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**Members of the Shadow Health and Wellbeing Board**

Tel: 01629 538324  
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Ref:  
Date: 24 May 2012

Dear Member

**Shadow Health and Wellbeing Board**

Please attend the meeting of the **Shadow Health and Wellbeing Board** to be held on **Thursday 31 May 2012** commencing at **10.00am** in **Committee Room No 1, County Hall, Matlock**

The agenda is set out below.

Yours faithfully



**John McElvaney**  
**Director of Legal Services**

**AGENDA**

1. Introductions and Apologies for Absence
2. To confirm the minutes of the meeting held on 29 March 2012
3. Developing the Draft Health and Wellbeing Strategy for Derbyshire
  - Consultation Results
  - Draft Strategy
4. Clinical Commissioning Groups Authorisation (Presentation)
5. 21<sup>st</sup> Century Health Public Engagement Process

6. Integrated Care Work Programmes Across Derbyshire
7. Information Sharing for Planning and Commissioning Services for Children and Families
8. Children and Young People's Joint Commissioning Priorities
9. Provider Engagement
10. Health and Wellbeing Board Round-Up Report

**MINUTES** of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 29 March 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
Dr A Dow	Tameside & Glossop Clinical Commissioning Group
Councillor C A Hart	Derbyshire County Council
I Johnson	Derbyshire County Council
Councillor C W Jones	Derbyshire County Council
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
R Marwaha	Erewash Clinical Commissioning Group
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
G Smith	NHS Tameside and Glossop
W Sunney	Hardwick Health Clinical Commissioning Group
T Thompson	NHS Derbyshire Cluster
Councillor R J Wheeler	South Derbyshire District Council

Also in Attendance – S Churchill (The National Forest Company), J Cox (Derbyshire County Council), Councillor S J Ellis (Derbyshire County Council), Councillor G Farrington (Derbyshire County Council), Councillor P Makin (Derbyshire County Council), Dr T Morkane (NHS Derbyshire), G Pickford (Derbyshire County Council), A Pritchard (NHS Derbyshire Cluster), L Wild (Derbyshire County Council)

Apologies for absence were submitted on behalf of H Bowen, A Layzell and S Savage

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

**13/12** **REVISED PLAN TO DELIVER THE STRATEGY FOR ACCOMMODATION, SUPPORT AND CARE FOR OLDER PEOPLE IN DERBYSHIRE** The Board was provided with details of the County Council's plans for the modernisation of accommodation, care and support for older people. The report that had been presented to the County Council's Cabinet

on 20 February 2012 had been circulated to Board members, and this had given specific details of the proposals. It was stated that the strategy was underpinned by an overall investment worth £200m in accommodation, care and support for older people. The plan attempted, wherever possible, to offer older people the option of an Extra Care facility within five miles of their current home and access to specialist services for dementia within ten miles of their current home.

Consultation had previously taken place on the developments in residential and community care services for older people, and this had included residents of care homes and day centres, relatives and staff. This consultation had stated that the plan was to look closely at the current 27 residential homes and day centres to establish which ones could be adapted and used alongside new services and facilities, and which ones would not be suitable. Cabinet had received the feedback from the first stage consultation, and had also agreed that second stage consultation would be undertaken with relevant parties where they were affected by specific proposals to implement the revised plan.

It was stated that stage 2 consultation would involve a separate consultation in respect of each establishment, and the outcome of each consultation would be reported back to Cabinet prior to any decision being made to close a particular home. The current proposal was that, subject to consultation, ten establishments would be redeveloped. It was the intention to commence the consultation as soon as possible, and this would be phased between April 2012 – March 2013. The outcome of the consultation would be the subject of future Cabinet reports. In the event of a decision being made to close an individual home, the transfer of residents to an alternative setting would be dependent on a full community care assessment being carried out in respect of every resident showing that they could be safely accommodated elsewhere.

Although the Board was in agreement with the proposals, it was felt that there needed to be inclusion of the Clinical Commissioning Groups and also individual GP practices where they had a link to individual homes. It was also stated that a timeline would be developed to highlight which areas of the county would be affected at a particular time.

It was emphasised to the Board that although the results of the Stage 1 consultation had been agreed, Cabinet had so far only agreed to the commencement of Stage 2 consultation. No decision would be made until after the consultation had taken place, and further details would be provided when appropriate.

**RESOLVED** to receive the report and endorse the stage 2 consultation, which will be undertaken with relevant parties where they are affected by

specific proposals to implement the revised plan to modernise accommodation, care and support for older people.

**14//12 ADULT CARE AND JOINT COMMISSIONING PRIORITIES**

**2012/13** The Adult Care Board had recently considered the Joint Commissioning Priorities for 2012/13, and subject to some minor amendments, had approved the proposals and had agreed to seek endorsement from the Shadow Health and Wellbeing Board. The proposals for 2012/13 built on some previous priorities, but also identified some new priority areas following discussions with the Clinical Commissioning Groups.

Details were given of the priorities agreed by the Adult Care Board, together with the key points of focus for each priority. These included safeguarding, frail older people and dementia, carers, learning disability, disabled people or people with a sensory impairment, transition to adult life, implementation of the Autism Act, and mental health services. It was stated that a group had been identified to take the work forward.

**RESOLVED** to endorse the Joint Commissioning Priorities between Adult Care and the local NHS for 2012/13.

**15/12 TAMESIDE AND GLOSSOP JOINT STRATEGIC NEEDS ASSESSMENT REVIEW 2012**

The Board was informed of the content and recommendations from the Tameside and Glossop JSNA Outcomes Review 2012. The issues relating to Glossop were highlighted, and these would be fed into the Derbyshire JSNA.

**RESOLVED** to (1) receive the report.

**16/12 DERBYSHIRE HEALTH AND WELLBEING STRATEGY UPDATE ON DEVELOPMENT OF STRATEGY AND CONSULTATION**

At the last meeting of the Board, the Health and Wellbeing Strategy high level priorities had been approved. Details were given on the plan for consulting on the high-level priorities and the full strategy when it was developed.

Views on the high level priorities were currently being sought from a wide range of stakeholders, and the requested response date was 22 April. The key aspects of the initial consultation and engagement process were stated:-

- A survey questionnaire on the high-level priorities had been developed
- Reports on the high-level priorities had been made to Cabinet and the County Council's Improvement and Scrutiny Committee. A report to the PCT Cluster Board was due to be presented in April.
- Information on the high level priorities and the Health and Wellbeing Strategy development would 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 had been published in Derbyshire First, which was circulated to all residents in the county
- A stakeholder event had been planned for 30 March, which would give stakeholders a further opportunity to discuss their views.

Once all the responses had been collated from the initial consultation on the high-level priorities, the Board would approve a draft Health and Wellbeing Strategy for consultation between June – September 2012. It was the intention to present the final strategy to the Board at its meeting on 27 September before it was published in the autumn.

**RESOLVED** to note the plans for consulting on the strategy.

#### **17/12 DEVELOPMENT OF THE HEALTH AND WELLBEING BOARD**

It was reported that the Shadow Health and Wellbeing Board was already making progress towards its core purpose, which was 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 would be required, and consideration needed to be given as to how the Board could make the most effective use of its capacity and add value as it moved forward.

It was suggested that it would perhaps be appropriate to hold Development Days, which would give members the opportunity to have less formal discussions about how they wanted the Board to develop, and consider how they could work together.

At each meeting, the Board received a number of reports and presentations covering a wide range of subjects. To ensure that these items were taken forward and developed, it was suggested that the Board established Task and Finish Groups on particular priority areas.

**RESOLVED** that (1) a Board Development Day be arranged for late spring; and

(2) the Board establishes Task and Finish Groups on specific issues as and when required.

**18/12 DELIVERING THE NATIONAL PUBLIC HEALTH AGENDA – THE NATIONAL FOREST** The Board received a presentation from Sophie Churchill, Chief Executive of the National Forest Company, on the contribution

made by the National Forest to the health and wellbeing of local populations, especially hard to reach groups.

The National Forest covered 200 square miles across parts of Derbyshire, Staffordshire and Leicestershire, and forest cover had trebled to around 20% of the area, most of which had public access. The National Forest already provided an important outdoor setting for physical and mental health, but the challenge was to use it more systematically through new commissioning arrangements.

In terms of current activity, there was now a network of trails and attractions, including a cycle centre. At Conkers Visitors Centre, there was a weekly three mile Conkers run, a 10k race annually and opportunities for volunteering. At Rosliston Forestry Centre, around 4000 people had previously participated in 'Get Active in the Forest'. This programme was jointly funded by NHS Derbyshire, South Derbyshire District Council, the National Forest Company, and fees and charges to users, and had been accredited with Natural England's Walking for Health Initiative.

Provision at Rosliston Forestry Centre was said to mirror 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. Over 300 people had so far participated in themed walks in 2011/12, and activity such as 'Bikeability' had taken place across South Derbyshire schools.

It was stated that recognising findings about the impact of outdoor health programmes, the National Forest had the potential to offer a sustained approach to increasing health through outdoor activity. The outdoor health infrastructure was now in place, and it was felt that it was an opportune time in which to make the most of this health asset. The area had:-

- Awareness that some populations had health issues which needed to be addressed in sustained and innovative ways
- Concentrated outdoor health opportunities which were free and/or very easily accessible to a wide population
- A non-elitist culture where everyone could 'have a go'
- A track record of partnership working to make the most of opportunities for health
- Volunteers and social networks, which could encourage ongoing participation

Despite this, it was stated that the opportunities were not yet fully exploited by local GP practices or other services. As such, The National Forest wanted the opportunity to be a frontrunner in using the new

commissioning arrangements to increase the number of referrals to appropriate and well-managed programmes.

**RESOLVED** to (1) note the report and the asset to health presented by the National Forest;

(2) note the scale of activity already happening to improve the health of hard-to-reach groups;

(3) advise 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; and

(4) consider 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.

**19/12 DELIVERING THE PUBLIC HEALTH AGENDA – HOW TRANSPORT AND COUNTRYSIDE SERVICES CAN SUPPORT KEY HEALTH PRIORITIES** The Board received a presentation from Geoff Pickford, Assistant Director Transport and Technical Policy, Derbyshire County Council, on the role that transport and countryside services played in supporting the health and wellbeing agenda.

The County Council managed and maintained a transport network that included 5,250km of road, 4,200km of footway and 50km of cycleway. On top of the basic infrastructure network, the authority provided a range of services that allowed the network to be used safely, sustainably and affordably. This included over 200 local bus services, support for community transport schemes, education and training programmes to encourage road safety, and information on public transport services and other travel options.

The County Council's Countryside Services managed many of the facilities that encouraged active and healthier lifestyles, and were accessed using the highway network. This included 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, and a number of events to enable enjoyment of the countryside.

Some examples were given of how transport and countryside services supported the Marmot Review policy priorities – giving children the best start in life, enabling people to maximise their capabilities and have control over their lives, creating fair employment and good work for all, ensuring healthy standards of living for all, creating and developing healthy and sustainable places and communities, and strengthening the role and impact of ill health prevention. Although these illustrated how the wider priorities of the review



could be supported and delivered through transport and countryside services, the emerging high level priorities for the Health and Wellbeing Board could provide greater focus for some of the activities, for example:-

- 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.

In terms of the way forward, it was proposed that a small group of officers from the Environmental Services Department act as the contact point for members of the Board who might wish to explore how transport or countryside services could support the delivery of a health and wellbeing project. This group would investigate and advise on the feasibility of proposals, liaise with other colleagues and partners, and initiate the delivery of the transport and countryside elements of the project.

**RESOLVED** to acknowledge 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

**20/12 TOBACCO CONTROL SERVICES IN DERBYSHIRE: THE CURRENT SERVICE AND KEY ISSUES** It was reported that smoking was a significant factor in causing health related inequalities, and smoking related illnesses were a major burden to health and social care services. Smoking cessation was one of three components of tobacco control, the other two being preventing the uptake of smoking and avoiding harm to others.

There was a national strategy, 'Healthy Lives, Healthy People: A Tobacco Control Plan for England'. This focussed on reducing the prevalence of smoking in adults over 18 years, young people under 15 years and smoking in pregnancy. These would be the priorities in Derbyshire, but particularly focussing smoking cessation services on smokers from routine and manual occupations.

There were two specialist services in Derbyshire – Fresh Start in Derby City and Derbyshire County Stop Smoking Services in Derbyshire County.

Both services were managed by Derbyshire Community Health Services. The specialist smoking service operated a young person's programme in schools, and this included smoking cessation clinics, and participation in the personal and social education curriculum. From April 2013, DsPH would be responsible for ensuring the effective delivery of tobacco control services according to need.

Derbyshire Action on Smoking was a partnership of all the Borough and District Councils, Derby City Council, Derbyshire County Council, and a range of other agencies that had an interest in tobacco control. The Partnership had an action plan covering a wide range of tobacco control issues, and the main areas of work currently being developed by the Partnership were detailed. The budget, which was held by Derbyshire County Stop Smoking Service, was committed for interventions around preventing uptake of smoking, 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, and monitoring and reporting on these issues.

The Derbyshire County Tobacco Control Steering Group had been set up to support and guide 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 had been to ensure that current provision was effective and to demonstrate that everything possible was being done to optimise the effectiveness of tobacco control. This included that the targets for four week quitters were delivered, that health inequalities for which smoking was a contributing factor were reduced by enhanced performance in deprived areas, and vulnerable groups.

The major activity and expenditure of the PCT was in relation to smoking cessation, and this was driven by a national performance target or '4 week quits', which had been a priority performance target for the PCT. There were three requirements to maximise the quit success rate – a smoker who was motivated to give up smoking, appropriate prescribing, and behavioural support from a trained adviser. People wanting support for smoking cessation would access a community pharmacist, their GP or contact the specialist stop smoking services. People were often signposted to specialist services, and the range of trained advisers was highlighted. There were three drugs prescribed for smoking cessation, and one was nicotine in the form of a replacement therapy (NRT).

The PCT had contracts (Local Enhanced Service) with pharmacists and general practitioners for the provision of 'enhanced' smoking cessation services. This included the additional training of staff and the ability to write a

requisition form for the supply of NRT by a pharmacist. It was noted that not all practices and pharmacies had signed up for a local enhanced service.

It was suggested that a Tobacco Control Sub-Group of the Health and Wellbeing Board needed to be established, and this group would provide the details of a Tobacco Control Strategy. A number of issues that could be considered in the strategy were presented.

**RESOLVED** to note the report.

**21/12**      **DERBYSHIRE SYSTEM INTEGRATED PLAN** The Derbyshire System Integrated Plan (DSIP) was the plan to deliver national, regional and local priorities for 2012/13 and beyond. It focussed on delivering now and building for the future by maintaining and improving quality and productivity, reducing unwarranted clinical variation and eliminating duplication, ensuring tight financial control during 2012/13, ensuring that statutory functions continue to be delivered, and supporting transition to the reformed architecture of the NHS. All PCT's were required to develop a similar Integrated Plan.

The DSIP had been built 'bottom up' with CCGs and upper tier local authorities making significant contributions to all relevant elements of the plan. It had also been developed in line with the requirements of the Midlands and East SHA. There had a number of versions of the plan submitted, and details were given of where to view the most current version.

All four Derbyshire CCGs had taken the DSIP to their Board meetings in February for approval, and the Derbyshire Chief Executive's meeting had formally signed off the document at the meeting on 2 March 2012.

**RESOLVED** to accept the Derbyshire System Integrated Plan for information.

**22/12**      **NHS COMMISSIONING BOARD/DIRECT COMMISSIONING**  
The Board received a presentation from Trish Thompson, Director of External Relations, NHS Derbyshire Cluster, on the NHS Commissioning Board and Direct Commissioning.

The Health and Social Care Bill had recently been passed, and this had radically redesigned the commissioning of health services at both a national and local level with the creation of CCGs, Public Health into local authorities, Public Health England, and Direct Commissioning into one body. The NHS Commissioning Board would have responsibility for direct commissioning, but it was felt that a more localised structure would need to be developed.

The vision and aim was to achieve excellence in primary care provision through commissioning which delivered a consistent offer to patients,

consistently built on the best clinical practice, gave equality of opportunity to providers, and provided great jobs for primary care commissioning staff.

The central element of the system, would provide the performance frameworks, central policies and procedures which local teams would use to transact relationships with providers and give routine assurance to the Board of the safety and effectiveness of provision. The local element of the system would comprise people working across health and care for the local office teams. It was noted that it would be within the local context that the majority of commissioning activity would be undertaken, and it was felt that local office teams were essential to maintain effective relationships with contractors that had been built up over a number of years. The relationship between the local and central teams would provide the space for all partners working locally to inform and drive the national strategy for the commissioning of primary care.

It was stated that there would be a number of opportunities, and the new primary care commissioning system would require individuals who did not believe that the job stopped once they had assurance that the basic contract had been delivered. Whilst the contractual relationship with GP practices sat with the NHS Commissioning Board, the actual day to day relationships would be within CCGs, and local office primary care commissioners would therefore need to work within these relationships. The local authority led JSNA processes would need to be aligned effectively with the NHS Commissioning Board strategy. Public Health England, through local authorities, would need to have a very clear strategic relationship with local teams in developing oral health strategies and delivering a more effective care pathway commissioning, and CCGs and the NHS Commissioning Board local office teams would need to work together on eye care pathway development.

Further discussions would take place over how this would impact in Derbyshire, and there would be a report to a future meeting of the Board.

**23/12**      **ROUND UP REPORT** A round-up of key progress in relation to Health and Wellbeing issues and projects was given.

The Health and Social Care Bill had completed its passage through the House of Lords on 20 March 2012. It now awaited Royal Assent, and was expected to be passed into law before Easter.

The Department for Health had published baseline estimates for the new NHS and Public Health commissioning architecture. For Derbyshire, the 2012/13 public health budget had been identified as £32.357m, which equated to a spend per head of £40. The budget was based on the spend information provided by Derbyshire and Tameside and Glossop PCTs. Final allocations would be set later in the year.

As reported at the last meeting of the Board, five CCGs were being supported by the PCT clusters to move towards authorisation. The process to appoint to the three leadership posts of chair, chief financial officer and accountable officer had commenced, with CCGs being asked to sponsor people they wished to nominate for the roles by the end of March. Individuals would then go through an assessment process, and once accredited as competent, they would enter the 'pool' to which CCGs would advertise their posts.

CCGs were also undertaking self-assessments as part of the pre-authorisation process to enable the SHA to determine in which wave they would seek formal authorisation. It was envisaged that there would be four waves of around 60 CCGs starting in the summer, and the process would review organisational competence against a number of domains.

The transition of Public Health to the County Council continued to make good progress, and highlights were the move into Chatsworth Hall of the senior Public Health team, detailed work on finance and contracts, due diligence and HR. The whole public health transition was being monitored by the SHA, and Derbyshire PCT Cluster had received positive feedback regarding progress to date. A meeting had been held recently to look at the options for transferring public health responsibilities from Tameside and Glossop PCT to Tameside Metropolitan Borough Council and Derbyshire County Council. More work would be required to ensure that this ran smoothly, and there would be a high level meeting in April/May to establish some principles that would guide the transition.

Amendments to the Health and Social Care Bill made clear that local authorities would be under a statutory duty to commission effective and efficient local HealthWatch organisations, and the key requirements were detailed. There had also been a commitment to ensure that the public could easily identify all HealthWatch bodies, both locally and nationally. This would be achieved through a programme of communication using local and national media.

The Derbyshire LINK contract had 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 had been involved in discussions with the Project Lead relating to their continued involvement as volunteers representing their communities. Information about the development of Derbyshire HealthWatch had been shared with a range of Boards, and it was reported that young people and community and voluntary sector providers represented at these meetings had noted their support for the overall aims of HealthWatch and would welcome further involvement when the service specification had been drafted. It was the intention to have

procurement documentation, including the service specification, ready for September 2012.

The Derbyshire Dignity Campaign had been launched as a joint Adult Care and Derbyshire NHS initiative in February 2011, and this was based on the Department of Health 10 point Dignity challenge. A bronze award had been developed, and currently 73 teams or services had applied, with 33 being successful. A silver standard was now being prepared for launch later in the year. Adult Care, Chesterfield and North Derbyshire Royal Hospital and Derbyshire Community Health Services had signed up to promote the 10 point challenge to support people being discharged from hospital.

Following the publication of the report 'Fair Society, Healthy Lives', a set of national indicators had been developed. The Marmot indicators had been designed to illustrate inequalities relating to social determinants of health, health outcomes and social inequality. These were published for each local authority in England. The 2012 data showed that Derbyshire was performing significantly better than the England average for the indicators relating to male life expectancy at birth, children achieving a good level of development at age 5, and people in households in receipt of means-tested benefits. However, Derbyshire was performing significantly worse than England in indicators relating to inequality in male disability-free life expectancy at birth and young people not in employment, education or training. Reducing health inequalities would be a key cross-cutting priority in the new Derbyshire Health and Wellbeing Strategy. The Marmot indicators would be published annually and would show the progress being made in Derbyshire.

## SHADOW DERBYSHIRE HEALTH AND WELLBEING BOARD

31 May 2012

### DEVELOPING THE DRAFT HEALTH AND WELLBEING STRATEGY FOR DERBYSHIRE

#### 1. Background

At the Health and Wellbeing Board meeting in January 2012 the five proposed high-level priorities for Derbyshire were approved.

A Derbyshire-wide public consultation on these proposed priorities was then undertaken in March and April 2012 by means of a questionnaire. The consultation closed on 22 April and a summary of survey responses received is included in the annex below.

The draft Health and Wellbeing Strategy for Derbyshire has been developed following the responses received.

Overall the consultation showed broad support for the proposed priorities and the focus areas for Derbyshire:

- Improve health and wellbeing in early years. Every child fit to learn and able to fully develop their potential communication, language and literacy skills. *(72% agreed with this priority)*
  - **In Derbyshire we will focus on early intervention and identification of vulnerable children and families (including children with disabilities)** *(91% agreed this should be the focus for Derbyshire)*
- Promote healthy lifestyles by developing services to prevent and reduce harmful alcohol consumption, substance misuse, obesity, physical inactivity, smoking and sexual ill-health. *(72% agreed with this priority)*
  - **In Derbyshire we will focus on preventing and reducing alcohol misuse, obesity and physical inactivity.** *(88% agreed this should be the focus for Derbyshire)*
- Improve emotional and mental health and provide increased access to mental health support services. *(67% agreed with this priority)*
  - **In Derbyshire we will focus on improving access to evidence-based primary care psychological therapies and other local services that support recovery from mental health problems.** *(86% agreed this should be the focus for Derbyshire)*

- Promote the independence of all people living with long term conditions and their carers. *(66% agreed with this priority)*
  - **In Derbyshire we will focus on community based support, self-care and care close to home, including increased use of evidence-based telehealth and telecare.** *(77% agreed this should be the focus for Derbyshire)*
- Improve the health and wellbeing of older people and promote independence into old age. *(67% agreed with this priority)*
  - **In Derbyshire we will focus on strengthening integrated working between health and social care providers and housing-related support services.** *(88% agreed this should be the focus for Derbyshire)*

## 2. Recommendation

The Health and Wellbeing Board to approve the draft strategy for full (three month) public consultation, subject to:

- Comments made at the HWB Board meeting
- Final sign off by the Chair.

**Alison Pritchard**  
**Consultant in Public Health**  
**Derbyshire County PCT**



## Consultation Response to the Health and Wellbeing Strategy

Report by Jayne Needham Public Health Strategy Manager

### 1. Background

During March and April 2012 a public consultation on the five high-level priorities for the Derbyshire Health and Well Being Strategy took place. The consultation was widely publicised and ended on 22<sup>nd</sup> April 2012. People were given the opportunity to respond either online or through a postal return.

In addition a stakeholder event was held on 30<sup>th</sup> March 2012 at County Hall Matlock to give partner agencies a chance to give their views on the five priorities.

The formal consultation received 385 responses. The stakeholder event was attended by 86 individuals representing a broad range of agencies.

The responses from this consultation are summarised below and have been used to inform the development of the health and wellbeing strategy. The information about people's views and experiences of health and wellbeing services will also be made available to commissioners and providers to better support their decision making about services in the future.

### 2. Quantitative response data; formal consultation

This is presented in table format attached.

#### ***a) Who are the priorities important for?***

Respondents were asked to identify if each of the five priorities was important for them as an individual, a community or Derbyshire. For every priority the respondents ranked "for Derbyshire " as the highest, with responses ranging from 71.8% to 65.8%.

#### ***b) Are the focus areas for each priority correct?***

Respondents were then asked if they felt the focus area selected for each priority was correct. The focus on early identification and intervention of vulnerable children and families generated the highest number of positive responses, 90.7% of people stating this to be the correct focus area for this priority. This was followed by "preventing and reducing alcohol misuse, obesity and physical activity" where 88.4% of people felt this to be the right focus. The focus for older people of "strengthening integrated working between health and social care providers and housing related support" was next with 88.3% of people agreeing with it. The mental health focus area of "improving access to the full range of evidence based psychological therapies" found 85.9% of respondents in agreement. Lastly 76.7% of respondents stated the long term conditions and carer focus area of "community based support, self-care and care close to home, including the increased use of evidence based telehealth and telecare" was correct.

**c) Do you agree with the stated actions to tackle each of the five priority areas?**

Respondents were asked to comment on whether they agreed with the stated actions to tackle each of the priority areas or whether they felt there were other actions which were missing.

The responses to this are summarised in Section B of the attached table. For example 70.0% of respondents felt that the most important action to tackle the issue of promoting the independence of people with long term conditions and their carers is to develop community support services.

<b>Final Health and Wellbeing Strategy Consultation Results</b>								
<b>Section A</b>		Yes focus is correct		No		Don't know		For you Community, or Derbyshire
<b>Early years Focus; Early identification and intervention</b>	1	293	90.7%	9	2.8%	21	6.5%	Derbyshire (71.8%)
<b>Lifestyles Focus; preventing and reducing alcohol misuse, obesity and physical activity</b>	2	274	88.4%	16	5.2%	20	6.5%	Derbyshire (71.8%)
<b>Mental health Focus: improving access to full range of evidence based psychological therapies</b>	4	256	85.9%	11	3.7%	31	10.4%	Derbyshire (66.6%)
<b>Long Term conditions/carers Focus: community based support, self care, and care close to home inc telecare telehealth</b>	5	230	76.7%	27	9.0%	43	14.3%	Derbyshire (65.8%)
<b>Older adults Focus: strengthening integrated working between health and social care and housing related support</b>	3	264	88.3%	10	3.3%	25	8.4%	Derbyshire (67.6%)
<b>Section B</b>								
<b><i>Do you agree with the stated actions to tackle each of the five priority areas?</i></b>								
<b>To tackle issue of improving health and wellbeing in early years</b>	1	Encourage families to eat healthily and take part in physical activity					283	73.9%
	2	Support services for new parents					260	67.9%
	3	Improving early literacy, language and numeracy skills					235	61.4%

	4	Services to reduce number of children on the at risk register	185	48.3%
	5	Other	83	21.7%
<b>To tackle issue of promoting healthy lifestyles to prevent and reduce alcohol etc</b>				
	1	Develop services to support people to become physically active maintain healthy weight	260	67.9%
	2	Develop other lifestyles services, targeting smoking, sexual health	223	58.2%
	3	Develop services to reduce harmful alcohol consumption	222	58.0%
	4	other	96	25.1%
<b>To tackle issue of promoting the independence of people with LTC and their carers</b>				
	1	Develop community support services	268	70.0%
	2	Develop services to promote self-management of LTC	218	56.9%
	3	Develop services to reduce hospital admissions and allow early discharge	203	53.0%
	4	Other	68	17.8%
<b>To tackle issue of improving mental health and increasing access to mental health services</b>				
	1	Ensure services available to all inc vulnerable groups	253	66.1%
	2	Develop services to support mental wellbeing	241	62.9%
	3	Develop services which help/enable people to remain in or return to work	240	62.7%
	4	Develop wide range of psychological therapy services	218	56.9%
	5	Other	58	15.1%
<b>To tackle the issue of improving health and wellbeing of older people and promote independence</b>				
	1	Ensure all care agencies provided services in partnership to improve health and wellbeing of older people	262	68.4%
	2	Ensure all care agencies provided services in partnership to maintain the independence of older people	254	66.3%
	3	Provided integrated hospital and community services	225	58.7%
	4	other	56	14.6%

**DERBYSHIRE COUNTY COUNCIL**

**DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD**

**31<sup>ST</sup> MAY 2012**

**Report of the (Chief Officer(s))**

**Clinical Commissioning Groups Authorisation**

**1. Purpose of the Report**

To inform the Health and Well Being Board of the process for Authorisation of Clinical Commissioning Groups( CCGs) in Derbyshire and to advise in respect of the role of the Board and the Local Authority in this process.

**2. Background**

The Board have received regular updates in respect of the policy in the Health and Social Care Bill and are familiar with the establishment of our local CCGs. The CCGs are working towards their authorisation and are applying for the 3<sup>rd</sup> wave in the autumn. This presentation is to ensure familiarity with the process and to ensure the Board are sighted on matters which will require action from them as part of this for example the 360 degree feedback.

**3. Next Steps/Way Forward**

The Board are asked to note the presentation (attached)

**4. Is an Equality Impact Assessment required?**

This will be carried out at service change level

**5. Recommendations**

The Board are asked to note the content of the presentation and to participate in the relevant activities to support our local CCGs towards authorisation.

**Trish Thompson  
Director External Relations  
NHS Derby City and Derbyshire County**

## **SHADOW DERBYSHIRE HEALTH AND WELLBEING BOARD**

**31 May 2012**

### **21<sup>st</sup> CENTURY HEALTH PUBLIC ENGAGEMENT PROCESS**

#### **1. Purpose of the report**

To inform the Board of the 21<sup>st</sup> Century health public engagement process that is currently underway and to explain the likely next steps.

#### **2. Background**

As a result of the ageing population in Derbyshire there is an ever increasing demand for health and social care services across the county. Developments of new technologies and greater expectations combined with demographic changes place serious challenges on health and social care organisations to deliver services within the financial constraints. In order to deliver high quality services commissioners and provider partner organisations have agreed to work collaboratively where it is appropriate to do so under a centrally co-ordinated and managed project to ensure delivery of the required outcomes.

The first stage of moving towards more integrated health and social care services is to establish the foundations and principles on which any future service changes and developments will be based. Once these principles have been established and agreed across partner agencies, current and future developments can be based on them regardless of whether the change is a single agency or collaborative endeavour.

This project is a joint health and social care project across the whole of Derbyshire i.e. County and City. As the work progressed it was decided to split it into two separate parts:

- First to consult and engage upon a set of principles that would be used to determine future services (currently underway)
- Second to consult upon any new service models and different ways of working that emerge from the work on integrated care and better care of people with long term conditions.

Following detailed discussion with colleagues in Adult Care within Derbyshire County Council it was agreed to separate out social care from the first phase of this work. This was because the Council had already completed early consultation on its strategy for Accommodation, Care and Support which had been reported to Cabinet in February 2012 and given the go ahead to proceed to the next stage.

The intention is that once the health service has consulted upon principles the two streams of work will be joined again around October as part of the delivery of the Health and Wellbeing Strategy.

### **3. Information and Analysis**

As background a briefing paper that was received by the County Council Improvement and Scrutiny Committee is attached as well as the leaflet that is being used to support the early stages.

An additional public meeting has been arranged for the High Peak area on 14 June 2012 following a request from local stakeholders and the engagement period has been extended accordingly.

### **4. Next Steps/Way Forward**

The feedback from the public will be taken and used to develop a common set of principles. These principles will then inform work undertaken with clinicians and other stakeholders over the summer months to reshape services. These proposals will then be consulted upon in the late autumn.

### **5. Is an Equality Impact Assessment required?**

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

### **6. Recommendations**

The Shadow Health and Wellbeing Board is asked to NOTE the current health public engagement programme.

**Jackie Pendleton  
Chief Operating Officer  
North Derbyshire CCG  
on behalf of all Derbyshire CCGs.**

More information from: [Jackie.Pendleton@northderbyshireccg.nhs.uk](mailto:Jackie.Pendleton@northderbyshireccg.nhs.uk)

## **Improvement and Scrutiny Committee Briefing**

### **21<sup>st</sup> Century Health and Social Care Project**

#### **A multi-agency project to respond to future opportunities and challenges of the changing health and social care landscape**

##### **Introduction**

Across the world health care systems are facing very challenging times: the worldwide recession; the progress that has been made in new treatments and technologies but the costs associated with that; the success of health and social care in achieving increased life expectancy, but the challenges that that creates. All of these are causing all health and social care commissioners and providers to ask big questions about how health care can best be provided in the 21<sup>st</sup> century. All countries are seeing big increases in the proportion of their country's budget being spent on health care which will become unsustainable if no action is taken. Across the world, governments and health professionals are considering ways in which health systems can change to meet the requirements of modern health care demands in an affordable way. Nationally and locally we are facing the same challenges.

As a result of this, local NHS and Social Care services are looking at how they can work together to manage their services better to meet these challenges and ensure we continue to provide high quality, safe and effective services within the financial resources available to us. The agencies involved are:

- NHS Derbyshire
- All four Clinical Commissioning Groups
- Derbyshire County Council – Adult Care
- Derby City Council – Adult Care
- Chesterfield Royal Hospital Foundation Trust
- Royal Derby Hospital Foundation Trust
- Derbyshire Community Health Service Trust
- Derbyshire Healthcare Trust (Mental Health Services)
- Derbyshire Health United (Out of Hours Services)
- East Midlands Ambulance Services

The proposal is to work together to establish a set of principles that each organisation can sign up to. These principles are based on the drivers outlined above. Once the principles have been agreed there will be a consultation period that all agencies will deliver together to get the public's views on the principles. These will then be amended according to the feedback. This will bring us to the second stage of the project. In the second stage agencies will identify any changes or improvements to services based on these principles that will help them to meet the challenges. These proposals will then be consulted on. This will either be done by each individual organisation or as a joined up group of health and social care organisations.

To date all agencies have identified their drivers, and the principles are being amended to ensure that they both cover all agencies' requirements and are written in a language that the public can understand. The draft set of principles are set out below.

## **The Principles**

### ***“Right care, right place, right time, right skills”***

**The overarching principle of the programme;** this principle will underpin the review of health and social care provision across partner organisations to meet the new challenges of the 21<sup>st</sup> century as described in the preface. The aim will be to ensure that pathways deliver the right care, in the right place, at the right time, by the right level of skilled staff, but at the same time ensure value for money.

Underpinning this core principle are a number of enabling strategies which will support the delivery of this programme. They are described below, and reflect what the programme team consider to be the most important underlying behaviours and values of influence in the process.

### **Integrated working**

This is to ensure that there is a focus on the team around the person. **Person centred care** should not be hampered by agency barriers, and treatment and support should be delivered considering the whole person. In order to achieve this, work will need to be undertaken to ensure we have a **flexible workforce** which can respond to the changing requirements of individuals and groups, and that can work across a matrix of providers. In addition, to enable safe and effective care and treatment **information sharing** across the agencies will need to improve, whilst also taking into account data protection.

### **Best use of resources**

The strategy will ensure that there is a focus on ensuring that we **reduce waste** and **avoid duplication**, either by improving our systems and processes, or by adopting **innovative solutions**, such as improvements in technology, or effective treatments, to ensure we are getting the best value for money we can. Through targeting the best use of resources we are able to ensure **the delivery of an equitable service** which will support the achievement of the same outcomes for everyone regardless of their circumstances, where they live and when they access services. This means people may not always receive exactly the same response but the outcome will be equitable.

### **Service User Experience**

This strategy will aim to ensure that we maintain or improve the experience of people using health and social care services. Opportunities such as the delivery of **care closer to home**; ensuring support is available to allow people to remain in their own homes for as long as possible, or a more effective ability to support people **managing their own health**, through a focus on lifestyle disease and promoting the prevention of their development, will support the delivery of this strategy. Moreover, a more developed understanding of the **No decision about me without me** agenda will ensure people are part of the planning and influencing of service developments, and become a real partner in relation to their individual care.



### **Timescales and Progress so far**

- Project sponsors have been identified from all agencies to ensure senior commitment.
- Project leads have been identified from all agencies to allow decision making can be signed off as the project progresses.
- Communication staff from all agencies have met to work on the drivers and principles and to translate them into public facing messages
- Engagement staff have met to discuss how the public will be involved, in terms of the distribution of information explaining the project, and the format of six public meetings that will be held to allow people to ask questions about the implications of agreeing to the principles

It was envisaged that the consultation activity would be undertaken throughout April but the revelation that Purdah would affect both local authorities means that a request has now gone to the project sponsors that this be put back 4 weeks.

**Nicola Longson**  
**Project Lead North Derbyshire CCG**

**Pam Purdue**  
**Project Engagement Lead**

## **DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD**

**31 May 2012**

### **INTEGRATED CARE WORK PROGRAMMES ACROSS DERBYSHIRE**

#### **1. Purpose of the report**

To inform the Board of the joint work that is currently underway across Derbyshire exploring more integrated ways of working.

#### **2. Background**

Each of the CCGs is working with the County Council and other colleagues to better integrate services for patients and the public. Each is taking a slightly different approach to this and it is key that everyone shares and learns from these experiences. These programmes are predominantly focusing on adult and frail and elderly people but the approach can easily be transferred to children's services should it prove successful.

#### **3. Information and Analysis**

All programmes provide a monthly update to the Derbyshire wide health and social care Chief Executives' forum. Progress is also discussed through the Adult Care Board at Derbyshire County Council and has links into the Capital Programme Board through Jackie Pendleton to ensure synergies and joint investment opportunities are identified.

#### **4. Next Steps/Way Forward**

Each of the updates attached gives progress and next steps.

#### **5. Is an Equality Impact Assessment required?**

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

#### **6. Recommendations**

The Shadow Health and Wellbeing Board is asked to NOTE the current work on redesigning services in a more integrated way.

**Jackie Pendleton  
Chief Operating Officer  
North Derbyshire CCG  
on behalf of all Derbyshire CCGs.**

More information from: [Jackie.Pendleton@northderbyshireccg.nhs.uk](mailto:Jackie.Pendleton@northderbyshireccg.nhs.uk)



## North Derbyshire Clinical Commissioning Group

### North Derbyshire Integrated Care Programme

#### 1. Introduction

North Derbyshire CCG held an event on the 20th October, which was attended by a range of health and social care practitioners from all agencies and part of the vision that evolved identified integrated care as a priority for the CCG and North Derbyshire partner organisations. A stakeholder event was held in December 2011 where a range of stakeholders from local authority, voluntary sector and patient groups were asked to provide input in to the initial priorities for this work.

Following these events the North Derbyshire Integrated Care Programme was set up to enable this vision to become a reality. To try to outline what this programme will look like this paper illustrates the approaches being taken.

#### 2. Integrated Working Programme

The term person centred approach is an often used phrase but in North Derbyshire it is intended to make this a reality that can be recognised by people by changing the scenario where the person has to fit around the existing services, to services being developed around the needs of the person. In order to challenge ourselves and ensure this is at the forefront of our minds a person is being imagined and followed in every scenario that is considered for future service change.

By using a person centred approach this will enable all organisational and condition specific boundaries to be removed reducing the risk of people falling foul to the system – the person is the constant through all service planning.

The attached diagram highlights the person centred approach and the steps it is believed make up the lifecycle of a patient's journey through the health and social care system. These life stages can also be seen in the draft Derbyshire County Council Health and Wellbeing strategic priorities which are currently out for consultation. The CCG has been working with public representatives to ensure that the steps in the process are recognisable. The person centred approach and use of 'Mr and Mrs Taylor' is central to the focus of the Integrated Care programme.

#### 3. Programme structure

The Integrated Working Group is the steering group that drives and supports the programme and includes executive representatives from all partner organisations across North Derbyshire. The individual organisations involved report back to their own Board and Governance structures on progress rather than there needing to be separate governance arrangements.

Task and Finish groups have been set up for each priority area. Each group has a sponsor from one of the partner organisations and is supported by representatives from the other partner organisations. Each task and finish group has clinical leadership and includes partner organisations management representatives.

Each group agrees and owns the scope and develops its own plans with clearly documented milestones. Governance structures are in place for reporting updates through the programme structures.

Other groups are in place or being developed to enable and enact the changes required. These include shared records, finance and contracting, engagement, best practice and procurement. Work is already underway to identify and explore best practice and investigate how this could be applied in North Derbyshire – for example a recent visit was made by a group from North Derbyshire partner organisations to Torbay to learn about their model for integrated care. Other models investigated by members of the group have been Cambridge and NW London.

#### **4. Next Steps**

In preparation for the future, when we receive the outcomes from the 21<sup>st</sup> Century consultation on the principles, we are looking at initial areas of focus of people with two long term conditions plus dementia, complex nursing home residents, end of life patients and COPD patients.

Areas for focus are initial service redesign activity include prevention, single assessment, health and social care system navigation, equitable patient outcomes 24/7, discharge and transfer.

Mapping, using person centred stories, is being used to drive service review and development in localities to ensure:

- That the patient and person centred approach is applied to any service redesign
- Progress is driven using patient centred outcomes and
- The CCG captures the hearts and minds of all partner organisations, clinicians and staff that will influence changes to future service provision.

By integrated partners in North Derbyshire mean identifying the needs of the person and working across all health, social care and voluntary sector organisations to ensure that all agencies work to meet those needs irrespective of agency boundaries. This links well with the approach taken within the Health and Wellbeing Strategy to put the person at the centre.

The types of outcomes that would be expected from this piece of work include:

- Mapping current service provision using current person centred journeys.
- Confirm areas to improve for example, prevention, single assessment, health and social care system navigation, equitable patient outcomes 24/7, discharge and transfer.

- Together, across all health and social care organisations identify solutions to improve areas identified.
- Propose the shape of future service provision across North Derbyshire and consult on this with the public.

## **5. 21<sup>st</sup> Century Health and Social Care Engagement Project**

This project started as a separate engagement and potential consultation vehicle to support all of the work on integrated care. At the recent Steering Group in the North it was suggested that there was confusion around the difference between the various strands of work; that the name 21<sup>st</sup> Century appeared to have gained some traction with partners and the public so a suggestion was made to badge all of the integrated working under this single heading.

However from discussions with colleagues in the south of the County/City this is not felt to be the right outcome for their programme of work as they wish any changes to community services to be kept separate from the integrated working programme.

Nicola Longson  
Programme Manager  
April 2012

Jackie Pendleton  
COO ND CCG  
April 2012

# North Derbyshire Integrated Care Programme – Overview

## Develop Person Centred Pathways

Introduce Mr and Mrs Taylor



Individual presents with need

First contact

Assess need

Treatment (if app)

Rehabilitation (if app)

Maintenance

Prevention

Individual has needs addressed

### Initial areas of focus in pathways

- Discharge planning and processes
- 24/7 service provision to meet required outcomes
- Health and social care system navigation
- Single assessment accepted by all partner organisations
- Prevention opportunities and services

## Steering Group

**Health & Social Care Integrated Working Group**  
Steering Group - membership includes nominated leads from all partner organisations.

### Task and Finish Groups for Priority Areas

**Frail & Elderly**  
Sponsor – Ben Milton  
**Initial Priority Areas**

- Complex with 2+ co-morbidities and dementia
- Complex NH patient
- End of Life

**Respiratory**  
Sponsor – Rick Meredith  
**Initial Priority Areas**

- Currently being defined
- COPD flagged

### Groups To Enable/Enact Required Change

Shared Records

Finance/  
Contracting

Engagement/  
Communications

21<sup>st</sup> Century Health and Social Care Project

All groups include reps from all partner organisations

### Focus on

- **Community and Person centred care**
- **Person centred outcomes**
- **Opportunities of Integrated Working**
- **Outcome of 21<sup>st</sup> Century consultation**

**Progress Update**

**Integrated Care Programme Sponsors Group**

**Southern Derbyshire Clinical Commissioning Group - Integrated Care Pathway for Frail and Elderly**

On 26 April 2012, the Integrated Care Programme Board agreed to appraise the current programme governance and programme controls to ensure progress to date has been adequately reflected, based on existing strong strategic support and direction, and to afford the opportunity to assure the programme next stages can be implemented with appropriate accountability control and wider stakeholder engagement.

Accordingly the vision and objectives of the Programme will be reaffirmed to support the development of a Stakeholder Engagement Plan and Communications Plan. Shirley-Ann Carvill has been appointed to provide additional programme support to our Part-time Director Di Prescott and will be drafting recommendations for the approval of the Programme Board and SDCCG Board. The overall patient benefits from implementing an integrated care pathway will be emphasised as the initial driver was based on identifying financial gains that has proven difficult to fully establish from existing integrated care pathfinders.

A recent stakeholder workshop, supported by Deloittes, was held to gain participation of health and social care partners in establishing a clear definition of frail and elderly. Deloittes are continuing with their financial scoping of an integrated care pathway for Southern Derbyshire and are due to submit their final report. As part of their remit they will assist in defining the scope of the population to be included in the initial development of the integrated care pathway that is currently aimed at the over 75 population. Additionally the Project Team are progressing the development proposal for Single Point of Access whilst formalisation of any new governance is considered.

A presentation was given on 16 April 2012 to the SDCCG Board to update on progress and GPs were enthusiastic to see the Programme move forward and to be actively involved.

The SDCCG Integrated Care Programme will continue to work with Partners in North Derbyshire to align pathway development and the formal role of the Programme Sponsors Group will be included in the governance review.

Andy Layzell

Chief Operating Officer

Southern Derbyshire Clinical Commissioning Group

## Project Highlight Report

<b>Project</b>	Southern Derbyshire Integrated Care System for Frail and Elderly
<b>Start &amp; end date</b>	November 2011 – Sept 2013
<b>Date</b>	4 May 2012
<b>Author</b>	Dianne Prescott on behalf of SDCCG and SD Integrated Care Steering Group

### Project Summary

Develop a whole system programme to develop an integrated care system for the frail and elderly as one of the highest priorities to improve care and deliver whole system financial sustainability.

Initially the intention was to focus the initial phase of this work in the city, but as the understanding of the model progressed it was agreed to extend the project to encompass the whole of Southern Derbyshire (and Erewash).

The Partner organisations are:

South Derbyshire Clinical Commissioning Group (including GP representatives)  
Erewash CCG  
Derby City Council Social Services  
Derbyshire County Social Services  
Derby Hospitals NHS Foundation Trust  
Derbyshire Community Health Services Trust (previously Derbyshire PCT provider arm)  
Derbyshire Healthcare NHS (previously Derbyshire Mental Health Trust)  
Derbyshire Health United (out of hours primary care provider company)  
East Midlands Ambulance service.

We are also engaging with voluntary and third sector organisations

The objectives of the integrated model are to

- To support the elderly to be as healthy as they can be
- To identify those at risk of poor health and support them at the earliest possible stage
- To maximise patient independence and enable the elderly to remain in their own homes where at all possible
- Provide timely and appropriate escalation of care to and within intermediate care in the home or to the appropriate level of care
- Ensure timely response
- Prevent avoidable hospital admissions

It is intended the integrated care system will provide:

- Robust patient register.
- A risk stratification tool suitable to identify elderly patients meeting the agreed criteria or at risk of requiring integrated care.
- Agreed protocols and care packages.
- Co-produced care plans fully involving patients and carers.
- Shared records and timely communication



- Co-ordinated integrated care delivery including social care.
- Care escalation and case conferencing.
- Aligned system incentives.

### **Project Plan Status**

Project timeline attached, indicating progress against milestones

### **Progress to date**

- Summary PID presented to Integrated Pathway Project Team
- Deloitte supported workshop to establish clear definition of frail and elderly
- Deloitte provided an interim report on financial impact/model of implementing integrated care pathway based on evaluation of selected case studies; developing SDCCG baseline
- Deloitte has provided a proposed integrated care pathway
- Additional interim programme support has been appointed
- Initial discussion with CLAHRC suggests more programme-based evaluation rather than clinical research evidence-based methodology across the pathway implementation
- Presentation to SDCCG Board 16 April 2012 on progress to date and next steps

### **Summary of work planned for the next period**

- Appraise the current programme governance and programme controls to ensure progress to date has been adequately reflected, opportunity to assure the programme next stages can be implemented with appropriate accountability control and wider stakeholder engagement
- Reaffirm clear vision and Programme objectives/scope
- Review Programme Management structure to incorporate governance and assurance recommendations with agreed Terms of Reference to include role of Programme Sponsors
- Consider MoU to reflect governance and programme structure review
- Highlight any variation to programme staffing requirements and budget
- Draft stakeholder engagement plan also to reflect any proposed formal governance changes
- Draft Communications Plan utilising existing communication channels
- Develop draft Summary PID for SPOA
- Development of detailed PID template to be applied to approved integrated care proposals
- Development of Programme Risk and Issue Log with risk rating methodology as well as RAG status
- Ensure all financial data supplied to Deloitte to complete their Final Report
- Review of Deloitte financial modelling and agree next steps at Programme Board

### **Current Programme Risks**

- Failure to secure non-recurrent programme support costs
- Limited success of Integrated care systems on reducing admissions
- Poor integration of programme with other care pathway initiatives

### **Issues for Escalation**

None

## Adult Care Board – 17<sup>th</sup> May 2012

### Health and Social Care QIPP Update on QIPP for LTC Programme

#### 1. Introduction

Erewash CCG & Hardwick Health CCG together with Adult Care are participating in the national QIPP programme for long term conditions run by the Department of Health under the leadership of Sir John Oldham. This paper provides an update of the progress made as part of the programme and outlines plans for implementation within Erewash CCG and Hardwick Health CCG areas.

The work is being led by Sir John Oldham and as part of this a Commissioning Development Programme has been set up to help organisations better manage long term conditions – and bring benefits to patients, clinicians and the NHS and Social Care as a whole.

The programme has several strands all of which are designed to improve the care experience of people living with Long Term Conditions.

Best practice in the management of long term conditions has three key principles:

1. **Risk Profiling** – this helps organisations identify LTC patients who are most likely to make a significant use of the NHS and Adult Care services to develop systems and services that are better able to manage this demand.
2. **Neighbourhood Care Teams** – these teams work across health & social care in a locality (neighbourhood), and provide patients with a key worker to help join up and co-ordinate their care.
3. **Self care/ Shared Decision Making** – the majority of care for LTC patients is delivered by themselves or their carer(s). Evidence shows that patients who are more involved in their own care have better outcomes. This principle looks to provide patients with the support and confidence to better manage their own condition(s).

It is noted that Derbyshire has been approved to participate in the pilot of personal health budgets for adults in Derbyshire. This will give people greater control of how they receive health care input which will support people to manage their health and well-being.

A group consisting of representatives from the CCGs, Adult Care, DCHS, EMAS, DHU and general practice are working together through the programme to improve our understanding and delivery across ALL three of the above principles. There is also involvement from a patient representative in the team attending the programme. It is considered that only by implementing all three of these core principles together can we expect to see the impact on delivering efficiencies and improved outcomes. These components need to be part of a coherent approach to change as research showed that it is the cumulative effect that makes the difference.

A priority of the Derbyshire Health & Well-Being Board will be to promote the independence of all people living with long term conditions and their carers. In Derbyshire we will focus on community based support, self-care and care close to home, including increased use of evidence-based telehealth and telecare. The proposed developments outlined in this paper will contribute to supporting delivery against this priority.

#### Risk profiling

Within Derbyshire the PARR {Patients At Risk of Readmission} Combined Model (see appendix 2 for more detail) is used as the risk stratification tool which is used by GP

practices and community matrons to identify patients at highest risk of hospital admissions who require intervention including selection for case management by community matron or other specialist nurse. There are issues about the long time delay (8 weeks or more) in hospital admission data being fed into the PARR tool to produce the risk list. It was proposed that as part of the local NHS Informatics Tender that risk stratification tool would be part of the service to be delivered but as this has been put on hold we need to take forward the work to look at future requirements around risk stratification tool. This would need to consider how Adult Care information including FACS eligibility could inform risk profiling.

The group have also explored the HAVOC tool developed by a GP in North Derbyshire. This tool supports GP practices to pull together the information on usage of urgent care services – GP, DHU, A&E, Admissions to produce an urgent care clinical dashboard which helps to identify people who are coming into contact with urgent care system and may require a proactive intervention. Hardwick & Erewash CCGs are proposing to pilot the HAVOC tool with a number of GP practices.

### **Integrated Health & Adult Social Care Teams**

Erewash CCG and Hardwick CCG are participating in the integrated care programmes for frail elderly in North Derbyshire and Southern Derbyshire. In addition, Erewash CCG and Hardwick Health CCG have integrated care as a strategic aim. The CCGs working with DCHS & adult care services plan to create **integrated teams** within localities. This will create a functionally integrated generic care team at a locality level comprising community matrons, district nurses, AHP's, social workers, specialist nurses and linked to GP practices. The integrated health and social care teams based around a **locality** will provide joined up and personalised health and social services. The health and social care staff will work together to offer patients a better quality service, with easier access to the services required. The exact make up of each locality and population coverage will differ depending on local circumstances. The generic teams will pull in specialist services when necessary, but treat a patient holistically, regardless of their condition(s). The integrated care team will provide a single main contact point for patients and carers. Each patient will have a key worker within this team who coordinates their care and acts as the point of contact.

The integrated care teams will focus on delivering care for the following patient group:

- People with complex health and social care needs including frail older people and those with multiple long term conditions who are at risk of hospital admission and significant deterioration in their health and well-being.

Key elements of the model which Hardwick and Erewash CCG are proposing to implement are:

- **Risk profiling** to support identification of patients who need proactive intervention (see above).
- **Case management** through community matrons to be available in all GP practices across the CCGs ensuring full population coverage.
- **Care Co-ordinator** role either at individual practice or locality level. They will act as a key contact for patients and work with colleagues in the integrated care team and externally to co-ordinate services and care elements for patients. In addition they will use information sources to identify people who are at high risk of hospital admission who need to be discussed at the Multi-disciplinary Team Meetings.
- Functionally **integrated health and adult social care teams** working at a locality level comprising community matrons, district nurses, allied health professionals, social workers, specialist nurses and linked to GP practices. The integrated health and social care teams based around a locality will provide joined up and personalised health and social services. The integrated teams will also develop relationships with Adult Social Services in Nottingham to improve communication and reduce duplication in processes where possible for patients living in Nottinghamshire but registered with a Derbyshire GP Practice.

- Improved **information sharing** across health & social care including access for the integrated care team to Framework I.
- **Hospital In-Reach** to support the effective management of patients within hospital and to support early discharge and avoidance of readmission.
- **GP Clinical Champion** in each GP practice as a lead GP for integrated care to include participation in weekly MDT meeting with integrated team to consider patients requiring review.

The outcomes which the integrated team will deliver include:

- Improved experience for people.
- People to receive better co-ordinated care and support.
- Services developed to ensure appropriate interventions are available at the right time.
- Improved communication and joint working between primary care, secondary care, intermediate care and Adult social care staff.
- More proactive and upstream care delivered to support people and avoid crisis.
- Improved efficiencies through reduction of duplication for example through inter-professional acceptance of each other's assessments.
- Improved efficiencies through reduction of hospital admissions and long term care home placements.
- Improved efficiencies through reducing delayed transfers of care.

There is a real interest between practitioners in taking forward integration at locality level. Further work is required to develop and agree the model to be implemented to transfer the concept of integration into the methods and approaches which will be required to deliver integration. This will need to define the outcomes/outputs and the delivery model to be implemented on the ground that will take account of local circumstances. The integration of social care staff into the integrated teams may either be virtual or through co-location.

There is the opportunity to share best practice as this is developed and inform development of integrated care for frail older people in North & Southern Derbyshire.

### **Self Care**

The Team from Erewash CCG and Hardwick Health CCG areas attended a learning event on 2<sup>nd</sup> May 2012 to look at how we can systematise self care. An action plan will be agreed from this event which will pull together the elements of the third strand of the programme change which is required to improve the management of long term conditions.

### **Recommendation to Adult Care Board**

It is recommended that the Adult Care Board note the proposed developments on integrated care in Erewash and Hardwick including considering how the model of integrated care will practically be implemented in Erewash and Hardwick areas.

Martin Cassidy  
Assistant Operating Officer  
Erewash Clinical Commissioning Group

Julie Vollar  
Group Manager - Commissioning  
Adult Care  
Derbyshire County Council

10 May 2012

## Appendix 1

### Integrated Neighbourhood Care Teams - Evidence

#### Evidence presented at LTC Development Programme

During the workshop on the Long Term Conditions Development Programme on 2nd February 2012 there was the opportunity to hear how other places in the country have created integrated neighbourhood care teams and the benefits that this has delivered for both patients and organisations.

The majority of people aged over 65 will have two or more long term conditions and those aged over 75 will have three or more conditions. With a growing elderly population the number of people with long term conditions is expected to grow by 252%. In addition, a study had shown that:

- Only 5% of people with dementia have just dementia
- Only 14% of people with diabetes have just diabetes
- Only 18% of people with COPD have just COPD

This included examples from Nottingham, North East London and Greenwich.

One speaker shared that of the top 1% of high risk population in an area, 50% of the patients will also be in receipt of Adult Care and therefore we have a joint interest in this group of patients. The integrated neighbourhood care teams were built around geographical areas of populations ranging from 30,000 to 50,000 with the general practices as the building block. The integrated teams included community matrons, district nursing services, care managers from social services, therapy services. In addition, mental health, learning disability services, crisis intervention/rapid response, rehabilitation, intermediate care beds were co-ordinated through the integrated team.

In Nottingham there are plans for a dementia outreach team and community geriatrician to be built upon the neighbourhood team model. In addition, integrated neighbourhood teams supported the development of stronger links with voluntary sector. A crucial role in making all of the integrated care teams work was identified as the Care Co-ordinator/Ward Clerk role. In addition, regular multi-disciplinary team meetings at general practice level were a core element in coordinating the care for people. It was not about co-location of staff but a framework for staff to come together to improve communication.

In terms of hard nosed outcomes integrated teams had delivered:

- reduction in hospital admissions (North East London),
- saving on care hours per patient
- 19% reduction in intensive home care packages
- 3% reduction in home care packages
- 35% reduction in permanent care home placements (Greenwich)

Speakers said that there was also a high level of staff satisfaction from working in an integrated way due to the improvements in reducing duplication, improved communication and better care for people.

Key factors for success included the change being owned and driven by champions across specialisms, a focus on good communication and being realistic about speed of implementation. The importance of engaging staff working at the front end in the development of the integrated service was seen as a prerequisite for getting staff buy into the change. The core message was to start with the patient and what was best for them. In addition it was recognised that senior management within organisations needed to be behind the change for it to stand any chance of proceeding.

## **Evidence from other sources**

### ***The benefits of integrated care***

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011).

***Care for older people in Torbay*** Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support (Thistlethwaite 2011).

***Chronic care management in Wales*** In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009. This represented an overall cost reduction of £2,224,201 (NHS Wales 2010).

Report to the Department of Health and NHS Future Forum from The King's Fund and Nuffield Trust. Integrated care for patients and populations: Improving outcomes by working together  
Nick Goodwin, Judith Smith, Alisha Davies, Claire Perry, Rebecca Rosen, Anna Dixon, Jennifer Dixon, Chris Ham. January 2012

## Appendix 2

### **PARR Combined Model**

A risk stratification tool called the Combined Predictive Model (the Combined Model) is used in Derbyshire and Derby City. The model is based on a comprehensive dataset of patient information, including inpatient (IP), outpatient (OP), and accident & emergency (A&E) data from secondary care sources as well as general practice (GP) electronic medical records. The information is currently used in Derbyshire to support the identification of people at risk of hospital admission who would benefit from case management by community matron or specialist nurse or other proactive intervention aimed at improving quality of life and reducing risk of hospital admission.

Case finding is essential for effective long term conditions management.

Predicting who is most at risk of emergency admissions is a critical function of case finding. Tools that can identify those who can most benefit from outreach and targeted interventions require a high degree of accuracy to ensure that there is a match between intervention intensity and risk.

The Combined Model is able to:

- Improve predictive accuracy for very high risk patients
- Predict risk of hospital admission for those patients who have not experienced a recent emergency admission
- Stratify risk across all patients in a given health economy to help NHS organisations understand drivers of utilisation at all levels

The ability to identify emerging risk patients will enable NHS organisations to take a more strategic approach to their care management interventions. For example, CCGs and partner organisations will be able to design and implement interventions and care pathways along the continuum of risk, ranging from

- Prevention and wellness promotion for relatively low risk patients
- Supported self-care interventions for moderate risk patients
- Early intervention care management for patients with emerging risk
- Intensive case management for very high risk patients.

## **SHADOW DERBYSHIRE HEALTH AND WELLBEING BOARD**

**31 May 2012**

### **INFORMATION SHARING FOR PLANNING AND COMMISSIONING SERVICES FOR CHILDREN AND FAMILIES**

#### **PURPOSE OF REPORT**

The purpose of this paper is to highlight issues in relation to information sharing for the purposes of planning and commissioning services and outline some proposed actions. This paper does not address information sharing about individual children and young people in relation to safeguarding.

#### **INFORMATION AND ANALYSIS**

Effective planning, commissioning and performance management requires the use of data and information. The information sharing agreement that exists in Derbyshire, and has been agreed by members of the Derbyshire Partnership Forum, sets out the rules and processes necessary for effective information sharing. However there are a number of reasons why we are increasingly experiencing problems in obtaining the data and information we require to plan and commission better services:

- Targeting services to those most in need requires us to be able to identify individual children, young people and families and this is a particular difficulty when requiring sensitive data, eg health and criminal justice. This has caused difficulty and delay in introducing new evidence based programmes eg Multi-Systemic Therapy and Family Nurse Partnership.
- Often the geography in Derbyshire means that people with particular vulnerabilities are spread over a wide area making the numbers in any one location so small that the need to protect confidentiality means that numbers cannot be shared – eg the numbers of teenage conceptions in a MAT area.
- The numbers of partners we need to work with is increasing. This is particularly an issue in health where the development of Foundation Trusts and Clinical Commissioning Groups significantly increases the number of independent organisations all operating information governance processes. This can result in different data being supplied eg DCC can access vaccination and immunisation data from Tameside and Glossop PCT which it cannot access for Derbyshire PCT residents.
- The inspection and regulation requirements of different partners are not joined up at a national level eg the requirements on children's centres to demonstrate health outcomes that are not routinely monitored by the NHS.



[Type text]

- Because different organisations collect, store and retrieve different data it is often difficult to arrive at a single agreed data set. This can result in misleading or skewed data, inconsistencies across different agencies or localities and an inability to identify areas of need.
- Initiative such as the Troubled Families programme require us to identify named families, children and young people, information that many agencies are not happy to share for the purposes of planning and commissioning.

## **RECOMMENDATIONS**

Members are asked to note, and use their local and national influence to support where appropriate, the following actions:

1. The majority of these issues are not exclusive to Derbyshire and there are a number of actions being taken at a national level which will hopefully improve the situation, for example:
  - In response to a request by the NHS Futures Forum, Dame Caldicott has commenced a review of the balance between protecting patient information and it's sharing to improve patient care and modernise health and social care.
  - As part of the Troubled Families programme the Government have brokered a new information sharing agreement with the Department of Work and Pensions and Job Centre Plus to provide information to help identify families to be part of the programme. It would be helpful if this type of agreement could be extended to other Departments.

We will continue to contribute to these reviews and initiatives and also lobby through professional bodies and our involvement in various pathfinders and pilots.
2. We are planning a workshop (4 July 2012) with a small number of representatives from CAYA, Adult Care and the NHS to specifically look at Information Governance and Caldicott requirements. The intention is to utilise external facilitation to challenge and develop our shared interpretation of the rules and regulations governing information sharing.
3. We are reviewing our information governance arrangements within CAYA and adult care, including the potential for greater joint working with our partner's information governance processes.

**Sally Savage**  
**Assistant Director – Commissioning, CAYA**  
**Derbyshire County Council**

## SHADOW DERBYSHIRE HEALTH AND WELLBEING BOARD

31 May 2012

### CHILDREN AND YOUNG PEOPLES JOINT COMMISSIONING PRIORITIES

#### PURPOSE OF REPORT

The purpose of this paper is to set out the joint commissioning priorities for 2012/13 for children, young people and families. These are essential to the delivery of the Health and Wellbeing Strategy, Derbyshire Children's Trust Board Priorities and the CAYA service priorities – as attached.

#### INFORMATION AND ANALYSIS

The joint commissioning priorities for the Derbyshire Children's Trust are:

1. **Early intervention and prevention** – there are a number of work streams that are fundamental to the delivery of the Children's Trust Early Intervention and prevention strategy:
  - **Early vulnerability pathway** to ensure that midwifery, health visiting, children's centres and other early years services are working together to identify and then work with the most vulnerable families. The Child Poverty Strategy will help us to support families where vulnerability is influenced by poverty.
  - **Health Visiting Implementation Plan** – the government have made a commitment to increase the number of health visitors and to target the service to those in most need over the period from 2011 - 15. As well as meeting government targets for increased numbers Derbyshire is an early implementer site for this programme and are focusing on the delivery of an improved 2 and a half year check for all children. We are also using this plan as a way of implementing the Family Nurse Partnership in areas of high teenage pregnancy rates.
  - **Parenting support** – we plan to implement a new ante-natal parenting programme across the county in this year. This will achieve a better balance between education on the ongoing needs of children and on the preparation for and the actual birth. We will also be delivering the new universal parenting programme in High Peak as one of three national pilot sites.
2. **Emotional and Psychological Wellbeing** is increasingly recognised as a vital aspect of children's overall wellbeing and as having a significant bearing on their ability to thrive and achieve. This year we wish to:
  - develop a **behaviour pathway** which will ensure that we are using effective interventions at the right time to support children and young people to behave appropriately
  - establish the needs in relation to **early attachment** and how we can reduce the effects in later life that we know are attributable to poor early attachment

- introduce **Multi-Systemic Therapy**, an evidence based programme that provides intensive support to young people aged 11 – 17 on the edge of custody or care.
3. **Children with ongoing care needs** who require high levels of support throughout their childhood require us to deliver joined up services across a wide range of agencies.
    - We fund children with the most **complex needs** via a pooled budget under a Section 75 agreement which has led to a reduction in costs and better co-ordination of care packages. We are extending this agreement to include joint funding of preventative packages to try to reduce the number of children needing more intensive support, including reducing the numbers requiring out of county care.
    - We wish to strengthen the way we consider the eligibility of children and young adults for **continuing care** funding.
    - We wish to increase the number of children and young people who have access to a **personal budget** for both their health and social care. This will be part of our response to the government’s proposals for a new approach to special educational needs and disability.
    - We are reviewing our **community paediatric service** to ensure that children are able to have their health needs met as close to home as possible and wherever appropriate avoid unnecessary hospital care.
  4. We are recommissioning the **specialist substance misuse service** to improve outcomes and provide a service that is more closely integrated with the multi-agency teams and local communities.
  5. We are in the process of agreeing a revised **school nursing** specification to deliver an equitable service across the county which is available to all school aged children and young people.
  6. We are working together to deliver the national **Troubled Families** initiative which will provide a significant proportion of the additional funding available via payment by results. We are currently at the needs assessment stage which includes agreeing the local outcomes we wish to target alongside those which are centrally proscribed.
  7. We are implementing our **speech, language and communication pathway** which targets improving communication skills in children under 5 as the basis developing lifelong literacy and other essential communication skills.

## RECOMMENDATIONS

Members are asked to note these priorities which have been agreed by the Children’s Trust Board at their May meeting.

**Sally Savage**  
**Assistant Director – Commissioning, CAYA**  
**Derbyshire County Council**

## **Children and Younger Adults Excellence Plan**

### **Aims:**

- **Keeping children and young people safe from abuse and neglect**
- **Ensure all children start school healthy and ready to learn**
- **Ensure all our young people are ready for the world of work**

### **Priority Outcomes:**

- Children are safer and remain part of their family and community.
- A safe, responsive and accessible safeguarding service which responds quickly and effectively to appropriate referrals.
- Reducing the numbers of children in care.
- Significantly increase in the proportion of children in care placed in DCC provided family placements (fostering and adoption).
- Ensure that disabled children, young people and their families benefit from outcomes focused personalised approaches and that disabled young people are supported to make a smooth transition to adult life.
- Improve early years development for children and close the gap for those from vulnerable groups.
- Children and their families have healthy lifestyles.
- Attainment and progress to be above national outcomes at all key stages.
- Closing the attainment gap for lower achieving groups and the rest of their cohort.
- Increased proportion of good and outstanding schools, settings, centres and providers and significant reduction in schools below the new national floor standards and in schools causing concern.
- Aspirations and opportunities for children, young people and parents are raised, particularly those with most need.
- All families, children and young people have access to timely information advice and guidance.
- Children and Young People actively participate in shaping our services.
- Ensure a balanced budget year on year and use the entire resource available to us to make the most difference.
- Demonstrate transformational change in outcomes and quality of services.
- Implement a thriving workforce strategy that is responsive to the changing working environment.

- Working in partnership to meet the aspirations of children, young people and families in Derbyshire.
- Using the total resource to make the most difference and can demonstrate improvement in outcomes.
- We are recognised as excellent by users, citizens, staff, politicians, inspectors and peers.

## **SHADOW DERBYSHIRE HEALTH AND WELLBEING BOARD**

**31 MAY 2012**

### **PROVIDER ENGAGEMENT**

#### **Purpose of the Report**

To consider proposals to engage with the larger providers of health care.

#### **Information and Analysis**

The role of the Health and Wellbeing Board in the context of the wider map of relationships is to establish the strategic framework within which resources from across organisational boundaries are applied to the outcomes identified in the Health and Wellbeing Strategy. Improved service integration is critical and we need to have effective mechanisms in place with all our partners.

The size and composition of the Shadow Health and Wellbeing Board largely reflects the prescribed core membership set out in the Health and Social Care Act. We have taken a conscious decision not to include provider representation on the grounds of conflict of interest.

Engagement with all stakeholders is taking place through the established Stakeholder Forum which has met twice to inform the work of the Board and the development of the Health and Wellbeing Strategy. Although this gives an opportunity for providers to work within the Board framework, effective engagement with providers is essential to promote integrated care.

It is proposed to invite those listed below to an exploratory meeting with the Chairman, with appropriate professional support, to discuss engagement and their role in the shaping and delivery of the Health and Wellbeing Strategy.

Derbyshire Community Health Service  
Chesterfield Royal Hospital  
Derby Hospitals  
Derbyshire Healthcare Trust (Mental Health Services)  
Derbyshire Health United (out of hours service)  
East Midlands Ambulance Service  
Local Pharmaceutical Committee  
Local Medical Committee  
Local Dentistry Committee  
Local Optometrists Committee  
Hospice movement representative

This first meeting could explore whether a formal Provider Forum would be appropriate within the Board Structure.

#### **RECOMMENDATION**

That an exploratory meeting be held with key provider organisations to discuss engagement and their role in shaping and delivery of the Health and Wellbeing Strategy.

## SHADOW DERBYSHIRE HEALTH AND WELLBEING BOARD

31 May 2012

### HEALTH & WELLBEING ROUND-UP REPORT

#### **Purpose of the report**

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

#### **Round-Up**

##### **Board Development – Bespoke LGA Offer**

The LGA has made an offer of bespoke support to Derbyshire to help with the leadership and development of the HWB Board. This work will inform a new Development Tool for Health and Wellbeing Boards across the country. The aim is to provide Boards with a tool that will enable them to move beyond assessing how ready the Board is and towards assessing how effective it is in practice. Boards will be supported to explore their strengths and weaknesses, develop their ambition and a clear sense of purpose and develop an approach which will help transform services and outcomes for local people.

A ½ day development session will be run by the LGA over the next few months. The following dates have been put forward to the LGA as possible options:

29 June (am or pm)  
4 July (pm)  
5 July (am)  
13 July (am)

Board members will be informed as soon as the date is confirmed.

Additionally, Board Members may be interested in a report by The King's Fund: 'Health and Wellbeing Boards: System Leaders or talking shops'. Please find a link to the report below: <http://www.kingsfund.org.uk/publications/hwbs.html>

For further information please contact Jane Cox, Policy Manager: [jane.cox@derbyshire.gov.uk](mailto:jane.cox@derbyshire.gov.uk)

#### **Troubled Families**

Derbyshire is a second round pilot area for the roll out of Community Budgets for families facing multiple problems. Since December, work has been taking place to develop a Community Budget Plan which meets the ambitions and long term aspirations of the County Council and partner agencies. The Plan

will adopt a phased approach with the new Troubled Families initiative kick-starting work as the first phase.

The Troubled Families initiative is one part of wider Community Budget plans for Derbyshire. New ways of working with families will be tested during the second phase through a small number of geographical pilots, which will commence from September 2012 onwards. Involving professionals, practitioners, local partners and the families themselves at the very earliest stages of this process is a priority. Evidence gathered and lessons learnt from the first and second phases will support the potential redesign and reshaping of existing services from April 2013 onwards.

The Government's Troubled Families Team expects local areas to deliver on three key outcomes:

- Reduced youth offending and anti-social behaviour (ASB)
- Improved attendance at school
- Increased numbers of adults into work

The Government will provide approximately 40% of the cost of working with a family facing multiple problems; local authorities and their partners are expected to provide the remaining 60% from existing resources.

The Derbyshire Project Group has already made progress on a range of tasks, which include:

- The development of a draft work plan to guide work on both the Community Budget and Troubled Families initiative.
- The identification and mapping of potential families using a range of agreed criteria and the establishment of a partnership Information Group to support this work.
- The development of potential models of working to roll out the initiative across the county.
- The development of a Troubled Families Business Plan.

Work is underway to ensure that all partner agencies have a shared understanding about the size, scale and scope of the project at the outset.

For further information please contact Sarah Eaton, Head of Policy & Research, DCC: [sarah.eaton@derbyshire.gov.uk](mailto:sarah.eaton@derbyshire.gov.uk)

### **HealthWatch Update**

The local multi- organisation project team is on track to tender in September for the provision of Local HealthWatch. Work will focus over the forthcoming months on ensuring that there is effective engagement with our local communities particularly in the co-production of the service specification and to ensure effective governance structures are in place.



There are a number of constraints that have been identified that may impact on the project timeframe being maintained to achieve the April 2013 deadline for setting up the Local HealthWatch Group. These concerns have been fed back to the Department of Health through the Local Government Association. These are;

- The funding from the Department of Health for the provision of HealthWatch is unlikely to be known until late in the Autumn
- Secondary legislation which might impact on the final description of the role and activity of Local HealthWatch is not expected to be available also in the autumn.

We also have to take on the responsibility from April 2013 for procuring specialist Health Advocacy services. There is currently a lack of guidance around this responsibility and no confirmation of the funding available to meet this need. Regional work is being undertaken to ameliorate this risk, firstly to see if we can access the current Department of Health contract for this service and to see if there could be a regional procurement response to gain efficiencies.

### **Tobacco Control**

A joint Council and PCT Task and Finish Group has been set up to review the Tobacco Control programmes. The group will look at how performance can be improved and how the budget can be used more efficiently and effectively to prevent potential overspending.

The Group will present a report to the Council's Public Health Group at the end of July, with initial proposals for improved performance and more efficient spending on the programmes.

The Health and Wellbeing Board will be kept informed of progress

For further information, please contact Dr Tony Morkane, Consultant/ Associate Director Public Health: [amorkane@nhs.net](mailto:amorkane@nhs.net)

### **The Government's Alcohol Strategy**

The national Alcohol Strategy was published in March 2012. The strategy sets out how the government is planning to tackle irresponsible drinking and reduce the harm caused by alcohol.

The new strategy includes:

- Plans to introduce a minimum unit price to tackle the availability of cheap alcohol;
- A commitment to work with industry to promote safe and responsible drinking through product labeling, combating under age sales, changing

the location of alcohol in stores and reducing the number of units in popular products;

- A review of the alcohol guidelines for adults;
- National social marketing campaigns, such as the Change4Life campaign to raise awareness of the harmful effects of drinking;
- The inclusion of questions on alcohol consumption within the NHS Health Check;
- Encouragement for hospitals to share non confidential information on alcohol related injuries with the police and other local agencies;
- Encouragement for hospitals to put in place alcohol liaison services within the hospital to support patients with alcohol problems.

The full strategy can be found on:

<http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy>

## **Making Every Contact Count (MECC)**

All organisations responsible for health, wellbeing and care of the public are in a position to train their staff to use every opportunity to promote health and wellbeing with their clients/service users. Delivering healthy messages in this way has become known as 'making every contact count' (MECC).

Although MECC happens at an individual level, if it is delivered systematically by large numbers of staff across a health & social care community, it has the potential to produce significant health gain at a population level.

In order to achieve a consistent approach to MECC, Public Health in Derbyshire has been leading on work on behalf of the SHA Cluster and has developed an implementation guide and toolkit for MECC which can be found at <http://nhs.uk/makeeverycontactcount>

A communication pack has also been developed. Each organisation has identified a Board level champion, an implementation lead and communications lead who will work together to engage all staff in the MECC initiative.

Derbyshire aims to roll out MECC in a coordinated way across all constituent organisations and to build on work already underway in Derbyshire Community Health Services (DCHS) and Derbyshire Healthcare NHS Foundation Trust (DHcFT). Leadership for this work will come from Public Health and the authors of the implementation guide and toolkit. This will also be done in partnership with Derby City.

For further information, please contact Maureen Murfin, Derbyshire Implementation Lead: [maureen.murfin@derbyshirecountypct.nhs.uk](mailto:maureen.murfin@derbyshirecountypct.nhs.uk)

## **NHS 111 Update**

The NHS 111 Service is now live across the north of Derbyshire and Derby City. The south of Derbyshire will be covered by the end of August 2012. To-date, the experience of the NHS 111 service has been very positive with consistently good feedback from patients and no issues raised by Emergency Departments or Primary Care in terms of any unexpected increases in activity. There has been some discussion with EMAS regarding the level of cases referred to 999, however, Derbyshire is not an outlier when compared to other NHS 111 sites and the NHS111 clinical Lead is reviewing individual cases to ensure cases are appropriately referred.

Derbyshire continues to be highlighted by the Department of Health as one of the best pilot sites nationally and they have recently praised the short film made within Derbyshire concerning the progress of NHS111 in the county.

Below is a link to the film:  
<http://www.youtube.com/watch?v=3GwNwVj3CWE&feature=youtu.be>

Arrangements for the procurement of the service are progressing with the aim to have a fully procured service in place for October 2013. A workshop was recently held in order to get input into the NHS111 and Out of Hours service specification from across the health community. This was a well attended event and will help to shape our future model.

Activity is steadily increasing in line with forecasts allowing time for additional staff to be recruited ready for the full coverage of Derbyshire. Negotiations are currently on-going with NHS Direct concerning the decommissioning of the 0845 service and the transfer of staff. The 0845 service will cease in Derbyshire from September 2012 and there is a communications plan to ensure that patients and the public know about the discontinuation of the 0845 service and the details of the new NHS111 service.

For further information, please contact Jackie Pendleton, Chief Operating Officer, North Derbyshire CCG:  
[Jackie.Pendleton@derbyshirecountypct.nhs.uk](mailto:Jackie.Pendleton@derbyshirecountypct.nhs.uk)

### **Health Visiting Implementation Plan in Derbyshire County**

The Government have made a commitment to increase the number of Health Visitors and to target the service to those most in need over the period from 2011-15. In Derbyshire we have met our targets for increased numbers in the first two years of this plan (11.6 whole time equivalent). Some of this increase has been achieved by the introduction of the Family Nurse Partnership into Chesterfield, North East Derbyshire, Bolsover, Erewash, Amber Valley and Swadlincote – our areas of highest rates of teenage pregnancy. Derbyshire has been invited to be an early implementer site for the programme which has meant we have been able to test out the use of new tools to improve the quality of assessments, especially in order to identify vulnerable children as early as possible to allow us to provide effective support. These are specifically improving the review undertaken at 2 years of age and introducing a new ante-natal review at 20 weeks of pregnancy – both of which are being piloted in Chesterfield.

For further information, please contact Jackie Pendleton, Chief Operating Officer, North Derbyshire CCG:  
[Jackie.Pendleton@derbyshirecountypct.nhs.uk](mailto:Jackie.Pendleton@derbyshirecountypct.nhs.uk)

### **Sustainable Health and Social Care**

The *Social Care Institute for Excellence (SCIE)* has recently produced a paper, entitled 'Sustainable health and social care: a briefing for Commissioners and health and wellbeing boards', which summarises the importance of sustainable healthcare for commissioners and health and

wellbeing board members. The briefing provides details of the key policy and operational drivers for a sustainable development approach to health and social care design and delivery. It includes specific detail regarding climate change and other environmental issues, but also covers social and economic sustainability, and gives provides good practice case studies.

Here is a link to the full briefing:

[http://www.sdu.nhs.uk/documents/publications/Scie\\_report Sustainable health and social care commissioners and wellbeing baords.pdf](http://www.sdu.nhs.uk/documents/publications/Scie_report_Sustainable_health_and_social_care_commissioners_and_wellbeing_baords.pdf)

### **Department of Health (DoH) Information Strategy**

The Department of Health published its Information Strategy on 21 May 2012. 'The Power of Information' sets a ten-year framework for transforming information for the NHS, public health and social care. The focus of the strategy is on improving access to information, including a commitment that people will be able to access their GP records online by 2015. Other ambitions are for test results to be available electronically and that people will be able to book or re-arrange their medical appointments online.

<http://www.dh.gov.uk/health/2012/05/information-strategy/>