DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE
ADULT CARE BOARD

THURSDAY 25 JUNE 2015
2:00PM TO 4:00PM
COMMITTEE ROOM 1, COUNTY HALL, MATLOCK,
DERBYSHIRE, DE4 3AG

A G E N D A

	Time	**Item**	**Lead**	**Information/ Discussion/ Decision**
1	2:00pm	Welcome & Introductions	Cllr Smith	
2	2:10pm	Minutes from the meeting held on 30 April 2015 (attached)	Cllr Smith	Information
3	2:20pm	Sensory Impairment Health Needs Assessment (attached)	Eleanor Rutter	Information
4	2:40pm	Malnutrition Survey Update (attached)	L Flynn	Decision
5	2:50pm	Mental Health Strategy (attached)	Tracey McGonagle	Decision
6	3:10pm	Older Persons Market Position Statement www.derbyshire.gov.uk/social_health/care_and_health_service_providers/contracting/default.asp	L Flynn	Information
7	3:20pm	Better Care Fund update (attached)	G Spencer	Information
8	3:30pm	Update 21st Century (verbal)	ND/Hardwick CCG/ A Milroy	Discussion
9	3:40pm	Update – STAR Board (verbal)	SDCCG/ MMcE	Discussion
10	3:50pm	Health Watch Update (available/circulated next week)	Karen Ritchie	Information
11	4:00pm	**FINISH**		
		The next meeting of the Adult Care Board will take place on Thursday 9 October at 2:00pm in Committee Room 1, County Hall, Matlock.		

Karen Lynam
On behalf of Mary McElvaney, Strategic Director - Adult Care Department
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DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

MINUTES OF A MEETING HELD ON THURSDAY 30 APRIL 2015 AT 2:00PM DERBYSHIRE COUNTY COUNCIL, COMMITTEE ROOM 1, MATLOCK HQ

PRESENT:

Cllr Paul Jones	PJ	Derbyshire County Council Cabinet Member (Adult Social Care) **Chair**
Cllr Rob Davison	RD	Derbyshire County Council Deputy Cabinet Member (Adult Social Care)
Cllr Dave Allen	DA	Derbyshire County Council Cabinet Member (Health & Communities)
Cllr Wayne Major	WM	Derbyshire County Council Shadow Cabinet Member (Adult Care)
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)
Jim Connolly	JC	Hardwick CCG
Mat Lee	ML	Derbyshire Fire and Rescue Service
Cllr Lillian Robinson	LR	North East Derbyshire District Council
Beverley Smith	BS	North Derbyshire CCG
Jenny Swatton	JS	Southern Derbyshire CCG
Tammi Wright	TW	Derbyshire Healthwatch

IN ATTENDANCE:

Karen Lynam	KL	Derbyshire County Council - Adult Care (Minutes)
Steve Phillips	SP	Derbyshire County Council – Adult Care

APOLOGIES:

Cllr Paul Smith	Derbyshire County Council Cabinet Member (Adult Social Care) **Chair**
Roger Miller	Derbyshire County Council – Adult Care
Lynn Wilmott-Shepherd	Erewash CCG
Michelle Shooter	Derbyshire Police
Jo Smith	South Derbyshire CVS
Narinder Sharmer	Derbyshire Carers
Steve McLernon	Derbyshire Fire and Rescue Service
Jacqui Willis	NDVA
Andy Layzell	Southern Derbyshire CCG
Karen Richie	Derbyshire Healthwatch
Karen Macleod	Derbyshire Probation

Clare Watson	Tameside & Glossop CCG
Clive Newman	Hardwick CCG
David Gardner	Hardwick CCG
Jim Hewlett	
Cath Walker	Derbyshire County Council
Mick Burrows	Southern Derbyshire CCG

Minute No	Item	Action
ACB 055/15	**WELCOME FROM CLLR PAUL JONES AND APOLOGIES NOTED** **MINUTES FROM THE MEETING ON 19 FEBRUARY 2015 & MATTERS ARISING** The minutes from 19 February 2015 were accepted. Matters Arising: 047/15 – The requirements for reporting deaths of people subject to DOLS has been reviewed with Dr Hunter the Derbyshire Chief Coroner and it was noted that this had been reviewed with legal advisors. AM reported that he had also reviewed the current arrangements for the management of DOLS assessments in view of escalation of referrals and the backlog reported to the Board. The conclusion reached is that the approach being taken and the measures put in place to monitor and manage risk are satisfactory and compliant with the guidance issued by the Department of Health. It was also reported that the Council was in receipt of some extra finance from the Department of Health for DOLS work.	
056/15	**REVISED TERMS OF REFERENCE** • Andy Searle (Chair of Safeguarding Adults Board) will be invited to attend the Adult Care Board. • The Terms of Reference were discussed and amendments suggested and accepted. The Final version will be sent to the Board.	**KL**
057/15	**CARE ACT – JULIE VOLLOR** Julie Vollor gave an update on the Care Act to the Board. • The first quarterly return will be issued shortly; the Care Act metrics have been agreed by ADASS/LGA with the DoH. There are already systems in place to collect all but two of the targets – Advocacy and Deferred Payments. Work is taking place to update the systems.	

	• Care "cap" – awaiting final guidance. On current estimates approximately 3,000 assessments will need to take place between September 2015 and April 2016. <u>Safeguarding</u> • Bill Nichol has been providing training on Safeguarding. • E-learning training on the Care Act – access to the packages for NHS staff. JV to ensure it is made available asap. • Agreed that links to the information be made available again – see below: - http://www.local.gov.uk/documents/10180/6869714/L14-759+Guide+to+the+Care+Act.pdf/d6f0e84c-1a58-4eaf-ac34-a730f743818d SCIE video link www.scie.org.uk/	**JV**
059/15	**<u>BETTER CARE FUND UPDATE – JULIE VOLLOR</u>** Julie Vollor updated the Board on the progress with the Better Care Fund. • S75 agreement has been signed. • The timing of the BCF national returns do not correspond with the Health and Wellbeing Board meeting dates, therefore we will always report retrospectively. • Scheme monitoring – implementation plan to be finalized, detailed specs, to be completed. • Each organization monitors and delivers its own schemes. There will be regular reports to HWB and ACB. • JV thanked the CCGs for getting final agreement signed off and the CCGs thanked DCC.	
059/15	**<u>UPDATE ON 21ST CENTURY BOARD</u>** BS outlined progress with the extensive programme work. The initial consultation and engagement exercise for Community Hubs has been completed and further work is in hand to develop proposals. It was noted that a workstream for services for people with a learning disability has been added to the programme. AM is the executive lead and is reviewing how work fits in with the existing planning and governance arrangements.	

060/15	**UPDATE ON STAR BOARD** • JS reported that groups are working through delivering "what's business as usual". • Workforce development as well as IT and information will be critical. • MMcE reported that a draft countywide vision statement for integration is being developed across both Boards and will be presented to the Health and Wellbeing Board.	
061/15	**DISTINCTIVE, VALUED, PERSONAL – WHY SOCIAL CARE MATTERS: THE NEXT FIVE YEARS - ADASS POSITION STATEMENT** The Association of the Directors of Adult Social Services (ADASS) has published a report "Why Social Care Matters: The next five years" which outlines the main challenges facing the adult care social care system. Recommendations in the report are aligned to the NHS Five Year Forward View and consider issues over the same time period. The report to the Adult care Board provides a summary of the main recommendations put forward by ADASS and considers the implications for partnership. The report outlines five recommendations: • Social Care Funding • Focus on providing quality services that prevent harm • New integrated models • Building and delivering a sustainable workforce • Strengthening local accountability and innovation To note the recommendations on pages 2 and 3 of the report.	
062/15	**DERBYSHIRE DIGNITY CAMPAIGN – FOR APPROVAL** Steve Phillips gave an overview of the above paper. The purpose of the report is to: Update the Board about progress of the Derbyshire Dignity Campaign and to propose a re-launch event to engage teams to achieve the Derbyshire Dignity Award. • There was a discussion concerning the revised structure to a single award.	

	• Agreed to have a re-launch and to ask for an elected member representative. JV gave thanks to Steve for all his hard work as he is retiring on 4 June. PJ also gave thanks to Steve.	
063/15	**HEALTHWATCH UPDATE** Tammie Wright provided an update on Healthwatch. She asked if the Adult Care Board would consider taking this through to the H&WB – **DA agreed** to do this. She explained how the process works when comments are received from the public. See P2 of Intelligence Report. Since last ABC – HW have produced: * Primary Care Report * Children and Young Persons Report * Carer's Discussion Paper Other reports to be published are on the Intelligence Document. PJ agreed that all the reports be brought to the June meeting.	**DA**
064/15	**ANY OTHER BUSINESS** None.	
	Future meetings of the Adult Care Board will take place on Thursday: 25 June 2015, Committee Room 1 9 October 2015, Committee Room 1 County Hall, Matlock.	

Towards a sensory impairment strategy for Derbyshire County

1. Summary and introduction

Public health importance of sensory impairment

Sensory impairment is extremely common among Derbyshire's older adults, has significant but reducible consequences, is in many cases preventable, is costly in terms of avoidable spend, and existing policy drivers argue for eye and hearing health improvement.

Fit with Derbyshire's Health and Well-being strategy: integrated services

The strategy refresh prioritises development of sustainable multi-agency approaches to keep people healthy and living independently in their own home. Fractured existing arrangements for promoting eye and hearing health and for delivering sensory impairment testing, treatment and support services suggest development is needed to help achieve this integration ambition.

Fit with transformation work stream priorities: independence at home

Sensory impairment challenges independence and self-management, so will impede achievement of transformation priorities; reducing the number of people in Derbyshire with disabling or socially isolating sight or hearing loss will facilitate their attainment.

Key message

A shared commitment to tackle sensory impairment in older adults is key to keeping people in their own homes for longer and to healthy ageing as part of the Derbyshire's proactive response to an ageing population.

The purpose of this document is to stimulate a conversation between local commissioners, providers, the public, service users, Elected Members, Units of Planning and the Health and Well-being Board regarding the importance of sensory impairment in Derbyshire—and what should be done about it.

The document begins by summarising the public health importance of eye and hearing health to the county, drawing on a bespoke literature review (Appendix 1), epidemiological profile (Appendix 2) and narrow-scope stakeholder survey (Appendix 3). It then outlines arrangements for local commissioning and provision of sensory impairment services (Appendix 4) and provides some insight into the service provider perspective on these. Implications of these findings are then considered in relation to the wider strategic context of health improvement in the county, followed by identification of possible actions to inform planning for change.

Sight (visual) impairment or loss includes any condition resulting in partial vision or blindness. We exclude presbyopia (age-related short-sightedness) from this assessment in order to maintain focus on preventable causes of sight loss. However, this does not devalue the relevance of sight problems that are correctable using lenses (termed 'refractive errors') as a cause of disability or other consequences when undetected.

Hearing impairment implies a reduced capacity to discern sounds and is broadly conductive (defects in sound transmission; about 10%) or sensorineural (defects in sound perception; about 90% of cases) in nature. Age-related sensorineural hearing loss is termed presbycusis. In contrast to presbyopia (resulting in the need for reading spectacles with age) presbycusis is never correctable, but its effects can be mitigated. Noise-induced hearing loss is important because it is preventable.

Sensory impairment (SI) is an umbrella term sometimes taken to include deficits in any of the senses (including touch, smell, taste) although more typically (as here) refers to a spectrum of loss affecting sight, hearing or both. Dual impairment may be described as deafblindness when it inhibits communication, information access and mobility.

2. Public health importance of sensory impairment

Deciding whether an issue constitutes a problem of public health importance is aided by reference to a simple framework. Public health concerns generally arise when an illness is common (or rare but serious), has important consequences, can be prevented via early intervention, is costly or has relevant policy/ political context. This framework is used throughout the health needs assessment (HNA) and in the present document to appraise evidence on the public health importance of sensory impairment to Derbyshire County. Evidence to inform this judgement was collated from three principle sources, these being a review of research and grey literature, epidemiological profiling using freely accessible data tools and an online stakeholder survey (see Table 1). A summary of findings is provided below; see also Appendices 1–3 for more detail, including references.

Table 1: Information sources to assess the public health importance of sensory impairment

Sources	**Public health importance evidence**				
	Prevalence	*Consequences*	*Prevention*	*Costs*	*Policy*
Literature	Y	Y	Y	Y	Y
Data tools	Y	Y	Y	Y	
Online survey		Y	Y		

2.1 How common is it?

Prevalence is a measure of how common a condition is, typically expressed as a percentage *proportion* (those with the condition divided by the whole population count) or as a *rate* (a number per head of population over a fixed time period).

Sight loss

Overall current and projected prevalence estimates for Derbyshire are as follows:

- The crude incidence rate of sight loss certifications in Derbyshire County during 2012–13 was 43.3 per 100,000 population—similar to the England rate (Public Health Outcomes Framework/PHOF indicator 4.12).
- There were about 5,040 people in Derbyshire County aged 65–74 years with moderate or severe visual impairment during 2014—a prevalence of 5.8%. By 2030 this number may increase to 6,003—largely reflecting the ageing population—with a slight drop in prevalence to 5.6% (POPPI estimate).
- There were about 8,668 people in Derbyshire County aged 75 years and older with moderate or severe visual impairment during 2014—a prevalence of 12.8% and double that of the 65–74 age group. By 2030 this number may increase to 14,595 with a slight drop in prevalence to 12.4% (POPPI estimate).
- About 60% of nursing home residents are visually impaired.

The most common causes of sight loss (excluding refractive errors) are age-related macular degeneration (AMD), glaucoma, diabetic eye disease (retinopathy), and cataract.

- **AMD** affects almost 4% of the population over 75 years and involves damage to the macula at the back of the eye (retina), which is responsible for central vision. AMD accounts for almost 60% of blind or partially sighted registrations. 'Dry' AMD is the more common type and is more gradual in onset than the more severe 'wet' type. The crude incidence rate of AMD in Derbyshire County during 2012/13 was 114.4 per 100,000 population—similar to the England rate (PHOF indicator 4.12). There is probably around 42,000 people with AMD aged 50 or over in the county.
- **Glaucoma** describes damage to the optic nerve, typically due to increased pressure inside the eye resulting in chronic open-angle glaucoma (COAG). Raised intra-ocular pressure (IOP) pressure without symptoms (ocular hypertension) may led to COAG. COAG accounts for around 12% of blindness among those aged 65 and over. The crude incidence rate of glaucoma in Derbyshire County during 2012/13 was 13.7 per 100,000 population—similar to the England rate (PHOF indicator 4.12). There is probably around 6,800 people with glaucoma aged 30 or over in the county (1.4% prevalence), with higher numbers in older age groups who are suspected to have glaucoma or have ocular hypertension.
- **Diabetic retinopathy** describes cumulative damage to the retina resulting from diabetes. It accounts for around 15% of severe sight impairment certifications among those aged 65–74 and about 4% among those aged 75–84 years (fewer diabetics live into older age). The crude incidence rate of diabetic eye disease in Derbyshire County during 2012/13 was 3.6 per 100,000 population—similar to the England rate (PHOF indicator 4.12). Around 15,000 county residents have background diabetic retinopathy, with another 1,700 having more advanced disease.
- **Cataract** is an opacity found in the lens at the front of the eye and may be present in around 1 in 3 people aged 65 or older. Around 6,800 people aged 55 or over in the county have cataracts that merit surgical treatment—a prevalence of 1.8%.

Hearing loss

The most common cause of hearing loss is age-related sensorineural loss, termed **presbycusis**; loss due to other causes (e.g. toxic drugs) is less common. It is important to note that noise-induced hearing loss is the second leading cause of hearing loss and is preventable. Action on Hearing Loss estimates a 1.32% overall prevalence for profound or severe hearing loss; there is currently no official certification system as for sight loss. Prevalence estimates for Derbyshire are:

- There were about 17,240 people in Derbyshire County aged 65–74 years with moderate or severe hearing impairment during 2014—a prevalence of 20%. By 2030 this number may increase to 20,565—largely reflecting the ageing population—with a slight drop in prevalence to 19% (POPPI estimate).
- There were about 30,967 people in Derbyshire County aged 75–84 years with moderate or severe hearing impairment during 2014—a prevalence of 64%. By 2030 this number may increase to 48,955 with a slight drop in prevalence to 62% (POPPI estimate).

- There were about 17,062 people in Derbyshire County aged 85 or older with moderate or severe hearing impairment during 2014—a prevalence of 88%. By 2030 this number may increase to 33,027 with a slight drop in prevalence to 85% (POPPI estimate).

2.2 What are the consequences?

The consequences of sight or hearing loss are similar and may include:

- **Increased falls** (and consequential hip fracture). There were nearly 42,000 falls among those aged 65 and over in the county during 2014; almost half of those 85 or older will fall. Nearly half of about 3,000 falls amongst blind and partially sighted Derbyshire residents in 2013 could be directly attributed to sight loss. Hearing loss also contributes to falling.
- **Exacerbation of dementia**. Dementia affects around 1 in 5 aged 85–89 and 1 in 3 beyond that. During 2014 there were around 10,660 people over 65 years with dementia in the county.
- **Mental ill health** may become manifest via an increased risk of depression, anxiety and stress.
- **Reduced quality of life** may result from communication difficulties, reduced perception of personal safety (e.g. in traffic), or disconnection from previous habits or hobbies.
- **Social isolation** can result from having to give up driving, feelings of loneliness (being more likely to live alone), reduced opportunity to interact, problems accessing information required to use public transport, and reduced ability to answer the door or phone.
- **Loss of independence** resulting from a reduced capacity to perform activities of daily living, which may require (earlier) relocation to a care home/ supported accommodation.
- **Reduced capacity to self-manage long-term conditions** is speculative, but feasibly might occur due to difficulties processing self-care information, performing some self-care routines, or risk of medication administration errors.

Provider perspective on mitigating consequences

Service provider views expressed during consultation offer the following insights:

- The most important priority for reducing the impact that sight and/or hearing impairment can have on the quality of life for older adults should be support people with sensory impairment to maintain a good quality of life and personal independence within their own homes, for as long as possible. Facilitating improved self-esteem (e.g. through participation) and access to emotional support/ psychological therapies is integral to this and was also ranked highly by respondents; this may suggest that the mental well-being impacts of sensory impairment in the county are underestimated.
- A clear majority (86%) of respondents felt staff working in health and social care services did not have access to suitable training on meeting the

communication needs of older adults with sight and/or hearing impairment, and concerns were raised over the uptake and impact of available training.[1]

- Mitigation of consequences should start as soon as possible following diagnosis; respondents strongly agreed (average 9/10 on a Likert scale) that all testing services should signpost to practical advice and provision of adaptations or equipment to support daily activities as soon as sensory impairment has been detected (or at device fitting).
- It was agreed (average 8/10 on a Likert scale) that this signposting should include emotional and financial support services.

2.3 How can it be prevented?

Prevention of sensory impairment can be considered in terms of primary prevention (risk factor control to prevent onset of impairment), early detection and screening (opportunistic or targeted testing for unrecognised impairment), and secondary prevention (treatment to reduce the consequences of established impairment).

Primary prevention

Primary prevention is about addressing modifiable lifestyle risk factors, preferably from as early an age as possible. Local authorities are the public health leaders here:

- **Diabetes** affects around 11,700 people aged 65–74 and 8,250 aged 75 and older in the county—a 13.4 and 12.2% prevalence respectively (POPPI estimate). Eating a healthy diet and taking adequate **exercise** can help prevent the onset of Type 2 diabetes (the more common form that is related to obesity)—thus reducing prevalence of diabetic eye disease.
- **Poor diet** may also contribute to onset of cataract and possibly presbycusis (age-related hearing loss)—perhaps by means of furring up the blood supply to the delicate structures involved in hearing.
- **Smoking** cessation is of particular relevance to prevention of AMD due to its role in causing vascular disease and smoking has also been implicated in contributing to onset of cataract and presbycusis.
- Use of **hearing protection** or avoiding exposure to excessive noise should help reduce noise-related hearing loss.

Early detection and screening

Organised efforts to systematically seek out (screen) or opportunistically test people for sensory impairment also depend upon identification of risk factors:

- Derbyshire's population is both increasing and ageing, with a higher proportion of the population aged over 65 years compared to England (ONS, 2011). **Age** is the single most important risk factor for sight and hearing loss.
- Aside from age, other risk factors for sensory impairment that can be targeted as part of testing initiatives include areas of higher **deprivation** (people living in deprived areas may delay presentation); **smokers**; **diabetics** (who are also at higher risk of glaucoma and cataract as well as retinopathy); people with known **vascular disease**; occupational history of **work in noisy**

[1] A NICE quality standard speaks to training & recording; see https://www.nice.org.uk/guidance/qs50/

environments; **ethnicity** (AMD is more common in Whites; glaucoma in Blacks; diabetes and cataract in Asians); and people with **learning disabilities** (who have a 10-folk risk of sight impairment).

- **Family history** also seems to be a factor increasing risk of glaucoma and cataract.
- The rate of opportunistic NHS **sight tests** per 100,000 county population carried out in 2012/13 was about 10,000 less compared to England (while prevalence of conditions causing sight loss was similar or increased in the county). Note that these numbers include detection of refractive errors leading to correction but also onward referral for investigation or confirmation of other eye disease.
- Attendance for **diabetic retinopathy screening** in 2011 was just over three quarters of the eligible county population (76.1%), 4% lower than the average for England. The NHS Diabetic Eye Screening Programme offers annual digital retinal photography to all identified diabetics aged 12 and over; such programmes have been shown to reduce diabetes-related sight loss.
- The rate of opportunistic NHS **hearing tests** per 1,000 county population carried out in 2012/13 was 19.02, which puts Derbyshire in the low middle of the national ranking. There is no national screening programme for adult hearing loss, but the potential benefit has been evaluated.[2]

Secondary prevention through treatment and support

While early detection can provide more timely access to support services, it also provides timely opportunities for more cost-effective treatment interventions (where available) that can be initiated before existing damage becomes more severe. The NHS leads on secondary prevention, with primary care playing a key role in ensuring this is delivered early by means of early identification:

- AMD in the 'dry' form has no treatment currently, while NICE guidelines (2008) advocate injection of a drug called ranibizumab into the eye for the 'wet' form to reduce loss of vision. As time is of the essence given the more rapid progression of wet disease a fast-track referral scheme is considered essential to improving outcomes for these patients. Hospital and outpatient data do not currently discriminate between dry and wet disease, making assurance of the wet AMD patient pathway challenging.
- Glaucoma can be treated by surgical drainage and/or medicinal eye drops, together with pressure monitoring.
- Diabetic retinopathy is treated through management of the underlying diabetes, laser photocoagulation ('spot welding') and sometimes removal of the gel from inside the eye if it may be lifting the retina causing bleeding.
- Cataract can be treated by day case surgical extraction with a lens implant.
- Presbycusis cannot be corrected, but its effects can be reduced via fitting of hearing aids and rehabilitation (post-fitting training and support). Typically

[2] Davis A, Smith P, Ferguson M, Stephens D, Gianopoulos I. Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. Health Technol Assess. 2007 Oct;11(42):1-294.

severe delay in presentation or referral for testing represents a significant lost opportunity for early intervention.
- Only one hospital was providing early intervention support for people with sight loss in the county as of 2013; a similar proportion (only 11%) of registered blind and partially sighted people were in receipt of social care during 2012/13 compared to England. Sight Support Derbyshire fulfil an important support role for those with sight loss; this includes supply of low-vision aids, rehabilitation. Mobility and sight support services (see Section 3).
- Hearing support services are commissioned by the CCGs from various providers, and provided by Derbyshire County Council (see Section 3).

Provider perspective on prevention opportunities
Service provider views expressed during consultation offer the following insights:

- Respondents strongly agreed (average 9/10 on a Likert scale) that older adults should be routinely offered information about sight and hearing tests when they visit their GP practice, regardless of whether they are reporting sight or hearing problems.
- Respondents were ambivalent (average 6/10 on a Likert scale) regarding the prospect of offering joint sight and hearing tests when older adults attend with either a vision or hearing concern (citing logistic difficulties), although some recognised potential to improve access.
- Training for health and social care staff working with older adults on how to identify sight and hearing problems was regarded as the top priority for prevention and awareness of sight and hearing impairment.

2.4 How costly is it?

The cost of sensory impairment in the county is estimated as follows:

- The NHS in Derbyshire County spent almost £30 million directly on vision-related problems during 2011/12, around £40 per person in keeping with average national spend; this corresponds to 2–3% of the local NHS budget. The indirect costs of around £92 per person for sight loss were estimated to be higher in the county than for England by almost £9 per person.
- About a fifth of total spend on accidental falls is on fallers with sight loss.
- The NHS in Derbyshire County spent nearly £8 million directly on hearing problems during 2012/13, which was the lowest spend of any Primary Care Trust (PCT) programme budget category.

Sensory impairment can incur costs for a variety of reasons including increased risk of hospital admission; prolonged hospital stay; outpatient attendance; devices/ assistive technologies; home adaptations; prescriptions; surgical treatments (both for conditions causing sight loss and their consequences, such as hip fracture, and cochlear implants); benefit entitlements (e.g. disability living allowance, attendance allowance); care home and other social support inputs; retinopathy screening programme delivery costs; sight tests and vouchers; hearing tests; and the opportunity cost of missed appointments resulting from communications problems.

2.5 What is the policy context?

Sensory impairment had received no attention in Derbyshire's Joint Strategic Needs Assessment (JSNA) until now; there had been no evidence assessment to inform a local policy. However, there are a number of relevant external policy drivers.

Ageing well

The Marmot Review[3] popularised a life course approach to health improvement, with public health team remits in Derbyshire as elsewhere forming around corresponding life course stages—including health and well-being in older age. Marmot also focussed attention on reduction of health inequalities across the life course, and there are clear links between disadvantage (as measured by area deprivation) and sensory impairment.

NHS England, in partnership with Age UK, has published a *Practical guide to healthy ageing.* This includes advice on *Looking after your eyes* (see Fig. 1) and *Get your hearing tested* (see Fig. 2).[4] The leaflet also links falls prevention to eye and hearing health and advocates booking hearing test when booking an eye test.

The World Health Organisation (WHO) released a statement in late 2014 declaring that 'ageing well' must be a global priority.[5] It notes that to deliver this, preventative strategies must extend beyond the health sector and require collective responsibility.

Outcomes frameworks

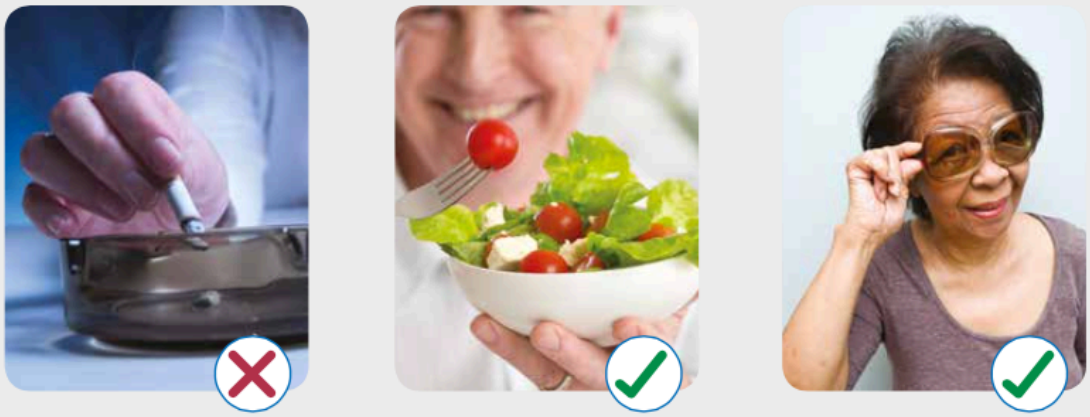
The NHS Outcomes Framework[6] includes five domains, all of which would be impacted by improvements in eye and hearing health—in particular enhancing quality of life for people with long-term conditions (Domain 2).

The Public Health Outcomes Framework (PHOF)[7] includes an indicator set specific to preventable sight loss: 4.12 breaks this down into indicators of prevalence for AMD, glaucoma, diabetic eye disease and also sight loss certifications. There is no PHOF indicator for cataract and none relating to hearing loss. A number of indictors in other domains would be impacted by improvements in eye and hearing health, including self-reported well-being (2.23); injuries due to falls in people aged 65 and over (2.24); health-related quality of life for older people (4.13); hip fractures in people aged 65 and over (4.14); and estimated diagnosis rate for people with dementia (4.16).

Adult Social Care Outcomes Framework (ASCOF)[8] includes a number of relevant indicators, particularly quality of life; support to maintain independence; and freedom from social isolation. As noted, however, only one in 10 registered blind and partially sighted people are in receipt of social care in the county.

[3] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[4] http://www.england.nhs.uk/wp-content/uploads/2015/01/pract-guid-hlthy-age.pdf
[5] http://www.who.int/mediacentre/news/releases/2014/lancet-ageing-series/en/
[6] https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015
[7] http://www.phoutcomes.info
[8] https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-ascof-2015-to-2016

Look after your eyes



Your eyes should give you a lifetime's service, but sometimes they can be affected by conditions that develop as you grow older.

It's easy to neglect your eyes because they rarely hurt when there's a problem. Having an eye test will not only tell you if you need new glasses, it will also check the health of the eye and can spot eye conditions before you become aware of them so they can be treated early. If you have a low income, you may be eligible for help with the cost should you need glasses or contact lenses.

An eye test can pick up eye conditions, such as glaucoma and cataracts, as well as general health problems, such as diabetes and high blood pressure.

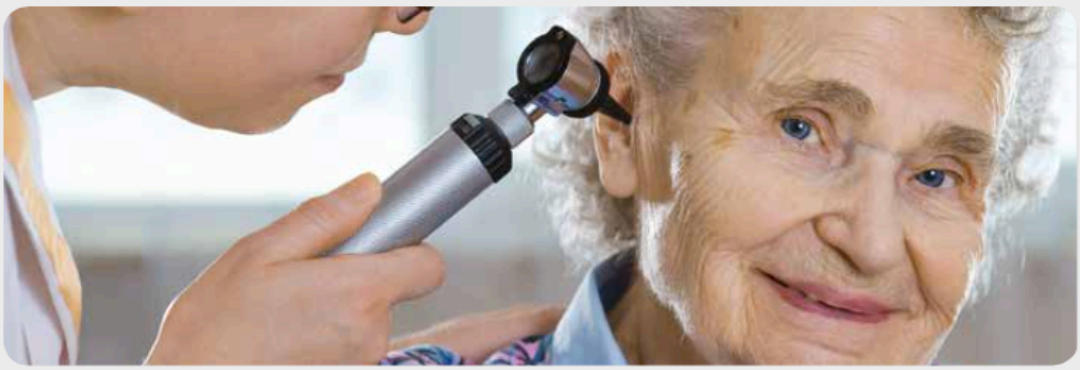
You can help keep your eyes healthy by

- not smoking – smoking damages the eye making it more likely to develop age-related macular degeneration and cataracts
- eating lots of fruit and vegetables
- protecting them from the sun by wearing sunglasses.

The good news is that if you're 60 or over, you can have a free NHS eye test every two years. You can have a free test every year if you're 70 or over.

Fig. 1: NHS England/ Age UK (2015) promotion of eye health as part of healthy ageing.

Get your hearing tested



Losing your hearing is a normal part of the ageing process, but because it happens gradually you may not notice any change.

You may realise you need to have the TV on louder or find you can't always follow conversations, especially in a group.

Having trouble hearing can make it hard to understand and follow a doctor's advice, to respond to warnings, and to hear doorbells and alarms. This can sometimes be frustrating, embarrassing, and even dangerous.

Don't delay in booking a hearing test. Why not book one when you book your eye test?

NHS hearing tests are free and can be arranged through your GP.

It is important to identify hearing loss early as treatment is more likely to be effective the earlier problems are diagnosed. The problem may be as simple as earwax, which is very easy to treat.

To do a quick hearing check before seeing your GP, use the free hearing check provided by Action on Hearing Loss.

It only takes five minutes and you can do it at home either by phone (0844 800 3838 (local rate), or online for free (www.actiononhearingloss.org.uk/hearingcheck). This check will indicate if you have hearing loss. If you have any concerns, speak to your GP.

Hearing aids are much smaller than ever before and will enhance your hearing.

Fig. 2: NHS England/ Age UK (2015) promotion of hearing health as part of healthy ageing.

NICE clinical guidelines

The National Institute for Health and Care Excellence (NICE) produced guidance (CG161; Jun 2013) on assessment and prevention of falls in older people.[9] Vision assessment and referral has been a component of successful falls prevention programmes; balance should also be assessed. A NICE guideline on supporting people with dementia (CG42; Nov 2006) advises taking account of sensory impairment when interpreting cognitive test results, when communicating information, and assessing care needs.[10] NICE quality standards cover glaucoma (QS7)[11] and, in the context of well-being in care homes, sensory impairment (QS50; no. 4).[12]

Eye health advocacy

In 2014 NHS England published a 'call to action' in response to the challenges posed by an ageing population with complex conditions and financial pressures; this included a campaign to improve eye health and provision of NHS eye health services.[13] A consultation report should cover value-for-money investment, pathways, prevention, integrated services, access, and service user involvement.

The UK Vision Strategy[14] is promoted by the charity VISION 2020 (UK) Ltd. as a cross-sector initiative implementing WHO's goal of eliminating avoidable blindness by 2020[15]. The 2013 refresh focusses on self-care of sight, timely access to treatment and support services, and societal participation for those with sight loss.

The College of Optometrists and Royal College of Ophthalmologists (representing providers) produced a series of guidance on commissioning better eye care in 2013.[16] These cover AMD, glaucoma, adults with low vision and urgent eye care—each offering a number of best practice recommendations.

Hearing health advocacy

In 2015 NHS England and the English Department of Health published *Action plan on hearing loss*.[17] It advocates good prevention (e.g. reducing noise-induced hearing loss), earlier diagnosis (e.g. better identification of at-risk groups), integrated services (e.g. increasing use of personalised care plans), increased independence and ageing well (e.g. access improvements), and good learning outcomes (e.g. better employment opportunities for hearing impaired adults).

Action on Hearing Loss made a submission (PH 91)[18] to the parliamentary Health Select Committee in 2011 calling for hearing loss to feature in JSNAs and feature in strategic plans. The submission also called for prevention through hearing protection;

[9] https://www.nice.org.uk/guidance/cg161
[10] http://www.nice.org.uk/guidance/CG42
[11] https://www.nice.org.uk/Guidance/QS7
[12] https://www.nice.org.uk/guidance/qs50
[13] http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/eye-cta/
[14] http://www.vision2020uk.org.uk/UKVisionstrategy/
[15] http://www.who.int/blindness/partnerships/vision2020/en/
[16] https://www.rcophth.ac.uk/standards-publications-research/commissioning-and-value-for-money-in-ophthalmology/resources/
[17] http://www.england.nhs.uk/2015/03/23/hearing-loss/
[18] http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1048/1048vw84.htm

more early diagnosis; better intelligence on hearing loss; improved access; reduction of hearing inequalities; and integrated commissioning informed by best practice.

The National Community Hearing Association (NCHA) and British Society of Hearing Aid Audiologists (BSHAA) published commissioning guidance for community-based adult hearing services in 2014.[19] This document argues that commissioners should facilitate early access to testing and support to mitigate spiralling costs that could result from an older population unwilling to accept disability as inevitable and demanding expensive technological solutions.

[19] http://www.the-ncha.com/commissioners/resources/

3. Current services in Derbyshire County

3.1 Commissioning responsibility and service provision

Information was collated by approaching commissioning organisations (and some provider organisations) to create a 'system map' for sensory impairment services; see Appendix 4. Fig. 3 provides an overview of the main players with responsibilities and/or other interests in this sector within Derbyshire County.

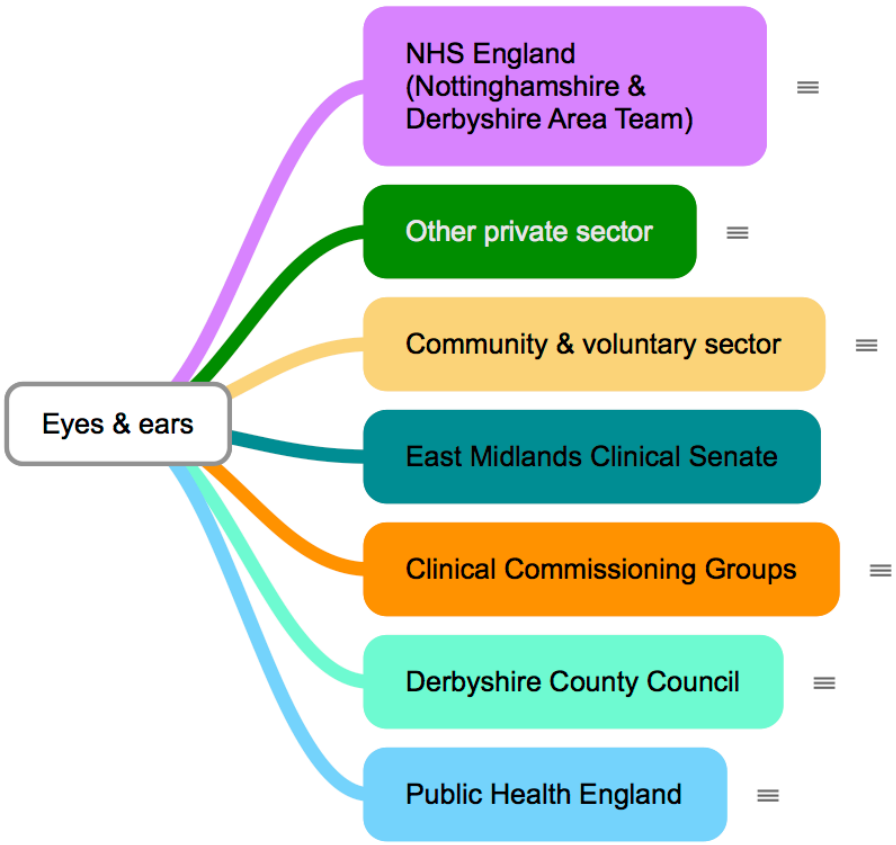


Fig. 3: Nodal map showing the main players with roles in sensory impairment services within the county.

The collapsed nodes in Fig. 3 obfuscate considerable complexity in local arrangements. A fully expanded diagram illustrating the bigger picture is provided in Appendix 1, although it is more pragmatic to take each main node in turn.

NHS England

The NHS England (NHSE) area team in Derbyshire and Nottinghamshire are responsible for local implementation of some nationally specified services (see Fig. 4). These services include defined ('Section 7A') public health screening services, in this case Diabetic eye screening. A Public Health England (PHE) commissioner who

is embedded within NHS England oversees this UK National Screening Committee programme locally; Chesterfield Royal Hospital NHS Foundation Trust and Derby Hospitals NHS Foundation Trust provide screening services. An NHSE Clinical Leadership Advisor looks after several Local Professional Networks (LPNs), one of which is the Eye Health LPN. The Eye Health LPN is broadly responsible for eye health needs assessment and for advocacy of eye health; there is no LPN for hearing health. Primary ophthalmic services are commissioned by NHSE's Dental and Optometry Contracts Manager, providing free NHS eye sight tests and NHS optical vouchers for discounted glasses/ contact lenses. NHSE also commission primary medical care from GP providers who may perform ear syringing and/or suction and may seek to improve identification of dementia and reduce unplanned admissions as part of a direct enhanced service (DES), both of which can be exacerbated by sensory impairment. GPs also have a remit to manage chronic disease, including diabetes which is very much linked to poor eye health.

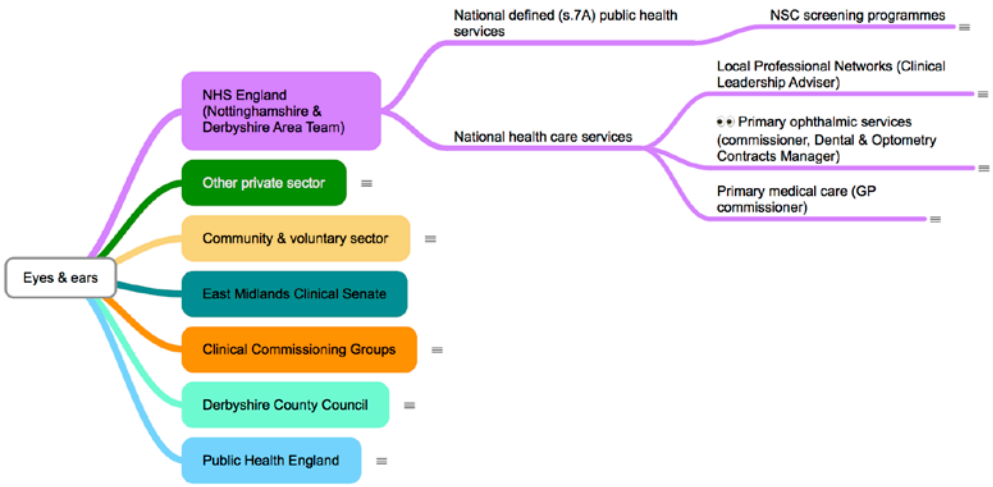


Fig. 4: Nodal map illustrating NHS England involvement in sensory impairment services (almost exclusively restricted to eye health); see full map for lower-tier branch detail.

Private sector

The private sector pays an important role in providing community-based services. Outside of formal commissioning arrangements private providers offer the public sight tests and hearing tests, with several now encouraging testing for dual sensory impairment (e.g. Boots, Specsavers, Scrivens, etc.). In addition a number of care homes within the county are registered as catering to people with sensory impairment.

Community and voluntary sector

A large number of community and voluntary sector organisations provide support services for people with sight problems and hearing problems.[20]

[20] See http://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/disability_support/

East Midlands Clinical Senate

The Senate have no direct role but through representing the interests of specialist services including ophthalmology and ear, nose and throat (ENT) are in a position to influence prioritisation and commissioning activity by CCGs.

Clinical Commissioning Groups

Five clinical commissioning groups (CCGs) select, purchase and performance-manage most health care for the people of Derbyshire (see Fig. 5).

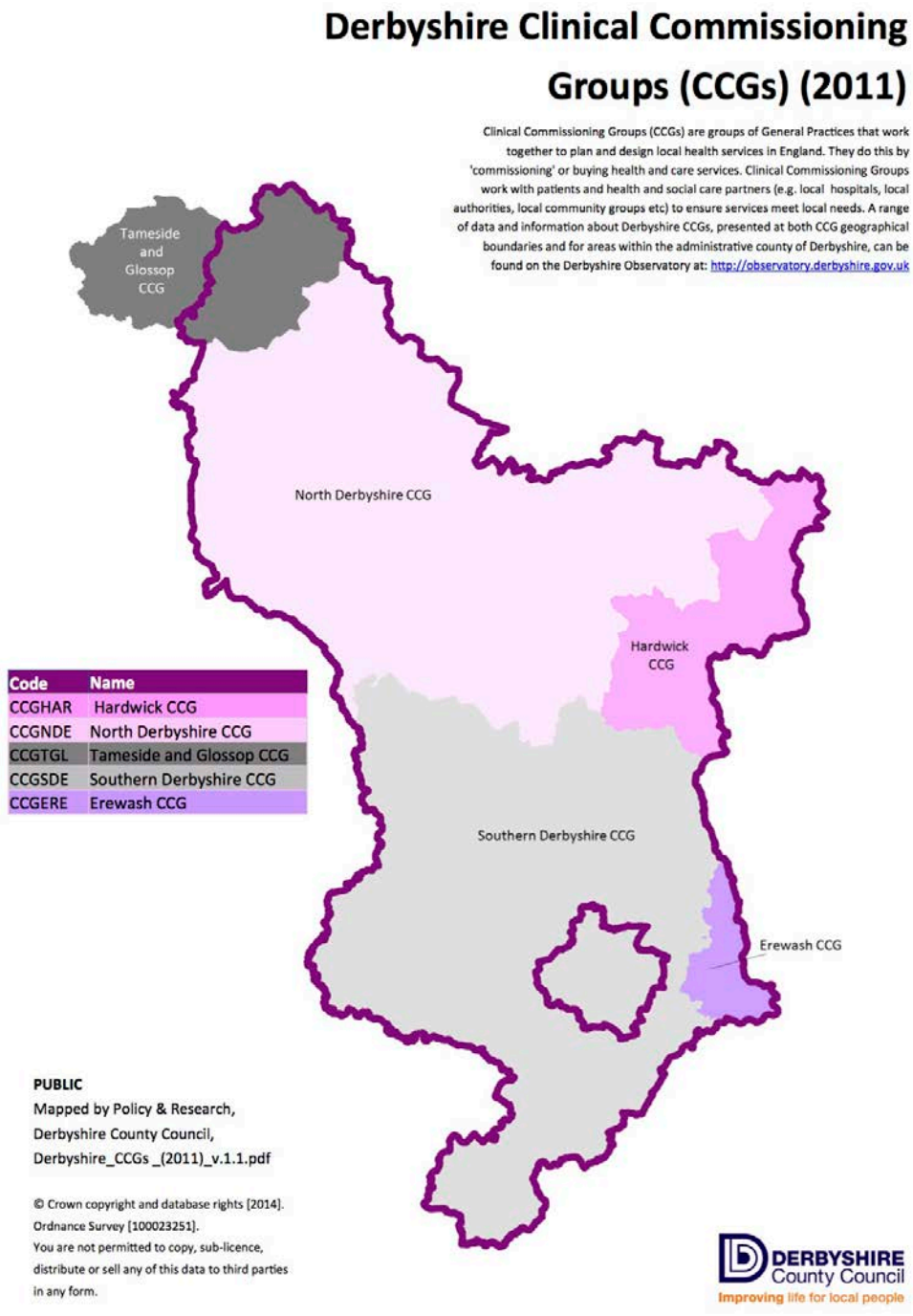


Fig. 5: Clinical Commissioning Groups (CCGs) in Derbyshire County.

Arguably, all CCGs have a vested interest in sensory impairment due to its impact on the avoidable admissions agenda (impairment causes falls, social isolation, exacerbation of dementia—for example). However, CCG commissioning can be divided into four main areas. The first of these is commissioning of ophthalmology and ENT services via the national 'payment by results' (PbR) contract (see Fig. 6).

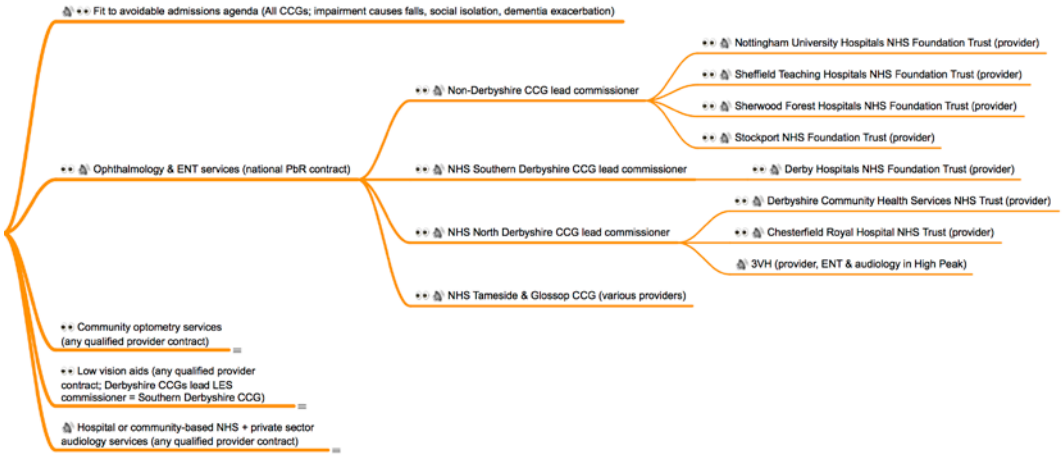


Fig. 6: Nodal map illustrating CCG commissioning of ophthalmology and ENT services (PbR).

In accordance with NHS Choose and Book, Derbyshire GPs refer patients to providers both within and outside of the county border. To simplify contracting CCGs have adopted a 'lead commissioner' model, whereby a CCG may negotiate service specifications and contracting on behalf of a number of CCGs who may be party to the agreement. To this end several non-Derbyshire CCGs lead commission ophthalmology and ENT services from Nottingham University Hospitals NHS Foundation Trust; Sheffield Teaching Hospitals NHS Foundation Trust; Sherwood Forest Hospitals NHS Foundation Trust; and Stockport NHS Foundation Trust. NHS Tameside & Glossop CCG contract with various providers in Greater Manchester. NHS Southern Derbyshire CCG are the lead commissioner for Derby Hospitals NHS Foundation Trust and NHS North Derbyshire CCG lead for Derbyshire Community Health Services NHS Trust, Chesterfield Royal Hospital NHS Trust and 3VH (a private provider of ENT & audiology in High Peak).

The second area concerns community optometry services via the 'any qualified provider' (AQP) contract (see Fig. 7). NHS Erewash CCG, NHS Hardwick CCG and NHS North Derbyshire CCG independently commission low vision and cataract assessments from various providers under locally enhanced service (LES) arrangements. NHS North Derbyshire and Hardwick CCGs jointly commission an intra-ocular pressure (IOP) and visual field refinement service and an ocular hypertensive monitoring service—both in the procurement stage as of this writing. NHS Southern Derbyshire CCG also independently commission low vision and cataract assessments, but in addition independently commission an IOP and visual field refinement service from LES providers. NHS Tameside & Glossop CCG

independently commission low vision and cataract assessments, and IOP refinement from various LES providers.

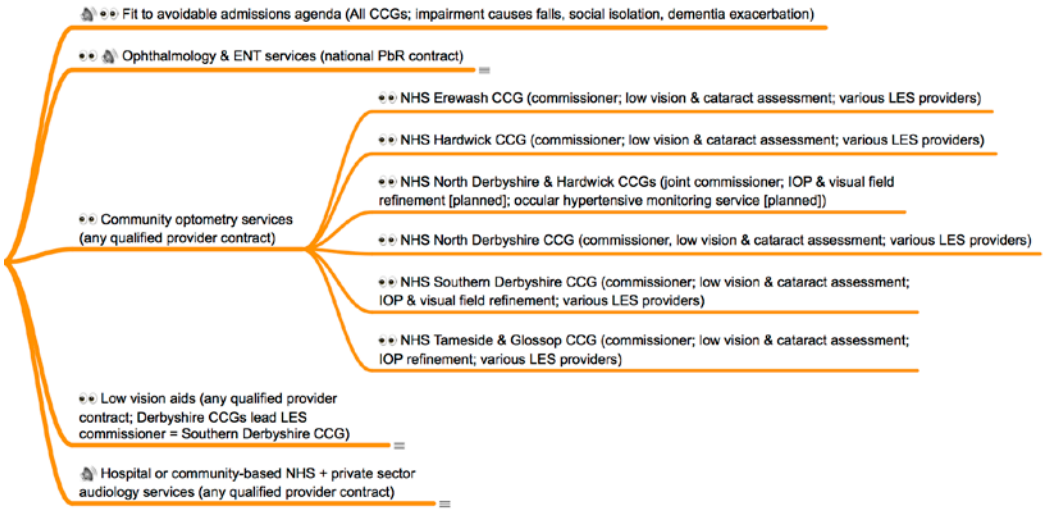


Fig. 7: Nodal map illustrating CCG commissioning of community optometry services (AQP).

The third area concerns commissioning of low vision aids. Southern Derbyshire CCG commissions these from Sight Support Derbyshire on behalf of Derbyshire CCGs.

The fourth area concerns hospital or community-based NHS and private audiology services via the AQP contract (see Fig. 8). Southern Derbyshire CCG leads on behalf of the Derbyshire CCGs, commissioning from Derby Hospitals NHS Foundation Trust; Chesterfield Royal Hospital NHS Trust; Nottingham University Hospitals NHS Foundation Trust; Boots Hearingcare (trading as Community Hearingcare Service); InHealth; Scrivens and Specsavers Hearing Centres. NHS Tameside & Glossop CCG commission from various Greater Manchester providers.

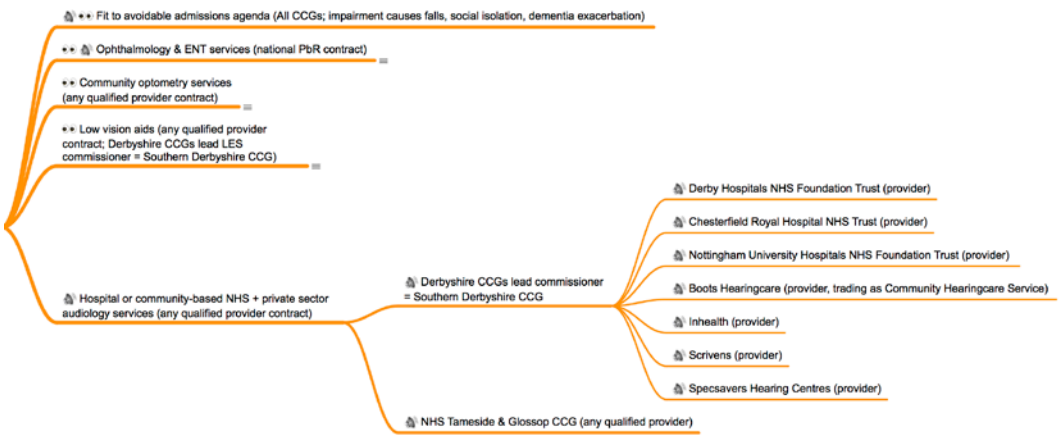


Fig. 8: Nodal map illustrating CCG commissioning of audiology services (AQP).

Derbyshire County Council

Derbyshire County Council (DCC) makes three main contributions to shaping sensory impairment services (see Fig. 9). The first of these is local leadership, via the Derbyshire Health and Well-being Board who can elect to suggest sensory impairment as a priority for the county or not (see below). The second contribution, also from public health, concerns local health improvement services. Although public health have no direct responsibility in this area, sensory impairment fits well with the 'ageing well' agenda (especially in relation to falls prevention and preventing avoidable admissions or social isolation) and with the 'lifestyles' agenda (particularly in relation to making every contact count—MECC—and diabetes education). Furthermore, public health provides commissioning advice to CCGs as part of the 'core offer' and via input into the Joint Strategic Needs Assessment (JSNA).

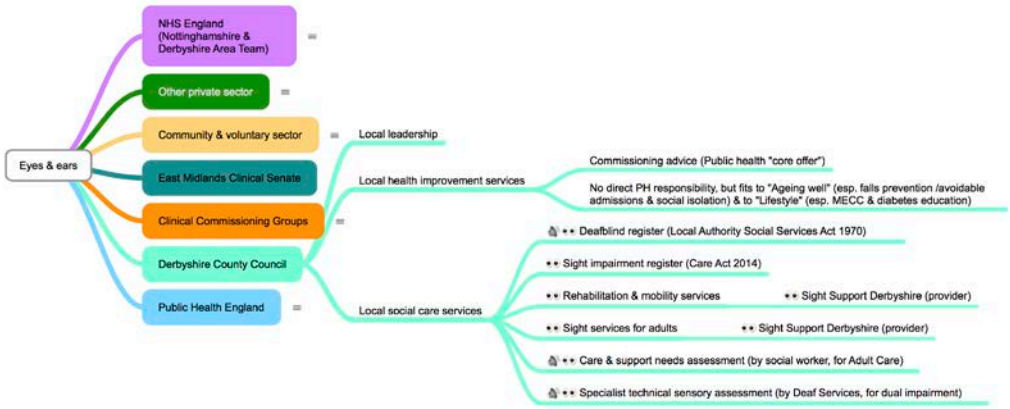


Fig. 9: Nodal map illustrating Derbyshire County Council's sensory impairment remits.

Social care services from DCC also play a key role. This includes maintenance of a deafblind register (under the Local Authority Services Act, 1970); maintenance of a sight impairment register (under the Care Act, 2014); rehabilitation and mobility services, and sight services for adults (both commissioned from Sight Support Derbyshire); care and support needs assessment (for individuals, conducted by a social worker from Adult Care); and specialist technical sensory assessment (for individuals with dual impairment, conducted by Deaf Services).

Public Health England

Public Health England (PHE) have had a very limited role, which was to monitor and report achievement against the Public Health Outcomes Framework (PHOF) indicator 4.12 relating to preventable sight loss. There is currently no national PHOF indicator relating to preventable hearing loss. The recent *Action plan on hearing loss* (see above) is set to strengthen PHE's role in relation to hearing health indicators, potential registration of impairment, and support for hearing needs assessment.

3.2 The public and service user perspective

A service user consultation was not part of this initial activity. We recognise the importance of engagement with service users during strategy development (below).

3.3 The commissioner perspective

The limited online stakeholder consultation did not allow engagement with all stakeholders.

3.4 The provider perspective

Evidence was collated from a restricted-scope stakeholder consultation and provided a number of useful insights into the service provider perspective.

Access

Improving access to services and support was considered important, and could be achieved via widespread awareness training coupled with self-referral options; joint sight and hearing assessments; local (possibly mobile or domiciliary) facilities and standardised care; and prevention-focussed promotion of early testing.

Timeliness

Unhelpful delays in sight loss registration process and access to support could undermine some of the advantages of early detection via interim falls, deterioration in mental state, etc., although it was noted that efficiencies might depend upon the source of referral and their awareness of pathways and processes. Lack of awareness among the public about hearing screening and support services could also contribute to delays.

Holistic care

There is a need for more comprehensive/ holistic single point-of-contact rather than distributed services, reducing the need for multiple contacts and avoiding inefficient duplication or inequity by geography.

Integrated services

Fractured care may relate to lack of service integration; respondents recognised the need for more integrated or joined-up working between testing, treatment and rehabilitation/ support services—this was ranked the second and third priority for prevention.

Pathways

Sub-optimal integration is perhaps reflected in the marginal majority view (57%) that pathways for referring older people who present with sight and/or hearing impairment for confirmation of diagnosis are not always clear; this was considered more so in the case of pathways for accessing support services following diagnosis (71% said pathways were not clear) but note this may not represent the commissioner perspective.

Obstacles

The most important barrier to delivering sight and hearing services in the community was considered to be cost.

Assets

The second-most important barrier to delivering sight and hearing services in the community was considered to be suitable premises to operate services from. Stakeholders identified a number of existing assets that could be utilised or better utilised, including GP surgeries; day care facilities; community hospitals; and council offices.

Client satisfaction

The level of information pertaining to service user satisfaction with services appears to be variable, ranging from none to regular non-independent questionnaires.

Performance indicators

Use of meaningful key performance indicators for assuring services likewise appears highly variable, making it difficult (if not impossible) to directly compare the value-for-money of provision across the county; a commissioner perspective on this concern is needed.

4. Strategic relevance to Derbyshire County

4.1 Fit with health improvement strategies

Derbyshire Health and Well-being strategy

Derbyshire's Health and Wellbeing Strategy is currently being refreshed. Four priority areas up to 2017 have been agreed, the most pertinent of which is to develop sustainable multi-agency approaches to keep people healthy and living independently in their own home.[21] Actions and performance measures are currently being drafted with a view to agreement in May 2015. The ambition of an integrated health and social care system will encompass person-centred services; flexible care provision; challenging assumptions; treating people with dignity and respect; planning and delivering services in partnership; promotion of healthy lifestyles; and building on joint workforce planning. This is to be operationalised via the Derbyshire Better Care Fund Plan and the transformation programmes in the North and South of the county and the Care Together programme in Tameside and Glossop. The current fractured arrangements for sensory impairment services (section 3) suggest development is needed if they are to help deliver on this integration ambition.

National Health Service (NHS) strategy

NHS England's *Five year forward view* ('5YFV', Oct 2014)[22] outlines how the NHS should respond to increasing demand (especially from an ageing population), rising costs, higher expectations and financial constraints. From the public health perspective it reiterates calls for more focus on prevention and reduction of inequalities (not to be confused with the duty of equality, which concerns countering discrimination). Reducing sensory health inequalities means reducing variation in health outcomes (like loss of sight) and in the social determinants of those outcomes through targeted prevention (proportionate universalism). The 5YFV—and thus prevention and inequalities reduction—should be reflected in the operating plans drawn up by Derbyshire's CCGs. This clearly extends to action on eye disease and hearing loss as part of 'proactive primary care'. Eye health is a 2013–16 priority for the Royal College of General Practitioners (RCGP).

Public Health England (PHE) strategy

Public Health England's own 5-year strategy[23] prioritises prevention of obesity (linked to diabetes and thus retinopathy), smoking (a risk factor for both sight and hearing loss) and dementia (which may be exacerbated by sensory impairment). Local efforts to prevent sensory impairment should dovetail with these wider prevention ambitions, but should be accompanied by interventions that reduce inequitable access to early sight and hearing testing, treatment and support.

[21] http://www.derbyshire.gov.uk/images/Agenda%20item%205%20-Health%20and%20Wellbeing%20Strategy%20Refresh_tcm44-261594.pdf
[22] NHS England. Five year forward view. 2014; Oct. http://www.england.nhs.uk/ourwork/futurenhs/
[23] Public Health England. From evidence into action: opportunities to protect and improve the nation's health. 2014; Oct. https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health

4.2 Fit with existing county work streams

Transformation work supporting independence into old age

Current transformation programmes within Derbyshire are working on integrating teams and delivering projects such as community hubs in the North of the county. Unit of Planning transformation priorities include keeping people safe and healthy (free from crisis and exacerbation); keeping people at home (out of social and healthcare beds; keeping people independent (managing with minimum support); redefining community services (enabling people to remain independent at home); and enhancement of flow (reducing/ shortening unplanned acute admissions and need for permanent admissions to care homes). Sensory impairment challenges independence and self-management, so will impede achievement of transformation priorities; reducing the number of people in Derbyshire with disabling or socially isolating sight or hearing loss will facilitate their attainment.

Falls prevention

Derbyshire County Council commission falls prevention from all Derbyshire CCGs and Tameside and Glossop CCG. The CCGs in turn require their acute and community providers to routinely assess all admissions aged 60 years or over for risk of falls; this assessment incorporates a question about sight problems and a referral pathway for sight testing. Falls risk assessments are also undertaken outside of these arrangements, for example by some housing associations, care homes and adult social care. In both cases no data are reported on sight test referral throughput.

Dementia detection and care

Routine assessments for possible dementia focus on memory problems rather than sensory impairment. However, there is anecdotal evidence from community sector partners that some hearing impairment in care settings is not being recognised at the time of such assessments, and could lead to inappropriate labelling when supply of a hearing aid might improve cognitive test performance. Care home residents are a known high-risk group for the triad of sight loss, hearing loss and memory difficulties.

4.3 Implications of the evidence

Consideration of the evidence collated for this needs assessment identifies a number of implications for the county.

Prevalence:

- **Imperfect records**: Certification of sight loss is an underestimate, but no similar register exists for hearing impairment that could be used to help identify and record vulnerable individuals.
- **Large numbers**: In 2014 about 13,708 county residents aged 65 or older had moderate or severe sight impairment and about 65,269 residents aged 65 or older had moderate or severe hearing impairment. While these numbers are large, they will become much larger still despite predicted falls in prevalence as the population grows and ages. Services would need to expand significantly to manage consequent increased demand.

Consequences:

- **Burden of ill health**: The cumulative effects of sensory impairment-associated falls and fractures; exacerbation of dementia; mental ill health; reduced quality of life; social isolation; loss of independence and reduced capacity to self-manage long-term conditions represent a phenomenal burden on patients, their families, health and social services, and on wider society.
- **Communication difficulties**: Those involved in caring for people with sensory impairment may need access to and encouragement to undertake training to improve communication with people who cannot see or hear well.
- **Missed opportunities**: Early identification of sensory impairment provides access to more effective treatment (in some cases) and rehabilitation services that can offset some of the disadvantage, disability, distress and injury that hidden sight or hearing loss may lead to. Asking brief questions about eye and hearing health in persons aged 65+ years would be consistent with making every contact count.
- **Resetting social norms**: Anecdotally people may be more willing to accept hearing loss as 'part of ageing' (we typically begin using hearing aids in our mid 70s, but tend to decide we need reading glasses far earlier in life). Redressing this would require a concerted promotional effort to signal that while some hearing loss may be inevitable as we age, it does not follow that disability need be.

Preventability:

- **Lifestyle choices**: Inadequate exercise, poor diet, obesity, diabetes and smoking contribute to the prevalence of sensory impairment and are modifiable risk factors (unlike age, for example). Reducing sensory impairment is yet another rationale for continued efforts to promote healthy lifestyles choices.
- **Hearing protection**: More visible promotion of hearing protection use to the current workforce will help reduce development of noise-induced hearing loss.
- **Early detection**: More opportunistic targeted testing (or improved screening uptake) might increase apparent prevalence of sensory impairment in the county, through better ascertainment of hidden disability. Evidence suggests that primary care and other partners could be doing more to encourage uptake of sight and hearing tests and attendance for retinopathy screening. The potential for co-testing for dual sensory impairment merits further exploration as part of discussions on integrating services.

Costs:

- **Avoidable spend**: The current health service spend of around £40 million on vision and hearing-related problems represents a substantive opportunity cost considering the potential to avoid some consequences and reinvest in prevention.

- **Spend in context**: While health care costs may seem sizeable they are modest in comparison to the more difficult to quantify wider costs and to the high prevalence of sensory impairment. This said, Derbyshire's comparatively higher indirect costs and lower sight testing rate suggests both whole system inefficiencies and unmet need.
- **Return on investment**: Prevention entails 'spending to save', but in a fractured system is inhibited when an organisation facing an up-front spend is not the same as the one reaping longer-term savings. This dilemma needs to be recognised, debated and resolved by partnerships that put prevention first in the wider interest. Sharing the benefits means sharing the risks.
- **Knowledge gaps**: Owing to the unexpected challenge of identifying responsible commissioners and providers, and the complexity of existing arrangements, initial requests for local cost information were not followed up.

Policy drivers:

- **National prominence**: The lack of an NHS England remit for hearing services (as for primary eye health)—and corresponding lack of a Local Professional Network for ear health and hearing-related PHOF indicators—may de-emphasise the importance of hearing impairment nationally. There are recent signs this may be changing, although irrespective of national steer Derbyshire may choose to establish hearing health as a public health priority and identify local outcome indicators.
- **Well-being strategy**: Sustainable multi-agency approaches to keep people healthy and living independently in their own home extends to an integrated approach to promotion of eye and hearing health and delivery of sensory impairment testing, treatment and support services.
- **Transformation agenda**: Reducing numbers in Derbyshire with disabling or socially isolating sight or hearing loss will facilitate attainment of the transformation priorities of promoting independence and self-management.

Provision of services and facilitating access

- **Local services**: Notwithstanding the importance of a choice of provider[24], the delivery of NHS audiology services in hospital settings seems at odds with a policy steer towards community-based services. Furthermore, this could be inadvertently 'medicalising' age-related hearing loss by association with the secondary care environment. Evidence that community-based sight services are preferred may extend to near-patient audiology; such a shift could help relieve the opportunity cost of limited hospital space for acute services.
- **Equality considerations**: Communication difficulties may be at the core of problems those with sensory impairment face accessing services; these equality barriers need to be understood and overcome to make better use of existing service provision.

[24] Monitor (2015). NHS adult hearing services in England: exploring how choice is working for patients. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409273/Adult_hearing_services_-_Monitor_s_report.pdf

- **One-stop testing**: The idea of co-testing hearing and vision has precedent in the co-screening for clustering of behavioural risk factors (e.g. smoking and drinking). At a minimum, asking questions about dual impairment would align with making every contact count (MECC). The next logical step might be dual testing. Several providers operating in the county (Boots, Specsavers, Scrivens) offer both hearing tests and sight tests, but there is no dual testing on NHS-commissioned pathways—and on private pathways this can be complicated (e.g. by lack of equipment in GP surgeries or community clinics when audiology is delivered). The community hubs model may be a vehicle for overcoming logistic obstacles.
- **Equity of provision:** County provision of some support services, such as low vision aids or rehabilitation for hearing problems appears variable. Little is known about access to services in the county by particular at-risk groups, such as those with learning disabilities, homeless people, or ethnic minorities.
- **Stakeholder perspectives**: The present paper offers some indications of the provider perspective, but gaps in relation to commissioner and service user views require filling.

4.4 Options and recommendations to Derbyshire County

Having considered the evidence on the importance of sensory impairment to the county, and noted alignment with the Health and Well-being Strategy and the transformation agenda, decision makers have several broad options:

- **Do nothing**: This option might be difficult to support, being reliant on spontaneous eye and hearing health improvement in the face of projections that predict a massive increase in numbers of affected people as Derbyshire's population increases and ages. Although it would enable resources to be spent elsewhere, inaction would raise ethical and moral concerns following completion of the sensory impairment needs assessment.
- **Prioritise preventing/ mitigating sight loss**: Taking this option is supported by well-established eye health advocacy, moderately large numbers of older Derbyshire residents with sight loss, a relatively robust evidence base on consequences, and indications that county testing/ screening performance is below the national norm. However, an exclusive focus on eye health would ignore the larger problem of hearing loss (in terms of numbers affected).
- **Prioritise preventing/ mitigating hearing loss**: Taking this option might be justified given the number of county residents with hearing problems exceeds the number with moderate or severe sight impairment roughly five-fold, yet attracts less than a quarter of the NHS spend on both problems. Hearing loss is moving up the policy agenda and having been relatively neglected, now may be the time for it to receive overdue attention.
- **Prioritise preventing/ mitigating sensory impairment**: This option would put sight and hearing loss on a more equal footing, recognising they often co-occur and produce efficiencies in their co-prevention, co-detection, and co-mitigation through integrated services designed around the whole person. It encourages wider partnership working and pooling of resources.

The following recommendations assume the preferred option is to prioritise preventing/ mitigating sensory impairment.

Recommendations to reduce prevalence via prevention

- P1: The Health and Well-being Board should advise partners in Derbyshire's health and social care networks to increase their efforts to promote eye and hearing health as part of the wider prevention agenda to keep people well and independent. Public Health England might be consulted for advice on the most effective strategies to achieve this.
- P2: Public health and CCGs should join forces financially and strategically to support an integrated countywide approach to preventing sight and hearing loss.
- P3: The Public Health Intelligence team in the council should work with Public Health England to identify suitable outcome measures to monitor progress in delivering improvements in hearing health (akin to the PHOF indicators for eye health).
- P4: Environmental health and the Health and Safety Executive should be included as partners in local integrated prevention campaigns, given their mandatory functions around use of hearing protection to prevent noise-induced hearing loss.

Recommendations to mitigate consequences via early detection/ intervention

- C1: NHS England's Local Professional Network for Eye Health should be consulted to explore potential reasons for and solutions to Derbyshire's lower-than-expected rate of sight testing.
- C2: Public Health England's NHS England-embedded regional screening lead should be consulted to explore potential reasons for and solutions to Derbyshire's lower-than-expected uptake of retinopathy screening.
- C3: Primary care/ adult care colleagues should be asked to routinely enquire about sensory impairment in persons aged 65 and over, including during NHS Health Checks, and to ensure sight and hearing testing is offered (and re-offered) to all care home residents, recognising the high prevalence of impairment in this readily targeted group. Detection of deficits needs to be clearly linked to onward referral for treatment or rehabilitation.
- C4: Health Education England should be petitioned to influence educators so that health professionals are trained to recognise the importance of eye and hearing health to maintaining independence and ageing well.
- C5: Adult care colleagues should be asked to specifically include mitigation of sensory impairment within personalised care plans.
- C6: County Council and CCG commissioners should require providers to collect data on sight test referral as part of falls risk assessments.
- C7: GPs and dementia service providers should include testing for sensory impairment as a routine aspect of cognitive assessment.
- C8: Educators involved in training members of the public should help those involved in caring for people with sensory impairment to access and

undertake training to improve communication with people who cannot see or hear well.

- C9: A social marketing campaign should be initiated, with Public Health England and other stakeholder input, aiming to de-normalise age-related hearing loss and promote the benefits of technological and other solutions to mitigate the disability this may cause.

Recommendations to integrate services and enhance cost-effectiveness

- R1: No recommendations should be enacted without prerequisite face-to-face consultation with the sight and hearing-impaired communities, noting that the County Council has made a commitment to the British Deaf Association Charter, which includes a consultation pledge. The information contained within the sensory impairment needs assessment (including scoping consultation with providers) will be of use in establishing a focus for wider consultation activities.
- R2: With support from the Adult Care Board and Units of Planning a further consultation effort should be made to elicit the perspective of service commissioners, who did not engage with the limited scope consultation undertaken as part of this assessment.
- R3: Commissioners should prioritise reshaping of existing provision to deliver integrated sensory impairment services that offer (where feasible) primary care-based choices for early assessment, advice, treatment and joined-up after-care/ rehabilitation. This may extend to closer integration between sight and hearing services in suitable facilities, such as community hubs.
- R4: Partnership working/ co-commissioning on a wider scale should ensure better provision of universal services for all county residents, with tailoring where needed to improve accessibility for harder-to-reach groups and concerted efforts to overcome challenging communication barriers that likely inhibit service use.

Recommendations to ensure policy support

- S1: The Health and Well-being Board should appoint a sensory impairment champion/ advocate at county level for eye and hearing health. This role would broadly ensure ‘sight and sound in all policies’ and drive forward the county’s strategic and transformation priorities of integration, independence and enabling self-management through improving eye and hearing health.
- S2: NHS England should be petitioned to appoint a regional lead for hearing health, akin to the role of NHS England’s Chair of the Local Professional Network for Eye Health. Given that age-related hearing loss is sensorineural in nature and has links to depression and dementia, it may fit within the remit of the East Midlands Mental Health, Dementia and Neurological Conditions Strategic Clinical Network.

5. Acknowledgements

The following persons made valuable contributions to the sensory impairment needs assessment this document summarises:

- **Daniel Youhana**, Medical Student, University of Nottingham (undertook the literature review and profiling work);
- **Zara Hammond**, Specialty Registrar in Public Health, Derbyshire County Council (undertook the stakeholder consultation work);
- **David Cartwright**, Chair, Local Professional Network for Eye Health in Derbyshire & Nottinghamshire (domain expert input for eye health);
- **Harjit Sandhu**, Head of Policy, National Community Hearing Association (domain expert input for hearing health);
- Service commissioners and providers who confirmed details of local arrangements.

April 2015

Dr Bruce McKenzie, Clinical Assistant Professor and Hon. Specialty Registrar in Public Health, University of Nottingham and Public Health England (East Midlands)

6. Appendices

A1. Sensory impairment literature review

A synthesis of literature covering the prevalence, consequences, prevention, costs and policy context of sensory impairment. *Daniel Youhana, University of Nottingham*

A2. Sensory impairment profiling

A synthesis of routinely available public domain data covering the prevalence, consequences, prevention and costs of sensory impairment in Derbyshire County. *Daniel Youhana, University of Nottingham*

A3. Sensory impairment stakeholder consultation

Report and findings from a modest-scope key stakeholder consultation conducted for Derbyshire County Council. *Zara Hammond, Specialty Registrar in Public Health*

A4. Map of sensory impairment service commissioning and provision

Dr Bruce McKenzie, University of Nottingham/ Derbyshire County Council

Malnutrition Survey 2014

Service Need & Evaluation, Adult Care

The Malnutrition Survey, first carried out during 2012, was repeated during July 2014. Over 2,900 older people had their risk for malnutrition assessed. 76% were assessed as Low risk, with 10% at High risk. More work needs to be done to raise awareness and counter the factors that lead to malnutrition in older people.

Final Version

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Summary & Recommendations

1. This report provides analysis of the data received back from the 2014 Nutrition Survey, carried out during July. Comparisons are drawn with the 2012 Survey.

2. The Cambridge Dictionary defines malnutrition as "*Weak and in bad health because of having too little food or too little of the types of food necessary for good health*".

3. The survey is designed to establish the prevalence of malnutrition amongst older people in Derbyshire. It was improved this time around by the inclusion of older people in a community health setting (including people at home).

4. In this most recent survey, the data for 3,019 people was gathered. The data for 65 respondents was excluded because they were aged under 65 on the survey day, and for a further 20 people, dates of birth were not provided. The resultant figure of 2,954 still compares well with the 2012 Survey, which comprised data for 2,632 people.

5. Results show that:
    a. 226 people had not received a MUST assessment at the time of the survey; the figure was 123 (almost half the rate) in 2012.
    b. We know from the ethnic background of people assessed that the sample is not proportionately representative of the wider Derbyshire older person's population with an under-representation of older people from an ethnic minority who comprise only 0.4% of the current sample.
    c. Average age of the sample is 86 years; females are older with an average age of 87 years and males younger with an average age of 83 years. The oldest person in the sample is 114 years and the youngest 64 years. There is a statistically significant yet weak correlation between age and the likelihood of being malnourished ($r=0.07$, $p<0.01$).
    d. Of the 2,699 people who had received screening, 2,042 (76%) were assessed to be in the Low category.
    e. Adopting a 99% confidence level, we can be certain that the true value lies between +/- 2.12% ie between 73.88% and 78.12%
    f. 312 (11%) were assessed as being in the Medium group and 345 (13%) were assessed as being in the High group. As anybody classified as High or Medium risk is considered to be malnourished, the survey gives us an estimate that between 26% and 22% of older people in Derbyshire who are in a care setting are malnourished.
    g. The results are broadly similar to 2012 (Figure 2 and Figure 3) which serves to underline the reliability of the findings overall. The slightly higher proportion in the Low category this time around is partly due to natural variation along with a more reliable estimate based on a larger sample size which included older people in a community health setting. Those people were not included in the 2012 survey.

    h. Other than location, there are no differences between the groups on MUST score (age, sex, ethnicity).

6. Recommendations:

   a. The survey has reliably shown that malnutrition is a condition that affects a significant proportion of older people in Derbyshire (between 22% and 26% of the older, cared for population) and is a threat to the health and wellbeing of those people. There is a continued need to raise attention and priority to malnutrition through a targeted campaign of awareness-raising generally.

   b. There is a need to continue to monitor the prevalence of malnutrition amongst older people in care settings across Derbyshire so that we can gauge how effectively care organisations are responding to the need to counter its apparent rising incidence. Care organisations need to monitor patient/client nutrition and in turn Derbyshire's Health & Wellbeing Board needs to receive evidence on an annual basis which demonstrates the effectiveness of the campaign to reduce its prevalence.

   c. The annual survey should be improved to enable a better understanding of the precise factors which lead to malnutrition. For example, *in hospital settings, to what extent is it to do with illness and impending surgery*?

   d. The augmented survey needs to encompass more older people in their own homes so that we can get a better understanding of "baseline" malnutrition levels.

Introduction

1. The *2011 Improvement and Scrutiny Review of Nutrition for Older People in the Community and Care Settings Including Hospitals* recommended that a screening survey be done to understand the prevalence of malnutrition amongst older people in Derbyshire. A multi-agency Nutrition Steering Group was established and led on the screening survey.

2. The first survey took place in May 2012, across the majority of Derbyshire's health and social care settings when 2,632 people aged 65 and over were surveyed in order to establish their nutritional status.

3. The 2012 survey provides a baseline set of data to inform health and social care commissioners and providers of the prevalence of malnutrition amongst older people in the local area.

4. Derbyshire has a growing number of older people, many of whom live alone. Given the geographically dispersed and rural nature of many of Derbyshire's communities, there is a likelihood that malnutrition may be on the increase. Females, who tend to live longer than males, are especially at risk.

5. Whilst acknowledging the difficulty of drawing more than an overview from data gathered by way of a simple survey, it is helpful to understand the basic trends about malnutrition that such an exercise can provide.

6. The survey has now been repeated during July 2014 and amended to include how many people are affected in the community and how can they be included in a future survey.

7. The key focal points of the second survey are to establish the reliability of the findings of the first whilst also extending the estimated prevalence to older people living in the community. It also serves as a check to indirectly evaluate the promotional work done by the Council following the first survey re the impact on raising the awareness of malnutrition.

Method

6. The Survey was run in a variety of settings, just like the 2012 one, including:

- Private residential care settings
- County Council residential care settings
- Hospital settings
- Community Health service settings eg health centre.

7. The survey tool recorded the nutritional risk status of an individual based on the BAPEN Malnutrition Universal Screening Tool (MUST). MUST is a tool used across various health and social care settings in Derbyshire. The tool scores an individual as being at a High, Medium or Low risk by taking into account their Body Mass Index, unplanned weight loss and any acute disease.

8. Anyone classified as High or Medium risk is considered to be malnourished.

9. At the time of the survey Derbyshire Healthcare NHS Foundation Trust had not fully implemented the use of MUST but recorded their service users on a similar basis.

10. There are some associated problems which should be be noted when considering the data.

11. Firstly, it is a “snapshot” at a single point in time which will be subject to bias. It does not provide any answers as to why individuals are at say, a High or Low risk. Any differences in risk between different people in different types of setting (eg hospital compared with their own home) are not necessarily attributable to the type of setting.

13. For those assessed whilst in hospital, there was no attempt to record whether patients were receiving palliative care or other medication that might have affected their nutritional intake and therefore result in a High MUST score.

14. There is also insufficient data from the survey returns to map where people had come from prior to the setting they were in at the time of the survey. Mapping of where people (who were not long-term residents/patients) were based at the time of the survey would not have given a true reflection of the prevalence of malnutrition in Derbyshire.

Results

15. Figure 1 profiles the obtained figures from the 2014 Survey.

16. In total we received data about 3019 people which is 388 more than took part in the 2012 survey. Unfortunately, date of birth information was missing for 20 of the returned cases, and a further 74 people were under 65 at the point of assessment so these were excluded from the analysis. 226 people did not receive a MUST analysis. This leaves 2699 people aged 65 and over who had had a MUST analysis during the survey.

17. The clear majority of older people surveyed have a MUST score which indicates they are at Low risk of being malnourished.

- 2042, (76%) were assessed in the Low risk category.
- 312, (11%) were assessed to be in the Medium risk group.
- 345 (13%) were assessed to be in the High risk group.

18. These figures are broadly similar to 2012 survey outturn, although the 2014 survey comprises 300 more respondents than last time.

19. Figure 2 allows direct comparison of numbers and Figure 3 enables direct comparison of proportions.

20. Whilst the numbers in the Low and Medium risk groups were very similar (369 compared with 345 and 306 to 312 respectively), the only group to show any real increase in numbers were those in the Low risk group, who numbered some 208 more than in 2012.

21. Proportionate share for each risk group shows change from 2012 to 2014 in the right direction ie there are fewer older people in High and Medium risk categories (15% and 12% respectively down to 13% and 11%, 27% combined down to 24% combined).

22. The largest proportionate shift is in the Low risk group which comprised 70% in 2012 and then has since increased to 76%. The higher proportion of older people in the Low MUST score category is encouraging but it is unclear to what extent it may be due to the awareness raising carried out following the 2012 survey or simply the result of using a larger sample this time around and therefore due to random variation. Regardless, it is clear that a significant number of older people are malnourished.

Are there Age and Sex Differences in Malnutrition Scores?

23. As females tend to live longer than males there are more females in the sample survey than males.

24. Females make up 69% (N=1852) of the total and males 31% (N=847). 73% of females have a Low MUST score compared with 81% of males.

25. 15% of females and 9% of males have a High MUST score. 12% of females and 11% of males have a Medium MUST score. Given that a Medium or High MUST score is an indicator of malnourishment, 27% of females and 20% of males are malnourished at the time of assessment (Table 2).

26. Average age of the whole sample is 86 years. Females have a higher average age than Males (87 years compared with 83.9 years). Age ranges from 64 years to 114 (Table 1 & Table 3).

27. There is a tendency for the incidence of malnourishment to increase with age, although the proportions of people with a Medium or High MUST score are lower at the highest age group.

Ethnic Background

28. The vast majority of people assessed are from a White background (99.6%, N=2687). Only 12 people were from a non-white ethnic group, of whom 5 people are the largest group and from a Black African/Carribean ethnic group (Table 5).

29. The proportion of people from an ethnic minority in this sample is lower than in the wider Derbyshire population.

Client Location at Time of MUST Assessment

30. Clients are in a range of settings at the point of assessment: residential care homes (private and local authority), hospital or in a community health setting (including at home) (Figure 5 and Table 6).

31. The largest group is in independent sector residential care (N=1207, 45%), followed by community health service setting (N=767, 28%), followed by local authority residential care (N=543, 20%) and then a hospital setting (N=182, 7%).

32. Table 7 provides the person's location at the time of the MUST assessment by their resultant MUST assessment score.

33. Table 7 shows that for those assessed as High, the largest number of people are resident in independent sector residential care (N=207, 60% of people with a High MUST score). 59 people (17% of those with a High MUST score) are in a community health setting, 48 (14%) are in a Derbyshire County Council home, and 31 (9%) are in a hospital setting.

34. We must guard against drawing a conclusion that being in a certain setting causes an older person to become malnourished primarily because this is a "snapshot" survey at a single point in time. People can become malnourished for a variety of reasons and may be so just prior to admission. In hospital settings, people may be about to have, or may just have had an operation at the point of MUST assessment for which they will not have been able to consume food.

35. The survey though did collect information about their provenance for people who were not in their usual home setting. This information is provided in Table 9, Table 10 and Table 11.

36. Perhaps the most notable of this latter analysis concerns people with a High MUST score as shown in Table 11. This shows that for people for whom "Admission from" is "Not applicable" (ie they are in their usual place of residence at the point of assessment) a very high proportion are in Independent Sector residential care homes (N=207, 60% of all people with a High MUST score). In contrast, 48 people (14%) are resident in a Derbyshire County Council home.

37. This raises a clear issue about diet and that residential care homes need to do more to ensure that older people, especially females in the older age groups, have sufficient food of the right kind.

Figure 1

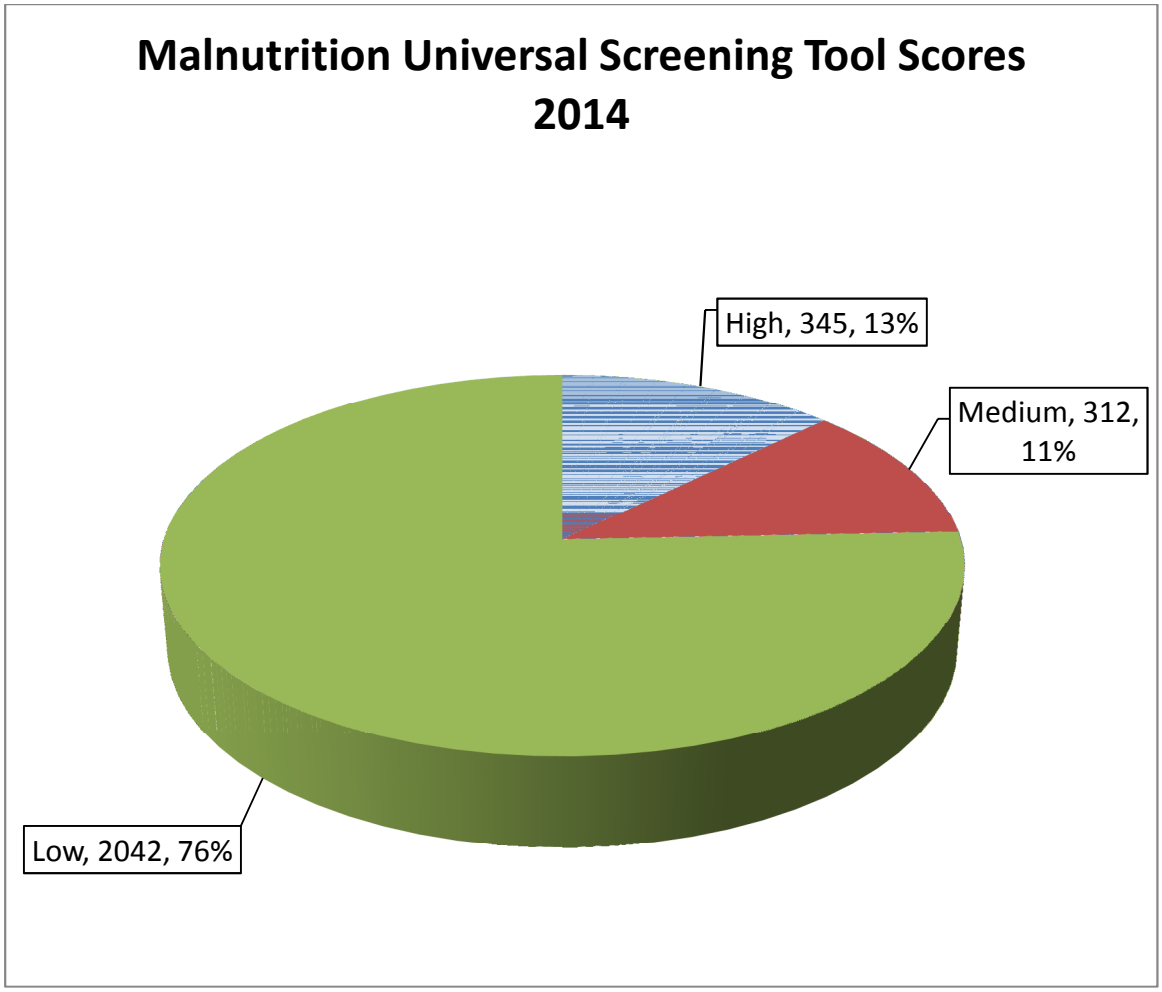

Malnutrition Universal Screening Tool Scores 2014
High, 345, 13%
Medium, 312, 11%
Low, 2042, 76%

Figure 2

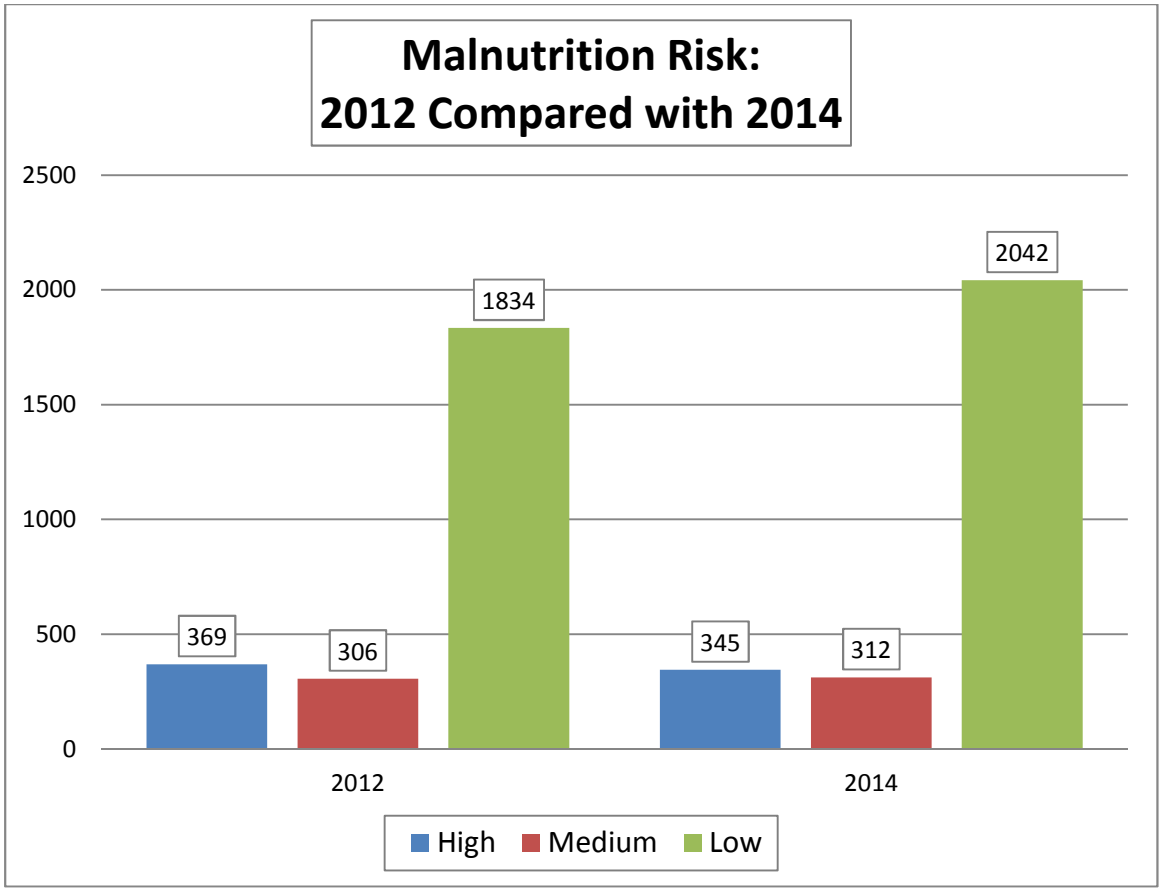


Figure 3

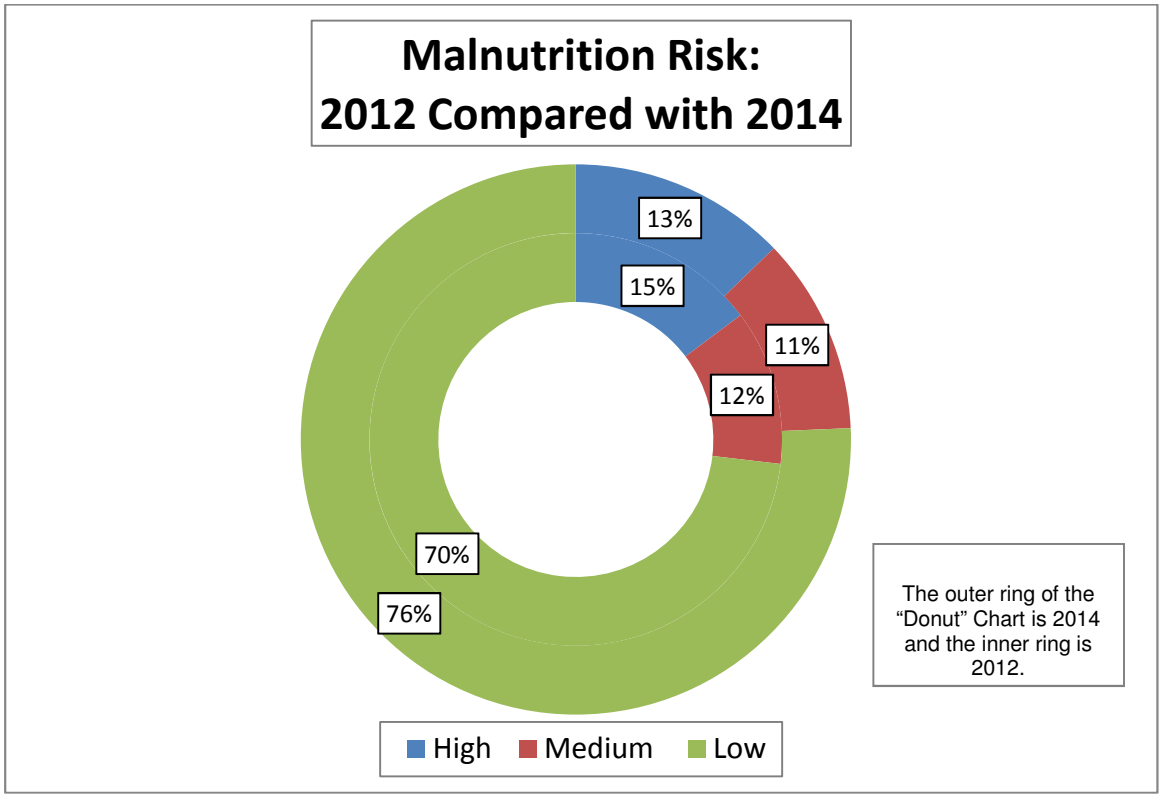


Figure 4

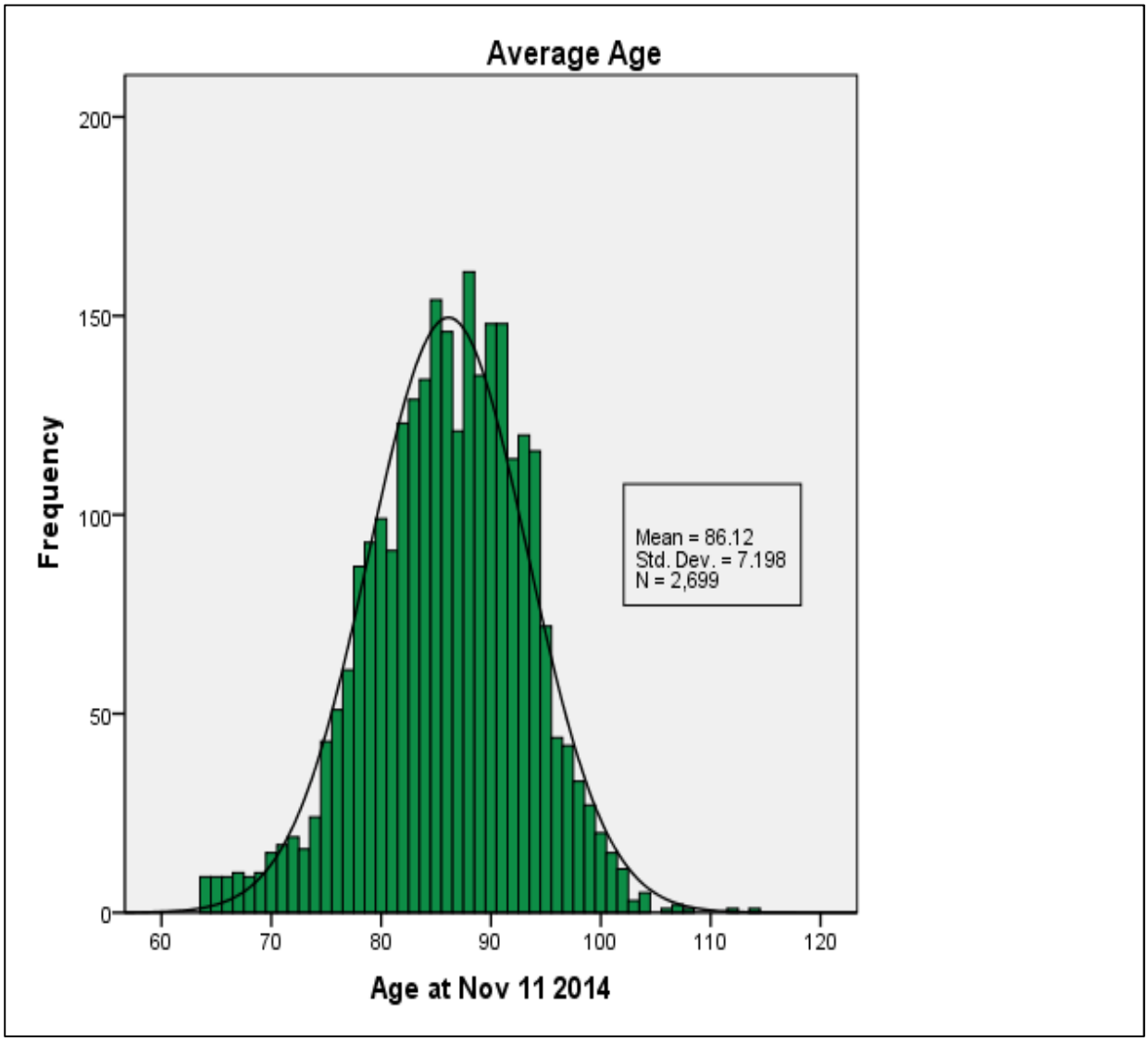


Table 1 Age Differences by Sex

Sex	Mean	N	Std. Deviation	Minimum	Maximum	Median
Female	87.13	1852	7.088	64	114	88.00
Male	83.90	847	6.940	64	102	84.00
Total	86.12	2699	7.198	64	114	86.00

Table 2 Grouped Must Score by Sex

			Sex		
			Female	Male	Total
Grouped MUST Score	LOW	Count	1358	684	2042
		% within Grouped MUST Score	66.5%	33.5%	100.0%
		% within Sex	73.3%	80.8%	75.7%
		% of Total	50.3%	25.3%	75.7%
	MEDIUM	Count	223	89	312
		% within Grouped MUST Score	71.5%	28.5%	100.0%
		% within Sex	12.0%	10.5%	11.6%
		% of Total	8.3%	3.3%	11.6%
	HIGH	Count	271	74	345
		% within Grouped MUST Score	78.6%	21.4%	100.0%
		% within Sex	14.6%	8.7%	12.8%
		% of Total	10.0%	2.7%	12.8%
Total		Count	1852	847	2699
		% within Grouped MUST Score	68.6%	31.4%	100.0%
		% within Sex	100.0 %	100.0%	100.0%
		% of Total	68.6%	31.4%	100.0%

Table 3 Grouped Age by Grouped Must Score

			Grouped Must Score			
			LOW	MEDIUM	HIGH	Total
Grouped Age	64 TO 69	Count	44	5	7	56
		% within Grouped Age	78.6%	8.9%	12.5%	100.0%
		% within Grouped MUST Score	2.2%	1.6%	2.0%	2.1%
		% of Total	1.6%	.2%	.3%	2.1%
	70 TO 79	Count	340	42	46	428
		% within Grouped Age	79.4%	9.8%	10.7%	100.0%
		% within Grouped MUST Score	16.7%	13.5%	13.3%	15.9%
		% of Total	12.6%	1.6%	1.7%	15.9%
	80 TO 89	Count	1004	139	154	1297
		% within Grouped Age	77.4%	10.7%	11.9%	100.0%
		% within Grouped MUST Score	49.2%	44.6%	44.6%	48.1%
		% of Total	37.2%	5.2%	5.7%	48.1%
	90 TO 99	Count	623	113	124	860
		% within Grouped Age	72.4%	13.1%	14.4%	100.0%
		% within Grouped MUST Score	30.5%	36.2%	35.9%	31.9%
		% of Total	23.1%	4.2%	4.6%	31.9%
	100 PLUS	Count	31	13	14	58
		% within Grouped Age	53.4%	22.4%	24.1%	100.0%
		% within Grouped MUST Score	1.5%	4.2%	4.1%	2.1%
		% of Total	1.1%	.5%	.5%	2.1%
Total		Count	2042	312	345	2699
		% within Grouped Age	75.7%	11.6%	12.8%	100.0%
		% within Grouped MUST Score	100.0%	100.0%	100.0%	100.0%
		% of Total	75.7%	11.6%	12.8%	100.0%

Table 4 Grouped Age by gender

			Sex		
			Female	Male	Total
Grouped Age	64 TO 69	Count	28	28	56
		% within Grouped Age	50.0%	50.0%	100.0%
		% within Sex	1.5%	3.3%	2.1%
		% of Total	1.0%	1.0%	2.1%
	70 TO 79	Count	234	194	428
		% within Grouped Age	54.7%	45.3%	100.0%
		% within Sex	12.6%	22.9%	15.9%
		% of Total	8.7%	7.2%	15.9%
	80 TO 89	Count	865	432	1297
		% within Grouped Age	66.7%	33.3%	100.0%
		% within Sex	46.7%	51.0%	48.1%
		% of Total	32.0%	16.0%	48.1%
	90 TO 99	Count	671	189	860
		% within Grouped Age	78.0%	22.0%	100.0%
		% within Sex	36.2%	22.3%	31.9%
		% of Total	24.9%	7.0%	31.9%
	100 PLUS	Count	54	4	58
		% within Grouped Age	93.1%	6.9%	100.0%
		% within Sex	2.9%	.5%	2.1%
		% of Total	2.0%	.1%	2.1%
Total		Count	1852	847	2699
		% within Grouped Age	68.6%	31.4%	100.0%
		% within Sex	100.0%	100.0%	100.0%
		% of Total	68.6%	31.4%	100.0%

Table 5 Grouped MUST Score by Ethnicity

			Grouped Must Score			
			LOW	MEDIUM	HIGH	Total
eth	Asian	Count	2	0	1	3
		% within eth	66.7%	.0%	33.3%	100.0%
		% within Grouped MUST Score	.1%	.0%	.3%	.1%
		% of Total	.1%	.0%	.0%	.1%
	Black African/Carribean	Count	5	0	0	5
		% within eth	100.0%	.0%	.0%	100.0%
		% within Grouped MUST Score	.2%	.0%	.0%	.2%
		% of Total	.2%	.0%	.0%	.2%
	Traveller	Count	1	0	0	1
		% within eth	100.0%	.0%	.0%	100.0%
		% within Grouped MUST Score	.0%	.0%	.0%	.0%
		% of Total	.0%	.0%	.0%	.0%
	Multiple Ethnic Group	Count	1	0	0	1
		% within eth	100.0%	.0%	.0%	100.0%
		% within Grouped MUST Score	.0%	.0%	.0%	.0%
		% of Total	.0%	.0%	.0%	.0%
	Other	Count	1	0	1	2
		% within eth	50.0%	.0%	50.0%	100.0%
		% within Grouped MUST Score	.0%	.0%	.3%	.1%
		% of Total	.0%	.0%	.0%	.1%
	White	Count	2032	312	343	2687
		% within eth	75.6%	11.6%	12.8%	100.0%
		% within Grouped MUST Score	99.5%	100.0%	99.4%	99.6%
		% of Total	75.3%	11.6%	12.7%	99.6%
Total		Count	2042	312	345	2699
		% within eth	75.7%	11.6%	12.8%	100.0%
		% within Grouped MUST Score	100.0%	100.0%	100.0%	100.0%
		% of Total	75.7%	11.6%	12.8%	100.0%

Figure 5

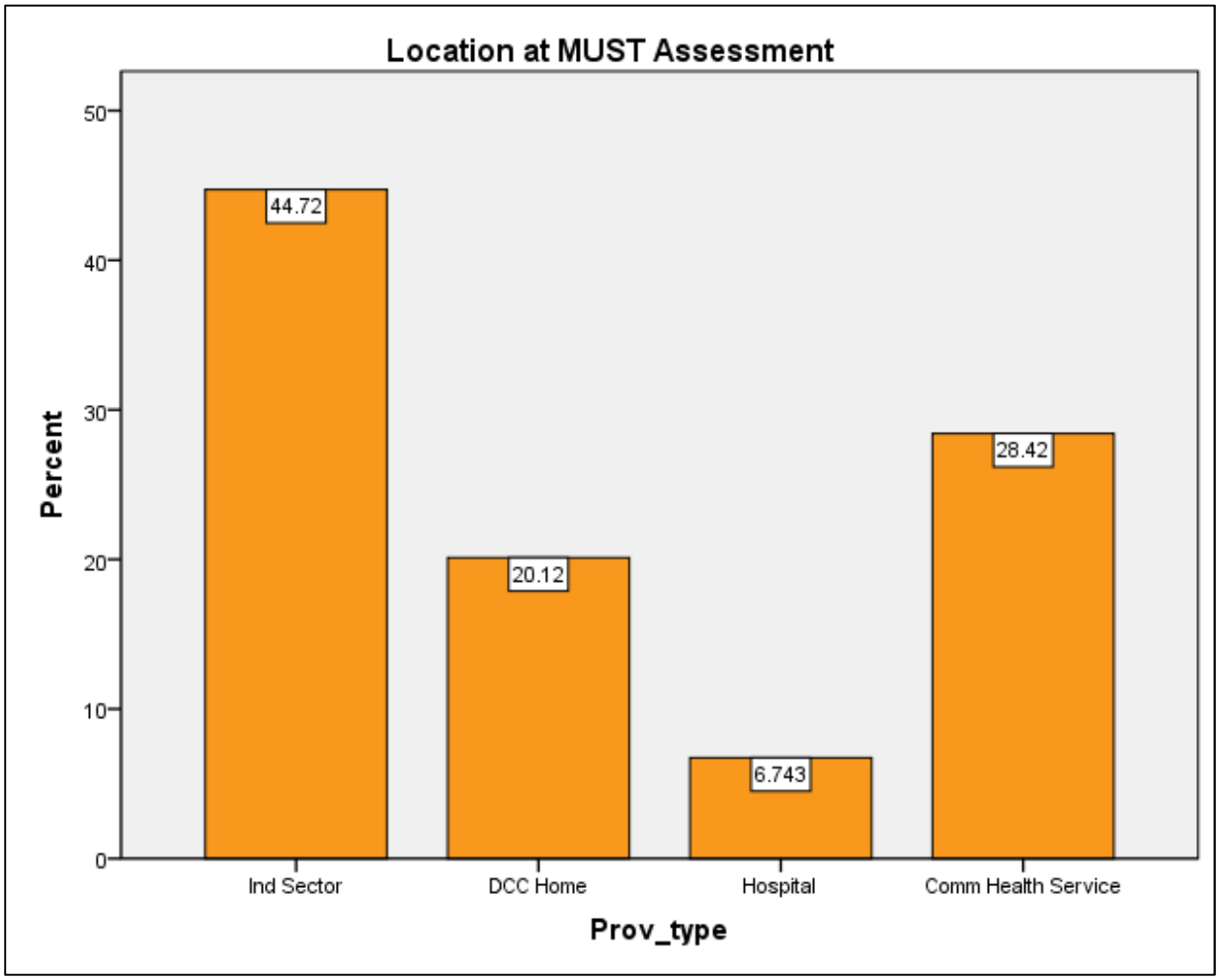


Table 6 Location at time of Assessment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Ind Sector	1207	44.7	44.7	44.7
	DCC Home	543	20.1	20.1	64.8
	Hospital	182	6.7	6.7	71.6
	Comm Health Service	767	28.4	28.4	100.0
	Total	2699	100.0	100.0	

Table 7 Provider type by Grouped MUST Score

			Grouped Must Score			
			LOW	MEDIUM	HIGH	Total
Prov_type	Ind Sector	Count	844	156	207	1207
		% within Prov_type	69.9%	12.9%	17.1%	100.0%
		% within Grouped Must Score	41.3%	50.0%	60.0%	44.7%
		% of Total	31.3%	5.8%	7.7%	44.7%
	DCC Home	Count	425	70	48	543
		% within Prov_type	78.3%	12.9%	8.8%	100.0%
		% within Grouped Must Score	20.8%	22.4%	13.9%	20.1%
		% of Total	15.7%	2.6%	1.8%	20.1%
	Hospital	Count	130	21	31	182
		% within Prov_type	71.4%	11.5%	17.0%	100.0%
		% within Grouped Must Score	6.4%	6.7%	9.0%	6.7%
		% of Total	4.8%	.8%	1.1%	6.7%
	Comm Health Service	Count	643	65	59	767
		% within Prov_type	83.8%	8.5%	7.7%	100.0%
		% within Grouped Must Score	31.5%	20.8%	17.1%	28.4%
		% of Total	23.8%	2.4%	2.2%	28.4%
Total		Count	2042	312	345	2699
		% within Prov_type	75.7%	11.6%	12.8%	100.0%
		% within Grouped Must Score	100.0%	100.0%	100.0%	100.0%
		% of Total	75.7%	11.6%	12.8%	100.0%

Table 8 Grouped MUST Score by Provenance

			Grouped Must Score			
			LOW	MEDIUM	HIGH	Total
Ad_From	N/a	Count	1812	273	302	2387
		% within Ad From	75.9%	11.4%	12.7%	100.0%
		% within Grouped Must Score	88.7%	87.5%	87.5%	88.4%
		% of Total	67.1%	10.1%	11.2%	88.4%
	Own Home	Count	128	24	19	171
		% within Ad_From	74.9%	14.0%	11.1%	100.0%
		% within Grouped Must Score	6.3%	7.7%	5.5%	6.3%
		% of Total	4.7%	.9%	.7%	6.3%
	Other Hospital Dept	Count	89	14	22	125
		% within Ad_From	71.2%	11.2%	17.6%	100.0%
		% within Grouped Must Score	4.4%	4.5%	6.4%	4.6%
		% of Total	3.3%	.5%	.8%	4.6%
	Community Hospital	Count	4	0	0	4
		% within Ad_From	100.0%	.0%	.0%	100.0%
		% within Grouped Must Score	.2%	.0%	.0%	.1%
		% of Total	.1%	.0%	.0%	.1%
	Care Home	Count	9	1	2	12
		% within Ad_From	75.0%	8.3%	16.7%	100.0%
		% within Grouped Must Score	.4%	.3%	.6%	.4%
		% of Total	.3%	.0%	.1%	.4%
Total		Count	2042	312	345	2699
		% within Ad_From	75.7%	11.6%	12.8%	100.0%
		% within Grouped Must Score	100.0%	100.0%	100.0%	100.0%
		% of Total	75.7%	11.6%	12.8%	100.0%

Table 9 LOW MUST Score: Admission by Location

			Prov_type				
			Ind Sector	DCC Home	Hospital	Comm Health Service	Total
Ad_From	N/a	Count	844	425	0	543	1812
		% within Ad_From	46.6%	23.5%	.0%	30.0%	100.0%
		% within Prov_type	100.0%	100.0%	.0%	84.4%	88.7%
		% of Total	41.3%	20.8%	.0%	26.6%	88.7%
	Own Home	Count	0	0	28	100	128
		% within Ad_From	.0%	.0%	21.9%	78.1%	100.0%
		% within Prov_type	.0%	.0%	21.5%	15.6%	6.3%
		% of Total	.0%	.0%	1.4%	4.9%	6.3%
	Other Hospital Dept	Count	0	0	89	0	89
		% within Ad_From	.0%	.0%	100.0%	.0%	100.0%
		% within Prov_type	.0%	.0%	68.5%	.0%	4.4%
		% of Total	.0%	.0%	4.4%	.0%	4.4%
	Community Hospital	Count	0	0	4	0	4
		% within Ad_From	.0%	.0%	100.0%	.0%	100.0%
		% within Prov_type	.0%	.0%	3.1%	.0%	.2%
		% of Total	.0%	.0%	.2%	.0%	.2%
	Care Home	Count	0	0	9	0	9
		% within Ad_From	.0%	.0%	100.0%	.0%	100.0%
		% within Prov_type	.0%	.0%	6.9%	.0%	.4%
		% of Total	.0%	.0%	.4%	.0%	.4%
Total		Count	844	425	130	643	2042
		% within Ad_From	41.3%	20.8%	6.4%	31.5%	100.0%
		% within Prov_type	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	41.3%	20.8%	6.4%	31.5%	100.0%

Table 10 Medium MUST Score: Admission by Location

			Prov_type				
			Ind Sector	DCC Home	Hospital	Comm Health Service	Total
Ad_From	N/a	Count	156	70	0	47	273
		% within Ad_From	57.1%	25.6%	.0%	17.2%	100.0%
		% within Prov_type	100.0%	100.0%	.0%	72.3%	87.5%
		% of Total	50.0%	22.4%	.0%	15.1%	87.5%
	Own Home	Count	0	0	6	18	24
		% within Ad_From	.0%	.0%	25.0%	75.0%	100.0%
		% within Prov_type	.0%	.0%	28.6%	27.7%	7.7%
		% of Total	.0%	.0%	1.9%	5.8%	7.7%
	Other Hospital Dept	Count	0	0	14	0	14
		% within Ad_From	.0%	.0%	100.0%	.0%	100.0%
		% within Prov_type	.0%	.0%	66.7%	.0%	4.5%
		% of Total	.0%	.0%	4.5%	.0%	4.5%
	Care Home	Count	0	0	1	0	1
		% within Ad_From	.0%	.0%	100.0%	.0%	100.0%
		% within Prov_type	.0%	.0%	4.8%	.0%	.3%
		% of Total	.0%	.0%	.3%	.0%	.3%
Total		Count	156	70	21	65	312
		% within Ad_From	50.0%	22.4%	6.7%	20.8%	100.0%
		% within Prov_type	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	50.0%	22.4%	6.7%	20.8%	100.0%

Table 11 High MUST Score: Admission by Location

			Prov_type				
			Ind Sector	DCC Home	Hospital	Comm Health Service	Total
Ad_From	N/a	Count	207	48	0	47	302
		% within Ad_From	68.5%	15.9%	.0%	15.6%	100.0%
		% within Prov_type	100.0%	100.0%	.0%	79.7%	87.5%
		% of Total	60.0%	13.9%	.0%	13.6%	87.5%
	Own Home	Count	0	0	7	12	19
		% within Ad_From	.0%	.0%	36.8%	63.2%	100.0%
		% within Prov_type	.0%	.0%	22.6%	20.3%	5.5%
		% of Total	.0%	.0%	2.0%	3.5%	5.5%
	Other Hospital Dept	Count	0	0	22	0	22
		% within Ad_From	.0%	.0%	100.0%	.0%	100.0%
		% within Prov_type	.0%	.0%	71.0%	.0%	6.4%
		% of Total	.0%	.0%	6.4%	.0%	6.4%
	Care Home	Count	0	0	2	0	2
		% within Ad_From	.0%	.0%	100.0%	.0%	100.0%
		% within Prov_type	.0%	.0%	6.5%	.0%	.6%
		% of Total	.0%	.0%	.6%	.0%	.6%
Total		Count	207	48	31	59	345
		% within Ad_From	60.0%	13.9%	9.0%	17.1%	100.0%
		% within Prov_type	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	60.0%	13.9%	9.0%	17.1%	100.0%

DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

25 June 2015

DERBYSHIRE COUNTY JOINT VISION AND STRATEGIC DIRECTION FOR MENTAL HEALTH

1) Purpose of the Report

The purpose of this report is to:

- To seek endorsement for the Derbyshire County Joint Vision and Strategic Direction for Mental Health 2014-19 (at Appendix 1)

- To inform Adult Care Board of progress on some key areas of the action plan

2) Information and Analysis

Background

In September 2014, the Adult Care Board endorsed the draft Direction of Travel for Mental Health in Derbyshire County and agreed to the Joint Commissioning Board for Mental Health to further engage with stakeholders to gain feedback on the document and to develop the associated action plan for 2014-16.

Since September 2014, the draft Direction of Travel has been cascaded widely to a range of stakeholders including service receivers, carers, voluntary sector providers, CCG Governing Bodies and other health and social care partner agencies, providers and their staff. Feedback from this engagement process has been acknowledged through a public statement summarising the analysis of the feedback and this has resulted in a number of changes to the document, including the vision statement.

The Strategy has also been refreshed during this time to reflect a number of new key policy documents such as the NHS Five Year Forward View, the refreshed Derbyshire Health and Wellbeing Strategy and changes to local commissioning plans, i.e. North and South Units of Planning and the Better Care Fund plan.

The Strategy document (Appendix 1) and action plan (Appendix 2) was approved at the Joint Commissioning Board for Adult Mental Health on the 10th June 2015.

3) Proposed Further Action

The annual Mental Health Strategy action plans will be monitored through the Joint Commissioning Board for Adult Mental Health and progress will be reported to the Adult Care Board and Health and Wellbeing Board annually. See Pg. 5 of the strategy document for an overview of the reporting and governance structure.

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.

The Joint Commissioning Board (JCB) membership will be refreshed to reflect the new commissioning architecture and ensure system-wide representation and to take account of the need to strengthen partnership working between Children and Younger People's mental health commissioning and service provision. The JCB membership refresh will be aligned with the natural end of the Crisis Care Concordat (CCC) Steering Group to ensure the continuation of good partnership working beyond the life of the CCC group. Membership will also ensure clear links into other strategic groups such as the 21st Century and Star Boards.

Engagement – Next steps

Opportunities for service receiver and carer engagement will be project planned alongside each action, i.e., involvement in themed work streams, (i.e., urgent care pathway development; suicide prevention framework).

A Mental Health Partnership Event is currently being planned for September 2015 to officially launch the strategy document; present the findings of the Public Health 'State of Mental Health in Derbyshire' report; provide an update on the Crisis Care Concordat and to engage with stakeholders through a series of workshops on particular work streams., i.e. Prevention, Urgent Care, Physical Health Needs and Dual Diagnosis as well as to prioritise topics for 'deep dive' analysis.

Measuring the impact of the strategy

All work streams contained in the action plan will have Key Performance Indicators (KPI's) and these will be monitored by the Joint Commissioning Board.

4) Update on some key areas of work

Crisis Care Concordat

In response to the Crisis Care Concordat (February 2014), local partnerships of local authority, health and criminal justice agencies have formed a steering group and have committed to and published 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. Additionally, a shared action plan has been developed and published with a commitment to review, monitor and track improvements and publish progress made. The Declaration and Action Plan are available to view on the national Crisis Care Concordat website, www.crisiscareconcordat.org .

Urgent Care Pathway review

In response to the Crisis Care Concordat, a whole-system Urgent Care review is in its early stages. The review will consider how health and social care, police, ambulance, probation and telephone triage and support services can change and develop working practices to improve outcomes for people in crisis and their experience of crisis response; reduce demand in the system and make best use of resources.

The review will also examine how community resources can be developed to provide alternatives to hospital admission, particularly addressing the current demand on mental health beds leading to the need to place people out of area.

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

An independent review of mental health service receiver and carer engagement mechanisms was carried out during April-September 2014 in partnership with Adult Care, CCG's, Derbyshire Healthcare Foundation Trust, DCHS and Derby City Council. The recommendations of this review have been considered by the Engagement Project Board and respective partner agencies and a service specification reflecting the agreed model is in development.

Once joint funding has been agreed and the service specification is completed, a period of engagement with service users and carers will follow to ensure that the proposed model going forward is fit for purpose. Following this process, a procurement exercise will follow with the new model planned to be implemented from 1 April 2016.

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 (County and City) to develop a shared outcomes framework which could provide evidence of the impact of mental health voluntary sector grant funded

support against the six themes of the strategy. The framework has been developed in partnership with mental health voluntary sector providers and will help to drive integration, enable organisations to deliver person-centred, outcomes-focussed support, as well as providing robust evidence of the value of their services in order to attract wider sources of funding. The framework 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.

The Outcomes Framework is currently being piloted by a small number of organisations to test for validity and ease of application.

Improving Access to Psychological Therapies (IAPT) Equity Audit and IAPT procurement

The 4 Derbyshire CCGs commissioned Public Health to develop a Health Equity Audit to assess the equity of IAPT services in Derbyshire, with respect to age, gender, ethnicity, geography, disability, long-term condition status, sexual-orientation and employment status. The report has made eleven recommendations which will inform future commissioning of IAPT across Derbyshire. A copy of the full report is available on the Derbyshire Observatory.

State of Mental Health in Derbyshire (JSNA) report

The JSNA for mental health is currently being refreshed by Public Health colleagues and the report should be available for publication late July 2015. This will inform commissioning plans going forward. The findings of the report will be presented at the Partnership Event in September 2015.

Specialist Mental Health Advocacy

A procurement process is currently underway to bring together Independent Mental Health Advocacy, Independent Mental Capacity Advocacy and the DoLS Paid Representative Service and NHS Independent Complaints Advocacy into one contract with a single point of access. The contract is expected to be awarded in October 2015 with the new service commencing from 1 April 2016.

Self-help review

A review of how self-help for mental health in the community can be further developed, supported and maintained, is currently underway and is aligned with the social capital work stream of the 21st Century Board.

Day opportunities review

A review of social inclusion opportunities and current VCS grant funded services and support for mental health is currently being planned. This will take into account responsibilities under the Care Act for Adult Care in relation

to prevention and will ensure alignment of future provision with the overarching themes of the strategy.

The review will look at how services and support can be personalised to meet the needs of both those who are eligible for a personal budget or personal health budget as well as those who are ineligible but require a range of support to overcome barriers in their daily lives related to their mental health, maintain their wellbeing and reduce or delay eligible support needs.

Action Plan 2014-16

The Action Plan for 2014-16 can be found at Appendix 2. This is not the final version as there are still some actions to be incorporated following further discussions with partners.

5) 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 areas of work are included in the Better Care Fund.

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.

6) Officer Recommendation

6.1) For Adult Care Board to note and endorse the Derbyshire County Joint Vision and Strategic Direction for Mental Health 2014-19

6.2) For Adult Care Board to note progress so far against some of the key areas of current work.

Julie Vollor
Assistant Director
Strategy & Commissioning
Adult Care

Dave Gardner
Assistant Director
Procurement & Commissioning
Hardwick CCG

The Derbyshire County

Joint Vision and Strategic Direction for Adult Mental Health

2014 – 2019

The Vision

"Whole communities will recognise and act upon factors that contribute to mental ill health such as poverty, abuse, work stress and lack of timely access to good support. Where support is required, people will achieve positive mental health by having access to high quality, local, person-centred 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
- Attention to the mental health of people with physical health problems
- 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

The Derbyshire County Joint Vision and Strategic Direction For Adult Mental Health 2014 – 2019

1. Introduction

The 'Derbyshire Joint Vision and Strategic Direction for Adult Mental Health 2007-17' was developed in partnership with service receivers, carers, clinicians and provider organisations. Since its publication in 2007, there have been a number of national policy drivers, new legislation and local strategic changes in commissioning and service delivery including:

- 2007 Department of Health's Commissioning framework for health and well-being
- 2010 Vision for Adult Social Care: Capable Communities and Active Citizens
- 2010 Equity and excellence: liberating the NHS
- 2010 Equalities Act
- 2011 Think Local, Act Personal: Next Steps for Transforming Adult Social Care
- 2011 National Mental Health Strategy: No Health without Mental Health
- 2012 No Health without Mental Health Implementation Framework
- 2012 Health & Social Care Act
- 2012 Transforming Care: a national response to Winterbourne View Hospital
- 2012 Preventing Suicide in England: a cross-government outcomes strategy to save lives
- 2012 Caring for our Future: reforming care and support (White Paper 2012 / Care Bill 2013)
- 2012-13 Development of national outcomes frameworks for Adult Social Care, NHS and Public Health
- 2013 The Francis Report
- 2013 Emergence of Health & Wellbeing Board and Clinical Commissioning Groups
- 2013 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
- 2014 Closing the Gap: priorities for essential change in mental health
- 2014 Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis
- 2014 The Care Act
- 2014 No assumptions – a narrative for personalised, co-ordinated care and support in mental health
- 2014 NHS Five Year Forward View
- 2014 Next steps towards Primary Care co-commissioning
- 2015 Guidance to support the introduction of access and waiting time standards for mental health services in 2015-16
- Publication of a number of National Institute for Health and Care Excellence (NICE) quality standards and pathways of care
- Implementation of the National Tariff Payment System for secondary 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

As a result, the Derbyshire Joint Commissioning Board for Mental Health put forward a proposal to the Adult Care Board to refresh the Derbyshire Joint Vision and Strategic Direction for Adult Mental Health 2007-17, to bring it up to date and in line with No Health without Mental Health, the new NHS, Adult Care and Public Health Outcomes Frameworks, the current focus of health and social care commissioning towards promoting well-being, delivering prevention and early intervention and a move to delivering more personalised care that reflects people's needs and aspirations.

It was agreed that the Joint Vision and Strategic Direction for Mental Health should be a 'live' document that can be responsive to changing national or local drivers and policy changes that require immediate consideration. As a live document, the strategy will be regularly reviewed and updated to reflect new legislation, strategies, guidance or commissioning intentions and referred to in Joint Strategic Commissioning meetings.

The refreshed strategy

- Takes account of recent national, regional and local drivers, policies and priorities relating to Adult Mental Health and wellbeing
- Outlines a joint strategic vision for mental health in Derbyshire for the next five years
- Identifies common high-level strategic 'themes' shared across health and social care
- Will inform the development and implementation of annual joint commissioning action plans for 2014-19 which will be developed in partnership with Public Health, Clinical Commissioning Groups, service receivers, carers and providers and reviewed on an annual basis.

The above proposals for the strategy refresh were presented to service receivers and service receiver representatives at a Stakeholder Event and there was consensus in regard to refreshing the strategy and for the following proposed themes:

1 Personalisation
2 Promotion, prevention and early intervention
3 Enablement and Recovery
4 Social inclusion, fair access and equity
5 Keeping people safe from avoidable harm
6 Integration

Governance

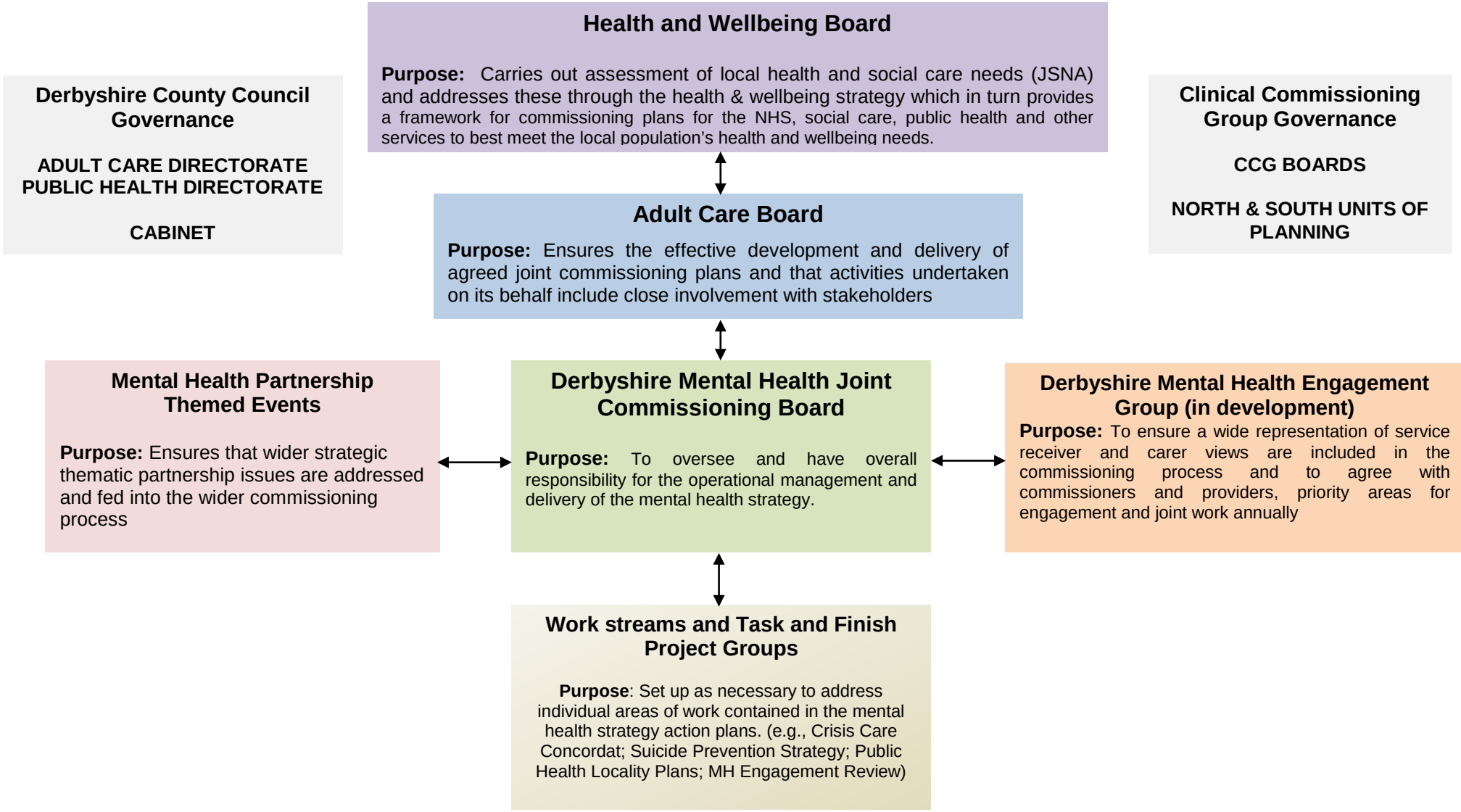
Implementation of the strategy and associated annual action plans will be overseen by the Mental Health Joint Commissioning Board established to bring together Derbyshire County Council Adult Care, Public Health, Derbyshire Clinical Commissioning Groups (CCG's), Healthwatch and representatives of service receivers and voluntary sector providers.

Each year, the Mental Health Joint Commissioning Board will link its action plan to:

- The Health & Wellbeing Strategy priorities
- Adult Care priorities
- Better Care Fund priorities
- Clinical Commissioning group priorities – North and South Units of Planning
- National strategies and policies
- Key performance indicators relevant to mental health
- Learning from needs assessment, national and local research and stakeholder engagement

The following diagram (Fig. 2) shows the reporting and governance structure for the Derbyshire Joint Mental Health Commissioning Strategy and where it fits within the current decision making system across health and social care. The Joint Mental Health Commissioning Board will coordinate its work around the overarching Mental Health strategy with the appropriate sub-groups from the current and emerging commissioning architecture, i.e., Better Care Fund, 21st Century Board, Star Board etc. The Joint Commissioning Board will be represented in these sub-groups.

Fig 2: Reporting and governance structures for the Derbyshire County Vision and Strategic Direction for Adult Mental Health



2. Impact of the Derbyshire County Vision and Strategic Direction for Adult Mental Health 2007 – 2017

The Derbyshire Vision and Strategic Direction for Adult Mental Health 2007 - 2017 set out a number of strategic objectives and priorities to be achieved across its ten-year duration.

Since the strategy was published in 2007, there have been considerable changes to national policy and arrangements for health and social care commissioning. These changes have impacted on the implementation of the strategy where some objectives were achieved successfully; some were overtaken by new national policy and some areas still needing to see progress.

There were 12 identified strategic priorities and 20 listed actions. Key areas of success include:

- Improving access to psychological therapy (IAPT) services which are now accessible across Derbyshire with a choice of provider
- Specialist mental health housing related support has been successfully implemented across the County
- There is full coverage of Health Trainer support across the County – this has recently been re-procured by Public Health into an enhanced Wellbeing service
- Implementation and funding of a mental health awareness training programme across the County
- Continued development of and support for service user, carer and voluntary sector provider networks
- Improved data collection and reporting across the secondary mental health and IAPT contracts
- 'Trevayler' crisis house established as a community alternative to acute patient care
- Key objectives of the Derbyshire Joint Carer's Strategy achieved
- Derbyshire Healthcare Foundation Trust (DHcFT) have received Dual Diagnosis training
- Healthy Body / Healthy Mind work programme piloted and mainstreamed to improve the physical health of people with mental ill health
- BME Mental Health Community Scheme launched with a number of BME groups having successfully completed the Mental Health First Aid training course
- Books on prescription available through libraries and via the 20 newly established Health & Wellbeing zones across the County

Areas of work that were less successful and/or require on-going consideration and input include;

- Continued improvement into the implementation of the Care Programme Approach to enable service receivers to be engaged in the details of their care pathways
- Opportunities for people with mental ill health to access employment
- Achieving equitable access to specialist psychotherapies in the north of the county
- Addressing the increase in the number of people requiring in-patient hospital care which has led to an overall increase in the number of 'out of area' placements.

3. The Challenge going forward

'The NHS belongs to the people: a call to action' (2013) set out the challenges facing the NHS which include rising demand with more people living longer with more complex and long term conditions and rising patient and carer expectations of the quality of care. This is set against a backdrop of an estimated funding gap which could grow to £30bn between 2013/14 to 2020/21.

Similarly, there is an urgent need to address the increasing demands placed on social care to improve outcomes and target resources by reducing the demand for hospital services and long-term care. At the same time Local Authorities are facing unprecedented government cuts over their budgets due to reductions in Government grants, inflation and greater demands on Adult Social Care; during 2013-18, Derbyshire County Council will have to deliver savings of £157 million from its budget, which is almost a third of the Council's total spending.

Mental health services and support will need to respond to these financial challenges over the next three to five years and beyond. The public sector financial constraints means that health and social care commissioners and providers will need to think radically about how services are commissioned and provided in order to keep within budgetary but also service quality parameters.

The NHS Five Year Forward View (2014) acknowledges the challenges faced by an ageing population and associated complexity of health issues. It sets out a longer term view of how health services need to change; arguing for a more engaged relationship with patients, carers and the public to promote wellbeing and prevent ill-health.

Health and social care commissioners and providers are responding to these challenges as outlined in the action plan (Appendix 2). For example, Derbyshire Healthcare NHS 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 require significant realignment of the workforce and workforce development to meet the future implementation requirements of the National Tariff Payment System (NTPS) and for integration between primary and secondary mental health services.

Legislative framework

The Health and Social Care Act 2012 set out specific obligations for the health system and its relationship with care and support services. It gives a duty to NHS England, Clinical Commissioning Groups, Monitor and Health & Wellbeing Boards to make it easier for health and social care services to work together to improve the quality of services and people's experience of them. This has been instrumental in driving forward the integration agenda in Derbyshire and is reflected in the Derbyshire Integration Plan, Better Care Fund plan and the North and South Units of Planning.

The Care Act 2014 contains the most significant reforms to Adult Social Care and social care funding for several decades. The Act brings historical 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 wellbeing, an individual's needs, views, feelings and wishes should be considered in all aspects of their wellbeing for 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. This reinforces the need to strengthen preventative services and those that promote recovery and independence. It also requires the promotion of integration of care and support with local authorities, health and housing services and other service providers to ensure the best outcomes are achieved for the individual. This includes strengthening partnerships with Children and Younger People's mental health commissioning and service provision. Integrated approaches to local commissioning also have an important role to play in promoting mental wellbeing and preventing mental illness, as part of the local Health and Wellbeing Strategy.

4. Local Context

It is estimated that 1 in 4 people experience mental ill health at some stage in their life. Mental health difficulties are wide-ranging, from common mental health problems, which include anxiety and depression, to more severe and enduring conditions such as personality disorders and psychosis. The number of adults in Derbyshire estimated to have a common mental health problem is 80,000, and there are 5,874 individuals with psychosis recorded at GP practices in Derbyshire.

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 it is important to consider these wider determinants alongside levels of prevalence and use of mental health services when planning services. Within Derbyshire,

- more than 1 in 4 people in Bolsover and Chesterfield live in the 20% most deprived areas, compared to 1 in 50 in Derbyshire Dales
- there is variation in long-term unemployment rates across the county with rates higher than the national average in Chesterfield and Erewash
- across Derbyshire, it is estimated that 5% of households are living in fuel poverty, but this ranges from 0.5% in a ward in South Derbyshire to 13.3% in a 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
- Amber Valley and Chesterfield have rates of alcohol-related admissions significantly higher than England
- all districts in Derbyshire, with the exception of South Derbyshire, have higher rates of disability or long term conditions than England

Mental health needs will also vary over time. Welfare reforms, changes to housing related support and local government spending cuts will impact on the level of mental health needs within Derbyshire. The impact will be disproportionate across the population with groups most affected including workless households, lone parents and disabled people.

In addition, variation in current service provision means that people with mental health needs across Derbyshire are not able to access equitable services.

A State of Mental Health in Derbyshire report is currently being developed, and will be published in September 2015. Meanwhile, further information on the mental health needs of Derbyshire can be found on the Mental Health, Dementia and Neurology Intelligence Network at the following link - http://fingertips.phe.org.uk/profile-group/mental-health

5. Scope of the Strategy

This strategy relates to the mental health needs of people aged 18 and above, including people with a learning disability, people with a dual-diagnosis, people in transition from children and young people's services, or from prison or forensic services. However, evidence suggests over 70% of adults with mental health difficulties first experienced problems in childhood or as a young adult. The national and local ambition reflected in the NHS Five Year Forward View (2014) favours a move towards ageless services and this direction of travel will be reflected in improved partnership working and strategic planning with DCC Children & Younger Adults department and CAMHS commissioners and in the implementation of the strategy going forward.

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

- 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)
- Derbyshire County Council Adult Care (DCCAC)
- Derbyshire County Council Public Health (DCCPH)

NHS Hardwick CCG is the coordinating commissioner for mental health contracts on behalf of all four Derbyshire CCG's. Tameside and Glossop Clinical Commissioning Group are working to a separate strategy but will work in partnership with Derbyshire County Council to meet the needs of Glossopdale residents.

The mental health strategy (amongst other strategic plans) sits alongside and influences the CCG commissioning intentions and the health economies Units of Planning. For Derbyshire there are two, the North Unit of Planning and South Unit of Planning. The health economies include CCG's, NHS England Area Teams (ATs), Providers, Health & Wellbeing Boards (HWBs) and Local Authorities. Health economies will create and own five year strategic plans for their area, completed at Unit of Planning level and using a collaborative approach across all partners to achieve integration at community level.

NHS England currently commissions many of the primary care services previously commissioned by Primary Care Trusts. For example, it is currently responsible for the majority of GP contracts. However, in September 2014, NHS England published "Proposed next steps towards primary care co-commissioning: an overview" and it is anticipated that CCG's will take on increasing responsibility for primary care commissioning starting with general practice services. NHS England also currently commission some of the more specialised mental health services such as in-patient eating disorder services, high, medium and low-secure mental health units, gender dysphoria services and perinatal mental health. Health and social care commissioners will continue to work in close partnership with the NHS England Area Teams through the regional and sub-regional networks.

In considering the scope of this strategy it is important to acknowledge the above plans as well as other strategic plans that cover services and support subject to alternative commissioning arrangements but which are important areas of mental health and wellbeing work., e.g. Children & Younger People, Dementia, Carer's, Substance Misuse, Autism, and Learning Disability. The Joint Vision and Strategic Direction for Adult Mental Health will have

strong links into these strategic plans. This will require close partnership working between services, departments and agencies in the development of annual action plans to ensure an integrated approach.

Fig 3: Strategic areas of need	
The **mental health needs of children and younger adults** – one in ten children aged between five and 16 has a mental health problem, and many continue to have mental health problems into adulthood.	The Children & Younger Adults department (CAYA) are working closely with CCG's, Public Health and other strategic partners to develop an integrated behaviour pathway aimed at prevention and early intervention. The draft 'Improving Children and Young People's Emotional Wellbeing Strategy in Derbyshire and Derby City 2015-19' has been completed and is awaiting ratification by the Health & Wellbeing Board. There are shared themes across adults and children's strategies.
Specialist in-patient and community health and social care services for **people with dementia**.	The needs of this population are addressed in the Derbyshire Dementia Joint Commissioning Strategy which has also recently undergone a refresh. The document can be found here Derbyshire Dementia Strategy 2014
Forensic services and mental health services for people in prison **and Offender Healthcare**	Responsibility for national and regional commissioning of these services transferred to NHS England from April 2013; however, it is important to make strong transition links into the local whole systems mental health pathway. The Care Act 2014 brought new responsibilities to Local Authorities to meet the social care needs of prisoners from 1 April 2015.
Substance Misuse / Dual Diagnosis services	Within the Safer Derbyshire Partnership, the Substance Misuse Commissioning Team and Community Safety Unit aim to reduce the harm caused by both drug and alcohol use. They are represented on the Mental Health Joint Commissioning Board and will contribute to the Mental Health Strategy Action Plan.
Carers of people with mental health needs including young carers, many of whom care for parents with mental ill health.	The needs of carers are addressed in the Derbyshire Carer's Joint Commissioning Strategy, however the importance of involvement for carers of people with mental ill health is acknowledged within the mental health strategy. The Carer's Strategy is due to be refreshed.
Derbyshire Suicide Prevention Steering Group	There is a multi-agency countywide Strategic Suicide Prevention Steering Group and a Derbyshire Suicide Prevention Strategic Framework for 2015-17 is currently being developed
Services and support for **people in mental health crisis**	The Mental Health Crisis Care Concordat Action Plan has been developed by Hardwick CCG, Derbyshire County Council, Derby City Council, Derbyshire Constabulary, East Midlands Ambulance Service, Derbyshire Healthcare Foundation Trust, and Derbyshire Community Health Services NHS Foundation Trust. The Derbyshire and Derby Crisis Plan which can be found here
Perinatal services	NHS England hold the responsibility for commissioning perinatal services but local commissioners will link in to the regional and sub-regional networks to ensure close partnership working
Health and Wellbeing Promotion and Prevention	Public Health are represented on the Mental Health Joint Commissioning Board and are currently developing a Mental Health Promotion and Prevention framework which will have clear links to the mental health strategy action plan
Services and support for **people with Autism**	A local Derbyshire partnership response to the Autism Act and the national strategy "Fulfilling and Rewarding Lives" is currently in development overseen by the Joint Derbyshire and Derby City Commissioning Board for Autism.
Services and support for **people with a Learning Disability**	The current Joint Commissioning Strategy is due to be refreshed and will take account of the Transforming Care Programme in response to the Winterbourne Action Plan.
Vulnerable people at risk of repeat anti-social behaviour, domestic and/or sexual violence	The Safer Derbyshire Partnership have a joint community safety agreement and a number of priority areas including domestic and sexual violence and safeguarding adults and children

6. Priority areas for mental health in Derbyshire

6.1 National – No Health without Mental Health

In February 2011, the Government launched "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 services with the aim of improving health and wellbeing outcomes for people with mental health problems. Derbyshire is committed, to implementing the principles of the national mental health strategy, No health without Mental Health, which aims to promote positive mental health and emphasises that mental health is everyone's business

Fig 4: No Health without Mental Health priorities					
More people will have good mental health	**More people with mental ill health will recover**	**More people with mental health problems will have good physical health**	**More people will have a positive experience of care and support**	**Fewer people will suffer avoidable harm**	**Fewer people will experience stigma and discrimination**
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 who develop mental health problems will have a good quality of life – 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 stable place to live	Fewer people with mental problems will die prematurely More people with physical ill health will have better mental health	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 own lives, in the least restrictive environment, and should ensure that people's human rights are protected.	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	Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

Fig 3: No Health without Mental Health

6.2 National and Local – Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Concordat. It focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

Following a local Mental Health Summit in June 2014, the Derbyshire and Derby City Crisis Care Concordat Declaration was signed and published nationally. It can be found here. The Derbyshire and Derby City Crisis Care Concordat Action Plan was developed and agreed by the Derbyshire multi-agency Crisis Care Concordat Steering Group. A copy of the Derbyshire and Derby City Action Plan can be found here.

6.2 Local - Derbyshire Health & Wellbeing Strategy

The vision for Derbyshire is to reduce health inequalities and improve health and wellbeing across all stages of life by working in partnership with communities. The overarching aims of the strategy are to reduce health inequalities, strengthen investment in prevention and deliver high quality care. The final agreed priorities for mental health for 2012-15 were as follows:

- **To improve emotional and mental health and provide increased access to mental health promotion, recovery and support services.**
- **To improve access to evidence-based primary care psychological therapies and other local services that support recovery from mental health problems.**

Underpinning actions for adult mental health
Promote mental health awareness raising/training across all partners in order to promote access to services and reduce stigma and discrimination. This training should reflect the particular needs of specific groups such as people with learning disabilities, speech, language and communications needs, people with dementia, BME groups and lesbian, gay, bisexual, and transgender (LGBT) groups
Ensure access to a wide range of evidence-based psychological therapy services in Derbyshire based on population need
Increase the range of opportunities for people with mental health problems to access support services and community facilities aimed at promoting recovery (such as education, financial/debt management support and advice, housing, befriending, leisure services, arts and cultural activities, library services, health promotion)
Ensure mental health services combine access to employment support to help people remain in or return to work if unemployed
Develop mechanisms to improve integration between children's and adult mental health services ('Think Family' approach)

The Health and Wellbeing Strategy has been refreshed for 2015-17 and four new priorities have been agreed by the Health & Wellbeing Board. These are

- Create healthy communities with reduced health inequalities
- Develop sustainable multi-agency approaches to keep people healthy and living independently in their own home
- Developing a collective approach to social capital
- A focus on children's mental health and emotional wellbeing (focus on self-harm and suicide prevention)

More detail on the updated priorities can be found at the following link

Health & Wellbeing Strategy refresh 2015-17

A large amount of feedback in relation to mental health was gathered during the consultation process for the development of the Health and Wellbeing Strategy and has been taken into consideration in development of the Vision and six strategic themes for the mental health strategy. The Derbyshire Health & Wellbeing Strategy 2012-2015, feedback from the consultation process and the Equality Impact Analysis can all be found on the Derbyshire Partnership website at the following link http://www.derbyshirepartnership.gov.uk/thematic_partnerships/health_wellbeing/strategy/

6.3 Local - Better Care Fund

The Better Care Fund includes existing NHS and social care funding, which will be jointly invested to achieve integration between health and social care and to achieve the best outcomes for people. In Derbyshire there is a move away from current isolated patterns of provision of care and by 2019 we want to place the local person at the centre of our actions, and so have adopted the definition of integration produced by National Voices:

"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me".

The Better Care Fund vision focusses on achieving a seamless health and social care system through a transformation programme 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 shown at Fig 5 (taken from Better Care Fund document) illustrates the direction of travel for the health and social care community in Derbyshire.

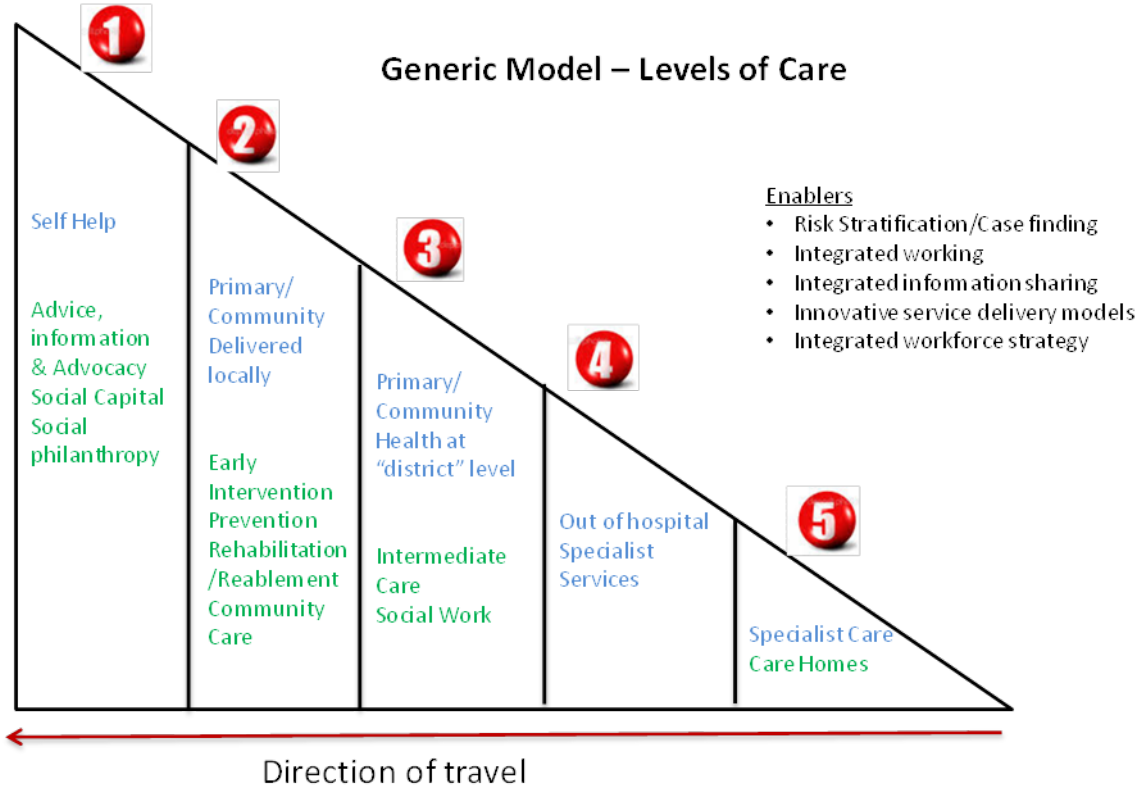


Fig. 5: Direction of Travel for Derbyshire health and social care community

The Better Care Fund Schemes are part of an overarching system transformation. The Health and Wellbeing Board agreed seven overarching system objectives to deliver integrated services that:

1. Build strong asset based communities
2. Support people to remain independent and in control of their lives
3. Provide support in the community when needed
4. Reduce the need for hospitalisation or admission to long term care
5. Improve outcomes and the quality of services provided
6. Reduce inequalities
7. Develop the necessary infrastructure to achieve objectives

These seven objectives, coupled to the five year CCG strategic plans (Units of Planning), have driven the development of the BCF projects. These projects have then been grouped into five broader themes:

1. Proactive intervention, self-help prevention and community resilience
2. Integration, integrated community based support
3. Reducing delayed discharges and admissions to hospitals and care homes, specific components of care
4. Delivering the Care Act
5. System enablers

Key initiatives for mental health include:

- Develop community crisis response mechanisms to prevent escalation and avoidable hospital admissions.
- Develop parity of esteem across the whole system pathway.

- Increase AMHP capacity to support preventative and enablement interventions.
- Introduce an enablement service by changing the focus of current Community Support. Workers using extra training and support

A copy of the Better Care Fund planning document can be found **here**

6.4 Local - Clinical Commissioning Group Priorities 2014/19

6.4.1 North Unit of Planning

North Derbyshire CCG and Hardwick CCG have joined together to develop the North Unit of Planning setting out the vision, direction of travel and actions for the future of healthcare across North Derbyshire. This has been developed in partnership with

- Derbyshire County Council -
  - Health and Wellbeing Board
  - Adult Care
  - Public Health
- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Trust
- Derbyshire Healthcare NHS Foundation Trust
- Derbyshire Health United (Out of Hours and 111 services)
- East Midlands Ambulance Service NHS Trust
- North Derbyshire Voluntary Action

The underlying principles for Mental Health care over the next five years are to ensure parity of esteem between physical and mental health and to deliver care as close to home as possible.

Key initiatives include:

- Increase capabilities of primary care
- Intermediate / crisis response service development
- Psychiatric Liaison Service (RAID)
- Integrated pathways for mental health and learning disability

A copy of the North Unit of Planning can be accessed **here**

6.4.2 South Unit of Planning

Southern Derbyshire CCG and Erewash CCG have joined together to develop the South Unit of Planning setting out a similar vision, direction of travel and actions for the future of healthcare across Southern Derbyshire and Derby City. Again, this has been developed in partnership with

- Derbyshire County Council
- Derby City Council
- Derby Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Trust
- Derbyshire Healthcare NHS Foundation Trust
- Derbyshire Health United (Out of Hours and 111 services)
- East Midlands Ambulance Service NHS Trust

Ambitions for mental health are

- Physical and mental health needs met in a coordinated way
- Integration of community teams including mental health
- Mental health Liaison and Diversion programme

A copy of the South Unit of Planning can be accessed **here**

7. The Vision

The vision states the overall aim and strategic direction of the Derbyshire County Mental Health Joint Commissioning Board for the next five years. The vision for mental health is aligned with the Derbyshire Better Care Fund vision and the North and South Units of Planning.

"Whole communities will recognise and act upon factors that contribute to mental ill health such as poverty, abuse, work stress and lack of timely access to good support. Where support is required, people will achieve positive mental health by having access to high quality, local, person-centred, mental health services appropriate to levels of need as well as a range of support that enables self-management, recovery and wellbeing"

The objectives underpinning the vision are outlined under the following six high level themes (see 8) and are built upon the following commissioning principles.

7.1 Whole Systems commissioning

Real choice will only be enabled if there is a whole system approach to commissioning 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 is a need to focus on developing integrated mental health pathways, rather than just 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 individual and 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 prevention and 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

7.2 Evidence-based commissioning

Commissioning decisions will need to take into account needs and assets at a local level through evidence from the Joint Strategic Needs Assessment (available June 2015). There is a rapidly increasing evidence base and development of research and best practice within mental health, including NICE guidelines and pathways as well as increasing opportunities for shared learning from funded pilots across the country for interventions that can promote mental wellbeing at and individual, community and population level.

7.3 Commissioning for quality, effectiveness, value and outcomes

The context and demands on health and social care commissioning are changing rapidly, with increasing pressure on health and social care budgets, changes to commissioning structures and the emergence of new policy and legislation. It is crucial to make the best use of diminishing resources and use creative approaches to commission the most effective and efficient, high quality services and support to respond to these rapid changes at a local level.

Commissioning for quality and maximum social value is concerned with making sure that scarce resources are allocated in ways that deliver measurable outcomes, promote wellbeing and make a positive difference to people and communities as well as minimising any significant negative impacts of newly commissioned services. This all needs to be located in a context of balanced and sustainable investment.

In times of austerity, there is an increasing need to develop and maximise awareness of universally available services as well as increasing individual, social and community capital.

As well as working towards the national outcomes frameworks it is important to work in partnership with service receivers and carers as well as voluntary sector providers to develop a local outcomes framework that is meaningful at an individual, community and a strategic level. This framework will recognise the diverse values of all involved, whether as commissioners, providers or service receivers. This process will also help to refocus voluntary sector services and support to deliver relevant parts of the developing integrated care pathways.

7.4 Stakeholder involvement and partnership working

We are committed to involving service receivers and carers throughout our organisations' activities and ensuring that this engagement makes a real difference. A review of current engagement processes for mental health is currently underway and this project will result in a sustainable model of engagement that is fully inclusive and can provide a wide range of opportunities for service receiver and carer involvement in the commissioning process and to influence service delivery.

8. The six strategic themes

The following 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 relate to the five year time period of the strategy and will meet at least one of the six themes.

Annual action plans

Action plans will be agreed annually throughout the five year life of the strategy. Relevant actions from the North and South Units of Planning, Better Care Fund and Public Health plans will also be incorporated. Each action plan, work-stream or service development will have its own set of outcomes relative to the specific piece of work and metrics and outcome measures will be agreed as each work-stream develops to enable us to evidence successful implementation of the commissioning intentions of the strategy. Many actions and work streams will have their own governance arrangements; however progress and delivery of outcomes will be monitored by the Joint Mental Health Commissioning Board.

The Action Plan for 2014-16 can be found at Appendix 2. This is not the final version as there are still some actions to be incorporated into the action plan following further discussions with partners.

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 • Increase access to welfare rights advice and support through strong links to Derbyshire anti-poverty strategy • Improve support and involvement for carers (including young 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

Theme 2- Promotion, prevention and early intervention

Promotion, prevention and early intervention

"I have the opportunity to maintain positive wellbeing, however, 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 the promotion of positive mental wellbeing (mental health promotion), as well as prevention of mental illness and early intervention.

Individual resilience and the ability to manage adversity contribute to maintaining positive mental wellbeing. Social capital, strong communities, support networks and stable life situations, act to enable resilience and contribute to the prevention of mental ill health. Therefore it is important to address the wider determinants of health that that contribute to mental ill health such as poverty, abuse, work stress and lack of timely access to good support.

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 fundamental to recovery. This includes strengthening the role of primary care in improving mental health outcomes; improving access to psychological therapies as well as regular health checks and recovery-focussed healthy lifestyle care planning (smoking cessation, weight management, tackling malnutrition, and drug and alcohol misuse). Integrating physical health into decisions about prescribing and monitoring of medication is also important.

Commissioning intentions:

- Develop a framework for mental health promotion, prevention and early intervention
- 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
- Work towards an all age mental health strategy

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 • Increase the range of opportunities for people with mental health problems to access support services and community facilities aimed at promoting recovery (such as education, financial/debt management support and advice, housing, befriending, leisure services, arts and cultural activities, library services, health promotion) • Support for community-based self help • Good quality, accessible information and advice • Ensure mental health services combine access to employment support to help people remain in or return to work if unemployed • Implement the Healthy Workplaces scheme with local employers • Development of peer support opportunities • Maximise individual and community assets • Recovery-focussed integrated care pathways • Improve access to regular physical health checks for people with severe mental illness

*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.

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 • Support people with mental ill health to maintain or find employment through a multi-agency approach • Develop opportunities for work experience • Review services and support for people with a dual diagnosis

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 community 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 and implement Derbyshire Crisis Care Plan • Support for individuals to develop person-centred safety and recovery plans • Liaison and diversion schemes –police, hospitals, prisons, probation including street triage • 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 • Review Urgent care pathway • Review Perinatal services

Theme 6-Integration

Integration ***" I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me"***
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 services and support • 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

Appendix 1 **Jargon Buster**

Asset based approach	A way of helping people by looking at what they have, rather than what they lack. This approach helps people make use of their existing skills, knowledge and relationships. It is also called a 'strengths-based approach', and can be used as a way of improving local areas, by promoting what is good about an area rather than focusing on problems. See also 'co-production'
Better Care Fund	Money that has been given by the Government to local areas to make the NHS and local councils in England work together better. The aim is to improve your experience by moving care out of hospital and into your home and sharing information so that everyone involved in your care understands your needs.
Care pathway	A plan for the care of someone who has a particular health condition and will move between services. It sets out in a single document what is expected to happen when, and who is responsible. It is based on evidence about what works best to treat and manage your particular condition.
Commissioner	A person or organisation that plans the services that are needed by the people who live in the area the organisation covers, and ensures that services are available. Sometimes the commissioner will pay for services, but not always. Your local council is the commissioner for adult social care. NHS care is commissioned separately by local clinical commissioning groups. In many areas health and social care commissioners' work together to make sure that the right services are in place for the local population.
Commissioning Authority	An organisation, such as a local council or NHS clinical commissioning group (CCG), that plans the services that are needed by the people who live in a particular area
Continuity of Care	There are two meanings to the phrase 'continuity of care': seeing the same doctor or other care professional every time you have an appointment, or having your care well-coordinated by a number of different professionals who communicate well with each other and with you. It is particularly important if you have a long-term condition or complex needs.
Crisis intervention	A way of helping people cope at a time of crisis when they are overwhelmed, and enabling them to remain in their home. It is used with people who have mental health problems, and with families who are facing challenges.
Dual diagnosis	A combination of severe illness and problematic drug or alcohol use. These two things are closely linked for many people. People with a dual diagnosis often have serious physical, social and psychological problems.
Early intervention	Action that is taken at an early stage to prevent problems worsening at a later stage. It may apply to children and young people, or to help that is offered to older people or people with disabilities to enable them to stay well and remain independent. See also preventive services.
Enablement	A way of helping you to become more independent by gaining the ability to move around and do everyday tasks for yourself. You may be offered enablement services if you have lost some daily living skills because of poor health, disability or a hospital stay. It usually lasts for around six weeks, takes place in your own home, and you won't have to pay.
Evidence based practice	When doctors or other care professionals use the best available evidence about what works most effectively, including evidence from people who have lived with a particular health condition, when deciding what treatment, care or support to offer you as an individual.
Health & Wellbeing Board	Every council area in England has a Health and Wellbeing Board to bring together local GPs, councillors and managers from the NHS and the council. Their job is to plan how to improve people's health and make health and social care services better in their area. Members of the public have the chance to be involved in the work of their local Health and Wellbeing Board through your local Healthwatch.
Integrated care	Joined up, coordinated health and social care that is planned and organised around the needs and preferences of the individual, their carer and family. This also involves integration with other services, eg., housing.
Joint Commissioning	When two or more organisations in a local area - usually the NHS and local council - work together to plan services to meet the needs of people who live in the area. Together the commissioners plan what kind of services should be available, who should provide them and how they should be paid for.

JSNA – Joint Strategic Needs Assessment	The process of identifying the future health, care and wellbeing needs of the population in a particular area, and planning services to help meet those needs. This process is led by your council, working with the NHS and private and voluntary organisations in your area.
Local Area coordination	An approach that is being used by some councils to help people live better, less isolated lives in their home area. Local area coordinators help people make the most of what is available locally, and make sure that communities are supportive and welcoming to older people and people with disabilities, mental health problems or other needs.
Local Area Teams	Teams in each council area that are responsible for buying services for local people from GPs, dentists and pharmacists.
NICE – National Institute for Health & Care Excellence	An organisation that provides advice and guidance to improve health and social care services in England and Wales. It looks at all the evidence on what works and what doesn't and how much it costs, and advises on what treatment and care should be offered to people. It doesn't have the power to insist that its guidance is followed in local areas.
Outcomes	In social care, an 'outcome' refers to an aim or objective you would like to achieve or need to happen - for example, continuing to live in your own home, or being able to go out and about. You should be able to say which outcomes are the most important to you, and receive support to achieve them.
Peer Support	The practical and emotional help and support that people who have personal experience of a particular health condition or disability can give each other, based on their shared experience. People support each other as equals, one-to-one or in groups, either face-to-face, online or on the telephone.
Personal budget	Money that is allocated to you by your local council to pay for care or support to meet your assessed needs. The money comes solely from adult social care. You can take your personal budget as a direct payment, or choose to leave the council to arrange services (sometimes known as a managed budget) - or a combination of the two. An alternative is an individual service fund, which is a personal budget that a care provider manages on your behalf. A personal health budget may also be available: it is a plan for your health care that you develop and control, knowing how much NHS money is available.
Personal health budget	An amount of money to pay for your specific health needs, given to you - or managed for you - by the NHS. It is based on your own individual care plan, which sets out your health goals and how your budget will help you reach them. You can spend it on things like therapies, personal care and equipment. You cannot use it to pay for emergency care or care you usually get from a family doctor. Using a personal health budget is a choice: you do not have to have one unless you want to. See also personal budget.
Personalisation	A way of thinking about care and support services that puts you at the centre of the process of working out what your needs are, choosing what support you need and having control over your life. It is about you as an individual, not about groups of people whose needs are assumed to be similar, or about the needs of organisations.
Person centred care	An approach that puts the person receiving care and support at the centre of the way care is planned and delivered. It is based around you and your own needs, preferences and priorities. It treats you as an equal partner, and puts into practice the principle of 'no decision about me without me'.
Preventive services	Services you may receive to prevent more serious problems developing. These services include things like enablement, telecare and befriending schemes. The aim is to help you stay independent and maintain your quality of life, as well as to save money in the long term and avoid admissions to hospital or residential care. Also known as 'Prevention'
Primary care	The first point of contact in the health service, usually your GP, practice nurse, local pharmacist, dentist or NHS walk-in centre. Primary care doctors deal with a wide range of health problems. They treat common illnesses, help you manage long-term conditions and refer you to a specialist doctor when necessary.
Public Health	Helping people stay healthy and preventing illness. Public health is about the health of the population as a group, rather than about individuals. People's health is affected by the individual decisions they make, and by decisions that are made by local councils and national governments.

Safeguarding	The process of ensuring that adults at risk are not being abused, neglected or exploited, and ensuring that people who are deemed 'unsuitable' do not work with them. If you believe that you or someone you know is being abused, you should let the adult social care department at your local council know. They should carry out an investigation and put a protection plan in place if abuse is happening. Councils have a duty to work with other organisations to protect adults from abuse and neglect. They do this through local safeguarding boards.
Secondary care	Care that you receive in hospital, either as an inpatient or an outpatient. This may be planned or emergency care. It is more specialist than primary care.
Self-directed support	An approach to social care that puts you at the centre of the support planning process, so that you can make choices about the services you receive. It should help you feel in control of your care, so that it meets your needs as an individual. See also: Personalisation
Social capital	The connections that are made between people who live in the same area or are part of the same community, and who are able to do things with and for each other. Strong neighbourhoods, clubs and groups help create a sense of community, enabling people to trust each other, work together and look out for each other.
Statutory organisations	Organisations that have a legal responsibility to do something, and whose role and powers are defined by law. They are different to voluntary organisations, which may provide some of the same services but which are not set up by law. Your local council is an example of a statutory organisation, as are the NHS trusts in your area. Local charities, care agencies and care homes are not statutory organisations
Transition	The process by which young people with health or social care needs move from children's services to adult services. It should be carefully planned, so that there are no gaps in the care young people receive. Young people and their families should be fully involved in the planning process.
Universal information and advice	Information and advice that is available to everyone in your local area. This should cover what care and support services are available in the area, how you can get these services, where you can find financial advice about care and support, and what to do if you are concerned about the safety and wellbeing of someone who has care and support needs. Councils are required by law to make information and advice available to everyone, regardless of who pays for the care and support you need.
Universal services	Services such as transport, leisure, health and education that should be available to everyone in a local area and are not dependent on assessment or eligibility.
User involvement	The involvement of people, who use services in the way that those services are designed, delivered and run. It may be an opportunity to use your experiences to make a particular service work better, and to be involved in decisions about things that affect you. User involvement takes different forms in different organisations, from voicing your opinion to getting actively involved in the way a service is run.
Wellbeing	Being in a position where you have good physical and mental health, control over your day-to-day life, good relationships, enough money, and the opportunity to take part in the activities that interest you.

Adapted from TLAP Care and Support Jargon Buster

DERBYSHIRE COUNTY MENTAL HEALTH STRATEGY ACTION PLAN 2014-16 (some items will carry over into 2016/17 Action Plan)

The action plan below has been developed to capture the key actions against the MH strategic direction over the period 2014-16 . The action plans have been grouped under key headings /work areas and are aligned to at least one of the 6 strategic themes. As the action plans have already been agreed as part of the CCG and LA commissioning priorities in 2014.15 these will be evaluated against the 6 strategic themes. The vision for the strategy is that the Derbyshire County Mental Health Joint Commissioning Board will review the actions and outcomes against the strategy annually but will also have the remit of identifying and proposing actions against strategic themes where there are gaps or where it is felt that the strategic direction is not being met. Action Plans for 2014-16 fall into 6 key headings although there will inevitable be cross over between them. These are; Urgent care; Primary care/Community; Prevention/Health promotion; Service Pathways; Parity of Esteem; Involvement

Urgent Care

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Keeping people safe from avoidable harm; Integration	Develop and publish Derbyshire multi-agency Declaration and Crisis Plan in response to the Crisis Care Concordat	Hardwick CCG (on behalf of all Derbyshire CCG's); Derbyshire County Council; Derby City Council; Derbyshire Police; DHcFT; DCHS; Probation; EMAS;	See Crisis Care Plan - individual outcomes related to each action. Reduced use of section 136 suite Street Triage extended Probation Pathway 111 phone line RAID	See Crisis Care Plan - individual outcomes related to each action	MH JCB / Health & Wellbeing Board	1.Finalise and publish Declaration to national CCC website	15 December 2014	☺	Dave Gardner / Sue Whetton
						2.Finalise DRAFT multi-agency Crisis Plan	02 December 2014	☺	
						3.Review DRAFT with Service Receiver representatives	4th-10th December 2014	☺	
						4.Publish DRAFT Crisis Plan to national CCC website	15 December 2014	☺	
						5.Review DRAFT plan and take FINAL version to H&WB Board for sign off	31st March 2015		
Prevention and Early Intervention; Enablement and Recovery; Keeping people safe from avoidable harm	Urgent Care Pathway Redesign	Derbyshire CCGs; DHcFT;	Fewer patients needing acute in-patient care and fewer patients placed out of area Improved Urgent Care Pathway including alternatives to in-patient care	Reduced need for in-patient care. More choice /alternatives, e.g. crisis beds, step down beds and opportunities for patients to remain in their home	CMDG; Mental Health JCB	Initial Steering Group meeting	11-Jun-15	☺	Dave Gardner
Promotion, Prevention and Early Intervention; Integration	Implement 24/7 RAID service at Chesterfield Royal Hospital	Hardwick CCG; NDCCG;	Improved liaison and diversion service at point of need	Patients will be triaged to the most appropriate service more quickly. Reduced number of unplanned admissions to acute care beds	Hardwick CCG; NDCCG	Establish RAID service within Chesterfield Royal Hospital	April 1st 2014	☺	Dave Gardner
						Increase provision to 24/7 availability	From January 15	☺	
						Activity/performance review	August 2015		

Primary Care / Community Care

Promotion, Prevention and Early Intervention; Social Inclusion, Fair Access and Equity; Enablement and Recovery	Reprocure IAPT countywide service	Hardwick CCG - Lead (on behalf of all Derbyshire CCG's)	Re-procurement of AQP contracts in line with end date of current contract. Continued choice of providers	Opportunity to open up the tender process to other providers, giving greater choice to patients.	Hardwick, Erewash, North Derbyshire & Southern Derbyshire CCGs.	Options appraisal to CCG Gov Bodies	January 2015	☺	racy McGonagle / Stacy Woodward
						Engage with providers/go out to mrkt	Jun-15	😐	
						Commence tender process TBC	TBC		
						Evaluate tenders	TBC		
						Award contracts	TBC		

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
						New service start date	Apr-16		

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Promotion, Prevention and Early Intervention; Social Inclusion, Fair Access and Equity; Enablement and Recovery	Day Opportunities / Social Inclusion Review	Derbyshire County Council Adult Care; Hardwick CCG (on behalf of all Derbyshire CCG's)	Equitable access across the County to personalised support to promote recovery from mental illness and to enable access to education, volunteering and employment opportunities	More people will recover from a period of mental ill health and be more connected to their local community; More people with mental ill health will be supported to achieve meaningful occupation in their lives	Hardwick, Erewash, North Derbyshire & Southern Derbyshire CCGs.	Scoping process	Jun-15	☺	Sue Whetton / Kate Burley
						Stakeholder Engagement	Jul-Aug 15		
Promotion, Prevention and Early Intervention; Social Inclusion, Fair Access and Equity; Enablement and Recovery	Self-help review	Derbyshire County Council Adult Care; Hardwick CCG; NDCCG; NDVA	Access to self-help groups and networks will improve across the North of the County	More people will be supported to establish, develop and maintain local self-help groups; more people will have access to a range of peer support in their local community to help them manage their mental health condition	Hardwick, Erewash, North Derbyshire & Southern Derbyshire CCGs.	Scoping process	May-15	☺	Sue Whetton / Kate Burley / Roger Kerry
						Stakeholder Event - Self-help showcase	Jun-15		
Promotion, Prevention and Early Intervention; Personalisation; Enablement and Recovery; Social Inclusion, fair access and equity	Erewash Community Services Review / MHS Innovation Fund Project	SDVSMHF; MHAG; Erewash CVS; Hardwick CCG; Erewash CCG; Derbyshire County Council - Adult Care; DHcFT	Improved access to self-help and community support for people with mental ill health in Erewash	Links to outcomes monitoring work currently being developed with Vol Sector. People report improved access into Vol sector and PH programmes	Hardwick and Erewash CCG's; Derbyshire County Council AC	Carry out scoping and mapping exercise		☺	Dave Gardner / Kate Burley / Ellie Wharton
						Hold engagement event in Long Eaton		☺	
						Hold Project Initiation meeting and establish project board	Jan-15	☺	
						Establish Co-ordination Group and Patient Reference Group	May-15		
						New posts for vSPA and Erewash Voluntary Action in post	May-15		
						Implementation of MHFA training, increased vSPA capacity, buddy system, role of Development worker	Ongoing		
						Evaluate Project	May-17		

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Integration; Personalisation; Social Inclusion, fair access and equity	Voluntary Sector Outcomes Monitoring Project	Hardwick CCG; Derbyshire County Council; SDVSMHF	Improved monitoring of outcomes in alignment with the Strategic Themes; less onerous data submission to funders for providers; Providers can demonstrate the contribution they are making to improving mental health across the health and social care sector; Commissioners can compare data from different voluntary sector organisations to demonstrate how strategic themes are being met and identify any unmet need across localities	Data submission and monitoring will be improved and be more intelligible to inform the commissioning and budget setting process	Hardwick CCG	Phase 1 - scoping and consultation	Jan - March 2014	☺	Kate Burley / Angela Kerry
						Phase 2 - Stakeholder Engagement	Mar-14	☺	
						Phase 3 - Analysis and Recommendations report	April - September 2014	☺	
						Phase 4 - Partner engagement	October - December 2014	☺	
						Agree Pilot with 4 organisations	Apr-15	☺	
						Quarterly reviews with organisations in pilot	July 2015, Oct 2015, Jan 2016, Apr 2016		
						Review of pilot and recommendations	May-16		
						Phase 5 - Proposals for implementation			
Promotion, Prevention and Early Intervention; Personalisation; Enablement and Recovery; Social Inclusion, fair access and equity	Bolsover Local Area Co-ordination Project	Derbyshire County Council - Adult Care/Public Health; Hardwick CCG; Bolsover DC; Bolsover LPG	Support people to find/develop non service solutions to problems (build resilience) Build supportive informal relationships (reduce isolation, increase contribution to community) Improve health outcomes and address health inequalities Build more welcoming, inclusive communities; Contribute to systems and cultural change	Evidence of people being diverted from more expensive, formal, services; Positive feedback from individuals, families and communities; Positive contribution to health improvement targets Awareness raised within communities about people with disabilities, mental ill health, and older people; Greater contribution from people with disabilities, mental ill health and older people in local communities Evidence of partnership working leading to joint outcomes and co-funding; Development of a community of practice driving strength based approaches; Local Area Coordination as the new front	Hardwick CCG; Derbyshire County Council Adult Care	Engage and contribute to the National Local Area Coordination Network	Jan-15	☺	Dave Gardner / Roger Kerry
						Program design and development ; Community engagement	Jan-Sept 2015; Jun/Jul 15	☺	
						Set up local Leadership/Operational Groups to drive system change	Jul-15		
						Community led recruitment; Agreed joint outcomes, performance monitoring schedules; Interim outcomes report	Sep-15		
						Local Area Coordination induction	Oct/Nov 2015		

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
				Area Coordination as the new front end of system delivery (focus on prevention and capacity building)		14 month formative evaluation; 2 year evaluation	Jan 2017; Nov 2017		

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Prevention / Health Promotion									
Promotion, Prevention and Early Intervention; Social Inclusion, Fair Access & Equity	Carry out IAPT Equity Audit	Derbyshire County Council Public Health	Improved commissioning intelligence to identify any gaps in current service provision for particular client groups or localities and to inform service specification for reprocurement exercise	Improved equity of access and equity of recovery demonstrated by the IAPT Dashboard	Public Health / Hardwick CCG	1. Present draft version to IAPT Steering Group	7th November 2014	☺	
						2. Circulate final version	January 2nd 2015	☺	
						3. Reflect findings in IAPT service specification and tariff methodology	January - May 2015	😐	
						4. Monitor increased access /recovery for identified groups	from 01/04/2016		
Promotion, Prevention and Early Intervention	Develop and implement a Mental Health Promotion and Prevention Framework	Derbyshire County Council Public Health	Identifying the evidence-based approaches and key population groups to target in the promotion of mental health and prevention of mental illness	Organisations amend current service provision in line with recommendations from framework	Public Health	Develop initial framework	Mar-15	☺	
						Engage partners with implementation of framework	Jul-15		
Promotion, Prevention and Early Intervention; Integration	Update JSNA for Mental Health	Derbyshire County Council Public Health	Improved commissioning intelligence for mental health across the County	Commissioning decisions in mental health are based on population needs	Public Health / Health & Wellbeing Board	Agree priorities and work programme	Mar-15	☺	
						Present initial State of Mental health in Derbyshire report	Jun-15	😐	
						Present information at State of Mental Health Event	Sep-15		
						Present information to Health and Wellbeing Board	Dec-15		
Promotion, Prevention and Early Intervention	Refresh Suicide Prevention Strategy	Derbyshire County Council/Derby City Council Public Health	Provide strategic co-ordination to reduce the number of suicides in Derbyshire	Outcome measures will be developed as part of the strategic framework	MH Joint Commissioning Board	Hold partnership event to explore current issues to inform refreshed strategy		☺	ttle / James Creaghan
						Establish Suicide Prevention group	Apr-15	☺	
						Develop co-produced plan with stakeholders	Jun-15		
						Hold partnership event to determine progress	Oct-15		
						Present progress to Health and Wellbeing board	Dec-15		

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Promotion, Prevention and Early Intervention	Suicide Awareness Training	Derbyshire County Council Public Health	Raised awareness of suicide and reductions in stigma and discrimination both in the workplace and in the community	Improved knowledge of mental health and suicide in public facing staff	MH Joint Commissioning Board	Approval process	Mar-15	☺	Iain Li
						Develop specification	Jun-15	☺	
						Procurement process	July/Aug 15		
						Training delivery to staff in various organisations	Sep -15-Jul 17		
Promotion, Prevention and Early Intervention	Mental Health Awareness Training	Derbyshire County Council Public Health / All CCG's	Raised staff awareness of mental health, reductions in stigma and discrimination and additional points of engagement/support for people with mental health issues	Improved knowledge of mental health in public facing staff	Derbyshire County Council Public Health	Approval process	Dec-14	☺	
						Develop specification	Feb-15	☺	
						Procure provider	April-May 2015		
						Training delivery to staff in various organisations	Jul 15-Jul 17		
Promotion, Prevention and Early Intervention, Integration	Social Prescribing Programme	Derbyshire County Council Public Health	Access to community interventions for people with low level mental health issues	People are supported to resolve low level mental health issues and wider determinants at sub-clinical level	Derbyshire County Council Public Health	Approval Process	Mar-15	☺	
						Develop specification and agree with vSPA providers	Apr-15	☺	
						Service delivery	May 2015 – April 2016		
						Evaluation	Jan-16		
Promotion, Prevention and Early Intervention;	Time to Change Campaign	All CCG's; Derbyshire County Council	Raised staff awareness of mental health and reductions in stigma and discrimination both in the workplace and in the community	See Individual Action Plans but some actions include: 1. appointing Senior Practitioners at Mental Health Champions across DCC Adult Care	All agencies	All partners to sign up to TTC Campaign and submit a Corporate Action Plan to the national website		☺	All
						Mental Health Awareness or Mental Health First Aid Lite training delivered to a cross section of staff across agencies		☺	

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Service Pathways									
Promotion, Prevention and Early Intervention; Social Inclusion, fair access and equity; Keep people safe from harm; Integration	Perinatal Services	Hardwick CCG / North Derbyshire CCG/ Family Action / DHcFT	Set up and implementation of Community Specialist Perinatal Services covering North Derbyshire and Hardwick CCG areas.	A Specialised Perinatal Community Psychiatric Team providing assessment, intensive support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services. Assisting with the detection and proactive management of women who are at risk of developing a serious perinatal post-natal mental illness.	Hardwick CCG / DHcFT / Family Action	Working group set up to develop service	May-13	☺	Stacy Woodward / Tara George / Kate Burley
						Pathways, networks agreed	Jan-14	☺	
						Specialist MH and Family Action Service commenced	Jul-14	☺	
						Evaluation of service	Summer 15		
Promotion, Prevention and Early Intervention; Personalisation; Enablement and Recovery; Social Inclusion, fair access and equity; Keeping people safe from harm; Integration	Dual Diagnosis Pathway	Hardwick CCG; Derbyshire County Council; DHcFT	Improved pathways for people with dual diagnosis	Patient experience reporting will form part of outocme measures. Primary care/GP feedback on accessibility of servcies for patients with a DD	Mental health JCB	Establish MHJCB Dual-diagnosis sub-group	Jul-15		Nik Howes / Tracy McGonagle
						Plan and hold a Dual Diagnosis Partnership event	Sep-15		
						Develop strategic themes and action plans linking into MH Strategy			
Promotion, Prevention and Early Intervention; Personalisation; Enablement and Recovery; Social Inclusion, fair access and equity; Keeping people safe from harm; Integration	18-25 Transition Pathway	Derbyshire County Council; CCG's, DHcFT., DCHSFT.,	Improved transition of young people from Children and Younger Adult's services to Adult's services	Reduction in the numbers of young people with mental health needs who do not successfully transfer to adult services and support	CAMHS Commissioning Group / Mental Health JCB	Sue Whetton to attend CAMHS Joint Commissioning Group	Nov-14	☺	Sue Whetton
						SW and MU to meet to scope out joint work programme	Jan/Feb -15	☹	

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Integration; Social Inclusion; Fair Access and Equity; Enablement and Recovery	Develop ASD Pathway	Hardwick CCG; Derbyshire County Council; Derby City Council; DHcFT	See Autism Strategy Action Plan	See Autism Strategy Action Plan	Autism Joint Commissioning Board	Develop service specification for delivery of autism assessment service	May-15		Dave Gardner / Tracey Sims / Stacy Woodward
						Develop Strategy for autism diagnosis	May-July 15		
						Gain agreement for BCF funded Project post to take an all age pathway approach	May-Jun 2015		
						Develop indicative allocation costs for BCF	30/06/2015		
						Work with County / City Councils to develop pathway for autism			
Promotion, Prevention & Early Intervention; Enablement and Recovery; Keep people safe from harm; Integration;	Enablement Offer from Adult Care	Derbyshire County Council - Adult Care	Time-limited (6 weeks) Enablement offer (no eligibility criteria) providing intensive short-term social work and practical interventions to enable client to self manage and overcome day to day practical issues impacting on mental health	More people will have the opportunity for earlier intervention to help them recover from or better manage their mental health	Derbyshire County Council	Phase 1 - scoping and TU consultation	Jan - Jun 2015	☺	Sue Whetton
						Phase 2 - SMT / Cabinet approval	Jun - Aug 2015		
						Phase 3 - UNISON and Staff engagement			
						Phase 4 - Implementation			
Parity of Esteem									
Promotion, Prevention and Early Intervention, Integration, fair access and equity, integration	Increased investment into MH services	4 Derbyshire CCGs	Safer staffing levels into community teams to improve access	Community teams will have manageable caseloads in line with NICE guidance. Improved patient access. Reducing waiting times	Hardwick CCG, DHcFT (through CMDG)	Agree additional investment for 2015/16	March 31st 2015	☺	Dave Gardner / Sohrab Panday
						DHcFT work with commissioners to draft proposals on how investment will be spent in 2015.16	By July 2015		
						Develop plans for 2016/17	By September 2015		

Strategic Theme/s	Action	Partnership / Agency	What will be achieved?	How will we know we have been successful?	Governance	Milestone	Milestone Date	RAG	Lead MHJCB member
Involvement									
Enablement and Recovery; Social Inclusion, Fair Access and Equity; Keep people safe from harm; Integration;	Provide hospital based non-statutory IMHA	Derbyshire County Council Adult Care / SDCCG	Provide access to specialist Independent Mental Health Advocacy for informal (Derbyshire) patients on all MH wards across Derbyshire	Equity of access to specialist advocacy for patients who are not formally detained under the MHA	DCC / Hardwick CCG	Agree SDCCG available funding split between City and County	Feb-Mar 2015	☺	Sue Whetton
						DCC SMT approval for interim additional funding for 15/16	Apr-15	☺	
						Agreement and sign off with Derbyshire MIND as interim provider for 15/16	April- May 2015	☺	
Enablement and Recovery; Social Inclusion, Fair Access and Equity; Keep people safe from harm; Integration;	Re-procure Mental Health Advocacy (IMHA / IMCA / DoLS Paid Representative / NHS ICA / Some Care Act IA)	Derbyshire County Council Adult Care	A single point of access to specialist statutory advocacy including MH specialist advocacy and Care Act Independent Advocacy for those who have already had involvement from an IMCA or IMHA (to ensure saemless provision and continuity)	A new service will be in place from 1 April 2016 for a minimum period of five years (with possibility to extend for a further 3 x 1 year periods). Close contractual and performance monitoring will ensure outcomes are delivered as required	Derbyshire County Council	1 year extension to current IMCA and IMHA contracts agreed	Mar-15	☺	Sue Whetton
						Finalise new service specification	May-15	☺	
						Procurement exercise Summer 2015	Jun - Jul 2015	☺	
						Cabinet approval process	Aug- Sep 2015		
						New contract awarded to start 1st April 2016	Oct-15		
Personalisation; Social Inclusion, fair access and equity	Review of mental health engagement processes and systems in Derbyshire	All CCG's (Hardwick CCG Lead); Derbyshire County Council; Derby City Council; DHcFT; DCHS	How we can work together with service receivers and carers	There will be improved opportunities for engagement and co-production available across the county and city for a wider range of people.	Hardwick CCG project (Funding by all agencies going forward)	Phase 1 Stakeholder Engagement - what works well / not so well in Derbyshire	April - June 2014	☺	Tracy McGonagle / Sue Whetton / Dave Gardner
						Phase 2 What works well elsewhere	July - August 2014	☺	
			How real time reporting of patient experience is captured and enacted upon			Phase 3 - development of financially viable options	August - September 2014	☺	
			How to implement service user monitoring in provider organisations and how service receivers can be involved in			Report and recommendations	Sep-14	☺	
			How service receiver and carer input in mental health commissioning decisions is facilitated			Partner Engagement	October 2014 - January 2015	☺	
						Board Recommendations for implementation	March/ April 2015	☺	
						Develop Service Specification	April - July 2015	☺	
						Governance process for agreement of model / funding	Jun-15		
						Stakeholder Engagement			
						Procurement exercise			
						Award of contract			

DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

25 JUNE 2015

Report of the Strategic Director of Adult Care

BETTER CARE FUND UPDATE

1. Purpose of the Report

The purpose of this report is to provide the Adult Care Board with an update of progress of the Derbyshire Better Care Fund

2. Information and Analysis

NHS England required all Health and Wellbeing Boards to complete a national reporting template for the fourth quarter reporting period of 2014-15 by 29 May 2015. The report focussed on the allocation, budget arrangements and national conditions of the Better Care Fund (BCF). In short it sought reassurance that the BCF was being delivered as described in the approved plan.

In addition to this information, the report allowed for Health and Wellbeing Boards to provide a written narrative outlining any changes to the approved BCF Plan and any variances in associated performance. A copy of the Derbyshire return is provided at Appendix 1 for information.

In summary, performance in relation to the Derbyshire BCF at the end of 2014-15 was on trajectory (Green) for five out of the six outcome metrics:

Indicator	Target	Result
Non-Elective Admissions (General & Acute) - Number of episodes per 100,000 population	3,108	2,970.7 (Green)
Permanent admissions of older people (aged 65 & over) to residential and nursing care homes per 100,000 population	688.4	745.4 (Red)
Proportion of Older People (65 & Over) Who Were Still At Home 91 Days After Discharge From Hospital Into Reablement / Rehabilitation Services	81.7%	87.1% (Green)
Delayed transfer of care from hospital per 100,000 (average number of days delayed per month)	968.2	605 (Green)
Patient Experience - GP Patient Survey Q32: In the last 6 months, have you had enough support from local services/organisations to help manage your long-term	65.90%	66.50% (Green)

condition		
Rate of Dementia Diagnosis	67%	67.30% (Green)

Whilst these results appear positive, the BCF Programme Board, as the accountable group for the implementation and monitoring of the BCF, has highlighted concerns around the result of the Non-Elective Admissions (NELS) metric.

The data used for this metric is drawn from the NHS England's Monthly Activity Return (MAR) data supplied by NHS Trusts. However, Clinical Commissioning Group partners have noted that this MAR data does not correspond with the Service Level Agreement Monitoring (SLAM) data they use for contractual payments. The Greater East Midlands Commissioning Support Unit has been asked to investigate this further to determine the cause/nature of this disparity and whether there will be a residual effect on the performance of this metric.

All health and social care services in Derbyshire performed well during 2014-15 to reduce both Delayed Transfers of Care (DTOC) and NELS. However, an unintended consequence of this appears to be an increase in admissions to residential/nursing care homes. Therefore a whole system wide approach to investigating this is being undertaken to identify where improvements can be made to ensure permanent admissions of older people into residential/nursing care are appropriate, and that those who are able to can return to the community.

3. Next Steps

The Health and Wellbeing Board will be required to provide further quarterly reports on the performance of the BCF for 2015-16 as follows:

- 28 Aug 2015
- 27 Nov 2015
- 26 Feb 2016
- 27 May 2016

The Adult Care Board will be kept informed of progress against the BCF in line with these reporting dates as well as the outcomes of the work outlined above.

4. Background Papers

The Better Care Fund Plan Parts 1 and 2 are available on the Derbyshire County Council
website: http://www.derbyshire.gov.uk/social_health/integrated_care/

5. Officer Recommendation

The Board is asked to:

- Consider and approve this report;
- Approve the next steps as set out in the report

Mary McElvaney
Strategic Director – Adult Care

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health & Wellbeing Board plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 29th May 2015

This initial Q4 Excel data collection template focuses on the allocation, budget arrangments and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1 2015/16 data collection.

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and associated performance trajectory that was approved.

Content

The data collection template consists of 4 sheets:

1) Cover Sheet - this includes basic details and question completion
2) A&B - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Narrative - please provide a written narrative
To note - Yellow cells require input, blue cells do not.

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
If the answer to the above is 'No' please indicate when this will happen.
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track for delivery (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Narrative

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.

Cover and Basic Details
Q4 2014/15

Health and Well Being Board	Derbyshire
completed by:	Graham Spencer
e-mail:	graham.spencer@derbyshire.gov.uk
contact number:	01629532072
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Dave Allen

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

Derbyshire

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements

Has the housing authority received its DFG allocation?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy

Selected Health and Well Being Board:

Derbyshire

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	We are in the process of establishing a link to the Demographic Batch Service in order to match historic records that don't have the NHS number.
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	A Direct Enhanced Service for GPs is in place, as outlined on pages 59-61 of the Derbyshire Better Care Fund Plan, to deliver a joint approach to assessment and care planning.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Consequential impacts have been built in to contracts for 2015/16. Parity of Esteem was included within the Derbyshire Better Care Fund Plan.

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

APPENDIX 1 **CONTROLLED**

Selected Health and Well Being Board:

Derbyshire

Data Submission Period:

Q4 2014/15

Narrative	remaining characters	31,473

Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.
Targets appear to be on trajectory for five out of the six outcome metrics. However, there appears to be some data disparity which we are currently investigating. The result for the local supporting metric relating to dementia diagnosis is 67.3% against the target of 67%. During a period of winter pressures the partnership was successful in reducing the number of non-elective admissions to hospital and in reducing the total number of days delayed for transfers of care. This can be attributed to the increased contribution and support of social work teams across the acute sector and the move to seven day working in this sector. However, initial analysis indicates that there has been a corresponding increase in the number of clients admitted to permanent nursing and residential care, which has not met its target. Local reports exist to monitor permanent admissions by locality and this intelligence will be used to keep the partnership informed of any variance from target in relation to permanent admissions to nursing and residential care. It's anticipated that this close monitoring will allow an optimum balance to be achieved between delayed transfers of care and permanent admissions to care. Work continues in the Units of Planning Urgent Care Board/System Resilience Groups.

Report for Adult Care Board 25th June 2015

Reports we have recently published:

- Primary Care Report

This was summarised in the last report to the board, but I was asked to present the report at this meeting, this can be found at: http://www.healthwatchderbyshire.co.uk/sites/default/files/final_version_primary_care.pdf

It gives a useful insight to the most prevalent positive and negative themes regarding primary care services in Derbyshire. The most common topics are quality of clinical staff (64 positive, 17 negative) and appointment system (45 positive, 26 negative).

Within the 232 comments received, there were 352 sentiments raised - 198 of these sentiments were positive, and 154 negative.

- Acquired Brain Injuries Service Evaluation

This report has not been published due to the sensitivity of the information in the report, i.e. the majority of information is provided through detailed patient stories which could lead to people being identified.

This has been shared with providers and commissioners and a formal response has been requested to the recommendations made which were:

- Our findings support the guidance outlined in NICE QS74, in particular that there needs to be more work done to prevent head injuries falling through the net. This will undoubtedly involve the engagement of GPs in education and training to recognise and diagnose head injuries, but also more timely investigations and treatments by A&E departments.

- The NICE guidelines and this report also identify the need for better co-ordinated services, in particular in relation to this report between health, social services and benefits agencies, to ensure positive outcomes for people with head injuries which should include any rehabilitation/support package post discharge.

- Our report also evidences the need for families and carers to be recognised and, if appropriate, involved in the investigation, treatment and care of someone with a head injury, which is also in the NICE guidance.

- We would also like to add that the availability and accessibility of information and support around brain injuries also needs to be evaluated to see if it is adequate to meet the needs of both the patients and their carers, and should encourage self-referral. Information should be transparent about waiting times.

So far I can report that:

The Acquired Brain Injuries report has received response from CRH, a combined response from the 4 Derbyshire CCGs and from NHS England. Outstanding responses are being pursued.

All unanimously welcome the report and explain the nature of provision or commissioning for acquired brain injury within their own service or organisation.

Several recommendations from the report are picked up in the CCG's response as requiring further development. These are information and signposting on discharge from hospital, and training for GPs to be more readily able to recognise signs of brain injury. The response concludes by saying that the HWD report offers evidence to support Health and Social Care Commissioners to revisit the current structure and function of acquired brain injury services in Derbyshire, with an aim of developing a more coherent service which supports a person and their families to better effect.'

The NHS England response also picks out and makes practical suggestions regarding the issue of GP training surrounding acquired brain injury.

Subsequent actions in line with these responses will be followed up by HWD with the CCGs and NHS England.

- Children and Young People's Report

This report highlighted what Children and Young People in particular have to say about Health and Social Care services. The most common themes included:

- The Environment – this played the largest part in the comments made by Children and Young People e.g. the waiting room is often considered boring, and they would like more to do while they wait.
- Waiting – children feel frustrated about waiting for appointments.
- Staff Attitude – Children and Young People have mixed experiences but where they are negative, they report feeling intimidated, judged, awkward, and nervous. Where they are positive they report being made to feel calm, listened too, and respected.
- Access to Services – again Children and Young People had mixed experiences but where they were negative it was due to difficulty making appointments, and appointments being at inappropriate times.

We have so far received 14 responses to the report recommendations, which includes 11 GP practices, NHS England, Chesterfield Royal Hospital and Derby Royal.

Responses to the report were really encouraging, with services considering and making a conscious effort to apply the feedback.

It was suggested by one of the services that we open up a discussion with the CQC about the provision of toys and books in waiting rooms to see if some balance can be made between infection control risk and the provision of a suitable waiting environment for children and young people. This was an area of concern for a number of GP Practices who had been advised to remove toys and books from waiting areas. We are in the process of doing this.

A draft summary of the responses has been collated, and is available on request from Karen Ritchie karen@healthwatchderbyshire.co.uk

- Carer's Discussion Paper

We continue to work proactively with, and monitor the impact of this discussion paper published in 2014 and any actions or outcomes as a result. The Discussion Paper summarises the comments and experiences of the carers we engaged with as part of this themed engagement activity, and gives a real and authentic insight in to the experiences of carers when using health and social care services. Since the report has been distributed we have received responses from a number of service providers and commissioners regarding the report. Most have welcomed it and triangulated it with their own data and all have welcomed the opportunity to discuss the needs of carers.

For a summary of responses to the paper and the impact it has had, please go to: http://www.healthwatchderbyshire.co.uk/sites/default/files/carers_discussion_paper_-_summary_of_actions_0.pdf

During Carers week 8th – 14th June we sent a letter to all GP practices in Derbyshire, highlighting the experience of carers and encouraging GP's to sign up to the carers pledge. We are awaiting replies, but have already received one replied to say that they will be signing up.

- Homecare services report

This piece of work was designed to engage with users of domiciliary care services and their carers, friends and family in order to strengthen their voice and to play an active part in how domiciliary services are delivered and designed in the future. It was published in June 2015.

Overall respondents were positive about the care received resulting with the majority indicating that they were very satisfied/satisfied with the care they, or their loved one, received.

Of the three main negative themes identified the lack of consistency with the carers visiting the service user was the most numerous issue.

Some dissatisfaction was reported with either administrative functions or poor communication with managers.

There was also some dissatisfaction with lack of consistency with the timings of the home visits.

On the whole, the findings were mainly positive. However, we would ask that providers of Homecare Services take into consideration the main negatives of the service and look at ways of addressing these concerns.

The full report can be found here: http://www.healthwatchderbyshire.co.uk/homecare-services-service-user-experience-report

- Enter and View reports are available for:
    - Canal Vue Care Home http://www.healthwatchderbyshire.co.uk/sites/default/files/canal_vue_care_home.pdf

- Whittington Care Home http://www.healthwatchderbyshire.co.uk/sites/default/files/final_report_whittington_care_home.pdf

- Chesterfield Royal Hospital NHS Foundation Trust Eye Clinic (to be published by the end of June)

Upcoming reports:

- Experiences of parents and carers using the Autism Pathway in Derbyshire – report will be with the providers for a response at the beginning of July.

- Summary report – the experiences of using Child and Adolescent Mental Health Services (CAMHS) to be sent to the providers for a response end of June 2015, published July 2015.

- Summary report - experiences of using cancer services – to be published July 2015.

- Brimington Care Centre Enter and View Visit, planned for late July 2015.

What Next …?

We are currently exploring (to finish July 2015):

- Learning Disabilities and reasonable adjustments in universal services

- Physical Disabilities and reasonable adjustments in universal services

New priorities for Sept –Nov 2015 will be agreed on the 2nd July at the Intelligence, Insight and Action Sub-Group.

Karen Ritchie
June 2015