Shadow Derbyshire Health and Wellbeing Board

29 November 2012
10.00am, Committee Room 1, County Hall, Matlock

A G E N D A

1. Introductions and Apologies for Absence

2. Minutes of the last meeting held on 27 September 2012

3. Derbyshire CCGs' Commissioning Strategies – CCG Leads
   - North Derbyshire – Dr David Collins
   - Southern Derbyshire – Andy Layzell
   - Hardwick Health – Colin Newman
   - Tameside and Glossop – Dr Alan Dow
   - Erewash – Dr Marcus Henn

4. East Midlands Ambulance Service Consultation (Verbal Report) – David Lowe

5. Winterbourne View Report – Bill Robertson

6. Adult Care Board Terms of Reference – Bill Robertson

7. Health Needs of Veterans – David Lowe

8. Health and Wellbeing Round-up report – David Lowe

9. Date of Next Meeting – 10am 24 January 2013, Committee Room 4

10. Any other Business

MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 27 September 2012 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 A Dow	Tameside & Glossop Shadow CCG
Dr M Henn	Erewash Shadow CCG
Councillor C W Jones	Derbyshire County Council
B Laurence	Derbyshire County Council
Councillor B Lewis	Derbyshire County Council
D Lowe	Derbyshire County Council
Dr A Mott	Southern Derbyshire Shadow CCG
J Pendleton	North Derbyshire Shadow CCG
B Robertson	Derbyshire County Council
I Thomas	Derbyshire County Council
Councillor Ms A Western	Derbyshire County Council
Councillor R J Wheeler	South Derbyshire District Council

Also in Attendance – J Cox (Derbyshire County Council), J Dosanjh (Derbyshire LINk), Councillor S J Ellis (Derbyshire County Council), S Hobbs (Derbyshire County Council), A Pritchard (NHS Derbyshire County), G Spencer (Derbyshire County Council), M Stafford-Wood (Derbyshire County Council)

Apologies for absence were submitted on behalf of Dr D Collins, A Layzell, Dr S Lloyd, Councillor P Makin, and T Thompson

43/12 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 26 July 2012 be confirmed as a correct record.

44/12 **DRAFT HEALTH AND WELLBEING STRATEGY FOR DERBYSHIRE: CONSULTATION RESULTS AND DEVELOPMENT OF STRATEGY** The three month consultation on the draft Health and Wellbeing Strategy for Derbyshire had ended on 2 September 2012. Over 200 questionnaires had been returned, and the responses indicated a strong level of support for the strategy and the proposed actions for each high-level priority. There had also been a range of suggestions on how the strategy could be improved. A summary of the survey responses and comments made, along with a list of responding organisations, was presented. An explanation was also given of how the strategy had been changed in response to the comments made.

Some of the common cross-cutting themes to emerge were highlighted:-

- The need for greater recognition of the value of the contribution made by partners and their role in shaping and delivering the strategy
- The need for more detail about how inequalities would be reduced including the importance of balancing countywide actions with locality-based needs assessments and planning
- More about how the strategy would make a difference and the availability of resources to deliver
- The need for greater integration of services
- More emphasis needed on preventive aspects of the strategy

These had now been addressed more explicitly throughout the strategy. In addition, a 'next steps' section had been included. The revised strategy had been circulated to the Board for comment and approval. It was also stated that many of the comments had related to a need for the Board to continue to develop and support partnership and locality working in Derbyshire. At the meeting, Board members made a number of points, particularly in relation to empowering individuals and communities within the prevention agenda to further strengthen the strategy.

RESOLVED to (1) approve the strategy; and

(2) note the wider issues raised about the need for continued development of, and support for, partnership and locality working.

45/12 WORKING TOGETHER EFFECTIVELY: INTEROPERABILITY IN HEALTH AND SOCIAL CARE (INFORMATION GOVERNANCE WORKSHOP REPORT) The continuing drive for delivery of integrated care, with pathways crossing organisational boundaries, had highlighted the challenges of sharing patient identifiable and sensitive information between organisations. Whilst some areas were clearly defined, the majority of incidences were complex, and careful consideration to ensure a legal basis for sharing was essential. To support County Council and NHS staff involved in taking a decision on information sharing, it had been agreed to hold a workshop event, the purpose of it being to update attendees on relevant aspects of the law. This had been held on 4 July 2012.

Details were provided on the content of the Information Sharing Workshop, along with outcomes and some recommendations that attendees had agreed would help continue working together in the future. The workshop had brought additional benefits to participants in building relationships between groups of staff in different organisations but facing similar challenges, and bringing insight to the processes that the County Council and NHS had in

place and the standards that both organisations met in ensuring that personal data was handled securely and appropriately within the law.

A number of areas had emerged from the workshop, and a brief summary was given of the areas which would benefit from more detailed discussion and further joint work:-

- Consent – gathering the right level of consent from an individual was essential to sharing information, and where a patient/service user consented to share their data, it was usually relatively easy to do so with appropriate safeguards. However, the generic consent given was not usually specific enough for the circumstances. This problem had been faced for a number of years, and would continue unless robust and jointly agreed consent models and a process for collection of consent was implemented. No model would meet all circumstances, but for well-established pathways of care, it would present a solution to current difficulties in sharing. It was felt that this would take a considerable time to build, but would be beneficial to start now.
- Information Sharing Protocol/Agreement – Derbyshire Information Access Group had previously led a piece of work to establish an overarching Information Sharing Protocol between a range of services from within the Derbyshire Partnership. This work required a refresh to take into account changes from the Health and Social Care Bill and changes in status to some NHS organisations. The agreement supported all signed up organisations by providing a framework for secure and appropriate exchange of a range of data which reduced the need for individual sharing agreements
- Joint working on information sharing – operational group – It was felt that, to optimise use of shared learning and ensure consistency of approach, it would be useful to establish a joint operational information governance group to tackle areas which required a joint approach. The first task of this group would be to update the Information Sharing Agreement, and the group would require accountability arrangements back to both the County Council and PCT Information Governance Committees to maintain compliance with each organisation's governance arrangements. Going forward, arrangements would need to be made to include wider partner agencies.

The Board felt that it would be useful to understand more about the work of the proposed operational information governance group to ensure that it would not be duplicating work. Further information was requested about the composition of the group and the inclusion of wider partners, particularly District Councils and the Police.

Although there was general agreement that such a group may be necessary, it was suggested that a further report be presented to the Board

providing additional information on the remit of the group and its links to other information governance groups prior to it being formally established.

RESOLVED (1) to receive and the report; and

(2) that the Board receives a future report that considers the establishment of an Information Governance Operational Group.

46/12 IMPROVEMENT AND SCRUTINY REVIEW OF NUTRITION OF OLDER ADULTS IN DERBYSHIRE A review into the nutrition of older people had previously been undertaken, and had highlighted four areas of improvement – communication, screening, training and development, and data and information. A multi-disciplinary steering group had been established to coordinate the implementation of the review's recommendations. Over the past year, the primary focus for the group had been planning and delivering a screening survey across health and social care settings in Derbyshire. The results of the survey were presented to the Board along with an update of progress against the recommendations.

The screening survey had shown that malnutrition in people aged 65 and over affected 24% of people in an acute setting, 26% of people in care home setting, and 32% of people in a community hospital. These results were said to be broadly in line with the results of the 2011 National Nutrition Screening Week. However, the survey was only a data collection exercise.

The latest update in respect of the recommendations made by the original scrutiny review was presented, and highlighted where improvements had been made and areas where work was still required. In terms of communication, more work was needed to promote the use of existing patient held records, although there had been improvements in the promotion of food choice for patients.

There had been a number of improvements reported within screening, with all organisations using the Malnutrition Universal Screening Tool (MUST) on a patient within 24 hours of admission. The monitoring of food not eaten by individuals was improving in most organisations, and Chesterfield Royal Hospital had stated that more needed to be done within the Trust on this.

With regard to training, there had been assurances that appropriate training on the use of equipment and the MUST assessment tool was taking place. However, more work needed to be undertaken on exploring volunteering opportunities and the training that could be given to volunteers. For the recommendation relating to data and information, the issue of openness of information was being implemented well, but it was not clear as to how often the information was accessed and by whom.

At the last meeting of the Steering Group in July 2012, it was noted that, despite the experience and willingness of the Group members to effect change, they did not have the authority within their organisations to make the necessary changes. It had also been noted that there was no coordinated approach to tackling malnutrition and no organisation was taking the lead. The Steering Group had therefore requested that the Improvement and Scrutiny Committee – Places made representations to the Shadow Health and Wellbeing Board on this issue, and the Committee had resolved to undertake this at its meeting on 12 September.

The Board agreed to oversee this work, and Public Health staff would lead this on behalf of the Board, and present an update report to the meeting in January 2013.

RESOLVED that the Board (1) receives and notes the audit screening report from the Nutrition Screening Group;

(2) receives and notes the progress report from the Nutrition Steering Group;

(3) takes on the responsibilities of the Nutrition Steering Group in implementing the recommendations of the Improvement and Scrutiny Review; and

(4) allocates lead responsibility to the Public Health Team and requests an update report to the meeting in January 2013.

47/12 DERBYSHIRE LINK'S OBSERVATIONS OF SERVICES DELIVERED AT GP PRACTICES THROUGHOUT DERBYSHIRE The remit of Derbyshire LINk was to independently collate information from the public and patients about experiences of their local health and social care services. Over the past 3-4 years, Derbyshire LINk had recorded concerns from members of the public in relation to their experiences when using their GP Practices, and LINk had established a sub-group to further investigate the emerging themes.

A pilot study had preceded the development of a questionnaire which had been disseminated to 983 members of Derbyshire LINk. There had been a response rate of 25%, and the findings of the data had been analysed. Quantitative intelligence had been used to explore some of the themes the Sub-Group had identified. Where the sub-group had had the opportunity to speak directly to patients, significant qualitative intelligence had been gathered.

A report had been produced on the observations of service delivery at GP Practices throughout Derbyshire, and this outlined seven

recommendations in response to the findings. These ranged from providing customer service training for reception staff to GP Practices engaging with Derbyshire LINk to find out what the local community were saying about their service delivery. A copy of the report had been circulated to members of the Health and Wellbeing Board.

Derbyshire LINk had formally sent the report to the CCGs. Acknowledgement of receipt of the report had been requested within 20 days, and a comprehensive response was requested by 31 December 2012.

The CCG representatives of the Board commented on the issues that had been raised. It was generally acknowledged that GP access was a national issue, and a number of surveys had been carried out which had raised the same concerns.

RESOLVED to (1) note the seven recommendations set out in the full report;

(2) acknowledge the report and support its findings and recommendations; and

(3) receive an update from Derbyshire LINk, incorporating the feedback from the CCGs.

48/12 JOINT COMMISSIONING UPDATE – ADULT CARE The Shadow Health and Wellbeing Board had previously endorsed the Joint Commissioning priorities for 2012/13 that had been agreed by the Adult Care Board. Since the last meeting of the Board, a range of actions had been completed, and these were detailed.

The developments related to agreed joint priorities, which were consistent with the emergent Health and Wellbeing Strategy for Derbyshire. The achievements reflected good joint working between the developing clinical commissioning groups, adult care and district and borough councils. This joint working would be further strengthened as joint commissioning structures and relationships were consolidated in the coming months.

RESOLVED that the progress on delivering the Joint Commissioning system and priorities for 2012/13 be noted.

49/12 DERBYSHIRE CLINICAL COMMISSIONING GROUPS' COMMISSIONING STRATEGIES At a meeting earlier in the year, the Board had received the commissioning intentions 2012/13 of the Derbyshire CCGs, and these had been developed in response to the publication of the NHS Operating Framework which was published each year and set out expectations and requirements for the following year. Commissioning

intentions were issued to the main providers of NHS services by the end of September each year, and set out the local intentions for significant service changes and changes to contracts.

The NHS system was changing, and so this year a national Mandate for the NHS would be issued which would be followed by planning guidance around the end of the year. Following this, the CCGs would go into detailed contract negotiations with providers for changes to take effect from 1 April 2013.

The CCGs were also currently developing commissioning strategies that would cover a 3-5 year period to enable longer term planning. There was no specific guidance for the strategies, but it was intended that they would support the implementation of the Derbyshire Health and Wellbeing Strategy and the JSNA; set out how the requirements of the new Mandate, the Outcomes Framework and planning guidance would be met; ensure the delivery of high quality services and good value for money in Derbyshire; identify local changes identified by GPs and other health and care professionals; and support the delivery of national and regional policy. The CCGs would complete their strategies by January 2013, but it was agreed that the draft priorities for each CCG would be presented to the Board at its meeting in November.

RESOLVED to (1) note the development of the commissioning strategies; and

(2) receive a short presentation by each CCG, setting out its proposed strategic priorities, at the meeting in November 2012.

50/12 **EREWASH CCG PRIORITIES 2012/13** The Board was presented with the Erewash CCG Priorities for 2012/13. The Health and Wellbeing Board priorities had been matched with the CCG Mission, CCG Focus and the high level CCG priorities. Also highlighted were the outcomes that it was hoped would be achieved. The document had been approved by the Erewash Board.

RESOLVED to note the Erewash CCG strategic priorities which are aligned to the Health and Wellbeing Strategy.

51/12 **HEALTH AND WELLBEING ROUND-UP REPORT** A round-up of key progress in relation to Health and Wellbeing issues and projects was given.

The first of four bespoke development sessions had been held with the LGA on 13 July 2012, and the Board had identified six priorities as areas that should be focused on through this process:-

- How to have serious conversations about difficulties and changes ahead
- Moving from trust to shared responsibility
- Developing a meaningful commissioning role as a board
- How to make things happen
- Understanding how money flows through the system
- Building Board member skills

A provisional date of 10 December 2012 had been set for the next Board Development, although a number of Board members could not make this date so an alternative would try to be found. The next workshop would focus on the first point listed and one other topic. Further details would be circulated prior to the workshop.

The authorisation process was continuing for each of the CCGs, and the application submission date for Wave 3 for Erewash, North Derbyshire, Southern Derbyshire and Tameside and Glossop was 1 October 2012, and 1 November 2012 for Wave 4 for Hardwick. Each CCG had to demonstrate its competence against 119 key criteria . Evidence submitted would be assessed and any of the criteria that were not fully met by the documentary evidence review would be probed on a site visit taking place in November for wave 3 and December for wave 4. It was anticipated that the outcome would be known by the end of December for wave 3 and January for wave 4.

Work was continuing within the CCGs, as contracts were being managed with providers to ensure quality and financial targets were delivered; winter planning was being coordinated across all sectors through the North and South Urgent Care operational groups; work on more integrated ways of working was being progressed; NHS 111 had been rolled out across Derbyshire and the tender for the permanent service to start from October 2013 had been released; and a joint commissioning coordination group for adult and children's service between the CCGs and the County Council had been established.

The revised plan to deliver the strategy for accommodation care and support was progressing. The Community Care Centre and Extra Care scheme in Swadlincote was expected to be handed over mid-November with a view to tenants moving in, and other services starting over the coming months. The scheme would provide 88 apartments, 16 long term beds for people with dementia, 16 short term beds for respite or intermediate care, and day services for up to 20 people. The scheme would also have a range of community facilities and a health and wellbeing zone.

Planning submissions had been submitted for two further community care centres at Darley Dale and Heanor, and a contractor was being sought to

build the centres. It was anticipated that work would commence early 2013 with a view to the centres being operational in 2014. Each centre would have 16 long term beds for people with dementia, 16 short term beds for respite or intermediate care, and day services for up to 20 people, along with a range of community facilities and a health and wellbeing zone.

Chevin Housing, in partnership with the Council, was moving three initial extra care schemes through planning to start construction in Chesterfield, Alfreton and Clay Cross. The schemes would all have community facilities and the Clay Cross scheme would have a day service facility for 20 people. It was anticipated that these would be ready for handover from the constructor in late 2014/early 2015.

District and Borough colleagues continued to be involved in local discussions about rent levels, service charges, affordability for local people, and planning issues. Discussions were also taking place at locality levels with Local Clinical Commissioning Groups to explore opportunities for integrated service provision.

Planning for the development of the Local HealthWatch service was on course, and the County Council's Cabinet had recently approved the facilitation of the procurement exercise to set up HealthWatch. The Health and Social Care Act had stated that HealthWatch should be a corporate body in its own right, and the emphasis had been to move away from having a host organisation. To enable this to occur, the procurement exercise included a short term contract with an organisation to help develop a new corporate body.

Derbyshire was facilitating the development of a new independent organisation with an independent board of trustees. Potential members of the Board would have to apply against a job description, highlight their skills and demonstrate the benefit they would bring to HealthWatch. The job description for board members and the application process were still to be determined. Once a new organisation had been established as HealthWatch, the County Council would look to grant aid the new corporate body to fulfil the role.

Work was also underway to engage the public in helping to determine what Derbyshire HealthWatch should look like. The recent Health and Wellbeing Stakeholder Engagement Forum had focused on gaining feedback on how HealthWatch should be inclusive and represent the views of people. There had also been support from the Youth Council, who had assisted with the development of documentation which would inform the development of Derbyshire HealthWatch.

The first meeting of the Derbyshire Local Education and Training Council (LET-C) had recently taken place. This sat under regional Local

Education and Training Boards, which reported to Health Education England. The LET-C brought together the main providers and commissioners of health care as well as representatives of training institutions, and was there to oversee all aspects of health training. Over the next few months, its remit and initial priorities would be agreed. The Health and Wellbeing Board and the County Council were represented on the Board by the Director of Public Health. At the first meeting, there had been an item relating to 'Making Every Contact Count', which was an initiative that had begun in Derbyshire but had been taken up as a regional NHS priority to ensure that all relevant workers in any professional group could help promote healthy lifestyles.

The Department of Health had published a document that described the arrangements for preventing, planning for and responding to health protection incidents and outbreaks within the new system. It also gave details about the nature of the local authorities' planned new duty to protect the health of the population. It outlined what the responsibilities of local authorities would be, but further clarification was required in certain areas. A more detailed report would be presented to the Board when more comprehensive information had been published by the Department of Health.

An event, organised by PCC, was to be held on 27 November 2012, and was aimed at director level staff and commissioners from local authorities, Public Health England and health and wellbeing boards responsible for public health within the primary care setting. It would explain how they could work with the CCGs and primary care to secure the necessary services and relationships to improve the public's health.

Agenda Item: 5

DERBYSHIRE COUNTY COUNCIL

SHADOW HEALTH & WELLBEING BOARD
29 NOVEMBER 2012

WINTERBOURNE VIEW

1. Purpose of the Report

To outline to the Shadow Health and Wellbeing Board the joint actions being taken by the local NHS and Adult Care to address the concerns raised by the treatment of people with learning disabilities at Winterbourne View private hospital.

Information and Analysis

Members of the Board may recall the Panorama television programme that showed the mistreatment of people with learning disabilities who had been placed at Winterbourne View. The private hospital was located near Bristol and the concerns raised about its service have resulted in considerable national and local action.

Appended to this report are two reports that have been considered by the Adult Care Board, Adult Care's Senior Management Team and Hardwick Clinical Commissioning Group/Derbyshire Cluster Board. They outline the continuing action that is being taken by local agencies to minimise the use of out of County private hospitals for people with learning disabilities and to review and wherever possible return to Derbyshire people currently placed out of County.

OFFICER RECOMMENDATION

That the Shadow Health & Wellbeing Board receives this report and seeks further reports updating it about progress on this topic.

Report into recent detail around Winterbourne Reviews

1. Purpose of this report

The purpose of this report is to provide SMT with information in relation to recent reviews around Winterbourne View Hospital. This report has been based on the South Gloucestershire's Serious Case Review (M, Flynn et al, 2012), (SG, SCR, 2012) and the Department of Health Review: Interim Report, Winterbourne View Hospital (2012), (DoH, 2012). For the purpose of gathering local information I also included in this review extracts from the Derbyshire County NHS, Hardwick Health CCG and Derbyshire Cluster Board, Update Briefing, (July,2012) (HH, CCG).

The fundamental principle to this report will be to firstly provide basic detail of the above reviews and reports and to inform DCC on the implications from Winterbourne.

2. Background

After the transmission of the Panorama *Under Cover Care: the Abuse Exposed* in May 2011, South Gloucestershire's Adult Safeguarding Board commissioned a serious case review (SG, SCR, 2012). It is not possible to consider the whole context of this report within this format due to the complexity and detail, however the overall findings, conclusions and lessons will be detailed below.

Identified Practice Issues at Winterbourne

- The average weekly fee of £3500 per week was no guarantee of patient safety or quality of service.
- There were high levels of staff sickness and staff turnover.
- Any concerns raised by patients were dismissed as unreliable.
- During 2010 "on the job" training and inadequate staffing levels persisted.
- Family involvement in decision making diminished when people turned 18 and came under the MHA (1983)

Agency Involvement within Winterbourne

- **NHS South of England (NHS SoE)-**
- Questions the independence of psychiatrists employed by independent hospitals.
- They highlight concerns over the adequacy of the Care Programme Approach.
- The NHS (SoE) highlight the absence of processes for NHS Commissioners to be informed around safeguarding as well as a failure on the part of commissioners to follow up on concerns.

- **NHS South Gloucestershire (Commissioning)-**
- Between 2008-2011, patients from Winterbourne visited local Accident and Emergency 78 times, whilst these were mostly in respect of seizures/injuries and self-harm, it was noted that there is no alerting system in place which is inclusive of all services.
- Patients records identified concerns around the lack of clarity in the use of medication and poor support around health issues. In addition the records confirmed the misuse of physical restraint throughout.
- There appeared to be a low threshold for detaining people on a section 3 under the Mental Health Act.

South Gloucestershire Council Adult Safeguarding

- Received 40 safeguarding alerts between Jan 2008- May 2011, it commissioned no places at Winterbourne.
- Alerts were treated as discrete cases and safeguarding policies and procedures were inconsistently followed by not chasing up with the local hospital their failures to produce reports into incidents.
- When the whistleblowing email was received by the council this was forwarded to CQC and there was an expectation by both parties that the acting manager (Winterbourne) was addressing this.

Findings and Recommendations

- There was no overall leadership among the commissioners of this service
- Commissioners did not follow up on concerns raised and continued to place people.
- Whilst advocacy was available this was controlled by Winterbourne.
- The inter-organisational response to the concerns raised by the whistleblower was ineffective.
- The volume and characteristics of the safeguarding alerts were not treated as a body of concerns.
- The existence and treatment of other forms of alert were not shared within the multi-disciplinary arena which did not allow for the allowance around the urgency and recognition of the serious concerns.
- "Hospitals for adults with learning disabilities and autism should not exist but they do. While they exist they should be regarded as high risk services."

3. Review of Proposals from Reports:

The DoH (2012) interim report highlights that the present health and care system is not meeting the needs of people with learning disabilities, autism or for people with behaviour that challenges. They identify 14 actions at a national level to drive good practice and to focus on improving outcomes for individuals. The key points from the 14 actions are:

- **Improve the capacity and capability of commissioning across health and care.**
  - **Contracts**- To embed Quality of Health principles in the system, using NHS contracting and guidance. (Jan, 2013)
  - **Service specification**- To develop a clear description of all the essential components of a model service. (March, 2013)
  - **Resources**-NICE to develop quality standards on learning disabilities and the autism. (July, 2012).
  - **Collaborative commissioning**- NHS Commissioning Board Authority will support CCG's to work together in commissioning service for people. Health and Wellbeing boards will bring together local commissioners of health and social care in all areas, to improve services.

- **Improve the quality of services which empower people with learning disabilities and their families to have choice and control.**
  - **Voice**- Healthwatch is currently being established both nationally and locally. This will act as a champion for those who have involvement with services.
  - **Personalisation**- NHS and local authorities to demonstrate that they have taken action to assure themselves and the public that personalised care and choice and control is available in all settings, including hospitals.

- **Providers**- Expectation that providers deliver high quality services and prevent abuse.
- **Quality**- The National Quality Board to publish a report in the Autumn to identify and take action to correct potential or actual serious failure.
- **Care Quality Commission**- The DoH will look at how CQC's registration requirements could be changed to drive up the quality of services.

Clarify roles and responsibilities and promote better integration

- **Integrated workforce-** LD Professional Senate (LDPS) to carry out a refresh of *"Challenging Behaviour: A Unified Approach".* (December, 2012)
- **Professional standards-** LDPS to develop core principles on a statement of ethics to reflect wider responsibilities in the new health and care system by April 2013.
- **Concordat-** DoH working with a variety of partners to sign up to a concordat committing each signatory to the actions they will take to deliver the right model of care.

Promote innovation and reduce use of restraint

- **Restraint-** DoH and Education will work with the CQC and others to drive up standards and promote best practice in the use of positive behavioural support.
- **Measuring Progress-** DoH and the NHS Commissioning board to agree details around data collection of people in hospitals.

Conclusions and Actions

- Everyone has a duty to drive up standards. Local action will drive up good practice.
- NHS and local authorities to demonstrate that they have taken action to assure themselves and the public by ensuring all clients are in receipt of personalised care and support with choice and control in all settings including hospitals.

- Health and social care commissioners working together to review the support and funding arrangements for people with behaviour which challenges and develop local action plans to deliver best support

- Contracts, specifications and robust monitoring to be in place with all providers.

In addition the Hardwick Health, CCG has highlighted the actions below for consideration. These recommendations are based on both the DoH (2012) interim report as well as the DoH letter to PCT and NHS executives (gateway 17822). These are:

- Commissioners need to urgently review the care plans for people in assessment and treatment units and identify and plan move on arrangements to the next appropriate service and care programme. The development of an implementation programme based on the Campus model (Campus 2) has been proposed to address this.

- Emerging CCG's, NHS commissioning board and LA's to work together to deliver innovative commissioning at the local level to establish person centred services

- Commissioners need to review advocacy services

- In response to CQC inspections of LD placements, the DoH are proposing that where lead commissioning arrangements are not already in place and the facility in question is a health care organisation the DH would expect the host Cluster PCT/Hardwick

CCG to take this lead commissioner role. Where the facility is a residential care home the DoH would expect the host local authority to take the lead commissioner role

4. Analysis of Adult Care Practice

This section of the report will focus on the implications of Winterbourne in relation to Derbyshire Adult Care and the present situation in respect of the following highlighted themes which have been taken from the Winterbourne Reports.

Themes

- **Quality Monitoring by DCC Adult Care**
- **Safeguarding**
- **Whistleblowing**
- **Out of County Placements**
- **Sharing of information within the Multi-Disciplinary Arena in Derbyshire**

4.1 Quality Monitoring by DCC Adult Care

At present there are quality monitoring systems in place for all residential/nursing placements within Derbyshire, this also includes domiciliary care agencies. Both the Older Adults and Learning Disability Contracting and Compliance Teams aim to visit each provider on a rolling 2-3 year programme. The aim and principle behind this programme is to work alongside private/independent providers to drive up standards and to support the overall improvement and development of services within Derbyshire. Where appropriate information collated within these visits is shared with fieldwork and outside parties including CQC, health, etc.

Provider Action Plans

Following visits an action plan is agreed with the provider in relation to areas for improvement. In circumstances where concerns are raised the contract team have the option of issuing a default notice to the provider which clearly outlines the detail of the required actions and timescales for these to be addressed. If the concerns are deemed as significant, then the contracts team have the option to escalate to suspension of new placements in the first instance or to suspend after little improvement following a default notice.

'Traffic Light' monitoring

The contracts team operate a traffic light system against each care provider. Homes that give the most concern have their monitoring visits brought forward. One of the indicators within this system highlights any provider that may have been involved in a significant amount of; safeguarding referrals, regular concerns flagged up by a whistleblower, warning notices from CQC and reports from fieldwork.

In addition one of the key themes within the Gloucestershire report was staff turnover within Winterbourne. In relation to this, the contracting team send out to all care homes on a quarterly basis a monitoring form to collect information about staff turnover amongst other things.

Serious concerns meetings

Where any member of staff in Adult Care, (fieldwork team, contracts team or safeguarding team), or any staff working within the health sector become aware of multiple or repeated concerns or non-compliance a serious concerns meeting is called.

The meeting should be convened by an appropriate manager from the identifying agency and should include all multi agency professionals. The aim of the meeting is to scope the approach and response to the concerns, share information and to agree an action plan. This could include making individual safeguarding referrals or to work with and support the provider to improve practice generally or to issue a default notice.

It is important to note that this programme is in place for registered residential and nursing placements for people who are either fully or part funded by the local authority. This approach does not include the monitoring of hospital placements such as Winterbourne as Adult Care does not contract for care in such settings.

Proposed Action

Jill Ryalls and Colin Selbie to visit each area Group Manager (fieldwork) to explain the importance of the serious concerns meetings and the expectation that they need to be led by the local team with support from Contracting and Safeguard leads, amongst others.

4.2 Safeguarding

It is clear from looking at South Gloucestershire's Serious Case Review into Winterbourne, that the local authority was aware of significant Safeguarding investigations (40 alerts in 3 years).

Potential Risks Identified

The Contracting and Compliance Team maintain electronic records that clearly show when a home has been subject to a safeguarding investigation. These records are regularly checked to ensure that there are no patterns of poor practice occurring.

For this system to be effective the Contracting Team need to be advised of all safeguarding investigations, including those undertaken by neighbouring authorities.

This information on management arrangements with individual homes is not widely available as it is held by the Contracting Team. Decision makers within Safeguarding only have access to individual client files through Framework i and would not be able to pick up any patterns of safeguarding/poor practice eg. medication errors, missed calls etc. This could lead to decisions being made about whether to take a concern into safeguarding without having knowledge around previous safeguarding where patterns and themes could be identified.

Proposed Action

- To consider how intelligence gathered around an individual provider over a period of time can be available to fieldwork to inform decision making when considering safeguarding.

4.3 Whistleblowing/Concerns

In South Gloucestershire's Serious Case Review into Winterbourne it was highlighted that the local authority had received the whistleblowing email and had referred this through to CQC whom had asked that the provider look into the issues raised. Neither party took responsibility of following up around this and ensuring that the issues raised had been adequately looked into.

Since Winterbourne there has been a significant increase in whistleblowing concerns from people who have involvement with outside services. Many of these alerts are

being passed to the Department by the CQC. Some are being sent to the local area teams others to Contracting Team.

Potential Risks Identified

- It is often unclear what CQC are going to do about a whistleblow/concern that they received. There is a sense that it is the LAs role to investigate rather than them. Contracting Team on receipt of alert from CQC send a reply asking what are they doing about the alert.

- Whilst in the majority of instances Whistleblowing is discussed within safeguarding proceedings it is not clear who has lead responsibility when a decision is made not to use this procedure. This is particularly problematic if there is no named client and the concerns are generic/systemic in nature.

Proposed Action

The Contracting Team to work with lead Safeguarding and Fieldwork colleagues to ensure that concerns not subject to safeguarding are investigated as per the roles and responsibilities as identified in the Escalation Policy.

4.4 <u>Out of County Placements</u>

It is clear from the serious case review that a significant number of clients living at Winterbourne were placed there from outside authorities. There are 126 clients with Learning Disabilities that Derbyshire has placed in residential and nursing placements outside of Derbyshire and collated detail from Framework i.

Sharing of information within the Multi-Disciplinary Arena in Derbyshire

At present there are quarterly information sharing meetings with CQC. The DCC contracts traffic light system is used to highlight any care providers that have concerns noted as red and amber and these are then discussed each in turn. This includes any actions taken and CQC also update us on any concerns/actions they are undertaking. Health representatives are also present at this meeting and safeguarding representatives are also invited.

It should also be noted that whilst we have quarterly meetings with CQC, the contracts managers also speak to CQC inspectors on a regular basis There is also a bi monthly meeting, called the “Joint Health and Adult Care Quality Group’, this covers managing quality in care homes and domiciliary care providers.

James Gough
Service Manager
Contracting and Compliance Team

NHS Derbyshire County

NHS Derby City

HARDWICK HEALTH CCG AND DERBYSHIRE CLUSTER BOARD MEETING
Date July 2012

Report Title: **Learning Disability – Update briefing on The DH Interim Report of Health Review of Winterbourne View Hospital**

Item No:

1. Background and context

The PCT Cluster Board has previously received an assurance briefing on the numbers of people in the care of Independent Hospitals whose care is commissioned by the Cluster PCT and the local actions taken. Hardwick Health CCG and the Cluster Governance Committee were appraised in March 2012 on the DH review and the implementation of the CQC inspections. This report provides the board with an update on the outcomes, recommendations and actions form the Health Review of Winterbourne View and the CQC Inspection report.

The DH has published an interim report as part of a review of events at Winterbourne View private hospital and a wider investigation into how the health and care system supports vulnerable people with learning disabilities and autism. The review was set up by the Care Services Minister Paul Burstow following the BBC Panorama programme, broadcast on 31 May 2011, showing abuse of patients at Winterbourne View.

The DH Interim Report responds to evidence that the health and care system is not meeting the needs of people with learning disabilities or autism and behaviour described as challenging. and sets 14 national actions to be taken to improve the care and lives of people.. The report is based on the findings of the CQC following inspections carried out at similar units to Winterbourne View

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The CQC's report, Learning Disability Services Inspection Programme: national overview (June 2012), has been published detailing its 145 inspections. It concludes that while no abuse on the scale of Winterbourne View was found, half of the hospitals inspected failed to meet CQC standards of care. The report can be found at http://www.cqc.org.uk/public/our-action-winterbourne-

view/review-learning-disability-services

The DH report also draws on the experiences and views of people with learning disability, autism, and challenging behaviour and their families, and the expertise of doctors, social workers and other care professionals

The national actions include promoting open access for families, advocates and visiting professionals, a programme of unannounced CQC inspections; a national public commitment to deliver the right care for people and work with the NHS Commissioning Board Authority to agree ways to embed Quality in NHS contracting and guidance.

The main findings set out in the interim report are that:

1. There are too many people in in-patient services for assessment and treatment and they are staying there for too long. This model of care has no place in the 21st century.
2. Best practice is for people to have access to the support and services they need locally to enable them to live fulfilling lives integrated within the community.
3. In too many services there is robust evidence of poor quality of care, poor care planning, lack of meaningful activities to do in the day, and too much reliance on restraining people.
4. All parts of the system– commissioners, providers, workforce, regulators and government – must play their part in driving up standards of care and demonstrating zero tolerance of abuse. This includes acting immediately where poor practice or sub-standard care is suspected.

The key objectives are to:

- improve commissioning across health and care services for people with behaviour which challenges with the aim of reducing the number of people using inpatient assessment and treatment services;
- clarify roles and responsibilities across the system and support better integration between health and care;
- improve the quality of services to give people with learning disabilities and their families choice and control;
- promote innovation and positive behavioural support and reduce the use of restraint; and
- establish the right information to enable local commissioners to benchmark progress in commissioning services which meet individuals' needs, improve the quality of care, and reduce the numbers of people in in-patient services for assessment and treatment.

The DH letter to PCT and NHS Executives dated 26th June 2012 – gateway 17822 asks that PCTs and LA's need to work together to assure themselves that they are continuing to take all action needed to improve outcomes for people with learning disabilities in preparation for the outcomes from the final report in to the events at Winterbourne View in the autumn.

2. Matters for consideration

The following are a highlighted sample of the actions and recommendations for commissioners taken from the DH Interim Health Review and the CQC report;

DH Interim Review:-

- NHS and local authorities to demonstrate that they have taken action to assure themselves and the public that in ensuring personalised care and support with choice and control in all settings including hospitals
- health and social care commissioners working together to review funding arrangements for people with behaviour which challenges and develop local action plans to deliver best support
- Contracts, specifications and robust monitoring are in place with all providers.

CQC report recommendations:-

- commissioners need to urgently review the care plans for people in assessment and treatment and identify and plan move on arrangements to the next appropriate service and care programme
- emerging CCG's , NHS commissioning board and LA's to work together to deliver innovative commissioning at the local level to establish person centred services
- Commissioners need to review advocacy services

There will need to be a local review of the action plan from the Commissioning for Quality LD SAF to cross reference the actions against those contained in the recent reports. Hardwick CCG will require a continued focus and effort in providing good systems for monitoring, strong leadership and clinical intelligence to assure the best possible care that is safe and responsive to LD patients is delivered and sustained.

In addition safeguarding issues related to people with a learning disability must be carefully considered and is fundamental, core business for any CCG. The approach on how this is managed is critical to the development of the LD lead CCG organisation and must demonstrate clear understanding, expertise and capacity to both protect and empower one of our most vulnerable groups of people.

The Care Quality Commission has published a report showing that the NHS needs better awareness of when and how to apply the Mental Capacity Act – Deprivation of Liberty Safeguards (MCA-DOLS) for patients. The safeguards are needed in all hospitals, for patients who may require restrictions such as

restraint that may amount to a deprivation of liberty.

In response to CQC inspections of LD placements, the DH are proposing that where lead commissioning arrangements are not already in place and the facility in question is a health care organisation the DH would expect the host Cluster PCT/Hardwick CCG to take this lead commissioner role. Where the facility is a residential care home the DH would expect the host local authority to take this lead commissioner role

Quality Monitoring

Local Castlebeck placements in the East Midlands

The Cluster PCT/Hardwick CCG has 4 people currently living in Cedar Vale, an independent hospital in the East Midlands. Reviews have taken place and work is on-going to plan with the individuals and their families so that the most appropriate support is procured. We anticipate one of the 4 individuals to move to a supported living environment in the near future as a planned part of the Derbyshire QIPP placement programme.

The Cluster/CCG has 1 individual placed at Croxton Lodge; this individual will be stepping down to a less restrictive environment within the same site, with the aim that their discharge planning is to return to Derby City. Since the October 2011 report 1 individual has been discharged from Croxton Lodge to return home to their family home in Derby City with a jointly commissioned support package.

Other Castlebeck placements

There is one individual placed for assessment and treatment in an independent hospital and 2 individuals living in a Nursing Home provided by Castlebeck both in the North of England. The individual in independent hospital provision is in process of transition planning for a suitable alternative to move closer to Derby. It is the aim for this person to move during 2012/13. The individuals in Nursing care are jointly funded with Derby City Council and care managed by the council.

Commissioners are monitoring care at all placements by direct involvement via our case managers and local authority care managers, in addition to liaison with other monitoring systems such as the regional lead Contract Management for Castlebeck and CQC national regulatory monitoring.

Continued Actions

The Cluster PCT/Hardwick CCG QUIP programme is underway with a case assessor in post for the County to make focussed transition plans for people to return to their local area wherever possible. The City will continue their efforts on implementing the discharge transition plans for the individuals who are ready to move on from independent hospital provision.

In a previous report to the Cluster Board it was proposed that for those who

remain or require a stay in an Independent hospital, commissioners would be advised to employ "Quality checkers" as part of our local and regional Quality and Commissioning processes. Quality checkers are people who have a learning disability themselves and their job is to gain honest feedback from the people being cared for as well as observing staff and the environment. This would be used as part of the reviewing and contracting process, but this would require investment by the CCGs.

Hardwick CCG are involved in an East Midlands Living Local programme, which includes a series of regional investments to support local areas in work jointly with the LAs to improve the care and support for people with a learning disability. The aim of one of these programmes is to support local areas in developing a personalised but consistent process to supporting adults with learning disabilities who are labelled as "challenging to services" to achieve suitable support and accommodation within their local area. Hardwick CCG will hold the regional budget allocation and are involved in planning of work with NHS Midlands and East on learning the lessons from Winterbourne.

Hardwick CCG and the Cluster PCT have 14 people with a Learning Disability placed in Independent Hospitals similar to those provided by Castlebeck, in addition to the 9 people placed within Castlebeck facilities.

The DH Review has reaffirmed that nationally there are concerns about patient safety and appropriateness of the model of care provided in Independent Hospitals and together with the PCT average lengths of stays in such establishments Hardwick CCG /Cluster Board might consider it a priority to move these individuals as soon as is possible.

The Derbyshire QIPP scheme employs a full time LD Nurse to review all placements in independent hospital and to move people on from hospital where this is clinically indicated. Contact has been made with the Derbyshire County Council Adult Care Commissioning Leads who are now part of the QIPP board structure.

The 23 individuals who are currently in Independent hospitals are in dispersed locations, some out of area and as such the planning work entailed in making detailed plans for commissioning alternatives is resource intensive. To be successful with individual procurement of alternative housing and support packages and smooth transition plans for all individuals ready to move on from Independent Hospitals will require a dedicated project team, working closely with LA colleagues and providers of housing and support. This would be similar in approach to the two recent successful Learning Disability campus re-provision programmes across County and City for which numerous positive lessons have been learned and could be replicated. This would likely bring about earlier than planned efficiency savings for the CCGs and promptly improve quality of care and improved lifestyle outcomes for the individuals concerned.

There is a regional framework contract in place for providers of hospital MH and LD rehabilitation care. Derbyshire County PCT is the coordinating commissioner for a number of these contracts. Hardwick CCG Mental Health contracting team

coordinate regional contract meetings and have ensured that there have been CQUIN on improving quality outcomes and on demonstrating safeguarding by providers.

The Castlebeck contract is held by Nottinghamshire PCT with other PCTs as associates. Some contracts where held by specialist commissioning but are no longer as they fall outside the minimum take arrangements. Arrangements for these contracts are required. Hardwick are leading on the work with EMPACT to re-procure these services with enhanced quality element in service specification. All CCGs in the East Midlands will be asked to contribute to the costs of management of these contracts via EMPACT. This work is required for CCG readiness and to enable effective quality management of these providers. A more detailed report on these contracts and re-procurement will be presented once the project work by EMPACT has been completed.

3. Actions and recommendations which will be considered by NHS Hardwick CCG Board on 24th July 2012

- **Note** – the DH Interim report and its recommendations and actions.
- **Consider –** the proposal for the investment in Quality Checkers
- **Review** - the continued steps being taken to ensure the CCGs/Cluster PCT is assured of the safety of patient care.
- **Consider** - that a Business Plan be developed to identify resources required to effect prompt moves for individuals out of independent hospitals.
- **Consider** the work on regional re-procurement, receive a report in future meeting and endorse the re-procurement process.

Name: Jackie Lawley - Learning Disability Commissioning,
David Gardner Head of Procurement and contracts

Sponsor: Wendy Sunney – COO – Hardwick Health CCG
Date: July 12th 2012

Agenda Item: 6

DERBYSHIRE COUNTY COUNCIL

SHADOW HEALTH & WELLBEING BOARD
29 NOVEMBER 2012

ADULT CARE BOARD TERMS OF REFERENCE

Purpose of the Report

To seek the agreement of the Shadow Health and Wellbeing Board to the Terms of Reference for the Adult Care Board.

Information and Analysis

The Adult Care Board, which is accountable to the Shadow Health and Wellbeing Board, has been operating with draft Terms of Reference to date. These have been reviewed at the Adult Care Board and amended to reflect the Board's responsibilities and activities. In addition, the membership of the Adult Care Board has been reviewed to reflect the changes in the structure of the local NHS. The proposed Terms of Reference are appended to this report.

OFFICER RECOMMENDATION

That the Shadow Health and Wellbeing Board agrees to the proposed Terms of Reference for the Adult Care Board.

Adult Care Board

15th November 2012

Draft Outline Role and Function

Reporting:

The Adult Care Board is a non-executive body that reports to the Shadow Health and Wellbeing Board. Any executive decisions will be made by the constituent agencies usual decision making processes.

The Adult Care Board is not a public meeting.

Role and Function:

The Adult Care Board will:

- participate in the development and implementation of the Joint Health and Wellbeing Strategy.

- ensure the effective development and delivery of agreed joint commissioning plans focussing on the themes of
    - prevention (non care based)
    - accommodation and support, including: housing related support, telecare, telehealth, extracare developments and adaptations
    - joint commissioning of health and social care services including prevention and integrated care and support
    - adult safeguarding
- agree to the formation of any task and finish groups required to deliver tasks allocated to, or agreed by, the Adult Care Board.
- to provide guidance and support to and receive reports from
    - Prevention – Strategic Partnership Group for Prevention
    - Supported Accommodation – Commissioning Group for Accommodation and Support Services
    - Safeguarding – Derbyshire Safeguarding Adults at Risk Partnership Board
    - Joint Commissioning Co-ordination Group
    - and as and when required from any sub group
- support the development of the Joint Strategic Needs Assessment and participate in delivering the actions to respond to its priorities.

- ensure that the joint commissioning processes and activities delegated by the Shadow Health and Wellbeing Board to the Adult Care Board are delivered effectively and efficiently.
- support the development of joint commissioning to achieve more efficient and effective outcomes through alignment, integration and transfer of resources as appropriate
- ensure that the activities undertaken on behalf of the Adult Care Board are based on co-production with local people or their representatives. This work will include close involvement with the LINk (and Healthwatch when it is established) together with other established stakeholder groups.
- Support the delivery of the key joint health and social care outcomes identified in national strategies, outcome frameworks and priorities.
- monitor the impact of the performance of constituent statutory organisations' budgets on local services.
- oversee any local adult health and social care pooled budgets agreed by the Shadow Health and Wellbeing Board.
- support the development of a skilled and sustainable workforce to commission and deliver adult health and social care.
- report to the Health and Wellbeing Board as required, including on matters delegated to the Adult Care Board.

Frequency of meetings:

The Adult Care Board will meet bi-monthly.

Proposed membership:

Jones	Cllr Charles	DCC – Cabinet Member Adult Care (Chair)
Allen	Cllr Dave	DCC Shadow Cabinet Member Adult Care
Bennett	Bryan	Derbyshire Fire & Rescue Service
Ellis	Stuart	DCC – Cabinet Support Member Adult Care
Foster	Russ	Derbyshire Police
Harris	Lynn	Safeguarding Board
Harrison	Cllr Barbara	Erewash District/Borough Council Representative
Laurence	Bruce	Acting Joint Director of Public Health or representative

Lemmon	John	South Derbyshire District/Borough Council representative
Matthews	James	DCC - Adult Care
McElvaney	Mary	DCC - Adult Care
Milroy	Andrew	DCC - Adult Care
Robertson	Bill	DCC - Adult Care
Robinson	Helen	Derbyshire Carers
Robinson	Cllr Lilian	NED District/Borough Council representative
Smith	Jo	South Derbyshire CVS – Voluntary Sector representative
Tomlinson	Gavin	Derbyshire Fire & Rescue Service
Watson	Clare	Tameside & Glossop PCT (CCG)
Willis	Jacqui	NDVA / Chief Executive – Voluntary Sector representative
Wright	Tammi	Derbyshire LINk
Rep to be notified		Probation Service
2 representatives from each of:		North Derbyshire CCG Southern Derbyshire CCG Erewash CCG Hardwick CCG

V5 14/11/2012

Agenda item 7

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 NOVEMBER 2012

Healthcare needs of Veterans

Purpose of the report

To advise the Board of the key health issues affecting Armed Forces veterans and their families and to set out the next steps in addressing their needs.

Background

Recent media attention on troops returning from conflicts in Iran and Afghanistan has renewed the interest in the duty of care the UK owes its serving personnel and veterans[1]. The Military Covenant aims to enshrine this duty of care in law and it has highlighted a specific group of people who may have very specific health needs. The four key principles of the Military Covenant for service people, their dependants and veterans are that:

- they suffer no disadvantage
- are able to manage their lives as effortlessly as anyone else
- receive continuity of public services
- can expect proper return for sacrifice

Regarding healthcare for veterans, the wording of the Military Covenant is:

"Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in Service, whether physically or mentally, should be cared for in a way which reflects the Nation's moral obligation to them, whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture."

As a result there have been a number of legislative initiatives to ensure that support for veterans remains a focus. These include:

- Armed Forces Act 2011: Annual duty to report on progress against the Military Covenant to Parliament including Health.
- Health & Social Care Bill 2011 which includes the duty of the NHS Commissioning Board to commission services on behalf of the Armed Forces (currently a PCT duty)
- NHS Mental Health Strategy 2011 which includes specific provision for veterans.

[1] In 2001 the UK Ministry of Defence formally defined the word "veteran" as a person who has served more than one day in any of the 3 services, together with his/her dependents.

At a local level, Armed Forces Community Covenants are intended to complement the National Military Covenant. The aim of the Community Covenant is to encourage local communities to support the Service community in their area and promote understanding and awareness amongst the public of issues affecting the Armed Forces community. All local authorities in Derbyshire have recently signed a joint Community Covenant along with representatives of the Armed Forces, Service Charities and the business community. The joint signing of the Community Covenant for Derbyshire demonstrates a commitment to the Armed Forces community and provides an opportunity to build a stronger co-ordinated approach to support service and ex-service personnel.

The Operating Framework for the NHS in England

The 2008/9 NHS Operating Framework required PCTs to provide an effective transition of care from Defence Medical Services to the NHS and to ensure that commissioned mental health services are culturally sensitive to the particular needs of veterans. Subsequently, the revision to the Operating Framework for the NHS in England 2010/11, identified the provision of appropriate treatment for veterans as one of two areas singled out as being given insufficient emphasis in Strategic Health Authority (SHA) plans. SHAs have been charged with ensuring continuity of this work during the NHS transition period.

The Operating Framework for the NHS in England 2012/13 states that SHAs should continue the work of their Armed Forces Network in delivering the principles of the Armed Forces Covenant for armed forces, veterans and their families until April 2013. The requirements are that the Ministry of Defence / NHS Transition Protocol should be implemented, meeting veteran's prosthetic needs and ensuring mental health services for veterans, and that NHS employers should be supportive towards volunteer reservists. Following April 2013, the new structures will need to take responsibility for addressing veterans' health needs.

Local policy context

In line with the latest NHS Operating Framework, 10 Regional Armed Forces Networks have been set up across the country covering each of the old SHA areas. The East Midlands Armed Forces Network was launched in February 2011and is a partnership consisting of the NHS, the Armed Forces, local authorities and veterans' charities. The purpose of the network is to oversee work which is being carried out to help veterans, service personnel and their families. In reality, it seems different regions are developing their networks in line with local needs, with relevant partners.

The East Midlands Armed Forces Network is currently active with partners that include representatives of the Armed Forces, veteran's community, NHS and the third sector. Work up to now has been around 'troubleshooting' health and housing issues with a focus on personnel who are in service but face numerous transitions from area to area. This, for example, causes issues around dropping down housing waiting lists. Work has been carried out around housing adaptions and other areas which have fallen outside of social services.

Nottingham City NHS, who leads the network, wishes to re-launch it in the New Year. This could be with the new Clinical Commissioning Groups which come into force in April 2013.

Key health issues affecting Veterans

There is no single reliable data source to measure the size of the veteran population in the UK. However it is estimated that there are around 4 million veterans (around 8% of the adult population) about half of whom left the Services before 1960. In addition, there are 5.4 million spouses, partners and dependants.

In the absence of actual data, by extrapolating the national figure of 8% of the 16+ population being veterans would suggest there are just over 50,000 ex-Armed Forces personnel living in Derbyshire.

Around 60% of all veterans in the UK are aged over 65 and account for such a high proportion of this generation that they are not generally recognised as having distinctive health needs. There are some exceptions, such as veterans exposed to nuclear tests, but for the majority their health needs are consistent with that of the wider ageing population.

Armed Forces families, spouses, partners and dependants of Service personnel need to register to receive healthcare through the NHS (including dentistry) in the same way as all other UK citizens. As a mobile community they encounter problems registering with GPs, NHS dentists and accessing NHS treatment. Service families have often moved by the time they have reached the top of waiting lists for appointments and treatments, this can seriously disrupt the provision of treatment. A 2011 MOD survey showed that 34% of Armed Forces families on a waiting list for an operation or consultants appointment, reported that their previous waiting time had increased as a result of moving location.

NHS priority treatment has been an entitlement for those in receipt of a War Pension since 1953 but GPs can be unaware of this fact. Since January 2008 this has been extended to all veterans with a Service related injury or illness, however priority is not given over patients with more pressing clinical needs. Research carried out by the Royal British Legion has found that few veterans receive this level of service, and most (81%) of GP's surveyed knew nothing or very little of their responsibility to provide it. Again there is the issue of identifying those who are entitled to priority treatment.

Recent research appears to confirm that service personnel are at greater risk of developing mental health problems than the general public, and often find it difficult to cope with civilian life when they return from the front line. A University of Manchester study in 2011 found that of the 233,803 people who left the services between 1996 and 2005, 224 had later killed themselves. The average age of those who took their own life was just 22, and the risk of suicide in the under-24s was between two and three times higher than in the general population or serving troops.

A separate report by researchers at the King's Centre for Military Health Research in London studied 821 service personnel, many of whom had been deployed to Iraq and some of whom were still serving. It found that 18 per cent had problems with alcohol abuse and 13.5 per cent suffered neurotic conditions such as depression. In addition, 4.8 per cent showed symptoms of Post-Traumatic Stress Disorder which is only slightly higher than the 3% observed in the general population. A Royal British Legion survey found that the prevalence of mental health disorders among younger veterans (aged 16-44 years) was three times that of the UK population of the same age.

Research shows that alcohol misuse is a problem in UK Armed Forces personnel and veterans, and is more frequent than among age and gender matched samples of the UK population. The prevalence of alcohol misuse among regular personnel was higher in those who have been to combat zones in Iraq or Afghanistan compared to those who have not (16% vs. 11%). A study investigating alcohol consumption among veterans of the Gulf and Bosnia conflicts found that heavy drinking (>30 units/week) was most common among younger personnel, particularly those who had served in Bosnia. Heavy drinking was also closely correlated with smoking, and slightly poorer subjective mental and physical health. However veterans were less likely to be heavy drinkers than those still serving.

Veterans in vulnerable groups have specific needs, and there are estimates of the number of veterans nationally in groups including living in communal establishments and in prison. An ONS report provided a separate estimate for veterans living in communal establishments, in 2007 this was estimated to be 28,437 male veterans and 4,761 female veterans.

There is conflicting information relating to military veterans in the criminal justice system and prison. Defence Analytical Services and Advice analysis estimated that 3.5% of the prison population were military veterans by examining details held on the prison data systems to Service leaver records. Nationally this represented 2,820 out of 81,071 prisoners. Reservists were excluded from this analysis; only data on regular service personnel could be matched. It should be noted that the report found that military veterans were less likely to be in prison that the non-veteran population. The Veterans In Prison Association project estimates that the true figure could be four times higher than this, with ex-servicemen reluctant to identify themselves due to feelings of embarrassment and not wanting to bring shame upon their regiment or squadron.

Next steps

- Informing local policy

Social care and public health policy impacts on a variety of areas where there is a clear need for service provision for the Armed Forces community. These include alcohol treatment to combat the higher incidence of alcohol misuse among Service personnel, mental health care provision for those struggling with

their combat experiences and elderly veterans requiring home adaptations to remain independent within their home.

At present, there is no clear information on veterans and the wider ex-Armed Forces community in Derbyshire and their specific health needs. This can make it difficult to inform social care and health policy and it would be appropriate for this to be considered as part of the development of the Joint Strategic Needs Assessment. If military veterans disclose their status this should be recorded to allow clinicians to assess whether their condition is related to their service and to refer in line with the commitments made in the Armed Forces Covenant.

There are also two key areas where immediate action could be taken to better serve the needs of veterans and their families around accessing healthcare and NHS priority treatment.

- Accessing healthcare

In September 2011 the Department of Health launched an e-learning package developed in partnership with the Royal College of General Practitioners to help GPs understand the issues impacting on the health of those serving in the Armed Forces, Reservists, the families of those serving, the bereaved and veterans. GPs who complete the course will be more likely to be able to identify a veteran and address their needs in a way that is appropriate to them. It is proposed that GPs are encouraged to access this package.

- NHS priority treatment

There is a need to ensure that health practitioners are fully aware of the rules regarding eligibility for priority treatment. It is proposed to work with Clinical Commissioning Groups to assist in ensuring that GPs are aware of NHS priority treatment.

Is an Equality Impact Assessment required?

As set out above the veterans and wider Armed Forces community form a significant section of the population of Derbyshire and a key action proposed is to consider information further as part of the Joint Strategic Needs Assessment.

Recommendations

It is recommended that the Board:

1. Note the key health issues affecting Armed Forces veterans
2. Agree the actions set out in the next steps section.

David Lowe
Deputy Chief Executive and
Strategic Director for Policy and Community Safety
Derbyshire County Council

Agenda Item No. 8

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 NOVEMBER 2012

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

Board Development
The second Board development session to be facilitated by the LGA will be held on 18 December 2012, starting at 1pm, with lunch available from 12:30.

The session will focus on one of the key priorities identified at the first session, which will be: How to have serious conversations about difficult changes ahead. The session will be in the format of a simulation event, where the Board will consider some real scenarios that require difficult decisions to be made in the foreseeable future.

For further information please contact Jane Cox, Policy Manager, DCC: jane.cox@derbyshire.gov.uk

HealthWatch

The HealthWatch Project Development Group has completed the engagement process to help determine what the new local HealthWatch service should focus on. The findings are being collated in a report that will be circulated to all interested parties once complete.

It was agreed to recruit an 'Implementer' to assist with the setting up of HealthWatch Derbyshire as a new not for profit organisation. Following a tender exercise the Council has appointed an organisation called Exact to assume the role of Implementer. *Exact* is now leading on recruiting an executive board before they assist the new board members in the development and setting up of the new HealthWatch organisation.
Board members will need to:

- be representative of our communities
- have a good mix of skills and experiences
- be willing to take on the role of being a trustee/director of a new organisation.

The opportunity to join the Board has been broadly advertised across Derbyshire, including through Derbyshire's network of voluntary and community sector organisations.

The County Council has written to the Hosts of Derbyshire LINk to advise that their contract will end on the 31st March 2013. It is planned that the new HealthWatch Derbyshire organisation will once established work with the LINk Hosts to ensure a smooth transition of activity including staffing.

For further information please contact James Matthews, Assistant Director Strategy & Commissioning, DCC: james.matthews@derbyshire.gov.uk

Update on Health Frameworks

The DoH published the technical refresh of the 'Public Health Outcomes Framework' (PHOF) on the 20 November 2012 at the same time as the PHOF Data Tool for England that contains the first set of baseline indicator data
The tool can be viewed at: www.phoutcomes.info
Further information and updates over time can also be found on Twitter @phoutcomes.

Building on the framework initially published in January 2012 (and refreshed in November 2012), the PHOF data have been produced by the network of Public Health Observatories in England, working together with government departments and other organisations on behalf of the Department of Health. The PHOF sets out overarching objectives for public health, the desired outcomes and the indicators that will help us understand how well public health is being improved, protected and the extent to which inequalities are being narrowed over time.

The tool contains data for 39 public health indicators split over **four domains**:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

The updated versions of the PHOF document and the DoH's press release can be found at: http://www.dh.gov.uk/health/tag/phof/

This follows the update of the NHS Outcomes Frameworks on 13 November 2012, which can be found here: http://www.dh.gov.uk/health/2012/11/nhs-outcomes-framework/

The publication of these frameworks including the Adult Social Care Outcomes Framework, due out imminently, constitute a structure for measuring improvement across the system and ensuring that the health and care challenges

For further information about the PHOF Data Tool, please contact: phoutcomes@sepho.nhs.uk.

The Chief Medical Officer's Annual Report

The Chief Medical Officer's annual report (volume 1) has just been published.

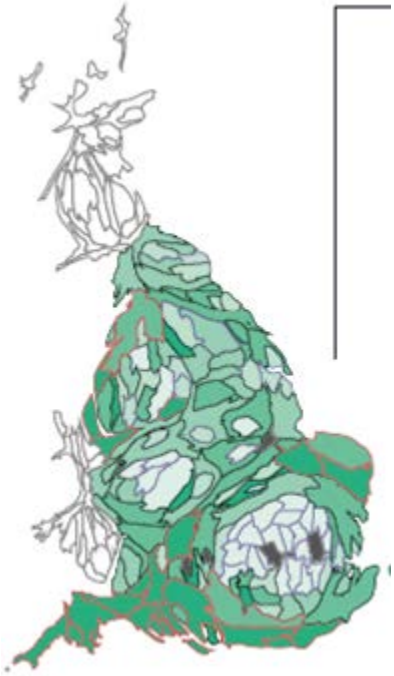
http://www.dh.gov.uk/health/2012/11/cmo-annual-report/

It contains a wealth of information, charts and maps covering:

- Demography
- Mortality, morbidity and well-being
- Risk factors
- Social determinants of health
- Healthcare

Three priority areas that are highlighted this year are liver disease, variable access to healthcare, and the importance of strengthening surveillance and intelligence systems.

If you've never seen the "population cartogram" of Great Britain, it looks something like this...



Annual Reports and Cancer Research

Below are links to a number of reports that Board Members may find useful:

- The Way Forward
  http://www.commissioningboard.nhs.uk/files/2012/07/way-forward-scn.pdf

- Cardiac Network Annual Report
  http://www.emcvn.nhs.uk/images/documents/network/Annual_Report_2012_FINAL_revised.pdf

- North Trent* Cancer Network Four Year review – Progress Report
  http://www.northtrentcancernetwork.nhs.uk/Downloads/Key-Documents/NEW%20VERSION%20Delivery_Against_Cancer_Outcomes_Framework_Yr_4.pdf

- North Trent* Cancer Network Annual Report
  http://www.northtrentcancernetwork.nhs.uk/Downloads/Annual-Reports/NTCN%20Annual%20report%202011-12.pdf

The North Trent area covers South Yorkshire, Bassetlaw and North Derbyshire i.e. all care that flows into Sheffield for specialist services.