Yorkshire and Humber Health and Well Being Collaborative
10-12.30 - 30th August 2011
Room 3E64, Quarry House, Leeds

AGENDA

1. Election of Chair, Membership and Terms of Reference

2. Discussion on Role, Purpose and Priorities.
   ‘Suite’ of brief supporting papers to support the discussion on:
   
   - Personalisation (“Think Local Act Personal”) Paper 2A
   - Commissioning – Paper 2B
   - Assistive Technology – Paper 2C
   - Workforce – Paper 2D
   - Dementia – Paper 2E
   - Public Health transition – Paper 2F
   - End of Life Care – Paper 2G
   - HealthWatch – Paper 2H
   - Health and Well Being Boards – verbal update
   - Health and Wellbeing Transition – Paper 2J

3. Resources to the work of the Collaborative and additional funding for social care

4. Next meeting
Yorkshire and Humber Health and Well Being Collaborative

Terms of reference, conduct of meetings and membership

1. Martin Farran, Executive Director for Adults and Communities at Barnsley Council, was the chair of the former Joint Improvement Board for Yorkshire and Humber and is also regional chair of the Association of Directors of Adult Social Services. Martin has agreed to chair the beginning of the meeting subject to a decision on appointing a chair for the Collaborative. It would also be useful to appoint a Vice Chair.

2. The terms of reference are attached for discussion and approval (Annex 1). They have been circulated widely over the last six months.

3. Views are sought on two issues on membership:
   a) Whether to seek a representative from Acute Foundation Trust providers
   b) One of a ‘pool’ of GP leaders rather than one named representative to attend the meetings

4. It is proposed that meetings take place quarterly but to ensure that business is not held up some decisions could be delegated to the chair (e.g. payment of invoices for work approved by the Collaborative) and by seeking the views of members through email.

5. Meetings will be minuted and it is proposed that the work of this Collaborative be open and that the minutes and papers should be made available for people to access on a regional website. To ensure good communication a summary will be produced that can be included for circulation in information bulletins.

6. Support will be provided by a small group of part-time contracted workers.

7. It is difficult to look much beyond 2011/12 and so the continuing need for the Collaborative should be reviewed after one year. However, the working presumption is that its life should not be beyond the conclusion of the White Paper transition

Bill Hodson
19th August 2011
Yorkshire & Humber
Health and Well-being Collaborative (HWC)

**DRAFT TERMS OF REFERENCE**

<table>
<thead>
<tr>
<th>Vision</th>
<th>To support partnerships between Local Government and the NHS in Y&amp;H to achieve improvements in quality, efficiency and effectiveness by reducing duplication of effort and sharing best practice.</th>
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<tbody>
<tr>
<td>Objectives</td>
<td>To gain improved outcomes in the health and well-being of people in Y&amp;H by supporting effective collaboration, innovation and efficiency between partners at a local and sub-regional level.</td>
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<tr>
<td>Aims</td>
<td>To support areas of collaboration that will have the greatest impact on improvement and increased efficiency and effectiveness through a co-ordinated approach. Specifically, the HWC would aim to:</td>
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<td>• Agree priority work areas between partners where it makes sense to work at a regional level</td>
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<td>• Commission products which can be used in local partnerships and reduce duplication of effort</td>
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<td>• Support the implementation of national policies and priorities where this demonstrably adds value</td>
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<td>• Promote and disseminate best practice – what works best</td>
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<td>• Support partners to align delivery for the benefit of customers and in the interests of efficiency</td>
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<td>• Support the transition into new working relationships and structures</td>
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<td>Membership</td>
<td>The HWC would have the following membership:</td>
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<tr>
<td></td>
<td>• Y&amp;H ADASS Chair</td>
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<td>• Y&amp;H ADCS Chair</td>
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<td></td>
<td>• PCT Cluster CEs representative</td>
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<td>• DPH representative</td>
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<td>• SHA representative</td>
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<td>• CCG representative</td>
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<td>• LGYH representative</td>
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<td>• NHS provider CE representative</td>
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<td>• Deputy Regional Director</td>
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<td>Total membership: 9</td>
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<td>Governance</td>
<td>The HWC would receive guidance from the Health Transitions Joint Leadership Group with members remaining accountable to their parent organisations. It would also work with Health and Well-being Boards across the region.</td>
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<td>Frequency:</td>
<td>Meetings would be held every three months at a venue and time agreed by the Chair The frequency of meetings would vary with the agreement of the Chair</td>
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</table>
| Support | The meetings would be supported by project workers and agencies such as:  
- Local Government Improvement and Development  
- Skills for Care  
(Papers will be posted on a common pre-existing web site and circulated to members one week in advance as far as possible.) |
| Responsibilities and Tasks | The HWC would:  
- Facilitate cross sector relationships and improvement arrangements  
- Agree specific time limited (Task and Finish) groups to address ‘tricky issues’ raised by partners, and oversee delivery as required  
- Conduct events and share emerging good practice  
- Commission time-limited projects or activities subject to the available budget |
| Links | Health Transitions Joint Leadership Group  
ADASS  
ADCS  
Regional DPH group  
Strategic Health Authority  
Primary Care Trust Clusters  
NHS Providers  
Department of Health  
LGYH  
The HWC will provide linkages to Health and Wellbeing Boards and consider requests and recommendations made by these boards to them for focussed collaboration and support. |
Yorkshire and Humber Health and Well Being Collaborative

Focus and Priorities

Background

1. The proposal to set up a Y&H Health and Well-Being Collaborative to strengthen joint working arrangements between local government and health came from discussions at the regional chief executive ‘summits’ and at the Regional Joint Health Transition Leadership Group. It was recognised that the core of partnership working between health and local government would be carried out in localities and sub-regions but that there was still a need to complement and support that work at a regional level.

2. Some key messages that came from those discussions were:
   - The importance of understanding what is best done locally, sub-regionally and regionally
   - The role that the Collaborative can play in supporting the broader collaboration between local government and health during a prolonged and complex transitional period
   - Being clear on the added value that the Collaborative brings to any work and the importance of effective links into the work being undertaken by other regional groups
   - The potential for tapping into the energy for change being generated e.g. the very strong support for the early implementation of health and well-being boards in Y&H and the emerging Clinical Commissioning Groups
   - Aligning the ambitions of the Collaborative to its capacity and resources

3. Staff attending the final Joint Improvement Programme conference in May 2011 were clear on the importance of regional leadership that models the commitment to joint working and encourages innovation based on a shared understanding, common priorities, joint interests, effective links and consistency of approach across health and local government.

   In terms of practical support those attending (over 140) said they valued a number of things that had been developed and funded regionally in the recent past:

   - Facilitating bringing people together from different localities and supporting regional networks.
• Effective communication on what’s happening in other localities, where to find information, named links etc.

• A library or repository of information – a hub for the region. This could be based in an existing regional website

• Products that can be used in more than one locality to support the work of front line staff

• Skilling people up to do what’s required of them – learning platforms. Sharing the learning and unlocking the skills within communities.

• Support on joint market development, commissioning and working to support communities.

Similar views on the ‘products’ that are useful to develop regionally were also expressed in a recent regional seminar for those developing Health and Well-Being Boards.

**Proposed Focus**

4. Following the regional chief executives ‘summit’ in October 2010 a set of principles were agreed to underpin joint working and the following overarching objective was accepted:

*The main driver for more integrated working between the NHS and local government is to enable them as commissioners jointly to:*

- Improve the health and well being of people in our communities
- Reduce health inequalities and social exclusion
- Improve health and social outcomes through our services
- Achieve savings and cost reductions
- Implement efficiencies to help meet increasing demand

The Health and Well-Being Collaborative’s success should be judged on how well it helps to achieve these aims.

5. To that end, the proposed terms of reference for the Collaborative its overarching aim as being

*To support areas of collaboration that will have the greatest impact on improvement and increased efficiency and effectiveness through a co-ordinated approach.*


Setting priorities

6. Discussions have taken place with many groups, stakeholders and individuals about the priorities for the Collaborative and, unsurprisingly, a single view has not emerged apart from a consensus that this should be a short list of high level issues on which the Collaborative can focus and make progress.

7. The most commonly mentioned topics can be grouped as follows:

   I. **Areas of cross-cutting common interest** – such as Early Years and Family Support and Personalisation of public services
   II. **Capacity Building** – such as Workforce Development, Joint/Integrated Commissioning
   III. ‘**Big Ticket items**’ – such as Dementia care, deployment of Assistive Technology, Learning Disabilities and Safeguarding
   IV. **Transition issues** – maximising the benefits of the transfer of public health responsibilities to local government (e.g. good practice on developing Joint Strategic Needs Assessments) and setting up effective Health and Well-Being boards (and Well-Being Strategies).
   V. **Leadership, Culture and Communications** – maintaining strong links and some capacity for collaboration that goes beyond localities at a time of upheaval and financial constraint, building and supporting important new responsibilities and relationships e.g. for and between leaders of emerging Clinical Commissioning groups and elected members

This amounts to a sizeable ‘shopping list’ and there is a risk that the Collaborative tries to take on more than it can deliver. Making choices about what it can take on and communicating this clearly will need to be the first task. The Collaborative will need to take a view on how many priorities it can reasonably manage to oversee and where a noticeable, positive impact could be made. In doing so it is important to distinguish between areas of work which are a priority but which do not require regional support and co-ordination and those that would benefit from that approach.

8. To stimulate debate at the meeting I have done a crude analysis of the issues set out above by setting them alongside some broad criteria:
   - Level of priority in Y&H
   - Scope for increasing improvement through the Collaborative
   - Scope for increasing efficiencies through the Collaborative
   - Assessment of whether effective regional or local arrangements are already in place and working well

9. On that basis the following ranking emerged:
A  Priority for H&WBC involvement
   •  Personalisation
   •  Joint/Integrated Commissioning
   •  Assistive technology

B  Possible Priority for H&WBC involvement but other arrangements in place
   •  Workforce development
   •  Dementia
   •  Public Health transition
   •  End of Life Care
   •  Learning Disabilities

C  Less Priority for H&WBC involvement and other arrangements in place
   •  Health and Well-Being Board development
   •  Safeguarding

N.B. I do not feel sufficiently briefed to form a view on issues relating to children and young people and this may be an area that the Collaborative may wish to prioritise.

10. Following this meeting those areas agreed to be in Category A would be the subject of more work to define what is needed and proposals brought back to the next meeting. Those in Category B are ones where the Collaborative may still have a role to play in the future but would have more of a watching brief with regular reports back to the Collaborative and perhaps a governance role. Those in Category C are ones where issues may emerge and can be brought to the Collaborative as necessary. This would apply to other areas not already included in the list above but which emerge as regional issues

11. To help the discussion a suite of briefings have been written on most of the issues set out above. It was not possible in the time available to provide a written briefing on them all.

Recommendations

12. That the Collaborative take time to discuss the issues raised in this report and determine its priority areas for future work.

Bill Hodson
Independent Consultant
20th August 2011
Yorkshire and Humber Health and Well Being Collaborative

Personalisation – the case for regional priority

Introduction – policy background

There is a clear expectation from Government that, despite cuts, local authorities and their partners need to deliver the new vision for social care. The vision is constructed in the context of major public sector review and reform. For example, the Government is currently considering the conclusions of the Law Commission on the legislative framework for social care, along with the Dilnot Commission on the future funding of long-term care. Of specific relevance is the Commission’s estimate that its future funding of social care proposals would cost the state around £1.7billion.

Combining with the financial pressure on the social care system is broader public sector reform. This reform shifts public sector services towards a personalised customer focused philosophy which emphasizes greater use of both the private and voluntary sectors.

A raft of NHS reforms mean local authorities will become responsible for local health care priorities working with Clinical Commissioning Groups linked to Health and Wellbeing Boards. Joint health and wellbeing strategic needs assessments, intelligence assessments about communities, as well as integrated housing needs assessments will drive local health and wellbeing commissioning and determine QIPP reviews and programmes. Overall central government will have much less control over how local health and social care services operate.

In this wider public sector reform context personalisation is a radical reform which fundamentally reduces citizen’s dependency on paternalistic institutions. Choice and control by citizens though personal budgets will lead health and social care which will no longer be controlled by professionals. Personalisation introduces self-care in local communities. It uses the skills of citizens themselves combined with voluntary and private sector providers of services to deliver major cost benefits to the public purse. Personalisation is therefore an integral part of the wider transformation programme changing the relationship between the citizen and the state.

Personalisation so far

It is fair to say that despite progress since 1996, when personal budgets (PB) were first introduced as part of the Putting People First initiative, personalisation has not delivered its full contribution to the vision for health and social care. Currently only 30% of people (about 400,000 nationally) who need a PB have one, and of these, only 14% receive their budget as a direct payment.

Performance is highly variable by local authority and by region, and measuring progress just on the basis of where the 30% target has been met is misleading. The milestones reporting in Yorkshire and the Humber which finished in March
2011 showed that major change has already taken place with achievements in a number of important areas, for example:

- A new self-directed support process is in place, including new resource allocation, self assessment and support planning processes
- Most LAs have a user led organisation operating to give advice guidance and support to personal budget holders
- Commissioning teams are well aware of personalisation and have generated market position statements and are engaging with providers on the need to respond to the personalisation agenda
- An eMarketplace, has been commissioned by local authorities which can track the development of the personalised market and increase the extent of real choice and control
- Personal health budget pilots have been developed and the possibilities of providing greater personalised provision in the long-term conditions and continuing health care fields is gathering pace
- Right to Control pilot sites are trailblazing the way to pool budgets across institutions
- Work on personalising transitions for young disabled children into adult services has progressed with a much greater awareness of the need to develop a self-directed support process as early as possible

However, the key challenge from central government through the Think Local Act Personal partnership is for councils to provide personal budgets to 1 million eligible people, primarily delivered as a direct payment, by 2013. This drive to deliver ‘authentic’ choice and control to individuals requires another step change in the capability of adult service departments, health and provider partners.

**Think Local Act Personal going forward**

The essential dilemma that council’s face is that they need to avoid a ‘lose: lose’ situation, where social care and health get increasingly financially constrained, in a situation where no alternative system to increase productivity while maintaining outcomes is developed. This results in less choice for citizens, worse outcomes for public money spent, more disputes and judicial reviews, and a generally a downward spiral of services and outcomes for citizens. Instead council’s need to create a ‘win: win’ scenario where social care is able to develop a more lean, less bureaucratic system, which reduces the onus on councils whilst giving more choice and more control to individuals. This will enable creativity to flourish providing an opportunity for positive outcomes to be delivered whilst less money is available.

Personalisation, as a strategic move towards self-management, is the only alternative social care model available. Furthermore it has the tools to be able to reduce process, remove costs from the system, and achieve the win: win scenario described. However, there are major challenges to making this happen. For example, councils spend, on average, £35m of every £100m on non-residential care and support but only approximately £5m is spent via PBs and only £2.5M via DPs. Given the Governments 2013 target and need to develop a ‘self-management’ personalised model of social care, commissioning practices, social work activity and spend associated with it will have to change significantly in a very short period of time.
It is clear from emerging documentation that there needs to be a major re-emphasis on the development of minimum processes for critical segments of the social care pathway, these aspects of personalisation are under developed and if not addressed will disable personalisation as a plausible response to the current issues facing health and social care.

These aspects of personalisation need to form the priority areas for a regional programme:

**Prevention**

a) Fully developing and utilizing an eMarketplace service which can deliver an information and advice portal, a social care product and services catalogue, messaging with providers, plus a transacting and review platform

b) Developing external and internal advisory services to support customers as they access universal information

c) Developing informal private and voluntary sector providers so that they can respond to social care needs in flexible and innovative ways

d) Develop commissioning approaches that shape the market rather than purchase from it. This means learning to build support services around informal networks of carers, families and friends, managing and being sensitive to issues of vulnerability in the process. Planning at community level for demographic changes and JSNA projections, and using market information from a developed eMarketplace tool.

**Supporting recovery and maximising independence**

a) Setting up multi-disciplinary teams of health and social care staff accessed through a single point of entry

b) Reduce hospital admissions by fully realising an integrated reablement-intermediate care system with health

c) Continuing to enhance the telcare ‘offer’ to help maintain independence from services

**Staying in control of ongoing support**

a) Focussing the Council’s social care resources on eligibility assessment and regular and frequent outcomes based reviews, and allowing support planning to be done externally to the Council.

b) Enabling carers, family, friends and third sector organisations to guide the use of money through an iterative support planning process

c) Review the workforce skills balance and competencies to make sure the formal workforce is fit for purpose and the informal work force has opportunities to develop and learn
d) Enhancing direct payments as a primary mechanism for achieving outcomes in the least bureaucratic way possible

e) Progressing Personal health budgets so that long-term conditions and continuing health care customers are able to self-manage as far as possible

f) Continuing to develop personalised transitions and personal budgets for young disabled people as they move from children’s services into adulthood. Promoting self-management from as early a point as possible in their family life.

**Benefits that can be realised**

Focussing on what activities need to be undertaken by the Council for all of the population and what it needs to do specifically for the social care population means better use of resources.

Quicker and leaner use of personal budgets will mean a more productive workforce

More choice and control being taken by citizens and social care clients means better outcomes.

Delivering leaner approaches to council support planning can release benefits to local authorities and citizens. Provisional independent evaluation of the advantage of reducing the complexity of direct payment processes shows savings of 49% compared to previous more bureaucratic account management process. Projected saving on 800 people suggest £0.5m efficiencies.

Recent studies show time-banking cost per member per year about £450 but generates savings per member per year of more than £1300

A befriending service developed to support older people, shows costs per person per year of £80, and savings per person per year of £300

Advice and support ‘community navigator’ costs are £480 per year per person supported, but savings can be at least £900 per person in the first year

At a regional level, the Yorkshire and Humber Joint Improvement Partnership, over the last three years has delivered a major project based improvement programme. The programme has all but concluded now, and the learning has been shared, principally by a regional conference in May 2011. However, much of the benefit from the individual projects (14 personalisation ones) needs to be realised across the region, not least to maintain the culture of sharing and collaborating to maximise the sharing of resources. The JIP programme saved £1.5 million between 2008-2011 as a result of bringing people together to learn and avoiding duplication.

Tim Gollins
August 2011
Yorkshire and Humber Health and Well Being Collaborative

Commissioning – a discussion paper

Background

1. *An Audit Commission definition* - ‘Commissioning is the process of specifying, securing and monitoring services to meet people’s needs at a strategic level. This applies to all services whether they are provided by the local authority, NHS, other public agencies or by the private and voluntary sectors’

2. There is nothing new in the concept of joint commissioning between and across local government and health services. It has been promoted in principle as a policy for decades and supported by many initiatives but despite good examples in many areas it has never become established as the key system for delivering improved outcomes for people.

3. The term joint commissioning is primarily used to describe when two or more commissioning agencies act together to coordinate their commissioning, taking joint responsibility for translating strategy into action. In practical terms this means making the best use of available resources to meet individual needs. Effective joint commissioning is crucially important in the process of developing a whole systems approach to service delivery and improving outcomes to users and carers. It includes a range of activities:
   - Needs assessment
   - Financial planning
   - Working in partnership with key stakeholders, including users, carers and service providers
   - Planning innovative services
   - Specifying and procuring services that will deliver and improve agreed health and social outcomes
   - Effective review and redesign of services and pathways of care.

4. Integrated commissioning takes this concept a step further and brings commissioning staff together into one unit. This has been a feature of the work of many Children’s Trusts. This ought to lead to more ‘joined-up’ care (although this can also be achieved through joint commissioning) resulting in integrated delivery of services, changing frontline working practices and adapting the mix of services to meet local requirements.

Context

5. Major changes are taking place within the NHS with the creation of the Commissioning Board at national level and the shift of responsibilities from PCTs to Clinical Commissioning Groups at local level.

6. The creation of Health and Well Being Boards in each local authority area will strengthen the role of councils in co-ordinating the response of local agencies to
the needs in their area and holding them to account. This brings in local, democratic accountability as well as strengthening the link to Public Health through the use of the Joint Strategic Needs Assessment to feed into to a joint Health and Well Being Strategy for a locality.

7. At local government level there continues to be interest in joining up commissioning strategies across departments (many councils have moved to Executive Directors with broad portfolios) to increase benefits for local communities. The importance of ‘non-social services’ such as housing, community safety, economic development, life-long learning and leisure as determinants of health is well understood but not always acted upon in commissioning.

8. The government has also continued to pursue its vision for the “Big Society” with the recent green Paper on modernising commissioning by increased use of the voluntary sector and social enterprises in the delivery of public services.

**Threats and Opportunities**

9. The upheaval in the organisation of the NHS, the restrictions on public sector spending and the plethora of government initiatives have the potential to create a climate of confusion that could lead to inertia or lost opportunities for finding creative solutions.

10. On the other hand, the scale of the changes and the financial challenge presents an opportunity for some radical re-thinking, the potential for closer links between local government and health and the formation of important new alliances – e.g. between GP commissioners and elected members.

11. In taking discussions forward it will be critical to distinguish between activities that are best delivered at:
   - local level,
   - cluster level,
   - regional level

12. A useful starting point could be to focus on outcomes – such as outcomes for public health that the government consulted on this year:

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<tr>
<th>Domain 1</th>
<th>Domain 2</th>
<th>Domain 3</th>
<th>Domain 4</th>
<th>Domain 5</th>
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<tbody>
<tr>
<td>Health Protection and Resilience: protect the population’s health from major emergencies and remain resilient to harm</td>
<td>Tackling the wider determinants of health: tackling factors which affect health and wellbeing and health inequalities</td>
<td>Health Improvement: Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities</td>
<td>Prevention of ill health: reducing the number of people living with preventable ill health and reduce health inequalities</td>
<td>Healthy life expectancy and preventable mortality: preventing people from dying prematurely and reduce health inequalities</td>
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</table>
13. Equally valid and complementary would be an approach based on principles such as:
   - Early intervention and prevention
   - Joined up care provision
   - Care close to home and community

**Role for the Collaborative?**

14. This paper is intended to stimulate debate on whether the Collaborative has a role to play in shaping future commissioning arrangements between local government and health or whether this is best left to localities to determine.

15. Discussions have already begun in the West Yorkshire area to try to find the common ground before final decisions on commissioning structures are made.

16. Points for consideration include:
   - Strategic Leadership – setting the tone for integrated, whole system solutions
   - Identifying some issues that justify regional commissioning approaches
   - Improving and sustaining high standards and skills for commissioning
   - Communication and linkages across localities and regions (i.e. not becoming introspective)

Bill Hodson
22nd August 2011
Yorkshire and Humber Health and Well Being Collaborative

Assistive Technology – Telecare and Telehealth – A briefing note

Context

1. In England we are faced with an ageing population and increasing levels of long-term conditions. According to the Department of Health, there are currently 15.4 million people in England living with a long-term condition. Telecare and telehealth are assistive technologies developed to address issues arising from the increase in long-term conditions.

2. Central government telecare policy over the last decade has focussed on encouraging councils to invest in telecare; growing the evidence base on the value of telecare; periodic grants to fund investment; vision and leadership; encouraging partnerships and service integration; and, mainstreaming telecare assessments. This policy framework for telecare does succeed in aligning local authority powers to invest in telecare and coordinate its use with incentives, given savings from telecare also accrue to local authorities. However, local political discretion results in variation in the availability of telecare and decisions to invest are dependent on local budgeting constraints.

3. In 2008 the Department of Health launched an evaluation of the Whole System Demonstrator Site programme for telecare and telehealth, which is being carried out by the Kings Fund and is due to report later in 2011.

Local Background and drivers

Telecare

4. The Yorkshire and Humber Region have been recognised nationally as achieving excellence in the deployment of Telecare - it featured in the Dept of Health’s 2009 “Best use of Resources in Adult social Care”. As a result an 18 month regional project was funded by the Department of Health (£138,000) and Joint Improvement Partnership (£90,000) to pump prime the development of tools and knowledge leading to efficiencies through increased use of Telecare. Stakeholders included all the Adult Social Care Directorates across the region and it was expected that many of these would contribute to building evidence, tools and knowledge.

5. Initial drivers were the “Our Health, Our Care, Our Say” White Paper outlining the key elements of transforming adult social care, followed by “Putting People First” which stated “Telecare to be viewed as integral not marginal”, and the Preventative Technology Grant to create infrastructure and increase the numbers of people being supported through Telecare solutions.
6. The aim of the project was to enhance service options and efficiencies and therefore the range of outcomes and benefits available to people in the region by the inclusion of Telecare.

7. Evidence from North Yorkshire County Council Adult and Community Services, other local authorities in Y&H, and national projects has been that Telecare can enhance people’s lives, give them greater choice and control over their lives and deliver efficiencies. Case studies from regional colleagues support this finding with Telecare being seen increasingly as the default service offer linked to reablement for people seeking support in the community.

**Telehealth**

8. Following a positive six month small scale pilot, NHS North Yorkshire and York issued a tender for the procurement of a further 2,000 telehealth systems set for deployment across the patch. This three-year contract was awarded to Tunstall Healthcare and commenced in April 2010. This marked the beginning of what would have made NHS North Yorkshire and York the largest scale telehealth project in the UK focussing on three main disease areas:
   - Chronic Obstructive Pulmonary Disease (COPD)
   - Chronic Heart Failure
   - Chronic Diabetes

9. It was identified early-on that in order to get the most from telehealth, it was not enough to simply install units in patients’ homes without first determining whether the existing care pathways would enable the benefits of telehealth to be fully realised. An intense process of clinical engagement ensued to critique existing pathways and develop new versions that embraced the technology and ensured that enhanced clinical outcomes could be achieved.

10. Latest figures available are that over 400 patients in North Yorkshire and York have now been referred to telehealth by their doctor or nurse. A survey of 200 patients currently using telehealth in North Yorkshire and York showed that 96 percent of them would recommend the technology to others, with 98 percent being either ‘satisfied’ or ‘highly satisfied’ with how it’s helping them manage their long term health condition.

11. The potential for assistive technology to assist in the care of people with dementia – both in their own homes and in residential settings – is being increasingly recognised as an important development area.

**Potential Efficiencies**

12. An illustration of the scale of efficiencies deliverable by appropriate use of Telecare in the Yorkshire and Humber local authorities is detailed below from a city, a metropolitan and a shire council, where Telecare is used as a service option to support and safeguard people’s risks, enable choice and control in their care, and deliver within the challenges of limited resources. Telecare is defined as lifeline and pendant only and Telecare add-ons with falls, bed sensors etc. Telecare add-
on figures are quoted below. Further information could be gathered for year-end figures:

- Leeds City Council had 3200 current Telecare (add-ons) service users of Telecare they conduct a rigorous process of analysing figures of traditional versus Telecare enhanced packages of care. Their findings are a net saving of £5500 per person.
- Rotherham Metropolitan Council had 9380 people with lifeline only and 1000 current Telecare (add-ons) service users. To overcome the challenges initially presenting when setting up Telecare they have simplified pathways for increase of service and simplified a menu of Telecare for staff to consider. There was significant leadership at director level to effect change and Telecare is embedded in the council’s Medium Term Financial Strategy.
- North Yorkshire county council had 2980 current Telecare (add-ons) service users with efficiency savings of £3100 - £3800 per user and continues its strategy to ensure Telecare is a key component in the commissioning and delivery of care for service users.

13. Extrapolating from the results in these 3 authorities to the 15 in the Yorkshire and Humber would indicate a potential for savings of over £100m.

14. Early figures from North Yorkshire and York’s telehealth programme indicated there was a 40% reduction in emergency hospital admissions and a 28% reduction in A&E attendances. Based on 35 patients who had been on telehealth for six months or more, acute commissioning savings are estimated at £88,655.

Follow on work

15. The Yorkshire and Humber project has now come to an end and the local authority representatives were asked to consider if there was any requirement for a second tranche of AT work or was this project completed. The regional local authority nominees defined their requirements for the next phase of assistive technology work as:

- Establish a Telecare performance framework, to ensure consistency and shared values for delivery in the public sector.
- Further regional Telecare work, as the systems and equipment evolve up to date knowledge, practice and efficient working practices are required.
- Combined Telecare monitoring/response services.
- Combined Telecare commissioning.
- European bid to push Telecare/Telehealth wider for buy in higher up in organisations and with Governments.
- Procurement - explore relationships with Telecare suppliers and impose what LA’s require not what providers want to make available; links to universal approach and interoperability of equipment.
- Telecare standards - meaningful for LA’s and health not Telecare Services Association standards which is primarily housing focus.
16. The Yorkshire and Humber Health Innovation and Education Cluster (HIEC) have produced a Telehealth Toolkit - a resource designed to support emergent commissioners, provider organizations and individuals to access the information required to introduce new technology-enabled service models for people with long term conditions. The toolkit includes background information on telehealth, evidence and business case for each of the approaches and illustrations of their deployment using a range of UK and international case studies. It is intended to support each stage of development from first idea to operational service delivery.

17. In partnership with the University of Hull and Sheffield Hallam University, HIEC have also developed an “Introduction to Telecare and Telehealth” which is available free over the web to health and social care staff in Yorkshire and Humber.

Role for the Collaborative?

18. This briefing is not a full appraisal of all that is happening in our region but does highlight the interest in assistive technology, its potential and its relevance. It would be a fair working presumption that there are more unrealised benefits to be exploited from the strategic deployment of technology and plenty of scope for a more joined-up approach across local government and health. This could be at the regional level but is most likely to be fruitful at a local and cluster level.

19. A useful starting point would be to commission a quick, one-off piece of work to appraise the current state of play across the region (best practice, lessons learnt etc.) and to convene a regional stock-take meeting. The outcome would be brought back to the Collaborative for consideration.

Bill Hodson
22nd August 2011
Yorkshire and Humber Health and Well Being Collaborative

Workforce

Introduction
Social care is set to change. There are a range of developments in government that are driving changes:

- Last year we saw the government publish its vision for adult social care: Capable Communities and Active Citizens.
- This year sees the publication of the Law Commission Review which will likely result in the development of a single unified legislative framework for adult social care in England & the Dilnot Commission on the future funding of social care.
- The ambition for the greater integration of Social Care, Health Care & Public health - local Health & Wellbeing Boards and Joint Strategic Needs Assessments to shape the commissioning of social care and health improvement services.
- The government’s wider ambition of creating a Big Society - for care and support service this will include greater involvement and engagement, with individuals and communities being given greater freedom & responsibility to improve care services.
- The Social Care Reform Bill, which is due to be published next year, is intended to establish a sustainable legal and financial framework for the future of Care & Support.

Nationally it is inevitable that demand for care and support will continue to increase. Skills for Care has developed a workforce simulation model (SfC 2010b) that has projected to 2025 the numbers of social care workers that may be needed to meet the future social care needs of adults and older people in England. They suggest that the number of people working in adult social care could increase from the current 1.6 million to between 1.8 million and 2.6 million in 2025, depending on how personalisation affects the demand for services.

Increased take-up of direct payments and the extension of personal budgets, alongside people funding their own care, will be instrumental in changing the shape of the workforce, for example leading to increases in the number of personal assistants. There will be changes to who employs the workforce, with more micro-employers, social enterprises and mutuals providing services.

In response to the Governments vision for adult social care; Skills for Care recently published Capable, Confident & Skilled: A workforce development strategy for people working, supporting and caring in adult social care

The need for developing a collaborative approach to integrated workforce planning taking into account the whole workforce across health and social care is a key aim of the WPB and is embodied in the InLAWS programme identified later. The connections with the emerging SHA Education and Training Board are essential

Work on current joint themes e.g. dementia, end of life care, medication are clear areas for joining our workforce development approaches and many examples of good practice already exist.

1. Workforce Programme Board Yorkshire and the Humber (WPB)
This has continued since the demise of the JIP and has attendance from all 15 Local Authority Workforce Development leads plus links with the HR Managers group for all
15 LA’s. It is chaired by Joan Beck, Director of Adults and Community at Doncaster Council and Skills for Care (SfC) provide admin, venue and delivery of projects through lead officers.

2. WPB Current Agenda Items

a) Leadership Programme
The University of Sheffield are working with SCIE to run their leadership programme in regional areas as well. WPB has gauged interest from councils in attending a regional leadership programme but some have local alternatives or are just starting out on this.

WPB role - for LA’s to buy into if no other existing programme available

b) National Minimum Data Set – Social Care
The National Minimum Data Set for Social Care (NMDS-SC) is to be introduced as the adult workforce data return from local authorities. The DH thinks there should be a central collection and a single source of social care workforce intelligence for the sector to underpin effective workforce planning and decision making and sees NMDS-SC as a rich source of information. In September 2011 there will be a requirement or a partial return with a full return required from September 2012.
SfC has presented the Y&H statistics, targets and achievements to the end of May 2011 to the WPB. Some of the CQC numbers may be showing lower than actual and the Data sharing agreements that had been set up previously were now out of date. Local Authorities have been asked to contact SfC if they wished to set up a Data Sharing Agreement to support independent and voluntary sector employers to register with NMDS-SC.
WPB role - to encourage take up of NMDS across all 15 LA’s… barriers shared and solutions discussed

c) Integrated local area workforce strategies (InLAWs)
InLAWs is a SfC and ADASS project established in 2009 with support from the Department of Health (DH) to develop effective ways to support workforce commissioning role across the local area, and to understand changing priorities in adult social care. It is providing a common methodology and practical tools designed to help the DASS and their teams to develop a skilled, capable and competent workforce i.e. “The Right workforce doing the right things at an achievable cost.”
A number of areas of work are proposed to support further implementation of InLAWs:
- Health and well being boards
- Workforce Outcome Tools
- Keeping existing InLAWs tools and resources up-date
- Provider Employer Engagement Financial modeling and workforce redesign
- Using InLAWs with social work

WPB role - to ensure InLAWS methodology engaged in all 15 LA’s.

d) End of Life Care Programme

The document relating to the End of Life Care Y&H SHA project involving the management of EoL champions in 800 care homes across the region has been finalised and circulated and the response so far has been positive. SfC has now received confirmation of the project and recruitment of a project Manager now underway.
WPB role is to provide an overseeing role of the delivery of the project across all 15 LA’s and steering group representative.
e) **E Learning Pool**

Funded through the JIP the following modules are included on the learning pool and will be linked to the Qualifications and Credit Framework (which has superseded NVQs):

- Assistive technology – almost complete
- End of Life Care – still in its early stages.
- Dementia – this is a SCIE created module
- Community Capacity Building – still in its early stages and this will be pitched at a higher level instead of just awareness raising

**WPB role** - All Local Authorities are to identify a lead person for learning pool

3. **WPB previous agenda items**
   - Carers Strategy
   - Individual Employer Development needs report

4. **Future agenda items**
   - Personal Assistant framework

5. **Link to the Collaborative**

   a) The WPB would benefit from strategic steer by the Health and Wellbeing Collaborative to ensure local authorities are represented at the SHA Education and Training Board as it is a crucial health and social care development forum. This was to be the Skills network and will be the conduit for funding future health and social care development activity

   b) There is a continuing need for co-ordination and overview which was provided through the JIP in the past and to maintain access to up-to-date information via a regional website. Links need to be maintained to other regional development groups e.g. on safeguarding, commissioning and personalisation.

Sally Gretton
Skills for Care
22nd August 2011
Yorkshire and Humber Health and Well Being Collaborative

The Health and Wellbeing Collaborative: Opportunities for living well with dementia

National Context

The National Dementia Strategy of 2009 sets out key changes to dementia care across a five year period. These changes address a number of critical features including better public awareness and understanding, improvement in all stages of the care pathway and recalibrating the health and social care workforce to ensure key skills are achieved to deliver safe and effective care.

The 17 objectives in the strategy have a focus on the NHS, Local Authorities and independent sectors achieving an integrated approach to provision and commissioning. More so, the strategy sets out clear expectations for improvement in specific care sectors both in terms of care quality and cost saving.

More recently in the NHS Operating Framework the DH has set out four themes which serve to frame improvement activity in 2010/11, these being:

- Early diagnosis
- Improved care in acute hospitals
- Care homes
- Reducing prescribing of antipsychotic medication

In July 2011 the DH launched the Dementia Commissioning Pack which offers a range of tools to enable outcome focused commissioning for these themes and amended them further by including care in the community alongside improving care in residential settings.

Yorkshire & Humber Context

There are some 61,000 people living with dementia in the Yorkshire and Humber region. Over the next 15 years it is likely that this number will increase by approximately 30,000. Across 60% of the region the percentage increase in the number of people with dementia is greater than the England average.

In April 2011 Bill McCarthy and Tony Hunter representing the NHS and Local Government across the region underlined the priority for dementia across local government and health. The joint work with YHIP, the SHA and localities has been articulated in a series of key papers.

‘The Case for Change’ (YHIP Jan 2011) sets out the locality positions against the 4 themes for improvement (see above). Given the current prevalence and expected demographic changes, an emphasis on early and timely diagnosis and increasing
public awareness whilst attending to changes in the way care services are organised and delivered is increasingly important. The emphasis on preventative services to impact on the use of emergency care, the use of assisted technology in services and a personalised approach to care seem to be critical opportunities.

The potential to achieve a more defined agenda to help people “live well” in the context of dementia should also be explored through the role of housing, leisure and related community agencies. The emphasis on a whole systems approach for people with dementia is critical.

There are particular groups living with dementia that will need specific and targeted responses from the NHS and Local Authorities, these include for example, people with learning disabilities and those from particular ethnic and heritage communities.

*Current Structures to support dementia*

The responsibility for delivery of the national strategy is clearly located within localities.

Within the Yorkshire and Humberside region there is already an active group of dementia leads within health, local government and the third sector. In addition the Dementia Programme Board brings together senior strategists and planners to consider pertinent issues and offers a bridge between localities and the existing strategic structures.

The Health and Wellbeing Collaborative may wish to consider therefore how it relates to existing regional groups and if it has a role in any of the following areas:-

- To ensure that joint working and planning is the norm within the region and that barriers between systems are recognised and minimised in strategic plans;
- To consider the wider public health agenda related to living well with dementia.
- To ensure that some of the cross-cutting issues such as assisted living, workforce development, housing and leisure etc take account of the national dementia strategy
- That regional or sub-regional improvements are sought through cluster collaboration. These will bring together elements of service that improve efficiency and delivery.
Yorkshire and Humber Health and Well Being Collaborative

Public Health Transition update

1 National work: Healthy Lives, Healthy People - Update and Way Forward


The guidance includes those elements where there is clarity and enables further planning and implementation to go forward. There are also a number of areas where further guidance is being prepared:

- Public Health outcomes framework;
- Public Health England Operating Framework;
- Public Health in Local Government and the DPH role (detailed guidance);
- Public Health Funding;
- Workforce and regulation of Public Health professionals.

2 NHS Cluster Operating Model

The national guidance on the Cluster Operating Model was also issued in July. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLibrary/Publicationslibrarysearchresults/index.htm?&selection=1&isAdvancedSearch=LetterCircularLibrary&defaultCategory=551&taxonomyLibraryNodeID=572/&Gateway=16436

It was confirmed in earlier guidance that Directors of Public Health posts should not be ‘clustered’ as their destination after the transition was expected to be to their respective Local Authority. The issuing of national guidance now offers the opportunity to describe and secure public health input to all clusters. Directors of Public Health have recommended that – for the transition period - they each retain a reporting route to the Cluster Boards – for the delivery of statutory public health functions and to secure a population health focus to each Cluster Board. In practice and for governance reasons there is likely to be a single public health vote at each Cluster Board – DsPH on each Cluster will need to agree how best to use this in advance of the formal meetings. Each Cluster has already established regular communications and networking between DsPH.

3 Yorkshire and Humber Update

The Public Health Transition Steering Group met on July 8th and discussed the following issues:

- Health and Well-Being Boards are being established in the region in shadow form. There are different models of operation reflecting different locality approaches. And in many areas there is the beginning of an understanding of
a cycle of activity for the Boards e.g. JSNA, health and well-being strategy, alignment of commissioning plans, which feels positive.

- The Directors of Public Health have agreed amongst themselves to support the continuation of the networks to share public health expertise on tobacco, obesity and alcohol. This will enable the rapid sharing of expertise and good practice and the development of common tools and approaches – where these are useful and more cost effective than developing local solutions.

- The public health ‘workstreams’ already operational as part of the PH Transition Steering Group will take forward key aspects of the forthcoming national guidance on public health. The health protection, screening, finance and workforce workstreams are particularly well connected to national work and leaders from the Yorkshire and Humber DsPH network have been directly involved in recent national workshops.

- The workforce and HR Group will be producing a ‘Frequently Asked Questions’ bulletin to address issues and explain the current position as far as possible – while national guidance is being prepared.

- The Dept of Health has asked local areas to identify the public health budget in preparation for the shadow year. Directors of Public Health and Directors of Finance in PCTs have been asked to work with local government colleagues on this and the deadline for submission is mid September.

- A peer support and assurance process for local public health transition has been developed by the SHA in collaboration with Directors of Public Health and the PH Transition Steering Group. The RDPH – supported by a DPH peer – will hold a series of discussions over the next couple of months with each local area on a common set of issues. These issues have also agreed nationally with the Public Health England Transition Team and in partnership with other regions. The outputs – both risks areas and good practice – will be shared with all DsPH, the SHA, the PH Transition Steering Group, Health Leadership Group and with the Public Health England Transition Team. Results could be shared with the Collaborative if there is interest.

4 Where to find out more:

- Directors of Public Health and their teams are the best source of information about the public health transition at local level.

- Dept of Health website has all the national guidance and updates.

- The SHA produces a transition newsletter every week which includes an update on all aspects of NHS transition including public health. These can be found at the following weblink. http://www.yorksandhumber.nhs.uk/what_we_do/commissioning_development/commissioning_development_newsletter/

Anita Parkin  
Director of Public Health for Bradford  
DPH representative on the Health and Well-being Collaborative  
August 2011
Yorkshire and Humber Health and Well Being Collaborative

National End of Life Care Programme (NEoLCP) – a regional response

Summary

1. The National End of Life Care Programme (NEoLCP) was launched in July 2008. This report gives a brief update on the rollout of the Social Care Framework for care at the end of life, “Supporting People to Live and Die Well”, which was first launched in July 2010, and sets out some recommendations on organising the regional response.

Background

2. The Social Care Framework for the NEoLCP – “Supporting People to Live and Die Well” – was launched in July 2010. Among its conclusions were:
   - The social care workforce – from domiciliary care workers to social workers and their managers – may need training and support to recognise the skills they already have and to develop new ones
   - The personalisation and re-ablement agendas offer significant opportunities for improving EoLC – although commissioners must take account of the needs of people unable to take full advantage of these approaches
   - Greater integration is needed across all care and support services, particularly between social and health care

3. Roadshows were held in all the regions as part of Phase 1 of its implementation and there were some common messages across the country:
   - A need to streamline processes and use single systems (e.g. assessment documentation)
   - Support, improve and simplify access to EoLC training across all levels of social care/work staff
   - Improve information-sharing and access to data across services
   - Better publicity and integration of local EoLC strategies/ action plans

4. There was a lot of interest locally with 167 people attending the Y&H roadshow in March 2011 with representatives from all areas in the region. However, the national team report that the proportion of people attending from local authority social care (15%) was noticeably less than in most other regions. The attached slide was built up during the Y&H roadshow from the ‘single actions to improve EoLC’ which each group was asked to identify.

5. In August 2010 proposals were invited for projects to act as test sites to support the rollout and implementation of the social care framework and to have the potential for national dissemination as well as enhancing local end of life care
provision. Eight sites were commissioned as well as an independent evaluation which will report in July 2011. In Y&H the topic was - Developing Key worker Competencies for domiciliary care workers to support an integrated pathway for end of life care, led by Hull and Wakefield PCTs, Hull CC + partners.

6. Phase 2 of the implementation of the social care framework has now been launched and this includes the plan to establish Regional Supporting People to Live and Die Well groups. It is intended that these groups would be co-ordinated and managed by the region, for the region. To help this along the national team have a small amount of funding to support one initiative in each region with a social care focus but a joined-up approach.

7. We are fortunate in having Professor Margaret Holloway (University of Hull) in our region who is the Social Care Lead for the NEoLCP. Professor Holloway’s colleague, Tes Smith, is leading on the implementation of Phase 2 and has written to a number of people in Y&H (who have expressed an interest in end of life care or who attended the roadshow) about setting up the regional group and making the offer of a small amount of financial support.

8. There is already a Regional End of life Care Pathway Leadership Board convened by the Strategic Health Authority as part of the “Healthy Ambitions” programme. This has links to each PCT locality but does not have direct involvement from social care. It would seem sensible to link any new work on the social care aspect of end of life care to this existing group provided that the focus is maintained.

This could be achieved by setting up a social care sub-group of the Regional End of Life Pathway Leadership Board led by a social care lead connected to ADASS with a representative joining the main board.

9. The Health and Well-Being Collaborative can provide the overview and co-ordinating role in supporting and promoting a more joined-up approach to end of life care in this region.

Recommendations

10. Agree for the Collaborative to have improving end of life care as one of the areas of work that it monitors and supports and to receive periodic updates.

11. Endorse bringing a new social care regional group into the same governance arrangements as the existing regional health group.

Bill Hodson
Independent Consultant
19th August 2011
Yorkshire and Humber Health and Well Being Collaborative

HealthWatch update

What is Local HealthWatch?

1. HealthWatch will be the independent consumer champion for the public i.e. service users, citizens, carers and patients – locally and nationally – to promote better outcomes in health for all and in social care for adults.

2. At the local authority level, Local HealthWatch will act as a point of contact for individuals, community groups and voluntary organisations when dealing with health and social care. Local HealthWatch will have a seat on local health and wellbeing boards to influence commissioning decisions by representing the views of local stakeholders. Information that Local HealthWatch gathers on patients’ and the public’s views and experiences of the NHS will inform HealthWatch England’s role in influencing health and social care services at the national level.

What are the responsibilities of Local HealthWatch?

3. Building on the LINks’ functions to involve and engage, to enter and view premises providing care to service users (as set out in the Local Government and Public Involvement in Health Act 2007) the following describe the additional functions for local HealthWatch.

4. Influencing - local HealthWatch will present the views and experiences of local service users to local managers and decision makers (as well as to HealthWatch England at the national level) and be part of the decision making process on the local health and wellbeing board. It will also hold local providers to account by reporting on services and making recommendations.

5. Signposting - providing information to service users to access health and social care services and promoting choice. Some signposting is currently provided by Primary Care Trusts (PCTs), as part of their Patient Advice and Liaison Services (PALS) responsibilities, and it is the signposting function of PCT PALS which Local HealthWatch will take forward.

6. As a corporate body, Local HealthWatch will be able to employ its own staff, as well as continue the LINk legacy of recruiting volunteers, and be subject to public sector duties such as the Equality Act 2010

Timetable

7. Both HealthWatch England and Local HealthWatch will now be established from October 2012. This is intended to give Local HealthWatch the opportunity to play a full role in clinical commissioning groups and health and wellbeing boards
when they are set up. Local Involvement Networks (LINks), which will cease to exist when Local HealthWatch comes into being.

8. From October 2012, subject to parliamentary approval, Local HealthWatch will also signpost people to information about health and social care services. This is one of a range of services currently provided by the PCT Patient Advice and Liaison Services (PALS).

9. Local authorities and Local HealthWatch will take formal responsibility for commissioning NHS complaints advocacy from April 2013.

**Funding options - consultation**

10. The Department is asking for views from all stakeholders, including LINks, on options for distributing the additional funding to local authorities for local HealthWatch, NHS Complaints Advocacy which is moving from the Department of Health, and PCT Deprivation of Liberty Safeguards (DOLS) which is moving from the NHS.

11. Subject to the passage of the Health and Social Care Bill, the Department (DH) will need to allocate funding for four duties which will pass from the NHS and DH to local authorities. The timetable is as follows:

<table>
<thead>
<tr>
<th>Funding</th>
<th>Transfer to Local Authorities</th>
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<tbody>
<tr>
<td>Local HealthWatch signposting element from PCT PALS</td>
<td>From October 2012</td>
</tr>
<tr>
<td>NHS Complaints Advocacy</td>
<td>From April 2013</td>
</tr>
<tr>
<td>PCT Deprivation of Liberty Safeguards</td>
<td>Potentially, from October 2012</td>
</tr>
<tr>
<td>Independent Mental Health Advocates</td>
<td>April 2013</td>
</tr>
</tbody>
</table>

12. The consultation is asking for views on allocation options for the first three of these duties. The government will look at allocation options for the Independent Mental Health Advocates (IMHAs) prior to the 2013 settlement. This additional funding to local authorities will be added to the current DH Learning Disabilities and Health Reform grant.

13. The majority of funding for Local HealthWatch will come from two sources:

   a) LINks are currently funded through Department for Communities and Local Government (DCLG) Formula Grant. This will continue for at least the remainder of the current spending review to 2014/15 for Local HealthWatch. This funding is not affected by this consultation.

   b) Funding for signposting responsibilities currently carried out by PCT PALS will be transferred from PCTs to local authorities in October 2012.
14. There will also be funding for:

a) Increased Demand for Choice: it is expected that patient demand for help to make choices will increase with the new arrangements. The government have allowed funding of £0.5m/£1m/£1.5m over 2012-13 to 2014-15 for an annual increase of 2.5% above the existing spend. This element of funding will transfer from October 2012.

b) Start up costs: the funding for these costs will be allocated in 2012-13.

15. The government are currently consulting on the formula for distributing funding and proposes that the funding an area needs to provide a Local HealthWatch will be proportionate to the relative need in each local authority for state supported social care as this is the best indication they have, at a local authority level, of people more likely to be in contact with the health and social care systems and who may require signposting services. The alternative would be size of the adult population.

16. Using relative need rather than size of adult population as the determinant would see some significant differences in this region. For example, Rotherham would receive approximately £35k more in funding and North Yorkshire would receive approximately £40k less.

Bill Hodson
22nd August 2011
Yorkshire and Humber Health and Well Being Collaborative

Health and Wellbeing Transition - Background Briefing Paper

1. What does this paper cover?
   a) The White Paper Equity and Excellence:
   b) The Mandate for the NHS
   c) Health & Wellbeing Boards
   d) Health Watch England
   e) Next Steps – Future Forum & Commission for Funding of Care Support

The White Paper Equity and Excellence: Liberating the NHS

2. This set out a vision that:
   a) Is genuinely centred around patients
   b) Achieves quality and outcomes that are the best
   c) Refuses to tolerate unsafe and substandard care
   d) Eliminates discrimination and inequalities
   e) Puts clinicians in the driving seat
   f) Is transparent, with more accountability for results
   g) Gives citizens more say in how the NHS is run
   h) Works much better across boundaries.
   i) Is more efficient and dynamic - less bureaucracy
   j) Is free from frequent and arbitrary political meddling

What is the Mandate?

3. The Mandate:
   a) Sets out the totality of what Government expects from the NHS Commissioning Board on behalf of the public
   b) It will comprise of a series of outcomes and objectives that the Board should work to achieve, and the financial settlement
   c) It will be a multi-year document (with annual refreshes)
   d) It will be the Government’s means of holding the Board to account for £80bn funding

4. The Mandate is one part of a bigger picture and the new system is not ‘driven’ by the Mandate alone
   a) The reforms change the relationship between DH and the NHS
   b) The Mandate is one of a number of forces that operate on the system
   c) DH will be one of a number of organisations which has an influence on the NHS
   d) It will change the nature of our work and the ways in which we operate
Health and Wellbeing Boards

5. **The Vision:**
   a) Collective leadership leading to integrated services that better meet individual and community needs
   b) Connect NHS and local government activity with all public sector spending to improve health and wellbeing of local populations
   c) Genuine practical collaboration between Councils, the NHS and communities, users and the public
   d) Greater democratic legitimacy and accountability to local people
   e) Potential for health and wellbeing boards to transform services and outcomes

6. **What the Bill does**
   a) Sets up the boards as Committees of local authorities
   b) Establishes a core membership, with flexibility to expand locally
   c) Puts mutual obligations on LAs and NHS commissioners to undertake JSNA and JHWS in partnership
   d) Expectation HWBs are involved throughout NHS commissioning process, so commissioning plans are in line with the JHWS
   e) Promotes joint commissioning and integrated provision
   f) Gives HWB a role in annual assessment of CCGs (& a non-statutory role in their initial authorisation)
   g) A duty for HWB to involve users & the public in JSNA - JHWS
   h) Keeps scrutiny functions separate from HWBs
   i) Leading to collective local leadership and partnership to ensure integrated care for individuals.

7. **Implementation**
   a) Local momentum; 137 out of 152 local areas signed up as early implementers
   b) Huge opportunity and significant challenges
   c) Focus on purpose, leadership and behaviours
   d) No one-size fits all solution; approaches must be right for local circumstances
   e) Need for shared learning to accelerate local progress
   f) Learning through doing; a learning network, bringing together local partners to learn together how to make health and wellbeing boards a success

8. **Timescales**
   a) Shadow running 2011/12 - local shadow working arrangements are established and shadow HWBs begin to refresh their JSNAs
   b) HWB early implementers running in 2011/12 onwards, to be tested alongside clinical commissioning group pathfinders
c) Implementation 2012/13 – HWBs operating on a non-statutory basis - co-producing joint health and wellbeing strategy in light of JSNA, and inputting into clinical commissioning group, NHSCB and Local Authority commissioning plans. By the end of the year, a JHWS will be in place in all 152 top tier LAs.

d) Final Stage, April 2013 onwards – health and wellbeing boards in place in every upper-tier local authority

HealthWatch

9. To help achieve this:
   a) Existing Local Involvement Networks (LINks) become local HealthWatch organisations.
   b) HealthWatch England will be a new independent consumer champion within the Care Quality Commission

Future Forum & Commission for Funding of Care Support

10. The next steps:
   a) Case for change
   b) Government welcomes work of commission
   c) Range of recommendations
   d) Government will take forward recommendations as priority
   e) Costs considered against other priorities & constrained resource
   f) Consider range of options within recommendations
   g) Potential Engagement process with stakeholders in the Autumn alongside Future Forum
   h) Focus on:
      • Dilnot
      • Quality
      • Developing market
      • Integration
      • Personalisation
   i) White Paper and progress report on funding in Spring
   j) Legislate at earliest possible opportunity

Damon Palmer
Department of Health
Health and Social Care Integration
23rd August 2011
Yorkshire and Humber Health and Well Being Collaborative

Resources to support the work of the Collaborative and additional funding for social care

Supporting the Collaborative

1. The concept is for a ‘virtual’ organisation given the limited resources available. This makes it more challenging than the support structures for the YHIP (Manager, office and support team) and JIP (programme team). The Collaborative is not a legal entity and therefore cannot directly employ staff.

2. Residual funding from the JIP is being used to fund a project worker on personalisation and development of an e-market place and to fund a worker providing financial and administrative support.

3. The DRD has agreed to make funds available to support the use of consultants or contractors or other one-off projects that will further the aims of the Collaborative. At present this is funding 2 part-time consultants on short term contracts and one worker supporting regional work on learning disabilities. The DRD will be entering into an agreement with LGYH to hold and administer this funding. It is proposed that approval for use of the funding be delegated to the Chair of the Collaborative in consultation with the DRD.

4. Following the closure of YHIP there are a small number of staff employed on fixed term contracts by the Strategic Health Authority on work which is aligned to the interests of the Collaborative – on mental health, learning disabilities, children and safeguarding. It would be helpful if these staff met with and liaised with the staff supporting the Collaborative from time to time so that we maximise their joint impact and minimise duplication and overlap.

Funding from Department of Health to support social care

5. There are 3 streams for NHS funding to support social care:

   I. Post discharge services and re-ablement - £150m nationally (£300m in 2012/13) plus presumed savings to the PCT from non-payment for certain emergency re-admissions to hospital. The funding can be transferred from PCTs to local partners or placed in pooled budgets. The proportional spend on health and social care services is for local determination.
II. **Carers Breaks** – new resources of £400m over 4 years to enable more carers to take breaks from their caring responsibilities. The NHS Operating Framework stated that PCTs should agree policies, plans and budgets with councils and carers’ organisations and that the money should be made available through a pooled budget and, as far as possible, as a personal health budget or direct payment.

III. **PCT Allocations for social care** – separate, non-recurrent PCT allocations of £648m (£622m in 2012/13) to be transferred to local authorities to invest in social care services to benefit health and improve overall health gain.

6. A ‘stock-take’ is currently being undertaken by the regional ADASS network to see how these funding streams are being fed out in localities.

Bill Hodson  
23rd August 2011
Update on LINks and HealthWatch
ADASS Commissioning Group Yorkshire and Humber – 29th July

1. Purpose

This paper gives an overview of the proposals to establish local HealthWatch, updating commissioning leads on the different aspects of the transition plan to move from LINks to HealthWatch, and highlights some of the key issues and implications for Local Authorities working with local partners in preparing for the new arrangements. This paper does not focus in detail on the functions of HealthWatch England or CQC’s role

2. Background

The Government’s health and social care reforms are centred on the fundamental principle that patients and the public must be at the heart of everything our health and care services do. This will only happen if there are mechanisms in place to involve and engage people in every aspect of how services are planned, commissioned, delivered and monitored. In practice, this means ensuring that consumer voice is integral to the way things are done, not an add-on, an optional extra, or isolated outside decision-making and planning – but a genuine shift to putting people’s views and experiences at their heart.¹

The NHS White Paper “Equity and Excellence: Liberating the NHS” proposes that from April 2012 HealthWatch becomes the independent national and local “consumer champion” for health and social care. Following the report by the NHS Future Forum and legislation being put in place, the functions and role of Local HealthWatch will be:

- Promoting and supporting community involvement and engagement of patients, carers and the public to ensure robust influence in strategic decision-making, commissioning and provision of local health and care services. A representative of the local HealthWatch organisation will sit on their local authority health and wellbeing board. (From October 2012)

- Provision of advice, information and signposting to help patients and the public access services and make choices. (From October 2012)

- Provision of independent advocacy and complaints (From April 2013)

HealthWatch England will support local HealthWatch by providing advice and national leadership. They will agree standards against

¹ HealthWatch Transition Plan, DH, March 2011, P.9
which local HealthWatch organisations and local authorities could benchmark performance and spread good practice. HealthWatch England (which will be a committee of CQC) and local HealthWatch organisations will be able to make recommendations to the Care Quality Commission to carry out an investigation.

The White paper proposes that areas should build on the current role of Local Involvement Networks (LINks), where it has strong foundations to create local HealthWatch organisations. However, local HealthWatch will have functions, roles and responsibilities not currently carried out by LINks, including stronger powers to shape and hold to account local services.

3. Local Authority Commissioning

Local HealthWatch organisations will be funded via local authorities and will be accountable to them for operating effectively and providing value for money. The exact shape of a local HealthWatch will not be prescribed from the centre; it will be for local authorities to set them up within context of their local priorities. The Government has said that local authorities can be flexible in who NHS advocacy and complaints services are commissioned from – either local HealthWatch, or other organisations with HealthWatch signposting these services to people.

Local Authorities will be commissioners and funders of local HealthWatch organisations and will also be subject to scrutiny in respect of adult social care, adding to the complexity of the arrangements.

The HealthWatch transition plan encourages Local Authorities to work with their LI*Nks, its host, and a wider range of partners to develop a local transition plan, putting in place the building blocks so that all stakeholders are involved in the transition and are prepared for the introduction of HealthWatch.

A number of key issues and queries about implementation have been raised by local authority commissioners in Yorkshire and Humber in response to the Transition Plan:

- The need to review current LINks effectiveness and efficiencies against an agreed benchmark for “What does good look like” in terms of the previous 3 years of LI*Nks activity, performance and outcomes.

- Fulfilling statutory duties and managing existing contracts – most authorities have rolled forward their LI*Nks contracts for

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2 The DH DRD office supports a network meeting of LA commissioners responsible for LI*Nks and strategic planning for healthwatch.
2011/12. Funding reductions have been made, although the picture with regard to the extent of the reduction has to be viewed against the council’s overall budget reductions, and underspends against existing host organisation contracts. Some local authorities have built in expectations that LINks host organisations will use their resource to self evaluate and report on their effectiveness and carry out development activities to support the local transition to HealthWatch.

- Concerns with regard to nature of development work with existing LINk hosts as potential future tenderer for HealthWatch and the implications for other organisations in the market place who may not be so directly involved in the design of future HealthWatch services.

- Potential issues around procurement rules in relation to tendering for services and managing the period between April 2012 and October 2012 when Local HealthWatch will be established as “bodies corporate”.

- Identification of the existing functions already present in PCTs for Patient Advice and Liaison (PALS) and ICAS (via the Carers Federation) which carry out advocacy complaint roles and implications for the staff currently employed by these organisations (TUPE).

- Building the business case, the service standards, and the need to specify contract value and cost the services, including the need to have fully qualified staff, that will meet the needs of each local area is challenging given the Local Authority funding settlement and budget positions. Local Authorities want clarity over the funding that will be available from DH for additional functions such as providing complaints advocacy services and supporting individuals to exercise choice.

- Alignment with existing adult social care commissioning strategies for a range of services from the voluntary and community sector for information, advice, signposting and advocacy.

- The need to understand more fully patient and public engagement functions carried out within the NHS and the nature of issues such as “facilitating choice” in the context of NHS services for treatment and care.

In its publication laying out the next steps for the reforms DH stated that local authorities will have funding for HealthWatch built into their existing allocations and will remain unringfenced in keeping with current local authority funding mechanisms. The document states that
this includes additional funding for NHS complaints advocacy and providing advice and information for people making choices.

We anticipate that HealthWatch will have available funding of £53.9 million for 2012/13 plus £3.2 million for start-up costs. In 2013/14, when local authorities take on responsibility for commissioning NHS complaints advocacy, the combined funding available for local HealthWatch and NHS complaints advocacy services will rise to £66.1m

4. DH Programme of Support

The transition plan proposes that to support LINks the Department will put in place a programme of Action Learning sets based on effective models of improvement through self-assessment, peer support and spreading good proactive. National reviews and evidence about effective practice will be made available.³

The learning network will also provide a context for HealthWatch pathfinders⁴ to test out different ways of delivering the functions of HealthWatch, challenging and supporting each other to develop innovative models and effective relationships. Nationally, the Department will support the programme of learning by networking pathfinders with action learning sets and making the connections with Health and Wellbeing Board early implementers and GPCC pathfinders. The national HealthWatch Programme Board and Advisory Group will continue to oversee the transition and support local implementation.

In Yorkshire and the Humber, in addition to supporting the existing LINks networks⁵, the DH DRD office will provide a stronger connection with Local Authorities through their commissioning leads for HealthWatch to support and facilitate connections and sharing of tools and resources to enable joint learning and problem solving. Outstanding issues not yet clear in terms of policy development will be fed back through the Local Government Group and to DH through its Local Government Task and Finish Group, together with potential barriers that need to be addressed with further advisory support to Local Government.

RM/July 2011
Amended August 24 2011

³ E.g. The Centre for Public Scrutiny, LGA and Patients Association review of LINks due Summer 2011.

⁴ Proposals were submitted to DH on 12th May. The LA network has been sharing the proposals which have been submitted by Leeds, Barnsley, Doncaster, Wakefield, Bradford, North East Lincolnshire, Sheffield and North Lincolnshire. An announcement on DH support to pathfinders is due in summer 2011.

⁵ Hull CVS are funded through the DH DRD office to run the regional LINks programme in 2011/12.
YORKSHIRE AND HUMBERSIDE HEALTH & WELLBEING
COLLABORATIVE

MINUTES OF MEETING 30th AUGUST 2011

Present: Martin Farran (Chair) Carole Hassan Chris Long
Anita Parkin Ann Carroll Carolyn Heaney

Apologies: Simon Large, Colin McIlwain, Elaine McHale

Also attending: Bill Hodson, Damon Palmer, Sharon Bolton, Rebecca Matthews, Nick Murphy

1. Welcome
All were welcomed to the inaugural meeting of the collaborative.

2. Apologies
Apologies were noted.

3. Structure and purpose of meeting
It was agreed that this meeting would be chaired by Martin Farran pending agreement of permanent chair and vice chair.

It was agreed that the chair and vice chair should not come from the same sector i.e. one each from the health and local government communities.

ACTION for all: Nominations were requested from all for the chair and vice chair by 19th September.

It was agreed that the main purpose of the meeting was to:

- Agree the Terms of Reference for the collaborative
- Verify membership
- Agree the areas of focus
- Agree where the collaborative should report to i.e. the governance links.
Martin Farran gave a brief overview of the reasons for the creation of the collaborative:

- A space for joint health and social care conversation and focus
- A structure to allow joint activity to benefit the region
- The predecessor organisation (the JIP) was successful but failed to get sufficient engagement from the health community.
- Avoidance of the multiple creation of similar solutions across the region.

4. **Terms of Reference**

Bill Hodson presented the Terms of Reference that had been previously circulated. These were discussed and the main points made were:

- It is key that the collaborative provides a conduit for 2 way communication by members to and from their constituent bodies and other regional groups.
- The collaborative should actively manage communications to ensure effective use of capacity across the region and ensure most effective use of resources.
- The collaborative should provide a regional perspective
- The collaborative should be clear about its mandate and who it is accountable to.
- The focus should be on a small number of issues that will deliver the most gains in quality and efficiency
- Attendance by providers should be consistent with these aims

The following actions were agreed:

- **Terms of Reference to be amended as necessary to reflect the points above** – Bill Hodson
- **All members to nominate a deputy to represent in their absence (with decision-making authority).**
- **Additional representation to be sought from Clinical Commissioning Consortia.**
- **Map of relevant Pathfinders/networks to be produced** – Bill Hodson / Nick Murphy.

5. **Priorities**

Martin Farran presented the suite of papers on areas for focus.
It was noted that without a representative from the children’s and families’ area there could not be a full discussion on this topic and this would have to be revisited at the next meeting. There was particular interest in work with families with complex and intensive needs.

The following issues were raised in discussion on the suite of papers:

I. **Personalisation (“Think Local Act Personal”)**
   - This is a system-wide issue that goes beyond health and social care
   - Personalisation is a principle or philosophy for how public services should be delivered that needs to be tied into commissioning and partnership arrangements. As such it is an agent for changing behaviours and culture
   - The challenging targets on Personal Health Budgets were noted

**ACTION:** Bring back a broader paper on Think Local Act Personal (e.g. covering access to universal advice and information) to the next meeting.

II. **Commissioning**
   - What does ‘integrated commissioning’ mean in the context of the new ‘architecture’ in health?
   - More value should be achievable by looking at the total expenditure in the region on some services and communities. Effective links between local government and QIPP have not really been made.
   - There is scope for commissioning across council boundaries
   - More clarity is needed on the role of the Health and Wellbeing Boards and the links to the NHS Commissioning Board

**ACTION:** Bring back a paper to the next meeting on commissioning across local government and health.

III. **Assistive Technology**
   - Potential for local government links and locality savings as the NHS moves to a single point of contact via 111.
   - Better, whole system alignment is needed to maximise the benefit of investment in new technology across telehealth and telecare
   - Clearer collective vision needed of what we are trying to achieve and how we are going to do it.
   - There needs to be a firm business case on efficiency savings
ACTION: Support for a regional meeting to do a ‘stock take of activity and bring back a further report to the next meeting.

IV. Dementia and Learning Disabilities
- There was recognition of the funding support already provided by the DRD to support regional work in these areas.
- The Collaborative needs to have good links to the existing regional, strategic groups.

V. End of Life Care
- Support was given to linking the new group needed to make progress on the social care framework to the existing regional group.
- It was felt that the existing group should take a wider view than cancer services.

VI. Workforce
- Better linkages were needed across health and social care and especially with staff in primary care settings.

VII. Other topics to be linked to the Collaborative
- Carers – links should be made to regional activity.
- HealthWatch – a watching brief as the new arrangements come into being and any transitional issues.

VIII. Work commissioned by the Joint Improvement Programme
(This was raised in correspondence subsequent to the meeting with the concern that these work-streams are no longer linked into a reporting body and therefore need to be linked to the Collaborative)
- Co-production and community capacity building – link to TLAP.
- User-Led organisations – link to TLAP.
- Integration.

ACTION – Bill Hodson to manage production of a list of activities which could be functionally ‘hosted’ by the collaborative.

After discussion it was agreed that the initial priorities for consideration of commissioning activity should be:
- Personalisation (Think Local Act Personal) looking system wide.
- Joint and Integrated Commissioning looking at areas where real benefits could be delivered (Dementia / Assistive Technology).
- Assistive Technology across health and social care.
ACTION – Bill Hodson to co-ordinate preparation of papers on these priorities for the next meeting

6. Resources
It was noted that funding would be provided by DH DRD £365K (plus £48K already spent) in addition residual funding from the JIP will be made available to the collaborative.

It was noted that DH DRD is already funding Dementia and LD activity.

It was noted that groups working on allied activities should report back to the Collaborative (e.g. Workforce, Dementia) to ensure best use of resources.

7. Items for the next meeting
- Think Local Act Personal
- Joint/integrated commissioning
- Assistive Technology
- Briefing paper on children and young people’s issues
- Update on resources to support the Collaborative

8. Date of Next Meeting
It was agreed the next meeting should be scheduled for early November.