Tuesday, 09 December 2014

Meeting of the Health and Wellbeing Board

Wednesday, 17 December 2014

2.00 pm

Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Board

Councillor Lewis (Chairman)
Caroline Dimond, Interim Director of Public Health
Pat Harris, Healthwatch Torbay
Graham Lockerbie, NHS England
Eleanor Rowe, Clinical Commissioning Group
Caroline Taylor, Torbay Council
Richard Williams, Torbay Council
Councillor Davies
Councillor Doggett
Councillor Pritchard
Councillor Scouler

Co-opted Members

Tony Hogg, Police & Crime Commissioner
Dr John Lowes, South Devon Healthcare NHS Foundation Trust
Mandy Seymour-Hanbury, Torbay and Southern Devon Health and Care NHS Trust
Vacancy – Community Development Trust

For information relating to this meeting or to request a copy in another format or language please contact:

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HEALTH AND WELLBEING BOARD
AGENDA

1. Apologies
To receive any apologies for absence, including notifications of any changes to the membership of the Committee.

2. Minutes (Pages 1 - 4)
To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 2 October 2014.

3. Declaration of interest

3(a) To receive declarations of non pecuniary interests in respect of items on this agenda

For reference: Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

3(b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda

For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

4. Urgent items
To consider any other items that the Chairman/woman decides are urgent.

5. Torbay's Carers Strategy 'Measure Up' 2015-17 (Pages 5 - 13)
To consider a report that informs the Board on consultation to develop an interagency carers strategy and the proposed priorities for action.

6. Refresh of the data informing the Market Position Statement for Adult Social Care and Support in Torbay 2014 onwards and The Children's Commissioning Plan and Sufficiency Strategy (Pages 14 - 60)
To consider a report that refreshes the data the Market Position Statement for Adult Social Care and Support in Torbay.

7. **NHS - Five Year Forward View** (Pages 61 - 101)
To receive a presentation on the NHS – Five Year Forward View.

8. **Initial Report - Health Protection** (Pages 102 - 118)
To receive a report that provides a summary of the assurance functions of the Health Protection Committee and significant matters considered since its inaugural meeting on 15 October 2013.

9. **Key priorities relating to the Special Educational Need and Disability Reforms** (Pages 119 - 126)
To receive an update on the priorities of the Special Educational Need and Disability reform work.

10. **Mental Health Crisis Care Concordat** (Pages 127 - 131)
To consider correspondence that seeks support for a declaration to made on the National Concordat website.

11. **Adult Safeguarding Peer Review** (To Follow)
To consider a report on the above.

12. **Torbay Safeguarding Children Board - Annual Report 2013-2014** (Pages 132 - 180)
To note a report that sets out the activities of Torbay Safeguarding Children Board for 2013-14.

The following items are for information only:

13. **Update Report - Adult Social Services** (Pages 181 - 182)
To receive an update on the current position of Adult Social Services.

14. **Update Report - Clinical Commissioning Group** (Pages 183 - 184)
To receive an update on the current position of the Clinical Commissioning Group.

15. **Update Report - Public Health** (Pages 185 - 188)
To receive an update on the current position of Public Health.

16. **Update Report - Healthwatch** (Pages 189 - 201)
To receive an update on the current position of Healthwatch.

17. **Update Report - Integrated Care Organisation** (Pages 202 - 205)
To receive an update on the current position of the Integrated Care Organisation.

TORBAY Health & Wellbeing BOARD
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Minutes of the Health and Wellbeing Board

2 October 2014

-: Present :-

Sam Barrell, Councillor Bobbie Davies, Caroline Dimond, Councillor Ian Doggett, Tony Hogg, Councillor Chris Lewis (Chairman), Dr John Lowes, Councillor Ken Pritchard, Mandy Seymour-Hanbury, Caroline Taylor and Richard Williams

(Also in attendance: Mayor Oliver and Councillor Neil Bent)

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23. Apologies

Apologies for absence were received from Councillor Christine Scouler and Graham Lockerbie (NHS England).

24. Minutes

The Minutes of the meeting of the Health and Wellbeing Board held on 16 September 2014 were confirmed as a correct record and signed by the Chairman.

25. Declaration of interest

Councillor Doggett declared a non-pecuniary interest as he is a lay member of the Joined Up Medicines Optimisation Group.

26. Urgent items

The item considered in Minute 27, and not included on the agenda, the Chairman being of the opinion that the item was urgent by reason of special circumstances i.e. the matter having arisen since the agenda was prepared and it was unreasonable to delay a decision until the next meeting.

27. S256 Social Care Funding for Health Benefit Allocation and Monitoring

Members considered a report that sought the endorsement of the Health and Wellbeing Board for the allocation of Section 256 funding for projects within the financial year 2014/15.

Resolved:

That the Health and Wellbeing Board endorse the funding allocations as set out in Appendix 1 to the submitted report.

28. 2014/15 Joint Strategic Needs Assessment

The Board considered a report that set out the executive summary for the 2014/15 Joint Strategic Needs Assessment (JSNA). Doug Haines, Public Health Epidemiologist, advised the Board that the JSNA had been updated and refreshed. The JSNA continues to follow a life course approach in understanding the needs and challenges of the population.

The JSNA comprises five narrative overviews covering the life course, each life course has a further standalone document providing a summary of need for that age group. The issues have then been brought together in the executive summary.

The Board was advised that the JSNA focused on Torbay and South Devon therefore reflecting the natural community around the main health provider – Torbay Hospital. Understanding the needs across this provider enabled a system wide approach to understanding the health and wellbeing needs of the community.

Members were informed that the delivery of JSNA for 2014/15 onwards will be through a new web platform. The web platform has been created to act as a consistent resource to enable people to access the shared knowledge and intelligence across South Devon and Torbay. The web platform also includes interactive tools including:

- Topic and area based overviews
- Interactive tools; population, community assets and community profile tools

Members welcomed the refresh of the JSNA and believed the challenge was to respond to the intelligence in order to improve the lives of people living in the Bay. Members felt a communications policy was required in order to support the work of the JSNA, with partner organisations thinking about how they would like the information to be disseminated through their organisation. Members welcomed the view that information analysts across partner organisations needed own the JSNA in order for the JSNA to be truly owned by the Bay.

29. Torbay and South Devon Integrated Prevention Strategy 2014/15 - 2019/20

The Board noted a report that set out the Torbay and South Devon Integrated Prevention Strategy 2014/15-2019/20. The purpose of the strategy was to provide a framework across the life-course for focused work on Prevention.

The Board was informed that the strategy identified priorities for action across three domains, behaviour, determinants and service design within each part of the life-course and links these to current or developing strategies and action plans.

Members welcomed the strategy and challenged whether mental health and substance abuse needed a greater focus.

30. Department for Education Children's Social Care Innovation Programme - Torbay Submission

The Board considered a report that set out a submission for funding under the focus area of 'rethinking children's social work.' Members were advised that the crux of the bid was to develop a Public Service Trust under the Local Integrated Service Trust using the traction of existing vehicles for integration such as the Integrated Care Organisation.

Resolved:

That an invitation to submit a full proposal should the Expression of Interest bid pass the first selection round with the Department of Education, be endorsed.

31. Draft - Torbay Housing Partnership Strategy Children's Services/Adult Services/Public Health

The Board received a draft copy of Torbay's Housing Partnership Strategy 2014-2018. Members were advised that it is recognised that good quality housing underpins other life chances, wellbeing and is a determinant of good health. Members were informed the strategy was not just about bricks and mortar but the communities in which people live, their hopes for themselves and each other. The strategy addresses these challenges and takes new opportunities to set ambitious plans.

The Board acknowledged that housing had been the missing piece of the jigsaw when attempting to tackle the 'causes of the causes' of poor health and welcomed the strategy.

32. Update Report - Health and Wellbeing Board Priority 8: Reduce Alcohol Consumption

Members received an update on the progress made on the Health and Wellbeing Board's priority of reducing alcohol consumption. Members were informed of the need to move the focus of reducing alcohol consumption from a health and social care arena to addressing the wider social issues. Members were informed that a strategy was being produced to reflect the new focus. The draft strategy will have four themes:

- Prevention of alcohol-related harm in adults
- Reduction of alcohol-related crime, disorder and impact on communities
- Protection of children and young people from harm
- Alcohol control

The Board was informed of the intention for partners to sponsor the theme that is most relevant to their organisation.

Resolved:

i) That the Health and Wellbeing Board notes the progress made in relation to the Joint Health and Wellbeing Strategy Priority 8 – Reduce Alcohol Consumption, as set out in the submitted report; and

ii) That the development of a new alcohol strategy and implementation plan be endorsed.

33. Update Report - High Level Joint Mental Health Commissioning Strategy for South Devon and NEW Devon CCGs, and Torbay, Plymouth and Devon Councils

The Board noted the update on the Mental Health Commissioning Strategy.

34. Update Report - Pioneer Progress

The Board noted the update on the progress of Pioneer.

35. Update Report - Community Safety Partnership

The Board noted the update on the Community Safety Partnership.

36. For Information Only - Update on Public Health

The Board noted the update on Public Health.

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Torbay's Carers Strategy 'Measure Up' 2015-17
Wards Affected:	All
To:	Health and Wellbeing Board **On:** 17 December 2014
Contact:	James Drummond, Lead Officer Carers Services
Telephone:	01803 208453
Email:	jamesdrummond@nhs.net

1. Purpose

1.1 To report to the Board on the consultation to develop an interagency Carers strategy for Torbay, for the period 2015 – 17, and the proposed priorities for action.

2. Recommendation

2.1 That the draft priorities for 'Measure Up' 2015 – 17 are endorsed by the Board and that the Board agree that an Action Plan is produced with clear targets, timescales and responsibilities for delivery. That the Torbay's Carers strategy Action Plan is reviewed annually and the Board updated on achievement.

3. Supporting Information

3.1 Unpaid caring is an increasingly significant issue for the population of Torbay. Census data (2011) shows that 12.3% of the population of Torbay are Carers against an England average of 10.2%; the proportion of carers age 65+ is 33% against an England average of 22%; and 4,684 carers in Torbay are providing 50 hours+ of caring per week, 50% more than the England average. The challenges for addressing the health needs of the population require attention to supporting unpaid carers, both to enable them to maintain their caring roles and to look after their own health and well-being. The contribution of unpaid caring to community care cannot be underestimated.

3.2 The Measure Up approach to Carer support in Torbay continues to be recognised as an example of national good practice. It is based on a long term, whole systems approach, grounded in assessment of local needs and an evidence base of what works. The model combines direct access services available to all carers (information, advice and emotional support); targeting groups of carers who are hard to reach or excluded; prevention of breakdown in carers mental and physical health; and working with communities and local organisations to develop community capacity to support carers.

3.3 The model focusses on prevention, early intervention and whole family working and we are confident that current support arrangements, and the

priorities identified in the strategy, will enable Torbay to be Care Act compliant.

4. Relationship to Joint Strategic Needs Assessment

4.1 There are a range of connections between the needs of Carers and the priorities identified in the JSNA. The following are examples:

Developing well – Data from known Young Carers shows a geographical correlation in terms of disadvantage, when compared with a map of the indices of multiple deprivation. Young Carers under 25 are vulnerable to poor outcomes. Evidence shows that 30% of Young Carers experience problems at school with attendance, attainment and social development, rising to 40% where they care within a family affected by substance misuse.

Living and working well – Nationally, some 3.6 million over-50s are unpaid carers, and of these, 792,000 have had to leave their job or change their hours to care for loved ones, with a significant impact on income.

Ageing well – As carers age and their own health deteriorates, their need for support will grow. Poor physical health among carers is a major predictor of psychological distress. Two-thirds of people with dementia live at home, with their family providing most of their care.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 The model for Carer support in Torbay is based on a whole system approach to meeting the health and social care needs of carers. There is a good fit with the underlying principles – addressing inequalities, a focus on prevention, and an integrated and joined up approach. Existing Carers support services and the proposed priorities for Measure Up 2015 – 17 will contribute to the outcomes identified for the 16 priorities in the strategy.

Appendices

Draft priorities Torbay's Carers Strategy 'Measure Up' 2015 - 17

Background Papers:
The following documents/files were used to compile this report:

Torbay Carers strategy 'Measure Up' 2012 – 14

Healthwatch Torbay - Review of Local Carers Services in Torbay

DH Carers Strategy: Second National Action Plan 2014 – 16

DH Response to the consultation on draft regulations and guidance for implementation of Part 1 of the Care Act 2014

Torbay Strategy for Young Carers Under 25

Torbay's Carers Strategy

'Measure Up' 2015 – 17

Draft priorities

Proposals for Torbay Carers Strategy Measure Up 2015 - 17

Foreword

This is the final stage of consultation on the priorities for our 'Measure Up 'interagency Carers strategy for 2015 – 17. This paper sets out our proposals for developing Carers support in Torbay for the next 3 years and explains how these have been arrived at.

This stage of the consultation will conclude at the end of November 2014 and the draft 'Measure Up' 2015 – 17 will be presented to Torbay Health and Well Being Board for joint agency endorsement in December 2014. Following this, an Action Plan will be produced.

There is a section at the back of this paper for you to send in your comments, responses, and challenges. Please let us have your views by 26th November 2014. The document can be read online and comments returned electronically to jamesdrummond@nhs.net

Thanks for your interest.

James Drummond
Lead Officer Integrated Carers Services.

1 Introduction

This paper contains proposals for the 5th edition of Measure Up for 2015 – 17. 'Measure Up' is a long term interagency Carers strategy for Torbay which has been in place for 15 years.
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The development of these strategy proposals has been based on the following:

- An independent survey of known Carers, sent out via Torbay Carers Register. The survey was carried out by Healthwatch Torbay. There were over 730 individual responses received and analysed.

http://healthwatchtorbay.org.uk/wp-content/uploads/2014/03/FINAL-HW-Torbay-Report-Review-of-Carers-Services.pdf

- Review of the achievements on priorities and targets that were set for Measure Up 2012 – 14 http://www.torbaycaretrust.nhs.uk/yourlife/adult_social_care/carers_support/Documents/Measure%20Up%202012-14.pdf for Strategy and Action Plan
- Learning from independent evaluations of Carers support in acute and community services, completed with the involvement of Carer Evaluators.
- Recent evidence for what works from local and national initiatives.
- Understanding of the requirements for Carer support in legalisation, particularly the Care Act 2014 and Children and Families Act 2014, national priorities from the government's national Carers strategy and relevant policy.
- Feedback from commissioners and partner agencies. (Agencies aim to learn by doing and through listening to what Carers tell us needs to improve. This is not always comfortable listening but many of the best ideas for services have come from listening to Carers and involving them in improvement)

The 'Measure Up' approach to Carer support combines:

- Direct access services - a universal offer of information, advice and emotional support, available to all Carers
- Prevention of breakdown in Carers mental and physical health

- Targeting specific groups of Carers - those who are hard to reach or excluded
- Development of flexible breaks services and "enabling" capacity to help individual Carers work out what will help them
- Work with communities and local organisations to use the assets they have to support Carers.

Unpaid caring is an increasingly significant issue for the population of Torbay:

- Torbay has 16,107 Carers, equal to 12.3% of the population, much higher than the England average of 10.2%.
- The proportion of Carers age 65+ is 33%, against the England average of 22%. As Carers age and their own health deteriorates their need for support may grow.
- There are 4,684 Carers in Torbay providing 50 hours + of caring per week (50% more Carers than the England average).
  (Based on 2011 Census data)

Torbay Carers Services and its partners want to respond to these challenges. Our long term approach, based on 7 key aims, is as relevant for 2015 – 17 as it has been in the past. The evidence is that a whole system approach - which means all agencies and providers should incorporate the needs of Carers in their services - has delivered significant improvement.

Some examples of positive progress resulting from the Measure Up strategy

- Carers Support Workers in all GP surgeries, in Torbay Hospital, Community Mental Health Teams, Older Peoples Mental Health team, and Substance Misuse services. These workers are key to enabling Carers to be identified and given support at any point in their journey.
- Development of the Torbay Strategy for Young Carers under 25 (2012 – 15), a partnership between Children and Adult services to deliver joined up support and a whole family approach See the strategy at: http://www.torbaycaretrust.nhs.uk/yourlife/adult_social_care/carers_support/Documents/Amended%20Torbay%20Strategy%20for%20Young%20Carers.pdf
- Development of Carers Health and Wellbeing checks which provide a "light touch" assessment and signpost Carers to available support in the community, whilst referring those with complex needs to statutory services.
- Developments at Torbay Hospital to improve Carer involvement based on a joint Carers Policy and an Action Plan agreed between South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust.
- Partnerships with the voluntary sector to develop flexible enabling approaches. Crossroads Care SW has established itself as a service that works with individual Carers and their families to find personalised solutions to their needs, encourages self help, and links with communities to mobilise local Carer support.
- We now have drop-in Carers Centres in each town in the Bay. Paignton Carers Centre was opened in March 2013 in the Paignton Library and Information Centre.
- Increase identification and awareness of Carers by 'targeting' specific staff groups. An example from 2013 is work with Community Nursing Teams, where Carer Awareness training was provided, paperwork was changed to make Carers a priority and progress was audited. This led to a dramatic increase in referrals for support.

2 Draft Priorities 2015 - 17

The following proposals for Measure Up 2015 – 17 are the result of the review and consultation to date. They are grouped together under the following categories:

- **Identification of Carers at the first opportunity.**
- **Information advice and support services available to all Carers.**
- **Carers Assessments proportionate to their needs.**
- **Developing a whole family approach to supporting Carers.**
- **Involvement of Carers in service delivery, evaluation and commissioning.**
- **Targeting groups of Carers for specific action.**

We are aware that in many cases, action in one category will impact on others. However the proposed priorities are set out as goals to be achieved. In the final version of the Strategy document they will be fitted into a 3 year Action Plan (2015 – 17) with timescales and responsibilities clearly shown. Carers and others can then monitor progress.

Priority 1 Identification of Carers at the first opportunity

- Provide a range of Carer Awareness training for staff across Torbay. Target one group of staff per annum for Carer Awareness training and measure the impact on identification of Carers. e.g. Receptionists in GP surgeries; Community Hospital staff; School Nurses; School Governors.
- Identifying hidden Carers. Establish a project to support Carers in mutual caring situations (e.g. adults with a learning disability caring for a parent) in partnership with the Lottery funded Ageing Better project.
- Increase take-up of the annual flu vaccination by Carers and signpost them to support.
- Deliver two publicity campaigns per annum to enable Carers to identify themselves, in partnership with local businesses.
- Agree targets for identification of Carers by GP practices.

Priority 2 Information, Advice & Support services available to all Carers

- Ensure that Carer specific information is easily accessible through face to face, telephone and web based access.
- Audit the quality of Carers' information available via agency websites and ensure links to other information providers (Children & Adults). Link relevant web content to improve ease of use (e.g Torbay Directory).
- Maintain Signposts for Carers Information service, (telephone and face to face) and extend availability of the service to weekends.
- Develop tailor made information for Carers on GP surgery reception screens.
- Maintain availability of Carers Centre in Brixham, Paignton and Torquay, offering drop in to local Carers.
- Provide for minimum of 1 day per week of Carers' Support Worker time in all GP practices and review the resource requirements.
- Maintain the direct access support services provided through Torbay Carers Register
    - Carers Emergency card
    - Safely Home Scheme
    - Signposts Newsletter
    - Carers Discount Scheme
- Increase the number of Carers receiving Carers' Register information by 10% per annum (baseline 2014)

- Establish and maintain a central point for the distribution of printed information to Carers and Staff on Carers' issues. Audit effectiveness of distribution system.
- Establish a Carers' Information Point (24/7) for Carers at Torbay Hospital.
- Identify areas for improvement of Carers' support in hospital discharge (acute and community).
- Improve access for Carers to education to support them in their caring role.
    - Review available education programmes.
    - Develop access to e-learning and Hiblio material.
    - Establish a joint agency agreement for Carers access to learning resources.
- Develop a 'circles of support' project with the voluntary sector to set up support networks in the community for individual isolated Carers.

Priority 3 Carers Assessments proportionate to their needs

- Ensure that our response to Carers is appropriate to the level of need and that we provide early access to Carers' Assessments and support, in line with a preventative approach.
- Ensure that attention is focused on the health of Carers through the offer of a Carers' Health and Wellbeing check. Carers will be offered a check at the point that they are identified as having support needs, as a light touch Carers Assessment – 1000 Health and Well Being Checks per annum to be provided by Carers' Support Workers in primary care.
- Take a whole family approach – particularly address the needs of Carers of disabled children and Young Carers.
- Embed the whole family approach into staff development and training programmes across Children's and Adult Services
- Monitor the number of assessments of disabled/vulnerable adults showing that parenting support was addressed.
- Review the current Carers' Assessment process in light of the Care Act 2014 and ensure a clear care pathway for Carers through the system, including Carers in employment.
- Develop a Carer friendly Self Assessment framework that can be completed online
- Review the current Carers' Questionnaire and Action Plan for Carers eligible for support.
- Review the assessment frameworks for Young Carers under 25 and Parent Carers of disabled children.
- Ensure availability of independent enabling and brokerage services for all Carers, including self funders, and agree pathways for those requiring Carers' Assessments from statutory services.

Priority 4 Developing a whole family approach to supporting Carers

- Implement the Strategy for Carers under 25 in Torbay. http://www.torbaycaretrust.nhs.uk/yourlife/adult_social_care/carers_support/Documents/Amended%20Torbay%20Strategy%20for%20Young%20Carers.pdf
- Establish the whole family approach in staff development, induction and ongoing training programmes across Children, Adult and Community services.
- Maintain specialist Young Carer and Young Adult Carer services.
- Embed Carer support and a whole family approach in Substance Misuse services.
- Prepare staff in Children and Adult Services for undertaking family assessment for disabled children in transition.
- Review support for Parent Carers of disabled children and develop a joint policy and action plan with Adult and Children's services that meets their needs.
- Promote services to Carers which focus on prevention/health promotion and self care. Set targets for numbers of Carers engaged with Lifestyles services.

Priority 5 Involvement of Carers in service delivery, evaluation and commissioning

- Review agency policies on involvement of Carers including payments.
- Develop Torbay Carers' Forum as an independent point of engagement, in partnership with Healthwatch Torbay.
- A minimum of two services a year will be evaluated using recognised evaluation methods and the results published. Where there is a national benchmark, the Torbay service will have to be in the top quartile.
- Actively support implementation of Devon Partnership Trusts 'Carers Charter' Monitoring Group to deliver the Charter promises in mental health services.
- Promote the use of Carer Evaluators in service review and evaluation. (Maintain a pool of 15 Carer Evaluators, including Carers under 25).
- Reduce duplication in Carer involvement by commissioners/agencies and develop a local protocol/good practice guide.
- Explore ways to make more effective use of volunteers and opportunities for Carers/former Carers to contribute. Complete the project on Carer volunteering in Torbay Hospital (Victor) and extend into the community.

Priority 6 Targeting specific groups of Carers for action

- Develop a policy and action plan for meeting the needs of Carers in employment and those wishing to go into employment.
- Review existing services to identify improvement to make them more accessible to Carers in employment, (information and advice services, Carers breaks etc.).
- Promote flexible working policies for Carers amongst local employers.

TORBAY Health & Wellbeing BOARD
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Title:	Refresh of the data informing the Market Position Statement for Adult Social Care and Support in Torbay 2014 onwards and The Children's Commissioning Plan and Sufficiency Strategy
Wards Affected:	All Torbay
To:	Torbay Health and Wellbeing Board **On:** 17 December 2014
Contact:	Julie Sharland and Claire Truscott
Telephone:	01803 208065
Email:	Juie.sharland@torbay.gov.uk / claire.truscott@torbay.gov.uk

1. Purpose

1.1 This is a refresh of the data in Appendix 1 of the document: A Market Position Statement for Adult Social Care and Support in Torbay 2014+. Data is added for the year 2013/14 (1 April 2013 – 31 March 2014) where available, or later data in some cases.

1.2 The Children's Commissioning Plan and Sufficiency Strategy is also included as a new Appendix 2.

2. Recommendation

2.1 That the Board view the refresh of Market Position Statement data for information.

2.2 That the Board note for information The Children's Commissioning Plan and Sufficiency Strategy.

3. Supporting Information

3.1 Appendix 1 is a refresh of the data in Appendix 1 of the Market Position Statement. The Market Position Statement was produced in February 2014 to provide information and analysis of benefit to providers of care and support services in Torbay. The purpose was to communicate to new and existing providers the things they need to know to help with business planning, investment decisions, response to opportunities, and to reduce the risk of wasted resources on poor investments or poorly targeted initiatives.

3.2 This refreshed document does not change any text or commissioning intentions of the Market Position Statement, but updates the data Appendix 1. Data was provided by Torbay and Southern Devon Health and Care NHS Trust, South Devon and Torbay Clinical Commissioning Group, Voluntary sector and private providers, Care Quality Commission, Homes and Communities Agency, and Torbay Council

3.3 Where there are notable changes in figures or situation (Table 11: Independent hospitals, Table 17: Families in emergency accommodation, Table 27: Employment support, Table 36: Support services) then text is included in the refreshed document to give possible reasons for these changes, background and/or note gaps in provision.

3.4 The original Market Position Statement was distributed widely, and discussed at multi provider forums. Feedback has been light and work will be done to further publicise and gain feedback.

3.5 In 2015 it will be decided which other service areas (such as Children's Services) should be included in an updated Market Position Statement, planned to be produced in that year.

3.6 The Children's Commissioning Plan and Sufficiency Strategy sets out the current Children's position and will be reviewed and merged as one document as part of the full review of the Existing Market Position Statement in 6 months to form a joint partnership document.

4. Relationship to Joint Strategic Needs Assessment (JSNA)

4.1 These documents support the JSNA as they include need and demand for services. Information from the JSNA was used in the Market Position Statement.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 These documents support this Strategy, showing need and demand for services. Market Position Statement data and the Children's Commissioning Plan and Sufficiency Strategy can support the priorities and outcomes of this Strategy.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 Future iterations of the JSNA and Joint Health and Wellbeing Strategy should take into account and use the information, commissioning intentions and vision within the Market Position Statement and Children's Commissioning Plan and sufficiency Strategy to ensure consistency and avoid duplication.

Appendices

Appendix 1: Data informing the Market Position Statement for Adult Social Care and Support in Torbay 2014+

Appendix 2: Children's Commissioning Plan and Sufficiency Strategy 2014-2019

Background Papers:
The following documents/files were used to compile this report:

Data was provided by the agencies and providers in Section 3 above**.**

Refresh of Appendix 1: Data Informing the Market Position Statement for Adult Social Care and Support in Torbay 2014+

Refresh produced in November 2014

This is a refresh of the data in Appendix 1 of the document: A Market Position Statement for Adult Social Care and Support in Torbay 2014+ which was published in February 2014. The Appendix is refreshed with data for the year 2013/14 (1 April 2013 – 31 March 2014) where available, or later data in some cases. Some of the layout of information has been changed from the original document following feedback. Table numbers have changed where extra tables have been added in or removed.

In 2015 it will be decided which other service areas (e.g. Children's Services- see Appendix 2) should be included in an updated Market Position Statement document. Appendix 2 includes the Children's Sufficiency Plan and Commissioning Strategy.

Key to abbreviations/terms used

CQC	Care Quality Commission
TSDHCT	Torbay and Southern Devon Health and Care NHS Trust
Under 5	This is used where figures relating to clients are 1-4, to protect identity
Over 5 **Over 10**	This is used in some cases where figures relate to clients to protect identity

1. Residential and nursing care homes

Table 1: Number of Torbay Local Authority supported permanent admissions to residential and nursing care during the year, split by age

Excludes admissions to group homes, full cost, Funded Nursing Care, Continence Care and Continuing Care contracts

Includes clients transferring from temporary to permanent care during the year

Year of admission	Number of admissions- by age at admission				Total
	18- 64 years	65-74 years	75-84 years	85 years and over	
2010/11	49	17	62	125	**253**
2011/12	31	21	65	104	**221**
2012/13	25	24	64	142	**255**
2013/14	29	20	64	117	**230**

Source: TSDHCT,

Table 2: The figures in the above table are shown as percentages in the table below

Year of admission	% of admissions- by age at admission				Total
	18-64 years	65-74 years	75-84 years	85 years and over	
2010/11	19.4%	6.7%	24.5%	49.4%	**100%**
2011/12	14.0%	9.5%	29.4%	47.1%	**100%**
2012/13	9.8%	9.4%	25.1%	55.7%	**100%**
2013/14	12.6%	8.7%	27.8%	50.9%	**100%**

Source: TSDHCT

Table 3a and 3b: Number of Torbay care homes split by their number of CQC registered beds

Please note: The number of beds will in some cases be higher than actual availability if a care home has let double rooms to single occupants or has chosen to operate at a lower than registered number.

Table 3a. As on 2 December 2013

Care home type	Number of homes with 25 beds and under	Number of homes with 26-50 beds	Number of homes with 51 beds and over	Total
Residential care	59	27	0	**86**
Nursing care	3	11	3	**17**
Total	**62**	**38**	**3**	**103**

Source: TSDHCT

Table 3b. As on 18 September 2014

Care home type	Number of homes with 25 beds and under	Number of homes with 26-50 beds	Number of homes with 51 beds and over	Total
Residential care	58	27	0	85
Nursing care	3	11	3	17
Total	**61**	**38**	**3**	**102**

Source: TSDHCT

Table 4a and 4b: Number of Torbay care homes, split by their CQC registered age ranges

Table 4a. As on 2 December 2013

Care home type	Number of homes- by registered age range		Total
	18-64 years	65 years and over	
Residential care	29	57	**86**
Nursing care	2	15	**17**
Total	**31**	**72**	**103**

Source: TSDHCT

Table 4b. As on 18 September 2014

Care home type	Number of homes- by registered age range		Total
	18-64 years	65 years and over	
Residential care	30	55	**85**
Nursing care	2	15	**17**
Total	**32**	**70**	**102**

Source: TSDHCT

Table 5: CQC registered care homes in England, as on 31 March of the year

Figures for the year 2014 have not been released at time of writing

Year	2012		2013	
Care home type	**Number**	**% split**	**Number**	**% split**
Residential care	13,134	74%	12,848	73%
Nursing care	4,672	26%	4,664	27%
Total	**17,806**		**17,512**	

Source: The state of health care and adult social care in England 2012/13, CQC, November 2013

Table 6: CQC registered care homes in Torbay, as on 31 March of the year

Year	2012		2013		2014	
Care home type	**Number**	**% split**	**Number**	**% split**	**Number**	**% split**
Residential care	92	84%	88	83%	86	83%
Nursing care	18	16%	18	17%	18	17%
Total	**110**		**106**		**104**	

Source: TSDHCT

Table 7: CQC registered care beds in England, as on 31 March of the year

Figures for the year 2014 have not been released at time of writing

Year	2012		2013	
Care bed type	**Number**	**% split**	**Number**	**% split**
Residential care	247,824	53%	244,232	53%
Nursing care	215,463	47%	218,678	47%
Total	**463,287**		**462,910**	

Source: The state of health care and adult social care in England 2012/13, CQC, November 2013

Table 8: CQC registered care beds in Torbay, as on 31 March of the year

Year	2012		2013		2014	
Care bed type	**Number**	**% split**	**Number**	**% split**	**Number**	**% split**
Residential care	1,915	76%	1,835	74%	1,848	74%
Nursing care	608	24%	652	26%	658	26%
Total	**2,523**		**2,487**		**2,506**	

Source: TSDHCT

1.1. Residential care homes

Table 9: Number of residents supported by Torbay Local Authority in residential care placements as on 31 March of the year, split by primary client type and age group

Includes temporary and permanent placements
Excludes fully self-funded, Health funded

	Physical disability		Mental health		Learning disability		Substance misuse and older vulnerable people			
Year	**18-64 years**	**65+ years**	**18-64 years**	**65+ years**	**18-64 years**	**65+ years**	**18-64 years**	**65+ years**	**Age unknown**	**Total aged 18+ years**
2011	16	296	62	192	119	29	Under 5	0	Over 10	739
2012	11	273	63	173	110	27	Under 5	0	Over 10	679
2013	12	234	59	219	101	30	Under 5	0	Over 10	674
2014	10	239	58	213	95	31	Under 5	0	Over 10	663

Source: Adult Social Care Combined Activity Return, TSDHCT

1.2. Nursing care homes

Table 10: Number of residents supported by Torbay Local Authority in nursing care placements as on 31 March of the year, by primary client type and age group

Includes temporary and permanent placements
Excludes fully self-funded, Health funded

There were errors in the table published in the original Appendix 1 of the Market Position Statement- within the 2011 and 2013 rows although the totals remain the same. These are rectified in the table below.

Year	Physical disability		Mental health		Learning disability		Substance misuse and older vulnerable people		Age unknown	Total aged 18+ years
	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years		
2011	11	70	0	8	0	0	0	0	Under 5	**90**
2012	8	62	0	7	0	0	0	0	Under 5	**79**
2013	7	53	Under 5	15	0	0	0	0	Under 5	**78**
2014	6	41	Under 5	23	0	0	0	0	Under 5	**74**

Source: Adult Social Care Combined Activity Return, TSDHCT

2. Independent hospitals

Please note: This section was known as 'Private hospitals' in the Market Position Statement document and original Appendix 1.

Table 11: Number of inpatients (adults) in independent hospitals in Torbay

On 13 August 2013 there were 3 independent hospitals, reducing to 2 independent hospitals by 19 September 2014.

Time period	Current number of inpatients	Number of those funded by South Devon and Torbay Clinical Commissioning Group	Number of bed spaces
As on 13 August 2013	21	17	32
As on 19 September 2014	17	8	27

Source: South Devon and Torbay Clinical Commissioning Group

There were 2 independent hospitals remaining in September 2014. One takes adults aged under 65 with mental health problems including those detained under the Mental Health Act. Another independent hospital took women with mental health and/or learning difficulties but since September 2014 has changed usage. Other

independent hospital provision has also changed usage in the last year. This has left a gap in service provision for adults, particularly women, with mental health and/or learning disabilities, particularly those with more complex needs.

3. Housing

Table 12: Tenure of housing in Torbay compared to England

EHCS- English House Condition Survey

Tenure	Dwellings 2011	Percent 2011	Torbay 2009	Torbay 2008	Torbay 2006	EHCS 2008
Owner occupied	44,870	70.1%	71.8%	71.8%	72.0%	68%
Privately Rented	13,950	21.8%	19.6%	19.4%	19.7%	14%
Housing Association (RSL)	5,160	8.1%	8.6%	8.8%	8.3%	8%
Local Authority*	0	0.0%	0.0%	0.0%	0.0%	10%
Total	**63,980**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Torbay Private Sector House Condition Survey 2006/2008/2009/2011

** Local authority figures are shown here for comparative purposes. Torbay's Council housing stock has been transferred and therefore forms part of the RSL figures.*

Table 13: Number of Torbay households living in temporary accommodation as on 31 March of the year

Year	Number of households
2008	183
2009	164
2010	107
2011	43
2012	43
2013	36
2014	57

Source: Housing Options Team, Torbay Council

Table 14: Number of applicants accepted as homeless by Torbay Council during the year

Year	Number of applicants
2007/08	109
2008/09	106
2009/10	109
2010/11	58
2011/12	57
2012/13	75
2013/14	56

Source: Housing Options Team, Torbay Council

Table 15: Number of housing advice enquiries made to Torbay Council during the year

No later information is available as recording systems have changed

Year	Number of enquiries
2009/10	12,018
2010/11	16,013
2011/12	19,694
2012/13	19,721
2013/14 (Quarter 1)	7,225

Source: Housing Options Team, Torbay Council

Table 16: Number of detailed homeless prevention cases started by Housing Options Team, Torbay Council, during the year

Detailed prevention work is started with a client if there is additional work that can be carried out to prevent homelessness after the initial interview with Housing Options Team and if the case is not immediately progressed onto becoming a homeless application.

Year	Number of cases
2009/10	370
2010/11	557
2011/12	511
2012/13	612
2013/14	702

Source: Housing Options Team, Torbay Council

Table 17: Number of families placed in emergency temporary accommodation by Torbay Council during the year

The figures below show a significant increase. This could be due to varied factors such as: the reduction in prevention and early intervention services across statutory and non statutory services due to budget reductions, recession and welfare reforms impacting on vulnerable people. Homelessness/housing issues have been slowly increasing across the country.

This information is no longer recorded

Year	Number of families
2011/12	106
2012/13	124
2013/14 (April – December 2013)	270

Source: Housing Options Team, Torbay Council

Table 18: Number and % of homeless applications and acceptances by Torbay Council during the year

Year	Number of applications	Number of acceptances	% of acceptances
2012/13	382	75	19.6%
2013/14	490	56	11%

Source: Housing Options Team, Torbay Council

Table 19: Number of Torbay households on the Devon Home Choice waiting list for social housing, who stated a wish to live in Torbay

This includes households identified as residing in Torbay, with a housing need (placed in band A- Emergency housing need, B- High housing need, C- Medium housing need, or D- Low housing need) who stated a wish to live in Torbay.

Please note: In the Market Position Statement document and original Appendix 1, the figure shown for 6 November 2013 is much higher than the figure below, at 3107 households. This is because it also included households who resided outside of Torbay who wished to live in Torbay, and included households in Band E- No housing need. The register has now been changed to no longer include households with no housing need.

Time period	Number of households
As on 6 November 2013	1,345
As on 10 September 2014	1,445

Source: Torbay Council

Table 20: Low cost housing in Torbay- completed by private registered providers (PRPs) of social housing, as on 31 March of the year

PRPs of social housing are registered with the Social Housing Regulator excluding Local Authority registered providers. Accommodation can be both owned and managed by a PRP so the figures in each column cannot be summed.

*Owned/ managed by PRPs

Year	General needs- Self contained- Owned* low cost rental accommodation	General needs- Bed space (non self contained)- Owned* low cost rental accommodation	General needs- Self contained- Managed* low cost rental accommodation	General needs- Bed space (non self contained)- Managed* low cost rental accommodation	Housing for older people- Owned* low cost rental accommodation (units/ bed spaces)	Housing for older people- Managed* low cost rental accommodation (units/ bed spaces)
2013	3,931	73	3,934	0	884	735
2014	4,018	73	4,018	73	989	840

Source: Homes and Communities Agency statistical returns for 2013 and 2014. For the full returns visit: https://nroshplus.homesandcommunities.co.uk

4. Personal and non personal care

Table 21: Number of Torbay adults receiving home care (personal and non personal care) during the year, split by primary client type and age

Excludes fully self-funded, Health funded, services deemed to mainly benefit carer

	Physical disability		Mental health		Learning disability		Substance misuse and older vulnerable people		Total aged 18+ years
Year	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	
2010/11	184	829	27	108	82	19	34	66	**1,349**
2011/12	167	845	10	121	99	24	34	40	**1,340**
2012/13	160	792	11	169	107	22	44	39	**1,344**
2013/14	148	753	12	166	111	23	53	47	**1,313**

Source: Referrals, Assessments and Packages of Care Return, TSDHCT

5. Social care re-enablement

Table 22: Number of referrals (people aged 18+) to re-enablement (Intensive Home Support Service) service in Torbay during the year

This service started in 2012/13

Year	Number of referrals
2012/13	6,600
2013/14	6,396

Source: TSDHCT

6. Equipment and adaptations

Table 23: Number of Torbay adults receiving equipment and adaptations during the year, split by primary client type and age

Excludes fully self-funded, Health funded, services deemed to mainly benefit carer

Year	Physical disability		Mental health		Learning disability		Substance misuse and older vulnerable people		Total aged 18+ years
	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	
2010/11	553	2,224	21	149	35	13	62	209	**3,266**
2011/12	532	2,240	19	168	43	8	41	95	**3,146**
2012/13	572	2,109	16	207	49	14	49	93	**3,109**
2013/14	528	2,181	22	206	69	13	44	95	**3,158**

Source: Referrals, Assessments and Packages of Care Return, TSDHCT

7. Disabled Facilities Grants

Table 24: Number of referrals (for all ages) for Disabled Facilities Grants in Torbay during the year, split by tenure of the client

Year	Owner Occupier	Private Tenant	Housing Association Tenant	Total
2010/11	75	7	35	**117**
2011/12	76	18	35	**129**
2012/13	71	21	42	**134**
2013/14	61	23	43	**127**

Source: Torbay Council

Table 25: Cancellation of Disabled Facilities Grant applications in Torbay (for all ages) during the year, split by the tenure of the client

High numbers of cancellations in 2013/14 are probably due to 'housekeeping' as there was a change in contract from 1 April 2014

Year	Owner Occupier	Private Tenant	Housing Association Tenant	Total
2010/11	20	Under 5	Over 5	**27**
2011/12	17	Over 5	Under 5	**28**
2012/13	20	9	6	**35**
2013/14	31	12	12	**55**

Source: Torbay Council

Table 26: Completed works (for all ages) using Disabled Facilities Grants in Torbay during the year

Works signed off and paid for during the year. Some clients may have had more than one element of work carried out e.g. bathroom and stair lift, so will appear more than once in this table. The referral date could well be in a different year.

Year	Stair lift	Access (ramps, widen doorways etc)	Bathroom	Other (Hoist, Extensions, Kitchen)	Total
2010/11	23	21	93	5	**142**
2011/12	26	12	70	5	**113**
2012/13	23	8	71	7	**109**
2013/14	21	15	67	Under 5	**106**

Source: Torbay Council

8. Employment support

Table 27: Number in Torbay using a supported employment service which supports people with poor mental health

There are 3 services which provide employment support in Torbay. The table below shows figures for 1 of these services which works to support people with mental health needs.

Numbers have increased significantly. This could be due to increased marketing and a shop front provision in Torquay.

Year	Number supported in the year	Number entering the service
2012/13	77	37
2013/14	113	72

Source: Supported employment service

9. Rapid response

Table 28: Number of visits in Torbay (to people aged 18+) by the Crisis Response Team during the year

Year	Number of clients
2010/11	4,384
2011/12	4,244
2012/13	5,334
2013/14	4,794

Source: TSDHCT

10. Day activities

Table 29: Number of Torbay adults receiving day care in during the year

Excludes fully self-funded, Health funded, services deemed to mainly benefit carer

	Physical disability		Mental health		Learning disability		Substance misuse and older vulnerable people		Total aged 18+ years
Year	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	
2010/11	29	182	Under 5	60	159	15	Over 5	14	**472**
2011/12	26	153	Under 5	49	154	7	5	Over 10	**409**
2012/13	13	115	Under 5	66	147	7	11	Over 5	**369**
2013/14	12	85	0	45	133	6	6	5	**292**

Source: Referrals, Assessments and Packages of Care Return, TSDHCT

11. Meals services

Table 30: Number of Torbay adults receiving meals during the year

Excludes fully self-funded, Health funded, services deemed to mainly benefit carer

	Physical disability		Mental health		Learning disability		Substance misuse and older vulnerable people		Total aged 18+ years
Year	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	
2010/11	19	234	Under 5	29	Under 5	Under 5	10	20	**315**
2011/12	11	190	Under 5	33	Under 5	0	6	9	**253**
2012/13	13	120	Under 5	38	Under 5	0	Under 5	Under 5	**181**
2013/14	5	71	Under 5	28	Under 5	0	Under 5	5	**114**

Source: Referrals, Assessments and Packages of Care Return, TSDHCT

12. Night sitting

Table 31: Number of Torbay clients (people aged 18+) receiving night sitting domiciliary care services during the year

Excludes fully self-funded, Health funded

Year	Number of clients
2010/11	12
2011/12	23
2012/13	32
2013/14	47

Source: Referrals, Assessments and Packages of Care Return, TSDHCT

13. Respite services

Table 32: Number of Torbay clients (people aged 18+) receiving respite services during the year

Please note: Figures for all years have been updated since the Market Position Statement and original Appendix 1 was published.

Excludes fully self-funded, Health funded

Year	Number of clients
2010/11	592
2011/12	582
2012/13	591
2013/14	598

Source: Referrals, Assessments and Packages of Care Return, TSDHCT

14. Personal assistants

A voluntary sector organisation helps people with employing and managing the payroll of a personal assistant/carer to provide support to live independently.

Table 33: Number of Torbay adults supported to employ a personal assistant/carer

Time period	Number of clients
As on 19 August 2013	166
As on 12 September 2014	173

Source: Voluntary sector organisation

15. Intermediate care

Table 34: Number of referrals- (people aged 18+) both urgent and non-urgent- to intermediate care service in the Torbay locality during the year

Year	Number of referrals
2010/11	3,074
2011/12	2,486
2012/13	2,294
2013/14	2,022

Source: TSDHCT

16. Community nursing

Table 35: Number of visits (to people aged 18+) by community nurse staff in the Torbay locality during the year

The proportion of visits to care homes is approximate because the first column showing visits to care homes excludes community matrons whereas the second column showing overall number of visits includes matrons.

Year	Number of community nursing (excluding matron) visits to care homes in Torbay	Overall number of community nursing visits in the Torbay locality (Community Matrons, Community Nurses, Specialist Nurses, Assistant Practitioner and Support Workers for Intermediate Care (SWIC)	Approximate proportion of community nursing visits to care homes in Torbay
2010/11	25,042	105,644	23.7%
2011/12	24,615	109,976	22.4%
2012/13	22,662	105,039	21.6%
2013/14	23,088	109,089	21.2%

Source: TSDHCT

17. Support services (previously known as Supporting People services)

Table 36: Number of people aged 16+ entering a short term support service (previously known as Supporting People services) in Torbay during the year, split by service type

Services are funded by Torbay Council. Clients use these services for between approximately 13 weeks and 2 years. Numbers entering services reduced in 2013/14 as some services closed in May 2014 due to Council budget decisions in response to central Government funding reductions.

Year	Services for children, families, young people, and domestic abuse	Services for older people	Services for single homeless, substance misuse, (ex) offenders, learning disability, mental health, and other needs	Total
2010/11	221	79	708	**1,008**
2011/12	317	112	593	**1,022**
2012/13	457	79	708	**1,244**
2013/14	453	56	608	**1,117**

Source: Torbay Partnership Commissioning Team and Centre for Housing Research, St Andrews University

Longer term services are also funded by Torbay Council that are often a permanent home for residents. As on 3 October 2014, 109 units of long term supported accommodation were funded- 84 of these were rented extra care accommodation where support and care are provided to help people live independently (the figure excludes shared ownership properties). Elements of the support worker/ alarm support in sheltered housing for older people have been funded in the past- as of March 2014 all Torbay Council funding for this type of service was withdrawn.

18. Advocacy services

Table 37: Referral of Torbay residents (people aged 18+ and a very small number of 16-17 year olds) to advocacy services during the year.

Year	Number of referrals
2010/11	196
2011/12	287
2012/13	318
2013/14	331

Source: Advocacy service providers

19. Community based short breaks

Table 38: Number of Torbay adults receiving short term residential care (not respite) during the year

Excludes fully self-funded, Health funded, services deemed to mainly benefit carer

Year	Physical disability		Mental health		Learning disability		Substance misuse and older vulnerable people		Total aged 18+ years
	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	18-64 years	65+ years	
2010/11	30	99	10	57	12	Under 5	Over 10	13	**239**
2011/12	16	124	0	27	Under 5	0	7	Under 5	**180**
2012/13	7	105	Under 5	56	Under 5	Under 5	13	5	**191**
2013/14	11	134	Under 5	55	6	Under 5	Over 10	9	**231**

Source: Referrals, Assessments and Packages of Care Return, TSDHCT

Appendix 2

Torbay Council's

Children's Commissioning Plan and Sufficiency Strategy. 2014-2019

Children and Young people's Placements

Contents

Introduction

The purpose of the Children's Commissioning Plan and Sufficiency Strategy is to set out how Torbay Council will meet the commissioning of services to meet the needs for children, young people and families requiring services provided by Torbay Council. Additionally the placement needs of current and future children in care and care leavers are identified in light of our understanding of their needs and current provisions.

This document sets out the current position and identifies the next steps that Torbay Council plans to take in order to commission services for children, young people and families. Torbay Council also to manage children's placement needs more effectively and achieve our aspiration to ensure sufficient local provision to enable choice and value for money.

In Torbay we endeavour to carefully match using a range of measures including the type and location of available placements to the needs of individual children. However we do currently need to place children outside of Torbay on occasions where an appropriate resource isn't available locally. In order to reduce this number we need to ensure there is sufficient choice of placements on offer to meet the needs of children and young people in Torbay.

This document is set within the context of national policy, legislation and guidance. It is linked to key local documents, in particular to Torbay Children and Young Peoples Plan 2019, Torbay Early Help strategy 2014, submitted to Health and Well Being Board June 2014 and Children's services 5 Year Forward Strategy June 2014.

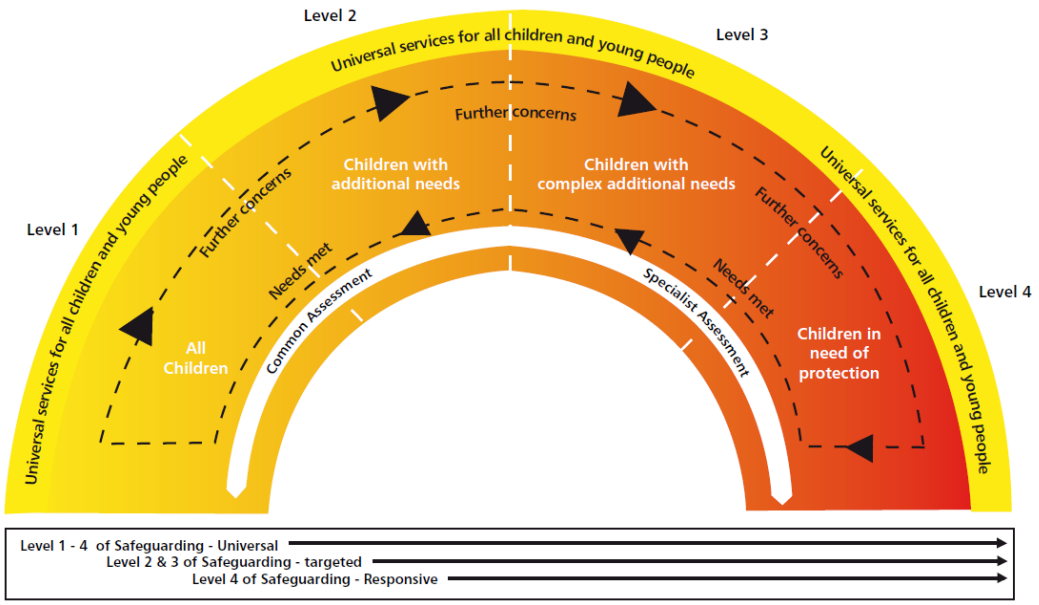
Local Authorities are required to take steps to secure, so far as is reasonably practicable, sufficient accommodation for children in care within their local area. In 2010, the Statutory Guidance for the Sufficiency Duty was issued. This guidance is explicit in placing a duty on Local Authorities to act strategically to address gaps in provision by ensuring that they include, in relevant commissioning strategies, their plans for meeting the sufficiency duty.

We know from research that maintenance of existing family ties, friendships and education, wherever possible, is crucial and significantly impacts on the likelihood of positive outcomes for

children. Local provision also makes it easier to 'wrap' services around children using local statutory and other services from a range of agencies in order to achieve better outcomes.

The Commissioning approach is supported by the newly formed joint commissioning partnership to ensure integration of Adults, Children and CCG Commissioning, a shared understanding, response and commitment to an effective partnership approach that secures good quality provision to meet local need.

The Children Act 2008 defines Sufficiency as "a whole system approach which delivers early intervention and preventative work to help support children and their families where possible, as well as providing better services for children if they do become looked after. For those who are looked after, Local Authorities and their partners should seek to secure a number of providers and a range of services, with the aim of meeting the wide-ranging needs of looked after children and young people within their local area."



However, the scope is not restricted to just making good quality placements; the intention is to co-ordinate the range of activity across Children's Services, including a clear focus on supporting families to stay together, wherever it is safe to do so, thus minimising the need for children to come into care, or supporting their timely return to their families.

The reduction in the level of funding for Local Authorities means that the focus on efficiency and value for money will be stronger than before. The challenge alongside this for Local Authority Children's Services will be to sustain or improve on service quality and good outcomes for service users.

To ensure that successful outcomes for young people are sustained, and the investment in placements by Children's Social Care is effective, it is important that we help young people to make smooth transitions from placements into independence, or into adult social care or other services.

The interface between adult and children's social care and other services is critical to the achievement of adult independence for our children and young people.

Working to ensure placements remain stable is also crucial as we know stability impacts significantly on outcomes. We also know that a child's different levels of complexity of need and challenging behaviours crucially affects what type of placement is needed and available, as well as the likely outcome. Torbay is developing a therapeutic model of intervention to provide alternatives to care for adolescents where their behaviour and the family dynamic is the primary factor for accommodating them and also for those who could be re-united with their families. Investing in multi agency assessments and more effective support services has been successful in meeting the needs of families and children earlier and therefore the numbers of children coming into care has reduced in contrast to regional and national trends. However our Looked After Children LAC population has grown 17% per year since 2010/11 and over the past 4 years spend on placements for LAC has increased by £8.4m. We have seen an increase in demand from Older Children and Parent and child need. Finding, in particular, that we are placing these parents in residential units in order to assess their parenting capacity, but then having insufficient local provision to enable a return to a supported unit.

This strategy addresses the needs of children and young people from birth to the age of 21, (or 25 where children's services continue to have statutory responsibility) including children and young people with disabilities who are, or who may be, accommodated. It meets the requirements of the sufficiency duty by collating needs and resource information and market analysis but also describes what needs to happen in relation to work with children in care or children at risk of coming into care.

The Commissioning and Sufficiency plan has identified **Six Strategic objectives**, all of which focus on reducing the numbers of children in our care where safe to do so, and using our resources in the most efficient and cost effective way. We have also identified key delivery activity for each objective.The document also includes some impact measures which will be monitored to evidence progress on delivery.

Strategic objectives and activity:

1. **To support Children and Young People to remain safely within their family/ community. Improve early help offer, and support Looked After Children (LAC) to return to live with their families as soon as possible and where it is safe to do so.**

We will deliver by :

- Providing access to early intervention and prevention services commissioned through our Early Help Strategy.
- Review our Children's Centres to ensure they target services for our most vulnerable families and extend the functional role and brief to support siblings of Under 5s up to age 11, whilst retaining their core offer and focus on universal provision.
- Align our work with the Troubled Families programme aimed at supporting families with multiple needs
- Identify new investment and re- commissioning opportunities to create new initiatives for preventing the need for care.
- Commission a New CAMHS provision to include Child Sexual Exploitation and Sexually Harmful Behaviour and Self Harm
- Development of the Children's Community Hub
- Work with adults to improve access to drug/alcohol, misuse services
- Identify increasing numbers of extended family members or kinship network who have capacity to provide care.
- ensure that suitable provision is developed for 16 to 17 year old young people who become homeless.
- Develop a to increase the use of Staying Put provision
- Review use and cost of remand provision for young people

This contributes to CYPP Priority: Children Have the Best Start in Life, and Children and Young People will be safe from harm, living in families and Communities.

Children's Service Forward Strategy: Right Child. Right place Right Time Better Outcomes in the Community

Children's needs are best served in their own families if this can be safely supported. Helping families stay together must therefore be a key focus for all Children's Services. Early identification of need and effective early intervention is essential. Early intervention and prevention services can reduce the number of children and young people reaching the threshold for care and needing to become LAC, avoid repeat entry into care or support them to return safely to their families in a timely manner.

We must manage risk effectively with families that are approaching the threshold for care, and work to ensure the right children come into care at the right times, and are supported to leave at the right time. We will provide a range of effective interventions which support families to make changes whilst always ensuring that children and young people are kept safe.

2. **To provide and commission the right mix of placements and support locally where possible to meet identified needs of children who are or may become Looked After (recognising that in some cases placements beyond a 20 mile radius in residential settings may be a positive option) as cost effectively as possible; the services provided should contribute positively to improving outcomes, maximising the child's potential and improve stability.**

We will deliver by:

- Recruit more in-house foster carers with the right combination of skills to meet the needs of children and young people in our care.
- Explore the use of KEEP + Intervention provision for carers
- Work in partnership with Independent Fostering Agencies, to negotiate the best possible price with them for existing placements, and commission future placements through the Preferred Provider Framework which will achieve efficiencies through reduced unit costs and inclusion of support services
- Review the role of Access to Resources, Permanence and SEN/ DIS panels to promote greater understanding of need and improve placement commissioning both in-house and external.
- Put in place a performance monitoring process to establish a better understanding of the needs of children coming in and out of care on a monthly basis, and to monitor the use of in-house and external placements. Role of review officer's feedback on placements to be improved.
- Specifically commissioning services to meet the needs of children and young people requiring specialist provision including parent and child placements complex residential placements and placements for Children with Disabilities.

This contributes to: CYPP Priority: Children and Young People Lead a Healthy and Happy Life, Children have the best start in life

Children's Services Forward Strategy: Right Child, Right Place, Right Time Efficiency and effectiveness, Performing Better as a Team

We need to be sure that we have the right range of placements to meet the assessed needs of Looked After Children. As a result of rising numbers of Children in Care, we do not currently have enough capacity in our in-house fostering service to meet the statutory requirements of placing within 20 miles of their homes. This means we have increased our use of Independent Fostering Placements. We particularly need foster carers who can manage challenging and risk taking behaviour, provide care for sibling groups and disabled children, and placements of parents and child.

3. **To plan effectively for Looked After Children to ensure they have stability and permanence, do not remain in care longer than is necessary and leave care positively. In particular supporting a successful transition into adulthood, and increasing permanent placement choices in fostering and adoption.**

We will deliver by:

- Focus on improving social work practice in relation to assessment and outcome based Care Planning, direct work with children, and management oversight of this work.
- Work closely with our partners to ensure the right support services from education, CAMHS, health and other universal and early intervention services are available to LAC, in order to prevent unnecessary placement breakdown, and meet identified needs.
- Promote detailed transition plans and develop services which enable successful transisitons to adulthood

This contributes to: CYPP Priority: Children and Young People lead a Healthy and Happy Life, Opportunities to participate and engage in community life
Children's Services Forward Strategy: Right Child. Right place Right Time, efficiency and effectiveness, Performing Better as a Team

Having a clear Care Plan in place is essential for children and young people in care, not only to ensure that they come into and exit care at the right times, but to meet our statutory obligations under the Care Planning Regulations. We need to ensure that children do not 'drift' through care, but have clearly-planned processes which allow them to be reunited with family and friends where possible, have stable, supported and well matched placements with alternative carers and exit the care system in a timely and positive way at whatever age this happens.
In order to support this we will:

4. **To continue regional partnership working, and increase local provider offer to improve the quality of placement provision so that the aspiration to use only Ofsted graded good or outstanding provision is eventually achieved.**

We will deliver by:

- Providing regular reports for all Looked After Children placed in Torbay, including provider Ofsted status
- Regularly inspect and review all providers
- Use regional partnership working to effectively understand the quality of provisions and the areas in which they are most skilled
- Review the provision for SEN
- Continue partnership conversations to develop further local joint commissioning opportunities.

This contributes to: CYPP Priority: Right Child, Right place, Right time, Children and Young People lead a Healthy and Happy Life,
Children's Services Forward Strategy: Right Child. Right place Right Time, Better Outcomes in the Community, efficiency and effectiveness, Performing Better as a Team

5. **To ensure we achieve, value for money, effective contract management, flexibility of provision and Quality**

We will deliver by:

- Reviewing the Placement process, to ensure clear accountability, quality assurance and robust contract management is in place for all contracts.
- Ensuring the IPA element of the contract are completed monitored and assessed again quality and compliance measures. Appointing a Peninsula Consultant to undertake bench marking and value for money analysis on all providers within the peninsula region
- Continue to participate in the Peninsula Partnership to ensure appropriate Market development and framework provision to meet need.
- Gain feedback from social workers and IRO service on service providers and quality based on outcomes for children and young people

This contributes to: Children's Services Forward Strategy: Right Child. Right place Right Time, efficiency and effectiveness, Performing Better as a Team

6. **Embed an approach that provides quality information to children, young people and families, carers and professionals and recognises and encourages feedback.**

We will deliver by:

- Work with providers to ensure good communication and information sharing
- Ensure the voice of the child is part of placement provision decision process, and that they understand reason for placement
- Development of the role of community directory and co – production of Torbay wide information and Advice Services
- Development of the Children's Community Hub

This contributes to: CYPP Priority: Children Have the Best Start in Life, Children and Young People lead a Healthy and Happy life, Children and Young People will be safe from harm, Living in families and Communities, Opportunities to participate and engage in community and public life.
Children's Services Forward Strategy: Right Child. Right place Right Time

Corporate Parenting

When they are elected, all councillors take on the role of 'corporate parent' to children looked after by their local authority. They have a duty to take an interest in the wellbeing and development of these children, as if they were their own. Although the lead member for children's services has particular responsibilities, the role of corporate parent is carried by all councillors, regardless of their role on the council. In Torbay the corporate parenting group meets regularly and meetings are held in two forums, the officers group and the members group. The groups take a very active interest in the quality of placements offered to children looked after by Children's Social Care. Senior Children's Social Care Managers meet with the group and report on current issues affecting children in care. Feedback on children and young peoples achievements are given to the group.

The Voice of the Child

Our commissioning and sufficiency strategy places the voice of the child at the centre of its activities, for all services established for children and young people, we take account of the views of those they are designed to serve. This means not only asking what services should look like, but also obtaining feedback about the experiences of using those services and considering how this feedback then creates a loop back into commissioning. Torbay's Participation Strategy supports the voice of the child at all levels of need and seeks to embed service design, delivery and feedback, with particular focus on listening and enabling those children and young people involved in our Child in Need, Child Protection and Children Looked After Services.

The Peninsula Procurement and Commissioning Partnership Current Arrangements

Torbay is a member of the Peninsula Commissioning and Procurement Partnership for children and young people's placements which is a longstanding collaboration between Cornwall Council, Devon County Council, Plymouth City Council, Somerset County Council, and Torbay Council.

Member authorities have an agreement to collaborate on the commissioning and procurement of independent sector foster care, children's homes and residential and day independent special school placements. These authorities have jointly tendered for services since 2009 and co-operate on the monitoring of the quality of provision undertaking joint site visits and investigations.

In 2012/13 the partnership started a major procurement exercise to retender the suite of Open Framework Agreements which underpin the commissioning of children's homes, day and residential special schools and fostering agencies provided by the independent sector.

The Peninsula frameworks retender opportunity will be open several times a year for new applications until March 31st 2017 in order to increase supply.

Once a provider is awarded a framework contract the provider is approved to supply individual placements to all five authorities, these are accessed using Individual Placement Agreements and contracts. In 2013 a new type of provision is being included for the first time which focuses on the delivery of accommodation and support for 16-25 year olds, with a specific focus on 16 -18 year old care leavers and those who meet Local Authority thresholds. Devon, Plymouth and Torbay will be the three authorities using this framework list currently.

Other Joint Commissioning

There are a small but significant number of placements for children and young people that are jointly funded by health or education, usually because of the high level of complex need and challenging behaviour of the children concerned. Torbay also commissions some services jointly with individual or groups of Peninsula member authorities where all the five member authorities do not wish to participate. Plymouth initiated a joint cost and volume contract for fostering with Devon and Torbay which has delivered significant savings

The Torbay Needs and Options Appraisal Process

The Peninsula Commissioning and Procurement Partnership Framework Agreements do not commit Torbay Council to expenditure with the suppliers on the framework. This commitment is only made when individual placement contract decisions are made. The Torbay needs and options appraisal system ensures that for all new placements, or placement moves, mini competitions are undertaken. This allows value for money judgements to be made at the point when each placement decision is made. Through improving market management, the availability of alternative placements is improving, and this is increasing our ability to improve quality and secure savings over time.

However it is important to note that wherever we are not able to secure a placement in Torbay this leads to a move for children away from family and friends as well as possibly a move of school. Placement stability is known to be key in attaining good educational and other outcomes for children. So Torbay is starting work with providers locally and in conjunction with the peninsula to improve placement supply closer to Torbay, as well as reducing the number of placement breakdowns that can then lead to out of area placements, to reduce disruption caused to established networks and schooling for a child or young person. Torbay is undertaking a review of the Placement Process to reflect the increase use of in house Foster placements and improve, accountability, quality and monitoring.

Deprivation

2009 figures show that just under one quarter (24.3%) of children under the age of 16 live in poverty across Torbay, this is higher than the England average of 22.0%. However, across Torbay's most deprived communities the proportion of children living in poverty is much higher again. The difference in life expectancy is as much as 7 years between our most deprived and most affluent wards.

Hotspots of child poverty, multiple deprivation, high levels of crime and unemployment are well documented locally in Tormohun, Ellacombe, Roundham with Hyde and Watcombe. However, within the wards of Blatchcombe and St Mary's with Summercombe there are pockets of deprivation and high proportions of children living in poverty.

Ethnicity

So far Torbay has not encountered difficulties in placing children due to particular ethnic needs.

Further research to be completed/ added.

Children with Special Educational Needs and or Disabilities

A recent change in legislation within Special Education Needs has developed how children are identified as in need. Previously a statement of Special Educational Needs (SEN) may be offered to students with significant needs and this is now replaced with an Education Health and Care Plan. Torbay is proactively working with this new guidance and promoting more joint working and increase in joint commissioning of services.

The numbers of children with a Special Education Need are quite small but 20.4 % of children in care have a statement. Services to Disabled Children are varied and include a range of services. The commissioning of services to meet the need of children and young people with disabilities is ongoing and focuses on a range of needs. This includes the commissioning of overnight short break services for disabled children.

The fostering service has a specialist role in the recruitment and support of foster carers who provide short breaks to children with disabilities. Further recruitment of foster carers with a range of specialist skills to meet the needs of children with disabilities and special educational needs is actively being undertaken.

Child and Adolescent Mental Health

One in four children will experience some form of emotional or mental health problem during their childhood and given the strong link between inequalities, and child and adolescent mental health the deprivation statistics for some localities are likely to impact on the mental health of children in Torbay. We also understand the increased levels of emotional challenge and trauma that children in care face.

Children living in deprived areas in Great Britain are more than twice more likely to have mental health problems than children in wealthy areas. Children and young people who are looked after and also young offenders have particularly high levels of mental health problems.

Torbay is in the process of writing a CAMHS Service Development Plan. This will be developed following a gap analysis, risk assessment of continuing to meet levels of urgent referrals and impact this may have on thresholds for routine work, and specifically for Looked After children.

Substance misuse

See appendix data

Teenage Pregnancy

Rates of teenage pregnancy in Torbay continue to be on a downward trajectory. A Teenage Pregnancy Partnership Plan is in place, and is currently being refreshed to ensure that we have the right services in place to better target those most vulnerable young people with clearer guidance around sexual exploitation, relationship violence and abuse and to counter low self esteem and aspirations.

Domestic Violence

Domestic violence is a significant feature in the lives of the children that receive support from the council. National research suggests that nearly 70% of children subject to Child Protection plans come from families where there are parental issues with domestic violence, mental health and alcohol and substance misuse. Local audits and research indicate that this is the case in Torbay. The recently commissioned Integrated Domestic Abuse Service, run by Sanctuary Supported Living, started September 2014.

The service also includes:

- Independent Domestic Violence Advisors (IDVAs) working with all high-risk cases through the Multi-Agency Risk Assessment Conference (MARAC)
- Outreach support
- Non statutory voluntary community perpetrator programme
- Support programmes for adults
- Tailored support for children and young people
- A survivors' group, designed to empower and assist participants to recognise an abusive relationship
- A telephone helpline for clients to help combat isolation
- Partner Link Work incorporating the Building Better Relationships Programme (funded by Probation)

Offending

Risk factors that appear to be implicated in the causes of anti-social behaviour and offending relate to individual children, their families, friends and peers, their education, and the neighbourhoods in which they live. The actual numbers of CYP coming to the attention of the criminal justice system through the court process is smaller and historically has significantly reduced from the levels seen 5 years ago. However there are increasing numbers now being dealt with via out of court disposals which allows the Youth Offending Team to intervene at an earlier stage. Whilst the numbers are lower the complexity and risk within the cases is greater.

Early Help: The Early Help Strategy

Torbay published an Early Help Strategy in September 2014. This describes a Partnership commitment to support the identification of early need for support and to co-commission services with local communities that will prevent the escalation of risk and need. Four priorities for Early Help are:

- **Children have the best start in life**
- **Children and young people lead a happy and healthy life**
- **Children and young people will be safe from harm living in families and communities**
- **Opportunities to participate and engage in community and public life**

Those families identified under the `Troubled Families' programme will be at the heart of our Early Help offer. Evidence nationally shows that these families are faced with a minimum of eight complex issues and that, without intensive support to turn them around, are likely to require intensive services at high cost and with increasing risk of poor long-term outcomes.

Children or Young People with High Levels of Complex Need

For children with the most complex needs that Children's Social Care looks after achieving good outcomes is a challenge and trends suggest that the needs of this group are increasing. These children are at risk of developing mental health problems, achieving poor educational outcomes and of experiencing multiple placement breakdowns unless effective interventions by social workers and placement providers working together in a family approach to a clear care plan are effective. CAMHS staff, Children's Social Care, the Virtual Schools team and substance misuse and other providers make significant contributions to care plans for this group of looked after children Torbay has already been successful in encouraging the development of independent sector foster care provision to accommodate children and young people with challenging behaviours and complex needs. We will as part of an invest to save initiative look to develop KEEP + to support foster placements, to further reduce those who would have been living in residential settings in the past. Further work is needed however and Torbay intends to continue this process to increase the number of providers able to offer placements with good outcomes for this group. and also to introduce a therapeutic programme for these young people to enable them to remain at home or to stabilise within a placement.

Secure settings

Secure settings are used very occasionally on welfare grounds for short periods for small numbers of young people and demand fluctuates. The nearest secure children's home is in Exeter and is run by Devon County Council. Torbay use of the welfare secure units is identified on an individual basis when secure accommodation is required for a young person. Any young person secured on criminal grounds (remanded) would be placed by the Youth Justice Board with the nearest facility being in Bristol. Any secure remand would be paid for by the local authority so the Youth Offending Team offer robust alternatives to the court where possible. However, a serious offence committed by more than one person under the age of 15 could potentially cause an upsurge in costs, which can create some volatility in the remand budget.

Parent and child placements

These placements provide accommodation for both parent and child together whilst the parent is being assessed, usually mothers and babies either in a residential setting, community based assessments or foster care. There are five Residential Family Centres registered by Ofsted in the South West, one run by Cornwall County Council and the rest by independent sector providers.

Parent and child foster care is provided by independent sector providers in the community under the cost and volume contract for fostering. Places are sometimes court ordered at short notice. It can be difficult to find placements with prices varying greatly. Some placements require high levels of supervision because of high levels of risk which leads to higher costs.

Torbay is actively recruiting foster carers to provide assessment and placements for Parent and their children within.

16+ pathways to independence

There are a number of placement options open to young people beyond 16, to help them move on from being looked after into independence and adulthood. In 2013 the Peninsula has developed a specific 16+ specification and included these types of placements in the Peninsula tender for the first time.

The Leaving Care Service supports all young people who are eligible to leaving care services from the age of 16. There are a range of placement types and options available to young people ages 16 to 25.

Staying Put is a new initiative link to recent legislative changes which enables young people to remain in their foster placement beyond 18. The placement ceases to be a foster placement and becomes a staying put/supported lodging arrangement, where the young person is expected to contribute towards the cost of the placement, either through earnings or housing benefit.
For in-house placements staying put arrangements are made directly with the foster carer. In the independent sector these are made on a spot purchase basis.
The specification for the Cost and Volume foster contract ties independent sector providers to the principle of offering staying put placements when appropriate. Providers have submitted indicative prices as part of the most recent tender. Work is under way with the Cost and Volume providers to include more detail in the specification.
Supported Lodgings are provided for young people aged over 16 usually purchased using a block contract with a voluntary sector supplier. These are similar to foster placements in that they place the young person in a family setting with a host rather than a foster carer, but are designed to encourage independence skills, with a view to moving the young person into their own accommodation as soon as is practical.
Torbay is currently working on a Prevention of Youth Homelessness Pathway and strategy and will seek to re-commission its local services once this is completed.

The payments consist of a 'rent' payment to the host, a payment to the provider to cover management costs, and a contribution from the young person.

For the first time in April 2013 the Peninsula Framework retender included the above 16+ services in the tender opportunity. An element of the 16 to 25 year old provision is unregulated, so the inclusion of these services will allow the authorities to work together to quality assure these services.

Adoption

Section to be added

CSE

Torbay are signed up to the peninsula framework for CSE and have agreed a set of tools and minimum data set. We are in the process of devising the pathway and protocol to ensure all agencies are clear and engaged in the process. This will give a consistency to the work and a clear pathway for young people to access support and intervention regarding CSE. Large scale police operations can impact on resource and services need to be responsive when needed.

Sufficiency Analysis / next steps Actions

Torbay is meeting the sufficiency duty from the point of view of purchasing placements for children from a range of providers, however closer examination of the market reveals that there is a need to:

- Increase the availability of placements within the Torbay area across a range of placement types.
- improve the quality of some provision, in particular children's homes.
- work with regional partners to increase the options for children if their needs are very specialist and only one provider is available locally.
- increase placement supply within 20 miles radius of Torbay in order to reduce the numbers of children that have to be placed outside of this area so that outcomes are improved for these children and they are nearer family and friends and can remain at the same school if possible. increase placement stability for children and young people.
- increase foster care placements in the following areas:
    - parent and child foster carers;
    - foster carer for sibling groups;
    - risk taking teenagers with complex and challenging needs (such as at risk of substance misuse and/or sexual exploitation and or with behaviour management or mental health issues);
    - children who pose a sexual risk;
    - and children who need to placed away from other children for a period of time.
    - Foster Carers able to take a child in an emergency

Commissioning/ Sufficiency Performance Monitoring

Performance monitoring/ Governance will be overseen by the Corporate Parenting group and Health and Wellbeing Board. The document is included as part of the Market Position Refresh of data as an additional Appendix.

An Action Plan will be developed to support the implementation of the strategy and the key Commissioning Objectives.

The strategy will be updated on an annual basis (within 6 months in first year) to reflect changes in needs or supply information, and respond to emerging policy initiatives.

All partners should be supported to recognise their role in implementation, through leadership, communication, supervision to promote good care planning practice, and clear accountability frameworks.

Key Impact Measures for Commissioning and Sufficiency Strategy Actions

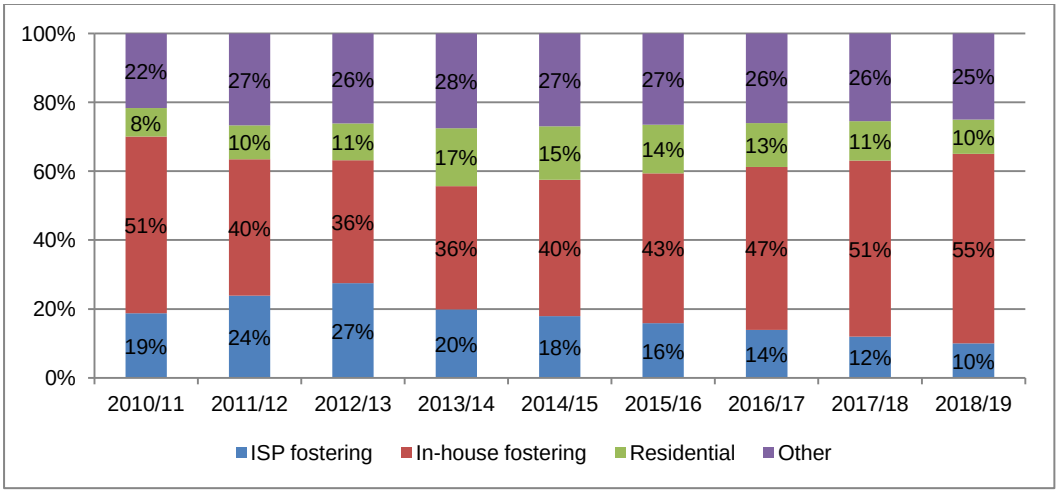
The following impact measures have been identified as the key indicators of the success of the strategy and will be closely monitored and reported on formally every six months for the duration of the strategy, linked to the Business plan.

Financial Year	IN-HOUSE % of CLA	ISP % of CLA	RESIDENTIAL % of CLA	OTHER % of CLA
2014/15	40%	18%	15%	27%
2015/16	43%	16%	14%	27%
2016/17	47%	14%	13%	26%

Overall Number of LAC – 5 year strategy says we will achieve 72 per 10K by March 2019 this equates to 180 (see table below)

Year	Strategy year	Nos in care	Rate per 10K
2014/15	Year 1	305	122
2015/16	Year 2	274	109
2016/17	Year 3	242	97
2017/18	Year 4	211	84
2018/19	Year 5	180	72

Current and Projected Spend on placements with independent providers
Number of Children beginning/ceasing to be LAC per month, by area and age band
Proportion of Residential, In-house Fostering, IFA fostering and supported living placements
As per the 5 year plan



Reduce the number of LAC placed outside of Torbay radius (no officially agreed target with members yet but we are currently above the national average for children placed 20+miles away so we should have a target of reducing this to national levels over the 5 years of the financial plan) –

Year	Strategy year	% placed 20+ miles from Torbay
2014/15	Year 1	23.7
2015/16	Year 2	20.8
2016/17	Year 3	17.9
2017/18	Year 4	15
2018/19	Year 5	12

Numbers of Looked After Children placed for adoption and made subject of SGO (no officially agreed target with members yet but we have agreed with members that our numbers of adoptions need to stay at or above 25/26 and we are just below the national levels for SGO disposals but to stay at or above this would require us to make 30+ SGOs every year)-

Year	Strategy year	SGO's started	
2014/15	Year 1	31	
2015/16	Year 2	26	
2016/17	Year 3	26	
2017/18	Year 4	26	
2018/19	Year 5	26	

Level of capacity, referrals to and actual placements made in in-house foster service

Net gain of in-house foster placements by locality and placement type – plan was to increase the % of fostering placements in house to equal 70% of all those in foster care currently we are at 62%.

Successful independent living for 18 plus year olds – A positive outcome for young people is to remain in their supported lodgings, foster care placements post 18 until they are ready to leave and become independent. Whilst a positive outcome for young people this increases has created a need for more long term foster placements and supported lodgings providers.

Length of time in placements - in principal we need to shorten the average length of placements but this has not been worked up as a target Complaints and quality issues/ changes made to services – link to QA priority work - draft Version 10 22.10.2014

Appendix 1

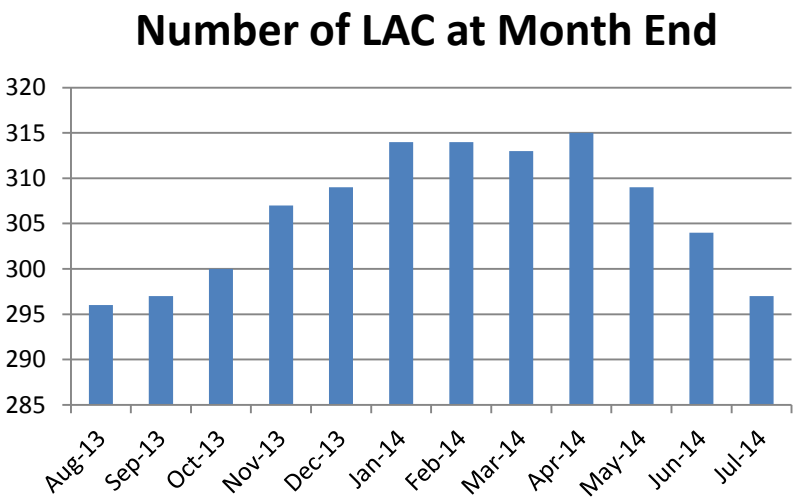
Demand – Referrals to Children's Social Care and Numbers of Children in Care

The number of children being referred to Children Services increased by 10% in 2013/4. The authority receives relatively high numbers of referrals compared to national and regional benchmarks.

Month	Police	Agency	Anon	Education	Health	Housing	LA	Other LA	Prisons	Probation	Other	Total
Jul-13	39	21	23	41	32	2	28	2	0	35	12	237
Aug-13	50	19	31	2	58	2	20	3	0	51	5	242
Sep-13	47	21	14	36	35	4	22	7	0	33	11	232
Oct-13	46	12	4	41	36	2	28	15	2	36	9	235
Nov-13	71	18	1	69	32	1	37	14	0	22	6	271
Dec-13	43	7	6	46	16	0	22	11	2	18	5	176
Jan-14	53	16	6	26	23	1	32	10	0	21	9	202
Feb-14	29	14	2	50	44	1	19	10	2	14	2	187
Mar-14	40	25	14	43	34	0	21	10	0	22	6	216
Apr-14	43	10	19	24	22	1	4	9	0	25	6	164
May-14	37	14	13	50	51	1	19	4	0	26	10	232
Jun-14	47	23	4	53	34	1	29	12	0	38	3	251
Jul-14	66	22	41	32	50	6	10	11	4	84	7	336

While the number of Looked After Children has been increasing, these figures are declining. This may be due to summer months with people on holiday, children moving into 16+ accommodation or the result of the preventative work carried out in the local communities.

Age at 31 March 2014	Boys	Girls
Under 1	8	2
1 - 4	25	22
5 - 9	37	41
10 - 15	78	47
16 - 17	17	37
18+ in community home	0	0
Total	165	149
total LAC March 31st 2014	314	



Appendix 2

Supply – Torbay's Placements for Children in Care

Local Provision

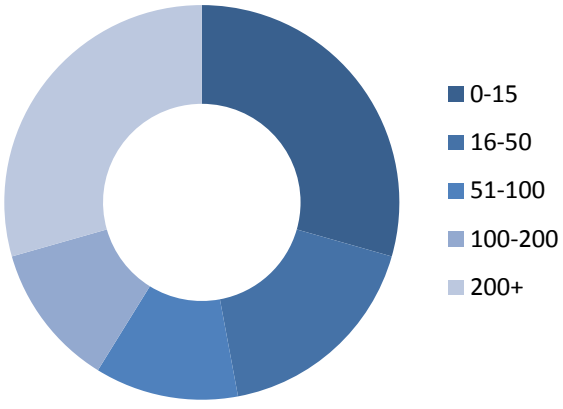
The most up to date statistics on the type of placements in use in both the independent sector and in-house by Torbay on one day, June 14 are as follows.

Local overview – fostering

Data needed

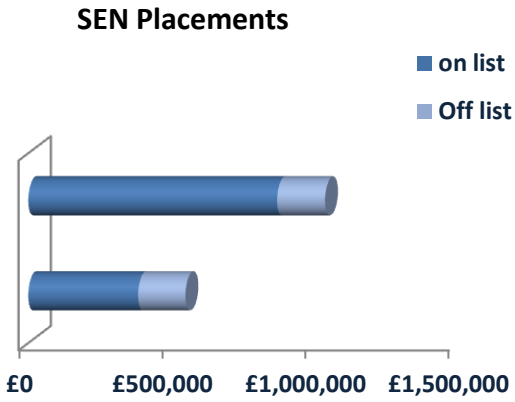
Local over view - Children's homes

Children's Residential Placements distance from Torbay (miles)



Some placements out of area are necessary for safeguarding, however, this pie chart highlights the need for more specialist care within our area.

The average annual cost of placements ON the preferred supplier list is £166,906, and £193,326 for the placements OFF list.

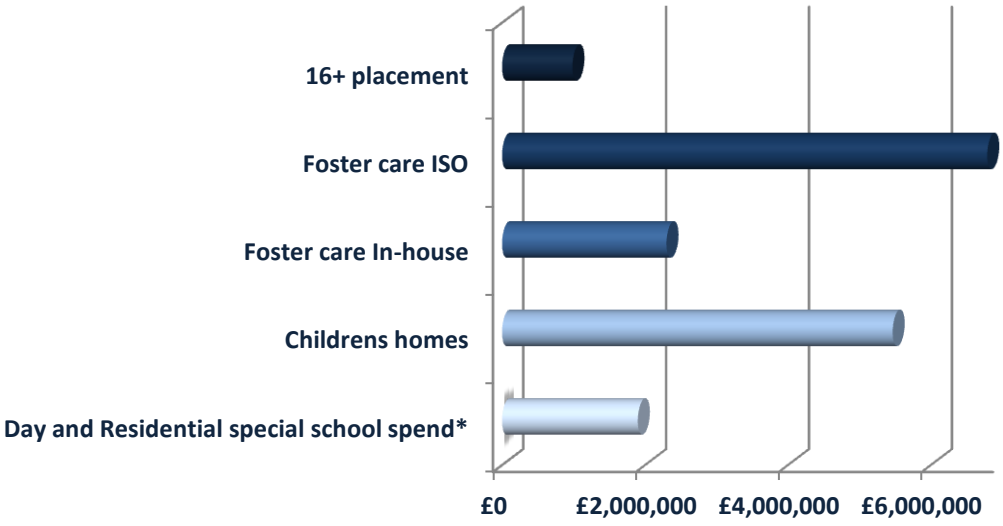


Local Overview of Non-maintained and Independent Sector residential Schools

Of the 19 children currently in non maintained and independent sector residential special schools, 3 are in non maintained special schools - this is based on 2 education and 1 joint funded education/social care health. There are 16 children in independent sector special schools, of this 14 are funded by social care and Education jointly and 2 by Education alone these 2 have emotional, behaviour difficulties. Some may be placed after difficulties have occurred in their previous placements. The schools provide weekly, term-time or full boarding and are based outside the Torbay boundary. Where possible we would aim to place within our local area but there are occasions where the most suitable placement cannot be found within this area.

The type of placement by sector and funding arrangements at the end of April 2014 snapshot was as follows:

Financial Overview of Torbay children's placements April 2013 – March 2014



The total spends for the financial year 2013-2014 shows £17.4 million spend. Within foster care £2.3million was spent in-house and £6.7million spent in the independent sector. It is estimated that the full cost of placing a child with in-house foster care is 50% less than through the Independent sector

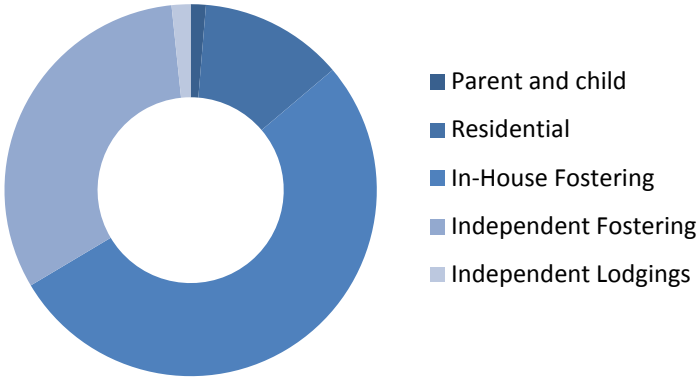
Quality Issues

Torbay Council aspires to use providers of children's social care placements graded good or outstanding by Ofsted the national regulator.

At the beginning of 2012, Ofsted introduced a number of radical changes covering much of their social care inspection activity toughening up the inspection framework. (Source Ofsted Annual Report 2011/12.) An amended inspection framework for children's homes and foster care was introduced in April 2012.

Torbay is working with Peninsula partner neighbour local authorities to improve the quality of provision by regularly monitoring providers, carrying out site visits and offering regular provider forums.

We are looking to further develop relationships with existing and potential providers to collaboratively meet and exceed the expectations of Ofsted, to ensure excellent quality of care for our children and those placed within out area from other authorities. Further we are thinking about new solutions to the growing needs of the children and families within our area and encouraging the right providers to invest in Torbay.



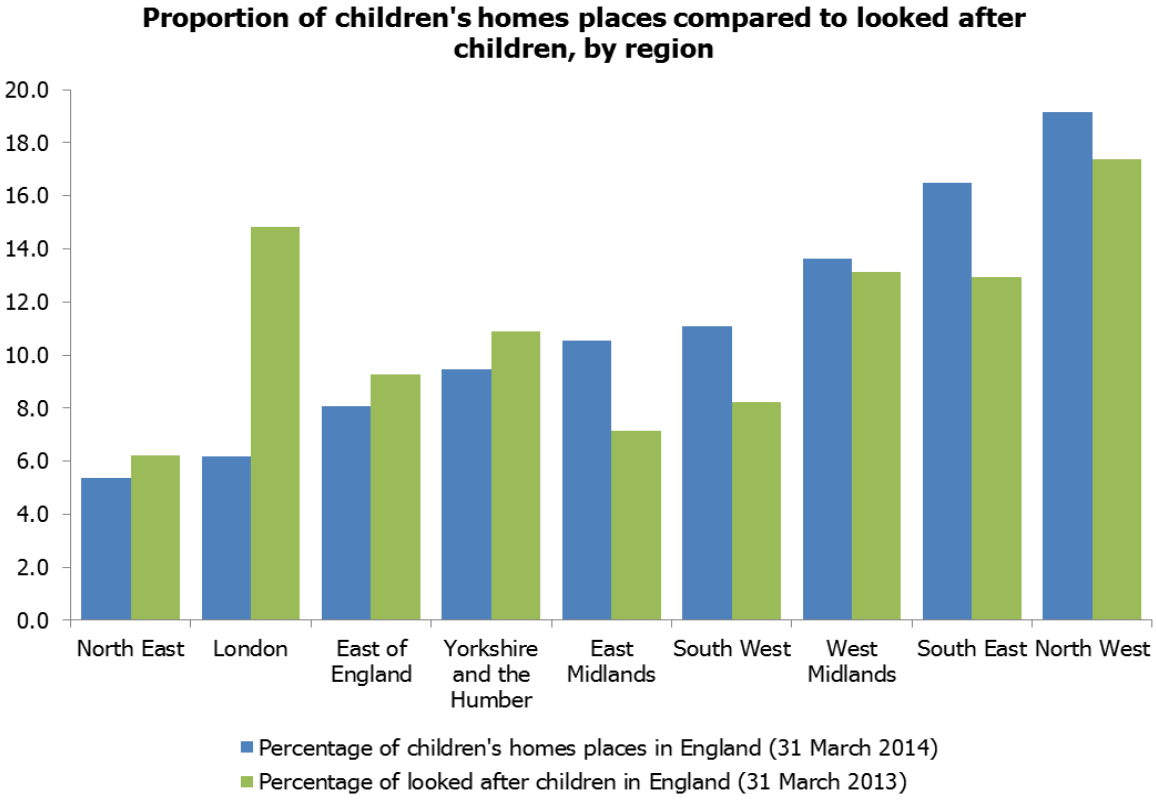
Children Homes

The current national percentage of good or better children's homes is 72%.12 The change to the Ofsted frameworks has been felt in the Peninsula area and has increased the number of children's homes in particular receiving an inadequate inspection grading.

Between the introduction of the revised children's homes inspection framework on 1 April 2012 and 31 December 2012, nationally 16% of homes received an outstanding overall effectiveness grade. This compares to 27% in the first nine months after the introduction of the children's homes inspection framework in April 2011.

Nationally five per cent of homes have received an inadequate overall effectiveness grade between the introduction of the revised framework on 1 April 2012 and 31 December 2012. This is an increase of three percentage points, from 2% in the first nine months after the introduction of the children's homes inspection framework in April 2011.

Torbay are seeking to identify key providers who have the capacity, ability, a proven reputation and high Ofsted results in the care of looked after children. In collaboration we intend to progress their market place position to one that will fit with the needs of the region that they are situated in.



Foster Care

Between the introduction of the new fostering inspection framework on 1 April 2012 and 30 September 2012, nationally 12% of fostering services received an outstanding overall effectiveness grade, this is a decrease from 30% in the first two years of the inspection cycle between 1 April 2010 and 31 March 2012.

Special Schools

Of the 50 residential special schools inspected in this period nationally 28 (56%) were outstanding for overall effectiveness, 15 (30%) were good, five (10%) were adequate and two (4%) were inadequate.

The Peninsula Regional picture

This graph shows that the South West have 11% of the children's homes places in England and 8% of England's looked after children. While this appears a healthy position, often children with specialist needs cannot be placed within Torbay, the Peninsular or even the South West. Torbay is working independently and together with the Peninsula to plan strategies to enhance the required market place to ensure sufficiency supply and value for money. While it is sometimes necessary for children to be placed out of area, we need to make sure that this only happens due to the child's specific safeguarding needs rather than lack of specialised providers.

The current numbers of outstanding and good providers in the Peninsula region is being affected by the toughening of the Ofsted grading system that is leading to changes of grading locally. There is a need to drive up quality of provision locally.

At the time of data collection the South West had ? outstanding providers. Torbay has ? Torbay Council in house fostering service was graded ? by Ofsted in ?.

On Peninsula Framework	Total	Outstanding	Good	Adequate	Inadequate	Suspended	Not Inspected
All Ofsted graded provision							
Total	129	12 (9%)	66 (51%)	29 (22%)	0	17 (13%)	5 (4%)
Lot1							
	86 (67%)	6 (7%)	42 (49%)	18 (21%)	0	16 (19%)	4 (5%)
Lot 2							
	15 (12%)	5 (33%)	9 (60%)	1 (7%)	0		
Lot 3							
	28 (22%)	1 (4%)	15 (54%)	10 (36%)	0	1 (4%)	1 (4%)
On Peninsula Framework							
Not Ofsted Regulated							
Lot 4							
	59	n/a	n/a	n/a	n/a	1 (2%)	n/a

*Source Children's homes inspection outcomes Oct to Dec 2012 Provisional Ofsted 04a1212CSC data children's homes

New framework tender fourth quartile, 2014

All providers within the Peninsula area are able to apply online via Pro Contract to the Framework of preferred providers with opportunities to join every six months. With the exception of the 16+ category, each provider is challenged on Complaints, Safeguarding, Challenging Behaviour and Safer Recruitment. The 16+ providers must score a minimum of 5 out of 10 or above in each of the three quality questions set.

Future Progress

The Peninsula commissioning and procurement partnership are focuses on the new Parent and Child Residential Family tender which is being led by Somerset and is a great opportunity to improve this provision which is very low in the area.

Gaps

- Learning disability placements
- Parent and child placements

The other placement area where there is a need to drive up quality locally is in the 16+ providers. These services are not regulated by Ofsted. In order to assist these providers specific guidance was produced after round one of the Peninsula tender process. Further development work is taking place regionally with Peninsula partners to improve the quality of these independent sector services.

Ofsted grades of Children's Homes within the Peninsula Area*

Within the Peninsula Area		Outstanding	Good	Adequate	Inadequate	Closed	Not Inspected
All Ofsted graded provision	TOTAL 118	8 (7%)	58 (31%)	43 (23%)	1 (1%)	0	8 (7%)
Children's Homes							
Cornwall	14 (12%)	0	9 (64%)	5 (36%)	0	0	0
Devon	40 (34%)	2 (5%)	26 (65%)	7 (18)	1 (3%)	0	4
Plymouth	6 (5%)	0	1 (17%)	3 (50%)	0	0	2 (33%)
Somerset	43 (36%)	3 (7%)	15 (35%)	23 (53%)	0	0	2 (5%)
Torbay	4 (3%)	0	4 (100%)	0	0	0	0
Within the Peninsula Area		**Outstanding**	**Good**	**Adequate**	**Inadequate**	**Closed**	**Not Inspected**
Residential Schools							
Cornwall	1 (1%)	0	1 (100%)	0	0	0	0
Devon	5 (4%)	1 (20%)	1 (20%)	3 (60%)	0	0	0
Plymouth	0	0	0	0	0	0	0
Somerset	2 (2%)	1 (50%)	0	1 (50%)	0	0	0
Torbay	0	0	0	0	0	0	0
Secure Units							
Cornwall	0	0	0	0	0	0	0
Devon	1 (1%)	0	1 (100%)	0	0	0	0
Plymouth	0	0	0	0	0	0	0
Somerset	0	0	0	0	0	0	0
Torbay	0	0	0	0	0	0	0

Information taken from Children's Homes List for Lac 20140602. June 2014

Action to improve quality

Torbay and Peninsula authorities have clearly signalled to local providers that the aim is to favour placements with good or outstanding providers and the authorities are actively working to assist more providers to reach this standard.
Also providers graded as inadequate by Ofsted are not eligible to join the Peninsula provider list.

The new framework list that first came into use on April 1st 2013 now has 141 sites listed for use offered by 39 organisations. Because this tender opens several times a year until March 31 2017 more providers will come onto the list on a regular basis each year increasing the supply of placements locally. For example in the current application round open at the moment over 20 further providers have applied to join the list

In the last tender round, 33 organisations submitted an application and 8 were successful. This resulted in 174 sites being added and 50 organisations on the framework. This result shows that the LA's expect a high level of quality and safeguarding for our placed children as well as value for money. Providers are encouraged to re-apply at the next round and offered support to improve their applications where necessary. The peninsula is approaching the deadline for the new tender applications, but it is unknown how many new providers will be applying. Successful providers will be added to the framework in December.

From information available publicly from Ofsted March 2013, within the Peninsula there are:

- 3 boarding schools with 429 places
- 113 children's homes with 415 beds, 86 in the private sector with 253 beds
- 5 further educational colleges with residential accommodation of 440 places
- 5 residential family centres with an estimated 27 places
- 1 secure home with 8 beds
- 13 Residential special schools with 560 places and
- 7 residential special schools> 295 days per year with 199 places

In the broader SW region in total (ie these figures already include providers listed by Ofsted in each Peninsula local authority area) there are 61 independent sector providers registered with Ofsted that could potentially come onto the Peninsula frameworks.

Recent national analysis of the independent sector foster care market indicates that the Peninsula has a similar pattern of provision to other peripheral areas in the UK such as the North East ie the big three foster care agencies have a larger share of the local market (@60% as opposed to @40% elsewhere). A strategy of ensuring a diverse market with mid-range competitors to the large nationals would be in the interests of ensuring sufficient supply and increasing value for money to maximise the purchasing power of the Peninsula authorities.

It is also notable that providers that enjoy a near monopoly as a regional supplier are less likely to be receptive to negotiation on price or other issues. The current co-ordinated Peninsula response to developing these markets and communicating with these suppliers is helpful.

Market Analysis

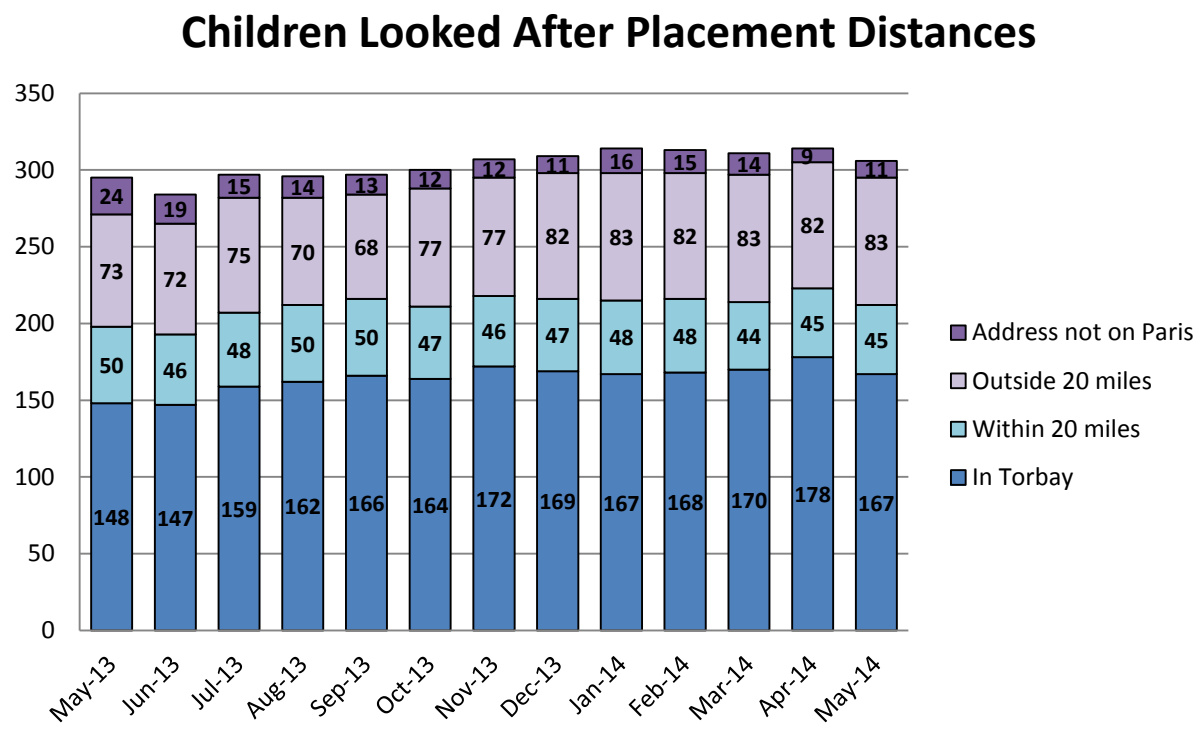
Most of the regional children's placement market of both children's homes and fostering is under pressure because of the increase in the numbers of children coming into care across the region, and the rise in the complexity of their needs.

Although there is currently a list of 141 provider sites available on the Peninsula frameworks list it has not always been possible to match a child to a placement within the local area., and this has knock on implications for outcomes for children and young people, as well as cost implications for the statutory and other agencies working with Torbay children in care.

We have particular shortages of foster care placements in the following areas: parent and child foster carers; foster carer for sibling groups; children from minority communities; young people on remand; risk taking teenagers with complex and challenging needs (such as at risk of substance misuse

Sufficiency of placements for looked after children
On April 2014 ? children were looked after by Torbay. Of these:
241 were placed in foster care.
39 were placed in children's homes, hostels or secure units and 4 were placed in residential special schools.

Within the 20 mile Torbay boundary the following placements are potentially available to meet the demand for placements – potentially possible if the registration details are looked at– spk to Bob Lord but we can say now :-



Address not on Paris = Children placed for adoption

Dec 2014.

FIVE YEAR FORWARD VIEW

October 2014

CONTENTS

FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **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. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

improve the NHS' ability to undertake research and apply **innovation** – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that **there *are* viable options for sustaining and improving the NHS over the next five years**, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.

CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients

having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

BOX 1: FIVE YEAR AMBITIONS ON QUALITY

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on

the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

Incentivising and supporting healthier behaviour. England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

Local democratic leadership on public health. Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.

Targeted prevention. While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

NHS support to help people get and stay in employment. Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.

Workplace health. One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.

BOX 2.1: A HEALTHIER NHS WORKPLACE

While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will: ● Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. ● Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. ● Support "active travel" schemes for staff and visitors. ● Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. ● Review with the Faculty of Occupational Medicine the strengthening of occupational health.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding

promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

Engaging communities

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

Supporting carers. Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

Encouraging community volunteering. Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural

areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

Stronger partnerships with charitable and voluntary sector organisations. When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

The NHS as a local employer. The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

The NHS as a social movement

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are

in fact precisely the sort of 'slow burn, high impact' actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.

CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in

and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This "social prescribing service" has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients' experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different.

But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the

outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

BOX 3.1: A new deal for primary care

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:

- *Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.*
- *Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*
- *Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.*
- *Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.*
- *Expand funding to upgrade primary care infrastructure and scope of services.*
- *Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.*
- *Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours

inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

New care model – Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do

this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the

forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

New care model - specialised care

In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with

the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

New care model - modern maternity services

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

New care model – enhanced health in care homes

One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of

models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

How will we support the co-design and implementation of these new care models?

Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above.

However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.

In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel.

In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several

hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a

fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

CHAPTER FOUR
How will we get there?

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

We will back diverse solutions and local leadership

As a nation we've just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in chapter two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no 'right' answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of 'special measures'.

We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and

behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.

More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage

recruitment and retention in parts of the country and in occupations where vacancies are high.

We will exploit the information revolution

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year the NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:

- Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health

professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

We will accelerate useful health innovation

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.

We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with

partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate

use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

We will drive efficiency and productive investment

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

Demand

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

Efficiency

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

Funding

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.

- In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

- In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

- In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will*

also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.

Better treatment and care for all*. It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

ABBREVIATIONS

A&E	Accident & Emergency
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
CT	Computerised Tomography
EBITDA	Earnings before interest, taxes, depreciation and amortisation
GP	General Practitioner
HEE	Health Education England
IPC	Integrated Personal Commissioning
IVF	In Vitro Fertilisation
LTCs	Long term conditions
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PHE	Public Health England
RCTs	Randomised Controlled Trials
TUC	Trades Union Congress
WHO	World Health Organisation


CareQuality
Commission


NHS
Health Education England


Monitor
Making the health sector
work for patients


NHS
England


Public Health
England


tda
Trust
Development
Authority
Quality. Delivery. Sustainability.

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Initial Report -Health Protection		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	17 December 2014
Contact:	Caroline Dimond		
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1. Achievements since last meeting

1.1 The following report to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council provides a summary of the assurance functions of the Health Protection Committee (of the three Boards) and significant matters considered since its inaugural meeting on 15th October 2013.

2. Challenges for the next three months

2.1 The report summarises action taken to date against the programme of health protection work priorities established by the committee for the period 2014 to 2015.

The report considers challenges under the following domains of health protection: communicable disease control and environmental hazards

1. Immunisation and screening: Improvement in immunisation and screening uptake rates including the introduction of Flu vaccine for all children aged 2, 3 and 4 year old;
2. Health care associated infections (HCAI): To continue to see a reduction in the cases of HCAI Infections in both acute and community settings in particular cases of *Clostridium difficile* and Methicillin-resistant Staphylococcus aureus (MRSA) infections.
3. Emergency planning: planning and resilience for potential cases of Pandemic flu and Ebola infections

3. Action required by partners

3.1 This report is for information and assurance purposes only

Appendices

None

Background Papers:
The following documents/files were used to compile this report: None

Health Protection Assurance Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council

September 2014

1. Introduction

1.1 The following report to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council provides a summary of the assurance functions of the Health Protection Committee (of the three Boards) and significant matters considered since its inaugural meeting on 15th October 2013.

1.2 The report considers the following domains of health protection:

- communicable disease control and environmental hazards
- immunisation and screening
- health care associated infections

1.3 The report summarises action taken to date against the programme of health protection work priorities established by the committee for the period 2014 to 2015.

2. Assurance Arrangements

2.1 On 1st April 2013 significant changes took place in the health and social care landscape following implementation of the new NHS and Social Care Act (2012). At this time, the majority of former NHS Public Health responsibilities transferred to upper tier and unitary local authorities including the statutory responsibilities of the Director of Public Health.

2.2 With regards to health protection, local authorities through their Director of Public Health, require assurance that appropriate arrangements are in place to protect the public's health. The scope of health protection in this context includes:

- prevention and control of infectious diseases
- national immunisation and screening programmes
- health care associated infections
- emergency planning and response (including severe weather and environmental hazards

2.3 The Health Protection Committee (and its Terms of Reference) was formally mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council.

2.4 The aim of the Health Protection Committee is to provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the public's health.

2.5 Terms of Reference (Appendix 1) for the Committee were agreed by Local Authority Directors of Public Health, their Health Protection Lead Officers as well as representatives from Public Health England (including Consultant in Communicable Disease Control), NHS England Area Team and the Clinical Commissioning Groups.

2.6 By serving three Local Authorities, the Committee allows health protection expertise from three public health teams to be pooled in order to share skill and maximise capacity. Furthermore, for external partners whose health protection functions serve a larger geographic foot-print, this model reduces the burden on them to attend

multiple health protection meetings with similar terms of reference and to consider system-wide risk more efficiently and effectively.

2.7 Supporting the Committee are a number of health protection subgroups support the Health Protection Committee in order to identify risks across the system of health protection and agree mitigating activities for which the Committee provides control and oversight. As illustrated in Appendix 2, these include:

- Health Care Associated Infection Programme Group
- Health Protection Advisory Group
- Devon, Cornwall and Isles of Scilly Screening and Immunisation Overview Group
- Local Health Resilience Partnership

2.8 Through the Local Authority Health Protection Lead Officers (Consultants in Public Health), Terms of Reference for each of these groups have been reviewed to ensure they reflect the assurance arrangements overseen by the Health Protection Committee.

2.9 The Lead Officers meet regularly and prior to the Health Protection Committee convening to review surveillance and performance monitoring information in order to identify health protection risks and/or underperformance. Officers are responsible for liaising with relevant partners to ensure that actions have been agreed to mitigate against a particular risk identified or to improve performance. The outcomes of these discussions are formally reported to the Health Protection Committee for consideration and agreement.

2.10 An inaugural meeting of the Committee was held on October 15th 2013 followed by further meetings on 9th December 2013, 4th February 2014, April 29th 2014 and 20th August 2014.

3. Prevention and Control of Infectious Diseases

Organisational Roles/Responsibilities

3.1 NHS England has responsibility for managing / overseeing the NHS response to an incident, ensuring that relevant NHS resources are mobilised and commanding / directing NHS resources as necessary. Additionally NHS England is responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health.

3.2 Public Health England through its consultants in communicable disease control will lead the epidemiological investigation and the specialist health protection response to public health outbreaks / incidents and has responsibility to declare a health protection incident, major or otherwise.

3.3 The Clinical Commissioning Group's role is to ensure through contractual arrangements with provider organisations that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening/diagnostic and treatment services).

3.4 The Local Authority through the Director of Public Health or their designate has overall responsibility for the strategic oversight of an incident / outbreak impacting on their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England supported by the Clinical

Commissioning Group. In addition, they must be assured that the local health protection system is robust enough to respond appropriately in order to protect the local population's health and that risks have been identified, are mitigated against and adequately controlled.

Surveillance Arrangements

3.5 Public Health England provides a monthly centre report for its catchment: Devon, Cornwall and the Isles of Scilly and Somerset. The report provides epidemiological information on cases and outbreaks of communicable diseases of public health importance. A quarterly report is produced for Devon County Council, Torbay Council and Plymouth City Council.

3.6 Two weekly bulletins are also produced throughout the winter months that provide surveillance information on influenza and influenza like illness and infectious intestinal disease activity (including norovirus). These bulletins report information for the Public Health England Centre geography (Devon, Cornwall and the Isles of Scilly and Somerset).

3.7 The Health Protection Advisory Group convened quarterly provides a forum for hospital microbiologists, environmental health officers, consultants in public health and infection control nurses to share intelligence and any risks identified in local arrangements to manage communicable disease incidence.

Tuberculosis (TB) Cluster – Teignbridge Area

3.8 The last decade saw an increase in TB cases in the South Devon area. In 2000-01 there was an outbreak of TB in Newton Abbot in a social group. Cases with the same 'strain' of TB are still being diagnosed in the wider community and recent cases appear to be linked to this earlier outbreak.

3.9 During December 2013, a small number of confirmed cases of active pulmonary TB were identified in the wider Teignbridge area.

3.10 An initial incident control meeting led by Public Health England was held which included attendance from Devon County Council's lead Consultant in Public Health on behalf of the Director of Public Health. A total of four incident meetings were held to monitor progress and to maintain good communication between partners.

3.11 To further reduce the risk of ongoing transmission by seeking to identify additional cases of active TB infection, the Incident Control Team decided to hold two direct access TB screening clinics at a community hospital in December 2013. These clinics were run collaboratively between respiratory teams at Royal Devon and Exeter NHS Foundation Trust Hospital and South Devon Healthcare NHS Foundation Trust Hospital. In addition, in January 2014, children and teaching staff at a primary school were also screened.

3.12 No further cases of active TB infection were identified through the screening activities undertaken. A small number of individuals were screened positive for latent (inactive and non-infectious) TB and were supported accordingly.

3.13 Organisationally, the incident highlighted a lack of clarity about who should pay for mass community TB screening which has now been considered in the draft Health Protection Committee-led Memorandum of Understanding between relevant partners.

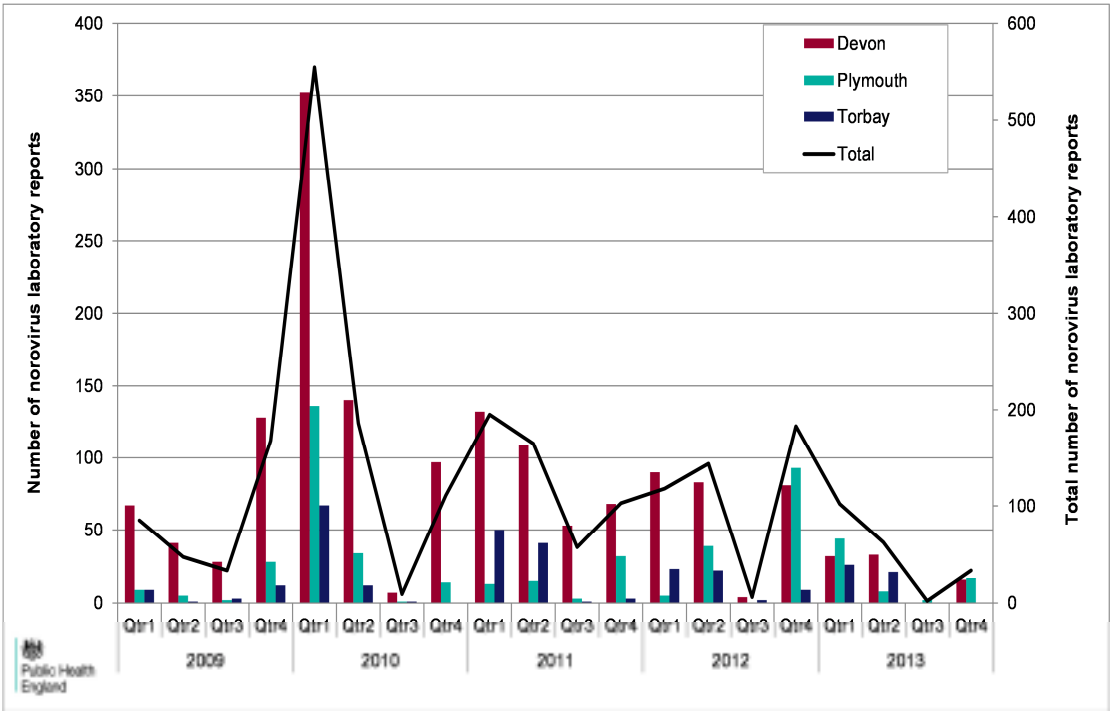
3.14 Additionally, the incident reminded partners of the need for ongoing awareness raising by public health colleagues to health-care professionals and the public about TB.

Norovirus 2013-14

3.15 Norovirus is the most common cause of infectious gastroenteritis (diarrhoea and vomiting) in England and Wales and is highly infectious. The Illness is generally mild and people usually recover fully within two to three days. Infections can occur at any age because immunity does not last. Historically known as 'winter vomiting disease', the virus is more prominent during the winter months, but can occur at any time of year. Outbreaks are common in semi-closed environments such as hospitals, nursing homes, schools and cruise ships.

3.16 As illustrated in Figure 1, norovirus laboratory reports have been lower during the 2013-14 season compared to previous seasons. The graphic cannot be used to estimate burden of disease as many cases will never be reported.

Figure 1: Quarterly laboratory reports of norovirus for the Local Authority areas of Devon County Council, Plymouth City Council and Torbay Council 2009-13.



3.17 During the season, a regional field epidemiologist from Public Health England (PHE) advised that weather-related factors such as humidity, rainfall and temperature have been implicated in the transmission of other viral Gastroenteritis and is it likely that they also have a role to play in norovirus transmission. As the winter period was deemed atypical as it had been wet but not overly cold, these conditions may have been responsible for the low norovirus activity. Seasonal influenza was also very low in the UK but in contrast, in parts of the United States which experienced a very cold winter the level of influenza activity was high.

3.18 In order to support best practice regarding infection control and the management of norovirus, Public Health England working with Local Authority public health teams cascaded information across health and social care services including care homes.

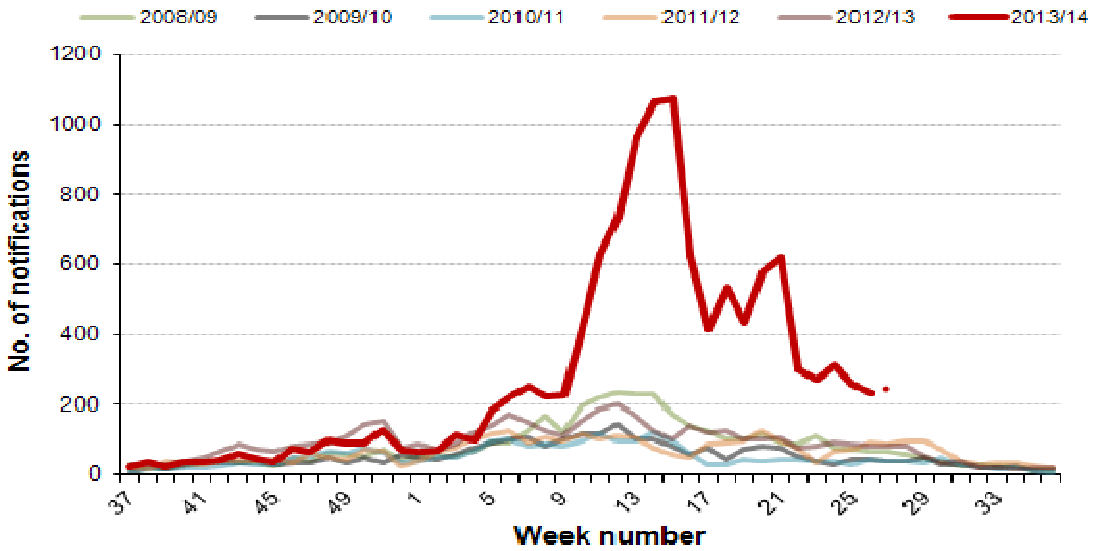
Scarlet Fever 2013-14

3.19 Scarlet fever is a common childhood infection caused by Streptococcus pyogenes (also known as group A streptococcus [GAS]). These bacteria are found on the skin or in the throat, where they can live without causing problems. Under some circumstances GAS can cause non-invasive infections such as pharyngitis, impetigo and scarlet fever. On rare occasions they can cause severe disease, including streptococcal toxic shock syndrome, necrotising fasciitis, and invasive GAS (iGAS) infection.

3.20 Routine national surveillance data for invasive and non-invasive GAS infections suggests a cyclical pattern with higher incidence peaks evident in notifications approximately every four years. Incidence of invasive disease tends to mirror that of superficial manifestations of GAS infection in many but not all years. As such, monitoring scarlet fever cases nationally can provide an early warning of increases in invasive disease. Seasonal trends show that increased levels of GAS infections typically occur between December and April, with peak incidence usually in March.

3.21 Public Health England (PHE) reported elevated levels of scarlet fever notifications across England (Figure 2). Between 9th September 2013 and 30th June 2014, a total of 12,121 cases were notified peaking at the beginning of April 2014.

Figure 2: Weekly scarlet fever notifications in England, 2009.09 onwards



3.22 Locally, there were 110 notifications of scarlet fever between September 2012 and July 2013 for Devon County Council, Plymouth City Council and Torbay Council combined. For the period September 2013 to July 2014, there were 208 notifications, an increase of 89%.

3.23 Over the period of increased scarlet fever activity, no significant increase in notifications of invasive group A streptococcus was observed.

3.24 Public Health England (PHE) are currently leading investigations to identify the reasons for the unusual escalation in scarlet fever, including microbiological investigation of causative strains.

3.25 Locally, in order to reduce ongoing transmission, Local Authority Public Health Teams wrote to schools and child care facilities providing information about the increase in cases and reiterating infection control advice. Public Health England published interim guidance for the public health management of scarlet fever outbreaks in schools and nurseries and other childcare settings to be deployed by local acute response centres.

4. Immunisation and Screening

Organisational Roles/Responsibilities

4.1 NHS England commission most national screening and immunisation programmes through Local Area Teams.

4.2 Public Health England is responsible for setting screening and immunisation policy through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff, employed by Public Health England, are embedded in the NHS Local Area Teams to provide accountability for the commissioning of the programmes and provide system leadership.

4.3 Local Authorities through the Director of Public Health require assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local population. Public health teams responsible for both protecting and improving the health of their local population under the leadership of the Director of Public Health are required to support Public Health England in projects that seek to improve programme coverage and uptake.

Surveillance Arrangements

4.4 Public Health England Screening and Immunisation Coordinators provide quarterly reports for each of the national immunisation and screening programmes. Due to data capture mechanisms (with the exception of the seasonal influenza vaccination programme) real time data are not available for each programme and reports are normally two calendar quarters in arrears. Reports are considered by lead Local Authority Consultants in Public Health and any risks identified are considered with Public Health England specialists to agree mitigating activities.

4.5 Arrangements for reporting incidents that occur in the delivery of programmes should be reported to the Director of Public Health for the Local Authority and to the Health Protection Committee. At time of writing, these processes are being reviewed to ensure they are fit for purpose.

4.6 Peninsula Immunisation and Screening Oversight Groups form part of the assurance mechanism to identify risks to delivery across all programmes and are attended by lead Local Authority Consultants in Public Health. In addition, specific programme groups are convened to oversee their development, most notably when changes to a programme have been agreed at a national level.

Immunisation Activity and Changes to the National Immunisation Programme 2013-14

4.7 The period 2013-14 observed significant activity regarding immunisation programmes and changes to the national immunisation schedule.

4.8 During the spring of 2013 and in response to a large outbreak in South Wales and smaller outbreaks in the North East and North West of England, a national emergency MMR catch-up campaign was launched to vaccinate unprotected children against measles, mumps and rubella. This involved significant collaboration between Public Health England, NHS England and Local Authority Public Health teams.

4.9 Additionally, the schedule for the Meningitis C immunisation was changed, replacing a second priming dose at four months to a booster in adolescence with effect from June 2013. Immunisation against Rotavirus was introduced to the childhood schedule in July 2013, shingles for people aged 70 years (and a catch-up cohort at 79 years) was introduced from September 2013 and a childhood flu vaccination for all two and three year olds (to be extended to children and young people from two years of age up to 16 over the coming years) was introduced.

4.10 The capacity required to oversee these changes has resulted in limited capacity across the health protection system to drive service improvement / development initiatives which are now prioritised for the period 2014-15.

Information Sharing

4.11 Over the period and following transition of public health teams to Local Authorities, a number of issues pertaining to access to, reporting of and sharing data between organisations that were not fully considered within the Health and Social Care Act 2012 have provided a significant challenge to health protection assurance functions locally, most notably within the area of screening and immunisation.

4.12 Public Health England have access to data sources that can be used to identify variation in uptake of immunisation and screening programmes at useful spatial levels (e.g. at GP practice level) but have limited analytical capacity to report on such variation, required to inform the assurance function of the Health Protection Committee and local collaborative improvement programmes.

4.13 Locally, and in line with agreement between the Lead Official for Statistics of Public Health England and the President of the Association of Directors of Public Health, information is now being shared on a product by product basis when it is required to support the day-to-day management / operation of an organisation and its decision making and on an urgent basis when this information is required to protect the population's health.

Seasonal Influenza

4.14 A priority area identified by the Health Protection Committee was to increase uptake of seasonal influenza vaccine, especially in groups under 65 years of age considered at risk due to underlying health conditions and who are eligible for free vaccination through the national programme. This was on the basis of poor uptake in this cohort following the 2013-14 programme reported at Clinical Commissioning Group level (Table 1).

Table 1: Public Health England Seasonal provisional flu vaccination figures 1 September 2013 – 31 January 2014

Clinical Commissioning Group	% of practices responding	65+ % vaccinated	6m-65 at risks % vaccinated	Pregnant women % vaccinated
NEW Devon	100%	72.2%	49.2%	40.3%
SD & Torbay	100%	69.1%	47.6%	38.2%
England	99.8%	73.2%	52.3%	39.8%
Target	**100%**	**75%**	**75%**	**N/A**

Source: ImmForm, Public Health England, PHE weekly bulletin 7 March 2014

4.15 A programme of work is being led by a Specialty Registrar in Public Health based at Devon County Council. The objectives of this programme of work are:

- to identify areas of comparatively low uptake of influenza vaccination (by geography and by patient group)
- to review the literature around best practice in optimising vaccination uptake
- to audit highest and lowest practice performance against a checklist of good practice
- to develop a strategy to improve uptake in lower uptake areas and overall
- to evaluate the impact of any changes

4.16 The work is being carried out on a collaborative basis involving all key stakeholders.

5. Health Care Associated Infections

Organisational Roles/Responsibilities

5.1 NHS England set out and monitor the NHS Outcomes Framework which includes Domain Five (safety), treating and caring for people in a safe environment and protecting them from avoidable harm. The Area Teams of NHS England hold local Clinical Commissioning Groups to account for performance against indicators under this domain, which includes incidence of healthcare associated methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and incidence of *Clostridium difficile*.

5.2 Public Health England through its consultants in communicable disease control will lead the epidemiological investigation and the specialist health protection response to health care associated infection outbreaks and has responsibility to declare a health protection incident.

5.3 The Clinical Commissioning Group's role is to ensure through contractual arrangements with provider organisations that health care associated infection standard operating procedures are in all provider contracts and are monitored regularly. Northern Eastern and Western Devon and South Devon and Torbay Clinical Commissioning Group's employ a lead nurse for health care associated infections. This is an assurance and advisory role. In addition, they must be assured

that the Infection Prevention and Control Teams (Acute hospitals and Torbay and Southern Devon Community) are robust enough to respond appropriately in order to protect the local population's health and that risks of health care associated infection have been identified, are mitigated against and adequately controlled.

5.4 The Local Authority through the Director of Public Health or their designate has overall responsibility for the strategic oversight of a health care associated infection incident impacting on their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England supported by the Clinical Commissioning Group.

Health Care Associated Infection Programme Group

5.5 The group was formed as a sub group of the Health Protection Committee. Its function is to work towards the elimination of avoidable health care associated infections (HCAI) for the population of Devon including the Unitary Authorities of Plymouth and Torbay, receiving health and social care interventions in clinical, home and residential care environments, through the identification of risks, the planning of risk mitigation actions and the sharing of best practice in the field.

5.6 It is a cross-agency forum involving Acute and Community NHS Trusts, Ambulance and Out of Hours Doctors, Public Health, Public health England, Medicines Optimisation and NHS England Area Team. The Group met for the first time in March 2014 and is scheduled to meet quarterly.

***Clostridium difficile* - Performance 2013-14**

5.7 The Northern Eastern & Western Devon Clinical Commissioning Group population objective including Acute Trust allocated cases was 264. End of year performance was within this at 215. The 2014-15 objective is 204 (rate 23.6 per 100,000 population)

5.8 In the Northern Eastern Western Devon Clinical Commissioning Group area Plymouth Hospitals NHS Trust over ran its nationally set objective. The Trust having earlier in the year recognised potential difficulties in compliance with the national objective had requested and received a review led by the Clinical Commissioning Group from which an action plan was drawn up and is being implemented.

5.9 The South Devon and Torbay Clinical Commissioning Group population objective was 95. End of year performance was within this at 86. The 2014-15 objective is 81 (rate 29.8 per 100,000 population).

5.10 Based on 2013-14 performance Southern Devon Healthcare NHS Foundation Trust and Plymouth Hospitals NHS Trust and both Clinical Commissioning Groups are at risk of not meeting the 2014-15 targets. However new guidance released in time for 2014-15 will enable Clinical Commissioning Groups to decide if cases are to be considered 'unavoidable' will help to mitigate against the risk in relation to acute Trust performance as such unavoidable cases do not have to be counted for the purposes of sanction implementation.

MRSA - Performance 2013-14

5.11 MRSA remained subject to a zero tolerance national objective with a requirement for Post Infection Reviews (PIRs) on every case of MRSA bacteraemia that occurred.

5.12 Northern Eastern & Western Devon Clinical Commissioning Group ended the year with seven cases of which five cases were attributed to two of the three Acute trusts and the remaining two occurred in the wider community and therefore attributed to the Clinical Commissioning Group.

5.13 South Devon and Torbay Clinical Commissioning Group ended the year with one case which occurred in the Acute Trust.

5.14 All cases were subject to Post Infection Reviews.

6. Work Programme 2014-15

6.1 The Health Protection Committee is providing oversight over the following programmes of work agreed as priority areas for the period 2014-15.

Seasonal Influenza

6.2 Seasonal Influenza (as outlined in 4.14 to 4.16).

Hepatitis C Strategy and Implementation

6.3 Hepatitis C is a blood borne virus which is an important cause of liver disease. The most common means of transmission in the United Kingdom is through intravenous drug use with shared equipment – it is estimated that nine out of 10 cases of Hepatitis C in this country are caused by injecting illegal drugs.

6.4 The control of Hepatitis C provides a challenge to the health sector from prevention through to treatment and aftercare and requires a coordinated response. To that end a strategy for the geographical catchment of North, East and West Devon and South Devon and Torbay Clinical Commissioning Groups was drafted in 2013 which requires review and adoption by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council. It is envisaged that Public Health England in partnership with Local Authority Public Health Teams will provide overarching leadership of the strategy and will identify priority actions for the period 2014-15.

TB Service Review

6.5 Following the TB cluster outlined in this report a number of issues were raised with regards to the hospital-based services commissioned to manage the treatment, contact tracing and screening of active cases of TB. These included:

- the capacity of providers to screen large cohorts over and above their existing service provision and agreement of meeting the additional costs required
- limited capacity to provide peripatetic / outreach work to communities historically harder to engage with
- limited capacity to provide directly observed therapy (DOT) on an outreach basis

6.6 It was also noted how well the TB teams from South Devon Health Care NHS Foundation Trust and Royal Devon and Exeter NHS Foundation Trust collaborated together and pooled expertise and capacity because the catchment area affected crossed the boundary of both providers.

6.7 These issues require consideration alongside the draft Collaborative Tuberculosis Strategy published in March 2014 and priority actions there within. The proposed formation of TB Boards outlined in the strategy, at the appropriate geographic spatial level, may provide the appropriate forum for considering local issues raised here as well as a broader review of services alongside lead Clinical Commissioning Group Commissioners.

6.8 Local Authority health protection lead consultants will work with Public Health England to oversee this programme of work on behalf of the Health Protection Committee.

Health & Social Care

6.9 It has been observed by the Health Care Associated Infections Programme Group that services to support health and social care services in community settings are limited across the geographical catchment served by the Health Protection Committee. Such services through their registration to the Care Quality Commission (CQC) are responsible for internal infection control policies and procedures and CQC is in turn responsible for ensuring compliance. However specialist support to provide training as well as a programme of audit against best practice are not routinely available across the geographical catchment served by the Health Protection Committee and this poses a risk to local assurance arrangements.

6.10 The Public Health England Acute Response Centre provides advice and information in response to community outbreaks in these settings. However, proactive and preventing work is not routinely available.

6.11 The Health Care Associated Infection Programme Group will be considering this as part of its own work programme for 2014-15 and will report formally to the Health Protection Committee.

7. Authors

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APPENDIX 1

Proposed Terms of Reference for a Health Protection Committee of the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council

1. Aim, Scope & Objectives

Aim

1.1 To provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the public's health.

Scope

1.2 The scope of health protection to be considered by the committee will include prevention and control of infectious diseases, immunisation and screening, health-care associated infections and emergency planning and response (including severe weather and environmental hazards).

Objectives

1.3 To provide strategic oversight of the health protection system operating across Devon, Plymouth and Torbay.

1.4 To oversee the development, monitoring and review of a memorandum of understanding that outlines the roles and responsibilities of the Public Health England Centre, NHS England Area Team, Clinical Commissioning Groups (Northern Eastern and Western Devon & South Devon & Torbay) and upper tier/lower tier / unitary authorities in relation to health protection.

1.5 To provide oversight of health protection intelligence reported to the committee and be appraised of risks, incidents or areas of underperformance.

1.6 To review and challenge the quality of health protection plans and arrangements to mitigate against any risks, incidents or areas of under-performance.

1.7 To share and escalate risks, incidents and under-performance to appropriate bodies (e.g. Health and Wellbeing Boards / Local Health Resilience Partnership, NHS England) when health protection plans and arrangements are insufficient to protect the public. The escalation route will depend on the risk or area of under-performance.

1.8 To agree an annual programme of work to further improve local health protection arrangements as informed by the respective Health and Wellbeing Strategies for Devon, Plymouth and Torbay and their Director of Public Health's Annual Report and Joint Strategic Needs Assessments.

1.9 To review and challenge arrangements for the delivery of existing and new national screening and immunisation programmes or extensions to existing programmes.

1.10 To promote reduction in inequalities in health protection across Devon, Plymouth and Torbay.

1.11 To oversee and ratify an annual Health Protection Committee annual report.

2. Membership

Chair: Director of Public Health

Members: *Chair – Health Protection Advisory Group (PHE CCDC/Health Protection Consultant)

*Chair - Devon, Cornwall and Isles of Scilly Screening & Immunisation Oversight Group – Consultant in Public Health *(group under development)*

*Chair – Local Health Resilience Partnership

*Chair – Health Care Associated Infections Programme Board *(group under development)*

Consultants in Public Health / Health Protection Lead Officers– (Devon County Council, Plymouth City Council and Torbay Council)

Head of Public Health Commissioning (Area Team – NHS England)

Head of Emergency Planning Resilience & Response – (Area Team – NHS England)

Chief Nursing Officer – (Northern Eastern and Western Devon Clinical Commissioning Group)

Director of Quality Governance – (South Devon and Torbay Clinical Commissioning Group)

3. Meetings & Conduct of Business

3.1 The Chairperson of the Health Protection Committee will be a Director of Public Health from either Devon County Council, Plymouth City Council or Torbay Council. Directors of Public Health serving these councils will review this position annually.

3.2 The quorum of the meeting will comprise the Chairperson of the Health Protection Committee or their deputy, the Chairperson of each of the four groups listed in 2 above (*) or their representative with delegated authority to make decisions on their behalf, at least one Local Authority Consultant in Public Health (Health Protection Lead Officer) and at least one of either the Chief Nursing Officer (Northern Eastern and Western Devon Clinical Commissioning Group or the Quality and Safety Lead (South Devon and Torbay Clinical Commissioning Group).

3.3 All meeting papers will be circulated at least seven days in advance of the meeting date.

3.4 The agenda (standing items listed in 3.6 below) and minutes will be formally recorded. Minutes listing all agreed actions will be circulated to members and those in attendance within 14 working days of the meeting.

3.5 Meetings will be held bi-monthly.

3.6 Standing agenda items will include the following:

3.6.1 *Performance report;*
3.6.2 *Risk register and action plan review;*
3.6.3 *Serious incidents requiring investigation;*
3.6.4 *Work-programme update;*
3.6.5 *Policy / evidence/guideline updates (All);*
3.6.6 *Any other business.*

3.7 A report of the meeting will be forwarded to members of the Health and Wellbeing Boards for Devon County Council, Plymouth City Council and Torbay Council and Local Health Resilience Partnership.

3.8 Terms of reference will be reviewed annually.

4. Author

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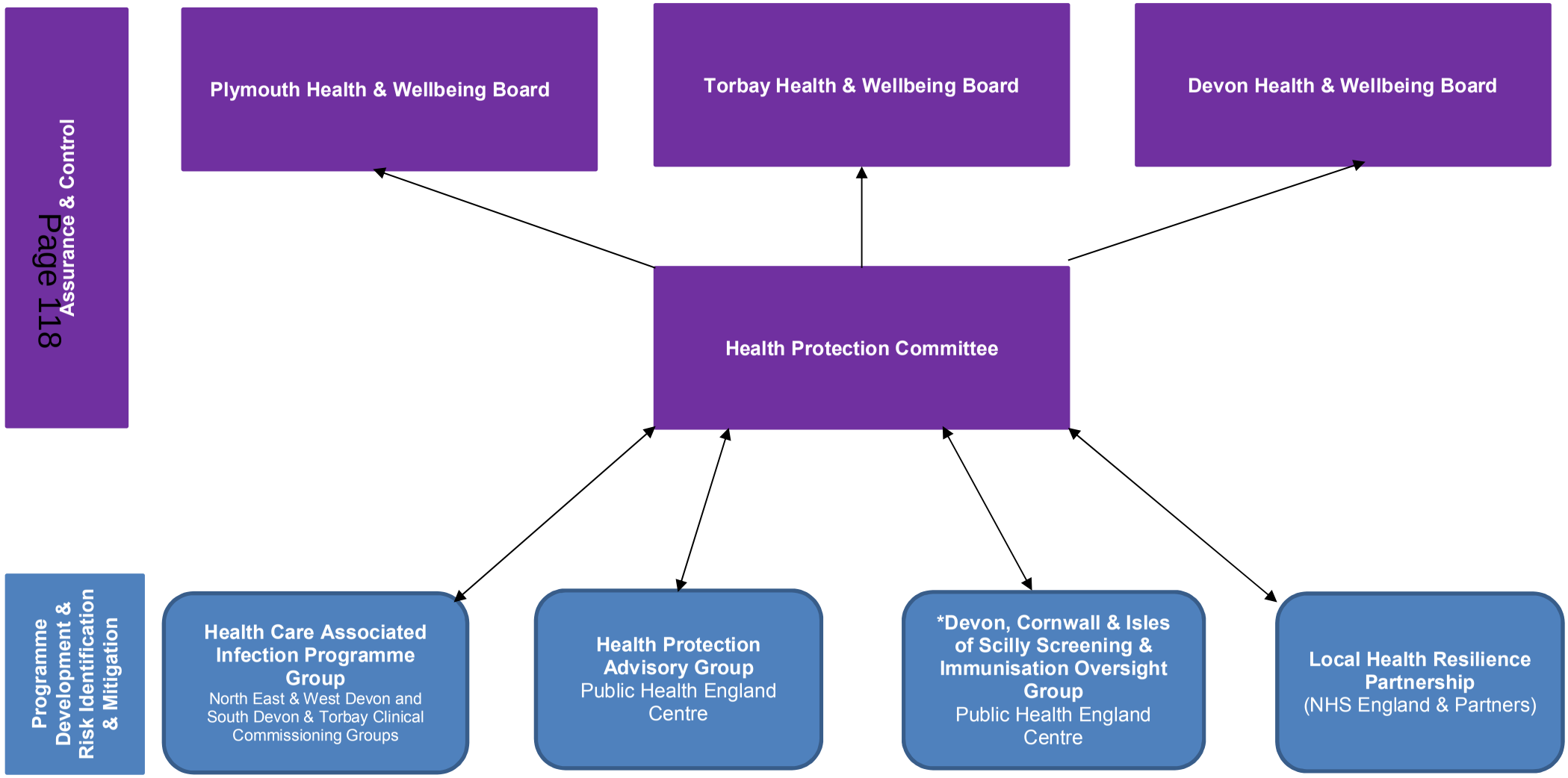
Devon County Council

APPENDIX 2

Health Protection Committee Reporting to the Devon, Plymouth and Torbay Health & Wellbeing Boards and its Relationship to Existing or Planned Health Protection Partnership Forums



***Group in development / Terms of Reference to be agreed.**

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Key priorities relating to the Special Educational Need and Disability Reforms
Wards Affected:	All Torbay
To:	Health and Wellbeing Board **On:** 17 December 2014
Contact:	Matthew Gifford / Dorothy Hadleigh
Telephone:	01803 208265
Email:	Matthew.gifford@torbay.gov.uk / dorothy.hadleigh@torbay.gov.uk

1. Purpose

1.1 To provide an update on actions following the report submitted to the Health & Wellbeing Board on 17 July 2014.

1.2 To provide an update on the current priorities of the Special Educational Need and Disability (SEND) reforms work.

2. Recommendation

2.1 It is recommended that the SEND Reforms Operational Leads group reports to the Partnership for Families Strategic Group.

3. Supporting Information

3.1 The SEND reforms went live on Sept 1 2014. The conversion of statements to Education Health and Care Plans (EHCPs) has already started with a schedule published and available on the SEND web pages. The conversion of statements to EHCPs must be completed by 2018.

3.2 The Torbay EHCP has been ratified by the Department for Education with the Personal Budget's section used as an exemplar for authorities.

3.3 The Torbay Local Offer is published and available to view at www.torbaydirectory.com/family. This will continue to develop over the next 12 months as the SEND team work with children, young people and families to ensure that all relevant services are included. There will be a survey for both families and professionals in February (6 months from 'go live') to capture feedback about the format and content of the Local Offer with the aim of providing evidence to guide further improvements. Comments on the Local Offer must be gathered and published and these will be made available in September 2015 (1 year after 'go live'). Comments on the Local Offer itself are being gathered by the Family Information Service.

3.4 Service users are being directed from the Local Offer website to the Healthwatch Torbay website in order to leave feedback on services. As a 3 month pilot, Healthwatch will provide the SEND Operational Leads with management information based on the feedback received. This information will be used to help identify the strengths and weaknesses of services for children, young people with SEND and their families, within Torbay.

3.5 Social media will be used to capture the views of children, young people and their families. The Parent Participation Forum will be managing a page to gather feedback from individuals and existing groups.

3.6 Two groups are under consideration as a forum for evaluating service user feedback and drafting recommendations to inform commissioning: Children & Young People Committee (where Healthwatch is an elected board member) and/or the Community Health and Wellbeing Forum (managed by Healthwatch).

3.7 The SEND Reforms Steering group met for the last time on 9 October 2014. This group will be replaced by a SEND Operational Leads group who will meet twice a term to manage SEND operational issues. This group includes decision makers from SEN, Children's Social Care, Adult's Services, Clinical Commissioning and Clinical Health. This group, which meets for the first time on 11th December 2014, will report to the Partnership for Families Strategic Group.

3.8 The SEND Operational Leads group will initially prioritise improving links between Children and Adult's, including transitional issues. This group will also be responsible for ensuring that joint commissioning of services considers and reflects the views gathered (see points 3.2, 3.3)

3.9 The Parent Partnership Service has been relaunched as SENDIASS (Special Educational Needs and Disability (SEND) Information, Advice & Support Service). The service, which is funded by the Department for Education and is overseen by the Council For Disabled Children, provides independent and impartial information, advice and support for children and young people with SEND, and their parents/carers. The new service is a collaborative working agreement between Torbay Community Development Trust and the Parent Participation Forum.

Appendices

- SEND Reforms Torbay – Oct 14 – quarterly update

Background Papers:
The following documents/files were used to compile this report:

- Special Educational Needs & Disability Code of Practice 0-25 years

Torbay Council

NHS
South Devon and Torbay
Clinical Commissioning Group

SEND Reforms Torbay

October 2014 (No.4)

The aim of this quarterly briefing is to give an update on the implementation of the SEND reforms which came into effect in September 2014. For further information on any aspect of the reforms please contact 01803 208953 or email *SENDreforms@torbay.gov.uk*

(hyperlinks are highlighted as bold italic green text)

As you will no doubt be aware the implementation date for the SEND Reforms – 1st September 2014- has meant a flurry of documents and website updates. Our event on the 10th September was once again very well attended, and Hugh Malyon's input stressed the need for us all to continually consider how we are engaging, and seeking the views, of the young people themselves. Hugh also stressed the importance of how the Local Offer is used / developed within Torbay in order to make it a 'user friendly' resource.

I would like to thank all those who have been involved in the 'lead in period' and the on-going commitment from all parties. The engagement from everyone involved has been impressive, and shows how committed a workforce we have here in Torbay in taking on board these changes, and what we need to do to support the children/ young people and their families in the future.

I look forward to continuing to work with you on these major changes, and hope that this briefing provides you with some insight into the developments which have occurred so far.

Dorothy Hadleigh, Schools Service Manager

Information Advice and Guidance: SENDIASS

We are pleased to announce the formation of SENDIASS Torbay, the new Special Educational Needs and/or Disabilities Information, Advice and Support Service which is a development of the former Torbay Parent Partnership Service. The changes reflect the guidance in the ***SEND Code of Practice section 2.4.***

The contact number for this service is 01803 208239.

The new service, working in partnership with The Community Development Trust and Torbay Parents Participation Forum, has recently recruited 3 temporary part-time **SEND Support and Administration** workers to provide drop-in facilities within community based offices in all three towns across the Bay:

- 2 days a week in Torquay based at Torbay Community Development Trust, Temperance Street, Torquay;
- 2 days a week in Paignton based at Healthwatch Torbay in Paignton Library;
- 2 days a week in Brixham based at YES at the Edge, Bolton Street.

The SEND Support and Administration workers are:

- Kelly-Marie Givens
- Alexandra Rendell
- Diane Stubley

Marianne Lewis will continue in her current role as Pupil/Parent Liaison Officer, and will oversee the work of the SEND Support and Administration workers based in the drop-in centres.

In addition to the **SEND Support and Administration** workers there is a requirement placed upon us to offer ***Independent Supporters*** to spend one-to-one time with families giving them the help and advice they need to progress through the new SEN assessment and Education, Health and Care planning process. Parents or young people can request an Independent Supporter by contacting SENDIASS Torbay on **01803 208239** or email ***info@sendiasstorbay.org.uk.***

A web page is currently under construction ***www.sendiasstorbay.org.uk*** and this will develop over the coming months.

If you have any queries the email address to use is ***info@sendiasstorbay.org.uk***

SEND Panel (previously known as EHCP Panel)

The SEND panel has been formed by merging the existing Statementing and Access To Resources Disability panels at the request of the SEND Steering Group. This relates to the SEND Code of Practice section 3.7:

> 'Partners must agree how they will work together. They should provide personalised, integrated support that delivers positive outcomes for children and young people, bringing together support across education, health and social care from early childhood through to adult life, and improves planning for transition points such as between early years, school and colleges, between children's and adult social care services, or between paediatric and adult health services'.

The panel has two roles:

1. To decide if statutory assessment is required; and if so:
2. To agree the service provision outlined in the EHCP

The SEND Panel met for the first time on 17th September and will meet fortnightly on a Wednesday morning to consider individual cases. For further information on multi agency decision making in EHCPs please refer to the Code of Practice ***3.7-3.12, 3.35, 9.7.***

Converting Statements to Education, Health and Care Plans (EHCPs)

The SEN team has recently employed 3 Education, Health and Care Plan Co-ordinators to manage the 900 conversions of Statements to EHCPs that will need to take place over the next 3 years. The new process must include face to face meetings with parents / young people to gather their views and inform the EHCP - Code of Practice ***Introduction x, xi, 1.17, 9.21-9.25.***

The Education, Health and Care Plan Coordinators are:

- Hannah Spencer, who joins from the Children's Disability Team;
- Lauren Wardle from the Adoption Service; and
- Mandy Astin who is seconded from the Portage Team (Mandy will also be the Portage Team lead).

The first group of children are currently in the process of having their Statements of SEN converted to an EHCP as part of the pilot. These children were in Year 5 (as at July 2014) attending mainstream school in preparation for Secondary transfer. The schedule below identifies the task in hand for this forthcoming year:

Year Group	Transfer Review Date	Number of Children
Early Years children entering school in September 2015	Transfer Review held in the month of the anniversary of their original finalised statement date	5
Year 5's (for the academic year 2014-15)	Transfer Review held in the month of the anniversary of their original finalised statement date	71
Year 9's (for the academic year 2014-5)	Transfer review held in the months of the anniversary of their original finalised statement	93
Year 11's (for the academic year 2014-15)	Transfer Review held in the autumn term of 2014	89
Post 16	Young people with a Learning Disability Assessment (LDA – Section 139A) can choose to continue to receive their additional support (if still required) from an LDA or request an EHC assessment. Information and support will be available for young people make this choice	125 (est.)

This schedule will be updated each year to reflect the changes in number of each year group.

- The Torbay Local Authority will write to inform schools of those children/young people's Transition Conversion Reviews which are due to be held that term.
- The settings/school/college will arrange the date and time of the ***Transition Conversion Review*** (which will replace the ***Annual Review*** on this occasion) and then advise all necessary parties.

Local Offer:

www.torbaydirectory.com/family

The Local Offer continues to develop, with the vast majority of schools and nurseries having their SEND information now available to view online. Additionally, the ***Children's Disability Team, Hearing Support Service, Integrated Youth Support Service, Youth Justice Team*** and ***Housing*** all have comprehensive local offer information available to view. The next step is to add the services in Health that provide support for people with SEND in Torbay and a session is planned for November to gather this information.

What has happened so far – Recap from the Family Information Service team

- Local Offer forms collected from nearly all education settings including schools, nurseries and childminders. These have been made available on the directory.

- More records have been added to the Local Offer section on the directory. This has included proactive research about best practice in other areas of the country and attempting to fill gaps we have recognised.
- We have added a link to enable users to rate and review services using the ***Healthwatch*** site.
- We have attended a regional seminar about the SEND reforms for Family Information Services which offered a useful opportunity to see how our progress compares with other areas and to share good practice across the region.
- **Reminder: If you already have a record on the directory but are not a service that is required to complete a Local Offer form, you can still add as much information to your record as you'd like. We would appreciate your support to make your record as useful as it can be. Please don't wait to be asked, you can contact us at any time to do this.**

To help us make the directory as user friendly as we need your help!

- Is your service linked under the correct search categories? (E.g. a service may be linked to the Social Care category but it would also be useful to be able to find it under Short Breaks). Please advise the Family Information Service of any changes you feel would help users find the information they require at ***FISenquiries@torbay.gov.uk.***
- Is there a service missing that should be included in the Torbay Local Offer? (statutory or non statutory). If so, please let us know!
- Is there any specific information that should be signposted?

In February we will be conducting a 6 month survey for young people, parents and professionals to guide any necessary improvements. The team will strive to continually improve the Local Offer based on what users tell us.

Local Offer:
Gathering views of children, young people and families

Healthwatch Pilot

A 3 month pilot has started using Healthwatch to gather the views of users of the services within the Local Offer. The aim of this is gain information to guide the commissioning of services within Torbay ***(Code of Practice 3.18)***

The Local Offer now contains a link at the foot of every page to Healthwatch where service users can leave their feedback on their experience of an organisation in the form of comments and a star rating. Healthwatch moderate this feedback and will provide reports to help a commissioning group from education, health and social care decide what services are priorities.

Children, Young People and Families – group feedback

Due to timescales, so far much of the focus has been on statutory services. We need to find ways of identifying what else is out there and what people think of those services.

Discussions with young people, parents, and Healthwatch are planned for early November to start working out what existing groups could be linked in with and how they could be used to help influence local commissioning priorities.

As part of the Local Offer task group we discussed the possibility of parents and young people setting up user groups on Facebook (for example) and gathering feedback on the quality and availability of services for people with SEND. It may be that these groups are already in existence, in which case we need to create links to use local knowledge.

Information Sharing

Information can be shared where there is a legitimate need to safeguard an individual or to actively support their care and wellbeing.

The statutory SEND assessment process ***(Torbay SEN Support Process 2)*** means that professionals will need to share information to inform a child / young person's EHCP (as was the case with the previous Statementing process). Traditionally this has been done by post, but the new statutory timeframe has been reduced by 6 weeks (from 26 weeks to 20 weeks). Once statutory assessment starts, professionals who have been involved in supporting a child will be asked to email information to the SEN team (as opposed to posting reports wherever possible). An inbox will be set up to receive and send secure emails to/from Education, Health and Social Care. We recognise that staff have concerns about what can / cannot be shared and we are working with Torbay Council and Health to create information sharing guidance which will be distributed in the near future.

Event: The Impact of The SEND Reforms – A New Way of Working

There was a lot of interest in the SEND reforms event at the RICC on 10th September, with over 100 professionals attending from Education, Health and Social care. Richard Williams, Director of Children's Services, set the scene by emphasising the importance of working together effectively, with families, and with other agencies. Hugh Malyon, speaking on behalf of a Torbay young people's user group, talked about the need to listen to young people and work with them when commissioning services.

Additionally, Hugh challenged people who run services for young people with SEND in Torbay to tell us about their service and make sure it's in the Local Offer.

Dorothy Hadleigh, School Service Manager and Peggy Seddon, Senior SEN Officer gave a detailed description of the new EHCP way of working and Adele Stephens from Adult's Services summarised the development of Personal Budgets within Adult's Services.

All of the presentations from the event can be found on the SEND reforms web pages or requested from ***SENDreforms@torbay.gov.uk.***

Participants were asked to leave any questions relating to the new EHCP process and a Torbay SEND Questions and Answers document has been created and made available on the SEND Reforms pages ***(please click here).***

Key Points include:-

- Professionals will not be expected to cost out their time for inclusion in an EHCP. Only services procured via a personal budget will need this level of detail.
- The EHCP process will not replace existing pathways or plans for Social Care or Health, the EHCP will work alongside these. The EHCP will ensure that all relevant information is available in one plan.
- A protocol for information sharing is being drawn up and will be distributed to all staff who will need to supply reports to inform an EHCP plan. Secure email options will be detailed within this protocol.
- The EHCP will be shared with all professionals who have made a contribution to the plan or with whom the parents/young person wish it to be shared.

Further support

The SEND reforms project team will ensure that relevant information continues to be made available on the SEND Reforms web page. In addition, as events to communicate changes are arranged, these will be publicised by team managers / email.

If you have an queries about the SEND reforms, please email ***SENDreforms@torbay.gov.uk*** or contact Matthew Gifford (SEND Reforms project manager) on **01803 208953.**

New Literature / Useful Links

- Supporting pupils at school with medical conditions
  https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3
- Social Care guide to the SEND reforms
  https://www.gov.uk/government/publications/send-guide-for-social-care-professionals
- Schools Guide to the SEND reforms
  https://www.gov.uk/government/publications/send-guide-for-schools-and-alternative-provision-settings
- Early Years Guide to the SEND reforms
  https://www.gov.uk/government/publications/send-guide-for-early-years-settings
- Further Education Guide to the SEND reforms
  https://www.gov.uk/government/publications/send-guide-for-further-education-providers
- Managing Changes to Legislation
  https://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014
- SEND Code of Practice
  https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

Department of Health | Home Office

From Rt Hon Norman Lamb MP
Minister of State for Care and Support
Department of Health
Richmond House
79 Whitehall
London SW1A 2NA

Rt Hon Mike Penning MP
Minister of State for Policing & Criminal Justice, Home Office
Home Office
2 Marsham St
London SW1P 4DF
Home Office

27 AUG 2014

To: Chairs of Health and Wellbeing Boards

MENTAL HEALTH CRISIS CARE CONCORDAT: Making change happen in your area

We are writing to make sure that leaders in every area recognise that they are expected to sign up to local declarations, demonstrating how they will implement the standards in the Crisis Care Concordat locally.

In February this year, the Department of Health and Home Office published the mental health Crisis Care Concordat. This sets out the standards that people experiencing a mental health crisis should expect of the public services that respond to their needs. It is available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

The Concordat is a joint agreement, written and agreed by over 20 national signatory organisations, including NHS England, the Home Office, the Association of Chief Police Officers, the LGA and ADASS, and the medical Royal Colleges.

Collaborative working

We are writing to describe the range of opportunities for Health and Wellbeing Boards to access support to develop a mental health concordat for their local communities, and to urge you to get involved in this work. These crisis responses typically involve the police, social services, mental health services and emergency care. The Concordat is about improving the way these services work together, to make sure that people in crisis get the care they need in the appropriate place.

Use of police cells

You will be aware that in around a third of the cases in which police officers detain people they believe to be in a mental health crisis, these people end up being taken to police custody, despite committing no crime. Last year, this happened nearly 8,000 times. The Concordat includes a commitment to halve the numbers who end up in police cells in this financial year, and to end the practice of placing under 18s in police cells.

National commitment

The Concordat is about the national commitment and action required to improve this situation. But we know that this is not enough on its own. This is why the Concordat states that all local areas should produce their own Local Crisis Declarations by December this year, because meaningful action and change happens on the ground, and every area is different and requires unique approaches and solutions to bring about the improvements we all want to see in place.

Mandate

All of this follows the refreshed Mandate from the Government to NHS England, which includes a new requirement for the NHS that "every community has plans to ensure no one in mental health crisis will be turned away from health services".

Local leadership

Because local leadership is such a vital part of this work, we are asking that you each consider the role your own Health and Wellbeing Board can make in helping partners come together to make these Declarations in your areas.

Mind: there to help with local Crisis Declarations

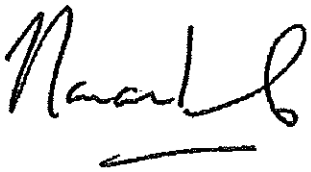
The Department of Health has contracted Mind, the mental health charity, to help support you in this work. They have produced a Concordat website at http://www.crisiscareconcordat.org.uk/ which contains a map that will display progress on ensuring every local area has a Declaration in place. There are also templates available on the website for Declarations, and information on what these should contain and which organisational partners should sign up to them.

Mind and the Department of Health are both available to provide advice and support in your areas, and are running a series of regional events. To find out more about this, please contact the team at crisiscareconcordat@mind.org.uk.

Of course, we know that many areas have already made a strong start on this work, and we certainly look forward to hearing about more examples of local engagement and success. The NHS has already set the requirement, in its guidance *Operational resilience and capacity planning for 2014/15*, for Declarations to be in place. This document is available at:

http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf

Yours sincerely,



Rt Hon Norman Lamb MP

Rt Hon Mike Penning MP

Operations & Delivery
NHS England
Peninsula House
Tamar View Industrial Estate
SALTASH
PL12 6LE

Chief Officers, Chief Executives and Accountable Officers

Statutory and voluntary organisations and agencies for mental health services in the Peninsula

14th November 2014

Dear Colleague

Mental Health Crisis Care Concordat for the Peninsula - Declaration

We are writing to seek your support for a declaration to be made on the National Concordat website on behalf of Peninsula organisations involved in mental health care. The **Mental Health Crisis Care Concordat** is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people in crisis receive urgent mental health care.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the national concordat. It focuses on four main areas: access to support before crisis point; urgent and emergency access to crisis care; quality of treatment and care when in crisis; and recovery and staying well.

The approach we have taken in the Peninsula follows on from the Call to Action for Mental Health conference held in February, where an agreement was reached to develop a Mental Health Crisis Care Concordat for the Peninsula, steered through a Learning and Action Set for Chief Officers from selected organisations. The Learning Set has involved service users and carers from the outset.

The Peninsula Learning and Action Set has started and will operate as an influential group of senior leaders, championing mental health issues, parity of esteem and transformation of the patient experience at Board level and in local, regional and national forums.

The organisations selected to form the Learning and Action Set are:

- Service user and carer (requested through Mind and Rethink);
- Peninsula main NHS mental health providers – Cornwall Partnership NHS Foundation Trust – Colin Quick, Devon Partnership NHS Trust – Melanie Walker and Plymouth Community Health -Dave McAuley;
- Devon and Cornwall Police - Sharon Taylor;
- Devon and Cornwall Police and Crime Commissioner – Andrew White;
- Peninsula CCGs – Kernow CCG - Dr Paul Cook, New Devon CCG – Dr Stephen Miller and South Devon & Torbay CCG – Dr Derek Greatorex;
- Local Authority Adult and Children's services - Carole Burgoyne;
- Voluntary sector- Samaritans- James Waghorn;
- South West Peninsula Academic Health Science Network – Ian Harrison;
- Acute Trust emergency care system leader - Anne Hicks;
- South Western Ambulance Service NHS Foundation Trust – David Partlow;

- Strategic Clinical Network for Mental Health in the South West- Justine Faulkner;
- Area Team, NHS England – Amanda Fisk.

This gives us a group of people from 11 sectors.

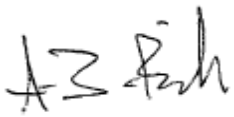
The Learning and Action Set will meet once every 6 weeks for approximately 12 months to enable the members of the Set to get to grips with the local issues and what needs to change. It will translate the experience of participants into a vision for improved mental health, providing the opportunity for understanding the perspectives of the various agencies and identifying and working through obstacles and opportunities for change to realise the local concordat.

In terms of national expectations, it is expected that all localities will have submitted their concordat declarations by the end of the year across England. Once declarations have been made they are submitted to the concordat website, which includes a map showing where progress has been made. The next step is then to develop an action plan that sets out in detail how we will continuously improve support for people in mental health crisis. The Peninsula makes sense as a locality for the declaration given the connection through the Strategic Clinical Network and also the work of the Learning and Action Set. Further details and a copy of the draft declaration can be found at:

www.crisiscareconcordat.org.uk

We would like to submit the declaration at the end of the month, and therefore request your support. Please do raise any issues of interest or any queries with Amanda Fisk. We will review feedback and anticipate, if everyone is in agreement, uploading the declaration on 1st December.

Yours faithfully



Amanda Fisk
Director of Operations and Delivery
NHS England
(Devon, Cornwall & Isles of Scilly Area Team)

Dr Adrian JB James MB BS FRCPsych
MSc (Criminol.)
Consultant Forensic Psychiatrist
Chair, Strategic Clinical Network for Mental Health in the South West

Cc: Jim Symington, National Concordat Implementation Team

torbaysafeguardingchildrenboard

Torbay **Safeguarding Children** Board

Annual Report

2013-2014

November 2014

Keeping children safe is everyone's responsibility

Torbay Council Children's Services ■ Police ■ Health ■ Connexions
Youth Offending Team ■ Probation ■ CAFCASS ■ Safer Communities ■ Fire Service
■ Schools ■ Community & Voluntary Sector
www.torbay.gov.uk/tscb

Foreword by Independent Chair

Welcome to the annual report of the Torbay Safeguarding Children Board for 2013-14. This report sets out the activities of the Board in the financial year 2013-14. This report is for all partners of the TSCB as well as informing the work of the Health and Wellbeing Board and providing assurance to the Executive Director of Torbay and the Council's Scrutiny Committee.

The report describes the work of the Board and its sub committees over the last year and notes areas of achievement as well as identifying further areas for improvement and future work. The business plan for the Board for 2014-15 and its identified priorities draw from the annual report. (http://www.torbay.gov.uk/tscbbusinessplan2014-15.pdf)

As is noted in the report there was change of Independent Chair in August 2013 and our priorities were set quite late in the year. A number of these have been rolled over into 2014-15.

The Board has created an Executive on which the senior members of the respective agencies sit as well as the chairs of the subgroups that report to the Board. This has allowed much more debate and challenge as well as linking the work of the subgroups up more tightly. In addition it has allowed the main Board to focus much more in depth on key areas as well as having significant input into the learning arising from Serious Case Reviews.

Over the last twelve months the Board has sharpened its focus on frontline practice, and strengthened the Multi Agency Case Review process. The ability for agencies to challenge more effectively and the Board to hold agencies to account has been strengthened and the impact of this can be seen through changes in practice and policy.

The priorities over the coming year will be to continue to look at early help arrangements and also develop better engagement with children, young people and their parents as part of our monitoring of multi professional safeguarding practice.

We will follow through on the work around training to make this more effective and look to strengthen multi agency working. A particular focus will be around the needs of looked after children particularly these placed outside the local area and also looking at how neglect is tackled at all levels within Torbay.

The TSCB will be developing closer links with Devon Safeguarding Children Board and looking to appoint a Manager to cover both Boards. In addition it is proposing to move to one Serious Review Group covering both Boards as well as a single back office and shared web site. There are real benefits in terms of improving capacity and building a more robust structure as a result of these developments.

The reductions in public expenditure and accompanying organisational change puts real challenge to building and sustaining effective safeguarding arrangements. It requires organisations to work even closer with one another to achieve this. The Board will be focusing on ensuring that all partners play their part in safeguarding the most vulnerable children and young people.

Contents

1. Essential information

Authorship: Lisa Jennings, Torbay Safeguarding Children Board (TSCB) Business Manager and David Taylor, Independent Chair of the TSCB

Approval Process: Approved at the TSCB meeting of 5th November 2014

Date of publication: November 2014

This report covers the period 1st April 2013 to 31st March 2014 and reflects the structures that were in place up to the end of March 2014

Contact: tscb@torbay.gov.uk

2. Executive Summary

The Torbay Safeguarding Children Board set itself a number of objectives in 2013 -14. This annual report sets out the progress in achieving these as well as the other work undertaken by the Board and its subgroups.

The Board undertook a review of training in this year and a finished report in respect to this has now been to the Executive. This recommended a greater synergy between the activities of the Board and single agencies as well as the development of a blended training programme in the next year. In addition there needs to be a greater emphasis on evaluating the impact of training. A particular success in this year has been the Best Practice Forums which have had a high level of multi agency attendance. The next stage will be to implement this and this will be a significant piece of work in 2014-15.

The Board has strengthened its approach to case auditing and performance management and the outcomes of this have been used to challenge practice as well as inform the deep dive whole Board events which have focused on issues such as Mental Health and also Child Sexual Exploitation (CSE). There is still more work to be done on gathering information from all partners and also getting feedback from children, young people and their families. This will be a priority for the Board in 2014-15.

The Board has focused on the Chid Sexual Exploitation work following the learning from Operation Mansfield. There has been training provided for schools and awareness raising with local businesses and schools. A CSE pathway has been agreed and work is being done to link the outputs from the CSE assessment tool to the Children's Journey threshold document. The Board intends to have a deep dive event focusing on CSE in 2014-15 as well as monitor the arrangements for agencies to work together and track the incidence of CSE in Torbay.

The Board has undertaken two serious case reviews (SCR) this year and both of these are to be published in the coming year. A serious case review which involved Torbay was published in Birmingham and the learning from this has been disseminated via a briefing report which all agencies were tasked with cascading to their staff.

The Board reshaped its operation this year and created an Executive to deal with detailed business of the Board and allowing the wider Board to focus in on particular areas. This has worked well and allowed the opportunity for front line workers to engage with senior managers. Similarly the attendance of the subgroup chairs at the Executive has allowed more understanding across the Board of different pieces of work. The Chair has produced a summary for all Board Members at the end of each Executive and everybody receives the papers and a standing invite to attend for any matter of interest. The Board have secured the participation of one lay member and are hoping to get somebody to represent the faith community in 2014-15.

The Board has demonstrated its challenge role and the Chair has attended the Health and Wellbeing Board on a number of occasions as well as meeting with senior managers in all agencies and also the Executive Director in Torbay Council. With the demise of the Children's Improvement Board the TSCB will have a more direct challenge role in respect to the Local Authority and its performance and in this year coming has made the safety and well being of Looked After Children as a priority.

In this year a Health subgroup, covering the far south west, has been set up as well as an Education Safeguarding Group for Torbay. Both of these groups report to the Executive. There is still outstanding work to resolve the lead Safeguarding role for the Local Authority in respect to schools as well as the LADO arrangements.

The Board has worked with Devon closely and there are now plans to have a joint Board and also Office Manager and to bring the Serious Case Review Groups together from January 2015. In addition there will be a joint conference in 2014 and a bringing together of the respective websites. These changes will give the Board added capacity and reduce demands on partners who cover both authorities.

In this year a practitioners group has been established and a facilitated event generated ideas and proposals in respect to early help arrangements. The practitioners group are looking to do further work on the effective functioning of core groups and also review the standards document.

Early help arrangements remain a priority of the Board and there will be a further audit of cases in 2015 as well as a themed event together with ongoing monitoring of activity.

The Board has worked hard to improve its communications and has produced a regular newsletter as well as doing some more targeted work to particular groups. Over the next year the Board will be developing its ability to reach key groups through the joint website and a number of themed campaigns.

The Board works with other authorities in the far south west and have jointly carried out a staff survey as well as administered the section 11 audit. The Board will be involve in the re-commissioning of the Child Death Overview Process (CDOP) service as well as influencing the specification of the south west child protection procedures.

3. Local background and context

Torbay is located within the South West region of England. It consists of 24 square miles of land spanning the towns of Torquay, Paignton and Brixham, which together occupy an east-facing natural harbour by the English Channel.

Torbay is highly populated with some 131,000 people across its 24 square miles. Torbay's position as a seaside community continues to prove popular as a retirement destination with the number of over 65's residing in the area being 7.3% higher than the England average. In addition the number of 0-19 year olds residing within Torbay is 2.9% lower than the national average.

There are pockets of severe deprivation and inequalities within Torbay. These pockets tend to be communities that experience poorer outcomes such as poorer educational attainment, poorer socioeconomic status, lower earnings and the lowest life expectancy.

Torbay is within the top 20% most deprived local authority areas in England and most deprived local authority in the South West for rank of average score. Torbay's relative position within the national model of deprivation has worsened in recent years.

In terms of income deprivation affecting children there has been an increase in the number of areas which rank in the top 10% most deprived. The increase in areas is across Torquay. The number of children aged 0 to 15 who are living in areas which rank in the 10% most deprived increased from 681 in 2007 to 2,301 in 2010.

Torbay has approximately 27,700 children and young people aged 19 and under. This is 21.1% of the total population. The proportion of state-funded pupils entitled to free school meals based on the January 2012 School Census is above the national average (Torbay 17.6%, national 16.9%).

Children and young people from minority ethnic groups account for 6.3% of the total statutory school age population, compared with 25.4% in the country as a whole. The largest minority ethnic groups are Mixed (1.3%), Any Other White Background (0.8%) and Asian (0.6%). The proportion of, state funded, compulsory school age pupils whose first language is believed to be other than English is below the national figure (Torbay 3.2, national 15.2).

Children Services in Torbay recorded 1100 referrals in 2013/14 which was 10% up on the previous year. The increase recorded last year was not linked to any changes in the systems or thresholds used by Children's Services during this time. Torbay's rates of referral are slightly below similar authorities and national benchmarks.

Ofsted (March 2013) found the thresholds and practice within the Safeguarding Hub to effective and safe.

The levels of referral are indicative of the levels of demand within the community and the ability and readiness of the public and partners to identify children about whom they are concerned. Contacts from Schools, Health and members of the public all rose by about 30% in 2013/14 compared to the previous year.

Internal auditing and independent research has confirmed that complex families involving significant levels of neglect and abuse, often linked to domestic violence, are a dominant feature of the referrals that social workers are dealing with. For example, an independent exploration of Torbay's practice by Social Finance and the NCB both noted the high levels of domestic violence in the referrals received by Children Services.

4. Statutory and legislative context for LSCBs

The TSCB is the key statutory mechanism for agreeing how local organisations cooperate to safeguard and promote the welfare of children within Torbay.

The core objectives of the Board are set out in section 14(1) of the Children Act 2004 as follows:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and

- to ensure the effectiveness of what is done by each such person or body for that purpose

Regulation 5 of the Local Safeguarding Children Board Regulations 2006 sets out the functions of the Board in order to fulfil those responsibilities, these include:

- Developing policies and procedures for safeguarding and promoting the welfare of children
- Communicating to local people and organisations the need to safeguard children, raising their awareness of how this can be done and encouraging them to do so
- Monitoring and evaluating the effectiveness of safeguarding work by TSCB members individually and collectively and agreeing ways in which this can improve
- Participating in the planning of services for children and young people in Torbay
- Undertaking Serious Case Reviews and advising Board members on lessons to be learned and actions to be taken
- Implementing an effective and co-ordinated response by Board members to the unexpected death of a child

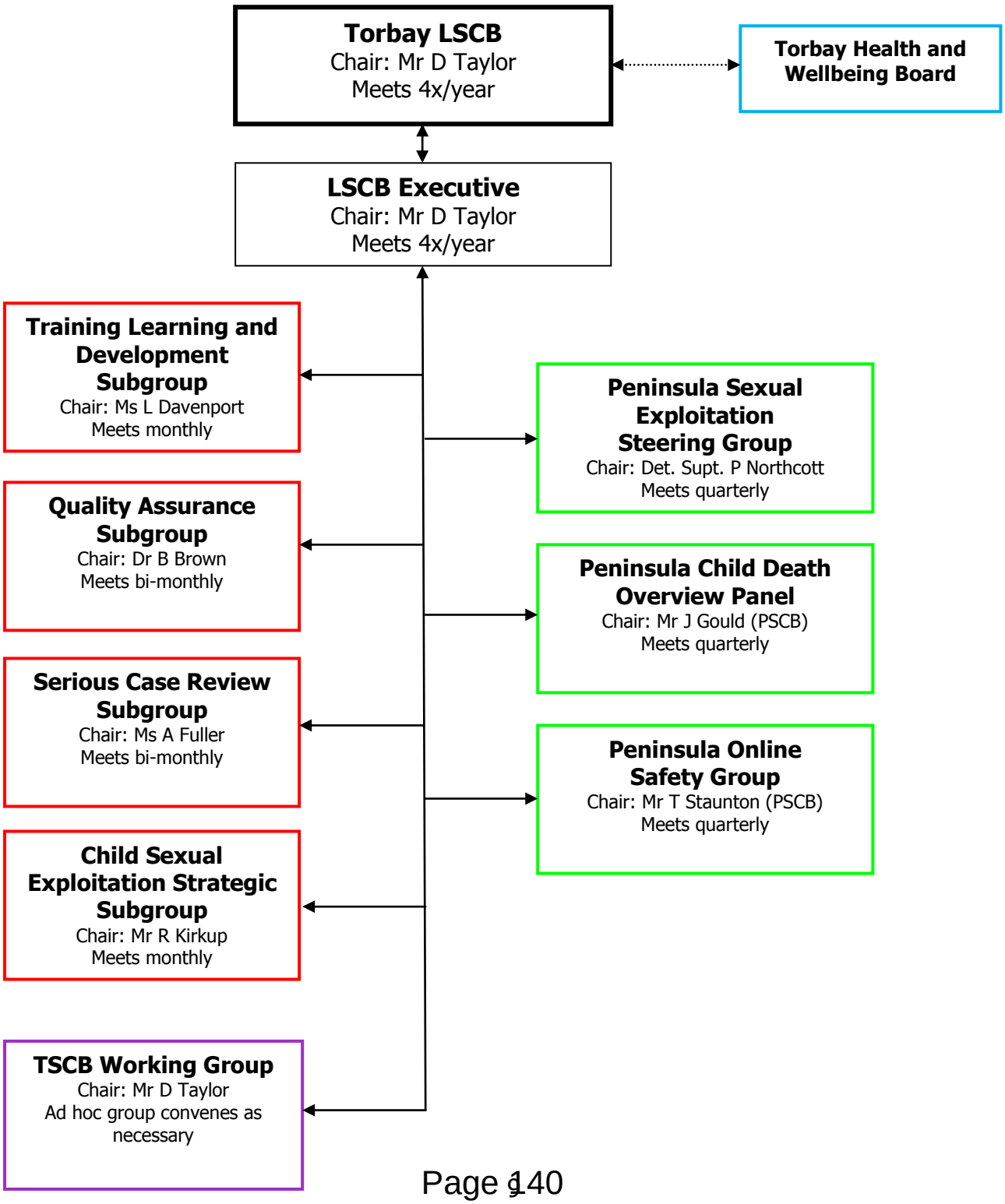
The full Terms of Reference of the TSCB can be found at www.torbay.gov.uk/tscb

5. Governance and accountability arrangements

TSCB Structure

At the start of 2013/2014 the structure of the TSCB was based on a full Board meeting which met four times per year and a Delivery Board which met four times per year. Following the appointment of David Taylor as Independent Chair in September 2013 a review of the TSCB's governance arrangements was completed. The full Board continues to meet four times per year and is supported by a smaller Executive which meets six times a year.

The diagram below outlines the structure of the TSCB and its associated subgroups and peninsula working groups at March 2014.



TSCB Office

The Board is supported by a small Business Unit which is responsible for both coordinating the work of the Board and its subgroups and ensuring the TSCB is supported in making informed decisions. The Business Unit employs an Independent Chair, Business Manager and two Coordinators.

TSCB Financial Statement

Partner agencies contribute to the TSCB budget on an annual basis. Contributions have remained set for last 2 years. The budget for 2013-14 was set at £122,151.00.

TSCB Business Unit	
Expenditure type	**Outrun £**
Staffing Costs	£98,936.11
Meeting Costs	£765.70
Admin & Office Costs	£1,424.99
Child Protection Procedures	£750.00
Child Death Overview Panel	£9,651.00
SCR Training	£3,590.68
TSCB Development Day	£652.00
Best Practice Seminars	£1,337.00
VCS Engagement	£2,500.00
Total	**£119,607.48**
Contribution from TSCB Partners	£122,151.00
Under spend for 2013-14	**£2,543.52**

The Budget for 2014-15 has been set at £123,981.00 with partner contributions agreed as follows:

Torbay Council £75,280.57
Torbay and Southern Devon Clinical Commissioning Group £28,673.02
Devon & Cornwall Police £13,861.30
Devon & Cornwall Probation £5,616.11

The costs associated with Serious Case Reviews are not covered by the main board budget. The costs associated with Serious Case Reviews in 2013-14 came to £31,759.13, and were covered by contributions from partner agencies.

Serious Case Reviews	
Expenditure type	**Outrun £**
Panel Chairs	£4,187.50
Overview Report Writers/Lead Reviewers	£23,582.19
Admin & Office Costs	£1,489.44
Training	£2,500
Total	**£31,759.13**

Each year partner agencies are asked to complete a training needs analysis which determines how many multi-agency training courses are required. The costs associated with Training in 2013-14 came to £23,113.60. Partners contribute to the costs based on the number of places they purchase.

Multi-Agency Training	
Expenditure type	**Outrun £**
Trainers	£21,859.60
Venues	£1,080.00
Printing Costs	£174.00
Total	**£23,113.60**

6. Summary of the sufficiency of safeguarding arrangements

Progress made against strategic/themed priorities in 2013-2014

Following the appointment of a new Independent Chair in August 2013 the September Board meeting was used to determine the Board's priorities: Multi-Agency Training, Multi-Agency Case Auditing, Child Sexual Exploitation and provision of Early Help.

Multi-Agency Training

The Training, Learning & Development Subgroup was commissioned by the Independent Chair to complete a review of Safeguarding Training in November 2013. The subgroup completed an initial analysis of the training position in November 2013. This was reported to the TSCB Executive in December 2013. In summary it drew the following conclusions:

- there is a training sub group in place with good cross agency representation uptake of training across agencies is inconsistent
- information on training standards does not help workers know what is expected of them
- the link between training and practice is not well defined
- the package of training is not sufficiently flexible to meet the diverse needs of organisations
- organisations are developing their own solutions departing from principles of multi agency training
- the TSCB does not receive sufficient assurance that staff have appropriate training to meet the requirements of their role
- funding streams restrict the opportunities to develop flexible training options

Details on how the subgroup has taken this forward can be found in the subgroup report on page 20.

Multi-Agency Case Auditing

The TSCB has set up a robust approach to case auditing on a bi yearly basis. Particular themes are chosen and the case audit relates to these. The learning from the case audits are considered by the executive of the Board and the Best Practice forum is used as a channel to disseminate key messages to practitioners. In addition changes are made to training programmes, practice guidance and procedures as a result of the audits as well as informing challenge to individual agencies from the Board.

For next year consideration is being given to undertaking auditing on a quarterly basis and thinking about how practitioners are involved more systematically.

In addition to the Multi Agency auditing the Board is also considering single agency audits and learning from these about the quality of safeguarding practice across organisations. Outcomes from the December 2013 audit can be found on our website.
(http://www.torbay.gov.uk/multiagencycaseaudit2013.pdf)

Child Sexual Exploitation

The Board established a new Subgroup in July 2013 to act as a conduit between the Peninsula CSE Steering Group and the local Missing and Child Sexual Exploitation Forum (M&CSE). The group have been pulling together a comprehensive strategy in relation to the way agencies respond to incidence of Child Sexual exploitation. This includes an emerging strategy to raise awareness in schools and the local community, agreeing a clear pathway for referrals via the MACSE and the safeguarding hub and thinking about how victims are best supported and protected.

In addition a specialist assessment tool has been devised based on the Derby model. These recommendations will be coming to the executive of the TSCB for approval in the next round of

meetings. It is planned to hold an in depth Board event looking at CSE early in 2014 which will look at feedback from young people and their families as well as some of the empirical data.

Early Help

The development of a robust approach to early help is an important part of the safeguarding pathway for vulnerable children. The Board has set up a practitioner group which will be looking at the Working Together 2013 guidance, as well as the existing arrangements and reporting back to the Executive in June in respect to this.

In addition through the case auditing the Board is looking at a spread of cases including early help which will inform this work. Through the sample of CAMHS cases the Board has raised the gap in tier 2 provision for CAMHS and also the supervision arrangements of agencies where cases are not subject to safeguarding plans. The Chair has also written to the Local Authority about the commissioning arrangements for children's centres and how well these are tied into the wider early help strategy.

Board Meetings

The Board agenda offers opportunities for information sharing and discussion, but also encourages questioning and challenge. Five meetings have taken place this year with a range of areas having been addressed. Appendix 1 sets out Board Membership.

The April Board meeting looked at the findings from **Ofsted's inspection** of Torbay's arrangements for the protection of children.

June's meeting looked at the **Sexual Harmful Behaviour Policy and Missing Persons Guidance.** It also identified some streams of work coming out of Working Together 2013.

September focused on the **Board's priorities** following the appointment on a new Independent Chair.

The December meeting looked at the findings from **multi-agency case audit activity** undertaken by the Quality Assurance Subgroup. The issues identified for the Board to consider included:

- Multi Agency Training
- Child Protection to Child in Need and step down arrangements
- Effectiveness and efficiency of Core Groups
- Supervision across the partnership
- Escalation – lack of confidence and knowledge

The Board agreed that they would initially focus on the effectiveness and efficiency of Core Groups and a working group was established…

It was also agreed that Torbay's Professional Differences Policy would undergo a review and re launch.

The March meeting concentrated on the emerging findings from an ongoing **Serious Case Review**

A summary of all Torbay Safeguarding Children Board meetings can be found on our website.
http://www.torbay.gov.uk/tscbboardmeetings.htm

Appendix 2 provides a breakdown of attendance at Board meetings.

Subgroup Updates

The TSCB is required to monitor and evaluate the effectiveness of what is done by the authority and partners individually and collectively to safeguard and promote the welfare of children. The TSCB undertakes this task through its business plan and subgroups.

Child Sexual Exploitation Strategic Subgroup

The Child Sexual Exploitation (CSE) Subgroup is responsible for supporting strategic delivery of the multi agency response to children and young people involved in or at risk of sexual exploitation.

The subgroup has also developed a **referral pathway, risk assessment toolkit** and **awareness campaign**. All of which are due to be launched in 2014-15 following sign off by the TSCB Executive.

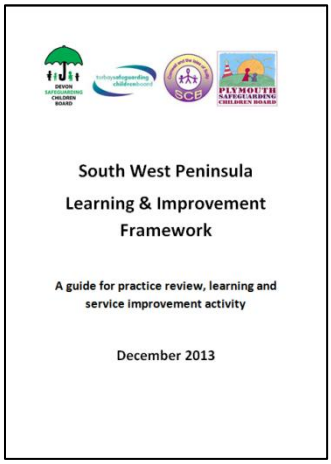
http://www.torbay.gov.uk/childsexualexploitation

Quality Assurance Subgroup

The Quality Assurance Subgroup meets every eight weeks. For the period April 2013 to March 2014 seven meetings were held. The subgroup is responsible for quality assuring the child protection work being undertaken by partner agencies and advising the Board on any required action arising from audits in order to improve safeguarding responses across the system.

In partnership with the far South West Peninsula LSCB's the Quality Assurance Subgroup has developed a **Learning & Improvement Framework.** Working Together 2013 requires all LSCBs to maintain a local Learning and Improvement Framework which is shared across local organisations who work with children and families. The framework sets out the LSCB's commitment and statutory obligations to ensuring learning and improvement not only takes place, but does so in a blame free, child centred culture. It describes where practice learning comes from, how it should be

disseminated and embedded in practice and finally arrangements through which service quality and improvement should be evaluated and monitored.



http://www.torbay.gov.uk/tscbguidance.htm

During 2013-14 the Subgroup piloted a **safeguarding survey with schools**. A sample of four schools were chosen from the 43 schools in Torbay and all staff within each of these schools were provided a safeguarding questionnaire to complete and return anonymously.

The focus of the questions was themed around the following aspects of safeguarding:

- creating a culture of safeguarding,
- safeguarding policies and procedures, and
- Training in safeguarding – specially low-level neglect and child sexual exploitation which were highlighted as areas of improvement in Torbay as a result of findings in recent Serious Case Reviews C24 and C26.

The survey identified that there are several areas of work required to develop further the safeguarding arrangements in existence.

There needs to be greater consistency in all schools seeking active participation of parent(s) / carer(s), children and staff when reviewing safeguarding policies and procedures. This might be achieved through the governing bodies of schools publishing the dates of its cyclical review of policies and procedures on the school website inviting contributions through a serious of standardised questions of a particular policy in terms of their personal experience of its implementation.

Embedding safeguarding culturally would be more effective if schools used staff meetings and briefings, written communiques and other identified modes of communication to ensure frequent and regular information and guidance on safeguarding was being communicated. This 'drip-drip' effect of succinct, accurate and relevant information sustained over time would enhance everyone's knowledge basis and raise confidence in dealing with concerns.

The promotion within schools of its procedures for managing allegations against teachers and other staff and of the school's whistleblowing policy would improve confidence in the process of raising concerns about the behaviour of colleagues irrespective of the individual's position within the school.

Induction and training content needs developing to raise awareness of topical local issues facing - schools – child sexual exploitation and low-level neglect. This could be achieved by production of a

standardised induction and level 2 training programme containing direct reference to identifying concerns in these areas.

The findings were presented to the Schools Steering Group who agreed to role out the survey across all Torbay schools. This was completed and resulted in the following recommendations:

1. Development of a standardised induction on safeguarding for use by all schools.
2. Commissioning the development of a participation strategy for stakeholders.
3. Commissioning of training programmes for staff around low-level neglect and child sex exploitation.
4. Development of a mechanism to allow the dissemination of safeguarding information to all staff within each school.
5. Yearly audit of this nature to establish whether there are any changes as a result of plans put in place.

In response the Board has agreed to introduce a dedicated Education Safeguarding Subgroup in 2014-15 to take the recommendations forward and will be reported on in next year's annual report.

The Subgroup undertook a **Multi-Agency Case Audit** in December 2013 which focused on pre-birth and child in need cases. The organisations covered within the audit were Police, Probation, Children's Social Care, Midwifery, Health Visiting, School Nursing and Education. Due to time constraints and capacity, on this occasion General Practice and Adult Mental Health records were not viewed.

The findings have been grouped into those specific to each area, then commonalities across the two. There was a notable improvement in more recent practice in the cases audited, reflecting the outcomes of the Ofsted inspection and commitment to improvement by all partners.

Pre-Birth Cases

Good Practice	Areas of concern
• Early identification of risk and compliance /adherence to Unborn Baby Protocol • Above leading to good outcomes for children within appropriate timescales for their development and attachment • Appropriate referrals into the Peri-Natal Mental Health Team • Evidence of clear identification of risk and contingencies in place (police) • Appropriate referrals into Family Health Partnership • Robust management oversight of cases by Named Midwife • Evidence of early risk identification and continued review as issues change (Social Care/Health)	• Delays in Parenting Assessments and other specialist assessments required to assess level of risk posed by parents • Is use of CP process appropriate in all cases • Clarity about CP process when child is accommodated • Poor contingency planning in one case where parents had moved out of Torbay • No clear links with Adult Services in one case when assessing risk • No access to current peri-natal mental health service for under 18's

Child in Need

Good Practice	Areas of Concern
• Some evidence of good visiting patterns being established by Social Workers and Health Visitors/School Nursing • Some evidence of effective supervision across health and social care allowing time for reflection, review of progress and identification of need to challenge (health) where there are delays • Good evidence of delays/decisions being challenged by health • Good evidence of child being seen following disclosure and roles of professionals being explained to them (police)	• Lack of consideration given to father being a protective or risk factor and able to provide a safe environment • Lack of specialist health input into the CP process, e.g. dental and ophthalmology in neglect case • Some evidence of passive involvement by HVs/SNs – focus more on Public Health than Safeguarding • Inadequate communication between Probation and Social Workers regarding levels of risks posed by adults – this was reciprocal • Lack of engagement of Specialist Services (Alcohol, substance misuse, mental health) in CP process/risk assessments • Some evidence of erratic or even absence of supervision within health and social care

Commonalities

Good Practice	Areas of Concern
• Overall it is clear that practice has sustained an effective change • Supervision is variable in frequency and recording but has improved • Outcomes for children have improved, with more timely interventions taking place	• Effectiveness of Core Groups, often not taking place, not being recorded, lack of clarity of partner agencies roles and responsibilities within the Core Group • Lack of challenge and escalation in respect of Core Groups and progress against plan • Step down from CPP to CIN – plans not always evident or communicated to other professionals • Contingencies not always considered • Evidence of cases being dropped when they move to CIN status (health) • Lack of clarity around legal thresholds and roles and responsibilities where children become looked after • Delays in Core Assessment completion, and the quality of them, often not using partner agency knowledge and expertise • Strategy discussions/meetings need to be widened to include other agencies and recorded

Section 11

Section 11 of the Children Act 2004 placesa duty on key persons and bodies to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

LSCBs are required to co-ordinate and ensure the effectiveness of partners, both individually and together, for the purposes of safeguarding and promoting the welfare of children, including arrangements made under the Section 11 duty. The far South West Peninsula LSCBs take a collaborative approach to Section 11 audits.

This means agencies covering more than one LSCB submit only one annual return to be used by all four safeguarding children boards. Partner agencies are required to self-evaluate their compliance against the standards and submit a safeguarding improvement plan for the coming 12 months. Agencies can assess their compliance using an audit tool reflecting the Children Act 2004 Agencies are also expected to report on the progress of improvements to safeguarding during the previous 12 months.

Additionally, under the Section 11 assurance process, the far South West Peninsula LSCBs expect front line staff working directly with children, and their immediate managers, to provide their views

about their agencies' policies, procedures and practices related to the safeguarding of children and comment on how to improve safeguarding children practice by responding to the Staff Safeguarding Children Survey. The results from these surveys provide further assurance of agency compliance and provide each LSCB with an indication of overall safeguarding children practice within their LSCB area. The individual agency survey reports present leaders of such agencies with comparative information and feedback from their staff on where safeguarding children practice is considered good and in place and where weaknesses exist and need improvement.

Peninsula Safeguarding People Staff Survey 2013
The Safeguarding People Staff Survey was managed on behalf of all LSCBs by the Devon Safeguarding Children Board (DSCB). The questions were aligned to the Section 11 guidance and the survey constituted a tool for Section 11 assurance agreed by the peninsula LSCBs. The survey was distributed to all agencies within the Peninsula LSCBs in Cornwall and the Isles of Scilly, Devon, Plymouth and Torbay for front line staff and their immediate managers during June 2013. Returns were collated by DSCB and distributed to agencies.

Section 11 process for 2014
Organisations will be asked to provide the following:

- to complete a declaration of compliance,
- to detail progress against the 2013 Action Plan and outline improvements planned for 2014,
- to reflect on the 2013 staff survey
- to detail subsequent improvements planned for 2014.

Performance data
The TSCB has worked hard to develop a performance data set that reflects the work of all agencies and looks at the effectiveness of our multi agency working in Safeguarding children and young people . We have had some success in this although there is still outstanding work in terms of getting good information back from some adult agencies in respect of the children subject to Safeguarding arrangements or children in need where they are a working with the parent. We are also keen to get better data re the CAMHS service both at level 3 and 4 as well as understanding those who currently are unable to access the service

In addition we are still trying to understand better the early help pathway and get better and more detailed information in respect to this including the participation of agencies as lead workers.

The Board have set as a priority in the 2014-15 business plan the gathering of feedback from children , young people and parents about the effectiveness of agencies in working together to support them and helping them tackle some of the underlying issues that are causing safeguarding concerns

The Board through its Quality Assurance subgroup is trying to distill from the report the key issues for the executive to consider so this really promotes effective challenge and change in the way that the agencies work together

Allegations Against People Who Work with Children
January to June 2014

This is a half yearly profile of allegation management activity in Torbay with commentary on service development.

Allegation Management Criteria:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child; or

- Behaved towards a child or children in a way that indicates s/he is unsuitable to work with children

Contacts
Employers/managers who make an initial inquiry to the LADO are asked to following this up in writing by means of completing a LADO referral form regardless of whether this meets the criteria or not.

If the referral is considered to meet the criteria it is accepted as a formal referral and placed on PARIS. If not it is logged in the LADO advice file.

Number of contacts that were not considered to meet the LADO criteria: 26

Note: These were more conduct type issues where a child was not harmed but where there was an inappropriate response to a child which the employer was advised to pursue through their disciplinary procedures

Referrals
Number of referrals that were considered to meet the LADO criteria: 24

Breakdown of LADO referrals that did meet the criteria:

Type of harm	
Physical	12
Sexual	10
Emotional	
Neglect	
Other	2

Inquiry Strands:
- Criminal Inquiry 6
- Assessment by Children's Services 5
- Disciplinary Inquiry by employer 19

Note: Some referrals will be managed down more than one strand

Outcomes

NFA	4
Disciplinary	19
Referral to DBS	3
Ref to regulatory body	2
Dismissal	1
Resignation	4
Additional training	5
Foster Panel	2
Unsubstantiated	3

Key trends

Physical harm	Most relate to inappropriate responses to children presenting challenging behaviour
Sexual harm	Most relate to the downloading of child pornography

Commentary
The data in-put, collection and documents supporting this activity needs to be reviewed to ensure it is delivering relevant information that may accurately and comprehensively provide a profile of allegation management activity.

People who consult the LADO are very willing to respond to the advice given, complete the referral form as requested and attend Allegations Management Meetings as required.

If they are advised to progress the issue under their disciplinary procedures they tend to respond to requests for outcomes in a timely manner.

Hence it is the LADO's experience that with those agencies the LADO has contact with the process is well respected and adhered to.

Whether all agencies are adhering to the allegations management process is unknown.

LADO arrangements
The LADO arrangements are currently under review. Since January 2014, one Reviewing and Safeguarding Officer has acted as Torbay's LADO whilst undertaking other Reviewing and Safeguarding duties e.g. Child Looked After Reviews, Chairing of Child Protection Meetings. However there are inherent weaknesses with only having one person who is familiar with the LADO system e.g. contingency planning for sickness, annual leave and resignation.

Private Fostering
A Private Fostering arrangement is one that is made privately (that is to say without the involvement of the local authority), for the care of a child under the age of 16 (under 18, if disabled), by someone other than a parent or close relative, with the intention that it should last for 28 days or more. Private Foster Carers may be from the extended family, such as a cousin or great aunt, or they may be a friend of the family or other non-relative, such as the parents of the child's friend. A person who is a close relative of the child, as defined by the Children Act 1989 (a grandparent, brother, sister, uncle or aunt (whether by full or half blood or by marriage or civil partnership) or step-parent) will **not** be a Private Foster Carer.

The annual report for Private Fostering within Torbay can be downloaded here

Serious Case Review Subgroup
The Serious Case Review (SCR) Subgroup meets every six weeks to discuss referrals, oversee ongoing SCRs and monitor progress on action plans. For the period April 2013 to March 2014 nine meetings were held. Four cases were referred resulting in the commissioning of one SCR. This review is ongoing therefore only limited information can be provided at this stage. The Overview Report will be published by the TSCB once the review is complete.

Revised statutory guidance has introduced greater flexibility about the methodology and processes which may be used in SCRs. Working Together 2013 sets out that:

> "LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro".

There are a number of different systems models is use, including the Social Care Institute for Excellence's (SCIE's) Learning Together systems model which the Board has utilisied for the SCR commissioned this year.

The Subgroup has continued to monitor overview actions arising from previous SCR, at March 2014 they were monitoring actions from four Serious Case Reviews:

	Number of actions	% Red	% Amber	% Green
JS	42	7%	0%	93%
C18	20	10%	25%	65%
C25	4	0%	100%	0%
C26	9	0%	44%	56%

Training, Learning & Development Subgroup

Across 2013/14, 40 training events/ forums were available to the children and young people's workforce in Torbay.

This included two Best Practice Forums which have been introduced into the training programme. These have received a positive response.

There have been 4 'The Child's Journey' events across this time period and these continue to be well attended (an i-learn module has also been created to enable greater accessibility or a refresh for learners who have attended the class based session).

Within 2013/14 the training, learning and development sub group separated from the Devon Safeguarding Children Board (DSCB)training and had the task of re-establishing the training programme, this has been delivered by Children's Services on behalf of the TSCB with the support of the sub group. Where possible the sub group have used the contracts already used by the DSCB (commissioned by Devon County Council (DCC)) and have continued to work with their workforce development team to ensure as far as possible parity across the Devon and Torbay borders. Therefore on the whole most courses are the same.

The Independent Chair of the Torbay Safeguarding Children's Board commissioned the Training Sub-group to complete a review of Safeguarding Training in November 2013. The request was informed by a Board development session held in June 2013 where Board members identified training as a key priority. In commissioning the review there was a recognition that there was a good range of training on offer and that there were strengths in the current system that could be built on. A Training and Practice Development Strategy was then created following this review.

The following principles were distilled from the feedback and create the building blocks on which the strategy has been developed:

- multi-agency
- personal accountability
- organisational commitment
- flexible and adaptable
- sharing best practice and current training offering - build on what we already have got
- value the contribution of all organisations
- quality assured

The Training and Practice Development Strategy will be completed in 2014 and the Training, Learning and Development subgroup will be creating a work plan to sit behind the strategy to ensure its implementation.

Peninsula Subgroup Updates

Peninsula Child Sexual Exploitation Steering Group

The Peninsula CSE steering Group has in the past twelve months reviewed the Peninsula protocol and re-written the document based on feedback from professionals, LSCB, CSE strategic groups and members of the Peninsula steering group. The following improvements have been made:

- Uses the Association of Chief Police Officers definition of CSE
- Incorporates 'Missing'
- Sets Objectives for the Steering Group
- Provides a standard Terms of Reference for the Strategic Group
- Provides a data set
- Provides clear guidance on information sharing
- Sets responsibilities regarding training and awareness
- Provides direction on the use of risk assessment 'tools'
- Provides clear referral pathways
- Provides flexibility for each Local Authority to deliver CSE and Missing provision based on their needs.

The protocol was presented for a final consultation at the Peninsula Steering Group on 29th April 2014 and the completed document has been presented to the four LSCB's for approval.
Missing and Child Sexual Exploitation, (MACSE) forums are now operational across the Peninsula. Theses forums are multi-agency, identifying and managing CSE risk to children at an early stage. The focus for the steering group has been establishing the membership and operational activity of these groups which has now been achieved. Over the next 12 months the group will be reviewing the impact these groups have on protecting children by collecting and reviewing data sets, auditing operational activity and seeking feedback from children.

Return home interview teams continue to see all missing reports and complete return home interviews where the case is not open to social care. Part of the return home interview includes the completion of a CSE risk indicator, allowing for escalation of any concerns.

Strategic CSE forums continue to translate and implement actions from the Peninsula Steering group into local areas. They develop and monitor the MACSE's ensuring good practice is shared and improvements are made. The chairs of the strategic group are members of the Peninsula Steering group.

The focus of the Peninsula CSE Steering group over the next 12 months will be review how each local authority area is delivering against the Peninsula CSE strategy under four categories, prevention, safeguarding, bringing Offenders to justice and raising public confidence.

The four strategic chairs will be asked to review the current strategy and develop their action plans for each LSCB against the strategy or inform the Peninsula Group where the strategy needs review to ensure it meets current needs.

Peninsula Child Death Overview Panel

Number of Torbay child death notifications in 2013-14:
During April 2013 – March 2014, there were 10 notifications of child death in the Torbay area. This represented 10.8% of the deaths in the South West Peninsula. Five of these required a rapid response.

Panel Case Reviews of Torbay Child Deaths in 2013-14
Seven Torbay child deaths from aggregated data from previous years were reviewed by the Child Death Overview Panel (CDOP In 2013-14. This constituted 9% of the CDOP cases reviewed in 2013-14 in the South West Peninsula. Of these reviewed deaths, three were expected and four were unexpected. There was a rapid response in one of these cases. The majority of cases (5) were under five years of age. Two of the cases had or were currently subject to a safeguarding plan. In three cases, there had been occurrence of domestic violence. A serious case review has been undertaken in respect to one of the cases. Two additional cases were fast-tracked (NAI) for urgent primary CDOP review in 2013-14.

Particular issues coming from the CDOP reviews have been

- Awareness of road safety by foreign students
- Consistency of advice re the resuscitation of young infants
- Gaps in provision of paediatric pathology
- Use of skeletal surveys for children under two who die
- Advice to Mother and Bay units about safe sleeping arrangements
- Risk analysis of expectant mothers with low BMI
- Advice to holiday let landlords re swimming pool safety and inclusion on environmental health website
- Hospital action plan assurance in relation to co-sleeping death
- Apparent Suicide and mental health referral / provision of services
- Children's treatment escalation plan where there is palliative care

In the forthcoming year, Torbay along with the three other Safeguarding Boards in the far south west are reviewing the arrangements for commissioning the CDOP service.

Peninsula Online Safety Group

The South West Peninsula LSCBs Child Online Safety Strategic Group seeks assurance from partner agencies for compliance with the group's implementation plan, including dissemination of multi-agency guidance and procedures.

Mobile phones and the Internet play a central part of children's lives today, and should be a core element of any strategy for keeping children safe from harm. Plymouth LSCB facilitates and leads the Peninsula LSCB group promoting Child Online Safety (COS). The group includes leading statutory and voluntary agencies, representatives from schools and youth services, and expert consultancy from the South West Grid for Learning (SWGfL)

Through 2013 the group concentrated on issues relating to the safeguarding of Children in Care or Adopted, and has ensured strong safeguards for children who are in care, fostered or adopted. It is widely recognised that the Internet has changed the boundaries of privacy" and "confidentiality", and new procedures are now in place to ensure protection of a child's identity, and the professional identity of associated practitioners. Concern has focussed upon the use of Facebook, as there are no legal controls on access by children pre- or post-13 years of age.

Schools have been advised on their increased responsibilities for their pupils, where any proven lack of safeguarding of the child's on-line activities could lead to legal action against that school, or individual professionals.

In February 2014 the group co-ordinated European Safer Internet Day (SID) for the fourth year, with significant events across the Peninsula. In Torquay, the Virtually S@fe project featured on the BBC3 Documentary 'Porn – what's the harm?'[1]. The Virtually S@fe project received a commendation in The MJ 2014 Awards. A special film on the dangers of Sexting[2] created by local young people was broadcast (http://www.torbayvirtuallysafe.co.uk/a-parents-guide-to-sexting/) reaching 30,000 people.

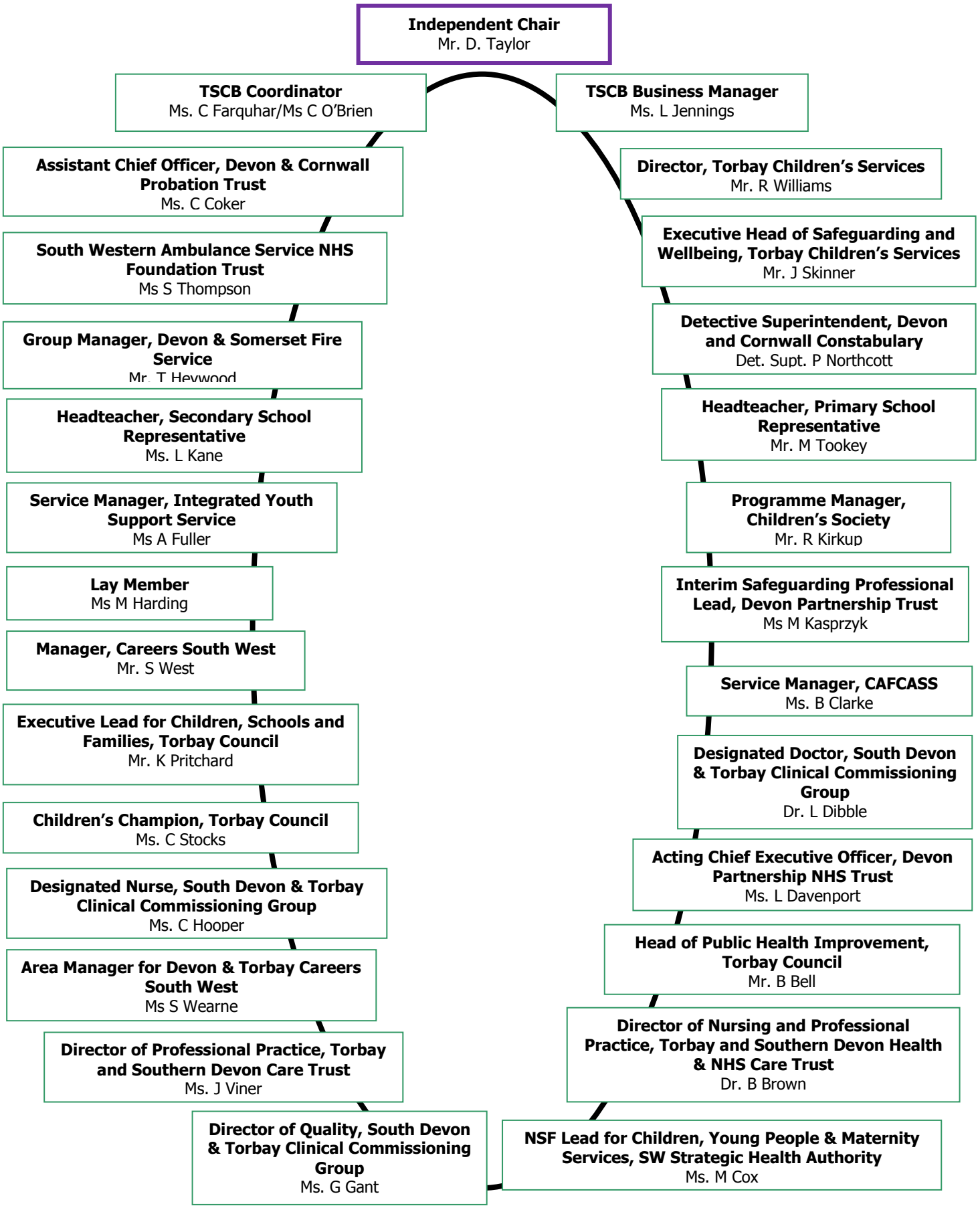
Plymouth University hosted the PSCB's event for secondary schools, with Year 9 students attending workshops for advanced online safety guidance, and sharing their experiences and suggestions for future safeguarding policies.

The PSCB ensured the establishment of strong links between the Group and the Missing & Child Sexual Exploitation strategic group formed by Peninsula LSCBs towards the end of 2013. As a result, the requirement for practitioners to understand risky online behaviours of children and young people was included in the first publication of the Peninsula Protocol for multi-agency safeguarding practice to tackle sexual exploitation, and was commended by the National Working Group tackling CSE in March 2014.

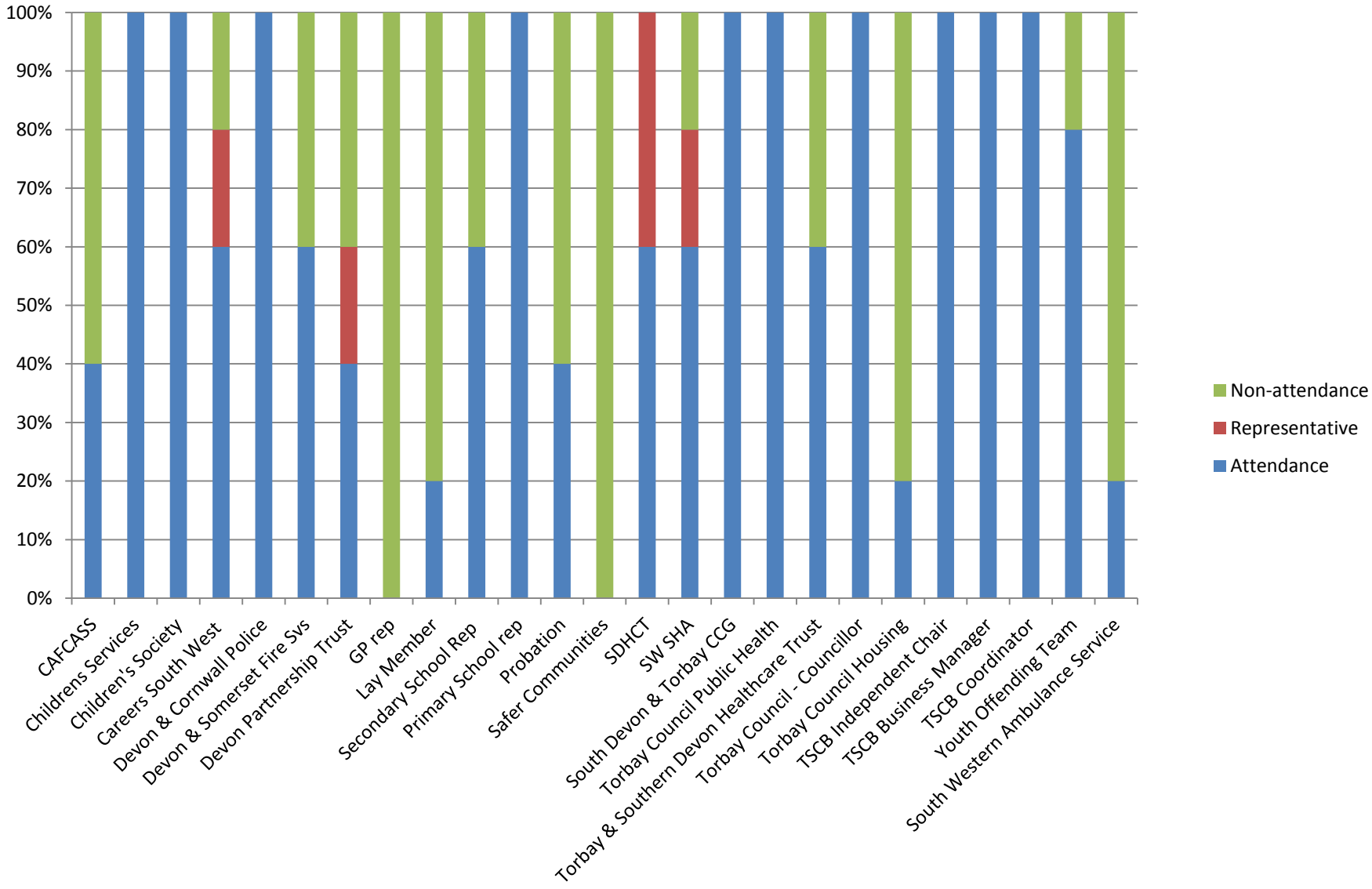
[1] http://www.bbc.co.uk/programmes/b040n2ph
[2] http://www.youtube.com/watch?v=7CoO3fjOGkM

Appendix 1: TSCB Membership as at March 2014

Clare – can you sort the formatting, it's not centred



Appendix 2: Attendance at Board Meetings



torbaysafeguarding childrenboard

Business Plan

2014-2015

Keeping children safe is everyone's responsibility

Torbay Council Children's Services ■ Police ■ Health ■ Careers South West
Youth Offending Team ■ Probation ■ CAFCASS
Safer Communities ■ Fire Service ■ Schools ■ Community & Voluntary Sector
www.torbay.gov.uk/tscb

Contents

Chairs Forward

The key role of the safeguarding Board is to promote effective multi agency working to ensure that children and young people are safe and able to thrive in a supportive environment.

This business plan sets out the key priorities for the Board over the next twelve months in order to help move towards this objective. There are great opportunities for developing new and more effective models of engaging with children and young people and their families and the TSCB will play its part in promoting closer work between all professionals and agencies to achieve this.

Introduction

This Business Plan outlines priority areas and associated action to be undertaken by Torbay Safeguarding Children Board during 2014-15. It draws together existing commitments as well as emerging priorities for the Board identified from the 2013-14 Annual Report and:

- Working Together 2013, Children Act 2004 and the Local Safeguarding Children Boards Regulations 2006
- TSCB Self Assessment
- The findings of Serious Case Reviews and Inspections
- Findings of multi agency audit activity
- Priorities identified by TSCB members

The Board is supported by a small Business Unit which is responsible for both coordinating the work of the Board and its subgroups and ensuring the TSCB is supported in making informed decisions.

The TSCB has five subgroups which take the lead on delivering the Business Plan:

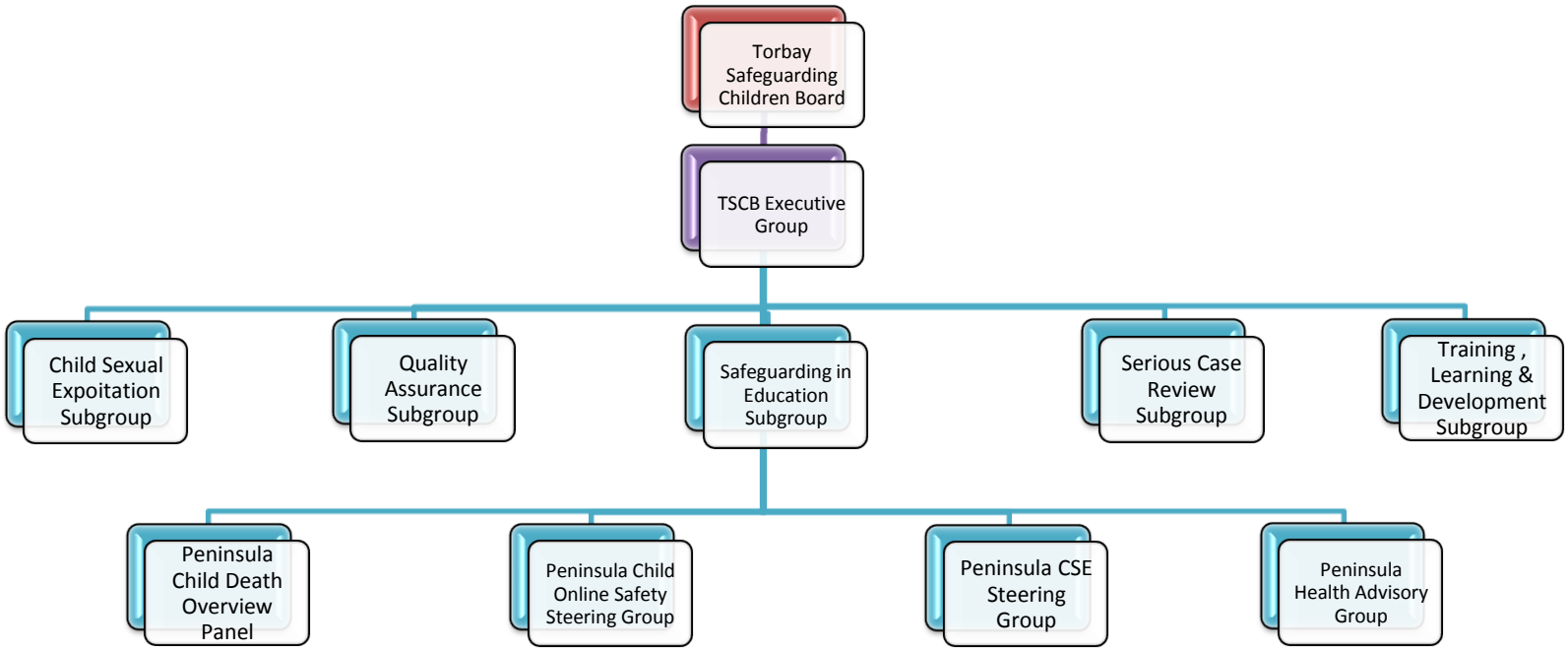
- Child Sexual Exploitation
- Quality Assurance
- Safeguarding in Education
- Serious Case Review
- Training, Learning & Development

Each subgroup has its own work plan for the forthcoming year, detailing its objectives and actions based on those contained within the business plan. In addition to the standing subgroups the Board has a 'Working Group' of multi-agency practitioners who come together as and when needed to follow up specific pieces of work tasked by the Board.

The TSCB also works closely with neighbouring LSCBs (Cornwall and the Isles of Scilly, Devon and Plymouth). Collectively the peninsula LSCBs have four steering groups:

- Child Death Overview Panel
- Child Sexual Exploitation Steering Group
- Online Safety Steering Group
- Health Advisory Group

TSCB Structure



Funding Arrangements

The TSCB is funded by contributions from its statutory partners. These contributions enable the Board to employ an Independent Chair, Business Manager and two Coordinators. The contributions also enable the TSCB to undertake key pieces of work including the development of multi-agency procedures.

The Budget for 2014-15 has been set at £123,981.00 with partner contributions agreed as follows:

Torbay Council £75,280.57
Torbay and Southern Devon Clinical Commissioning Group £28,673.02
Devon & Cornwall Police £13,861.30
Devon & Cornwall Probation £5,616.11

Progress against this plan will be reviewed and monitored by the Executive Group, with Chairs of the relevant subgroups reporting on progress against their actions to this group. Where necessary and appropriate the Executive Group will highlight areas of concern and good practice to the full Board meetings for further action.

Our Priorities

The TSCB has agreed the following priorities for 2014-15:

1. Listening to children, young people and their families

The Munro Review of Child Protection emphasises the importance of the quality of the relationship between the child and family and professionals and its impact on the effectiveness of help given. A key measure of the success of child protection systems is whether children are receiving effective help when they need it.

The audit work undertaken by the Board throughout 2012-13 has repeatedly demonstrated that the child's journey was difficult to follow, with limited evidence of the child's views across agencies records.

We will be looking to incorporate systematically into our performance data and other work of the Board the views of children, young people and parents in order that we are better able to improve the quality of multi professional practice and provide appropriate challenge where necessary.

2. Early Help

The Government's response to the Munro Review accepted the value of a local early help for safeguarding, and suggested a role for LSCBs in quality assuring early help plans. The development of an effective early help pathway was seen as a priority arising from a focus group of professionals facilitated by the safeguarding Board. This includes the development of a clear and robust de- escalation policy.

3. Multi agency partnership engagement

Serious Case Reviews in Torbay have identified that professionals have a tendency to work in isolation. In addition audits have demonstrated a lack of effective links between adult and children's services, a lack of professional challenge amongst workers and concern around the effectiveness of multi-agency working in respect of child protection. In response the Board has introduced Best Practice Forums to provide partners with an opportunity to come together on a regular basis to build relationships and improve information sharing. In addition the Board will be promoting the introduction of the signs of safety model which will facilitate more effective sharing of risk and coming to clear multi agency agreements about appropriate action to take.

4. Looked after children

The numbers of looked after children in Torbay have risen by 67% since 2009 with a higher than average number of children having experienced more than one placement. At the end of March 2014 the number of children looked after in Torbay was 312. Looked after children are sometimes extremely vulnerable and the Board will look closely at their outcomes particularly in relation to children placed in residential settings, out of area and those who have a history of going missing and how all agencies are contributing to meeting their needs.

5. Neglect

Neglect is the most common reason for children to be subject to a child protection plan in Torbay (47% of plans at March 2014). Neglect has also featured in local Serious Case Reviews and was the subject of the Board's 2012 Annual Conference. At a whole population level the health outcomes for children and

young people are poor by comparison to neighbouring authorities with higher levels of obesity and teenage pregnancy.

The Board has already introduced the Graded Care Profile, a tool for practitioners to measure neglect in 2013. Through targeted case auditing and also looking at other sources of data we will be looking in depth at how effective we are being in tackling neglect and promoting timely intervention when there are concerns about the care provided for children and young people.

Action Plan

Priority 1: Listening to children, young people and their families				
Aim	Action Required	Time Scale	Desired Outcome	Subgroup Responsible
To ensure children, young people and their families have opportunities for their views and opinions to be heard in respect of their experience of safeguarding services	Develop methods of consulting with children/families following their involvement in safeguarding processes Commissioners of services to ensure that there is regular feedback from service users Strengthen links between the TSCB and existing arrangements for consulting with children and young people Involve family members in audits/case reviews where possible TSCB performance reports to include 'child's voice' element	April 2015	Children and young people's needs are known Families are listened to when we examine practice The TSCB understands how children, young people and their families view the multi-agency safeguarding system The TSCB are able to reflect back and influence how services are developed The TSCB have a regular flow of information from children, young people and their families who have been involved in safeguarding services	Quality Assurance Subgroup

Priority 2: Early help				
Aim	Action Required	Time Scale	Desired Outcome	Subgroup Responsible
To develop a framework for Early Help that supports multi-agency working	Refresh the 'Child's Journey' threshold document to ensure it includes: - the process for the early help assessment and the type and level of early help service to be provided, and - the criteria, including the level of need, for when a case should be referred to Children's Social Care for assessment and statutory services Agencies to sign up to early help and implement the framework Raise awareness of early help tools and how to use them QA and performance reports provided to the TSCB	April 2015	Children & young people experience more responsive services at an earlier stage of need Working Together 2013 fully implemented	TSCB Working Group / Early Help Strategic Group

Priority 2: Early help				
To continue to develop and deliver multi-agency safeguarding training	Training strategy to be approved by the TSCB Executive and work to be started on bringing this strategy to life i.e. policies, competency frameworks		Multi-agency workforce is sufficiently informed and skilled to provide Early Help	Training, Learning & Development Subgroup

Priority 3: Multi agency partnership engagement				
Aim	Action Required	Time Scale	Desired Outcome	Subgroup Responsible
To publish local protocols for assessment and professional involvement	Develop a local protocol which sets out clear arrangements for how cases will be managed once a child is referred into local authority children's social care Publish information on the process for referring cases in and out of children's social care Update and re-issue the Childs Journey / TSCB Standards document	April 2015	Multi-agency workforce understands the process for escalating and de-escalating concerns Working Together 2013 fully implemented	TSCB/Principal Social Worker
Provide opportunities for partner agencies to network	Hold regular multi-agency Best Practice Forums Agree shadowing and secondment opportunities across the partnership Multi-agency training to be re-enforced within the TSCB training,	April 2015	Multi-agency workforce understands the roles and responsibilities of agencies Establish reciprocal arrangements for the induction of new staff Agencies share information and challenge one another	Training, Learning & Development Subgroup

Priority 3: Multi agency partnership engagement				
	learning and development strategy			
Establish effective performance and quality assurance processes	Undertake a minimum of 4 multi agency thematic audit exercises per annum Develop a communication plan to publicise the learning Review the TSCB key performance indicators and the process for monitoring performance	September 2014	The TSCB are able to reflect back how services are safeguarding children	Quality Assurance Subgroup
Develop a family approach to safeguarding	Develop clear protocols between adult and children's services Work with partners to implement the Signs of Safety model	April 2015	Effective joined up approach Consistent multi-agency working	TSCB/Principal Social Worker

Priority 4: Looked after children				
Aim	Action Required	Time Scale	Desired Outcome	Subgroup Responsible
Ensure children looked after by the local authority are well supported and fulfil their potential	Monitor key information, including: - Numbers of young people who go missing / return home interviews - Numbers of Young People vulnerable to CSE - Numbers of young people missing from education Ensure commissioners demonstrate that effective safeguarding arrangements are in place	April 2015	The TSCB understands the needs and experiences of children and young people who are looked after Children and young people's placements are more stable	Quality Assurance Subgroup
Ensure children placed in Torbay by other local authorities have their	Monitor how well children are progressing	April 2015	The TSCB understands the needs and experiences of children	Quality Assurance Subgroup

Priority 4: Looked after children				
needs met			and young people who are looked after in Torbay	

Priority 5: Neglect				
Aim	Action Required	Time Scale	Desired Outcome	Subgroup Responsible
Develop an effective response to Neglect	Develop and implement a neglect strategy Multi Agency Case File Audit (MACA) to review how effective tackling neglect is in Torbay Engage with the Health and Wellbeing Board to tackle the underlying causes of neglect	April 2015	Improved understanding of prevalence and patterns of neglect Children do not have to suffer extended periods of neglect before effective intervention is taken	Quality Assurance Subgroup
To ensure the Graded Care Profile (GCP) is effectively utilised by lead professionals	To develop: - GCP i-learn modules to guide practitioners within the use of the tool. - Commission a Level 3 Emotional Abuse and Neglect Course.	April 2015	Families where there are factors which increase the risk of neglect are identified and early help is offered Multi-agency workforce utilise appropriate tools to measure neglect and avoid drift	Training, Learning & Development Subgroup

Priority 5: Neglect				
	- Commission level 4 emotional abuse and neglect course to include Graded Care Profile. - Monitor the impact of GCP			
Run a public awareness campaign for parents, especially fathers about the fragility of babies and the dangers of shaking (SCR C40)	Implement the NSPCC's Preventing Non-accidental head injury (NAHI) programme.	April 2015		Training, Learning & Development Subgroup/Health and Wellbeing Board

Title:	**TSCB Business Plan Update**		
Report to:	**TSCB Executive**		
Prepared By:	**David Taylor**	Contributors:	
Date Prepared:	**28th October 2014**	Date of Meeting:	**5th November 2014**

The TSCB Executive agreed the Business Plan on 30th July 2014. This report is an update on progress in terms of moving forward its priorities.

The Executive is asked to consider how some of the areas which have been graded red or amber might be moved forward. This is particularly so in terms of getting greater feedback from children and young people and their families in terms of shaping services

Listening to children and young people

There have been a number of discussions with commissioners about getting feedback from children and young people and families in respect to but as yet no tangible products arising from this. The commissioner for children's services in TSCB is attending the January meeting of the executive to update on progress.

We have requested the Reviewing officers to do some exit interviews with children, young people and families who have been subject to Safeguarding plans and are awaiting some indication of when this can commence.

We have consulted with parents, children and young people as part of our auditing process and most recently this is being done as part of our neglect audit by Checkpoint.

As chair I have requested to have a regular meeting with young people in Torbay for some themed discussions and would be looking to involve Board members in these.

In respect to looked after children, there has been a report from Checkpoint identifying some of the key issues for young people in care and this will inform the Boards work in this area.

We are keen to have feedback from children and young people through all partner agencies about how well we all work together to support them and their families and in particular are interested in young people accessing the CAMHS service and also receiving early help and support .

RATING FOR THIS AREA IS: Red

Early help

The early help strategy has been refreshed and the pathway revised. There is multi agency

agreement about the approach.

There are three joint funded Education social worker post established between the Local Authority and schools. There are also plans to set up a CAMHS tier 2 service. In addition there is recommissioning of the Children's centres and steps to link in CAMHS services more closely. There is work being undertaken to build capacity in specific communities and to enhance multi professional working.

A multi agency practitioners group has looked at the child's journey and threshold and these have fed into the review of the early help arrangements.

A best practice forum has been held to share the strategy re early help, and also raise awareness of the family information service and the resources that might be available

The training for early help will be delivered in 2015.

As yet there is no good information about the early help work and the participation of different agencies in this.

RATING FOR THIS AREA: Amber

Multi agency partner engagement

Work is underway in revising the standards and the process for undertaking assessment and the mutual, responsibilities of partners. There was a best practice event when frontline staff had a chance to look at and amend these documents.

There is a multi agency group revising the Child's Journey and ensuring some of the indicators of Child Sexual Exploitation are built into this document.

There needs to be a clear step down protocol which is monitored and has appropriate professional support.

There are clear arrangements to promote shadowing as part of the induction arrangements for all agencies through a joint programme.

The programme for case auditing and events to publicise it is in place and a draft programme has been devised. The migration to our new website gives us more possibilities for effective dissemination.

Work is underway about building stronger arrangements with Adult Services and a Think Family Protocol is coming to the January 2015 Executive to support this.

Work is underway in respect to the Signs of Safety Development and the Board has earmarked funds to support the roll out.

RATING FOR THIS AREA IS: Green

Looked after children

The Boards intention is to complement the work of the corporate parenting group rather than

duplicate it and it is focusing on Safeguarding issues for looked after children including exposure to Child Sexual Exploitation.

The Board has requested information about looked after children particularly in relation to those who are placed out of area, who go missing and also the level of restraints in the settings where they live.

It is proposed to run a themed event in June 2015 focusing on looked after children and as part of this we will be looking to engage with looked after children as well as undertaking a themed audit to inform this work.

RATING FOR THIS WORK: Amber

Neglect

The Board has undertaken an audit in respect to neglect and has identified that this is the area where it will focus on in it's December meeting. The Chair of the Health and Wellbeing Board has been invited to attend this event which will look at neglect in the context of the Torbay Poverty Strategy and some of the wider public health determinants of neglect.

There is training underway to promote the use of the graded care profile by professionals.

Consideration will be given to devising a summarised version of this which might be easier for frontline workers to use on a routine basis.

RATING FOR THIS: Amber

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Update Report – Adult Services
Wards Affected:	All
To:	Health and Wellbeing Board **On:** 17 December 2014
Contact:	Caroline Taylor – Director Adult Social Services
Telephone:	01803207116
Email:	caroline.taylor@torbay.gov.uk

1. Achievements/Update since last meeting

- The latest position in the financial year has indicated that the commissioning of adults services from TSDHCT has been progressing in line with the ASA with some overspend but with recovery plans in place. CES contract has also predicts an overspend position but with recovery plan in place, although demand is up 22%. Achievement is positive against a background of challenging cost reduction targets.

- Consultation and co-production on the implementation of our Learning Disabilty commissioning strategy progresses well following an engagement event 'festival of ideas'.

- A challenge was made to fees for care homes and we await the outcome of a judicial review on this matter.

- The tender process for Domiciliary Care (Living Well At Home) is in its final stages with a preferred bidder. The new contracts will start from 1 April 2014 and will develop an outcomes based system in partnership with the Trust following due diligence process.

- The process of acquisition of TSDHCT continues to progress with the expected timetable for completion and the start of the ICO in August/September 2015.

- Progress continues to be made on aging well project to combat social isolation led by the voluntary sector.

- Community Services Engagement-joint work with CCG on rethinking future of community services progresses well. Public views appear to support some of the national government thinking on providing care at home or in home like settings and a desire for further integrated care around the individual and self care.

- Decommissioning of discretionary services continues, although a solution for homeless hostel in Torquay has been found.

- BCF-Better Care Fund has been approved. These have a number of joint schemes for health and care.

- The preparation for implementation of the care bill is progressing well. We await the financial confirmation of the government contribution to these new cost pressures.

2. Challenges for the next three months

- The need to focus on delivery whilst the acquisition process goes through its determination is a continued risk to our local system.

- DOLS continues to be a major pressure in the system since the Cheshire West ruling-despite putting additional resource into assessing Deprivation of Liberty Safeguards this remains a concern.

3. Action required by partners

- Work to develop the pioneer bid as a programme to report to HWBB and to encompass system wide changes is underway.

Title:	Update Report –South Devon and Torbay Clinical Commissioning Group (SDTCCG)		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	17 December 2014
Contact:	Dr Sam Barrell, Chief Clinical Officer		
Telephone:	01803 652454		
Email:	viki.kirby@nhs.net		

1. Co-commissioning of Primary Care

Co-commissioning of Primary Care will give CCGs the option of having increased control of the NHS budget for primary care. It is seen as potential key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations, and offers an opportunity to develop more affordable services through efficiencies gained by better aligning primary, community and secondary care commissioning. It can also enable the development of new models of care such as multi-specialty community-centred providers, and complete primary-to-acute care systems.

Three primary care co-commissioning models are available:

i. Greater involvement in primary care decision-making (building on existing practice)
ii. Joint commissioning arrangements (sharing responsibility and associated risks)
iii. Delegated commissioning arrangements

Ongoing assurance of co-commissioning arrangements would form part of the established CCG assurance process. It is well recognised that conflicts of interest will need to be carefully managed and specific guidance in this regard is expected in December 2014.

2. NHS Five Year Forward View

Simon Stevens, Chief Executive of NHS England, published the 5 Year Forward View in October, which sets out his thinking on the future of the NHS. The report details the need for new models of care, with more emphasis on prevention and self-care, technology and a joined-up integrated health and care system, all of which we have been working towards in line with our Plan on a Page. It also acknowledges that the NHS needs more investment and resource.

The report also suggests one option could be forming Accountable Care Organisations (ACOs) where all services are joined up and provided as one whole system, but Simon Stevens says it is up to local areas to decide on which of the suggested models to pursue.

3. Community Services Engagement

From 1 December, consultation is open within the CCG's coastal locality on proposals for community services in the Dawlish and Teignmouth area. The consultation is for twelve weeks – breaking for two weeks over Christmas, and picking up again in the New Year.

The preferred proposed option is to use Dawlish Community Hospital as an urgent care centre for medical / sub-acute beds, with an 8am-8pm MIU supported by imaging (x-ray)seven days a week. Teignmouth Community Hospital would focus on health and wellbeing with therapy-led beds for rehabilitation, day surgery and a community hub, with an emphasis on multi-agency working. Teignmouth will have a wide range of outpatient clinics. Both hospitals would continue to offer community outpatient services such as dressings, as frequent travel would become burdensome for these patients.

The consultation is being conducted mainly as discussions with local community groups and organisations, but will include the following public meetings:

- Wednesday 14 January, 1pm-3pm, the Strand Centre, Dawlish
- Thursday 15 January, 6pm-8pm, the Alice Cross Centre, Teignmouth
- Thursday 22 January, 1pm-3pm, the Village Hall, Bishopsteignton

4. New CCG Engagement Committee

A new committee for our CCG has been established, including both Healthwatch Devon and Healthwatch Torbay, to oversee engagement activity relating to all aspects of the CCG's business.
It will support the implementation of the CCG's procurement, engagement and experience strategies, taking a whole commissioning-cycle view and planning key engagement activities accordingly. It will:

- Advise and support commissioners in tailoring engagement processes;
- Discuss and plan the CCG's most effective ways of working with Healthwatch;
- Discuss issues and areas of success and learning from locality engagement forum representatives to strengthen links between the CCG and the public and local communities.

5. Joined Up Update

We have been busy driving our Pioneer work forward, with key headlines including:

- Progress towards a single point of access to address social isolation and support children and families. It combines voluntary and statutory services;
- Development of a multi-disciplinary frailty hub for holistic, active care and support;
- Continuation to progress 7 day working across the patch;
- Shared GP records in some areas, and development of this in others;
- A £6m Ageing Better BIG Lottery fund to tackle isolation & loneliness in over 50s;
- Acute and community mental health services aligned to a single pathway with voluntary sector and crisis support. A multi-disciplinary one-stop memory clinic and peer-led perinatal services are also in place.

We have a new JoinedUp/Pioneer Manager to lead the project, and further developed ways in which to bring our health and social care community together to achieve JoinedUp objectives.

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Update Report – Public Health		
Wards Affected:	Torbay-wide		
To:	Health and Wellbeing Board	**On:**	17 December 2014
Contact:	Dr Caroline Dimond		
Telephone:	01803 207344		
Email:	Caroline.dimond@torbay.gcsx.gov.uk		

1. Achievements since last meeting

1.1 JSNA.

The JSNA has now been published and circulated and a series of workshops are planned to enable partners to access and use the on-line tools.
It has been very well received and will be built on further in the coming months.

1.2 Public Health Awareness day

Public Health Torbay held a half day workshop for the wider public health workforce, on the 14th November at Upton Vale, Torquay. The purpose was to present a current picture of the range of public health work in Torbay. With presentations from the Public Health team, and Public Health England, the event outlined the new local and national structure, the aims and challenges of public health, and the role of intelligence. It encouraged attendees to think about how their role fits into the bigger public health picture and how to develop opportunities to network and encourage partnership working. There were a number of group based breakout sessions covering a range of topics including community development, healthy weights, the built environment, early years, mental health, ageing and healthy lifestyles. Based on the success of the initial event, Public Health will organise future events for the wider workforce, and any ideas for topics will be welcome.

1.3 Work on developing the Health Torbay Framework

Public Health Torbay are developing 'Healthy Torbay', a framework for action across the wider or social determinants of health. The framework aims to find ways of embedding public health in all council activities and ensure we are tackling the wider determinants of health, such as poor housing, poverty, access to open spaces and transport. There is a strong focus on what the council can achieve through realigning its existing services to achieve public health outcomes, improving the health of the people of Torbay and tackling health inequalities. This upstream or prevention model also helps to address the demands on the health service, the economic cost of ill health and the

wider social costs of poor health. The Framework consists of a short policy document and a draft action plan.

Examples of actions that are being developed as part of the plan are to reduce unintentional injuries in home; use planning controls to 'health proof' major developments; develop walking and cycling infrastructure; reduce the impact of fast food takeaways; reinvigorate the healthy schools programme across Torbay; fund a Physical Activity Coordinator post to increase physical activity; target smoking in pregnancy and following childbirth and develop a healthy workplace programme.

1.4 Embedding prevention in the work of partners.

Public Health Torbay has been working with the CCG and ICO to support the integration of prevention. Meetings have taken place regarding SPOC, information and advice platform development and integrated preventative services.

The redesign of the lifestyles delivery model and pathways has been shared and used by the ICO to inform their developments. Further work is planned to inform the embedding of prevention and ensure that public health commissioned services are consistent with delivery.

Public health staff continue to work closely with CCG partners by regularly spending time working at the CCG base, thus ensuring that prevention and public health is involved in all commissioning discussions.

1.5 Health Protection

Emergency Planning – Torbay Council was involved in the Pandemic Flu exercise named Exercise Cygnus, which took place during October 2014.This provided valuable lessons in terms of ensuring that Business Continuity and Risk Management plans are in place fpr the Council.
Due to the emergence of the Ebola virus in West Africa, the final stages of Exercise Cygnus were cancelled, in order to ensure that Council Leaders were kept abreast of the progress and implications. The Council Senior Leadership Team was updated, and received regular briefings on the international situation**.**
Flu - With the flu season approaching, there is a vaccination of the 'at risk' groups programme recommended from September 2014. This includes pregnant women, carers, those aged over 65 years and health and social care workers. We are promoting a Devon-wide campaign to raise uptake for 'at risk' groups and carers with the aim of improving uptake of flu vaccination and preventing spread of the disease.
All 2, 3 and 4 year olds will be offered an annual nasal flu vaccination. Torbay Council and the CCG have hosted Fun Flu Party to immunise 2000 children from Torquay practices over the course of one day. This will be held at the International Rivera Conference Centre and will provide fun activities as well as health promotional activities for children and their families at the same time as giving the flu vaccine.
Sepsis - We are involved in campaigns aimed at the prevention of both paediatric and adult sepsis which were launched early October. This included care pathways for GPs, minor injury units, the 111, ambulance services as well as acute and community hospitals, and individuals in their own homes.

2. Challenges for the next three months

We now need to work with colleagues in both the CCG and in Torbay Council to deliver the plans in the Integrated Prevention Strategy.

Particular areas of focus in the next 3 months will be;

Mental Health

As demonstrated in the recent HWBB seminar, there may be an awareness of the importance of prevention but there is little co-ordination in the many ways that prevention/early intervention initiatives are delivered and understood. The CCG, Torbay Council and the community and voluntary sector all have the challenge of working together to progress the agenda which will develop emotional wellbeing across the life course.

In addition, with Torbay having the highest suicide rate for middle aged men in the South West, (and higher than the England average) we have a lot to do to make Torbay a suicide safe area to live in.

Public Health will be leading on both these areas. To get involved contact Gerry Cadogan in the Public Health team: Gerry.cadogan@torbay.gcsx.gov.uk

Alcohol.

Having suggested a way forward for a partnership approach to alcohol, we now collectively need to agree to develop and take forward actions within the emerging strategy.

We are also inviting staff from across the main public sector organisations in Torbay and South Devon to join the Dry January initiative. For more information contact Sue Mills in the Public Health team: susan.millse@torbay.gcsx.gov.uk

Embedding Prevention.

There is still much work to do to embed prevention within provider services. Focus for the next three months will be on the lifestyle services and the link to localities and on the Integrated Prevention Services within the ICO.

For more information contact caroline.dimond@torbay.gcsx.gov.uk or Bruce.bell@torbay.gcsx.gov.uk

Knowledge and intelligence.

Meetings are also planned to agree the next steps to develop the knowledge and intelligence function across both council and NHS with a view to bringing together work on needs analysis, performance and evidence review.
For more information contact Doug.Haines@torbay.gcsx.gov.uk

Title: Update Report -Healthwatch Torbay

Wards Affected: All

To: Health and Wellbeing Board **On:** 17 December 2014

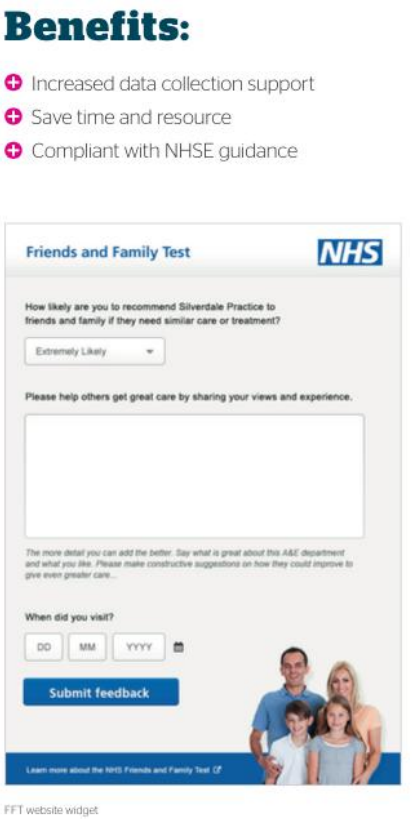
Contact: Pat Harris
Telephone: 01803 402751
Email: pat.harris@healthwatchtorbay.org.uk
www.healthwatchtorbay.org.uk

1. Achievements since last meeting

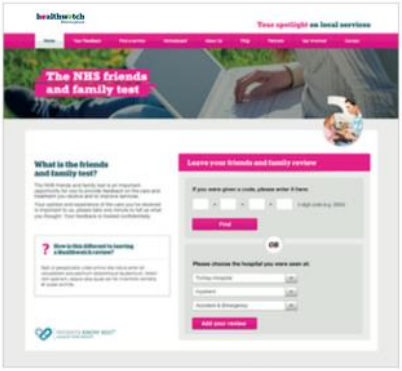
1.1 **Patient experience platform (PEP) feedback centre**

Our rate and review system is still being used by the public, particularly at our recent consultation caravan events in Torbay's town centres (***a mini report of which is in appendix 1***). We continue to work with the South West Academic Health Science Network (SWAHSN) and NHS England to roll it out across the South West peninsula with other local Healthwatch. The development of the friends and family test (FFT) aspect of the system is complete and due to be implemented imminently. Some screenshots are on the right FYI.

We have so far gathered over 320 reviews of nearly 300 Torbay providers, including 20 official complaints about services.



FFT website widget



FFT Healthwatch form

FFT Informatics

1.2 **Enter & View -** We continue to train and develop community researchers for Healthwatch Torbay and have advertised for Enter & View volunteers, and will be shortlisting suitable applicants in the New Year. Training for Enter & View is also scheduled for the New Year. A local Care Home owner has offered us the opportunity to visit and pilot an Enter & View visit in the home using our rate & review system. There is also the possibility, following a recent report (***appendix 2***), that there will be a requirement to visit GP to gain a better understanding of some of the issues faced by both patients and GP Practices.

1.3 **Peer Assessment for Local Government Association** (LGA) – Healthwatch Torbay CEO Pat Harris was successful in being recruited to attend a 2-day training course in October at Warwick University to undertake Peer Assessments for Health and Wellbeing Boards in other regions. The LGA will give advanced notice when they require her to participate in an assessment for another Authority. The training gave a valuable insight into how Health and Wellbeing Board's operate and when they are not being effective and how this can be addressed. Following on from this, a new toolkit is now being made available by the LGA called "Making an Impact through Good Governance" for Health and Wellbeing Boards. There is some local discussion currently taking place to reorganise Overview and Health Scrutiny Boards and see where key decisions are made and how Healthwatch can influence these.

1.4 **Community Health & Wellbeing Forum** – further meetings and discussions have taken place to formulate a community Health & Wellbeing Forum for Torbay, designed to join together community activity/engagement in Torbay and streamline engagement which would be fed into appropriate bodies. Ideally the Forum would not only be about providing insight, but also empowering individuals and communities to play their full role in society through participating in decision making and shaping service delivery for the better. The Community and Health and Wellbeing Forum would be ensuring involvement at all levels through various networks and would develop a set of engagement tools, training and a coordinated approach to engagement activities.

1.5 **Healthwatch England Special Inquiry -** Our national partners, Healthwatch England's special national inquiry into the care that people receive following discharge from hospital, care homes and mental health units will be released in three stages over December 2014 and January 2015, with Healthwatch Torbay having supplied local views in support of the report. We look forward to viewing the findings and communicating these to the Torbay public.

1.6 **Dementia Awareness Project (Purple Angel Scheme)** - Following a visit from Debbie Sorkin, National Director of Systems Leadership for the LGA, she was extremely impressed with the work Healthwatch had conducted surrounding Dementia Awareness and fed this back to the HSJ Summit. It was held up as a true example of strategic innovation in health and social care, so Torbay is on the sector radar as far as this is concerned. She also spoke to Anna Bradley, Chair of Healthwatch England at the event, and she was really interested in the work as they will be looking for stories about productive and innovative ways that Healthwatch at local level has engaged with

communities. There will be opportunities to feed this into future work. There were a number of Public Health England people at the event as well, and she emphasised the central role that public health was playing in driving population health/integration forward in the Local Vision programmes.

2. Challenges for the next three months

2.1 **Current Issues -** The main recent quality issues raised via both the system and public engagement events include:

- **Appointment systems at GP Surgeries** – further feedback has again established this as the biggest issue amongst the Torbay public, with most reviewers finding booking an appointment very difficult and confusing, some saying due to this they are using the Out of Hours Doctors more. (***Appendix 2)***
- **Hospital Waiting times** – we have received further feedback highlighting increasing waiting times at Torbay Hospital (particularly in A&E) and also increased time on waiting lists for surgery and/or general appointments.
- **Mental Health Services** – feedback is growing surrounding this area, with many people visiting us to express dissatisfaction and genuine upset with the withdrawal of support services due to funding. Many have said their need for support may lead them to their GPs a lot more and other services who may not be as specialised, leading to a drain on services and isolated, stressed, unsupported people. (***A further basic summary report of these issues can be found in appendix 3)***
- **Recent issues** – there have been other specific issues too, including:
  Torbay Hospital - references to early discharge, difficulty getting in touch for reassurance following cataract surgery, not enough staff available in fracture clinic meaning a patient was sent home on morphine and asked to return the next day to set the bone.
  GPs - reception staff attitude to confidentiality and publicly asking reasons for appointment despite lack of medical knowledge, and patient communication problems surrounding GP surgery mergers.

  All feedback has been logged in our system for further analysis, and, where relevant, members of the public have been referred to PALS and/or SEAP.

2.2 **Growing demand -** Feedback centred on the difficulty booking GP appointments and waiting times at hospitals is growing, suggesting that the pressure of demand is growing for services too. The withdrawal of Mental Health services may also negatively impact on this pressure and growing demand, as we are seeing more and more distressed and anxious people come through to us with issues around mental health services.

3. Action required by partners

3.1 **Coping Strategy** – A coping strategy must be discussed and developed now to ensure that this feedback doesn't continue to grow to a point where patients may become increasingly dissatisfied or even not treated in time to help.

healthwatch Torbay

CONSULTATION CARAVAN EVENTS

Summary Report

October 2014

FREEPHONE 08000 520 029
www.healthwatchtorbay.org.uk
Registered Charity Number: 1153450

CONSULTATION CARAVAN
Summary Report 2014

healthwatch Torbay

Introduction

In September 2014, we visited each of Torbay's town centres - Torquay, Paignton & Brixham to gather feedback from local people on health & social care services.

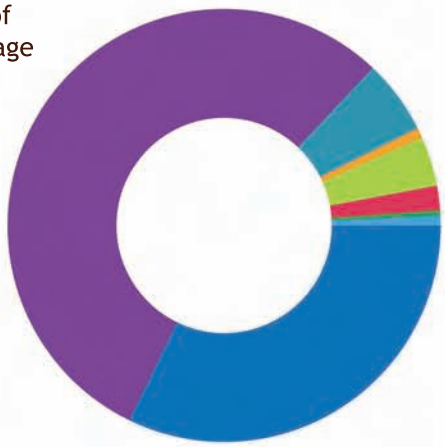
The Healthwatch staff team and a team of volunteers took to the streets in a 'Consultation Caravan' (left) to encourage members of the public to share their service experiences. We visited Fore Street, Brixham on Tuesday 23rd September from 10am-3pm, Victoria Street, Paignton on Thursday 25th September from 10am-3pm, and Union Street, Torquay on Saturday 27th September from 10am-4pm. We spoke to hundreds of people and acquired 204 reviews in all, 82 from Paignton, 69 from Brixham, and 53 from Torquay. We were also joined by representatives from the South Devon & Torbay Clinical Commissioning Group (CCG), Support Empower Advocate Promote (SEAP), and Abdominal Aortic Aneurysm (AAA) Screening.

Types of Services Reviewed

The type of services reviewed by the 204 members of the public can be seen in the diagram on the right. GPs and Hospitals (mainly Torbay) accounted for 86.5% of the total reviews. Below are the average ratings provided for all providers.

Cleanliness	★★★★☆
Quality of care	★★★★☆
Quality of food	★★★½☆
Staff Attitude	★★★★☆
Treatment explanation	★★★★☆
Waiting Time	★★★½☆

Reviews (by provider type)



Category	%
Hospitals	32.2%
GPs	54.8%
Dentists	5.6%
Social Care	0.7%
Pharmacies	3.7%
Other	0.0%
Opticians	1.9%
Emergency Care	0.4%
Community Based	0.7%

Top Three Issues/Trends

The most frequent issues raised via our consultation caravan events included:

Appointment systems at GP Surgeries

Feedback established this as the biggest issue amongst the Torbay public, with most reviewers finding booking an appointment very difficult and confusing, and some even saying that due to this they are using the Out of Hours Doctors service more and more.

Hospital Waiting times

We received feedback highlighting increasing Hospital waiting times (particularly in A&E) and also increased time on waiting lists for surgery and/or general appointments.

Mental Health Services

Feedback is growing in this area, with many people expressing dissatisfaction and upset with the withdrawal of support services. Many have said their need for support has led them to their GPs a lot more, and other services (who may not be as specialised), leading to a drain on services and isolated, stressed, unsupported people.

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Follow Up Actions

All feedback has been logged in our system for further analysis and monitoring. Overall, six official complaints were made via our caravan events concerning the following types of service provider: 1 GP, 3 Hospitals, 1 dentist, and 1 social care. **None were serious safeguarding issues**. We have begun the official complaints process for these and where relevant, the members of the public have been referred to the Patient Advice and Liaison Service (PALS) and/or Support Empower Advocate Promote (SEAP).

NHS South Devon Healthcare NHS Foundation Trust

seap Support Empower Advocate Promote

NHS South Devon and Torbay Clinical Commissioning Group

Other relevant actions involving feedback from our event include:

- The Care Quality Commission (CQC) integrated rate & review data into their regional GP reports.
- Rate & review data has also been used to inform local Special Educational Needs and Disabilities (SEND) Reforms.
- Rate & review data was used to address an issue with the Appointment Booking system of a particular Torbay GP Surgery, who responded by conducting their own patient survey in order to optimise their system.
- We have been asked by the South Devon & Torbay Clinical Commissioning Group to provide a more detailed report into the area of Mental Health Services and its impact on other services.

Summary & Recommendations

Feedback centred on the difficulty booking GP appointments and waiting times at hospitals is growing, suggesting that the pressure of demand is growing for services too. The withdrawal of Mental Health services may also negatively impact on this pressure and growing demand, as we are seeing more and more distressed and anxious people come through to us with issues around mental health services.

We have been asked by South Devon & Torbay Clinical Commissioning Group to provide a detailed report into the area of Mental Health Services and its impact on other services.

A coping strategy must be discussed and developed now to ensure this feedback doesn't continue to grow to a point where patients may become increasingly dissatisfied or even not treated in time to help.

We will be raising this report to the Torbay Health & Wellbeing Board for consideration/discussion on how to achieve its recommendations.

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Information Summary

Whilst speaking to the public, we also enquired about Healthwatch Torbay as an organisation and asked for public opinion on our rate & review system. It was very positive indeed:

Over a third of those we spoke to were already aware of Health-watch Torbay, an increase of over 10% from the last caravan events we hosted 12 months ago.

The overwhelming majority of people we spoke to (98%) think our Rate & Review is a good idea with 86% stating they would use it again. Those who didn't cited the fact they didn't have a computer or that they didn't feel it would make a difference.

Recommendations

An increased awareness campaign for both Healthwatch Torbay as an organisation, and the rate & review system itself.

Assigning specific members of staff to visit providers or organisations to showcase the system direct to the public.

Thank you to everyone who helped contribute to this report, particularly the general public who gave us their time. For more information please call, visit us online, or meet us in person at Paignton Library.

Healthwatch Torbay is the ONLY independent consumer champion for health and social care in Torbay, South Devon.

Health & social care providers have to consult with – and be influenced by – their local community in order to develop and improve the services they provide.

YOU can directly influence these services by letting us know how they are performing via your own experiences.

Whether positive or negative, let us know and we will pass all feedback on to the actual decision-makers in charge. By law they have to listen to us and respond to our feedback or recommendations.

So please get in touch today and share your story with us.

Call, email, visit us in person, or take a look at our website; where you can publicly rate & review a service anonymously at the click of a button.

Together, we can really make a difference.

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TORBAY GP APPOINTMENT SYSTEMS

Feedback Summary Report

November 2014

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www.healthwatchtorbay.org.uk
Registered Charity Number: 1153450

Torbay GP Appointment Systems
Feedback Summary Report 2014

healthwatch Torbay

Introduction

In November 2014, independent health & social care consumer champion Healthwatch Torbay was asked to provide more details on feedback gathered around GP appointment systems and waiting times, after highlighting this as one of the main issues raised by the Torbay public. Overall, since April 2013, we have received a total of 254 instances of public feedback from across the whole of Torbay that is directly related to Torbay GP services. Of this, 152 cases (60%) were centred around GP appointment systems and waiting times. The following report looks into more detail at this feedback.

Facts and Figures

For the purposes of this report we will NOT be showing a comparison chart of all the 24 registered GP Surgeries in Torbay. Some have received more feedback than others and it is unfair to make assumptions on individual surgeries' appointment systems based on this. However, we can view an average ratings summary of how members of the public rate all GP Surgeries in Torbay, on the right.

As you can see, many people generally feel that the care they receive and the attitude of staff is very good at 4 out of 5 stars, however the waiting time ratings remain simply 'okay' at 2.5 stars out of 5.

Of the 152 cases of feedback centred on GP appointment systems and waiting times, 92 (61%) were negative and 60 (39%) were positive.

Average Ratings

CATEGORY	RATING
Cleanliness	★★★★½
Quality of care	★★★★☆
Quality of food *(n/a)*	
Staff Attitude	★★★★☆
Treatment explanation	★★★★☆
Waiting Time	★★½☆☆

**Due to category limitations, 'Appointment Systems' could not be included as a separate category, however, we have recieved plenty of feedback in this area*

Case Study

Most individual GP surgeries appear to have a mixture of both positive and negative feedback, we identified one particular surgery in Torquay whose patient feedback kept following the same trend. Most of the feedback we received from their patients regarding their appointment system included the feeling that:

- It was always difficult to make an appointment spend time waiting to get through to find no appointments available
- Calling at 8.30am was not user-friendly, particularly for people with work/childcare commitments
- Booking a same-day appointment was extremely difficult
- There was a need for a more flexible approach, including more evening/weekend appointments

Healthwatch Torbay contacted the surgery to inform them of this and found that the surgery had indeed tried a number of different systems for booking appointments but was struggling to cope with increased demand. They scheduled an extensive patient survey to guide them on the precise way of coping with this demand and implement a revised booking system. They have since invited us in to better understand the situation GPs and their patients are in regarding the booking of appointments.
We hope to take advantage of this opportunity imminently.

Torbay GP Appointment Systems
Feedback Summary Report 2014

healthwatch Torbay

Patient Feedback Quotes

"Doctors are good if you ever get to see them. Appointment system is obstructive and badly designed, it seems to prevent access to a doctor."

"I have never been refused an appointment with a Doctor; at times it may not be my registered GP but you will be seen, even if it means sitting in the waiting room for a time."

"You ring for an appointment and can't get one with the same doctor, no patient continuity there. When you do get one it is never to suit you, and as a full-time worker this causes problems. Then the doctor overruns by 30mins. Bring back Saturday mornings and late appointments for full-time workers ONLY."

"Doctors are good if you can see them, but it seems the only time they fit you in is if it's for the kids. You have to pretend it's an emergency to get in on the same day."

"Told to phone at 8.30am to book an appointment and can't get through. When you eventually get through you have to wait 2-4 weeks for an appointment with the GP you want. You can only talk about one problem per appointment too."

"They will always arrange a visit to a GP if it's really urgent. Their evening surgery and advanced booking is a very good idea."

"I had to call the surgery 31 times before I got through to make an appointment with my GP. This is due to having to call at 8.30am. This also made me late for work and is not at all user-friendly for people having to travel to work or drop children at school."

"I don't go a lot, but it's always difficult to make an appointment. They always tell you to 'ring tomorrow' if you want the same day appointment. Only recently have they decided to let you ring in advance."

"Waiting times can be bad but that's understandable. Big sign outside welcoming new patients but they're too busy with current patients to fit new patients in."

"I have not found the Doctor First service very helpful for my own health or my husband's. Continuity of care is poor and they do not seem to have time to follow up patients. It seems overcrowded and you never see the same doctor twice, so you have to explain things over and over again."

"Surgery is okay, but you have to go through a receptionist first who isn't medically qualified, I don't want to give private details of symptoms over the phone."

"Attitude of staff is good, but the phone-in system puts pressure on doctors. When phoning in I explained to them that I didn't want to end up at A+E again and they responded accordingly."

"I cannot now see my doctor without first having a telephone consultation. If I want to speak to the doctor I should be able do it face to face. If you have a busy work schedule a telephone consultation prior to asking to see the doctor can also be inconvenient."

"Okay overall, but waiting times can be long and I have difficulty getting an appointment. Also had a bad experience with poor staff attitude when I was unable to see my choice of GP. Looking to change GP surgery."

"Good online service. Ordering prescriptions and booking appointments online works well and we can usually be seen within less than a day."

"Getting an appointment is usually difficult as they do not want to pre-book and you have to phone up on the day. When you work and have to wait for a phone back from the doctor, this is a problem. As I only see the doctor when it is urgent I find myself having to go to the out of hours doctors - which shouldn't happen."

"Good access to GP appointments, however sometimes difficult to book an appointment with a nurse. You can phone up and set an appointment on the same day. You may have to wait to see a specific Doctor though."

Summary

The Torbay public we have engaged with have established booking systems in GP surgeries as one of their main issues, with most reviewers finding booking appointments very difficult and confusing, and some even saying that due to this they are feeling the need to use services like A & E and the Out of Hours Doctors service more and more.

Many are even saying that waiting times and high demand is understandable given the current climate of the health sector and that the sevice they recieve once they have booked an appointment is very good. We have received positive feedback around improved online services and the implementation of advanced bookings for non-urgent issues and also evening/weekend surgeries.

Recommendations

- An optimal GP Appointment booking system is hard to define, however, there seems to be a need for all Torbay GP surgeries to adopt a uniformed approach to booking systems (including online services, advanced booking, evening/weekend surgeries) and ensuring that this is communicated to patients effectively.
- A broader investigation is required to better understand the issues faced by both patients and GP Surgeries in order to effectively cope with the increasing demand to see a GP.

Thank you to everyone who helped contribute to this report, particularly Torbay GP Surgeries for their cooperation.

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Public Feedback Summary – Torbay Mental Health Services

Please find below an overview of public feedback gathered by independent health & social care consumer champion Healthwatch Torbay relating to Mental Health Services in the local area. These have been gathered either at engagement events, online, on the phone or in person at our walk-in centre during 2014.

Individual Concerns

- Client feels that there is a stigma in Torbay re. Mental Health issues
- Client is anxious regarding making their wishes/concerns clear to medical professionals
- Failure of mental health services locally re. Client's son aged 26. Client /family paid for Priory Bristol and regular CBT locally. Son making good progress.
- Client reported assault/verbal abuse by hospital security staff. Police and Support worker advised on return home. Client referred to Torbay Hospital Complaints team and also requested Walnut Lodge contact client shortly.
- Client used to be supported by Culverhay but on leaving had no links to community support.
- Client advised by Waverley in writing that there is a 9 – 12 month wait for CBT. Client has decided to pay for Hypertherapy privately out of their benefits and now has an appointment with Cool House for their Triumph over Phobia Course.
- Client's bi-polar adult son was having trouble sleeping. He self-medicates for bi-polar. Son rang his GP surgery and his GP left him a prescription to help him sleep. The prescribed drug has contraindications for bi-polar so should not have been given. Client contacted crisis team over this and was told to take son to A&E. Client to contact Practice Manager directly.
- Client under care of Waverley team in June 2014 until committed to prison. Concern from parents over lack of support in prison and on release. Waverley Recovery Worker was very proactive informing Prison Services of person needs and recommendation that transfer to Langdon on release. Release from Leonard Stocks, no referral to Waverley. Also caused damage after alcohol intake - evicted and therefore homeless.
- Client with mental health issues feeling desperate and unsupported but cannot receive support anywhere in Torbay due to being banned from his GP Surgery and local community services (Culverhay) due to problems controlling anger and violence. Feels he has nowhere to go for help.
- Concern from a 3rd party who is supporting a lady living locally with Mental Health problems. Apparently the individual is also having problems financially and does not conform to the JOB Centre re accessing a job so therefore does not get any income. However, the individual concerned will not admit she has any MH problems, although client believes the individual has been involved with Waverley. The individual does not currently have a support worker. The police were recently involved. Finding it difficult to get some support/guidance.
- Client cited a lack of support from Culverhay and support being withdrawn.
- Waverly House run a brilliant service but client felt the support was discontinued to early.
- Client didn't feel like they could, as a young person, approach local GP surgery for their own personal mental health problems. Felt uncomfortable as their family cannot take them.
- A number of clients have, however, mentioned how pleased they were with the service on Haytor ward at Torbay Hospital when they have had the opportunity to 'visit'.

General Concerns

Our recent consultation caravan engagement days in Torquay, Paignton and Brixham town centres - where we engaged with over 200 people – found over 20 members of the public wanting to express anonymously their dissatisfaction and genuine upset with the withdrawal of mental health support services due to funding. Many said their need for support led them to their GPs, the Out of Hours Service at Torbay Hospital, and some mentioned visiting other services who may not be as specialised – such as pharmacists, Citizens Advice Bureau – to ask for help as they feel so isolated, stressed and unsupported.

Summary

Feedback centred on the issue of Mental Health Services and the withdrawal of some services is growing.

Their demand appears to be increasing, as we are seeing more and more distressed and anxious people come through to us with issues around mental health services. This could negatively impact on other health & social care services as these people seek further specialist community support.

Recommendations

Healthwatch Torbay are represented at The Devon Partnership Trust Carers Charter Committee where trends are identified following Carer feedback about Mental Health Services in the local area and ensure the Carers Charter Commitments are followed and help, support and assistance is received when needed.

However, a much wider-reaching coping strategy must be discussed and developed now by key partners across Torbay to ensure that this demand and pressure on services doesn't continue to grow to a point where patients may become increasingly dissatisfied or even not treated in time to help.

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Title:	Update Report – Integrated Care Organisation (ICO) Summary During Monitor's "Stage 2" assessment
Wards Affected:	All
To:	Health and Wellbeing Board **On:** 17 December 2014
Contact:	ICO Programme Manager
Telephone:	01803 656118
Email:	chris.winfield@nhs.net

1. Achievements since last meeting

1.1 Key projects are outlined in the attached report 'ICO summary'.

2. Challenges for the next three months

2.1 Key challenges have been identified and are contained in the attached report.

3. Action required by partners

3.1 The ICO Programme manager asks for the information to be noted.

Appendices

ICO summary

Background Papers:
The following documents/files were used to compile this report:

ICO Summary

During Monitor's "Stage 2" assessment

Date: 19th November 2014
Author: ICO Programme Manager

1 Rationale

The ICO will deliver greater **flexibility**, unhindered **collaboration** and long-term **sustainability**.

The business case is about joining together two organisations to develop a comprehensive integrated health and care service that is **better than the sum of the existing parts**. The integration of our two trusts will **remove artificial barriers** created by organisational boundaries.

SDH's chosen strategy (in partnership with members of the wider community) was one of **vertical integration**, and this has now been practically enabled by the TDA's decision to divest itself of TSD.

We believe that the creation of our integrated care organisation will not only improve local health and social care services, but also **protect them for the future**. The ICO's financial projections show **a sustainable picture** that would not be realistically possible as a stand-alone organisation.

2 Main elements of system change

- Aligned provider incentives (through organisational integration)
- Aligned commissioner incentives (through pooling commissioning budgets and sharing future risk)
- Support care model changes (greater pace, scale and sustainability)
- Remove artificial organisational barriers (fewer "transactions" and interfaces for service provision)
- Further sharing of corporate functions (merge finance, business info, etc.)
- Next step towards harmonising cultures (new opportunities to standardise care provision, quality and people management)

3 Key statistics

	SDH *Baseline*	**TSD** *Baseline*	**SDH + TSD** *Year 5*	**ICO** *Year 5*
Population served	300,000	375,000	375,000	375,000
Turnover (2012/13)	£232m	£142m	£401m	£374m
CIP plan	£11.0m	£5.9m	£28.6m*	£10.6m
Number of staff (WTE)	3,544	1,688	5,369	4,807
Number of beds required	508	193	701	597

** This is the combined CIP that would be required to break even for the two trusts.*

Non-recurrent costs		***Recurrent costs and benefits***		
Local transition cost investment	Transition support requested	Corporate cost reduction	Community investments	Care model cost reduction
(£4.4m)	(£7.0m)	£1.8m	(£4.8m)	£10.6m

4 What will it mean for…

…patients and service users

In terms of flexibility we may see staff changing their place of work, adapting their skills to fill new roles, changing their approach to care from 'What's the matter with you?' to 'What matters to you?' In terms of collaboration, care teams won't be restricted to colleagues from the same trust – or even the public sector.

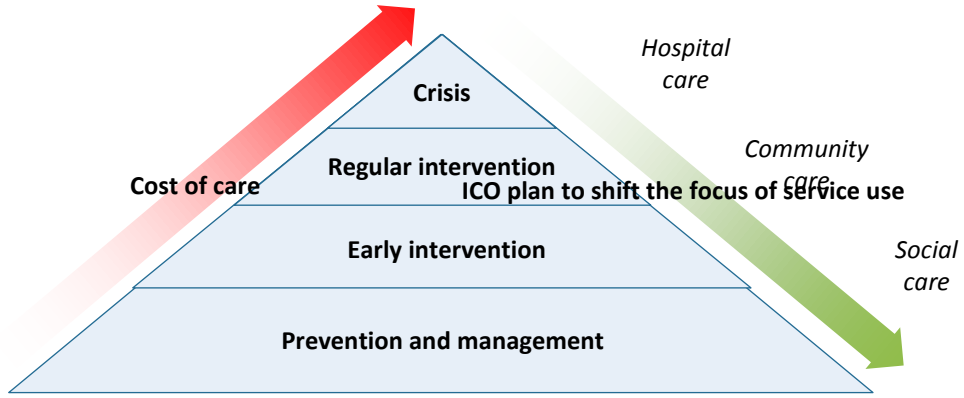
From consultants to GPs to volunteer meals on wheels, all will be part of the same dynamic group working together to support the individual. For staff the ICO represents a more secure future employer as financial targets are met through innovation and redesign rather than cuts and contraction.

…staff

For service users the ICO's flexibility means their needs are more likely to be met through community services before they become a clinical issue; people will be more proactive in their own care and condition management.

In terms of collaboration, greater team working will mean patients having to tell their story less frequently, different professionals understanding your case history; more intuitive processes to ensure more is done with fewer visits, simple ways to access medical and non-medical support. A sustainable ICO means local control over service provision, and financial pressures not leading to widespread cuts in services.

…"the system" (i.e. Social care, community health care and the hospital)



5 Who is leading the change programme?

6 Key projects (from a total of 30)

1. Organisational integration	2. Corporate service developments	3. Health and care developments
• Corporate governance • Clinical governance • Comms and engagement • Workforce and OD	• Merge financial services • Merge information & reporting • Harmonise back office functions • Operational structure	• Frailty service • Single Point of Contact (SPOC) • Long-term Conditions • Community teams and hospitals

7 Key challenges

1. Funding and mobilising appropriate change management resources.
2. Confirming technical details and approval of budget pooling and risk share arrangements.
3. Ensuring the whole community is fully behind delivering the service changes, even though many important members have not aligned incentives like the ICO will do.
4. Delivering rapid transformational change within the ICO without disruption to existing services.
5. Coordinating clear and consistent communications for immediate stakeholders and the wider community.
6. Providing confidence in level and timing of benefits when many aspects are dependent on changing behaviours of service users.
7. Providing confidence that local authority budgets will not be cut further, with risk from other parties passing on to the ICO wholesale.

All of these challenges will be addressed in the course of developing the integration plan, a draft of which was submitted on 1st October, and a final version of which will be ready for the "Stage 3" assessment.

8 Timeline