DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE ADULT CARE BOARD

THURSDAY 1 DECEMBER 2016
10:00 – 12:00 NOON
MEMBERS ROOM, COUNTY HALL, MATLOCK, DERBYSHIRE, DE4 3AG

A G E N D A

	Time	**Item** Apologies:	**Lead**	**Information/ Discussion/ Decision**
1	10:00am	Welcome & Introductions		
2	10:10am	Minutes and matters arising from the meeting held on 15 September 2016 (attached)		Information
3	10:20am	STP Update	Joy Hollister	Discussion
4	10:35am	Learning Disability Transforming Care Update	Joy Hollister	Information
5	11:50am	Healthwatch • Summary Report (attached) • Intelligence Report (attached)	Karen Ritchie	Information
6	11:10am	Falls Pathway and HNA Update	Darran West	Information
7	11:20am	Working to help vulnerable residents stay warm and well at home (attached)	Bill Purvis	Discussion
8	11:40am	Better Care Fund 2016-17 Quarter 2 Performance Return (attached)	Graham Spencer	Information
9	11:55	AOB		
10	12:00noon	**FINISH**		
		The next meeting of the Adult Care Board will take place on Thursday 16 March 2017 at 10:00am in Members Room, County Hall, Matlock.		

Pam Greaves
On behalf of Joy Hollister, Strategic Director - Adult Care Department
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DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

MINUTES OF A MEETING HELD ON

MONDAY 15 SEPTEMBER 2017 AT 10:00AM

DERBYSHIRE COUNTY COUNCIL, MEMBERS ROOM, MATLOCK HQ

PRESENT:

Joy Hollister	JH	Derbyshire County Council – Adult Care
Cllr Rob Davison	RD	Derbyshire County Council Deputy Cabinet Member (Adult Social Care)
Beverly Smith	BS	ND CCG
Rachel Madin	RM	ND CCG
Jim Connolly	JC	Hardwick CCG
Karen Ritchie	KR	Healthwatch
Davinder Johal	DJ	Derbyshire Fire and Rescue Service
John Simmons	JS	Healthwatch
Stella Scott	SS	CVS
Jacqui Willis	JW	NDVA - Chief Executive
Jon Clark	JCl	Derbyshire Police
Helen Weston	HW	Derbyshire Carers
Helen Dillistone	HD	Southern Derbyshire CCG
Isabel Fleming	IF	Childrens Services, ND CCG, Erewash & Hardwick CCGs

IN ATTENDANCE:

Pam Greaves	PG	Derbyshire County Council - Adult Care (Minutes)
Graham Spencer	GS	Derbyshire County Council – Adult Care

APOLOGIES:

Cllr Paul Smith	Derbyshire County Council Cabinet Member (Adult Social Care) **Chair**
Cllr Dave Allen	Derbyshire County Council Cabinet Member (Health & Communities)
Julie Vollor	Derbyshire County Council – Adult Care
Clare Watson	Tameside & Glossop CCG
Navinder Sharma	Derbyshire Carers

Dave Gardner	Hardwick CCG
Eleanor Rutter	Adult Care Public Health
Karen Macleod	Derbyshire Probation
Kate Majid	ND CCG

Minute No	Item	Action
	WELCOME FROM CLLR DAVISON (CHAIR)AND APOLOGIES NOTED	
ACB 107/16	**MINUTES FROM THE MEETING ON 14 SEPTEMBER 2015 & MATTERS ARISING** The minutes from 16 June 2016 were accepted as a true record.	
108/16	**STP UPDATE** JH updated the group on the Derbyshire/Derby City/NHS England footprint. Timescales : • Financial assumptions check 16/9/16 • Framework submission for NHSE approval – October 2016 Initial feedback has been positive. Still work to be completed on: • Workforce • Digital Roadmap IT • Assets – building bases The aim is to provide a seamless service and will share the plan asap. KR - Shaun Thornton has been working on a plan for a wider stakeholder involvement and will feed back on this. BS – Health and Equalities and financial gap. This is a shared Derbyshire problem. 21st Century event went very well. Using different channels of communication to reach the public and get them on board at an earlier stage. JS - Healthwatch Regional agree that getting people on board earlier needs to happen throughout all counties. RD - Cllr Allen has written to Jeremy Hunt re Sustainability and	**KR/ST**

	Transformation Plans. **Feedback Noted**	
109/16	**LEARNING DISABILITY TRANSFORMING CARE UPDATE - JH** Post Winterbourne Project. New models of care needed: • How many people are still in residential care? • How do we get them out? • How do we stop people entering residential care? It may be a small number of people but every person counts. **JH to provide regular updates.**	**JH**
110/16	**HEALTHWATCH UPDATE – KR** KR briefed the group on the positive reports that had come out of the surveys: 'What makes for a positive Health of Social Care experience?' • Lots of positive experiences about staff • Access to services • Environment – chairs, waiting rooms etc • Told why they are waiting to reassure These are important issues and can cost virtually nothing but make a huge difference to clients. The results of the surveys were sent out to agencies and many have taken it on board. This is a public document and can be found on their website. Getting some responses from GPs and some are beginning to see the benefit but still need back up from the CCGs to get everyone on board. VSPA are completing the survey over the phone and getting good responses. It is important to remember that LD and Supported Housing clients cannot go elsewhere so when they receive a good service it can change their lives. HD has invited KR to present the report at a SD CCG meeting.	

	'Living with Substance Misuse' Responses still coming in so KR will share once completed. Full report will be available in October. • Some small providers need to catch up with patient experience reports • Hardwick and DHU – good responses • Pledges will be checked at 6 monthly intervals JH informed the group that the Carers; Advocacy and Mental Health Tender reports will be going to Cabinet on the 20th September 2016. • KR to feedback Positive Health and Substance misuse to future meeting • KR to feedback from Manchester conference. **Report noted**	**KR** **KR** **KR**
111/16	**BCF QUARTER 1 – GS** GS presented the BCF report to the group. Discussed were the performance measures: 1. Non elective admissions – better but not on target 2. LT support – reducing numbers entering care 3. Delayed Transfers of Care - a lot of work done on this topic and performance has improved but more work to be done to meet targets 4. Re-ablement Service - Doing well. Action Plan due shortly. 5. Patient experience – high 6. Dementia – relatively high. GS pointed out that these are the H&WB figures and not individual CCGs. Local and national problems with recruitment. Next report due 20/11/16 Report to be shared at Health & Wellbeing Board next week. **Report noted.**	

112/16	**FALLS PATHWAY – ER** ER sent her apologies to the meeting. ER to ensure CCGs are sited on the report as it will be a joint report. ER to complete and bring back to next meeting.	 **ER** **ER**
113/16	**AOB** None	
	Dates of future Adult Care Board meetings: • 1 December 2016, 10:00 – 12:00, Members Room, County Hall, Matlock • 16 March 2017, 10:00 – 12:00, Members Room, County Hall, Matlock • 15 June 2017, 10:00 – 12:00, Committee Room 2, County Hall, Matlock • 21 September 2017, 10:00 – 12:00, Committee Room 1, County Hall, Matlock • 18 January 2018, 10:00 – 12:00, Committee Room 1, County Hall, Matlock	

Intelligence Report – November 2016

Please direct all enquiries to Helen Hart, Intelligence and Insight Manager, helen@healthwatchderbyshire.co.uk or 01773 880786.

All our reports can be found at http://www.healthwatchderbyshire.co.uk/category/our-work/

New Reports

Experiences of using Health and Social Care Services before, during and after Mental Health Crisis.

The topic was selected by the Intelligence, Insight and Action Committee of Healthwatch Derbyshire (HWD), who regularly appraise all the comments and experiences received by the organisation. The committee recommended this engagement priority due to a number of comments relating to experiences before, during and after mental health crisis.

The engagement activity was conducted between May – July 2016. Using focus groups of two or more participants.

Focus groups took part across Derbyshire with a total of 40 responses collected, 20 from the north of the county, and 20 from the south.

The Mental Health Crisis Concordat in Derbyshire was the framework for the engagement activity. The key principles from the concordat were captured on a prompt sheet for Engagement Officers to use, and refer to, when talking to participants. The Mental Health Crisis Concordat Delivery Group have been receptive to the work of HWD and the insight that this independent source of patient feedback can offer, and have pledged to use the findings in this report to inform their 2017 action plan.

Summary of findings

There are several positive themes that have emerged from the findings, these were:

- Telephone support lines appear to be valued and provide support for some participants.
- Support groups appear to be valued and provide support for some participants.
- The speed and quality of response made by police on most, but not all occasions.
- The value and difference made by easy contact systems and positive relationships with community psychiatric nurses (CPNs).
- Consistently positive feedback regarding Trevayler House.

Negative themes that emerged included:

- Focusline number is regularly engaged.
- Being passed around between services pre-crisis, and a lack of coordination. No sense of ownership from professionals to deal with the emerging situation.
- Access to, availability of and continuity with CPNs.
- Lack of consistency in dealing with and responding to mental health crisis in General Practice.
- Waits/delays in being seen in Accident and Emergency (A&E).

- Knowing where to go and what to do when needing support and action pre and post crisis.
- Police ability to identify and respond to potential overdoses.
- Lack of identification and recognition of the mental health needs that an individual has, or perceives that they have.
- Police did not always explain restraint, when used.
- Occasional use of prison cells for people in mental health crisis.
- Distress caused by supervised toileting/showering in secure units.
- No relationship with named nurse in secure units, so of limited/no value.
- Lack of activities in secure units.
- Lack of awareness of physical health needs when in secure units.
- Lack of time with staff when in secure units.
- Little awareness of or value placed on advocacy.
- Self-harm risks in rooms at The Priory.

Recommendations

1. Provide clear information for patients, friends, family and carers about where to go, and what to do in a developing crisis situation.
2. Work to develop coordination of, and show real ownership of developing crisis situations.
3. Address access issues to Focusline.
4. Maximise access to, availability of and continuity with CPNs.
5. Support General Practice to deal with and respond to mental health crisis.
6. Work to improve patient experience in A&E.
7. Address police ability to identify and respond to potential overdoses.
8. Police to explain restraint when used.
9. Address and seek to minimise use of police cells for people in mental health crisis.
10. Consider distress caused by supervised toileting/showering in secure units, and consider alternative solutions.
11. Develop role/purpose of name nurse in secure units.
12. Consider provision of appropriate activities in secure units.
13. Consider how physical health needs are accommodated by secure units.
14. Appropriate awareness raising of advocacy and its purpose.
15. Consider and take any necessary action required to address reported self-harm risks in rooms at The Priory.

Current status of the report – This report is currently out for response, and will be published early in December. A summary of responses will be provided in future editions of the intelligence report.

Enter and View visits to Derbyshire County Council Care Homes

During 2016/2017, HWD was commissioned by Derbyshire County Council (DCC) to conduct a range of unannounced visits to their establishments across the county. This consisted of 22 services supporting older persons and four services supporting people who have learning disabilities.

Visits are undertaken by the HWD Enter & View Authorised Representative volunteers who are fully trained.

A summary report has been produced to encapsulate the visits that have taken place between June -September 2016. Individual reports for each service are normally

completed within 6 weeks of a visit being undertaken and sent to DCC as part of their internal quality assurance processes.

As the Enter & View reports were commissioned primarily for DCC's own consumption, individual reports are not placed in the public domain as is usually the case with Healthwatch Enter & View reports. However, a tri-annual summary report was agreed to be made public and published at the end of September 2016, January 2017 and March 2017.

The September summary report can be found at:

http://www.healthwatchderbyshire.co.uk/2016/10/dcc-care-home-enter-view-summary-report/

GP Patient Online Services Report

This report looks at public awareness of, and access to, GP online services in Derbyshire.

The GP Patient Survey of 2014 shows that 34% of patients said they would prefer to book their appointments online[1]. This being the case, only 7% actually do.

Both the 2014/15 and 2015/16 GP contract required GPs to show a commitment to expanding and improving the online services for their patients.

Online services were required to include:

- online appointment booking
- online repeat prescriptions service
- online updating of general details such as change of address
- online access some information from patient medical records.

The aim is not to replace traditional methods of contacting a practice, but offer additional ways to make it easier and more convenient.

Given this information, i.e. the requirement of GPs to offer online services, and the survey results around low levels of use in 2015, HWD decided to examine the situation in Derbyshire. We looked in detail at public awareness of, and access to, online services that are currently being offered.

Summary of Findings

- Findings from the survey show that the majority of patients are unaware of the full range of online services that are being offered
- The majority of patients found out about online services through promotion within the surgery
- Findings from the survey show that online repeat prescriptions and booking appointment remain the most popular online services used by patients

[1] GP Patient Survey results, July 2014: https://gp-patient.co.uk/surveys-and-reports#july-2014 Note: this question has been dropped from the GP Patient Survey as of January 2015.

- In April 2016, not all GP surgeries were offering the full range of online services.
- Most users of online services found them easy to use
- 94% of people who used their GP online services would recommend them to family and friends
- In April 2016, most GP surgery websites were not providing comprehensive information addressing online security and privacy concerns
- In April 2016, most GP websites were not providing adequate information about how to register for online services.

Recommendations

1. Online services should be promoted under one tab/link on the website in order to make online services more visible and easier to navigate.
2. GP websites should provide their Data Protection Policy and provide simple and clear information about how patient records will be safeguarded.
3. GPs should ensure that they are offering the full complement of online services.
4. Registration – GPs should consider the difficulties for people who do not have photo ID, and promote alternatives when registering for online services.
5. There should be 'Help Services' available to offer explanatory notes for ease of use, including commonly asked questions and answers.
6. GPs should continue to promote their online services in particular to those who are infrequent users of the service.
7. GP practice websites should offer google translate allowing for greater access to non-English speakers.
8. To reassure patients that online services are not intended to replace traditional ways of contacting a GP practice, over the phone or in person but simply offer additional ways to interact with them.

Current status of the report – This report has been published and is available on the HWD website. We received 53 responses from GP practices across the County, and a response from 4 of the CCG's in Derbyshire. The majority of responses stated that they found the report useful, and used the recommendations to improve their patient online services. There are too many responses to summarise here, but they can be found in the report published on our website. Click on this link http://www.healthwatchderbyshire.co.uk/2016/11/gp-patient-online-services-report/. A list of the GP practices who responded is also available.

Living with Substance Misuse Report

HWD has published a report highlighting the experiences of individuals living with substance misuse accessing health and social care services in Derbyshire.

This engagement activity took place from January 2016 - mid-April 2016.

Engagement Officers carried out engagement activity in drug treatment centres, community recovery projects and in other locations and worked collaboratively with SPODA to set up two focus groups with carers in Chesterfield and Ilkeston.

A total of 59 responses were collected, out of these:
- eight related to alcohol dependency
- 41 related to drug dependency
- six related to dependency on prescription drugs

- four related to dependency on drugs and alcohol.

In addition to the 59 people we spoke to who were living with substance misuse, we also spoke to a total of 15 carers and 15 members of staff to hear their perspective on how individuals living with substance misuse experience accessing health and social care services.

Summary of findings

- With regards to the participants we spoke to, more people told us that they had turned to substance misuse because of their mental health than because of any other reason.
- Some participants living with substance misuse went on to develop mental health problems.
- Participants found it difficult to access mental health services as there appeared to be a rule that their substance misuse must be addressed first before they would be treated by mental health services.
- Mental health crisis teams do not take referrals from drug treatment staff who are not nurses.
- Various staff members spoke about the difficulty of making referrals for mental health support, including drug key workers, voluntary sector staff and other health and social care professionals.
- For most participants their GP was the first point of call to address substance misuse problems.
- There were mixed experiences reported by both participants and carers of the support offered by GPs. Some participants reported that GPs listened to them, were caring and referred on to other support and treatment, whilst others felt not listened to, ignored and dismissed without adequate support.
- There were some concerns and issues around GP prescribing.
- There were concerns about the lack of adequate management of pain and lack of referral to pain management clinics by GPs.
- There was a reported lack of support/understanding from GPs for carers and their needs.
- There were mixed experiences of services provided by acute hospitals. Some participants felt that there is a stigma to drug/alcohol misuse, which led to them being judged, and not treated with dignity and respect. However, some staff were reported as being brilliant, kind and understanding regardless.
- There was a feeling that drug/alcohol users were discharged from hospital settings without adequate community support.
- Generally positive experiences were reported regarding pharmacies, East Midlands Ambulance Services and dental services.
- Some participants reported that social workers were felt to be judgmental, difficult to contact and changed often.
- There appears to be concerns over the effectiveness of social workers when children were on a supervision order, e.g. home visits.
- There were concerns that out of date swab testing kits are being used.
- There was a reported need for advocacy support during social care meetings.
- There seem to be some themes across most of the drug treatment centres, which are:
    - Long waits to see key worker.
    - The waiting room experience/environment was not seen to be conducive to recovery.
    - Inflexible systems and behaviours from services and staff.
    - The management of prescriptions, e.g. holding back etc.
    - Complaints systems and feedback mechanisms not seen as effective.

  - The demands of paperwork and preparation for panel hearings.
  - The effectiveness of treatment outcome framework paperwork.
- There were concerns about drugs being sold outside of Bay Heath House and the impact this had on an individual's recovery.
- SPODA was spoken about very favourably.
- Derbyshire Alcohol Advice Service was spoken about very favourably.
- Community recovery projects were mostly spoken about favourably, with participants valuing the activities they provide, and the peer support they offer.
- There were reported issues with travel/access to community recovery projects and mutual aid courses.
- There were mixed comments about the usefulness of mutual aid courses.
- There were reports of the drug rehabilitation requirement test being ineffective as no sanctions seemed to follow.
- There is an apparent lack of drug treatment for short custodial sentences.
- Judgmental attitude of some health and social care professionals.
- Some participants reported that the stigma and shame around substance misuse has a huge impact on both users and carers.
- Carers reported not knowing where to go to for support.

Recommendations

- GPs to consider whether there are clear criteria to trigger referrals to pain management clinic.
- Family members of individuals with a substance misuse problem should be recognised as carers, listened to and to have their needs considered in their own right.
- Effective supervision in pharmacies to ensure that the methadone/subutex has been ingested.
- Ensure that precautions are taken at pharmacies to protect confidentiality, and to preserve the dignity and respect of people collecting medication.
- Consider the need for people who misuse substances to access a full range of mental health services
- Consider which professionals can make referrals to the crisis team.
- Consider how advocacy support can be made available to assist in social care meetings.
- Information sharing agreements should be adhered to in drug treatment centres, to improve communication and to use the family as a vehicle to aid in the recovery process.
- Prescriptions for methadone/subtext should not be held back.
- Consider the waiting room environment in drug treatment centres to minimize negative experiences for users.
- To address the issue of drug pushers at the main entrance to Bay Heath House.
- Address the issues around the complaints systems at drug treatment centres, and how these could be improved.
- Review the effectiveness of the treatment outcome profile.
- Consider more flexible appointments in drug treatment centres, to accommodate people who work, cultural beliefs etc.
- Consider the role of peer support in drug treatment centres.
- Work to ensure that the prescribing roles and any limitations to the prescribing ability of different health care professionals are clearly understood.
- Professionals to ensure that any referrals made to community recovery projects happen at the best time for recovery.
- Address the geographical coverage of community recovery projects and mutual aid courses.

- Community Recovery Project should encompass a wide range of elements such as horticultural sessions, employability, peer mentoring, sports/exercising, art therapy and mindfulness.

Summary of some of the responses with actions pledged

CCGs - We plan to take the report to the respective quality meetings with our providers to explore what can be done to improve patient experience.

In particular in our review of urgent care services we will review the ways in which non nursing or medically qualified staff can refer to the crisis teams.

We note the concern expressed that patients cannot access mental health services unless their substance misuse problem had been resolved first. We have already taken action to improve this. For example, the psychological therapies services we now commission are required not to exclude automatically substance misuse but will discuss with the patient or referrer and come to a considered clinical opinion on the suitability of the person for treatment.

Derbyshire County Council Public Health - We will seek assurances from the provider that a refreshed complaints procedure is readily available and easily understood by all service users. Service users must have confidence that their complaints will be dealt with promptly, responded to appropriately and will not have a negative impact on their treatment.

Chesterfield Royal NHS Foundation Trust - Since reading this report, we have already made the following changes:

- Basic substance misuse awareness training is currently included in nurse induction and HCA core training.

- The Urgent Care Village project proposal includes an assessment area to support people with mental health needs when waiting in the Emergency Department; however, there is no firm date for this at present.

We will be making the following changes:

- We will build on current training provision to support staff to understand the effects of different substances, to understand the experiences of patients who use substances and to raise awareness of the support and advice available. Current training will be supplemented by a mixture of formal training, point of care, drop-in sessions and e-learning packages.

- The training needs identified at the stakeholder focus group will be subject to further discussion at the Trust's Professional Education Group to ensure that requirements will be met.

- Carer involvement with substance users is to be incorporated within the carers CQUIN/quality strategy work, to ensure those who require it are identified as carers and offered appropriate support.

- We will share a patient story with Board on the experiences of an ex-substance user, to bring their experiences to the forefront and support understanding of patients who use substances.

- We will implement rolling health messages on ED TV screens and bespoke materials to hand out to patients, to capture those who are not necessarily ready to discuss their substance misuse.

- We will implement stakeholder focus groups to respond to issues and recommendations from Healthwatch and other feedback mechanisms in the future.

Derbyshire Healthcare NHS Foundation Trust - The response was comprehensive in response to the recommendations, and can be found in full in the report.

Responses were also received from Derby Teaching Hospitals, Tameside Hospital, Derbyshire County Council Adult and Children's Services.

Current status of the report – This report has been published and is available on the HWD website. http://www.healthwatchderbyshire.co.uk/2016/09/substance-misuse-report/ The actions referred to in the responses made will be periodically checked for progress by Healthwatch, with progress reported in future intelligence reports.

Update on a selection of earlier reports

These reports have been summarised in earlier versions of this Intelligence Report, and can be found on our website under 'Our Work'. Reports with updates to include are as follows:

➢ What makes a positives Health or Social care experience?

This report has now been published and all responses received can be found at

http://www.healthwatchderbyshire.co.uk/2016/08/positives-report/

This report, in contrast to others published by HWD, is designed to focus on the large number of positive experience we have received. The report shares this with providers, commissioners and other relevant parties to enable them to reflect on and judge what they can learn from this. The report shows that some improvements to services need cost very little and in many cases, nothing at all.

The report is based on 620 comments received between, 1st April 2014 - 31st December 2015. The services most talked about were hospitals and GP practices.

➢ Access to Health Services for People with Learning Disabilities Report

This report has been published with responses to the recommendations and can be found at:

http://www.healthwatchderbyshire.co.uk/2016/02/access-to-health-services-for-people-with-learning-disabilities/

The content of the responses received from service providers and commissioners was extensive and very encouraging. All organisations have been recently contacted by HWD for an update on the actions pledged.

All responses demonstrate a real ongoing commitment to improving services for people with learning disabilities, with many organisations providing an update on the initiatives they are working on. One example of this is discussion around a county wide 'stop' sign which has the potential to be agreed and adopted across a range of services – progress on this and other actions will be supported and monitored by HWD with highlights reported in future editions of the intelligence report.

- **Autism Pathway Report**

This report has been published with responses to the recommendations and can be found at: http://www.healthwatchderbyshire.co.uk/2015/11/autism-pathway-report/

Six months on from publishing our Autism Pathway Report last September, we requested an update from the Derbyshire Children's Autism Co-ordination Group on 4th February 2016. We received a detailed response outlining the actions that had been taken, or were currently in progress. This is available here: http://www.healthwatchderbyshire.co.uk/wp-content/uploads/2015/11/Autism-Report-Recommendations-Update-DCC.pdf

Linda Dale, Head of Commissioning and Partnerships Children's Services, Derbyshire County Council, stated that:

"The Healthwatch Report is directly influencing the development of new pathways and support for children and young people with autism, although we recognise that this work is far from complete."

As many of the actions were still progressing, we have agreed to follow up again in September 2016 **(update is pending)**.

These actions include:

Mapping of the current autism training and support which is offered by services to evaluate whether it is sufficient, co-ordinated and meeting needs. This extends beyond education providers and will include education and training offered to parents/carers, young people and professionals across education, social care and health.

Southern Derbyshire is looking at implementing a more structured pathway approach and it is anticipated that a leaflet for parents regarding what to expect when and where, will be available as part of the process.

A review of the autism information on the Local Offer.

Funding has been identified through 'Future in Mind' to increase the provision of training in Southern Derbyshire – discussions are underway to agree how this can be utilised most effectively. The mapping work will inform this.

Chesterfield Royal Hospital have developed an information leaflet on 'What to expect'. In the North, Chesterfield Royal Hospital is working on developing a process for second opinions, when the professional opinion differs to that of the parents.

Derbyshire Healthcare has confirmed that an action plan is in place to respond to the Healthwatch report and this is currently under review.

Engagement priorities and reports due: Sep 2016 - March 2017

- Experiences of using maternity services and health and social care services for young children.
- LGBT+ experiences of using health and social care services.
- The Accessible Information Standard – exploring experiences of accessing health and social care services for patients with a sensory impairment.

Enter & View
Tri-annual Summary Report

Visits commissioned by Derbyshire County Council 2016-2017

WHAT IS ENTER AND VIEW? Healthwatch Derbyshire (HWD) is part of a network of 148 local Healthwatch across the country established under the Health and Social Care Act 2012. Healthwatch Derbyshire represents the consumer voice of those using local health and social services.

The statutory requirements of all local Healthwatch include an "Enter and View" responsibility to visit any publicly funded adult health or social care services. Enter and View visits may be conducted if providers invite this, if Healthwatch Derbyshire receive information of concern about a service and/or equally when consistently positive feedback about services is presented. In this way we can learn about and share examples of the limitations and strengths of services visited from the perspective of people who experience the service at first hand.

Visits conducted are followed by the publication of formal reports where findings of good practice and recommendations to improve the service are made.

Main Office Details: Healthwatch Derbyshire, Suite 14, Riverside Business Centre, Foundry Lane, Milford, near Belper, Derbyshire DE56 0RN Tel: 01773 880786.

Healthwatch Responsible Officer: David Weinrabe (Enter & View Officer)
Tel: 01773 880786 or Mobile: 07399 526673

1. The context

During 2016/2017, Healthwatch Derbyshire was commissioned by Derbyshire County Council (DCC) to conduct a range of unannounced visits to their residential services across the county. The service profile and range includes 22 services supporting older persons and 4 services supporting people who have learning disabilities/difficulties.

Visits have been managed by the Healthwatch Enter & View Officer and the principles of the annual schedule agreed with the DCC Service Manager (Direct Care) Quality and Compliance, Emma Benton. The schedule has also been co-ordinated with CQC local inspectors to ensure that visits by either organisation are not in too close in proximity to one another.

Visits are undertaken by the Healthwatch Derbyshire Enter & View Authorised Representative volunteers who are fully trained to undertake such activities.

This summary report represents those visits that have been undertaken between June - September 2016 and where the visit reports themselves have been fully completed. Such reports are normally published within 6 weeks of a visit being undertaken and sent to DCC as part of their internal quality assurance processes.

As the Enter & View reports were commissioned primarily for DCC's own consumption, individual reports are not placed in the public domain as is usually the case with Healthwatch Enter & View reports. However, a tri-annual summary report was agreed to be made public and published at the end of September, January and March.

2. Completed visits

No.	Service Visited	Type of Service	Date of Visit	Authorised Representatives
1	Ada Belfield House, Belper	Older Persons	Monday 6th June	Patrick Ashcroft & Helen Barker
2	Goyt Valley House, New Mills	Older Persons	Monday 6th June	Lesley Surman & Caroline Hardwick
3	New Bassett House, Shirebrook	Older Persons	Monday 20th June	Helen Barker & Philip Arrandale
4	Staveley Community Care Centre, Staveley	Older Persons	Tuesday 21st June	Kevin Sadler & Barbara Arrandale
5	Lacemaker Court, Long Eaton	Older Persons	Wednesday 13th July	Brian Cavanagh & Bob Clemson
6	The Leys, Ashbourne	Older Persons	Friday 22nd July	Helen Barker & Dave Mines
7	Gernon Manor, Bakewell	Older Persons	Monday 8th August	Caroline Hardwick & Shirley Cutts
8	Holmlea,Tibshelf	Older Persons	Thursday 11th August	Barabara Arrandale & Kevin Sadler
9	Florence Shipley, Heanor	Older Persons	Friday 12th August	Philip Arrandale & Dave Mines

Eight further visits have been undertaken since the above were fully completed, 1 of these is, at the time of this report, out with the service concerned and awaiting their response. In addition 1 service response from the above list is awaited which has been unavoidably delayed. 7 others are in process of the draft reports being developed.

3. Acknowledgements

Healthwatch Derbyshire would like to thank DCC, the care home unit managers, residents, visitors and staff for their contributions to these Enter and View visits undertaken from June - September 2016, and to those who have been involved subsequently.

4. Purpose of the visits

- To enable Healthwatch Derbyshire Authorised Representatives (ARs) to see for themselves how services are being provided in terms of quality of life and quality of care principles.
- To capture the views and experiences of residents, family members/friends and staff.
- To consider the practical experience of family/friends when visiting the service in terms of access, parking and other visitor facilities.
- To identify areas of resident satisfaction, good practice within the service and any areas felt to be in need of improvement.
- To support DCC Direct Care Services internal quality audit system.

5. Disclaimer

This summary report collates the findings gathered across the range of visits undertaken on the specific dates as set out above. Such reports are not suggested to be a fully representative portrayal of the experiences of all residents and/or staff and/or family members/friends encountered but provide an account of what was observed and presented to HWD ARs at the time of their visits.

6. Methodology

During visits ARs are provided with a set of standardised evidence-gathering tools developed by Healthwatch Derbyshire especially for the DCC commission of visits (Appendices 1-4).

The following techniques were generally used by ARs in undertaking each visit:

- Direct observation of interactions between staff and residents.
- Participant observation within therapeutic/social activities where appropriate.
- Assessing the suitability of the environment in which the service operates in supporting the needs of the residents.
- Observing the delivery and quality of care provided.
- Talking to residents, visitors and staff (where appropriate and available) about their thoughts and feelings regarding the service provided.
- Observing the quality and adequacy of access, parking and other facilities for visitors.

7. Summary of key data & findings across all visits

- Each visit on average took approximately 3 hours to undertake.
- Observations by ARs generally included the full range of residents and staff present during the visit.
- Due to the nature of the capacity limitations of many residents, discussions and/or questionnaire based interviews were restricted. In total approximately:

  (i) 38 residents were able to respond to questionnaire based interviews,
  (ii) 14 relatives/friends participated in questionnaire based interviews,
  (iii) 32 members of staff participated in questionnaire based interviews.

- the services provide a homely, welcoming and comfortable environment.
- the homes demonstrated a very good standard of care being delivered by committed and skilled staff which is recognised by residents and relatives alike.
- there is a distinct contrast between older and more modern designed homes in the quality of some facilities available to residents.
- maintenance of garden areas and outside spaces is often challenging to up-keep.

8. Detailed findings across all visits

8.1 Location, external appearance, ease of access, signage, parking

There has been noted variation across services visited in terms of age and appearance from those builds constructed around the 1960's to 'state of the art' contemporary designs. The aesthetic contrast between such builds is marked, as is often the quality of resources available to residents of the comparative services.

The older buildings inevitably provide challenges in terms of external appearance and maintenance but all services were noted to be sited in good locations in proximity to their local communities.

Some services have been a little difficult for ARs to find but it is recognised that signage from main roads leading to service locations may not be possible or in some cases desirable to institute.

Parking facilities in terms of adequate spaces have been variable but generally satisfactory.

8.2 **Initial impressions** (from a visitor's perspective on entering the home)

Regardless of the age of buildings, ARs reported consistently positive impressions when visiting services. Wherever they went ARs felt warmly welcomed by all services.

All services entered were described generally by ARs as pleasant, homely and relaxed environments which appeared clean and fresh.

8.3 **Facilities for and involvement with family/friends**

All homes generally provided good facilities for visitors and maintained flexible visiting times. All homes had a number of more discreet and private places, albeit in communal areas, where they could engage with their loved ones. There was also the option to use the bedrooms of the resident if wished.

All relatives/friends of residents tended to speak with evident satisfaction with the overall care that their loved ones were receiving. They felt adequately involved in the support of their loved ones acknowledging invitations to Residents' Meetings when they occurred. All relatives felt comfortable with raising concerns if and when they arose.

In a few homes, relatives were actively engaged with such activities as garden maintenance (see 8.7.6 for further details).

Good practice noted in some homes was:

(i) Availability of relatives taking meals with their loved ones during their visits.
(ii) Provision of overnight stays at the home for relatives.
(iii) Play facilities for child relatives who visited.

8.4 **Internal physical environment**

8.4.1 Décor, lighting, heating, furnishing & floor coverings

Overall this was considered very satisfactory across the homes visited. It was evident that thought had gone into trying to achieve as 'homely' an atmosphere as possible through the selection of décor/furnishings used and their arrangement within the communal spaces.

It was noted that a regular maintenance and, for older properties, refurbishment programmes were in place albeit that ARs occasionally noted the need for some further attention to be made to the environments.

8.4.2 **Freshness, cleanliness/hygiene & cross infection measures**

ARs often noted the absence of offensive odours which reflects well on the standards of cleanliness and freshness within the homes visited.

Some homes maintained hand sanitizers whilst others did not. It is acknowledged that hand sanitizers are a secondary means of reducing cross-infection compared to effective hand washing. However, there were no concerns generally raised by ARs about cross-infection or evidence of standards not being adequate.

8.4.3 Suitability of design to meet needs of residents

All the homes visited were supporting older persons who commonly were living with varying degrees of dementia and mobility problems. The homes were generally designed well in meeting such needs. There was however evidence to suggest that in some homes dementia friendly signage could be improved.

Other design improvements relate to the understandable challenges of the older buildings where the sizes of communal toilets, bedroom size, the absence of en-suite facilities and sometimes limitations of choices between taking baths or showers were evident. It was acknowledged that much was being done to reduce the impact of these deficits and enabling as much dignity and choice in such matters as resources would allow. Nevertheless, these more limited facilities are not in-keeping with contemporary standards of care.

It is acknowledged that refurbishment plans proposed for these homes are addressing some of the issues and other services are earmarked for relocation to future 'new builds'.

8.5 Staff support skills & interaction

8.5.1 Staff appearance/presentation

The impressions given by all staff encountered was of appearing both physically smart and professional in their approaches as well as being polite and cheerful as they went about their work.

The following sub-sections (8.5.2-8.5.4) were often reinforced by the testimony of residents spoken to as well as relatives and reflects the overall undoubted quality of the care work-forces across the homes visited.

8.5.2 Affording dignity and respect

This was considered to be managed in a highly skilled manner. Staff appeared to be constantly employing high level practical and interactional skills to support each individual's dignity and respect. Consent appeared to be naturally obtained during all interactions. Conversations with residents were often conducted using a quiet tone to promote privacy. This was even more evident where a resident's more personal needs were being addressed and reflected a discrete approach.

8.5.3 Calm, empathic approach to care giving

All interactions between staff and residents appeared to reflect care, sensitivity and affection.

8.5.4 Attentiveness and pace of care giving

Staff were noted in their interactions to be focussed on the person being engaged with. They were also proactive in supporting individuals showing great awareness of the needs of people being supported and their capacities. There was no sense of people, being rushed and staff were observed to generally work with the resident at their own pace.

8.5.5 Effective communications – alternative/augmentative systems and accessible information

The communication strategies employed were generally good although as indicated under 8.4.3 some improvements in dementia friendly signage could be introduced in some areas.

Alternative/augmentative systems of communication were not readily in evidence nor necessarily obviously required by residents. However, some consideration may need to be made for those residents with or acquiring sensory impairments.

Generally information for residents appeared broadly accessible but in some cases, for example menu choices, did not appear to be always presented in an alternative way with pictures or symbols. This may be something that homes will need to introduce more consistently as their residents' capacities reduce, and in response to the Accessible Information Standard which has been required to be complied with since July 31st 2016.

8.6 Resident's physical welfare

8.6.1 Appearance, dress & hygiene

The vast majority of residents were observed to be clean, tidy in appearance and well dressed in clothing that was either chosen by them or chosen appropriately on their behalf. The personal hygiene of residents appeared to be good.

The predominant population of women residents had access to and used hairdressing and manicuring services available in most of the homes. The fewer male residents encountered maintained appropriately tidy hairstyles and shaving preferences, presumably of their own choice.

8.6.2 Nutrition/mealtimes & hydration

Throughout the visits meals were noted to be of a very good standard and residents consistently expressed being highly satisfied with the choice and quality. ARs shared mealtimes with residents during a few visits and provided testimony to the satisfaction that residents had expressed. It was also noted how flexible services were in accommodating the choices of residents if they changed their minds about a meal they had previously decided upon.

Snacks and drinks were generally made available by staff throughout the day but it was not always evident if residents with capacity, with or without support, could make their own drinks and snacks more flexibly.

The dining experiences were managed well to create a dignified and pleasantly social occasion in which residents could take their meals

8.6.3 Support with general & specialist health needs

Homes visited appeared to be well supported in meeting the health needs of the residents. It was apparent that GPs either called regularly or in a timely manner when asked to call. Regular district nursing, chiropody and physiotherapy services appeared to be available regularly or on request. It was noted that hand massage was offered in some homes.

Residents generally expressed confidence about the support received for their health needs and felt well looked after by the care staff in times of being unwell.

8.6.4 Balance of activity & rest

Homes generally reflected a stimulating but unpressurised atmosphere for residents to choose to be active or more restful during each day. Gardens were available to access (see 8.7.6) and internal communal areas incorporated comfortable seating and foot stools to aid relaxation with music or television available for entertainment.

Generally there were areas where, for example, books or board games were available although ARs did not observe these facilities being used during their visits.

Bed times and getting up times were considered flexible and residents appreciated this choice and freedom.

Most homes appeared to employ an Activities Co-ordinator organising programmes of activities to meet residents' needs (see section 8.7.4).

8.6.5 Ensuring comfort

ARs overall identified a clear sense of both physical and emotional comfort in all of the homes visited. Residents themselves expressed a consistent view of feeling as "at home" as they could be.

8.6.6 Maximising mobility and sensory capacities

Across all visits it was noted that residents were regularly encouraged to maintain their mobility and in some areas regular exercise sessions were held. Whilst undoubtedly there are a number of residents who have auditory or visual impairments it was not always clear as to how these were supported and optimised.

In one or two services, ARs were informed of hearing loop systems being installed but they did not appear to be used and were often restricted to one location of the home. Only one home mentioned that they have an optician visiting regularly.

It was also less common for ARs to come across evidence of consistent sensory and/or cognitive stimulation. However, one home did demonstrate good practice by having made a 'memory book' for a gentleman who found this therapeutic to look at when he felt disoriented or distressed. Another was reported to have individualised 'memory boxes' in the bedrooms.

The more modern homes appeared to have more resources available to help stimulate residents and offering some reality orientation stimuli in communal areas and 'memory rooms' plus themed areas of the home based on 'bygone times'.

8.7 Resident's social, emotional and cultural welfare

8.7.1 Personalisation & personal possessions

All homes demonstrated that they had in place approaches which recognised and respected each resident as an individual.

Residents were enabled to keep personal possessions in their rooms and in some homes were able to bring in their own furnishings once assessed from a health and fire safety perspective. Personal furniture tended not to be permitted in the more modern establishments.

Bedroom doors in some homes were personalised with pictures and the person's name. Some residents held their own keys and some had control of their money both factors were presumed to be based on capacity.

Whilst pets were evident in some homes in others there appeared to be an absence of pets, large or small.

8.7.2 Choice, control & identity

As indicated through preceding sections of this report, there appeared to be a good level of choice and control afforded to residents with their unique identities

generally being promoted and respected.

8.7.3 Feeling safe and able to raise concerns/complaints

All residents encountered by ARs expressed their confidence in raising any concerns as did relatives that were met. Residents' Meetings appear to be held in all homes but ARs did not obtain any evidence as to the effectiveness of these in raising issues or ideas to help improve the experience of residents.

8.7.4 Structured and unstructured activities/stimulation

As indicated under 8.6.4, homes employed Activities Co-ordinators to organise activities and events for residents. ARs found the range and frequency of activities a little 'patchy' across the homes ranging from very good and satisfied residents to some homes that did not have an Activities Co-ordinator in post at the time of the visit. In these cases appointments were being awaited. It was noted however that residents generally did not express dissatisfaction with activities which were available.

8.7.5 Cultural, religious/spiritual needs

It appeared that the majority of residents were local people coming from a predominantly Christian background. Homes appeared to generally have made good links with local churches of different denominations who visited the home. Some residents attended their own place of worship of choice either independently or via their relatives taking them.

There was no evidence that the cultural needs of residents either in term of life-style, customs, practices or dietary preferences were not being met.

8.7.6 Gardens – maintenance & design/suitability for use/enjoyment

The outside spaces for many of the homes are large labour intense areas to manage. DCC has contracts to maintain the basic requirements of grass cutting and shrub maintenance but the rest seems to fall upon the resourcefulness of the Unit Manger and his/her team.

The quality and up-keep of gardens was observed by ARs to be variable ranging from the 'beautiful' to the 'needing tender loving care'. Many homes rely upon volunteers, relatives, staff plus keen and able residents to maintain their gardens.

For those homes which struggle to maintain gardens adequately this was noted to be a stark contrast to the care and attention which is evident within the internal environment of the home. This, in some way, is detracting from the fuller quality of life that residents could enjoy in living in their total home environment both inside and outside.

9. Additional issues

The Healthwatch Derbyshire Enter & View Officer and DCC Service Manager (Direct Care) Quality and Compliance, Emma Benton maintain regular communications concerning visits, reports and evaluations of visits. These are conducted on an 8 weekly basis.

The Healthwatch Derbyshire Enter & View Officer has established comprehensive systems of communications with the care homes and has engaged in a series of courtesy visits to homes over the past 6 months.

10. Elements of good practice/standards of care

- Good facilities for visitors and in some homes overnight stays are available.
- Outside play facilities in one home for child relatives who visited.
- Relatives very satisfied with the overall care of their loved ones.
- High standards of cleanliness and freshness within the homes visited.
- Staff polite, cheerful and professional in approach.
- Staff supporting each individual's dignity and respect.
- Staff/resident relationships reflecting care, sensitivity and affection.
- Residents appeared clean, tidy in appearance and well dressed.
- Meals are of a very good standard and residents highly satisfied with the choice and quality.
- Dining experiences were dignified and pleasantly social occasions.
- Residents confident of being looked after by care staff if unwell.
- Residents regularly encouraged to maintain their mobility.
- Residents and relatives confident in raising any concerns.
- Some homes used, 'memory books/boxes', reality orientation, 'memory rooms' and themed 'memory areas'.

11. Recommendations

Individual reports for each home include recommendations that have already been responded to satisfactorily by the services concerned. This summary report therefore is not intending to repeat these but place them into a broader context where DCC may lead in supporting recommendations for application across all residential services.

In addition this summary report has enabled Healthwatch to collate issues which did not necessarily feature highly in previous recommendations but nevertheless are proposed as worthy of consideration.

12. Considerations for DCC from this Summary Report

12.1 Clarification of policy and practice with respect to the use of hand sanitizers (8.4.2)

12.2 Review and monitoring of dementia friendly signage (8.4.3)

12.3 Strategies to improve the quality of provision especially within older homes regardless of whether relocation is being planned (8.4.3)

12.4 To ensure residents have the choice available to take baths or showers (8.4.3)

12.5 To review how the needs of residents who have sensory impairments are being met (8.5.5. 8.6.6)

12.6 To ensure that the requirements of the Accessible Information Standard are clearly being met in relation to each resident (8.5.5)

12.7 To enable residents with capacity to have access to facilities to make their own drinks and snacks (8.6.2)

12.8 To ensure that programmes of sensory and/or cognitive stimulation are available to all appropriate residents (8.6.6)

12.9 To consider the possibility of introducing pets in homes in accordance with the wishes of residents (8.7.1)

12.10 To ensure a more consistent service of Activities Co-ordinators across all Homes (8.7.4)

12.11 To provide more effective systems to support homes in coping with garden maintenance demands (8.7.6)

13. Service Provider Response

The following responses from Derbyshire County Council were received in relation to the considerations generated by this report as outlined above:-

12.1 Clarification of policy and practice with respect to the use of hand sanitizers (8.4.2)

Response: The Derbyshire County Council Infection Control Policy states that in some areas of establishments water free sanitizer will be provided where there are no suitable washing facilities.

12.2 Review and monitoring of dementia friendly signage (8.4.3)

Response: Improving way finding and signage has been agreed as a priority for our Capital and Revenue budget spend this year and all care homes have recently used the Kings Fund Audit tool to assess "dementia friendliness" and one aspect highlights appropriate signage. Procurement of appropriate signage is being arranged centrally to ensure consistency in our approach in future.

12.3 Strategies to improve the quality of provision especially within older homes regardless of whether relocation is being planned (8.4.3)

Response: DCC Cabinet has approved an expenditure of £4.1m capital on Direct Care Homes for Older People. A program of improvements has been mapped out and prioritised. Work will be scheduled based on agreed priorities. This includes refurbishment in some homes and others having money to improve bath/ shower facilities, health & safety, infection control and improving the dementia friendly environment.

12.4 To ensure residents have the choice available to take baths or showers (8.4.3)

Response: Adult Care are prioritising the refurbishment of bathroom facilities as part of the program of improvements, this will include access to shower facilities where appropriate.

12.5 To review how the needs of residents who have sensory impairments are being met (8.5.5. 8.5.11)

Response: Residents have their sensory needs addressed on an individual basis and recorded on their plan of care. This information is reviewed on a regular basis and as needs change. All establishments have regular visits to and from specialists including referrals to appropriate organisations with regards to their sensory impairment. We are also able to access different forms of assistive technology where this has been

highlighted as a need. All homes have a loop system installed; however the majority are fixed systems that are situated in communal areas.

12.6 To ensure that the requirements of the Accessible Information Standard are clearly being met in relation to each resident (8.5.5)

Response: A new form has been devised which captures the individual communication needs of residents. Awareness is being raised through discussions and the form is completed with residents with consent and stored within their care records (both paper and electronic). Staff information sessions are also being held ensuring a consistent approach is maintained and staff are aware that information about communication needs should be shared with other agencies (if consent is given). Staff are being made aware that the form must be completed for each and every resident. On the resident's electronic records, the communication needs are recorded in an area that is highly visible to so any department/team accessing the record will know to provide information. When after a discussion it is found that a resident has no 'special communication needs', this is still recorded on their electronic and paper records so other staff know the form has been completed and a discussion about information needs undertaken.

12.7 To enable residents with capacity to have access to facilities to make their own drinks and snacks (8.5.7)

Response: Most establishments have these facilities available where it is safe and practical. This is an area that will be addressed with regards to the ongoing refurbishment plan.

12.8 To ensure that programmes of sensory and/or cognitive stimulation are available to all appropriate residents (8.5.11)

Response: Adult Care has a large number of staff who have been trained on how to facilitate different activities including how to involve residents with sensory loss and/or dementia.

12.9 To consider the possibility of introducing pets in homes in accordance with the wishes of residents (8.6.1)

Response: Managers of establishments encourage residents to discuss whether they would like pets within their care home. Establishments do arrange visits from therapy pets where residents have identified they would want this.

12.10 To ensure a more consistent service of Activities Co-ordinators across all Homes (8.6.4)

Response: The recent reconfiguring of staffing arrangements within care homes has involved the introduction of the Senior Care Worker role. One of their responsibilities will be to coordinate a program of activities which will be delivered by the staff team as a whole. We have moved away from the idea of having one stand-alone activities coordinator and expect all staff to engage in activities with residents whenever possible.

12.11 To provide more effective systems to support homes in coping with garden maintenance demands (8.6.6)

Response: The garden maintenance contract for care homes is currently being reviewed. This will lead to ensuring a consistent ongoing garden maintenance plan is in place.

November 2016

Derbyshire Healthy Home Programme

Introduction

The Derbyshire Healthy Home Programme identifies and targets very low income residents suffering from long term illnesses made worse by the cold e.g. respiratory, cardiovascular, mobility-impairing conditions, mental health conditions, diabetes and cancer.

These individuals are so impoverished that **cannot afford to keep their property warm, despite their susceptibility to the cold,** and so are at **high risk of cold weather mortality and morbidity.**

Derbyshire Public Health commissioned an established partnership of all the district council housing authorities in Derbyshire, known as the LAEP to deliver the programme up to the 31st March 2018.

The LAEP has access to its own unique sources of funding secured from government and other external sources to fund essential capital works for as many clients as possible during 2016/17 and 2017/18. During 2017/18, the programme will target 510 residents living in 300 households.

The client group

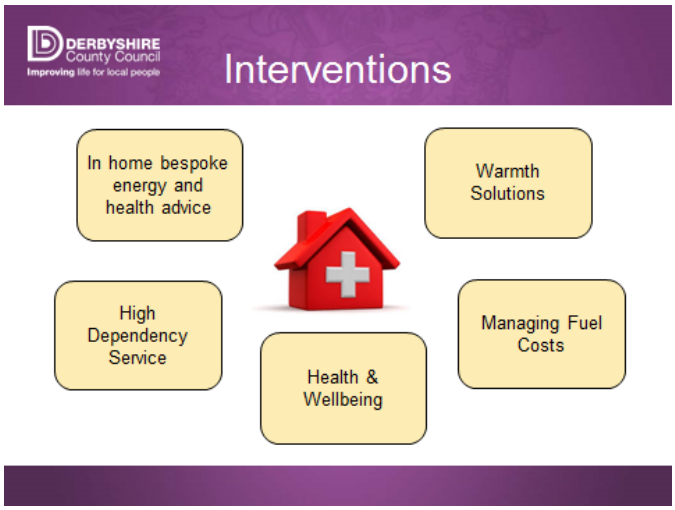
The programme is offered as a prevention service to GP practices across Derbyshire and also accepts eligible referrals from trusted sources including Adult Care, district councils, Citizen's Advice, the Fire and Rescue Service, Hospital Discharge and the Home Improvement Service, where these organisations are unable to assist.

Most clients have been unable to tackle their situation by themselves; many are housebound and have issues which require sensitive and labour intensive assistance. Many homes encountered have ineffective or broken heating systems, are poorly insulated and draughty; all clients struggle to pay their fuel bills and are forced to keep the heating off to minimise fuel bills, often with disastrous consequences.

Interventions

Clients are visited and assessed within 3 days or immediately if deemed necessary. The assessment leads to a service delivery plan of up to five evidence-based warmth, wealth and wellbeing interventions.

All interventions are person-centred and delivered sensitively by a team of five officers with expertise in housing, domestic energy and fuel poverty. This approach is resource intensive, often requiring multiple home visits, co-ordination of a package of assistance and a financial investment to the property by the programme. Clients experience substantial improvements in their circumstances and in their ability to keep warm and well at home and usually report significant improvements in their health



The service operates across Derbyshire and aims to:

- Respond rapidly and flexibly at short notice to urgent/desperate/high risk situations involving poorly residents living in cold homes.
- Commission and install necessary capital home heating improvements within a few weeks
- Subsidise essential capital works with a grant from the LAEP hardship fund when an householder does not have the financial means to pay
- Access Government grants, Energy Company subsidies, charitable funding and Local Authority specific grant awards.
- Provide a comprehensive range of integrated interventions in the home to ensure householders can afford to keep warm and well

Strategic aims of the programme

- To impact upon the rates of cold weather mortality and morbidity and associated costs incurred by Adult Care and NHS acute services
- To reduce the detrimental health effects of cold and damp homes on those individuals with long term health conditions most affected by cold and damp living conditions and consequently impact on the wider determinants of health
- To help these individuals keep warm, healthy and living independent in their own home in accordance with the principle of the Derbyshire Wedge
- To reduce health inequalities and improve health and wellbeing across all stages of life.

Circumstances encountered

The programme has been carefully designed to provide comprehensive and bespoke interventions which accommodate the very wide range of needs and personal circumstances encountered by this particular group of vulnerable residents.

All residents are in poverty and are often frail and elderly, with multiple health conditions, a lack of family support, no expertise around managing energy finances and no access to capital funding for essential heating repairs/maintenance.

Some residents are housebound and are therefore **unable to access services which are not provided in the home**.

Issues around disability, literacy, mental health, self-care, hoarding and chaotic lifestyles are often present, making it especially difficult for these householders to resolve the issues which are preventing them from being able to keep warm and well.

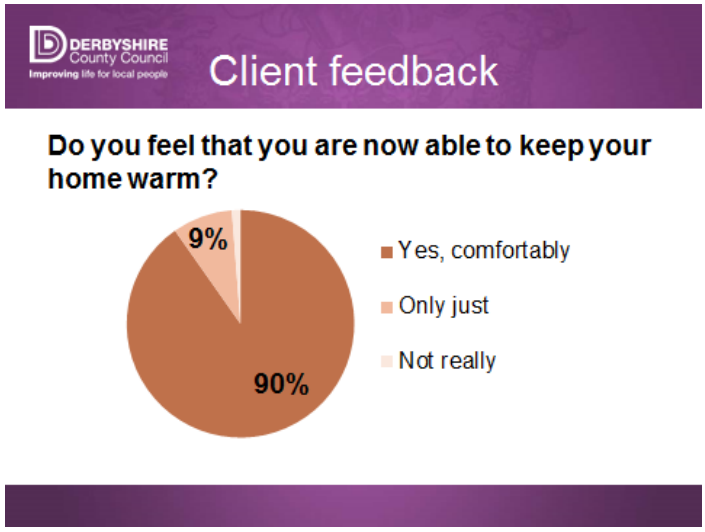
The programme receives many letters of gratitude from clients e.g.

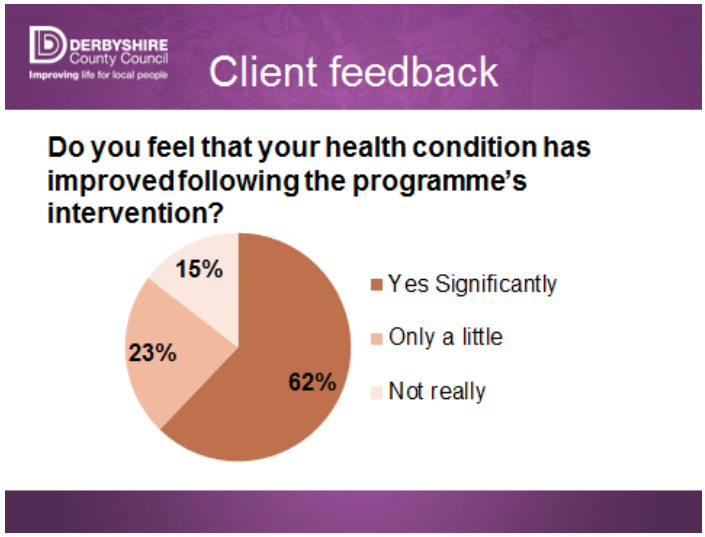
I would like to take this opportunity to thank you and all the Derbyshire County Council staff who took the decision to allow me to have the boiler installed.I could say thank you a million times yet that does not come close to my gratitude for helping me. Nomore climbing up to the loft (even with my bionic knees) to correct the pressure. I had in the pasthad to pay the plumbers between £25 and £30 just to do that and it had happened 4 times. I decided to do it myself with the consequence that I got stuck.I eventually figured out how to come down but I was for a moment scared.

I would like to say, anyway, THANK YOU from the bottom of my heart for providing me with this boiler. It is terrific.

Client feedback

All clients are sent a feedback form and around 60% return a completed form.





DERBYSHIRE COUNTY COUNCIL
ADULT CARE BOARD

1 December 2016

Report of the Strategic Director of Adult Care

BETTER CARE FUND 2016-17: QUARTER 2 PERFORMANCE RETURN

1. Purpose of the Report

To inform the Adult Care Board of the performance and work of the Derbyshire Better Care Fund as at the second quarter reporting period of the 2016-17 financial year.

2. Information and Analysis

This report has been split into two sections comprising:
- Summary of the National Quarter 2 (Q2) 2016-17 Reporting Template
- General Better Care Fund (BCF) Performance Overview

National Q2 2016-17 Reporting Template
The Better Care Support Team published the Q2 2016-17 National Return template on 21 October 2016 with the expectation that completed templates would be returned by 25 November 2016, following sign-off from respective local Health and Wellbeing Boards (HWBs). Requirements of the Q2 template mirror those of quarterly returns previously reported to the Adult Care Board during 2015-16.

As with previous quarterly reporting arrangements, the Q2 return will be reported retrospectively to the Health and Wellbeing Board at its next meeting in January 2017. Further quarterly reports will be provided during 2016-17 in line with the national reporting timescales set out below:

- Quarter 3 return due 24 February 2017;
- Quarter 4 return due 24 May 2017.

The BCF Programme Board reviewed and approved the submission of the performance return at its meeting on 18 November. Detailed information concerning the measures and responses required can be found in Appendix 1.

General BCF Performance Overview
A table summarising performance at the Q2 2016-17 reporting period is provided at Appendix 2. Based on Q2 performance levels, four of the six

metrics are forecast to achieve their targets. More information on each of the metrics is provided below.

Metric 1, non-elective admissions (NEAs) to hospital, current performance suggests year-end target will not be achieved despite showing improved performance. At a countywide level for the BCF we have data available for 97% of the HWB area. Based on what we can analyse there has been a reduction in NEAs during Q2 from Q1 in 2016-17. Despite this improvement performance is still above the BCF Plan. Further analysis of the data has shown that two areas have seen reductions in admissions whilst two have seen an increase over their BCF plan. The largest reduction in any area this quarter was 129 admissions, with largest increase being 254 admissions.

Metric 2, permanent admissions to residential or nursing homes, is showing as on target. However, it should be noted that there is a time-lag in reporting for this indicator and the quarterly rates change throughout the year. This aside, there has been a continued decrease in the number of people having to go into a permanent care setting throughout 2015-16 and continuing into 2016-17.

Metric 3, people still at home 91 days after a period of reablement is showing as on target. There has been a slight decrease in performance compared to Q1; however, there was an increase in referrals to the service with more people remaining at home in Q2 compared to Q1 2016-17.Current performance levels suggest that this is on track to achieve the year-end plan.

Metric 4, Delayed Transfers of Care (DToC) continue to be higher than planned despite significant investment, through the BCF, to support the reduction of DToCs as well as the development of the required DToC Action Plan. The data for Q2 indicates that DToC rates have continued to rise and now are at their highest level for two years.

Some of the work undertaken during the last quarter has included development of a ‘Zero Days’ pilot to begin in Derby during Quarter 3; improved access to provision of weekend therapy services; enhancements to systems within acute settings to improve patient flow and reduce reasons for delays; development of an improved Discharge to Assess Model (D2AM)

Furthermore, the Quality, Assurance, Performance and Resilience Group (QAPR) has been established at an STP level to oversee the work of the new A&E Delivery Boards which has replaced the former System Resilience Groups and taken on their responsibility for monitoring system resilience and system flow. The BCF DToC Action Plan is currently being refreshed in line with the wider system flow work arising from the STP.

Metric 5, the locally chosen patient experience metric is showing as on target. There has been change as this indicator is reported on a six-monthly cycle. The latest results suggest that improvements to support services in the community are having a positive impact on people with long-term conditions.

Metric 6, the percentage of people diagnosed with dementia in relation to prevalence rates continues to improve, with Q2 outturn showing a 0.7 percentage point increase over Q1 2016-17. Dementia has been a key local priority since the beginning of the BCF, and continued investment in a range of health and care services for people living with dementia and their carers remains a priority for 2016-17.

3. Background papers:

Copies of the 2015-16 and 2016-17 Better Care Fund Plans and associated documents can be found on the Derbyshire County Council website at: http://www.derbyshire.gov.uk/social_health/integrated_care/

4. Officer Recommendations

The Adult Care Board is asked to:

1. Receive the report and note the responses provided in the National Quarterly Reporting template;
2. Note the work being undertaken across the health and social care system to achieve the high-level metric targets.
3. Continue to receive regular updates on the progress of the Better Care Fund throughout 2016-17.

Graham Spencer
Group Manager – Better Care Fund

BCF 2016-17 Q2 RETURN

SECTION 1: COVER

Q2 2016/17	
Health and Well Being Board	**Derbyshire**
completed by:	Graham Spencer
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Contact Number:	01629532072
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Dave Allen

SECTION 2: BUDGET ARRANGEMENTS

Have the funds been pooled via a s.75 pooled budget?	Yes

SECTION 3: NATIONAL CONDITIONS

Condition (please refer to the detailed definition below)	Q1 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')
1) Plans to be jointly agreed	Yes	Yes
2) Maintain provision of social care services	Yes	Yes
3) In respect of 7 Day Services – please confirm:		
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes	Yes
4) In respect of Data Sharing – pleas confirm:		
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes

SECTION 4: INCOME AND EXPENDITURE

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	£64,991,159
	Forecast	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	
	Actual*	£16,247,790					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	£64,991,159
	Forecast	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	
	Actual*	£16,247,790	£16,247,790				

SECTION 4: INCOME AND EXPENDITURE (CONTINUED)

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	£64,991,159
	Forecast	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	
	Actual*	£16,247,790					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	£64,991,159
	Forecast	£16,247,790	£16,247,790	£16,247,790	£16,247,790	£64,991,159	
	Actual*	£16,247,790	£16,247,790				

Commentary on progress against financial plan:	There has been some potential slippage identified within the expenditure plan. This will continue to be monitored monthly by the BCF Finance and Performance sub-group with appropriate action to be undertaken if necessary. It is anticipated that the total pool will be spent by year end.

SECTION 5: SUPPORTING MEASURES

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	At a countywide level for the BCF we have data available for 97% of the HWB area. Based on what we can analyse there has been a reduction in NEAs during Q2 from Q1 in 2016-17. Despite this improvement performance is still above the BCF Plan. Further analysis of the data has shown that two areas have seen reductions in admissions whilst two have seen an increase over their BCF plan. The largest reduction in any area this quarter was 129 admissions, with largest increase being 254 admissions.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Despite significant investment, through the BCF, to support the reduction of DToCs as well as the development of the required DToC Action Plan, DToCs continue to be higher than planned. The data for Q2 indicates that DToC rates have continued to rise and now are at their highest level for two years. Some of the work undertaken during the last quarter has included development of a 'Zero Days' pilot to begin in Derby during Quarter 3; improved access to provision of weekend therapy services; enhancements to systems within acute settings to improve patient flow and reduce reasons for delays; development of an improved Discharge to Assess Model (D2AM) Furthermore, the Quality, Assurance, Performance and Resilience Group (QAPR) has been established at an STP level to oversee the work of the new A&E Delivery Boards which has replaced the SRGs and taken on their responsibility for monitoring system resilience and system flow. The BCF DToC Action Plan is currently being refreshed in line with the wider system flow work arising from the STP.

SECTION 5: SUPPORTING MEASURES (CONTINUED)

Local performance metric as described in your approved BCF plan	Number of people diagnosed and the prevalence of dementia.
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The percentage of people diagnosed with dementia in relation to prevalence rates continues to improve, with Q2 outturn showing a 0.7 percentage point increase over Q1 2016-17. Dementia has been a key local priority since the beginning of the BCF, and continued investment in a range of health and care services for people living with dementia and their carers remains a priority for 2016-17.

Local defined patient experience metric as described in your approved BCF plan	GP Patient Survey: Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? (Respondents answering "Yes, definitely" or "Yes, to some extent")
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The Q2 figure relates to the results of the GP Satisfaction Survey undertaken between January and March 2016 as reported at the Q1 monitoring period. The outturn as at July 2016 shows 70.17% of people responding to the survey felt that they were receiving appropriate support from services in the local area to meet their Long Term Condition. (The outturn for the same monitoring period in 2015-16 was 64.9%). Performance is currently on track to achieve the planned target.

SECTION 5: SUPPORTING MEASURES (CONTINUED)

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The Q2 admission rates continue to suggest that the year-end target will be achieved. However, there is often a time-lag in receiving data for this indicator so the current position should still be viewed with a degree of caution.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The Q2 outturn shows 86% of people were still at home 91 days following discharge; therefore current performance continues to be on track to achieve the BCF plan. This is a slight decrease in performance compared to Q1; however, there was an increase in referrals to the service with more people remaining at home in Q2 compared to Q1 2016-17.

SECTION 6: ADDITIONAL MEASURES

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Shared via Open API
From Hospital	Shared via interim solution	Shared via Open API	Shared via interim solution	Shared via Open API	Shared via interim solution	Shared via interim solution
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via Open API	Shared via interim solution	Shared via interim solution

SECTION 6: ADDITIONAL MEASURES (CONTINUED)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From Mental Health	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Shared via Open API	Shared via interim solution
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	Live	In development	Live	Live	Live
Projected 'go-live' date (dd/mm/yy)			not available			

3. Proposed Measure: Is there a Digital Integrated Care Pilot Currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot currently underway

SECTION 6: ADDITIONAL MEASURES (CONTINUED)

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	22
Rate per 100,000 population	2.8

Number of new PHBs put in place during the quarter	9
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	77%

Population (Mid 2016)	785,513

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

SECTION 7: NARRATIVE

Please provide a brief narrative on overall progress, reflecting on performance in Q2 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Highlights and successes

The following have been identified as areas of particular note during quarter two:

- Non-elective admissions have reduced from quarter one and are now closer to the original BCF plan figures.
- Residential admission rates continue to show encouraging signs of reduction;
- Dementia diagnosis rates continue to improve on a quarterly basis and are above the national average;
- A development plan and associated budget has been approved for development of the autism pathway (identified as a development area within the BCF plan).

Challenges and concerns

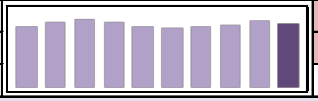
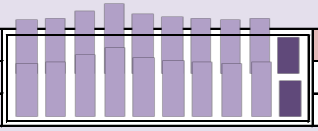
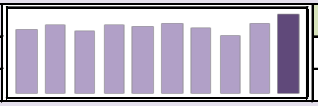
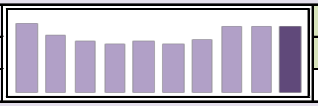
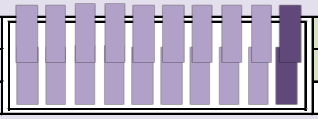
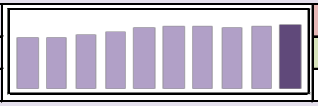
- Delayed Transfers of Care – challenge to reduce an increasing number of bed days lost to delays. This is a system wide problem that BCF is assisting with, but is not the single solution for. Improved system ownership of the problems causing delays is emerging through development of the two A&E Delivery Boards
- Workforce capacity remains an area of concern both in terms of existing capacity and retention and ability to recruit and retain new staff across the health and care system (and across all sectors of provision). The issue is not limited to rural areas either and remains a challenge for the system wide Workforce Delivery Group to address.

Potential actions and support

- Ensuring delivery of BCF aligned activity contributes effectively to system-wide winter planning;
- Continued development & monitoring of BCF risk assurance to ensure programme is delivering as planned.

BCF National Reporting Metrics: Quarterly Performance Summary

APPENDIX 2

Metric	Reporting Period[1]	Q1	Q2	Q3	Q4	Year End (*Projection*	Year End Target	Quarterly Performance Trend (Q1 2014 - Q1 2016)	Performance Against National Average
1. Non-Elective Admissions (NEAs) General and Acute - actual number[2]	**2014/15**	21,081	20,795	21,723	21,141	**84,739**	**N/A**		**BELOW**
	2015/16	22,264	21,816	22,529	22,786	**89,394**	**N/A**		**BELOW**
	2016/17	21,259	20,790			***85,036***	***84,100***		**N/A**
2. Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes (Rate per 100,000 population)[3]	**2014/15**	182.5	183.1	200.1	232.1	**797.8**	**688.4**		**BELOW**
	2015/16	193.6	189.3	183.8	178.2	**744.9**	**669.2**		**N/A**
	2016/17	180.5	148.8			***658.6***	***743.6***		**N/A**
3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**2014/15**	81.6%	86.6%	79.0%	87.1%	**83.6%**	**81.7%**		**ABOVE**
	2015/16	84.1%	89.4%	82.4%	73.6%	**82.4%**	**82.5%**		**N/A**
	2016/17	88.4%	86.0%			***87.2%***	***85.3%***		**N/A**
4. Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	**2014/15**	859.3	703.8	644.6	605.0	**703.2**	**985.9**		**ABOVE**
	2015/16	632.7	596.8	655.3	830.2	**678.8**	**966.0**		**ABOVE**
	2016/17	825.4	854.3			***839.85***	***710.6***		**N/A**
5. Patient Experience - GP Patient Survey Q32: Percentage answering "yes" - In the last 6 months, have you had enough support from local services/organisations to help manage your long-term condition?	**2014/15**	70.32%	70.32%	70.80%	70.80%	**70.56%**	**65.90%**		**ABOVE**
	2015/16	70.41%	70.41%	70.50%	70.50%	**70.46%**	**66.20%**		**ABOVE**
	2016/17	70.20%	70.20%			***70.20%***	***66.50%***		**N/A**
6. Percentage of people diagnosed compared to prevalence of dementia.	**2014/15**	59.5%	58.9%	61.9%	64.7%	**61.3%**	**67.0%**		**BELOW**
	2015/16	70.5%	71.5%	71.3%	70.6%	**71.0%**	**68.0%**		**ABOVE**
	2016/17	72.1%	72.8%			***72.5%***	***71.0%***		**N/A**

Notes:

1. 2014/15 is BCF Baseline Year and used as comparator.
2. NEAs data source changed for 2016/17, no RAG rating available for previous reporting years. Figures provided equate to 97% of total NEAs in Derbyshire - remaining 3% of data is not obtainable.
3. There is a time-lag in receiving data for this indicator, therefore quarterly outturns are subject to change during the year and so current outturns should be viewed with this in mind.