Agenda Item No. 4

# DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

## 24 JANUARY 2013
## NUTRITION IN THE ELDERLY

***"Prevention and treatment of malnutrition should be at the heart of everything we do to ensure older people can live more independent, fulfilling lives".***

**Malnutrition Task Force**

## Purpose of the Report

To inform the Health and Wellbeing Board on the issue of nutrition in the elderly following on from earlier work undertaken by the Improvement and Scrutiny Committee. The report recommends how this programme may be embedded in 'day to day' health and social care practice.

A proactive systematic approach to the identification and management of malnutrition in the community and care settings is recommended. In addition an integrated (NHS/Social Care/Independent sector) structure will ensure the plan, activities and programmes become embedded within good caring professional practice.

## 1. Background

Malnutrition is a state in which a deficiency in energy, protein and other nutrients causes measurable adverse effects in tissue, organ function and clinical outcome. The prevalence of malnutrition rises with age and in older people with a long term conditions Evidence indicates that 14% of the elderly living at home or in care are at risk of malnutrition.

The health effects of malnutrition have an influence on all the NHS and social care outcome frameworks. Inappropriate dietary intake contributes significantly to acute and chronic morbidity and hence prolonged hospital admissions and rehabilitation periods and also impacts upon morbidity. Malnutrition in the elderly is everyone's business.

Assessing and managing nutrition is a crucial component of health and social care for the elderly and in adding 'life to years'.

A national Malnutrition Task Group has been established which will provide guidance on implementing The British Association for Parenteral and Enteral Nutrition (BAPEN) malnutrition and hydration driver guidance

This report encapsulates the work previously undertaken by the 'Nutrition Review Steering Group' and the Improvement and Scrutiny Committee. It recommends

an evidence based plan, considering the main themes from the previously undertaken work.

### 1.1. Definition of Malnutrition

Nutrition support should be considered in people who are malnourished as defined by any of the following:

- A body mass index (BMI) of less than 18.5Kg/$m^2$ ( Body weight in kg/ Height in metres)
- Unintentional weight loss of greater than 10% within the last 3-6 months
- A BMI of less than 20kg/$m^2$ and unintentional weight loss greater than 5% within the last 3-6 months

### 1.2. Types of malnutrition

There a 4 types of malnutrition:

1. Specific malnutrition, associated with clinical disease - eg rheumatoid arthritis
2. Sudden malnutrition, resulting from marked changes in food intake following physical trauma eg surgery or mental trauma such as bereavement
3. Recurrent malnutrition - which is severe malnutrition following a worsening cycle of illness and poor nutrition
4. Longstanding malnutrition characterised by chronic poor eating habits and a long latent period between the nutritional deficiencies and their clinical appearance.

### 1.3. Risk factors for malnutrition

1. Socio economic : social isolation, financial, lack of nutritional knowledge and difficulty getting around the physical environment
2. Psychological: depression, cognitive impairment, psychotic disorders and bereavement
3. Physical: Long term medical conditions, physical disability multiple medications and diseases which cause appetite loss eg rheumatoid arthritis.

### 1.4. Demographic Changes

Between 2012 and 2020 there will be a 27% increase from 65,000 to 106,000 in the resident population > 75years for Derbyshire. A greater proportion of the elderly will have a long term condition eg dementia which will increase the risk of malnutrition and other conditions including osteoporosis.

## 2. Planning previously undertaken in Derbyshire

A nutrition summit for Derbyshire took place in April 2011 and concluded:

- 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. It was agreed that the MUST (

malnutrition universal screening tool) is the preferred method of assessing the risk of malnutrition
- Training for professionals on the importance of nutrition and hydration should be developed and embedded
- Information for staff and carers regarding nutrition and hydration
- A countywide multidisciplinary team should be established to oversee the above priorities.

Following this summit a multiagency multi professional Nutrition Steering Group was established to take forward the recommendations of the review. The recommendations centred on:

1. Screening: The Malnutrition Screening Tool (MUST) is used in care settings within 24 hours of admission. It is important to note that no equivalent screening is established for people living in their own homes. This particularly applies to the frail elderly patients with for example COPD, heart failure
2. Monitoring of food not eaten by patients in care settings
3. Staff training in malnutrition awareness
4. Information: in relation to the on-going monitoring of malnutrition in care settings and the type of care plans implemented to address malnutrition

On the 16 May 2012 a review of the nutrition of older people in the community and care settings was undertaken led by the Improvement and Scrutiny Committee. A summary of this attached to the Health and Wellbeing Board report 27 September 2012 (Appendix 1)

The review found that of the 2,632 people > 65 years who were surveyed, 26% were considered to be malnourished by the MUST score combining the high (14%) and medium (12%) risk scores. 70% of people were considered to be low risk

Of the 369 people who were considered to be at high risk of malnutrition:-
- 17% of people in acute settings
- 26% of people were in care homes
- 32% of people in a community hospital
- 0% of people in mental health settings

The review did not include an assessment of malnutrition of people living in their own homes and this must be considered in any future work.

## 3. Evidence and Good Practice

### 3.1. National Institute for Health and Clinical Evidence.

NICE Clinical Guideline 32 – Nutrition support in adults (oral nutrition support, enteral tube feeding and parenteral nutrition. This provides guidance on which

categories of patients require nutritional support and the method of support NICE Quality Standard 24 Nutrition support for adults. The standards are as follows:

- Standard 1 screening for the risk of malnutrition in different settings using a validated screening tool egg MUST. Health and social care professionals need to be trained to use a validated tool - in hospitals and care homes, day care and registration with GP surgeries
- Standard 2 People who are malnourished or at risk of malnutrition have a management care plan that aims to meet their complete nutritional requirements
- Standard 3 Documentation and communication of results and nutrition support goals All people who are screened for the risk of malnutrition have their screening results and their nutrition support goals documented in writing and communicated when the care setting changes
- Standard 4 Self management of artificial nutrition support
  People managing their own artificial nutrition support and/or their carers are trained to manage their nutrition delivery system and monitor their wellbeing

The NICE quality standards provide 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

**3.2 Care Quality Commission (CQC)**
The CQC has produced a Provider Compliance Assessment document on meeting nutritional needs which assesses people who use services to ensure they are supported to obtain adequate nutrition and hydration.

**3.3 Essence of Care**
The NHS has produced an Essence of Care document for food and drink. The document details a benchmark of good practice for each of a range of specified factors to deliver person centred care.

**5.4. National Malnutrition Task**
Derbyshire is represented on the National Malnutrition Task Force
**http://www.malnutritiontaskforce.org.uk/resources.html**
Derbyshire is described on the web site as having an integrated approach to addressing malnutrition.

**5.5. NHS and Social Care Outcomes Framework**
The quality standards related to the NHS and Social Care Outcomes Frameworks are as follows:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions and for people with care and support needs
- Helping people to recover from episodes of ill health

- Ensuring that people have a positive experience of care and support
- Treating people in a safe environment and protecting them from avoidable harm and safe-guarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Malnutrition in the elderly will influence **all** of these quality standards

## 6. CONCLUSIONS

Assessing the state of nutrition in the elderly is the responsibility of every health and social care professional. A multiagency plan needs to be developed, based on the Improvement and Scrutiny Committee recommendations to ensure that nutrition and hydration are considered and managed in the elderly by all health, social care and voluntary sector staff. The work of the Scrutiny Committee has made sound progress towards achieving this but a mandate from the Health and Wellbeing board to drive forward the work further would ensure that a full multiagency approach is adopted with all health and social care agencies engaging fully with the agenda and securing positive improvements.

## 7. RECOMENDATIONS

- The multiagency Nutrition Steering Group is 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.
- Implementing and maintaining this programme will be the responsibility of the Adult Care Board which will report on progress to the Health and Wellbeing Board
- The Health and Wellbeing Board will mandate the progress of this 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.

**Anthony Morkane**

**Associate Director of Public Health**

**NHS Derbyshire County**

Agenda Item No 5

# DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

## 24 January 2013

## WINTERBOURNE VIEW

**Purpose of the Report:**

To update the Shadow Health and Wellbeing Board on progress in:

- Responding to the latest Department of Health initiatives arising from Winterbourne View:
- Local proposed actions to address the needs of people with learning disabilities, including people with complex needs or who require behaviour support

To seek support for the proposed additional actions.

**Information and Analysis:**

Since the last meeting of this Board, the Department of Health has 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 our local actions and proposals are attached as Appendix One and Two.

The Adult Care Board considered these reports and following a detailed discussion approved the recommendation that “a project group is urgently formed with representation from the local NHS, Adult Care and CAYA to ensure the actions detailed in this and other papers dealing with Winterbourne View are addressed”.

In addition the Adult Care Board agreed to develop an Accommodation, Care and Support Strategy for local people with learning disability or autism. This will cover a broader population than just the local people placed in hospital but is necessary to minimise the use of hospitals for people with a learning

disability. An initial concept report outlining the proposed strategy will be prepared for the next Adult Care Board meeting in March.

**Recommendations**:

The Shadow Health and Wellbeing Board support the Adult Care Board's proposal to:

- Establish a project group to lead the local actions around the Winterbourne View report
- Prepare an Accommodation, Care and Support Strategy for local people with a learning disability or autism.

Appendix 1

**DERBYSHIRE COUNTY COUNCIL**

**ADULT CARE BOARD**

**11 JANUARY 2013**

# UPDATED REPORT ON RECENT DETAIL AROUND WINTERBOURNE REVIEWS

## 1. Purpose of this report

The purpose of this report is to provide SMT and the Adult Care Board with updated information in relation to recent reports into Winterbourne View Hospital.

This is a follow up document from the previous Report into Winterbourne View which was presented to the Adult Care Board on the 15th November 2012. This paper highlights the key recommendations from the recently published Department of Health Review, Transforming Care; *"A National Response to Winterbourne View Hospital", Dec,* 2012.

In addition attached is a report from Hardwick CCG outlining progress against key milestones identified by the Department of Health.

## 2. Context

The attached report from Hardwick CCG indicates that there are 23 local people with learning disabilities placed in independent hospitals. In addition there are 134 people in out of county care homes placements funded by Adult Care and of these 79 are placed in immediately adjacent areas or close to Derbyshire. The remaining 55 live further afield.

## 3. Overview of Findings and Recommendations from; Transforming Care; *"A National Response to Winterbourne View Hospital", Dec,* 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 recommendations are detailed below.

- An end to all inappropriate placements by 2014 – so that every person with challenging behaviour gets the right care in the right place.

- Any adult who is in a specialist autism or learning disability hospital setting will have their care reviewed by 1 June 2013.

- Stronger accountability and corporate responsibility for owners and directors of private hospitals and care homes:

    - The Department of Health (DH) will examine how organisations and their Boards of Directors can be held to account for the provision of poor care or harm, and set out proposals in the spring to strengthen the system where there are gaps.
    - Tighter regulation and inspection of providers.
    - The Care Quality Commission (CQC) will tighten inspection and regulation of hospitals and care homes for vulnerable groups, with more unannounced inspection and greater involvement of service users and their families.
    - The CQC will hold organisations to account more vigorously for any failures to provide good quality care in line with the legal requirements.

- To improve quality and safety standards, including more staff training and better leadership in care settings:

    - New guidance will be published on training standards, codes of conduct, better commissioning practices and a code of ethics by various national bodies in 2013.
    - Stronger rules on social services departments' responsibilities for safeguarding are included in the draft Care and Support Bill.
    - The DH will work with professionals, providers, people who use services and families to develop and publish by end 2013 guidance on best practice so that physical restraint is only used as a last resort where someone’s safety is at risk and never to punish or humiliate.

- Better local planning and national support:

    - The NHS and local councils are expected to work more closely on joint plans in future, with pooled budgets to ensure adults with challenging behaviour get the support they need.
    - A new NHS and local government-led joint improvement team, funded by the DH, will help guide local teams, supported by a Concordat pledging commitment from over 50 national partners to raise standards.

- Greater transparency and strong monitoring of progress:

    - The DH will develop a range of measures and key performance indicators to help local councils assess the standard of care in their area.
    - The Learning Disability Programme Board, chaired by the Minister for Care and Support, will monitor progress and publish milestones.

## 4. Required Action

The Review makes it clear that the Government expects urgent progress to be made on improving standards. The following local actions are required;

- Changes in services so that there are better outcomes for people with learning disabilities.

- A locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour by April 2014.

- Local commissioners should have pooled budgets so that health and social care money is in the same place. Areas that do not pool budgets will be asked to explain why not.

- Everyone will have a named care coordinator and will have their care reviewed by June 2013.

- Planning good care starts with children. The Children and Families Bill will bring in a new single way to assess children. These are called Education, Health and Care Plans. This means good planning for children when they grow up.

## 5. Conclusion

- Whilst there are ample guidelines across health and care, the needs of this highly vulnerable group were not being addressed.

- However it is believed and intended that every action identified within the document, supported by a Concordat drawn up between all partners, will deliver the required real change. This will involve greater regulation, more stringent review processes and better communication lines including the encouragement for whistleblowing.

## 6. Recommendation

It is recommended that a project group is urgently formed with representation from the local NHS, Adult Care and CAYA to ensure the actions detailed in this and other papers dealing with Winterbourne are addressed.

**Appendix 2**

## Hardwick Clinical Commissioning Group

Draft report for CCG

**Update on LD commissioning activity and winterbourne compliance progress based on Key points raised in David Nicholson's letter on Winterbourne.**

The CCG is asked to note we have completed the Self Assessment Framework, with a positive meeting with NHS Midlands and East. However the formal response has not yet been received from Midlands and East. Once this has been received an action plan for each CCG will be produced.
The CCGs are also asked to note that Hardwick has held the resource (on behalf of the East Midlands) for the Living Local Project which has been delivering on a number of projects to support repatriation and care for people with complex needs in the community.

We have separately produced a paper in October for 4plus 4 on joint commissioning of carers short breaks in the county council localities.
We are also providing support to North Derbyshire CCG Commissioning team in reviewing specialized LD services within DCHS.
A clinical reference group for learning disabilities has started meeting and is currently reviewing dementia care pathways. Hardwick Lead GP is Dr. Tim Parkin.

**Winterbourne View Actions Update**
This update needs to be read in context of the Winterbourne report that went to Hardwick Board and was circulated to all CCGs in July 2012, the Local Authority paper on Winterbourne presented at Adult Care Board and the Options Appraisal for Joint Commissioning. (November 2012)

David Nicholson has written to SHAs on 28th Nov to prepare the ground for the Winterbourne View update report.
His letter is in italics.

*I'm letting you know that LD commissioners in PCT's and LA's (in handing over LD commissioning responsibilities to the CCGs) need to be prepared to make plans to:*

1. *Develop by 1 April 2013 and maintain local registers of all people placed in NHS-funded care, setting out clearly which CCG and Local Authority is responsible for them*.
   **Response**

We have a record of all (23) people placed in independent hospitals
We have initiated the regional protocol by which we inform other CCGs of placements and they inform us
We have started to make up the register of people for whom we are not the responsible CCG but who are in Independent hospitals in Derbyshire. We have discussed this with the providers and they have started sending us their lists of residents.
This is also being developed for CHC cases in residential and nursing homes.

2. *review by 31 May 2013 the care of all people in learning disability or autism inpatient beds and, based on that review, develop a comprehensive personal care plan for each individual, based on their and their families' needs and agreed outcomes*

   **Response**

   We have reviewed all patients in Hospital beds we have plans to move those that could be moved based on comprehensive care plan. However the individual's needs are complex and we have to tender for specific packages. Two such cases are going to tender in January and this will be the start of an ongoing process. We have 23 patients in total in hospital placements with a learning disability. The number is set to decline and we are retaining a LD nurse in the quip program in 2013 on to continue to review all patients and formulate individual care plans and we have worked with local authority to agree a process of going forward with complex cases.

3. *as a result of that review, bring back into community-based settings as soon as possible, and no later than 31 May 2014, everyone inappropriately placed in hospital;*

   **Response**

   We have no one inappropriately placed in hospital in that all those placed have high needs, detained under the MH act etc. But we can bring some people with extended length of story home if we commission complex packages. This approach has started and will be complete by May 2014. It will require continued commitment to CCGs to fund the LD nurse in the IPP project and this has been raised formally within the contract round.

4. *commission independent advocacy support as needed by people in hospital settings and their families to support them in moving on;*

   **Response**

   As part of the regional procurement exercise independent advocacy will be re-assured but we have already ensured there is advocacy in place for the independent hospitals we commission from and the details will be publically available on their websites in January. We have found that the individual case workers we have dedicated to this task work effectively to move people on and this is being done in a collaborative fashion with

carers and with the person themselves. The LD nurses we employ for the task are there to advocate moving people on.

5. *have in place, as part of their formal annual plans for 2014/15, an evidence-based strategic plan to commission the range of local health and care support services required to meet the needs of children and adults with challenging behavior in their locality; and;*

   **Response**

   We have commissioned the National Development Team (NDTI) for Inclusion to advise on pathway changes to ensure no one goes to a hospital when it can be avoided and none stays there for care only for treatment. They have engagement meeting with professionals on 6 December with carers in January and have already met with Local authority and CCG commissioners. We have raised the process in the Adult Care Board in the county. Hardwick will be attending the transitions board in the county to ensure we support the transition from Children's to adult services seamlessly and can plan alternatives at an early stage in pathways. CHC are already now reviewing younger people so there is seamless transition to adult services. We have taken to adult care Board a paper on options for lead commissioning. This is being worked on in more detail but the aim is to consider integrated pathway that can meet the needs more seamlessly and ensure there is a clear approach and leadership of complex commissioning where CHC and Community care responsibilities and Hospital budgets overlap.

6. *ensure that health and social care commissioners commission against clearly defined standards of quality, safety and openness in contracts with all providers to drive up quality.*

   **Response**

   This is an explicit part of the work we have contracted NDTI to take forward as part of the procurement exercise. We already have CQUIN in place and contract meetings. Jim Connell Hardwick Chief Nursing Officer will be part of the project board regionally and involved in contract review of existing providers regarding quality. In addition we have commissioned the health facilitators team to develop a cohort of people with a learning disability to act as quality checkers in homes and we will be aligning this initiative with health watch when in place. The regional procurement board has representation on the national team who are producing a revised service specification for LD and we thus can be assured that our contracts will reflect the emerging best practice standards.

Responsible COO Andy Gregory
Responsible Lead and report owner David Gardener

Agenda Item No 6

# DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

## 24 January 2013

## HEALTH AND WELLBEING STRATEGY: ACTION PLANNING AND PERFORMANCE MANAGEMENT APPROACH

### Purpose of the report

To seek approval for the proposed Action Planning and Performance Management Approach for the Derbyshire Health and Wellbeing Strategy.

### Background

In September 2012 the Board approved the Health and Wellbeing Strategy that sets out the priorities of partners across Derbyshire that they will focus on to achieve the vision: 'To reduce health inequalities and improve health and wellbeing across all stages of life by working in partnership.

### Information and Analysis

### Action Planning

To ensure the successful implementation and delivery of the Strategy, detailed action plans are being developed and a Lead Officer has been allocated for each of the actions outlined in the Strategy. The Lead Officers from each of the five priorities in the Strategy will meet to develop and agree a SMART Action Plan for their priority. The five priorities are:

- Health and Wellbeing in Early Years
- Healthy Lifestyles
- Mental Health and Wellbeing
- Long-term conditions and carers
- Older People's Health and Wellbeing

The action plans will be supported by indicators identified from the national frameworks for Public Health, NHS, Adult Care, Children and CCGs, as well as local indicators that will show how Derbyshire is performing.

The action plans will be approved by the Health and Wellbeing Co-ordination Group who will monitor the progress being made. Areas of significant underperformance will be reported to the Board by exception.

**Performance Reporting**
It is proposed that the Health and Wellbeing Board receive a performance report on a specific priority from the Strategy at each of its meetings during 2013/14, as follows:

May 2013 – Health and Wellbeing in Early Years
July 2013 – Healthy Lifestyles
September 2013 – Mental Health and Wellbeing
November 2013 –Long-term conditions and carers
January 2014 – Older People's Health and Wellbeing
March 2014 – Summary of progress made over the year and areas of focus for the following year.

The report will comprise a summary of the outcome indicators for the priority and commentary on progress being made. It will identify those areas of work that are on target, those that are making progress but need to do more and those where immediate action is required to improve performance.

The approach will be introduced from April 2013. As the monitoring and reporting of performance develops, it may become appropriate for Board members to take ownership of particular priorities.

**Is an Equality Impact Assessment required?** An EIA was carried out during the development of the Health and Wellbeing Strategy and is available on the website: http://www.derbyshirepartnership.gov.uk/images/HWB%20Strategy%20EIA%20Appendix%20A_tcm39-212471.pdf

**Recommendations**

It is recommended that the Board approve the Action Planning and Performance Management Approach outlined in the report for the Health and Wellbeing Strategy.

Agenda Item No. 7a

# DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

## 24 JANUARY 2013

## DERBYSHIRE CLINICAL COMMISSIONING GROUPS LEAD COMMISSIONING RESPONSIBILITIES

### Purpose of the report

To inform the Shadow Board about the lead commissioning roles agreed across the Clinical Commissioning Groups (CCGs) in Derbyshire.

### Background

During 2011, CCGs were developing across the area previously covered by Derbyshire County PCT and as the Health & Wellbeing Board is aware the configuration was eventually settled at four CCGs. At the same time, the NHS was under immense pressure to cut management costs and staff levels across the PCT were reduced by close to 50% through voluntary redundancy and a vacancy freeze.

Early in the life of CCGs a robust method of working closely together and sharing scarce resources was discussed. It was agreed that whilst every CCG remained accountable for all of the services commissioned for its population, it was not possible for every CCG to employ or buy in the necessary skills within the £25 per head of population running costs limit.

It was also not efficient for every individual CCG to directly commission services from a large provider. For example, Derbyshire Community Health Service NHS Trust provides services to all four CCGs but this is through a single contract which is more efficiently managed by one team on behalf of all.

A process was therefore undertaken that looked at the staff available and where they were located and lived, the location of the main providers and the geographic areas they covered. This resulted in a series of agreed lead roles which are set out below.

### Information and Analysis

### Southern Derbyshire CCG leads on:

Derby Hospitals NHS Foundation Trust contract
Burton Hospital Contract (main commissioner though is Staffordshire based CCG)
Urgent care in South of County and City

DRAFT

**Erewash CCG leads on:**

East Midlands Ambulance Service
Home Oxygen Service
Patient Transport Services contract with NSL
Voluntary sector contracts
Nottingham University Hospitals NHS Trust (main commissioner is a Nottingham CCG)

**Hardwick CCG leads on:**

Derbyshire Healthcare NHS Foundation Trust contract
Mental health services
Learning disability services
Care homes contracts
Sheffield Teaching Hospitals NHS Foundation Trust (main commissioner is in Sheffield CCG)

**North Derbyshire CCG leads on:**

Derbyshire Community Health Service NHS Trust contract
Chesterfield Royal Hospital NHS Foundation Trust contract
Derbyshire Health United out of hours contract
NHS 111 contract plus procurement
Urgent care in North of County
Stockport Hospitals NHS Foundation Trust (main commissioner is in NW CCGs)

**Next Steps**

**Is an Equality Impact Assessment required?**

No, this will be carried out at individual service change level.

**Recommendations**

The Shadow Health and Wellbeing Board is asked to note the lead roles and responsibilities of each CCG.

**Jackie Pendleton**
**Chief Officer (Designate)**
**North Derbyshire CCG - On behalf of all Derbyshire CCGs.**

More information from: Jackie.Pendleton@northderbyshireccg.nhs.uk

DRAFT

Agenda Item No. 7b

**DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD**

**24 JANUARY 2013**

# DERBYSHIRE CLINICAL COMMISSIONING GROUPS EVERYONE COUNTS – PLANNING FOR PATIENTS 2013/14

## Purpose of the report

To inform the Shadow Board of the NHS planning guidance for 2013/14 and the way in which the CCG plans will be signed off by the NHS Commissioning Board Area Team following discussion with the H&WB on the three local priorities for each CCG.

## Background

The NHS Commissioning Board (NHS CB) published its planning guidance to all commissioners in December 2012. A link to the full suite of documents is below although the key points are captured in this briefing.

http://www.commissioningboard.nhs.uk/everyonecounts

The following is the Executive Summary lifted from the main document:

**Empowered local clinicians delivering better outcomes; increased information for patients to make choices; and greater accountability to the communities the NHS serves**

These are the principles behind our new approach to planning clinical led-commissioning from April 2013.

As the body charged with overseeing and supporting this new system the NHS Commissioning Board exists to enable excellence in healthcare. The NHS Outcomes Framework and NHS Constitution set out the goals and responsibilities – but the approaches for delivery will vary and local commissioners will have freedom to develop those that work in their community. Healthcare success in the future will be judged on the quality of outcomes.

At a time of significant financial challenge, where we need to ensure all organisations are robust to address the challenges facing them, this document lays out five offers to help commissioners deliver for the public: support for routine NHS care seven days a week; greater transparency on outcomes; mechanisms to enhance patient feedback; better data collection to drive evidence-based medicine; and for high professional standards. Alongside these are details of the package of guidelines and incentives that demonstrate a new relationship between those

directly developing services and those working at a national level. Among the measures covered in this document are:

**Listening to patients**

- The rights of patients set out in the NHS Constitution are vital. They must be delivered.
- Customer convenience - the NHS will move to providing seven days a week access to routine healthcare services.
- Real-time experience feedback from patients and carers by 2015.
- A Friends and Family Test to identify whether patients would recommend their hospital to those with whom they are closest.

**Focusing on outcomes**

- Publication of consultant-level outcome data covering mortality and quality for ten surgical and medical specialties.
- NHS Outcomes Framework will now inform NHS planning. Commissioners will be expected to prioritise and make improvements against all indicators.

**Rewarding excellence**

- Continued financial and related levers and enablers for clinical commissioning groups to use when commissioning for better patient outcomes.
- A Quality Premium for clinical commissioning groups who secure quality improvement against certain measures from the NHS Outcomes Framework
- Support for clinical commissioning groups to define their local QIPP challenge and set milestones.
- CQUIN payments only available to providers who meet the minimum requirements concerning the high-impact innovations, as set out in *Innovation, Health and Wealth*.
- During 2013/14, a fundamental review of the incentives, rewards and sanctions available to commissioners to drive improvements in care quality.

**Improving knowledge and data**

- NHS Standard Contract to require all NHS providers to submit data sets that comply with published information standards.
- *Care.data* - a modern knowledge service for the NHS will provide commissioners with timely and accurate data.

**Information and Analysis**

Each CCG must submit a first draft plan by 25 January covering the following:

1. “Plan on a Page” including key elements of transformational change. This is what the H&WB received from each CCG at its last meeting.

2. A template covering :

- Self certification of commitment to delivery of the rights and pledges of the NHS Constitution, Mandate and *Clostridium difficile* objective;
- Self certification of assurance that provider cost improvement plans are deliverable without impacting on the quality and safety of patient care;

3. Trajectory for dementia diagnosis rates and Improving Access to Psychological Therapies (IAPT) - proportion of people entering treatment;

4. Trajectories for locally selected priorities;

5. Activity trajectories for four key measures – elective finished first consultant episodes(FFCEs), non-elective FFCEs, first outpatient attendances, A&E attendances;

6. Financial information, including a brief overview of financial position, underlying assumptions and associated risks.

The three local priorities are expected to be those areas which have already been identified in CCG clinical commissioning strategies and linked to the H&WB Strategy. It is not a requirement that each CCG will identify the same priorities. Each CCG will attend the H&WB meeting on 24 January ready to outline the areas that they will be submitting the following day.

The priorities have to be measurable as they will form part of a quality premium payment (see Appendix One) which will be made in 2014/15 if all targets are met.

Also attached are details of the Outcomes Framework measures (Appendix two) and the NHS Constitution and other targets (Appendix Three) that must be achieved.

**Next Steps**

**Is an Equality Impact Assessment required?**

No, this will be carried out at individual service change level.

**Recommendations**

The Shadow Health and Wellbeing Board is asked to:

- Note the planning guidance and requirements for CCGs in 2013/14.

**Jackie Pendleton**
**Chief Officer (Designate)**
**North Derbyshire CCG - On behalf of all Derbyshire CCGs**

More information from: Jackie.Pendleton@northderbyshireccg.nhs.uk

**Appendix One**

**2013/14 Quality Premium Briefing**

The NHS Commissioning Board (NHSCB) have published guidance[1] on the new 'Quality Premium', which is being introduced in 2013/14 and is intended to reward CCGs for improvements in the quality of the services they commission and for associated improvements in health outcomes and reducing qualities.

The Quality Premium will be paid to CCGs in 2014/15 – reflecting the quality of services commissioned in 2013/14 – and is in addition to the CCG's main financial allocations for 2014/15 and on top of its £25 per head running costs allowance.

Payment of the Quality Premium will be based on four national measures and three local measures and is distributed as follows:

**National Measures**

| NHS Outcomes Framework Domain | Quality Premium Measure | Threshold | Value |
|---|---|---|---|
| Domain 1: preventing people from dying prematurely | Potential years of life lost from causes considered amenable to healthcare. | The potential years of life lost will need to reduce by at least 3.2% between 2013 and 2014. | 12.5% of quality premium |
| Domain 2: Enhancing quality of life for people with long term conditions.<br><br>Domain 3: Helping people to recover from episodes of ill health or following injury | Avoidable emergency admissions | Reduction or a zero per cent change in emergency admissions between 2013/14 and 2014/15. | 25% of quality premium |
| Domain 4: ensuring that people have a positive experience of care | 1. Roll-out of Friends and Family Test<br>2. Patient experience for acute inpatient care and A&E services | 1. All relevant local providers to have delivered the nationally agreed roll-out plan for FFT<br>2. Improvement in average FFT scores for acute inpatient care and A&E services between Q1 2013/14 and Q1 2014/15. | 12.5% of quality premium |

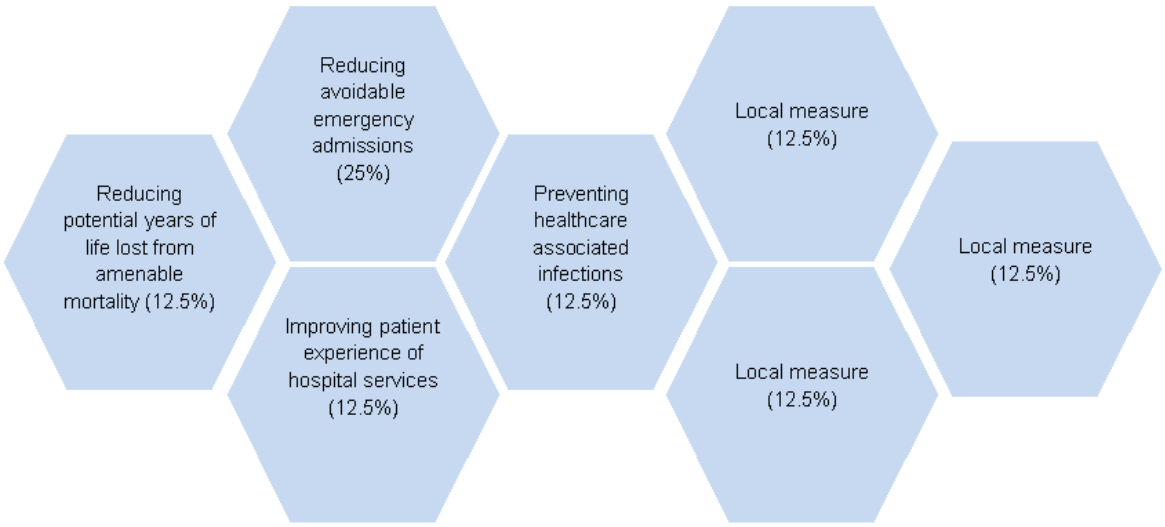
[1] http://www.commissioningboard.nhs.uk/files/2012/12/qual-premium.pdf

| | | | |
|---|---|---|---|
| Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm | 1. Incidence of MRSA bacteraemia<br>2. Incidence of C. difficile | 1. No cases of MRSA bacteraemia for the CCG's population; and<br>2. C. difficile cases are at or below defined thresholds for CCGs. | 12.5% of quality premium |

**Local Measures**

The Quality Premium will include three local measures (to be identified by the CCG in the planning round). These measures should focus on local issues and priorities, especially where the outcomes are poor compared to others and where improvement in these areas will contribute to reducing health inequalities.

**Overall distribution of quality reward**




It should be noted that even if the CCG achieves the above measures the NHSCB reserves the right to either not make a payment or reduce the payment where they consider there to be quality failures. For example the NHSCB will reduce the payment in the following circumstances:

- CCG does not manage within its total resource envelope for 2013/14
- CCG's providers do not meet the NHS Constitution rights or pledges for patients including the:
    - 18 weeks Referral to Treatment standards
    - 4 hour waits in A & E
    - 62 day waits from urgent GP referral to first definitive treatment for cancer
    - 8 minute response for Category A red 1 ambulance calls

**Appendix Two**

NHS Outcomes Framework measures which the NHS Commissioning Board and Clinical Commissioning Groups will use to track progress (i.e. data can be generated at clinical commissioning group level and a baseline can be determined against which progress can be considered).

| **Domain** | **Measures that are suitable for both in year and annual assessment** | **Measures that are suitable for annual assessment only** | **In Quality Premium** |
|---|---|---|---|
| Preventing people from dying prematurely | None | Potential years of life lost (PYLL) from causes considered amenable to healthcare<br>Under 75 mortality rate from cardiovascular disease<br>Under 75 mortality rate from respiratory disease<br>Under 75 mortality rate from liver disease<br>Under 75 mortality rate from cancer | Potential years of life lost (PYLL) from causes considered amenable to healthcare |
| Enhancing quality of life for people with long term conditions | Combined measure of<br><br>Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)<br><br>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s and 2 measures from domain 3. | Proportion of people feeling supported to manage their condition<br>Health-related quality of life for people with long-term conditions<br>Dementia Diagnosis Rates | Combined measure of:<br><br>Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)<br><br>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s<br><br>Emergency admissions for acute conditions that should not usually require hospital admission.<br><br>Emergency admissions for children with lower respiratory tract infections (LRTI) |

| Domain | Measures that are suitable for both in year and annual assessment | Measures that are suitable for annual assessment only | In Quality Premium |
|---|---|---|---|
| Helping people to recover from episodes of ill health or following injury | Combined measure as above with:<br><br>Emergency admissions for acute conditions that should not usually require hospital admission<br>Emergency admissions for children with LRTI<br>Emergency readmissions within 30 days of discharge from hospital | Patient Reported Outcome Measures (PROMs) for elective procedures: i)Hip replacement, ii)Knee replacement, iii)Groin hernia, iv)Varicose Veins | Combined measure with above indicator. |
| Ensuring that people have a positive experience of care | Patient experience of<br>i GP Services<br>ii GP Out of Hours services<br>Friends and family test | Patient experience of hospital care (needs attribution to CCG) | Patient experience measure |
| Treating and caring for people in a safe environment and protecting them from avoidable harm | Incidence of healthcare associated infection: MRSA<br>Incidence of healthcare associated infection: *Clostridium difficile* | None | Incidence of healthcare associated infection: MRSA and *Clostridium difficile* |

**Appendix Three**

**Expected rights and pledges from the NHS Constitution 2013/14 (subject to current consultation) including the thresholds the NHS Commissioning Board will take when assessing organisational delivery**

**Referral To Treatment waiting times for non-urgent consultant-led treatment**

Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%

Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%

Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%

**Diagnostic test waiting times**

Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99%

**A&E waits**

Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95%

**Cancer waits – 2week wait**

Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%

Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%

**Cancer waits – 31 days**

Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%

Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%

Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%

Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%

**Cancer waits – 62 days**

Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%

Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%

Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set

**Category A ambulance calls**

Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)

Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%

**Mixed Sex Accommodation Breaches**

Minimise breaches

**Cancelled Operations**
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
**Mental health**
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.

**Additional measures NHS Commissioning Board has specified for 2013/14.**

**Referral To Treatment waiting times for non-urgent consultant-led treatment**
Zero tolerance of over 52 week waiters
**A&E waits**
No waits from decision to admit to admission (trolley waits) over 12 hours
**Cancelled Operations**
No urgent operation to be cancelled for a 2nd time
**Ambulance Handovers**
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

Agenda Item No. 8

**DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD**

**24 January 2013**

**Together for a healthier future**
**The Tameside & Glossop Public Health Annual Report 2012**

## Purpose of the report

To inform the Board about the availability of the Public Health Annual Report for Tameside & Glossop 2012.

## Background

The Director of Public Health has the responsibility to produce a Public Health Annual Report on the state of the health of local people. This Report has been produced in a magazine style format to make it as accessible as possible to a wide audience.

## Aims of the Report

The aims of the Report are 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 uses "nudge" theory by highlighting positive health behaviours. It also showcases the collaborative work that is in place.
- There is a Top Ten Tips section which provides advice on how to protect and improve health with links to supportive services and further information to enable people to make positive choices.
- The Cost Effectiveness section demonstrates the potential for cost savings to both the health system and the wider economy from public health interventions.
- Shaping the Future outlines the public health approaches to protecting and improving health within the context of the wider impacts of a shrinking public sector. This section defines some of the plans and interventions which will have a positive impact on health including the wider determinants, health and social care systems and direct support for lifestyle programmes.

There is a joint commitment to tackling health inequalities experienced by individuals, groups and areas to narrow the gap in health experience, achieve a greater level of fairness and improve health outcomes wherever possible. This commitment will 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
- minimise any negative health impacts of policies and programmes

The report is available on the NHS Tameside & Glossop website http://www.tamesideandglossopccg.org/strategies/public-health/tameside-and-glossop-public-health-annual-report?site_locale=en.
The contents of the report are underpinned by the Tameside & Glossop JSNA.

**Next Steps/Way Forward**

The Health & Wellbeing Board are asked to note the contents of the Report and how it relates to the Health & Wellbeing Strategy. The report has been presented at the Tameside & Glossop CCG Board and the Tameside Health & Wellbeing Board.

**Is an Equality Impact Assessment required?** No
**If yes, has one been carried out?** Yes/No

**Recommendations**

Board members are 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.

**Elaine Michel**
**Interim Director of Public Health**
**NHS Tameside & Glossop**

# Together for a Healthier Future

## Tameside and Glossop Public Health Annual Report 2012

Useful Facts

Elaine's Top Ten Tips to BE SAFE

Cost Effective Interventions

A Celebration of Success

Shaping the Future

# Contents


03 Introduction

04 Useful Facts

06 Elaine's Top Ten Tips to BE SAFE

08 Cost Effective Interventions

09 A Celebration of Success

14 Shaping the Future

18 Actions from the Public Health Annual Report 2010

19 Useful Links

# 01 Introduction

**I'm delighted to present to you this celebration of health in Tameside and Glossop. People are living longer, healthier lives than ever before.**

There are a great range of programmes and projects in place that are supporting people to make healthier choices easier. These enable us all to improve and protect the health of ourselves, our families, friends and communities.

**A Celebration of Success** section gives you a flavour of some of the approaches we are working on with local people and partners to enable better levels of health and wellbeing. There is a great commitment across a wide range of partners to support and enhance the ability of all sections of the population to be as healthy as possible. Please take a few moments to look at some of these projects which have been organised from cradle to grave.

**Elaine's Top Ten Tips to BE SAFE** section provides useful advice to help you and your family to stay well. These are linked to additional sources of advice and support that you can make use of.

I know that these are challenging economic times for many people which can create barriers for people wanting to maintain high levels of mental and physical wellbeing. This means we need to work smarter and find ways of investing in health improvement and prevention now to save later. You will find a short section,

**Cost Effective Interventions,** showing the value for money interventions which help people to stay well and save money for both public and private sector organisations. At this time of major change and financial pressure, working together is absolutely vital to make the best use of our resources.

**Shaping the Future** section outlines how we are planning to provide public health leadership, advice and support to enable a whole system approach to improving health for everyone. We plan to ensure effective engagement and promotion of the benefits of good health with individuals, families and communities to create environments that promote and support health.

There is a joint commitment to level up the quality of services so that people get what they need to maintain their health including equitable access to services. We are looking to people to use scarce public sector services responsibly to ensure they are available to those who can benefit.

There are plans for major changes to the health and social care services that are available in your area. We are committed to engage with local people and organisations to get good value for money from our services. We are jointly committed to tackling health inequalities experienced by individuals, groups and areas, and to narrow the gap in health experience, and outcomes wherever possible. This commitment will 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
- minimise any negative health impacts of policies and programmes.

**Elaine Michel**
Interim Director of Public Health

# 02 Useful Facts

## Starting well

There were **3593** babies born in Tameside and Glossop in 2010/11.

**2 out of 3** mothers started breast feeding their babies at birth in 2010/11.

**Just over** half of the children in Tameside achieved a good level of readiness to start school.

## Developing well

**3 out of 4** students achieved 5 or more A* to C grades in 2011.

**1 in 4** children in Tameside live in poverty.

Over **2,300** children in Reception Year and **1,728** children in Year 6 are a healthy weight.

**About 1 in 3** children who are 5 years old in Tameside have at least one decayed, missing or filled tooth.

## Living well

**Just over 1 in 3** 15 to 24 year olds in 2011 were screened for chlamydia (a sexually transmitted disease).

Since January 2012 we have delivered **3,000** community Health Checks to find risks of serious illness such as heart disease, stroke and diabetes.

The estimated population for Tameside & Glossop is **250,784.**

Approximately **75%** adults in Tameside and Glossop are non smokers.

In 2011 the Stop Smoking Service helped **over 2,000** people to quit smoking.

**1 in 5** mothers in Tameside and Glossop smoke when their baby is delivered.

There were over **6,600** alcohol related hospital admissions for 2011/12 in Tameside.

**253 households** received Warm-Front grants to improve the energy efficiency of their homes in 2011/12, amounting to £409,350 of investment.

## Working well

In 2010/11 **just over 3,600** people started apprenticeship schemes in Tameside.

**1 in 5** 16 to 18 year olds in Tameside are in apprenticeships.

About **95,000** people in Tameside are in employment.

## Ageing well

**Half** of people over 65 years who had a hip fracture returned to their home following hospital treatment.

There are approximately **22,240** carers in Tameside.

Over **6,000** people aged 65 and over receive community-based services.

There are nearly **1,500** people aged 65 years and over living in a care home.

During 2011/2012 the Community Response Service in Tameside supported nearly **4,500** people to remain in their own homes safely.

Over **two thirds** of the people who use the re-ablement service leave with either no package or a reduced package of care due to support in regaining and developing skills to maintain independence.

## Dying well

**About 1 in 5** people that die, died in their own home.

The percentage of people dying from Alzheimer's disease, dementia and senility is significantly lower than for England.

Tameside has more beds providing Care Home Support for the size of our population compared to England.

# 03 Elaine's Top 10 Tips to BE SAFE

## 01 Be Smoking Wise

The single best thing you can do for your health is to not take up smoking or give up if you do. **Smokefree Tameside and Glossop** offer free local support to help you stop smoking. For more information or to book a session call 0161 366 2000.

## 02 Be Germ Wise

Handwashing is one of the best ways of preventing infections, especially those that cause diarrhoea, vomiting, coughs and sneezes. Always wash your hands after using the toilet, before eating or handling food, and after handling animals.

## 03 Be Fire Wise

A smoke alarm could save your life and that of your family. Make sure you have one fitted and that it's working. Have an escape plan in case a fire does happen. You can book a FREE Home Fire Safety Check by calling 0800 555 815 or filling in the **form on line.**

## 04 Be Road Wise

Accidents on the road are a major cause of injury and death for children of all ages. Keep yourself and your children safe by setting a good example and teaching them the rules of the road. The **Department of Transport's THINK! Education website** includes a wealth of road safety information and resources.

## 05 Be Sex Wise

Ashton Primary Care Centre (Tel 0161 342 7101) offers sexual health advice, tests and treatment for sexually transmitted infections, all methods of contraception including implants, coils, emergency contraception, and pregnancy testing. SAFE **www.tgsafe.co.uk** is a free and confidential website for people that promotes local services.

## 06 Be Immunisation Wise

Childhood immunisations are the safest way to protect your child from the risk of complications from infections such as polio, meningitis C and measles. People over 65 years and with some long term conditions are immunised to prevent flu and pneumonia. If you want more advice, please contact your GP.

## 07 Be Cancer Wise

Cancers that are found earlier are more likely to be treated successfully. **The NHS cancer screening programmes** for breast, cervix and bowel cancer increase the chance of finding a cancer early so make sure you take up your screening offer when it comes.

## 08 Be Alcohol Wise

Adults should not regularly drink more than 3-4 units a day if you're a man or 2-3 units a day if you're a woman. Also have a few alcohol-free days each week. If you're worried you are drinking too much, make an appointment to talk to your GP.

## 09 Be People Wise

Talk to people around you and remember to also listen. Talk to someone if you're feeling distressed or upset. Do something nice for a friend or neighbour.

## 10 Be Health Wise

Free NHS Health Checks, for people aged 40 – 74, helps in early identification of risks related to long term conditions like heart disease, stroke, diabetes and kidney disease. To book your free health check, simply contact your GP.

# 04 Cost Effective Interventions

All public sector organisations need to tighten their belt, whilst also meeting the needs of local people. Therefore, we have to make sure we spend our money wisely and to best effect. An important way of doing this is to bring together the services delivered by different organisations such as the NHS, local authorities, voluntary and community agencies. These integrated services are then better value for money, more effective and easier for local people to use.

Waiting until after people become ill or frail before providing treatment does not make sense either. It is much better value to keep people healthy and living independently as they grow older. It is therefore essential that we provide programmes, services and information that help and support people, their families, their communities and their workplaces to be healthy and well at all stages of life.

This chapter highlights some of the programmes or actions that can help to provide local services at a lower cost, but in a more effective way.

## Smoking

NICE estimates that providing stop smoking support creates £11.37 of savings for every £1 spent. This is due to NHS savings and the value of health gained. Employers also save an average of £1,664 per year in productivity for every smoker who quits.

## Obesity

If 10,000 fewer people were obese there would be around 150 fewer people with coronary heart disease, 1,156 fewer people developing Type 2 diabetes and 9801 fewer people with high blood pressure. Locally this would mean savings of over £1,000,000 (1 million) in prescribing costs for chronic heart disease, diabetes and hypertension.

## Workplace health

The economic evidence shows that promoting wellbeing in the workplace can save £9 for every £1 invested.

## Alcohol

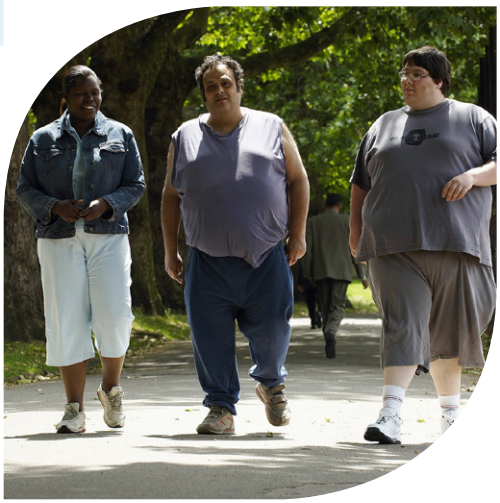
For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels resulting in reduced costs from alcohol related A&E attendances and hospital admissions.

## Respiratory disease

For every 10 teenagers that don't become smokers, nearly £9,000 can be saved each year because of the treatment for respiratory disease that will no longer be needed.

## Sexual health

Investing in contraceptive services is very cost effective with an estimated saving of £11 for every £1 invested.



# 05 A Celebration of Success

## Starting well

### Good Infant Mortality

Babies under one year of age are more likely to survive into childhood in Tameside and Glossop compared to the North West and England averages.

### Breastfeeding

Locally, breastfeeding increased significantly in the five years from 2005 to 2010, and a new Peer Support Programme was commissioned for 2011 to maintain this improvement. The service is now being provided by Home Start who are recruiting and training local volunteers.

### Vaccination and Immunisation

There has been an upward trend in childhood immunisation in 2011/12, with rates for children reaching their second birthday exceeded the 95% targets set for the national programme. The target of 95% for the 1st, measles, mumps and rubella (MMR) vaccine was achieved and maintained for the first time.

### Oral Health

Dental health of 5 year olds in Tameside has improved significantly since 2009. Targeted approaches focusing on the most vulnerable

groups including the Bangladeshi community of Hyde, have resulted in 112 children aged 3 to 6 years attending the dentist for the first time during the past eight months to have fluoride varnish applied to their teeth.

Other programmes include: sustainable community 'brush and paste' sales schemes, available to all families and vulnerable adults across Tameside. Making every contact count, parents of children aged 6 months to 5 years receive advice, resources and information on local NHS dental services, from health visitors, dentists, under five childcare providers, child and adult social care staff, and voluntary organisations.

## Developing well

### Reduction in Teenage Pregnancy

To help young people avoid unplanned pregnancies we ensure young people have easy access to services and more choice in where they can be supported, get advice and obtain the contraception method most suited to their needs. Less young women are becoming pregnant in their teens now, with a fall of over 3% in recent years.

In 2011/12 our young people focussed SAFE service reached 6,335 young people, almost double the amount as in the previous year. Our services continue to ensure that they work together to reach those young people most in need of support. The challenge to provide the best possible support continues so that we can ensure more young people are supported to make informed choices.

**If you have any contraception or sexual health concerns please call 0161 342 7101 or talk to your GP or Practice Nurse or visit the website www.tgsafe.com**

### Fewer young people smoke and drink

The Trading Standards North West Survey into the smoking and drinking behaviour of young people aged 14-17 showed that smoking rates at age 14 halved from 2009 to 2011, but are still 50% higher than national rates. The number of 15 year olds who smoke has fallen but there is a high proportion of young people in Tameside and Glossop who smoke compared to England.

### More young people are a healthy weight

As part of the National Child Measurement Programme (NCMP),every year children in Reception Year (aged 4-5 years) and Year 6 (aged 10-11 years) have their height and weight measured during the school year to help inform planning and delivery of local services for children. The percentage of overweight children in Reception Year in Tameside and Glossop has fallen in 2010/11 compared to the last two years and is currently lower than the England and North West average. The percentage of overweight children in Year 6 has also fallen locally in the past year, whereas there has been an increased number in the North West and England.

### Achievement in education

There has been a 68% growth in apprenticeships in Tameside, and now a fifth of 16-18 year olds are in apprenticeships. This means that we are on course to achieve our target of having a quarter of this age group in apprenticeships. A key factor in the development of apprenticeship numbers and quality was the close working of Tameside's training providers with the National Apprenticeship Service.

## Living well

### Reduction in CVD mortality

Heart disease and stroke deaths continue to reduce in line with the rest of England as more prevention and better treatment take effect. Further reductions in smoking and the impact of NHS Health Checks will help us to continue this improvement.

### Low Road Traffic Accidents (RTAs)

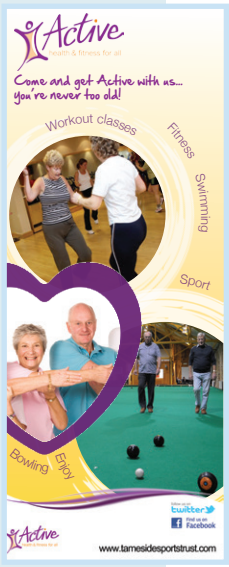
In Tameside during 2011 there were 57 people either killed or seriously injured in road traffic accidents, down from an average of 64 per year from 2005-2010. In 2011/12 a local safety scheme programme was put into place for accident 'hot spots'.

### Chewing Tobacco in Hyde

Chewing tobacco causes a number of health problems including mouth and throat cancer, dental disease and heart disease. Chewing tobacco products are often sold without any health warning on them, and are cheap compared to cigarettes. In Tameside & Glossop chewing tobacco is commonest in people of Bangladeshi origin, particularly middle and older aged women. To address this issue an integrated project with teams from community development, trading standards, the voluntary sector and health services each providing their own expertise and experience was set up. A bottom-up approach was used with the local community helping to plan, design, coordinate, and implement the project. The community has taken ownership of the health message, making it truly sustainable. This project was the overall winner of the "Community Control" category at the North West Public Health Awards 2012.

### Sexual health

Achieving good sexual health and being able to make informed choices about contraception are important issues that people often need to address at different times of their life. Together we aim to support those with a greater need for support to be as sexually healthy and informed about contraception as they can be. In 2011/12 more young people were tested for chlamydia than ever before and achieved almost the highest uptake of tests in the whole of Greater Manchester. Prevention of sexually transmitted infections through targeted work remained a focus in 2011. Our partners at the Lesbian and Gay Foundation, for example, delivered HIV prevention campaigns across a wide range of services in Tameside and Glossop.




### My Active Life

My Active Life is a highly popular and successful physical activity programme that supports people aged 40-74 who have attended an NHS Health Check either through their GP or in the community. In Tameside, it is delivered by **Tameside Sports Trust.** Nearly 2,000 people have participated in the programme in Tameside since it started in January 2012, with over six in ten people saying they had improved their physical activity levels and nine in ten reporting that they felt healthier. In Glossop it is delivered by **D C Leisure** with nearly 50 referrals over the last three months.

## Health Trainers

Health Trainers help local people set realistic goals for improving their lifestyle such as losing weight, eating a balanced diet and exercising regularly, offering sessions over six months. Health Trainers already see clients in community and primary care locations but the team is now able to offer sessions in some GP practices.

Health Trainers are part of Pennine Care NHS Foundation Trust and last year the service helped nearly 1,000 people to improve their health and lifestyle. For more information, please contact **Health Improvement Service** on 0161 366 2000.

## Screening

Screening programmes for breast, cervical and bowel cancer, and also for diabetic eye disease and abdominal aortic aneurism (AAA) all identify disease early. This allows treatment to be given to prevent more serious illness, and can save lives. All these programmes are well used by local people, and continue to provide good services in line with national standards.

## Affordable Warmth

In Tameside and Glossop there are lots of people who cannot afford to keep their homes warm, or are forced to make a choice between heating their home and other basic essentials such as food.

In 2009, we launched the Affordable Warmth Strategy. Free insulation is available to all Tameside residents until the end of December 2012.Grants are also available for fuel efficiency measures such as new heating systems. During 2011/12 Tameside residents received in excess of £409,000 through the warm-front scheme to improve the energy efficiency of their homes, with a further 1,381 installations of loft and cavity wall insulation through the 'Get Toasty' scheme.

## CARA

CARA (Community Assessment and Rapid Access Team) provides an inclusive assessment and access to a physiotherapist, nurse and occupational therapist. It is a single point of contact with referrals from Tameside Hospital, GPs, health and social care staff, ambulance and self referrals. CARA has a team based at Tameside Hospital who facilitate early discharge and manage a Short Stay Intervention Unit. CARA works in partnership with North West Ambulance Service and has an intensive falls programme for house bound patients. It supports critical patients within 1 hour and responds to a community referral between 1 to 2 days. CARA endeavours to provide an effective link between health and social care and has completed 5,000 visits this year to support patients.

## Citizens Advice Bureau (CAB) – Glossop

Four GP surgeries in Glossop have held successful sessions run by CAB. They have seen 220 people and have provided help and support for over 700 issues.

The sessions have helped people manage nearly £400,000 of debt and claim appropriate benefits of over £350,000.

## What will you miss?

This social marketing campaign ran from January to March 2012 to promote the local stop smoking support that is available in places with the highest smoking rates. It also encouraged men and manual workers, who have been less likely to ask for help to quit in the past, to use the service.

## Cancer Awareness

'Don't be a Cancer Chancer' and 'Be Clear on Cancer' social marketing campaigns have successfully encouraged local people to see their GP if they have symptoms that could be cancer such as 'blood in poo', a persistent cough or 'blood in pee', so that new cases of cancer can be spotted and treated earlier. The three year Macmillan pilot funded the Community Cancer Awareness Project 'Let's be clear – get it checked'. It is recruiting and supporting local volunteers who are also promoting early presentation of cancer symptoms to GPs by raising awareness of common symptoms of lung, breast and bowel cancers.

### Wealth, Health and Wellbeing/ Financial Inclusion in the Community

The Health Improvement Team in South Denton developed a collaborative partnership with five key services: Citizen's Advice Bureau, Credit Union, Affordable Warmth, Children's Centres, and

Work Solutions. The team have helped over 200 people with problems linked with debt, and offered them access to legitimate sources of credit and support. The model is now being rolled out to other areas within Tameside and Glossop. This project received the commended award in the "Addressing Inequalities" category at the North West Public Health Awards 2012.

### Mental Health

The Primary Care Mental Health service has increased their range of therapies on offer, such as Cognitive Analytic Therapy (CAT) therapy and mindfulness, and is maintaining their 50% recovery rate. A single point of access is now up and running for all primary and secondary care referrals.

## Working well

### Workplace Health

Approximately 2,500 employees in Tameside belong to organisations that have made a commitment to workplace health. In addition, Kerry Foods, IKEA and Tameside Hospital have also undertaken workplace health programmes and they also hope to apply for

GREATER MANCHESTER
GOOD WORK: GOOD HEALTH

a workplace charter status in the near future. Other businesses who have adopted workplace initiatives since January 2012 include Ashton Sixth Form College, Clarion Loss Prevention Ltd, Gorse Hall Kids' Club Nursery Group, Diamond Window Cleaners, Fire Station Nursery Group, BT, Tesco in Hattersley and Brother UK Ltd.

For more information on Workplace Health in Tameside, please contact: Monica Gartside, Workplace Health Lead, TMBC monica.gartside@tameside.gov.uk

### Creating employment

Although things have been tough recently for people trying to find work, there are still examples of good news locally. Tameside are now the second highest area in Greater Manchester for recruitment in the over 25s. Local work clubs have been set up at New Charter accommodation in Audenshaw (Stanhope) and Dukinfield (Central Estate), and New Charter's Great Opportunities programme helped 17 unemployed people to find a permanent job last year.

In addition, two successful bids to the Government's Regional Growth Fund (RGF) have gained Government commitment to invest over £6m in Tameside, safeguarding over 600 local jobs. There is also good news about new local businesses, with the Intensive Start Up Service (ISUS) programme supporting 315 start-ups between 2009 and 2011 against a target of 275.

### Five Ways to Wellbeing

Five ways to wellbeing is a way to better mental health using simple steps. It's fun, flexible and aimed at everyone. More information about the 5 ways to Connect, Be Active, Take Notice, Keep Learning and Give can be found on the council web link,

**http://www.tameside.gov.uk/5waystowellbeing**

The Year of Health & Wellbeing was launched in 2012. Your local NHS funded a Community Grants Scheme for 7 voluntary and community group projects to contribute to the '5 Ways to Wellbeing, facilitated by Tameside Third Sector Coalition (T3SC). They range from green gyms, creative writing, radio skills, drumming and much more. **take a look**

## Ageing well

### Better life expectancy

Life expectancy has been increasing in Tameside and Glossop, and is now 76 years for men and 80 years for women.

There is a combination of reasons for this, including:

- People are choosing healthier lifestyles, e.g. being more active or being a healthy weight or giving up smoking
- Improved health care treatments, such as for cancer and heart disease.
- Provision of quality housing. Social housing providers have increasingly improved the standards of their housing stock over the years.
- Good uptake of effective health improvement programmes for babies and children which protect and prevent illness, such as immunisation
- Effective screening and health improvement programmes, which detect potential life threatening diseases early, e.g. screening for cancer and 'Know your numbers' campaign which provided blood pressure checks in the community.

### Carers

There are around 22,240 carers in Tameside who need our support. NHS Tameside & Glossop has invested £ 250,000 in 2011/12 and £750,000 in 2012/13 with a further £1,000,000 (1 million) being invested by 2014/15, to help people in their role as a carer.

The second **Joint Strategy for Carers** for NHS Tameside and Glossop and Tameside Metropolitan Borough Council (TMBC) was launched in March 2012, with an action plan that will be implemented over the next two years. It builds upon the good work that has been done over the last three years. TMBC continues to promote the Tameside Emergency Carers Card and as at 31st March 2012, 659 carers had signed up to the scheme. Early intervention work also continues with young carers in transition to encourage them to register with the Carers Centre and to access the services available to them once they reach the age of 18.

### Flu vaccines

Flu uptake rates for the over 65's rose to 77% exceeding the World Health Organisation and Department of Health targets. The Midwifery service at Tameside hospital offered flu vaccine to pregnant women, one of only a few antenatal units in the country to do so. Almost half these women took up flu vaccinations in Tameside in 2011, which is the second highest uptake in England.

### Expert Patient Programme

The Expert Patient Programme helps patients who have a long term condition such as arthritis, diabetes, and heart disease. It focuses on giving patients the necessary knowledge and skills, so that they feel confident managing their condition. The sessions are facilitated by people who are themselves living with a long-term condition. The courses have access to bilingual tutors to ensure that this opportunity is open to all members of the community. There are currently four programmes annually. This is being expanded to include a wider range of conditions which can benefit from this innovative and effective approach, such as pain management, substance and alcohol abuse, and respiratory disease.

### Telehealth

Telehealth describes the use of technology in the homes of patients to help monitor and manage their health, with the support of on-hand healthcare professionals. NHS Tameside & Glossop, working with a range of health and social care partners, are supporting patients with a range of long-term conditions to benefit from this technology. So far 265 units have been issued to patients. This will help patients to avoid unnecessary emergency admissions to hospital, and allow them to receive excellent care and support whilst being able to remain in the comfort of their own home. This project has been shortlisted for the 2012 Health Services Journal awards.

### C.difficile

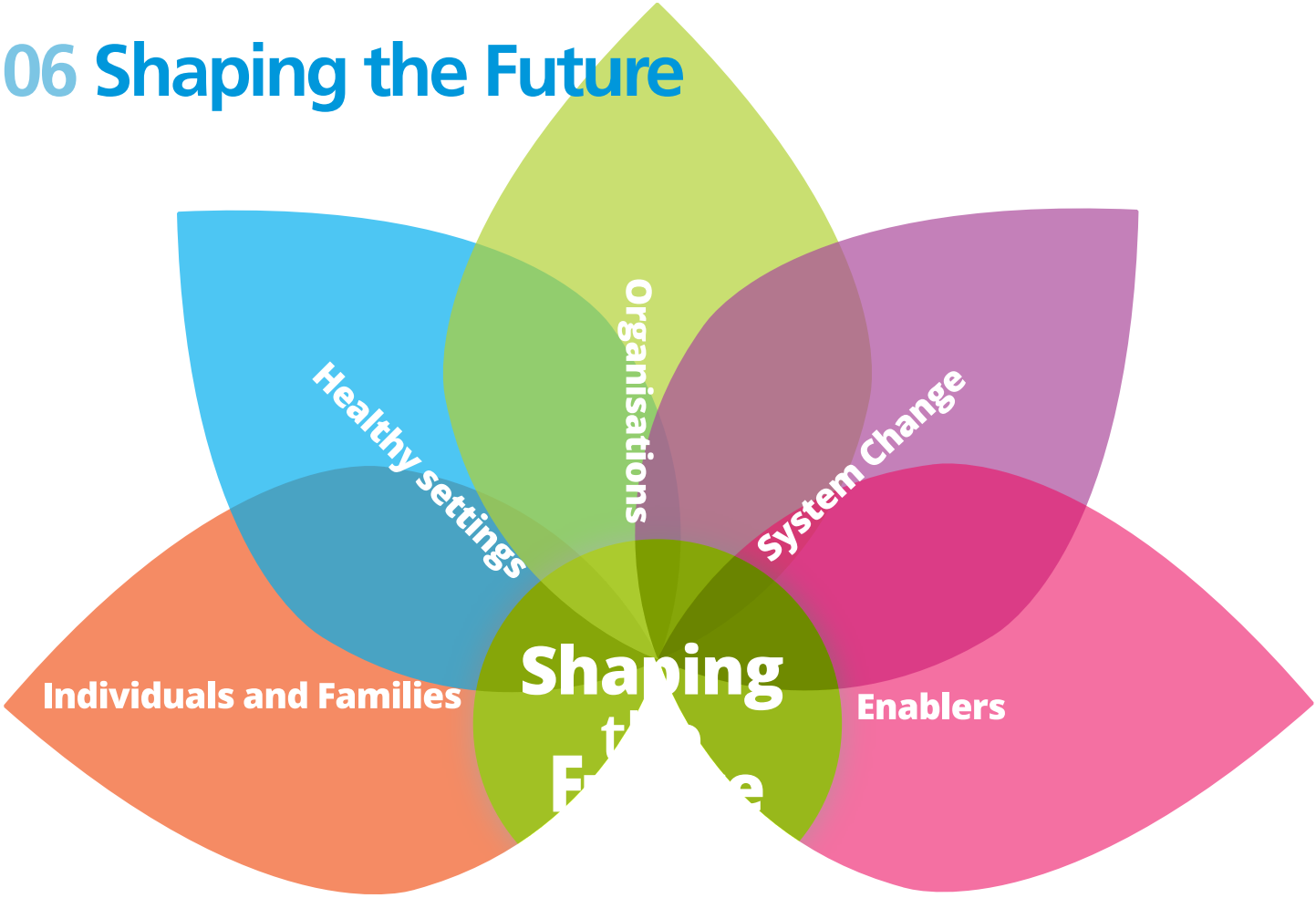
C.difficile rarely causes problems in healthy people. But older people can be more at risk when taking antibiotics that upset the balance of bugs in the gut. C.difficile infection can be serious. It can also spread from person to person but this is rare due to good infection control in hospitals and care homes. Reviewing the amount and type of antibiotics prescribed for older people has led to a 50% reduction in C.difficile cases locally.

## Dying well

### End of Life Care

Good co-ordination of services at the end of life can enable people to spend their last weeks and hours in their preferred place of care. Training and use of the National Gold Standards Framework and Liverpool Care Pathway for End of Life Care by health and care services is helping to ensure that local families are properly supported at this difficult time and that people have a choice of where they want to spend their last days.

# 06 Shaping the Future




The movement of public health departments back to local government creates an excellent opportunity to drive health improvement across the whole system. At this time of major change and financial pressure for the public and private sector, working together is absolutely vital. The shadow Tameside Health & Wellbeing Board have identified tackling poverty and increasing healthy employment opportunities as a priority. At a time of constraint on public finances it is vital we enable people to stay well and maintain their independence throughout life, supporting people past retirement into a healthy and active old age. In addition, there must be a focus on local inequalities, with services working with the most vulnerable in our community, particularly those that may be adversely affected by changes in the economy such as reduced employment and public sector spending such as changes to the benefits system and pressures on health and social care budgets.

The contribution that individual people can make should not be underestimated either. Local people, their families and their communities will be encouraged and enabled to become more responsible and active in promoting and supporting health and wellbeing. Our joint aim is to make healthy choices easier and to embed improving and protecting health throughout all public and private sector strategies to maximise the return on investment for all our collaborative actions.

Public health advice will be made available directly to the Clinical Commissioning Group (CCG) to make sure that commissioners of health care services are supported around evidence based, cost effective health care that is available to all based on need.

A key focus is that all front line staff 'Make Every Contact Count', by ensuring they support people who they provide services for to make healthier choices in order to enhance long term health benefits.

## Individuals and Families

### Innovative ways of engaging people by using social media

We are currently working on a campaign focusing on raising awareness of the negative health impacts of smoking, alcohol and obesity, targeting young people aged 12 to 19 living in the Tameside and Glossop area. We will support young people to develop resources that they can relate to using social media like facebook, text services, peer support, art and activism as a more effective way to engage people to think about their health.

### Early Identification

Early identification programmes help to find people at risk before they develop serious illnesses such as diabetes, heart disease and respiratory disease. Programmes such as NHS Health Checks and lung functions tests offer free tests that help in identifying health risks and provide support for making lifestyle changes.

### Making Every Contact Count

Over the past couple of years we have delivered Very Brief Advice training focusing on smoking, alcohol and healthy weight to over 650 frontline staff that represent over 30 different professions and agencies across Tameside and Glossop. We are also working on a research project to understand the difficulties faced by primary and community care staff in the delivery of Making Every Contact Count, in order to overcome any barriers in the future. Our aim is to make sure that health messages are provided appropriately and effectively when people are ready to make a change.

### Responsible citizenship

We all have a duty to be responsible citizens and contribute to our community. We can do this by offering volunteering opportunities to help people who need support, working with schools to embed these values in our young people, encouraging people to recycle, promoting cultural and social integration and making people feel safe in their neighbourhoods. Using health and social care services only when they are needed can ensure that people with serious health problems are seen in a timely way.

## Healthy settings

The settings based approach to public health and health improvement involves a holistic and collaborative method which integrates action across risk factors. The aim is to maximise disease prevention using a "whole system" approach.

We are working on a range of projects that are in various stages of development, implementation and evaluation, including early years, healthy schools, healthy community programmes and workplace health programmes.

## Organisations

### Levelling up access and quality in primary care

We will continue to work with partners, particularly the Clinical Commissioning Group. For example, local GP practices will compare themselves to national standards and neighbouring practises over a range of issues

such as, access to services, health outcomes and referrals. We need to ensure that there is an effective quality service provided consistently and systematically by all primary care providers. By doing this we can be confident that all local residents will receive the best care, early identification of illness and access to effective medicines and treatments regardless of where they live.

### Getting service user views

Making sure that the services we offer are of a high quality, accessible, acceptable and available to all who can benefit is an ongoing commitment of all providers. A local example of an innovative approach is the Mystery Shopper insight into contraceptive and sexual health services. Young people are carrying out a programme of visits and contacts with local sexual health services, such as GP practices, pharmacies and community services to find out how accessible and approachable they are for young people. They will base their views on the 'You're Welcome' standards for young people friendly services. Commissioners and providers of sexual health services will use the results to ensure front line sexual health services are effective in meeting the needs of young people. This approach, if successful, will be used for other services.

### Children's agenda

The Healthy Child Programme is the national requirement for support, screening and health promotion from conception to leaving school. It describes the roles of midwives, health visitors, school nurses and other health and care staff in the universal offer to families, as well as the additional responses to particular needs. As local services are reviewed, integrated and revised these national standards will provide a key framework for ensuring excellence in services and outcomes.

## System Change

### Integration of health and social care

Too often services users are frustrated with the complexity and fragmentation of service provision. Integrating services delivered by a range of health and social care organisations ensures that the resulting service is better at meeting the needs of local people, whilst delivering better value for money.

The CCG have committed to service integration with Tameside MBC and Derbyshire CC within their new 5-year strategy. For example, they are developing new ways of joint working around dementia, with the ultimate aim of implementing an integrated health and social care pathway. Further integration is being investigated, particularly around illnesses that make it difficult for people to live independently at home.

In addition, Tameside MBC are leading on four Area Programmes, formerly under the banner of Community Budgets and Local Integrated Services, which aim to improve outcomes for local people and communities whilst achieving better value for money.

The programmes are delivered in areas with high service use and each has a specific focus: ex offenders and their families, complex families, worklessness and early years. They have an early intervention approach, which aims to actively case manage and connect the right people to the right services at the right time. The success of these pilots will make the case for a new model where investment is moved from reactive services to early intervention and holistic support.

### Greater Manchester Public Health Network – planned collaborative service

The aim of the refreshed Network approach to joint working is to provide support to public health leaders to strengthen local action through:-

- Using evidence based reviews across Greater Manchester to lead to more cost effective delivery of services
- Improving outcomes for local communities and securing the Health Premium for additional investment in the area
- Providing economies of scale on health issues which affect relatively small numbers of people such as refugees and migrants
- Supporting sector led improvement such as urgent care, hospital care, holistic approaches to dementia, early years at a Greater Manchester level
- Collaborative working on health protection such as emergency planning

- The ability to lobby on local issues such as minimum unit price for alcohol

### Hospital Redesign: Healthier Together

Key partners are working with Tameside NHS Hospital Foundation trust to reconfigure health care provision to support integrated patient pathways and ensure people access the right care at the time they need it. Examples include ensuring that only people who require emergency treatment use the service, provision of same day consultant clinics to avoid unnecessary hospital admissions and provision of outpatient services at different times of the day to enable better access. The 'Healthier Together' programme across Greater Manchester CCGs also considers these issues with further potential for more effective service provision across Greater Manchester.

### Focus on system redesign and public sector reform

"Prevention is better than cure", and early intervention can mean that more serious problems are avoided later on. No-one wants to use an ineffective service, or waste time with an inefficient one. Ensuring improved cost effectiveness is a key ingredient of all local service redesign and public sector reform. The Public Health Department will be a key player in shaping future approaches to realising the full health potential of local services for local people. This will be by providing evidence reviews, proposing and supporting radical changes where better outcomes can be achieved.

A programme of Health Equity Audits will be carried out to inform commissioners about access and outcomes across different groups who can benefit from a service.

## Enablers

### Reviewing public health programmes against local needs

Public health services are moving back into the remit of local government. This provides an opportunity to relook at what services are currently commissioned, expectations about the public health role of local authorities and look for economies of scale with other services that local authorities provide. The aim is to get the best return on investment for preventive services so they can support as many people as possible. The programmes include lifestyle support, drug and alcohol treatment, falls prevention, sexual health and contraceptive services, school nurses and Health Checks: they all have a real focus on keeping people well.

The services will be reviewed as the allocation of resources for local government is known at the end of the year. Factors that will be taken into account are: local health needs, value for money, improved health outcomes, the number of people using the service and the contribution to keeping people well.

### A programme of Health Impact Assessments (HIA)

Health Impact Assessment is a structured method for assessing and improving the health impact of projects and policies. We are proposing to develop a rolling programme of HIA in order to maximise health gains and reduce negative effects where possible. We plan to start with a review of "Enterprising Tameside": the economic strategy supported by the Prosperous Tameside Board and the Health and Wellbeing Board.

### Capacity building

'Health is everyone's business' is the message we promote when working with partners. However, with reduced resources and capacity, it is important that partners are supported to develop the relevant knowledge and skills to maximise the impact they can have on health at all levels: individual, community and population. Therefore, a programme of capacity building is being developed with partners, including GPs, councillors, local authority staff, CCG staff, police and fire service, which will describe health, the determinants of health and a common approach to needs assessment to underpin and inform commissioning decisions.

# 07 Actions from the Public Health Annual Report 2010

**Action Look at ways of providing NHS Health Checks in community venues as well as increase uptake in GP surgeries**

Currently, 40 out of 42 GP practices in Tameside and Glossop deliver NHS Health Checks. During 2011 /12 GP practices invited 18, 242 eligible patients aged between 40-74 for NHS Health Checks and 7, 614 checks were comleted. Since January 2012, Health Checks have been carried out across different community venues across Tameside and Glossop, including libraries, places of worship, shopping centres, community centres, market places, residential areas, and on the Health Bus. During this time, 3,007 Health Checks have been carried out in the community.

**Action Train more front-line staff to identify patients with alcohol related harm and support them**

Over 750 front-line staff have been trained to provide Alcohol Identification and Brief Advice (IBA) and Brief Intervention (BI) across primary care, community care, hospitals, local authorities and the voluntary sector since 2010.

**Action Reduce the number of people suffering a stroke by continuing to develop a "mini stroke" (TIA) service including training and education**

We have worked with the cardiac and stroke network, and our provider colleagues at Tameside Foundation Trust, to develop local daily clinics for patients with suspected TIAs, thus ensuring that patients are seen within the 24 hour deadline from presentation at their GP surgery. We have also delivered education sessions to primary care staff on identifying and managing TIAs, and support to refer patients to hospital for the appropriate treatment.

**Action General practice will be supported with training and practice visits from the immunisation co-ordinator to maintain current trends and improve vaccine uptake in under 65 at risk groups**

Flu vaccination uptake rates in the under 65's at risk rose to 58%. Plans are in place to continue to support practices to work towards the increased target of 70% uptake.

**Action Extending community health development work into disadvantaged wards of Stalybridge and Dukinfield**

Key themes that were identified on mapping need in these areas include, alcohol and substance misuse, smoking particularly amongst school aged children, poor diet and physical activity. Delivery of health improvement activity to improve health in Dukinfield and Stalybridge areas has started seeing progress with the delivery of healthy eating initiatives, such as cook and eat. Relationships with key partners in the area are being fostered and joint initiatives are being planned around alcohol harm reduction and smoking.

**Action Target 1000 additional referrals to the Stop Smoking Service in 2011 – 2012 from hospital and community services**

Increasing referrals into the Specialist Stop Smoking Service continues to be a priority. To encourage referrals into the service from all front line community staff, we are continuing to invest in Very Brief Advice training, and are examining with front line staff why opportunities to refer people to the Stop Smoking Service are missed. This information will be used to improve the content and delivery of future training, and to identify further training requirements for different groups of staff.

# 08 Useful Links

**Websites:**

NHS Tameside and Glossop

Tameside Metropolitan Borough Council

Derbyshire County Council

High Peak Borough Council

Tameside and Glossop Clinical Commissioning Group

**Publications:**

Tameside and Glossop Joint Strategic Needs Assessment

Derbyshire Joint Strategic Needs Assessment

Tameside Health and Wellbeing Strategy (draft)

Derbyshire Health and Wellbeing Strategy (draft)

**Thanks to:**

Alison Bohannon
Alison Lewin
Alison Whelan
Anna Moloney
Carole Hill
Clare Symons
Clare Watson
Dave McConalogue
David Armitage
Debbie Bishop
Gideon Smith
James Mallion
Jody Stewart
John Smith
Julie Annakin
Julie Murray -Shephard
Karen Simpson
Kate O'Donnell
Lee Forsyth
Linda Dunn
Lyndsey Whiteside
Lynette Hayes
Monica Gartside
Pamela Watt
Paula Whittaker
Ruth Langley
Ruth Tweedie
Swapna Mistry

**Tameside and Glossop Public Health Team**

Tameside Metropolitan Borough Council,
Wellington Road,
Ashton-under-Lyne
OL6 6DL

Tel: 0161 342 2949

Agenda Item No 10

**DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD**

**24 January 2013**

# REPORT FOR DERBYSHIRE HEALTH AND WELLBEING BEING BOARD IMPLEMENTATION OF HEALTHWATCH DERBYSHIRE

## Purpose

To provide an update on work being undertaken to establish Healthwatch Derbyshire and to outline the current progress and future schedule.

## Background

Following a tender quote process, Adult Care appointed Exact on 1 November 2012, to undertake the Implementation Project to create Healthwatch Derbyshire. The setting up of Healthwatch Derbyshire as a not-for-profit organisation will allow the Council to sign a contract for the delivery of the Healthwatch service directly with the organisation from 1 April 2013.

## HealthWatch Derbyshire (HWD) Implementation Plan

On 7 November 2012, Exact advertised widely for applicants interested in being a member of the HWD Executive Board. A selection panel of commissioners from the Council and LINk Steering Group members reviewed all the applications and agreed to offer appointments to 6 applicants. The HWD Executive Board accordingly has 8 members which includes the current Chair and Deputy of the LINk Steering Group who were both passported onto the group to allow for continuity from Derbyshire LINk. The current LINk Steering Group Chair will continue as Acting Chair for HWD until at least 1 April 2013. Future targeted recruitment will be made to bring the DHW Executive Board up to the proposed 12 members.

The HWD Board met on 11 and 14 January 2013 to address the decisions that they need to make to help formalise the Board and prepare for the future Healthwatch role. Tasks to be addressed by them include;

- The registration of the organisation and it's Legal Status
- Recruiting a staff team including consideration of transferring staff from Derbyshire LINk
- IT (web address/email addresses/website)
- Office accommodation

**Independent Complaints and Advocacy Service (ICAS)**

The responsibility for commissioning of the ICAS service for NHS Complaints, transfers from the Department of Health to Local Authorities from the 1st April 2013. This service is available for individuals who wish to have an Advocate support them through their NHS complaint.

Derbyshire County Council has decided to be part of a regional procurement exercise for the provision of this service and has been involved in awarding the contract to POwHER. The contract is for one year (with possible one year extension) from 1 April 2013. Derbyshire Commissioners including a representative from a local CCG will be part of the regional management group of this contract.

**Recommendation:**

That the report is noted with further update reports about the implementation of HealthWatch to be submitted to this Shadow Board.

Agenda Item: 11

**DERBYSHIRE COUNTY COUNCIL**

**SHADOW HEALTH & WELLBEING BOARD**

**Thursday 24 January 2013**

# CHILDRENS TRUST 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 Children's Trust Board.

## Information and Analysis

The Children's Trust Board has been operating successfully in Derbyshire over a number of years, both as a statutory and non-statutory body. The Terms of Reference have been reviewed by the Board to ensure that the Board is now able to successfully operate as an accountable sub-group to the Shadow Health and Wellbeing Board.

They have 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 of the Board has been reviewed to reflect the changes in the structure of the local NHS. The Terms of Reference proposed by the Children's Trust Board are appended to this report.

## OFFICER RECOMMENDATION

That the Shadow Health and Wellbeing Board agree to the proposed Terms of Reference for the Children's Trust Board.

**Sally Savage**
**Assistant Director Commissioning**
**27th December 2012**

# DERBYSHIRE CHILDREN AND YOUNG PEOPLE'S TRUST BOARD

# TERMS OF REFERENCE

# November 2012

**Terms of Reference and Vision Statement:**

## 1. Purpose

1.1 To improve the wellbeing of all children and young people who live within or receive services in Derbyshire whilst redressing inequalities between the most disadvantaged children and their peers. This will be achieved by working together to improve outcomes for children and young people and their families:

- Safer children - better protected including fewer children suffering bullying and neglect.
- Healthier children - arriving at school fit to learn.
- Improved attainment by all children at all ages including better progress made by vulnerable groups and improving schools.
- Involved young people, contributing to their local communities.
- Achieving success for all - well qualified young people becoming successful adults.

## 2. Function

2.1 The Children and Young People's Trust Board's role in improving outcomes for children is by commissioning services from within the County Council, NHS, voluntary and community sector, Police and other service providers.

## 3. The Derbyshire Children and Young People's Trust Board will:

3.1 Actively promote its vision, aims and beliefs (Appendix 1) and will expect compliance with it from all those working with children and young people and their families in Derbyshire.

3.2 Develop and promote priority outcome areas, reviewing them on a regular basis to take into account progress and performance in achieving them, changing needs and opportunities.

3.3 Operate as the thematic partnership board for children and young people within the local strategic plan, Health and Wellbeing Board and Derbyshire Partnership Forum.

3.4. Commission services to deliver the identified priority outcomes as set out in its annual plan in accordance with agreed commissioning standards and policy.

3.5 Take into account the requirements of central government and will respond to external review and inspection.

3.6 Work in partnership with the Local Safeguarding Children Board to ensure that all agencies working with children and young people in Derbyshire are applying effective processes and the highest standards to keep them safe from harm.

3.7. In conjunction with the Local Safeguarding Children Board monitor the performance of the Locality Planning and Commissioning Groups and will receive regular updates on the implementation of the Locality Plan and performance against local and national targets and indicators.

## 4. Membership and Meeting Arrangements

4.1 The following people will be members of the Derbyshire Children and Young Peoples Trust Board as representatives of commissioners and providers of children and young people's services.

| **Member** | **Representing Agency** |
|---|---|
| Lead Elected Member for Young People (Chair) | Derbyshire County Council |
| Cabinet Member for Education | Derbyshire County Council |
| Strategic Director of Children and Younger Adults | Derbyshire County Council |
| Cabinet Support Member for Young People | Derbyshire County Council |
| Police and Crime Commissioner or nominee | Derbyshire Police Authority |
| Chief Constable or nominee | Derbyshire Constabulary |
| Chief Officer or nominee | Derbyshire Fire and Rescue Service |
| Chief Executive or nominee | Derbyshire Community Health Services NHS Trust |
| Chief Executive or nominee | Derby Hospitals NHS Foundation Trust |
| Chief Executive or nominee | Chesterfield Royal Hospital NHS Foundation Trust |
| Chief Executive or nominee | Derbyshire Healthcare NHS Foundation Trust |
| Chief Executive or nominee | Tameside and Glossop Community Healthcare (Business Group of Stockport Hospital Foundation Trust) |
| Chief Probation Officer or nominee | Derbyshire Probation Service |
| District and Borough Council representatives (2 Elected Members, 1 Chief Executive) | District and Borough Councils |
| Director of Public Health | Derbyshire County Council |
| Voluntary Sector | Derbyshire VCI Consortium and 3D |
| Young People x 2 | Youth Council |

| | |
|---|---|
| Schools 1x Primary, 1x Secondary 1x Special School | |
| Higher Education Colleges | Chesterfield College |
| Clinical Commissioning Group | Clinical Commissioning Groups x 5 |
| National Commissioning Board (NHS) | Local Area Team Children's Lead |
| Chair LSCB | |

4.2 The Trust can co-opt additional members on a temporary or permanent basis, with agreement of Board members.

4.3 Trust Board meetings will take place bi-monthly.

4.4 Reports for each meeting will be circulated at least 10 days in advance of the meeting.

4.5 Administrative support for the Trust Board will be provided by the Corporate Resources Department, Derbyshire County Council.

4.6 Meetings will be quorate if at a minimum, there is attendance of:

- Chair or Vice Chair
- Strategic Director of CAYA or representative
- Director of Public Health or representative
- 2 other representatives

4.7 The Chair will be the current Lead Member for Young People. The Vice-Chair will be elected by the Trust Board for a two year period. The Vice-Chair will not be a member or officer of the County Council. The Vice-Chair can be changed if that individual is removed from the membership of the Board by their nominating authority.

4.8 Wherever possible, decisions will be reached by consensus. In exceptional circumstances and where decisions cannot be reached by 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.

4.9 Any personal or prejudicial interests held by members should be declared on any item of business.

4.10 The Children and Young People's Trust Board will be regarded as a "working group" for Access to Information Act purposes and consequently meetings shall not be open to the press or public.

4.11 Freedom of Information (FOI) Act provisions shall apply to all partnership business.

4.12 The minutes of the Board meetings, once agreed as an accurate record, will be published at www.derbyshire.gov.uk/childrenstrust

## 5. Budget

5.1 Financial management is a key element of good governance therefore decisions should not be made in the absence of budget information. Most of the resources under the control of the Strategic Director of Children and Younger Adults and statutory agencies are earmarked and proscribed.

5.2 The Trust Board will influence the way in which mainstream funding is used in order to improve outcomes for children, young people and their families. This will include making plans for the integration and alignment of budgets including, where appropriate, preparation for budget pooling arrangements.

5.3 The Trust Board will influence the way in which pooled funds such as Child and Adolescent Health Service (CAMHS), Drug and Alcohol Action Team (DAAT) and Youth Offending Service (YOS) are allocated in order to improve outcomes for children, young people and their families.

5.4 The Trust Board will allocate pooled and other funds as they become available in order to improve outcomes for children, young people and their families.

5.5 The Trust Board may advise the realignment of resources where there is evidence that services are not contributing to the improvement of outcomes for children, young people and their families, so that they can be discontinued and the resources reallocated.

## 6. Expectations of the Chair and Board Members:

**Members will:**

6.1 Represent the Trust Board by promoting the vision, priorities and outcomes outlined in its plan, to local strategic partnerships, central government departments, inspectorates and other networks as appropriate.

6.2 Participate in partnership events, training and task and finish working groups of the Board as appropriate.

6.3 Contribute to the development of the Trust Board partnership as an effective, efficient and inclusive team including raising concerns with the Chair if necessary.

## 7. Key Relationships and Accountabilities

7.1 The Trust Board will work within the strategic framework agreed by the Derbyshire Partnership Forum and Health and Wellbeing Board.

7.2 Clinical Commissioning Groups (CCGs) in Derbyshire, Tameside and Glossop and the DCC Cabinet have agreed to delegate to the Children and Young People's Trust Board responsibility for the governance of commissioning for children's services, including shifts in investment, service improvement and standards. Both will set the overall budgets for children's services annually and monitor budget expenditure accordingly during the year. The CCG Boards and DCC Cabinet will expect to approve the Trust Board plan and receive an annual report on progress. Cabinet will

also expect to receive reports on and approve major changes to the plan or significant service reviews.

7.3 The Trust Board will delegate some commissioning responsibilities to subsidiary agencies and partnerships as follows:

- To the CCGs in Derbyshire and Tameside and Glossop. Unless and until a Section 75 agreement has been signed, the PCTs will retain responsibility for commissioning healthcare for children, young people and families provided by community healthcare services, local hospital trusts and GPs.
- To Locality Planning and Commissioning partnership groups.
- To schools, school clusters, colleges and children's centres for universal and targeted services.
- To the Youth Offending Service Board, CAMHS Executive, DAAT, Youth Council, Disabled Children's Commissioning Group to improve outcomes in these specific areas.

7.4 The Trust Board will oversee the relationship between commissioners and those providing children's services, ensuring they all contribute to implementing the plan, maintain standards and improve children and young people's lives.

## 8. Delegation

8.1 The Trust Board will devolve responsibility for ensuring the delivery of improved outcomes for children, young people and families to:

- Children's Joint Commissioning Co-ordination Group
- Local Safeguarding Children's Board
- Locality Planning and Commissioning Partnership groups
- Working groups
- Task and finish groups

8.2 The Trust Board will agree the Terms of Reference for these groups.

To be responsible for co-ordinating, implementing and monitoring project and receive reports on their work at least once a year.

## 9. Review

9.1 The work of the Trust Board will be subject to regular review, taking into account stakeholder opinion and experience. The Trust Board will be successful if it can demonstrate that it has contributed to improving outcomes for children and young people through the implementation of its plan of priority outcomes.

## 10. Signatures

**APPENDIX 1**

**Derbyshire Children and Young People's Trust - Our Vision**

**OUR VISION**

To ensure the best possible outcomes for children and young people.

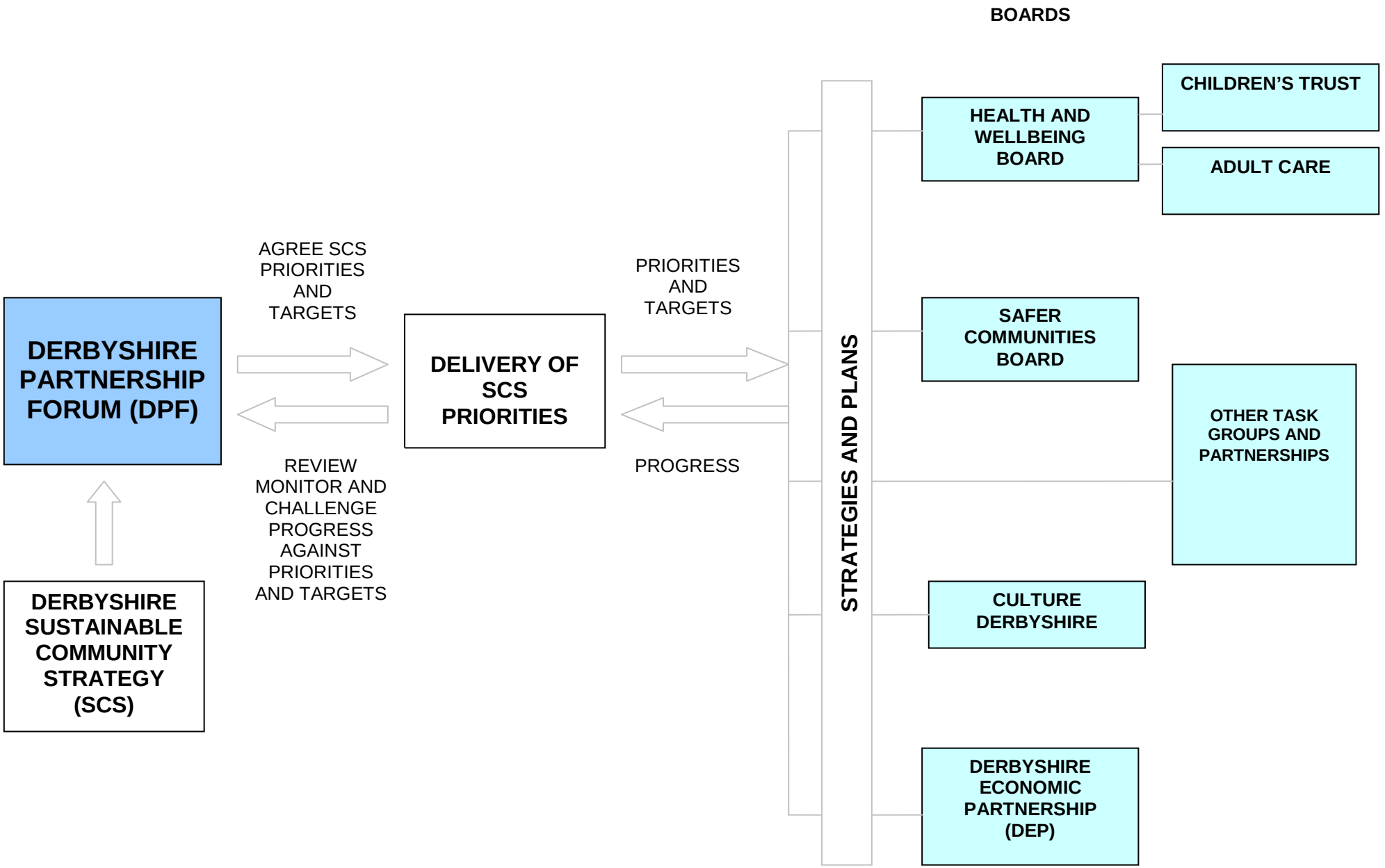
**OUR AIMS**

Our aim is to ensure that everyone working with children and young people and their families will do their best to enable them to be healthy and feel safe.

**OUR BELIEFS**

Our vision is based on a set of beliefs which include:

- All children and young people aged 0-19 and their families should benefit from improved services across Derbyshire.
- Children, young people and their families and carers will be at the centre of all arrangements in Derbyshire to improve outcomes and their participation is essential.
- Services should be available and accessible, as far as possible in places such as children's centres, schools and health centres which most children and their families routinely visit.
- All children's agencies should provide the quickest possible response as well as the best possible service.
- Staff in all children's services should, as far as possible, work and be trained together and share a common understanding.
- Changes to services should only be made where children and young people's experience will improve.
- The voluntary and community sector has a key role to play in the development and delivery of services.
- Staff from all agencies should work together wherever this is likely to improve services.
- Services should be linked together so that there is only one common initial assessment.


BOARDS
DERBYSHIRE PARTNERSHIP FORUM (DPF)
AGREE SCS PRIORITIES AND TARGETS
REVIEW MONITOR AND CHALLENGE PROGRESS AGAINST PRIORITIES AND TARGETS
DELIVERY OF SCS PRIORITIES
PRIORITIES AND TARGETS
PROGRESS
STRATEGIES AND PLANS
HEALTH AND WELLBEING BOARD
CHILDREN'S TRUST
ADULT CARE
SAFER COMMUNITIES BOARD
OTHER TASK GROUPS AND PARTNERSHIPS
CULTURE DERBYSHIRE
DERBYSHIRE ECONOMIC PARTNERSHIP (DEP)
DERBYSHIRE SUSTAINABLE COMMUNITY STRATEGY (SCS)

Agenda Item No 12

# DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

## 24 January 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**

**Health and Wellbeing Summit**
A Health and Wellbeing Summit will be held on the afternoon of 5 March 2013 at County Hall, Matlock. The event will look at the progress that has been made towards implementing the health care reforms in Derbyshire over the past year.

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

**Board Development**
At the second development session with the LGA on 18 December, the Board discussed a number of scenarios relating to difficult decisions they may need to make as a Board. This highlighted a range 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 will be held at 9:30am on Friday 8 February at Cromford Wharf. The focus of the session will be on 'Falls and Bone Health'. The intention is for the Board to meet in confidential session and then for the Board to meet formally to take a decision on changes to dealing with falls and bone health.

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

**CCG Journey Towards Authorisation**
As H&WB members are aware the CCGs are going through a rigorous process to demonstrate competence to become a standalone NHS statutory body. Four CCGs are in wave three with Hardwick in wave four. All CCGs have been through their evidence submission and panel review day. All except Hardwick have also had their current position moderated through a

national process to ensure consistency of approach by panels. As a result of this Erewash, North Derbyshire and Southern Derbyshire CCGs have been confirmed as having no outstanding criteria to satisfy. Hardwick should receive the outcome of their moderation panel next month. Tameside and Glossop have 14 outstanding red ratings covering 5-areas (eg there were three for not having a signed CSU contract), all of which have been addressed except for the appointment of the hospital doctor to the governing body. The next steps will be that each CCG is considered at a national conditions panel and full authorisation will be agreed with or without conditions as necessary to satisfy any outstanding points.

The CCGs will become established as statutory bodies from the date they are authorised (mid-February and mid-March (for Hardwick)) although staff will not formally transfer over until 1 April 2013.

CCGs are now starting detailed contract discussion with providers following the publication of the NHS planning guidance (see separate item on H&WB agenda). All contracts must be signed off before the end of March 2013 and this will include any services previously commissioned by the PCT for public health which will transfer over to the County Council. CCGs and Council colleagues are working closely together to ensure a smooth transfer of these responsibilities.

For further information please contact Jackie Pendleton, Chief Officer (Designate), NHS North Derbyshire Clinical Commissioning Group Jackie.pendleton@northderbyshireccg.nhs.uk

**EMAS Update**

The EMAS Board met on 10th January 2013 to consider feedback from the consultation and following feedback and analysis from the consultation the Board has determined to undertake further analysis on the Estate Business Case to ensure proposals will work operationally and financially. Further discussion will take place between EMAS staff and Senior Managers to finalise the Estate Business Case which will now be considered by EMAS Board on 25 March 2013.

For further information please contact Graham Spencer, Improvement and Scrutiny Officer, DCC graham.spencer@derbyshire.gov.uk

**Public Health Outcomes Framework: Two important new profiles.**

Two documents have come out that present detailed local data on health and social care outcomes in Derbyshire which will serve as a baseline at the point at which the new NHS and public health systems come into being.

The first document is the new Public Health Outcomes Framework profile based on all of the outcomes which is embedded below, along with a detailed

presentation prepared by the public health informatics team showing how we compare with CIPFA (Chartered Institute for Public Finance and Accountability) ”statistically neighbouring” comparator authorities in areas of challenge.

PHOF_17.pdf

Presentation1.pptx

This covers a very wide range of indicators from child poverty, school attainment and employment status to vaccination uptake, healthy behaviours and measures of disease and mortality. For the 76 indicators for which comparisons can be made, Derbyshire scores significantly above the national average on 38, similar to the national average on 27 and significantly below national average on 11. The areas of challenge include road safety, breastfeeding, smoking in pregnancy, young people not in education, employment or training and avoidable mortality from cardiovascular disease. The areas of good and less good may reflect both factors intrinsic to the nature of the geography and population of Derbyshire (eg our thousands of miles of rural roads) and the performance of our services… or both in combination.

These indicators will form part of the basis of the county’s Joint Strategic Needs Assessment and some of them will contribute to the monitoring of progress against the health and wellbeing board’s strategic priorities.

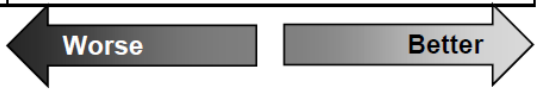
The second is an “Outcomes benchmarking support pack: LA level” from the NHS Commissioning board which compares us with our ONS cluster authorities on a set of high level outcome indicators from three outcomes frameworks: those for the NHS, public health and adult social care. There are 17 indicators and Derbyshire scores above the cluster average on 12, but there are also areas of challenge, although for a few indicators it is not always clear where an “ideal” score might lie (eg admissions to residential and nursing care). Pasted below is the summary chart of all overarching outcomes but for those interested, the whole document it is on:
http://www.commissioningboard.nhs.uk/files/2012/12/la-e10000007.pdf

## Derbyshire spine chart
## (shows all overarching indicators)

The chart below shows the distribution of the LAs on each indicator in terms of ranks. This LA is shown as a red diamond. The yellow box shows the interquartile range and median of LAs in the same ONS cluster as this LA. Each indicator has been orientated so that better outcomes are towards the right (light blue).
This chart supports the spider chart by providing a single page summary of all the available overarching indicators.

This LA is in the Mining & Manufacturing cluster

| Outcome Indicator | LA and cluster distribution (LAs ranked; right = better outcomes) |
|---|---|
| 1a Potential years of life lost (PYLL) from causes considered amenable to healthcare | |
| 1bi Life expectancy at age 75 (Males) | |
| 1bii Life expectancy at age 75 (Females) | |
| 2 Health-related quality of life for people with long term conditions | |
| 3a Emergency admissions for acute conditions that should not usually require hospital admission | |
| 3b Emergency readmissions within 30 days of discharge from hospital | |
| 4ai Patient experience of GP services | |
| 4aii Patient experience of GP out-of-hours services | |
| 4aiii Patient experience of dental services | |
| 0.1i Proxy for healthy life expectancy a birth using Disablility Free Life Expectancy (DFLE) at age 16 | |
| 0.2ii Life expectancy at birth | |
| 0.2iii Slope Index of Inequality in life expectancy at birth [proxy dataset] | |
| 1A Social care-related quality of life | |
| 2A(1) Permanent admissions to residential and nursing care homes (age 18-64) | |
| 2A(2) Permanent admissions to residential and nursing care homes (age 64+) | |
| 3A Overall satisfaction of people who use services with their care and support | |
| 4A Proportion of people who use services who feel safe | |




For further information please contact Bruce Laurence, Acting Director of Public Health Bruce.Laurence@derbyshire.gov.uk

**Falls and Bone Health Pathway**

The task and finish group for falls and bone health met in Dec 2012. Their remit was to consider the current falls and bone health service provision for Derbyshire, identify gaps in the current provision and explore ways to improve patient outcomes in a clinically and cost effective manner.

A great deal of positive change has occurred in the previous 4-5 years, including the commencement of fracture liaison services within the acute hospitals, the inclusion of osteoporosis within the Quality and Outcomes framework[i], participation by the two main acute trusts in the National Hip Fracture Database[ii] and the development of the "Strictly No Falling" quality branding and database to support evidence based community exercise provision. However, a number of the necessary services and interventions are still not provided or provision is inequitable and incomplete thus reducing the potential clinical and cost benefits.

The main findings from the task and finish group meeting for board consideration are:

1. The management of hip and fragility fracture patients by the two main acute trusts is improving but is still not in accordance with the recommendations of national guidance specifically NICE CMG 46 (2012). Services provided by acute trusts outside of Derbyshire need to be included in future discussions to ensure equity for these patients. Some of these issues can be addressed through specified contract/service level agreements. It is not yet known if they would require additional investment separate to the current block contract provisions.
2. Services for patients with mental health need, in particular dementia, and care home populations require specific attention. The mental health trust is not currently commissioned to deliver falls specific interventions and the management of falls patients with dementia in both the specialist DCHS and community services is not suitably adapted to cater for the needs of dementia patients.
3. The current fracture liaison services provided at Royal Derby and more recently at Chesterfield Royal aspire to deliver in accordance with best practice. Operational and capacity issues indicate that elements of core practice which are required to maximise the cost effectiveness of the service are not being delivered. This includes monitoring of medications commencement and long term adherence in the >75 year population and long term adherence in the < 75 population. Links into falls prevention services are not embedded which also reduces the effectiveness of the services. Tighter contract/SLA requirements (which may require investment in the short term) would address these issues.
4. An integrated care pathway from Royal Derby using a single common access point is still in the early delivery stages but is being reported positively. There is a need for clarity on how falls and fracture work is

included within the integrated care pathway/single point of access work in the North to ensure equity of service provision.

5. Audit of the county wide falls recovery service is required to establish the effectiveness and future funding implications.
6. Development of non-transported fallers protocol into the north of the county to ensure patients who experience frequently falls and ambulance attendance without transport to hospital are referred through to primary care for investigation.
7. Transport issues for frail elderly accessing community services, funding implications for partner organisations to support access and potential links into the personalised budget agenda
8. Sustainability issues of developing evidence based exercise groups in rural areas.
9. Support for professionals, patients and carers to be informed of services and how to access them
10. Embedding of social enterprise model of footcare across the county to establish equitable service provision through a pump priming model of development. Consideration of funding implications of this model.

It is 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 will be needed. Detailed joint working is required before the level of this additional investment can be fully stated however it is likely to both recurrent and non-recurrent which will be necessary. At the time of writing the only specified investment into falls prevention is £35k from public health funding falls exercise advisor posts and non-recurrent section 256 monies used to pilot the falls recovery service and footcare social enterprise models both limited either by geography or population cohort.

It is clear that the funding provision should not fall to any one organisation because cost benefits from an effective falls and bone health pathway will be across both the health and social care sector, and primary and secondary prevention work.

---

[i] QOF 2012 Osteoporosis http://www.nice.org.uk/nicemedia/live/13536/55551/55551.pdf

[ii] National Hip Fracture database 2012 http://www.nhfd.co.uk/003/hipfractureR.nsf/luMenuDefinitions/CA920122A244F2ED802579C900553993/$file/NHFD%20National%20Report%202012.pdf?OpenElement

For further information please contact Jayne Needham, Senior Public Health Strategy Manager, Public Health jayne.needham@derbyshirecountypct.nhs.uk

# Derbyshire LINk's Observations of Service Delivery at GP Practices throughout Derbyshire

*Sub Group Members*

*Mr David Briggs*
*Mrs Sandra Brown*
*(Deceased 4th August 2012)*
*Mrs Pat Bygate*
*Mr John Martin*

*supported by*

Mrs Jas Dosanjh
Derbyshire LINk Community Involvement Worker

**July 2012**

# Contents


| | Page |
|---|---|
| Executive Summary | 3 |
| Background/Introduction | 3 |
| Methodology | 3 |
| Results | 4-9 |
| Findings | 9-10 |
| Observations | 10-12 |
| Recommendations | 12-13 |
| Conclusion | 13-16 |
| Acknowledgements | 16-17 |
| Appendices | 17-26 |

# 1 Executive Summary

This report explicitly illustrates the views of the Derbyshire Local Involvement Network (LINk) membership when using GP Practices across the County.

The findings illustrate the positive experience that is encountered by the majority of patients. However the report also highlights some areas within the process that could be improved.

This report can therefore be instrumental in assisting bodies such as Clinical Commissioning Groups (CCGs) to make improvements to overall patient experience, as well as developing an on-going, two-way communication process between patients and the service provider. Although the report presents the findings for the County, the results have been further broken down into CCG areas. Each of the Chief Operating Officers will receive a copy of the results appertaining to their Clinical Commissioning areas.

# 2 Background/Introduction

Over the past 3-4 years Derbyshire LINk has recorded concerns from members of the public in relation to their experiences when using their GP Practices.

A Sub-Group was formed in 2010 to investigate emerging themes from the Derbyshire LINk database, "*difficulty in getting an appointment, attitude of staff, privacy & confidentiality, request to speak directly to a GP/home visits,"* and *"what is a patient participation group."*

Initially, in order to research this further 6 focus groups were formed and a report, What the Patient Thinks was compiled on the findings in March 2011.

While the LINk Community Involvement Workers continued to gather information from members of the public throughout the County to gain further understanding, the Sub-Group set upon devising a patient satisfaction questionnaire. This would be distributed to the Derbyshire LINk Membership to complete.

# 3 Methodology

The Sub-Group made contact with 5 GP Practices in the Chesterfield locality who very kindly allowed them to run a pilot of the questionnaire that had been designed.

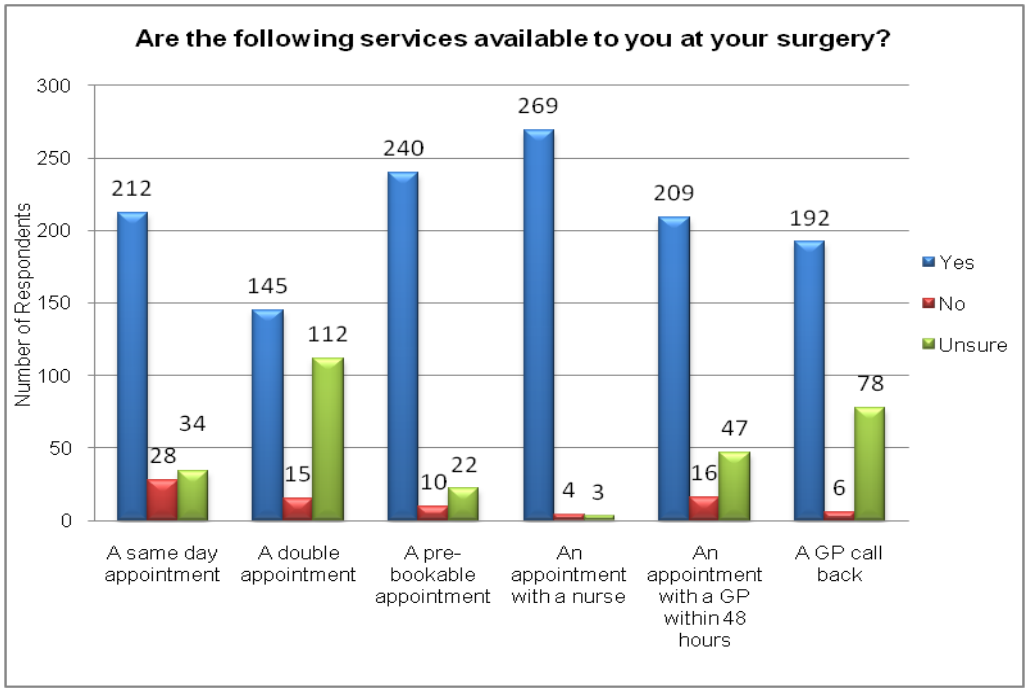
This involved the Sub-Group members sitting with patients in the GP Practice waiting rooms and going through the questionnaires. This gave the Sub-Group an opportunity to capture qualitative as well as quantitative data.

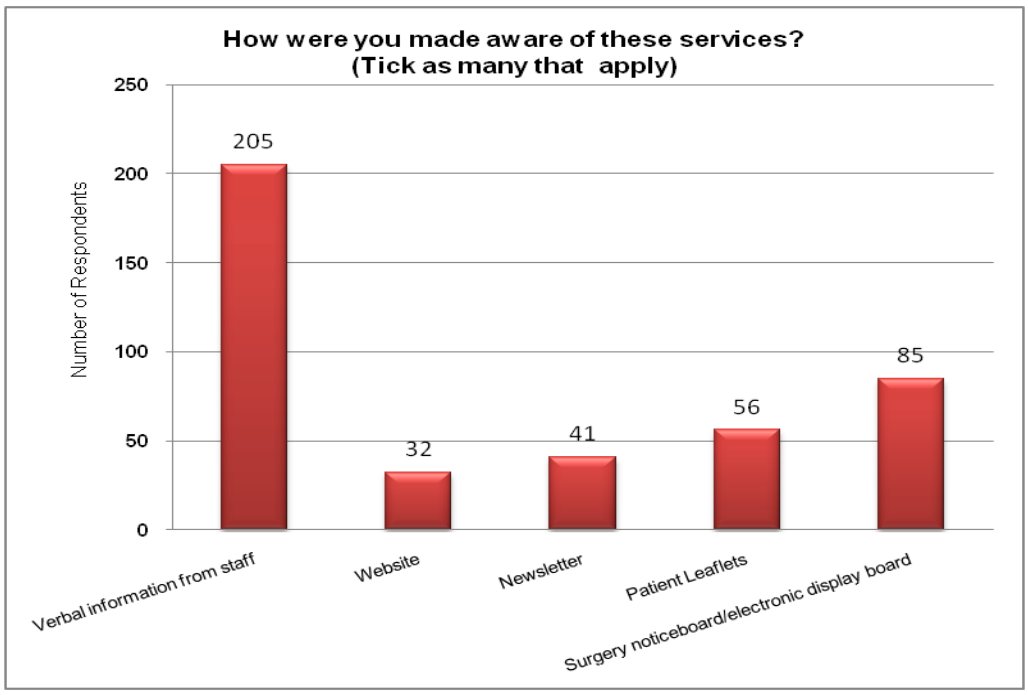
Having completed the pilot study it was then decided that the questionnaire would be disseminated solely to members of Derbyshire LINk. By definition, the LINk membership consists of individuals and groups of people who have taken an active interest in trying to improve their local Health and Social Care services. It was hoped that this would lead to a positive questionnaire response rate and for those responses to be an accurate representation of people's thoughts and experiences regarding their GP surgery.

# 4 Results

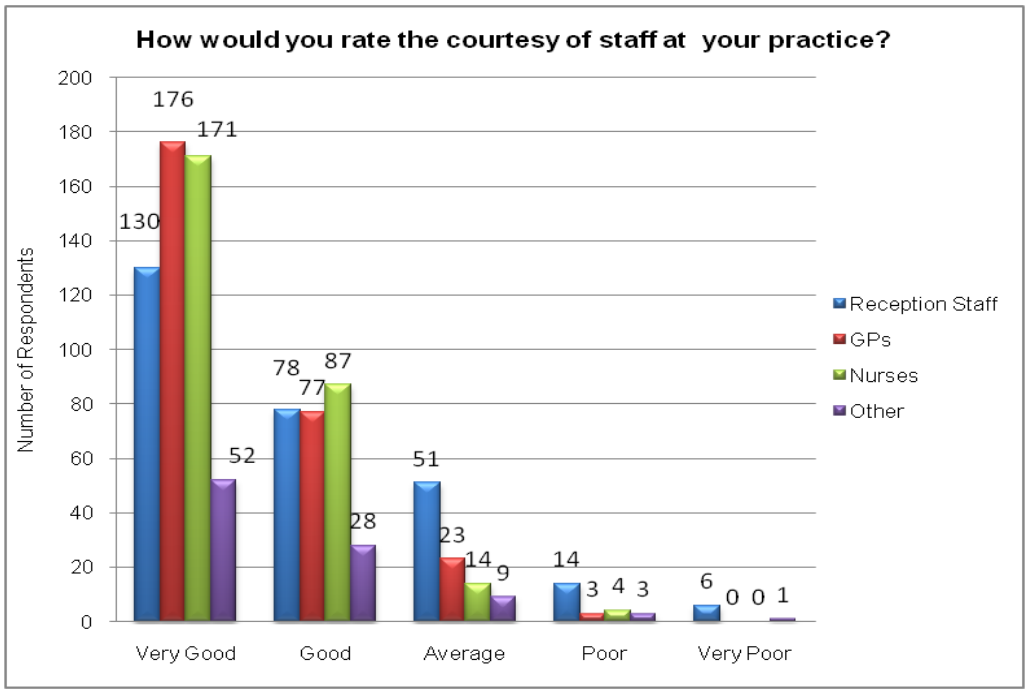
Derbyshire LINk members were asked the following categorised questions, with responses received as shown. The questionnaire was sent to 983 members with a response rate of 28% (279). The analysis also revealed that not all respondents answered each and every question.

## *4.1 Appointment System*



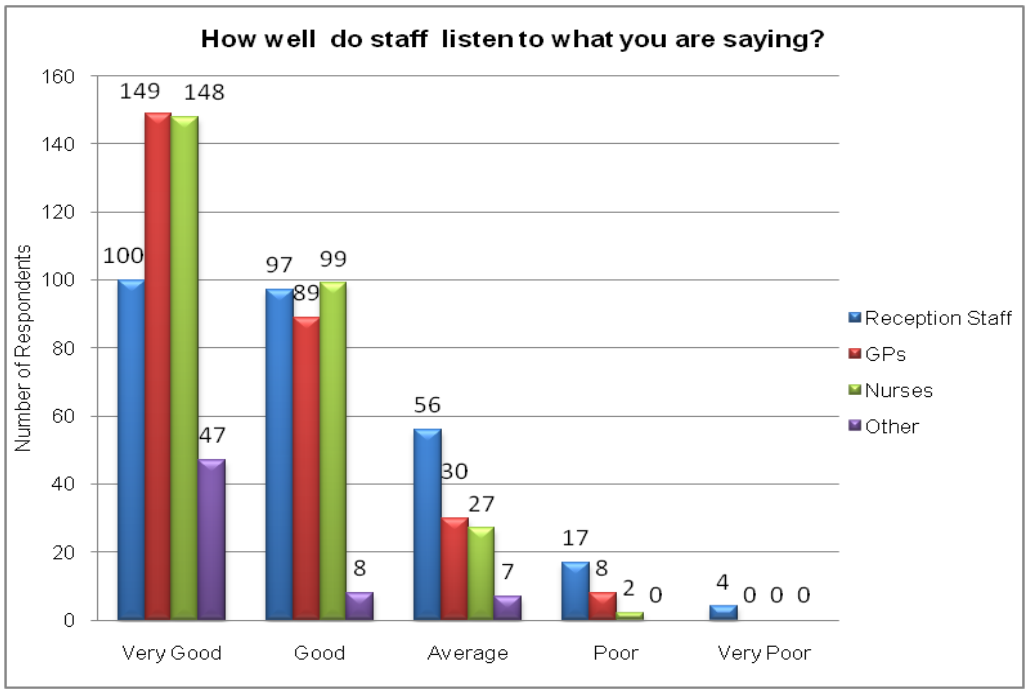



### *4.2 Staff*



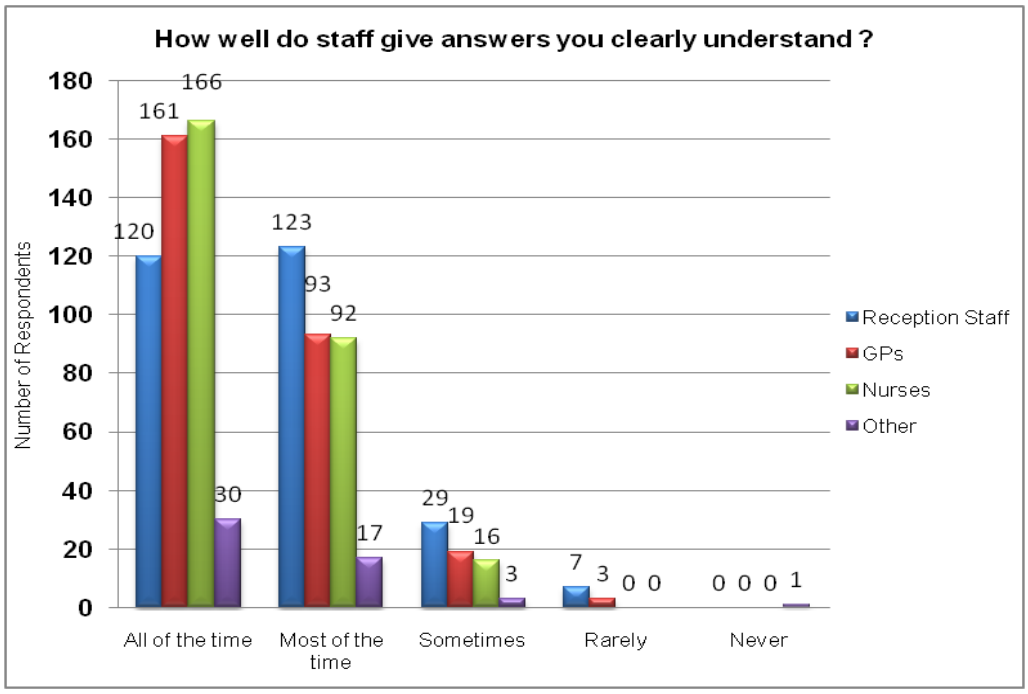

Respondents selecting 'Other' were asked to specify. In the case of this question, these included:-

Admin staff behind the scenes, audio tester, phlebotomy nurses, CAB, chiropodist, cleaners "all", community health assistant, counselling, dietician, district nurse, health care assistants, health trainers, health visitor, locum doctor/nurse, midwife, occasional visiting consultant, office manager, pharmacist, pharmacy staff, phlebotomist, physiotherapist, podiatrist, practice manager and admin staff, practice staff, reception staff and triage nurse.



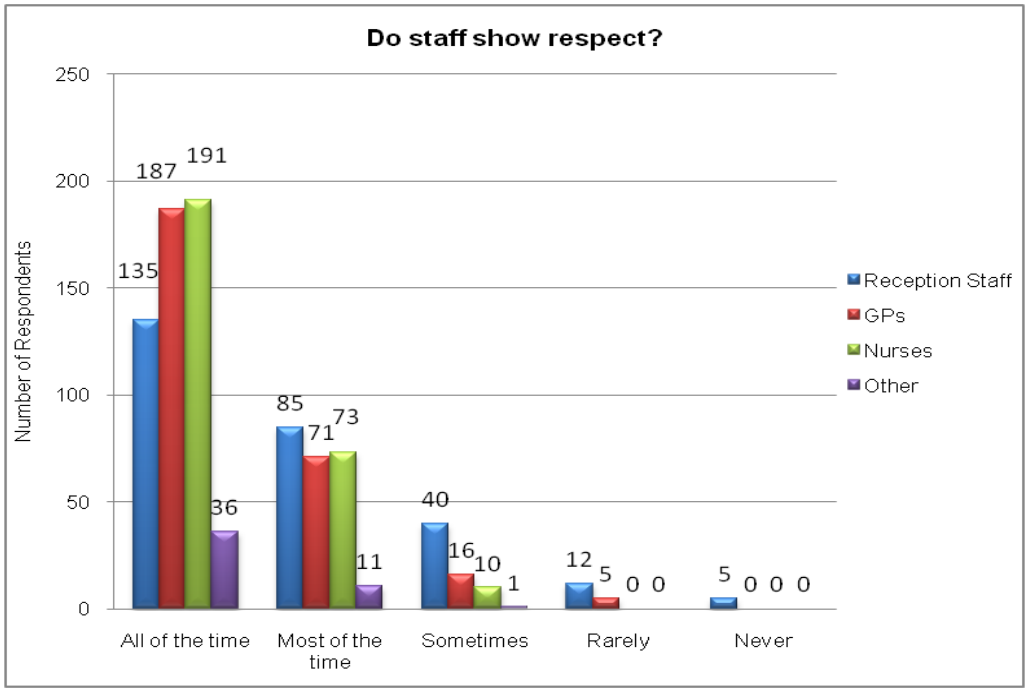
Respondents selecting 'Other' were asked to specify. In the case of this question, these included:-

Admin staff, audiology, counselling, dietician, dispensing staff, district nurses, Dr "L", health care assistants, IT assistant, office staff, pharmacy, pharmacy staff, physiotherapist, PPG secretary, practice staff, receptionist-the acoustics of the new building are not at fault but even conversations can be heard/confidentiality/embarrassment issue.



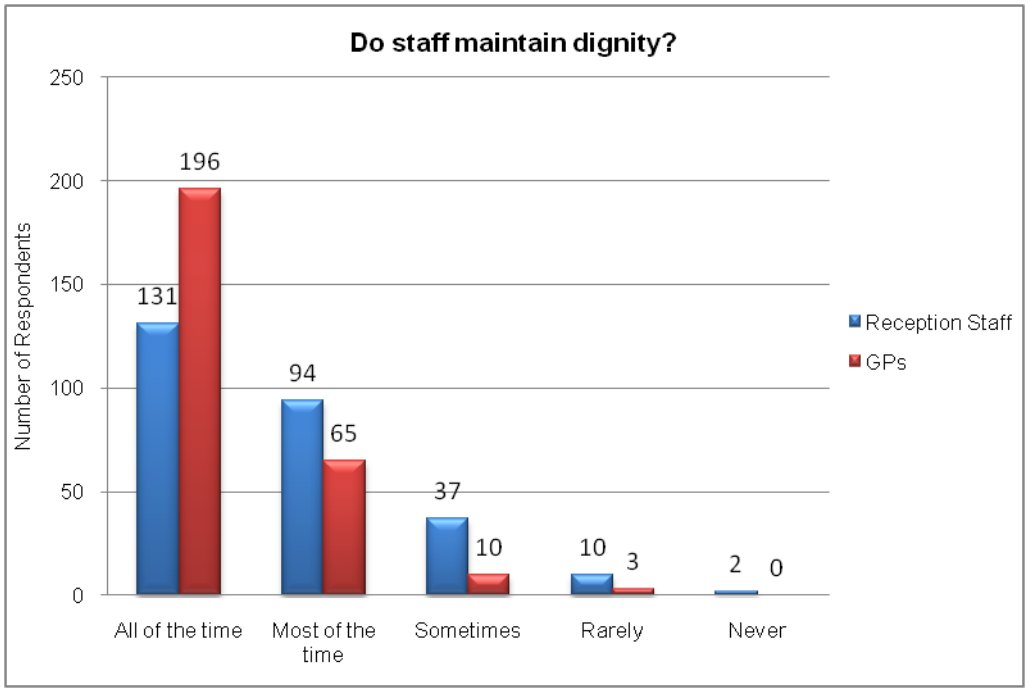

Respondents selecting 'Other' were asked to specify. In the case of this question, these included:-

Dietician, dispensary staff, health care assistants, health visitor, IT assistant, midwife, office staff, pharmacy, phlebotomist, physiotherapist, practice manager, counsellor, pharmacy staff and PPG secretary,



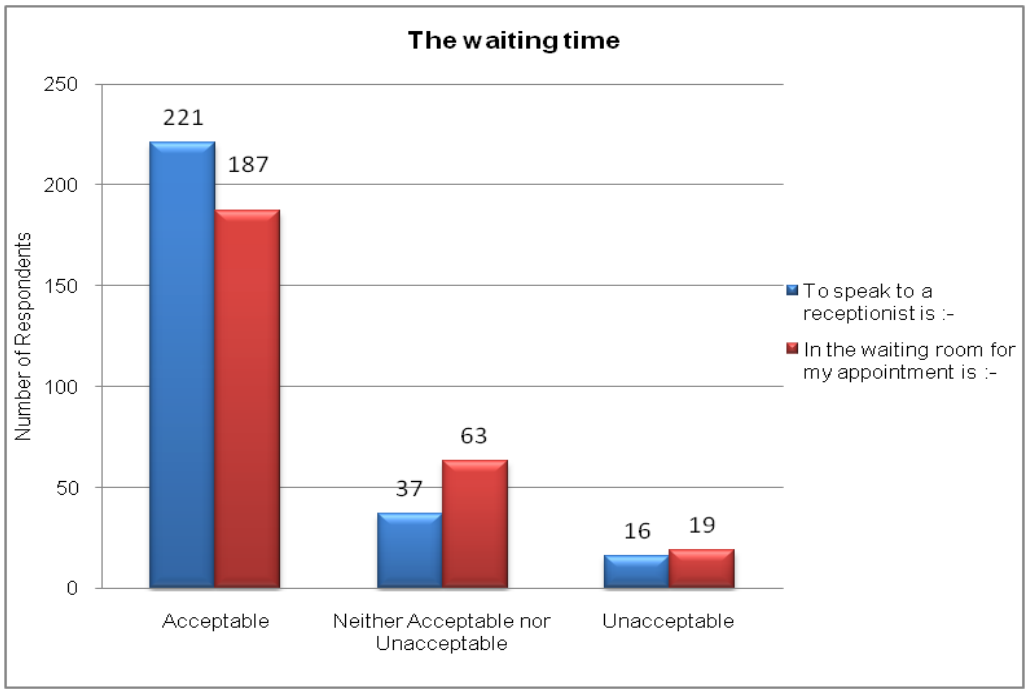

Respondents selecting 'Other' were asked to specify. In the case of this question, these included:-

Dietician, dispensary staff, Health care assistants, health visitor, IT assistant, office staff, pharmacy staff, physiotherapist, and PPG secretary.

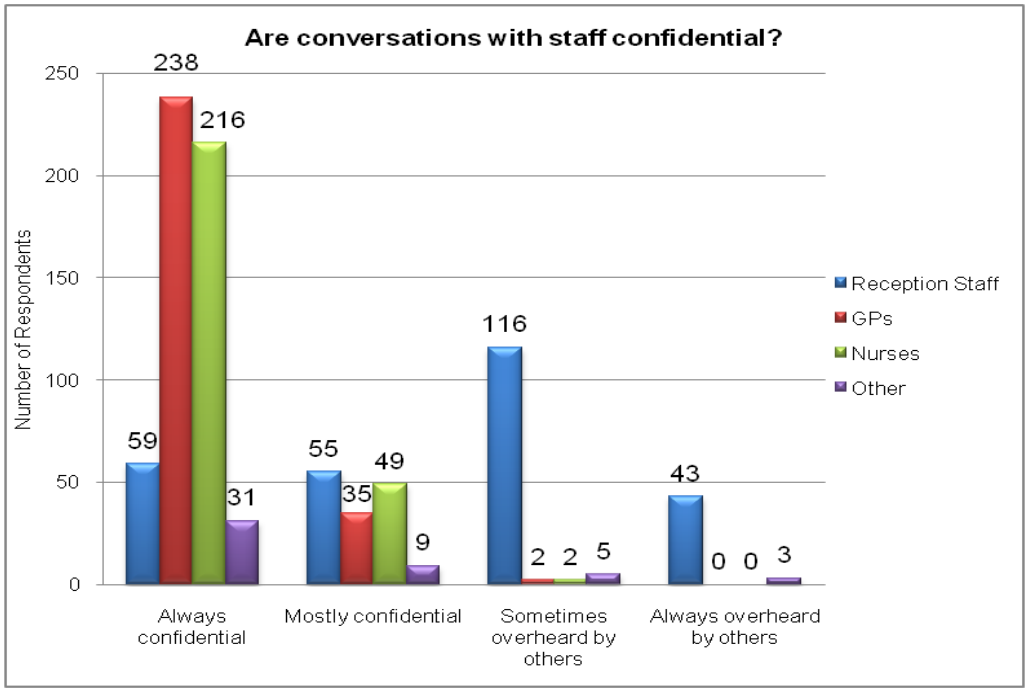


### 4.3 *Waiting Times*

Derbyshire LINk members were asked to comment on the waiting times at the surgery to speak to a receptionist and in the waiting room for their appointment.



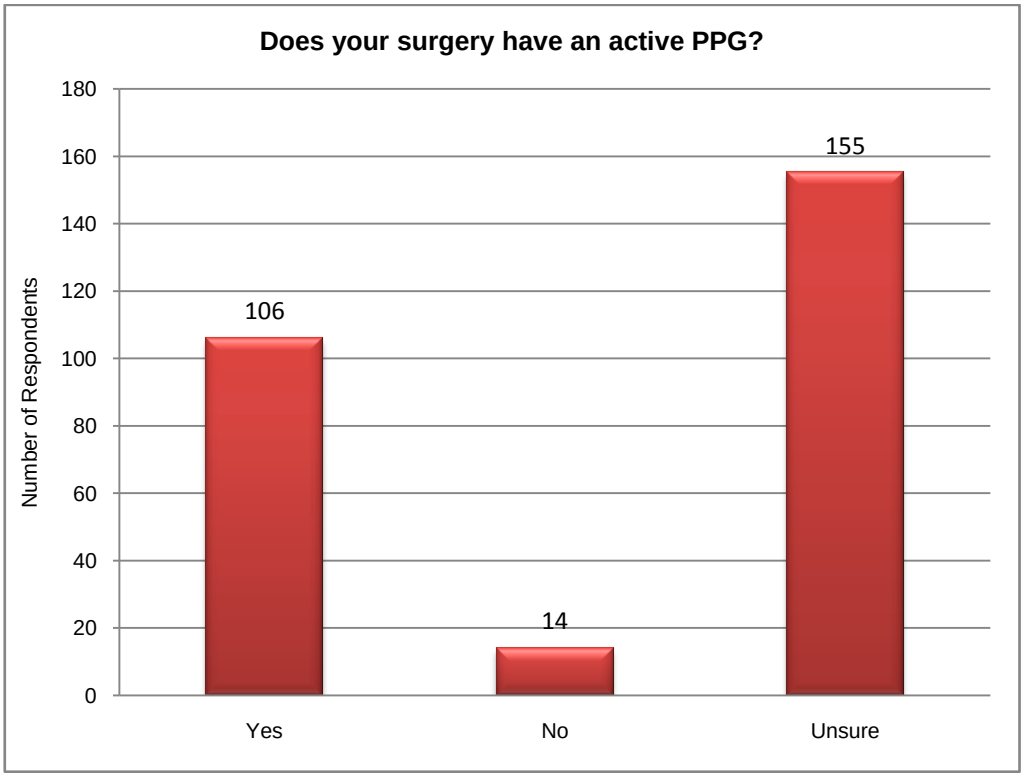

### 4.4 *Privacy and Confidentiality*




Respondents selecting 'Other' were asked to specify. In the case of this question, these included:-

Admin staff, audio tester, counsellor, deaf support, dietician, dispensary staff, district nurses, IT assistant, pharmacy staff, physiotherapist, and PPG secretary.

### *4.5 Patient Participation Groups (PPG's)*




# 5 Findings

## 5.1 Qualitative Findings

From the pilot questionnaire, the Sub-group gained information for a quantitative analysis however where the Sub Group had the opportunity to speak direct to patients, significant qualitative intelligence was gathered. For example, concerning the difficulties patients experienced in actually making contact with their surgery in order to make an appointment. *"It is really difficult to get through to make an appointment with the doctor …"*

One gentleman explained how one particular morning he had called his surgery to make a GP appointment but to no avail. He resorted to going into the surgery to make the appointment at reception. He then had to make a second visit that morning to attend the appointment. He pointed out another couple who had done exactly what he had done. He went on to explain it was a regular occurrence.

Similar problems are significantly and clearly evidenced by the intelligence recorded on the Derbyshire LINk database. This data is continuously updated and Appendix B evidences this. Even though the comments shown are for the last 6 months (January – June 2012), there is further historical data.

The Sub-Group however thought it more pertinent to develop quantitative intelligence to explore the original themes the Sub-Group had identified. These were, how informed patients are about the appointment types available at their surgery, how staff interacted with them, privacy and confidentiality and information about Patient Participation Groups (PPG's). For example patients were asked if they were aware of the availability of certain services within their surgery; the availability of a double appointment.

5.2 Quantitative Findings

A response of 112 (41%) of a total of 272 respondents recorded that they were unsure whether a double appointment was available at their surgery, with a further 15 (5.5%) clearly recording that their surgery did not offer this type of appointment.

The responses to this line of questioning reveals that almost half of the patients were unclear as to the availability of this appointment type.

Also, a similar question explored the patient's knowledge as to the availability of a GP call back. This question revealed that a collective response of 84 (30.2%) of 276 respondents either recorded that their surgery did not offer, or were unsure if their surgery offered, this service.

This analysis indicates that patients are not fully informed as to the basic availability of the types of appointments offered by their surgeries.

The line of questioning then moves on to how patients were made aware of the services provided by their surgery. (Patients were asked to tick as many formats of communication as applicable.) From a response rate of 419, patients found verbal information from staff to be the most effective method of communication at 49% (205), followed by surgery notice boards/electronic display boards 20.2% (85) and patient leaflets 13.3% (56). The latter two however can only be effective providing the information is kept up to date, is clearly displayed and made readily available.

On the questioning of the courtesy of surgery staff, analysis revealed that reception staff 'scored' the lowest. This is also evidenced on the Derbyshire LINk database. However some consideration has to be given to the fact that it is the reception staff that have the most frequent communication with patients. Nonetheless, consideration should be given to providing specific 'Customer Service' training to relevant staff members.

Patient privacy and confidentiality is of paramount importance and the analysis reveals that this is mostly compromised by reception staff/location of reception desk. A concerning collective response of 159 (58.2%) of 273 respondents indicated that their conversations with reception staff were either sometimes, or always, overheard by others.

Finally in respect of Patient Participation Groups overall half of respondents revealed that they were unsure whether their surgery had an active PPG – 155 (56.4%) of a total of a total of 275 respondents.

# 6 Observations

The observations given below are the personal views of the Sub Group Members. These are all based on their own observations, gained during the whole of the project.

## *6.1 Pat Bygate*

At the first meeting of the Sub-Group we discussed what could be achieved from the group. Our thanks goes to Jas, our LINk Community Involvement Worker, whom we could not have achieved this excellent data without her support.

Jas gave us data to read that had been collated from the Derbyshire LINk database. From this it was decided to initially choose a number of GP practices in the Chesterfield locality

to visit. The strategy was to meet and interview the practice managers and then go into the practices with a pilot questionnaire for the patients to complete while they waited for their GP appointment(s).

Whilst giving out the questionnaires to patients, I found it very interesting to hear what questions the patients were asking. The main one being, *"… will it make a difference to the care I get?"*

Reassurances had to be given to patients that no names would be taken and that all questionnaires would be completed anonymously.

I have found it very interesting and enlightening going into GP practices asking the practice managers how they manage the running of their practice. Some were very honest about the difficulties and acknowledged they do not always get it right but were, however, willing to change things after discussing the problems with their staff; others were not so forthcoming.

One particular practice provides customer service training for their staff, which was evident when I visited the surgery. For example, for patients needing a further appointment, the receptionist went out of her way to book an appointment that was convenient for the patient.

In comparison, at another practice where a patient asked for a further appointment, which was for 1 week's time, the receptionist asked the patient to contact the surgery nearer the time.

It has become very clear in the data collected that there is a need for practice receptionists to have some form of training on how to deal with the patient. The majority of patients are ill at the time they contact their practice therefore need help getting an appointment. Customer service training would therefore be helpful.

There is not enough information made available to the patients about what a Patient Participation Group (PPG) is, what its function is, who can join and how to join. How can patients join a PPG if they are not aware of its existence and what it entails? I am also aware there is also reluctance by some practices to have one.

Some practices are using their internet website(s) as a virtual PPG but they should be mindful that not every patient has a computer. One question that arose, *"… is it being done for the practice or the patient?"*

I have enjoyed being part of this project very much. I hope that some improvements could be made from the data we have collected.

### *6.2 John Martin*

I found the experience of being involved in the Sub-Group very enlightening. I attended 3 practices as part of the pilot, before we went Countywide via the Derbyshire LINk Membership.

Whilst there seems to be a genuine problem with getting appointments, there is some reluctance to actually say so when asked to record it on a questionnaire. Surprisingly, the results show a substantial majority are satisfied with their particular system, although this is not reflected by the issues recorded on the LINk database.

On the attitude of receptionists, most people couldn't speak highly enough of the staff. In fact I found all the staff at the practices I attended to be very cooperative.

At one practice I did notice a lady had been waiting a long time for her appointment and eventually had to go to the desk, but it transpired she had not heard her name called out, and the GP had been looking for her. It appeared there had been a degree of mis-communication.

### *6.3 Jas Dosanjh*

I have worked on this particular project from the onset with the Sub-Group and found it to be a very interesting journey.

My work involved communicating with practices from arranging meetings for Sub-Group members with practice staff, to co-ordinating mutual dates and times in order to carry out the pilot questionnaire. During this process I witnessed the perspective of the patient whilst carrying out the pilot survey to experiencing some inconsistent standards in effective and timely communication by certain practices.

When I met and spoke with patients whilst carrying out the pilot survey, most were happy with the clinical aspect of their experiences. Some however were exacerbated by the systems and processes set up by their practices when wanting to arrange a GP appointment.

This is continually reaffirmed by the comments captured from the public throughout the County. Generally intelligence reveals that members of the public do not find it easy to get through to their GP Practices in order to make appointments.

In my first report I mentioned staff attitudes playing a vital role in shaping an individual's perception of the care they experience. So, even though data like Patient Satisfaction Surveys/National GP Survey provide very valuable information, there is no substitute for the patient's voice.

Freud observed, *"Mortals can keep no secret. If their lips are silent they gossip with their fingertips; betrayal forces its way through every pore."* Thus sensing what others feel without them saying, can capture the essence of empathy.

It is very rare others tell us what they feel in words. It is normally communicated in what is not said, for example in the tone of voice, facial expressions or, as Feud said, though their body language.

The ability to sense these subtle communication cues can help to develop the ability to empathise, thus allowing to have the ability to build a rapport and respond to an individual as a unique person, eventually coming down to providing a good customer service. When a patient is feeling poorly and vulnerable, he/she is not in the right frame of mind. Therefore he/she wants to be dealt with in a *way* that illustrates the member of staff is there to help.

## 7 Recommendations

7.1 Staff attitudes play a vital role in shaping an individual's perception of the care they experience. Reception staff have the most frequent communication with patients therefore consideration should be given in providing "customer service" training.

7.2 All practices should make basic key information available to patients, for example, information on the availability of double appointments, and GP call backs. This

information should to be made readily available, clearly displayed and kept up-to-date.

7.3 A more staggered appointment system through the working day could be considered. For example, releasing batches of appointments at key times through the day. This would allow for patients group such as the elderly and mums with young children to have minimal difficulty when wanting to see a GP/Nurse because they would be able to obtain appointments between the hours of 9am-5pm.

7.4 Appointments should be made available via the internet in order to help ease the bottleneck that is created at key times of the day, but we recognise this could potentially have its problems with patient's different levels of IT skills.

7.5 Practices should consider how reception areas can be adapted in order to ensure privacy and confidentiality for patients.

7.6 Practices should consider promoting what a Patient Participation Group (PPG) is, its purpose, how to join and the work carried out through the most effective methods of communication. Although a virtual PPG would be perfectly acceptable as a way of accessing patient views, nonetheless there was a lack of knowledge amongst respondents as to whether their practice had an active PPG.

7.7 For GP Practices to make an effort to engage with Derbyshire LINk (set to evolve into Local Healthwatch) in order to help them find out what the local community are saying about their service delivery.

## 8 Conclusion

Derbyshire LINk's Sub-Group acknowledge the GP Practice appointment system process is a difficult problem to solve. These problems are not unique to Derbyshire, however it still requires addressing.

The group does recognise that Clinical Commissioning Groups (CCGs) are aware of problems with this in certain areas and they are looking at ways to make the patient experience better.

The challenge is that all practices have different models of operation, therefore it is not possible to make generic recommendations; one size does not fit all. For this reason it proved difficult for the Sub-Group to make further recommendations.

Practices should consider customer service training for their staff. Reception staff are often the first point of contact for patients when initiating the process of using the NHS. Reception staff therefore play an important role as a front line service. Bigger practices/medical centres appeared to deliver a more impersonal service. This may highlight where customer service training could prove beneficial in helping to improve the patient experience.

One particular group of practices in North Derbyshire are "buying in" customer services training as a result of an in-house survey they carried out.

A large proportion of Derbyshire LINk Members were unsure if their practice had a Patient Participation Group (PPG). This could have been for a number of reasons:-

- Patients are not interested in knowing what a PPG is and what its purpose is.
- PPGs are not actively being promoted therefore patients are unaware of its existence.
- The practice does not have a PPG.

A PPG allows :-

- for patients to be involved in the decision making process of what services are delivered within their practice and to give feedback on the quality of these services. Thus meeting the needs of the local community the practice serves.
- for a two-way communication process to exist between the patient and the practice staff, thus allowing for the breakdown of barriers.
- for PPG members to help the wider community to help themselves take more responsibility for their health.

An example of where a PPG has been working well for some time is in South Derbyshire.

Chris Jackson is the PPG Chair of Gresleydale Healthcare Centre. Jenny Wainwright is the Practice Manager and Janice Pallett is a PPG Member of Gresleydale Healthcare Centre. They were asked to give commentaries as to why they felt their PPG worked.

**Chris Jackson (PPG Chair) - Gresleydale Healthcare Centre**

*"Two years ago, due to the economic climate, I chose to sell my companies (none NHS related) and take early retirement. I wanted to keep myself alert, so looked around for voluntary organisations to which I thought I might be able to bring some benefits, as well as keeping me off the streets!*

*I spent a while at an Aircraft Museum, and then stumbled across the Gresleydale PPG, from reading their notice board within my doctor's practice.*

*Eighteen months ago, I went along to one of their monthly meetings, where I was made to feel very welcome. They had existed as an enthusiastic group for some years, had made some contribution to the Practice, but were now hampered by petty squabbles and personal agendas.*

*So I got involved, took on a few minor tasks and delivered results. Then an opportunity arose and I was proposed as Chairman, which I accepted.*

*At that point I was not aware of the sweeping changes being made to the NHS, that PPGs would become indispensable to that common vision, and above all, gain a degree of influence. I did, however, quickly see the potential developing, and grasped it with both hands.*

*The group I inherited are all good people, with differences, but that mattered as much as similarities, varied skills, but overall a desire to support each other. It was easy for me to steer the group by introducing a little tact and diplomacy, a degree of professionalism and balancing the necessary compromise.*

*Once the PPG was functioning smoothly and producing positive results, (which was the reward for the members) I set about networking the other six Locality PPGs, increasing our patient spread from 9000 to 55000 people.*

*It was this action that really set us on course.*

*It can be a lonely position as Chair, so now having colleagues, who have since become friends, have made the job so much easier. We share progress and ideas, on a monthly meeting basis (venue supplied by Gresleydale Healthcare Centre) and countless email and telephone sessions, the experiences, success or otherwise of our groups, the results of our individual tasks, and help our practices work together, where we can bring benefit to other organisations who are assisting our patients.*

*As a group, we have introduced to our practices, the following:-*

- *Patient Comment cards, (three simple all embracing questions), which we analyse, resolve and post the results on our notice board if required.*
- *Posters and notice boards.*
- *Unified constitutions, codes of conduct, confidentiality clause, working practice.*
- *Shared with our practice's the results of working practice being tried or adopted by other practices, some outside our area.*
- *Caused the PPGs and practice's to work in partnership to achieve the common goal of improving services for patients. Practice's are now seeing the PPG as an asset and valuable partner.*

*On the occasions when we attend NHS update and progress talks we are regularly approached by other active PPG groups, seeking advice on our achievements and progress, something we are keen to assist with and will be looking to expand across the CCG area. We are also sharing our experience with the PCT who have taken an interest in our model.*

*But above all, we consider that our biggest success to date is our appointment to a seat on the Locality Commissioning Panel, where we expect to make a meaningful contribution.*

*It has been a busy eighteen months, with hard work and a few droughts, but shoots have appeared, now just watch us grow."*

**Jennifer Wainwright – Gresleydale Healthcare Centre, Practice Manager**

*"The work of Patient Participation Groups (PPGs) varies from practice to practice – there may be a particular interest in fund raising, practice services, or a preference to look at the bigger picture and national/local networking. I personally think all are important and have relevance and it is perfectly possible to incorporate all interests or any individually.*

*The reason why I believe the Gresleydale PPG has thrived, is because it has been able to evolve to meet volunteer's interests and there is respect for all efforts. Whilst there have been some significant challenges, they have been made stronger by sticking to their beliefs.*

*The Gresleydale Practice welcomes all input and suggestions from its PPG and whilst not all can be delivered, discussions are treated with the respect deserved. The group has been in existence for several years and has always been sincerely appreciated hence the reason probably why it is still in existence."*

**Janice Pallett – Gresleydale PPG Member**

*"I joined the Gresleydale PPG three years ago. It seemed quite dormant when I joined but when Chris Jackson came as Chair it escalated with a sub-group doing fund raising. Whilst Chris goes to meetings and also joins with the other five doctors surgeries in the area, we all contribute in different ways bringing ideas and subject matters to the meeting.*

*We also work with the doctors and staff trying to solve problems such as those regarding the appointment system. For example, patients not attending their appointments (DNA). The PPG thought of a process whereby patients can dial "0" if they want to cancel appointments. This is an easy and straightforward process for patients to cancel their unwanted appointment hence helping to reduce DNA's.*

*I have organised a tour round Queen's Hospital, Burton, for the PPG. We also produce a newsletter which we distribute around the area."*

What is demonstrated above is that an ongoing two-way conversation between patients and the service provider can exist and it can work so that ultimately it improves the patient experience.

Another aspect Derbyshire LINk picked up through the LINk database (see Appendix B) during this piece of work was older patients wanting to have the option of being able to see the same GP, especially for a long standing illness/condition. Appendix C details the study undertaken by University of Leicester. This study provides evidence to suggest that there is a link between patients having continuity within their treatment and hospital admission rates.

Information about the appointment system, prescriptions and updates need to be constantly communicated with the patients in order to help ease the bottleneck problem that is caused at certain times of the day.

Services require regular feedback to understand whether the changes they are making are the right ones and are genuinely improving the experience of patients.

The key is to get the basics right.

# 9 Acknowledgements

Derbyshire LINk would like to thank the Sub-Group:

Sandra Brown, LINk Member for her involvement and positive contribution in the first part of the project. Derbyshire LINk is sad to announce Sandra was unable to carry on with her commitment due to ill health and she sadly passed away in the early hours of Saturday morning, 4th August 2012.

David Briggs, LINk Steering Group Chair, was involved in the first part of the project.

Pat Bygate, LINk Member.

John Martin, LINk Steering Group Member/Champion.

All took time out of their hectic schedules to selflessly assist Derbyshire LINk with this piece of work and without their help, and others alike, such functions of Derbyshire LINk would be restricted.

The Sub-Group would like to thank:-

The 5 GP Practices in the Chesterfield locality for allowing the questionnaire to be tested.

Chris Jackson (Chair of Patient Participation Group, Gresleydale Healthcare Centre, Church Gresley, Swadlincote, South Derbyshire), Janice Pallett, (Derbyshire LINk Steering Group Member and Gresleydale Healthcare Centre PPG Member) and Jenny Wainwright (Practice Manager of Gresleydale Healthcare Centre, Church Gresley, Swadlincote, South Derbyshire).

Finally, Derbyshire LINk would like to thank their joint Hosts Amber Valley CVS and NDVA for their continued support and guidance.

## 10 Appendices

**Appendix A**
See Page 18
Derbyshire LINk Patient Satisfaction Questionnaire

**Appendix B**
See Page 23
Comments from the Derbyshire LINk Database, January – June 2012.

**Appendix C**
See Page 26
University of Leicester, 2012, Allowing Patient Access to Chosen GP Would Reduce Cost to the NHS

Derbyshire LINk

# GP Access – Patient Satisfaction Questionnaire

Dear Member

## WE WANT TO HEAR YOUR VIEWS

As Derbyshire LINk's ongoing program of monitoring Health and Social Care Services, the Derbyshire public and LINk members have reported comments with regards to GP Practices. To further investigate these themes we have devised the attached questionnaire.

We would be grateful if you would take a few minutes to answer the following questionnaire and return using our Freepost address to:-

**Freepost RSTB-ASHY-USTZ**
**c/o Amber Valley CVS – Derbyshire LINk**
**33 Market Place**
**Ripley**
**Derbyshire**
**DE5 3HA**

***Please note your individual responses will not be personally identifiable***

## We want to help improve the services you receive

**CLOSING DATE: 16 MARCH 2012**

If you would like to discuss further please contact:
**Mrs Jas Dosanjh**
**Derbyshire LINk Community Involvement Worker**
**Tel: 01773 512076**
**Email: jas@derbyshirelink.org.uk**

Amber Valley Centre for Voluntary Services
Registered Charity No.1102412
A Company Limited by Guarantee.
Registered in England No. 4763194

NDVA
Registered Charity No. 1134329
A Company Limited by Guarantee.
Registered in England No. 6956527

Derbyshire LINk

# GP ACCESS - PATIENT SATISFACTION QUESTIONNAIRE
# CLOSING DATE: 16 MARCH 2012

## SURGERY DETAILS

1. **Name of your Surgery**

2. **Location of your Surgery (e.g. Matlock, Horsley Woodhouse)**

## APPOINTMENT SYSTEM

3. **Are the following services available to you at your surgery?**

| | *Yes* | *No* | *Unsure* |
|---|---|---|---|
| A same day appointment? | ○ | ○ | ○ |
| A double appointment? | ○ | ○ | ○ |
| A pre-bookable appointment? | ○ | ○ | ○ |
| An appointment with a nurse? | ○ | ○ | ○ |
| An appointment with a GP within 48 hours? | ○ | ○ | ○ |
| A GP call back? | ○ | ○ | ○ |

4. **How were you made aware of these services? (Tick as many that apply).**

- ☐ Verbal information from staff
- ☐ Web Site
- ☐ Newsletter
- ☐ Patient Leaflets
- ☐ Surgery notice board/electronic display board

## STAFF

**5. At your surgery, how would you rate the courtesy of the following staff?**

| | *Very Good* | *Good* | *Average* | *Poor* | *Very Poor* |
|---|---|---|---|---|---|
| Reception staff | ○ | ○ | ○ | ○ | ○ |
| GPs | ○ | ○ | ○ | ○ | ○ |
| Nurses | ○ | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ | ○ |

If you selected 'other' above please state who below.

**6. At your surgery, how well do you think the following staff are listening to what you are saying?**

| | *Very Good* | *Good* | *Average* | *Poor* | *Very Poor* |
|---|---|---|---|---|---|
| Reception staff | ○ | ○ | ○ | ○ | ○ |
| GPs | ○ | ○ | ○ | ○ | ○ |
| Nurses | ○ | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ | ○ |

If you selected 'other' above please state who below.

**7. Do the following staff give answers that you can clearly understand?**

| | *All of time* | *Most of the time* | *Sometimes* | *Rarely* | *Never* |
|---|---|---|---|---|---|
| Reception staff | ○ | ○ | ○ | ○ | ○ |
| GPs | ○ | ○ | ○ | ○ | ○ |
| Nurses | ○ | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ | ○ |

If you selected 'other' above please state who below.

**8. Do you feel the following staff show you respect?**

| | *All of the time* | *Most of the time* | *Sometimes* | *Rarely* | *Never* |
|---|---|---|---|---|---|
| Reception staff | ○ | ○ | ○ | ○ | ○ |
| GPs | ○ | ○ | ○ | ○ | ○ |
| Nurses | ○ | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ | ○ |

If you selected 'other' above please state who below.

**9. Do you feel staff maintain dignity?**

| | *All of the time* | *Most of the time* | *Sometimes* | *Rarely* | *Never* |
|---|---|---|---|---|---|
| Reception staff | ○ | ○ | ○ | ○ | ○ |
| GPs | ○ | ○ | ○ | ○ | ○ |

## WAITING TIMES

**10. In general, the waiting time at the surgery**

| | *Acceptable* | *Neither Acceptable nor Unacceptable* | *Unacceptable* |
|---|---|---|---|
| to speak to a receptionist is | ○ | ○ | ○ |
| in the Waiting Room for my appointment is | ○ | ○ | ○ |

## PRIVACY & CONFIDENTIALITY

**11. Are your conversations with the following staff confidential?**

| | *Always confidential* | *Mostly confidential* | *Sometimes overheard by others* | *Always overheard by others* |
|---|---|---|---|---|
| Reception staff | ○ | ○ | ○ | ○ |
| GPs | ○ | ○ | ○ | ○ |
| Nurse | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ |

If you selected 'other' above please state who below.

## PATIENT PARTICIPATION GROUP (PPG)

**12. Does you surgery have an active PPG?**

○ *Yes* ○ *No* ○ *Unsure*

## CLASSIFICATION

**Any information given in this section is purely to help us analyse the data collated and is for classification purposes only.**

13. **What is your age group?**

| Under 16 | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75-84 | 85+ |
|---|---|---|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

14. **What village/town do you live in? (e.g. Ticknall, Ripley, Buxton).**

15. **What is your Postcode?** If you do not want to give your full postcode, please just provide the first half of your code, i.e. DE6

16. **What is your gender?**

***Derbyshire LINk would like to thank you for taking the time and trouble to complete this questionnaire.***

Please return the questionnaire using our FREEPOST address below:-

**Freepost RSTB-ASHY-USTZ**
**c/o Amber Valley CVS - Derbyshire LINk**
**33 Market Place**
**Ripley**
**Derbyshire**
**DE5 3HA**

## **Appendix B: -** Comments from the Derbyshire LINk database

| Type | Subject | Full Details | District | Category |
|---|---|---|---|---|
| Issue | When calling to make appointment, don't feel that it is appropriate for receptionist to ask if reason for calling is "new" or "ongoing". "Triage nurse is lovely." | When desperate for someone to come and see husband, want things sorted quickly and efficiently. | Erewash | Appointment System |
| Issue | Phone is engaged from opening until half an hour later, when all the appointments for the day have gone. Can't book in advance unless GP allows this if they want to see you for a follow on appointment. I get up early, walk, and book at reception. | | Amber Valley | Appointment System |
| Issue | Between 0800-0845 when you press one for appointments the phone line sometimes just goes dead which is frustrating. | | Amber Valley | Appointment System |
| Issue | Constantly have to redial to get an appointment - it is a lottery to see if you get one. Went in to reception to book an appointment and was told I had to book over the telephone. Very frustrating. | | Amber Valley | Appointment System |
| Compliment | Take a ticket on arrival, and then you are called for your appointment by ticket number. Great system saves any confusion at a busy practice. Same comment x 2. | | Amber Valley | Appointment System |
| Compliment | It is simple and straight forward to get a GP appointment at this practice. | | Amber Valley | Appointment System |
| Compliment | I am pleased to be registered at this practice, the service it good and the appointment system is good and easy to use. | | Amber Valley | Appointment System |
| Compliment | I like the appointment system - you can get in on the day if it is really necessary and you can book in advance if non urgent. When I was taken ill recently they saw me straight away. | | Amber Valley | Appointment System |
| Compliment | They have a good appointment system at this practice and really promote the GP calling you back to save the need for an appointment. | | Amber Valley | Appointment System |
| Compliment | I really like the convenience of the drop-in style appointments at this practice. | | Amber Valley | Appointment System |
| Compliment | I find the appointment system works well and the GPs are friendly and helpful. | | Amber Valley | Appointment System |
| Issue | Very long wait to see your GP of choice, often several weeks. | | Amber Valley | Appointment System |
| Issue | I have to wait too long for appointments to see Dr @@@@@@. | | Amber Valley | Appointment System |
| Issue | 2-3 week delay to see doctor of choice. | | Amber Valley | Appointment System |
| Issue | Not happy with appointment service, I had to wait 23 days for an appointment with my GP of choice. | | Amber Valley | Appointment System |
| Compliment | 4 x comments saying that the appointment system is very good, it is quick and easy to get through on the phones and there are appointment times available when you get through. | | Amber Valley | Appointment System |
| Compliment | I can have my blood pressure taken at short notice with a nurse. | | Amber Valley | Appointment System |
| Compliment | It is a good service at @@@@@@@@@@. They nearly always get you in after surgery and all the doctors are good. | | Amber Valley | Appointment System |
| Compliment | They have a very good appointment system at this practice. Very caring and helpful. | | Amber Valley | Appointment System |

| | | | | |
|---|---|---|---|---|
| Compliment | Excellent service, rang at 8.15am on 27/12/11 which was first working day after Christmas and got an appointment the same morning. Brilliant. | | Amber Valley | Appointment System |
| Compliment | The surgery has an effective telephone call back system if I want a call from my GP. | | Amber Valley | Appointment System |
| Compliment | There is a flexible appointment system allowing me to book with my GP of choice, and they have a good system for emergency appointments at the end of each clinic. | | Amber Valley | Appointment System |
| Compliment | The electronic booking in system is useful and easy to use and saves you waiting at reception. | | Amber Valley | Appointment System |
| Compliment | I can normally get an appointment very quickly at this practice when I need to be seen. | | Amber Valley | Appointment System |
| Compliment | The appointment system for routine diabetic checks is good at this practice and works smoothly. | | Amber Valley | Appointment System |
| Compliment | Very good appointment system and very good with children. The GPs make positive decisions. | | Amber Valley | Appointment System |
| Issue | When you call for an urgent appointment, you have to wait at least 2/3 days. To see you own Dr, you have t wait 5 days (Named) Drs are very good. Some of the other Drs English isn't very good & can cause confusion | | Chesterfield | Appointment System |
| Issue | 5 days waiting time for an appointment to get the morning after pill, in the end I had to go in and wait for 5 hours for the urgent appointment. | | Chesterfield | Appointment System |
| Issue | I had to wait two weeks for an appointment to get the morning after pill. | | Chesterfield | Appointment System |
| Compliment | Easy to get appointment, children always seen the same day | | Derbyshire Dales | Appointment System |
| Compliment | Always offered convenient times, no waiting. Appointments run on time. | | Derbyshire Dales | Appointment System |
| Issue | If you ring first thing in the morning for an appointment then you are OK, but once the reserved appointments have gone if you ring later in the day for an appointment then it is days and days until you can get in. | | South Derbyshire | Appointment System |
| Issue | Longest waiting time which patient has had to wait is 1/2 hour. A 10 min wait is reasonable. Some GP's run late. | | South Derbyshire | Appointment System |
| Compliment | Easy to get appointment. Reception & GP very polite. Would prefer to see same GP. 1 particular GP is due to retire. He is wonderful. Patient trust this GP. Can generally get same day appointment. "Works well." | | South Derbyshire | Appointment System |
| Issue | Difficult to get appointment with GP dealing with ailment. Would like consistency of seeing the same GP. | ExampleRang Monday morning for an appointment for Tuesday with a specific GP. Told that was the GP's day off therefore not doo-able.So receptionist then offered an appointment for that Monday ironically with the GP patient wanted in the first instance."Whole system is wrong."When a GP wants to see a patient in 1 month's time, this is not possible for whatever reason. Should be able to make an appointment in 3 months time. | South Derbyshire | Appointment System |
| Issue | 2 x comments - very hard to get appointments to be seen quickly at this practice. | | Erewash | Appointment System |

| | | | | |
|---|---|---|---|---|
| Issue | Called surgery to make appointment, was kept waiting 18 mins. | Patients have resorted to going to the surgery. Reception staff now will see to one patient at the reception desk and one patient on the telephone.<br><br>Don't know what a solution is. Only aware of how it is becoming. Could practices have 1 hour where patients can just drop in to see a GP ?<br>One situation encountered when the GP did not make a home visit. | Erewash | Appointment System |
| Compliment | "Went for a blood test, more or less on time." | | Erewash | Appointment System |
| Issue | Long waiting times. GP's always running behind by at least 15 - 20 minutes. | | Derbyshire Dales | Appointment System |
| Issue | You have to ring the Surgery at 8am, by 8.30am all the appointments have been taken. I have to queue outside at 7:40 amongst 20 other people to get an appointment. | | North East Derbyshire | Appointment System |
| Issue | In can be several weeks to get an appointment with a GP even if you are prepared to see any of them. If you want a specific GP you stand no chance. | | Bolsover | Appointment System |
| Compliment | Really happy with this practice and they have a good easy to use appointment system. | | Amber Valley | Appointment System |
| Issue | The phone lines get jammed in the morning it is very hard to get through to the practice. Once you get through it is great. | | Amber Valley | Appointment System |
| Issue | Given the choice between regimented 10 minute appointments and flexible appointments meaning that clinics run late, four patients at this practice said that they would prefer flexible clinics that run late. | This practice are sticking to 10 minute slots and have notices up to advise patients of this | South Derbyshire | Appointment System |
| Issue | If you ring first thing in the morning for an appointment then you are OK, but once the reserved appointments have gone if you ring later in the day for an appointment then it is days and days until you can get in. | | South Derbyshire | Appointment System |
| Issue | Only 8-9am window for getting an appointment which is a small opportunity and is not convenient. You can book by email but not with nurses etc. There is little continuity with the same GP. | | Amber Valley | Appointment System |
| Issue | I struggle to get an appointment when my child is poorly. She only has one kidney so if she's sick, she needs to be seen immediately as she won't be getting any nutrition. Really worry. | | High Peak | Appointment System |
| Issue | "Exceptionally long waiting time from certain doctors, their help is poor and they do not give useful advice. | | Erewash | Appointment System |
| Issue | I only have a mobile and can never seem to get through the phone lines, I have to physically walk into the surgery to make an appointment. | | North East Derbyshire | Appointment System |
| Issue | Saw the GP with severe stomach cramps and D&V, the only advice I was given was to drink water. | I later admitted myself into A&E, I was diagnosed with severe Gastritis and was administered morphine. | North East Derbyshire | Appointment System |
| Compliment | The District Nurses ring me up to see if I need anything and I am able to see Dr. @@@@@@ as soon as I need to. There are two late nights and a Saturday morning. | | National | Appointment System |
| Issue | "I think waiting times need to be improved." | | Erewash | Appointment System |

**Appendix C**

University of Leicester, 2012, Allowing Patient Access to Chosen GP Would Reduce Cost to the NHS, [Online] Available at: <http://www2.le.ac.uk/offices/press/press-releases/2012/april/allowing-patient-access-to-chosen-gp-would-reduce-costs-for-the-nhs> <Accessed: 28th June 2012>

# 11 Bibliography

Derbyshire LINk: What The Patient Thinks. Erewash & South Derbyshire by Jas Dosanjh March 2011. Report is available from Derbyshire LINk.

**DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD**

**24th January, 2013**

**Feedback to Board regarding Derbyshire LINk's Observations of Services Delivered at GP Practices throughout Derbyshire Report**

## Purpose of the Update

This update is to inform the Board of the responses received from the Clinical Commissioning Groups to the aforementioned report. As requested by the Board at 27th September 2012 meeting.

## Background

Derbyshire LINk originally presented the attached Report to this Board on 27th September 2012. It was recommended the Board maintain an interest in this particular subject. The Board requested an update in due course from Derbyshire LINk of its progress. The report was sent formally to all 4 Clinical Commissioning Groups (CCGs) and Tameside & Glossop PCT (CCG) requesting acknowledgment of receipt of the report within 20 days but to then further provide a comprehensive response by 31st December 2012. The report has not yet been placed in the public domain.

## Responses from the Clinical Commissioning Groups:-

Erewash Clinical Commissioning Group

*Response received 4 January 2013*

There are a number of areas of work the CCG are undertaking in order to look at improving access and are planning to continue this into the next financial year. This includes Quality and Outcomes Framework – Review of A&E attendances, Practice Development Programme – this involves acting upon patient feedback and involving Patient Participation Group, Primary Care Clinical Quality Indicators Scheme – whereby practices must demonstrate they are reviewing their access arrangements via capacity and demand but also to have an action plan to address improvement.

Hardwick Clinical Commissioning Group

*Response received 13 December 2012*

The CCG's Quality and Clinical Governance Committee have been asked to receive Derbyshire LINk's Report and ensure this issue is responded to appropriately. The Hardwick Practice Managers Group has been asked to take this forward ensuring they review best practice within the CCG and outside. They will also benchmark where they stand now and review the reports developed by Quality Outcomes Framework and the PPE (Patient and Public Experience) DES (Directed Enhanced Service) survey results. The CCG have also explained they have recommended this work is fed into the planned primary care strategy.

North Derbyshire Clinical Commissioning Group
*Respond received 2 January 2013*
The CCG gave a comprehensive explanation of the work being done. This includes Analysis of Data, A&E Patient Surveys, and Customer Care/Patient Experience Training amongst other things. The Derbyshire LINk Report has been used by the CCG to inform the ongoing work of the CCG in the areas of access and service delivery.

Southern Derbyshire Clinical Commissioning Group
*Response received 22 October 2012*
The CCG are in the process of pulling together information on any work that is, or has been, undertaken within the areas Derbyshire LINk has highlighted and will provide feedback accordingly.

Tameside and Glossop PCT (CCG)
*No response received.*

**Next Steps/Way Forward**
Is an Equality Impact Assessment required? **No**
If yes, has one been carried out? **N/A**

**Recommendations**
Derbyshire LINk would like the Board to acknowledge and take note of this feedback. It also requests the Board maintain an interest in this particular subject and asks for an update from the necessary organisations to understand how matters are progressing on a regular basis.

Access within Primary Care is a continuous matter of concern for the general public. It is therefore imperative that Derbyshire LINk can actively provide evidence for the Derbyshire public and patients, for whom we represent, that this significant concern is held at the forefront of the relevant organisations and, crucially, that they are responding in a positive manner.