DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE ADULT CARE BOARD

THURSDAY 12TH JANUARY 2012
2:00PM TO 4:00PM
COMMITTEE ROOM 1, COUNTY HALL, MATLOCK, DERBYSHIRE, DE4 3AG

A G E N D A

1.	Welcome & Introduction from Cllr Charles Jones	Cllr Jones
2.	Noted Apologies: Trish Thompson, Rakesh Marwaha, Jackie Pendleton	"
3.	Minutes from the meeting 10th November 2011 (attached)	"
4.	JSNA Presentation: (to follow) CCG needs from the JSNA – How can we help?	L Flynn
5.	Alignment of Adult Social Care Outcome Framework and NHS Indicators (attached)	J Vollor
6.	Whole System Demonstrator Programme (attached)	R Paul
7.	The £20 billion question (attached) - See link: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1583&pageNumber=2	B Robertson
8.	Joint Commissioning Agenda 2012/13: 1. A report from the Joint Regional Event in the East Midlands: November (attached) 2. A report to the Adult Care Board on 15th September which outlined the previous joint commissioning priorities (attached) 3. The latest NHS Operating Framework (Operating Framework for the NHS in England 2012/13) 4. Papers submitted by CCG's and Adult Care (attached)	All
9.	CCG Development	A Layzell
10.	Learning Disability Joint Short Break Review (attached)	J Matthews
11.	Autism Strategy (attached)	J Matthews
12.	Healthwatch Update (attached)	J Matthews
13.	Health & Wellbeing Board Issues	All
14.	The next meeting of the Adult Care Board will take place on 15th March 2012 at 2:00pm in Committee Room 1, County Hall, Matlock.	
15.	Any other business	

Julie Hardy
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DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

MINUTES OF A MEETING HELD ON THURSDAY 10TH NOVEMBER 2011 AT 2:00PM DERBYSHIRE COUNTY COUNCIL, COMMITTEE ROOM 1, MATLOCK HQ

PRESENT:

Cllr Charles Jones	CJ	Derbyshire County Council - Cabinet Member (Adult Care) **Chairman**
Cllr Dave Allen	DA	Derbyshire County Council – Elected Member
Jem Brown	JB	Derbyshire County Council – Adult Care
Stephanie Cook	SC	Derby City PCT
Cllr John Lemmon	JL	South Derbyshire District Council
James Matthews	JM	Derbyshire County Council – Adult Care
Mary McElvaney	MMc	Derbyshire County Council – Adult Care
Andrew Milroy	AM	Derbyshire County Council – Adult Care
Jayne Needham	*JN*	*Attending on behalf of A Pritchard - NHS Derbyshire County*
Clive Newman	*CN*	*Attending on behalf of W Sunney – Hardwick CCG*
Ram Paul	RP	Derbyshire County Council – Adult Care
Bill Robertson	BR	Derbyshire County Council – Strategic Director Adult Care
Helen Robinson	HR	Derbyshire Carers
Jo Smith	JS	South Derbyshire CVS: representing voluntary & community sector
Jennifer Stothard	*JSt*	*Attending on behalf of J Pendleton – North Derbyshire CCG*
David Timcke	DT	NDVA: representing voluntary & community sector
Tammi Wright	TW	Derbyshire LINk
Jacqui Willis	JW	NDVA representing voluntary & community sector

APOLOGIES:

Sally Adams	High Peak Clinical Commissioning Group
Avi Bhatia	Erewash Clinical Commissioning Group (CCG)
Huw Bowen	Chesterfield Borough Council
Richard Brunt	Derbyshire Fire Service
David Collins	North Derbyshire Clinical Commissioning Group (CCG)
Cllr Stuart Ellis	Derbyshire County Council – Support Cabinet Member (Adult Care)
Russ Foster	Derbyshire Police
Lynn Harris	Derbyshire County Council – Safeguarding Board
Sean King	High Peak Clinical Commissioning Group (CCG)
Bruce Laurence	NHS Derbyshire County
Andy Layzell	Southern Derbyshire Clinical Commissioning Group
Steven Lloyd	Hardwick Health Clinical Commissioning Group (CCG)
Rakesh Marwaha	Erewash Clinical Commissioning Group (CCG)
Andrew Mott	Southern Derbyshire Clinical Commissioning Group (CCG)
Jackie Pendleton	North Derbyshire Clinical Commissioning Group (CCG)
Rosemary Plang	Derbyshire Probation Service
Alison Pritchard	NHS Derbyshire County
David Sharp	NHS Derbyshire County
Wendy Sunney	Hardwick Clinical Commissioning Group (CCG)

Trish Thompson	NHS Derbyshire County
Gavin Tomlinson	Derbyshire Fire Service
Clare Watson	Tameside & Glossop PCT (CCG)
Jane Yeomans	South Derbyshire Clinical Commissioning Group (CCG)

Minute no	Item	Action
	WELCOME FROM CLLR CHARLES JONES AND APOLOGIES NOTED	
ACB 001/11	**DERBYSHIRE HANDY VAN NETWORK** • JB provided the Board with a briefing on the background of the Derbyshire Handy Van Network scheme along with the developments and achievements to date. • The Network is in place to support vulnerable people and people at risk in their own homes. There is a signposting facility to other appropriate services, via First Contact, which directs individuals to services which may be beneficial to them. • The performance of the network is monitored on a quarterly basis and is managed through the contract management process. • The Network has installed and maintained Telecare for high risk victims of domestic abuse since December 2010 and all Adult Care packages following a phased roll-out during August 2011. • Going forward, the Network's expanding role in installing and maintaining Telecare and community alarm equipment forms a key part of the service re-design being undertaken by Adult Care Accommodation and Support that should result in significant long term benefits. • For more information on the Derbyshire Handy Van Network please contact Jem Brown at jem.brown@derbyshire.gov.uk or on 01629 532068.	
002/11	**TRUSTED BEFRIENDING NETWORK CABINET REPORT 21.06.2011** • JB provided the Board with a briefing on the development of a Trusted Befriending Network following the Cabinet report submitted and approved on 21st June 2011. • It was confirmed that South Derbyshire CVS were successful in being recruited as the Strategic Partner to deliver the befriending network. South Derbyshire CVS will be looking at the current provision and quality standards. • It was noted that we have the largest single authority Trusted Trader Scheme in place. This same approach is being applied to the Befriending Service. • The service is available to all adults, whether in receipt of services, or self-funders. • We anticipate reaching an additional 1000 users than are currently supported. • South Derbyshire CVS are to work with current providers to undertake a gap analysis. • JS confirmed that someone has now been recruited to the post to work on this new network.	

- JS passed thanks to Adult Care for a pleasant experience during the recruitment / tendering process.
- For more information on the Trusted Befriending Network please contact Jem Brown at jem.brown@derbyshire.gov.uk or on 01629 532068.

003/11 **ACCOMMODATION AND SUPPORT: TELECARE/TELEHEALTH**

- RP provided the Board with a briefing on the work on Telecare and Telehealth and future planning for joint commissioning with partner agencies.
- Negotiations are progressing with a proposed consortium, based on the three district and borough councils in Derbyshire who run their own community alarm centres, namely Chesterfield Borough Council, Bolsover District Council and South Derbyshire District Council, to provide alarm monitoring services.
- A joint (NHS and Adult Care) project has commenced (along with the Royal Hospital at Chesterfield) on Telecare/health. The targeted client group are people with long-term conditions who have Health and Social Care needs. The project aims include improving health and well-being, demonstrating efficiencies and return on investment.
- A national randomised trial on Telecare/health has taken place and in response to this the Department of Health is expected to emphasise the important contribution of telecare and telehealth.
- For more information on the use of Telecare / Telehealth please contact Ram Paul at ram.paul@derbyshire.gov.uk or on 01629 532015.

004/11 **URGENT CARE / 24/7 / FRAIL ELDERLY / LONG TERM CONDITIONS INITIATIVES**

- 24/7 Offer: What should the whole systems approach be?
- C Newman, Assistant Operating Officer from Hardwick CCG spoke about the common problems to be jointly targeted and some of the projects in place or being developed. These include:-
  - Virtual Community Ward
  - Unique Care / Working Together (social workers working within practice team)
  - Risk Prediction Tools
  - New approaches to working with care homes
  - Combined Record Systems
- It was agreed that the Adult Care Board should have an oversight of the projects involving integrated care between the local NHS and Adult Care. Further discussions over a possible Steering Group, which would feed into the Adult Care Board will be required. **BR**
- AM confirmed that an Urgent Care Network Board is now in place which links into the CCG's, the 24/7 developments, winter planning and responding to emergencies.
- DA queried the consistency around the County.
- JS sought confirmation that the role of voluntary and community sector will be included.
- It was agreed that there should be agreed principles across the county to ensure consistency of outcome and that a further report should be prepared for the next Adult Care Board. **All**

005/11 **COMMISSIONING BOARD / COMMISSIONING SUPPORT**

- The most recent Department of Health proposals on providing commissioning support to CCG's was outlined and discussed. There are different views locally between the CCG's about how commissioning support could best be provided. By the next Adult Care Board there should be confirmed national position and direction of travel.

006/11 **CLINICAL COMMISSIONING GROUP ISSUES**

High Peak:

- Working with Derbyshire Community Services on Integrated Business Plan.
- Developing local networks.
- K Hickey is now an official member of the CCG Board.

North:

- Winter Pressures – Integrated Care work is on-going.

007/11 **HEALTH AND WELLBEING BOARD: 24TH NOVEMBER 2011**

- The next Health and Wellbeing Board will receive a report on personalisation in Adult Care. There will also be an update on Healthwatch including the intention to set up a small inter-agency group to prepare the service specification and oversee procurement of the service. **JM**

DATE OF NEXT MEETING

The next meeting of the Adult Care Board will take place on Thursday 12th January 2012 - 2:00pm – 4:00pm Committee Room 1 County Hall, Matlock.

Agenda Item 5

DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

12TH January 2012

ADULT CARE AND NHS OUTCOMES FRAMEWORKS 2012-13

1. Purpose of the Report

To update the Board on the Adult Care and NHS Outcomes Frameworks for 2012/13; and to outline options for the joint Partnership priorities and indicators for 2012/13.

2. Information and Analysis

The Department of Health has issued the following Frameworks for 2012/13:

- Adult Social Care Outcomes Framework (ASCOF) 23 November 2011: see Appendix 1
- NHS Outcomes Framework 7 December 2011: see Appendix 2
- NHS Operating Framework 22 December 2011: see Appendix 3

The NHS Outcomes Framework, together with the Adult Social Care Outcomes Framework, and the forthcoming Public Health Outcomes Framework aim to support the Government's desire to improve integration of health, social care and other local government services.

Locally, in March 2011 four indicators were suggested as joint Adult care/ NHS Partnership indicators, based on draft Government proposals. As detailed in Appendix 4, amendments have subsequently been made to those indicators that Government has identified as the joint responsibility of both Adult Care and the NHS.

2.1 Adult Care

The Adult Social Care Outcomes Framework (ASCOF) is intended to be the beginning a conversation about the state of adult social care both locally and nationally by:

- Nationally, giving an indication of the strengths of social care and success in delivering better outcomes for people who use services; it is intended to support Government's role in reporting to the public and Parliament on the overall system and to influence national policy development;
- Locally, for 'benchmarking' and comparison between areas. The aim is to enable councils to compare their results with others and discuss policy approaches with outstanding performers to share learning and best practice. It will also support the "local account" of social care in an area by providing high-level information to underpin the narrative of these accounts.

The ASCOF is not a national performance management tool and there are no national targets set against any of the measures. It is not a fixed framework and the aim is to publish an updated handbook alongside each year's agreed ASCOF (usually in March before the year starts), with a further update in the autumn (alongside the letter to councils setting out changes to data collections) if needed.

The outcome measures span four domains measured through 17 indicators covering:

- Enhancing quality of life for people with care and support needs;
- Delaying and reducing the need for care and support;
- Ensuring that people have a positive experience of care and support;
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

2.2 NHS

a) The purpose of the NHS Outcomes Framework is:

- To provide a national level overview of how well the NHS is performing, wherever possible in an international context;
- To provide an accountability mechanism between the Secretary of State for Health and the proposed NHS Commissioning Board; and
- To act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities.

It is structured around five domains:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

There are twelve overarching indicators covering the broad aims of each domain, 27 improvement areas looking in more detail at key areas within each domain, and 60 indicators measuring the overarching and improvement outcomes.

7 indicators are a shared responsibility with the public health system and Public Health and Local Authorities (subject to the publication of the final Public Health Outcomes Framework); and as set out in Appendix 4 – one is a whole system indicator located in the ASCOF, two are replicated in the ASCOF and four have a complementary indicator included in the ASCOF.

b) NHS Operating Framework sets out the planning, performance and financial requirements for NHS organisations in 2012/13 and is the basis on which they will be held to account. There are four key themes and 36 Performance Measures for national accountability for all NHS organisations during 2012/13:

- Putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;
- Completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;
- Increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and
- Maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.

The Secretary of State will use the NHS Outcomes Framework as the basis for the mandate to the NHS Commissioning Board; and PCT clusters and emerging CCGs are asked to ensure that they are in a position to publish data when available and certainly from 2013/14.

3. OFFICER'S RECOMMENDATIONS

1. To note the Adult Care, NHS and the forthcoming Public Health Outcomes Frameworks for 2012/13;
2. Views of the board are sought on key joint commissioning priorities for 2012/13;
3. To agree Partnership Indicators for 2012/13.

Appendix 4

The following indicators are replicated, complementary or whole system - across both the NHS and Adult Care

Type of Indicator	ASCOF	NHS Outcomes Framework	Draft Partnership Indicators proposed March 2011
Replicated	Proportion of older people (65 and over) who are still living at home 91 days after discharge from hospital into rehabilitation, intermediate care or rehabilitation (2B)	Proportion of older people (65 and over) who were: (i) still at home 91 days after discharge into rehabilitation; (ii) offered rehabilitation following discharge from acute or community hospital (No. 3.6)	Proportion of older people (65 and over) who are still living at home 91 days after discharge from hospital into rehabilitation, intermediate care or rehabilitation (ASCOF 2B)
Complementary	Social care-related quality of life (1A)	Health-related quality of life for people with long-term conditions (No. 2)	
	The proportion of people using adult social care services who have control over their daily life (1B)	Proportion of people feeling supported to manage their condition (No. 2.1)	NI 124 People with a long term condition supported to be independent and in control of their condition – Note: indicator deleted from the national Adult Care data set
	Carer-reported quality of life (1D)	Health-related quality of life for carers (No. 2.4)	
	Proportion of adults in contact with secondary mental health services in paid employment (1F)	Employment of people with mental illness (No. 2.5)	
Whole System	Delayed transfers of care from hospital; and those attributable to social care 100,000 population (2C)	No specific indicator	This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult

			population, and is an indicator of the effectiveness of the interface within the NHS, and between health and social care services.
			NI 129 End of Life Care Access to appropriate care enabling people to be able to choose to die at home – Note: indicator deleted from the national Adult Care data set. There is a new NHS indicator included in the 2012/13 NHS Outcomes Framework No. 4.6 "Improving the experience of care for people at the end of their lives" an indicator to be derived from the survey of bereaved carers – not ready until 2012/13

2011/12 Adult Social Care Outcomes Framework at a glance

*Placeholder in 2011/12 **Deferred to 2012/13

1 Enhancing quality of life for people with care and support needs

Overarching measure

1A. Social care-related quality of life

Outcome measures

People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.

1B. The proportion of people who use services who have control over their daily life
1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments

Carers can balance their caring roles and maintain their desired quality of life.

1D. Carer-reported quality of life**

People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

1E. Proportion of adults with learning disabilities in paid employment
1F. Proportion of adults in contact with secondary mental health services in paid employment
XX. Proportion of working age adults in contact with social services in paid employment (to replace 1E/1F)*
1G. Proportion of adults with learning disabilities who live in their own home or with their family
1H. Proportion of adults in contact with secondary mental health services living independently, with of without support

2 Delaying and reducing the need for care and support

Overarching measures

2A. Permanent admissions to residential and nursing care homes, per 1,000 population
*XX. Effectiveness of prevention/preventative services**

Outcome measures

Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.

*XX. Effectiveness of prevention/preventative services**

Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.

2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
*XX. Effectiveness of early diagnosis, intervention and reablement: avoiding hospital admissions**

When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

2C. Delayed transfers of care from hospital, and those which are attributable to adult social care
*XX. Effectiveness of reablement: regaining independence**

3 Ensuring that people have a positive experience of care and support

Overarching measure

People who use social care and their carers are satisfied with their experience of care and support services.

3A. Overall satisfaction of people who use services with their care and support
3B. Overall satisfaction of carers with social services**

Outcome measures

Carers feel that they are respected as equal partners throughout the care process.

3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for**

People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.

3D. The proportion of people who use services and carers who find it easy to find information about support

People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

This information can be taken from the Adult Social Care Survey and used for analysis at the local level.

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Overarching measure

4A. The proportion of people who use services who feel safe

Outcome measures

Everyone enjoys physical safety and feels secure.
People are free from physical and emotional abuse, harassment, neglect and self-harm.
People are protected as far as possible from avoidable harm, disease and injuries.
People are supported to plan ahead and have the freedom to manage risks the way that they wish.

4B. The proportion of people who use services who say that those services have made them feel safe and secure
*XX. Effectiveness of safeguarding services**

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
Cancer
1.4 i One-and ii five-year survival from colorectal cancer
iii One-and iv five-year survival from breast cancer
v One-and vi five-year survival from lung cancer
vii under 75 mortality rate from cancer*

Reducing premature death in people with serious mental illness
1.5 *Excess under 75 mortality rate in adults with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality* ii Neonatal mortality and stillbirths

Reducing premature death in people with learning disabilities
1.7 *An indicator needs to be developed*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions*

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **

Enhancing quality of life for people with dementia
2.6 *An indicator needs to be developed*

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures
3.1 **Patient Reported Outcomes Measures** (PROMs) for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia
iv Varicose veins

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 Proportion of older people (65 and over) who were i still at home 91 days after discharge into rehabilitation*** ii offered rehabilitation following discharge from acute or community hospital ***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services ii GP Out of Hours services iii NHS Dental Services
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator to be derived from the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator to be derived from a Children's Patient Experience Questionnaire*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b safety incidents involving severe harm or death

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Twelve overarching indicators
covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13
at a glance

*Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.

** A complementary indicator is included in the Adult Social Care Outcomes Framework

***Indicator replicated in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

Annex – National performance measures

Quality

1 Preventing people from dying prematurely

- Ambulance quality (Category A response times)
- Cancer 31 day, 62 day waits

2 Enhancing quality of life for people with long term conditions

- Mental health measures (Early intervention; Crisis resolution; CPA follow up, IAPT)
- Long term condition measures (Proportion of people feeling supported to manage their condition; Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)

3 Helping people to recover from episodes of ill health or following injury

- Emergency admissions for acute conditions that should not usually require hospital admission

4 Ensuring that people have a positive experience of care

- Patient experience of hospital care
- Referral to Treatment and diagnostic waits (incl. incomplete pathways)
- A&E total time
- Cancer 2 week waits
- Mixed-sex accommodation breaches

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

- Incidence of MRSA
- Incidence of *C. difficile*
- Risk assessment of hospital-related venous thromboembolism (VTE)

Public Health

- Smoking quitters
- Health checks

Resources

- Financial forecast outturn & performance against plan
- Financial performance score for NHS trusts
- Delivery of running cost targets
- Progress on financial aspects of QIPP
- Acute bed capacity
- Activity (eg Elective and non-elective consultant episodes; Outpatients; Referrals)
- Numbers waiting on an incomplete Referral to Treatment pathway
- Health visitor numbers
- Workforce productivity
- Total pay costs
- Workforce numbers (clinical staff and non-clinical)

Reform

- **Commissioning Development**
  - % delegated budgets
  - Measure of £ per head devolved running costs
  - % authorisation of clinical commissioning groups
  - % of General Practice lists reviewed and "cleaned"
- **Public Health**
  - Completed transfers of public health functions to local authorities
- **FT pipeline**
  - Progress against TFA milestones
- **Choice**
  - Bookings to services where named consultant led team was available (even if not selected)
  - Proportion of GP referrals to first outpatient appointments booked using Choose and Book
  - Trend in value/volume of patients being treated at non-NHS hospitals
- **Information to Patients**
  - % of patients with electronic access to their medical records

DERBYSHIRE COUNTY COUNCIL
ADULT CARE BOARD

12th January 2012

Report on the Whole System Demonstrator Programme Findings and Derbyshire's Telecare and Telehealth Pilot

1. Purpose of the Report

To inform members of the findings of the Whole System Demonstrator Programme and progress on the joint Derbyshire Telecare and Telehealth pilot.

2. Information and Analysis

2.1 The Operating Framework for the NHS in England 2012/13 is in the second year of the quality and productivity challenge and the final year of transition to the new commissioning and management system for the NHS. The framework sets out the scale and nature of that challenge, requiring up to £20 billion of efficiency savings by 2014/15. The NHS will need to make innovative, sustainable changes that bring about improvements in quality and productivity to all parts of the NHS; a clear example is the use of telehealth to improve services for patients with long term conditions. It also states that:

"Telehealth and telecare offer opportunities for delivering care differently and more efficiently. Use of both of these technologies in a transformed service can lead to significant reductions in hospital admissions and better outcomes for patients. Using the emerging evidence base from the Whole System Demonstrator programme, PCT clusters working with local authorities and the emerging clinical commissioning groups (CCGs) should spread the benefits of innovations such as telehealth and telecare as part of their ongoing transformation of NHS services. They should also take full consideration of the use of telehealth and telecare as part of any local reconfiguration plans."

2.2 In December 2011 the Department of Health (DH) published headline results of the Whole System Demonstrator (WSD) programme. It is the largest randomised control trial of Telecare/health services in the world, with nearly 6,000 participants. The results have now been evaluated by multidisciplinary teams, working across health and social care. The results are positive and have been peer reviewed. The states that if used correctly, Telecare/health can improve the quality of lives for patients and carers and deliver:

- a 15% reduction in A&E visits
- a 20% reduction in emergency admissions
- a 14% reduction in elective admissions
- a 14% reduction in bed days and
- an 8% reduction in tariff costs.

It also demonstrates a 45% reduction in mortality rates.

2.3 The government has also set out its ambition to extend the use of new and emerging healthcare technologies to three million people over the next five years. The report states that: 'At least three million people with Long Term Conditions and/or social care needs could benefit from using telehealth and telecare.' To achieve this level of change the Department of Health is planning to work in collaboration with industry, the NHS, social care and professional partners for a "Three Million Lives" campaign. This is not a national target or a government guarantee of delivery; instead it is about the Department providing national leadership, strategic direction, and advice to NHS and social care organisations; with support from industry who would be responsible for creating the market and working with local organisations to deliver the change. A plan for the 'Three Million Lives' campaign is still in the early stages of development and further information will be available in due course.

3. Developments in Assistive Technology Services

3.1 As reported to the Adult Care Board meeting on 19th November 2011. The Care Performance Partners consultancy (CPPC) conducted a Telecare and Telehealth evaluation project for Derbyshire County Council. The evaluation report was positive and stated that Telecare was effective in supporting or managing risk for all users, with 32% of people receiving telecare to avoid or defer additional Social Care or NHS services. The cumulative efficiency gains (from 91 cases only) were between £73,073 and £81,192 for Adult Care and for NHS services in the range of £26,467 to £29,408. The CPPC report also made a number of recommendations including making the case for joint commissioning of Assistive Technology provision.

3.2 As was also reported to the Board meeting on 19th November, a joint Telecare/health pilot has been established, modelled on Kent County Council's Whole System Demonstrator (WSD) and other Telehealth evaluations programmes. It has been suggested that Derbyshire's pilot would target 250 joint Health and Adult Care clients with long-term conditions. The aims of this project include supporting people to live independently, alleviating the input from carers, reducing hospital admissions and reducing demand on GP, Nursing and Care services. Research is being conducted to identify client groups and localities, using prevalence data for hospital admissions rates and practice profile information to identify areas which could be the focus for the pilot work.

3.3 Further service planning and developments in Assistive Technology and associated services were approved by Derbyshire County Council Cabinet. The developments include reconfiguring a number services and contracts such as the Handy van Network, Wardens and Alarm monitoring service to aid the work on Telecare/health.

3.4 In addition to the above, Adult Care has conducted an options appraisal of procurement methods that could deliver the remaining elements of Assisted Technology Services such as expertise, investment in equipment development and management. Options include a partnership or joint vehicle via a competitive dialogue process.

3.5 This dialogue will result in a partnership or other joint vehicle which would bring in external investment and expertise in a number of areas including developing assisted technology products, marketing, service redesign and management. This approach should promote a greater level of diversification and organic growth using an increased pool of resources. The service would be transformational (fit for the future), deliver a user forward effective service, and provide economies of scale and a return on investment.

4. Officer's Recommendations

The Adult Care Board is asked to note the work on Telecare and Telehealth and to recognise its cost effective contribution to meeting health and social care needs.

Whole System Demonstrator Programme

Headline Findings – December 2011

Introduction

We know that people, particularly those with long term conditions, don't want to spend time in hospital unnecessarily, they want to have more control over decisions made about their care and they want to live a normal life.

To make decisions people need information and care services that respond to their needs, not the other way round. We want to make sure that people have access to services and information that help them make their own decisions and one way of doing this would be to enable people to get real time data on their own health status in real time. That is what assistive technology such as telehealth and telecare can do.

The Whole System Demonstrator programme was set up by the Department of Health to show just what telehealth and telecare is capable of. To provide a clear evidence base to support important investment decisions and show how the technology supports people to live independently, take control and be responsible for their own health and care.

The programme was one of the most complex trials ever undertaken by the Department of Health and will continue to provide useful information as the analysis continues, in particular we await the final results for telecare. But we want to share the telehealth headlines now, to help as many people as possible, as early as possible.

The first set of initial findings from this programme is now available. They show that, if delivered properly, telehealth can substantially reduce mortality, reduce the need for admissions to hospital, lower the number of bed days spent in hospital and reduce the time spent in A&E.

The key is to integrate these technologies into the care and services that are delivered. Going forward this evidence gives us confidence that we can transform the way services are delivered and ensure that we use appropriate technology to put people at the centre, and in control.

"Now if my condition changes I can speak to someone quickly and they have a record and can see what has changed - they know what to do to sort it out." – WSD trial participant

The Whole System Demonstrator programme

The Whole System Demonstrator (WSD) programme has been one of the most complex and comprehensive studies the Department has ever undertaken, and has yielded a wide range of very rich data.

The WSD programme was launched in May 2008. It is the largest randomised control trial of telehealth and telecare in the world, involving 6191 patients and 238 GP practices across three

sites, Newham, Kent and Cornwall. Three thousand and thirty people with one of three conditions (diabetes, heart failure and COPD) were included in the telehealth trial. For the telecare element of the trial people were selected using the Fair Access to Care Services criteria.

There are many different types of telehealth and telecare but each of the three sites made their own decisions on the equipment they would use in their health and social care economies. That in itself was not a problem for the study, as the proposition being analysed was "*Does the use of technology as a remote intervention make a difference?*" As each site used different equipment and had differing populations there is confidence that the results are transferable to other locations.

"It changes the whole concept of my life. I can get on with my daily activities... and am totally independent." – WSD participant

Evaluation

The study was set up in such a way that there was at least 12 months data on all participants by the end of September 2010.

Evaluation of the data from the programme has been undertaken by six of the major academic institutions - City University London, University of Oxford, University of Manchester, Nuffield Trust, Imperial College London and London School of Economics. The study looked at the data under five themes (service utilisation, participant reported outcomes such as quality of life; cost effectiveness; user and professionals experience; and influence of organisational factors to adoption) and papers will be published in due course, including the WSD evidence on telecare. More detailed analysis of the data will result in further papers being published over the coming months and years.

Early headline findings

The early indications show that if used correctly telehealth can deliver a 15% reduction in A&E visits, a 20% reduction in emergency admissions, a 14% reduction in elective admissions, a 14% reduction in bed days and an 8% reduction in tariff costs. More strikingly they also demonstrate a 45% reduction in mortality rates.

What Happens Now?

At least three million people with Long Term Conditions and/or social care needs could benefit from using telehealth and telecare. To achieve this level of change the Department of Health is

planning to work with industry, the NHS, social care and professional partners in a collaboration with a difference, the “Three Million Lives” campaign.

This is not a national target or a government guarantee of delivery, instead it is about the Department providing national leadership, strategic direction, and advice to NHS and social care organisations; with support from industry who would be responsible for creating the market and working with local organisations to deliver the change.

The detailed workplan for the ‘Three Million Lives’ campaign is still in the early stages of development with all stakeholders and further information will be available in due course.

Definitions

Long Term Condition – any health condition that cannot at present be cured, but can be managed with medicines and/or therapy. This includes conditions such as diabetes, heart failure, COPD, arthritis, depression.

Telehealth (remote care) - Electronic sensors or equipment that monitors vital health signs remotely, e.g. in your own home or while on the move. These readings are automatically transmitted to an appropriately trained person who can monitor the health vital signs and make decisions about potential interventions in real time, without the patient needing to attend a clinic

Telecare - Personal and environmental sensors in the home that enable people to remain safe and independent in their own home for longer. 24 hour monitoring ensures that should an event occur the information is acted upon immediately and the most appropriate response put in train.

Gateway Ref: **16972**

DERBYSHIRE ADULT CARE BOARD

12 January 2012

THE NATIONAL £20 BILLION QUESTION ABOUT DEMENTIA: DERBYSHIRE'S RESPONSE

1. Purpose of the Report

To assess the current situation in Derbyshire against the eight key recommendations of the House of Commons All-Party Group on Dementia's report 'The £20 billion question: an inquiry into improving lives through cost-effective dementia services' published July 2011.

2. Information and Analysis

Background

The All-Party Parliamentary Group (APPG) on Dementia was created in 2007 to promote dementia as a health and social care priority.

In December 2010 the APPG on Dementia began an inquiry into how best use resources currently spent on dementia and improve outcomes for people with dementia and their carers.

A key stimulus for the inquiry was pressure on health and social care budgets and an urgent need to improve cost-effectiveness. There was also evidence showing that dementia was estimated to cost the UK £20 billion in 2010 which is expected to grow to over £27 billion by 2018.

The APPG was interested in:

- Examples of good practice in dementia care, which are value for money and consistently deliver good outcomes; and

- Bringing these together in a report as a useful tool for providers and commissioners of dementia care.

Evidence was requested from people with dementia, carers, health and social care professionals, care home and home care providers, academics, regulators and trade bodies. They were asked what they see as barriers to achieving quality and cost-efficient dementia care across the UK, and what opportunities there are to develop knowledge-sharing and best practice in this area.

In July 2011 the APPG published the inquiry report: 'The £20 billion question: an inquiry into improving lives through cost-effective dementia

services'. The report identifies four main conclusions and developed eight recommendations:

1. **Whole Systems:** It is vital to consider dementia care as a whole system to improve cost-effectiveness;
2. **Hospital Environments:** Environmental changes can help improve experiences of hospital stays; but there should be greater efforts to prevent inappropriate hospital admissions by investing in community services;
3. **Community services:** Under half of people with dementia receive a diagnosis which is a first step to getting a support package. Specific types of services have the potential to improve quality of life and cost-effectiveness. People with dementia can benefit from both pharmacological and non-pharmacological interventions from the early stages of the illness;
4. **Care homes:** It is vital that care homes provide a good quality of life for people with dementia, as most care home residents will have some form of dementia.

The test of how effectively the APPG report's recommendations are addressed in the County rests on Derbyshire's Dementia Commissioning Strategy (developed by the County Council and NHS Derbyshire County). The strategy is informed by national guidance such as the National Dementia Strategy 2009 and Quality Outcomes for People with Dementia 2010; and was developed followed the Transforming Community Services work undertaken in 2009/10. It also built on local information such as the 'Lets Talk' events which were Derbyshire wide consultation events held with people with dementia and their carers.

<u>The 8 APPG recommendations are outlined below and the Derbyshire response is detailed under 'what we are doing'</u>

Recommendation 1. Better collaboration and integration
The different sectors involved in local dementia care systems must work collaboratively to consider how resources could be used more effectively. A well balanced and integrated approach to providing support for people with dementia requires joint planning and also consideration of how costs and savings can be shared.

What we are doing:

1. **Joint Commissioning –** development and implementation of the Derbyshire dementia strategy has been coordinated through a County-wide joint Adult Care and NHS Dementia Commissioning Group. The group is adapting to work with the new Clinical Commissioning Groups;

2. **Derbyshire Dementia pathway -** An integrated Adult Care and NHS pathway is at the core of the joint strategy. The aim is to offer quality services at each stage of the illness along the pathway;
3. **Information Prescription -** a directory of information is available on the both the Derbyshire County Consortia's and Derbyshire County Council websites. It contains signposts to information and services that are available for individuals, including links to specific and wider preventative services;
4. **Health Equity Audit (HEA) -** completed for Derbyshire in 2010. A HEA is a process through which looks at local inequities in the causes of ill health and in access to services. Historically Derbyshire has helped an above average number of older people to remain living in their own homes, which is what older people prefer.

Recommendation 2. Sharing expertise

Sharing expertise between the different sectors involved in dementia care can help to improve the quality and cost-effectiveness of services. There are a number of examples of this, many of which have been recommended by national guidelines and strategies. The pressure on budgets makes it increasingly urgent that these ways of working are established. They include:

- Hospital psychiatric liaison teams
- Care home outreach teams
- Palliative care outreach teams.

What we are doing:

1. **Older Peoples' Mental Health Liaison Service -** specialist support to Chesterfield Royal Hospital Foundation Trust including accident and emergency departments, medical assessment units, inpatient wards and the admissions and discharge team. The aims are avoiding unnecessary admissions; supporting assessment; providing signposting; and ensuring older adults admitted into acute beds for physical reasons also receive mental health care. The service is being enhanced over the winter and will be evaluated; this service is also being put in place over this winter period at Royal Derby FT, and will also be evaluated. Royal Derby has also put in place a senior Nurse specialising in Dementia to lead developments across the trust.
2. **Hospital training -** Chesterfield Royal is developing a training strategy to embed more understanding and expertise across the wider workforce. This has included training 8 senior staff in Dementia care as well as implementing Dementia awareness training across all the relevant work force. This has also been accelerated as part of the winter initiatives.
3. **Derbyshire Dignity Campaign -** as part of a broader joint Adult Care and NHS Dignity campaign, a partnership project was launched on

24th October 2011 at Chesterfield Royal Hospital: to offer a positive pathway and experience of dignity from admission to timely and safe discharge, including avoiding unnecessary delays in departure from hospital;

4. **Specialist Dementia Home Care Service -** a specialist service runs in South Derbyshire. A pilot project, in planning, will start in April 2012 in North Derbyshire with a service jointly provided between the Derbyshire Health Care Foundation Trust and Adult Care. The pilot will be researched to determine it's impact on admissions into hospital assessment and acute beds and care home admission and assess the feasibility of extending the service;
5. **In reach Service for Care Homes -** a pilot in 3 care homes (Osmaston Grange, Belper; Ashgate House, Chesterfield; Holly Tree Lodge, Derby) is offering practical support in the delivery of high quality person-centred care to people with dementia. Selection of the homes was on the basis of having more than 10 residents on antipsychotic drugs; any residents on more than one antipsychotic and the homes needed to say if they had already used any other therapies. The pilot has been set up specifically as part of the drive to reduce use of anti-psychotic drugs and will be evaluated to see how this approach if successful can be extended.

Recommendation 3. Early intervention
There must be a clear focus on early intervention in dementia. This is both cost-effective and likely to improve the quality of life of both people with dementia and their carers. An 'invest to save' approach may be required, but it is vital that a long-term perspective is adopted, given the potential gains of focusing on early intervention.

What we are doing:

1. **Memory Assessment Service (MAS) -** A Specification and model have been developed ensuring more venues for the MAS to promote early diagnosis and open up access to health and social care support. Phase 1 roll-out has incorporated sites across the whole of Derbyshire, including Derby City. Access to counselling support is available at the point of diagnosis; along with wider support via Living well programmes and dementia support. Current services operate from Staveley Centre, Dovedale Day Hospital, Swadlincote and Midway Day hospital. It is anticipated that future sites will include venues in Amber valley, the Dales, High Peak as well as some GP practices. The initial sites have been regarded as a pilot and will be evaluated to assess the type of venues that work most effectively.
2. **Living Well Programme -** a time-limited 8 week programme provided by the Derbyshire Health Care NHS Foundation Trust and Derbyshire Community Health Services for people and their carers following

diagnosis and includes provision of information, education and other assistance. All People going through the MAS with a confirmed diagnosis are offered the Living Well programme. Data about usage is just beginning to be collected.

3. **Dementia Cafes -** the Alzheimer's Society offers a number of cafés across the County. Funding for the service is a partnership – either from the Society itself; through funding support from Adult Care e.g.in High Peak and North Dales; Staveley and Chesterfield. NHS Derbyshire are providing funding towards an additional 5 cafes. The aim in every instance is to provide easily accessible and welcoming café sessions for people with dementia and their carers. This opens up opportunities for support needed including peer support. The cafes are catering currently for approx 1800 people, over half of whom are carers.
4. **Service Level Agreements (SLA's) -** SLA's are being written to include specific outcomes for commissioned services (for both Direct Care and contracted services). The aim is to shape services where research evidence suggests they will reduce inappropriate admissions to hospital or long stay care.

Recommendation 4. Improved co-ordination

Improving the co-ordination of dementia services presents an opportunity to improve outcomes for people with dementia and also increase the efficiency of services. The Group calls for:

- Increased use of key workers to act as a single point of contact and a coordinator of care (which professional takes on this role should depend on the circumstances of the individual with dementia, but they must have sufficient authority to instigate change within a person's care package)
- Improved sharing of information and data between different sectors.

What we are doing:

1. **Dementia support service –** this will be extended Countywide in March 2012; giving people with dementia and their carer's access to a named support worker. Additional components of the service include direct support; advice and information; referral to a 'Living Well' programme; providing dementia cafes; carer support groups and access to the Carer Information Programme. This will build on the current variable service availability into equitable County wide provision.
2. **Staveley Community Care Centre (CCC) -** opened in 2010 as a local hub for delivering services to older people with more complex levels of need especially adults living with dementia; providing carers with information, carer services and respite opportunities. The Centre has open public areas, services that are based in the centre, as well as 16

short and 16 long term residential care places. The building has won a dementia friendly design award from Stirling and has facilities for health service staff to undertake sessional work. The concept is our benchmark of coordinated service delivery for people with dementia;

3. **Swadlincote CCC -** to open in September 2012 with the additional feature of extra care apartments on site.
4. **Capital Investment Project -** planning of Staveley and Swadlincote CCC's has involved a high level of engagement between a range of stakeholders. A bid for PFI funding to build a further 6 CCC's was unsuccessful so a report is being prepared for Cabinet to take forward a revised capital strategy which involves developing further service hubs based on local opportunities across the County and extra care facilities with partners. Evidence suggests that extra care settings serve well to avoid the need for long term admission to residential care homes.
5. **Urgent Need Services –** In the north-east of the County Adult Care and NHS partners are reviewing the cohesiveness of services which need to respond quickly to keep people in the community. This includes establishing a single point of access to services for reablement; intermediate care; support for early hospital discharge etc. The intention is to produce a plan which details how each component part should best contribute to achieving good outcomes. This work is anticipated to have Countywide relevance too.

Recommendation 5. Training in dementia care
The level of training in dementia amongst health and social care staff is still inadequate, despite the opportunity to improve the quality and efficiency of dementia care. The Group calls for the implementation of the recommendation within the NICE guideline – that all staff working with older people in the health, social care and voluntary sectors have access to training in dementia care that is consistent with their roles and responsibilities.

What we are doing:

1. **Adult Care Staff Education and Training Centre (SETC) -** has developed and implemented a 'Person Centred Care Consultancy Model' of workforce development as part of a project to reduce the inappropriate use of anti psychotic drugs. The approach has added value to the standard of training available at Staveley CCC and the model is now being expanded to include other establishments in Derbyshire. There are still some planned training dates for Staveley CCC and a series of three entire programmes planned for Hillcrest Care Home at Kirk Hallam. In 2012 the SETC will be working together with Chesterfield Community Mental Health Team to train staff who will work in the specialist dementia home care service described in Recommendation 2 item 4.

Training involves an intensive, time limited, person centred approach using the social model of dementia care, working with the whole staff group to:

- Increase well being
- Reduce ill being
- Reduce the use of inappropriate anti psychotic medication
- The model centres around key areas:
  - Audit;
  - Action Planning;
  - Staff training in line with the Derbyshire Workforce Dementia Learning and Development Strategy.

2. **Anti-Psychotic Drugs -** The above model has also supported the establishment of a protocol for reviewing and monitoring people on anti-psychotic medication. This has resulting in a reduction in the number of people on anti psychotic medication and/or the levels of anti- psychotic medication prescribed to people (see also rec 6 item 5 below).
3. **Derbyshire Dementia Education Partnership -** a multi-disciplinary group created to drive forward action to improve training and education. It has identified several key actions, such as the development of quality standards to ensure services commissioned meet the required training standards. An E-Learning package pilot is taking place, aimed at providing basic dementia awareness to independent and private sector care homes.

Recommendation 6. Diagnosis

Rates of diagnosis must increase in order to ensure people with dementia have access to the treatment, services and information that they require in order to live well with the condition.

- The Group calls for ongoing campaigns to raise public awareness and reduce stigma, in order to encourage people to seek help if they are concerned about their memory or other symptoms;
- It is important that general practitioners are given the support they need to respond appropriately to people who are concerned they may have dementia. This includes increasing the length of GP training so that there is scope for including an adequate level of training about dementia within the curriculum.

What we are doing:

1. **Memory Assessment Service** - as in Recommendation 3 above;
2. **Living Well Programme -** as in Recommendation 4 above;
3. **Dementia support service -** as in Recommendation 4 above;

4. **Increased GP liaison -** locally driven initiatives involving Community Mental Health Teams include working with some GP's to co-locating MAS services. Clinical Commissioning Groups are also currently looking at priorities.
5. **East Midlands Regional Group** - Adult Care has representation on the East Midlands Regional and Clinical Leads group which has developed prescribing guidelines for the region to promote minimal use of anti psychotic drugs. During October – November 2011 an audit on the use of antipsychotics for people with dementia took place. The aim is to prompt reviews and reduce the inappropriate use of antipsychotics as part of a national campaign.
6. **'Quest' sessions -** provide education for GPs and other primary care staff with focus on Dementia; specific training from consultant psychiatrists on how to manage people with dementia. Sessions have already taken place in relation to early diagnosis and memory assessment and the additional session relating to End of Life care for people with dementia.
7. **Dementia Awareness/ Reducing Stigma Initiatives -** these include:
   - Writing a 'social model' of dementia which offers a set of principles on which person centred care is based. This model now underpins all service level agreements and the type of service it requires can be seen e.g. in the intergenerational work at Staveley Community Care Centre;
   - Annual national dementia awareness week - the Joint Commissioning Group actively supports such initiatives ;
   - Numbers diagnosed – The number of new clients with a primary diagnosis has been showing significant increases in recent years, suggesting increased awareness. NHS Derbyshire is predicting an increase in incidence in the County of 50% by 2025.

Recommendation 7. Supporting carers

Carers are the mainstay of support for people with dementia and providing support to help them carry on caring is fundamental to providing a good-quality and cost-effective dementia care service. Good quality respite care is a vital part of carer support and this must include night respite services.

What we are doing:

1. **Joint Commissioning Strategy for Carers -** this has led to a number of initiatives linked to the national strategy including the funding of short breaks; developing a peer group support directory described below. The emergency card and contingency-planning form part of the carer assessment process and helps carers to think about how caring impacts on them. The strategy also focuses on the important role the Health Service plays in supporting carers in both primary and hospital settings. Carers' champions have been established who have

worked with hospital staff to develop a carer hospital discharge checklist;

2. **Staveley Community Care Centre -** one of the venues for carers' support is helping to raise service standards. Carers say they prefer the format of a carers support group run simultaneously with support for the cared-for so this format is being replicated e.g. via the dementia support service;
3. **Dementia training for carers -** 6 programmes are being delivered by the Alzheimer's Society across Derbyshire, two in each locality running simultaneously. The programme offers 6 sessions giving information on the illness, challenging behaviour, benefits information and also gives the opportunity for peer support. So far sessions have been well attended and feedback has been excellent.
4. **Carers' Directory –** the first edition was issued in December 2011. Information is divided by area and is a mix of general information about organisations to help individuals and local support groups. This Directory has been produced by Derbyshire Carers Association in partnership with the County Council and will be updated regularly.
5. **Carers' Activity Breaks -** Carers have had the opportunity to access a range of breaks which have enabled them to have time outside there caring roles. .These have included Pilates and relaxation sessions Other Carer prefer just to meet with people to share experiences. Carers say they really value being able to support each other and often make lasting friendships through attendance at carers groups.
6. **Carers' Respite Breaks** - NHS Derbyshire and Adult Care have put together a funding proposal for Carers' Breaks. This will include the development of personal budgets for carers.

Recommendation 8. Sharing best practice
In order to encourage the uptake of cost-effective services that improve outcomes for people with dementia, the Group recommends that evidence of good practice and potential cost savings is widely shared and acted upon.

What we are doing:

1. **Working Age Dementia/ Young onset** – research has been completed to understand what support is available nationally for people with young onset dementia and their carers. We are currently building on this information through interviews with Derbyshire people to learn from their experiences. The outcomes with recommendations for improvements will be reported initially to the Adult Care senior management team.
2. **Person Centred Services -** Adult Care has introduced a format of person centred services with personal budgets being made available to meet eligible needs. This gives the individual greater choice and

control over their support. A Brokerage service is assisting people to connect with services they choose and through this process the Brokerage service is building up information about demand which will inform the commissioning process in future.

The move to person centred services has been supported by extensive training for Fieldwork staff. Staff are better skilled to support people to identify what their choices are and the goals they wish to achieve in their lives. This information is then channelled into the formal assessment systems being used by Adult Care.

3. **East Midlands Compendium of good practice -** this is to share good practice. The Staveley CCC is included.
4. **Dementia Research Group -** this group has been established by Adult Care and has built links with local Universities to ensure that commissioning intentions are evidence based. The group has devised a set of research questions relating to needs arising from the progressive stages of dementia. The group is actively looking for funding sources and will increasingly use research opportunities to inform the success of current commissioning and inform the future.
5. **Derbyshire Dignity Campaign -** the campaign is coordinated by the Adult Care Commissioning team in partnership with NHS Derbyshire County. Over 60 service teams across the County have already taken the bronze standard challenge designed to look at and improve practice. An event on 1 November 2011 attended by 170 people included people showcasing their good ideas for promoting dignity and respect. In 2012 the intention is to raise the bar and to encourage teams to reach higher standards in terms of dignity, starting with a silver standard workshop on 1 February 2012.

3. Recommendation

That the Board notes the contents of this report including work already done and supports work in progress.

The £20 billion question: An inquiry of the APPG on Dementia into improving lives through cost effective dementia services

Dear Colleague,

We are writing to make you aware of the above report which is of crucial importance to local authorities in the current financial context.

Report available here

There are 750,000 people with dementia in the UK, a number that will rise to 1 million people by 2021. With the cost of dementia reaching £20 billion a year, investing in high quality, cost-effective dementia services must be a priority. The APPG inquiry identified that significant resources are spent on poor quality care, often at crisis point, yet there are opportunities to save money in dementia care while improving outcomes. This new report looks at some of the ways that this can be achieved and can help local authorities meet the financial pressures facing them.

The report is based on evidence from people with dementia, carers, commissioners, professionals, providers and regulators. It provides good practice examples and is designed to be a useful tool for commissioners of dementia services.

The report highlights that closer working between health and social care teams and investment in early intervention services not only means better care for some of the most vulnerable people in our society, but saves money as well. A number of key recommendations have come out of the report:

1. Better collaboration and integration between different parts of the dementia care sector is crucial: this should include joint planning to ensure well coordinated dementia care, that shares costs and savings
2. Expertise should be shared between the different parts of the dementia care system: hospital liaison teams, care home outreach teams and palliative care outreach teams
3. Greater promotion of the need for early intervention: this is important in improving quality of life. It is also cost-effective, therefore an invest-to-save approach must be adopted
4. Improved co-ordination: there should be increased use of key workers and sharing of information between the sectors
5. More training in dementia care: enabling staff to provide high quality, efficient care
6. Increasing rates of diagnosis and follow up support is crucial: there is a need for campaigns to raise public awareness, reduce stigma, extend GP training to make it comparable with other specialisms and to enable GPs to learn about dementia in the community setting

7. Greater Support for carers: supporting carers to carry on caring, including good quality respite during the day and at night
8. Increased sharing of best practice to improve uptake of cost-effective services and services that improve quality of life

With difficult financial choices facing both the NHS and local government, it is vital that opportunities for delivering better value for money in dementia care services are grasped. I hope that you will take the time to read through this report and its recommendations and consider how they could be implemented in your area in order to improve the lives of people affected by dementia.

Alzheimer's Society provides secretariat for the APPG and can be contacted if you have any questions or would like to request a hard copy of the report. Please do contact Vicki Combe, Public Affairs Manager, Alzheimer's Society by emailing **Vcombe@alzheimers.org.uk** or calling 020 7423 3584.

Yours sincerely,

Baroness Sally Greengross
Chair, APPG on Dementia

Cllr David Rogers OBE
Chair, Community Wellbeing Board

Agenda Item 8

Derbyshire County Council
Adult Care

Further to the email circulated on 16th December you will note that agenda item 8 refers to Joint Commissioning discussions.

The purpose is for us to put together a paper on our joint commissioning priorities for 2012/13 and for this paper to be submitted for mandating by the Health and Wellbeing Board later in March.

To assist with preparing for this agenda item the below documents were circulated:

- A report from a joint regional event on Joint Commissioning in the East Midlands in November which I think provides a useful framework.
- A report to the Adult Care Board on 15th September 2011 which outlines the previous joint commissioning priorities. I am suggesting we write another for 2012/13.
- The latest NHS Operating Framework 2012-13. (Please click here: Operating Framework for the NHS in England 2012/13)

To facilitate this agenda item discussion each Clinical Commissioning Group was asked to provide a short report of their current/proposed joint priorities with Adult Care, Adult Care have prepared a similar report (see attached).

It is proposed that the Adult Care Board set up a short term task and finish group to use the reports and the Adult Care Board discussion to prepare our draft Joint Commissioning Priorities for consideration at the next Board meeting. These priorities may be countywide or focussed on one or more Clinical Commissioning Groups.

LOCAL GOVERNMENT AND HEALTH TRANSITIONS

JOINT COMMISSIONING IN THE EAST MIDLANDS

NOVEMBER 2011

The Health and Social Care Bill 2011 highlights the requirement for Local Authorities and the NHS to work more closely together, with duties to promote joint commissioning and integrated provision between health, public health and social care.

The changes occur in the context of financial pressures, reduced capacity and changing stakeholders. It is vitally important that part of the solution is ensuring that existing successful joint arrangements are maintained and built upon, as well as new opportunities developed.

Three pieces of regional work on joint commissioning were agreed by the NHS Transitions Board. Early work involved clarifying:

What do we think good joint commissioning looks like?

Joint Strategic Needs Assessment

- Describes the assets & future needs of communities
- Raises and summarises the key issues & questions to be addressed
- Evidence is used to inform analysis of priorities & commissioning decisions about future pattern of services
- Has a clear citizens voice as part of it

Joint Commissioning Strategy

- Strategic outcomes agreed for all areas of joint health & social care activity
- Includes preventative activity and services
- Includes wider local government services where relevant

Supported by:

- Strong joint senior leadership
- A core commitment to involve users and carers as co-production partners
- A costed implementation plan with outcomes, time-scales and dependencies
- Analysis of the costs and benefits to different stakeholders of the impact of commissioning strategies and that these are considered upfront
- Joint market development strategy

Joint Financial Investment Plan

- This does not necessarily require a pooled budget, but should consider the potential benefits
- Identify funding commitments
- Consideration of system issues such as IT and workforce development that underpin service change

Agree how:

- Anticipated savings will be split across agencies
- Financial risks will be managed and shared
- New cost pressures will be managed

Joint Governance

- Structure at Director level to oversee implementation
- Reporting to formal joint Board & local Health & Wellbeing Board

Joint Commissioning Event:

An East Midlands event was held on 9th September in Kegworth, with representation from a combination of Primary Care Trust (PCT) Clusters, Strategic Health Authority (SHA), Department of Health (DH), Commissioning Cluster Groups (CCGs) and Local Authorities (LAs).

The Institute of Public Care at Oxford Brookes University has been involved in a number of pieces of work/research in this field and their presentations on the day challenged us to consider the following points:

What are the ways in which we can analyse**, predict and prepare for demand in a more integrated way across whole systems?** Can we better predict and avoid high costs in care by:

- Jointly understanding collectively the routes people take and what events/conditions trigger people into higher care needs/costs across health and social care?
- Integrating services at the point of care delivery?
- Moving to commissioning for outcomes not processes?

Quality of care delivery in areas such as falls, stroke and continence remain too variable and can lag behind recognised good practice in certain parts of pathways. This leads to poor results and outcomes for both health and social care.

There is still **insufficient research** to inform commissioners about what works best, for example, the impact of stroke rehabilitation interventions in community settings is not well researched.

Criteria to influence where to focus our efforts in terms of integration could include:

- Areas of high spend
- Areas where there is good, well established methodology to improve outcomes
- Areas where there are quick wins to be had, things that are readily amenable to change
- Areas where consumers are likely to come on board and readily engage with changes

A **new era of commissioning** is dawning, with different tasks, tools and players coming into the system. Traditional strategic commissioning methodologies and cycles need to adapt, as increasingly statutory commissioners will be directly contracting for fewer services, but will need to facilitate choice in a market for an increasing number of self-funders and Personal Health) Budget holders.

Commissioning and market development skills and capacity need to be able to deliver new ways of working required, for example, gathering good market intelligence (e.g. sharing information to establish a joint view of supply, demand, and gaps), understanding of market structures and intervention strategies (e.g. when and how to intervene) are much needed in the field of integrated commissioning and these are sometimes scarce skills.

Strategically, the **commissioning dimensions** to consider for the future could be described as "individuals" "the place", and "the market." We should note that councils are fundamentally changing their roles as a result, e.g. divesting provision, enabling personalisation and seeking integrated solutions.

Market position statements, service prospectuses and framework contracts, (taking into account whole pathways, and outcomes across the system, rather than individual pieces/silos), could lead to different procurement opportunities, processes, and more creative solutions with providers. Different relationships between commissioners and providers are required in this context, and other than operating within a pure competition/tendering environment, or using this as the default solution. This is a capacity building requirement for the new system.

The importance of public health intelligence, developing the JSNA (e.g. to go beyond analysis) and the need for more health economics skills generally were all highlighted in the question and answer sessions following the presentation.

Round table discussion then focused on the following 3 questions:

- What are our priorities for integrated commissioning?
- What structures are needed to facilitate local conversations?

- Do we need a common template to assess/support development of our local state of readiness/progress with integration? If so what should be the headings of this template/checklist?

Joint Commissioning Checklist

Questions for health and local government, to inform strategic conversations regarding establishing local joint commissioning arrangements.

1. What key outcomes to we want to achieve for our customers and how might a joint approach add value to what we need to do?

2. What are our priorities and time-scales for joint commissioning over the next two years?

3. Have evidence based examples of integration which have resulted in improved outcomes elsewhere been considered?

4. Do the priorities have a good fit with JSNAs and with Health and Wellbeing Strategies? Are they aligned at District level where relevant?

5. Have we gained joint agreement and ownership on our priorities between local government and commissioning consortia? Is the input of clinicians clearly defined, targeting best use of their expertise?

6. Have we expressed our priorities as a jointly agreed a set of strategic outcomes we wish to achieve across the system? For example, reduced admissions to hospital,/residential care.

7. What arrangements need to be in place to deliver the integrated commissioning priorities; people, skills, joint financial investment, capacity? In what structures; virtual, hosted, joint, bought in?

8. What local governance arrangements need to sit under Health and Well Being Boards to deliver the priorities? Are these action orientated, focusing on the priority outcomes, with clarity of roles?

9. Over time can the Health and Wellbeing Board and its substructures evidence clear examples of facilitating change and removing barriers to delivery e.g. by their particular intervention?

10. Are succinct, jointly agreed market position statements in place for priority areas? Over time is there evidence of change towards these with positive relationships between commissioners and providers developing?

Joint Commissioning Template

The following template is designed as a tool which could be used to as it is, or adapted for more detailed work on the what 's, how's and why's of joint commissioning. This could be used, for example, as the basis for a workshop or focused meeting.

It includes an initial list of variables that will affect the potential impact of joint commissioning in any area, to which local additions e.g. agreed strategic priorities, may be added.

A worked example for one area is given at the end.

	Do people receive services from both health & ASC ?	Which elements? a) Needs analysis b) Strategic planning & service redesign c) Procurement, contract management & monitoring. d) Market shaping e) Review individual & strategic outcomes	What level? a) CCG b) more than 1 CCG c) LA d) county/PCT cluster e) sub-national
UNIVERSAL SERVICES			
Information & advice			
Health Promotion			
Health outcomes: - smoking cessation - reducing obesity			
PREVENTION & EARLY INTERVENTION SERVICES			
Re-ablement & Intermediate Care			
Assistive technology - Stand alone - Telecare - Telehealth			
Carers support			
GENERIC SERVICES			
Acute			
Planned Care			
Emergency & urgent care			
Supported living/extra care			
High cost packages (including CHC)			
Community Equipment			
Domiciliary care			
Day services			

Residential & nursing care			
CLIENT/PATIENT GROUP SPECIFIC			
Mental Health			
Learning Disabilities			
Drug & Alcohol			
Offenders			
Dementia			
Long Term Conditions - COPD - Stroke - Diabetes			
End of Life			
Maternity			
Children's			
SUPPORT FOR PBS & PHBs			
Person centred support planning			
Brokerage			
Direct Payment Support Service			

Variables when considering potential for joint commissioning	**1 = low** **3 = medium** **5 = high**
The extent to which local people are likely to need both health and social care support to meet their needs	
The potential to improve outcomes for individuals	
Potential scale of savings to current total budget across health and social care	
Extent to which capacity in key knowledge and skills required is available	
Minimum size of team/resource required to deliver and be sustainable	
Potential to deliver benefits above and beyond those that could be achieved independently	
Degree to which collaboration will facilitate meeting each agencies strategic agenda	
Level of resource required to implement, versus level of benefit	

EXAMPLE

High cost packages (including CHC)	Yes. People do not remain with one agency. As needs change may shift between social care, joint, to sole health responsibility in non linear fashion.	Risk - potential for disproportionate , very high number of high cost cases in a CCG Specific skills & knowledge set needed. Individuals move across areas of health & ASC responsibility. Value in joint work a) through e) to improve individual and organisational outcomes.	
		a) Needs analysis Yes, combined intelligence will deliver better planning for the future (reduce out of area placements?) and enable providers to know demand for different types of service.	CCG level data required. Skills & resources may be shared at e.g. LA/County level.
		b) Strategic planning & service redesign Yes	LA level to link with Health & Well being Boards
		c) Procurement, contract management & monitoring. Yes to reduce duplication, negotiate fair prices & avoid problems of provider not being approved by agency to whom responsibility may move.	LA level or higher? Jointly agreed and incentivised outcomes
		d) Market shaping Yes to have more market influence.	County level or higher?
		e) Review individual & strategic outcomes. Yes.	Individual outcomes to be reviewed at CCG level. Skills to do this may be provided at wider level, MDTs (consider optimum level of integration across health & ASC). Strategic outcomes at level of b).

Report for Adult Care Board
12th January 2012

Proposed Commissioning Priorities with Local NHS

Carers
- Proposed Lead Commissioning – Adult Care
- Personal Budgets
- Respite
- Joint Contracts

Learning Disability
- Proposed Lead Commissioning – Adult Care
- Community Lives
- Person Centred Planning
- Short Breaks

Autism
- Autism Act & Statutory Guidance implementation

Urgent Care – Keeping People at Home
- Hospital Admission and Discharge
- Intermediate Care / Reablement
- 24/7

Stroke
- Early Supported Discharge
- Stroke Support Services

Accommodation & Support for Older People
- Community Care Centre Development
- Extra Care (including intermediate care)

Employment: for example
- Learning Disabilities
- Mental Health
- Carers
- Younger Disabled People

Transition to Adult Life Young Disabled People/CAMHS etc

- Transferring support from Children's to Adults health and social care services
- Integrated Community Equipment Service (ICES)

Mental Health Services

- Delivering 'No Health without Mental Health'

Long Term Conditions

- Joint case-finding and managing
- Disabled Facilities Grant
- ICES

Safeguarding

- Dignity & Respect (standards)
- Safeguarding (policy & Procedure)

Information & Prevention

- Universal Services
- Co-ordinating Access to information

Engagement & Co-production

- To underpin strategic commissioning decisions/priorities

ADULT CARE BOARD

15th September 2011

JOINT COMMISSIONING OF ADULT HEALTH & SOCIAL CARE

1. Purpose of the Report

To provide a summary of the joint adult health and social care commissioning priorities previously agreed by the Health & Wellbeing Partnership; and to set out initial proposals for future lead joint commissioning.
To summarise some initial developments and proposal for future joint / lead commissioning within the Clinical Commissioning Group Framework.

2. Information and Analysis

2.1 Background

The core functions of the Adult Care Board will be to oversee the four key strands of strategy, commissioning and performance namely:

- Prevention (non-care based) – primary link with Public Health commissioning
- Accommodation with support – linked to the Capital Programme Board and District/ Borough Councils strategic housing responsibilities
- Joint Commissioning of Health and Social Care Services
- Adult Safeguarding – multi-agency response

2.2 Current Joint Commissioning Priorities

The joint commissioning strategies (Carers, Younger Disabled People and People with a Sensory Impairment, Older People, and for People with Learning Disabilities) were developed within an agreed framework of joint commissioning principles and in the context of the implementation of personalisation in Derbyshire.
The priorities are based on locally identified needs as set out in the Joint Strategic Needs Assessment and key national strategies; and were subject to substantial consultation with clients, family carers and other key stakeholders.

The joint adult health and social care commissioning priorities set out below were agreed by the Health & Wellbeing Partnership in September 2010. These are:-

<u>Over-arching Priorities</u>:
- Evidence based investment;
- The delivery of efficiencies to ensure balanced and sustainable investment in services.

Older People – Priorities:
- Good quality, consistent information about services;
- Improved pathways including hospital discharge/avoidable admissions;
- Specialist care for people with dementia;
- Choice and flexibility in day services.

Learning Disability – Priorities:
- Everybody to have a person centred plan and the outcomes to be monitored;
- Working in partnership to improve the range of housing options available;
- Ensuring more people have a Health Care Action Plan.

Carers – Priorities:
- Carer's breaks that are flexible and responsive to carer's needs;
- Information and advice, including a directory of services, available in a range of places for example GP Surgeries, hospitals and libraries.

Disabled People or People with a Sensory Impairment – Priorities:
- Improve access to community transport and social care transport services;
- Equality of access to health provision and health care for people with long-term conditions;
- Improve accessible housing;
- Support Disabled People to remain in work.

2.3 Lead Commissioning within the Emergent Clinical Commissioning Group Framework

Hardwick Health will be the lead commissioner for Mental Health, and Adult Care will work on joint commissioning proposals with Wendy Sunney and David Gardner.

Adult Care has offered to become the lead commissioner for Learning Disability and Carers services, with a pooled budget being established for these purposes.

There were a number of complexities around Older People which would benefit from an individual discussion with each of the Clinical Commissioning Groups.

2.4 Integrated 24/7 community care capability

A meeting is being convened with community health care providers to explore opportunities to develop an integrated 24/7 community care capability. This will be aimed at reducing inappropriate admissions to hospital or long-term care and to enhance current hospital discharge arrangements – with a particular focus on older people.

The work will, initially, form part of the Winter Plan; but will be part of a longer term strategic development, including local discussions on how it could be developed for each Clinical Commissioning Group area.

3. Performance Management

The focus of the Adult Care performance management is on the outcomes of the implementation of the commissioning priorities.

As part of a corporate Derbyshire County Council requirement Adult Care has set four priority indicators specifically for Adult Care which will have targets set for them, taken from the national Adult Social Care Outcomes Framework (2011/12). These are:

- NI 127 Self reported experience of social care users
- NI 130 Social Care clients receiving Self Directed Support
- NI 135 Carers receiving needs assessment or review and a specific carers service, or advice and information
- NI 141 Number of vulnerable people achieving independent living

Four partnership working indicators have also been provisionally fed in to the corporate process. It was recognised that these had not been set in partnership and that the Clinical Commissioning Groups should have an opportunity to look at the other indicators within the national framework:

- NI 124 People with a long-term condition supported to be independent and in control of their condition
- NI 125 Achieving independence for older people through rehabilitation/ intermediate care
- NI 129 End of Life Care – access to appropriate care enabling people to be able to choose to die at home
- NI 131 Delayed transfers of care from hospitals

4. Recommendations

This paper is being brought to the Adult Care Board for discussion and agreement as appropriate.

Julie Vollor
Adult Care Group Manager - Commissioning

2012-13 Joint Derbyshire Commissioning Intentions

1.0 Background

2012/13 will be a year of transition with the influence of Clinical Commissioning Groups increasing as they begin to take on responsibilities from the primary care Trust. As such these commissioning intentions have been developed jointly between the 5 Derbyshire Clinical Commissioning Groups and NHS Derbyshire cluster outlining some of the key challenges to be faced during the 2012/13 contracting year.

This document is intended to supplement CCG local commissioning intentions and highlight areas which the CCG's intend to collaboratively commission or remain under the responsibility of the cluster to commission.

2.0 Context

Specific requirements will be detailed within the Operating Framework for the NHS in England 2012/12 (due to be published in November 2011). It is expected that the Operating Framework will reflect the NHS existing priorities and the latest evidence based guidance.

2012/13 will see a continuation and heightening of the challenge to maintain or improve quality whilst increasing productivity and encouraging innovation and prevention strategies (QIPP). As such a common underlying priority across the health community is the realisation of the financial savings associated with QIPP delivery programmes as established in previous years and those due to be implemented in 2012/13.

The financial assumptions of the CCG's is that there will be zero growth in funding allocation set against a backdrop of continuing growth in activity and resource requirements and as such the financial outlook is challenging across the health community.

The required levels of savings/ QIPP targets to be delivered by the CCG's during 2012/13 has been identified as follows:

- Erewash CCG - £6m
- Hardwick Health CCG - £6m
- High Peak CCG - £2m
- North Derbyshire CCG - £10m
- South Derbyshire CCG - £41m

There will be further amendments as financial allocations become clearer.

3.0 Commissioning priorities

The following areas have been identified as areas of commissioning that are county wide and as such will affect all five Clinical Commissioning Groups. It should be noted that CCGs may have additional commissioning intentions under these headings so reference should also be made to individual plans.

3.1 Urgent Care: we will be working towards a full roll out of the 111 pilot by 2013. During 2012 a procurement exercise will take place to identify a future provider for the 111 service. The tender will also cover out of hours clinical service and we will look to see what other innovative service improvements can be delivered.

3.2 Cancer Services: we will look to comply with the Operating Framework Guidance for 2012/13.

3.3 Children and young people: the following areas have been identified as priorities for the commissioning of children and young people's services:

- Increase in Health Visitor capacity and implementation of Family Health Partnerships
- Revised specification for children's occupational and physiotherapy, school nursing and children's speech and language therapy within existing resources/ QIPP requirements
- Review of community paediatrics service
- A review of provision of antenatal parenting courses within existing resources/ QIPP requirements

3.4 East Midlands Specialised Commissioning Group: EMSCG has released detailed commissioning intentions. A summary of some of the key areas affecting local providers are included below:

- There will be a national "pick-list" of CQUIN schemes for Specialised Services for 2012/13 and beyond and CQUIN payments will be targeted at a range of tangible, high impact quality improvements
- National QIPP plans will focus on the biggest areas of Specialised Commissioning spend including cardiac care, neurological conditions, and renal provision. There will also be a set of local QIPP plans to address specific issues across the new SCG cluster
- Key Performance Measures to measure outcome and quality of services
- Major Trauma Centre to be commissioned at Nottingham University Hospitals

3.5 Medicines Management: all Providers are expected to use medicines effectively and efficiently to avoid medicine related harm and admissions and ensure wastage is minimised. Providers must abide by Joint Area Prescribing Committee decisions, guidelines and policies as per the medicines management website. Black status drugs must not be prescribed. Pharmacy Advisors working with practices will continue to promote effective prescribing in primary care.

3.6 Mental Health: the following areas have been identified as a priority for the commissioning of mental health services;

- Deliver IAPT services across all practices and develop psychological therapy services to address the gaps in integration and current provision of therapies and support.
- Support the development of PbR for mental health
- With local authorities to re-commission carer support services for mental health within less or existing resources

- With local authorities review and consider re-commissioning Out of hours support line for mental health
- Work to bring as many people in placements out of county back to services as near to home and in the least level of security clinically appropriate
- In partnership with the local authorities and voluntary sector infrastructure organisations develop outcome based monitoring arrangements for the voluntary sector.
- In partnership with the voluntary sector deliver primary care mental health training programme
- Working with local authorities support the move to personalised services
- Support recovery based approaches to service delivery.

3.7 Learning Disabilities: the following areas have been identified as a priority for the commissioning of learning disabilities services;

- Together with Derby City and Derbyshire County Council, work towards transferring the lead commissioner role for Learning Disability services
- Together with Derbyshire County Council undertake a review of short break services
- Together with Derbyshire County Council develop the autism pathway consistent with the Autism Act and subsequent guidance
- On LD for Derby City we are looking at accelerating the placement in the community from out of area of people with LD and exploring the possibility of personal health budgets.

3.8 Community Services: the following areas have been identified as a priority for the commissioning of community services

- A review of the frail elderly pathway and current services to support the provision of care at home or close to home as possible. This will include a review of the provision of assessment and treatment services for the frail elderly including establishment of rapid referral and access routes into the appropriate care setting. Work will be undertaken to further develop integrated working with health and social care to maximise utilisation of current resources and ensure appropriate access to available services with both health and social care
- A review of consultant led planned care services provided within the community will be undertaken to review demand for services and ensure best value in relation to use of resources is obtained across the whole health economy
- Further roll out of the changes agreed through the introduction of the district nursing specification during 2011/12
- The implementation of any qualified provider for the contracting of the following community services:
    - Community podiatry
    - Musculo-skeletal services for back and neck pain
    - Primary care psychological therapies (adults)
- The requirement for the provision of information to meet the community minimum dataset

3.9 Ambulance Services: East Midlands Procurement and Commissioning and Transformation (EMPACT) have developed a draft 'Commissioning Intentions Working Paper' which sets out seven areas of development for ambulance services. Please refer directly to this paper for more information.

3.10 Dental

- The PCT is looking to establish a Local Professional Network (LPN) pilot scheme in line with the National Commissioning Board's (NCB) developments for Primary Care, so that outcomes and processes can be developed ahead of the NCB introduction in 2013
- We will continue to ensure access to dental services across the region urgent care/ new patient sessional contracts have been renewed for a further period of time to 2013
- The PCT will continue to support the dental pilot scheme introduced in 2011 for practices in the region

3.11 Pharmacy

- The New Medicines services will be introduced by pharmacies and patients will be able to obtain advice and assurance about the medicines they are prescribed
- New Market entry regulations for Pharmacies are currently out to the public for consultation and it is expected that these regulations will be introduced some time during 2012, and PCTs will follow the new guidance

3.12 Optometry

- It is anticipated that if possible the Glaucoma Referral Refinement scheme will be introduced across all locations for the region during 2012

3.13 PLCV**:** procedures of limited clinical value will continue to be incorporated into the Derbyshire PLCV Policy to ensure the effective use of resources. The Department of Health has made it clear that a referral is not an authority to treat where policies setting out procedures which have not been commissioned are included in contracts. CCGs will be responsible for implementing and monitoring the PLCV policy within the contracts they lead on.

4.0 Quality

4.1 CQUIN: schemes will be required to meet national requirements. Local CQUIN schemes must support QIPP.

4.2 Strategic Health Authority Priorities: CCGs are committed to delivering the 5 priorities identified by NHS Midlands and East. They are:

1. Elimination of pressure ulcers
2. Ensuring 'every patient contact counts' through systematic Public Health advice delivered by front line professionals
3. Significantly improving quality and safety in primary care
4. Ensuring radically strengthened partnerships between the NHS and local government
5. Delivering a revolution in patient and customer experience

4.3 Clinical Variation: the CCGs are also committed to reducing clinical variation to improve quality and increase value. The Atlas of Variation, Summary Hospital-level Mortality Indicator (SHMI) and other indicators will support this work across both primary and secondary care.

4.4 Outcomes: the CCGs will continue to work on commissioning outcomes as and when they are released.

5.0 Contracting Intentions

The following sets out the contracting requirements common across all CCG's and contracts.

- For each contract a lead CCG has been identified to act as co-ordinating commissioner across all CCG's and associate PCT/CCG's where appropriate. This lead CCG will have the responsibility for representing all CCG's in that PCT during contract negotiations.
- As CCG's are not statutory bodies they will not have organisation codes however it is expectation that all 2012/13 activity plans will be agreed and monitored at CCG level.

The following timeline sets out the expected deadlines in relation to the contract agreement process:

Nov	Dec	Jan	Feb	Mar	April
★ Operating framework published		★ 2012/13 PbR tariff published	★ Contract agreement reached	★ Final contract sign off	

NHS Erewash Clinical Commissioning Group

Commissioning Intentions 2012-13

1.0 Introduction

This document outlines the draft commissioning intentions for 2012-13 for NHS Erewash Clinical Commissioning Group (ECCG).

This reflects the initial commissioning intentions to deliver local and national priorities. This document should be read in conjunction with the 2012-13 Joint Derbyshire Commissioning Intentions which have been developed jointly by the five Clinical Commissioning Groups in Derbyshire. The Joint Derbyshire Commissioning Intentions supplement these local commissioning intentions and highlight areas which the CCG's intend to collaboratively commission or remain under the responsibility of the cluster to commission. Both sets of commissioning intentions signal to providers any significant commissioning and service changes as part of a wider engagement process with providers ahead of the contract negotiations for 2012-13. This will allow providers the opportunity to take account of commissioner requirements and review their own service plans.

In addition, both this document and the Joint Derbyshire Commissioning Intentions are supplemented by the East Midlands 2012-13 Collaborative Commissioning Intentions Framework which highlights the areas where East Midlands' commissioners have signalled an intention to work collaboratively on common issues during the 2012-13 contract negation round.

Erewash CCG is composed of 13 practices serving around 100,000 population. The CCG has a requirement to commission health services for its population and to do so whilst staying within financial balance. With expectations of nil growth in finances in 2012-13, ECCG faces a significant challenge to improve quality and deliver efficiencies and at the same time meet the increasing population health needs. To meet the QIPP challenge the CCG will need to use its resources more effectively and to increase productivity in every area of work we undertake and in all services commissioned. Providers will be required to play their part in working collaboratively with commissioners to realise the required efficiencies.

We have put in place measures to involve clinicians in our commissioning cycle and contracting for 2012-13 including involvement of GPs directly in contract discussions and service review. This will be underpinned through on-going dialogue between clinicians within primary and secondary care throughout the year.

1.1 Financial Assumptions

The expectation for 2012-13 is that there will be nil growth in funding. The CCG will be required to continue to meet the health needs of the population within the overall resource limit. To make up for the shortfall in growth, the CCG will need to deliver significant improvements in Quality, Innovation, Productivity and Prevention (QIPP). An indication of the QIPP requirement for 2012-13 for Derbyshire County is that almost £27 million of savings will be needed which equates to 3.47% of the budget. QIPP targets for 2012-13 are still indicative and are dependant on several variables such as actual levels of growth received in 2012-12 and the successful delivery of QIPP efficiency and actual activity outturn in 2011-12.

2.0 Principles

The mission statement for NHS Erewash CCG is to deliver "Better Care. Better Health. Better Value." The aim is to deliver improved outcomes and quality for patients, to deliver the necessary QIPP requirements by improving efficiency and quality; deliver integrated partnership working to improve the delivery of services on the ground to patients and strengthening clinician and public involvement in our commissioning role.

The guiding principles that inform the commissioning intentions and subsequent contracting dialogue with providers are as follows and it is expected that all main providers will agree to these.

a) The shared objective of ECCG and providers in facing the current financial challenge is to transform the services we offer patients that further improves the quality and clinical and cost effectiveness.
b) All organisations will be required to deliver their required part in service changes to improve quality and effectiveness in order to secure added value in services within existing resource constraints. We will use incentives within contracts to support delivery the required service change.
c) National and local priorities to be delivered within available resources.
d) We will work with the public, local authority and partner organisations to understand the need for service changes and to commission services which are of high quality but also deliver improved efficiency and value for money.
e) We are working with Primary Care to reduce unwarranted clinical and operational variation. It is expected that clinicians in Secondary Care and community services will also work to deliver reductions in clinical variation.
f) We will support the greater integration of services through use of appropriate contract levers and incentives.
g) We will work with providers and partner organisations to tackle any long standing health community issues even if these cannot be resolved in the normal annual contracting round.
h) The CCG will commission services in accordance with the Operating Framework for 2012-13 and other national guidance.
i) Where no specific mention is made of a service or area within this document the Derbyshire County PCT's Contracting Intentions for 2011/12 will continue to be relevant.

3.0 Areas of potential change

This section flags up to providers areas of service change within ECCG which will impact on activity to be commissioned in 2012-13.

3.1 Unwarranted Clinical Variation

Please also refer to s.4.3 of the 2012-12 Joint Derbyshire Commissioning Intentions.
The CCG has identified specific clinical pathways to be included in the Quality and Productivity Indicators for primary care and has established an additional local CQUIN scheme proposal to tackle unwarranted clinical variation.

The aim of the Quality and Productivity Indicators is to seek to improve the quality of care provided to patients and deliver productivity gains by identifying and in turn providing alternative care options to avoid inappropriate referrals and emergency admissions. The focus is on:

- Prescribing

- Outpatient Referrals
- Emergency Admissions

The purpose of the indicators is to contribute to the productivity savings by undertaking reviews (internal and external) of current practice by GPs. This will be facilitated by analysis of specific data that looks to understand the reasons and, if appropriate, ways to address outlier performance in the areas set out above. The indicators also aim to support Practices to deliver care in line with pathways to reduce unnecessary secondary care activity.

Practices will be undertaking internal review and external peer review of emergency admissions and development of action plan and identification of specific actions which can be put into place to reduce avoidable A&E attendances and admissions such as Right Care Plans (see below), improved management of patients in nursing homes and proactive management of patients.

By 31st March 2012, 2% of the patient population with Rightcare plans in place with priority given to the following patient groups (extending to 5% in 2012/13):-

- Patients with 3 or more admissions, A&E attendances, or Out of Hours attendances in the previous year (adults only)
- Severe COPD patients
- End of Life patients
- New nursing home patients

In addition, practices will be focussing on implementing the pathway for COPD patients with key interventions aimed at reducing A&E attendance and hospital admission:

- Self management plans and standby medication for appropriate patients
- Review of patients following discharge from hospital with referral on to other services where appropriate
- Annual influenza and pneumococcal vaccinations

In relation to first outpatient referrals, practices will be undertaking an internal peer review of all referrals to the top 6 specialties within their practice and subsequent post review of the outcomes of referrals. The main specialties within Erewash CCG are:

- Dermatology
- Trauma & Orthopaedics
- Gynaecology
- ENT
- Ophthalmology
- General Medicine

In addition practices are required to make:

- Use of the Integrated Diabetes Service Pathway as replacement to all appropriate Diabetes hospital referrals
- Full use of the Procedures of Limited Clinical Value policy

It is expected that this will deliver:

- 10% reduction in GP referrals
- 15% reduction in emergency admissions.

These assumptions will be fed into activity plans for 2012-13.

3.2 Community services

To enable patients to be treated in the most appropriate setting, there is a requirement to review existing community services provided by health and social care. The utilisation review of acute hospital and community hospital beds in Derbyshire and Nottinghamshire shows that there is scope to make more effective use of existing beds by providing alternative levels of care in the community. We will work with acute providers and Derbyshire Community Health Services (DCHS) to identify gaps in services and commission appropriate alternative services in the community to deliver care in settings aligned to the patient's clinical needs.

ECCG plans to work with DCHS and Social Services to develop a new model for the proactive management of patients at risk of hospital admission. This will build on general practice as the locus of integration, with community matrons and district nurses and GP practice staff and social care, working to support proactive management of the practice population. This will also enhance integrated services through the involvement of social care. Work to develop the new model of care is being undertaken through the Department of Health QIPP for LTC Programme taking place in East Midlands.

ECCG will explore development of community services within Nottingham to consider if any of these developments should be offered within Erewash and will use existing contract links to consider early adoption of new developments.

3.3 Ophthalmology

ECCG will explore the possibility of establishing a primary care assessment service for eye conditions delivered by local opticians with the aim of providing a local assessment and treatment service for patients with minor eye conditions.

3.4 Right Care Pathways

ECCG will explore the adoption of the right care pathways developed through the East Midlands Right Care Workstream for Urology and General Surgery which had secondary and primary care clinician involvement in the development of the pathways. We will consider the adoption of these evidence based pathways and seek to commission local arrangements to deliver the best value pathways. This incorporates LUTS, scrotal swelling, hernia repair and rectal bleeding. This will also explore the development of patient decision making aids.

Linked to the work by GP practices on outpatient referrals, the CCG will review pathways and services around Trauma & Orthopaedics, Dermatology and Ophthalmology.

3.5 DVT

ECCG will explore the possibility of introducing a DVT screening test in primary care to reduce avoidable referrals to hospital.

3.6 Phlebotomy
ECCG will review the phlebotomy service following changes in the Primary Care funding arrangements.

3.7 Diabetes
ECCG intends to commission an integrated intermediate level 2 diabetes service through a competitive tender process. The service will commence in 2012/13. This service will move secondary care activity into community settings bring care closer to home for Erewash patients.

3.8 Urgent Care
We are currently reviewing the urgent care pathway at Ilkeston Minor Injuries Unit (MIU). We wish to change the operating hours to 8am-8pm, 7 days a week, with cover over night from Out Of Hours provider. We wish to extend the X-ray hours so that they run concurrently to the daytime MIU and also ensure that children under 5 can be x rayed. We are exploring the possibility of blood analysis at Ilkeston MIU which would help us to pilot the diversion of Category C calls away from acute care providers to the MIU.

3.9 Trauma and Orthopaedics
We will be reviewing the T&O pathway to understand reasons for higher then average activity. ECCG will be exploring opportunities to reduce activity and commission at the national average.

3.10 Frail elderly including Dementia
ECCG will be working closely with the Southern Derbyshire CCG who is leading on a project to improve the care of frail elderly including those people suffering from dementia. This will include learning from the evaluation of the Older Peoples Mental Health Liaison Service currently being piloted at RDHFT.

4.0 Contract
NHS Erewash CCG leads on the following contracts for the Derbyshire Cluster:

- Nottingham University Hospital NHS Trust
- University Hospital Leicester
- Birmingham Children's Hospital NHS Foundation Trust
- Voluntary Sector Contracts
- Private Hospitals for patient choice –ISTC, BMI and Ramsey

The following reviews/ developments will be undertaken throughout 2012/13:

4.1 Elective surgical intervention: will be commissioned in the least clinically intensive setting for treatment in line with British Association of Day Surgery rates and regional best practice.

4.2 Maternity: any new pathway tariffs developed for maternity services within the PBR system in 2012/13 will be used by ECCG as the currency to fund maternity services.

4.3 111: ECCG will introduce the 111 national initiative to the Erewash area. We are currently exploring the options of working with the Derbyshire or Nottinghamshire to ensure the best out of hours care for our population.

4.4 Consultant to consultant ratios: we will expect providers to improve their consultant to consultant referral ratios in order to move into upper quartile national performance.

4.5 Coding review: we will work with Nottinghamshire PCT as lead commissioner to implement the coding review commissioned through EMPACT.

4.6 Re-admissions: funding for readmissions will be paid in line with national guidance.

4.7 Independent Treatment Centre: we will be working with the lead commissioner Nottingham City PCT on a decision about retendering/or other for the contract for the provision of services at Nottingham Treatment Centre. Work will take place locally to identify services which would benefit from being delivered in the Treatment Centre and where services can be moved out into community locations.

4.8 Waiting times: we will commission no further reductions in waiting times for routine elective admissions, agreeing where clinically appropriate and necessary, and minimum waiting time standards for routine outpatients and operations across the CCG.

4.9 New to follow up ratio: We will expect upper quartile/ decile national performance on this area. We will work with trusts to reduce the first to follow up appointments to those of the most efficient providers nationally. We expect provider to develop improved standards of communication between primary and secondary care. Opportunities to move away from routine follow up outpatients following surgery in favour of patient directed open follow ups will be promoted.

We will continue to be represented on the NUH Clinical Contract Group which is exploring ways of reducing new to follow up appointments.

4.10 Information from providers: ECCG requires all providers to provide the CCG and constituent practices with electronic information on a daily basis of A&E attendances, admissions, discharges, outpatients, pathology, radiology and other hospital services. This is required to assist GP practices in the identification of patients who may require additional support from primary care in order to facilitate early discharge from hospital, ensure a safe discharge back home and provide proactive care to help avoid readmission to hospital. This data will be fed into an Urgent Care Clinical Dashboard for use by practices to support proactive management of patients.

An improved Schedule 5 is being developed in Nottingham and Derby for this year's contract round.

4.11 Excess treatment costs: excess treatment costs have to be considered within the cost envelope of the commissioners. Researchers should discuss excess treatment costs with the provider trust where the costs will be incurred. The provider trust should be able to cover these costs through existing commissioning arrangements and are expected to do so as part of the NHS tariff. Exceptionally, where the provider trust feels they are not able to cover the costs, it is the trust (not the researcher) who should present a business case to the commissioners for additional funding.

Martin Cassidy, Programme Lead, Strategy & QIPP
Ciara Scarff, Contracts and Performance Improvement Manager

HARDWICK CLINICAL COMMISSIONING GROUP

COMMISSIONING INTENTIONS 2012/2013

1. INTRODUCTION

Hardwick Clinical Commissioning Group (HCCG) comprises 16 practices with a registered population of 103k. HHCCG aims to meet the challenge of commissioning healthcare services care for an area with high levels of deprivation and health need, as well as providing consistently high quality primary care.

HCCG is the lead commissioner for the following contracts; Barlborough NHS Treatment Centre, Derbyshire Healthcare Foundation Trust (DHcFT), Improving Access to Psychological Therapy contracts and Care Homes. The CCG are also lead Associate Commissioner for mental health services for Nottinghamshire, Staffordshire, Leicestershire, Sheffield, Pennine and regional lead on a number of Rehabilitation contracts. The CCG is also lead associate for Derbyshire for the Sheffield Teaching Hospitals NHS FT, Sherwood Forest FT, Sheffield Children's NHSFT, Doncaster & Bassetlaw NHS FT, The Rotherham FT, Leeds Teaching Hospitals, The Claremont and Thornbury contracts. Also the CCG is associate commissioner for Chesterfield Royal FT (CRH), Derbyshire Community Health Service (DCHS) and Derbyshire Health United (DHU). The CGC is the lead associate for Mental health NHS provider contracts on the Derbyshire borders and also for some key regional mental health and LD independent hospitals.

The purpose of this document is to outline the commissioning intentions of HCCG for 2012/13 as an early message of intent to give providers an opportunity to inform and engage with the development process.

2. VALUES AND VISION

The values and vision of HCCG are as follows:

- **To deliver personalised patient-centred care to the CCG population**
- **To support patient-centred care through effective commissioning**
- **To support equitable distribution of health resources**
- **To be financially viable**
- **To support and sustain a model of general practice which is cost-effective and value-for-money**

Hardwick CCG Strategic Objectives:

- **High quality patient care** in commissioned and provided services is paramount to the development of the organisation.
- **Patient choice and engagement** is at the heart of the organisation.
- An organisation which is **responsive and accountable** to its population and the wider healthcare system.
- A **national leader in both the provision and commissioning** of services in response to population need.
- An **organisation of collaborators** across all boundaries whether these are geographical, organisational or cultural boundaries.
- **Extensive and embedded clinical engagement** to underpin robust decision-making process.
- **Financial stability** across all areas of the organisation.

3. COMMISSIONING INTENTIONS:

As for 2011/12, a common underlying theme for commissioning in 2012/13 remains the delivering of recurrent NHS financial savings and to achieve the delivery of the QIPP programme through a clinically led approach.

Also Hardwick CCG would expect providers to deliver the Department of Health requirements for the implementation of Payment by Results, by adopting an approach with minimum financial risk to CCGs and Derbyshire Cluster.

3.1. PRIMARY AND COMMUNITY CARE

- Develop and shape the proposed service design changes for community services including changing bed models, increasing intermediate care provision, and implementation of the SPA.
- Implement robust case management embedded in every practice.
- Increase the level of appropriate use of RightCare for patients at risk of emergency admission particularly for patients nearing the end of life and patients with long term conditions.
- Implement the Basket of Services in each practice within the CCG.
- Together with DCC, develop and help shape a sustainable model for integrated health and social care for people with complex long term conditions and to implement it.
- Review the support offered to Care Homes to increase quality of care and reduce emergency admission including pharmacy and nutrition support. Develop and coordinate the level of

primary care provided to patients in care homes across the CCG to reduce emergency admissions to secondary care.

- Review the provision of generalist and specialist palliative care bed levels available in the community.

- Develop solutions for patients who frequently attend services, this may include community based health promotion services.

- Develop a research and development cell or 'skunk works' to formulate commissioning solutions in the areas of timely visit management to reduce A+E attendance and pain management in the community.

3.2. ACUTE CARE & URGENT CARE

- Ensure implementation of the Operating Framework guidance on payment for readmissions; to include ensuring appropriate acute and community services are in place to reduce avoidable readmissions.

- The CCG will commission services in accordance with the Operating Framework for 2012/13 and will take account of the 2012/13 Payment by Results Guidance and any other national directives.

- Consolidate the pathway out of acute care and back into the community through timely and quality discharges including transforming current teams working across the interface.

- Work with Chesterfield Royal Hospital FT (CRH) to further develop the Ambulatory Care pathway at CRH to embed sustainable change which enables increased access to senior decision makers and reduced delays to the patients and costs to system of treating ambulatory patients.

- Develop improved standards of communication and understanding between primary and secondary care.

- Ensure T&O referrals have been appropriately screened on or before referral to ensure the relevant criteria is adhered to.

- Continue to work with providers and clinical commissioners to ensure compliance with the Procedures of Limited Clinical Value Policy. If a patient is treated for a procedure/condition within the Policy and approval is not granted for exceptional circumstances, then HCCG will not pay for the treatment. The policy will also include surgical thresholds criteria for referrals. The policy will also include procedures and treatments for low volume high cost procedures requiring prior approval. Any such individual patient level approvals must be approved by HCCG or via the IFR route.

- Ensure emergency ambulances are utilised efficiently and effectively in the community and alternative to conveyance to acute hospital are widely understood and implemented. Develop clinical advice pathways for urgent care providers to access primary care clinicians and information.

- New drugs and treatments should not be introduced into practice without the knowledge and consent of HHCCG. All new technologies should be anticipated in advance and their introduction should be commissioned through negotiated contractual changes during the annual contracting round. There should be no in year cost pressures for commissioners caused by the unanticipated introduction of new drugs and treatments. Any digression will be reported to MMT as agreed.

- The Individual Funding Request (IFR) route should not be used for the introduction of new technologies or to fund treatment either covered within current contracts or of limited clinical effectiveness. Prior approval will be required for a number of high cost and low volume procedures to ensure that national and local policies are being followed.

- Where no specific mention is made of a service or topic within this document, then Derbyshire County PCT's Contracting Intentions for 2011/12 will continue to be the relevant statement of HCCG's position unless superseded by changes to Payment by Results.

3.3. MENTAL HEALTH AND LEARNING DISABILITY

Mental Health Commissioning Intentions specific to HCCG:

- The CCG will pilot integrated care pathway for people with dementia across primary, community, and secondary care to address inequalities and to explore where the costs fall in the new arrangements. The CCG will also explore training in dementia for home care staff in all localities where it isn't currently available with the aim of reducing avoidable emergency admissions.

- The CCG will commission the refreshing of the MH needs assessment for Derbyshire.

- Review clinical care pathways and make recommendations where appropriate regarding changes to contracts or services.

Mental Health Commissioning Intentions across all CCGs:

- The MH services available to Derbyshire patients who live in Nottinghamshire will be reviewed.

- The CCG will ensure improved provision of information by LD providers to fulfil SHA requirements and all practices are to be providing health checks to fulfil SHA requirements.

- Together with Derby City and Derbyshire County Councils, the CCG will work, towards transferring the lead commissioner role for Learning Disability services.

- Together with High Peak CCG review the service provision for the adult care pathway in the High Peak.

- Deliver IAPT services across all practices and develop primary care mental health services to address the gaps in current provision of therapies and support.

- Work with secondary health care providers to have primary care facing mental health services and as and when resources allow embedded CPN roles within practices

- Support the development of PbR for mental health.

- Together with Derbyshire County Council develop the autism pathway consistent with the autism act and subsequent guidance.

- Work with East Midland Specialist commissioning group to ensure the transition of all minimum take services to the Midlands and East Cluster.

- With local authorities to re-commission carer support services for mental health.

- With local authorities review and consider re-commissioning Out of hours support line for mental health.

- Work to bring as many people in placements out of county back to services as near to home and in the least level of security clinically appropriate.

- In partnership with the local authorities and voluntary sector infrastructure organisations develop outcome based monitoring arrangements for the voluntary sector.

- In partnership with the voluntary sector deliver primary care mental health training programme.

- Working with local authorities support the move to personalised services.

- Support recovery based approaches to service delivery.

3.4. CHILDRENS SERVICES

- The CCG intends to work with DCC and the Derbyshire Children and Young People's Trust to implement an integrated pathway for children aged 5 to 19 in primary care.

4. PATHWAY DEVELOPMENTS

- **111**
  Some of the member practices in HCCG will be part of the first wave pilot for introducing 111 in Derbyshire and the remainder will be included in the second wave pilot.

- **Ophthalmology**
  Options for a community pathway to reduce referrals to secondary care ophthalmology services will be explored and implemented in 2012/13; this may include a community glaucoma follow up service.

- **Neurology**
  Specific clinical guidelines for neurology pathways will be revised and implemented, possibly including Headache Management.

- **DVT**
  A community pathway for providing D-Dimer testing across the CCG will be implemented fully in 2012/13.

- **Alcohol**
  The CCG will identify lead contacts within CCGs and the DAAT and understand existing pathways of care.

- **Carpal Tunnel**
  Review the carpal tunnel pathway, with a view to utilising Nerve Conduction Study testing at Barlborough NHS Treatment Centre.

- **Heavy Menstrual Bleeding**
  All practices will implement the HMB pathway in primary care if not already done so. Further work will be done to explore options for the secondary care element of the pathway.

- **Obstetrics**
  The audit of hospital emergency admissions during pregnancy will be reviewed with a view to identifying areas for pathway development and possible future commissioning

HIGH PEAK CLINICAL COMMISSIONING GROUP

A SUB – COMMITTEE OF NHS DERBYSHIRE

7th October 2011

High Peak Clinical Commissioning Group

Statement of Commissioning Intentions 2012/13

Introduction

The High Peak Clinical Commissioning Group (HPCCG) is composed of 8 practices whose GPs and staff between them have a long history of providing primary care services to this geographically distinct area and are well acquainted with the health needs of its population. The HPCCG faces an unprecedented challenge – to reduce expenditure to its equity share of the former Derbyshire Primary Care Trust's budget as determined by a national funding formula. This means improving the quality of services while reducing costs by in the region of £4.5m. This can only be achieved by significantly changing the way health services are delivered and working practices. The HPCCG welcomes the opportunities which this challenge will bring to work with provider organisations and other partners in new and innovative ways.

Principles

- Engage local people and listen to local views – the HPCCG will involve local communities and consider local interests in the design and provision of services, as far as it is practicable to do so.

- Accessible services – services which do not need to be provided in an acute hospital setting should be located as close to home as possible, whilst accepting that in a predominantly rural area some travel will be a necessity

- Tackling inequalities – resources will be targeted at areas of known deprivation and highest need informed by local Health Needs Assessments and the Joint Strategic Needs Assessment.

- Challenging historical provision – the HPCCG will work with the public, local authority and partner organisations to understand the need for change and to commission services which are of high quality but also adaptable, efficient and economical. All provider organisations will be required to deliver their part in service changes, and partnership working will be vital to developing new ways of delivery.

- Following due process – where services are commissioned or re-commissioned, the HPCCG will follow the required 'Any Qualified Provider' or other relevant procurement guidance.

- The CCG will commission services in accordance with the Operating Framework for 2012/13 to be published later in the Autumn and with other national directives.

HIGH PEAK CLINICAL COMMISSIONING GROUP

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- Where no specific mention is made of a service or topic within this document then the Derbyshire County PCT's Contracting Intentions for 2011/12 will continue to be the relevant statement of the HPCCG's position unless superseded by changes to Payment by Results.

Areas of Potential Change

The HPCCG commissions either directly or through the lead of a neighbouring CCG an extensive range of services for its population. It is not possible or desirable to seek to change all of these services in a short space of time. Outlined below are the areas of service which the CCG will be concentrating upon in the first instance.

Acute Hospital Care

Out patients
The full range of outpatient specialties will continue to be commissioned and a range of providers will be involved in order to enable patients to have choice at the point of referral. However, a review of outpatient services is ongoing and the HPCCG hereby gives notice that some decommissioning of services may be the outcome. The volume and nature of the decommissioning is not yet determined but the intention is that outpatient services delivered in locations in the High Peak should reduce, not duplicate or supplement, those provided in acute hospitals and where possible local access will be increased.

Follow Up Outpatient Appointments
It is the intention to reduce the ratio of first to follow up appointments to those of the most efficient acute providers nationally. One way of doing this will be to work with providers to identify patients in a number of specialties who are referred to secondary care for an opinion. The patient can be discharged to the care of the GP with a management plan after the first outpatient appointment and will not require a follow up at a hospital. Many patients currently are followed up by GPs and acute providers thereby duplicating effort.

Elective procedures, Day Case and Outpatient Procedures
The British Association of Day Surgery (BADS) sets out a list of procedures and for each the ratio of procedures that can be carried out as an outpatient procedure rather than as a day case. The HPCCG will not pay day case rates for procedures which can be carried out in an outpatient setting because of inefficiency in the service delivery of acute providers.

Procedures of limited clinical value (PLCV)
The aim of the HPCCG is to commission evidence based procedures and the current PLCV policy is the result of a careful assessment and review of the published evidence. It is likely that policies which set out the circumstances in which commissioners will, or will not, fund certain procedures will continue to evolve. Where procedures are not commissioned or are commissioned against certain criteria only, the HPCCG will not pay for procedures which do not comply with the PLCV policy even though a referral may have been made to an acute provider. The

HIGH PEAK CLINICAL COMMISSIONING GROUP

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DoH has made it clear that a referral is not the authority to treat where policies setting out procedures which are not commissioned are included in contracts.

Urgent Care
Clinical Commissioners will work with acute providers to limit the continued expansion of demand for urgent care. This may involve greater scrutiny of the reasons why people attend at Emergency Departments and the reasons for admission from the Emergency Department.

Length of Stay
The HPCCG will commission efficient services which reduce unnecessarily long lengths of stay usually associated with transfers between wards and handovers between clinicians. In so doing it is expected that the number of excess bed days will reduce and associated costs will be removed from contracts with acute providers.

Readmissions
It is anticipated that there will be changes to the Payment by Results regime for readmissions in 2012/13, acute providers becoming responsible for patient care for 30 days following discharge and tariffs being amended to reflect this additional responsibility. The HPCCG will abide by the PbR payment mechanism for readmissions for 2012/13.

Maternity Services
It has been suggested that a pathway cost for maternity services will be introduced into Payment by Results including all outpatient midwifery and consultant led contacts, non-delivery events and a delivery event. Should such a pathway cost be introduced in 2012/13 this will be the currency by which the HPCCG will fund maternity services.

Review of Pathways
A number of sources of information are available to the HPCCG against which to benchmark its use of services. These include data toolkits, the national Right Care data and locally commissioned reviews. From these sources a number of areas have been identified for further work to ensure that pathways are efficient as possible and operate in the best interests of patients. Through the work of the CCG's Clinical Reference Group it is intended that the following pathways will be considered as a priority in 2011/12 with a potential for impact upon contracts in 2012/13:-

- Cardiovascular disease, in particular palpitations
- Trauma & Orthopaedics and in particular musculoskeletal pathways and hip replacements
- Deep Vein Thrombosis (DVT) identification and treatment
- Dermatology
- Ophthalmology, in particular raised intraocular pressure

Targets
Sufficient activity will be commissioned to meet the HPCCG's commitment to achieve patients' rights under the NHS Constitution and particularly with regard to 18 week

wait pathways, cancer referral to diagnosis and referral to treatment targets, A&E waiting times and stroke pathways.

Older People with Complex Health Needs

As life expectancy increases so does the number of people who live with multiple co-morbidities and long term conditions. The HPCCG will work with all NHS, Social Care and Independent Sector Providers to improve packages of care for older people with complex health needs, targeting resources at those with the greatest needs. Provision should be as local to home as possible. The re-commissioning of a supported care bed in the High Peak is under consideration in order to prevent avoidable admissions to an acute setting.

NHS funded nursing care and complex packages of care will continue to be commissioned by the Continuing Care team responsible to the Derbyshire PCT Cluster until the National Commissioning Board is established.

End of Life

It is the intention of the HPCCG to enable patients to die at home where they choose to do so. The Gold Standards Framework and the Liverpool Care Pathway will be instrumental in allowing this to happen.

Specialised commissioning

Currently the HPCCG commissions specialised services as the East Midlands Specialised Commissioning Group (EMSCG) do not commission from providers in the North West and the North West SCG does not commission for the population of Derbyshire. The arrangement will change with the establishment of the National Commissioning Board (NCB) and the transfer of specialised commissioning for a defined number of services to the NCB. It is not anticipated that flows of patients into Manchester hospitals for cardiac surgery and cancer treatments, for example, will change but it is anticipated that the NCB will introduce policies which are nationally consistent.

The introduction of new technology

New drugs and treatments should not be introduced into practice without the knowledge and consent of the HPCCG. All new technologies should be anticipated in advance and their introduction should be commissioned through negotiated contractual changes during the annual contracting round. There should be no in year cost pressures for commissioners caused by the unanticipated introduction of new drugs and treatments.

Individual Funding Requests (IFRs)

The IFR route should not be used for the introduction of new technologies. Prior approval will be required for a number of high cost and low volume procedures to ensure that national and local policies are being followed.

HIGH PEAK CLINICAL COMMISSIONING GROUP

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Primary Care
The commissioning of Primary Care Medical, Dental, Pharmaceutical and Ophthalmology services will continue to be the responsibility of the PCT Cluster until such time as the National Commissioning Board is established. The HPCCG will seek to influence the commissioning of primary care services where it can be demonstrated that efficiency and outcomes for patients can be improved.

Medicines Management
All providers are expected to use medicines effectively and efficiently to ensure that wastage is minimised. Pharmacy advisors working with practices will continue to promote effective prescribing in primary care.

Community Services
A range of community services to meet the needs of local people will be commissioned in locations that avoid the need to travel excessive distances. It is anticipated that the HPCCG will review the business case setting out proposals for the future of community hospitals and will take into account the health needs of the local community in doing so. Greater scrutiny will be made of the reasons for admission to community hospitals, though it is accepted that bed days in community hospitals will continue to be required. Better information to support the use of community services by practices will be essential.

111 – new NHS telephone number to provide a single point of access to all non-emergency NHS services
The HPCCG will work with the PCT Cluster to introduce the 111 national initiative to the High Peak. Out of Hours services will continue as at present until the point at which it is necessary to retender the service.

Mental Health
Work has commenced with providers and stakeholders in order to evolve current delivery arrangements to an integrated model that offers the required service improvements, demonstrates full and effective use of the High Peak allocation of the mental health budget and demonstrates the full and effective engagement of all providers in this health care system. A phased timetable for action has been produced.

Notice is hereby given that it may be necessary to tender for a single provider to ensure the effectiveness of an integrated model of care if such a model cannot be achieved through joint working between providers.

Quality, Innovation, Productivity and Prevention (QIPP)
A major event has been arranged for the 19th October when the CCG Board and key partners will be meeting to determine how best to meet the considerable financial challenges facing the Clinical Commissioning Group. The outcomes from this event will inevitably impact on most if not all providers and more details will be forthcoming at a later date if not already covered in this Statement of Commissioning Intentions.

North Derbyshire Clinical Commissioning Group

Commissioning Intentions 2012/2013

1 Background

The North Derbyshire Clinical Commissioning Group (NDCCG) is composed of 30 practices with a registered population of 227,915. The GPs and staff between them have a long history of providing services to this urban and rural population which contains a wide spectrum of social deprivation.

NDCCG is the lead commissioner for Chesterfield Royal Hospital Foundation Trust (CRHFT), Derbyshire Community Health Services (DCHS), Home Oxygen Services for the East Midlands and Ashgate Hospice. The CCG is also an associate commissioner for a number of other local contracts. The CCG is responsible for supporting the Cluster PCT (and future National Commissioning Board) in providing assurances around quality of primary care provision across North Derbyshire CCG constituent General Practices.

The purpose of the document is to outline the commissioning intentions for NDCCG for 2012/13, highlighting NDCCG initial key priorities and the agenda for service change across providers. This document should be read in conjunction with the Derbyshire wide commissioning intentions document as this details all of the county wide commissioning priorities.

Whilst these commissioning intentions will give providers an initial view of the priority areas for the ND, the CCG, with all key partner organisations, are developing integrated working agreements which will endeavour to deliver an integrated vision and commissioning plan.

NDCCG is committed to a clinically led evidence based approach to service commissioning involving patients, the public, carers and collaborative working with providers and other partners.

2 Values and Visions

- To improve health outcomes for individuals and communities
- To improve the quality of care for patients registered with CCG member practices and those unregistered but living within the geographical area of the CCG through effective partnerships with other organisations and with local people.
- To conduct all business in a fully inclusive and clinically led way engaging with member practices, patients and the public and key partners.
- To work jointly with Derbyshire County Council to develop the Joint Strategic Needs Assessment (JSNA) using available health data but also bottom up intelligence from primary care on very local needs.
- To encourage innovation and strive to find new and better ways of commissioning services
- To support improvements in productivity and deliver cost reduction and value for money by commissioning quality services.
- To bring more health services closer to local people by improving primary and community based services to improve outcomes.

- To improve the experience of local patients by complying with Statutory duties to ensure health services are provided promptly, safely and effectively by:
    - Promoting continuous quality improvement
    - Assuring that services commissioned are of appropriate quality
    - Intervening where adequate quality and safety standards are not being met and early warning signs are being raised
    - Observing the duty to consult and involve patients and communities in the planning and delivery of services
- To renew the focus on prevention to improve wellness and avoid patients having to go into hospital unnecessarily
- To improve the provision of urgent care in primary care and the community and develop more responsive urgent care services.
- To undertake all preparatory and development work necessary to achieve Authorisation by April 2013.

3 Commissioning Priorities

3.1 Integrated Working

CCGs are fundamentally different to previous NHS commissioning organisations. They are clinically led and their approach to service redesign will be different. The key priorities for NDCCG include:-

- Living within the recurrent allocation given to the CCG by the Department of Health
- Ensuring investment is shifted away from less clinically effective services to enable the CCG to meet the needs of the ageing population.
- Believing that the best way to achieve the above 2 points is to ensure collaborative and close working relationships with all health and social care partners leading to less waste and more integrated services.
- Reducing unwarranted clinical variation.

A meeting of all Health and Social Care partner organisations was held in October 2011 at which agreement was gained to work in a truly integrated manner across Health and Social Care in North Derbyshire. This new way of integrated working should result in delivery of the following:-

- A shared vision on the future of health and social care for North Derbyshire
- Integrated commissioning plans
- Investigation of options around financial models and risk sharing.
- Integrated service provision to limit the continued expansion of demand for urgent care.
- Ongoing identification of programmes of work e.g. diabetes care, shared assessments.

A number of priority areas where integrated programmes of work are already underway are summarised below.

Frail and Elderly

Delivery of a review of the current problems with regard to the care of the frail and elderly, followed by integrated pathway development and implementation. Including a focus on dementia services, rehab, end of life care and quality discharges.

Shared Records
Work stream to focus on IT solution opportunities available to the CCG and partner organisations to enable better access to shared patients records across North Derbyshire.

Baseline Review of Existing Change of Work
A review to identify all existing change and development work which is underway across Health and Social Care in North Derbyshire.

Respiratory Care
Undertake a review of the respiratory care pathway which is currently in place across Health and Social Care in North Derbyshire, and loot at opportunities for a collaborative provider model or joint venture.

Access to Senior Decision Makers in Secondary Care
The CCG will work with Chesterfield Royal Hospital FT (CRHFT) to further develop the Ambulatory Care pathway at CRHFT to embed sustainable change which enables increased access to senior decision makers, reduced delays to the patient and reduced costs to the system.

Developing Community Services to Provide Care Closer to Home
North Derbyshire CCG will work closely with our community service provider (DCHS) to develop and determine the service redesign changes required to support patients to receive high quality care at home or as close to home as possible, including health and maintaining independent living and quality of life..

This may include changing the community bed provision both in terms of clinical and capacity requirements, increasing intermediate care and community nursing provision both in relation to capacity and breadth of service provision and increasing ease of access for professionals to community services, potentially through the use of a single point of access and clinical navigation service. A pilot Single Point of Access will be evaluated and if benefits are not demonstrated this will be decommissioned.

The CCG as the lead commissioner for DCHS is continuing to support them in the development of their integrated business plan to support them with their application for authorisation as a foundation trust.

3.2 Ensuring Value for Money

The CCG is committed to working on the following work areas to help ensure value for money from the available CCG funding whilst being clinically led.

Pathway Development
The North Derbyshire CCG's Clinical Reference Group has identified the following pathways to be developed as a priority in 2011/2012 with a potential for impact upon contracts in 2012/13.

- Hip and knee pathways
- COPD pathway
- Optometry pathway
- DVT pathway

- Avoidable admissions – The CCG will work with primary care and all other health care providers to increase the level of appropriate use of RightCare for patients at risk. of emergency admission particularly for patients nearing the end of life and patients with long term conditions.
- Dermatology
- Heavy Menstrual Bleeding

Further areas of focus continue to be identified through these locally, clinically led pathway development groups, which include representatives from across primary and secondary care.

Maternity Services

The CCG will implement the decision of the Cluster Board in relation to the review of maternity services provided from the Darley Dale Birthing Centre, and will be fully involved in specifying a new community based model should the unit close.

Reducing Unwarranted Clinical Variation

The North Derbyshire CCG is focusing on reducing clinical variation across the CCG through the use of regular monthly performance reports and locality budget management clinical discussions. These include the use of data toolkits, the national Right Care data and local commissioned reviews. Through review of these data sources a number of areas have been identified for the further work to ensure that pathways are efficient as possible and operate in the best interest of patients.

Referral and Medicines Management Team

The CCG has established a referrals and medicines management team (RMMT) which will build on the success of the medicines management teams, to share good practice and reduce clinical variation. This team will target outlier practices first for a robust GP peer to peer discussion supported by medicines management team colleagues and locality managers. Action plans will be agreed and these will be monitored monthly and repeat visits agreed to review performance.

North Derbyshire Clinical Commissioning Group

CCG Joint Work Areas with Adult Social Care

Derbyshire Adult Care Board
12 January 2012

1) Strategic Priority Areas

The priority for North Derbyshire CCG during 2012 will be to develop the integrated work streams as discussed within the whole system event group held on the 20th October.

The current project areas identified are:-

- Frail and Elderly
- Shared Records
- Respiratory Services
- Diabetes Services

Within these projects a number of work streams will be developed with specific task and finish groups working together to determine the future service model to be delivered across all providers, the quick wins to be delivered, the engagement and consultation process to be undertaken and the finance and contractual implications of the proposed changes.

2) How this fits with current joint work areas

Specific projects are currently being jointly worked on between the CCG and DAC, these include:-

- Specialist Dementia Home Services Pilot – Chesterfield Area
- Winter Pressures Pilot with DCHS
- 24/7 access to services with DAC, DCHS and DHU
- Falls Recovery Service roll out across the county

General work being undertaken across CCG and DAC to improve working relationships:-

- Provision of social worker to attend GP practice MDT on regular basis
- Joint sign up to roll out of dignity in care campaign by DAC, CRH and DCHS

3) Future Joint Work priorities

It is expected that the following work areas will fall under the integrated working project areas:-

- Use of Telehealth – within respiratory work stream
- Review of re-ablement, intermediate care, falls services and dementia services – within frail elderly work stream
- Review of Short Breaks Services – jointly with Hardwick Health as part of Learning Disabilities commissioning
- Procurement of 111 service and potential links to DCHS Single Point of Access and future possible links with roll out of Telehealth

SOUTHERN DERBYSHIRE CLINICAL COMMISSIONING GROUP

COMMISSIONING PLAN 2012/13

Covering Derby City, South Derbyshire, Amber Valley and the southern part of Derbyshire Dales

About this Commissioning Plan

Southern Derbyshire Clinical Commissioning group (SDCCG) is a sub-committee of NHS Derbyshire and Derby City (previously the PCTs for Derbyshire County and Derby City). SDCCG has delegated responsibility for the commissioning of the majority of NHS services for all patients registered with its constituent GP practices. The CCG also commissions services for unregistered and temporary patients residing within its geographical boundary. The total registered population is estimated to be 523,000 and covers the whole of Derby City as well as Amber Valley, South Derbyshire and the southern part of Derbyshire Dales.

The Board of SDCCG first started to meet formally in November 2011. One of its first tasks is to identify the commissioning priorities for 2012/13 and subsequent years. To do this, the CCG will build on previous work and experience, but will also consult with local clinicians, local authorities, providers and the public to develop an agreed set of priorities. This will not be a one-off process (we are unlikely to get everything right first time) and needs to continue to evolve over time.

The priorities in this plan will be described in two different ways:

- Locality priorities. SDCCG works through four localities:

    - Amber Valley & South Derbyshire Dales
    - Derby Advanced Commissioning (DAC)
    - Derby Commissioning Network (DCN)
    - South Derbyshire

    Each of the localities has started to identify local issues affecting their local populations. There is still more work to be done but the CCG is committed to ensuring that these priorities are taken forward. Two of the localities (DAC and DCN) are effectively coterminous with the Derby City boundary, so they are shown as a single locality in this Plan.

- Priorities which we believe need to be taken forward across the whole of the SDCCG area. Some of these may be determined nationally; others will be based on local information and intelligence.

The draft priorities in this Plan have been based upon:

- An analysis of health need. The locality summaries are based upon the relevant Joint Strategic Needs Assessments undertaken in collaboration with the City and County Councils; and upon other sources of information on health need.
- Experience of local services – or where gaps in local services have been identified.

The vision of Southern Derbyshire Clinical Commissioning group is:

To continuously improve the health and wellbeing of the people of Southern Derbyshire, using all resources as fairly as possible.

We will do this by:

- providing local clinical leadership to the NHS, and working with everybody who can contribute;
- being open and accountable to our patients and communities; ensuring they are at the heart of everything we do;
- understanding our population and addressing inequalities so that services are in place to meet needs
- planning services to best meet those needs now and in the future
- aiming to secure the best quality, best value health and social care services we can afford
- using our resources fairly and effectively.

Our Financial Plan

To be completed

Commissioning Priorities for the whole of Southern Derbyshire Clinical Commissioning Group (draft)

1. Dementia care
    - An increasing issue because of demographic change
    - Improve care of dementia patients in acute hospitals
    - Move towards more community based diagnosis and care
    - Greater support foe carers
2. Integrated Care
    - Focus on meeting the needs of frail and elderly people
    - Initial work to start in Derby City
    - Some care is poor at present and fragmented between providers
    - Current models of care are financially not sustainable
    - Consider implications for community services
3. Health inequalities
    - Prioritise which inequalities to prioritise and link to the Equality Delivery Scheme
    - Move towards greater consistency in what is commissioned from primary care
    - Reduce inequalities in the provision of Health Visitors
4. Planned care
    - Develop care pathways based on the work of joint clinical groups
    - Commission Any Qualified Provider services in Podiatry, Physiotherapy, and Psychological therapies
    - Pilot shared decision-making between patients and clinicians
5. Mental Health
    - Work with clinicians to identify the key issues in southern Derbyshire – particularly in the City
    - Critically examine the costs and outcomes of services in southern Derbyshire
    - Reduce the number of out-of-county placements
6. Support for carers
    - Top priority for service users and local authorities
    - Greater provision of short breaks and other respite
    - Move towards pooled budget and lead commissioning with local authorities

Health Need in Amber Valley and southern Derbyshire Dales

The health of people in Amber Valley is mixed compared to the England average.

- Deprivation is lower than average, however 4,085 children lived in poverty in 2008.
- Life expectancy for both men and women is similar to the England average. Life expectancy is 7.4 years lower for men and 6.7 years lower for women in the most deprived areas of Amber Valley than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011).
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and the latter is worse than the England average.
- About 18.4% of Year 6 children are classified as obese. A higher percentage than average of pupils spend at least three hours each week on school sport. 72.7% of mothers initiate breast feeding and 16.0% of expectant mothers smoke during pregnancy.
- Hospital stays related to alcohol misuse and self harm are similar to or better than the national average. The estimated number of drug misusers is lower than the national average. The number of people diagnosed with Diabetes is higher than East Midlands and the national average.

The health of people in Derbyshire Dales local authority is generally better than the England average.

- Deprivation is lower than average, however approximately 1,300 children lives in poverty recorded in 2008.
- Life expectancy is 4 years lower for men and 5.8 years lower for women in the most deprived areas of Derbyshire Dales than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011)
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.
- About 14.7% of Year 6 children are classified as obese, significantly better than the England average. Higher percentages than average of pupils spend at least three hours each week on school sport.
- 72.7% of mothers initiate breast feeding and 16.0% of expectant mothers smoke during pregnancy.
- An estimated 18.1% of adults smoke and 23.0% are obese. The rate of road injuries and deaths is higher than average.
- The incidence of malignant melanoma is significantly worse in Derbyshire Dales compared to the region and England.

The Priorities for Amber Valley and south Derbyshire Dales Locality (draft)

- Care homes
- COPD/pulmonary rehabilitation
- Stroke
- Mental health
- Use of A&E/minor injury units
- Phlebotomy
- Ambulatory Blood Pressure monitoring

Health Need in Derby City

The health of people in Derby is generally worse than the England average.

- Deprivation is higher than average and 13,665 children lived in poverty in 2008. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 12.6 years lower for men and 9.5 years lower for women in the most deprived areas of Derby than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011).
- The early death rate from heart disease and stroke has fallen over the last 10 years but remains worse than the England average. Major causes of death, including deaths due to smoking, cancer, heart disease & stroke are all higher than the England and East Midlands average.
- About 19.4% of Year 6 children are classified as obese. A higher percentage than average of pupils spend at least three hours each week on school sport.
- Levels of teenage pregnancy and tooth decay in children are worse than the England average.
- Estimated levels of adult smoking are worse than the England average, but other adult lifestyle measures are similar to the national average.
- Hospital stays for alcohol related harm, self harm are higher than the national and East Midlands average. Estimated rates of drug misuse and new cases of TB are also higher than the national average.
- The numbers of people in the city who are blind, partially-sighted or have a visual impairment are predicted to increase year-on-year, as are the number of people with physical disabilities.
- Over the next five years, cases of late onset dementia in the population of Derby are expected to increase by 27% to over 4000 individuals, half of whom will be diagnosed with Alzheimer’s disease.

The Priorities for Derby City

Health Need in South Derbyshire

The health of people in South Derbyshire is generally similar to the England average.

- Deprivation is lower than average, however 2,540 children lived in poverty in 2008.

- Life expectancy for both men and women is similar to the England average. Life expectancy is 8.4 years lower for men and 4.5 years lower for women in the most deprived areas of South Derbyshire than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011).

- Early death rates from cancer and from heart disease and stroke have fallen over the last 10 years and are similar to the England average.

- South Derbyshire has a COPD prevalence of 1.9% which is higher than the other 3 localities of the CCG and also higher than the England average rate of 1.6%. This is not surprising since South Derbyshire was a well known mining community and, thus, rates of COPD have been high as a result of this.

- About 17.3% of Year 6 children are classified as obese. 54.4% of pupils spend at least three hours each week on school sport. 72.7% of mothers initiate breast feeding and 16.0% of expectant mothers smoke during pregnancy.

- An estimated 21.2% of adults smoke and 24.0% are obese.

- The rate of road injuries and deaths is higher than average.

- Hospital stays for self harm are worse than England and East Midlands.

The Priorities for South Derbyshire Locality

- To improve the care of frail and elderly people, particularly through development of the Swadlincote Community Care Centre
- Improved access to Psychological Therapy (IAPT) Services
- To target Chronic Obstructive Pulmonary Disorder (COPD) through implementation of the Derbyshire COPD Integrated Care Pathway
- Chronic Heart Disease (CHD)
- Teenage Pregnancy
- Childhood Obesity

Southern Derbyshire Clinical Commissioning Group is focussing its work during 2012/13 around three themes.

The development of our commissioning priorities – in order to improve the health of the people of southern Derbyshire and stay within our financial allocation (and this Commissioning Plan describes how we propose to do this)

As a new organisation, to develop our links and communications with:

- GP practices (the CCG's members)
- Patients and the public (to help them understand the role of the CCG)
- Other stakeholders such as local authorities and providers (with whom we share many objectives)
- Our own staff

The CCG's Engagement Strategy will describe how we propose to do this

To develop as a mature organisation which can be authorised as an independent body. We have set the milestones that we need to achieve and the governance arrangements that will underpin our work

For details on any of these areas, please contact .....

DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

12TH January 2012

JOINT REVIEW OF SHORT BREAK SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

1. Purpose of the Report

To update the Board regarding the joint review of short breaks for people with a learning disability.

2. Information and Analysis

The need to review short-break services provided by health and social care in Derbyshire was identified in the Learning Disability Joint Commissioning Strategy 2009-2014. This joint strategic aim is also detailed in the Department of Health Learning Disability Self Assessment Framework.
This states that a locally approved and joint commissioning plan should be in place and outlines the need to develop a joint breaks plan**.** The intention to carry out a joint review has been announced by health commissioners as part of the action plan identified by the framework.
The action plan is monitored by the County Council Improvement and Scrutiny Committee as part of the action from the Access to Healthcare Review for People with a Learning Disability.

Adult Care is looking to review services as part of the commitment to carers and in response to personalisation. The work will also inform and contribute to the developing Community Lives programme which is aimed at improving the way day services are delivered for people with a learning disability.
Health commissioners have identified the need to determine how the plan for short breaks in the future fits with health strategic objectives following a review of learning disability health care services. Independently, the National Development Team for Inclusion undertook a review of Derbyshire County Health Care Services and recommended that short break provision should not be part of specialist services.

Initial auditing of the current provision has highlighted that there are significant areas for developments within the current health and social care short break services.

These are to:

- create improved equity both geographically and across health and social care settings (current services are available predominantly in the north of the County);
- address gaps in the availability of short break provision for people with complex support needs, including autism;
- increase the range of short breaks service so that they offer more choice and flexibility and fit with a person centred approach. This will link with the developing Community Lives programme;
- develop further efficiency through the allocation of appropriate and targeted use of resources.

Current Commissioned Services

The current model for Learning Disability short breaks services is predominantly bed-based services directly provided by either health or social care. The Council's Shared Lives scheme also provides limited access to short breaks within a family setting. Occasional spot contracts with independent providers are in place but few providers offer this service within Derbyshire.

Health provision is concentrated in the North of the County and is provided by Derbyshire Community Health Services. No health beds are available from Derbyshire Healthcare NHS Foundation Trust following the recent removal of a short break service.

The review will provide a detailed up to date map of services across health and social care. This will be considered against the demographic data identified in the Joint Strategic Needs Assessment and a summary will be included in the next report.

The Review

The initial stages of the review are now underway. A jointly funded Project Manager employed by health has been in post since mid-October 2011. This stage of the review will confirm current service activity including costs, carer/user satisfaction levels and provide an outline property audit. The detailed information will inform the next stage in the development of a joint strategy.

The overall review will be completed by December 2012 and will identify the future service model across health and social care. Work will be aligned with the recommendations in the Joint Derbyshire Carers Commissioning Strategy 2009-2014.Short break bookings will continue to be taken by all services during the review.

Other Considerations

Short break services provided by Adult Care are subject to statutory charging regulations whilst health services are free at the point of delivery. This will need to be considered when identifying any future joint models of support and built in to the public consultation process.

Officer's Recommendations

1. The Board notes the joint review of short breaks for people with a learning disability;
2. An update report on progress is made to the Board in summer 2012.

Deborah Jenkinson
Learning Disability Commissioning Adult Care

DERBYSHIRE COUNTY COUNCIL

Adult Care Board

12th January 2012

Implementation of the Fulfilling and Rewarding Lives Strategy for Adults with Autism in England.

Purpose of the Report

To inform the Board of progress in the implementation of Fulfilling and Rewarding Lives (March 2010) the strategy for adults with autism in England.

Background:

The Autism Act 2009 was introduced following a number of campaigns. The Act has been described as a unique and ground-breaking piece of legislation and is the only condition specific legislation in existence. The Act required the development of a strategy and accompanying statutory guidance to be issued by the Department of Health to local authorities, NHS bodies and NHS Foundation Trusts. The strategy 'Fulfilling and Rewarding Lives' was published in March 2010 and the statutory guidance in December 2010.

The Act decreed that the guidance is to be treated as though it were issued under section 7 of the Local Authority Social Service Act 1970 (LASS Act). This means that local authorities must ''follow the path charted by the guidance, with liberty to deviate from it where the authority judges on admissible grounds that there is good reason to do so but without freedom to take a substantially different course''. Though the LASS Act does not directly apply to NHS bodies the Autism Act makes it clear that for the purposes of the guidance ''an NHS body is to be treated as if it were a local authority within the meaning of the LASS Act''. Therefore both organisations must not only take account of the guidance but follow the relevant sections or provide good reason why they are not doing so to avoid judicial review or default action by the Secretary of State.

Statutory Guidance

This report identifies the four main elements of the guidance and how in Derbyshire we are working to meet the requirements.

1. Local planning and leadership in relation to the provision of services for adults with autism

- Local authorities should allocate responsibility to a named joint commissioner/senior manager to lead commissioning of community care services for adults with autism. The named commissioner should participate

in relevant local and regional strategic planning groups and partnership boards.

Responsible commissioner identified. Derbyshire also lead the regional strategic planning group.

- Plans should be developed reflecting the needs identified in Joint Strategic Needs Assessments (JSNA's).

  We have completed Autism Specific JSNA's for both Adults and Children. This work has been highlighted as a good practice and was the first in the region to be completed. The assessment has highlighted that people with Autistic Spectrum Disorder (ASD) who do not have a learning disability or mental health needs have difficulty accessing support. A link between Autism and a social drift towards the criminal justice system has also been identified, this association requires further investigation.

- LA, NHS bodies and NHS Foundation Trusts should develop local commissioning plans and review then annually. They should include not only social care services but also where relevant health services and interventions, which help improve the health outcomes of adults with autism.

  A sector wide planning group is in operation and commissioning plans are currently being developed based on the JSNA, local consultation and findings from the Department of Health self-assessment tool issued to assist planning. This work includes identifying a service model to address the needs of people with ASD who are currently

2 Training of staff

- General autism awareness training should be made available to all staff working in health and social care. The core aims are to ensure that staff are able to identify potential signs of autism and understand how to make reasonable adjustments in their behaviour, communication and services for people who have a diagnosis or display these characteristics.

  Awareness raising training is available across health and social care covering the County. A new course has been launched in Adult Care which is also open to independent providers. Autism is included in the induction programme for health and social care staff. Adult social care teams have been briefed on the legislation.

- In addition to this areas should provide specialist training for those in key roles that have a direct impact on access to services for adults with autism. The end goal is that within each area there are some staff that have clear expertise in autism.

  A training group is in place with health and social care representation to develop enhanced training particularly for social work and assessment staff. All staff are to attend the awareness training and workers will be identified within teams who will develop enhanced skills and expertise.

3 Identification and diagnosis of autism in adults, leading to assessment of needs for relevant services

- Each area should put in place a clear pathway for diagnosis, from initial referral through to assessment of needs.
- Each area should appoint a lead professional to develop diagnostic and assessment services for adults with autism
- The Director of Adult Social Services is responsible for ensuring that the correct processes are in place within the local area for:

a) conducting assessment of needs
b) the prompt sharing of information between diagnostic services and adult services about adults diagnosed
c) timely notification of the entitlement to an assessment of needs and where relevant, a carers assessment.

Currently a diagnostic service is provided by Sheffield this will be transferred to Derbyshire in April 2012 and will be provided by Derbyshire Healthcare Foundation Trust. Diagnosis is also available for people with an associated learning disability from clinicians within the learning disability specialist health services. The pathway describing the process of referral for diagnosis, immediate post diagnostic support and referral on to adult social care for personalised support will be publicly available by 1st April 2012. Social workers will be able to access support from NHS services making any diagnosis.
A lead clinician has been identified and is working on the diagnostic service. It is intended to develop a post diagnostic short term support service particularly aimed at people with Asperger's which will also act as a resource for social workers.

4 Planning in relation to the provision of services to people with autism as they move from being children to adults

- The Local Authority needs to comply with existing legal obligations under statutory guidance around transition planning.
- Professionals working with a young person with autism approaching transition including child and adolescent mental health services (CAMHS), special needs co-ordinators and social workers should inform the parents and young person of their right to a community care assessment and inform carers of the right to a carer's assessment.
- Workers should also inform social services that this individual is approaching adulthood and may need a community care assessment.

Adult and children commissioners are meeting to ensure the adult and children's autism strategies complement and support each other. Autism is to be addressed in the transition pathway and training is being implemented including e-learning packages within children's services. Joint work with GP's regarding accurate recording of people with autism and staff training is planned.

Other Considerations

The Autism Strategy Programme Board chaired by the Minister for Care, Paul Burstow MP is responsible for overseeing progress against the Adult Autism Strategy. The Board has written to Directors of Adult Social Services (Gateway Reference 17031 20th December 2011) requesting Autism specific data. This will be collated by the Public Health Observatory to provide a national picture of progress.

Officer's Recommendations

1. The Board notes the progress made in achieving the implementation of Fulfilling and Rewarding Lives (March 2010) the strategy for adults with autism in England.
2. An update report on progress is made to the Board in summer 2012.

Deborah Jenkinson
Learning Disability Commissioning - Adult Care

Report for Adult Care Board
January 2012

Shaping Derbyshire HealthWatch

1. Purpose

To provide an update on work being undertaken to develop a local HealthWatch service in Derbyshire and to outline the likely timetable for its procurement.

2. Background

HealthWatch will be the new consumer champion for health and social care in England. It will exist in two distinct forms;

- Local HealthWatch organisations which will be set up at a local level, with a proposed start date of October 2012
- HealthWatch England which will operate at a national level.

2.1 HealthWatch England

HealthWatch England will be a national organisation that will enable the collective views of the people who use NHS and social care services to influence national policy. It will be a statutory committee of the Care Quality Commission (CQC), with a Chair who will be a non-executive director of CQC. HealthWatch England will have its own identity within CQC, but it will be supported by CQC's infrastructure and it will have access to CQC's expertise.

2.2 Local HealthWatch

The Council has the responsibility to facilitate the development of an effective local Derbyshire HealthWatch service, with a recently revised proposed start date of April 2013. Derbyshire HealthWatch will provide;

- Opportunities for people to have their say about the quality and development of their local health and adult social care services.
- Promote opportunities for local people to influence the commissioning of local public services and to provide additional voices to scrutinise them.
- Signpost people to sources of information and advice to help people access and make choices about services.
- A service to support people to gain access to independent complaints advocacy, if they need help to complain about NHS services.

It is planned for Derbyshire HealthWatch to take on all current Derbyshire LINk (Local Involvement Network) statutory roles and functions, build upon what is already working well and have a specific focus on the need to be representative of diverse communities.

2.2.1 Background to Derbyshire LINk

LINks were established following the Local Government and Public Involvement in Health Act 2007. The Derbyshire LINk was awarded, following a tender

exercise, to a consortia bid made by Amber Valley Council for Voluntary Services and North Derbyshire Voluntary Action. These organisations acted as a 'Host' to the Derbyshire LINk. This contract has been extended whilst planning is undertaken to develop a new service specification for Derbyshire HealthWatch before going to tender for the new service.

2.2.2 Operational Model and Governance of LINk

The Derbyshire Host was tasked with employing the LINk staff and to initially offer management and technical support whilst a LINk steering group was established. The LINk steering group is made up of volunteers who are representative of their communities and have expressed a willingness to take on the responsibility of overseeing the work of the LINk. Discussions have been held with the Chair of the LINk steering group about how the volunteers and members of the LINk could be encouraged to continue with their engagement when the service changes to HealthWatch.

3. Planning for Derbyshire HealthWatch

The draft Health and Social Care Bill that is currently going through Parliament, places a duty on all Local Authorities in England which provide Adult Social Care services to commission a local HealthWatch service. The Department of Health (DoH) has stated that the proposed timetable for commencing HealthWatch is October 2012 with local HealthWatch starting in April 2013

Derby City Council on behalf of the Local Authorities in the East Midlands Region has commissioned a partner agency, following a competitive exercise, to assist with the design of Local HealthWatch provision. The organisation that was successful is the Community Development Foundation and they are helping commissioners and representatives of local LINks work through various guidance issued by the DoH and CQC. The work programme has already commenced and consists of 5 sessions for commissioners and 4 workshops for LINks members. To encourage collaboration between the two groups, LINks members will be invited to one of the commissioners' sessions, and commissioners will be invited to one of the LINks' workshops.

4. Next Steps

The current provisional timetable set by DoH for the delivery of Derbyshire HealthWatch requires a service to be prepared and in place by April 2013. It is planned to have procurement documentation including the service specification ready for Spring 2012 to achieve this deadline. Adverts to tender the service will follow soon after with a target of having Derbyshire HealthWatch in place by April 2013.

A small project group has been set up to oversee the development of a vision for HealthWatch in Derbyshire.

This group will take on the responsibility for shaping the specification in partnership with local stakeholders. It includes representation from; Derbyshire

County Council Adult Care, Derbyshire County Council Policy Unit, Derbyshire County Council Children and Younger Adults, Derbyshire Primary Care Trust Cluster, Derby City Council and it is proposed to invite the Chair of the Derbyshire LINk.

5. HealthWatch Funding

The Department of Health has now indicated the arrangements for funding the LINk until the end of March 2013 and our local Healthwatch:

- The LINk should be funded so that it can continue until the start of the local HealthWatch in April 2013. Funding for this continues to be in the local Government Formula Grant
- HealthWatch start-up funding of £3.2m nationally will be allocated to Councils as part of the Department of Health Learning Disabilities and Health Reform Grant. This should amount to around £0.47m for Derbyshire.

6. Recommendation

That work continues on developing a vision for Derbyshire HealthWatch to include;

- drafting the local HealthWatch service specification, taking account of any further Department of Health guidance about the expectations of HealthWatch and funding available.

- Identify with colleagues in Derby City potential ways of ensuring that each HealthWatch organisation provides clear advice across Health boundaries and to consider how infrastructure costs might be shared to promote Best Value.

- To promote within the tender the expectation that a Host provider will work with the HealthWatch membership to develop a distinct/high profile organisation that has its own corporate identity.

- To ensure that all new contracts set by Derbyshire Adult Care and the local NHS require providers to take responsibility to promote to people HealthWatch when it is operational.

- That further reports are submitted to the Adult Care Board updating it on progress in establishing Derbyshire HealthWatch

- To consult with local voluntary and community sector providers about how HealthWatch might complement their information and advice services