John McElvaney
Solicitor
Director of Legal Services
County Hall
Matlock
Derbyshire
DE4 3AG

Tel: 01629 538324
Ask for: Gemma Duckworth
Ref:
Date: 22 March 2012

Members of the Shadow Health and Wellbeing Board

Dear Member

Shadow Health and Wellbeing Board

Please attend the meeting of the **Shadow Health and Wellbeing Board** to be held on **Thursday 29 March 2012** commencing at **10.00am** in **Committee Room No 1, County Hall, Matlock**

The agenda is set out below.

Yours faithfully

John McElvaney.

John McElvaney
Director of Legal Services

A G E N D A

1. Introductions and Apologies for Absence

2. To confirm the minutes of the meeting held on 26 January 2012

3. Revised Plan to Deliver the Strategy for Accommodation, Support and Care for Older People in Derbyshire

4. Adult Care and Joint Commissioning Priorities 2012-13

5. Tameside and Glossop Joint Strategic Needs Assessment Review 2012

6. Derbyshire Health and Wellbeing Strategy Update

7. Development of the Health and Wellbeing Board

8. Delivering the Health Agenda:
    - National Forest
    - Environmental Services

9. Tobacco Control Services in Derbyshire: The Current Service and Key Issues

10. Derbyshire System Integrated Plan (DSIP)

11. NHS Commissioning Board/Direct Commissioning Presentation

12. Round-Up Report

13. Any Other Business

MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 26 January 2012 at County Hall, Matlock

PRESENT

Councillor A I Lewer (in the Chair)

D Briggs	Derbyshire LINK
Councillor J Burrows	Chesterfield Borough Council
Dr D Collins	North Derbyshire Clinical Commissioning Group
Councillor C A Hart	Derbyshire County Council
Councillor C W Jones	Derbyshire County Council
Dr S King	High Peak Clinical Commissioning Group
B Laurence	Derbyshire County Council/Derbyshire County PCT
Councillor B Lewis	Derbyshire County Council
Dr S Lloyd	Hardwick Health Clinical Commissioning Group
D Lowe	Derbyshire County Council
E Michel	NHS Tameside and Glossop
Councillor C R Moesby	Derbyshire County Council
Dr A Mott	Southern Derbyshire Clinical Commissioning Group
J Pendleton	North Derbyshire Clinical Commissioning Group
B Robertson	Derbyshire County Council
W Sunney	Hardwick Health Clinical Commissioning Group
I Thomas	Derbyshire County Council
T Thompson	NHS Derbyshire Cluster
Councillor R J Wheeler	South Derbyshire District Council

Also in Attendance – J Cox (Derbyshire County Council), Councillor S J Ellis (Derbyshire County Council), Councillor G Farrington (Derbyshire County Council), J McElvaney (Derbyshire County Council), S Pintus (Derbyshire County PCT), A Pritchard (NHS Derbyshire), and D Timcke

Apologies for absence were submitted on behalf of Dr A Dow, A Layzell, Councillor P Makin, and S Savage

1/12 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 24 November 2011 be confirmed as a correct record.

2/12 **JOINT STRATEGIC NEEDS ASSESSMENT** An update was provided on the process and timetable for the development of the Joint Strategic Needs Assessment (JSNA) in Derbyshire. The JSNA had been a statutory requirement for upper-tier local authorities and primary care trusts since 2008, and the Government expected it to have a strengthened role, and alongside Health and Wellbeing Strategies, would be 'the pillars of local decision making'.

Health and Wellbeing Boards were due to become statutory in April 2013, and at this time would take on the statutory responsibility for undertaking the JSNA and Health and Wellbeing Strategy. Recent guidance had identified a number of key aspects for the Health and Wellbeing Board in shaping an approach to the JSNA.

There was an expectation that Health and Wellbeing Boards should take action now on refreshing the JSNA and developing Health and Wellbeing Strategies, and should emphasise the role of the Health and Wellbeing Board in local leadership, integration and the engagement of key stakeholders. It was proposed that the Board adopted an 'outcomes-based approach', and local authorities, NHS Commissioning Boards and Clinical Commissioning Groups would need to take due regard of the JSNA and Health and Wellbeing Strategy when drawing up their commissioning plans. The Director of Public Health would act as the 'lynchpin' between local health and local authority services, and there would be a clear shift in the focus of the JSNA from not only identifying need but also as a tool to analyse available assets and resources. Draft guidance on the JSNA and Health and Wellbeing Strategies would be released in January 2012, and indicative timetables had been suggested, proposing that a JSNA refresh commenced in January 2012, priorities identified in April 2012, and the strategy to be developed in May 2012.

In terms of the approach in Derbyshire, the current core data set underpinning the JSNA was being refreshed and cross checked with the indicators in the three national outcome frameworks. The Health and Wellbeing Strategy was adopting the life career approach reflected in the national strategy, and it was important to enable an understanding of the health and wellbeing challenges in Derbyshire in an accessible form for all.

The JSNA steering group was currently consulting on and developing a template that would tell the story of health and wellbeing in Derbyshire, and a number of examples would be used to highlight the variation across Derbyshire, and it would be possible to focus on predominant issues facing a particular population group. These snapshots would be developed using key expert input and include inequalities and vulnerability as relevant. The number of narratives produced using an agreed template would be determined by relevant stakeholders, and the approach would be complemented by summary geographical or local district spine profiles.

It was the intention to make the Derbyshire Observatory a one stop portal for all information on health and wellbeing, and the development of Instant Atlas was important to enable people to explore the different aspects of health and wellbeing. It would be necessary to develop relevant geographies within Instant Atlas to allow use by different organisations and

communities, and a 'where I live' feature would be developed to enable users to bring together information to develop a snapshot of health and wellbeing.

The main aim of the JSNA in telling the story of health and wellbeing was to inform the priorities for action and allocation of resources. The JSNA would identify the main health and wellbeing needs for different populations and local areas, and the Health and Wellbeing Board could then prioritise these.

Each refresh of the JSNA should be a mixture of core data sets and filling identified gaps. It was stated that the core data set would evolve, but should cover the three outcome framework indicators. The JSNA Steering Group would identify gaps and develop a prioritised work programme. It would also be possible to develop joint working arrangements where appropriate with Derby City.

It was noted that asset mapping was a new expectation of the JSNA process, and national guidance suggested that an asset could be anything that could be used to improve outcomes. Others referred to asset mapping as identifying the skills, strengths, and knowledge of communities. A piece of work had been carried out in North East Derbyshire, and had engaged local people and locally elected representatives. People had been asked what assets they valued in their local community that contributed to health, and the results had identified a range of important resources, and it was felt that this could be carried out across the county.

It was important to engage the public in the JSNA and Health and Wellbeing Strategy, and rather than asking what the needs were, it could be possible to present local communities with the identified health and wellbeing needs and to ask people about solutions and what positive things were happening in their community that could be built on.

A summary of the process was given, along with a proposed timescale for the next steps. The refresh of data sets and predominant health issues would be identified for prioritisation by the Health and Wellbeing Board in April 2012; the Instant Atlas would be available in May; further work on evidence and resources would be completed for identified priority areas in June/July; and by September, an approach to asset based assessment would have been developed for agreement by the Board.

RESOLVED to endorse the approach to the JSNA and to mandate the JSNA Steering Group to develop and implement the proposed action plan for the JSNA.

3/12 DERBYSHIRE HEALTH AND WELLBEING STRATEGY DEVELOPMENT: PROPOSED HIGH LEVEL PRIORITIES At the last meeting

of the Board, the Health and Wellbeing Strategy Group had been tasked with developing a small number of high level priorities around which the full strategy could be developed. The priorities needed to be those with clear benefits and would need to be linked with clear outcome indicators. The Task Group had reviewed existing plans and priorities, the evidence base for effectiveness and cost-effectiveness had been taken into account, and the views of the Strategy Reference Group had been sought. From this, a proposed list of high-level priorities had been developed, and these were detailed, along with the relevant indicators from each of the three outcome frameworks.

Key strategic aims across all priority areas would be to improve health and wellbeing by **reducing health inequalities,** to **strengthen investment in evidence-based prevention and early intervention** and for all partners to deliver **high quality care that promoted privacy and dignity along with robust safeguarding processes**:

- Improve health and wellbeing in early years. Every child fit to learn and attain the highest levels of literacy. **Focus on early identification and intervention of vulnerable children and families (including children with disabilities)**
- Develop lifestyle services to prevent and reduce harmful alcohol consumption, obesity, physical inactivity, smoking and sexual ill-health. **Focus on preventing and reducing alcohol misuse, obesity and physical inactivity**
- Promote the independence of all people living with long term conditions and their carers. **Focus on providing community based support and care close to home including increased use of evidence-based telehealth and telecare**
- Improve emotional and mental ill-health and provide increased access to mental health services. **Focus on improving access to the full range of evidence-based psychological therapies (services that offer treatments for depression and anxiety disorders and other complex mental health problems)**
- Improve health and wellbeing of older people and promote independence into old age. **Focus on strengthening integrated working (pathways/referral mechanisms etc) between health and social care providers and housing-related support services (Las/registered social landlords/voluntary sector)**

Once agreed, the high level priorities would form the framework around which the full Strategy would be developed. The Strategy Task and Reference Groups would continue to work with the Health and Wellbeing Board in developing the strategy by June 2012, and feedback would be sought throughout the process. This would be closely linked with the ongoing development/refresh of the JSNA, and with emerging commissioning plans of

partner organisations. The publication of the final strategy in June 2012 would ensure that it could be a core part of partner's planning cycles for the 2013/14 year onwards.

The Board was in general agreement of the proposed high-level priorities, but commented on a number of issues that it was felt should be included, particularly drug/substance misuse, and the reference to telehealth and telecare, which could be broadened to self care. The document would be subject to further stakeholder consultation and the comments raised would therefore be considered.

RESOLVED to approve the proposed high-level priorities, taking into account the comments made, and to note the plans for developing the strategy.

4/12 PUBLIC HEALTH OUTCOMES FRAMEWORK 2013-16 The Board was presented with an overview of outcomes and indicators from the Public Health Outcomes Framework, which had recently been published. There were 66 indicators, and these would be public health outcomes from 2013. Of these, 29 were ready, but a number were classed as 'placeholder', which meant that these were the least developed indicators. It would be the responsibility of the County Council to show where improvements had been made, in partnership with the Health and Wellbeing Board.

5/12 OBESITY SERVICES IN DERBYSHIRE: COMMISSIONED SERVICES AND FUTURE STRATEGY ISSUES Obesity was a significant risk factor for many diseases that resulted in long-term ill health and disability, with a resource impact upon health and social care. Obesity provided a key link between disease and lifestyle topics, and as a result, obesity was now emerging as the key health improvement priority.

The national strategy A Call to Action on Obesity in England and the preceding Public Health white paper proposed that Tier 1 local authorities would take on responsibility for commissioning weight management services from April 2013.

Details were provided of the overweight and obesity rates as measured in Derbyshire in 2009/10 for Reception and Year 6 children. It was noted that obesity rates had almost doubled between Reception and Year 6, which reflected that national trend. However, there was a significant variation of obesity prevalence across the county. It was also estimated that there was approximately 190,000 adults in Derbyshire who were overweight or obese, and one of the challenges was that obesity was not generally perceived by the public as a problem.

A number of local services had been introduced and amended, based on a growing evidence base as to the most effective methods of prevention and treatment. In terms of the current approach, NHS Derbyshire County had taken an innovative approach to commissioning weight management interventions, and this included universal breastfeeding training for health workers and Children's Centre staff, investment in a targeted peer breastfeeding support service for the most disadvantaged wards, investment in the universal prevention programme Five60 for all primary school children, integration of the specialist weight reduction service into the Healthy Lifestyle Hub model, and development of the psychology led Tier 3 weight management programme for the morbidly obese.

With regard to early years and childhood obesity, Derbyshire wide levels of childhood obesity were lower than the population of England as a whole, although there were areas where childhood obesity was higher than the national average. In line with national trends, childhood obesity was increasing, which suggested that there needed to be a strengthened interagency approach. Details were given of the prevention and weight management initiatives – breastfeeding, maternity services, paid peer support, health visiting services, Healthy Start, HENRY (health exercise nutrition for the really young), National Child Measurement Programme, Five60, and the Family Weight Management Programme, which was a pilot that would target obese children and young people and their parents/carers. Evidence had indicated that parental participation was key to facilitate a change in family lifestyle choices, as the majority of obese children had at least one obese parent.

For adult obesity, Derbyshire had significantly worse levels than the population of England as a whole, and the Derbyshire Obesity Pathway outlined the services within the county that had been commissioned to combat obesity. In terms of prevention, details were given of the schemes that had been established – Walking for Health Programme, Active Derbyshire Partnership, Derbyshire 2012 Olympic legacy, and health trainer and health champion programme. For weight management, the Healthy Lifestyle Hub had been launched, and in recognition that not everyone would want to access traditional leisure services, providers had been commissioned to offer six available activities, including walking and activities suitable for older people. There was also the Health Referral Scheme and Waistwise, which had been incorporated to deliver in the Hub. It was anticipated that over 3,100 people would successfully complete the Healthy Lifestyle Hub programmes over the current year.

The Tier 3 Specialist Weight Management Service was a psychology led service for the morbidly obese, and an aim of Tier 3 was to reduce the number of people progressing to bariatric surgery by providing an alternative successful weight loss method. It was stated that the service had been

adapted to treat the client over a longer period of time to achieve the target weight loss goal and embed sustainable lifestyle behaviour change.

There were two interventions that were highlighted, but fell outside of the responsibility being transferred to the local authority. The first was prescribing, and from 2009/10 to 2010/11 there had been a reduction in prescribing. The second was bariatric surgery, which had also seen a reduction.

The way forward was discussed, and included developing a strategic framework. A number of principles underpinned the strategic approach, including highlighting and challenging the public perception of obesity, early intervention, parents who were obese shaping the environment in which their children grew up, consistent messages about food and physical activity, and that responsibility was with everyone.

A number of comments were raised by the Board, including that early intervention was key, and that it was essential to have a co-ordinated approach across all organisations. It was stated that it was the role of the Board to ensure that its views were delivered across organisations, and it was agreed that it would be useful to deliver this to the Children's Trust Board.

RESOLVED to (1) endorse the importance of the early years, including the key roles of health visitors, the importance of antenatal intervention, strengthening the links between maternity services and the Healthy Lifestyle Hub model;

(2) support development of obesity programmes to explore further support for weight management through intense family support models; and

(3) consider the possibility of a Commission or similar approach within Derbyshire to gather views and evidence to determine what can be done locally and to help engage wider stakeholders to encourage acknowledgement of responsibility towards obesity.

6/12 **CLUSTER LOCAL INTEGRATED PLAN** Following the annual publication of the Operating Framework, all PCT Clusters were required to develop and submit to the Department of Health a single system-wide Integrated Plan which included PCT Cluster Plans, CCG Plans, Public Health transitional plans, Provider activity planning and Quality Outcomes and Measures. This would reflect a range of requirements, performance challenges, and feedback.

The timeline was presented to the Board, and it was stated that the Plan would be developed with local authorities prior to final sign off on 31 March 2012.

RESOLVED to note the report and to receive a copy of the Derbyshire Local Integrated Plan at a future meeting.

7/12 DERBYSHIRE CLINICAL COMMISSIONING GROUPS UPDATE An update was provided on the progress in establishing CCGs in Derbyshire. The required pace of development of CCGs had increased significantly, with an expectation that each would enter a full 'shadow' year carrying out all functions from April 2012, ready for authorisation from September/October 2012 through to March 2013.

The Cluster Strategic Health Authorities were carrying out a series of Gateway Reviews of CCGs, and these were currently scheduled to look at configuration and capacity to perform all functions, governance and leadership. At the first Gateway, each CCG in the Midlands and East SHA had been given a rating, and High Peak CCG had been asked to consider its future as it was considered that it would be very difficult to fulfil all the statutory functions with a small population and resultant management cost available. It was stated that the Group had discussed this, and had agreed that it would not pursue authorisation as a standalone CCG, but would look to join an existing CCG as a locality. The preferred option was North Derbyshire CCG, and it was hoped that this would be confirmed shortly.

There was an expectation by both Strategic Health Authorities that all configuration issues would be resolved by the end of January, so that CCGs could be confident on which geographical basis they were moving forward.

Draft guidance had been issued on the make up of CCG governing bodies, and how the three key roles of the Chair, Accountable Officer and Chief Financial Officer would be identified and appointed. Consideration was being given to the roles of Chair and Accountable Officer, and it was unlikely that a post of Chief Executive would exist in the new commissioning structure.

In terms of next steps, the authorisation process was expected to be a combination of a number of elements – pre-application submission, application form with documented evidence of track record, 360 degree feedback from key partners and stakeholders, and site visit. Authorisation was currently expected to be in a series of 'waves' on a monthly basis from July (with a decision in October) through to October (with a decision in January).

RESOLVED to note the ongoing development of CCGs within Derbyshire and the expectations around the authorisation process.

8/12 DERBYSHIRE CLINICAL COMMISSIONING GROUPS' COMMISSIONING INTENTIONS FOR 2012/12 The Board was informed of

the NHS Operating Framework for 2012/13, and of the collective and individual commissioning intentions of the Derbyshire CCGs. Each year the NHS was issued with a set of expectations and requirements for the following financial year, and commissioners were required to issue a set of commissioning intentions.

During the next six weeks, contracts would be negotiated with all providers of NHS services which would commit to activity levels and funding from April 2012-2013. The PCT Cluster would also be coordinating a submission to the Cluster Strategic Health Authority detailing how all the targets and requirements of the Operating Framework would be met, along with a financial plan.

RESOLVED to note the national expectations of the local health system for the coming financial year as well as the emerging plans for the individual CCGs.

9/12 PUBLIC HEALTH TRANSITION UPDATE In Derbyshire, the PCT and the County Council had been working together on the transfer of the public health team and its functions, and it was expected that by April 2012, new arrangements would exist in shadow form and by April 2013, full legal responsibility would have been transferred.

In the past six months, planning had been strengthened by the development and work of a Transition Steering Group. This group brought together officers of both organisations, and had developed joint plans across a range of areas. These were detailed, along with progress and any issues arising. There were also a number of specific issues and concerns, and these related to policy development, parallel organisational changes, support structures in the PCT and public health, Glossopdale, links to Derby City and performance management.

In general, progress was good, but lots of detailed work remained around the transfer of staff, IT and contracts. It was stated that 2012 would be a busy period, but it would be important to keep public health services running well, and look at new opportunities that could emerge from the transition process. The public health team in the PCT worked closely with a number of stakeholders, and it was noted that these links would need to be protected through the transition process.

RESOLVED to note the progress made towards the transfer of public health responsibilities to the council, and to support the general approach being taken.

10/12 UPDATE ON THE NHS 111 IMPLEMENTATION IN DERBYSHIRE In July 2010, the Government had stated its commitment to a

national roll out of the new NHS 111 service. The aim was to develop a coherent 24/7 urgent care service that made sense to patients when making choices about their care. This would incorporate GP out of hours' services and provide urgent medical care for people registered with a GP elsewhere. The service would be more accessible by introducing a single telephone number.

There was a requirement to have full coverage throughout England by the end of March 2013, although this could be through a pilot project initially with full procurement to follow. This was the approach being adopted in Derbyshire, with a pilot working with Derbyshire Health United, the current out of hours GP service, with formal procurement due to be completed by October 2013, based on learning from the pilot. The national NHS Direct telephone number would be discontinued by April 2013.

North Derbyshire CCG was leading the work on behalf of all CCGs in Derbyshire. The pilot had a phased implementation, and the first phase of the pilot went live on 25 October 2011 in the Matlock, Bakewell and Chesterfield areas of Derbyshire. It was felt that the first phase of the pilot had been very successful, and activity had been within expected levels and had increased gradually since the service went live.

The 111 service was being implemented in four phases – Bakewell, Matlock and Chesterfield in October 2011, the rest of North Derbyshire from 20 February 2012, Derby City in March 2012, and the rest of southern Derbyshire in August 2012.

NHS111 would replace the existing health information and assessment service offered by NHS Direct on 1 April 2013, although it was likely that the NHS Direct service would stop earlier than this in some areas. In Derbyshire, discussions were taking place around the possibility of stopping the service from September 2012, and this would allow the moving of funding from the existing NHS Direct service to support the NHS111 pilot.

Derbyshire had chosen to pilot the service with the intention to have a procured joint NHS111 and Out of Hours service in place by October 2013. It was the intention to hold a workshop in April 2012 to consider what other services could be attached to 111 to make a more integrated resource for all people.

RESOLVED to note the progress being made on the implementation of NHS111.

11/12 **HEALTH AND WELLBEING ROUND-UP REPORT** A round-up of key progress in relation to Health and Wellbeing issues and projects was given.

The second reading of the Health and Social Care Bull had been completed in the House of Lords on 12 October 2011, and the Bill had then been put forward to a committee of the whole House for line by line examination, which had taken place on 21 December 2011. Further line by line examination of the Bill was yet to be scheduled.

At the beginning of January, the Department of Health had announced that the new start date for the establishment of the local HealthWatch was April 2013. The local work to prepare for procuring HealthWatch would continue, and it was expected that LINk funding would be extended locally until the end of March 2013. The Department of Health had also announced that there would be a small amount of funding in 2012/13 for the start up costs of establishing the local HealthWatch, and that HealthWatch England would be operational from October 2012.

Work had been undertaken to identify existing mechanisms for engaging stakeholders in the work of the Health and Wellbeing Board, and further work was to be undertaken to clarify existing mechanisms and to identify ways for stakeholders to access information and be more engaged in the work of the Board. A further report would be presented to the next meeting of the Board outlining a comprehensive plan. In the meantime, a further meeting of the Stakeholder Engagement Forum had been planned for the end of March, with the primary focus being to gain feedback on the draft priorities for the Health and Wellbeing Strategy.

At its meeting on 12 January, the Adult Care Board had agreed to establish a limited number of joint commissioning priorities for 2012/13. A task and finish group had been set up, and the proposed priorities would be considered at the next Adult Care Board, with the final proposals being submitted to the Health and Wellbeing Board.

Community Budgets for troubled were currently running in 16 areas of the country. The County Council was participating in the roll out of Community Budgets as a Phase 2 area, and had recently consulted with partners through the Derbyshire Partnership Forum about developing an approach and plan for Derbyshire to be in place from April 2012. The development of a Community Budget for troubled families presented an opportunity for partners to review, reshape and redesign services. Plans were likely to focus on the piloting of the project in a small number of geographical communities across the county in the first instance.

A new Troubled Families Team at the Department for Communities and Local Government had recently been established. A new Troubled Families initiative had been launched by the Team, and this was similar to existing Family Intervention models. £448 million was available nationally to support

the scheme, which would provide 40% of the total costs. The remaining 60% match funding would be sought from local authorities and their partners. All upper tier authorities had been asked to put plans in place before the end of March 2012 to ensure that the scheme was operational from 1 April 2012. A key piece of work to be undertaken as part of the scheme was the identification and mapping of families of families who met established criteria by February 2012, and this would ensure that there was an accurate understanding about the extent of such families in Derbyshire. Work to establish how feasible this was within the county was currently taking place with key agencies, and this was likely to inform any decision about participation in the Troubled Families initiative from April 2012 onwards.

A Child Poverty Needs Assessment had been produced, and had been presented to the Children's Trust Board. Having identified in some detail the scale of child poverty in Derbyshire, and its implications in terms of health, wellbeing and achievement, work would move into the next phase. This would involve looking at what was already in place for supporting children and families in poverty, talking to a range of stakeholders, and developing a strategic approach to taking further action within the resources available.

The Derbyshire Alcohol Advisory Service was a county-wide service where all referrals for Tier 2 and above were received and then allocated to a service Tier. The Derbyshire Drug and Alcohol Partnership Board had recently received a report from Jane Bethea, Speciality Registrar in Public Health, which assessed equity of access to the Service. A brief summary of the findings had showed that older patients over 60 years of age had poorer equity of access, the more affluent individuals had poorer access, and there were wide variations in referrals by GPs and by geographical area. This report had made a number of recommendations for further investigation and action, and these were to be considered by the CCGs.

A number of important policy documents had been produced recently, and these were highlighted.

RESOLVED to note the report.

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

REVISED PLAN TO DELIVER THE STRATEGY FOR ACCOMMODATION, SUPPORT AND CARE FOR OLDER PEOPLE IN DERBYSHIRE

1. Purpose of Report

To bring to the attention of the Health and Wellbeing Board the County Council's plans for the modernisation of accommodation, care and support for older people.

2. Information and Analysis

The strategy is underpinned by an overall investment worth £200m at current values in accommodation care and support for older people in Derbyshire.

The plan attempts, wherever possible, to offer older people the option of an Extra Care facility within 5 miles of their current home and access to specialist services for dementia within 10 miles of their current home.

Stage 2 consultation will be undertaken with relevant parties where they are affected by specific proposals to implement the revised plan.

Attached as Appendix One to this report is the approved Cabinet Report outlining the County Council's plans to modernise accommodation, care and support for older people.

3. Recommendation

That the Health and Wellbeing Board receives the report and endorses the plan to modernise accommodation, care and support for older people.

Bill Robertson
Strategic Director, Adult Care

Agenda Item No:

DERBYSHIRE COUNTY COUNCIL

CABINET

20th February 2012

REPORT OF THE STRATEGIC DIRECTOR – ADULT CARE

REVISED PLAN TO DELIVER THE STRATEGY FOR ACCOMMODATION, CARE AND SUPPORT FOR OLDER PEOPLE IN DERBYSHIRE

ADULT CARE

1. Purpose of the Report

The purpose of this report is to seek Cabinet approval for a revised plan to deliver the strategy for accommodation, care and support for older people in Derbyshire which involves investment in Specialist Community Care Centres and Extra Care housing developments which would over time, replace the majority of the existing DCC homes for older people.

The strategy is underpinned by an overall investment worth £200m at current values in accommodation care and support for older people in Derbyshire.

Cabinet is requested to approve further detailed, phased consultation on the revised plan.

2. Information and Analysis

2.1 Background to the Strategy

The strategy for accommodation, care and support for older people in Derbyshire is underpinned by national and local policy for adult care.

It encompasses the:

- Government's vision for adult social care articulated in "A Vision for Adult Social Care: Capable Communities and Active Citizens", Nov 2010, and "Think Local, Act Personal: Next Steps for Transforming Adult Social Care", Nov 2010;
- Department of Health policy for older people as expressed in the "National Service Framework for Older People" and highlighted in "Better Health for Old Age" Nov 2004, "Everybody's Business" Nov 2005, and the "Putting People First" Concordat, Dec 2007;

- Department of Health policy for older people with mental health needs expressed in the recent “Living Well With Dementia” strategy, 3 Feb 2009, and the carers’ strategy, “Carers at the heart of 21st Century families and communities”, June 2008, and “No Health without Mental Health”, Feb 2011;
- All-Party Parliamentary Group on Dementia, July 2011, recommendations into improving lives through cost-effective dementia services;
- The Audit Commission report on ‘Joining up health and social care: improving value for money across the interface’, Dec 2011;
- Derbyshire Sustainable Community Strategy, 2009-14;
- Derbyshire’s Council Plan – Leading the Way 2010- 2014;
- Derbyshire Adult Care Service Plan 2010-14.

The overwhelming conclusions from various policy documents, including those above, is that better and more cost effective outcomes for older people can be achieved through a coherent framework of prevention services to support independent living and by providing more choice and control through personalised care services.

Specifically for people with dementia, better outcomes can be achieved along with greater value for money in dementia care, by making changes to service provision or adopting new ways of working. These include approaches that encompass the whole of the care system or pathway; putting a focus on earlier intervention to prevent crises for both individuals and their carers, whilst at the same time recognising the need for more targeted, intensive, and person-centred types of support.

Derbyshire’s strategy of accommodation, care and support for older people which also supports the Derbyshire Dementia Strategy, places a high priority on enabling people to stay in their own home, whilst offering an opportunity for that home to be in a more supported environment, such as Extra Care, when appropriate. It aims to provide individuals with an alternative model that facilitates a real choice between supported living at home and living in residential care, which will be retained for those with the most complex needs.

Key to this approach is:

- Good quality early diagnosis and intervention for all.
- Easy access to care, support and advice following diagnosis, facilitated by a dementia support service so that people can live well with the condition (with collaboration and integration across different services).
- High quality intermediate care linked to hospital admission and discharge processes.
- Well co-ordinated community personal support services.

- Support for carers through Derbyshire Carers' Strategy, including good quality respite services, to ensure they can continue to be the mainstay of support for people with dementia.
- Provision of accommodation and centres within which services can be delivered.

Key design features within the physical resources will:

- Incorporate high standards of dementia friendly design
- Promote independent living
- Exceed minimum standards
- Be suitable for a range of services including drop-in, day and residential services
- Have the ability to respond to changing needs
- Be flexible for future use.

The strategy encompasses the development of Specialist Community Care Centres providing a network of high quality dementia friendly buildings across Derbyshire that will become the focal point for delivering services to older people with more complex levels of need. Focusing on dementia, Specialist Community Care Centres will provide:

- A range of flexible day opportunities for people in the community which include advice and information services, day respite, rehabilitation and health and support services and;
- Short-term intermediate and respite care for older people; and
- Long-term care for older people with dementia and more complex needs.

The Centres will be part of a hub and spoke model of services to support the Dementia Pathway; they will be the hubs that provide countywide access to centres of dementia care excellence; with spokes providing outreach into the community, including Extra Care housing.

2.2 Development of specialist community care centres and Extra Care in Derbyshire

Agreement to build the first Specialist Community Care Centre in Middlecroft, Staveley, was given by Cabinet on 8th January 2008. Cabinet also agreed an application for PFI credits to the Department of Health for further Specialist Community Care Centre developments.

In October 2008 Cabinet approval was given for the development of a Specialist Community Care Centre combined with Extra Care housing in Swadlincote.

In March 2009 Cabinet agreed to proceed with the preparation of an outline business case for Department of Health social care PFI credits for four Specialist Community Care Centres to the value of £66.8m.

In July 2009 Cabinet agreed to the establishment of a Strategic Project Board and a Steering Group for Specialist Community Care Centres and Extra Care Housing, and also agreed to the preparation of an expression of interest for PFI credits for 2 further Specialist Community Care Centres.

In September 2009 Cabinet agreed to the proposed consultation on the vision, outcome and benefits of the accommodation, care and support strategy for older people in Derbyshire. This included the potential impact on existing residential care homes and day services for older people, the criteria for evaluating their fitness for purpose within the new service model, and any implications for decommissioning.

In March 2010 the Department of Health informed the Council that an allocation in principle had been confirmed by the Minister for Care Services for £39.9 million PFI credits which could be combined with the £66.8m approved from the 2008 bid round. The letter went on to explain that this did not constitute a firm commitment to revenue support as this required final approval by the Treasury's Project Review Group. The Council was, however, invited to proceed to full outline business case submission.

In June 2010 Cabinet agreed to the submission of the full outline business case to the Department of Health for PFI credits for 6 Specialist Community Care Centres across Derbyshire, and agreed the proposed locations of the six centres.

On 13th July 2010 Cabinet agreed to go to the market with three sites for the development of Extra Care housing through a partnership arrangement with private sector contractors / developers / registered social landlords. This procurement included the option to develop up to 600 units of Extra Care housing.

2.3 Stage 1 Consultation on the developments in residential and community care services for older people

As outlined above, Cabinet agreed in September 2009 for consultation to be undertaken on the vision, outcomes and benefits of the accommodation, care and support strategy for older people in Derbyshire. The consultation was broad ranging and included consultation with residents of residential care homes and day centres for older people, their relatives / carers, and staff within units. The consultation set out that the Council's desire to develop Residential and Community Care Centres and add to the existing number of extra care housing schemes to replace older homes and services.

The consultation stated that the plan was to look closely at the current 27 residential homes for older people and day centres to establish which ones could be adapted and used alongside new services and facilities, and which ones would not be suitable to meet the challenges of the future. It stated that the proposal, over a number of years, was to close those homes and / or day services which could not be adapted as new services were developed. The consultation stated that no decisions had been made about the long term future of any individual home for older people at that stage.

The consultation set out agreed criteria to evaluate current residential facilities including resources centres within residential accommodation. Those criteria were:

- The quality of the physical environment

- The cost of bringing the building up to the Care Quality Commission's minimum standards for new facilities.

- The fitness for purpose of the building to meet the future service delivery model

- The size of the land the facility or service sits on (possibility of developing the site for Residential and Community Care Centres or Extra Care Housing as part of the Extra Care Housing strategy)

- The value of the land the facility or service sits on (to be used to continue to develop new services)

- The proximity of the service or facility in relation to services planned within the Residential and Community Care Centre programme and other service developments for older people

In August 2010 Cabinet received details of the positive feedback on the first stage of consultation on the development of the strategy for accommodation care and support. That report to Cabinet also provided feedback on the evaluation of current residential stock. The outcome of the evaluation was that none of the existing homes would meet the full set of requirements for the new service model. Four homes were identified, however, as having three star environmental ratings, which would make them most suitable to provide residential care to physically and mentally frail residents. These homes are Castle Court (Castle Gresley), The Grange (Eckington), Whitestones (Chapel en le Frith) and Thomas Colledge (Bolsover).

Cabinet agreed that second stage consultation would take place, as the proposals are brought forward, on the potential impact of individual proposals for specific homes for older people as well as day care centres.

Cabinet were asked to note that the second stage of consultation would provide information on, and receive views on

- Likely timescales for any changes affecting individual services and facilities
- Special considerations that should be applied to their specific services
- How the transitional process would take place
- How the process could be shaped to meet resident, relatives and staff needs

As described later in this report, following consultation, further reports which include the views of consultees will be brought to Cabinet on a home by home basis in order that decisions can be made on their future.

The Cabinet report also set out that the timing of the consultation would be dependent upon confirmation of PFI credit funding by the Treasury and availability of land sites for the Residential and Community Care Centres – it being necessary to be certain that land sites were available before entering into the procurement process for their development.

As explained above, the PFI credit funding was not forthcoming, and second stage consultation would now be based on the potential impact of the revised plan and recommendations set out in this report.

2.4 The need to review the plan to deliver the strategy

The final outline business case was positively reviewed by the Department of Health, and the Council was encouraged to make an application for a further £3m PFI credits to support land assembly. Unfortunately, following on from the Comprehensive Spending Review undertaken in the autumn of 2010 the Council was advised in April 2011 that the PFI credit funding would not be continuing.

The Cabinet Member and the Strategic Director of Adult Care undertook to review the options for the delivery of the strategy without PFI credits within a revised model, which is the subject of this report.

2.5 Accommodation and care capacity within the original Specialist Community Care and Extra Care plans

The plan for Community Care Centres was detailed in the Outline Business Case for Residential and Community Care Centres approved by Cabinet on 1st June 2010. That was complemented by plans for Extra Care, set out in the report to Cabinet on the Proposals for the Delivery of Extra Care Housing in the County on 13 July 2010, which included a revised business case for Extra Care housing in Derbyshire.

Together these two reports set out the basis for a plan which would deliver eight Residential and Community care centres and 600 units of Extra Care housing, whilst also retaining some DCC residential care homes with some specialism in dementia or other complex needs.

The plan included:

- 128 long term beds for people with dementia (across 8 centres)
- 64 short term respite (across 8 centres)
- 64 intermediate care beds (across 8 centres)
- 160 day care places (20 places each in 8 centres)
- 8 Health and wellbeing zones
- 600 Extra Care units (aiming to establish at least one scheme in each District or Borough)
- 130 residential care beds in current DCC establishments providing dementia friendly long term support, respite or intermediate care provision.

Unfortunately, as set out in the section above, the PFI money was withdrawn as part of a Treasury and Department of Health review of PFI funding. During the course of the subsequent Adult Care review an additional issue has arisen from the collapse of Southern Cross which has signalled instability in the independent residential care market. This has focussed attention on how the strategy should achieve some alternative options to residential care provision through an extended Extra Care housing provision.

2.6 Revised model for accommodation, care and support

The review of the plan provided an opportunity to expand the model to include a choice of Extra Care housing for those who currently only have the option of independent sector residential care. The revised model reconfigures the resources and services contained within the original plan with an additional 1000 units of Extra Care housing. The revised plan, would therefore, replace the major part of the current stock of traditional residential care run by Derbyshire County Council with specialist community care centres and extended access to Extra Care housing throughout Derbyshire.

The key features of the revised model involve:

- Consolidation of specialist dementia services into a reduced number of Community Care Centres, giving optimal possible coverage across the county
- Use of geographically spread Extra Care schemes to locate specialised services as part of a more dispersed hub and spoke model of provision through what would previously have been delivered through eight Community Care Centres:
- An increased range of agreements with partner agencies to deliver health and wellbeing zones

2.7 Service configuration and capacity within the revised plan

The revised plan maintains the service elements that were agreed by Cabinet for the original plan, adds an additional 1000 units of Extra Care housing, and aims to deliver them through a different service configuration.

The plan attempts, wherever possible, to offer older people the option of an Extra Care facility within 5 miles of their current home, and access to specialist services for dementia within 10 miles of their current home. A cross boundary approach has been taken, using the latest demographic analysis of need available to achieve an equitable distribution of resources.[1]

[1] Planning for Care research 2008, published 2009

In summary the revised provision would comprise:

- 4 Specialist Community Care Centres[2] providing:
    - 4 health and wellbeing zones
    - 4 day care services accommodating a total of 80 people at any one time
    - 64 long term dementia beds
    - 32 respite beds and
    - 32 intermediate care beds

  In addition to the two centres at Staveley and Swadlincote referred to in section 2.2 of this report, it is proposed to locate the additional centres at a site adjacent to the Whitworth Hospital at Darley Dale, and at the Florence Shipley residential home in Heanor (the latter being dependent on the outcome of the consultation on the proposed closure of this home).
- 2 geographically dispersed Specialist Community Care Centres covering the Ashbourne and the west Derbyshire Dales area, and the High Peak area providing, on a networked basis:
    - 2 health and wellbeing zones
    - 3 day care centres accommodating a total of 55 people at any one time
    - 20 long term dementia beds
    - 10 respite beds and
    - 8 intermediate care beds, (with provision of intermediate care in Ashbourne through St Oswald's hospital)
- 8 additional health and wellbeing zones provided through the health and wellbeing strategy
- Approximately 1600 Extra Care apartments across 27 sites[3] (1583 in current plan, 88 of which would be used for residential care). Some of these sites would incorporate elements of the dispersed Specialist Community Care Centres in High Peak and the west of Derbyshire Dales as described above. Some would incorporate elements of the service capacity contained within the original plan. These are summarised below:
    - 7 schemes with day care facilities for a total of 140 people at any one time
    - 1 scheme providing 8 units of respite care
    - joint investment in 2 schemes providing 16 intermediate care apartments), and
    - 3 schemes providing 48 apartments for specialist long term dementia care (32 provided by independent sector).

[2] See Map: Proposed Specialist and Residential Community Care Provision – see Appendix A
[3] See Map: Proposed Extra Care Provision – see Appendix B

- 4 current DCC homes for older people providing 129 beds including a range of traditional long term beds and 24 short term beds.
- In addition to the above, discussions and negotiations are on-going with health partners and particularly Derbyshire Community Health Services on the inclusion of NHS provision and investment within a number of the proposed developments. These will be the subject of further reports to Cabinet as the proposals are developed.

Of the 27 current homes for older people (including two resource centres) it is proposed that four would be maintained as residential homes for older people (Castle Court at Castle Gresley, Whitestones at Chapel en le Frith, Thomas Colledge at Bolsover, and The Grange at Eckington).

2.8 Site and land assembly to deliver the revised plan to deliver the strategy for accommodation, care and support

Most of the sites required to deliver the revised plan as set out above are already in the ownership of Derbyshire County Council. There are however, two sites which would have to be purchased from the NHS. These are on land owned by the NHS, one of which is situated at the Whitworth Hospital, adjacent to the current hospital buildings.

Heads of Terms have been agreed with the NHS for the Whitworth land including purchase price of £500,000., Outline planning approval has been obtained for a community care centre on the site, and money to purchase the site is included within the Capital Plan for 2012-13. It is proposed that the purchase of the land and the commissioning of the Community Care Centre for the Whitworth site proceeds as soon as possible, subject to approval of this report. The development of this site is not dependent on the outcome of any other proposal outlined in this report.

In addition, up to seven sites outside the ownership of the Authority and the NHS are required for Extra Care developments to ensure the appropriate geographic spread. These are potentially in the Bolsover/Clowne area, Heanor area, Ashbourne area, Swanwick area, Hathersage/Bakewell area, Belper area and possibly Chapel en le Frith area.

The estimated capital resources required to secure these sites have been set out in the Financial Considerations section of this report.

2.9 Procurement options and timescales for the specialist community care centres

A range of procurement proposals for Specialist Community Care Centres have been considered.

The proposed procurement option is to use an OJEU restricted tender process, which would enable a shortlist of suitable construction contractors to be selected to tender on a competitive basis; for either or both schemes together. Qualifying bidders would submit

tenders based on a designed and specified scheme. An award would be made by selecting the most economically advantageous tender, which would take into account price and timely construction amongst any other factors. Using this route enables the Authority to achieve competition, which ensures value for money, as well as the freedom to select the most appropriate form of construction contract for the works.

Within the proposed restricted tender process, the proposal is to utilise a design and build procurement route, using the standard JCT form of contract, which would have the following advantages:

- Earlier involvement by the developer in detailed design process.
- An early start on site could be achieved to deliver the Community Care Centres which, as the hub of the revised model of service delivery, would need to be in place within the first phase of the plan to deliver the strategy for accommodation care and support.
- Cost certainty and risk transfer - there is a fixed price and the contractor takes the risk on 'unknown' items, and includes cost risk within the tender.
- Best value: the contractor has the ability to alter the design and specification with Council approval to achieve the same output, encouraging a more economical solution.

On 31st January 2012 Cabinet approved the publication of an OJEU notice inviting tenders to provide architectural services including submission of reserved matters applications to achieve detailed planning permission on sites which have existing outline planning approval, for two community care centres included in this report, covering the Erewash, Long Eaton and Amber Valley, and Derbyshire Dales East and North areas. Cabinet noted that the successful tenderer would be novated to the construction company appointed to design and build the Community Care Centres, and also noted that professional services, including structural engineering, mechanical and electrical service engineering, landscape architecture, project management, quantity surveying/Employer's Agent services, construction design management (CDM) co-ordinator services (H&S) and clerk of works would be provided by the Corporate Property Division. These services have been benchmarked against the East Midlands Property Alliance Framework to ensure the Council is achieving best value by providing these services in house.

Where specialist input is required that is not available within the Corporate Property Division, external consultants would be considered, and any such appointments would be made in accordance with the Authority's Financial Regulations and EU procurement rules as necessary.

The projected timescales for the delivery of the two Specialist Community Care Centres are:

Design and procurement of construction contractor: March 2012 – Jan 2013

Site enabling works and construction: Jan 2013 – May 2014

Practical completion and handover: Summer 2014

2.10 Procurement proposals and timescales for the Extra Care housing

The Authority currently has 200 Extra Care housing delivered in partnership with district and borough councils and registered social landlords. On 13th July 2010 Cabinet agreed to go to the market with three sites at Cressy Fields (Alfreton), Foolow Court (Chesterfield) and Clay Cross former school, for the development of Extra Care housing through a partnership arrangement with private sector contractors/developers. The procurement process for seeking an Extra Care Partner, through the Competitive Dialogue Process, commenced with the issue of an OJEU Notice on 1st November 2010 setting out an option to develop up to 600 units using additional sites.

At its meeting on 31st January 2012 Cabinet agreed that Chevin Housing should be selected as the Authority's Preferred Bidder, subject to Condition Precedent of Planning Approvals being granted for each of the three sites. The three sites currently being developed will deliver approximately 200 units, leaving an additional 400 that can be commissioned from the preferred bidder within this procurement. Legal advice is that the current procurement could provide up to an additional 60 units, which represents an additional 10% of the contract award.

In addition to the existing 200 extra care units, and the 600 currently in procurement, it is proposed that the Council should undertake a further competitive dialogue to procure up to 800 units of Extra Care housing, bringing the total to 1600 units. It is further proposed that the OJEU notice should be kept as flexible as possible to allow the revised service configuration to be delivered using the existing and proposed Extra Care procurements. The notice would also indicate that it is the intention that the Council commissions housing related support from the successful partners. The housing related support will work in association with the 24/7 unplanned personal care and support service in Extra Care, provided as part of the new service model.

The intention is that the Authority would have at least two partners simultaneously delivering the Extra Care programme in Derbyshire. Due to the work undertaken within the current procurement process, the proposed new competitive dialogue timescale will be shorter as the Authority has already determined a benchmark for some elements of the solution, thus reducing the number of areas left to be agreed in detailed dialogue.

The simultaneous delivery using at least two partners should ensure the delivery of the Extra Care programme within a five year timescale (2012 – 2017).

2.11 Consultation arising from the proposed plan

2.11.1 *Stage 2 consultation*

Homes for older people

Stage 2 will involve a separate consultation in respect of each establishment. The consultees will include current residents, service users and their families, staff and relevant trade unions, independent sector providers and relevant representative groups such as Age UK. The outcome of each consultation exercise will be reported back to Cabinet prior to any decision being made to close a particular home.

The paragraphs below set out the current proposals in respect of the residential and day care establishments for older people operated by Derbyshire County Council.

Subject to consultation, it is proposed that 10 establishments (comprising eight homes and two resource centres) would be re-developed within the new plan. For the homes, this would require the current service to be provided elsewhere and the home demolished, followed by a new build for newly commissioned services. Those homes are Florence Shipley (Heanor), Holmelea (Tibshelf), New Basset House (Shirebrook), Derwent House (Chesterfield), The Spinney (Brimington), Beechcroft (West Hallam), Hazelwood (Cotmanhay), and The Dales (Repton). For the two resource centres Ecclesfold (Chapel en le Frith) and Underhall (Darley Dale), this would require negotiation with local housing providers about a possible redesign of existing resources for extra care housing.

Gernon Manor in Bakewell is also being considered for a possible conversion to meet the needs of people with learning disabilities.

The revised plan would replace the provision made in the remaining 12 current homes for older people which, based on the first stage consultation and evaluation, it is considered uneconomic to bring up to minimum standards expected for new services. This would build on a process established after the 2001 Best Value Review of Residential Homes for Older People which has resulted in the closure of 8 homes as new, fit for purpose, facilities have been proposed. The closure of 12 current homes would be subject to Stage 2 consultation and an Equality Impact Assessment at an appropriate time. They comprise Ada Belfield (Belper), Rowthorne (Swanwick), The Glebe, (Alfreton), The Willows (Ripley), East Clune (Clowne), Red House (Chesterfield), The Leys (Ashbourne), Briar Close (Borrowash), Hillcrest (Erewash), Ladycross House (Sandiacre), Southlands (Erewash) and Goyt Valley House (High Peak).

Day Services

It is proposed that the revised plan would, if approved, deliver specialist day services within eight Extra Care schemes, including those at Clay Cross Resource Centre and Amber Vale which would, subject to consultation, be relocated in the current extra care procurement described in paragraph 2.8 above. The plan may impact on up to another nine existing day services. Where day services have the potential to be affected service users, staff and carers would be consulted as appropriate within Stage 2 consultation.

Any proposal to close an individual home would be the subject of a further report to Cabinet prior to a final decision being made.

2.11.2 Priorities for the implementation plan requiring Stage 2 consultation

The immediate priorities for Stage 2 consultation are for those establishments which:

- Would release sites that will be required for the Community Care Centre programme and the next phase of extra care procurement
- Are in the proximity of a proposed or new Community Care Centre or Extra Care development
- Have been selected on the basis of their physical condition and / or occupancy levels (taking availability of local alternative care into consideration)

They are:

- Florence Shipley (Heanor)
- The Dales (Repton)
- Derwent House (Chesterfield)
- Lady Cross House (Sandiacre)
- Beechcroft (West Hallam)
- Amber Vale Resource Centre
- Holmelea (Tibshelf)
- New Bassett House (Shirebrook)
- The Spinney (Brimington)
- Hazelwood (Cotmanhay)
- Clay Cross Resource Centre

If closed, some of these would, within the revenue model currently being proposed, release revenue funding for phase 1 of the implementation plan - the delivery of three Specialist Community Care Centres (Swadlincote, Heanor and Darley Dale) and the 3 extra care schemes at Foolow Court (Chesterfield), Cressy Fields (Alfreton) and Clay Cross.

It is proposed that consultation be started as soon as possible and be phased between April 2012 and March 2013. The outcome of the consultation, and implications arising therefrom, will be the subject of future Cabinet reports. This may include further changes to the revised plan should it be decided, following consultation, that individual establishments should not close.

The future of the remaining homes will be consulted on within Stage 2 consultation at a later date as and when the phased developments are realised within the overall programme.

In the event of a decision being made to close an individual home, the transfer of residents to an alternative setting would still be dependent on a full community care assessment being carried out in respect of every resident showing that they could be safely and carefully accommodated elsewhere, and reference would be made to the Council's "Closure and Major Change Guidelines".

2.12 Governance

It is proposed that the current governance arrangements would continue for the whole programme. These were agreed by Cabinet on 14th July 2009 and 13th October 2009 and comprise:

- Adult Care PFI Cabco
- Strategic Project Board
- Steering Group

Individual project and implementation groups would be convened as appropriate for the different components of the plan, and would be directly accountable to the three overarching groups set out above.

2.13 Communication Strategy

The delivery of the programme would involve Adult Care and partner agencies. A communication strategy is already in place for the Capital Investment Programme. A revised and detailed plan would be developed to ensure that consistent communications are delivered to support the proposed commissioning and decommissioning changes that would be required across all agencies involved.

3. Financial Considerations

3.1 Capital Budget

Appendix C shows the capital costs and income for the:

- Construction of 2 Specialist Community Care Centres
- Purchase of 88 specialist beds
- Costs of additional sites and capital receipts.

Both options detailed in **Appendix C** are based on highest build costs estimates.

Option 1 shows property valuations at May 2010 which are considerably lower than those shown in option 2, based on 07/08 land valuations.

Option 1 was put forward as part of the capital bid process for 12/13. There is likely to be a phasing of funds required for the project over a number of years commencing in 2013/14 and ending in 2015/16.

The gross costs and anticipated receipts are estimates based on the most accurate information available at the time, and may vary as market conditions change. As costs are firmed up, further reports would be submitted to Cabinet as necessary.

The net cost to the Council is anticipated to be approximately £37million with a related private sector investment worth £150million at current values. The capital investment of £37 million will result in an annual £2.4 million financing charge.

3.2 Revenue Budget

The revenue budget detailed in Appendix D shows that the proposed care model for the accommodation, care and support strategy would be delivered within existing adult care revenue resources. The care and housing related support costs cover 4 Specialist Community Care Centres, 27 Extra Care sites incorporating both short and long term beds, 4 homes for older people, and 8 day care centres to be incorporated within the new Extra Care schemes.

Overall the financial model shows a saving of £1.4 million on revenue expenditure, but the inclusion of the financing charge would result in a net increase in costs. Without this investment however, there will be limited opportunity for DCC to prevent the future costs associated with delivery of the current service model from escalating beyond the limits that DCC can resource.

Adult Care may be able to derive further savings if the Dilnot Commission report on social care[4], outlining proposed changes to funding of care for the elderly, is implemented. The current revenue saving of £1.4 million on revenue expenditure includes net loss of income of around £10million resulting from a move from residential to housing based model of care.

3.3 Adult Care Capital Project Team Budget

The budgeted costs of the Adult Care capital project team, including the posts referred to in the Human Resource Consideration section of this report, is £306,522. This is contained within the existing Adult Care revenue budget.

3.4 External Advisers Budget

Cabinet gave approval to appoint technical, legal and financial advisors to the project (30th June 2008, 16 September 2009). The budget of £2 million for the appointments is held corporately, and it is envisaged that this would be spent in line with forecasts.

3.5 Charging and affordability of revised model of accommodation, care and support

3.5.1 Long Term Care in Specialist Community Care Centres

Under current statutory charging regimes the charges applied would be those which apply to residential accommodation. This may be subject to changes in the forthcoming Adult Care White Paper.

3.5.2 Short term or temporary care in Specialist Community Care Centres

Under current statutory charging regimes the charges for short term care apply where an admission is temporary; either if the agreed intention is for it to last for a limited

[4] The Commission on Funding of Care and Support presented its findings to the Government in its report Fairer Care Funding, published on 4th July 2011

time period, such as respite or intermediate care, or there is uncertainty that permanent admission is required.

Any services which form part of a package of intermediate care as defined in the Community Care Act Regulations 2003 must be provided free of charge for 6 weeks.

An assessment of ability to pay is not required for up to the first eight weeks of a respite care stay. It is for the local authority to decide whether it will carry out a financial assessment or whether it will charge an amount that it appears reasonable for the resident to pay. DCC has a standard charge for the first 3 weeks of a respite stay (currently £114.75 per week), after which a formal financial declaration and financial assessment is undertaken.

3.5.3 Extra Care Housing

People who enter Extra Care housing can do so through an outright purchase, a shared ownership, or rental basis. The rents payable would normally be eligible for housing benefit. In addition, a service charge is payable by all residents which is normally eligible for housing benefit for those who are in rented accommodation.

Derbyshire County Council is committed to ensuring that Extra Care housing is available to all older people who wish to take advantage of it, and is therefore committed to maintaining service charges at an affordable level for those who are not eligible for support through housing benefit.

Adult Care is therefore involved in developing a model of housing related support and pre-invested 24/7 unplanned personal care which would separate housing related support from housing management and thus reduce the service charge which is payable by individuals. This integrated package of support and pre-invested care would be funded from personal budgets, which would be retained by individuals who choose to move into Extra Care housing. The normal maximum co-funding contribution of approximately £25 per week, for those in receipt of attendance allowance, will apply to personal budgets. Those with capital in excess of £50,000 are liable to make a greater contribution.

The issues outlined above are also referred to in the equality opportunity considerations section of this report. The model of integrated housing related support and pre-invested 24/7 unplanned personal care would be the subject of a further report to Cabinet in the near future.

4. Human Resource Considerations

The staffing establishment within the Adult Care Capital Project Team includes 1 Group Manager (grade 15) and 2 Service Managers (grade 13) which was approved by Cabinet on 1 October 2010 as part of Adult Care's reorganisation, subject to successfully gaining the PFI funding. It was agreed that the posts would be reviewed in the event PFI funding did not materialise.

It is proposed that, subject to approval of this report, these posts be established to ensure continuity for the duration of the programme. Costs would continue to be met from within the Adult Care revenue budgets.

The team also has a member seconded from Corporate Procurement services. Additional support would continue to be provided by Property, Finance and Legal Services, together with inputs from other Adult Care specialists as required.

Additional human resource issues within the Extra Care and other Community Care Centres which would arise from the proposed revised plan relate to the:

- Development of an appropriate pre-invested service personal care and support model to provide 24/7 unplanned personal care and support within the Extra Care schemes.
- Development of a service specification for a commissioned housing related support model which integrates with pre-invested 24/7 unplanned personal care.
- Relocation of day services from Clay Cross Resource Centre and Amber Vale Resource Centre to the Clay Cross and Cressy Fields Extra Care schemes respectively (subject to the outcome of consultation).
- Decommissioning of selected homes for older people to support the transition from residential provision to Extra Care provision.
- Development of service models for short term and long term care of people with dementia in DCC and independent sector provision.
- Development of an intermediate care model in partnership with NHS.
- Development of a specialist day care model for people with dementia.

It is acknowledged that the possible home closures outlined in this report may have significant human resources implications for the staff working at these homes. These matters will be the subject of further development as the revised plan to deliver accommodation care and support progresses, with any associated changes being subject to consultation with employees and trade unions and in accordance with the employment policies of the Council.

5. Legal Considerations

Proposals to make changes in service provision require consultation with those affected, including service users, staff and carers. Any final decisions must also take into account the rights of service users as set out in the Human Rights Act 1998. In assessing these proposals, the Council should also have regard to its statutory duties under the National Assistance Act 1948 and subsequent community care and equalities legislation.

In so far as the Equality Act 2010 is concerned, Stephen Knafler QC, has advised as follows:-

“Under the Equality Act 2010, Cabinet members are reminded that they are under a personal duty, when considering what decision to make, to have due regard to, in short,

the need to protect and promote the interests of persons with protected characteristics (e.g. persons who are vulnerable on account of age, gender re-assignment, pregnancy or maternity, race, disability, religion or belief, sex, sexual orientation). Attention is drawn to a publication by the Equality and Human Rights Commission, called ' Using the Equality Duties to Make Fair Financial Decisions' *(recently updated and called 'Making Fair Financial Decisions')*, see appendix F, for a reasonably detailed summary of the responsibilities of Cabinet members.

Section 149 requires a public authority to have due regard to the need to

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by/or under the Act
- Advance equality of opportunity between persons who share a 'relevant protected characteristics' and persons who do not share those characteristics.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

There are exclusions but the provision of community care services is not one of them.

Having had careful regard to the equality analysis, and also the consultation responses, Cabinet members are under a personal duty to have due (that is, proportionate) regard to the need to protect and promote the interests of persons with protected characteristics (see above) and (i) to consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms, (ii) to remove any unlawful discrimination, harassment, victimisation and other prohibited conduct, (iii) to consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics, and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics, (iv) to consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Whilst Cabinet members are under a duty to have serious regard to the need to protect and promote the interests of persons with protected characteristics, in the ways just described, in reaching their decision, they may also take into account other considerations, such as the desirability of providing cost-effective and good quality services. They may ultimately decide that those types of considerations ultimately justify a decision that does to some extent adversely impact on persons with protected characteristics."

Leading Counsel's advice has also been taken on the validity of Stage 1 consultation for the revised plans to deliver the accommodation, care and support strategy. The advice was that the Stage 1 consultation results were still valid and therefore the Council could proceed to Stage 2.

Procurement of contracts relating to the Community Care Centres and further Extra Care provision will be necessary through a competitive tender process to comply with EU procurement regulations and the Council's Financial Regulations.

6. Equal Opportunity Considerations

Two Equality Impact Assessments were undertaken in preparation of the original PFI capital investment project; the first on the proposed service model at Staveley, completed in May 2010, and the second on the design and location of Community Care Centres and the initial Extra Care schemes, completed in September 2010.

The outcomes of those Equality Impact Assessments have underpinned the work undertaken to identify appropriate sites in the revised plan to deliver the accommodation, care and support strategy for older people in Derbyshire, and specific issues raised have been included in draft specifications for building designs and service models.

An update of the demographic information, level of need, and access to service facilities has been undertaken in preparation for the revised model of accommodation, care and support. This has led to the aspiration that the majority of older people living in Derbyshire will have specialist services within 10 miles of their current home, and Extra Care housing within 5 miles of their current home. The allocation of resources within the model has been made reflecting the different levels of need across electoral divisions.

The mix of tenure within the Extra Care schemes is being, and will continue to be negotiated with developers to reflect local demand. The rent and service charges are being negotiated with developers, Registered Housing Landlords and local housing benefit officers to enable the scheme to be accessible to all groups. This involves separating out housing related support from the housing management costs which will reduce the level of service charges.

A review of the access issues and crime statistics for each of the proposed locations has been undertaken to ensure that they are best suited in terms of location and access for the community.

An updated Equality Impact Assessment has been completed in February 2012 for the accommodation, care and support strategy, including the potential for home closures and the impact this would have on affected persons; this can be found in Appendix E. Detailed Equality Action Plans would be undertaken on a site by site basis as part of the re-commissioning plan.

Equality Impact Assessments for specific services to be commissioned and decommissioned would be undertaken on a case by case basis and would take into account the responses to the consultation processes carried out as part of the consultation on the revised plan to deliver the strategy for accommodation, care and support for older people in Derbyshire. Resulting equality action plans would be co-ordinated across the whole strategy. No decision will be made to close a particular home without full consideration being given to the outcome of the Equality Impact Assessment carried out in respect of that home.

7. Other Considerations

In preparing this report the relevance of the following factors has been considered: prevention of crime and disorder, environmental, health, and transport considerations.

8. Key Decision

Yes

9. OFFICER'S RECOMMENDATIONS

That, having had regard to the equality impact assessment attached to the report, Cabinet:

10.1 Approves the revised plan to deliver the strategy for accommodation, care and support for older people in Derbyshire.

10.2 Approves the commitment of the Capital Investment required for this strategy, which was approved within the Capital Plan for 2012/13 by the Council on 1st February 2012.

10.3 Notes that Stage 2 consultation will be undertaken with relevant parties where they are affected by specific proposals to implement the revised plan, as set out in paragraph 2.11 of this report, with immediate priorities for consultation being those identified in section 2.11.2.

10.4 Notes that further reports will be submitted to Cabinet following the Stage 2 consultations. These reports will include alternative options if it is considered inappropriate to proceed with any specific proposal as a result of the consultation.

10.5 Notes that the responses to consultation on the proposals within the revised plan will have regard to the Equality Impact Assessment and will inform Equality Impact Plans.

10.6 Approves the purchase of land adjacent to Whitworth Hospital at Darley Dale for the purpose of developing a Community Care Centre on this site, subject to Heads of Terms being agreed by the Director of Property Services.

10.7 Approves the acquisition of other sites not currently in the ownership of Derbyshire County Council, required for Extra Care developments as set out in this report. These acquisitions will be subject to detailed Heads of Terms being agreed by the Director of Property Services.

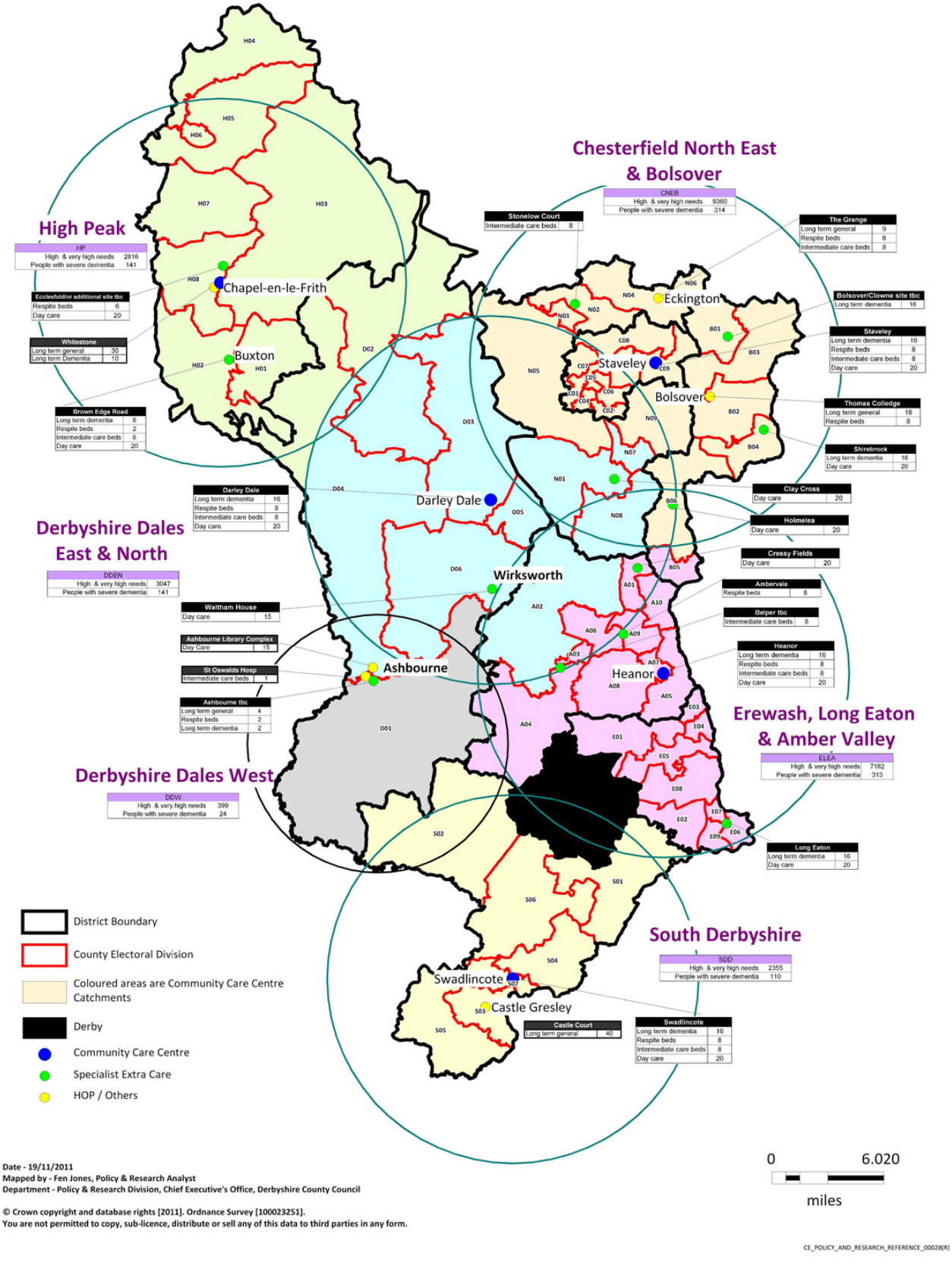
10.8 Approves the proposals for the procurement of Community Care Centres as set out in section 2.9 of this report, with the location of the proposed Community Care Centre in the Erewash, Long Eaton and Amber Valley area being subject to the outcome of the stage 2 consultation on the proposed closure of the Florence Shipley home.

10.9 Approves the proposals for the procurement of Extra Care Housing as set out in section 2.10 of this report, with the final locations being subject to the outcome of site specific consultation as set out in section 2.11 of this report.

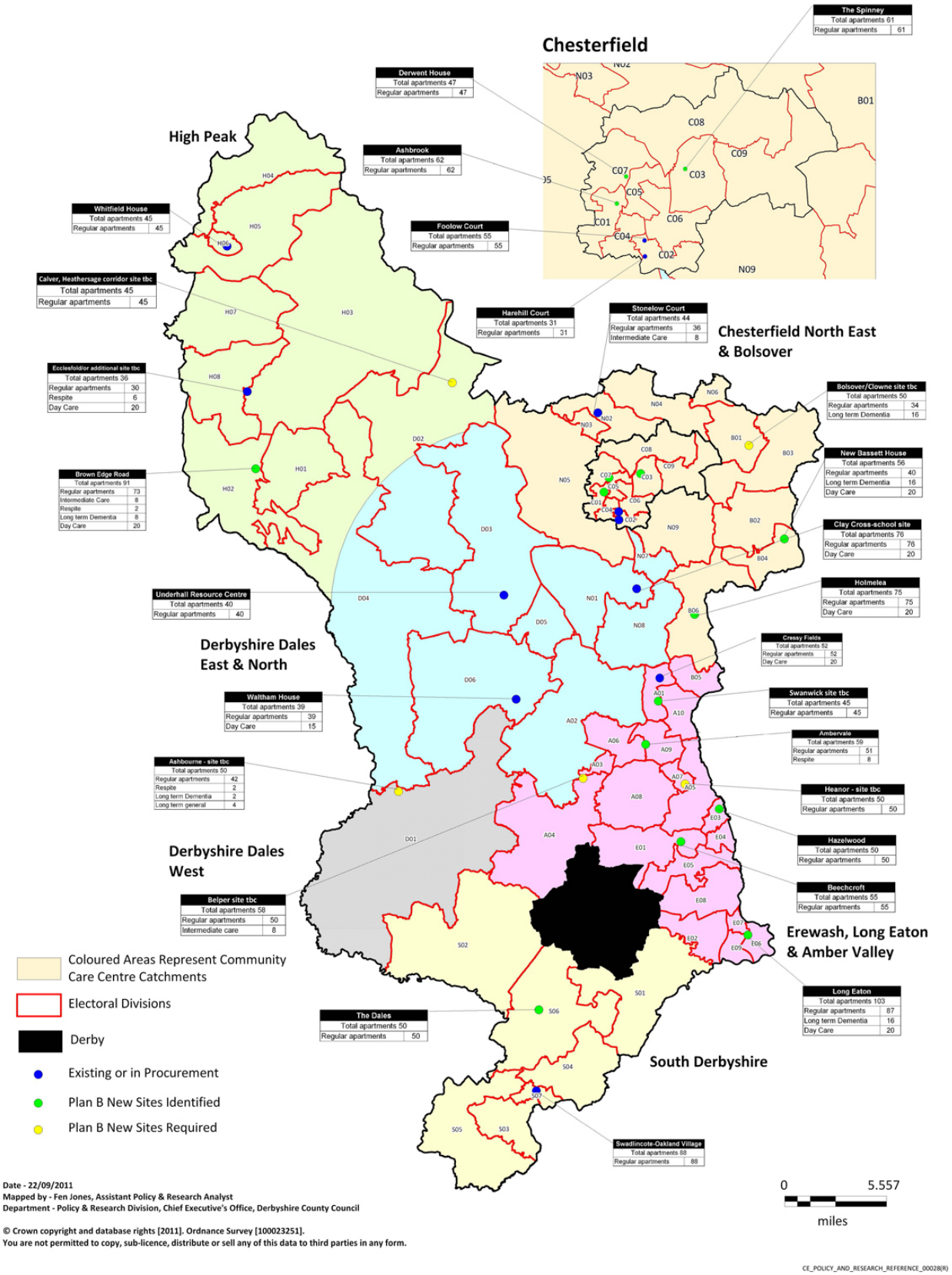
10.10 Notes that further reports on the development and progress of the strategy will be submitted in due course, including proposals for NHS investment and facilities on specific site developments.

Bill Robertson
STRATEGIC DIRECTOR – ADULT CARE
County Hall
MATLOCK

Appendix A: Map 1 - Proposed Specialist and Residential Community Care Provision



Appendix B: Map 2 - Proposed Extra Care and other Specialist Provision



Date - 22/09/2011
Mapped by - Fen Jones, Assistant Policy & Research Analyst
Department - Policy & Research Division, Chief Executive's Office, Derbyshire County Council

CE_POLICY_AND_RESEARCH_REFERENCE_00028(R)

Appendix C: Capital Costs for Adult Care

	May 10 valuations	07/08 valuations	
Capital costs	£		
2 new RCCC's Centres	21,500,000	21,500,000	2 x 32 bed
Extra care sites 6 day centres	0	0	£2m From existing resource in capital programme
Refurbishment of 3 existing homes	2,750,000	2,750,000	Ecclesfold, Thomas Colledge and The Grange
Purchase of six day care centres	2,000,000	2,000,000	
Purchase of 56 care beds	6,720,000	6,720,000	£120,000 per unit
Purchase of 32 independent sector beds	3,840,000	3,840,000	£120,000 per unit
Procurement of additional sites	7,800,000	7,800,000	7 sites
Demolition costs	2,000,000	2,000,000	
Gross capital requirements	46,610,000	46,610,000	
Capital revenue from disposal of 12 Hops sites	8,700,000	13,875,000	
Capital revenue from disposed day care sites	785,000	785,000	Clay Cross, Lincote, and Shirevale
Total Capital Contribution	9,485,000	14,660,000	
Net Capital requirement	37,125,000	31,950,000	
Private sector investment	£150,000,000		

Appendix D: Revenue Costs for Adult Care

Revenue Costs	**£**		**Comments**
3 new RCCC's Centres	3,788,376		Based on 3 x 32 bed
Day care costs 7 sites 230 places	2,100,000		Based on £8,000 per client exclusive of Staveley
Costs of 56 Specialist beds in extra care	1,747,200		£600 per bed per week
Service charge for 88 specialist beds in extraca	320,320		Service charge £70 per unit per week
Preinvested care/ housing related support	5,328,446		2 person 24/7 hours preinvested for all 27 sites
based on 1538 units			
Individual Personal care budgets	7,205,308		Average 6.5 hours preinvested additional 6 hours moderate and 12 hours high need
4 existing hops and Stavley Centre	3,459,212		Current budgets
Telecare	250,000		Additional investment check existing centres
Catering at 3 new RCCC's	300,000		Additional investment
Cost of independent sector beds high need	1,500,000		32 high dependency beds @ £900 from PCT income
Loss of hops income	5,598,398		663 beds at £162 per bed
Total costs	31,597,260		
Revenue Sources Currently Identified	**£**		**Comments**
In house Hops budgets	16,364,850		All HOPs, Extracare and RCCC's
Independent Sector Residential Budgets	9,216,480		Net budget for 840 beds in independent sector
PCT Contribution budget	1,500,000		Additional money from PCT
Day care budgets	2,000,000		Current older people day care budgets
Client contribution / Co-funding	905,592		£25 per person for 900 units based on 60% of beds
Residential Income budget	1,880,320		Total income for 4 hops and 4 rococo's
Income from rental of independent sector beds	166,400		£100 per bed per week based on 32 beds
Utilites and food savings	1,000,000		
Total revenue budget available	33,033,642		
Revenue shortfall/(surplus)	-1,436,382		

Appendix E: Equality Impact Assessment

Derbyshire County Council
Equality Impact Assessment Record Form 2012

Department	Adult Care
Service Area Responsible	Capital Investment Project
Chair of Assessment Group	Katey Twyford
Title of Policy/ Service/ Function	**Strategy for Accommodation, Care and Support for Older People in Derbyshire**

(i) Change History

Version	Date	Reason	Name
1.00	26/11/2010	Final version 1 published on DCC website	Katey Twyford
1.01	12/12/2011	Updated version to reflect revised plan to deliver the strategy for accommodation, care and support for older people in Derbyshire	Katey Twyford
2.00	20/02/2012	Final version 2 submitted with Cabinet Report for Accommodation Care and Support for Older People in Derbyshire	Katey Twyford

Stage 1. Prioritising what to impact assess

1.1 ***Why has this policy, service or function been chosen?***

Derbyshire County Council wishes to transform its residential provision for older adults and provide facilities that meet future demographic need and the aspirations of potential customers. A key element of this service is the development of Community Care Centres (CCC) and Extra Care (EC) housing, with proposals in place to provide schemes across the county. As part of this it is intended that those homes that were evaluated as not meeting current physical standards would be closed as the new model develops, subject to detailed consultation in respect of each establishment. This equality impact assessment (EIA) will include evaluation of the impacts emanating from location and design on those schemes developed to date. In addition, it will also seek to ensure that learning from this, including feedback from users and communities of interest, is incorporated into the planning and design for any future schemes. This will seek to ensure any equality weaknesses can be addressed before further new developments are undertaken. This equality impact assessment is complemented by an EIA for each new service model to be commissioned for each of the centres, and by an Equality Impact Plan for any sites or services that are decommissioned, but this report will highlight some of the key issues that will face those people in establishments which are proposed for closure, subject to consultation.

1.2 Why does the policy, service or function exist/ what is its purpose? Who should benefit?

The purpose of this policy is to improve the quality and appropriateness of accommodation and support services for older people across Derbyshire ensuring that services are fit for the future, based on the 2001 Best Value Review that indicated that some homes did not meet current physical standards at that time. The service model will provide a dispersed hub and spoke model of centres providing independent accommodation, residential accommodation, and both in and outreach services as part of the integrated network of support to the local community.

Each new build will have a public area, the aim of which is to provide a community resource for older people and their carers, with no requirement to have a formal assessment of need.

The nature of these developments is that they will also have potential to provide benefits to other members in the community such as young or disabled people.

Stage 2. Pulling an assessment team together

Name	Area of expertise/ role
Katey Twyford (Chair)	Programme Manager – Capital projects
Sharon O'Hara *	Project Manager – Extra Care
Liz Ewbank	Project Manager – Property Services
Kathy Ross *	Project Manager – Capital Investment Projects
Richard Norman	Programme Support Manager – Capital Investment Projects
Dave Chadwick*	Senior Surveyor, Property Services
Jean Sturman	Projects and Health & Safety Officer
Representatives	Capital Investment Stakeholder Reference Group
Representatives	Swadlincote Local Implementation Group
Oonagh McKay *	Derbyshire Friend - Lesbian, Gay, Bisexual and Transgender (LGB&T) Specialist Support and Advocacy Services

- Contributed to the original version 1 equality impact assessment, since moved post / organisation.

Stage 3. Scoping of the assessment / identifying likely issues

This EIA assessment will look at aspects of the CCCs and Extra Care service including the following components

- Sites
- Design

Although, due to the availability of suitable sites, there is limited choice in relation to the location of CCCS and Extra Care schemes there are things that can be done to ensure that any disadvantages are mitigated. In addition, the design and layout of the schemes help to make them suitable for all service users so that certain groups are not disadvantaged in using the facilities. The main issues that need consideration are:

1. **The location of sites in terms of:**
1. Accessibility
2. Serving the Community
3. Proximity to other services
4. Transport
5. Perceived barriers
6. Sustainability and impact on local businesses
7. Safety and Security
8. Affordability (of Extra Care rents and sale)

It is the aspiration of the Authority that there will be a specialist service within an actual or dispersed community care centre within 10 miles of the majority of the people of Derbyshire. It is the aspiration that there will be an extra care scheme within 5 miles of the majority of people of Derbyshire.

2. **The physical characteristics, environment and topography of the site in terms of:**

- Accessibility
- Transport
- Perceived barriers
- Safety and Security

3. Accessibility and inclusive design

- Attractive and appropriate environments for all users, staff and visitors
- Welcoming
- Appropriate facilities - gender, age, black and ethnic minority groups, religious groups etc
- Minimise any potential barriers to usage that may be created by design

This EIA is complementary to the EIAs undertaken by Commissioning teams within Adult Care in relation to contracts or service level agreements for the different components of the service model.

So far as the proposed home closures are concerned, it is proposed that detailed EIAs will be undertaken on a home by home basis before final decisions are made by Cabinet. At this stage, this EIA will address only equalities issues at a higher level.

Stage 4. Pulling together all the information

Extra Care and Community Care Centres

Name of source	Reason for using
Local demographics – source: • Census • Joint Strategic Needs Assessment (JSNA) Projections • Health data • Delivering housing for an ageing population 2005 • Planning4Care	To provide a profile of the county and its population, communities and projections of need. The needs of the population of Derbyshire have been analysed by electoral division according to; those with all social care needs, those with high and very high needs, and those with severe dementia. These have been used to allocate the available resources equitably across Derbyshire: the high and very high needs and severe dementia needs have been used as an indicator of relative demand for specialist services, and the all needs has been used as an indicator for demand for extra care provision.
Information about location, bus routes, local services etc	To look at each locality to determine how well it is supplied by public transport and other services that will be used by people attending the community care centres and Extra Care facilities.
Site surveys undertaken by external architects and Derbyshire County Council Estates Department	These provide information about each location and what can be provided on the sites. This can assist the council to confirm the suitability of a site for a scheme or highlight potential issues that will need to be addressed.
Crime Statistics, including anecdotal evidence of hate crime in areas where locations have a reputation for being intolerant of minority groups – Source • Joint Strategic Needs Assessment (JSNA)	This will identify any potential safety and security issues.
Housing values –source district council housing strategies Extra Care Housing Strategy 2006 East Midlands Regional Housing strategy 2004- 10 Sustainable planning for housing an ageing population 2008 Website of comparative housing prices per area	This data will assist us to assess the affordability of the Extra Care scheme in particular to ensure that as far as possible rents and service charges are reasonable for local people.

Name of source	Reason for using
Potential impact on local people re affordability – including levels of affordable rent, service charges, other charges and housing benefit	An analysis will be undertaken, involving district councils, extra care development partners, and welfare rights advisors to establish a model of costs that are affordable to local people. The analysis will highlight the potential impact of different rent and service charge levels on six main groups: Those who rent: • On low income and housing benefit • On middle income • On high income Those who purchase: • On low income • On middle income • On high income An individual's capital will also be taken into account within the model.
Service user engagement – including feedback from regular meetings, events and workshops Community Reference Group input to procurement process for extra care housing.	This will enable us to get feedback from service users about the type of facilities they would like to see in the future and how they feel about those already provided.
Statutory Requirements – Part M/ National Minimum Standards of the Care Quality Commission (CQC)	This information will be used to ensure that there is no conflict between the statutory requirements that have to be met and our desire to create inclusive design.
Guidance & Standards Homes and Communities Agency (HCA) design Guide for affordable housing Design principles for Extra Care Housing Learning Improvement network /CSIP 2008) Stirling University –Designing for dementia	This will ensure that the design of any building meets recognised quality standards and ensures that the facilities meet the needs of all service users whatever their particular requirements.
Specific Design Guidelines such as Building Research Establishment Environmental Assessment Method (BREEAM), Commission for Architecture and the Built Environment (CABE) etc University of Sheffield – EVOLVE toolkit (checklist for ensuring Extra Care design quality)	This information will be used to ensure that each project team is up to date with the technical guidance on what is best practice in relation to the design of the community care centres and Extra Care Housing.
Travel Plans for each scheme as developed	These plans will give advice about how travel issues and transport will be addressed to ensure that the schemes are as accessible as possible.

Proposed Home Closures

Name of source	Reason for using
Research documentation on home closures and the impact on health and wellbeing of residents. Association of Directors of Social Services Good Practice in Supporting Older People during Residential Care Closures, 2011.	To compare latest research and if necessary update Derbyshire's Home Closure and Major Change guidelines.

Stage 5. Assessing the impact or effects

5.1 What does customer feedback, complaints, and discussions with stakeholder groups tell you about your service, policy and function, including which aspects are seen as negative, inaccessible, unhelpful, difficult to use etc?

Two main areas of feedback are included in this section:

1 General feedback from consultation:

A Perspectives survey (No 51) 'Consultation on Capital Investment Programme' has been carried out which asked Derbyshire citizens about the proposed CCC's and Extra Care housing developments. Many comments were positive and respondents welcomed the new facilities offering opportunities for increased independence and choice.

In terms of design, the positive comments that were raised included:

- Provision of en suite bathroom facilities in the community care centre
- Provision of a smoking room in the community care centres
- Overall agreement that schemes offer more privacy than existing provision

However, the main comments for further consideration were:

- Concern that the centralised locations of schemes may take resources away from local areas
- Potential distress caused by possible moves from existing residential care to the new facilities – *see stage 6, action point 4*
- Visitors were concerned that they may need to travel longer distances to visit relatives – *refer to individual Travel Plan for each Scheme*
- People stated they were concerned about mixed sex facilities, and wanted facilities that would enable couples to share – *see stage 6, action point 7*

2 Feedback from the Community Reference Group

Focussed presentations to the Capital Investment Project community reference group have been used to gain additional feedback on any items specifically related both to the service model and the analysis of need across the county, and in relation to the design of the extra care schemes. Key points included:

- Greater detail about how consultation innovation can be achieved in the Derbyshire developments
- The consultation structures for the three sites in relation to the partnership and the Community Reference Group
- If a 'strolling disability access audit' would be conducted prior to building

handover?

- Whether gardens on the scheme would be overshadowed by the taller buildings or be north facing?
- The importance of maximising light in the schemes was of paramount importance
- How much service costs will be and what they will cover?
- Number and location of car parking for tenants on the schemes and for visitor parking
- How access to upper floors is possible during a power outage
- Whether pets are allowed
- Security in the public areas and how the potential for vandalism is managed?

As can be seen, whilst the feedback related to the Council's overall strategy, most comments related to the proposed Specialist and Community Care Centres and Extra Care Housing. The response which relates directly to the proposed home closures is the potential anxiety caused by possible moves from existing residential care to new homes.

5.2 What does your information tell you about the effects of the policy, service or function on the lives of different groups or communities? Is any of this negative or unwanted?

Groups	**Effects identified from data/ information**
Older adults	National research and evidence suggests that closures of home carries the risk of distress for families and residents, loss of friendship groups, loss of continuity of care from trusted carers, and inappropriate re-provision of care within a new care setting. If badly managed, in extreme cases this could.result in depression, and or physical deterioration leading to premature death. Experience of previous well-handled home closures in Derbyshire has informed the development of Derbyshire's Closure and Major Change guidelines. This has minimised the impact on Derbyshire residents, and follow up work in new homes has enabled residents to live with a good quality of life in their new care setting. Older adults will represent the main source of referrals to the residential aspect and day opportunities located within the centres. The services are targeted at people with a diagnosis of dementia and their carers. The open areas, bistro and well-being zone are a community facility to be accessed by people of all ages within the locality. The development of the first scheme identified a problem with the **noise levels/ acoustics** in certain part of the building, which means that these areas may not be ideal for people with hearing loss or impairment – *see stage 8, action 1* The location of the sites is restricted due to appropriate **land availability**. However, the location may cause difficulties for people using the services if **transport** to and from a particular area is limited. This may also cause

Groups	Effects identified from data/ information
	difficulties for visitors – *Individual Travel Plans will be undertaken for each scheme where details of travel are set out more specifically* The **large scale of the building design** may result in people having to walk a long way to reach their rooms/facilities – *see stage 8, action 4* The fact that parts of the **building are open to the local community** may make older people feel vulnerable because they may worry about security– *see stage 8 action* 6 Older people who are comfortable using existing local services may find it uncomfortable to **move away from their communities** to be accommodated in new facilities – *see section 6, action 4* Older people have requested **smoking room** provision in the resource centres and this has been provided– *see section 6, action 10* The need for **high levels of lighting** within individual apartments of extra care was identified. This has been integrated into the build specification. Older people on the Community Reference Group were concerned the **disability access** issues were considered at all stages; potential developers for the extra care schemes have made a commitment during the procurement dialogue process to work with the community reference group around disability design issues and to undertake disability access audits on the completed buildings. The analysis of **crime statistics** in October 2011 revealed that there were episodes of crime and anti-social behaviour in all areas where the proposed sites are located. The following issues were identified: • Vehicle crime was small, but could be minimised if developers adopt the 'secure by design' standards required by the Council • Burglary varied across the county, but will be minimised by security measures put in place by the developers • Anti-social behaviour and shoplifting varies, but tends to be higher in sites in town centres. This will be minimised by the Council's design requirement for 'progressive privacy' • Public disorder and weapons, and violent crime is more prevalent in town centre locations. This will be minimised by the Council's design requirement for 'progressive privacy'

Groups	Effects identified from data/ information
	See stage 6, action 19 The analysis of **affordability of rent and service charges** modelled rents ranging from £130 - £137, and service charges ranging from £40 - £60. The main impact arising is on those individuals who are just above the income and or capital thresholds for benefits, particularly housing benefits, who will see diminishing savings as a result of paying the higher end spectrum of rent and service charges. *See stage 6, actions 17 and 18.*
Younger adults	Younger adults in the Community Stakeholder Reference Group have indicated that they would be interested in getting involved with the interior design to ensure that it reflects their taste. *For all the above – see stage 6, action 5*
People with Disabilities	The accommodation, care and support plans will provide additional facilities not currently available to younger people with dementia; access to Extra Care apartments and specialist Community Care Centres with dementia appropriate facilities. Due to the limited availability of appropriate sites the location of the buildings may not be in the centre of the town making them hard to reach by public transport – *refer to individual Travel Plans for each scheme where details of travel are set out more specifically.* Poor acoustics in large communal areas and multiple/group use of the building at some sites may cause distraction and distress for some service users – *see stage 8, action 1* Lack of height adjustable kitchens in Extra Care schemes may disadvantage people in wheelchairs– *see stage 8, action 8* Lack of adjustable height tables may stop people in wheelchairs using craft rooms or IT – *see stage 6, action 8* The fact that service users may be visible to others when using facilities may not be acceptable to some people including those with disabilities (i.e. hairdressers/ gym) – *see stage 6, action 9*
BME communities	The availability of appropriate sites could result in them being located away from BME communities, which could reduce accessibility and mean ethnic minority groups may not feel welcome – *see stage 6, action 11*

Groups	Effects identified from data/ information
	The kitchen/ café design may not be able to provide for the range of dietary requirements held by service users. The lack of provision of separate sinks and storage areas may make it difficult to comply with preparation requirements for Kosher or Halal foods. – *see stage 6 action 12* People from certain black and minority ethnic communities may be less happy with mixed sex facilities – *see stage 6, action 13*
Gender	The dementia friendly design may result in colour schemes being used which are more feminine in style. This may make facilities less appealing to men – *see section 6, action 14* Lack of childcare facilities may cause problems for attendees with children – *see section 6, action 15*
Sexual orientation	Information provided from Lesbian, Gay Bisexual and transsexual (LGBT) Groups has indicated that there could be a demand for people to have access to shared living space – *see section 6, action 7*
Other groups – religious	Many religious groups require access to a quiet room that can be used for prayer or contemplation. Having friends or family members able to stay over is also particularly important in some faiths at end of life (such as Hinduism). Many religions have dietary requirements that will need to met if kitchen design precludes them being prepared on site. *See stage 6, action 12*
Common to all groups with protected characteristics	Lack of privacy when accessing computers in the communal areas – *see stage 6, action 8* Consideration may need to be given to the possibility that some people may be less keen on mixed sex facilities – *see stage 6, action 13*

Stage 6 Ways of reducing or removing unwanted effects

What small steps could be taken to achieve improvements? Please outline the main things that need to be altered to reduce any illegal, negative and unwanted impact.

1. The benefits of using screens, sound absorbing wallpapers and furnishings in the existing scheme where the acoustics are poor will be considered within each scheme as appropriate.

2. Existing schemes are quite large and service users find they have to walk some distance. Work is being done in existing schemes to ensure that occasional seating is provided along key routes where possible given fire regulations.

Lesson learned are being incorporated into the specification and design plans for emerging schemes.

3. We have confirmed that all existing schemes have progressive security measures which will protect the privacy and security and residents and prevent people moving from the communal areas to the residential areas. Progressive privacy is a key area for evaluation in bid proposals for future schemes.

4. To support people (service users, residents and relatives) who are anxious about leaving existing communities we will minimise the potential distress and aim to sensitively handle any transition arrangements by :
    - adhering to the Adult Care Closure and Major Change Guidelines
    - undertaking detailed decommissioning equality impact assessments for each establishment proposed for closure or transfer including: consulting with service users and relatives, and groups on the impact of any potential closure, providing appropriate reassurances
    - providing Assistant Director oversight of the assessment and transition process for individuals in transition due to home closure, that will include input from relevant health professionals, and will include monitoring the risks and impacts of the process on individuals as it proceeds
    - providing timely and appropriate information on the process for all those involved
    - undertaking detailed assessment and personal support planning for each individual to support any transfers, tailored to their individual circumstances
    - phasing moves gradually so people get familiar with new environment
    - replicating the activities that people used to do in original environment
    - moving people in small friendship groups
    - identifying any gaps in provision of health or social care
    - ensuring continued access to specific or special interest groups, including support for people to attend LGBT groups, which could be out of the locality of the scheme
    - working with human resources to minimise staff loss from the establishment to be closed, and ensure continuity of staff involved in care of individuals or group if possible.
      See Stage 8, Action10
    - The ultimate safeguard is that in the event of a decision being made to close an individual home, the transfer of residents to an alternative setting would still be dependent on a full community care assessment being carried out in respect of every resident showing that they could be safely and carefully accommodated elsewhere, and reference would be made to the Council's "Closure and Major Change Guidelines".

5. To ensure schemes are appealing to younger people we will:
    - ensure younger people are on reference group who can give us their views and feedback
    - provide images of younger people around the scheme
    - link with schools to provide intergenerational activities.

6. We will ensure that we translate material into various languages and formats where required.

7. In line with Care Quality Commission Regulations for living space, we will ensure flexibility of bedroom arrangements in the community care centres to enable couples, including same sex couples to share living space. For example, allocation of two rooms where one could be a bedroom and the other a lounge area.

8. We will look at measures to ensure privacy for people to enable them to access the internet.

9. We will consider options for hairdressing and exercise etc to be undertaken in less visible areas of the building.

10. We will ensure that the design of future community care centres incorporates a smoking room.

11. Work will be done with commissioning, field work teams, and development partners to explore the most appropriate ways in which black and minority ethnic communities can remain in touch with cultural groups and clubs. This may include facilitating specific groups and clubs to operate services and activities from within the community care centres and extra care schemes.

12. The use of specialist local external caterers will be considered to either bring in appropriate meals or encourage innovative ways in which meals can be prepared from the community care centres. The proposals for catering within each of the extra care schemes will be evaluated as part of the procurement process.

13. Work will be done to explore the most appropriate use of the building for instances where mixed sex accommodation becomes an issue. For example, there may be opportunities for sectioning of a wing or corridor.

14. The authority will ensure that service user groups are consulted over the interior design, in particular gaining the views of people of all ages and gender.

15. People with unwanted toys will be encouraged to donate them for the use of children and young people accessing/visiting the centres.

16. Work will be done to raise awareness amongst younger people using the centres that the design and colour scheme are more appropriate for people with dementia.

17. On-going work will be undertaken with District and Borough Councils, and with development partners, to ensure that the cost of extra care schemes are affordable to those across the range of different capital and income thresholds, and to those who both wish to rent and to own the extra care schemes. This will need to be kept under review as the current housing benefit regulations are in the process of being updated.

18. Work will be undertaken with Registered Social Landlords within the extra care schemes to develop integrated/complimentary models of pre-invested 24/7 unplanned personal care support and for housing related support. The intention is to commission the most cost-effective models for individual tenants, which will minimise service charges and optimise the relationship

between pre-invested support, personal budgets and co-funding contributions.

19. We will ensure that future buildings for Specialist Community Care Centres and Extra Care housing will be built to allow ‘progressive privacy’ and to meet ‘secure by design’ standards.

Stage 7 Finding out whether your assessment has identified what people think needs changing.

A stakeholder event was held to discuss design and other issues with a wide range of local community representatives. Following this a Community Reference Group was established, who have been involved in this EIA process along with the Local Implementation Group dealing with each individual scheme. These forums provide a fair representation of the equality groups and will continue to be involved as each new element of the implementation plan begins to be developed.

Stages 8 and 9. Action planning, target setting and monitoring

TARGETS / SUCCESS CRITERIA

ACTION	LEAD RESP	PARTNER INPUT	RESOURCES	PERFORMANCE INDICATORS/ MILESTONES	QUALITY ASSURANCE
1. Include acoustic requirements in Output Specification to ensure the future schemes meet expectations	LE	Service Provider	None	Output specification to be updated following acoustic analysis	Output spec
2. Consider any transport issues at each scheme taking account of the existing work being done on sustainable transport and day care.	Local Implementation Group	Environmental services Developer	Officer time	**Linked to Benefit Realisation** *(Provision of facilities that are accessible to the wider community).* Access to services and facilities by public transport, walking and cycling. Participation in regular volunteering People using the service will have their mobility optimised.	Travel Plans signed off by Environmental Services CIP wider Project Team
3. At the design stage include spaces for the provision of occasional dementia friendly seating around schemes to provide informal rest areas	LE	Architects Housing Association/ development partners		Have the clients maintained their independence (Supporting People) Increased numbers of older people remaining with good quality lives at home.	Robust and detailed Output Specification – using the Equality Proofing Checklist for New Builds and Major refurbishments

ACTION	LEAD RESP	PARTNER INPUT	RESOURCES	PERFORMANCE INDICATORS/ MILESTONES	QUALITY ASSURANCE
4. Consideration to be given to reduce travel distances for tenants during the design brief	SO'H	Developer/ Housing Association		Have the clients maintained their independence People using the service will have their mobility optimised.	Design Brief Feedback from tenants
5. Ensure 'secured by design' (SBD)accreditation for all schemes	LE	Design group	Accreditation costs	Receipt of the Secured By Design award	Robust and detailed Output Specification – using the Equality Proofing Checklist for New Builds and Major refurbishments
6. As each scheme is designed ensure that 'progressive privacy' [5]measures built into each scheme	LE SOH	Design group	Cost of security measures and accreditation		Robust and detailed Output Specification – using the Equality Proofing Checklist for New Builds and Major refurbishments Stirling University accreditation
7. Ensure the schemes accurately reflect the demographics of the location in which they are situated	CIP group	Design group Community reference group BME groups	Cost of meetings Costs of additional to the design spec	Service User and staff profile is representative of the local community	Ongoing monitoring of staff and service user profile
8. Ensure that all future developments of Extra Care housing schemes have some adjustable height kitchens.	CIP group	Design groups	Costs of additional to the design spec	Response of development partners to the bid specification.	Tender proposal meets or exceeds the Council's

[5] Where a building has open access as well as residential accommodation, designing to achieve progressive privacy encourages the public into open access areas whilst protecting the privacy of residents and discouraging access into private residential areas. This is achieved through a combination of design and security measures.

ACTION	LEAD RESP	PARTNER INPUT	RESOURCES	PERFORMANCE INDICATORS/ MILESTONES	QUALITY ASSURANCE
					expectations
9. Continue to work with development partners, Registered Social Landlords, District and Borough housing planners and housing benefit officers to ensure that scheme rents and service charges are affordable to local people. In addition the work will ensure that individual residents / tenants benefit from integrated models of 24/7 unplanned personal care and housing related support, which complements their personal care budget.	CIP group	District Housing leads Registered Social Landlords	Time	Level of rent and service charges at each scheme Optimum mix of pre-invested element of personal budgets within self-directed support.	Benchmark across schemes in DCC and with non HCA subsidised schemes in other authorities.
10. Undertaken consultation and EIA on any establishments proposed for closure, and report these back to Cabinet for decision	Assistant Director of Adult Care	Advocacy groups, health colleagues	Time	Cabinet report on consultation outcome and EIA for each establishment proposed for closure	Director of Adult Care and the Accommodation Care and Support Strategic Project Board

Stage 10. Have your main actions been added to the relevant business or service plan(s)?

Please indicate below which actions to which plans

Action planned	Business / Service Plan	How will performance be tracked and reported?
The acoustic requirements has been detailed in the design specification for all future schemes	Output Specification	Procurement specification for Community Care Centres Procurement specification for extra care housing Procurement Evaluation Criteria
Transport issues will be considered at each scheme	Output Specification	As above Travel plans for each scheme
At the design stage we will ensure inclusion of space for dementia friendly seating	Output Specification	Procurement evaluation criteria
Schemes will be designed to protect the security of all users and we will expect the contractor to obtain 'Secured by design' accreditation	Output Specification	Procurement evaluation criteria
The schemes will be designed to ensure that areas that are strictly for use by residents will be secure and private	Output Specification	Procurement evaluation criteria
Consultation groups will seek to include representation from all the protected characteristic groups (as defined by the Equalities Act 2010 such as the people with disabilities)	Consultation plan	Feedback from these groups
Consultation and EIAs will be undertaken in a timely fashion to support the plan's progression	Adult Care business plans	Reports back to Cabinet

Step 11. Publishing your assessment

Please indicate below:

Your assessment has been signed off for publishing by

Version 1: Capital Investment Project Strategic Project Board 27 September 2011
Version 2: Proposed Cabinet Report Accommodation Care and Support Strategy, 20th February 2012

Your assessment was published on

Medium/ location	Date
Version 1: DCC Website	26/11/2010
Version 2: DCC Website	TBC

Signed

Date

Added to DCC website

Appendix F

Making fair financial decisions

This guidance has been updated to reflect the new equality duty which came into force on 5 April 2011. It provides advice about the general equality duty. Advice about the specific duties will be added at a later date when the specific duties regulations for England and Scotland have been finalised.

Introduction

With major reductions in public spending, public authorities in Britain are being required to make difficult financial decisions. This guide sets out what is expected of you as a decision-maker or leader of a public authority responsible for delivering key services at a national, regional and/or local level, in order to make such decisions as fair as possible.

The new public sector equality duty (the equality duty) does not prevent you from making difficult decisions such as reorganisations and relocations, redundancies, and service reductions, nor does it stop you from making decisions which may affect one group more than another group. The equality duty enables you to demonstrate that you are making financial decisions in a fair, transparent and accountable way, considering the needs and the rights of different members of your community. This is achieved through assessing the impact that changes to policies, procedures and practices could have on different protected groups (or protected characteristics under the Equality Act 2010).

Assessing the impact on equality of proposed changes to policies, procedures and practices is not just something that the law requires, it is a positive opportunity for you as a public authority leader to ensure you make better decisions based on robust evidence.

What the law requires

Under the equality duty (set out in the Equality Act 2010), public authorities must have ‘due regard’ to the need to eliminate unlawful discrimination, harassment and victimisation as well as to

advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not.

The protected groups covered by the equality duty are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The duty also covers marriage and civil partnerships, but only in respect of eliminating unlawful discrimination.

The law requires that public authorities demonstrate that they have had 'due regard' to the aims of the equality duty in their decision-making. Assessing the potential impact on equality of proposed changes to policies, procedures and practices is one of the key ways in which public authorities can demonstrate that they have had 'due regard'.

It is also important to note that public authorities subject to the equality duty are also likely to be subject to the Human Rights Act. We would therefore recommend that public authorities consider the potential impact their decisions could have on human rights.

Aim of this guide

This guide aims to assist decision-makers in ensuring that:

• The process they follow to assess the impact on equality of financial proposals is robust, and
• The impact that financial proposals could have on protected groups is thoroughly considered before any decisions are arrived at.

We have also produced detailed guidance for those responsible for assessing the impact on equality of their policies, which is available on our website:
http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSED/equality_analysis_guidance.pdf

The benefits of assessing the impact on equality

By law, your assessments of impact on equality must:
• Contain enough information to enable a public authority to demonstrate it has had 'due regard' to the aims of the equality duty in its decision-making

• Consider ways of mitigating or avoiding any adverse impacts.

Such assessments do not have to take the form of a document called an equality impact assessment. If you choose not to develop a document of this type, then some alternative approach which systematically assesses any adverse impacts of a change in policy, procedure or practice will be required.

Assessing impact on equality is not an end in itself and it should be tailored to, and be proportionate to, the decision that is being made.

Whether it is proportionate for an authority to conduct an assessment of the impact on equality of a financial decision or not depends on its relevance to the authority's particular function and its likely impact on people from the protected groups.

We recommend that you document your assessment of the impact on equality when developing financial proposals. This will help you to:

• **Ensure you have a written record of the equality considerations** you have taken into account.

• **Ensure that your decision includes a consideration of the actions that would help to avoid or mitigate any impacts on particular protected groups**. Individual decisions should also be informed by the wider context of decisions in your own and other relevant public authorities, so that particular groups are not unduly affected by the cumulative effects of different decisions.

• **Make your decisions based on evidence**: a decision which is informed by relevant local and national information about equality is a better quality decision. Assessments of impact on equality provide a clear and systematic way to collect assess and put forward relevant evidence.

• **Make the decision-making process more transparent**: a process which involves those likely to be affected by the policy, and which is based on evidence, is much more open and transparent. This should also help you secure better public understanding of the difficult decisions you will be making in the coming months.

• **Comply with the law**: a written record can be used to demonstrate that due regard has been had. Failure to meet the equality duty may result in authorities being exposed to costly, time-consuming and reputation-damaging legal challenges.

When should your assessments be carried out?

Assessments of the impact on equality must be carried out at a **formative stage** so that the assessment is an integral part of the development of a proposed policy, not a later justification of a policy that has already been adopted. Financial proposals which are relevant to equality, such as those likely to impact on equality in your workforce and/or for your community, should always be subject to a thorough assessment. This includes proposals to outsource or procure any of the functions of your organisation. The assessment should form part of the proposal, and you should consider it carefully **before** making your decision.

If you are presented with a proposal that has not been assessed for its impact on equality, you should question whether this enables you to consider fully the proposed changes and its likely impact. Decisions not to assess the impact on equality should be fully documented, along with the reasons and the evidence used to come to this conclusion. This is important as authorities may need to rely on this documentation if the decision is challenged.

It is also important to remember that the potential impact is not just about numbers. Evidence of a serious impact on a small number of individuals is just as important as something that will impact on many people.

What should I be looking for in my assessments?
Assessments of impact on equality need to be based on relevant information and enable the decision-maker to understand the equality implications of a decision and any alternative options or proposals.

As with everything, proportionality is a key principle. Assessing the impact on equality of a major financial proposal is likely to need significantly more effort and resources dedicated to ensuring effective engagement, than a simple assessment of a proposal to save money by changing staff travel arrangements.

There is no prescribed format for assessing the impact on equality, but the following questions and answers provide guidance to assist you in determining whether you consider that an assessment is robust enough to rely on:

• **Is the purpose of the financial proposal clearly set out?**
A robust assessment will set out the reasons for the change; how this change can impact on protected groups, as well as whom it is intended to benefit; and the intended outcome. You should also think about how individual financial proposals might relate to one another. This is because a series of changes to different policies or services could have a severe impact on particular protected groups.

Joint working with your public authority partners will also help you to consider thoroughly the impact of your joint decisions on the people you collectively serve.

Example: A local authority takes separate decisions to limit the eligibility criteria for community care services; increase charges for respite services; scale back its accessible housing programme; and cut concessionary travel. Each separate decision may have a significant effect on the lives of disabled residents, and the cumulative impact of these decisions may be considerable. This combined impact would not be apparent if the decisions were considered in isolation.

• **Has the assessment considered available evidence?**
Public authorities should consider the information and research already available locally and nationally. The assessment of impact on equality should be underpinned by up-to-date and reliable information about the different protected groups that the proposal is likely to have an impact on. A lack of information is not a sufficient reason to conclude that there is no impact.

• **Have those likely to be affected by the proposal been engaged?**

Engagement is crucial to assessing the impact on equality. There is no explicit requirement to engage people under the equality duty, but it will help you to improve the equality information that you use to understand the possible impact on your policy on

different protected groups. No-one can give you a better insight into how proposed changes will have an impact on, for example, disabled people, than disabled people themselves.

• Have potential positive and negative impacts been identified?

It is not enough to state simply that a policy will impact on everyone equally; there should be a more in-depth consideration of available evidence to see if particular protected groups are more likely to be affected than others. Equal treatment does not always produce equal outcomes; sometimes authorities will have to take particular steps for certain groups to address an existing disadvantage or to meet differing needs.

• What course of action does the assessment suggest that I take? Is it justifiable?

The assessment should clearly identify the option(s) chosen, and their potential impacts, and document the reasons for this decision. There are four possible outcomes of an assessment of the impact on equality, and more than one may apply to a single proposal:

Outcome 1: No major change required when the assessment has not identified any potential for discrimination or adverse impact and all opportunities to advance equality have been taken.

Outcome 2: Adjustments to remove barriers identified by the assessment or to better advance equality. Are you satisfied that the proposed adjustments will remove the barriers identified?

Outcome 3: Continue despite having identified some potential for adverse impacts or missed opportunities to advance equality. In this case, the justification should be included in the assessment and should be in line with the duty to have ‘due regard’. For the most important relevant policies, compelling reasons will be needed. You should consider whether there are sufficient plans to reduce the negative impact and/or plans to monitor the actual impact, as discussed below.

Outcome 4: Stop and rethink when an assessment shows actual or potential unlawful discrimination.

• **Are there plans to alleviate any negative impacts?**
Where the assessment indicates a potential negative impact, consideration should be given to means of reducing or mitigating this impact. This will in practice be supported by the development of an action plan to reduce impacts. This should identify the responsibility for delivering each action and the associated timescales for implementation. Considering what action you could take to avoid any negative impact is crucial, to reduce the likelihood that the difficult decisions you will have to take in the near future do not create or perpetuate inequality.

Example: A University decides to close down its childcare facility to save money, particularly given that it is currently being under-used. It identifies that doing so will have a negative impact on women and individuals from different racial groups, both staff and students.

In order to mitigate such impacts, the University designs an action plan to ensure relevant information on childcare facilities in the area is disseminated to staff and students in a timely manner. This will help to improve partnership working with the local authority and to ensure that sufficient and affordable childcare remains accessible to its students and staff.

• **Are there plans to monitor the actual impact of the proposal?**
Although assessments of impact on equality will help to anticipate a proposal's likely effect on different communities and groups, in reality the full impact of a decision will only be known once it is introduced. It is therefore important to set out arrangements for reviewing the actual impact of the proposals once they have been implemented.

What happens if you don't properly assess the impact on equality of relevant decisions?

If you have not carried out an assessment of impact on equality of the proposal, or have not done so thoroughly, you risk leaving yourself open to legal challenges, which are both costly and time-consuming. Recent legal cases have shown what can happen when authorities do not consider their equality duties when making decisions.

Example: A court recently overturned a decision by Haringey Council to consent to a large-scale building redevelopment in Wards Corner in Tottenham, on the basis that the council had not considered the impact of the proposal on different racial groups before granting planning permission.

However, the result can often be far more fundamental than a legal challenge. If people feel that an authority is acting high-handedly or without properly involving its service users or employees, or listening to their concerns, they are likely to be become disillusioned with you.

Above all, authorities which fail to carry out robust assessments of the impact on equality risk making poor and unfair decisions that could discriminate against particular protected groups and perpetuate or worsen inequality.

As part of its regulatory role to ensure compliance with the equality duty, the Commission will monitor financial decisions with a view to ensuring that these have been taken in compliance with the equality duty and have taken into account the need to mitigate negative impacts where possible.

Agenda Item No: 4

SHADOW DERBYSHIRE HEALTH & WELLBEING BOARD

29 March 2012

ADULT CARE AND JOINT COMMISSIONING PRIORITIES 2012-13

1. Purpose of the Report

To seek the Board's endorsement of the Joint Commissioning Priorities between Adult Care and the local NHS for 2012/13.

2. Information and Analysis

The Adult Care Board considered the proposed Joint Commissioning priorities for 2012/13 at its meeting on 15th March. Subject to some minor amendments the Board approved the proposals and also agreed to seek their endorsement by the Shadow Health and Wellbeing Board.

The proposals for 2012/13 build on some previous priorities, but also identify some new priority areas following discussions with the Clinical Commissioning Groups.

3. Proposed Joint Commissioning Priorities 2012/13

Outlined below are the priorities agreed by the Adult Care Board, together with the key points of focus for each priority.

Safeguarding: protecting vulnerable adults from abuse by getting help to those at risk quickly. Work with local partners to ensure a full range of high quality health and care services is available. Continue the roll-out of the Dignity and Respect challenge across the county.

Frail Older People and Dementia: modernising accommodation care and support involving investment in Specialist Community Care Centres and Extra Care housing developments, providing a range of services including: respite and intermediate care access to good quality information and advice; developing integrated pathways, with a particular focus on urgent care 24/7 aimed at keeping people at home, hospital discharge and access to respite for carers; early diagnosis and specialist care for people with dementia; choice and flexibility in day opportunities and high quality of care.

Carers: flexible Carers' breaks that are flexible and responsive to carers' needs; information and advice available in a range of places, including libraries and GPs' surgeries. Adult Care is proposing to be the Lead Commissioner for carers.

Learning Disability: continue with the Community Lives programme which seeks to increase usage of community resources; Person Centred

Planning and the outcomes of the plans to be monitored; working in partnership to improve the range of housing available; ensuring more people have a Health Action Plan. Adult Care is proposing to be the Lead Commissioner for people with a Learning Disability.

Disabled People or people with a sensory impairment: improving access to community transport and social care transport services; equality of access to health provision and health care for people with long term conditions; improvements in the availability of accessible housing; support disabled people to remain in work;

Transition to Adult Life: joint working to support younger people in transition to adult life;

Implementation of the Autism Act: ensure that the service developments are in place to fulfil statutory requirements;

Mental Health Services: Deliver the new national strategy 'No Health without Mental Health' including revising commissioning arrangements and implementation of the jointly agreed position statement.

3. OFFICER'S RECOMMENDATION

That the Shadow Health and Wellbeing Board endorses the Joint Commissioning Priorities between Adult Care and the local NHS for 2012/13.

Appendix 1

The following indicators are replicated, complementary or whole system (i.e. across both Adult Care and the NHS)

Type of Indicator	Adult Social Care Outcomes Framework	NHS Outcomes Framework	Additional comments
Replicated	Proportion of older people (65 and over) who are still living at home 91 days after discharge from hospital into rehabilitation, intermediate care or rehabilitation (2B)	Proportion of older people (65 and over) who were: (i) still at home 91 days after discharge into rehabilitation; (ii) offered rehabilitation following discharge from acute or community hospital (No. 3.6)	
Complementary	Social care-related quality of life (1A)	Health-related quality of life for people with long-term conditions (No. 2)	
	The proportion of people using adult social care services who have control over their daily life (1B)	Proportion of people feeling supported to manage their condition (No. 2.1)	
	Carer-reported quality of life (1D)	Health-related quality of life for carers (No. 2.4)	
	Proportion of adults in contact with secondary mental health services in paid employment (1F)	Employment of people with mental illness (No. 2.5)	
Whole System	Delayed transfers of care from hospital; and those attributable to social care 100,000 population (2C)	No specific indicator	This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population, and is an indicator

			of the effectiveness of the interface within the NHS, and between health and social care services.
			NI 129 End of Life Care Access to appropriate care enabling people to be able to choose to die at home – Note: indicator deleted from the national Adult Care data set. There is a new NHS indicator included in the 2012/13 NHS Outcomes Framework No. 4.6 “Improving the experience of care for people at the end of their lives” an indicator to be derived from the survey of bereaved carers – not ready until 2012/13

Agenda Item No: 5

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

TAMESIDE AND GLOSSOP JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) REVIEW 2012

Purpose of the report

To inform the Board of the content and recommendations from the Tameside and Glossop JSNA Outcomes Review 2012.

Information and Analysis

The Public Health team has carried out a review of health needs to identify priorities for 2012/13. This was a benchmarking exercise of headline outcome indicators which contribute to the lower life expectancy in Tameside and Glossop when compared to areas with very similar populations. The full exercise is available from Elaine Michel: it has been reviewed by the Tameside Health & Wellbeing Board who have supported the recommendations which will form part of the Joint Health & Wellbeing Strategy. The report also seeks support from the Derbyshire Health & Wellbeing Board.

Tameside & Glossop has a higher mortality rate for both men and women than England. The top causes of this difference are deaths from cardiovascular disease and respiratory disease: this makes up 79% of the gap. Whilst progress has been made in reducing premature deaths from CVD, the gap with England has remained the same since 2002. In contrast deaths from respiratory disease have increased in the area against a declining trend in England. Outcome indicators for alcohol and smoking are poor in comparison to England for prevalence, morbidity, hospital admissions and mortality. Programme budgeting data shows high spend and poor outcomes for CVD and respiratory disease. It should also be noted that the internal gap in mortality in Tameside & Glossop is not decreasing, showing that people in more disadvantaged areas have a greater likelihood of dying prematurely than those in more affluent areas with little or no progress being made to narrow this inequality.

In order to make a significant difference to avoidable mortality, reduce morbidity from cardiovascular and respiratory disease and increase the amount of healthy years of life experienced by local people the following ambitious programme is proposed with a clear focus on improving health outcomes, reducing hospital admissions, reducing avoidable premature deaths and decreasing the gap in mortality with other comparable areas in England. A benchmarking exercise against best practice evidence based guidance has been carried out on the four key areas to identify areas for focus

which will make a real difference. This is supported by an equity review identifying variation in primary care, areas for clinical advice and availability of supportive services. There are detailed plans available from the public health team which underpin the summaries provided in Appendix 1.

The programme will make notable contributions to the following areas in the NHS Outcomes Framework 2012/13:-

- Potential years of life lost from causes considered amenable to healthcare
- Life expectancy at 75 – males and females
- Reducing mortality from major causes of death aged under 75: cardiovascular disease, respiratory disease, liver disease, cancer
- Reducing emergency admissions for acute conditions that should not usually require hospital admission

The overall ambition is to:-

- Reduce smoking prevalence to the NW average ie 5% less adults smoking
- Reduce the rising trend in alcohol related admissions
- Work towards reducing the rise in obesity in children, families and adults
- Improve early identification and care for people with respiratory disease through levelling up of quality in primary care with the aim of reducing the number and cost of hospital admissions
- Narrow the gap in CVD mortality by improving early identification and quality of care

Summary of proposal

The overarching aims are identified below. These have been identified as areas which will make the most difference to improving health and reducing early deaths.

1. Engage with and understand local people's perspective, through a social marketing approach, to quitting smoking, reducing harmful alcohol consumption and encouraging healthy weight. This will inform a targeted approach to reduce smoking prevalence, a population shift in alcohol related harm and a focus on healthy weight.

2. Systematically embedding advice and support for smokers and those misusing alcohol within all clinical contacts will engender behaviour change. By *Making every contact count* evidence shows that 1 in 8 people will change their behaviour. Positive therapeutic conversations on lifestyles are a powerful tool that all clinicians should include in their duty of care for patients in primary, community and secondary care.

3. Levelling up quality in primary care, in relation to early identification and long term condition management, is one of the most important factors identified in the National Support Team for Health Inequalities conclusions about the impact of health care. The practice that patients receive their treatment from makes the identifiable difference between likelihood of healthy life expectancy and that of avoidable premature death regardless of population demographics.
    a. Maintain progress on Healthchecks to meet national target as a minimum
    b. Project team to work with practices to improve the quality of LTC registers
    c. Practice IT systems to have appropriate prompts
    d. Implementation of COPD pathway including primary care, secondary care, training staff, assisted discharge and home oxygen service

4. Access to high quality accessible services:
    a. Smoking cessation services should be of uniformly high quality in primary care, in pharmacies and the specialist service with quit status confirmed by CO monitoring and the offer of choice of medication. Patients should always be offered a choice of provider to suit their needs around time and place to encourage achievement of quitting.
    b. Alcohol services are not equitably available across primary care, secondary care and the criminal justice system. There is a severe lack of capacity against identified need for tier 2 and 3 services plus community detoxification. It is proposed that services should be combined and increased to provide a single point of access, a seamless service for all patients and follow up post treatment to support long term behaviour change.
    c. Production of young people's alcohol pathway supported by a young people's alcohol treatment service.
    d. Healthy weight services are minimal with limited investment. It is proposed to increase the choice of services available and scale up their availability proportionate to need to create a range of options including increased access to physical activity support

5. A settings approach around workplace health and healthy schools will be supportive initiatives delivered jointly with local authorities.

6. The wider issues around alcohol and tobacco are included in joint plans with partners. Their contribution will be enhanced and delivered through the Smokefree Alliance, the Alcohol Harm Reduction Strategy and the Obesity Strategy. This includes a focus on workplace health, action on illicit and illegal aspects of tobacco and alcohol, reducing harm for children and young people, a healthy schools programme,

creating environments that support physical activity, encouraging healthy eating and changing social norms through a range of campaigns at local, regional and national level.

Recommendations

1. Members are asked to consider the content and recommendations of this JSNA review
2. Support inclusion of additional funding requirements through the prioritisation process of the Tameside & Glossop CCG
3. Consider the implications for levelling up quality of care around long terms conditions management
4. Support the CQUIN's on smoking and alcohol in Tameside FT and Tameside & Glossop Community Services
5. Endorse the need for collaborative working around the wider agendas of tobacco, alcohol and healthy weight.

Elaine Michel
Interim Director of Public Health
March 2012

Appendix 1

Public Health Outcomes/ QIPP Plans- Tobacco
SUMMARY

Case for change:

Every year over 80,000 people in England die from tobacco use. It can be seen from figure 1 below that deaths from smoking are greater than the combined total of the six next greatest causes of preventable deaths. 26% of adults in Tameside & Glossop smoke (about 59,000 people); this is higher than the North West (23%) and England (21%). **It would take 11,315 quits to reduce the smoking rate in Tameside and Glossop to the national average.** Each year smoking costs Tameside £66 million. Over 500 deaths per year in Tameside & Glossop are attributable to smoking; and 2,500 hospital admissions. Smoking-related deaths are a major contributor to the low male and female life expectancy in Tameside & Glossop. Tobacco helps to perpetuate poverty, deprivation and health inequality. In Tameside, those that suffer greatest are: men, routine and manual workers, children and unborn babies exposed to second-hand smoke, and those with existing health conditions, e.g. Mental Health problems, CVD, COPD.

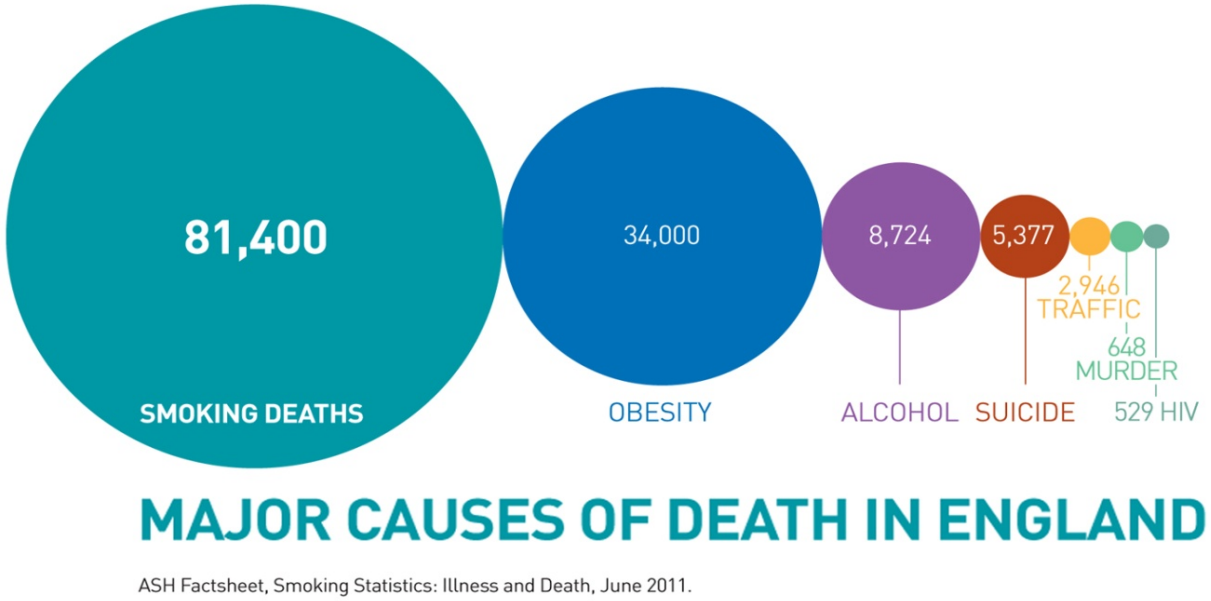


Figure 1: Deaths in England by preventable causes

Links to Outcome Frameworks

PH Outcomes Framework: -2.3 Smoking status at time of delivery
-2.9 Smoking prevalence- 15 year olds
-2.14 Smoking prevalence- adults (over 18s)

NHS Outcomes Framework -1.1 Under75mortality rate from cardiovascular disease
-1.2Under75mortality rate from respiratory disease

Table 1: Benchmarking and recommendations

Current provision	Gaps in provision	Action needed	Investment needed	QIPP Outcomes
Social Marketing Re-run and evaluation of social marketing campaign *What will you miss?* focussed on deprived tobacco users	On-going sustained recruitment campaigns targeted at routine and manual groups Insight work into effective social marketing and effective SSS configuration to increase recruitment of young women and their partners Sustained recruitment campaigns targeted at young women and their partners	Ongoing social marketing campaign to recruit routine and manual smokers to SSS-content and delivery needs to be altered in response to evaluation of current campaign Insight work with young women and development of effective social marketing materials. Sustained campaign targeting young women.	Rolling recruitment of routine and manual groups: £50,000-£60,000 recurrent Insight work with young women: £10,000- non-recurrent Development of new resources targeted at young women: £10,000- non-recurrent Rolling recruitment of young women: £50,000- £60,000- recurrent	**Productivity** 100 extra 4-week quitters (assuming 75% relapse rate) would save £24,696 of outpatient and elective admissions[1] **Prevention** 100 4-week quitters will lead to 10 fewer strokes and 8 fewer MIs over next 10 years Quits among young women will also reduce SATOD rates and reduce exposure of children to second-hand smoke

[1] NICE costing template for PCTs and providers http://guidance.nice.org.uk/PH5/CostingTemplate/PCT/xls/English

Brief advice by all frontline community staff All front line staff to be trained in very brief interventions; 400 staff trained 2010/11- £20,000 per year to deliver brief advice training- recurrent	In 2010/11 community services referred 92 smokers to SSS Assuming the 400 individuals trained in 2010/11 have contact with 300 patients each[2], and 26% are smokers =31,200 conversations per year. Assuming 4% of smokers except a referral to SSS[3] this cohort of staff should generate 1,248 referrals each year.	Implementation of systematic brief advice to all smokers by all frontline staff at every opportunity	Brief advice training- funded from existing budgets Cost of CQUIN for community referrals to SSS	**Productivity** 1,248 extra referrals to SSS and 624 extra 4-week quits per year; would save £154,103 of outpatient and elective admissions[4] **Prevention** 624 4-week quits will prevent 63 MIs and 78 strokes over the next 10 years.
Primary care Universal implementation of Ask, Advise, Act across primary care including full choice of available support	Not all smokers identified on primary care records Smokers not advised about health benefits of stopping at every opportunity Smokers ready to quit not always offered a referral to support outside the practice	Primary care to check all patient's smoking status and offer full choice of stop smoking services available, not just within the practice	Primary Care Quality support team to help identify smokers Primary care training- £20,000	**Quality** Increase in access to support offered to patients attempting to quit

[2] Unite/CPHVA Professional team, June 2007 FACT SHEET DETERMINING OPTIMUM CASELOAD SIZES
[3] Based on economic modelling from NICE guidance on brief interventions for smoking cessation http://www.nice.org.uk/guidance/PH1
[4] NICE costing template for PCTs and providers http://guidance.nice.org.uk/PH5/CostingTemplate/PCT/xls/English

Brief advice by all healthcare staff in secondary care In 2010/11 240 people were referred to SSS. Universal implementation of Ask, Advise, Act across secondary care.	All smokers entering hospital should have a conversation about quitting before, during and after their stay. Target of 1,250 quit attempts	Implementation of systematic brief advice to <u>all</u> smokers by <u>all</u> frontline staff at every opportunity	Cost of CQUIN implementation (Unknown) Training for practitioners- £20,000	**Productivity** An extra 624 4-week quitters (assuming 75% relapse rate) would save £154,103 of outpatient and elective admissions[5] **Prevention** 624 4-week quits will prevent 63 MIs and 78 strokes over the next 10 years.
Reduce smoking in pregnancy Opt out scheme has been implemented for pregnant women who smoke leading to 542 women being offered support to quit by SSS.	To reduce SATOD from current rate of 23% to current national rate of 14% would require 269 extra women to quit before or during pregnancy.	All pregnant smokers to be offered a range of support to quit, including SSS, peer support	Cost of peer support, brief intervention training for Volunteer Doulas and support for maternity unit from SSS	**Prevention and Productivity** If SATOD rates fell to 14%- approximately 430 fewer neonatal bed days- a saving of £169,205 per year
Reduce impact of SHS on children 200 staff trained in 2010/11 to raise awareness and support people to sign up to the project with the aim of recruiting 1,000 families. £3,600 to launch Take 7 Steps Outside- non-recurrent	Recruit families to Take 7 Steps Outside campaign	Implementation of systematically recruiting all families to Take 7 Steps Outside at every opportunity	Funded from existing budgets	**Prevention** Reduced admissions for childhood smoking-related diseases

[5] NICE costing template for PCTs and providers http://guidance.nice.org.uk/PH5/CostingTemplate/PCT/xls/English

Prevent children and young people from starting smoking Disseminate Regional Smoke and Mirrors campaign to local young people	Effective delivery of anti-smoking message to young people	Link in with the regional work on Smoke and Mirrors initiative and to strengthen communication methods for young people.	Cost of health mentors/ youth groups/ schools to implement	**Prevention** Long-term savings of treating fewer smoking-related diseases
Workplace policy Joint (TMBC) Workplace health improvement post £20,000- recurrent.	Workplace Health Improvement Officer to work in partnership with Workplace Smoking Advisor and partners to work more effectively with target groups including routine and manual workers.	Workplace Health Improvement Officer to recruit one company per month (12 per year) and refer 100 employees to SSS	Funded from existing budgets	**Productivity** Employers will save an average of £1664 per year in productivity for every smoker who quits[6]. 50 4-week quitters (assuming 75% relapse rate) would save £12,348 of outpatient and elective admissions[7]. **Prevention** 50 4-week quitters will lead to 5 fewer strokes and 6 fewer MIs over next 10 years

Top tips for reducing smoking related harm in Tameside and Glossop

All healthcare staff

-Systematically embed Ask, Advise, Act across whole system of primary and secondary care. Ensure all physicians and allied professionals are clear that this is a core duty of care.

-Ensure referrals to SSS are automatically built into care pathways for health conditions that are caused by or affected by tobacco, including pregnancy

[6] http://www.stopsmokingsolutions.co.uk/stopsmokingsolutions_truecosts.htm

[7] NICE costing template for PCTs and providers http://guidance.nice.org.uk/PH5/CostingTemplate/PCT/xls/English

Tier 2- stop smoking services

-Ensure a good quality service for smokers trying to quit, evidenced by the global use of carbon monoxide monitors to validate quits, low numbers of quitters lost to follow-up, and the routine and accurate recording of socio-economic status.

Local authority

-Ensure wide reach of workplace policy, including enforcement of smoke free grounds and cars and support for smokers to quit.

Schools and youth services

-Embed tobacco agenda into all schools, providing a healthy setting for children and young people.

-Promote not smoking as the norm.

-Encourage families to sign up to Take 7 Steps Out and engage young people with the Smoke & Mirrors campaign.

Appendix 2

Public Health Outcomes / QIPP Plan – Alcohol
SUMMARY

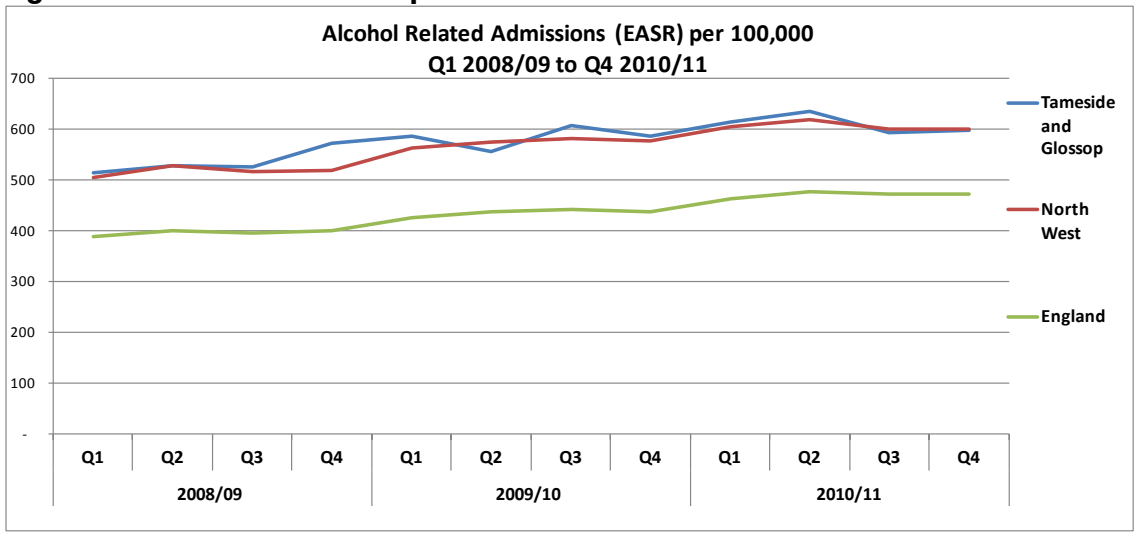
Case for change:
Alcohol harm in Tameside and Glossop is extensive and is an important factor that adversely affects the overall quality of life and perpetuates inequalities. According to Local Alcohol Profiles for England, compared with the national averages, Tameside has significantly worse harmful and binge drinking and worse, but not significantly worse, hazardous drinking.

There are an estimated 14,000 harmful drinkers and 6,000 dependent drinkers in Tameside and Glossop who would benefit from evidence based alcohol interventions. We also have a high rate of alcohol related hospital admissions.

Links to National Outcomes Frameworks:

- NHS Outcomes Framework 2012/13 – Under 75 mortality from liver disease
- Public Health Outcomes Framework 2013/16 – Alcohol related hospital admissions
-

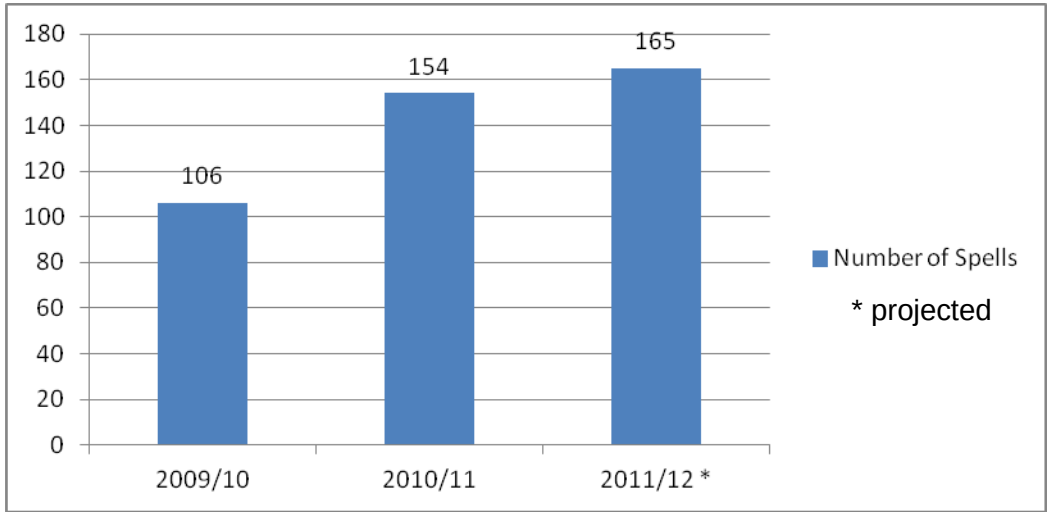
Figure 1: Alcohol related hospital admissions 2008/09 to 2010/11



(**Source:** http://www.lape.org.uk/index.html published October 2011)

The figure above shows the Rates for Alcohol Related Admissions per 100,000 population for the 3 years 2008/09 through to 2010/11 for Tameside & Glossop, the North West, and England. The admissions for 2010/11 are higher than in 2009/10, however the rate of increase is slower than for North West as a whole.

Figure 2: Hospital Spells for Alcoholic Liver Disease for Tameside and Glossop Residents, 2009/10 to 2011/12



Source: PBR 2012

The total number of hospital spells for alcohol liver disease increased by 45% between the financial years 2009/10 to 2010/11 with the total cost of alcohol liver disease increasing by approximately £209,000. For the financial year 2011/12 the number of spells is projected at 165 with an associated cost of £450,617.

Table 1: Benchmarking and recommendations for considerations

Current provision	Gaps in provision	Action needed	Investment needed	QIPP Outcomes
Tier 1: Identification and Brief Advice (IBA) delivered by a range of partners Hypertension LES in primary care	Lack of Social Marketing programme	Commissioning and delivery of social marketing campaign	**£50,000 to £60,000 New Investment (Non-recurrent)**	**Prevention:** behavioural change, leading to reduction in alcohol related harm. Promote self-help **Productivity:** workplace initiatives will raise
	No alcohol pathway for young people	Development and implementation of a young people's alcohol pathway	**£50,000 New investment (Non-recurrent)**	
	Healthy schools programme – alcohol will be a key topic	Commission the local healthy schools programme – delivery planned 2012/13	Funded from existing budget	

DES in primary care				awareness about alcohol harm and lead to a more productive workforce
	Workplace health	Implementation of the workplace health programme Workplace health post has been recently recruited and will work closely with public health	Jointly funded from existing budget	
Tier 1 & 2: Brief Intervention (BI) delivered in a range of settings BI LES in primary care CQUINs with Community Healthcare and Hospital	Lack of robust data (new monitoring system now in place) CQUIN - not on target for 2011/12.	CQUINs to continue BI LES has been commissioned	Funded from existing budgets	**Prevention:** behavioural change Reduction in alcohol related harm (this will reduce alcohol related hospital admissions)
	Not enough tier 2 provision in acute and community setting	Programme to increase tier 2 provision in acute and community	**£ 50,000** **Recurrent**	
Current provision	**Gaps in provision**	**Action needed**	**Investment needed**	**QIPP Outcomes**
Tier 2 & 3: NES DAS ADS Branching Out SUFSS Alcohol treatment requirements (ATR)	Integrated service for Tier 2 and 3 and community detox with link to a hospital liaison service. Holistic and systematic referral pathway is needed from all relevant community services such as criminal justice, probation etc.	Existing services redesigned and commissioned as an integrated service.	**£ 400,000** **Partly generated by service redesign and partly funded by new investment** **(Recurrent)**	**Quality:** better access across the tiered service **Innovation:** new model **Prevention:** reduced hospital admissions

Tier 4: Smithfield Chapman Barker Unit Approximately 73 patients will be seen at Smithfield and Chapman Barker Unit in 2011/12	Limited capacity for non-complex cases. No day care detox facility. Approximately 330 dependent drinkers should have access to specialist services	Development of tier 4 provision to support day care detox (and also provide inpatient support)	**£100,000 New investment (Recurrent)**	**Quality:** will provide safe daytime environment, avoiding the need for inpatient care **Innovation:** building capacity for detox with focus on re-integration.

Top tips for reducing alcohol related harm in Tameside and Glossop for adults

Social marketing:

- Social marketing campaign that is specifically targeted at adults with the aim of raising awareness of 25% of those engaged, which would lead to modified behaviour

Settings:

- Raise alcohol awareness through the delivery of workplace charter (as an award for local employers). Recruit 10 employers a year to deliver workplace award focussing on alcohol

Services:

- Service redesign to develop an integrated service for tiers 2 and 3 and community detox with a link to hospital liaison service by March 2013
- Systematic awareness raising of staff and robust approach around Brief Advice and signposting to ensure that services are used appropriately. Approximately 6250 people should reduce their drinking to within lower-risk levels as a result of 500 staff delivering alcohol IBA.
- Services should be acceptable, accessible and timely, underpinned by a clear outcome based performance framework. Based on evidence 330 dependent patients (1 in 18 dependent drinkers) would access specialist services.

Top tips for reducing alcohol related harm in Tameside and Glossop for children and young people

Social marketing:

- Social marketing campaign that is specifically targeted at children and young people with the aim of raising awareness of 25% of those engaged, which would lead to modified behaviour

Settings:

- Raise alcohol awareness in schools (through the local healthy schools programme). 50% of schools in Tameside to sign up to the delivery of the local healthy school programme by March 2013.

Services:

- Review the scale of investment for service targeted at children and young people by March 2013
- Develop of a comprehensive alcohol pathway by March 2013

Appendix 3

Public Health Outcomes/QIPP plan - COPD

Case for change:

COPD is an incurable disease of the lungs which is not fully reversible, unlike asthma, and is usually progressive. Early diagnosis and treatment can markedly slow the decline in lung function and lengthen the time patients can lead active lives.

There are an estimated 4,100 people missing from primary care COPD registers, and those that are registered (around 5,800 people) can experience poor disease management, leading to exacerbations and emergency admission to hospital. Indeed, COPD mortality has risen in recent years in Tameside and Glossop, whilst the rate fell nationally. A local COPD pathway is currently being developed for the first time and should be ready for implementation in Spring 2012 (issues highlighted by 'Gaps in provision' below are included within this pathway).

Links to Outcomes Frameworks:

- NHS Outcomes Framework 2012/13
  - 1.2. Under 75 mortality rate from respiratory disease
  - 2. Enhancing quality of life for people with long-term conditions
  - 4. Ensuring that people have a positive experience of care

- Public Health Outcomes Framework 2013-16
  - 4.7 Under 75 mortality rate from respiratory disease

Figure 1: COPD Directly Standardised Mortality Rates for Tameside and Glossop, 2001 to 2009 and projected to 2014.

Source: NHS Information Centre

Table 1: Benchmarking and recommendations

Current provision	Gaps in provision	Action needed	Investment needed	QIPP outcomes
Stopping smoking: Referral pathways in place across partner agencies , primary and secondary care to Stop Smoking Service (SSS) CQUINS in place with TGH and Community Services to increase referral.	Lack of systematic referral across COPD pathway. (see Tobacco Plan) Low CQUIN uptake (see Tobacco Plan)	Leadership/championing /commitment to ensure systematic referral within primary care as per pathway.	No additional resources needed – SSS can absorb additional capacity needed.	**Prevention:** £28,000-£88,000 could be saved /yr/100 smokers aged 45 that quit. **Quality** – improved quality of healthcare provided to at risk patients.
Early diagnosis: Inclusion on COPD disease register; provision of new spirometry equipment for primary care; provision of accredited training for PNs. Opportunistic lung function interventions via SSS and additional Know it, Check it, Treat it campaign. (1st outreach event: 64 tests; 14/22% were asked to see their GP.)	Wide practice variation: • QOF prevalence range: o 0.9% to 5.1%; o average 2.4%; o NW average 2.1%. o Eng average 1.6% • 5,849 on COPD register; estimated 4,111 missing. • Estimated actual/ expected prevalence: o T&G: 5.0% o NW: 4.3% o England: 3.6% Scale not large enough to effectively tackle quantity of those thought to be missing from registers.	Systematic implementation of case finding with at risk patients and quality diagnosis, including spirometry as per pathway. Case fining LES. Evaluation of Know it, Check it, Treat it campaign to inform further role out of similar events.	Increased early diagnosis will lead to increased prescribing costs – (see below); and increased QOF payments: **£120,000, recurrent** (if local prevalence rises to expected prevalence). **Non-recurrent:£40,000** to support renewed focus. **Recurrent: £25,000** needed every 2 years to renew training accreditation. **Recurrent: £16,000** /yr (4 -5 events/quarter). (Possibly covered by existing budgets–tbc).	**Prevention** – increased early diagnoses leads to more effective disease management and reduction in hospital admissions. **Quality** – improved quality of primary health care for at risk patients.

Current provision	Gaps in provision	Action needed	Investment needed	QIPP outcomes
Self management support for patients with COPD: development of self care plans; Expert Patient Programmes (EPP); and telehealth support for appropriate patients.	Inconsistent application, review and quality of self care plans within primary care. EPP: 12 COPD patients trained; 36-40 spaces commissioned for 2012/13. But low uptake amongst practices and patients. Telehealth capacity is 180, rising to 240 in 2011/12; 390 in 2012/13.	Systematic implementation of effective self care plans. Support and promotion of EEP amongst practices and patients. Continued evaluation of telehealth service and capacity.	No additional cost implications. Expert Patient Programme (EPP). EPP network needs support to be more successful post 2012/13. Telehealth funded from existing LTC budget.	**Prevention** – preventing exacerbations, progression and hospital admissions. **Quality:** Effective and quality care for COPD patients **Innovation:** new ways of supporting patients.
Regular and quality patient reviews.	Inconsistent application of NICE guidance and disease management reviews, including recording of patients' disease profile. (Addressed within new COPD pathway).	Systematic implementation of quality reviews as per pathway. Recording of patient disease profile to enable improved targeting/ funding of relevant interventions. Training/awareness raising for frontline staff.	Potential savings released from improved prescribing and prevention of hospital admissions. **£20,000** recurrent.	**Prevention** – preventing exacerbations, progression and hospital admissions. **Quality:** Effective reviews will ensure patients receive the most appropriate and relevant care.
Proactive disease management by health care professionals. Secondary care costs £900,000 higher than expected due to higher	Full implementation of NICE guidance.	Review of guidance against current practice, including prescribing.	Potential **£240,000 recurrent** (to be reviewed) needed for full implementation (which may take 3 yrs) due to increased case finding. But	**Prevention:** reduced hospital admissions/length of stays etc • Year 1: £100,000 • Year 3-5: total £450,000/ year if

Current provision	Gaps in provision	Action needed	Investment needed	QIPP outcomes
admissions and admission costs, and excess beds days.			offset by prescribing review.	admission rate lowered to NW rate, which is only 32% higher than expected.
Pulmonary Rehabilitation (PR); primary care review of patient pathway post exacerbation/ hospital discharge.	No Assisted discharge (AD) service; NICE suggests 150 or more capacity needed. Pilot for 10 patients running Feb-Apr 12. LTCT don't cover weekends; CARA are not COPD specialists.	Evaluation of pilot. Business case to be developed by June 2012.	**Recurrent: £100,000** to extend LTCT access and CARA specialism.	**Quality:** more effective and quality care for COPD patients.
	Inconsistent review of patients in primary care, post discharge.	Systematic implementation of quality reviews as per pathway.	No additional funding needed.	**Productivity:** Increased effectiveness of Oxygen service/review.
	PR: NICE suggests 575 or more capacity; but T&G capacity is less.	Review PR service and capacity against commissioning toolkit due spring 2012.	May need to increase PR investment until case management improvements become effective.	
	Home oxygen assessment/review service not currently available.	Service is currently being retendered/ commissioned.	**Recurrent £200,000** – offset against **£74,500** potential savings from validation of register.	
	Gaps in pathway between hospital, social care and intermediate support.	Improved links via implementation of pathway.	Re-enablement fund available to Local Authority could support pathway.	
	No ambulatory care pathway in place.	Ambulatory care pathway to be imple-mented by March 2012.	TBC	

Top tips

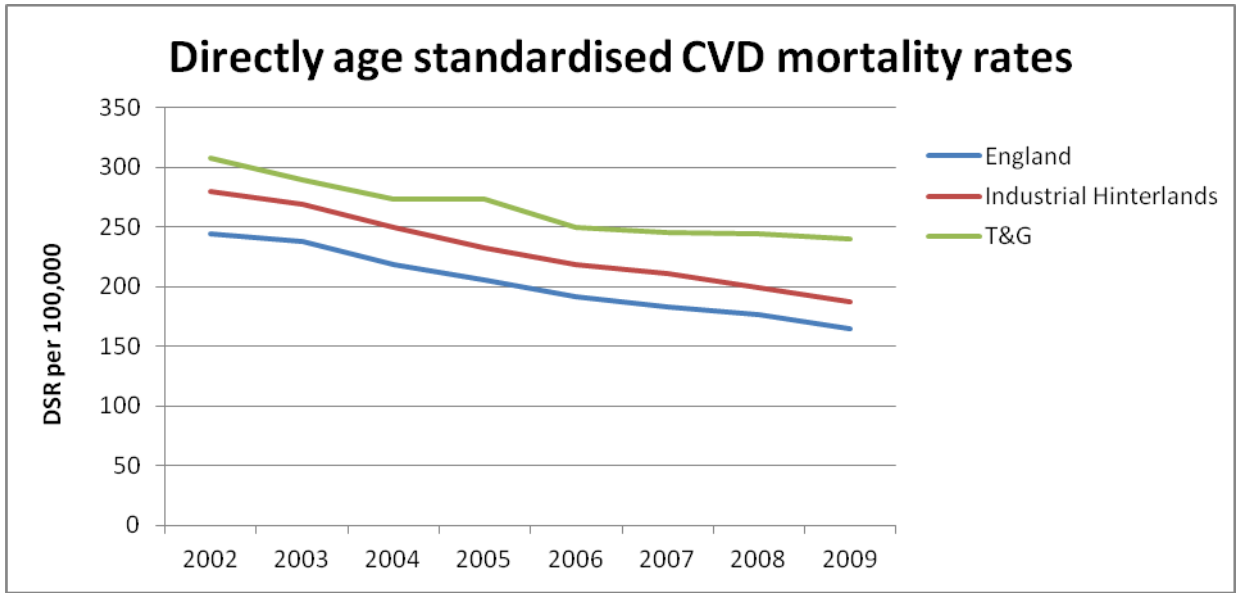
- Support from all agencies to implement new COPD pathway from Spring 2012, including understanding local COPD disease profile and systematic referral to SSS.
- Systematic case finding for early identification and diagnosis. Within 2 years:
  - Bottom 5 GP practices (current prevalence 0.9% - 1.4%) to reach PCT's average prevalence (2.4%).
  - PCT average to reach England's expected prevalence (3.6%).
- All patients should have an up-to-date and effective self management plan, possibly including EEP and telehealth, by March 2013:
- Proactive disease management via case and prescription review
- After hospital admission:
  - Ensure AD meets capacity and specification needed
  - GPs should review all patients post exacerbation/hospital admission.

Appendix 4

Public Health Outcomes/ QIPP Plans- Cardiovascular Disease
SUMMARY

Case for change:

Tameside & Glossop has a high rate of cardiovascular disease, which contributes significantly to a lower life expectancy for local residents than in England as a whole. Since 2006, deaths from CVD in Tameside and Glossop per 100,000 of population have not fallen significantly (see figure below) and account for 35% of all deaths[8], whilst nationally mortality continues to fall. About half of the decline during the 2000s in England is due to the prevention of CVD events and about half to improved acute medical treatment[9]. In 86% of CVD cases, risk factors are modifiable. As part of its overview function, the Personal and Health Services Scrutiny Panel will continue to monitor the effectiveness of services to reduce levels of CVD over the coming months and years.



Tobacco is considered in a separate report and has not been included here.

[8] NHS Tameside and Glossop CVD HNA report 2010

[9] Smolina K et al. Determinants of the decline in mortality from acute myocardial infarction in England between 2002 and 2010: linked national database study *BMJ* 2012;344:d8059 http://www.bmj.com/content/344/bmj.d8059

Links to Outcome Frameworks

PH Outcomes Framework:
-2.11 Diet
-2.12 Excess weight in adults
-2.13 Proportion of physically active and inactive adults
-2.17 Recorded diabetes
-2.22 Take up of the NHS Health Check programme- by those eligible
-4.4i Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)

NHS Outcomes Framework:
-1.1Under 75 mortality rate from all cardiovascular disease
-3.4 Improving recovery from stroke

Table 1: Benchmarking and recommendations

Current Provision	Gaps in provision	Action needed	Investment needed	QIPP Outcomes
NHS Health Checks (people aged 40-75 not already diagnosed with CHD, CKD or DM) Target: Each year invite 20% of eligible population (13,860) and deliver health check to 75% of those invited (10,395) Health Check budget 2010/11 £250,000 £87,000 staffing support for primary care	In 2010/11 Q1-3 combined 10,600 people have been invited and 4,437 received a health check (42%)	To achieve target 3,513 people invited in Q1-3 still need to receive a health check- implement best practice from high achieving practices to others	Continue staffing support for primary care- £87,000 non-recurrent Increase capacity for health trainers service to accept referrals for physical activity Prescribing costs	If targets met[10]: **Quality** 90 people diagnosed with diabetes **Prevention** 500 extra people prescribed statins (NNT to prevent one CVD event 32[11]). 300 extra people prescribed anti-hypertensives (5-year NNT to prevent one CVD event 34[12]-37[13]).

[10] Figures from DH Ready Reckoner
[11] http://guidance.nice.org.uk/CG67/CostingTemplate/xls/English
[12] Stafilas PC et al Efficacy and costs of treatment of mild-to-moderate uncomplicated hypertension in Greece American Journal of Hypertension 2005;18:228A http://www.nature.com/ajh/journal/v18/n4s/full/ajh2005924a.html
[13] Ferruci L et al Treatment of isolated systolic hypertension is most effective in older patients with high risk profile Circulation 2001;104:1923-1926 http://circ.ahajournals.org/content/104/16/1923.full

(2011/12 non-recurrent)				**Productivity** 69 fewer hospital admissions for CVD events saves £320,229[14]
QOF Registers Reduce gap between expected prevalence and number of patients on CHD, hypertension, TIA and diabetes disease registers Additional staffing support at individual practice level to identify the gap between the number of actual and expected patients on chronic disease registers. For practices already achieving maximum achievement extra payments for performance above this upper threshold	The PCT estimates the following patients are missing from current QOF registers based on expected prevalence (the range of numbers of missing patients in individual practices are shown in brackets) : CHD 1,338 (range from 52 more than to 119 fewer than expected prevalence) Hypertension 24,480 (range from 105 to 1,627 fewer than expected prevalence) Stroke 321 (range from 79 more than to 53 fewer than expected prevalence) CKD 1,740 (range from 116 more than to 278 fewer than expected prevalence)	Identify more patients with the following conditions: CHD: 134 per year Hypertension: 2,448 per year Stroke: 32 per year CKD: 174 per year Diabetes: 323 per year	Cost of support for practices and for extra payments above 90% QOF achievement- amount to be confirmed Cost of case finding £60,000 non-recurrent Primary Care Quality Team to find people, follow-up, chase non-responders IT solutions to aid practices to identify missing pateints	**Quality** To reduce variation in standard of care of patients across Tameside & Glossop **Prevention** Identification and appropriate treatment of CHD, hypertension, TIA, CKD and diabetes will prevent avoidable CVD events **Productivity** fewer hospital admissions for CVD events

[14] NICE National costing report: Prevention of cardiovascular disease June 2010http://www.nice.org.uk/nicemedia/live/13024/49325/49325.pdf: average cost of a hospital admission for a CVD event is £4614

	Diabetes 3,226 (range from 208 more than to 283 fewer than expected prevalence)			
Physical activity Health trainers to do initial assessments on 1560 people and develop Personal Health Plans on 936 people 2010-11 Partnership work related to promoting physical activity TMBC £7000 DCC £5000 2011-12 Partnership work related to promoting physical activity TMBC £7000 DCC £1000 Non recurrent programmes "My Active Life" TMBC £39350 DCC £6650	Over 1,000 people in Tameside and Glossop have CHD- they should all receive a referral to the health trainer service	Increase referrals of people with CVD risk factors to health trainers Pathway design to embed referral to health trainers for all patients identified at risk of CVD	Increase capacity for health trainers service to accept referrals for physical activity Primary care training- £10,000	**Quality** Care offered to patients with CVD risk factors **Prevention** To increase physical activity levels in patients with CVD risk factors Males running for an hour a week reduces their CVD risk by 42%[15]
Obesity Health trainers to focus on the prevention and management of obesity in children Weight Matters	Over 1,000 people in Tameside and Glossop have CHD- all those that are obese should receive a referral to the Weight Matters service	Increase referrals of obese people with CVD risk factors to Weight Matters Pathway design to	Weight Matters Contract- recurrent, to include advisor £16,472 recurrent- to scale up capacity to accept referrals for all over-	**Quality** Care offered to obese patients with CVD risk factors **Prevention** To achieve

[15] Tanasescu M, Leitzmann MF, Rimm EB, Willett WC, Stampfer MJ, Hu FB. Exercise type and intensity in relation to coronary heart disease in men. JAMA 2002;288(16):1994-2000.

Contract £?- part of Health Improvement contract with Pennine Care Additional 2011-12 investments Weight Matters advisor £16,472. Childhood obesity projects £61,920.		embed referral to Weight Matters for all obese patients identified at risk of CVD	weight and obese patients at risk of CVD. Childhood obesity projects £61,920 recurrent Primary care training- £10,000	downward trend in level childhood obesity
Cardiology QIPP plans Expansion of primary care based diagnostics and management for heart failure and acute chest pain Cost of GPwSI and diagnostic equipment £unknown	Targets for 2012-13: -Heart Failure Reduce Outpatients First appointments by 200 and follow-ups by 509 -Rapid Access Chest Pain Reduce outpatients first appointments by 126 and follow-ups by 252 -Reduce heart failure admissions by 42 -Reduce ECHOs by 300	Continue to divert patients from secondary care referrals to primary care diagnostics and management	Cost of GPwSI- recurrent and diagnostic equipment £unknown	**Productivity** Reduction in secondary care activity for cardiology
Stroke- quality of secondary care	TGH was in the lower quartile for the national Sentinel audit 2010: -Only 7% of patients received a CT scan within 1 hour (target 50%) and 81% within 24 hours (target 90%) -Only 61% of patients spent 90% of their time on a stroke unit (2010-11 Q4) -Fewer than 40% of patients with AF or stroke were anti-coagulated on discharge	To meet Sentinel audit targets for 2012-13	Funded from existing budgets	**Quality** Improved stroke outcomes **Productivity** Reduced length of stay

Top tips for reducing CVD ill health and deaths in Tameside and Glossop

Health Checks
-Invite 20% of eligible population and deliver health checks to 75% of those invited
QOF
-Identify missing people from chronic disease registers
Design and implement a pathway for universal care of all CVD patients
-Embed referrals to health trainers into treatment pathway for people with CVD risk factors
- To include referrals for; physical activity, obesity, affordable warmth
QIPP plans
-Use QIPP plans to divert care from secondary to primary care
Quality of care in hospital
-Use Sentinel audit to monitor improvement the quality of local stroke services in secondary care

Agenda item No: 6

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

DERBYSHIRE HEALTH AND WELLBEING STRATEGY: UPDATE ON DEVELOPMENT OF STRATEGY AND CONSULTATION

Purpose of the report

To update the Board on the process and revised timetable for consulting on, and developing the Derbyshire Health and Wellbeing Strategy.

Background

At the Health and Wellbeing Board meeting in January the Health and Wellbeing Strategy high level priorities were approved. This paper describes the plans in place for consulting on the high-level priorities and the full strategy when it is developed.

Information and analysis

Views on the high level priorities are currently being sought from a wide range of stakeholders, with a requested response date by 22nd April.

Key aspects of the initial consultation and engagement process:

- A survey questionnaire on the high-level priorities has been developed which can be completed electronically or as a paper copy. Paper copies are available on request and have also been distributed to all libraries and GP practices in Derbyshire. The consultation questionnaire can be accessed on https://www.surveymonkey.com/s/HealthPriorities
- Reports on the high-level priorities have been made to Cabinet and to the DCC Improvement and Scrutiny Committee in March. A report to the PCT Cluster Board will be made in April.
- Information on the high level priorities and the Health and Well Being Strategy development will also be presented to a number of key groups such as the Health and Social Care Forums, community forums, 50+ forums, LINk membership and the learning disability, mental health and BME forums.
- An article has been published in Derbyshire First which is circulated to all residents in Derbyshire County.
- A Stakeholder Event is planned for 30th March which will afford a further opportunity for stakeholders to discuss their views.

An Equality Impact Assessment is also being carried out and will inform the development of the Strategy.

Next Steps/Way Forward
Once all the responses have been collated from the initial consultation on the high-level priorities, the draft Health and Well Being Strategy will be published in May and a three month consultation on the full strategy will run between June and September 2012. The final strategy will presented to the Health and Wellbeing Board in September before being published in the autumn. A list of key dates is outlined below:

- Consultation on draft priorities - 22 April 2012
- Draft Strategy produced by - 23 May 2012
- Approval of draft Strategy for consultation by Board - 31 May 2012
- Formal consultation on draft Strategy - 1 June to 1 September 2012
- Approval of final Strategy by Board - 27 September 2012

Recommendation
That the Board note the plans for consulting on the strategy.

Alison Pritchard
Consultant in Public Health
NHS Derbyshire

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

DEVELOPMENT OF THE HEALTH AND WELLBEING BOARD

Purpose of the report

To put forward plans for the further development of the Shadow Health and Wellbeing Board.

Background

The Derbyshire Health and Wellbeing Board was established in shadow form in July 2011, following the requirements set out in the Health and Social Care Bill.

The Shadow Board is already making progress towards its core purpose, which is to join-up commissioning across the NHS, social care, public health and other services to improve health and wellbeing outcomes and better quality of care within available resources. Work to ensure the effective involvement of agencies and Elected Members will be required and the Board now needs to consider how it can make the most effective use of its capacity and add value as it moves forward.

Suggestions for further development

Board Development Day

Ensuring the Board continually develops to meet its core purpose and add value will be a priority over the next year. It may be appropriate to hold Development Days, which will give members the opportunity to have less formal discussions about how they want the Board to develop. This would also give members the opportunity to consider how they can work together on different areas to add value. This should enable the development of stronger working relationships amongst Board members and a clearer understanding of partner organisations cultures, working arrangements and priorities.

It is recommended that an independent facilitator lead part of the day to encourage members to look at issues from new or different points of view. Areas that may be useful to consider for discussion at such an event in Derbyshire include:

- Health and Wellbeing Strategy
- Aspirations for the Health and Wellbeing Board,
- An asset-based approach to health
- How information is shared
- How Board members will hold one another to account.

The Board may also wish to include discussions on specific public health issues, such as, Obesity, Physical Activity, Alcohol, Literacy etc, which align to Health and Wellbeing priorities.

Task and Finish Groups
At each of its meetings, the Board receives a number of reports and presentations covering a wide range of subjects. To take these items forward and develop them further the Board could establish Task and Finish Groups on particular priority areas, for examples on obesity, alcohol, diabetes, information sharing etc. The Groups would be required to put Board decisions and strategy into action and report progress to the Board on a regular basis.

Is an Equality Impact Assessment required? No

Recommendations
It is recommended that:

- A Board Development Day be arranged for late spring
- The Board establishes Task and Finish Groups on specific issues as and when required

David Lowe
Strategic Director – Policy and Community Safety
Derbyshire County Council

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

DELIVERING THE NATIONAL PUBLIC HEALTH AGENDA
THE NATIONAL FOREST

Purpose of the report
To inform the Board of the contribution made by the maturing National Forest to the health and wellbeing of local populations, especially hard-to-reach groups, and to ask for commitment to increase these benefits under the new public health arrangements.

Background
The National Forest stretches for 200 square miles across parts of Derbyshire, Staffordshire and Leicestershire. Forest cover has trebled to c20% of the area, most of which has public access. The population of the Forest is 200,000 with c10m people living within 90 minutes, including the population of Derby and other cities.

The National Forest won the Sustainable Development UK Award in 2008. Its creation is led by the National Forest Company, a small Non-Departmental Public Body supported by Defra. This year it will create c150ha of new forest: this compares favourably with something over 2000ha being created annually in England.

Parts of South Derbyshire lie within the forest, including parts of the Heart of the Forest around Moira, which has been extensively restored since mining, the town of Swadlincote and the forestry centre of Rosliston.

The health profile of South Derbyshire does not deviate greatly from national averages. National priorities of healthy life expectancy and reducing inequalities in healthy life expectancy and obesity are reflected in South Derbyshire.

The National Forest already provides an important outdoor setting for physical and mental health, thanks to the commitment and outreach work of those running facilities and programmes. The challenge is to use it more systematically through new commissioning arrangements.

Current Activity
The Heart of the Forest, on the border between South Derbyshire and Ashby de la Zouch in North West Leicestershire, is a c7 mile area, previously home to mining and extraction from which the land has been dramatically transformed. There is now a network of trails and attractions, including a

Youth Hostel, a Forestry Commission cycle centre with miles of paths and Conkers Visitor Centre. There is a weekly 3 mile Conkers run, a 10k race annually and opportunities for volunteering. This area is served by the National Forest Charitable Trust which is seeking to increase further community engagement.

At Rosliston Forestry centre, c 4000 people participated in 'Get Active in the Forest' in 2011. This programme is jointly funded by NHS Derbyshire, South Derbyshire District Council, the National Forest Company and fees and charges to users, with a core budget of c£55k pa. It won the National Lottery Best Sports Project in 2008 and is accredited within Natural England's Walking for Health initiative.

Provision at Rosliston Forestry Centre mirrors the 'life course approach', with activities for young people at risk of exclusion, adults with learning disabilities and mental health issues, parents with children and older people, some of whom are vital volunteer walk leaders. Over 300 people have participated in themed walks so far in 2011/12 and specialist groups are formed such as Nordic walking for people with mental health issues. Activity such as 'Bikeability' takes place across South Derbyshire schools and has reached 1500 pupils this year.

Research on the long-term health benefits of walking

Recent research has been carried out by Natural England on the longer-term impact of Walking for Health. This programme is intended to convert the less active to exercise. The evaluation found that many already enjoyed walking in some capacity before they joined and the average participant was white, non-disabled, middle-class, retired and female. Less than 7% said they were referred by their GP but 3 in 10 had one or more of the medical conditions on the questionnaire.

The findings were that the programme delivered modest activity increases for those with a pre-existing sedentary lifestyle and prolonged an active life for others. But it did not get the intended swathes of inactive people across the Government's 3 x 30 minutes a week threshold nor tapped harder to reach or diverse groups.

Whilst The National Forest is an amazing resource for everyone, the public investment in it is particularly justified through its reaching those who particularly need its benefits.

Making the most of walking and other outdoor exercise in The National Forest and beyond

Recognising findings such as these about the impact of outdoor health programmes, The National Forest has the potential to offer a sustained approach to increasing health through outdoor activity, avoiding the pitfalls of

preaching to the converted and targeting those who would most benefit. The outdoor health infrastructure is now in place and it is an important time in which to make the most of this health asset.

The area has:

- Awareness that some populations have health issues which need addressing in sustained and innovative ways.
- Concentrated outdoor health opportunities which are free and / or very easily accessible to a wide population.
- A non-elitist culture where everyone can ‘have a go’.
- A track record of partnership working to make the most of opportunities for health.
- Volunteers and social networks, which can encourage ongoing participation.

However, the opportunities are not yet fully or systematically exploited by local GP practices or other services and the take-up of facilities is reliant on outreach by those facilities. The National Forest would welcome the opportunity to be a frontrunner in using the new commissioning arrangements to increase exponentially the numbers of referrals to appropriate and well-managed programmes.

Is an Equality Impact Assessment required? No

Recommendations

1. The Board notes this report and the asset to health presented by The National Forest.
2. It notes the scale of activity already happening to improve the health of hard-to-reach groups.
3. It advises the National Forest Company and its partners on how new public health commissioning models could make full use of the outdoor facilities for health presented by the Forest.
4. It considers engaging with Rosliston Forestry Centre and its partners on the basis that this represents good practice which could be developed into a national exemplar of commissioning for Public Health.

Sophie Churchill
Chief Executive
The National Forest Company

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

DELIVERING THE PUBLIC HEALTH AGENDA – HOW TRANSPORT AND COUNTRYSIDE SERVICES CAN SUPPORT KEY HEALTH PRIORITIES

Purpose of the Report

To inform the Board of the important role that transport and countryside services can play in supporting the health and wellbeing agenda, and to provide contacts to initiate discussions and project development.

Background

Transport is not a means to an end in itself but exists to connect people to something or someone, somewhere. This is true whatever the journey purpose: those that are essential such as the trip to work, to school, to the shops or to health services; those that are more a matter of choice, but no less important, such as visiting friends or family, or for leisure purposes.

Transport and countryside services provide many of the links and facilities that enable people to get around, and some of the leisure activities that are the destination of those journeys. These services are therefore planned to play a key role in supporting wider agendas, whether they are social, economic or environmental. With appropriate direction and support, they can help to deliver the new, shared public health responsibilities too.

Information and Analysis

The county council manages and maintains a huge transport network that includes:

- 5,250km of road
- 4,200km of footway
- 50km of cycleway

The majority of the budget is spent on maintenance work to keep these assets in good physical condition and also clear of snow and ice in the winter. Improvements to the network ensure that facilities are safer and more accessible for users, with street lighting, pedestrian crossings, bus stops and shelters, traffic calming and traffic signs meaning that the needs of many different types of road user are catered for.

On top of the basic infrastructure network the authority provides a range of services that allow the network to be used safely, sustainably and affordably:

- Over 200 local bus services, plus transport services for school, special educational needs and adult care passengers
- Support for community transport schemes

- Education and training programmes to encourage road safety, whether walking, cycling or driving.
- Information on public transport services and other travel options for people across the county

The county council's countryside services also manage many of the facilities and attractions that encourage active and healthier lifestyles, and are accessed using the highway network and its services:

- 5,200km of public rights of way
- 300km of off-road greenway multi-user trails
- 5 country parks and 6 visitor centres
- 19 wildlife sites and 13 local nature reserves
- Numerous events to allow enjoyment of the countryside

Budgets for providing and maintaining these assets and services are under pressure, and the focus is on making service provision as effective and efficient as is possible. However, the funds available remain significant as is the service's capacity for supporting the health and wellbeing agenda. Some of the service efficiencies can be achieved by improving procurement and management. However, service effectiveness can be improved by tailoring these assets and services to achieve wider objectives, by achieving more with less, maximising partnership working or encouraging volunteering.

Delivering High Level Priorities – Tackling Health Inequalities

Transport and countryside services are provided by the county council's Environmental Services Department in conjunction with many other partners and organisations in the business and voluntary sectors. If these services are to be effective in supporting the work of the Health and Wellbeing Board, it is important that their role is properly understood and that the health and wellbeing objectives are incorporated in service provision and design.

One of the county council's highest priorities is to ensure that the transport network is as safe as possible for all users. This is achieved through physical improvements to infrastructure combined with education and training programmes aimed at changing personal behaviour. The overall trend in road casualties in Derbyshire is one of a significant reduction both in numbers and in severity. However, there remain issues of concern that may have an impact on health and wellbeing, such as inequalities in child casualty rates across the county or casualty numbers for older car drivers not reflecting the progress made for other groups.

Some examples of how transport and countryside services support the Marmot Review policy priorities are included below:

Giving children the best start in life

- Providing infrastructure, education and training and transport to ensure children get to school safely and on time
- Encouraging healthy ways to get to school that mean children are alert and ready to learn
- Creating green spaces and play opportunities for younger people

Enabling people to maximise their capabilities and have control over their lives

- Making transport more affordable for younger, older and disabled people through concessionary fares schemes for public transport
- Supporting community transport schemes for people unable to use conventional buses and trains
- Keeping roads and footways clear of snow on key routes and around priority services and facilities

Creating fair employment and good work for all

- Supporting economic growth through targeted transport investment in highways and transport services that encourage development of sites that provide new job opportunities
- Providing early morning and late evening bus services that support journeys to and from work
- Supporting Groundwork Organisations that equip people with practical skills and experience

Ensuring healthy standards of living for all

- Reducing the number of people killed or seriously injured on Derbyshire's roads through engineering improvements and targeted training and education programmes
- Providing transport services to shops, hospitals, GP surgeries and health centres
- Addressing traffic congestion, noise and air pollution to reduce the impact of transport on people's health

Creating and developing healthy and sustainable places and communities

- Using local materials and sensitive design to create a sense of "place"
- A network of easily accessible trails, country parks, wildlife sites and nature reserves that encourage exercise and a more active lifestyle
- Shaping new developments to support walking and cycling rather than just the car

Strengthening the role and impact of ill health prevention

- Prioritising community transport services for older people to attend well-being services or to access preventative health care
- Ensuring access to the countryside is available across the county and not just the national park

- Providing green health projects that can take GP referrals to provide exercise and tackle mental health issues

While these examples illustrate how the wider priorities of the review can be supported and delivered through transport and countryside services, the emerging high level priorities for the Health and Wellbeing Board can provide greater focus for some of these activities, such as:

- Supporting the drive for improving early years literacy by providing safe journeys to school on foot, by scooter, by bike or by bus
- Supporting self-care, independent living and avoidable mortality inequalities in elderly people by providing affordable and accessible transport to shops, social centres, health services
- Tackling obesity by making walking and cycling a safer, more natural choice for everyday journeys and as a leisure choice

Next Steps/Way Forward

The ability to assist in delivering wider objectives depends on an understanding of the issues to be resolved and on a collaborative approach to finding solutions.

It is proposed that a small group of Environmental Services Department officers acts as the contact point for members of the Board who may wish to explore how transport or countryside services might support the delivery of a health and wellbeing project. This small group would investigate and advise on the feasibility of proposals, liaise with other colleagues and partners where appropriate, and initiate the delivery of the transport and countryside elements of the project.

This collaborative approach worked well with the former Sustainable Communities Board as part of the Local Area Agreement, where a transport sub-group developed appropriate transport initiatives in support of wider objectives. The group included representatives from the county council, primary care trusts, Derbyshire Sport, community transport, parish council representatives and many others.

Initiatives included:

- A destination and motivational signage scheme in Tibshelf, aimed at encouraging walking and cycling to school and work using the Five Pits and Silverhill Trails
- A demand-responsive bus service in the area south of Ashbourne to improve rural accessibility to services
- Developing independent travel training initiatives to encourage younger people to use public transport, with a view to expanding to include older people in future.

Is an Equality Impact Assessment required? No

Recommendations
That the Board acknowledges the role that transport and countryside services have in helping to deliver health and wellbeing priorities and objectives, and that members contact the following officers to discuss and progress initiatives as appropriate:

- **Countryside services** - Allison Thomas, Assistant Director Planning and Environment
- **Transport services** - Geoff Pickford, Assistant Director Transport and Technical Policy

Geoff Pickford
Assistant Director Transport and Technical Policy
Derbyshire County Council

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

TOBACCO CONTROL SERVICES IN DERBYSHIRE: THE CURRENT SERVICE AND KEY ISSUES

Purpose of the report

To inform the Board about the Tobacco Control Services in Derbyshire and update them on the current service and key issues.

Background

In spite of the improvement in mortality in Derbyshire from cardiovascular diseases in recent years these diseases mainly coronary heart disease contribute to about 34% of all deaths. If respiratory diseases are included, excluding lung cancer, then these smoking related diseases in addition to cardiovascular disease contribute approximately 50% of all deaths.

Smoking is a significant factor in causing health related inequalities.

Smoking related diseases are a major burden to health and social care services in terms of outpatient attendances and inpatient admissions, inappropriate admissions and social care support for people with long terms conditions.

Smoking cessation is one of three components of tobacco control. The other two are preventing the uptake of smoking and avoiding harm to others e.g. passive smoking at home or in the car. Second hand smoke is a risk to the health of non-smokers, and, despite the legislation introduced in 2007, significant numbers of people continue to be exposed to the harmful effects of other people's smoke in the home environment.

Effective Tobacco Control requires both National e.g. the ban on smoking in public places and local measures such as effective local specialist services and producing a social norm for a non-smoking community. The purchase of cigarettes is price sensitive.

There is a National strategy *Healthy Lives, Healthy people: A Tobacco Control Plan for England.*

"*There is clear evidence that the most effective tobacco control strategies involve*
taking a multi-faceted and comprehensive approach at both national and local level"

(DoH 2011)

Information and Analysis
The strategy focuses on reducing the prevalence of smoking in adults over 18 years (18.5% or less by 2015); young people under 15 years (12% or less by 2015) and smoking in pregnancy (11% or less by 2015). These will be the priorities in Derbyshire but particularly focusing smoking cessation services on smokers from routine and manual occupations. There is Department of Health *Local Stop Smoking Services Service Delivery and Monitoring Guidance 2011/12.*

There is NICE public health / best practice guidance on smoking cessation services and technical appraisals on smoking cessation drugs. There are two specialist services in Derbyshire: 'Fresh Start' in Derby City and Derbyshire County Stop Smoking Services in Derbyshire County. Both services are managed by Derbyshire Community Health Services (DCHS).

For a person who smokes 20 cigarettes a day it costs them ~ £2000/ year at retail prices. Many smokers, particularly those from poorer communities purchase 'black market' cigarettes. Although customs and excise try to limit the sale of illegal tobacco products the service priorities do not always give tobacco products a high priority.

Trading Standards attempt to limit the sale of tobacco products to minors.

The specialist smoking service operates a young persons programme in schools. This includes smoking cessation clinics, and participation in schools personal and social education curriculum by working with parents and teachers and direct class input.

From April 2013 DsPH will be responsible for ensuring the effective delivery of tobacco control services according to need.

Derbyshire Action on Smoking.
Derbyshire Action on Smoking is a partnership of all the borough and district councils (including Derby City Council), Derbyshire County Council, Derbyshire Fire and Rescue Service, H M Revenue and Customs, Derbyshire Police, Connexions, Derby Hospitals, Derbyshire County Stop Smoking Service, Fresh Start and other agencies that have an interest in tobacco control.

The Partnership has been in existence for around twenty years and meets three or four times a year. The partnership has an action plan covering a wide range of tobacco control issues.

The main areas of work currently being developed by the partnership are:
- Sustaining and developing the DAS partnership
- Preventing the uptake of smoking by young people

- Supporting smoke free compliance in business premises claiming an exemption under the health Act 2006
- Smoke free homes and cars

The budget which is held by DCSSS is committed as follows:

- Interventions around preventing uptake of smoking. (training to over 3000 young people this financial year)
- Interventions to promote stopping smoking in the workplace
- Support for smoke free public places
- Coordinating the DAS Partnership
- Promoting Smoke Free Homes and Cars
- Providing training to raise awareness of the dangers of second hand smoke
- Monitoring and reporting on all of the above.

Derbyshire County Tobacco Control Steering Group (DTCSG)

The Group was set up in 2007 with the purpose of supporting and guiding the efforts needed to reduce tobacco related mortality and morbidity and to narrow the health inequalities caused by smoking and exposure to second hand smoke.

The PCTs main role has been to ensure that current provision is effective and efficient and to demonstrate that everything possible is being done to optimise the effectiveness of tobacco control. This includes that the targets for four week quitters are delivered ; that health inequalities for which smoking is a contributing factor are reduced by enhanced performance in deprived areas (e.g. Bolsover) and vulnerable groups (e.g. mental health service users).

Smoking Cessation

The major activity and expenditure of the PCT is in relation to smoking cessation. This activity is driven by a national performance target or ‘4 week quits’, which has been a ‘priority’ performance target for the PCT in recent years. This is a simple measure of performance i.e. a smoker sets a quit date with a specialist adviser and with pharmacological support, usually NRT, they have quit smoking 4 weeks later.

It is desirable to achieve this as efficiently and cost effectively as possible and more desirable to have at 52 week ‘quits’ and people giving up smoking permanently.

The majority of people who give up smoking do so without support. .They either just quit or they may purchase an NRT product over the counter. However this is the least effective way of giving up smoking with many smokers relapsing . For a successful quit attempt appropriate prescribing and behavioural support is necessary particularly for people with complex smoking histories.

There are three requirements to maximise the quit success rate: a smoker who is motivated to give up smoking; appropriate prescribing, and; behavioural support from a trained adviser.

People wanting support for smoking cessation will access a community pharmacist, their GP or contact directly the specialist stop smoking services (DCSSS) People are often signposted to specialist services either through contact with their GP, a visit to the dentist or following an inpatient admission.

The range of trained advisers include DCSSS staff, pharmacists and pharmacy technicians, practice nurses and practice health care assistants. Any professional who is in contact with smokers e.g. dental hygienists, occupational health staff can be trained as an adviser.

There are three drugs which are prescribed for smoking cessation. Two of these drugs varenicline and bupropion can only be prescribed by a general practitioner. Varenicline is the most prescribed drug.

The third drug is nicotine in the form a replacement therapy (NRT). It comes in many forms e.g. gums, patches, tablets, aerosol. Smokers with complex histories may have become addicted to nicotine in inhaled tobacco smoke and NRT is a 'pure' substitute without all the other harmful chemicals in tobacco smoke – but can be addictive.

NRT is supplied in several ways: over the county (supermarket, pharmacy) FP10 prescription by a GP or supplied by a trained adviser via a requisition form. A requisition form is a 'prescription' only for an NRT product which can be written by a trained adviser. The requisition forms are written by any professional who has been through accredited training provided by DCSSS and dispensed by a community pharmacist.

The PCT have contracts (Local Enhanced Service) with pharmacists and general practitioners for the provision of 'enhanced' smoking cessation services. This includes the additional training of staff under the requirements of the Adviser LES and the ability to write a requisition form for the supply of NRT by a pharmacist (NRT LES). Performance in terms of '4 week quitters' is remunerated. This fee structure is agreed with the LMC (local medical committee) and LPC (local pharmaceutical committee).

Not all practices and pharmacies have signed up for a local enhanced service. To dispense NRT community pharmacies have a contract – an NRT LES. This details the payment a pharmacist receives for processing the requisition form and dispensing NRT. This is in addition to the payments received under the Adviser LES. These fees are negotiated with the LPC. A prescription charge applies to all products. However a majority of clients are exempt prescription charges. Pharmacists obtain supplies of NRT at the best possible

price and charge the PCT at drug tariff rates. The overspend is largely due to the cost of NRT.

Finance
The budget with DCSSS is £1.14M after QUIPP savings have been made.
In addition there is a budget for Derbyshire Action on Smoking of £184k
The FP10 prescribing budget for NRT, Varenicline and Buprion is £813k.
Both the Pharmacy and GP LESs total £248k

Outline Strategy
A Tobacco Control sub-group of the Health and Wellbeing Board needs to be established and the member ship agreed. This group will provide the details of a Tobacco Control Strategy.

Issues to consider in the strategy are:

1. Measurement of the extent of the problem
2. Measures of performance .
3. Prevention of uptake including customs and excise and trading standards
4. Promoting non-smoking as a social norm and Making Every Contact Count
5. The role of primary care
6. The role of the specialist service
7. Efficiency and cost effectiveness and testing the market

Recommendation
That the Board note the contents of the report

Dr Tony Morkane
Consultant/Associate Director of Public Health
NHS Derbyshire

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 MARCH 2012

DERBYSHIRE SYSTEM INTEGRATED PLAN (DSIP)

1. Purpose of the Report

To inform the Board on the Derbyshire System Integrated Plan (DSIP).

2. Background and Context

The Derbyshire System Integrated Plan (DSIP) is the Derbyshire system plan to deliver national, regional and local priorities for 2012/13 and beyond. It focuses on delivering today and building for tomorrow by:

- Maintaining and improving quality and productivity.
- Reducing unwarranted clinical variation and eliminating duplication and waste.
- Ensuring tight financial control during 2012/13.
- Ensuring statutory functions continue to be delivered.
- Supporting transition to the reformed architecture of the NHS.

All PCT's are required to develop a similar Integrated Plan.

The DSIP has been built 'bottom up' with clinical commissioning groups (CCGs) and upper tier local authorities making significant contributions to all relevant elements of the plan.

It has also been developed in line with the requirements of the Midlands and East (M&E) SHA as set out in their commissioning framework.

There have been several iterations of the plan submitted to the SHA. SHA feedback has been positive and the cluster has responded proactively to strengthen the plan where required.

At the time of writing this paper the most current version of the DSIP is v4.0 which can be viewed at the following link:

http://www.derbycitypct.nhs.uk/documents-downloads/corporate-documents/

N.B. Please note there are also a large number of appendices at this link which Board members may or may not wish to also review.

3. Key Matters for Consideration

- All four Derbyshire CCGs have taken the DSIP v3.0 to their February Boards for approval.
- The Derbyshire Chief Executives Forum, which includes leadership from both City and County Councils formally signed off the DSIP v3.0 plan at the meeting on 2nd March.

The DSIP will continue to be refined iteratively following 9th March submission as required to support effective delivery

4. Assessing Equality Impact

The Derbyshire system integrated plan (DSIP) is the Derbyshire system plan to deliver national, regional and local priorities for 2012/13 and beyond. Successful delivery of the entirety of the plan should ensure the objectives of the Equality Delivery system are met:

- Better health outcomes for all.
- Improved patient access and experience.
- Empowered, engaged and well-supported staff.
- Inclusive leadership at all levels

5. Recommendation

Accept the Derbyshire System Integrated Plan for information

Trish Thompson
Director – External Relations
NHS Derbyshire

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

29 March 2012

HEALTH & WELLBEING ROUND-UP REPORT

Purpose of the report

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

Round-Up

Progress of the Health and Social Care Bill through Parliament

The Health and Social Care Bill completed its passage through the House of Lords on 20 March 2012, when the House of Commons considered the House of Lords amendments to the Bill. It now awaits Royal Assent and is expected to be passed into law before Easter.

NHS and Public Health budgets

The Department for Health has published baseline estimates for the new NHS and Public Health commissioning architecture. For Derbyshire, the 2012/13 public health budget is identified as £32.357m which equates to a spend per head of £40. In the East Midlands, spend per head ranges from £24 in Leicestershire to £52 in Leicester. This budget is based on the spend information provided by Derbyshire and Tameside and Glossop PCTs. The Department states that "whilst these should be recognised as estimates at this stage, and further analysis is needed before 2013/14 allocations can be set, they do support initial planning by emerging clinical commissioning groups and local authorities." Final allocations will be set later this year but the estimates provide a sensible basis for initial planning.

Clinical Commissioning Group (CCG) Update

As reported to the last Health and Wellbeing Board five clinical commissioning groups (CCGs) are being supported by the PCT clusters to move towards authorisation:

Erewash
Hardwick
North Derbyshire
Southern Derbyshire
Tameside and Glossop

The process to appoint to the three leadership posts of chair, chief financial officer and the accountable officer has started with CCGs asked to sponsor people they wish to nominate for these roles by end of March. The PCT and Strategic Health Authority (SHA) is also able to nominate people. Each of the

individuals will then go through an assessment process to determine their development needs followed by an assessment against the core competencies required to carry out the role. Once "accredited" as competent individuals they will enter the "pool" to which CCGs will advertise their posts.

The CCGs as organisations are also undertaking self assessments as part of the pre-authorisation process to enable the SHA to determine in which wave they will seek formal authorisation. It is envisaged at this stage that there will be four waves of approximately 60 CCGs starting in the summer and the process will review organisational competence against a number of domains including leadership, strategic plans, partnership working and patient and public engagement. This will include evidence submitted by the CCGs themselves but also questionnaires seeking feedback from key partners.

Public Health Transition

The Transition of Public Health to the County Council continues to make good progress with each of the work streams reporting positively at the Transition Steering Group. Highlights to report are the move into Chatsworth Hall of the senior Public Health team, detailed work on finance and contracts, due diligence and HR. There is senior leadership to this project and strong cooperation between the NHS and County Council teams.

The whole public health transition is monitored by the SHA and Derbyshire PCT Cluster has received positive feedback from SHA regarding progress to date.

An important meeting was held recently looking at the options for transferring public health responsibilities from Tameside and Glossop PCT to Tameside Metropolitan Borough Council and Derbyshire County Council. Much more work will be needed to ensure that this runs smoothly, and there will be a high level meeting in April or early may to establish some principles that will guide the transition.

HealthWatch

Amendments to what is now the Health and Social Care Act make clear that local authorities will be under a statutory duty to commission effective and efficient local HealthWatch organisations.

The key requirements are:

- Local HealthWatch organisations must be corporate bodies
- They must be not for profit organisations
- Local HealthWatch must be able to employ staff

There has also been a commitment to ensure that the public can easily identify all HealthWatch bodies, both at the local and national levels. This will be achieved through a programme of communication using local and national media, including voluntary sector and trade press, and making use of web-based communication.

At a local level the Derbyshire LINk contract has been extended to the end of March 2013 to ensure a smooth transition with the commencement of Derbyshire HealthWatch in April 2013. Members of the LINk Steering Group have been involved in discussions with the Project Lead relating to their continued involvement as volunteers representing their communities will have a positive contribution towards the success of HealthWatch. Information about the development of Derbyshire HealthWatch has been shared at the Children's Trust Board, South Derbyshire Health and Social Care Forum and with the North Derbyshire Voluntary Sector Forum. Young people and Community and Voluntary sector providers represented at these meetings noted their support for the overall aims of HealthWatch and would welcome further involvement when the service specification is drafted. It is planned to have procurement documentation including the service specification ready for September 2012 to achieve the deadline of having a HealthWatch service in place for April 2013.

Derbyshire Dignity Campaign

On 25 February 2011 the Derbyshire Dignity Campaign was launched as a joint Adult Care and Derbyshire NHS initiative. It is based on the Department of Health 10 point Dignity challenge. A bronze award has been developed and currently 73 teams or services across statutory and independent sector providers have applied. 33 have been successful. A silver standard is now being prepared for launch later in the year.

In addition to these awards, Adult Care Chesterfield and North Derbyshire Royal Hospital and Derbyshire Community Health Services have signed up to promote the 10 point challenge in support people being discharged from hospital.

Marmot Review

Following the publication of the report 'Fair Society, Healthy Lives' in 2010, (the Marmot Review into health inequalities in England), a set of national indicators - the Marmot indicators – have been developed.

The Marmot indicators are designed to illustrate inequalities relating to social determinants of health, health outcomes and social inequality. They are published for each local authority in England.

The 2012 data shows that Derbyshire is performing significantly **better** than the England average for the following indicators:

- Male life expectancy at birth
- Children achieving a good level of development at age 5
- People in households in receipt of means-tested benefits

Whereas Derbyshire is performing significantly **worse** than England for the following indicators:

- Inequality in male disability-free life expectancy at birth
- Young people not in employment, education or training (NEET)

Reducing health inequalities will be a key cross-cutting priority in the new Derbyshire Health and Wellbeing Strategy. The Marmot indicators will be published each year and will show the progress being made in Derbyshire.

The full indicators can be accessed on http://www.lho.org.uk//LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

The summary graph for Derbyshire is shown on the following page.

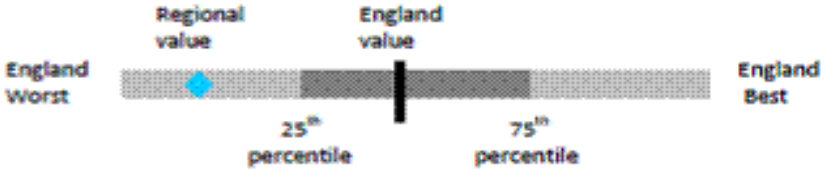
UCL Institute of Health Equity

London Health Observatory

Marmot Indicators for Local Authorities in England, 2012 - Derbyshire

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for this local authority is shown as a circle, against the range of results for England, shown as a bar.

- Significantly better than the England value
- Not significantly different from the England value
- Significantly worse than the England value



	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	78.8	78.4	78.6	73.6		85.1
2	Inequality in male life expectancy at birth (years)	7.7	9.0	8.9	16.9		3.1
3	Inequality in male disability-free life expectancy at birth (years)	12.6	11.2	10.9	20.0		1.8
	Females						
4	Female life expectancy at birth (years)	82.5	82.4	82.6	79.1		89.8
5	Inequality in female life expectancy at birth (years)	5.6	5.8	5.9	11.6		1.2
6	Inequality in female disability-free life expectancy at birth (years)	9.8	9.7	9.2	17.1		1.3
	Social determinants						
7	Children achieving a good level of development at age 5 (%)	61.3	59.4	58.8	49.5		71.4
8	Young people not in employment, education or training (NEET) (%)	8.5	6.1	6.7	12.3		2.6
9	People in households in receipt of means-tested benefits (%)	12.2	13.3	14.6	32.8		4.7
10	Inequality in percentage receiving means-tested benefits (% points)	25.4	26.0	29.0	55.1		4.6