

# Essex Health and Wellbeing Board

<b>14:00</b>	<b>Tuesday, 20 May 2014</b>	<b>Weeley Council Chambers, Tendring District Council, Council Offices, Weeley, CO16 9AJ,</b>
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## Quorum:

One quarter of membership and will include:

- At least one Essex County Council elected Member
- At least one Clinical Commissioning Group Representative
- Essex County Council *either* Director of Adults Services, Director for Children's Services or Director for Public Health

## Membership:

Councillor David Finch  
Mike Adams  
Councillor Anne Brown  
Dr Anil Chopra  
Councillor Terry Cutmore  
Ian Davidson  
Jacqui Foile  
Councillor John Galley  
Dr Rob Gerlis  
Dr Mike Gogarty  
Dr Sunil Gupta  
Dr Lisa Harrod-Rothwell  
Dave Hill  
Joanna Killian  
David Marchant  
Councillor Ann Naylor  
Andrew Pike  
Dr Gary Sweeney  
Peter Tempest

Essex County Council (Chairman)  
Healthwatch Essex  
Essex County Council  
Basildon and Brentwood CCG  
Essex District Councils  
Essex District Councils  
Voluntary Sector  
Essex District Councils  
West Essex CCG  
Essex County Council  
Castle Point and Rochford CCG  
Mid Essex CCG  
Essex County Council  
Essex County Council  
Essex District Councils  
Essex County Council  
NHS England  
North East Essex CCG  
Essex County Council

## Co-opted Members:

Nick Alston  
Simon Hart

Essex Police & Crime Commissioner  
Independent Chair ESCB & ESAB

## For information about the meeting please ask for:

Ann Coldicott, Governance Officer

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## Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	<b>Apologies and Substitution Notices</b> The Committee Officer to report receipt (if any)	
2	<b>Minutes of meeting held on 27 March 2014</b>	7 - 14
3	<b>Declarations of Interest</b> To note any declarations of interest to be made by Members	
4	<b>Questions to the Chairman from Members of the Public</b> The Chairman to respond to any questions relevant to the business of the Panel from members of the public, notice of which has been given in advance.	
5	<b>Matters of Governance</b> To receive a report by Dave Hill, Essex County Council	15 - 26
6	<b>Healthwatch</b> To receive a report by Mike Adams/ Tom Nutt, Healthwatch Essex	27 - 78
7	<b>Update on Essex 5 Year Plan</b> To receive a report by Dave Hill, Essex County Council and Clare Morris, West Essex CCG and Andrew Pike, NHS England	79 - 82
—	<b>BREAK</b>	
8	<b>Learning Disabilities (Adults)</b> <ul style="list-style-type: none"><li>• Integrated Health and Social Care Strategy and Commissioning Approach</li><li>• Winterbourne View Action Plan Progress Report</li></ul> To receive a presentation by Steve Allen, Essex County Council and Clare Morris West Essex CCG	83 - 96

- 9 Care Bill** **97 - 120**  
To receive a report by James Bullion/ Peter Fairley, Essex County Council
- 10 Date of Next Meetings**  
To note that there will be a special meeting held on Thursday 19 June 2014 at 2.30pm at Essex County Council, County Hall, Duke Street, Chelmsford.
- To note that the next ordinary meeting will be held on Tuesday 15 July 2014 at 2.00pm at Brentwood Borough Council, Town Hall, Ingrave Road, Brentwood, Essex CM15 8AY
- 11 Urgent Business**  
To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.
- 12 Urgent Exempt Business**  
To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

### **Exempt Items**

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.



**MINUTES OF A MEETING OF THE ESSEX HEALTH AND WELLBEING BOARD  
HELD ON 27 MARCH 2014 AT BRAINTREE DISTRICT COUNCIL, BOCKING END,  
BRAINTREE CM7 9HB**

Present:

**Members**

Tom Abel (Vice Dr Anil Chopra)	Basildon and Brentwood CCG
Mike Adams	Healthwatch Essex
Councillor John Aldridge	Essex County Council
Dr Kamal Bishai (Vice Dr Rob Gerlis)	West Essex CCG
Councillor Terry Cutmore	Essex District Councils
Ian Davidson	Essex District Councils
Councillor David Finch	Essex County Council (Chairman)
Jacqui Foyle	Voluntary Sector
Councillor John Galley	Essex District Councils
Dr Mike Gogarty	Essex County Council
Sunil Gupta	Castle Point and Rochford CCG
Dr Bryan Spencer (Vice Dr Lisa Harrod-Rothwell)	Mid Essex CCG
Joanna Killian	Essex County Council
David Marchant	Essex District Councils
Councillor Ann Naylor	Essex County Council
Sheila Norris (Vice Dave Hill)	Essex County Council
Andrew Pike	NHS England

**Officers**

Ann Coldicott	Essex County Council
Charlotte Downes	Essex County Council

**1. Apologies and Substitutions**

Apologies were received from:

Dr Rob Gerlis with Dr Kamal Bishai as his substitute	West Essex CCG
Simon Hart, Co-opted Member	Independent Chair ESCB and ESAB
Nick Alston, Co-opted Member	Essex Police and Crime Commissioner
Dr Anil Chopra with Tom Abel as his substitute	Basildon and Brentwood CCG
Dave Hill with Sheila Norris as his substitute	Essex County Council
Dr Lisa Harrod-Rothwell with Dr Bryan Spencer as her substitute	Mid Essex CCG

**2. Minutes**

The minutes of the meetings of the Health and Wellbeing Boards held on 14 January and 12 February 2014 were approved as a correct record and signed by the Chairman subject to the following correction regarding Minute 8 National Autism 2<sup>nd</sup> Self Assessment – the report was presented by Councillor John Aldridge, Essex County Council and not Linda Hillman as stated.

### **3. Declarations of Interest**

Andrew Pike, NHS England advised that he is one of the assessors regarding the Better Care Fund Final submissions.

### **4. Questions to the Chairman from Members of the Public**

No questions were submitted.

### **5a. Essex CCG 2 Year Operational Plans and Essex 5 Year Strategic Plan**

The Board received a presentation led by Sheila Norris, Essex County Council seeking endorsement of the Clinical Commissioning Group (CCG) 2 year operational plans which were due to be submitted in final form to NHS England as required under NHS planning guidance by 4<sup>th</sup> April 2014 and received an update on proposals for producing CCGs 5 year strategic plans, in preparation for submission to the Health and Wellbeing Board in June 2014; and for producing a larger 'Unit of Planning', in preparation for submission to the Health and Wellbeing Board in September 2014.

The Board noted that for Essex the 'Unit of Planning' should be the Essex HWB area. The Business Management Group (BMG) of the HWB proposed that the 5 year Plan should be an integrated plan for health and social care and had already discussed an outline for developing a draft. The Plan would set out:

- key messages from the JSNA and local needs assessments, including views from service users and patients
- plans for different populations eg older people, working age adults
- identify key Essex enablers and plans for developing these eg data sharing and workforce
- impact of these plans for citizens, commissioners, providers, staff etc
- governance for delivering the plans and monitoring performance and impact.

The BMG had also proposed that an event should be held in May 2014 on the model of the Accelerated Design Event that took place last year. This would provide an opportunity to revisit the vision agreed at last year's event, agree the main elements of the Plan and begin work on the content.

During discussion on this item comments were made about:

- The importance of dialogue.
- Being confident that other organisations have the capacity to deliver what is expected of them.



**Resolved:**

1. That the CCG 2 year operational plans (attached to the report as appendices) for submission to NHS England be endorsed; and
2. That proposals for progressing 5 year strategic plans be agreed.

**5b. Presentation of the final Better Care Fund template for approval for submission**

The Board received a presentation led by Sheila Norris, Essex County Council seeking agreement to submit the Better Care Fund (BCF) templates (attached to the report) to NHS England as required under NHS Planning Guidance by 4<sup>th</sup> April 2014.

The Board were reminded that they need to agree 2 year BCF plans by 4<sup>th</sup> April 2014. In considering the BCF plans the HWB were required to consider whether “they were sufficiently challenging and would deliver tangible benefits to the local population” (linked to the Joint Strategic Needs Assessment and Health and Wellbeing Strategy).

The BCF plan is required to identify which organisation will hold the pooled fund. It had been agreed, in principle, to establish a pooled Better Care Fund from 1<sup>st</sup> April 2015 under section 75 of the National Health Service Act 2006 and for Essex County Council to host on behalf of all partners.

The plans were required to meet 6 national conditions:

- Jointly agreed plans
- Protection for social care services
- 7 days services (discharge and avoidance of unnecessary weekend admissions)
- Data sharing (based on NHS number)
- Joint assessments and care planning with accountable named professional
- Agreement on consequential impact of changes on the acute sector.

The February draft BCF passed through the assurance process with 20 items marked “green” out of a possible 27.

Points raised through the assurance process and by HWB in February have been addressed in the final submission, in particular:

- Implications for the Acute Sector: acknowledgement that more work on this was needed. The final version describes the modelling activity underway and the timetable for completing this activity.
- Reviewed ambition on targets for:
  - effectiveness of reablement (despite the acknowledgement that Essex is already performing above the regional average and in the top quartile for its target metric). We have slightly increased our target from 82% to 84%.

- avoidable emergency admissions. Agreed to maintain target level at a time of population increase. Planned further modelling.

The BCF submission involved the completion of a template covering the HWB area. There is a narrative section covering vision, aims and objectives and sections showing how Essex had met the BCF requirements including provider and service user engagement; fulfilment of the national conditions; planned changes to services covering the BCF schemes; implications for the acute sector of these changes; governance and risks. The rest of the submission covers metrics: baselines and targets proposed against the required and local agreed measures; and details of BCF investment with expected financial benefits.

Having revised the BCF draft plan and taken account of feedback from NHS England (Local Area Team and local government peers) through the assurance process, it was recommended that this now be endorsed by HWB. In doing so it is recognised that there are aspects of the BCF plans which, in common with other areas, require further work and refinement. In these instances action plans with clear timescales have been included in the template. There will be further reporting to HWB on progress in implementing these plans and preparation for the pooled fund in 2015/16.

The Board made the following comments:

- Dr Gary Sweeney confirmed the BCF had been considered by his Board and there was one outstanding matter of principle – the need to be able to attribute health monies to a health outcome and he requested assurance that this can be achieved. The Board agreed this.
- Confirmation that £16M was in social care base budget, £6M was scheme specific and the use of a further £5M was to be determined.
- Risk assessment of spend on acute hospital activity was important.

#### **Resolved:**

- 1.1. That the BCF (attached as appendices 2 & 3 of the report) for submission to NHS England by 4 April 2014 be endorsed; and
- 1.2. That the proposal contained within the BCF templates that ECC will hold the pooled budget also be endorsed.

#### **5c. Primary Care Strategy**

The Board received a report presented by Andrew Pike, Area Director, NHS England.

The Board noted that the Essex Area Team was developing a new primary care strategy for Essex. A strategy had been produced following engagement with stakeholders across Essex. A full version of the draft strategy will be available at the end of March. The Area Team will then have a series of engagement events across Essex co-hosted with the respective CCGs. A final primary care strategy will be produced for the end of June 2014.

The report provided the HWB with some key headlines from the strategy.

***Primary care is the heart of the wider health and social care system. Our vision for primary care in Essex is that it should provide the same high quality service over seven days a week fully integrated with other services creating new models of care and pathways that patients use confidently.***

The new model of primary care will make a commitment to deliver the following key areas:

Consistent  
High Quality  
Responsive and Accessible  
Integrated  
Sustainable  
Preventative

Some questions for engagement by the Board were set out as follows in the report:

- Do stakeholders endorse the objective to bring primary care services together to form hubs which provide a superior service for patients?
- How far should these hubs go?
- Should clear statements about minimum standards patients can expect to receive be included in the strategy?
- Do you welcome seven day working for primary care?
- Do you think pharmacists, dentists and opticians could be doing more in the community? If so, what could they be doing?
- Should we embrace new technologies to deliver primary care services differently?
- Should the strategy state that all GP contracts should eventually (in the next five years) be held by at least two GPs in partnership to ensure stability and sustainability?

During discussion on this item the following comments were made or questions were asked:

- Is there an overview of what investment is needed in specific areas to provide similar services across the area? The Board were advised that 3 and a half million had already been assigned to providing new buildings in

Stansted, Ongar and Frinton and other schemes had been put forward for Witham and Braintree.

- Councillor Ann Naylor asked for an assurance that there would be investment for training. The Board were advised that the plan was to provide a training hub which would enable training to be provided to a larger group.
- There was a general acceptance that services for people with a learning disability could be better.
- Mike Adams asked for an assurance that public engagement would be at the forefront of developing the strategy.
- Andrew Pike confirmed that whilst the Strategy was being co-ordinated by NHS England, local ownership was required. He urged members of the Board to speak to his colleague Ian Stidston in more detail about the proposals.

**Resolved:**

That the proposed Strategy be noted.

**6. Implications of the Children and Families Act for Children with Special Educational Needs and Disability (SEND)**

The Board received a report by Tim Coulson, Essex County Council advising the Board of the implications of the new legislation for joint commissioning of services for Children with SEND between Education, Health and Social Care and asking the Board to consider and approve the next steps in ensuring that Essex has a co-ordinated response to the new SEND legislation in the Children and Families Act in time for its implementation in September 2014.

The legislation requires:

- Greater focus on outcomes and achievement for children and young people with SEND;
- The Local Authority to work with health to jointly commission services to deliver integrated support for children and young people with SEN 0-25;
- Consultation with children, young people and their parents in delivering the new system;
- Cooperation with a range of local providers to deliver the new system including providers with whom relationships may not be so well established currently, for example post 16 education and training providers;
- Publication of a local offer of SEN services and provision;
- Local Authority to publish comments on the adequacy of the Local Offer and what steps it will take to improve services where complaints are made.

- Provision of a coordinated education, health and care assessment for CYP 0-25 and a new EHC Plan if required; this will replace the current system of SEN statements in schools and Learning Disability Assessments (LDAs) in further education and training;
- Offering those with EHC plans the option of a personal budget;
- Reviewing transition from children to adult services and whether to use the new power to provide children's services to over 18s to smooth transition

The Government is currently developing a new SEN Code of Practice which will act as the statutory guidance on implementing these requirements. Draft versions have been available for consultation and a final version is now awaited by spring 2014.

The draft Code of Practice also places an expectation on CCGs that a Health Officer (DHO) should be identified, whose role will be to ensure that the CCG is meeting its statutory responsibilities for SEN.

During discussion of this item the following comments were made or questions asked:

- SEN services will apply to children/ young people upto 25 years old, the cost of this change will need to be considered along with what happens to the person once they are over 25.
- Data sharing would be an essential part of implementing these changes.
- Mike Adams advised that Healthwatch were at present undertaking work around aspirations, personal budgets and practicalities and advised that he would talk to Tim Coulson direct.
- The Board were advised that more work was required in order to scope the cost of the proposed changes.

#### **Resolved:**

That the proposals of the SEND strategic Oversight Group as to how Essex is going to implement the SEND reforms be agreed specifically that:

- The Strategic Maternity, Children and Young People's Integrated Commissioning Group will oversee and manage the development of joint commissioning in priority areas with health, education and social care, for example, speech and language, occupational therapies as set out in the Integrated Commissioning Intentions document.
- Acknowledge the commitment required of Health partners as outlined in the NHS Mandate and NHS England operational plan, including engagement in the relevant SEND work streams to implement the bill;
  - Joint commissioning

- Education, Health and Care (EHC) Plans
- Personalisation
- Local Offer

## **7. OFSTED Inspection Feedback**

Joanna Killian, Essex County Council advised that a major inspection of Children's Services had recently been undertaken at Essex County Council and she was delighted to announce the outcome was "Good". The inspectors had observed children in care were happy and doing well and had also mentioned the good partnership working at Essex.

## **11. Date of next meeting**

The Board noted that its next ordinary meeting is scheduled to take place on Tuesday 20 May at 2pm, at Tendring District Council, Town Hall, Station Road, Clacton-on-Sea CO15 1SE.

The Board also noted that there would be an extraordinary meeting which is scheduled to take place on Wednesday 19 June at 2:30pm, in Committee Room 1 at County Hall, Chelmsford.

## **12. Urgent Business – Harwich and Clacton Maternity Unit**

The Board were advised that there was significant local concern in the Tendring area regarding temporary changes to services affecting the Harwich and Clacton Maternity Unit and the possibility of having to travel to Colchester. The matter was due to be discussed at the local Health and Wellbeing Board and at Health Overview and Scrutiny Committee.

Chairman  
20 May 2014

<b>Report to Health &amp; Wellbeing Board</b>	<b>Reference number</b> <b>HWB/13/14</b>
<b>Date of meeting</b> 20 May 2014	<b>County Divisions affected by the decision</b> All Divisions
<b>Title of report</b> Matters of Governance for consideration by Health and Wellbeing Board	
<b>Report by</b> Dave Hill, Executive Director for People Commissioning	
<b>Enquiries to</b> Sheila Norris, Integrated Commissioning Director - Telephone 07740 180043, email <a href="mailto:sheila.norris@essex.gov.uk">sheila.norris@essex.gov.uk</a>	

## 1. Purpose of report

- 1.1. Key developments such as the Better Care Fund, pooled budgets and integrated and joint commissioning arrangements require a more agile approach to governance. This report suggests various amendments to bring about a more streamlined approach to decision making, which includes making changes to the membership of the HWB. This report asks the Board to consider and amend the governance and accountability arrangements for Health and Social Care integration.

## 2. Recommendations

- 2.1 Agree to appoint the following additional members of the Health & Wellbeing board:
  - (a) two representatives of the acute hospitals trusts (Colchester Foundation Trust and the Mid-Essex, Princess Alexander, Basildon and Thurrock and Southend NHS Trusts); and
  - (b) one representative from each of the North Essex Partnership Trust and the South Essex Partnership Trust

Such representatives to be appointed by the Board on the nomination of the relevant trust(s)

- 2.2 Wind up the Business Management Group.

- 2.3 Establish a Secretariat representing health partners (membership to be agreed by a future report to the Board) to plan the Board's business and to ensure that regular strategic reports are considered by the Board, giving assurance on agreed spend and outcomes in pooled budget areas.
- 2.4 Agree that the Board will appoint task and finish groups, chaired by a HWB member, to undertake special reviews on specific areas to report back to the Board on their findings.
- 2.5 Establish a 'Health and Social Care Programme and Project Board, representing health partners (membership to be agreed by a future report to the Board), to manage the health and social care integration agenda
- 2.6 Confirm that the Board will (subject to approval by the ECC Cabinet and CCG Boards) consider annually the County wide pooled budget arrangements between Essex County Council and the CCG's, including the 'envelope' of resources
- 2.7 Recommend that each CCG invites a member of the Council, nominated by the Leader, to attend and speak at their Board meetings.
- 2.8 Confirm that the key activity of strengthening and mobilising communities arising from the 'Who Will Care?' commission is progressed by the Essex Partnership Board, with regular reports to the Board.

### **3. Background and Proposal**

- 3.1 Health and wellbeing boards are an important feature of the reforms introduced by the government in the Health and Social Care Act 2012. The overall purpose of the boards is to bring together bodies from the NHS, public health and local government, including Healthwatch as the patient's voice, jointly to plan how best to meet local health and care needs. The Board's full composition and terms of reference are set out in appendix 1, but the principal statutory duties are:
  - 1. to assess the needs of their local population through a Joint Strategic Needs Assessment (JSNA).
  - 2. to set out how these needs will be addressed through a joint health and wellbeing strategy that will offer a strategic framework in which CCGs, local authorities and NHS England can make their own commissioning decisions.
  - 3. to promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets.
- 3.2 The size of Essex gives it unusual complexity. There are five CCGs, 5 Acute Hospitals, 12 District Councils and a diverse community and voluntary sector. Southend and Thurrock unitary councils, with a further two CCGs in those areas, also add complexity.
- 3.3 The existing operating model and governance structure between the Council and the NHS/CCGs requires further development. The volume of business relating to



health and social care integration programmes has increased and current arrangements were not designed to support the leadership and delivery of a complex change agenda. For example, much of the detail of integration programmes needs to be agreed on a CCG locality basis and ECC Members are not party to these discussions. As the health and social care integration process gains pace the governance arrangements are in need of review.

- 3.4 Other partner agencies such as district councils, Police, voluntary sector also have a close interest in health and social care integration, and any new arrangements need to recognise their role. No changes are proposed to the involvement of these partners in HWB arrangements but they have an interest in the recommendation below relating to 'Who Will Care?'
- 3.5 Hitherto the governance arrangements have had at their centre the Health and Wellbeing Board (HWB). This ran for a year in shadow form, before becoming a statutory body in April 2013. The HWB is required to be constituted as a committee of the County Council and is governed by the structures and processes of the Council.
- 3.6 The Better Care Fund (BCF) has deepened and accelerated the integration agenda and further integration is now confirmed government policy, with an expectation of full integration by 2017/18. The BCF will bring about a 'pooled budget' situation from 2015/16 between the Council and the five CCGs. These pooled budgets, although hosted by the Council, will effectively be the vehicle for progressing a joined up and integrated approach to commissioning and delivery of services.
- 3.7 The emergence under BCF of pooled budgets between the Council and 5 CCGs (although pooled budgets between the Council and wider NHS are not new), raise some very particular issues regarding governance. Effectively the Better Care Fund plans are a joint statement of deployment of resources and outcomes, between the CCGs and the County Council. As a result it is necessary to review how the Board Operates.

### **Future Support for the Board**

- 3.8 In and around the Health and Wellbeing Board there are presently a number of functional groups that have been formed. Any review of future arrangements needs to consider these in the round alongside the HWB. The prime group is known as the Business Management Group (BMG). This is comprised of senior Council officers and the Accountable Officers from the five CCGs. NHS England and Healthwatch also attend. The BMG meets fortnightly and its role, remit and purpose has grown in the 18 months that it has existed. In order to improve management of business, it is proposed to replace the business management group with two groups (there may be many common members of these groups, but the functions are distinct and separate):
  - a. A secretariat for the HWB to manage the agenda planning and business of the Board and ensure that regular high level reports are considered by the board, giving assurance on agreed spend and outcomes on pooled budget areas; and

- b. A programme and project board. This will need to support the HWB to fulfil its statutory functions. In particular it will need to manage the complexity and drive the delivery of the broader health and social care integration agenda. The scope and content of the programme overseen by this board and its terms of reference will need to be agreed by the HWB. It will also be important for the board to ensure there are robust arrangements in place to manage delivery of individual programmes and projects.

### **Membership of the Board**

- 3.9 The role and place of the acute hospitals is key in the health and social care integration agenda, but at present they have not featured in the HWB or other governance arrangements. Neither have other providers of health care. At a simple level, acute hospitals are 'commissioned' by the CCG's, but there is a growing view nationally that unless the acute hospitals are embedded into the partnership arrangements, then transformation of the NHS and social care system will not progress at pace. While the membership of providers offers the opportunity for agreement across the health and care system, it also presents some challenges if HWB is considering commissioning. Further consideration will be necessary to address how to avoid conflicts of interest for providers when the Board is considering Commissioning matters.

### **'Deep-Dive' in specific areas**

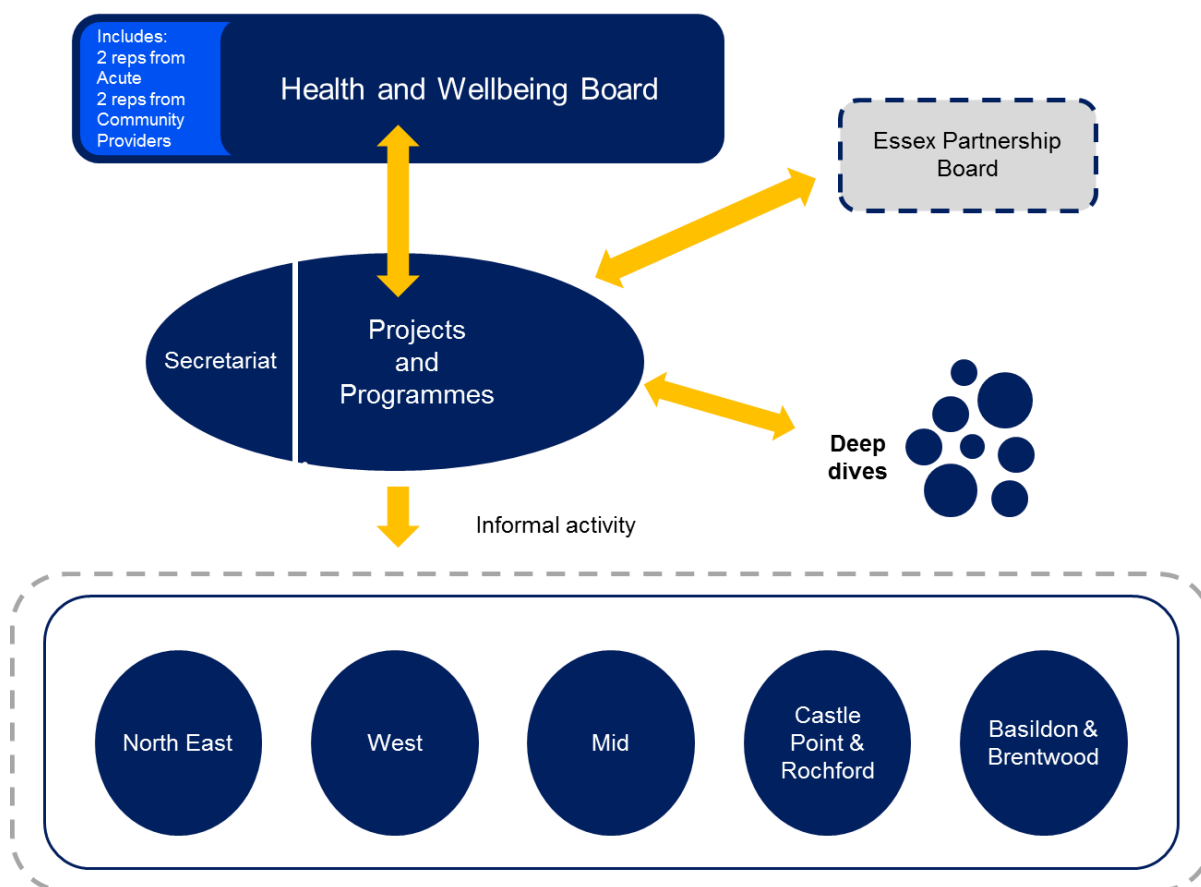
- 3.10 There will be occasions on which the HWB may decide it needs a more in-depth look at a particular area of health or care to support HWB's understanding of the issue. To enable this HWB should have the facility to ask for a task and finish group to undertake a 'deep dive' on a specific area, chaired by a nominated HWB member, with co-opted members as required to monitor progress and report back to the HWB on their findings.
- 3.11 Outside the formal governance arrangements, there should of course be regular meetings of partners to consider the health and care agenda and discuss how this should be progressed.

### **Working with CCG Boards**

- 3.12 It is proposed that the Board should agree annually via Cabinet the county wide pooled budget arrangements between Essex County Council and the CCG's, including the 'envelope' of resources.
- 3.13 In order to promote closer working between the Council and CCGs it is recommended that CCG boards invite a nominated Council member to attend as observers at CCG Board meeting to ensure that within the overall budget parameters that local CCG decisions can be made within the CCG board structures. We recognise that currently neither the Council nor CCGs have the power to appoint to CCG boards. Indeed the regulations do not allow local authority members to join CCG boards. Our intelligence suggests that there may be plans afoot to change these regulations as other HWB areas are finding this prohibition unhelpful. In the meantime Members would attend as observers.

### **‘Who Will Care?’**

- 3.14 That the key activity of strengthening and mobilising communities arising from the ‘Who Will Care?’ commission is ‘owned’ by the Essex Partnership Board, with regular reports to the HWB.
- 3.15 A diagrammatic map of the proposed new arrangements is shown below.



3.15 Next steps include:

- Inviting the 5 Essex acute hospitals to agree their representation to HWB
- Inviting NEPT and SEPT to become members of the HWB
- Reviewing the HWB terms of reference. In particular these would need to cover the requirement for providers to excuse themselves from discussion of items involving commissioning decisions
- Agreeing the scope, format and frequency of high level reports to the HWB to give assurance on agreed spend and outcomes on pooled budget areas.
- Bringing proposals on membership and terms of reference for the secretariat and programme and project management board to the HWB to agree. The arrangements for managing individual programmes and projects also need to be reviewed to ensure these are robust.

- Discussing further with CCGs the arrangements for a Council member to attend CCG boards and nominate these Members.
- Developing detailed proposals on county wide pooled budget arrangements between Essex County Council and the CCG's, including the 'envelope' of resources. These arrangements will culminate in a set of S75 agreements which will be submitted to Cabinet for formal approval.

#### **4. Policy context**

- 4.1. The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.
- 4.2. Health and wellbeing boards are a key part of broader government plans to modernise the NHS to:
  - a) ensure stronger democratic legitimacy and involvement
  - b) strengthen working relationships between health and social care, and,
  - c) encourage the development of more integrated commissioning of services
- 4.3. The Government's stated policy intention is that health and social care integration should be the norm by 2018 and has interdependency with:
  - a) Everyone Counts: Planning for Patients 2014/15 to 2018/19
  - b) The Care Bill
  - c) The announcement of the Better Care Fund (previously referred to as the Integration Transformation Fund) was made in June 2013 as part of the 2013 Spending Round.
- 4.4. The Essex Health and Wellbeing Board agreed the first health and wellbeing strategy for Essex at its inaugural meeting in March 2013. The vision of the strategy is:
 

*By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.*
- 4.5. In March 2014 (and in line with national guidance and timescales), the Essex Health and Wellbeing Board (and the Essex County Council Cabinet) approved submission of the Essex Better Care Fund plans to NHS England. This set out the proposals for spending the Better Care Fund in Essex for 2015/16 onwards and agreed in principle to establish a pooled Better Care Fund from 1st April 2015 under section 75 of the National Health Service Act 2006 and for Essex County Council to host on behalf of all partners. This paper further provides for ECC to agree annually via Cabinet the county-wide pooled budget arrangements between Essex County Council and the CCG's, and to nominate a Council

member onto each CCG board to ensure that within the overall budget parameters that local CCG decisions can be made within the CCG board structures

- 4.6. The review, and proposed extension of, membership is in line with a key recommendation in the 'Who Will Care?' report, published in September 2013. The independent commission, chaired by Sir Tom Hughes-Hallett, made a number of recommendations, including a view that "ideally the leadership [of the Essex health system] must include providers as well as commissioners and, through Healthwatch, the voice of the Essex people." This proposal fulfils that recommendation.
- 4.7. The Health and Wellbeing Board is also crucial to the achievement of a number of the County Council's aspirations as set out in its Corporate Outcomes Framework (agreed in January 2014), specifically the achievement of the following outcomes:
  - Children in Essex get the best start in life
  - People in Essex enjoy good health and wellbeing
  - People in Essex live in safe communities and are protected from harm
  - People in Essex can live independently and exercise control over their lives

## **5. Financial Implications**

- 5.1. Although there are no financial implications as a direct result of these recommendations, the HWB is an extremely influential body and will have significant involvement in allocating future funding streams against the backdrop of the current financial climate for both the NHS and local government.

The Better Care Fund (BCF) has deepened and accelerated the integration agenda and further integration is now a confirmed government policy with an expectation of full integration with 5 years. For 2014/15, reference Department of Health (DH) Local Authority Social Services Letter LASSL (DH) (2014) 1 which set out the two components of funding allocations, the NHS transfer (£900 million) and preparing for the Better Care Fund (£200 million). For Essex for 2014/15 the total £27.131m broken down to NHS transfer of £22.199m and preparing for the Better Care fund £4.932m. This will rise to a minimum Better Care Fund of £94.9m in 2015/16 and be managed through 'pooled budget' arrangements between the Council and the five Clinical Commissioning Groups (CCG's). Pooled budgets are mandatory from April 2015 under the Government's BCF programme, and will be hosted by the Council. They are effectively the vehicle for progressing a joined up and integrated approach to the commissioning and delivery of services.

- 5.2. The financial context for the integration of health and social care is both challenging and uncertain. Health and Adult Social Care services in Essex collectively spend around £2.5 billion each year. Essex County Council spends

around 43% of its 2014/15 net revenue budget on Adult Social Care. The current MTRS for the service incorporates additional funds of £89m over the period to 2016/17 for inflation and demographic growth, offset by planned savings across the service over the same period of £75.3m. Further savings are likely to be required to close the current budget gap reported at County level of £69m. The five CCG's, also need to make aggregate savings in the region of £84.0m<sup>1</sup> (5%) of their combined budgets totalling £1,631.0m for 2014/15.

## **6. Legal Implications**

- 6.1 The HWB was established by the Council as a result of the Health and Social Care Act 2012. The Board's existing membership and terms of reference are reproduced as Appendix 1. As the Appendix demonstrates, the Board has a minimum statutory membership but the Council or the Board may appoint additional members. The Board also has minimum statutory terms of reference which the Council may enhance. As yet it has not chosen to do so. The resourcing and configuration of social care and public health remain responsibilities of the Council's executive. Accordingly advancing the integration agenda requires close working between the Board and the Council's Cabinet in addition to co-operation with CCGs and other health partners.
- 6.2 Additional members of the Board will fall within the statutory definition of co-opted members of the Council. As such they will be subject to the Council's Code of Conduct and statutory requirements resulting from the Localism Act 2011, relating to the disclosure and registration of interests.
- 6.3 By virtue of Regulation 12 and Schedule 5 of the National Health Service (Clinical Commissioning Groups) Regulations 2012 local authority members are not eligible to serve as members of CCG Boards. However if a CCG Board so decided there would be no objection to such a member attending by invitation. If the law in this respect changes, a further report will be brought to the Board.

## **7. Staffing and other resource implications**

- 7.1 There are no staffing implications as a result of these recommendations.

## **8. Equality and Diversity implications**

- 8.1 This report proposes governance changes and is not expected to have any adverse impact on any group with a protected characteristic under the Equality Act 2010.

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<sup>1</sup> Health and Social Care Integration Workshop 18-19 June 2013, page 7

**9. Background papers**

None

## Appendix 1 – Current Membership and Terms of Reference of Health and Wellbeing Board

The Board is established in accordance with Section 194 of the Health and Social Care Act 2012 and constituted to meet local requirements.

### Membership

<b>Membership Statutory Member</b>	<b>How Nominated or Appointed</b>
3 x County Councillors*	As nominated by County Council Leader
Essex County Council Director for Adult Social Care (DASS)	By appointment to post
Essex County Council Director for Children's Services (DCS)	By appointment to post
Essex County Council Director for Public Health (DPH)	By appointment to post
Health Watch Essex	Nominated by Health Watch Essex
North East Essex CCG	Nominated by North East Essex CCG
Mid Essex CCG	Nominated by Mid Essex CCG
West Essex CCG	Nominated by West Essex CCG
Basildon & Brentwood CCG	Nominated by Basildon & Brentwood CCG
Castle Point & Rochford CCG	Nominated by Castle Point and Rochford CCG
<b>Other Member</b>	<b>How Nominated or Appointed</b>
Chief Executive of Essex County Council	By appointment to post
4 Borough/City/District Council Representatives	Nominated by Borough/City/District Council Leaders and Chief Executives Group
Voluntary Sector representative	Nominated by EACVS
NHS Commissioning Board Essex LAT Director	By appointment to post

\*statutory requirement for at least one County Council elected member

The Health and Wellbeing Board has the duty to encourage integrated working. It must:

- for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner;
- in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 (arrangements between NHS bodies and local authorities) in connection with the provision of such services;
- lead the creation, development and publication of the joint health and wellbeing strategy for the Essex health and wellbeing system and recommend to partners;
- approve the publication of the latest version of the Joint Strategic Needs Assessment (JSNA); and
- ensure the development of the JSNA for the County (incorporating the required Pharmaceutical Needs Assessment).

The Board's powers are constrained by its terms of reference and any additional powers that may be delegated by the Council to the Board possibly following agreement with partner authorities. If despite advice, the Board took a decision that went beyond its powers, such a decision would be of no effect.

This will be achieved by:

- engaging partners and stakeholders in the system to oversee development and delivery, within collective available resources, of:
- integrated commissioning and care;
- improving population health status;
- reducing health inequalities;



- ensuring that Integrated Plans have regard to the Joint Strategy and JSNA assessments and, where appropriate, Community Budget business cases;
- holding one another accountable as partners & in partnerships for progress on outcomes in the joint strategy;
- securing democratic legitimacy and involvement in planning and delivery of health and wellbeing services;
- receiving assurance through Health Watch Essex on effective public engagement in commissioning locally;
- approving and monitoring progress on community budget business cases for Health and Wellbeing, Families with Complex Needs, Strengthening Communities and any other relevant business cases that may emerge;
- reviewing current or emergent financial, organisational and service challenges or failures across health and wellbeing services in Essex;
- ensuring system assets are identified and engaged in developing whole system solutions for health and wellbeing;
- developing the framework and system rules to enable partnership working;
- promoting learning and innovation and best practice in partnership working in Essex;
- promoting learning and innovation in person-centred service delivery;
- working collaboratively with neighbouring Health and Wellbeing Boards; and
- encouraging the development of local Health and Wellbeing Board arrangements within Essex



Essex Health and Wellbeing Board	<b>HWB/14/14</b>
Date: 20 <sup>th</sup> May 2014	

### Information and Signposting – proposal and outline plan

Report by: Mike Adams, Chairman, Healthwatch Essex

Enquiries to: Tom Nutt, Chief Executive Officer, Healthwatch Essex

([thomas.nutt@healthwatchessex.org.uk](mailto:thomas.nutt@healthwatchessex.org.uk), 01376 572829)

Purpose of report and Decision Areas and Recommendations	<p>The purpose of this report is to set out a brief summary of current proposals and plans for the creation of a new Information and Signposting service for Essex, to be delivered by Healthwatch Essex in 2014-15. These proposals remain subject to continued discussion between Healthwatch Essex, ECC and wider stakeholders with health and social care.</p> <p><b><i>The Health and Wellbeing Board is asked to note the contents of the report, and is invited to comment on the proposals and to contribute to the planning and implementation of the proposals.</i></b></p>
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## BACKGROUND AND CONTEXT

This report sets out a brief summary of current proposals and plans for the creation of a new Information and Signposting service for Essex, to be delivered by Healthwatch Essex in 2014-15. These proposals remain subject to final agreement between Healthwatch Essex and ECC, as well as continued discussion with wider stakeholders within health and social care.

The following section addresses considerations and background work that has been conducted to date, including:

1. the **policy framework** as set by the Health and Social Care Act 2012, as well as local initiatives such as the Who Will Care? Commission;
2. **people's experiences of finding out about health and social care** services, as captured by in an in-depth study undertaken by Healthwatch Essex, and;
3. a **stakeholder consultation** based on a wide variety interviews with people from statutory organisations across the health and social care economy.

### 1. Policy framework

The provision of a countywide Information and Signposting service across health and social care is a requirement of the Health and Social Care Act 2012. This sets out one of the functions of a local Healthwatch organisation as being to:

'provide advice and information about access to local care services and about choices that may be made with respect to aspects of those services'

This reflects part of the government's wider intentions in reforming health and social care – a position that is further elaborated in policy literature produced by the Department of Health and the Local Government Association. For example, in the LGA's publication, *Establishing Local Healthwatch: Advice, information and signposting* (2012), the role of local Healthwatch organisations is set out as follows:

'In addition to ensuring that the voices of service users, patients and the public are heard in the design, commissioning and delivery of services, the functions of local Healthwatch created by the Health and Social Care Act 2012 include providing a advice and information service to the public about accessing health and social care services and choice in relation to aspects of those services. Later policy documents refer also to a "signposting" service, so the assumption now is that the function should be described as 'advice, information and signposting'.

The Government's purpose in creating this function is "to enable people to take more control of their own health, treatment and care, and understand and use the increased choices available to them".

Local Healthwatch is intended to provide a single point of contact to help people find information about the choices they have or to put them in touch with the right advocacy organisation.'

This statutory framework is relatively clear, and, significantly, it also dovetails into the work of local initiatives, such as the Who Will Care? Commission. For example, in calling for the citizens of Essex to 'take control of [their] own health and that of [their]

families', the Commission put forward recommendations that aim to promote the empowerment of citizens through better access to information. The Commission's suggestion was for:

'An easy to navigate Citizen's Guide to Care in Essex showing how each aspect of care can be accessed and what the core offering to the citizen comprises. This will be supported by a communication strategy, which will support the desire to create a new contract with the citizen – the "SatNav" of care in Essex.

Funding for the Information and Signposting service is made available from the Department of Health Local Reform and Community Voices Grant, via Essex County Council.

## **2. People's experiences of finding out about health and social care**

Whilst this policy framework provides a relatively clear exposition of the overall aim of any prospective information and signposting service, Healthwatch Essex believes fundamentally that any new provision should be oriented closely around people's needs and their lived experience of finding out about health and social care.

In Autumn 2013, Healthwatch Essex conducted an in-depth-study of people's experiences of finding out about health and social care. A series of focus groups were conducted, with a view to obtaining multiple perspectives and insights into local people's information and signposting experiences, preferences and needs.

Eight focus groups were conducted between October and December 2013 with a range of people, including young people, disabled people, informal carers and people with mental health conditions. A total of 59 people took part. The findings were as follows:

### *Experiences*

- Participants described frequently only obtaining information or being directed to services in informal ways, for example 'stumbling across' information following chance meetings with people in similar situations to themselves.
- Health and social care professionals were perceived to be ideally placed to provide information and signposting to health and social care services but lacked time and knowledge to be effective in this role.
- Information and signposting by health and social care professionals was reactive and failed to take into account people's holistic needs, including, for example, emotional support needs and changing needs across key transition points in people's health and social care journeys.
- It was often down to luck that people received information and signposting from health and social care professionals, and sometimes only when they were in contact with professionals for a non-related reason.

- Written information was sometimes provided by professionals, but this was viewed as impersonal and unhelpful when not given in conjunction with personal communication and support.
- Use of the internet to seek information was popular, especially for personal or sensitive issues.
- Poor website design, accessibility issues, and finding information were all barriers to successful use of the internet.
- Conflicting, overwhelming, out of date and inaccurate information were all issues for people using the internet to find out about health and social care services.
- The internet was also perceived as less helpful for finding local information and personalised or individually-tailored information.
- Health and social care staff who responded to telephone queries for information were often lacking knowledge about services, listening skills and the ability to volunteer comprehensive information.
- People often had to make multiple phone calls in order to obtain information, or were passed on to other departments and services with no-one taking responsibility for answering queries and questions.
- Social Care Direct was experienced as being particularly difficult to obtain information from.
- There was a lack of information around mental health issues, including information about signs and symptoms of mental health conditions, and information about crisis support.

#### *Suggestions for improvements*

- Participants wanted a one stop shop for information and signposting to local health and social care services.
- A one stop shop should provide locally-specific and detailed information about statutory and voluntary and community sector services.
- A website and telephone helpline contact details should be extensively publicised to ensure broad awareness.
- Information should be available in multiple formats and be accessible outside normal working hours.
- Of particular importance was a physical presence where people could obtain face to face support with their information and signposting queries.

- Staff recruited to provide information and signposting should receive full training to ensure they have a sympathetic and empathetic attitude, and the skills and ability to gain a holistic understanding of an individual client's needs.
- Staff should take ownership of queries and ensure that clients are kept up to date with progress in obtaining information.
- Peers (who are paid and trained) were viewed as especially valuable in information and signposting roles.
- Information outreach, link and liaison officer roles within health and social care organisations would ensure that people's information and signposting needs are met at the point of care.

### **3. Stakeholder consultation**

During the period October–December 2013, Healthwatch Essex conducted a stakeholder consultation with health and social care organisations across Essex. Senior level professionals (e.g. CEO, Chief Operating Office, Director of Nursing), as well as frontline patient experience managers, were interviewed.

In addition, we spoke to the Citizens Advice Bureau, although Healthwatch Essex has not yet undertaken wider or in-depth consultations with voluntary sector organisations. This was intentionally planned for a later stage, reflecting the view that the initial focus of any prospective service should be on providing information and signposting to services with the statutory sector.

In total, 16 interviews were conducted covering:

- CCGs - 5
- NHS Trusts - 5
- Other - 6 (including CAB, community providers, Essex County Council, NHS England)

The consultation took the form of a semi-structured interview, focussing on the following topics:

1. Demand
2. Supply
3. User groups
4. Organisational dimensions

#### *1. Demand*

There was clear consensus around the future growth in demand for signposting and information services. The majority of stakeholders saw demographic factors, such as an ageing population and improvements in the treatment of long-term illness, as key drivers in this context. The majority of those interviewed also noted that demand was localised in the sense that patients were often seeking solutions in their specific vicinity.

In addition, the growing integration between health and social care was widely identified as a key factor in an anticipated increase in the demand for signposting and information services. A number of stakeholders noted that what patients want is an “end-to-end service”. One senior CCG stakeholder said:

“Patients just see it as their care – not healthcare and social care.”

One stakeholder in a Trust spoke for many others when they said:

“Patients are looking for a solution, not just information.”

This was supported by a widely expressed view that demand from patients is becoming more sophisticated and this is, in part, driven by them being better informed (often by their own online research). This led to a further observation that many patients, having answered their own questions online, then seek reassurance and/or validation from speaking to a ‘real person’. However, a number of stakeholders (particularly those responsible for frontline patient experience work) did emphasise that patients were often looking for practical information such as the “who, what, where and how of services”. Stakeholders from the voluntary/provider sector noted that the question often asked was “what am I entitled to?”

A number of stakeholders pointed out that there was latency within the demand for signposting services that had an impact on both resourcing and on how the extent of a service is defined. One stakeholder in a CCG expressed the challenge as follows:

“People don’t complain because they either don’t know how to or think that nothing will get done.”

Closely allied to this was the dimension of expectation management raised by a stakeholder in the voluntary sector. Speaking for an organisation that handles around 10,000 requests for information and advice per year, this stakeholder felt it was essential for their organisation to set realistic expectations as to what clients could expect in terms of engagement and support.

In one NHS Trust, the focus was on the interaction of demand across health and social care, particularly in the context of mental health patients. It was highlighted that, within mental health, there is a historic ‘culture of dependency’ that can directly impact on what is expected of a signposting or information service. However, there was also recognition that building the capability of these patients to do things for themselves is part of a wider agenda.

Demand management was not an issue that was directly referred to by stakeholders. Attempts to prompt discussion of this mostly led to discussion of how organisations can be resourced and equipped to meet demand as it occurs. However, discussions around ‘self-service’ capabilities (particularly web based) did tend to focus on how this might help to reduce demand for person-to-person contact.

## *2. Supply*



Across the range of stakeholders the issue of how increasing demand is and will be met was a consistent focus. A number of key issues were raised by many of the stakeholders.

Fragmented provision was highlighted as a particular concern in terms of meeting demand. Although a number of stakeholders spoke in positive terms about the provision of localised solutions – often facilitated by collaboration with voluntary sector partners - many also saw this as a major challenge. One stakeholder from the voluntary sector saw their role as:

“...trying to prevent bouncing clients.”

At the same time, it was recognised by some in the CCGs that organisational changes had exacerbated this problem and that this could lead to patients getting ‘lost’ in the system.

It became apparent from interviewing stakeholders that no one has a comprehensive picture of existing provision. Most stakeholders were clear about provision within their own organisation or area, but were less informed about what was happening elsewhere.

A number of stakeholders raised the topic of a centralised database to help ensure that the information that lay behind an improved ‘front end’ was accurate and up-to-date. However, it is clear that, across the commissioning areas and within individual organisations, many different solutions and platforms are in use.

One of the most unifying dimensions across the stakeholder base was the enthusiasm for creating a single point of access for signposting services. Most saw this as an overlay to existing provision enabling the current arrangements to work in a better, more consistent fashion. A number of stakeholders pointed out that a single access point would lend itself to marketing and promotion being undertaken in a consolidated fashion and would help to build universal awareness of the service.

Several stakeholders, particularly those outside commissioning organisations, were enthusiastic about developing a wider range of physical access points. Amongst these, GP surgeries, adult education centres, children’s centres, health centres, pharmacies and libraries were the most frequently mentioned. Some stakeholders noted that by developing outreach capabilities (for example using trained ‘navigators’ in libraries, developing the role of pharmacy staff or Village Agents), access to supported information provision could be improved.

The recognition of fragmentation in current provision led many stakeholders – particularly those in commissioning organisations – to suggest the need for a centralised data source. However, this was often tempered by a perception that there would be (possibly insurmountable) challenges around integration with existing data sources, the initial data harvesting and subsequent maintenance of such a database. As one stakeholder in a CCG stated:

“Primary care does not have the capacity to feed in data.”

In addition, several stakeholders noted that either data was concentrated around a small number of individuals (often in PALS teams) and was not stored in any systematic

or transferable format. It was also noted by one stakeholder that recent cuts in budgets had resulted in a “knowledge drain” in this area with many experienced signposting staff having left the service.

### *3. User groups*

Some stakeholders highlighted levels of inconsistency that have resulted in patchy services that are inaccessible for some user groups.

One stakeholder (with a background in nursing) drew particular attention to this issue in relation to the following groups:

- English as a Second Language
- Deaf
- Blind

Another, again with a nursing background, emphasised the inconsistency that pervades the system, particularly in relation to carers who find it is they who have to chase the information they need. This was summed up as:

“They (carers) couldn’t get information, they couldn’t get through to Social Care. There was complete dissonance between health and social care. They had to do all the running around.”

This problem was highlighted as being particularly troubling in relation to patients (and their carers) in the following ‘high volume, high risk’ groups – dementia, stroke, stoma care, cancer (lung, prostate, breast).

### *4. Organisational dimensions*

A common theme emerging from the stakeholder consultation was the need to look at how information and signposting provision might be streamlined, not just within the healthcare setting, but across health and social care.

One stakeholder in a CCG drew attention to their plans to create an integrated gateway for health and social care packages and saw this as a potential foundation that could underpin a more coordinated approach to providing information and signposting services. The critical dimension with this potential development is that it is focussed around a fundamental organisational realignment which includes elements that would directly impact on the provision of information and signposting service – including a single contact number, a directory of services and a centralised database.

Other stakeholders in CCGs were very aware of the impact of the lack of inter-organisational integration on information and signposting. Although a number of stakeholders referred to their organisation’s use of the Datix platform for managing patient feedback and complaints, these were fundamentally free-standing capabilities. Similarly, a number of stakeholders provided copies of the directory of services for their organisation, but with the caveat that this document is:

“Probably out of date the minute it is printed.”

Several stakeholders referenced their organisation's website as a key tool in providing information for patients. However, several highlighted the challenges they faced in keeping these up-to-date. One stakeholder offered the following assessment:

"our website is rubbish... actually, could we say sub-optimal?!"

Although others reflected the variable quality of the content on their organisations' website, they recognise the role they can and do play in providing better navigation through the system for patients. One stakeholder in the NHS highlighted the importance of providing online information, saying:

"[we] must do this.. it's part of our reputation management."

A significant number of stakeholders highlighted the complexity of the health service and the interface with the social care system as an important barrier to providing good information. Some stakeholders noted that it is difficult for professionals to understand every aspect on the two services and that cross-sector cooperation and collaboration was often pragmatic (for example around hospital discharges or support for cancer patients) and lacked any strategic dimension.

Looking to the future, a number of stakeholders pointed to a need to 'de-risk' engagement with patients so that information and advice could be provided without anxiety about litigation. However, it was recognised that accountability and helpfulness sometimes appeared to be difficult to reconcile.

Stakeholders in the CCGs were understandably concerned with any potential increase in workload that a new information and guidance service might create for their staff. This was commonly seen as a particular issue with the initial provision of data and the ongoing upkeep of it. One stakeholder suggested that the service start out on a small scale – "providing a directory enquiries type service" – building up in sophistication over a period of time.

## PROPOSALS

This section addresses current plans for the proposed Information and Signposting, including:

1. the **definition and scope** of the service;
2. a **two-phased timeline** for the introduction and development of the service, and;
3. **Outcomes and benefits.**

The proposal remains provisional, subject to final agreement between Healthwatch Essex and Essex County Council, and dialogue with wider stakeholders as set out below. This includes a final sign-off by the Healthwatch Essex Strategic Body.

### 1. Scope and definition

Close dialogue between Essex County Council and Healthwatch Essex, as well as wider stakeholders, has underlined the importance of clarifying the scope and definition of the prospective service. It is clear from the policy framework that *information*, *advice* and *signposting* are intended to be at the core of the service. But what do these definitions actually mean, in practice?

### *Information*

Definition: 'the open and accessible supply of material deemed to be of interest to a particular population. This can be either passively made available or actively distributed'.<sup>1</sup>

*Implications (for Healthwatch Essex, for partners, and for the people of Essex):* It is proposed that Healthwatch Essex develops a comprehensive repository of knowledge and facts about health and social care in Essex that can be shared with people via multiple platforms – including the telephone, the internet, printed literature, social media and other forms of outreach. This information base will contain details about services that have been supplied by service-providers themselves, as well as drawing upon existing sources of information (such as databases held by 111, NHS Choices, and voluntary sector organisations). This will necessitate close partnership working and co-operation, and the opportunity is for Healthwatch Essex to consolidate this existing information into one single place. Opportunities to integrate data and systems will be explored, to assess the merit of such an approach – but in the initial stages, it is the centralisation of knowledge (rather than systems) that will add value. Moreover, as the presentation of this information will be informed by the lived experience of people using and accessing the services themselves, Healthwatch Essex will be able to offer a more user-focussed or 'customer-friendly' service to the people of Essex.

### *Advice*

Definition: 'offers guidance and direction on a particular course of action which needs to be undertaken in order to realise a need, access a service or realise individual entitlements'

*Implications:* If the simple provision of information is insufficient to meet people's needs, it is proposed that Healthwatch Essex provides 'guidance or direction' to individuals only so far as it relates to how they might further access the particular advice that they need. Healthwatch Essex will *not* provide specialist advice to people, but would instead offer signposting (see below) or perhaps a 'soft handoff' to an appropriate statutory agency or voluntary sector advice provider, such as Social Care Direct or Age UK. This will require establishing appropriate protocols between agencies, so that 'soft handoffs' can be achieved to smooth individual pathways.

### *Signposting*

Definition: 'the process of giving a client the details of other organisations that will be able to help them'.

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<sup>1</sup> On definitions see, for example, Margiotta et al, 2003, *Are you listening? Current practice in information, advice and advocacy services for older people* (York: Joseph Rowntree Foundation).

*Implications:* If we accept that these definitions of ‘information’ and ‘advice’ form the basis of any new Healthwatch Essex service, then signposting will logically be at the heart of the work.

Healthwatch Essex recognises that many stakeholders have highlighted the risk that the proposed service may extend (intentionally or otherwise) into areas in which Healthwatch Essex would have neither the capability nor capacity to deliver. Such areas – which would be ruled categorically out of scope – include:

#### *Advocacy*

Definition: ‘the provision of support and encouragement, or representation of individuals’ views, needs or rights’.

*Implications:* Healthwatch Essex will *not* offer an advocacy service, but would be well placed place to signpost people to advocacy services when appropriate. A potential benefit to partners and individuals is that better and quicker access to information and/or advice, and hence better and quicker access to services, may help to reduce demand for complaints advocacy. More importantly, it should also ensure that people in need of advocacy are able to access the right kind of advocacy support at the right time. This will require close working between Healthwatch Essex and advocacy providers – which will also allow Healthwatch Essex to glean a system-wide picture of trends in advocacy provision, which will form a key part of Healthwatch’s evidence base to influence the commissioning and provision of health and social care services.

In the light of these definitions, Healthwatch Essex is suggesting that the terms ‘information and signposting’, and not ‘advice’, are most appropriately used to delineate the scope of the proposed service

In summary, consideration of the statutory framework, as well as discussions with Essex County Council, stakeholders and service users, have led an emerging consensus as to what the proposed service should – and should not – do. This is set out in the following tables:

The service *should*:

- Identify what information already exists and how to access it;
- Identify unmet needs so gaps in information can be plugged;
- Have its finger on the pulse of the latest information and news and know where to direct people;
- Fully understand and champion the NHS Constitution and the concept of Personalisation;
- Build people’s knowledge of local Healthwatch as an information and advice resource, ensuring visibility and ease of access;

- Develop relationships with commissioners and providers and provide them with information/intelligence about what issues individuals are requesting information or support around, and also unmet needs;
- Make sure people can get information in different formats that meets their need, e.g. electronic, hard copy, Braille, preferred language translations;
- Use a range of channels to distribute information including but not limited to face-to-face, telephone, web and email;
- Make full use of social networking, and other tools, to reach communities that are otherwise under-represented;
- Have the capacity and systems to direct people to services they require;
- Ensure that it provides feedback to individual members of the public;
- Have systems in place that can record and aggregate information requests for intelligence purposes that complies with the Data Protection Act 1998, and other relevant statutes and regulations.

The service *should not*:

- Tell people what to do, or what course of action to take, or give their opinions about what people should do;
- Give clinical guidance, or anything that could be thought to be clinical guidance or advice on medical interventions or conditions;
- Build up case work;
- Provide counselling;
- Undertake referrals (unless following agreed protocols with local organisations, or a potential safeguarding issue);
- Manage complaints;
- Be a replacement NHS Direct or 111 service.

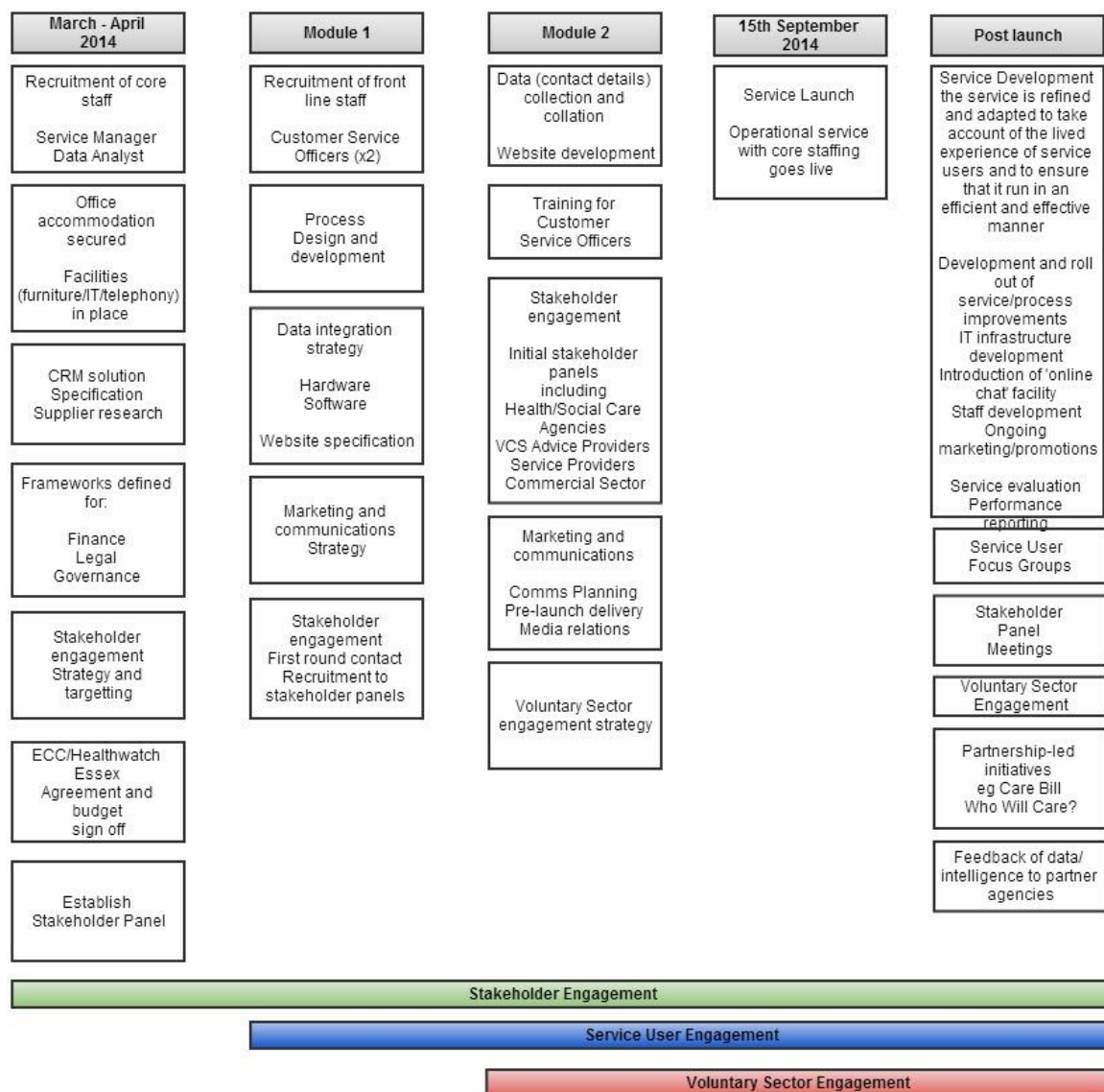
## **2. A two-phased timeline**

The overall project timeline is framed around a proposed launch date for the Healthwatch Essex service in September 2014. A top level timeline is shown on the below.

Phase One covers the period up to September, with Phase Two commencing thereafter. Phase one is aimed at ensuring that a basic infrastructure is in place, and will cover:

- The basic infrastructure of an information and signposting service (staffing, technology, process design, data/information);
- Further stakeholder engagement (including continued service user engagement), so that the service meets initial needs/expectations. Engagement with the voluntary sector is a crucial and new component of this;
- Performance metrics;
- Protocols and processes in place to ensure that data/intelligence is feedback to partner organisations, as appropriate.
- Development of 'Citizens Guide to Care'

Phase Two will see the development and expansion the service, including marketing, exploitation of new technologies, partnership working, and development and implementation of the proposed 'Citizens' Guide to Care'.







### 3. Outcomes and benefits

Healthwatch Essex intends to create a service that will add value by increasing opportunities for coordination, consolidation and collaboration amongst existing providers and future partners, and with clear benefits for service users and the wider public.

*For service users and the public*, it offers the prospect of a better access via a single point of contact, a more seamless journey through the health and social care landscape and the potential for better outcomes. It is worth emphasising that a crucial underlying principle of the service proposed by Healthwatch Essex is that information provided by the service will be informed by the lived experience of service users and the public themselves, thereby creating a more 'customer-focussed' ethos.

In addition to providing this improved 'customer interface' to health and social care, Healthwatch Essex also believes that there are significant benefits that can accrue to the wider health and social care economy through the development of a strong set of partnerships across the health, social care and the voluntary sector. This will enable Healthwatch Essex to build higher levels of:

- *Coordination and consistency*: both at a strategic and operational level, across the county and between health and social care agencies.
- *Inter-agency sharing*: of knowledge, resources and best practice, including staff training and development.
- *Data collection, collation, analysis and reporting*: to inform the development of future policy and to underpin service improvement.

In summary, the new service is being designed to add value at both an individual and a system-wide, strategic level. In addition, the service will complement the core purpose of Healthwatch Essex – through significantly enhancing the capacity of Healthwatch Essex to consolidate evidence of people's voice and lived experience, and to use this to shape and improve the commissioning and provisioning of health and social care services.

### FINANCIAL IMPLICATIONS

Essex County Council (ECC) receives funding through a variety of sources including Department of Health Local Reform and Community Voices Grant, with a requirement to support Healthwatch services. In 2014/15, £780,000 is budgeted for Healthwatch; £480,000 supports the annual operating costs and £300,000 is available to deliver the Information and Signposting service for health and social care.

No additional funding is sought or required from ECC or NHS partner organisations, and the operational structure of the service is designed to fit within the allocated £300,000 funding envelope. The two-phased approach to the introduction of the prospective service is intended to ensure that ECC and NHS partner organisations are fully involved in the design and implementation of the new provision.

As set out in this report, the initial focus of the service is upon improving citizen access to information and services, and to improve inter-agency handling and use of intelligence and management information. At this stage, there has been no modelling of the potential financial benefits of the service, although it is anticipated that this could include a reduction in unnecessary contacts between citizens and statutory agencies, and improved self-management of people's health and social care needs. These outcomes are in-line with the recommendations of the recent Who Will Care? Commission report, ECC's developing customer experience strategy, and the integration agenda between health and social care.

## **EQUALITY AND DIVERSITY**

These proposals have been designed with a commitment to equality and diversity at their centre. For example, the user engagement conducted to date was designed to capture the lived experience of a diverse range of 'consumers' of information, reflecting differences based on age, geography, disability, health condition or a combination of these. This recruitment approach meant individual focus groups were reasonably homogenous, ensuring a constructive group dynamic with participants that were comfortable with each other, and that the experiences of a range of people were explored across the groups. A full description of this is set out in the accompanying report, *Exploring people's experiences of finding out about health and social care services*. (see Background Papers).

Enhanced and wide-reaching access to information is at the heart of the proposals. As the plans develop, Healthwatch Essex will ensure that the access needs of all citizens are met (thereby addressing deficits within the current system), including (for example) people with sensory impairments, or people with language or cultural barriers that prevent appropriate or meaningful access information about health and social care.

A full EIA will be completed as part of the planning process.

## **BACKGROUND PAPERS**

None

# **Exploring people's experiences of finding out about health and social care services**

## **Report of findings**

**December 2013**

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## Executive summary

### Background and method

- This qualitative focus group study aimed to explore people's experiences of finding out about health and social care services in Essex, and understand potential ways of improving people's information-seeking journeys.
- Eight focus groups were conducted between October and December 2013 with a range of people, including young people, disabled people, informal carers and people with mental health conditions. A total of 59 people took part.

### Findings

#### *Experiences*

- Participants described frequently only obtaining information or being directed to services in informal ways, for example 'stumbling across' information following chance meetings with people in similar situations to themselves.
- Health and social care professionals were perceived to be ideally placed to provide information and signposting to health and social care services but lacked time and knowledge to be effective in this role.
- Information and signposting by health and social care professionals was reactive and failed to take into account people's holistic needs, including, for example, emotional support needs and changing needs across key transition points in people's health and social care journeys.
- It was often down to luck that people received information and signposting from health and social care professionals, and sometimes only when they were in contact with professionals for a non-related reason.
- Written information was sometimes provided by professionals, but this was viewed as impersonal and unhelpful when not given in conjunction with personal communication and support.
- Use of the internet to seek information was popular, especially for personal or sensitive issues.
- Poor website design, accessibility issues, and finding information were all barriers to successful use of the internet.
- Conflicting, overwhelming, out of date and inaccurate information were all issues for people using the internet to find out about health and social care services.
- The internet was also perceived as less helpful for finding local information and personalised or individually-tailored information.

- Health and social care staff who responded to telephone queries for information were often lacking knowledge about services, listening skills and the ability to volunteer comprehensive information.
- People often had to make multiple phone calls in order to obtain information, or were passed on to other departments and services with no-one taking responsibility for answering queries and questions.
- Social Care Direct was experienced as being particularly difficult to obtain information from.
- There was a lack of information around mental health issues, including information about signs and symptoms of mental health conditions, and information about crisis support.

#### *Suggestions for improvements*

- Participants wanted a **one stop shop** for information and signposting to local health and social care services.
- A one stop shop should provide **locally-specific and detailed information** about statutory and voluntary and community sector services.
- A website and telephone helpline contact details should be **extensively publicised** to ensure broad awareness.
- Information should be available in **multiple formats** and be accessible outside normal working hours.
- Of particular importance was a physical presence where people could obtain **face to face support** with their information and signposting queries.
- Staff recruited to provide information and signposting should receive full training to ensure they have a **sympathetic and empathetic attitude**, and the skills and ability to gain a holistic understanding of an individual client's needs.
- Staff should take **ownership of queries** and ensure that clients are kept up to date with progress in obtaining information.
- **Peers** (who are paid and trained) were viewed as especially valuable in information and signposting roles.
- **Information outreach, link and liaison officer roles** within health and social care organisations would ensure that people's information and signposting needs are met at the point of care.

## **1. Introduction and background**

Essex County Council requested that Healthwatch Essex undertake a scoping exercise to determine the potential nature of an integrated signposting resource for health and social care services across the county. The scoping exercise aimed to gather stakeholder input from the widest possible constituency of commissioners, providers and consumers and to use this to develop a model that will meet the needs of organisations as diverse as hospital trusts, CCGs, voluntary bodies and service providers.

A desktop review was conducted to understand existing research in this area. This highlighted the need for up to date and local research to understand the views and experiences of people in Essex. Evidence from existing studies shows that information needs are variable and complex, depending on people's situation and circumstances. Different people or groups face different barriers to obtaining information.

In order to develop a model that places patients, service users, carers and members of the public at its heart, Healthwatch Essex has run a series of focus groups as part of the scoping exercise outlined above. These focus groups involved a diverse range of people with a view to obtaining multiple perspectives and insights into local people's information and signposting experiences, preferences and needs.

## **2. Purpose and aims**

The purpose of the focus group research is to ensure that the views and experiences of people who need information and signposting can be considered in proposals for county-wide information and signposting provision covering health and social care services in Essex.

The aim of the focus groups was to explore and understand people's experiences of finding out about local health and social care services, specifically:

- the sorts of information people needed in their particular situations, and why/when they needed information;
- where people got information and how easy this was to do;
- quality of information and/or signposting people received;
- people's suggestions for improvements to information and signposting services.



### 3. Design, methodology and ethics

A series of eight focus groups were planned and set up with the assistance of local voluntary sector organisations. In order to ensure that the views and experiences of a diverse range of ‘consumers’ were included in the research, Healthwatch Essex approached a range of voluntary sector organisations that work with different groups, either based on age, geography, disability, health condition or a combination of these. This recruitment approach meant individual focus groups were reasonably homogenous, ensuring a constructive group dynamic with participants that were comfortable with each other, and that the experiences of a range of people were explored across the groups.

Using focus groups to explore and understand people’s information needs and highlight problems or barriers to accessing information was beneficial for this research in two main ways:

- obtaining multiple views and experiences in a short period of time;
- interaction between participants in the group setting produced useful insights, especially relating to suggestions for improvements to existing information and signposting services.

An approach letter was sent to voluntary sector organisations asking for their assistance and offering an honorarium payment for recruiting focus group participants and arranging a venue (see appendix A). These organisations then invited people to take part, sending an invitation letter and information sheet about the research on behalf of Healthwatch Essex (see appendix B/C).

Focus group participants signed a consent form prior to taking part in the group discussion (see appendix D). Each group was moderated by two researchers (report authors) using a focus group topic guide (see appendix E). Focus group discussions were digitally recorded and transcribed verbatim. Data from the focus groups were analysed using the framework approach, to identify key themes and allow for exploration of similarities and differences across the groups.

This focus group study was reviewed and granted ethical approval by Essex County Council’s Research & Analysis Unit Research Governance Group (Ref: 09/10/13).

## 4. Sample

Eight focus groups were carried out over a two-month period from late October to early-December 2013. A total of 59 people took part in the eight groups, of whom 35 were female and 24 were male. Table 1 below provides details of the focus groups and a breakdown of focus group participants.

**Table 1: Focus group participants**

Group	Participants
Carers (LD)	8 participants (7 female, 1 male) <ul style="list-style-type: none"> <li>Parent carers of adults and children with learning disabilities including Down's Syndrome, severe learning disabilities and autistic spectrum disorders</li> </ul>
Disabled people	9 participants (5 female, 4 male) <ul style="list-style-type: none"> <li>7 participants with range of disabilities including vision impairment (blindness and low vision), physical disability, developmental disability and mental health conditions</li> <li>2 participants with expertise in information and signposting for disabled people</li> </ul>
Family carers	9 participants (6 female, 3 male) <ul style="list-style-type: none"> <li>7 participants with full time caring responsibilities for spouses or partners with range of conditions including dementia, Parkinson's, ME, MS and mental breakdown</li> <li>2 participants with filial caring responsibilities</li> </ul>
General users	6 participants (2 female, 4 male) <ul style="list-style-type: none"> <li>Range of health and social care experience including participant with chronic life limiting disease and participants with family caring responsibilities</li> <li>Group included volunteers for Citizens Advice with experience of information and signposting for CAB clients</li> </ul>
Mental health	4 participants (3 female, 1 male) <ul style="list-style-type: none"> <li>Group included service user and statutory and third sector service providers with experience of information and signposting for mental health service users and family carers</li> </ul>
Older people	6 participants (4 female, 2 male) <ul style="list-style-type: none"> <li>Range of health and social care experience including family caring</li> <li>Group included volunteers for Age UK with experience of information and signposting for Age UK clients</li> </ul>
Refugees/asylum seekers	8 participants (4 female, 4 male) <ul style="list-style-type: none"> <li>Refugees/asylum seekers from Zimbabwe and Sierra Leone</li> </ul>
Young people	9 participants (4 female, 5 male) <ul style="list-style-type: none"> <li>Aged 16 to 18 years</li> </ul>
<b>Total</b>	<b>59 participants (35 female, 24 male)</b>

## 5. Findings

### 5.1 Experiences

Across the eight focus groups there was consensus that obtaining adequate information and signposting in relation to health and social care services was dependent to a large extent on luck. Participants described frequently only obtaining information or being directed to services in informal ways, for example 'stumbling across' information following chance meetings with people in similar situations to themselves.

*"I'm new to the area and if it wasn't for the fact that I bumped into someone with a guide dog that I started talking to, I wouldn't have known about the support in the area."* (Disabled people group F12)

This situation was viewed as inadequate and people did not want to have to rely on peers for information. However, participants experienced various challenges to obtaining information through more formalised channels. These difficulties were related to the role played by health and social care professionals, use of the internet, and the skills of staff answering information and signposting queries. A key area of concern was the lack of information available relating to mental health issues. These challenges and concerns are discussed in more detail below.

#### 5.1.1 Role of health and social care professionals

Although focus group participants felt health and social care professionals could and should play a key role in information and signposting, they were realistic about the challenges to professionals being effective in this role. Professionals were perceived to lack both the time and knowledge (especially of local voluntary and community services) to be effective. GPs and consultants, for example, were viewed as being ideally placed to provide information about health and social care services, but in reality it was often down to luck, whether people would receive adequate information and signposting from professionals or their GP practice.

*"I think a lot of it for service users is pot luck as to where they hear about services...It's not a postcode lottery, it's like a member of staff lottery, if you get a good GP, or a good person ... at the trust... that then can ...just completely widen [your] options...whereas [you] could come across a staff member that isn't so good at giving out the information."* (Mental health group F7)

*"I'm very fortunate to have been referred to my local hospice but there are many people I imagine with neurological diagnosis, who may only see their consultant once a year, who don't go to a hospice. So how do they understand where they can get chiropodist or a dietician, people who can't swallow food anymore, where do they go if they're walking becomes so ... if they're a single person with an annual trip to see a neurologist, living on their own, aren't a patient of a hospice, I don't know what they do." (General users group F9)*

*"GPs don't put out the leaflets...they say 'You've got X condition, see you in six months'. Where is the information we need? No one is there for us." (Family carers group, M00)*

Focus group participants felt that professionals tended to concentrate on health or social care issues in isolation and often failed to see the 'whole person' and how their needs were interrelated. This meant professionals did not make a holistic assessment of an individual's needs and offer sufficiently tailored information and signposting in response to these needs.

*"There's always more than one thing, [but] they [medical professionals] don't seem to ... see that, they don't see you as a whole person...when it comes to supporting people emotionally, [ ] I don't think... [the NHS] recognises that and it would be better if they could link more to say 'Okay, we haven't necessarily got the time to support you emotionally but we know there's this, this and this', signposting to all of these wonderful charities." (Disabled people group F11, 23)*

Focus group participants also felt that information and signposting tended to be offered in a reactive way once people had reached a point of crisis. This was frustrating as people saw information and signposting as having preventive potential, enabling and empowering individuals to access support and services that would hopefully ensure they did not reach crisis.

*"They wait until you're in crisis before you get offered anything. That's the thing that's sad because I don't want to be completely disabled before my child gets support, just because nobody is listening and I'm coping." (Carers (LD) group F23)*

*"Doing the voluntary work, I'm now seeing people that are newly visually impaired and they're just so isolated because they're told they've got bad eyes, they're told this is going wrong, this is going to happen, this is your next hospital appointment ...*

*and then they're just left to get on with it and they don't know there's all these things out there and what's available and what help's available.” (Disabled People Group F12)*

*“All through life, all the transition times, from birth and diagnosis, starting school and then the transition into secondary school and then adulthood and further education, they're all key times when you need a lot of information to be able to make the right choices for your child... you need the information to be able to be on the correct path and all the services that are available.” (Carers (LD) group F11)*

Focus group participants often obtained information or were signposted only by chance, following contact with a health or social care professional that was unrelated to the issue for which they needed information or signposting.

*“The first time I realised that I wasn't well informed with my sons was when – and I think it was a paediatrician when... one of them had a school medical and said, ‘Of course you get DLA?’, and nobody had told me that they could be entitled to that... and I said ‘But nobody's ever told me about this’ and that was the first time I realised that there were things I should have been told about and the boys were entitled to.” (Carers (LD) group F7)*

*“Luckily I had another child...and the health visitor came to visit me and my older son was in and out of hospital, he was still in nappies just before he started school and I was finding it extremely expensive and ...hard to cope ...She just asked me the simple question, ‘How are you coping with the hospital?’, I said ‘That's fine, I can cope with all that and the travelling but paying for these nappies and trying to find these big nappies’, she said ‘Aren't you getting them free?’ and that was the first I knew and then she said, ‘Aren't you getting DLA?’...She made such a difference...she gave me the information to help me.” (Carers (LD) group F10)*

Where professionals did provide information and signposting, this was sometimes delivered in an impersonal way, without additional communication and support, and did little to reassure people. Often, printed information was out of date, containing contact information for organisations that no longer existed, or had changed their names and telephone numbers. Information was also given that was relevant for specific geographical areas within Essex only, and therefore not useful for people living outside those areas.

*“Somebody lying in a hospital bed with the thought of having part of their body removed and all they get is a five or six page pamphlet from the trust saying, ‘There you go, that’s what happens, go away and read it’, nobody comes to discuss it with them and nobody sits down with them... consultants I don’t think have got the time to spend bedside manner, explaining everything but there should be a back-up to the consultant, [someone] that’s coming through on the wing, to say ‘Right, now we’ll help you go further’.”* (Disabled people group M5, 12)

### 5.1.2 Use of the internet

Focus group participants explained that the internet was often the first port of call for seeking information. For young people and people with mental health conditions, the internet was often seen as a preferred source of information, particularly for information of a sensitive or personal nature.

*“I wouldn’t consider going into school and asking some of the medical staff about a problem... I’d rather just Google it.”* (Young people group M4)

However, a number of problems with using the internet were raised by focus groups participants. Poor website design was frustrating for many, including for people with disabilities for whom many websites offered only limited accessibility.

*“More and more information [is] now web based because it is cheap to produce and easy to produce and it’s easier to send people off to a website [but] so many of those websites are totally inaccessible because of their design... it isn’t only sighted people that have the problem, there are different problems for different disabilities.”* (Disabled people group M10)

Focus group participants discussed how it could be difficult to find information on the internet, and if they were successful in finding it, there was then the issue of the extent to which information could be considered trustworthy. Information might be biased depending on who was responsible for posting the content (for example, drug companies), or unreliable and out of date. The internet also often resulted in overwhelming or conflicting information.

*“I got like 50 billion things, all slightly different, there’s American versions and English versions and you just don’t know what one to look at because they’re all slightly different... It’s a bit hard because you can’t really trust, if you find one website which you think you can trust then look at another one to compare and they’re completely*

*different, that's why people don't usually trust certain websites.” (Young people group F6)*

*“As far as the internet's concerned... older people find it difficult because there's so much information, and a lot of them don't use it because it's a lot of hassle.” (Older people group F19)*

The internet was also seen as less useful in relation to local information being available and kept up to date, and personalised or individually-tailored information.

*“Websites are not the answer by themselves, they are part of the answer; they're particularly good at either the very technical stuff at one end of the very general stuff at the other. As soon as you need interaction and a discussion happening, then forget it, a website's hopeless.” (Disabled people group M25)*

*“There are different services in different areas and so... it's not always relevant for the whole of an area, it's having small localised services and where do people go for that knowledge, that expertise?” (Mental health group F10)*

*“If I look at my condition on NHS Direct, it gives me MIND and Rethink, it doesn't delve into any local levels... what I didn't know, there was a local support group for me as well. So on a national level, I think information's a lot easier to find because you just Google it.” (Disabled people group F5, 14)*

Finally, the internet did not help when people did not know the questions they needed to be asking.

*“If you don't know the question, how do you look for the answer? If you don't know there's something out there, you don't know to ask for it.” (Disabled people group F22)*

### **5.1.3 Skills of staff answering information and signposting queries**

An area frequently reported by participants as a key cause of frustration was the skills of health and social care staff answering telephone queries and dealing effectively with those. Participants discussed a number of problems when seeking information about health and social care services including staff being unknowledgeable about the issue that they were providing the service for, poor listening skills, and not being honest and open about when

they didn't know something. In contrast assistance from staff that took the time to listen, were knowledgeable and volunteered comprehensive information, and treated people compassionately eased people's frustrations.

*"If I talk to [one person], he's curt, rude, gives the minimum of information, only gives you what you specifically ask for. I talk to [another person] and he lays it all out in front of you and tells you what you want to know without you even asking the questions... The person that you talk to can be as nice as pie and they can help you a tremendous amount, or they can just do what they've got to do to get rid of you."*  
(General users group M14)

Often, focus group participants experienced being continually passed on to another department or service, sometimes going round in circles and having to make multiple telephone calls to get the information they needed. This was experienced as frustrating and emotionally draining because of the time-intensive nature of chasing information and the emotional energy required in disclosing complex personal circumstances to multiple personnel.

*I've phoned up for something before now and it's been about my third or fourth phone call before I've got to where I need to be, to get that information. Well we haven't got time for that."* (Carers (LD) group F28)

*"Social Services say 'Oh no, you don't need to phone me, you need to phone [the domiciliary care agency]' and then you phone [the domiciliary care agency] and they say 'No, it's the doctor that should be dealing with that', and by the time you've finished with four or five phone calls trying to get round, you end up back with the social worker... you really don't know where to go, who's responsibility it is to sort out what question."* (General users group F21)

Focus group participants described more positive experiences in relation to telephoning NHS Direct compared with Social Care Direct.

*"They must have the right training on that phone because the phone is the first point of contact... NHS Direct took a while to get it right and I'm not sure they've done it but they're getting there."* (Disabled people group F28)



Social Care Direct seemed to be especially difficult to access information from, with participants describing long waits to get through, and then poor communication with staff who they felt lacked knowledge, did not listen properly, and were not empathetic.

*“You phone somebody ... and the person you're speaking to doesn't understand what you're talking about. Let's be honest, they've got to have a massive mindset to cover all the disabilities that might phone through to them and I feel for them for that, but the general, the basics are not ask silly questions and that's a polite way of putting it and having to constantly repeat yourself because they're not listening to you.”* (Disabled People Group M7)

*“You can get all sorts of really good information off [the internet] as to the sort of services that are provided ... but when it actually comes to accessing those services ...the actual contact then can sometimes leave a bit to be desired... The problems [we] had accessing the right sort of information and the right sort of services [for our disabled step daughter]... There was just a lot of ignorance on behalf of the social workers.”* (Older people group M6)

#### **5.1.4 Information gaps – mental health**

A key theme to emerge across the focus groups was the lack of information available relating to mental health, including signs and symptoms, sources of support and local services and information about benefits.

*“A lot of my friends started getting depression through school... I knew that they had depression; I didn't know how to help them... I wasn't aware of who to go about it and it got to a point where one of my friends was considering suicide.”* (Young people group M3)

*“My Dad had quite a heavy case of depression... my Mum and sister didn't realise and it almost got to the stage where it was too late, so it's the sort of thing that I feel there should be more put out, more information... it should be clearer in the public eye, signs of depression.”* (Young people group M2)

*“I recently went to my GP surgery, had 10 minutes to spare, walked around the notice boards, nearly every wall was covered with some kind of leaflet or campaign or public notice, there was a tiny one about mental health... I was told there are no public notices about mental health and that's true, I'd never seen an advert or a*

*poster, other than dementia, never, ever seen the clinical signs of mental health and I wonder why, there's always ones for heart attacks and strokes and diabetes, why is there never one for mental health?." (Mental health group M3)*

Information relating to mental health was perceived as being only available to people who had already been referred to mental health services and that information at an earlier stage, available to and aimed at both individual and family members, would provide a preventive source of support. Such information should be available in a variety of locations including GP surgeries and pharmacies.

*"At the moment, information [about other support services] is only provided when someone is quite a long way down the journey...someone maybe goes into hospital or has crisis support... and it's perhaps as they're getting better...whereas it would be good if people knew about services when they were becoming unwell, or could maybe be prevented from deteriorating." (Mental health group F21)*

It is of particular concern that focus group participants felt that information about how to get crisis support was confusing and not readily available.

*"The last time I had a psychotic episode which was about two years ago, we didn't have a clue who to contact so we went through our GP who put us through to the trust, who said "you can phone a crisis team", couldn't get through to them, we had a horrific journey the first time because we didn't know they existed... It gets confusing, there's different numbers for different times, which is a bit of a problem." (Disabled people group F19)*

*"People need to know who to contact in case of a crisis. Crisis contact information is particularly important to relatives and it's not readily available." (Mental health group F6)*

Mental health problems were frequently brought up in the discussion among refugee and asylum seeker focus group participants. There were particular stresses associated with their asylum seeker status, including living in overcrowded or temporary accommodation. These issues which meant there was often associated anxiety and depression, which without access to benefits and the ability to pay for prescriptions was sometimes self-medicated with alcohol.

*“With Britain, all our things are not moving and one thing which is killing us, making us all sick like this is because of stress which they put you, you want a place to stay, you want a place to work, so that you can do something in this country but you can’t.”*  
(Refugee/asylum seeker group F7)

*“You end up going for a cheap beer in the supermarket, you drink yourself totally out!”* (Refugee/asylum seeker group M15)

## 5.2 Suggestions for improvements

There was consensus across the focus groups in terms of suggestions for improvements to information and signposting services. Focus group participants felt that there was a clear need for a centralised one stop shop approach to the provision of health and social care information and signposting. This approach should combine a well-publicised single point of contact, comprising a website and telephone helpline. It was considered crucial that a multi-media approach to the provision of information was taken, in conjunction with a physical presence in the form of local information hubs where people could access locally-specific and face-to-face information and signposting support. Careful recruitment and training of staff was seen as vital in ensuring a quality one stop shop service. Finally, focus group participants also discussed the importance of trained (and paid) peers, or outreach/liaison workers in information and signposting roles.

### 5.2.1 One stop shop

Focus group participants felt there was a definite need for a centralised repository of information about local health and social care services. This would ensure that patients, service users, carers and members of the public would know that they could obtain information from a single, trustworthy source.

*“[People] don’t know where to go to get the information ... Particularly when things often happen very suddenly in life and things change quickly and often [people] are trying to root around to find out about housing, care, all this kind of stuff, and they don’t know where to go. So to have one central point to go to who can say this is what’s available, these are the kinds of things that might be available to you, this is how you contact them, is very good.”* (Older people group F6)

It was particularly important to focus group participants that the one stop shop would be able to provide locally-specific information, relating to statutory and voluntary and community sector services available in particular geographical areas of Essex. This information also

needed to be as detailed as possible regarding actual services provided, dates, times and venues for group meetings and information on how to get to venues including public transport provision.

*“I’d like to be able to put my region in so that I can pick up my postcode, my local support groups, I can find out how many members each of them have, what they talk about, whether they have guests, I want as much information as possible.”* (Disabled people group F14)

*“[I want to know about] actual individual services that they provide...not just...‘Here’s a leaflet about the service provider with the basic list of services’. That doesn’t say anything to me, I want more information.”* (Mental health group M17)

*“We don’t get the right information about what services actually do.”* (Family carers group F00)

Focus group participants also talked about the importance of publicising the website address and telephone helpline number for a one stop shop.

*“I think I’d want big advertising, I’d want radio, online, TV ,newspaper, press, everything, I would want to be able to know as much about where I can get [information about] health and social care [services], as I do about how to stop smoking, put it that way. I want to know it so well that it’s second nature.”* (Disabled people group F36)

*“We all know 999, I think we’re all beginning to get to know 111...but if there was a central point for people to ring in...and then that could act as the signpost to... whatever’s located in your area...The most efficient way of doing it would be just to have a single number in the area which people can ring and...to spread information about that number and make sure everybody in the county has got that number, and then people can be referred on to other specialist advisers.”* (Older people group M18,19)

### **5.2.2 Multi-media approach and a physical presence**

Focus group participants felt that a one-size fits all approach was not suitable in meeting different people’s information needs. They wanted information to be available in multiple formats including interactive and multi-media formats. Websites needed to be accessible

and information services should also be available outside working hours. It was felt that such measures would ensure that information was as accessible as possible.

*“If there were a hub it’s no good doing it in Braille, audio and printed, that’s not good enough, you need to be read by someone who has dyslexia, you need to understand that someone with chronic fatigue syndrome will access your service at midnight, it has to be accessible to everybody and it shouldn’t just be ‘We’ll make it as accessible as possible’, that’s not good enough.” (Disabled people group M28)*

*“You’ve got to think that most people of our age join social networks so if you used the likes of Twitter, Facebook, whatever, just use that and you’d get your point across and people would understand it.” (Young people group M21)*

Perhaps most important for focus group participants was that any one stop shop should also have a physical presence. While focus group participants were keen to have a website and telephone helpline, they also wanted opportunities for face to face contact when searching for information. A variety of ways of doing this were mentioned in the groups, including having information points in existing locations (such as Post Office, pubs, GP surgeries, libraries) or via individual information champions. Village agents, Neighbourhood Watch or local area coordinators based on the Australian Local Area Coordination model were discussed as having a potential role in the provision of information and signposting for local health and social care services. For more rural areas, mobile units were also seen as a means of ensuring a physical presence for a one stop shop.

*“People at a desk to talk to... real people! Citizens Advice are nearly there I think. The model’s a good model, even if they don’t have enough appointments or staff, it’s a good model, having a physical base.” Disabled people group F32)*

*“I know it’s gone out of fashion a long time ago, but to have a local resource presence...[a] physical presence where people can just pop in, where all the different providers, statutory or other, have some sort of investment, whether they have someone there one day a week or more than that or less than that or they make sure they keep their information up to date and everyone knows about each other.” (Mental health group F19)*

Face to face communication was also valued as a key means of obtaining personalised and individually-tailored information that was not possible to get through other information gathering methods such as use of the internet.

*“There’s nothing like having a conversation face to face with someone and you ask them the question, ‘What can I do about this?’ and they tell you and then you say, ‘Well yes, I understand that but in my case, I can’t do that because so and so’, and you can really get down to the nitty gritty of things, which you can’t do on a computer. (General users group M8)*

*“I needed the face to face to get the information I needed, to find out what information I could get, so the websites wouldn’t have done it because when you’re using the Screen Reader, you get bored, you get half way down, you haven’t found what you want and you go away and do something else to be honest.” (Disabled people group F25)*

*“If you’re speaking to an individual it’s quicker than either filling in a form or looking on the internet, plus you’ve got your own unique questions and unique situation and a person can answer your individual questions or say, “I can come back to you”, or whatever.” (Older people group F13)*

### **5.2.3 Importance of recruitment and training**

Focus group participants emphasised the importance of recruitment and training of information telephone line and helpdesk staff with the skills both to search for information and signpost, but also to reassure callers and visitors. They discussed how it was often the sympathy and empathy of people answering information queries that was most helpful, and that even if information and signposting was not provided, sympathy and empathy could be helpful to the person seeking information in beginning to cope themselves.

*“It’s partly about attitude...If that person has shown some sympathy and listened to me, even though they couldn’t do anything, it would have helped me...Because you get a feeling that somebody cares about my particular problem, that’s good and it makes me feel better, and actually helps me to cope in very practical ways as well. Just the simple act of talking to someone who acts sympathetically and responds sympathetically.” (Older people group M13)*

*“It’s the personal touch, whereby people are getting support by speaking to somebody rather than sitting on their own reading something, and still not quite understanding where they are. It’s very impersonal, looking up things on the internet, especially if you’re upset or you’re vulnerable, you probably need a little bit of comfort, a little bit of reassurance”. (General users group F8)*

*“The relief that somebody is listening to me at long last. May not be able to do much but at least they’re listening and be able to suggest which way to go... that can make such a difference...information and how it’s delivered is so important.” (Older people group M10)*

There was also discussion of the ability of staff to ask questions of the caller or visitor that would enable them to obtain a more holistic picture of their health and social care needs. For example, an individual might call with a single issue or query, but the right questioning will reveal multiple issues for which information and signposting can be helpful.

*“It’s nice to be able to come to one place to be able to get information on a number of subjects...Expertise...makes a lot of difference because ...[it’s] the capability, I think, to be able to find the problems that people have. ...They might come with one problem and actually there might be five or six more problems behind that one.” (Older people group F8)*

*“They can sense your frustration sometimes and come to your rescue, where you wouldn’t normally have asked the question, they’re actually giving you information that you didn’t know you wanted at one time.” (Disabled people group M26)*

The focus group discussion with refugees and asylum seekers also revealed the importance of cultural awareness of staff and a basic understanding of the range of needs (and obstacles to obtaining information and support) for this group.

Finally, it was important that staff took ownership of queries and made every effort to keep the caller fully informed as to the progress or otherwise being made in searching for information.

*“That first contact, that person that picks the phone up is the most important person in the world, if they actually give you the impression they might know something of what you’re talking about, then you’ve got the confidence to carry on speaking to*

*them...I don't mind even talking to someone if they say, 'I don't know but I'll find out' ... And as long as they come back to you with the information. Even if they come back and say, 'Sorry, I haven't been able to find out anything but I'll keep digging for you'.*" (Disabled people group M27)

#### **5.2.4 Role of peers and information outreach/liaison workers**

There was also frequent mention of the usefulness of peers in information and signposting roles. Focus group participants felt that peers who were paid and had undertaken training, were particularly helpful in empowering people through sharing their knowledge of navigating health and social care services and sources of support. Peers were able to connect with the individual searching for information, and offer their own lived experience to support others in their information seeking journeys.

*"Empathy, the first point is empathy. If you speak to someone who's been there, understands it, you've got a connection straightaway, this is what the peer support training does."* (Mental health group M13)

*"You feel like you're on your own and I feel parents and carers are a very good support for each other because without having to say anything, you already know half their life story because you've been there."* (Carers (LD) group F11)

Whether staffed by peers or not, focus group participants also placed value on outreach, link worker and liaison officer roles within health and social care organisations. Such roles were seen as vital in providing local information and signposting for people at point of diagnosis, consultation or treatment.

*"They're calling it a 'carers advisor' but call it what you like, the label is not relevant is it? It's the role and somebody should be able to say 'I've made you an appointment with Mrs Jones and she will be able to talk you through all the kind of things that are local', and you can ask her, and she should be able to know all these things, but they get rid of these people and then just keep printing brochures – but actually get rid of the brochures and get some people!"* (Carers (LD) group F21)

*"Having a dementia support worker at our hospital is a really good thing to do...It's right on the spot...you don't have to go looking for them. They know what's out there, I hadn't got a clue"* (Family carers group F00)



## 6. Summary

This qualitative focus group study aimed to explore people's experiences of finding out about health and social care services in Essex, and understand potential ways of improving people's information-seeking journeys. Eight focus groups were conducted between October and December 2013 with a range of people, including young people, disabled people, informal carers and people with mental health conditions. A total of 59 people took part.

The study found that people's experiences of information and signposting in relation to health and social care services were variable, dependent to a large extent on luck, and lacked local detail. Various challenges to obtaining information were discussed, including:

- the lack of time and knowledge among health and social care professionals to effectively listen to patients, carers and services users and provide individually-tailored information and signposting;
- conflicting and unreliable or out of date information obtained via the internet; and,
- poor communication skills of staff and a lack of care and compassion being shown when answering information and signposting queries.

A further key area of concern was the lack of information available relating to mental health issues.

There was widespread consensus that a new, centralised and consolidated approach to health and social care information and signposting was needed. This one stop shop approach should combine a well-publicised single point of contact, comprising a website and telephone helpline. Focus group participants wanted a multi-media approach to the provision of information, as well as a physical presence in the form of local information hubs where people could access locally-specific and face-to-face information and signposting support. Careful recruitment and training of staff was seen as vital in ensuring a quality one stop shop service was provided where service users felt they were treated with care and compassion. Finally, focus group participants also discussed the importance of trained (and paid) peers, or outreach/liaison workers in information and signposting roles.

## 7. Appendices

## Appendix A – Approach letter to VCS groups



RCCE House  
Threshelfords Business Park  
Inworth Road  
Feering  
Essex  
CO5 9SE

[insert date] 2013

Dear [insert contact name for organisation/group],

### **Request for assistance with research project**

I am writing to you about a research study looking at people's experiences of finding out about local health and social care services. The study is being funded and carried out by Healthwatch Essex. Healthwatch Essex is the new independent consumer champion created to gather and represent the views of people who use health and social care services. The purpose of the research is to ensure that the views and experiences of people who need information and signposting in relation to health and social care services can be considered in proposals for county-wide information and signposting provision covering health and social care in Essex.

In order to understand people's views and experiences of finding out about local health and social care services, we are running several focus groups across Essex. We would be very grateful if you would assist us with recruiting participants for one of these focus groups. We would like to run a focus group with six to eight people that you are in contact with. The focus group could take place either at your organisation or another suitable local venue that you could suggest to us. The focus group would be run by an experienced focus group moderator/facilitator and would last between 1.5 and 2 hours. The topics covered in the focus group will include:

- The sorts of information people have needed in their particular situations, and why/when they have needed information;
- Where people have got information needed and how easy this was to do;
- Quality of information and/or signposting people have received;
- Suggestions for improvements to information and signposting services.

We will provide you with copies of a letter and information sheet to give out to potential participants (please see attached) and will liaise with you regarding the date, venue and time of the focus group.

**Continued overleaf**

As a thank you for your assistance in recruiting a focus group on our behalf Healthwatch Essex will make an honorarium payment to your organisation. If you would like any further information please contact me by phone on 01376 572829 or email [clarissa.penfold@healthwatchessex.org.uk](mailto:clarissa.penfold@healthwatchessex.org.uk).

We really hope that you will be able to assist us in this research which will allow us to understand people's views and experiences in more depth.

Yours sincerely,



**Clarissa Penfold**

Lead Researcher, Healthwatch Essex

## Appendix B – Invitation to participate



RCCE House  
Threshelfords Business Park  
Inworth Road  
Feering  
Essex  
CO5 9SE

[insert date] 2013

Dear [organisation to insert name]

### Invitation to take part in a focus group

I am writing to you about a research study looking at people's experiences of finding out about local health and social care services. The study is being funded and carried out by Healthwatch Essex. Healthwatch Essex is the new independent consumer champion created to gather and represent the views of people who use health and social care services. The purpose of the research is to ensure that the views and experiences of people who need information and signposting in relation to health and social care services can be considered in proposals for county-wide information and signposting provision covering health and social care in Essex.

In order to understand people's views and experiences of finding out about local health and social care services, we are running several focus groups across Essex. We have asked [insert name of organisation/group] to help us organise a focus group, and they are inviting people to take part on our behalf.

We would like to invite you to take part in a focus group to discuss your views and experiences relating to accessing information about health and social care services. Focus groups will last between 1.5 and 2 hours and will take place in [insert location & venue at [insert time and date OR a specific time and date to be arranged]]. The topics covered in the focus group will include:

- The sorts of information you have needed in your situation, and why/when you have needed information;
- Where you have got information you needed and how easy this was to do;
- Quality of information and/or signposting you have received;
- Suggestions for improvements to information and signposting services.

The attached information sheet provides more information about the research and what taking part will involve.

**Continued overleaf**

If you would like to take part in a focus group, please would you let [insert nominated person from organisation] know, either in person or by telephone. Taking part is voluntary and completely up to you. Healthwatch Essex will write a report summarising key findings from the focus groups but no-one looking at the study findings will be able to identify you in any way. Helping with study will not affect any support you receive.

We really hope that you will be able to take part in this research which will allow us to understand people's views and experiences in more depth. We will feed back what we discover to the authorities, who have a legal responsibility to use our findings to shape and improve services.

If you would like any further information please do not hesitate to contact me by phone on 01376 572829 or email [clarissa.penfold@healthwatchessex.org.uk](mailto:clarissa.penfold@healthwatchessex.org.uk)

Yours sincerely,



**Clarissa Penfold**

Lead Researcher, Healthwatch Essex

## **Appendix C – Participant information sheet**

## **PARTICIPANT INFORMATION SHEET**

### **Research Study:**

## **Exploring people's experiences of finding out about local health and social care services in Essex**

**We would like to invite you to take part in a focus group for an independent research study. This research study is being carried out by Healthwatch Essex.**

**Before you decide whether to take part you need to understand why the research is being carried out and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you like more information - our contact details are at the end of this sheet.**

### **What is the purpose of the study?**

This research study will explore people's experiences of finding out about local health and social care services. The purpose of the research is to ensure that the views and experiences of people who need information and signposting in relation to health and social care services can be considered in proposals for county-wide information and signposting provision covering health and social care in Essex.

In order to understand people's views and experiences of finding out about local health and social care services, we are running several focus groups across Essex.

### **What is the role of Healthwatch Essex in this research?**

Healthwatch Essex is funding and carrying out this research. Healthwatch Essex is the new independent consumer champion created to gather and represent the views of people who use health and social care services. Healthwatch Essex will play a role at both national and local level and will make sure that the views of the public and people who use services are taken into account. Healthwatch Essex has a network of volunteers and also works with existing voluntary and community groups to find out what matters to our citizens. Healthwatch Essex also funds a research programme and undertakes research projects, including this study, to try and understand people's views and experiences in more depth. We will feed back what we discover to the authorities, who have a legal responsibility to use our findings to shape and improve services.

### **What will happen to the results of the research study?**

Presentation, reports or publications resulting from the research will not identify any one who has taken part. Anonymous results from the study will be presented to key people responsible for commissioning or delivering health and social care services in Essex. There will also be a short written report of the research findings, which will be available to access via the Healthwatch Essex website. Findings may also be published in academic journals and presented at professional and academic conferences.

### **Why are you inviting me to take part?**

We have approached a range of voluntary sector organisations to help us recruit people to take part in focus groups for this research. Each organisation is approaching people they are in contact with and inviting them to take part in a focus group. By recruiting focus groups in this way we hope to ensure that we capture a diverse range of views and experiences, and are able to understand people's different information needs and preferences.

**CONTINUED OVERLEAF**



### **Do I have to take part?**

Involvement in this research study is entirely voluntary and it is completely up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect any current or future support you receive in any way. Throughout all aspects of the research you have a right to:

- withdraw from the study at any time;
- choose not to share information with us.

### **What will happen to me if I do take part?**

You will be given the date, time and venue for the focus group in advance. On the day, you will meet with between five and seven other people who are also taking part. All people taking part will be in contact with the same organisation that gave you the invitation letter, so you may know them. Everyone taking part will be reminded to keep what they hear during the group confidential.

The focus group will be run by an experienced focus group moderator or group facilitator who will introduce topics and keep the discussion going, ensuring everyone gets an opportunity to contribute. The focus group will last between an hour and a half and two hours and the discussion will cover people's personal experiences of accessing information about local health and social care services.

Topics covered in the group discussion will include:

- The sorts of information you have needed in your situation, and why/when you have needed information;
- Where you have got information you needed and how easy this was to do;
- Quality of information and/or signposting you have received;
- Suggestions for improvements to information and signposting services.

The focus group discussion will be tape-recorded so we have an accurate record of what people say. The tape recording will be transcribed, and anonymised. The recording will be deleted after transcription. The data will then be analysed by the research team.

The focus group moderator/ facilitator will ask you to sign a consent form agreeing to take part in the interview.

### **Are there benefits in taking part?**

There are no direct benefits to you as an individual. We will be making an honorarium payment to the organisation that has given you letter about this research. This is to thank them for their time in selecting people to take part and helping us to organise the focus group. We hope that this research will generate knowledge that will inform policy more widely in relation to future commissioning and provision of information and signposting services.

### **Will my taking part in the study be kept confidential?**

Your responses are completely confidential. All data will be given a code to ensure anonymity and stored in a locked filing cabinet or on a password protected computer secured against unauthorised access. No-one else will know you have taken part unless you choose to tell them.

If you tell us something that indicates there is a risk of harm to yourself or someone else, then we will follow a 'disclosure protocol'. This involves seeking advice on whether we should disclose (tell a relevant agency or authority) this risk. Someone will contact you first to talk about it before taking further action.

### **Has this study been reviewed by a research ethics committee?**

Research undertaken by Healthwatch Essex is considered by an independent group of people, called a research ethics committee, to protect your interests. This study has been reviewed and approved by Essex County Council Research & Analysis Unit Research Governance Group (Ref: 09/10/13).

**For further information please contact:**

**Clarissa Penfold, Lead Researcher**

**Tel: 01376 572829,**

**Email: [clarissa.penfold@healthwatchessex.org.uk](mailto:clarissa.penfold@healthwatchessex.org.uk)**

**Website: [www.healthwatchessex.org.uk](http://www.healthwatchessex.org.uk)**

Healthwatch Essex Limited. A company limited by guarantee and registered in England No. 8360699. Registered office: RCCE House, Threshelfords Business Park, Inworth Road, Feering, Essex, CO5 9SE.

Participant Identification Number:

## Exploring people's experiences of finding out about local health and social care services in Essex

Essex County Council Research & Analysis Unit Research Governance Group ethical approval ref: 09/10/13

### CONSENT FORM FOR FOCUS GROUP PARTICIPANTS

Name of focus group moderator/facilitator: [INSERT NAME]

Lead researcher contact details: *Clarissa Penfold, Healthwatch Essex, RCCE House, Threshelfords Business Park, Inworth Road, Feering, Essex, CO5 9SE.*

Tel: 01376 572829; Email: [clarissa.penfold@healthwatchessex.org.uk](mailto:clarissa.penfold@healthwatchessex.org.uk)

#### You will be given a copy of this consent form to keep

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and my responses are completely confidential. I am free to withdraw at any time, without giving any reason, without my employment or legal rights being affected.
3. I agree to take part in a focus group facilitated by the focus group moderator/facilitator named above and for the focus group discussion to be tape-recorded.
4. I agree to the anonymised data being archived for up to five years after the end of the research, for use in this study. I understand that data will be destroyed after this period and that all identifying information about me will be removed to protect my identity.
5. I agree to take part in the above study.

☐☐☐☐☐

Participant name [please print]

Date

Signature

Moderator/facilitator name  
[please print]

Date

Signature



### Information & signposting – understanding people’s experiences of finding out about local health and social care services

#### Focus Group Topic Guide

##### **Purpose of research:**

The purpose of the research is to ensure that the views and experiences of people who need information and signposting in relation to health and social care services can be considered in proposals for county-wide information and signposting provision covering health and social care in Essex.

##### **Research aims/objectives:**

To explore and understand:

- how patients, service users, carers and members of the public currently find out about local health and social care services;
- how easy it is for people to get the information they need;
- people’s experiences of the quality of information and signposting
- people’s perspectives on how information and signposting services could be improved.

#### **1. Welcome & introduction**

- Before start, check everyone has signed consent form.
- Welcome from moderator /facilitator.
- Introduce Healthwatch Essex and explain research (part of wider project to determine the potential nature of an integrated signposting resource for health and social care services across the county).
- Explain nature and purpose of focus groups – to explore and understand people’s experiences of finding out about health and social care services. Explain that there are several focus groups taking place.
  - Style of questioning
  - No right/wrong answers
  - ‘Obvious’ questions as don’t want to make assumptions about views/experiences

- During focus group discussion we will explore:
  - The sorts of information each of you has needed for your situation, and why/when you have needed information;
  - Where you have got information you needed and how easy this was to do;
  - Quality of information and/or signposting you have received;
  - Suggestions for improvements to information and signposting services.
- Remind discussion should last about an hour to an hour and a half. Remind discussion will be tape recorded to make sure we get an accurate record of what is said. Recording will be transcribed and analysed for the report. Everything people say will remain anonymous – all names will be removed and no comments will be attributable to any identifiable individual.
- Remind participants that we ask them to respect each other's confidentiality about any personal details shared today.
- Any questions before start? Explain that we'd like to hear about their own personal experiences but are happy for participants to talk more generally if they wish.

## **(BEGIN RECORDING)**

### **2. Background**

Ask each participant to introduce themselves, including:

- Their name
- Where they live
- Brief description of contact they have (or have had in the past) with health and social care services

Prompts (contact with health and social care services – themselves or relative/friend)

- Health services e.g. -
  - GP
  - Pharmacy
  - Health centre
  - A&E
  - Hospital (outpatient / inpatient)
  - Community nursing team
  - Health & wellbeing clinics / classes
  - Hospice
  - residential care home (for yourself or a relative)
  - community support and activities
  - support groups
  - day centres
  - respite care
  - help for people with disabilities including learning disabilities
  - financial support / benefits
  - information and advisory services, and advocacy
  - support for carers
- Social care services e.g. –
  - Equipment, aids and appliances
  - help in the home (home care services e.g. personal care, meals on wheels, home help)

### 3. Information needs

Ask participants to talk about the sorts of information they have needed in their situation:

- What information did they need, and
- Why did they need information at that time (i.e. triggers)?

Use prompts for section above (information needs about) and:

- condition-specific information (e.g. treatments available)
- making a complaint
- advocacy services

### 4. Sources of information and accessibility

Ask participants **where** they got the information they needed – how they got in touch, how easy was this to do? Explore difficulties getting certain types of information

**[Co-moderator to make a note of information sources on flipchart to refer back to in next section (section 5)]**

Prompts (information sources):

- |                              |   |
|------------------------------|---|
| • GP surgery/pharmacy        | • school                                  |
| • health professional        | • Post Office                             |
| • alternative therapists     | • faith organisation                      |
| • social services            | • internet                                |
| • community or support group | • media                                   |
| • library                    | • friends/family                          |
| • information centre         | • NHS Direct/111/PALS/ Social care direct |
| • CAB                        |   |

### 5. Quality of information and/or signposting

Views of information / signposting accessed:

What was **good** about it:

- Quality of information / signposting
- Was information / signposting useful / helpful – probe: why / in what way?
- Was format of information appropriate/accessible
- For face-to-face / telephone / email – ask how helpful staff were
- Web-based material – ability for people to manage their own information needs

What was **not so good** about it?

- Conflicting information from different sources
- Information / signposting not helpful – why not / in what way?
- Information formats
- Unhelpful staff

## 6. Suggestions for improvements to information and signposting services

Ask participants to reflect back on the information and signposting support they have received and what has come up in the group discussion, and think about:

**Preferences** for getting information about local health and social care services and other sources of support. What would make it easier? How could provision of information be improved?

Prompts (how, where, when, who):

- **Format**
  - Face-to-face / in person
  - Print
  - Internet/website
  - Local directories
  - Telephone
  - Information in other languages
  - Text messages
- **Location**
  - GP surgeries
  - Pharmacies
  - Libraries
  - Supermarkets
  - Central information point/one-stop shop
- **Opening hours**

Probe reasons for preferences:

**Awareness** - how could information & signposting services be promoted so people are aware of how to access them? How and where should information & signposting services be advertised?

**Patient and service user feedback** – ‘NHS choices’ and ‘Patient opinion’ websites where you can rate services – do people use these? ‘Trip advisor’ type information – would something like this be useful in finding out about / choosing services? What do people think?

**Any other comments and concluding thoughts:** [to explore important things that people designing an integrated signposting resource ought to consider/think about] In an ideal world what would be the easiest way for you to get information about your local health and social care services?

**(RECORDER OFF)**

**Thank everyone for their participation and final reminder about confidentiality**

- What will happen next [findings will be included in report for Essex County Council]
- Questions about the research [spare copies of participant information sheet available if people would like one to take away]
- Contact details if further questions [provide leaflets ‘Have you heard of Healthwatch Essex?’ & ‘Volunteer for us’]

Essex Health and Wellbeing Board	<b>HWB/015/14</b>
Date: 20 <sup>th</sup> May 2014	

## Essex 5 Year Strategic Plan Process

Report by Clare Morris

Enquiries to Sheila Norris

Purpose of report and Decision Areas and Recommendations	<p>1.1. The purpose of this report is to inform the Health and Wellbeing Board of progress in completing the Essex Planning Unit (Essex Health and Wellbeing Board area) 5 Year Strategic Plan (Essex 5 Year Strategic Plan).</p> <p>The Board are requested to:</p> <p>1.2. Agree to receive a presentation on progress in producing the draft Essex 5 Year Strategic Plan following a partnership event on 6<sup>th</sup> May.</p> <p>1.3. Note that the Essex Health and Wellbeing Board will be asked to consider, at their meeting on 19<sup>th</sup> June, the draft plan. Note that the Final Essex 5 Year Strategic Plan will be submitted to Health and Wellbeing Board to consider for approval on 25<sup>th</sup> September 2014.</p> <p>Note the process and approach outlined above that CCGs and ECC are following with NHS England Local Area Team (LAT) to create the Essex 5 Year Strategic Plan.</p>
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Background and context.	<p><b>2. Background and proposal</b></p> <p>2.1. Essex Health and Wellbeing Board have agreed that an Essex 5 Year Strategic Plan will be created to include programmes of work by ECC and the CCGs to integrate health and care. The plan will aim to ensure that the interdependencies between the CCGs and ECC are identified and managed effectively</p> <p>2.2. CCG 5 Year Strategic Plans covering 2014/15 to 2018/19 are required by NHS England. The Essex 5 Year Strategic Plan is being developed jointly by ECC, our five Clinical Commissioning Groups and NHS England in line with NHS England guidance.</p> <p><b>Context</b></p> <p>2.3. In December 2013 Sir David Nicholson, Chief Executive, NHS England launched Everyone Counts – Planning for Patients 2014/15 to 2018/19. This document outlined the ambitions of NHS England and its approach to strategic, operational and financial planning.</p> <p>2.4. The Government’s intention is for NHS and local government social care services to have adopted models of commissioning and be delivering integrated care and support. This was outlined with the publication of Integrated Care and Support; Our Shared Commitment by NHS England and the Local Government Association and NHS England’s A Call to Action published in July 2013. The shared commitment expresses the intention that integration will be achieved within 5 years.</p> <p>2.5. Health and Wellbeing Boards are required to endorse CCG 5 year strategic plans that are required to be submitted in draft form to NHS England by 20th June 2014.</p> <p>2.6. The Essex 5 Year Strategic Plan is currently being developed. It will be an overarching plan for the Essex Health and Wellbeing Board area supported by 5 Clinical Commissioning Group plans. This will be reported to Cabinet in detail on 24<sup>th</sup> June 2014. The Plan will take account of NHS England guidance and will include our shared strategy with CCGs for integration with social care. The recently agreed Better Care Fund plan for 2015/16 and the CCG 2 Year Operational Plans will be reflected in the</p>
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	<p>strategy.</p> <p>2.7. The financial context for the integration of health and social care is both challenging and uncertain. Health and Adult Social Care services in Essex collectively spend around £2.5 billion each year. Essex County Council spends around 43% of its 2014/15 net revenue budget on Adult Social Care. The current MTRS for the service incorporates additional funds of £89m up to 2016/17 for inflation and demographic growth, offset by planned savings across the service over the same period of £75.3m. Further savings are likely to be required to close the current budget gap reported at County level of £69m. The five CCG's, also need to make aggregate savings in the region of £84m<sup>[1]</sup> (5%) of their combined budgets totalling £1,631.0m for 2014/15.</p> <p><sup>1</sup> <i>Health and Social Care Integration Workshop 18-19 June 2013, page 7</i></p>
Options/Proposals	None
Equality and Diversity	As this is a strategy there are no direct Equality and Diversity implications. However, the Essex 5 Year Strategic Plan will lead to a series of initiatives by the Council and its partners. These will require Equality and Diversity Impact Assessments as this work proceeds.
Background Papers	None





<b>Report to Health &amp; Wellbeing Board</b> <b>Report of Nick Presmeg</b>	<b>Reference number</b> <b>HWB/16/14</b>
<b>Date of meeting</b> 20 <sup>th</sup> May 2014 <b>Date of report</b> 1 <sup>st</sup> May 2014	<b>County Divisions affected by the decision</b> All Divisions (North-East, Mid, and West Essex initially but will impact on south East and South
<b>Title of report:</b> The Integrated Health and Social Care Strategy for Adults with Learning Disabilities in North Essex 2014 - 2017	
<b>Report by:</b> Nick Presmeg, Director of Integrated Commissioning and Vulnerable People, Essex County Council	
<b>Enquiries to:</b> Phil Brown, Commissioning Support Manager, Essex County Council	

## 1. Purpose of report

- 1.1. The purpose of this report is to present the integrated health and social care strategy for adults with learning disabilities in North Essex to the Health and Wellbeing Board.
- 1.2. The report also describes the commissioning approach that has been agreed between the North-East, Mid, and West Essex CCG's ("North Essex CCGs") and Essex County Council ("ECC") for adult learning disability services in North Essex.

## 2. Recommendations

- 2.1. The Board is asked to endorse the integrated health and social care strategy for adults with learning disabilities in North Essex.
- 2.2. The Board is asked to acknowledge the integrated commissioning approach that has been developed in North Essex for adults with learning disabilities.

- 2.3. The Board is asked to acknowledge that this commissioning approach is the first stage in developing a whole Essex approach for the commissioning of learning disability services for adults, and that the ambition is for the strategy to become a whole Essex strategy as integrated commissioning arrangements are progressed in South Essex. A mandate to request the necessary additional resources to define and agree these new Pan-Essex arrangements is planned for July of this year.

### **3. Background and proposal**

- 3.1. A project was initiated in April 2013 to integrate the commissioning of adult learning disability services in North Essex.
- 3.2. There were key business drivers for this project. These included:
- The opportunity to implement integrated commissioning within a relatively well defined area to inform future integrated commissioning projects.
  - The requirement to respond to the national Winterbourne View action plan, which requires integrated pathways for people with learning disabilities and behaviours that challenge, supported by pooled budget arrangements.
  - The opportunity to support the Working Age Adult Increasing Independence programme through increasing the opportunities to deliver innovative commissioning solutions across the health and social care economy.
- 3.3. Due to the complexities of the commissioning arrangements for learning disability services in South Essex (that include the unitary authorities of Southend and Thurrock), the intention of the project was to develop integrated commissioning arrangements in North Essex first, and then use this learning to extend the arrangements to include South East and South West Essex CCGs.
- 3.4. To achieve an integrated commissioning approach the project had four main deliverables which included:
- An integrated health and social care strategy describing the priorities for service transformation;
  - Joint commissioning arrangements for commissioning and contracting with health & social care providers underpinned by a Section 75 agreement.
  - Financial arrangements that support integrated commissioning.
  - Governance arrangements across the partnership with delegated decision making mandates.
- 3.5. The strategy was developed jointly by commissioners working for ECC and on behalf of the North Essex CCGs. At the same time as the development of the strategy, the Increasing Independence programme consulted with adults with a learning disability. Their views have shaped the core principles within the strategy.

- 3.6. A key message from the Increasing Independence consultation was that service users and family carers welcome and indeed expect greater integration between health and social care services.
- 3.7. Proposals for integrated commissioning arrangements have been agreed between ECC and the North Essex CCGs, with ECC taking on lead commissioning responsibility for specialist health services for adults with learning disabilities in north Essex.
- 3.8. An agreement made pursuant to the provisions of section 75 National Health Service Act 2006 to integrate health and social care functions (the "Section 75 Agreement") has been documented which describes how these commissioning arrangements will work in practice. The s75 Agreement is in the process of being agreed by the relevant legal departments within ECC and West Essex CCG (who are acting on behalf of the 3 North Essex CCGs). These integrated arrangements position ECC as the Lead Commissioner on behalf of both social care and the North Essex CCGs health. ECC will therefore be acting on behalf of health
- a) in monitoring the performance of existing health contracts
  - b) and acting on behalf of health in terms of defining the future integrated contractual arrangements with the market, acting within the Guidance of Responsible Commissioner with other CCG and local authorities.

The Section 75 Agreement also describes the financial arrangements that will support the integrated commissioning approach. It proposes that a "pooled fund" comprising of monies contributed by ECC and the North Essex CCGs is created to support integrated commissioning. This pooled fund includes the funds to support the integrated commissioning and the necessary funds to discharge the existing health contracts.

The Section 75 Agreement describes the governance arrangements for the integrated commissioning approach. An Integrated Commissioning Executive Board will be created to oversee the commissioning arrangements; the pooled fund; and to monitor progress in implementing the key actions from the strategy. Membership of the Board will include senior managers from both ECC and the North Essex CCGs.

- 3.9. The proposals to integrate the commissioning of adult learning disability services were agreed at the Executive Boards of each of the North Essex CCGs in March 2014.
- 3.10. The proposals have been supported by Strategic Commissioning Board and are being proposed to the Member for approval as a Cabinet Member Action. This has been added to the Forward Plan for consultation and is planned for final signature by the Lead Member during May.
- 3.11. The Section 75 Agreement will be presented to the Health and Wellbeing Board once it has been formally signed off by all parties.

#### **4. Policy context**

- 4.1. The strategy and proposed commissioning approach is consistent with the vision declared in the Joint Health and Well Being Board Strategy for Essex (2013) that:

*“By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.”*

- 4.2. The strategy is also consistent with the *Increasing Independence Programme for Working Age Adults* that was agreed by the Cabinet in March 2014.

#### **5. Financial Implications**

- 5.1. The Council's expenditure described in the strategy is based on the financial model agreed for the Increasing Independence programme by Cabinet in March 2014. The CCGs expenditure is based on their current levels of expenditure and will be agreed as part of the Section 75 agreement.

#### **6. Legal Implications**

- 6.1. One of the implications of the strategy is a move towards greater integration of commissioning and a move towards integrated delivery across health and social care.
- 6.2. As outlined above, the first pilot of this integration is starting between the North Essex CCGS and ECC.
- 6.3. The Section 75 Agreement provides the legal mechanism that allows ECC to act on behalf of the North Essex CCGs in delivering an integrated commissioning function and, in particular, to manage the contracts related to the health funds of £12.763 million that have been placed within the pooled fund. The Section 75 Agreement is a one-year agreement that is intended to pave the way for a longer-term arrangement which will include the CCGs in the South of the county. These subsequent steps in the partnership will require new legal agreements that will supersede this initial Section 75 Agreement and further consultation will also be required in due course.

#### **7. Staffing and other resource implications**

- 7.1. The employee who previously commissioned specialist learning disability health services on behalf of the North Essex CCGs retired in April 2014. Included within the Pooled Fund is a sum of £100,000 from the North Essex CCGs that provides the funding for ECC to take on this role. ECC is in the process of recruiting

someone to fulfil that role and they will work as an ECC employee within the commissioning function for vulnerable people.

## **8. Equality and Diversity implications**

- 8.1. The purpose of the strategy and the integrated commissioning approach is to address the inequalities experienced by people with learning disabilities.
- 8.2. An Equality Impact Assessment has been completed as part of the strategy and is included as an Appendix.

## **9. Background papers**

- 9.1. The strategy *“Better Lives, Better Health for Adults with Learning Disabilities in North Essex - An integrated strategy for adults with learning disabilities 2014 – 2017”*

An Easy Read version of the strategy is also available. Both the strategy and Easy Read versions of the strategy were presented to the Learning Disabilities Partnership Board in March 2014.

- 9.2. The Consultation Document for the Increasing Independence Programme for Working Age Adults.
- 9.3. The Response to the Increasing Independence Consultation.







<b>Report to Health &amp; Wellbeing Board</b> <b>Report of Nick Presmeg, Director of Integrated Commissioning and Vulnerable People</b>	<b>Reference number</b> <b>HWB/17/14</b>
<b>Date of meeting</b> 20 <sup>th</sup> May 2014 <b>Date of report</b> 1 <sup>st</sup> May 2014	<b>County Divisions affected by the decision</b> All Divisions
<b>Title of report:</b> A progress update on the Winterbourne View Action Plan	
<b>Report by:</b> Nick Presmeg, Director of Integrated Commissioning and Vulnerable People, Essex County Council	
<b>Enquiries to:</b> Phil Brown, Commissioning Support Manager, Essex County Council	

## **1. Purpose of report**

- 1.1. The purpose of this report is to provide the Health and Wellbeing Board with a progress update on the actions from the national Winterbourne View Concordat, and to make the Board aware of the challenges to the local health and social care system in implementing these actions. This report builds upon the update that was presented to the Board in July 2013.

## **2. Recommendations**

- 2.1. The Board are asked to acknowledge the significant progress that has been made so far in implementing the commitments from the Winterbourne View Concordat.
- 2.2. The Board are also asked to acknowledge that the national milestone of discharging all those people living in hospitals by June 2014 will not be met. The building blocks to enable a successful transition from hospital to community based settings have been put in place; however the complexity of some of the individuals involved has meant that the work will need to continue at the pace they need to ensure a successful move. Discussions with the national

Winterbourne Joint Improvement Programme Board have indicated that most other areas are in a similar position, and in a recent visit the national Joint Improvement team were assured by the significant progress that Essex has made.

- 2.3. The Board are asked to acknowledge the challenges associated with implementing the commitments from the Winterbourne View Concordat. In particular the additional financial pressures to the local health and social care system arising from not having a national mechanism to transfer funds from the NHS Specialist Commissioning Group as people transfer to locally funded services; and the inherent difficulties associated with the structure of NHS commissioning that have acted as a barrier to developing effective commissioning relationships between the NHS Specialist Commissioning Group and the local authority and Clinical Commissioning Groups of Essex.

### **3. Background and proposal**

- 3.1. In December 2012, The Department of Health published a comprehensive review of the service failures that led to the abuse that took place at the Winterbourne View Hospital entitled “Transforming Care – A national response to Winterbourne View Hospital”. This was accompanied with a clear programme of action agreed by a range of stakeholders. The action plan tasked local authorities and CCGs to work together on four main areas:
- i. Identifying people with learning disabilities living in hospital based settings.
  - ii. Ensuring that all of these people had a person centred review by June 2013 with clear plans in place for discharge to community based settings if they no longer required in-patient care.
  - iii. Ensuring that those people identified as no longer needing in-patient care are discharged by June 2014.
  - iv. For local authorities and Clinical Commissioning Groups (CCGs) to develop a joint plan to improve local services for people with learning disabilities and behaviours that challenge with the presumption that the plan is supported by pooled budget arrangements.
- 3.2. There were no Essex residents placed at Winterbourne View, however there were 36 Essex residents with learning disabilities living in hospital based settings. Essex responded proactively. In October 2012, the National Development Team for Inclusion (NDTI) was commissioned to undertake an external audit of services for people whose behaviours are deemed as challenging. The audit did not find any evidence of abuse in the services they visited. A project was instigated in partnership with the Essex Clinical Commissioning Groups (CCGs) and the local authorities and CCGs of Southend and Thurrock to implement the audit recommendations.
- 3.3. The table below provides an update on progress achieved so far:

Action	Progress to Date
1. Identifying people with learning disabilities living in hospital based settings by April 2013.	<p>All 36 people with learning disabilities living in hospital were identified within the required deadline. 25 were placed and funded by the NHS Specialist Commissioning Group (SCG) and 11 were placed and funded by the Clinical Commissioning Groups (CCGs) of Essex.</p> <p>The SCG is responsible for funding low and medium secure services. The CCGs are responsible for funding assessment and treatment and locked rehabilitation services.</p>
2. Ensuring people living in hospital had a person centred review by June 2013.	<p>The NHS SCG reviewed the 25 people they were responsible for. The reviews for the 11 people funded by the local Clinical Commissioning Groups (CCGs) were jointly undertaken with Essex County Council (ECC) social workers, local community nurses, and independent support planners where appropriate. The reviews identified 14 people who no longer required in-patient services, 7 of whom were funded by the SCG and 7 funded by local CCGs.</p>
3. Ensuring that those people identified as no longer needing in-patient care are discharged by June 2014.	<p>CCG Funded Placements:</p> <ul style="list-style-type: none"> <li>• 2 people have moved successfully to community based settings.</li> <li>• 1 person was moved from their placement due to concerns highlighted in their review about the appropriateness of the support being received. Plans are in place for them to move back to the family home by June 2014.</li> <li>• A comprehensive person centred plan is underway with 2 people to explore their future accommodation and support options when they leave hospital. These cases are particularly complex and their moves are unlikely to be completed by June 2014.</li> <li>• 2 people have been assessed by their Responsible Clinician as needing to remain within in-patient services for further treatment beyond 2014.</li> </ul> <p>SCG Funded Placements:</p> <ul style="list-style-type: none"> <li>• 1 person has moved into a community based placement and plans are in an advanced state for a further person to move to a community based placement by June 2014.</li> <li>• A subsequent review undertaken by ECC staff raised questions about whether 1 person is actually an Essex citizen. Essex continues to support the planned discharge whilst this issue is being resolved.</li> <li>• 1 person has been assessed by their Responsible Clinician as needing to remain within in-patient services for further treatment beyond 2014.</li> <li>• The remaining 3 people been allocated to the ECC Complex Behaviour Team as more information is required about their future accommodation and support needs.</li> </ul>
4. For local authorities and	<p>A draft commissioning plan for people with learning disabilities whose behaviour is deemed as challenging has been developed in partnership with the NHS Commissioning Support Unit (on behalf</p>

<p>Clinical Commissioning Groups (CCGs) to develop a joint plan supported by pooled budget arrangements.</p>	<p>of the 7 CCGs including Southend and Thurrock); the unitary authorities of Southend and Thurrock; family carers; users by experience and health and social care providers. The NDTi provided additional support in developing the plan because of their expertise in this area. The plan is being presented to the family carers and experts by experience on the 6<sup>th</sup> May to ensure it reflects their views. The plan will then be submitted to the Health and Wellbeing Board for approval.</p> <p>The joint commissioning arrangements agreed between the North Essex CCGs and ECC will create a “pooled budget” which provides a mechanism to allow the money to follow the person as they transfer from health to social care funded placements. Discussions are underway with the South Essex CCGs to achieve a similar arrangement.</p>
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- 3.4. A significant barrier in making progress for individuals has been the difficulty engaging with the NHS Specialist Commissioning Group (SCG). The SCG were responsible for undertaking the reviews for the people they fund. Concerns were raised early on in the process about the quality of these reviews and the lack of information that ECC and the CCGs received about the people in question. These concerns have been raised by the local CCGs in a letter to the NHS Commissioning Board. This is a national issue and not one that is just peculiar to Essex.
- 3.5. A practice has emerged in some of the Independent Hospitals used by the SCG of “stepping down” people from secure services to their own locked rehabilitation services. This means that the organisation retains the person (and the funding associated with the person). These moves are often planned in advance of any involvement from either the CCG (who becomes responsible for funding the person once they step down) or the person’s allocated social worker, making it particularly difficult for prospective placements to be challenged. Again these concerns have been raised by ECC and the local CCGs to the national Winterbourne Joint Improvement Programme Board. Collectively we would want much more robust commissioning from the SCG to ensure local commissioners are involved much earlier in any proposed moves, particularly as the SCG have identified 3 people at a potential cost of £550k that could step down from SCG funded secure services to CCG funded locked rehabilitation services.
- 3.6. A number of mitigating actions have been taken to ensure that people are not delayed unnecessarily from being discharged. ECC has created additional social work capacity through the creation of the Complex Behaviour Team. The team has prioritised the SCG placements because of the concerns raised earlier, and continues to support the discharge arrangements for those people ready to move to community based placements. The team will also monitor those people who need to remain in hospital to ensure that they are safe and their treatment and support is appropriate.
- 3.7. A series of workshops has taken place to establish an integrated pathway between the local specialist health services and ECC to avoid preventable admissions and ensure that those people who are admitted only stay for the

minimum amount of time required. Clear specifications have been developed for the teams as part of this process describing their contribution to the overall care and support pathway.

3.8. The national Winterbourne Joint Improvement Programme has allocated Essex additional support due to the size and complexity of the county. In a recent visit on the 25<sup>th</sup> April the person allocated to support Essex was both assured by the progress that Essex had made, and identified considerable strengths in our approach. These included the robust project and programme methodology applied; the quality of co-production in developing the local plan; the use of an external organisation to act as a “critical friend” and to support improvement; and the joint working and shared commitment between the local authority and local CCGs to progress the agenda.

3.9. The next steps include:

- A joint health and social care forum consisting of senior managers from specialist health and social care services will oversee the implementation of the integrated pathway to avoid preventable admission to hospitals in the future and ensure that those people who are admitted only stay for the minimum amount of time required.
- Commissioners and the ECC Commercial Team are working to develop the local social care market to ensure the appropriate supply of locally based services to avoid preventable admissions to hospitals.
- The Complex Behaviour Team will ensure the remaining people living in hospital that are ready to discharged move into community based settings. It should be noted that some of these people have lived in hospitals for most of their adult life so any transition to a new service will need to be completed at their pace.
- Integrated commissioning arrangements for learning disability services will be developed in South Essex, mirroring the arrangements already achieved in North Essex.
- Work will start on an Integrated Service Specification for 2016 to formalise the joint working arrangements being developed by the health and social care forum.

#### **4. Policy context**

4.1. The Winterbourne View Concordat and the project “Services for people with learning disabilities and behaviours that challenge” are fully consistent with the vision of the Health and Well Being strategy for Essex. In particular:

- supporting individuals in exercising personal choice and control, and influence over the commissioning of relevant services;
- enabling local communities to influence and direct local priorities for better health and wellbeing strengthening their resilience and using community assets to reduce demand;
- promoting integration across the health and social care systems to ensure that services are planned and commissioned in an integrated way where it is beneficial to do so.

## **5. Financial Implications**

- 5.1. The national Winterbourne View Concordat stated that local authorities should not be disadvantaged as people move from health funded to social care funded placements. The council has been working with the local CCG's to explore funding arrangements to reduce the risk of organisations being unfairly disadvantaged. However there are no plans for the funding from the SCG to transfer to local authorities or CCGs when people are discharged from secure services. The council and the CCGs have raised this issue with the national Winterbourne Programme Board.
- 5.2. The additional cost to ECC as a result of the 3 people that have transferred from health funded placements to social care funded placements is £231,808 per annum.
- 5.3. The 3 North Essex CCG's and ECC have agreed to integrated commissioning arrangements for learning disability services with the County Council acting as lead commissioner. This will be supported by a pooled budget arrangement that provides a mechanism for the money to follow the person for any future transfers from health funded services to social care services. Discussions with the 2 CCG's in South Essex are underway to achieve similar arrangements.
- 5.4. The potential cost to ECC of the 3 people that are still to transfer from CCG funded placements is estimated to be £550k. These costs are currently within the pooled budget arrangement between the North Essex CCGs and ECC. However £370k of this money is currently locked into the block contract with Hertfordshire Partnership University NHS Foundation Trust (HPFT).
- 5.5. The potential cost pressure to ECC of the 5 people still to transfer from SCG funded placements to social care funded placements is estimated to be £925k. There is also a potential cost pressure to the CCGs of £550k when the 3 people step down from SCG funded secure services to CCG funded locked rehabilitation services.
- 5.6. Essex will continue to raise the issue of the additional cost pressures associated with implementing the actions from the Concordat. In the recent stocktake submitted to the national Programme Board Essex argued that a special fund should be made available to local authorities and CCGs to mitigate the financial impact of implementing the Winterbourne Concordat in the same way that funds were made available to support the re-provision of the old learning disability long stay hospitals.

## **6. Legal Implications**

- 6.1. The Council has statutory duties to safeguard people affected by its operations. This includes responsibilities for people placed by the council, regardless of their

location. The oversight provided by the Health and Wellbeing Board represents a useful assurance that the Council is discharging its duties.

- 6.2. The primary remit of the Health & Wellbeing Board is to encourage integrated working, prepare a number of statutory documents and ensure commissioning plans are in alignment with the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy.
- 6.3. The Minister wrote to the Chairs of all Health and Wellbeing Boards saying that *'Health and Wellbeing Boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition on the plan and ensure the right clinical and managerial leadership and infrastructure is in place to deliver the co-produced plan. Health and Wellbeing Boards will, no doubt, also want to take an active interest in how far the other commitments.... particularly those relating to care reviews having been completed by June 2013 have been achieved as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings. It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined up services from the NHS and local councils in the future and see real change for this very vulnerable group. Health and Wellbeing Boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individual; which is closer to home and which will lead to a dramatic reduction in the number of in-patient placements and the closure of some large in-patient settings.'*

## **7. Staffing and other resource implications**

- 7.1. The Council has invested in a newly formed Complex Behaviour Team consisting of a Team Manager, 2 Senior Practitioners, and 3 Social Workers. The team became Operational in February 2014.
- 7.2. The Complex Behaviour Team will be expected to work as part of an integrated health and social care system to support adults with learning disabilities whose behaviour is deemed as challenging. They will work alongside the existing ECC Behaviour Advice Team and the specialist learning disability health services provided by the South Essex Partnership University NHS Foundation Trust (SEPT), Hertfordshire Partnership University NHS Foundation Trust (HPFT), and Anglian Community Enterprises (ACE).
- 7.3. Facilitated workshops have taken place involving all staff to develop joint working protocols so the teams work together as part of an integrated health and social care system. Managers from these services will meet on a monthly basis to embed the joint working protocols.

## **8. Equality and Diversity implications**

- 8.1. As this is a progress report no Equality Impact Assessment has been undertaken. However the purpose of the Winterbourne View Concordat is to address the inequalities experienced by people with learning disabilities who display behaviours that challenge or who have additional mental health needs.

## **9. Background papers**

- 9.1. There are no background papers to this report.



<b>Report to Health &amp; Wellbeing Board</b> <b>Report of Cllr Aldridge</b>	<b>Reference number</b> <b>HWB/18/14</b>
<b>Date of meeting</b> 20 May 2014 <b>Date of report</b> 16 April 2014	<b>County Divisions affected by the decision</b>  All Divisions
<b>Title of report:</b> Care Bill	
<b>Report by</b> Cllr John Aldridge, Cabinet Member for Adult Social Care	
<b>Enquiries to:</b> Peter Fairley, Head of Policy and Strategy (People)	

**1. Purpose of report**

- 1.1. To update the Health and Wellbeing Board on the progress of the Care Bill, to note its scope and implications, and to note the timescales for implementation.

**2. Recommendations**

- 2.1. To note the contents of the report

### **3. Background and proposal**

3.1. The Care Bill was introduced to Parliament on 10<sup>th</sup> May 2013 and represents the biggest legislative change to adult social care since 1948. It is expected to receive Royal Assent in May 2014.

3.2. The bulk of the Care Bill's reforms are due to be implemented from 1 April 2015, although some aspects (the cap on care costs and revised financial eligibility thresholds) will be implemented from 1 April 2016.

3.3. The Care Bill consolidates social care law into a single statute and would place broad duties on local authorities in relation to care and support, focusing on the promotion of 'individual well-being'. Duties would also be imposed on local authorities to:

- prevent care and support needs arising, including by providing information and advice (including access to independent financial advice);
- promote the integration of care and support services with health services (for the purposes of the Bill, Housing is a health-related service);
- promote diverse and quality care services; and
- to co-operate with relevant partners, such as local NHS bodies, in providing care and support.

3.4. The Care Bill will:

- Introduce a new national minimum eligibility threshold to access services – this is likely to be set at a level deemed 'substantial' although an early draft of the regulations indicated the threshold may be lower in practice than our current definition of substantial.
- Introduce new legal rights for carers
- Provide the basis of a system for charging for care, including a new cap on eligible care costs. It would also introduce a legislative basis for personal budgets for social care, and independent personal budgets for people whose care and support needs are not being met by a local authority. For example, it would:
  - Introduce a cap (£72,000 for over 65's from April 2016) on the costs that people will have to pay for care and set out a universal deferred payment scheme so that people will not have to sell their home in their lifetime to pay for residential care.
  - Provide free life time care for people with eligible needs that arose before their 18th birthday;
  - Increase the asset threshold for financial support from the local authority with residential care costs from the current £23,250 to £118,000;

- Provide a duty to assess people with care needs who are in prison and make arrangements to meet those needs as if the individual was ordinarily resident in the local authority area in which the prison is based

3.5. In addition, the Bill would:

- Allow for the introduction of Ofsted-style ratings for hospitals and care homes so that patients and the public can compare organisations or services and make informed choices about where to go.
- Establish a unified regime for detecting and intervening in failures in care quality and financial performance at NHS hospitals.
- Introduce a statutory “duty of candour” for health service providers and make it a criminal offence for providers to supply or publish false or misleading information.
- Establish the Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental public bodies.

3.6. Integration of Health and Social Care

The Care Bill requires a local authority to exercise its functions with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would:

- promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area
- contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or
- improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

3.7. At a high level the implications of the Care Bill for Essex County Council include:

- Reform of Care and Support – including the introduction of a cap on care costs to which local authorities will have to respond in terms of managing financial impact as well as administrative requirements
- Responding to the Francis Enquiry – including the introduction of a ratings system and failure regime for care providers
- Increase in demand and scope for adult social care services – including assessment, support planning, and review for both individuals and carers
- Increase in information recording / monitoring requirements – Care Accounts, Individual Personal Budget statements for all individuals with an eligible need will be required.
- Greater volume of adult social care related contacts into the Contact Centre
- Developing new services / redesigning existing services to meet our new brokerage / information & advice duties
- The challenges of managing ‘portable’ assessments

## **4. Policy context**

- 4.1. The Care Bill is a radical reform of social care law and is directly relevant to the achievement of the Essex Joint Health and Wellbeing Strategy and a number of the County Council's priority corporate outcomes, especially:
- People in Essex enjoy good health and wellbeing;
  - People have aspirations and achieve their ambitions through education, training and lifelong-learning;
  - People in Essex live in safe communities and are protected from harm;
  - People in Essex can live independently and exercise control over their lives.
- 4.2. The Care Bill also further promotes the integration and health and social care. The Government's ambition is for Health & Social Care integration to be the norm by 2018. Essex County Council and the 5 clinical commissioning groups (CCGs) have recently submitted our Better Care Fund application and to submit our 2 year operational plans and 5 year strategic plans to government. The Care Bill gives legislative basis to the Better Care Fund.
- 4.3. Implementation of the Care Bill is mandatory.
- 4.4. In line with national guidance, the County Council and the Clinical Commissioning Groups (CCGs) in Essex are working on integration through the Better Care Fund (BCF) schemes and finance, including preparation for the implementation of the Care Bill.

## **5. Financial Implications**

- 5.1. Central government has committed to fully funding the financial impact of any changes arising from the Care Bill; however initial analysis undertaken within the council indicates that the total available funding for Essex County Council is likely to be inadequate to meet the expected increase in demand for services.
- 5.2. ECC has approved one off funding from its reserves of £802,000 in 2014/15 to fund staffing resources to analyse the potential impact of the Care Bill. Work is on-going to scope the cost of implementing the Bill, with an expectation that funding for costs incurred in 2014/15 will be allocated from the £4.9m of Better Care Fund (BCF) monies available in 2014/15 as per the BCF guidance of 1<sup>st</sup> April 2014: "NHS S256 Payments to Local Authorities 2014/15 including BCF Integration Payment". The guidance makes clear that in making payments in accordance with these Directions, the Board is to have regard to the commitment in the White Paper "Caring for our Future; reforming care and support" published July 2012, to the effect that payments under section 256 may be used to cover the revenue costs to local authorities in the relevant financial year of the commitments in that White Paper.

- 5.3. ECC's initial high level estimate of the likely cost of the changes from the Care Bill in 2015/16 is around £30m. Further detailed work is currently in progress to inform the council's budget setting process, with further analysis needed to refine the costs as the draft Care Bill guidance and regulations are published (expected to be from June 2014 onwards). Funding for implementing the changes required in 2015/16 will be via two sources; the BCF and ECC's core revenue settlement from central government although it should be noted that the latter is reducing year on year. Over the three years to 2016/17, central government's core revenue funding to Essex is likely to reduce by £100m.
- 5.4. ECC's ongoing revenue costs could, based on initial estimates, rise to at least £42m in 2016/17. Funding in 2016/17 is yet to be confirmed but will be distributed via the BCF and the revised Relative Needs Formula within the core revenue settlement. Further work is being undertaken to analyse the full financial implications of the Bill over the medium term to long term but costs are likely to increase further post 2016/17.
- 5.5. As such, the introduction of the Care Bill represents a significant financial risk to ECC unless further funding from central government is allocated.

## **6. Legal Implications**

The Care Bill proposes significant changes to the law relating to adult social care which will have ramifications on practice and procedure as well as on the resourcing needs to manage the anticipated increase in demand and new statutory duties. The failure to have the resources and necessary changes in place in readiness for implementation of the new law could leave the Council vulnerable to legal challenge as well as cause damage to its reputation.

## **7. Staffing and other resource implications**

There are no staff implications arising from this decision. However, any implications identified as a result of the published regulations, will form part of the Final Business Case to be developed.

## **8. Equality and Diversity implications**

- 8.1. The Department of Health has produced 11 impact assessments for the Care Bill, which each incorporate an equality impact assessment. These are available via <https://www.gov.uk/government/publications/the-government-published-a-series-of-impact-assessments-alongside-the-care-bill>
- 8.2. The Department of Health will publish detailed guidance and regulations for consultation. This is expected to commence in May/June 2014.

## **9. Background papers**

### **9.1. Presentation to the Health and Wellbeing Board, 20 May 2014**

# The Care Bill

## Presentation to Health and Wellbeing Board

Date: May 2014

Contacts:

James Bullion (People Commissioning)  
Peter Fairley (Policy and Strategy)



# What is the Care Bill?

- Biggest reform of adult social care since 1948
- Royal Assent expected in May 2014
- Bulk of the reforms will 'go live' 1 April 2015
- A new cap on personal contributions towards eligible care costs (the 'cap on care') is due to start from 1 April 2016
- The Bill has a focus on wellbeing and preventing, reducing, and delaying needs from developing.
- The Bill could impose considerable extra costs on social care and will be challenging to implement
- The Bill further promotes integration of health and social care

## Wellbeing Includes:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional well-being;
- Protection from abuse and neglect;
- Control by the individual over day-to-day life
- Participation in work, education, training or recreation;
- social and economic well-being;
- Domestic, family and personal relationships;
- Suitability of living accommodation;
- The individual's contribution to society

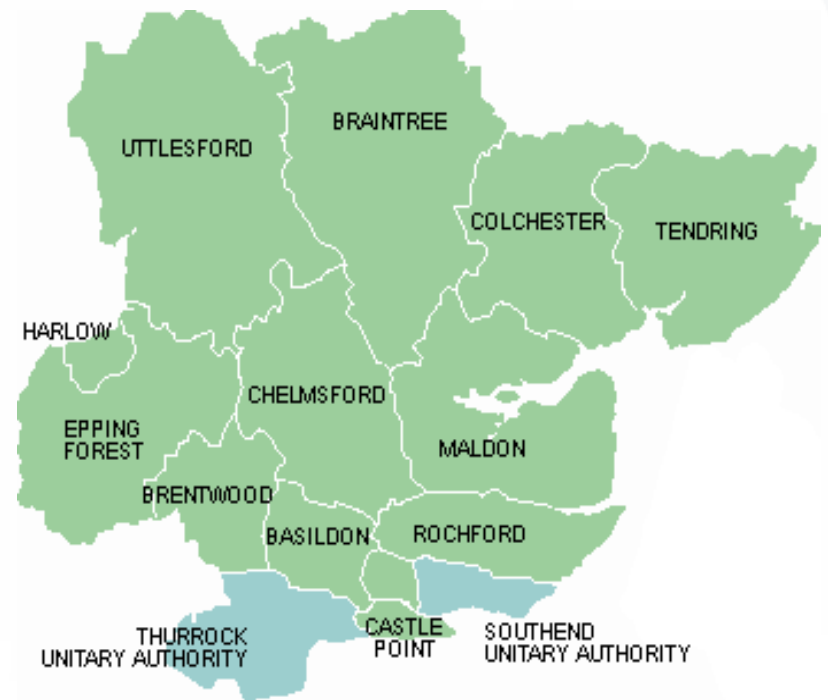


## Context 1: Who gets social care?

- Adult social care is for individuals who are 18 or over
- Access is via a statutory assessment
- To qualify you must have assessed needs of substantial or above
- Thresholds are set out in national guidance “Prioritising Need” (Dept. of Health, 2010)
- Essex CC currently carries out some 18,000 assessments a year
- ECC also provide support for carers who can have an assessment in their own right
- Majority of customers are older people 65 plus

## Context 2: the demographic challenge

- Essex population getting older and larger
- 6% growth 2001-11; +20% to 2033
- 18.3% Essex residents aged over 65 (national figure = 16.4%).
- Between 2008-33, working age people to fall from 60% to 55% of the Essex population; older population to grow from 21% to 28% of the population. By 2031 there will be more people over 60 than under 20
- Almost 10% of our residents provide informal care to relatives, friends or neighbours. Over half of the people providing unpaid care are people aged over 50.



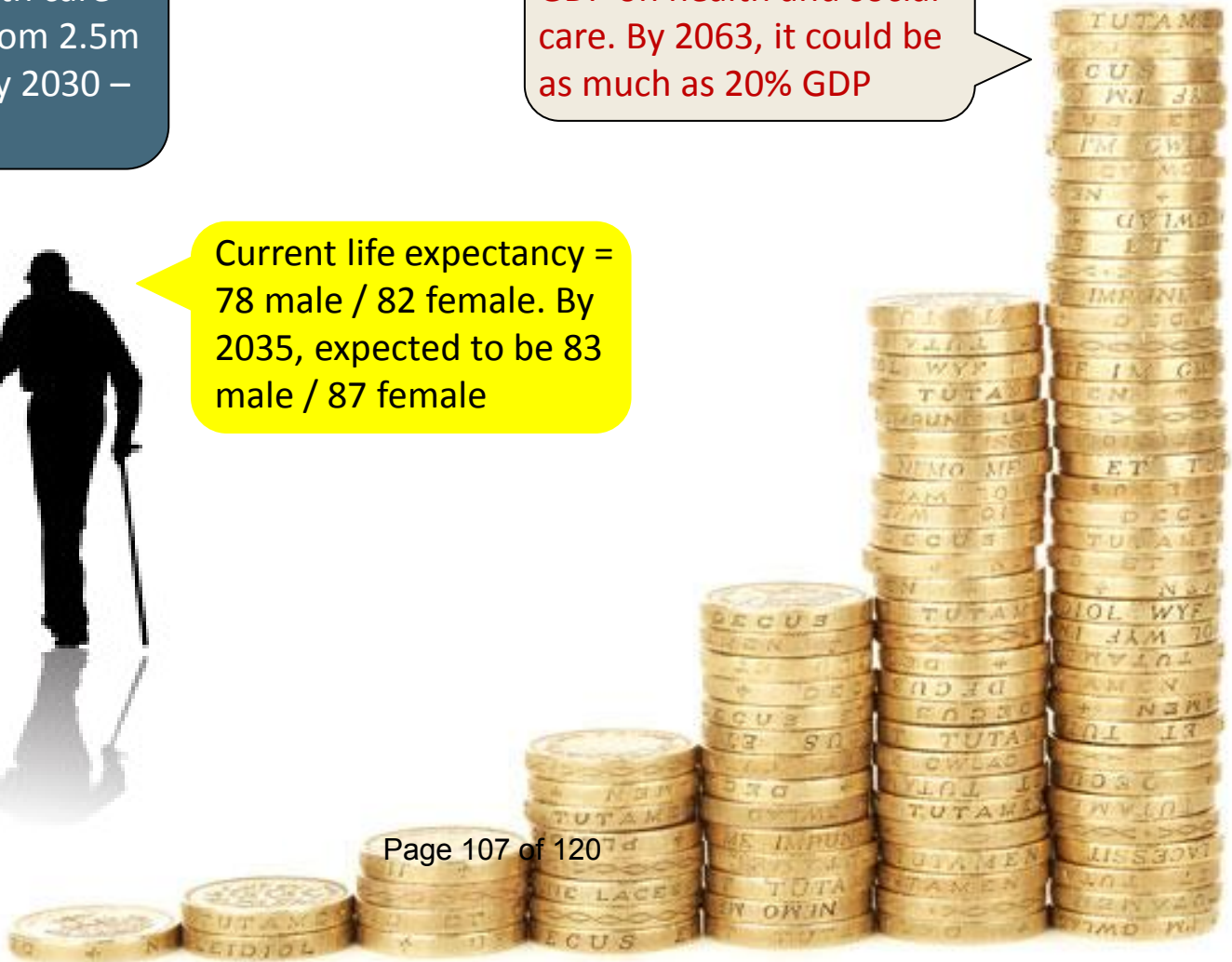
# Context 3: the affordability challenge

Nationally, the number of people over 65 with care needs will grow from 2.5m in 2010 to 4.1m by 2030 – a 60% increase

UK currently spends 9.5% GDP on health and social care. By 2063, it could be as much as 20% GDP



Current life expectancy = 78 male / 82 female. By 2035, expected to be 83 male / 87 female



# Care Bill – timetable

The timetable is challenging – the bulk of the reforms go live in April 2015

Key requirements	Timing
Duties on prevention and wellbeing	From April 2015
Duties on information and advice (including advice on paying for care)	
Duty on market shaping	
National minimum threshold for eligibility	
Assessments (including carers' assessments)	
Personal budgets and care and support plans	
New charging framework	
Safeguarding	
Universal deferred payment agreements	
Extended means test	From April 2016
Capped charging system	
Care accounts	

# The Care Bill – a quick summary of key changes (1)

## Proposed reform

Changes to eligibility – new national minimum threshold may well expand eligibility

Introduction of a cap on lifetime costs from April 2016 (for eligible care needs) – including free lifetime care for people with eligible needs whose needs arose before their 18<sup>th</sup> birthday

Asset threshold for support with residential care raised from £23,250 to £118,000

Right to a Deferred Payment Agreement

Duty to maintain a Care Account for all individuals, recording accrual against personal cap

Duty to assess, support plan and review all individuals

Expanded duty to identify, assess and provide support for carers

# The Care Bill – a quick summary of key changes (2)

## Proposed reform

‘Portable’ care packages – duties to ensure continuity of care where individuals move local authority areas

Explicit requirement to provide universal but personalised information and advice service, including access to independent financial advice

Expanded New statutory duties to broker services that prevent, reduce or delay needs from developing (universal)

Duty to promote integration of care and support with health services (for the purposes of the Bill, Housing is considered a health-related service)

A new right for young people, parents, carers to request a care and support assessment before they reach 18

A duty to assess people with care needs who are in prison and make arrangements to meet those needs as if the individual was ordinarily resident in the local authority area in which the prison is based

# Duties towards carers

- New rights to assessment for carers – they do not need to request one. The only requirement is that the carer ‘may have needs for support – whether currently or in the future’.
- A national eligibility threshold also brings greater clarity around entitlement for carers and for those they care for
- A new duty on local authorities to provide or arrange for services, facilities or resources which will prevent or delay the development of, or reduce the needs for care and support of carers
- Almost 10% of our residents provide informal care to relatives, friends or neighbours. Over half of the people providing unpaid care are people aged over 50.

# National minimum eligibility criteria

- Will provide a national minimum standard – ensuring greater consistency across the country
- Government propose to set it at ‘substantial’ but the draft regulations indicate that it looks more like ‘moderate’
- Formal consultation on revised criteria expected June 2014



## Draft national minimum eligibility threshold for adult care and support

A discussion document

June 2013



# The Care Cap

- The Bill will place a cap on eligible care costs. It is intended that the cap will be £72,000 when it is introduced in April 2016 for those over 65
- Cap will be tapered for those under 65; care will be free for life if needs identified before 18
- Contribution towards the cap is calculated as based on what the local authority would pay to meet the eligible needs of the individual and does not include living costs.
- If you need residential or nursing care, the local authority will make an assessment of what it will do to meet your eligible needs. If you cannot find a home you like within this budget, you or your family will have to "top up" the difference. These additional payments will not count towards the care cap.
- Living costs are currently estimated to be approximately £12,000 per year
- The financial threshold for support with care costs is set to be increased to £118,000 worth of assets or less
- Public awareness is low, non-existent

# Care Accounts, Personal Budgets and Independent Personal Budgets

Given a legal basis for the first time:

- **Personal Budgets** - If an individual is assessed as having eligible care needs and they qualify for local authority support, they will be given a personal budget which shows the costs of meeting that person's needs.
- **Independent Personal Budgets** – These are provided where individuals have eligible needs but do not receive local authority support. It will show the rate the local authority would pay to meet those needs.
- **Care Account** - This will show how someone is progressing towards the costs cap. Once a person reaches the cap, the local authority will have to pay any further costs of meeting the person's eligible needs

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- Requirement for regular statements (likely to be annual).

# Information and Advice Service

The service must provide information and advice on:

- The care system and how it operates
- the choice of types of care and support, and the choice of providers, available to those who are in the authority's area
- how to access the care and support that is available
- how to access independent financial advice on matters relevant to the meeting of needs for care and support
- how to raise concerns about the safety or well-being of an adult who has needs for care and support

# Assessments

The authority must assess—

- (a) whether the adult does have needs for care and support, and
- (b) if the adult does, what those needs are.

The duty applies regardless of the authority's view of—

- the level of the adult's needs for care and support, or
- the level of the adult's financial resources.

An assessment must include—

- the impact of the adult's needs for care and support on an individual's well-being
- the outcomes that the adult wishes to achieve in day-to-day life, and
- whether, and if so to what extent, the provision of care and support could contribute to the achievement of those outcomes.

Assessments can be refused but a local authority must carry out an assessment if the adult does not have capacity to refuse or is in danger of abuse/neglect

# Integration: The Care Bill and the Better Care Fund

- Government policy is clear – integration is the way forward and must be achieved by 2018.
- Significant progress is expected by 2015 – Better Care Fund is the driver
- Care Bill makes integration the default position when commissioning services and places a duty on both CCGs and local authorities to co-operate for that purpose

# Conclusions

1. The Care Bill is a massive change to adult social care – the biggest since the 1940s
2. The Bill brings some welcome changes, include new rights for carers, clarity on a national minimum eligibility criteria, and a focus on prevention and also further promoting integration between health and social care
3. However, the reforms could create additional demand and generate cost pressures on adult social care
4. There is much to do to prepare for implementation of the reforms and to ensure that systems and people are ready for the changes. There is very little time to prepare (the bulk of the reforms are due to be implemented in April 2015) and the detailed regulations are not due to be published until June

This report has been prepared by  
Essex County Council's Strategy function

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