DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE ADULT CARE BOARD

THURSDAY 18 SEPTEMBER 2014
2:00PM TO 4:00PM
MEMBERS ROOM, COUNTY HALL, MATLOCK, DERBYSHIRE, DE4 3AG

AGENDA

	Time	Item	Lead	Information/ Discussion/ Decision
1	2:00pm	Welcome & Introductions	Cllr Neill	
2	2:05pm	Minutes from the meeting held on 17 July 2014 (attached) and Matters Arising	Cllr Neill	Information
3	2:15pm	Health and Wellbeing Board (attached)	James Ilott	Discussion
4	2:30pm	Direction of Travel Mental Health	Julie Vollor/Dave Gardner/ Sue Whetton	Decision
5	2:45pm	Healthwatch Update	Peter Arnold	Information
6	3:00pm	Public Health Report (attached)	Eleanor Rutter	Information
7	3:15pm	BCF Update • Risk Share and IEG File • Information Sharing Protocol	Cllr Neill	Information
8	3:45pm	Joint Dementia Strategy – Measures (attached)	J Vollor	Information
9	4:00pm	**FINISH** The next meeting of the Adult Care Board will take place on Thursday 20 November 2014 at 2:00pm in Members Room, County Hall, Matlock		

Apologies – Cllr Dave Allen, Mary McElvaney

Karen Lynam
Acting Minute taker for Mary McElvaney, Strategic Director - Adult Care Department
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DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

MINUTES OF A MEETING HELD ON THURSDAY 17 JULY 2014 AT 2:00PM DERBYSHIRE COUNTY COUNCIL, COMMITTEE ROOM 1, MATLOCK HQ

PRESENT:

Cllr Clare Neill	CN	Derbyshire County Council Cabinet Member (Adult Social Care) **Chair**
Cllr Dave Allen	DA	Derbyshire County Council Cabinet Member (Health & Communities)
Cllr Wayne Major	WM	Derbyshire County Council Shadow Cabinet Member
Mary McElvaney	MMcE	Derbyshire County Council – Acting Strategic Director (Adult Care)
Andrew Milroy	AM	Derbyshire County Council – Adult Care
Julie Vollor	JV	Derbyshire County Council – Adult Care
Mat Lee	ML	Derbyshire Fire and Rescue
Peter Arnold	PA	Derbyshire Healthwatch
Lynn Wilmott-Shepherd	LWS	Erewash CCG
David Gardner	DG	Hardwick CCG
Niki Cartwright	NK	North Derbyshire CCG
Jo Smith	JSm	South Derbyshire CVS
Jenny Swatton	SW	Southern Derbyshire CCG
Eleanor Rutter	ER	Derbyshire County Council (Public Health)

IN ATTENDANCE:

Karen Lynam	KL	Derbyshire County Council - Adult Care (Minutes)

APOLOGIES:

Cllr Lillian Robinson	North East Derbyshire District Council
Jacqui Willis	NDVA
Clive Newman	Hardwick CCG
Kaye Knowles	Probation
Andy Layzell	Southern Derbyshire CCG
Roger Miller	Derbyshire County Council – Adult Care
Steve Pintus	Derbyshire County Council (Public Health)
Tony Morkane	Derbyshire County Council (Public Health)
Jayne Needham	Derbyshire County Council (Public Health)
Narinder Sharma	Derbyshire Carers
Gavin Tomlinson	Derbyshire Fire and Rescue
Umar Zamman	Derbyshire Fire and Rescue
Karen Macleod	Derbyshire Probation

Brian McKeown	Derbyshire Police
Cllr Barbara Harrison	Erewash Borough Council
Rakesh Marwaha	Erewash CCG
Avi Bhatia	Erewash CCG
Jim Connolly	Hardwick CCG
Andy Gregory	Hardwick CCG
Steven Lloyd	Hardwick CCG
Jackie Pendelton	North Derbyshire CCG
David Collins	North Derbyshire CCG
Andrew Mott	Southern Derbyshire CCG
Cllr John Lemmon	South Derbyshire District Council
Clare Watson	Tameside & Glossop CCG
Sarah Hadfield	

Minute No	Item	Action
	WELCOME FROM CLLR NEILL AND APOLOGIES NOTED	
ACB 024/14	**MINUTES FROM THE MEETING ON 15TH MAY 2014 & MATTERS ARISING** The minutes from 15th May 2014 were accepted as a true and accurate record. Matters Arising not on Agenda: JV – Joint Dementia Strategy Milestones to be brought back to the next meeting. CN asked for the Health and Wellbeing Board to be a standard agenda item. This will enable notes to be shared with the Children's Trust and enable them to report to each other. KL to send to James Ilott.	JV/KL KL
025/14	**VULNERABLE ADULTS RISK MANAGEMENT (VARM)** Mat Lee provided a verbal update and spoke about a case study that Derbyshire Fire and Rescue Service (DFRS) have conducted. He explained the process and how information can be shared. In order to meet the VARM criteria the person must be a high risk. Referrals are now coming from Adult Care straight to DFRS. People that hoard are a real risk for fire. DFRS ran an awareness event in May which was well received and a good opportunity for all agencies to get together. MMcE said that the Peer Review team was very impressed with the theme on Safeguarding and thought VARM was good practice.	

026/14	**<u>LOCALITY PROJECT CHESTERFIELD</u>** AM provided a handout presentation and gave an overview. DCC are developing a good relationship with Public Health and North Derbyshire CCG at a locality level. The objective is to provide a safe, sustainable, integrated and effectively coordinated system of personalized adult care and support, working in, with and for the community. This will: • Develop a network of engaged professionals. • Build a programme of community capacity development work based on one or two GP practice communities located in Chesterfield neighborhoods with priority needs. • Map existing community assets and needs. The project is still in its early stages and a workshop to explore community social work and community capacity will be set up. Initial meetings have taken place. Next stage is to widen out to all that are relevant. AM will take a paper to SMT on evidence based approach in the future.	
027/14	**<u>CCG 5 YEAR PLANS/UNITS OF PLANNING</u>** o LWS – their plans were re-submitted 20 June 2014 – no feedback yet. o JSw – BCF is part of their plans. o Adult Care/Voluntary Sector to sign off plans. Action – JSw to let MMcE know. o CN and DA do integration board between them. Erewash – two groups of work being done/workshops re understanding what motivates people to go to A&E at certain times. South Derbyshire – review of single point of access – Adult Care staff are working with this group.	**JSw**

028/14	**<u>BETTER CARE FUND (BCF) SHARED RISKS AND REWARDS</u>** **<u>BCF UPDATE</u>** Julie Vollor provided an updated report on the BCF. The purpose of the report is to update the Adult Care Board with three key areas: • Government announcements made on 5 July 2014 which changes the national policy implementation arrangements for the Better Care Fund. • The requirement for all areas to resubmit their BCF plans in response to these changes. • Our local response and next steps. Regional and national assurance has been taking place to assess BCF plans against national requirements. o The ability of plans to demonstrate evidence based schemes to reduce avoidable emergency admissions to a sufficient level of ambition. o The involvement of acute providers in approving local plans. o There is now a very strong emphasis on the avoidable emergency admissions metric. o Pay for performance has been re-introduced. o A requirement that a proportion of the funds allocated from 2015/16 are spent on NHS provision outside of acute hospital settings. Recommendation: • Consider and discuss the implications of the changes outlined in the report. • Approve the next steps/actions as set out in the report. • Provide joint leadership and support in directing the work of the Joint Commissioning Co-ordination Group over the next period of BCF resubmission. CN and DA attended NNE CCG. They are to let CN have their project initiation document. These will be passed around the group.	
029/14	**<u>SPECIALIST HOME CARE EVALUATION</u>** Becky East (Derbyshire County Council Needs and Intelligence Team) was in attendance for this item. She provided an overview of the paper. The report can be shared and will be enclosed with these minutes.	**KL**

030/14	**HEALTHWATCH** • Peter Arnold provided an updated report on Healthwatch which is to share relevant public opinions and experiences in an evidenced based way to inform and influence key stakeholders from across the health and care community in Derbyshire. • A further update will be provided at the next meeting in September.	**PA**
031/14	**ANY OTHER BUSINESS**	
	The next meeting of the Adult Care Board will take place on Thursday 18 September 2014 at 2:00pm in Committee Room 1, County Hall, Matlock.	

DERBYSHIRE
County Council
Improving life for local people

Health and Wellbeing Strategy 2015-17

Bringing in a sharper focus

Steve Pintus and James Ilott

DERBYSHIRE
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Refresh-the approach

- The existing life course approach continues to provide the spine for the approach in Derbyshire
- Much of the work in the previous strategy continues to address the challenges identified by information and intelligence
- The refresh identifies the need for a sharper focus where the Health and Wellbeing Board can succeed through its leadership to bring about significant impact on the outcomes of the strategy
- The four themes identified apply across the life course and represent the components necessary for a sustainable future relationship between public services and the people of Derbyshire

DERBYSHIRE
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The vision for Derbyshire

To reduce health inequalities and improve health and wellbeing across all stages of life by working in partnership with our communities

- **Outcome 1**: Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life.
- **Outcome 2**: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

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Proposed Strategic approach

- **Derbyshire as a healthy place** – key element of Marmot and a focus on wider determinants
- **Resilience** – a positive shift away from seeing people as vulnerable and dependent
- **Integration** – a recognition that no one agency has the solution
- **Inequity** – recognising the importance of fairness in tackling health inequalities

Under each priority area identify flagship actions and key measures of success

Question for discussion:

- **What is the key initiative which would benefit from the ownership and leadership of the HWB to help achieve success?**

ADULT CARE BOARD

18 September 2014

DERBYSHIRE JOINT VISION AND STRATEGIC DIRECTION FOR MENTAL HEALTH

Direction of Travel

a) Purpose of the Report

The purpose of this report is to:

- Provide an update on the development of the revised Derbyshire Joint Vision and Strategic Direction for Mental Health
- To seek endorsement for the proposed high level themes set out in the direction of travel document at Appendix 1
- To seek endorsement for the Joint Derbyshire Mental Health Commissioning Group to engage with stakeholders to develop action plans and determine priorities based on these themes whilst keeping Directorate (DCC), CCG Governing Boards and the Adult Care Board informed.

b) Information and Analysis

Background

The 2007, "Derbyshire Vision and Strategic Direction for Adult Mental Health' document was originally planned to span ten years to 2017. However, in July 2013, the Adult Care Board approved a rewrite of the document to take account of a significant number of changes to the national policy context and new legislation, a new national strategy - No Health without Mental Health, as well as local strategic changes in commissioning and service delivery.

The strategy relates to the mental health needs of people aged 18 and above, including people with a dual diagnosis and people in transition from children and young people's services, or from prison or forensic services. The strategy excludes the needs of people with dementia as these are addressed in a separate Joint Dementia Strategy.

The strategy covers services that are currently commissioned and those that will be commissioned by:

- Derbyshire County Council Adult Care (DCCAC)
- Derbyshire County Council Public Health (DCCPH)
- NHS Southern Derbyshire Clinical Commissioning Group (SDCCG)
- NHS North Derbyshire Clinical Commissioning Group (NDCCG)
- NHS Erewash Clinical Commissioning Group (ECCG)
- NHS Hardwick Clinical Commissioning Group (HCCG)

The strategy excludes services commissioned by Tameside and Glossop Clinical Commissioning Group.

Hardwick CCG has a County lead role in the NHS for commissioning and contracting for mental health services and has jointly developed the draft strategy with DCC Adult Care and Public Health.

All work will be governed by the Adult Care Board and Health and Wellbeing Board but will be overseen by the Derbyshire Mental Health Joint Commissioning Board of which membership includes:

- Derbyshire County Council Adult Mental Health Commissioning Lead
- Derbyshire County Council Public Health Mental Lead
- Hardwick CCG Mental Health Commissioning Leads (representing all CCG's and with open invitation for all CCGs to attend)
- GP clinical leads.
- Southern Derbyshire Voluntary Sector Mental Health Forum representative
- North Derbyshire Voluntary Action - Mental Health representative
- Healthwatch – Mental Health representative
- Derbyshire Voice – service receiver representatives

Context

Mental health is moving up the policy agenda across government and improving outcomes for people with mental health problems has been reflected in a number of recent policies and guidance including, 'No Health without Mental Health' (2011) and more recently 'Closing the Gap' (2014). As a result, the health and social care community need to jointly respond by transforming the support and care available to people with mental health problems. This means not only focusing on delivering a choice of high quality treatments and support to those who need them but also by focussing on promotion, prevention and parity of esteem. Parity of esteem will ensure that there will be earlier identification of mental health needs and preventive strategies put in place so that mental health and physical health needs are treated in a joined up way.

Another recent key publication requiring an urgent partnership response is the Crisis Concordat (2014) which aims to bring all key partners together to agree strategies for the prevention of mental health crises where possible and in making sure effective crisis and emergency response systems are in place.

The Care Act (2014) brings care and support legislation into a single statute. It is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. To promote individual wellbeing, people's needs, views, feelings and wishes should be considered in all aspects of people's wellbeing from physical and mental health, through dignity and respect to control over their daily needs, access to employment, education, social and domestic needs and the suitability of their accommodation.

The Better Care Fund, which comes into full effect in 2015/16, is intended to further develop integration of health and social care for the benefit of the individual. In 'Integrated care and support: our shared commitment', integration was defined by National Voices as being able to '*plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me'*. This closely echoes the messages from local consultation and engagement.

To support the delivery of more integrated and personalised care, commissioned services will need to be based on recovery approaches, personalisation and delivering social inclusion outcomes using a whole system approach which pays attention to, and supports a wide range of options. This includes for example, support from friends and families, universal and community services, individual purchasing and broader commissioning, and person-centred options for treatment and emergency support. There will need to be development of integrated mental health pathways, rather than stand-alone specialist services. This will require a whole-system approach, recognising the need to build on and strengthen individual and community assets.

Derbyshire Healthcare Foundation Trust (DHcFT), the main provider of secondary mental health services across Derbyshire, is currently implementing a significant Transformation programme. New patient pathways are proposed that will require significant realignment of the workforce and workforce development to meet the implementation requirements of the National Mental Health Tariff Payment System and for integration between primary and secondary mental health services.

Integration of mental health specialist services with primary care integrated teams is a key concern for Clinical Commissioning Groups.

Progress to date

Since the last report to the Adult Care Board the following actions have taken place in relation to development of the revised strategy:

a) Detailed analysis of feedback from the Health and Wellbeing strategy consultations held in March 2012. This consultation process provided very rich data from a wide range of stakeholders around priorities for mental health in Derbyshire and has helped to determine the proposed vision statement, high level themes and commissioning intentions for the new draft strategy.
b) An extensive desktop review of current mental health policies, strategies, commissioning frameworks, guidance and best practice examples to determine statutory requirements, national strategic objectives, quality indicators and commissioning principles.
c) A review of what has been achieved against the priorities of the existing strategy 2007-17

d) Formal and informal consultation and engagement with a range of stakeholders including partners, service receivers, carers, statutory and voluntary sector providers and their representatives.
e) Development of the Direction of Travel document and identification of high level themes in partnership with Adult Care, Public Health and Hardwick CCG.
f) An engagement event held on 25th September 2013 with service receivers and service receiver representatives. The reasons for the strategy refresh and the proposed high level themes at Appendix 1 were validated and endorsed.
g) Service receiver and carer views gained from DHcFT engagement around their Transformation agenda.
h) Informal discussions regarding the principles of the proposed high level themes with key representatives of Derbyshire's four Clinical Commissioning Groups.

Additionally, each of the CCG's has been involved in extensive engagement and consultation around their annual locality action plans.

c) <u>Proposed Further Action</u>

As the CCG's publish their refreshed action plans, relevant actions will be incorporated into the wider Derbyshire County Mental Health Strategy annual action plan. Additionally, any relevant actions from the Better Care Fund plan and the Locality Public Health plans will also be incorporated. The annual Mental Health Strategy action plans will be managed through the Joint Commissioning Board for Mental Health and progress will be reported to the Adult Care Board and Health and Wellbeing Board.

Action plans will be agreed annually throughout the five year life of the draft strategy and the strategy document will be revisited on a regular basis and refreshed where necessary to reflect any major changes to policy and legislation.

<u>Engagement – Next steps</u>

As the high level themes in the draft strategy were identified through extensive national stakeholder engagement as well as local consultation and engagement feedback, it is not proposed to consult more widely on the themes but rather on the detail and priorities underneath. It is therefore proposed to work with the themes detailed at Appendix 1, in partnership with CCG's, Public Health, Police, Probation, statutory and voluntary sector providers, service receivers and carers to develop and deliver precise plans and costed priorities.

Opportunities for service receiver and carer engagement will be project planned alongside each action, i.e., involvement in themed work streams, (such as pathway development, suicide strategy, outcomes monitoring etc.) as well as opportunities for engagement in decision making about future priorities.

As the proposed Partnership Board evolves it is intended that this will be a wider stakeholder forum to discuss Derbyshire-wide strategic issues such as the Crisis Concordat and the Suicide Strategy.

Crisis Care Concordat

In response to the Crisis Care Concordat (February 2014), across England, local partnerships of local authority, health and criminal justice agencies are being asked to agree and commit to

- A jointly agreed declaration that mirrors they key principles of the national Concordat, a commitment for local agencies to work together to continuously improve the experience of people in mental health crisis
- Development of a shared action plan and a commitment to review, monitor and track improvements
- Improving performance in the key area of using police stations as places of safety – by reducing the number of such uses, and by working towards a fast-track assessment process whenever a police cell is used
- Evidence of sound local governance arrangements

Hardwick CCG has taken the lead role for co-ordinating a multi-agency group to bring together local informatics and intelligence on the Concordat themes. A Mental Health Summit was held on 25th June 2014 and a further partnership event will be held in the autumn with the aim of producing the Derbyshire multi-agency action plan for the Health and Wellbeing Board.

Development of co-production model of service receiver and carer engagement

At the service receiver stakeholder event held in September 2013, attendees were consulted about how they wish to be engaged in the future development of the strategy and there was strong consensus for developing genuine co-production opportunities. In response to this, (along with economic drivers) an independent review of mental health service receiver and carer engagement mechanisms is currently underway in partnership with Adult Care, CCG's, Derbyshire Healthcare Foundation Trust and Derby City Council. The recommendations of this review (due September 2014) will be considered by the Engagement Project Board and respective partner agencies prior to a further period of stakeholder engagement. The outcome of this process will ensure a sustainable partnership model for future engagement and co-production opportunities in commissioning decisions and to ensure that client and carer experience feeds into a continuous service improvement process related to mental health in Derbyshire.

Development of a shared outcomes framework

Hardwick CCG commissioned Southern Derbyshire Voluntary Sector Mental Health Forum (SDVSMHF) to assist health and adult care commissioners in developing shared outcome measures across mental health voluntary sector grant funded organisations. Work so far has included an audit of existing CCG and Adult Care funded Service Level Agreements and an extensive survey completed by grant funded Provider organisations. A Provider Event

hosted by SDVSMHF and North Derbyshire Voluntary Action (NDVA) on 25th March focussed on identifying outcomes and outcome measures related to the proposed high level themes. Following Adult Care Board approval of the direction of travel, it is proposed to develop and implement a shared outcome framework across voluntary sector commissioned services that will be aligned to the high level themes of the strategy.

A shared outcome framework will help to drive integration and enable organisations to ensure that outcomes for individuals are in alignment with the strategic objectives as well as providing robust evidence of the value of their service in order to attract wider sources of funding. It will also enable commissioners to identify gaps in support at a strategic level as well as strengthening existing client feedback mechanisms to promote continuous service improvement.

Finalising the strategy document

The Direction of Travel document will be circulated to governing bodies of CCGs and partners for comment prior to the draft Joint Vision and Strategic Direction for Mental Health being finalised. This will then be presented to the Adult Care Board for recommendation and for endorsement by the Health and Wellbeing Board.

Financial Considerations:

The funding streams indicated for the strategy vary across a number of departments and agencies and will need to be negotiated on an annual basis between Adult Care, Public Health and Clinical Commissioning Groups.

Some joint commissioning arrangements may also be made in collaboration with neighbouring authorities where appropriate to achieve economies of scale.

The Joint Commissioning Group is mindful of the need to refer back to the Adult Care Board for decisions which involve any significant service change. The group is also aware of the need to refer back if any significant decommissioning is proposed.

Action plans will reflect the need to deliver savings across the sector.

Officer Recommendation

For Adult Care Board to note and endorse the Direction of Travel document as well as the recommendations in the 'Proposed Further Actions' section of this report.

Julie Vollor
Assistant Director
Strategy and Commissioning
Adult Care

Dave Gardner
Assistant Director
Procurement and Commissioning
Hardwick CCG

The Joint Vision and Strategy for Mental Health in Derbyshire County 2014 - 2019

Direction of Travel

The Vision

"People are able to achieve positive mental health by having access to high quality, local mental health services, appropriate to levels of need, as well as a range of support that enables self-management, recovery and wellbeing"

What will be different over the next five years?

There will be improved:

- Integration of services and resources at community and provider level
- Information about services and resources available
- Choice of evidence based treatments and support
- Provision of support for people experiencing crisis
- Support to find meaningful occupation or employment
- Support to address both mental health and physical health needs
- Support and involvement for carers
- Integration between children and younger adults and adult mental health services

There will be more:

- Integration and co-ordination of care resulting in seamless wrap-around support
- Service receiver control and choice in care planning
- Involvement of service receiver and carers in the decision making processes about service provision and support
- Effective use of specialist (secondary)care services targeted at those who need them the most and at a time when they need it
- Attention to the physical health of people with mental health problems (and vice versa)
- Raising awareness of mental health and wellbeing and tackling stigma in local communities.

There will be less:

- Inequity of provision of services across the County
- Avoidable harm and injury
- Stigma and discrimination associated with mental ill health
- Dependency on out of area admissions for those with acute care needs

1. Background

This document sets out the proposed direction of travel for the joint vision and strategy for mental health services across Derbyshire.

Some of the most vulnerable groups in our community are those who experience mental ill health. The overarching aims of the strategy will be to reduce health inequalities, strengthen investment in prevention, and deliver high quality care by demonstrating a collective commitment to improving the health, well-being and outcomes for people experiencing mental ill health in Derbyshire.

The Joint Vision and Strategic Direction for Mental Health will continue to be developed collaboratively with all key partners and stakeholders in the NHS, Local Authority, and Voluntary Sector and with service receivers and carers.

The intention is that the Joint Vision and Strategic Direction for Mental Health will be a 'live' document that will be responsive to changing national or local drivers and policy changes. The vision and strategy will

- Take account of national, regional and local drivers, policies and priorities relating to adult mental health and wellbeing across health and social care.
- Guide the commissioning and provision of mental health services across Derbyshire.
- Outline a joint strategic vision for mental health in Derbyshire for the next five years
- Identify common high-level strategic 'themes' shared across health and social care
- Inform the development and implementation of annual joint commissioning action plans for 2014-19.

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2. Context

It is estimated that 1 in 4 people will experience mental ill health at some stage in their life. Mental health difficulties are wide-ranging in nature from common mental health problems such as anxiety and depression to more severe and enduring conditions such as personality disorders and psychosis. Mental ill health is also a major cause of poor physical health. The number of adults in Derbyshire estimated to have a common mental health problem is approximately 93000.

There are a number of factors that place an individual at higher risk of developing mental ill health such as unemployment, poor housing and physical ill health , and therefore, as well as reviewing levels of prevalence and use of services, it is also important to consider the wider determinants of health within Derbyshire. A recently published summary of mental health indicators highlighted that the following are significantly worse in Derbyshire compared to England:

- The proportion of the population with a limiting long term illness, and over 50% of people with a long term physical health condition such as heart or lung disease, diabetes or arthritis will also have a mental health problem
- Hospital admission rates for mental health, in particular admission rates for unipolar depressive disorders and self-harm
- 16-18 year olds not in employment, education or training
- The rate of hospital admissions for alcohol attributable conditions

Wider determinants of health vary across Derbyshire and these are known to have a significant impact on mental health. It is therefore important that these are taken into consideration when planning and developing services and support. Examples of wider determinants likely to have an impact on mental health in Derbyshire include;

- Within Bolsover and Chesterfield more than 1 in 4 people live in the most deprived areas, compared to 1 in 50 in Derbyshire Dales
- Variation in long-term unemployment rates across the county, with rates higher than the national rate in Chesterfield and Erewash
- An estimated 5% of households are living in fuel poverty, but this ranges from 0.5% in Hilton ward in South Derbyshire to 13.3% in Ashover ward in North East Derbyshire
- Rates of violent crime in Derbyshire are lower than the England rate, however Chesterfield and Erewash both have rates higher than the national rate

Additionally, current welfare reforms, changes to housing support and local authority spending cuts will potentially impact on the level of mental health need within Derbyshire. The impact is likely to be disproportionate across the population, with groups most affected including workless households, lone parents, and disabled people.

There is currently variation in service provision across Derbyshire meaning that people with mental health needs are not able to access equitable services.

Further information on the mental health needs of Derbyshire can be found in the following resources:

Community Mental Health Profile for Derbyshire
www.nepho.org.uk/cmhp/index.php?pdf=E10000007

Health Profiles (available at county and district level)
www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

Derbyshire Health Needs Assessment 2011
http://observatory.derbyshire.gov.uk/IAS/Custom/resources/HealthandWellbeing/Health_Needs_Assessments/Derbyshire_MHNA_Sept2011.pdf

Equity in Mental Health Services in Derbyshire
http://observatory.derbyshire.gov.uk/IAS/Custom/resources/HealthandWellbeing/Mental_Health_Profiles/Equity_in_MH_services_in_Derbyshire_report.pdf

Mental Health Locality Profiles
https://observatory.derbyshire.gov.uk/IAS/healthandwellbeing/healthprofiles/mentalhealthprofiles.aspx

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3. Key Drivers

No Health without Mental Health

In February 2011, the Government launched the new mental health strategy **"No Health Without Mental Health; a cross Government mental health outcomes strategy for people of all ages"** that marked out the intention to bring a "parity of esteem" between mental health and physical health with the aim of improving health and wellbeing outcomes for people with mental health problems. The key aims of the strategy are person-centred care with a strong emphasis on locally derived priorities and locally designed service delivery.

A wide range of partner organisations, including user and carer representatives, providers, local government and government departments, worked with the Department of Health to agree a set of shared objectives to improve mental health outcomes for individuals and the population as a whole. The six shared objectives are as follows:

- **More people will have a positive experience of care and support**
  Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their lives, in the least restrictive environment and should ensure that people's human rights are protected

- **More people will have good mental health**
  More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems by starting well, developing well, working well, living well and ageing well

- **More people with mental ill health will have good physical health**
  Fewer people with mental health problems will die prematurely and more people with physical ill health will have better mental health

- **More people with mental health problems will recover**
  More people who develop mental health problems will have a good quality of life, a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable place to live

- **Fewer people will experience stigma and discrimination**
  Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease

- **Fewer people will suffer avoidable harm**
  People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service

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Other key relevant policies, legislation and commissioning frameworks since the last strategy was written in 2007 are listed below:

- Department of Health's Commissioning framework for health and well-being (2007)
- Vision for Adult Social Care: Capable Communities and Active Citizens" (2010)
- Equity and excellence: liberating the NHS (White Paper 2010)
- Equalities Act (2010)
- Think Local, Act Personal: Next Steps for Transforming Adult Social Care (2011)
- National Mental Health Strategy: No Health without Mental Health (2011)
- No Health without Mental Health Implementation Framework (2012)
- Health & Social Care Act (2012)
- Transforming Care: a national response to Winterbourne View Hospital (2012)
- Caring for our Future: reforming care and support (White Paper 2012 / Care Bill 2013)
- The Francis Report (2013)
- Emergence of Health & Wellbeing Board and Clinical Commissioning Groups (2013)
- Development of national outcomes frameworks for Adult Social Care, NHS and Public Health (2012/13)
- The NHS belongs to the people: A Call to Action (2013)
- A Future Vision for Mental Health (2013)
- Starting today – The future of mental health services (2013)
- Whole-person care: Achieving parity between mental and physical health (2013)
- Closing the Gap (2013)
- Crisis Care Concordat (2014)
- The Care Act (2014)
- No assumptions – a narrative for personalised, co-ordinated care and support in mental health (2014)
- Publication of a number of National Institute for Health and Care Excellence quality standards and pathways of care
- Implementation of the National Tariff Payment System for secondary care mental health services

The key messages and headlines from the above are illustrated in the table below:

Fig 1: Key Policy Headlines	
1. Evidence based commissioning	2. Values based commissioning
3. Commissioning for outcomes	4. Partnership working
5. Employment opportunities	6. Volunteering opportunities
7. Parity of esteem	8. Access to education
9. Tackling inequalities	10. Increasing resilience / self-management
11. Prevention	12. Early intervention
13. Integration	14. Community Engagement / Participation
15. Recovery	16. Peer support
17. Tackling stigma and discrimination	18. Support for carers
19. Asset-based development	20. Involvement and co-production
21. Information, advice and advocacy	22. Choice and control
23. Personalisation	24. Personal budgets
25. Seamless, integrated pathways of care	26. Access to specialist services
27. Crisis resolution / crisis response	28. Improved primary care mental health offer

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4. The Vision for Mental Health Services in Derbyshire County

"People are able to achieve positive mental health by having access to high quality, local mental health services, appropriate to levels of need, as well as a range of support that enables self-management, recovery and wellbeing"

The vision for mental health is aligned with the Derbyshire Better Care Fund vision and approach that is focussed on achieving a seamless health and social care system involving:

- Maximising the health and wellbeing of the population
- Placing the person at the centre of service planning and delivery
- Making best use of available funding by challenging assumptions and embracing innovation
- Ensuring organisational boundaries do not get in the way of a seamless service for local people
- Recognising the value of social capital
- Building on current joint workforce planning
- Strengthening partnerships at a community level

The model below (taken from Better Care Fund document) illustrates the direction of travel for the health and social care community in Derbyshire. The proposed themes and commissioning intentions for mental health in Derbyshire are in alignment with this.

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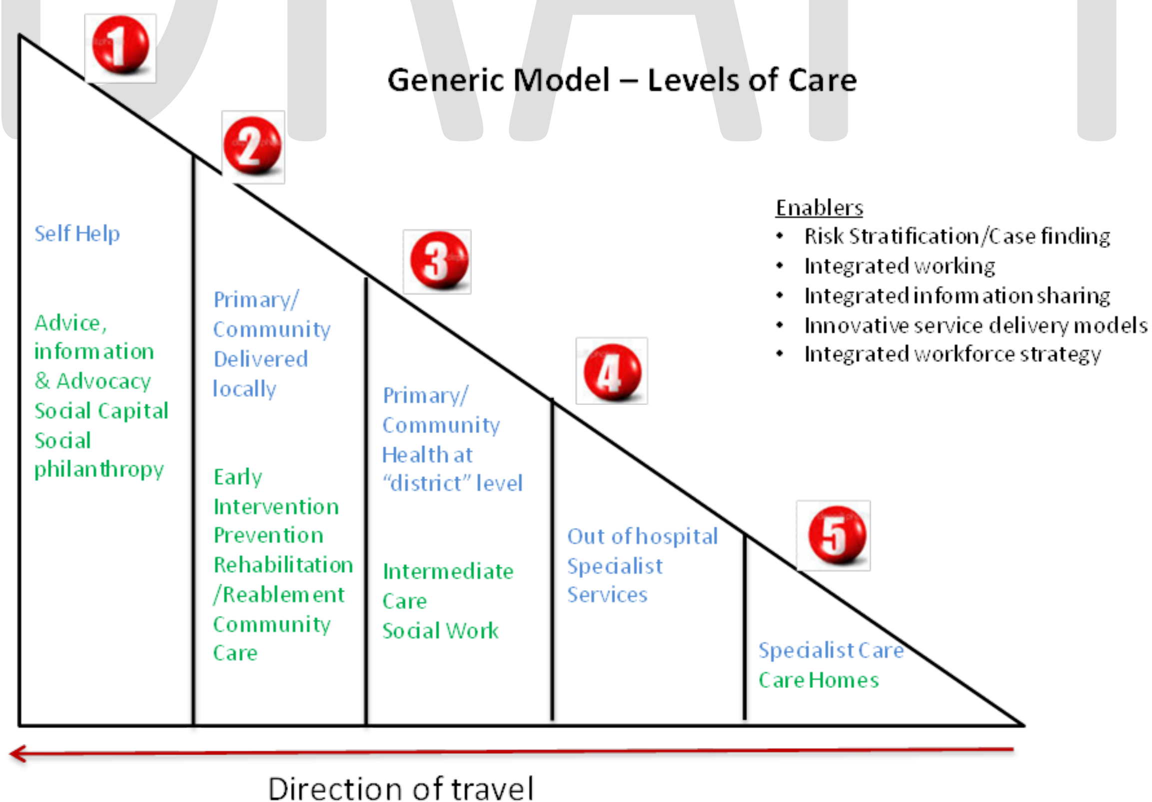
Fig. 2 Direction of Travel for Derbyshire health and social care community



To support the delivery of integrated and personalised care, commissioned services will need to be based on early intervention, recovery approaches, personalisation, and delivering social inclusion outcomes using a whole system approach which pays attention to, and supports, a wide range of options. This includes for example, support from friends and family, universal and community services, individual purchasing and broader commissioning, and person-centred options for treatment and emergency support. There will need to be development of integrated mental health pathways, rather than stand-alone specialist services. This will require a whole-systems, whole-person, innovative approach that is responsive to local need and which recognises the need to build on and strengthen community assets.

Our aim is to work collaboratively and to commission services that:

- Are equitable
- Are focussed on recovery and provide the best possible outcomes for service receivers, their families, and their carers'
- Are person-centred and provide service receiver choice and control
- Recognise the importance of early intervention
- Meet the challenge of addressing stigma and discrimination
- Support individual needs through flexible service provision
- Support people to remain independent in their own home and community
- Maximise available resources and focus on collaboration between agencies
- Work collaboratively across administrative boundaries
- Provide services as close to a person's home as possible
- Respond to people in crisis at the point of need
- Ensure parity of esteem
- Are high quality, evidence-based and draw on best practice
- Promote dignity and respect

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5. Proposed Strategic Themes

The proposed strategic themes have been developed in response to key policy drivers, local consultation and engagement feedback and the commissioning intentions of Derbyshire Clinical Commissioning Groups (NHS) and Derbyshire County Council in working to a joint strategy. All commissioning intentions will meet at least one of the six themes. There will be a strong focus on outcomes and each theme will have agreed actions. Each action will have clearly identified work streams and governance arrangements and progress and delivery of outcomes will be monitored by the Joint Mental Health Commissioning Board.

Engagement on each of the themes and actions will be evidenced as part of the review process.

Fig 3: Theme 1- Personalisation

Personalisation *"I am supported to take control, live more independently, and have more choice through well supported care"*
Personalisation is about meeting the needs of individuals in ways that work best for them, including recognising and supporting family carers. It is about empowering individuals to make informed decisions and choices about how they want to live their lives and the help they need to do so. It is also about equipping people with the information, freedom and confidence to manage their own health and take control of their lives. This involves building community resilience and wellbeing through local strategic commissioning so that people have a good choice of support including access to universal services, appropriate information and advice and access to self-help and support by user-led organisations.
Commissioning intentions: • Promote and improve involvement, engagement and co-production opportunities with service receivers and carers in the design, delivery and evaluation of services • Promote and develop personalised approaches to care in all settings • Maximise choice and control • Promote individual and community assets • Improve support and involvement for carers by working with them to better understand their needs • Encourage the use of health and social care personal budgets for mental health service receivers whilst ensuring that those who wish to can still access more traditional forms of care

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Fig 4: Theme 2- Promotion, prevention and early intervention

Promotion, prevention and early intervention *"Support and help is available to me at an early stage if I begin to feel unwell or where circumstances in my life are likely to have a detrimental effect on my mental health"*
The greatest opportunities to reduce levels of mental ill health in the long term lie in mental health promotion, as well as mental illness prevention and early intervention. Early intervention through accessible, timely and responsive support and services as well as the provision of accessible information and advice promoting healthy lifestyles and overall wellbeing is key to recovery. This includes access to psychological therapies as well as regular health checks and recovery-focussed healthy lifestyle care planning (smoking cessation, weight management, tackling malnutrition, drug and alcohol misuse). Integrating physical health into decisions about prescribing and monitoring of medication is also important.
Commissioning intentions: • Improved and equitable access to a range psychological therapies • Wider public and targeted physical health and wellbeing intervention programmes to enable people to make informed choices and make positive lifestyle changes • Mental health awareness raising & promotion of wellbeing through national Time to Change campaign and local action plans • Improve the physical health and wellbeing of people with mental ill health • Liaison and diversion schemes, i.e. psychiatric liaison in hospitals • Improved and equitable access to services and support for those in crisis • Promotion of self-management approaches and improved management of long term conditions • Improved and accessible information, advice and advocacy

Fig 5: Theme 3-Enablement and recovery

Enablement and recovery

"I have opportunities for self-help and taking control and the information and advice I need to feel empowered and make choices"

Recovery-oriented* services aim to support people to build lives for themselves outside of mental health services with an emphasis on hope, control and opportunity. People who develop mental health problems should get as much support to gain a good quality of life, have stronger social relationships, a greater ability to manage their own lives, a greater sense of purpose, and the skills they need for living and working.

"Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life".

Commissioning intentions:

- Organisational transformation and workforce development
- Support for community-based self help
- Good quality, accessible information and advice
- Access to education and employment support opportunities
- Development of peer support opportunities
- Maximise individual and community assets
- Recovery focussed integrated care pathways

*Supports a user-centred concept of 'recovery' in which recovery is a personal journey of learning to live well, despite the continuing or long-term presence of mental health support needs.

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Fig 6: Theme 4-Social Inclusion, fair access and equity

Social Inclusion, fair access and equity

"Opportunities are available to me without discrimination or unfairness"

More people who develop mental health problems will have a good quality of life, a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable place to live

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease

Commissioning intentions:

- Promote and improve involvement, engagement and co-production opportunities with service receivers and carers in the design, delivery and evaluation of services
- Improved and equitable access to a range of psychological therapies
- Actively challenge stigma and discrimination through national Time to Change campaign and local action plans
- Improve accessibility to services and support to improve outcomes for those who find services hard to engage with
- Maximise individual and community assets
- Support people with mental ill health to stay in or enter employment
- Access to education and employment support

Fig 7: Theme 5-Keeping people safe from avoidable harm

Keeping people safe from avoidable harm

"There is a planned and balanced approach to crisis and risk that I feel confident in and does not undermine my sense of being in control of my life and my recovery"

This theme is concerned with improving the system of care and support so that people in crisis because of a mental health condition are kept safe by getting the right care at the right time and from the right people to ensure the best possible outcomes. This includes agencies working together to prevent crises happening whenever possible, through intervening at an early stage; to improve individuals' experience (people who use crisis care services, carers and professionals) and reduce the likelihood of harm to the health and wellbeing of service receivers, carers and professionals.

It is also concerned with strengthening clinical practice, positive risk management and continuity of care, so that people are protected from the risk of suicide.

Commissioning intentions:

- Improved and equitable access to services and support for those in crisis, avoiding hospital admissions where possible and appropriate
- Equitable access to specialist independent mental health and mental capacity advocacy
- Strengthen crisis response through a multi-agency partnership approach and develop Derbyshire Crisis Plan
- Support for individuals to develop person-centred safety and recovery plans
- Liaison and diversion schemes –police, hospitals, prisons, probation
- Continue to review out of county placements and repatriate people back to Derbyshire
- A refreshed suicide strategy and associated partnership action plan
- Implement the social care reforms set out in the Care Act 2014

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Fig 8: Theme 6-Integration

Integration

" I can easily access the right advice, support and treatment"

Promoting seamless care and service delivery across health and social care interfaces and other statutory and voluntary organisations with services wrapped around a person's needs and with individuals knowing what is available to them and from where.

Commissioning intentions

- Workforce and organisational transformation to achieve integration
- Strengthening partnerships at an organisational and community level
- Integration between primary and secondary care and social care
- Better continuity of care for mental health and physical health
- Continue to develop Liaison and Diversion schemes through partnership working
- Improved transition between child and adolescent and adult mental health
- Development of recovery-focused care pathways across health, social care and the voluntary sector
- Implementation of the National Tariff Payment System
- Integration of care and support between health, housing and social care
- Improved co-ordination between emergency and mental health services
- Implement systems and culture change to achieve the best outcomes for individuals as possible, making the best use of resources

healthwatch Derbyshire

Carers Discussion Paper

Definition of a Carer

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Anyone can become a carer; carers come from all walks of life, all cultures and can be of any age. Many feel they are doing what anyone else would in the same situation; looking after their mother, son, or best friend and just getting on with it. Many carers don't see themselves as carers. It takes carers an average of two years to acknowledge their role as a carer, as they find it difficult to see their caring role as separate from the relationship they have with the person for whom they care, whether that be parent, son or daughter, or friend. (NHS Commitment to Carers May 2014).

Carers don't choose to become carers: it just happens and they have to get on with it; if they did not do it, who would and what would happen to the person they care for? It's likely that every one of us will have caring responsibilities at some time in our lives, which may involve juggling caring responsibilities with work, study and other family commitments.

Some carers, in particular younger carers are not known to be carers. They don't tell relatives, friends or health and care professionals about their responsibilities because of fear of separation, guilt, pride or other reasons. This can make carers 'invisible'.

The roles and responsibilities of carers can vary hugely, from help with everyday tasks such as getting out of bed, personal care such as bathing and administering medication to emotional support such as helping someone cope with the symptoms of mental illness.

Young Carers are children and young people who often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. Some Young Carers may undertake high levels of care, whereas for others it may be frequent low levels of care. Either can impact heavily on a child or young person.

Context and Rationale

Carers are a hugely important asset to society, however too often carers do not receive the recognition and support that they need and deserve. We need to do more to help identify, support and recognise their vital roles. Helping carers to provide better care and to stay well themselves will contribute to better lives for those needing care.

NHS England produced their commitment to carers in May this year, which sets out a series of commitments that NHS England will do to support carers, reflecting what NHS England has heard from carers during a number of engagements.

These were the emerging themes that came out of the NHS England engagement exercise with carers and influenced their commitment to carers:

- Recognise me as a carer (this may not always be as 'carers' but simply as parents, children, partners, friends and members of our local communities).
- Information is shared with me and other professionals.
- Signpost information for me and help link professionals together.
- Care is flexible and is available when it suits me and the person for whom I care.
- Recognise that I may need help both in my caring role and in maintaining my own health and wellbeing.

- Respect, involve and treat me as an expert in care.
- Treat me with dignity and compassion.

Some of these emerging themes are mirrored in our own engagement activity.

This along with the Care Bill 2012, which for the first time ensures carers will be recognised in the law in the same way as those they care for, (i.e. carers will have legal rights to assessment and support), has prompted Healthwatch Derbyshire to produce this discussion paper. It looks at the experiences of carers in Derbyshire, with the hope that this will help to influence the design and delivery of services locally, at a time where there is commitment to change.

"The Care Bill in many respects marks a quiet revolution in our attitudes towards, and expectations of, carers. At last, carers will be given the same recognition, respect and parity of esteem with those they support. Historically, many carers have felt that their roles and their own well-being have been undervalued and under-supported. Now we have a once in a lifetime opportunity to be truly acknowledged and valued as expert partners in care." Dame Philippa Russell, Chair of Standing Commission on Carers.

Methodology

This report is based on the following evidence:

- 64 comments directly from carers on our database with a date range of 28th August 2013 – 5th August 2014.
- It is also based on discussions that took place during the 'Celebration of Young Carers Event' on the 11th July 2014, including a focus group with Young Carers.
- A focus group and one-to- one interviews with service users and carers with an acquired brain injury.
- Themes evidenced during a Carers Conference hosted by Healthwatch Nottinghamshire that backed up themes we had gathered.

Findings

Awareness of carers and understanding of their needs amongst GPs

- The Carers Voice Network expressed frustration that there was no access to last minute GP appointment to take into account their caring responsibilities and the inability to know when they will be free to go to the Doctors.
- Another carer said their GP was not supportive.
- Others we spoke to one carer who said that their GP doesn't even know they are a carer, and has not asked.
- Littlewick GP Practice have a carer's champion, and one carer feels there should be one at their practice.
- In conversations carers said that they did not know that they should be registered as carers with their GP practice.
- From our information it would appear information about support groups/services doesn't seem to happen through GPs.

Knowledge and information

- A group of carers supporting people with Alzheimer's said that they were not aware of carer's breaks or organisations that could support them, such as Crossroads, and there was a general consensus that carers have to go out and find information for themselves instead of being signposted, but say they lack time to do this.
- One Young Carer said they didn't understand about personal budgets.
- Information can be a source of comfort for carers, e.g. one Young Carer expressed gratitude for information about his father's condition.

- Five carers with a learning disability were concerned with the lack of accessible information about medication to inform them of how and when it should be taken, and what the side effects are.
- A number of learning disability carers were also concerned about the lack of contact and communication from social care, and were quite distressed about the looming cuts to adult care, and the additional pressure this will put on parents and siblings to provide more personal care.
- Some carers we spoke to did not know Derbyshire Carers Association existed.
- Some carers said that they were not told what to expect when someone they cared for returned home from hospital.

Peer support

Opportunities for carers to meet up whilst supporting their loved ones are welcomed, e.g. the Movers and Shakers exercise class for those with Parkinson's disease. "Not only do those with the disease benefit from the sessions, it gives the carers an opportunity to attend and forge friendships with other carers."

Respite and support

- One carer expressed a need to be able to take their cared for to a group and be able to leave to catch up on chores etc. but weren't able to do this, e.g. art group at Moira Replan, but she did state "he loves it." She also expressed a concern that these were only for 6 weeks.

- There is relief expressed about getting away from caring responsibilities and being able to forget about them for a little while. "…it helps me cope, allows me to get away from the home environment and to helps me forget about my caring responsibilities." This was a Young Carer.

- Carer expressed frustration that she can't go out as no care service can sort dialysis out, i.e. no one is trained to do it and they don't have the resources to train staff. She feels this puts a lot of strain on her as a carer not being able to get out.

- 'Carers Break Grant Scheme' is a welcome relief from caring responsibilities and we received a number of comments from learning disability carers who valued this and want it to continue. However, there are reports of delays in getting the money, one carer was waiting 4 months; another was declined. The Carers Break Grant Scheme is also set to reduce from £250 to £200 at a time when carer's responsibilities will increase due to budget cuts.

- A positive comment was made about a care manager from Derbyshire County Council (DCC) and the additional support they have offered, but no support on a Sunday and carer says he can't manage.

- Positive comment received about Derbyshire Carers Association, "they have been great, they really have supported me through my concerns and the worker (named) has given me lots of information". This was welcomed as the carer had received no support from anywhere else or a carers assessment.

- Positives comments have been received from carers of people with long term conditions, e.g. cancer. Carers reported being very happy with the support from Macmillan and Ashgate Hospice most of whom stated that all workers had compassion and not only cared for the patient but the whole family. (See also Healthwatch Derbyshire's Service Evaluation of Ashgate Hospice).

- There were two comments regarding Derbyshire Carers Association not being very accessible. It was stated that people who are profoundly deaf cannot access any support because Derbyshire Carers Association won't provide interpreters. It was also stated that they do not provide groups or support for working carers other than an out of hours advice line that is manned one evening a week.

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- Some carers reported being happy with the support and treatment on the Renal Ward at Chesterfield Royal Hospital. Carers stated that the Ward Clerk rings them if NSL are going to be late with transport so that they can prepare meals at certain times.

Support for Young Carers

- Support for Young Carers was valued, i.e. counselling, activities and opportunities for peer support provided by Action for Children in particular, but it's now short-term (6 months). One carer said, "… its 6 months counselling, when will care continue indefinitely?"

  Another person said, "My son had 6 months of support but this stopped in March, this was such a disappointment for him as it gave him an opportunity to have his independence. His caring hasn't stopped or changed in anyway, I don't understand why he couldn't have more support,"

  There were a number of comments calling for longer-term support and real concern amongst a number of carers about cuts in services provided by Action for Children, which is causing anxiety and distress. No real knowledge of what will happen then, what other services are available for Young Carers?

- In the comments from Young Carers it is thought there is a lack of understanding of Young Carers needs amongst other professionals, e.g. GPs. GPs didn't talk to them about their cared for and many Young Carers said they are not registered as a carer at their surgery. It was suggested that more carers champions at GP surgeries could help support carers.

- It came across in discussions that many Young Carers were depressed and many were self-harming. In the focus group it was stated that when they see their GP they are looked at as having a mental health condition and referred to CAMHS, but they do not go further than that and look at the root cause which is their caring responsibilities. They stated that they are not signposted anywhere even though they expressed distress at how many hours of personal care they do each week. One Young Carer said he sleeps at the foot of his Dad's bed, because he worries about him and he needs to help him go to the toilet. The Young Carer gets up at 5am to prepare his Dad's medication, breakfast for the whole family and get everyone washed and dressed. This Young Carer is only 10.

- In our discussion with Young Carers it was stated that they would like 'Young Carers Leads' in schools. Young Carers expressed concerns over difficulty doing homework, getting to school on time and generally achieving what they should, but there isn't much awareness of this within a school setting. It was noted that one carer said their teacher publicly told a large classroom of children that he was self-harming. Carers reported trying to do their homework in lunch breaks, but this meant that they sometimes didn't eat. They also said that they are given after school detentions for not handing in their homework on time. Some Young Carers said they also struggled sleeping because of depression from their caring responsibilities and the personal care tasks they undertake at night, but this was not acknowledged by teaching staff. Young Carers also said that teachers won't allow them time off to see their parents in hospital.

- Two Young Carers said that their medication for depression wasn't explained to them by the GP, they weren't aware of the side effects and struggled to read the leaflets.

- Young Carers talked about being depressed due to their caring roles, and that all they see is barriers to a good future. One said that they could see themselves being on benefits for the rest of their life or having a mental health condition. Another carer said that they have heard people talking about early intervention but they think it's just a 'buzz word' as it doesn't actually happen.

- Isolation is an issue with not enough opportunity to be with others, friends etc.

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- Support with practical tasks, such as one Young Carer wanting help to bathe his Mum, was a common issue for Young Carers.

- Lack of awareness/recognition about being a carer was a theme until they received support, which was then welcomed, i.e. didn't recognise the situation they were in. "The support has made me realise that I am a Young Carer, I didn't realise how many Young Carers there are, it gave me a sense of awareness and means I can talk to others."

- One Young Carer stated that he was assessed as a Young Carer by a Social Worker when he was 16, but 2 years later, he is now 18, and he has still not received any support. He says he would like support and feels it would give him a confidence boost.

- Another carer said that they have only just been allocated a Social Worker after 7 years. His brother also loves sensory equipment but they can't afford it.

- Two Young Carers expressed concern that they were unable to get support while the Social Worker was on holiday, being told that they had to wait till they returned.

- Some Young Carers also expressed concern that they were unable to get in touch with their Social Worker despite repeated attempts which led to anxiety. Sometime other professionals were having to get involved e.g. teachers to get the Social Worker to respond to the Young Carer. Social Workers were described as being evasive and not very supportive.

- Not being involved in decisions about their care and treatment was an issue, "I am a Young Carer and I have been feeling down for a while. I was referred to CAMHS but I don't know who by. I would like to be involved in decisions more and helped with support and not to be just looked at like I have a mental health condition".

- It was stated that there appears to be some confusion in Adult Care when a family is referred for an Adult Care Assessment, with the family getting moved around services, sometimes the referral is made to children's services, when what is needed is an Adult Care package for the cared for.

- Young Carers valued the support of Rethink, but others in the group didn't know how to access it.

- Young Carers we spoke to would like to be able to access the Short Breaks Grant that adults can apply for. They don't feel able to access recreational activities due to their caring roles and as the Action for Children budget has been cut, they do not have the opportunity to go on days out with them anymore.

- A Young Carers also requested an Emergency Card scheme, and would like a single point of access to contact when they are at crisis point.

When asked what they would like, Young Carers replied by saying:

- Professionals to talk to them more about the cared for, they would like to be included in meetings and be told when someone is going to their home to see the cared for.
- They would like help to stop self-harming, they do not want medication they want their caring responsibilities to reduce and to be able to access more help such as personal budgets for the cared for and small break grants for themselves.
- They would like more help and support for their parents from the Mental Health Trust and from Adult Care.
- They would like GPs not to look at them as having a mental health condition but to actually be compassionate and help them to get out of the situation.
- All of them said they would do less caring if they had someone else to help.

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- They would like CAMHS professionals to understand their situation, they would like the room to be less clinical and they would like to meet them in a different environment such as Action for Children or in a Children's Centre.

Lack of Continuity of Support

- Lack of continuity of support comes out in a number of comments, having to explain everything again and build up a new relationship for a new worker. This can happen within a service, and because of transition to a new service, e.g. Action for Children to DCC. "I was very angry when
  the service changed as I was getting people coming to my house that I didn't know, I am happy with the Action for Children staff as they are aware of my child's needs and my needs. They have a family approach which is brilliant." Another Young Carer was referred to CAMHS. She said this had been ongoing for 2 years but was not helping her. She would prefer to have the support from Action for Children's Support Worker.

- One carer said, "… you can build up a relationship and you can trust your Social Worker when you have the continuity of the same worker … you don't know when you are going to lose that worker and when someone does go there is a large gap before someone new comes to see you."

- Support received from Think Carer was praised by one carer, "The support I get from Think Carer is very good, the worker (named) is brilliant and very helpful." However, it was criticised by 3 others for being only time limited, "Mental Health Carers need long term support not just for 6 weeks, the early intervention is important but we need someone close by when we reach crisis point. I don't feel comfortable being passed over to another organisation (named) to be assessed again." The length of wait was also an issue for one carer.

- There are a number of very positive comments about the services provided by Action for Children, but dismay and concern over the short-term nature of that support, currently 6 months, as caring responsibilities don't change. (See 'Young Carer' section above).

- One of the main themes identified in the conversations we have had seems to be the disparity between three main services for carers, which are Derbyshire Carers Association, Think Carer and Action for Children. Although Derbyshire Carers Association provide ongoing support to the carer, even when the cared for, has passed away and has the budget to put on many different day trips and groups for carers, Think Carer, the mental health support for carers, can only provide a time limited support package. This can sometimes only be accessed when the carer reaches crisis point, then carers are given 6 months of intensive support. However, following on from this cares have reported being left feeling they need more support but don't know where to turn. Action for Children can also only provide support in most cases for a limited period of 6 months, carers can re-refer back but some are not aware of this process. Action for Children have stated that they would like to support Young Carers throughout their caring roles but their service specification has changed and they have had a budget cut.

Recognition of Carers needs

- The Carer Voice Network felt quite strongly that there was an issue with non-emergency patient transport companies (Arriva and NSL Derby) not allowing carers the opportunity to travel with their cared for to and from appointments. On a number of occasions carers have been told they are not allowed. This is particularly problematic if the cared for person lacks capacity or suffers with dementia as the journey with a stranger can be very daunting and sometimes frightening. Carers are being told they must follow on using their own means of transport. For those that don't have transport, they are advised to follow the driver in a taxi. The carers state that this seems an unnecessary exercise, not to mention a costly one. There are also issues regarding carers arriving later than the patient transport and the drivers leaving the patient to their own devices to wait for their appointment.

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- There was an issue with Adult Care whereby a relative didn't feel Adult Care had any sense of urgency about arranging a care package for his brother ready for him coming out of hospital. The relative felt that it was just being left up to him to sort out care. When the Social Worker did come out no carers assessment was carried out. The carer was signposted on to a number of other agencies, but given no real information about them or the support they could offer.

- Another carer said, "My husband has just been re-assessed for a personal budget as he struggles to go out. My needs and expertise as his carer were ignored. I get quite stressed having to deal with everything. I haven't had a Carer's Assessment nor have I been signposted anywhere for support." In a similar circumstance, the carer of a child with learning disabilities said that when her son was re-assessed some support hours were taken away. She said that she didn't receive a Carer's Assessment and will be providing more support now that her son's package has been reduced.

- One carer, caring for her husband who has had a stroke, said that she had no help at all, and there had been no carers assessment done.

- Carers seem to feel generally that adult care's carer assessments are just a tick box exercise, and that social care staff just rush through them and put down the information they want to. It was reported by one carer that when the report came back to the carer the information was very different from what was discussed.

- Another carer tried to ring up and get a visit from a Social Worker, but was referred to the Duty Social Worker each time, she does not feel comfortable talking to the Duty Social Worker about her personal problems on the telephone saying, "I have a right to dignity."

- Ten Mental Health Carers felt they can only access support when they reach crisis point. This was backed up by other comments we have received, "The only way that carers or service users can access support or help is when they reach crisis point."

- Carers reported that trying to get hold of Social Workers seem to be a problem, or that sometimes they don't visit when they say they will. Other professionals have had to chase up Social Workers to get them to get in touch with carers, this seems to be an issue for Young Carers in particular.

- One Young Carer said that her Mum was given an appointment at Ripley, but her Mum can't drive and couldn't get to the appointment due to poor mobility. The carer tried to contact the Social Worker for support and advice but couldn't' get in touch. The carer has been left feeling that the Social Worker isn't interested in supporting her Mum with her depression.

- A carer of a Mum who is refusing to receive support from Homecare services says that she thinks her Mum needs mental health support and is left to provide the care when her Mum refuses the support. She says that this is affecting her own health.

- On the flip-side one comment taken said, "My wife's Social Worker quickly resolved a last minute re-admission to the Hartington Unit, she got her a bed and liaised with the Community Psychiatric Nurse (CPN). She has been great by advising me on my rights as a carer and she seems concerned about my own health." Another was equally complementary saying that her Social Worker rushed through an assessment for them, the support has been great and appointments came through quickly. They were also signposted well to one-to-one support.

Carers not being involved in care and treatment

- A Young Carer who cares for his Dad who drinks a lot, said he came away from Accident and Emergency (A&E) with his Dad, not knowing how to treat his wound and what medication he should take. Despite attending A&E frequently he has still not been referred to a support service. He says he isn't recognised as a Young Carer.

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- A son said he wasn't kept informed of what care and treatment his Mum was having on the ward. The hospital did not discuss the discharge plans with him either. When he went to visit his Mum, she would tell him what had happened that day e.g. she had an x-ray one particular day, but none of the staff told him what was going on. The hospital then went on to discharge his Mum without putting a care package in place, and he was not asked to be involved in the process. He was very distressed by this. He also went on to say his Mum had several admissions into different hospitals over the past year and a care package was never put into place for when she was discharged at any time. He did not know who and where to turn to for help and assistance.

- Five learning disability carers expressed concern that they can't stay with their cared for when they are in an acute setting, or can't arrange for the support worker to be there. These carers have said that people with learning disabilities are not cared for very well in an acute setting because staff haven't got the time to spend with them. It was stated that there should be learning disability liaison nurses that specifically deal with individuals in an acute setting, and admission should trigger their support but in their experience this rarely happens. These same carers also stated that hospitals don't communicate with them very well about treatments and discharges.

- A carer of someone with a head injury said that their cared for had been set an objective during physiotherapy but they had not been involved or told about this. As the one person who cares for them most of the time, they said it felt wrong not to be involved in the setting of the objective.

Other Issues

- Issue with use of Carers Emergency Card, as carer was rushed into hospital, and too ill to say he had one. Wife subsequently didn't get the care she needed in his absence. Should there be a procedure in place to prevent this from happening?

- Learning Disability Carers are concerned that information provided in Health Checks is not being recorded on the Personal Health Files. This means that the person with Learning Disabilities struggles to retain the information.

Summary of Findings

- There appears to be a lack of awareness amongst GPs of carers in their practice and a lack of understanding of their needs.
- Carers report a lack of information and signposting. Where they have received information they have found this useful.
- Carers welcome the opportunity to meet other carers and have reported feeling isolated.
- Respite and support is valued, but in some cases it's not meeting needs, there is a gap, or it just isn't being provided.
- There is a lot of concern about cuts in services for Young Carers, and what is available following the 6 months of support offered by Action for Children.
- The lack of continuity of support is causing anxiety and distress amongst carers.
- There are carers that are not being identified, assessed and supported, even with identification, support doesn't necessarily follow.
- Carers' needs aren't taken into account by patient transport companies, or the needs of the cared for to be accompanied by their carer.
- Carers are expressing concern about not being involved in discussion about treatment and care.
- Carers Emergency Card scheme – how does someone know that there is one in place, should someone be too incapacitated to say?

- There appears to be disparity in the level of service that the 3 main carers support services. With Think Carer for mental health carers and Action for Children for Young Carers only being able to provide time limited support, while Derbyshire Carers can provide on-going support.

Recommendations

- That service providers and commissioners take into account this intelligence alongside their own, discuss their commitment to change and provide a response for Healthwatch Derbyshire to feedback to patients and the public.

- Establish consistency in the support available to carers, from all providers. Short-term support was extensively criticised.

- Address the need for more information and signposting. Consider the need for a one stop shop for information for carers, i.e. one phone number or pack of information covering all services.

- Address the lack of earlier intervention, as many carers feel they have to reach crisis point before support is offered or available.

- Raise awareness of carers needs amongst all professionals, e.g. GPs, teachers, hospital staff.

- Respect and recognise carers so they are involved in the treatment and care decisions made about the people they care for.

- Ensure carers assessments are completed in line with current legislation.

Responses from Carer Organisation:

We asked a number of carer organisations to read and respond to the report, before we published and circulated it. We wanted to ensure that it accurately reflected the wider views of carers and those that represent them in Derbyshire. These were the responses we received:

thinkcarer

"thinkcarer recognises that Carers are a "critical and crucial asset" who should be supported in ways that best serves their needs.

Once thinkcarer has received a referral from either a professional or a self-referral from the carer or family, the carer is contacted within 5 working days with an appointment. The data that we have in relation to carers accessing the service indicates that we are responding to carers within the specified time frame.

It has been reported to thinkcarer, however, that carers are not always made aware of our service in a timely manner. Professionals who become involved with a carer, need to consider the needs of the carer immediately and refer without delay.

The thinkcarer contract is to deliver a time limited service and operates on a brief intervention model. This links to a clear model of delivery that focuses around recovery and community integration for the carer. We recognise that all carers have different needs and, as such, this is reflected in their individual care plan so, for some carers, 6 sessions as identified within the contract may vary in carers receiving less or more sessions. Where it is identified that a carer needs formal counselling then our role is to ensure that the carer goes onto access this service. We make it clear that carers can also re-refer if their circumstances change."

Carmel Swan, thinkcarer.

Draft

Action for Children

"I feel the comments made do reflect what information we get from some of our service users. What isn't mentioned is that we are a 'time limited service' rather than a 6 month service and each young person will be provided with support based on their own and families individual needs.

Unfortunately that will mean for some a 6 month support package with the option of keeping in touch with us through network events and website. They can also be re-referred to the service should their circumstances change. For others this may mean that they continue to receive support for a longer period of around 18 months to 2 years. Each young person will receive support with coping strategies to enable them to cope alone without services in place and workers do try to make sure they are not left totally isolated.

Of course this is different from pre 2012 when often young people received support either until they stopped caring or when they reached 18 years, but this is no longer possible due to the change in service spec.

There is a gap in suitable services to pass on young people to once they reach 18 years.

I do feel there is still some way to go in recognising Young Carers especially were GPs are concerned and some Adult Services, it is also very difficult to get Adult Services to recognise the effect having caring responsibilities at such a young age has on children and young people. Therefore they do not often take this into consideration when assessing an adult for care services."

Karen Martin, Practice Team Leader, Derbyshire Young Carers Service, Action for Children.

Karen Ritchie
Chief Executive.
5th September 2014

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Appendix one: Key facts about carers

Carers across the UK

- There are almost seven million carers in the UK – that is one in ten people. This is rising.
- Every year in the UK, over 2.3 million adults become carers and over 2.3 million adults stop being carers. Three in five people will be carers at some point in their lives in the UK.
- Out of the UK's carers, 42% of carers are men and 58% are women.
- The economic value of the contribution made by carers in the UK is £119bn per year.
- Over the next 30 years, the number of carers will increase by 3.4 million (around 60%).
- The number of people over 85 in the UK, the age group most likely to need care, is expected to increase by over 50% to 1.9 million over the next decade.

Young Carers and young adult carers

- 13,000 of the UK's Young Carers care for over 50 hours a week.
- Following a survey in 2010, the BBC estimated that there are 700,000 Young Carers in the UK.
- Young adult carers aged between 16 and 18 years are twice as likely to be not in education, employment, or training (NEET).
- In total there are 290,369 carers in the UK who are aged 16-24.

Older carers

- In England and Wales, just under one million (950,000) people over 65 are carers.
- 65% of older carers (aged 60-94) have long-term health problems or a disability themselves.

Mental health

- Up to 1.5 million people in the UK care for someone with a mental health problem.

Learning disabilities

- 14% of carers (approx. 840,000) care for people with learning disabilities including autistic-spectrum conditions.

Substance misuse

- At the very least, nearly 1.5 million adults in the UK are affected by a relative's drug use.

Employment

- There are 4.27 million carers of working age living in the UK; 2.44 million (57%) of these are women and 1.83 million (43%) are men.
- The employment rate for carers is at 67% (72% of men and 62% of women); over half of those who are not working say that they want to do so.
- £5.3bn has been wiped from the economy in lost earnings due to people who've dropped out of the workforce to take on caring responsibilities.
- One in five carers gives up employment to care.

Finance

- In an online survey of 800 carers conducted by The Princess Royal Trust for Carers in July 2010 53% have borrowed money as a result of their caring role – 61% have borrowed from a friend or relative and 41% have used overdrafts.

Benefits

- Out of carers surveyed, 35% of carers had missed out on state benefits because they didn't realise they could claim them.

Health and wellbeing

- A four year study of 392 carers and 427 non-carers aged 66-92 found that carers who were reporting feelings of strain had a 63% higher likelihood of death in that period than non-carers or carers not reporting strain.

Dementia

- There are currently 700,000 people living in the UK with dementia.
- Two thirds of people with dementia live at home and most are supported by unpaid carers.

These facts can be found at http://www.carers.org/key-facts-about-carers

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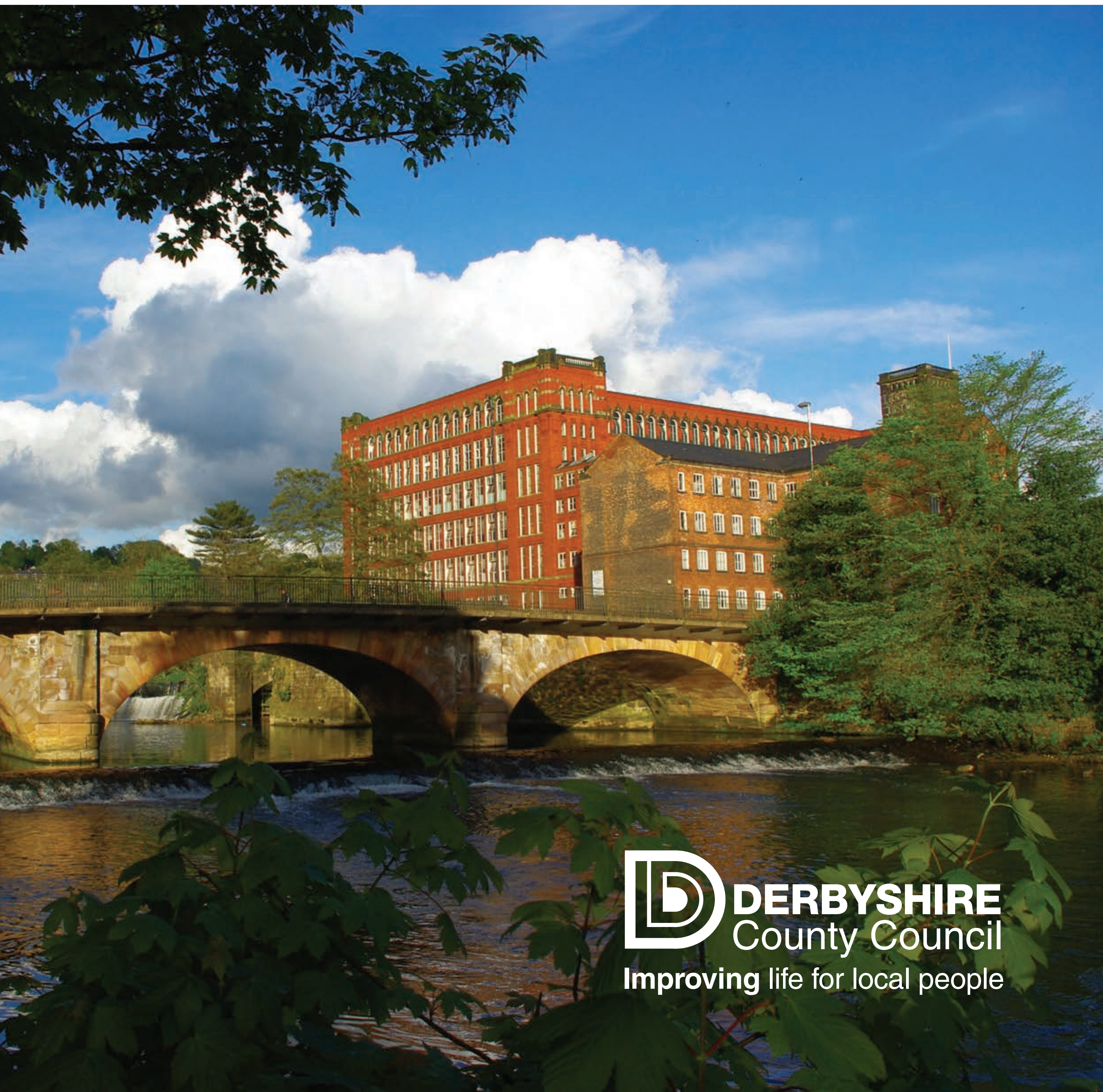
A fairer, healthier Derbyshire

Derbyshire Director of Public Health
Annual Report 2014



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Letter to Councillor Anne Western, Leader of Derbyshire County Council

Dear Councillor Western,

I am delighted to publish this, my first Annual Report, as Director of Public Health for Derbyshire. My role as a public health consultant at the heart of the council gives me an opportunity to assess the health and wellbeing of local people and see where we might do better.

Derbyshire has developed excellent initiatives and strong systems to improve health and wellbeing, working in partnership with a wide range of stakeholders. However this is a difficult time as the economic downturn is making life hard for many people, and that may take a toll on their health. There are no quick fixes for that and its shadow may be long.

In this report I portray health not as something separate, but as the foundation for a full and enjoyable life. What makes people healthy is much the same as what makes them happy – having a satisfying role in life with prospects, feeling mentally and physically fit, and living in a decent community and a society where people of all ages and backgrounds have a fair chance in life.

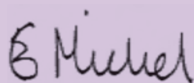
Every area is facing similar issues and we need to share ideas and problems with others and learn together. My own experience suggests that there are ideas elsewhere that we can pick up and apply in Derbyshire.

Throughout this report I will discuss what could improve or harm health now and in the future with a specific focus on the impacts of the wider economic issues that make so much difference to people's opportunities for a satisfying life. I will also stress the importance of encouraging the whole of society to work together to improve people's lives, and how we can better engage the public and those who provide services in joining together in a way that can work in everyone's interest.

This report is focused on evidence and opportunities. The report examines the links between health and the economy, a complex area but one potentially containing untapped benefits. Each chapter includes recommendations, which I will return to in future Annual Reports.

I provide some suggestions about how we can push faster for real improvements in the health and wellbeing of all, with a specific focus on tackling health inequalities.

Yours sincerely



Elaine Michel
Director of Public Health
Derbyshire County Council

Improving financial inclusion

CONTEXT

In Derbyshire we want everyone to have access to appropriate financial services and products so they can manage their money effectively. People also need to have adequate knowledge, skills, confidence and motivation to manage money well. This is what we call financial inclusion. A dual approach, targeting both access to services and money management skills is required to tackle the converse problem: Financial Exclusion.

There is strong evidence to show that poverty and financial exclusion impair physical and mental health and wellbeing and reduce life expectancy. There are also strong links between financial exclusion and poor mental health, family breakdown, re-offending, social exclusion, homelessness and employment opportunities. One particularly distressing example is that of suicide rates which rose with the onset of austerity and now remain higher than before the economic downturn in 2007.

Financial exclusion costs money, with individuals paying more for everyday transactions: without a bank account it costs more to cash a cheque, pay a bill or pay for goods and services, particularly high cost items such as energy. Credit availability is limited and very expensive and individuals often resort to high cost lenders to borrow money.

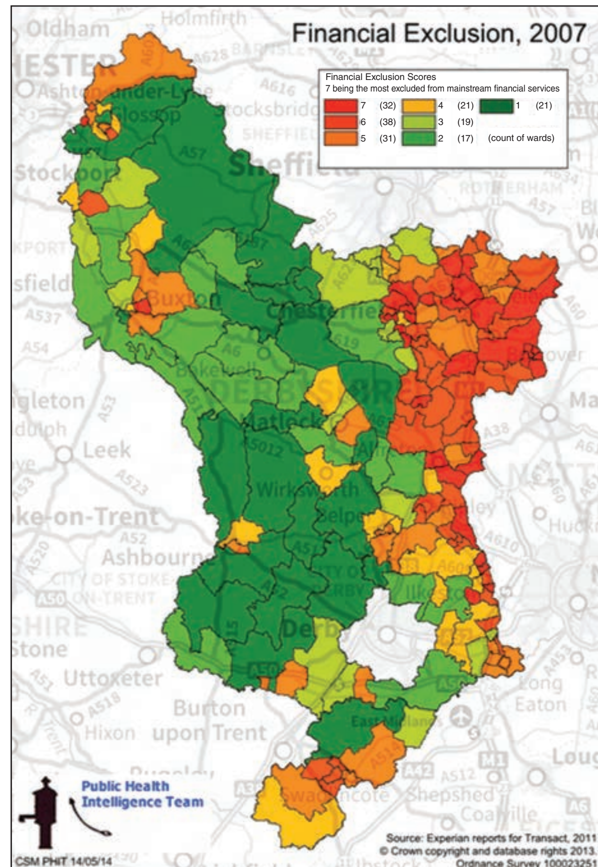
The following statistics provide a snapshot of some key indicators of financial exclusion in the UK:

- 11% of low income households have no bank account.
- Outstanding personal debt stood at £1.44 trillion at the end of February 2014 – a significant proportion of this is likely to be unmanageable debt.
- Average household debt in the UK (excluding mortgages) was £6,018 in February 2014.
- 52% of people are struggling to pay their bills.
- 30% of UK households have no savings at all.
- One property is repossessed every 18 minutes.
- Redundancy can often be the final straw; tipping people who were coping financially, into financial exclusion. An average of 1,282 people were made redundant every day between November 2013 and January 2014.
- Every day 266 people are declared insolvent or bankrupt.
- Citizens Advice Bureaux deal with more than 7,000 debt problems each day.
- 200,000 people living in rural areas in the UK do not have a bank account and have only limited access to services that help people deal with financial exclusion.
- Oxfam estimates that recent welfare reforms have pushed 1.75 million of the UK's poorest households deeper into poverty.

DERBYSHIRE FACTS AND FIGURES

- There are an estimated 100,000 financially excluded people in Derbyshire.
- Derbyshire Citizens Advice Bureaux are seeing a huge rise in demand for benefits and debt advice stretching their ability to cope. In the last three years debt and benefit related enquiries have increased by 25%.
- There are now 22 food banks in Derbyshire all of which report an increasing need for emergency food parcels.

- Derbyshire County Council estimates that £112m of means tested benefits goes unclaimed in Derbyshire each year.
- Sheffield Hallam University estimates that welfare reforms will remove £219m a year from the Derbyshire economy.



WHAT CAN HELP?

Interventions that are likely to make the most difference are those which build individual and community resilience, thus increasing the ability to cope with uncertainty and to recover successfully from unpredictable and traumatic events. A partnership approach is essential as no single agency can resolve the complexities of financial inclusion alone.

Income maximisation

The living wage is a carefully calculated wage designed to provide employees with a minimum standard of living. Currently it is set at £7.65 per hour (£8.80 in London), compared to the minimum wage of £6.31 per hour. Currently some 4.8 million people (20% of the working population) work for less than the living wage. The living wage is good for employers, reducing absenteeism by 25% and good for employees, for example, 75% report increases in work quality as a result of receiving the living wage. It is also realistic and achievable: Derbyshire County Council is one of over 100 local authorities that have a living wage policy already. The public health argument in support of the living wage is clear:

Professor Kate Pickett, Professor of Epidemiology at the University of York, describes paying the living wage as "the single best action that I believe local authorities can take to reduce health inequalities".

Tackle under-claiming of benefits

Low uptake of benefits is important as it leaves those not claiming their entitlement in greater poverty than they need to be, with greater levels of hardship and potentially greater risk to health. Low uptake is a particular problem where the benefit in question is a means-tested one.

Research suggests that the most common reasons for non-uptake include lack of awareness of entitlement, previous (bad) experience of claiming, complexity of the tax and benefits system and stigma associated with means testing.

Increasing uptake of benefits not only helps individuals, but also supports local communities. Evidence from the New Economics Foundation demonstrates the positive impact on local economies of benefit take-up campaigns as poorer people have a greater tendency to spend their income within their own areas.

Interventions that are successful at improving uptake of benefits include: specialist welfare benefits advisors helping people to apply for their benefits and supporting appeals if their claims are initially rejected; Citizens Advice Bureau provision on the high street and in settings where people who need advice tend to go, such as GP surgeries and Children's Centres; and free, confidential telephone helplines such as Derbyshire County Council's Benefits Helpline tel: 0845 120 2985. Easy access to self-help advice websites such as Citizens Advice www.adviceguide.org.uk/ and National Debtline www.nationaldebtline.org/EW/Pages/default.aspx are a good resource for people who have access to and the skills to use the internet.

Money management

Improving basic numeracy and literacy skills is imperative. There is a direct correlation between low level numeracy skills and financial exclusion. Around half of all adults in the UK have numeracy skills no better than those expected of an 11 year old. Recent reports have found that numeracy is a bigger determinant of future life chances and disadvantage than literacy. More than a quarter of working age adults in Derbyshire have no qualifications at all. This is higher than the England average of 23%.

Derbyshire's Credit Unions are a great source of safe, affordable loans and staff are on hand to help residents with advice about savings, debt or financial worries.

Access to services

Many things can improve access to financial services: banks promoting their basic bank accounts, increasing the number of free ATMs (cash machines), especially in disadvantaged and rural areas and utility companies extending discounts to people on prepayment cards. Many Credit Unions offer 'jam jar' accounts which allow people to set up direct debits to help them to manage their budgets.

ASSETS AND CURRENT WORK

Promoting financial inclusion

Promoting financial inclusion is a priority of many agencies in Derbyshire, demonstrated by the 55 partners of Financial Action and Advice Derbyshire, the County's financial inclusion partnership. The partnership is implementing a strategy to promote financial inclusion: FAAD Strategic Action Plan.

Examples of current actions to promote financial inclusion include:

- Ensuring people are receiving tax credits and benefit entitlements through the County Council Welfare Rights team and local advice agencies. www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/money_and_legal_matters/welfare_benefits/default.asp

- Provision of debt advice by the Citizens Advice Bureau, including sessions in most of Derbyshire's GP surgeries and in all Derbyshire's Children's Centres. www.derbyshirecab.org.uk/
- Supporting the expansion of Credit Unions in Derbyshire to increase their capacity to make instant loans to provide an ethical and safe alternative to pay day lenders and loan sharks. www.derbyshire.gov.uk/community/consumer_advice/payday_lenders/alternatives_to_payday_loans/default.asp
- Tackling loan sharks – promoting the work of the Illegal Money Lending Unit by raising awareness and campaigning to encourage reporting of illegal moneylending. www.gov.uk/report-loan-shark

Bolsolver District Council's Health and Wellbeing Bus visits local communities to offer residents a wide range of support and advice about health, finances, skills and employment.

Credit Unions are a community alternative to high street lenders or payday loans.

Sue* (32) from Brampton, turned to Chesterfield and North East Derbyshire Credit Union when her chronically ill husband stopped receiving sickness benefits.

The couple supported their family of five for 13 years on his salary working as a maintenance and repair operative.

He had to give up his job when he started to collapse unexpectedly at work and the couple had to rely on benefits to clothe and feed their children.

When he was invited to attend a work capability assessment at the Jobcentre the couple expected to receive a letter informing them of the results of his medical.

Sue said: "We didn't know his benefits had been stopped until I went to the bank to pay some bills and there was no money in the account. The Jobcentre said they wrote to us but we didn't receive the letter.

"We quickly got into arrears with bills and started to receive threatening letters from debt collectors.

"Just before Christmas the bailiffs turned up at our door demanding payment and I had to give them everything I'd put away for the children's presents on top of what I could borrow from friends.

"I called up the Credit Union as a last resort and was really pleased they managed to see me within days.

"They were so supportive and didn't just want to discuss money. When I talked about what was happening I just burst into tears. But they gave me a cup of tea, a box of tissues and even a hug.

"They told me about their family loans that I could pay back gradually with family allowance. I was so pleased that I didn't have to go to a payday lender and get into even more trouble.

"I borrowed £500 and am paying back £10 a week, which is affordable."

**Name changed to protect identity.*

> "I was so pleased I didn't have to go to a payday lender."

Wealth, Health and Wellbeing Project

This project takes an outreach approach in deprived neighbourhoods. Selecting a community of 100–150 households, it involves three steps over three weeks. On week one a leaflet is posted through doors asking questions that may indicate an issue related to financial exclusion, e.g. are you in debt, do you need help finding employment, do you need affordable credit, can you afford to heat your home, would you like help to improve your health and do you have children?

During the second week workers knock on doors asking if residents need help with any of these issues and if so, appointments are made for the following week.

On week three staff arrive on the outreach bus to provide advice to those with appointments. Residents can choose to be seen on the bus or in their homes.

On average, 40% of households respond to the leaflet and 50% of respondents benefit from at least one of the services on offer.

Sara* and Pete* a married couple, both of whom work, earn a joint income of £12,000. They have a mortgage to pay as well as other living costs so their finances are tight. Sara was worried about the cost of her energy bill. She didn't know how she was going to pay it and thought that she would have to take out a pay day loan. During the door knocking stage of the project she was relieved to find out that she could make an appointment with somebody who specialised in affordable warmth that would come to her house and talk through her options. The first issue was that Sara and Pete had never read their meter as they didn't know how, so had been over paying for many years unknowingly. The second issue was their lack of confidence to ring up the utility company; they also didn't know they could ask to be put on a lower tariff. The affordable warmth advisor rang the company on their behalf and succeeded in moving them to a cheaper tariff which would save £325 over the year. They also had problems paying their council tax and were in arrears with this so were helped to make an appointment with the Citizens Advice Bureau worker to help them address this.

**Names changed to protect identity.*

> "On average, 40% of households respond to the leaflet and 50% of respondents benefit from at least one of the services on offer."

Financial Capability

Money management skills are an important aspect of financial inclusion. However, 54% of people say they do not budget, 25% of people aged over 55 do not understand their bank statements and 18 million people regularly run out of money before pay day. Below are some examples of how we are developing financial capability in Derbyshire:

- Financial inclusion awareness sessions have been promoted via voluntary, community and public sector networks. They are offered to front line workers and volunteers who come into contact with members of the public and help them understand issues related to financial exclusion. This enables them to signpost service users requiring help to agencies such as Citizens Advice Bureaux, Derbyshire County Council's Welfare Benefits Team, council housing teams and food banks.
- Schools are being supported to deliver financial capability training to children, with lesson plans, resources and free training for teachers available to primary schools.
- Adult education in Derbyshire has a focus on basic numeracy and literacy skills supported by other skills training to help people become 'work ready'.
- Money management skills training for vulnerable adults which covers issues such as how to set a household budget, interpreting bank statements, understanding the true cost of loans by calculating annual percentage rates (APRs) and where to find help with debt problems.

RECOMMENDATIONS

1. Make Derbyshire a 'Living Wage' economy. All major public sector employers to consider applying for accreditation with the Living Wage Foundation (www.livingwage.org.uk/how-become-living-wage-employer). Their example should be followed by private and voluntary sector employers where feasible.
2. Invest additional resources to support a multi-agency approach to ensure that more people receive their full benefit entitlement, aiming for an additional £10m of benefit take up.
3. Continue to invest in money management skills through adult education, schools, community groups and geographical communities at greatest risk of financial exclusion.
   - Target; anyone who enrols on a work related training programme, every child in year six and year 11, anyone receiving advice on debt, benefits or taking out a loan from a Credit Union.
   - Target; geographical communities identified through mapping by using creative techniques to encourage community engagement.
4. Treble the percentage of the population who are members of Credit Unions in Derbyshire from the current 6,123 (less than 1%) to 18,000 over the next three years by:
   - providing financial support to Credit Unions in Derbyshire to expand the areas where they have a presence.
   - Derbyshire County Council encouraging its staff to join local Credit Unions and to make regular savings through payroll deduction.
   - Derbyshire County Council maintaining the ban on payday lenders being accessed through its public computers in libraries and continuing to instead provide information about local Credit Unions as an alternative.

Reducing child poverty

CONTEXT

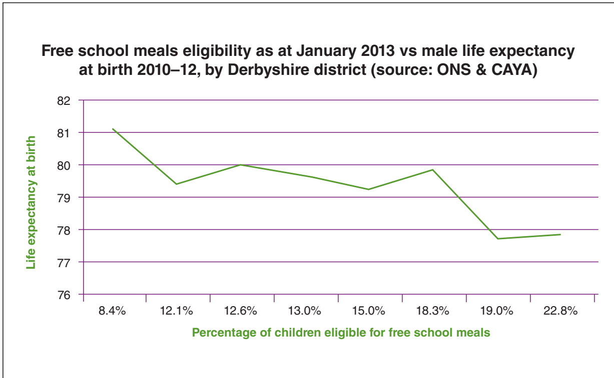
The UK has one of the worst rates of child poverty in the industrialised world. There are 3.5 million children living in poverty in the UK today.

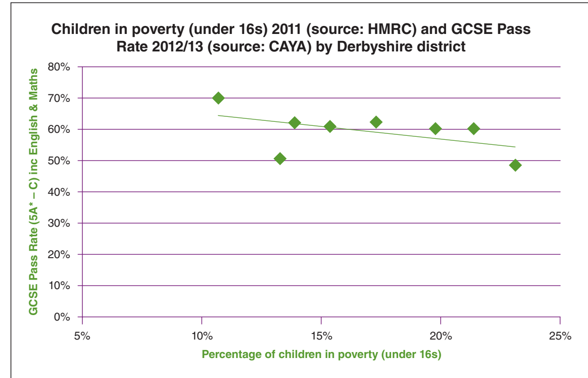
Poverty blights childhood, with children living in poverty experiencing cold, hunger and missing out on activities and holidays. It also has a serious impact on health.

The definition of poverty is a household living on an income less than 60% of the national average. More than half of poor households are in work but do not have enough resources to meet their needs; 66% of children growing up in poverty live in working households.

Children who experience persistent poverty are more likely to have emotional and behavioural problems than their contemporaries living above the poverty line. For under-fives these experiences have a lasting impact on their wellbeing throughout life and older children recognise the difference between themselves and their peers and their wellbeing suffers as a result.

Children living in poverty are more likely to adopt unhealthy behaviours and to be obese; to suffer from diabetes, asthma, poor dental health; to develop mental ill-health and cancer and experience a lower life expectancy. In deprived households both infant and maternal mortality is higher, there is a greater rate of postnatal depression and breastfeeding rates are lower.





Poverty and poor health is a self-perpetuating cycle: poverty causes poor health, and poor health causes poverty. Children living in poverty often have lower educational attainment than their peers: by the age of three, poorer children are estimated to be, on average, nine months behind children from more wealthy backgrounds and by 16, children receiving free school meals achieve 1.7 grades lower at GCSE. The resultant impact on job opportunities and future earnings ensures that poverty passes from generation to generation, with poor children four times more likely to be poor adults.

Whilst the current rate in Derbyshire is less than that in the UK (17% compared with 27%) that still means that nearly 23,000 children under the age of 16 live in poverty.

Estimates suggest that current government policies could lead to an extra 600,000 children living in poverty by 2015/16, compared with 2012/13; rising to 4.7 million by 2020.

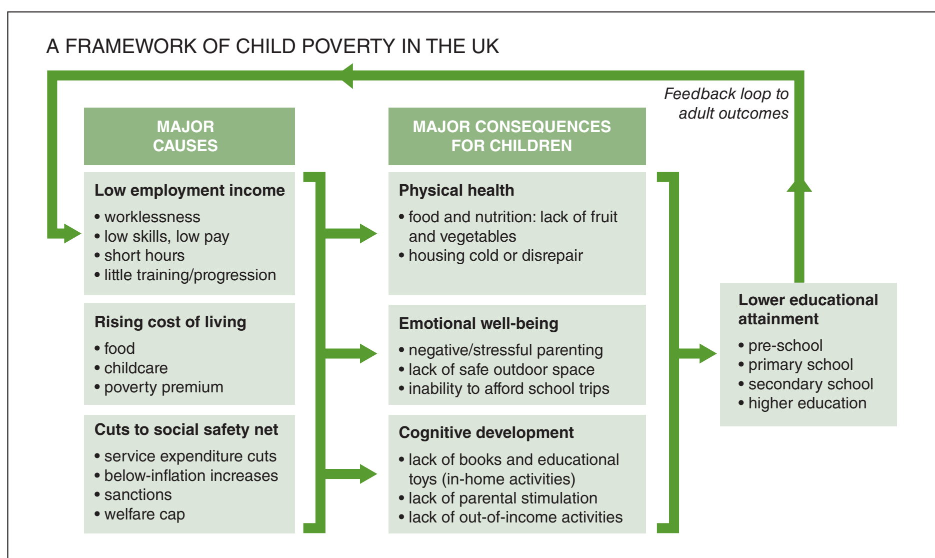


Diagram courtesy of Save the Children, A Fair Start for Every Child. www.savethechildren.org.uk/sites/default/files/images/A_Fair_Start_for_Every_Child.pdf

WHAT CAN HELP?

Evidence suggests that it is not just getting adults into work that will reduce child poverty but also looking at reducing the cost of living and essential items, improving insecure, low paid and low skilled jobs and improving the quality of childcare.

These approaches fall into three main categories: –

Helping the family to come out of poverty

Evidence shows that instead of career progression with a resultant increase in wages, people in low paid, low skilled, insecure jobs dip in and out of employment on consistently low wages. Whilst cost-of-living increases, their wages do not. Improving insecure, low paid and low skilled jobs that do not lead onto better jobs helps to reduce child poverty directly and improves future job prospects for children thus reducing the chance of them continuing in the cycle of poverty.

Increases in the levels of working lone parents and benefits paid to families contributed to a dramatic reduction between 1998/9 and 2011/12 when around 1.1 million children were lifted out of poverty.

Mitigating the current effects of poverty

Children who are living in poverty can experience more physical and mental health problems than their peers; often as the result of not being able to afford a healthy diet or access to physical activity and the pressure of realising they do not have the same opportunities as friends not living in poverty. Addressing this can prevent health problems both current and in the future. This can be through initiatives such as free school meals, subsidised or free school uniform and free childcare places.

Preventing children in poverty becoming adults in poverty

Improving the quality of free childcare not only allows parents to work, it also allows children living in poverty to access support around learning, raising aspirations and early detection of any problems that may prevent educational achievement. Accessing free early education helps the most vulnerable children to be ready and able to learn once they start school.

ASSETS AND CURRENT WORK

Work needs to be done on a national and local level to support pre-school and school age children living in poverty.

Early Years

Breastfeeding support for mothers throughout Derbyshire can improve the health of babies and can reduce the risk of obesity, Type II diabetes and a range of infections. It also has significant benefits for the mother including financial benefits. Formula milk can cost up to £540 for the first year, plus there is the cost of feeding equipment; breastmilk is free!

Teenage parents are more susceptible to postnatal depression and to living in poverty. The Family Nurse Partnership is an intensive support programme to help teenage parents through the antenatal period, up to the child's second birthday supporting the family and preventing problems developing. Outcomes include increased breastfeeding rates, higher employment rates and lower numbers of safeguarding incidents.

Derbyshire's Children's Centres can direct parents to get support with housing, benefit entitlements and debt issues. They have links with the Citizens Advice Bureau, Credit Unions, Jobcentre Plus and The Law Centre. They work with parents to help maximise their income by offering training and volunteering opportunities to improve job prospects. Work is done with parents to reduce substance or alcohol misuse so that any income is directed to supporting their children. Children's Centres also offer support to access food banks, crisis monies, the Derbyshire Discretionary Fund (www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/money_and_legal_matters/managing_money/derbyshire_discretionary_fund/default.asp), white goods, fruit and vegetable cooperatives, free nursery provision, affordable warmth schemes and children's activities.

The Derbyshire 'Every Child a Talker' (ECAT) and the new 'Every Child a Mover' (ECAM) programmes are targeted to accelerate educational progress of the most vulnerable children, actively assessing their developmental level and putting in strategies to support them.

In Derbyshire, 1,696 children are currently eligible to receive 15 hours of free early education (increasing to 3,200 from September 2014). There is currently 75% uptake although in some of the most deprived areas this is as low as 31%, further creating inequalities in accessing early support.

The Early Years Quality Improvement Service works with 282 early years settings including independent schools, pre-schools, nurseries, full day-care settings, Children's Centres, child-minders, playgroups, out of school clubs on a day-care site and stand-alone out of school provision. They work with providers to ensure children at risk of developmental delay are identified at the earliest opportunity and appropriate interventions put in place.

School Age Children

In September 2014 universal free school meals will be implemented for every pupil in reception, year one and year two. This will allow children to have a free, nutritionally balanced hot meal. As it will ease family budgets it may enable older siblings to also have a hot lunch. It is hoped it will reduce some of the stigma that can exist around free school meals and increase uptake in those at greatest need. www.derbyshire.gov.uk/education/schools/your_child_at_school/meals/default.asp

A breakfast club pilot across Derbyshire offers children in schools with the largest percentage of free school meals, a nutritious breakfast alongside informative, fun activities. Breakfast clubs help academic achievement with improved attainment, attendance, punctuality, concentration and behaviour.

The Raising Aspirations programme works to combat the perception in some children that working life will at best mean an unskilled role with a low wage. It provides initiatives for children and their families to discover more about the world of work and the opportunities available to them. The programme offers targeted work alongside universal initiatives.

Two letters from primary school pupils thanking Derbyshire County Council for providing their Breakfast Club:

I want to thank you for providing us with breakfast in the morning. We are also writing to say thank you and that we enjoy our breakfast.

Breakfast has helped us to work confidently and kept us awake during lesson time. Our favourite breakfasts are: sausage cob and rice crispies. These breakfasts are so delicious and we can't wait for next week. My least favourite breakfasts are: brioche and flapjack. We are also looking forward for having different breakfasts besides the breakfast we eat in a morning.

We are extremely thankful for the appetizing breakfasts we eat in a morning. We would like to hear from you with a reply.

Yours sincerely
Lisa, Chris and Beth

We are writing because we want to say a big, big thank you for all the wonderful breakfasts you have provided us every morning! We all appreciate it very much.

Giving us breakfast has helped us to be healthier, most of us are on time and give us lots of energy during the morning. On Monday, we have brioche, Tuesday, hot dog, Wednesday, flapjack, Thursday, toast and Friday, cereal. We can have Corn Flakes or Rice Krispies and we all sit around a table and have a nice chat.

We just want say another huge thank you and would love it if you came to our school and even ate some breakfast with us and see how much you've helped us.

Yours sincerely
Isobel, Tim, Martha and Paul

Names changed to protect identity

There are a range of parenting programmes across Derbyshire which aim to alleviate the stress of day to day parenting and impact on those with more complex needs. This can be particularly useful for parents in poverty who have additional stresses which can affect relationships with their children.

Three health projects offer support to homeless young people who need health advice, information about budgeting, benefits and employment advice. They support some of the most vulnerable young people and give them information and skills to prevent them living in poverty in the future or to currently move out of it. Multi-agency teams also provide families and young people with food vouchers, support to access debt counselling and hardship funds.

Uni-fi is an initiative that seeks to radically transform the relationship between Derbyshire County Council and the children in its care, with the aim of improving their life chances. An endowment for children in care is currently being trialled. This provides a financial budget to support each young person enabling them to make choices and increase opportunities to achieve their potential and realise their ambitions. Uni-fi seeks to counter both the financial and other disadvantages that can be associated with growing up in care.

Teatime for Boys

The Young Persons Health Project in Clay Cross set up 'Teatime for Boys' to support young men living in homes affected by poverty. After looking at school attendance, anti-social behaviour and health needs, a Friday evening group was set up aiming to spend a significant amount of time with approximately eight young men aged 12 to 13 years. Every Friday the young men are warmly welcomed and led in some relaxation activity. As a team they decide what they would like to eat, shop for ingredients, make the food and then sit together to eat. Whilst eating the young men and youth workers can talk about the past week – any issues with home, school, friends or concerns. Any food left over can be taken back to their family (including jointly made birthday cakes) establishing an important connection with home. Teatime for Boys' outcomes include improving self-worth, team working, cookery skills, healthy-eating, budgeting and responsibility. The young men turn up every week, this commitment alone is a significant outcome. Supportive relationships are built within the group and with trusted adults, allowing an important emotional support system to be developed. The group offers space for young men to think about their problems or simply to forget them and to enjoy time with others.

New Mills and Chapel Children's Centre group

During the recent OFSTED inspection of New Mills and Chapel Children's Centre group, strong partnership working was highlighted as a strength which contributed to the outstanding judgement in 'leadership and management'. "I feel that having clear links and working protocols with partner agencies helps to identify those in need of support at the earliest possible opportunity. Within the Children's Centre we have links with all partner agencies including the voluntary sector, resulting in positive outcomes for families."

Emma Steeples, Children's Centre coordinator

New Mills Children's Centre work in partnership with statutory and voluntary services and as part of these working arrangements we hold regular meetings with the local food bank. At a recent meeting it was identified that one young woman, Sarah* had attended for more than six sessions. Knowing she was regularly attending the food bank was an indicator that she was struggling to manage on the income she had and prompted further support. Following up on this information helped the Children's Centre to assess and maximise Sarah's family's income. Support through the Citizens Advice Bureau service running from within the centre, resulted in Sarah accessing further benefits and consolidating debts to increase her family's income by £30 a week. Working in partnership with GPs, social care, health visitors and police has ensured that a multi-agency plan is in place to support the needs of the children and family and has prevented them being impacted further by the effects of poverty.

**Name changed to protect identity.*

RECOMMENDATIONS

1. Support parents to improve skills, qualifications, training and experience to improve employment outcomes by ensuring that organisations such as adult education, Children's Centres and social enterprises look at childcare arrangements and flexibility of hours to ensure accessibility for parents including currently working parents
2. Increase the uptake of free school meals and breakfast clubs and assist schools to make sure their breakfast clubs are self-supporting and sustainable. Aim for:
   - Increased uptake of free school meals in primary schools from 82% to 87% (from September 2014 – to include universal free school meals at KS1).
   - Increased uptake of free school meals in secondary schools (KS3) from 74% to 80%
3. Increase uptake of free early education places for eligible two year olds in Derbyshire from 75% to 80%. (NB: The number of eligible children will rise from 1,696 to 3,200 in September 2014).

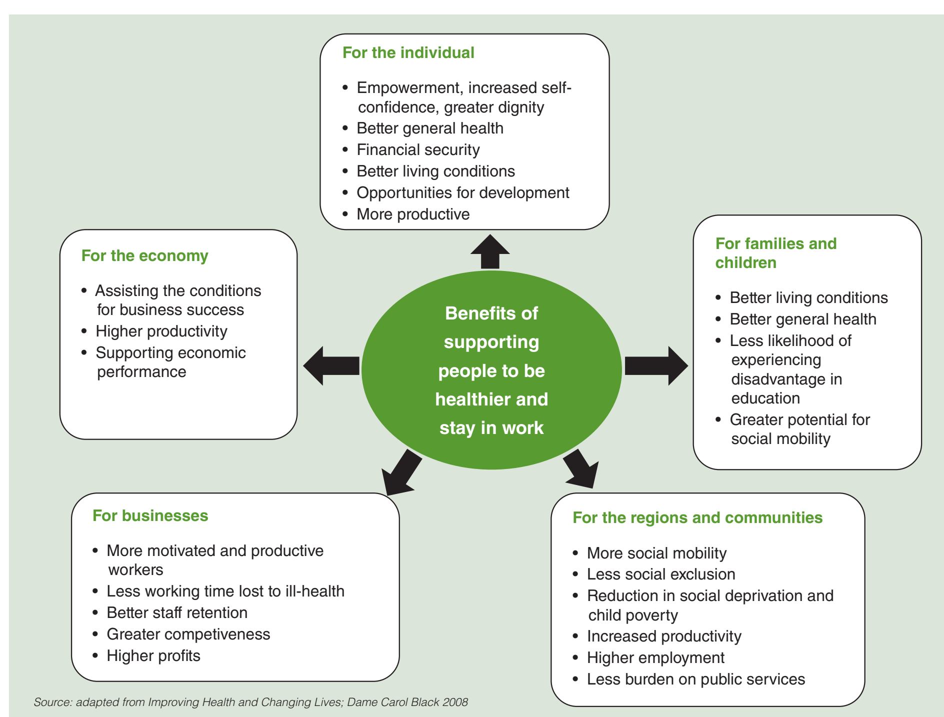
The importance of the economy and work

CONTEXT

For most people, work is good for their health and well-being. Conversely, unemployment is linked to poorer physical and mental health. During periods of economic downturn self-reported ill-health and limiting long-term illness increase.

Evidence shows that people in lower paid jobs are at an increased risk of heart disease, cancer, sickness absence, depression and other health conditions than those earning more within the same organisation.

Maintaining a healthy workforce has a range of economic benefits for individuals, employers and society as a whole.



Source: adapted from Improving Health and Changing Lives; Dame Carol Black 2008

Unemployment affects health in three main ways:

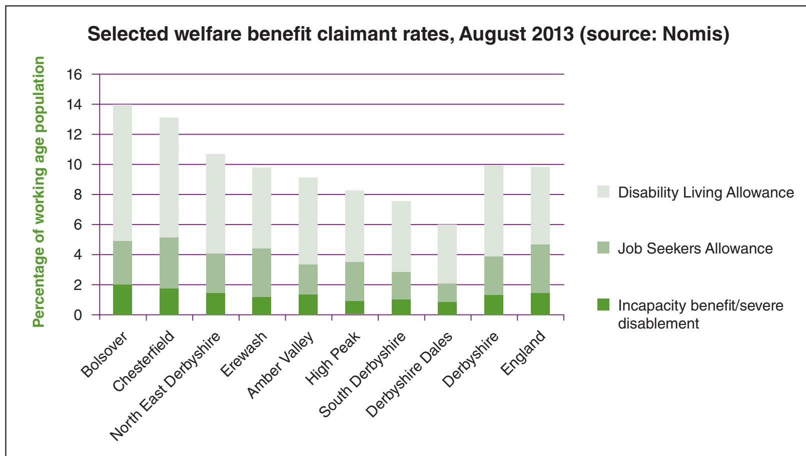
- Financial – leading to poorer living standards, fewer social connections and lower self-esteem.
- Psychological – acting as a trigger for anxiety, distress and depression.
- Behavioural – often leading to an increase in smoking and alcohol consumption and a decrease in physical activity.

For people in employment, the longer someone is on sick leave, the less likely it is they will return to work and their chances of becoming dependent upon benefits increases. Studies have shown that the best window of opportunity for a return to work is between one month and six months.

In April 2014 Derbyshire's unemployment claimant rate of 2.1% remained below the East Midlands and England with figures of 2.6% and 2.7% respectively. At district level, Chesterfield had the highest rate (2.9%), which is above both the regional and national averages. The lowest rates were in Derbyshire Dales (0.9%) and South Derbyshire (1.4%).

At the very local level, around one in five (37) of the county's 179 wards have an unemployment rate above the national average, mostly clustered in the urban areas in the east and north-west of the county. Of the 15 wards with the most severe unemployment problems, five are located in Erewash, four in Chesterfield, three in High Peak, two in Bolsover and one in North East Derbyshire. Amber Valley and Derbyshire Dales had no areas with high concentrations of unemployed people.

Uptake of welfare benefits across Derbyshire varies by district. Those with a disability are particularly far from the job market with over 40% being economically inactive compared to less than 20% in the general population. For DLA (disability living allowance) claimants in Derbyshire the most common disabling condition is learning disability, followed by arthritis, then psychosis.



The percentage of employees who had at least one day off work in the previous week varies across Derbyshire districts from 1.5% in Derbyshire Dales to 3.3% in the High Peak (compared with an average of 2.2% in England). Absence nationally is highest in the public sector (within that the health sector has highest rates) and is higher amongst women than men. The most common cause of short-term absence is minor illness, whereas for long-term absence it is acute medical conditions (such as stroke or heart disease) followed by mental ill-health.

The recession disproportionately affected young people's job prospects. The number of young people aged 16 to 24 who were not in education, employment or training (NEETs) peaked in 2011 but has only declined slowly since. With around one in five young people unemployed, the persistence of high youth unemployment is storing up health and societal problems to come.

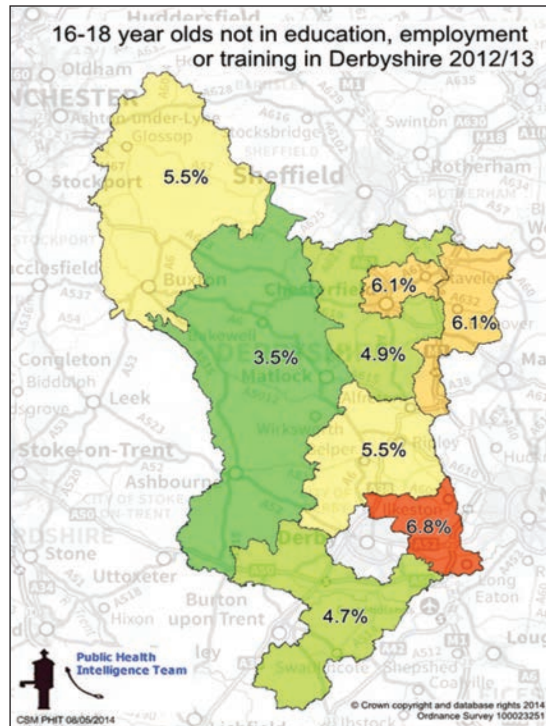
WHAT CAN HELP?

Measures that impact on individual employability

There are specific interventions that have been shown to be effective in helping young people into employment. These include:

- Encouraging young people to take up volunteering opportunities.
- Provision of relevant and meaningful work experience opportunities.
- Encouraging parents to be actively involved in their children's learning.
- Provision of extracurricular activities that are structured and involve partnerships with the family, school and community institutions.
- Provision of work based learning e.g. apprenticeships.

- Intensive one-to-one support for young people who are classed as NEET that identifies their needs and aspirations. This includes Activity Agreements. These take the form of a negotiated contract between the young person and their Personal Adviser or Keyworker that identifies the specific steps the young person should take to progress to education, employment or training. The young person receives intensive support from the Personal Adviser or Keyworker to help them achieve their goals.



Juniper's 'Mint' programme, in the High Peak, aims to help 16 to 19 year olds not in education, employment or training to attain skills. Training is completed in interesting ways to meet the needs of young people that have previously had negative experiences at school. They operate a 100% progression promise and aim to progress every student in to sustainable jobs with training or apprenticeships.

Annabel* joined the Mint programme in August 2013. After missing much of her secondary education she had no qualifications in Maths or English. Annabel completed the course and gained a level two BTEC extended certificate in work skills, and functional skills in both English and Maths. Having qualifications enabled her to progress in to an apprenticeship in interior design; a career she had always assumed was out of reach to her. Annabel is doing well in her apprenticeship and hopes to be fully qualified within the next two years.

**Name changed to protect identity.*

Initiatives that promote a community of responsible employers

On 31st January 2013, the Social Value Act came into force. This ground-breaking new law has the potential to transform the way public services are purchased, requiring public bodies to consider choosing providers based on the social value (i.e. economic, social and environmental benefits) created in an area and not on cost alone. Local authorities and other public bodies can use the Social Value Act to help those facing the greatest barriers to employment into work.

Organisational policies and structures that promote workplace health

Organisations can support the health and wellbeing of employees by implementing interventions based on components of good quality work identified by Sir Michael Marmot, Director of the Institute of Health Equity and MRC Research Professor in Epidemiology at University College London. These include:

- Reviewing the working environment and job design.
- Providing fair earnings and job security.
- Providing training, learning and promotion.
- Providing a work-life balance e.g. through offering flexible working arrangements.
- Supporting employees with a health condition to remain in and return to work e.g. amending work roles, adapting the work environment and providing an alternative job.
- Encouraging active travel e.g. car sharing scheme.
- Providing a programme of health promotion activities.
- Providing health screening e.g. health checks and access to smoking cessation services.

All of the above can be incorporated into an overall workplace health and wellbeing approach. Evidence indicates that approaches which combine several of these components have a greater effect on employees' health and wellbeing.

ASSETS AND CURRENT WORK

Action to address work and health issues needs to be taken at national, county and local levels.

In 2013 the government released a discussion paper which sets out further reform proposals on both the supply and demand side of the labour market. This provides a set of proposals and principles for supporting people with a disability or health condition into employment. The forthcoming delivery plan will help to inform our local approach to supporting individuals whose health condition is a barrier to employment. www.gov.uk/government/publications/the-disability-and-health-employment-strategy-the-discussion-so-far

Nationally, the Government is taking steps to overcome barriers to work for people with health problems or a disability. Fulfilling Potential: Making It Happen (2013): A cross-Government strategy – odi.dwp.gov.uk/fulfilling-potential/index.php

At county level, Local Enterprise Partnerships (LEPs) link local authorities with their business communities. They play a central role in deciding on, and funding, local economic priorities and activities to drive economic growth and create local jobs. Derbyshire is covered by two LEPs, D2N2 (Derby, Derbyshire, Nottingham and Nottinghamshire, www.d2n2lep.org/) and SCR (Sheffield City Region, sheffieldcityregion.org.uk/about/growthplan/), who have recently submitted their Strategic Economic Plans to government. These plans form the basis of negotiations with government on the amount of money each LEP will receive to deliver economic growth within their area. By incorporating social inclusion and health into their strategic objectives they have significant power to reduce economic disadvantage and nurture growth that benefits those at greatest health need.

The Derbyshire Economic Partnership has also drafted an economic strategy statement which, having gone out for consultation is being finalised as this report goes to press. This document defines where Derbyshire can add value to strategic economic plans but also sets out the conditions which will drive economic growth in the county. The strategic objectives aim to provide support to people in overcoming barriers to employment and addressing the root causes of exclusion and poverty such as health and well-being, and skills gaps. Activity will be focused on disadvantaged communities with high levels of economic inactivity, particularly within the North East Economic Zone.

Target communities include:

- people with health and wellbeing issues, including those with mental health problems
- the financially excluded
- children and young people (including NEETs)
- people with multiple and complex needs
- households with worklessness
- adults with physical and learning disabilities

At local level, councils across Derbyshire deliver a wide range of initiatives to support people furthest from the job market to find, and remain in, employment. Examples include:

- Bolsover District: Help to Work. This is a directory of support that is available to people with disabilities in the district, www.helptowork.org.uk/
- North East Derbyshire: Working Communities Project. This project helps unemployed people to overcome barriers and develop skills to get a job, www.nederbyshire.gov.uk/business/working-communities/
- Derbyshire County Council: Disability Employment Project. This aims to improve the employment prospects of local people with a disability, www.derbyshire.gov.uk/working_for_us/equal_opportunities/disability_employment_project/

Markham Vale Workforce Recruitment and Training Service

As part of developing its 200 acre business park at Markham Vale, Derbyshire County Council provides a free service to support the workforce needs of businesses locating to the site. The council works in collaboration with its clients and organisations that operate in the supply and training of labour to maximise employment for local unemployed residents. This service has resulted in over 150 people, including the long-term unemployed, access a range of opportunities in logistics, customer services and other sectors.

Having attended college to learn painting and decorating, Simon,* aged 25, found he was unable to find employment. He was referred to the Sector Based Work Academy for a major distribution centre based at the Markham Vale site. As a result of the council's project he was successful in obtaining employment. He has subsequently developed his skills base and experience with potential for promotion. He now owns his own vehicle and is able to make long terms plans for his future.

**Name changed to protect identity.*

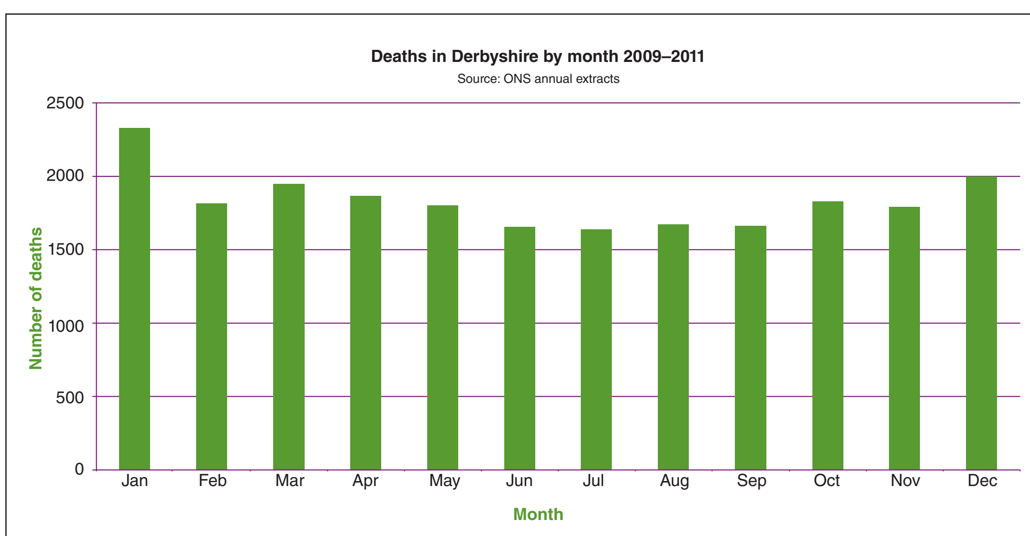
RECOMMENDATIONS

1. Develop a more coherent and coordinated approach between schools, colleges, businesses, training providers and local authorities to support young people aged 16 to 24 to access education, training or employment opportunities.
2. All public sector bodies in Derbyshire should embed social value into commissioning and procurement practices to encourage employers to include the health and wellbeing of their employees as part of their business model.
3. Through the development of a healthy workplaces approach, ensure employers and people with a disability are aware of and access the opportunities that exist to support them into, and to stay in, employment – such as the 'Access to Work' scheme.
4. Derbyshire County Council should tackle health inequalities by working with partners in developing a Healthy Workplaces approach targeted at businesses located in disadvantaged areas employing a high level of low paid, low skilled, manual or retail staff who carry a higher burden of ill-health.
5. The Economic Strategy would benefit from the specific inclusion of the health and social care sector which is a significant contributor of jobs to the Derbyshire economy and is estimated to be 16% of the D2N2 workforce. There are opportunities for collaborative working with the Derbyshire Local Education and Training Council to promote and secure jobs in the sector where there are current gaps in provision. Many of these jobs require high levels of skill and have attractive salaries. Such opportunities should be explored to maximise the ability of local people to access these jobs.
6. Public health support is recommended on relevant boards such as the D2N2 Skills Board and opportunities for joint working should be identified through the Derbyshire Economic Statement to enable collaborative alliances between Public Health and colleagues in economic regeneration at both local and county level to be developed further.

Reducing the impact of cold weather

CONTEXT

Every year in England, mortality is on average 19% higher in the winter months, compared to the rest of the year. The recent publication, The Health Impacts of Cold Homes and Fuel Poverty stated that "countries which have more energy efficient housing have lower excess winter deaths, and that this is due to better preparedness for cold weather and well-insulated, well-heated and energy-efficient homes". The number of excess winter deaths in the UK is higher than many other European countries that have colder winters such as Finland, Denmark and Germany.



The majority of these additional deaths are caused by an increase in the rates of heart attacks, strokes and respiratory disease during the cold weather. A smaller proportion are due to influenza and falls. Households that are at highest risk of poor health during the winter months are those classified as being in fuel poverty.

The key drivers behind fuel poverty are:

- the energy efficiency of the property (and therefore, the energy required to heat and power the home)
- the cost of energy
- household income.

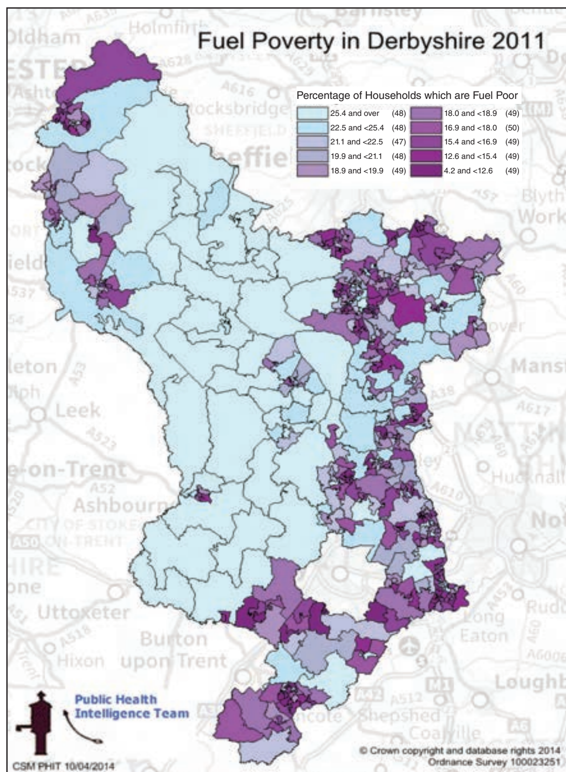
Within Derbyshire, in 2012/13 there were an estimated 463 excess winter deaths, a rate which is similar to the national average.

Until 2013, households were defined as being fuel poor if they had to spend more than 10% of their income on fuel to maintain a satisfactory heating regime. The government recently changed the definition, with households now said to be in fuel poverty if:

- they have fuel costs that are above average, and
- if they were to spend that amount they would be left with a residual income below the official poverty line.

Regional data suggests that the change in definition will reduce the number of households classified as being in fuel poverty by approximately one quarter.

In Derbyshire, using the pre-2013 definition, there were nearly 83,000 households living in fuel poverty; that is just under one in five of all households. This figure is likely to reduce to approximately 60,000 using the new definition. Derbyshire Dales has the second highest proportion of fuel poor households in England, with 27% of households living in fuel poverty. Across Derbyshire, the highest rates of fuel poverty are found in the rural communities.



There are certain groups within Derbyshire that are more likely to meet the definition of fuel poverty and therefore be at increased risk of poor health during the winter months:

- people with long-term respiratory or cardiovascular illness.
- people on low incomes, especially
  - those living in rural locations with restricted fuel choices, or
  - families with young children living in poorly insulated, private rented accommodation, or
  - older people unable to economically heat a larger family home.

WHAT CAN HELP?

Evidence shows that simple measures to improve housing conditions (better insulation, draft proofing and energy efficient heating systems) and increasing the ability to pay for energy, provide measurable health improvements.

What can individuals do?

- improve their knowledge of issues related to affordable warmth and share this knowledge to support vulnerable households to reduce their fuel costs.
- take every opportunity to maximise their income and actively take up offers aimed at improving people's ability to effectively heat their homes.
- plan for future price rises and make sure paying energy bills is prioritised as part of household budgeting.

What can communities do?

- with the support of local authorities and community and voluntary sector organisations, form community schemes to increase buying power and reduce costs, such as bulk oil purchase cooperatives.
- with the support of local authorities and community and voluntary sector organisations, participate in collective switching schemes to new energy providers or tariffs.
- collectively participate in council-endorsed schemes offering free or low cost external insulation.
- encourage the identification of vulnerable people in their community so that they can be signposted to agencies who can offer support.

High Peak CVS Big Energy Saving Network project

Between December 2013 and March 2014, High Peak Community and Voluntary Support ran a project to help vulnerable households identified as being highly unlikely to switch energy providers to get a better deal, or to claim an energy-related benefit. The project reached over 230 people, including vulnerable consumers and frontline workers and volunteers.

Households supported to make changes to reduce their fuel costs included:

- an elderly couple losing heat by keeping the trap door to their loft open permanently.
- a woman in her 80s who had got into fuel debt by leaving her electric immersion heater permanently switched on.
- a young, single mother on a low income and with a new baby was supported to get a better energy deal, changing prepayment meters to ordinary meters and identifying the benefits to which she may be entitled.
- the manager of a community centre mainly used by older people attended a project workshop and subsequently ran advice surgeries to help the centre-users reduce their energy costs.

What can organisations do?

- recognise the impact that cold, damp housing can have on an individual's health and the measures that can mitigate these risks.
- systematically assess and refer vulnerable individuals for support to access energy efficiency and income maximisation advice. Initially, organisations should agree an appropriate process to allow this.
- actively support the Derbyshire County Council funded scheme aimed at the most vulnerable living in cold, damp housing.
- adopt the wide range of evidence-based affordable warmth interventions to ensure county-wide provision and reduce inequity in service provision.
- within the scope of data sharing agreements, share intelligence across organisations.
- support partnerships such as The Local Authority Energy Partnership to access investment from central government or energy providers on a large scale.

GP Affordable Warmth scheme

Mr Smith's* wife died recently. He has a heart condition and diabetes, which makes him particularly susceptible to the cold. He relies on a single gas fire and electric heaters upstairs which he has found are very expensive to run. His GP from Jessop Medical Centre contacted Amber Valley Borough Council because of concerns about the impact the poorly-heated house was having on Mr Smith's health.

Amber Valley Borough Council arranged for the Home Improvement Agency to visit to see how Mr Smith could be helped. They helped Mr Smith apply for funding for heating improvements. Two months later central heating was installed, and Mr Smith was given additional advice to make sure that his fuel bill was manageable and that he understood the tariff that he was on.

**Name changed to protect identity.*

ASSETS AND CURRENT WORK

Action can be taken at national and local level to reduce fuel poverty and mitigate its effects.

Nationally, the Cold Weather Plan gives advice to professionals from health and social care organisations on preparing for the effects of winter weather on people's health. www.gov.uk/government/publications/cold-weather-plan-for-england-2013

The Local Authority Energy Partnership (LAEP) is a partnership whereby Derbyshire's district councils, county council and the Peak District National Park Authority work together to alleviate fuel poverty and promote energy efficiency. The partnership has coordinated county-wide actions such as providing practical advice, area-wide insulation schemes and maximising income from government and energy company schemes. In 2013, the LAEP secured over £1 million funding to replace 350 broken or inefficient boilers in fuel poor households across Derbyshire.

Derbyshire County Council have recently invested significant resources to identify and target individuals with health conditions most likely to be exacerbated by cold and damp housing. People are supported to access advice on energy efficiency and ways to maximise their income to improve their ability to comfortably heat their homes. The service will use a range of data sources to identify those people who live in the least energy efficient homes, are on low incomes and have long term conditions associated with excess winter deaths. They will be contacted by a health professional and with their consent, will be referred through to the District Council who will provide direct support both practical and in certain cases, financial to ensure that barriers to improving the energy efficiency of their homes are reduced and interventions provided.

All of the district and borough councils produce bi-annual Home Energy Conservation Act reports. These reports set out the actions that each authority undertakes to support the delivery of energy efficiency and help tackle fuel poverty. Information is available on each Council's website.

Currently, borough councils produce individual Affordable Warmth Strategies; however Derbyshire County Council and the district and borough councils are now working together to produce a joint Affordable Warmth Strategy which will further strengthen the partnership working across Derbyshire to tackle fuel poverty.

Community and voluntary sector organisations also support affordable warmth initiatives across Derbyshire. Rural Action Derbyshire operates an Oil Buying Scheme that uses the power of collective purchasing to offer discounted prices on heating oil for those consumers not connected to the mains gas network. Provision of advice about affordable warmth is included within the Pennies and Pounds project that supports older people in North Derbyshire.

RECOMMENDATIONS

1. Partner agencies across Derbyshire, using LAEP as a coordinating forum should mitigate the reduction in financial resources available from central government for affordable warmth schemes, by working cooperatively to maximise access to affordable warmth schemes, grants, incentives and opportunities.
2. Derbyshire and Nottinghamshire LAEP, and other local organisations representing those most in need, should advocate to the Department of Energy and Climate Change on the impact of the changes in government policy and subsequent impact on the housing condition and health of vulnerable households.
3. Development and implementation of a county-wide strategy to systematically identify and refer vulnerable households should be prioritised, co-ordinated through a suitable forum such as the LAEP or the Derbyshire Housing and Health Strategy Group.
4. Member organisations of the Health and Wellbeing Board should prioritise implementation of the Derbyshire County Council affordable warmth programme to identify individuals with poor health at increased risk of winter mortality and ensure that their staff are aware that the programme has been identified as a strategic priority.

Summary of recommendations

Financial inclusion

1. Make Derbyshire a 'Living Wage' economy. All major public sector employers to consider applying for accreditation with the Living Wage Foundation (www.livingwage.org.uk/how-become-living-wage-employer). Their example should be followed by private and voluntary sector employers where feasible.
2. Invest additional resources to support a multi-agency approach to ensure that more people receive their full benefit entitlement, aiming for an additional £10m of benefit take up.
3. Continue to invest in money management skills through adult education, schools, community groups and geographical communities at greatest risk of financial exclusion.
   - Target; anyone who enrols on a work related training programme, every child in year six and year 11, anyone receiving advice on debt, benefits or taking out a loan from a Credit Union.
   - Target; geographical communities identified through mapping by using creative techniques to encourage community engagement.
4. Treble the percentage of the population who are members of Credit Unions in Derbyshire from the current 6,123 (less than 1%) to 18,000 over the next three years.

Child poverty

5. Support parents to improve skills, qualifications, training and experience to improve employment outcomes by ensuring that organisations such as adult education, Children's Centres and social

enterprises look at childcare arrangements and flexibility of hours to ensure accessibility for parents including currently working parents

6. Increase the uptake of free school meals and breakfast clubs and assist schools to make sure their breakfast clubs are self-supporting and sustainable. Aim for:
   - Increased uptake of free school meals in primary schools from 82% to 87% (from September 2014 – to include universal free school meals at KS1).
   - Increased uptake of free school meals in secondary schools (KS3) from 74% to 80%.
7. Increase uptake of free early education places for eligible two year olds in Derbyshire from 75% to 80%. (NB: The number of eligible children will rise from 1,696 to 3,200 in September 2014).

Employment and health

8. Develop a more coherent and coordinated approach between schools, colleges, businesses, training providers and local authorities to support young people aged 16 to 24 to access education, training or employment opportunities.
9. All public sector bodies in Derbyshire should embed social value into commissioning and procurement practices to encourage employers to include the health and wellbeing of their employees as part of their business model.
10. Through the development of a healthy workplaces approach, ensure employers and people with a disability are aware of and access the opportunities that exist to support them into, and to stay in, employment – such as the 'Access to Work' scheme.
11. Derbyshire County Council should tackle health inequalities by working with partners in developing a Healthy Workplaces approach targeted at businesses located in disadvantaged areas employing a high level of low paid, low skilled, manual or retail staff who carry a higher burden of ill-health.
12. The Economic Strategy would benefit from the specific inclusion of the health and social care sector which is a significant contributor of jobs to the Derbyshire economy and is estimated to be 16% of the D2N2 workforce. There are opportunities for collaborative working with the Derbyshire Local Education and Training Council

to promote and secure jobs in the sector where there are current gaps in provision. Many of these jobs require high levels of skill and have attractive salaries. Such opportunities should be explored to maximise the ability of local people to access these jobs.

13. Public health support is recommended on relevant boards such as the D2N2 Skills Board and opportunities for joint working should be identified through the Derbyshire Economic Statement to enable collaborative alliances between Public Health and colleagues in economic regeneration at both local and county level to be developed further.

Affordable warmth

14. Partner agencies across Derbyshire, using LAEP as a coordinating forum should mitigate the reduction in financial resources available from central government for affordable warmth schemes, by working cooperatively to maximise access to affordable warmth schemes, grants, incentives and opportunities.
15. Derbyshire and Nottinghamshire LAEP, and other local organisations representing those most in need, should advocate to the Department of Energy and Climate Change on the impact of the changes in government policy and subsequent impact on the housing condition and health of vulnerable households.
16. Development and implementation of a county-wide strategy to systematically identify and refer vulnerable households should be prioritised, co-ordinated through a suitable forum such as the LAEP or the Derbyshire Housing and Health Strategy Group.
17. Member organisations of the Health and Wellbeing Board should prioritise implementation of the Derbyshire County Council affordable warmth programme to identify individuals with poor health at increased risk of winter mortality and ensure that their staff are aware that the programme has been identified as a strategic priority.

Progress on challenges highlighted in the 2013 Annual Report

What we highlighted last year	Progress made
Starting and developing well	
Low rates and inequalities in breastfeeding initiation in Derbyshire	■ A county-wide Breastfeeding Peer Support Service started in April 2014, interviews for peer supporters are underway at the time of going to press and most areas have recruited to these new positions. ■ UNICEF have awarded Derbyshire with an 'Outstanding' accreditation at Stage three of the Baby Friendly award.
Inequalities in childhood obesity in year six	■ A new Breakfast Club service is now jointly funded by Derbyshire County Council's Public Health and Children and Young Adults teams, aiming to improve attainment, attendance, punctuality, concentration and behaviour. ■ A maternal obesity pilot programme that offers physical activity to pregnant women has been extended to Queens Park Sports Centre. ■ The Five60 programme for Years three, four and five has continued to develop to include a focus on encouraging children to be more active outdoors, by delivering road safety messages. ■ The Food for Life partnership has targeted schools with the highest rates of obesity and focussed on enjoyment of a healthy diet including growing, cooking and eating.
High rates of smoking in pregnancy	■ A pilot financial incentive scheme to help pregnant smokers to quit proved successful, so this service will be built into our redesign of lifestyle services. This should help us reach our target of getting smoking in pregnancy down 11% by December 2015.
A social gradient in A&E admissions for 12 to 19 year olds for self-harm Poor emotional health of children in care	■ We are developing: – A children and young people's mental health promotion and emotional wellbeing action plan – a Young People's Risky Behaviour strategy (to include self-harm, sexual health, smoking and substance misuse). – A parenting strategy – An integrated Public Health Nursing Service for youngsters aged 0 to 19.
Adulthood	
Rising levels of adult obesity across Derbyshire	■ We have developed a partnership approach to nutrition called Heart of Derbyshire and, with colleagues in Derbyshire Sport; we have refreshed the Active Derbyshire partnership plan. One of the actions in the plan aiming to reduce sedentary behaviour is the Workforce Challenge, encouraging all employers and employees to sign up with their own physical activity challenge. A new fund to tackle sedentary behaviour at locality level has also been created to encourage innovation.

A need for more integrated and holistic support for people wanting to make lifestyle changes	■ Two major reviews were completed in the last year on tobacco control and obesity. As a result a new integrated wellbeing service distributing resources to areas of highest need will be in place later this year. This approach brings together the resources for smoking, weight management and health trainers to form an integrated service.
A need to extend and embed MECC (Making Every Contact Count)	■ Plans to extend MECC to other, non NHS agencies are well developed. The approach includes both an online training tool and a training function built into the integrated wellbeing service.
An ambition for Derbyshire County Council to accelerate the Healthcheck programme	■ Derbyshire County Council's strong leadership has increased the number of Health Checks undertaken in Derbyshire and we are close to our 60% target. We aim to increase this to at least 66% in 2014/15 aspiring to reach 75%. For 2014/15 we will promote a recall process for those people who have not responded to an invitation. We have successfully piloted a GP outreach Health Check in a village hall which offers later evening appointments. These have been fully booked for the three month pilot which has been extended to cover the summer months. We are looking at developing the same model within Bolsover. Plans are in place to improve access to Health Checks especially in areas of highest deprivation.
Ageing well	
Under-diagnosis of dementia and a forecast of increasing numbers of sufferers	■ The dementia strategy for Derbyshire has been reviewed to assist NHS partners, social care, Public Health and the voluntary sector to shape services to support the prevention, diagnosis and treatment of dementia.
An increasing need for joined up services to prevent falls in older people	■ Public Health have provided an additional investment of £275,000 to strengthen the primary falls prevention work which takes place across the county. This will enable people who have fallen or are at risk of falling to attend long term exercise sessions aimed at improving and maintaining their balance and strength.
Uptake of bowel cancer screening of 58% in 2012	■ The latest figure for uptake of bowel cancer screening in 2013 was almost 60%. NHS England's Area Team, who are now responsible for national screening programmes, have developed a health improvement strategy which aims to increase uptake of bowel cancer screening in parts of the county where the uptake is particularly low.
Healthcare	
The establishment of a Clinical Effectiveness Team within DCC to support Clinical Commissioning Groups (CCGs)	■ The way Public Health supports the NHS is currently under review in Derbyshire with the aim being to improve co-ordination and impact on health improvement and reduction in health inequalities. Most of the functions of the Clinical Effectiveness Team will be maintained, but within a wider 'offer' of specialist Public Health support to the CCGs in Derbyshire.

	■ All Derbyshire CCGs have Public Health input at senior management team level to ensure that the public health principles of prevention, health-improvement, fairness and cost-effectiveness are considered in CCG decision-making. ■ Public Health are in the process of finalising a prevention strategy to guide NHS and other partners in planning to prevent ill-health and loss of independence.
Sexual health	
A need for a more integrated specialist contraception and sexually transmitted infections service model	■ A sexual health needs assessment and review of existing sexual health services has been undertaken. Recommendations including developing an integrated sexual health service were presented to Derbyshire County Council Cabinet and approved. A tendering process will start later this year to commission a Derbyshire County Integrated Sexual Health Service. This will be in place from April 2015 and will improve access to STI testing and treatment, contraception and sexual health promotion and HIV prevention services across the county.
A need to maintain investment in prevention to avoid rising treatment costs for poor sexual health outcomes	■ Derbyshire has begun implementation of the national chlamydia screening 3Cs & HIV programme. This supports practices across England to provide the '3Cs': a chlamydia screen, signposting or provision of contraceptive advice and free condoms, during routine consultations with young adults. The programme also includes delivering HIV testing in primary care for adults.
Mental health and wellbeing	
Access to talking therapies for some, but not all areas of Derbyshire	■ Access to talking therapies is now available across the county, and we plan to undertake a health equity audit of the services later this year to make sure they are reaching those at greatest need.
A need for people with long term physical health conditions to have their mental health needs met too	■ A psychiatric liaison service (RAID) (rapid assessment interface discharge) has been established at Royal Derby Hospital, and CCGs have agreed to commission a similar service at Chesterfield Royal Hospital to ensure that hospital patients' mental health needs are assessed and support is offered where necessary.
People suffering mental illness on average die younger than the general population	■ CCGs and Public Health continue to jointly fund the Healthy Body Healthy Mind Programme which works to improve the physical health of individuals with mental health problems.

Economic austerity can have a wide-ranging, damaging impact on people's mental health, including increased risk of suicide	■ The suicide prevention strategy is updated annually, and work continues with a wide range of stakeholders to reduce the rate of suicide in Derbyshire. This includes provision of mental health awareness and suicide prevention training. ■ Public Health have provided financial support to Credit Unions and food banks to support those at risk of developing mental health problems through financial crisis. ■ Derbyshire County Council have signed up to the Time to Change campaign to reduce stigma and mental health discrimination.
Substance misuse	
A planned review of intensive, inpatient detox services	■ A review of the completion and outcome data for inpatient detox services over the past three years is currently underway. This will give us a better understanding of whether the existing service provides effective treatment for our investment. We will then look at all potential service providers to develop a 'preferred provider' list which meets the needs of service users from across the county.
A planned review of family and carer support	■ The family and carer service has funded from a grant for 2014/15 whilst we redesign it to best meet the needs of families and carers of people who misuse drugs or alcohol in Derbyshire.
A need for recovery focused alcohol services	■ Specialist alcohol services for dependent drinkers have been redesigned and the new service started in April 2014. We are still in the process of redesigning services that provide alcohol misuse information and advice, signposting and referral, and aftercare.
Plans to train successful service users to become 'recovery champions'	■ We have a scheme with RIOT (Recovery Is Out There) from Staffordshire who are all volunteers, in recovery themselves. Their remit is to make recovery more visible and achievable for service users. Volunteers sit in waiting rooms of the mainstream treatment services and take opportunities to discuss treatment and recovery from the perspective of a recovered service user. Their longer term aim (2014/15) is to develop a qualification to use when identifying local recovery champions to develop their skills and experience, and these local recovery champions will take forward visible recovery across Derbyshire.
Plans to pilot a peer support scheme at Foston Hall prison	■ Two peer mentors were originally identified, although one was subsequently deemed to be unsuitable. The remaining peer supporter is doing extremely well and they are now actively recruiting for more volunteers to support prisoners wanting to recover from drug or alcohol problems.

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DERBYSHIRE
County Council
Improving life for local people

HEALTH AND WELLBEING BOARD

4th September 2014

IMPLEMENTATION OF THE BETTER CARE FUND: UPDATE

Purpose of report

The purpose of this report is to update the Health and Wellbeing Board about the key changes to the Better Care Fund (BCF) national requirements.

Background

National guidance was originally issued in August 2013 and January 2014, which required all Health and Wellbeing Boards to approve and submit a local final Better Care Fund Plan by April 4th 2014.

BCF plans had to demonstrate the support of all partners including acute providers, meet a number of national conditions, and provide a baseline and trajectory against five national and one agreed local metric (dementia diagnosis) against which the performance of the plan would be measured.

2014/15 is the preparatory year for the BCF. The full implementation of the developments within the plan and the financial allocations associated with these developments do not come into effect until 2015/16. For Derbyshire our BCF plan assumes a pooled budget of £61.489 million which it should be noted is not new money and is made up of funding from existing resources.

During April and May regional and national assurance took place to assess the 151 BCF plans against the national requirements. During this period there were a series of discussions between NHS England (NHSE) and Local Government, including ministerial level meetings between the Department of Health and the Department of Communities and Local Government to discuss the levels of assurance BCF plans provide at this early stage, in particular:

- The ability of plans to demonstrate evidence based schemes to reduce avoidable emergency admissions to a sufficient level of ambition;
- The involvement of acute providers in approving local plans.

At the time of the original BCF submissions in April the BCF performance and financial regime did not entail any funds being held back centrally on the basis of performance. However there was a clear expectation that a local contingency/risk pool would need to operate, to be set out within the Section 75 agreement for each BCF, with effect from 2015/16. If performance against the metrics did not reach the locally agreed thresholds, funds from this risk pool would be used to mitigate the financial consequences between partners.

There is also an expectation that if local areas were falling short of their trajectories additional support and oversight from NHSE and Local Government would be in place, where necessary, to assist with getting plans back on track.

Derbyshire's BCF plan submissions on 4th April and 7th May set out the level of contingency partners agreed for the financial plan, and the Joint Commissioning Co-ordinating Group is leading the work needed to develop the Section 75 agreement and supporting risk sharing agreement.

On 5th July 2014 an announcement was made by the Department of Health setting out some fundamental changes to the BCF planning arrangements which we will need to take account of in the Derbyshire BCF resubmission.

Six areas were 'fast-tracked' to resubmit their plans 9th July (Nottingham County, Sunderland, Wiltshire, Greenwich, Liverpool and Reading). They were issued with draft revised submission templates for this purpose. Derbyshire was not in this cohort. The aim was to take a sample of the best draft plans ahead of the publication of refreshed guidance which are envisaged to provide exemplar plans for other areas to use as part of improving their own plans. These are unlikely to be available until week commencing 8th September, although sections may be released earlier.

On 11th July 2014 letters were sent out to the chairs of Health & Wellbeing Boards jointly from the Department of Health, Department of Communities and Local Government, NHS England and the LGA.

Every Health and Wellbeing Board is asked to sign off and resubmit their Better Care Fund Plan no later than midday on 19th September 2014. This will be followed by a regional and national assurance process using criteria set out in a comprehensive 42 page document. It is anticipated that by 3rd October all BCF plans will have been reviewed and assessed. The revised BCF template includes some new questions, some revised questions and some questions are unchanged (See table Appendix 1).

There are several main areas of change/concern to note in taking forward our local response, all of which are subject to further clarification and guidance.

1. The guidance and templates to be completed are being updated on a regular basis; which have additional annexes and questions for completion. In addition, the recently established national *Better Care Fund Task Force* now issues a weekly newsletter which also contains various clarifications and guidance; and is setting up significant numbers of webinars in response to the queries they are receiving, to cover specific topics, for example there were five in the week of 25th August. A couple of regional workshops have also been arranged at very short notice.

The main areas where nationally and locally, we are seeking clarification are:

- Definition of the 3.5% ambition for reducing emergency admissions; and clarification of the baseline figure being used;
- Section 75 agreements, including advice on risk sharing arrangements;
- Risk Stratification and Information Governance issues;
- The BCF evidence base, interventions and their impact on metrics.

The revised Technical Guidance issued on 18th August now includes a section setting out 'what good looks like' with criteria for each section of the BCF template, and each BCF plan will be expected to meet those detailed requirements in the September submission, as well as the review assurance criteria.

The pace of changes to guidance and requirements being announced makes it challenging to finalise our local agreements; but all parties are committed to achieving completing the requirements of the BCF and to submit on time for the 19th September.

2. There is now a very strong emphasis on the avoidable emergency admissions metric which will drive a number of potential changes and requirements:

   - Avoidable emergency admissions are the sole indicator underpinning the Pay for Performance element of the BCF. This is on the basis that "a reduction in total emergency admissions is a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community";
   - The original BCF metric has now been expanded to include all non-elective admissions (general and acute);
   - There is a change to the level of ambition for the emergency admissions metric. Each Health and Wellbeing Board is asked to propose their own performance pot based on their level of ambition for reducing emergency admissions – with a guideline reduction of at least 3.5 per cent.
   - There is likely to be a greater level of risk for Derbyshire in achieving the performance levels within the BCF plan;
   - There is more centralised and regular upward reporting requirements than anticipated, including three 'checkpoint' returns (8th August, 27th August and 12th September) which have to be completed jointly by the Clinical Commissioning Groups and Derbyshire County Council – and submitted to NHS England;
   - The pressure to achieve the reduction in non-elective admissions risks the BCF plan becoming focused wholly on reducing the admissions within one financial year; and reduces our ability to implement medium term integration and prevention schemes, which are key to a sustainable change in shifting care outside of hospital.
   - The original range of metrics against which the plan will be measured remains, as an indicator of local joint working and integration.

3. <u>Pay for performance has been re-introduced</u>: A proportion of Derbyshire's current performance allocation, that is, our share of the national £1bn performance element of the fund, will be paid for delivery of the emergency admissions target. That proportion depends on the local level of ambition of the target.

- The amount of the Derbyshire BCF affected by the payment for performance is estimated to be £15m, of which:
  - Approximately £5m will be the performance-related element. At each of the four 'payment points' each CCG will be able to release money into the BCF pooled fund, on the basis of performance to date. If the target is not achieved in a quarter, then the amount relating to the activity not achieved will be held back by the CCGs for 'remedial reallocation', which in reality will be to pay for activity. Where targets are met, the money will be released to the pooled budget and the decision on how funds are to be spent has to be agreed between the CCGs and the Health and Wellbeing Board. The contingency plan part of the BCF also needs to include actions to be implemented in the event that the emergency admission target is not met.
  - The remaining £10m (estimate at time of writing) must be spent on NHS commissioned out-of-hospital services. This funding should be transferred by the CCGs into the pooled fund at the beginning of 2015/16 for investment. The revised BCF plan must include a breakdown of spend; including the amount identified as NHS-commissioned spend. The breakdown of spend in the revised BCF plan must also distinguish between how much NHS commissioned spend is coming from the minimum pooled fund, versus the actual pooled fund, which in Derbyshire also includes the funding for the Community Equipment Service.
- This approach reduces our locally flexibility in relation to risk pooling arrangements.

The above changes and risks they represent could jeopardise the progress already being made between partners in Derbyshire as we set out our plans to transform health and care over the next 5 years. The revised plan template includes the original national conditions: BCF plans to be jointly agreed, protection for social care services, 7 day services, better data sharing based on the NHS number, joint approach to assessments and care planning, lead accountable professional and agreement of the impact of the changes on the acute sector.

The change in focus could lead to increased tensions between local government and NHS partners both nationally and locally, due to the high level of emphasis being placed on NHS finances/activity, which could be seen to be detracting from other aspects of the vision for integration, affecting the overall balance of BCF plans for the future, and placing additional risks on Adult Care budgets in particular.

It is essential that we jointly assess the local implications of the above changes, work together on assessing the risks and mitigations, and agree any adjustments needed to our BCF plan together, so that we can:

- Continue our good progress in developing integrated care and support for local people;
- Provide a consistent message as a partnership about our intentions;
- Resubmit our BCF plan in line with the national requirements.

Workplan

a) The work to digest the guidance and resubmit our BCF plan in line with the national timetable continues and is being led by the Joint Commissioning Co-ordination Group.

b) To consider the feasibility/timing of an additional Health and Well Being Board meeting ahead of submission or agree alternative sign-off arrangements and confirm these arrangements as soon as possible.

c) The Joint Commissioning Co-ordination Group continues to meet to consider implications collectively and provide assurance that preparations and various analyses are already underway for the resubmission, using the materials provided by the national Better Care Fund Task Force.

d) Detailed actions include:

   - Assessing the feasibility and risks associated with the 3.5% emergency admissions threshold, including quantifying the financial risks;
   - Analysing our current and future spend on NHS providers outside of the acute setting;
   - More detailed analysis by BCF scheme (this work was already in progress) against each of the BCF metrics to give additional assurance on impact by scheme;
   - Recommending any adjustments to the plan;
   - Populating the revised submission templates;
   - Digesting the additional guidance when available.

Consultation/Patient and Public Involvement

The revised draft guidance requires additional information on patient experience. It also clarifies the metric; that the national measure will not be in place in time to measure improvements in 2015/16. Health and Wellbeing Boards are asked to provide local plans in line with revised guidance. The timescales for resubmission are likely to prevent wider engagement.

Resource Implications

The changes to the national arrangements for the BCF could lead to a reduction in the funds available within the Derbyshire BCF, depending on the pay for performance guidance which has not yet been finalised.

In addition the level of officer time (Adult Care and CCG) should not be underestimated.

Conclusions/Recommendations

The Health and Wellbeing Board is asked to:

- Consider and discuss the implications of the changes outlined in the report;
- Approve the next steps/actions as set out in the report;
- Provide joint leadership and support in directing the work of the Joint Commissioning Coordination Group over the next period of BCF resubmission.

Julie Vollor
Acting Assistant Director Strategy and Commissioning

Appendix 1

New questions	3) The case for change 4) Plan of action 5) Risks and contingency 6) Alignment 8) Implications for acute providers Annex 1: Detailed scheme description Annex 2: Provider commentary
Slightly revised questions	2) Vision for health and social care services 5) Risks and contingency 7) Protection of social care services 8) Engagement
Questions which have not changed	1) Summary details 7) National conditions