioners may not always be qualified to clinically assess a carer's physical or mental health. Where a health need is identified as part of the assessment, the carer should be referred back to their GP so that this health need may be addressed.

2. 3 Understanding the duties to address the needs of Young Carers, Parent Carers and to adopt a "whole family approach"

Both the Care Act 2014 and the Children and Families Act 2014 address the needs of Young Carers clearly and directly. The Children and Families Act 2014 builds on the Children Act 1989 to amplify the rights to improve how Young Carers and their families are identified and supported, and extends the right to an assessment of their support needs to all Young Carers under the age of 18 regardless of who they care for, what type of care they provide or how often they provide it. Thus, the principle of the whole family approach applies across all age groups and across all categories of care.

This change also introduces a requirement to make an assessment on the appearance of need. The new provision works alongside measures in the Care Act 2014 (Sections 60-64) to enable a "whole-family approach" to assessment and support, for example in addressing the inter-related needs of Young Carers and their families.

We have heard that many Young Carers take on their role because of multiple care needs in the family and that many Young Carers find themselves with a long-term career in care within their family. Equally, it is now becoming increasingly common to find multiple caring in families, with major implications for some family members.

The intention of the whole family approach is for local authorities and their partner agencies to take a holistic view of the person's needs, in the context of their wider support network. The approach must consider both how the individual Carer or their support network or the wider community can contribute towards meeting the outcomes they want to achieve (see above), and whether or how the needs for care and support impact on family members or others in their support network.

There is a particular need for NHS bodies and the local authority to work closely when planning to support the discharge of patients from hospital and this is covered by Schedule 3 of the Care Act 2014.

2. 4 Delegation of authority for carers' needs assessments

Section 79 of the Care Act 2014 provides for local authorities to delegate some, but not all, of their care and support functions to other parties. This power to delegate is intended to allow flexibility for local approaches to be developed in delivering care and support, and to allow local authorities to work more efficiently and innovatively, and provide better quality care and support to local populations.

However, as with all care and support, individual wellbeing should be central to any decision to delegate a function.

Delegation does not absolve the local authority of its legal responsibilities. When a local authority delegates any of its functions, it retains ultimate responsibility for how the function is carried out.

The Care Act 2014 is clear that anything done (or not done) by the third party in carrying out the function, is to be treated as if it has been done (or not done) by the local authority itself. This is a core principle of allowing delegation of care and support functions.

Where a local authority delegates its responsibility for Carers' needs assessments, it needs to assure itself that these assessments are compliant with the Care Act 2014.

3 An integrated approach to the identification, assessment and support of Carer health and wellbeing needs

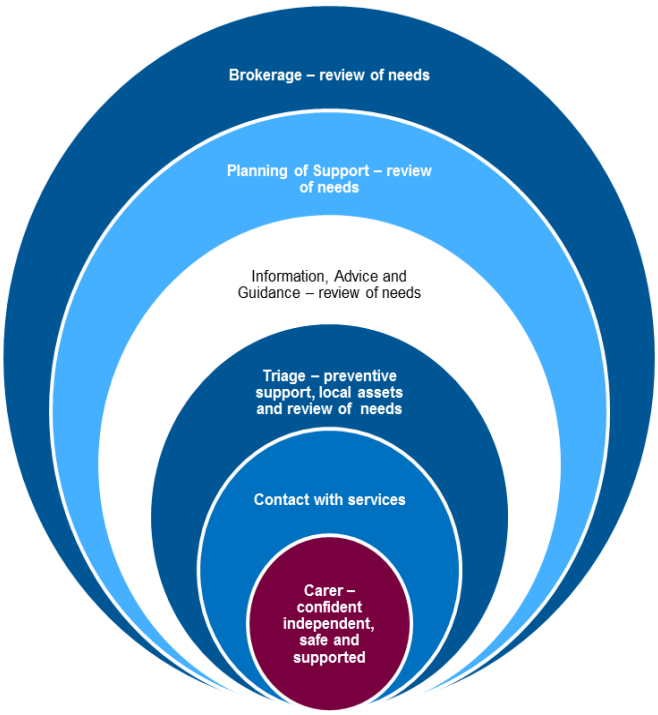
3. 1 The aim of the approach

The aim of this work was to develop an integrated approach to the identification, assessment and support of Carers' health and wellbeing needs across health and social care to:

a. maintain the independence, physical health and emotional wellbeing of Carers and their families
b. empower and support Carers to manage their caring roles and have a life outside of caring
c. ensure Carers receive the right support, at the right time, in the right place
d. respect the Carer's decision about how much care they will provide and respect the Carer's decision about not providing care at all

The integrated approach sits on a number of supporting principles which are discussed more fully below and which will be used to support and promote the implementation of a combined process across health and social care.

The proposed integrated approach for identifying and assessing carers' and wellbeing needs



3.2 The approach explained

The central aim is to keep the Carer at the centre, or core, of the “onion”. This preserves the Carer’s independence, their family and social network relationships, and their ability to undertake their caring role. The Carer’s primary care team has a crucial role in initiating the discussion about the Carer’s support needs and in supporting and maintaining Carer health and wellbeing. The primary care team also has a crucial role in identifying Carers.

The integrated approach recognises that, under the Care Act 2014, Carers have the right to request a formal Carer’s assessment of their own needs at any time.

When a registered Carer has any contact with the NHS they are to be asked the core questions to identify whether or not they feel they are in need of additional support, either in order to continue their caring role or to continue contributing to their family and social networks.

Suggested core and supplementary questions are included below. It is recognised that some care settings will need to ask different questions, or phrase questions differently, according to the communication and information needs of the individual carer presenting to that setting.

The inclusion of these questions in this document is to encourage local debate about the range of questions that could be used to initiate a discussion with the Carer of their changing support needs.

Suggested core questions

Throughout our engagement process, it was suggested that the following could provide the basis for a key question to initiate a discussion about a Carer’s changing needs:

- Do you look after someone who couldn’t manage without your help and support?

This should then be followed by one or more supplementary questions, for example:

- As a result of you being here having (medical) treatment would you be able to continue that care?
- Will you need any extra support because of your own health needs/medical treatment which we are discussing today? (if the answer to this question is “yes” the Carer should be asked what support they need)
- Are you willing/able to continue your caring role?

There may also be an opportunity for services to identify Child/Young Carers by asking along the following lines:

- Are there any children in the household?
- Will any of these children be involved in caring?

Where the Carer identifies they are in need of support, or may need support in the future, the healthcare practitioner should seek to establish what needs the Carer may have as it may be possible to meet these needs during the consultation. Where this is not possible, the Carer should be asked if they are aware of the local Carer support organisation and, if not, referred to the local Carers support organisation.
If social care or carer support practitioners are identifying a health need as part of their Carers assessment they should have the ability to refer the Carer back to their GP for health support.

In some areas, NHS primary care services employ care navigators, or other Carer link/support workers, to offer carers advice and information about accessing local support, and, in some cases, to arrange this support on behalf of the Carer. In these cases, it would be useful to ensure primary care and local Carer support work closely to provide the Carer with a seamless service and avoid unnecessary duplication.

The Carers support organisation will then discuss the Carer's situation, including their ability to provide the patient with the required level of care, the wellbeing needs of the family, to assess the level of need and work with the Carer to meet these.
This could include referral to other local support, carer support training, preventive services, or referral into the formal needs assessment process. The focus is on meeting needs as quickly as possible to prevent them from escalating and becoming more complex.

For older Carers, many of whom have their own health problems, this discussion could include continuing healthcare arrangements, how this may impact on the Carer's capacity to care, and planning to mitigate against possible failure of the continuing healthcare provider, to ensure that a vulnerable couple is not left without support. It may be useful to complete an initial assessment of support needs and a risk assessment within this discussion.

Where a Carer is offered, or requests, a formal needs assessment, the primary care team may wish to consider what further information, advice and guidance (including advocacy) the Carer requires, at this stage, in order to ensure that the Carer is fully informed about the needs assessment process and how they can prepare for this. In some cases, this may require arranging for an advocate to assist the carer.

In other cases, local Carer support organisations have received delegated authority from the local authority to provide a seamless service for Carers and work closely with the primary care team.

Where a Carer has evidence of support needs and meets the eligibility criteria as set out in the Care Act 2014, this will be picked up during support planning, at which point a more thorough discussion will take place about the ability of the local care support market to meet the identified needs of the Carer, and where additional services may have to be bought in or commissioned. This provides an opportunity for Carers to identify previously unmet need in an area.

A Carer's financial situation may be financially assessed in relation to services provided directly to the carer if a local authority has decided to charge carers. Where a local authority arranges care and support to meet a person's needs, it may charge the adult, except where the local authority is required to arrange care and support free of charge.

The new framework is intended to make charging fairer and more clearly understood by everyone. The overarching principle is that people should only be required to pay what they can afford. People will be entitled to financial support based on a means-test and some will be entitled to free care.

The principles are that the approach to charging for care and support needs should:

- ensure that people are not charged more than it is reasonably practicable for them to pay
- be comprehensive, to reduce variation in the way people are assessed and charged
- be clear and transparent, so people know what they will be charged
- promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control
- support carers to look after their own health and wellbeing, and to care effectively and safely
- be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs
- apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings
- encourage and enable those who wish to stay in or take up employment,

education or training or plan for the future costs of meeting their needs to do so, and

- be sustainable for local authorities in the long-term.

Source: *Care and Support Statutory Guidance*, Chapter 1

In practice, the expectation is that local authorities should apply a 'light-touch' to assessing whether or not to charge for carer support services, "a local authority should ensure that any charges do not negatively impact on a carer's ability to look after their own health and wellbeing and to care effectively and safely… excessive charges are likely to lead to carers refusing support, which in turn will lead to carer breakdown and local authorities having to meet more eligible needs of people currently cared for voluntarily." (*Care and Support Statutory Guidance*, sections 8.50 and 8.51).

The needs of the Carer and their family will be reviewed at regular stated intervals, or when a key transition point is reached, to see what new or emerging needs have developed and to identify additional support may be required. This will be particularly important at key transition points (see below) or when the Carer is approaching the end of their caring role.

3. 3 Supporting Principles

The integrated approach to identifying and assessing Carer health and wellbeing needs rests on a number of supporting principles. These principles are also included in the template Memorandum of Understanding at Appendix One to this document.

Each of these principles covers a number of practical points and each of these practical points features examples of positive practice, in order to encourage and enthuse other practitioners and commissioners to replicate or build on success. These examples of positive practice are summarised in Appendix Two.

In developing a local Memorandum of Understanding, it may prove necessary to develop local supporting principles. Again, this should be based on local discussion and agreement.

3.3. 1 Principle 1 – We will support the identification, recognition and registration of Carers in primary care

The role of the primary care team as the one to which all Carers have access is recognised as being paramount in supporting Carers and maintaining the capacity of Carer to care, if they so choose.

There is a need to improve the registration and assessment of Carers, including Young Carers, in primary care so that their needs can be identified more quickly and before their health and wellbeing deteriorates.

3.3. 2 Principle 2 - Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health.

Carers have a dual role as both providers of care for the cared for and as clients of services as a result of the caregiving role which affects their own health and wellbeing. Thus, primary care has a unique opportunity to make a telling contribution to improving the lives of Carers.

Primary care teams are already seeking to support carers in a number of practical ways, including offering Carers flexible appointment times, longer appointments, offering Carers appointments on Sundays, and referrals to a range of local services through Carer/social prescribing schemes.

There is also a need for local agencies to work together in developing integrated support to meet the identified and emerging needs of Carers.

3.3.3 Principle 3 - Carers will be empowered to make choices about their caring role and access appropriate services and support for them and for the person they look after

Carers need to be aware of their entitlement to request to an assessment of their needs in their own right, independent from any assessment of the person for whom they care.

Carers' main support needs may be support with their own health or with information and education to help them provide skilled caregiving and support for the cared for, either of which may be best addressed directly by healthcare practitioners at the time.

Many areas produce directories of Carer support services and some of these are comprehensive. Depending on identified need, referral to the local Carer support organisation may be the best way to ensure that carers receive the support they

need when they need it. Carers will be supported to exercise choice and make well-informed decisions about the support options available to them.

It is acknowledged that Carers are free to choose not to care, or to decide on the amount of care they will provide. Whatever decision a Carer makes should be respected by the staff with whom they come into contact.

The wellbeing needs of the Carer's family will be taken into account when identifying suitable support. The Carer will be supported to plan for life beyond caring, including where the Carer wishes to reduce the amount of care they provide, or where they are no longer able, or no longer wish, to continue their caring role.

3.3. 4 Principle 4 - The staff of partners to this agreement will be aware of the needs of Carers and of their value to our communities

NHS staff would benefit from Carer awareness training. Provision of Carer awareness training in health and social care induction and ongoing professional development programmes is desirable. This training should be offered by integrated health and social care teams to ensure consistency of approach.

Care staff will recognise signs of distress and diminished capacity that may affect the ability or willingness of Carers to continue caring, so that they can ask the Carer if they are in need of support. Care staff will also be aware of local Carer support organisations so that the Carer can be sign-posted. In some cases, care staff may be able to make the referral on behalf of the carer.

Where social care practitioners are identifying a health need as part of their Carers assessment they should have the ability to refer the carer back to their GP for health support.

The aim of this principle is for care staff to work holistically with the Carer and cared for and be aware of Carers' needs from diagnosis, discharge planning and reviews. Staff could provide the carer with information and/or refer early to support to try to avoid a crisis situation or a breakdown in the Carer's health.

3.3. 5 Principle 5 - Carers will be supported by information sharing between health, social care, Carer support organisations and other partners to this agreement.

We understand that the biggest risk to Carers is the failure to share information sensibly. We will work to remove burden of Carers having to repeat information and will reduce the barriers to effective sharing of information.

The registration of Carers in General Practice is key to this as being identified as a Carer will generate a READ code on the Carer's personal medical record and this will accompany that Carer whenever and wherever they use the NHS in England (by being shown on the Summary Care Record). Within integrated services, social care staff will have access to the Summary Care Record.

Service specifications for many Carer support services, including those that have been delegated to undertake needs assessments on behalf of the local authority, provide for data-sharing and processing arrangements that comply with information governance and data protection requirements. Examples of these are included in Appendix Two.

Improved sharing of information will help to identify vulnerable Carers earlier, improve the identification of Carers and the assessment of their support needs, and could improve the responsiveness of support to the changing needs of Carers. However, it is important to check that the Carer consents to this information being shared and has the capacity to give informed consent.

3.3. 6 Principle 6 - Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision-making and reviewing services.

Carers will be actively involved in the planning of care for the cared for. Carers will have their views taken into account when planning care in advance. Carers will be fully engaged in the planning, redesign and shaping of services.

It is acknowledged that whilst Carers will be expert in the preferences, context and disease history of the patient, they will often not be expert in the disease(s), its course and management and how to deal with emerging caregiving challenges. Carers may, therefore, still need support from healthcare practitioners to empower them to fully fulfil their role as expert partners.

Services will be continuously monitored and reviewed, with Carer inputs, in order to demonstrate where desired health outcomes are being achieved and to identify those areas in need of improvement.

3.3. 7 Principle 7 - The support needs of Carers who are more vulnerable or at key transition points are identified early.

The use of risk stratification tools will allow for predicative modelling through which to develop the necessary preventive and other support resources to meet the needs of vulnerable Carers or those Carers approaching key transition points, including:

- Young Carers as they leave primary school and approach secondary school

and, again, as they leave secondary school to go on to further education
- Young Carers as they move from adolescence to adulthood
- Parents as Carers, particularly parents of children with physical or learning disabilities as they leave the family home or as they become eligible for adult services
- Carers of people with substance misuse problems
- Carers aged over 75
- LGBT Carers
- Carers from BAME (Black, Asian and Minority Ethnic) communities
- Carers with multiple caring roles (e.g., Carers of partners and additional older or other relatives requiring care and support)
- Recognition of additional support needs of bereaved Carers.

3. 4 Benefits of the integrated approach

There are a number of important benefits, and possible benefits, to this approach:

- the focus is on supporting the independence of Carer and the wellbeing of the Carer and their families
- the needs of Carer and their families are identified as, or before, they arise
- the Carer can be fast-tracked to preventive and low-level support, including wellbeing checks
- safeguarding issues can be highlighted more quickly
- there is likely to be a reduction in Carer/family crisis and breakdown
- the Carer's right to opt for a formal Carer's assessment, where the eligibility Criteria are met, is clearly identified
- the approach avoids unnecessary referral to more complex services and will reduce unnecessary demand on these more complex (and more costly!) services
- the identification, assessment and provision of support for Carers from vulnerable groups will help to reduce health inequalities
- the approach will encourage social cohesion through identification and use of other local assets available to support the Carer
- the support needs of the Carer are continually reviewed
- the Carer is supported at key transition points, including any escalation or change in needs, in particular as they approach the end of their caring role.

3. 5 Thinking Carer across the local health and social care system

In order to ensure that Carers receive the right support at the right time and in the right place, Carers demonstrating eligible needs should be referred to the local Carer support organisation to have their immediate wellbeing needs addressed.

Where a Carer indicates they have a physical or mental health need during an interaction with the NHS, this health need should be addressed as soon as possible, after which the healthcare practitioner should initiate a discussion about the Carer's wider support needs and refer to the local Carer support organisation.

Partnership working and co-operation is key to providing a joined up seamless services. This will include joint working between the local authority, the NHS, voluntary organisations, education, public health, housing and local communities to support Carers.

Central to this joint working will be the development of local data and information sharing processes between agencies, so that information follows the Carer across their own care and support pathway without them constantly having to re-tell their story. Practical examples of how this can be achieved are included in Appendix Two.

The needs of Carers should also be recognised by commissioners and planned for. Work through the local Health and Wellbeing Board and the Joint Strategic Needs Assessment will include identification of the needs of Carers, including young Carers and young adult Carers in the local area; this identification will be crucial in avoiding crisis breakdowns.

The local Joint Health and Wellbeing Strategy will include shared strategies for meeting these identified needs, setting out arrangements for working together and the actions that each partner will take individually and collectively.

Local partners should set out their arrangements for periodic audit and the provision of assurance to the Council, Health and Wellbeing Board, Clinical Commissioning Group, and the public, on how the memorandum of understanding is being implemented. Feedback from Carers, their representatives and the cared for should be an essential element of these audits.

There is an opportunity to include Carers and service users as "experts by experience" in these audits - if Carers are to be genuine partners in strategic development, they have to understand how, why and when things can go wrong in order to achieve the ambition of co-designing the future.

Examples of where local partners have adopted an integrated approach to supporting Carers across a district can be found at:

http://www.coastalwestsussexccg.nhs.uk/our-commitment-to-carers

http://www.hertsdirect.org/docs/pdf/c/carstrat2015.pdf

www.surreynhscarersprescription.org.uk

http://www.wandsworthccg.nhs.uk/localservices/Pages/Carers-Support.aspx

4. Moving forward with our Commitment to Carers

NHS England will continue to work with its partners in CCGs, NHS providers, local Authorities, and the third sector, in order to deliver on the Commitment to Carers.

In 2016/17 we are proposing further work to demonstrate how an integrated approach to the identification and assessment of Carer health and wellbeing need is making a difference to their lives of Carers and their families.

This will include the development of an outcomes framework to identify where an integrated approach is making a difference a difference, work to develop positive practice to help Primary Care identify and support Carers, work to include Carer support within new models of care, and targeted work with vulnerable groups to identify challenges they may face in accessing Carer support.

Appendix One: Template Memorandum of Understanding

Memorandum of Understanding between

[insert partner organisations on the local Health and wellbeing Board]

OR

[insert name of Director of Adult Social Care] and [insert name of Commissioning Lead for local Clinical commissioning group] - :

Supporting an integrated approach to the identification and assessment of Carers' health and wellbeing needs

1. Introduction

This Memorandum of Understanding (MOU) sets out the agreed approach to supporting the implementation of an integrated approach to the identification and assessment of Carers' health and wellbeing needs across [insert name of district].

a. The local authorities [insert name of local authority/authorities]; and
b. The following commissioners and providers of NHS-funded care:
- [Insert name of CCG(s)]
- [List all acute NHS Trusts and FT's in area, including tertiary & specialist]
- [insert name of Director of Public Health]
- [Insert name of ambulance trust(s)]
- [Insert name of independent sector providers]
- [Insert name of mental health trusts – if applicable]
- [Insert name of community providers – if applicable]
- [Insert name of voluntary sector care providers – if applicable]

c. The local Carer support organisation(s) [insert name(s)]
d. Other local partners:
- [insert names of relevant local partner organisations]

2. Our vision for Carers

[insert name of district/borough] is a place where Carers are recognised, supported and valued, both in their caring role, and as individuals.

3. Working together to support Carers

Partners agree to co-operate with each other, to promote the wellbeing of individual Carers, and to adopt a whole family approach in their work to support local Carers of all ages, in order to:

a. maintain the independence and physical and mental health of Carers and their families

b. empower and support Carers to manage their caring roles and have a life outside of caring

c. ensure that Carers receive the right support, at the right time, in the right place

d. respect Carers' decisions about how much care they will provideand respect Carers' decisions about not providing care at all

4. Key principles

The integrated approach to identifying, assessing and supporting Carers' health and wellbeing needs rests on a number of supporting principles. Each of these principles covers a number of practical points and each of these practical points features examples of positive practice, in order to encourage other practitioners and commissioners to replicate or build on success.

These examples of positive practice are summarised in Appendix Two.

Partners to the Memorandum of Understanding agree that:

4.1 Principle 1 – We will support the identification, recognition and registration of Carers in primary care.

4.2 Principle 2 - Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health.

4.3 Principle 3 - Carers will be empowered to make choices about their caring role and access appropriate services and support for them and the person they look after.

4.4 Principle 4 – The staff of partners to this agreement will be aware of the needs of Carers and of their value to our communities.

4.5 Principle 5 - Carers will be supported by information sharing between health, social care, Carer support organisations and other partners to this agreement.

4.6 Principle 6 - Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision-making and reviewing services.

4.7 Principle 7 - The support needs of Carers who are more vulnerable or at key transition points will be identified early.

5. Moving forwards

Actions arising from this agreement will form part of our commissioning plan for Carers and of a more detailed action plan.

We will put in place arrangements for periodic audit and the provision of reasonable assurance to the Council, Health and Wellbeing Board, Clinical Commissioning Group, and the public, on how this memorandum of understanding is being implemented and how our work is making a difference to carers. Feedback from Carers, their representatives, and the cared for, will be an essential element of these audits.

We will involve Carers, in recognition that they are ‘experts by experience’, in monitoring and reviewing services, and when seeking to redesign, commission or procure Carer support services.

We will put programmes for learning and development in place to raise the awareness and understanding of the needs of Carers and their families, and of local Carer support services.

We will design training and support for those undertaking Carers needs assessments to have the necessary knowledge and skills. This will include ensuring that practitioners in the local authority and partner agencies are aware of the specific requirements concerning Carers of the Care Act 2014 and amendments to the Children and Families Act 2014 and accompanying Guidance and Regulations.

6. Thinking Carer across the system

By supporting carers we are also supporting the cared for. No one should have to care alone.

In order to ensure that carers receive the right support, at the right time, and in the right place, a Carer who indicates that they require additional support or that their capacity or willingness to continue caring is diminished, should be referred to the local Carer support organisation to have their immediate needs addressed.

Where a Carer indicates they have a health need during an interaction with the NHS, this health need should be addressed as soon as possible, after which the healthcare practitioner should initiate a discussion about the Carer's wider support needs and refer to the local Carer support organisation.

Partnership working and co-operation is key to providing a joined up, seamless service. This will include joint working between the local authority, the NHS, voluntary organisations, education, public health, housing and local communities to support Carers.

Central to this joint working will be the development of local data and information sharing processes between agencies, so that information follows the Carer across their own care and support pathway without them constantly having to re-tell their story. Practical examples of how this can be achieved are included in Appendix Two.

The needs of Carers should also be recognised by commissioners and planned for. Work through the local Health and Wellbeing Board, the Better Care Fund Board, and the Joint Strategic Needs Assessment, will include identification of the needs of Carers, including Young Carers and Young Adult Carers in the local area; this identification will be crucial in avoiding crisis breakdowns.

The local Joint Health and Wellbeing Strategy will include shared strategies for meeting these identified needs, setting out arrangements for working together and the actions that each partner will take individually and collectively.

This memorandum of understanding will be subjected to an annual review.

7. Signatories

Name and title	Organisation	Signature

Appendix Two: Resources to support core principles

Principle 1 - We will support the identification, recognition and registration of Carers in primary care. The role of the primary care team as the one to which all Carers have access is recognised as being paramount in supporting Carers and maintaining the capacity of Carer to care, if they so choose. There is a need to improve the registration and assessment of Carers, including Young Carers, in primary care so that their needs can be identified more quickly and before their health and wellbeing deteriorates.	
Some CCGs run Carer accreditation schemes for practices, to promote innovation and recognise good practice in supporting Carers	http://carersinwiltshire.co.uk/our-services/gp-support/
Some Carer support services work closely with GPs in identifying and registering Carers	http://www.carersleeds.org.uk/
The Carers Trust provides useful advice for primary care staff on practical ways in which carers can be identified in primary care	http://www.carerssupportcentre.org.uk/professionals-2/resources-for-gp-practices/how-to-identify-carers/
Derbyshire Carers Association has developed a carers pledge which promotes the identification of Carers within primary care	http://www.derbyshirecarers.co.uk/carers-pledge
Carers Support Centre Bristol and South Gloucestershire has a dedicated team which supports practices across the district to identify, inform and support all Carers	http://www.carerssupportcentre.org.uk/professionals-2/gp-practices/practice-managers-carer-leads/

Principle 2 – Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health. Carers have a dual role as both providers of care for the cared for and as clients of services as a result of the caregiving role which affects their own health and wellbeing. Thus, primary care has a unique opportunity to make a telling contribution to improving the lives of Carers. Primary care teams are already seeking to support carers in a number of practical ways, including offering Carers flexible appointment times, longer appointments, and referrals to a range of local services through Carer/social prescribing schemes. There is also a need for local agencies to work together in developing integrated support to meet the identified and emerging needs of Carers.	
There is an opportunity to build on best practice and use annual Carer health checks as an opportunity to identify Carer needs at a key entry point to the needs assessment pathway. This service also provides an online booking service for carers	http://www.healthpromotiondevon.nhs.uk/projects/carers-wellbeing http://www.devoncarers.org.uk/devon-carers
In some areas, GP surgeries have designated Carers Leads and run dedicated Carers clinics, to identify and check the needs of carers	http://carersinwiltshire.co.uk/our-services/gp-support/
In other areas, and where the Carer agrees, the provision of an online assessment/self-assessment form allows for primary care to link more easily with the rest of the needs assessment process	https://mycitizenportal.oxfordshire.gov.uk/web/portal/pages/help/other http://mychoicemycare.org.uk/i-need-help-with/being-a-carer/carers-assessments.aspx

In some areas, GPs are offering Carers-only appointments on Sundays	https://www.manchestercommunitycentral.org/news/carers-accessing-sunday-gp-appointments
It is also possible to recognise, support and value Carers through the use of Carers passports. In some cases these can offer Carer discounts on a range of services	http://www.carersinherts.org.uk/how-we-can-help/carer-services/carers-discount-passport
Some GPs are prescribing Carer breaks, as part of a wider Carer prescription scheme. Guidance for GPs can also be accessed by clicking on this link	http://www.actionforcarers.org.uk/professionals/general-practitioners/surrey-gp-carers-prescription/
In some areas, practice staff can access a wide range of resources to help them support Carers	http://www.carersinherts.org.uk/help-us-help-carers/carers-health-information-for-gps/downloads
All Carers should be given information, appropriate to their needs, about local Carer support services and the rights of Carers to an assessment, including right to request an advocate. In Hackney, the local authority has worked with partner agencies to ensure that local Carers receive advice, information and guidance that meets their individual needs and circumstances	www.hackney.gov.uk/Assets/Documents/carers-information-pack.pdf
Some Carer support organisations have been commissioned to work specifically within general practice, in order to provide integrated support for Carers. In other areas, primary care teams and Carers organisations work in partnership to support carers	http://www.supportforcarers.org/what-we-offer/gp-or-professional http://www.leedsnorthccg.nhs.uk/our-priorities/supporting-carers/

North Somerset CCG, Avon and Wiltshire Mental Health Partnership NHS Trust and charity Second Step are working in partnership, “Positive Step in North Somerset”, to provide psychological therapies for people with a range of issues including anxiety or panic, trauma, obsessions and depression. Carers receive tailored help thanks to a thriving talking therapies programme aimed at helping them find the strength to carry on. The psychological therapies (IAPT) service for Positive Step in North Somerset has helped more than 500 carers with therapy and support since launching three years ago	https://www.england.nhs.uk/mentalhealth/case-studies/positive-step/

Principle 3 - Carers are empowered to make choices about their caring role and access appropriate services and support for them and the person they look after.

Carers need to be aware of their entitlement to request to an assessment of their needs in their own right, independent from any assessment of the person for whom they care. Carers' main support needs may be support with their own health or with information and education to help them provide skilled caregiving and support for the cared for, either of which may be best addressed directly by healthcare practitioners at the time. Many areas produce directories of Carer support services and some of these are comprehensive. Depending on identified need, referral to the local Carer support organisation may be the best way to ensure that carers receive the support they need when they need it. Carers will be supported to exercise choice and make well-informed decisions about the support options available to them.

It is acknowledged that Carers are free to choose not to care, or to decide on the amount of care they will provide. Whatever decision a Carer makes should be respected by the staff with whom they come into contact.

The wellbeing needs of the Carer's family will be taken into account when identifying suitable support. The Carer will be supported to plan for life beyond caring, including where the Carer wishes to reduce the amount of care they provide, or where they are no longer able, or no longer wish, to continue their caring role.

Some Carer support organisations provide comprehensive information about Carers' rights	https://www.carersuk.org/help-and-advice/get-resources/carers-rights-guide
Some Carer support organisations also provide training on the choice and safe use of equipment to help support the cared for or on safe manual handling of the cared for	https://www.sutton.gov.uk/info/200335/at_home/1076/staying_in_your_own_home/4 http://www.birminghamcarershub.org.uk/free-safe-moving-handling-training/

Carers have told us they would also welcome more information and training on the safe prescribing of medication, and for clearer information about the patient's condition(s), its development and the prognosis	http://www.sja.org.uk/sja/what-we-do/community-projects/carers-support-programme.aspx
Carers have asked for clear information on how to access support out of hours and in emergencies There are a variety of carers emergency contact schemes in operation, some run by Carer support organisations, others run in partnership with the local authority	http://www.doncastercarersservice.org.uk/carers_emergency_contact_scheme/ http://www.kentcarersemergencycard.org.uk/ http://www.carerssupportcentre.org.uk/free-message-in-a-bottle-service/ http://www.yorkcarerscentre.co.uk/adult-carers/carers-emergency-card/
Some Carer support organisations run courses to help carers care with confidence, addressing themes ranging from handling emotions, looking after the Carer's own health, and dealing effectively with professionals and service providers	http://www.sunderlandcarers.co.uk/caringwithconfidenceprogramme.html http://www.yorkcarerscentre.co.uk/
Some organisations provide advice and support to carers who wish to return to work after their caring role has ended	https://www.carers.org/help-directory/after-caring

Principle 4 - All health and social care staff will be aware of the needs of carers and of their value to our communities.

Care staff would benefit from Carer awareness training. Provision of Carer awareness training in health and social care induction and ongoing professional development programmes is desirable.

Care staff will recognise signs of distress and diminished capacity that may affect the ability or willingness of Carers to continue caring, so that they can ask the Carer if they are in need of support. Care staff will also be aware of local Carer support organisations so that the Carer can be sign-posted. In some cases, care staff may be able to make the referral on behalf of the carer. Where social care practitioners are identifying a health need as part of their Carers assessment they should have the ability to refer the carer back to their GP for health support.

The aim of this principle is for care staff to work holistically with the Carer and cared for and be aware of Carers' needs from diagnosis, discharge planning and reviews. Staff could provide the carer with information and/or refer early to support to try to avoid a crisis situation or a breakdown in the Carer's health.

Some NHS organisations recognise Carers within their corporate induction programmes	http://www.gloshospitals.nhs.uk/en/Wards-and-Departments/Other-Departments/Education-Learning-and-Development/Induction/?id=6151 http://southtees.nhs.uk/patients-visitors/carers-supporting-your-needs-and-rights/
Some Carer support organisations employ hospital liaison workers to raise awareness of issues affecting Carers across local hospitals and other health services	http://www.carerssupportcentre.com/north-lincolnshire/information-for-healthcare-pro

Some Carer support organisations run Carer awareness training for professional health and social care staff, with a number segmenting this training to address the particular needs of Adult Carers, Young Adult Carers and Young Carers Some organisations provide this training online	https://www.carersuk.org/for-professionals/training/e-learning http://www.carerssupportcentre.org.uk/professionals-2/carers-awareness-training/ http://www.ycctraining.co.uk/
Some Carers organisations provide information on the signs of Carer stress	https://www.carers.org/help-directory/managing-stress
Some Carer support organisations have produced DVDs and video clips as a more flexible approach to raising awareness with health and social care agencies of the issues affecting Carer health and wellbeing	http://www.sunderlandcarers.co.uk/dvd.html

Principle 5 - Carers will be supported by information sharing between health, social care and Carer support organisations. We understand that the biggest risk to Carers is the failure to share information sensibly. We will work to remove burden of Carers having to repeat information and will reduce the barriers to effective sharing of information. Improved sharing of information will help to identify vulnerable Carers earlier, improve the identification of Carers and the assessment of their support needs, and could improve the responsiveness of support to the changing needs of Carers. The registration of Carers in General Practice is key to this as being identified as a Carer will generate a READ code on the Carer's personal medical record and this will accompany that Carer whenever and wherever they use the NHS (by being shown on the Summary Care Record). Within integrated services, social care staff will have access to the Summary Care Record. Service specifications for many Carer support services, including those that have been delegated to undertake needs assessments on behalf of the local authority, provide for data-sharing and processing arrangements that comply with information governance and data protection requirements.	
In some cases, data exchange and sharing between agencies is covered as part of the contract or SLA	https://democracy.wandsworth.gov.uk/documents/s34738/14-565%20Integrated%20Carer%20Support%20Services%20-%20Appendix%20A.pdf
In other cases, data processing contracts have been agreed to share information about Carers, and their support needs, between agencies	Available on request from Jane Weller, Commissioning and Contract Manager, Liverpool City Council jane.weller@liverpool.gov.uk
A Shared Care Record has been developed in Salford, under the Integrated Care Programme to support personalised care planning between health, mental health and social care	http://www.salfordtogether.com/wp-content/uploads/2016/04/Salford-Shared-Care-Record-Screenshots.pdf

Principle 6 - Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision-making and reviewing services.

Carers will be actively involved in the planning of care for the cared for. Carers will have their views taken into account when planning care in advance. Carers will be fully engaged in the planning, redesign and shaping of services. It is acknowledged that whilst Carers will be expert in the preferences, context and disease history of the patient, they will often not be expert in the disease(s), its course and management and how to deal with emerging caregiving challenges. Carers may, therefore, still need support from healthcare practitioners to empower them to fully fulfil their role as expert partners.

Services will be continuously monitored and reviewed, with Carer inputs, in order to demonstrate where desired health outcomes are being achieved and to identify those areas in need of improvement.

Involving Carers in the planning of care can have significant benefits for the cared for	http://www.sabp.nhs.uk/advice/care-planning
The contribution of Carers in advance care planning is cited as good practice	http://www.ncpc.org.uk/freedownloads http://www.gloucestershireccg.nhs.uk/your-services/eolc/advanced-care-planning/
The involvement of Carers in personal care planning is also recognised as being beneficial	https://professionals.carers.org/involving-carers-planning
Carers are also involved in advance care planning and shared decision-making. The provision of patient decision aids (or PDAs) may support the involvement of Carers in this process	https://www.england.nhs.uk/ourwork/pe/sdm/tools-sdm/pda/ http://www.harrogateandruraldistrictccg.nhs.uk/reports-and-publications/shared-decision-making/

Carers will be fully engaged in the planning of services. Some areas have reviewed their care market around the needs of carers, in order to promote individual choice and control, and the personalisation/ tailoring of services to meet individual Carer circumstances and preferences	www.hertsdirect.org/hertsmpe
Many NHS trusts have their own strategies for involving Carers in the planning, delivery and evaluation of its mental health services	http://www.5boroughspartnership.nhs.uk/basepage.aspx?ID=5697 http://www.nsft.nhs.uk/Get-involved/Pages/Service-user-and-carer-involvement.aspx http://www.sssft.nhs.uk/service-users-carers/our-service-user-and-carer-charter

Principle 7 - The support needs of Carers who are more vulnerable or at key transition points are identified early.

The use of risk stratification and carer recognition tools will allow for predicative modelling through which to develop the necessary preventive and other support resources to meet the needs of Carers approaching key transition points. The aim of this principles of to protect and support vulnerable Carers and to reduce health inequalities. It is important that commissioners ensure that this data is collected, handled and managed through arrangements that comply with information governance and data protection requirements.

Carers within the following groups face the same challenges and difficulties as all Carers, but often face additional problems in accessing or using support.

NHS Salford CCG and Salford Council use a risk stratification tool to help identify Carers who may need a bit of extra help to live their lives	www.salfordccg.nhs.uk/vulnerable-standards
Action for Carers Surrey has worked closely with local CCGs in developing a Carers recognition tool to determine the level of stress on Carers and can be used to prioritise need and support plans for the Carer. It has been designed to help to support and inform clinical decisions around the role of the Carer	http://www.actionforcarers.org.uk/professionals/general-practitioners/forms-information-and-other-downloads-gps/
Carers aged over 75 – NHS England, Age UK, Public Health England, and other partners, have produced a healthy ageing guide, and a sister publication, “a practical guide to Healthy Caring”	https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/healthy-ageing/ https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/healthy-caring/

Young Carers as they leave primary school and approach secondary school, as they leave secondary school to go on to further education, and as they move from adolescence to adulthood	http://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/young-carer-transition-in-practice/transition-in-care-act-children-and-families-act.asp
The National Carer Family Network promotes the rights and views of those caring for a person with a learning disability	http://www.familycarers.org.uk/
Connexions Dudley provides a transition guide for parents/Carers of teenagers with learning difficulties and/or disabilities	http://www.connexionsdudley.org/about-2/resources-publications/
The Children's Society Young Carers in Focus programme and Carers Trust run the Young Carers in Schools scheme to improve the identification and support of young carers in schools	http://www.youngcarer.com/resources/young-carers-schools
Parents as Carers, particularly parents of children with physical or learning disabilities as they leave the family home or as they become eligible for adult services. A directory of local parent carer groups can be accessed at this link	http://www.cafamily.org.uk/what-we-do/parent-carer-participation/what-is-a-parent-carer-forum/
The National Network of Parent Carer Forums exists to develop good practice and effective participation for parent Carers	http://www.nnpcf.org.uk/

Leicestershire County Council runs a 'take a break' scheme for parent carers of disabled children	http://llrchildcare.proceduresonline.com/chapters/p_take_break.html
Lesbian, Gay, Bisexual and Trans (LGBT) Carers Age UK has produced a number of guides for older Carers who identify themselves as being Lesbian, Gay, Bisexual or Trans A number of LGBT Carer support groups exist to inform and advise LGBT Carers about the support available to them and to work with commissioners in representing the views and interests of LGBT Carers	http://www.ageuk.org.uk/health-wellbeing/relationships-and-family/lgbt-information-and-advice/lesbian-gay-bisexual-or-transgender-in-later-life/ http://www.ourgateshead.org/news/lgbt-carer-support-group http://www.thecarerscentre.org/our-services/adult-carers/reachingout/ http://lgbt.foundation/information-advice/Carers/
Carers from Gypsy, Roma and Traveller communities Carers Support West Sussex and the Sussex Traveller Advisory Group are working in partnership to identify and support the needs of Carers from these communities Carers Federation in Nottingham provide training, clinics, help and advice in the community for Gypsy, Roma Travellers	http://www.carerssupport.org.uk/all-carers/travellers/grt-health-and-caring http://www.sussextag.org.uk/ https://www.carersfederation.co.uk/services/the-clinic/gypsy-roma-traveller-health/

Military Carers and Military Young Carers - spouses and children in military families may be caring for a parent/sibling who has returned from combat injured, both physically and/or emotionally, or they may be caring for a parent who has health problems while their other parent is away with the military	
Carers Trust provides a national voice for the needs of Military Carers and Young Military Carers	https://www.carers.org/community/blog/who-are-military-young-carers-and-why-do-we-need-raise-their-profile
In Wiltshire, local partners have been running a pilot online support service to carers of people suffering from severe mental illness (SMI) in the Armed Forces Community over a one-year period. This pilot is currently being evaluated	http://www.fim-trust.org/news/the-forces-in-mind-trust-awards-a-grant-to-wiltshire-mind-to-provide-a-pilot-project-offering-online-support-to-carers-in-the-armed-forces-community/
The Sussex Armed Forces Network works to improve the lives of armed forces communities. This links closely with local Carer support organisations, provides Carer awareness training and employs a Carers and Families Liaison worker	http://www.sussexarmedforcesnetwork.nhs.uk/about/
Carers of people with substance misuse problems - since 1997, Derbyshire County Council has funded Spoda to provide services to address the wide range of complex issues facing Carers of people with substance misuse problems. It was recognised that the shame and stigma associated with substance use meant that Carers do not fit well within generic carer services	www.spoda.org.uk

Carers from BAME (Black, Asian and Minority Ethnic) communities Bristol Black Carers supports carers and those whom they care for to access mainstream care and health related public services Carers First Nottingham City Carers team has African Caribbean, South Asian and Ethnic Minority Carer Support Workers who can offer culturally appropriate information including, language support for South Asian carers Gateshead Carers Association has published an evaluation of its work to support "hidden" carers	 http://www.bristolblackcarers.org.uk/ https://www.carersfederation.co.uk/services/adult-carer-support/adult-carers-nottingham-city/carers-federation-support-workers/ http://www.nemhdu.org.uk/news/2016/1/4/gateshead-carers-association-reaching-hidden-carers-project-evaluation-report
Carers and bereavement The death of the person being cared for can often lead to a double bereavement – the loss of a loved one and the loss of the caring role. Many health-related charities and carer support organisations offer bereavement support, with many areas running support groups for bereaved carers Young Carers and bereavement - a number of national and local groups support bereaved children, young people and their families.	 http://www.carersinherts.org.uk/how-we-can-help/carer-services/carers-bereavement-group http://carers-network.co.uk/bereaved-carers-support-group/ http://www.griefencounter.org.uk/ http://www.mosaicfamilysupport.org.uk/parents-and-carers4.asp

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Joint local area SEND update

Health and Wellbeing Board **Date: 24th May 2017**

Author: Lyn Frith, Strategic Commissioner SEND, Swindon Borough Council

Wards: All

Locality Affected: All

Parishes Affected: All

1. Purpose and Reasons

1.1 This report provides an update on progress in readiness for the new joint local area SEND inspection.

1.2 From May 2016 all local areas in England have been 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.

2. Recommendations

The Board is recommended to:

2.1 Note the arrangements for the forthcoming joint local area SEND inspection, and monitor progress towards implementing the strategy to deliver better outcomes for children and young people with SEND in Swindon.

3. Detail

Background to the inspection

3.1 In April 2016 Ofsted and the CQC published the framework for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities.

3.2 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.

3.3 It is important to note that these inspections will evaluate how effectively the local area meets its responsibilities, and not just the local authority. This includes Clinical Commissioning Groups (CCGs), Public Health, NHS England for specialist services, early year's settings, schools, and further education providers.

3.4 During the inspection, inspectors will visit a range of providers to gather evidence, including nurseries, schools, colleges and specialist services.

Further information on the subject of this report can be obtained from Lyn Frith, 01793 463217, LFrith@swindon.gov.uk.

3.5 If inspectors become aware of concerns of a safeguarding or child protection nature, they will make additional enquiries to satisfy themselves that such matters are being dealt with appropriately. If they remain concerned, this could include inspectors referring individual cases to the local authority or an inspection of the individual service or provider in line with Ofsted or CQC's duties and powers.

3.6 The starting point for the inspection is the expectation that leaders for the local area should have an understanding of strengths and aspects that require development.

3.7 To support local areas assess how well arrangements are working and compare delivery across local areas, the Department for Education has produced a local area SEND report which presents the statistics on SEND for Swindon and provides the opportunity to compare our performance with other areas. This can be found at: http://lginform.local.gov.uk/reports/view/send-research/local-area-send-report?mod-area=E06000030&mod-group=ADASSRegions_SouthWestern&modify-report=Apply.

3.8 As of 1st March 2017 a total of 20 letters had been published by Ofsted following inspections thoughout England. Of those, five areas (Sefton, Suffolk, Surrey, Rochdale and Hartlepool) are required to provide a Written Statement of Action because of significant weaknesses in the local area's practice. The Local Authority and CCG are responsible for submitting the Written Statement of Action.

Our Self-assessment

3.9 Detailed self-evaluation has been an ongoing process and has recently been updated utilising the recently published tool provided by the Council for Disabled Children. A joint improvement plan will be developed with the CCG.

3.10 The CCG Governing Body oversees the joint arrangements for SEND and the contribution of health. The CCG have also undertaken a detailed self-evaluation and presented this to the SEND Strategic Board in September 2016. The improvement plan for the CCG will be overseen by the Joint Commissioning Group (JCG), reporting to the Health and Wellbeing Board.

3.11 The inspection framework, and therefore our self-evaluation, is evaluated under three headings as identified below. The areas for development are monitored through the Quality Improvement sub-group of the SEND Strategic Board, reporting through JCG to the Health and Wellbeing Board. The key strengths and areas for development are as follows under each heading.

Heading 1: Our effectiveness in identification of children and young people who have special educational needs and/or disabilities

3.12 *Strengths*

3.12.1 Effective screening processes are in place to identify need in new-born infants.

3.12.2 Advisory teaching staff and educational psychologists help to ensure that children receive the support they need to be able to gain access to pre-school settings, nursery education and the Reception class in school.

3.12.3 Practitioners who identify the need for additional support to help children access early-years settings can seek extra funding.

3.12.4 The Special Education Needs Resource and Assessment Panel (SENRAP) contributes well to identifying and providing for the needs of young people who have special educational needs and/or disabilities.

3.12.5 Assisted speech and language equipment provided to a child or young person travels with them to ensure access to the most appropriate equipment to support learning during their education and transition into adult life.

3.12.6 The local area's 'early help' assessment process is a good example of joint working across the education, health and care workforce. Early help records are used effectively as part of the graduated response before a request is made for a statutory assessment of special educational needs.

3.12.7 Integrated service delivery in early years has ensured timely and effective assessment of need. This helps to identify children who need referral to speech and language support and ensures that children receive in-depth assessment leading to early identification of their needs and health care.

3.13 *Progress against previously identified areas for development*

3.13.1 In September 2016 we had identified the percentage of pupils with a statement or EHC plan was high at 3.8% compared to an average of 2.8% in all English authorities. This was also a concern as the % was increasing year on year. We have now stabilised this position and predict a reduction to 3.7% in 2017.

3.13.2 We now understand why this figure is so high. The % of children with a statement or EHCP is calculated on the school population and does not include children in FE settings. The % of children with a statement or EHCP up to the end of year 11 in Swindon is slightly below the national average, however, for those in post 16 provision it is significantly higher. This is explained by our relatively small mainstream sixth form population and our large special school sixth form population.

Further information on the subject of this report can be obtained from Lyn Frith, 01793 463217, LFrith@swindon.gov.uk.

3.13.3 We will continue to closely monitor our figures to ensure we remain in line with national averages up to the end of year 11 and develop our post 16 offer to reduce the % of children with a statement or EHCP educated in special schools.

3.13.4 We have significantly reduced the time that children and young people have to wait for their plan to be finalised. 69.4% were completed within 20 weeks (excluding exceptions) in 2016 compared to 37.6% (Eng 55.5%) in 2015. In October and December 2016 we completed 100% of assessments within 20 weeks.

3.13.5 A full review of the ASD pathway is underway, currently, there are 470 un-booked appointments within the GWH community paediatrics clinics and 351 booked first appointments. This totals 821 with an average waiting time of 41.8 weeks. Approximately 25% of children referred to the ASD service are discussed at the complex case meetings.

3.13.6 In response to the increased demand for ASD assessments and to support the required reduction in wait times, the CCG has agreed £330,610 additional funding to procure the following additional resources:

- **£37,525k** to create an additional **Educational Psychologist Post** to operate from the GWH paediatric department. This will improve access to assessment and help to identify issues with the assessment of attachment or Learning Difficulties by greatly increasing the sensitivity and specificity of the diagnostic process.

- **£100,000k** to fund 1 WTE Paediatric Consultant post within the GWH paediatric department. This will also reduce the number of un-booked appointments and average waiting times in the department and increase clinic capacity.

- In addition, the CCG has also agreed to invest an additional £65,085 into improving resources for safeguarding processes at GWH. This will release clinician's time to contribute to the ASD diagnostic pathway.

- A further £128k will be invested into the Paediatric Therapy Service to recruit 1WTE Occupational Therapist and 1.8 WTE Community Speech and Language Therapists. These posts will provide 26 additional sessions per week for diagnosis and therapy on the ASD pathway.

3.13.7 In order to monitor the effectiveness of these additional resources, the children's services commissioner is developing detailed implementation and monitoring plans in collaboration with GWH and SBC, aimed at

achieving and evidencing a sustained reduction in waiting times over the next 12 months.

Heading 2: Our effectiveness in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities

3.14 *Strengths*

3.14.1 Parents, carers and children and young people are involved in regular reviews. Co-produced plans mean that children are at the heart of the education, health and care plans.

3.14.2 Access to high quality health services is well established within specialist resourced provision and special schools.

3.14.3 Some good examples exist of joined-up working both within health teams and other partners. For example, the multi-agency unit based at Uplands learning campus.

3.14.4 The existence of joint multi-disciplinary health clinics at the Saltway centre assist families understanding of roles and responsibilities and reduced duplication.

3.15 *Areas for development*

3.15.1 Although the annual review process is sound if a re-referral is required, this can mean that needs are met too slowly. The policy, which outlines what happens when health appointments are missed, requires review to ensure greater flexibility when dealing with vulnerable children and parents.

3.15.2 Parents, carers and young people are not sufficiently aware of the role they could play in helping to shape the local offer and the mechanisms to do so. Providers and parent carer groups have a greater role to play in using the local offer as a medium to share information to access specialist services used by the local area.

3.15.3 The local offer is not easy to navigate for some families. Some parents continue to be unaware of its purpose.

- **Action for Improvement:** The local authority and CCG are working in partnership with Contact a Family and Swindon Parent Carer Forum to develop and improve co-production with parents which includes improvements to the local offer website and joint strategic needs assessment to support joint commissioning for SEND.

3.15.4 Leaders from education, health and social care do not yet have an agreed strategy for sharing expertise and training staff to benefit children and young people who have special educational needs and/or disabilities. This limits the capacity of leaders to evaluate the impact of this work on pupils' outcomes.

- **Action for improvement:** We have a strategy for the training of Social Care staff and those within our Community Health/Early Help staff that require it. This involves the commissioning of both direct training and coaching and the development of a e-learning module in relation to their contribution to the EHCP process and the writing of outcome based plans. The development phase has commenced and will include a workshop with all Social Care/ Community Health/Early Help Managers on the 14th March. A mechanism for measuring the impact of training on pupil outcomes is under development.

3.15.5 A single pathway to develop provision, particularly for young people aged 19-25 is still in development.

3.16 *New Areas for Development*

3.16.1 Swindon is currently reviewing its approach to joint commissioning for special educational needs and/or disabilities which requires endorsement by senior leaders across the area.

3.16.2 Very few families have taken up the offer of a personal budget as part of an EHCP.

Heading 3: Our effectiveness in improving outcomes for children and young people who have special educational needs and/or disabilities

3.17 *Strengths*

3.17.1 The % of SEN pupils with a statement or EHC plan achieving a `good level of development' at foundation stage (2014/15) is above national average.

3.17.2 The impact and visibility of staff in specially commissioned named roles, in education and health, are having a significant positive effect on the progress of the special educational needs and disability reforms. Formal networking across education, health and social care has increased since 2014.

3.17.3 The proportion of schools in the area that are good or better has risen in the last three years.

3.17.4 The proportion of children and young people placed out of area as a result of their special educational needs and/or disability has reduced in the last three years.

3.17.5 The % of children and young people with special educational needs and/or a disability who are permanently excluded from school remains below the national average.

3.17.6 Most staff in education, health and social care accessed training on the special educational needs and disability reforms and understand their roles in implementing these reforms.

3.17.7 Individual providers are aware of their responsibility to monitor children and young people's progress in a range of outcomes. Increasing numbers of children in the early year's foundation stage are meeting their developmental targets.

3.17.8 Robust checks are in place to monitor the pupils who are home educated, who have medical needs and are educated in hospital.

3.18 *Areas for development*

3.18.1 Pathways for 19-25 year olds, to support young people into adulthood require further development.

- **Action for improvement:** Transition is a strategic priority for the local authority and plans are in place to improve outcomes for young people as they prepare for adulthood.

3.19 *Progress against previously identified areas for development*

3.19.1 Fixed term exclusions for children and young people with special educational needs and/or disabilities remain unacceptably high. However, following the inspection of one of our Special Schools, an improvement plan is now in place and we anticipate a significant reduction in fixed term exclusions as a result.

3.20 *New Areas for Development*

3.20.1 The percentage of adults with learning disabilities in paid employment has fallen for 2015/16, widening the gap between Swindon (3.7%) and England (6.6%).

- **Action for Improvement:** Swindon is offering supported internships through a number of different providers and have introduced transition link workers in Adult Social Care to work with targeted group of service users with a strong focus on work opportunities.

Further information on the subject of this report can be obtained from Lyn Frith, 01793 463217, LFrith@swindon.gov.uk.

3.20.2 The progress of pupils who have statements or education, health and care plans and for those receiving support for special educational needs and/or disabilities is insufficient. In particular, the progress of pupils from key stage 2 to the end of key stage 4 continues to be below national levels for pupils compared with all pupils in English and mathematics.

3.20.3 The % of 19 year olds with SEN support (Swindon 22.6%, Eng 32.1%) or a statement of SEN or EHC plan (Swindon 6.7%, Eng 13.8%) qualified to level 3 has fallen well below national average.

- **Action for Improvement:** The Education Challenge board has been established to address a wide range of concerns regarding academic achievement across Swindon.

4. Alternative Options

4.1 There are no alternative options as all local areas will be inspected at least once during a five-year period.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 There are no financial or procurement implications arising as a result of this report.

Legal and Human Rights Implications

5.2 There are no legal and human rights implications arising as a result of this report.

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

5.3 There are no other direct implications arising as a result of this report.

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

Further information on the subject of this report can be obtained from Lyn Frith, 01793 463217, LFrith@swindon.gov.uk.

7. Background Papers

7.1 The framework for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities.

7.2 DfE Local Area SEND report.

8. Appendices

8.1 None.

Further information on the subject of this report can be obtained from Lyn Frith, 01793 463217, LFrith@swindon.gov.uk.

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Long Term Conditions Joint Strategic Needs Assessment

Health and Wellbeing Board **Date: 24th May 2017**

Author: Christopher Bartlett, Senior Public Health Intelligence Analyst, Swindon Borough Council

Wards: All

Locality Affected: All

Parishes Affected: All

1. Purpose and Reasons

1.1 Improvements in medical treatment and success in public health interventions have resulted in people having longer lives, often with some form of long-term morbidity or disability. In England, the Department of Health estimates that over a quarter of the population have a Long Term Condition (LTC). An increasing number of these people also have a co-morbidity (or co-morbidities) and so are in a state of Multi-Morbidity. The on-going management of LTCs and Multi-Morbidity is now a central task of the NHS and care services.

1.2 In this Joint Strategic Needs Assessment (JSNA) for Swindon, we have drawn upon existing data sources (such as the 2011 Census and Quality and Outcomes Framework registers) to estimate the "LTC prevalence pool" in Swindon UA. We have also applied the Symphony Model to the Swindon population to estimate the magnitude of groups of LTC patients and impute their activity in our local health and social care system. Symphony is a record-linkage project, which has used "real life" health and social care data from Somerset to identify patterns of activity in a population. We also used the model to investigate other issues relating to LTCs within Swindon, such as Multi-Morbidity, costs and the effects of deprivation. The JSNA informs decisions about how services are commissioned and designed.

1.3 The draft LTC JSNA 2017 Bulletin is attached at Appendix 1 to the report and highlights the findings. The full JSNA report will be made available at: http://www.swindonjsna.co.uk/.

2. Recommendations

The Board is recommended to:

2.1 Note and approve the recommendations identified in the Swindon Long Term Conditions Joint Strategic Needs Assessment, as set out in paragraphs 3.10 to 3.23 of this report.

3. Detail

3.1 The objective of the LTC JSNA is to identify the needs of the Swindon population in relation to LTC, working with our local partners to formulate recommendations that will help inform future cost-effective and impactful commissioning.

Further information on the subject of this report can be obtained from Christopher Bartlett, 01793 444683, cbartlett@swindon.gov.uk.

Key messages

3.2 Although with a subject such as LTCs (in which definitions are broad and various), it is not possible to give definitive and precise answers. We believe that this JSNA provides useful and credible working estimates for use by the local Health and Care community.

3.3 In total, 32.2% of all people and 69.2% of people aged 65 years or more in Swindon UA may have one or more LTCs. An LTC prevalence of 32.2% amounts to 69,820 persons in 2015 (32,518 males and 37,301 females).

3.4 LTCs are numerically most common in middle-aged people, because there is a large number of middle-aged people in Swindon. These middle-aged people will have a noticeable impact on health and care services as they move into the ranks of older people in the coming years.

3.5 The actual prevalence rates, the likelihood of having an LTC, however, are greater in older people, and the LTCs are likely to be more severe for them. The Symphony model suggests a prevalence rate among people aged 65+ years of 69.3% in Swindon. This equates to 22,915 people.

3.6 For many conditions, it is usual, rather than exceptional, to have additional co-morbidities.

3.7 Although affluence only modestly works against the development of LTCs, affluent people may cope considerably better than more deprived people, may have fewer co-morbidities and they seem to feel less limited by their health problems.

3.8 There is a stronger link with deprivation in people aged 65 years or more, who have three or more LTCs. In total, 17.4% of people aged 65+ had three or more conditions, 5,757 people in all. Symphony suggested that the prevalence ranged from 13.6% in the least deprived decile of the Swindon population to 25.4% in the most deprived decile.

3.9 The most common conditions, as proportions of people aged 65+ years with three or more conditions, were: hypertension (high blood pressure) 83.2% (4,788 persons), Coronary Heart Disease, 43.0%, (2,474 persons), diabetes 40.7%, (2,345 persons), cancer 37.1% (2,137 persons) and stroke 29.0% (1,672 persons).

Recommendations

3.10 Accept the LTC Profile and the “Ageing Well JSNA Report” as providing complementary pictures of LTCs, health resilience and coping throughout the life-course and particularly in Older Age, in the population of Swindon.

3.11 Accept the main prevalence estimates of LTCs in this Profile, (derived from the Symphony Model) to be used as pragmatic, working estimates of the size of the LTC prevalence pool in Swindon.

3.12 Conduct a literature review to find evidence of which interventions have been shown to be effective in different parts of the population, with regard to: the primary prevention of LTCs, the secondary prevention of LTCs, self-management, resilience and coping skills in people with existing LTCs. Best professional practice and horizon-scanning (of emerging thought and issues in managing LTCs) are also to be encompassed in the review.

3.13 The literature review also to include investigation of the resilience and coping skills of more affluent people, so that these skills might be extended in Swindon to more deprived people.

3.14 The literature review to be conducted with respect to people at different stages of life, young adulthood, middle-age, and Older Age, people with different levels of health and people from different ethnic and socio-economic groups.

3.15 The literature to be investigated with regard to carers and the relationship of their own health to health events in the people for who they care, in support of a forthcoming “Carers’ JSNA Report”.

3.16 Explore further ways of exploiting IT, telehealth and telecare to improve and support the health of people with LTCs.

3.17 Conduct further statistical work on LTCs, particularly with a view to understanding social care needs, and include mapping Symphony model measures at the level of small-area geography. This could be complemented by the use of outputs from Swindon CCG’s SOLLIS system (based on actual primary care patient data). The outputs could also include measures of: “Frailty”, the various diagnostic, risk and resource groupings within SOLLIS, Groups identified in the literature as likely to be at high risk of requiring state-funded social care; such groups to include people with three or more LTCS, aged 65 years or more and living in deprived areas.

3.18 Consult Public and Patient groups through Healthwatch to gain insights into how local people cope with LTCs.

3.19 Share emerging findings with representatives of the “Sustainability and Transformation Plan” Team which is taking a strategic view of health and care services in Bath and North East Somerset, Swindon and Wiltshire.

3.20 Employ appropriately the interventions in the Swindon population, as identified in the literature review.

3.21 Target these interventions in the population as appropriate. Further intelligence work to support this and MOSAIC geo-demographic segmentation to indicate

which channels of communication should work best with different segments of the population.

3.22 Improve and support the health of people with LTCs through "joined-up" or "accountable care", that is services which are combined and co-located. Joined-up services could include "one-stop shop" treatment and care facilities, for example, for diabetes and its cardiovascular co-morbidities. It could also include "care managers" or "care co-ordinators" (such as the community navigators) who support those patients who have to receive care from different facilities and specialties.

3.23 Co-operate with partners in the aspiration for a health-promoting physical environment, including housing for people with LTCs (recent guidance on this topic has been published by Public Health England).

4. Alternative Options

4.1 Continue with the present Long Term Conditions management processes and strategies. This could lead to continued increase in the prevalence of Long Term Conditions and Multi-Morbidity, severity of diseases and higher costs.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 There are no known financial implications at this stage.

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 (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 There should be no significant staffing or other implications arising from this report.

5.4 Care of people with Long Term Conditions utilises 70% of hospital and primary care budgets in England and makes up 50% of GP appointments and 70% of inpatient days. Reducing the number of people with Long Term Conditions (and Multi-Morbidity) in Swindon will reduce the cost of care and improve the health and wellbeing of Swindon residents.

Diversity Impact Assessment

5.5 Based on the information contained in this report we do not believe that there is any adverse impact for any protected equality characteristic group as set out in the Equality Act 2010.

Risk Management

5.6 No specific risks have been identified at this stage for this report.

6. Consultees

6.1 The Director of Finance (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 – Long Term Conditions Joint Strategic Needs Assessment Bulletin.

Further information on the subject of this report can be obtained from Christopher Bartlett, 01793 444683, cbartlett@swindon.gov.uk.

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Appendix 1

Swindon's Joint Strategic Needs Assessment

Long Term Conditions (LTCs)

Key Points:

- Although with a subject such as LTCs (in which definitions are broad and various), it is not possible to give definitive and precise answers, we believe that this Profile provides useful and credible working estimates for use by the local Health and Care community.
- In total, 32.2% of all people and 69.2% of people aged 65 years or more in Swindon UA may have one or more LTCs.
- LTCs are numerically most common in middle-aged people, because there is a large number of middle-aged people in Swindon.
- However, the actual prevalence rates, (the likelihood of having one or more LTCs), are greater in older people, and the LTCs are likely to be more severe for them.
- For many conditions, it is usual, rather than exceptional, to have additional LTCs.
- Although affluence only modestly works against the development of LTCs, affluent people may cope considerably better than more deprived people, may have fewer co-morbidities and they seem to feel less limited by their health problems.
- There is a stronger link with deprivation in people aged 65 years or more, who have three or more Long Term Conditions.
- Intelligence from further work including a literature search, horizon scanning, use of the Mosaic segmentation tool and risk stratification data should be employed, along with the information in this JSNA to design targeted interventions in Swindon with the dual aims of improving health and reducing cost.

What is Joint Strategic Needs Assessment (JSNA)?

JSNA helps us to understand:

- What we know about the current health of local people
- How their needs are being met
- What we think their future needs are likely to be
- How their needs can best be met

The JSNA process involves many different partners and is overseen by Swindon's Health and Well-Being Board. Understanding Swindon's changing population, the factors that affect health and well-being, the town's assets and the implications for future services are vital in setting priorities and planning future services. This JSNA Bulletin examines the topic of Long Term Conditions (LTCs).

Introduction

Improvements in medical treatment and success in public health interventions have resulted in people having longer lives, often with some form of long-term morbidity or disability. In England, the Department of Health estimates that over a quarter of the population have a Long Term Condition (LTC).

An increasing number of these people have more than one LTC and so can be said to have a co-morbidity (or co-morbidities). Such people are often described as being in a state of Multi-Morbidity (MM). The on-going management of LTCs and Multi-Morbidity is now a central task of the NHS and care services.

In this profile for Swindon UA, we have drawn upon existing data sources (such as the 2011 Census and QOF registers) to estimate the "LTC prevalence pool" in Swindon UA. We have also applied the Symphony Model to the Swindon population to estimate the magnitude of groups of LTC patients and impute their activity in our local health and care system.

The Symphony Model is a record-linkage project, which has used "real life" health and social care data from Somerset to identify patterns of activity in a population. We have also used the model to investigate other issues relating to LTCs within Swindon, such as Multi-Morbidity, costs and the effects of deprivation.

The population of Swindon UA was 217,160 people at mid-2015. Even if our current expectations of rapid growth have to be revised in the near future, Swindon's population is predominantly middle-aged and these people will inevitably move into Older Age.

Although Swindon is less deprived than the average Local Authority, many different grades of affluence and poverty are present within it. About 15.4% of the Swindon UA population belong to a Black or Minority Ethnic Group (BME group).

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Using Socio-Demographic and Epidemiological Measures to estimate the "LTC Prevalence Pool"

Disability data from a national survey suggest a prevalence of 18% (in the adult population only), while measures from the 2011 Census for Swindon UA indicate slightly lower proportions, 15.4% ("Long Term Health Problem with limitations") and 16.6% ("Less than Good Health") (in people of all ages). For both these census measures older people and less affluent people tended to report higher levels of impairment.

People from ethnic minorities in Swindon reported relatively low levels of impairment, probably because these groups are younger, on average, than non-BME groups.

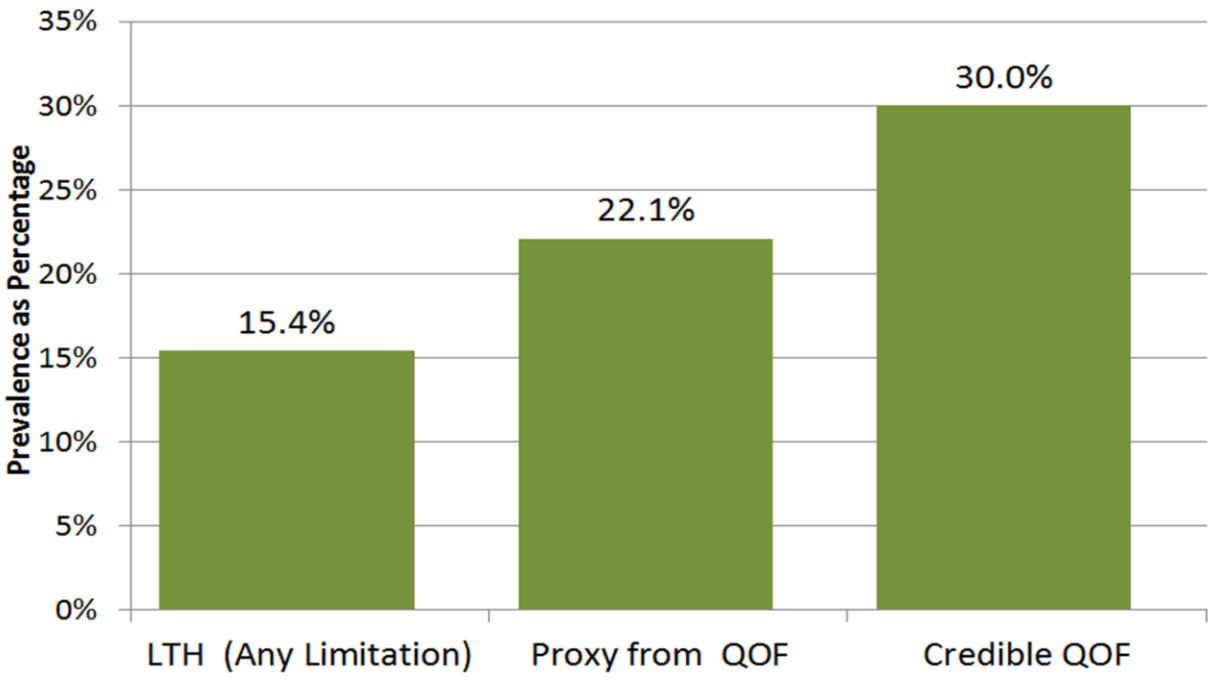
The QOF (Quality Outcome Framework) registers maintained by primary care doctors, record the number of people with specific chronic diseases, and so form a valuable source of information for investigating LTCs in Swindon. Unlike survey measures, QOF figures are medically verified, but they count diseases, (such as Coronary Heart Disease (CHD) and Cancer) and not people.

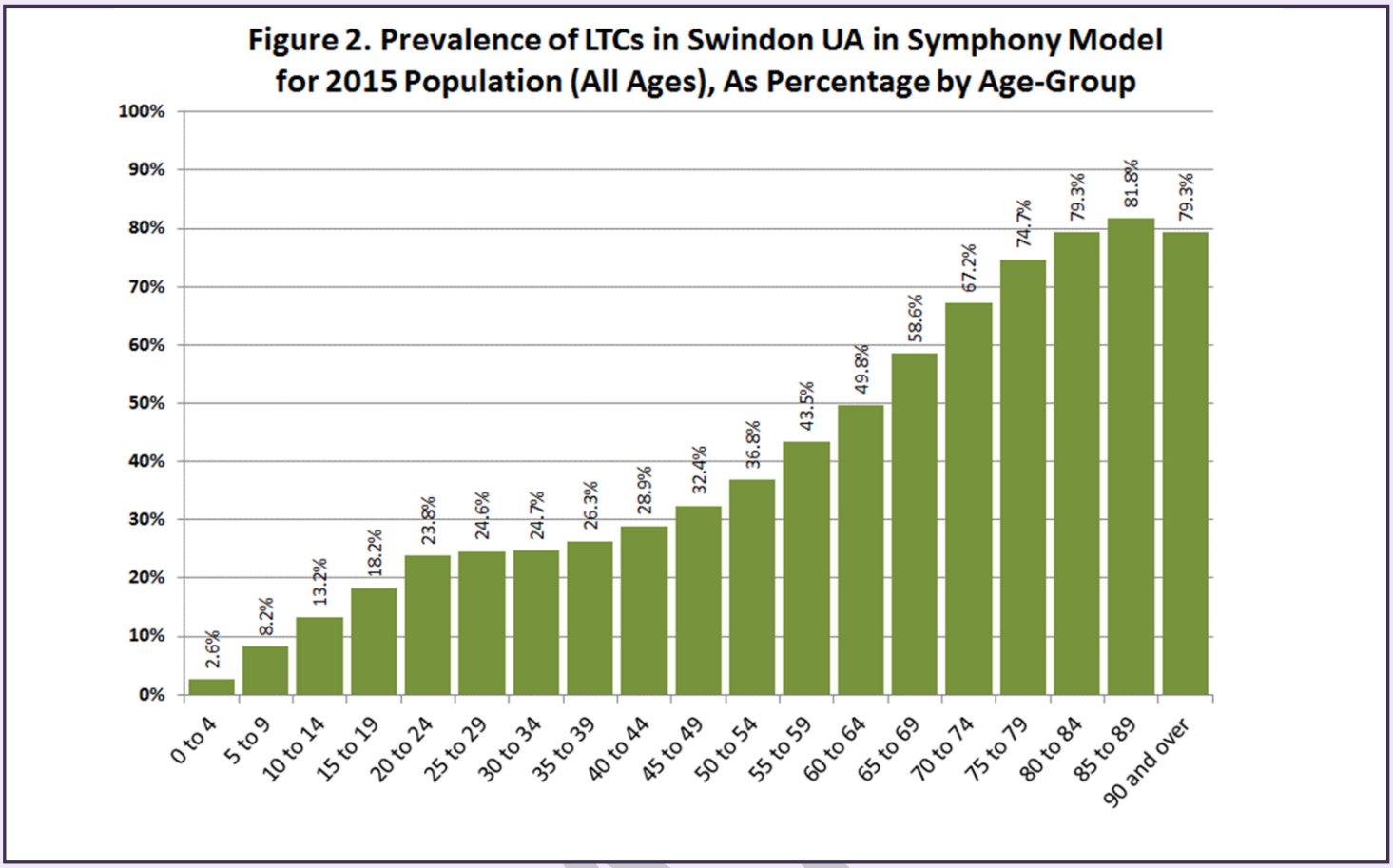
A pragmatic solution to the issue of counting individual people can be found by using a QOF indicator (relating to helping people stop smoking) which combines a basket of conditions, (including asthma, Coronary Heart Diseases, diabetes, high blood pressure, kidney diseases, stroke, lung disease), but counts each patient only once. This robust measure extracted from QOF, (which we have named "Proxy from QOF") records a prevalence of 22.2%.

However, a number of important conditions do not feature in "Proxy from QOF". Thus, a plausible approach which we have devised, called "Credible QOF" includes several additional common conditions (such as Cancer and depression). "Credible QOF" indicates that a percentage of about 30% for LTCs is probably more realistic.

The QOF percentages relate to the situation in the Swindon population at the end of March 2016 and can be taken as applicable to the whole population. A comparison of the census "Limitation" measure and QOF percentages can be seen in Figure 1.

Figure 1. Approximated Prevalence of LTCs in Swindon UA using Census and QOF 2015/2016





The "LTC Prevalence Pool" estimated from the Symphony Model

Outputs from the Symphony model suggest a LTC prevalence of 32.2% for Swindon, a value in line with the "Credible QOF" figure, which we have mentioned above. An LTC prevalence of 32.2% amounts to 69,820 persons in 2015. That is 32,518 males and 37,301 females.

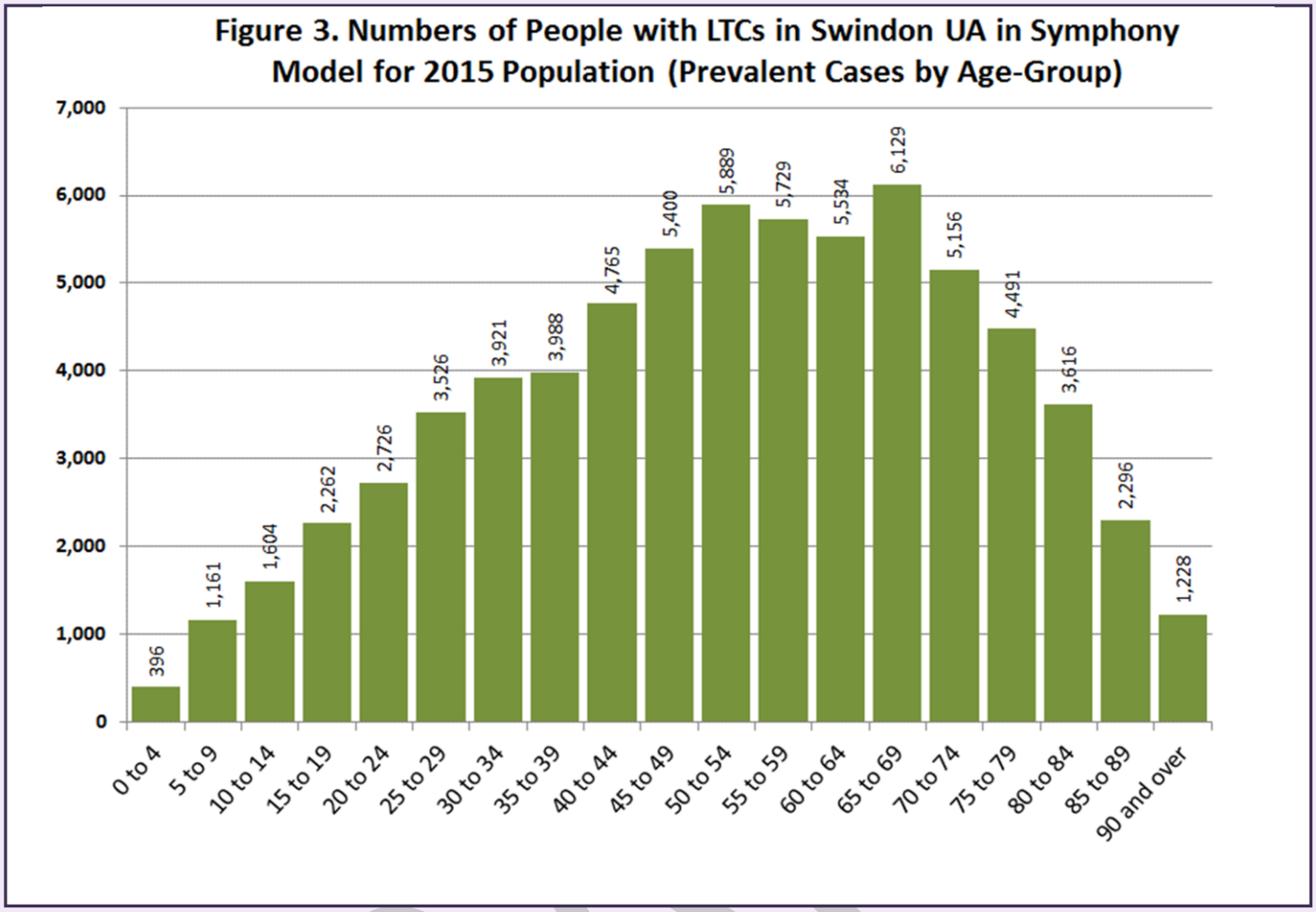
According to the Symphony model, 21.0% of people in the population had only one condition, 7.2% had two conditions, while 3.9% had three or more conditions. Figure 2 shows how the prevalence rate of having at least one LTC rises with age in the Swindon population.

Nevertheless, the greatest numbers of cases (people with at least one LTC) in Swindon were to be found in middle-aged people, as depicted in Figure 3, because middle-aged people predominate in the Swindon population. These middle-aged people will have a noticeable impact on health and care services as they move into the ranks of older people in the coming years.

The Symphony model suggests a prevalence rate among people aged 65+ years of 69.3% in Swindon. This equates to 22,915 people.

Although the number of cases was not as great as among middle-aged people, people aged 65+ in the Symphony model were more likely to have co-morbidities. In approximate terms, just over one half of people aged 65+ years with any condition, were in a state of multi-morbidity, having co-morbidities alongside their main condition. In the 65+ age-group, 30.7% of people had one condition only, 21.2% had two conditions and 17.4% had three or more conditions.

Other evidence suggests that older people with LTCs are more likely to have more severe problems and are more likely to need increased support from health and care services.



LTCs and Deprivation in the Symphony Model

The Symphony Model divided the whole Swindon population into five groups and produced an analysis of the rate of LTCs, comparing these five groups.

The percentage of people with at least one LTC varied according to deprivation group, with the more deprived groups being more likely to have at least one condition.

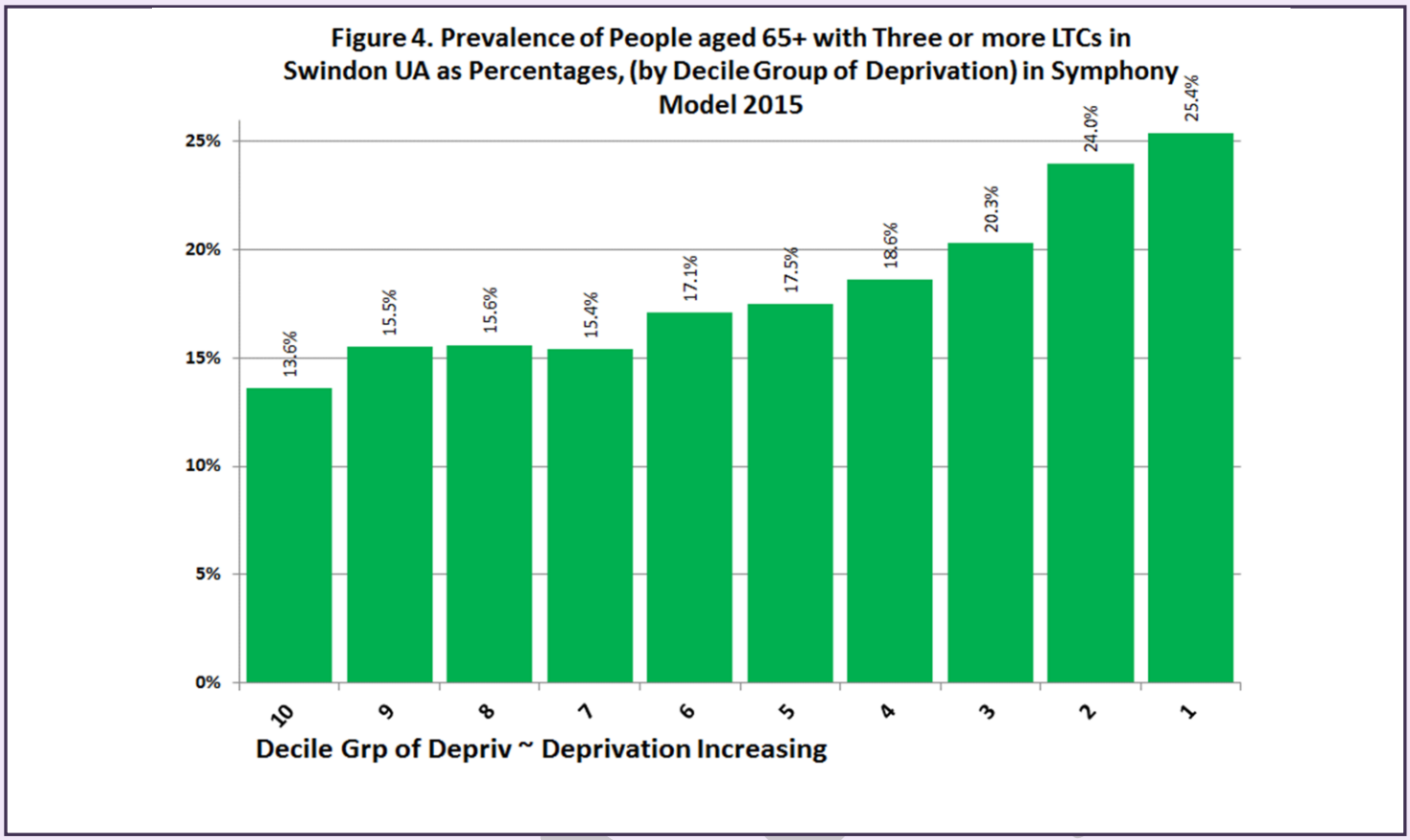
Nevertheless, this variation was moderate, rather than striking. In all, 35.7% of people in the most deprived group (Group 1) had at least one condition, 32.4% of people in Group 3 had at least one condition, whilst in the least deprived group (Group 5) the proportion was 30.1%. Thus Group 1 was about 19% higher than Group 5, but this was a difference of six percentage points.

Three or more LTCs, Age and Deprivation in the Symphony Model

There was a steeper gradient according to deprivation for people aged 65+ years with three or more LTCs, however (see Figure 4). In total, 17.4% of people aged 65+ had three or more conditions, 5,757 people in all. The rate of having three or more conditions became more frequent as deprivation increased.

Working with ten groups graded according to deprivation, Symphony suggested that the least deprived group (Group 10) had a rate of 13.6%, while the most deprived group (Group 1) had a rate of 25.4%, a difference of about 12 percentage points.

The most common conditions, as proportions of people aged 65+ years with three or more conditions, were: hypertension (high blood pressure) 83.2% (4,788 persons), CHD, 43.0%, (2,474 persons), diabetes 40.7%, (2,345 persons), cancer 37.1% (2,137 persons) and stroke 29.0% (1,672 persons).



Multi-Morbidity estimated from the Symphony Model

About one third of those people with any condition had more than one condition and so were in a state of Multi-Morbidity. The presence of co-morbidities appears to be common, and physical co-morbidities often exist alongside mental ill-health conditions, such as depression and dementia.

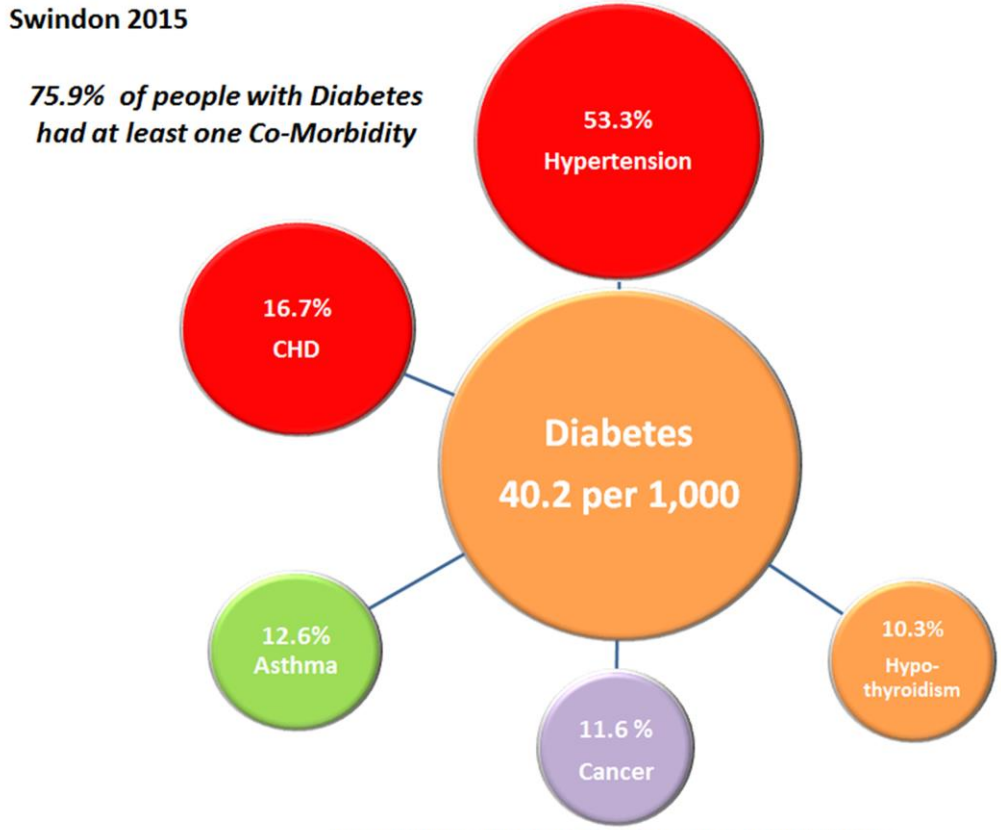
In the instances of stroke and Chronic Obstructive Pulmonary Disease (COPD), for example, multi-morbidity could be described as the norm, with over 80% of people with these conditions having at least one other health condition.

Figure 5 shows the multi-morbidity structure for people with diabetes in Swindon. About half of people with diabetes also had high blood pressure (hypertension) and about one-sixth of people with diabetes also had Coronary Heart Disease. There were smaller proportions with asthma, cancer, and low thyroid functioning.

The multi-morbidity structure of depression is depicted in Figure 6. About a half of people with depression had at least one other condition and this was usually a physical LTC. Asthma and high blood pressure were the most common co-morbidities.

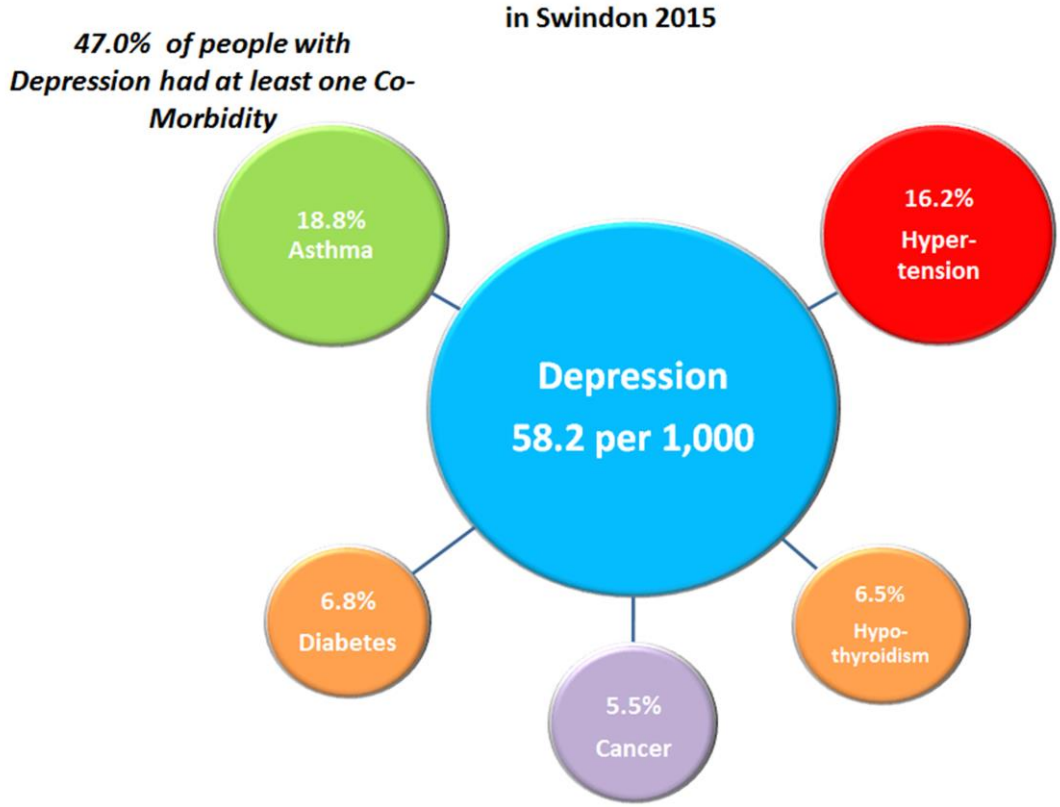
Among the mental health conditions, dementia seemed to adhere to a more physical health configuration, with 81.3% of people having at least one co-morbidity. Dementia was co-morbid with four of the most common chronic diseases, namely diabetes (15.7%), cancer (16.4%), Coronary Heart Disease (23.4%) and hypertension (52.0%).

Figure 5. Period Prevalence of Diabetes with its five most common Co-Morbidities in Swindon 2015



Source: Imputed through Symphony Matrix Model 2015.

Figure 6. Period Prevalence of Depression with its five most common Co-Morbidities in Swindon 2015



Source: Imputed through Symphony Matrix Model 2015.

Lifestyle Factors and LTCs

A central component of a strategy to prevent LTCs will be the improvement of lifestyle across the population. The overall smoking prevalence in adults in Swindon in 2015 was 18.7%, an encouraging reduction from 21.5% in 2012. National surveys indicate that smoking is becoming a less frequent occurrence in people in old age, with only about 12% of those aged 65 to 69 years in England and 3% aged 90 years or more in England maintaining the habit.

With regard to conspicuous harm resulting directly from alcohol misuse, in the years 2014 to 2015, 1,358 people in Swindon were admitted to hospital with this type of problem, an indication of the way misuse of alcohol can dramatically affect a person's health.

With respect to overweight or obesity, Swindon faces a considerable challenge, having a comparatively high percentage of people with excess weight. In the period 2012 to 2014, 69.5% of adults in Swindon had excess weight, that is, they were categorised as being either overweight or were in the more extreme category of being obese. This was significantly higher than the figure for England as a whole which was 64.6%.

Key Recommendations

Key recommendations are as follows:

- Accept the LTC Profile and the "Ageing Well JSNA Report" as providing complementary pictures of LTCs, health resilience and coping in Swindon

- Accept the main prevalence estimates of LTCs for Swindon in this Profile, (derived from the Symphony Model)

- Conduct a literature review to find evidence of which interventions have been shown to be effective in different parts of the population, with regard to preventing and coping with LTCs, including telehealth and also the role of carers

- Conduct further statistical work on LTCs, particularly with a view to understanding groups identified in the literature as likely to be at high risk of requiring state-funded social care; such groups to include people with three or more LTCS, aged 65 years or more and living in deprived areas

- Target interventions in the population as appropriate. Further intelligence work to support this and use of MOSAIC geo-demographic segmentation to show which channels of communication should work best with different segments of the population

- Improve and support the health of people with LTCs through "joined-up" and "accountable care

- Co-operate with partners to maintain a health-promoting physical environment, including housing, for people with LTCs

Where to find more information

This Bulletin is an abbreviated version of the JSNA LTC Profile 2017. The full Profile can be found on Swindon's JSNA website: swindonjsna.co.uk

The website contains a range of other documents about health and well-being in Swindon.

If you have any queries please contact Chris Bartlett (Cbartlett@Swindon.gov.uk)

This bulletin was published in May 2017.

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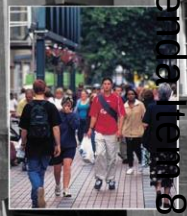
Police & Crime Commissioner for Wiltshire and Swindon

Police and Crime Plan 2017-21



www.wiltshire-pcc.gov.uk

Reasons for new plan

- Requirement following PCC election
- Crime and demand continues to change
- Refinement – direction remains the same
- Plan directs areas for focus – not a checklist of all work
- Transformation to improve services

Police & Crime Commissioner for Wiltshire and Swindon

TYPICAL DAILY DEMAND
for Wiltshire Police

There will be approximately
1 officer
on duty for every 800 people living in the area

Officers will deal with:
30 violent crimes, **43** thefts, **10** burglaries, **7** car crimes and **1** anti social behaviour incidents

33 people
will be arrested by officers

Officers will issue:
4 cautions, **1** penalty notice for disorder and **1** cannabis warning

Officers will carry out:
8 stop searches

Repond to **8 reports**
of missing persons, four that are high or medium risk

Answers **1,072**
calls for assistance, of which 30% require a response

Respond to approximately
10 incidents
associated with people with mental health issues

Attend the scene of
4 road traffic collisions
and **7 road offences**

TYPICAL ONGOING DEMAND
for Wiltshire Police

As well as reacting to calls we also undertake proactive work to safeguard the public, including...

Supporting more than
1,000 families
on the Troubled Families programme

Policing approximately
12 organised crime groups

Supporting victims of domestic abuse through a monthly average of
500 incidents

Managing approximately
1,107
sexual and violent offenders under a multi-agency public protection arrangement

NEW THREATS:

Child Sexual Exploitation

Exploitation of the vulnerable

Cyber crime and fraud

Historic sex abuse

SETS DIRECTION:

- Police and Crime Plan
- National policing requirements
- Regional Control Strategy
- Assessment of threats, risks and harms

ENABLERS:

People and Culture, Leadership, Estates, ICT, Financial Strategy

Police and Crime Plan 2017-21

Aim: Keep Wiltshire and Swindon as one of the safest places in the country

Priority 1	Prevent crime and keep people safe
Priority 2	Protect the most vulnerable people in society
Priority 3	Put victims, witnesses and communities at the heart of everything we do
Priority 4	Secure a quality service that is trusted and efficient

Police & Crime Commissioner for Wiltshire and Swindon

Key things to deliver

- Community Policing teams are consistently delivered and preventing crime
- Increase and retain volunteers in policing
- Coordination and integration with partners
  - Public protection
  - Mental health
  - Preventive services
  - reducing reoffending
- Victims & CJS modernisation
- Modernisation of police culture, workforce & ICT

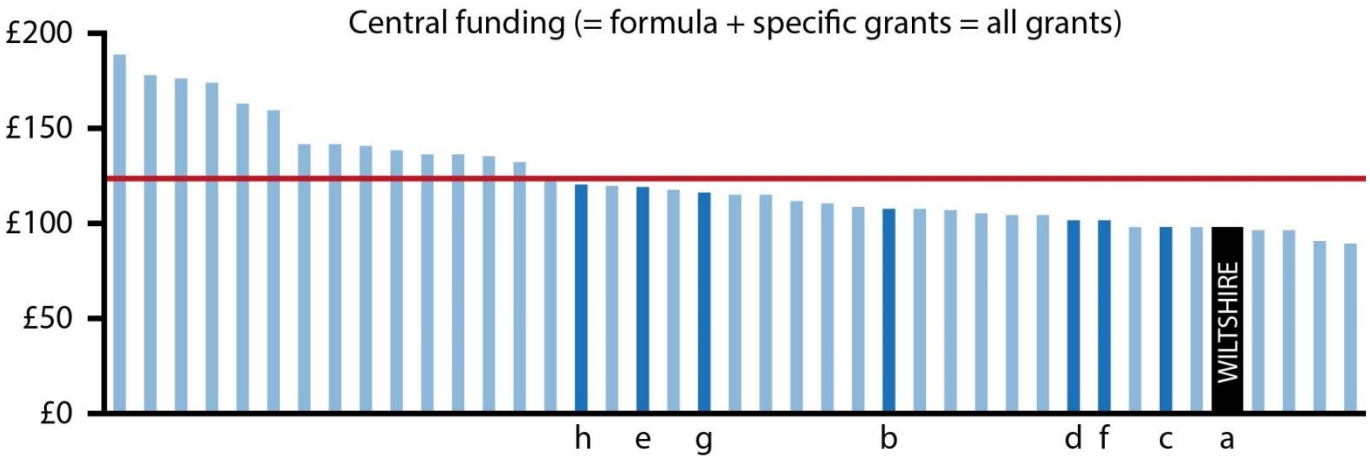
pcc
Police & Crime Commissioner for Wiltshire and Swindon

Fair Funding for Wiltshire

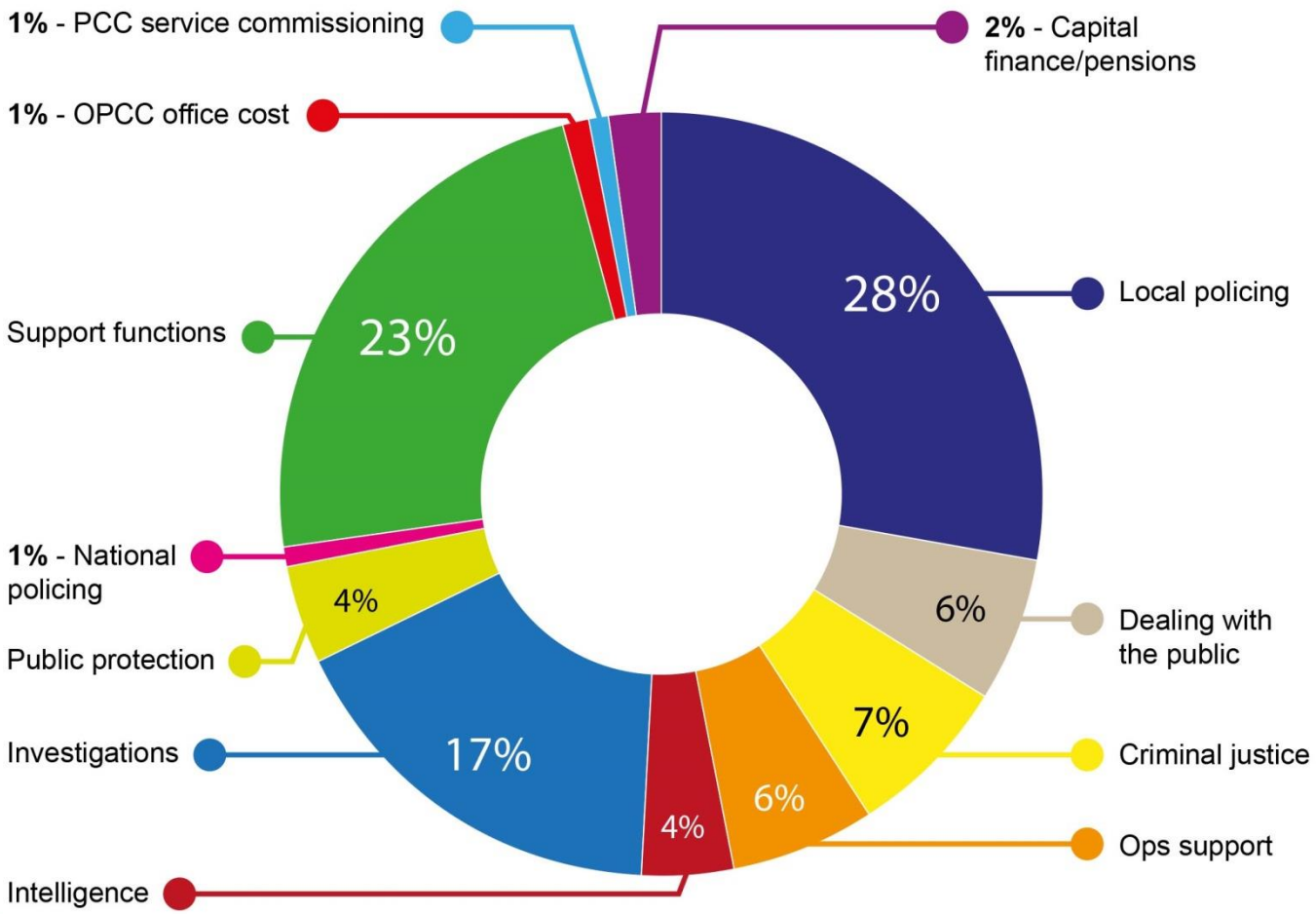
CENTRAL GOVERNMENT FUNDING FOR POLICE BY FORCE PER PERSON

Wiltshire receives one of the lowest levels of central government funding for policing in comparison with other police forces.

	2016-17
Wiltshire	£156.20
National average	£177.20
Most Similar Group (MSG)	£174.90



How we use resources?



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Development of Accountable Care in Swindon

Health and Wellbeing Board **Date: 24th May 2017**

Author: Nicki Millin, Accountable Officer, Swindon Clinical Commissioning Group

Wards: All

Locality Affected: All

Parishes Affected: All

1. Purpose and Reasons

1.1 To provide the Health and Wellbeing Board with an outline of the considerations in developing an Accountable Care system in Swindon.

2. Recommendations

The Board is recommended to:

2.1 Note the contents of the report and discuss any areas where further clarification may be required.

3. Details

What do we mean when we talk about Accountable Care

3.1 With lots of different parts of the NHS system… from GP practices to hospitals and urgent care centres, we're aiming for everyone to work together to provide high-quality care for patients. This makes the system less complicated, less fragmented, and reduces hospital delays. Getting referred when we need to should be more straightforward too….as everyone who needs to work together on a patient are part of the same team, using the same system.

3.2 This means each organisation providing care to the local community is pooling resources to support the joint commissioning and delivery of health and social care for everyone. It does not mean that all providers will be merged into one 'super organisation'.

Why are we considering this in Swindon?

3.3 The Five Year Forward View highlighted that the NHS cannot continue to provide services using traditional models, we are seeing duplication in the system and significant challenges in relation to available capacity. Within Swindon we are seeing:

3.3.1 Rising demand for Same Day / Urgent care services.

3.3.2 Demand for inpatient care exceeding supply.

3.3.3 Care Homes feel unsupported- easier to dial 999/ request admission.

Further information on the subject of this report can be obtained from Nicki Millin, 01793 683700, nicki.millin@swindonccg.nhs.uk.

3.3.4 Social care demand exceeding budgets.

3.3.5 Difficulty in recruiting GPs - impact on sustainability and resilience of practices.

3.3.6 Limited clinical linkages between primary and secondary care.

3.3.7 Population and demand rising faster than resources.

3.3.8 Significant areas of new housing developments within the town and the New Eastern Villages which increase demand on existing services beyond available capacity.

Values and principles needed in the development of a system

3.4 At a Board to Board event between Swindon Clinical Commissioning Group (CCG) and Great Western Hospitals NHS Foundation Trust, members identified a number of values and principles which would be important in the development of an Accountable Care system:

3.4.1 It must benefit the people of Swindon.

3.4.2 It needs to be a system that is simple to understand for both patients and service users.

3.4.3 The sum of the parts must be greater than the whole.

3.4.4 It needs to retain a local feel.

3.4.5 Team Swindon is a positive way to describe the system working together and across organisational barriers. People would need to feel that 'Team Swindon' would be a great place to work, this would involve a degree of cultural and organisational change.

3.4.6 It needs to empower staff to work differently, to think holistically about patients.

3.4.7 It needs to reduce health inequalities by targeting specific areas and groups in Swindon.

3.4.8 There needs to be clarity and consistency of communication.

3.4.9 Agreed and meaningful organisational clinical outcomes/priorities to guide decisions.

3.4.10 It needs to enable us to live within one budget for Swindon – living within our means (the Swindon pound).

3.4.11 It needs to enable the free flow of information which will reduce transactional costs.

Service alignment in new care models

3.5 The new national care models suggest we consider aligning services to defined geographies, 'place based'. A place-based model suggest that care needs to be organised around different geographies and population groupings. This reflects the need to deliver local, joined up care for different patient groups as well as the need to manage some services across a wider geography due to scarcity of resources, workforce or demand. This considers the different levels of provision that may be required within Swindon and across neighbouring geographies.

3.5.1 Tier 1: 50,000 – 80,000 population: Organising care around defined populations will support a patient-centric model and enable care management and co-ordination for complex patients. Evidence suggests that this size of population enables services to be delivered at some scale whilst enabling a personalised patient experience. Some Urgent & Emergency Care will take place at these levels including access to pharmacy and WICs or UCCs.

3.5.2 Tier 2: circa 250,000 - 500,000 populations: At a scale of circa 500,000 the majority of planned care and U&EC services will become viable although some services may still operate as a hub and spoke model with neighbouring hospitals. While services are delivered at this scale they should be fully integrated with other areas of provision.

3.5.3 Tier 3: Over 1m population: Some services, as is currently the case, will need to be delivered on a much wider scale. This would include tertiary services where complexity and volume require such a scale. It also includes specialist/acute Mental Health services 111 services and Ambulance Services. In addition, some preventative/public health services will take place across the wider geography.

Clinical Work streams

3.6 In developing new models of care in Swindon there are a range of issues which need to be considered including differing service delivery and a number of enabling work streams to support these new models. A clinical work shop was held on 30th March with a follow-on workshop 10th May.

3.6.1 **Proactive and preventative care**

Consideration of how we intend to support healthy communities, particularly with the growing size of the town. Key to this will be community empowerment and engagement activities. This workstream includes a wide range of partners, stakeholders and our public.

3.6.2 **Urgent and Emergency Care**

We continue to see significant challenges to the capacity in place to support people wishing to access on the day services, some of whom will be in crisis and require an immediate response. Areas to consider are:

- Single telephone number for Swindon, with on line alternative.
- Clinical triage of all requests, using new technologies.
- Face to face appointments same day, with access to patient records, but no guarantee of continuity of practitioner, in a local venue but not necessarily at the local GP practice, with direct access to diagnostics and secondary care advice.
- Supported by new clinical roles – Advanced Nurse Practitioner, Paramedic.

Within Swindon we have the GP access clinics (SUCCESS services) alongside the Carfax Walk In Centre, 111 services are being tendered including a new clinical hub model, and we are in the process of developing a Nursing Home model.

National guidance specifying urgent care models is feeding into the development of this clinical model.

3.6.3 **Chronic Disease management and ongoing care**

Key to managing the urgent care demand is the development of services for those with Chronic and multi co-morbid diseases. There is a lot of evidence nationally in relation to the models of care for these cohorts of patients and areas to consider include:

- Patients identified by a clinical intelligence unit using a variety of risk stratification tools.
- Delivery based in defined (3?) clinical localities in community health premises- fewer seen in hospital settings.
- 15 minute appointments and continuity of practitioner (who is not necessarily a medic).
- Both generic and specialist clinics delivered through a multidisciplinary team approach, including secondary care specialist.
- Coordinated through multi-disciplinary team meetings.
- Linked community programme to enhance lifestyle modification supported by Community Navigators.

3.6.4 **High Intensity Care**

- Dedicated community teams focussed on supporting those with the most intensive care needs for a time limited period, possibly using virtual ward model.
- Based in three localities.
- Regular multi-disciplinary team reviews of target groups such as over 75s admitted to hospital with secondary care input.
- Includes specialist continuing health care, mental health and learning disability specialists.
- Builds on existing specialist teams, bring skill sets together.

3.6.5 **Interface with scaled up primary care**

- Mixed economy of new primary care organisations- eg super-practice, federation or standalone practices.
- Assume working to three localities in Swindon.
- Could take on running of same day and/or chronic disease and/or high intensity services for circa 80k population.
- Develop an agreed Swindon-wide risk, reward and support structure.
- Revisit estates strategy to ensure plans are in place to support this new way of working.

3.7 Enabling Work streams

3.7.1 **Workforce**

- Develop a single workforce plan: Establish a single workforce plan across organisations which includes the ability to have a passport to enable staff to transfer across care settings.
- Collectively identify new roles across the system as well as training needs of the existing workforce to deliver the new models of care.
- Increase access and communication: Establish a culture of shared access and communication across the system. This will enable in-reach into acute settings and support in the community.
- Identify a lead for Team Swindon to drive this work stream.

3.7.2 **IM&T**

- Shared analytics: Develop a shared approach to management information and reporting. This includes the development of shared definitions and data gathering.
- Single view of population: Develop a single view of the population that is shared across organisations to enable effective management of risk.
- Interoperable IM&T: Develop an interoperable system that enables each part of the system to access real-time information.

3.7.3 **Estates**

- Shared understanding of capital investment: Take a place-based view on capital investment decisions so that they optimise the existing health and care estate.
- Understand the current estate: Understand the existing estate across the health and public service economy to inform decision-making. Development of health campus model across a number of acute and primary care sites.
- Adopt a flexible approach to estates: Consider how to use estate flexibly to optimise overheads and provide the right care across Swindon, recognising the need to optimise the use of the estate on the Great Western Hospital site to ensure use of PFI financed facility is maximised.

3.7.4 **Finance and Commissioning**

- Align incentives to promote prevention: Develop ways to change incentives in the system through alternative payment and reward mechanisms. This should flow through organisations and workforce.
- Joint financial planning: To agree priority investments that benefit the system. This would form the basis of a place-based budget reflecting the need to demonstrate system financial balance.
- Understand system baseline: Collectively establish and agree the system baseline. Identify fixed and variable costs in the system.

<u>Benefits of Accountable Care</u>

3.8 There are a range of potential benefits that could be achieved from moving to an Accountable Care system, for patients, staff and improving use of resources:

3.8.1 **Benefits to patients of moving to an Accountable Care System**

- Improved access to same day services.
- Increased amount of care for chronic disease delivered locally, with increased continuity of practitioner.
- More systematic and structured approach to Chronic disease management.
- Better coordinated transfers of care ie Hospital to community.
- Hospitals freed up for those that really need its services.
- A sustainable way of providing care.
- Support for local communities to help themselves and get involved in priority setting and service development.

3.8.2 **Benefits to staff working in an Accountable Care System**

- Development of clear career structure for GPs including portfolio careers across different care settings.
- New roles for clinical practitioners in supporting same day and chronic disease care.
- New opportunities for care in local settings increased.
- Enhanced education and training.
- Better IT to help practitioners be effective.
- Sustainable care delivery systems.

3.8.3 **Better use of resources across the health and social care system**

- Improved, more structured chronic disease management could reduce inappropriate same day care, reduce the numbers of admissions and length of stay.
- Better care coordination could reduce the number remaining in community intensive care such as intensive packages of care, nursing homes and specialist placements.
- Improved appointment systems at scale could make better use of resources over 7 days ie fewer short term locums, better use of estate.
- New workforce arrangement could increase productivity eg ANPs, retention of GPs, improved staff satisfaction.

- Evidence and big data based clinical hub could help target resources better and support research more quickly.
- Empowered communities could increase their capacity to self-care.
- Lifestyle changes could delay/ prevent disease in the longer term.
- Sharing of back office functions across provider and commissioner organisations improving efficiency.
- Minimising some of the administrative processes in the current contractual system between commissioners and providers will release capacity to support other work.

What are the risks to developing an Accountable Care System?

3.9 A senior leaders event considered the risks involved in developing a new system:

3.9.1 Transformation change is costly.

3.9.2 The benefits do not materialise.

3.9.3 Different priorities between NHS and Local Authority.

3.9.4 Lack of freedom to change/ Regulatory barriers.

3.9.5 Different governance across organisations slows down decision making.

3.9.6 Unmet need/financial pressures.

3.9.7 Management of patient expectation.

3.9.8 Double running/confusion/increased costs

3.10 A risk register will be put in place as the programme is formalised and structures put in place.

Governance

3.11 The development of Accountable Care within Swindon will sit across several organisations including (but not limited to) Swindon Clinical Commissioning Group, Swindon Borough Council; Great Western Hospitals NHS Foundation Trust; Avon and Wiltshire Partnership Trust and Primary Care.

3.12 The recommendation is that we develop an Accountable Care Alliance Board which would oversee the development of the proposals for the new models which would then be taken through the constituent organisations Governance for review and approval. This Alliance Board would oversee the implementation and delivery of the different work streams once a mandate and approval has been given and report back regularly to constituent organisations.

3.13 A draft Memorandum of Understanding for the development of Accountable Care in Swindon and a Terms of Reference for the Alliance Board is attached as Appendix 1 and 2.

Communications Strategy

3.14 A key element to developing the models of care will be a clear engagement strategy.

3.15 Initial clinical workshops have been held, this needs to be followed up with an ongoing series of opportunities for clinicians to engage with the development of pathways.

3.16 Conversations with our public will be key to ensuring that they are influencing the development of services in Swindon and can drive the development of outcome measures for any new model of care. We will be working with our colleagues in Healthwatch to draw up a timetable of events throughout the coming year to ensure continued involvement in the evolution and refinement of the service models. These events will be jointly hosted across health and social care organisations.

3.17 We will also want to engage regularly with our wider stakeholders such as the voluntary sector providers.

3.18 The draft communications strategy is attached at Appendix 3.

3.19 Next Steps

3.19.1 **Activities completed during March/April 2017**

- Governance arrangements drafted with shared Board papers.
- Engagement with wider provider base including care home sector.
- High level draft programme plan developed.
- Programme structure developed and work stream leads identified.
- Programme mobilised.
- Clinical workshops held to begin development of new models.

3.19.2 **Develop Operating Model and Outline Business Case: June/July 2017**

- Refinement of clinical models.
- Commence Public ‘conversations’.
- Exploration of contracting models.

- Develop commissioning model options appraisal.
- Analysis of system spend and potential interventions and other activities.
- Populate the core components of a high level operating model.
- A set of quick wins and high level outcomes should be agreed.
- Engagement with regulators.
- Ongoing Public 'conversations'.
- Ongoing engagement with clinical teams.

4. Alternative Options

4.1 Services to remain configured in the way they are currently delivered.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 Finance models will be developed which will need to be incorporated into a business case for consideration by relevant organisations before any new mechanisms can be introduced.

Legal and Human Rights Implications

5.2 None to note. This remains under review throughout the development of the new models and pathways.

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

5.3 Workforce remains a key challenge to ensure sustainability of services. Appropriate estate for the delivery of services will be a consideration. These will be reviewed within the enabling work streams.

Diversity Impact Assessment

5.4 Each work stream once commenced will have an Equality and Diversity Impact Assessment.

Risk Management

5.5 Some high level risks were identified and are included in section 3.8. A risk register will be developed with high level risks also being included on the CCG Risk Register for transparency.

6. Consultees

6.1 The development of Accountable Care has been discussed in a number of different fora over the last 18 months. Recent events include:

- H&WBB Chairs Advisory Group.
- Board to Board event: Swindon CCG and Great Western Hospitals NHS Foundation Trust.
- Swindon CCG GB development session and CLG meeting.
- STP Board.
- H&WBB Provider Forum.

6.2 The Director of Finance and the 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 - Memorandum of Understanding for the Development of Accountable Care.

8.2 Appendix 2 - Terms of Reference for Accountable Care Alliance Board.

8.3 Appendix 3 - Communications and Engagement Strategy.

Further information on the subject of this report can be obtained from Nicki Millin, 01793 683700, nicki.millin@swindonccg.nhs.uk.

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DRAFT

DATE **2017**

1. **NHS SWINDON CLINICAL COMMISSIONING GROUP**
2. **SWINDON BOROUGH COUNCIL**
3. **GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST**

MEMORANDUM OF UNDERSTANDING FOR THE DEVELOPMENT OF ACCOUNTABLE CARE IN SWINDON

No	Date	Version Number	Author
1	04/04/2017	1 – Draft 1 04/04/17	JL
2	10/04/2017	2 – Draft 2 10/04/2017	JL
3	27/04/2017	3 – Draft 3 post GB meeting on 27/04/2017	JL
4	4/5/2017	4 – Draft 4 post GWH Board	JL
5			
6			

Date: **2017**

This Memorandum of Understanding (**MoU**) is made between:

1. **NHS SWINDON CLINICAL COMMISSIONING GROUP** of The Pierre Simonet Building, North Swindon Gateway, North Latham Road, Swindon SN25 4DL;
2. **SWINDON BOROUGH COUNCIL** of Civic Offices, Euclid Street, Swindon SN1 2JH;
3. **GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST** of Great Western Hospital, Marlborough Road, Swindon SN3 6BB;

(each a "**Party**" and together the "**Parties**").

RECITALS

1. The Five Year Forward View published in October 2014 (the "**Forward View**") sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care." This is further supported by the Next Steps on the NHS Five Year Forward View published in March 2017.
2. In entering into and performing their obligations under this MoU, the Parties are working towards the implementation of an integrated care model which is comparable to those highlighted in the Forward View. In particular, this MoU is intended to support the parties' ongoing work towards the establishment of accountable care ("**AC**") for Swindon.
3. This MoU sets out the Swindon AC Alliance Board's shared commitment to AC, what it means for organisations that want to be part of the AC construct and what it means for those that do not want to be part of it.
4. The Parties will set out a timetable for the AC development that incorporates the due diligence process as set out in this MoU and the intent that the AC will become operational from May 2017.
5. All Parties acknowledge that there is further work to be completed to fully describe the concepts within AC (e.g. how will the capitated budget be calculated and how will risk and reward be calculated) and to meet the timetable.
6. The Parties are committed to ensuring that all communications relating to AC are easily understood and are transparent.

OPERATIVE PROVISIONS

1. Definitions and interpretation

1.1 In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2 In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a reference to a "**Party**" is a reference to a party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

1.2.2 a reference to writing or written includes faxes and e-mails.

2. Purpose and effect of MoU

2.1 The Parties have agreed to work together on behalf of patients and the population of Swindon and Shrivenham to ensure that integrated, high quality, affordable and sustainable health and care services are delivered in the most appropriate way to the patients and population of Swindon and Shrivenham to ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities. The Parties wish to record the basis on which they will collaborate with each other in developing a model for AC in this MoU.

2.2 This MoU sets out:

2.2.1 The Parties' commitment to the AC Principles as organisations;

2.2.2 what is expected of Parties who are to be part of the AC;

2.2.3 what is expected of Parties who are not to be part of the AC; and

2.2.4 what is expected from the due diligence process.

2.3 The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, save as provided in paragraph 2.4 below, this MoU shall not be legally binding.

2.4 Paragraphs 10, 11 and 13 shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

2.5 In addition to the MoU, the Parties will seek to agree the following additional documents to manage their relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail:

2.5.1 a standalone confidentiality agreement;

2.5.2 a protocol to manage conflicts of interest; and/or

2.5.3 a protocol to manage the sharing of information in accordance with competition law requirements.

3. Commitments to the AC Principles

3.1 The Parties agree to the following commitments in relation to the principles of the operation of AC in Swindon.

3.2 The Parties intend that AC shall:

3.2.1 Work towards a shared vision of integrated service provision to benefit the people of Swindon and Shrivenham, retain a local feel and be simple to understand for both patients and service users.

3.2.2 Ensure that 'Team Swindon' is seen in a positive way to describe the system working together and across organisational barriers. People need to feel that 'Team Swindon' is a great place to work, which will involve a degree of cultural and organisational change.

3.2.3 Ensure staff feel empowered to work differently and to think holistically about patients.

3.2.4 Reduce health inequalities by targeting specific areas and groups in Swindon.

3.2.5 Ensure clarity and consistency of communication.

3.2.6 Ensure agreed and meaningful organisational clinical outcomes/priorities to guide decisions.

3.2.7 Operate within one budget for Swindon – living within our means (the Swindon pound).

3.2.8 Ensure the free flow of information to reduce transactional costs.

(the "**AC Principles**").

4. AC Membership

4.1 The Parties intend that any organisation who is to be a member of the AC proposals shall:

4.1.1 commit to the AC Principles and shared outcomes. The Parties acknowledge that the delivery of health outcomes twinned with sustainability for the whole system are the biggest determining factor for success of AC (in other words, the organisational success of each Party is not a determining factor in judging the success of AC). The whole being greater than the sum of the parts;

4.1.2 agree to actively work towards developing shared responsibility for the system-wide financial sustainability including risk and reward and scoping the potential financial arrangements that could underpin such a system for example, the development of capitated budgets;

4.1.3 commit to being part of AC at this stage and shall engage with further work to define the financial arrangements;

4.1.4 acknowledge that the consequence of the financial arrangements is that each Party will have a share in the financial risk and reward;

4.1.5 agree to work towards developing how the principle of proportionality of impact and risk share will operate within the AC governance and decision making; and

4.1.6 It is acknowledged that each party has its own distinct governance arrangements and is accountable to its own Board of Directors. But at the same time in taking their own organisational decisions, to ensure that those are aligned to the goal of AC in Swindon and not contrary to the outcomes parties are seeking to achieve together.

5. Other AC providers

5.1 The Parties accept that a number of organisations may not be appropriate to be or wish to be AC members and consider that organisations that deliver services to the population of Swindon and Shrivenham who are not AC members shall:

5.1.1 contribute to the health and wellbeing of the population through the delivery of their contracted services;

5.1.2 acknowledge that AC shall determine the clinical strategy and direction and contracts are set to deliver the clinical strategy;

5.1.3 have a voice in developing the clinical pathways as AC will need to harness the clinical expertise of all providers of services to the population of Swindon and Shrivenham; and

5.1.4 acknowledge that in relation to commissioning arrangements, contracts with organisations outside the AC membership could be separate from the capitated arrangements that operate for organisations within the AC membership as set out in Paragraph 4 above.

6. Involvement of Primary Care

6.1 Whilst this MoU does not include providers of primary care services at this stage the Parties all acknowledge that primary care is a vital aspect in the creation of an effective AC construct for Swindon and Shrivenham. The involvement of primary care representatives will be a key consideration and the Parties agree that representatives of primary care will be invited to consider their position under this MoU at such point as the providers of primary care services have agreed their operating structure to engage with the Parties in the AC process.

7. Due Diligence

7.1 The Parties each commit in principle to operating as a member of the AC and shall work through a due diligence process together during 2017/18 to assess the viability and detail of the AC construct.

7.2 Any Parties who have not decided as to whether they intend to be an AC member or to be a provider working outside of the AC at the date of this MoU shall confirm their position to the other Parties as soon as practicable and thereafter undertake due

diligence in an agreed process if they decide that they are committed to being a AC member. The admission process for new members to the AC will require the approval of at least 75% of the existing members allowing for the entry of additional parties at later stages.

7.3 Parties that have decided not to be part of the AC do not need to engage in the due diligence process.

8. Term and Termination

8.1 This MoU shall commence on the date of signature by all the Parties, and shall expire on the earlier of the execution of a formal legally binding agreement between the Parties in connection with the delivery of AC or 31 March 2018.

8.2 Any Party may withdraw from this MoU by giving at least 90 calendar days notice in writing to the other Parties.

9. Variation

9.1 This MoU, may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

10. Charges and liabilities

10.1 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU including in respect of any losses or liabilities incurred due to their own or their employee's actions.

10.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

11. No partnership

11.1 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

12. Counterparts

12.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Party has executed at least one counterpart.

13. Governing law and jurisdiction

13.1 This MoU shall be governed by and construed in accordance with English law and each Party agrees to submit to the exclusive jurisdiction of the courts of England.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
NHS SWINDON	)	
COMMISSIONING GROUP	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
SWINDON BOROUGH COUNCIL	)	
	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	)	
	)	DATE:

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DRAFT SWINDON ACCOUNTABLE CARE ALLIANCE BOARD TERMS OF REFERENCE

1 Purpose

1.1 The Swindon Accountable Care Alliance Board (the "Alliance Board") has been established to provide strategic direction to the Alliance to inform the development of Accountable Care in Swindon. The Alliance Board will hold to account the Planning and Project Team for the performance of the alliance such that it achieves the objectives set for it.

2 Status and authority

2.1 The Alliance is established by the Participants, who remain sovereign organisations, to provide a financial and governance framework for the delivery of the Services. The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

2.2 The Alliance Board is established to lead and coordinate activities associated with the development of Accountable Care in Swindon until such time as organisational forms are agreed. Members of the Partnership Board agree to follow the principle of – form follows function – and therefore the form of any future organisation to deliver Accountable Care will only be agreed once the function has been scoped and agreed through the work to define future clinical pathways.

2.2 The Alliance Board will function through engagement between its members so that each Participant makes a decision in respect of, and expresses its views about, each matter considered by the Alliance Board. The decisions of the Alliance Board will, therefore, be the decisions of the Participants, the mechanism for which shall be authority delegated by the Participants to their representatives on the Alliance Board.

2.3 Each Participant shall delegate to its representative on the Alliance Board such authority as is agreed to be necessary in order for the Alliance Board to function effectively in discharging the duties within these Terms of Reference. The Participants shall ensure that each of their representatives has equivalent delegated authority. Authority delegated by the Participants shall be defined in writing and agreed by the Participants, and shall be recognised to the extent necessary in the Participants' own schemes of delegation (or similar).

2.4 The Participants shall ensure that the Alliance Board members understand the status of the Alliance Board and the limits of the authority delegated to them.

3 Responsibilities

3.1 The Alliance Board will:

(a) ensure alignment of all organisations to the Swindon Accountable Care vision and objectives;

(b) promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Participants;

(c) formulate, agree and ensure that implementation of strategies for achieving the Alliance Objectives and the management of the Alliance;

(d) discuss strategic issues and resolve challenges such that the Alliance Objectives can be achieved;

(e) respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Alliance or any Participants to the extent that they affect the Participants' involvement in the Alliance;

(f) agree policy as required;

(g) agree performance outcomes/targets for the Alliance such that it achieves the Alliance Objectives;

(h) review the performance of the Alliance, holding the Planning and Project Team to account, and determine strategies to improve performance or rectify poor performance;

(i) ensure that the Planning and Project Team identifies and manages the risks associated with the Alliance, integrating where necessary with the Participants' own risk management arrangements;

(j) generally ensure the continued effectiveness of the Alliance, including by managing relationships between the Participants and between the Alliance and its stakeholders;

(k) ensure that the Alliance accounts to relevant regulators and other stakeholders through whatever means are required by such regulators or are determined by the Alliance Board, including, to the extent relevant, integration with communications and accountability arrangements in place within the Participants;

(l) address any actual or potential conflicts of interests which arise for members of the Alliance Board or within the Alliance generally, in accordance with a protocol to be agreed between the Participants (such protocol to be consistent with the Participants' own arrangements in respect of declaration and conflicts of interests, and compliant with relevant statutory duties);

(m) oversee the implementation of, and ensure the Participants' compliance with, this Agreement and all other Services Contracts;

(n) review the governance arrangements for the Alliance at least annually.]

4 Accountability

4.1 The Alliance Board is accountable to the Participants.

4.2 The Alliance Board will provide routine updates within the STP to ensure visibility of progress and sharing of learning from the work in Swindon with other parts of the STP who will be progressing similar work over the next 1-2 years.

4.3 The minutes of the Alliance Board will be sent to the Participants within 7 days.

4.4 The minutes shall be accompanied by a report on any matters which the Chair considers to be material. It shall also address any minimum content for such reports agreed by the Participants.

5 Membership and Quorum

5.1 The Alliance Board will comprise:

Accountable Officer, NHS Swindon Clinical Commissioning Group
Clinical Chair, NHS Swindon Clinical Commissioning Group
Lay Member, NHS Swindon Clinical Commissioning Group
Director of Adult Social Services, Swindon Borough Council
Director of Public Health, Swindon Borough Council
Elected Member, Swindon Borough Council
GP Representative (on behalf of primary care)
LMC Representative (on behalf of primary care)
Chief Executive, Great Western Hospitals NHS Foundation Trust
Medical Director, Great Western Hospitals NHS Foundation Trust
Director of Finance, Great Western Hospitals NHS Foundation Trust
Director of Strategy, Great Western Hospitals NHS Foundation Trust
Clinical Director, Avon and Wiltshire Mental Health Partnership NHS Trust
CEO, Avon and Wiltshire Mental Health Partnership NHS Trust.

5.2 Other members/attendees may be co-opted as necessary.

5.3 The Alliance Board will elect a Chair and a Deputy Chair from amongst its members.

5.4 Where the Chair is absent, the Deputy Chair shall take on the role of the Chair.

5 Conduct of Business

6.1 Meetings will be held monthly.

6.2 The agenda will be developed in discussion with the Chair. Circulation of the meeting agenda and papers via email will take place one week before the meeting is scheduled to take place. In the event members wish to add an item to the agenda they need to notify the Company Secretary, NHS Swindon Clinical Commissioning Group who will confirm this with the Chair accordingly.

6.3 At the discretion of the Chair business may be transacted through a teleconference or videoconference provided that all members present are able to hear all other parties and where an agenda has been issued in advance.

6.4 At the discretion of the Chair a decision may be made on any matter within these Terms of Reference through the written approval of every member, following circulation to every member of appropriate papers and a written resolution. Such a decision shall be as valid as any taken at a quorate meeting but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.

7 Decision Making and Voting

7.1 The Alliance Board will aim to achieve consensus for all decisions of the Participants.

7.2 To promote efficient decision making at meetings of the Alliance Board it shall develop and approve detailed arrangements through which proposals on any matter will be developed and considered by the Participants with the aim of reaching a consensus. These arrangements shall address circumstances in which one or more Participants decides not to adopt a decision reached by the other Participants.

8 Conflicts of Interests

8.1 The members of the Alliance Board must refrain from actions that are likely to create any actual or perceived conflicts of interests.

8.2 The Alliance Board shall develop and approve a protocol for addressing actual or potential conflicts of interests among its members (and those of the Planning and Project Team). The protocol shall at least include arrangements in respect of declaration of interests and the means by which they will be addressed. It shall be consistent with the Participants' own arrangements in respect of conflicts of interests, and any relevant statutory duties.

9 Confidentiality

9.1 Information obtained during the business of the Alliance Board must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).

9.2 Members of the Alliance Board are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Alliance. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

10 Support

10.1 Support to the Alliance Board will be provided as part of a programme management approach.

10.2 The programme structure and supporting work groups will be developed and agreed as part of the Alliance Board work plan.

11 Review

11.1 These Alliance Board terms of reference will be formally reviewed annually.

Appendix 3

NHS
Swindon
Clinical Commissioning Group

The Development of Accountable Care in Swindon

Communications and Engagement Strategy April 2017 – April 2019

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NHS Swindon Clinical Commissioning Group (CCG) and Great Western Hospitals NHS Foundation Trust

Strategy	Accountable Care System – Communications and Engagement Strategy
Strategy Reference	tbc
Strategy Statement	This document sets out a proposed Communications and Engagement Strategy for the development of an Accountable Care System (ACS) in Swindon and Shrivenham.
Version Number	0.2
Version Date	20.04.2017
Review Date	31.03.2018
Author	Ruth Atkins, Head of Corporate Communications and Engagement, Swindon CCG (With support from Chris Trow, Associate Director of Strategy, GWH NHS FT)
Responsible Owner	Nicki Millin, Accountable Officer, Swindon CCG Kevin McNamara, Director of Strategy, GWH NHS FT
Approving Body	Swindon Accountable Care Partnership Board

Document Control
Reviewers & Approvals

This document requires the following reviews and approvals

Name	Position		Version Approved	Date Approved

Revision History

Version	Revision Date	Details of Changes	Author
0.1	12/4/2017		Gill May
0.1	12/4/2017		Caroline Gregory
0.1	18/4/2017		Chris Trow
0.1	19/4/2017		Nicki Millin

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0.1	20/4/2017		Denise McLennan

Acknowledgement of External Sources

List any documents from external institutions that have been used to inform the writing of this strategy.

Title/Author	Institution	Comment / Link

Links or overlaps with other key documents & strategies

Document Title	Version and Issue Date	Link/Document

Distribution & Consultation

This document has been distributed to the following people

Name	Date of Issue	Version
SCCG Governing Body	27/4/2017	0.2

Document Version Numbering

Document versions numbered “0.1, 0.2, 2.4”, are draft status and therefore can be changed without formal change control. Once a document has been formally approved and issued it is version numbered “Issue 1.0” and subsequent releases will be consecutively numbered 2.0, 3.0, etc., following formal change control.

Freedom of Information

If requested, this document may be made available to the public and persons outside the healthcare community as part of NHS Swindon Clinical Commissioning Group’s commitment to transparency and compliance with the Freedom of Information Act.

Accessibility

This document is available in other styles, formats, sizes, languages and media in order to enable anyone who is interested in its content to have the opportunity to read and understand it. These alternatives include but are not limited to:

- Alternative languages and dialects
- Larger and smaller print options (font 8 to 18)
- Simplified versions including summaries and translation into symbols
- Audio or read versions
- Web based versions that can be zoomed into or shrunk on screen
- Braille

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1.0	**Introduction** This document sets out a proposed Communications and Engagement Strategy for the development of an Accountable Care System (ACS) in Swindon and Shrivenham. This strategy links to the Bath and North East Somerset, Wiltshire and Swindon Clinical Commissioning Groups Sustainability and Transformation Partnership.
2.0	**Background and national context** Accountable Care Partnerships or Organisations or Systems emerged as a key part of NHS policy for the next five years to 2020/21. They feature in the Five Year Forward View (FYFV), published in October 2014 by NHS England as part of essential actions to manage quality and financial sustainability for the NHS. NHS England has recently published its 'Next Steps' document, taking stock of progress against the FYFV and charting the way forward and this further identified the development of accountable Care Partnerships or Organisations or Systems.
3.0	**Local context**
3.1	The Five Year Forward View highlighted that the NHS cannot continue to provide services using traditional models, we are seeing duplication in the system and significant challenges in relation to available capacity. Within Swindon we are seeing: • Rising demand for same day / urgent care services • Demand for inpatient care exceeding supply • Care Homes feeling unsupported- it is easier to dial 999/ request admission • Social care demand exceeding budgets • Difficulty in recruiting GPs which is impacting on the sustainability and resilience of practices • Limited clinical linkages between primary and secondary care • Population and demand rising faster than resources • Significant areas of new housing developments within the town and the New Eastern Villages which increase demand on existing services beyond available capacity.
3.2	A Board to Board event was held on 27 February 2017 between Swindon CCG (SCCG) and Great Western Hospitals NHS Foundation Trust (GWH NHS FT) to enable members to consider system wide risks and benefits to the development of an Accountable Care System (ACS) and to identify what would be the values and principles for a system to be effective. A representative of Swindon Borough Council (SBC) attended the meeting and SBC are supportive in principle to an ACS.
3.3	A presentation has been made to the private meeting of the Health and Wellbeing Chairs Advisory Group.
3.3	<u>What do we mean when we talk about Accountable Care</u>? With lots of different parts of the NHS system, from GP practices to hospitals and urgent care centres, we are aiming for everyone to work together to provide high-quality care for patients. This makes the system less complicated, less fragmented, and reduces hospital delays. Getting referred when we need to should be more straightforward, as everyone who needs to work together on a patient are part of the same team, using the same

system.

This means each organisation providing care to the local community is pooling resources to support the joint commissioning and delivery of health and social care for everyone.

The organisations involved with the development of an Accountable Care System are:

- Swindon CCG
- GWH NHS FT (acute and community)
- AWP
- SBC
- Primary care

*This list will expand as we move through the process.

4.0 Guiding Principles

The communications and engagement activity will be guided by a number of key principles which are listed in Appendix 1.

5.0 Communications and Engagement Objectives

Good communication and engagement will be at the heart of the development of the Accountable Care System (ACS).

5.1 The Communications and Engagement Objectives are to:

- Explain why the local NHS needs to change;
- Ensure that staff and all stakeholders understand the broad concept of what an ACS for Swindon and Shrivenham is (and is not);
- Explain how the ACS fits with the existing Bath and North East Somerset, Swindon and Wiltshire and Swindon Sustainability and Transformation Partnership;
- Explain to patients/public what this will mean for them: faster access to services, being seen by different clinical staff, being treated in different places, use of technology);
- Explain what the benefits are to patients and the public of moving to an ACS;
- Reassure all audiences that this is a piece of work which will make a positive impact on local people's lives and the quality of care they receive;
- Explain and share with staff the benefits to them of working in an ACS;
- Proactively support the programme through timely, interactive internal and external communications that creates an understanding of and commitment to the change programme;
- Provide key information to stakeholders relating to the future provision of local NHS and Social Care services;
- Ensure the public has a voice in this process;
- Develop programmes for emotional/mindset changes;
- Ensure staff and stakeholders can have their views heard; and
- Ensure consistency in all communications from all organisations involved.

6.0 Audiences / Stakeholders

6.1 **Patients and the public**

- Service users
- Service user's families and carers

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	• Patient/public engagement forums • Public
6.2	**Community, voluntary and service user groups** • Health and social care organisations such as Age UK • Local community and voluntary groups • Care Homes • Domiciliary Care providers
6.3	**Clinicians, staff, service providers** • Local GPs • LMC • CCG Governing Body • GWH NHS FT Board • AWP Board • GWH NHS FT clinical directors • All clinicians across all care • NHS England • Other providers e.g. BMI, SWAST • STP organisations • PALS
6.4	**Local authority – Swindon Borough Council** • Councillors • Health, Adult and Children Services Overview and Scrutiny Committee • Health and Wellbeing Board • Council chief executives and directors • Social care staff
6.5	**Representatives** • Healthwatch • Trade unions • Professional bodies • Local representative committees – LDC, LPC, LOC
6.6	**Influencers** • MPs • NHS Improvement • Health Education England • NHS England • Department of Health • NHS Employers
6.7	**Media and campaign groups** • Local media • Trade media (e.g. HSJ) • Campaign Groups (e.g. Keep our NHS Public, Save our NHS)

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7.0 Communication and Engagement Methods

The information to be communicated should be tailored to meet the audience's needs at the right time. The methods will depend on:

- The importance of the information being communicated;
- The level of engagement required;
- The interest of the audience in the message;
- How the target audience prefers to receive information and whether it involves relaying information it requires two-way communication.

7.1 **Internal channels**

The main methods for communicating with staff across the organisations are:

SCCG	Monthly Staff Briefing, monthly e-newsletter, emails, staff intranet and team meetings
GWH NHS FT	tbc
SBC	tbc
AWP	tbc
GP member practices	Fortnightly GP e-newsletter, emails, locality meetings and practice meetings.

(A separate list and channels, frequency, delivery and audience will be produced for each of the above).

7.2 **External channels**

All main external channels will be used including:

- **Digital**: websites, e-bulletins, video
- **Social media**: Twitter and Facebook
- **Print media**: local and trade
- **Broadcast media**: local radio and TV
- **Face-to-face**: public and existing meetings, focus groups and workshops
- **Printed materials**: posters, leaflets

7.3 We will develop a single voice toolkit which organisations can use to meet their communication and engagement needs.

8.0 Narrative and Key Messages

8.1 It is crucial that partner organisations involved in delivering the transformation needed can clearly articulate why change is needed, what this will mean for local people and how they can contribute. A central narrative will help to achieve this. A first draft will be produced and further refined with input from stakeholders.

8.2 <u>Messages</u>

The messages will be developed and refined as we develop them with the work streams which will support the Accountable Care Partnership Board.

- In the way of developing an ACS we will be taking about Team Swindon – organisations working together.
- We need to think differently about how we deliver services in Swindon and

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	Shrivenham to meet the changing needs of our population; • In order to take advantage of new opportunities and create a better future for patients, we must adapt the way we do things. This does not mean doing less for patients. • Doing things better and more efficiently usually means a better experience and outcomes for patients; • We know we need to use our limited resources wisely (the Swindon £), to meet the demands on our system and stay within our allocated budgets. By working together, we can plan our services to deliver the maximum benefit for patients; • We want input from patients, residents and communities to make sure the Accountable Care System is truly representative of local people and responsive to local need; • Patients will be healthier, need to visit their GP or hospital less often, when patients get sick they will recover more quickly and be treated in better surroundings – often their own home. Services will be easy to access and services will be safer and more efficient. Our staff will be better trained and more able to do their job; • Organisations working together across Swindon and Shrivenham makes sense to do so; • It is too early to say what changes are needed, however as initial ideas become more detailed we are committed to engaging with patients / public as appropriate.
9.0	**Resources**
9.1	It is anticipated that partner organisations will absorb the costs of any local communication and engagement activity.
9.2	The Head of Communications and Engagement for Swindon CCG will lead on the development and implementation of this strategy with support from the Communications Teams at the CCG and GWH NHS FT.
10.0	**Risks** A risk register will be developed as part of the overall ACS programme. Specific communication and engagement risks include the risk to public and clinical perception of decisions being made without their involvement.
11.0	**Equality and Diversity** An Equality and Impact Assessment will be undertaken as part of the development of this strategy.
12.0	**Engagement and Consultation**
12.1	An initial clinical workshop took place on 30 March, and will be followed up with a series of opportunities for clinicians to engage with the development of pathways.
12.2	Conversations with our public will be key to ensuring that they are influencing the development of services in Swindon and are able to drive the development of outcome measures for any new model of care. We will be working with our colleagues in Healthwatch to draw up a timetable of events throughout the coming year to ensure continued involvement in the evolution and refinement of the service models. These events will be jointly hosted across health and social care organisations.

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12.3	We will also want to engage regularly with our wider stakeholders such as the voluntary sector providers.
12.4	{The NHS has a legal duty to involve patients, the public and local organisations when developing and considering proposals for substantial variations in the provision of services. NHS England has produced explicit and informative guidance documents to support commissioners and providers to ensure they are adequately informed on the best practice models for service change.}
13.0	**Time line and Action Plan**
13.1	**Activities completed during March/April 2017** • Governance arrangements drafted with shared Board papers • Engagement with wider provider base including care home sector • High level draft programme plan developed • Programme structure developed and workstream leads identified • Programme mobilised • Clinical workshops held to begin development of new models
13.2	**Strategic Alignment to be completed: April/May 2017** During April/May, the Swindon system should carry out a number of strategic alignment activities. • Exploration of contracting models • Refinement of clinical models • Develop commissioning model options appraisal • Commence Public 'conversations' • Analysis of system spend and potential interventions and other activities • Populate the core components of a high level operating model. • A set of quick wins and high level outcomes should be agreed.
13.3	**Develop Operating Model and Outline Business Case: May/June 2017** During May/June, the Swindon system will develop the Operating Model and an Outline Business Case • Board level review and authorisation • Engagement with regulators • Ongoing Public 'conversations' • A set of quick wins and high level outcomes should be agreed. • Ongoing engagement with clinical teams A Communications and Engagement action plan to advance the objectives contained in this strategy are attached (see Appendix 2 and Appendix 3). Any Communication and engagement activities will take account of Purdah).

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14.0	**Monitoring, evaluating, reviewing and reporting our work** Communications and engagement activity will be evaluated, reviewed and monitored on an on-going basis. This will provide flexibility to adapt and adjust to staff and stakeholders' communication and engagement needs and deliver the best information.
15.0	**Review** This strategy will be reviewed in Six months (September 2017).
16.0	**Implementation** The Head of Corporate Communications and Engagement, Swindon CCG is responsible for making sure the strategy is enacted. The Governance of how the strategy will be delivered will be through the Accountable Care Steering Group.

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Appendix 1: Communication and Engagement Principles

The communications and engagement activity will be guided by a number of key principles:

- **Respectful**: showing respect for our local population, avoiding unfair stereotypes, acknowledging the different needs of individuals and populations
- **Developed in partnership**: our work will be shared openly to ensure we get the widest possible feedback and create the strongest possible plans
- **Clear and professional**: demonstrating pride and authority in what we do
- **Modern**: portraying Swindon ACS and the NHS in a way that is up-to-date and current
- **Proactive**: we recognise the ACS partners need to be proactive in its approach and wherever possible will attend existing meetings and go to where people are
- **Accessible**: understood by the target audience, easily obtainable and available in other languages, symbols or formats, and abbreviations will always be explained
- **Honest**: avoiding misleading information or false promises, being honest even where the message is difficult
- **Cost-effective**: showing that budgets have been used wisely
- **Alignment:** communications will be aligned to the organisation's vision and values, and the principles and aims of the NHS as a whole
- **Listening:** mechanisms for feedback, review and evaluation; and communication and engagement will evolve to reflect that feedback
- **Open to change:** we will apologise and change if we get something wrong
- **Responsive:** ensuring that we react quickly and fully to partner, GP practice, patient and public queries and questions.

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Appendix 2: High Level Communications and Engagement Action Plan

May - June 2017	July - September 2017	October	November
• Agree strategic approach for communications and engagement (presented to SCCG Governing Body in April and GWH Board in May) • Establishment of a Communications and Engagement work stream with terms of reference • Production of a first draft of the ACS narrative (look at narrative from Denise – have asked her for this) • Full list of stakeholders (gathered from stakeholder lists each organisation holds) • Stakeholder mapping exercise • Key partners and representative organisations engaged around the broad principles and some specifics of an ACS • List of initial organisations to engage with identified – attending groups and meetings that are already in place • Staff information prepared – core messages • Public information prepared – core messages • Presentation material prepared • Specific area identified on SCCG website (and GWH) • Briefing material produced • Develop and start to implement a communication plan for primary care. • Briefing for	• Refresh of staff and public information as needed • Refresh of presentation material as needed • Refresh of briefing material as needed • Dashboard in place for monitoring communication and engagement activity • Spokespeople/advocates identified and offered support •	• Report produced on communication and engagement activity to-date	• Further briefing for MPs. OSC, Health and Wellbeing Board

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Healthwatch and Health and Wellbeing Board • Engagement meetings • Issue a press release /briefing for the media? • Develop a six-month calendar of opportunities to communicate / engage with the public, staff and other stakeholders			

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Appendix 3 – Communications and engagement workstream overview

Area	Action	April 2017	May	June	July
Communications & Engagement Work stream	Establish the workstream and produce terms of reference				
Primary Care engagement	Production of communications & engagement plan specifically for primary care				
Patient / public/staff / Stakeholder engagement	Scope and record activity to date in Swindon & Shrivenham				
	Completed stakeholder analysis				
	Representation at OSC				
	Representation at H&WB Board				
	MP engagement				
	Engage with staff side unions at GWH and staff side at SCCG				
	Engage with voluntary groups				
Media / PR	Develop and implement a media handling plan				
	Media training if needed				
Materials	Develop FAQs				
	Develop briefing materials for the different audiences				
	Develop presentation material				
	Develop website material				
	Develop social media plan				
	Develop ACS newsletter				
	Develop patients / people's stories				

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Consideration of Joint Commissioning Group Minutes

Health and Wellbeing Board **Date: 24th May 2017**

Author:	Sue Wald – Director of Adult Services, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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 9 March and 20 April 2017, the minutes of which are attached at Appendix 1 and 2 to the report.

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 9 March and 20 April 2017, 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 9 March and 20 April 2017 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.

Further information on the subject of this report can be obtained from Sue Wald, 01793 465713, swald@swindon.gov.uk.

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 9 March and 20 April 2017. 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 9 March 2017.

8.2 Appendix 2 – Minutes of the Joint Commissioning Group held on 20 April 2017.

Further information on the subject of this report can be obtained from Sue Wald, 01793 465713, swald@swindon.gov.uk.

JCG Minutes for Meeting 9th March 2017

Present:

Sue Wald	SBC – Director Adult Social Services
Jackie Walker	SBC - Change Lead & Head of Finance, Vulnerable People
Phillipa Lamb	SBC – Strategy & Development Manager
Joy Kennard	SBC – Head of Commissioning
Lyn Frith	SBC - Strategic Commissioner SEND
Esther Schmidt	SBC/CCG – Joint Children's Commissioner
Sheila Baxter	CCG - Mental Health Joint Commissioner
Gill May	CCG- Executive Nurse
Sharon Pell	CCG- Associate Director for Quality

1.	**Welcome & Apologies** Apologies: Thomas Kearney (CCG), Graeme O'Malley (CCG); Karen Reeve (SBC), Caroline Gaulton (SBC), Matthew Hawkins (CCG)	
2.	**Notes of previous meeting 07th Feb 17** Minutes relating to Children Review (page 2) Karen Reeve (DCS) has written to the CCG outlining a number of areas of concern, some of which contradict what is summarised under the Children's Review in the minute 7/2/17. It was noted CCG are responding to the points raised by Karen Reeve in writing. **Matters arising** • SW has circulated the amended terms of reference which will be shared with Health and Wellbeing Board at the next meeting • Discussions ongoing between JW/AP/SB to understand the evidence and criteria for £192k spend for mental health. It was noted as this is part of section 75 agreement, any funding changes require a12 month notice period, which has been given by CCG. CCG have also advised that the governance of this budget needs to be finalised. • SW has shared the previous work undertaken by Newton on A&E attendance at GWH with Go'M • SW informed the meeting that Cabinet had agreed for SBC to receive additional capacity to reshape adult social care and to tackle the ongoing cost pressures through better demand management. SW suggested Newton Europe could run a session to share the learning from their recent diagnostics on older people and with physical disabilities which has informed the change programme.	JW/AP/SB SW

	<u>Progress on SEND reforms from CCG perspective</u>. Presentation by ES attached for information. Key areas noted: The national trend shows a significant rise in the number of children diagnosed with Autistic Spectrum Disorder (ASD) – diagnosis has more than doubled since 2004. The average waiting time for ASD diagnosis is currently 41.8 weeks. There is a weekly referrals meeting to triage the cohort and under 5's and cases with safeguarding concerns are prioritised. 55 children are waiting for OT support and 64 children are waiting for Speech and language support. CCG has invested an additional £330,610. £128k has been identified to increase capacity to 65% and reduce waiting time to 13 weeks. £37,525k has been provided to fund an additional Educational Psychologist. Need to clarify whether funding has been allocated to GWH or SBC. CCG will receive monthly performance data from Saltway and GWH which will include impact measures to evaluate the effectiveness of commissioning decisions and inform future commissioning intentions. ES is not currently receiving data on TAMHS. PL to follow up SBC performance team and SBC Head of Early Help as a performance dashboard is regularly provided for TAHMS service. However, it was noted the TaHMS dashboard will include additional activity not funded by CCG as majority of funding is raised through trading with schools. ES mentioned work is underway to co-design a model for CAMHS and TAMHS which will provide a seamless service. Parent/carer forum and health watch will be consulted on proposals. A joint improvement SEND Action plan is in development between SBC and CCG Plans are in place to boost the uptake of Personal health budgets with an initial focus on children who are wheel chair users ES working with MG to develop robust criteria to assist with decision making on health funding for children with complex needs. **ACTION:** ***PL to request TaMHs performance dashboard is shared with ES*** **<u>Children's Services Review</u>** Currently identifying areas of investment, impact and what needs to change. A review of the funding arrangements for supporting parents whose children are on the ASD pathway is underway to assess whether shifting resources to more parenting courses may be the preferred option recognising the positive impact good parenting has on this cohort of children. It was noted that SBC is leading on the preparation of an Early Help Strategy for Swindon. The strategy is informed by latest research, best practice, government policy and local analytics. This document should help inform future commissioning intentions.	**PL**

	ACTION: ***ES's presentation to be circulated with the minutes*** **<u>Transition Programme</u>** Update report shared with JCG members. It was noted a transition stakeholder event was being held at Sanford House until 8.00 pm which so far had been well attended with positive feedback The transition programme aims to improve joint working between Children, Adults and Economy services so children are identified earlier, aspirations of children and families are raised, and children and young people are supported to develop life skills alongside education, training and employment opportunities in preparation for adulthood. The commissioning workstream of the programme is addressing how we can secure a more outcome focussed model of support and encourage new providers into the market	
3	**<u>Place of Safety Section 136</u>** Still awaiting the consultation paper which was planned for Monday 13th March 2017. SBC was concerned with the delay in the consultation and the tight timescales. It was highlighted that the impact of changes on partners (e.g. operational & financial) as well as children and young people (travel) need to be considered if the service is re-located at Devizes There will be three public meetings as well as information in local press, letters to MPs, councillors and GP surgeries. On the prosed changes. An online survey is also to provide feedback. A presentation is planned for H&O Scrutiny in May 2017. **Action**: ***To circulate the consultation document***	SB
4	**Revision on 75 changes 2017/18** Financial schedules have been circulated and shared and are being reviewed by CCG. Additional funding for ASC will be available via BCF. Noted any changes to schedule requires 12 month notice period. Latest picture is that possibly up to £3m additional funding may be available to support older people services, demand for adult social care and hospital discharge in Swindon. Swindon Borough Council will be proposing how additional money will be allocated led by the cabinet Member. It is likely that sign off of the additional investment will need to go through Health & Wellbeing Board. t is important agencies assess the impact of budgetary decisions across the partnership. We are still awaiting BCF guidance and there will be tight turnaround to finalise and consult on our plan before H&W Board.	
5	**Older People/Physical Disability Programme** During December 2016, SBC undertook an assessment of our Adult Social Care Services for older people and people with physical	

disabilities with support from the external consultants Newton. The assessment identified:

- Opportunities for working differently
- Lack of clarity around the front door-referral process into ASC
- Missed opportunities for conversation with families and older people as to what their needs are
- Opportunity to adopt a more strengths bases approach to assessment e.g. what can people do for themselves, and what is it that SBC ASC need to do
- Delays in the hospital and link between hospital social work team and the discharge team-GWH staff is not clear
- Staff spend approx. 30% of their time on paperwork & 10% on direct contact with service users
- Some SBC/GWH staff not clear on what to record and where
- Evidence of multiple recording on different systems and evidence of no recording
- Re-enablement only available following an OT assessment in GHW

The following areas were identified for improvement opportunities which will also potentially deliver significant savings in the longer term:

Front Door Project

- To work with the Sanford house organisations to make sure we are doing as much prevention as possible and they we are diverting people into community based solutions where that is the right thing to do, for those who do need help they get it quickly. Leads are Eve Marshall and Caroline Gaulton

- To work with Social Workers, partners from the voluntary sector go into a design phase and test a different way of working before it is rolled out. This is planned from April to October 2017.

Acute work stream

- To clarify the roles and functions of: the (DART) Discharge, Assessment and Referral Team and Social Work Team at GWH
- To reduce delays particularly around assessments and make sure those who need social care are identified as early as possible and the right conversations take place at the right time to get people home as soon as possible
- Stop inappropriate referrals and admissions to nursing care and focus on getting people home. SBC to work with GHW staff to understand the high rate of admissions to nursing homes. Spend on nursing care is high and a disproportionate number of people are being admitted.

New ways of Working

- To address the lack of direct contact time spent with service users. Currently direct contact with older people and their families is estimated to be between 8-10%, direct contact with service users with Learning Disabilities is about 13% and predicted direct

	contact with Children is approx. 18%. Staff spend approximately 3-5 hours per week visiting service users and 20 hours per week on paperwork. Assessment and review process are being streamlined, paperwork reviewed and practice shifted to adopt an outcome focussed approach to working • To make reablement more accessible and targeted to improve uptake • To support SBC with re-tendering of Domiciliary care contract and the residential and nursing home contract with a focus on commissioning for outcomes rather than services. • To improve processes to collect client and health contributions for care where eligible The benefits of the programme will be tracked and we will share learning, methodologies and expertise with colleagues over the time of the programme.	
7	**Better Care Fund** • No guidance available yet. PL and G'OM in process of refreshing 16/17 BCF Plan for 17/18. PL incorporating children's services to reduce the need to prepare a separate joint commissioning intentions document. The draft BCF 17/18 will need to be cleared by CCG Executive Board. • SW and Graham have been advised of schemes headings but these may change in due course	
6	**AOB** **Action:** ***JCG to receive minutes from SEND Board as a standing agenda item every alternative meeting*** **Action**: ***LF to send a proposal for establishing a separate joint commissioning group for SEND to be considered at the next meeting*** **Action**: ***JK to confirm who will attend and present performance data at the monthly AWP contract meeting following John Hugh's departure*** LF informed the group SBC is commissioning are high needs provision funding review to prempt spend of the capital grant. It was noted that any revenue implications would also need to be considered. LF/PN scoping the review April 5 2017 **ACTION**: ***LF bring scoping document and identify any revenue implications within the term of reference*** PL thanked CCG and GWH input into the ADASS Adult Social Care self assessment	**MN** **LF** **JK** **LF**

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Appendix 2

JCG Minutes for Meeting 20th April 2017

Present:

Sue Wald	SBC – Director Adult Social Services
Jackie Walker	SBC - Change Lead & Head of Finance, Vulnerable People
Phillipa Lamb	SBC – Strategy & Development Manager
Cherry Jones	SBC – Director of Public Health
Karen Reeve	SBC – Director of Children's Services
Esther Schmidt	SBC/CCG – Joint Children's Commissioner
Sheila Baxter	CCG - Mental Health Joint Commissioner
Graham O'Malley	CCG - Project Manager
Gill May	CCG - Executive Nurse
Joss Conway	CCG Finance
Sharren Pells	CCG - Associate Director for Quality
Claire Bradley	CCG Finance
Ric Whalley	Newton Europe
Christoffer Redlund	Newton Europe

1.	**Welcome & Apologies** Welcome: Ric Whalley and Christoffer Redlund Newton Europe Apologies: Thomas Kearney (CCG), Caroline Gaulton (SBC), Matthew Hawkins (CCG)	
2.	**Newton Europe**- Adult Social care transformation work is being supported by Newton. Focussed work has been undertaken to analyse the decision making process across health and social care system to gain insight into the increasing demand on adult social care and nursing care provision. The attached presentation highlights the key findings which identified that from the 27 cases looked at, 59% of the outcomes for these individuals were not ideal. Factors impacting on this included family pressure, decisions being made at a point of crisis, lack of early input by social care, patients not being kept mobile, reablement referrals having to go via OT, patients not being encouraged to maintain mobility during their hospital episode, a tendency to 'prescribe' rather having a dialogue with the patient/carers to look at strengths and opportunities. The Newton work needs to be shared with DTOC Board and A&E Delivery Board to support improvement across the health and social care system to improve patient flow. GWH is working with Vanguard to analyse 'decision-making' at the front door. There are 5 task and finish subgroups. This work needs to align with the transformation in Adult Social Care and learning shared to drive improvement and reduce cost pressures across the health and social care system. **Action:** Circulate Newton presentation	

	Action: Share Newton work with DTOC Board and A&E Delivery Board	
3.	**Minutes from the 9th March 17** **Action tracker-**updated The following actions were added • Mental health issue on funding 192k to action tracker. Nicki Millian (CCG) has given notice of change to MH funding and CCG will inform the LA how these people will be funded for 17/18 and going forward. Further work needs to be undertaken to assess the impact of the changes to funding arrangements. **Action**: update from CCG on impact of changes to MH funding **Matters arising (not covered by the agenda)** **Children's Review** Children's review – performance data received from Saltway. Review is on target to report in May 2017. Mark Green and Louise Campion are SBC representatives on the Review Board. It was agreed to share project report and progress headlines with JCG. **Action** –Project Plan to be circulated with JCG papers	SB ES/MN
4.	**AWP Contracts** Clare Deards, Head of Social Work will attend AWP contract meetings to discuss performance. Phillipa Lamb to follow up **Action** –PL to liaise with Clare Deards and Sheila Baxter to clarify dates and content for AWP contract meetings	PL/SB
5.	**Special Educational Needs Update** Special Educational Needs Development (SEND) Strategy Board notes circulated with JCG papers as requested A paper to explain the need and purpose of establishing a SEND joint commissioning group is not yet available. **Action**: LF (SBC) to circulate paper including a diagram to demonstrate links with existing groups and their membership for next meeting	LF
6.	**CQC Inspection** Karen Reeve provided an update to the Board	
7.	**Budget and Performance** Year end outturn figures for both SBC and CCG have not yet been validated so will be brought to the next meeting. SW (SBC) presented 17/18 ASC budget and explained how the additional £2.9m allocated to adult social care in Swindon following the Chancellor announced in the 2017 Spring Budget that councils would receive additional money over the next three years for social care.(presentation attached to	

	meeting notes) **Action**: SBC and CCG to bring 16/17 outturn to next meeting **Action**: Set up follow up meeting to finalise the community health budget (Section 75 funding) and CCG to bring update budget to next meeting.	SW/JW/ JW/MH
8.	**Integrated Personal Commissioning** **Grame O'Malley** (CCG): provided the following update regarding Personal Health Budgets (PHB). • Swindon position - 9 people declared as receiving PHB (2 children/7 adults)…this is a slight improvement from 16/17 which declared 8 • CHC team are embedding PHB in their processes so expect to see some increase during 2017/18 • Meeting to be mindful of targets (120 PHBs by 2019 and 466 by 2021) • Personnel resource is the key issue to progressing PHBs beyond Continuing Health Care – CCG are working up paper to propose resource investment (via Amanda du Cros) • Targeting joint funded care packages will boost performance (particularly children 7 young people • Need to identify key individual within SBC that CCG can link to move forward joint packages • Meeting with NHS England Integrated Personal Commissioning team Monday 24/04/17 to discuss supports available to support improving our performance • Confirmation is sought that the Personal health Budget Local Offer has been formally agreed by Health & Wellbeing Board – this is an NHS England requirement ES is working with SBC colleagues to identify opportunities for Children and young people to have personal health budgets. There are 20 potential cases identified who have person-centred outcome led care plans who may be eligible. Need confirmation that the Local offer for Personal Health budgets has been to Health and Wellbeing Board (HWB). **Action**: Local offer relating to Personal Health Budgets will be circulated with the minutes for virtual approval with a recommendation to go to the HWB	MN/CJ
9.	**Better Care Fund Update** The policy framework has been circulated but still awaiting guidance. The BCF Plan has been refreshed but the schemes for 17/18 and high impact changes and investment have yet to be finalised. It was agreed to circulate the draft plan once planning template and guidance have been issued. **Action:** To circulate the draft BCF Plan when planning template and guidance have been issued	SW/MN
10.	**Place of Safety Consultation**	

	Stakeholder engagement event has been held. AWP are presenting proposals to Health and Overview Scrutiny on 25 April 2017. Main concerns relate to transport and the impact regarding clients and staff. AWP have established a task and finish group to review transport issues as well as any potential impact on response times required by the Police and Crime Bill. It was raised that a balanced evaluation of the proposals needs to be presented addressing risks, and implications for clients and staff alongside the benefits. The Chair of the Health and Wellbeing Board and the Cabinet Member for Adults will be writing to AWP regarding the proposals. Consultation is planned to close in May with feedback in early June.	
11.	**AOB** Note to organise JCG meetings outside school holidays	MN