Shadow Derbyshire Health and Wellbeing Board

10am Thursday, 21 March 2013

Committee Room 1

AGENDA

1. Introductions and Apologies for Absence

2. Minutes of the last meeting held on 24 January 2013

3. New regulations and draft revised Board Terms of Reference – David Lowe

4. The role of District Councils in delivering the HWB Strategy- Huw Bowen (presentation)

5. Public Health Programme Review – Elaine Michel

6. Falls and Bone Health Pathway Update – Jayne Needham

7. Adult Care Prevention Strategy – Bill Robertson

8. Review of Chronic Pain Services in Derbyshire – Councillor Garry Purdy

9. Health and Wellbeing Round-up report – David Lowe
    - Healthier Together
    - Health and Wellbeing Summit
    - Francis Report
    - EMAS Update
    - HealthWatch Update

10. Any other Business

11. Date of Next Meeting – 10am 23 May 2013, Committee Room 1

MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 24 January 2013 at County Hall, Matlock

PRESENT

Councillor A I Lewer (in the Chair)

D Bailey	Derbyshire LINk
H Bowen	Chesterfield Borough Council
Councillor J Burrows	Chesterfield Borough Council
Dr D Collins	North Derbyshire Shadow CCG
Dr A Dow	Tameside and Glossop Shadow CCG
A Gregory	Hardwick Shadow CCG
Councillor C A Hart	Derbyshire County Council
Dr M Henn	Erewash Shadow CCG
Councillor C W Jones	Derbyshire County Council
B Laurence	Derbyshire County Council
A Layzell	Southern Derbyshire Shadow CCG
Councillor B Lewis	Derbyshire County Council
D Lowe	Derbyshire County Council
M Meggs	Derbyshire County Council
E Michel	NHS Tameside and Glossop
Dr A Mott	Southern Derbyshire Shadow CCG
J Pendleton	North Derbyshire Shadow CCG
B Robertson	Derbyshire County Council
Councillor R J Wheeler	South Derbyshire District Council
M Whittle	NHS Commissioning Board

Also in Attendance – J Cox (Derbyshire County Council), J Dosanjh (Derbyshire LINk), Councillor S J Ellis (Derbyshire County Council), Councillor G Farrington (Derbyshire County Council), S Hobbs (Derbyshire County Council), C Mitchell (Exact Consultants), C Shearer, G Spencer (Derbyshire County Council), and J Willis

Apologies for absence were submitted on behalf of S Allinson, I Thomas and Councillor A Western

1/13 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 29 November 2012 be confirmed as a correct record.

2/13 **NHS COMMISSIONING BOARD** The Board received a presentation from M Whittle on the role and design of the NHS Commissioning Board. This had been established as a special health authority on 31 October 2011, and as an executive non-departmental public body on 1 October 2012. It played a key role in the Government's vision to modernise the NHS and to secure the best possible outcomes for patients. From April 2013 onwards, the

Board would become a non-departmental public body, would be fully operational and would take on full statutory requirements.

The Commissioning Board would be a patient-focused, clinically-led organisation that had the culture, style and leadership to improve outcomes for patients. It had a number of specific functions, including allocating resources to CCGs, supporting CCGs to commission services on behalf of their patients, and having direct responsibility for commissioning services for primary care, military and prison health services, high secure psychiatric services and specialised services. Another role of the Commissioning Board was to uphold the principles and values of the NHS Constitution.

The NHS Commissioning Board had a number of aims – improved health outcomes as defined by the NHS Outcomes Framework, that people's rights under the NHS Constitution were met, and that the NHS bodies operated within resource limits. These aims would enable that patients and the public had more choice and control over their care and services, that clinicians would have greater freedom to innovate and shape services around the needs and choices of patients, and the promotion of equality and the reduction of inequality in access to healthcare.

The structure of the Board was detailed. There would be Area Teams, which would be the local presence and these would commission high quality primary care services, support and develop CCGs, assess and assure performance, and develop local partnerships and stakeholder relationships, including representation on Health and Wellbeing Boards. There would also be four regions, which would provide clinical and professional leadership, co-ordinate planning, operational management and emergency preparedness, and undertake direct commissioning functions and processes within a single operating model.

It was stated that the NHS Commissioning Board was a nationwide organisation, which would provide simplicity, aid efficiency, and ensure singularity of approach. It was the intention to ensure that everything that the Board did contributed to improving outcomes, had been clinically-led, promoted equality and supported a reduction in health inequalities, was informed by the needs, views and wishes of patients and the public, and promoted innovation and put research into practice.

The overall running costs budget of £527m represented a reduction of almost half on costs and staff, compared to the current costs of functions transferring to the Board. Around 75% of the budget would be deployed locally, and this reflected that the majority of the NHS Commissioning Board's functions would be carried out locally, with the majority of people based in local area teams and regions. It also provided a strong local presence to best manage the transition. There were eight directorates, with nearly half of the

senior posts filled by clinical staff and it was stated that a range of clinical professions were represented. A structure of these was given.

3/13 **NUTRITION IN THE ELDERLY** The Board was informed of the issue of nutrition in the elderly, following on from work that had been undertaken by the Improvement and Scrutiny Committee, and details were given on how this could be embedded in 'day to day' health and social care practice. A pro-active systematic approach to the identification and management of malnutrition in the community and care settings was recommended, and in addition, an integrated structure would ensure that the plan, activities and programmes became embedded within professional practice.

The prevalence of malnutrition rose with age, and in older people with a long term condition. Evidence indicated that 14% of the elderly living at home or in care were at risk of malnutrition. The health effects of malnutrition had an influence on all the NHS and social care outcome frameworks, Assessing and managing nutrition was a crucial component of health and social care for the elderly and in adding 'life to years'. A national Malnutrition Task Group had been established, and this would provide guidance on implementing The British Association for Parenteral and Enteral Nutrition malnutrition and hydration driver guidance.

It was stated that the report presented to the Board encapsulated work previously undertaken by the Nutrition Review Steering Group and the Improvement and Scrutiny Committee. An evidence based plan was recommended, considering the main themes from the previously undertaken work. It was reported that, between 2012 and 2020, there would be a 27% increase in the population of over 75 year olds in Derbyshire. A greater proportion of the elderly would have a long term condition, which would increase the risk of malnutrition.

A nutrition summit for Derbyshire had taken place in April 2011, and this had concluded that better communication between professionals in the statutory and voluntary sectors should be established, screening for malnutrition in health and social care settings and the community should be embedded, and it had been agreed that the MUST (malnutrition universal screening tool) was the preferred method of assessing the risk of malnutrition. It had also concluded that training for professionals on the importance of nutrition and hydration should be developed and embedded, there should be information for staff and carers regarding nutrition and hydration, and a countywide multi-disciplinary team should be established to oversee the priorities.

Following the summit, a multi-agency, multi-professional Nutrition Steering Group had been established to take forward the recommendations.

These had centred on screening, monitoring of food not eaten by patients in care settings, staff training in malnutrition awareness, and information, particularly in relation to the on-going monitoring of malnutrition in care settings and the type of care plans implemented to address malnutrition.

A review of the nutrition of older people in the community and care settings had previously been undertaken, led by the Improvement and Scrutiny Committee. The review had found that of the 2,632 people aged over 65 who had been surveyed, 26% had been considered to be malnourished by the MUST score combining the high risk (14%) and medium risk (12%) scores. 70% had been considered to be low risk. Of the 369 people who had been considered to be at high risk of malnutrition, 17% of people had been in acute settings, 26% had been in care homes, 32% had been in a community hospital and none had been in mental health settings.

In terms of evidence and good practice, there was NICE Clinical Guidance 32 – Nutrition support in adults, and this provided guidance on which categories of patients required nutritional support and the method of support in NICE Quality Standard 24 Nutrition support for adults. The NICE quality standards provided clear guidance in terms of the quality measure, process and the responsibilities of health and social care providers and commissioners, and should be used to shape future service audits.

It was also noted that the Care Quality Commission had produced a Provider Compliance Assessment document on meeting nutritional needs, which assessed people who used services to ensure that they were supported to obtain adequate nutrition and hydration. The NHS had produced an Essence of Care document for food and drink, and this detailed a benchmark of good practice for each of a range of specified factors to deliver person centred care. Derbyshire was represented on the National Malnutrition Task Force, and was described as having an integrated approach to addressing malnutrition. There were quality standards related to the NHS and Social Care Outcomes Framework, and these were detailed. Malnutrition in the elderly would influence all of the quality standards.

Assessing the state of nutrition in the elderly was the responsibility of every health and social care professional, and it was stated that a multi-agency plan needed to be developed, based on the recommendations of the Improvement and Scrutiny Committee, to ensure that nutrition and hydration were considered and managed in the elderly by all health, social care and voluntary sector staff. The work of the Scrutiny Committee had made sound progress towards achieving this, but it was felt that a mandate from the Health and Wellbeing Board to drive forward the work further would ensure that a full multi-agency approach was adopted, with all health and social care agencies engaging fully with the agenda and securing positive improvements.

RESOLVED that (1) the multi-agency Nutrition Steering Group be re-established to review and implement NICE guidance and best practice documents and develop a sustainable plan fulfilling the aim of the Malnutrition Task Force and the recommendations made by the Improvement and Scrutiny Committee;

(2) implementing and maintaining the programme will be the responsibility of the Adult Care Board, which will report on progress to the Health and Wellbeing Board; and

(3) the Health and Wellbeing Board will mandate the progress of the work and the requirement for all health and social care agencies to engage with the agenda not just within care settings but also within the community.

4/13 **WINTERBOURNE REPORT UPDATE** Since the last meeting of the Board, the Department of Health had issued 'A National Response to Winterbourne View Hospital'. The details of the report, its expectations of local health and social care commissioners and providers, and local actions and proposals were presented.

The Adult Care Board had considered the reports, and had approved the recommendation to form a project group urgently, with representation from the local NHS, Adult Care and CAYA, to ensure that the actions detailed in papers dealing with Winterbourne View were addressed.

In addition, the Adult Care Board had agreed to develop an Accommodation, Care and Support Strategy for local people with a learning disability or autism. This would cover a broader population than just the local people placed in hospital, but it was necessary to minimise the use of hospitals for people with a learning disability. An initial report, outlining the proposed strategy, would be presented to the next meeting of the Adult Care Board. This would then be presented to the Health and Wellbeing Board at a future meeting.

A query was raised as to how there could be an assurance that care homes were treating people appropriately. In response, it was stated that there was to be a quality inspection of all care homes across the county, and it was the intention to have this completed by the end of February 2013. Work was also taking place to look at how to improve care in homes.

RESOLVED to support the Adult Care Board's proposal to (1) establish a project group to lead the local actions around the Winterbourne View report; and

(2) prepare an Accommodation, Care and Support Strategy for local people with a learning disability or autism.

5/13 HEALTH AND WELLBEING STRATEGY – ACTION PLANNING AND PERFORMANCE MANAGEMENT APPROACH The Board had previously approved the Health and Wellbeing Strategy, which set out the priorities of partners across Derbyshire. To ensure the successful implementation and delivery of the Strategy, detailed action plans were being developed, and a lead officer had been allocated for each of the actions outlined in the Strategy.

The action plans would be supported by indicators identified from the national frameworks for Public Health, NHS, Adult Care, CAYA and CCGs, as well as local indicators that would show how Derbyshire was performing. The action plans would be approved by the Health and Wellbeing Co-ordination Group, which would monitor the progress being made. Areas of significant under-performance would be reported to the Board by exception.

It was proposed that the Board received a performance report on a specific priority from the Strategy at each of its meetings during 2013/14, with a summary of progress made over the year and areas of focus for the following year reported at the meeting in March 2014. The report would comprise a summary of the outcome indicators for the priority and commentary on progress being made. It would also identify those areas of work that were on target, those that were making progress but needed to do more, and those where immediate action was required to improve performance. The approach would be introduced from April 2013, and as the monitoring and reporting of performance developed, it could become appropriate for Board members to take ownership of particular priorities.

RESOLVED to approve the Action Planning and Performance Management Approach outline for the Health and Wellbeing Strategy.

6/13 DERBYSHIRE CLINICAL COMMISSIONING GROUPS – LEAD COMMISSIONING RESPONSIBILITIES The Board was informed about the lead commissioning roles agreed across the CCGs in Derbyshire.

During 2011, CCGs had been developing across the area previously covered by Derbyshire County PCT, and the configuration had eventually been settled at four CCGs. At the same time, the NHS had been under pressure to cut management costs, and staff levels across the PCT had been reduced by almost 50%.

A robust method of working closely together and sharing resources had been discussed, and it had been agreed that whilst every CCG remained accountable for all of the services commissioned for its population, it would not be possible for every CCG to employ or buy in the necessary skills within the £25 per head of population running costs limit. It would also not be

efficient for every individual CCG to directly commission services from a large provider.

A process had therefore been undertaken that looked at the staff available, where they were located and lived, the location of the main providers and the geographic areas they covered. This had resulted in a series of agreed lead roles for CCGs, and these were highlighted.

RESOLVED to note the lead roles and responsibilities of each CCG.

7/13 DERBYSHIRE CLINICAL COMMISSIONING GROUPS – EVERYONE COUNTS – PLANNING FOR PATIENTS 2013/14 The NHS Commissioning Board had published its planning guidance to all commissioners in December 2012. An executive summary of the main document was provided, and this highlighted the principles behind the new approach to planning clinical led commissioning from April 2013.

It was noted that the NHS Outcomes Framework and NHS Constitution set out the goals and responsibilities, but approaches for delivery would vary and local commissioners would have the freedom to develop those that worked in their community. The guidance laid out five offers to help commissioners deliver for the public, and alongside these were details of the guidelines and incentives that demonstrated a new relationship between those directly developing services and those working at a national level. Among the measures covered were listening to patients, focusing on outcomes, rewarding excellence, and improving knowledge and data.

Each CCG had to submit a first draft plan by 25 January 2013, covering a range of issues, one of which was a trajectory for locally selected priorities. The three local priorities were expected to be those areas which had already been identified in CCG clinical commissioning strategies and linked to the Health and Wellbeing Strategy. Each CCG presented to the Board its three priorities:-

North Derbyshire
Single point of access
111 Service
Work with Chesterfield Royal around the length of time in hospital

Erewash
Reducing health inequality
Integrating care
Supporting people with long term conditions

Hardwick – it was stated that the priorities were subject to a voting process, but it was likely that they would be:-

The development of a Virtual Ward
Cancer screening for people with learning disabilities
Care homes, in particular primary care plans for individuals

South Derbyshire
End of life care
Stroke rehabilitation – being discharged from hospital earlier with proper care
Falls prevention or Diabetes care

Tameside and Glossop – the CCG had a later submission, so was currently working on its priorities, but proposals were:-
Health inequalities
Alcohol
Disease registers
End of life care plan

It was reported that the priorities had to be measurable, as they would form part of a quality premium payment, which would be made in 2014/15 if all targets were met.

The Board was also presented with details of the Outcomes Framework measures and the NHS Constitution and other targets that had to be achieved.

RESOLVED to note the planning guidance and requirements for CCGs in 2013/14.

8/13 TOGETHER FOR A HEALTHIER FUTURE – THE TAMESIDE AND GLOSSOP PUBLIC HEALTH ANNUAL REPORT 2012 The Board received a presentation from E Michel regarding the Tameside and Glossop Public Health Annual Report 2012. The Director of Public Health had a responsibility to produce a Public Health Annual Report on the state of the health of local people. The report had been produced in a magazine style format to make it as accessible as possible to a wide audience.

The aim of the report was to celebrate success across the whole system by focusing on the improvements in outcomes and access to health improving services over the last year. This used the 'nudge' theory by highlighting positive health behaviours, and it also showcased the collaborative work that was in place.

There was a Top Ten Tips section which provided advice on how to protect and improve health with links to services, and further information to enable people to make positive choices. The Cost Effectiveness section demonstrated the potential for cost savings to both the health system and the wider economy. There were immense challenges facing local people and

organisations to improve health within reducing financial resources, and Shaping the Future outlined the public health approaches to protecting and improving health, and defined some of the plans and interventions which would have a positive impact on health. It was felt that there was an opportunity to make a difference, and it was a case of encouraging people to make healthy steps via the use of social media, and the use of a health impact assessment.

There was a joint commitment to tackling health inequalities and areas to narrow the gap in health experience, achieve a greater level of fairness and improve health outcomes wherever possible. The commitment would be underpinned by a programme of work to maximise health gain from all investments, work towards fair access for all to preventative initiatives, enable equitable outcomes from health and social care services, and minimise any negative health impacts of policies and programmes.

The report was available on the NHS Tameside and Glossop website, and the contents of the report were underpinned by the Tameside and Glossop JSNA. It had also been presented to the Tameside and Glossop CCG Board and the Tameside Health and Wellbeing Board.

RESOLVED that Board members be asked to circulate as widely as possible through their networks to community groups and colleagues in the Glossopdale area. They are particularly asked to consider how they might promote the Top Ten Tips to Be Safe.

9/13 FEEDBACK REGARDING DERBYSHIRE LINk's OBSERVATIONS OF SERVICES DELIVERED AT GP PRACTICES THROUGHOUT DERBYSHIRE Derbyshire LINk had presented its report entitled 'Observations of Service Delivery at GP Practices throughout Derbyshire' to the Board in September 2012, and it had been recommended that the Board maintained an interest in this subject. An update had been requested from Derbyshire LINk.

The report had been sent to all four Clinical Commissioning Groups and Tameside and Glossop PCT, and acknowledgement of receipt of the report had been requested within 20 days, with a further comprehensive response required by 31 December 2012. Feedback had been received from three CCGs, all of which highlighted similar issues.

It was stated that Derbyshire LINk wanted the Board to acknowledge and take note of the feedback received. It was also requested that the Board maintained an interest in the subject, and that there be an update from the necessary organisations on a regular basis.

Access within primary care was a continuous matter of concern for the general public, and it was essential that Derbyshire LINk could provide evidence that this was at the forefront of the relevant organisations, and that it was being responded to positively. It was the intention to feedback to the public the comments of the CCGs on the report, but it was agreed that any specific comments would be made anonymous.

10/13 IMPLEMENTATION OF HEALTHWATCH DERBYSHIRE An update was provided on the work being undertaken to establish HealthWatch Derbyshire.

Following a tender process, Adult Care had appointed Exact to undertake the implementation project to create HealthWatch Derbyshire. The setting up of HealthWatch Derbyshire as a not-for-profit organisation would allow the Council to sign a contract for the delivery of the HealthWatch service directly with the organisation from 1 April 2013.

In terms of the Implementation Plan, Exact had advertised for applicants interested in being a member of the HealthWatch Derbyshire Executive Board. A selection panel of commissioners from the Council and LINk Steering Group members had reviewed the applications and had agreed to offer appointments to six applicants. The Executive Board presently had eight members, which included the current Chair and Deputy of the LINk Steering Group. The current LINk Steering Group Chair would continue as Acting Chair for HealthWatch Derbyshire until at least 1 April 2013, and there would be further targeted recruitment to bring the Executive Board to the proposed twelve members.

The HealthWatch Derbyshire Board had met on two occasions to discuss the decisions that were needed to help formalise the Board and to prepare for the future HealthWatch role. Tasks to be addressed included the registration of the organisation and its legal status, recruiting a staff team, including consideration of transferring staff from Derbyshire LINk, IT and office accommodation.

The Board was also informed that the responsibility for the commissioning of the Independent Complaints and Advocacy Service (ICAS) for NHS Complaints would transfer from the Department of Health to Local Authorities from 1 April 2013. The County Council had decided to be part of a regional procurement exercise for the provision of the service, and had been involved in awarding the contract to POwHER. The contract was for one year from 1 April 2013. Derbyshire Commissioners, including a representative from a local CCG, would be part of the regional management group for this contract.

RESOLVED that the report be noted, with further update reports about the implementation of HealthWatch to be submitted to the Board.

11/13 CHILDREN'S TRUST BOARD TERMS OF REFERENCE The Children's Trust Board had been operating successfully for a number of years, both as a statutory and non-statutory body. The Terms of Reference had been reviewed to ensure that it was now able to successfully operate as an accountable sub-group to the Shadow Health and Wellbeing Board.

The Terms of Reference had been amended to reflect the Board's responsibilities and activities with regard to the health and wellbeing of children, young people and families. In addition, the membership had been reviewed to reflect the changes in the structure of the local NHS. The proposed Terms of Reference were presented, and it was noted that there needed to be a couple of amendments to the membership.

RESOLVED to agree to the proposed Terms of Reference for the Children's Trust Board.

12/13 HEALTH AND WELLBEING ROUND-UP REPORT A round-up of key progress in relation to health and wellbeing issues and projects was given.

A Health and Wellbeing Summit was to be held on the afternoon of 5 March 2013, and this would look at the progress that had been made towards implementing the health care reforms in Derbyshire over the past year. This would replace the Stakeholder Day that had been planned.

The second development session with the LGA had been held in December, at which the Board had discussed a number of scenarios relating to difficult decisions they could need to make as a Board. This had highlighted a number of key issues for consideration, including clarity over the role of the Board, governance and accountability arrangements, the decision making process and the format of meetings. The next session would be held on 8 February 2013, when the focus would be Falls and Bone Health. It was the intention for the Board to meet in confidential session and then to meet formally to take a decision on changes to dealing with falls and bone health.

CCGs were going through the process to demonstrate competence to become a stand-alone NHS statutory body. Four CCGs were in wave three, with Hardwick in wave four. All CCGs had been through the evidence submission and panel review day, and all except Hardwick had also had its current position moderated through a national process to ensure consistency of approach by panels. Erewash, North Derbyshire and Southern Derbyshire CCGs had been confirmed as having no outstanding criteria to satisfy, and it was noted that Hardwick would receive the outcome of its moderation panel in

February. Tameside and Glossop had 14 outstanding red ratings covering five areas, all of which had been addressed except for the appointment of the hospital doctor to the governing body. In terms of next steps, each CCG would be considered at a national conditions panel, and full authorisation would be agreed with or without conditions as necessary.

CCGs would become established as statutory bodies from the date they were authorised, although staff would not formally transfer over until 1 April 2013. CCGs were now starting detailed contract discussions with providers following the publication of the NHS planning guidance. All contracts had to be signed off before the end of March 2013, and this would include any services previously commissioned by the PCT for public health which would transfer over to the County Council.

The East Midlands Ambulance Service (EMAS) Board had recently met to consider feedback from the consultation. Following analysis from the consultation, the Board had determined to undertake further analysis on the Estate Business Case to ensure that proposals would work operationally and financially. Further discussion would take place between EMAS staff and senior managers to finalise the Estate Business Case, which would be considered by the EMAS Board on 25 March 2013.

There were two new documents that presented detailed local data on health and social care outcomes in Derbyshire which would serve as a baseline at the point at which the new NHS and public health systems came into being. The first document was the new Public Health Outcomes Framework profile, which was based on a range of outcomes. For the 76 indicators for which comparisons could be made, Derbyshire scored significantly above the national average on 38, similar to the national average on 27 and significantly below the national average on 11. The indicators would form part of the basis of the county's Joint Strategic Needs Assessment, and some would contribute to the monitoring of progress against the Health and Wellbeing Board's strategic priorities.

The second document was an 'Outcomes Benchmarking Support Pack: LA level' from the NHS Commissioning Board, which compared Derbyshire with the ONS cluster authorities on a set of high level outcomes indicators from three outcomes frameworks – those for the NHS, public health and adult social care. There were 17 indicators, and Derbyshire scored above the cluster average on 12, but there were also areas of challenge.

The Task and Finish Group for falls and bone health had met in December 2012, and the remit had been to consider the current falls and bone health service provision for Derbyshire, to identify gaps in the current provision and to explore ways to improve patient outcomes in a cost effective manner. It was noted that a great deal of positive change had occurred over recent

years, but a number of the necessary services and interventions were still not provided or provision was incomplete, thus reducing the potential clinical and cost benefits. The main findings from the Task and Finish Group for Board consideration were detailed.

It was apparent that in order to develop, continue or extend existing services to meet both the needs of the population and the requirements of national policy and audit, further investment was needed. Detailed joint working would be required before the level of the additional investment could be fully stated, although it was likely to be both recurrent and non-recurrent. Currently, the only specified investment into falls prevention was £35,000 from public health funding for falls exercise advisor posts and non-recurrent Section 256 monies used to pilot the falls recovery service and footcare social enterprise models. It was clear that funding provision should not fall to any one organisation as cost benefits from an effective falls and bone health pathway would be across both the health and social care sector, and primary and secondary work.

Agenda Item No. 3

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

21 March 2013

HEALTH AND WELLBEING BOARD REGULATIONS AND REVISED TERMS OF REFERENCE

Purpose of the report

To inform the Board of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and request that consideration is given to the revised draft terms of reference for the Board in order that they may be approved by Council at its Annual General Meeting on the 25th May 2013.

Background

The new Regulations setting out the requirements for Health and Wellbeing Boards were published in February to enable local authorities to finalise preparations for the boards and health scrutiny arrangements as they become statutory in April 2013.

Information and Analysis

The Regulations make provision for the disapplication and modification of certain enactments relating to local authority committees appointed under section 102 of the Local Government Act 1972, insofar as they are applicable to a health and wellbeing board established under section 194 of the Health and Social Care Act 2012. The regulations aim to provide local areas with the flexibility and freedom to shape their health and wellbeing boards as best fits with local circumstances. The Board will be a committee of the Council. In particular:

- health and wellbeing boards will be free to establish sub-committees and delegate functions to them;
- voting restrictions have been lifted so that non-elected members of a health and wellbeing board (i.e. CCG representative, local Healthwatch, Directors of Public Health, Children's Services and Adult Social Services and any wider members) could vote alongside nominated elected representatives on the board.
- political proportionality requirements have also been lifted so that the question of political proportionality of health and wellbeing board membership is left to local determination.

In relation to health scrutiny, the regulations make provision for local authorities to review and scrutinise matters relating to the planning, provision and operation of the health service in their area. They replace the

previous 2002 regulations on health scrutiny and give local authorities greater flexibilities in how they discharge their health scrutiny functions. The discharge of functions by health and wellbeing boards fall within the remit of scrutiny however, the core functions are not subject to call in as they are not executive functions of the Council. Health and Wellbeing Boards can also ask scrutiny committees to look at different aspects of health and wellbeing and make recommendations to the board.

Certain elements of the previous regulations have been preserved but there are new obligations on NHS bodies, relevant health service providers and local authorities around consultations on substantial developments or variations to services to aid transparency and local agreement on proposals.

Revised draft Terms of Reference
Following the publication of the Regulations, the terms of reference for the Health and Wellbeing Board have been revised (attached at Appendix A) and are presented to the Board for consideration and comment.

Full Council has discretion in relation to the County Council membership of the Board.

The Board will also need to consider the overall structure of the Board and associated groups, such as the Children's Trust, the Adult Care Board, the Health Protection Group, the Safeguarding Board and the JSNA Steering Group.

The JSNA Steering Group has been in place for a number of years and was established before the new requirements relating to Health and Wellbeing Strategies were introduced, therefore it is timely for a review to take place to ensure the Group can deliver the new requirements.

Recommendations
It is recommended that the Board:

1. Comment on the draft terms of reference to inform Council at its meeting on the 15th May. (Contact: jane.cox@derbyshire.gov.uk)
2. Receive a presentation from the Safeguarding Board to further develop Board members' understanding of the role of this Board at a future meeting.
3. Request a review of the JSNA Steering Group.

David Lowe
Deputy Chief Executive and Strategic Director
(Health and Community Safety)
Derbyshire County Council

Derbyshire Health and Wellbeing Board

The Derbyshire Health and Wellbeing Board will lead and advise on work to improve the health and wellbeing of the people of Derbyshire through the development of improved and integrated health and social care services.

Terms of Reference

The Board will:

1. Identify and develop a shared understanding of the needs and priorities of local communities in Derbyshire through the development of the Derbyshire Joint Strategic Needs Assessment (JSNA) with the Clinical Commissioning Groups. In particular the Board will;

    - The Derbyshire JSNA is reviewed, refreshed and further developed taking into account the latest evidence and data so that it is fit for purpose and reflects the views of local people, users and stakeholders.

    - The JSNA drives the development of the Joint Derbyshire Health and Wellbeing Strategy and influences other key plans and strategies across the county.

    - The County Council and Clinical Commissioning Groups demonstrate how the JSNA has driven commissioning decisions.

2. Prepare, publish and oversee the Joint Health and Wellbeing Strategy for Derbyshire to ensure that the needs identified in the JSNA are delivered in a planned, coordinated and measured way. Specifically, the Board will:

    - Take account of the health needs, inequalities and risk factors identified in the Derbyshire JSNA along with recommendations set out in the Director of Public Health's Annual Report.

    - Develop an agreed set of strategic priorities to focus both collective effort and resources across the county.

    - Ensure that plans are in place to deliver the Board's strategic priorities and outcomes.

    - Challenge the performance of delivery plans taking action as necessary to support underperformance through the agreement of recovery and improvement plans.

- Review the commissioning plans for healthcare, social care and public health to ensure that they have due regard to the Joint Derbyshire Health and Wellbeing strategy and take appropriate action if they do not.

- Receive reports from other strategic groups and partners in the county responsible for delivery, including specialist commissioning groups.

- Develop mechanisms to measure, monitor and report improvements in health and wellbeing outcomes ensuring linkages with performance frameworks for the NHS, public health and local authorities.

3. Develop effective mechanisms to communicate, engage and involve local people and stakeholders in Derbyshire to ensure that the work of the Board reflects local needs. Specifically, the Board will:

    - Ensure that appropriate structures and arrangements are in place to ensure the effective engagement and influence of local people and stakeholders.

    - Represent Derbyshire in relation to Health and Wellbeing issues across localities and at a sub-regional and national level.

    - Work closely with the Derbyshire HealthWatch ensuring that appropriate engagement and involvement with existing patient and service user involvement groups takes place.

    - Appoint and direct task and finish groups to undertake assessment and development work in respect of particular projects on behalf of the Board in order to enable the Board to make recommendations regarding public health needs and to develop the Health and Wellbeing Strategy

4. Oversee the totality of public sector resources in Derbyshire for health and wellbeing and drive a genuine collaborative approach to commissioning. Specifically the Board will:

    - Oversee and develop a shared understanding of the totality of health and wellbeing commissioning expenditure in Derbyshire.

    - Retain a strategic overview of the work of commissioners in the county.

- Support joint commissioning of NHS, social care and public health services and identify those service areas in Derbyshire where additional improvements in joint commissioning are required to achieve the Board's priority outcomes.
- Recommend the development of aligned or pooled budgets and encourage partners to share or integrate services where this would lead to efficiencies and improved service delivery.

- Make recommendations on the allocation of resources and on the priority of key projects to service providers and/or localities to achieve jointly agreed objectives.

- Have an overview of major service reconfigurations in the county by relevant service providers and make recommendations to those providers to enable improved and integrated service delivery.

Membership

The composition of the Derbyshire Health and Wellbeing Board will broadly follow the statutory model. It will comprise:

- Leader of County Council (Chair)
- Cabinet Member for Public Health
- Cabinet Member for Adult Care
- Cabinet Member for Young People
- Shadow Cabinet Member for Public Health
- Director of Public Health
- Strategic Director of Adult Care
- Strategic Director for Children and Younger Adults
- Strategic Director of Health and Community Safety
- Two elected representatives of the District Councils (supported by one Chief Executive)
- One representative from each of the Clinical Commissioning Groups
- One representative of the HealthWatch Derbyshire
- NHS Commissioning Board (when required)
- Public Health England (when required)

The Board can co-opt additional members as it considers appropriate.

All non-Councillor members of the Board are co-opted Members.

Meetings of the Board

Frequency

- The Health and Wellbeing Board will meet on a bi-monthly basis.
- The date, time and venue of meetings will be fixed in advance by the Board and an annual schedule of meetings will be agreed.
- Additional meetings may be convened at the request of the Chair.

Voting

- The Health and Wellbeing Board will operate on a consensus basis.
- In exceptional circumstances, and where decisions cannot be reached by a consensus of opinion, voting will take place and decisions agreed by a simple majority.
- Where there are equal votes the Chair of the meeting will have the casting vote.
- On occasions when a member of the Board cannot attend, that Member should nominate a substitute to attend, but the substitute will not have a vote

Declaration of Interests

- Any interests held by Members or co-opted members should be declared on any item of business at meeting in accordance with the Council's Code of Conduct for Members and the Localism Act 2011

Quorum

- A quorum of five will apply for meetings of the Health and Wellbeing Board including at least one elected member from the County Council and one representative of the Clinical Commissioning Groups.

Access to Information/Freedom of information

- The Board shall be regarded as a County Council committee for access to information purposes and meetings will normally be open to the press/public.

Papers

- The agenda and supporting papers shall be in the standard format, circulated at least five clear working days in advance meetings and published on the County Council website.

- The agenda and supporting papers shall be in a standard format and circulated at least five clear working days in advance of meetings.

- The minutes of decisions taken at meetings will be kept and circulated to partner organisations as soon as possible.

- Minutes will be published on the County Council web site.

Scrutiny

- Decisions of the Health and Wellbeing Board will be subject to scrutiny, but will not be subject to the “call-in powers” of the Improvement and Scrutiny Committee.

Review

- These terms of reference will be reviewed annually or earlier if required.

Agenda Item No. 5

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

21 March 2013

Strategic review of public health programmes

Purpose of the report

To provide the Shadow Health & Wellbeing Board with an overview of the planned public health programme review, its purpose, the membership of the panel and the anticipated outcomes

Background

Local authorities become responsible for the delivery of public health programmes from 1st April 2013 under the provision of the Health and Social Care Act 2012. The financial allocation within the ring fenced public health budget was released in December 2013. This was based on the minimum guarantee of resources for local authorities to enable them to continue public health programme delivery. It also included an increase in funding until March 2015. The funding allocation is £34.7m with an uplift of 2.8% in 2013/14 and again in 2014/15. The vast majority of the allocated funding is to provide a range of contracted services plus staffing costs for the public health department.

Purpose of the strategic review

As a matter of good practice, a review of contracts that are migrating to a different organisation, should be set in place. The aim of the review has a number of outcomes to:-

- Provide assurance to the county council, wherever practicable, that the commissioned services are value for money, meet local needs and the priorities identified in the Health & Wellbeing Strategy, JSNA and the Public Health Outcomes Framework.
- Consider the effectiveness of provision of mandatory services.
- Create an opportunity to redesign services or align them with other services provided by local authorities
- Consider decommissioning services that are not performing or delivering their agreed outcomes
- Enable an overview of the range of commissioned programmes to be reviewed by geography, age, vulnerability etc to consider fair shares allocation of resources

- Identify gaps in provision that need to be met based on population health needs and inform the use of the additional resource

This will be through a robust systematic process which has been developed across the NW to enable a thorough review of the public health service areas. These are:-

- For children and young people
- Substance misuse services
- Sexual health services
- Lifestyle programmes
- Preventative programmes for older people

The review will take place in April. It will consider:-

- Evidence of need for the service and fit with Derbyshire priorities
- Benchmarking of performance against comparator areas for cost effectiveness and outcomes
- Customer satisfaction
- Alignment with cross organisational pathways
- An assessment of risks around the services
- Identification of gaps within programme areas and against population need

Panel membership

A range of organisations have agreed to support this review to enable a rounded picture to be formed. They include:-

- The Director and Deputy Director of Public Health
- The Deputy Chief Executive of Derbyshire CC
- Senior leads from both Adult Social Care and Children & Young People's services
- A Chief Officer representing district councils
- A Chief Officer representing CCG's
- A representative nominated by Healthwatch

Outcomes of the review

The panel will enable the Director of Public Health to develop an informed view of the need for continuation of services, redesign or decommissioning.

This will form the basis for clear recommendations to the Council about deployment of the public health resource over the next few years.
Is an Equality Impact Assessment required? This will form part of report to Council

Recommendations

The report is to inform the Board of the approach.

Elaine Michel
Director of Public Health
Derbyshire County Council/NHS Derbyshire County

Agenda Item No. 6

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

21 March 2013

FALLS AND BONE HEALTH PATHWAY

Purpose of the report

Following the board development session focussing on falls and bone health; to confirm proposals to improve the falls and bone health pathway for Derbyshire.

Background

The effect of falls and reduced bone health impacts on the services delivered by all partners on the Health and Wellbeing board. Proposals to improve the current pathways have been considered in detail at the shadow board meetings of 26 July 2012, 24 January 2013 and the board development session on 8 February 2013. Following the development session when proposals for improvements and investment were debated in detail, board members' agreed the following:

1. A joint approach with shared responsibilities was required to improve the pathways and hence outcomes.
2. Improvements could be made through service redesign or tightening of contractual arrangements. Other improvements would require investment.
3. Public health, adult care and the four CCG's would consider their individual responsibilities in improving care and outcomes' and would report back to the March board meeting on what resource commitment they could provide over a given timescale to secure the necessary improvements.
4. Public health would provide advice and support to adult care and the CCG's when requested to identify the evidence base and strengthen service agreements and contracts to secure improved care and outcomes for patients/service users.
5. Once investment and resources have been agreed at the March board, the Task and Finish group for falls and bone health will be the vehicle for driving forward identified actions. All partners will ensure suitable representation at this group is provided for each of their organisations. The Task and Finish group will be chaired by the Director of Public Health and will develop an implementation plan incorporating timeframes, partner action and required investments and will provide regular updates on activity to the Health and Wellbeing board.

Update following Development Session

1. Southern Derbyshire CCG has requested that the falls and bone health work forms part of the integrated care work being prioritised by the CCG.
2. A meeting to discuss improvements to the use of ambulance services in the pathway has been requested with Erewash CCG
3. A meeting to discuss improvements for patients with dementia in the pathway has been arranged with Hardwick CCG
4. A meeting to discuss the improvements to the services with Chesterfield Royal and Derbyshire Community Health Services has taken place with North Derbyshire CCG.

Recommendations

1. Board members agree existing and future resource and funding commitments for the improvement, development and expansion of an effective falls and bone health pathway from primary prevention work through to secondary care provision.
2. Board members agree to the delivery of the improvements being determined through the Falls and Bone Health task and finish group and ensure suitable attendance by representatives of their organisation is provided to support this group.

Jayne Needham

Senior Public Health Manager

Derbyshire Public Health

Agenda Item No. 7

DERBYSHIRE COUNTY COUNCIL

SHADOW HEALTH AND WELLBEING BOARD

21ST March 2013

ADULT CARE PREVENTION STRATEGY 2011 – 2014 IMPLEMENTATION UP-DATE

Purpose of the Report

To inform the Shadow Health and Wellbeing Board of the findings of the recent Prevention Strategy stakeholder meeting and to seek support for recommendations for the development of the Adult Care prevention agenda up to and beyond April 2014.

Information and Analysis

A prevention (services and support) stakeholders meeting was held in November 2012. The aim of the meeting was to:

- Up-date stakeholders on what had been achieved since the launch of the Prevention Strategy against its specified action programme
- Establish greater shared purpose for the further work that remains to be done to implement the strategy up to 2014
- Contribute to the strategic planning for the prevention agenda beyond April 2014.

90+ attendees from statutory, independent and voluntary/community sector organisations from across Derbyshire, involved in prevention work for adults attended.

The review event considered:

- The key national and local influences on the prevention agenda currently and expected over the next few years
- The work that remains to be completed
- The key future priorities.

The Adult Care Board considered a detailed report including coverage of these themes. In implementing the future prevention priorities the Adult Care Board emphasised the importance of a collaborative approach including the Clinical Commissioning Groups, Public Health, District and Borough Councils as well as Adult Care.

The recommendations endorsed by the Adult Care Board are that there should be a focus on certain priorities to strengthen delivery of the current strategy now and what should happen after 2014?

Responses to these questions were collated and are summarised below.

1. What remains to be done?

- More work is needed to ensure the right information is available to the right people at the right time, with a focus on helping people to help themselves, and make good decisions
- Access to health and wellbeing information is needed in a wider choice of settings
- Not clear that commissioning decisions are fully joined up across health and social care sectors; new CCG's need to invest effort in sharing how the system will work, how commissioning decisions are made, generally of what is happening in their areas and positively linking with the social care prevention agenda.

2. What are the priorities?

- To promote sources of information as opposed to the information itself
- To establish better inter-organisation communication co-ordination/sharing of information
- To develop strong county-wide, cross organisational approaches to the co-ordination of preventative services and support
- To establish the First Contact sign-posting mechanism as the sign-posting mechanism of choice for Derbyshire and grow its take-up
- To improve hospital discharge support/home from hospital services to reduce inappropriate re-admissions
- To invest in more primary falls prevention provision
- To ensure wherever possible and practicable, that prevention provision supports safeguarding/preventing harm
- To increase number of middle aged people doing exercise/choosing healthier lifestyles
- To provide more support for VCI sector and small service providers to pursue development of self-sustaining business models for delivering prevention services
- To focus on helping people to help themselves and take more responsibility for their health and wellbeing needs
- To focus on preventative provision that supports peoples social needs and helps tackle loneliness and depression, including supporting carers, improving the 'connectedness' of people.

3. Opportunities to strengthen partnerships locally and at a county level?

- Improve links between housing, health and social care provision
- Make better use of Health Centres as spaces for opening up prevention and early intervention opportunities
- Engage with the private sector, e.g. Tesco, who run a community engagement programme, and often have space for community groups to meet in supermarkets
- Support neighbourhood networks
- Focus on partnership working that enables shifts in funding from crisis provision to prevention provision
- Disseminate Pocket Guides to Adult Care to Parishes/Parish Clerks.

What should happen after 2014?

- Clear and clearly defined priority outcomes for prevention and allocate the available resources accordingly
- Sustained and additional prevention provision paid for by a shift in resources from acute/intensive provision.

Summary

The analysis of the discussions points to a need to increase focus on the following work areas:

- Information and communication
- Access to existing services, improving sign-posting to make better use of current provision
- Improved partnership, joint working and networking
- Capacity building prevention support to better meet social needs.

Strategic planning for the prevention agenda up to and beyond April 2014 needs to pursue actions to take forward the following:

- To consider driving a county-wide cultural and resource shift away from crisis management to prevention and a continued emphasis on the significant resource shift from acute/intensive provision to prevention and early intervention.
- Enhanced partnership working and greater integration of opportunities for information, advice and communication
- Further developing the evidence base to better explain the impact and outcomes of prevention and early interventions
- Establishing First Contact as the agency to agency referral tool of choice for prevention work for Derbyshire

- Confirming the contributions and commitments to the Adult Care Prevention Strategy from the wide range of partners that are involved in prevention work
- Defining a new set of core, optimal, and desirable outcomes for prevention services in Derbyshire by April 2014 up to 2017, consistent with the new general and specific duties for prevention set out in the Care and Support Bill currently before Parliament.

RECOMMENDATION

That the Shadow Health and Wellbeing Board notes the findings of the recent Prevention Strategy stakeholder meeting and supports the recommendations as the basis for the development of the Adult Care prevention strategy and prevention work up to and beyond April 2014.

Bill Robertson

Strategic Director Adult Care

Derbyshire County Council

Agenda Item No. 8

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

21 March 2013

IMPROVEMENT AND SCRUTINY REVIEW OF CHRONIC PAIN SERVICES IN DERBYSHIRE

Purpose of the report

To present to the Shadow Health and Wellbeing Board the final report of the Improvement and Scrutiny Review of Chronic Pain Services in Derbyshire.

Information and analysis

The Improvement and Scrutiny Committee - People, at its 27 June 2012 Committee meeting, resolved to undertake a review of the management and delivery of chronic pain services across Derbyshire. The final report of this review was approved by the Committee at its 23 January 2013 meeting, and subsequently presented to the Council's Cabinet for information on 5 March 2013. A copy of the review is provided at Appendix 1.

The purpose of the review was to look at the systems within Derbyshire for assessing, referring, treating, and managing chronic pain. The review also looked at the role of primary and secondary care services, and the role of commissioners. It also sought the views of people with chronic pain as well as looking at different models of delivery in other parts of the country.

The review used three broad lines of inquiry to investigate the management of chronic pain in Derbyshire:

1. What is the current approach to pain management in Derbyshire?
2. How does this compare nationally with recognised good practice services and policies?
3. What is the service user and health professionals view?

Following this work, the review has identified the need for improvements to be made, particularly in addressing inequity of some service provision and making professionals, particularly those in Primary Care, as well as the public, aware of the services currently available.

The review makes five recommendations to be considered by NHS Commissioners and providers in Derbyshire. It is hoped that these

recommendations will lead to a more integrated and accessible chronic pain service for the people of Derbyshire.

The review report requests that the Derbyshire Health and Wellbeing Board use its influence with NHS services in Derbyshire to convene a steering group to oversee the implementation of the review's recommendations. The steering group should be time-limited and be representative of commissioning and provider organisations in Derbyshire, it will also be required to update the Council's Health Scrutiny Function on progress against the recommendations. This is an approach that was used on a previous scrutiny review of nutrition in the elderly and was well received by all organisations involved.

Recommendations

1. That the Shadow Health and Wellbeing Board receives and notes the final report of the Improvement and Scrutiny Review of Chronic Pain Services

2. That the Shadow Health and Wellbeing Board convene a multi-agency steering group to take forward the review recommendations.

Councillor Garry Purdy
Vice-Chairman, Improvement and Scrutiny Committee-People
Derbyshire County Council

Improvement and Scrutiny Committee – People

Improvement and Scrutiny Review

Chronic Pain Services in Derbyshire

January 2013

Final v1.3

"A great deal of work and effort have clearly gone into producing this report for which chronic pain suffers will be grateful to you and your team."

Mr D Woodward, Secretary for COPING Derbyshire

"The Chronic Pain Team in Derby broadly welcome the findings of the Scrutiny Committee's report. Chronic Pain has long been a "Cinderella speciality" that has not attracted attention commensurate with its prevalence within the community"

Mr A Searle, Lead Clinician, Pain Services Derby Hospitals NHS Foundation Trust

"I thought on the whole this was a very fair description of a complex situation and am heartened on behalf of our patients that interest is being shown in the topic"

Dr D Farquharson, Consultant in Anaesthesia and Lead Consultant Pain Medicine, Clinical Director, Directorate of Critical Care, Chesterfield Royal Hospital NHS Foundation Trust

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Introduction

I am pleased to present this report on the review of the management of chronic pain services in Derbyshire. I am very grateful for the support that we have received in undertaking the review from a wide range of people across the health services in and around Derbyshire, as well as the service users we have met.

Chronic Pain is something that I have first-hand experience of, so undertaking this review has been very interesting. I am indebted to the Pain Consultant who, in 2010, highlighted their concerns about chronic pain services from a national perspective. Their assistance, and provision of Hansard papers highlighting the national problem, led by Lord Luce, helped me put forward this review as an idea for the committee. I am therefore grateful to the Committee in agreeing to undertake this review.

There are elements of this review that echo the last review that I led on malnutrition in Derbyshire - both topics have not been seen as 'big issues' in the county, yet there is a plethora of reports and recommendations at a national level calling for improvements in services to be made particularly as they both have hidden 'knock-on' effects to the health and social care services including those in Derbyshire.

Also, as with the malnutrition review, we have found a lack of suitable data to help support our recommendations, so we have listened carefully to what the health professionals and service users have had to say. I hope that this review reflects those views.

The review has looked at other areas of the country and identified some very good pieces of work. Learning elements from these have been used in formulating the recommendations for Derbyshire. We have not simply tried to impose a model from somewhere else as we recognise that such an approach would not be to anyone's benefit.

We have made a number of recommendations which we hope will be taken forward and used to drive improvement in chronic pain services in Derbyshire. The current changing health and social care landscape should help in implementing these recommendations as clinicians will be at the heart of the decision making process. We recognise that finances are at a premium and so we have tried to make the recommendations apply to what already exists.

Councillor Garry Purdy
Vice-Chairman of the Improvement and Scrutiny Committee – People

Executive Summary and recommendations

Improvements must be made to chronic pain services in Derbyshire. This is despite the review finding that the services provided are of a good quality, and user satisfaction is also good for pain clinic services. Derbyshire is not alone, though in requiring improvement as highlighted in the recent National Pain Audit Final Report 2010-2012 (Dr Foster Research Ltd et al, 2012, pp. 8-9). This review has come to its judgement by looking at chronic pain services in Derbyshire and speaking and listening to:

- Commissioners of services;
- Providers of services; and perhaps most importantly
- Service users – those who live with/suffer from chronic pain.

The review has also looked at different models of delivering chronic pain services in other parts of the country to see what could be learnt from them and applied to Derbyshire where necessary.

Any improvements that are made need to be backed up by clear leadership and so it was helpful to the review that during the review process the Derbyshire Health and Wellbeing Strategy 2012-2015 was published and included a priority on promoting the independence of people with long-term conditions – of which chronic pain is one.

The review therefore requests that the Derbyshire Health and Wellbeing Board convene a steering group to oversee the implementation of the following recommendations:

Recommendations	
1.	**A chronic pain needs assessment should be undertaken in Derbyshire to determine the prevalence and need of chronic pain suffers. The results of which should be used to inform the planning/reconfiguration of services and ensure resources are being targeted at the right areas.**
2.	**Development and implementation of clear referral guidelines for GPs and other Primary Care Professionals.**
3.	**Improve the quality of public information to include details on signposting who can help, where to go, and on how to cope with living with chronic-pain – promotion of existing self-help guides e.g. The Pain Toolkit.**
4.	**Consideration should be given to the commissioning of community based services to reach more rural areas and vulnerable people subject to outcome of the needs assessment.**
5.	**Ensure that access to chronic pain services is supported by multi-disciplinary assessment team(s) and multi-disciplinary pain teams including physiotherapy and psychological therapy support.**

1. Setting the scene

1.1 Reason for the review

1.1.1 Chronic pain is a silent epidemic that can devastate people's lives (Fritchie, 2008, p. 1). It has no regard to age, gender, race etc. It brings with it not just physical pain but other consequences such as fatigue, inability to work and depression (Moore, 2011). There are an estimated 7.8million people in the UK suffering from chronic pain (Donaldson, 2009, p. 33) – 70% of which are under 60 years old. This is equivalent to 91,000 people in Derbyshire - across all ages.

1.1.2 There have been a number of reviews and reports at a national level calling for improvements in the management of chronic pain services. There have also been calls for improved patient involvement in designing services and ensuring there is clear and accessible information available to existing and potential service users/sufferers of chronic pain. It was only in February 2012 that chronic pain was recognised as a long-term condition in its own right by the then Minister of State for Care Services, the Rt Hon Paul Burstow MP (Hansard, 2012).

1.1.3 The purpose of this review, therefore, was to look at the current systems within Derbyshire for assessing, referring, treating and managing chronic pain. The review looked at the role of commissioners, providers of services, and sought the views of people with chronic pain.

1.1.4 The scoping report for the review set out three broad lines of inquiry to investigate the management of chronic pain in Derbyshire:

1. What is the current approach to pain management in Derbyshire?
2. How does this compare nationally with recognised good practice services and policies?
3. What are the service user's and health professional's views of the Derbyshire service?

1.1.5 Within the context of this review the definition of chronic pain is taken from the British Pain Society:

> *Chronic pain is continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery.* (The British Pain Society, 2008)

1.1.6 The following section provides some contextual information on chronic pain services at a national level before outlining the services available in Derbyshire and addressing the broad lines of inquiry behind this review.

1.2 The National picture

1.2.1 There have been numerous reports over the past few years that have attempted to highlight the need for improvements to chronic pain services in England and Wales. In 2000 the Clinical Standards Advisory Group (CSAG) reported on the state of services for patients with chronic and acute pain, making a number of recommendations to NHS Trusts and Health Authorities. These included reviewing provision in relation to need within an area; improving access to multi-disciplinary chronic pain teams; and ensuring reasonable access to chronic pain management programmes (Clinical Standards Advisory Group, 2000, p. 4).

1.2.2 Some improvements to services were made, but not enough at a national level and in 2007 the Chronic Pain Policy Coalition was formed and launched its manifesto to help improve the lives of people living with chronic pain. This stated that an effective approach to the management of chronic pain should comprise Education, Empowerment, Collaboration, Early Access, and Measurement i.e. including pain as a vital sign (Chronic Pain Policy Coalition, 2008).

1.2.3 In 2009, the then Chief Medical Officer, Sir Liam Donaldson, included an entire chapter of his 2008 Annual Report on pain (chronic and acute) and the need to improve pain management services nationally. In this report he highlighted the debilitating impact that chronic pain has on the life of an individual. The limitations of existing services and infrastructures to cope with demand and support individuals to manage their conditions were also criticised. Nine action points were recommended to health professionals including improvements to training for health professionals; development of a model pain service or pathway of care; improved data collection and reporting for chronic pain.

1.2.4 The first ever English Pain Summit was held in London in 2011 bringing together representatives from the British Pain Society, Chronic Policy Coalition, Faculty of Pain Medicine and Royal College of General Practitioners. Out of this summit came another series of recommendations aimed at supporting a principle that: "…*people with chronic pain have a right to the safest, most effective treatments and services, including structured self-management support, no matter where they live"* (Policy Connect, 2012, p. 7).

1.2.5 In October 2012 the British Pain Society published a Pain Pathway for the 'Initial assessment and early management of pain'. The first in a series of five patient pathways created by the British Pain Society and based upon National Institute of Clinical Excellence (NICE) guidelines, scientific evidence and other published guidelines. The pathways have been designed to support care and commissioning.

1.2.6 In December 2012, the final report of the first ever National Pain Audit was published. The audit, funded by the Healthcare Quality Improvement Partnership, was undertaken over three years from 2010 to 2012 with the aim of both improving NHS services for people with chronic pain whilst establishing a national data collection system that will enable services to monitor performance and share data nationally. This report was an indirect response to the 2000 CSAG report and, again, makes a number of recommendations to health and social care services to improve chronic pain services – which bodies such as the British Pain Society are helping to implement e.g. through the pain pathways.

1.2.7 There are also a number of knock-on effects for people suffering from chronic pain. These are more likely to occur if that person does not get access to suitable support in a timely manner. These effects can include depression, loss of employment, loss of self-identity, and social isolation to name a few. The recent National Pain Audit highlighted that people living with chronic pain conditions endure a very low quality of life when compared to all health conditions in the UK (Dr Foster Research Ltd et al, 2012, p. 40). Chronic pain is not a purely medical issue, both the National Pain Audit and the Pain Consultants and chronic pain sufferers we have spoken to as part of this review have highlighted a greater coordination between health and social care is needed to help people to live with their conditions.

1.2.8 In summary, at a national level there have been a lot of repeated requests from various campaign groups and professional bodies for improvements to be made in the services available to people with chronic pain. Recurring themes have included:

- Improving access, quality and coordination of services;
- Improving data quality;
- Making timely referrals to a service;
- Raising awareness of chronic pain amongst health professionals;
- Supporting people to self-manage their condition.

1.3 The Local picture

1.3.1 There are a number of services available for people with chronic pain at the local level – the more common are pain management services at:

- Chesterfield Royal Hospital NHS Foundation Trust
- Derby Hospitals NHS Foundation Trust
- Nottingham University Teaching Hospitals NHS Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust

Other pain management related services are provided by Derbyshire Community Health Services NHS Trust and Staffordshire and Stoke on Trent Partnership NHS Trust.

1.3.2 ***There is also, as at the national level, a lack of data on the prevalence of chronic pain in Derbyshire***. The only figures available relate to the number of patients referred to a pain service with the provider organisations. There is also, no requirement to report specifically to commissioners on waiting times. It should, however, be noted that patient experience of using the services was monitored by the providers the review team spoke to.

1.3.3 It should also be noted that the shadow Health and Wellbeing Board for Derbyshire included, as one of its priorities for the Health and Wellbeing Strategy 2012-2015, the following:

Promote the independence of people living with long term conditions and their carers – *because helping people to manage their condition better can significantly improve quality of life and reduce the need for hospital or emergency care.*

1.3.4 With the Department of Health recently acknowledging that chronic pain is a long-term condition in its own right it is hoped, through the recommendations of this review and the priority of the Health and Wellbeing Board, that chronic pain services in Derbyshire can be improved.

1.4 Review process

1.4.1 A scoping report, outlining the remit of the review, was agreed by the Improvement and Scrutiny Committee-People in June 2012, and a working group of Members was established to conduct the majority of the review work on the Committee's behalf.

1.4.2 Between September and December, the review working group met with representatives and received information from the following organisations:

- COPING – Derbyshire Chronic Pain Support Group

- Chesterfield Royal Hospital NHS Foundation Trust
- Derby Royal Hospitals NHS Foundation Trust
- Derbyshire Community Health Services NHS Trust
- North Derbyshire Clinical Commissioning Group
- Southern Derbyshire Clinical Commissioning Group
- Staffordshire and Stoke on Trent Partnership NHS Trust

1.4.3 In looking at good practice elsewhere in the country, the review working group also spoke with and received information from:

- Dr Chris Barker, Clinical Director for NHS Sefton's Chronic Pain Community Services;
- Val Conway, Clinical Lead-Consultant Nurse with the Community Chronic Pain service at Kent Community Health NHS Trust;
- Dr Ollie Hart, Sloan Medical Practice, Sheffield – for information relating to Sheffield Health Trainers and Sheffield Pain Pathways.

The review was also complimented by a desktop research exercise.

2. Findings from the review

The scoping report for this review identified three broad lines of inquiry – this section details the findings of the review to those three questions.

2.1 What is the current approach to pain management in Derbyshire?

2.1.1 In order for the review team to sufficiently answer this line of inquiry, it had to understand what services are available for people living with chronic pain in Derbyshire, and whether these services are part of a coordinated county-wide service.

2.1.2 The review established that the main services provided in Derbyshire were the two outpatient pain clinics provided by Chesterfield Royal and Derby Hospitals NHS Foundation Trusts. These services are commissioned by the local Primary Care Trust (PCT). Some people may also access pain services outside of Derbyshire such as at Stockport or Tameside Hospitals – but these services are not commissioned by the local PCT. The only service that is provided out of County and is partly commissioned by the PCT is a community chronic pain service in East Staffordshire.

2.1.3 Chesterfield Royal Hospital provides a pain management and rehabilitation service which seeks to integrate with other departments, where necessary for the patient, such as physiotherapy, psychology (through a service level agreement with the Community Health Psychology Service which includes a pain management programme), hydrotherapy, MRI scanning etc. A patient's treatment will be based on their referral information and a diagnostic from the Consultant. The majority of referrals are primary (via GP) and inter-hospital ones with a growing number of people self-referring to the service. The waiting time, at the time of the review, between referral and first appointment is three to four weeks.

2.1.4 Derby Hospitals provide a multi-disciplinary pain management service. Referrals to the service are made in similar fashion as with Chesterfield, but each referral is assessed by a multi-disciplinary assessment team, which determines the best pathway of care for that patient. As with Chesterfield, Derby includes psychological support within its services. The waiting times from referral to first appointment were slightly longer at Derby, 11 weeks, at the time the review took place, though this was in part due to a Consultant post vacancy. The waiting time for accessing psychological support was six weeks. It was also noted that the Trust have struggled to engage with commissioners in the past in trying to improve the accessibility and provision of pain services.

2.1.5 Table 1 below shows the number of patients seen by the two pain clinics over the last financial year. In speaking to lead Consultants at both Chesterfield and Derby, it was recognised that the pain clinics have accommodated rising demand and tightening service specifications with static resources as part of the wider NHS efficiency agenda. This has put a strain on the delivery of the current system that requires clearer commissioning intentions to effectively resolve. The main area of concern was ensuring sufficient time could be given to existing patients for follow-up appointments whilst meeting demand from increasing numbers of new referrals. It should also be noted that there will be a number of patients in

Derbyshire accessing other primary or secondary services related to a pain condition that will not be recorded in these figures, along with those who live with a condition and access no services at all.

Table 1: Commissioned Activity 2011-12

	Derby Hospitals	Chesterfield
Day Care	*678*	*1,496*
Out Patient (1st appointment)	*1,144*	*690*
Out Patient (follow-up)	*2,653*	*2,286*
Out Patient Procedure		*650*
Elective		*26*
Non Face to Face Outpatient		*158*
Total	***4,475***	***5,306***

(Source: North Derbyshire and Southern Derbyshire Clinical Commissioning Groups)

2.1.6 As previously stated, there are other services available to people suffering with chronic pain other than the pain clinics. Derbyshire Community Health Services NHS Trust provides a number of services that link into the pain management agenda:

- Health Psychology Service – this has a service level agreement with Chesterfield Royal Hospital to provide a psychology based service for patients suffering from chronic pain – during 2011-12 the service received approximately 100 patients via this referral route. An additional 20 patients came from other departments at Chesterfield Royal, and a further 50 were direct referrals from Primary Care services e.g. GPs.
- The Trust is also commissioned to provide Pain Management Programmes (group based therapy) in Chesterfield and North East Derbyshire – approximately 100 people during 2011-12 were seen by these services.
- A group for people with pain also operates in the High Peak and North Dales and is delivered by an Occupational Therapist and Physiotherapist;
- The Trust also provides a small psychoeducational service called 'Living with Long Term Conditions Programme' which currently provides advice to people living with any long term condition to support and educate them into self-managing and improving their wellbeing;
- The Trust is also in the process of developing an Integrated Clinical Assessment Treatment Services (ICATS) for planned care and outpatient services – with initial work focussed on patients with musculoskeletal conditions. The aim of the services is to provide them with earlier access to assessment, diagnostic and management services. Such an approach should reduce the number of unnecessary referrals into secondary care. The project also aims to address inequity of service provision through identifying where gaps exist in provision of community based services. This would ensure that patients are being referred to the right services at the right time. Section 2.2 considers a similar model already in operation in East Kent.

2.1.7 Another service available for people in Derbyshire living with chronic pain, particularly those in the southern part of the county, is a community based chronic pain management service provided by Staffordshire and Stoke on Trent Partnership NHS Trust:

- The service was commissioned jointly in 2011 by Staffordshire, Derbyshire and Leicestershire & Rutland PCTs;
- This is a multi-disciplinary community based service (currently provided from Hill Street Health and Wellbeing Centre, Stapenhill, Burton) providing assessment and management of chronic pain. The team includes a Pain Consultant, Nurse, Physiotherapist, Psychologist and Pharmacist;

- It is available to patients living in Derbyshire (and Derby City) though patients have to be referred into the service via a professional (e.g. GP, Clinical Psychologist, secondary care);
- The service has received around 130 patients from Derbyshire in its first year – with average waiting time from referral to first appointment of six weeks. With a similar waiting time for accessing a Pain Consultant or Psychologist.

2.1.8 In speaking with providers of the services it is clear that there is currently no coordinated approach to pain management in Derbyshire across the whole health-care system. This is not to say that the quality of the services available is not adequate – but that the manner in which services have 'evolved' has not been well managed at a county level. The Consultants at both Chesterfield and Derby echoed this view by suggesting that pain services are 'Cinderella' services yet, as Sir Liam Donaldson stated in his report, back pain alone costs the UK economy an estimated £12.3billion per year and pain prescriptions cost the NHS £584million (Donaldson, 2009, pp. 33,34).

2.1.9 The review was unable to find clear evidence of any referral guidelines or service pathways for either health professionals or people living with chronic pain to help them understand where to go to discuss their condition, though the lack of any such guidelines at a national level has not helped this situation. COPING reported that they have been providing assistance to people who contact their group on navigating pathways of care.

2.2 How does this compare nationally with recognised good practice services and policies?

2.2.1 In determining what is considered good practice, the review identified some 'advocates' of chronic pain management services through research. Three key individuals responded to these requests. They all had some involvement in different approaches to helping individuals cope with living with chronic pain. They were:

- Dr Chris Barker, Clinical Director for NHS Sefton's Chronic Pain Community Services;
- Val Conway, Clinical Lead-Consultant Nurse with the Community Chronic Pain service at Kent Community Health NHS Trust;
- Dr Ollie Hart, Sloan Medical Practice, Sheffield.

The following provides an overview of these services.

NHS Sefton - Community Pain Service

- The Community Pain Service offers full diagnostic assessment and evidence based treatment for patients with sub-acute, chronic and challenging acute pain conditions.
- Referrals come via patient's GP or Consultant if they have come via secondary care.
- Triage of referrals takes place upon receipt of referral with subsequent face to face clinical assessment and treatment as appropriate. New patient referral appointment with the GP Specialist will last approximately 30 minutes – this comprises diagnostic and psycho-social evaluation.
- The team is multidisciplinary comprising a General Practitioner Specialist in Pain Medicine, Pain Physiotherapist, Specialist Pharmacist, and Clinical Psychologist, Specialist Pain Nurse, Physiotherapist and Occupational Therapist and two medical secretaries.
- The service manages approximately 85% of all referrals with remainder referred on to more specialist intervention based services;
- Patients can be discharged from the service – any that are can re-enter the service without a referral within the first 12 months, after this period a referral letter from GP would be required i.e. treated as new patient again.
- The service also operates a patient volunteer group whereby existing/former patients provide a support and 'champion' role for fellow patients.
- Commissioning model is based on a long-term conditions framework similar to other services such as diabetes.
- Commissioning of service has been supported by a Public Health Needs Assessment which surveyed chronic pain sufferers and people in GP practices to determine the level of need in the area.

Kent Community Health NHS Trust – Community Chronic Pain Service

- Kent Community Health provides an Integrated Clinical Assessment and Treatment Service (ICATS) for people suffering from chronic pain;
- The service operates a Single Point of Access model for all chronic pain referrals in the area.
- All new referrals into the service are paper triaged by either senior community clinicians or hospital anaesthetists on a rota basis (there is an agreed referral criteria – see Appendix 1)
- The remit of the service is to:
  - Support patients to achieve long term self-management and reduce dependence on healthcare systems;
  - Support referrers with help and advice through email / telephone support;
  - The Hospital Pain service specialises in more interventional techniques, such as specialist injections and patients whose care is inextricably linked with other hospital services, e.g. orthopaedics, rheumatology etc;
- The Community Chronic Pain Service provides a moderate, long term, self-management approach
- Community service receives 400-500 new referrals each month (commissioned for 500). Of those referrals approximately 60% will remain within the community service and the remaining 40% will be directed to the acute service
- The service discharges similar number of patients per month as it receives in referrals. Discharge does not mean that a patient is 'cured' of chronic pain, but that they are able to self-manage their condition effectively.
- Community service operates a 12 month open door policy for patients who have been discharged – 82% patients sustain discharge, 9% directly refer back into service and 9% referred via GP after 12 month period.
- Waiting times for community service are 0-4 weeks and 9-10 weeks for hospital.
- Patient satisfaction with community service is high and there are a number of methods for capturing this.
- Community service has helped to reduce duplicate referrals and provide GPs with clear pathway for referring patients.
- Work with pharmacy services has reduced the analgesic prescribing budget

2.2.2 Both of the services provided in Sefton and Kent were actively supported by the whole healthcare system in that commissioners and providers came together to improve the services for the patient. When discussing the Kent model, Val Conway was keen to stress the importance of looking at what services already exist and matching the skills of professionals to the right services rather than reinventing the wheel. The use of peer support in the Sefton model was encouraging – Dr Barker pointed out how it helps new people coming into a service to not only learn about what is available but also see that they are not alone.

2.2.3 With these two examples, there are some clear comparisons that can be drawn with the Derbyshire services. All of the services use a team comprising different skilled health professionals. All services use some form of triaging system, though with Sefton and Kent it is community based with input from the acute (hospital) service. Having a clear point of contact for making referrals is important and echoes the original recommendations from the CSAG report in 2000 around accessibility.

2.2.4 The use of a Public Health Need Assessment in the Sefton case was a helpful example of improving locally available data to inform the planning and delivery of services. This too has been a criticism nationally in relation to the management of chronic pain services. Determining the differing needs of people living with chronic pain in Derbyshire is vital in helping to improve the existing level of service.

Recommendation	
1.	**A chronic pain needs assessment must be undertaken in Derbyshire to determine the prevalence and need of chronic pain suffers. The results of which should be used to inform the planning/reconfiguration of services and ensure resources are being targeted at the right areas.**

2.2.5 Managing chronic pain, however, is not just about getting a patient to see the right person in a timely manner. It is also about helping to support the individual to learn more about the long-term effects of living with such a condition. In Sheffield, the PCT piloted a Health Trainer programme during 2011 to help support individuals with chronic pain in their own community (see also case study below). This was another example of needs analysis identifying areas for improvement.

NHS Sheffield – Health Trainers Chronic Pain Programme

- 2011 – Sheffield health needs assessment highlighted a burden on services from chronic pain sufferers;
- Sheffield Community Chronic Pain programme developed with funding from Department of Health Transforming Community Services award – piloted a community based Health Trainer programme from July 2011-March 2012;
- Aim of pilot to explore whether community-based programme may be more effective in enabling self-management than traditional secondary-care services;
- Health Trainers worked with chronic pain clients to self-manage their condition. Health Trainers were people who lived/worked in community and work across primary care and community settings – therefore have good knowledge of the area in which a client resides;
- Individuals were identified through GPs and referred onto Health Trainers programme.
- Clients involved in the programme showed that people with chronic pain go through stages related to their condition, experiencing denial, a sense of loss, and uncertainty about their capacity to manage. All participants mentioned experiences of isolation and some cases of depression, all due to loss of the prior functioning.
- The Health Trainers provided time for clients to develop understanding of their chronic pain by developing rapport with them, helping them to accept their condition, and providing opportunities for them to move toward active management;
- Clients were asked to complete a wellbeing questionnaire at the beginning and end of the programme. Of those that completed the programme improvements were cited in their self-efficacy (8%), general health (35%), and wellbeing (53%).
- Clients mentioned life management goals that focussed on managing finances, environmental restructuring, strategies for gaining family support, and learning to negotiate systems so that they could better access services and activities were the most valuable outcomes from participating in the programme. This differs from outcomes normally associated with health trainer programmes as they tend to be lifestyle changes such as diet, smoking, and physical activity.
- The programme evaluation report suggested the outcomes achieved lay a good foundation for people wanting to achieve good health outcomes – essentially a lower tier of outcomes not previously considered. Though it was not possible to quantify the overall cost effectiveness of this pilot service.

2.2.6 Developing services based on needs and providing support to patients within the services is important as these examples have shown. However, there is no use in developing and improving services if the patients (and potential patients) and Health Professionals are not aware of the services available and how to access them. Another project initiated in Sheffield has sought to address this issue through the development of a web-based information portal – www.sheffieldbackpain.com. This service was developed as part of improvements to the local pathway for people suffering from back pain in Sheffield. The website provides a web-based resource for GPs on referral pathways etc., whilst providing promotional and educational information to the public and patients.

2.2.7 A similar type of programme, albeit on a small scale, currently exists in Derbyshire – the 'Living with Long Term Conditions' programme operated by Derbyshire Community Health Services NHS Trust. However, this is a more generic psychoeducational programme that looks at all types of long-term condition, and is not specific to chronic pain. The NHS Sheffield example is slightly different to other Health Trainer programmes in the Country, including Derbyshire, as it is provided directly through the voluntary/community sector. However, it did have benefits to those using the service and highlights that chronic pain is not just a purely medical issue – effective management encompasses the broader health and social care service areas.

2.2.8 In respect of this review, the services being delivered in Derbyshire appear to be similar to those provided elsewhere in the country. However, the differences occur in the management and coordination of those services at a more strategic level and ensuring equitable access for everyone.

2.3 What is the service user and health professionals view of the Derbyshire service?

2.3.1 Gaining the views of people living with chronic pain and accessing services in Derbyshire was important to give this review some credibility. The difficulty the review working group found was identifying any patient support groups for people suffering with chronic pain. Only one such group was identified during the review process, COPING (COPING, 2012), although others have since been highlighted to the review working group. The review team met with members of the group in September 2012 and heard first hand of the difficulties people had faced in getting suitable treatment and support for their condition. The following comments are from members of the COPING group who wished to share their views with the review.

Chris felt that more needed to be done in relation to medication in terms of the information given to individuals during any pain management process:

"Not enough information was given to me when I was prescribed with medication so I didn't always know what it was for; let alone what the side effects were".

Gwyneth was concerned by the lack of help/support available to help people make informed decisions about what course of treatment they should follow e.g. surgery, pain relieving injections etc. The timescales for seeing a Pain Consultant were too long and had an effect on the mental wellbeing of some people. She also felt that:

"…there needs to be a more joined up approach between different [medical] *disciplines* [within a hospital setting] *to combat some of the mental issues such as depression experienced by chronic pain suffers whilst they wait for treatment".*

2.3.2 Concerns raised by the COPING group members were not just about the lack of information, accessibility and timeliness of the service. One member, Derek, was very keen to point out that the apparent lack of knowledge on chronic pain among some GPs he had seen over many years had had the effect of worsening his condition. He was also concerned about the lack of community based-support services:

"An individual's medical history isn't taken into account [by GPs] *where chronic pain is concerned and can have damaging consequences. We have had a number of people contact COPING who have been close to suicide because they could no longer cope and did not have strong enough support around them"*

2.3.3 Whilst the group were keen to highlight areas where services could be better, they were also keen to stress that, in most cases once they had received a service it had made a difference to them – though not always for the long-term. The review working group asked members of

COPING a series of questions based on the Essence of Care 2010 Benchmarks[1] for the Prevention and Management of Pain to determine their overall view of the services in Derbyshire and whether or not they felt services were 'patient-focussed':

Q. Have you received timely and appropriate access to services to manage pain?
- Whole group response was 'no'.

Q. Do you feel you are an active partner in the decisions made about your pain management?
- Whole group response was 'no'. Some group members commented that because they have no medical knowledge they put their trust in the hands of the professionals – but if the level of care they receive is not appropriate they are not knowledgeable enough to challenge.

Q. Do you have an ongoing, comprehensive assessment of your pain?
- Whole group response was 'no'.

Q. Is the care you receive for your pain planned, evaluated and revised on a regular basis? If so, are you actively involved with this?
- Whole group response was 'no'. There was an element of this for those that went through a Pain Management Programme.

Q. Do you have the knowledge and skills to understand how best to manage pain?
- The group felt that chronic pain was something you have to learn to live with and that the NHS locally had not been effective in its support to sufferers – hence the establishment of this group.

Q. Are you enabled to manage your pain when you wish to/as appropriate to do so?
- Those that had been through the Pain Management Programme felt that they had.

Q. Do you feel that there is good partnership working between the agencies that assist in your pain management?
- Whole group response was 'no'. It was not felt that different agencies, let alone different departments within the Hospital [Derby] communicated with each other well.

13. Are you involved in any reviews by the commissioners and/or providers of these services?
- Whole group response was 'no'

2.3.4 The response to these questions was not unexpected, but was disappointing nonetheless to the working group.

2.3.5 The service user view was very helpful in providing a steer on areas for improvement, though the review working group recognised that the views supplied may not necessarily be representative of everyone in Derbyshire who accesses chronic pain related services.

2.3.6 In the meetings with representatives from service providers in Derbyshire the review working group asked for their views on the problem areas facing their services – these were summarised as:
- Access for people in isolated/rural communities is poor;
- Services are 'bottlenecking' due to an increase in referrals outweighing the provision of available services;

[1] The Essence of Care Benchmarks were introduced by the Department of Health in 2001 and revised in 2010. They are a set of tools designed to help practitioners take a patient focussed look at their service.

- Access to psychological services is inequitable with a historical trend of services only being available in northern parts of the county;
- Psychological services currently available tend to focus on group-based work – there is a stigma attached to using psychological services and particularly where offered as a group based service (though majority of community based services are one-to-one);
- GPs are not always aware of the service available for their patients;
- There has been a lack of interest, historically, from the various Commissioning bodies responsible for health services in Derbyshire over the years;
- There is a poor understanding and lack of signposting to lower level support services that would assist people in living with chronic pain.

2.3.7 It was clear to the review working group that both service users and providers felt that more needs to be done to make existing services better in Derbyshire. Chronic pain is a long-term condition from which very few people will fully recover. As with other long-term conditions, services should be set up where ever possible to help people get to a point where they need minimal contact with professional services, rather than rely on them.

Recommendations	
2.	**Development and implementation of clear referral guidelines for GPs and other Primary Care Professionals.**
3.	**Improve the quality of public information to include details on signposting who can help, where to go, and on how to cope with living with chronic-pain – promotion of existing self-help guides e.g. The Pain Toolkit.**
4.	**Consideration should be given to the commissioning of community based services to reach more rural areas and vulnerable people subject to outcome of the needs assessment.**
5.	**Ensure that access to chronic pain services is supported by multi-disciplinary assessment team(s) and multi-disciplinary pain teams including physiotherapy and psychological therapy support.**

3.1 Conclusions

3.1.1 **The management of chronic pain services in Derbyshire needs to improve** – this is not just the view of the review working group but of the service users and professionals involved in delivering services in Derbyshire. Section 1 highlighted the numerous reports calling for changes in chronic pain services at a national level and it appears that the issues arising from these, summarised at the end of section 1.2, equally apply to Derbyshire:

- Improving access, quality and coordination of services;
- Improving data quality;
- Making timely referrals to a service;
- Raising awareness of chronic pain amongst health professionals;
- Supporting people to self-manage their condition.

3.1.2 In order to improve access, quality and coordination of services there needs to be clear leadership. The Derbyshire Health and Wellbeing Board, currently in shadow form, will have the role of shaping the health and social care services for Derbyshire in the coming years from April 2013. As stated in the opening section – one of the priorities for the Board is to '*Promote the independence of people living with long term conditions and their carers*'. This is also a priority within the NHS Quality Outcomes Framework for 2013-14.

3.1.3 Improving services, whilst requiring leadership, will also require improved working relations between commissioners and providers. The move from one Primary Care Trust to more localised Clinical Commissioning Groups should assist in this process as closer working relations could emerge when clinicians are more closely involved in the decision making process.

3.1.4 It will be difficult, however, to make improvements if the evidence is not there to support it. The review working group was not able to find any chronic pain prevalence or needs data for Derbyshire, yet it was heartened by the work undertaken in other areas of the country which was used to support improvements in services. This is a role that the County Council's Public Health function should consider more closely.

3.1.5 Raising the awareness of chronic pain is a job for everyone – though more clearly defined referral guidelines would be useful. The British Pain Society is developing general referral guidelines which could assist local services in Derbyshire. Some form of public facing promotion would also help people to be aware of what to do and where to go if they think they are suffering from chronic pain.

3.2 Recommendations

3.2.1 The review therefore requests that the Derbyshire Health and Wellbeing Board convene a steering group to oversee the implementation of the following recommendations:

Recommendations	
1.	**A chronic pain needs assessment must be undertaken in Derbyshire to determine the prevalence and need of chronic pain suffers. The results of which should be used to inform the planning/reconfiguration of services and ensure resources are being targeted at the right areas.**
2.	**Development and implementation of clear referral guidelines for GPs and other Primary Care Professionals.**
3.	**Improve the quality of public information to include details on signposting who can help, where to go, and on how to cope with living with chronic-pain – promotion of existing self-help guides e.g. The Pain Toolkit.**
4.	**Consideration should be given to the commissioning of community based services to reach more rural areas and vulnerable people subject to outcome of the needs assessment.**
5.	**Ensure that access to chronic pain services is supported by multi-disciplinary assessment team(s) and multi-disciplinary pain teams including physiotherapy and psychological therapy support.**

3.2.2 One possible mechanism for implementing these recommendations would be for the Derbyshire based Clinical Commissioning Groups to consider developing a joint chronic pain service specification to be delivered through an initiative, such as Any Qualified Provider Programme, to improve the accessibility of services. However, it is recognised that any such specification would need to ensure that services are joined up rather than fragmented. This would also involve service providers and users in its development and be brought to the Committee for consultation as it would constitute a service reconfiguration.

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Appendix 1

Referral Guidelines for Chronic Pain Management in East Kent

East Kent Hospitals University NHS
NHS Foundation Trust

Kent Community Health NHS
NHS Trust

Referral Guidelines for Chronic Pain Management in East Kent

Pain services in East Kent consist of a comprehensive multidisciplinary service within primary care and an interventional service within secondary care to support patients to develop self management strategies, enhance their quality of life and reduce dependency on healthcare services.

Referral Criteria

(Please see overleaf for explanatory notes)

- Have had pain for more than 3-6 months
- Have tried simple analgesic management
- Have had investigations to rule out treatable pathology
- No “red flags” (direct referral to secondary care)
- Referrals are made through Choose and Book whenever possible
- Referral documentation is completed and attached

Exclusions

- Severe unstable psychiatric illness: Certain personality disorders, severe untreated depression
- Current substance abusers not undergoing addiction management
- Patients currently waiting for surgical intervention

Your referral should include the following information:

- Diagnosis and brief history of pain
- Details of current medications
- Treatments tried
- Relevant investigations and results
- Psychosocial history, if appropriate
- Any past psychiatric history
- Details of any previous pain clinic referrals
- Patients’ and referrers’ expectations

CRITERIA	Explanatory Notes
Have had pain for more than 3-6 months	This is in line with accepted definition of "chronic pain"
Have tried simple analgesic management	Regular paracetamol, NSAIDS (where appropriate) Tricylics Anticonvulsants for neuropathic pain as indicated by local guidelines
Have had investigations to rule out treatable pathology	Acceptance and development of self-management strategies is impeded when patients are expecting a solution or cure for their pain
No "red flags" (direct referral to secondary care)	Chronic Pain is a routine service. Referral to assessment times – up to 4 weeks. Patients requiring urgent attention should be referred to the appropriate clinical discipline in secondary care
Referrals are made through Choose and Book whenever possible	This allows timely triaging and into the correct service area
Referral documentation is completed and attached	You have a comprehensive knowledge of your patient. This information will help us triage the referral appropriately and allocate your patient to the most appropriate clinician on a timely basis
EXCLUSIONS:	
Severe unstable psychiatric illness: certain personality disorders, severe untreated depression	This would pose a barrier to the methods used in chronic pain management and prevents the patient from achieving a successful outcome
Current substance abusers not undergoing addiction management	It is recognised that these patients are unable to engage in pain management

Contact details for Chronic Pain Referral Point (East Kent)
St Augustine's Business Centre
125 Canterbury Road
Westgate-on-Sea
Kent. CT8 8NL .
Tel : 01843 830172/830173 Fax: 01843 830171
Referrals can be made via Choose and Book (indirectly bookable) to Chronic Pain Referral Point (East Kent).

For help and advice email to: chronicpainicats@nhs.net.
We will reply within 24 hrs to your questions. Alternatively, please see our medicines guidelines http://www.painmedguidelines.co.uk/

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Agenda Item No. 9

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

21 March 2013

HEALTH & WELLBEING ROUND-UP REPORT

Purpose of the report

To provide the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

Round-Up

Healthier Together

In order to deliver the best possible joined up health and care, NHS Greater Manchester, alongside partners in the public sector, is looking to undertake a radical improvement of their Health and Social Care System. To support this system overhaul, Healthier Together reviews Greater Manchester's existing health and care services. One of the key areas of focus of the review is the way that the hospital system works. Healthier Together also reviews community services and primary care and considers the vital relationship with social care and local authority partners.

The full report alongside a public discussion document can be viewed at: http://www.derbyshirepartnership.gov.uk/thematic_partnerships/health_wellbeing/meetings/

For further information please contact Elaine Michel, Director of Public Health, DCC: elaine.michel@derbyshire.gov.uk

Health and Wellbeing Summit

The Derbyshire Health Summit was held on Tuesday 5 March 2013 and was attended by over 180 individuals representing around 100 organisations. The event provided the opportunity for stakeholders to hear about the NHS Reforms in Derbyshire, Public Health Transition, HealthWatch Derbyshire, the Clinical Commissioning Group's Perspective and 21st Century Healthcare.

The event included a Question and Answer session for delegates. The panel answered some of the questions on the day, but did not have enough time to answer all of the questions. Answers to the questions are currently being compiled and will be sent to delegates soon.

The presentations are available to view at:
http://www.derbyshirepartnership.gov.uk/thematic_partnerships/health_wellbeing/stakeholder_engagement/march2013/

For further information please contact Jude Wildgoose, Policy Manager, DCC: judith.wildgoose@derbyshire.gov.uk

The Francis Report

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on the 6th February 2013. The report details the neglect and suffering of patients, primarily caused by a serious failure on the part of the Mid Staffordshire NHS Foundation Trust.

It sets out various recommendations for preventing similar failures elsewhere such as the fostering of a culture which puts the patient first, developing a shared set of values as well as ensuring openness, transparency and accountability for all levels of the organisation. It is also suggested that all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of the report and decide how to apply them to their own work.

A more detailed report will be provided at the next Health and Wellbeing Board meeting. The full report can be viewed at:
http://www.midstaffspublicinquiry.com/

For further information please contact Elaine Michel, Director of Public Health, DCC: elaine.michel@derbyshire.gov.uk

East Midlands Ambulance Service Update (EMAS)

The EMAS Estates strategy 'Being the Best' went out for formal consultation from 17th September 2012 to 17th December 2012. The consultation period was extended and ended on 31st December 2012.

The EMAS executive team attended a variety of meetings on request to present the consultation options and proposals. A series of three further stakeholders events were held in Leicestershire, Lincolnshire and Derbyshire in the first two weeks in January with invitations sent to attendees from Acute Trusts, GP's, Patients, CCG's, EMAS Staff and Union Representatives and LINks members. Stakeholders were asked to consider criteria and weight and score estate configuration options.

EMAS currently have 66 ambulance bases and the proposed options range from 'no change' to moving to having between 13-23 'hubs' and up to 118 'community ambulance points' (i.e. deployment locations). The proposed options have varying benefits for improving efficiency, performance

improvement and operational effectiveness. The associated consultation documents are available on the EMAS website http://www.emas.nhs.uk/get-involved/being-the-best-consultation/

Feedback from the consultation and the results of the stakeholder events are being collated into an Estates Business Case which will be presented at EMAS Trust Board meeting in March.

For further information please contact Rakesh Marwaha, Chief Operating Officer, Erewash CCG: rakesh.marwaha@derbyshirepct.nhs.uk

HealthWatch Update

From April 1st 2013, HealthWatch Derbyshire will take on its responsibility as the "new, independent consumer champion for health and social care".

HealthWatch Derbyshire is being set up as a Company Limited by Guarantee with Charitable status. The Executive Board now has eight out of its planned twelve members. Further targeted recruitment will be initiated shortly for the additional four members. Agreement has been reached for the existing LINk staff to be transferred to HealthWatch Derbyshire and premises for the new organisation have been secured in Milford.

HealthWatch Derbyshire is now preparing its business plan which will identify in detail how it will fulfil its role and functions. This will emphasise supporting rather than supplanting existing local voluntary and community sector organisations that work with the local NHS and Adult Social Care.

For further information please contact Colin Selbie, Group Manager, Contracting & Compliance, DCC: colin.selbie@derbyshire.gov.uk