DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE
ADULT CARE BOARD

THURSDAY 17TH MAY 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: L Harris, J Pendleton	"
3.	Minutes from the meeting 15th March 2012 (attached)	"
4.	Accommodation, Support & Care DVD	M Cann
5.	• Dignity & Respect Campaign (attached) • Prime Minister's Challenge on Dementia: Delivering major improvements in dementia care and research by 2015 (attached)	S Phillips/ C Wright J Vollor
6.	Frail Elderly / Long Term Conditions (attached)	J Vollor/ M Cassidy/ W Sunney
7.	Joint Working relating to Improvement & Scrutiny Committee (verbal)	B Robertson
8.	• CCG Development • Commissioning Support: Current Position & Next Steps	CCG's
9.	Draft Care and Support Bill (verbal)	B Robertson
10.	Health & Wellbeing Board: • Agenda Items for Meeting on 31st May 2012	All
11.	Any Other Business	-
	The next meeting of the Adult Care Board will take place on 12th July 2012 at 2:00pm in Committee Room 1, County Hall, Matlock.	

Julie Hardy
PA to Bill Robertson, Strategic Director - Adult Care Department
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DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

MINUTES OF A MEETING HELD ON THURSDAY 15TH MARCH 2012 AT 2:00PM DERBYSHIRE COUNTY COUNCIL, COMMITTEE ROOM 1, MATLOCK HQ

PRESENT:

Cllr Charles Jones	Derbyshire County Council Cabinet Member (Adult Care) **Chairman**
Cllr Stuart Ellis	Derbyshire County Council – Support Cabinet Member (Adult Care)
Cllr Dave Allen	Derbyshire County Council – Elected Member
Bryan Bennett	Derbyshire Fire (representing Richard Brunt)
Russ Foster	Derbyshire Police
Lynn Harris	Derbyshire County Council – Safeguarding Board
Andy Layzell	Southern Derbyshire Clinical Commissioning Group
James Matthews	Derbyshire County Council – Adult Care
Mary McElvaney	Derbyshire County Council – Adult Care
Alison Pritchard	NHS Derbyshire County – Public Health
Bill Robertson	Derbyshire County Council – Strategic Director Adult Care
Helen Robinson	Derbyshire Carers
Cllr Lilian Robinson	North East Derbyshire District Council
Mark Self	Derbyshire Probation Service (representing Rosemary Plang)
Jo Smith	South Derbyshire CVS: representing voluntary & community sector
Wendy Sunney	Hardwick Clinical Commissioning Group (CCG)
Jonathan Wardle	North Derbyshire CCG (representing Jackie Pendleton)
Jacqui Willis	NDVA: representing voluntary & community sector

APOLOGIES:

Sally Adams	High Peak Clinical Commissioning Group (CCG)
Avi Bhatia	Erewash Clinical Commissioning Group (CCG)
Richard Brunt	Derbyshire Fire Service
David Collins	North Derbyshire Clinical Commissioning Group (CCG)
Stephanie Cook	Derby City PCT
Cllr Barbara Harrison	Erewash Borough Council
Sean King	High Peak Clinical Commissioning Group (CCG)
Bruce Laurence	NHS Derbyshire County / Derbyshire County Council
Cllr John Lemmon	South Derbyshire District Council
Steven Lloyd	Hardwick Health Clinical Commissioning Group (CCG)
Rakesh Marwaha	Erewash Clinical Commissioning Group (CCG)
Andrew Milroy	Derbyshire County Council – Adult Care
Andrew Mott	Southern Derbyshire Clinical Commissioning Group (CCG)
Jackie Pendleton	North Derbyshire Clinical Commissioning Group (CCG)
Rosemary Plang	Derbyshire Probation Service
Trish Thompson	NHS Derbyshire County
David Timcke	NDVA: representing voluntary & community sector
Gavin Tomlinson	Derbyshire Fire Service
Clare Watson	Tameside & Glossop PCT (CCG)
Tammi Wright	Derbyshire LINk

Minute no	Item	Action
	WELCOME FROM CLLR CHARLES JONES AND APOLOGIES NOTED	
ACB 019/11	**MINUTES FROM THE MEETING ON 12TH JANUARY 2012 & MATTERS ARISING** • The minutes from 12th January 2012 were noted and agreed.	
020/11	**PUBLIC HEALTH OUTCOMES** • A Pritchard provided the Board with an update and briefing papers about: o NHS; Public Health and Adult Social Care Outcomes Framework o Healthy Lives, Healthy People: Improving outcomes and supporting transparency (Public Health Outcomes Framework) • For more information please contact Alison Pritchard at alison.pritchard@derbyshirecountypct.nhs.uk or on 01332 888149.	
021/11	**DERBYSHIRE HEALTH AND WELLBEING STRATEGY DEVELOPMENT: PROPOSED HIGH-LEVEL PRIORITIES** • A Pritchard provided the Board with an update on the proposed high-level priorities for the Derbyshire Health and Wellbeing Strategy. o Improve health and wellbeing in early years. Every child fit to learn and attain the highest levels of literacy. o Promote healthy lifestyles by preventing and reducing harmful alcohol consumption, substance misuse, obesity, physical inactivity, smoking and sexual ill-health. o Promote the independence of all people living with long term conditions and their carers. o Improve emotional and mental ill-health and provide increased access to mental health services. o Improve health and wellbeing of older people and promote independence into old age. • Pre-consultation will now take place, followed by full 3 month consultation – followed by a revised submission to the Health and Wellbeing Board following this. • For more information please contact Alison Pritchard at alison.pritchard@derbyshirecountypct.nhs.uk or on 01332 888149.	
022/11	**ACCOMMODATION AND SUPPORT STRATEGY** • B Robertson provided the Board with an update on the accommodation, care and support strategy for older people. The strategy is to develop extra care housing as an alternative to traditional residential care, targeting short term and long term care around dementia and development of dementia pathway. • 600 + 1000 additional units of extra care housing will be provided and the Council has 3 new developments underway. • 4 Specialist Community Care Centres will provide: o 4 health and wellbeing zones o 4 day care services accommodating a total of 80 people at any	

one time
    - 64 long term dementia beds
    - 32 respite beds and
    - 32 intermediate care beds
- Recommendations by the County Council Cabinet were to:
    - Approves the revised plan to deliver the strategy for accommodation, care and support for older people in Derbyshire.
    - Approves the commitment of the Capital Investment required for this strategy, which was approved within the Capital Plan for 2012/13 by the Council on 1st February 2012.
    - Notes that Stage 2 consultation will be undertaken with relevant parties where they are affected by specific proposals to implement the revised plan, as set out in paragraph 2.11 of this report, with immediate priorities for consultation being those identified in section 2.11.2.
    - Notes that further reports will be submitted to Cabinet following the Stage 2 consultations. These reports will include alternative options if it is considered inappropriate to proceed with any specific proposal as a result of the consultation. **BR**
    - Notes that the responses to consultation on the proposals within the revised plan will have regard to the Equality Impact Assessment and will inform Equality Impact Plans.
    - Approves the purchase of land adjacent to Whitworth Hospital at Darley Dale for the purpose of developing a Community Care Centre on this site, subject to Heads of Terms being agreed by the Director of Property Services.
    - Approves the acquisition of other sites not currently in the ownership of Derbyshire County Council, required for Extra Care developments as set out in this report. These acquisitions will be subject to detailed Heads of Terms being agreed by the Director of Property Services.
    - Approves the proposals for the procurement of Community Care Centres as set out in section 2.9 of this report, with the location of the proposed Community Care Centre in the Erewash, Long Eaton and Amber Valley area being subject to the outcome of the stage 2 consultation on the proposed closure of the Florence Shipley home.
    - Approves the proposals for the procurement of Extra Care Housing as set out in section 2.10 of this report, with the final locations being subject to the outcome of site specific consultation as set out in section 2.11 of this report.
    - Notes that further reports on the development and progress of the strategy will be submitted in due course, including proposals for NHS investment and facilities on specific site developments.
- There was a general discussion about the plan with the following points noted:
    - There will be an opportunity for Health colleagues to develop services.

- Adult Care meeting with Health colleagues on 20th March to discuss the Joint Commissioning Agenda.
- Swadlincote Centre is currently being built - due to be finished September/October 2012.
- Adult Care Offer: Joint with Health – every older person in Derbyshire should have a development within 5 miles of where they currently live.
- First consultation will be for Florence Shipley in Heanor and this will commence in April 2012.
- Equality Impact Assessment will be undertaken on the consultation.
- CCGs commented on the importance in the transition period of beds for patients. They are currently experiencing difficulties in waiting for beds.
- Early onset of dementia is critical.
- Ratio of 1 to 4 staffing in the Community Care Centres to be followed in the new centres, which is the same as the Staveley Centre.
- Funding issues between Health and Local Authority – problems experienced within Staveley. Would the communication regarding funding for new centres take place on an incremental basis – timescale for this requested. BR confirmed that a programme planned up to 2016/17 can be shared.

- For more information please contact Bill Robertson at bill.robertson@derbyshire.gov.uk or on 01629 532432.

023/11 **JOINT COMMISSIONING PRIORITIES**

- J Matthews presented the Board with an update on the Joint Commissioning Priorities for 2012/13, seeking approval for the proposed joint commissioning priorities and partnership indicators - Agreed. The agreed priorities are:
  - Safeguarding
  - Frail Older People and Dementia
  - Carers
  - Learning Disability
  - Disabled People or People with a Sensory Impairment
  - Transition to Adult Life
  - Implementation of the Autism Act
  - Mental Health Services
- W Sunney highlighted that the Dignity in Care Development Programme is now in place – started to visit homes. The programme is viewed in a positive manner and is currently being rolled out throughout the County.
- L Harris gave an update on Safeguarding Board representation – work is currently being undertaken regarding appropriate representation at meetings. There needs to be a link between safeguarding and CCG's. **LH/JM**
- Agreed for report to be submitted to the Health and Wellbeing Board.
- For more information please contact James Matthews at james.matthews@derbyshire.gov.uk or on 01629 532004.

024/11 **PREVENTION: JOINT SUPPORT FOR VOLUNTARY SECTOR**

- J Matthews presented the Board with an outline of the range and extent of joint Adult Care and NHS financial support for the voluntary and community sector – to be noted.
- It was expressed by the Voluntary Sector that they are given as much notice as possible should any of the current funding be reviewed.
- For more information please contact James Matthews at james.matthews@derbyshire.gov.uk or on 01629 532004.

025/11 **COMMISSION ON DIGNITY AND CARE FOR OLDER PEOPLE**

- J Matthews presented the Board with a progress update on the Derbyshire Dignity and Respect Campaign and to report on the recent national Delivering Dignity report – to be noted.
- The Bronze award is currently being implemented.
- Responses to the national report's recommendations need to be submitted by by 27th March 2012. A final report will be published before the summer.
- It was noted that Chesterfield Royal Hospital is delivering improved dignity and respect following its joint sign up to the dignity 10 point challenge.
- For more information please contact James Matthews at james.matthews@derbyshire.gov.uk or on 01629 532004.

026/11 **CLINICAL COMMISSIONING GROUP DEVELOPMENTS**

- A Layzell provided the Board with an update on CCG developments:
  - High Peak CCG is merging with North Derbyshire CCG.
  - Authorisation of CCG's will be undertaken in 4 waves: June / July / August & October 2012. They will become formal bodies from April 2013. The approval process includes 360º survey of major stakeholders.
  - Formal appointments to Boards are being made.
  - Development of Commissioning Support Functions: Greater East Midlands Commissioning Support Unit is being developed.

027/11 **INTEGRATED CARE**

- W Sunney provided an update on long-term conditions:
  - Fast-track programme across East Midlands is in place.
  - 9 month accelerated implementation includes patient surveys and data collection. 1st workshop focussed on risk tools, 2nd workshop on Health & Social Care locality teams and 3rd workshop on promoting self-care.
  - Learning Network with other CCG's is being developed. Future paper with proposals to be brought to the Adult Care Board in May.
- A Layzell provided an update on Frail / Elderly:
  - Set up easy access route through single point of access.
  - Common areas of development being looked at.
  - Financial analysis to take place.
- J Wardle provided an update on reviewing care pathways for North Derbyshire CCG.

028/11 **HEALTH AND WELLBEING BOARD AGENDA**

- The following agenda and information items for the Health and Wellbeing Board to be held on Thursday 29th March 2012 were discussed:
  - Joint Commissioning
  - Accommodation, Care and Support Strategy
  - Commission on Dignity and Care for Older People CCG Development Update
  - Frail and Elderly Progress
- It was suggested that a report from the Police on the vulnerable / people susceptible to harm be put forward to the next Adult Care Board in May – to go forward to the Health and Wellbeing Board thereafter. **RF**

DATE OF NEXT MEETING

The next meeting of the Adult Care Board will take place on Thursday 17th May 2012 - 2:00pm – 4:00pm Committee Room 1 County Hall, Matlock.

DERBYSHIRE ADULT CARE BOARD

17 May 2012

DERBYSHIRE DIGNITY AND RESPECT CAMPAIGN

1. Purpose of the Report

The purpose of this report is to:

- Inform the Board about work to date relating to the joint Derbyshire dignity and respect campaign.
- To seek the endorsement of the Board for a launch of a silver standard award to follow the successful launch of the bronze standard award.

2. Information and Analysis

Background

Nationally health and social care services are facing regular criticism about levels of dignity and respect afforded to people who use the services. Many types of poor face to face level practice can easily be rectified.
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On 25 February 2011 the Derbyshire Dignity Campaign was launched as a joint Adult Care and Derbyshire NHS initiative to flag up any 'less than best' practice and to do something about it. The campaign includes a bronze standard award. The launch derived from a national Dignity in Care campaign based on a 10 point Dept. of Health challenge as at **Appendix A.**

The Derbyshire campaign asks all teams to register a dignity champion who will work with their team to achieve a bronze dignity award. The bronze award is related to the 10 point dignity challenge and for each point (to which 3 bullet points are added on the assessment form for clarity) an answer is required to the question 'is this the best we can do?' Where the answer is 'no' the applicant has to list what is going to be done to make the necessary improvement.

The launch meant that it is policy for all Adult Care (AC) teams to participate. In December 2011 the AC Contracts team made achievement of the bronze standard a requirement for quality premium payments for independent sector home care providers (means ultimately a potential total of 64 applications). Later in 2012 the same is likely to be applied to the 80 providers of residential services.

Teams in the NHS; the voluntary sector and other public bodies are also encouraged to seek the bronze award.

Current publicity about the bronze campaign amongst health sector teams especially pharmacy is anticipated to increase applications.

During 2012 some bronze holders will need to resubmit and be reassessed as the 12 months duration on certificates expires on current awards. We are proposing to systematically give early reminders to holders so they can update applications and resubmit.

To date 92 applications for the bronze award have been submitted with successful achievers so far listed at **appendix B.**

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Assessments are done by volunteers from Adult Care, the NHS and Enable Housing. A day is set aside each month and volunteers call in if they can and stay as long as they can. It is encouraging that resubmitted applications are generally much improved after an unsuccessful first attempt.

Administration of applications is done through AC Business Services and the processing of applications has evolved into a system which works well.

The Dignity campaign is also being used to integrate dignity standards as part of the revised admission and discharge pathway at the Chesterfield Royal Hospital Foundation Trust (CRHFT). This is a joint approach between Derbyshire Community Health Services, CRHFT and Adult Care.

On 1st February 2012 a workshop was held at the Post Mill Centre, South Normanton including professionals and members of the public to recommend what silver standard should involve and proposals below regarding silver standard are based on this.

Proposed Further Action

Steering group: A steering group of volunteer colleagues keeps arrangements on course. Membership is fluid and the group meets when there is a need to do so with core members attending when they can.

This arrangement seems to work satisfactorily but the group would benefit from a reporting mechanism to the Adult Care Board for accountability and added partnership impact. . .

Bronze Standard: The system has run satisfactorily so far as outlined above but the campaign is gaining momentum so a shortage of assessment capacity is anticipated as more NHS applications and Contracted services participate.

AC senior management team are considering asking for every Group Manager to nominate 2 staff each as assessors who can be called upon to formally support the dignity campaign or arrange cover if need be..

We need NHS colleagues to likewise add to assessment capacity and the support of the Board is sought to achieve a NHS level of staff commitment to the campaign equivalent to that in AC.

Silver Standard - the proposed cover form at **appendix C** suggests the format and how applications might be initially screened and then assessed.

If the Board endorses the proposed silver standard a formal launch will be required, and it is suggested that this is in autumn 2012.

Appendix A also shows in italics the key points from the Prime Minister's Dementia Challenge (March 2012). Some of the points relate exclusively to dementia, others are generic. The italics are added to strengthen the generic silver standard and prompt dementia specific ideas for appropriate services. This version of the 10 point challenge is proposed to underpin the silver standard.

Financial Considerations:

Many of the service improvements identified at bronze level have been cost free. The campaign has started to save some time and produce better outcomes too. This is being achieved by the dignity network exchanging good ideas e.g. the two presenters at the silver standard workshop on 1st February 2012 have respectively put time and effort into environmental enhancement and in dignified dining. Both have widely shared their work which is being adopted quickly and easily, so this process of local best practice sharing will be developed further.

Variable amounts of additional time are put in by colleagues within and outside Adult Care for monthly assessment days or attending periodic steering group meetings. As numbers of new or renewal applications (the latter from 1st November 2012) for bronze standard grow for reasons explained above we anticipate capacity challenges regarding assessments.
The format proposed in appendix C will require for each monthly assessment day organising three people to make up a panel to assess silver standard applications.

OFFICER RECOMMENDATION

To take forward the promotion of dignity and respect as suggested in the 'proposed further action' and 'financial considerations' sections of this report i.e.

1. The Dignity campaign Steering Group to be accountable to the Adult Care Board. It is recommended that half yearly reporting takes place
2. The Board supports nomination of AC and NHS staff who can give a commitment when required to participate in bronze and silver standard assessments (for which role briefing and support is available).
3. Adoption of the silver standard format with a launch in 2012

Appendix A

The Dignity 10 Point Challenge

The Prime Minister's Challenge on Dementia March 2012 referenced in italics. This is to strengthen the generic silver standard and prompt dementia specific ideas for appropriate services.

1. Have a zero tolerance of all forms of abuse

2. Support people with the same respect you would want for yourself or a member of your family
   - *I am treated with dignity and respect*

3. Treat each person as an individual by offering a personalised service.
   - *I am respected as an individual*

4. Enable people to maintain the maximum possible level of independence, choice and control
   - *I know what I can do to help myself and who else can help me*

5. Listen and support people to express their needs and wants
   - *I am confident that my end of life wishes will be respected. I can expect a good death*

6. Respect people's right to privacy.

7. Ensure people feel able to complain without fear of retribution.

8. Engage with family members and carers as care partners.
   - *Those around me and looking after me are well supported and understand how to maximise my independence*

9. Assist people to maintain confidence and a positive self-esteem.
   - *I can enjoy life*

10. Act to alleviate people's loneliness and isolation.
    - *I feel part of the community and I am inspired to participate in community life*
    -

Appendix B

These are the establishments, organisations or teams who have been successful so far:

- Bramble Lodge
- Stonelow Court
- Pendlebury Court
- Queens Court
- Jubilee Day Services
- Derwent House
- Morton Grange Nursing Home
- Holbrook Hall Residential Care Home
- The Risings Rest Home
- Ecclesfold Resource Centre
- Milford House Care Home
- Willow Bank Residential Home
- North Derbyshire Women's Aid
- Care Relief Team
- EMAS NHS Trust
- Lincote Resource Centre
- Nether Hall Care Home
- Bankcroft Day Centre
- The Bungalow, Newhall
- Rykneld Homes
- Ashfields Care Home
- South Derbyshire Home Care Team
- Commissioning Team
- Whitestones Home for Older People
- Shirevale Resource Centre
- Cottage Care Ltd
- The Deprivation of Liberty Safeguarding Team
- Brookdale Unit, Ash Green

- Derbyshire Fire Service Prevention and Inclusion Team
- The Spinney, Brimington
- Red House Care Home, Chesterfield
- Parkwood Day Centre, Alfreton
- Glossop Community Mental Health Project
- Independent Living Services
- Trident Reach the People Charity – Derbyshire Young People's Service
- Bolsover Home Care Team
- Mediline Nurses and Carers Ltd
- Goyt Valley House
- Chesterfield and North Easy Derbyshire CAYA Home Care Team
- Independent Care Link

Appendix C

Derbyshire Dignity Campaign: Silver Standard Cover Form

NHS Derby City and NHS Derbyshire County

OVERVIEW

The challenge at silver standard is to produce a piece of work which develops bronze a stage further by developing one or more of the 10 points chosen from the original dignity challenge (listed at **appendix A** of this Adult Care Board report).

This cover note is a self-check to ensure that the basic requirements for silver standard have been considered.

When you have completed this cover note please preferably email it to us although this cover form can be posted. (Details of how to send it are below).

ASSESSMENT

After receipt of this cover note has been acknowledged, you will be invited to book an appointment to present your silver standard piece of work to a panel of three people.

The panel is made up of colleagues who work in a variety of health, social care and voluntary sector settings.

A date each month is programmed ahead and appointments can be made for teams to come and present your silver standard work for up to 50 minutes including questions and answer time.

Evidence can be presented in many ways e.g. pictures, written, DVD etc.

Appointment slots booked via James.Hatch@derbyshire.gov.uk
Tel. 0169 532209

Assessors will not normally do visits but in some circumstances this will be needed to understand work done for silver so would be negotiated.

NB Current bronze award holders only can apply for silver standard

THE SILVER CHALLENGE

Your piece of work should be based on a theme e.g. 'nutrition' which is very relevant to the service for which you work. This can be something you are already doing or an idea devised as a result of the challenge.
NB You are welcome to discuss your initial ideas with dignity assessors if you wish.

PLEASE DO NOT SUBMIT YOUR APPLICATION FOR SILVER STANDARD UNLESS YOU CAN ANSWER 'YES' TO ALL OF THE QUESTIONS BELOW
(Except for those marked optional)

BASICS

The bronze standard required the registration of a team member as a dignity champion

Champions: Will you be able to confirm the name(s) of your local dignity champion(s) whose names are registered on the national website.

The bronze challenge award asked for action points to be identified where the answer was 'no' to the question 'is this the best we can do?' during the bronze 10 point challenge.

Action Plan: Will you be able to show an action plan which shows evidence of continuing service improvement?

Evidence of customer involvement is essential and the more the clients are involved at every stage, the better. A client registered as a dignity champion will strengthen the application. This applies to informal carers too where they are involved.

Customer Involvement: Will you be able to show evidence of significant customer involvement in your silver standard work?

All the team needs to be involved particularly 'front line' staff. Good management is shown by the way the whole team is involved.

Involvement of frontline staff: Will you be able to show that all the team are involved in your silver standard work?

Independent references may endorse the value of the application if appropriate e.g. from partner organisations or people who have the service.

Independent References: Will you be able to endorse your application for silver standard with references? (optional)

DEVELOPMENT OF THE IDEA

Some fact finding is expected to find out more about your chosen theme and what might have been done already.

Fact-Finding: Will you be able to demonstrate that you have been done some fact-finding to make sure your idea is based on best practice?

You will need to demonstrate the process you have taken the silver standard work through.

Process: Have you been through a process similar to the outline below?

- getting information together;
- getting the idea properly formulated;
- getting underway;
- a spell of trial and error
- have some encouraging results.

Evidence of working in partnership is likely to add value e.g. other organisations; informal carers.

Partnership: Will you be able to offer evidence of partnership working?

The best pieces of work look likely to continue and develop further.

Sustainability: Are you able to be confident that your piece of work will continue and develop?

RESULTS

The key purpose of the dignity campaign is to make practical changes which get good results.

Silver standard is not necessarily about a huge piece of work but evidence is needed of real improvement to the experience of dignity and respect for people who have the service.

Where the service includes involvement of informal carers positive outcomes for them clearly strengthen the piece of work.

Results: Will you be able to offer real evidence of positive results for the people who have the service and (where appropriate) their carers?

It saves time and money when good ideas are shared and others 'avoid reinventing the wheel'

Adding Value: Has you work attracted interest with others wanting to adopt your idea (optional)

Others might wish to adopt your idea. You might wish to share only an edited or anonymised version which is fine.

Are you prepared to share your idea on the Derbyshire County Council website

(optional)

IF YOU HAVE ANSWERED 'YES' TO ALL THE QUESTIONS ABOVE:

Please give a brief description of your silver standard piece of work theme and why this is relevant for your service.

STANDARDS FOR SILVER AWARD HOLDERS

- Award holders are expected to maintain continuous improvement
- There will be an 18 month expiry date on the certificate but there will be no need to renew the bronze award
- The certificate will be removed if standards are found to drop.

NOW PLEASE SEND THIS FORM TO US

- Preferably email to James.Hatch@derbyshire.gov.uk
- Or post to James Hatch; Adult Care; County Hall; Matlock; DE4 3AG. Tel. 01629 532209

Adult Care Board – 17th May 2012

Health and Social Care QIPP
Update on QIPP for LTC Programme

1. Introduction

Erewash CCG & Hardwick Health CCG together with Adult Care are participating in the national QIPP programme for long term conditions run by the Department of Health under the leadership of Sir John Oldham. This paper provides an update of the progress made as part of the programme and outlines plans for implementation within Erewash CCG and Hardwick Health CCG areas.

The work is being led by Sir John Oldham and as part of this a Commissioning Development Programme has been set up to help organisations better manage long term conditions – and bring benefits to patients, clinicians and the NHS and Social Care as a whole.

The programme has several strands all of which are designed to improve the care experience of people living with Long Term Conditions.

Best practice in the management of long term conditions has three key principles:
1. **Risk Profiling** – this helps organisations identify LTC patients who are most likely to make a significant use of the NHS and Adult Care services to develop systems and services that are better able to manage this demand.
2. **Neighbourhood Care Teams** – these teams work across health & social care in a locality (neighbourhood), and provide patients with a key worker to help join up and co-ordinate their care.
3. **Self care/ Shared Decision Making** – the majority of care for LTC patients is delivered by themselves or their carer(s). Evidence shows that patients who are more involved in their own care have better outcomes. This principle looks to provide patients with the support and confidence to better manage their own condition(s).

It is noted that Derbyshire has been approved to participate in the pilot of personal health budgets for adults in Derbyshire. This will give people greater control of how they receive health care input which will support people to manage their health and well-being.

A group consisting of representatives from the CCGs, Adult Care, DCHS, EMAS, DHU and general practice are working together through the programme to improve our understanding and delivery across ALL three of the above principles. There is also involvement from a patient representative in the team attending the programme. It is considered that only be implementing all three of these core principles together can we expect to see the impact on delivering efficiencies and improved outcomes. These components need to be part of a coherent approach to change as research showed that it is the cumulative effect that makes the difference.

A priority of the Derbyshire Health & Well-Being Board will be to promote the independence of all people living with long term conditions and their carers. In Derbyshire we will focus on community based support, self-care and care close to home, including increased use of evidence-based telehealth and telecare. The proposed developments outlined in this paper will contribute to supporting delivery against this priority.

2. Risk profiling

Within Derbyshire the PARR {Patients At Risk of Readmission} Combined Model (see appendix 2 for more detail) is used as the risk stratification tool which is used by GP practices and community matrons to identify patients at highest risk of hospital admissions who require intervention including selection for case management by community matron or other specialist nurse. There are issues about the long time delay (8 weeks or more) in hospital admission data being fed into the PARR tool to produce the risk list. It was proposed that as part of the local NHS Informatics Tender that risk stratification tool would be part of the service to be delivered but as this has been put on hold we need to take forward the work to look at future requirements around risk stratification tool. This would need to consider how Adult Care information including FACS eligibility could inform risk profiling.
The group have also explored the HAVOC tool developed by a GP in North Derbyshire. This tool supports GP practices to pull together the information on usage of urgent care services – GP, DHU, A&E, Admissions to produce an urgent care clinical dashboard which helps to identify people who are coming into contact with urgent care system and may require a proactive intervention. Hardwick & Erewash CCGs are proposing to pilot the HAVOC tool with a number of GP practices.

3. Integrated Health & Adult Social Care Teams

Erewash CCG and Hardwick CCG are participating in the integrated care programmes for frail elderly in North Derbyshire and Southern Derbyshire. In addition, Erewash CCG and Hardwick Health CCG have integrated care as a strategic aim. The CCGs working with DCHS & adult care services plan to create **integrated teams** within localities. This will create a functionally integrated generic care team at a locality level comprising community matrons, district nurses, AHP's, social workers, specialist nurses and linked to GP practices. The integrated health and social care teams based around a **locality** will provide joined up and personalised health and social services. The health and social care staff will work together to offer patients a better quality service, with easier access to the services required. The exact make up of each locality and population coverage will differ depending on local circumstances. The generic teams will pull in specialist services when necessary, but treat a patient holistically, regardless of their condition(s). The integrated care team will provide a single main contact point for patients and carers. Each patient will have a key worker within this team who coordinates their care and acts as the point of contact.

The integrated care teams will focus on delivering care for the following patient group:

- People with complex health and social care needs including frail older people and those with multiple long term conditions who are at risk of hospital admission and significant deterioration in their health and well-being.

Key elements of the model which Hardwick and Erewash CCG are proposing to implement are:

- **Risk profiling** to support identification of patients who need proactive intervention (see above).
- **Case management** through community matrons to be available in all GP practices across the CCGs ensuring full population coverage.
- **Care Co-ordinator** role either at individual practice or locality level. They will act as a key contact for patients and work with colleagues in the integrated care team and externally to co-ordinate services and care elements for patients. In addition they will use information sources to identify people who are at high risk of hospital admission who need to be discussed at the Multi-disciplinary Team Meetings.
- Functionally **integrated health and adult social care teams** working at a locality level comprising community matrons, district nurses, allied health professionals, social workers, specialist nurses and linked to GP practices. The integrated health and social care teams based around a locality will

provide joined up and personalised health and social services. The integrated teams will also develop relationships with Adult Social Services in Nottingham to improve communication and reduce duplication in processes where possible for patients living in Nottinghamshire but registered with a Derbyshire GP Practice.

- Improved **information sharing** across health & social care including access for the integrated care team to Framework I.
- **Hospital In-Reach** to support the effective management of patients within hospital and to support early discharge and avoidance of readmission.
- **GP Clinical Champion** in each GP practice as a lead GP for integrated care to include participation in weekly MDT meeting with integrated team to consider patients requiring review.

The outcomes which the integrated team will deliver include:

- Improved experience for people.
- People to receive better co-ordinated care and support.
- Services developed to ensure appropriate interventions are available at the right time.
- Improved communication and joint working between primary care, secondary care, intermediate care and Adult social care staff.
- More proactive and upstream care delivered to support people and avoid crisis.
- Improved efficiencies through reduction of duplication for example through inter-professional acceptance of each other's assessments.
- Improved efficiencies through reduction of hospital admissions and long term care home placements.
- Improved efficiencies through reducing delayed transfers of care.

There is a real interest between practitioners in taking forward integration at locality level. Further work is required to develop and agree the model to be implemented to transfer the concept of integration into the methods and approaches which will be required to deliver integration. This will need to define the outcomes/outputs and the delivery model to be implemented on the ground that will take account of local circumstances. The integration of social care staff into the integrated teams may either be virtual or through co-location.

There is the opportunity to share best practice as this is developed and inform development of integrated care for frail older people in North & Southern Derbyshire.

3. Self Care

The Team from Erewash CCG and Hardwick Health CCG areas attended a learning event on 2nd May 2012 to look at how we can systematise self care. An action plan will be agreed from this event which will pull together the elements of the third strand of the programme change which is required to improve the management of long term conditions.

4. Recommendation to Adult Care Board

It is recommended that the Adult Care Board note the proposed developments on integrated care in Erewash and Hardwick including considering how the model of integrated care will practically be implemented in Erewash and Hardwick areas.

Martin Cassidy
Assistant Operating Officer
Erewash Clinical Commissioning Group

Julie Vollor
Group Manager - Commissioning
Adult Care
Derbyshire County Council

10 May 2012

Appendix 1

Integrated Neighbourhood Care Teams - Evidence

Evidence presented at LTC Development Programme

During the workshop on the Long Term Conditions Development Programme on 2nd February 2012 there was the opportunity to hear how other places in the country have created integrated neighbourhood care teams and the benefits that this has delivered for both patients and organisations.

The majority of people aged over 65 will have two or more long term conditions and those aged over 75 will have three or more conditions. With a growing elderly population the number of people with long term conditions is expected to grow by 252%. In addition, a study had shown that:

- Only 5% of people with dementia have just dementia
- Only 14% of people with diabetes have just diabetes
- Only 18% of people with COPD have just COPD

This included examples from Nottingham, North East London and Greenwich.
One speaker shared that of the top 1% of high risk population in an area, 50% of the patients will also be in receipt of Adult Care and therefore we have a joint interest in this group of patients. The integrated neighbourhood care teams were built around geographical areas of populations ranging from 30,000 to 50,000 with the general practices as the building block. The integrated teams included community matrons, district nursing services, care managers from social services, therapy services. In addition, mental health, learning disability services, crisis intervention/rapid response, rehabilitation, intermediate care beds were co-ordinated through the integrated team.

In Nottingham there are plans for a dementia outreach team and community geriatrician to be built upon the neighbourhood team model. In addition, integrated neighbourhood teams supported the development of stronger links with voluntary sector. A crucial role in making all of the integrated care teams work was identified as the Care Co-ordinator/Ward Clerk role. In addition, regular multi-disciplinary team meetings at general practice level were a core element in coordinating the care for people. It was not about co-location of staff but a framework for staff to come together to improve communication.

In terms of hard nosed outcomes integrated teams had delivered:

- reduction in hospital admissions (North East London),
- saving on care hours per patient
- 19% reduction in intensive home care packages
- 3% reduction in home care packages
- 35% reduction in permanent care home placements (Greenwich)

Speakers said that there was also a high level of staff satisfaction from working in an integrated way due to the improvements in reducing duplication, improved communication and better care for people.

Key factors for success included the change being owned and driven by champions across specialisms, a focus on good communication and being realistic about speed of implementation. The importance of engaging staff working at the front end in the development of the integrated service was seen as a prerequisite for getting staff buy into the change. The core message was to start with the patient and what was best for them. In addition it was recognised that senior management within organisations needed to be behind the change for it to stand any chance of proceeding.

Evidence from other sources

The benefits of integrated care
Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011).

Care for older people in Torbay Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support (Thistlethwaite 2011).

Chronic care management in Wales In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009. This represented an overall cost reduction of £2,224,201 (NHS Wales 2010).

Report to the Department of Health and NHS Future Forum from The King's Fund and Nuffield Trust.
Integrated care for patients and populations: Improving outcomes by working together
Nick Goodwin, Judith Smith, Alisha Davies, Claire Perry, Rebecca Rosen, Anna Dixon, Jennifer Dixon, Chris Ham. January 2012

PARR Combined Model

A risk stratification tool called the Combined Predictive Model (the Combined Model) is used in Derbyshire and Derby City. The model is based on a comprehensive dataset of patient information, including inpatient (IP), outpatient (OP), and accident & emergency (A&E) data from secondary care sources as well as general practice (GP) electronic medical records. The information is currently used in Derbyshire to support the identification of people at risk of hospital admission who would benefit from case management by community matron or specialist nurse or other proactive intervention aimed at improving quality of life and reducing risk of hospital admission.

Case finding is essential for effective long term conditions management. Predicting who is most at risk of emergency admissions is a critical function of case finding. Tools that can identify those who can most benefit from outreach and targeted interventions require a high degree of accuracy to ensure that there is a match between intervention intensity and risk.

The Combined Model is able to:

- Improve predictive accuracy for very high risk patients
- Predict risk of hospital admission for those patients who have not experienced a recent emergency admission
- Stratify risk across all patients in a given health economy to help NHS organisations understand drivers of utilisation at all levels

The ability to identify emerging risk patients will enable NHS organisations to take a more strategic approach to their care management interventions. For example, CCGs and partner organisations will be able to design and implement interventions and care pathways along the continuum of risk, ranging from

- Prevention and wellness promotion for relatively low risk patients
- Supported self-care interventions for moderate risk patients
- Early intervention care management for patients with emerging risk
- Intensive case management for very high risk patients.

North Derbyshire Clinical Commissioning Group

North Derbyshire Integrated Care Programme

1. Introduction

North Derbyshire CCG held an event on the 20th October, which was attended by a range of health and social care practitioners from all agencies and part of the vision that evolved identified integrated care as a priority for the CCG and North Derbyshire partner organisations. A stakeholder event was held in December 2011 where a range of stakeholders from local authority, voluntary sector and patient groups were asked to provide input in to the initial priorities for this work.

Following these events the North Derbyshire Integrated Care Programme was set up to enable this vision to become a reality. To try to outline what this programme will look like this paper illustrates the approaches being taken.

2. Integrated Working Programme

The term person centred approach is an often used phrase but in North Derbyshire it is intended to make this a reality that can be recognised by people by changing the scenario where the person has to fit around the existing services, to services being developed around the needs of the person. In order to challenge ourselves and ensure this is at the forefront of our minds a person is being imagined and followed in every scenario that is considered for future service change.

By using a person centred approach this will enable all organisational and condition specific boundaries to be removed reducing the risk of people falling foul to the system – the person is the constant through all service planning.

The attached diagram highlights the person centred approach and the steps it is believed make up the lifecycle of a patient's journey through the health and social care system. These life stages can also be seen in the draft Derbyshire County Council Health and Wellbeing strategic priorities which are currently out for consultation. The CCG has been working with public representatives to ensure that the steps in the process are recognisable. The person centred approach and use of 'Mr and Mrs Taylor' is central to the focus of the Integrated Care programme.

3. Programme structure

The Integrated Working Group is the steering group that drives and supports the programme and includes executive representatives from all partner organisations across North Derbyshire. The individual organisations involved report back to their own Board and Governance structures on progress rather than there needing to be separate governance arrangements.

Task and Finish groups have been set up for each priority area. Each group has a sponsor from one of the partner organisations and is supported by representatives from the other partner organisations. Each task and finish group has clinical leadership and includes partner organisations management representatives.

Each group agrees and owns the scope and develops its own plans with clearly documented milestones. Governance structures are in place for reporting updates through the programme structures.

Other groups are in place or being developed to enable and enact the changes required. These include shared records, finance and contracting, engagement, best practice and procurement. Work is already underway to identify and explore best practice and investigate how this could be applied in North Derbyshire – for example a recent visit was made by a group from North Derbyshire partner organisations to Torbay to learn about their model for integrated care. Other models investigated by members of the group have been Cambridge and NW London.

4. Next Steps

In preparation for the future, when we receive the outcomes from the 21st Century consultation on the principles, we are looking at initial areas of focus of people with two long term conditions plus dementia, complex nursing home residents, end of life patients and COPD patients.

Areas for focus are initial service redesign activity include prevention, single assessment, health and social care system navigation, equitable patient outcomes 24/7, discharge and transfer.

Mapping, using person centred stories, is being used to drive service review and development in localities to ensure:

- That the patient and person centred approach is applied to any service redesign
- Progress is driven using patient centred outcomes and
- The CCG captures the hearts and minds of all partner organisations, clinicians and staff that will influence changes to future service provision.

By integrated partners in North Derbyshire mean identifying the needs of the person and working across all health, social care and voluntary sector organisations to ensure that all agencies work to meet those needs irrespective of agency boundaries. This links well with the approach taken within the Health and Wellbeing Strategy to put the person at the centre.

The types of outcomes that would be expected from this piece of work include:

- Mapping current service provision using current person centred journeys.
- Confirm areas to improve for example, prevention, single assessment, health and social care system navigation, equitable patient outcomes 24/7, discharge and transfer.

- Together, across all health and social care organisations identify solutions to improve areas identified.
- Propose the shape of future service provision across North Derbyshire and consult on this with the public.

5. 21st Century Health and Social Care Engagement Project

This project started as a separate engagement and potential consultation vehicle to support all of the work on integrated care. At the recent Steering Group in the North it was suggested that there was confusion around the difference between the various strands of work; that the name 21st Century appeared to have gained some traction with partners and the public so a suggestion was made to badge all of the integrated working under this single heading.

However from discussions with colleagues in the south of the County/City this is not felt to be the right outcome for their programme of work as they wish any changes to community services to be kept separate from the integrated working programme.

Nicola Longson
Programme Manager
April 2012

Jackie Pendleton
COO ND CCG
April 2012

North Derbyshire Integrated Care Programme – Overview

Develop Person Centred Pathways

Introduce Mr and Mrs Taylor

Individual presents with need

- First contact
- Assess need
- Treatment (if app)
- Rehabilitation (if app)
- Maintenance
- Prevention

Individual has needs addressed

Initial areas of focus in pathways

- Discharge planning and processes
- 24/7 service provision to meet required outcomes
- Health and social care system navigation
- Single assessment accepted by all partner organisations
- Prevention opportunities and services

Steering Group

21st Century Health and Social Care Project

Health & Social Care Integrated Working Group
Steering Group - membership includes nominated leads from all partner organisations.

Task and Finish Groups for Priority Areas

Frail & Elderly
Sponsor – Ben Milton
Initial Priority Areas
- Complex with 2+ co-morbidities and dementia
- Complex NH patient
- End of Life

Respiratory
Sponsor – Rick Meredith
Initial Priority Areas
- Currently being defined
- COPD flagged

Groups To Enable/Enact Required Change

Shared Records

Finance/ Contracting

Engagement/ Communications

All groups include reps from all partner organisations

Focus on

- **Community and Person centred care**
- **Person centred outcomes**
- **Opportunities of Integrated Working**
- **Outcome of 21st Century consultation**

Project Highlight Report

Project	Southern Derbyshire Integrated Care System for Frail and Elderly
Start & end date	November 2011 – Sept 2013
Date	4 May 2012
Author	Dianne Prescott on behalf of SDCCG and SD Integrated Care Steering Group

Project Summary

Develop a whole system programme to develop an integrated care system for the frail and elderly as one of the highest priorities to improve care and deliver whole system financial sustainability.

Initially the intention was to focus the initial phase of this work in the city, but as the understanding of the model progressed it was agreed to extend the project to encompass the whole of Southern Derbyshire (and Erewash).

The Partner organisations are:

South Derbyshire Clinical Commissioning Group (including GP representatives)
Erewash CCG
Derby City Council Social Services
Derbyshire County Social Services
Derby Hospitals NHS Foundation Trust
Derbyshire Community Health Services Trust (previously Derbyshire PCT provider arm)
Derbyshire Healthcare NHS (previously Derbyshire Mental Health Trust)
Derbyshire Health United (out of hours primary care provider company)
East Midlands Ambulance service.

We are also engaging with voluntary and third sector organisations

The objectives of the integrated model are to

- To support the elderly to be as healthy as they can be
- To identify those at risk of poor health and support them at the earliest possible stage
- To maximise patient independence and enable the elderly to remain in their own homes where at all possible
- Provide timely and appropriate escalation of care to and within intermediate care in the home or to the appropriate level of care
- Ensure timely response
- Prevent avoidable hospital admissions

It is intended the integrated care system will provide:

- Robust patient register.
- A risk stratification tool suitable to identify elderly patients meeting the agreed criteria or at risk of requiring integrated care.
- Agreed protocols and care packages.
- Co-produced care plans fully involving patients and carers.
- Shared records and timely communication
- Co-ordinated integrated care delivery including social care.

- Care escalation and case conferencing.
- Aligned system incentives.

Project Plan Status

Project timeline attached, indicating progress against milestones

Progress to date

- Summary PID presented to Integrated Pathway Project Team
- Deloittes supported workshop to establish clear definition of frail and elderly
- Deloittes provided an interim report on financial impact/model of implementing integrated care pathway based on evaluation of selected case studies; developing SDCCG baseline
- Deloittes has provided a proposed integrated care pathway
- Additional interim programme support has been appointed
- Initial discussion with CLAHRC suggests more programme-based evaluation rather than clinical research evidence-based methodology across the pathway implementation
- Presentation to SDCCG Board 16 April 2012 on progress to date and next steps

Summary of work planned for the next period

- Appraise the current programme governance and programme controls to ensure progress to date has been adequately reflected, opportunity to assure the programme next stages can be implemented with appropriate accountability control and wider stakeholder engagement
- Reaffirm clear vision and Programme objectives/scope
- Review Programme Management structure to incorporate governance and assurance recommendations with agreed Terms of Reference to include role of Programme Sponsors
- Consider MoU to reflect governance and programme structure review
- Highlight any variation to programme staffing requirements and budget
- Draft stakeholder engagement plan also to reflect any proposed formal governance changes
- Draft Communications Plan utilising existing communication channels
- Develop draft Summary PID for SPOA
- Development of detailed PID template to be applied to approved integrated care proposals
- Development of Programme Risk and Issue Log with risk rating methodology as well as RAG status
- Ensure all financial data supplied to Deloittes to complete their Final Report
- Review of Deloittes financial modelling and agree next steps at Programme Board

Current Programme Risks

- Failure to secure non-recurrent programme support costs
- Limited success of Integrated care systems on reducing admissions
- Poor integration of programme with other care pathway initiatives

Issues for Escalation

None

Dianne Prescott
Part-time Programme Director
30 April 2012

Progress Update

Integrated Care Programme Sponsors Group

Southern Derbyshire Clinical Commissioning Group - Integrated Care Pathway for Frail and Elderly

On 26 April 2012, the Integrated Care Programme Board agreed to appraise the current programme governance and programme controls to ensure progress to date has been adequately reflected, based on existing strong strategic support and direction, and to afford the opportunity to assure the programme next stages can be implemented with appropriate accountability control and wider stakeholder engagement.

Accordingly the vision and objectives of the Programme will be reaffirmed to support the development of a Stakeholder Engagement Plan and Communications Plan. Shirley-Ann Carvill has been appointed to provide additional programme support to our Part-time Director Di Prescott and will be drafting recommendations for the approval of the Programme Board and SDCCG Board. The overall patient benefits from implementing an integrated care pathway will be emphasised as the initial driver was based on identifying financial gains that has proven difficult to fully establish from existing integrated care pathfinders.

A recent stakeholder workshop, supported by Deloittes, was held to gain participation of health and social care partners in establishing a clear definition of frail and elderly. Deloittes are continuing with their financial scoping of an integrated care pathway for Southern Derbyshire and are due to submit their final report. As part of their remit they will assist in defining the scope of the population to be included in the initial development of the integrated care pathway that is currently aimed at the over 75 population. Additionally the Project Team are progressing the development proposal for Single Point of Access whilst formalisation of any new governance is considered.

A presentation was given on 16 April 2012 to the SDCCG Board to update on progress and GPs were enthusiastic to see the Programme move forward and to be actively involved.

The SDCCG Integrated Care Programme will continue to work with Partners in North Derbyshire to align pathway development and the formal role of the Programme Sponsors Group will be included in the governance review.

Andy Layzell

Chief Operating Officer

Southern Derbyshire Clinical Commissioning Group