Wiltshire Council
Where everybody matters

AGENDA

Meeting: **HEALTH AND WELLBEING BOARD**

Place: Kennet Room - County Hall, Trowbridge BA14 8JN

Date: Thursday 20 November 2014

Time: **3.00 pm**

Please direct any enquiries on this Agenda to Will Oulton, of Democratic and Members' Services, County Hall, Bythesea Road, Trowbridge, direct line 01225 7139358 or email william.oulton@wiltshire.gov.uk

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Voting:
Cllr Jane Scott – (Leader of the Council) - **Chairman**
Dr Stephen Rowlands – (CCG Chairman) - **Vice Chairman**
Dr Simon Burrell (CCG – Chair of NEW Group)
Dr Toby Davies (CCG – Chair of SARUM Group)
Debra Elliott (NHS England)
Christine Graves (Healthwatch)
Cllr Keith Humphries (Cabinet Member Public Health, Protection Services, Adult Care and Housing)
Angus Macpherson (Police & Crime Commissioner)
Cllr Laura Mayes (Cabinet Member for Childrens Services)
Cllr Ian Thorn (Opposition Group representative)
Dr Helen Osborn (CCG – Chair of WWYKD Group)

Non-Voting:
Dr Gareth Bryant (Wessex Local Medical Committee)
Patrick Geenty (Wiltshire Police Chief Constable)
Carolyn Godfrey (Wiltshire Council Corporate Director with statutory responsibility for Children's Services)
Chief Executive or Chairman representative Salisbury Hospital FT (Peter Hill)
Maggie Rae (Wiltshire Council Corporate Director with statutory responsibility for Adult and Public Health Services)
Cllr Sheila Parker (Portfolio Holder for Adult Care and Public Health)
Chief Executive or Chairman representative Bath RUH (James Scott)
Deborah Fielding or Simon Truelove (Chief Officer or Chief Finance Officer)
Iain Tully or Julie Hankin (Avon and Wiltshire Mental Health Partnership (AWP))
Chief Executive or Chairman representative Great Western Hospital (Nerissa Vaughan)
Ken Wenman (South West Ambulance Service Trust)

AGENDA

1 **Chairman's Welcome and Introductions**

2 **Apologies for Absence**

3 **Minutes** *(Pages 1 - 10)*

To confirm the minutes of the meeting held on 25 September 2014 *(copy attached)*.

4 **Declarations of Interest**

To declare any personal or prejudicial interests or dispensations granted by the Standards Committee.

5 **Chairman's Announcements** *(Pages 11 - 16)*

a) Peer Challenge
b) Health & Wellbeing Awards
c) Mental Health Strategy

6 **The Royal National Hospital for Rheumatic Diseases and the Bath Royal United Hospital**

Following the announcement of foundation trust status, there will be a joint presentation regarding the work of the Royal United Hospitals Bath NHS Foundation Trust with the Royal National Hospital for Rheumatic Diseases

Presenters: James Scott (Chief Executive of Royal United Hospitals Bath NHS Foundation Trust) and Kirsty Matthews (CEO of The Royal National Hospital for Rheumatic Diseases)

7 **Child and Adolescent Mental Health Services** *(Pages 17 - 22)*

The purpose of the item is to consider the analysis of declined referrals and the initial proposed actions to ensure that children and young people get the right support where there are concerns about their emotional wellbeing.

Presenters: Carolyn Godfrey (Corporate Director, Wiltshire Council) and Deborah Fielding (Chief Officer, NHS Wiltshire CCG)
Report author: Julia Cramp (Associate Director, Wiltshire Council)

8 **Avon and Wiltshire Mental Health Partnership (AWP) Care Quality Commission (CQC) Inspection** *(Pages 23 - 28)*

To outline AWP's action plan in response to the latest CQC inspection.

Presenter: Dr Elizabeth Hardwick (Interim Clinical Director for Wiltshire, AWP) and Iain Tulley (Chief Executive, AWP).
Report author: Julie Hankin (Clinical Director Wiltshire, AWP)

9 **Wiltshire and Deprivation of Liberty Safeguards (DoLS)** *(Pages 29 - 36)*

A report in response to a request for an update from Healthwatch Wiltshire, on plans to respond to a recent judgement by the Supreme Court that has clarified Deprivation of Liberty Safeguards.

Presenter: James Cawley (Associate Director, Wiltshire Council) and Jacqui Chidgey-Clark (Director of Quality and Safety, Wiltshire CCG)
Report author: Heather Alleyne (Interim Head Safeguarding, Wiltshire Council)

10 **Wiltshire Adult Safeguarding Board Annual Report** *(Pages 37 - 40)*

To present details of the Board's annual report, noting in particular the implications for commissioners and providers.

Presenter: Margaret Sheather (Independent Chair, Wiltshire Safeguarding Adults Board)
Report author: Heather Alleyne (Interim Head Safeguarding, Wiltshire Council)

11 **NHS - Five Year Forward View** *(Pages 41 - 42)*

To provide a summary and give an opportunity to discuss the implications of the Five Year Forward View, for Wiltshire.

Presenter and report author: Debra Elliot (Director of Commissioning, NHS England)

12 **Systems Resilience and Getting Ready for Winter**

To update the Board on arrangements to ensure system resilience and immediate plans for winter.

Presenter: Jo Cullen (Group Director, West Wiltshire, Yatton Keynell and Devizes NHS Wiltshire CCG) and James Cawley (Associate Director, Wiltshire Council)
Report Author: Jo Cullen

12a **Operational Resilience and System Capacity Planning (ORCP)** *(Pages 43 - 48)*

To update the Health and Wellbeing Board on the CCG response to recent NHS England guidance for operational resilience and system capacity planning.

12b **Getting Ready For Winter** *(Pages 49 - 60)*

To ensure awareness of arrangements for winter preparedness amongst key partners, allied to the work on systems resilience.

13 **Better Care Plan and 100 Day Challenge Update**

To receive a verbal update on the results of the 100 Day Challenge, so far, and the implications for the delivery of the Better Care Plan.

Presenter: James Roach (Integration Direction, Wiltshire Council)

14 **End of Life Update and Joint Strategic Assessment (JSA)** *(Pages 61 - 72)*

To consider an update of the Joint Strategic Assessment on End of Life Care and receive a draft Implementation Plan for the End of Life Care Strategy.

Presenter and Report Author: Jacqui Chidgey-Clark (Director of Quality and Patient Safety, Wiltshire Clinical Commissioning Group).

15 **Urgent Items**

16 **Date of the Next Meeting**

Thursday, 15 January at 3:00 pm, in the Salisbury Room, County Hall, Trowbridge.

Wiltshire Council
Where everybody matters

WILTSHIRE HEALTH AND WELLBEING BOARD

MINUTES OF THE WILTSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 25 SEPTEMBER 2014 AT KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

Present: Peter Hill (Chief Executive of Salisbury Foundation Trust), Angus Macpherson (Wiltshire Police and Crime Commissioner), Christine Graves (Healthwatch Wiltshire), Cllr Laura Mayes (Cabinet Member, Children's Services), Dr Gareth Bryant (Wessex Local Medical Committee), James Scott (Chief Executive of Royal United Hospital), Carolyn Godfrey and Maggie Rae (Corporate Directors, Wiltshire Council), Deborah Fielding (Chief Officer CCG) and Simon Truelove (Chief Finance Officer CCG), Dr Julie Hankin (Avon & Wiltshire Mental Health Partnership), Debra Elliott (NHS England), Dr Toby Davies (CCG – Chair of Sarum Group), Dr Helen Osborn (CCG – Chair of WWYKD Group), Cllr Jane Scott OBE (Chairman and Leader of the Council)

Also Present:

Kevin McNamara (Great Western Hospitals), Cliff Turner (Independent Chair of Wiltshire Safeguarding Children Board), Nick Wilson and Joanna Bates (South Western Ambulance Services Foundation Trust), James Cawley, Frances Chinemana, Julia Cramp, Robin Townsend and Laurie Bell (Associate Directors, Wiltshire Council), David Bowater (Corporate Support, Wiltshire Council), Emma Cooper (Chief Executive, Healthwatch Wiltshire).

56 **Chairman's Welcome and Introduction**

The Chairman welcomed everyone to the meeting, reminding all present that this was a public meeting where members of the public were encouraged to become involved in the debate that would arise.

57 **Apologies for Absence**

Apologies were received from:

- Nerissa Vaughan, Great Western Hospitals
- Cllr Keith Humphries
- Ken Wenman, South Western Ambulance Service NHS Foundation Trust
- Cllr Ian Thorn
- Jacqui Chidgey-Clark

58 **Minutes**

The minutes of the previous meeting held on 25 September 2014 were approved as a correct record with the following amendments:

That reference to the Shingles update, that 90 years be replaced by 79 years.

59 **Declarations of Interest**

No declarations of interest were received.

60 **Chairman's Announcements**

Signing of Mental Health Crisis Care Concordat
The Chair stated that she was pleased to announce that the concordat had been signed just prior to the start of this meeting. The concordat had previously been considered by the Board, and she extended her thanks to those that produced it, and stated the Council and Partners would work to honour it.

Updates on Mental Health Strategy
The Chair stated that, as discussed at the last meeting, the strategy was set to go to consultation shortly and a full update together with a draft action plan will be available at the next meeting on 20 November.

Shingles Vaccination
Debra Elliott from NHS England updated on the activity of the working group. A written update was circulated at the meeting. Additional work could be undertaken to generate some local press releases and campaigning to support the national campaign.

Winterbourne View
The Chair stated that work continued to move 9 ex-Winterbourne View patients to appropriate placements in the local area.

End of Life Care
The Chair stated that the first meeting of the care at home sub-group and the intention for a full update on 20 November.

Sustainability in the Health and Social Care
The Chair stated that, prior to the meeting, there had been a presentation from Dr David Pencheon on sustainability in the Health and Social Care. The Council and partners had agreed to consider his proposals. Officers would be asked to disseminate further information to partners about what was discussed with a view to bringing the issue back to another meeting of the Partnership.

Avon and Wiltshire CQC Report
Dr Julie Hankin stated that 150 inspectors inspected facilities across the whole trust, including all the inpatient, community, crisis teams and ECT team sites in Wiltshire. The key messages arising from the report included some warning notices, one of which related to Wiltshire regarding the learning from incidents. Other warning notices related to environment issues on sites outside of the Wiltshire Area.

The Chair noted that a more formal update, regarding actions, was scheduled to come to the next meeting.

61 **Children's Health and Wellbeing**

A) Children's Community Health Services
Julia Cramp, Associate Director for Commissioning, Performance and School Effectiveness, provided an update on the timetable for re-commissioning of Children's Community Health Services.

Attention was drawn to the fact that it was a joint commissioning project, and that there had been a range of activities, including events and surveys, to engage with relevant groups. This had built on some existing engagement work on previous strategies. The timetable for the procurement process had been set, and would include a marketing event to any interested providers. The deadline for new contract is January 2016.

Some partners expressed concern of the potential negative impacts of the process, and officers stated that they were aware of these issues and wished to build on the good work that already exists.

Reference was made to the experience of the procurement of CAMHS and the impact that had had on service quality. As this was a priority area, it was agreed to this should be discussed at a future meeting.

Resolved to note the report.

B) Disabled Children's Charter
The meeting noted that, a year ago, the Board had signed the Disabled Children's Charter, which had been developed by a range of bodies. The report set out how the Board was meeting the 7 standards of the Charter. *Areas of strength included engaging with children, young people and their families, Wiltshire was noted as an area of best practice; and that strong governance, including through the sub-group of Children's Trust to contribute to this agenda.*

The Chair stated that this positive message should be shared.

Laura Mayes it was note that the Children's Minister had visited the Council and had been impressed with Wiltshire's approach including the use of one

telephone number and there being a single point of contact, used to sign post parents to the right help. The importance of ensuring that the Doctors and healthcare professionals are aware of this new contact number was reiterated.

Resolved to note the report.

62 **Joint Strategic Assessment (JSA)**

Maggie Rae, Corporate Director, Wiltshire Council, presented the Joint Strategic Assessment which would inform the development of the Health and Wellbeing Strategy to ensure local priorities were met. It was noted that the the Board had previously agreed to refresh the Joint Health and Wellbeing Strategy one year on. It was acknowledged that there had been a number of changes in the past 18 months, including the publication of the Better Care Plan, that would need to taken account of.

In response to a question, officers clarified that the data collected as part of the JSA would be Peter Hill – clarity that it is a collection of data that will inform subsequent strategies.

Jane – want to make sure that Wellbeing, not just Health. Can we set in place update on our stragtegy taking in the relevant evidence. Officers expressed a desire to work with those partners that have recently joined the Board and to make sure they are engaged. Officers were asked to convene an operational working group to consider issues arising from the JSA.

RESOLVED:

1. **To note the content of the JSA for Health and Wellbeing 2013-14.**
2. **To agree to begin the refresh of the Health and Wellbeing Strategy for Wiltshire, to be informed by the content of the JSA for Health and Wellbeing.**
3. **To agree that the JSA for Health and Wellbeing continues to form part of this Board's workplan and approve the timeline for producing the refreshed Health and Wellbeing Strategy and the JSA for Health and Wellbeing 2014/15.**

63 **Annual reports**

a) Wiltshire Safeguarding Children Board

Cliff Turner, Chair of the Wiltshire Safeguarding Children Board, presented their annual report. In his presentation noted that Ofsted had inspected the Board in 2013. This was followed up with an optional peer review in 2013 which helped the Board to address issues arising from the review. These included improving

representation and relations with the Clinical Commission Group and NHS England, which had since been addressed.

The Board wished to improve the engagement of young people, and take a more analytical view on the Safe Guarding system and how it works for young people locally. Looking forward, the Board wanted to make sure scrutiny of local arrangements was good, keeping a focus on neglect, early help – getting involved with issues to prevent serious damage; makin sure training reflects current needs and priorities – offering on a multi-agency basis – giving a chance to promote links with partners. A child sexual exploitation (CSE) strategy group, chaired by Clive Turner, was looking at efforts to tackle these issues. Arising from this work would be a number of activities to raise public awareness of CSE, and what people can do, with an aim to promote a zero tolerance approach. This will be a focus of the Wiltshire Assembly. That said there was recognition that, whilst it should be a priority, the extent CSE should be kept in perspective as more children are at risk of neglect and other forms of abuse. Officers offered a more extensive briefing about CSE prior to the next Health and Wellbeing Board meeting. It was noted that following a request, a representative from the Bath RUH would be invited to the Wiltshire Safeguarding Children Board. The Chair thanked Mr Turner for his presentation.

Resolved to note the Wiltshire Safeguarding Children Board (WSCB) Annual Report 2013-2014.

b) Public Health Annual Report

Maggie Rae, Corporate Director, Wiltshire Council, presented the Public Health Annual Report, which had been considered recently by the Health Select Committee It was noted that this was the first year that Public Health had reported from within the wider family of the Council. It was noted that Health and Social Care Act had presented officers with a good opportunity to work with partners like NHS England on issues such as Shingles Screening. It was noted that integration of public protection, leisure and public health should have a positive impact on effective working. This integrated system has been tested in the last 12 months, including with recent measles outbreak and local flooding. Officers were pleased with how these have been dealt with.

Areas that continued to be a priority included: Smoking cessation, Health Trainer programme, Excess weight in school age children and adults, and cardiovascular disease.

Resolved to note the Public Health Annual Report 2013-14

64 **Healthwatch update**

Healthwatch Wiltshire
Emma Cooper, Healthwatch Wiltshire, presented the initial findings of a review of complaints processes in Wiltshire. In the presentation and subsequent discussion, it was noted that complaints, feedback from customers, are valuable data for improving services. The NHS Constitution makes pledge to encourage feedback. In the light of some fatal failures, such as Staffordshire Hospital, reviews had highlighted the need to overhaul complaints system nationally. Healthwatch had led a national campaign calling for improvements to the system. A local review had been undertaken to feed into the national picture. It had been an opportunity to talk to providers, to identify gaps and areas of best practice.

The experience of users was that the system can be confusing and hard to navigate. There isn't standard language, across different providers in health and social care, and this can add to the confusion. There had been too many instances that information, on websites for instance, was not up to date, sign posting people to the wrong people, and that information for those with learning difficulties were often the most out of date.

Some young people are too scared and/or embarrassed to raise a concern, and it was recognised that raising concerns can be challenging and upsetting. Some people want to raise feedback outside of formal complaints. The issue of how anonymous trend information could shared with Health Watch, and how can innocent bystanders raise concerns.

Examples of good local practice included GWH voicebook, Salisbury Hospitals app, and Ambulance Trust's 'getting in touch' leaflets which use good plain English. Most providers are in the process of reviewing their procedures and providers were encouraged to make sure their website and documentation is up to date.

A national report will be presented to Government shortly. Healthwatch did not look at Social Care complaints but will shortly as part of other review. It was noted that there was an invitation to providers to invite Healthwatch to work with them on engaging with young people.

Resolved

1. **To note the content of Healthwatch Wiltshire's report on complaints and concerns.**

2. **To approve the recommendations, outlined in the report, which are designed to improve the complaints system for the benefit of patients, service users, and carers.**

65 **Better Care Plan**

Better Care Plan

James Roach, Integration Director, Health & Social Care, presented the latest update on the Better Care Plan and the 100 day challenge.

In the presentation and subsequent discussion, it was noted that Wiltshire was one of five localities nationally that have signed off their plan; That there was real need to move the plan into action, the 100 day challenge seeks to address this; and that Risk Share Agreement identified a Wiltshire target of 3.75% reduction in hospital admissions.

As part of the 100 day challenge, officers were able to measure data on a daily basis so that problems could be dealt with swiftly. The focus was on self support and self care, involving the voluntary sector, to improve delivery. The one number, single point of access has been launched – this has been made available to secondary care staff. The three demonstrator sites were progressing well, with an aim to go live in December. A national funding award on Single View of the Customer could be forthcoming. The key risks, especially managing demand, were identified in the report.

Partners expressed pleasure with the efforts so far and wished to see the current level of performance sustained. It was recognised that some hospitals were seeing more positive results than others, and that ensuring the workforce was appropriately trained and resourced was key. Wiltshire Council was planning to develop an in house academy for social workers, and it was a future ambition to possibly extend this train health workers for the future. It was recognised that recruiting staff in some areas of Wiltshire was a real challenge; it was hoped that families returning from oversees military stations would provide some recruitment opportunities.

Officers were asked to circulate the slides to partners for their information.

Resolved

1. **To note the update on the Better Care Plan in particular its continued status as part of the national fast track process.**

2. **To note the change in admission avoidance ambition to a 3.75% reduction from an original ambition of 4.5 % in line with the national requirement, and that this represents a significant challenge for the system given current demands on the system.**

3. **To note that the ambitious aim to reduce non-elective length of stay by 2 days has also been retained.**

4. **To support the engagement programme that is currently being undertaken locally with each of the area boards.**

5. **To note the progress that is being made as part of the 100 day challenge.**

66 **Right Care 2**

Joanna Bates, Clinical Development Officer, from South Western Ambulance Service NHS Foundation Trust (SWAFST) presented plans to reduce conveyance to Emergency Departments.

In the presentation and subsequent discussion, it was noted that the aim of the scheme was to keep people out of A&E and staff across the trust area had reduced the number taken there. The first phase of the scheme to identify the reasons that people are referred to hospital. Pilot schemes were using clinical staff to assess patients over the phone to determine where patients should best be treated. The trust was looking to develop skills for staff so they feel able to discharge people at the scene, and looking at how GPs can participate in telephone triage and assisting crews in preventing admissions to hospitals. Improvements in access to patient's electronic records and sharing information to enable crews to access information on site to improve care from the crews. The Trust was in discussions with Higher Education providers to develop a diploma to train staff in advanced assessment.

The second phase of the scheme was looking to map community services, and focus on appropriate conveyance of non-urgent cases to community care, particularly those with long-term care needs. It was hoped that this would improve patient experience of care. It was recognised that further work could be undertaken in partnership with colleagues from hospitals and mental health services to improve outcomes for patients. The impact of the closure of facilities outside of Wiltshire was noted. The Chair thanked officers for their presentation.

Resolved to note the presentation.

67 **Funding Transfer to Social Care**

The Board was formally asked to approve the use of the funds outlined in the report and to authorise the transfer from NHS England.

Resolved

1. **To endorse the use of the S256 transfer as set out in the report.**

2. **To authorise the relevant Council officers to sign off the S256 Agreement between Wiltshire Council and NHS England and request that an invoice is raised to NHS England so that the transfer can take place.**

68 **Date of Next Meeting**

The Chair reminded the Board that the next meeting was on Thursday 20 November 2014, t the usual time of 3pm, to be held at County Hall, Trowbridge.

69 **Urgent Items**

There were no urgent items.

(Duration of meeting: 15:00 – 17:05)

The Officer who has produced these minutes is Will Oulton of Democratic & Members' Services, direct line 01225 713935, e-mail william.oulton@wiltshire.gov.uk

Press enquiries to Communications, direct line (01225) 713114/713115

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Chairman's Announcement - Health and Wellbeing Peer Review

In October, Wiltshire's Health and Wellbeing Board invited a peer challenge team to visit and look at how we do things in Wiltshire - providing friendly challenge and offering their ideas on the arrangements to improve the health and wellbeing of the residents of Wiltshire.

The peer team included the leader of Warwickshire County Council, a GP, the Chief Officer of West Berkshire Clinical Commissioning Groups and a director of public health. They spoke to a wide range of people – over 125 people in 47 sessions over several days - including representatives from hospitals, the ambulance service, public health and social care teams, GPs, carers and volunteers.

Initial feedback has been very positive. Overall, they were very impressed with the passion and commitment of everyone involved and thought we were doing the right things in the right way.

A detailed written report and recommendations is likely to be received in the next couple of weeks and this will be considered by the Health and Wellbeing Board at its next meeting.

I would like to thank everyone involved who gave their time to contribute to the outcomes of the review.

Cllr Jane Scott OBE
Chair, Wiltshire Health and Wellbeing Board

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Chairman's announcement – Wiltshire Public Health Awards 2015

Nominations are now open for Wiltshire's Public Health Awards 2015!

You can put forward anyone who helps people to live healthier lives in Wiltshire. It's easy. Nominate your own organisation's work, a project or club you've been involved in or the work of a project, person or organisation you know about. Don't be shy – this is about publicising achievements and acknowledging the contribution of everyone involved.

You can nominate anyone that helps people live healthier lives in Wiltshire. Nominees might, for example, include exercise classes in village halls, healthy eating programmes in work canteens, activities taking place in local schools, parks or leisure centres. They may be run by a range of organisations such as community groups, sports clubs, small businesses, the NHS, local authorities, the emergency services, the military, the prison service, schools, pre-schools, colleges, large employers or faith groups.

The most recent event received over 100 nominations from across the county, celebrating the diversity and quality of work of individuals, groups, organisations and businesses that helped improve the health and wellbeing of our local communities.

Details of the full list of award categories and how to nominate can be found on the following webpage www.wiltshire.gov.uk/publichealthawards.

Alternatively you can contact the Public Health Awards Team at:

Email: awards@morganroberts.co.uk

Postal Address:
Public Health Awards
Communications, First Floor
County Hall
Wiltshire Council
Trowbridge
Wiltshire
BA14 8JN

We look forward to hearing about your achievements.

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Chairman's Announcement - Update on Draft Joint Mental Health and Wellbeing Strategy and its public consultation

At its meeting on the 31st July 2014, the Health and Wellbeing Board was given a briefing about the progress in development of the Draft Mental Health and Wellbeing Strategy.

Members were keen to ensure that the strategy remained a focus for the Board and a further update was requested for the September meeting followed by a more detailed item (to include the strategy itself plus a draft implementation plan) for November 2014.

The draft content of the strategy was approved to go forward for consultation by Wiltshire Council Cabinet on 16th September 2014 having previously been approved in the same manner by the CCG Executive. It was additionally presented for information to the Wiltshire Clinical Commissioning Board and to the Health Scrutiny panel for information.

The consultation draft is now available and the full consultation can be found at www.wiltshire.gov.uk/mental-health-wellbeing-strategy.htm.

The consultation launched on 10th October 2014 (to coincide with World Mental Health Day) and received good media coverage. Stakeholders and partners have been advised of the launch of the consultation and some group face-to-face engagement events are currently being organised to offer a range of opportunities for people's voices to be heard.

The Interim Mental Health Joint Commissioning Board (MH JCB) is currently leading on the development of the implementation plan as well as commissioning intentions and commissioning plans for services into the future. The overarching implementation plan for the strategy is in initial stages of development and will continue to evolve throughout the consultation period and beyond to reflect responses and feedback.

The MH JCB hopes to be in a position to share a draft of the overarching implementation plan with the Health and Wellbeing Board in March 2015.

Karen Spence, Public Health Specialist
Barbara Smith, Mental Health Contract & Commissioning

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Wiltshire Council

Health and Wellbeing Board

November 2014

Child and adolescent mental health services: analysis of referrals

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Executive Summary

Nationally there continues to be a focus on children and young people's emotional wellbeing and concern that the number of children with difficulties is growing and that support is not being provided at an early enough stage to prevent future diagnosable mental health difficulties. Due to the national focus and also local concerns about access to the CAMHS Primary Mental Health Service, an analysis of all referrals declined during April and May 2014 has been undertaken.

Proposal(s)

The Health and Wellbeing Board is asked to consider the analysis of declined referrals and the initial proposed actions to ensure children and young people get the right support where there are concerns about their emotional wellbeing.

Reason for Proposal

In May, the Health and Wellbeing Board considered the draft Emotional Wellbeing and Mental Health Strategy for children and young people. One of the objectives within the strategy is to improve access to CAMHS, including the Primary Mental Health Service. The Board asked for further information about the analysis of declined referrals that has recently been undertaken.

Carolyn Godfrey	**Deborah Fielding**
Corporate Director	**Chief Officer**
Wiltshire Council	**NHS Wiltshire CCG**

Wiltshire Council

Health and Wellbeing Board

Date: November 2014

Child and adolescent mental health services: analysis of referrals

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Purpose of report

1. Children and young people's mental health services are currently the subject of a national inquiry (UK Parliament's Health Committee) to address the issues about both the extent to which children and adolescents are affected by mental health problems and the difficulties with gaining access to appropriate treatment and a new national taskforce has been established.

2. This report provides an update to the Health and Wellbeing Board on the work to analyse referrals made to the Child and Adolescent Mental Health Service (CAMHS) in April and May 2014 which were declined. The analysis was carried out to develop a better understanding of the reasons for declining referrals made to CAMHS in Wiltshire. The analysis can then inform discussion about what action needs to be taken to ensure that children and young people get the right support where there are concerns about their emotional wellbeing.

Background

3. The national strategic direction of travel suggests that we focus on the following to improve children and young people's mental health outcomes:

    - Early intervention – at the earliest and most effective point in life
    - Appropriate identification; early and effective evidence based treatment
    - Increasing the number who improve their mental health
    - Good physical health, health behaviours and resilience
    - Good information, awareness raising, positive mental health promotion
    - Asking children and young people how they feel – participation and involvement
    - Transitions – ending the "cliff-edge of lost support"[1]

4. The Children and Young People's Trust Emotional Wellbeing and Mental Health Commissioning Strategy 2014-2017 has recently been approved by the Children's Trust. In line with the national mental health strategy "Closing the gap: priorities for essential change in mental health[2]" published in January

[1] Closing the Gap, Priorities for essential change in mental health, January 2014
https://www.gov.uk/government/publications/mental-health-priorities-for-change
[2] Closing the Gap, Priorities for essential change in mental health, January 2014
https://www.gov.uk/government/publications/mental-health-priorities-for-change

2014, and the views of professionals, children and young people in Wiltshire, our priorities are:

Priority 1: Promote positive mental health and build resilience in children and young people

- Priority 2: Build capacity and knowledge in the children's workforce and primary care
- Priority 3: Improve access to primary and specialist child and adolescent mental health services (CAMHS)
- Priority 4: Ensure effective access, referral routes and pathways to services

Child and Adolescent Mental Health Services in Wiltshire

5. There is a Single Point of Access into the Primary Child and Adolescent Mental Health Service (PCAMHS) and the Specialist Child and Adolescent Mental Health Service (CAMHS) in Wiltshire. The Council funds PCAMHS for early support for emotional and emerging mental health difficulties, and the CCG funds the specialist service for mental health problems.

6. On the 1st May 2012, the Healthy Minds primary mental health service provided by Wiltshire Council transferred to Oxford Health and was integrated with specialist CAMHS via a single point of access. At the time of transfer, performance data was not available for comparison.

7. Wiltshire PCAMHS is staffed by 10 mental health practitioners offering assessment and brief interventions for children and young people with a mild mental health presentation. The service also includes management of the Single Point of Access currently handling approximately 200 routine referrals per month. Urgent and emergency referrals are routed directly to specialist CAMHS.

8. The following data is taken from the Performance Assessment Framework supplied by Oxford Health for contract monitoring and shows that:

- The total number of referrals received into the Single Point of Access has increased year on year
- The total number of direct contacts has increased year on year
- The number of referrals accepted by Oxford Health (PCAMHS and CAMHS) has increased from 1,100 in 2012/13 to 1,214 in 20131/14

Indicator description	**2012/13**	**2013/14**
Number of referrals received into the Single Point of Access (SPA)	1,892 (avg 158 per month)	2,063 (avg 172 per month)
Number of referrals accepted for Primary CAMHS (includes 'waiting list' initiative undertaken following transfer to Oxford Health from Healthy Minds so average inflated for 2012/13).	1,019 (avg 85 per month)	786 (avg 66 per month)
Number of referrals not accepted as meeting criteria	792	848

Indicator description	2012/13	2013/14
	(avg 66 per month)	(avg 71 per month)
Number of referrals fast tracked to Specialist CAMHS	81 (avg 8 per month)	428 (avg 36 per month)
Number of discharges monthly (excluding transfers)	1,787 (avg 149 per month)	1,502 (avg 125 per month)
Number of direct contacts	1,569 (avg 131 per month)	3,060 (avg 255 per month)
Offered appointment within 4 weeks of referral acceptance	91%	61%

9. Please note that the 2012/13 data is only for the 10 months from 1 May 2012. The referral and decline rates are skewed in this year as it includes the transfer of the existing Healthy Minds caseload and waiting list which were added to the Oxford Health electronic system: this was in excess of 400 cases.

10. Waiting lists are also skewed by the 2012/13 data. In 2012/13, PCAMHS launched a waiting list initiative for all the waiting list cases which were transferred by employing existing PCAMHS and CAMHS staff to work extra sessions and on Saturday mornings.

11. In April and May 2014, 347 referrals were made through the Single Point of Access to Wiltshire Child and Adolescent Mental Health Services (CAMHS). This number does not include urgent or emergency referrals which are fast-tracked to the specialist service. 73 of the 347 referrals made through the Single Point of Access were declined (21%).

Key points from analysis

12. The majority of the declined referrals were made for young people aged 11-17 years (44 referrals, 60% of total).

13. The largest number of declined referrals by area were from Trowbridge (areas defined using first 3 digits of home postcode) – 11 of the declined referrals analysed (15%).

14. The largest number of declined referrals analysed by referrer, were from GPs – 47 of the declined referrals analysed (64%).

15. Reasons noted for referral were grouped by behaviour / anger; low mood; anxiety; self harm; bullying / peer issues; family issues and undefined thoughts of self harm. The most common reason for referral was difficult behaviour / anger - this occurred 28 times in reasons for referral (some referrals were made for more than 1 reason). 19 of these declined referrals were made by GPs – there were multiple reasons for decline of these referrals.

16. Reasons noted for referrals being declined were grouped by:

- No mental health need
- Mental health needs not clear
- No increase or change in presentation;
- No evidence of an appropriate first line intervention, e.g. School Nurse, Counselling
- Different medical / paediatric pathway needed
- No detailed information in the referral
- Referral made without young person's consent

17. Of the 73 declined referrals, 58 (79%) were declined because there was either no evidence of mental health need; mental health needs were not clear; or there was no increase or change in presentation (some referrals were declined for more than 1 reason). 36 of these declined referrals were from GPs. It was clear that a parent had completed the referral form in 2 instances – both of these referrals came from GP practices, without any clarity about whether the GP had seen the child or undertaken any form of clinical assessment.

Main Considerations

18. The Primary Mental Health Service is a relatively small service with funding of just over £458K. There is more demand on the service than can be met with the current staff capacity. One of the other key services that could provide short term intervention around emotional wellbeing, School Nursing, is also a small service with approximately 22 FTE Nurses for 234 schools.

19. Whilst the number of declined referrals is causing huge frustrations for GPs, schools and families, it is important to note that CAMHS is a mental health service. The analysis of declined referrals suggests we need to consider what other early intervention support is available (which may be provided by other organisations such as the Council or the voluntary and community sector) to address behavioural/anger issues in children and young people. We also need to assist referrers in knowing who is best placed to provide support for children, young people and their families in order to prevent mental health issues arising.

20. Within the draft implementation plan that sits alongside the Emotional Wellbeing and Mental Health Strategy, a number of actions are being considered to help children and young people to get the right support at an early stage. Examples include:

    - Offering training to secondary schools to help them promote emotional resilience in young people, eg, Mindfulness training which has a strong evidence base for managing anxiety.
    - Offering additional training and support to schools and GPs on recognising and responding to concerns about emotional wellbeing and emerging mental health difficulties, for example, Youth Mental Health First Aid courses, and training by CAMHS doctors for GPs on clinical and risk assessment of mental health difficulties.

- Setting out a clear pathway for accessing early support, including counselling services such as Talkzone, the School Nursing Service, the Council's Behaviour Support Service and the Primary Mental Health Service.
- Getting consent from parents/young people being referred to CAMHS that they are happy to be signposted to alternative support if the referral does not meet the criteria for PCAMHS – thereby stopping referrals 'bouncing back' to professionals and getting help to children and young people more quickly.
- Development of a self-harm 'app' by Oxford Health to support young people.
- Development of information sheets for staff working in universal services listing 'approved' websites/resources that young people may find useful – eg, the YoungMinds website.

Financial Implications

12. There are no specific financial implications although the CCG and Wiltshire Council may wish to consider future funding for the Primary Mental Health Service and future investment in earlier support, such as counselling. The Council funds Primary CAMHS, whilst the CCG funds specialist CAMHS.

Carolyn Godfrey	**Deborah Fielding**
Corporate Director	**Chief Officer**
Wiltshire Council	**NHS Wiltshire CCG**

Report Authors:
Julia Cramp, Associate Director (Wiltshire Council / CCG)
Commissioning, Performance and School Effectiveness

Lucy Kitchener, Lead Commissioner, Emotional Wellbeing and Looked After Children, Children's Services, Wiltshire Council
Phone: 01225 718221

Date: 14 October 2014

Background Papers

Published documents: None

The following unpublished documents have been relied on in the preparation of this report:

Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014 - 2017

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: **Avon and Wiltshire Mental Health Partnership (AWP) Care Quality Commission (CQC) Inspection**

Executive Summary

The report provides a summary of the recent inspection findings and the response of AWP to these.

Proposal(s)

It is recommended that the Board notes the update from AWP.

Reason for Proposal

The update outlines the measures being undertaken to ensure a good quality service is provided.

Iain Tulley **Dr Elizabeth Hardwick**
Chief Executive **Interim Clinical Director for Wiltshire**
Avon and Wiltshire Mental Health Partnership

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Avon and Wiltshire Mental Health Partnership (AWP) Care Quality Commission (CQC) Inspection

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Purpose of Report

1. To outline AWP's action plan in response to the latest CQC inspection.

Background

2. The new CQC inspection methodology across health and social care commenced in 2013. For mental health providers the pilot wave inspections took place in January 2014 to October 2014.

3. The key changes to the inspection regime included a move from focused compliance based inspections by generic inspectors to judgement based, comprehensive inspections carried out by expert inspectors working with clinical advisors and service user and carer "experts by experience". The inspection considers the core domains of safety, effectiveness, caring, responsiveness and well-led across all core services and for the provider as a whole.

4. For providers inspected within the pilot waves although a full comprehensive inspection was carried and compliance action may be taken a shadow rating only was given which is not formally published.

5. AWP volunteered to be a pilot site for the early inspections to test out the improvement process already in place and progress the trust's application to become a foundation trust.

6. The inspection was carried out through the week of the 9th June. This was a weeklong process involving a team of approximately 80 inspectors, including clinical specialist advisors and service users. The team inspected every inpatient ward within the trust and a sample of community services in addition to interviews, focus groups with staff, listening events with service users and public and unannounced night visits.

Trustwide key findings

7. The report commended the transformation journey of the trust and the clinical focus and priorities. It stated good quality of care overall and compassionate care demonstrated by staff across the trust.

8. However 4 warning notices and 10 compliance actions were imposed following the report.

The warning notices related to:

Fromeside (secure service)

- Environment and ligatures
- Staffing numbers, supervision and management

- Hillview Lodge, Bath (acute in-patient unit)
  - Environment

- Whole trust
  - Failure to take action consistently on issues raised through governance mechanisms, by staff and by service users

9. All issues identified through the warning notices have been acted upon and responded to within the set timescales. The trust is awaiting CQC reinspection of these areas to confirm whether the warning notices will be lifted.

Findings with regard to Wiltshire

10. Wiltshire services inspected were:

    - Imber ward, Green Lane Hospital – adult general ward
    - Beechlydene ward, Fountain Way – adult general ward
    - Ashdown ward, Fountain Way – Psychiatric intensive care unit
    - Amblescroft North and South, Fountain Way – older adults inpatient care
    - Place of safety – Green Lane Hospital
    - Place of safety – Fountain Way
    - ECT service – Green Lane Hospital
    - North intensive team – crisis and home treatment service
    - South intensive team – crisis and home treatment service
    - North recovery team – adult community mental health service
    - South CIT team – older adults community mental health service

11. The report commented on good overall quality of care and staff who were compassionate and treated patients with dignity and respect.

12. The ECT team highly commended by chair in verbal feedback to trust.

13. Robust local governance processes and processes for managing performance and behaviour issues were found with no concerns re safeguarding.

14. Good multi agency local working was commented on.

15. Feedback from service users contacted was that there had been no issues with access to crisis services

Key issues relating to Wiltshire

16. Areas of concern within the report relating to Wiltshire were

    - Environment
        - Places of safety- ligature point and non barricadeable door in Fountain Way and concerns in both regarding the therapeutic environment for a person in distress
        - Fountain Way – temperature in clinic rooms, seclusion and wards
    - Medicines storage, stock management and waste management
    - Staff numbers, supervision and training – Ashdown and Beechlydene mentioned specifically with concern to staff numbers but concerns across all
    - Delays both in MHA assessments and transfers of care
    - Equipment maintenance at Fountain Way
    - Staff felt isolated from the trust management structures

Process followed post report

17. Pre and post summit meetings were held with the CCG and local authority to discuss the findings in the local context and agree actions. Meetings were also held with local managers and teams.

18. A trust action plan was agreed with the CQC to address all warning notices and compliance actions within the allocated timescales. This was shared with the CCG and a set of local action plans were agreed with CCG/LA, capturing the trust issues and local ones and monitored through the existing monthly performance meeting

19. The CQC confirmed on initial unannounced visit in June that many of the issues originally raised within Fountain Way had already been dealt with. We are awaiting notification of the formal CQC reinspection to determine whether the warning notices will be lifted.

20. All equipment has now been serviced and has a maintenance schedule. An updated SLA is now in place with Salisbury District Hospital.

21. Anti ligature work has been carried out and new furniture ordered for the places of safety.

22. Medication storage and waste issues have been addressed and a new governance group has been set up within the locality to monitor medicines management and compliance with standards.

23. There is a temporary closure of beds in Fountain Way on both Ashdown and Beechlydene to ensure the service is functioning at safe and therapeutic staffing levels and an Intensive staff recruitment campaign is ongoing.

24. A staff concerns log has been launched on the locality webpage.

25. Supervision arrangements have improved – 87.7% in Wiltshire in October (trust target 85%) and ongoing weekly monitoring is in place.

26. All teams and wards have training plans in place to achieve full compliance and additional local training is being arranged where necessary. This includes a focus on the Mental Capacity Act.

27. Caseload profiling work was implemented in the CMHTs in the summer and the focus is currently on embedding work.

Report Author: Dr Julie Hankin, Clinical Director Wiltshire, AWP

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Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Wiltshire and Deprivation of Liberty Safeguards (DoLS)

Executive Summary

This report has been prepared for the Health and Wellbeing Board to ensure that the board are kept up to date with the difficulties experience by the DoLS Service in Wiltshire following an unprecedented increase in referrals for authorisations following the recent Supreme Court Ruling. It is hoped that the report will demonstrate the high level partnership commitment to tackling the issues raised.

Proposal(s)

It is recommended that the Board notes the update.

Reason for Proposal

To keep the Board updated on the issues for the service.

James Cawley
Associate Director, Adult Care Commissioning, Safeguarding & Housing
Wiltshire Council

Jacqui Chidgey-Clark,
Director of Quality and Patient Safety,
NHS Wiltshire CCG

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Wiltshire and Deprivation of Liberty Safeguards (DoLS)

Purpose of Report

1. To ensure that the board kept up to date with the difficulties experience by the DoLS Service in Wiltshire Council and the subsequent effect on health care provision within Wiltshire and surrounding areas, following an unprecedented increase in referrals for authorisations following the recent Supreme Court Ruling. It is hoped that the report will facilitate high level partnership commitment to tackling the issues raised.

Background

2. The Deprivation of Liberty Safeguards (DoLS) were developed as a result of the Bournewood judgement in 2004. This situation related to a young man with profound learning disabilities and an autistic spectrum disorder. He was informally kept in hospital (i.e. not detained under the Mental Health Act) against the wishes of his family. The situation as considered through the Court of Appeal, House of Lords, and European Court of Human Rights, where it was finally determined that he had been unlawfully detained.

3. Part of the Mental Capacity Act 2005, but not implemented until 2009, Deprivation of Liberty Safeguards are intended to ensure that people who lack capacity to consent to specific arrangements are not deprived of their liberty or restricted any more than is necessary, and that there are legal routes to challenge situations where it is felt that the level of deprivation is inappropriate. The specific arrangements have, until recently, related to people being accommodated in a Registered Care Home or Nursing Home, or staying in a hospital, for the purposes of receiving care or treatment. This excludes people who are detained under the Mental Health Act, as this legislation affords them the appropriate protections.

4. From 2009, Local Authorities were the Supervisory Bodies (i.e. responsible for authorising Deprivations of Liberty) for people with local Ordinary Residence, in a funded placement in another authority, in both Registered Nursing and Residential Care Homes, and in April 2013 assumed this responsibility in relation to Hospitals, the latter having previously been the responsibility of PCTs.

5. The process for assessing whether a person is :- being deprived of their liberty; and whether or not this is in their best interest; and whether this is the least restrictive option available is very prescribed and many believe the current process and related administrative burden on Councils to be overly bureaucratic. It involves specifically trained staff (Best Interests Assessors or

BIAs and S12 Doctors), and specialist advocacy (Independent Mental Capacity Advocates).

What is a Deprivation of Liberty?

6. If it is thought that a resident or patient in a Residential Care Home, Nursing Home or on a hospital ward requires a level of restriction of freedoms and choices that amounts to "deprivation of liberty" then an application must be sent to the Supervisory Body who are the local Council for an authorisation for this purpose. The definition of a mere restriction of liberty that would not require an authorisation as distinct from a deprivation of liberty that does require an authorisation has never been well defined, and has recently been subject to legal challenge.

7. Broadly, what was happening prior to May of this year was that whether or not a person was being deprived of their liberty was a judgement based on:

   i. Whether the level of restriction on a person's freedoms were of such a level that they amounted to deprivation of liberty, and if so;

   ii. How reasonable/minimised the restrictions were.

8. Requests for DoLS authorisations were often triggered by extent to which a person appeared to disagree with, be unhappy with, or challenge through their behaviour, the restrictions placed upon them in order for them to receive the required care and support, or treatment.

Based on this definition of a deprivation of liberty Wiltshire Council has historically received the following number of requests for authorisation on a yearly basis	
2013/14 Applications made: 164	Authorisations given: 70
2012/13 Applications made: 154	Authorisations given: 60
2011/12 Applications made: 153	Authorisations given: 70

What Has Changed?

9. In May 2014 the Supreme Court rulings (P v Cheshire West and Chester Council and P&Q v Surrey County Council) has now judged that exactly the same test of deprivation must be applied to all people regardless of their disability who lack capacity, and makes reference to the level of intrusion that result from the care and support arrangements, irrespective of whether a person appears to object to them.

10. The acid test for determining that there is a deprivation of liberty according to Lady Hale in Cheshire West, involved establishing:

    i. That the person is **subject to continuous supervision** and control;

    ii. It was made clear that relevant factor for this could include controlling who the person could have contact with and the activities they could participate

in. However no further guidance was given on what amounted to 'continuous supervision'. One interpretation of this ruling is that all patients or residents in a care home or on a hospital ward are being continuously supervised so it is difficult to see who would fall outside this category;

iii. That the person is **not free to leave.** The area and duration of the confinement is also relevant.

11. Relevant factors for 2, include not being able to leave the placement without supervision and not being free to leave in order to reside somewhere else.

12. Lady Hale maintained in her judgement that one ought to err on the side of caution when determining what constitutes a deprivation of liberty clarifying her thinking in the statement below:

> *"If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage."*

13. In addition, the judgement has broadened its scope in terms of where the deprivation of an individual's liberty can occur, to include supported living, shared lives, post 18 residential college provisions, hospices and even in the individual's own home. The Supervisory Body function cannot however authorise a deprivation in these settings, applications need to be to the Court of Protection. Those living at home who may be receiving state arranged care support via a LA and whose liberty may be deprived currently will have to be subject to a S 16 MCA welfare application to the Court of Protection.

14. Discussions continue to take place on a national level as to the full implications of the Supreme Court Judgement. A report by the House of Lords has suggested that the DoLS are 'not fit for purpose'. However, in order for the Judgement to be challenged, it must be heard in the European Court. Were this to occur, it is highly unlikely that any revisions would be implemented within the next 24-36 months. As such, there is no option but to adhere to this directive.

Implications for all Councils

15. The implication is that every person who lacks capacity to agree to being accommodated in a residential care home and/or to their care plan will now be considered to be deprived of their liberty, and therefore the processes for authorising Deprivation must be followed.

16. NHS commissioned Healthcare providers should now be applying to the Council for authorisation for deprivation of liberty for people who cannot consent to being in hospital or their treatment, because they are unconscious, unless they have given prior consent such as for elective surgery.

17. Deprivation of Liberty authorisations can only be for an absolute maximum of a year, after which the full process must be undertaken again. Should a deprivation be authorised for a shorter period, that authorisation cannot be ended or extended without the full process being undertaken. Ongoing authorisations will need to be repeated for some people year on year if they remain deprived of their liberty.

18. Those living at home who may be receiving state arranged care support via a LA and whose liberty may be deprived currently will have to be subject to a S 16 MCA welfare application to the Court of Protection. Every referral to the Court of Protection involves significant preparation, and has a minimum cost of £400 (at 04/2014). In addition, the Court may decide to appoint an Official Solicitor and require the appointment of a range of independent practitioners (for example Social Worker or Psychiatrist) to carry out independent assessments to assist the Court to make a decision on what arrangements are in the person's best interests. The costs of such appointments are borne by the parties involved, and in the circumstances under consideration here, by the party seeking authorisation of the deprivation of liberty. This will either be the NHS or the Council, although depending on the outcome of the financial assessment, the person who is the subject of the Court referral may be required to pay their own costs or refund the council if they are not eligible for Legal Aid.

19. There is significant concern nationally about the implications of this judgement, the burden placed upon Councils and the NHS is significant, and the implications for families cannot be underestimated. The increase in Council involvement with people who fund their own support as a result of the Care Act will increase this burden even further, as even advising families on how to support people safely may result in involvement in a referral to the Court of Protection. Further legal clarification on this point will be needed next year.

Wiltshire Councils Response to the increase in demand for authorisations.

20. In the six months since the ruling was made in March 2014, Wiltshire – in common with other local authorities – has been grappling with the additional demands this has placed on our resources. 500 assessments are yet to be allocated to Best Interests Assessors, meaning that statutory time scales are not being adhered to. Currently the Wiltshire DoLS service receives 30 requests for authorisations on a weekly basis.

21. Unlike a number of other County Councils who have relied on independent best interest assessors to complete the back log of assessments Wiltshire has taken a view that a sustainable solution must be found that will not only address the current back log but also puts us in a secure position to cope with the increase in demand throughout the coming years.

Short-Term Support and Mitigation of Corporate Risk

22. The following steps are already being taken to mitigate Wiltshire Councils' corporate risk and to support current service delivery in the short term:

a) 12 month secondment of a senior BIA to the DoLS team (June 2014 to June 2015)

b) Some funds have been made available for additional BIAs to be recruited via Social Work agencies but recruitment is almost impossible because of the national demand.

c) 30 hours of additional administration support, to assist with the increase in admin.

d) The formation of a Task & Finish Group which meets 4 weekly to review service pressures and corporate risks and take action to make improvements.

e) Commissioned bespoke Wiltshire Council training programme from Bournemouth University, leading to the training of 20 new BIAs who should be fit to practice by December 2014 (longer term benefit)

f) Maintaining links with neighbouring authorities in order to develop joint strategies & approaches

g) Commissioning Independent BIAs when available to undertake assessments in the short term.

h) Keep abreast of National Directives (ADASS, DoH, COP)

i) Work in partnership with legal services, who are taking forward work in relation to DoLS applications for people who are not in care home or hospital settings

j) As well as an increase in assessments there has also been a knock on effect for the admin side of the team. 1 full time additional administrator to support the DoLS Service full time for a six month period – currently at recruitment phase. Streamlining administration tasks has begun so that these require less staff time.

k) As customers and their families are often supported by independent advocates or IMCA's this has increased the number of referrals to SWAN advocacy. Ongoing this will have a cost implication for the council and must be adequately resourced to ensure that customers and their families are supported throughout the DoLS process if required.

l) The following criteria has been devised as a way of prioritising requests being made:

   i. Is the person in an acute or psychiatric hospital or hospice?
   ii. Is the person experiencing high levels of distress as a result of the arrangements in place?
   iii. Would the person have met the requirements for a DoLS Authorisation prior to the Supreme Court Judgement in March 2014?
   iv. Is anyone objecting to the arrangements in place on the person's behalf?
   v. Is the person subject to safeguarding procedures?

23. The following mitigating actions are being taken by NHS Wiltshire CCG for commissioned services:

- A regular update is provided at monthly Clinical Quality Review Meetings by providers to the commissioners. Wiltshire CCG has to take into account the different approach of Bath and NE Somerset and Swindon Borough Councils, particularly in relation to cases referred to the coroner following the death of a patient whose assessment has not been completed. The Wiltshire coroner's view is different to that of the other councils and has caused concern for providers.

- NHS Wiltshire CCG is working with the University of West of England to provide bespoke training for all commissioner and provider Safeguarding leads within Wiltshire, the following is currently under development and the programme will begin in January 2015:

    1) Launch event
    Led by the Head of Adult Safeguarding, NHS Wiltshire CCG and UWE, launch followed by cafe style workshops with some trigger questions that will help further inform action learning sets. Four UWE academics are involved in the planning, desk top research of the topics and current best practice in preparation of the whole project and for facilitation at the launch event.

    2) Action learning sets
    Two hour events over 12 weeks with safeguarding leads from end Jan/Feb 2015. Five action learning groups facilitated by academics with participants focused learning relating to designing a policy, action plan or demonstrating application to practice. The number may be defined by the launch workshop and take place off UWE premises to be decided by the action learning group membership.

    3) Master classes of themed rolling programme
    Themes: MH Act and Advocacy, MH act and noncompliance, MH act and DNAR decisions, and MH act and restraints. Face to face approach using case studies. Two hour sessions with approx. 20 per group from end of January. Ambassadors under the mentorship of UWE academic facilitators will roll out these master classes.

    4) Rapid immersion event
    One day event for a mixed audience that would be themed around the MH capacity act. Two UWE academics will lead the day and to do an evaluation report.

    5) Evaluation
    Baseline audit to begin with identifying what is available now and then, following the above interventions, an evaluation to ensure these made a difference to practice.

24. NHS Wiltshire CCG is committed to sharing best practice across Health and Social Care, this programme has been supported by NHS England and has

been identified as an area of Best Practice. The CGG is now sharing with other CCGs to ensure a joined up approach.

Medium to Long-Term Support and Mitigation of Corporate Risk

25. The following steps are already being taken to mitigate corporate risk and support current service delivery in the medium to long term:

    a) Agreement has been reached for all newly training BIAs to be released from duties in the operational teams to complete one best interest's assessment a week. From January 20 BIAs will be available to do this work. The total number of assessments that can be completed as a result of the increase in available BIA's from January 2015 to January 2016 will be **1040.** This will clear the back log of assessments.

    b) As this level of assessment will cover the back log but not the additional assessments that are coming through an ongoing training programme has been implemented and we are identifying further Wiltshire Council employees in a position to undertake 6 month BIA training starting in January 2015. It is anticipated that all level 2 Social Workers with at least 2 years post qualifying experience and all level 3 social workers will receive training as a BIA on a rolling programme and then be available to undertake assessments on a weekly basis. In this way if or when trained members of staff leave the Council we are able to maintain a sustainable number of BIAs for the requests that are coming in.

    c) The DoLS Lead encourages a verbal discussion with service providers prior to the submission of requests, to ensure that basic criteria are met – several providers still fail to recognise that the mental capacity requirement has to be met, in order to pursue an Authorisation under DoLS.

    d) Wiltshire Council & Swindon Borough Council have a Care Skills Partnership Group which has and continues to identify information which will help to inform providers about the changes in legislation and practise, specific to these geographical areas.

    e) The WSAB have agreed to undertake a small scale audit of how DoLS matters are addressed during safeguarding work. The purpose is to identify good practice and also issues that need further development or reinforcement through targeted training. This is likely to take place in December or January in view of the current pressures on the DoLS team.

James Cawley
Associate Director, Adult Care Commissioning, Safeguarding & Housing
Wiltshire Council

Jacqui Chidgey-Clark
Director of Quality and Patient Safety
NHS Wiltshire CCG

Report Author: Heather Alleyne, Interim Head of Quality Assurance and Safeguarding.

Wiltshire Council

Health and Wellbeing Board

20th November 2013

Wiltshire Safeguarding Adults Board Annual Report 2013-14

Executive summary

The purpose of the report is to present the Annual Report of the Wiltshire Safeguarding Adults Board (WSAB) for comment and acceptance by the Health and Wellbeing Board. The Annual Report reviews the work of the Board during 2013-14 and sets out the priorities for the current year; it includes contributions from all partner agencies. The WSAB is accountable to the Health and Wellbeing Board, which is why the report is being presented.

Proposal

That the committee:

a) Comments on the Annual Report.

b) Accepts it as the partnership to which the Safeguarding Adults Board is accountable.

Reason for proposal

The Wiltshire Safeguarding Adults Board brings together key agencies from across the county at senior level to ensure that their shared responsibilities for safeguarding adults who are defined as "at risk" are effectively fulfilled. It has been agreed that it should be accountable to the Health and Wellbeing Board as the senior partnership body that has responsibility for the issues with which the Safeguarding Board deals. It is therefore appropriate to present the Annual Report to the Health and Wellbeing Board.

Author: Margaret Sheather, Independent Chair of Wiltshire Safeguarding Adults Board

Contact details: ☎ 07766-228389
✉ m.sheather@btinternet.com

Wiltshire Safeguarding Adults Board Annual Report 2013-14

Purpose of report

1. The purpose of the report is to present the Annual Report of the Wiltshire Safeguarding Adults Board (WSAB) for 2013-14 for comment and acceptance by the Health and Wellbeing Board.

Background

2. The purpose of the Wiltshire Safeguarding Adults Board (WSAB) is to ensure that all agencies work together to minimise the risk of abuse to adults at risk of harm and to protect and empower vulnerable adults effectively when abuse has occurred or may have occurred. The WSAB aims to fulfil its purpose by:

    - Maintaining and developing inter-agency frameworks for safeguarding adults in Wiltshire, including determining policy, facilitating joint training and raising public awareness.
    - Co-ordinating the safeguarding adults work undertaken by those organisations represented on the WSAB and monitoring and reviewing the quality of services relating to safeguarding adults in Wiltshire.

3. Part of its responsibilities is to produce an Annual Report which reviews the past year's work and sets out priorities for the coming year. The report for 2013-14 is attached as Appendix 1 to this report.

4. The Annual Report was also presented to the Wiltshire Council Health Select Committee on 23rd September for their consideration and comment. Following that discussion a further priority action was added to the report in relation to examining more fully the reasons for the increased number of alerts being received.

Main considerations for the committee

5. There are several points to bring particularly to the Board's attention.

6. Changes in public service structures and reductions in funding continue to have a significant impact on the membership and work of the Board. In the current year Healthwatch has joined the Board, there is a change of representation from the Probation service in the light of their new structure, and a further change of police representation as new appointments are made there. Increased workloads for partner representatives affect the degree to which they are able to contribute to the activities of a partnership body such as the WSAB.

7. The Care Act 2104 has now passed and so the adults safeguarding work will be on a statutory footing with effect from April 2015. Extensive statutory guidance has now been issued to support the implementation of the Act and the WSAB will be working on ensuring that its arrangements reflect those requirements.

8. Progress has been made during the year, responding both to national change and to local needs, summarised in the Foreword and set out in more detail in the body of the report. The successful establishment of a Service User Reference Group is one of the highlights of this year's work.

9. A Serious Case Review has been carried out this year, independently chaired, and a summary of its conclusions can be found in Section 4 of the report. An Action Plan in response to the review is just being finalised and will be incorporated into the Business Plan.

10. The remainder of the report includes:

    - The overall developments and achievements of the Board described in section 3 and those of the partner agencies in section 6.
    - The continued increase in the volume of safeguarding work identified in section 5 and the associated data in Appendix 3.
    - The priorities for the current year and beyond, that are set out in section 8.
    - The full Business Plan at Appendix 5.

Environmental impact of the proposal

11. There are no environmental impacts from this report.

Equality and diversity impact of the proposal

12. The work of the WSAB has a significant role to play in promoting equality. It contributes to ensuring that all Wiltshire residents, whatever their circumstances or needs for support, can live free from the fear of harm or abuse, that they are treated with dignity and their choices respected.

Risk assessment

13. There are no specific risks associated to the proposed actions in this report. However, the assessment and management of risk generally is central to effective safeguarding work, both with individuals who are at risk and in the management of safeguarding in individual organisations and by the WSAB. The Board has established a risk register to ensure that it tracks any risks to the overall safeguarding arrangements that may arise. This has been particularly important during the intense period of change that has affected partner organisations.

Financial implications

14. There are no financial implications arising directly from this report. The WSAB has not yet established a specific identified budget, but work continues to agree how funding of the board's main activities can be appropriately shared among key partners. The Health and Wellbeing Board received a report at its September 2013 meeting on this topic and agreed at that time that the funding for Serious Case Reviews should be split between the Police and Crime Commissioner, the Clinical Commissioning Group and Wiltshire Council. It also decided to receive a report at a future meeting about the overall funding both for the children's and adults safeguarding boards, and this report is now being prepared.

Legal implications

15. There are no legal implications arising directly from this report.

Background papers

The following unpublished documents have been relied on in the preparation of this report: None.

Appendices

Appendix 1 – Wiltshire Safeguarding Adults Board Annual Report 2013-14

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: The NHS Five Year Forward View

Executive Summary

The NHS Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England.

Proposal(s)

It is recommended that the Board notes the update on the Forward View from NHS England.

Reason for Proposal

The Forward View will have significant implications for all partners.

Debra Elliott
Director of Commissioning
Bath, Gloucestershire, Swindon and Wiltshire Local Area Team
NHS England

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: The NHS Five Year Forward View

The NHS Five Year Forward View

1. The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

2. The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

3. The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

Debra Elliott
Director of Commissioning
Bath, Gloucestershire, Swindon and Wiltshire Local Area Team
NHS England

Appendices

Appendix 1: NHS Five Year Forward View

Wiltshire Council

Health and Wellbeing Board

20th November 2014

Subject: Operational Resilience and System Capacity Planning (ORCP)

Executive Summary

The paper outlines the re focus of the Wiltshire Urgent Care Working Group into a System Resilience Group, that will be mandated to ensure that health and social care capacity and demand, both elective and non-elective, is managed in a robust and systematic way across all local providers.

The paper sets out an overview of the process for submission of the final operational Resilience and Capacity Plan for Wiltshire to NHS England at the end of September that details the local provider capacity; how best practice within planned and urgent care is being implemented; and the health and social care investments to support operational resilience.

The paper provides a system wide confidence level of secondary care delivery against the 4hr Accident and Emergency Department target and details additional 2014/15 investments across the health and social care system that has a direct and indirect impact on delivery.

Proposal(s)

It is recommended that the Board notes the information.

Reason for Proposal

To update the Health and Wellbeing Board on the CCG response to recent NHS England guidance for operational resilience and system capacity planning, and to assure its members that the CCG has processes in place to ensure compliance. Progress against delivery will be monitored through the multi-stakeholder System Resilience Group (SRG) meetings and monthly mandated reports and monitoring tracker documentation to NHS England.

Jo Cullen, Group Director, West Wiltshire, Yatton Keynell and Devizes NHS Wiltshire CCG

James Cawley, Associate Director, Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Operational Resilience and System Capacity Planning (ORCP)

Purpose of Report

1. To update the Health and Wellbeing Board on the CCG response to recent NHS England guidance for operational resilience and system capacity planning, and to assure its members that the CCG has processes in place to ensure compliance. Progress against delivery will be monitored through the multi-stakeholder System Resilience Group (SRG) meetings and monthly mandated reports and monitoring tracker documentation to NHS England.

Background

2. In June NHS England confirmed to the CCG the requirements that need to be in place to ensure operational resilience during 2014/15 for both urgent and planned care.

3. This guidance moved beyond planning for urgent care over winter, and brought together planned care into the system wide year round resilience framework. This wider remit was partly informed by the recent pressures that have been seen in delivery of the referral to treatment (RTT) standard, but was primarily driven by the principle of good local healthcare planning being equally focussed and resilient across planned and urgent care.

4. The guidance sets out best practice requirements across planned and urgent and emergency care that each local system should reflect in their local plan, and the evolution of Urgent Care Working Groups into System Resilience Groups (SRGs).

5. The guidance sets out the expectation that the System Resilience Groups will need to expand their remit to include elective as well as urgent care. They will become the forum where capacity planning and operational delivery across the health and social care system is co-ordinated. Bringing together both elements within one planning process underlies the importance of whole system resilience and that both parts need to be addressed simultaneously in order for local health and care systems to operate as effectively as possible in delivering year round services for patients.

6. As such, and within the programme management system implemented by the CCG to deliver the 5 year Strategic Plan, the CCG is leading a System Resilience Group, ensuring that all partners across health and social care are included, inclusive of commissioners and providers (the amended Terms of Reference for this Group are included as **Appendix 1**).

7. Health and social care delivery for the people of Wiltshire is met by a number of providers, many of whom due to geography are linked into not only the Wiltshire SRG, but also neighbouring SRGs co-ordinated by the Clinical Commissioning Groups. Whilst there is already this degree of cross representation within the SRGs it is likely that in the future, based on preliminary feedback from the national review

of urgent and emergency care that Wiltshire SRG will form part of a wider strategic resilience group responsible for the planning, oversight and governance of a regional or sub-regional urgent care system.

8. The CCG had to submit an operational resilience plan from all its major providers, including those who have a regional or wider geographical coverage, such as Care UK who provide NHS 111 and South Western Ambulance Service NHS Foundation Trust who provide emergency services. We will seek to ensure, and support, dissemination of provider and commissioner assumptions so that system resilience within Wiltshire, and with health and social care providers across boundaries is seamless and improves patient experience and clinical outcomes. The full submitted plan is at **Appendix 2**.

9. The CCG is strategically supporting the implementation of a number of redesign schemes, including, but not limited to, community transformation, additional primary care capacity through Transformation of Older People schemes, coordination of patient facing health and social care services through Simple Point of Access, increased capacity through intermediate care beds and patient flow initiative within our three local acute hospitals. This is being delivered through funding agreed in 2013/14 and through health and social care integration via the Better Care Fund programme. As such, the CCG has ensured that appropriate governance structures are in place to link the System Resilience Group through the both the CCG and Wiltshire Council Governance Groups as appropriate.

10. At the meeting of 18th September 2014 the Wiltshire System Resilience Group reviewed the operational resilience and capacity plan and supporting investment tables that identified the allocation of £6.876m to support health and social care provision in 2014/15. Based on this information, a peer review of provider resilience presented at the meeting, knowledge of historic provider performance during times of increased demand and an awareness of current provider challenges Wiltshire SRG have applied a confidence factor of 80% for the delivery of the 4 hour Accident and Emergency target at Salisbury Hospitals NHS Foundation Trust.

11. Working with the Swindon SRG, and based on this wider information, the impact of local GWH facing investment, Wiltshire SRG have applied a confidence factor of 50%, for the achievement of GWH delivering the 4 hr A&E target.

12. Working with BaNES SRG, and based on this wider information, the impact of local RUH facing investment, Wiltshire SRG have applied a confidence factor of 65%, for the achievement of RUH delivering the 4 hr A&E target.

13. This has been arrived at by Wiltshire SRG applying a confidence factor against individual provider delivery and weighting this against each provider's impact to whole system delivery. Further funding was announced on 27 October as additional national A&E funds, and allocations to local providers are being confirmed.

Jo Cullen
Group Director, West Wiltshire, Yatton Keynell and Devizes
NHS Wiltshire CCG

Appendices

Appendix 1: Terms of Reference for the System Resilience Group
Appendix 2: Wiltshire Operational Resilience and Capacity Plan submitted

APPENDIX 1: TERMS OF REFERENCE FOR THE WILTSHIRE SYSTEM RESILIENCE GROUP (SRG)

1 **PURPOSE, SCOPE AND FUNCTION**

1.1 The purpose of the Wiltshire System Resilience Group is to;

- To provide a strategic, delivery and monitoring forum to ensure operational resilience and referral to treatment requirements are achieved throughout 2014/15 for the local health and social care systems for the people of Wiltshire.
- To co-develop strategies and collaboratively plan safe, efficient services for patients for elective and non-elective care.
- To review, analyse and challenge drivers of system pressures in order to support the development of solutions through a collaborative approach.
- To build consensus across members and stakeholders, advising especially on the use of non-recurrent funds and marginal tariff.
- To develop and sign off operational and resilience capacity plans, ensuring compliance with all mandatory elements and involvement with all key local organisations.
- To support the reporting requirements and deadlines set out by NHSE within 'Operational Resilience and Capacity Planning for 2014/15', published 13th June 2014.
- Support, as required, appropriate resources to the Wiltshire CCG urgent care programme structure / project teams to deliver the outputs contained within the CCG Five Year Plan.
- Collaborate, share and learn from other SRG's
- To be a member and participate in any strategic resilience group that may operate at a sub-regional or regional level

2 **MEMBERSHIP**

2.1 Core Membership

The SRG will be chaired by the Clinical Chair of Wiltshire CCG. In addition, core membership will comprise of;

- Clinical GP Chair of each Locality Group in Wiltshire CCG
- Chief Officer, Wiltshire CCG

CEO or delegate of the following provider organisations;

- Salisbury Hospitals NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust (acute and community services)
- Royal United Hospital
- South Western Ambulance Service NHS Foundation Trust
- Avon and Wiltshire Mental Health Partnership Trust
- Wiltshire Council commissioner representative
- Wiltshire Council provider representative
- Medvivo Limited
- Care UK Limited
- Arriva Transport Solutions

Additional members (or delegate) will include;

- CFO for Wiltshire CCG.
- Group Director from each Locality Group in Wiltshire CCG.
- Director of Integration for Wiltshire CGG and Wiltshire Council.
- Director of Quality and Patient Safety for Wiltshire CCG.
- Director of Planning, Performance and Corporate Services for Wiltshire CCG.
- Medical Advisor for Wiltshire CCG
- Associate Director for Commissioning Urgent Care Wiltshire CCG.
- Head of Information for Wiltshire CCG.
- Director of Commissioning NHSE Area Team.
- Director of Public Health (Emergency Planning).
- CEO of Wiltshire Healthwatch.
- Representation from Vocare Group
- Chief Executive of Care Partnership
- Representative from Help to Live at Home providers
- Wessex LMC Representative.
- Chair of Swindon SRG.
- Chair of BaNES SRG.

2.2 **SRG Secretariat**

The Associate Director of Commissioning Urgent Care for Wiltshire CCG will ensure the provision of the secretariat to the group in respect to:

- Agenda setting
- Circulation of papers;
- Support and develop the delivery of the work plan

3 **AUTHORITY**

The SRG is authorised to require the provision of such information and access to such personnel, as it is required to discharge its duties/responsibilities. The SRG is authorised to take outside professional advice as appropriate in particular to make external comparisons.

4 **ACCOUNTABILITY**

Accountability for the effective functioning of the Wiltshire SRG will be to Wiltshire CCG Governing Body, via Wiltshire CCG Programme Governance Group (PGG), and where applicable, will ensure appropriate governance with the Wiltshire Better Care Fund Programme Governance Group, (BCG PGG).

5 **PERFORMANCE MANAGEMENT**

The SRG will monitor and evaluate its performance against appropriate thresholds and locally agreed performance metrics. These may include but not be limited to;

- Where applied the use of the 70% marginal tariff.
- Accurate capacity modelling in non-elective demand.
- Disposition data from NHS 111.
- Effectiveness of seven day working within primary and social care.
- Linkages to Better Care Fund (BCF).
- Review and monitoring of established pathways for high intensity users.
- Review and monitoring of processes to minimise delayed discharge
- Reduction in permanent admissions of older people from care facilities
- Monitoring the use and outcomes of risk stratification tools
- The development and benefit of real time data capture to inform system wide intelligence, including ED capacity management tools.
- Analysis of capacity and demand for elective services
- Delivery of an agreed RTT timeline for common pathways including a review of local rules against national guidance.
- Review and monitoring of ‘right acre, right time, right place’ principles

6 **FREQUENCY OF MEETINGS**

Meetings will be held (quarterly / bi-monthly / monthly) or as required and will be arranged 12 months in advance. All communications relating to meetings will be disseminated and papers/reports circulated in a timely manner.

Agenda items should be forwarded to the Associate Director of Commissioning Urgent Care for Wiltshire CCG Secretariat one week prior to meetings.

7 **QUORUM**

A quorum of 6 members must be present to constitute a valid meeting with a minimum representation of 4 core member organisations. There must be one additional Clinical Member in addition to the Chair. The Chair will determine the appropriateness of the represented organisations to make decisions.

Date 16th June 2014

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Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Getting Ready for Winter

Executive Summary

Jane Ellison MP, Minister for Public Health, has written to Health and Wellbeing Boards to raise awareness of the Get Ready for Winter Campaign. This short paper provides an outline of the work underway in Wiltshire.

Proposal(s)

It is recommended that the Board notes the activity underway.

Reason for Proposal

To ensure awareness of arrangements for winter preparedness amongst key partners, allied to the work on systems resilience.

James Cawley
Associate Director, Adult Social Care Commissioning, Safeguarding & Housing
Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Getting Ready for Winter

Purpose of Report

1. To ensure awareness of arrangements for winter preparedness amongst key partners, allied to the work on systems resilience.

Background

2. Jane Ellison MP, Minister for Public Health, has written to Health and Wellbeing Boards to raise awareness of the Get Ready for Winter Campaign. A copy of the letter is at **Appendix 1**. This short paper provides an outline of the work underway in Wiltshire.

Main Considerations

3. The letter raises key elements of Winter Preparedness, set out below, with an outline of activity underway.

Influenza

4. Wiltshire Council has undertaken the following actions promoting flu vaccinations throughout the county:
    - Identifying and promoting flu vaccination among frontline staff;
    - Offering flu vaccination among the wider workforce at a reduced rate;
    - Providing information to both the general public and staff regarding those who are eligible for free flu vaccination via:
        - Area board health fair events; campaign information table within County Hall; distribution of leaflets to all libraries.
        - Dissemination of posters and leaflets to all maternity services in the area, including flu passports and scan mount cards displaying a reminder to pregnant women to take up the flu vaccination.
        - Supporting Early Years and Childcare settings in reducing infection risks

Norovirus

5. Norovirus, also known as winter vomiting disease, causes gastroenteritis and is highly infectious. Symptoms include vomiting, projectile vomiting, diarrhoea and fever. The virus is easily transmitted through contact with infected individuals from one person to another and outbreaks are

common in semi-enclosed environments such as hospitals. The illness caused by the virus is usually mild, self-limiting and lasts for 1 to 2 days with most people making a full recovery within a couple of days. However, it can be dangerous for the very young and elderly people leading to admission to acute care if they become dehydrated as a consequence of vomiting or diarrhoea thus increasing the risk of outbreaks.

6. Wiltshire CCG has worked with Local Acute Trusts and community hospitals to ensure robust action plans are in place (based on national guidelines published by Health Protection England) to identify and manage patients who may present with or develop the infection during their inpatient stay.

7. Public Health England's AGW team has also issued a revised version of the Norovirus toolkit (2014) which is useful in supporting preparations and response for viral gastroenteritis across health & social care. The toolkit include two sets of resources: one set that can be used to raise awareness of Norovirus within the wider community at this time of the year and a second set that can be used when it is known that a virus is circulating in the community.

Health and Social Care Integration

8. Work continues on a range of initiatives as part of the 100 day challenge and the delivery of the Better Care Plan. A summary of these is attached for ease as Appendix 2.

Cold Weather

9. Wiltshire Council works closely with the Wiltshire Affordable Warmth Partnership to reduce the impacts of fuel poverty in the county. Wiltshire Council has also promoted the information contained in the 'Cold Weather Plan for England' in the following ways:
   - Increasing awareness by proactively publicising the website on the Wiltshire Council website.
   - Protecting the vulnerable by disseminating cold weather action cards to social care staff and providers.
   - Increasing awareness in the community by making the cold weather plan an integral part of community resilience workshops.
   - Increasing our preparedness by reviewing our business continuity and emergency plans in line with current best practice.

10. We have launched a new initiative to make people's homes safer, warmer and cheaper to heat by working in partnership with Wiltshire Fire and Rescue Service to develop Warm & Safe Wiltshire. A new Advice and Referral hub at County Hall in Trowbridge will provide people with advice and information about ways of cutting their energy bills, getting the best deals from gas and electricity suppliers and improving fire safety in their homes.

11. There are around 28,000 households in fuel poverty in Wiltshire, according to figures from the Department of Energy and Climate Change. Warm and Safe Wiltshire aims to provide practical help to increase comfort and safety levels by providing, for example, draught proofing kits and fire prevention equipment to eligible households through a team of Warm and Safe community-based surveyor.

James Cawley
Associate Director, Adult Social Care Commissioning, Safeguarding & Housing
Wiltshire Council

Report Authors:
James Cawley, Associate Director, Adult Social Care, Wiltshire Council
Frances Chinemana, Associate Director, Public Health, Wiltshire Council
James Roach, Integration Director, Wiltshire Council / CCG

Appendices

Appendix 1 – Letter from Jane Ellison MP, Public Health Minister
Appendix 2 – Overview of Health and Social Care Integration

Department of Health

From Jane Ellison MP
Parliamentary Under Secretary of State for Public Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

22 October 2014

Dear Health and Wellbeing Board Chairs,

Getting Ready for Winter

I am writing to make you aware of the 'Get Ready for Winter' campaign which was launched on Wednesday, 22nd October 2014. This campaign has cross-government input and is hosted by the Met Office. Other key elements of winter preparedness for the health and care system are:

Influenza – 'Flu'

Flu is an unpredictable but recurring pressure that the NHS, the social care system and the public face each winter. For most healthy people, it is an unpleasant but usually self-limiting disease with recovery generally within a week but for at-risk groups it is much more serious.

Effective local flu planning is an integral part of wider winter planning and the annual flu immunisation programme is a critical element of the system-wide approach for delivering robust and resilient health and care services. I urge everyone to continue to support delivery of the Annual Flu Plan (accessible here https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/306638/FluPlan2014_accessible.pdf), published on 28 April 2014, with as much energy as possible.

Flu immunisation really is crucial in protecting those at risk and GPs will as you know, offer free flu vaccinations to:

- people aged 65 years and over
- clinical at-risk groups
- pregnant women
- carers and Health and social care workers *and*
- residents in long-stay care homes

Uptake of the vaccine in some of these groups remains disappointingly low and we hope that, with your support, we can help to encourage individuals eligible for free vaccinations to take them up.

Key actions are:

- Encourage flu vaccination in at-risk groups and ensure that staff in contact with vulnerable individuals have access to flu vaccination (particularly social care and NHS staff).
- Encourage good hand hygiene, to reduce the spread of flu and other infections in all settings e.g. "catch it, bin it, kill it" campaign.
- Information about the annual flu programme and resources can be found here https://www.gov.uk/government/collections/annual-flu-programme and if you would like further information please email immunisation@phe.gov.uk.

Norovirus

Norovirus is the most common cause of infectious gastroenteritis (diarrhoea and vomiting) in England and outbreaks occur regularly each winter with disruptions to the provision of public services such as closures of hospital wards or schools. It is generally mild and people usually recover fully within 2-3 days but it can be dangerous for the very young and elderly.

The most effective control measures are:

- attention to good infection control practice, including hand washing with soap and water (not relying on alcohol gels as these do not kill the virus);
- prompt segregation of affected patients, *and*
- good communication with staff, patients, visitors and other local organisations.

Guidance on norovirus, including management in community health and social care settings and a poster for winter can be found here https://www.gov.uk/government/collections/norovirus-guidance-data-and-analysis

Health and Social Care integration

Actions to reduce winter mortality, and morbidity, and winter pressures on the NHS and social care system provide opportunities for greater integration of health and care commissioning.

PHE has recently published tools that:

- forecast total non-elective and avoidable emergency admissions. Local area can use this data to confirm that their Better Care Fund (BCF) plans address any adverse trends identified by the tool (accessible here

http://www.yhpho.org.uk/default.aspx?RID=203927).

- give local areas access to indicators related to the BCF and enables comparison with other local authority areas and to the national average. For access to the site and feedback please contact Justin Robinson at justin.robinson@phe.gov.uk

Cold Weather Plan

The Cold Weather Plan for England launched on 21st October is operationally led by Public Health England, NHS England and the Local Government Association. The Plan focuses on reducing harm to health in winter and unnecessary hospital visits and should be considered by all orgnaisations, including Health and Wellbeing Boards. The 2014/15 edition and its associated documents are available here: https://www.gov.uk/government/publications/cold-weather-plan-for-england-2014.

I know that for many, local authorities winter plans are well developed and I am sure that as the clocks go back this weekend, many people will be encouraged to prepare for the winter ahead. As ever, I would like to thank you for the work that you do to promote the health of your communities.

Kind regards,

JANE ELLISON

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Appendix 2 - Overview of Health and Social Care Integration

Our principle	Our objectives for integration	Our measures
We will shift our services from being paternalistic to ensuring that services are designed for and with the people who use them.	People will be involved in the redesign of integrated services	• Patients and service users will be involved in pathway reviews, service specifications and tendering.
Care will be as close to home as possible, with home always as the first option **We will focus care around the person, building up from communities of approximately 20,000 people** **We will join up care at a local level and will work with communities to integrate care around clusters of GP practices and other community settings**	We will create multi-disciplinary teams, wrapped around primary care clusters, providing integrated, accessible care in local communities. These teams will work across community health services, social care, mental health, voluntary sector, commissioned Help to Live at Home providers and other community resources such as sheltered housing. Services will match levels of needs in each community and existing inequalities in levels of service provision in some parts of the county will be levelled out.	• Emergency attendances and admissions to acute hospitals will not increase • Long-term care home admissions will be reduced • Activity levels of community health services will increase • Patient and customer experiences of services will improve
We will ensure that care is coordinated for all older people, particularly to support those at risk of deterioration and hospital admission.	We will create a team around the person, with someone to coordinate care between all professionals and agencies involved, so that people at the receiving end feel in control.	• Emergency attendances and admissions to acute hospitals will not increase • Every older person will have a named GP and a coordinated support plan • It will be possible to share information between professionals so that care is more effective, more timely and more safe
We will build on the council's work with local communities on the development of campuses	Within the next 5 years, we will see accessible locations within communities bringing together services such as primary and community health with leisure, library and other council services and the voluntary sector. Facilities can be used imaginatively as a resource to promote health and wellbeing and provide treatment.	• Patient and customer experiences of services will improve.
We will support individuals and communities to take more personal responsibility for their own	We will focus our investment in voluntary and community services, working towards a shift in investment towards	• Reliance on urgent and crisis services will reduce. • Patient and customer

health and wellbeing	more preventative services and more accessible information and advice to promote self-care and independence	experiences of services will improve – people will feel more in control of their care
We will ensure that carers are supported	We will continue to use our carer's pooled budget to provide options for carers and we will plan for new responsibilities to carers under the Care and Support Bill. We will offer carers personal budgets to allow them more choice and control over their support	• Carers' experiences of services will improve
More people will be supported to remain independent	We will develop our intermediate care services to prevent hospital admission and provide a 'stepping stone' for people recovering from a hospital stay. Intermediate care for people with mental health and dementia needs will be strengthened We will seek to implement a system wide approach to Discharge to Assess	• Delayed transfers of care will be reduced • Emergency attendances and admissions to acute hospitals will not increase • Decisions about long term care will not be taken in hospital and admissions to long term care will be reduced • Activity levels of community health services will increase
We will ensure that people have access to the right support when they need it.	People with complex health conditions, including dementia, often need support in the middle of the night or at weekends, and we believe community health and support services should be available 24/7	• People will access new out-of-hours services and unnecessary admissions to acute hospitals will be avoided
We will take a holistic approach, with locally accessible services to support mental health needs	We will integrate mental health and dementia care into our local services and we will support communities to be dementia friendly. We will seek to provide specialist care in community settings We will improve the joint management of the patient s across acute and community care.	• Long-term care home admissions will be reduced for people with dementia • People with mental health needs will not be delayed in hospital
We will ensure that people with dementia can remain independent and living at home for as long as possible within supportive communities.		• A toolkit for dementia friendly communities will be available for Area Boards to use • A Neighbourhood Return scheme will be trialled to support people with memory problems who go missing

People with dementia will be diagnosed early, so that the most appropriate treatment and support is provided to maintain independence		• Diagnosis of dementia within primary care will increase
We will continue to develop outcomes-focussed commissioning, based on our Help to Live at Home model of commissioning	We will commission service providers, including care homes, to focus on outcomes for individuals, in order to give people the maximum independence and choice.	• Care providers will work to contracts with incentives to deliver the best outcomes for individuals • This will reduce the reliance on both acute and community beds
We will reduce duplication of assessments and support plans	We will develop shared assessments and support plans, with appropriate information-sharing systems, and support plans owned by the individuals that they support. We will develop our IT systems	• The number of people with their own single support plan will increase • Patients and customers will say they are be better informed about services
We will minimise delays, with a focus on reducing high numbers of delayed transfers of care across the system	We will review processes for discharge from hospital to minimise delays. The Improvement plan for DTOCs will be overseen by the Integration Director as part of the Better Care Programme We will invest in capacity planning and in 'surge' capacity for community-based services so that our services can better cope when demand is greatest. We will put in place system wide solutions such as the Discharge to Assess programme with home as the default once patient is medically stable We will develop a culture of '7-day discharge'	• The number of delayed transfers of care will be reduced •
We will invest in the capacity and competency of the health and care workforce	We will increase the capacity of the community-based workforce, and ensure they have the skills to support people with complex needs. We will develop a skills	• The objectives of our workforce plan will be met, including increased competencies, improved recruitment and retention of care and support staff.

	academy approach to model and address the supply challenge we are facing. We are benefitting from a systems leadership review which will inform the type of skills, competencies and leadership model we seek to develop in the future.	• The workforce will say they feel valued • The domiciliary care workforce will have a structured career path and zero hour contracts will be minimised

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: End of Life Care

Executive Summary

To report to the Health and Wellbeing Board progress of the multi-agency Wiltshire End of Life Programme Board, which is working to deliver the aims of the End of Life Care strategy. This will include an update on the development of a Joint Strategic Assessment (JSA) on End of Life Care.

The aim of this work stream is to ensure the patient and their family or other informal carer receive the care and support that meets their identified needs and preferences through the delivery of high quality, timely, effective individualised services and that respect and dignity are preserved both during and after the patient's life.

A dedicated multi-disciplinary programme has been developed and work streams are moving towards implementation.

Proposal(s)

It is recommended that the Board:

i. Receives the update on the End of Life programme and implementation progress
ii. Receives the Joint Strategic Assessment (JSA) and provides any comments on the draft document

Reason for Paper

To update the Health and Well Being Board on progress on:

- Development of the End of Life programme, agreed implementation and deliverability to date
- Development of an End of Life JSA

Jacqui Chidgey-Clark
Director of Quality and Patient Safety
Wiltshire CCG

Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: End of Life Care

Purpose of Report

1. To provide a further update on the multi-agency Wiltshire End of Life (EoL) Programme and the deliverability of the work streams to date. The paper also includes the draft Joint Strategic Assessment (JSA), which has been produced by Public Health in consultation with the Programme Board.

Background

2. The key aim of the programme is to develop patient and family centred care that improves patients' and family's experience. Planning and delivering this requires the involvement of a wide range of agencies and the membership of the Programme Board and the associated working groups reflects this. There are presently in excess of 20 organisations and interest groups in the programme's work and this membership is under continual review. A list of these feature in **Appendix 1**. In working towards the aim of improving the experience of care, the following objectives have been identified:
   - To ensure that individuals can access appropriate high quality care at all times. To deliver this we will need to ensure that all providers are skilled and competent in delivering high quality EOL care services. Services will need to be effective and efficient and this will need to include cost effectiveness.
   - To reduce inappropriate transfers of care from all settings
   - That people are empowered to plan their care and supported to die in their preferred place of care
   - That patients and families have choices and feel informed about them
   - That services are flexible and there are equitable services for those with dementia

Main Considerations

<u>Implementation Update</u>

3. To deliver the key objectives, the Programme Board has targeted its action plan to deliver the following eight key work streams, which were derived from feedback from multi-agency stakeholders:

   1. Needs Assessment – Public Health
   2. Current Service Mapping – CSSU

3. Allowing a Natural Death – (Treatment Escalation Plan and DNACPR)
4. Electronic Patient Care Co-ordination System (EPaCCs)
5. User Experience – Patient's Association
6. CHC Fast Track process review
7. Education
8. Care at Home

Each of these groups now has project management resource provided by the CCG and multi-agency involvement in the groups. A table documenting the recent work streams and planned next action milestones for each project features in **Appendix 2**.

4. The Allowing a Natural Death work stream is nearing completion. A Treatment Escalation Plan (TEP) form has been agreed to ensure a patient's wishes are documented and shared. The aim of this work stream, which is now moving into the implementation stage, is to improve communication across the health economy and prevent repetitive difficult conversations for patients and their families. A copy of the form features in **Appendix 3**.

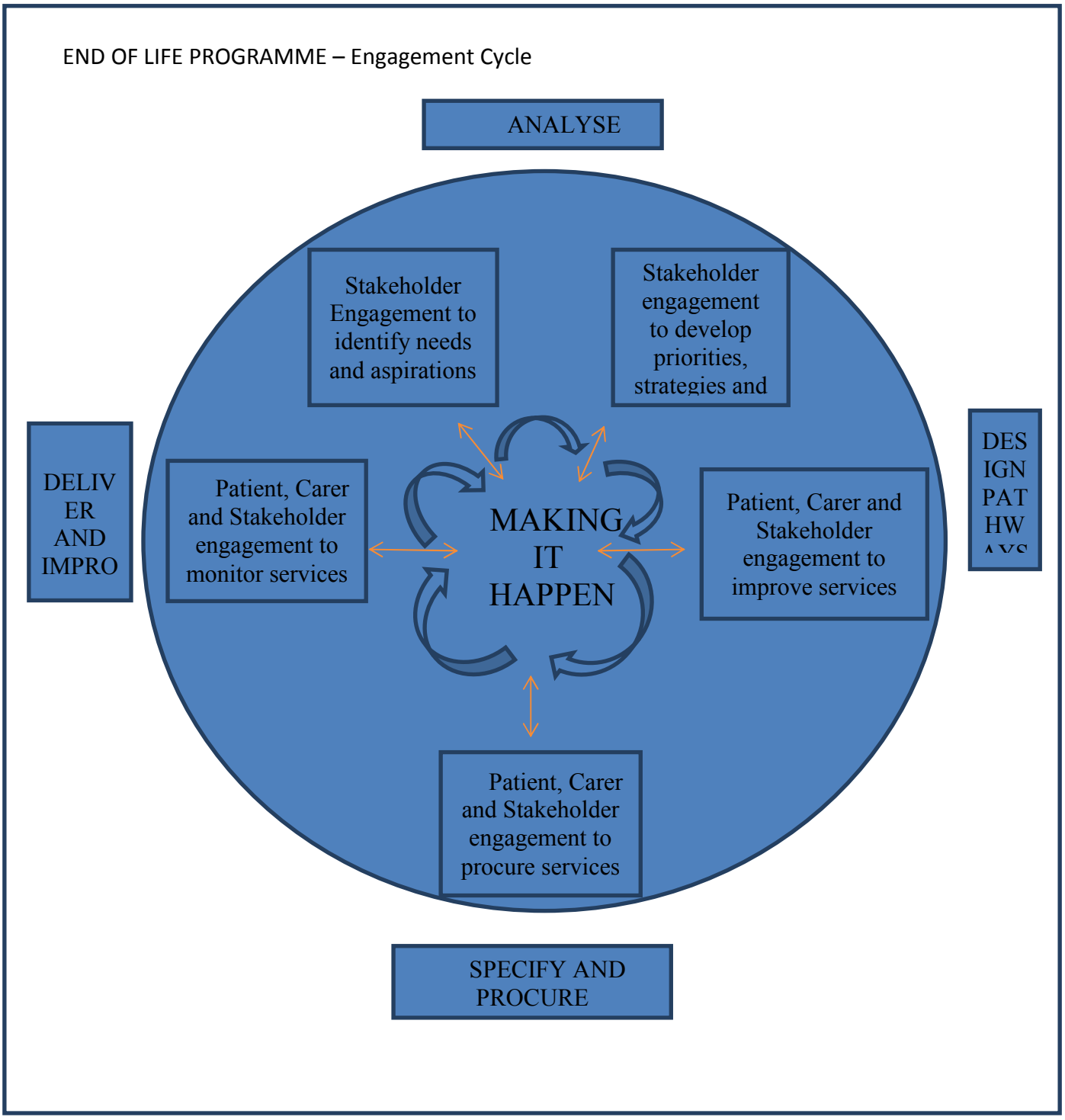
   The group has obtained agreement for roll out from all but one provider, which is being addressed. Bath and North East Somerset CCG also wish to adopt this process, which will create continuity for patients and providers.

5. Public Health is leading the multi-agency development of a Joint Strategic Assessment (JSA). This has now been completed and was discussed at the September End of Life Programme Board. A copy features in **Appendix 4**.

6. An Education Project lead has now been appointed and the project brief defined. Education will be a key umbrella function linking with all project managers. There will be a separate education stream focusing on diagnosis of the terminal phase with care homes, domiciliary workers and night sitting providers.

7. A multi-agency workshop, including service users, has been held to explore what a good death looks like and define the phases of death. The next workshop will be focusing on support to keep those patients who want to remain at home through the declining and dying phases.

8. A draft Communication and Engagement Strategy for the End of Life programme has been developed. This includes a work stream to obtain patient, family and carer feedback on current service provision via the Patient's Association.



Risk Assessment

9 The End of Life Programme has a risk register as part of the project management approach. The key current risks and mitigating actions feature in the table below:

Risk	Mitigating Actions
1. EPaccs – Current system not technically supported leading to risk in event of IT failure	Plans to cease use April 2014 and link with new IT community model
2. Baseline for provision and spend on End of Life Care still not	Escalated at CCG director level

provided by CCSU	
3. Patients transferred inappropriately to acute hospital due to lack of communication between multi-agency providers. Repetitive sensitive discussions around patient's end of life wishes	Revised Treatment Escalation Plan process (TEP) to be introduced Wiltshire wide Improved communication via TEP and Anticipatory Care Plans
4. One provider not signed up to new TEP process and documentation	Escalated to Medical Director and Clinical Chair level for resolution

Financial Implications

10. There are currently no Quality, Innovation, Productivity and Prevention (QIPP) savings target associated with this work programme. However, the vision is to reduce preventable acute hospital admissions for patients who are in the end of life phase. Requirements for care at home provision will be mapped as part of that work stream including financial elements.

Conclusions

11. The multi-agency programme, which was formed from the creation of the End of Life Strategy, is moving towards implementation phase. Work is continuing at pace to ensure the aims and objectives of the programme are met.

Jacqui Chidgey-Clark
Director of Quality and Patient Safety
Wiltshire CCG

Report Author: Lucy Baker, Interim Associate Director- Wiltshire CCG

Background Papers
Published documents: End of Life Strategy
The following unpublished documents have been relied on in the preparation of this report: End of Life Communication and Engagement Strategy - Draft

Appendices
Appendix 1 - Stakeholders involved in the End of Life Programme Board and associated work groups
Appendix 2 – Project work streams update - attached
Appendix 3 - Copy of Treatment Escalation Plan (TEP) - attached
Appendix 4 – Copy of Joint Strategic Assessment (JSA) - attached

Appendix 1 - Stakeholders involved in the End of Life Programme Board and associated work groups:

- Patient and carer representatives
- Various GP's from across the county
- Dorothy House Hospice
- Prospect Hospice
- Salisbury Hospice
- Great Western Hospital
- Great Western Community Services
- Royal United Hospital
- Salisbury Foundation Trust
- Wiltshire Council
- Medvivo
- Cruse Bereavement
- Patients Association
- Marie Curie
- Community Team for People with Learning Disabilities
- South Western Ambulance Service
- BaNES CCG
- The Complete Group
- Order of St John's Care Homes
- Somerset Care
- Mi Homecare
- Carers Programme
- Macmillan Cancer Support
- Healthwatch
- Harmoni 111
- Avon and Wiltshire Mental Health Partnership
- Motor Neurone Disease Association

Appendix 2 – Project work streams update - attached
Appendix 3 - Copy of Treatment Escalation Plan (TEP) - attached
Appendix 4 – Copy of Joint Strategic Assessment (JSA) - attached

Project/Topic	Owner	Progress made, including performance outcomes	Dependencies	Planned Activities for next period	Status	Risk
Education	Carole Hewitt	Dedicated project lead now in post and project brief revised.	• Care at Home • EPaCCs • CHC Fast Track • Allowing a Natural Death	Development of educational work stream around diagnosis of terminal phase with care homes, domiciliary workers and night sitting services. Links with project managers to define educational elements throughout work streams as part of transition to implementation phase.	G	G
Care at Home (Project)	Louise Sturgess	Awaiting baseline costing information from CSU. Initial workshop held October 2014 to map current pathway and provision.	• Service mapping • Needs Assessment • Links to BCF 72 hour work	Second multi-disciplinary workshop November 4th 2014.	G	G
EPaCCS	Jo Whitford	Further meetings with Stakeholders completed. Data cleansing now underway. Options appraisal being drawn up for next Programme Board (Nov).	Link to Allowing a Natural Death and Better Care Fund	Options appraisal and recommendations being drafted in preparation for discussion at November Programme Board	A	A
User Experience	Patient's Association (Louise Worswick) CCG Liaison Emily Shepherd	Defined clear expectations from Patient's Association regarding data capture	Benchmarking and evaluation for • Education • Care at Home • EPaCCs • CHC Fast Track • Allowing a Natural Death	Draft questionnaire and follow up telephone script by November 1st. Full exercise to be completed by December 31st 2014.	A	G
CHC Fast Track	Teresa Blay/Dawn Griffiths	The process map of the current pathway has been completed and the group is obtaining data on the speed and quality of care. Stakeholders have audited current use of the services to establish the level of adherence to the fast track referral criteria and a report produced.	Delivery of the changes required to optimise the use of these services will require support from the education work stream and availability of "standard" community services.	A sub group has been established to finalise the a patient information and will meet in early October with a view to the recommendations being available for consideration by the Programme Board in November. The report of recommendations from	G	G

Project/Topic	Owner	Progress made, including performance outcomes	Dependencies	Planned Activities for next period	Status	Risk
		A workshop to review all findings, review patient information and work on the commissioning care plan has been held. The audit review has confirmed that a high proportion of the sample of referrals were not eligible for fast track care within the definition of the scheme. The issues underlying this are being addressed.		the audit and care pathway work will be developed by the end of October for the November Programme Board. A need for training and education for providers has been identified and this will be taken to the education work stream		
Allowing a Natural Death	Louise French	The EOL Programme Board approved the Treatment Escalation Plan (TEP) tool subject to minor grammatical changes. The form will now be used across Wiltshire by all relevant Wiltshire Stakeholders. There is a partial exception in the case of RUH, who have approved the tool and will recognise it but are working towards their implementation plans. Bath and North East Somerset CCG have agreed to adopt the same TEP tool to provide continuity across the health economy.	• EPaCCs • Care at Home • Education	Closure of this Project and commencement of an implementation project that will link to the education work stream.	G	G
Current Service Mapping	CSSU	CSSU have confirmed that they have not commenced this work. BS new lead at CSU has completed scoping opportunity paper to define what information could be produced.	Programme direction	Recommendation that CSU are advised to complete the work as requested in January.	R	A
Needs Assessment	Sue Odams (Public Health)	EoL programme Board received draft report Sept 2014.	Programme direction	Final draft expected at the end of October. JSA to be presented to Health and Well Being Board on November 20th 2014.	G	G

Guidance for completing Treatment Escalation Plan and Resuscitation Decisions

• This form should be completed legibly in black ball point pen
• Complete patient details (including address) or affix patient's identification sticker

Life Expectancy
The Second Annual Report of the End of Life Care Strategy (DH, 2010) recognised the challenge of identifying who is approaching end of life, and acknowledged that we need to do more to improve the present situation. One of its recommendations was the adoption of the 'surprise question', where a health professional asks themselves, 'Would I be surprised if this patient were to die within the next 6–12 months?' If the answer is no it should lead the professional to consider completing the TEP and RD form.

When completing this form it is important that the healthcare professional has knowledge of end of life procedures and documents. If in doubt refer to your organisation's End of Life Policy.

Healthcare professional making the Treatment Escalation Plan (TEP) and resuscitation decision
Ideally the TEP and resuscitation decision should be made by the most senior medical clinician looking after the patient. However, if a more junior member of staff is completing the form it must be in consultation with their registrar or consultant and documented in the medical notes.

TEP and resuscitation decision review
A fixed review date is not recommended, the TEP is considered as 'indefinite' unless clearly cancelled. The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another and admitted from home or discharged home.

Capacity/advance decisions
If there is any reason to doubt capacity of the patient, a Metal Capacity Assessment must be completed. The two stage Mental Capacity Test is on the back of the form. The assessment of mental capacity is only in relation to the decisions made in relation to this form at the time of the assessment. If capacity changes the form (including capacity) must be reviewed and documented. Clearly document any best interest decision in relation to the Treatment Escalation Plan and resuscitation decision. For further information and guidance please refer to your local multiagency safeguarding policy and procedure and the 'Mental Capacity Act 2005 Code of Practice' (2007).

Summary of communication with patient
State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why. It is good and recommended practice to discuss treatment decisions with every patient but if this would cause distress without any likelihood of benefit for the patient or if the patient lacks capacity this should be recorded.

Summary of communication with patient's relatives or friends
If the patient does not have capacity their relatives, friends or an IMCA must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney (LPA) for health and welfare to make health-related decisions on their behalf, the doctor must ensure that the LPA is valid before consulting the Welfare Attorney (WA). A WA may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original LPA. That person will make decisions as if they are the patient themselves. All their decisions must be in the patient's best interest. If it is felt the WA is not acting in the patient's best interest the Office of the Public Guardian must be informed along with the local Safeguarding Team. Ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes. For further guidance on Best Interests Principles see overleaf.

Members of multidisciplinary team
Ensure that the TEP decisions have been communicated to all relevant members of the multidisciplinary health and social care teams involved in caring for the patient.

Communication across other healthcare settings
For TEP or End of Life patients, the original of this form should accompany the patient on transfer if appropriate. This document remains valid until reviewed/endorsed by the receiving healthcare professional.

Discharge and TEP/DNACPR
Prior to discharge the content of the form should be reviewed and if the patient and/or family are informed about its contents and it is relevant to the clinical situation the original form should accompany the patient. Ensure conversations with the patient and family regarding this are documented. Ensure a photocopy of the form remains in the notes and it is communicated to the GP in the discharge letter.

Ambulance and TEP
In the community the most recent TEP form should be placed at the front of the patient's record.

Organ donation
Patient and family wishes regarding organ/tissue donation after death should be ascertained and documented. It is essential for staff to establish if the patient has previously expressed the wish to be a donor; and if the patient is on the NHS Organ Donor register or carries a Donor Card. Please refer to your organisation's guidelines relating to organ donation.

If following clinical review treatment decisions are changed:
• Clearly score through this form, then sign and date the discontinuation
• File at the back of the patient's notes
• Document the change of decision in the patient's notes
• Complete a new form and insert in the patient's notes

The process for making best interest decisions in serious medical conditions in patients over 18 years

Start by assuming that the patient has capacity. If there is doubt, proceed to the two stage test of capacity:
Stage 1: Does the person have an impairment of, or a disturbance in the functioning of their mind or brain?
Stage 2: Does the impairment of disturbance mean that the patient is unable to make a specific decision when they need to? Their capacity for this decision can be assessed by four functional tests:

1. Can they understand the information? NB. This must be imparted in a way the patient can understand.
2. Can they retain the information? NB. This only needs to be long enough to use and weigh the information.
3. Can they use or weigh up the information? NB. They must be able to show that they are able to consider the benefits and burdens of the alternatives to the proposed treatment.
4. Can they communicate their decision? NB. The healthcare professional must try every method possible to enable this.

The result of each step of this assessment should be documented, ideally by quoting the patient.

↓

Does the patient have the capacity to make this decision for themselves?

YES → Ask the patient.
NB. An eccentric or unwise decision does not imply a lack of capacity.

↓ **NO**

If there an Advance Decision to Refuse Treatment (ADRT) and/or a Personal Welfare Lasting Power of Attorney (PW-LPA)?

YES →
- If the ADRT is the most recent decision:
  - Check that the circumstances of the ADRT match the current circumstances and that the ADRT is valid and applicable.
  - The ADRT then overrides any previous ADRT or LPA appointment.
  - Follow the decision(s) stated in the ADRT.

- If the appointment of a PW-LPA is the most recent decision:
  - Check with the Office of the Public Guardian that it has been registered and includes the authority to decide on serious medical conditions.
  - This PW-LPA then overrides any previous ADRT or LPA appointment.
  - Fully inform the PW-LPA of the clinical facts.
  - Ask the PW-LPA for their decision.

NB. There may be more than one LPA.

↓ **NO**

Is the patient without anyone who could be consulted about their best interests?

YES →
- In an emergency, act in the patient's best interests (see below).
- For any other serious medical decisions, involve an Independent Mental Capacity Advocate (IMCA) which are available locally.

↓ **NO**

- **Appoint a decision maker** (usually after an interdisciplinary team discussion) who should:
  - Encourage the participation of the patient.
  - Identify all the relevant circumstances.
  - Find out the person's views (ie. wishes, preferences, beliefs and values). These may have been expressed verbally previously, or exist in an ADRT or Advance Care Plan made when the patient had capacity.
  - Avoid discrimination and avoid making assumptions about the person's quality of life.
  - Assess whether the patient might regain capacity.
  - If the decision concerns life-sustaining treatment, not be motivated in any way by a desire to bring about the person's death.
  - Consult others (within the limits of confidentiality): this may include an LPA, IMCA or Court Appointment Deputy.
  - Avoid restricting the patient's rights.
  - Take all of this into account (ie. weigh up all these factors in order to work out the patient's best interests).
- **Record the decisions.**
- **Agree review dates and review regularly.**

If there is unresolved conflict, consider involving;
- The Local Ethics Committee
- The Court of Protection, possibly through a Court Appointment Deputy (CAD)

NHS

Treatment Escalation Plan (TEP) and Resuscitation Decision Record

This form is for clinical guidance and it does not replace clinical judgement

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Address:

Write in black ballpoint pen only

Mental Capacity
Do you have reason to doubt the the capacity of the individual to be involved in making these decisions?

Tick: **Yes** ☐ **No** ☐

If Yes you **must** complete the mental capacity assessment overleaf.
Mental Capacity Act (2005)

If the patient is currently very unwell or in the event their condition deteriorates

	Yes	No
Is admission to an acute hospital appropriate?		
Are IV fluids appropriate?		
Are IV antibiotics appropriate?		
Are oral antibiotics appropriate?		
Is artificial feeding appropriate?		
Is De-activation of Implantable Cardioverter-Defibrillator (ICD) appropriate?		

	Yes	No
Acute setting only		
Is ward non-invasive ventilation appropriate?		
Is a referral to critical care appropriate?		
Is a referral for dialysis appropriate?		

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION	Tick
NOT FOR RESUSCITATION/ ALLOW A NATURAL DEATH	Tick

Sign:

Date: **Time:**

Name:

Role: **GMC No:**

Document Rationale/Best Interest for treatment decisions and resuscitation states (be as specific as possible):

There is a legal requirement that the Treatment Escalation Plan and resuscitation decision are discussed with the patient or their Health and Welfare Attorney. Have the treatment decisions been discussed with the patient's relatives/NOK /carers/Health and Welfare Attorney? Tick: **Yes** ☐ **No** ☐

If no, document reason .....

If yes, provide a brief summary of what was discussed and with whom:.....

.....

.....

..... Date ..... Time .....

All treatment decisions above should be reviewed as the patient's clinical condition changes

Have you documented in Medical Notes that TEP form has been completed. Tick: **Yes** ☐ **No** ☐

If appropriate has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Tick: **Yes** ☐ **No** ☐

Date this document was discontinued: .....
Name:
Signed:
Role: GMC No:

On discharge if appropriate and the patient and or family have been informed of the decisions then the original form should accompany the patient and a photocopy should remain in the medical notes

Mental Capacity Assessment

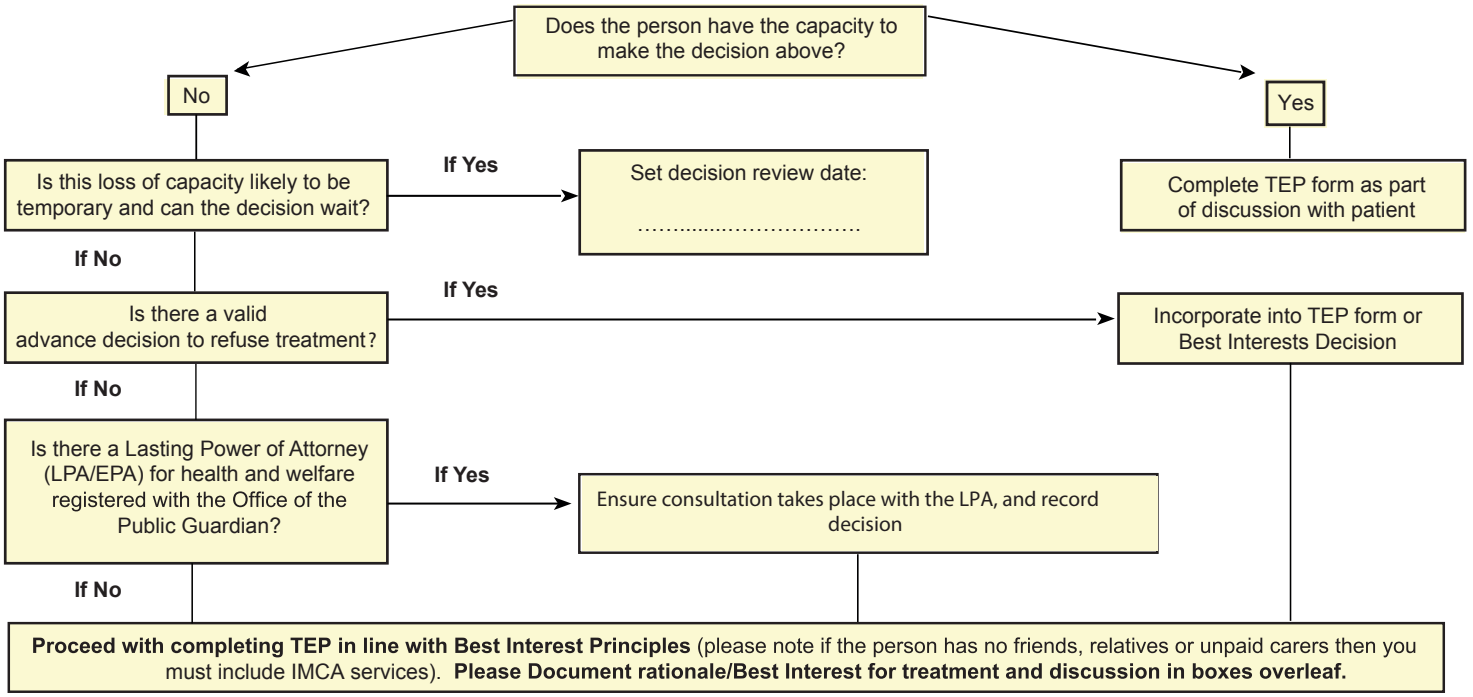
The Mental Capacity Act (2005) requires you to assume that individuals have capacity, unless you suspect the person has an impairment or disturbance of the mind or brain. It also requires any assessment to be time and decision specific. If you suspect someone lacks capacity you are required to complete a Mental Capacity Assessment.

Does the individual have an impairment or disturbance of the functioning of the mind or brain, which may impact on their ability to make the required decision?

Document Details:.....

What is the decision which needs to be made?

4 step assessment - can the patient?	Yes	No	Comment
1. Understand information about the decision to be made?			
2. Retain that information in their mind?			
3. Use or weigh that information as part of the decision making process?			
4. Communicate their decision (by talking, using sign language or any other means?)			



This form should be completed legibly in black ball point ink

- Complete patient details in the top right hand corner
- The date and time of completing TEP should be entered
- This TEP will be regarded as 'INDEFINITE' unless it is clearly cancelled
- The TEP should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, and admitted from home or discharged home

If following clinical review, treatment decisions are changed:

- Clearly score through this form, then sign and date the discontinuation
- File at the back of the patient's notes
- Document the change of decision in the patient's notes
- Complete a new form and insert in the patient's notes

On discharge if appropriate and the patient and or family have been informed of the decisions then the original form should accompany the patient and a photocopy should remain in the medical notes