SUMMARY OF HEALTH AND WELLBEING STAKEHOLDER ENGAGEMENT FORUM

30th March 2012 at County Hall, Matlock

Introduction and background information

The Derbyshire Health and Wellbeing Board involves partners in the development of the health and wellbeing agenda primarily through its Stakeholder Engagement Forum. The forum is held twice a year and the first event took place in September 2011. At this event partners discussed how best to engage stakeholders in the work of the board and began to develop priorities. Over 110 individuals representing 59 organisations attended.

Since the first forum, initial priorities have been narrowed down to a set of five draft priorities which will form the basis of a Health and Wellbeing Strategy for Derbyshire. The second meeting of the forum, held on 30th March 2012, was an opportunity for partners to hear about how the draft priorities were established and to feed in their views. The event was attended by 86 individuals (see appendix 1 for full list of attendees).

The following priorities and key areas of focus (in bold) were presented for discussion and attendees were asked to consider the following questions.

- Is the priority right and is the focus right?
- Are we already doing a lot either individually or in partnership to meet the priority?
- What more could we do (in partnership)?
- How can we co-ordinate this better?
- What are the barriers to achieving this?
- How can we overcome them collectively?

Draft Health and Wellbeing Priorities

- Improve health and wellbeing in early years. Every child fit to learn and attain the highest levels of literacy. **Focus on early identification and intervention of vulnerable children and families (including children with disabilities)**

- Promote healthy lifestyles by preventing and reducing harmful alcohol consumption, obesity, physical inactivity, smoking and sexual ill-health. **Focus on preventing and reducing alcohol misuse, obesity and physical inactivity**

- Promote the independence of all people living with long term conditions and their carers. **Focus on community based support, self-care and care close to home, including increased use of evidence-based telehealth and telecare**

- Improve emotional and mental ill-health and provide increased access to mental health services. **Focus on improving access to the full range of evidence-based psychological therapies (services that offer treatments for depression and anxiety disorders and other complex mental health problems)**

- Improve health and wellbeing of older people and promote independence into old age. **Focus on strengthening integrated working (pathways/referral mechanisms etc) between health and social care providers and housing-related support services (LAs/registered social landlords/voluntary sector)**

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

Common challenges

Though the five priorities were addressed separately, the following issues were common to all discussions.

- **Communication, education and motivating people to change** – Encouraging people to take responsibility for their health and motivating individuals to change their behaviour are significant challenges which could be more effectively tackled through partnership working. In particular there are opportunities to better utilise the frontline workforce of all partner organisations to improve understanding of communities and more effectively promote health related messages. A culture change is essential, to reduce dependency on NHS and combat the perception that the government will look after everyone.

- **Understanding, skills and expertise among partners' staff** – Beyond communication, there is a need for partners to understand the health agenda alongside their own priorities. Partners could work together to ensure staff from all partner organisations are trained and briefed appropriately to tackle health and wellbeing issues (which have a knock on effect on many other problems).

- **The geography of Derbyshire** – The consistency of services available and access to services cause problems for the delivery of health services in Derbyshire, in particular individuals' access to transport. Partners could work together to join up existing services so that people can find it easier to access services and partners can achieve greater efficiencies.

- **Future housing provision** – Decent housing is fundamental to good health and partners could assist in sharing information which will help plan for future housing which is appropriate to individuals' need (in particular those with long term limiting illness and older people)

- **Community support –** The fragmentation of communities and consequent lack of informal support has a significant impact on health and wellbeing. Both young and older people would benefit from a partnership approach which recognised the importance of informal local networks, carers, groups and volunteers etc.

- **Consistency of service provision** – Linked to the above point, short term funding for community based support and health services is a barrier to improving health.

- **Focus on prevention** – Underpinning all the above points is the need for partners to focus on preventing the causes of ill health (in particular poverty, literacy and housing) wherever possible rather than treating the symptoms.

Summary of group discussions on high-level priorities

The following section summarises the discussions which took place between partners on each of the five health and wellbeing priorities.

Improve health and wellbeing in early years. Every child fit to learn and attain the highest levels of literacy. **Focus on early identification and intervention of vulnerable children and families (including children with disabilities)**

All groups commented on the wording of the priority, in particular the specific reference to literacy. It was suggested that the emphasis on literacy in the overarching priorities should be re-considered, and that reaching optimum levels of capability should be the aim. One group suggested that the wording be changed to **'ready to learn and fully develop their potential communication, language and literacy skills'**. It was also felt that a reference to emotional wellbeing was needed. Young carers should be included and all children should be the focus of the priority not just the under 5's. Partners felt strongly that children should be prioritised to ensure their needs are met.

Provision and quality of services

There is a need to tackle the issue of services pulling out at critical times and outcomes deteriorating. Children should not be allowed to 'fall through the net'. Tackling skill shortages in staff to effect change with hard to reach families is also important, in particular the need to raise aspirations among particular communities (and all young people) as this often becomes self-fulfilling. The family nurse partnership model provides a potential way forward. A lack of engagement with specialist services for fear of having children removed is a major barrier to reaching this target. The reputation of social workers needs addressing through education in schools.

Support in communities

Partners felt that there is a need to consider using communities in building strength in communities - not just helping families. Children's services could think more widely about the resources available within a community, e.g. forest schools. Children's Centres could be better utilised as an outlet for children's primary health care. This would also tackle the under-use of children's centres by the most vulnerable groups.

Family support

Partners agreed that there is a need to tackle the obesity problem in children by tackling parents with similar difficulties. How you engage fathers is important in improving outcomes for children and the best practice examples identified and need to be built on. Targeting effective sex education is essential in secondary schools in order to tackle teenage pregnancies and deprivation cycles from repeating.

Measuring success

Additionally attendees highlighted the problem of measuring success, particularly because children develop at different rates.

Promote healthy lifestyles by preventing and reducing harmful alcohol consumption, obesity, physical inactivity, smoking and sexual ill-health. **Focus on preventing and reducing alcohol misuse, obesity and physical inactivity**

Overall, partners noted that the three areas of focus for this priority are all related to poverty and linked to poor literacy levels. These two bigger problems must be also tackled in order to achieve healthier lifestyles.

In terms of the priority wording, it was suggested that the word 'recovery' should be including in overall priority. However there may be many different interpretations, so perhaps the principle is required rather than the word.

Communication, education and motivation to change

Communication and education were areas where partners felt strongly that a partnership approach could improve health outcomes. People need to be able to access services, understand what will improve their health and be motivated to change. Partnership working is required to promote messages, especially to 'hard to reach' groups. Partners should use existing groups and organisations to communicate and publicise events and services.

Communications need to appeal to different audiences and be appropriate for different audiences, e.g. consider the format of information (and support available) for those with poor literacy, mental health issues and learning difficulties. Information should not be too clinical. It is also important to deliver messages differently to different groups (e.g. people on mental health drugs can gain weight so messages about calorie intake could offend).

New methods of communication and education are required to deal with people who are in 'denial' about their responsibility towards health. This may require a more community based approach to use local knowledge (speaking directly to people/ asking the right questions) to understand why they do not take responsibility for their health. It may also be important to engage people for different reasons, where the health benefits are secondary (e.g. economic motivations, saving money, cycling). There is a need for people to understand that their health is their responsibility and enable them to help themselves through better education and personal choices. It was noted that 'middle class drinkers' drinking every night don't consider that they have a problem and this needs to be addressed. Also in terms of obesity, partners felt they could work together to improve physical activity levels in children and among those (adults and children) who are very unfit without being obese (e.g. Xbox culture). Linked to this is the need to help people to prepare healthy meals instead of quick ready meals and to education people about portion sizes. It was suggested that businesses could help with this.

Some specific examples of interventions included green gyms (which need to be better promoted), intergenerational activities (e.g. mobility scooters in parks to get different groups involved), positive cultural activities, village games etc. More competition in schools could also be encouraged, to foster an early interest in sport and exercise. The continuity and sustainability of activities, due to funding and other constraints is problematic.

The role of parents and grandparents in educating young people about a healthy lifestyle and providing motivation is crucial and vice versa.

Service provision

Partners noted a lack of consistency in service provision across Derbyshire and Glossop. Programmes need to run year after year not just appear as 'one offs'. The infrastructure to help communities is disappearing, often brought about by funding difficulties. This also affects voluntary and community groups, which are well placed to prevent expensive acute care by intervening at an earlier stage.

Services need to be tailored to individual needs to enable people to move forward depending on their circumstances at that time in their life e.g. getting out of bed for one person, going to college for another, walking to post box for another.

In terms of communication and information, partners could help to make 'Every contact counts' work effectively. All frontline staff across partners should have the information and knowledge to help and provide consistent key messages. This could also be promoted via occupational health and via information clinics in public places such as supermarkets. Expertise could also be cascaded out through existing networks to build up skills in communities, e.g. health trainers.

Although they are not current priorities, partners noted that work must continue on substance misuse, mental health issues and smoking, as they all have links to wider health problems.

There is concern about changes to the delivery of youth services and how this will impact upon the provision of sexual health advice and support. Partners felt strongly that this service must continue as a priority.

The '5 Ways to Wellbeing' project that has been run in the High Peak area has been successful and was given as a good example to follow for promoting and encouraging health and wellbeing.

The Beth Johnson Foundation was also cited as providing a good example of an organisation that has made significant progress in improving people's health and wellbeing. It is a "learning" organisation that operates in the real world, acting as a catalyst for initiatives that support positive ageing and has done a lot of good intergenerational work.

Partners felt that, as part of the lifecycle, 'dying well' needs to be built into the Health and Wellbeing Strategy and needs to run through the other priorities, as it can happen as part of any stage.

Promote the independence of all people living with long term conditions and their carers. **Focus on community based support, self-care and care close to home, including increased use of evidence-based telehealth and telecare**

Service provision and access to services

Partners agreed that the relationship between health and social care professionals needs to be improved and services should be better integrated.

The future impact of a growing population with long term conditions and the need for forward planning of alternative accommodation or adapted existing accommodation suitable for purpose is a significant challenge. Research (utilising the JSNA) is required to understand the future needs of this group, in particular defining who is included and identifying their housing needs. There are concerns about dropping the threshold to access services which means individuals fall out of statutory services and then go into crisis. Also, if day centres disappear older people need a simple system to find alternatives. All partners can help by signposting people to existing services.

In planning future services, a person centred approach is required not condition centred. Choice and control of the service is important, along with good information and understanding of conditions. The cost effectiveness of small funding pots was questioned and the lack of ring fencing of funding for specific needs. There is a significant health promotion role for the voluntary sector. Ideas include a resource database, signposting role, community directory, information and advocacy. There is uncertainty about whether the availability of funding in the Living with Long Term Conditions (LWLTC) Programme (transferred from the Expert Patient Programme).

Best evidence and knowledge of long term conditions needs to be provided at point of diagnosis for a range of conditions. The capacity of services for rehabilitation (stroke/ cardiac) is an important consideration alongside access to (and awareness

of) services among people with learning disabilities. Where appropriate these services should be integrated with mainstream services. Cultural barriers were also mentioned e.g. gypsy, homeless, minority ethnic.

There should be early access to telecare and the opportunity to try out telecare. Telehealth questions about specific equipment should ensure that access criteria ensure the correct patients are targeted. Transaction services need to be improved.

There is concern about the impact financially of people coming off incapacity benefit. Improvements should also be made to discharge planning to ensure integrated pathways out of hospital. A problem was identified about the contact acute/ primary care/ community services.

Self-management and prevention

Partners agreed that there is a need to shift the culture for patient not to be dependent on the NHS. Prevention is too low a priority and services need to promote the self-management of long term conditions. It is important to develop community support services (e.g. role of community matron to facilitate patient to manage their condition, peer support and buddying) to reduce hospital admissions and early discharge. Organised structures need to be put in place to ensure the sustainability of these organisations/groups. People should not be isolated due to their condition. Community support is essential. All professionals need to be better educated about managing conditions.

Support for carers

At time of diagnosis support (practical, emotional, financial) is required for carers to cope/support patients. There should be greater public awareness of the status of carers and an emphasis on funding for their support. Employment law around the personalisation agenda may affect carer employment.
There were also comments from attendees that a greater emphasis needs to be placed upon end of life care for all ages, ensuring that dignity is maintained and choice of place to die should be respected.

Transport

Partners noted that transport and accessibility are key challenges. People must have appropriate transport to access services and alternatives to ambulances, particularly where services are closing. A model in the Cotswolds and Cornwall for co-ordinated emergency transport (including out of hours) was mentioned.

Improve emotional and mental ill-health and provide increased access to mental health services. **Focus on improving access to the full range of evidence-based psychological therapies (services that offer treatments for depression and anxiety disorders and other complex mental health problems)**

Partners agreed that the definition was too medical and clinically focused and suggested the following changes.

- ‘local services that support recovery’ not treatment
- Add equitable and ‘for all ages’
- Use the word wellbeing (or more positive wording) rather than focussing on mental **ill**-health
- Remove the word ‘improving’
- Add prevention and acknowledge carers
- Replace with ‘a variety of interventions’

Partners questioned how the evidence base was developed. There is a need to ensure that current provision i.e. IAPT is fully evaluated and used to influence priorities.

There was a very clear feeling that the focus should be shifted towards prevention. Partnership activities should work towards a pro-active and preventative model. There could be greater partnership working around safeguarding and ensuring consistent provision and definition (e.g. if not ‘severe and enduring’ cases may drop through the net). Partners also suggested an investigation of what support is in place prior to psychological services intervention. Partners should work together to identify community based evidence/outcomes i.e. personalised budgets.

It was suggested that partners could work together to ensure joined up services and full engagement across all ages. Expertise and intelligence needs to be shared more effectively among partners alongside improved training for professionals (e.g. social workers). Training for professionals i.e. social workers is urgently required.

Specifically, it was suggested that crisis team (CAT) intervention could be improved through partnership working. Partners also noted that the current 6-12 week intervention is ineffective.

The following obstacles were highlighted by partners.

- Individual relationships with statutory providers i.e. lack of trust
- Lack of sustainable core funding (funding is short-term and leads to inconsistency in core services)
- Lack of horizon scanning i.e. future epidemic of drug induced psychosis
- Stigma around mental health and lack of awareness and understanding
- Access to services/ no mental health accident and emergency services
- Geographical and ethnic and socio-economic boundaries
- Various problems related to GPs including knowledge and understanding, inconsistency of GP practice boundaries and support from GPs

Improve health and wellbeing of older people and promote independence into old age. **Focus on strengthening integrated working (pathways/ referral mechanisms etc) between health and social care providers and housing-related support services (LAs/ registered social landlords/ voluntary sector)**

Partners felt that the priority needs to include ‘care’, as some people are very independent and just need care. There are also many who are healthy but still required care. It was suggested that the priority is a bit narrow and should be wider than just health and housing. If it were extended to community and voluntary sector

groups and networks, cultural and leisure activities etc this would help to make stronger communities.
The statement should be applicable to all settings such as hospitals and care homes where isolation and dignity are also important issues for older people.

Support in the community

Partners noted that loneliness is a bigger killer in over 75s than smoking and that neighbourliness and informal caring are extremely important in improving the health and wellbeing of older people. There was a great emphasis on community based support. For example, the library service take books to older people and this may be the only person they see. Some older people never have visitors. A system of carers, led by GP/ consultant should be put in place. There should be a person responsible for older people, such as the person who visits daily.

There needs to be recognition that the state cannot provide everything. There is a need to use the energy and capability in communities as there is knowledge in communities to support people. In Europe every town has a community centre and is community focussed. Children believe that the Government looks after everyone.

One of the barriers to improving community based support is a lack of consistent and continuous funding. Many community groups cannot access core funding, they can only apply for funding for specific projects. The Community and Voluntary Sector is best placed to provide this support but the statutory sector should recognise that it is fragile due to funding and ageing volunteers. There is a need to ensure that people with local level support needs have the right support in the community, as they currently do not receive a service.

Intergenerational projects were felt to be important, to benefit both older people and young families. Older people spend too much time at home as their children move away and young families also lack support without older relatives nearby. The demographics of Derbyshire show that the percentage of 20-40 year olds is below the national average. In the future this will affect levels of support available. An example was given where is some parts of the country people can let part of their house to a younger person. In London some people let parts of their garden to other to use as an allotment. All people should be safe but partners believed that unnecessary bureaucracy/ health and safety/ CRB checks etc often prevented informal relationships and community projects from developing (e.g. Community Transport encouraging young people to help older people who may need assistance to get around town). Some areas (e.g. Bolsover) do not have a befriending service. Patient Participation Groups could offer volunteers to visit older people. Partners felt that it was very important to continue to provide support and advice to carers of elderly relatives.

Prevention

Prevention should be prioritised and funded e.g. exercise, health and social activities, trainers and more intervention Arts projects help to improve health and wellbeing particularly for older people and this work is currently being embedded.

Green spaces and walking groups are important – Walks for Health and Next Steps were funded with £60,000 of Choosing Health money from the PCT – this ceases March 2013. Falls prevention advice, lunch clubs and other support can be signposted via First Contact. First Contact should be included as part of the strategy, it needs to be a community level. All partners can help to promote this service.

Service provision

Partners agreed that services need to be tailored to individual needs and appropriate for diverse communities (e.g. not everyone wants a luncheon club). Many don't access services because they are unaware of what is on offer. People feel better if they can choose their own service. Some people will not take a free service, but are happy to pay.

Integrating services means different solutions for different parts of Derbyshire. All partners need to know about all services (e.g. housing options, First Contact) through a shared information source to successfully signpost.

Current services are patchy and there needs to be a minimum basic service developed to ensure that patients are not left in hospital. Funding in areas has been short term and not joined up, which has left people with low aspirations.

There is a need to assess the capacity of care homes (as many are closing) to ensure capacity is adequate and dignity in care is achieved. Partners asked if the County Council has any say in the running of private care homes. A strategy on care homes may be required.

Ways to communicate

Information on services should be marketed more widely in places like GPs surgeries. Marketing needs to be professional and recognise that many older people don't have the internet. Flu jab clinics could provide the opportunity to inform older people about services. Voluntary and community sector provide lots of support. DCC Cultural and Community Services are promoting Health Zones in Libraries, a model which could be replicated elsewhere.

Housing and transport

Focus is required on strengthening integrated working between health and social care providers and housing-related support services to ensure older people live in an 'appropriate home'. New housing needs to be appropriate for older people and a choice is required. Large homes which are difficult to maintain cause ill health and ill health can cause poor housing conditions. A culture shift is required to assess housing if it is not suitable, not everyone wants to go into sheltered housing. Housing needs to be age appropriate and built to enable independence. Very little 'affordable housing' is built with these needs in mind.

People aged 80+ are unlikely to be driving so in Derbyshire transport is an issue. Concern was raised over the future of subsidised bus services.

Appendix 1 - Attendees

Steve	Allinson	NHS Tameside and Glossop Clinical Commissioning Group
Barbara	Arrandale	Chesterfield Walking for Health
Philip	Arrandale	Chesterfield Walking for Health
Cathy	Ayrton	DCC - Adult Care
Rachel	Bassett-Darby	Rethink Mental Illness
Bryan	Bennett	Derbyshire Fire & Rescue Service
Phil	Binding	Mental Health Action Group Co-ordinators
Margaret	Blount	Derbyshire Sport
Tim	Braund	Derbyshire Dales District Council
Sarah	Burkinshaw	DCC - CAYA
Mick	Burrows	Derbyshire Drug & Alcohol Action Team
Martin	Cassidy	Erewash Clinical Commissioning Group
Debbie	Chesterman	Walking for Health South Derbyshire, Amber Valley & Erewash
Nick	Chischniak	Derbyshire & Nottinghamshire Chamber of Commerce
Patrica	Coates-Walker	AIM Awards (OCNEMR)
Assistant Chief Constable Dee	Collins	Derbyshire Constabulary
Jodie	Cook	Bolsover Community Voluntary Partnership
Alexander	Cope	
Professor Guy	Daly	University of Derby
Shirley	Davidson	First Taste
Edwina	Edwards	Bakewell and Eyam Community Transport
Pete	Edwards	Erewash CVS
Dorothy	Feldman	Hardwick Health
Lee	Fletcher	Metropolitan Care & Support
Peter	Frakes	Derbyshire Older People's Advisory Group
Mike	Garner	Relate Derby
Gill	Geddes	Volunteer Centre Derbyshire Dales
Jackie	Goacher	Amber Valley Borough Council
Joanne	Goodison	Derbyshire Carers Association
Judy	Gould	Peak District National Park Authority
Lynn	Gradwell	Barnardo's
Emma	Hagger	Derbyshire Dales, Amber Valley & Erewash Citizens Advice Bureau
Cllr Carol	Hart	DCC - Elected Member
Steve	Helps	Derbyshire Fire & Rescue Service
Kathryn	Henderson	Derbyshire Community Health Services
Jane	Hicken	NHS Derbyshire County
Joanne	Illingworth	Heanor Development Trust
Rachel	Ineson	MacIntyre Lifelong Learning
Sharron	James	Rethink Mental Illness
Roger	Kerry	NDVA
Angela	Kerry	Southern Derbyshire Voluntary Sector Mental Health Forum
Angela	Kirkham	Derbyshire Sport
David	Lowe	DCC – Policy & Community Safety
Adrian	Lunn	MacIntyre Lifelong Learning
Jacqui	Marsh	Alzheimer's Society Derbyshire
Kirstie	Matkin	DCC - Cultural & Community
Mary	McElvaney	DCC - Adult Care
Jill	Meads	Clowne and District Community Transport
Stephen	Minter	High Peak CAB
Kirk	Monk	Amber Valley Borough Council

David	Moorby	MacIntyre Lifelong Learning
Dr Andrew	Mott	Southern Derbyshire Clinical Commissioning Group
Maureen	Murfin	NHS Derbyshire County
John	O'Brien	Hearing Help Amber Valley
Natalie	Price	Bolsover Local Strategic Partnership
Pam	Purdue	North Derbyshire Clinical Commissioning Group
Angela	Quinn	Amber Valley CVS
Debbie	Race	Derbyshire Carers (LD)
Rona	Rawson	Derbyshire Federation for Mental Health
Brian	Redding	DCC - Youth Offending
Helena	Reynolds	DCC - Cultural & Community
Nikki	Rhodes	Derbyshire Voice
Karen	Rigg	Volunteer Centre Glossop
Karen	Robinson	Sight Support Derbyshire
Alison	Scott	Derbyshire Alcohol Advisory Service
Mark	Self	Derbyshire Probation Trust
Andy	Shooter	Community Sports Trust
Cllr Chris	Short	Amber Valley Borough Council
Jonathan	Simcock	Derbyshire Dales CVS
John	Simmons	Derbyshire Older People's Advisory Group
Honor	Simpson	Making Space
Sheila	Smith	Chesterfield Royal Hospital NHS Foundation Trust
Paul	Smith	Glossop Community Transport
Vicky	Smyth	South Derbyshire District Council
Siobhan	Spencer	Derbyshire Gypsy Liason Group
Jackie	Spencer	South Derbyshire Citizens Advice Bureau
Lesley	Stevens	Derbyshire Dales & High Peak LSP
Robert	Taylour	DCC - Cultural & Community
Allison	Thomas	DCC - Env Services
David	Timcke	NDVA & LINk Co-host
Lynn	Tory	Relate Chesterfield
Rachel	Toseland	Golding House
Sarah	Wainwright	Framework Derbyshire Accommodation, Ressettlement and Training Support
Kathy	Webster	NHS Derbyshire County
Cllr Anne	Western	DCC - Elected Member
Pam	Wood	South Derbyshire CVS
Judith	Woolley	Heanor & District 50+ Forum